# COMPREHENSIVE REGIONAL COMMUNITY HEALTH ASSESSMENT

**PREPARED FOR:** Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties

**PREPARED BY:** COMMON GROUND HEALTH | DECEMBER 2022

Common Ground Health

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Data in this report was pulled during 2021 through March of 2022.
See chart-specific source information.



Cover photo courtesy of VisitFingerLakes.com
Canandaigua Lake, Ontario

# INTRODUCTION

The Prevention Agenda is New York State's blueprint to help improve the health and well-being of its residents and promote health equity through state and local action. Every three years, New York State requests that local health departments and their local hospital systems work together to create a joint community health assessment and improvement plan using the Prevention Agenda guidelines. Local entities must choose two areas in which to focus community improvement efforts during the plan period. Local entities can choose from five priority areas:

1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment
3. Promote Healthy Women, Infants and Children
4. Promote Well-Being and Prevent Mental and Substance Use Disorders
5. Prevent Communicable Diseases

Throughout the cycle, public health and hospital systems value the input and engagement of key partners and community members, who are critical to help determine which priorities are most important to the community members, and what actions ought to be taken to improve the population's health. The following report summarizes pertinent information relating to the above priority areas. It is well known that residents live, work, and seek services beyond their county of residence. The health and well-being of residents in a neighboring county may impact the needs and services in other counties. In addition, collaborative practices such as shared messaging and lessons learned may help to expand the reach and success of like-interventions. It is for this reason that the nine counties in the Finger Lakes Region have further collaborated to complete one comprehensive regional health assessment. Following the comprehensive assessment of the health of the entire region, this report contains a chapter specific to each county in the region. This focused chapter highlights specific needs, including additional demographic indicators, main health challenges and underlying behavioral, political, and built environmental factors contributing to the county's overall health status.

Photo courtesy of Livingston County Department of Health

# KEY FINDINGS

The Finger Lakes region's health has been challenged by a variety of factors and circumstances ranging from demographic changes to public health crises. Addressing these challenges requires creative thinking, careful planning and coordinated action, all of which are described in this community health assessment.

Although the region's population overall is projected to shrink, the region will experience an increase in the number of older adults over the next several years. Projections indicate an 11% increase in the 65+ population over the next five years, which necessitates an increase in capacity for healthcare and social services. The expected increase in older adults, paired with a predicted decline in the number of working age adults locally, will further exacerbate the workforce demands.

Despite the long-standing existence of several unique populations in the region, including migrant farm workers, Amish/Mennonite, Native American and Alaska Natives and refugees, to name a few, researchers have been challenged to collect and interpret data and health statistics on their unique health needs. In addition to these populations, there are other demographic factors which may impact health outcomes and status in any particular county including race, ethnicity, age, income, education and the infrastructure that makes up the built environment. When interpreting the data shared below, which correspond with the five priority areas outlined in the Prevention Agenda, consideration should be made as to how the characteristics of each county may influence the health statistics.

## Chronic Disease

Chronic disease has been a longstanding priority area for many of the counties in the Finger Lakes region. Focus areas such as healthy eating and food security, physical activity, tobacco prevention and preventative care and management have all been areas of concern in the region to varying degrees. In the past, efforts in the region have largely focused on reducing illness, disability and death related to hypertension, tobacco use and secondhand smoke along with reducing obesity in children and adults. In general, the areas for improvement in the Finger Lakes Region revolve around tobacco prevention (specifically e-cigarette/vaping) and chronic disease preventative care and management. On a smaller scale, healthy eating and food security are also areas worth noting. It is important to note that current data do not necessarily include the impact of COVD-19 effects on access to healthy foods and therefore may actually be a larger area of concern than what is depicted in the data.

## Healthy and Safe Environment

A healthy and safe environment may relate to a number of different aspects such as the air we breathe, the water we drink and use for recreation, incidence of interpersonal violence, injuries and more. In light of the growing aging population in the region, it is important to ensure safe home environments free from fall-inducing obstacles. Fall prevention techniques such as balance programs have been popular in the region and have demonstrated an improvement in rates of falls in the 65+ community for several counties. In addition, work-related hospitalizations have steadily decreased over the years. While the majority of residents (75%) in each county indicate feeling safe in their homes, there are some communities with proportionately higher rates of domestic violence and/or homicide mortality that have lower rates of perceived home/neighborhood safety.

## Maternal and Child Health

Maternal and child health are vital to the health of the community. Overall, total births in the region are declining, which is likely in part due to several factors: a decrease in teen pregnancy rates and enhanced education and access to contraceptive options which prevent unplanned pregnancies. The rate of early entrance into prenatal care varies across counties and is lowest in areas with a greater number of Amish and Mennonite populations and those with limited access to obstetric and gynecological providers. In a positive finding, the rates of children receiving the recommended well-child visits and blood lead screenings have increased across all counties in the last ten years. These screenings will aid in early detection of disease or developmental delays, which can be treated and managed at an early stage.

## Mental Well-Being and Substance Use Disorders

Mental well-being and substance use disorders have been areas of improvement for a number of reasons, including as they relate to the opioid epidemic. Also of concern is the pandemic's impact (including isolation, loss of loved ones and disheartening news cycles) on individuals of all ages. The majority of the data reviewed do not yet reflect the impact of the pandemic, but we know anecdotally and have heard from mental hygiene department representatives and 211 call monitoring, that the need for mental health treatment has intensified. Data from 2016 and 2018 indicate an increase in diagnosis of depressive disorders for all nine of the Finger Lakes Region counties. However, it is important to note that an increase in diagnosis is not the only piece of the puzzle; it may also indicate an increased awareness of mental health support available and the reduction of stigma in seeking help. In reality, the data may be depicting a truer estimate than it has in years past. Suicide mortality regional trends revealed a finding consistent with national estimates: rates of suicide increased for the 45+ age group and are higher among males than females. Finally, the rate of opioid overdose deaths has increased over the years, along with an increase in admissions to OASAS programs.

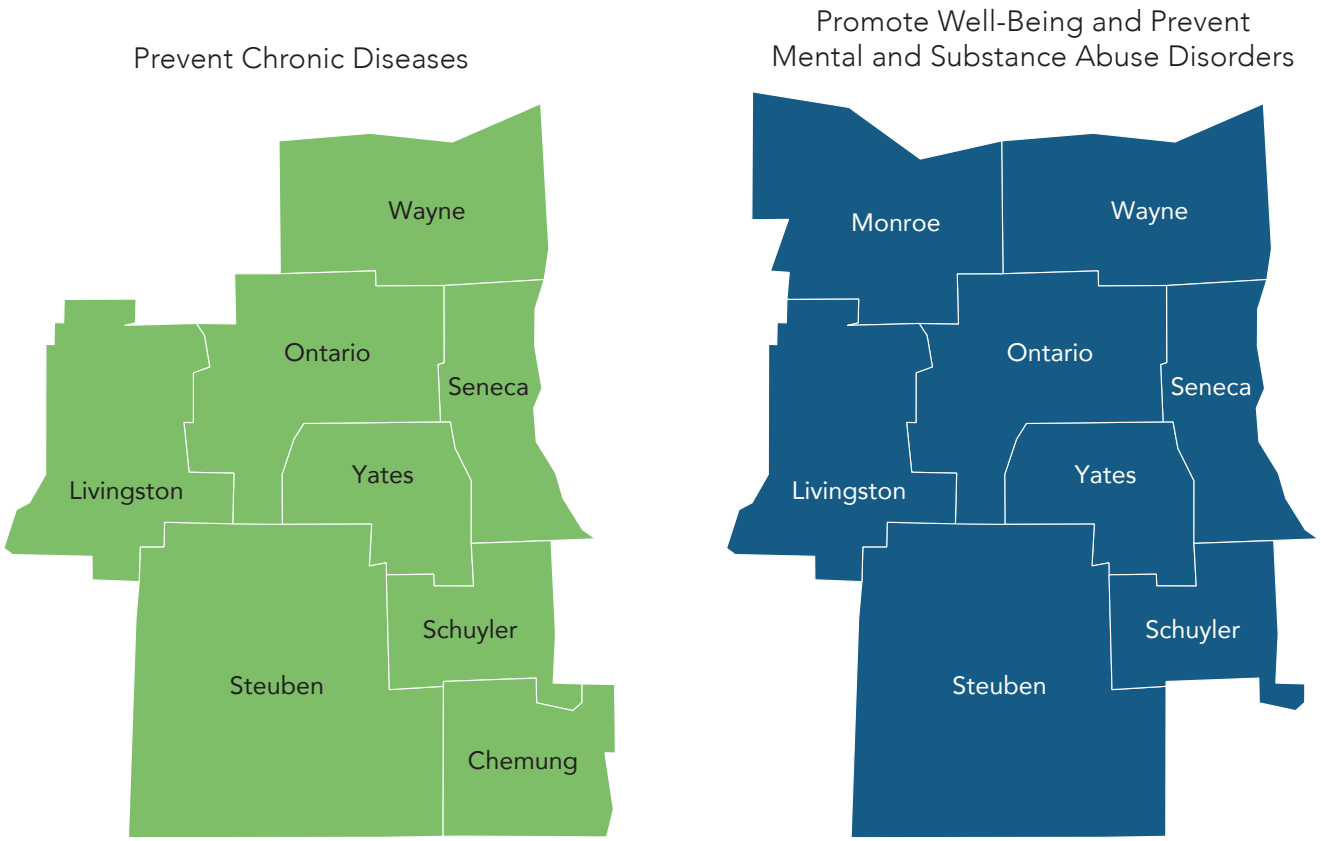
## Communicable Disease

The most prominent communicable disease of note is COVID-19. In recent months, efforts have largely been focused around increasing vaccination rates, particularly in areas where rates were below 50% of the population at the time this assessment was created (in the Finger Lakes Region, mostly the southern tier counties). This in part may be attributed to general vaccine hesitancy (especially in populations that do not typically seek out vaccinations), but also may be due to a lack of access to transportation and health care providers due to the rural nature of these communities. Cases of sexually transmitted infections, including gonorrhea and chlamydia, have increased in the last few years due to either or both an increase in testing or an outbreak in a particular county. The increase in sexually transmitted infections may also be related to the increased incidence of opioid use disorders, as those may lead to sexual behaviors. An interesting phenomenon is the disease prevalence difference among men and women. Women are nearly twice as likely to have a diagnosis of chlamydia as men.

## Regional Priority Alignment

After a detailed review of key metrics and data related to each of the five priority areas, local health departments and hospitals, together with their respective community health improvement workgroups, identified the priority areas displayed in the map below. The most frequently selected priority areas include Promote Well-Being and Prevent Substance Use Disorders (8 out of 9 counties) and Prevent Chronic Disease (8 out of 9 counties):

### Map 1: Priority Area Selection by County



Pier at Lake Ontario, Irondequoit, Monroe County
Photo by Common Ground Health

The top focus areas included Healthy Eating and Food Security and Prevent Mental Health and Substance Use Disorders. To address these areas of need, counties were tasked with identifying solutions to address those health indicators. Below is a summary of the most frequently cited interventions. Collaboration amongst counties may aid in the success of these interventions:

| HEALTHY EATING & FOOD SECURITY | |
|---|---|
| **Goal Area** | **Intervention** |
| Goal 1.2 Increase skills and knowledge to support healthy food and beverage choices | Intervention 1.0.4 Multi-component school-based obesity prevention interventions |
| Goal 1.3 Increase food security | Intervention 1.0.6 Screen for food insecurity, facilitate and actively support referral |

| PREVENT MENTAL HEALTH & SUBSTANCE USE DISORDERS | |
|---|---|
| **Goal Area** | **Intervention** |
| Goal 2.2 Prevent opioid and other substance misuse and deaths | Intervention 2.2.4 Build support systems to care for opioid users or at risk of an overdose |
| Goal 2.4 Reduce the prevalence of major depressive disorders | Intervention 2.4.2 Strengthening resources for families and caregivers |
| Goal 2.5 Prevent suicides | Intervention 2.5.4 Identify and support people at risk: Gatekeeper Training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, postvention, safe reporting and messaging about suicides |

Courtesy of Finger Lakes Tourism Alliance

## Regional Assets and Resources to be Mobilized

The Finger Lakes region has extensive experience in collaboration and coordination among its partners. To support the Prevention Agenda efforts, all hospitals and public health departments have several key organizations, programs and initiatives to leverage for success. There are two designated agencies that promote and facilitate collaboration among the region: Pivital Public Health Partnership
(previously, the S2AY Rural Health Network) and Common Ground Health.

### Pivital Public Health Partnership

Pivital Public Health Partnership is a collaboration of eight local health departments including Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties. The network focuses on improving the health and well-being of Finger Lakes residents by promoting health equity in populations who experience disparities.

### Common Ground Health

Common Ground Health covers the same geographic area as Pivital, with the addition of Monroe County. The agency brings together leaders from health care, business, education and other sectors to find common ground on health challenges and bring attention to health inequities based on geography, socio-economic status, race and ethnicity.

Both of these agencies together help support the work of the Community Health Improvement Plan process and continually strive towards highlighting alignment, leveraging shared resources, and creating opportunities for shared learning. With facilitation and coordination by each agency, local leaders are able to regularly meet to discuss health challenges and issues as a team and devise plans towards improving the health of all Finger Lakes residents (via Pivital's Public Health Directors/Board Development Committee and Common Ground Health's quarterly Regional Leadership meeting). Regular discussions regarding challenges in health outcomes and resources take place at both of these meetings.

In addition to the resources available at both Pivital and Common Ground Health, there are regional workgroups and local nonprofit organizations. Pivital has helped in leading regional workgroups designed to address health needs of residents. The workgroups include:

### Regional Opioid Task Force

With funding through the Health Resources and Services Administration (HRSA), the Pivital Public Health Partnership formed a Regional Opioid Task Force to address the opioid epidemic. The Task Force consists of 12 counties (Steuben, Schuyler, Chemung, Ontario, Wayne, Yates, Livingston, Allegany, Genesee, Orleans, Seneca, and Wyoming), spanning from the Southern Tier, throughout the Finger Lakes, and into Western New York. The Task Force's mission is to bring awareness to the community, train and inform providers in evidence-based practices around opioid use, provide access to real-time overdose data, as well as connecting those with substance use disorder to appropriate treatment and support.

The full Task Force, with participation from over 140 individuals, meets on a quarterly basis and has representation from a diverse population including: public health officials, government entities, treatment providers, community coalitions, National Guard counterdrug representatives, and other community members.

## Obesity Regional CHIP Workgroup

One of Pivital Public Health Partnership's Regional Workgroups focus is Child and Adult Obesity and Food Access. In early 2020, members determined that it was important to concentrate on these areas because regionally, the rates were below the New York State Prevention Agenda target.

Moving forward utilizing Results-Based Accountability, the group will work toward improving the statistics around obesity through different programs and community outreach with the local health departments and our partners within this workgroup.

In addition to the Regional CHIP Workgroup, Pivital plans to facilitate a quarterly Public Health Educators' Meeting, which would focus on unified messaging, social media planning, and serve as a platform to share ideas.

Local nonprofit organizations are additional assets and resources that the Finger Lakes region leaders may mobilize when implementing their community health improvement plans.

Though the task is great, these organizations and many other community partners are committed to continue their work of promoting better health outcomes throughout the Finger Lakes region.

Photo courtesy of Livingston County Department of Health

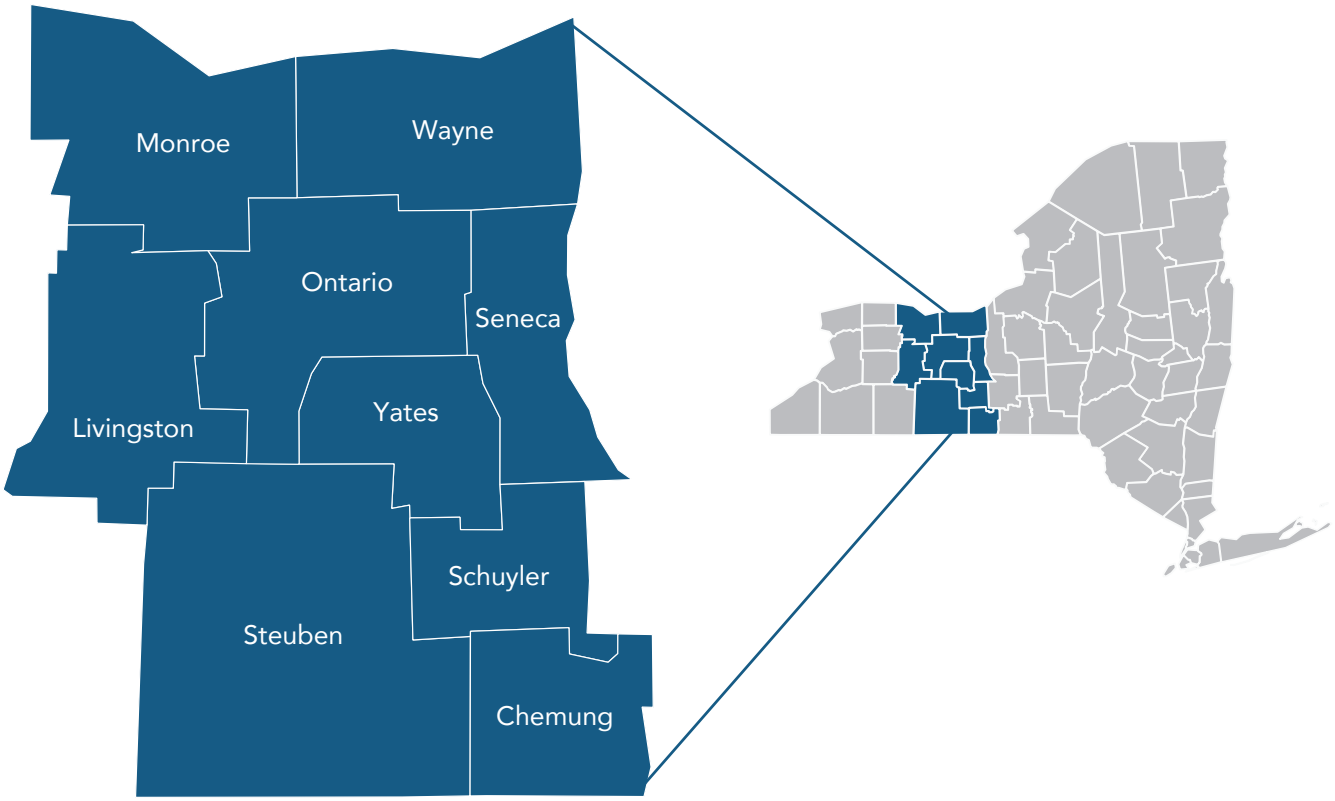
# COMPREHENSIVE REGIONAL COMMUNITY HEALTH ASSESSMENT

## DEMOGRAPHICS

### Community Description: The Finger Lakes Region

Located in the western half of New York State, the Finger Lakes region includes nine counties: Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties (Map 2). The region is home to both rural and urban communities that provide recreational activities that include hiking, skiing, and access to water sports, wineries, museums and historical sites. Larger cities, such as the City of Rochester in Monroe County, the cities of Canandaigua and Geneva in Ontario County, and the City of Elmira in Chemung County attract visitors of all ages to the region. Despite these assets, the region experiences health related issues and illnesses just like many other communities. The following assessment will take a closer look at the health and well-being of residents of the Finger Lakes region as it relates to the New York State Prevention Agenda and its goals and objectives.

#### Map 2: The Finger Lakes Region



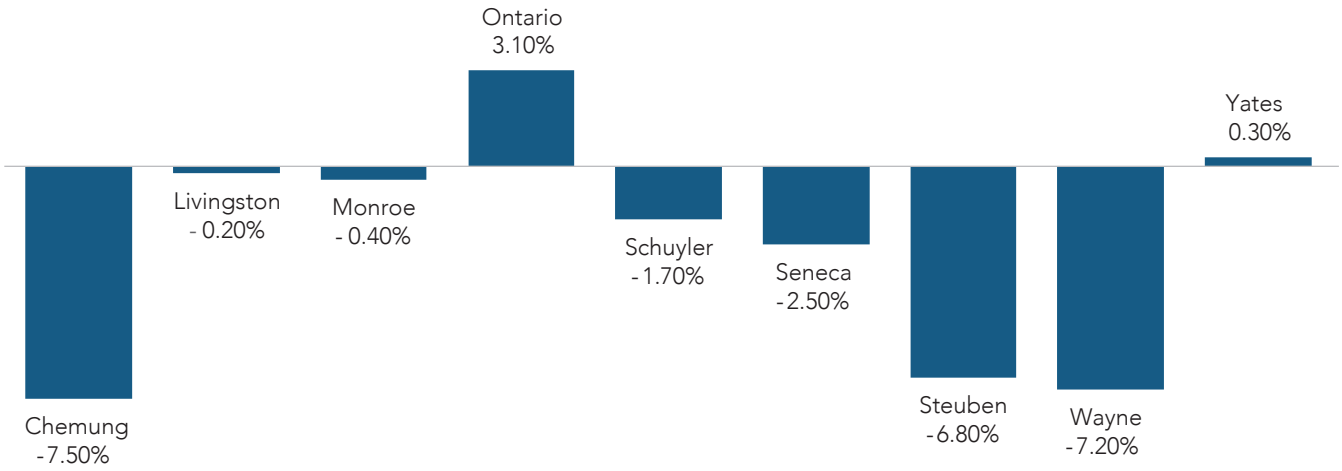
## Population Estimates

There are 1.28 million people living in the Finger Lakes region, an overall estimate that has not changed significantly over the past several years. Estimates projecting into the year 2040 demonstrate a slight decrease in the population by 1.4% or 18,000 residents. Stratified by county, see Figure 1, are the projections over the next twenty years. For the vast majority of counties, we see a decrease in population estimates to varying extents. Some of the largest changes expected are in Chemung, Steuben and Wayne Counties with those counties anticipated to lose nearly 7-7.5% of their populations.

In contrast, there is an anticipated increase in Ontario County's population (3%) over the next two decades. This may be attributed an American Association of Retired Persons (AARP) report issued in 2018 that indicated that the City of Canandaigua was voted one of the top places in the U.S. to live and retire in.[1]

Throughout this report, there are data on health outcomes that show dramatic differences in some of the less-populated counties, such as Yates County. Some of these rate fluctuations may be attributed to small overall numbers that have an outsized effect on the rates.

### Figure 1: Percent Change in Population from 2020 to 2040



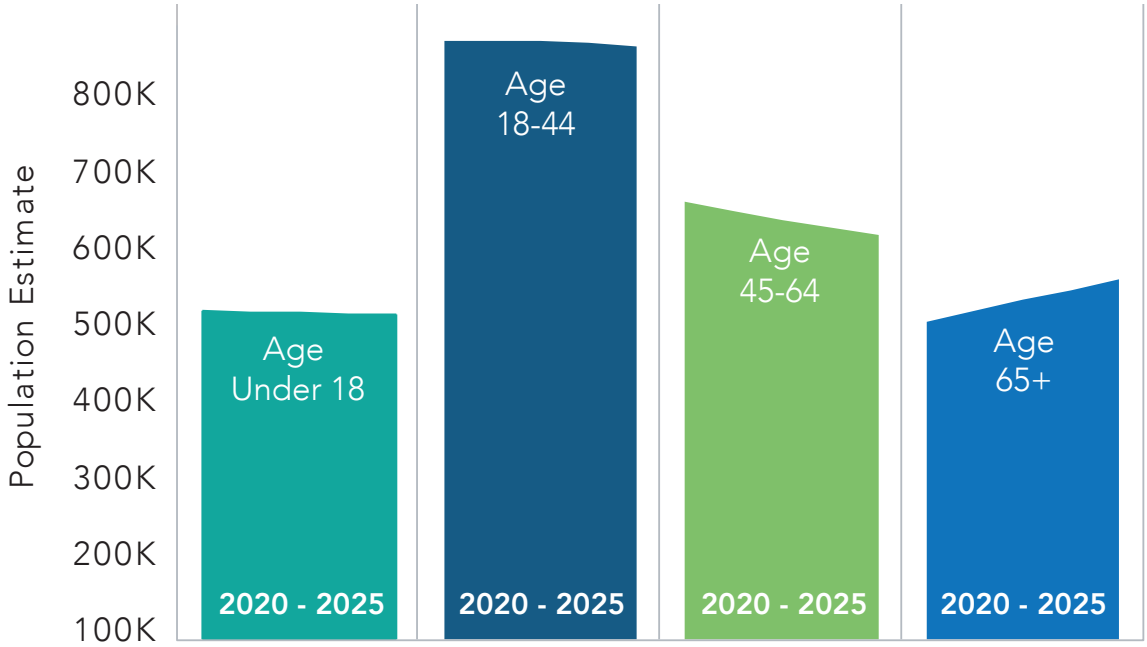

Source: Cornell University Program on Applied Demographics


1. Source: AARP the Magazine, AARP's 10 Best Places to Live for Under $40,000 a Year

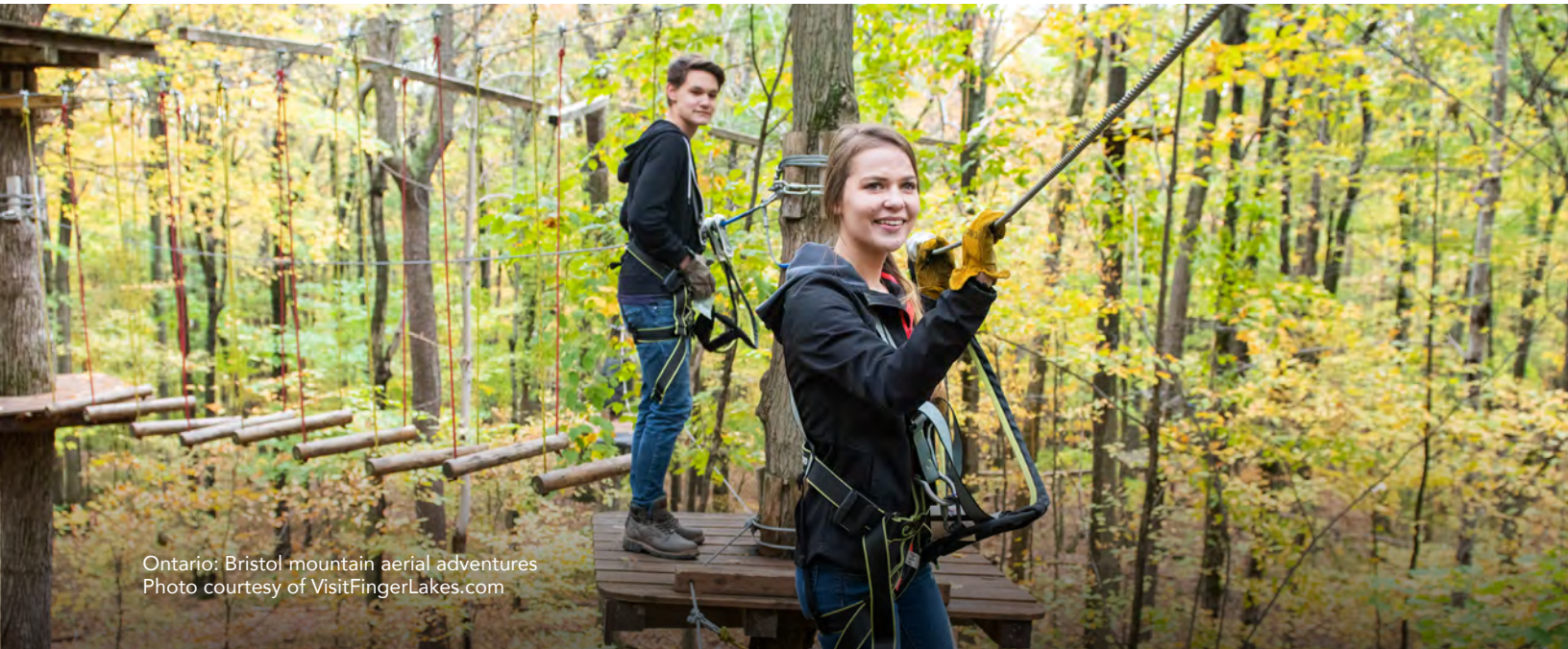
## Age Group

Over the next five years, Cornell University projects an 11% increase in the 65+ population in the region (Figure 2). This increase in the aging population, coupled with a transition to in-home care for the elderly, will place a greater demand for geriatric and chronic disease management on the healthcare community than there has been in years past. These findings are similar across all counties in the region and should be accounted for when planning for future healthcare workforce needs.

### Figure 2: Population Projections by Age Group, Finger Lakes Region




Source: Cornell University Program on Applied Demographics, 2020-2025

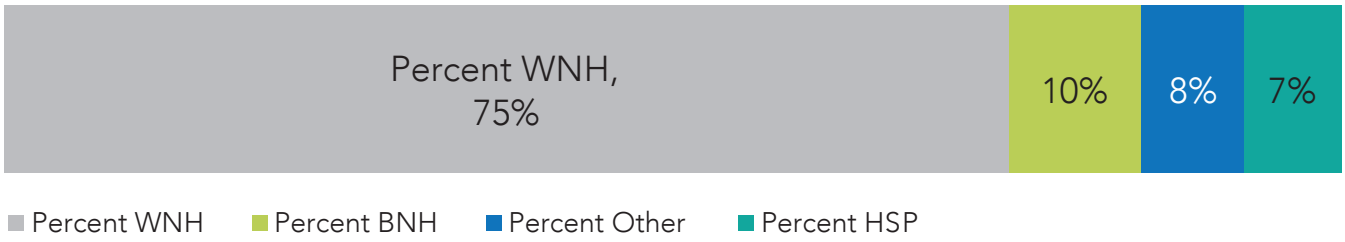


Ontario: Bristol mountain aerial adventures
Photo courtesy of VisitFingerLakes.com

## Race/Ethnicity

Three quarters of the Finger Lakes region population is White Non-Hispanic. Ten percent are Black Non-Hispanic, followed by eight percent 'Other' and seven percent Hispanic (Figure 3).

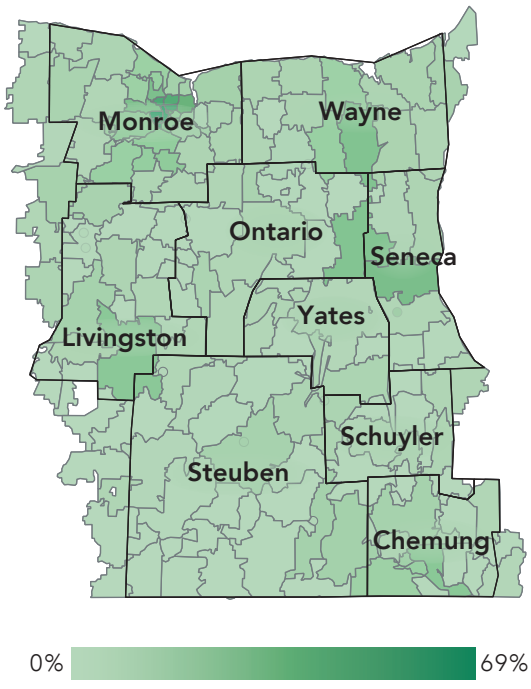
### Figure 3: Race/Ethnicity Population Estimates



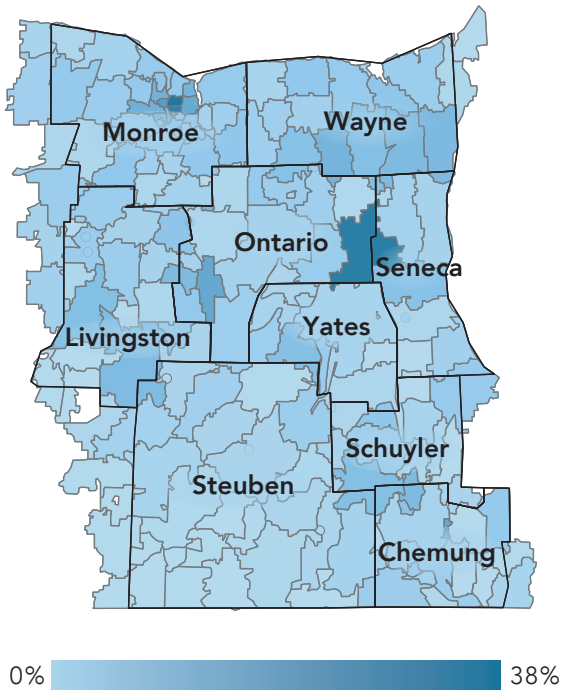

Source: US Census Bureau 2020

Diversity increases in larger cities in the Finger Lakes, including in Rochester (Monroe County), Geneva (Ontario and Seneca Counties), Dansville (Livingston County) and Elmira (Chemung County). Map 3 depicts the percent of each ZIP code's population that are Black Non-Hispanic and Map 4 depicts the percentage of each ZIP code's population that are Hispanic.

### Map 3: Black Non-Hispanic Population by ZIP Code (Percent of Population)




### Map 4: Hispanic Population by ZIP Code (Percent of Population)




Source: US Census Bureau 2020

## Migrant Farm Workers

The 2017 Census of Agriculture reported that, at some point during 2017, there were almost 25,000 workers on farms in the Finger Lakes region. One-third of the workers were unpaid and probably represented family members or coop workers. The vast majority (16,607) were paid workers, but not necessarily in full time or permanent positions. One half of the paid workers were either contract migrant workers or, if on the payroll, worked less than 150 days during the year. Almost 3,000 migrant workers were reported by Wayne County farms. This is the highest in the region followed by Yates County (536 migrant workers reported in 2017).

Almost 20% of the region's farms contracted with migrant farm workers. Because migrant farm workers move from job to job depending on the season, a single migrant worker may be counted by multiple farms, therefore the total number of migrant workers is potentially an over count of individuals (Table 1).

### Table 1: Farms and Hired Workers

| County | Farms with Hired Workers | Farms with Migrant Workers | Hired Farm Labor* | | Migrant Workers** | Unpaid Workers*** |
|---|---|---|---|---|---|---|
| | | | Total | Work <150 days | | |
| Chemung | 90 | 1 | 258 | 150 | (D)† | 438 |
| Livingston | 148 | 12 | 844 | 298 | 131 | 840 |
| Monroe | 148 | 20 | 1,120 | 619 | 256 | 664 |
| Ontario | 223 | 22 | 1,283 | 682 | 293 | 670 |
| Schuyler | 105 | 9 | 527 | 356 | 85 | 461 |
| Seneca | 173 | 21 | 760 | 483 | 248 | 850 |
| Steuben | 333 | 20 | 1,479 | 892 | 151 | 2,041 |
| Wayne | 264 | 126 | 4,169 | 3,046 | 2,924 | 879 |
| Yates | 281 | 52 | 1,543 | 1,147 | 536 | 1,136 |
| **Total Finger Lakes Region** | **1,765** | **283** | **11,983** | **7,673** | **4,624** | **7,979** |

*Hired Farm labor does not include contract/migrant workers
**Migrant farm workers are workers whose employment requires travel that prevents the worker from returning to his or her permanent place of residence the same day
***Unpaid workers includes agricultural workers not on the payroll who performed activities or work on a farm or ranch.
Source: US Department of Agriculture, 2017 Census of Agriculture
† Suppressed to avoid disclosing data for individual farms

A 2007 study conducted in New York found that "poverty, frequent mobility, low literacy, language and cultural barriers impede farmworkers' access to primary health care."[2] Several organizations provide services to the migrant population, including local federally qualified health centers and health departments. However, even though the services are available, seasonal workers have limited time to seek care and, because so many move frequently, follow-up visits or ongoing care for chronic conditions are often intermittent. This may impact some of the health outcomes data explored later in this report.


2. Migrant and Seasonal Farmworkers, Health Care access and HIV/AIDS in this Population, Statewide AIDS Services Delivery Consortium and Advisory Group, May 2007

## Amish/Mennonite

The Amish and Mennonite population are a unique asset to the Finger Lakes region and constitute a significant portion of the farming industry in several communities. Finding accurate and up-to-date data on Amish and Mennonite populations and their health outcomes can be a challenge, especially at the county level. This population often does not respond to surveys such as those conducted by the U.S. Census Bureau. However, Elizabethtown College Amish Studies, The Young Center, collects data on annual population estimates. In New York State, the center identified 59 settlements and 167 districts in the state, which amounts to an estimated 21,725 Amish people.[3] The report also states that in the Finger Lakes region, there are an estimated 3,455 Amish persons with larger subsets located in Jasper and Woodhull, Steuben County, and Romulus and Ovid, Seneca County.[4]

However, these estimates do not include the Mennonite population. Local Mennonite churches also collect information on their members and may share this information with trusted public health officials. The Groffdale Conference Mennonites (Old Order Mennonites), for instance, release an annual map of its congregation. Groffdale Conference Mennonite families span the area between Canandaigua and Seneca Lakes (Yates County) and from Geneva (Ontario and Seneca County) all the way down to Reading, NY (Schuyler County). In 2018, the church reported a total of 697 Groffdale Conference Mennonite households throughout Yates, Ontario, Schuyler and Steuben Counties, the majority of whom reside in Yates County. Important to note, however, is that these data do not include the Crystal Valley Mennonite and Horning Order groups – two additional congregations that are found in the region.

Cultural practices of Amish and Mennonites must be considered when reviewing data and planning health initiatives. It is customary in Amish and Mennonite cultures to practice natural and homeopathic medicine when it comes to family planning, preventative and dental care, vaccinations, etc. Late entrance into prenatal care and home births are common occurrences. Children attend school through eighth grade and learn farming and other trades throughout childhood and adolescence, creating the potential for unintentional and farm-related injuries. Bikes and horse drawn buggies are common forms of transportation and, combined with speeding motor vehicles on rural roads, there is the potential for traffic accidents. Health-related decisions are often based on the attitudes, beliefs and practices of church leadership. These factors, along with anticipated growth in this population, create unique challenges for Public Health practitioners. However, research around the subject of immunization has shown that "in health matters, the Amish are pragmatists. When approached with facts by individuals whom they trust and when immunization [and other care] is easy to obtain, most Amish are willing to be immunized. Knowledge of the Amish culture, flexibility and diligence on the part of the health personnel generally leads to high compliance rates."[5]

## American Indian and Alaska Native population

In 2020 just over 2,400 residents of the Finger Lakes region identified themselves as American Indian and Alaska Native alone. However, it is important to note that this estimate does not include residents who identify as multiple races.[6] The majority of American Indian and Alaska Natives in the Finger Lakes region live in Monroe County (54%) followed by Steuben, Chemung and Ontario County (8% for all three).

3. "Amish Population, 2021." Young Center for Anabaptist and Pietist Studies, Elizabethtown College. http://groups.etown.edu/amishstudies/statistics/population-2021/

4. Amish Population in the United States by State and County, 2021. Statistics were compiled by Edsel Burdge, Jr., Young Center for Anabaptist and Pietist Studies, Elizabethtown College, in cooperation with Joseph F. Donnermeyer, School of Environment and Natural Resources, The Ohio State University, and with assistance from David Luthy, Heritage Historical Library, Aylmer, Ontario.

5. Gertrude Enders Huntington, Chapter 9 Health Care, The Amish and the State, Donald B Kraybill editor

6. Source: U.S. Census Bureau, 2020.

A fact sheet released by the Indian Health Service (IHS) in 2019 stated that American Indians and Alaska Natives die sooner and at higher rates than other Americans in several different categories, including, but not limited to, "chronic liver disease and cirrhosis, diabetes mellitus, chronic lower respiratory disease, unintentional injuries, assault/homicide and intentional self-harm/suicide." The IHS report also indicated that American Indian and Alaska Native residents have a life expectancy of nearly 5.5 years less than all other races in the United States.[7]

These health disparities exist for a number of different reasons but largely correlate back to inadequate educational opportunities, disproportionate rates of poverty, discrimination in the delivery of health services, and the impact of historical intergenerational trauma of experiencing centuries of racial discrimination.[8] The inequities in health outcomes shown in Table 2 speak to the dire need for improved health data collection and surveillance. The imbalance of funding for the Indian Health Service (it is noted in reports that funding for the IHS and Native American health care have historically and continue to be inequitable and unequal in comparison to other federal health care programs) has resulted in an unmet need for adequate medical and public health services for the American Indian and Alaska Native population. The combination of all of these factors has a direct effect on health outcomes, including the incidence of disease and mortality.[7]

## Table 2: Age Adjusted Mortality Disparity Rate per 100,000 Population by Race/Ethnicity**

| | American Indian and Alaska Native (AI/AN) (2009-2011) | U.S. All Races (2010) | Ratio: AI/AN to US All Races |
|---|---|---|---|
| **All Causes** | **999.1** | **747.0** | **1.3** |
| **Alcohol-induced** | 50.5 | 7.6 | 6.6 |
| **Chronic liver disease and cirrhosis** | 42.9 | 9.4 | 4.6 |
| **Diabetes mellitus (diabetes)** | 66 | 20.8 | 3.2 |
| **Accidents (unintentional injuries)*** | 93.7 | 38 | 2.5 |
| **Assault (homicide)** | 11.4 | 5.4 | 2.1 |
| **Influenza and pneumonia** | 26.6 | 15.1 | 1.8 |
| **Drug-induced** | 23.4 | 12.9 | 1.8 |
| **Intentional self-harm (suicide)** | 20.4 | 12.1 | 1.7 |
| **Septicemia (blood poisoning by bacteria)** | 17.3 | 10.6 | 1.6 |
| **Nephritis, nephrotic syndrome (kidney disease)** | 22.4 | 15.3 | 1.5 |

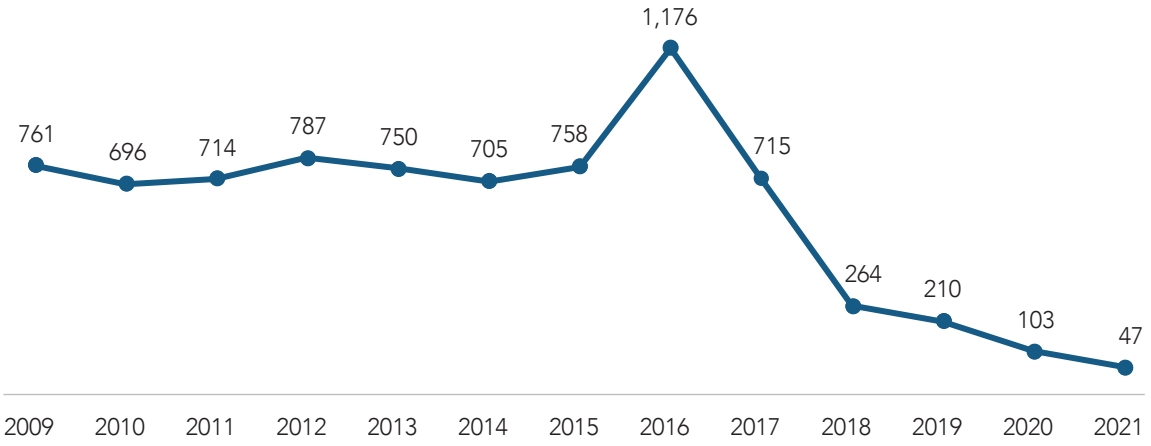
*Unintentional injuries include motor vehicle crashes
**Causes shown are only those with a ratio greater than 1.5. Please see direct source for complete list.
NOTE: Rates are adjusted to compensate for misreporting of American Indian and Alaska Native race on state death certificates. American Indian and Alaska Native age-adjusted death rate columns present data for the 3-year period specified. US All Races columns present data for a one-year period. Rates are based on American Indian and Alaska Native Alone; 2019 census with bridged-race categories.
Source: Indian Health Service, Indian Health Disparities Report, 2009-2011

7. Indian Health Services, Indian Health Disparities, 2019
8. US Commission on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans, 2018

## Refugee populations

The refugee population is a unique population, which requires specific and attentive care. In recent years, Rochester (Monroe County) has opened its doors to a number of refugees, reaching a peak in 2016 of over 1,100 families resettled in the county (Figure 4). Prior to 2017, resettlement rates in the greater Rochester area had been among the highest in New York, just behind Utica and Buffalo. Federal refugee policies enacted over the past several years, coupled with the COVID-19 pandemic, have greatly reduced the number of recent resettlements. It will take several years to rebuild the infrastructure and reestablish the historical rates that were seen in the past decade.

### Figure 4: Number of Refugee Resettlements, Monroe County




Source: Catholic Charities Family and Community Services. Data pulled mid-2021.

Steuben County: Keuka Lake
Photo courtesy of the CorningFingerLakes.com

Table 3 shows that the majority of those that are foreign-born living in the Finger Lakes region have become naturalized US Citizens (57%). The naturalization rate varies by county, from as low as 43 percent in Steuben County to 70 percent in Wayne County. Residents coming from other countries may face significant challenges in adapting to the United States' disease prevention and treatment culture and, as such, should be cared for and tended to in a way that is respectful of and collaborative with the customs and beliefs of their heritage.

## Table 3: Foreign-Born Population Estimates and Naturalization Rate by County

| | Foreign-born population | Percent Naturalized U.S. citizen | Percent Not a U.S. citizen |
|---|---|---|---|
| **Chemung** | 2,567 | 54 | 46 |
| **Livingston** | 2,277 | 44 | 56 |
| **Monroe** | 64,681 | 58 | 42 |
| **Ontario** | 4,134 | 52 | 48 |
| **Schuyler** | 327 | 61 | 39 |
| **Seneca** | 875 | 58 | 42 |
| **Steuben** | 3,094 | 43 | 57 |
| **Wayne** | 2,698 | 70 | 31 |
| **Yates** | 519 | 57 | 43 |

Source: US Census Bureau, 2015-2019 5-Year Estimates

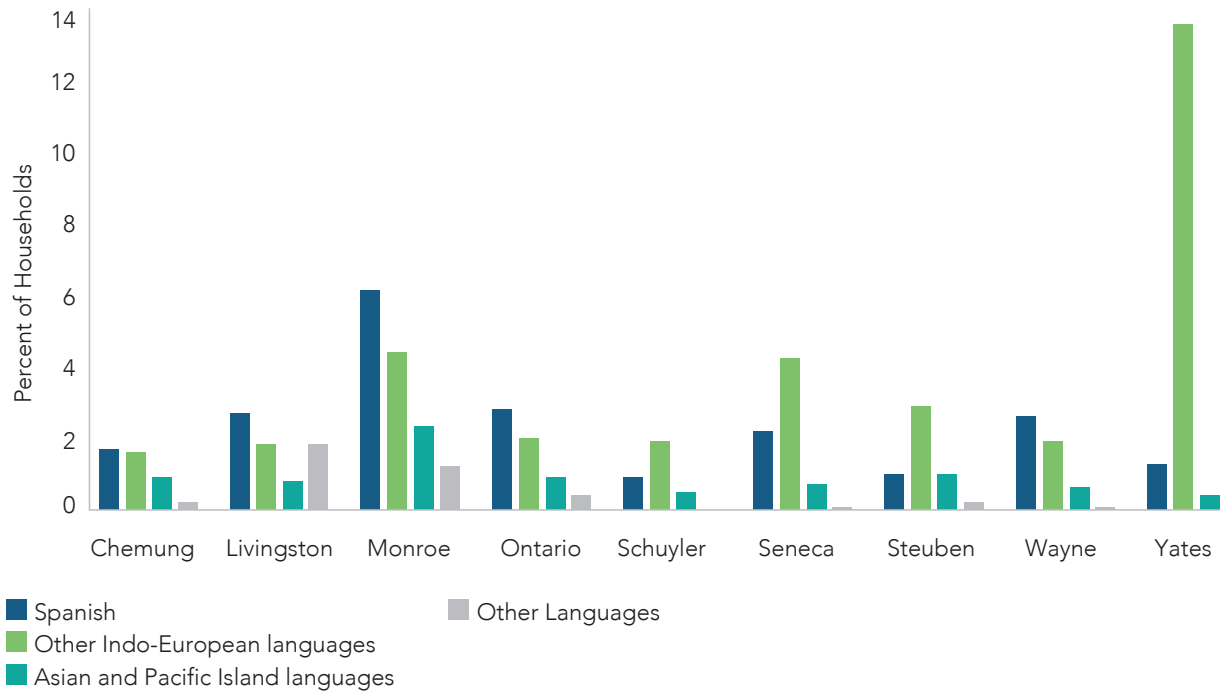
Canandaigua boat houses in winter
Photo courtesy of VisitFingerLakes.com

George Mason University Institute for Immigration Research reports 31% of Rochester's immigrants have immigrated in the last decade (since 2010). The majority of those immigrants are Jamaican (10%) followed by Cuban (7%), Chinese (6%) and Dominican (6%).[9] Providing care for refugee individuals and families can be a challenging and unique experience. Research has documented several challenges to providing refugees healthcare, including basic needs such as English education, orientation to the United States Healthcare System, and the need for cultural sensitivity on the part of providers and interpreters or case managers.[10]

## Household languages

Providers of all types (medical, social service, etc.) should be aware of language and cultural differences when working with patients/clients. Being respectful of a person's cultural practices is important to building a trusting and positive relationship. A system where health providers are culturally responsive can help improve patient health outcomes and quality of care. In addition, it can help to eliminate disparities in outcomes.[11] The majority of residents in the Finger Lakes region speak English, but a small percentage speak limited English (<1.5% of total population per county). Other languages frequently spoken in homes include Spanish, Asian and Pacific Island languages, and other Indo-European languages (Figure 5). In Yates County, it is likely the large percent of other Indo-European languages can be attributed to the Amish and Mennonite populations.

### Figure 5: Percent of Households Speaking a Language Other than English




Source: US Census Bureau, 2015-2019 5-Year Estimates

9. Source: George Mason University Institute for Immigration Research, Immigration Data on Demand (iDod) Report, 2018

10. Kotovicz F, Getzin A, Vo T. Challenges of refugee health care: perspectives of medical interpreters, case managers, and pharmacists. J Patient Cent Res Rev. 2018;5:28-35. doi: 10.17294/2330-0698.1577

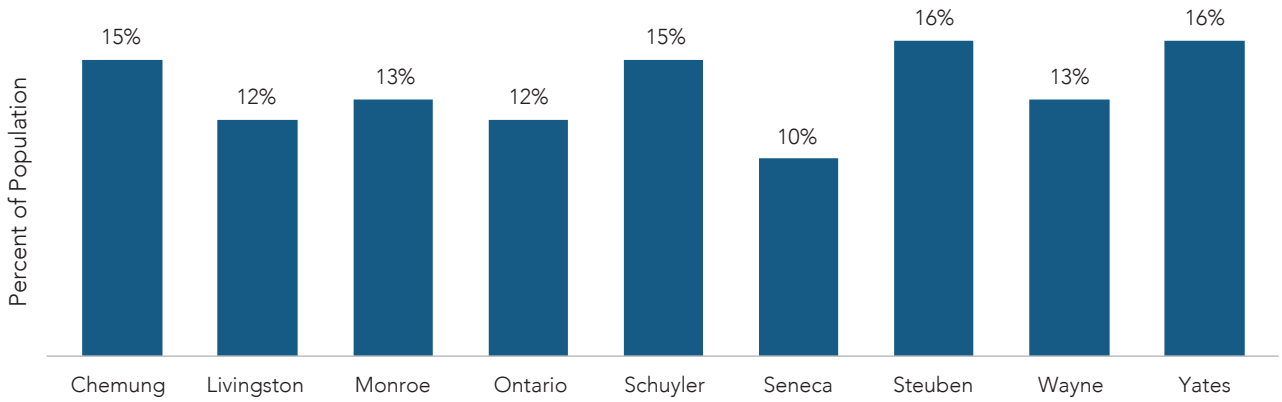
11. Source: Health Policy Institute at Georgetown University, "Cultural Competence in Health Care: Is it important for people with chronic conditions?"

## Disability

Those living with any form of disability (physical, activity or daily functioning impairments) are at greater risk for development of chronic conditions, including obesity, heart disease, and diabetes. Creating a built environment that helps eliminate structural barriers and building a culture of inclusion helps to reduce disparities in health outcomes for the disabled. Doing so requires support from a variety of change initiatives such as policy, system and environmental changes.

In the Finger Lakes region, an average of 13.5% of residents are living with a disability. The rates range from 10% in Seneca County to 16% in Steuben and Yates County (Figure 6).[12]

### Figure 6: Disability Rate by County, Total Population




Source: US Census Bureau 2015-2019 5-Year Estimates

Livingston County, Dansville balloons
Photo courtesy of Livingston County Department of Health

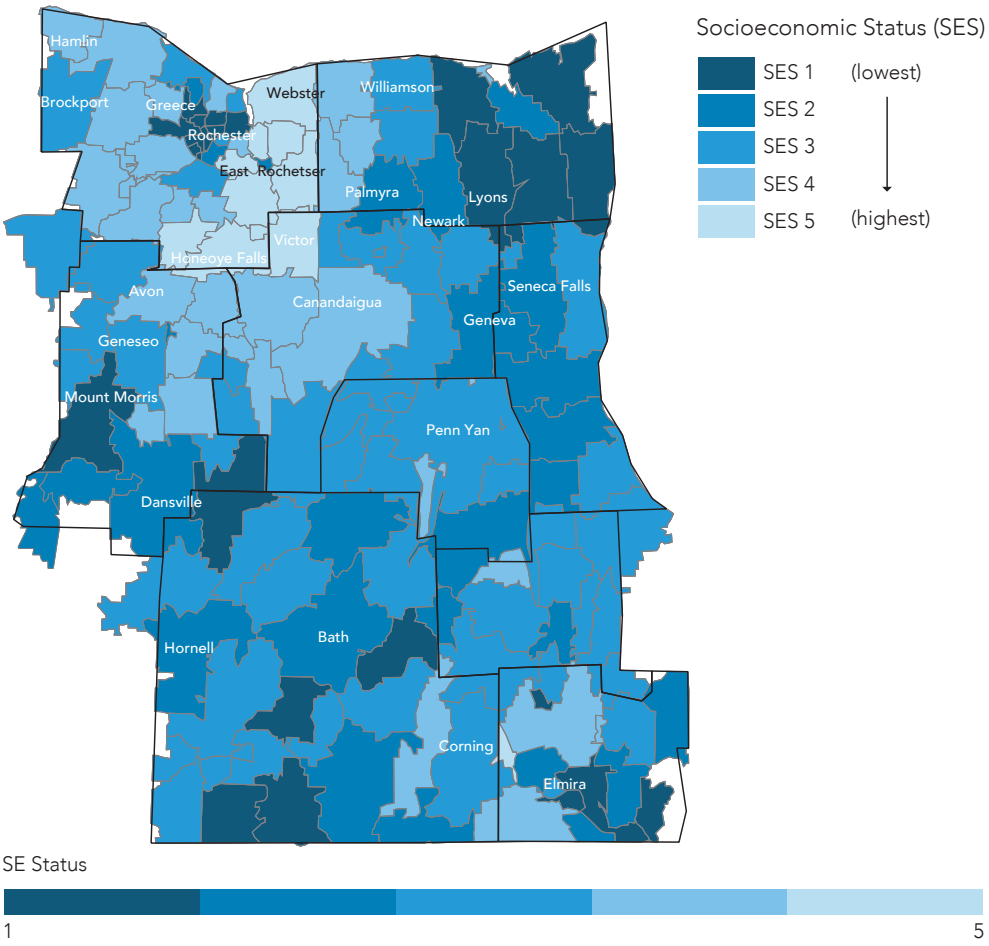
12. Source: US Census Bureau American Community Survey

## Poverty

Socioeconomic status[13] affects several areas of a person's life, including their health status. Data have revealed that low-income families are less likely to receive timely preventative services or have an established regular healthcare provider when compared to families with higher incomes. Map 5 reveals the socioeconomic status by ZIP codes in the Finger Lakes region. Note that almost half of Wayne County was found to be in the two lowest socioeconomic quintiles in the region, and pockets of poverty exist throughout the nine counties such as in Elmira (Chemung County), Wayland and southern Steuben County and Mount Morris (Livingston County).

One of the factors influencing socioeconomic status is income, which is largely driven by employment status. Having a job may afford a person the ability to maintain safe and adequate housing, purchase healthy foods, remain up to date on health visits, and more. Educational attainment is another factor influencing socioeconomic status. The 2019 American Community Survey estimates 27% of Finger Lakes region residents have received a Bachelor's degree or higher, which has increased since 2011 (24%). The prevalence of higher educational attainment in those over the age of 25 is highest in Monroe and Ontario Counties, at 39 and 36 percent, respectively. Research has linked lower Socioeconomic Status with lower academic achievement.

### Map 5: Socioeconomic Status in the Finger Lakes region



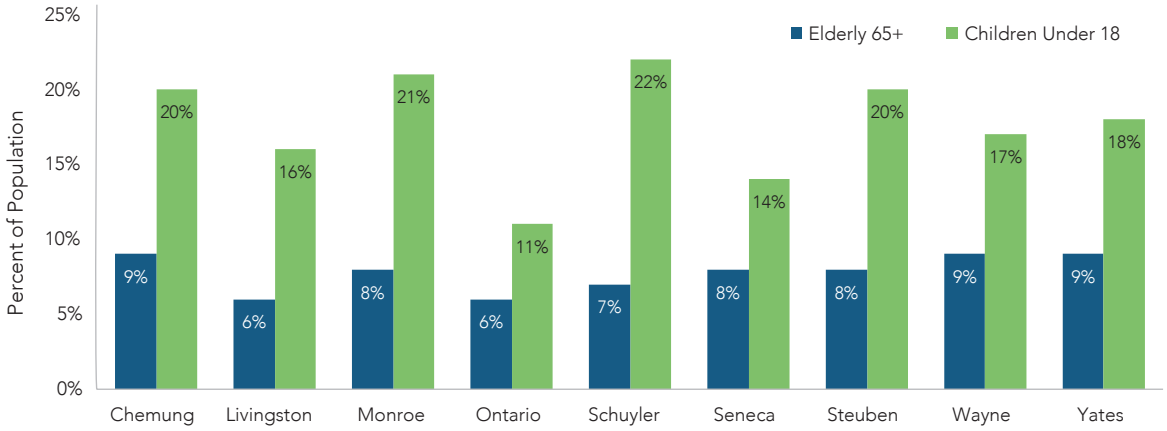

Source: Data provided by US Census Bureau, Analysis completed by Common Ground Health

13. Common Ground Health's estimation of socioeconomic status is developed by ZIP Code, U.S. Census and American Community Survey data. It is based on the average income, average level of education, occupation composition, average value of housing stock, age of the housing stock, a measure of population crowding, percentage of renter-occupied housing, percent of persons paying more the 35% of their income on housing, and percent of children living in single parent households.

Of particular concern are vulnerable populations, such as the elderly living in poverty and youth living in poverty (Figure 7). Research has shown that children living in poverty are more likely to have poor academic achievement, drop out of high school, and are more likely to be unemployed later in life. In addition, children living in poverty are more likely to experience economic hardship in adult years and are more likely be involved in the criminal justice system than children who never experienced poverty first hand.[14]

Additional concerns are about the elderly population, aged 65+, who are living in poverty. Older adults are more likely to live on a fixed income, relying upon Social Security, savings and/or pension plans to support all of their needs. Elderly women are more likely to report living in poverty, or living in higher rates of poverty, as a result of lower retirement incomes due to a variety of reasons, including lower lifetime earnings, time taken off for caregiving, occupational segregation and other issues.

## Figure 7: Percent of Population Living in Poverty, Age Group Stratification




Source: US Censusu Bureau 2015 2019 5 - Year Estimates

Regardless of age group, when stratified by race/ethnicity, poverty rates are even higher for minority populations (Table 4).[15] Black Non-Hispanic and Hispanic persons live in poverty at more than three times the rate of White Non-Hispanics. When considering all of the implications poverty has on health – decreased access to health care, less likelihood to receive timely preventative care, less likelihood of higher education, etc. - it is no wonder we see disparities in health outcomes by race and ethnicity.

## Table 4: Percent of Population Living in Poverty by Race/Ethnicity, Finger Lakes region

| White Non-Hispanic | Black Non-Hispanic | Hispanic |
|---|---|---|
| 9% | 32% | 30% |

Source: US Census Bureau 2015-2019 5-year estimates

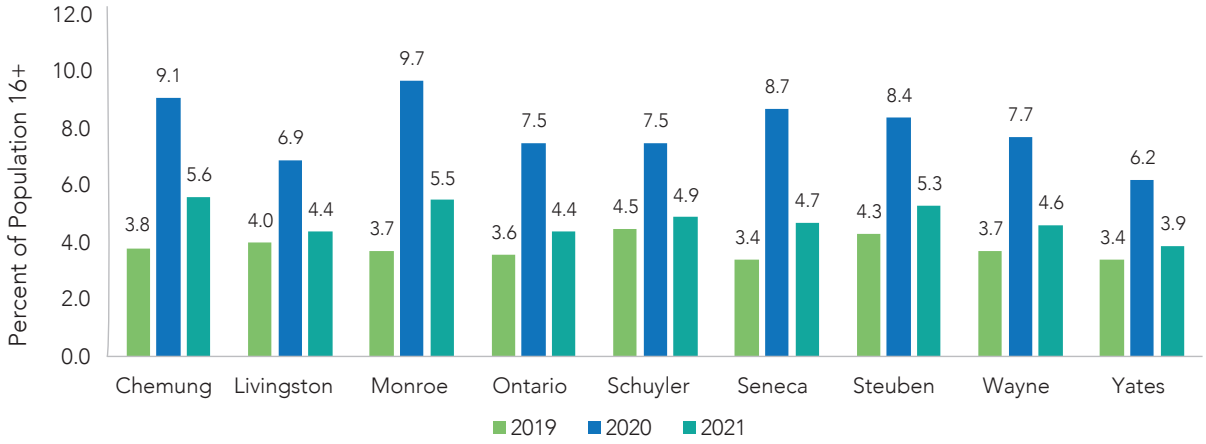
14. The State of America's Children, 2020 Child Poverty

15. Source: National Council on Aging including data from Social Security Administration, National Institute on Retirement Security and Bureau of Labor Statistics

## Unemployment

Unemployment rates have been significantly impacted by the COVID-19 pandemic. The economy experienced a significant downturn due to the closing of businesses and schools. Many residents became unemployed with these closures. Those with positions that allowed for it worked remotely from home. All were placed in a variety of difficult situations, including managing personal needs, navigating childcare, overseeing their children's remote learning, and managing adult caregiving responsibilities. The pandemic generated a significant amount of unemployment, which is only just beginning to decrease one year later. According to the Bureau of Labor Statistics, three industry sectors most exposed to shut downs included restaurants and bars, travel and transportation, and entertainment. For some counties, such as Livingston and Schuyler, the unemployment rate is similar to pre-pandemic estimates but for others, like Chemung, Steuben and Monroe County, there are still significant concerns (Figure 8).

### Figure 8: Unemployment Rates by County




Source: NYS Department of Labor, 2019-2021

Over the next ten years, Rochester Works, an employment and training organization, reports a projected decline in construction, retail and leisure and hospitality employment. The report also indicates a job loss rate disproportionately impacting women and people of color.[16]

## Health Insurance Status

Health insurance helps individuals access the care that they need. Similar to populations who experience low socioeconomic status, the uninsured are less likely to receive or seek preventative care such as health screenings, are less likely to have an established regular healthcare provider, and are more likely to use the emergency room for services that could have been provided in a primary care provider setting. Since the implementation of the Affordable Care Act, the rate of uninsured individuals in the Finger Lakes region has decreased in the past six years from 11% to 5% of residents.

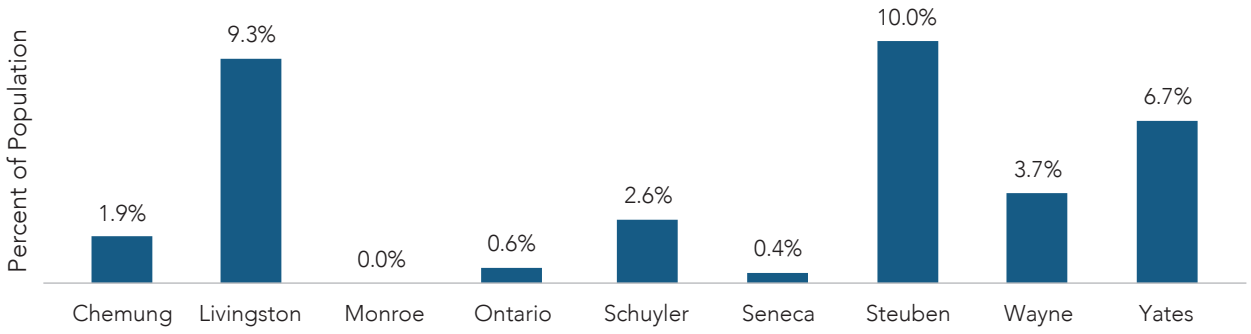

16. Rochester Works, COVID-19 Pandemic Recovery Watch, Monroe County and the Finger Lakes (Revised 9/28/2021).

This is a step in the right direction, but access to health insurance is not the only barrier to health care. Underinsured individuals, or those who have high deductibles that affect their ability to access healthcare, are also a real concern. Transportation, lack of provider availability (including difficulty scheduling with providers) and cost (i.e. cost of care, time away from work, and childcare) were repeatedly identified as barriers and top concerns in My Health Story 2018 survey responses and are areas that provide opportunities for improvement. Anecdotally, we know that the COVID-19 pandemic has exacerbated these concerns and resulted in patients delaying preventative care needs due to office closures or delays in elective procedures. The impact this has had on reopening in the Finger Lakes and other communities across the State have resulted in longer wait times and insufficient office hours or availability to meet the demand of the delayed care.

## Broadband Access

Nearly thirty years ago, access to personal home internet access was a novelty available only to a small portion of New York State residents. Today, access to reliable high-speed internet is considered a necessity by many. The internet is utilized in ways that help residents communicate and connect with each other and find new and effective ways to work, learn and play. In light of the COVID-19 pandemic, availability of broadband access at home was elevated to a new level of necessity with remote learning, work, and accessibility to healthcare options like telehealth being heavily utilized. While New York State overall has great accessibility to broadband, there are portions of the state, and specifically within the Finger Lakes region, that are at a disadvantage because their access is inadequate, unreliable, or unavailable. The Office of the State Comptroller estimates that eight percent of the Finger Lakes region and Southern Tier do not have broadband accessibility.[17] Steuben (10% of county population) and Livingston (9.3% of county population) counties are the top 6th and 7th, respectively, in the state for those without broadband accessibility (Figure 9).

### Figure 9: Percentage of Population without Broadband Available in their Area, 2021




Source: Office of the State Comptroller

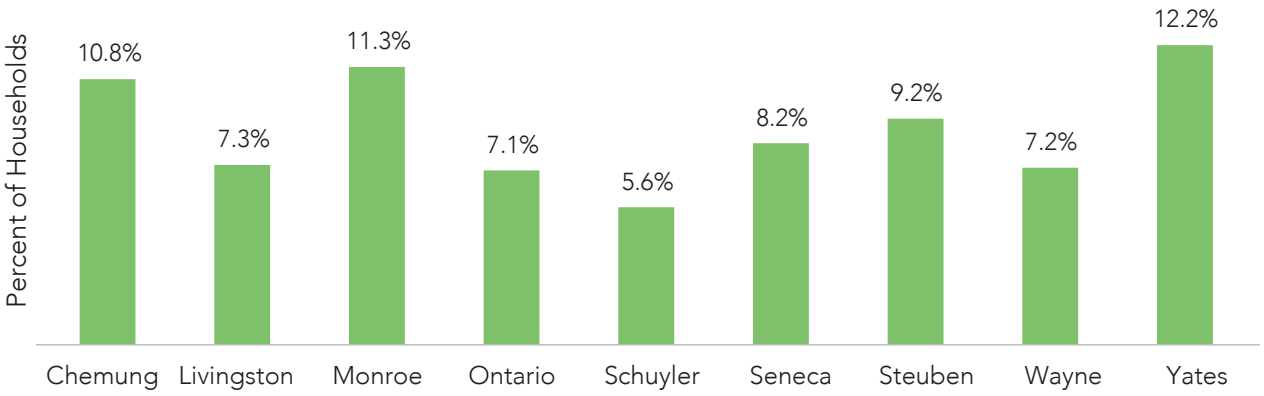


17. Office of the State Comptroller analysis of Federal Communications Commissions, *Fourteenth Broadband Deployment Report* January 19, 2021. Data are based on a 25/3 Mbps standard relied on by the Federal Communications Commission.

## Transportation

Access to a personal vehicle can affect an individual's overall health status in a number of ways. Unreliable, inconsistent or inconvenient transportation (either personal vehicle, medical taxis or public transportation) can cause strain on the ability to access health care services. This could result in missed or delayed health care appointments, leading to increased health expenditures and overall poorer health outcomes. Figure 10 demonstrates the percent of each county's households in the Finger Lakes region with no vehicle access. Larger cities, such as Rochester in Monroe County and Elmira in Chemung County have higher percentages of their households with no vehicle access (20% of households or more). In addition, Yates County has a high percentage of no motor vehicle access households due to the higher percentage of Amish/Mennonites who predominantly rely on horse and buggy for their transportation needs.

### Figure 10: Percent of Households with No Vehicle Access




Source: US Census Bureau 2015-2019 5-Year Estimates

Steuben County, Hikers on the Finger Lakes Trail
Photo by Stu Gallagher
Courtesy of the CorningFingerLakes.com

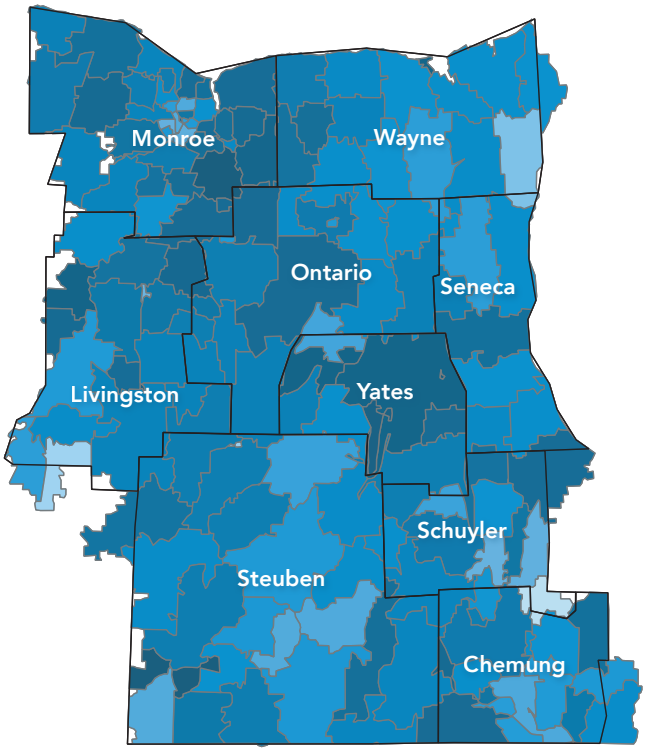
## Life Expectancy

Genetics are not the only indicator of an individual's life expectancy. Demographic factors such as socioeconomic status, employment, income, education and economic well-being, the quality of and accessibility to health systems and services, and personal health behaviors all impact one ultimate measure of health: life expectancy. Stratified by ZIP code, the Finger Lakes region has life expectancy estimates that range from 66 to 85 years of life. Map 6 shows the life expectancy estimates at birth by ZIP code and highlights the ZIP codes with the highest and lowest life expectancy estimates in the region.

### Map 6: Life Expectancy by ZIP Code

ZIP Codes with Highest Life Expectancy

| | | |
|---|---|---|
| 14441 | Yates | 84 |
| 14545 | Livingston | 84 |
| 14534 | Monroe | 80 |
| 14839 | Steuben | 80 |




Average Life Expectancy

ZIP Codes with Lowest Life Expectancy

| | | |
|---|---|---|
| 13146 | Wayne | 70 |
| 14808 | Steuben | 68 |
| 14836 | Livingston | 68 |
| 14824 | Schuyler | 66 |

Source: New York State Department of Health Vital Statistics, 2014-2016



9. March of Dimes, Premature Babies and Long-Term Health Effects of Premature Birth, www.marchofdimes.org.
10. Stanford Children's Health, Low Birthweight

## Leading Causes of Death

The top two leadings causes of death in all nine counties of the Finger Lakes region are cancer and heart disease (Table 5). This is consistent with national data from the CDC, which shows the two leading causes of death since 2015 have been heart disease and cancer.[18] Chronic lower respiratory disease (CLRD), a disease which causes shortness of breath caused by airway obstruction, most commonly caused by tobacco smoking (including second hand smoke), is also within the top five causes in all nine counties in the region (not pictured).

### Table 5: Leading Causes of Death, 2018

| | 1st Cause | 2nd Cause | 3rd Cause |
|---|---|---|---|
| **Chemung** | Heart Disease<br>208.1 per 100,000 | Cancer<br>167.6 per 100,000 | Chronic Lower Respiratory Diseases (CLRD)<br>48.8 per 100,000 |
| **Livingston** | Cancer<br>171.8 per 100,000 | Heart Disease<br>124.7 per 100,000 | Alzheimer's Disease<br>59.2 per 100,000 |
| **Monroe** | Cancer<br>153.8 per 100,000 | Heart Disease<br>137.1 per 100,000 | Unintentional Injury<br>57.1 per 100,000 |
| **Ontario** | Cancer<br>157.9 per 100,000 | Heart Disease<br>138.4 per 100,000 | Chronic Lower Respiratory Diseases (CLRD)<br>40.8 per 100,000 |
| **Schuyler** | Cancer<br>156.1 per 100,000 | Heart Disease<br>152.8 per 100,000 | Chronic Lower Respiratory Diseases (CLRD)<br>88.1 per 100,000 |
| **Seneca** | Heart Disease<br>191.3 per 100,000 | Cancer<br>152.2 per 100,000 | Chronic Lower Respiratory Diseases (CLRD)<br>55.1 per 100,000 |
| **Steuben** | Heart Disease<br>182.3 per 100,000 | Cancer<br>180.6 per 100,000 | Chronic Lower Respiratory Diseases (CLRD)<br>63.6 per 100,000 |
| **Wayne** | Cancer<br>154.6 per 100,000 | Heart Disease<br>143.8 per 100,000 | Unintentional Injury<br>63.4 per 100,000 |
| **Yates** | Heart Disease<br>154.6 per 100,000 | Cancer<br>135.3 per 100,000 | Unintentional Injury<br>66.4 per 100,000 |

Source: New York State Department of Health Vital Statistics, 2018


18. Ahmad, F. B., & Anderson, R. N. (2021). The leading causes of death in the US for 2020. JAMA, 325(18), 1829-1830.

## Leading Causes of Premature Death

Consistent with the leading causes of death, the top two causes of premature death (death before age 75) in the Finger Lakes region are Cancer and Heart Disease. Unintentional Injury and Chronic Lower Respiratory Disease (CLRD) are two other leading causes that are consistent across all counties in the region (Table 6).

### Table 6: Leading Causes of Premature Death, 2018

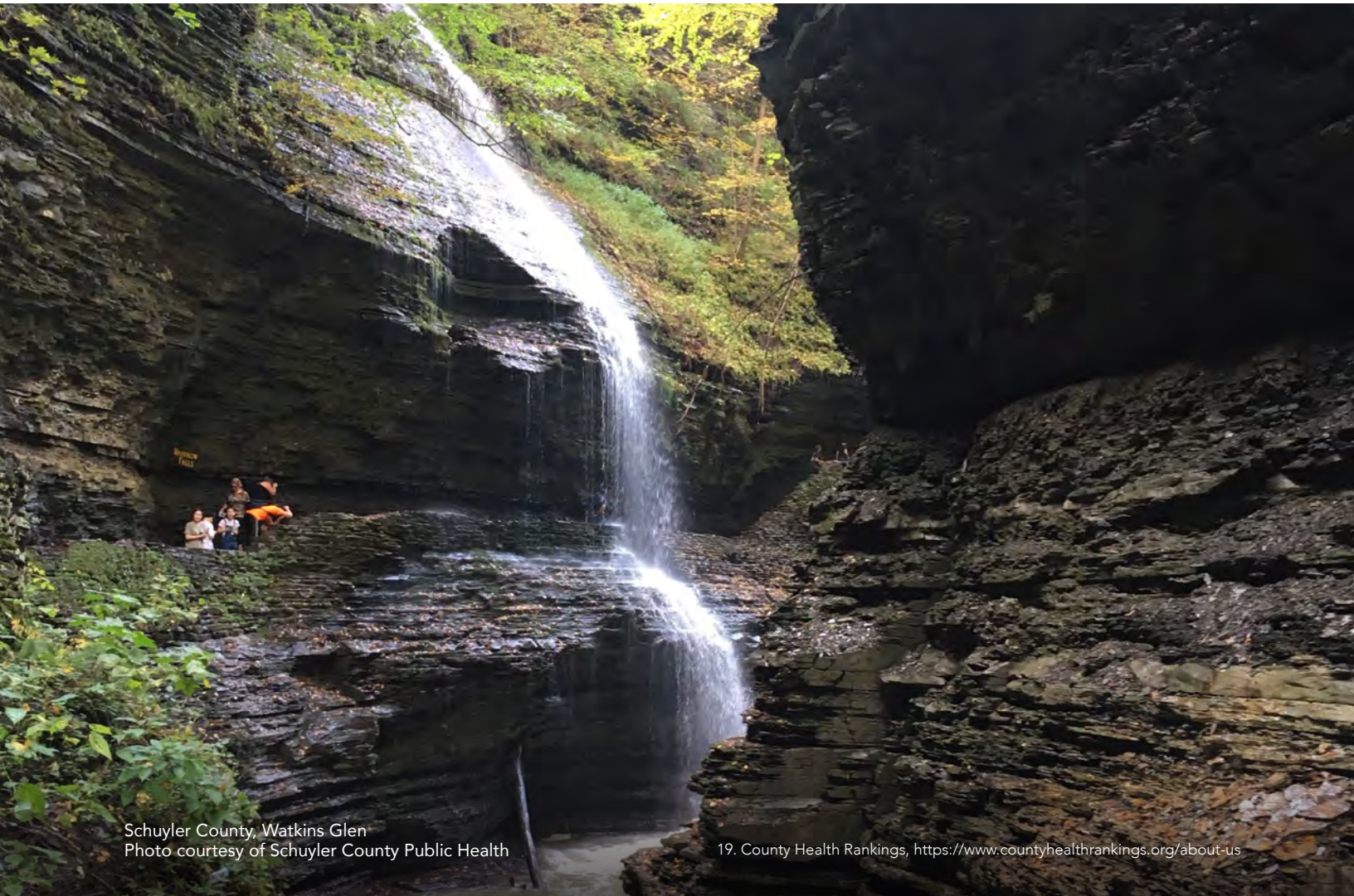
| | 1st Cause | 2nd Cause | 3rd Cause |
|---|---|---|---|
| **Chemung** | Cancer<br>97.0 per 100,000 | Heart Disease<br>90.5 per 100,000 | Unintentional Injury<br>41.8 per 100,000 |
| **Livingston** | Cancer<br>103.4 per 100,000 | Heart Disease<br>54.9 per 100,000 | Unintentional Injury<br>44.0 per 100,000 |
| **Monroe** | Cancer<br>81.3 per 100,000 | Heart Disease<br>48.4 per 100,000 | Unintentional Injury<br>44.8 per 100,000 |
| **Ontario** | Cancer<br>80.8 per 100,000 | Heart Disease<br>53.3 per 100,000 | Unintentional Injury<br>30.2 per 100,000 |
| **Schuyler** | Cancer<br>67.3 per 100,000 | Heart Disease<br>39.8 per 100,000 | Diabetes<br>21.6* per 100,000 |
| **Seneca** | Cancer<br>84.7 per 100,000 | Heart Disease<br>82.5 per 100,000 | Unintentional Injury<br>36.1 per 100,000 |
| **Steuben** | Cancer<br>103.9 per 100,000 | Heart Disease<br>69.7 per 100,000 | Chronic Lower Respiratory<br>24.4 per 100,000 |
| **Wayne** | Cancer<br>88.5 per 100,000 | Heart Disease<br>49.9 per 100,000 | Unintentional Injury<br>45.3 per 100,000 |
| **Yates** | Cancer<br>79.4 per 100,000 | Heart Disease<br>51.8 per 100,000 | Unintentional Injury<br>58.9 per 100,000 |

Source: New York State Department of Health Vital Statistics, 2018

## County Health Rankings

By combining all the factors listed above, the University of Wisconsin Population Health Institute has created the County Health Rankings & Roadmaps, a program that works to improve health outcomes for all and to close the health disparities gap between those with the most and least opportunities for good health.[19] By creating this metric/set of metrics, the County Health Rankings give counties in the Finger Lakes region the opportunity to measure themselves against other counties in New York State and monitor changes over time. Table 7 shows the rank of each county in the Finger Lakes region from 2011 to 2020. The rankings cover all counties in New York and range from 1 to 62 with the lower ranking indicating better performance in measurement of health outcomes. Ontario and Monroe County have shown consistent rankings since 2011. Ontario has an average rank of 10 with its highest being 13 and lowest being 7. Monroe was similar to Ontario in change over time, but with an average rank of 36, a high of 39, and a low of 32. Livingston, Schuyler, Yates County are of some concern, as both had ranks in the top 10 but are now ranked at 23, 34, and 27, respectively.

As the county health rankings model has evolved over the years, new and additional data elements have been factored into the score, which may have impacted these counties. Along with this, most of the counties in the Finger Lakes region saw their score fall between 2016 and 2017, which coincides with the dramatic worsening of the opioid epidemic in the region. This significantly impacted overall and premature mortality, two major factors in the county health rankings. One county in the region that has seen a positive trend is Steuben, which saw a trend of improving rank through 2016 and has improved again over the last two years after a slight regression. Overall, Steuben ranks 15 places higher in 2020 than in 2011.



Schuyler County, Watkins Glen
Photo courtesy of Schuyler County Public Health

19. County Health Rankings, https://www.countyhealthrankings.org/about-us

## Table 7: County Health Rankings and Roadmaps; Health Outcomes Ranking

| County | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| Chemung | 59 | 60 | 60 | 60 | 59 | 50 | 57 | 49 | 55 | 53 |
| Livingston | 8 | 5 | 1 | 1 | 7 | 12 | 9 | 9 | 12 | 23 |
| Monroe | 33 | 37 | 33 | 38 | 38 | 33 | 32 | 35 | 39 | 35 |
| Ontario | 7 | 8 | 11 | 10 | 10 | 13 | 8 | 12 | 9 | 13 |
| Schuyler | 3 | 11 | 29 | 44 | 19 | 18 | 26 | 46 | 48 | 34 |
| Seneca | 26 | 27 | 23 | 26 | 45 | 25 | 20 | 18 | 37 | 48 |
| Steuben | 52 | 53 | 44 | 40 | 34 | 31 | 42 | 45 | 38 | 37 |
| Wayne | 30 | 46 | 46 | 45 | 39 | 21 | 28 | 44 | 51 | 40 |
| Yates | 10 | 10 | 6 | 8 | 13 | 15 | 16 | 6 | 14 | 27 |

1 62

Data Source: County Health Rankings. 2011 - 2020, Analysis Completed by Common Ground Health

The next section of this report will focus on health outcomes and behaviors that may impact life expectancy estimates and will be stratified by county, ZIP code, race/ethnicity and age group whenever possible or appropriate.

Livingston County, Be Well in Nunda
Photo courtesy of Livingston County Department of Health

# HEALTH INDICATORS

## Prevent Chronic Diseases

Preventing chronic disease has been a long-standing priority area in the nine-county Finger Lakes region. In the past, efforts largely have been focused on reducing illness, disability and death related to hypertension, tobacco use and second hand smoke, along with reducing obesity in children and adults. Obesity is known to lead to long-term health complications and may lead to development of diabetes, hypertension, and premature mortality due to related conditions. This section will focus on exploring data related to chronic diseases in the region.

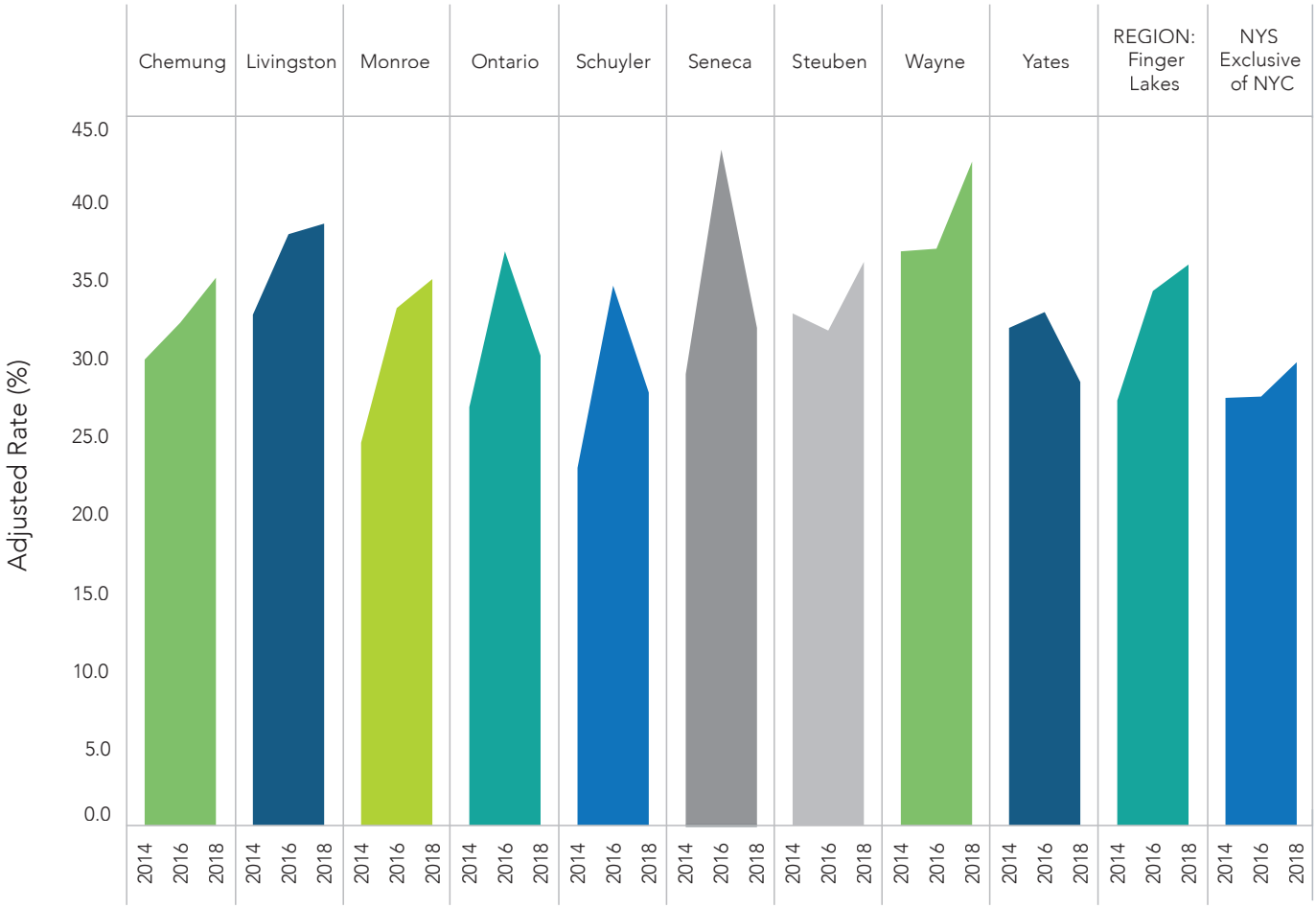
## Obesity

In developing the Prevention Agenda, New York State has identified four focus areas in the Prevent Chronic Disease priority area: Healthy Eating and Food Security, Physical Activity, Tobacco Prevention, and Chronic Disease Preventative Care and Management. In reviewing the data in the Finger Lakes region, the biggest areas for improvement are around Tobacco Prevention (specifically e-cigarette/ vape use) and Chronic Disease Preventative Care and Management. On a smaller scale, Healthy Eating and Food Security are also areas worth noting. There is also a worrisome trend with overall food security in light of the COVID-19 pandemic.

The trends varied in data from 2014, 2016 and 2018. Chemung, Livingston, Monroe, Steuben, and Wayne all showed a trend of increasing rates of obesity. Ontario, Schuyler, and Seneca showed increases from 2014 to 2016 and then decreases from 2016 to 2018 (Figure 11). Seneca showed the greatest decrease from 2016 to 2018 (12%), which is likely due to their focus on Healthy Eating and Food Security, Tobacco Prevention and Preventative Care and Management of Chronic Diseases to help reduce obesity in the previous improvement plan. Yates County was the only county whose rate of obesity was not higher in 2018 than 2014, with a small reduction from 32% to 28%. Looking at the Finger Lakes region vs. the state (minus NYC), the rate of obesity and upward trend in the region was higher than the state.

Elmira, Chemung County
Photo credit: iStock.com/DenisTangneyJr

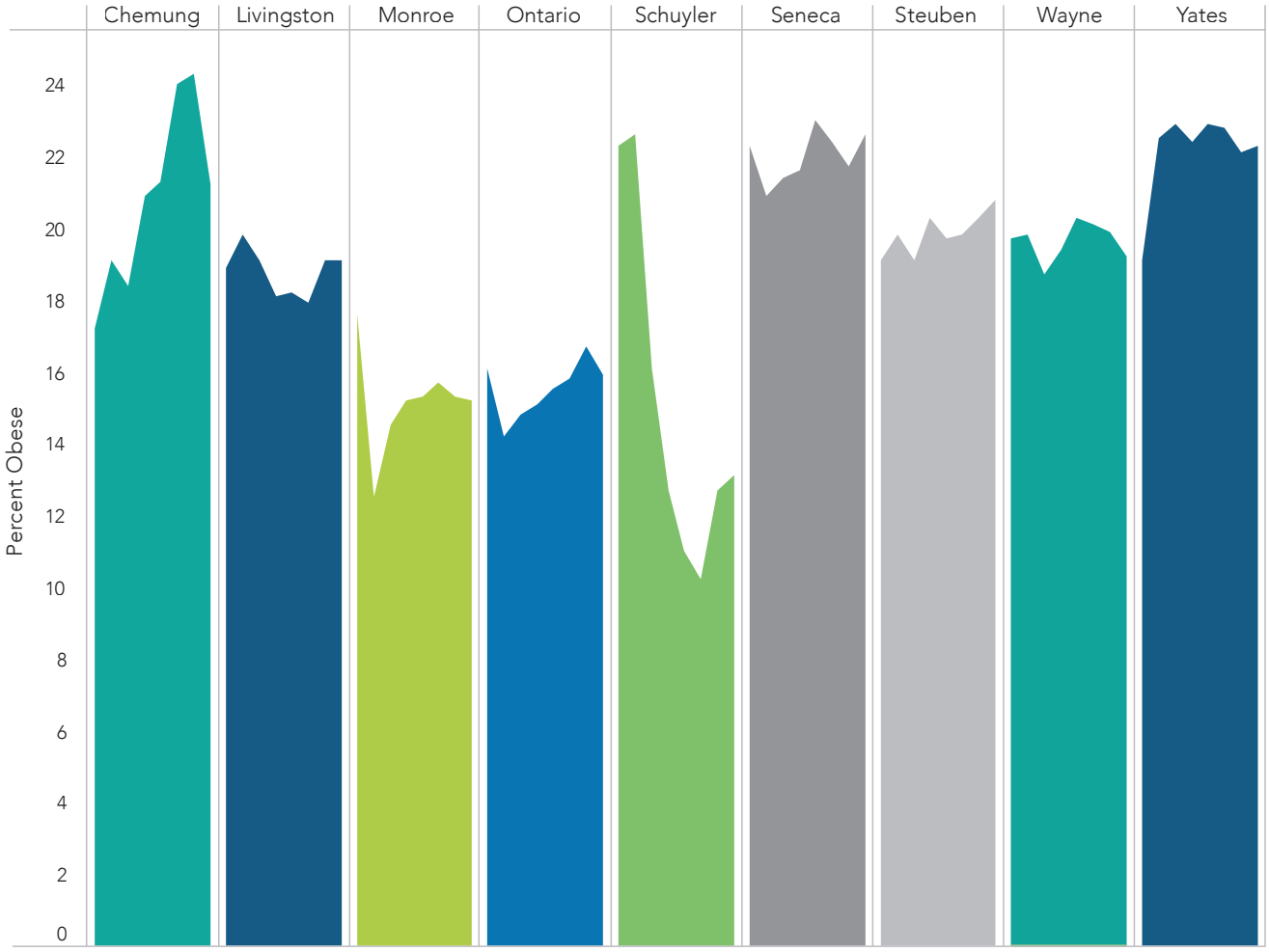
## Figure 11: Percent of Adults (18+) who are Obese




Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2013-2014, 2016, & 2018. Analysis Completed by Common Ground Health

Childhood obesity rates in the Finger Lakes region have also been fairly stable. Figure 12 shows the trend of obesity for students in the area from the Student Weight Data Explorer. Looking at state trends, "In New York State, obesity rates are decreasing among elementary school students, but are on the rise among middle and high school students."[20] For the Finger Lakes region, the counties that had an overall upward trend saw greater increases in obesity for middle/high school students similar to the overall state trend.

## Figure 12: Percent of Students with Obesity in the Finger Lakes Region




Data Source: NYS DOH, Health Data Connector, 2010 – 2019

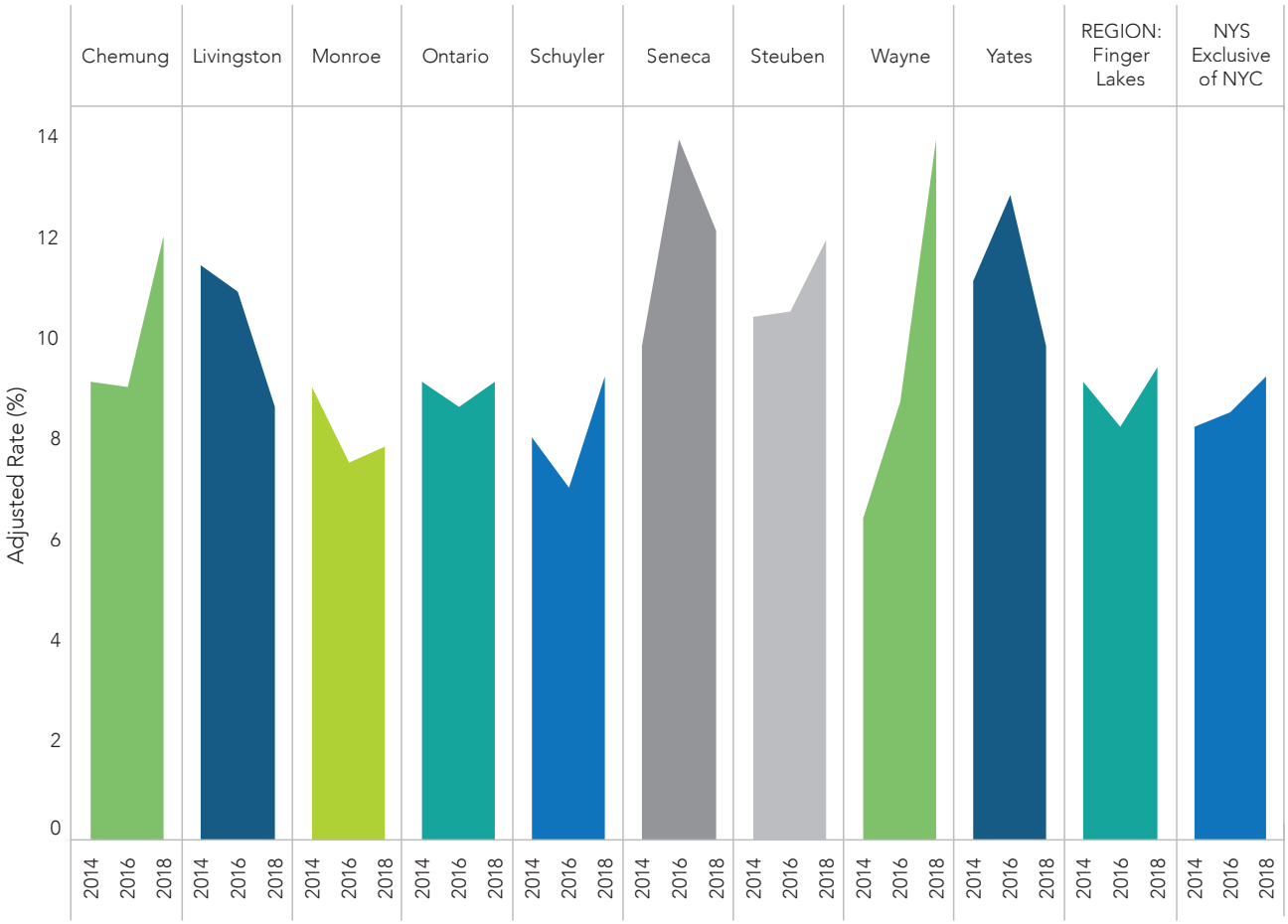


20. https://nyshc.health.ny.gov/web/nyapd/student-weight-data-explorer

## Diabetes

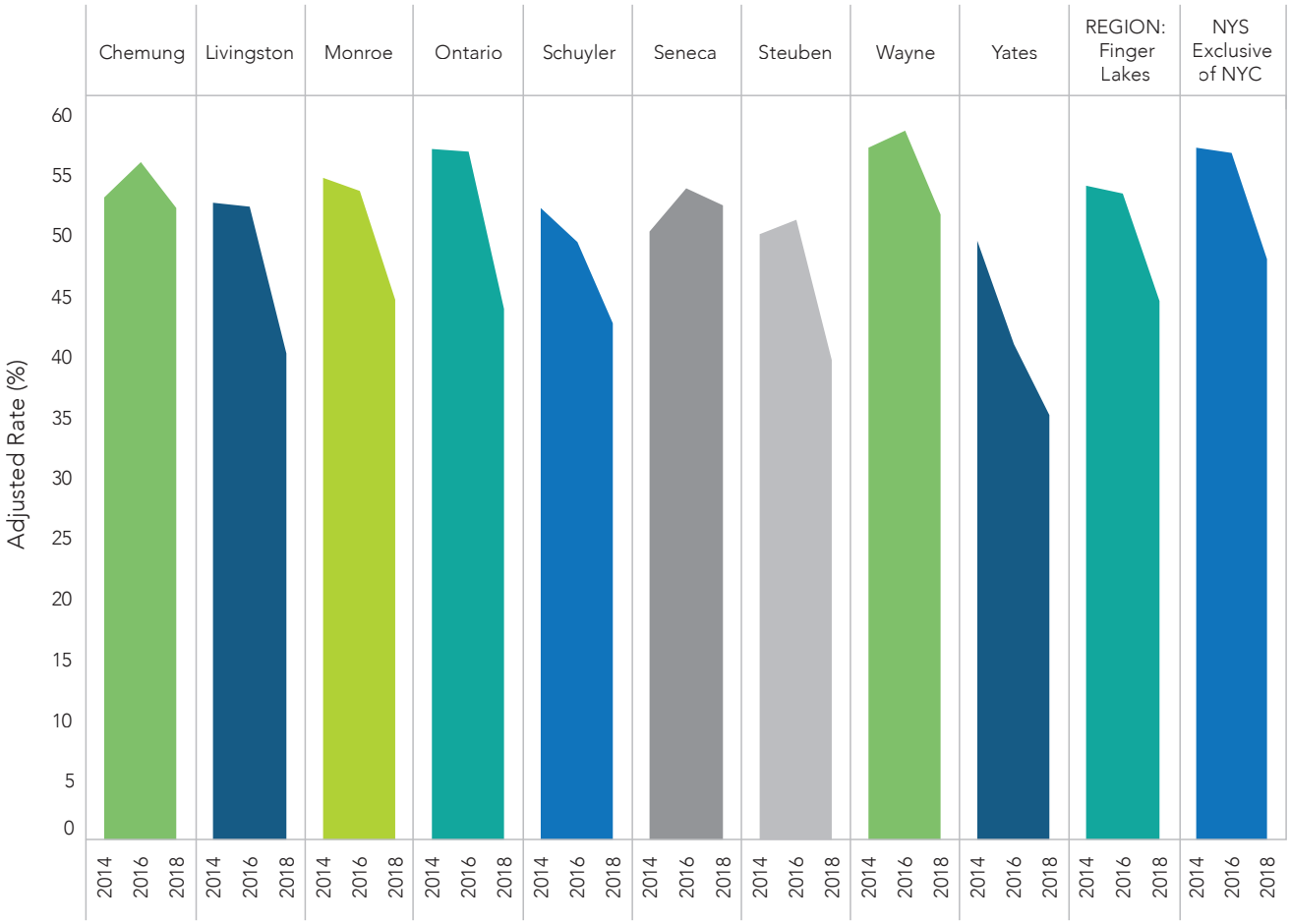
One area that has not seen an improvement is diabetes screening. Rates of diabetes among adults varied in from 2014 to 2018 (Figure 13) and appeared to increase in five counties. In comparing the Finger Lakes region overall vs. the state, both the region and state showed a similar trend from 2014 to 2018. Individual counties' experiences varied. However, diabetes screening rates decreased from 2014 to 2018 in each of the nine counties (Figure 14) among those 18 years and older. This trending is reflected in the Finger Lakes region and the state. Therefore, the reduction in testing must be considered prior to interpreting the rates of diabetes diagnoses given potential for undiagnosed occurrence of disease.

### Figure 13: Adults with Diabetes




Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2013-2014, 2016, & 2018. Analysis Completed by Common Ground Health

## Figure 14: Adults (18+) who Received Prediabetes/Diabetes Testing



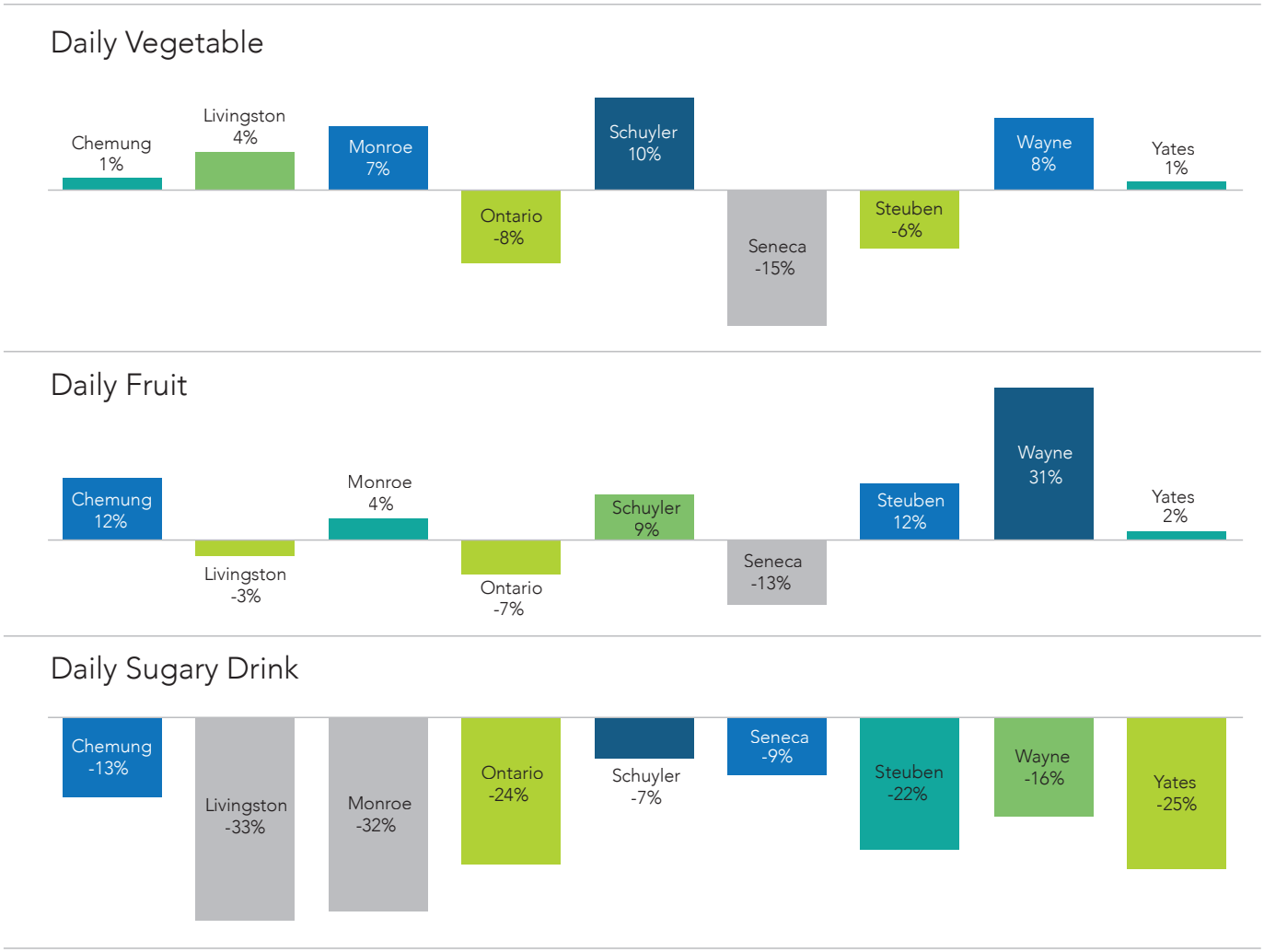

Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2013-2014, 2016, & 2018. Analysis Completed by Common Ground Health

## Healthy Eating

With regard to healthy eating, the trends from 2016 to 2018 were mostly positive. Figure 15 shows the percent change in daily fruit, vegetable, and sugary drink consumption. For daily fruit and vegetable consumption, a positive change (shown as a positive number with a darker color) is a promising trend. Six of the nine counties show a positive change in fruit and vegetable consumption.

For sugary drink consumption, a negative change (negative number or lighter color) shows progress. All nine counties in the Finger Lakes region made progress in this area, with the percent of the population reducing daily consumption of a sugary drink ranging from about 7% to about 33%.

### Figure 15: Percent Change of Fruit, Vegetable, and Sugary Drink Consumption




Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016 & 2018.
Analysis by Common Ground Health.

Healthy eating habits are important when it comes to decreasing the incidence of obesity in children and adults. According to My Health Story 2018 survey data, 9% of the region's respondents reported the nearest grocery store is 20+ minutes away, where vehicles are needed to access them. Of note, the majority of residents (75% of respondents) indicated they usually get their fruits and vegetables from a supermarket or grocery store or local grocery store (47%). A substantial amount of residents also utilize local farm stands (39%), farmers markets (29%), or grow their own in their garden (22%), with estimates for all three of these sources being higher in Schuyler, Seneca, Wayne and Yates Counties.

Respondents to the My Health Story 2018 survey were also asked what were the biggest challenges or barriers keeping them from eating healthier. Table 8 reveals barriers reported by residents. The biggest barrier to eating healthier, particularly for those with low income, was that healthy food was too expensive. Other issues which rose to the top were not having enough time and lack of knowledge of how to shop for and prepare the food. This presents an opportunity to help educate and inform the community on how to shop for and prepare in-season fruits and vegetables, which may help contain costs of eating healthier for the consumer. Not surprisingly, the table also reveals that affordability of healthy food was a larger concern for those of a lower income status. Nearly 60% of those with incomes less than $25k reported a cost barrier vs. 25% of those over $75k. Transportation, supplies and equipment, and knowledge of how to cook and prepare foods were also areas predominantly identified by low-income respondents.

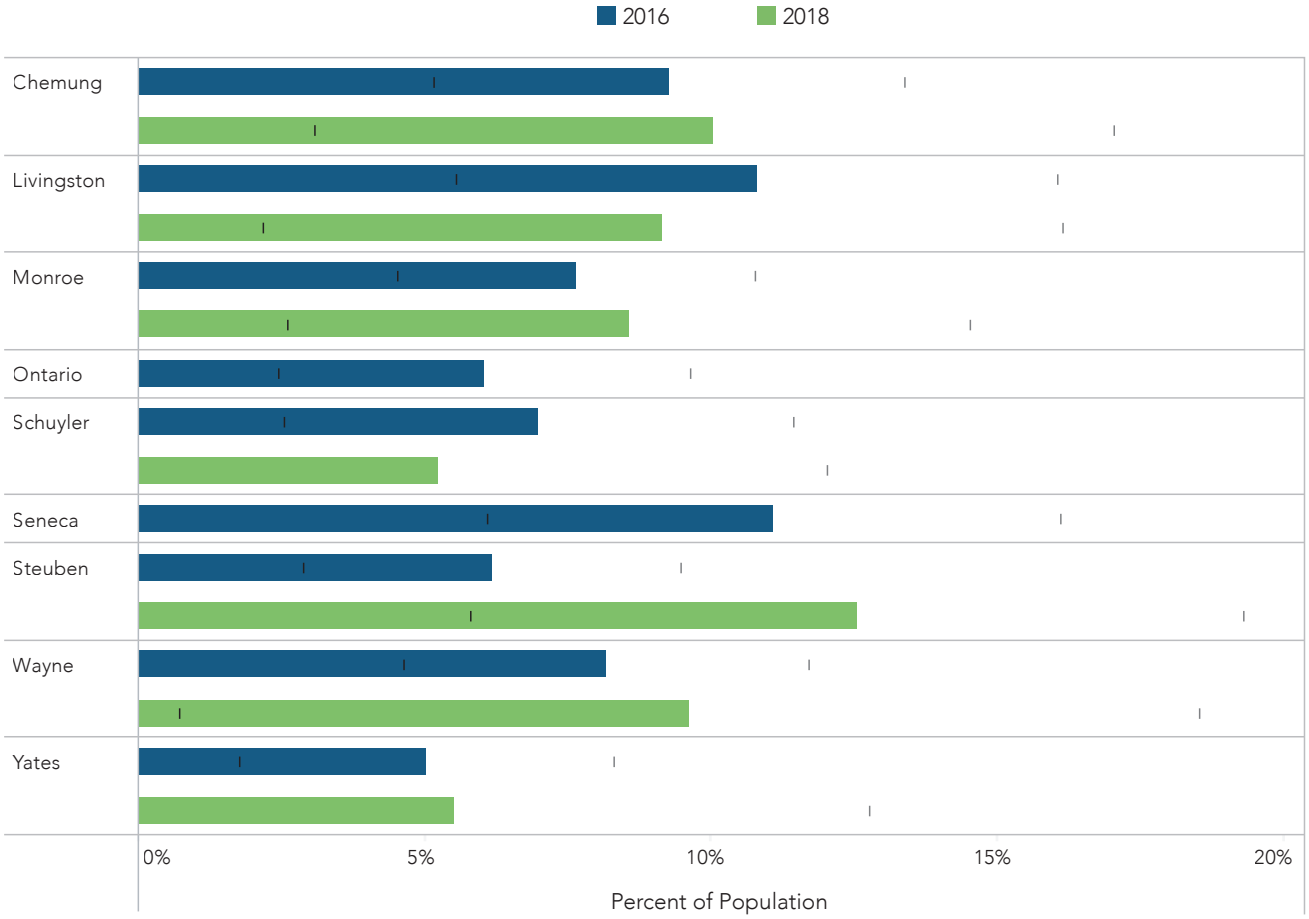
## Table 8: Barriers to Healthy Eating

| | under $25K | $25-50K | $50-75K | $75K+ |
|---|---|---|---|---|
| Buying healthy food is too expensive | 54% | 47% | 38% | 20% |
| I don't enjoy the taste of healthy food | 5% | 7% | 10% | 8% |
| I don't have anyplace nearby to buy healthy food | 6% | 5% | 2% | 2% |
| I don't have the supplies and equipment I'd need to cook healthy food | 9% | 5% | 4% | 1% |
| I don't have the time to shop for, and prepare, healthy food | 14% | 21% | 22% | 23% |
| I don't have the transportation to go shopping for healthy food | 12% | 3% | 1% | 0% |
| I don't know how to cook and prepare healthy meals that taste good | 11% | 15% | 14% | 10% |
| I don't want or need to eat healthier than I already do | 8% | 8% | 10% | 10% |
| I really don't have any barriers keeping me from eating healthy food | 22% | 32% | 42% | 49% |
| The others in my household don't eat healthy, and we eat together | 9% | 10% | 12% | 12% |

Data Source: My Health Story survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.

While data around fruit, vegetable and sugary drink consumption is showing some promising trends in eating habits, food insecurity is an issue in the region and contributes to the challenges around making healthy eating choices.

## Figure 16: Food Insecurity[21]



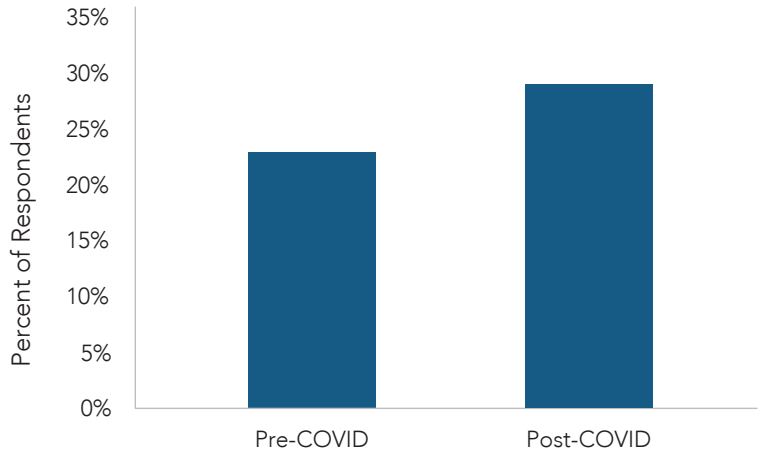

Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016 & 2018. Analysis Completed by Common Ground Health

In general the region's rate of food insecurity has been fairly stable, with only Steuben County showing large increases. While it showed a greater than 5% increase in food insecurity over the two year time period, the wide confidence intervals on these rates indicate caution be taken before drawing any strong conclusions from these increases. It does indicate that food insecurity, as it relates to other goals on the Prevention Agenda, should be explored further.


21. 2018 Data for Ontario and Seneca County not shown due to large standard error

The COVID-19 pandemic has greatly impacted a number of Prevention Agenda focus areas. The following figure (Figure 17) shows the impact COVID-19 has had on people's anxiety around having enough food until they had more money to buy more. In addition to the data below, the survey revealed that almost half (45%) of the respondents know someone struggling with food security as a result of the COVID-19 pandemic. The findings further emphasize the need to address food security concerns in the region.

## Figure 17: Percent of Respondents who were Worried if Their Food Would Run Out Before They Got Money to Buy More




Data Source: Pivital Public Health Partnership (formerly S2AY Rural Health Network Inc,) The Impact of COVID-19 on Food Security and Healthy Eating

Photo by Chelsie Renae
Photo courtesy of Livingston County Department of Health

## Physical Activity

While healthy eating is a major component of preventing and managing chronic diseases, so is physical activity and exercise. My Health Story 2018 provided us with data on barriers to being physically active, as shown in Table 9. Similar to the perceived expense of healthy food previously discussed, the affordability of exercise opportunities is noted as a barrier predominantly seen in the lower income population (25% of respondents vs. 7% of high-income respondents). Safety of neighborhoods, support systems, and transportation were three additional measures, which appear to be greater concerns for low-income respondents.

### Table 9: Barriers to Being Physically Active

| | under $25K | $25-50K | $50-75K | $75K+ |
|---|---|---|---|---|
| I always seem to be too tired to exercise | 28% | 30% | 33% | 26% |
| I can't afford a gym membership or other fitness opportunities | 39% | 26% | 18% | 8% |
| I can't exercise because of a physical limitation or disability | 22% | 12% | 12% | 8% |
| I don't have a safe place nearby to get more exercise | 9% | 6% | 3% | 2% |
| I don't have anyone to exercise with, and don't like to exercise alone | 18% | 16% | 16% | 10% |
| I don't have the time to get more exercise | 23% | 42% | 47% | 55% |
| I don't have transportation to get to places where I could get more exercise | 14% | 4% | 1% | 0% |
| I don't want or need to be more active than I already am | 10% | 8% | 9% | 9% |
| I really don't have any barriers keeping me from being physically active | 16% | 25% | 24% | 31% |
| My life is too complicated to worry about exercise | 10% | 11% | 10% | 9% |

Data Source: My Health Story survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.

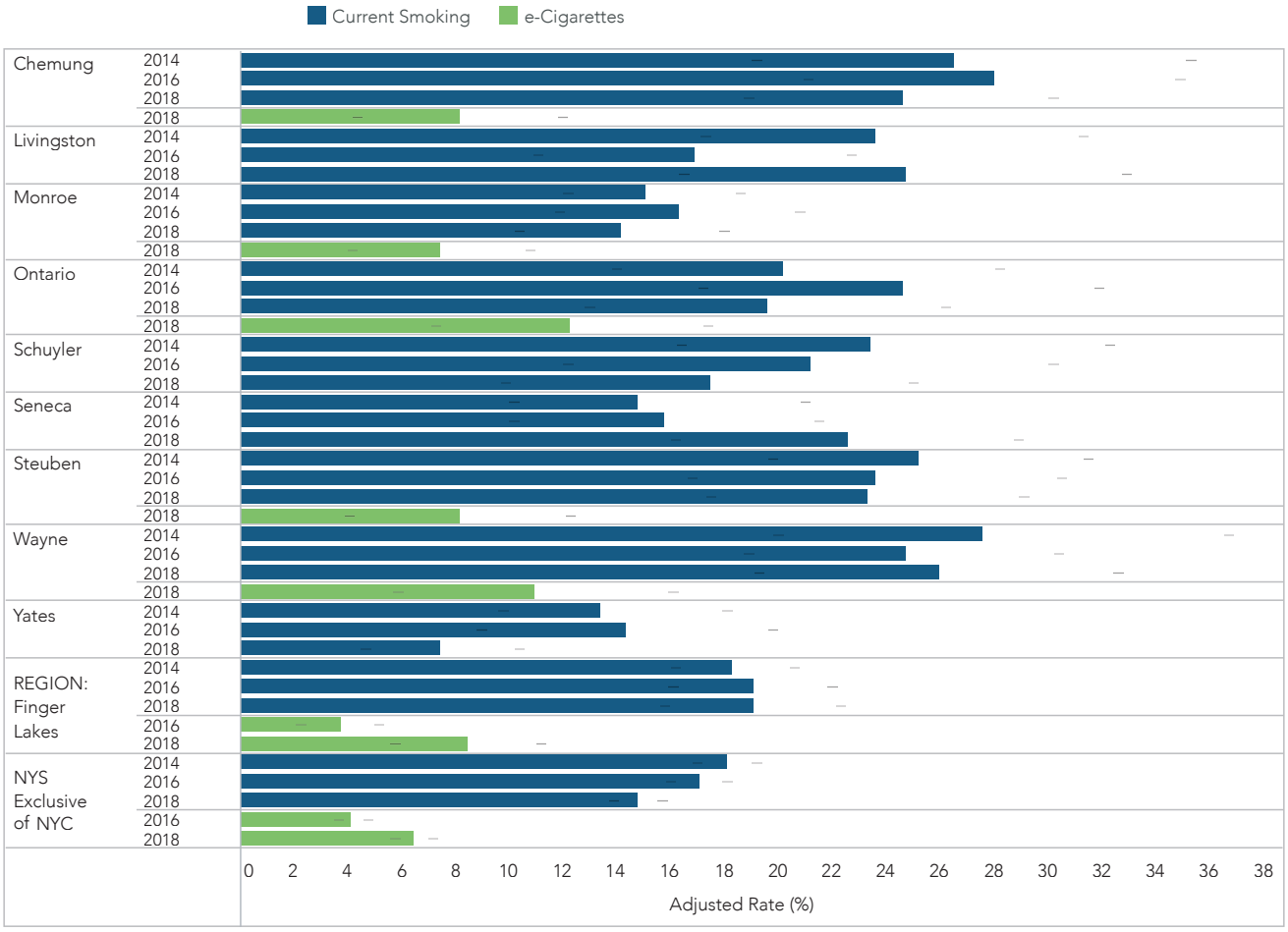
The impact of COVID-19 on people's physical activity has been different based on socio-economic factors. For instance, when gyms closed early in the pandemic, some people with the means were able to invest in home gyms, and many have continued with those habits since gyms have reopened.[22] Along with this, many have taken to different outdoor activities, such as running, hiking, biking and walking during COVID. While physical activity increased 4.4% during the pandemic, adult obesity conversely also increased by 3% during the first year of the pandemic. Researchers said the rise in obesity may have been linked to an increase in alcohol consumption and a decrease in smoking.[23]


22. https://runrepeat.com/fitness-trends
23. https://www.ajpmonline.org/article/S0749-3797(22)00095-2/fulltext

## Tobacco Use

Another area of concern in the chronic disease priority area is tobacco use. In the previous Community Health Assessment, five of the nine counties chose Tobacco Prevention as a focus area. The following figure (Figure 18) shows the trend of cigarette use from 2013-2014 to 2018 and e-cigarette use from 2016 to 2018.

### Figure 18: Percent of Adults (18+) Who Smoke Every Day or Some Days[24]




Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2013-2014, 2016 & 2018. Analysis Completed by Common Ground Health

While the rate of cigarette use across all nine counties and the Finger Lakes region was fairly stable, the increase in e-cigarette use is a cause for concern. The Finger Lakes region saw a roughly 5% increase in use of e-cigarettes or other vaping products without a corresponding reduction in cigarette use. In comparison to the state data, this was double the increase (2% vs. 5%). This is likely due to the simultaneous use by respondents of both cigarettes and e-cigarettes. Reported use of e-cigarettes as well as other nicotine delivery systems (vape pens, JUULs, etc.) have been identified as areas of concern in several of the Finger Lakes region counties.

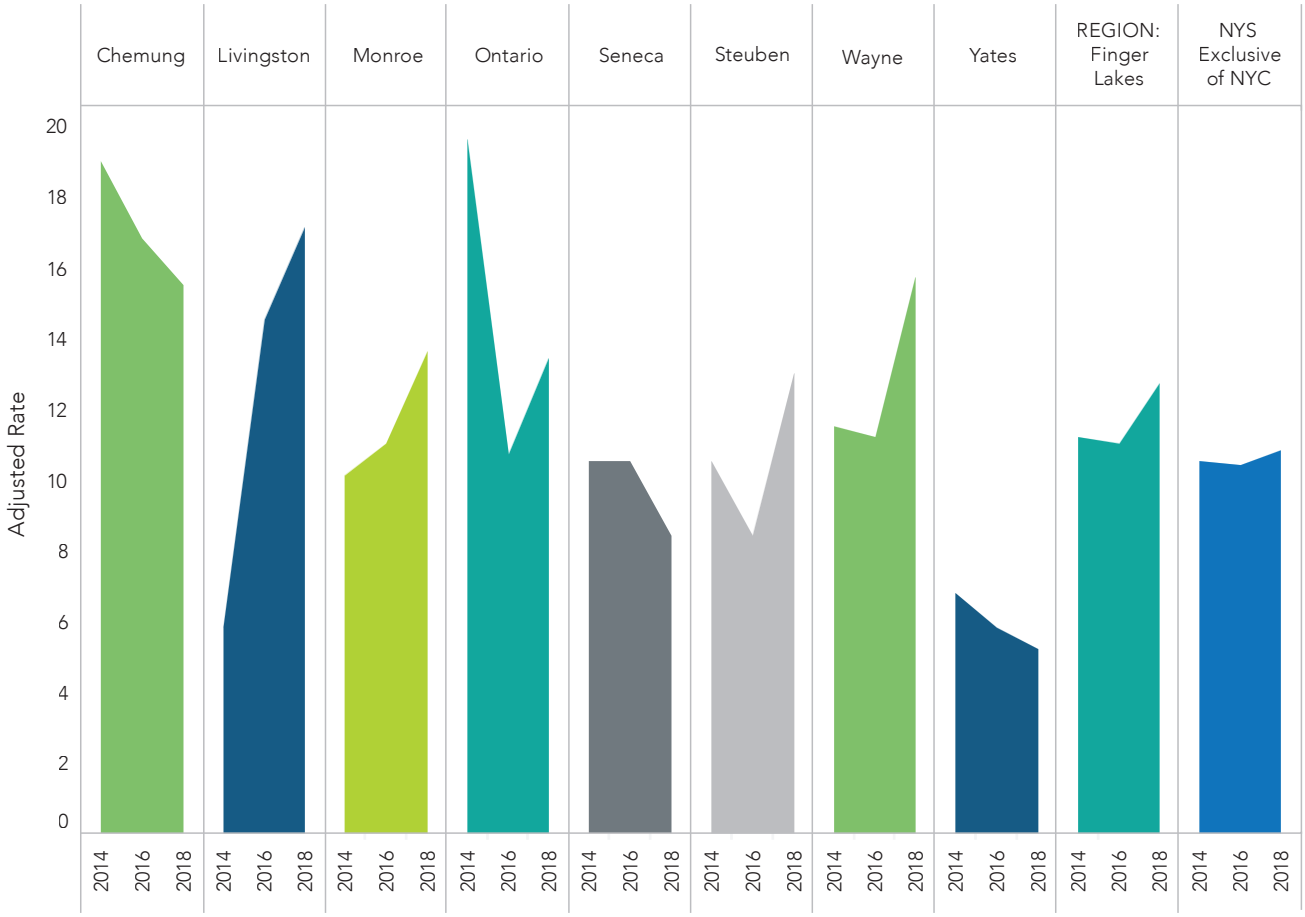

24. 2016 E-Cigarette Data at the county level, 2018 E-Cigarette Data for Livingston, Schuyler, Seneca, and Yates County not shown due to large standard error

In 2016, the rates of e-cigarette use were thought by many partners to be higher than what was reported likely due to the sparse availability of data. Anecdotal data suggests that many individuals have switched from cigarette to e-cigarette use under the impression that e-cigarettes are "safer." This perception that vaping is harmless is false, and vaping has been shown to impair the development of child and adolescent brains. In addition, gray market child-friendly chemical flavorings and colorings in the vape liquids may also damage the oral mucosa and airway and increase the risk of developing lung cancer, hypertension, stroke, heart attack and premature mortality.[25] The alarming increase in e-cigarette usage in the Finger Lakes provides an opportunity to improve community health. A focus on targeting young adults (18–24) may prove most beneficial as this population is more likely to report e-cigarette usage than any other age group.

## Asthma

Another chronic disease that has been monitored through the Community Health Assessment process is asthma. In looking at the trend of data across the Finger Lakes region from 2013-2018, we see variation between the different counties. Chemung, Seneca, and Yates counties have seen a downward trend, Livingston, Monroe, and Schuyler have seen an upward trend, while Ontario, Steuben, and Wayne have been volatile in that time frame. The Finger Lakes region and state did not show significant change in the time period. Figure 19 displays this data.

### Figure 19: Percent of Population with Asthma




Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2013-2014, 2016, & 2018. Analysis completed by Common Ground Health. Schuyler County excluded due to lack of trend data points.

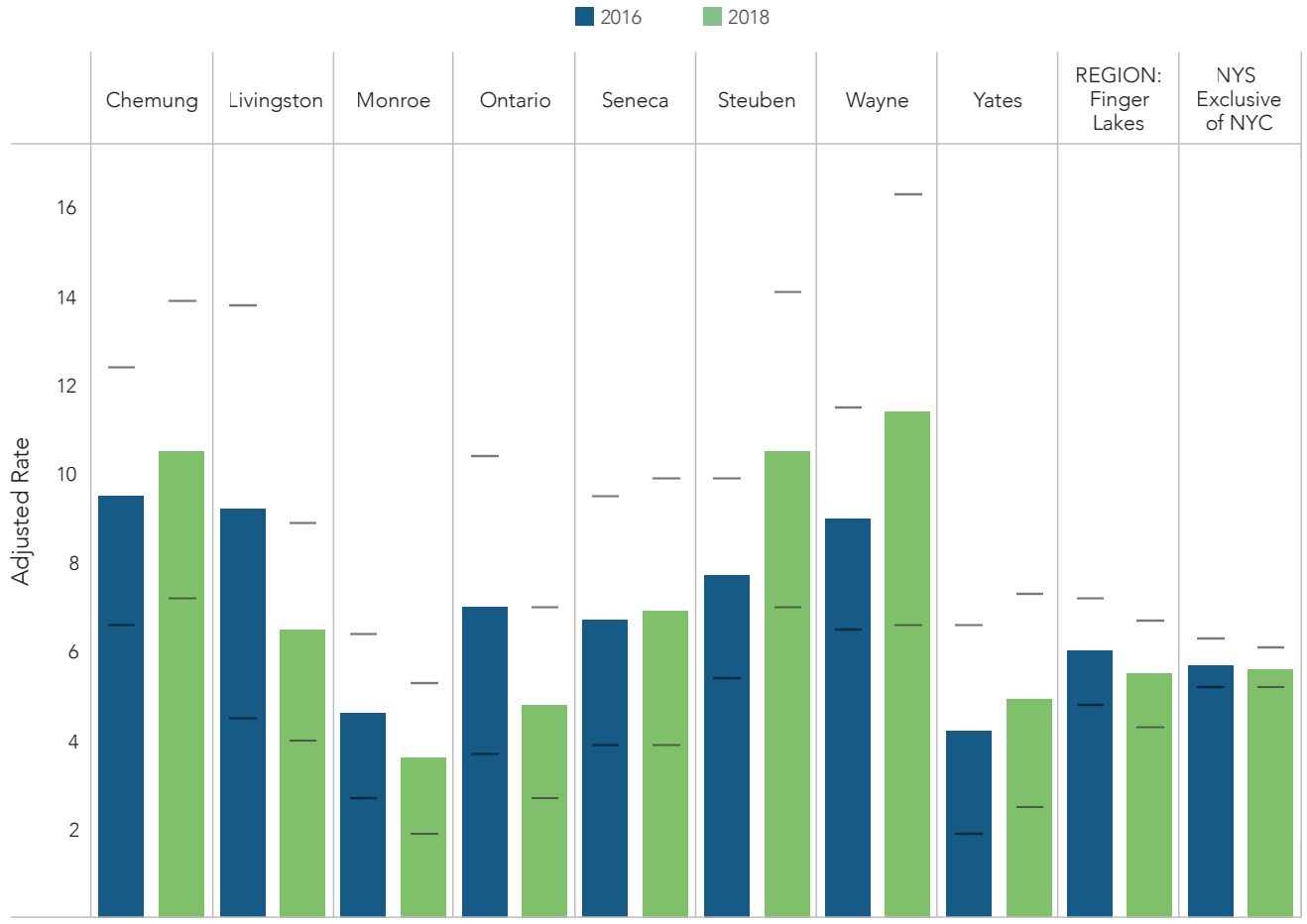


25. Muthumalage, T., Lamb, T., Friedman, M.R. et al. E-cigarette flavored pods induce inflammation, epithelial barrier dysfunction, and DNA damage in lung epithelial cells and monocytes. Sci Rep 9, 19035 (2019). https://doi.org/10.1038/s41598-019-51643-6error

## COPD

Similar to asthma, the prevalence of chronic obstructive pulmonary disease (COPD) in the Finger Lakes region is not showing any clear trends. Looking at the data from 2016 and 2018, the prevalence rate in the different counties, the Finger Lakes region, and state did not show either positive or negative trends and no county had a change of more than 3% in either direction, as shown in Figure 20.

### Figure 20: Percent of Population with COPD




Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016, & 2018. Analysis completed by Common Ground Health. Data for Schuyler County excluded due to large standard error.

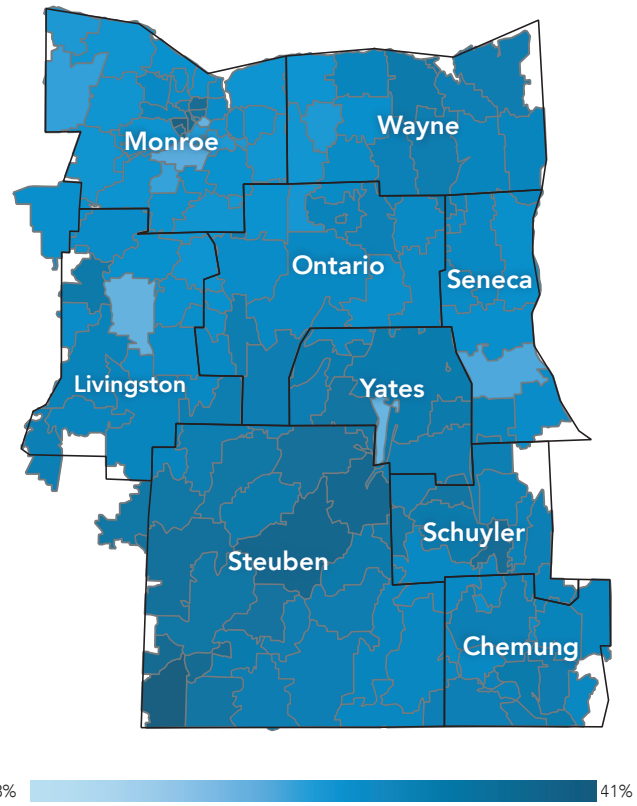
## Hypertension

An estimated 32% of adults in the Finger Lakes region have been diagnosed with hypertension. Undiagnosed or mismanaged hypertension can lead to a wealth of poor health outcomes including heart attack, stroke, kidney disease and heart failure. Map 7 demonstrates the prevalence of hypertension by ZIP code within the Finger Lakes region. Rates among the adult population range from 20% in Keuka (Yates County) to 41% in Rochester (Monroe County) and Rexville (Steuben County).

### Map 7: Percent of Adults (18+) with Diagnosed Hypertension

ZIP Codes with Highest Rate of Hypertension

| | | |
|---|---|---|
| 14877 | Steuben | 41% |
| 14611 | Monroe | 41% |
| 14810 | Steuben | 40% |
| 14874 | Steuben | 40% |
| 14840 | Steuben | 39% |
| 14608 | Monroe | 39% |
| 14839 | Steuben | 39% |
| 14621 | Monroe | 38% |
| 14865 | Schuyler | 38% |
| 14619 | Monroe | 38% |




County Estimates

| | |
|---|---|
| Chemung | 34% |
| Livingston | 29% |
| Monroe | 30% |
| Ontario | 31% |
| Schuyler | 35% |
| Seneca | 31% |
| Steuben | 36% |
| Wayne | 31% |
| Yates | 34% |

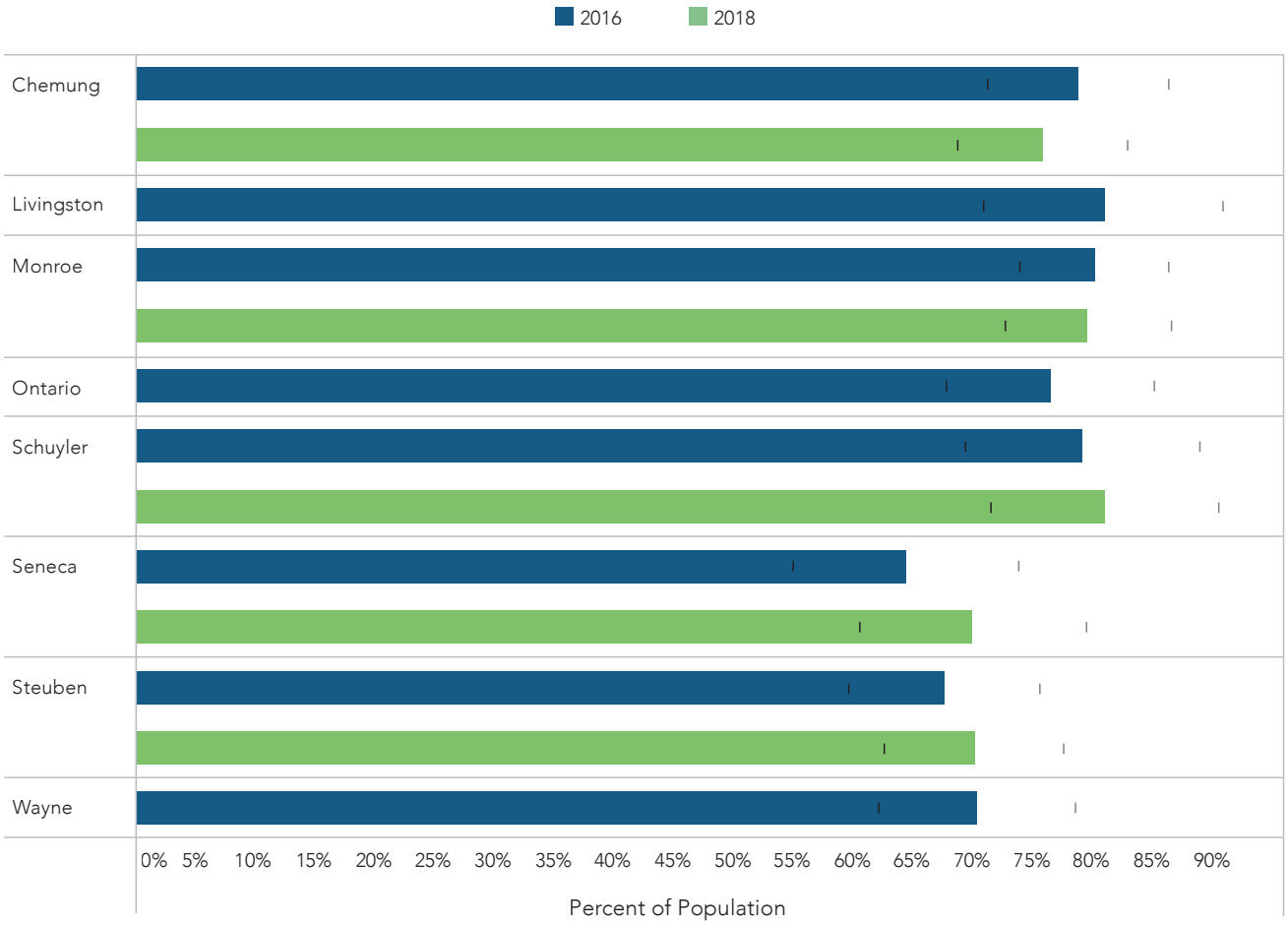
Source: CDC Places, 2018

Photo courtesy of Livingston County Department of Health

## Cancer Screening

Screening for disease is an important preventative tool used to help detect, manage and treat disease in its early stages. One disease area where that is of particular importance is cancer. Across NYS and the Finger Lakes region, three types of cancer screenings are monitored: Breast, Cervical, and Colorectal. No data for Cervical Cancer screening could be displayed due to large standard error for the data. Looking at the trend for screenings from 2016 to 2018, all counties had no significant change in their rate of cancer screenings. Figure 21 and Figure 22 show the trends of rates for breast and colorectal cancers, respectively.

### Figure 21: Breast Cancer Screening Rate[26]

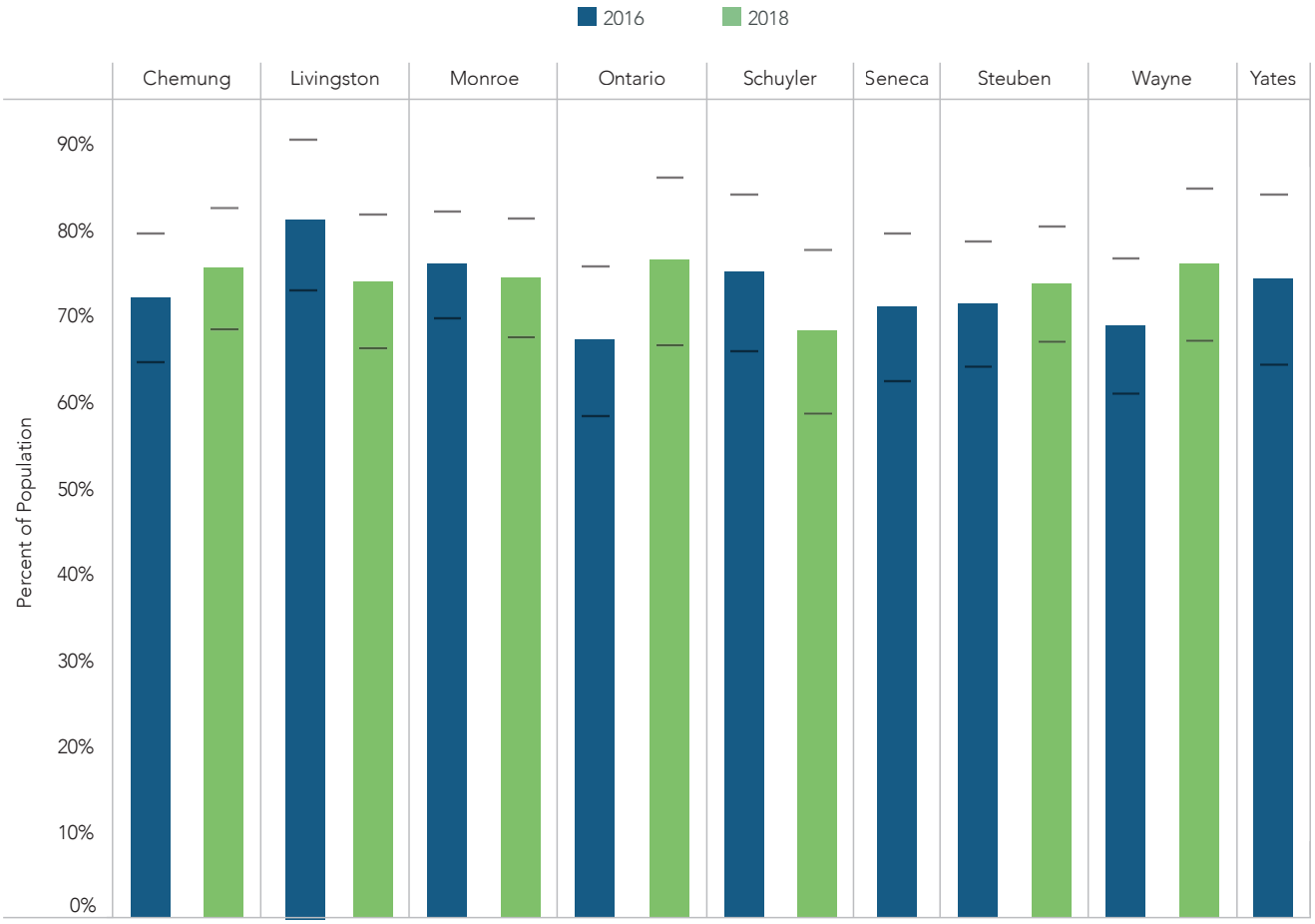



Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016, & 2018. Analysis Completed by Common Ground Health



26. 2018 Data for Livingston, Ontario, and Wayne County not shown due to large standard error. 2016 and 2018 Data for Yates County not shown due to large standard error

## Figure 22: Colorectal Cancer Screening Rate



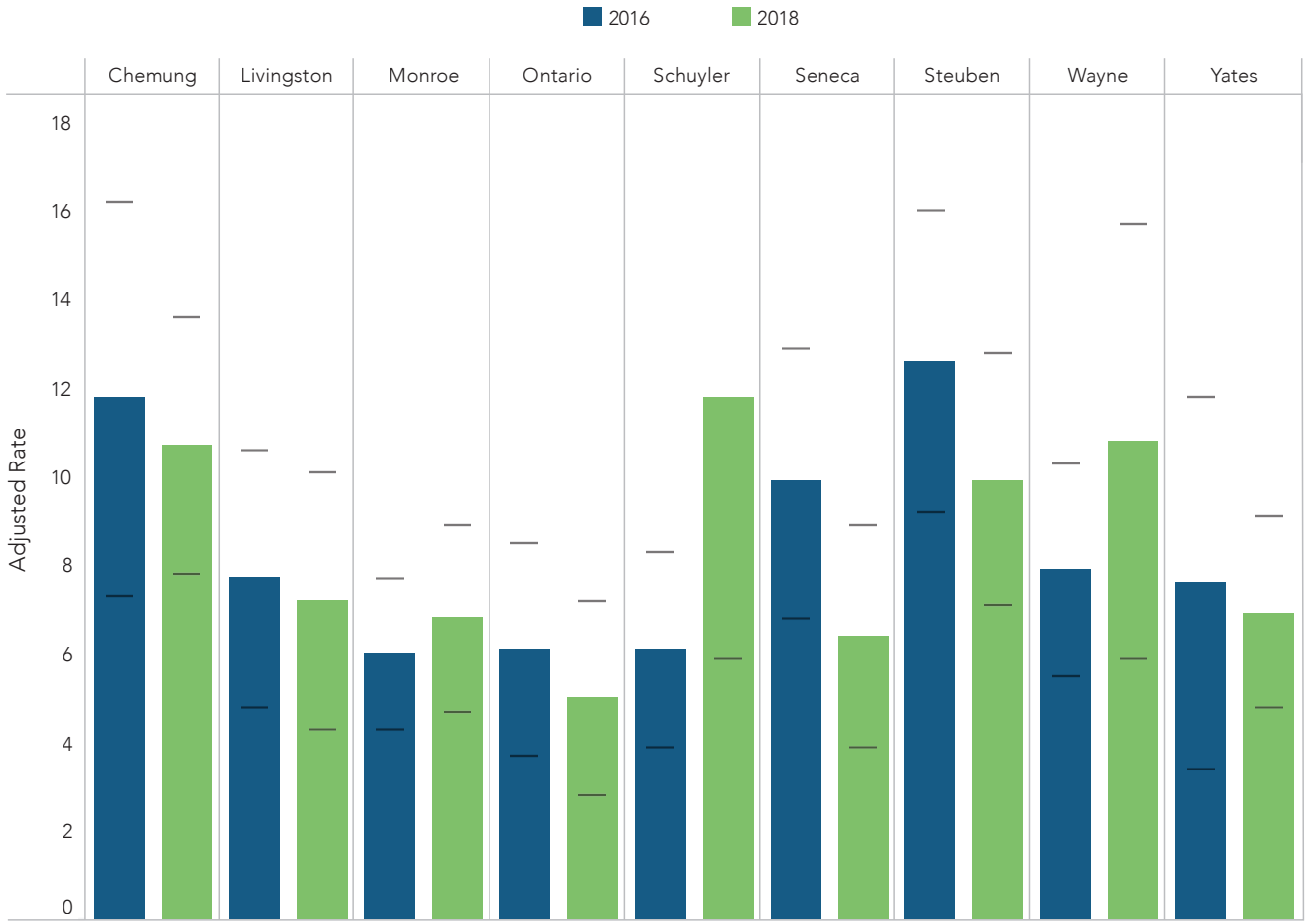

Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016, & 2018. Analysis Completed by Common Ground Health

Canadice Lake, Ontario County
Photo courtesy of VisitFingerLakes.com

## Cardiovascular Disease

Cardiovascular disease has long been a condition that has negative impacts on our community. Data from the CDC/Vital Statistics shows that cardiovascular disease has been the leading cause of death in the US since 2015.[27] In the Finger Lakes region, the rate of cardiovascular disease from 2016 to 2018 was low (<15%), but trends across the region are variable. Most counties have been stable, with Schuyler and Wayne showing increases and Seneca and Steuben showing decreases in rates. While these increases may be something to look into, the wide confidence intervals shown in Figure 23 indicate that caution should be taken in drawing any significant conclusions from the data.

### Figure 23: Rate of Cardiovascular Disease




Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016, & 2018. Analysis Completed by Common Ground Health



27. Source: National Center for Health Statistics. National Vital Statistics System: mortality statistics (http://www.cdc.gov/nchs/deaths.htm). Data for 2015-2019 are final; data for 2020 are provisional.

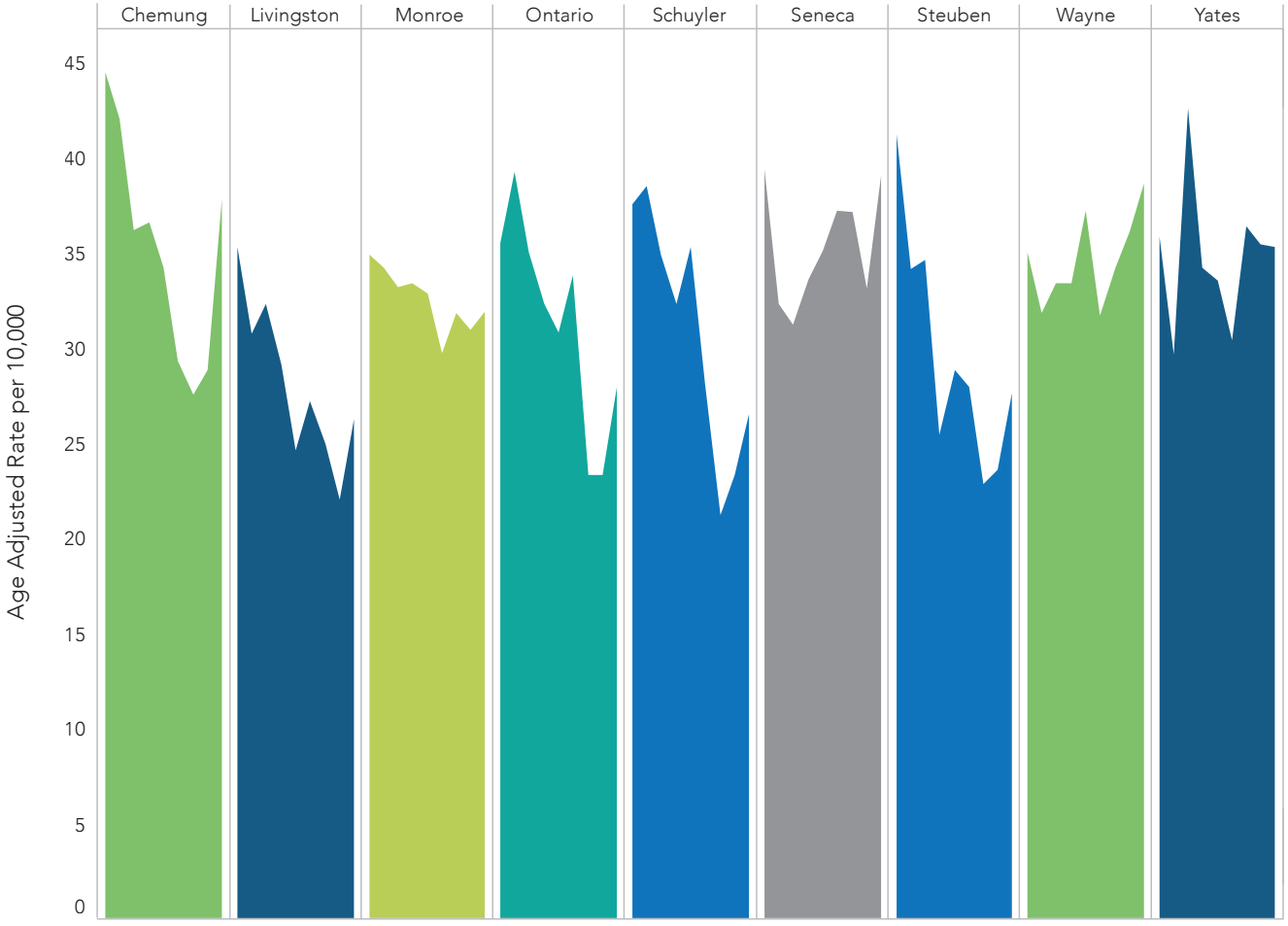
## Promote a Healthy and Safe Environment

Healthy and safe environments relate to all dimensions of the physical environment(s) in which we live, work and play that impact health and safety. This includes the air we breathe, the water we drink and utilize for recreational use, interpersonal violence, incidence of injury, and more.

### Falls in the 65+ Population

One indicator of the healthy and safe environment is falls in the 65+ population. Between 2009 and 2018, the age-adjusted rate of hospitalizations related to falls has been steady in the region, averaging around 30 per 10,000 as shown in Figure 24. Some communities, such as in Livingston County, have focused on fall prevention in previous health improvement plans. This work appears to be having the desired effect as that county has one of the lowest fall rates in the region.

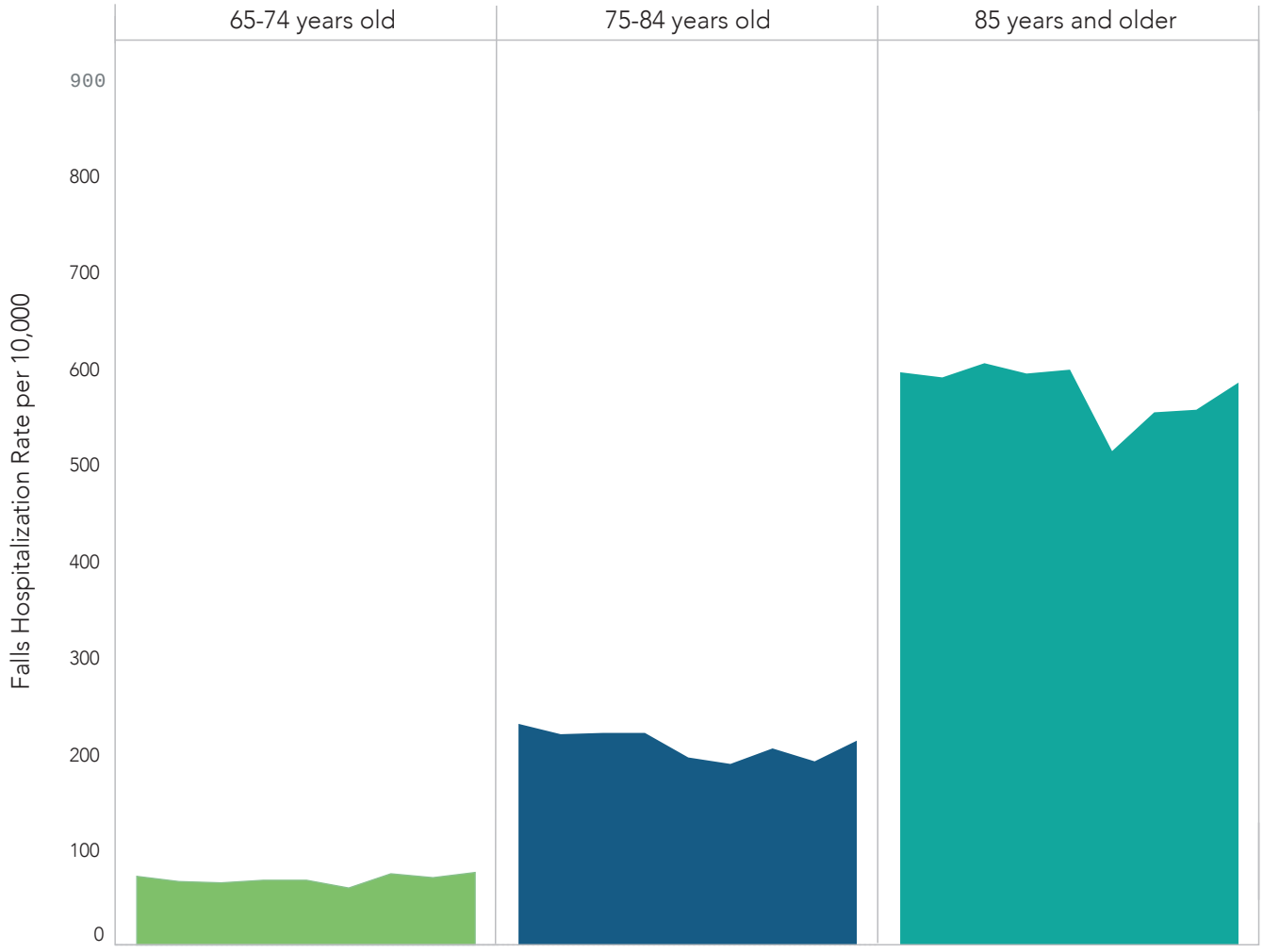
### Figure 24: Age Adjusted Rate of Fall Hospitalization




Data Source: NYS DOH, Community Health Indicator Report, Years 2009 - 2018. Analysis Completed by Common Ground Health

Looking more closely at the geriatric population within Monroe County, we see consistent rates from 2009 – 2018 (Figure 25). Other counties in the Finger Lakes region follow a similar trend. As the population ages, older individuals will be more likely to have a hospitalization from a fall. While this might indicate a higher rate of falls in older age groups, it is also likely to be driven by the frailty of older populations.

## Figure 25: Fall Hospitalization Rate in Monroe County, Ages 65 and Older

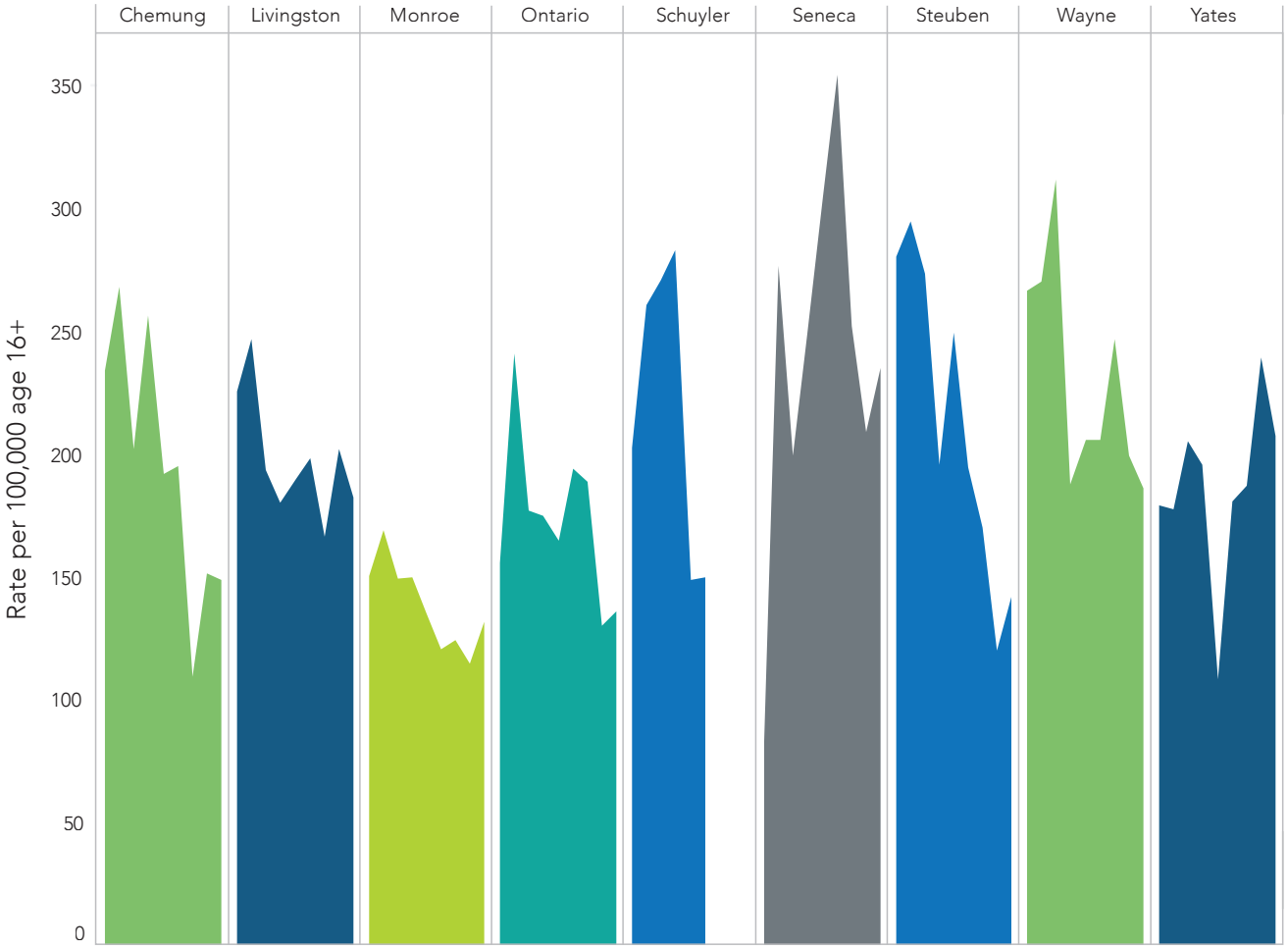



Data Source: NYS DOH, Community Health Indicator Report, Years 2009 - 2018. Analysis Completed by Common Ground Health

## Work Related Hospitalizations

Another indicator of environmental health is work place safety. Fewer injuries and hospitalizations related to work show an increased focus by employers and employees on maintaining a safe environment. In looking at the data from 2009 – 2018, work injury-related hospitalization rates are either steady or decreasing across the Finger Lakes region (Figure 26).

### Figure 26: Work Related Hospitalizations per 100,000 - Age 16 and Up

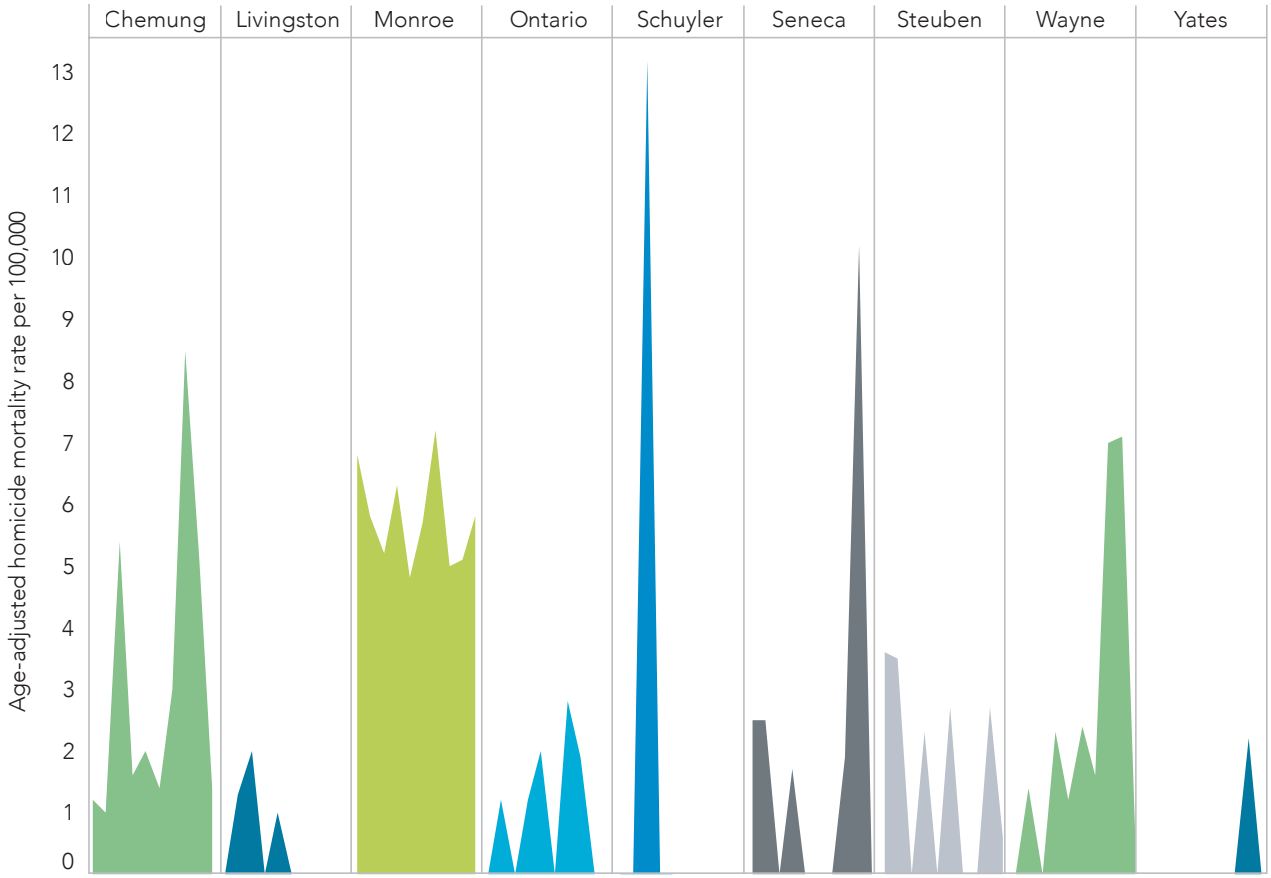



Data Source: NYS DOH, Community Health Indicator Report, Years 2009 - 2018. Analysis Completed by Common Ground Health

## Perceived Neighborhood Safety

The perception of safety in one's neighborhood and home is another indicator of environmental health. Violence in some neighborhoods has long been a concern and a major factor in reducing the life expectancy of Black men. In addition, the presence of violence in one's neighborhood may increase rates of stress and anxiety among residents, with a corresponding decrease in rates of physical activity and perceived safety. Long-term, this may lead to greater rates of poor emotional well-being, chronic disease and more. Looking at the trends from 2009 – 2017 at the county level, homicide mortality rates per 100,000 are flat or trending slightly downward (Figure 27). Of note, small numerators and/or denominators may cause arbitrary fluctuations in the results and should be taken into consideration when interpreting the data. While this data is encouraging, the more recent trends from 2018-2021 are not yet reflected in this analysis.

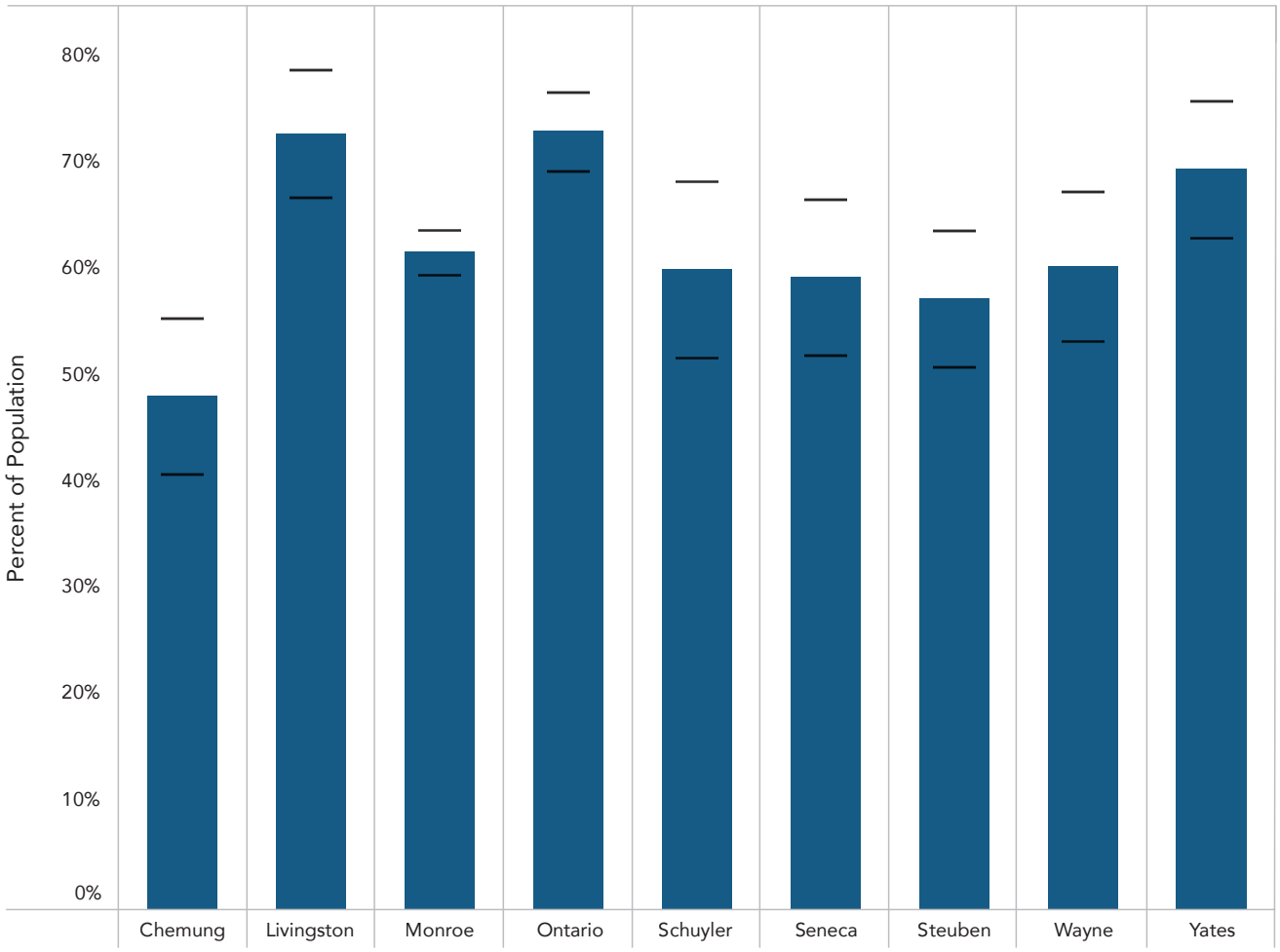
### Figure 27: Age Adjusted Homicide Mortality Rate per 100,000




Data Source: NYS DOH, Community Health Indicator Report, Years 2009 - 2018. Analysis Completed by Common Ground Health

Along with static or declining homicide rates, My Health Story offered insight into how people feel about their neighborhoods. In all but one county in the Finger Lakes region, a majority of respondents (about 60%) felt safe in their neighborhoods (Figure 28).

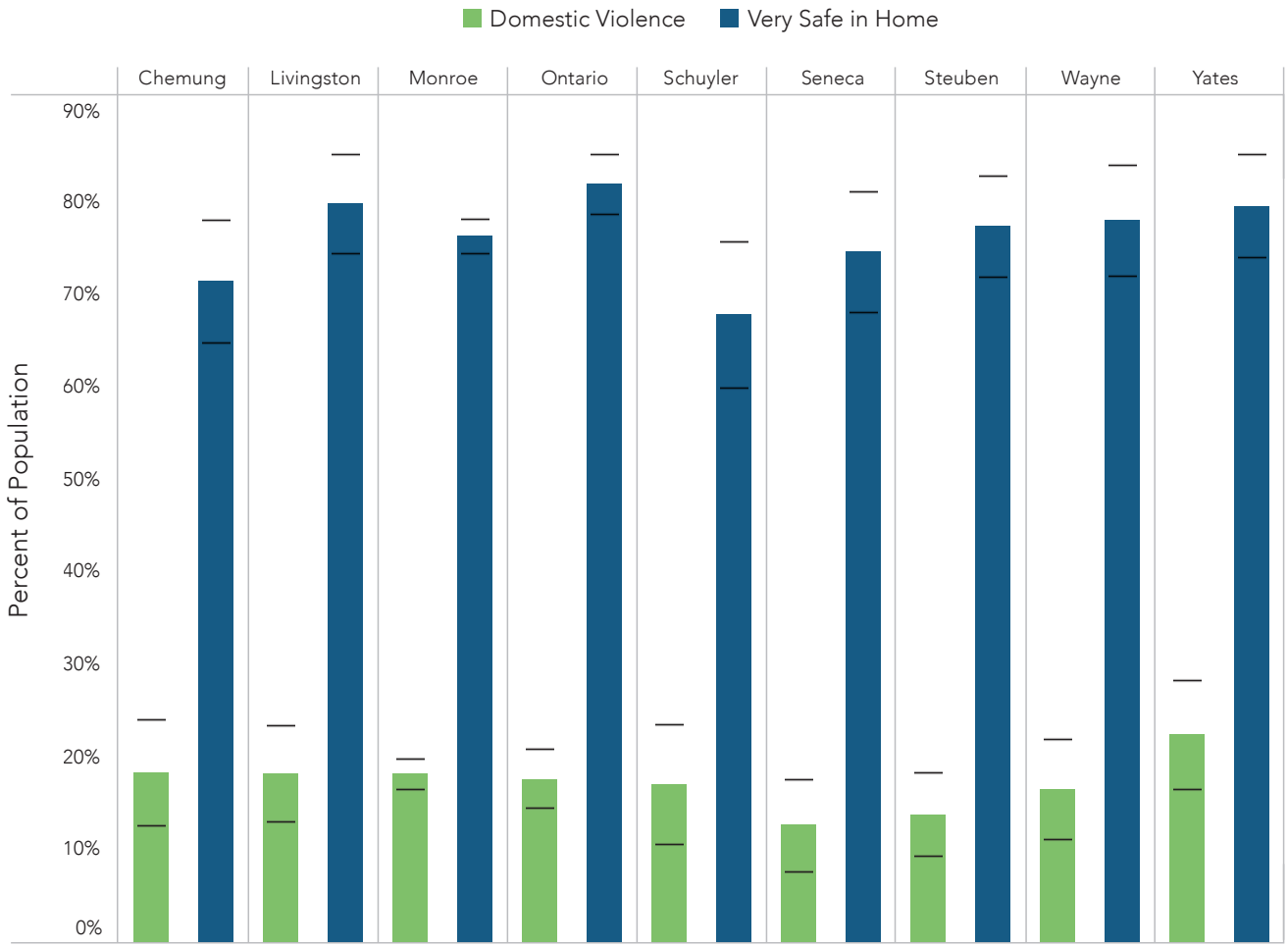
## Figure 28: Percent of Population Reporting Feeling Very Safe in Their Neighborhood




Data Source: My Health Story survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.

Not only did respondents report feeling safe in their neighborhoods, a large majority (about 75%) reported feeling very safe in their homes (Figure 29). This directly correlates to the rate of reported domestic violence.

## Figure 29: Respondent Indicators for Home Safety




Data Source: My Health Story survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.

Livingston County, Be Well in Nunda
Photo courtesy of Livingston County Department of Health

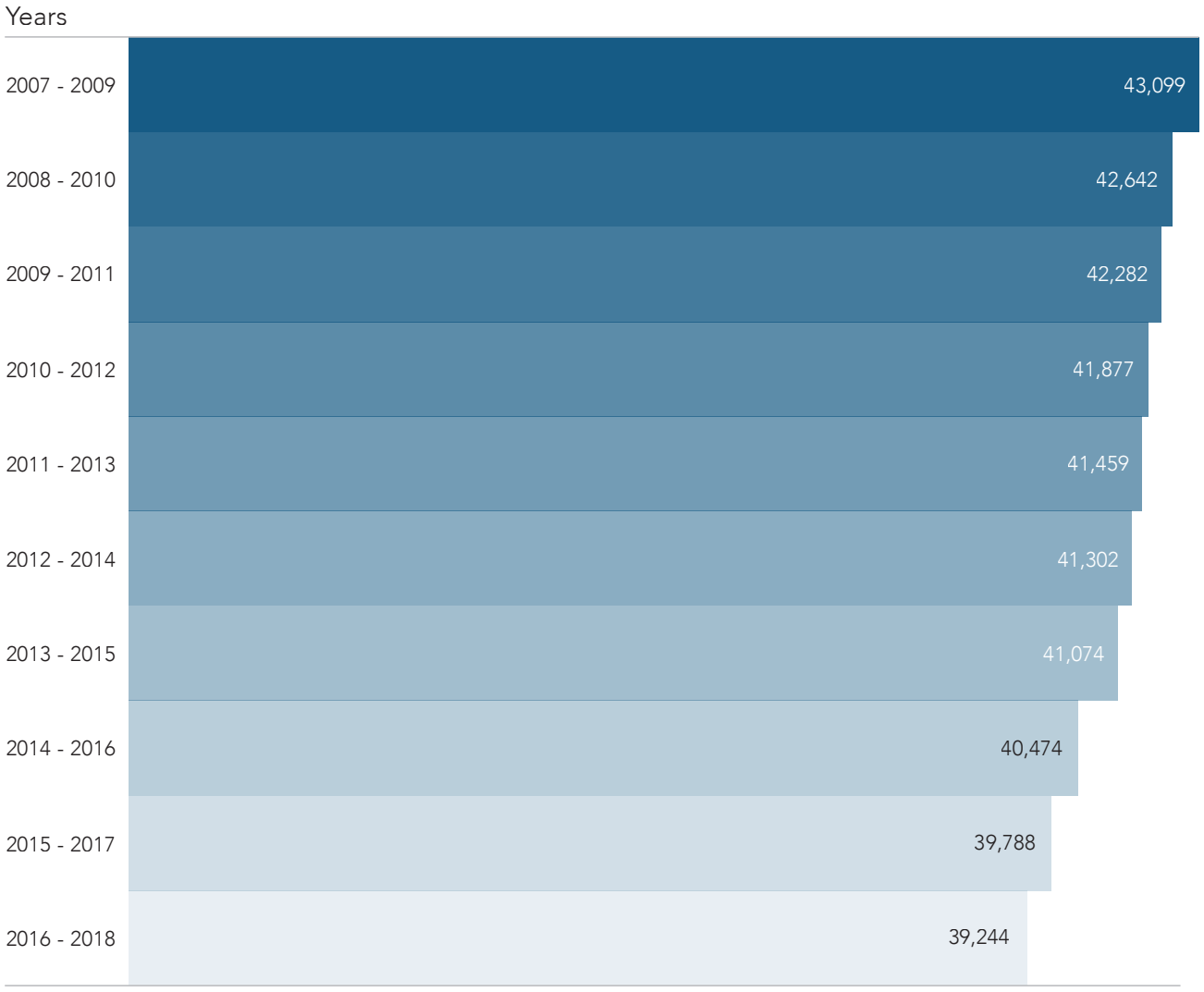
## Promote Women, Infants, and Children

Maternal and pediatric health have been areas of focus for Finger Lakes Region counties in several past Community Health Assessments. According to Healthy People 2020, "improving the well-being of mothers, infants and children is an important public health goal for the United States. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities and the health care system."

## Total Births

New York State tracks a number of maternal and pediatric well-being metrics including low birth weight, premature births, teen birth and pregnancy rates, and infant/neonate deaths. Overall, since 2007, there has been a steady decrease in the total number of births in the Finger Lakes region. For the past two 3-year periods (2015-2017 and 2016-2018), total births in the Finger Lakes region have been below 40,000 (Figure 30).

### Figure 30: Total Births in the Finger Lakes region




Source: New York State Perinatal Data Profile, 2007-2018

## Prenatal Care

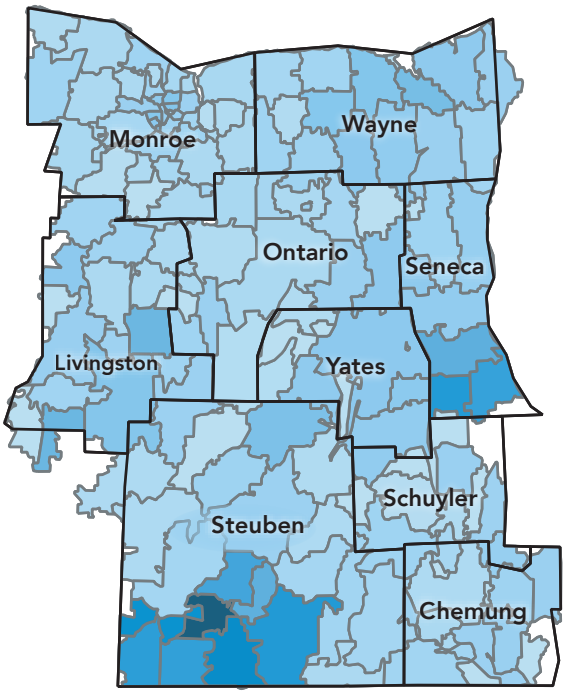
Receiving early and adequate prenatal care is important for ensuring a healthy pregnancy. At these visits, health care providers order vaccinations and tests and help with managing maternal chronic diseases that may have an impact on pregnancy. In addition, health care providers inform women about steps they can take to prevent complications. Ensuring timely prenatal care is obtained can help to lower the incidence of premature birth, low birth weight babies and infant mortality.[28]

In the Finger Lakes region, the majority of mothers receive timely prenatal care. However, Map 8 demonstrates the distribution of those receiving late or no prenatal care by ZIP code. ZIP codes with the highest rates of late or no prenatal care are in the southern portions of Seneca and Steuben Counties, with nearly 10% of the total births in each of these ZIP codes receiving late or no prenatal care. ZIP code 14855 in Jasper, Steuben County, New York had the highest rate of total births with late or no prenatal care, 35%. Of note, there were a total of 74 births that occurred in this ZIP code during the two year time frame. The area is noted to have a large Amish population who traditionally seek natural and homeopathic forms of medicine and would be less likely to seek prenatal care during pregnancy. In addition, this area of Steuben County does not have access to a local obstetrics and gynecology practice. Residents needing care need to travel to Corning or Hornell to access these services.

### Map 8: Percent of Births that Received Late or No Prenatal Care

ZIP Codes with Highest Rate of Late or No Prenatal Care

| | | |
|---|---|---|
| 14855 | Steuben | 35% |
| 14898 | Steuben | 24% |
| 14839 | Steuben | 22% |
| 14801 | Steuben | 19% |
| 14860 | Seneca | 19% |
| 14877 | Steuben | 18% |
| 14885 | Steuben | 17% |
| 14847 | Seneca | 17% |
| 14819 | Steuben | 16% |




Data by County/Region:

| | |
|---|---|
| Chemung | 3% |
| Livingston | 4% |
| Monroe | 3% |
| Ontario | 3% |
| Schuyler | 2% |
| Seneca | 10% |
| Steuben | 9% |
| Wayne | 5% |
| Yates | 3% |
| NYS Excl. NYC | 4% |

Source: NYS Department of Health Perinatal Data Profile 2016-2018
Late or no prenatal care is defined as care initiated in the third trimester or not at all


28. National Center for Biotechnology Information, Factors Associated with Lack of Prenatal Care in a Large Municipality, 2014

## Premature Births

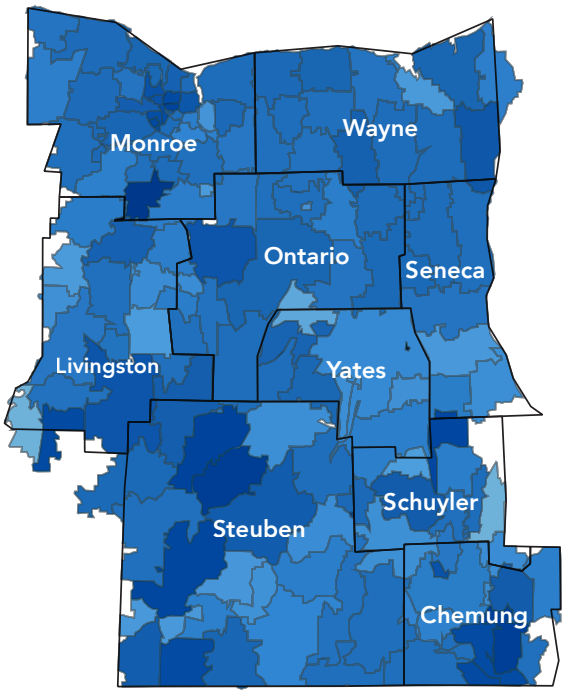
A baby born prematurely (<37 weeks gestation) is at risk for several health complications including jaundice, anemia, apnea, and more. The earlier in pregnancy a baby is born, the more likely it is that the baby will need to spend time in the neonatal intensive care unit (NICU). Long-term health complications associated with premature birth include intellectual and developmental delays, problems with communicating, getting along with others, and even taking care of him or herself. Neurological disorder, behavioral problems, and asthma may also occur.[29]

According to the New York State Department of Health Perinatal Data Reports, there are pockets within each county that have higher rates of premature birth (Map 9). The ZIP code with the highest rate of premature birth is found in Yates County, a county with a large population of Amish/ Mennonite which, as discussed in previous sections, likely impacts rates of prenatal care and negative birth outcomes, such as prematurity, low birth weight and infant mortality. In addition, the county's population is quite small in comparison to nearby counties (just 25,000 residents) and small numerators may cause significant fluctuation in the rates. In comparison to New York State, excluding New York City, the Finger Lakes region ranks favorably.

### Map 9: Percent of Births that were Premature

ZIP Codes with Highest Rate of Premature Births

| | | |
|---|---|---|
| 14441 | Yates | 30.0 |
| 14543 | Monroe | 20.0 |
| 14809 | Steuben | 18.1 |
| 14861 | Chemung | 17.5 |
| 14826 | Steuben | 16.7 |
| 14605 | Monroe | 16.3 |




Data by County/Region:

| | |
|---|---|
| Chemung | 10.0 |
| Livingston | 7.5 |
| Monroe | 10.3 |
| Ontario | 9.0 |
| Schuyler | 7.7 |
| Seneca | 7.4 |
| Steuben | 9.5 |
| Wayne | 9.2 |
| Yates | 9.3 |
| NYS Excl. NYC | 10.6 |

Source: NYS Department of Health Perinatal Data Profile 2016-2018
Premature births are defined as births that occurred before 37 weeks gestation


29. March of Dimes, Premature Babies and Long-Term Health Effects of Premature Birth, www.marchofdimes.org.

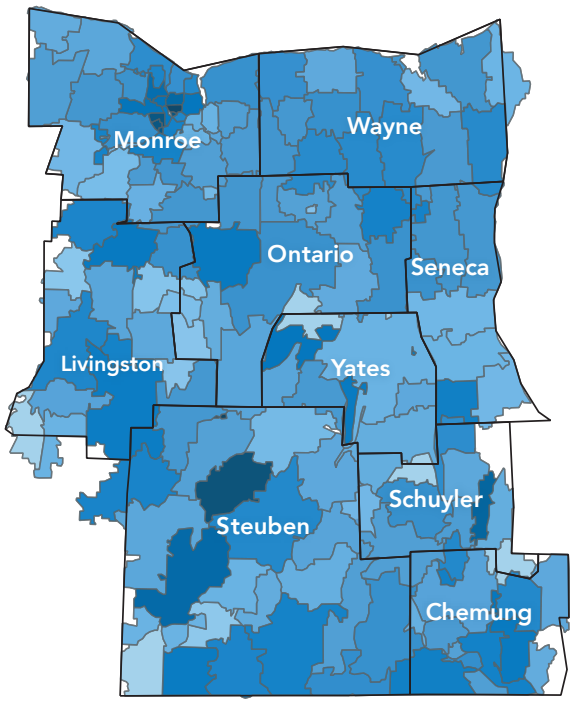
## Low Birth Weight Babies

A child born at a low birth weight may suffer a range of health complications at birth. Some of the common issues for a low birth weight newborn include low oxygen levels, breathing complications due to immature lungs, difficulty feeding and gaining weight, neurological and gastrointestinal problems, infection, and more. Of note, premature birth is the primary cause of low birth weight.[30] In comparison to New York State excluding NYC, the Finger Lakes region again ranks favorably (Map 10). Within the region, Monroe, Chemung and Steuben Counties have the highest rates of low birth weight.

### Map 10: Percent of Births that were Low Birth Weight

ZIP Codes with Highest Rate of Low Birth Weight Babies

| | | |
|---|---|---|
| 14808 | Steuben | 16.7 |
| 14605 | Monroe | 16.3 |
| 14809 | Steuben | 15.1 |
| 14604 | Monroe | 14.6 |
| 14611 | Monroe | 14.6 |
| 14619 | Monroe | 14.6 |




Data by County/Region:

| | |
|---|---|
| Chemung | 7.2 |
| Livingston | 5.8 |
| Monroe | 7.7 |
| Ontario | 5.9 |
| Schuyler | 5.3 |
| Seneca | 5.5 |
| Steuben | 6.8 |
| Wayne | 6.5 |
| Yates | 5.4 |
| NYS Excl. NYC | 7.7 |

Source: NYS Department of Health Perinatal Data Profile 2016-2018
Low Birth Weight is defined as birth weight between 100-2499 grams


30. Stanford Children's Health, Low Birthweight

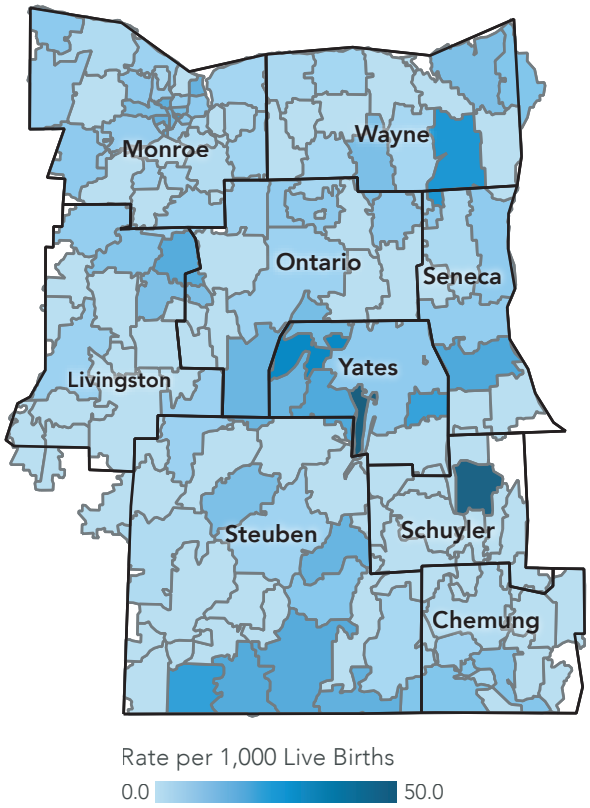
## Infant Mortality

Prematurity and its related conditions are the leading cause of infant mortality. Reducing rates of premature birth may have a direct correlation on rates of infant mortality (deaths that occur within the first twelve months). Shown below in Map 11 is a map of infant mortality rates by ZIP code from 2016-2018. Rates are nearly 50 per 1,000 live births in two ZIP codes – one of which is located in Yates and the other in Schuyler County. It is again important to note, however, that both of these counties are relatively small (Yates – 25,000 residents; Schuyler – 18,000 residents) and their small numerators may inadvertently inflate rates. Of note, New York State has set a goal for the Infant Death Rate (deaths which occur at less than twelve months of age) at 4.0 per 1,000 live births to be achieved by 2020.[31]

### Map 11: Infant Mortality Rate per 1,000 Live Births

ZIP Codes with Highest Rate of Infant Mortality

| | | |
|---|---|---|
| 14478 | Yates | 50.0 |
| 14818 | Schuyler | 48.8 |
| 14507 | Yates | 35.7 |
| 14433 | Wayne | 28.4 |
| 14604 | Monroe | 24.4 |
| 14885 | Steuben | 24.4 |
| 14842 | Yates | 23.8 |




Data by County/Region:

| | |
|---|---|
| Chemung | 3.1 |
| Livingston | 3.8 |
| Monroe | 6.5 |
| Ontario | 4.4 |
| Schuyler | 4.8 |
| Seneca | 7.1 |
| Steuben | 6.3 |
| Wayne | 5.5 |
| Yates | 16.5 |
| NYS Excl. NYC | 4.9 |

Source: NYS Department of Health Perinatal Data Profile 2016-2018
Infant deaths are those that occurred at less than 12 months of age

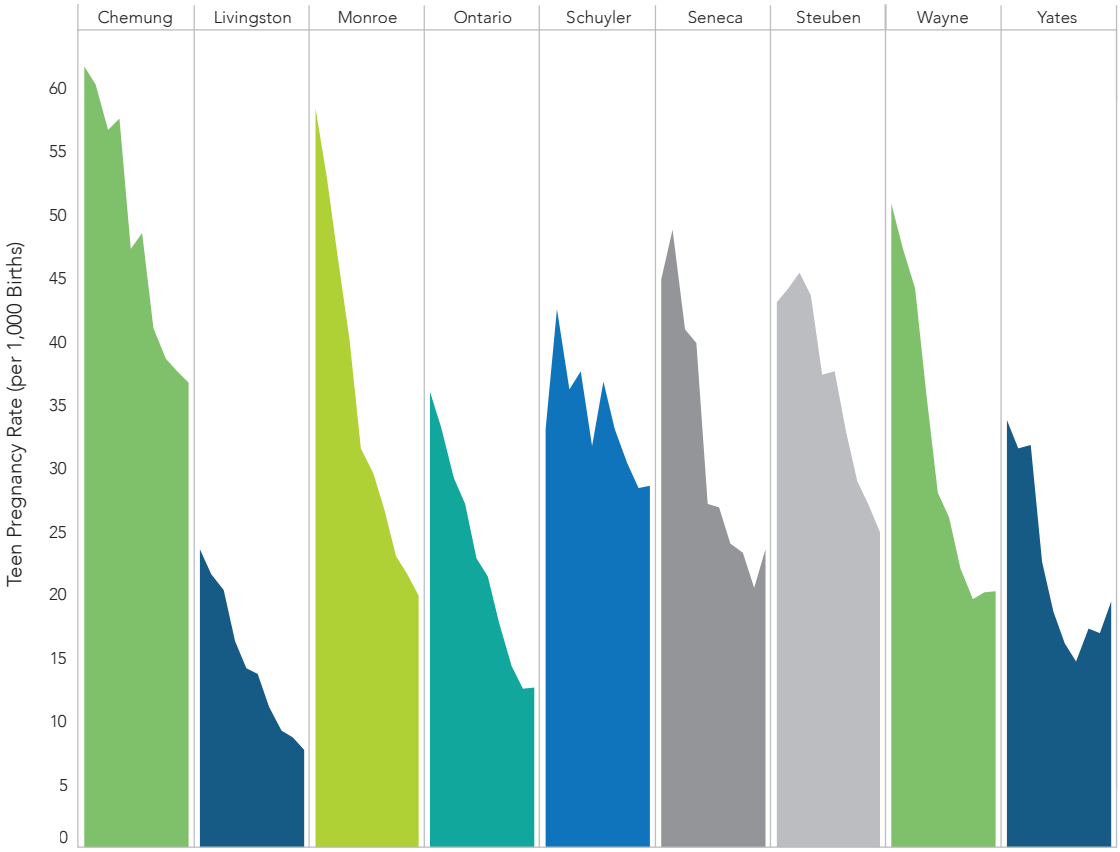

31. While this report was created in 2021 and 2022, data on years 2019 and 2020 are not yet available.

## Teen Pregnancy

Two areas in which we have seen significant decreases over the past decade and a half are teen pregnancy and teen birth rates. The difficulties of raising a child are often amplified for teenage parents as their new responsibilities can conflict with primary and secondary education, employment and other opportunities for personal growth and development. In addition, teenage pregnancy can have a different impact on personal relationships than adult pregnancy and may result in a decrease in support from family, friends and the child's father figure. Given these challenges, teen parents tend to experience higher rates of single parenthood, perinatal depression and poverty. Communities are also affected by the long-term health consequences of increased child poverty and maternal depression rates.[32] There are higher rates of Child Protective Service involvement and foster care placement for children of teenage pregnancies as well as higher rates of incarceration in the child's adolescent years.[33] All of these factors may contribute to the prevalence of other health outcomes and demographics (such as single parent households and poverty estimates) listed in this report.

As seen in Figure 31, teen pregnancy rates have decreased significantly in all 9 counties in the Finger Lakes region. All counties (except Schuyler) have shown a decrease of ~20 pregnancies per 1,000 since 2007. The smaller decrease in Schuyler is likely due to smaller number of total births, as they had about 500 births during the 3-year period compared to other counties that had 1,000 births or more in that same timeframe. The Finger Lakes trend mimics a similar national decrease in teen pregnancy.

### Figure 31: Teen Pregnancy Rate per 1,000 Births




Data Source: New York State Vital Statistics Data, 2007 - 2018. Analysis Completed by Common Ground Health

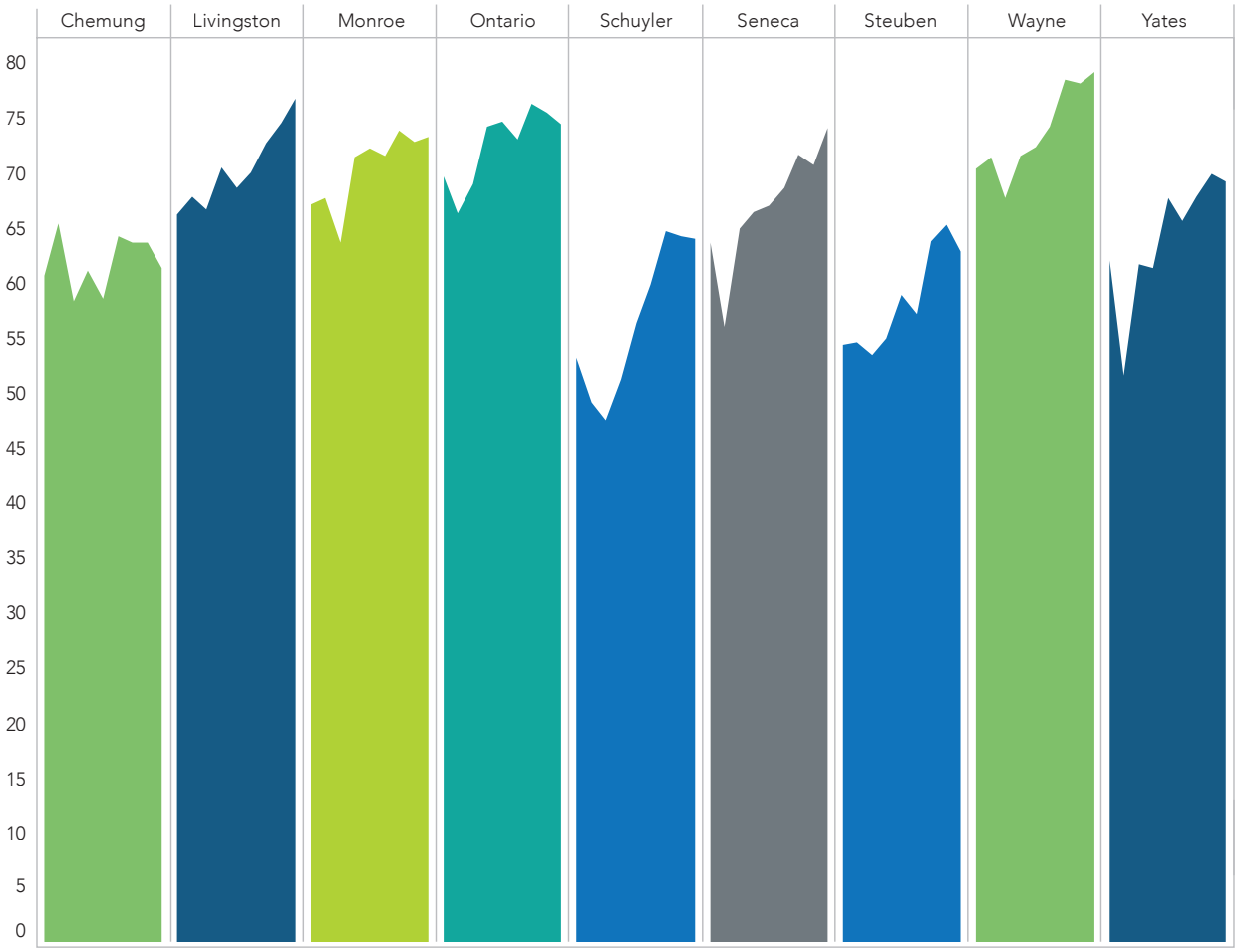


32. The Urban Child Institute, How Adolescent Parenting Affects Children, Families and Communities, 2014
33. Youth.gov, Adverse Effects of Teen Pregnancy, 2008

## Well-Child Visits

As mentioned in previous sections of this report, screening plays an important part in preventing and properly treating diseases. During the first 3 years of life, the tests, screenings, and vaccines being administered are essential in helping children become healthy and successful. With this in mind, children attending the appropriately scheduled well child visits is an important metric to ensure this happens. New York State tracks the percent of children who attend the recommended number of well-child visits that are covered by state insurance (Medicaid, managed Medicaid, Child Health Plus, etc.). Figure 32 shows the trend of this percentage across the Finger Lakes region.

### Figure 32: Percentage of Children with Recommended Number of Well-Child Visits in Government Sponsored Insurance Programs - 2010 - 2018



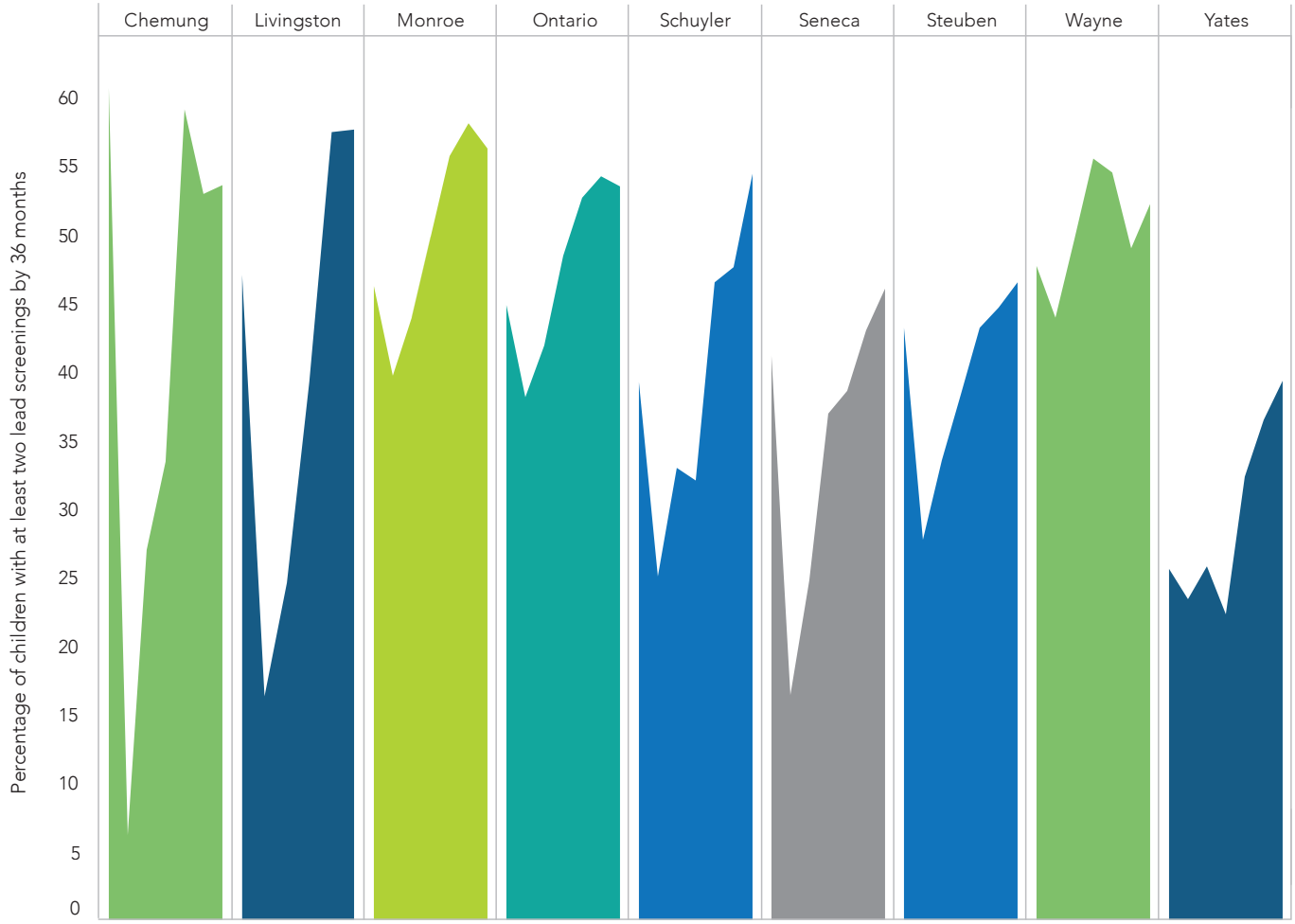

Data Source: New York State Vital Statistics Data, 2010 - 2018. Analysis Completed by Common Ground Health

Over the 9 year period shown in the chart, all 9 counties have seen an upward trend in the percent of children receiving their recommended number of well-child visits. This is likely due to many counties and providers making maternal and child health a focus for recent community health improvement plans. Along with this, the impact of the adoption of telehealth practices in response to COVID-19 will be interesting to monitor with regard to how it impacted this rate in 2020 and beyond.

## Blood Lead Level Screening in Children

One important screening that happens during the aforementioned well-child visits is blood lead level screenings. "Asymptomatic lead poisoning has become more common in children. Blood lead levels of greater than 5 µg per dL are associated with impairments in neurocognitive and behavioral development that are irreversible."[34] The recommendation is for children to have at least two screenings in the first 36 months of life. Across the Finger Lakes region, all 9 counties have been able to show an upward trend of this screening from 2009 to 2018, several hitting their highest rates in 2018, as shown in Figure 33.

### Figure 33: Percentage of Children with at Least Two Lead Screenings by 36 months - 2009 - 2018




Data Source: New York State Vital Statistics Data, 2007 - 2018. Analysis Completed by Common Ground Health


34. Mayans, L. (2019). Lead poisoning in children. American family physician, 100(1), 24-30.

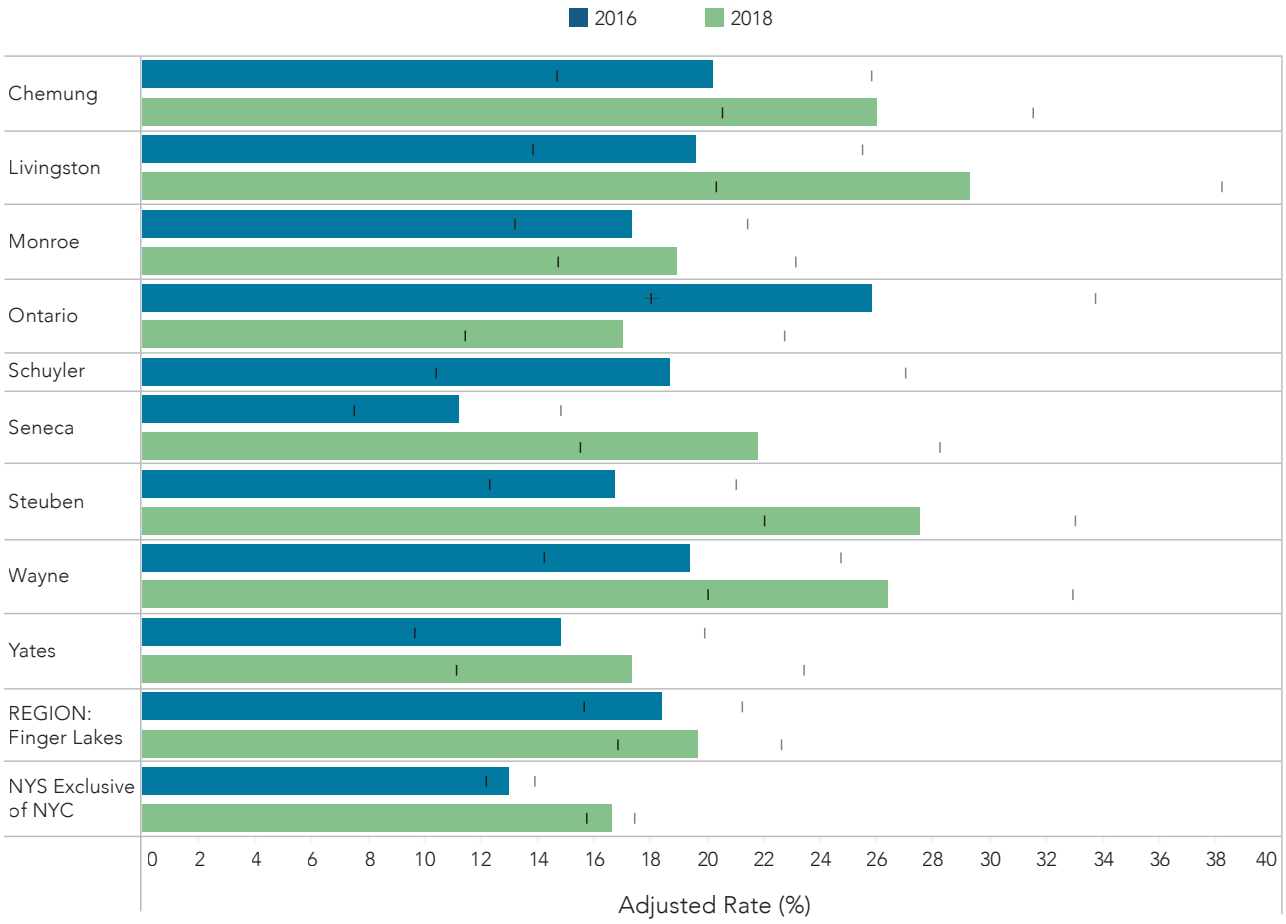
## Promote Well-Being and Prevent Mental and Substance Use Disorders

A rise in the incidence of mental health conditions and substance use disorders has been seen across the nation and region for the past decade. In 2020, the COVID-19 pandemic only exacerbated the concerns and challenges communities were experiencing in these areas. Increased isolation, loss of loved ones, and a disheartening news cycle were major factors related to the pandemic that contributed to challenges with mental health and well-being.

## Mental Health Well-Being

A review of rates of depressive disorders in the Finger Lakes region from 2016 to 2018 reveals that there has been an increase in the rates in 7 of the 9 counties, as seen in Figure 34. Along with this, the rates in the Finger Lakes region and counties were higher than the rate for the state. While one would think an increase in diagnosed depressive disorder is a concerning trend, the opposite might actually be true. Awareness of mental health, the reduction of stigma in certain communities (specifically, men and minorities), and increased access to care may be driving the rates up. Both the reduction of stigma and increased access to care may be allowing those who would previously not have received it to get the care they need.

### Figure 34: Percent of Population with a Depressive Disorder[35]

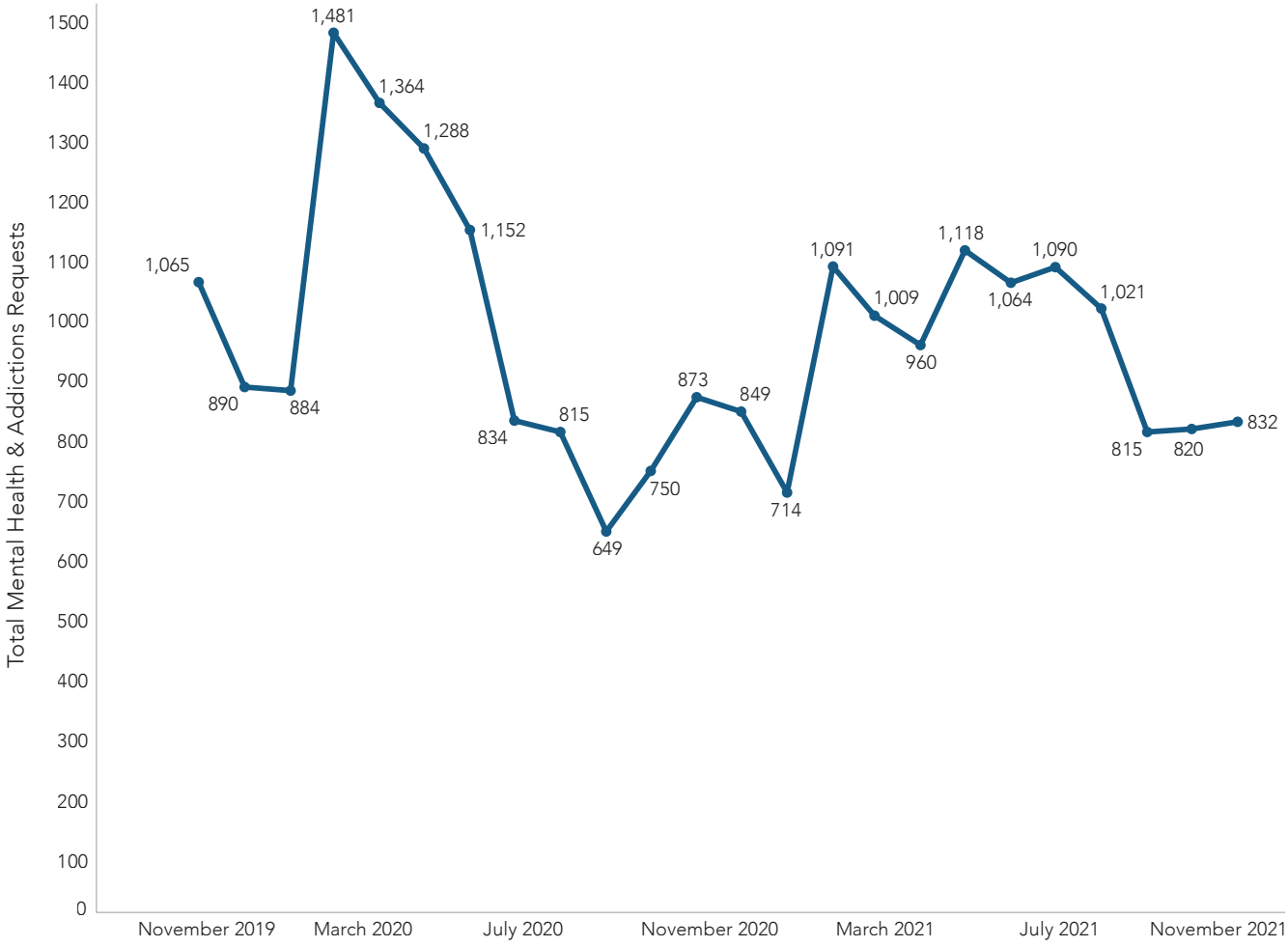



Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016, & 2018. Analysis Completed by Common Ground Health


35. 2018 Data for Schuyler County not shown due to large standard error

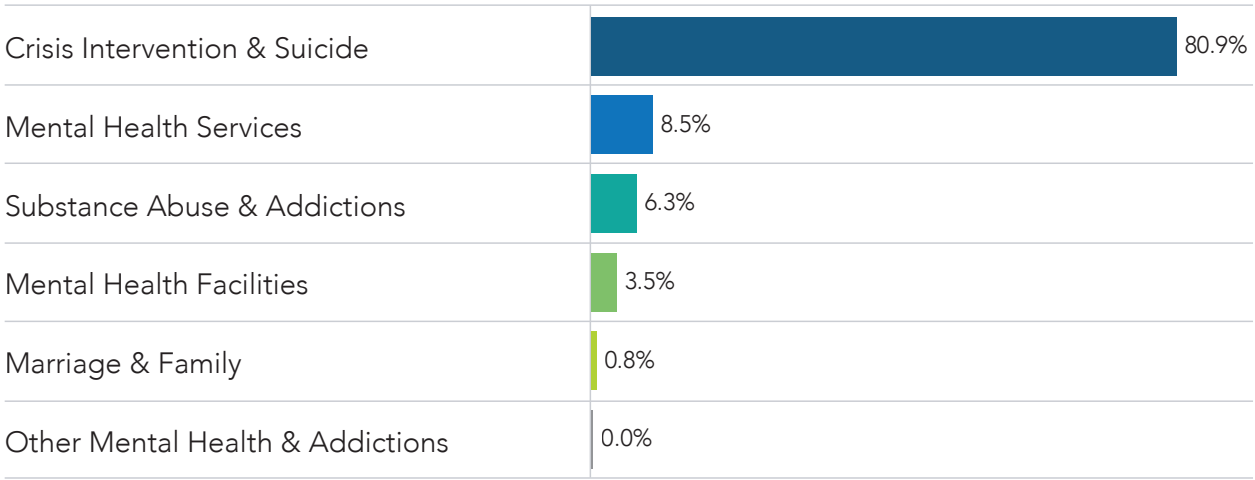
COVID-19 has increased the incidence of depression and anxiety across the globe. Looking at data from 211 Lifeline and 211 Counts, we can see the increase in calls related to mental health at the beginning of the pandemic and a high incidence for most of 2021. Figure 35 shows the trend for the Finger Lakes region, while Figure 36 shows the type of requests 211 has received related to mental health from 12/2020 to 11/2021.

## Figure 35: Trend of 211 Mental Health Calls – Finger Lakes region




Data Source: 211 Lifeline, 211 Counts, December 2019 to November 2021

## Figure 36: Top 211 Mental Health Requests – Finger Lakes region



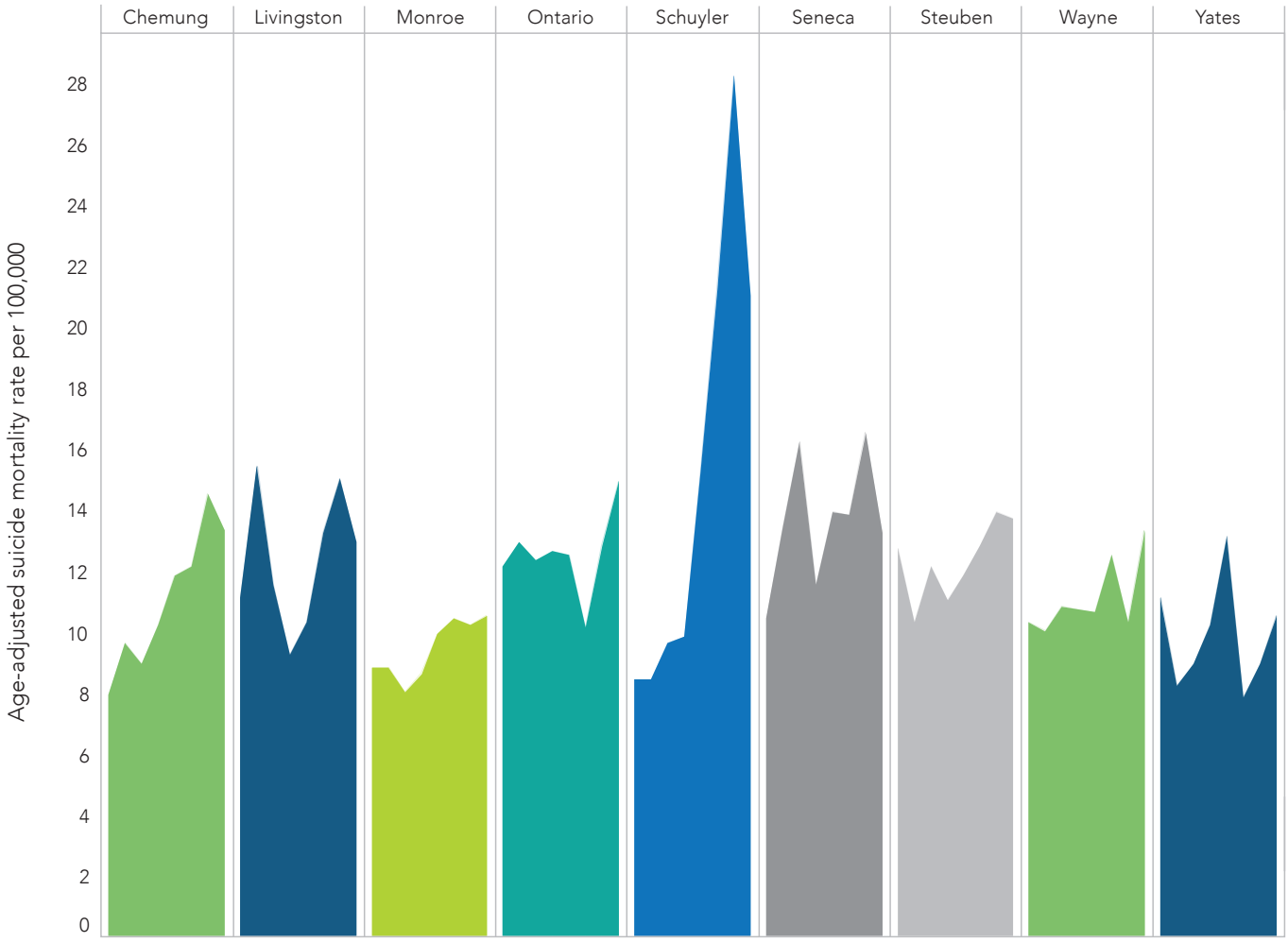

Data Source: 211 Lifeline, 211 Counts, December 2019 to November 2021

Ontario County
Photo courtesy of VisitFingerLakes.com

Another area of concern related to mental health and well-being is the number of deaths by suicide. A review of data across the Finger Lakes region from 2009-2019 revealed that the 3-year moving average of the death rates per 100,000 have decreased only in Yates County.

Rates in all the other Finger Lakes counties increased, with Schuyler showing a marked increase in 2018. Figure 37 shows this data.

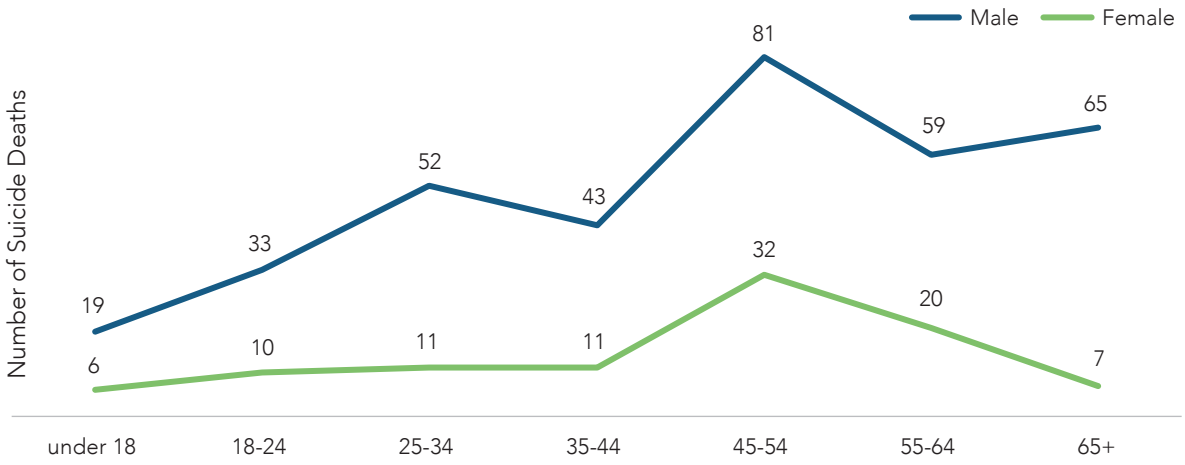
## Figure 37: Age-Adjusted Suicide Death Rate per 100,000, 3-Year Moving Average




Data Source: New York State Vital Statistics Data, 2009 - 2019. Analysis Completed by Common Ground Health

When stratified by age group and sex, the highest rate of suicides in the Finger Lakes region occurs in the male population, ages 45-54. A similar spike occurs in females for the same age group (Figure 38). These findings are consistent with national statistics. A study completed in 2019 revealed several risk factors for suicidal behaviors common to both genders, including previous mental and substance abuse disorder and exposure to interpersonal violence. Male-specific risk factors included disruptive behavior/conduct problems, feelings of hopelessness, parental separation or divorce, a friend's suicidal behavior and access to means.[36] Female-specific risk factors included eating disorders, depressive symptoms and interpersonal problems.

## Figure 38: Suicide Rates by Age Group and Gender, Finger Lakes Region




Source: NYSDOH Vital Statistics, 2013 - 2017

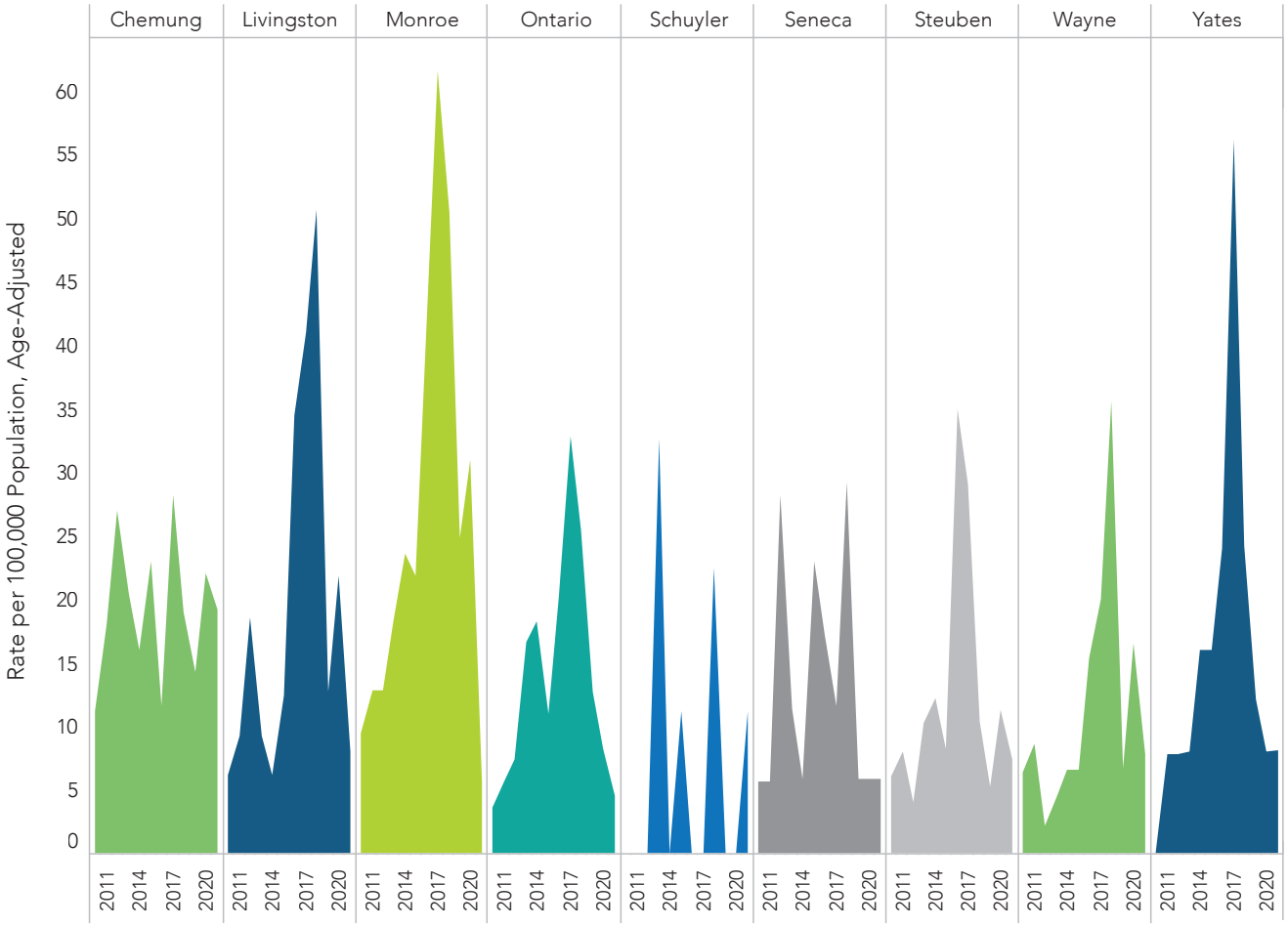
Ontario County, Kershaw Park, Canandaigua
Photo courtesy of VisitFingerLakes.com

36. Miranda-Mendizabal, A., Castellvi, P., Pares-Badell, O., Alayo, I., Almenara, J., Alonso, I., Alonso, J. (2019). Gender differences in suicidal behavior in adolescents and young adults: Systematic review and meta-analysis of longitudinal studies. International Journal of Public Health, 64(2), 265–283. 10.1007/s00038-018-1196-1.

## Substance Use Disorders

One area that has received a great deal of attention across the nation and in the Finger Lakes region is the opioid epidemic. Impacting all races, ethnicities, and socio-economic groups, Opioid Use Disorders have a significant negative impact on health outcomes for those with the condition. While the impact of opioid use disorder on comorbid conditions (mental health, medical conditions) is an area of concern, opioid overdose death rates are a major indicator of the success or failure of interventions. Reviewing the data in Figure 39, there appears to be a peak of overdose deaths in the Finger Lakes region in 2017 and 2018.

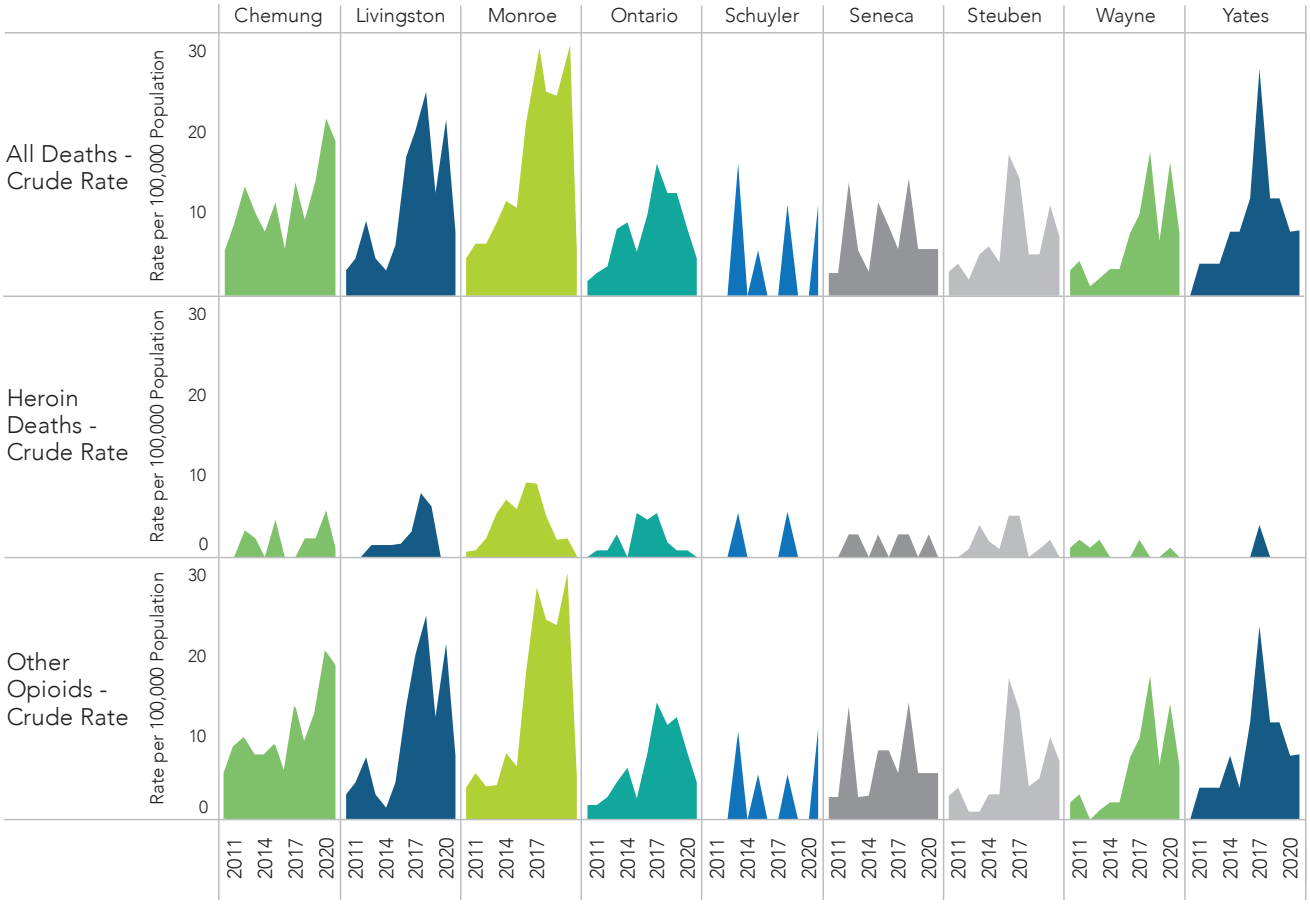
### Figure 39: All Opioid Overdose Deaths: Age-Adjusted rate per 100,000




Data Source: Data Source: New York State Vital Statistics Data, 2010 - 2020. Analysis Completed by Common Ground Health

Looking for reasons for the increase in overdose deaths around 2016 and subsequent decrease around 2018, we can look to other data for correlation. While there was an increase in heroin-related deaths around this time period (Figure 40), the increased prevalence of fentanyl (a synthetic often sold as heroin) was the major driver of the increase in opioid-related deaths. Figure 40 shows the increase in both the overall and synthetic (mostly fentanyl) death rates.

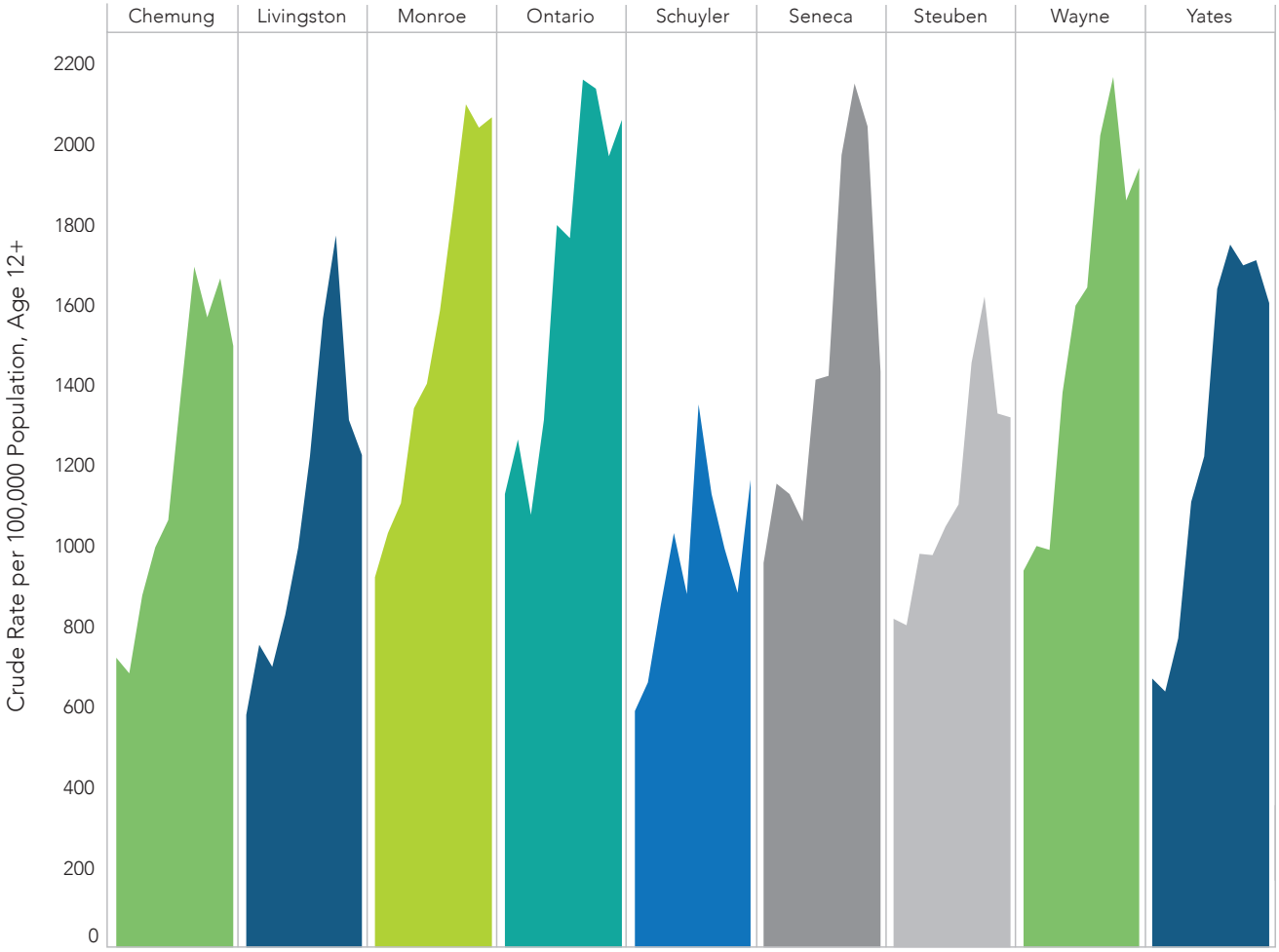
## Figure 40: Opioid Overdose Death Comparison




Data Source: Data Source: New York State Vital Statistics Data, 2010 - June 2021. Analysis Completed by Common Ground Health

Regarding the decrease that started around 2017, this could be correlated to more people entering treatment. As shown in Figure 41, admission rates to OASAS programs doubled across the Finger Lakes region from 2010 to 2019.

## Figure 41: Admissions to OASAS Programs Related to Opioids, Age 12+




Data Source: Data Source: New York State Vital Statistics Data, 2010 - 2019. Analysis Completed by Common Ground Health

One other area reviewed was administration of Naloxone (commonly known as NARCAN) by EMS during this time period. The data shows a decrease in Naloxone treatment by EMS from 2017 – 2019, but there could be a number of factors contributing to this. There has a been a great deal of work in communities in the Region to get Naloxone into the hands of opioid users and their loved ones, which may have contributed to a decrease in the need for its use by EMS. Along with this, the increased potency and availability of fentanyl on the streets may have contributed to a decrease in use of Naloxone as an opioid user may have already died by the time EMS arrived.

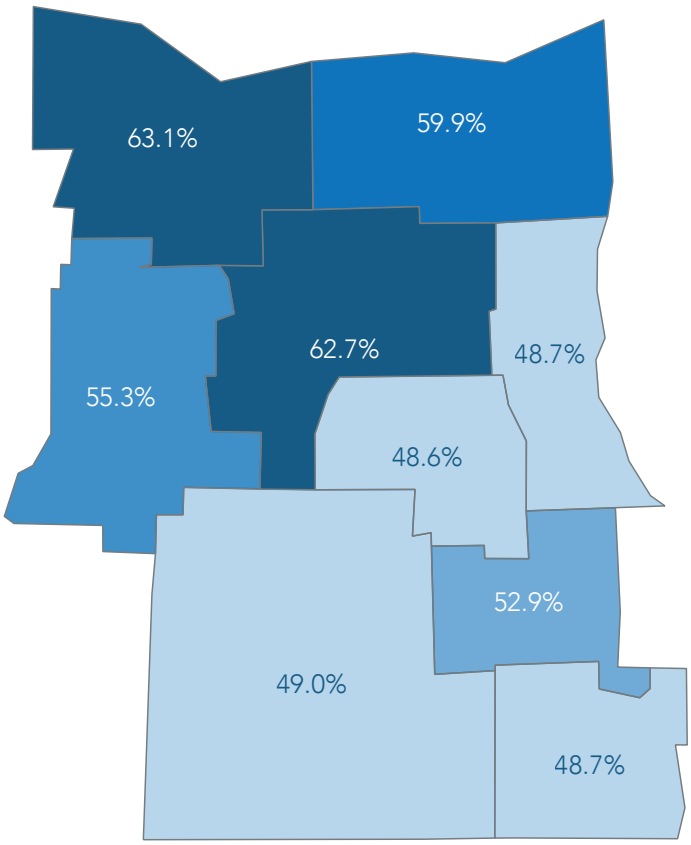
As with most measures reviewed in this assessment, COVID-19 had a negative impact on progress made in this area. Data from Monroe County shows a significant increase in overdose deaths in 2020, with 238 deaths, an all-time high and a 132% increase (181 to 238) from 2019. Along with this, another concerning trend from the Monroe County data is the impact on the Black community. Looking at the data from 2018, 2019, and 2020, the number of opioid-related deaths has more than doubled (25 to 68) and the percent of total deaths has increased about 15% (13% to 27%). Monroe County also reported similar increases for all other races, with deaths doubling (10 to 24) and the percent of all deaths doubling (5% to 10%).

# PREVENT COMMUNICABLE DISEASES

## COVID-19 Pandemic

The past two years have seen our community deal with the COVID-19 Pandemic. The impact of both the disease and vaccination efforts has been very different for different geographic, racial/ethnic, and socioeconomic groups. A number of different interventions were rapidly deployed to combat the disease and ensure as many people as possible were vaccinated. Map 12 shows the overall vaccination rate by county in the Finger Lakes region. Darker blue counties have a higher vaccination rate, lighter blue counties have a lower one. This percentage shows fully vaccinated persons (either receiving both doses for 2 dose vaccines or 1 dose of J&J's) as a percentage of total population. It does not remove populations that at the time were ineligible or recently eligible (under 5 years and 5-11 years old) from the denominator.

### Map 12: Percent of Total Population who Have Completed their COVID-19 Vaccinations




ZIP Codes with <40% of Population Vaccinated

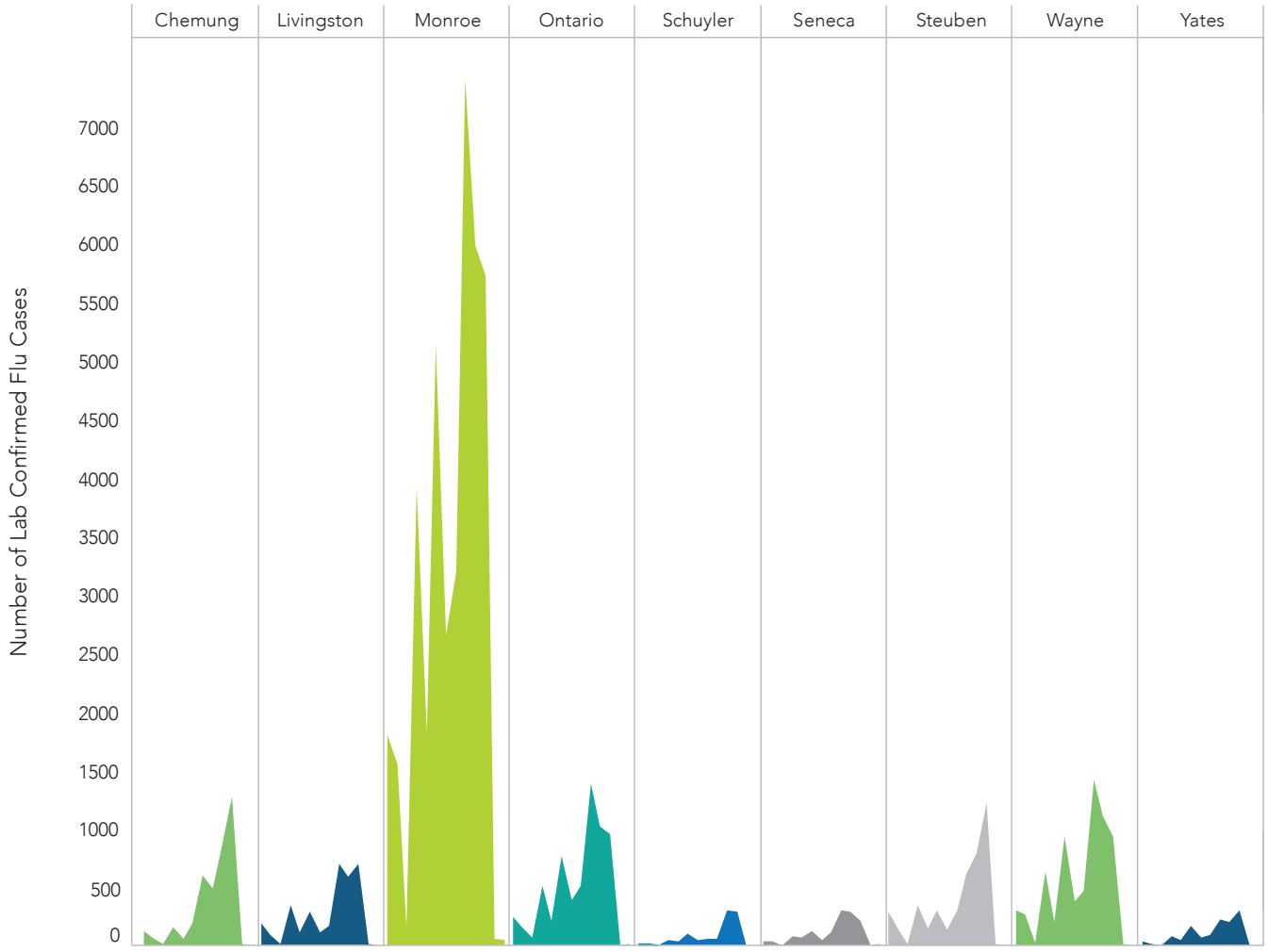
| | | |
|---|---|---|
| 14588 | Seneca | 9.9% |
| 14856 | Steuben | 14.7% |
| 14541 | Seneca | 25.7% |
| 14842 | Yates | 25.9% |
| 14839 | Steuben | 26.5% |
| 14898 | Steuben | 26.7% |
| 14529 | Steuben | 31.4% |
| 14820 | Steuben | 31.8% |
| 14855 | Steuben | 32.2% |
| 14614 | Monroe | 33.3% |
| 14885 | Steuben | 33.5% |
| 14877 | Steuben | 35.1% |
| 14478 | Yates | 35.2% |
| 13146 | Wayne | 37.2% |
| 14837 | Yates | 37.2% |
| 14486 | Livingston | 39.0% |
| 14846 | Livingston | 39.9% |

Data Source: NYS DOH, New York State Statewide COVID-19 Vaccination Data by County, 2021.11.08. Analysis Completed by Common Ground Health

## Flu

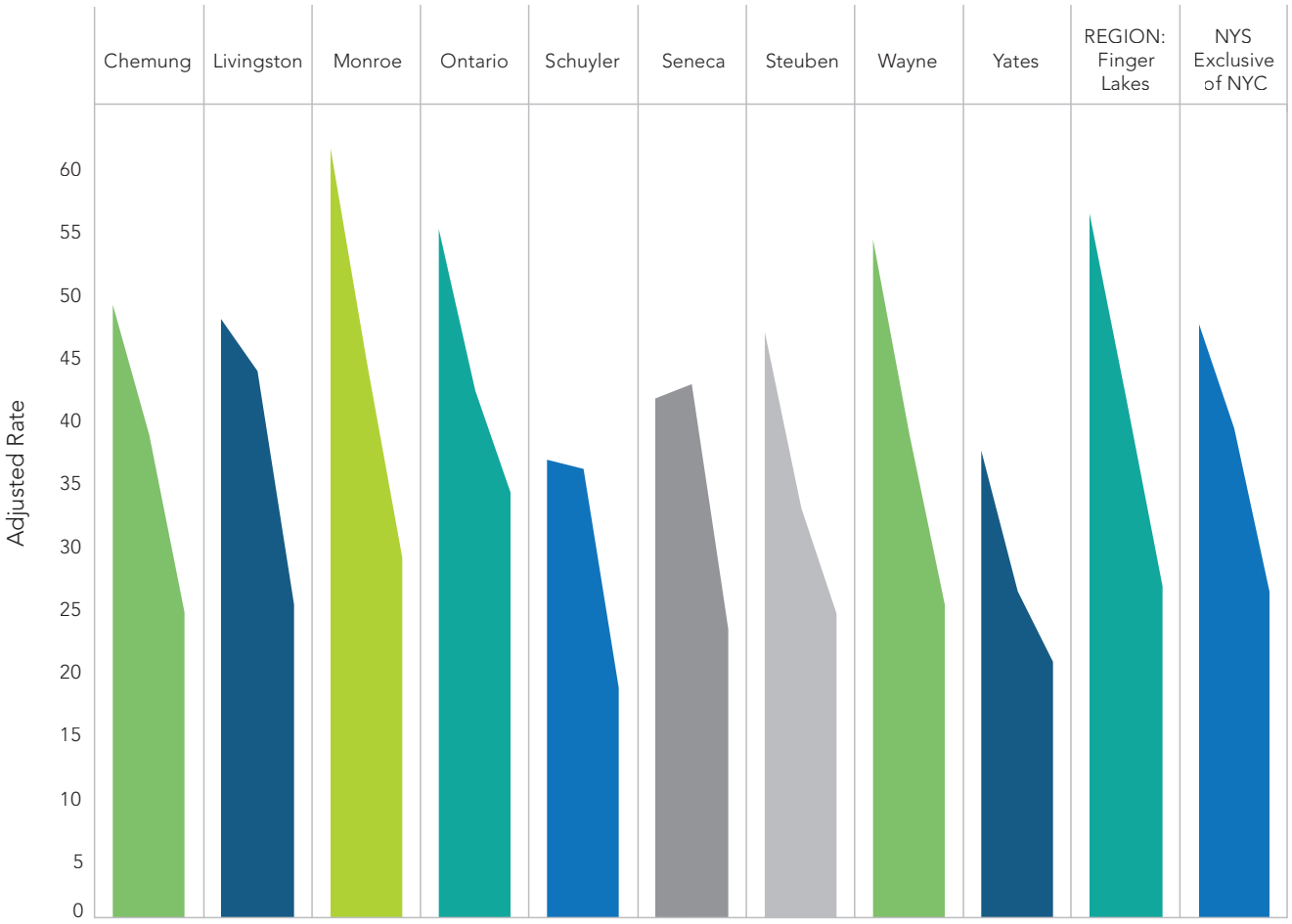
While COVID-19 has impacted our community in ways that were previously unimagined, another similar disease, the flu, saw a drastic decrease in 2020 and 2021 before increasing again in 2022. Many of the precautions that were put into place to limit the spread of COVID-19 (masking, social distancing, distance learning for schools, etc.) essentially ended the 2019-2020 flu season and kept numbers at unprecedented lows during the 2020-2021 and 2021-2022 seasons (Figure 42). In the 2020-2021 flu season, many of the more rural counties had confirmed cases in the single digits. Of concern is the number of people reporting they received a flu shot in recent years has been trending down in the Finger Lake Region (Figure 43).

### Figure 42: Lab Confirmed Flu Cases




Data Source: NYS DOH - Influenza Activity, Surveillance and Reports, 2009 - 11/2021. Analysis Completed by Common Ground Health

## Figure 43: Percent of Persons Reporting Receiving a Flu Shot



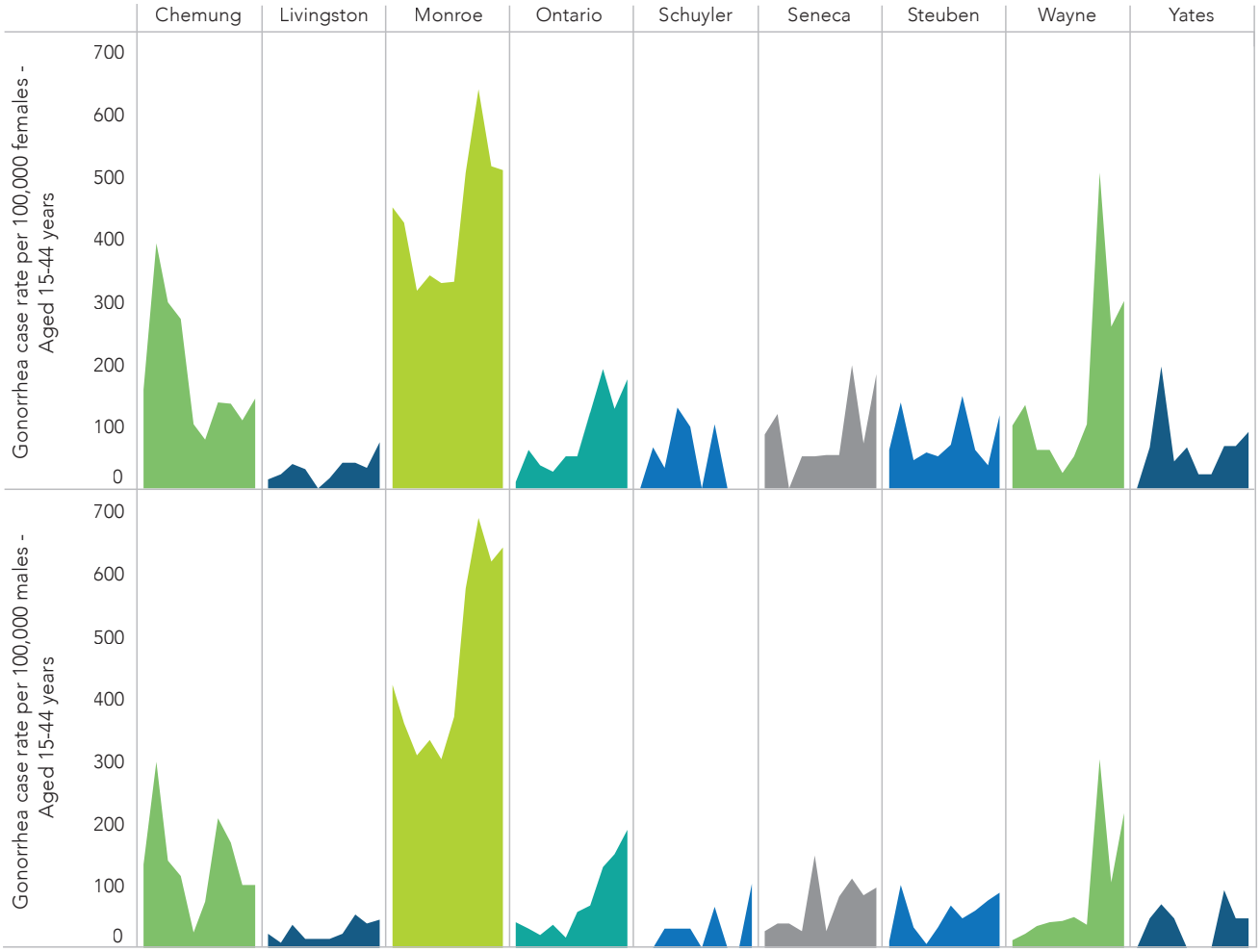

Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2013-2014, 2016, & 2018. Analysis Completed by Common Ground Health

Letchworth State Park
Photo courtesy of Livingston County Department of Health

## Sexually Transmitted Infections

Sexually transmitted infections (STIs) are important preventable communicable diseases to consider. Gonorrhea, Chlamydia, and HIV are all STIs that New York State regularly tracks and reports on at community levels. Looking at the data on Gonorrhea cases in the Finger Lakes region, there appeared to be a spike in 2015/2016, with rates staying higher in the following years in Monroe, Ontario, Seneca, and Wayne Counties (Figure 44). This could be the result of increased testing or of outbreaks in those areas. It may also be related to the increased incidence of Opioid Use Disorders, as those in active addiction are more likely to engage in risky behaviors.

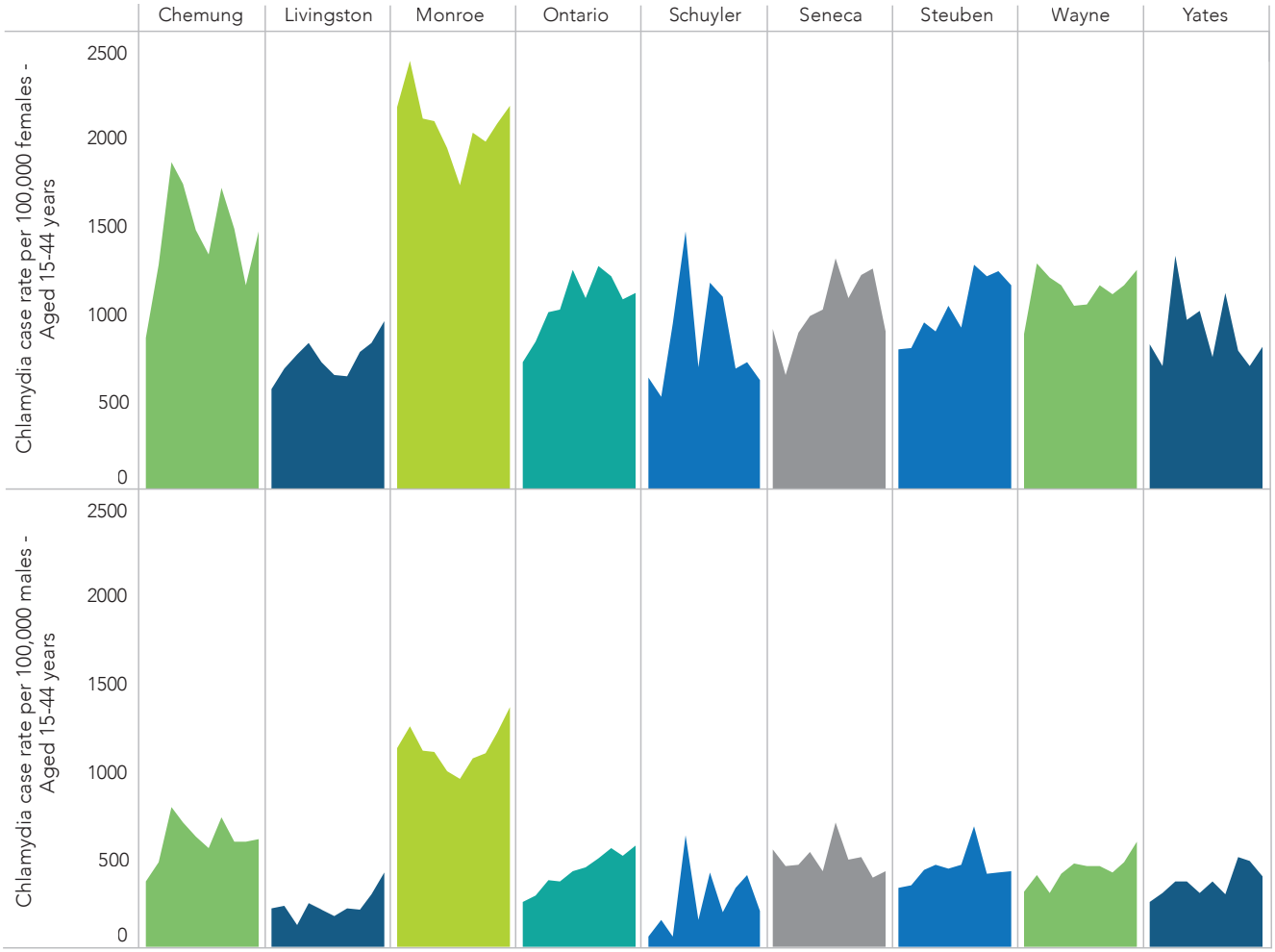
### Figure 44: Gonorrhea Case Rate per 100,000 Female/Male Aged 15- 44




Data Source: NYS DOH, Community Health Indicator Report, Years 2009 - 2018. Analysis Completed by Common Ground Health

While there has been an increase in Gonorrhea cases across the Finger Lakes region, cases of Chlamydia did not see significant change between 2009 and 2018. One area to note with Chlamydia is the prevalence in women vs. men. As seen in Figure 45, the case rate per 100,000 is about double for women compared to the rate for men in all counties in the Finger Lakes region. This relationship has been seen across the country, as per the CDC.[37]

## Figure 45: Chlamydia Case Rate per 100,000 Female/Male aged 15- 44

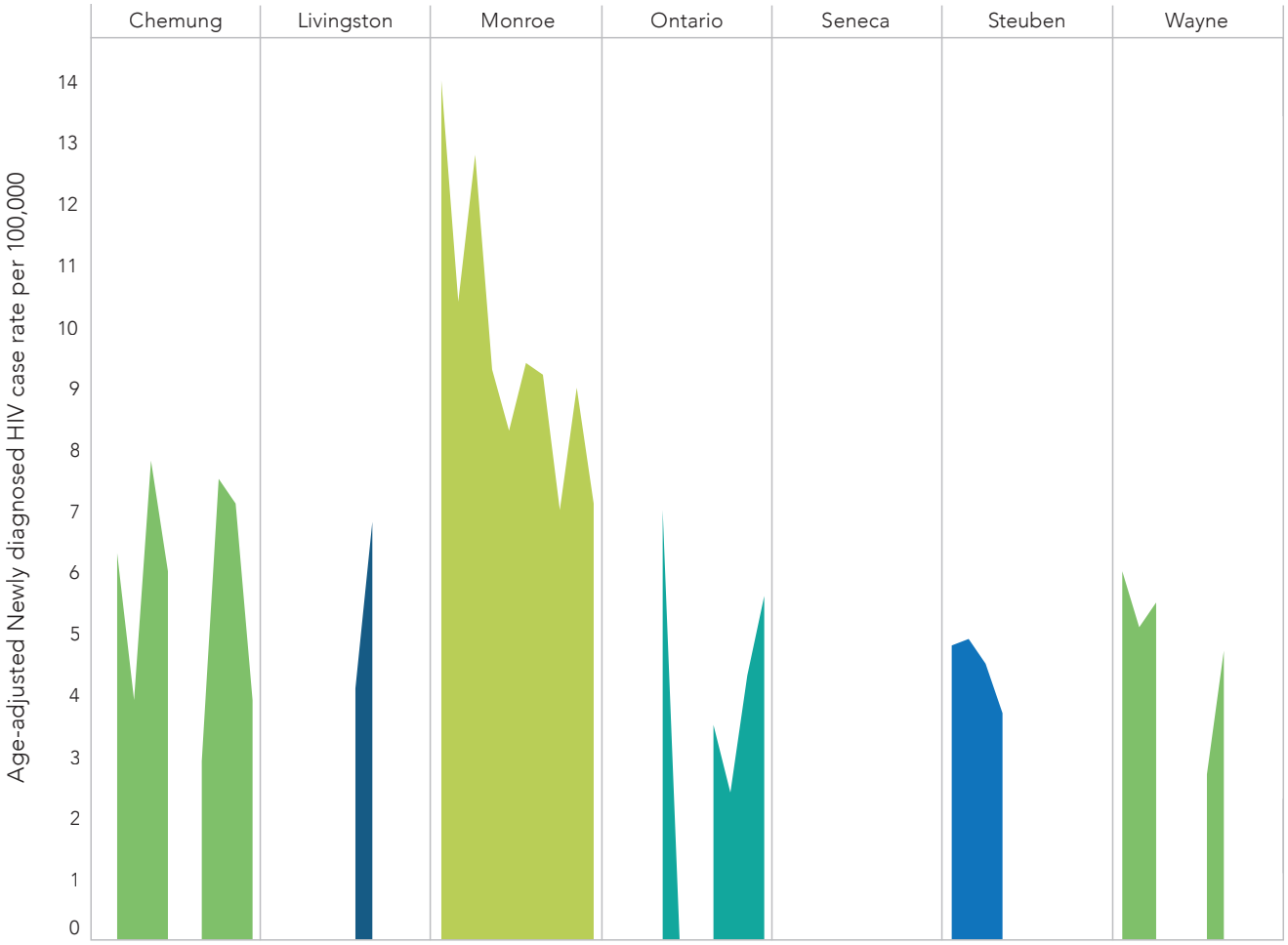



Data Source: NYS DOH, Community Health Indicator Report, Years 2009 - 2018. Analysis Completed by Common Ground Health


37. https://www.cdc.gov/std/chlamydia/stats.htm

There have been a number of improvements in the treatment and prevention of HIV since the height of the AIDS epidemic in the 80's and 90's. Since 2009, the rate of new HIV infections in Monroe County has shown a downward trend (Figure 46). Due to small sample sizes in the rest of the counties of the Finger Lakes region, no trends can be inferred in them. While there were reports of increased new HIV infections in 2020 across the Finger Lakes region, the rate of these new infections per 100,000 did not significantly change. In Monroe County, there were 54 cases in 2019 (rate of 7.1) and 74 cases in 2020 (rate of 9.7), which is still lower than the historical rates seen from 2009-2011 (14.0, 10.4, and 12.8, respectively). Monitoring of these rates and looking for root causes of the increase in new diagnoses would be beneficial, as there are interventions that can be put into place to help reduce new infections. One factor contributing to the 2020 increase in the rates of new HIV infections was COVID-19, as limited in-person medical services and concerns about health/safety may have prevented people in high risk groups (IV drug users, sex workers) from accessing services which may have helped them prevent HIV infection.

## Figure 46: Age-adjusted Newly Diagnosed HIV cases rate per 100,000




Data Source: NYS DOH, Community Health Indicator Report, Years 2009 - 2018. Analysis Completed by Common Ground Health

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# CHEMUNG COUNTY

| COUNTY NAME: | CHEMUNG COUNTY |
|---|---|
| Participating local health department and contact information: | Chemung County Health Department<br>Peter Buzzetti<br>Director of Public Health<br>pbuzzetti@chemungcountyny.gov<br>607-737-2028 |
| Participating Hospital/ Hospital System(s) and contact information: | Arnot Health<br>Aaliyah Williams<br>Community Health Services and Population Health Coordinator<br>aaliyah.williams@arnothealth.org<br>607-737-4100 (ext 1131) |
| Name of entity completing assessment on behalf of participating counties/ hospitals: | Common Ground Health<br>Zoë Mahlum<br>Health Planning Research Analyst<br>zoe.mahlum@commongroundhealth.org<br>585-224-3139 |

Chemung County
Welcome to Elmira sign in Chemung County, NY

# EXECUTIVE SUMMARY

Through the use of Results-Based Accountability, Chemung County in partnership with Arnot Health has chosen to focus their 2022-2024 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) on the following priority areas, with the low income population as their identified disparity to address.

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Prevent Chronic Disease** | |
| Overarching Goal | Reduce obesity and the risk of chronic disease |
| Focus Area | Healthy eating and food security |
| Focus Area | Tobacco prevention |

| **Promote Healthy Women, Infants and Children** | |
|---|---|
| Focus Area | Perinatal and infant health |
| **Disparity** | **Low income population** |

Health Priorities Partnership, a group of diverse partners who span all sectors of the community, participated in the prioritization process and disparity and intervention identification. While a complete list of partners is available within the Chemung County Chapter under "Community Health Improvement Plan/Community Service Plan", agencies present represented academia, not-for-profits and community organizations, businesses, the general public, and local government. They included the Chemung County Public Health Department, Arnot Health, Southern Tier Tobacco Awareness Coalition (STTAC), Mothers & Babies Perinatal Network, the Twin Tiers Breastfeeding Network, Comprehensive Interdisciplinary Developmental Services (CIDS), Economic Opportunity Program (EOP), Cornell Cooperative Extension, and more. Partners' roles in the assessment were to help inform and select the 2022-2024 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings. Community was involved in the 2018 My Health Story survey and inclusion of community was considered as part of the oversight committee. The 2022 My Health Story survey is currently underway, and this will help gain community insight on key health matters in the county and surrounding areas. Both primary and secondary data were reviewed including, but not limited to, the US Census Bureau American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, data collected from Pivital Public Health Partnership (formerly known as S2AY Rural Health Network) and Common Ground Health's My Health Story 2018 survey, 211 Helpline, and the Statewide Planning and Research Cooperative System (SPARCS).

The process of Results-Based Accountability included evaluation of a pre-read document, which contained detailed county-specific analyses related to the five Prevention Agenda priority areas, followed by a multi-voting technique to select the priority areas. Participants were asked to consult with other members of their organizations and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Partners came to a consensus to address the top priority areas identified by the survey, then additional county-specific data was collected, shared and evaluated to help determine which objectives, disparity, and interventions should be selected. Interventions selected included, but were not limited to:

- 1.0.2 Quality nutrition (and physical activity) in early learning and childcare settings.
- 2.2.5 Increase access to community-based interventions that provide mothers with peer support via home visits in the prenatal and early postpartum period.
- 3.1.2 Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.

A complete list of interventions and process measures is available in the CHIP.

The Health Priorities Partnership meets bi-monthly to improve the health of Chemung residents and will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings. Partners and the community will continue to be engaged and apprised of progress via these meetings.

Chemung County
An aerial view of Elmira
Photo Credit: iStock.com/Jacob Boomsma

# PLANNING AND PRIORITIZATION PROCESS

Chemung County followed a process called Results-Based Accountability to develop their needs assessment and improvement plans. There are several components to Results-Based Accountability, some of which include defining the community, engagement of a diverse group of stakeholders (including organizations representing underserved, low-income and minority populations), data collection and analysis, prioritization of health issues and disparity identification, and discussion of root causes for selected health issues to help identify appropriate and effective interventions. For additional information on Results-Based Accountability, this process is described in its entirety in Appendix 2. To pinpoint root causes of selected health concerns, the committee evaluated behavioral, environmental, social determinants of health, and policy causes that may be contributing to the current status of those concerns.

As demonstrated in the health indicator section, each county's residents face their own unique and challenging issues when it comes to their community, yet commonalities remain. There are a number of demographic and socioeconomic indicators which may impact health and are consistent concerns across the region. For example:

## AGE:

Variances in age can impact a community's health status. Older adults require more frequent medical check-ins, are more prone to illness, falls and unintentional injuries, and often experience more co-morbid conditions than younger adults and children. In addition, aging adults may not have access to a vehicle and rely on family, friends or public transportation for accessing basic needs and medical appointments. The strain of caring for an elderly adult may also negatively affect the caregiver. A community with higher rates of elderly adults may have worse reported health outcomes than a younger community.

## POVERTY:

Low income residents are more likely to experience a breadth of health issues not seen as often in wealthier residents. For example, lower socioeconomic status is linked to higher incidence of chronic disease, shorter life expectancy, and lower rates of good social, emotional and physical health. Low income may also force a person to choose between basic needs (such as housing, food, clothing, etc.) and preventative medical care. Often, and not surprisingly, the person will choose the basic need over preventative medical care. A community with higher rates of impoverished residents is likely to have worse health outcomes than wealthier communities.

## EDUCATION:

Education levels have been known to be a predictor of life expectancy. The Centers for Disease Control and Prevention reports that 25-year-old adults without a high school diploma can expect to die nine years sooner than college graduates. People who attain higher education levels are more likely to seek health care, preventative care services, and earn higher wages. A more educated community may, therefore, have better health outcomes than a low educated community.

## HOUSING:

Access to quality and affordable housing is imperative to ensuring basic needs are met. Housing structures that are safe, clean, up to code and affordable help to improve community health. When incomes are consumed on rent or mortgages, residents may lack funds for preventative care services, medications, and healthy foods. Additionally, outdated, substandard housing puts tenants at risk for asthma and lead poisoning (especially children).

Each of the above indicators impacts the health of the community. The next section takes a closer look at these demographic and socioeconomic indicators and also includes a review of behavioral and political environments in Chemung County that impact the health of its residents. Finally, the section will highlight the community's assets and resources that may be leveraged to improve health through identified evidence-based interventions.

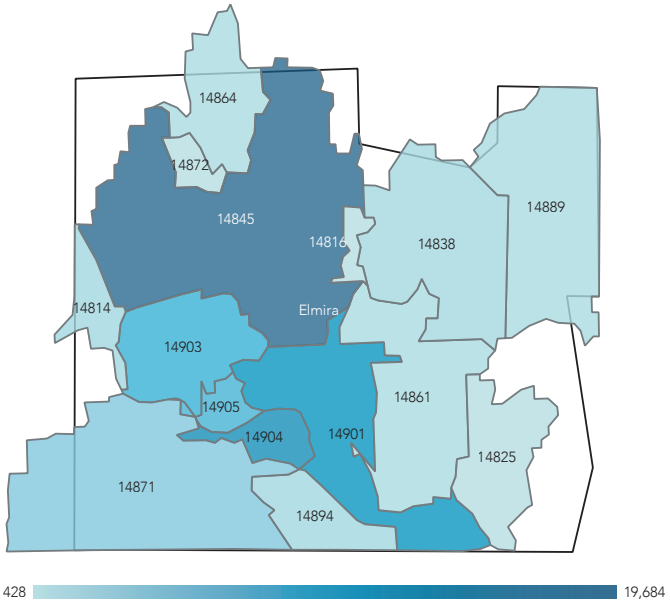
# COUNTY CHAPTER – CHEMUNG COUNTY

## Demographic and Socioeconomic Health Indicators

Chemung County is located in the southernmost portion of the Finger Lakes region, right along the New York and Pennsylvania state border. There are 84,148 total residents spread throughout the county, but areas with the densest population include the Village of Horseheads (14845) and the City of Elmira (14901, 14904). The majority of residents are white non-Hispanic (about 87%), with the remainder of residents consisting of Black non-Hispanic (about 7%), Hispanic (about 4%) and other (about 2%) individuals. An estimated 22% of the county's population are women of childbearing age, and about 15% of Chemung County is living with some form of disability.[1]

The majority of those living with a disability in Chemung County are 65 years of age or older (about 73%). The three types of disabilities most prevalent to this age group are independent living difficulty (about 14%), hearing difficulty (about 15%), and ambulatory difficulty (about 22%). Additionally, 31% of the population aged 65 years or older are living alone. Population projections from Cornell University's Program on Applied Demographics (Figure C2) show that the largest age group within Chemung County currently are the residents aged 18-44, followed by the 45-64 age bracket. However, within the next few decades, the 65 years and older population is expected to grow. As this population grows, there will be a greater demand on health care needs and services including chronic disease management and geriatric care.

### Map C1: Chemung County Population by ZIP Code




Source: Claritas ZIP-level estimates and CDC Bridged-Race county-level estimates, Year 2020 Population data and allocation methods developed by Common Ground Health

### Figure C2: Population Projections for Chemung County

Source: Cornell University - Program on Applied Demographics, County Projections Explorer, Year 2020. Analysis Completed by Common Ground Health.

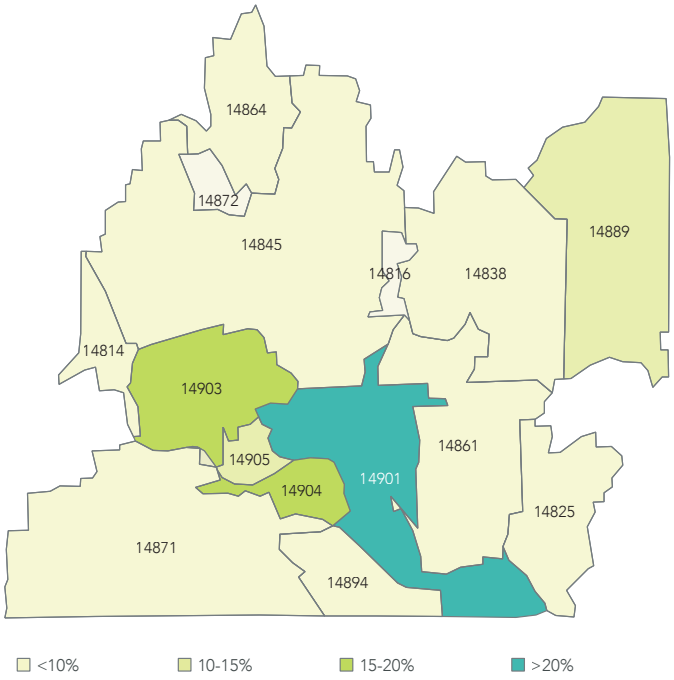


1. American Community Survey (ACS) 2019 5-Year Estimates

An estimated 1 in 7 individuals (about 14%) within Chemung County are living below the poverty level. As shown in Map C3, the highest rates of poverty are found within Elmira, where more than 20% of the population is living in poverty.

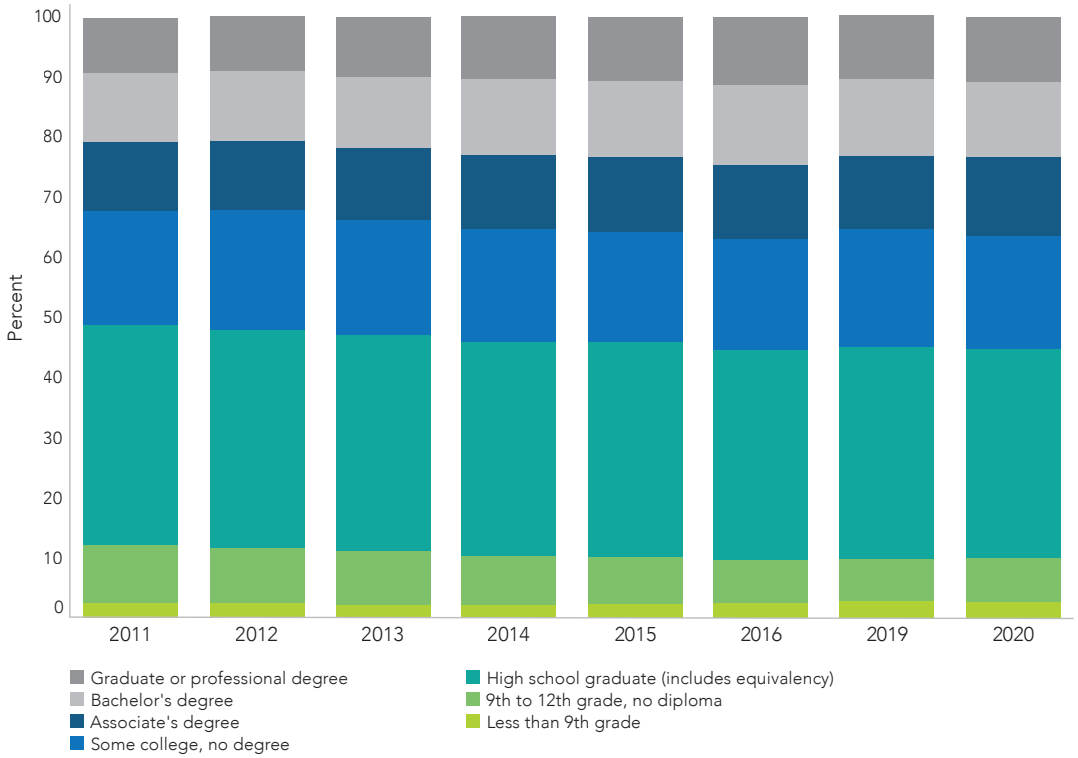
Educational attainment levels in Chemung County have remained consistent from 2015 to 2020, as shown in Figure C4. Of note, approximately 45% of the population has completed high school (or equivalency) or less as their highest level of education (compared to about 38% in NYS and the US), and roughly 10% of the population has completed less than a high school degree (compared to 13% in NY and 12% in the US). This is important to highlight as higher educational attainment generally equates to greater health outcomes.[2]

## Map C3: Percent of Population Living in Poverty




Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

## Figure C4: Educational Attainment of Residents Aged 25+



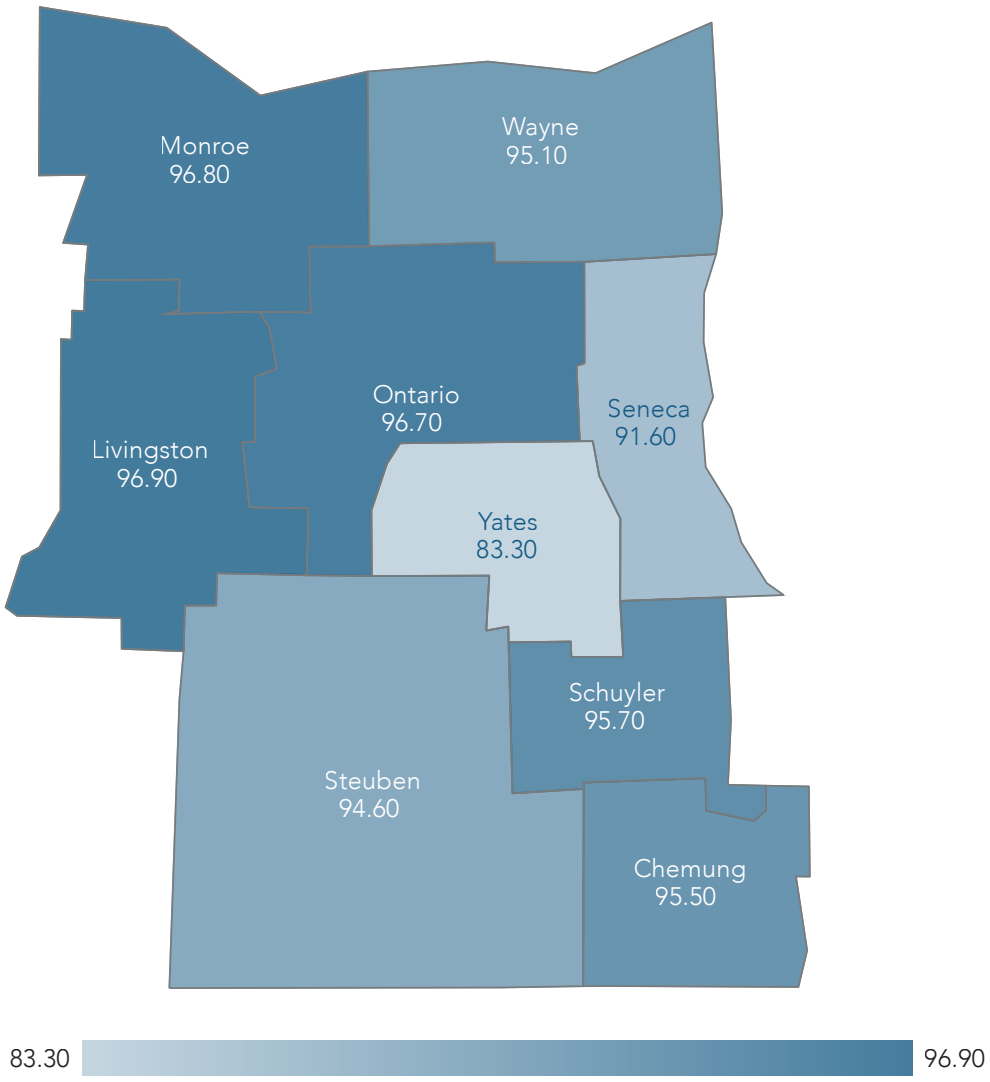

Data Source: US Census Bureau, American Community Survey (ACS), Year 2020.
Analysis Completed by Common Ground Health



2. Hahn, R. A., & Truman, B. I. (2015). Education Improves Public Health and Promotes Health Equity. International journal of health services: planning, administration, evaluation, 45(4), 657–678. https://doi.org/10.1177/0020731415585986

Map C5 shows the percent of the population with health insurance, by county, for the Finger Lakes region. In 2020, about 96% of Chemung County residents had health insurance coverage, which increased from about 95% in 2017. This is compared to about 95% of New York State residents with health insurance in 2020, and about 91% of residents nationwide.

## Map C5: Percent of Population with Health Insurance




Source: US Census Bureau, ACS, Year 2020
Analysis Completed by Common Ground Health

Obtaining health insurance is not the only factor in accessing healthcare. Availability and accessibility to providers are equally important considerations. Some providers are in greater demand than others, though. Largely providers are sparse in the most rural areas, which may be cause for concern for those with lack of transportation to access services. A summary of providers and locations is below:

**Mental Health Providers:** Chemung County has a ratio of one mental health provider to 320 residents. This is compared to New York State, which has one provider to 310 residents.[3] Mental health providers are defined here as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care. Within Chemung County, the majority of mental health providers are located near Elmira, with a scattering near Horseheads as well; however, the eastern side of the county (Van Etten) is served by Tioga County as a pattern of care by choice of those in need.[4]

**Dental Health Providers:** Dental providers are available at a rate of 3.9 providers per 10,000 population, compared to 3.7 per 10,000 for New York State. Again, these dental practices are located primarily in Elmira and Horseheads in the western half of the county.

**Primary Care Providers:** The rate of primary care providers within Chemung County is 11.8 per 10,000 population, which is greater than New York State's rate of 10.9. Chemung County nurse practitioners are available at a rate of 7.4 nurse practitioners per 10,000 population (NYS 3.5). The same geographical challenge is present again, as both primary care providers and nurse practitioners are located near Elmira and Horseheads on the western half of the county.

With regard to housing, about 32% of Chemung County residents rent versus own their own home. The average household size is greater than two people for both renter- and owner-occupied units. Of note, about 38% of residents are paying 35% or more of their household income in rent costs, which is considered an overburdened household. Likely these same households may be experiencing financial strain in other components of their life (food, healthcare, etc.). Out of all occupied housing units, about 11% have no vehicles available and an additional approximately 35% have access to one vehicle. Regarding transportation, about 2% of all 211 calls within the past year in Chemung County were for transportation assistance: 41 calls for medical transportation (2% went unmet), 19 for automobile assistance (11% went unmet), 8 for public transportation, and 5 for ride share services. The majority of transportation requests originated from Horseheads (14845) and Elmira (14901, 14904).



3. 2022 County Health Rankings for Mental Health Providers (uses 2021 data)
4. Commissioner of Chemung County Departments of Social Services and Mental Hygiene

## Main Health Challenges

On February 8, 2022, a diverse group of stakeholders, representing various aspects of the community as well as underserved and minority populations, were invited to attend a health priority-setting meeting (a complete list of stakeholders can be found in the Community Health Improvement Plan/Community Service Plan section). At this meeting, participants reviewed the overarching goals of the New York State Prevention Agenda and relevant qualitative, quantitative, primary and secondary data. A pre-read document containing detailed county specific analyses relating to the five Prevention Agenda priority areas was sent to all participants for review in advance. Primary and secondary data were collected from a variety of sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, Pivital Public Health Partnership (formerly S2AY Rural Health Network), Common Ground Health's My Health Story survey, and 211 Helpline. My Health Story 2018 was a regional survey completed on behalf of nine counties in the Finger Lakes Region. Its primary purpose was to gather qualitative and quantitative data from Finger Lakes Region residents on health issues in each county. Health departments, hospitals and other local partners were instrumental in distributing the survey to community members including disparate populations. The survey was updated in the summer and fall of 2022 and will be used to help inform potential shifts in strategies to improve the priority areas selected by Chemung County.

After initial review of the priority areas, a multi-voting technique was used to select the priority areas. Participants were asked to consult with other members of their organization and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Chemung County had twenty four members of the Health Priorities Partnership team participate in the survey. As a result, the following areas were selected for the 2022-2024 Community Health Improvement Plan:

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Prevent Chronic Disease** | |
| Focus Area | Healthy eating and food security |
| Focus Area | Tobacco prevention |

| **Promote Healthy Women, Infants and Children** | |
|---|---|
| Focus Area | Perinatal and infant health |
| **Disparity** | **Low income population** |

Following this selection, Common Ground Health gathered data on all objectives from the New York State Prevention Agenda within the chosen priority areas (Healthy Eating and Food Security & Perinatal and Infant Health). Objectives were color coded based on data status to help focus attention where it was needed most. Red objectives were neither meeting the Prevention Agenda goal nor trending in a favorable direction, yellow objectives were either not meeting the Prevention Agenda goal or not trending in a favorable direction, and green objectives had both met the goal as well as trended in a favorable direction. Objectives that were color coded as gray represented a lack of current and/or reliable data. Color coded data on objectives were presented to the team during April's Health Priorities Partnership meeting and partners utilized the data, as well as potential scope and interest of the group, to determine the objectives with which they would proceed. Color-coding for selected objectives can be found in the appendix.

While Tobacco Prevention did not rise to the top during priority area selection, data demonstrated that this is an issue in Chemung County; Chemung County is ranked 4th highest in the state for percentage of current smokers (~23%),[5] and the percentage of adults who smoke is double that of the Prevention Agenda goal. The county has several assets and resources to address the health issue. Because of this, the Chemung County Health Priorities Partnership decided to focus on Tobacco Prevention in addition to the other two focus areas previously identified.

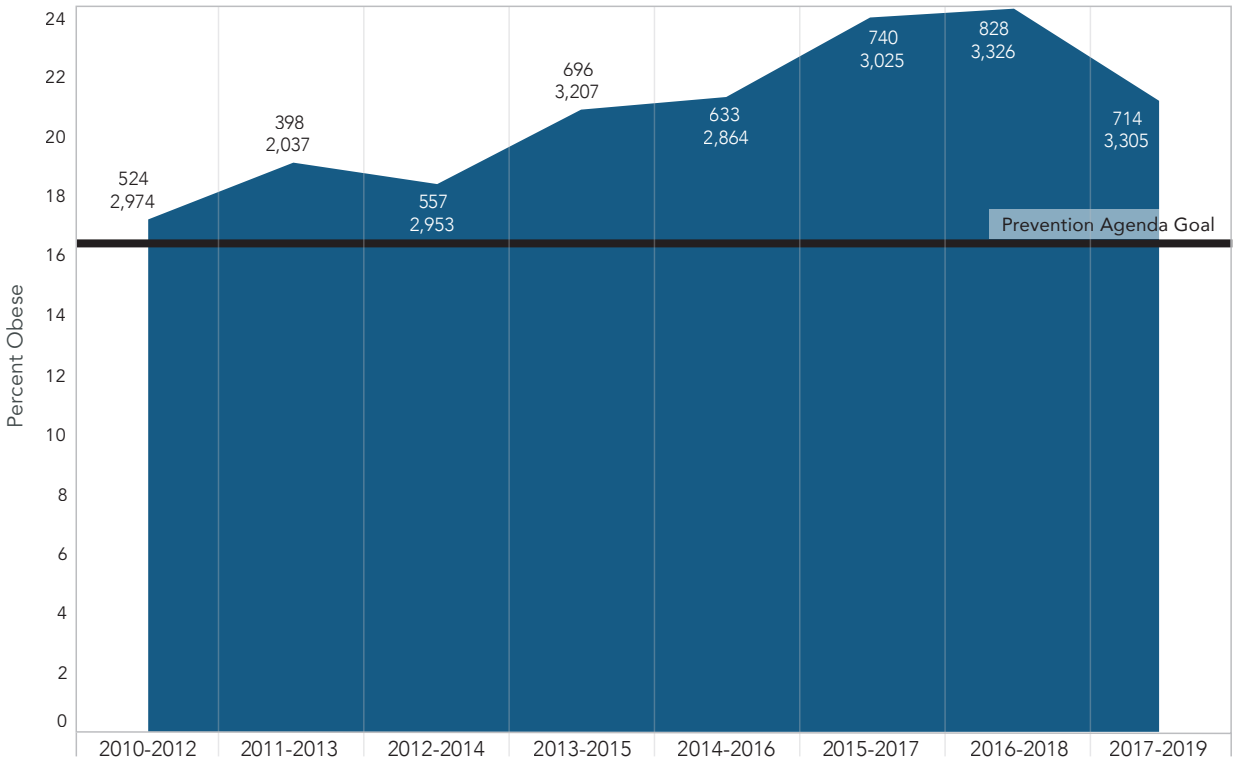
## Risk and Protective Factors Contributing to Health Status

Chemung County has selected three focus areas on which to anchor their 2022-2024 Community Health Improvement Plan. This section will take a closer look at the behavioral, environmental, political and unique risk and protective factors contributing to the health status of those areas.

### Healthy Eating and Food Security

Childhood obesity within Chemung County has been consistently above the Prevention Agenda goal of 16.4% for many years, with about 21% of school-aged children reported as obese as of 2017-2019. In New York State, the percent of students with obesity ranged between about 17-18% from 2010-2012 to 2017-2019.

### Figure C6: Percent of Students with Obesity




Data Source: NYS DOH, Health Data Connector, 2010 – 2019



5. NYS Behavioral Risk Factor Surveillance System, data as of August 2020 (NYS Department of Health Prevention Agenda Dashboard)

Several co-morbid conditions such as metabolic, cardiovascular, orthopedic, neurological, hepatic, pulmonary, and renal disorders are associated with childhood obesity.[6] A number of behavioral, environmental, social determinants of health and policy factors were identified by community partners as contributors to this health concern. Partners noted behavioral and environmental factors such as consumption of fast food rather than home-cooked meals, lack of time and energy to cook and children's limited acceptance of healthful foods, the belief that healthy food is more expensive, and less physical activity due to increased screen time and the COVID-19 pandemic. During the winter, especially, there are less organized opportunities for children to be active. Additionally, middle and high school children have increased their consumption of energy drinks. Committee members highlighted that fruits and vegetables do not keep as long as packaged foods do, and packaged foods that are less nutrient-dense and more calorie-dense often taste good, are less expensive, keep longer, and are more readily accessible for some.

The contribution that poverty has on the prevalence of obesity was also acknowledged, as was accessibility and the increasing costs of goods and services we now face as an outcome of the pandemic. Economic instability can negatively impact children in a number of ways; parents with limited income may not have the resources to feed, cloth, or adequately house their children. Driving to the grocery store can become challenging due to lack of transportation or inadequate funds for gas. Increased consumption of packaged foods due to transportation barriers, limited accessibility, or limited knowledge on how to prepare home-cooked meals are contributing factors of obesity prevalence. Education, health literacy and reading levels are important considerations as well; families and individuals must be met at and educated from their level of understanding regarding reading nutrition labels, filling out SNAP benefit forms, applying for WIC, etc.

Regular access to healthcare is a preventative measure with regard to obesity. It represents a point of contact and consistent care, a source of reliable health information, and much more. For many, though, access is limited due to lack of transportation, lack of insurance or inadequate coverage, distance to the clinics, or limited number of providers in rural areas.

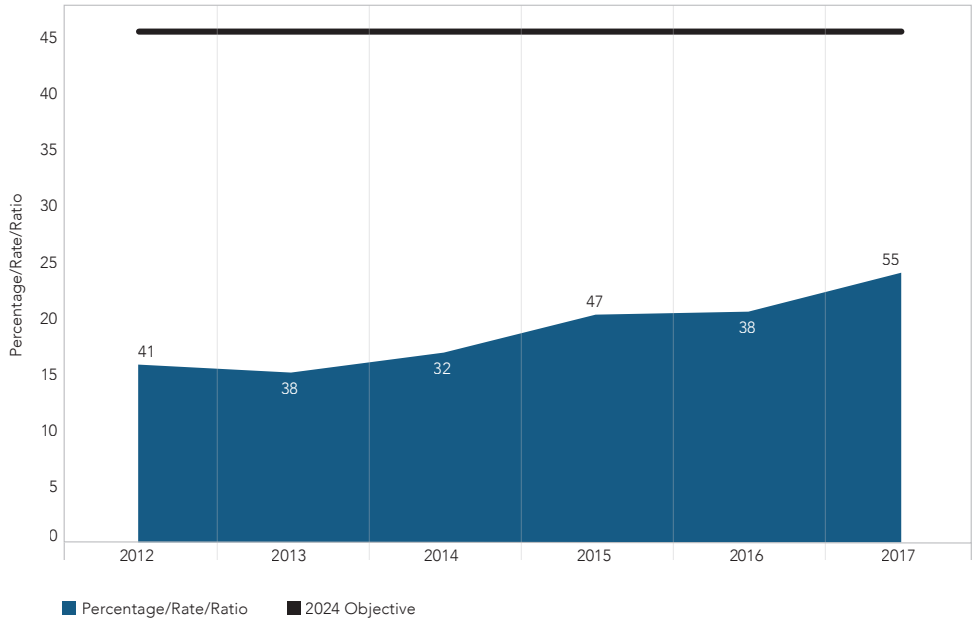
Currently, within Chemung County, several community partners are already working within this space, delivering programs such as First 1,000 Days, Kitchen Stork, educational classes, curbside meal programs, food programs, Health Meets Home, Health Meets Food, CATCH program in schools, and cooking classes to help decrease the percentage of children with obesity in early learning, childcare settings and schools. First 1,000 Days is a new Comprehensive Interdisciplinary Developmental Services Inc. (CIDS) program serving high-risk pregnant women and children aged 0-3, in which referrals will be generated through a partnership with Arnot Health and other community organizations. Kitchen Stork is a program that addresses food insecurity and maternal health needs that is operated through the Finger Lakes Performing Provider System (FLPPS), the Food Bank of the Southern Tier (FBST), CIDS, Arnot Health, and Meals on Wheels. It offers nutritious food, kitchen and cooking supplies, and virtual cooking classes for mothers who are expecting. Health Meets Home is a food prescription program, targeting individuals with prediabetes, offered through Arnot Health, Eastside Clinic, Lake Erie College of Osteopathic Medicine (LECOM) and the FBST. Students deliver groceries, recipes and nutrition information to participants, as well as monitor their hemoglobin A1c, blood pressure and weight. Health Meets Food is a Culinary Medicine Program designed to help change the dialogue between healthcare professionals and their patients about food. With a collaboration of LECOM and Arnot Health, medical students complete the Health Meets Food curriculum and then offer a class for the community. Families are welcome to join the six-session community class. Participants learn about the importance of healthy eating habits, prepare healthy recipes, and then eat them together at the end of the class. The Food Bank of the Southern Tier offers Kids Farmers' Markets (KFM) in Chemung County over a period of several weeks in the summer. KFMs are no-cost distribution events that provide fresh fruits and vegetables to children at risk of hunger or food-insecurity who may not have access to produce on a regular basis. Additionally, AIM Center for Independent Living's Community Nutrition Program provides food and basic goods to those in need a few times per month, with both pick-up and delivery available.


6. NIH National Library Of Medicine, Childhood obesity: causes and consequences, Journal of Family Medicine and Primary Care, 2015

## Perinatal and Infant Health

Breastfeeding during infancy can provide a number of health benefits for mother and baby alike. For infants, specifically, it can reduce the risk of asthma, obesity, type 1 diabetes, ear infections, sudden infant death syndrome (SIDS), and more.[7] The percent of Chemung County infants enrolled in WIC who were exclusively breastfed at 6 months of age increased from about 16% in 2012 to about 24% in 2017 (about 42% in NYS) (Figure C7), but this was still well below the Prevention Agenda goal of 45.5%. The rate of exclusively breastfed infants at discharge was 66% in 2021.

### Figure C7: Percent of Infants Enrolled in WIC who are Exclusively Breastfed at 6 Months of Age




Pediatric Nutrition Surveillance System (PedNSS), data as of October 2018
Analysis Completed by Common Ground Health

Health Priorities Partnership noted many factors contributing to breastfeeding rates within Chemung County. Members stated that there can be a lack of support for breastfeeding; well-intentioned family members and/or pediatricians may encourage new families to supplement with formula early in the breastfeeding relationship. This can have a negative impact on the mother's milk supply. Some mothers may lack support at home to help care for older children, and thus do not feel they have the time to devote to breastfeeding or pumping their milk. Second, some younger mothers feel uncomfortable with the idea of breastfeeding, thus education on benefits of breastfeeding is very important; the provision of a clean, comfortable, private space by doctors' offices and businesses accommodate mothers so they may feel confident breastfeeding or expressing their milk wherever they are. Additionally, education is needed for the breastfeeding person regarding their rights around pumping in the workplace. Behavioral factors identified included personality traits, mental health, and substance abuse. Breastfeeding can be challenging at times, so if the mother doesn't have adequate resources, they are less likely to continue. With regard to mental health, having effective coping mechanisms for those challenging days is important, and if a mother has experienced any type of trauma in her past then breastfeeding could potentially be a trigger for her. Environmental factors that can play into breastfeeding rates include what home-life is like for the breastfeeding individual, accessibility of services, transportation to appointments, and more. One positive outcome of the pandemic, however, has been the increased availability of virtual consults. Additionally, there may be cultural differences among various racial and ethnic populations that contribute to breastfeeding rates as well.


7. CDC – Breastfeeding: Why It Matters, 2021

Barriers to breastfeeding were also noted by the Health Priorities Partnership team. To start, mothers sometimes feel judged no matter how they choose to feed their babies. If they bottle feed with formula, others may judge them for not breastfeeding. Yet, if they are breastfeeding in public, they may be told to "cover-up" or receive other unsolicited advice. Some mothers also experience a lack of support upon return to work. Although the law supports mothers having time and space to pump, this is only for organizations with greater than fifty employees, thus it does not cover smaller private businesses. Even in larger organizations where this right is protected by law, some mothers feel guilty taking pumping breaks due to pressure from coworkers. Another barrier experienced by some comes in the form of family support. One example is if the infant's grandmother was not able to successfully breastfeed the mother, these fears may be passed onto the mother regarding her own experience. Others may voice they want to pump so the father can feed the baby in order to bond, when there are many other ways for that to occur without interrupting the breastfeeding.

Currently, at Arnot Ogden Medical Center, the International Board Certified Lactation Consultant (IBCLC) meets with breastfeeding families in the hospital setting and follows up by phone post-discharge. Many of their nursing staff have obtained their Certified Lactation Counselor (CLC) and are able to assist during the inpatient stay as well. Outpatient lactation services are available through WIC, Chemung County Public Health, and pediatric offices, or by CLCs or IBCLCs in private practice. Four of their offices have achieved the "Breastfeeding Friendly" designation. Prenatal breastfeeding education modules are available online for families to purchase and learn at their own pace. Twin Tiers Breastfeeding Network (TTBN) hosts a monthly virtual Baby Bistro free of charge; TTBN's Resource Directory handout is updated regularly and provided to families upon discharge. TTBN also sponsors annual Breastfeeding Friendly awards in conjunction with World Breastfeeding Week to raise awareness. The NICU values breastmilk and breastfeeding families; they are partnered with The New York Milk Bank to provide pasteurized human donor milk to neonates born prior to 32 weeks gestation or weighing <1500g at birth. Arnot hosts a licensed Breast Milk Depot and is able to accept breastmilk donations from registered donors. A Breast Pump Rental Program was initiated where hospital-grade breast pumps are available to rent in order to help their pump-dependent mothers establish an abundant milk supply. Arnot Health will continue to promote skin-to-skin contact whenever possible, specifically within the OR for C-section deliveries (looking at policy, procedure and tools to safely do so). TTBN and Maternal Child Health Network (MCHN) will also promote skin-to-skin contact. A grant has also been approved by the Fund For Women in the amount of $850 to finance a Lactation Resources and Lending Library in the Lactorium at Arnot Ogden Medical Center. WIC has been working to reduce the belief that "there isn't enough milk" through packets provided to participants, educating all mothers on hand expression through Stanford University videos, increasing peer counselor communication prenatally, and by using the Breastfeeding Attrition Prediction Tool to help gauge a mother's breastfeeding knowledge, support and confidence. WIC also works to increase breastfeeding by offering peer support via home visits and promoting early skin-to-skin contact in the hospitals.

## Tobacco Prevention

Tobacco use is the most prominent preventable cause of death and disease in the United States, and accounts for approximately 480,000 deaths annually. Additionally, greater than 16 million Americans have, at minimum, one disease caused by smoking.[8] Smoking can cause health issues such as cancer, heart disease, stroke, lung diseases and COPD, diabetes, immune system problems, and much more. Secondhand smoke is equally detrimental as it causes stroke, lung cancer and coronary heart disease in adults and an increased risk of SIDS, respiratory infections, middle ear disease, and asthma in children. Women who smoke during pregnancy increase their risk for pregnancy complications and miscarriages and increase their baby's risk of certain birth defects,[9] premature birth, low birth weight, and infant death.



8. HealthyPeople.gov: Tobacco Use, 2022
9. CDC: Smoking & Tobacco Use – Health Effects, 2020

The Chemung County adult smoking prevalence is about 23%, compared to New York State prevalence of about 13%. When considering only adults with household incomes less than $25,000 who smoke, Chemung County's percentage escalates to about 40% versus about 20% in New York State.[10] The Healthy People Maternal and Child Health Indicators from 2021 illustrated that only about 86% of births within the hospital are to mothers who abstained from smoking during their pregnancy; this increased since 2019 when it was about 80%, but still falls short of the Healthy People goal of 98.6% or more. When adult Chemung County residents were surveyed in 2021 regarding their tobacco use, about 69% of respondents reported that, at their last visit, their healthcare provider did not provide counseling, resources, or medication to assist in quitting smoking, which increased from about 45% in 2019.[11]

Health Priorities Partnership members reported that higher tobacco retail density is associated with greater tobacco use among adolescents and decreased quit attempts for adult cigarette smokers who want to quit; there are 87 tobacco retailers in Chemung County. Partners also noted educational attainment as another contributing factor, as well as a history of high smoking rates (which causes more exposure in the home and allows smoking to be viewed as the "norm"). Additionally, tobacco use disproportionately affects communities of people who have been marginalized and targeted with advertising and marketing by the tobacco industry including people in low-income communities, racial and ethnic minorities, sexual and gender minorities, and people living with mental illness and substance use disorders.

Committee members reflected on which programs and interventions are successful in reducing tobacco use and highlighted the following: changing the community environment to support a tobacco-free norm, reducing the negative impact of tobacco product marketing and price promotions on youth and adults at the point of sale, and increasing the number of local laws and voluntary policies that prohibit tobacco use in outdoor areas. Additionally, members felt that decreasing secondhand smoke exposure in multiunit housing (with an emphasis on policies that protect the health of low socioeconomic status residents), promoting policies that reduce tobacco use imagery in youth-rated movies, on the internet and social media, and promoting the use of the Five A's (Ask, Advise, Assess, Assist, Arrange) and NYS Quitline with providers would be beneficial to the community. Chemung County has worked with the Center for a Tobacco-Free Finger Lakes (CTFFL) at the University of Rochester Medical Center in the past and would like to continue this relationship, and the Wilmot Cancer Institute had offered remote smoking cessation sessions. Lastly, Mothers & Babies Perinatal Network offers Quit Kit, which is a smoking cessation program for pregnant and parenting smokers.

## Community Assets and Resources to be Mobilized

The Finger Lakes Region already has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies that promote and facilitate collaboration: Pivital Public Health Partnership (formerly the S2AY Rural Health Network) and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors – hospitals, insurers, universities, business, nonprofit, faith communities and residents – to collaborate on strategies for improving health in the region. Both agencies provide support, collaboration and resources to improve the health of Chemung County residents.



10. NYS Behavioral Risk Factor Surveillance System, 2018 (data as of August 2020)
11. Southern Tier Tobacco Awareness Coalition: Adult Community Tobacco Survey, 2021

To address Prevention Agenda objectives within the Healthy Eating and Food Security focus area, organizations such as the Economic Opportunity Program (EOP), Comprehensive Interdisciplinary Developmental Services (CIDS), Arnot Health, school districts such as Elmira City, Horseheads, Elmira Heights and private districts, Food Bank of the Southern Tier, WIC, AIM Center for Independent Living, Cornell Cooperative Extension, Steuben Rural Health Network, the YWCA, and Finger Lakes Eat Smart New York (FLESNY) were identified as capable partners to address this health concern.

Likewise, with regard to the Perinatal and Infant Health priority area, various partners will be contributing to these interventions. Arnot Health, schools such as Elmira City, Horseheads, Elmira Heights and private districts, CIDS, WIC, Mothers & Babies Perinatal Network, EOP, major employers in the county, Chamber of Commerce, faith-based organizations, Chemung County municipalities, obstetricians and pediatricians may provide their time, energy and resources toward this effort.

Community partners identified by the committee to aid in addressing root causes of tobacco use include Arnot Health, the Elmira City School District, agencies such as CASA-Trinity, Mothers & Babies Perinatal Network, CIDS, Center for Tobacco-Free Finger Lakes (CTFFL), Wilmot Cancer Institute, as well as the Chemung County municipalities. Resources available to accomplish these goals include the Southern Tier Tobacco Awareness Coalition (STTAC) and the Reality Check youth program, CTFFL, Mothers & Babies Quit for Kids, CIDS, Chemung County ATUPA program, NYS Quitline, and Wilmot Cancer Institute's free smoking cessation program.

Through implementation of the Community Health Improvement Plan, Health Priorities Partnership members will work to leverage these pre-existing agencies and services. The Chemung County Community Health Improvement Plan document has a full description of interventions and partner roles.

Chemung County Clerk's Office
Photo credit: Common Ground Health

## Community Health Improvement Plan/Community Service Plan

As previously discussed in Main Health Challenges, a multi-voting technique was used to select the priority areas for the Community Health Assessment and Community Health Improvement Plan, in addition to a unified desire based on data to continue to address tobacco prevention. County specific pre-read documents were provided to Chemung County Health Priorities Partnership and prioritization partners, which included updated data measures for each of the five priority areas outlined in the Prevention Agenda. This was followed with additional county specific data on objectives within the survey-identified priority areas to help identify objectives, disparities and interventions to include within the plan. A concerted effort took place during the month of December to ensure the governing Community Health Assessment and Community Health Improvement Plan body, Health Priorities Partnership, was equipped with a diverse and inclusive group, which represented all areas of health and well-being in the county. The following organizations were engaged in Chemung County's planning and prioritization process:

| CHEMUNG COUTY PLANNING AND PRIORITIZATION AGENCIES | | |
|---|---|---|
| Chemung County Health Department | Pivital Public Health Partnership | Blue Cross Blue Shield |
| Cornell Cooperative Extension/ SNAP-Ed | CASA-Trinity | Arnot Health |
| Chemung County Youth Bureau (CCYB) | Common Ground Health | Southern Tier Tobacco Awareness Coalition (STTAC) |
| AIM Center for Independent Living | Food Bank of the Southern Tier | Mothers & Babies Perinatal Network |
| Chemung County Planning | Catholic Charities | Man 2 Man |
| Economic Opportunity Program (EOP) | Elmira City School District (ECSD) | Chemung County Department of Aging and Long Term Care |
| Planned Parenthood | Guthrie Healthcare System | Women, Infants, & Children (WIC) |
| Chemung County Department of Human Services (CCHS) | Lions Club - Diabetes | Wilmot Cancer Institute |
| Steuben Rural Health Network | Comprehensive Interdisciplinary Developmental Services (CIDS) | Town of Southport Recreation Department |
| Lake Erie College of Osteopathic Medicine (LECOM) | Center for a Tobacco Free Finger Lakes | NAACP – Elmira/Corning |

Interventions to target the selected priority areas were discussed and determined by the public health department and their team of community partners at Chemung County Health Priorities Partnership meetings. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will continue to take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Chemung County Community Health Improvement Plan. All interventions selected are evidence based or evidence-informed and strive to achieve health equity by focusing on creating greater access for the low-income population, the disparity identified by Chemung County.

Health Priorities Partnership, a group of diverse partners who meet bi-monthly to improve the health of Chemung residents, will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

## Dissemination

This Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) was created in partnership between the Chemung County Health Department, Arnot Health, and community partners. It will be disseminated to the public in the following ways:

- Through a media release summarizing the results and offering the opportunity for the public to attend Health Priority Partnership meetings.
- It will be made publicly available on the Chemung County Health Department, Arnot Health, and Pivital Public Health Partnership websites.
- Chemung County Health Department and Arnot Health will share the link for the CHA on their social media accounts.
- It will be presented to, and reviewed by, the Chemung County Board of Health and a designated team of executives of Arnot Health.

The websites that will have the Chemung County Community Health Assessment 2022-2024 posted are:

- Chemung County Health Department: https://chemungcountyny.gov/735/Community-Health
- Arnot Health Department: https://www.arnothealth.org/

# APPENDIX 1

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Propeller plane towing a glider takes off at Harris Hill Park, Elmira, Chemung County
Photo by RedBridge https://stock.adobe.com/contributor/209808310/redbridge

# APPENDIX 2

## RESULTS-BASED ACCOUNTABILITY™

Results-Based Accountability™ is a disciplined way of thinking and acting to improve entrenched and complex social problems.[12] To facilitate CHA/CHIP development, resulting in a CHIP that measurably improves health, the following steps were followed:

1. **Define the Community:** Data collection is an important first step. In this step, it is important to gather data for the community at large (county-level data) as well as data that identified vulnerable populations within the community who are at risk for poorer health outcomes. This can happen by collecting and analyzing data that shows differences in rates of illness, death, chronic conditions and more in relationship to demographic factors. The planning committee brainstormed specific potential vulnerable populations in the county to be considered with data collection.
2. **Engage Stakeholders:** Population health requires engagement from many sectors. Complex social, economic and environmental factors are all determinants of health; therefore, there is no one organization, department or program that can be held solely responsible for the health of a population. Diverse engagement began in November/December 2021, early in the CHA development process. Committee partners completed an exercise to brainstorm potential new partners from the following sectors: Local Government, Businesses, Not-for-Profit and Community Organizations, Academia and the General Public. The following questions were used to assist brainstorming:
   - Who are those with potential interest and influence who can contribute to the CHA/CHIP process?
   - What population do they represent? (including vulnerable populations identified in Step 1)
   - Identify their potential level of interest and influence (High Interest/High Influence, Low Interest/ High Influence, High Interest/Low Influence, Low Influence/Low Interest)
   - Who would be the best person on the committee to extend an invitation to the selected potential new partner?

After an assessment of brainstormed information, personal invitations were made to selected potential new partners to address any gaps on the committee and the need for diverse engagement.

3. **Engage in Comprehensive Data Collection:** Both primary and secondary data were collected. Disaggregated data was collected by race, gender, income and geography as available to identify vulnerable populations and to assist in strategy development. Data sources included, but were not limited to:
   - Common Ground Health: My Health Story
   - County Health Rankings
   - Vital Statistics
   - Behavioral Risk Factor Surveillance Survey (BRFSS)
   - United States Census Bureau
   - Cornell University Program on Applied Demographics
   - Statewide Planning and Research Cooperative System (SPARCS)
   - New York State Department of Health Perinatal Data Profile
   - S2AY Rural Health Network Inc,: The Impact of COVID-19 on Food Security and Healthy Eating
   - Outreach to county committee partners for data from their respective organizations.


12. Results-Based Accountability - Overview and Guide (clearimpact.com)

4. **Prioritize Health Issues:** Data was analyzed and presented by Common Ground Health. After a review of analyzed health outcome data for trends, current state against benchmarks or Prevention Agenda targets, and differences among populations, a multi-voting tool was used by committee members to rank the health issues using selected criteria to identify top Focus Areas, which identified Prevention Agenda Priority Areas.
5. **A Deeper Dive of data was conducted by Common Ground Health.** To enhance the picture of the selected Focus Areas, related Prevention Agenda objective data was presented. A table with objectives and their status colors was created to help with the selection of objectives for this CHA/CHIP cycle.
   - Green Status – the prevention goal metric has been met and the trend of that metric is in the correct direction of the goal or steady
   - Yellow Status – either the prevention goal has not been met but the trend is in the correct direction or the goal has been met but the trend is in the wrong direction
   - Red Status – the goal has not been met and the trend is in the wrong direction
   - Gray Status – there is limited data on this metric available at this time

In addition, person, place and time was analyzed:

- **Person** - Are there certain populations at higher risk for poor outcomes? For example, are outcomes different based on age, race/ethnicity, education, or socio-economic status?
- **Place** - Are the outcomes in the county higher or lower than neighboring counties and the rest of the state? Are there high-risk neighborhoods in the county?
- **Time** - Do the trends over time show the outcomes improving, remaining the same, or declining?

If multiple objectives were identified, additional consideration was given to objectives that may have a greater impact on long term health and also have a good chance of positively impacting other objective indicators.

6. **Develop the Story Behind the Data:** Understanding the story behind the data ("WHY" the data looks the way it does) contributes to an increased understanding of the factors that impact the current state, as well as identifies contributing causes and potential solutions designed to have maximum impact. Results-Based Accountability's *Turn the Curve Thinking* was conducted for selected CHIP objectives/indicators to examine:
   - What is the story? What are the contributing causes to the trend of the selected CHIP objectives, including behavioral, environmental, policy and social determinant of health factors? 5 WHYS was conducted to help identify root causes.
   - Who are the partners that have a role in impacting contributing causes? What community assets or resources can be mobilized to impact identified causes?
   - What works to address identified contributing causes (including evidenced based interventions)?

*Turn the Curve Thinking* also determined a data development agenda, where counties identified if any additional data was needed on selected objectives and/or disparities, as well as a plan on how to collect that data.

7. **Select CHIP Interventions:** Upon completion of *Turn the Curve Thinking*, criteria was used to select interventions that will be included on the CHIP. Criteria used included:
   - How strongly will the proposed strategy impact progress as measured by the baselines?
   - Is the proposed strategy feasible?
   - Is it specific enough to be implemented?
   - Is the strategy consistent with the values of the community and/or agency?

*Turn the Curve Thinking* resulted in interventions which were linked with contributing causes and partners who could have an impact. It is our goal that, with successful implementation of diverse strategies by diverse partners, there will be a collective impact on *Turning the Curve* for the better on our CHIP objectives.

8. **Engage in Continuous Improvement:** To effectively monitor progress and effectiveness of each organization's contribution to selected CHIP objectives, intervention performance measures were identified that answer the questions:
   - How much did we do?
   - How well did we do it?
   - Is anyone better off?

Monitoring these intervention specific performance measures will identify if any focused quality improvement projects are required to improve intervention effectiveness and/or if revisions to CHIP interventions are required.

Scenic view from the Chemung River from the Lackawanna Trail
Photo by Kyle https://stock.adobe.com/contributor/209427526/kyle

# APPENDIX 3

## HEALTHY EATING & FOOD SECURITY: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 1.1 | Decrease the percentage of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WICJ) | | |
| 1.2 | Decrease the percentage of children with obesity | | |
| 1.4 | Decrease the percentage of adults ages 18 years and older with obesity | | |
| 1.6 | Decrease the percentage of all adults ages 18 years and older with obesity (among adults living with a disability) | | FLR Data Only |
| 1.13 | Increase the percentage of adults with perceived food security | | FLR Data Only |
| 1.5 | Decrease the percentage of adults ages 18 years and older with obesity (among adults with an annual household income of <$25,000) | | FLR Data Only |
| 1.7 | Decrease the percentage of adults who consume one or more sugary drinks per day | | |
| 1.8 | Decrease the percentage of adults who consume one or more sugary drinks per day (with an annual household income of <$25,000) | | FLR Data Only |
| 1.9 | Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day | | |
| 1.14 | Increase the percentage of adults with perceived food security ( among adults with an annual household income of <$25,000) | | FLR Data Only |
| *Note: Objectives 1.10, 1.11 and 1.12 had limited/unreliable data. | | | |

## PERINATAL & INFANT HEALTH: REDUCE INFANT MORTALITY & MORBIDITY SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 2.1.1 | Decrease Infant Mortality Rate | | |
| 2.1.2 | Decrease Percentage of Preterm Births | | |
| 2.1.4 | Decrease Rate of Infants Born with Neonatal Abstinence Syndrome and/or Affected by Maternal Use of Drugs of Addiction | | |
| 2.1.5 | Decrease the Sudden Unexpected Infant Death (SUID) Mortality Rate | | No Trend Available, but below PA goal |
| Note: Objective 2.1.3 had limited/unreliable data. | | | |

## PERINATAL & INFANT HEALTH: INCREASE BREASTFEEDING SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 2.2.1.2 | Increase the percentage of infants who are exclusively breastfed in the hospital among Black, non-Hispanic infants | | Small Numbers = Volatile Rates |
| 2.2.2.2 | Decrease the percentage of infants supplemented with formula in the hospital among breastfed Black, non-Hispanic infants | | Small Numbers = Volatile Rates |
| 2.2.3.0 | Increase the percentage of infants enrolled in WIC who are breastfed at 6 months among all WIC infants | | |
| 2.2.1.1 | Increase the percentage of infants who are exclusively breastfed in the hospital among Hispanic infants | | |
| 2.2.1.0 | Increase the percentage of infants who are exclusively breastfed in the hospital among all infants | | |
| 2.2.1.3 | Increase the percentage of infants who are exclusively breastfed in the hospital among infants insured by Medicaid | | |
| 2.2.2.0 | Decrease the percentage of infants supplemented with formula in the hospital among breastfed infants | | |
| 2.2.2.1 | Decrease the percentage of infants supplemented with formula in the hospital among breastfed Hispanic infants | | |
| Note: Objectives 2.2.3.1 & 2.2.3.2 had limited/unreliable data. | | | |

# CHEMUNG COUNTY: SELECTED OBJECTIVES

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 1.2 | Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC]) | | |
| 2.2.3.0 | Increase the percentage of infants enrolled in WIC who are breastfed at 6 months by 10% from 41.4% (2016) to 45.5% among all WIC infants | | |
| 3.11 | Decrease the prevalence of any tobacco use by high school students | * | |
| 3.1.6 | Increase the number of municipalities that adopt retail environment policies, including those that restrict the density of tobacco retailers, keep the price of tobacco products high, and prohibit the sale of flavored tobacco products | * | |
| 3.2.1 | Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%. | * | |
| 3.2.3 | Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among adults with income less than $25,000) | * | |
| 3.3.3 | Increase the number of multi-unit housing units (focus should be on housing with higher number of units) that adopt a smoke-free policy by 5000 units each year | * | |
| * Color-coding not available, objective was selected later in the CHA/CHIP process. | | | |

# LIVINGSTON COUNTY

| COUNTY NAME: | LIVINGSTON COUNTY |
|---|---|
| Participating local health department and contact information: | Livingston County Department of Public Health<br>Jennifer Rodriguez<br>Director of Public Health<br>jrodriguez@co.livingston.ny.us<br>585-243-7270 |
| Participating Hospital/ Hospital System(s) and contact information: | UR Medicine \| Noyes Health<br>Tara Coffey<br>Tara_Coffey@urmc.rochester.edu<br>585-335-4359 |
| Name of entity completing assessment on behalf of participating counties/ hospitals: | Common Ground Health<br>Catriona Spier<br>Catriona.Spier@commongroundhealth.org<br>585-224-3107 |

Livingdton County Letchworth State Park
Photo Credit: Stephen Crane

# EXECUTIVE SUMMARY

Through the use of Results-Based Accountability, Livingston County in partnership with UR Medicine | Noyes Health, has chosen to focus their 2022-2024 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) on the following priority areas, with low socioeconomic status as their identified disparity to address.

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Healthy eating and food security |
| **Disparity** | **Low Socioeconomic Status** |

A complete list of participating partners is available within the Livingston County Chapter under "Community Health Improvement Plan/Community Service Plan." These agencies represent academia, not-for-profits, community organizations, local businesses, community members, and local government. This includes the Livingston County Department of Health, Common Ground Health, Pivital Public Health Partnership, Genesee Valley Health Partnership (GVHP), Tri-County Family Medicine, Be Well in Nunda, CASA-Trinity, Genesee Valley Boces, ARC GLOW, and residents of Nunda. Partners' roles in the assessment were to help inform and select the 2022-2024 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings.

The community was involved in the 2018 My Health Story survey and inclusion of community input was considered as part of the oversight committee. The 2022 My Health Story Survey was being conducted in the summer and fall of 2022 as this document was produced, and it will provide community insight on key health matters in the county and surrounding areas. In addition, community input was garnered via focus groups with Positive Expressions Infant Feeding Support, Office for the Aging Advisory Group, Hand In Hand Mental Health Support Group, and Cultures Learning Together. A Forces of Change Assessment was conducted with GVHP which identified forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. Both primary and secondary data were reviewed by the Livingston County CHA Leadership Team including, but not limited to, the US Census Bureau American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, data collected from Pivital Public Health Partnership (formerly known as S2AY Rural Health Network), Prevention Needs Assessment data from CASA-Trinity, Food Insecurity Data from Livingston County Department of Health, Common Ground Health's My Health Story 2018 survey, 211 Lifeline, and the Statewide Planning and Research Cooperative System (SPARCS).

The process of Results-Based Accountability included evaluation of a pre-read document, which contained detailed county-specific analyses related to the five Prevention Agenda priority areas, followed by a multi-voting technique to select the priority areas. The Livingston County CHA Leadership Team participants were asked to consult with other members of their organizations and to complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Partners came to a consensus to address the top priority areas identified by the survey, and then additional county-specific data was collected, shared, and evaluated to help determine which objectives, disparity, and interventions should be selected. The NYSDOH Prevention Agenda was utilized to identify evidence-based interventions. The interventions selected included, but were not limited to:

### Prevent Chronic Diseases

- Screen for food insecurity, facilitate and actively support referral
- Multi-component school-based obesity prevention interventions: support policy and environmental changes that target physical activity and nutrition before, during, or after school

### Promote Well-Being and Prevent Mental and Substance Use Disorders

- Identify and support people at risk
- Promote connectedness, and teach coping and problem-solving skills
- Create protective environments

A complete list of interventions and process measures is available in the CHIP (Appendix 6). In order to engage the broad community in the development and implementation of the CHIP, specific committees that focus on the above priorities provided vital input. These committees include Be Well in Livingston/Chronic Disease Prevention, Trauma Informed Care, and the Suicide Prevention Task Force. These committees are comprised of key stakeholders and community members.

In forthcoming Livingston County CHA Leadership Team and GVHP meetings, group members will identify and address new data, review the family of measures/performance report, and discuss any mid-course corrections in interventions and processes that need to take place. Partners and the community will continue to be engaged and apprised of progress via these meetings, reports, and presentations.

Gardens at Vitale Park on Conesus Lake
Photo: iStock.com/Debora_Truax

# COUNTY CHAPTER – LIVINGSTON COUNTY

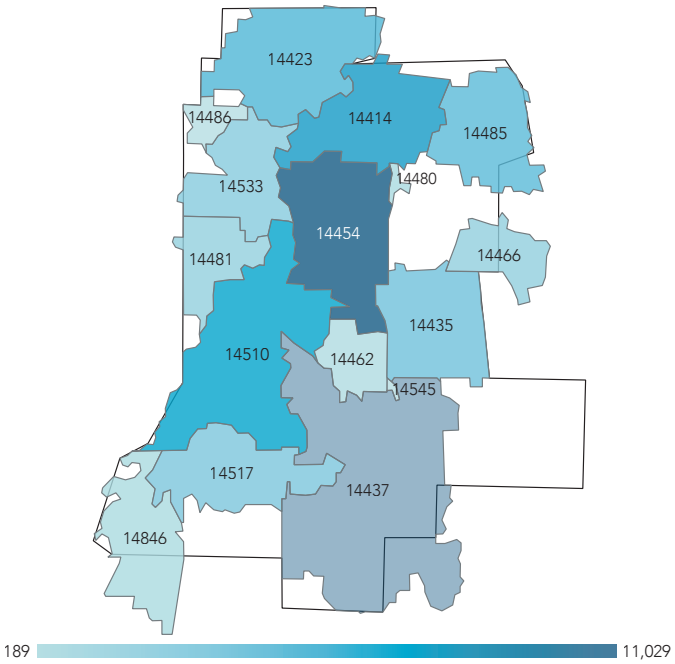
## Demographic and Socioeconomic Health Indicators

Livingston County is home to a wealth of land preserved for outdoor recreation and enjoyment, including Letchworth State Park and Conesus and Hemlock Lakes. Located just south of Monroe County, Livingston County residents who are able to commute to Rochester may have access to a broader range of urban employment opportunities. A total of 63,218 people live in Livingston County, concentrated in the town of Geneseo, which borders Conesus Lake, and in the southeastern town of North Dansville (Map L1).

The majority of Livingston's residents (about 86%) are White Non-Hispanic.[1] The town of Mount Morris (ZIP code 14510 in Map L1) has a relatively high percentage (approximately 8%) of Hispanic residents.

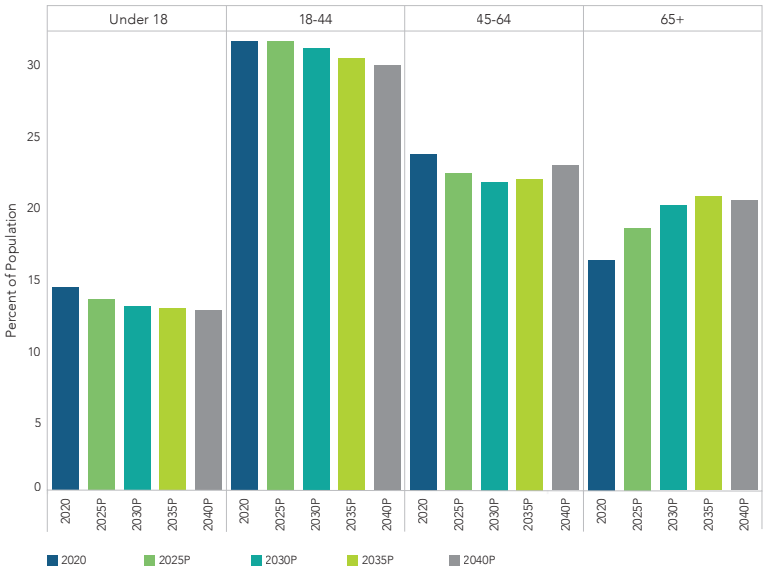
Approximately 30% of adults aged 65 or older in Livingston County are living with a disability and around 12% are living alone. Population projections from Cornell University's Program on Applied Demographics (Figure L2) show the largest age group within Livingston County are those aged 18-44. Both the 45-64 and 65 years and older age groups are expected to grow over the next few decades, which will create a greater demand on health care needs and services, including chronic disease management and geriatric care.

### Map L1. Population Density Map - Livingston County, NY




Data Source: US Census Bureau, American Community Survey, 2020 5-year Estimate

### Figure L2. Population Projections for Livingston County, NY




Data Source: Cornell University – Program on Applied Demographics, County Projections Explorer (accessed March 2022)

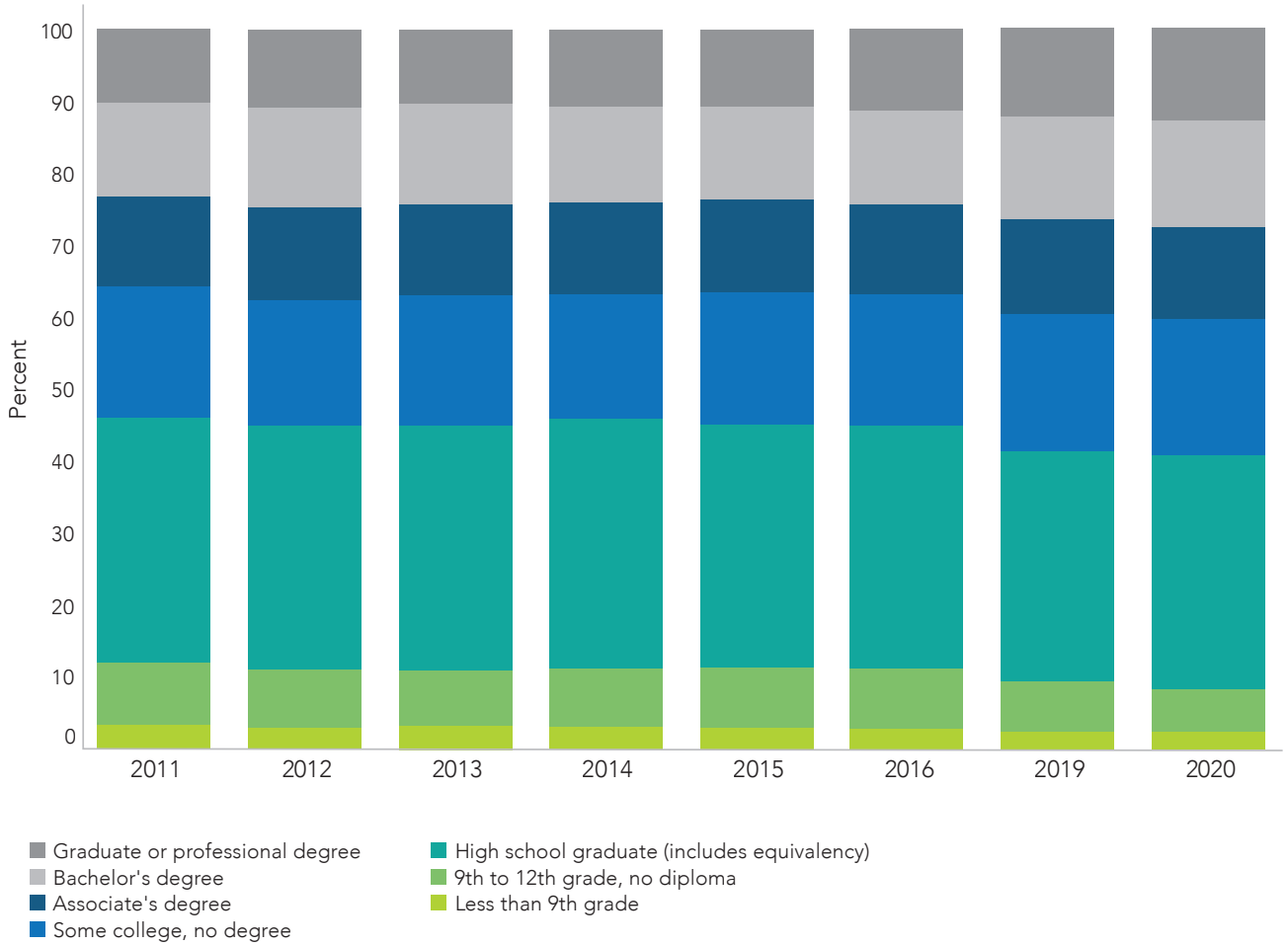
 1. US Census Bureau, American Community Survey, 2020 5-Year Estimate

Veterans make up almost 8% of Livingston County's population.[2] The most recent Census data shows that about three-quarters of housing units in Livingston County are owner-occupied as opposed to rented. About 40% of those who are foreign-born and living in Livingston County become naturalized U.S. Citizens, which is one of the lowest naturalization rates in the 9-county Finger Lakes region. Approximately 7% of residents aged 5 years or older speak a language other than English, over two thirds (36%) of whom speak Spanish.

Broadband internet access reaches around 85% of Livingston County residents, leaving 15% without access to high-speed internet at home. With schools transitioning to remote learning in 2020 due to the COVID-19 pandemic, this limited internet access was likely a barrier to many children who could not access their learning materials from home.

The percentage of individuals aged 25 years and older who earned a bachelor's degree or higher in Livingston County has increased from about 24% in 2015 to almost 28% in 2020, and is among the higher college education attainment rates in the Finger Lakes region.[3] These rates were higher for women (30%) than for men (25%) in 2020.

## Figure L3. Educational Attainment of Residents Aged 25+

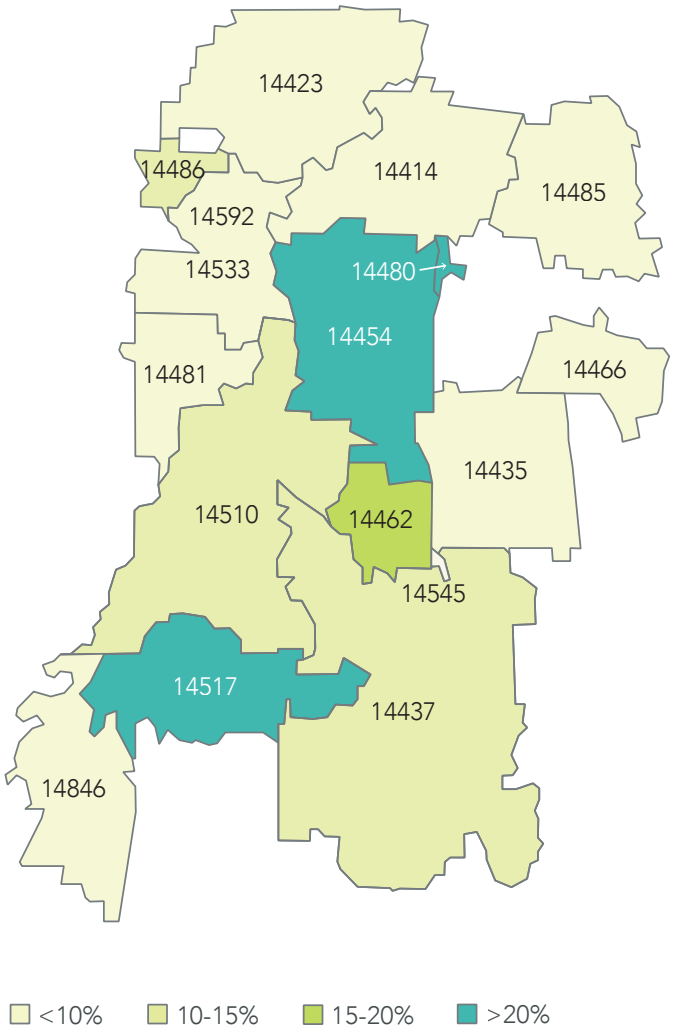



Data Source: US Census Bureau, American Community Survey (ACS), Year 2020.
Analysis Completed by Common Ground Health


2. Source: US Census Bureau, American Community Survey, 2020 5-Year Estimate
3. Source: US Census Bureau, American Community Survey, 2020 5-Year Estimate

The highest poverty rates in Livingston County are found in Geneseo, Groveland, Nunda, Mount Morris, and Dansville (Map L4). The poverty rate for residents with less than high school education is significantly higher (22%) than for those who obtained a bachelor's degree or higher (3%). Though the rate of males and females who have not completed high school are close (10% and 7%, respectively), the difference in poverty rates for these two groups shows a disparity. The 2020 poverty rate was about 17% for males who did not finish high school and almost 30% for females with the same educational attainment. A potential explanation for this disparity is the type of employment available to those without higher education.

## Map L4. Poverty Rates in Livingston County, NY

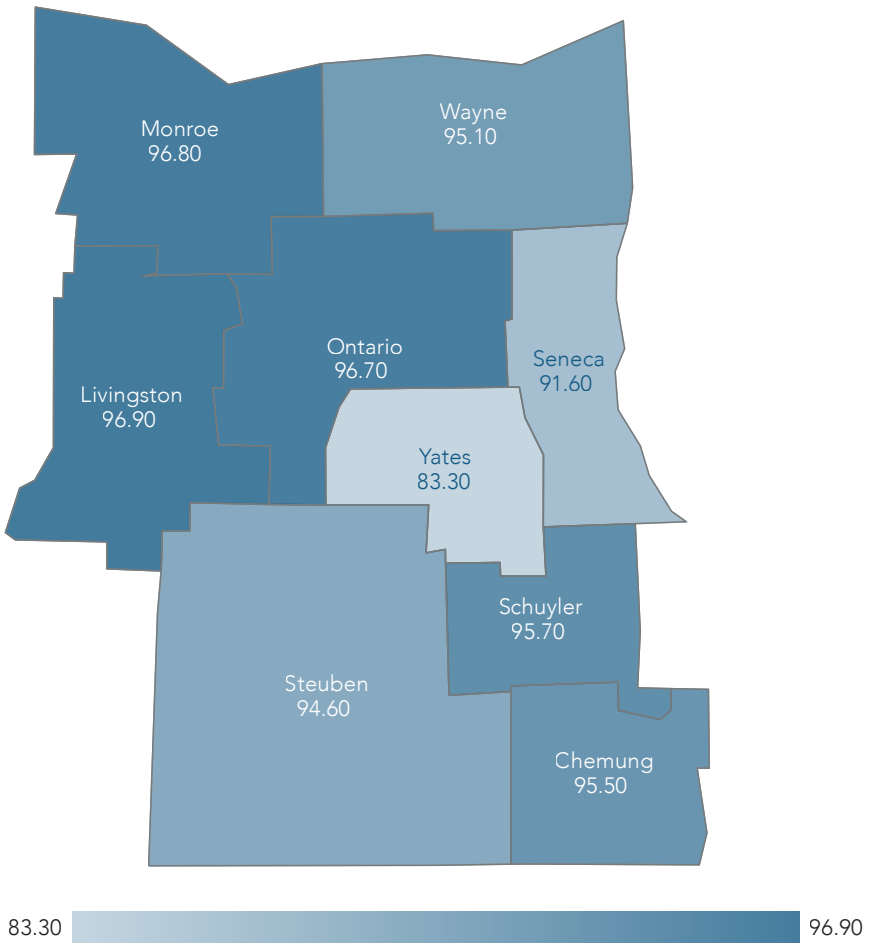



Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

The uninsured rate for Livingston County saw a steady decline from 2015 to 2019 with a slight increase in 2020 bringing the rate to 3.7% for males and 2.5% for females.[4] This is consistent with trends in the Finger Lakes region. As of 2020, approximately 97% of residents had access to health insurance (Map L5). Access, however, is not the only barrier to receiving health care.

Another concern is underinsurance, or insurance that still leaves health care inaccessible such as high deductibles, which make paying for care difficult even with insurance coverage. Transportation, lack of provider availability (including difficulty scheduling with providers), and cost (including cost of care, time away from work, and childcare) are additional factors which ought to be considered from an accessibility standpoint.

## Map L5. Percent of Population with Health Insurance, by County




Source: US Census Bureau, ACS, Year 2020
Analysis Completed by Common Ground Health

 4. United States Census Bureau, 2020 5-year Estimates

### Mental Health Providers:

In Livingston County, there are about 87 mental health providers per 100,000 population, which is less than half of the New York State rate of about 200 per 100,000. Providers are primarily located in Geneseo with a few in Mount Morris, one in Lima, one in Livonia, and one in Caledonia. UR Medicine | Noyes Health provides services in Dansville and Avon. There are far fewer providers offering addiction and substance use care in Livingston County, with a rate of just over 3 providers per 100,000 population. This is much lower than the New York State rate of 22 per 100,000.[5] Addiction and substance abuse providers are located in Dansville and Geneseo.

### Dental Health Providers:

Dental health providers in Livingston County are more evenly-spread with almost 23 per 100,000 and locations spanning the entire county in Dansville, Mount Morris, Avon, Lakeville, and Geneseo.

### Primary Care Providers:

The rate of primary care providers in Livingston County (71 per 100,000) approaches but is still lower than that of New York State (111 per 100,000).[6] As with dental health providers, primary care providers are evenly-spread across the County.

## Main Health Challenges

On March 17, 2022, a diverse group of stakeholders representing various sectors of the community were invited to attend a health priority setting meeting. At this meeting, participants reviewed the overarching goals of the New York State Prevention Agenda and relevant qualitative, quantitative, primary, and secondary data. A pre-read document containing detailed county-specific analyses relating to the five NYS Prevention Agenda priority areas was sent to all participants for review in advance. Data was collected from a variety of sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, primary data collected from Pivital Public Health Partnership, Prevention Needs Assessment data from CASA-Trinity, food insecurity data from Livingston County Department of Health, Common Ground Health's My Health Story Survey, and 211 Lifeline. My Health Story 2018 was a regional survey completed on behalf of nine counties in the Finger Lakes Region. Its primary purpose was to gather primary qualitative and quantitative data from Finger Lakes region residents on health issues in each county. Health departments, hospitals, and other local partners were instrumental in distributing the survey to community members, including disparate populations. The survey was updated in the summer and fall of 2022. It will be used to help inform potential shifts in strategies to improve the priority areas selected by Livingston County.

After initial review of the priority areas, a multi-voting technique was used to select the priority areas to focus on. Participants were asked to consult with other members of their organization and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Livingston County conducted focus groups in relation to the priorities, which are specified on the next page.


5. Centers for Medicare and Medicaid Services, CMS-National Plan and Provider Enumeration System (NPPES), May 2021
6. Centers for Medicare and Medicaid Services, CMS-National Plan and Provider Enumeration System (NPPES), May 2021

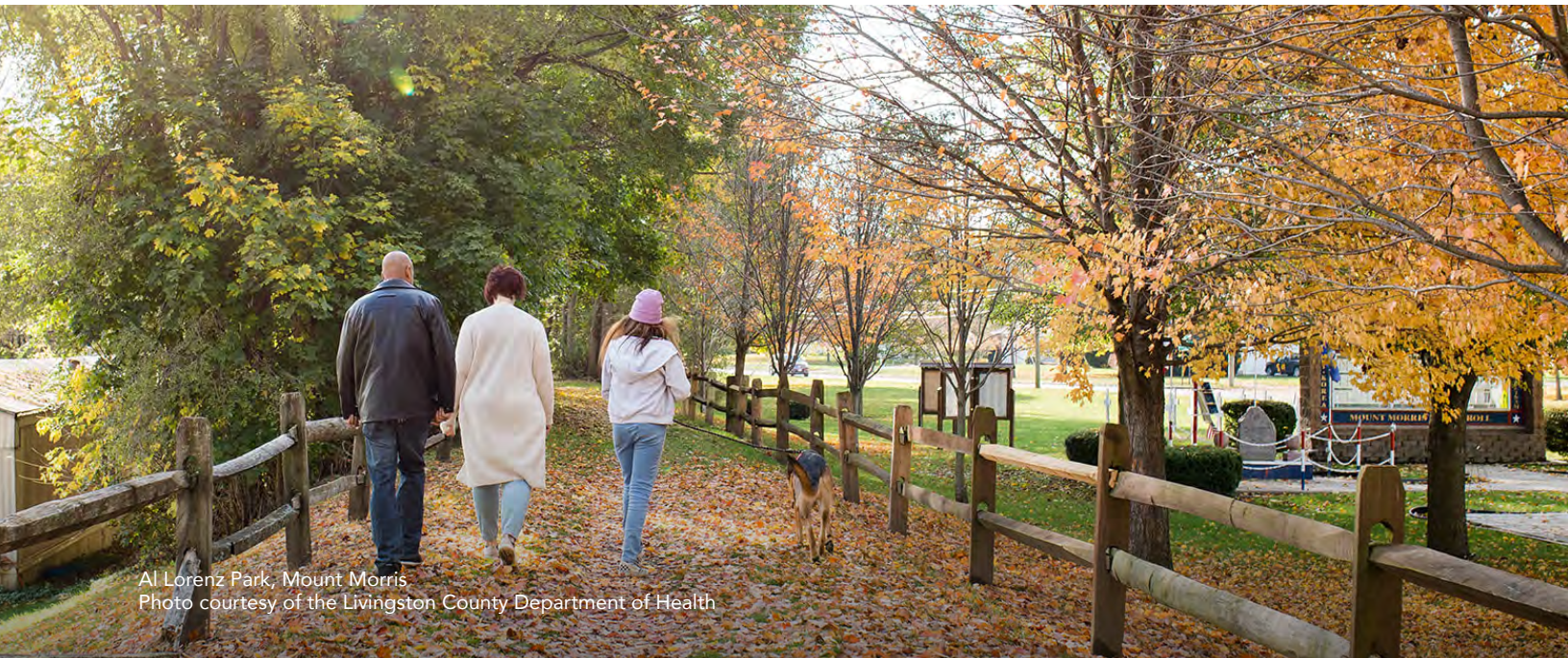
Enhancing community engagement was a priority throughout the CHA process. Community input was garnered via focus groups with Positive Expressions Infant Feeding Support, Office for the Aging Advisory Group, Hand In Hand Mental Health Support Group and Cultures Together. A Forces of Change Assessment was conducted with GVHP which identified forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. Responses from these assessments were incorporated into the CHIP development. As a result, the following areas were selected for the 2022-2024 Community Health Improvement Plan:

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Healthy eating and food security |
| **Disparity** | **Low Socioeconomic Status** |

After selecting priority and focus areas, Common Ground Health gathered data on all objectives from the New York State Prevention Agenda within the chosen priority areas. Objectives were color-coded based on data status to help focus attention where it was needed most. Red objectives were neither meeting the Prevention Agenda goal nor trending in a favorable direction, yellow objectives were either not meeting the Prevention Agenda goal or not trending in a favorable direction, and green objectives had both met the goal as well as trended in a favorable direction. Objectives that were color coded as gray represented a lack of current and/or reliable data. Color coded data on objectives were presented to the team in April 2022 meeting and partners utilized the data, as well as potential scope and interest of the group, to determine the objectives with which they would proceed.

Utilizing Results-Based Accountability, Pivital facilitated "Turn the Curve" thinking to analyze the story behind the data or root causes with the Livingston County CHA Leadership Team. This helped the group identify evidence-based strategies from the NYS Prevention Agenda to address the chosen priorities, which were incorporated into the CHIP.



Al Lorenz Park, Mount Morris
Photo courtesy of the Livingston County Department of Health

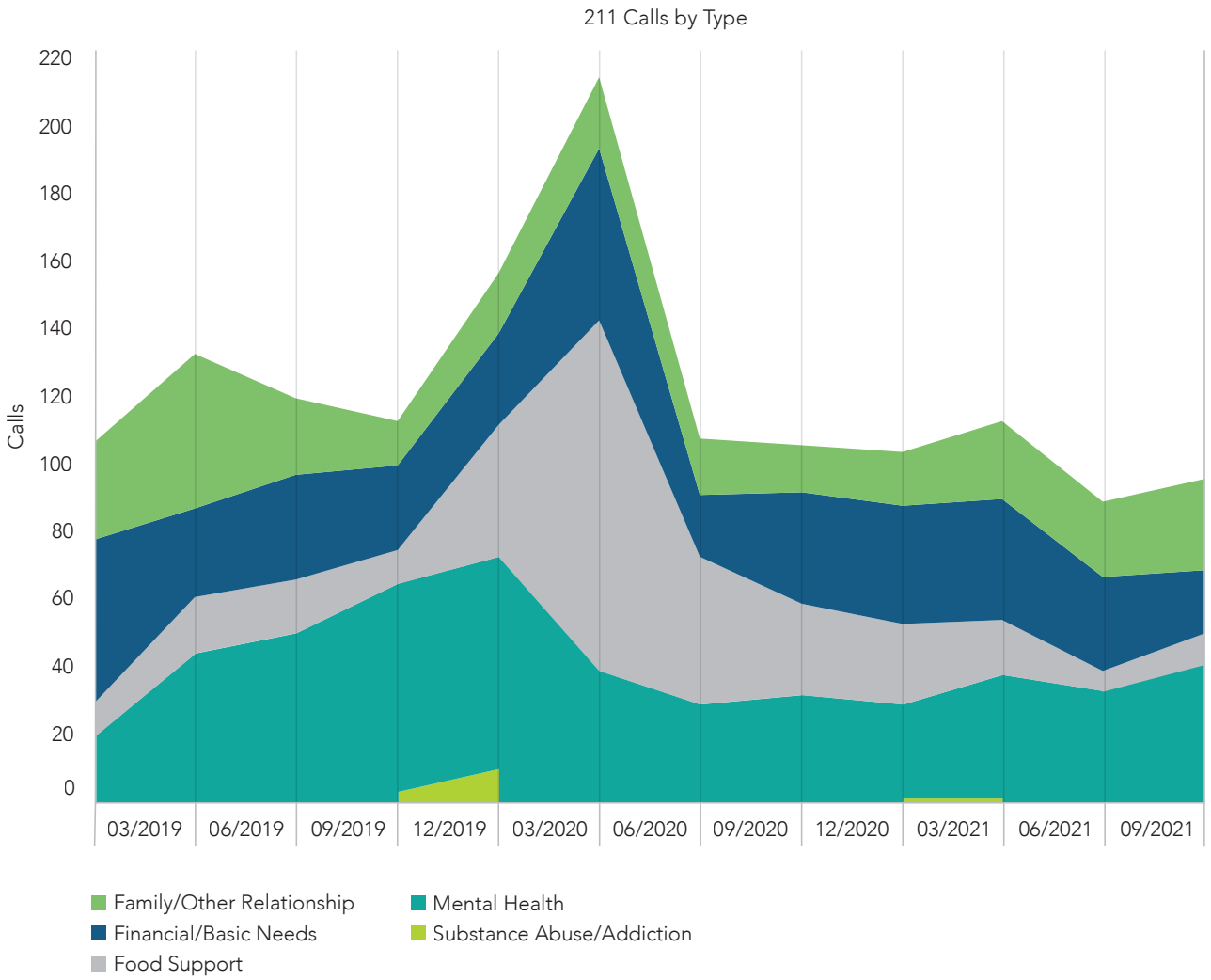
## Risk and Protective Factors Contributing to Health Status

Livingston County has selected two focus areas on which to anchor their 2022-2024 Community Health Improvement Plan. This section will take a closer look at the behavioral, environmental, political, and unique risk and protective factors contributing to the health status of those areas.

### Prevent Mental and Substance Use Disorders

The 2018 Behavioral Risk Factor Surveillance System dataset shows that Livingston County ranked second-highest for depressive disorders (27%) compared to the other 8 counties in the Finger Lakes region.[7] The COVID-19 pandemic has played a role in increasing mental health concerns throughout Livingston County. Throughout the pandemic, calls for mental health services were one of the top four issues noted by Goodwill Lifeline 211. (Figure L6)

### Figure L6. Goodwill 211 Lifeline Call Counts - Livingston County, NY

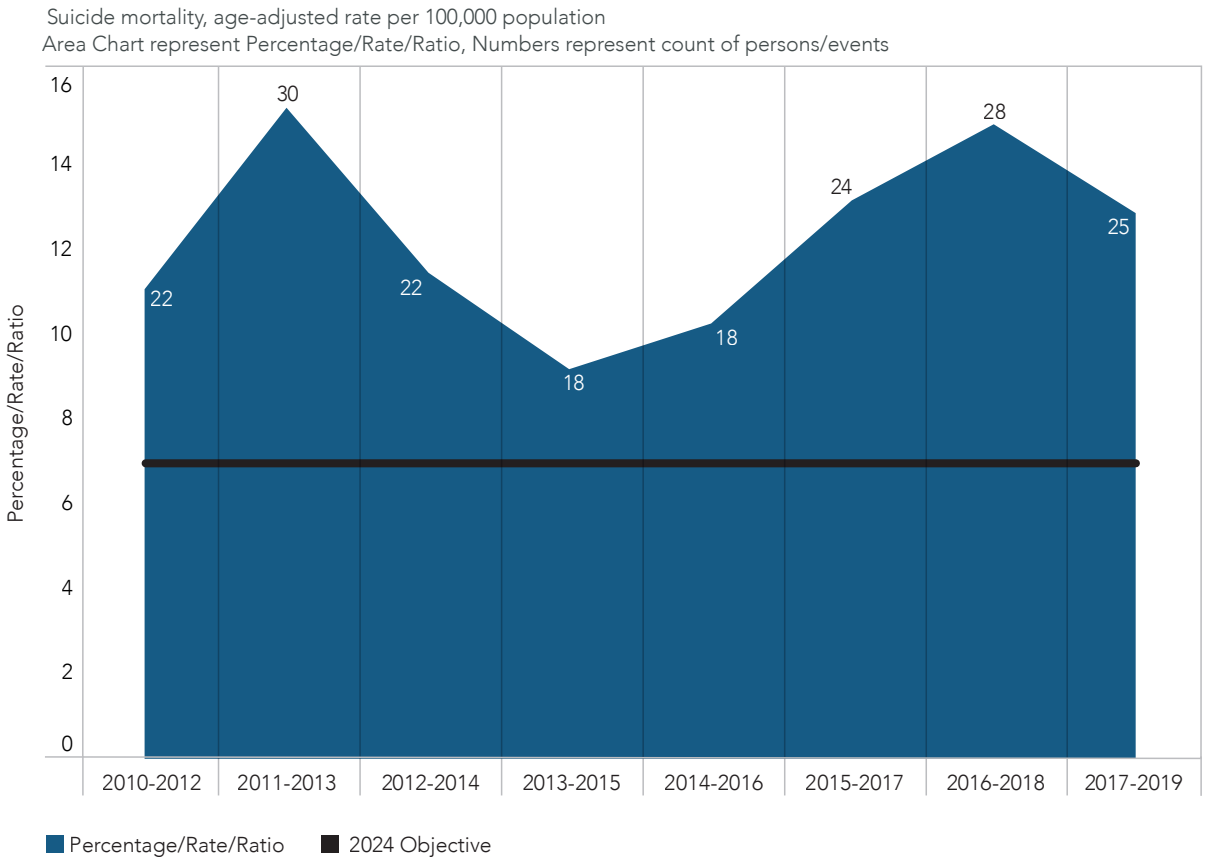



Data Source: Goodwill/211 Lifeline, Year 2019 - 2021. Analysis Completed by Common Ground Health


7. Behavioral Risk Factor Surveillance System, 2018

The Livingston County Sheriff's Office experienced an increase in mental health-related calls starting in 2020 and continuing throughout 2022. The suicide rate in Livingston County has been increasing since 2015 (Figure L7). Recent data from the Monroe County Medical Examiner's Office for 2020 and 2021 is inconclusive given the number of cases pending. However, initial data shows a drop in suicides reported from 2019 to 2021. The rate of major depressive disorders increased from 19% in 2016 to 27% in 2018, and is likely to have further increased due to the pandemic.[8] Rates of adults reporting poor mental health days have grown in Livingston from 12% in 2013-2014 to 16.4% in 2018.

## Figure L7. 3-Year Suicide Rate for Livingston County, NY




Vital Records, data as of January 2022
Analysis Completed by Common Ground Health

In regards to children's mental health, Prevention Needs Assessment survey results for Livingston County report increasing rates of students feeling that "life is not worth it" from 23% in 2008 to 28% in 2020.[9] The percentage of students feeling that they are "no good" increased from 31% to 39% across the same timeline. Feelings of depression among youth have also increased from 22% in 2008 to 35% in 2020.

County partners have noted a lack of mental health providers as one of the major barriers to receiving therapy, leading to unmanaged mental health conditions. Unfortunately, this is a common problem in rural communities. While it is important to recommend treatment for mental illness, people also need help finding providers. More providers in Livingston County are needed to address this issue.



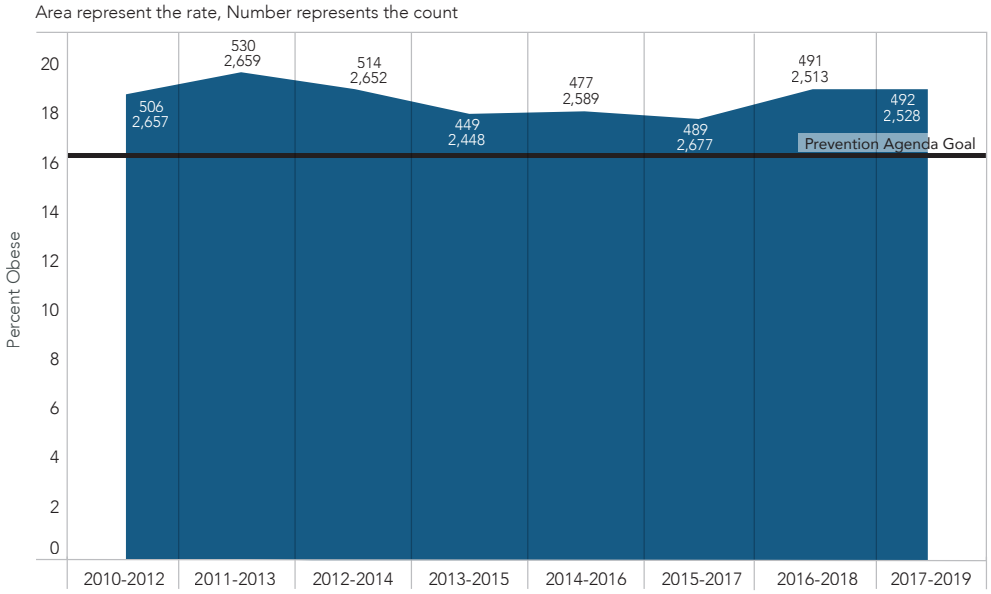
8. Source: Behavioral Risk Factor Surveillance System, 2018
9. Source: Prevention Needs Assessment Survey Results – Livingston County – All Schools, 2004-2020

## Healthy Eating and Food Security

There are a number of health measures related to healthy eating and food security published in the 2018 BRFSS dataset. Livingston County has the highest rate in the Finger Lakes region for several measures, including difficulty completing errands (12%, self-reported poor physical health (22%, and cost as a barrier to receiving medical care (10%. The associations between these measures and healthy eating and food security are clear. Difficulty completing errands alone or in combination with poor physical health makes it harder to get to the grocery store for healthy food. It is also harder to participate in physical activities that could assist with weight management/reduction. Cost as a barrier to receiving medical care may lead to unmanaged chronic illness, such as obesity, which may negatively impact the ability to be physically active.

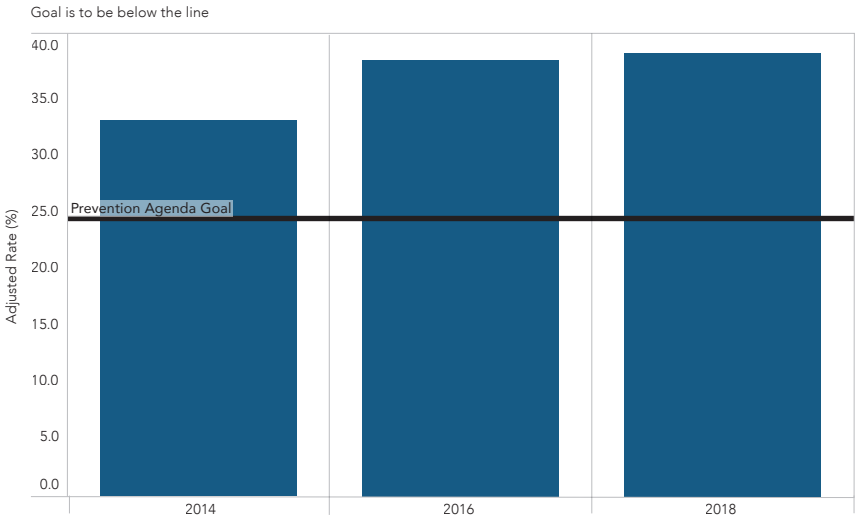
The adult and childhood obesity rates in Livingston County (see Figures L8 and L9 below) are both above the New York State Prevention Agenda goals of 25% and 16.4%, respectively.

### Figure L8. Childhood Obesity in Livingston County, NY




Data Source: NYS DOH, Health Data Connector, 2010 – 2019

### Figure L9. Adult Obesity Rates, Livingston County, NY



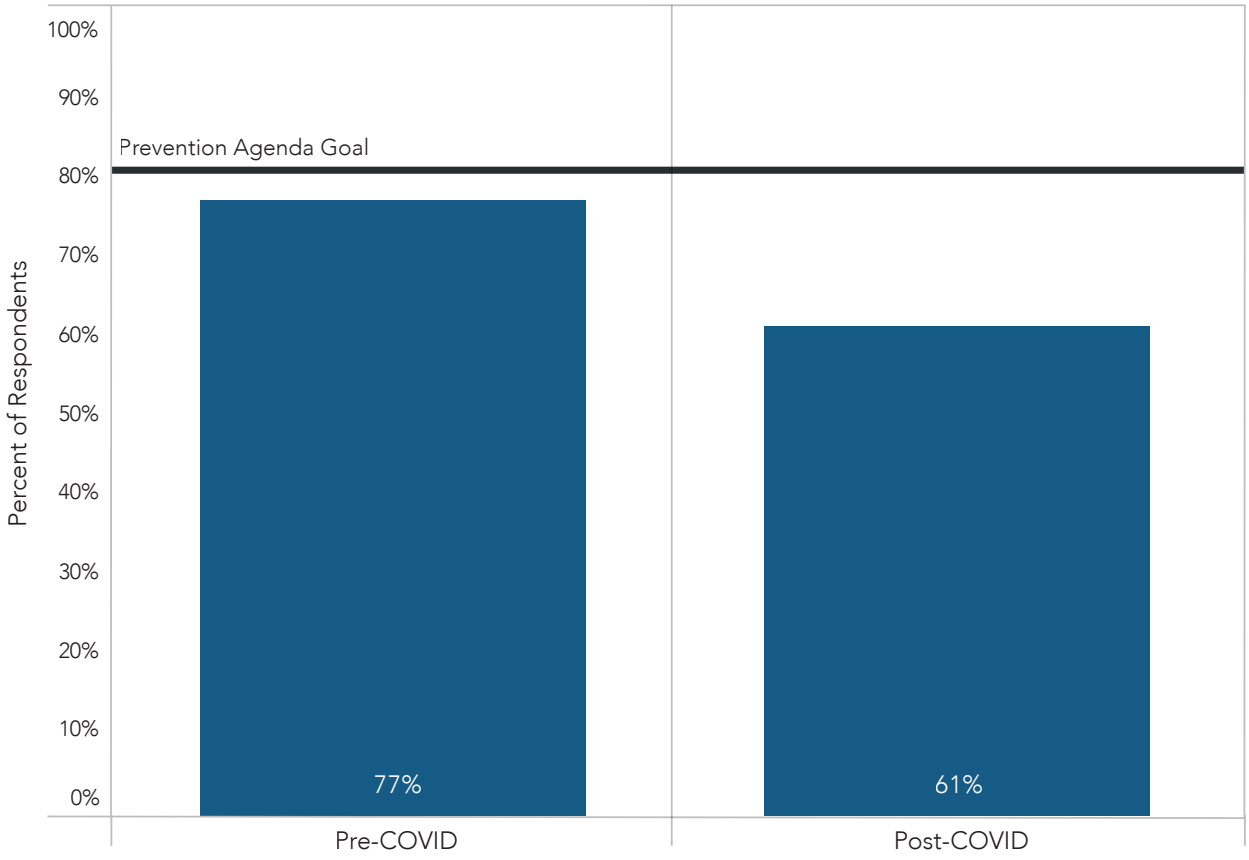

Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2013-2014, 2016, & 2018. Analysis Completed by Common Ground Health

The pandemic further reduced peoples' ability to purchase healthy food or to find opportunities to exercise for a number of reasons including:

- Loss of work/income
- Lack of child care
- Increased responsibilities at home (caring for sick family members, helping children navigate virtual learning)

Food security in the Finger Lakes region has decreased since the start of the COVID-19 pandemic. Before the pandemic, regional food security data showed around 77% of individuals reporting they had enough food. According to a survey conducted by Pivital Public Health Partnership (S2AY Rural Health Network at the time), by 2021 food security had decreased to about 61%, (Figure L10). Pivital Public Health Partnership also reported that regional consumption of fruit and vegetables has decreased since the start of the pandemic, presumably because these foods are more expensive and spoil quickly, making them a less economical choice.[10]

## Figure L10. Food Security, Finger Lakes Region, NY

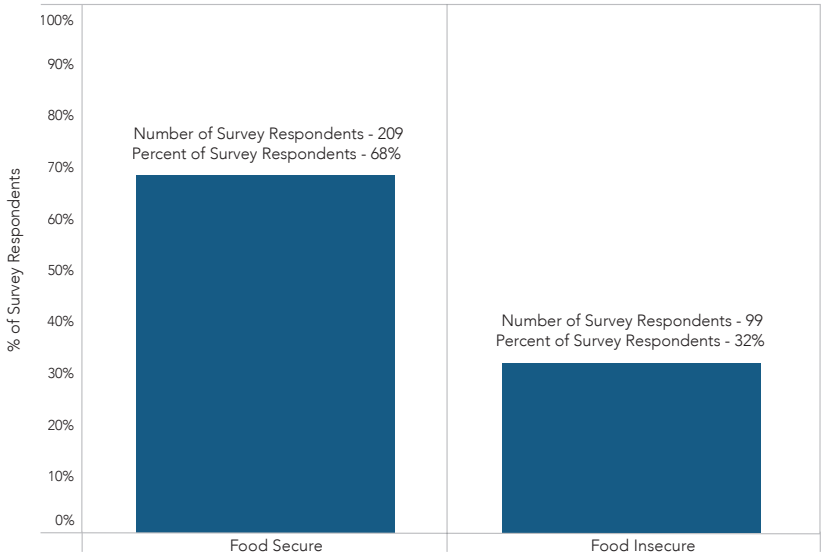



Source: Pivital Public Health Partnership, 2021. Analysis Completed by Common Ground Health.

 10. Pivital Public Health Partnership, 2021 Food Security Data

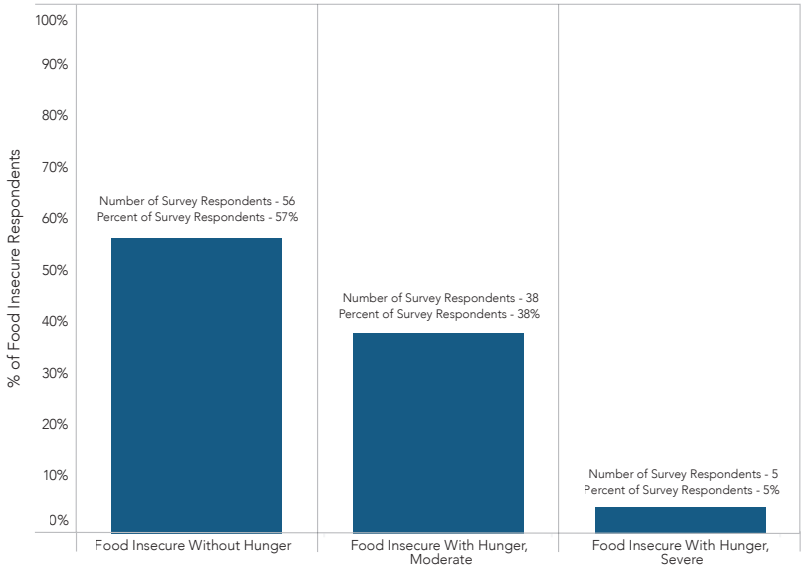
Goodwill 211 Lifeline call data show that calls related to food support increased greatly in the first year of the pandemic (Figure L6). The Livingston County Food Security Survey conducted from January to March 2022 reported a 32% rate of food insecurity (Figure L11). According to the report "Understanding Food Insecurity in Livingston County," the survey results likely have sampling bias and cannot provide an accurate rate of food insecurity in Livingston. However, the responses of people experiencing food insecurity can offer some insight into the dynamics of food insecurity in Livingston. Of those respondents who reported food insecurity, 43% reported moderate (38%) or severe (5%) hunger (Figure L12). Additionally, 48% didn't eat as much as they should, 38% were hungry but didn't eat, 10% lost weight, and 4% didn't eat for a whole day (Figure L13). Further findings from the survey conclude that limited financial resources and difficulty accessing grocery stores are the two largest contributors to food insecurity in Livingston County. Lastly, there is a high rate of food insecurity in Geneseo, which is both a food desert and the home of the largest college in Livingston County.

## Figure L11. Food Insecurity, Livingston County, NY



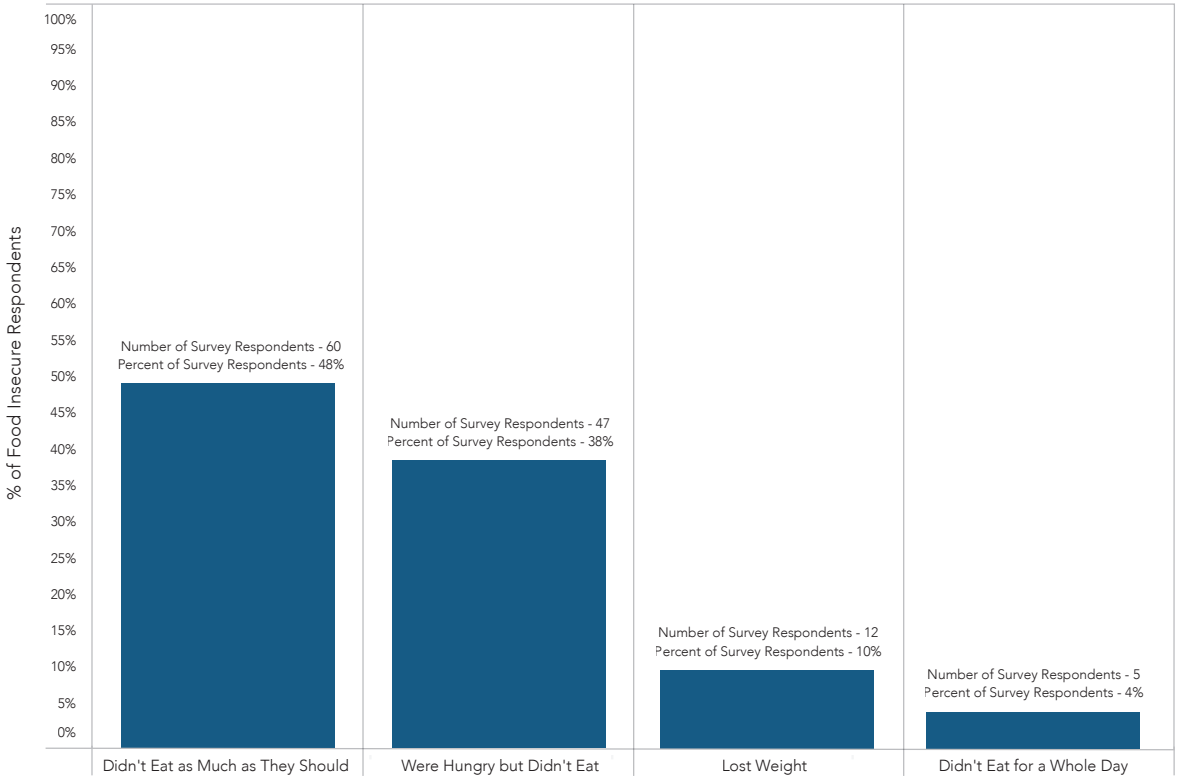

Source: Understanding Food Insecurity in Livingston County Survey, 2022
Analysis Completed by Common Ground Health

## Figure L12. Food Insecurity, Livingston County, NY




Source: Understanding Food Insecurity in Livingston County Survey, 2022.
Analysis Completed by Common Ground Health

## Figure L13. Food Insecurity, Livingston County, NY




Source: Understanding Food Insecurity in Livingston County Survey, 2022.
Analysis Completed by Common Ground Health

Partners noted that there is a lack of knowledge around which foods are considered healthy and how to prepare healthy meals. In addition, increased costs of food, rent, and utilities make it difficult for residents to focus on buying healthier food as other necessities tend to take priority. Livingston County residents may not be aware of their options for accessing healthy food, which include online grocery shopping, assistance picking up groceries, and using EBT benefits on Amazon. There are programs in Livingston that could be helpful, but many partners feel that residents need more help understanding and accessing these resources. Partners also feel that SNAP benefits are difficult to obtain. One reason cited as to why residents cannot use SNAP benefits at farmers markets and other locations is that vendors state SNAP reimbursements are challenging to obtain.

## Community Assets and Resources to be Mobilized

The Finger Lakes Region already has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies that promote and facilitate collaboration: Pivital Public Health Partnership (previously the S2AY Rural Health Network) and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors – hospitals, insurers, universities, business, nonprofit, faith communities, and residents – to collaborate on strategies for improving health in the region. Both agencies provide support, collaboration, and resources to improve the health of Livingston County residents.

Fortunately, there are many assets and resources in the community to be mobilized to promote well-being and prevent mental and substance use disorders. For 24/7 crisis services, residents of Livingston County can call 2-1-1 and receive a variety of therapeutic supports. These mobile services are currently available to adults and children during and after business hours, and Livingston County Mental Health Services is working on securing grant funding to expand the current services to better meet the needs of the community.

Across Livingston County, efforts are being made to address poor mental health. The Livingston County Sheriff's Office recognizes that the response to 9-1-1 calls related to mental health crises needs to improve and shared that the Department is training staff on more effective methods for handling these types of calls. The Suicide Prevention Task Force of the Genesee Valley Health Partnership (GVHP), which was formed in 2013, continues its work to lower the suicide rate in the county. Their work includes using evidence-based trainings and enhancing awareness of services for those with suicidal ideation.

Access to guns and other lethal means is another major issue impacting the suicide rate in Livingston County. Livingston County has implemented Lock and Talk Livingston. This program is aimed at preventing self-harm and suicide by promoting safe storage of firearms and medications. The hope is to limit access to these lethal means during a mental health crisis. According to Livingston County's Suicide Prevention Task Force, Lock and Talk Livingston "…gives community members the opportunity to become educated about the signs of suicide risk and how to act as a catalyst to care…" This program has been widely successful across the county.

Livingston County also has evidence-based suicide prevention gate-keeper programs intended to train individuals to recognize risk factors and assist when possible. One program, S.A.V.E., stands for Signs of suicide, Asking about suicide, Validating feelings, and Encouraging help/Expediting treatment. It is a two-hour training program intended to educate veterans and those who serve this population. Another program, called WAV (Worried About a Veteran), developed by the Division of Veterans' Services and the Office of Mental Health, is a resource geared towards military families and caregivers. The focus of these programs is paying attention to warning signs and, like the Lock and Talk program, reducing access to lethal means. Mental Health First Aid, which is included in the "stress less" focus of the Be Well initiative, is an evidence-based program that provides training to both adults and youth, teaching trainees to recognize risk factors for suicide, as well as modeling preventive responses.

Livingston County has several initiatives aimed at preventing chronic diseases and reducing obesity and food insecurity, including Be Well in Livingston. An initiative of the Genesee Valley Health Partnership, Be Well in Livingston, has the slogan "Eat Better, Move More, and Stress Less." This program is aimed at reducing obesity among county residents by implementing policy, system, and environmental change. This initiative utilizes evidence-based strategies and local resources. These include implementing SNAP nutritional classes and Coordinated Approach to Child Health (CATCH) through Cornell Cooperative Extension in local schools, chronic disease self-management programs through UR Medicine | Noyes Health and URMC Center for Community Health and Prevention, and WIC through the Livingston County Department of Health. GVHP has been working with the community to address the lack of grocery stores in Mount Morris, a food desert, by searching for grant funding. Some of the offerings in Livingston County via Cornell Cooperative Extension include parenting classes, financial management, and literacy education, which help residents learn how to feed a family on a budget.

Resources which help residents with access to food include Foodlink food distribution sites throughout the county. From 2021 to 2022, there was a 157% increase in the number of households served by the Foodlink Mobile Pantry and a 66% increase in the number of households served by the Foodlink Food Pantry. This was a result of additional food distributions sites becoming available. This demonstrates that increased access to food is still a major need in the county, especially as people recover from the pandemic.

In terms of food security, Livingston County residents continue to struggle with access to healthy and affordable foods. Specifically in Mount Morris, where the nearest grocery store is a 15-minute drive away, residents tend to rely on places like the Dollar General for their food. In an effort to increase access to healthy foods and local resources, the Be Well in Mount Morris Committee developed an "Eat Better" resource. This lists farmer's markets, restaurants, food pantries, and resources including WIC and OFA programs, Mount Morris Central Schools' Backpack Food Program, and more. This document continues to be distributed throughout the community. County partners see this as an opportunity to improve screening for food security, to facilitate referrals to SNAP, and to track/evaluate the progress of these efforts. Additionally, Ride Livingston can be promoted more broadly so that residents know about this transportation resource, as it may increase their access to healthy food.

Farmers markets are available in several areas of the county. In addition, Linwood and Nunda implement a Farm Drop, which provides access to healthy, locally produced food to community members.

Promoting and utilizing the aforementioned assets and resource will continue to help improve the health of the community in both priority areas as well as to address the social determinants of health to ensure health equity. A complete list of Livingston County assets and resources is located in Appendix 4. This list was developed with the assistance of the CHA Leadership Team and the Office for the Aging Advisory Committee.

## Community Health Improvement Plan/Community Service Plan

As previously discussed in the Main Health Challenges section, a multi-voting technique was used to select the priority areas for the Community Health Assessment and Community Health Improvement Plan. Livingston County prioritization partners received county specific pre-read documents. These documents included updated data measures for each of the five priority areas outlined in the Prevention Agenda. This was followed with additional county specific data on objectives within the chosen priority areas to help identify objectives, disparities, and interventions to include within the plan. A concerted effort took place during the month of December to ensure the Livingston County Community Health Assessment Leadership Team, which oversees the process, was equipped with a diverse and inclusive group representing all areas of health and well-being in the county. The following organizations were engaged in Livingston County's planning and prioritization process:

| LIVINGSTON COUTY PLANNING AND PRIORITIZATION AGENCIES | | |
|---|---|---|
| Livingston County Department of Health | Common Ground Health | Pivital Public Health Partnership |
| Genesee Valley Health Partnership | Tri-County Family Medicine | Nunda Residents |
| Be Well in Nunda | CASA-Trinity | Genesee Valley BOCES |
| SUNY College at Geneseo | Lifespan | Livingston County Center for Nursing & Rehabilitation |
| Livingston County Office for the Aging | Health and Wellness Referral Services | Catholic Charities |
| Cornell Cooperative Extension | Foodlink NY | Town of Nunda |
| Livingston County Workforce Development & Youth Bureau | Livingston County Mental Health | Arc GLOW |
| Livingston County Sheriff 's Office | 4 Square Church | Chamber of Commerce |
| Excellus | URMC \| Noyes Health | Elizabeth Wende Breast Center |
| Genesee Valley Arts Council | RESTORE | Migrant Center |
| RTS Livingston | Genesee Valley Health Partnership | |

The CHIP's designated overseeing body, Genesee Valley Health Partnership and the CHA Leadership team, meets a minimum of twice per year. The group has historically reviewed and updated the Community Health Improvement Plan and will continue to fulfill that role. During meetings, group members will identify any midcourse actions that need to be taken and modify the implementation plan accordingly. Progress will be tracked during meetings via partner reports and will be recorded in meeting minutes and a CHIP progress chart. Partners and the community will continue to be engaged and apprised of progress via website postings, email notification, and at the annual State of the County Health Report presentation in Livingston County. In addition, the ongoing collaborative process for updating and revising the assessment, including new information on data, will occur during the annual State of the County Health Report presentation and during GVHP membership meetings and subcommittee meetings such as the Suicide Prevention Task Force and Be Well meetings. These committees are comprised of diverse community sectors including community members. Recruitment of new members occurs on partners' websites and social media. The GVHP Board reviews annual membership to identify gaps in membership based on current health priorities.

## Dissemination

The executive summary of the 2022-2024 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) was created in partnership between the Livingston County Department of Health and UR Medicine | Noyes Health. It will be disseminated to the public in the following ways:

- Made publicly available on the Livingston County Department of Health main website and social media sites
- Made publicly available on the UR Medicine | Noyes Health main website and social media sites
- Made publicly available on the Genesee Valley Health Partnership website
- Made publicly available on the Pivital/S2AY Rural Health Network website
- Made publicly available on additional partners websites (Cornell Cooperative Extension, local community-based organizations, etc.)
- Shared with all appropriate news outlets in the form of a press/media release
- All partners including CHA Leadership Team and GVHP members will be requested to share the document via their organizations' websites as well
- The full regional CHA will be shared on Common Ground Health's website (www.commongroundhealth.org)

A list of websites that have the documents posted are included below:

Livingston County Public Health: https://www.livingstoncounty.us/doh.htm
UR Medicine | Noyes Health: https://urmc.rochester.edu/noyes.aspx
Genesee Valley Health Partnership: https://www.gvhp.org
S2AY Rural Health Network: http://www.s2aynetwork.org/regional-community-health-assessment.html

In addition, the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) will be shared with Livingston County's governing entity.

# APPENDIX 1

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Section V Cross Country Championships, Livingston County
Photo Credit: Common Ground Health

# APPENDIX 2

## RESULTS-BASED ACCOUNTABILITY™

Results-Based Accountability™ is a disciplined way of thinking and acting to improve entrenched and complex social problems.[11] To facilitate CHA/CHIP development, resulting in a CHIP that measurably improves health, the following steps were followed:

1. **Define the Community:** Data collection is an important first step. In this step, it is important to gather data for the community at large (county-level data) as well as data that identified vulnerable populations within the community who are at risk for poorer health outcomes. This can happen by collecting and analyzing data that shows differences in rates of illness, death, chronic conditions and more in relationship to demographic factors. The planning committee brainstormed specific potential vulnerable populations in the county to be considered with data collection.
2. **Engage Stakeholders:** Population health requires engagement from many sectors. Complex social, economic, and environmental factors are all determinants of health; therefore, there is no one organization, department, or program that can be held solely responsible for the health of a population. Diverse engagement began in November/December 2021, early in the CHA development process. Committee partners completed an exercise to brainstorm potential new partners from the following sectors: Local Government, Businesses, Not-for-Profit and Community Organizations, Academia, and the General Public. The following questions were used to assist brainstorming:
   - Who are those with potential interest and influence who can contribute to the CHA/CHIP process?
   - What population do they represent? (including vulnerable populations identified in Step 1)
   - Identify their potential level of interest and influence (High Interest/High Influence, Low Interest/ High Influence, High Interest/Low Influence, Low Influence/Low Interest)
   - Who would be the best person on the committee to extend an invitation to the selected potential new partner?

After an assessment of brainstormed information, personal invitations were sent to selected potential new partners to address any gaps on the committee and the need for diverse engagement.

3. **Engage in Comprehensive Data Collection:** Both primary and secondary data were collected. Disaggregated data was collected by race, gender, income and geography, as available, to identify vulnerable populations and to assist in strategy development. Data sources included, but were not limited to:
   - Common Ground Health: My Health Story
   - County Health Rankings
   - Vital Statistics
   - Behavioral Risk Factor Surveillance Survey (BRFSS)
   - United States Census Bureau
   - Cornell University Program on Applied Demographics
   - Statewide Planning and Research Cooperative System (SPARCS)
   - New York State Department of Health Perinatal Data Profile
   - S2AY Rural Health Network Inc,: The Impact of COVID-19 on Food Security and Healthy Eating
   - Outreach to county committee partners for data from their respective organizations.
   - Community Focus Groups


11. Results-Based Accountability - Overview and Guide (clearimpact.com)

4. **Prioritize Health Issues:** Data was analyzed and presented by Common Ground Health. After review of analyzed health outcome data for trends, current state against benchmarks or Prevention Agenda targets, and differences among populations, a multi-voting tool was used by committee members to rank the health issues using selected criteria to identify top Focus Areas, which identified Prevention Agenda Priority Areas.
5. **A Deeper Dive** of data was conducted by Common Ground Health. To enhance the picture of the selected Focus Areas, related Prevention Agenda objective data was presented. A table with objectives and their status colors was created to help with the selection of objectives for this CHA/CHIP cycle.
   - Green Status – the prevention goal metric has been met and the trend of that metric is in the correct direction of the goal or steady
   - Yellow Status – either the prevention goal has not been met but the trend is in the correct direction or the goal has been met but the trend is in the wrong direction
   - Red Status – the goal has not been met and the trend is in the wrong direction
   - Gray Status – there is limited data on this metric available at this time

In addition, person, place and time was analyzed:

- **Person** - Are there certain populations at higher risk for poor outcomes? For example, are outcomes different based on age, race/ethnicity, education, or socio-economic status?
- **Place** - Are the outcomes in the county higher or lower than neighboring counties and the rest of the state? Are there high-risk neighborhoods in the county?
- **Time** - Do the trends over time show the outcomes improving, remaining the same, or declining?

If multiple objectives were identified, additional consideration was given to objectives that may have a greater impact on long term health and also have a good chance of positively impacting other objective indicators.

6. **Develop the Story Behind the Data:** Understanding the story behind the data ("WHY" the data looks the way it does) contributes to an increased understanding of the factors that impact the current state, as well as identifies contributing causes and potential solutions designed to have maximum impact. Results-Based Accountability's *Turn the Curve Thinking* was conducted for selected CHIP objectives/indicators to examine:
   - What is the story? What are the contributing causes to the trend of the selected CHIP objectives, including behavioral, environmental, policy and social determinant of health factors? 5 WHYS was conducted to help identify root causes.
   - Who are the partners that have a role in impacting contributing causes? What community assets or resources can be mobilized to impact identified causes?
   - What works to address identified contributing causes (including evidenced based interventions)?

*Turn the Curve Thinking* also determined a data development agenda, where counties identified if any additional data was needed on selected objectives and/or disparities, as well as a plan on how to collect that data.

7. **Select CHIP Interventions:** Upon completion of *Turn the Curve Thinking*, criteria was used to select interventions that will be included on the CHIP. Criteria used included:
   - How strongly will the proposed strategy impact progress as measured by the baselines?
   - Is the proposed strategy feasible?
   - Is it specific enough to be implemented?
   - Is the strategy consistent with the values of the community and/or agency?

*Turn the Curve Thinking* resulted in interventions which were linked with contributing causes and partners who could have an impact. It is our goal that, with successful implementation of diverse strategies by diverse partners, there will be a collective impact on *Turning the Curve* for the better on our CHIP objectives.

8. **Engage in Continuous Improvement:** To effectively monitor progress and effectiveness of each organization's contribution to selected CHIP objectives, intervention performance measures were identified that answer the questions:
   - How much did we do?
   - How well did we do it?
   - Is anyone better off?

Monitoring these intervention-specific performance measures will identify if any focused quality improvement projects are required to improve intervention effectiveness and/or if revisions to CHIP interventions are required.

Snowy Hemlock Lake in early spring
Photo: iStock.com/wildcatmad

# APPENDIX 3

## LIVINGSTON COUNTY OBJECTIVE SUMMARY

***Remaining objectives within the selected focus areas had limited or unreliable data**

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 2.2.4 | Reduce the Prevalence of Major Depressive Disorder | | Only 2 data points (2016, 2018) |
| 2.5.2 | Reduce age-adjusted Suicide Mortality Rate | | |
| 2.2.3 | Reduce the Opioid Analgesics Prescription for Pain | | |
| 2.2.4 | Reduce all ED visits Involving Any Opioid Overdose | | |
| 2.1.2 | Reduce Age-Adjusted Rate of Adult Binge Drinking in Past Month | | |
| 2.2.1 | Reduce Age-Adjusted Overdose Deaths Involving Any Opioid | | |
| 2.2.2 | Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder | | |
| 1.1.1 | Decrease the Percentage of Children with Obesity (Ages 2-4 yrs, Participating in WIC) | | |
| 1.1.2 | Decrease the percent of children with obesity | | |
| 1.1.4 | Decrease the Percentage of Adults with Obesity | | |
| 1.1.6 | Decrease the Percentage of Adults with Obesity (living with a disability) | | Finger Lakes Region |
| 1.1.5 | Decrease the Percentage of Adults with Obesity (annual household income <$25,000) | | Finger Lakes Region |
| 1.1.13 | Increase the Percentage of Adults with Perceived Food Security | | |
| 1.1.8 | Decrease the Percentage of Adults who Consume One or More Sugary Drinks Per Day (annual household income <$25,000) | | Finger Lakes Region |
| 1.1.14 | Increase the Percentage of Adults with Food Security (annual household income <$25,000) | | Finger Lakes Region – No income |
| 1.1.10 | Decrease the Percentage of Adults who Consume Less than One Fruit and Less Than One Vegetable Per Day | | One Year (2016) for Livingston; Pivital Public Health Partnership data for Finger Lakes Region |
| 1.1.7 | Decrease the Percentage of Adults who Consume One or More Sugary Drinks Per Day | | |

# APPENDIX 4

## COMMUNITY ASSETS - AUGUST 2022

| INSTITUTIONS | PHYSICAL SPACE | LOCAL ECONOMY |
|---|---|---|
| Catholic Charities | Nutritional sites | Farmer's markets |
| Pennysavers | Concerts/social events | Food pantries and pop-up pantries |
| Parish Outreach Center | Walking trails/scenery | Local wi-fi |
| Hospice - Bereavement Support Groups | Congregate meal sites | Community participation (Advocates, volunteers, and supervisors) |
| Livingston County Veterans | Playgrounds | Community employers (Livingston County, Barilla, Coast, etc.) |
| American Legion | Schools - pools, parks | Livingston County government |
| Meals on Wheels | State, County, local parks | Workforce Development |
| Genesee Valley Health Partnership | Conesus Lake | Summer Youth Employment Program |
| Cornell Cooperative Extension | Greenway | Residential rehabilitation |
| Democrat/Republican parties | Fitness Center | Agriculture, farms |
| Hand in Hand | Community Centers - Dansville, Hemlock, Sparta/Ossian | Small businesses |
| RESTORE | Sidewalk systems | LC Economic Development |
| Chamber of Commerce | Electric car charging stations | Local art, galleries, and crafts |
| Churches | Grocery stores | Housing market and property |
| Office for the Aging | Local stores and shops (Nunda Lumber and Hardware, etc.) | Media (Radio stations, local news) |
| Sheriff's Department | CASA Community Center | |
| Be Well | Fairgrounds - Hemlock, Caledonia | |
| URMC \| Noyes | Airports - Dansville, Geneseo | |
| Local health care providers (Tri County, Stony Brook Pediatrics, Mosaic Health, Center for Sexual Health) | Fairs and festivals (Dogwood Festival, Balloon Festival) | |
| Libraries | Sports courts - pickleball | |
| Educational institutions | Respite housing | |
| (SUNY Geneseo, GCC, local schools) | Jemison Place | |
| Financial institutions | Willow Creek Venue | |
| (GVFCU) | Restaurants | |
| Tepeyac Welcoming Center | Historical sites | |
| Mental Health | Campgrounds | |
| DOH (MICHC, WIC) | Recreational facilities (movie theaters, bowling alleys) | |
| RTS, Ride in LivINgston, Medicaid Transport, Turbo Taxi | Health and wellness venues (gyms, physical therapy offices, etc.) | |
| Geneseo Breast clinic | Pharmacies | |
| Nursing Homes (Morgan Estate, LC CNR (Dialysis Program)) | | |
| ARC | | |
| CASA | | |
| Law enforcement - First Responders, Ambulance, Fire Department | | |
| Mobile Mental Health | | |
| Skybird | | |
| Chances and Changes | | |
| United Way | | |
| Genesee Valley BOCES | | |

# COMMUNITY ASSETS - AUGUST 2022

| INDIVIDUALS | ASSOCIATIONS |
|---|---|
| Volunteers | VFW |
| Retirees | Civic clubs (Kiwanis, Rotary, Lions, etc.) |
| Sr. club presidents | Hospice homes |
| Doris Marsh - Calico Country Learners, seed plant | Seniorama |
| Ron Neidermier - 4H, for children, fire department) | Children's Protection Association |
| Tradesmen, carpenters, handymen | Scottsburg Euchre Club |
| Charlene Sayers - Caledonia | Dansville YMCA |
| Patty Piper - Be Well in Nunda | Youth Bureau |
| Boy/Girl Scout Troop Leaders | Gardening clubs |
| MRC volunteers | Learning Together - Spanish classes |
| Lynne Mignemi | Core Learning |
| Patty Genther – Livonia | Caregiver support groups Living Healthy classes |
| Health specialists | Rainbow Alliance |
| Christa Barrows - caregiving support and programming | Summer recreation programs |
| Yoga/Pilates instructors | Genesee Valley Council of the Arts |
| Farmers | Fish and Game clubs |
| Child care providers | Cancer support groups |
| Health care providers (doctors, nurses, dentists, optometrists, physical therapists, etc.) | Thriving and Surviving |
| | Camp Stella Maris |
| | Child Care Council Inc. |
| | Partners for Progress |

Livingston County Courthouse
Photo courtesy of Livingston County Department of Health

# APPENDIX 5

## OUTCOME PRIORITIES

| All Priorities Identified | Community Survey | Forces of Change | OFA Focus Group | Migrant Worker Focus Group | Breastfeeding Friends Focus Group | Helping Hands Focus Group | Community Health Data |
|---|---|---|---|---|---|---|---|
| Mental Health | | X | X | | | X | X |
| Chronic Disease | | | X | | X | X | X |
| Alcohol/ Substance Abuse | | | | | | | X |
| Aging | | | X | | X | X | |
| Tobacco Use | | | | | | | |
| Child Abuse/ Neglect | | | | | | | |
| Access to Health Care | | X | X | X | X | | |
| Domestic (Family) Violence | | | | | | | |
| Injury Prevention/ Safety | | | X | | X | X | X |
| Oral Health | | | | X | | | |
| Immunizations/ Infectious Disease | | | | X | | | X |
| Maternal/Child Health | | X | | | X | | X |

# MONROE COUNTY

| COUNTY NAME: | ONTARIO COUNTY |
|---|---|
| Participating local health department and contact information: | **Monroe County Department of Public Health**<br>111 Westfall Rd, Rochester, NY 14620<br>(585) 753-6000<br>Representative: Marielena Vélez de Brown, MD, MPH<br>MarielenaVelezdeBrown@monroecounty.gov |
| Participating Hospital/ Hospital System(s) and contact information: | **Strong Memorial Hospital**<br>601 Elmwood Ave, Rochester, NY 14642<br>(585) 275-2100<br>Representative: Wendy Parisi<br>Wendy_Parisi@URMC.Rochester.edu<br><br>**Highland Hospital**<br>1000 South Ave, Rochester, NY 14620<br>(585) 473-2200<br>Representative: Tim Holahan, MD<br>Timothy_Holahan@URMC.Rochester.edu<br><br>**University of Rochester Medical Center**<br>https://www.urmc.rochester.edu/ |
| | **Rochester General Hospital**<br>1425 Portland Ave, Rochester, NY 14621<br>(585) 922-4000<br>Representative: Katherine Sienk, LMSW<br>Katherine.Sienk@RochesterRegional.org<br><br>**Unity Hospital**<br>1555 Long Pond Road, Rochester, NY 14626<br>(585) 723-7000<br>Representative: Katherine Sienk, LMSW<br>Katherine.Sienk@RochesterRegional.org<br><br>**Rochester Regional Health**<br>https://www.rochesterregional.org |
| Name of entity completing assessment on behalf of participating counties/ hospitals: | **Monroe County Community Health Improvement Workgroup**<br>Center for Community Health & Prevention<br>46 Prince St, Rochester NY, 14607<br>(585) 224-3082<br>Chair: Theresa Green, PhD, MBA<br>Theresa_Green@URMC.Rochester.edu<br>Coordinator: Dan Green, MPH<br>Daniel_Green@URMC.Rochester.edu |

# INTRODUCTION

The Prevention Agenda is New York State's blueprint to help improve the health and well-being of its residents and promote health equity through state and local action. Every three years, New York State requests that local health departments and their local hospital systems work together to create a joint community health assessment and improvement plan using the Prevention Agenda guidelines. Local entities must choose two areas in which to focus community improvement efforts during the plan period. Local entities can choose from five priority areas:

1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment
3. Promote Healthy Women, Infants and Children
4. Promote Well-Being and Prevent Mental and Substance Use Disorders
5. Prevent Communicable Diseases

Throughout the cycle, public health and hospital systems value the input and engagement of key partners and community members, who are critical to help determine which priorities are most important to the community members, and what actions ought to be taken to improve the population's health. The following report summarizes pertinent information relating to the above priority areas. It is well known that residents live, work, and seek services beyond their county of residence. The health and well-being of residents in a neighboring county may impact the needs and services in other counties. In addition, collaborative practices such as shared messaging and lessons learned may help to expand reach and success of like-interventions. It is for this reason that the nine counties in the Finger Lakes Region have further collaborated to complete one comprehensive regional health assessment. Following the comprehensive assessment of the health of the entire region, this report contains a chapter specific to the county in the region with the largest number of residents and highest population density, Monroe County. This focused chapter highlights specific needs, including additional demographic indicators, main health challenges and underlying behavioral, political, and built environmental factors contributing to the region's overall health status for residents located in the dense urban and suburban, and resource-centric county.

High Falls, Rochester, Monroe County
Photo credit: iStock.com/kickstand

# EXECUTIVE SUMMARY

After examining local Monroe County data and the NYS Prevention Agenda Dashboards, we identified areas where Monroe County health indicators were worse than the state and failed to meet the Prevention Agenda goals for 2024. Importantly, extensive community engagement and input were gathered and incorporated before deciding on the following two areas as the main health challenges of focus for the 2022-2024 CHNA/CHIP:

| PRIORITIES AND GOALS FOR THE 2022-2024 CHNA AND CHIP ARE AS FOLLOWS: | |
|---|---|
| **Promote Healthy Women, Infants, and Children** | |
| Objective 1 | Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child populations. |
| Intervention | Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course. |

| **Promote Well-Being to Prevent Mental and Substance Use Disorders** | |
|---|---|
| Objective 2.1 | Strengthen opportunities to build well-being and resilience across the lifespan |
| Intervention | Integrate social and emotional approaches across the lifespan. Support programs that establish caring and trusted relationships with older people. |
| Intervention | Enable resilience for people living with chronic illness: Strengthen protective factors including independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety. |
| Intervention | Use thoughtful messaging on mental illness and substance use: Expert opinion in messaging about Mental, Emotional, and Behavioral Health humanize the experiences and struggles of person living with disorders; highlight structural barriers; avoid blaming people for the disorder or associate disorders with violence. |
| Objective 2.2 | Facilitate Supportive Environments to promote respect/dignity for all ages |
| Intervention | Mental Health First Aid (MHFA) is an evidence-based public education program that teaches people how to respond to individuals who are experiencing one or more acute mental health crises or are in the early stages of one or more chronic mental health problems. |
| Intervention | Implement policy and program interventions that promote inclusion, integration, and competence. |

Although both of these areas will address disparities, the "Promote Healthy Woman, Infants and Children" focus area specifically calls out inequities based on race and socioeconomic status.

## CHA and CHIP Development Process

### Infrastructure for Community Planning and Implementation

The Community Health Improvement Workgroup (CHIW) brings together leaders from the Monroe County hospitals (University of Rochester Medical Center's Strong Memorial Hospital and Highland Hospital, Rochester Regional Health's Rochester General Hospital and Unity Hospital) and the Monroe County Department of Public Health (MCDPH). The CHIW includes representation from several community agencies, including Common Ground Health, FLPPS and United Way, and together we work to prioritize the community health needs summarized in the Community Health Needs Assessment (CHNA) and develop and implement a Community Health Improvement Plan (CHIP) to begin to address those needs in our county.

## Community Engagement

Throughout the needs assessment process, representatives from the CHIW met with several community groups for feedback on the selected focus areas as well as goals and recommended interventions. The meeting dates for some of the most significant groups input sessions are shown below in Table 1 and the comments, recommendations, and full summaries of these discussions are available in the "Community Engagement" section of the CHNA. The CHNA and CHIP were reviewed and adapted based on group feedback at each meeting, and discussed at the monthly CHIW meetings, until consensus was reached on the identified focus areas and types of intervention.

### Table M1: Significant Group Input Sessions for Monroe County 2022-2024 CHIP Development

| GROUP | DATE |
|---|---|
| Community Advisory Council | September 21, 2021 |
| Monroe County Board of Health | November 10, 2021 |
| Maternal Child Health Advisory Group | November 17, 2021 |
| African American and Latino Health Coalitions | December 16, 2021 |
| Maternal Child Health Advisory Group | February 17, 2022 |
| Community Advisory Council | March 22, 2022 |

Additionally, in 2018 Common Ground Health conducted a regional "My Health Story" survey of community members to learn more about health behaviors and barriers to healthy lives. With particular attention to gathering input from a diverse group of participants, over 4,000 people were surveyed. The survey asks about a wide range of topics from access to medical and dental care to perceptions of personal safety and satisfaction with work. This data was an important source of community input and the next My Health Story Survey is planned for 2022.

### Data Review

Data were collected from a variety of sources to complete this needs assessment. Sources include, but are not limited to, the US Census Bureau American Community Survey, New York State Expanded Behavioral Risk Factor Surveillance System, CDC Places, 211/Life Line, My Health Story, and County Health Rankings. Particular attention was given to the New York State Prevention Agenda Dashboards. Data were collected for the most recent timeframe available during the data collection phase which took place in Winter 2021/Spring 2022. Data sources are referenced throughout the CHNA and CHIP.

## Prioritizing Health Needs

The CHIW followed the AHA ACHI Community Health Improvement Process model in conducting the CHNA and CHIP. In ranking the many health needs of Monroe County, the CHIW members developed criteria for prioritization prior to reviewing data. Those top criteria are:

- Significant need substantiated by data
- Ability to intervene ahead of a problem
- Importance of the problem to the community
- Importance of the problem to the community *in light of the pandemic*
- Solutions that address the full age spectrum of the community
- Feasibility of solutions

After a thorough examination of many diverse data sources, and after multiple discussions among the CHIW members, there was a strong inclination to not change the priority areas from the 2019-2021 Community Health Needs Assessment and Improvement Plan. It was agreed that Monroe County has made significant progress on establishing the infrastructure to support initiatives in the areas of mental health and disparities in maternal and child health. This inclination was supported also by the COVID pandemic slowing down implementation work on the CHIP in the past few years.

Rochester skyline at night, Monroe County
Photo credit: Common Ground Health

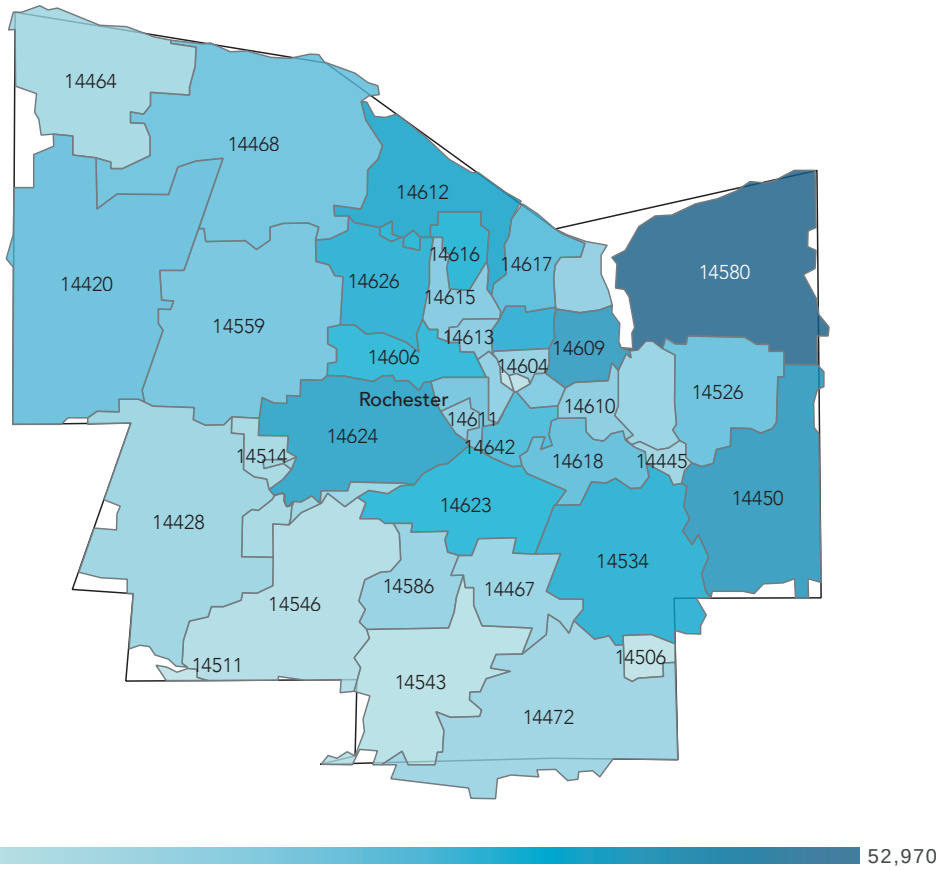
# County Chapter – Monroe County

Contained in this chapter are additional demographic and socioeconomic health indicator data relating to Monroe County. In addition, a summary of assets and resources, process for prioritizing health needs, improvement plan initiatives and distribution of those results will also be discussed.

Additional Demographic and Socioeconomic Health Indicators

Monroe County is the most populous county in the Finger Lakes Region (743,084 residents in 2020, 59% of region's population) and contains the largest metro area, the City of Rochester (206,075 residents in 2020, 28% of county population). The largest ZIP code population is Webster (14580) where there are nearly 52,000 residents (Map M2). Each geographic area in the county (the City of Rochester and Monroe County suburbs) has considerably different demographic, socioeconomic and health outcomes which are reflected in life expectancy estimates shown previously.

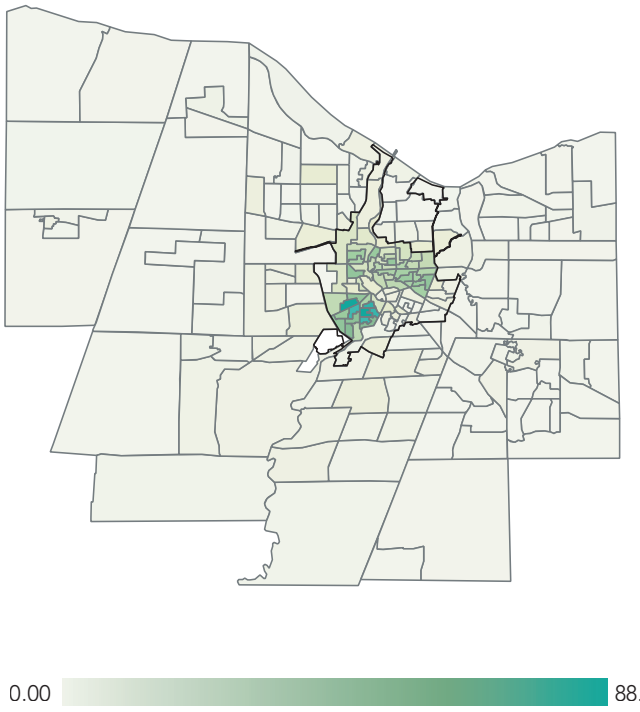
## Map M2: Population by ZIP Code in Monroe County



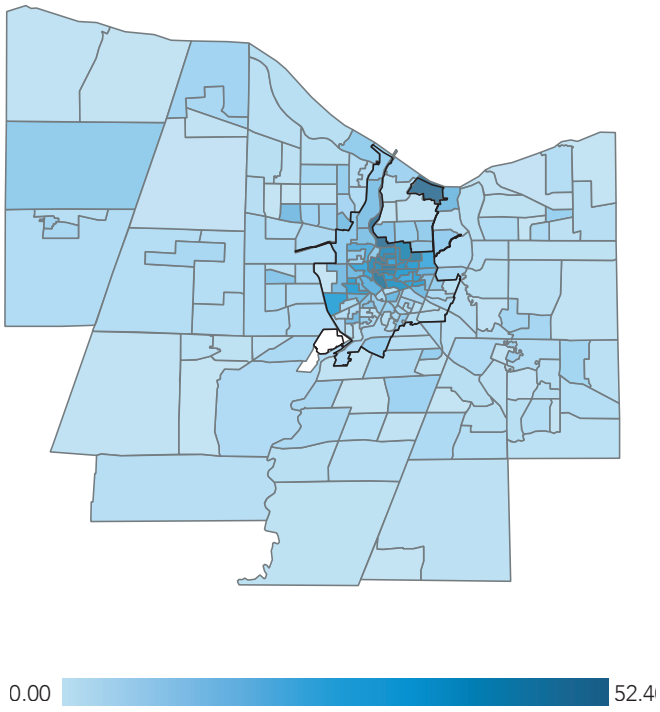

Source: Claritas zip-level estimates and CDC Bridged-Race county-level estimates, Year 2020.
Population data and allocation methods developed by Common Ground Health.

The majority of residents in Monroe County are White Non-Hispanic (70%) followed by African American (15%), Hispanic (9%) and Other (10%). While the white population has decreased over the past decade, the Census Bureau reports an increase in those reported as Black or African American, Asian and those who identify as two or more races. This coincides with the 2020 Census, and some researchers feel people may choose to identify differently than in years past based on home DNA tests and DNA registries like 23andMe and Ancestry.com.[1] As shown in Map M3 and Map M4 below, the majority of Black or African American and Hispanic residents live in the City of Rochester.

### Map M3: Monroe County Black Non-Hispanic Population by Census Tract (Percent of Population)




### Map M4: Monroe County Hispanic Population by Census Tract (Percent of Population)

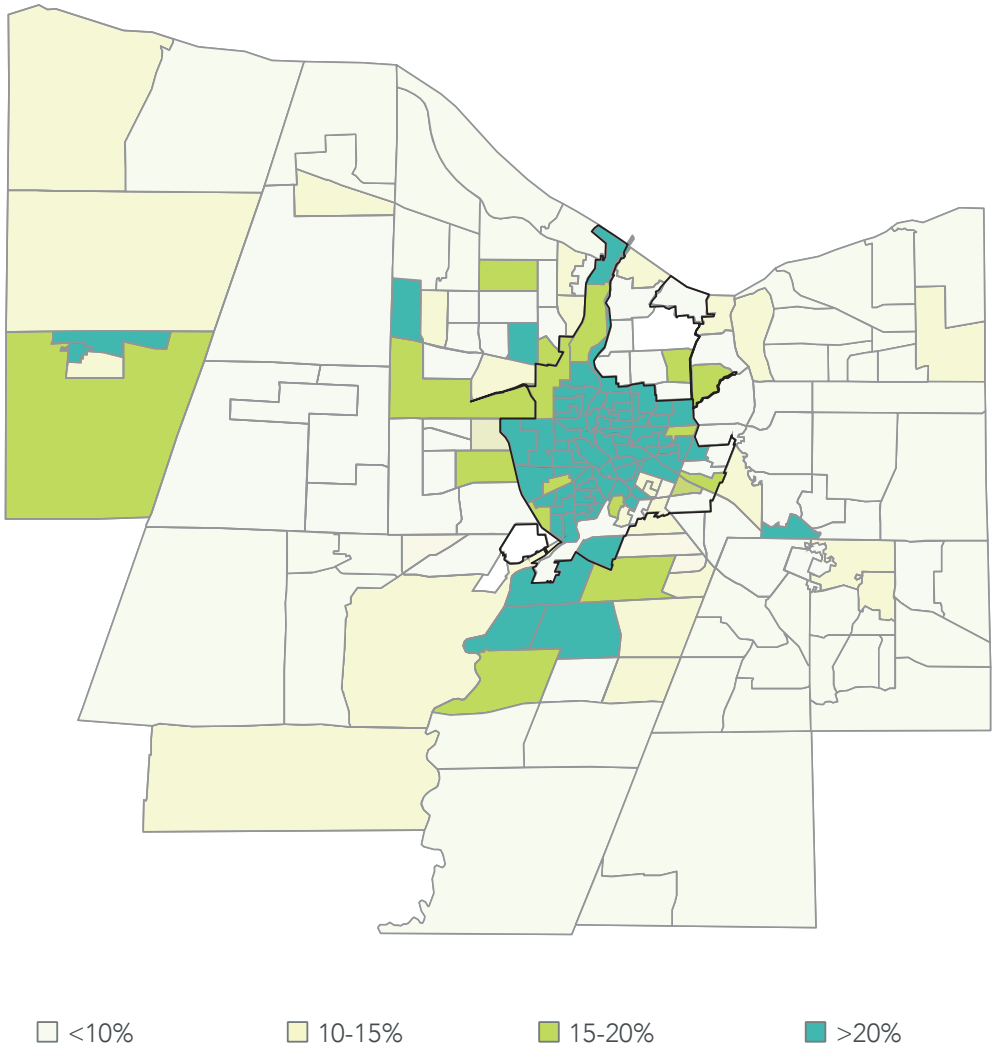



Another important demographic factor to consider is age, especially the older adult population. According to the US Census, "in less than two decades, the graying of America will be inescapable: Older adults are projected to outnumber kids for the first time in U.S. history."[2] Projections indicate that by the year 2035, there will be a larger population of older adults (age 65 and over) than children (under 18). Since 2017, the number of older adults in Monroe County has increased by about 10,000 while the number of children has decreased by about 5,000.[3] Data indicate that the elderly population is growing at a higher rate in the suburbs in comparison to the City of Rochester and, as such, efforts to increase volume of services and support focused on the elderly population may be more efficiently targeted in the outlying suburb communities.


2. https://www.census.gov/library/stories/2018/03/graying-america.html
3. US Census Bureau, American Community Survey

While age can impact one's health, another important factor is a person's socio-economic status. For example, lower socioeconomic status is linked to higher incidence of chronic disease, shorter life expectancy, and lower rates of good social, emotional and physical health. In Monroe County, about 14% of residents are living in poverty. When looking at the difference between the City of Rochester and the suburbs, we see a stark difference. About 30% of City of Rochester residents live in poverty compared to about 8% in the suburbs. In addition to place-based differences, there is a large disparity in poverty rates among those who did not graduate high school (about 32%) and those who graduated and/or have received higher education (about 14%). Data have shown that females are more likely to live in poverty (about 15%) compared to the overall population (about 14%), and males in the county tend to have slightly lower rates of poverty (about 13%), though the differences are not statistically significant.[4] Map M5 shows the distribution of poverty in Monroe County by census tract. Poverty is concentrated within the City of Rochester with most of the tracts having poverty rates of 15% or higher, some having rates over 40% of the population.

## Map M5: Poverty by Census Tract

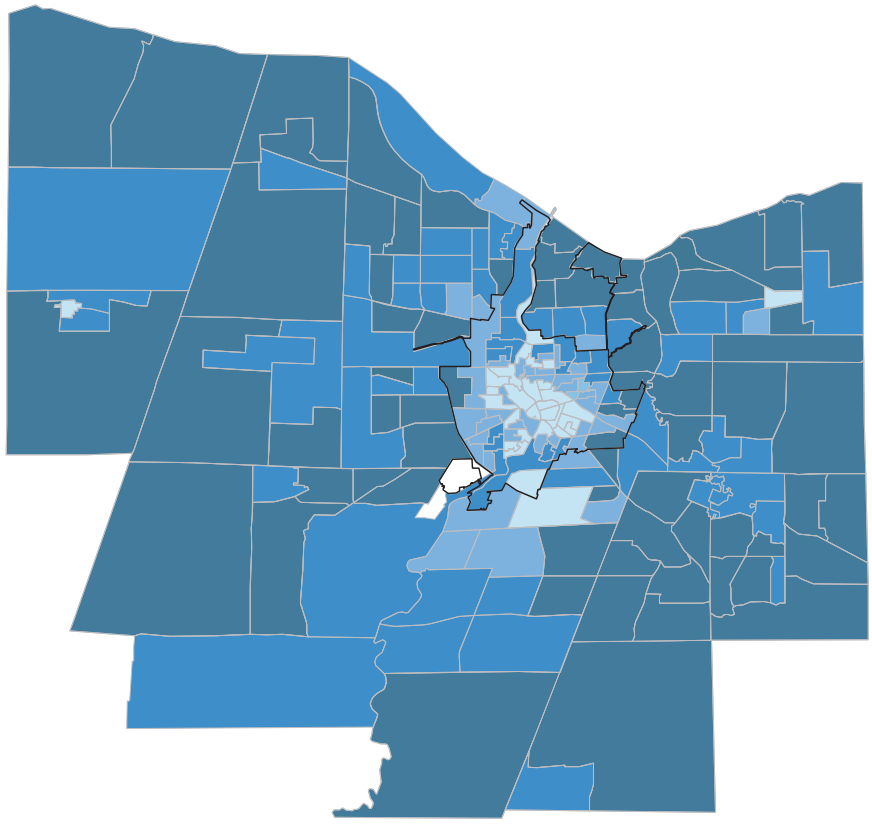



Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

 4. US Census Bureau, American Community Survey

Along with poverty, housing costs also have an impact on one's health and ability to pay for needed care. From 2011 to 2020, the median value of a home in Monroe County has risen about 15% from $132,000 to $152,000. Along with that, the cost of housing has gone up significantly since the beginning of the pandemic, with the median price for an American home up nearly 20 percent in a year.[5] According to the Census Bureau, those paying 35% of their gross income or more for housing (owner with and without mortgages and renting) had been decreasing through 2020. However, the percentage of families with housing costs greater than 35% of their gross income is less than half for those who own vs rent (about 15% vs. about 45% of housing units). Along with disparity between those who rent vs own, residents in the city have higher percentage of family units whose housing costs are more than 35% of their gross income (10%) as compared to residents in the suburbs (5%). Map M6 shows the distribution of owner occupied residences in Monroe County. There is only one tract within city limits that has a home ownership rate higher than 75%, while the majority of suburban tracts have rates of at least 50% or greater.

## Map M6: Owner Occupied Residents by Tract (Percent of Housing Units)



Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

Another demographic factor that contributes to one's ability to manage one's health is education. In Monroe County, there has been an increase since 2015 in the number of individuals over the age of 25 who have a high school diploma or GED. However, this varies by geography. Only about 50% of city residents have graduated high school or received a GED in comparison to about 80% of suburban residents. In conjunction with this, rates of Bachelor's degree attainment is improving overall, yet a disparity remains between the city and suburbs with about 15% and about 30%, respectively, having obtained a Bachelor's degree.


5. https://www.nytimes.com/2022/01/20/upshot/home-prices-surging.html

Last but not least, the ability to be able to better afford care through health insurance impacts one's ability to maintain health. In Monroe County, over 95% of the population has insurance coverage. For most demographics factors available from the Census Bureau regarding insurance coverage (including age, sex, educational attainment), the 95% coverage rate holds, while there are a few areas (foreign born residents, several minority groups), whose rates are slightly lower (between 90-95%).

**Deaf Population:** Monroe County is unique in our attention to health of populations of Deaf sign language users and people with hearing loss, two health disparity populations overlooked by most health research and programs. The issues are particularly important in Rochester, with our large population of Deaf sign language users and many older adults with hearing loss. Rochester Institute of Technology (RIT) estimates that in the Rochester area there are 42,674 people who are deaf or have serious difficulty hearing, including 19,438 persons younger than 65 years old.[6]

Monroe County has a large, vibrant, and diverse Deaf population with deep local historical roots.[7] The Rochester School for the Deaf (RSD), established in 1876 and still operating today, works with deaf and hard-of-hearing children and their families. RSD also employs Deaf teachers and staff and has an active alumni association. The National Technical Institute for the Deaf (NTID) was established as one of the colleges of Rochester Institute of Technology (RIT) in 1966 to provide postsecondary technical education to people who are deaf or hard of hearing. Today, NTID is the largest technical college for deaf and hard-of-hearing students in the USA, with approximately 1,400 NTID students included in the more than 15,000 RIT students. NTID and RIT employ faculty and staff who are Deaf, and a number of NTID/RIT graduates remain in Rochester. University of Rochester research and clinical training programs include Deaf graduate students, medical students, and fellows. Deaf people migrate to Rochester, attracted by the economic, social, and educational opportunities.

## Main Health Challenges

There are many health challenges in Monroe County, similar to the health challenges for the Finger Lakes region, as described in the Comprehensive Regional Health Assessment. In the fall/winter of 2021 and early spring of 2022, a review of existing health data was conducted to identify the top needs to be addressed by hospitals, the health department and community agencies in Monroe County. Several sources of data were reviewed, primarily the New York State Prevention Agenda Dashboards. The results of that review follow.

Initial conversations with the Community Health Improvement Workgroup (CHIW) members about priorities for the 2022-2024 resulted in a general desire to continue with the previously selected health challenges as areas of focus. Most local data collection processes were put on hold during the COVID period including the My Health Story survey and the Youth Risk Behavior Survey.

6. https://www.ntid.rit.edu/news/rochester-areas-deaf-population-better-defined

7. Barnett S, Cuculick J, DeWindt L, Matthews K, Sutter E. National Center for Deaf Health Research: CBPR with Deaf Communities. In: Wallerstein N, Duran B, Oetzel J, Minkler M, eds. Community-based Participatory Research for Health: Advancing Social and Health Equity. 3rd ed. San Francisco, CA: Jossey-Bass; 2018:157-174.

The New York State Prevention Agenda dashboards were examined for areas where Monroe County performed worse than the rest of New York State and did not meet the New York State Prevention Agenda goals for 2024. Together, and based upon review of the data included in the Comprehensive Regional Health Assessment, the team has selected the following priority and focus areas for the 2022-2024 Community Health Improvement Plan:

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Promote Well-Being |

| **Promote Healthy Woman Infants and Children** | |
|---|---|
| Focus Area | Cross-Cutting Healthy Women, Infants and Children |
| Disparity | Race and Ethnicity (specifically looking at disparities for Black and Latina women and children), Low SES groups, and geographic locations (zip codes and census tracts) that have a high prevalence of the previous two groups |

## Risk and Protective Factors Contributing to Main Health Challenges

### Promote Well-Being

When looking at the behavioral risk factors that may impact one's well-being, there are a number of mental health related metrics available. One survey that provides a number of these metrics is the Behavioral Risk Factor Surveillance System (BRFSS) survey that generally is completed bi-annually. From 2016-2018, the data reveals a slight decrease in the rate of respondents reporting 14 or more poor mental health days in the past month (12% to 11%) but an increase in those reporting to have been told they have been diagnosed with a depressive disorder (17% to 19%). An increase in depressive disorder diagnosis is not necessarily a negative component. When coupled with the poor mental health day reports, it appears there may be a decrease in symptoms of the disorder. An increase in diagnosis may be attributed to better recognition of signs and symptoms on behalf of the patient, reduced stigma leading to greater societal acceptance and social norms of seeking care, screening for disorders, accessibility of services, and more. Common Ground Health's My Health Story Survey in 2018 asked respondents about their mental health. Similar to BRFSS, 15% of respondents shared that they were experiencing poor mental health. Along with this, 46% of the respondents to the survey reported feelings of anxiety and 51% reported feelings of depression. From those reporting feelings of anxiety or depression, it is unknown how many have visited a healthcare provider and been diagnosed with a disorder, yet it indicates a significant need to address the issue in the county.

Substance use is another factor that can impact one's well-being. Looking at data from BRFSS, the rate of binge drinking among adults increased four percentage points in 2018 from 2014 and 2016, from 18% to 22%. Primary data collected from My Health Story 2018 indicated 10% of county respondents reported alcohol addiction while 7% reported drug addiction. One positive note for well-being is that of those reporting an addiction in My Health Story, over 75% reported receiving some form of help for that addiction.

As discussed, neighborhood and built environment is another component of a person's overall well-being. Being safe in one's home and neighborhood may lead to greater opportunities for play and recreational activity as well as feelings of security. While we all experience any number of stressors in the other areas of our life (work, school, caregiving and social commitments), having a stable and safe place to return to is critical. Monroe County, more specifically the City of Rochester, has long struggled with violence in certain neighborhoods and a great deal of work has been done to help make the neighborhoods safer. Some of this work has appeared to have paid off, as property crime has been declining since 2012. Unfortunately, the trend of aggravated assaults has shown an increase since 2014, with 2020 and 2021 represented the first and second most aggravated assaults, respectively, since 2012. Lastly, 2021 had the most homicides on record since 2012 (66), which was about 2 times greater than other year recorded.[8] Along with this data, My Health Story asked respondents about their neighborhood safety, to which 62% in Monroe County reported having a safe neighborhood. On top of safety in their neighborhood, My Health Story asked about safety in the home and domestic violence. Across Monroe County, 76% of respondents reported feeling very safe in their home, while 18% reported some form of domestic violence occurring.

A political factor impacting the well-being of Monroe County and specifically the City of Rochester is structural racism. A recent study by researchers at Harvard University, Stanford University, and the U.S. Census Bureau found that Black children are less likely to reap the benefits of upward mobility and more likely to slip down the rungs of prosperity.[9] With the majority of Black residents living within City of Rochester, we continue to see where these factors have created disparities in the health outcomes of the community.

Age is another underlying factor which may contribute to mental well-being statistics. As stated above, the county's older adult population is growing. A report from National Academies of Sciences, Engineering, and Medicine (NASEM) in 2020 found that nearly one-fourth of adults aged 65 and older are considered to be socially isolated, which may directly influence rates of poor mental health.[10] This issue has only been exacerbated by the COVID-19 pandemic, as older adults' access to and ability to use technology to maintain connection, especially for the oldest and those in poor health, is a barrier to combat loneliness.[11]

In addition, poverty and financial strain are other factors that can impact one's well-being. As stated above, the City of Rochester has a significant concentration of poverty in the county and we see that reflected in the data from My Health Story, which shows higher reported anxiety and depression for those living in the City of Rochester. Notably, those making an income of $25,000 to $50,000 in the City of Rochester had even higher reported rates of anxiety, depression, and significant feelings of stress compared to those with higher incomes.

Food security concerns are well-being factors that have become more prominent since the COVID-19 Pandemic. Data from 211 Lifeline reveal at the beginning of the pandemic (March 2020 to September 2020) a significant increase in calls pertaining to food support, with a 10x increase in Q3 2020 from the number of calls in 2019. These data were specifically reviewed as one proxy to identify community unmet needs. While there are still concerns about food security, the data from 211 show that if people are struggling with food support, they are no longer reaching out to 211 as the number of calls per quarter was similar to 2019 levels for the last two quarters of 2021.

8. https://data-rpdny.opendata.arcgis.com/pages/crime

9. Raj Chetty, Nathaniel Hendren, Maggie R Jones, Sonya R Porter, Race and Economic Opportunity in the United States: an Intergenerational Perspective, The Quarterly Journal of Economics, Volume 135, Issue 2, May 2020, Pages 711–783, https://doi.org/10.1093/qje/qjz042

10. National Academies of Sciences, Engineering, and Medicine. 2020. Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System. Washington, DC: The National Academies Press. https://doi.org/10.17226/25663external icon.



11. Lena Dahlberg (2021) Loneliness during the COVID-19 pandemic, Aging & Mental Health, 25:7, 1161-1164, DOI: 10.1080/13607863.2021.1875195

As discussed above, the rising cost of housing, especially for those in the City of Rochester, can have a significant impact on one's well-being. While wages have risen in the last 10 years (about 15% increase in median income), these increases have only kept pace with housing costs (also risen by about 15% for rent and median house price)[12] and total inflation.[13] Having a greater portion of one's income dedicated to housing costs limits the ability to spend money on other things that can maintain or improve well-being, such as medical and mental health care, healthy food, and leisure activities. Not only are the rising costs a concern for renter,[14] but a lack of homes for purchase[15] is adding stress to those who are looking to join the housing market.

After consideration of all of the above, the group has decided to focus on two areas including: Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan and Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages. The hospitals and health department, along with community partners, made significant strides in addressing well-being in Monroe County from 2019-2021. Areas of improvement focused on community wealth building, mental health first aid, stigma reduction, and trauma informed assessments and trainings.

**Community Wealth Building:** In 2020, the financial stress of the pandemic impacted local businesses, individual, and hospital systems. Many community wealth building initiatives transitioned to financial well-being and support systems for those experiencing hardships due to COVID-19. The Mayor's Office of Community Wealth Building has hosted virtual job and opportunity fairs, an entrepreneur's resource program, and financial empowerment centers. Financial Empowerment Centers offer 1:1 meetings, and the advisors are trained to help with COVID related financial struggles like obtaining stimulus checks, negotiating with loan providers, creating emergency budgets, and connecting with other local resources.

Additionally, Rochester Regional Health (Rochester General and Unity) and University of Rochester (Strong and Highland) both signed the Rochester Monroe Anti-Poverty Initiative (RMAPI)'s Employer pledge, committing to many steps to community wealth building and supported employment, including a $15 minimum wage for all employees. In addition, the County Executive agreed to increase pay rates of the lowest-paid county employees.

**Mental Health First Aid:** Mental Health First Aid is an evidence-based training program for adults to learn to recognize and respond to warning signs of acute mental health events for either children or other adults. The CHIW facilitated connections between the Youth Mental Health First Aid (YMHFA) Course administrators and new target audiences in our community. Prior to the pandemic, the course was offered as a large group in-person class, however the trainings have been adapted to online administration during the pandemic. The virtual or in-person course was offered for foster parents connected to the Monroe County Department of Health. Another session was offered 6/28/21 to approximately 20 employees at the City of Rochester recreation centers or R-Centers.

12. US Census Bureau, American Community Survey
13. https://www.macrotrends.net/countries/USA/united-states/inflation-rate-cpi
14. https://www.whec.com/rochester-new-york-news/surging-rent-prices-concerning-some-rochester-residents/6402854/
15. https://spectrumlocalnews.com/nys/rochester/news/2022/03/01/data-shows-rochester-to-be-toughest-housing-market-in-u-s-

**Stigma Reduction:** The Monroe County Department of Health conducted a study in early 2020 that was presented to the CHIW at the February 2020 CHIW Meeting. The study looked at de-identified discharge documents from local Emergency Departments for patients who had presented with Opioid Use Disorder. The review found that often patients were not being offered support for their underlying substance use disorder. More than 40% of the hospital notes had no mention of the substance use disorder. The Health Department also conducted a review of the language used in the discharge notes and determined whether the language was templated (automatically filled in) or whether it had been written by the provider. Of the discharge instructions, 25% contained language that was considered stigmatizing. To address both concerns studied in the Health Department's reviews, the CHIW convened a meeting of ED providers from all local hospitals on September 14, 2020. At this meeting, the providers expressed an interest in using approved non-stigmatizing language. To develop the best and most patient-centered language, the CHIW enlisted community members with lived experience from two local peer advocate organizations: Liberty Resources and ROCovery Fitness. Having peers with lived experience will ensure that the language is as accurate, patient centered, and non-stigmatizing as possible. The recommended language was shared with Emergency Department Directors at each of the hospitals, and each hospital has integrated the new documents into their discharge planning.

**Trauma Informed Assessments and Trainings:** Rochester Regional Health hosted a trauma informed care training session led by Cheryl Martin from the local nonprofit CCSI on RRH's Reidman Campus for their Ambulatory Care team. Nancy Pecora, RN, later presented the results and reflections from this learning session to the CHIW at their July 2019 meeting, and Cheryl Martin presented about the use of motivational interviewing in trauma informed care to the CHIW. A summary of the free and paid resources available to conduct trauma informed assessments (TIA) of an organization was assembled. CCSI offers a nationally recognized TIA called the TRUST tool (Trauma Responsive Understanding Self-Assessment Tool). In September 2019, Amy-Scheel Jones from CCSI presented to the CHIW on the TRUST tool and the TRUST-S, which is specifically designed for schools to complete TIAs. This free tool is being used by the Special Children's Services department at the Monroe County Department of Public Health to survey staff on trauma informed knowledge and responsiveness.

Other accomplishments in mental health and well-being can be read about in the 2019-2021 Monroe County Community Health Improvement Plan Implementation Final Report.

Ontario Beach Park, Rochester
Salute to Seniors 2022
Photo Credit: Common Ground Health

## Cross-Cutting Healthy Women, Infants and Children

Over the last decade, Monroe County has seen improvement in a number of informative maternal and infant health metrics. Unfortunately, despite the improvements in unintended pregnancy, teen births, and accessibility to care, there is still a distinct difference in outcomes between residents living in the City of Rochester and those living in the suburbs. Since 2007, the overall unintended pregnancy rates in Monroe County have decreased from 35% to 28% of live births (2018). While this statistic is a positive finding, the difference in unintended pregnancy between race/ethnicity and income shows a significantly different story. From 2016 to 2018, the rate of unintended pregnancies among the White population was about 18% of live births. For Black and Latinas, the rates were almost 50% and 40% of live births, respectively. By insurance carrier, a proxy for income, unintended pregnancy rates are significant higher for the Medicaid population (43% of live births) compared to those with private health insurance (14% of live births).[16] These disparities highlight two potential area of focus for the county in terms of education and prevention efforts. Research has shown that unintended pregnancies affect many other key maternal and infant health indicators and is associated with increased health risks for both mom and baby. This includes complications due to premature birth, low birth weight, and reduced mental and physical health. The effects of these outcomes may be a result of reduced preconception health, higher risky behavior rates during pregnancy and delayed prenatal care; all factors associated with unintended pregnancy.

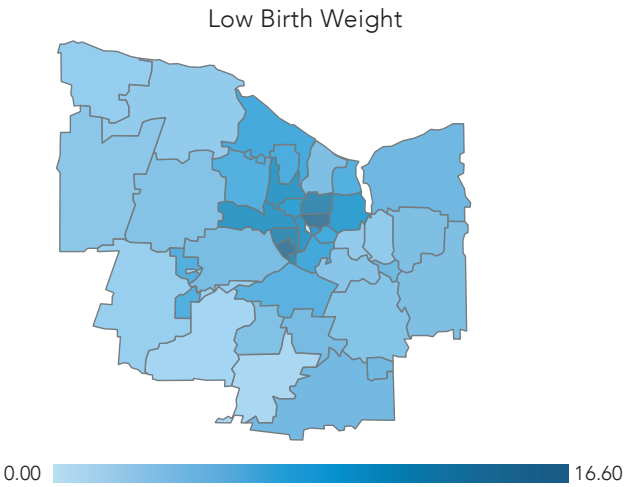
A significant area of progress for Monroe County has been the decrease in teen pregnancy rates coupled with improved graduation rates for young women in the Rochester City School District. From 2015 to 2019, a number of city zip codes with female poverty rates above 20% saw a decrease in teen pregnancy rates of around 15 pregnancies per 1,000 teen women. In the same time period, the graduation rate for young women in the Rochester City School District increased by 13% (50% in 2015 to 63% in 2019). This is an important accomplishment as the difficulties of raising a child are often amplified for teenage parents as their new responsibilities can conflict with primary and secondary education, employment, and other opportunities for personal growth and development. In addition, teenage pregnancy can have a different impact on personal relationships than adult pregnancy and may result in a decrease in support from family, friends, and the child's father figure. Given these challenges, teen parents tend to experience higher rates of single parenthood, perinatal depression and poverty. Communities are also affected by the long-term health consequences of increased child poverty and maternal depression rate. There are higher rates of Child Protective Service involvement and foster care placement for children of teenage pregnancies as well as higher rates of incarceration in the child's adolescent years. The child is also at greater risk for physical, behavioral and mental health issues, being less prepared for kindergarten (in terms of skills sets and readiness to learn), and are more likely to drop out of high school and experience and unintended teen pregnancy themselves. As a result, improvements in this area will impact a plethora of other indicators from a long-term perspective not only in the world of maternal and infant health but in the overall health and well-being of adults and experiences of poverty, educational attainment, employment opportunities and more.

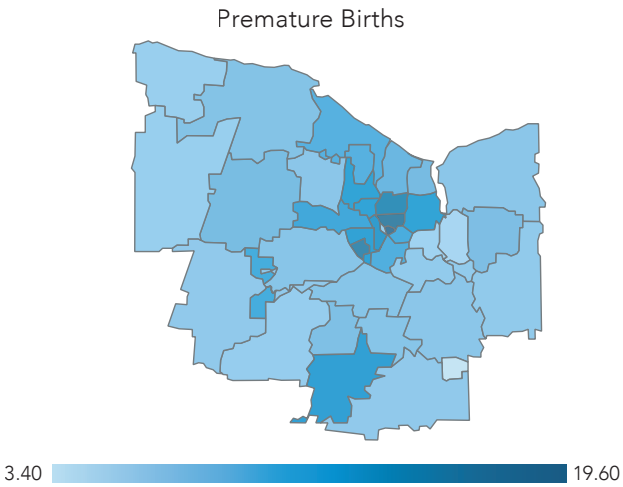
Gestational diabetes and hypertension during pregnancy are both significant concerns for the mother and fetus as pregnancy is then classified as high risk. During 2016 to 2018, Black and Latina women represented a slightly higher share of admissions and ED visits related to gestational diabetes and hypertension during pregnancy than their representation in the population (about 30% of visits vs. about 20% of the population).[17]

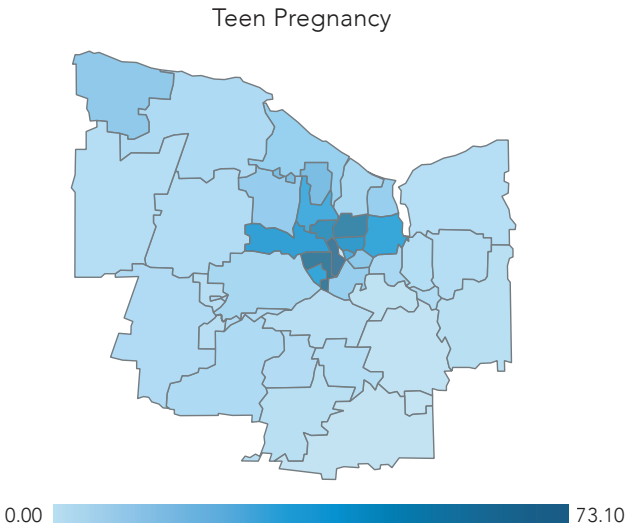

16. Vital Records, NYSDOH, Analysis by Monroe County Department of Health and Common Ground Health
17. Statewide Planning and Research Cooperative System (SPARCS)

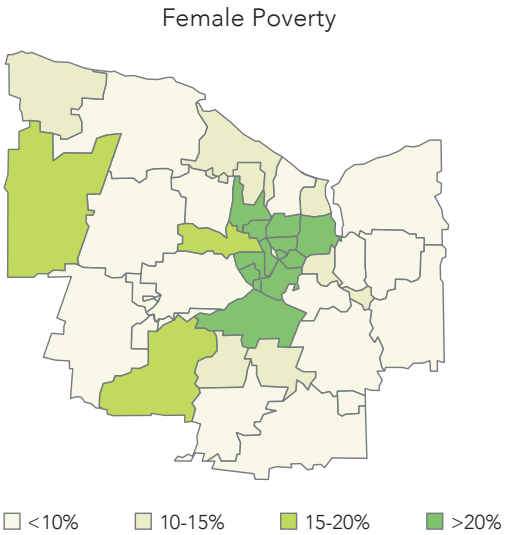
Regarding a number of important metrics regarding infants (infant mortality, premature birth, and low birth weight) and teen pregnancy, we see a correlation to poverty. For the zip codes in Monroe County with greater than 20% of women in poverty, we see the highest percentage of concentration for these negative maternal and birth outcomes as a percentage of total Monroe County births. Map M7 below shows this correlation for low birth weight, premature births, teen pregnancy and poverty.

## Map M7: Infant Health Indicators and Poverty




Source: NYSDOH, Perinatal Data Profile, Years 2017-2019
Analysis Completed by Common Ground Health

Source: US Census Bureau, ACS, Year 2019
Analysis Completed by Common Ground Health

Examining the distribution of maternal and child health outcomes quickly reveals significant disparities between the high risk ZIP codes on Rochester and the rest of Monroe County.

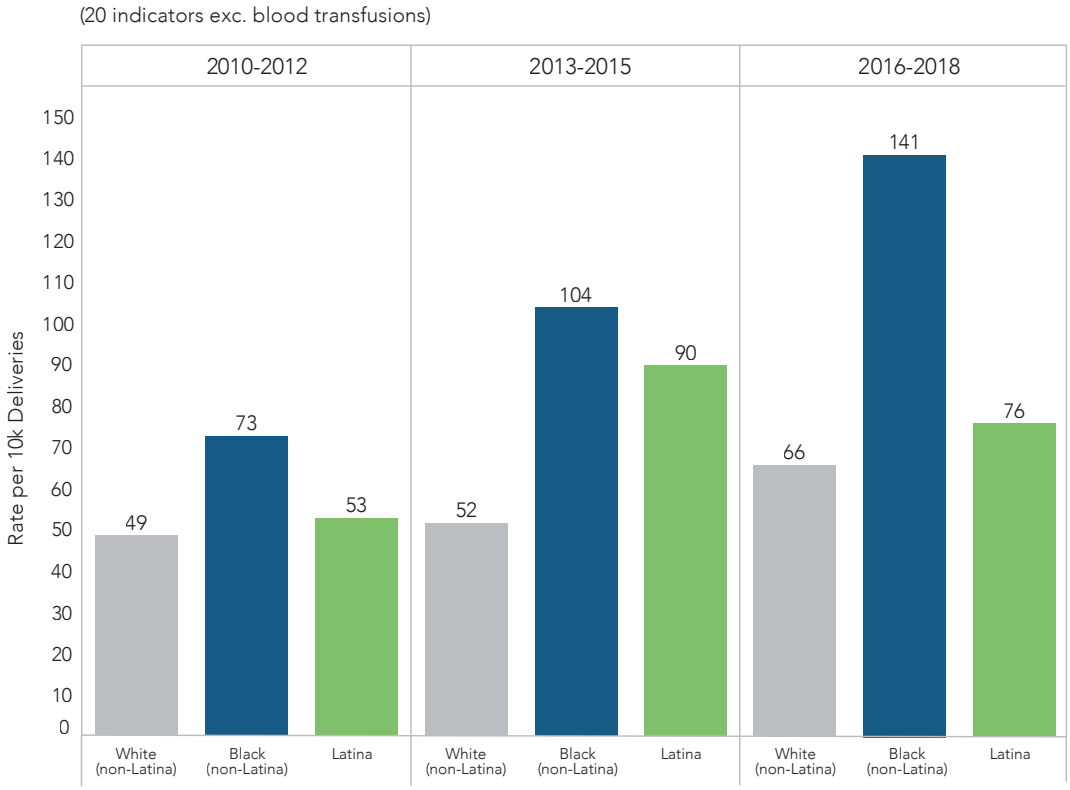
### Table M8: Monroe County Maternal and Child Health Outcomes

| | All County | | County minus High Risk ZIPs* | | High Risk ZIPs* only | |
|---|---|---|---|---|---|---|
| | 2020 (n=7,416) | 2021 (n=7,591) | 2020 (n=4,723) | 2021 (n=5,022) | 2020 (n=2,693) | 2021 (n=2,569) |
| **Maternal Characteristics (%)** | | | | | | |
| Age less than 18 | 0.9 | 1.1 | 0.4 | 0.4 | 1.9 | 2.3 |
| Education less than HS | 9.6 | 8.7 | 3.6 | 3.7 | 20.5 | 18.7 |
| Medicaid Funded Delivery | 46.5 | 44.4 | 29.4 | 28.5 | 76.5 | 75.5 |
| Ethnicity is Black/AA | 23 | 22.4 | 8.8 | 10 | 48 | 46.9 |
| Hispanic | 13.8 | 13.5 | 7.4 | 7.6 | 25.1 | 25 |
| Pregnancy Interval <18 mnths | 27.2 | 28.2 | 29.3 | 29.6 | 23.7 | 25.7 |
| **Prenatal Outcomes (%)** | | | | | | |
| Smoked During Pregnancy | 11.3 | 7.7 | 7.9 | 5.5 | 17.2 | 12.2 |
| Illegal drug use | 10 | 6.8 | 4.4 | 3.8 | 19.8 | 12.7 |
| Alcohol use | 3 | 2.5 | 3.1 | 2.8 | 2.7 | 1.8 |
| Hypertension | 15.6 | 16.3 | 15.8 | 16.4 | 15.3 | 16.2 |
| Unintended pregnancy | 24.7 | 22.7 | 17.3 | 16.7 | 38.7 | 35.5 |
| Gestational Diabetes | 8.2 | 8.1 | 8.5 | 8.7 | 7.6 | 7 |
| WIC Participation | 32.1 | 31.7 | 18.4 | 18.9 | 56.1 | 56.6 |
| **Perinatal Outcomes (%)** | | | | | | |
| Very Low Birth Weight | 1.5 | 1.3 | 0.8 | 1 | 2.6 | 2 |
| Low Birth Weight | 5.9 | 6.4 | 3.9 | 4.9 | 9.4 | 9.3 |
| VLBW & LBW | 7.4 | 7.7 | 4.8 | 5.8 | 12 | 11.3 |
| Preterm delivery <28 weeks | 0.7 | 0.5 | 0.5 | 0.5 | 1 | 0.5 |
| All Preterm Delivery <37 wks | 8.3 | 9 | 6.4 | 7.5 | 11.6 | 11.9 |
| **Postdelivery Outcomes (%)** | | | | | | |
| Infant in NICU | 12.7 | 14.5 | 10.8 | 12.9 | 16.2 | 17.6 |
| Infant in foster care | 0.3 | 0.3 | 0.1 | 0.2 | 0.5 | 0.4 |
| *High risk ZIP Codes = 14605, 14606, 14607, 14608, 14609, 14611, 14613, 14619 and 14621 | | | | | | |

Source: Monroe County Perinatal Network Fast Facts 2020, 2021.
Aggregate Provided by Finger Lakes Regional Perinatal Center

Thankfully, the number of maternal deaths are very small and, as such, leave statistical analyses unclear regarding clear patterns and trends at the county-level. However, from 2013-2017 there were a total of 11 maternal deaths for Monroe County, which is comparable to the NY state average per 1,000 births. Other indicators which may precede mortality are rates of severe maternal morbidity. This measure may consider more serious cases of complications during childbirth that, if left unresolved, may have resulted in death. This includes things such as renal failure, sepsis, and respiratory distress. In looking at the trend of severe maternal morbidity from 2010 – 2018, we see increasing rates among black mothers and a rate that is double of white and Latina mothers from 2016 – 2018. Figure M9 shows this data and suggests that focusing objectives for minority groups may provide great benefit to the community.

## Figure M9: Severe Maternal Morbidity Rates in Monroe County




Source: NYSDOH, Statewide Planning and Research Cooperative System (SPARCS), Years 2012-2018
Analysis Completed by Common Ground Health

As discussed in the focus area regarding well-being, we see a difference in the safety of neighborhoods between the City of Rochester and the suburbs. While this impacts the well-being of the entire community, it can have an even greater effect on pregnant and post-partum women. It is clear that that psychosocial, cultural and environmental stressors experienced during gestation can be detrimental to pregnancy and maternal and fetal health, and recent studies suggest that prenatal stress can have consequences that span generations.[18]

Institutional racism is another factor that impacts the health outcomes of Monroe County. As shown above, minority women have poorer health outcomes when pregnant. Along with this, institutional racism continues to impact Black residents' ability to secure housing, as Black homebuyers continue to be turned down for mortgages at more than double the rate of White applicants.[19]

18. Coussons-Read M. E. (2013). Effects of prenatal stress on pregnancy and human development: mechanisms and pathways. Obstetric medicine, 6(2), 52–57. https://doi.org/10.1177/1753495X12473751
19. https://empirejustice.org/wp-content/uploads/2017/12/river-runs-dry-ii.pdf

After consideration of all of the above, the group has decided to focus on two areas including: Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote equity for maternal and child health populations has been selected. When the Community Health Improvement Workgroup (CHIW) selected maternal child health as a priority area for the Monroe County 2019-2021 Community Health Improvement Plan (CHIP), an advisory group of content experts was created called the Maternal Child Health Advisory Group (MCH-AG). Over 72 members from 34 organizations or departments across Monroe County have met quarterly for the 3 years during the implementation phase of the plan and beyond. An average of 30+ attendees of providers and community leaders of social, health, and education agencies attend the quarterly meetings. Members include representatives from the following key agencies:

| | |
|---|---|
| Healthy Baby Network | Rochester Regional Health |
| School Based Health Clinics | University of Rochester Medical Center |
| Metro Council for Teen Potential | Accountable Health Partners |
| The LARC Initiative | Planned Parenthood |
| In-Control | Rochester City School District |
| Anthony Jordan Health Center | Nurse Family Partnership |
| Highland Family Planning | Common Ground Health |
| March of Dimes | Finger Lakes Performing Provider System |
| Monroe County Department of Public Health | United Way |

The Complete Streets Makeover at Parsells Avenue and Greeley Street, Rochester
Photo credit: Common Ground Health

The overarching focus of the MCH-AG is to address the goal of the 2019-2021, and now 2022-2024, CHIP: addressing disparities in maternal and child health. The MCH-AG first reviewed the results of several recent focus groups conducted with Rochester community members around issues related to disparities in maternal and child health outcomes. After several discussions about these various results, the group decided to explore the key disparity drivers of sub-optimal birth spacing, housing insecurity, and institutional racism and potential solutions for the future work of the MCH-AG. This group was able to begin to address these drivers in several ways, discussed below.

| BIRTH SPACING | HOUSING | INSTITUTIONAL RACISM |
|---|---|---|
| A team from the MCH-AG participated in a Systems Integration Prototyping pilot program. This team, composed of representatives from the YWCA, Nurse Family Partnership, the Society for the Protection and Care of Children (SPCC), and Social Work at URMC, studied and applied Human Centered Design principles and created a final model and process workflow for standardized entry and easy linking of new families with support services that best fit their needs. The prototype will easy entry to social supports to discuss and encourage appropriate birth spacing.<br><br>MCH-AG is the community advisory group for Roc Family Teleconnects. Modeled after the evidence-based Family Connects program, Roc Family Teleconnects is a "light touch" assessment visit, typically performed in person by a registered nurse, but conducted via phone due to the Covid-19 pandemic. | The CHIW and the MCH-AG collaborated with the United Way of Greater Rochester to apply for a Robert Wood Johnson Foundation grant studying the racial equity impacts of the Eviction Prevention Pilot Initiative (EPPI) initiated through the Systems Integration Project. EPPI aims to connect Rochester residents with money for assistance with rent and mortgage relief through the CARES act and other funding streams. Although this grant was not funded, the CHIW and MCH-AG will continue to find ways to link pregnant women and young families to housing resources.<br><br>Several informational sessions were given during the MCH-AG meetings, including in May 2021 when Katrina Korfmacher shared Rochester Healthy Homes Partnership (RHHP) website, and where to find eviction prevention resources and other tenant needs. | Through a PCORI grant funded project, "Community Collaboration for the Exploration of Local Factors Affecting Black Mothers' Experiences with Prenatal Care," researchers conducted listening sessions in Jan and Feb 2020 with stakeholder groups including clinicians, Black patients who recently delivered, researchers, and community organizations like Healthy Baby Network. Results were presented to the MCH-AG in November 2020.<br><br>Work continues with organizations and researchers involved in the PCORI project to improve systems' responses to the experiences of women in the listening sessions.<br><br>All hospitals have health equity initiatives happening in 2021. |

Other accomplishments in maternal child health are detailed in the 2019-2021 Monroe County Community Health Improvement Plan Implementation Final Report.

## Community Assets and Resources to be Mobilized

The not-for-profit hospitals and the local public health department who are engaged in the Community Health Improvement Workgroup (CHIW) for this process are instrumental assets for addressing the health needs in Monroe County.

### UR Medicine

As part of one of the nation's top academic medical centers, UR Medicine forms the centerpiece of the University of Rochester Medical Center's patient care network. UR Medicine consists of Strong Memorial Hospital (including Golisano Children's Hospital and the Wilmot Cancer Institute), as well as Highland Hospital, Thompson Health, Noyes Health, St. James Hospital, Jones Memorial Hospital, the Eastman Institute for Oral Health, UR Medicine Home Care, the Highlands at Pittsford and Highlands at Brighton, nine urgent care centers, an extensive primary care network, and the University of Rochester Medical Faculty Group. URMC's student rosters include more than 400 medical and MD-PhD students, 500 graduate students, and 800 residents and fellows, all of whom are engaged in community service throughout their education. Two UR Medicine hospitals, Strong Memorial and Highland, and the Strong West Emergency Department in Brockport, are located in Monroe County.

The University of Rochester Medical Center (URMC) aspires to make every person feel safe, welcome, and supported at all times; to be a place where everyone, regardless of identity or challenges they face, is lifted up to become their best and healthiest selves; to serve as a powerful force for eliminating racism, division, and exclusion in our communities and beyond. URMC's Equity & Anti-Racism Action Plan serves as a blueprint for coordinating this work, and is focused on five action steps: Build, Recruit, Nurture, Exemplify, and Engage.

### Strong Memorial Hospital

The University's health care delivery network is anchored by Strong Memorial Hospital, an 846-bed, University-owned teaching hospital. Strong boasts a state-designated Level 1 Trauma and Burn Center, pioneering liver, kidney and heart transplant programs, a comprehensive cardiac service, and esteemed programs for conditions such as Parkinson's disease, epilepsy and other neuromuscular illnesses. Pediatric tertiary services are delivered through the 132-bed Golisano Children's Hospital, the leading pediatric referral center in Western New York offering specialized services, including critical care, a 68-bed Level 4 NICU, and a full range of medical and surgical subspecialty care.

With a solid reputation for quality, Strong Memorial has consistently earned the annual National Research Corporation "Consumer Choice Award" for more than two decades. In 2018, the hospital earned re-designation as a Magnet® hospital from the American Nurses Credentialing Center (ANNC), a division of the American Nursing Association. Recognized around the globe as the gold standard for nursing excellence, fewer than 8 percent of American hospitals currently hold this honor.

U.S. News & World Report consistently lists Strong Memorial's adult and pediatric specialty programs in its rankings of Best Hospitals in America. Over the past several years, Strong has ranked in multiple adult specialties in the Top 50 – Neurology and Neurosurgery; Nephrology; Otolaryngology; and Diabetes and Endocrinology. In addition, Strong has been recognized for "high-performing" specialties – Cardiology & Heart Surgery; Gastroenterology and GI Surgery; Geriatrics Orthopedics; Urology; and Pulmonology – with scores in the top 10 percent of nearly 5,000 hospitals analyzed. Recently, Golisano Children's Hospital ranked in Pediatric Neurology and Neurosurgery; Nephrology; and Neonatology.

The Joint Commission awarded special recognition to the Program in Heart Failure and Transplantation for both its heart failure and ventricular assist device programs. Strong offers the only comprehensive cardiac program in Upstate New York, with prevention services, leading-edge treatments and devices, surgical options, and Upstate New York's only cardiac transplant service. The center was the first in Upstate to implant a total artificial heart.

Strong Memorial's cardiac and stroke programs are honored by the American Heart Association/ American Stroke Association's Get with the Guidelines initiative. Strong also is recognized with the Target: Stroke Honor Role, which cites hospitals that have consistently and successfully reduced the time between a stroke victim's arrival at the hospital and treatment. Further improving treatment for stroke patients, Strong debuted Upstate NY's first mobile stroke unit, partnering with local EMS providers to bring highly specialized staff, equipment and medications right to the patient, providing lifesaving care before the patient reaches the hospital.

## Highland Hospital

An affiliate of the University of Rochester Medical Center, Highland Hospital is a 261-bed community hospital committed to providing compassionate patient- and family-centered care. Its more than 2,900 employees help provide outstanding care to patients from the Rochester area and surrounding counties. Signature services include Evarts Joint Center, Geriatrics, Geriatric Fracture Center, Bariatric Surgery Center, OB/GYN and GYN Oncology, and Highland Family Medicine. Highland also offers Surgery, Radiation Oncology, Women's Services, and a network of more than 11 Primary Care-affiliated practices. Highland Family Medicine is one of the largest providers of Family Medicine in upstate New York with an extensive network comprised of Highland Hospital and University of Rochester Medical Center physicians. It also houses the University of Rochester's Family Medicine Residency Training Program. Highland is the first hospital in Rochester to establish a health information center exclusively for women and the first hospital in Rochester to launch the Hospital Elder Life Program (HELP) for seniors at risk of delirium and other cognitive or physical difficulties. Six specialty areas at Highland Hospital achieved "high performing" status: Knee Replacement, Hip Replacement, Cardiology, COPD, Kidney Failure, and Diabetes.

Highland Hospital conducts many community health initiatives throughout the year. Examples include free or low-cost health education programs on topics related to nutrition, heart health, and bariatric surgery. Also, Highland's Breast Imaging Center sponsors a free mammography screening day for uninsured/underinsured women.

In late 2016, the hospital completed construction on a new two-story, 30,000 square-foot building that provides room for six new operating rooms and a 26-bed Observation Unit. In 2020, construction began on a new four-story patient tower that is planned to add an additional 58 patient rooms and help modernize the patient experience at Highland Hospital. Construction is scheduled to be completed sometime in 2023.

## Rochester Regional Health

Rochester Regional Health is an integrated system providing healthcare solutions that matter, wherever and whenever our community needs them most. Formed in 2014 with the joining of Rochester General and Unity Health systems, Rochester Regional Health was built on a foundation of providing inclusive and community-based care that is of the highest quality. Rochester Regional Health is a leading provider of comprehensive care and brings to its mission a broad spectrum of resources, an ability to advocate for better care, a commitment to innovation and an abiding dedication to caring for the community. In January 2021, Rochester Regional Health and St. Lawrence Health entered into an affiliation agreement. RRH now serves families in communities across Western New York, the Finger Lakes, and the North Country. Our dedication to excellence and commitment to this region and its people, all ensure that we are well- positioned to thrive in the future. The system includes nine hospitals that serve the community as a truly integrated health services organization. The RRH network includes:

- Hospitals and physicians
- Urgent Care locations
- ElderONE/PACE and home health programs
- Outpatient laboratories
- Rehabilitation programs and surgical centers
- Independent and assisted living centers and skilled nursing facilities

## Rochester General Hospital

Rochester General Hospital serves the greater Rochester and Finger Lakes region and beyond. The hospital combines the resources, skills, and accomplishments of Rochester Regional Health in an integrated network of nationally recognized, community-focused services. The full care continuum includes comprehensive ambulatory services; leading cardiac, orthopedic, neuroscience, oncology, surgery, women's health, and medicine programs; more than 80 primary and specialty medical practices; innovative senior care programs, facilities, and independent housing; a wide range of chemical dependency and behavioral health services; and ACM Medical Laboratory, a global leader in patient and clinical trials testing, with worldwide locations and lab partnerships.

Rochester General Hospital is a 528-bed tertiary care hospital that has been serving the residents of the Rochester Region and beyond since 1847. Rochester General Hospital offers primary medical care and a broad range of specialties. Rochester General Hospital's medical staff includes over 1,000 primary care physicians and specialists, many of whom have offices at the hospital and throughout the community.

## Unity Hospital of Rochester

Unity Hospital of Rochester serves the greater Rochester and Finger Lakes region and beyond. The hospital combines the resources, skills, and accomplishments of Rochester Regional Health in an integrated network of nationally recognized, community-focused services. The full care continuum includes comprehensive ambulatory services; leading cardiac, orthopedic, neuroscience, oncology, surgery, women's health, and medicine programs; more than 80 primary and specialty medical practices; innovative senior care programs, facilities and independent housing; a wide range of chemical dependency and behavioral health services; and ACM Medical Laboratory, a global leader in patient and clinical trials testing, with worldwide locations and lab partnerships.

Unity Hospital is a 471-bed community hospital in the town of Greece. After a four-year total renovation in 2014, Unity is now the only Monroe County hospital to feature all private patient rooms and free parking. Unity offers a broad range of specialty centers, including the Golisano Restorative Neurology & Rehabilitation Center, the Charles J. August Joint Replacement Center and the August Family Birth Place. The hospital is also a NY State-designated Stroke Center.

## Monroe County Department of Public Health

The Monroe County Department of Public Health (MCDPH) provides direct public health services designed to protect the public from disease and environmental hazards, and community leadership to ensure improved health status of individuals, families and the environment. Services include education, preventive services, and enforcement of health codes and medical policies. Divisions include:

- The Nursing Services Division protects and promotes the health of the community through support, education, empowerment, and direct nursing care services. Programs and services include immunizations, tuberculosis control, sexually transmitted disease prevention and treatment, HIV screening and treatment, and overseeing the Children's Detention Center.
- The Maternal and Child Health Division includes WIC - a supplemental food and nutrition program for women and children, Nurse Family Partnership, an evidence-based, nurse-led home visiting program for first time mothers with limited income, Starlight Pediatrics, which provides medical care for children in foster care, and Children With Special Healthcare Needs.
- The Special Children's Services Division includes the Early Intervention (EI) Program, which services children (Birth - 2) who are at risk of developmental delays and the Pre-School Special Ed Program which serves children ages 3-5 who have delays that may affect their education.
- The Division of Environmental Health provides information, education, and inspection of facilities, in addition to emergency response at incidents that threaten the public's health and the environment. Environmental Health promotes the health of the community by providing information and education; inspection of facilities or conditions that affect public health and the environment; enforcement of provisions of the Public Health Law, the New York State Sanitary Code, and the Monroe County Sanitary Code; emergency response to incidents that threaten public health and the environment; and coordination of planning for activities that protect public health and the environment.
- The Division of Epidemiology and Disease Control provides expertise in epidemiology and data analysis to the Department and the community. The Division publishes community health assessments, develops community health improvement plans with input from stakeholders, and provides public health data for community organizations to utilize for grant writing, education and policy development. The Division also conducts surveillance, epidemiological investigations, and community intervention to prevent and control communicable diseases in accordance with New York State Department of Health requirements.

Other programs within the MCDPH organization include the Office of Public Health Preparedness, which coordinates response to large-scale public health emergencies and communicable disease events; Office of the Medical Examiner, which investigates all unattended deaths; and Vital Records, providing Monroe County birth and death records.

## Other Important Community Resources and Assets

In additional to the hospitals and health department, there are numerous other community-based organizations either attending CHIW meetings and contributing to the 2022-2024 CHIP or working outside the scope of the 2022-2024 CHIP focus areas. All of these organizations work to advance the health of Monroe County and are an integral part of our community. These resources include but are not limited to the following.

### Center for Community Health & Prevention (CCHP)

URMC has a commitment to community health, recognized as its fourth mission along with research, education, and patient care. The Center for Community Health & Prevention was established in 2006, and is supported by URMC financial, legal, and management infrastructure. The CCHP changed its name from The Center for Community Health in 2017 to include Prevention, an important pillar of its mission. The CCHP supports and facilitates community-academic public health partnerships, and provides consultation to faculty, staff, and students who wish to establish community initiatives and research. The mission of the CCHP is to "join forces with the community to promote health equity; improve health research, education, services, and policy; and establish local and national models for prevention and community engagement.

Through disease prevention and healthy living programs, research, education, and policy—the Center for Community Health & Prevention works to create environments that support healthy behaviors. From disease surveillance, to clinical programs, to workforce navigation, to cancer prevention and diabetes prevention programs, the Center, made up of 60 employees, encompasses a wide variety of programs and initiatives aimed at preventing disease to create a healthier community. Dr. Theresa Green, the CCHP Director for Education and Policy, and Dan Green, the Health Policy Coordinator work with all local hospitals, and the Monroe County Department of Public Health, and many community partners to coordinate the CHNA/CHIP Process. The Community Health Improvement Workgroup convenes monthly at the Center.

### Common Ground Health

Common Ground Health is a community-based health planning agency dedicated to promoting the health of the region's population. The organization provides a neutral community table for planning among health systems and community organizations throughout the Finger Lakes region. Their mission is "Through regional collaboration and partnerships, we bring greater focus to community health issues via data analysis, resident engagement, and solution implementation." Common Ground Health provides coordination and staff support to the African American and Latino Health Coalitions, and takes the lead with Healthi Kids, a policy and advocacy coalition for children.

### Healthi Kids

The Healthi Kids Coalition is a grassroots community coalition and an initiative of Common Ground Health. Since 2008, they have been advocating for healthier kids in the City of Rochester and across the Finger Lakes region (Monroe, Wayne, Livingston, Ontario, Yates, Steuben, Schuyler, Seneca and Chemung counties). They believe in the power of youth and resident voice to co-create solutions, influence decision makers, and transform systems that support healthy development for all kids. Their agenda embraces kids and families at the center of all decision making. They advocate for policies, systems, and environmental changes that nurture the physical, social, emotional, and cognitive development of kids from birth to age 8. They do this by focusing on policies that promote healthy habit building and healthy relationships, create safe and secure environments and psychological safety, and cultivate skills and competencies of adults who care for children.

## African American Health Coalition

The African American Health Coalition seeks to improve health equity for Black residents in the Rochester-Finger Lakes region. The African American Health Coalition seeks to improve health equity for Black residents in the Rochester-Finger Lakes region. The long-standing advocacy and advisory group brings together community members, organizational leaders and the health care workers of our region to coordinate efforts to improve health for Black people. The coalition works to identify health inequities for African Americans and works to improve the collection of data on race and ethnicity. Coalition members also advocate with health systems and other organizations to improve outcomes for people of color. The coalition meets monthly at Common Ground Health. A portion of the meeting is open to the public.

## Latino Health Coalition

The Latino Health Coalition works to improve health equity for the Hispanic community in the Rochester-Finger Lakes region. The long-standing advisory group has addressed a variety of health concerns for Latinos, including youth risk behaviors, language barriers, economic stress and cultural competency. The coalition continues to work to improve the collection of data on race and ethnicity. The coalition also advocates for policies that support healthy behaviors. It works to improve the scope, quality and availability of health services in the Latino community. The Latino Health Coalition meets monthly at Common Ground. A portion of the meeting is open to the public.

## Finger Lakes Performing Provider System (FLPPS)

The Finger Lakes Performing Provider System (FLPPS), the former regional DSRIP organization, is a partnership comprised of 19 hospitals, 6,700 healthcare providers and more than 600 healthcare and community-based organizations in a 13-county region (Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming and Yates counties). FLPPS' vision is to create an accountable, coordinated network of care that improves access, quality and efficiency of care for the safety net patient population.

FLPPS is divided into five geographic sub-regions, termed Naturally Occurring Care Networks (NOCN). These Networks represent the full continuum of care and organizational leadership within a shared geographic service area. Each NOCN is led by a participant workgroup that represents the healthcare providers and community-based organizations in their area.

The FLPPS Partnership includes a diversity of healthcare and community-based providers including:

- Hospitals
- Primary Care Physicians (PCP) / Pediatricians
- Federally Qualified Health Centers (FQHC)
- Health Home/Care Management organizations
- Community-Based Organizations (CBO)
- Behavioral Health organizations (Mental Health & Substance Use Disorder)
- Skilled Nursing Facilities (SNF)
- Organizations serving individuals with Intellectual & Developmental Disabilities

## Monroe County Office of Mental Health (MCOMH)

The Monroe County Office of Mental Health joined the CHIW as the 2019-2021 goals and objectives changed to include more focus in mental health and well-being initiatives. MCOMH is an administrative division within the Department of Human Services and is the governmental entity authorized to receive and allocate public mental hygiene funds in accordance with NYS law. As the agency charged with system oversight and encouragement of programs aimed at prevention and treatment, the MCOMH:

- Develops a comprehensive county plan for mental health, developmental disability, and alcohol/substance abuse services.
- Allocates funding to local agencies based on community priorities, treatment outcomes, and program performance.
- Ensures coordination of services across levels of care and among an array of community providers.
- Assists in the transformation of our system to providing flexible services that are person/family centered, strengths-based, culturally competent, recovery-oriented, and evidence-based.

To accomplish these objectives, the MCOMH oversees the local service system through a variety of sub-contracts; provides fiscal oversight and technical assistance to agencies; and collaborates extensively with other DHS and county divisions, service providers, and community groups. Provider contracts are monitored by Coordinated Care Services, Inc. (CCSI) on behalf of MCOMH.

## Rochester Regional Health Information Organization (RHIO)

The Rochester RHIO (Regional Health Information Organization) is a secure, electronic health information exchange (HIE) serving authorized medical providers and over 1.4 million patients in Monroe, Allegany, Chemung, Genesee, Livingston, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates counties in upstate New York.

The service allows a medical care team to share records across institutions and practices, making patient information available wherever and whenever needed to provide the highest quality care. Multiple studies conducted by the Weill Cornell Medical College on the Rochester RHIO — published in peer- reviewed journals — conclude that patients benefit from reduced hospital admissions and readmissions, as well as fewer repeated radiology imaging tests. Through its work locally and with New York State, the RHIO is recognized for its progressive, innovative approach to supporting collaborative health care. The mission of the Rochester RHIO is to provide the greater Rochester medical service area with a system for a secure health information exchange that allows for timely access to clinical information and improved decision making. The primary goal is to share patient healthcare information in a secure environment to improve patient care and to reduce system inefficiencies. The Rochester RHIO is a critical link in the Statewide Health Information Network of New York (SHIN-NY) and seeks to collaborate with health information exchange efforts across New York State.

## 211 Life Line

211 Life Line is a free, 24-hour confidential phone, chat, text service, and searchable online database. 211 brings a compassionate approach to providing information, referral and crisis/suicide prevention services for Monroe, Wayne, Ontario, Livingston, Cayuga, and Seneca Counties. 211 has been accredited in the areas of Information & Referral Services and Suicidology for 20+ years and added Online Emotional Support accreditation in 2013.

## Community Health Improvement Plan/Community Service Plan

As previously discussed in Main Health Challenges, a multi-voting technique was used to select the priority areas for the Community Health Needs Assessment and Community Health Improvement Plan. County specific pre-read documents were provided to the Monroe County Community Health Improvement Workgroup (CHIW) team which included updated data measures for each of the five priority areas outlined in the Prevention Agenda. This was followed with additional county specific data on objectives within the chosen priority areas to help identify objectives, disparities and interventions to include within the plan. A concerted effort took place during the month of November to ensure the governing CHIW team was equipped with a diverse and inclusive group which represented all areas of health and well-being in the county. The following organizations were engaged in Monroe County's planning and prioritization process:

| MONROE COUNTY PLANNING AND PRIORITIZATION AGENCIES | | |
|---|---|---|
| UR Medicine | Rochester Regional Health | Monroe County Department of Public Health |
| Center for Community Health & Prevention (CCHP) | African American Health Coalition | Latino Health Coalition |
| Finger Lakes Performing Provider System (FLPPS) | Monroe County Office of Mental Health (MCOMH) | Rochester Regional Health Information Organization (RHIO) |
| 211 Lifeline | Common Ground Health | |

Interventions to target the selected priority areas were discussed and determined by the public health department and their team of community partners at Monroe County CHIW meetings. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will continue to take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Monroe County Community Health Improvement Plan. All interventions selected are evidence based or evidence-informed and strive to achieve health equity by focusing on creating greater access for the low-income population, the disparity identified by Monroe County.

The Monroe County CHIW team, a group of diverse partners who meet monthly to improve the health of Monroe residents, will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Team members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

## Planning, Prioritization & Dissemination Process

Unlike the other health departments in the region, Monroe County chose to use a different process for the CHNA/CHIP. The Monroe County Community Health Needs Assessment was conducted using the American Hospital Association (AHA) Community Health Needs Assessment Toolkit and process, which is also approved by New York State.

### Figure M10: AHA Community Health Assessment Model

This model has community engagement as its center, which is a characteristic that is important to the Monroe County CHIW. The CHIW started by reflecting on successes and barriers from the last CHNA/CHIP iteration and implementation period, as well as reviewing the NYS Department of Health and IRS requirements. The CHIW set criteria for prioritizing needs, and identified stakeholders and informant groups that would be critical to the process.

The community was defined as the residents of Monroe County, the primary geography for all four hospitals and health department represented.

### Data Collection

Data were collected from a variety of sources to complete this needs assessment. Sources include, but are not limited to, the US Census Bureau American Community Survey, New York State Expanded Behavioral Risk Factor Surveillance System, CDC Places, 211 Life Line, My Health Story, and County Health Rankings. Particular attention was given to the New York State Prevention Agenda Dashboards. Data were collected for the most recent timeframe available during the data collection phase which took place in Winter 2021/Spring 2022. Data sources are referenced throughout this document.

### Process for Identifying and Prioritizing Community Health Needs and Interventions

The Community Health Improvement Workgroup (CHIW) representing each hospital, the health department and several community partners, meets monthly to discuss successes and challenges in addressing the goals of the Community Health Improvement Plan. In the summer of 2021, the CHIW began the 2022 CHNA process by having hospital representatives to the CHIW meet personally with their hospital's leadership to discuss needs and/or disparities that the healthcare systems identified as community health priorities. The priority areas from these meetings were then discussed in relation to the NYS Prevention Agenda focus areas as well as needs identified by the Monroe County Department of Public Health and the community.

In fall 2021, the CHIW contemplated important considerations to be used to prioritize significant community needs. CHIW members discussed important characteristics for ranking the many needs that will surface after examining the data. The CHIW members felt it would be important to focus on needs and interventions to address those needs that met the following top criteria:

- Ability to intervene ahead of a problem
- Importance of the problem to the community
- Importance of the problem to the community in light of the pandemic
- Solutions that address the full age spectrum of the community
- Feasibility

Prioritization criteria were developed prior to the examination of data to identify important priority health needs for Monroe County. The Monroe County Department of Public Health and the Common Ground Health were instrumental in updating, analyzing and sharing data for the CHIW to examine. Several areas of concern were identified and listed during this time of data review, consistent with hospital needs as well as the prioritization criteria.

After a thorough examination of many diverse data sources, and after multiple discussions among the CHIW members, there was a strong inclination to not change the priority areas from the 2019-2021 Community Health Needs Assessment and Improvement Plan. It was agreed that Monroe County has made significant progress on establishing the infrastructure to support initiatives in the areas of mental health and disparities in maternal and child health. This inclination was supported also by the COVID pandemic slowing down implementation work on the CHIP in the past few years. An important next step in establishing the priority health issues was to gather significant community input.

## Gathering Community Input

### Community Survey: My Health Story 2018 and 2022

In 2018, Common Ground Health conducted a regional survey of community members to learn more about health behaviors and barriers to healthy lives. With particular attention to gathering input from a diverse group of participants, over 4,000 people were surveyed. The survey asks about a wide range of topics from access to medical and dental care to perceptions of personal safety and satisfaction with work. To capture each individual's unique story, several questions are open-ended with an opportunity for unstructured feedback.

The results of the survey indicated that the top concern for adults in Monroe County across all races, geographies, and socioeconomic status levels was mental health, as shown in Figure M11. Survey respondents were asked what the priority health area should be for Monroe County to address for adults, and the overwhelming response was mental health.

My Health Story 2022 took place in the summer of 2022 and included indicators related to impacts of the COVID pandemic. If results show a different priority mentioned for Monroe County work, then the CHIW will adjust to meet those requests.

## Figure M11: Health Concerns for Adults from My Health Story 2018

## 211 Data Results

211 Life Line—a free, 24-hour confidential phone, chat, text service, and searchable online database—shared with the CHIW that the biggest percentage of calls in 2020 were related to social determinants of health, especially food insecurity. According to the 2-1-1 dashboard from Nov. 2020 to Nov. 2021, the highest number of calls were related to housing and shelter, followed closely by food.

## Maternal Child Health Advisory Group

The Maternal Child Health Advisory Group (MCH-AG) is a group of content experts convened quarterly by the CHIW in 2019 to provide advice on issues relevant to promoting healthy women, infants, and children. The MCH-AG has over 80 members from over 30 health, education, or social organizations or departments in Monroe County. This group acts as an advisory body to the CHIW.

At the MCH-AG meeting on November 17, 2021, the group discussed areas of need within maternal/child health in Monroe County. Discussion included choosing a focus area and goals encompassing community doula initiatives, food home delivery and nutritionist initiatives, the systems integration prototype project, lactation care management programs. Additionally, comments leaned toward addressing social determinants of health as a broad cross-cutting category that will affect all the categories of perinatal, infant, child, adolescent, maternal and women's health. The input from community agencies supports this focus: housing, transportation, issues of birth spacing, and institutional racism have been identified as barriers to positive health outcomes.

At the MCH-AG meeting on February 17, 2022, the group discussed possible intervention strategies to improve the health of Monroe County via addressing disparities in maternal and child health. These included integrating the support services flow chart into electronic medical records and/or distributing a paper copy for perinatal social workers' use; creating an all-encompassing home visiting program brochure; increasing access to reliable contraception; incorporating new family, early childhood, and infant mental health services; supporting doulas; supporting social support for vaccinations; expanding our view of trauma; and integrating support services in the Rochester City School District.

## Monroe County Board of Health

On November 10, 2021, representatives from the CHIW met with the Monroe County Board of Health. During this meeting, discussion points on the CHNA highlighted housing insecurity and homelessness as key social determinants of health. The group was supportive of continuing work on the previous CHIP focus areas, and supportive of the Systems Integration Project as a tool for providers to assess social determinants of health and provide referrals to address these barriers.

## Community Advisory Council

The URMC Community Advisory Council (CAC) was created in 2006 to provide community expertise to URMC and the Center for Community Health and Prevention for identifying health needs and developing strategies to reduce disparities and promote health equity. Membership in the CAC includes representation from health and social service agencies, local government, the city school district and the faith community.

At the CAC meeting on September 21, 2021, there was discussion on prioritizing goals for upcoming CHIP to include areas where Monroe County has worse outcomes than NYS. Feedback from the CAC included the need for earlier indicators of mental health problems to avoid violence and suicides and a suggestion to include violence prevention in CHIP as Monroe County rates of assault related hospitalizations are worse than NYS. Maternal Child Health outcomes are worse in high poverty areas of Monroe County than the NYS rates. In the spring of 2021, the CAC researched and ranked priorities for improving health outcomes. The top 3 areas of interventions to improve health outcomes were improving housing access, promoting well-being to prevent mental and substance use disorders, and violence prevention.

The CAC was also surveyed in early-mid December of 2021 to gauge what this group of community representatives think is the most important focus area that hospitals and the health department in Monroe County should be focusing on for its residents. The survey results (n = 12) demonstrated that the CAC viewed the priority of the NYS Prevention Agenda focus areas as the following: (1) preventing chronic diseases, (2) promoting well-being and preventing mental and substance use, (2) promoting a healthy and safe environment, (4) promoting healthy women, infants and children, and (5) preventing communicable diseases.

Additionally, the CAC identified two priority goals in the focus area of mental health and well-being. These goals were: strengthen opportunities to build well-being and resilience across the lifespan (Goal 1.1) and prevent and address adverse childhood experiences (Goal 2.3).

At the CAC meeting on March 22, 2022, representatives from the CHIW shared the results of the survey with the CAC as well as collected input on the status of the 2022-204 CHNA/CHIP. The CAC was supportive of continuing work on the previous CHIP focus areas.

### African American Health Coalition and Latino Health Coalition

The African American Health Coalition (AAHC), beginning as a task force in 2002, is an advisory group that provides community data on health outcomes for African Americans, and advocates with health systems to improve outcomes for people of color.

The Latino Health Coalition (LHC) is an advisory group that began in 1998, addressing health concerns for Latinos including youth risk behaviors, language barriers, economic stress, and cultural competency. The coalition provides community data on health outcomes for Latinos and advocates for policies that support healthy behaviors and the availability of health services for the Latino Community.

A joint meeting with the AAHC and LHC was held on December 16, 2021 to gauge what these groups of community representatives think are the most important focus areas, that hospitals and the health department in Monroe County should be focusing on for its residents.

Initial survey results (n = 32) from the meeting demonstrated that the joint AAHC/LHC collective viewed the priority of the NYS Prevention Agenda focus areas as the following: (1) promoting well-being and preventing mental and substance use, (2) preventing chronic diseases, (3) promoting safe environments, (4) promoting healthy women, infants, and children, and (5) preventing communicable diseases.

Additionally, the joint AAHC/LHC collective identified three priority goals in the focus area of mental health and well-being. These goals were: strengthen opportunities to build well-being and resilience across the lifespan (Goal 1.1), prevent and address adverse childhood experiences (Goal 2.3), and facilitate supportive environments that promote respect and dignity for people of all ages (Goal 1.2).

Further discussion indicated that focusing on addressing language access needs, healthy eating, food security, and safe and affordable housing were priority areas for the groups. Interest in incorporating AAHC and LHC members in the CHIW was also indicated. Following presentation and discussion, the CHIW officially invite a member from both the LHC and AAHC to join the CHIW. Invitations to both groups were extended and a representative from the AAHC presently sits on the CHIW.

## Dissemination

The executive summary and full text documents of the Monroe County Combined Community Health Needs Assessment and Improvement Plan for 2022-2024 will be made available on the websites of:

**URMC:** Strong Memorial Hospital and Highland Hospital

- https://www.urmc.rochester.edu/community.aspx

**Rochester Regional Health:** Unity Hospital and Rochester General Hospital

- https://www.rochesterregional.org/about/community-investment

**Monroe County Department of Public Health**

- https://www.monroecounty.gov/health-health-data

Physical copies of the Monroe County 2022-2024 CHNA/CHIP executive summary will be made available at the Center for Community Health & Prevention, Common Ground Health, and other community partner locations as requested. Printouts and digital copies of any CHIP related documents are always available upon request to interested parties.

Cobbs Hill, Rochester, Monroe County
Local church congregants meet to walk around Cobbs Hill Reservoir in Rochester as part of the church's health ministry
Photo Credit: Common Ground Health

# APPENDIX 1

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Participants in the 2019 Active Transportation Summit tested out a bike share program in Rochester.
Photo Credit: Common Ground Health

# ONTARIO COUNTY

| COUNTY NAME: | ONTARIO COUNTY |
|---|---|
| Participating local health department and contact information: | **Ontario County Public Health**<br>Mary Beer<br>Public Health Director<br>Mary.beer@ontariocountyny.gov<br>585-396-4343 |
| Participating Hospital/ Hospital System(s) and contact information: | **UR Medicine Thompson Health**<br>Amanda Reynolds<br>Amanda_Reynolds@URMC.Rochester.edu<br>585-396-6589 |
| | **Rochester Regional Health Clifton Springs Community Hospital**<br>Maura Snyder<br>Maura.Snyder@rochesterregional.org<br>315-462-9561 |
| | **Geneva General Hospital and Soldiers and Sailors Memorial Hospital (Finger Lakes Health)**<br>Lara Turbide<br>Lara.turbide@flhealth.org<br>315-787-4053 |
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# INTRODUCTION

The Prevention Agenda is New York State's blueprint to help improve the health and well-being of its residents and promote health equity through state and local action. Every three years, New York State requests that local health departments and their local hospital systems work together to create a joint community health assessment and improvement plan using the Prevention Agenda guidelines. Local entities must choose two areas in which to focus community improvement efforts during the plan period. Local entities can choose from five priority areas:

1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment
3. Promote Healthy Women, Infants and Children
4. Promote Well-Being and Prevent Mental and Substance Use Disorders
5. Prevent Communicable Diseases

Throughout the cycle, public health and hospital systems value the input and engagement of key partners and community members, who are critical to help determine which priorities are most important to the community members, and what actions ought to be taken to improve the population's health. The following report summarizes pertinent information relating to the above priority areas.

It is well known that residents live, work, and seek services beyond their county of residence. The health and well-being of residents in a neighboring county may impact the needs and services in other counties. In addition, collaborative practices such as shared messaging and lessons learned may help to expand reach and success of like-interventions. It is for this reason that the nine counties in the Finger Lakes Region have further collaborated to complete one comprehensive regional health assessment. Following the comprehensive assessment of the health of the entire region, this report contains a chapter specific to Ontario County. This focused chapter highlights specific needs, including additional demographic indicators, main health challenges and underlying behavioral, political, and built environmental factors contributing to the region's overall health status for residents located in the county.

# EXECUTIVE SUMMARY

From March of 2020 to March of 2022, local health departments were enmeshed in COVID-19 mitigation to the exclusion of all other programming. This significantly impacted the department and its partners' ability to perform Community Health Improvement Plan (CHIP) activities, much less complete a CHA.

Nonetheless, Ontario County Public Health (OCPH) gathered stakeholders and with the help of Common Ground Health and Pivital Public Health Partnership, completed a CHA. After applying Results-Based Accountability to our findings, in collaboration with UR Medicine Thompson Health, Clifton Springs Hospital and Clinic, and Finger Lakes Health, priority areas were chosen, and the 2022-2024 Community Health Improvement Plan was created. Chosen foci and disparity are noted in Table O1.

### Table O1: Priorities Chosen using Results-Based Accountability

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Prevent Chronic Disease** | |
| Overarching Goal | Reduce obesity and the risk of chronic disease |
| Focus Area 1 | Healthy eating and food security |
| Objective 1.2 | Decrease the percentage of children with obesity |
| **Disparity** | **Low socioeconomic population** |

| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
|---|---|
| Focus Area 2 | Prevent mental and substance use disorders |
| Goal 2.4 | Reduce the prevalence of major depressive disorders |
| Objective 2.42 | Reduce the past-year prevalence of major depressive episodes among adolescents aged 12-17 years. |
| **Disparity** | **Low socioeconomic population** |

## CHA and CHIP Development Process

The Ontario County Health Collaborative (OCHC), a group of diverse partners who span all sectors of the community, participated in the prioritization process and disparity and intervention identification. While a complete list of partners is available within the Ontario County Chapter under Community Health Improvement Plan/Community Service Plan, partners represented academia, not-for-profits and community organizations, businesses, the public, and local government. They included the Ontario County Public Health Department, UR Medicine Thompson Health, Rochester Regional Health/Clifton Springs Community Hospital, Finger Lakes Health/Geneva General Hospital, the Partnership for Ontario County, and Ontario County Mental Health.

Partners' roles in the assessment were to review findings, use their expertise to provide anecdotal data (due to pandemic-related data gaps), and collaboratively select priority areas, objectives, interventions, and measurement parameters for the 2022-2024 CHIP. Members were asked to consult with other stakeholders at their organizations for additional input. Common Ground Health obtained, compiled, and provided regional and Ontario County specific data at OCHC meetings in 2022. A matrixed, online survey was used to help the group discern the magnitude of the problem identified by each priority area, its impact on other health outcomes, the impact of social determinants of health, and the capacity of partners to work on identified priorities. Results of the survey were reviewed, and the group found consensus, as noted in Table O1. At subsequent meetings, Common Ground Health shared data targeted to chosen Focus Areas. This informed the group's choice of goals, objectives, and interventions. The complete list of interventions and process measures is available in the CHIP Appendix.

Data sources included, but were not limited to, the US Census Bureau American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, data collected from Pivital Public Health Partnership (formerly known as S2AY Rural Health Network), Common Ground Health's 2018 My Health Story, 211 Lifeline, and the Statewide Planning and Research Cooperative System (SPARCS). Additionally, a focus group of mental health professionals met twice in the summer of 2022 and provided observations, expertise, and anecdotal evidence of the effect of the COVID-19 pandemic on the mental health of children and adults in Ontario County and the Finger Lakes Region.

The pandemic necessitated a curtailed community health assessment. Public Health spearheads CHA/CHIP/CSP development, and local health department employees and leadership were otherwise engaged during the months when this process should have started. A full community-based survey could not be completed. The Ontario County community had previously weighed in via Common Ground Health's 2018 My Health Story survey. At this writing, the 2022 My Health Survey is circulating in the community. It will provide additional insight into residents' opinions and experiences related to their health. This information will be analyzed and will inform potential additions to Ontario County's CHIP in 2023.

The Ontario County Health Collaborative (OCHC), outside of CHA/CHIP development, meets monthly and will oversee progress on the Community Health Improvement Plan. Partners will provide quarterly updates about interventions, and Public Health will monitor process measures and outcomes and share quarterly reports with group members. OCHC partners will address the need for mid-course corrections or changes in processes. Every quarter, mental health providers will meet with Public Health and hospital system partners in lieu of the regularly scheduled health collaborative meeting to review mental health CHIP/CSP interventions and process measures.

Kershaw Park, Canandaigua, Ontario County
Photo courtesy of VisitFingerLakes.com

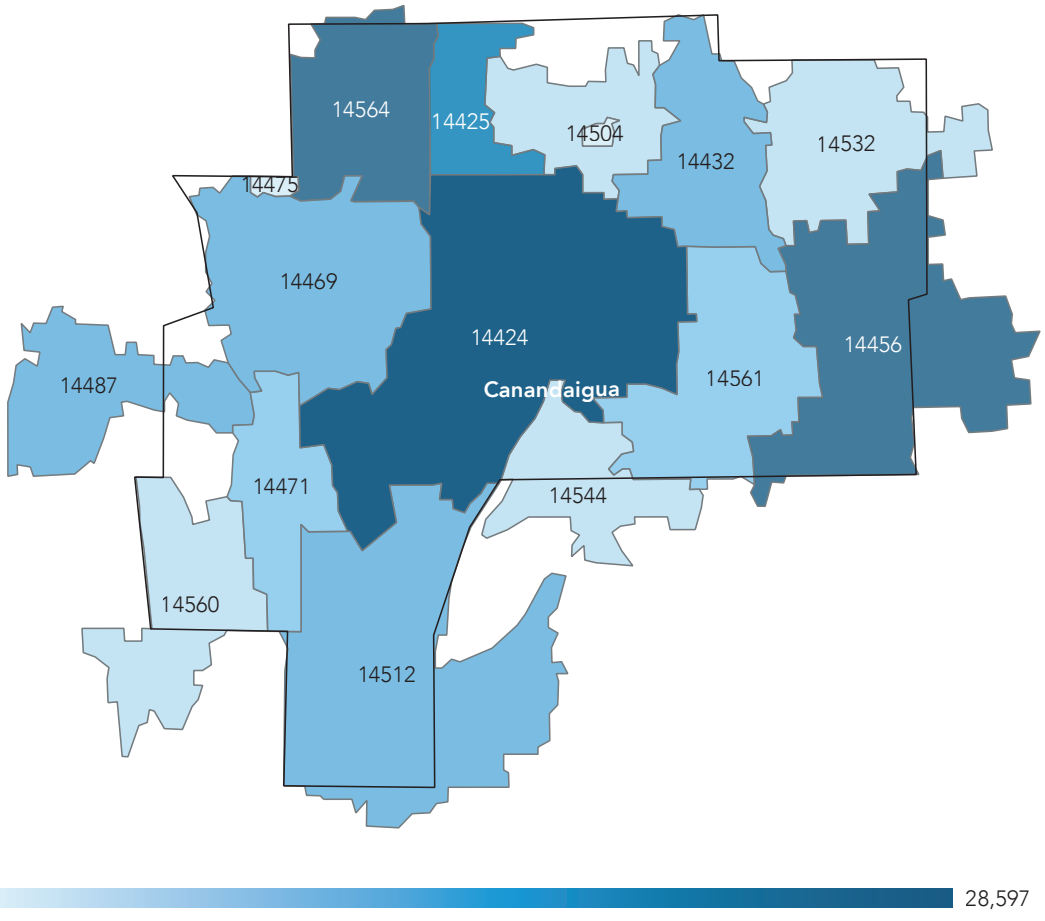
# COUNTY CHAPTER – ONTARIO COUNTY

## Demographic and Socioeconomic Health Indicators

Ontario County is located eight miles from the city of Rochester in the Finger Lakes region of New York. The county includes two cities, 16 towns, nine villages, two colleges and nine school districts. The cities of Canandaigua (the county seat) and Geneva are located at the northern ends of Canandaigua and Seneca Lakes, respectively, and contain approximately 21% of the county's population. Honeoye and Canadice Lakes are in Ontario County, while Hemlock Lake forms a part of the county's western border. Ontario is bordered in the north by Wayne and Monroe counties, in the west by Monroe and Livingston counties, in the south by Steuben and Yates counties, and in the east by Seneca County.

Ontario County is home to 109,774 people.[1] Canandaigua, Geneva, Victor, and Farmington are the most populous ZIP codes. All other ZIP codes in the county had populations of 6,000 or fewer residents. Map O2 shows the population distribution by ZIP code in Ontario County.

### Map O2: Population by ZIP Code in Ontario County

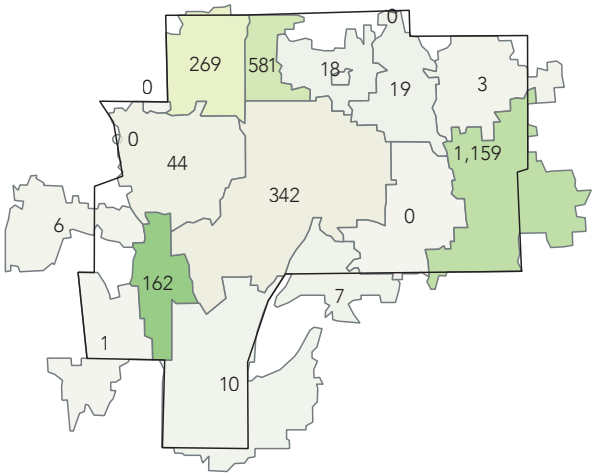



Source: Claritas zip-level estimates and CDC Bridged-Race county-level estimates, Year 2020
Population data and allocation methods developed by Common Ground Health

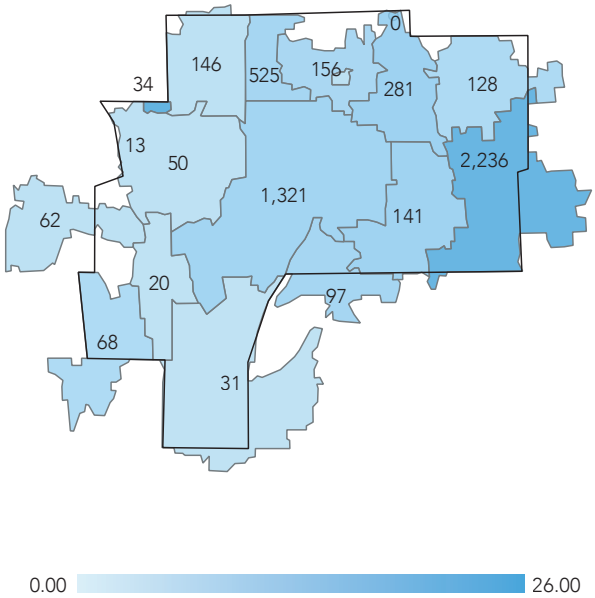
 1. US Census Bureau, American Community Survey, 2020

Most residents in Ontario County are White Non-Hispanic (93%) followed by Hispanic (5%), African American (3%), Two or More Races (3%), Some Other Race (2%) and Asian (1%). The White, Black, Asian, and Hispanic populations in Ontario County have been stable over the past decade.

### Map O3: Ontario County Black Non-Hispanic by ZIP Code (Percent of Population and Count)




### Map O4: Ontario County Hispanic Population Population by ZIP Code (Percent of Population and Count)




Data Source: US Census Bureau, American Community Survey (ACS), Year 2020.
Analysis Completed by Common Ground Health

In addition to more typical minority populations, Ontario County is home to a growing Mennonite enclave. In recent years, many traditional, multigenerational farms have been sold to Mennonite families. It is difficult to ascertain the number of Mennonites in the county, but observationally, the population has increased significantly in the last twenty years. It's not unusual to see horse-drawn buggies on busy roadways and community members in retail outlets (identifiable by attire). Mennonite owned produce and dry good stores are commonplace across the county. There are five Mennonite schools in Ontario County, which conclude at grade eight. Teachers are often young, unmarried women with no formal training. The health department reviews school vaccine coverage and has fostered relationships with church leaders and families. Many Mennonite children receive vaccines at the health department, and health educators have been invited in to teach first aid and CPR to students. These relationships are essential as this population will undoubtedly continue to grow.

Farming requires farm workers. Ontario County attracts migrant farm workers who travel from community to community for planting and harvesting. The county is fortunate to have a Federally Qualified Healthcare Center (FQHC) with an active migrant health program. Dedicated, bilingual staff serve clients at farms and at a modern facility in Geneva.

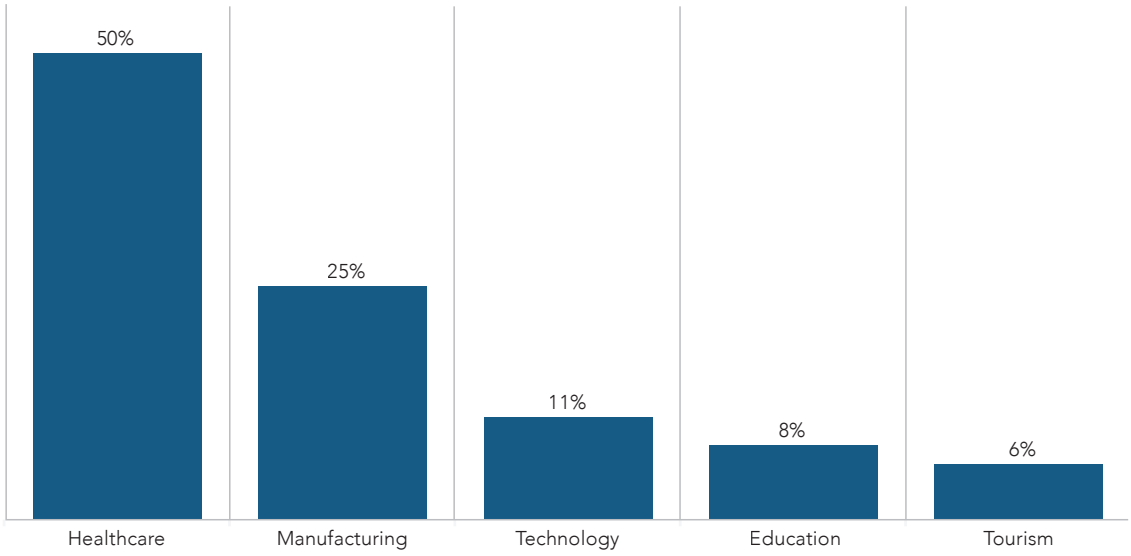
Though considered rural, Ontario is the most urbanized of the counties in the Finger Lakes Region (not including Monroe). It is home to many lakes, farms, breweries, vineyards, tourist businesses, and vacation properties. The New York State Thruway travels through the northern part of the county east to west, with routes 96 and 5 and 20 running roughly parallel a few miles south. Major roadways are well maintained and well-traveled. They provide ready access to jobs and services in neighboring communities and ease of travel for tourists, of which there are many.

Unlike other Finger Lakes counties, it is predicted Ontario County's population will grow by 3% over the next two decades. The Towns of Victor and Farmington on the northeast edge of the county continue to experience rapid growth as farmland is bought up by developers and converted into businesses and housing. Additionally, there has been an influx of individuals who work in Rochester (Monroe County) but prefer to live in a more rural area.

According to the US Census, "in less than two decades, the graying of America will be inescapable: Older adults are projected to outnumber kids for the first time in U.S. history."[2] Projections indicate that by the year 2035, there will be a larger population of older adults (age 65 and over) than children (under 18). Since 2017, the number of older adults in Ontario County has increased by about 2,000 while the number of children has decreased by about 500.[3] Seniors are evenly distributed across the county, with a slightly higher concentration in the Canandaigua area where there are numerous living facilities for older adults.

The Ontario County Department of Economic Development reports that dairy farms, vineyards, orchards, and field crops cover approximately 40% of county land. The top ten employers encompass healthcare, technology, manufacturing, education, and tourism. Figure O5 shows the percentage of Ontario County residents employed by the top 5 employment sectors.

## Figure O5: Employment by Sector in Ontario County




Source: Ontario County Economic Development, 2021 Analysis Completed by Common Ground Health

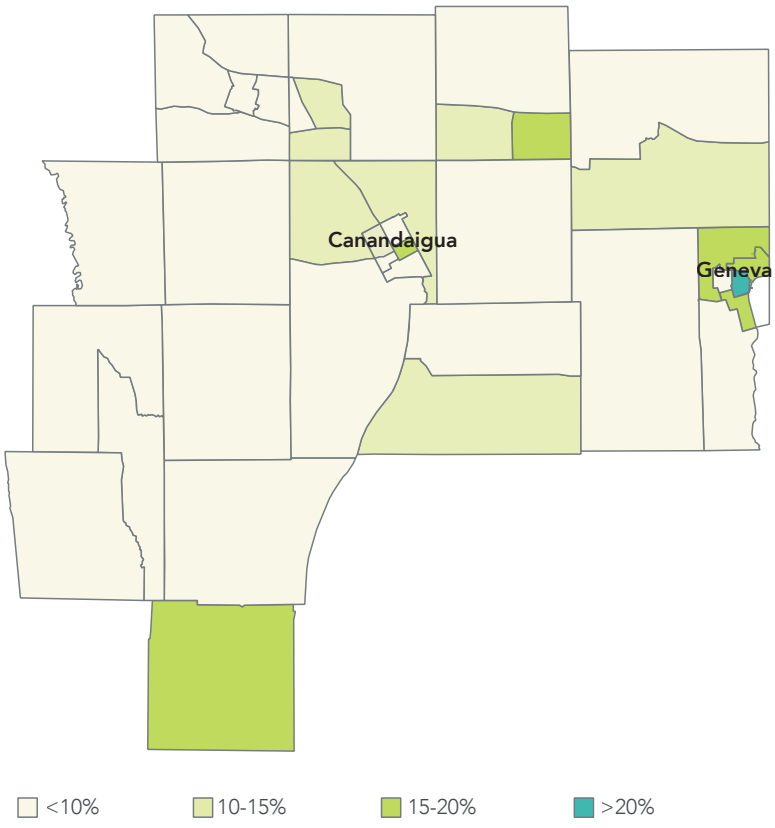

2. https://www.census.gov/library/stories/2018/03/graying-america.html
3. US Census Bureau, American Community Survey

## Social Determinants of Health

Social determinants of health are conditions in which people live, work and play that impact their overall health and well-being. This may include population dynamics, the natural and built environment, poverty, and more. These determinants were reviewed and considered as part of the prioritization process and are summarized below:

In 2020, 9% of Ontario County residents were living in poverty, the lowest county number in the region while being the 2nd largest county by population. While the rates are low for the entire county, there are some pockets of higher poverty, most notably within the ZIP code/census tracts on the eastern edge of the county (Geneva). In addition to place-based differences, there is a large disparity in poverty rates among those who did not graduate high school (22% impoverished) and those who graduated and/or have received higher education (3% impoverished). Map O6 shows the distribution of poverty in Ontario County by census tract. Poverty is concentrated within the City of Geneva with most of the tracts having poverty rates of 15% or higher. It also encompasses the only tract in the county with a poverty rate greater than 20%.

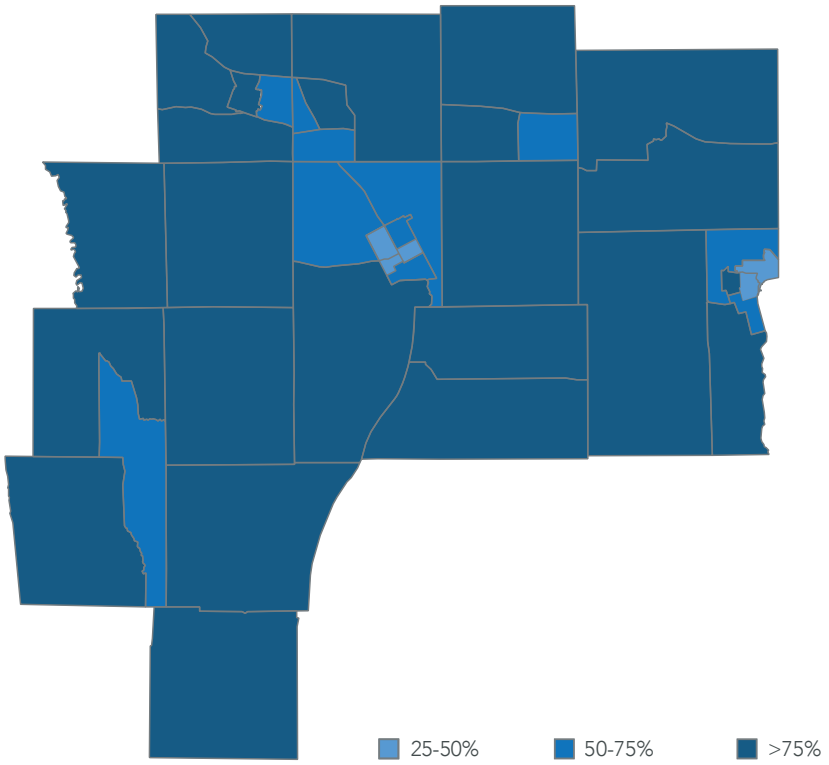
### Map O6: Poverty by Census Tract




Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

Related to poverty, another important factor the health of residents is their housing. Map O7 shows the distribution of owner-occupied residences in Ontario County. Home ownership is high in Ontario County, with 73% of residents owning their homes. Only 5 tracts (3 in Canandaigua and 2 in Geneva) have ownership rates lower than 50%.

## Map O7: Owner Occupied Residents by Tract (Percent of Housing Units)




Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

From 2011 to 2020, the median value of a home in Ontario County has risen ~22% from $134,000 to $163,000. Along with that, the cost of housing has gone up significantly since the beginning of the pandemic, with the median price for an American home up nearly 20 percent in a year.[4]

Poverty impacts housing, and both housing and poverty impact health. Though the county has many beautiful, expensive homes, it lacks affordable housing for residents at socioeconomic disadvantage. Median values are inflated by expensive new builds, multimillion dollar lake properties, and lack of inclusion of rental housing in the US Census Bureau data regarding this indicator. Old, poorly maintained rentals and a handful of apartment complexes remain the only options for many young, working families and residents on fixed or otherwise limited incomes.

 4. https://www.nytimes.com/2022/01/20/upshot/home-prices-surging.html

According to the Census Bureau, there has been a decline in the percentage of families that pay 35% or more of their gross income on housing. However, individuals who rent are twice as likely to spend more than or equal to 35% of their earnings on housing than those who own (35% versus 15%). Unfortunately, the recent spike in home values and assessments has driven landlords to raise rents significantly on very short notice. A concerning observation reported by Ontario County Department of Social Services/Emergency Housing Unit, is a rise in homelessness among families.

Educational attainment affects the socioeconomic status of Ontario County's residents, and socioeconomic status affects educational opportunities. The number of individuals over the age of 25 who have a high school diploma or GED in Ontario County has been stable since 2015. The county enjoys an almost 90% mean high school graduation rate. The rate of residents attaining bachelor's degrees, though stable since 2015, varies significantly by ZIP code. Sixty percent of residents in Victor ZIP codes have earned a bachelor's degree, while only 15 percent have in ZIP codes in Farmington, Manchester, and Gorham.

Tied to educational attainment and employment is health insurance coverage. In Ontario County, more than 95% of the population has insurance coverage. For most demographic factors available from the Census Bureau (age, sex, educational attainment), the 95% coverage rate holds. Disparity exists among foreign-born residents and minority groups with rates of coverage between 85-95%. As members of the growing Mennonite community seldom purchase health insurance, in the future, coverage rates in the county may decline.

## Main Health Challenges

The novel coronavirus was the main health challenge of the last two years. To pretend otherwise would be unwise. Pandemic mitigation has affected the ability of the health department to assess the community in full. Prevention Agenda data is outdated, with some datasets covering years prior to the last CHA/CHIP cycle. Little local data is available except for that data related to COVID-19.

What we do know is that the pandemic has affected residents' physical and mental health and access to preventive services. It has increased unemployment, decreased food security, and exacerbated lack of trust in the government, including Public Health. The healthcare community is understaffed, many medical providers are burnt out, and one in three public health workers are considering leaving their organization in the next year.[5]

The public seems to be ready to move on, but local public health workers do not have that luxury. They are providing core public health programs, trying to maintain and hire staff, working to recoup funds expended on COVID mitigation, while planning and staffing mass vaccination clinics.

This is the backdrop of our CHA.

Throughout the winter and spring of 2022, members of the Ontario County Health Collaborative (OCHC) met monthly. Partners included the county's three hospital systems, community-based organizations, clergy, community members, a college, and a Federally Qualified Healthcare Center. Representatives from Ontario County Public Health, the Pivital Public Health Partnership (previously the S2AY Rural Health Network) and Common Ground Health walked partners through the NY State Prevention Agenda Dashboard, reviewing Action Plans, Focus Areas, Goals, and potential interventions. Primary and secondary qualitative and quantitative data were presented, discussed, and analyzed.


5. Smith, C. (2022, March 30). Public Health Employee Survey reveals a workforce crisis. Governing. Retrieved September 19, 2022, from https://www.governing.com/now/public-health-employee-survey-reveals-a-workforce-crisis

Data were collected from a variety of sources in an effort to identify Ontario County's main health challenges. These included the American Community Survey, the Enhanced Behavioral Risk Factor Surveillance System (BRFSS), Vital Statistics, NYS Communicable Disease Electronic Surveillance System, Pivital Public Health Partnership, the NYS Department of Education, the US Census, 2-1-1 Lifeline, the Ontario County Community Survey and Risk and Protective Factor Survey and Common Ground Health's My Health Story Survey, 2018.

In 2018, My Health Story Survey was administered in Ontario County. Its purpose was to gather primary qualitative and quantitative data from residents about health attitudes, behaviors, and challenges. OCPH and community partners ensured this survey reached all corners of the county, including historically disparate populations. The survey was updated during the spring and summer of 2022 and began to be circulated in early August. Though too late to apply to this CHA, findings will be shared with stakeholders this fall and winter and will inform Ontario County's CHIP/CSP activities moving forward.

After review and analysis of available data and discussion of social determinants of health, a matrixed survey was used to prompt group members to consider and rate the significance of identified health indicators and the feasibility of addressing them collaboratively. Results of the survey pointed group members to the NYS Prevention Agenda's action plans for Preventing Chronic Diseases and Promoting Well-Being and Preventing Mental and Substance Use Disorders. A targeted review of county-specific data related to these two areas ensued as did discussion about the effects of the pandemic on food security, physical activity, employment, chronic disease, and mental health (See Appendix 3 for more info on this process).

Partners ultimately chose to collaborate on the NYS Prevention Agenda's (PA) Prevent Chronic Disease Action Plan, Focus Area 1, Healthy Eating and Food Security with the overarching goal of reducing obesity and the risk of chronic disease. They agreed it was feasible to target efforts on Objective 1.2, Decrease the Percentage of Children with Obesity among Public School Students, by providing school and daycare-based education about healthy eating and physical activity. Though mental health and substance use disorders were identified as areas of immediate concern, data concerning the impact of COVID-19 pandemic was lacking. In May of 2022, Public Health enlisted the assistance of Ontario County's Director of Mental Health in gathering mental health and substance use prevention providers together to discuss the impact of the COVID-19 pandemic on behavioral health.

This served as a focus group by proxy, as well as a work group to select goals and interventions around the NY State PA's priority of Preventing Mental and Substance Use Disorders. The group met in June and July and through discussion and review of a root cause analysis, chose Goal 2.4, Objective 4.4.2, Reduce the Past-year Prevalence of Major Depressive Episodes among Adolescents aged 12-17-years. This group will continue to meet quarterly to report progress and share outcomes.

Looking upstream and choosing to work with school-aged children in both of our chosen focus areas is intentional. Historically it has been difficult to engage schools in CHIP/CSP interventions. The COVID-19 pandemic solidified relationships and built trust and respect between schools and the health department. Maintaining this relationship will be invaluable to Ontario County Public Health and its partners.

As a result, the following areas were selected for the 2022-2024 Community Health Improvement Plan:

| | |
|---|---|
| Priority Area: | Prevent Chronic Diseases |
| | **Focus Area:** Healthy Eating and Food Security |

| | |
|---|---|
| Priority Area: | Promote Well-Being and Prevent Mental and Substance Use Disorders |
| | **Focus Area:** Mental Health & Substance Use Disorders Prevention |

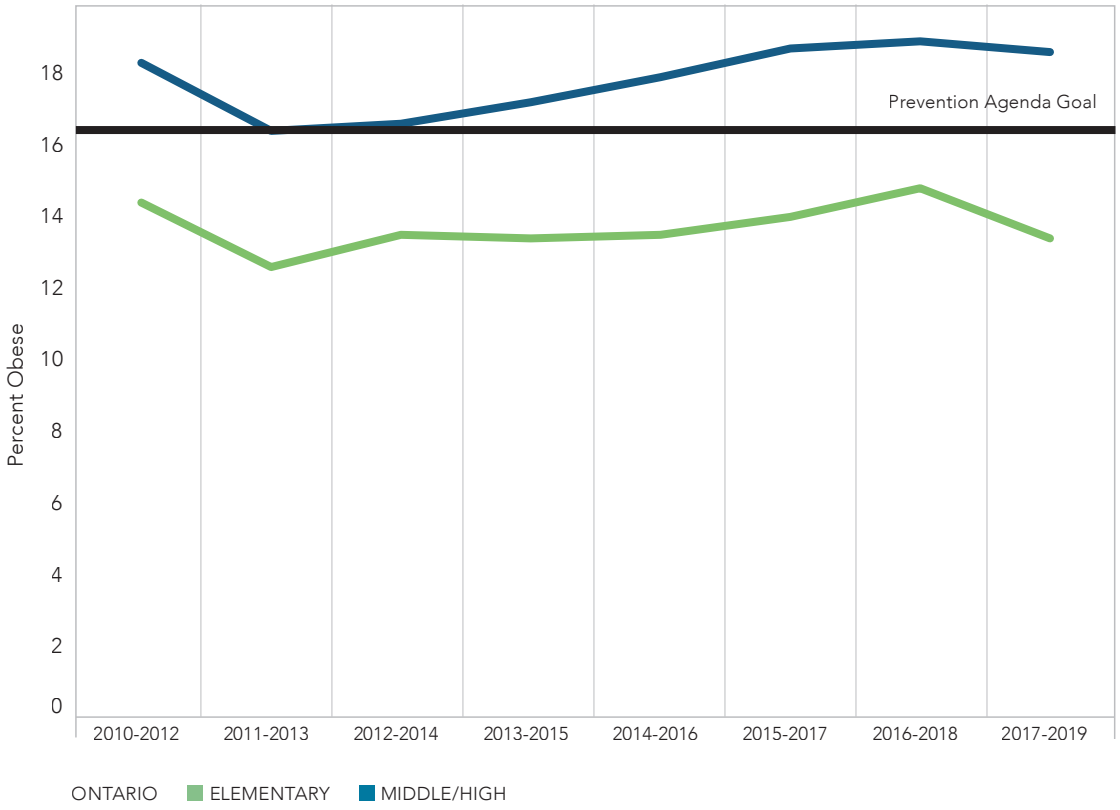
| | |
|---|---|
| Disparity: | Low Income/SES |

## Risk and Protective Factors Contributing to Main Health Challenges

### Healthy Eating and Food Security

Substandard nutrition is directly related to the development and progression of chronic diseases. There are many behavioral and environmental risk factors that affect healthy eating and food security. One way to assess the nutritional health of a community is by exploring obesity rates of children via the Student Weight Status Category Reporting System. Though percentages of obese and overweight children have been stable for the last twenty years, older students are more likely to be classified as overweight or obese than younger counterparts. Figure O8 shows the percentage of students with obesity in Ontario County schools by grade level (Elementary vs. Middle/High School).

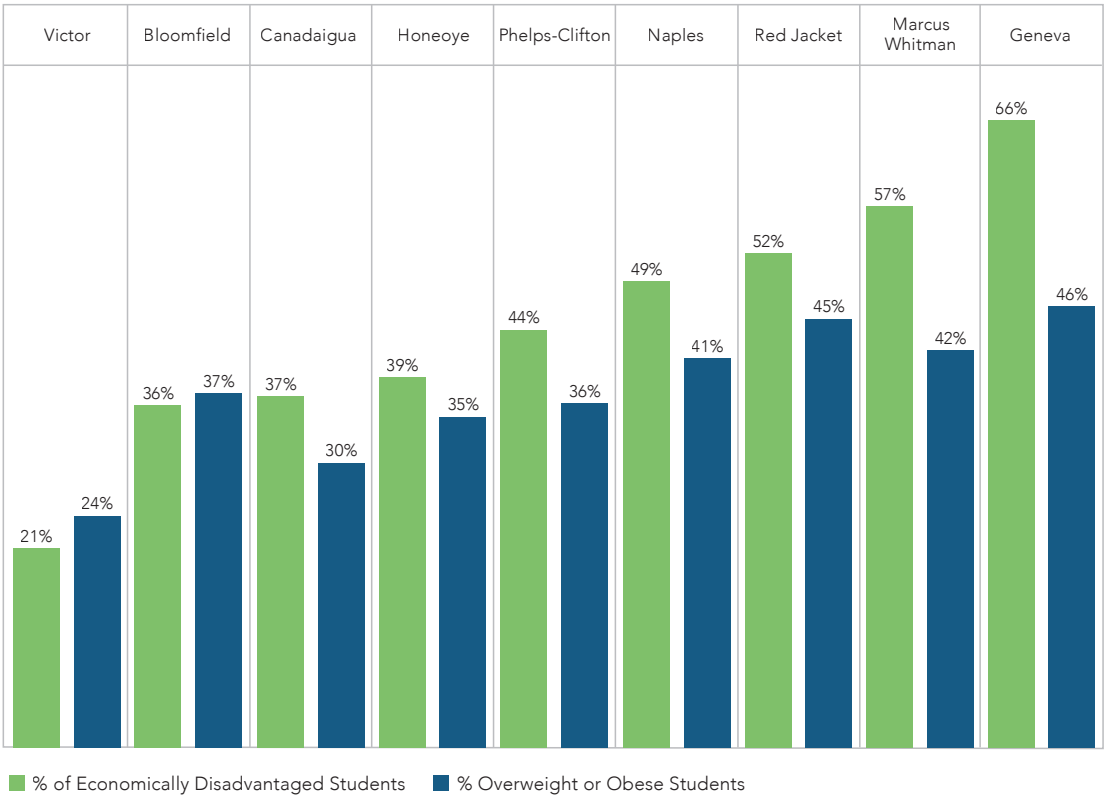
### Figure O8: Percent of Students with Obesity in Ontario County Schools




Data Source: NYS DOH, Health Data Connector, 2010 – 2019
Analysis Completed by Common Ground Health

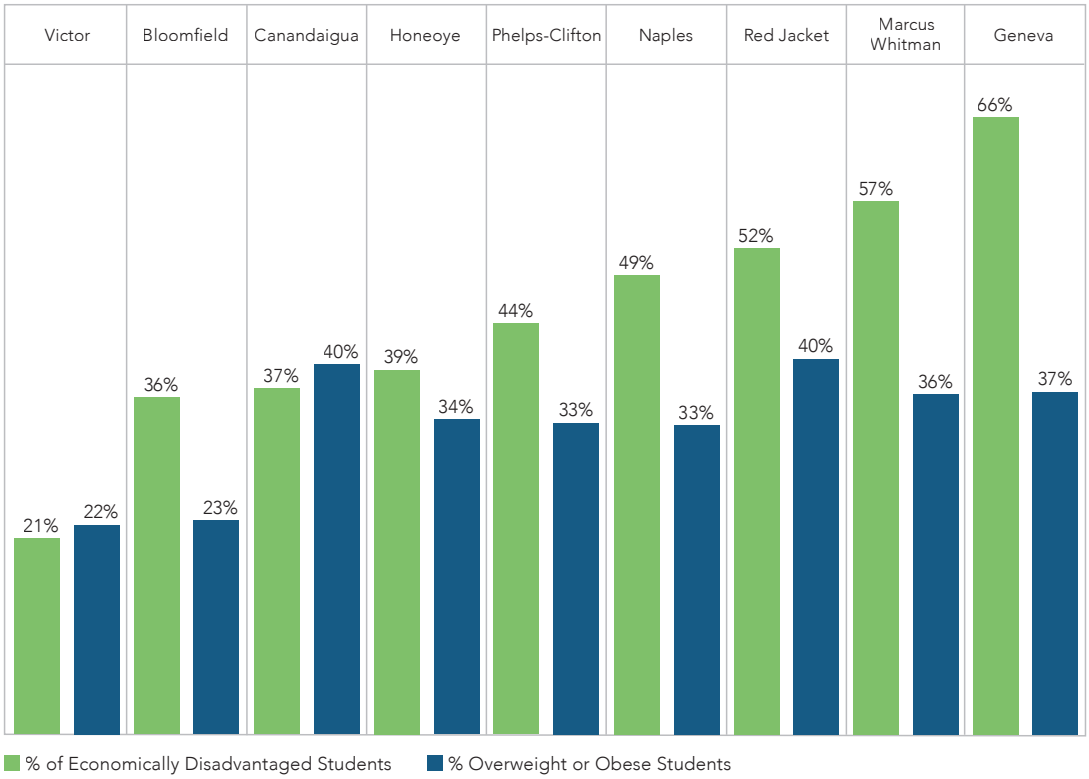
Upon further analysis, it is obvious that children in some school districts are heavier than others. In Ontario County, there are higher percentages of obese and overweight middle and high school students in districts with higher percentages of children at economic disadvantage (see Figure O9). The difference between the most affluent community and least is remarkable (24% for the former; 46% the latter). This inequity leaves these children at risk for the development of chronic diseases. Additionally, obesity is often an indicator of lack of access to healthy foods (food insecurity). Food insecurity may adversely affect a child's growth and development and general health. It may increase asthma risk and contribute to behavioral problems at home and school. When looking at the correlation between overweight/obesity and economic disadvantage at the elementary level, there does not appear to be the same correlation as with the older students (Figure O10).

## Figure O9: % Overweight/Obese Students vs. % Economically Disadvantaged Students - Middle/High School in Ontario County Districts




Source: New York State Education Department (NYSED), Years 2018-2019
Source: NYS DOH, Health Data Connector, 2018-2019
Analysis Completed by Common Ground Health

## Figure O10: % Overweight/Obese Students vs. % Economically Disadvantaged Students - Elementary School in Ontario County Districts




Source: New York State Education Department (NYSED), Years 2018-2019
Source: NYS DOH, Health Data Connector, 2018-2019
Analysis Completed by Common Ground Health

Ontario County, Geneva Community Yoga
Photo courtesy of VisitFingerLakes.com

Elementary schools may provide environments that level the nutritional/physical activity playing field between children of varying economic status. Younger children's days are more scripted and may include opportunities for physical exercise (recess). Many children attend regulated afterschool programs where snacks are nutritious, and exercise is encouraged. Additionally, young children are less likely to feel embarrassed about receiving reduced or free breakfasts and lunches at school. Conversely, adolescents have less opportunities for physical activity during the school day. They may forego free meals to avoid stigma and resort to filling up on fast or convenience foods before and after school. Many return to empty homes at the end of the school day without adult supervision of screen time and snacking. Finally, hormonal fluctuations and changes in sleep patterns may contribute to weight gain as children go through puberty.

The differences between elementary school children and their older counterparts noted above do not tell the whole story of childhood obesity. Mental health affects obesity and obesity affects mental health. Studies suggest that multiple adverse childhood experiences (ACEs) may increase the likelihood of obesity in children, 2-5 years later.[6] In the 2021 Youth Risk and Protective Factor Survey of 5 rural school districts in Ontario County, the percent of children who had experienced more than 2 ACES, was twice as high for 12th graders as it was for 6th graders (43% and 19%, respectively), which seems to correlate higher ACE scores with increased obesity.

There is growing research that demonstrates the need to address childhood obesity and psychosocial problems simultaneously. An integrated public health approach is needed and should include policy makers, healthcare providers, educators, and organizations that interface with children, teens, and families.[7] Ontario County Public Health and its partners believe that this can be done by encouraging early childhood education and modeling (school/daycare gardens, Eating the Rainbow, Coordinated Approach to Child Health, etc.), providing nutrition and parenting support to caregivers (Positive Parenting Program), standardizing food insecurity and mental health screening tools in pediatric practices, and equipping educators and Student Resource Officers to respond to mental health crises during the school day.[7]

Over the course of the two previous CHIPs, Ontario County Public Health has collaborated with school cafeteria managers and community partners to increase the number of fresh fruits and vegetables available during the school day. Additionally, sugar sweetened beverages have been removed from most schools' vending machines. Schools that have actively pursued "farm-to-table" initiatives continue to do so, but not all districts have embraced this model.

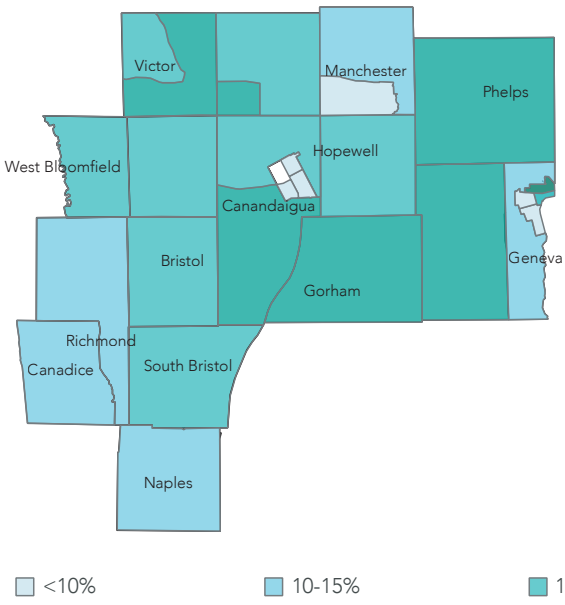
Ontario County is home to a thriving farming community. It would seem everyone has access to fresh, healthy foods during the summer and fall when roadsides are dotted with fruit and vegetable stands. Additionally, farmers' markets are usual weekend occurrences in the cities of Canandaigua and Geneva and other communities. These are important assets, but access remains a problem for some residents.

6. https://doi.org/10.1111/obr.13204, Schroeder, K., Schuler, B. R., Kobulsky, J. M., & Sarwer, D. B. (2021). The association between adverse childhood experiences and childhood obesity: A systematic review. Obesity Reviews, 22(7), e13204.

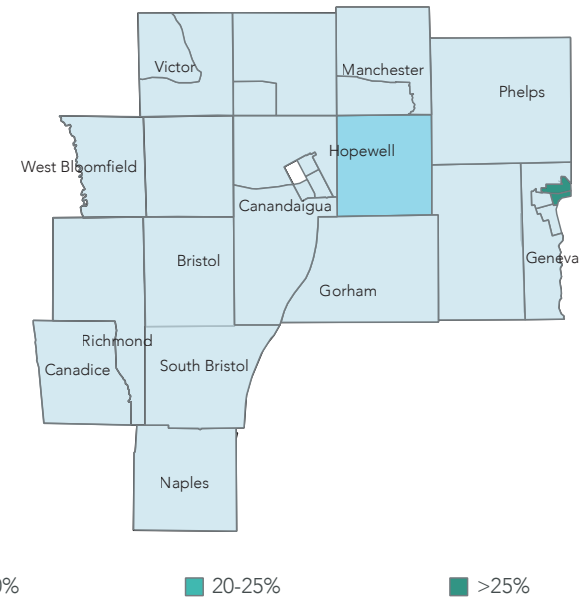
7. Small L, Aplasca A. Child Obesity and Mental Health: A Complex Interaction. Child Adolesc Psychiatr Clin N Am. 2016 Apr;25(2):269-82. doi: 10.1016/j.chc.2015.11.008. Epub 2016 Jan 22. PMID: 26980129.

In the previous CHIP, members of the Ontario County Health Collaborative partnered with the Regional Transit System (RTS) to provide grocery store targeted bus routes to individuals living in Geneva's food desert, as well as for seniors residing in adult care facilities. Unfortunately, the COVID-19 pandemic curtailed this intervention considerably. Public transportation is less developed in rural areas. County residents who do not drive are at the mercy of busy family members, infrequent bus routes, and private taxi services. Maps O11 and O12 show the census tracts in Ontario County that have access issues for children and persons/families receiving SNAP benefits.

## Map O11: Percentage of Children Ages 0-17 SNAP more than 1 mile from a Supermarket




## Map O12: Percentage of Housing Units receiving benefits more than 1 mile from a Supermarket



Data Source: USDA, Food Environment Atlas, Year 2019
Analysis Completed by Common Ground Health

Ontario County, Harriet Hollister Park
Photo courtesy of VisitFingerLakes.com

Anecdotal data points to significantly decreased food access and security during the COVID-19 pandemic (March 2020-March 2022). Children who previously received two meals a day at school, were now home with parents who were trying to juggle work, sick family members, remote learning, childcare, and tighter budgets. School districts, churches, civic organizations, the United Way, and local food pantries became a lifeline to tens of thousands of Ontario County residents. From July 2021 to June 2022, Foodlink Inc. served about 3,600 households a month in Ontario County.

The Boys and Girls Club of Geneva estimates they provided 200,000 meals to residents of Geneva during the pandemic with assistance from state funding, the Geneva City School District, and Hobart and William Smith Colleges. During the lockdown (Mar-Aug 2020), 350 breakfasts and 480 dinners were distributed five days a week. From September 2020 to June of 2021, 150 dinners were provided every school day. At this writing, the Boys and Girls Club continues to distribute groceries to 450 families twice a month (1,800 individuals). Of these, 90 are delivered to those unable to attend a drive-thru.

The first year of the upcoming CHIP will focus on assessing the full impact of the pandemic on food access and security in Ontario County and using these findings to forge new partnerships and develop future programming.

## Mental Health & Substance Use Disorders Prevention

The NY State Prevention Agenda Dashboard provides data about depression in adults and adolescents from the National Survey on Drug Use and Health (NSDUH). In the most recent report (2020) the percentage of adolescents who had experienced a depressive episode in the preceding 12 months rose from 4% in 2004-2007 to 8% in 2016-2019. Forty-three percent of youth who experienced depression received treatment. Though this is similar to national trends, it remains unacceptable.[8]

The lack of treatment available to depressed adolescents came as no surprise when mental health providers met as a subcommittee of OCHC in June and July of 2022. What was surprising was the lack of awareness group members (hospitals and health department included) had about programs other than their own. This lack of knowledge applied also to New York State as their Office of Mental Health's Program Finder website noted only four outpatient clinics in Ontario County. Though there is a lack of service providers, this is an obvious under-representation.

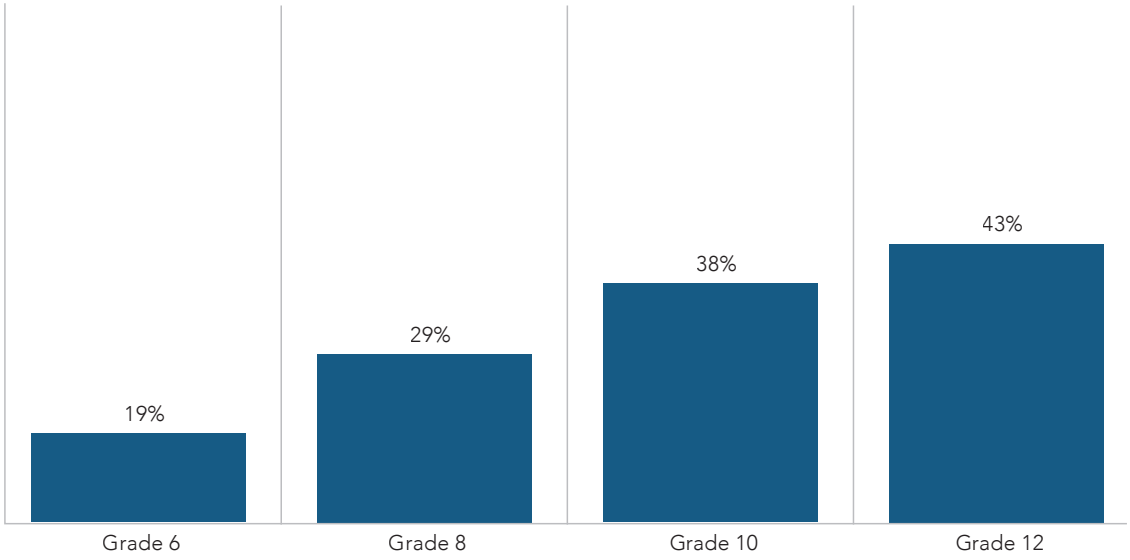
Every two to three years, the Partnership for Ontario County administers the Evalumetrics Youth Survey (EYS) to adolescents during the school day. The EYS is based on the Risk and Protective Factor Model developed at the University of Washington by J. David Hawkins, Richard Catalano, and Janet Miller. Students are queried about depression, substance use, violence, suicidal ideation, family and community attachment, social emotional distress, and adverse childhood events. Self-injurious behaviors and bullying are also included in the survey.

8. Khesht-Masjedi MF, Shokrgozar S, Abdollahi E, Habibi B, Asghari T, Ofoghi RS, Pazhooman S. The relationship between gender, age, anxiety, depression, and academic achievement among teenagers. J Family Med Prim Care. 2019 Mar;8(3):799-804. doi: 10.4103/jfmpc.jfmpc_103_18. PMID: 31041204; PMCID: PMC6482750.

Students from five school districts participated in the 2021 EYS: Bloomfield, Honeoye, Gorham-Middlesex (Marcus Whitman), Midlakes (HS), and Naples. These districts are rural with student censuses between 569 and 1,549, K-12. Of particular concern in the most recent survey were responses surrounding depression, trauma (Adverse Childhood Experiences), and suicidal ideations and attempts.

Of sixth graders, 37% reported feeling sad or depressed most days in the year prior. This jumped to >43% among seniors. Across all grades 40-50% reported their lives "lacked purpose." Undoubtedly, the COVID-19 pandemic contributed to these findings. Though the pandemic was temporary, the effects of isolation, food insecurity, fear/anxiety related to family finances or illness, and lack of reprieve from abusive caregivers could affect this cohort for many years. Additionally, the survey showed many children had experienced more than 2 adverse childhood events (ACEs) in their lifetime. By senior year over 40% reported at least 2 ACEs. Figure O13 shows this data.

## Figure O13: Ontario County Adolescents Reporting more than 2 ACEs

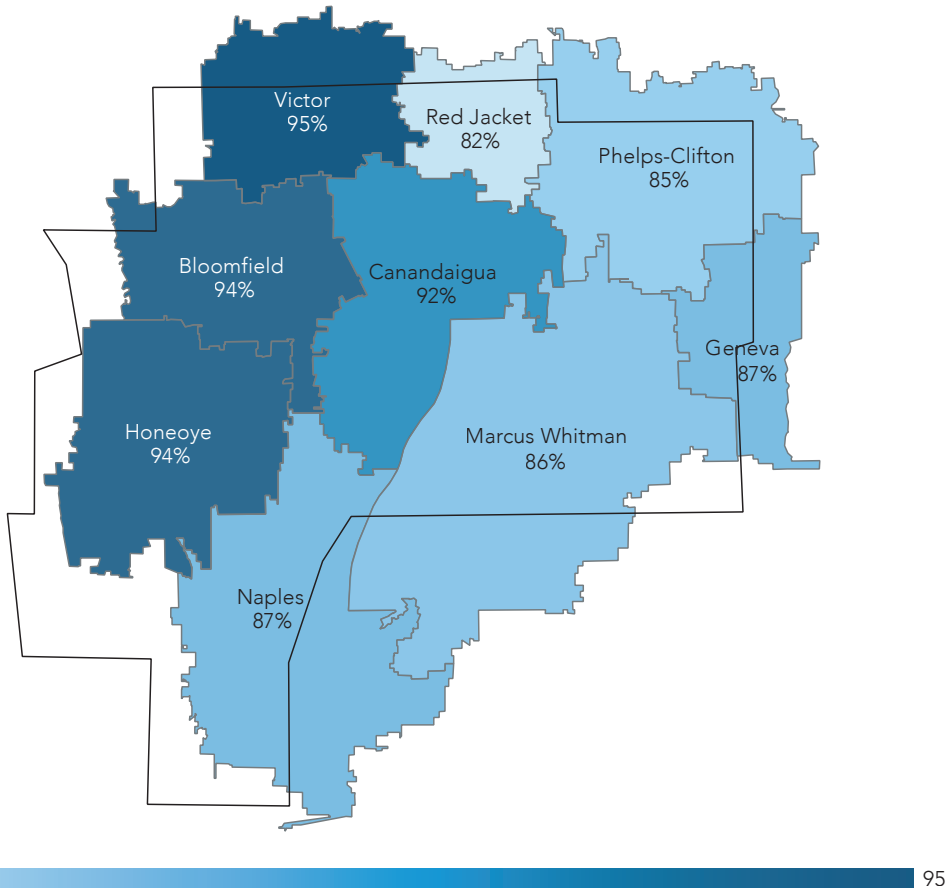



Source: Evalumetrics Youth Risk and Protective Factors Survey, 2021
Analysis Completed by Common Ground Health

Ontario County Courthouse
Photo courtesy of VisitFingerLakes.com

Poor mental health can affect concentration and energy levels, which can hinder academic performance. Research suggests depressed children have lower GPA's and higher dropout rates, which may affect pursuit of advanced degrees or trades, employability, and future earning potential. Additionally, adolescents with a history of two or more ACE's are at increased risk for behavioral issues, which may result in frequent absences and suspensions.[9] Ontario County is home to nine school districts with a mean graduation rate of 89.5%. High school graduation rates decrease as incomes fall moving west to east across the county. Map O14 shows this data.

## Map O14: High School Graduation Rates, Ontario County Districts




Source: New York State Education Department (NYSED), Years 2019-2020
Analysis Completed by Common Ground Health

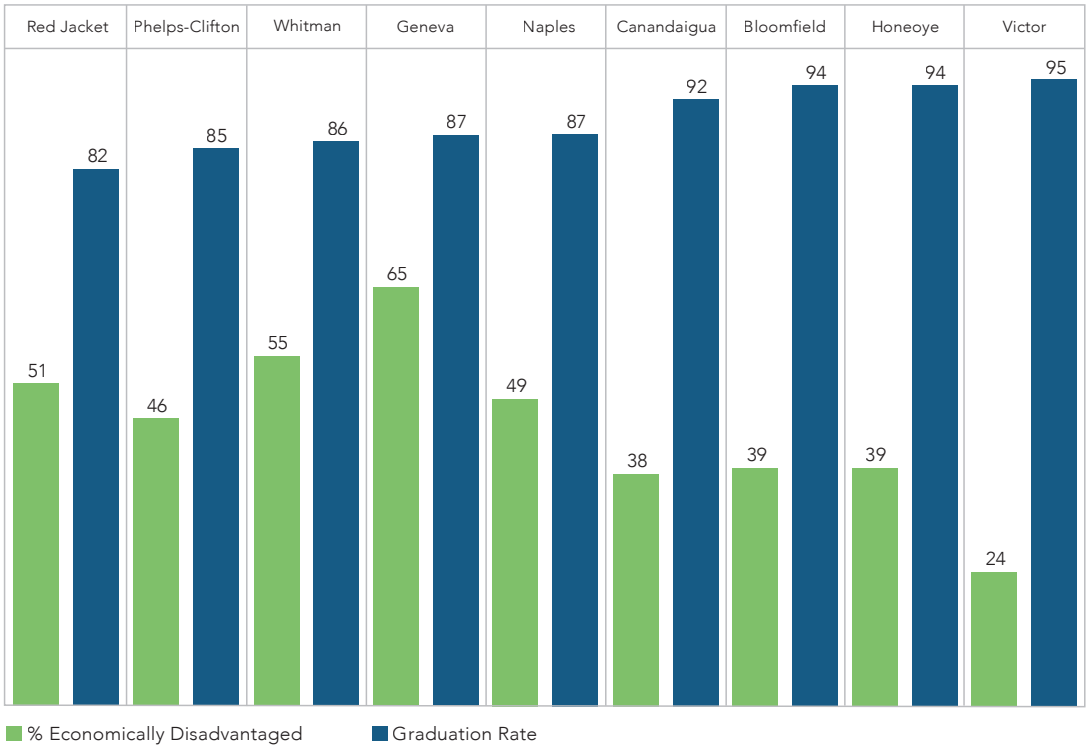


9. Agnafors, S., Barmark, M., Sydsio, G. Mental Health and Academic Performance: A Study on selection and causation effects from childhood to early adulthood. Social psychiatry and psychiatric epidemiology. Retrieved September 19, 2022, from https://pubmed.ncbi.nlm.nih.gov/32813024/

As stated throughout this report, the impact of poverty is widespread on one's health and ability to achieve. Looking at the data for Ontario County, we see that reflected in the graduation rate. Figure O15 shows the correlation between the percent of students who are economically disadvantaged and the district on time graduation rate (students graduating in June of their cohort year).

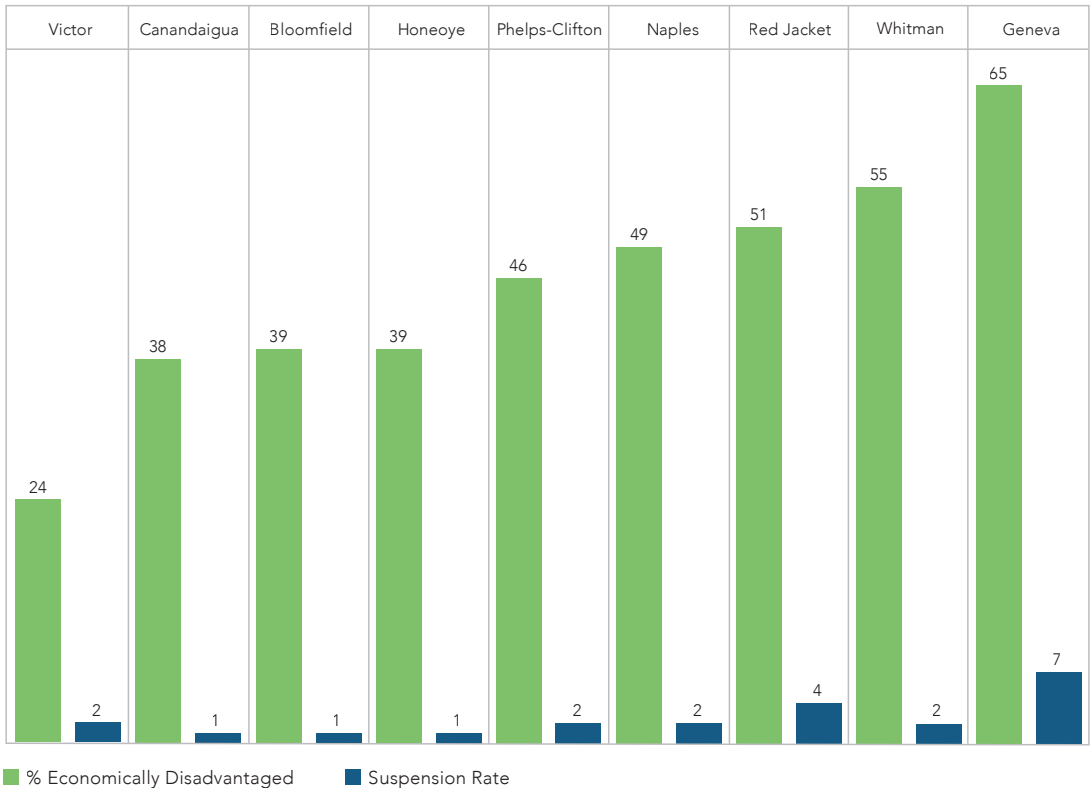
In addition to fewer students graduating, more students are serving suspensions on any given day in districts with higher rates of economically disadvantaged students. (Figure O16) As well as being counter-productive to a child's education, time out of the classroom is isolating and stigmatizing. If the family relies on free breakfasts and lunches, the child may not eat. Parents may be forced to decide between missing work or leaving their child unsupervised and abusive family members from whom the child is free during the school day may be present in the home if the child is suspended.

## Figure O15: Graduation Rate vs. % of Economically Disadvantaged Students




Source: New York State Education Department (NYSED), Years 2018-2019
Analysis Completed by Common Ground Health

## Figure O16: Suspension Rate vs. % of Economically Disadvantaged Students




Source: New York State Education Department (NYSED), Years 2018-2019
Analysis Completed by Common Ground Health

Research has shown that children living in poverty have worse academic achievement, higher school dropout rates, and are at elevated risk for unemployment as adults. They are also more apt to have contact with the criminal justice system than children who never experienced poverty firsthand.[10]

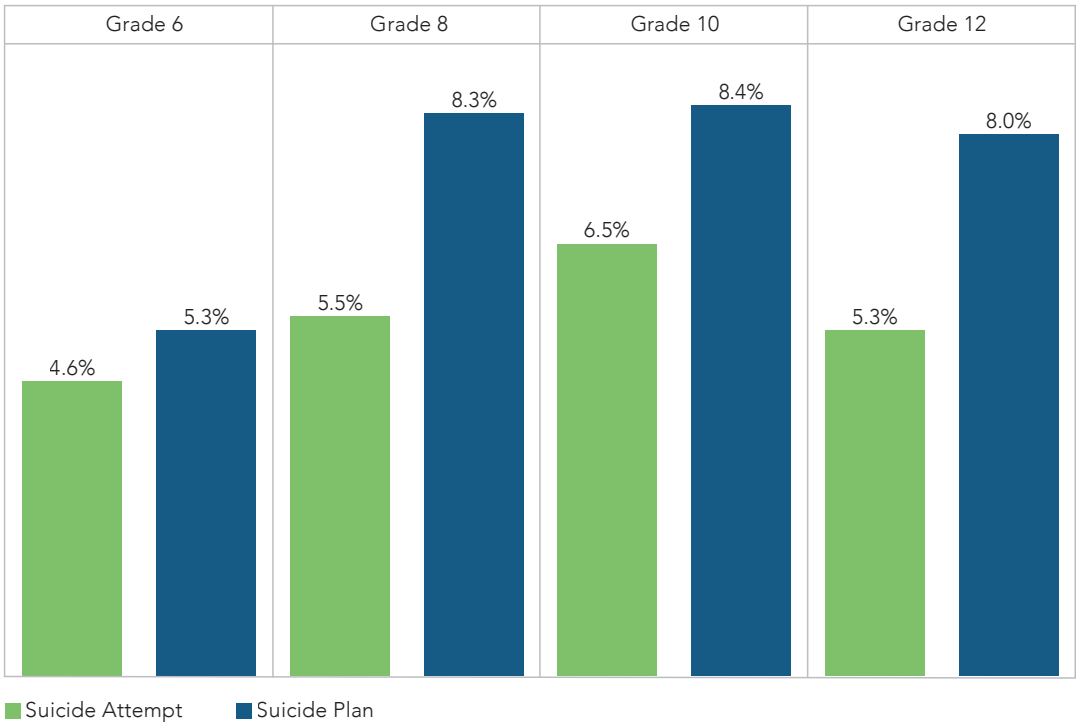
Lack of success in school is a predictor of future low socioeconomic status, higher rates of inadequate housing or homelessness, poor nutrition, lack of access to healthcare, and increased incidence of chronic disease. Poor mental health contributes to lack of success in school with a significant negative correlation between academic achievement and anxiety and depression.[11]

10. The State of America's Children, 2020 Child Poverty

11. Khesht-Masjedi MF, Shokrgozar S, Abdollahi E, Habibi B, Asghari T, Ofoghi RS, Pazhooman S. The relationship between gender, age, anxiety, depression, and academic achievement among teenagers. J Family Med Prim Care. 2019 Mar;8(3):799-804. doi: 10.4103/jfmpc.jfmpc_103_18. PMID: 31041204; PMCID: PMC6482750.

Perhaps the most disturbing data collected by the EYS was regarding suicide. More than 5% of sixth graders and 8% of 8th, 10th and 12th graders reported having a plan in place for taking their own lives (Figure O17). This represents 50-77 Ontario County children from these five, small schools. Additionally, 4.6-6.5% of students in these grade levels had attempted suicide in the previous 12 months.

## Figure O17: Suicidal Ideation and Attempts by Grade Level



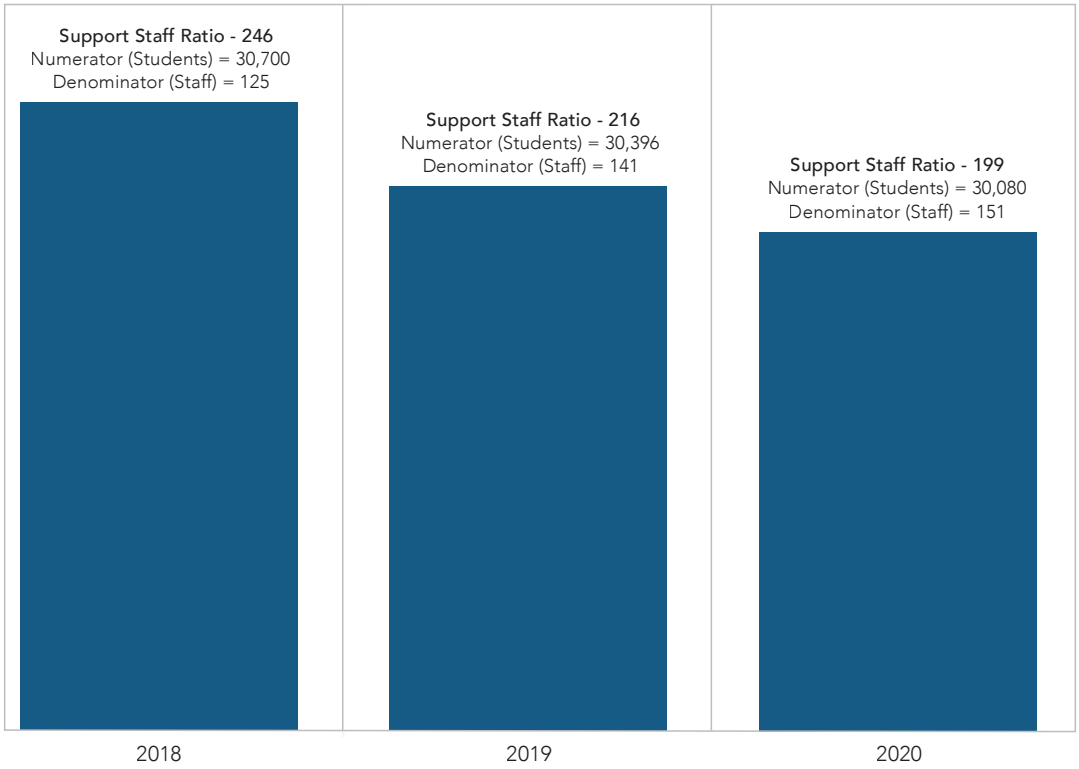

Source: Evalumetrics Youth Risk and Protective Factors Survey, 2021
Analysis Completed by Common Ground Health

In efforts to understand capacity of schools to address mental health issues with students, Common Ground Health compared the number of mental health "support" positions (social workers and counselors) in Ontario County's nine school districts to the number of students enrolled. A Support Staff Ratio metric was created and reflects what a typical caseload would be for these staff members; a lower number being preferable.

Ontario County, Canandaigua Lake in the summer
Photo credit: Rikki van Camp/Bare Bulb Studio

From 2018-2020, there is a promising trend, but potential caseloads remain very large particularly as these same staff members often shoulder the responsibility of completing and maintaining student individualized education programs (IEPs) for their district. Formally trained individuals working for the school cannot meet the mental health needs of all students. Figure O18 shows this data.

## Figure O18: Support Staff Ratio for Ontario County




Data Source: NYSED, Years 2018 – 2020
Analysis Completed by Common Ground Health

New financial streams are available to place trained social workers in schools to provide counseling to students and families. Ontario County Mental Health has hired and placed professionals in one of nine school districts with success. Unfortunately, there are not enough qualified providers in the region to expand this program to other schools. Increasing capacity of schools to address mental health requires a school wide approach that involves teachers, administrators, school resource officers (SRO's), and others.

Why are our children depressed; why do they feel hopeless? When mental health providers met the summer of 2022, they asked themselves this question as part of a root cause analysis. Social factors (lack of community connectedness, social pressures, acceptance by peers, societal norms, standards of beauty, social media, etc.) and family factors (lack of family attachment, blending of families, divorce, poor parenting, family mental health, etc.) were identified as two leading contributors, with lack of availability of services and personal factors ranking third and fourth, respectively. The need is great, mental health services are limited, and waiting lists are long. It is vital to increase capacity of schools to identify and assist children at risk for depression, anxiety, and other mental illnesses.

A community cannot address mental health or chronic disease without first considering the social determinants of health that affect its population. When this is done, the relationships between socioeconomic status, mental health, obesity, and chronic disease become obvious. After completing Ontario County's 2022 Community Health Assessment, partners knew it was imperative to focus interventions upstream: on children and adolescents and their families.

## Community Assets and Resources to be Mobilized

The Finger Lakes Region has two designated agencies that promote and facilitate collaboration: Pivital Public Health Partnership (previously the S2AY Rural Health Network) and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors – hospitals, insurers, universities, business, nonprofit, faith communities and residents – to collaborate on strategies for improving health in the region. Both agencies support efforts of the local health department to improve the health of Ontario County residents.

As already noted, the Ontario County Health Collaborative meets monthly with community partners. During brainstorming sessions between May and August of 2022 partners identified assets and resources within Ontario County that could be mobilized toward selected objectives and interventions. These include relationships and experience with previous CHIP partners, schools, Cornell Cooperative Extension, Boys and Girls Clubs, Youth Club Houses, churches, food pantries and many others.

There is good mental health work being done in the county. OCHC meetings included mental health providers and it is clear there is a vibrant community of concerned and knowledgeable individuals focusing on this work. The programming already in place and the buy-in from this group of professionals places the County in a good position to address the mental health of adolescents in a concerted fashion.

Ontario County has three, small hospitals which is unusual for a rural county. Residents can tap into unique services offered by each facility and receive care locally rather than travelling to large medical centers in surrounding urban counties. Additionally, inpatient mental health and addictions treatment are available and situated across the street from each other in Clifton Springs. Unfortunately, there are no psychiatric inpatient pediatric beds in the county.

COVID-19 brought obvious challenges, but with it came some opportunities. The local health department (LHD) helped schools, daycares, and the community navigate the pandemic. Many relationships were forged and strengthened. Schools relied heavily on the LHD and grew to trust the judgment of its members. Health department staff became intimately familiar with school nurses, superintendents, principals, coaches, and social workers. These will be important allies as we address obesity and mental health in school-aged children. Additionally, the LHD's social media page has a much larger readership than pre-pandemic. There is increased community awareness of the department's roles, responsibilities, and contributions.

Ontario County is scenic and boasts walking trails, lakes, parks, and playgrounds. Most villages and towns maintain their sidewalks and most residents report feeling safe in their community. From a bird's eye view, Ontario County appears affluent and well-situated. Unemployment is relatively low, most people own their own home, schools perform well on average, healthcare is accessible, and unlike most other NY counties, Ontario County is growing. Additionally, community leaders and municipalities are supportive of the work of the health department, which is fully staffed and high functioning. The devil, of course, is in the details: our pockets of poverty and food insecurity, inferior rental properties, childhood obesity, depression among our teens.

Over the course of the next three years, we'll work together as a community to mitigate our challenges, address our disparities, and leverage our resources as we implement our CHIP/CSP.

## Community Health Improvement Plan/Community Service Plan

As previously noted in Main Health Challenges, group discussion and consensus were used to select priority areas for Ontario County's Community Health Improvement Plan/Community Services Plan. Once priority areas were chosen, additional targeted data were acquired and presented to partners as they delineated objectives, identified disparities, and considered interventions. During OCHC meetings, partners were asked to identify interventions already in place as well as those that would be feasible to initiate, sustain, and measure. Input was compiled and summarized by LHD staff and a list of interventions, contributing partners, and family of measures was presented to partners on 9/8/2022. This first draft of the CHIP was accepted by group members with minimal additions. Health department staff will make necessary adjustments and finalize this document after which time hospital partners will present it to their boards.

A full description of objectives, interventions, process measures, partner roles and resources are available in the Ontario County Community Health Improvement Plan Appendix. All interventions selected are evidence based or evidence-informed and strive to achieve health equity by targeting residents of low socioeconomic status.

OCHC is a diverse array of people who meet together monthly. Some are professionals who work in the community, some represent community-based organizations, and some are community members who have hearts for public health. Each partner provides a unique voice that resonates from their experiences with the populations they serve.

Our three hospitals keep partners abreast of the status of healthcare delivery and education in the county. Food Justice of Geneva, Inc. provides fresh fruits and vegetables to low-income individuals via neighborhood food boxes, churches, and food pantries. They provide perspective on the Geneva community and the food desert that exists there. Office for the Aging helps group members understand the unique struggles of older residents on fixed incomes. College health center staff remind us that community college students are often adult learners juggling jobs, families, and finances. They may be having to choose between tuition and groceries. Family Promise provides emergency housing for families and offers a glimpse into the changing face of homelessness. Community members and clergy who provide emergency food tell us that food insecurity is common, even in a community where most people own their own home. Agri-Business Child Development reminds partners that Ontario County is a farming community, and we need to take care of those who plant, tend, and harvest our fruits and vegetables. Mental health practitioners help us understand how mental illness affects everything: relationships, education, employability, homelessness, drug and alcohol use, physical health, etc. Without these partners and others, it would be impossible to undertake a CHA, create a CHIP/CSP, and identify our most vulnerable residents who might otherwise being overlooked.

In addition to providing expertise, perspective, and representation, CHIP/CSP partners provide quarterly updates on interventions and outcomes. The LHD organizes this information and provides a report to OCHC partners quarterly, and to New York State, annually. Over the course of the next three years, group members will undertake interventions via their own organizations, support OCHC partners' programming through expertise and advertising, assess each other's progress, celebrate successes, and adjust the CHIP/CSP, as needed.

### The following organizations were engaged in Ontario County's planning and prioritization process:

| ONTARIO COUTY PLANNING AND PRIORITIZATION AGENCIES | | |
|---|---|---|
| Agri Business Child Development | ARC of Ontario | Canandaigua Churches in Action |
| Cancer Services Partnership | Clifton Springs Behavioral Health Rochester | Rochester Regional Health Clifton Springs Hospital |
| Common Ground Health | Cornell Cooperative Extension | Council on Alcoholism and Addiction of the Finger Lakes (CAAFL) |
| Family Promise | Finger Lakes Community College | Finger Lakes Community Health |
| Geneva General Hospital and Soldiers and Sailors Memorial Hospital (Finger Lakes Health) | Finger Lakes WIC | FL Area Counseling and Recovery Agency (FLACRA) |
| Food Justice of Geneva, Inc. | Helio Health | Lifespan |
| Lions Club | Ontario County Office for the Aging | Ontario County Mental Health |
| Ontario County Public Health | Ontario County Youth Bureau | SNAP Ed |
| Partnership for Ontario County | Pivital Public Health Partnership | SPOA |
| UR Medicine Center for Community Health & Prevention | UR Medicine Thompson Health | UR Medicine Wilmot Cancer Center |
| Tobacco Action Coalition of the Finger Lakes | | |

## Dissemination

On behalf of the Ontario County Health Collaborative, Ontario County Public Health will share the Community Health Assessment and the CHIP/CSP documents with Ontario County's governing body (Board of Supervisors via Health and Human Services Standing Committee) and with the community via its website and social media platforms:

- Website: https://ontariocountyny.gov/904/Community-Health-Improvement-Plan
- Facebook: https://www.facebook.com/OCPHealth

# APPENDIX 1

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# APPENDIX 2

## RESULTS-BASED ACCOUNTABILITY™

Results-Based Accountability™ is a disciplined way of thinking and acting to improve entrenched and complex social problems.[12] To facilitate CHA/CHIP development, resulting in a CHIP that measurably improves health, the following steps were followed:

1. **Define the Community:** Data collection is an important first step. In this step, it is important to gather data for the community at large (county-level data) as well as data that identified vulnerable populations within the community who are at risk for poorer health outcomes. This can happen by collecting and analyzing data that shows differences in rates of illness, death, chronic conditions and more in relationship to demographic factors. The planning committee brainstormed specific potential vulnerable populations in the county to be considered with data collection.
2. **Engage Stakeholders:** Population health requires engagement from many sectors. Complex social, economic and environmental factors are all determinants of health; therefore, there is no one organization, department or program that can be held solely responsible for the health of a population. Diverse engagement began in November/December 2021, early in the CHA development process. Committee partners completed an exercise to brainstorm potential new partners from the following sectors: Local Government, Businesses, Not-for-Profit and Community Organizations, Academia and the General Public. The following questions were used to assist brainstorming:
   - Who are those with potential interest and influence who can contribute to the CHA/CHIP process?
   - What population do they represent? (including vulnerable populations identified in Step 1)
   - Identify their potential level of interest and influence (High Interest/High Influence, Low Interest/ High Influence, High Interest/Low Influence, Low Influence/Low Interest)
   - Who would be the best person on the committee to extend an invitation to the selected potential new partner?

After an assessment of brainstormed information, personal invitations were made to selected potential new partners to address any gaps on the committee and the need for diverse engagement.

3. **Engage in Comprehensive Data Collection:** Both primary and secondary data were collected. Disaggregated data was collected by race, gender, income and geography as available to identify vulnerable populations and to assist in strategy development. Data sources included, but were not limited to:
   - Common Ground Health: My Health Story
   - County Health Rankings
   - Vital Statistics
   - Behavioral Risk Factor Surveillance Survey (BRFSS)
   - United States Census Bureau
   - Cornell University Program on Applied Demographics
   - Statewide Planning and Research Cooperative System (SPARCS)
   - New York State Department of Health Perinatal Data Profile
   - S2AY Rural Health Network Inc,: The Impact of COVID-19 on Food Security and Healthy Eating
   - Outreach to county committee partners for data from their respective organizations.

 12. Results-Based Accountability - Overview and Guide (clearimpact.com)

4. **Prioritize Health Issues:** Data was analyzed and presented by Common Ground Health. After a review of analyzed health outcome data for trends, current state against benchmarks or Prevention Agenda targets, and differences among populations, a multi-voting tool was used by committee members to rank the health issues using selected criteria to identify top Focus Areas, which identified Prevention Agenda Priority Areas.
5. **A Deeper Dive of data was conducted by Common Ground Health.** To enhance the picture of the selected Focus Areas, related Prevention Agenda objective data was presented. A table with objectives and their status colors was created to help with the selection of objectives for this CHA/CHIP cycle.
   - Green Status – the prevention goal metric has been met and the trend of that metric is in the correct direction of the goal or steady
   - Yellow Status – either the prevention goal has not been met but the trend is in the correct direction or the goal has been met but the trend is in the wrong direction
   - Red Status – the goal has not been met and the trend is in the wrong direction
   - Gray Status – there is limited data on this metric available at this time

In addition, person, place and time was analyzed:

- **Person** - Are there certain populations at higher risk for poor outcomes? For example, are outcomes different based on age, race/ethnicity, education, or socio-economic status?
- **Place** - Are the outcomes in the county higher or lower than neighboring counties and the rest of the state? Are there high-risk neighborhoods in the county?
- **Time** - Do the trends over time show the outcomes improving, remaining the same, or declining?

If multiple objectives were identified, additional consideration was given to objectives that may have a greater impact on long term health and also have a good chance of positively impacting other objective indicators.

6. **Develop the Story Behind the Data:** Understanding the story behind the data ("WHY" the data looks the way it does) contributes to an increased understanding of the factors that impact the current state, as well as identifies contributing causes and potential solutions designed to have maximum impact. Results-Based Accountability's *Turn the Curve Thinking* was conducted for selected CHIP objectives/indicators to examine:
   - What is the story? What are the contributing causes to the trend of the selected CHIP objectives, including behavioral, environmental, policy and social determinant of health factors? 5 WHYS was conducted to help identify root causes.
   - Who are the partners that have a role in impacting contributing causes? What community assets or resources can be mobilized to impact identified causes?
   - What works to address identified contributing causes (including evidenced based interventions)?

*Turn the Curve Thinking* also determined a data development agenda, where counties identified if any additional data was needed on selected objectives and/or disparities, as well as a plan on how to collect that data.

7. **Select CHIP Interventions:** Upon completion of *Turn the Curve Thinking*, criteria was used to select interventions that will be included on the CHIP. Criteria used included:
   - How strongly will the proposed strategy impact progress as measured by the baselines?
   - Is the proposed strategy feasible?
   - Is it specific enough to be implemented?
   - Is the strategy consistent with the values of the community and/or agency?

*Turn the Curve Thinking* resulted in interventions which were linked with contributing causes and partners who could have an impact. It is our goal that, with successful implementation of diverse strategies by diverse partners, there will be a collective impact on *Turning the Curve* for the better on our CHIP objectives.

8. **Engage in Continuous Improvement:** To effectively monitor progress and effectiveness of each organization's contribution to selected CHIP objectives, intervention performance measures were identified that answer the questions:
   - How much did we do?
   - How well did we do it?
   - Is anyone better off?

Monitoring these intervention specific performance measures will identify if any focused quality improvement projects are required to improve intervention effectiveness and/or if revisions to CHIP interventions are required.

# SCHUYLER COUNTY

| COUNTY NAME: | SCHUYLER COUNTY |
|---|---|
| Participating local health department and contact information: | Schuyler County Public Health<br>Jill Kasprzyk<br>Director of Public Health<br>jkasprzyk@co.schuyler.ny.us<br>607-535-8140 |
| Participating Hospital/ Hospital System(s) and contact information: | Schuyler Hospital<br>Christina Brink<br>Executive Director, Clinical and Nursing Operations<br>brinkc@schuylerhospital.org |
| Name of entity completing assessment on behalf of participating counties/ hospitals: | Common Ground Health<br>Zoë Mahlum<br>Health Planning Research Analyst<br>zoe.mahlum@commongroundhealth.org<br>585-224-3139 |

Schuyler County, Watkins Glen
Photo courtesy of Elizabeth Watson

# EXECUTIVE SUMMARY

Through the use of Results-Based Accountability, Schuyler County in partnership with Schuyler Hospital has chosen to focus their 2022-2024 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) on the following priority areas, with the low income population as their identified disparity to address.

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Preventive care and management |
| **Disparity** | **Low income population** |

The Schuyler County CHA/CHIP team, a group of diverse partners who span all sectors of the community, participated in the prioritization process and disparity and intervention identification. While a complete list of partners is available within the Schuyler County Chapter under "Community Health Improvement Plan/Community Service Plan," agencies present represented academia, not-for-profits and community organizations, businesses, the general public, and local government. They included the Schuyler County Public Health Department, Schuyler Hospital, Cancer Services Program, Mental Health, MR Hess Home Works, and more. Partners' roles in the assessment were to help inform and select the 2022-2024 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings. Community members were involved in the 2018 My Health Story survey, and inclusion of community was considered as part of the oversight committee. The 2022 My Health Story survey took place in the summer and fall of 2022, and this will help gain community insight on key health matters in the county and surrounding areas. Both primary and secondary data were reviewed including, but not limited to, the US Census Bureau American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, data collected from Pivital Public Health Partnership (formerly known as S2AY Rural Health Network) and Common Ground Health's My Health Story 2018 survey, 2-1-1 Helpline, and the Statewide Planning and Research Cooperative System (SPARCS).

The process of Results-Based Accountability included evaluation of a pre-read document, which contained detailed county-specific analyses related to the five Prevention Agenda priority areas, followed by a multi-voting technique to select the priority areas. Participants were asked to consult with other members of their organizations and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Partners came to a consensus to address the top priority areas identified by the survey, then additional county-specific data was collected, shared and evaluated to help determine which objectives, disparity, and interventions should be selected. The selected objectives are:

- 2.2.3 Reduce the opioid analgesics prescription for pain, age-adjusted rate by 5% to 350.0 per 1,000 population
- 2.4.1: Reduce the past year prevalence of major depressive episode among adults aged 18 or older by 5% to no more than 6.2%. - Tracking Indicator
- 2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000.
- 4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines
- 4.1.3 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years)

A complete list of goals, objects and interventions and process measures is available in the CHIP.

The Schuyler County CHA/CHIP team, outside of CHA/CHIP development, meets bi-monthly to improve the health of Schuyler residents and will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings. Partners and the community will continue to be engaged and apprised of progress via these meetings.

Hector Falls, Schuyler County
Photo credit: iStock.com/Different_Brian

# PLANNING AND PRIORITIZATION PROCESS

Schuyler County followed a process called Results-Based Accountability to develop their needs assessment and improvement plans. There are several components to Results-Based Accountability, some of which include defining the community, engagement of a diverse group of stakeholders (including organizations representing underserved, low-income and minority populations), data collection and analysis, prioritization of health issues and disparity identification, and discussion of root causes for selected health issues to help identify appropriate and effective interventions. For additional information on Results-Based Accountability, this process is described in its entirety in Appendix 2. To pinpoint root causes of selected health concerns, the committee evaluated behavioral, environmental, social determinants of health, and policy causes that may be contributing to the current status of those concerns.

As demonstrated in the health indicator section, each county's residents face their own unique and challenging issues when it comes to their community, yet commonalities remain. There are a number of demographic and socioeconomic indicators which may impact health and are consistent concerns across the region. For example:

## AGE:

Variances in age can impact a community's health status. Older adults require more frequent medical check-ins, are more prone to illness, falls and unintentional injuries, and often experience more co-morbid conditions than younger adults and children. In addition, aging adults may not have access to a vehicle and rely on family, friends or public transportation for accessing basic needs and medical appointments. The strain of caring for an elderly adult may also negatively affect the caregiver. A community with higher rates of elderly adults may have worse reported health outcomes than a younger community.

## POVERTY:

Low income residents are more likely to experience a breadth of health issues not seen as often in wealthier residents. For example, lower socioeconomic status is linked to higher incidence of chronic disease, shorter life expectancy, and lower rates of good social, emotional and physical health. Low income may also force a person to choose between basic needs (such as housing, food, clothing, etc.) and preventative medical care. Often, and not surprisingly, the person will choose the basic need over preventative medical care. A community with higher rates of impoverished residents is likely to have worse health outcomes than wealthier communities.

## EDUCATION:

Education levels have been known to be a predictor of life expectancy. The Centers for Disease Control and Prevention reports that adults aged 25 without a high school diploma can expect to die nine years sooner than college graduates. Persons who attain higher education levels are more likely to seek health care, preventative care services, and earn higher wages. A more educated community may, therefore, have better health outcomes than a low educated community.

## HOUSING:

Access to quality and affordable housing is imperative to ensuring basic needs are met. Housing structures that are safe, clean, up to code and affordable help to improve community health. When incomes are consumed on rent or mortgages, residents may lack funds for preventative care services, medications, and healthy foods. Additionally, outdated, substandard housing puts tenants at risk for asthma and lead poisoning (especially children).

Each of the above indicators impacts the health of the community. The next section takes a closer look at these demographic and socioeconomic indicators and also includes a review of behavioral and political environments in Schuyler County that impact the health of its residents. Finally, the section will highlight the community's assets and resources that may be leveraged to improve health through identified evidence-based interventions.

# COUNTY CHAPTER – SCHUYLER COUNTY

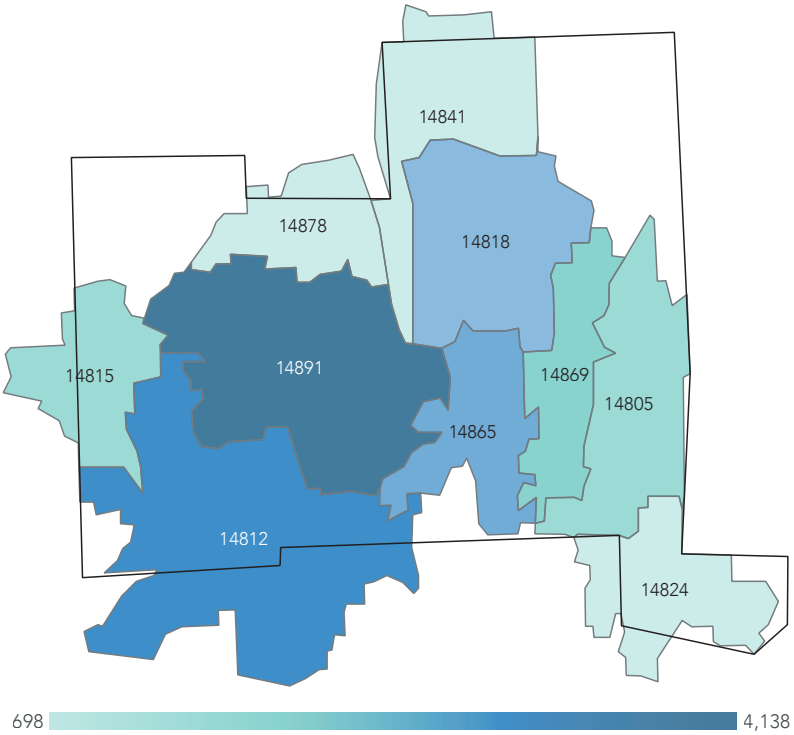
## Demographic and Socioeconomic Health Indicators

Schuyler County is located in the southern portion of the Finger Lakes Region, at the base of Seneca Lake. It is home to the popular state park, Watkins Glen, which attracts both residents and tourists. There are 17,898 total residents spread throughout the county, but areas with the densest population include the Village of Watkins Glen (ZIP code 14891, population 4,138) and Beaver Dams (ZIP code 14812, population 3,149) (Map SC1). The population is primarily white non-Hispanic (95%), followed by the black non-Hispanic (2%), Hispanic (2%), and other racial and ethical groups (1%), respectively. Of note, there is a congregation of Amish and Mennonite families who reside in the county; the 2022 Old Groffdale and Midwest Horse and Buggy map shows approximately 32 households in Schuyler County (yet does not capture the driving Mennonite population). The cultural implications that this population has on the Schuyler County community must be considered when analyzing and reviewing any of the data contained in the chapter. The population often turns to natural and homeopathic medicine when it comes to family planning, preventative and dental care, vaccinations, etc. Children also only attend school through the eighth grade before turning to farming and other trades to support their families. These cultural practices directly influence the public health assessments; examples include health insurance estimates, educational attainment, poverty, vaccination rates, prenatal care, and more. Additionally, women of childbearing age (aged 15 to 50 years) comprise approximately 20% of the population, and about 18% of individuals are living with some form of disability.[1]

Schuyler County, Catherine Creek
Photo courtesy of Elizabeth Watson

1. American Community Survey (ACS) 2019 5-Year Estimates

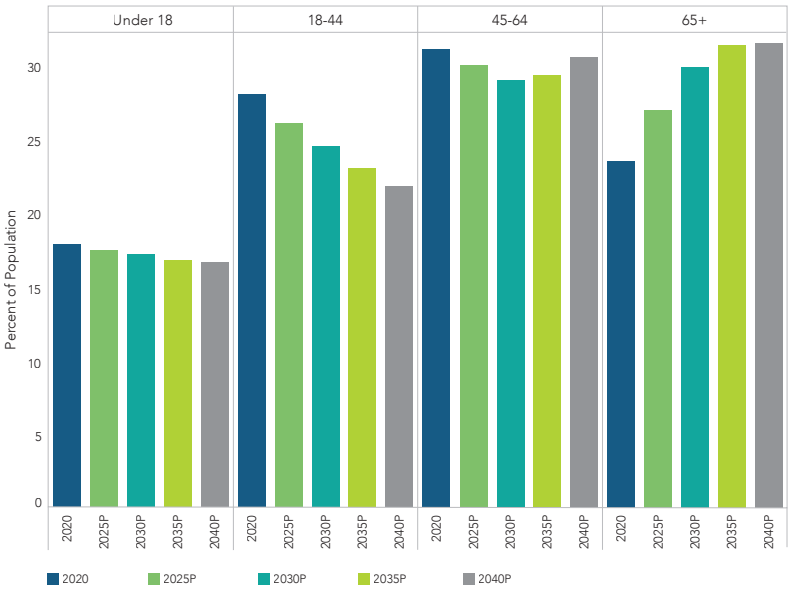
## Map SC1: Schuyler County Population by ZIP Code




Source: Claritas zip-level estimates and CDC Bridged-Race county-level estimates, Year 2020. Population data and allocation methods developed by Common Ground Health.

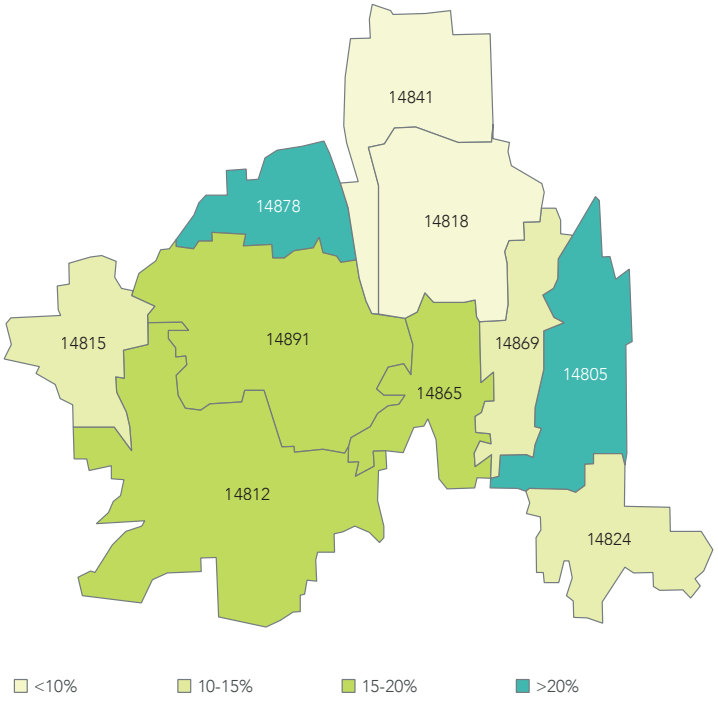
The majority of residents living with a disability in Schuyler County are 65 years of age or older (about 70%). The three types of disabilities most prevalent to this age group are independent living difficulty (about 13%), hearing difficulty (about 15%), and ambulatory difficulty (about 20%). Additionally, around 27% of the population aged 65 years or older are living alone, which may increase the potential of loneliness and emotional challenges, falls and physical safety difficulties, and financial difficulties. Population projections from Cornell University's Program on Applied Demographics (Figure SC2) show that the largest age group within Schuyler County currently are the residents aged 45-64, followed by the 18-44 age bracket. Based on the current population age structure we can infer that, within the next few decades, the 18-44 population will decrease and the 65+ population is expected to grow. As the 65+ population grows, there will be a greater demand on health care services, including chronic disease management and geriatric care.

## Figure SC2: Population Projections for Schuyler County




Source: Cornell University - Program on Applied Demographics, County Projections Explorer, Year 2020
Analysis Completed by Common Ground Health

## Map SC3: Percent of Population Living in Poverty

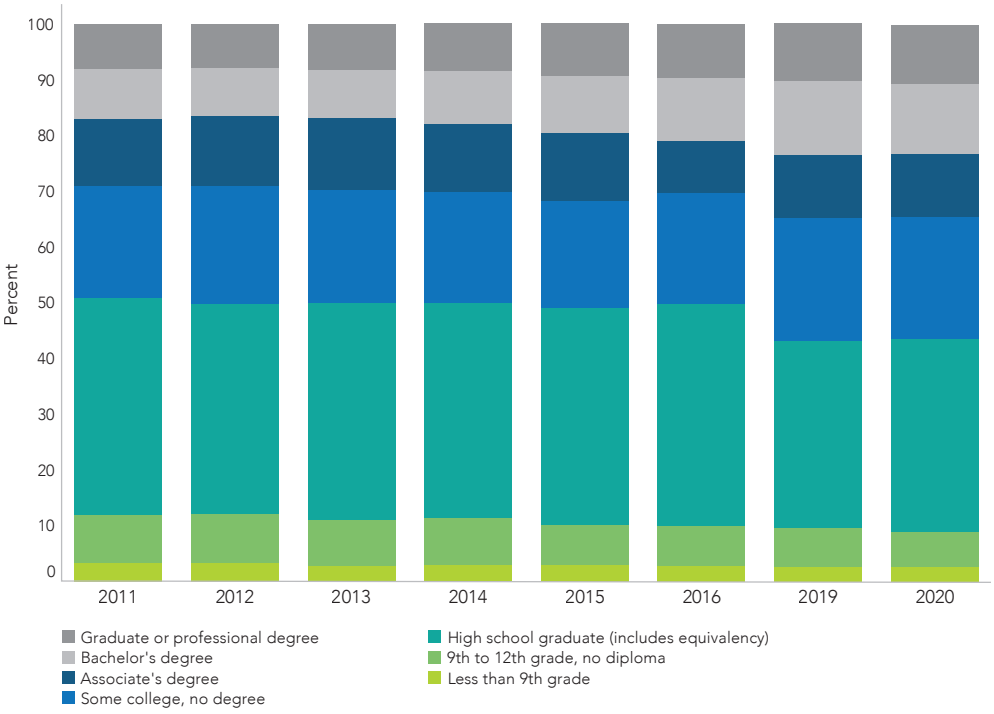



Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

An estimated 1 in 6.5 individuals (about 15%) within Schuyler County is living below the poverty level. As shown in Map SC3, the highest poverty rates are seen within Rock Stream (14878, about 21% of the population) and Alpine (14805, about 23% of the population). Moreover, the most densely populated area (Watkins Glen, Beavers Dam, and Montour Falls) falls within the second highest poverty rate bracket (about 15%, about 15%, and about 19% respectively) in Schuyler County.

As seen in Figure SC4, educational attainment within Schuyler County has experienced a few slight improvements over recent years. From 2015 to 2020, the percent of residents who either graduated high school (or equivalency) or had a lower level of educational attainment decreased by about 6% (from about 49% to about 44%).

## Figure SC4: Educational Attainment of Residents Aged 25+



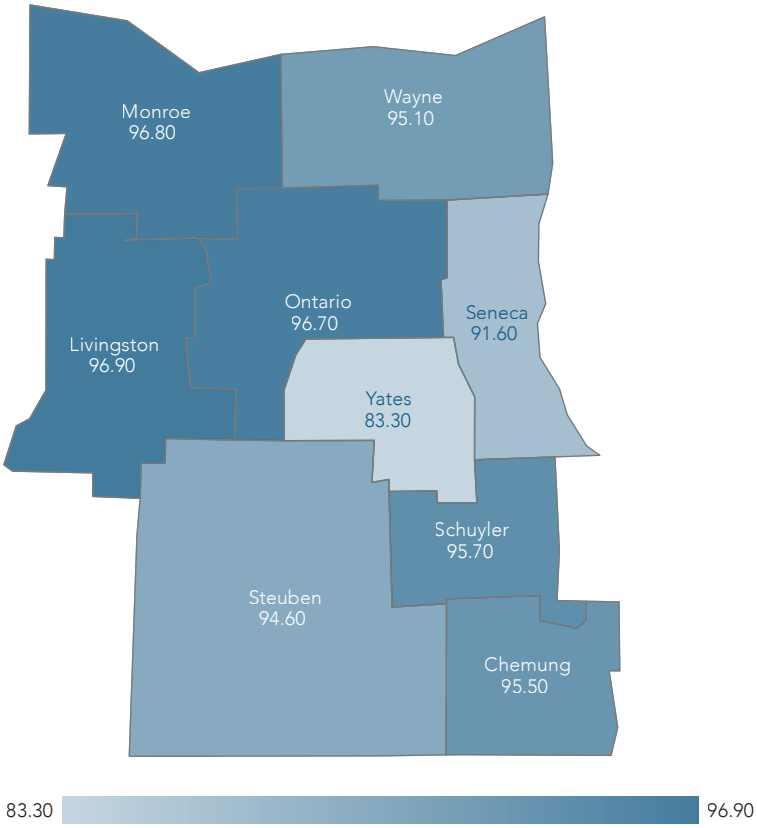

Data Source: US Census Bureau, American Community Survey (ACS), Year 2020.
Analysis Completed by Common Ground Health

On the other hand, the percentage of those who participated in some college (with no degree) increased by about 3% and residents with higher education (associates, bachelors, or graduate/ professional degree) increased by about 3%. This can positively affect the community as higher educational attainment generally equates to greater health outcomes.[2]



2. Hahn, R. A., & Truman, B. I. (2015). Education Improves Public Health and Promotes Health Equity. International journal of health services: planning, administration, evaluation, 45(4), 657–678. https://doi.org/10.1177/0020731415585986

## Map SC5: Percent of Population with Health Insurance




Source: US Census Bureau, ACS, Year 2020
Analysis Completed by Common Ground Health

Availability and accessibility to providers are equally important considerations regarding accessing healthcare. The Department of Health and Human Services states that nearly 32% of Schuyler County is living within a health professional shortage area (HPSA) compare to 27% of New York State residents. For each segment of health listed below, providers tend to be centered in Watkins Glen or on the perimeter of Seneca Lake. However, the majority of dental health, mental health, nurse practitioners and primary care providers in Schuyler County are on the local transit schedule, and there is also a Dial to Ride program that brings residents to providers as well. However, Schuyler County does not have any birthplaces. Labor and delivery occur outside of Schuyler County, with greater transportation barriers to accessing services.

**Dental Health Providers:** Dental health providers are available at a rate of 2.8 per 10,000 population[3] within Schuyler County, which is lower than New York State's rate of 3.7.

**Mental Health Providers:** Schuyler County has a ratio of one mental health provider to 540 residents, if all residents were divided evenly among providers. This is compared to a ratio of one provider to 310 residents for New York State.[4] Mental health providers are defined here, as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care.

**Nurse Practitioners:** Nurse practitioners are accessible at a rate of 1.7 providers per 10,000 population, which is approximately half the rate of New York State (3.5).

**Primary Care Providers**: Though still below New York State's rate of 10.9 providers per 10,000 population, primary care providers are more plentiful than nurse practitioners within Schuyler County at a rate of 10.0. Primary care providers play a critical role in preventive services and screenings.


3. Centers for Medicare and Medicaid Services, CMS – National Plan and Provider Enumeration System (NPPES), 2021
4. 2022 County Health Rankings (using 2021 data for this measure)

With regard to housing, about 25% of residents rent versus own their home. The average household size is greater than two people for both renter- and owner-occupied units. Of note, about 40% of residents are paying 35% or more of their household income in rent costs, which is considered an overburdened household. The demand for available housing to own and rent is high in Schuyler County because the housing stock is insufficient (across all market segments – high, medium and low income), poor quality of housing, conversion of long term housing into short term vacation rentals, and long term housing is used as vacation (second) homes.[5] The seasonal vacancy rate for Schuyler County is 16.7%, indicating many vacation or second homes.[6] The Village of Watkins Glen adopted a zoning law in January 2022 to cap the amount of short-term vacation rentals within the Village of Watkins Glen, to help maintain permanent housing for long-term residents.[7] Other communities in Schuyler County are looking into if they have to have a similar zoning law. Private developers in Schuyler County have also converted and built some housing, but this has not helped decrease the demand for long-term housing for residents.

Out of all occupied housing units, about 6% have no vehicles available and an additional 34% have access to one vehicle. Schuyler County Transit Transportation Link-Line noted some challenges with regard to transportation throughout the county for residents: 1) buses run Monday through Friday but not on the weekends; 2) most bus routes run until 6 PM but there have been requests for later routes; 3) rural locations that are spread out throughout the county present a logistical and economical challenge with regard to how to best serve residents. More funding is needed to be able to expand these routes. Meanwhile, Schuyler County has limited coverage by local taxis, Lyft and Uber. Dial to Ride is available to residents, but has limited hours and days of operation.

## Main Health Challenges

On February 10, 2022, a diverse group of stakeholders, representing various aspects of the community as well as underserved and minority populations, were invited to attend a health priority setting meeting (a complete list of stakeholders can be found in the Community Health Improvement Plan/ Community Service Plan section). At this meeting, participants reviewed the overarching goals of the New York State Prevention Agenda and relevant qualitative, quantitative, primary and secondary data. A pre-read document containing detailed county specific analyses relating to the five Prevention Agenda priority areas was sent to all participants for review in advance. Primary and secondary data were collected from a variety of sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, Pivital Public Health Partnership (previously S2AY Rural Health Network), Common Ground Health's My Health Story survey, and 211 Helpline. My Health Story 2018 was a regional survey completed on behalf of nine counties in the Finger Lakes Region. Its primary purpose was to gather qualitative and quantitative data from Finger Lakes Region residents on health issues in each county. Health departments, hospitals and other local partners were instrumental in distributing the survey to community members including disparate populations. The survey was updated in the summer and fall of 2022 and will be used to help inform potential shifts in strategies to improve the priority areas selected by Schuyler County.

5. Schuyler Countywide Comprehensive Plan Amended June 2015
6. National Association of Counties (NACo), Housing Solutions Matchmaker Tool – A Diagnostic Tool for Local Officials, March 2022
7. Village of Watkins Glen Zoning Law, NY, Section 23.17 Short Term Rentals (STRS), January 18, 2022

After initial review of the priority areas, a multi-voting technique was used to select the priority areas. Participants were asked to consult with other members of their organization and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Schuyler County had fifteen members from their committee participate in the survey. As a result, the following areas were selected for the 2022-2024 Community Health Improvement Plan:

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Preventive care and management |
| **Disparity** | **Low income** |

Following this selection, Common Ground Health gathered data on all objectives from the New York State Prevention Agenda within the chosen priority areas, including data that identified differences in health status and health behavior rates among demographic and geographic factors, as available. Objectives were color coded based on data status to help focus attention where it was needed most; red objectives were neither meeting the Prevention Agenda goal nor trending in a favorable direction, yellow objectives were either not meeting the Prevention Agenda goal or not trending in a favorable direction, and green objectives had both met the goal as well as trended in a favorable direction. Objectives that were color coded as gray represented a lack of current and/or reliable data. Color coded data on objectives were presented to the team during April's CHA/CHIP meeting and partners utilized the data, as well as potential scope and interest of the group, to determine which objectives they would pursue. Color-coding of selected objectives can be found in the appendix.

## Risk and Protective Factors Contributing to Health Status

Schuyler County has selected two focus areas on which to anchor their 2022-2024 Community Health Improvement Plan. This section will take a closer look at the behavioral, environmental, political and unique risk and protective factors contributing to the health status of those areas.

**Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders**

**Prevent Mental and Substance Use Disorders**

The opioid overdose epidemic has been a significant public health concern for several decades now. The CDC stated that the number of drug overdose deaths has quadrupled since 1999,[8] and provisional data from November 2021 showed an estimated 100,306 drug overdose deaths in the United States from April 2020-April 2021. This represented an approximately 29% increase from the previous year.[9] One method of decreasing access and, therefore, possible addiction and adverse outcomes, is by prescribing less opioid analgesics and utilizing other options for pain management instead. Trended data for Schuyler County showed a rate of 688.3 opioid analgesic prescriptions per 1,000 population in 2012 compared to 422.1 per 1,000 population in 2020, decreasing by about 39%. In 2020, the opioid analgesic prescription rate in Schuyler County is nearly 1.2 times higher[10] than in the Finger Lakes Region (349.5 per 1,000 population) and New York State, excluding New York City (342.6 per 1,000 population).

8. CDC: Understanding the Opioid Overdose Epidemic, March 2021
9. CDC: Drug Overdose Deaths in the US Top 100,000 Annually, November 2021
10. New York State Department of Health – Opioid Data Dashboard (County Level: Schuyler County)

The rate consistently decreased within Schuyler County between 2012-2020, which is a positive feat that community partners attribute to initiatives taken within the county. First, primary care clinic patients sign a drug contract before beginning any controlled medications, which helps to inform the patient about the medication as well as hold them accountable for its use. Most prescribers are also required to consult the Prescription Monitoring Program Registry when writing scripts for controlled substances as part of the I-STOP Program, which helps them to identify patient treatment history and any red flags for substance abuse.[11] Secondly, providers are now recommending either physical therapy or alternative pain medications as first line of therapy as opposed to opioid analgesics. Additionally, insurance companies are limiting scripts for seven days, making it more difficult for patients to get access, and pharmacies have a policy in place that they cannot switch the prescription to another pharmacy but rather the prescriber would need to do so. Beginning in the spring of 2022, Schuyler Hospital began using an opioid risk assessment tool as well.

While there are already effective interventions in place which have helped to decrease the rate of opioid analgesic prescriptions over the past decade, the rate still remains above the Prevention Agenda goal of 350 prescriptions per 1,000 population. Areas where community partners identified continued challenges with further decreasing opioid analgesic prescriptions included certain diagnoses that typically use these medications (such as back pain), the fact that opioid anelgesics are an easy treatment for providers to prescribe, and certain patients come into clinics asking for these medications specifically. Additionally, should physical therapy be used as a treatment for pain rather than an opioid analgesic prescription, it is possible that the patient may encounter barriers to obtaining physical therapy (such as access, coverage, transportation, etc.).

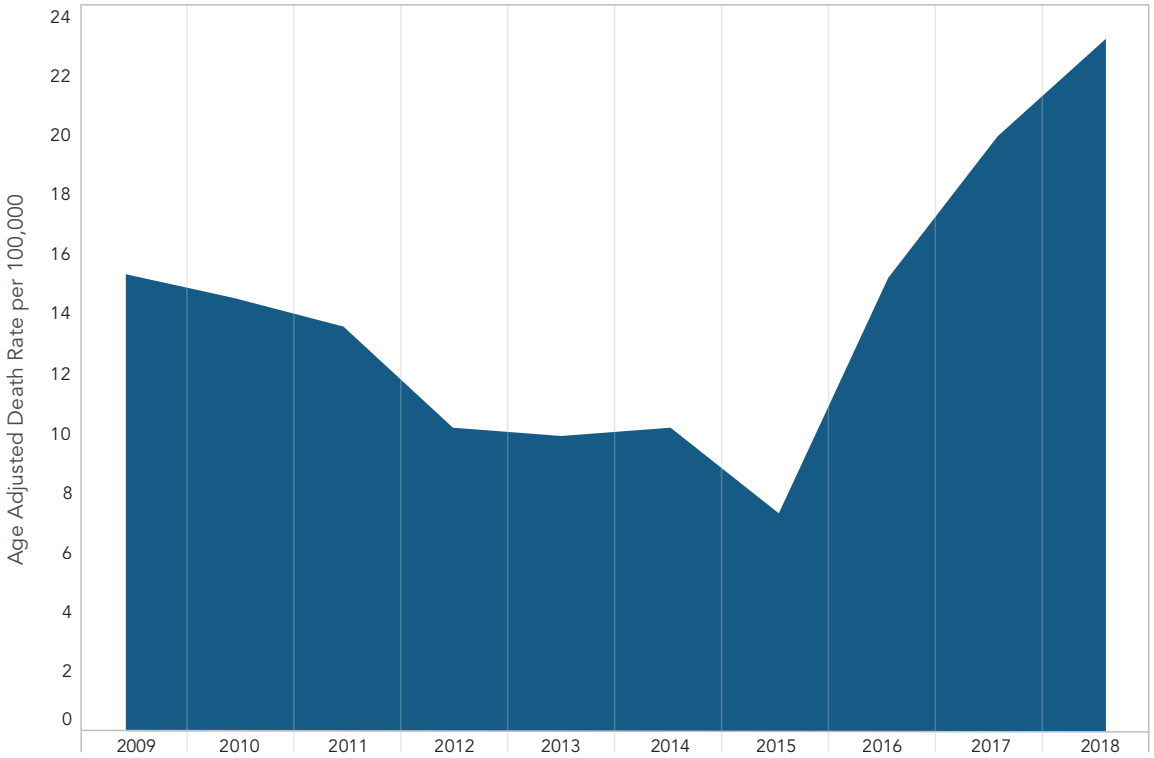
Rates of depressive disorders among adults increased within Schuyler County from 16% in 2016 to 24% in 2018. These percentages specifically reference depression, major depression, dysthymia, and minor depression. New York State excluding New York City in comparison increased from 13% of adults with depressive disorders in 2016 to about 17% in 2018.[12] Percent change for Schuyler County during that timeframe was an increase of 50%, whereas NYS excluding NYC was approximately an increase of 28%; this indicated a strong need for depression interventions. With the occurrence of the COVID-19 pandemic and the current state of mental health within the nation, it is likely that this percentage has increased since then. Depression affects a person's entire wellbeing, including both mental and physical health. It could lead to adverse outcomes such as difficulty sleeping, heart disease, worsening of chronic conditions, substance use disorders and, in more extreme cases, suicide. The CHA/CHIP committee discussed how depression affected residents within Schuyler County, as well as potential contributing factors to the increase the county has witnessed over recent years. Partners felt stigma surrounding mental health and fears regarding treatment for mental health.

High levels of adverse childhood experiences (ACES) were some of the behavioral causes of the increased depression prevalence. Also contributing to this concern were environmental issues such as fewer activities in which the public can participate, limited public transportation, a high patient to provider ratio, the climate and impact of seasonal depression, the COVID-19 pandemic, increased social isolation, and lack of support groups for those experiencing depression. Social determinants of health also contribute via low income, job insecurity, un/underinsured with regard to healthcare, disability status, substance misuse, history of abuse, age, and family history. Partners also voiced how different policies may be worsening the situation. For example, there are a lack of incentives for providers in underserved areas. There are also no grants to provide training for officers or EMTs in crisis intervention involving people with depressive disorder. Additionally, there is a lack of access to inpatient treatment facilities within Schuyler County.


11. NYS Department of Health: I-STOP/PMP - Internet System for Tracking Over-Prescribing - Prescription Monitoring Program, September 2021
12.Behavioral Risk Factor Surveillance System (BRFSS) 2016 & 2018

Decreasing rates of suicide mortality is a third objective for Schuyler County. Suicide rates within Schuyler County were on a gradual decline from 2009 to 2015 (as shown in Figure SC6),[13] but began to increase again in 2016 and continued to climb to an even higher rate of 23.2 per 100,000 in 2018. The 2022 County Health Rankings (which used data from 2016-2020) showed the age-adjusted number of deaths due to suicide per 100,000 population for Schuyler County was 21 (error margin of 15-38), compared to 8 (error margin of 5-25) within New York State.

## Figure SC6: Four-Year Average of Age-Adjusted Suicide Mortality Rate per 100,000 Population




Data Source: New York State Vital Statistics Data, 2009 - 2018.
Analysis Completed by Common Ground Health

Partners attributed the suicide rates within Schuyler County to a number of factors. These include the stigma surrounding mental health and asking for help, a lack of a "sense of belonging," people no longer feeling like they are part of something bigger (possibly due to technology and busy lifestyles), and lost connections and isolation (leaving fewer close relationships in which their "signs" could be noticed). The COVID-19 pandemic has only furthered the latter. Additionally, some people have concerns around confidentiality should they decide to seek mental health services, while others experience the "it won't happen to me" mentality.


13. Note: 4-year average utilized instead of 3-year as rates were unstable due to small numerators.

Environmental causes noted included a lack of education around mental health and suicide, lack of resources, providers and funding, untreated depression or manic episodes, social economics, and lack of diversity and inclusion. Furthermore, there is a high incidence of adverse childhood experiences within the community, no in-patient clinics, high availability of alcohol, barriers to transportation, and isolation associated with the rural geography. Current initiatives within Schuyler County that are effective at addressing these root causes consist of support groups, gatekeeper trainings, evidence-based therapies, depression screenings, education on mental health and resources, trained crisis staff within healthcare, normalizing going to doctors and medical providers, as well as having those providers be approachable and client-oriented. Coordination of mental health services with services to support individuals has also been helpful, as has telehealth capabilities (more readily available for local providers); there is flexible scheduling with current mental health clinic hours in Schuyler County. Not only can local providers assist residents, but there are national telehealth mental health providers available to residents as well, and a new national suicide number to call.

### Priority Area: Prevent Chronic Diseases

### Preventive Care and Management

Cancer screenings are an essential preventive care service that help to detect cancers earlier on when they are more treatable. Pre-pandemic, in 2018 in Schuyler County, about 81% of women aged 40 and older and about 85% of women aged 50-74 completed breast cancer screenings,[14] as well as about 62% of adults aged 50-75 completed colorectal cancer screenings.[15] During the same year, the Finger Lakes region as a whole reported about 71% of women aged 40 and older and about 80% of women aged 50-74, who had an annual household income of less than $25,000, participated in breast cancer screenings.[16] More recent data from the Cancer Services Program shows that, between September 1, 2018 and July 20, 2022, the following screenings were conducted within Schuyler County: Schuyler Hospital Primary Care Center completed 29 clinical breast exams (CBEs) for 16 clients and 7 pap smears for 7 clients, Schuyler Hospital completed 35 mammograms for 21 clients, 4 diagnostics and 4 HPVs, and Schuyler Hospital Montour Falls Extension Clinic completed 2 CBEs and 1 pap smear. With the onset of the COVID-19 pandemic, the nation noticed a troublesome decline in cancer screenings. A paper published in March 2022 showed that cancer screening rates are generally still below pre-pandemic levels (at least through early 2021), especially with colorectal screenings.[17] A study from JAMA Oncology in April 2021 estimated (through July 2020 alone) that disruptions from the pandemic caused more than 9 million breast, colorectal and prostate cancer screenings to be missed.[18]

Not only had the pandemic deterred individuals, but additional challenges to cancer screenings were identified by Schuyler County community partners. The Cancer Services Program (CSP) noted that patients are, often times, afraid of having the screenings completed because they lack an understanding of the procedure itself. Many have also reported that they cannot afford a screening nor treatment if the screening returned with a positive cancer diagnosis. While programs exist in the county to help with such matters, not all are aware of these services and benefits.

14. Behavioral Risk Factor Surveillance System 2018
15. CDC PLACES 2018
16. Behavioral Risk Factor Surveillance System 2018
17. American Cancer Society Journals: Cancer – A national quality improvement study identifying and addressing cancer screening deficits due to the COIVD-19 pandemic, March 2022
18. TODAY: After cancer screenings fell during COVID-19, an effort to reverse the trend, March 2022

Other behavioral factors noted included fear of the unknown and the treatments, lack of an established relationship with a primary care provider, unknowns for the transgender community, as well as being unaware of the need for screenings (screenings may not be seen as important by the patient until symptoms arise). Some members of the public are also unaware of their family history, which can play a major role in their own health. Lack of transportation is another barrier that prevents residents from attaining timely preventive screenings; Medicaid transportation services are available but are not always reliable, and there is limited public transportation. Other social determinants of health considerations include being un/underinsured, a Health Professional Shortage Area for the Medicaid population (for both primary care and mental health care) in Schuyler County, limited childcare, limited employment opportunities that offer benefits, and many individuals living in "survival mode" which places screenings lower on their priorities.

Currently, there are several positive policies in place to promote cancer screenings. First, there are alerts within the electronic medical record at Schuyler Hospital to discuss screenings with patients, for breast cancer screenings specifically; this system was updated in 2022 with quick order sets as well. Second, same day breast cancer screening scheduling is available at the hospital. Third, with regard to colorectal cancer screening, Cologuard is available in offices for patients to utilize. Fourth, the hospital now has Rural Health designation that allows general surgeons to conduct screenings, which increases access to specialty services regardless of insurance type. Schuyler Hospital also has campaigns going out currently along with care coordinators to close gaps based on their payer noncompliant reports. Lastly, the No Surprise Act requires that the patient is provided a quote that is within $400 of the cost incurred. Schuyler County Public Health held educational sessions using an inflatable colon to educate people at community events about colorectal cancer screenings and local resources prior to the pandemic, and also completed focus groups with community members to understand why they have not been screened. In addition, they developed educational campaigns with NYCSP and a local survivor, which were used on social media. One policy that is negatively impacting the goal of increased screenings is when a "screening" is determined to be "diagnostic," as diagnostic brings with it additional costs.

## Community Assets and Resources to be Mobilized

The Finger Lakes Region already has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies that promote and facilitate collaboration: Pivital Public Health Partnership (previously the S2AY Rural Health Network) and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors – hospitals, insurers, universities, business, nonprofit, faith communities and residents – to collaborate on strategies for improving health in the region. Both agencies provide support, collaboration and resources to improving health of Schuyler County residents.

During brainstorming sessions at the May 12 and June 9, 2022, CHA/CHIP meetings, the following partners were identified to assist with the Prevent Mental and Substance Use Disorders objectives: Department of Social Services, Catholic Charities, school districts, the Chamber of Commerce, local community-based organizations, Schuyler County transit, Mental Health, fitness centers, VA Finger Lakes Healthcare System, MR Hess Home Works, SAFE, RPA #24, the Public Health Department, medical providers, Schuyler Hospital, insurance companies, pharmacies, libraries and churches. The CHA/CHIP team also identified a number of community partners who can assist in increasing cancer screening rates. Family and friends of patients can be resources when it comes to some of the behavioral causes identified previously, and partners such as primary care providers, the hospital, Public Health, Department of Social Services, Office for the Aging, food pantries, New York Cancer Services Program, The ARC of Chemung-Schuyler, and the Medicaid transport program could all partake in this initiative to work toward better outcomes.

Through implementation of the Community Health Improvement Plan, Schuyler County CHA/CHIP partners will work to leverage these pre-existing agencies and services. The Schuyler County Community Health Improvement Plan document has a full description of interventions and partner roles.

## Community Health Improvement Plan/Community Service Plan

As previously discussed in Main Health Challenges, a multi-voting technique was used to select the priority areas for the Community Health Assessment and Community Health Improvement Plan. County specific pre-read documents were provided to the Schuyler County CHA/CHIP team which included updated data measures for each of the five priority areas outlined in the Prevention Agenda. This was followed with additional county specific data on objectives within the chosen priority areas to help identify objectives, disparities and interventions to include within the plan. A concerted effort took place during the month of November to ensure the governing Community Health Assessment and Community Health Improvement Plan body was equipped with a diverse and inclusive group which represented all areas of health and well-being in the county. The following organizations were engaged in Schuyler County's planning and prioritization process:

| SCHUYLER COUNTY PLANNING AND PRIORITIZATION AGENCIES | | |
|---|---|---|
| Southern Tier Cancer Services Program | ProAction | VA Finger Lakes Healthcare System |
| Schuyler Hospital | Cornell Cooperative Extension | Foodbank |
| Pivital Public Health Partnership | Schuyler County Public Health | Schuyler County Coalition on Underage Drinking and Drugs (SCCUDD) |
| Schuyler County Social Services | Schuyler County Chamber of Commerce | Schuyler Hospital Primary and Convenient Care (PCC) |
| Common Ground Health | Community Services | Schuyler County Mental Health |
| Schuyler County Sheriff | Schuyler County Office of the Aging | MR Hess Home Works |
| URMC Wilmot Cancer Institute | The Falls Home | University of Rochester Medical Center |
| Catholic Charities | | |

The public health department and their team of community partners at Schuyler County CHA/CHIP meetings discussed and determined interventions to target the selected priority areas. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will continue to take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Schuyler County Community Health Improvement Plan. All interventions selected are evidence based or evidence-informed and strive to achieve health equity by focusing on creating greater access for the low-income population, the disparity identified by Schuyler County.

The Schuyler County CHA/CHIP team, a group of diverse partners who meet bi-monthly to improve the health of Schuyler residents, will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

## Dissemination

The Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) will be shared via Schuyler County Public Health's website and social media pages:

- Website: https://schuylercounty.us/621/About-Schuyler-County-Public-Health
- Facebook: https://www.facebook.com/SchuylerPublicHealth
- Instagram: https://www.instagram.com/schuyler_ph/
- Twitter: https://twitter.com/SchuylerCoPH

Seneca Lake pier, Watkins Glen, Schuyler County
Photo credit: iStock.com/AlbertPego

# APPENDIX 1

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# APPENDIX 2

## RESULTS-BASED ACCOUNTABILITY™

Results-Based Accountability™ is a disciplined way of thinking and acting to improve entrenched and complex social problems.[12] To facilitate CHA/CHIP development, resulting in a CHIP that measurably improves health, the following steps were followed:

1. **Define the Community:** Data collection is an important first step. In this step, it is important to gather data for the community at large (county-level data) as well as data that identified vulnerable populations within the community who are at risk for poorer health outcomes. This can happen by collecting and analyzing data that shows differences in rates of illness, death, chronic conditions and more in relationship to demographic factors. The planning committee brainstormed specific potential vulnerable populations in the county to be considered with data collection.
2. **Engage Stakeholders:** Population health requires engagement from many sectors. Complex social, economic and environmental factors are all determinants of health; therefore, there is no one organization, department or program that can be held solely responsible for the health of a population. Diverse engagement began in November/December 2021, early in the CHA development process. Committee partners completed an exercise to brainstorm potential new partners from the following sectors: Local Government, Businesses, Not-for-Profit and Community Organizations, Academia and the General Public. The following questions were used to assist brainstorming:
   - Who are those with potential interest and influence who can contribute to the CHA/CHIP process?
   - What population do they represent? (including vulnerable populations identified in Step 1)
   - Identify their potential level of interest and influence (High Interest/High Influence, Low Interest/ High Influence, High Interest/Low Influence, Low Influence/Low Interest)
   - Who would be the best person on the committee to extend an invitation to the selected potential new partner?

After an assessment of brainstormed information, personal invitations were made to selected potential new partners to address any gaps on the committee and the need for diverse engagement.

3. **Engage in Comprehensive Data Collection:** Both primary and secondary data were collected. Disaggregated data was collected by race, gender, income and geography as available to identify vulnerable populations and to assist in strategy development. Data sources included, but were not limited to:
   - Common Ground Health: My Health Story
   - County Health Rankings
   - Vital Statistics
   - Behavioral Risk Factor Surveillance Survey (BRFSS)
   - United States Census Bureau
   - Cornell University Program on Applied Demographics
   - Statewide Planning and Research Cooperative System (SPARCS)
   - New York State Department of Health Perinatal Data Profile
   - S2AY Rural Health Network Inc,: The Impact of COVID-19 on Food Security and Healthy Eating
   - Outreach to county committee partners for data from their respective organizations.

 12. Results-Based Accountability - Overview and Guide (clearimpact.com)

4. **Prioritize Health Issues:** Data was analyzed and presented by Common Ground Health. After a review of analyzed health outcome data for trends, current state against benchmarks or Prevention Agenda targets, and differences among populations, a multi-voting tool was used by committee members to rank the health issues using selected criteria to identify top Focus Areas, which identified Prevention Agenda Priority Areas.
5. **A Deeper Dive of data was conducted by Common Ground Health.** To enhance the picture of the selected Focus Areas, related Prevention Agenda objective data was presented. A table with objectives and their status colors was created to help with the selection of objectives for this CHA/CHIP cycle.
   - Green Status – the prevention goal metric has been met and the trend of that metric is in the correct direction of the goal or steady
   - Yellow Status – either the prevention goal has not been met but the trend is in the correct direction or the goal has been met but the trend is in the wrong direction
   - Red Status – the goal has not been met and the trend is in the wrong direction
   - Gray Status – there is limited data on this metric available at this time

In addition, person, place and time was analyzed:

- **Person** - Are there certain populations at higher risk for poor outcomes? For example, are outcomes different based on age, race/ethnicity, education, or socio-economic status?
- **Place** - Are the outcomes in the county higher or lower than neighboring counties and the rest of the state? Are there high-risk neighborhoods in the county?
- **Time** - Do the trends over time show the outcomes improving, remaining the same, or declining?

If multiple objectives were identified, additional consideration was given to objectives that may have a greater impact on long term health and also have a good chance of positively impacting other objective indicators.

6. **Develop the Story Behind the Data:** Understanding the story behind the data ("WHY" the data looks the way it does) contributes to an increased understanding of the factors that impact the current state, as well as identifies contributing causes and potential solutions designed to have maximum impact. Results-Based Accountability's *Turn the Curve Thinking* was conducted for selected CHIP objectives/indicators to examine:
   - What is the story? What are the contributing causes to the trend of the selected CHIP objectives, including behavioral, environmental, policy and social determinant of health factors? 5 WHYS was conducted to help identify root causes.
   - Who are the partners that have a role in impacting contributing causes? What community assets or resources can be mobilized to impact identified causes?
   - What works to address identified contributing causes (including evidenced based interventions)?

*Turn the Curve Thinking* also determined a data development agenda, where counties identified if any additional data was needed on selected objectives and/or disparities, as well as a plan on how to collect that data.

7. **Select CHIP Interventions:** Upon completion of *Turn the Curve Thinking*, criteria was used to select interventions that will be included on the CHIP. Criteria used included:
   - How strongly will the proposed strategy impact progress as measured by the baselines?
   - Is the proposed strategy feasible?
   - Is it specific enough to be implemented?
   - Is the strategy consistent with the values of the community and/or agency?

*Turn the Curve Thinking* resulted in interventions which were linked with contributing causes and partners who could have an impact. It is our goal that, with successful implementation of diverse strategies by diverse partners, there will be a collective impact on *Turning the Curve* for the better on our CHIP objectives.

8. **Engage in Continuous Improvement:** To effectively monitor progress and effectiveness of each organization's contribution to selected CHIP objectives, intervention performance measures were identified that answer the questions:
   - How much did we do?
   - How well did we do it?
   - Is anyone better off?

Monitoring these intervention specific performance measures will identify if any focused quality improvement projects are required to improve intervention effectiveness and/or if revisions to CHIP interventions are required.

Schuyler County, View of Seneca Lake from the Town of Reading
Photo courtesy of Elizabeth Watson

# APPENDIX 3

## PREVENT MENTAL & SUBSTANCE USE DISORDERS: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 2.1.2 | Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month | | |
| 2.2.4 | Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate | | |
| 2.4.1 | Reduce the prevalence of major depressive disorders | | |
| 2.5.2 | Reduce the age-adjusted suicide mortality rate | | |
| 2.2.3 | Reduce the opioid analgesics prescription for pain, age-adjusted rate | | |
| 2.2.1 | Reduce the age-adjusted overdose deaths involving any opioid | | |
| 2.2.2 | Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder | | |
| Note: Objectives 2.1.1, 2.1.3, 2.3.1, 2.3.2, 2.3.3, 2.4.2, 2.5.1, and 2.6.1 had limited/unreliable data. | | | |

## PREVENTIVE CARE & MANAGEMENT: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 4.3.2 | Decrease the percentage of adult Black Medicaid members with diabetes whose most recent HbAlc level indicated poor control (>9%) | | NYS Data Only |
| 4.3.5 | Increase the percentage of adult Black Medicaid members who had hypertension whose blood pressure was adequately controlled during the measurement year | | NYS Data Only |

# PREVENTIVE CARE & MANAGEMENT: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 4.1.1 | Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines - Age 40+ | | FLR Data Only |
| 4.1.1 | Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines - Age 50-74 | | FLR Data Only |
| 4.1.3 | Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 5O to 75 years) | | |
| 4.2.1 | Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% | | |
| 4.2.2 | Increase the percentage of low-income ( <$25,000) adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% | | FLR Data Only |
| 4.3.3 | Decrease the percentage of adult Medicaid members aged 18-44 with diabetes whose most recent HbAlc level indicated poor control (>9%) | | NYS Data Only |
| 4.3.6 | Increase the percentage of adult Medicaid members 18-44 who had hypertension whose blood pressure was adequately controlled during the measurement year | | NYS Data Only |
| 4.3.8 | Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups - All | | |
| 4.3.9 | Increase the percentage of members (ages 5-64) who were Identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 5-18 (MMC) | | Western NY Data Only |
| 4.3.9 | Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 19-64 (MMC) | | Western NY Data Only |
| 4.3.10 | Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year - 19-64 (MMC) | | Western NY Data Only |
| 4.3.11 | Increase the percentage of adults with HTN who are currently taking medicine to manage their high blood pressure | | |

# PREVENTIVE CARE & MANAGEMENT: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 4.1.4 | Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (adults with an annual household income less than $25,000) | | FLR Data Only: Age 50-75 |
| 4.1.5 | Increase the percentage of adults aged 50-64 who receive a colorectal cancer screening based on the most recent guidelines | | FLR Data Only |
| 4.2.3 | Increase the percentage of children and adolescents ages 3 - 17 years with an outpatient visit with a primary care provider or OB/GYN practitioner during the measurement year who received appropriate assessment for weight status during the measurement year by 5% - HMO | | Western NY Data Only |
| 4.2.3 | Increase the percentage of children and adolescents ages 3 -17 years with an outpatient visit with a primary care provider or OB/GYN practitioner during the measurement year who received appropriate assessment for weight status during the measurement year by 5% - MMC | | Western NY Data Only |
| 4.3.1 | Decrease the percentage of adult members with diabetes whose most recent HbAlc level indicated poor control (>9%) - HMO | | |
| 4.3.1 | Decrease the percentage of adult members with diabetes whose most recent HbAlc level indicated poor control (>9%) - MMC | | |
| 4.3.4 | Increase the percentage of adult members who had hypertension whose blood pressure was adequately controlled during the measurement year - HMO | | |
| 4.3.4 | Increase the percentage of adult members who had hypertension whose blood pressure was adequately controlled during the measurement year - MMC | | |
| 4.3.7 | Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups - 0-4 | | |
| 4.3.7 | Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups - 0-17 | | |
| 4.3.7 | Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups - All | | |
| 4.3.8 | Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups - 0-4 | | |

## PREVENTIVE CARE & MANAGEMENT: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 4.3.8 | Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups - 0-17 | | |
| 4.3.9 | Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 5-18 (Commercial HMO) | | Western NY Data Only |
| 4.3.9 | Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 5-18 (Commercial PPO) | | Western NY Data Only |
| 4.3.9 | Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 19-64 (Commercial HMO) | | Western NY Data Only |
| 4.3.9 | Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 19-64 (Commercial PPO) | | Western NY Data Only |
| 4.3.10 | Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year- 5-18 (Commercial HMO) | | Western NY Data Only |
| 4.3.10 | Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year- 5-18 (Commercial PPO) | | Western NY Data Only |
| 4.3.10 | Increase the percentage of members (ages 5-64 ), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of a.so or greater during the measurement year- 5-18 (MMC) | | Western NY Data Only |
| 4.3.10 | Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year - 19-64 (Commercial HMO) | | Western NY Data Only |

## PREVENTIVE CARE & MANAGEMENT: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 4.3.10 | Increase the percentage of members (ages 5-64 ), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year - 19-64 (Commercial PPO) | | Western NY Data Only |
| 4.4.1 | Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition | | Western NY Data Only |
| *Note: Objectives 4.1.2, 4.3.12, and 4.4.2 had limited/unreliable data. | | | |

## SCHUYLER COUNTY: SELECTED OBJECTIVES

| | | | |
|---|---|---|---|
| 2.2.3 | Reduce the opioid analgesics prescription for pain, age-adjusted rate | | |
| 2.4.1 | Reduce the prevalence of major depressive disorders | | |
| 2.5.2 | Reduce the age-adjusted suicide mortality rate | | |
| 4.1.1 | Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines - Age 40+ | | FLR Data Only |
| 4.1.1 | Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines - Age 50-74 | | FLR Data Only |
| 4.1.3 | Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) | | |

# SENECA COUNTY

| COUNTY NAME: | SENECA COUNTY |
|---|---|
| Participating local health department and contact information: | Seneca County Department of Public Health<br>Scott King<br>Director of Public Health<br>sking@co.seneca.ny.us<br>315-539-1951 |
| Participating Hospital/ Hospital System(s) and contact information: | Geneva General Hospital and Soldiers and Sailors Memorial Hospital (Finger Lakes Health)<br>Lara Turbide<br>Lara.turbide@flhealth.org<br>315-787-4053 |
| Name of entity completing assessment on behalf of participating counties/ hospitals: | Common Ground Health<br>Catriona Spier<br>Catriona.Spier@commongroundhealth.org<br>585-224-3107 |

Downtown Waterloo, Seneca County
Photo credit: iStock.com/Wirestock

# EXECUTIVE SUMMARY

Through the use of Results-Based Accountability, Seneca County in partnership with Geneva General Hospital and Soldiers and Sailors Memorial Hospital (Finger Lakes Health) and has chosen to focus their 2022-2024 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) on the following priority areas, with zip code as their identified disparity to address.

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |
| **Disparity** | **ZIP code** |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Healthy eating and food security |

A complete list of participating partners is available within the Seneca County Chapter under "Community Health Improvement Plan/Community Service Plan." Agencies represented academia, not-for-profits, community organizations, local businesses, community members, and local government. These included Cornell Cooperative Extension, Pivital Public Health Partnership, Common Ground Health, Cancer Services Program of Finger Lakes Region, United Way of Seneca County, Seneca County Community Counseling Center, Seneca Towns Engaging People for Solutions (STEPS), Finger Lakes Community Health, Council on Alcoholism, Tobacco Action Coalition of the Finger Lakes, Children and Family Resources, Seneca County Youth Bureau, Finger Lakes Health (Geneva General). Partners' roles in the assessment were to help inform and select the 2022-2024 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings. Community was involved in the 2018 My Health Story survey and inclusion of community was considered as part of the oversight committee. The 2022 My Health Survey was conducted during the summer and fall of 2022, and this will help gain community insight on key health matters in the county and surrounding areas. Both primary and secondary data were reviewed including, but not limited to, the US Census Bureau American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, data collected from Pivital Public Health Partnership (formerly known as S2AY Rural Health Network) and Common Ground Health's My Health Story 2018 survey, 211 Lifeline, and the Statewide Planning and Research Cooperative System (SPARCS).

The process of Results-Based Accountability included evaluation of a pre-read document, which contained detailed county-specific analyses related to the five Prevention Agenda priority areas, followed by a multi-voting technique to select the priority areas. Participants were asked to consult with other members of their organizations and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Partners came to a consensus to address the top priority areas identified by the survey, then additional county-specific data was collected, shared and evaluated to help determine which objectives, disparity, and interventions should be selected. Interventions selected included, but were not limited to:

- Identify and support people at risk for metal and substance use disorders;
- Strengthen access and delivery of suicide care;
- Create protective means to reduce access to lethal means among persons at risk of suicide;
- Limit access to less healthy food and beverages;
- Increase the availability of fruit and vegetables;
- Screen for food insecurity and facilitate and actively support referral.

A complete list of interventions and process measures is available in the CHIP.

In forthcoming CHIP meetings, group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings. Partners and the community will continue to be engaged and apprised of progress via these meetings.

Seneca County white deer
Photo courtesy of Senecawhitedeer.org

# PLANNING AND PRIORITIZATION PROCESS

Seneca County followed a process called Results-Based Accountability to develop their needs assessment and improvement plans. There are several components to Results-Based Accountability, some of which include defining the community, engagement of a diverse group of stakeholders (including organizations representing underserved, low-income and minority populations), data collection and analysis, prioritization of health issues and disparity identification, and discussion of root causes for selected health issues to help identify appropriate and effective interventions. For additional information on Results-Based Accountability, this process is described in its entirety in Appendix 2. To pinpoint root causes of selected health concerns, the committee evaluated behavioral, environmental, social determinants of health, and policy causes that may be contributing to the current status of those concerns.

As demonstrated in the health indicator section, each county's residents face their own unique and challenging issues when it comes to their community, yet commonalities remain. There are a number of demographic and socioeconomic indicators which may impact health and are consistent concerns across the region. For example:

## AGE:

Variances in age can impact a community's health status. Older adults require more frequent medical check-ins, are more prone to illness, falls and unintentional injuries, and often experience more co-morbid conditions than younger adults and children. In addition, aging adults may not have access to a vehicle and rely on family, friends or public transportation for accessing basic needs and medical appointments. The strain of caring for an elderly adult may also negatively affect the caregiver. A community with higher rates of elderly adults may have worse reported health outcomes than a younger community.

## POVERTY:

Low income residents are more likely to experience a breadth of health issues not seen as often in wealthier residents. For example, lower socioeconomic status is linked to higher incidence of chronic disease, shorter life expectancy, and lower rates of good social, emotional and physical health. Low income may also force a person to choose between basic needs (such as housing, food, clothing, etc.) and preventative medical care. Often, and not surprisingly, the person will choose the basic need over preventative medical care. A community with higher rates of impoverished residents is likely to have worse health outcomes than wealthier communities.

## EDUCATION:

Education levels have been known to be a predictor of life expectancy. The Centers for Disease Control and Prevention reports that 25-year-old adults without a high school diploma can expect to die nine years sooner than college graduates. People who attain higher education levels are more likely to seek health care, preventative care services, and earn higher wages. A more educated community may, therefore, have better health outcomes than a low educated community.

## HOUSING:

Access to quality and affordable housing is imperative to ensuring basic needs are met. Housing structures that are safe, clean, up to code and affordable help to improve community health. When incomes are consumed on rent or mortgages, residents may lack funds for preventative care services, medications, and healthy foods. Additionally, outdated, substandard housing puts tenants at risk for asthma and lead poisoning (especially children).

Each of the above indicators impacts the health of the community. The next section takes a closer look at these demographic and socioeconomic indicators and also includes a review of behavioral and political environments in Seneca County that impact the health of its residents. Finally, the section will highlight the community's assets and resources that may be leveraged to improve health through identified evidence-based interventions.

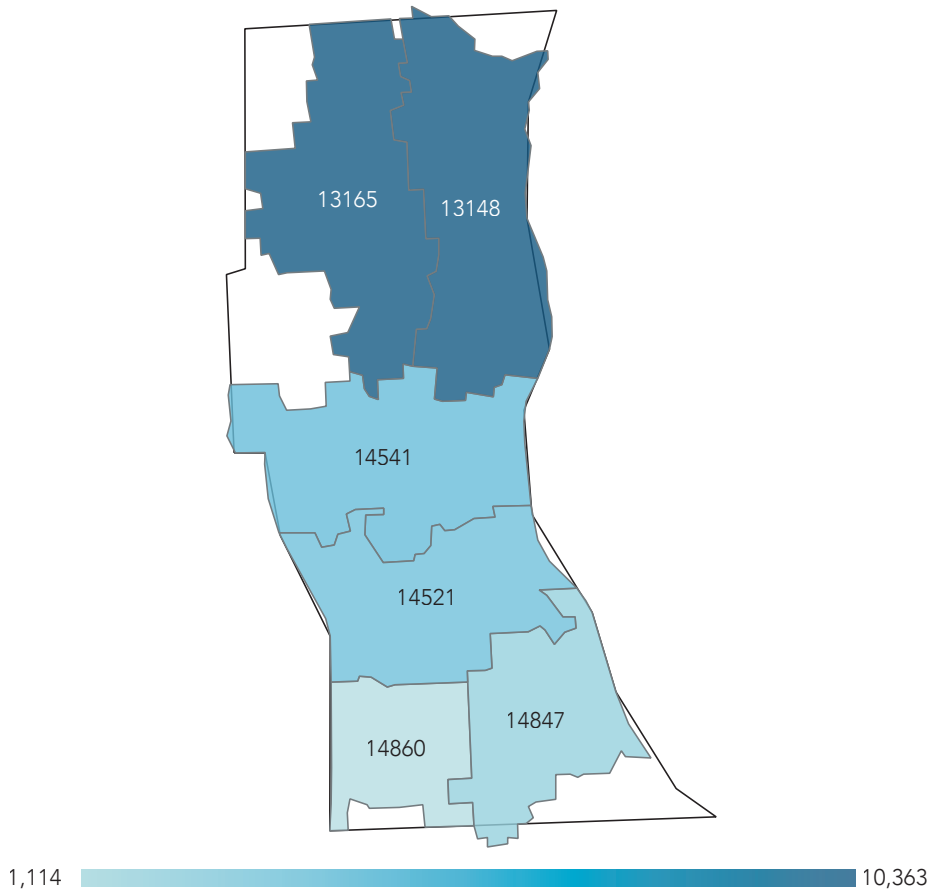
# COUNTY CHAPTER – SENECA COUNTY

## Demographic and Socioeconomic Health Indicators

Seneca County is located between two Finger Lakes, Seneca and Cayuga. In the northeastern corner of the county lies Montezuma National Wildlife Refuge, a 10,000 acre bird sanctuary that offers walking trails and bald eagle-watching. Residents of Seneca County can also enjoy the outdoors by visiting state parks along both Seneca and Cayuga Lake, as well as visiting the Finger Lakes National Forest, part of which is located in south Seneca County and continues into Schuyler County further to the south.

The County's population totals 34,295 people, with the largest population centers in the northern half of the county in the towns of Waterloo, Seneca Falls, and Fayette.[1] Seneca County consists of about 88% White non-Hispanic residents, 5% Black non-Hispanic residents, and 4% Hispanic residents. In Seneca County, 7% of residents 5 years or older speak a language other than English, about one third of whom speak Spanish.

### Map SE1. Population Density Map - Seneca County, NY

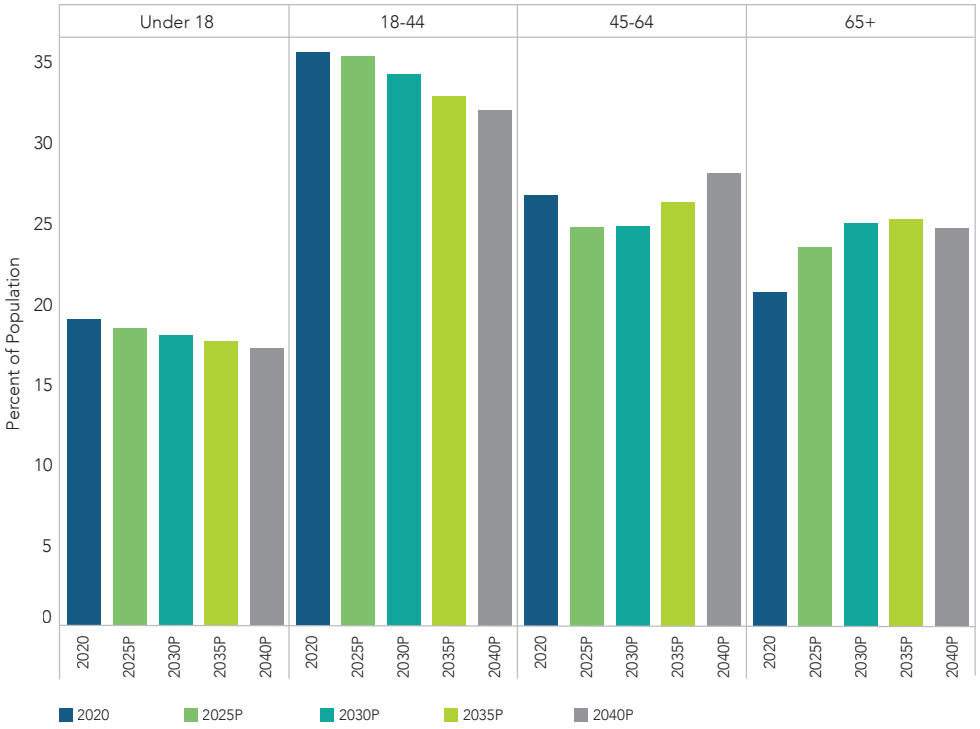



Data Source: Population data and allocation methods developed by Common Ground Health with Claritas zip-level estimates and CDC Bridged-Race county-level estimates.


1. United States Census Bureau, 2020 ACS 5-Year Estimates

Around 35% of the population of those 65 and older in Seneca County are living with a disability.[2] Over 5% of the 65 and older population is living alone. Population projections from Cornell University's Program on Applied Demographics show that the largest age group within Seneca County is those aged 18-44, but the 45-64 and 65+ age groups are predicted to steadily increase over the next few decades (Figure SE2).

## Figure SE2. Population Projections for Seneca County




Data Source: Cornell University – Program on Applied Demographics, County Projections Explorer (accessed March 2022).

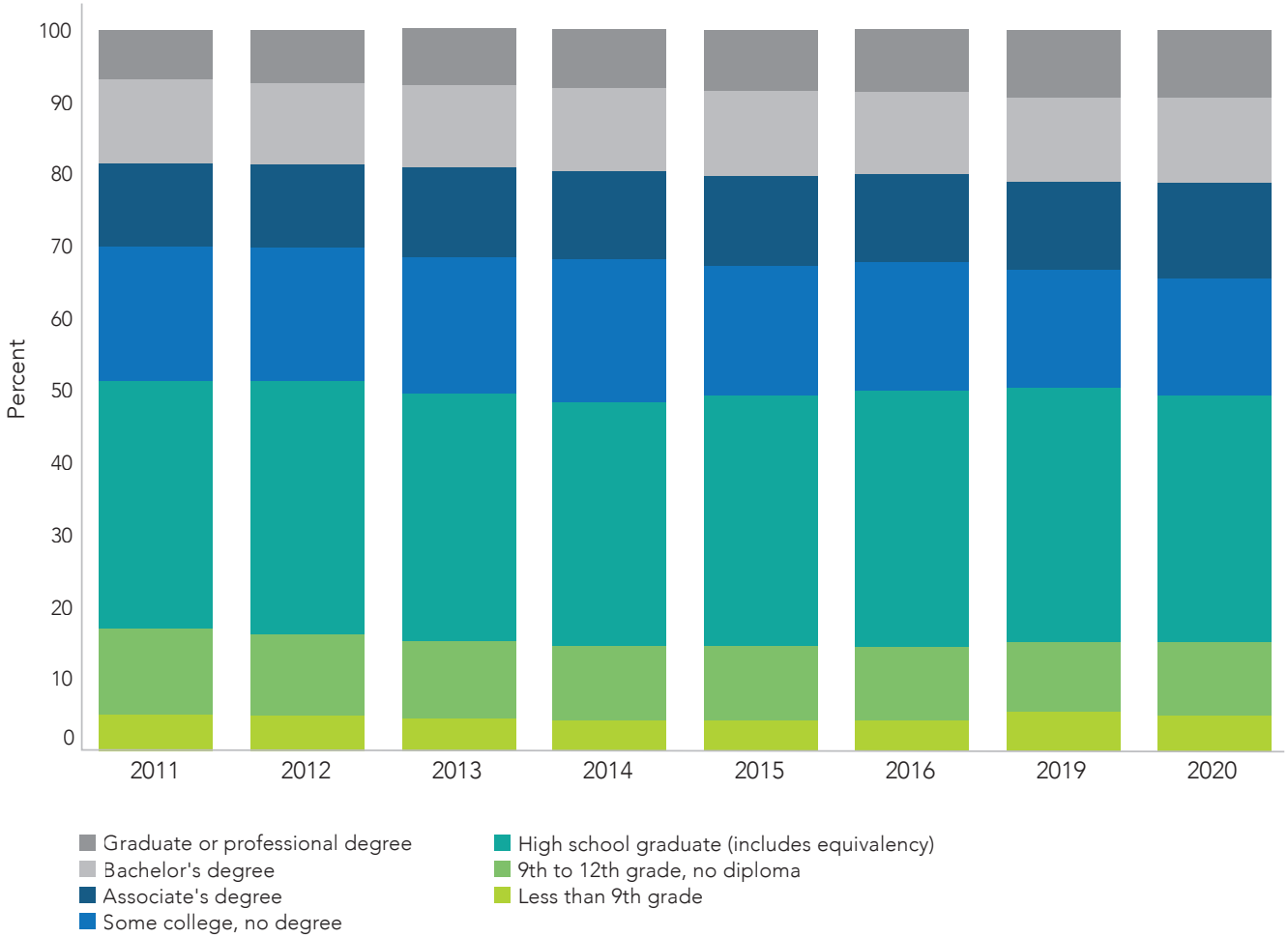
Seneca County Courthouse complex
By marjobani - Own work, CC BY-SA 4.0,
https://commons.wikimedia.org/w/index.php?curid=61596174

2. United States Census Bureau, 2020 ACS 5-Year Estimates

Educational attainment levels have remained fairly consistent from 2015 to 2020 (Figure SE3). Comparing females to males, a greater percentage of Seneca County females aged 25 or older earned a bachelor's degree or higher (25.7%) compared to males (17.3%).

Looking at poverty levels related to educational attainment, women in Seneca County who did not graduate from high school have a higher poverty rate (35%) than males with the same educational attainment (15%).[3] One explanation for this difference in poverty rates may be that labor jobs that do not require higher education tend to be more accessible to males than females.

## Figure SE3: Educational Attainment of Residents Aged 25+



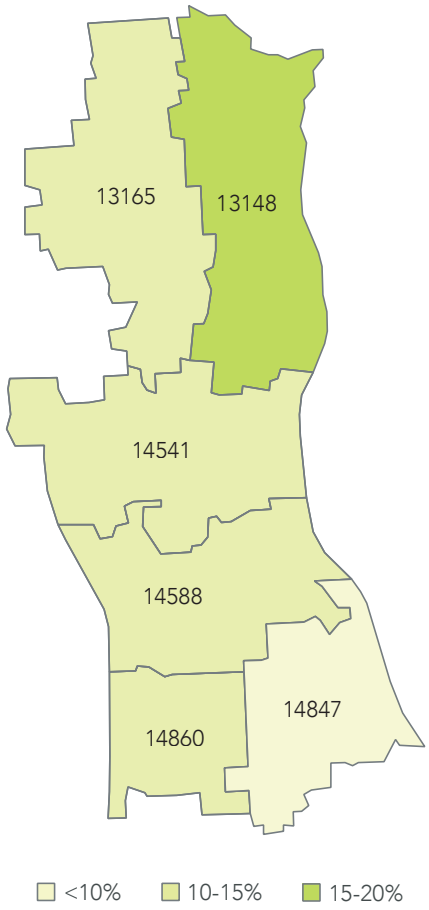

Data Source: Cornell University – Program on Applied Demographics, County Projections Explorer


3. United States Census Bureau, 2020 ACS 5-Year Estimates

Poverty rates in Seneca County are highest in the northeastern towns of Seneca Falls and Tyre, and are lowest in the southeastern town of Covert (Map SE4). It is noted that substantial poverty does exist in Covert, though, as data for the town is skewed due to very high-income residents living along Cayuga Lake. The overall poverty rate for Seneca County is approximately 12%.[4]

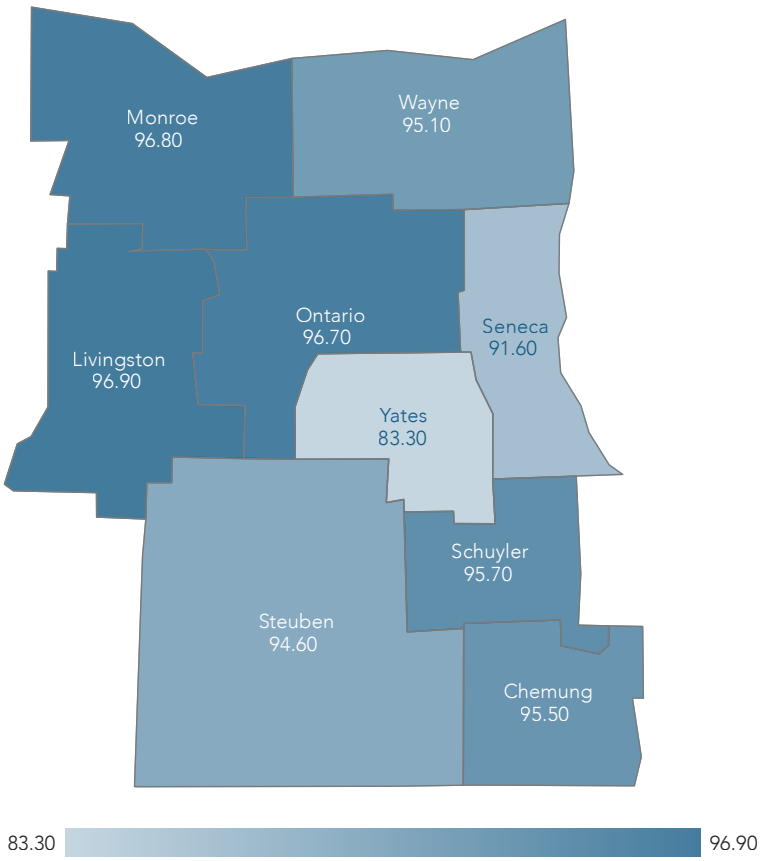
The uninsured rate for Seneca County has seen a slight decrease over the last 5 years but is still among the highest in the region at 6.9% for females and 10% for males.[5] In 2020, over 91% of Seneca County was insured (Map SE5). Access to health insurance, however, is not the only barrier to receiving health care. Another concern is underinsurance, or insurance that still leaves health care inaccessible such as high deductibles that make paying for care difficult even with insurance coverage. Transportation, lack of provider availability (including difficulty scheduling with providers) and cost (including cost of care, time away from work, and childcare) are additional factors, which need to be considered from an accessibility standpoint.

## Map SE4. Percent of Population in Poverty




Source: US Census Bureau,
American Community Survey, Year 2020
Analysis Completed by Common Ground Health

## Map SE5. Percent of Population with Health Insurance, by County




Analysis Completed by Common Ground Health



4. United States Census Bureau, 2020 5-year estimates.
5. United States Census Bureau, 2020 ACS 5-Year Estimates

**Mental Health Providers:** Mental health providers are available in Seneca County at a rate of 145 per 100,000, which is among the higher county rates in the Finger Lakes region.[6] This rate is still below the state rate of 200 per 100,000. These providers are predominantly located in Waterloo and Seneca Falls, leaving a gap in the southern half of the county. Seneca County has the highest rate of addiction and substance abuse providers (35 per 100,000) in the Finger Lakes region, even higher than the New York state rate of 22 per 100,000 population. Again, these providers are located in the northern half of the County, leaving a gap in service for those living in southern Seneca County.

**Dental Health Providers:** Seneca County has a very low rate of dental health providers (about 6 per 100,000 population) compared to the New York state rate of almost 38 per 100,000. One dental provider is located in Ovid and most other providers are located in Seneca Falls and Waterloo. Southern Seneca County residents may also utilize providers located in Trumansburg approximately one half mile south of Covert.

**Primary Care Providers:** Primary care providers are available in Seneca County at a rate of about 71 per 100,000 population, which is slightly lower than the New York state rate of 111 per 100,000 population. Primary care providers are concentrated in Waterloo and Seneca Falls with one Federally Qualified Health Center located in Ovid.

## Main Health Challenges

On May 11, 2022, a diverse group of stakeholders representing various aspects of the community attended a health priority-setting meeting. At this meeting, participants reviewed the overarching goals of the New York State Prevention Agenda and relevant qualitative, quantitative, primary and secondary data. A pre-read document containing detailed county specific analyses relating to the five Prevention Agenda priority areas was sent to all participants for review in advance. Data were collected from a variety of sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, primary data collected from Pivital Public Health Partnership and Common Ground Health's My Health Story Survey, and 211 Lifeline. My Health Story 2018 was a regional survey completed on behalf of nine counties in the Finger Lakes Region. Its primary purpose was to gather primary qualitative and quantitative data from Finger Lakes Region residents on health issues in each county. Health departments, hospitals and other local partners were instrumental in distributing the survey to community members including disparate populations. The survey will be updated in the fall of 2022 and will be used to help inform potential shifts in strategies to improve the priority areas selected by Seneca County.


5. United States Census Bureau, 2020 ACS 5-Year Estimates
6. Centers for Medicare and Medicaid Services, CMS-National Plan and Provider Enumeration System (NPPES), May 2021

After initial review of the priority areas, a multi-voting technique was used to select the priority areas to focus on. Participants were asked to consult with other members of their organization and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinants of health considerations, and capacity to address the issue for each priority and focus area discussed. As a result, the following areas were selected for the 2022-2024 Community Health Improvement Plan:

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |
| **Disparity** | **ZIP Code** |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Healthy eating and food security |

Following this selection, Common Ground Health gathered data on all objectives from the New York State Prevention Agenda within the chosen priority areas. Objectives were color coded based on data status to help focus attention where it was needed most. Red objectives were neither meeting the Prevention Agenda goal nor trending in a favorable direction, yellow objectives were either not meeting the Prevention Agenda goal or not trending in a favorable direction, and green objectives had both met the goal as well as trended in a favorable direction. Objectives that were color coded as gray represented a lack of current and/or reliable data. Color coded data on objectives were presented to the team during the April meeting and partners utilized the data, as well as potential scope and interest of the group, to determine the objectives with which they would proceed.

## Risk and Protective Factors Contributing to Health Status

Seneca County has selected two focus areas on which to anchor their 2022-2024 Community Health Improvement Plan. This section will take a closer look at the behavioral, environmental, political, and unique risk and protective factors contributing to the health status of those areas.

### Healthy Eating and Food Security

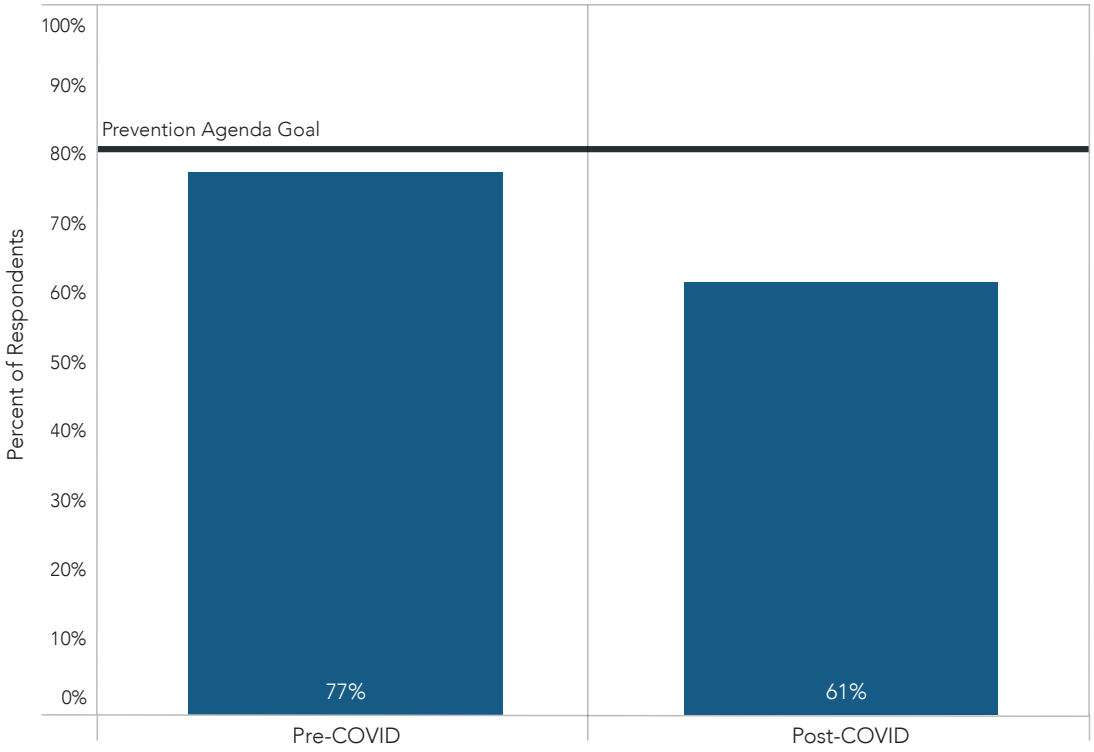
In the results of the 2018 Behavioral Risk Factor Surveillance Survey (BRFSS), Seneca County tied with Schuyler County for the second highest rate of consumption of sugary beverages in the nine-County Finger Lakes region (22%).[7] The survey also showed that close to one third of adults and almost one quarter of children in Seneca County are obese. Both consumption of sugary beverages and obesity are signs of food insecurity. Consumption of sugary beverages may be an indicator of food insecurity as these beverages are less expensive and more easily fit into a budget than healthier drinks such as milk. Obesity may indicate food insecurity due to the poor nutritional content of many of the more affordable food choices in stores and in restaurants. Sugary drinks are also linked to obesity, as they are main sources of added sugars in American diets, especially if they are the primary beverage consumed in a household.[8]

7. Behavioral Risk Factor Surveillance System, 2018
8. Centers for Disease Control and Prevention. Get the Facts: Sugar-Sweetened Beverages and Consumption. https://www.cdc.gov/nutrition/data-statistics/sugar-sweetened-beverages-intake.html

Data from the 2021 Feeding America Map the Gap report show that food insecurity affected 12% of Seneca County residents, and 17% of Seneca County children.[9] These rates were calculated using 2019 data from the American Census Bureau and do not yet reflect the impact the COVID-19 pandemic had on food insecurity. A recent survey conducted by Pivital Public Health Partnership looking at food security rates shows that, pre-COVID, about 77% of the Finger Lakes region felt food secure but in 2022, the same survey found that only about 61% felt food secure (Figure SE6).

## Figure SE6. Regional Food Security, Pre- and Post-COVID

Respondents in the region who reported never being worried that food would run out before they got money to buy more.




Source: Pivital Public Health Partnership, Year 2021. Analysis Completed by Common Ground Health.

Assuming Seneca County follows the same trend as the region, it is reasonable to assume that the food insecurity rates are likely even higher today. Food pantry data from Foodlink show that an increased number of households were served in 2022 compared to 2021, indicating that access to food is still a pressing issue in Seneca County. The number of households served by the Lodi Food 4 All Foodlink pantry increased by almost 60%, the number served by Seneca County mobile Foodlink pantry increased by 127% and the number served by the South Seneca Foodlink Pantry increased by about 54% from 2021 to 2022.[10]

In terms of addressing food insecurity, community health advocates who participate in the CHIP in Seneca County have noted that stigma around food insecurity and utilizing SNAP benefits play a role in peoples' willingness to address food security for themselves and/or their families in Seneca County. Lack of transportation, especially in the southern region of Seneca County, creates another barrier to accessing food regularly. For some, the bus is their only mode of transportation and bus routes are very limited on weekends when many people have the time to go grocery shopping. Other factors impacting food security in Seneca County include lack of knowledge about cooking and lack of understanding of the mind/body food connection and how eating healthier foods impacts overall health.


9. Map the Meal Gap. Feeding America. 2021
10. Foodlink Food Pantry Data. 2021-2022

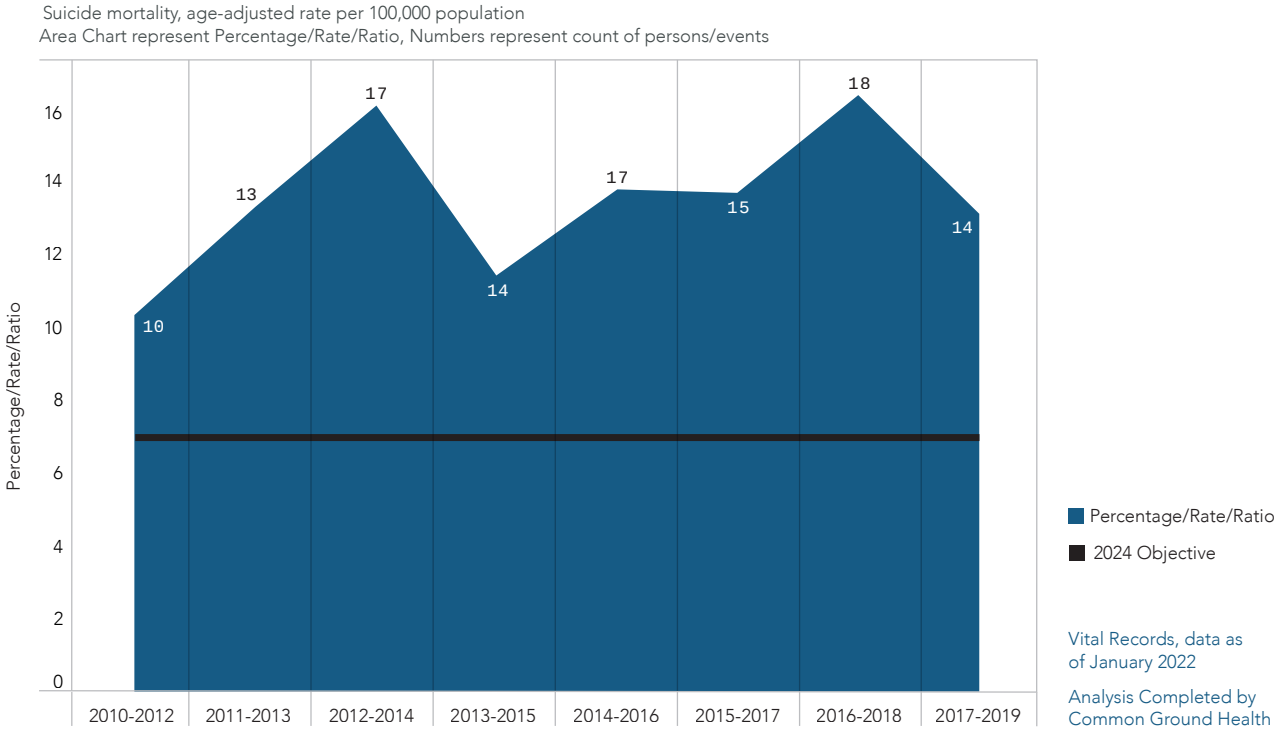
There are a number of efforts in Seneca County intended to increase access to food. Food pantries were well-attended throughout the pandemic and still very necessary, even during times of reduced COVID transmission. There are currently 7 food pantries across the county, some of which are open only on weekends, and others are open on some or all weekdays. There are thriving farmers markets in Seneca Falls, Waterloo, and Ovid, all of which accept SNAP benefits, further increasing access. Foodlink's mobile market also accept SNAP benefits, and this may be expanding in the future. Foodlink also has a mobile food pantry that visits Seneca County twice per month, once in Waterloo and once in Ovid. The food at the mobile pantry is available for free for anyone who attends. At all three Seneca County farmers markets, people who spend $5 with EBT cards receive an additional $2 in "Fresh Connect" coupons, which can be used for SNAP qualifying food items at the market. There are 3 community gardens and Seneca County residents are very interested in growing their own food. My Health Story data from 2018 showed that approximately 43% of residents use local farm stands to buy food. For the past three years, home gardening kits have been provided to families through the Seneca County Cornell Cooperative Extension (SCCCE) Farm To School and Master Gardener programs. Kits are also delivered through public schools and made available at local libraries. SCCCE plans to continue this program.

## Prevent Mental and Substance Use Disorders

BRFSS data from 2018 show that Seneca County residents had the highest rate of respondents who indicated that they felt limited in activities due to physical, mental, or emotional problems (28%) compared to the other 8 counties in the Finger Lakes Region.[11] Related to physical activity, Seneca County residents also had the highest rate of arthritis (39%). Both of these measures impact physical activity, a lack of which is associated with poor mental health. When people are experiencing poor mental health, it is often difficult to continue with day-to-day activities. Similarly, when people feel limited in their activities, due to conditions such as arthritis, this can in turn lead to poor mental health.

Suicide rates in Seneca County have remained above the Prevention Agenda goal of 7 per 100,000 from approximately 11 per 100,000 in 2010 to almost 18 per 100,000 in 2018 (Figure SE7).

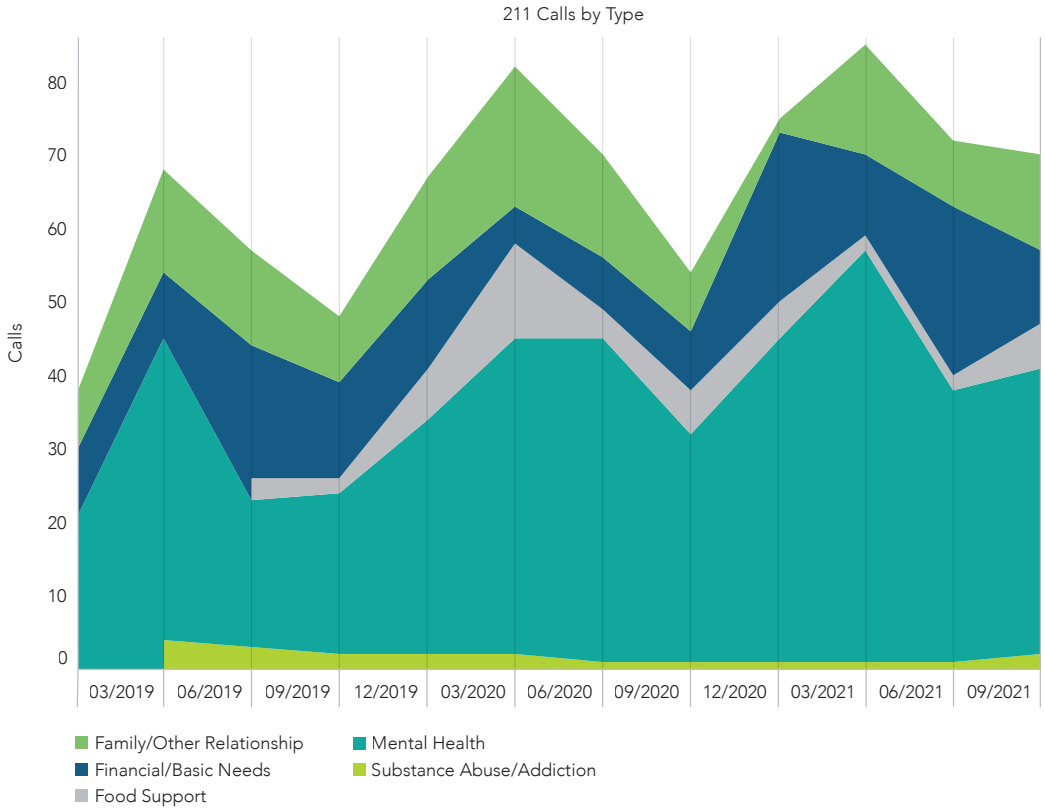
### Figure SE7. Suicide Mortality Rate, Seneca County, NY




 11. Behavioral Risk Factor Surveillance System, 2018

According to partners in the CHIP process, the COVID-19 pandemic increased the acuity of mental health visits at Seneca County 24-hour crisis response facilities, especially for the under-18 age group. Goodwill 211 Lifeline call data show that mental health is the main call type, with increases in this type of call in mid-year 2020 and mid-year 2021 (Figure SE8).

## Figure SE8. Goodwill 2-1-1 Lifeline Call Counts




Data Source: Goodwill/211 Lifeline, Year 2019 - 2021. Analysis Completed by Common Ground Health

Visits to the Seneca County Community Counseling Center have steadily increased from pre-COVID to the present, highlighting the need for continued focus on mental health care within the county.[12] Though every suicide assistance service in Seneca County is offered for free, county partners indicate that stigma surrounding mental health care is prominent and likely prevents people from seeking care. Partners also note that individual causes to high suicide rates in Seneca County include poverty rates, poor housing, depression, substance use disorder, and stresses from the COVID-19 pandemic.

In addition to the above listed individual causes, there are several environmental causes for suicide that partners feel are present in Seneca County. These environmental causes include:

- Lack of social activities (especially for youth)
- Alcohol use as a socialization method that can lead to substance use disorders
- Social isolation in the southern half of the county
- Difficulty accessing services for young children (increased need during pandemic)
- Lack of awareness of resources available for mental health in the county.

 12. Seneca County Community Counseling Center, 2019-2022

Community Resilience Estimates from the US Census provide an indicator of how well a community can withstand the effects of an event such as a pandemic.[13] In Seneca County, about 38% of residents have 1-2 risk factors and about 25% have 3+ risk factors for poor resilience. Risk factors for low community resilience include low-access to broadband internet, income-to-poverty ratio, single/zero caregiver household, crowding, communication barriers, and households without full-time employment.

During CHIP meetings, partners noted that there are several mental health initiatives either currently in place or included in future planning in Seneca County. Connecting with schools to promote mental health and awareness of mental illness is important to the county. Every public school district has Office of Addiction Services and Support (OASAS) licensed staff in their buildings, and as a best practice, there are satellite mental health clinics in every public school. The Teen Mental Health First Aid program is being implemented in Seneca Falls and Youth Mental Health First Aid is applied in smaller segments in all of the Seneca County districts. Seneca Falls and South Seneca districts are systematically training staff during the 2022-2023 school year. Finger Lakes Health Systems has adopted the abbreviated Columbia Suicide Severity Screen zero suicide initiative into their electronic record. Currently, they are only using it if a positive depression screen is indicated during the visit. The Seneca County Mental Health Department is currently working with Finger Lakes Health System to see how they can support them in screening at every visit regardless of a positive or negative depression screen. It would be beneficial if this initiative could be incorporated into all health care sites in Seneca County. Additionally, the Mental Health Awareness Training Grant, a three year SAMSHA grant, has allowed for mental health to be prioritized by providing funds for youth and teen mental health first aid workshops. This grant runs through October of 2023.

## Community Assets and Resources to be Mobilized

The Finger Lakes Region has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies that promote and facilitate collaboration: Pivital Public Health Partnership (previously the S2AY Rural Health Network) and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors – hospitals, insurers, universities, business, nonprofit, faith communities and residents – to collaborate on strategies for improving health in the region. Both agencies provide support, collaboration and resources to improve the health of Seneca County residents.

To address food security, Waterloo and Lodi public libraries will begin offering free food at "little free pantries" which will expand upon the overall availability of food in the north and south of the County by providing two additional locations for residents to access food when needed. In addition, Seneca County intends to use grow towers in schools to help educate students about nutrition and the basics of growing food indoors.

Seneca County is initiating a Lock & Talk program, originally piloted in Virginia and successful in nearby Livingston County.[14] This initiative engages people who own firearms in dialogue about how they should store or maintain these potential means of suicide out of reach and locked in order to prevent suicide. Participating partners in this initiative include gun retailers and the Department of Environmental Conservation who provide gun locks to residents. This program is more readily accepted than gun-control initiatives in rural counties due to its emphasis on safe firearm ownership rather than no firearm ownership.


13. Source: United States Census, Community Resilience Estimates, 2019
14. Lock & Talk. https://lockandtalk.org/

### Community Health Improvement Plan/Community Service Plan

| SENECA COUNTY PRIORITIZATION AGENCIES | | |
|---|---|---|
| Cornell Cooperative Extension | Pivital Public Health Partnership | Common Ground Health |
| Cancer Services Program of Finger Lakes Region | United Way of Seneca County | Seneca County Community Counseling Center |
| STEPS – Seneca Towns Engaging People for Solutions | Finger Lakes Community Health | Council on Alcoholism |
| Tobacco Action Coalition of the Finger Lakes (TACFL) | Children and Family Resources | Seneca County Youth Bureau |
| Finger Lakes Health (Geneva General Hospital) | | |

## Dissemination

The Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) will be shared with Seneca County residents on the Seneca County Public Health website, as well as posted to Seneca County Public Health's social media page on Facebook. Digital and/or print copies will also be shared with the Seneca County Board of Health, and with the Seneca County Board of Supervisors.

Seneca County Public Health: senecacountyhealthdepartment.com

Facebook: facebook.com/SenecaCountyHealth/

Hospital: flhealth.org

Seneca County
Photo credit: iStock.com/Jitalia17

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Seneca County Romulus, NY
Photo credit: iStock.com/Willowpix

# APPENDIX 2

## RESULTS-BASED ACCOUNTABILITY™

Results-Based Accountability™ is a disciplined way of thinking and acting to improve entrenched and complex social problems.[13] To facilitate CHA/CHIP development, resulting in a CHIP that measurably improves health, the following steps were followed:

1. **Define the Community:** Data collection is an important first step. In this step, it is important to gather data for the community at large (county-level data) as well as data that identified vulnerable populations within the community who are at risk for poorer health outcomes. This can happen by collecting and analyzing data that shows differences in rates of illness, death, chronic conditions and more in relationship to demographic factors. The planning committee brainstormed specific potential vulnerable populations in the county to be considered with data collection.
2. **Engage Stakeholders:** Population health requires engagement from many sectors. Complex social, economic and environmental factors are all determinants of health; therefore, there is no one organization, department or program that can be held solely responsible for the health of a population. Diverse engagement began in November/December 2021, early in the CHA development process. Committee partners completed an exercise to brainstorm potential new partners from the following sectors: Local Government, Businesses, Not-for-Profit and Community Organizations, Academia and the General Public. The following questions were used to assist brainstorming:
   - Who are those with potential interest and influence who can contribute to the CHA/CHIP process?
   - What population do they represent? (including vulnerable populations identified in Step 1)
   - Identify their potential level of interest and influence (High Interest/High Influence, Low Interest/ High Influence, High Interest/Low Influence, Low Influence/Low Interest)
   - Who would be the best person on the committee to extend an invitation to the selected potential new partner?

After an assessment of brainstormed information, personal invitations were made to selected potential new partners to address any gaps on the committee and the need for diverse engagement.

3. **Engage in Comprehensive Data Collection:** Both primary and secondary data were collected. Disaggregated data was collected by race, gender, income and geography as available to identify vulnerable populations and to assist in strategy development. Data sources included, but were not limited to:
   - Common Ground Health: My Health Story
   - County Health Rankings
   - Vital Statistics
   - Behavioral Risk Factor Surveillance Survey (BRFSS)
   - United States Census Bureau
   - Cornell University Program on Applied Demographics
   - Statewide Planning and Research Cooperative System (SPARCS)
   - New York State Department of Health Perinatal Data Profile
   - S2AY Rural Health Network Inc,: The Impact of COVID-19 on Food Security and Healthy Eating
   - Outreach to county committee partners for data from their respective organizations.


13. Results-Based Accountability - Overview and Guide (clearimpact.com)

4. **Prioritize Health Issues:** Data was analyzed and presented by Common Ground Health. After a review of analyzed health outcome data for trends, current state against benchmarks or Prevention Agenda targets, and differences among populations, a multi-voting tool was used by committee members to rank the health issues using selected criteria to identify top Focus Areas, which identified Prevention Agenda Priority Areas.
5. **A Deeper Dive of data was conducted by Common Ground Health.** To enhance the picture of the selected Focus Areas, related Prevention Agenda objective data was presented. A table with objectives and their status colors was created to help with the selection of objectives for this CHA/CHIP cycle.
   - Green Status – the prevention goal metric has been met and the trend of that metric is in the correct direction of the goal or steady
   - Yellow Status – either the prevention goal has not been met but the trend is in the correct direction or the goal has been met but the trend is in the wrong direction
   - Red Status – the goal has not been met and the trend is in the wrong direction
   - Gray Status – there is limited data on this metric available at this time

In addition, person, place and time was analyzed:

- **Person** - Are there certain populations at higher risk for poor outcomes? For example, are outcomes different based on age, race/ethnicity, education, or socio-economic status?
- **Place** - Are the outcomes in the county higher or lower than neighboring counties and the rest of the state? Are there high-risk neighborhoods in the county?
- **Time** - Do the trends over time show the outcomes improving, remaining the same, or declining?

If multiple objectives were identified, additional consideration was given to objectives that may have a greater impact on long term health and also have a good chance of positively impacting other objective indicators.

6. **Develop the Story Behind the Data:** Understanding the story behind the data ("WHY" the data looks the way it does) contributes to an increased understanding of the factors that impact the current state, as well as identifies contributing causes and potential solutions designed to have maximum impact. Results-Based Accountability's *Turn the Curve Thinking* was conducted for selected CHIP objectives/indicators to examine:
   - What is the story? What are the contributing causes to the trend of the selected CHIP objectives, including behavioral, environmental, policy and social determinant of health factors? 5 WHYS was conducted to help identify root causes.
   - Who are the partners that have a role in impacting contributing causes? What community assets or resources can be mobilized to impact identified causes?
   - What works to address identified contributing causes (including evidenced based interventions)?

*Turn the Curve Thinking* also determined a data development agenda, where counties identified if any additional data was needed on selected objectives and/or disparities, as well as a plan on how to collect that data.

7. **Select CHIP Interventions:** Upon completion of *Turn the Curve Thinking*, criteria was used to select interventions that will be included on the CHIP. Criteria used included:
   - How strongly will the proposed strategy impact progress as measured by the baselines?
   - Is the proposed strategy feasible?
   - Is it specific enough to be implemented?
   - Is the strategy consistent with the values of the community and/or agency?

*Turn the Curve Thinking* resulted in interventions which were linked with contributing causes and partners who could have an impact. It is our goal that, with successful implementation of diverse strategies by diverse partners, there will be a collective impact on *Turning the Curve* for the better on our CHIP objectives.

8. **Engage in Continuous Improvement:** To effectively monitor progress and effectiveness of each organization's contribution to selected CHIP objectives, intervention performance measures were identified that answer the questions:
   - How much did we do?
   - How well did we do it?
   - Is anyone better off?

Monitoring these intervention specific performance measures will identify if any focused quality improvement projects are required to improve intervention effectiveness and/or if revisions to CHIP interventions are required.

Sampson State Park in Romulus, Seneca County
Photo credit: iStock.com/jimfeng

# APPENDIX 3

## SENECA COUNTY OBJECTIVE SUMMARY

***Remaining objectives within the selected focus areas had limited or unreliable data**

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 2.1.2 | Reduce Age-Adjusted Percentage of Adult Binge Drinking in Past Month | | |
| 2.2.4 | Reduce the Prevalence of Major Depressive Disorder | | Only 2 data points (2016, 2018) |
| 2.2.3 | Reduce age-adjusted Suicide Mortality Rate | | |
| 2.2.3 | Reduce the Opioid Analgesics Prescription for Pain | | |
| 2.2.4 | Reduce all ED visits Involving Any Opioid Overdose | | |
| 2.2.1 | Reduce Age-Adjusted Overdose Deaths Involving Any Opioid | | |
| 2.2.2 | Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder | | |
| 1.1.2 | Decrease the Percent of Children with Obesity | | |
| 1.1.6 | Decrease the Percent of Adults with Obesity (living with a disability) | | Finger Lakes region |
| 1.1.5 | Decrease the Percent of Adults with Obesity (annual household income <$25,000) | | Finger Lakes region |
| 1.1.13 | Increase the Percent of Adults with Perceived Food Security | | |
| 1.1.14 | Increase the Percentage of Adults with Food Security (annual household income <$25,000) | | Finger Lakes region – no income |
| 1.1.10 | Decrease the Percentage of Adults who Consume Less than One Fruit and Less Than One Vegetable Per Day | | |
| 1.1.4 | Decrease the Percent of Adults with Obesity | | |
| 1.1.1 | Decrease the Percentage of Children with Obesity (Ages 2-4 yrs, Participating in WIC) | | |
| 1.1.7 | Decrease the Percentage of Adults who Consume One or More Sugary Drinks Per Day | | |
| 1.1.8 | Decrease the Percentage of Adults who Consume One or More Sugary Drinks Per Day (annual household income <$25,000) | | Finger Lakes region |

# STEUBEN COUNTY

| COUNTY NAME: | STEUBEN COUNTY |
|---|---|
| Participating local health department and contact information: | **Steuben County Public Health**<br>Darlene Smith<br>Director of Public Health<br>dsmith@steubencountyny.gov<br>607-664-2438 |
| Participating Hospital/ Hospital System(s) and contact information: | **Arnot Health**<br>Aaliyah Williams<br>Community Health Services and Population Health Coordinator<br>aaliyah.williams@arnothealth.org<br>607-737-4100 (ext 1131)<br><br>**Ira Davenport Memorial Hospital**<br>Elizabeth Weir<br>Site Administrator/VP of Nursing<br>Elizabeth.weir@arnothealth.org<br>607-776-8670<br><br>**Guthrie Corning Hospital**<br>Carly Nichols<br>Program Manager<br>Carlyr.nichols@guthrie.org<br>607-756-3852<br><br>**St. James Hospital**<br>Athena Ackley<br>Behavioral Health Assessment Officer<br>Athena_ackley@urmc.rochester.edu<br>607-247-2323 |
| Name of entity completing assessment on behalf of participating counties/ hospitals: | **Common Ground Health**<br>Zoë Mahlum<br>Health Planning Research Analyst<br>zoe.mahlum@commongroundhealth.org<br>585-224-3139 |

Steuben County, in partnership with local hospital systems - Arnot Health, Guthrie Corning Hospital and St. James Hospital – and other community health organizations, have used Results-Based Accountability to focus their 2022-2024 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) on the priority areas shown below. Low socioeconomic population is their identified disparity to address.

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Healthy eating and food security |
| **Disparity** | **Low socioeconomic population** |

Smart Steuben, a group of diverse partners who span all sectors of the community, participated in the prioritization process and disparity and intervention identification. While a complete list of partners is available within the Steuben County Chapter under "Community Health Improvement Plan/ Community Service Plan", agencies present represented academia, not-for-profits and community organizations, businesses, the general public, and local government. They included the Steuben County Public Health Department, Arnot Health and Corning and St. James Hospitals, the Steuben Rural Health Network, Cornell Cooperative Extension, Oak Orchard Health, ProAction, and more. Partners' roles in the assessment were to help inform and select the 2022-2024 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings. The Steuben community was involved in the 2018 My Health Story survey and inclusion of community input was considered as part of the oversight committee. The 2022 My Health Story survey is being conducted through the fall, and this will help gain community insight on key health matters in the county and surrounding areas. Both primary and secondary data were reviewed including, but not limited to, the US Census Bureau American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, data collected from Pivital Public Health Partnership (formerly known as S2AY Rural Health Network) and Common Ground Health's My Health Story 2018 survey, 211 Helpline, and the Statewide Planning and Research Cooperative System (SPARCS).

Bridge over Chemung River in Corning, Steuben County
Photo credit: iStock.com/Joseph Trentacosti

The process of Results-Based Accountability included evaluation of a pre-read document, which contained detailed county-specific analyses related to the five Prevention Agenda priority areas, followed by a multi-voting technique to select the priority areas. Participants were asked to consult with other members of their organizations and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinants of health considerations, and capacity to address the issue for each priority and focus area discussed. Partners came to a consensus to address the top priority areas identified by the survey, then additional county-specific data was collected, shared and evaluated to help determine which objectives, disparity, and interventions should be selected. Interventions selected included, but were not limited to:

- 1.0.4 Multi-component school-based obesity prevention interventions.
- 2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.
- 2.4.2 Strengthening resources for families and caregivers.

A complete list of interventions and process measures is available in the CHIP.

Smart Steuben, outside of CHA/CHIP development, meets bi-monthly to improve the health of Steuben residents and will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings. Partners and the community will continue to be engaged and apprised of progress via these meetings.

Steuben County, Keuka Lake
Courtesy of the CorningFingerLakes.com

# PLANNING AND PRIORITIZATION PROCESS

Steuben County followed a process called Results-Based Accountability to develop their needs assessment and improvement plans. There are several components to Results-Based Accountability, some of which include defining the community, engagement of a diverse group of stakeholders (including organizations representing underserved, low-income and minority populations), data collection and analysis, prioritization of health issues and disparity identification, and discussion of root causes for selected health issues to help identify appropriate and effective interventions. For additional information on Results-Based Accountability, this process is described in its entirety in Appendix 2. To pinpoint root causes of selected health concerns, the committee evaluated behavioral, environmental, social determinants of health, and policy causes that may be contributing to the current status of those concerns.

As demonstrated in the health indicator section, each county's residents face their own unique and challenging issues when it comes to their community, yet commonalities remain. There are a number of demographic and socioeconomic indicators which may impact health and are consistent concerns across the region. For example:

## AGE:

Variances in age can impact a community's health status. Older adults require more frequent medical check-ins, are more prone to illness, falls and unintentional injuries, and often experience more co-morbid conditions than younger adults and children. In addition, aging adults may not have access to a vehicle and rely on family, friends or public transportation for accessing basic needs and medical appointments. The strain of caring for an elderly adult may also negatively affect the caregiver. A community with higher rates of elderly adults may have worse reported health outcomes than a younger community.

## POVERTY:

Low income residents are more likely to experience a breadth of health issues not seen as often in wealthier residents. For example, lower socioeconomic status is linked to higher incidence of chronic disease, shorter life expectancy, and lower rates of good social, emotional and physical health. Low income may also force a person to choose between basic needs (such as housing, food, clothing, etc.) and preventative medical care. Often, and not surprisingly, the person will choose the basic need over preventative medical care. A community with higher rates of impoverished residents is likely to have worse health outcomes than wealthier communities.

## EDUCATION:

Education levels have been known to be a predictor of life expectancy. The Centers for Disease Control and Prevention reports that adults aged 25 without a high school diploma can expect to die nine years sooner than college graduates. Persons who attain higher education levels are more likely to seek health care, preventative care services, and earn higher wages. A more educated community may, therefore, have better health outcomes than a low educated community.

## HOUSING:

Access to quality and affordable housing is imperative to ensuring basic needs are met. Housing structures that are safe, clean, up to code and affordable help to improve community health. When incomes are consumed on rent or mortgages, residents may lack funds for preventative care services, medications, and healthy foods. Additionally, outdated, substandard housing puts tenants at risk for asthma and lead poisoning (especially children).

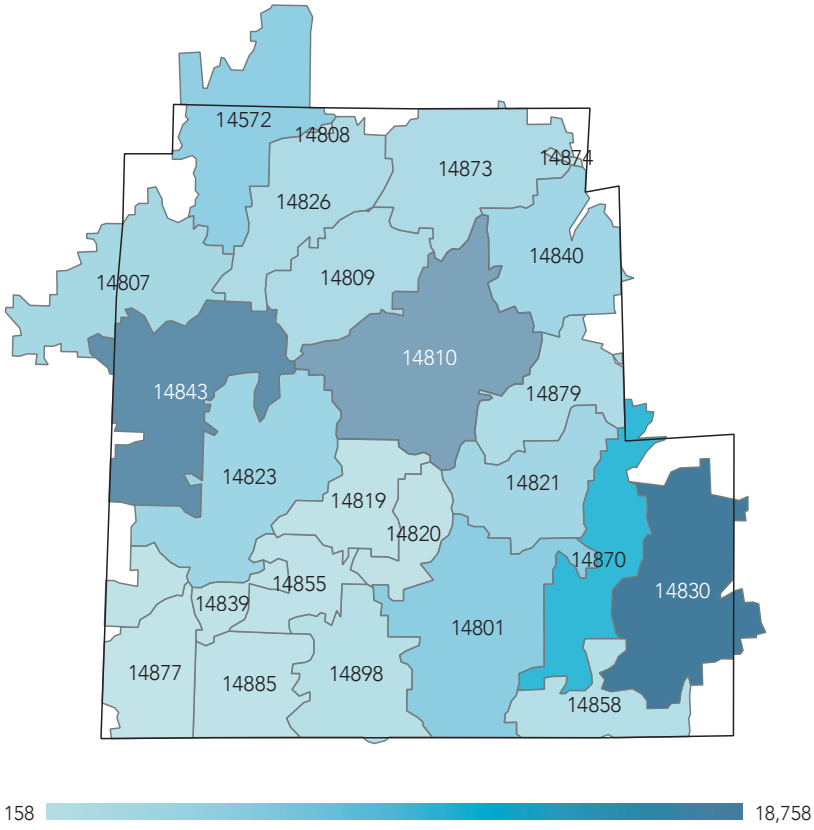
Each of the above indicators impacts the health of the community. The next section takes a closer look at these demographic and socioeconomic indicators and also includes a review of behavioral and political environments in Steuben County that impact the health of its residents. Finally, the section will highlight the community's assets and resources that may be leveraged to improve health through identified evidence-based interventions.

# COUNTY CHAPTER – STEUBEN COUNTY

## Demographic and Socioeconomic Health Indicators

Steuben County is located in the southernmost portion of the Finger Lakes Region, situated between Allegany and Chemung Counties and bordering the Pennsylvania state line. There are 93,584 total residents spread throughout the county, but areas with the densest population include Corning (14830), Bath (14810) and Hornell (14843) (Map ST1). The population is primarily white non-Hispanic (94%), with Black non-Hispanic, Hispanic and other individuals each representing 2% of the remainder of the population. Women of childbearing age comprise approximately 21% of the population, about 11% are veterans, and 15% of individuals are living with some form of disability.[1]

### Map ST1: Steuben County Population by ZIP Code

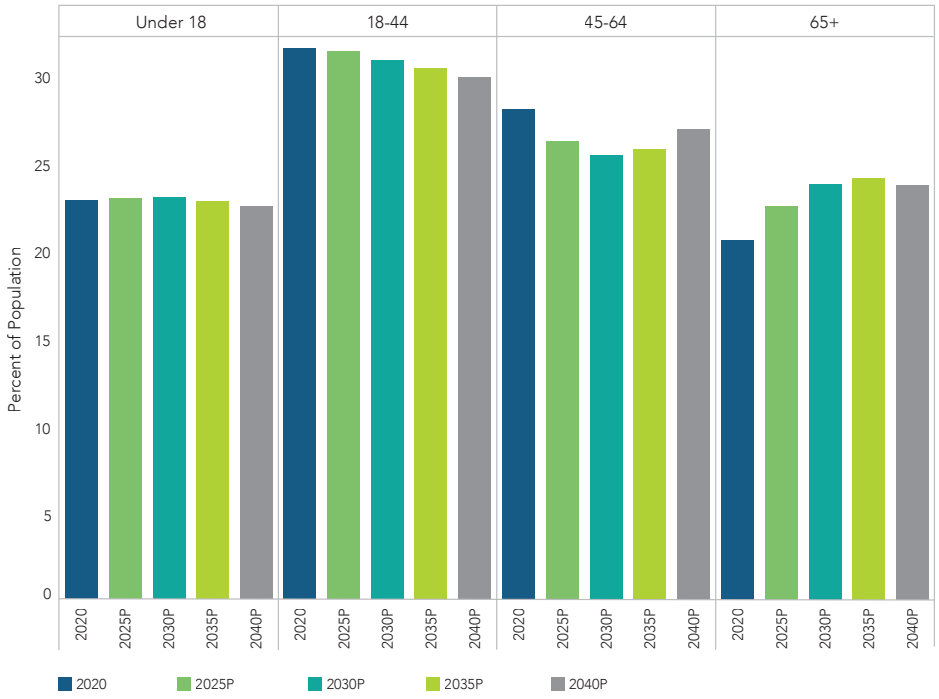



Source: Claritas zip-level estimates and CDC Bridged-Race county-level estimates, Year 2020. Population data and allocation methods developed by Common Ground Health.

The majority of those living with a disability in Steuben County are 65 years of age or older (about 68%). The three types of disabilities most prevalent to this age group are independent living difficulty (about 11%), hearing difficulty (about 14%), and ambulatory difficulty (about 20%). Additionally, about 28% of the population aged 65 years or older are living alone.


1. American Community Survey (ACS) 2019 5-Year Estimates

## Figure ST2: Population Projections for Steuben County

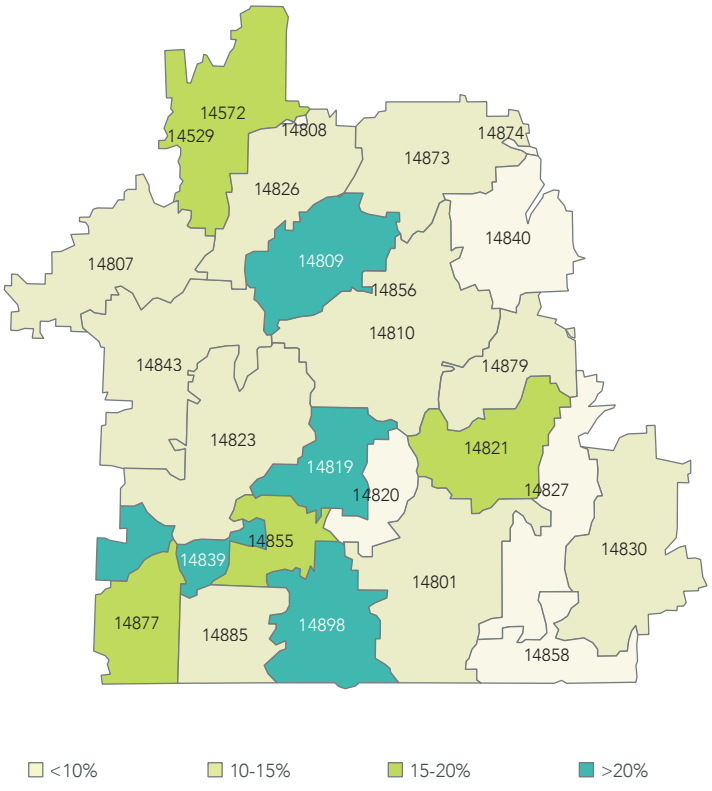



Source: Cornell University - Program on Applied Demographics, County Projections Explorer, Year 2020
Analysis Completed by Common Ground Health

Population projections from Cornell University's Program on Applied Demographics (shown in Figure ST2) show that the largest age group within Steuben County currently is residents ages 18-44, followed by the 45-64 age bracket. However, within the next few decades, the 65+ population is expected to grow. As this population grows, there will be a greater demand on health care needs and services including chronic disease management and geriatric care.

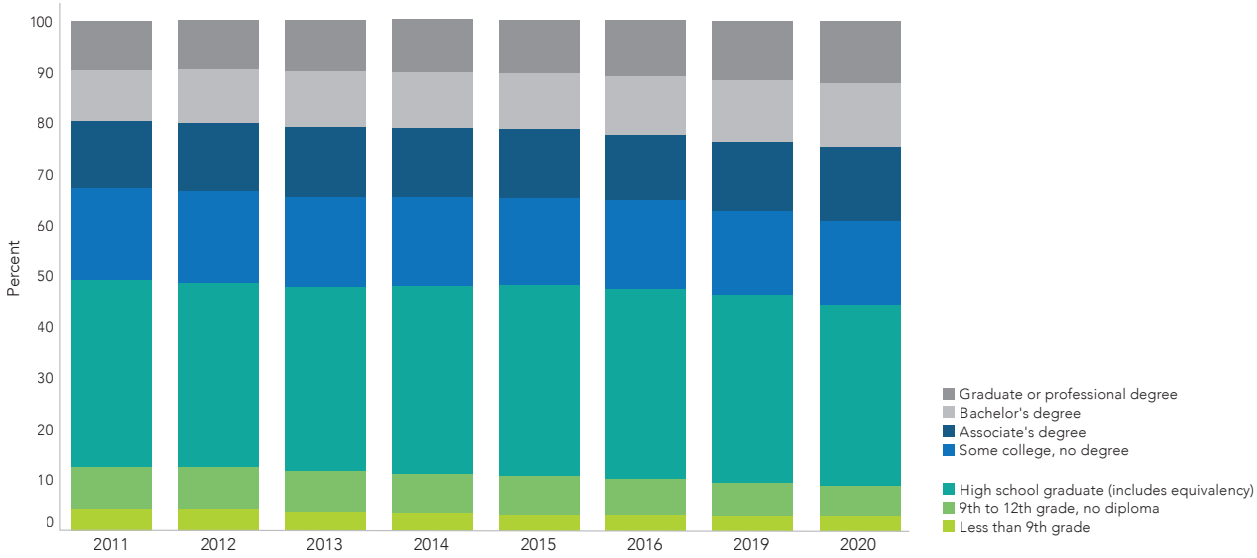
An estimated 1 in 7 individuals (about 14%) within Steuben County are living below the poverty level. As shown in Map ST3, ZIP codes with the highest poverty rates are primarily located in the southwestern portion of the county, with the exception of ZIP code 14809.

## Map ST3: Percent of Population in Poverty




Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

## Figure ST4: Educational Attainment of Residents Aged 25+

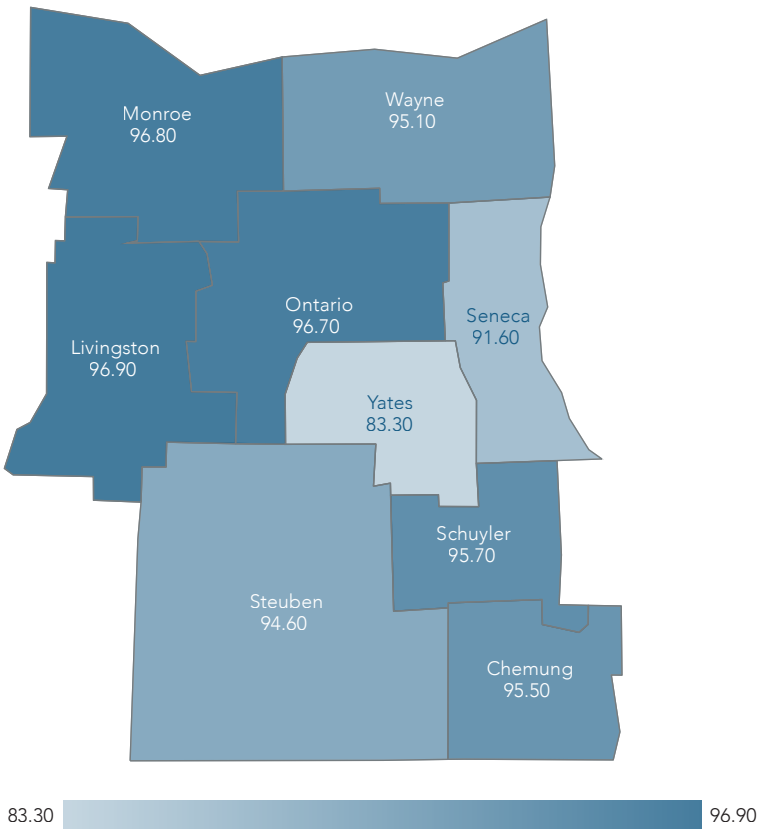



Data Source: US Census Bureau, American Community Survey (ACS), Year 2020.
Analysis Completed by Common Ground Health

As seen in Figure ST4, educational attainment levels have remained fairly consistent from 2015 to 2020. However, in recent years, Steuben County has seen a slight increase from approximately 35% in 2015 to about 39% in 2020 in higher education attainment (percentages mentioned include associate's, bachelor's, and graduate/professional degrees). This can positively affect the community as higher educational attainment generally equates to greater health outcomes.[2]

Map ST5 displays the percent of the population with health insurance, by county, for the Finger Lakes Region. In 2020, about 95% of Steuben County was insured, which increased from about 93% in 2017.

## Map ST5: Percent of Population with Health Insurance, by County




Source: US Census Bureau, ACS, Year 2020
Analysis Completed by Common Ground Health



2. Hahn, R. A., & Truman, B. I. (2015). Education Improves Public Health and Promotes Health Equity. International journal of health services: planning, administration, evaluation, 45(4), 657–678. https://doi.org/10.1177/0020731415585986

Obtaining health insurance is not the only factor in accessing healthcare. Availability and accessibility to providers are equally important considerations. The Department of Health and Human Services states that nearly 35% of Steuben County's population is living in a Health Professional Shortage Area (HPSA) compared to 27% of New York State residents. Providers are generally sparse in the most rural areas, which may be cause for concern for those with lack of transportation to access services. A summary is below:

**Mental Health Providers:** Mental health providers in Steuben County are available at a ratio of one mental health provider per 480 residents, which is compared to the NYS ratio of one provider per 310 residents.[3] Mental health providers are defined here as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care. Of note, Steuben County Community Mental Health Center, both Mental Health and Steuben County Alcohol and Substance Abuse Services (SCASAS) departments, now offers Medication-Assisted Treatment as well, including buprenorphine.

**Dental Health Providers:** Dental health providers are available at a rate of 2.0 per 10,000 population within Steuben County, which is lower than New York State's rate of 3.7.[4] Dental providers are concentrated primarily in the Hornell, Bath, and Corning locations.

**Primary Care Providers:** Primary care providers within Steuben County are available at a rate of 9.2 per 10,000 population, compared to the NYS rate of approximately 11.0. Primary care providers are available in similar locations as dental providers, but nurse practitioners (Steuben County rate of 4.9 per 10,000 population, NYS rate of 3.5) are more readily available in southwestern Steuben.[5]

**Housing:** With regard to housing, about 27% of Steuben County residents rent versus own their own home. The average household size is greater than two people for both renter- and owner-occupied units. Of note, about 33% of residents are paying 35% or more of their household income in rent costs, which is considered an overburdened household. Likely, these same households may be experiencing financial strain in other components of their life (food, health care, etc.).

**Transportation:** Out of all occupied housing units, about 9% have no vehicles available and an additional about 34% have access to one vehicle. When comparing across the Finger Lakes Region, 211 calls within the past year regarding transportation assistance were highest within Steuben County with 947 calls (followed by Monroe County with 741). Approximately 88% of those transportation request calls were for medical transportation, and another 8% were for public transportation. The majority of transportation requests originated from Bath (about 31%), Corning (22%), Hornell (about 12%), and Painted Post (about 12%).

3. 2022 County Health Rankings for Mental Health Providers (using 2021 data)
4. Centers for Medicare and Medicaid Services, CMS-National Plan and Provider Enumeration System (NPPES), May 2021
5. US Department of Health and Human Services, Health Resources and Services Administration, HRSA-Health Professional Shortage Areas Database, May 2021

## Main Health Challenges

On February 1, 2022, a diverse group of stakeholders representing various aspects of the community as well as underserved and minority populations, were invited to attend a health priority setting meeting. At this meeting, participants reviewed the overarching goals of the New York State Prevention Agenda and relevant qualitative, quantitative, primary and secondary data. A pre-read document containing detailed county specific analyses relating to the five Prevention Agenda priority areas was sent to all participants for review in advance. Primary and secondary data were collected from a variety of sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, primary data collected from Pivital Public Health Partnership and Common Ground Health's My Health Story Survey, and 211 Helpline. My Health Story 2018 was a regional survey completed on behalf of nine counties in the Finger Lakes Region. Its primary purpose was to gather primary qualitative and quantitative data from Finger Lakes Region residents on health issues in each county. Health departments, hospitals and other local partners were instrumental in distributing the survey to community members including disparate populations. The survey was updated in the summer and fall of 2022 and will be used to help inform potential shifts in strategies to improve the priority areas selected by Steuben County.

After initial review of the priority areas, a multi-voting technique was used to select the priority areas. Participants were asked to consult with other members of their organization and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinants of health considerations, and capacity to address the issue for each priority and focus area discussed. Steuben County had twenty eight members of the Smart Steuben team participate in the survey. The following areas were selected for the 2022-2024 Community Health Improvement Plan:

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Healthy eating and food security |
| **Disparity** | **Low socioeconomic status population** |

Following this selection, Common Ground Health gathered data on all objectives from the New York State Prevention Agenda within the chosen priority areas. Objectives were color coded based on data status to help focus attention where it was needed most; red objectives were neither meeting the Prevention Agenda goal nor trending in a favorable direction, yellow objectives were either not meeting the Prevention Agenda goal or not trending in a favorable direction, and green objectives had both met the goal as well as trended in a favorable direction. Objectives that were color coded as grey represented a lack of current and/or reliable data. Color coded data on objectives were presented to the team during April's Smart Steuben meeting and partners utilized the data, as well as potential scope and interest of the group, to determine the objectives with which they would proceed. Color-coding of selected objectives can be found in Appendix 3.

## Risk and Protective Factors Contributing to Health Status

Steuben County has selected two focus areas on which to anchor their 2022-2024 Community Health Improvement Plan. This section will take a closer look at the behavioral, environmental, political and unique risk and protective factors contributing to the health status of those areas.

### Prevent Mental and Substance Use Disorders

The opioid overdose epidemic has been of concern for several decades now. The CDC stated that the number of drug overdose deaths has quadrupled since 1999,[6] and provisional data from November 2021 showed an estimated 100,306 drug overdose deaths in the United States from April 2020-April 2021. This represented an approximately 29% increase from the previous year.[7] Per the Statewide Planning and Research Cooperative System (SPARCS) database, the rate of emergency department visits within Steuben County related to opioid use increased from 38.2 per 100,000 in 2016 to a rate of 65.8 in 2017, then decreased to rates of 56.6 and 55.7 per 100,000 in the following two years. ODMAP data for Steuben County showed 141 overdoses with 9 fatalities in 2020, 264 overdoses with 15 fatalities in 2021, and 74 overdoses with 5 fatalities through March 31st of 2022.

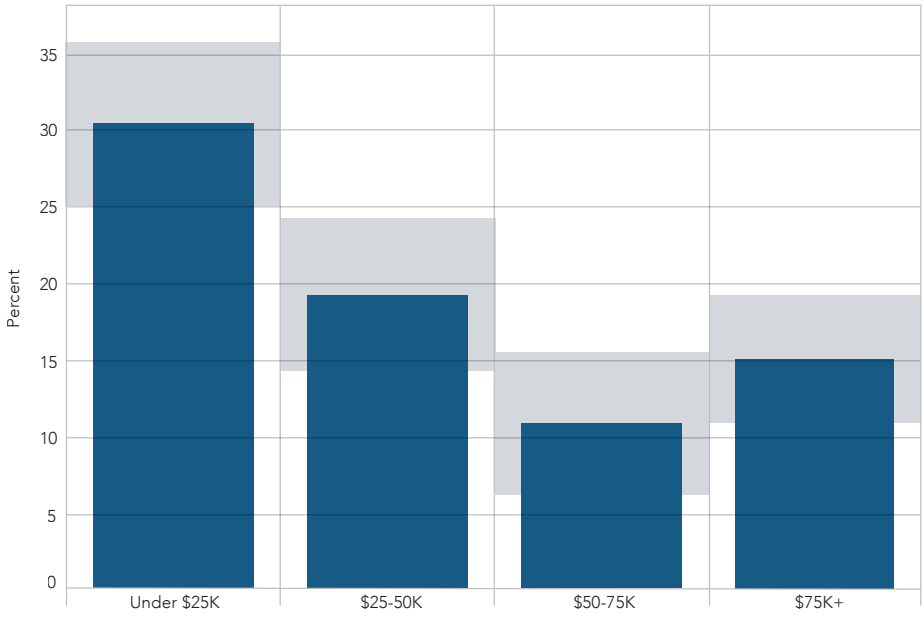
Steuben County partners noted contributing factors such as: the county is understaffed with resources such as mental health providers and social workers; a lack of affordable housing and appropriate housing, especially for those trying to get sober and maintain sobriety; unemployment; and a lack of coping skills on behalf of the patient. Additionally, it was noted that bail reform is resulting in reduced or lacking accountability and intervention in regard to the legal system. Probation and parole struggle with being able to hold clients accountable for noncompliance with treatment, continued use, and reoffending. Partners said under bail reform, clients go to jail and are quickly released with a follow up court appearance, but may not show. The courts are limited with consequences as well, which perpetuates the cycle.

Current efforts to decrease opioid overdoses within Steuben County include the Opioid Committee's application for a training program for naloxone, an opioid overdose antidote, which has been approved by the Department of Health, as well as peers available through AIM Independent Living Center, Catholic Charities and Steuben County Alcoholism and Substance Abuse Services (SCASAS). There are medication drop boxes at 16 locations in Steuben, including at Ira Davenport Memorial Hospital (IDMH), Corning Hospital, and Guthrie Corning Centerway. Also, at the IDMH emergency department, if patients are interested in getting help with opioid abuse, they are connected with a social worker who provides information on outpatient services and helps to schedule a first appointment. In addition, IDMH has six beds dedicated to medically managed detoxification; patients are then either discharged to an inpatient setting or set up with outpatient support visits. All Arnot practitioners have their prescribing of controlled substances monitored and benchmarked, and they follow the New York State Department of Health regulations regarding opiate prescribing. Arnot Health also provides access to board certified addiction medicine physicians, an inpatient addiction unit and many primary care locations that utilize suboxone in treating opiate addiction, and utilize the CAGE-AID Substance Abuse Screening on all patients 18 or older to look for possibility of an alcohol or substance use disorder. They provide two separate pain management sites that recommend non-opiate medications as well as interventions such as spine injections, physical therapy, acupuncture, manipulations, and healthy lifestyle practices.


6. CDC: Understanding the Opioid Overdose Epidemic, March 2021
7. CDC: Drug Overdose Deaths in the US Top 100,000 Annually, November 2021

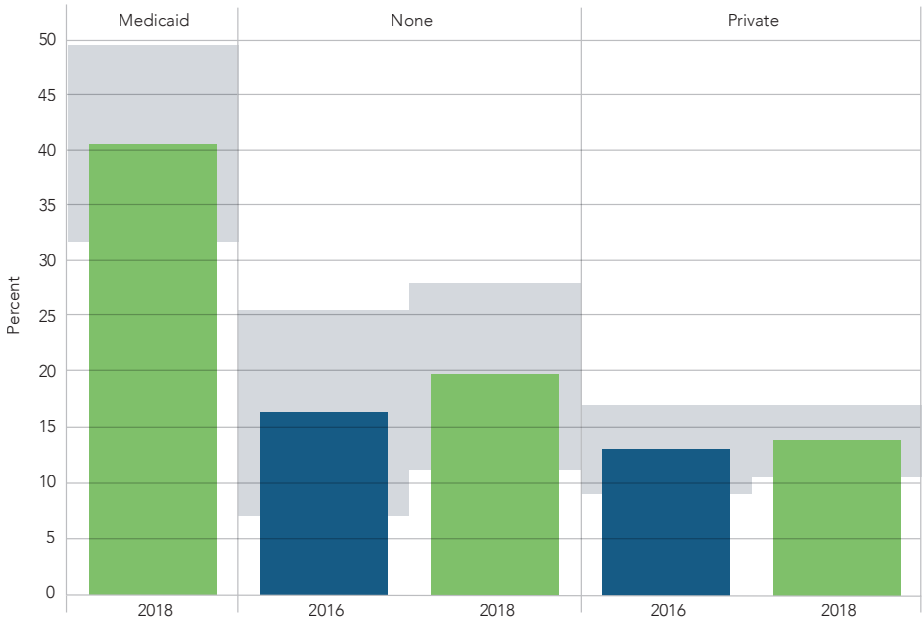
Rates of depressive disorders among adults increased within Steuben County from 18% in 2016 to 28% in 2018.[8] Additionally, within the Finger Lakes Region, adults with household incomes of less than $25,000 had a higher rate of depression than adults with higher household incomes (Figure ST6), as were those with Medicaid as their health insurance compared to no health insurance or private (Figure ST7). These percentages specifically reference depression, major depression, dysthymia, and minor depression. With the occurrence of the COVID-19 pandemic and the current state of mental health within the nation, it is likely that this percentage has increased since then.

## Figure ST6: Percent of Adults within the Finger Lakes Region who have been told they have a Depressive Disorder (by Household Income)




Data Source: BRFSS 2018
*This data includes depression, major depression, dysthymia, and minor depression.
**Prevention Agenda goal for major depressive disorders = 6.2%

## Figure ST7: Percent of Adults within the Finger Lakes Region who have been told they have a Depressive Disorder (by Insurance Type)




Data Source: BRFSS 2018
*This data includes depression, major depression, dysthymia, and minor depression.
**Prevention Agenda goal for major depressive disorders = 6.2%

Depression affects a person's entire wellbeing, including both mental and physical health. It could lead to adverse outcomes such as difficulty sleeping, heart disease, worsening of chronic conditions, substance use disorders and, in more extreme cases, suicide. Prioritization partners discussed how depression affected individuals of all ages within Steuben County, as well as potential contributing factors to the increase the county has witnessed over recent years. Partners felt stress, unemployment, housing concerns, and a lack of readily available treatment within the county contributed to the rate of depression among adults.

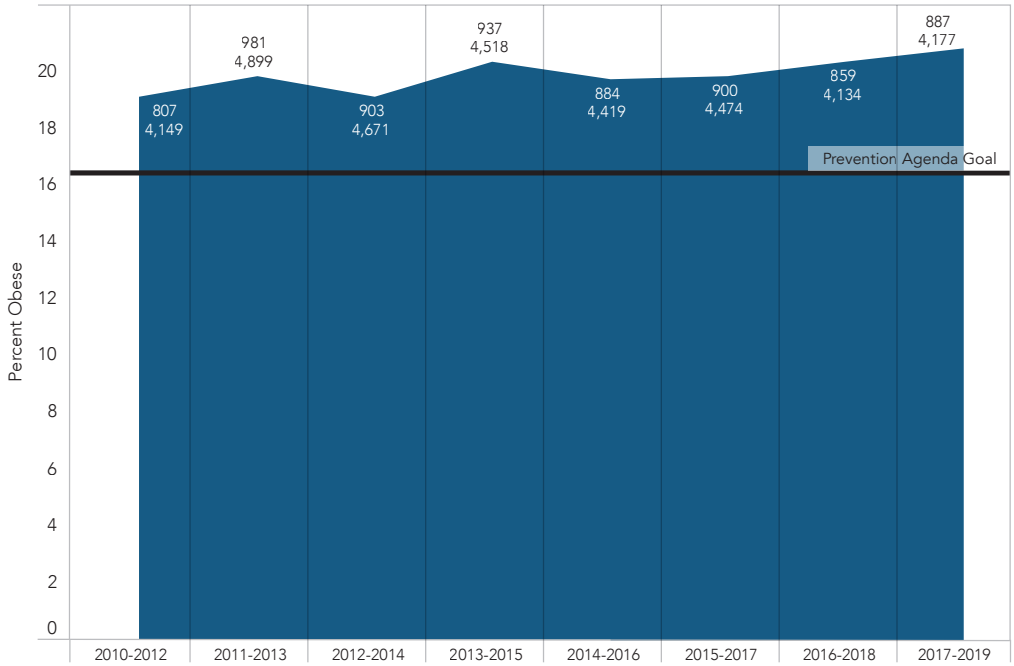
With regard to children's mental health specifically, it was noted that schools are having difficulty finding help for students in crisis. Additionally, there is a lack of social and fun activities for children to participate in, parental stress is trickling down to children, and they face isolation, social media, bullying, and burnout. The Steuben Prevention Coalition's Prevention Needs Assessment from 2021 surveyed 8th, 10th, and 12th grade students. The results showed that 393 respondents from Steuben County indicated they seriously considered suicide during the past 12 months, 309 said they made a plan, 82 actually attempted suicide one time, 77 attempted two to three times, 16 attempted four to five times, and 11 indicated they attempted suicide six or more times. Partners noted that these numbers were similar to those from 2019, thus COVID-19 was likely not the major contributor to this problem.

Within Steuben County, ProAction holds Neuroscience Epigenetics ACES Resilience (NEAR) trainings, Catholic Charities provides Healthy Families programs and curricula on social media safety, and the Opioid Prevention Task Force and the Department of Veterans Affairs are actively working on campaigns to destigmatize mental health.

## Healthy Eating and Food Security

Despite years of focus and interventions, childhood obesity within Steuben County has been consistently above the Prevention Agenda goal with about 21% of school-aged children reported as obese as of 2017-2019 (Figure ST8).

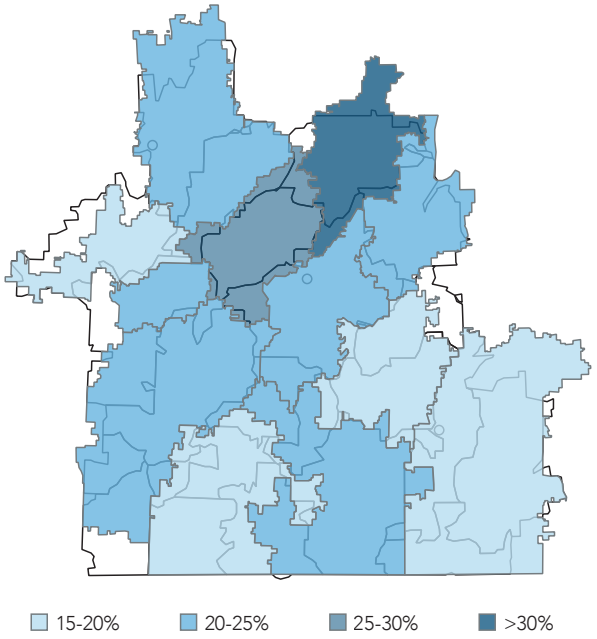
### Figure ST8: Percent of Students with Obesity



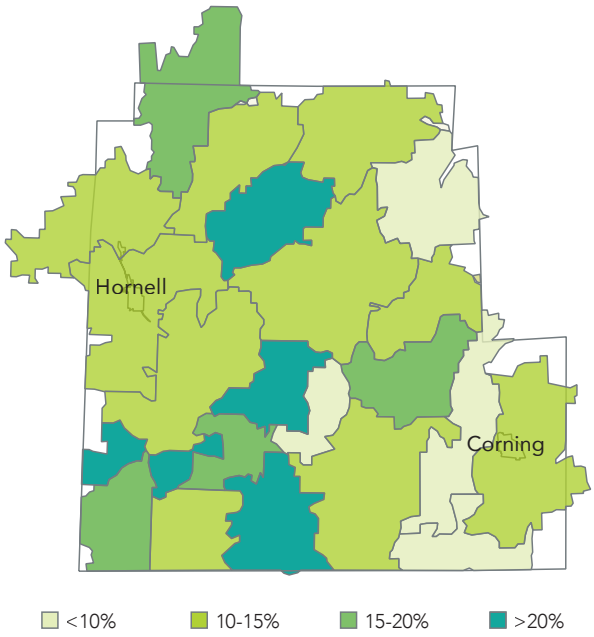

Data Source: NYS DOH, Health Data Connector, 2010 – 2019

Several co-morbid conditions such as metabolic, cardiovascular, orthopedic, neurological, hepatic, pulmonary, and renal disorders are associated with childhood obesity.[9] A number of behavioral and environmental factors were identified by community partners as contributors to this health concern. The cost associated with eating healthful foods is a barrier (Map ST9), and access to reliable transportation to purchase these items is also a barrier. Parents may lack knowledge around handling, preparation and storage of fresh fruits and vegetables, thereby limiting children's intake. Convenience is a key factor; families are often busy and "on the run," leaving less time and energy for home-prepared meals. At school, children have access to nearby fast food restaurants. The Steuben Prevention Coalition reported an increase in acceptance and consumption of energy drinks among children; in 2021, approximately 41-43% of surveyed 8th, 10th, and 12th graders were consuming energy drinks. Specifically with the onset of COVID-19, screen time increased and there were less playdates, recess and structured exercise.

## Map ST9: Percent of Students with Obesity (Left) and Percent of Steuben County Population Living in Poverty (Right)




Source: NYSDOH, Health Data Connector, Years 2017-2019
Analysis Completed by Common Ground Health




Source: US Census Bureau, ACS, Year 2019
Analysis Completed by Common Ground Health

 9. NIH National Library Of Medicine, Childhood obesity: causes and consequences, Journal of Family Medicine and Primary Care, 2015

Currently, within Steuben County, Cornell Cooperative Extension's Expanded Food and Nutrition Education Program offers an evidence-based nutrition education curriculum to parents of children aged 5-18, and they received a grant to provide meal-kits-to-go with each lesson so parents can cook the meal they learned to prepare at home. SNAP Ed of the Southern Finger Lakes provides an evidence-based nutrition program to those living in poverty and holds classes at local food pantries. Childcare programs such as Head Start utilize the "Eat Well Play Hard" and "I Am Moving I Am Learning" curriculums, which also engage parents through recipes. Steuben Rural Health Network at The Institute for Human Services' programs Girls on the Run of the Southern Tier and Cope2Thrive educate youth on eating well, physical activity and coping skills.

The Corning Youth Center offers cooking classes, and Catholic Charities Prevention Services provides healthy lifestyle programs. Additionally, the Childcare Council has a farm to preschool program that helps keep childcare programs connected to the farmers markets throughout the county.

## Community Assets and Resources to be Mobilized

The Finger Lakes Region already has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies that promote and facilitate collaboration: Pivital Public Health Partnership (previously the S2AY Rural Health Network) and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors – hospitals, insurers, universities, business, nonprofit, faith communities and residents – to collaborate on strategies for improving health in the region. Both agencies provide support, collaboration and resources to improve health of Steuben County residents.

During brainstorming sessions at the May 3, 2022 Smart Steuben meeting, partners identified several additional assets and resources within Steuben County that could be mobilized toward selected objectives and interventions. Organizations and programs such as the YMCA, Cornell Cooperative Extension (including SNAP and 4-H programs), Corning Youth Center, ProAction (including Head Start and WIC), Girls on the Run of the Southern Tier, school districts, and food pantries were identified as potential partners and resources with regard to decreasing childhood obesity. Several of these organizations are actively involved in the community health improvement plan process and are working towards the same goal of improving health and well-being of not only youth, but the population as a whole. The collective impact approach of working together with various organizations to achieve the same goal through different pathways is a tactic that may prove more successful than a siloed approach.

Similarly, ProAction, Catholic Charities Prevention Services, faith communities, Office for the Aging, the Steuben Prevention Coalition and its Opioid Committee, Department of Veterans Affairs, hospitals, and 211 were noted as resources to help improve mental health and decrease substance use within the community.

Through implementation of the Community Health Improvement Plan, Smart Steuben partners will work to leverage these pre-existing agencies and services. The Steuben County Community Health Improvement Plan document has a full description of interventions and partner roles.

## Community Health Improvement Plan/Community Service Plan

As previously discussed in Main Health Challenges, a multi-voting technique was used to select the priority areas for the Community Health Assessment and Community Health Improvement Plan. County specific pre-read documents were provided to Smart Steuben and prioritization partners, which included updated data measures for each of the five priority areas outlined in the Prevention Agenda. This was followed with additional county specific data on objectives within the chosen priority areas to help identify objectives, disparities and interventions to include within the plan. A concerted effort took place during December 2021 to ensure the governing Community Health Assessment and Community Health Improvement Plan body, Smart Steuben, was equipped with a diverse and inclusive group, which represented all areas of health and well-being in the county. The following organizations were engaged in Steuben County's planning and prioritization process:

| STEUBEN COUNTY PLANNING AND PRIORITIZATION AGENCIES | | |
|---|---|---|
| Steuben County Public Health | Community Services/Steuben County Alcohol and Substance Abuse Services (SCASAS) | Oak Orchard Health |
| Pivital Public Health Partnership | UR St. James Hospital | Pregnancy Resource Center of the Valleys |
| Arnot Health | Guthrie Clinic/Corning Hospital | Steuben Prevention Coalition/ Opioid Committee |
| Common Ground Health | VA Finger Lakes Healthcare System | Southern Tier Library System (STLS) |
| Pro Action of Steuben & Yates, Inc. | Finger Lakes Community Health | Hornell YMCA |
| Steuben Rural Health Network at THE INSTITUTE FOR HUMAN SERVICES, INC. | Southern Tier Tobacco Awareness Coalition (STTAC) | Corning Wegmans |
| County Legislature | Tri-County Family Medicine | Catholic Charities/Steuben Prevention Services |
| Community Services/Suicide Prevention Coalition | Corning Community College | UR Primary Care |
| Cornell Cooperative Extension | | |

Interventions to target the selected priority areas were discussed and determined by the public health department and their team of community partners at Smart Steuben meetings. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will continue to take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Steuben County Community Health Improvement Plan. All interventions selected are evidence based or evidence-informed and strive to achieve health equity by focusing on creating greater access for the low socioeconomic status population, the disparity identified by Steuben County.

Smart Steuben, a group of diverse partners who, outside of CHA/CHIP development, meet bi-monthly to improve the health of Steuben residents, will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

## Dissemination

The Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) will be shared with Steuben County's governing entity as well as posted to Steuben County Public Health's website and social media pages:

- Website: https://www.steubencountyny.gov/281/Community-Health
- Facebook: www.facebook.com/SCNYPublicHealth and www.facebook.com/smartsteuben
- Instagram: @steubenpublichealth
- Twitter: @steubencohealth

Steuben County, Keuka Lake in Autumn
Courtesy of the CorningFingerLakes.com

# APPENDIX 1

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# APPENDIX 2

## RESULTS-BASED ACCOUNTABILITY™

Results-Based Accountability™ is a disciplined way of thinking and acting to improve entrenched and complex social problems.[12] To facilitate CHA/CHIP development, resulting in a CHIP that measurably improves health, the following steps were followed:

1. **Define the Community:** Data collection is an important first step. In this step, it is important to gather data for the community at large (county-level data) as well as data that identified vulnerable populations within the community who are at risk for poorer health outcomes. This can happen by collecting and analyzing data that shows differences in rates of illness, death, chronic conditions and more in relationship to demographic factors. The planning committee brainstormed specific potential vulnerable populations in the county to be considered with data collection.
2. **Engage Stakeholders:** Population health requires engagement from many sectors. Complex social, economic and environmental factors are all determinants of health; therefore, there is no one organization, department or program that can be held solely responsible for the health of a population. Diverse engagement began in November/December 2021, early in the CHA development process. Committee partners completed an exercise to brainstorm potential new partners from the following sectors: Local Government, Businesses, Not-for-Profit and Community Organizations, Academia and the General Public. The following questions were used to assist brainstorming:
   - Who are those with potential interest and influence who can contribute to the CHA/CHIP process?
   - What population do they represent? (including vulnerable populations identified in Step 1)
   - Identify their potential level of interest and influence (High Interest/High Influence, Low Interest/ High Influence, High Interest/Low Influence, Low Influence/Low Interest)
   - Who would be the best person on the committee to extend an invitation to the selected potential new partner?

After an assessment of brainstormed information, personal invitations were made to selected potential new partners to address any gaps on the committee and the need for diverse engagement.

3. **Engage in Comprehensive Data Collection:** Both primary and secondary data were collected. Disaggregated data was collected by race, gender, income and geography as available to identify vulnerable populations and to assist in strategy development. Data sources included, but were not limited to:
   - Common Ground Health: My Health Story
   - County Health Rankings
   - Vital Statistics
   - Behavioral Risk Factor Surveillance Survey (BRFSS)
   - United States Census Bureau
   - Cornell University Program on Applied Demographics
   - Statewide Planning and Research Cooperative System (SPARCS)
   - New York State Department of Health Perinatal Data Profile
   - S2AY Rural Health Network, Inc.: The Impact of COVID-19 on Food Security and Healthy Eating
   - Outreach to county committee partners for data from their respective organizations.


12. Results-Based Accountability - Overview and Guide (clearimpact.com)

4. **Prioritize Health Issues:** Data was analyzed and presented by Common Ground Health. After a review of analyzed health outcome data for trends, current state against benchmarks or Prevention Agenda targets, and differences among populations, a multi-voting tool was used by committee members to rank the health issues using selected criteria to identify top Focus Areas, which identified Prevention Agenda Priority Areas.
5. **A Deeper Dive of data was conducted by Common Ground Health.** To enhance the picture of the selected Focus Areas, related Prevention Agenda objective data was presented. A table with objectives and their status colors was created to help with the selection of objectives for this CHA/CHIP cycle.
   - Green Status – the prevention goal metric has been met and the trend of that metric is in the correct direction of the goal or steady
   - Yellow Status – either the prevention goal has not been met but the trend is in the correct direction or the goal has been met but the trend is in the wrong direction
   - Red Status – the goal has not been met and the trend is in the wrong direction
   - Gray Status – there is limited data on this metric available at this time

In addition, person, place and time was analyzed:

- **Person** - Are there certain populations at higher risk for poor outcomes? For example, are outcomes different based on age, race/ethnicity, education, or socio-economic status?
- **Place** - Are the outcomes in the county higher or lower than neighboring counties and the rest of the state? Are there high-risk neighborhoods in the county?
- **Time** - Do the trends over time show the outcomes improving, remaining the same, or declining?

If multiple objectives were identified, additional consideration was given to objectives that may have a greater impact on long term health and also have a good chance of positively impacting other objective indicators.

6. **Develop the Story Behind the Data:** Understanding the story behind the data ("WHY" the data looks the way it does) contributes to an increased understanding of the factors that impact the current state, as well as identifies contributing causes and potential solutions designed to have maximum impact. Results-Based Accountability's *Turn the Curve Thinking* was conducted for selected CHIP objectives/indicators to examine:
   - What is the story? What are the contributing causes to the trend of the selected CHIP objectives, including behavioral, environmental, policy and social determinant of health factors? 5 WHYS was conducted to help identify root causes.
   - Who are the partners that have a role in impacting contributing causes? What community assets or resources can be mobilized to impact identified causes?
   - What works to address identified contributing causes (including evidenced based interventions)?

*Turn the Curve Thinking* also determined a data development agenda, where counties identified if any additional data was needed on selected objectives and/or disparities, as well as a plan on how to collect that data.

7. **Select CHIP Interventions:** Upon completion of *Turn the Curve Thinking*, criteria was used to select interventions that will be included on the CHIP. Criteria used included:
   - How strongly will the proposed strategy impact progress as measured by the baselines?
   - Is the proposed strategy feasible?
   - Is it specific enough to be implemented?
   - Is the strategy consistent with the values of the community and/or agency?

*Turn the Curve Thinking* resulted in interventions which were linked with contributing causes and partners who could have an impact. It is our goal that, with successful implementation of diverse strategies by diverse partners, there will be a collective impact on *Turning the Curve* for the better on our CHIP objectives.

8. **Engage in Continuous Improvement:** To effectively monitor progress and effectiveness of each organization's contribution to selected CHIP objectives, intervention performance measures were identified that answer the questions:
   - How much did we do?
   - How well did we do it?
   - Is anyone better off?

Monitoring these intervention specific performance measures will identify if any focused quality improvement projects are required to improve intervention effectiveness and/or if revisions to CHIP interventions are required.

# APPENDIX 3

## HEALTHY EATING & FOOD SECURITY: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 1.1 | Decrease the percentage of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]) | | |
| 1.2 | Decrease the percentage of children with obesity | | |
| 1.4 | Decrease the percentage of adults ages 18 years and older with obesity | | |
| 1.6 | Decrease the percentage of all adults ages 18 years and older with obesity ( among adults living with a disability) | | FLR Data Only |
| 1.7 | Decrease the percentage of adults who consume one or more sugary drinks per day | | |
| 1.13 | Increase the percentage of adults with perceived food security | | FLR Data Only – S2AY Regional Survey data included |
| 1.5 | Decrease the percentage of adults ages 18 years and older with obesity (among adults with an annual household income of <$25,000) | | FLR Data Only |
| 1.8 | Decrease the percentage of adults who consume one or more sugary drinks per day (with an annual household income of <$25,000) | | FLR Data Only |
| 1.9 | Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day | | |
| 1.14 | Increase the percentage of adults with perceived food security (among adults with an annual household income of <$25,000) | | FLR Data Only |
| Note: Objectives 1.10, 1.11, and 1.12 had limited/unreliable data | | | |

# PREVENT MENTAL & SUBSTANCE USE DISORDERS: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 2.2.4 | Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate | | Only three data points (2016-2018), no real trend |
| 2.4.1 | Reduce the prevalence of major depressive disorders | | Only two data points (2016, 2018) |
| 2.5.2 | Reduce the age-adjusted suicide mortality rate | | |
| 2.1.2 | Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month | | Only two data points (2016, 2018) |
| 2.2.3 | Reduce the opioid analgesics prescription for pain, age-adjusted rate | | As of 2019 |
| 2.2.1 | Reduce the age-adjusted overdose deaths involving any opioid | | Crude rate through 2021 is below goal |
| 2.2.2 | Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder | | As of 2019 |
| 2.5.1 | Reduce suicide attempts by New York adolescents (youth grades 9 to 12) who attempted suicide one or more times in the past years | | |
| Note: Objectives 2.1.1, 2.1.3, 2.3.1, 2.3.2, 2.3.3, 2.4.2, and 2.6.1 had limited/unreliable data. | | | |

# STEUBEN COUNTY: SELECTED OBJECTIVES

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 1.2 | Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC]) | | |
| 2.2.4 | Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.3 per 100,000 population | | Only three data points (2016-2018), no real trend |
| 2.4.1 | Reduce the past year prevalence of major depressive episode among adults aged 18 or older by 5% to no more than 6.2%. | | Only two data points (2016, 2018) |

# WAYNE COUNTY

| COUNTY NAME: | WAYNE COUNTY |
|---|---|
| Participating local health department and contact information: | Wayne County Department of Public Health<br>Diane Devlin, RN, MS, BSN<br>Director of Public Health<br>ddevlin@co.wayne.ny.us<br>315-946-5749 |
| Participating Hospital/ Hospital System(s) and contact information: | Newark Wayne Community Hospital<br>Maura Snyder<br>Vice President of Operations<br>Maura.Snyder@rochesterregional.org<br>315-359-2644 |
| Name of entity completing assessment on behalf of participating counties/ hospitals: | Common Ground Health<br>Catriona Spier<br>Catriona.Spier@commongroundhealth.org<br>585-224-3107 |

Wayne County Sodus Bay Lighthouse
Photo credit: Wayne County Tourism

# EXECUTIVE SUMMARY

Through the use of Results-Based Accountability, Wayne County Public Health and Newark-Wayne Community Hospital, along with community stakeholders and partners, have chosen to focus their 2022-2024 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) on the following priority areas, with specific disparities selected for each objective (available in the CHIP document).

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area 1 | Healthy eating and food security |
| Focus Area 2 | Tobacco Prevention |

A complete list of participating partners is available within the Wayne County Chapter under "Community Health Improvement Plan/Community Service Plan." Agencies represented academia, not-for-profits, community organizations, local businesses, community members, and local government. These included Wayne County Public Health, Newark-Wayne Community Hospital, Pivital Public Health Partnership, Common Ground Health, Wayne County Aging and Youth, Wayne County Action Program, Wayne County Department of Social Services, Evalumetrics Research, Finger Lakes Community Health, Wayne Finger Lakes BOCES, Wayne County Behavioral Health, community members, Mosaic Health, Cancer Services Program, Cornell Cooperative Extension, Wayne County Rural Health Network, Council on Alcoholism & Addictions of the Finger Lakes, and Tobacco Action Coalition of the Finger Lakes. Partners' roles in the assessment were to help inform and select the 2022-2024 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings. Common Ground Health's 2022 My Health Story survey is currently underway, and this will help gain community insight on key health matters in the county and surrounding areas. Both primary and secondary data were reviewed including, but not limited to, the US Census Bureau's American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, Wayne County Evalumetrics Youth Survey (EYS), communicable disease and dental reports, data collected from Pivital Public Health Partnership (formerly known as S2AY Rural Health Network) and Common Ground Health's My Health Story 2018 survey, 211 Lifeline, the New York State Prevention Agenda Dashboard, County Health Rankings, and the Statewide Planning and Research Cooperative System (SPARCS).

The process of Results-Based Accountability included evaluation of a pre-read document, which contained detailed county-specific analyses related to the five Prevention Agenda priority areas, followed by a multi-voting technique to select the priority areas. Participants were asked to consult with other members of their organizations and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Partners came to a consensus to address the top priority areas identified by the survey, then additional county-specific data was collected, shared and evaluated to help determine which objectives, disparity, and interventions should be selected. A complete list of disparities, interventions, and process measures is available in the CHIP.

In forthcoming CHIP meetings, group members will identify and address any mid-course corrections in interventions and the implementation processes that need to take place. In addition, partners and the community will continue to be engaged and apprised of progress via these meetings.

# PLANNING AND PRIORITIZATION PROCESS

Wayne County followed a process called Results-Based Accountability to develop their needs assessment and improvement plans. There are several components to Results-Based Accountability, some of which include defining the community, engagement of a diverse group of stakeholders (including organizations representing underserved, low-income and minority populations), data collection and analysis, prioritization of health issues and disparity identification, and discussion of root causes for selected health issues to help identify appropriate and effective interventions. For additional information on Results-Based Accountability, this process is described in its entirety in Appendix 2. To pinpoint root causes of selected health concerns, the committee evaluated behavioral, environmental, social determinants of health, and policy causes that may be contributing to the current status of those concerns.

As demonstrated in the health indicator section, each county's residents face their own unique and challenging issues when it comes to their community, yet commonalities remain. There are a number of demographic and socioeconomic indicators which may impact health and are consistent concerns across the region. For example:

## AGE:

Variances in age can impact a community's health status. Older adults require more frequent medical check-ins, are more prone to illness, falls and unintentional injuries, and often experience more co-morbid conditions than younger adults and children. In addition, aging adults may not have access to a vehicle and rely on family, friends or public transportation for accessing basic needs and medical appointments. The strain of caring for an elderly adult may also negatively affect the caregiver. A community with higher rates of elderly adults may have worse reported health outcomes than a younger community.

## POVERTY:

Low income residents are more likely to experience a breadth of health issues not seen as often in wealthier residents. For example, lower socioeconomic status is linked to higher incidence of chronic disease, shorter life expectancy, and lower rates of good social, emotional and physical health. Low income may also force a person to choose between basic needs (such as housing, food, clothing, etc.) and preventative medical care. Often, and not surprisingly, the person will choose the basic need over preventative medical care. A community with higher rates of impoverished residents is likely to have worse health outcomes than wealthier communities.

## EDUCATION:

Education levels have been known to be a predictor of life expectancy. The Centers for Disease Control and Prevention reports that adults aged 25 without a high school diploma can expect to die nine years sooner than college graduates. Persons who attain higher education levels are more likely to seek health care, preventative care services, and earn higher wages. A more educated community may, therefore, have better health outcomes than a low educated community.

## HOUSING:

Access to quality and affordable housing is imperative to ensuring basic needs are met. Housing structures that are safe, clean, up to code and affordable help to improve community health. When incomes are consumed on rent or mortgages, residents may lack funds for preventative care services, medications, and healthy foods. Additionally, outdated, substandard housing puts tenants at risk for asthma and lead poisoning (especially children).

Each of the above indicators impacts the health of the community. The next section takes a closer look at these demographic and socioeconomic indicators and also includes a review of behavioral and political environments in Wayne County that impact the health of its residents. Finally, the section will highlight the community's assets and resources that may be leveraged to improve health through identified evidence-based interventions.

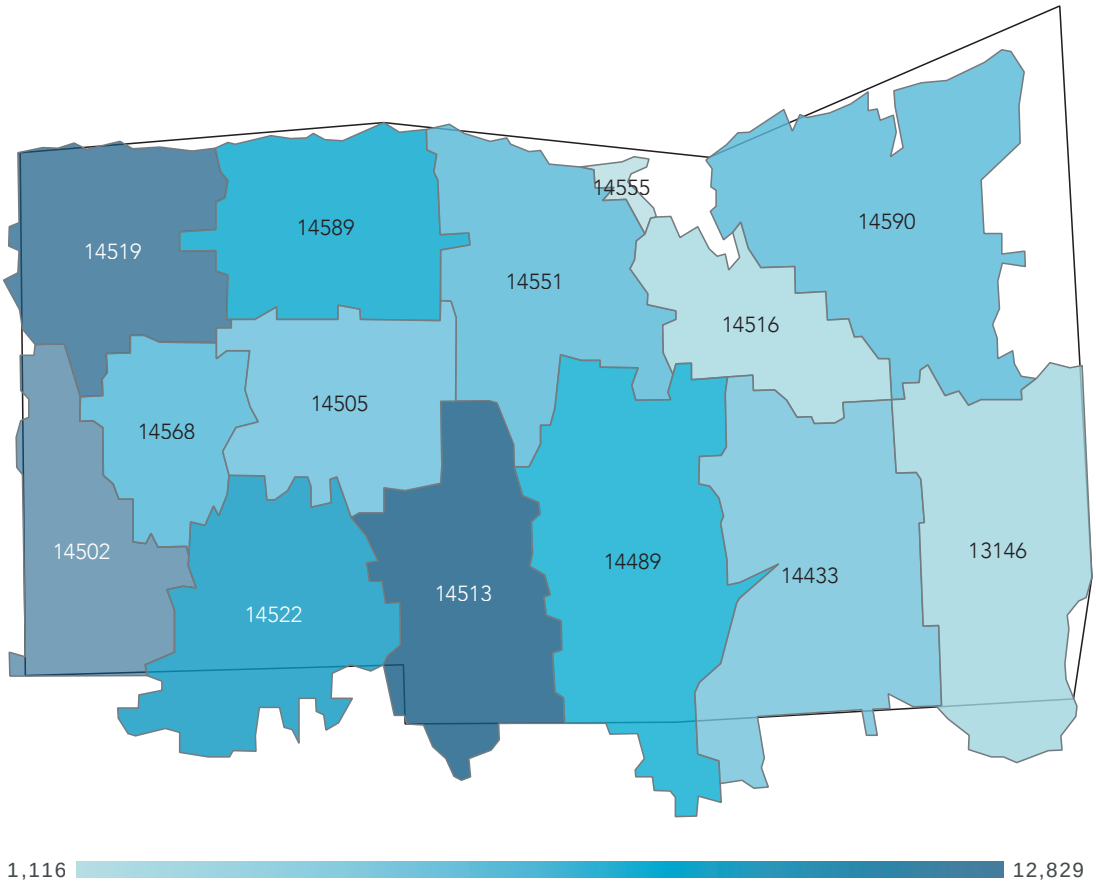
# COUNTY CHAPTER – WAYNE COUNTY

## Demographic and Socioeconomic Health Indicators

Nestled between the cities of Rochester and Syracuse, Wayne County is a rural, agriculturally-based county known for its rural charm, vast apple orchards, drumlins, and scenic beauty. Wayne County's northern border comprises 35 miles of Lake Ontario shoreline. Lake Ontario and the Western New York canal system provide a variety of opportunities for residents and visitors to participate in water activities, as well as fishing and hiking.

A total of 90,103 people live in Wayne County, concentrated on the western the towns of Ontario, Newark, and Macedon (Map W1). While the majority of Wayne County's residents (about 89%) are White non-Hispanic, the county is becoming more diverse with a growing Hispanic population. As of the 2020 Census, just over 4% of Wayne County's residents are Black non-Hispanic, and about 4.5% are Hispanic. Those who speak a language other than English make up about 5% of the population over 5 years of age, about half of whom speak Spanish. Compared to the other 8 counties in the Finger Lakes region, Wayne County has the highest percentage of foreign-born individuals who become naturalized United States citizens (70%). Veterans make up about 9% of the adult population. About 34% of older adults aged 65+ are living with a disability and around 12% of those 65 and older are living alone.[1]

### Map W1. Wayne County Population Density by ZIP Code



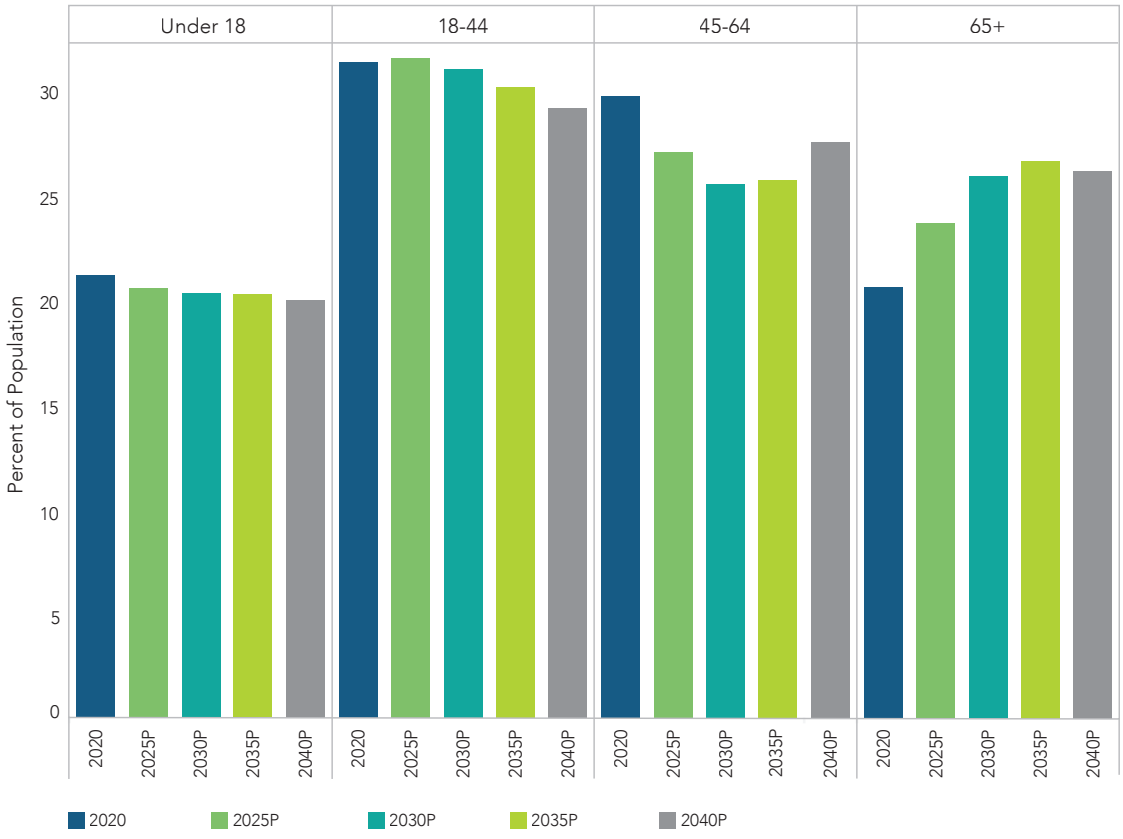

Source: Claritas zip-level estimates and CDC Bridged-Race county-level estimates, Year 2020.
Population data and allocation methods developed by Common Ground Health.


1. United States Census Bureau, 2020 ACS 5-Year Estimates

While population projections from Cornell University's Program on Applied Demographics show that the largest age group within Wayne County are those aged 18-44, the 45-64 and 65+ age groups are expected to grow over the next few decades (Figure W2). As these populations grow, there will be a greater demand on health care needs and services including chronic disease management and geriatric care.

Wayne County also has a large migrant worker population. Wayne County farms reported almost 3,000 migrant workers, which is the highest in the region. Finger Lakes Community Health (FLCH) serves a large number of Latinx and/or migrant workers in Wayne County, offering Spanish-speaking providers, home visits for patients unable to travel to a health center, migrant camp health clinics, and discounts based on income and household size.

## Figure W2. Population Projections for Wayne County, NY

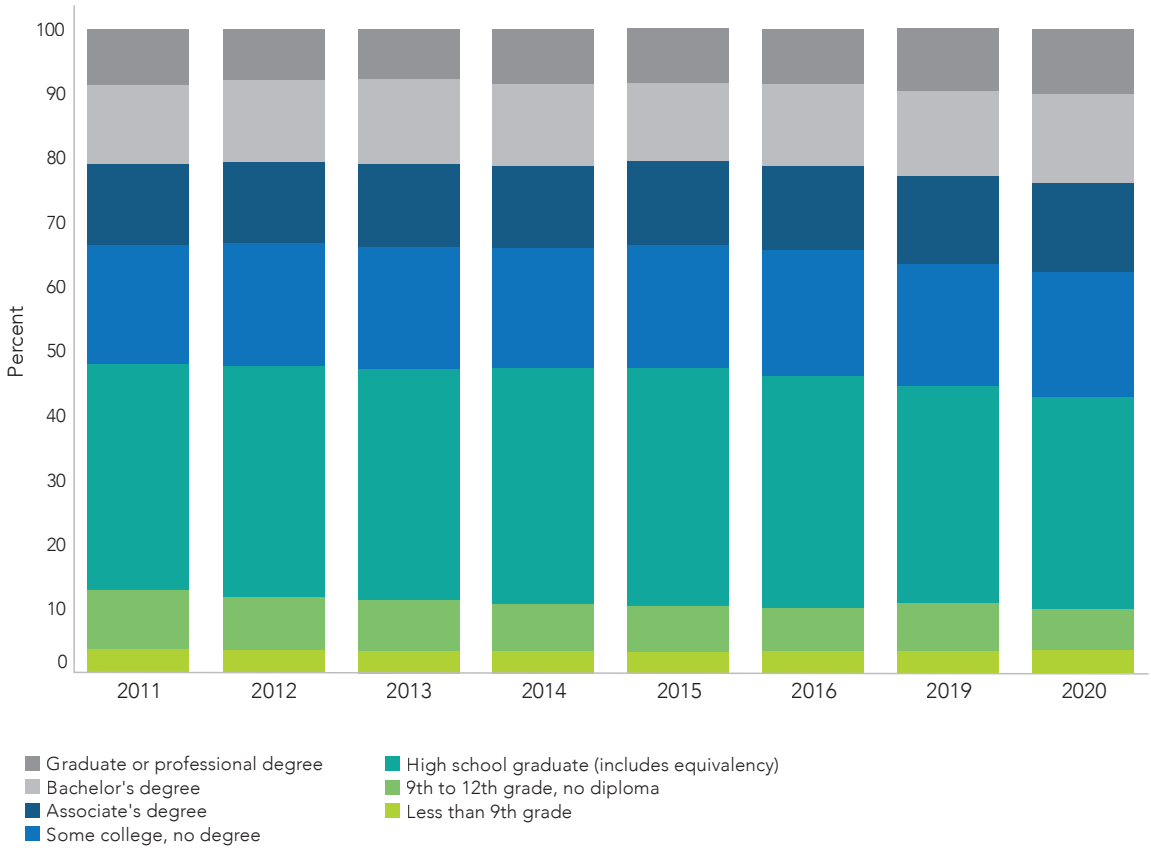



Source: Cornell University - Program on Applied Demographics, County Projections Explorer, Year 2020
Analysis Completed by Common Ground Health

Broadband internet access is limited to 81% of the population, meaning nearly one fifth of the County's residents do not have access to high-speed internet at home.[2] With schools transitioning to remote learning in 2020 due to the COVID-19 pandemic, this limited internet access was likely a barrier to many children who could not access their learning materials from home. In the fall of 2021, approximately 3,400 Wayne County households were without high-speed internet.[3]

Educational attainment has remained fairly stable overall from 2015 to 2020 (Figure W3). Looking specifically at Wayne County residents aged 25 years and older who earned at least a Bachelor's degree, this rate has slightly increased from around 21% in 2015 to about 24% in 2020.2 This increase was greater for males than for females.[2]

## Figure W3. Educational Attainment of Residents

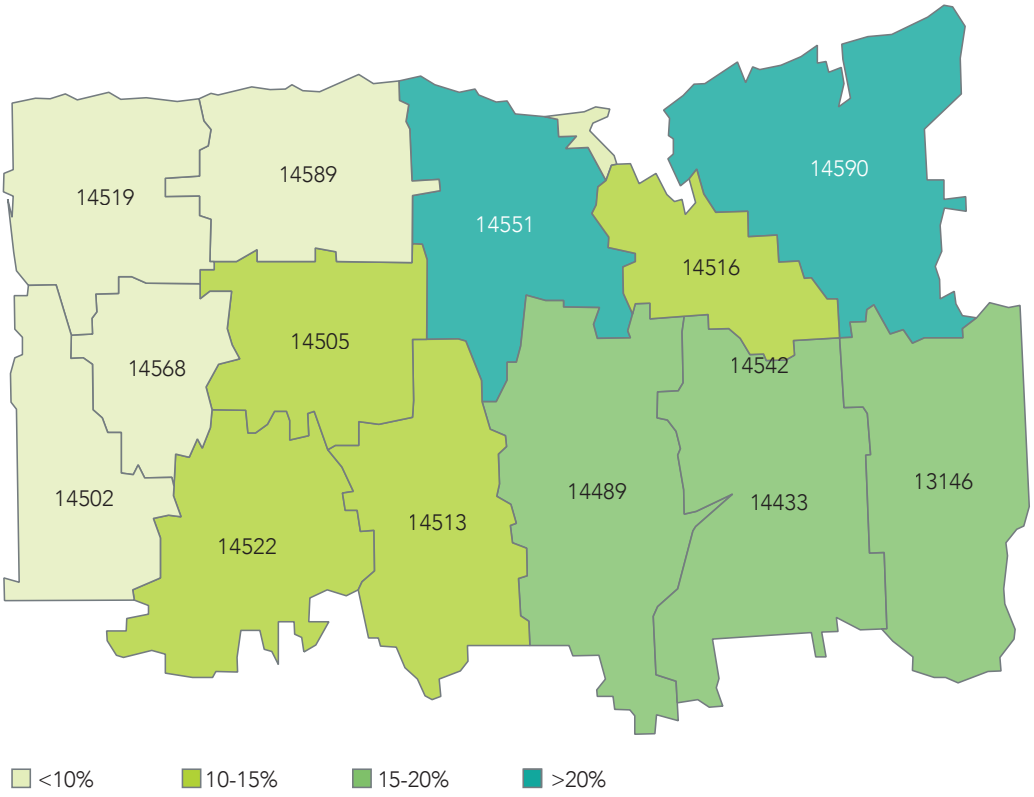



Data Source: US Census Bureau, American Community Survey (ACS), Year 2020.
Analysis Completed by Common Ground Health

2. United States Census Bureau, 2020 ACS 5-Year Estimates
3. Wayne County Looking to Improve Internet Access. Vivenzio. https://www.fingerlakesdailynews.com/2022/04/30/1421738/

The overall poverty rate in Wayne County is 11.6%, and for those who did not graduate high school, the poverty rate is almost doubled (20.8%).[4] There is a notable difference between the eastern and western sides of the county, with higher poverty rates seen in the eastern towns of Red Creek, Wolcott, Sodus, Clyde, Savannah and Lyons (Map W4). The difference in poverty rates between men and women is stark. Men in Wayne County are dropping out of high school at slightly higher rates than females (11% vs 9%, respectively), but females 25 and older who have not completed high school are experiencing much higher poverty rates (29%) than men (15%).[4] The single parenting rate for males is about half of the rate for females. Looking at all families with children, single female parents make up 13% whereas single male parents make up just over 6%.[4] The cost of daycare could be a contributing factor.

## Map W4. Percent of Population in Poverty by ZIP Code, Wayne County, NY

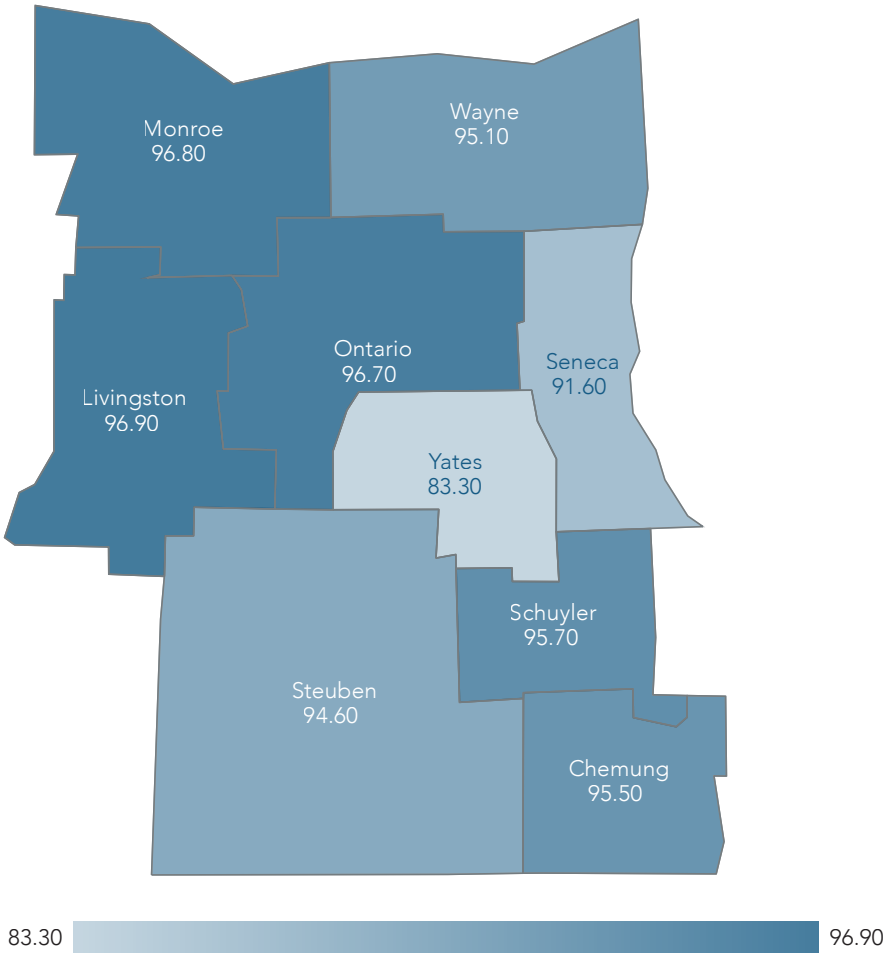



Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

In terms of housing, for those who rent their living space, over 38% are spending more than a third of their household income on rent. Almost 11% of occupied housing units have *no* vehicles available, and 35% of housing units have only one vehicle available.[5] Living in a rural county like Wayne, it can be very difficult to keep up with medical visits and obtain groceries, or to travel for a higher-paid job without access to a personal vehicle.


4. United States Census Bureau, 2020 ACS 5-Year Estimates
5. United States Census Bureau, 2020 ACS 5-Year Estimates

## Map W5. Percent of the Population With Health Insurance by County, Finger Lakes Region




The uninsured rate for Wayne County saw a steady decline from 2015 to 2019, with a slight increase in 2020 due to negative impacts related to the COVID-19 pandemic. This is consistent with trends throughout the Finger Lakes Region. As of 2020, about 95% of Wayne County residents were covered by health insurance (Map W5). Access to health insurance, however, is not the only barrier to receiving health care. Another concern is underinsurance and high deductibles, which make it difficult to pay for care even with insurance coverage. Transportation, lack of provider availability (including difficulty scheduling with providers) and cost (including cost of care, time away from work and childcare) are additional factors that should be considered from an accessibility standpoint.

Source: US Census Bureau, ACS, Year 2020
Analysis Completed by Common Ground Health

**Mental Health Providers:** Mental health & substance abuse providers are primarily located in Lyons, NY. In addition, Wayne Behavior Health clinicians are located within in every school district in Wayne County. Wayne County has a rate of about 78 mental health providers per 100,000, which is lower than the New York State rate of almost 200 per 100,000 population. Providers are primarily located in Lyons and Ontario with a gap in service in the northeastern corner of the county.[6] Addiction and substance abuse providers are available at a rate of around 17 per 100,000 and are only located in Lyons, Newark, and Ontario leaving the entire eastern and north central portions of the county without coverage in this area.

**Dental Health Providers:** Dental health providers are available at a rate of 23 per 100,000 residents in Wayne County, compared to about 38 per 100,000 in New York State.[6] Dental care providers are spread out more than the mental health providers, though there is the same gap in providers in the northeastern corner of the county. Many dental providers in Wayne County do not accept Medicaid insurance, further reducing access to dental care.

 6. Centers for Medicare and Medicaid Services, CMS-National Plan and Provider Enumeration System (NPPES), May 2021

**Primary Care Providers:** The rate of primary care providers in Wayne County is approximately 52 per 100,000 people, just about half of the New York State rate of 111 per 100,000.These providers are fairly evenly-spread across the county with a cluster in the southwestern corner.[7] Wayne County residents are facing a lack of specialty care which is a problem across the entire county, but is more pronounced on the eastern side of the county.

## Main Health Challenges

On March 18, 2022, a diverse group of stakeholders representing various aspects of the community were invited to attend a health priority setting meeting. At this meeting, participants reviewed the overarching goals of the New York State Prevention Agenda and relevant qualitative, quantitative, primary and secondary data. A pre-read document containing detailed county specific analyses relating to the five Prevention Agenda priority areas was sent to all participants for review in advance. Data were collected from a variety of sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, primary data collected from Pivital Public Health Partnership and Common Ground Health's My Health Story Survey, and 211 Lifeline. My Health Story 2018 was a regional survey completed on behalf of nine counties in the Finger Lakes Region. Its primary purpose was to gather primary qualitative and quantitative data from Finger Lakes Region residents on health issues in each county. Health departments, hospitals and other local partners were instrumental in distributing the survey to community members including disparate populations. The survey will be updated in the fall of 2022 and will be used to help inform potential shifts in strategies to improve the priority areas selected by Wayne County.

After initial review of the priority areas, a multi-voting technique was used to select the priority areas to focus on. Participants were asked to consult with other members of their organization and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and local capacity to address the issue for each priority and focus area discussed. As a result, the following areas were selected for the 2022-2024 Community Health Improvement Plan:

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area 1 | Healthy eating and food security |
| Focus Area 2 | Tobacco Prevention |

 7. Centers for Medicare and Medicaid Services, CMS-National Plan and Provider Enumeration System (NPPES), May 2021

Following this selection, Common Ground Health gathered data on all objectives from the New York State Prevention Agenda within the chosen priority areas. Objectives were color-coded based on data status to help focus attention where it was needed most. Red objectives were neither meeting the Prevention Agenda goal nor trending in a favorable direction, yellow objectives were either not meeting the Prevention Agenda goal or not trending in a favorable direction, and green objectives had both met the goal as well as trended in a favorable direction. Objectives that were color coded as gray represented a lack of current and/or reliable data. Color coded data on objectives were presented to the team during April's Wayne Health Improvement Partnership meeting. Partners utilized the data, as well as potential scope and interest of the group, to determine the objectives with which they would proceed.

## Risk and Protective Factors Contributing to Health Status

Wayne County has selected three focus areas on which to anchor their 2022-2024 Community Health Improvement Plan. This section will take a closer look at the behavioral, environmental, political and unique risk and protective factors contributing to the health status of those areas.

### Prevent Mental and Substance Use Disorders

2021 Evalumetrics Youth Survey (EYS) data showed that 37% of middle school students and 43% of high school students in Wayne County felt sad or depressed most days in the past year (Table W6). Between 8-12% of grade-school students made a plan for suicide (showed suicide ideation) in 2021 and 14-18% injured themselves when upset. The COVID-19 pandemic completely shifted the way grade-school students attended school, socialized with friends, and participated in physical activities. No doubt, this has impacted the above-stated mental health measures in Wayne County.

In addition to self-harm ideation and depressive feelings, almost 30% of middle and high school students had experienced two or more Adverse Childhood Experiences (ACEs) as of the 2021 survey (Table W6), which have a proven negative impact on mental health, according to the Centers for Disease Control.[8]

### Table W6. Mental Health Measures for Grade-School Students, Evalumetrics Youth Survey - Wayne Partnership, 2021

| | MIDDLE SCHOOL | | HIGH SCHOOL | |
|---|---|---|---|---|
| | White | Non-White | White | Non-White |
| Sad/Depressed | 37% | 37% | 43% | 46% |
| Suicide Ideation | 8% | 10% | 9% | 12% |
| 2+ ACEs | 27% | 30% | 38% | 39% |

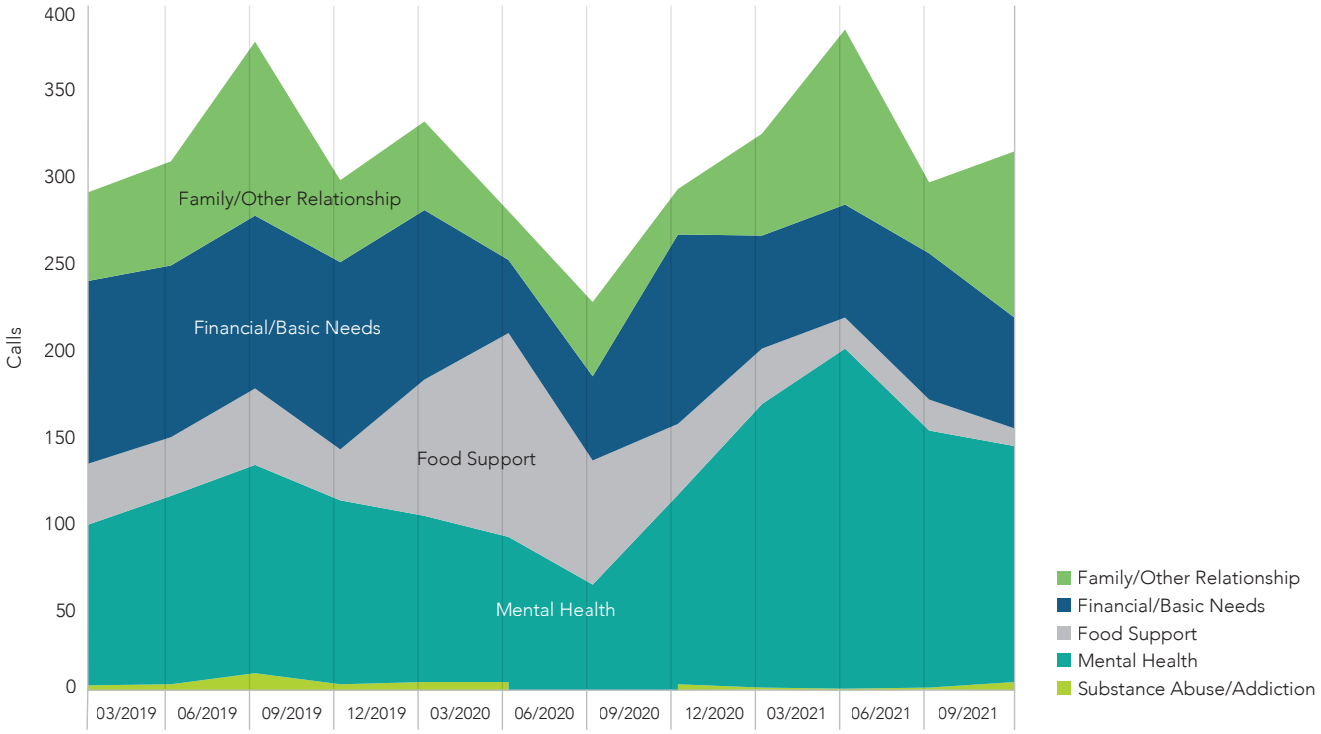
Data Source: Evalumetrics Youth Survey – Wayne Partnership, 2021



8. Centers for Disease Control and Prevention. (2019, November 5). Adverse Childhood Experiences (ACES). Centers for Disease Control and Prevention. Retrieved July 29, 2022, from https://www.cdc.gov/vitalsigns/aces/index.html#:~:text=Overview,the%20body%20responds%20to%20stress.

Goodwill 211 Lifeline calls in the Finger Lakes region from 2019 through 2021 showed sharp increases in calls related to family/other relationships, financial/basic needs, and food support. Looking specifically at Wayne County, 211 calls related to mental health showed a surge from 69 calls in mid-2020 to 196 calls in mid-2021 (Figure W7). Calls in other categories increased as well, but these rises seemed to be more a part of a cyclical trend rather than the conspicuous peak seen for mental health. This is indicative of the heavy toll the COVID-19 pandemic took on mental health for Wayne County residents. By the end of 2021, the rate had decreased to 136, which is encouraging, but still higher than the pre-2020 high of 44 calls.

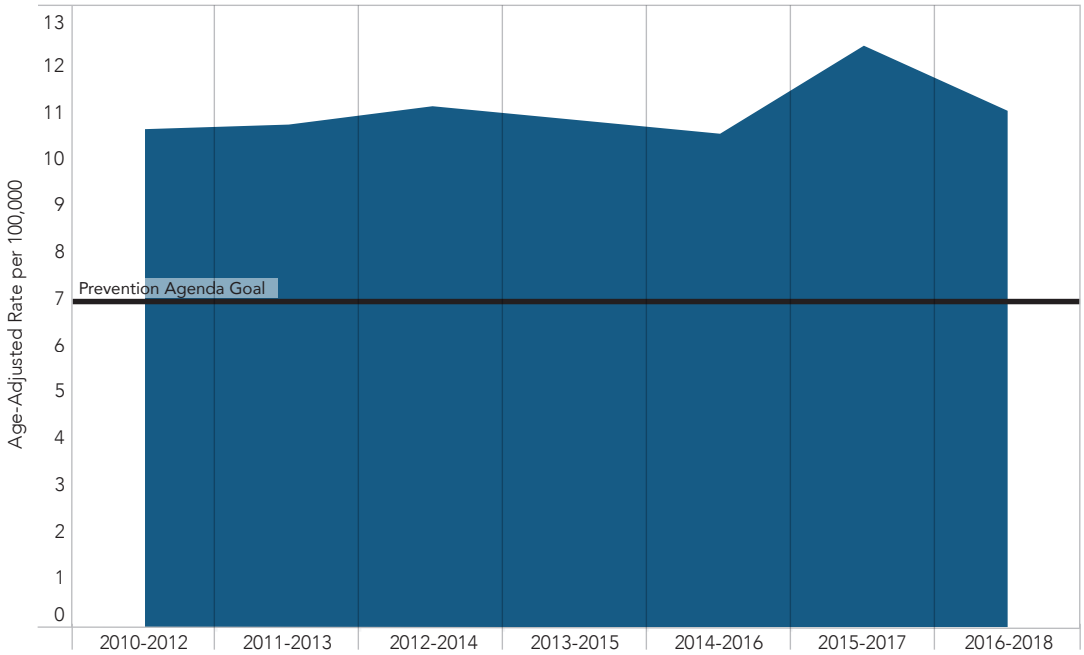
## Figure W7. Goodwill 211 Lifeline Call Counts - Wayne County, NY



Wayne County aerial view of Sodus
Photo credit: iStock.com/JacobBoomsma

Wayne County suicide mortality rates have been steadily above the prevention agenda goal of 7 per 100,000 population for the last decade (Figure W8).

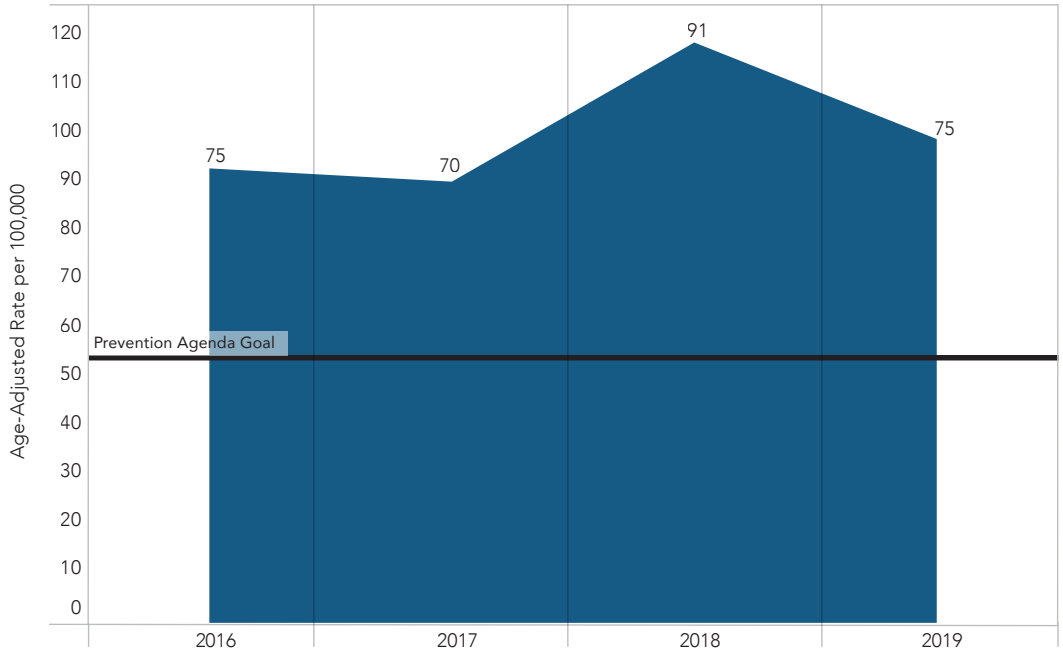
## Figure W8. Suicide Mortality Rate, Wayne County, NY




Data Source: New York State Vital Statistics Data, Year 2009 - 2018.
Analysis Completed by Common Ground Health

Over the last three years of available data, emergency department visit rates involving opioid overdose have increased (Figure W9).

## Figure W9. Emergency Department Visits Involving Any Opioid Overdose, Wayne County, NY




Source: SPARCS, 2016 - 2019. Analysis Completed by Common Ground Health.

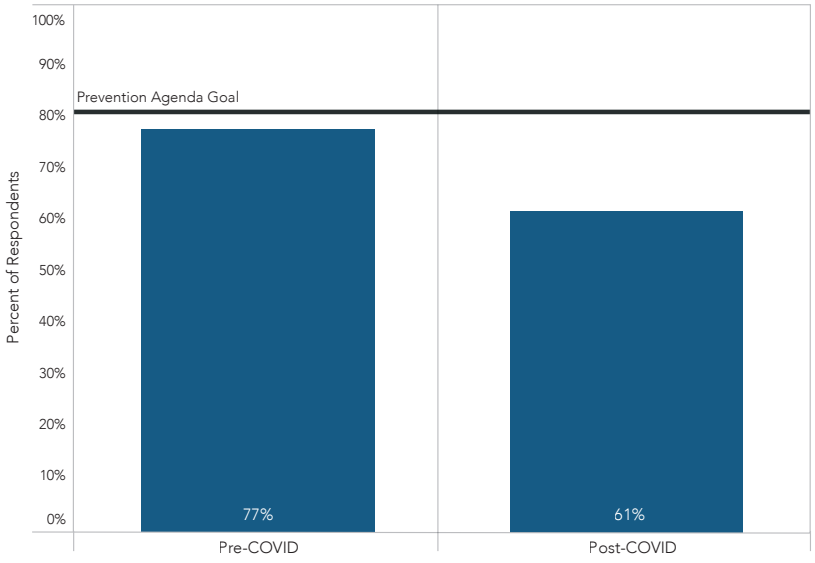
The Wayne County Partnership is a group of county agencies, non-profit agencies, school districts, faith-based communities, and parents that first convened in October of 2011 to discuss the state of families in Wayne County.[9] Since 2011, the Partnership has worked with a consultant to develop a prevention planning process and has gathered data on several important metrics, and has identified objectives and strategies to improve behavioral health, academic performance, and family support systems. The latest action in January 2022 was to recognize that community attachment was lacking, and to strengthen the resources to help communities and families feel connected again. The work of the Partnership helps to address issues that are known to be causes of poor mental health among children.

## Healthy Eating and Food Security

There are a number of health measures tied to healthy eating and food security for which Wayne has the highest rate or is tied for the highest rate, compared to the other 8 counties in the region. These measures are rates of: diabetes (15%), heart attack (10%), heart disease (7%), obesity (41%), and obesity above the age of 35 (45%).[10] The overall obesity rate in Wayne County increased from 2016 to 2018, (37% to 41%).[10] The rate of adults with diabetes also increased across the same time period (10% to over 15%) and was the highest in the region in 2018.[10] Though pre-diabetes testing has decreased in every county in the region since 2016, over half of Wayne County residents are still being screened (56%).[10] These chronic conditions are all related to healthy eating and food security, and all were impacted by the COVID-19 pandemic, which made it even harder for people to afford healthy food or to find time to exercise due to increased responsibilities at home, whether due to lack of child care, or caring for sick family members.

Examining food security among school-aged children, 12% of White middle school students and 17% of non-White middle school students reported feeling food-insecure in the 2021 EYS survey. The food insecurity rate was the same for White high school students (12%) but dropped to 9% for Non-White high school students. Food security in the Finger Lakes region has decreased since the start of the COVID-19 pandemic. Before the pandemic, regional food security was around 77%, but by 2021 it had dropped down to about 61%, according to a survey conducted by Pivital Public Health Partnership (S2AY Rural Health at the time) (Figure W10). Pivital Public Health Partnership also reported that regional consumption of fruit and vegetables has decreased since the start of the pandemic, presumably because these foods are more expensive and spoil quickly, making them a less economical choice.[11]

**Figure W10. Food Security, Finger Lakes Region, NY**




Source: Pivotal Public Health Partnership, Year 2021. Analysis Completed by Common Ground Health.

9. Wayne County Partnership. https://www.waynepartnership.org/our-mission
10. Behavioral Risk Factor Surveillance System, 2018
11. Pivital Public Health Partnership, 2021 Food Security Data

Discussing causes for reduced food security and obesity during CHIP meetings, partners noted that the COVID-19 pandemic brought an increase in Supplemental Nutrition Assistance Program (SNAP) enrollees; however, it was also noted that those who had never used SNAP benefits before tend to be reluctant to use their benefits in stores due to potential stigma of being seen needing governmental assistance.

Collaborations among various organizations, schools and the community around food insecurity and obesity prevention position the county well to be able to address and improve the health status of its residents. Cornell Cooperative Extension (CCE) operates in Wayne County and offers partnerships with experts and trained volunteers who bring information on agriculture (both commercial and community), nutrition, health, finances, energy efficiency, etc. to Wayne County residents. According to their website, their "ability to match university resources with community needs … [plays] a vital role in the lives of individuals, families, business, and communities throughout Wayne County. The CCE also shares information online such as school exercise facility schedules so that Wayne County residents can be informed about various opportunities to increase their physical activity levels."

Currently, SNAP ED is working with Finger Lakes Community Health to provide fruit and vegetable prescriptions to patients seen by FLCH providers in order to increase access to fresh produce among migrant and Latinx populations in Wayne County.

Foodlink offers curbside markets in Rochester, NY but only offers pantry deliveries of non-perishable items in Sodus. Food distribution occurs at various locations and sites across Wayne County including Lyons, Clyde, Sodus, and Newark.

The town of Sodus provides a great example for other communities to model their activities to increase access to healthy foods and improve the nutritional status of their residents. Community gardens, farmer's markets and seed libraries are great examples of the various ways Wayne County communities are creating opportunities to increase access to healthy food for all.

Health center representatives noted that they also incorporate food insecurity screening into their visits and make appropriate referrals when food insecurity is identified.

## Tobacco Prevention

High school students in Wayne County were asked about marijuana use in the last 30 days. Students reported using marijuana at a higher rate (12%) than cigarette smoking (3%), but vaping had the highest use rate at 18% for White and 20% for non-White High School students (Table W11).

EYS Survey data from previous years show that any cigarette use among high school students has been on a downward trend since 2013 starting between 27-37% and ending between 10-16% by 2021.

### Table W11. Tobacco, Vaping, and Marijuana Use in last 30 Days - Evalumetrics Youth Survey - Wayne Partnership, 2021

| | MIDDLE SCHOOL | | HIGH SCHOOL | |
|---|---|---|---|---|
| | White | Non-White | White | Non-White |
| Marijuana | 1% | 2% | 12% | 12% |
| Cigarettes | 0% | 1% | 3% | 3% |
| Vape/E-cigarettes | 6% | 10% | 18% | 20% |

Data Source: Evalumetrics Youth Survey – Wayne Partnership, 2021

## Community Assets and Resources to be Mobilized

The Finger Lakes Region already has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies that promote and facilitate collaboration: Pivital Public Health Partnership (previously the S2AY Rural Health Network) and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors – hospitals, insurers, universities, business, nonprofit, faith communities and residents – to collaborate on strategies for improving health in the region. Both agencies provide support, collaboration and resources to improving health of Wayne County residents. Wayne County has a long history of innovative collaboration around health planning, and it has taken inter-county cooperation to a new level in the Finger Lakes region.

Newark Wayne Community Hospital, an affiliate hospital of Rochester Regional Health, is a huge asset in Wayne County. It has a 300-bed capacity, offers many services including gynecology, orthopedics, pulmonary care, a birthing center, and was the first of its kind in New York State to offer a telemedicine program for its patients. The University of Rochester Medical Center also offers urgent care through F.F. Thompson Hospital in Newark. Finger Lakes Community Schools (FLX Community Schools) offers support to children and families living in Wayne County. Using evidence-based and restorative practices, FLX Community Schools provides technical assistance and training to schools, which in turn supports the development of culturally responsive, trauma-informed Community Schools. Throughout the pandemic, collaborations between Wayne County Public Health and all eleven school districts within Wayne County became stronger.

| WAYNE COUNTY PLANNING AND PRIORITIZATION AGENCIES | | |
|---|---|---|
| Wayne County Public Health | Newark-Wayne Community Hospital | Cancer Services Program |
| Common Ground Health | Community Members | Cornell Cooperative Extension (Wayne) |
| Council on Alcoholism & Addictions of the Finger Lakes | Finger Lakes Community Health | Mosaic Health |
| Pivital Public Health Partnership | Tobacco Action Coalition of the Finger Lakes | Wayne County Action Program |
| Wayne County Aging and Youth | Wayne County Behavioral Health | Wayne County Department of Social Services |
| Wayne County Rural Health Network | Wayne Finger Lakes BOCES | |

## Dissemination

The Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) will be shared with Wayne County's governing entity as well as posted to Wayne County Public Health's website and social media pages.

Wayne County Public Health: https://www.wcphny.com/

Newark-Wayne Community Hospital: https://www.rochesterregional.org/about/community-investment

# APPENDIX 1

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# APPENDIX 2

## RESULTS-BASED ACCOUNTABILITY™

Results-Based Accountability™ is a disciplined way of thinking and acting to improve entrenched and complex social problems.[12] To facilitate CHA/CHIP development, resulting in a CHIP that measurably improves health, the following steps were followed:

1. **Define the Community:** Data collection is an important first step. In this step, it is important to gather data for the community at large (county-level data) as well as data that identified vulnerable populations within the community who are at risk for poorer health outcomes. This can happen by collecting and analyzing data that shows differences in rates of illness, death, chronic conditions and more in relationship to demographic factors. The planning committee brainstormed specific potential vulnerable populations in the county to be considered with data collection.
2. **Engage Stakeholders:** Population health requires engagement from many sectors. Complex social, economic and environmental factors are all determinants of health; therefore, there is no one organization, department or program that can be held solely responsible for the health of a population. Diverse engagement began in November/December 2021, early in the CHA development process. Committee partners completed an exercise to brainstorm potential new partners from the following sectors: Local Government, Businesses, Not-for-Profit and Community Organizations, Academia and the General Public. The following questions were used to assist brainstorming:
   - Who are those with potential interest and influence who can contribute to the CHA/CHIP process?
   - What population do they represent? (including vulnerable populations identified in Step 1)
   - Identify their potential level of interest and influence (High Interest/High Influence, Low Interest/ High Influence, High Interest/Low Influence, Low Influence/Low Interest)
   - Who would be the best person on the committee to extend an invitation to the selected potential new partner?

After an assessment of brainstormed information, personal invitations were made to selected potential new partners to address any gaps on the committee and the need for diverse engagement.

3. **Engage in Comprehensive Data Collection:** Both primary and secondary data were collected. Disaggregated data was collected by race, gender, income and geography as available to identify vulnerable populations and to assist in strategy development. Data sources included, but were not limited to:
   - Common Ground Health: My Health Story
   - County Health Rankings
   - Vital Statistics
   - Behavioral Risk Factor Surveillance Survey (BRFSS)
   - United States Census Bureau
   - Cornell University Program on Applied Demographics
   - Statewide Planning and Research Cooperative System (SPARCS)
   - New York State Department of Health Perinatal Data Profile
   - S2AY Rural Health Network, Inc.: The Impact of COVID-19 on Food Security and Healthy Eating
   - Outreach to county committee partners for data from their respective organizations.

 12. Results-Based Accountability - Overview and Guide (clearimpact.com)

4. **Prioritize Health Issues:** Data was analyzed and presented by Common Ground Health. After a review of analyzed health outcome data for trends, current state against benchmarks or Prevention Agenda targets, and differences among populations, a multi-voting tool was used by committee members to rank the health issues using selected criteria to identify top Focus Areas, which identified Prevention Agenda Priority Areas.
5. **A Deeper Dive of data was conducted by Common Ground Health.** To enhance the picture of the selected Focus Areas, related Prevention Agenda objective data was presented. A table with objectives and their status colors was created to help with the selection of objectives for this CHA/CHIP cycle.
   - Green Status – the prevention goal metric has been met and the trend of that metric is in the correct direction of the goal or steady
   - Yellow Status – either the prevention goal has not been met but the trend is in the correct direction or the goal has been met but the trend is in the wrong direction
   - Red Status – the goal has not been met and the trend is in the wrong direction
   - Gray Status – there is limited data on this metric available at this time

In addition, person, place and time was analyzed:

- **Person** - Are there certain populations at higher risk for poor outcomes? For example, are outcomes different based on age, race/ethnicity, education, or socio-economic status?
- **Place** - Are the outcomes in the county higher or lower than neighboring counties and the rest of the state? Are there high-risk neighborhoods in the county?
- **Time** - Do the trends over time show the outcomes improving, remaining the same, or declining?

If multiple objectives were identified, additional consideration was given to objectives that may have a greater impact on long term health and also have a good chance of positively impacting other objective indicators.

6. **Develop the Story Behind the Data:** Understanding the story behind the data ("WHY" the data looks the way it does) contributes to an increased understanding of the factors that impact the current state, as well as identifies contributing causes and potential solutions designed to have maximum impact. Results-Based Accountability's *Turn the Curve Thinking* was conducted for selected CHIP objectives/indicators to examine:
   - What is the story? What are the contributing causes to the trend of the selected CHIP objectives, including behavioral, environmental, policy and social determinant of health factors? 5 WHYS was conducted to help identify root causes.
   - Who are the partners that have a role in impacting contributing causes? What community assets or resources can be mobilized to impact identified causes?
   - What works to address identified contributing causes (including evidenced based interventions)?

*Turn the Curve Thinking* also determined a data development agenda, where counties identified if any additional data was needed on selected objectives and/or disparities, as well as a plan on how to collect that data.

7. **Select CHIP Interventions:** Upon completion of *Turn the Curve Thinking*, criteria was used to select interventions that will be included on the CHIP. Criteria used included:
   - How strongly will the proposed strategy impact progress as measured by the baselines?
   - Is the proposed strategy feasible?
   - Is it specific enough to be implemented?
   - Is the strategy consistent with the values of the community and/or agency?

*Turn the Curve Thinking* resulted in interventions which were linked with contributing causes and partners who could have an impact. It is our goal that, with successful implementation of diverse strategies by diverse partners, there will be a collective impact on *Turning the Curve* for the better on our CHIP objectives.

8. **Engage in Continuous Improvement:** To effectively monitor progress and effectiveness of each organization's contribution to selected CHIP objectives, intervention performance measures were identified that answer the questions:
   - How much did we do?
   - How well did we do it?
   - Is anyone better off?

Monitoring these intervention specific performance measures will identify if any focused quality improvement projects are required to improve intervention effectiveness and/or if revisions to CHIP interventions are required.

Wayne County Chimney Bluffs
Photo credit: Wayne County Tourism

# APPENDIX 3

## WAYNE COUNTY OBJECTIVE SUMMARY*

### Remaining objectives within the selected focus areas had limited or unreliable data

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 2.2.4 | Reduce all ED visits involving any Opioid Overdose | | |
| 2.4.1 | Reduce the Prevalence of Major Depressive Disorder | | Only 2 data points (2016 and 2018) |
| 2.2.3 | Reduce the Opioid Analgesics Prescription for Pain | | |
| 2.5.2 | Reduce the Age-Adjusted Suicide Mortality Rate | | |
| 2.2.2 | Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder | | |
| 2.1.2 | Reduce the Age-Adjusted Percentage of Adult Binge Drinking During Past Month | | |
| 2.2.1 | Reduce the Age-Adjusted Overdose Deaths Involving Any Opioid | | |
| 1.1.4 | Decrease the Percentage of Adults with Obesity | | |
| 1.1.6 | Decrease the percentage of adults with obesity (living with a disability) | | Finger Lakes region |
| 1.1.13 | Increase the percentage of adults with perceived food security | | Finger Lakes region |
| 1.1.14 | Increase the percentage of adults with food security (annual household income of <$25,000) | | Finger Lakes region |
| 1.1.1 | Decrease the Percentage of Children with Obesity (Ages 2-4 yrs, Participating in WIC) | | |
| 1.1.5 | Decrease the percentage of adults with obesity (annual household income of <$25,000) | | Finger Lakes region |
| 1.1.9 | Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (All Adults) | | |
| 1.1.2 | Decrease the percent of children with obesity | | |
| 1.1.7 | Decrease the percentage of adults who consume one or more sugary drinks per day | | |
| 1.1.8 | Decrease the percentage of adults who consume one or more sugary drinks per day (household income <$25,000) | | |

# YATES COUNTY

| COUNTY NAME: | YATES COUNTY |
|---|---|
| Participating local health department and contact information: | Yates County Department of Public Health<br>Sara Christensen<br>Director of Public Health<br>schristensen@yatescounty.org 315-536-5160 |
| Participating Hospital/ Hospital System(s) and contact information: | Geneva General Hospital and Soldiers and Sailors Memorial Hospital (Finger Lakes Health)<br>Lara Turbide Lara.turbide@flhealth.org<br>315-787-4053 |
| Name of entity completing assessment on behalf of participating counties/ hospitals: | Common Ground Health<br>Zoë Mahlum<br>Health Planning Research Analyst<br>zoe.mahlum@commongroundhealth.org<br>585-224-3139 |

Yates County Vineyard on Keuka Lake
Credit: iStock.com/jimfeng

# EXECUTIVE SUMMARY

Through the use of Results-Based Accountability, Yates County in partnership with Finger Lakes Health has chosen to focus their 2022-2024 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) on the following priority areas, with the population whose household income is less than $25,000 as their identified disparity to address.

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Healthy eating and food security |
| **Disparity** | **Population with household income of less than $25,000** |

Choose Health Yates, a group of diverse partners who span all sectors of the community, participated in the prioritization process and disparity and intervention identification. While a complete list of partners is available within the Yates County Chapter under "Community Health Improvement Plan/ Community Service Plan", agencies present represented academia, not-for-profits and community organizations, businesses, the general public, and local government. They included the Yates County Public Health Department and Department of Social Services, Yates Prevention Coalition, FLACRA, Yates County Sheriff's Office, Finger Lakes Health, and more. Partners' roles in the assessment were to help inform and select the 2022-2024 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings. The community was involved in the 2018 My Health Story survey and their needs were considered by Choose Health Yates when developing the CHA and CHIP. The 2022 My Health Story survey was launched during summer 2022 and data collection continued through the fall; this update will help gain community insight on key health matters in the county and surrounding areas. Both primary and secondary data were reviewed including, but not limited to, the US Census Bureau American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, data collected from Pivital Public Health Partnership (formerly known as S2AY Rural Health Network) and Common Ground Health's My Health Story 2018 survey, 211 Helpline, and the Statewide Planning and Research Cooperative System (SPARCS).

The process of Results-Based Accountability included evaluation of a pre-read document, which contained detailed county-specific analyses related to the five Prevention Agenda priority areas, followed by a multi-voting technique to select the priority areas. Participants were asked to consult with other members of their organizations and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Partners came to a consensus to address the top priority areas identified by the survey, then additional county-specific data was collected, shared and evaluated to help determine which objectives, disparity, and interventions should be selected. Interventions selected included, but were not limited to:

- 1.0.6 Screen for food insecurity, facilitate and actively support referral.
- 2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.
- 2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days.

A complete list of interventions and process measures is available in the CHIP.

Choose Health Yates, outside of CHA/CHIP development, meets bi-monthly to improve the health of Yates residents and will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings. Partners and the community will continue to be engaged and apprised of progress via these meetings.

Yates County Vineyard on Keuka Lake
Photo by Luke Petrinec, Courtesy of the CorningFingerLakes.com

# PLANNING AND PRIORITIZATION PROCESS

Yates County followed a process called Results-Based Accountability to develop their needs assessment and improvement plans. There are several components to Results-Based Accountability, some of which include defining the community, engagement of a diverse group of stakeholders (including organizations representing underserved, low-income and minority populations), data collection and analysis, prioritization of health issues and disparity identification, and discussion of root causes for selected health issues to help identify appropriate and effective interventions. For additional information on Results-Based Accountability, this process is described in its entirety in Appendix 2. To pinpoint root causes of selected health concerns, the committee evaluated behavioral, environmental, social determinants of health, and policy causes that may be contributing to the current status of those concerns.

As demonstrated in the health indicator section, each county's residents face their own unique and challenging issues when it comes to their community, yet commonalities remain. There are a number of demographic and socioeconomic indicators which may impact health and are consistent concerns across the region. For example:

### AGE:

Variances in age can impact a community's health status. Older adults require more frequent medical check-ins, are more prone to illness, falls and unintentional injuries, and often experience more co-morbid conditions than younger adults and children. In addition, aging adults may not have access to a vehicle and rely on family, friends or public transportation for accessing basic needs and medical appointments. The strain of caring for an elderly adult may also negatively affect the caregiver. A community with higher rates of elderly adults may have worse reported health outcomes than a younger community.

### POVERTY:

Low income residents are more likely to experience a breadth of health issues not seen as often in wealthier residents. For example, lower socioeconomic status is linked to higher incidence of chronic disease, shorter life expectancy, and lower rates of good social, emotional and physical health. Low income may also force a person to choose between basic needs (such as housing, food, clothing, etc.) and preventative medical care. Often, and not surprisingly, the person will choose the basic need over preventative medical care. A community with higher rates of impoverished residents is likely to have worse health outcomes than wealthier communities.

### EDUCATION:

Education levels have been known to be a predictor of life expectancy. The Centers for Disease Control and Prevention reports that adults 25-year-old adults without a high school diploma can expect to die nine years sooner than college graduates. People who attain higher education levels are more likely to seek health care, preventative care services, and earn higher wages. A more educated community may, therefore, have better health outcomes than a low educated community.

### HOUSING:

Access to quality and affordable housing is imperative to ensuring basic needs are met. Housing structures that are safe, clean, up to code and affordable help to improve community health. When incomes are consumed on rent or mortgages, residents may lack funds for preventative care services, medications, and healthy foods. Additionally, outdated, substandard housing puts tenants at risk for asthma and lead poisoning (especially children).

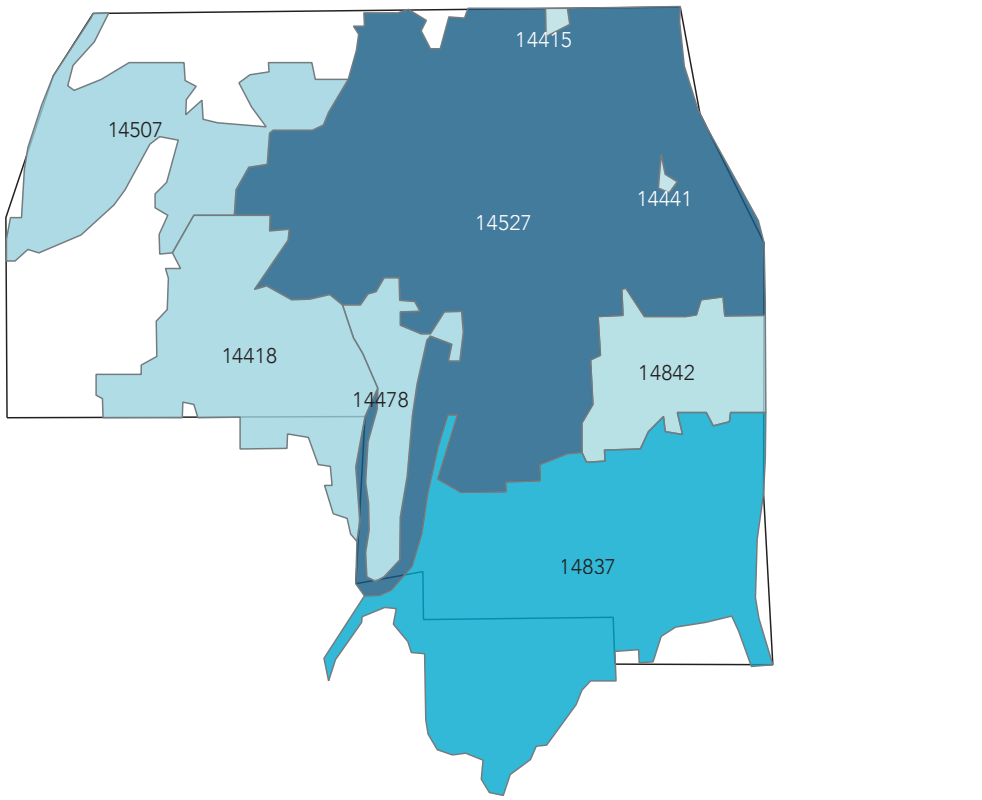
Each of the above indicators impacts the health of the community. The next section takes a closer look at these demographic and socioeconomic indicators and also includes a review of behavioral and political environments in Yates County that impact the health of its residents. Finally, the section will highlight the community's assets and resources that may be leveraged to improve health through identified evidence-based interventions.

# COUNTY CHAPTER – YATES COUNTY

## Demographic and Socioeconomic Health Indicators

Yates County is located in the heart of the Finger Lakes Region, connected to the lower halves of both Ontario and Seneca Counties. It is home to the popular Keuka Lake, which attracts residents and tourists from all over to appreciate the natural beauty of the county. There are 24,774 total residents spread throughout the county, but areas with the densest population include Penn Yan (14527) and Dundee (14837). The population is primarily White non-Hispanic (about 95%), with Black non-Hispanic, Hispanic and other individuals representing about 1%, about 2% and about 1% of the population respectively. There is a large congregation of Amish and Mennonite families who reside in the county; the 2022 Old Groffdale and Midwest Horse and Buggy map shows approximately 630 households in Yates County (yet does not capture the driving Mennonite population who reside within Yates County, which continues to grow each year). The cultural implications that this population has on the Yates County community must be considered when analyzing and reviewing any of the data contained in the chapter. The population often turns to natural and homeopathic medicine when it comes to family planning, preventative and dental care, vaccinations, etc. Children also only attend school through the eighth grade before turning to farming and other trades to support their families. These cultural practices directly influence things such as health insurance estimates, educational attainment, poverty, vaccination rates, prenatal care, and more. Additionally, women of childbearing age comprise approximately 22% of the Yates County population, and about 12% of individuals are living with some form of disability.[1]

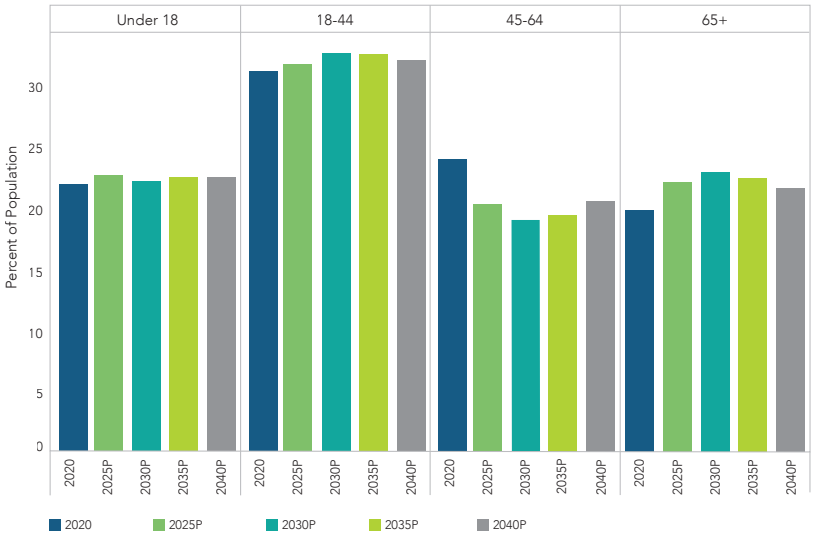
### Map Y1: Yates County Population By ZIP Code




Source: Claritas zip-level estimates and CDC Bridged-Race county-level estimates, Year 2020.
Population data and allocation methods developed by Common Ground Health.

 1. American Community Survey (ACS) 2019 5-Year Estimates

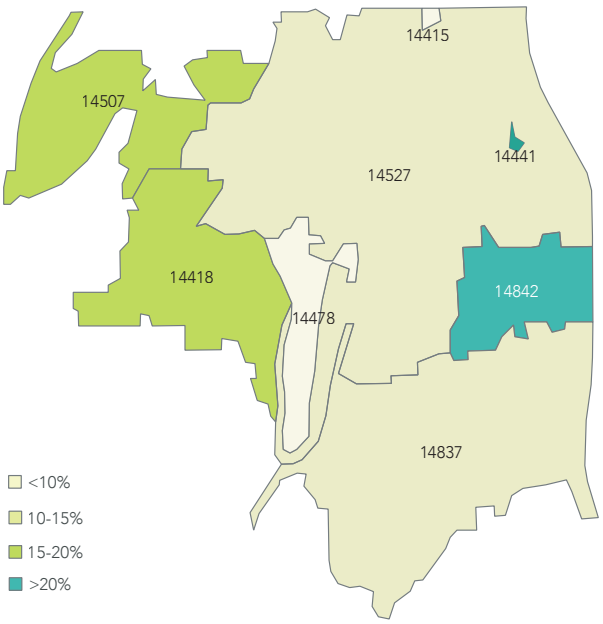
## Figure Y2: Population Projections for Yates County




Source: Cornell University - Program on Applied Demographics, County Projections Explorer, Year 2020. Analysis Completed by Common Ground Health.

The majority of those living with a disability in Yates County are 65 years of age or older (63%). The three types of disabilities most prevalent to this age group are independent living difficulty (about 10%), ambulatory difficulty (about 13%), and hearing difficulty (about 15%). Additionally, about 26% of the population aged 65 years or older are living alone.[2] Population projections from Cornell University's Program on Applied Demographics (Figure Y2) show that the largest age group within Yates County currently are the residents aged 18-44, followed by the 45-64 age bracket. The predictions for 2040 show a slight increase in all age groups, with the exception of residents age 45-64, which show a decrease. As the 65 years and older population grows, there will be a greater demand on health care needs and services including chronic disease management and geriatric care.

## Map Y3: Percent of Population Living in Poverty



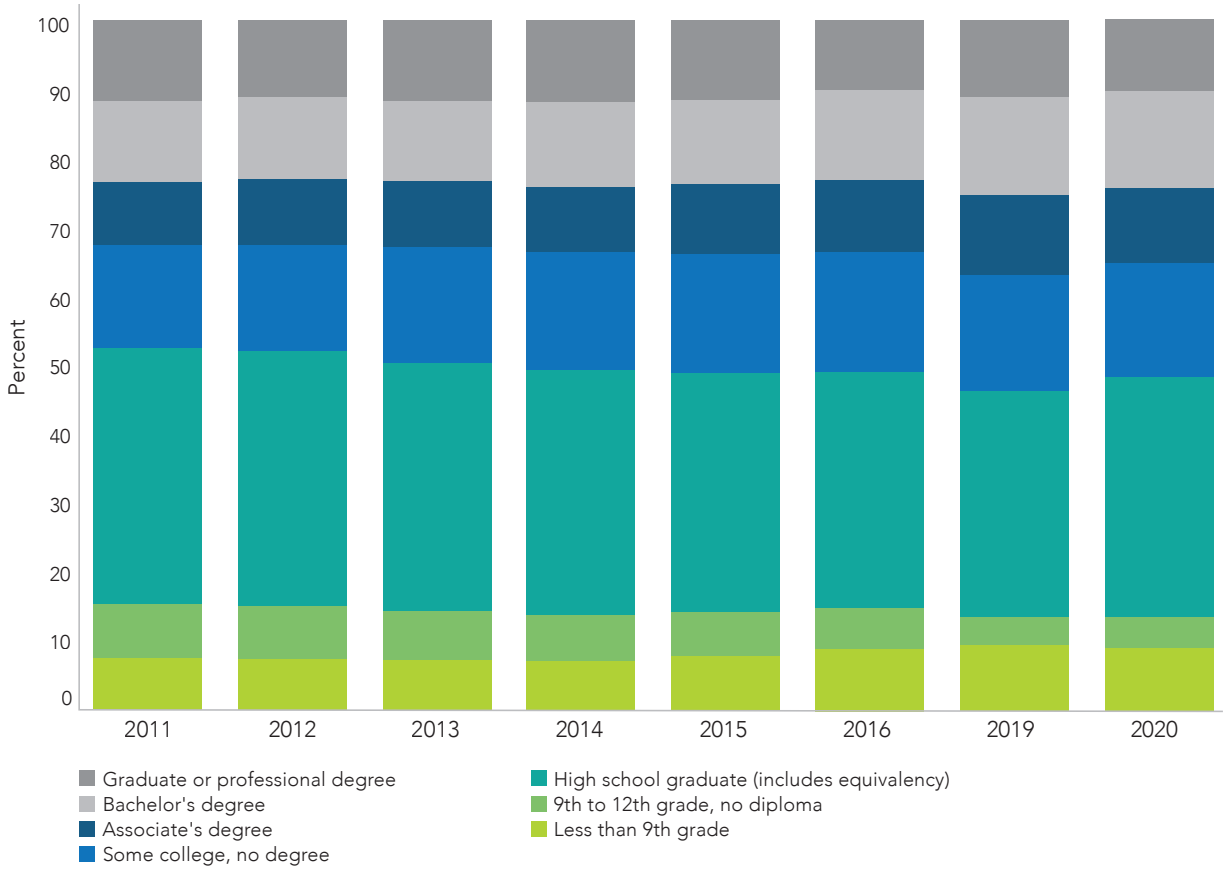

Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

An estimated 1 in 8.4 individuals (about 12%) within Yates County are living below the poverty level. As shown in Map Y3, the areas with the highest rates of poverty include Dresden (ZIP code 14441, about 26%) and Himrod (14842, about 37%). The entire western portion of the county (Middlesex and Branchport) falls within the second highest bracket of 15-20% of individuals living in poverty.

With regard to housing, about 20% of Yates County residents rent versus own their home. The average household size is greater than two people for both renter- and owner-occupied units. Of note, about 42% of residents are paying 35% or more of their household income in rent costs, which is considered an overburdened household. Likely, these same households may be experiencing financial strain in other components of their life (food, health care, etc.). Out of all occupied housing units, about 12% have no vehicles available and an additional about 29% have access to one vehicle. Data from 211 calls within Yates County over the past year show about 4% of calls were for transportation assistance. Specifically, 4 calls were received for medical transportation, 3 for public transportation (2 of which went unmet), and 1 for automobile assistance (which also went unmet). Six of the eight total requests originated from Penn Yan (14527).

Educational attainment levels have remained fairly consistent from 2015 to 2020, with a few slight shifts (as shown in Figure Y4). Of note, throughout the presented time period, approximately 48% of Yates County population hold a high school degree (or equivalency) or less as their highest level of educational attainment, which may be attributed to the large Amish and Mennonite populations. This is an important factor when examining the health of a population as higher educational attainment generally equates to greater health outcomes.[3]

## Figure Y4: Educational Attainment of Residents Aged 25+



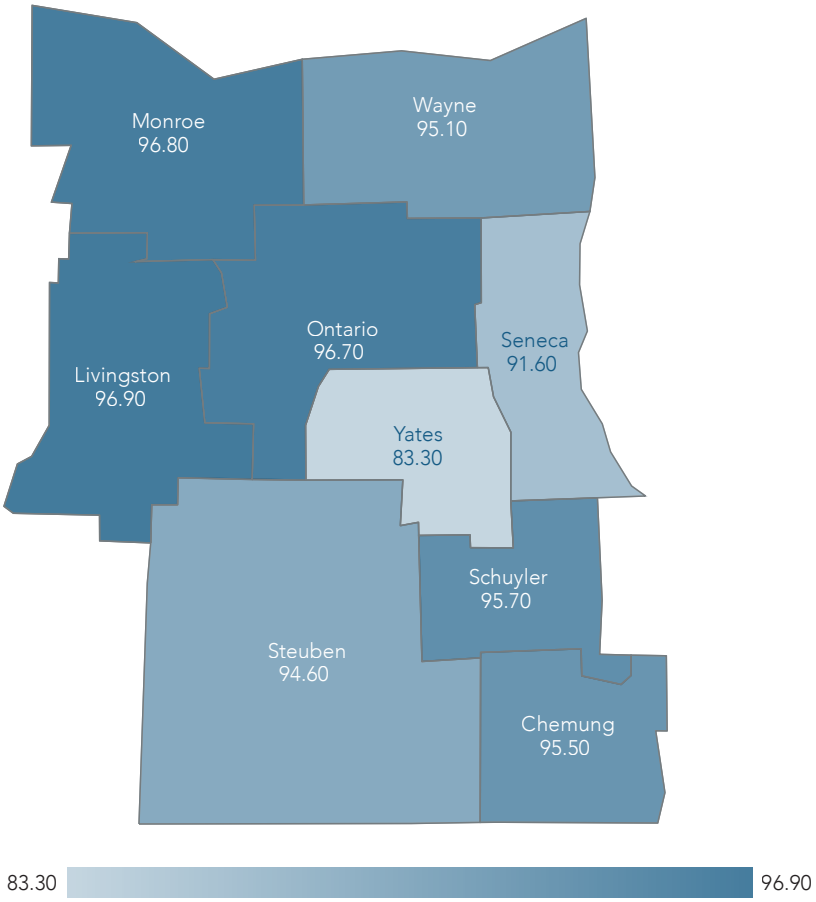

Data Source: US Census Bureau, American Community Survey (ACS), Year 2020.
Analysis Completed by Common Ground Health



3. Hahn, R. A., & Truman, B. I. (2015). Education Improves Public Health and Promotes Health Equity. International journal of health services: planning, administration, evaluation, 45(4), 657–678. https://doi.org/10.1177/0020731415585986

Map Y5 displays the percent of the population with health insurance, by county, for the Finger Lakes Region. In 2020, about 83% of Yates County was insured which, despite its increase from about 80% in 2017, still represents the lowest rate within the region.

## Map Y5: Percent of Population with Health Insurance, by County




Source: US Census Bureau, ACS, Year 2020
Analysis Completed by Common Ground Health

Obtaining health insurance is not the only factor associated with accessing healthcare. Availability and accessibility to providers are equally important considerations. The Department of Health and Human Services states that nearly 33% of Yates County's population is living in a Health Professional Shortage Area (HPSA) compare to 27% of New York State residents.[4] Some providers are in greater demand than others, though. Largely providers are sparse in certain areas of the county, which may be cause for concern for those with lack of transportation to access services. A summary is below:

**Mental Health Providers:** Yates County has one mental health provider per 850 residents (if all residents were spread equally across providers), compared to New York State's ratio of one provider to 310 residents.[5] Mental health providers are defined, here, as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care.

**Dental Health Providers:** Dental health providers are available at a rate of 6.9 providers per 10,000 population in Yates County (compared to a NYS rate of 3.7);[6] they are located primarily in Rushville and Penn Yan.

4. US Department of Health and Human Services, Health Resources and Services Administration, HRSA-Health Professional Shortage Areas Database, May 2021
5. 2022 County Health Rankings (using 2021 data).
6. Centers for Medicare and Medicaid Services, CMS – National Plan and Provider Enumeration System (NPPES), May 2021

**Primary Care Providers:** Nurse practitioners exist at a rate of 2.8 practitioners per 10,000 population within Yates County, which is lower than the NYS rate of 3.5. They are located mainly within Penn Yan, but also have a presence in Dundee. Primary care providers are available at a rate of 7.3 providers per 10,000 population, which is also less than the NYS rate (10.9). Primary care providers are predominantly based in Penn Yan, with some presence in Dundee and Rushville.

## Main Health Challenges

On February 17, 2022, a diverse group of stakeholders, representing various aspects of the community as well as underserved and minority populations, were invited to attend a health priority-setting meeting (a complete list of stakeholders can be found in the Community Health Improvement Plan/ Community Service Plan section). At this meeting, participants reviewed the overarching goals of the New York State Prevention Agenda and relevant qualitative, quantitative, primary and secondary data. A pre-read document containing detailed county specific analyses relating to the five Prevention Agenda priority areas was sent to all participants for review in advance. Primary and secondary data were collected from a variety of sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, Pivital Public Health Partnership (formerly S2AY Rural Health Network), Common Ground Health's My Health Story survey, and 211 Helpline. My Health Story 2018 was a regional survey completed on behalf of nine counties in the Finger Lakes Region. Its primary purpose was to gather qualitative and quantitative data from Finger Lakes Region residents on health issues in each county. Health departments, hospitals and other local partners were instrumental in distributing the survey to community members including disparate populations. The survey was updated in the summer and fall of 2022 and will be used to help inform potential shifts in strategies to improve the priority areas selected by Yates County.

After initial review of the priority areas, a multi-voting technique was used to select the priority areas. Participants were asked to consult with other members of their organization and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Yates County had twenty two members of the Choose Health Yates team participate in the survey. As a result, the following areas were selected for the 2022-2024 Community Health Improvement Plan:

| PRIORITY AREAS & DISPARITY | |
|---|---|
| **Promote Well-Being and Prevent Mental and Substance Use Disorders** | |
| Focus Area | Prevent mental and substance use disorders |

| **Prevent Chronic Diseases** | |
|---|---|
| Focus Area | Healthy eating and food security |
| **Disparity** | **Population with household income of less than $25,000** |

Following this selection, Common Ground Health gathered data on all objectives from the New York State Prevention Agenda within the chosen priority areas. Objectives were color coded based on data status to help focus attention where it was needed most. Red objectives were neither meeting the Prevention Agenda goal nor trending in a favorable direction, yellow objectives were either not meeting the Prevention Agenda goal or not trending in a favorable direction, and green objectives had both met the goal as well as trended in a favorable direction. Objectives that were color coded as gray represented a lack of current and/or reliable data. Color coded data on objectives were presented to the team during April's Choose Health Yates meeting and partners utilized the data, as well as potential scope and interest of the group, to determine the objectives with which they would proceed. Color-coding for selected objectives can be found in the appendix.

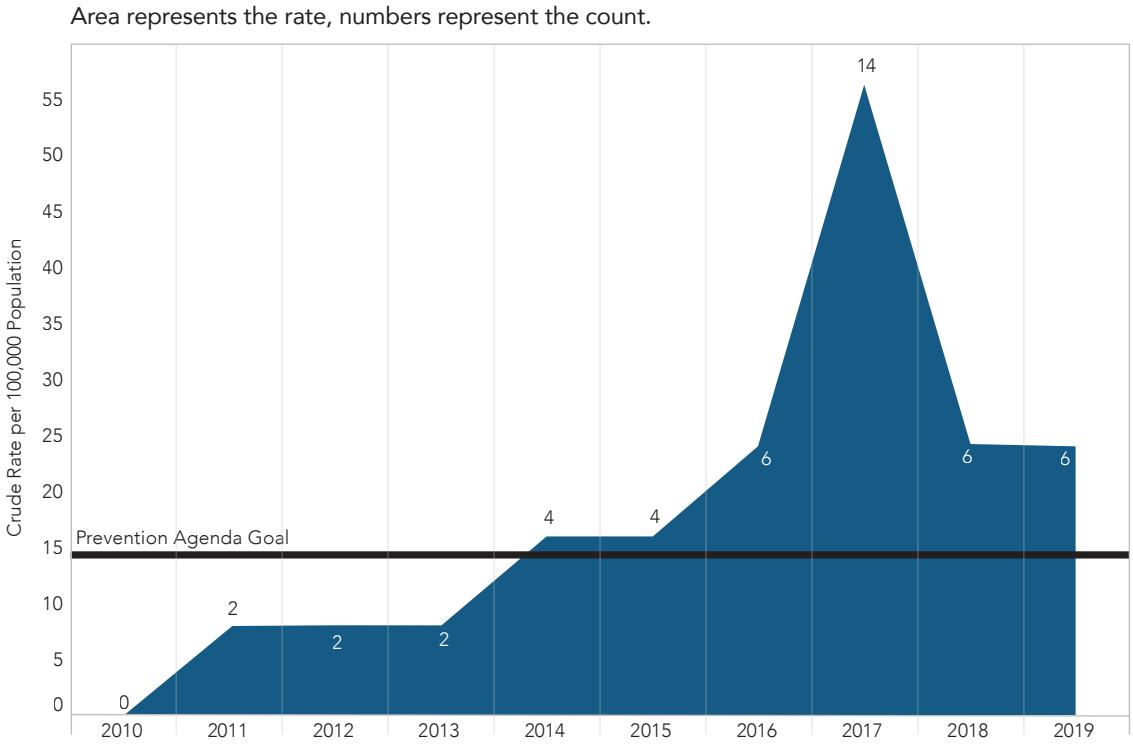
## Risk and Protective Factors Contributing to Health Status

Yates County has selected two focus areas on which to anchor their 2022-2024 Community Health Improvement Plan. This section will take a closer look at the behavioral, environmental, political and unique risk and protective factors contributing to the health status of those areas.

### Prevent Mental and Substance Use Disorders:

The opioid overdose epidemic has been a public health concern for several decades now. The CDC stated that the number of drug overdose deaths has quadrupled since 1999,[7] and provisional data from November 2021 showed an estimated 100,306 drug overdose deaths in the United States from April 2020-April 2021. This represented an approximately 29% increase from the previous year.[8] Per New York State Vital Statistics, the crude rate of opioid overdose deaths per 100,000 population within Yates County has been increasing, as shown in Figure Y6.

### Figure Y6: Crude Rate (per 100,000 population) of Opioid Overdose Deaths




Data Source: Data Source: New York State Vital Statistics Data, 2010 - 2021.
Analysis Completed by Common Ground Health



7. CDC: Understanding the Opioid Overdose Epidemic, March 2021
8. CDC: Drug Overdose Deaths in the US Top 100,000 Annually, November 2021

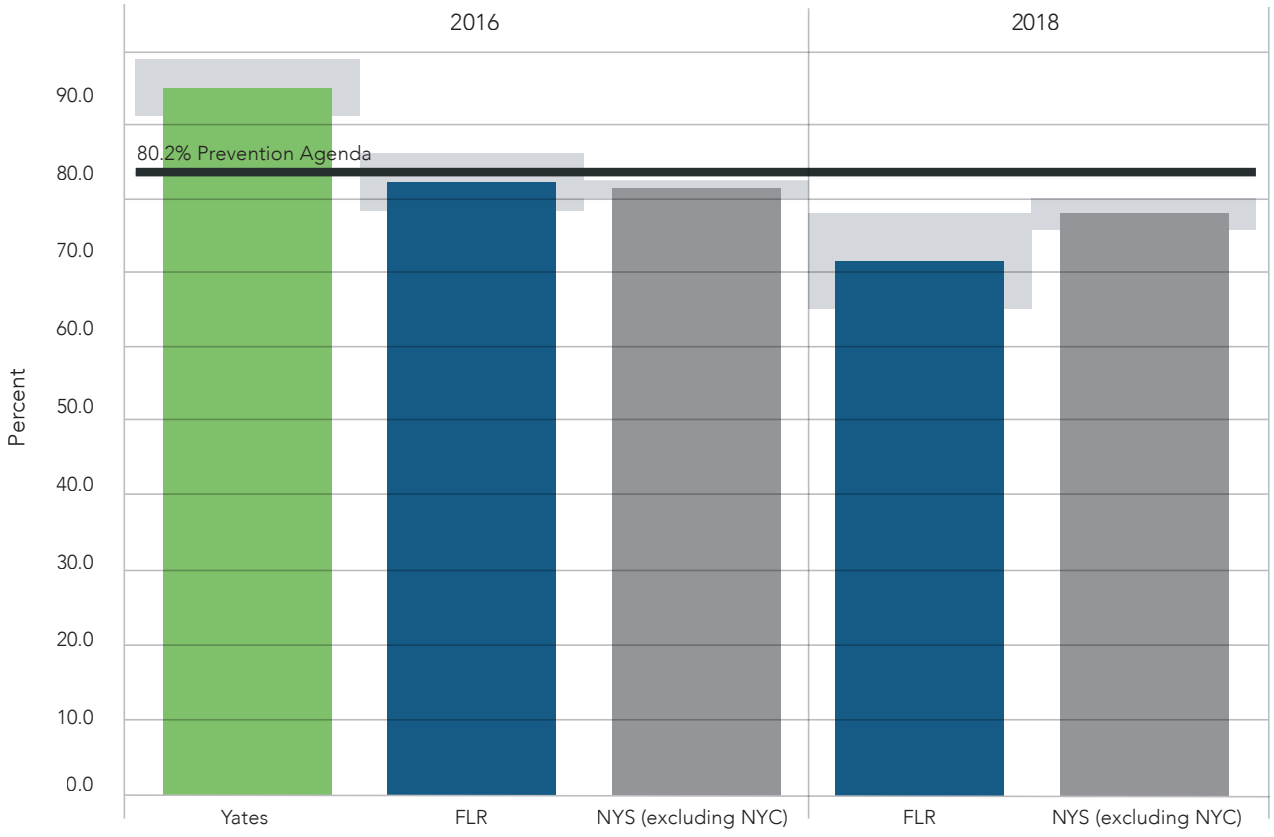
Choose Health Yates community partners discussed factors that may be contributing to the opioid overdose death rates seen within Yates County. Potential behavioral causes included matters of mental health, physical health, access to opioids, and childhood experiences. Within mental health, partners felt that untreated trauma, mental health disorders and depression, low self-esteem, sensory seeking behaviors, and an inability to effectively cope with stressors contribute to this health concern. Physical pain is another contributing factor; unrelieved pain may increase the use and abuse of opioids, which also highlights the concern of using opioid pain medications. Childhood depression and anxiety, adverse childhood experiences (ACES), invisible disabilities such as communication challenges, and delayed treatment for ADHD may also increase the risk of use. Partners noted how the feeling of isolation as well as physical isolation (rural locations) plays a role in opioid use and abuse; isolation limits access to services and leaves individuals without support. Social determinants of health such as low income, unemployment, inflation, lack of transportation, housing insecurity, and being un/underinsured contribute further. Additionally, Choose Health Yates partners discussed how certain policies that are in place currently may or may not be helping the situation. For instance, punishment for children who act out in school versus trying to understand and help with the root cause of the outburst, lack of prevention education within schools, providers unwilling or unlicensed to prescribe medical interventions for opiates, and the potential need of reinforcement and training on the referral process for hand-off to treatment facilities may be contributing factors.

Current efforts to decrease opioid overdose deaths include prescribing less opioid analgesic prescriptions, and Helping to End Addiction Long-Term's (HEAL) effort to find alternatives for pain management. The Yates Prevention Coalition (YPC), who serves as the advisory board for HEAL, works to prevent substance use/opioid overdose deaths, and recently just provided sharps containers to the Yates County Sheriff's office for deputies to keep in their patrol cars. The Yates County Sheriff's Office holds two Annual Drug Take Back Days each year and has a safe drug disposal site in the jail. HEAL also offers education programs on the use of Narcan, and has a grant to expand current evidence-based practices or implement new ones focused on reducing opiate deaths. Suboxone prescriptions, to help with withdrawal symptoms, and follow up on referrals are being utilized by Emergency Department and community site physicians. FLACRA recently expanded support to jails, with funds for Medication Assisted Treatment (MAT) implementation and follow up. FLACRA and Keuka College are in partnership to offer Yates County residents the opportunity to be trained in Youth & Adult Mental Health First Aid (MHFA). Additionally, Narcotics Anonymous peer support groups are offered through the Council on Alcoholism and Addictions of the Finger Lakes, who also provide Screening, Brief Intervention and Referral to Treatment (SBIRT) services. The primary goal of SBIRT is to identify and effectively intervene with those who are at moderate or high risk for psychosocial or health care problems related to their substance use.

## Healthy Eating and Food Security:

Food security is an economic and social condition of ready-access by all members of a household to nutritionally adequate and safe food.[9] A person experiencing food insecurity, or a lack of adequate and nutritious food, is at increased risk for development of chronic diseases (such as diabetes, heart disease, or cancer), obesity, weakened immune system, pregnancy risks, and negative impacts on mental health.[10] Behavioral Risk Factor Surveillance System data from 2016 showed 91% of Yates County adult residents were food secure. While 2018 data for Yates County was unreliable (rates were suppressed due to small sample size), Figure Y7 shows a decline in percent of adults with food security was observed between 2016 and 2018 for the Finger Lakes Region (about 79% to about 69%) and Upstate New York (about 78% to about 75%).

### Figure Y7: Percent of Adults with Food Security, by Location



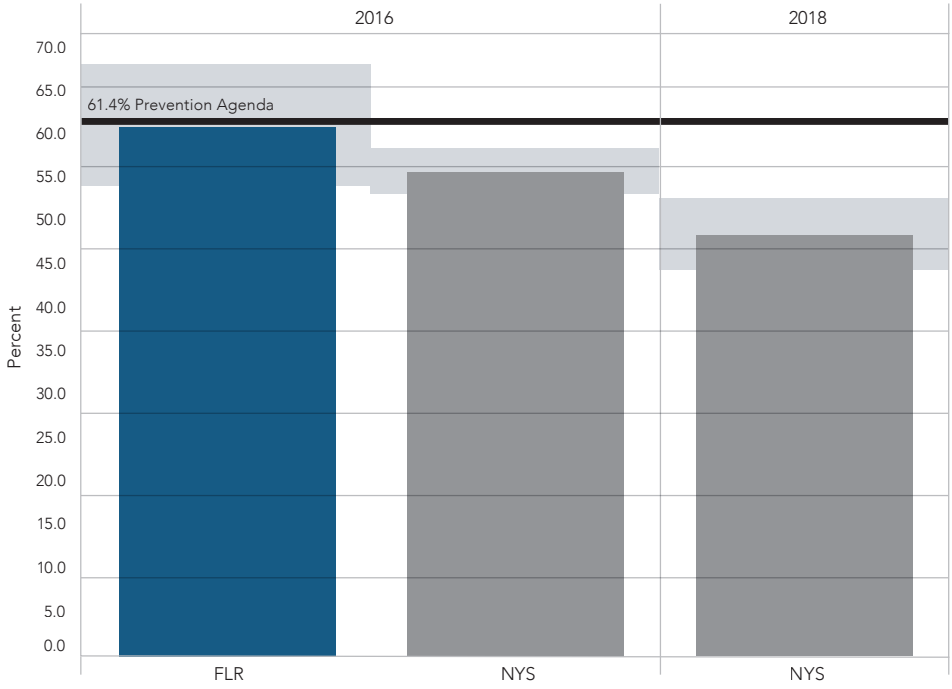

Data Source: BRFSS 2016-2018



9. Dictionary.com
10. Nourish by WedMD, What is Food Insecurity, August 2019

This was compared to Behavioral Risk Factor Surveillance System data regarding food security for adults who specifically have a household income of less than $25,000, as shown in Figure Y8. This figure highlights a decline in percent of adults (with a household income of less than $25,000) with food security in NYS between 2016 and 2018, but also highlights that while about 79% of all adults in the Finger Lakes region had food security in 2016 (Figure Y7), only about 61% of adults with less than $25,000 household income were food secure (Figure Y8). This indicates an even greater need for food security among this population.

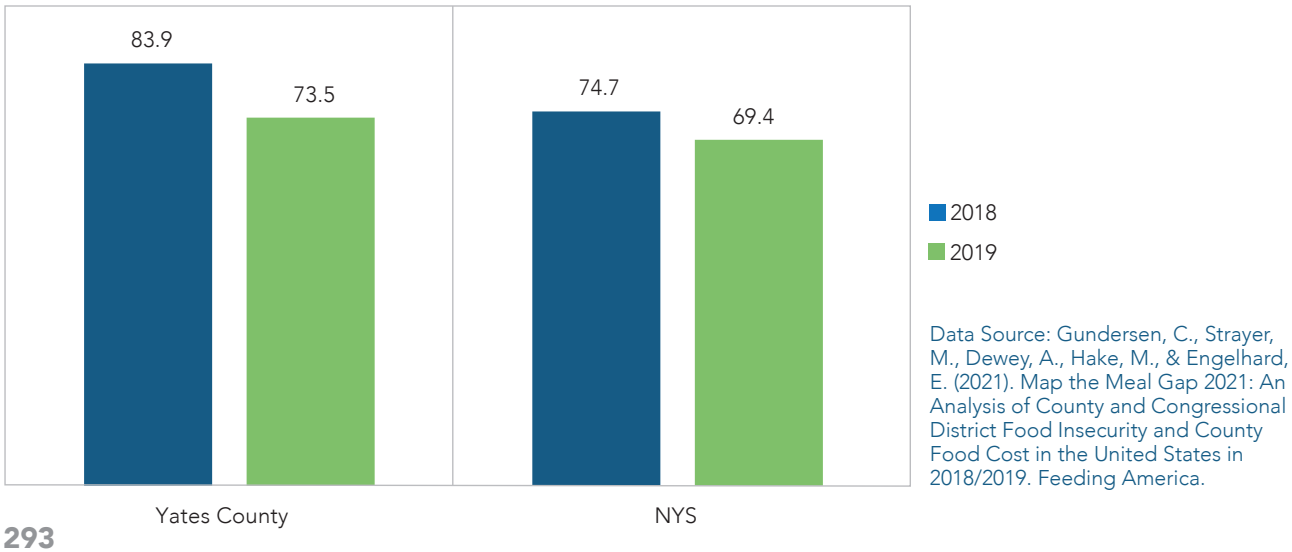
## Figure Y8: Food Security among Adults with <$25,000 Household Income




Data Source: BRFSS 2016 - 2018

Feeding America data from 2018 and 2019 on food insecurity shows that the estimated percent of food insecure individuals who live in households with income at or below low threshold in NYS is higher for Yates County compared to NYS for both of those years (Figure Y9).

## Figure Y9: Estimated Percent of Food Insecure Individuals who live in Households with Income at or Below Low Threshold in State




Data Source: Gundersen, C., Strayer, M., Dewey, A., Hake, M., & Engelhard, E. (2021). Map the Meal Gap 2021: An Analysis of County and Congressional District Food Insecurity and County Food Cost in the United States in 2018/2019. Feeding America.

Additionally, data from a regional survey conducted by Pivital Public Health Partnership showed food insecurity within the Finger Lakes Region rose from 26% in March 2019-2020 to 40% in March 2020-2021, and continued to climb to 53% in March 2021-2022.

Choose Health Yates community partners discussed factors that may be contributing to the level of food security and insecurity seen within Yates County. Potential behavioral causes included eligibility for benefits (such as SNAP) but not yet enrolled, financial planning and management, and issues with food and product hoarding from the pandemic that leaves shelves bare. Environmental contributors identified included the public being under-informed of local fresh produce markets, and poor access to grocery stores. For the latter, the Dundee community was specifically cited as their only grocery store closed down recently, thus residents tend to procure food from dollar stores or nearby mini-marts or gas stations. Partners also acknowledged the large roles that inflation and cost of living, un/underemployment, and financial hardship and poverty play in food insecurity.

Yates County residents who participated in the 2018 My Health Story survey reported that they tend to get their produce from one or a combination of the following: chain supermarkets or superstores (71%), farm stands (64%), local grocery stores (55%), farmer's market or public market (30%), and from their own gardens (26%). Data from a regional survey conducted by Pivital Public Health Partnership showed that some residents within the Finger Lakes Region decreased their use of farmer's markets and CSAs between 2019 and 2022 (from approximately 40% to 26%), meanwhile the use of food pantries increased during that timeframe (from approximately 14% to 25%).

Currently, within this space, the Department of Social Services is working to connect those who are eligible with SNAP benefits. As of May 2022, there were 1850 total active SNAP benefits cases: about 29% of active cases were those aged 0-18, about 24% aged 19-40, about 21% aged 41-60, and about 26% of active cases were those aged 61 and older.[11] Other initiatives include pop-up pantries, mobile food trucks, Living Well has a food pantry with "grab-n-go" lunches, as well as Milly's Pantry Backpack Program. Cornell Cooperative Extension (CCE) and Finger Lakes Community Health (FLCH) piloted a workshop series where they gave away $200 food vouchers to qualifying individuals to encourage residents to buy local foods. CCE also offers in-person cooking classes on how to prepare fresh produce, and have recipes that are based on dietary needs (such as lowering cholesterol, diabetes, low-carbohydrate, etc.). ProAction of Yates County also has various programs that help residents receive access to food, such as Meal-on-Wheels for those aged 75 and older, Shut & Delivery (which delivers food to the geographically isolated), nutrition site at St. Marks in Dundee (for Dundee residents to receive meals), and Hope Center and Keuka Food Pantry (which provide food to approximately 80 seniors per month). ProAction also has farmer's market coupon booklets (each coupon is worth $5) that they distribute to clientele who are struggling with access to meals.

## Community Assets and Resources to be Mobilized

The Finger Lakes Region already has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies that promote and facilitate collaboration: Pivital Public Health Partnership (previously the S2AY Rural Health Network) and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors – hospitals, insurers, universities, business, nonprofit, faith communities and residents – to collaborate on strategies for improving health in the region. Both agencies provide support, collaboration and resources to improve the health of Yates County residents.

 11. Data provided by Yates County Department of Social Services.

During brainstorming sessions at the June 16, 2022, Choose Health Yates meeting, community partners, resources and assets were discussed pertaining to the selected objectives. It was noted that primary care providers, Family Counseling Services of the Finger Lakes, the Council on Alcoholism and Addictions of the Finger Lakes, mental health providers, Yates INSYGHT, Children and Youth Single Point of Access (C-SPOA) and school counselors, as well as school districts are partners that can be leveraged to help decrease opioid overdose deaths. Additional partners and programs noted included the Department of Social Services, legislators, NYS CHAMP Program, Yates County Sheriff's Office, and hospitals. Likewise, to assist in increasing the percent of adults with food security, Choose Health Yates can engage the Public Health Department, health care providers including primary care providers and health systems including Finger Lakes Health, Finger Lakes Community Health and others, Cornell Cooperative Extension, Department of Social Services, Foodlink, ProAction, food pantries, school districts, local farmers and grocery stores, and legislators to help accomplish this goal.

Through implementation of the Community Health Improvement Plan, Choose Health Yates partners will work to leverage these pre-existing agencies and services. The Yates County Community Health Improvement Plan document has a full description of interventions and partner roles.

## Community Health Improvement Plan/Community Service Plan

As previously discussed in Main Health Challenges, a multi-voting technique was used to select the priority areas for the Community Health Assessment and Community Health Improvement Plan. County specific pre-read documents were provided to Choose Health Yates and prioritization partners, which included updated data measures for each of the five priority areas outlined in the Prevention Agenda. This was followed with additional county specific data on objectives within the chosen priority areas to help identify objectives, disparities and interventions to include within the plan. A concerted effort took place during the month of December to ensure the governing Community Health Assessment and Community Health Improvement Plan body, Choose Health Yates, was equipped with a diverse and inclusive group, which represented all areas of health and well-being in the county. The following organizations were engaged in Yates County's planning and prioritization process:

| YATES COUNTY PLANNING AND PRIORITIZATION AGENCIES | | |
|---|---|---|
| Yates County Public Health | Yates County Chamber of Commerce | Council on Alcoholism & Addictions of the Finger Lakes (CAAFL) |
| S2AY Rural Health Network (now Pivital Public Health Partnership) | Penn Yan Elementary School | Yates County Department of Social Services |
| Tobacco Action Coalition of the Finger Lakes (TACFL) | Inclusive Network Supporting Youth and families towards Growth, Health, and Teamwork (INSYGHT) | Yates County C-SPOA |
| Common Ground Health | Yates Community Center | Our Town Rocks |
| Yates County Community Services | Finger Lakes Health | Finger Lakes Community Health |
| Community Members | | |

Interventions to target the selected priority areas were discussed and determined by the public health department and their team of community partners at Choose Health Yates meetings. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will continue to take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Yates County Community Health Improvement Plan. All interventions selected are evidence based or evidence-informed and strive to achieve health equity by focusing on creating greater access for those with a household income of less than $25,000, the disparity identified by Yates County.

Choose Health Yates, a group of diverse partners who meet bi-monthly to improve the health of Yates residents, will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

## Dissemination

The Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) will be shared via the Yates County Public Health website and social media pages:

- Website: https://www.yatescounty.org/211/Public-Health
- Facebook: https://www.facebook.com/yatescountypublichealth/
- Instagram: https://www.instagram.com/yatescounty.ph/
- Twitter: https://twitter.com/yatescountyph

It will also be available at Finger Lakes Health's website www.flhealth.org.

Yates County Courthouse
Photo Credit: By Shuvaev - Own work, CC BY-SA 4.0, https://commons.wikimedia.org/w/index.php?curid=44122392

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# APPENDIX 2

## RESULTS-BASED ACCOUNTABILITY™

Results-Based Accountability™ is a disciplined way of thinking and acting to improve entrenched and complex social problems.[12] To facilitate CHA/CHIP development, resulting in a CHIP that measurably improves health, the following steps were followed:

1. **Define the Community:** Data collection is an important first step. In this step, it is important to gather data for the community at large (county-level data) as well as data that identified vulnerable populations within the community who are at risk for poorer health outcomes. This can happen by collecting and analyzing data that shows differences in rates of illness, death, chronic conditions and more in relationship to demographic factors. The planning committee brainstormed specific potential vulnerable populations in the county to be considered with data collection.
2. **Engage Stakeholders:** Population health requires engagement from many sectors. Complex social, economic and environmental factors are all determinants of health; therefore, there is no one organization, department or program that can be held solely responsible for the health of a population. Diverse engagement began in November/December 2021, early in the CHA development process. Committee partners completed an exercise to brainstorm potential new partners from the following sectors: Local Government, Businesses, Not-for-Profit and Community Organizations, Academia and the General Public. The following questions were used to assist brainstorming:
   - Who are those with potential interest and influence who can contribute to the CHA/CHIP process?
   - What population do they represent? (including vulnerable populations identified in Step 1)
   - Identify their potential level of interest and influence (High Interest/High Influence, Low Interest/ High Influence, High Interest/Low Influence, Low Influence/Low Interest)
   - Who would be the best person on the committee to extend an invitation to the selected potential new partner?

After an assessment of brainstormed information, personal invitations were made to selected potential new partners to address any gaps on the committee and the need for diverse engagement.

3. **Engage in Comprehensive Data Collection:** Both primary and secondary data were collected. Disaggregated data was collected by race, gender, income and geography as available to identify vulnerable populations and to assist in strategy development. Data sources included, but were not limited to:
   - Common Ground Health: My Health Story
   - County Health Rankings
   - Vital Statistics
   - Behavioral Risk Factor Surveillance Survey (BRFSS)
   - United States Census Bureau
   - Cornell University Program on Applied Demographics
   - Statewide Planning and Research Cooperative System (SPARCS)
   - New York State Department of Health Perinatal Data Profile
   - S2AY Rural Health Network, Inc.: The Impact of COVID-19 on Food Security and Healthy Eating
   - Outreach to county committee partners for data from their respective organizations.

 12. Results-Based Accountability - Overview and Guide (clearimpact.com)

4. **Prioritize Health Issues:** Data was analyzed and presented by Common Ground Health. After a review of analyzed health outcome data for trends, current state against benchmarks or Prevention Agenda targets, and differences among populations, a multi-voting tool was used by committee members to rank the health issues using selected criteria to identify top Focus Areas, which identified Prevention Agenda Priority Areas.
5. **A Deeper Dive of data was conducted by Common Ground Health.** To enhance the picture of the selected Focus Areas, related Prevention Agenda objective data was presented. A table with objectives and their status colors was created to help with the selection of objectives for this CHA/CHIP cycle.
   - Green Status – the prevention goal metric has been met and the trend of that metric is in the correct direction of the goal or steady
   - Yellow Status – either the prevention goal has not been met but the trend is in the correct direction or the goal has been met but the trend is in the wrong direction
   - Red Status – the goal has not been met and the trend is in the wrong direction
   - Gray Status – there is limited data on this metric available at this time

In addition, person, place and time was analyzed:

- **Person** - Are there certain populations at higher risk for poor outcomes? For example, are outcomes different based on age, race/ethnicity, education, or socio-economic status?
- **Place** - Are the outcomes in the county higher or lower than neighboring counties and the rest of the state? Are there high-risk neighborhoods in the county?
- **Time** - Do the trends over time show the outcomes improving, remaining the same, or declining?

If multiple objectives were identified, additional consideration was given to objectives that may have a greater impact on long term health and also have a good chance of positively impacting other objective indicators.

6. **Develop the Story Behind the Data:** Understanding the story behind the data ("WHY" the data looks the way it does) contributes to an increased understanding of the factors that impact the current state, as well as identifies contributing causes and potential solutions designed to have maximum impact. Results-Based Accountability's *Turn the Curve Thinking* was conducted for selected CHIP objectives/indicators to examine:
   - What is the story? What are the contributing causes to the trend of the selected CHIP objectives, including behavioral, environmental, policy and social determinant of health factors? 5 WHYS was conducted to help identify root causes.
   - Who are the partners that have a role in impacting contributing causes? What community assets or resources can be mobilized to impact identified causes?
   - What works to address identified contributing causes (including evidenced based interventions)?

*Turn the Curve Thinking* also determined a data development agenda, where counties identified if any additional data was needed on selected objectives and/or disparities, as well as a plan on how to collect that data.

7. **Select CHIP Interventions:** Upon completion of *Turn the Curve Thinking*, criteria was used to select interventions that will be included on the CHIP. Criteria used included:
   - How strongly will the proposed strategy impact progress as measured by the baselines?
   - Is the proposed strategy feasible?
   - Is it specific enough to be implemented?
   - Is the strategy consistent with the values of the community and/or agency?

*Turn the Curve Thinking* resulted in interventions which were linked with contributing causes and partners who could have an impact. It is our goal that, with successful implementation of diverse strategies by diverse partners, there will be a collective impact on *Turning the Curve* for the better on our CHIP objectives.

8. **Engage in Continuous Improvement:** To effectively monitor progress and effectiveness of each organization's contribution to selected CHIP objectives, intervention performance measures were identified that answer the questions:
   - How much did we do?
   - How well did we do it?
   - Is anyone better off?

Monitoring these intervention specific performance measures will identify if any focused quality improvement projects are required to improve intervention effectiveness and/or if revisions to CHIP interventions are required.

Yates County Crooked Lake Historic District
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# APPENDIX 3

## HEALTHY EATING & FOOD SECURITY: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 1.1 | Decrease the percentage of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]) | | |
| 1.6 | Decrease the percentage of all adults ages 18 years and older with obesity (among adults living with a disability) | | FLR Data Only |
| 1.13 | Increase the percentage of adults with perceived food security | | FLR Data Only |
| 1.2 | Decrease the percentage of children with obesity | | |
| 1.4 | Decrease the percentage of adults ages 18 years and older with obesity | | |
| 1.5 | Decrease the percentage of adults ages 18 years and older with obesity (among adults with an annual household income of <$25,000) | | FLR Data Only |
| 1.14 | Increase the percentage of adults with perceived food security (among adults with an annual household income of <$25,000) | | FLR Data Only |
| 1.7 | Decrease the percentage of adults who consume one or more sugary drinks per day | | |
| 1.8 | Decrease the percentage of adults who consume one or more sugary drinks per day (with an annual household income of <$25,000) | | |
| 1.9 | Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day | | |
| Note: Objectives 1.10, 1.11, and 1.12 had limited/unreliable data | | | |

## PREVENT MENTAL & SUBSTANCE USE DISORDERS: SUMMARY

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 2.2.1 | Reduce the age-adjusted overdose deaths involving any opioid | | |
| 2.4.1 | Reduce the prevalence of major depressive disorders | | |
| 2.2.4 | Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate | | |
| 2.5.2 | Reduce the age-adjusted suicide mortality rate | | |
| 2.1.2 | Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month | | |
| 2.2.2 | Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder | | |
| 2.2.3 | Reduce the opioid analgesics prescription for pain, age-adjusted rate | | |
| Note: Objectives 2.1.1, 2.1.3, 2.3.1, 2.3.2, 2.3.3, 2.4.2, 2.5.1 and 2.6.1 had limited/unreliable data. | | | |

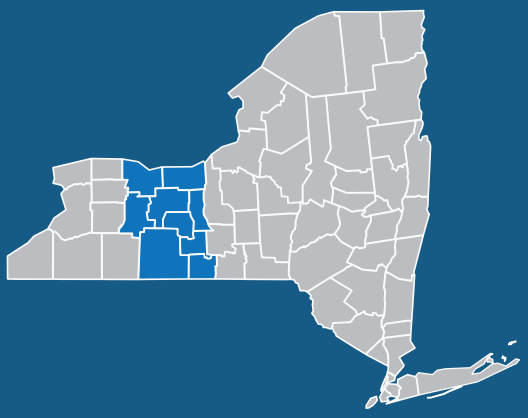
## YATES COUNTY: SELECTED OBJECTIVES

| OBJECTIVE | OBJECTIVE DESCRIPTION | STATUS | NOTES |
|---|---|---|---|
| 1.13 | Increase the percentage of adults with perceived food security | | FLR Data Only |
| 2.2.1 | Reduce the age-adjusted overdose deaths involving any opioid | | |

Common Ground Health

# ABOUT COMMON GROUND HEALTH

Founded in 1974, Common Ground Health is the health planning organization for the nine-county Finger Lakes region. We bring together health care, education, business, government and other sectors to find common ground on health issues. Learn more about our community tables, our data resources and our work improving population health at www.CommonGroundHealth.org.



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