Goal: Reduce the number of adults who develop chronic diseases and slow the progression of existing chronic diseases

Objective 1: Increase by 20% the number of adults participating in chronic disease prevention and management programs by December 2018.
Strategy 1: Provide education to individuals on identifying and preventing chronic disease.

Activities	Outcome Measure	Time Line	Responsible Team Members	Completed
S1.A Identify existing chronic disease activities and resources. (ie. screenings, programs) ➢ Compile list of existing programs. ➢ Compile list of gaps/ needs for programs	Completed list of existing resources and gaps	March 2014	**Lead** – BCHD **Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Area Agency on Aging	
S1.B Promote existing programs and services ➢ Refer clients/customers to programs that may be of interest or benefit ➢ Post promotional material on webpage and Facebook ➢ Promote programs/services at outreach events	Promotional Materials available on agency webpages Track number of referrals made and promotional materials distributed	December 2014	**Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Bay County Health Department, Area Agency on Aging	
S1.C Attend various outreach events providing information on chronic diseases	Number of outreach events attended Number of educational materials distributed	December 2014	**Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Bay County Health Department	
S1.D Develop a media campaign ➢ News Releases, Facebook, PSA's	News Releases created and sent to media outlets Monthly Facebook posts	December 2014	**Lead** – BCHD **Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Bay County Health Department	
S1.E Implement chronic disease screenings throughout the year	Number of screenings held Collect aggregate data on participants	December 2014	**Lead** – McLaren Bay Region **Key Partners** – McLaren Bay Special Care	

Goal: Reduce the number of adults who develop chronic diseases and slow the progression of existing chronic diseases

Objective 1: Increase by 20% the number of adults participating in chronic disease prevention and management programs by December 2018.
Strategy 2: Provide education to individuals on ways to better manage chronic diseases

Activities	Outcome Measure	Time Line	Responsible Team Members	Completed
S2.A Identify existing chronic disease management programs. ➢ Compile list of existing programs. ➢ Compile list of gaps/needs	Completed list of existing resources and gaps	March 2014	**Key Partners** – HSCC, McLaren Bay Region, McLaren Bay Special Care, Heartland, Bay County Health Department, Area Agency on Aging	
S2.B Promote existing programs and services ➢ Refer clients/customers to programs that may be of interest or benefit ➢ Post promotional material on webpage and Facebook ➢ Promote programs/services at outreach events	Promotional Materials available on agency webpages Track number of referrals made and promotional materials distributed	December 2014	**Key Partners** – HSCC, McLaren Bay Region, McLaren Bay Special Care, Heartland Bay County Health Department, Area Agency on Aging	
S2.C Attend various outreach events providing information on chronic disease programs	Number of outreach events attended Number of educational materials distributed	December 2014	**Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Bay County Health Department,	

Goal: Reduce the number of adults who develop chronic diseases and slow the progression of existing chronic diseases

Objective 2: Reduce by 10% the number of surveyed adults who say they are not participating in meaningful physical activity and proper nutrition by 2015.
Strategy 1: Identify, promote and provide low cost physical activity and nutrition programs

Activities	Outcome Measure	Time Line	Responsible Team Members	Completed
S1.A Identify existing activities and resources. ➢ Compile list of existing programs. ➢ Compile list of gaps/ needs for programs	Completed list of existing resources and gaps	March 2014	**Lead** – BCHD **Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Region 7 AAA, DOA	
S1.B Promote existing programs and services ➢ Refer clients/customers to programs that may be of interest or benefit ➢ Post promotional material on webpage and Facebook ➢ Promote programs/services at outreach events	Promotional Materials available on agency webpages Track number of referrals made and promotional materials distributed	December 2014	**Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Region 7 AAA, DOA, BCHD	
S1.C Provide/participate in family/community Events that incorporate interactive learning activities.	Number of outreach events attended Number of educational materials distributed	December 2014	**Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Region 7 AAA, DOA, BCHD	
S1.D Develop a media campaign ➢ News Releases, Facebook, PSA's	News Releases created and sent to media outlets Monthly Facebook posts	December 2014	**Lead** – BCHD **Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Region 7 AAA, DOA	
S1.E Cooking demos in conjunction with other community events	Number of cooking demos held Collect aggregate data on participants	December 2014	**Lead** – Division on Aging **Key Partners** – McLaren Bay Region, McLaren Bay Special Care, Heartland, Region 7 AAA, DOA	

Goal: Reduce the number of adults who develop chronic diseases and slow the progression of existing chronic diseases

Objective 1: Increase by 20% the number of adults participating in chronic disease prevention and management programs by December 2018.
Objective 2: Reduce by 10% the number of surveyed adults who say they are not participating in meaningful physical activity and proper nutrition by 2015.
Strategy 3: Develop additional community-based partnerships.

Activities	Outcome Measure	Time Line	Responsible Team Members	Completed
S3.A Collaborate with HHSC to communicate need to work together to develop and facilitate needed programs /services ➢ Put Healthy People Healthy Bay on the HSCC meeting Agenda	HPHB representation at HSCC meetings	December 2014	**Key Partners** – HSCC, Bay County Health Department	
S3.B Invite other community organizations to be part of HPHB Refer clients/customers to programs that may be of interest or benefit ➢ Continue to invite organizations to participate in Healthy People Healthy Bay	Increased representation within HPHB coalition	December 2014	**Key Partners** – HSCC, Bay County Health Department	