Ontario County

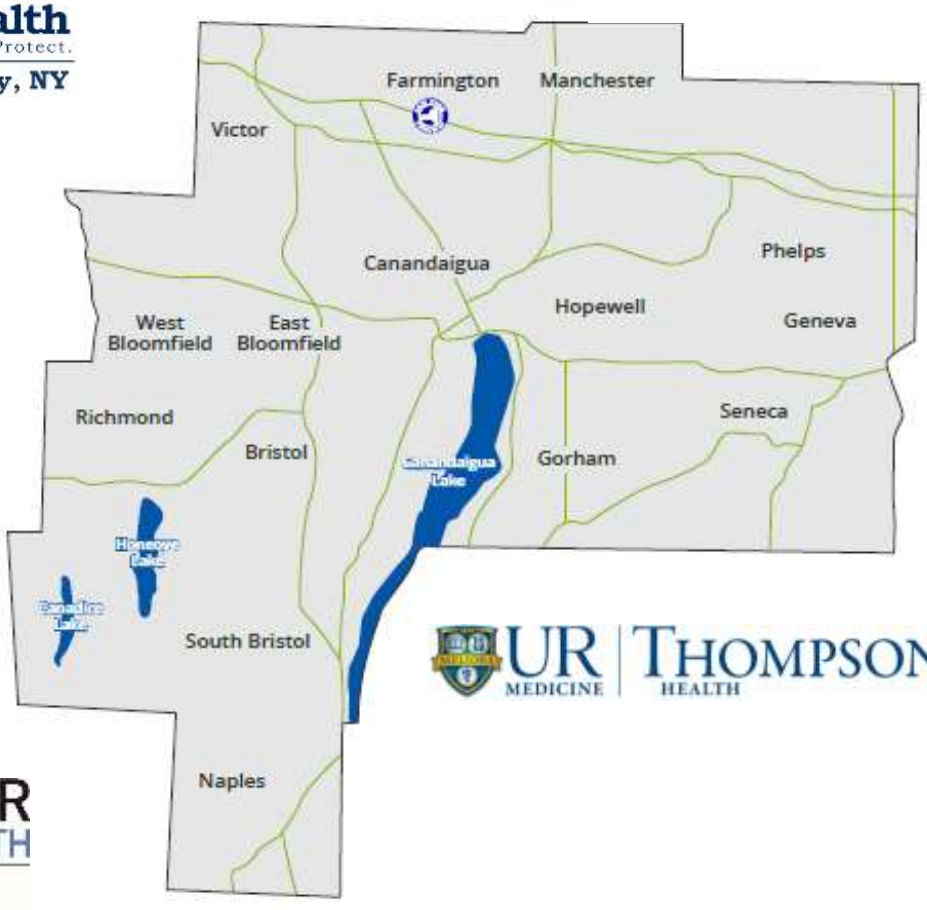
Community Health Assessment/Community Service Plan

2016-2018

December 9th, 2016

Public Health
Prevent. Promote. Protect.
Ontario County, NY

Finger Lakes Health



UR MEDICINE | THOMPSON HEALTH

ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic

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Introduction:
The 2016-2018 Ontario County Community Health Assessment/Community Services Plan was developed by Ontario County Public Health, Finger Lakes Health, UR Thompson Health, and Rochester Regional Health-Clifton Springs Hospital and Clinic, with assistance from the S2AY Rural Health Network.

The S2AY Rural Health Network (S2AY RHN) has assisted Finger Lakes counties with the development of Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) for the last five cycles. Currently, the Network encompasses Seneca, Wayne, Yates, Steuben, Schuyler, Livingston, Chemung, and Ontario counties. Its mission is -*To integrate, promote and expand appropriate components of the Public Health service delivery system to improve health outcomes for all residents of the Network region.*

The Ontario County Health Collaborative (OCHC) coordinated the development of this plan during monthly meetings. OCHC is a multi-disciplinary group of community organizations led by Ontario County Public Health. In addition to the healthcare systems already mentioned, community partners are numerous and are noted throughout this document. See Attachment 1 for the OCHC Membership List.

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Executive Summary:

1. **Priorities and Disparities:**

Priorities: Ontario County (Ontario County Public Health, Finger Lakes Health, UR Thompson Health, and Rochester Regional Health-Clifton Springs Hospital and Clinic) will address two priority areas, and four focus areas within them.

- **Priority Area 1:** Prevent Chronic Diseases
    - *Focus Area 1:* Reduce Obesity in Children and Adults
    - *Focus Area 2:* Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
    - *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings
- **Priority Area 4:** Promote Mental Health and Prevent Substance Abuse
    - *Focus Area 2:* Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

Disparity: Low socioeconomic status (SES) has a negative impact on health and health-seeking behaviors. Ontario County will address this disparity in its 2016-2018 CHIP/CSP. This population suffers higher obesity and smoking rates, lower breastfeeding rates and more difficulty accessing mental health services.

Ontario County Public Health, Finger Lakes Health, UR Thompson Health, and RRH-CSHC will address low SES using evidence based activities (as outlined in the CHIP chart, Attachment 16). All activities will be tied to Priority Area One- Prevent Chronic Diseases. Interventions to address low SES will target three specific populations. The first intervention relates to Goal 1.1 (Create Community Environments that Promote and Support Healthy Food and Beverage Choices and Physical Activity). Partners will target the Geneva area (low-income population)

with evidence based nutrition/physical activity programs. The second applies to Goal 1.3 (Expand the Role of Health Services Providers and Insurers in Obesity Prevention). This intervention will address low-income mothers (less likely to breastfeed) by assisting Federally Qualified Health Centers (FQHCs) in their efforts to become Breastfeeding Friendly Certified through the NYSDOH. The final area of focus applies to Goal 2.1 (Prevent Initiation of Tobacco Use by Youth and Young Adults, Especially among Low SES Populations). Activities will address the density of tobacco vendors and their proximity to schools and will include implementation of policies to protect low-income youth from tobacco marketing.

2. Changes from 2013: The first priority has not changed (Prevent Chronic Diseases – Focus on Obesity) from the 2013 CHA and CHIP, although strategies have evolved, as is evidenced in the CHIP Chart (Attachment 16). In 2013, the second chosen priority was Prevent Chronic Disease, with a focus on hypertension. In addition to continuing these efforts, the new CHIP/CSP will include an additional priority area - Priority Area Four- Promote Mental Health and Prevent Substance Abuse. The developing opioid epidemic and lack of access to mental health care are concerns for Ontario County. Increases in opiate related emergency room visits indicate county residents are being affected by the substance abuse/opioid epidemic.

3. Data Analysis: In S^2AY Network Counties, data analysis began with an update for the eight-county region conducted by the Finger Lakes Health Systems Agency (FLHSA) focusing on data related to priorities in the 2013 CHA. Priority areas in 2013 were obesity, hypertension, diabetes, heart disease, tobacco use, and falls/slips/trips in the >65 year old population. Emerging issues included behavioral health and low back pain.

Additionally, Public Health and the hospital systems requested data collection regarding emerging issues encountered during the Delivery System Reform Incentive Payment (DSRIP) needs assessment and as a result of their work in the community.

On March 4, 2016, S^2AY presented this data to the Public Health (PH) Directors and hospital representatives (Attachment 3). Data sources included the following: 2013-2014 Expanded Behavioral Risk Factor Surveillance Survey (EBRFSS), 2010 Census Bureau and 2015 American Community Service Estimates, 2010-2014 SPARCS data set, NY State Prevention Agenda data set (updated 2016), 2014 Aggregated Claims Data, 2014 NY State Vital Statistics, and the 2015 Regional High Blood Pressure Registry summary (Attachment 2). The review included county-specific data, as well - County Prevention Agenda Dashboard (updated 2016), Community Health Indicator Reports (2010-2014), Sub-County Data Reports (2016 report), Leading Causes of Death Indicators (2012-2014), and County Health Rankings (2016). In addition to the primary data reviewed from the high blood pressure registry, other primary data was obtained from the Partnership for Ontario County's Young Adult Survey 2015 (Attachment 7), a Public Health System Assessment Survey (Attachment 6) and through focus group input (Attachments 3 and 4).

4. Partners and Roles: While the primary partners in the assessment process include Ontario County Public Health, Finger Lakes Health, UR Thompson Health, RRH-CSHC, S^2AY RHN and the FLHSA, many other community stakeholders have contributed to this process, via participation in the Ontario County Health Collaborative (OCHC). OCHC oversaw the assessment process and the development of the CHIP. They will oversee implementation of the CHIP, as they have done for the last two CHA/CHIP/CSP cycles. Detailed partner roles regarding implementation are found the CHIP Chart (Attachment 16).

5. Community Engagement: After identifying high priority needs for Ontario County, nine diverse focus groups met throughout the county to review data and share perceptions (Attachments 4 and 5). Focus group participants were invited to attend the upcoming priority-setting meeting, as well. Another invitation for community involvement and input occurred after the priority-setting meeting. A media release delineating community priorities was distributed to media outlets and posted on the websites of OCHC partners.

6. Evidence-based interventions (EBI)/strategies/activities: After choosing priorities, the OCHC used the NY State Prevention Agenda Refresh Chart to determine which evidence-based interventions (EBIs) were applicable. EBI's to address Priority One (Prevent Chronic Disease) include Stanford's Chronic Disease Self-Management Program (CDSMP); using electronic health records (EHRs) to refer to community-based interventions; policy/practice implementation (helping worksites implement breastfeeding-friendly policies); and promotion of the Regional Hypertension Registry. For Priority Area Two (Promote Mental Health and Prevent Substance Abuse) interventions include reducing harm by offering Narcan (naloxone) trainings; reducing supply and diversion control through "lock your meds" campaigns; increasing community access to prescription drop boxes; and facilitating drug take back days.

7. Evaluation of Impact and Process Measures: Process measures are indicated in the attached CHIP and correlate with the objectives chosen from the NYS Prevention Agenda Refresh Chart for chronic disease. These include tracking the percentage of adults with one or more chronic diseases who have attended a self-management program; the number of providers using EHRs to trigger patient education and referral to EBIs; the number of primary care practices participating in the Hypertension Registry; and similar measures.

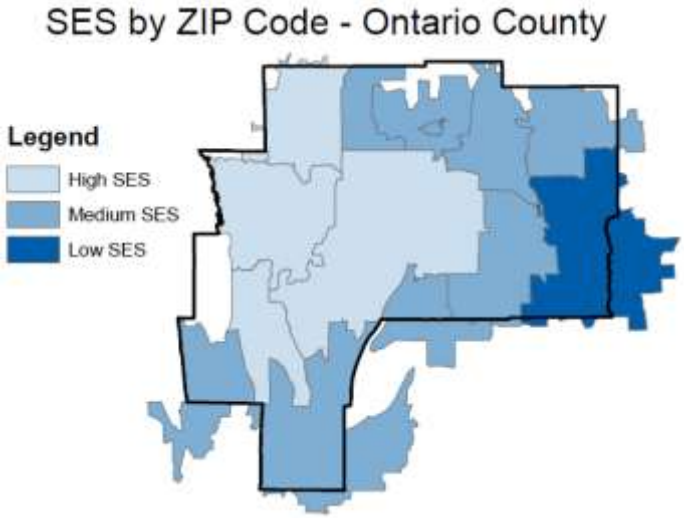
The promotion of mental health and prevention of substance abuse will be evaluated by tracking the number of trainings held for prescribers, identifying the number of medication drop boxes in the community, and recording the number of pounds of medications received at “drug take back” events. OCHC meets monthly and the agenda for these meetings focuses on tracking and measuring progress, identifying barriers, and strategizing how work together to overcome obstacles to implementation of the CHIP. OCHC will report progress to NYSDOH per the established schedule

1. Community Description and Health Needs

Community Description

The service area for this Community Health Assessment includes all of Ontario County, New York.

Ontario County is a rural county located in the western portion of New York State in the Northern Finger Lakes. Its western border is just 8 miles from Rochester. Parts of northwestern Ontario County serve as bedroom communities for those who work in Rochester. The County includes 2 cities, 16 towns, 9 villages, 2 colleges, and 9 school districts (17 schools). The two cities, Canandaigua (the County seat) and Geneva, are located at the northern ends of Canandaigua and Seneca Lakes respectively, and contain approximately 25% of the County's population. Honeoye and Canadice Lakes are located in Ontario County and 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.



Source: 2007-2011 American Community Survey and 2010 US Census Bureau of Statistics

Socioeconomic Status (SES) reflects the combination of education, income and occupation. The map provided here indicates most Ontario County residents, with the exception of the eastern border, fall into medium to high socio-economic status categories (2007-2011 American Community Survey and 2010 US Census Bureau). The annual median household income is $57,318 compared to $54,482 for the nation and the per capita income is $30,346 compared to $28,555 for the nation (2010 US Census Bureau, American Community Survey Estimates, 2010-2013). According to 2016 USDA data, the county poverty rate is 11.5% with 15.2% of children 0-17 years living in poverty in 2014.

Ontario is the most urban of the counties in the S2AY RHN due to its proximity to Rochester, but is still predominantly rural with a land mass of 644 square miles. Its population, estimated at 109,561 in 2015, is growing. Population density is approximately 170 persons per square mile (US Census Bureau Population Estimates Program, 2015). The New York State Thruway traversing the northern edge of the county and Routes 5 and 20 running roughly parallel, provide easy access to jobs in neighboring labor markets.

Population Size - 55 year trend, US Census Quickfacts						
Census Year	**Seneca**	**Yates**	**Steuben**	**Ontario**	**Wayne**	**Yates**
1960	31,984	15,044	97,691	68,070	67,989	18,614
1970	35,083	16,737	99,546	78,849	79,404	19,831
1980	33,733	17,686	99,217	88,909	84,581	21,459
1990	33,683	18,662	99,088	95,101	89,123	22,810
2000	33,342	19,224	98,726	100,224	93,765	24,621
2010	35,251	18,343	98,990	107,931	93,772	25,348
2015 est.	34,833	18,186	97,631	109,561	91,446	25,048

According to the US Census Bureau Population Estimates Program-2015, Ontario County has a relatively high dependency ratio, with 20.6% of the population estimated to be under age 18, 4.9% under age 5, and 18.3% aged 65 or over.

Approximately 94% of the population is white, 2.7% is Black/African American and the remainder other or mixed races. In 2015, Ontario County's Hispanic population was estimated to be 4.4%. Almost 7% (6.8%) of residents reported speaking a language other than English at home (3,301 indicating they spoke Spanish). In the 2010 census, 2,667 people indicated that they spoke English "less than very well." Migrant farm and seasonal workers support many farms in the county, as well as the horseracing track in Farmington.

Ontario County is home to a growing Mennonite community. Adult community members speak English, as well as a German dialect (Pennsylvania Dutch) among peers and in the home. Mennonites seek out healthcare in doctor's offices, FQHC's, health departments, urgent care centers and local hospitals.

Health Needs

The Health Needs Assessment was conducted in a similar fashion for each county in S^2AY RHN. This process began with a summary assessment of the regional data, comparing each county (Attachment 2). Though data was compiled regionally, each county held their own focus groups and gathered information specific to their own community. Additionally, a sub-regional focus group was held in coordination with DSRIP through the Finger Lakes Performing Provider System (FLPPS) in each of the three Naturally Occurring Care Networks (NOCNs) in the region.

Ontario County is part of the Finger Lakes NOCN, along with Wayne, Seneca, and Yates and Counties.

Additionally, each county including Ontario held their own priority setting meeting and worked through county-specific committees (OCHC in Ontario County) to review data, analyze needs and develop priorities.

Based on analysis of all data for the region, the major health issues include, from highest to lowest:

1. Hypertension (tobacco use, cerebrovascular disease, heart)
2. Substance Abuse (specifically related to opioids)
3. Obesity
4. Mental Health
5. CLRD (COPD)
6. Teen Pregnancy
7. Injury Prevention (falls)
8. Dental Health

1. **Hypertension:** According to the Centers for Disease Control and Prevention (CDC), approximately 30% of adult Americans have Hypertension (HTN); only half (52%) are well controlled. In Ontario County, 38.0% of adults have been diagnosed with HTN by a physician (2013-2014 EBRFSS). Though incidence is higher than the national estimate, Ontario County has one of the higher control rates in the region; 71% according to the Finger Lakes Hypertension Registry (FLHSA/RBA High Blood Pressure Registry, June 2016). According to 2012-2014 Vital Statistics Data, Ontario County has an age-adjusted cerebrovascular disease (stroke) mortality rate of 36.5 per 100,000, which is significantly higher than both the New York State rate (25.6) and the Finger Lakes Region rate (33.5). The age-adjusted percentage of adults who have taken a course or class to learn how to manage their chronic disease or condition (including hypertension, diabetes and arthritis) is slightly higher in Ontario County (10.0%) than in the region (9.5%) and NY State (9.7%) (2013-2014 EBRFSS). The percentage of pregnant women in WIC with hypertension during pregnancy (12.1%) also exceeds the State rate (7.1%) and places Ontario County in the 4th quartile for this measure (2009-2011 NYS Pregnancy Nutrition System – WIC Program Data).

2. **Substance Abuse:** Data reflect a sharp increase in emergency department visits for substance abuse and mental health issues, as well as admissions for heroin overdose (see Power point presentations, Attachments 2 and 3). Consideration of the opioid epidemic included discussions of mortality rates, premature loss of life, criminal behaviors,

incarceration, and the impact of substance abuse disorders on the entire family, including children of addicts.

3. **Obesity:** After adjustment for age, 55.6% of adults in Ontario County are either overweight or obese (2013-2014 EBRFSS) and 31.2% of Ontario County children are overweight or obese (85th percentile or higher) (2012-2014 DOH health ranking data). Obesity increases the risk for diabetes (11.2% of Ontario County adults) and HTN (38.0% of Ontario County adults) (2013-2014 EBRFSS). In addition to these, obesity increases the risk of heart disease, low back pain, arthritis, high cholesterol and several types of cancer (Attachment 5, Focus Group on Obesity). Targeting obesity will also address these preventable conditions. Obesity related data and other statistics cited below can be reviewed in the Ontario County 2013-2014 EBFRSS at: https://www.health.ny.gov/statistics/brfss/expanded/2013/county/docs/ontario.pdf

4. **Mental Health:** Mental health and access to behavioral health services remain a concern for residents of the Finger Lakes Region. Poor mental health is tied to smoking, substance abuse, homelessness and incarceration. It is impossible to address these related issues without considering barriers to the treatment of mental illness.

5. **CLRD/COPD:** According to the 2013-2014 EBFRSS, the age-adjusted percentage of adults identifying as smokers in Ontario County is 20.1%, significantly higher than the New York State rate (15.9%). The age-adjusted death rate due to Chronic Lower Respiratory Disease is 41.8 per 100,000, more than a third higher than New York State as a whole at 29.8 per 100,000 (2012-2014 Vital Statistics Data). Tobacco use is a significant contributor to this health problem. The tobacco use rate for those with a household income under $25,000 is 31.9%, higher than the region (30.9%) and New York State (24.2%) (2013-2014 EBRFSS). Additionally, the rate of cigarette smoking for residents reporting poor mental health is higher in Ontario County at 36.5% than for the Finger Lakes Region (33.1%) and New York State (29.9%) (2013-2014 EBRFSS).

6. **Teen Pregnancy:** The teen pregnancy rate in Ontario County is not significantly different from the region or New York State (2012-2014 Vital Statistics Data: aged 10-14 years - 0.5 per 1,000, aged 15-19 years – 21.7 per 1,000, and aged 18-19 years – 38.9 per 1,000). The impact of teen pregnancy spans generations. According to the Centers for Disease Control and Prevention (CDC), teenaged mothers and their children are less apt to complete high school and are more likely to live in poverty and have poorer health outcomes than adult counterparts. For these reasons, OCHC included teen pregnancy as an issue to be ranked during the priority setting process.

7. **Injury Prevention (falls):** Falls are most common in those over the age of 65. The US Census Bureau Populations Estimates Program, 2015, reflects that 18.3% of Ontario County residents are age 65+. Ontario County had the second lowest incident of falls in the region with 27.8% of the population age 65+ reporting at least one fall in the last 12 months (EBRFSS, 2013-2014). According to the 2012-2014 Vital Statistics Data, the age-adjusted falls hospitalization rate for Ontario County was 32.1 per 10,000, slightly lower than New York State (34.0 per 10,000). As the population continues to age, falls will be a growing concern in the region. As falls can heavily affect quality and longevity of life, this priority area will be monitored throughout the next CHIP cycle.

8. **Dental health:** Good oral health is essential to general health. According to the 2013-2014 EBRFSS, 76.9% of Ontario County adults visited a dentist within the past year, slightly higher than the region (72.6%) and New York State (69.3%). Unfortunately, tooth decay continues to affect some county residents, particularly those with limited access to prevention and treatment services. Untreated tooth decay and gum disease lead to pain, localized abscesses, bloodstream infections, preterm labor and disfigurement. Among adults, untreated decay and tooth loss can affect self-esteem and employability.

   According to the NYSDOH, untreated decay among children has been associated with difficulty in eating, sleeping, learning, and proper nutrition. An estimated 51 million school hours are lost due to cavities. Almost one fifth of all health care expenditures in children are related to dental care. Of third grade children in Ontario County, 48.2% experience dental caries (3rd quartile per NYSDOH oral health survey, 2009-2011).

   Each year S^2AY RHN Dental Steering Committee updates a list of dentists accepting Medicaid products. Ontario County is fortunate to have dental care available to low-income and Medicaid patients through Finger Lakes Community Health (Geneva Community Health), Regional Primary Care Network (Rushville Community Health Center), and Canandaigua Churches in Action Supply a Smile. Additionally, Ontario County has collaborated with Health Economics Group, Inc. to provide a dental benefits card to defray the cost of dental care at participating dentists. Attachments 2 and 3 fully describe the health needs data.

Health Care Access and Challenges

Lack of access to healthcare influences health outcomes and socioeconomic status limits access to healthcare. Ontario County is diverse, economically. Many residents easily access healthcare while others struggle, significantly. Pockets of the county have mental health and primary care HPSA (health professional shortage area) designation demonstrating a potential lack of access to healthcare services (see chart below).

HPSA Name	ID	Type	FTE	# Short	Score
	069 Ontario County				
Low Income-Finger Lakes Tri-County	13699936ND	Population Group	3	8	11
Geneva City		Minor Civil Division			
Geneva Town		Minor Civil Division			
Gorham Town		Minor Civil Division			
Hopewell Town		Minor Civil Division			
Manchester Town		Minor Civil Division			
Phelps Town		Minor Civil Division			
Seneca Town		Minor Civil Division			
Medicaid Eligible - Eastern Ontario/Ontario Service	736999360W	Population Group	0	1	10
Geneva City		Minor Civil Division			
Geneva Town		Minor Civil Division			
Gorham Town		Minor Civil Division			
Hopewell Town		Minor Civil Division			
Manchester Town		Minor Civil Division			
Phelps Town		Minor Civil Division			
Seneca Town		Minor Civil Division			

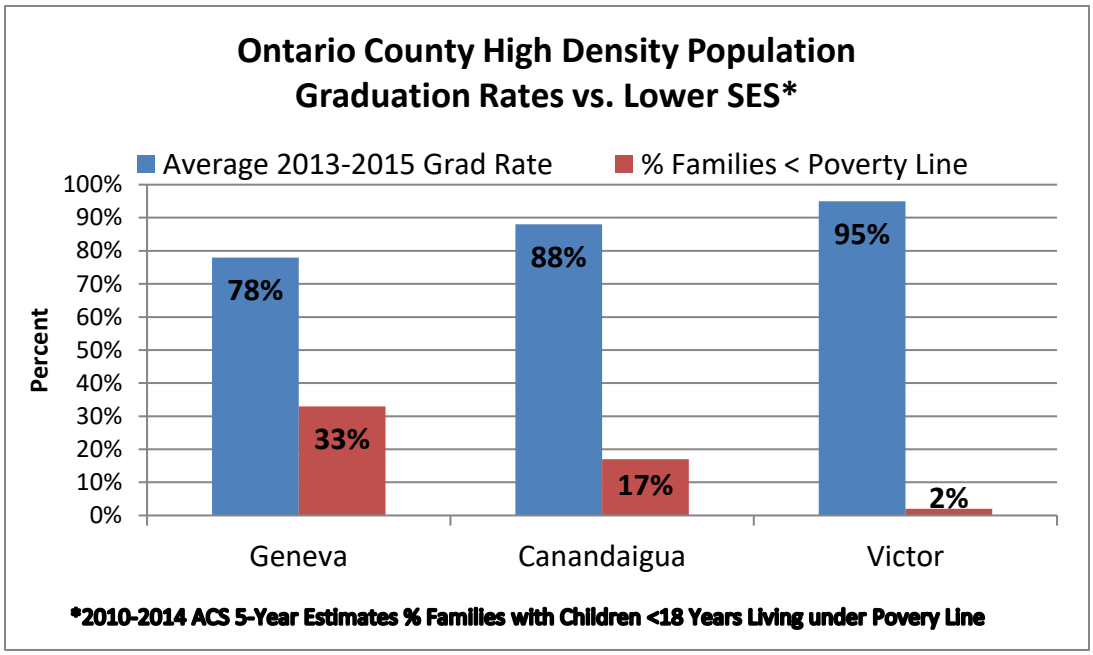
https://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx

The county is fortunate to have three local hospitals. Over the course of the last few years, two have become affiliated with large health systems in Monroe County. This has resulted in previously independent primary care physicians becoming employees of large, teaching hospitals. Access to primary care for the under/uninsured populations has improved as system-owned practices widely accept Medicaid while small, privately owned practices often do not. Additionally, HPSA status allows for loan forgiveness for physicians recruited to Ontario County. Satellites of large hospital systems in small communities improve access to state of the art diagnostic, surgical and specialty care for all residents. Additionally, Ontario County has a local Planned Parenthood office and three Federally Qualified Healthcare Centers (FQHCs), one of which houses a Migrant Health Program and telemedicine.

Many factors affect the quality of health and healthcare in rural communities. Lower income levels, greater numbers of uninsured, higher rates of smoking by some groups, language barriers, cultural and religious beliefs, predisposition to illness based on race/ethnicity, historic lack of access to health care/screening, lack of transportation and lower educational levels can negatively impact health outcomes. Cultural norms and behaviors throughout Ontario County were considered during CHIP development.

Education is a predictor of SES and SES influences one's ability to make healthy choices and access healthcare. Many parts of Ontario County are economically privileged and have excellent high school graduation rates, but pockets of poverty and low educational attainment remain. The relationship between SES and high school graduation rates in Ontario County's most dense populations is seen in the chart below. This illuminates the needs of residents in the Geneva area

and the importance of seeking out community partnerships to develop and deliver Public Health initiatives to the eastern part of Ontario County.



Lower SES areas frequently have higher rates of uninsured and under insured persons. Ontario County Public Health's partnership with the S^{2}AY RHN ensures residents have access to NY State of Health Navigators and a Community Health Advocate Program; initiatives for identification of gaps, linkage to health insurance, and assistance with accessing healthcare providers.

Transportation and affordability were repeatedly cited as barriers to healthcare access, during community focus groups. These issues are not new or isolated to Ontario County. Two years ago, Ontario County expanded public transportation options by contracting with the Regional Transit Service (RTS). RTS continually assesses transportation needs and bus routes are adjusted, as necessary.

As previously noted, the Mennonite population in Ontario County is growing. Traditionally, Mennonites do not purchase health insurance and do not participate in private, state or federally funded programs (Medicaid, Medicare, and Social Security). The community itself serves as a safety net for unanticipated health care needs and expenses. Early prenatal care and other preventive care, including immunizations are declined by some sects. Many Mennonites farm and farm accidents are a concern in Ontario and surrounding counties. Mennonite children attend school through eighth grade. Transportation is often by horse and buggy, an additional challenge to accessing healthcare.

S^{2}AY RHN represents the region's Public Health Departments and leads the way in clarifying and informing the navigation of changing reimbursement structures to maintain/improve access to care. Members of the OCHC have considered emerging issues in the health care system during

the development of the CHIP. Finger Lakes Health, Ontario County Public Health and the S^2AY RHN have been active participants in DSRIP, working to implement alternative models of care and improved care coordination.

Promising initiatives such as the New York Medicaid Redesign, the Centers for Medicare and Medicaid Services Triple Aim, the Affordable Care Act, New York State of Health and Patient Centered Medical Homes have helped to address some access to care issues.

Risk Factors

Behavioral, environmental, and socioeconomic factors affect health outcomes. According to the Centers for Disease Control and Prevention (CDC), scientists recognize five determinants of health of a population:

- Biology and genetics- family of origin, sex, age
- Individual behavior-injection drug use (needles), unprotected sex, smoking
- Social environment-discrimination, income, gender
- Physical environment-urban vs. rural, overcrowding, crime
- Health services. Access to quality health care and health insurance (previously discussed in this document)

The sub-groups for these risk factors include lower-income, lower-educational level and social isolation, as well as individual genetic predispositions for chronic disease, mental illness and alcohol/substance abuse. Most factors discussed here are social in nature. The use of technology is an emerging risk factor to be considered.

Physical Factors

As stated in the demographic section, Ontario is the most urbanized of the counties in the Finger Lakes Region due to its proximity to Rochester. It is still predominantly rural with a population density of approximately 170 persons per square mile (US Census Bureau, Population Estimates Program 2015).

Transportation is a challenge for many residents scattered throughout rural parts of the county. Driving long distances can be an insurmountable barrier to the elderly and the uninsured Medicaid-ineligible population with limited financial means. Most residents are not within walking distance of a grocery store where they can purchase fresh fruits and vegetables.

Additionally, the physical environment is a major consideration. Older housing, poor indoor air quality, long snowy winters and limited opportunities for physical activity contribute to the burden of chronic disease in Ontario County.

Many rural residents have private wells, many of which are not fluorinated and some of which may have poor water quality. Lack of a fluoridated water supply in some parts of the county contributes to physical risk factors.

Social Factors-Policy and Legal

Social reform cannot occur without policy change, but with change, comes challenges. With the implementation of the Affordable Care Act in 2014, came the challenge of helping the community understand a new, complex system. Creation of smoke free areas by employers and local governments has decreased secondhand smoke exposure, while creating enforcement challenges. Tough stances on substance abuse and DWI/DUI improve safety, but add significantly to the incarcerated population. The threat of deportation keeps undocumented migrant workers away from preventive healthcare, ultimately driving up healthcare costs.

Ontario County has the highest number of convictions for DWI/DUI in New York State and is home to a 282-bed jail. Average census is 220 (increased from 163 in 10 years). The number of inmates affected by substance abuse and mental health continues to rise, as does the complexity of medical conditions encountered among inmates. Jail staff provides healthcare, mental health counseling, education and rehabilitative services to inmates. Ontario County Public Health collaborates with the jail to provide health education and vaccination services.

Social Factors-Economic

Poverty statistics described previously affect a resident's ability to access health care. Income levels can restrict basic needs such as heat, food, adequate shelter, medical, and prescription care. Inadequate housing affects health outcomes. Some homes still have no indoor plumbing and many county residents use wood as their main heat source. 8.4% of Ontario County residents live in mobile homes (2010-2014 American Community Survey).

The current economic situation and budget cuts over the last few years have affected the local health care environment. Providers have a more difficult time, with a seemingly increasing number of individuals electing to skip routine medical and dental care due to lack of employment, resources, insurance and/or high deductibles. Some providers refuse to accept Medicaid, potentially limiting access to this population. Additionally, the cost of fuel is still a consideration for residents as the expense reduces funds available for health related items and the ability to obtain healthcare services and/or pay for prescriptions.

Persons with limited means and other social risk factors (family stressors, lack of education, mental illness) are also more likely to engage in unhealthy habits such as

tobacco use or alcohol abuse. Social isolation and the cultural acceptance of tobacco and alcohol increase the risk of substance abuse, depression and poor mental health. Living in poverty is associated with poorer health status, an increased risk of having inadequate health insurance, and lower use of health services.

While the economic status of County residents overall is good, as noted in the demographic section, 25.2% of City of Geneva residents live below the poverty level (ACS, 2010-2014). Per capita income is $20,634; almost 37% below the NYS average of $32,829 (USCensus Quick Facts, 2016).

Social Factors-Education

Lack of education is a determining factor of economic stability and is associated with poorer health and less likelihood of seeking healthcare, especially preventive services. As noted previously, educational attainment is not consistent throughout the county. High school graduation rates vary significantly from town to town as evidenced in the chart below.

Ontario County Graduation Rates

2016 NYSED.gov

School	2013 %	2013 #	2014 %	2014 #	2015 %	2015#
Canandaigua	88%	323	86%	322	89%	313
Bloomfield	96%	73	93%	80	88%	73
Geneva	81%	169	76%	133	77%	141
Marcus Whitman	86%	101	85%	91	88%	107
Honeoye	83%	58	80%	44	88%	60
Red Jacket	91%	71	77%	48	92%	69
Naples	93%	65	95%	70	89%	50
Victor	95%	330	94%	294	95%	291
Midlakes	82%	125	86%	118	91%	138
Total County	88%	1275	87%	1155	89%	1208

Lack of educational opportunities for men and women of color and diverse ethnicity creates a healthcare workforce challenged with providing culturally and linguistically competent services, in some parts of the county.

The high cost of Early Intervention programming is a factor that the Public Health community faces. The health department works with state and local officials and schools to manage these costs while providing quality service to the children enrolled. Public Health also assists school health programs on an “as needed” basis to provide up-to-date health education/information.

Social Factors-Personal

- Values and behavior systems-older residents refusing to take use Medicaid and Food Stamps because they consider it a "hand-out".
- Fear and distrust of medical community among some groups.
- Cultural differences and fear of government officials on the part of migrant and seasonal workers.
- Lack of a private vehicle. Reliance on public transportation and constraints of bus schedules and wait times.
- Lack of education and personal experience regarding the value and need for preventive healthcare.
- Low health literacy.
- Inappropriate use of the Emergency Room- Use for non-emergencies, as well as, allowing health conditions to grow so severe emergency care is required.
- For a significant portion of females, family-planning services are the only access point to primary care services.
- Crime rate or perceptions about it from media reports, cause individuals to fear seeking healthy, outdoor activities for their families in some communities.
- Cultural and familial acceptance of tobacco, alcohol or drug use.

Technology Factors

Ontario County has numerous media outlets but changes in technology have brought new challenges as public health explores novel ways to reach residents. Relationships with two local newspapers are strong and provide a valuable mechanism for education and messaging, but this traditional method, like TV and radio has limitations in the age of technology. Distractions and competing information are rampant. Residents have seemingly endless options-cable television, social media, satellite radio, the internet, smart phone apps, etc. Additionally, there is no TV station in Ontario County and public health competes with numerous entities in the Rochester area for airtime and health messaging.

Internet access in Ontario County is widely available and with convenience come challenges. Large portions of the population seek medical advice from websites some of which are unreliable, misleading, for-profit or fraudulent. Additionally, some who could benefit from reliable sites may not have access or have low literacy levels or computer skills. Disparities in access to health information, services, and technology can result in lower usage rates of preventive services, less knowledge of chronic disease management, higher rates of hospitalization, and poorer reported health status. Historically, the internet has been frustrating for older residents. Thankfully, this population is growing in their use of computers, cell phones and email.

A designated staff member updates Ontario County Public Health's web site frequently with educational materials and announcements. The department also has a Facebook page and Twitter account. Ongoing training of staff is necessary to keep up with rapidly evolving technology. Public Health practitioners must stay abreast so messages aimed at specific groups are distributed via appropriate channels. Likewise, being "heard" amid millions of other messages in this competitive environment is challenging.

Other Factors Specific to Ontario County

- State budget cuts affecting health care and government at local levels, cuts to public health programs and unfunded mandates.
- Unemployment rates
    - The New York State Dept. of Labor reported the unemployment rate in Ontario County was 4.1% compared to 4.6% for the Finger Lakes Region and a New York State rate of 5.1% (as of September 2016). While cumulatively better than the region and NY State, it is important to remember some pockets of the county are disproportionately affected.
- Use of hospitalists by local health systems poses unique challenges for the smooth transition from inpatient status to care in the home (i.e. obtaining physician's orders; medication management).
- Increased immunization costs and complicated immunization schedules may influence provider participation in adult and children immunization programs, thus increasing the burden of the local health department.
- Smoking Rate
    - Though strides have been made in worksites, campuses, and parks regarding smoke-free policies, 20.1% of the adult population still smokes (2013-2014 EBRFSS). Reaching populations where smoking is still the norm presents a challenge.
- Non-coverage of dental costs by health insurers. Limited services for Medicaid/Medicare populations.

Emerging Factors

Emerging issues in the health care system were also discussed, and Finger Lakes Health, Ontario County Public Health and the S^2AY Rural Health Network have all been active participants in DSRIP (Delivery System Redesign Incentive Program), working to implement alternative models of care and improved care coordination. Members also work in coordination with the FLHSA on the Population Health Improvement Program (PHIP) through Regional Leadership meetings that occur regularly.

2. Data Reviewed and Analyzed:

The data review and analysis were extensive. The process began with a data update for the eight county region conducted by the FLHSA at the request of S^2AY and the county. Data collection

and analysis efforts focused on data related to Ontario County and regional priorities from the 2013 CHA. The hospitals and Public Health also agreed to analyze emerging issues based on recognition of changing community needs and input from the needs assessment performed for DSRIP by the FLHSA. In addition to the DSRIP needs assessment, data sources for this review included:

- Expanded Behavioral Risk Factor Surveillance Survey (2013-2014)
- Census Bureau (2010 Census and 2015 American Community Survey estimates)
- SPARCS data (2010-2014)
- NY State Prevention Agenda data set (updated 2006)
- Aggregated Claims Data (2014)
- NY State Vital Statistics (2014)
- Regional High Blood Pressure Registry (2015)

This data was reviewed and S^{2}AY Network delineated the highest need areas for the county and summarized in a Power Point presentation (Attachment 3). In addition to the above sources, additional reviewed data included:

- County Prevention Agenda Dashboard (updated 2016, data from various dates)
- Community Health Indicator Reports (2010-2014)
- Sub-County Data Reports (2016 report, data various years)
- Leading Causes of Death Indicators (2012-2014)
- County Health Rankings (2016 report, data from various years)
- Partnership for Ontario County's Young Adult Survey 2015

In addition to the primary data reviewed from the high blood pressure registry, other primary data was obtained through the Partnership for Ontario County's Young Adult Survey and the focus groups described in this document (Attachment 5, pages 125-143).

3. Priorities, Disparities and Community Engagement:

Ontario County (including Ontario County Public Health Department, Finger Lakes Health, UR Thompson Health, and RRH-CSHC) chose to address two priority areas and four focus areas within them.

- **Priority Area 1:** Prevent Chronic Diseases
  - *Focus Area 1:* Reduce Obesity in Children and Adults
  - *Focus Area 2:* Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
  - *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings
- **Priority Area 4:** Promote Mental Health and Prevent Substance Abuse
  - *Focus Area 2:* Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

Note: Priority and focus areas are set by the New York State Department of Health Prevention Agenda. Selected priorities and foci are labeled and numbered per NY State guidelines.

Disparity to Address

Based on population demographics, our disparity focuses on socioeconomic status rather than culture or race.

During 2016-2018, Ontario County Public Health, Finger Lakes Health, UR Thompson Health, and RRH-CSHC will address the disparity of low socioeconomic status (SES) in regard to the prevention of chronic disease (Priority Area 1), using evidence based activities, as outlined in the CHIP chart (Attachment 16). SES will be addressed in Goal 1.1 (create community environments that promote and support healthy food and beverage choices and physical activity). This goal targets the Geneva area (low income population) with evidence based nutrition/physical activity programs.

Goal 1.3 (expand the role of health care health services providers and insurers in obesity prevention) targets low income mothers by working with Federally Qualified Health Centers (FQHCs) to become Breastfeeding Friendly Certified through the NYSDOH.

Goal 2.1 (prevent initiation of tobacco use by youth and young adults, especially among low socioeconomic status populations) targets low income youth by implementing policies to protect youth from tobacco marketing and working to limit the density of tobacco vendors and their proximity to schools.

Goals were chosen by the OCHC based on analysis of the data and potential to reach disparate populations.

Community Engagement

The S2AY Rural Health Network used the Mobilizing for Action through Planning and Partnership (MAPP) process to engage the community in a collaborative assessment process and collectively develop priorities.

The MAPP process is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs, and forming effective partnerships for strategic action. The MAPP tool was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Public Health Practice Program Office, Centers for Disease Control and Prevention (CDC). A work group comprised of local health officials, CDC representatives, community representatives, and academicians developed MAPP between 1997 and 2000. The vision for implementing MAPP is:

"Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action". The MAPP process encompasses several steps.

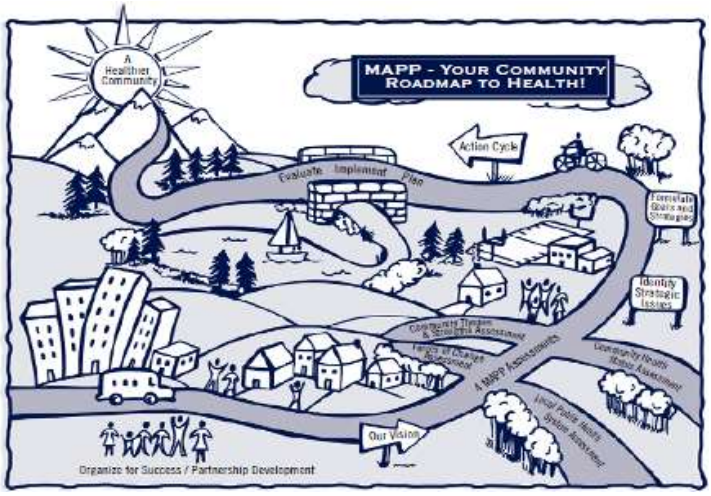
1. Organize for Success- Partner Development

This included representatives of the Ontario County Health Collaborative discussed above. This collective, multi-disciplinary group oversaw the assessment process and the development of the CHIP.

2. Assessments

Four assessments inform the entire MAPP process. The assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods. The use of four different assessments is a unique feature of the MAPP process. Most planning processes look only at quantitative statistics and anecdotal data. MAPP provides tools to help communities analyze health issues through multiple lenses.

The first assessment examined the Community Health Status Indicators. This includes relevant secondary statistical data as well as some primary data.



The second assessment evaluated the effectiveness of the Public Health System and the role of Ontario County Public Health Department within that system. This was done using a modification of the Local Public Health System Assessment tool developed by the CDC and NACCHO. This was also conducted via an electronic survey on Survey Monkey. A diverse group of key informants were chosen to complete the survey, including community leaders who are familiar in some way with the local public health system. The assessment was completed through the use of a more user-friendly version of the CDC and NACCHO tool, Local Public Health System Assessment (LPHSA). Each of the ten essential public health services was rated by the group by ranking the series of indicators within each Essential Service to determine areas of strength and areas needing improvement within the Local Public Health System.

The third assessment was the Community Themes and Strengths Assessment that was conducted through focus groups which were held throughout the County. This assessment looked at the issues that affect the quality of life among community residents and the assets the County has available to address health needs. These were held in conjunction with the

fourth assessment that looked at the "Forces of Change" that are at work locally, statewide and nationally, and what types of threats and/or opportunities are created by these changes.

3. Identification of Strategic Issues

This step included both developing the list of major health issues based on all the data obtained, and prioritizing these issues.

4. Formulate Goals and Strategies

This step involved discussion and analysis of the data related to the chosen priorities to determine which strategies could best address the issues. All of these steps in the collaborative MAPP process are detailed more fully below:

The process of Community Engagement using MAPP

Ontario County Public Health, Finger Lakes Health, UR Thompson Health, and RRH-CSHC, with assistance from the S2AY Rural Health Network, conducted a comprehensive assessment of the community, which provided the basis for the Prevention Agenda priority areas selected above. The assessment process included a thorough review of county specific data around health needs, compared to neighboring counties, the region, and the State as a whole. As noted above, this included data collection and analysis by both the FLHSA and S^{2}AY. The OCHC, which includes FQHCs (Finger Lakes Community Health and Regional Primary Care Network (RPCN), Food Link, faith-based representatives, schools and CBOs, oversaw the assessment process. After the data was analyzed and prepared, this data was shared in the form of focus group presentations to county residents. Ontario County conducted nine separate focus groups with key informants throughout the county to solicit feedback. Focus groups were selected to include a broad diversity of community members from different segments of the community, including populations that experience health disparities as outlined in this report. Focus groups that were conducted include a group of first responders, a Tools for Social Change group (community coalition), a senior citizen group, the Canandaigua Rotary Club, a senior meal site, a group of county leaders, a probation group, the Population Health Committee at Thompson Health, and the Finger Lakes NOCN. Additionally, a Public Health System Assessment was completed as part of the MAPP process using key informants as respondents, and input incorporated into the decision-making process (Attachment 6).

After the completion of the focus groups, the Ontario County Health Collaborative (OCHC) invited focus group participants, all community members, health care organizations, and human service agencies to participate in the prioritization of the most pressing health needs identified from the data collection and focus group input. The method used to identify strategic issues was a basic priority rating system known as the Hanlon Method. Focus group participants and community members were invited to this meeting through email, media releases, and postings on websites and social media platforms (Public Health, Hospitals, S2AY Rural Health Network, and other partners). S^{2}AY prepared another Power Point presentation for this "Priority Setting"

meeting. At this meeting, S²AY presented the data shared with the focus groups, along with key slides from the EBRFSS and Community Health Indicator Reports, after using all data and surveys already mentioned to develop the presentation. Input from the focus groups was analyzed and considered when developing a list of priorities for the group to rank that S²AY created from all of the data reviewed and analyzed (list of issues to rank attached). The group was also offered the opportunity to add any additional issues that they believed needed to be ranked to come up with priorities. In Ontario County, the group added teen pregnancy.

The Hanlon Method was used to rank issues. The presentation summarizing the Hanlon Method (Attachment 10) was reviewed with participants and priorities were ranked (list of ranked issues, Attachment 12). Hanlon uses the Basic Priority Rating (BPR) System formula found below:

BPR = (A + 2B) X C: where A= the size of the problem, B= the severity of the problem and C=the effectiveness of the solution.

The effectiveness of the solution (C) is more heavily weighted than the size (A) or seriousness (B) of the problem as community resources are limited and decisions about allocation must be made with careful consideration of the likelihood of success. Participants also consider the weight of the propriety, economic feasibility, acceptability, resources and legality (PEARL) of issues in this ranking system. Numerical values were determined by each participant for size, severity and effectiveness, and then plugged into the formula along with average PEARL scores. It is important to note that while the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still a method that is largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since respondents ranked each component (size, seriousness and effectiveness of the solution, as well as the PEARL factors) individually using a paper ranking form (blank rating sheet attached), the rankings were not heavily influenced by group dynamics.

After the preliminary priorities were chosen in June of 2016, the halfway point of the assessment process, the results of the health needs ranking session were posted for community input, via press releases, social media, and websites (Public Health, Hospitals, S2AY Rural Health Network, and other partners, Attachment 14 and 15). These posts requested community feedback and input around the ranked priorities. The next three meetings of the OCHC were then focused on finalizing the priorities, choosing disparities based on an additional analysis of the data within each priority area, and choosing the interventions, strategies and activities to address the selected priorities and disparities.

The OCHC meets on a monthly basis and invites participation from county health care organizations, businesses, law enforcement, government agencies, residents and any other individuals or organizations that wish to work on improving the health of Ontario County residents.

4. Community Health Improvement Plan (CHIP):

Lessons Learned/Progress on Current CHIP

Since 2013, Ontario County has focused on Chronic Disease Prevention:

- Priority 1: Reduce Obesity in Children and Adults
- Priority 2: Decrease Hypertension Rates.
- Disparity addressed-low SES

Here are some highlights of our journey.

OCHC invited Food Link to join the collaborative November 2013. Shortly thereafter, UR Thompson Health pursued an MOU and began hosting mobile food pantries in May 2014. Through discussions at OCHC, arrangements were made for SNAP benefit cards to be accepted at weekly Curbside Markets. These began at UR Thompson Health in the fall 2014. The partnership between Food Link and UR Thompson Health has made it possible for thousands of families to receive fresh fruits and vegetables and other healthy foods. Similar markets and pantries are being held in Geneva and Clifton Springs in partnerships developed around the OCHC table.

OCHC began a healthy restaurant dining initiative in 2014. Fifteen restaurants joined, offering healthy substitutions and displaying initiative signage and health messaging. After evaluation and discussion, OCHC re-formatted the initiative for 2017. Members will now collaborate with two food pantries in the Geneva area to provide education re healthy eating. Partners include the Salvation Army, the Center for Concern, Ontario County Public Health, Eat Smart NY, and the Partnership for Ontario County.

Since its inception in 2013, the Breastfeeding Partnership (Ontario County specific) has expanded to include all nine Finger Lakes Counties. In 2014, the Partnership brought Certified Lactation Counselor training to the Canandaigua area. It opened the area's first Baby Café in 2015 and has assisted numerous daycares, businesses and hospitals as they pursue NYSDOH Baby Friendly status. In May 2016, UR Thompson Health reported 74% pf births were exclusively breastfed at discharge.

Since the inception of the Finger Lakes Hypertension Registry in 2013, the Finger Lakes Health Services Agency (FLHSA) has created a database of almost 14,000 BP readings in Ontario County. The average control rate for the nine Finger Lakes Counties is 68%. Ontario County's control rate is 71%. Our target is 85%. The most significant disparity related to BP control was socioeconomic status. This baseline data provides the Public Health and medical communities with valuable information on which to strategize and build programming.

Goals for CHIP 2016-2018

Chronic Disease Prevention

Goal 1.1 Create community environments that promote and support healthy food and beverage choices and physical activity.

Goal 1.3 Expand the role of health care health services providers and insurers in obesity prevention.

Goal 2.1 Prevent initiation of tobacco use by youth and young adults, especially among low socioeconomic status (SES) populations.

Goal 3.2: Promote use of evidence based care to manage chronic diseases (CDSMP)

Goal 3.3 Promote culturally relevant chronic disease self-management education.

Promote Mental Health and Prevent Substance Abuse

Goal 2.1 Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults.

The OCHC spent many meetings developing and refining the attached Community Health Improvement Plan (Attachment 16, CHIP Chart). It was created using the template provided by the NYSDOH and the "Refresh Chart" for the Prevention Agenda (Attachment 16). It sets measurable goals, delineates responsibilities and describes the intended contributions of hospital and Public Health partners (dollar amounts and/or FTEs).

The CHIP chart is, in essence, a work plan to improve the health of the community. It outlines the actions each partner will take to address the priority areas the group chose together. It clearly defines the disparate population and ensures a consolidated effort to improve health outcomes for this group.

5. Maintaining Engagement and Tracking Progress:

The OCHC oversees the implementation, monitoring, and evaluation of the CHIP. Every member is aware of his organization's responsibilities pertaining to CHIP activities. When partners complete CHIP activities, they notify the OCHC secretary who updates the document and records whether tasks are complete, in process or no longer applicable

OCHC partners review the CHIP chart six times a year during monthly meetings. This creates accountability within the group, prevents redundancy, provides opportunities for collaboration, and ensures the reporting, assessment and modification of CHIP activities, as necessary. Partners share best practices, discuss barriers and celebrate successes. This process sometimes brings to

light the need for additional community partners. Since the 2013 CHIP/CHA, numerous new members have been recruited. OCHC meetings are always an open forum. The Public Health Director reports progress quarterly to the Ontario County Board of Supervisors, Health and Medical Services Committee. Finger Lakes Health, UR Thompson Health, and RRH-CSHC communicate Community Service Plan (CSP) updates to their respective hospital boards annually. Activities are shared quarterly with the S2AY RHN board.

6. Dissemination:

The executive summary of the 2016-2018 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)/Community Service Plan (CSP) created in partnership between the lead entities (Ontario County Public Health, Finger Lakes Health, UR Thompson Health, and Rochester Regional Health-Clifton Springs Hospital and Clinic) will be disseminated to the public, as follows:

- Media release: The PIO for Ontario County Public Health will send a media release the first quarter of 2017, with a summary of the CHA/CHIP/CSP and invitation for public participation/input. Updates, changes, and accomplishments throughout the cycle (2016-2018) will be distributed via media releases, as well.
- The following will post the CHA/CHIP/CSP on their websites,
    - Ontario County Public Health
    - UR Thompson Hospital
    - Finger Lakes Health
    - Rochester Regional Health-Clifton Springs Hospital and Clinic
    - S2AY Rural Health Network
    - Other partnering entities, including but not limited to,
        - Cornell Cooperative Extension
        - Finger Lakes WIC
- OCHC partners will share web links for CHA/CHIP/CSP on social media accounts (Facebook, LinkedIn, Twitter, etc.).
- The Public Health Director will share CHA/CHIP/CSP with the Ontario County Board of Supervisors, Health and Medical Services Committee.
- The QI Director will share CHA/CHIP/CSP with the Ontario County Professional Advisory Council (PAC)

Links to websites where documents are posted:

- *Ontario County Public Health:* http://www.co.ontario.ny.us/publichealth
- *Finger Lakes Health:* https://www.flhealth.org/
- *UR Thompson Health:* http://www.thompsonhealth.com/default.aspx
- *Rochester Regional Health-Clifton Springs Hospital:* https://www.rochesterregional.org/locations/hospitals/clifton-springs-hospital-clinic/
- *S2AY Rural Health Network:* http://www.s2aynetwork.org/community-health-assessments.html

Ontario County Health Collaborative (OCHC)

Membership List 2016

- Ontario County Public Health
- Thompson Health
- Finger Lakes Health
- Clifton Springs Hospital and Clinic
- Ontario County Youth Bureau
- Geneva Community Health (Finger Lakes Community Health)
- Rushville Health Center (Regional Primary Care Network)
- Food Link
- Ontario County Office for the Aging
- Finger Lakes Visitors Connection
- S2AY Rural Health Network
- Finger Lakes Health Systems Agency
- Cornell Cooperative Extension
- Finger Lakes BOCES
- Breast Cancer Coalition of Rochester
- United Way
- Lifespan
- Tobacco Action Coalition of the Finger Lakes
- Catholic Charities
- Zion Church
- Wayne County Action Program
- Finger Lakes Community College
- Geneva Central School District
- SPCC WIC
-

Finger Lakes Health Systems Agency

Regional Leadership Meeting

March 4, 2016

Anne Ruflin, Chief Planning Officer
Albert Blankley, Director of Research and Analytics
Catie Horan, Regional Health Planner and Data Analyst

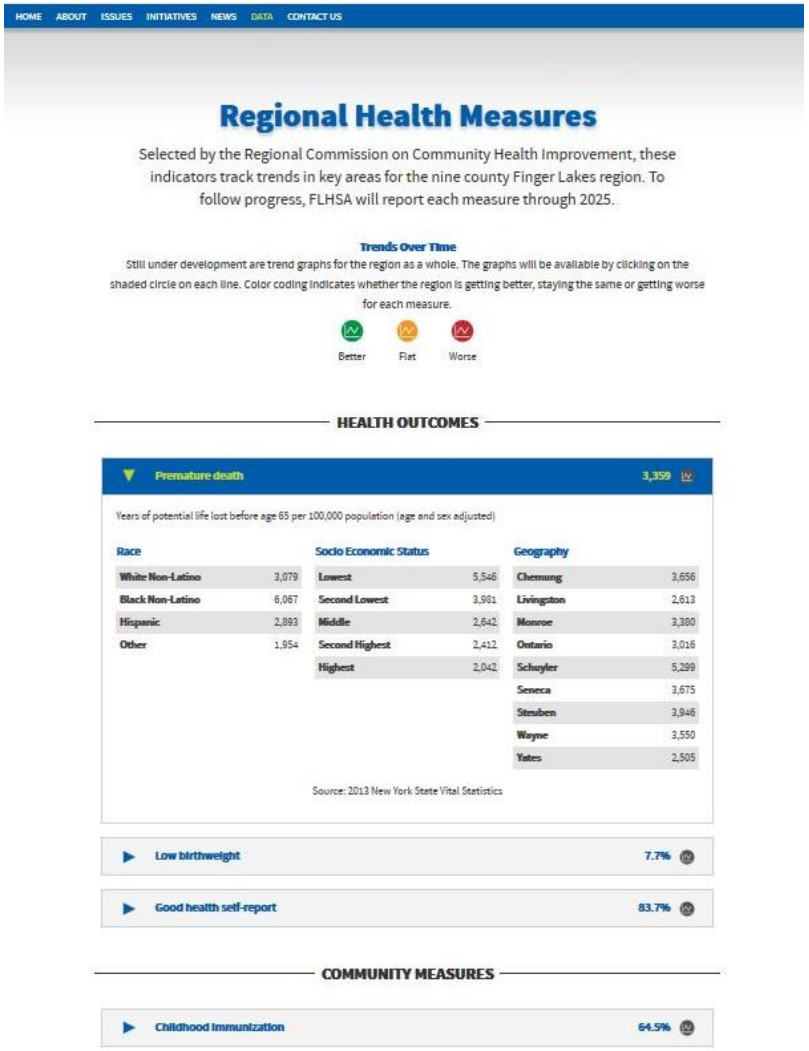
Research & Analysis Updates

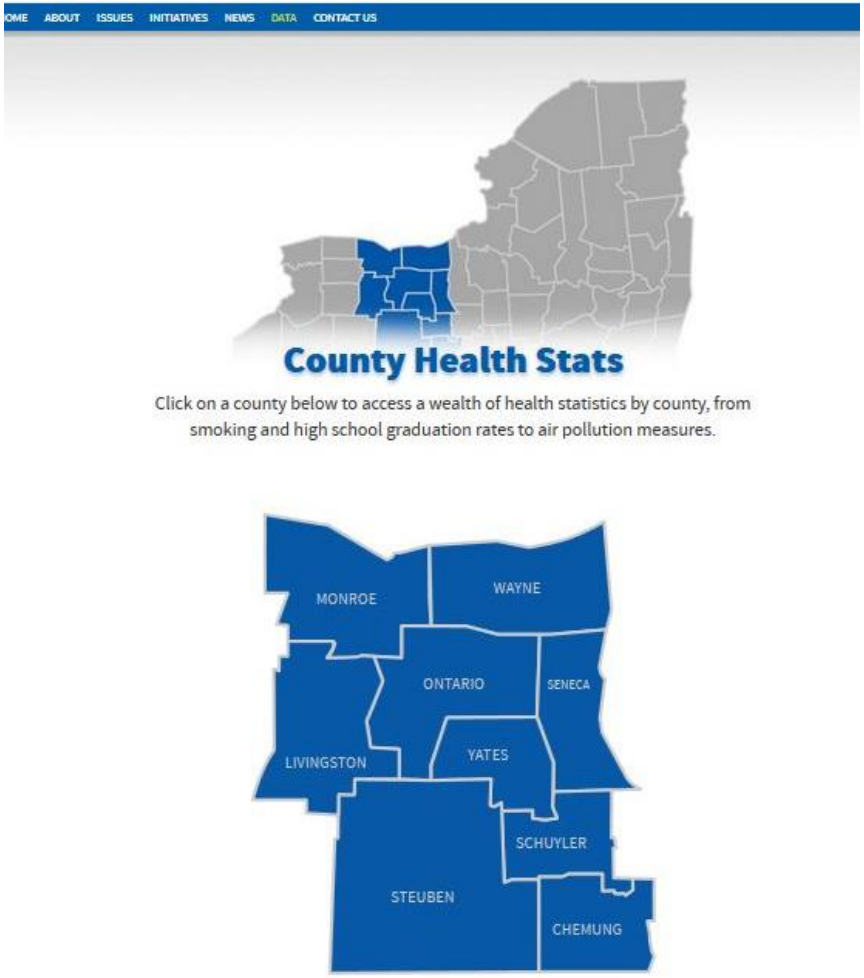
- Continuous Capability Enhancement

- Regional Population Health Measures

- Community Insight & Input

FLHSA Website Enhancements



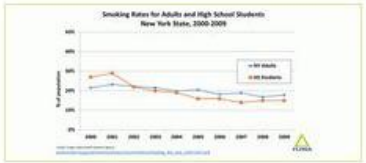


FLHSA Website Enhancements

HOME ABOUT ISSUES INITIATIVES NEWS DATA CONTACT US

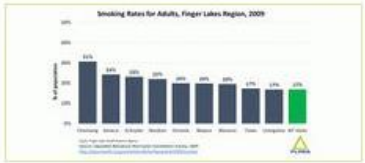
Insights

Browse our gallery of agency slides and charts. Users may download an image or Powerpoint file with the underlying data.



Smoking rates for adults and high school students, New York State, 2000-2009

Smoking tobacco contributes to 25,500 deaths annually in New York State by increasing the risk for cancer, cardiovascular disease and respiratory disease. These figures do not include deaths from cigarette-related burns and second-hand smoke. In New York State, an estimated 389,000 individuals currently between the ages of one and 17 eventually will die from smoking during their lifetime. While adult smoking rates have declined in



Smoking rates for adults, Finger Lakes Region, 2009

Smoking rates within the region tended to be higher in the southern counties of Chemung, Seneca, Schuyler and Steuben. All but two counties, Yates and Livingston, exceeded the New York State rate of 17 percent in 2009.

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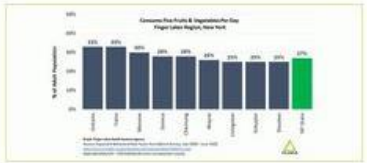


Rate of fruit and vegetable consumption, Finger Lakes Region

The 2005 Dietary Guidelines for Americans indicates that individuals should consume between five and thirteen servings of fruits and vegatables per day. The Harvard School of Public Health says that a diet rich in fruits and vegatables lowers the risk for many serious health issues such as heart disease, high blood pressure and stroke.

Residents of Ontario and Yates counties are most likely to indicate that they consume at least five servings of fruits and

FLHSA

Finger Lakes Health Systems Agency

An Analytic Review of Selected Priority Areas

2016 Community Health Assessments, Community Health improvement Plans, and Community Service Plans

Approach & Methodology

- FLHSA met with community leaders representing the counties in the Finger Lakes Region.
- The 2016 updates to the CHIP/CHAs require counties to select two priority areas and one disparity. They are also encouraged to explore emerging health issues.
  - Community leaders stated interest in looking at data related to 2013 CHA priority areas
  - Community leaders also stated interest in looking at three emerging health issues

2013 Community Health Assessment Priority Areas

County	Issue #1	Issue #2	Disparity
Chemung	Reduce Obesity in Children and Adults	Reduce Tobacco Use	Reduce tobacco use of low income populations including those with mental health and substance abuse issues.
Livingston	Prevent Chronic Disease: Obesity/Diabetes	Promote Mental Health/Prevent Substance Abuse	Decrease Obesity in Low-Income Populations
Monroe	Reduce Obesity	Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure	Increase access to high-quality chronic disease preventive care and management in clinical and community setting.
Ontario	Reduce the Rate of Obesity in Children and Adults	Reducing the Rate of Hypertension	Reducing Obesity Among the Low-Income Population
Schuyler	Reduce Obesity in Children and Adults	Reduce Illness, Disability and Death Related to Diabetes	Screen for Diabetes Risk 10% of the County's 20-49 Year Old Population, as many do not have Primary Care Physician nor Health Insurance Coverage. Once Screened for their Risk of Diabetes, they would be Referred to a Primary Care Physician (PCP) and if Appropriate a Navigator to be Screened for Health Insurance Eligibility.
Seneca	Reduce Obesity in Children and Adults	Prevent Substance Abuse and Other Mental, Emotional, and Behavioral Health Disorders	Tobacco use among those with Poor Mental Health
Steuben	Reduce Obesity in Children and Adults	Reduce Heart Disease and Hypertension	Promote Tobacco Cessation, Especially Among Low SES Population and Those with Mental Health Illness
Wayne	Reduce Obesity	Reduce Heart Disease	Reduce Obesity Among Low-Income Population
Yates	Prevent Obesity	Prevent Hypertension	Access to Specialty Care for the Low-Income Population

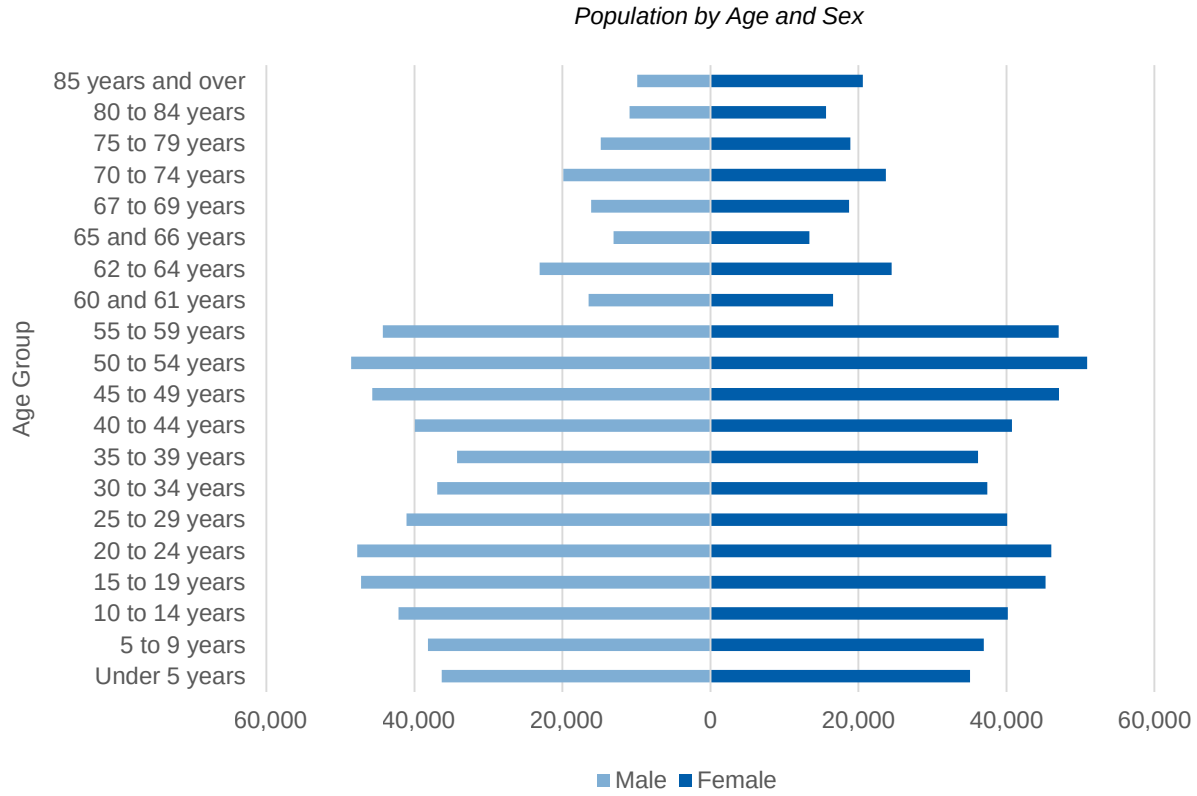
Approach & Methodology, Continued

- The process of data collection began with a review of the New York State Prevention Agenda Dashboard
  - Additional data were collected from:
    - The Expanded Behavioral Risk Factor Surveillance System;
    - The Statewide Planning and Research Cooperative System (SPARCS);
    - NYSDOH VITAL Statistics Mortality file;
    - FLHSA High Blood Pressure Registry; and
    - FLHSA Multi-Payer Claims Database
- Data were compared to either the New York State Prevention Agenda Objective for 2018 or Upstate New York

THE FINGER LAKES REGION: DEMOGRAPHICS

The Finger Lakes Region

- There are approximately 1,281,374 persons living in the Finger Lakes Region. Age/Gender distributions are essentially equivalent, but begin to shift towards the female population starting at age 75.

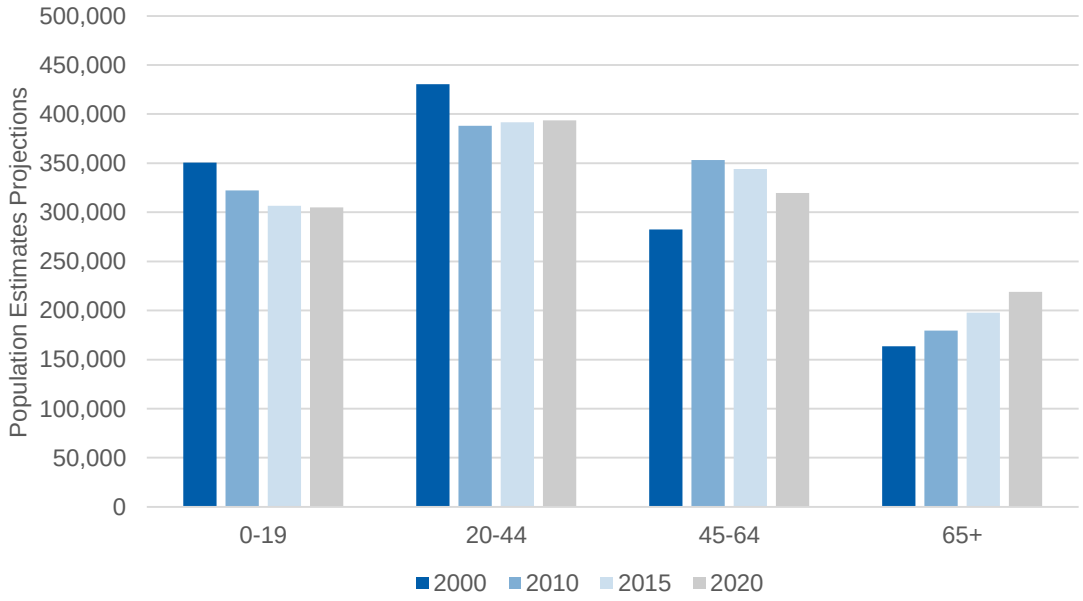


Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2010-2014

The Finger Lakes Region, Continued

- Population projections show little change in the pre-school, school aged and adults of child bearing ages by 2020. The 45-64 population will decrease slightly, while the 65+ age group will grow.

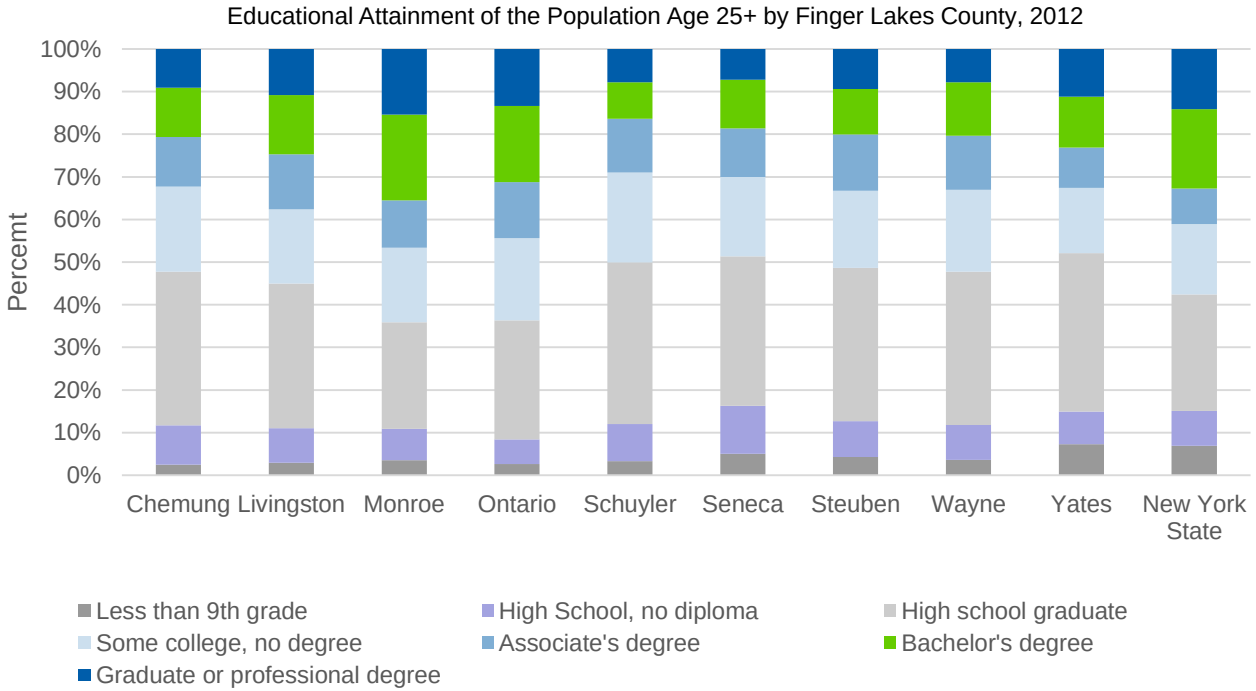
2000 to 2020 Population Trends by Age Group



Data Source: Cornell University, Program on Applied Demographics 2011 Population Projections

The Finger Lakes Region, Continued

- There are higher rates of post-secondary educational attainment in Monroe and Ontario County. Over half of Schuyler, Seneca, and Yates County have only achieved a high school degree or less.

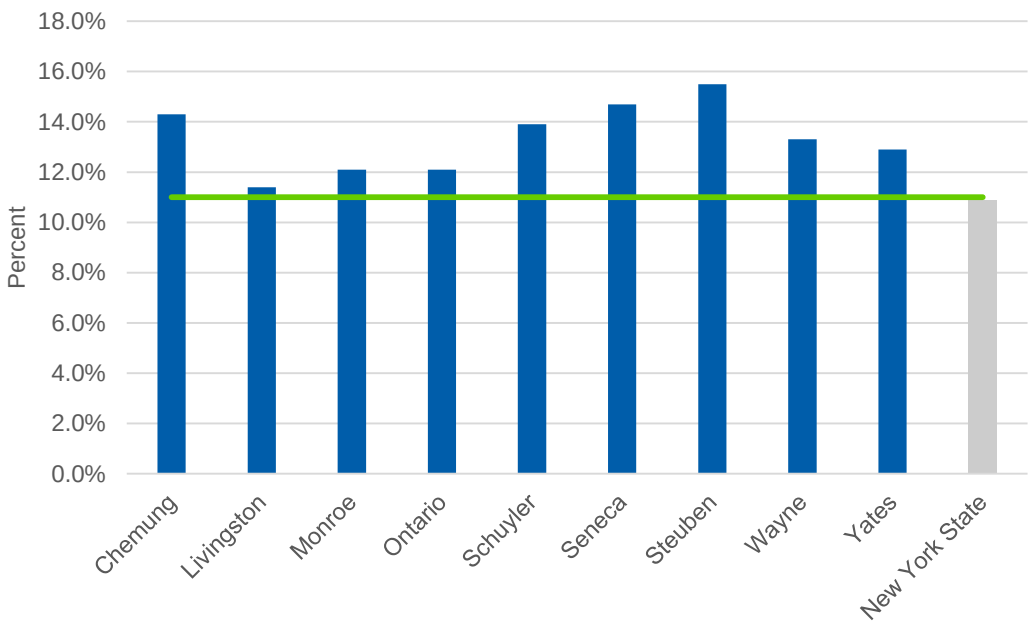


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

The Finger Lakes Region, Continued

- Rates of persons living with a disability the region are higher than the New York State average. Steuben County rates are the highest in the region (15.5%).

Percent of Non-Institutionalized Population with a Disability by County, 2012

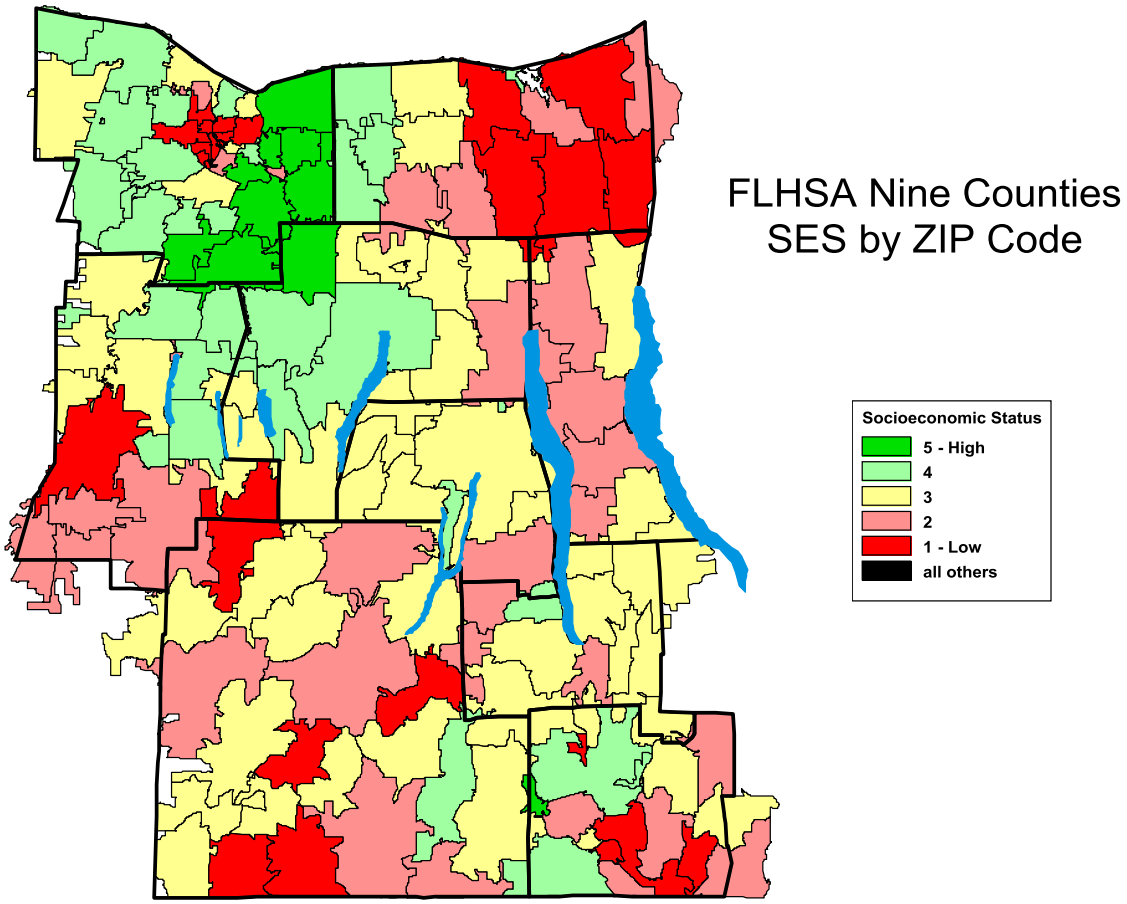


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

The Finger Lakes Region, Continued

- Socioeconomic status affects various aspects of a person's health. A substantial portion of the region is living at a low socioeconomic status.

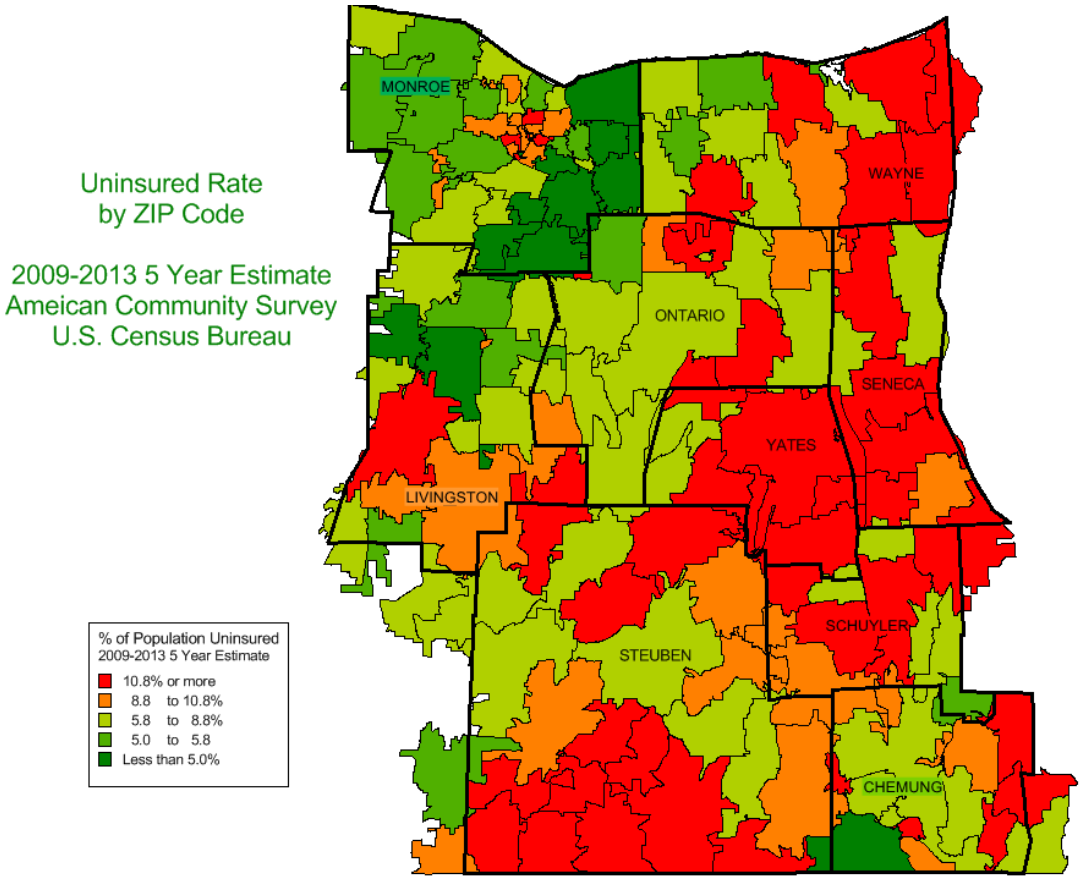
Socioeconomic Status of Finger Lakes Region based on ZIP Code



The Finger Lakes Region, Continued

- There is a high percentage of the eastern and southern portions of the Finger Lakes Region who are uninsured.

Percent of Finger Lakes Region Uninsured by ZIP Code



DATA UPDATES:
THE EIGHT PRIORITY AREAS

The Eight Priority Areas

- 2013 Community Health Assessment Priority Areas
  - Obesity
  - Tobacco Use
  - Chronic Disease
    - Hypertension
    - Diabetes
    - Heart Disease
- Emerging Health Issues
  - Behavioral Health
  - Falls, Slips and Trips in 65+ Population
  - Low Back Pain

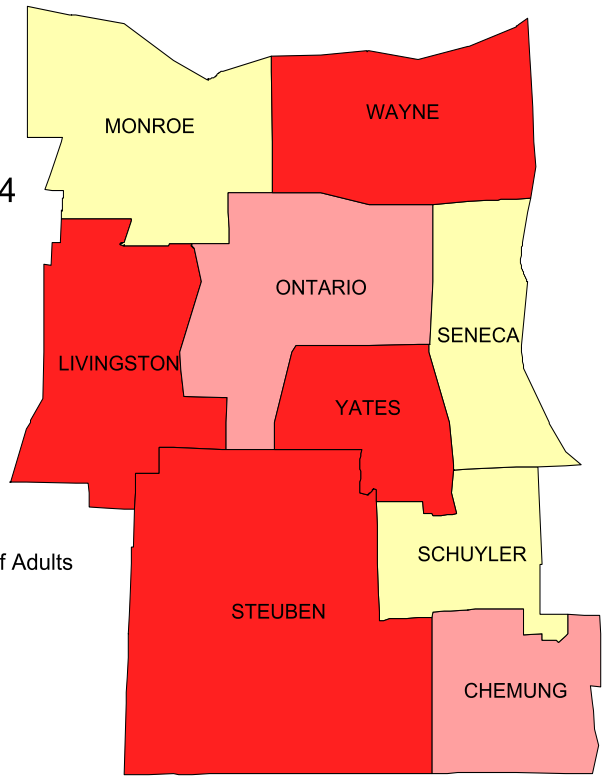
PRIORITY AREA 1: OBESITY

Obesity

- Obesity remains a significant issue in the Finger Lakes Region.

Percent of Adults who are Obese in Finger Lakes Region

Percent of Obese Adults
In Finger Lakes Region, 2013-2014



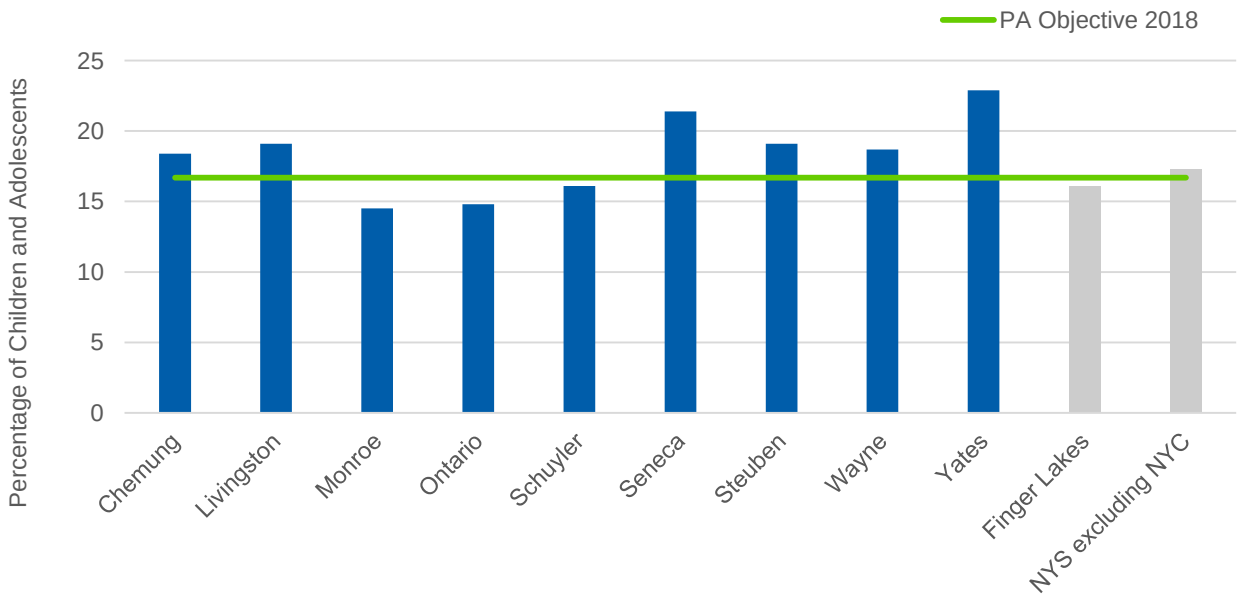
The Prevention Agenda Objective for 2018 is 23.2% of Adults

Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Obesity

- Childhood obesity in the Finger Lakes Region is highest in Yates and Seneca County.

Percentage of Children and Adolescents who are Obese



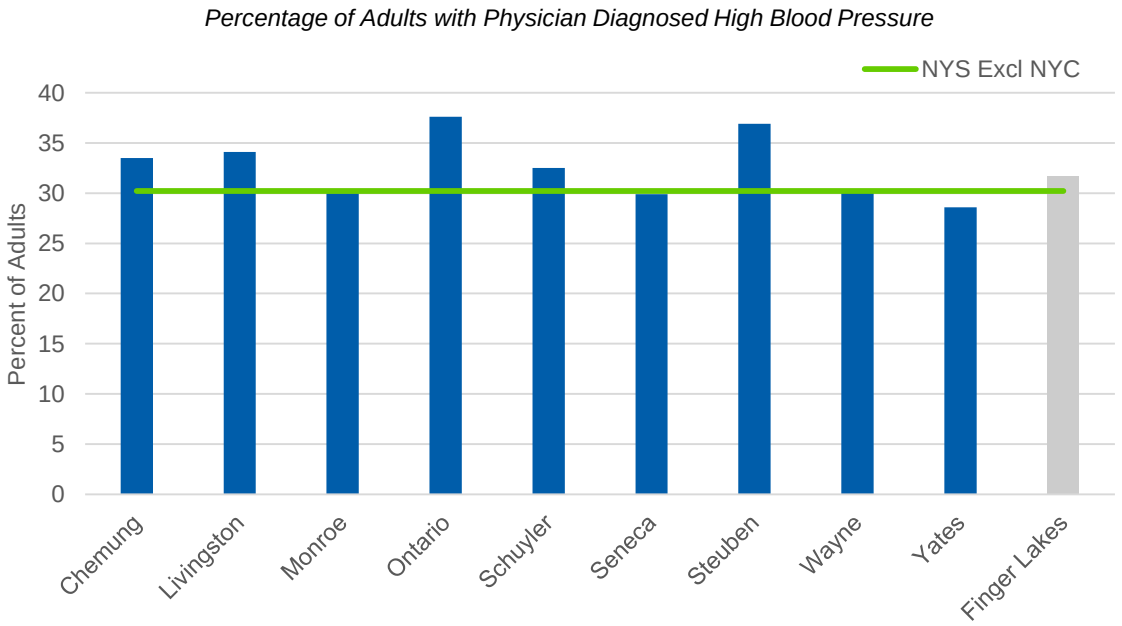
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2012-2014

PRIORITY AREAS 2-4: CHRONIC DISEASE

HYPERTENSION, DIABETES, AND HEART DISEASE

Chronic Disease- Hypertension

- According to the CDC, approximately 30% of adults are diagnosed with hypertension. This rate is slightly elevated in the Finger Lakes Region.

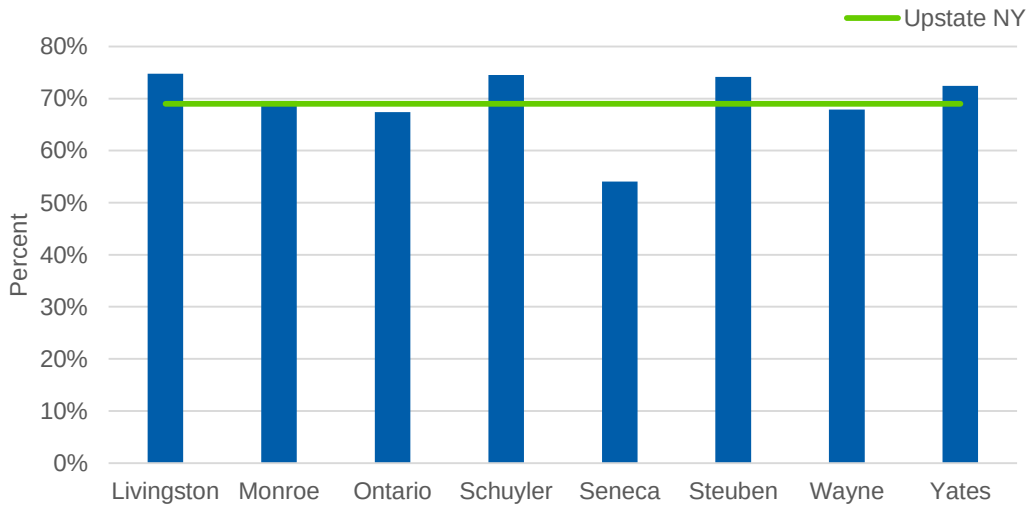


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Chronic Disease- Hypertension

- Hypertension control rates are higher in the Finger Lakes Region than in Upstate New York.

Hypertension Control Rates, June 2015

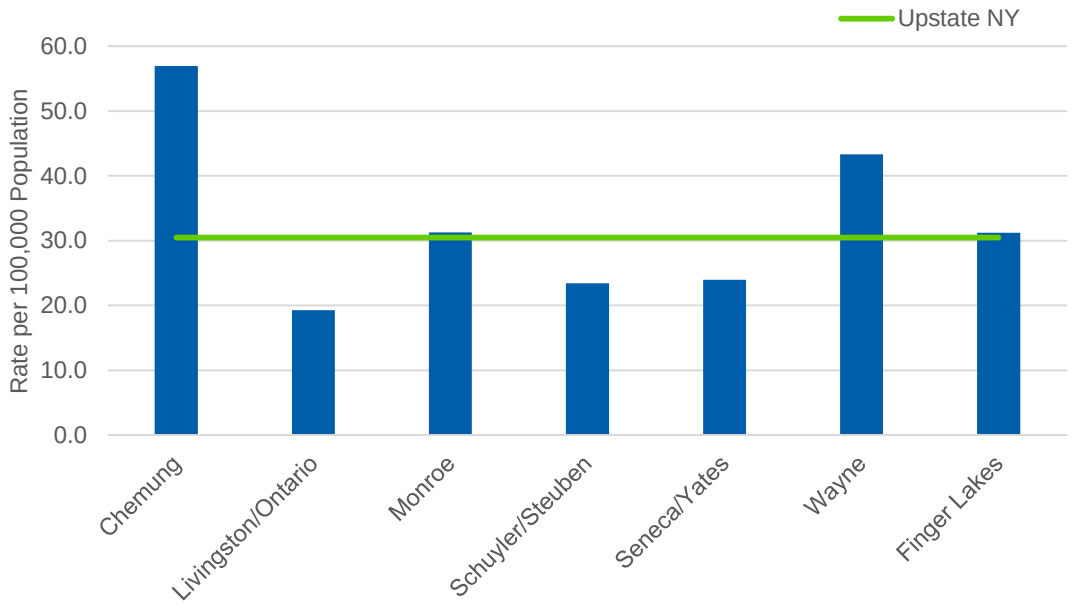


Data Source: FLHSA/RBA High Blood Pressure Registry, June 2015
Note: Chemung has been excluded due to small sample.

Chronic Disease- Hypertension

- Hypertension PQIs are also lower than Upstate New York for several counties.

Rate of Inpatient Prevention Quality Indicators for Hypertension Discharges per 100,000 Population

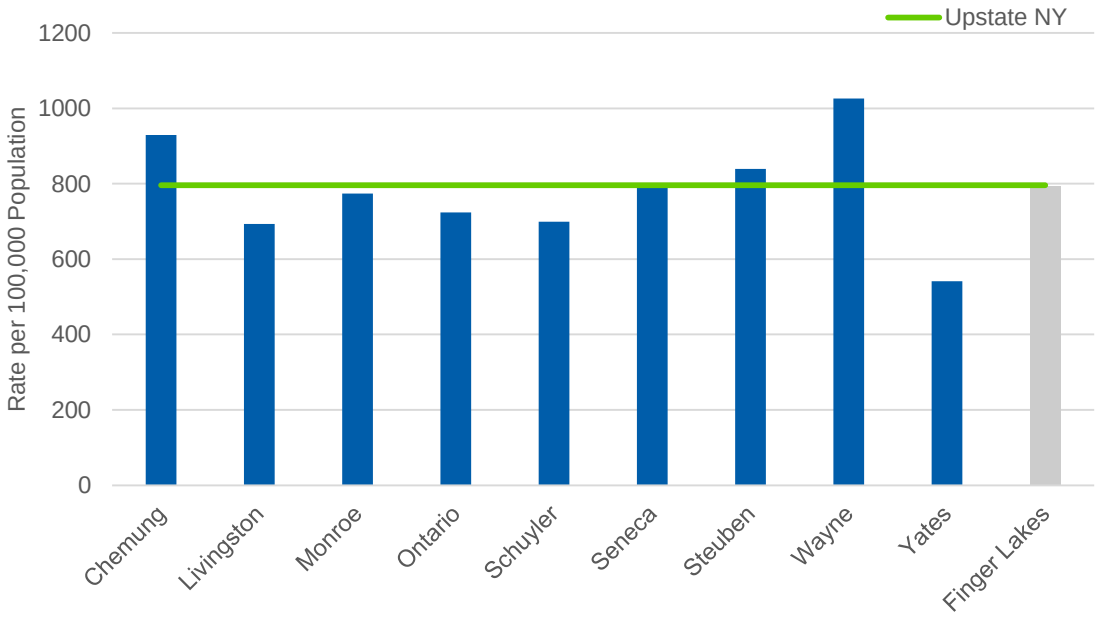


Data Source: SPARCS, 2013
Hypertension as a primary or cormorbidity diagnosis

Chronic Disease- Heart Disease

- Heart Disease admission rates in the Finger Lakes Region are highest in Wayne and Chemung County.

Rate of Inpatient Heart Disease Admissions per 100,000 Population

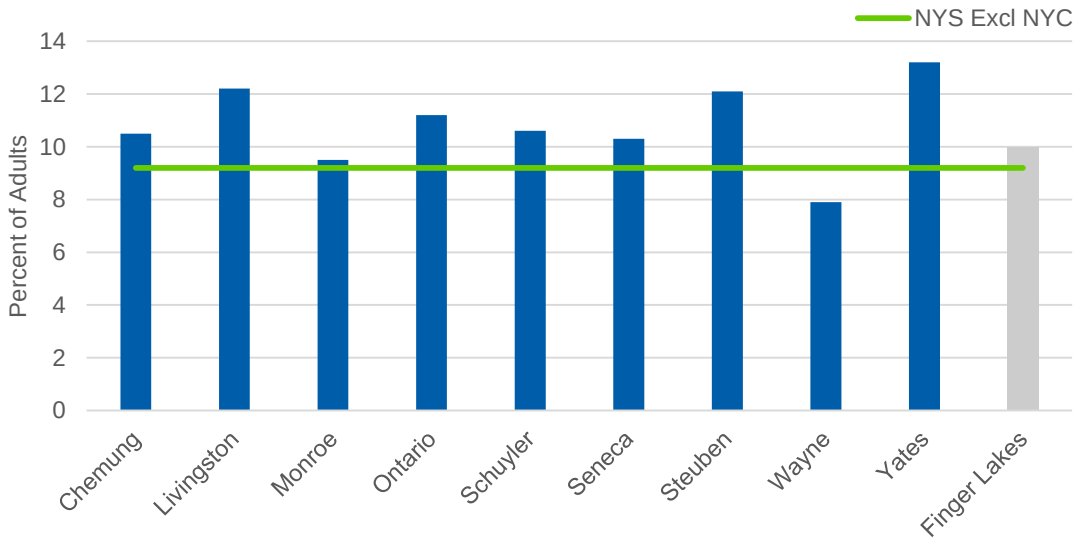


Data Source: SPARCS, 2013

Chronic Disease: Diabetes

- The percentage of adults with physician diagnosed diabetes in the region are higher than the New York State average.

Percentage of Adults with Physician Diagnosed Diabetes

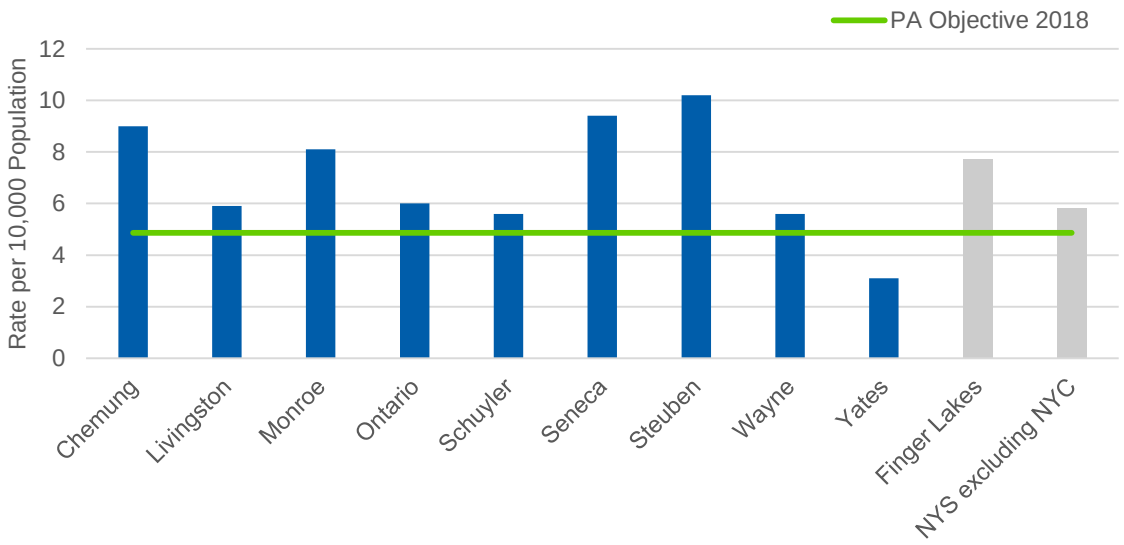


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Chronic Disease: Diabetes

- Rates of diabetes short-term complications in the region are higher than the Prevention Agenda Objective, with the exception of Yates County.

Rate of Hospitalizations for Short-Term Complications of Diabetes per 10,000 Population

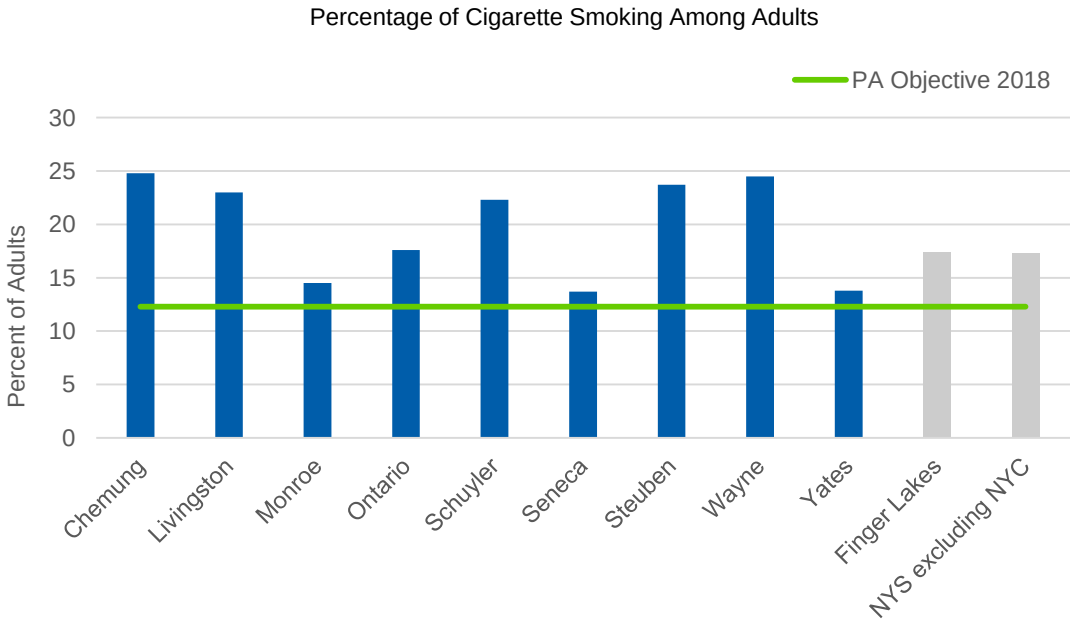


Data Source: New York State Prevention Agenda, 2011-2013

PRIORITY AREA 5: TOBACCO USE

Tobacco Use

- Rates of cigarette smoking adults in each county are significantly higher than the Prevention Agenda Objective for 2018.

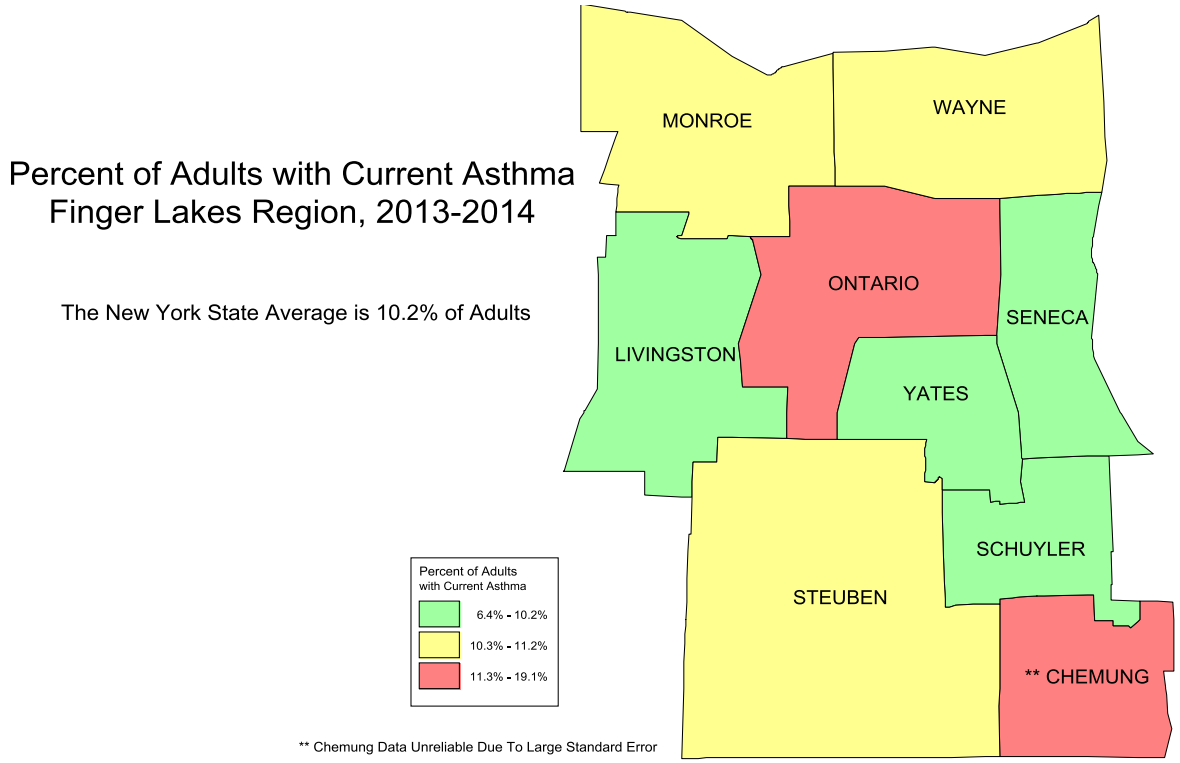


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Tobacco Use

- Rates of adults with current Asthma are highest in Chemung and Ontario County.

Percent of Adults with Current Asthma in the Finger Lakes Region 2013-2014

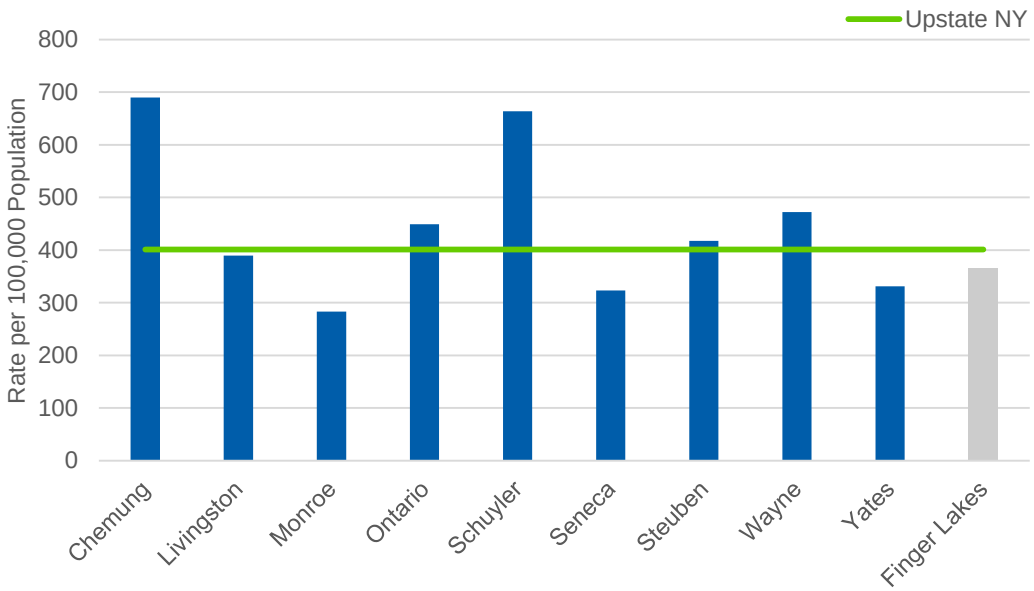


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Tobacco Use

- Rates of respiratory PQIs in the region are highest in Chemung and Schuyler County.

Rate of Respiratory Prevention Quality Indicators

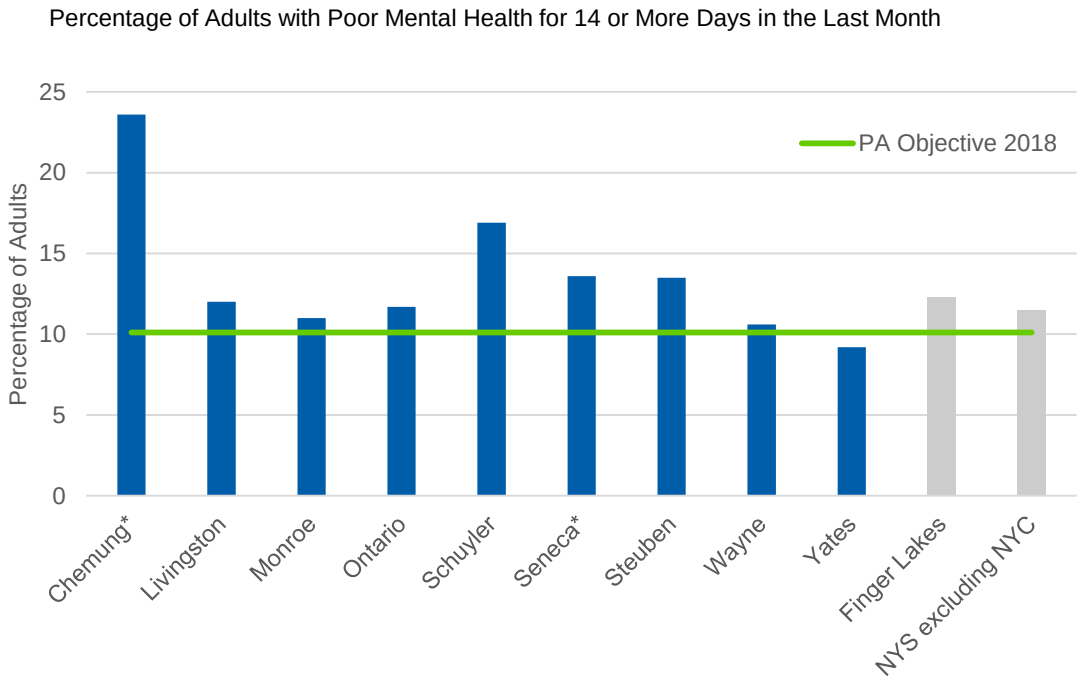


Data Source: SPARCS, 2013

PRIORITY AREA 6: BEHAVIORAL HEALTH

Behavioral Health

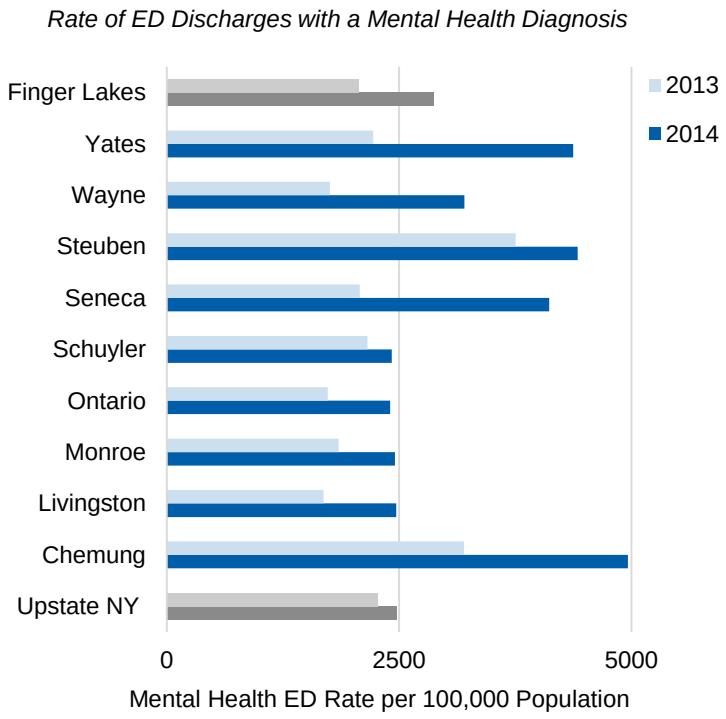
- Rates of poor mental health in the region are highest in Chemung and Schuyler County.

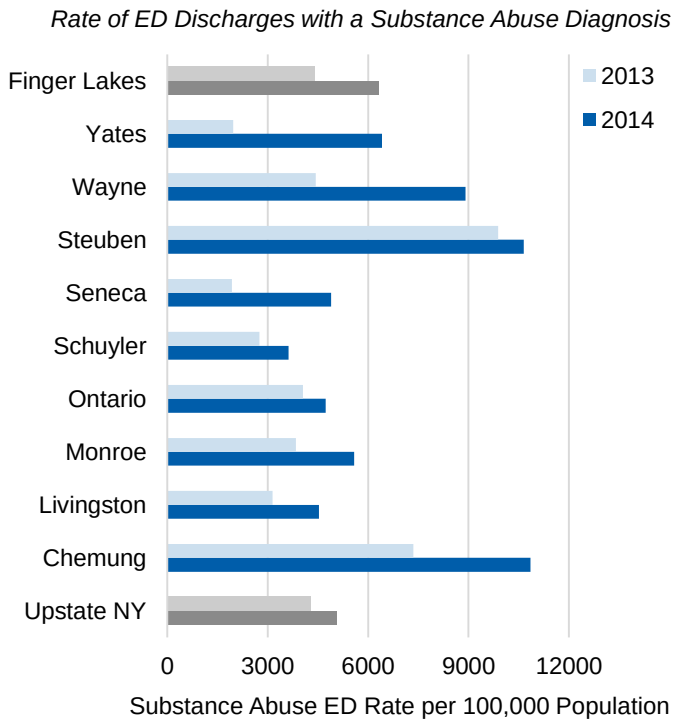


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error.

Behavioral Health

- Rates of ED visits related to Mental Health or Substance Abuse have increased regionally from 2013-2014.



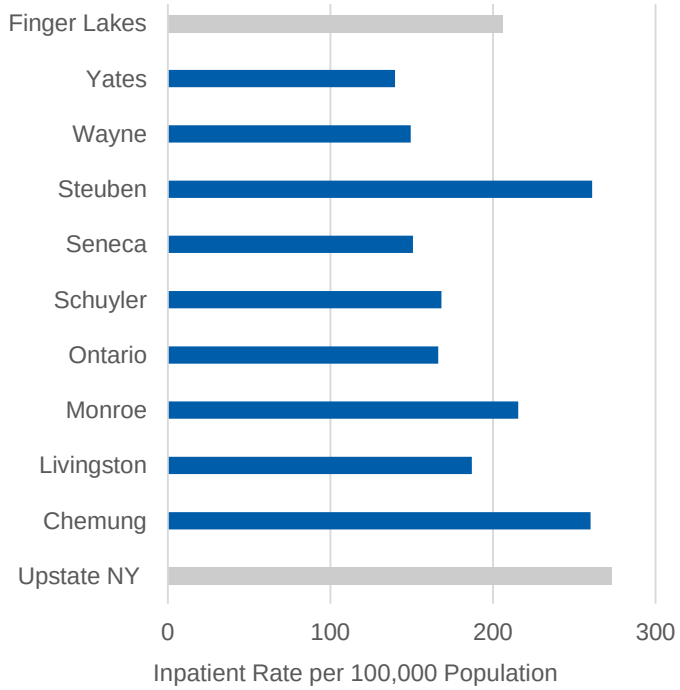


Data Source: SPARCS, 2013-2014. Diagnosis includes primary or comorbidity

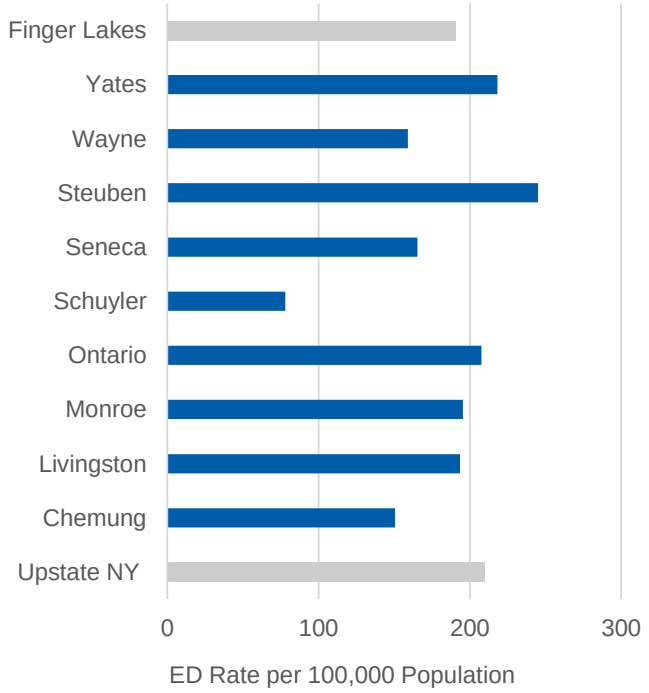
Behavioral Health

- Inpatient admissions related to opiate abuse are lower than Upstate New York rates. However, Steuben and Yates have higher ED rates than Upstate New York.

Rate of Inpatient Admissions with an Opiate Diagnosis



Rate of ED Discharges with an Opiate Diagnosis

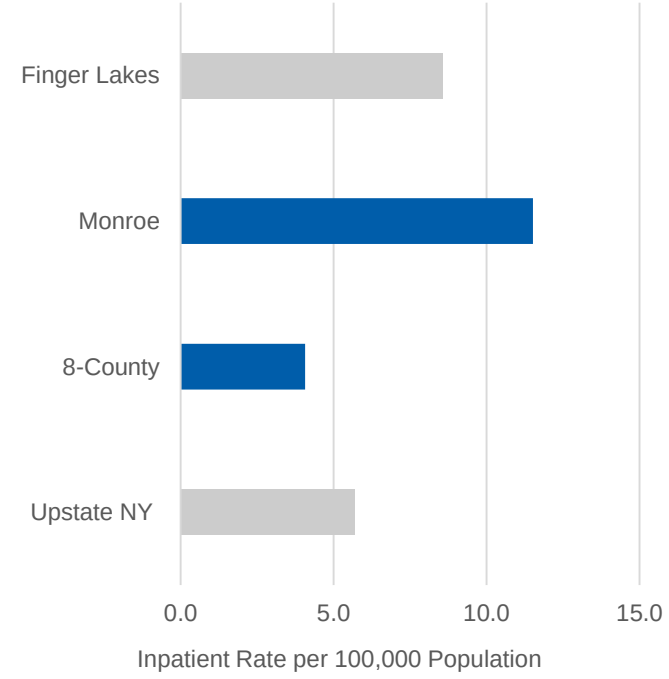


Data Source: SPARCS, 2014

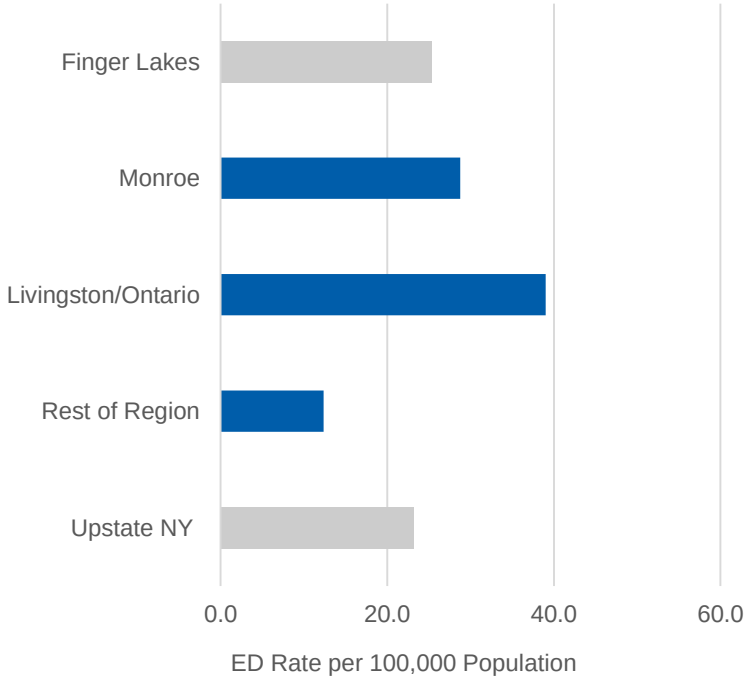
Behavioral Health

- Heroin overdoses in the region are a concern for numerous counties in the Finger Lakes Region.

Rate of Inpatient Admissions with a Heroin Overdose Diagnosis



Rate of ED Discharges with a Heroin Overdose Diagnosis

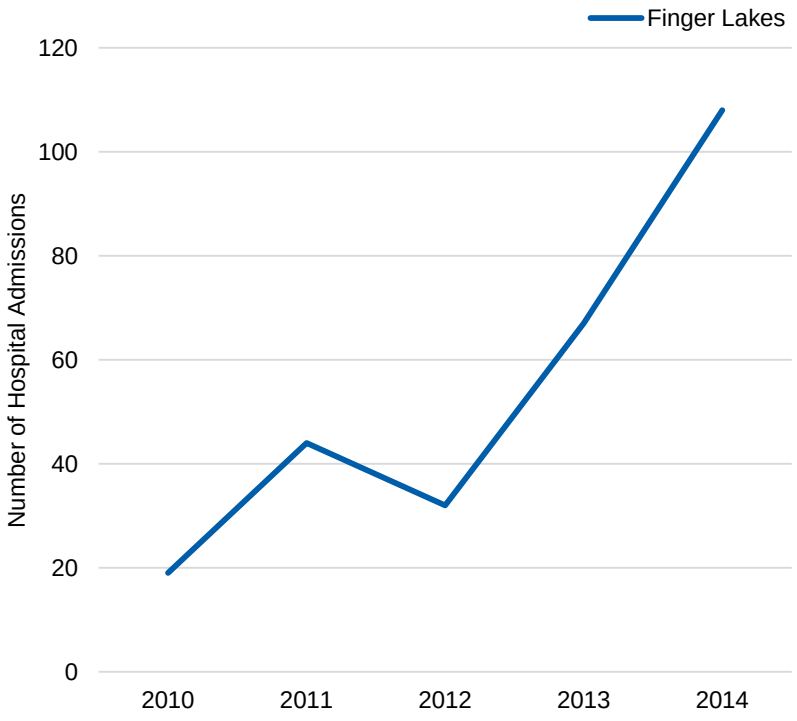


Data Source: SPARCS, 2014

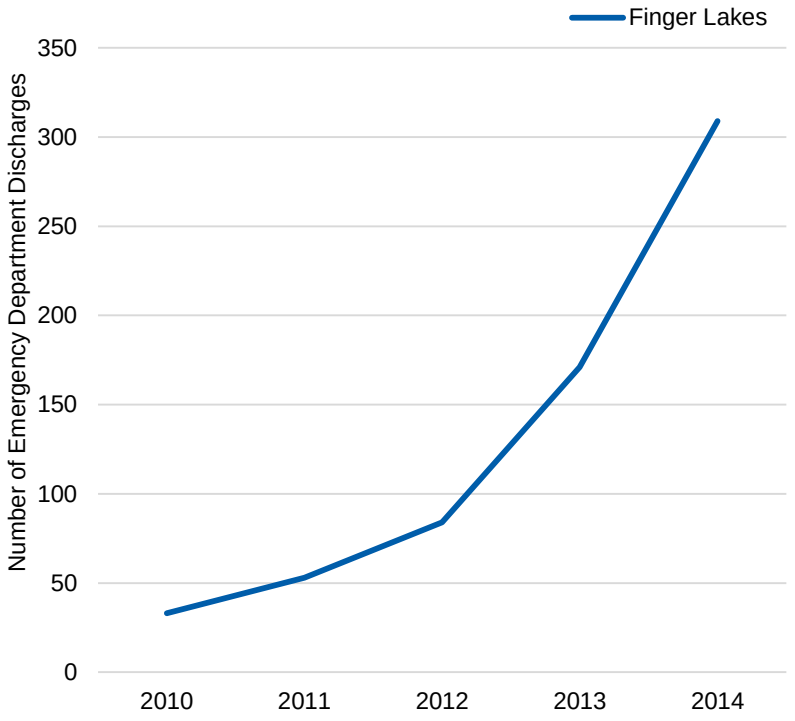
Behavioral Health

- 5-Year trends show a dramatic increase in the number of heroin overdoses in the Finger Lakes Region.

Number of Heroin Overdose Hospital Admissions for Finger Lakes Region, 2010-2014



Number of Heroin Related Emergency Department Overdoses for Finger Lakes Region, 2010-2014

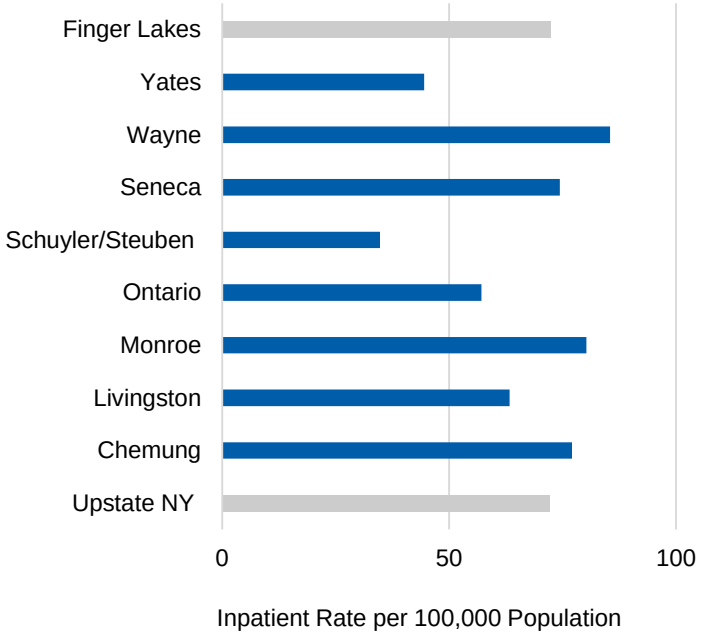


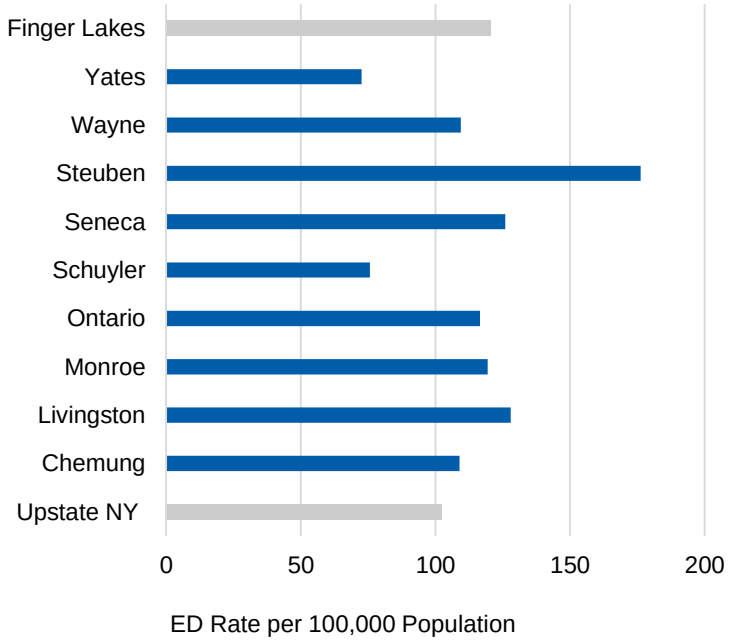
Data Source: SPARCS, 2010-2014

Behavioral Health

- Self-inflicted injury rates are higher than the Upstate New York average for many counties in the Finger Lakes Region.

Rate of Inpatient and ED Discharges with a Self-Inflicted Injury Diagnosis



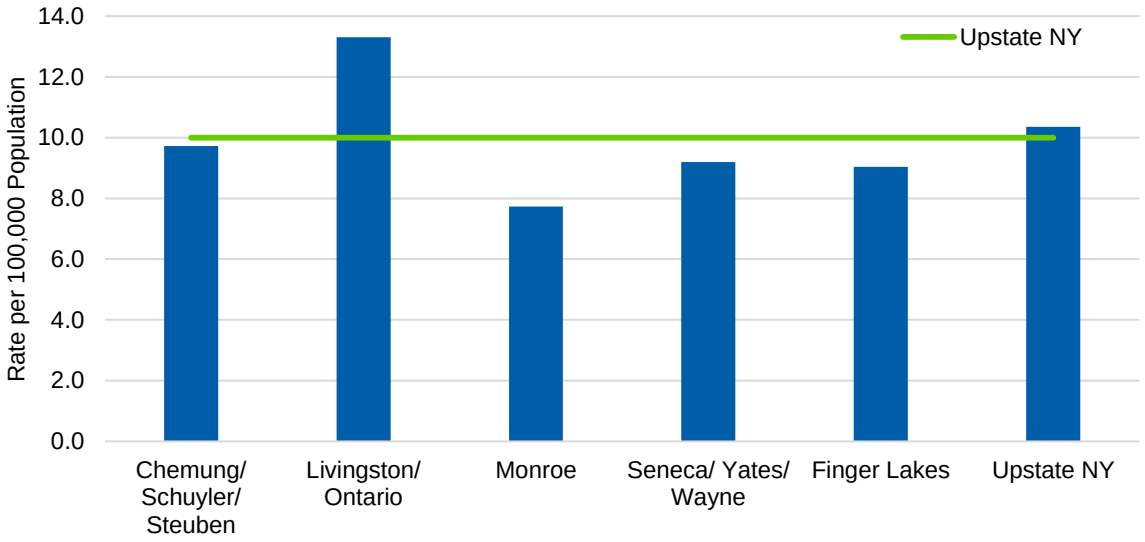


Data Source: SPARCS, 2014

Behavioral Health

- Suicide rates are also higher than the Upstate New York average for some counties in the Finger Lakes Region.

Suicide Mortality Rate per County



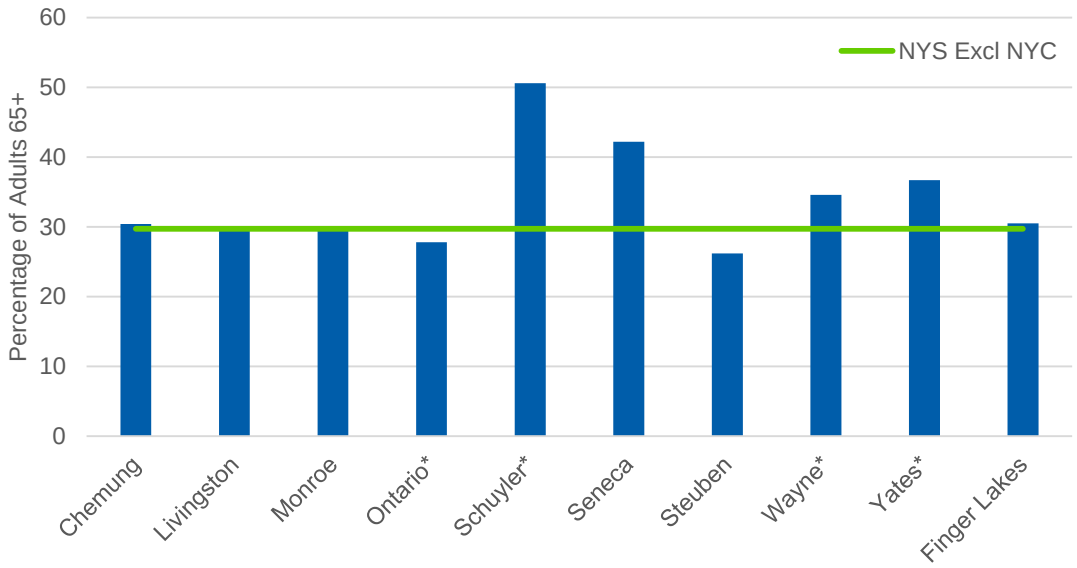
Data Source: New York State Department of Health Vital Statistics, 2013

PRIORITY AREA 7: FALLS, SLIPS AND TRIPS IN THE 65+ POPULATION

Falls, Slips and Trips

- Schuyler County has the highest rates of falls, slips and trips in the 65+ population in the region.

Percent of Adults Aged 65+ with at Least One Reported Fall in Past 12 Months

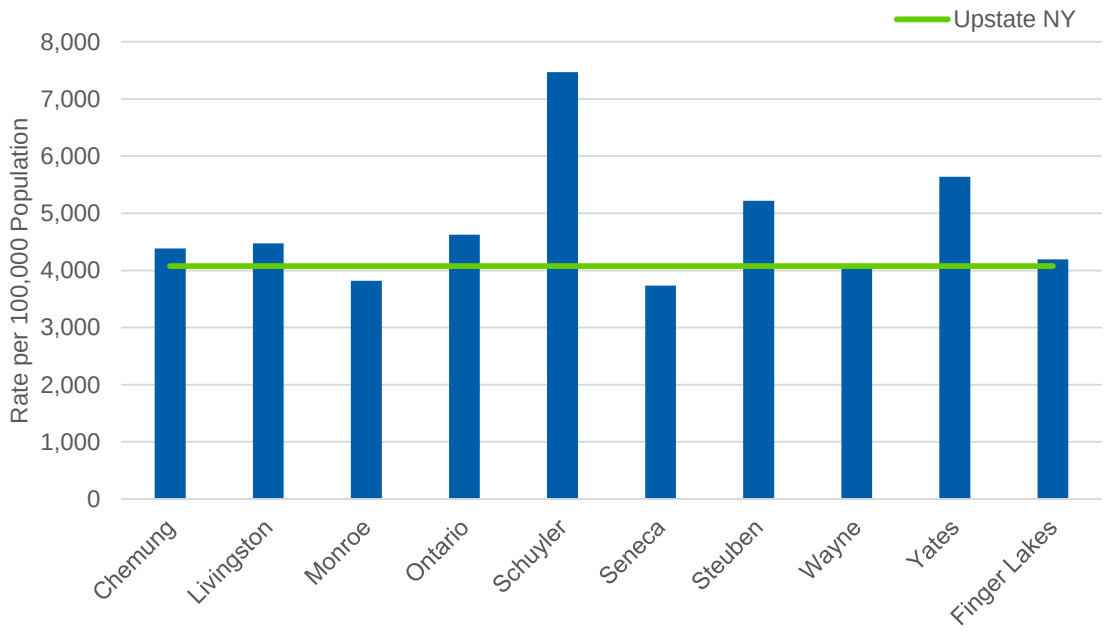


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error

Falls, Slips and Trips

- Schuyler County also has the highest rate of emergency department visits for the 65+ population related to falls, slips and trips

Rate of ED Fall Visits per 100,000 for Population Aged 65+



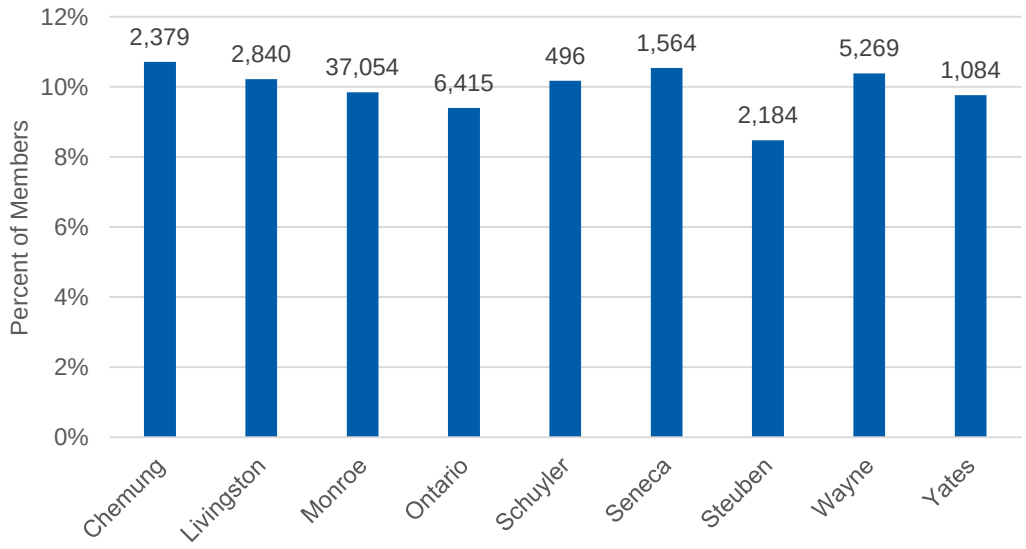
Data Source: SPARCS, 2013

PRIORITY AREA 8: LOW BACK PAIN

Low Back Pain

- The percent of the members in the FLHSA claims database with a diagnosis for low back pain (i.e. sciatica, unspecified low back pain, etc.).

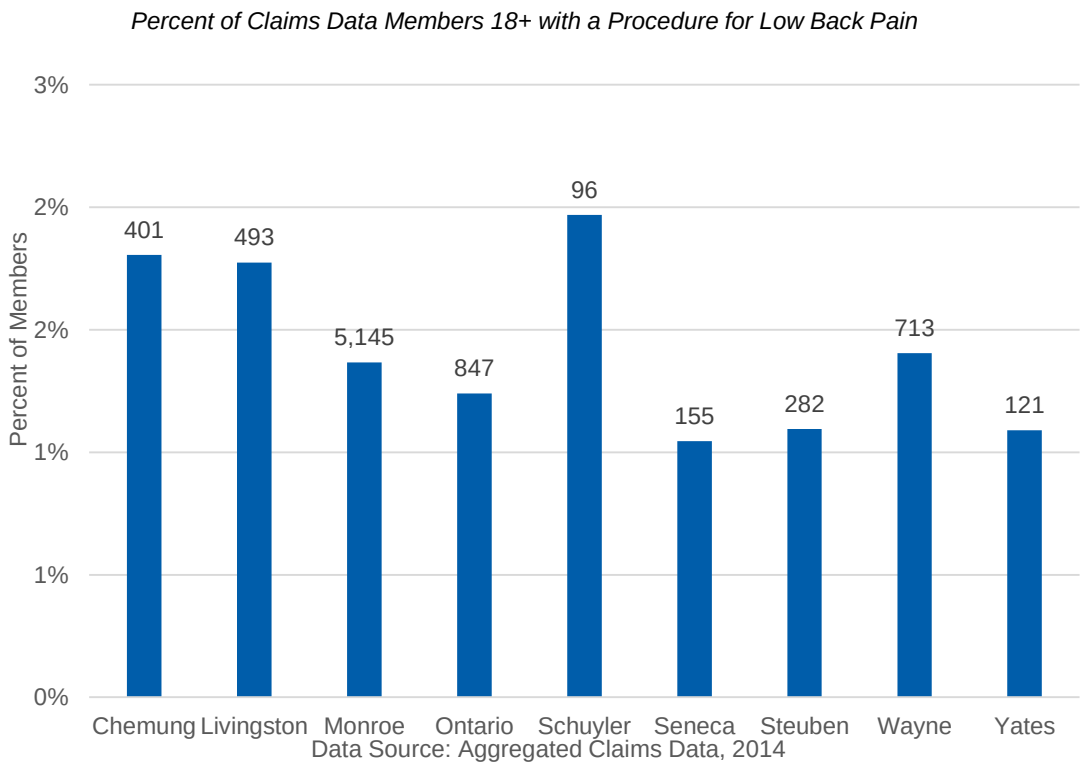
Percent of Claims Data Members 18+ with a Diagnosis for Low Back Pain



Data Source: Aggregated Claims Data, 2014

Low Back Pain

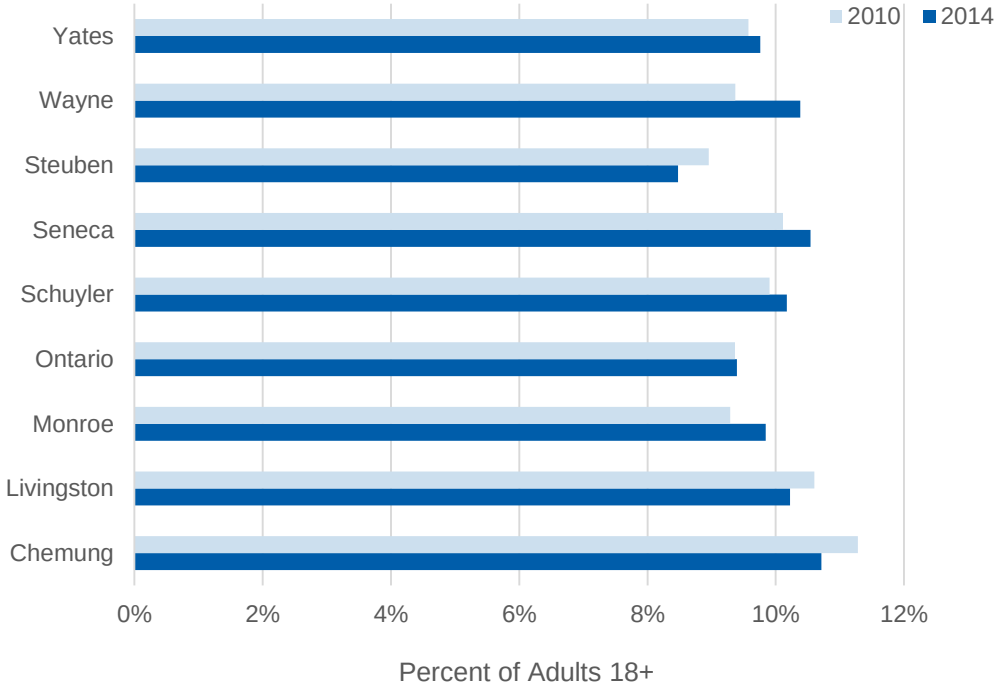
- Percent of the members in the FLHSA claims database with a procedure code for low back pain (i.e. spinal/nerve injections).



Low Back Pain

- Data from 2010-2014 for low back pain diagnoses in the region have not changed much.

Percent of Claims Data Members 18+ with a Diagnosis for Low Back Pain, 2010-2014



Data Source: Aggregated Claims Data, 2010-2014

KEY FINDINGS

Key Findings

- The 2013 CHA priorities remain areas for concern in the Finger Lakes Region.
- Behavioral Health issues, and specifically substance use disorders, are a significant emerging health issue across the Finger Lakes Region.
- SES was the most commonly reported disparity in the 2013 CHAs.

- Specific disparity data for some of the measures provided may be producible. Specific data requests can be sent to catiehoran@flhsa.org.

A copy of the report and PowerPoint slides are available on the Finger Lakes Health Systems Agency website.

www.flhsa.org

QUESTIONS?

FLHSA

Finger Lakes Health Systems Agency

Finger Lakes Health Systems Agency is the region's health planning center. Through extensive data collection and analysis, the agency identifies community needs, then brings together residents, hospitals, insurers, physicians and other community partners to find solutions. Located in Rochester, FLHSA serves the nine counties of Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates.

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585.224.3101 • www.flhsa.org

Ontario County Health Needs Focus Groups

Agenda

- Welcome & Orientation
- Ontario County Data
- Community Input
- Community Strengths
- Summary/Next Steps

S2AY Rural Health Network

- An affiliation of eight (8) Public Health Departments including Steuben, Chemung, Schuyler, Seneca, Livingston, Ontario, Wayne and Yates Counties
- Staffed by local consulting group Human Service Development/Grants to Go

Community Health Assessment/Community Service Plans

- Every few years, the Public Health Departments and hospitals in each county need to look at local health-related needs (called a Community Health Assessment – or CHA) and develop a plan to address them (called Community Health Improvement Plan – CHIP for Public Health and Community Service Plan – or CSP for the hospitals)

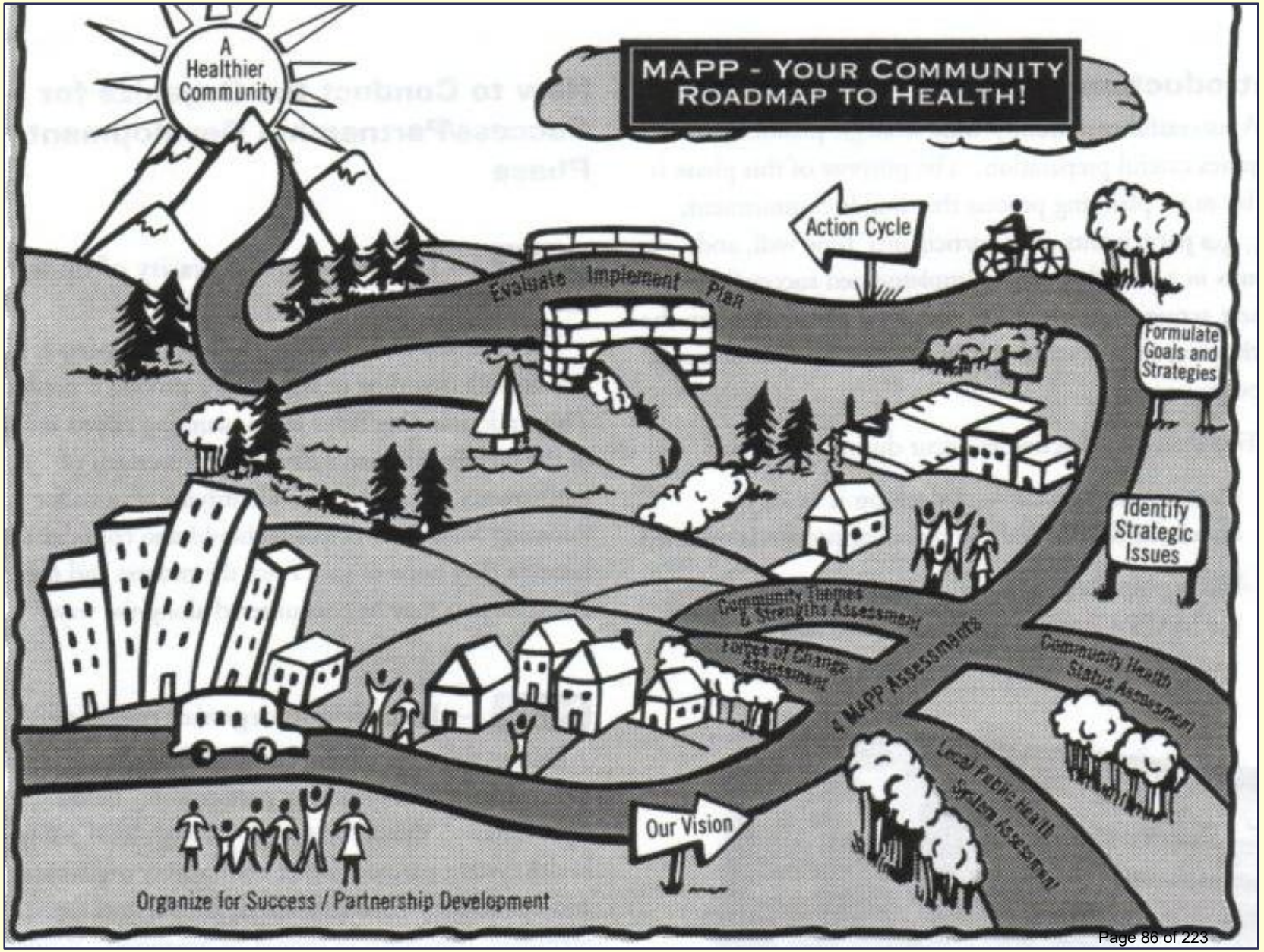
Joint CHA/CHIP/CSP

- This year, Ontario County Public Health, Thompson Health, Finger Lakes Health and Clifton Springs Hospitals are working together to create one document that assesses needs and develops plans to address them over the next three years

Help!!!!

- We have all the data regarding health needs, but what we also need is YOUR input and thoughts about health-related needs and how to address them
- So we are running a series of meetings like this one throughout the county from now through the end of May to get community input regarding needs

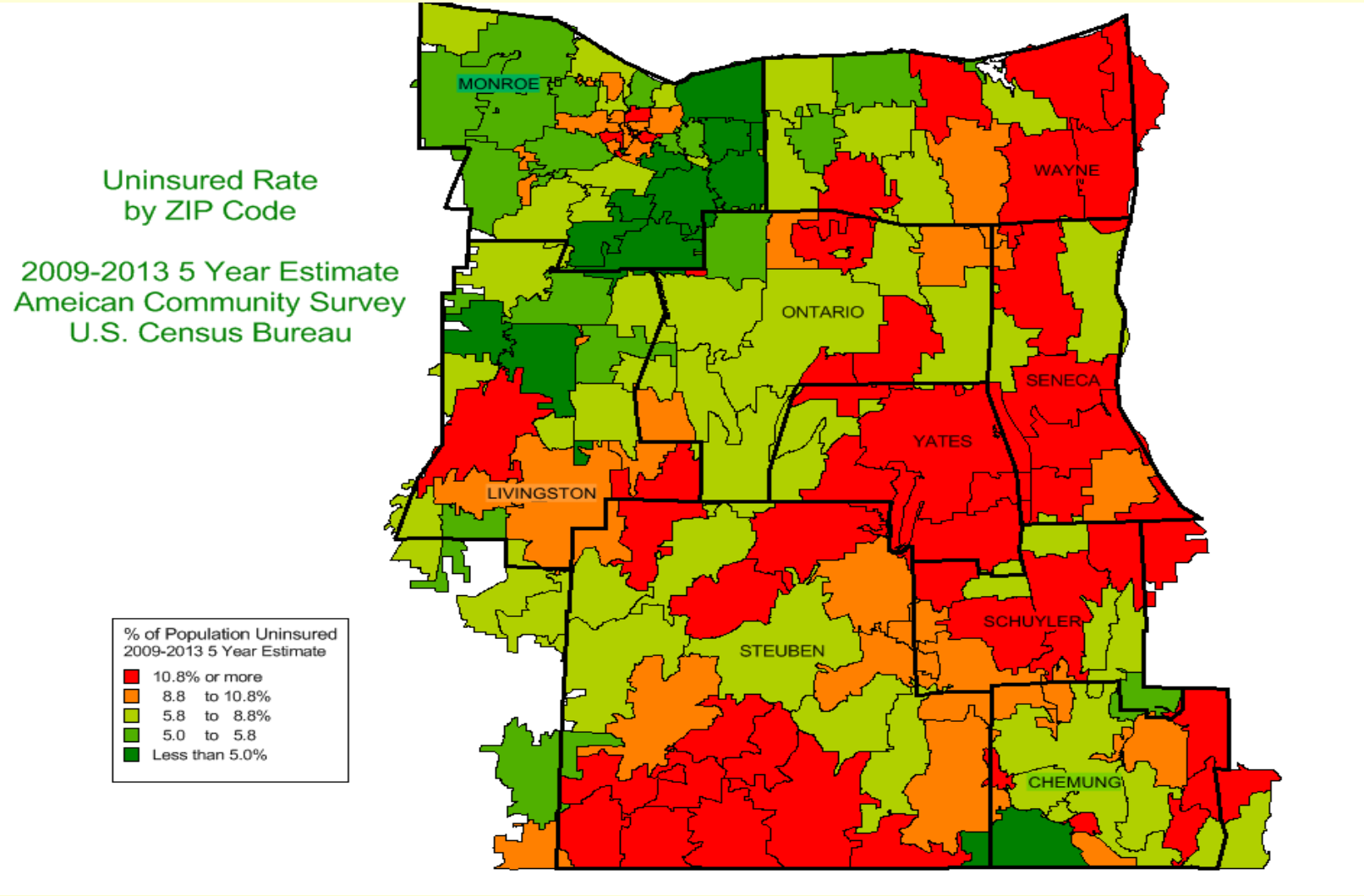
MAPP - Mobilizing for Action through Planning and Partnerships



Data says…

- A data report for the entire region was prepared by a Rochester-based group called the Finger Lakes Health Systems Agency (FLHSA) and is hot off the press
- We will share some of it with you here, along with a few other pieces of information, to get us started

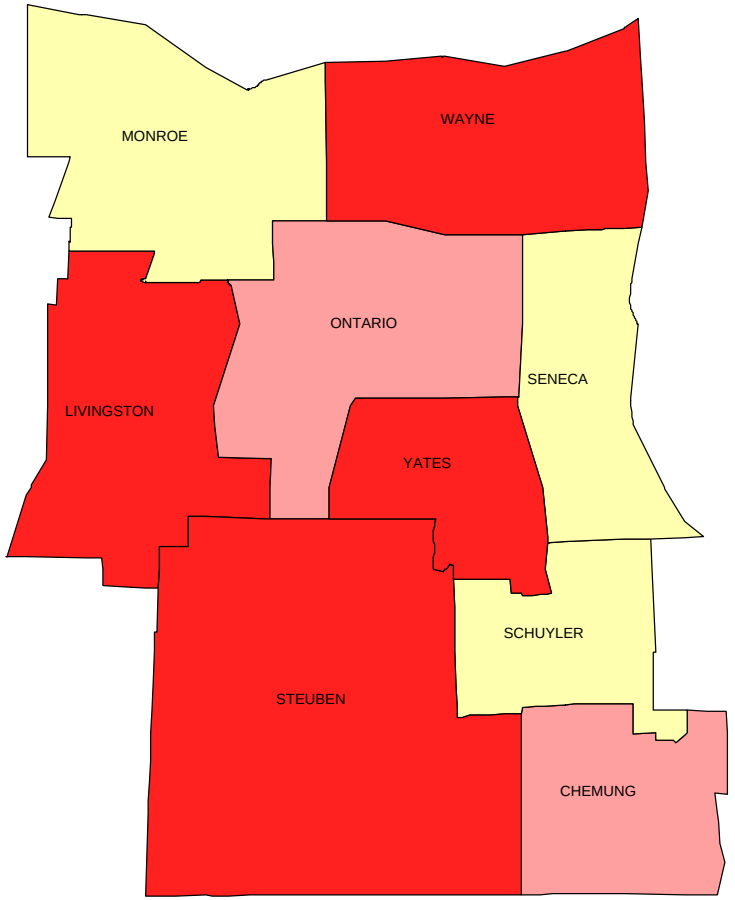
Data says…high rates of uninsured



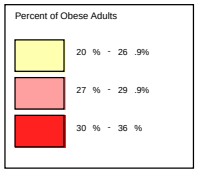
Data says: High rates of Obesity – 28.8% of adults in Ontario County are obese

Percent of Obese Adults

In Finger Lakes Region, 2013-2014



The Prevention Agenda Objective for 2018 is 23.2% of Adults

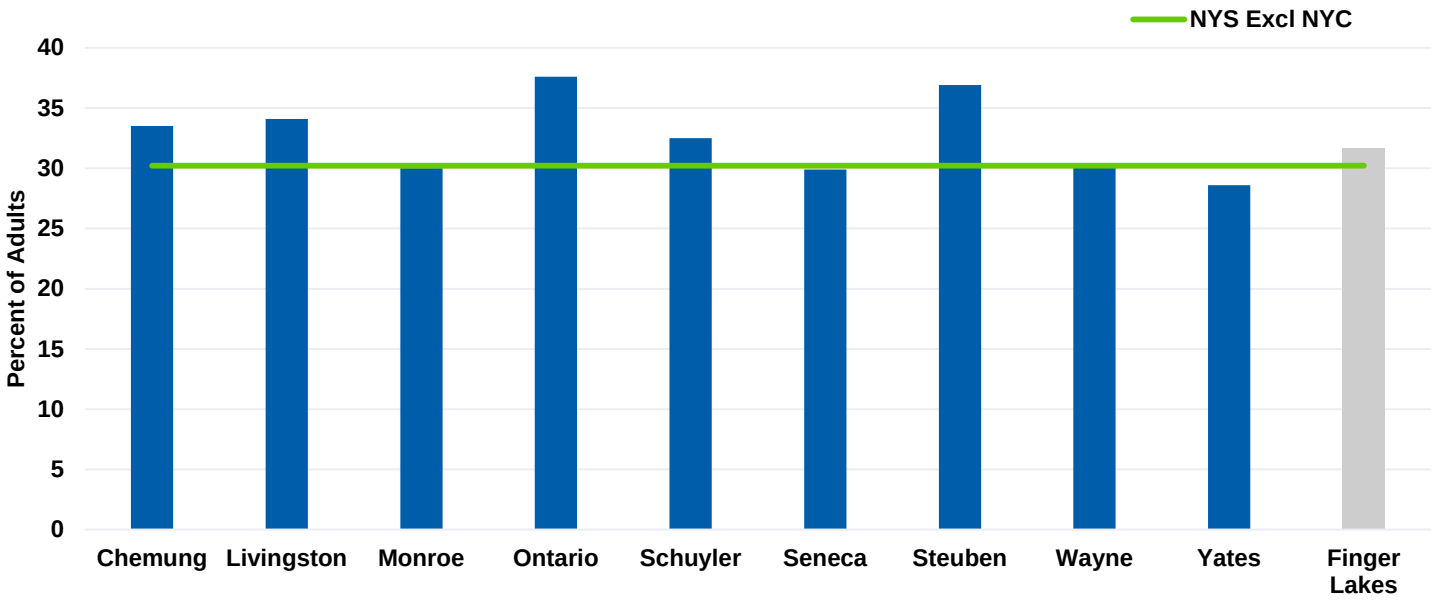


Why is obesity important?

Can lead to many other problems including:

- Heart disease
- Hypertension
- Diabetes
- Lower back pain
- Arthritis
- High cholesterol
- Several forms of cancer
- And in fact, several of these things are also higher than we would like to see them in Ontario County…

Data says…Ontario has a pretty high rate – 38% -of adults with physician-diagnosed high blood pressure



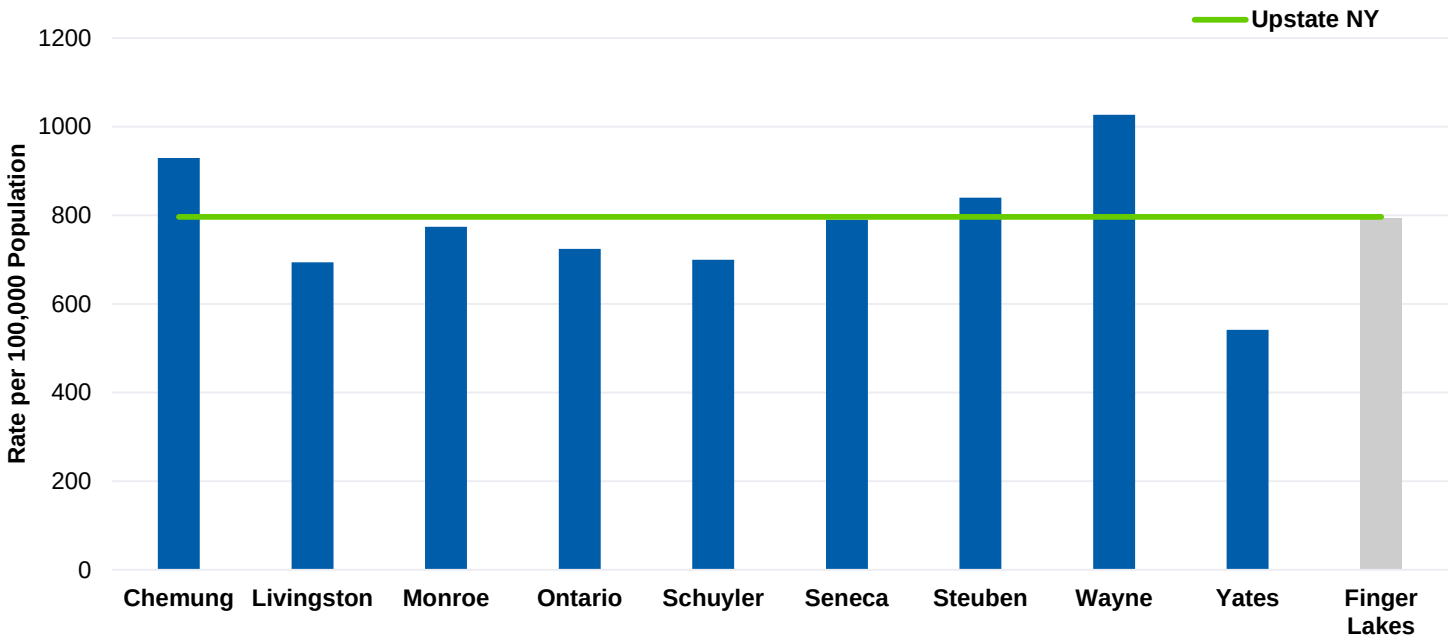
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Percentage of pregnant women in WIC with hypertension during pregnancy

Source:2009-2011 NYS Pregnancy Nutrition Surveillance System - WIC Program Data as of July, 2015

	Women with gestational hypertension				Average WIC births	Crude
Region/County	2009	2010	2011	Total	2009-2011	Rate
Reg- 10 Finger Lakes						
Chemung	57	71	64	192	665	9.6
Livingston	41	40	31	112	272	13.7
Monroe	450	437	438	1,325	3,797	11.6
Ontario	51	57	62	170	469	12.1
Schuyler	s	16	s	16	94	5.7
Seneca	8	10	12	30	138	7.2
Steuben	69	84	59	212	586	12.1
Wayne	43	47	39	129	456	9.4
Yates	17	14	10	41	110	12.4
Region Total	736	776	715	2,227	6,527	11.4
New York State	9,103	9,242	8,850	27,195	127,077	7.1

Data says…. Better for heart disease incidence though



Data Source: SPARCS, 2013

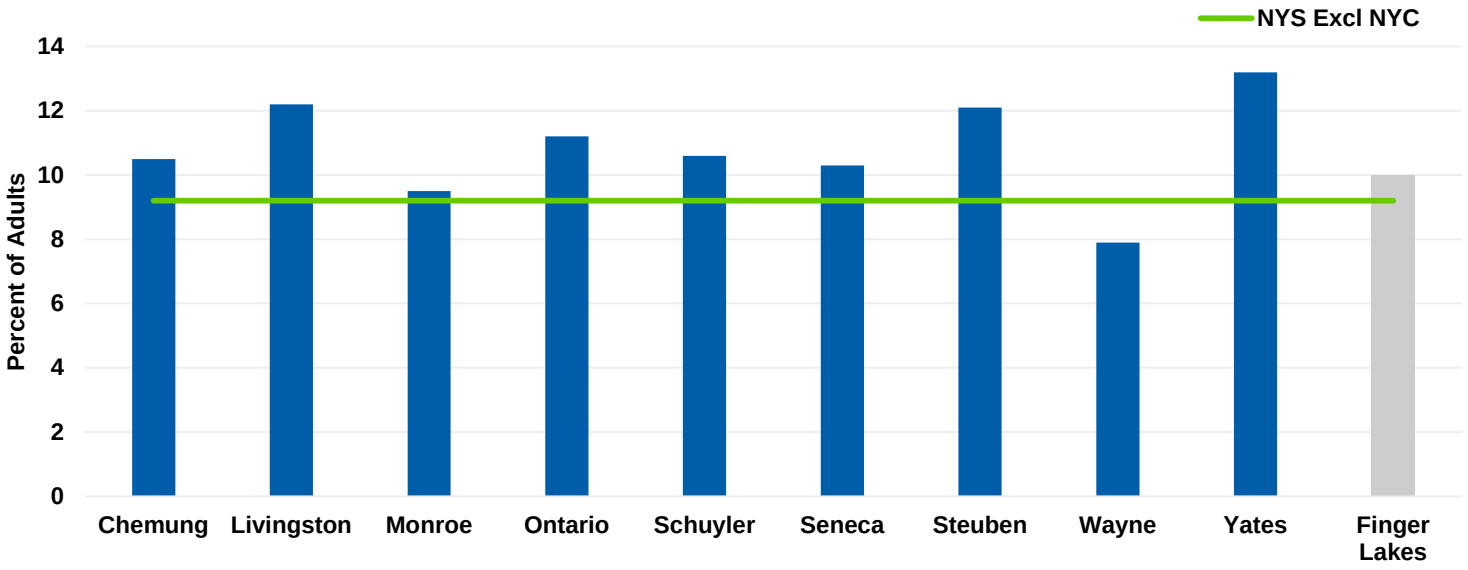
Heart attack mortality rate per 100,000

Source:2011-2013 Vital Statistics Data as of February, 2015

Adjusted Rates Are Age Adjusted to The 2000 United States Population

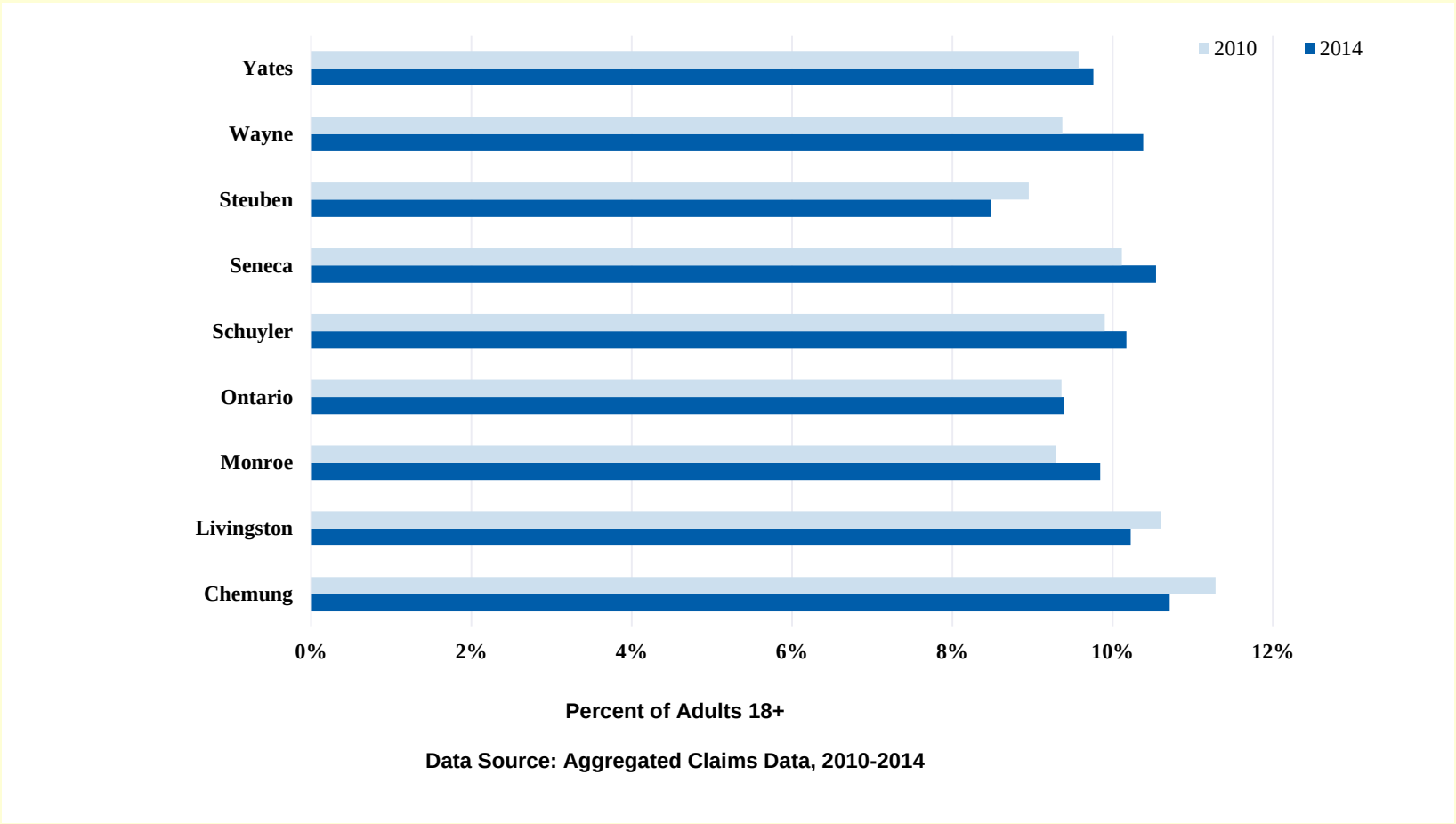
	Deaths				Average population	Crude	Adjusted
Region/County	2011	2012	2013	Total	2011-2013	Rate	Rate
Reg- 10 Finger Lakes							
Chemung	33	42	35	110	88,752	41.3	29.7
Livingston	25	28	19	72	64,862	37.0	30.4
Monroe	382	421	404	1,207	747,681	53.8	42.7
Ontario	69	60	57	186	108,716	57.0	42.0
Schuyler	8	17	17	42	18,445	75.9	55.0
Seneca	17	21	6	44	35,304	41.5	29.9
Steuben	47	52	39	138	98,915	46.5	34.1
Wayne	41	48	52	141	92,957	50.6	40.3
Yates	16	15	19	50	25,318	65.8	46.9
Region Total	638	704	648	1,990	1,280,950	51.8	40.0
New York State	7,489	7,218	7,201	21,908	19,562,195	37.3	31.3

Data says….Percentage of adults with physician diagnosed diabetes – 11.2%



Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

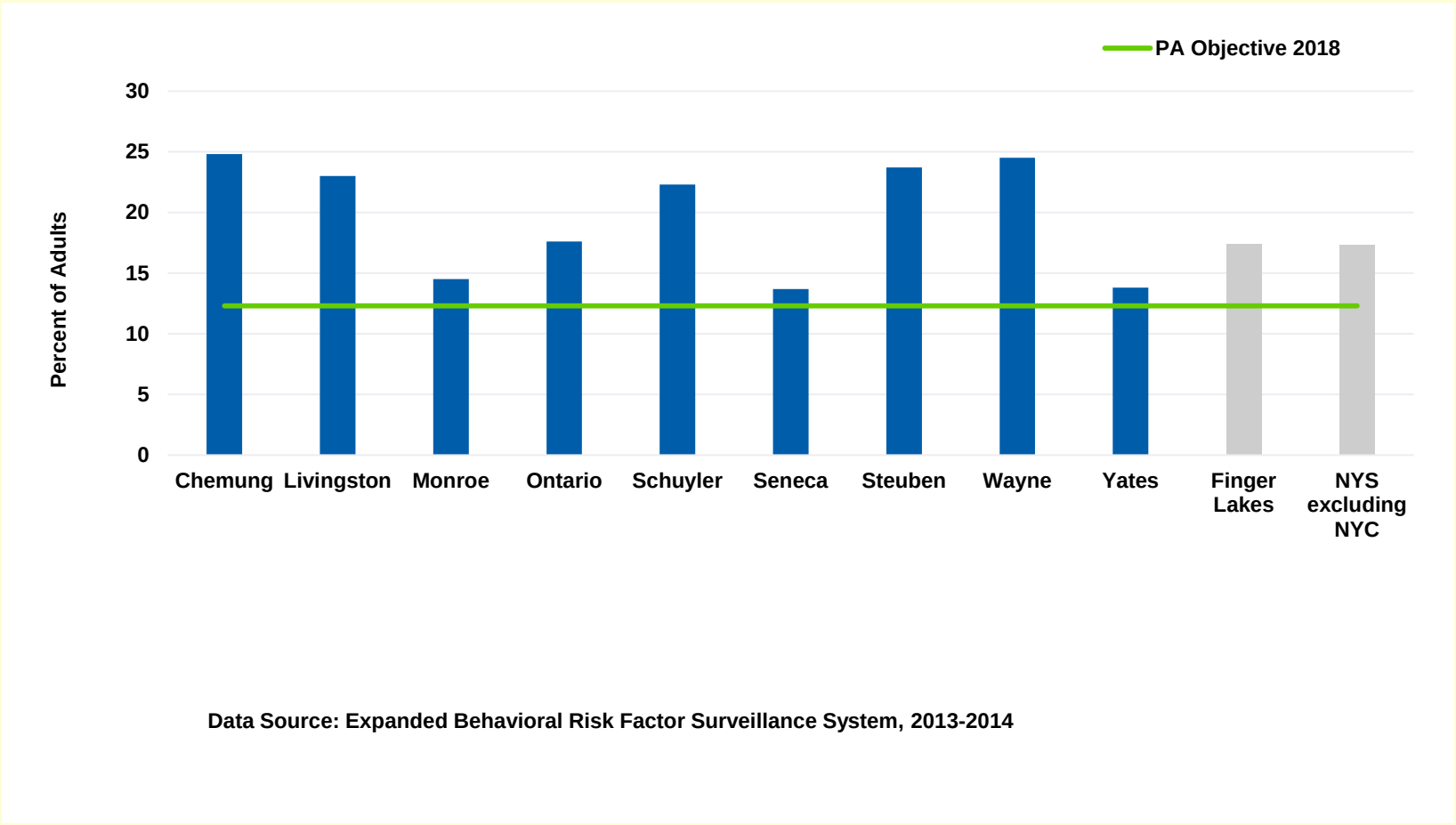
Data says…Percent of Claims Data Members 18+ with a Diagnosis for Low Back Pain, 2010-2014



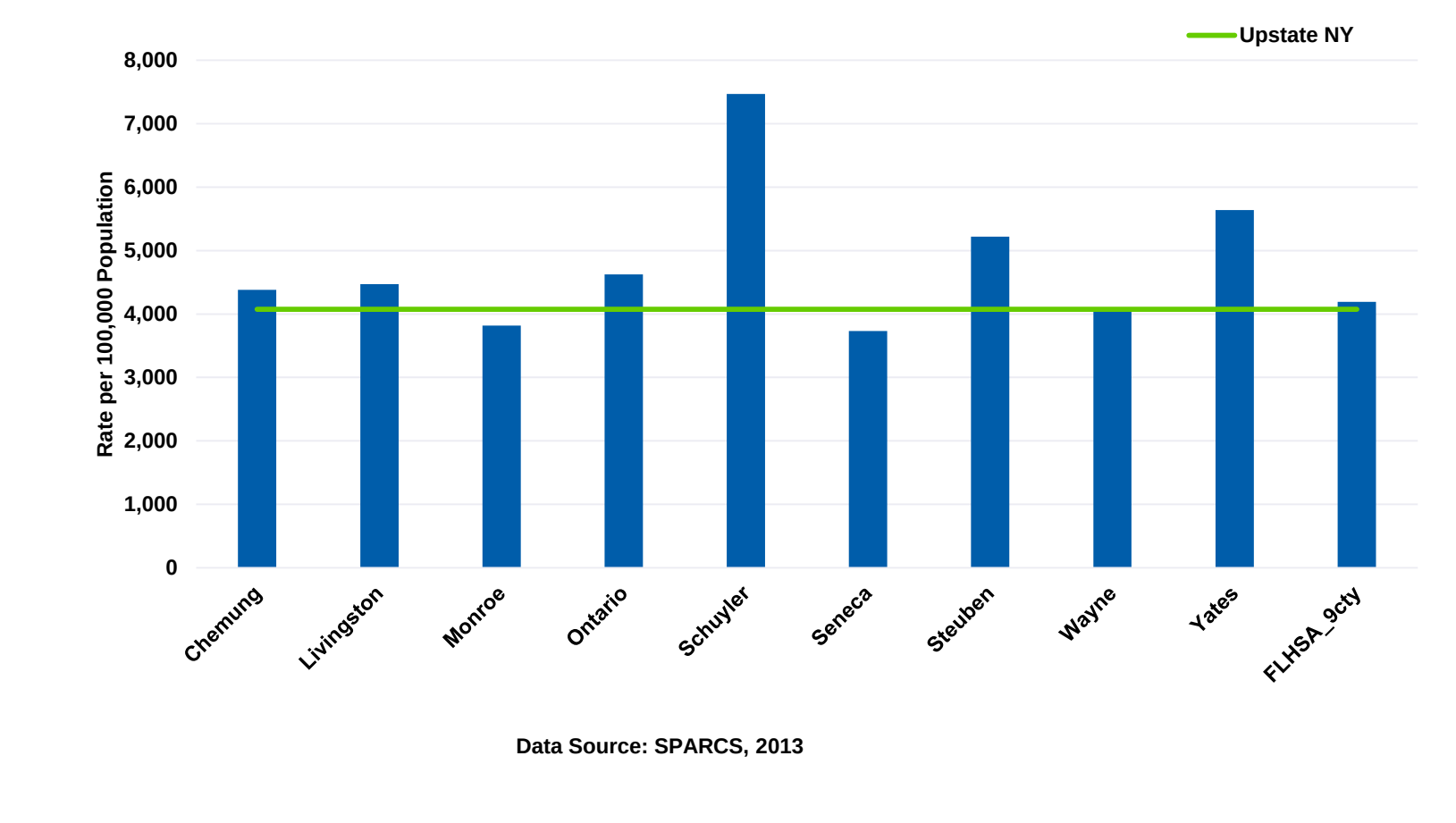
Other health problems

- In addition to obesity and the problems related to that (heart disease, diabetes, hypertension and lower-back pain), there are other problems in the region where we have above average rates:
- Tobacco use- related to cancer, asthma/COPD and hypertension
- Behavioral health problems
- Falls – for the 65 and over population

Data says… Percentage of cigarette smokers in Ontario County = 17.6%



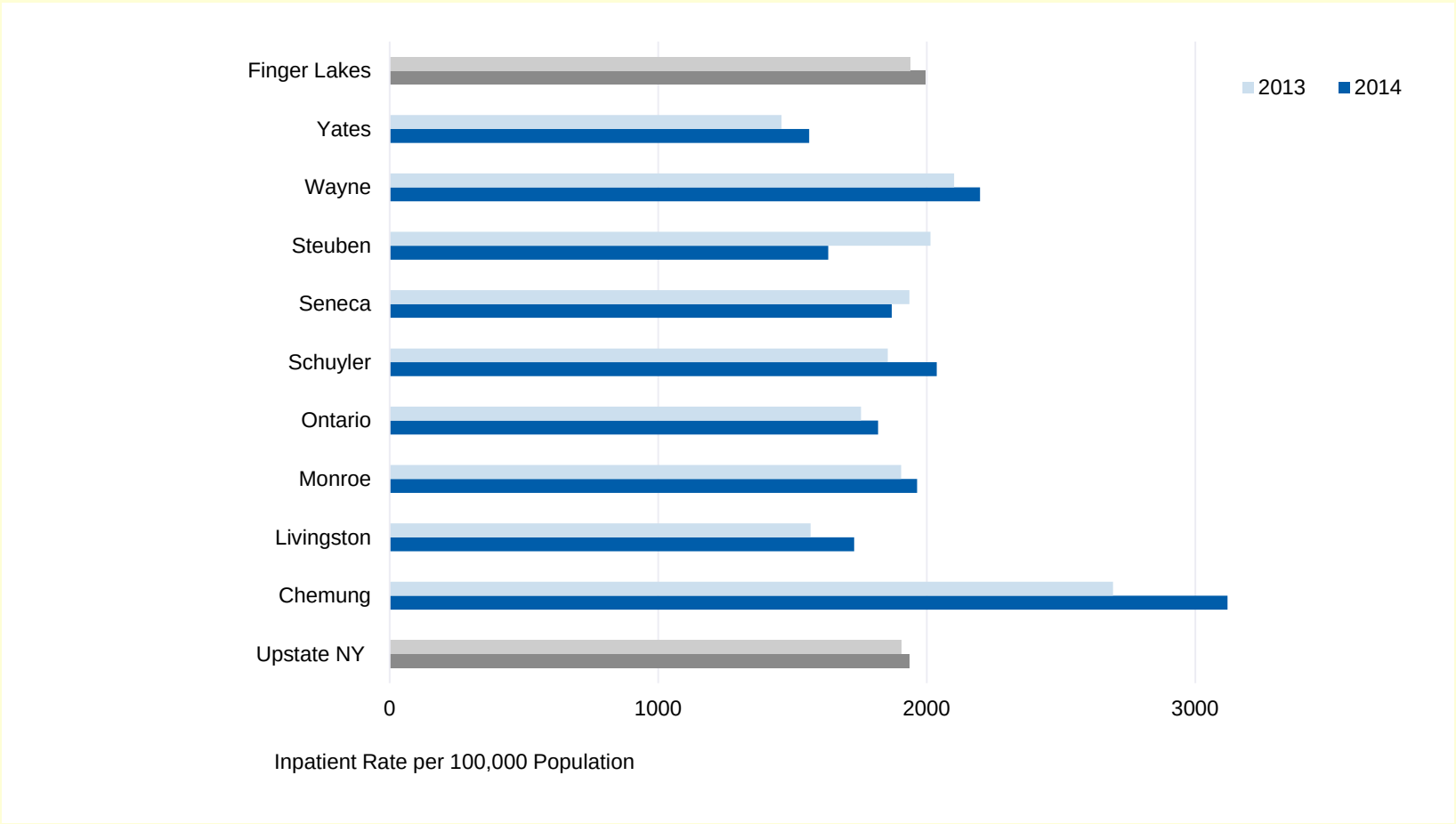
Data says…ED Visits per 100,000 for falls for those aged 65+



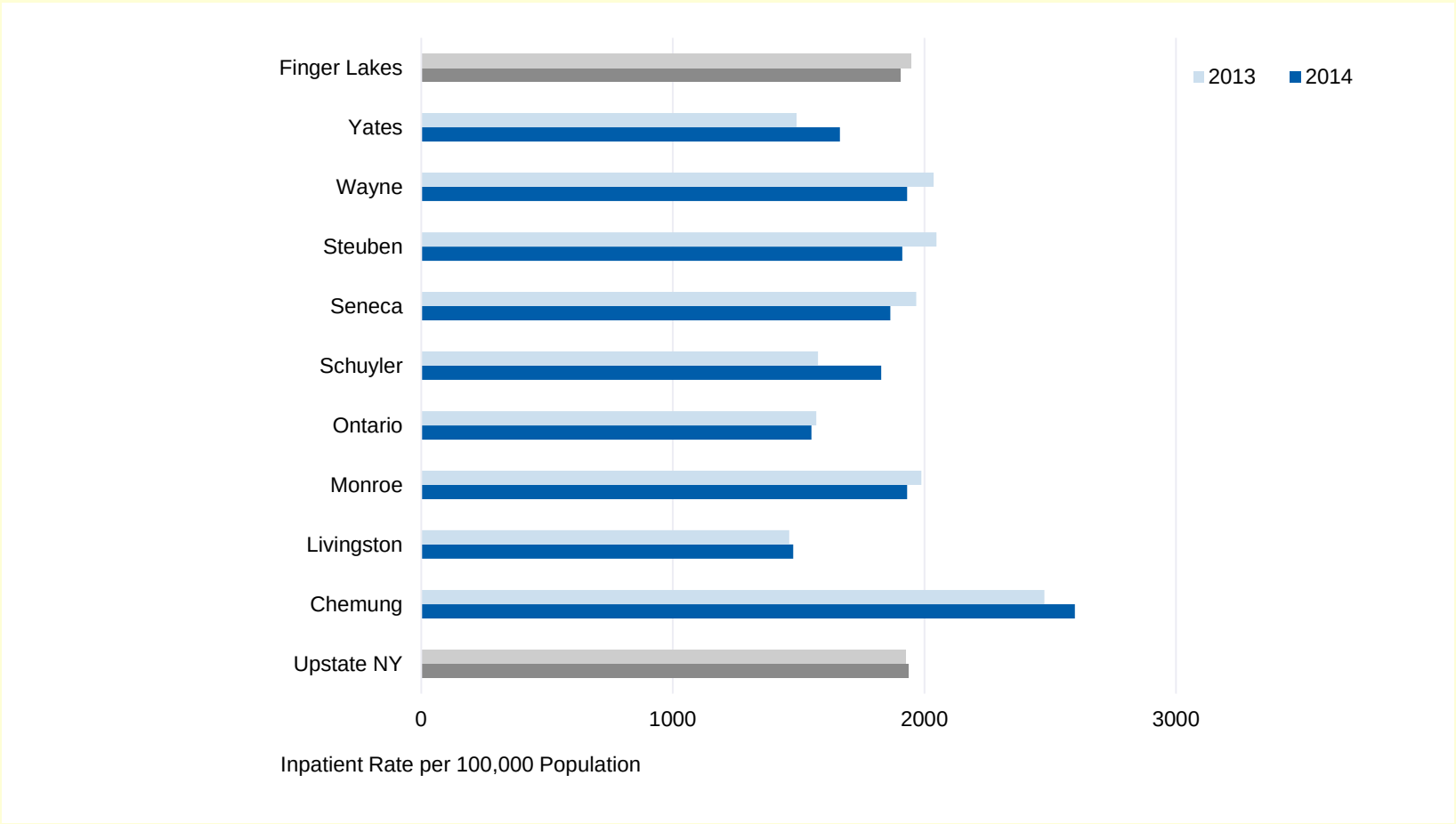
Behavioral Health

- Behavioral health can be defined as issues that effect our well being, but that are not typically considered to be part of our physical health
- In general, behavioral health includes mental health and substance abuse

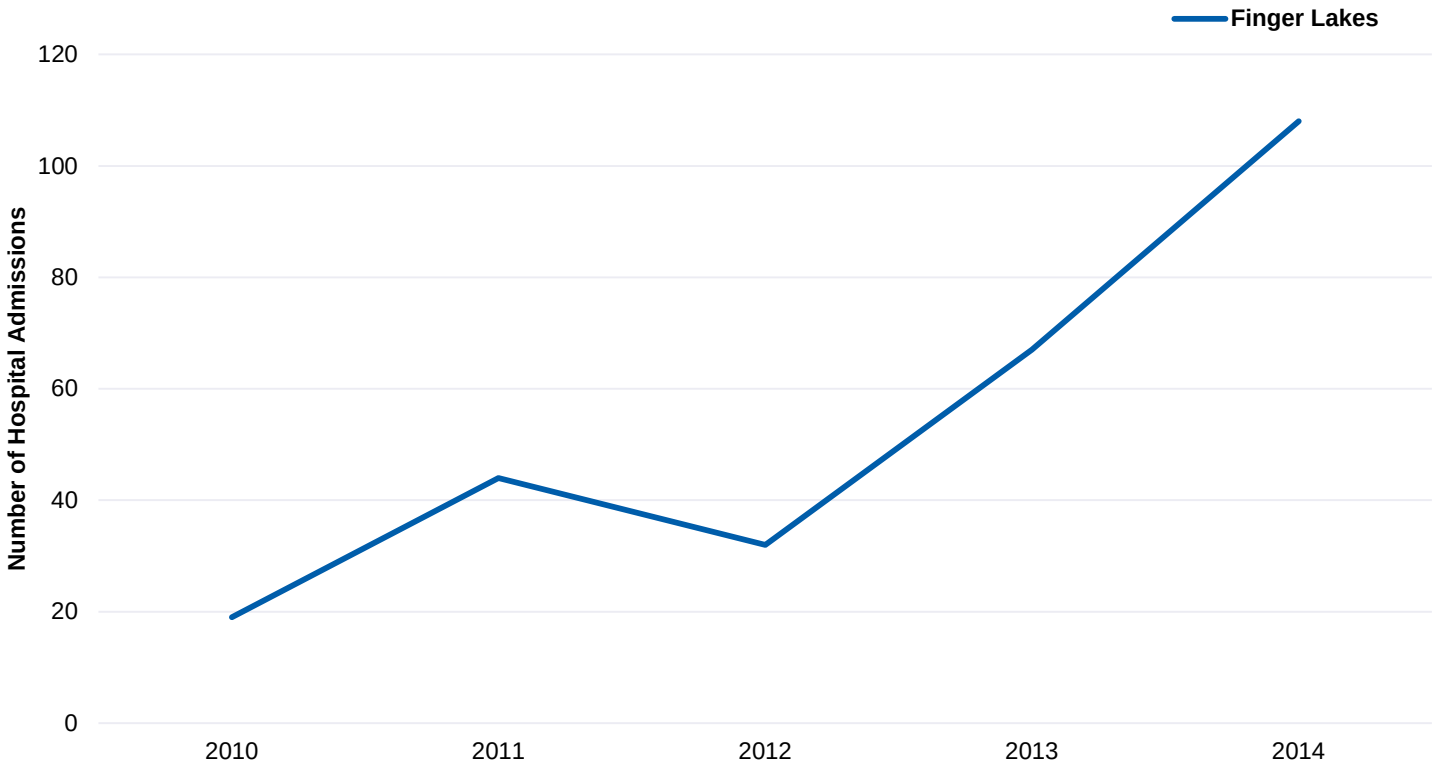
Mental health – Inpatient discharges with a mental health diagnosis



Substance abuse- Inpatient discharges with a substance abuse diagnosis

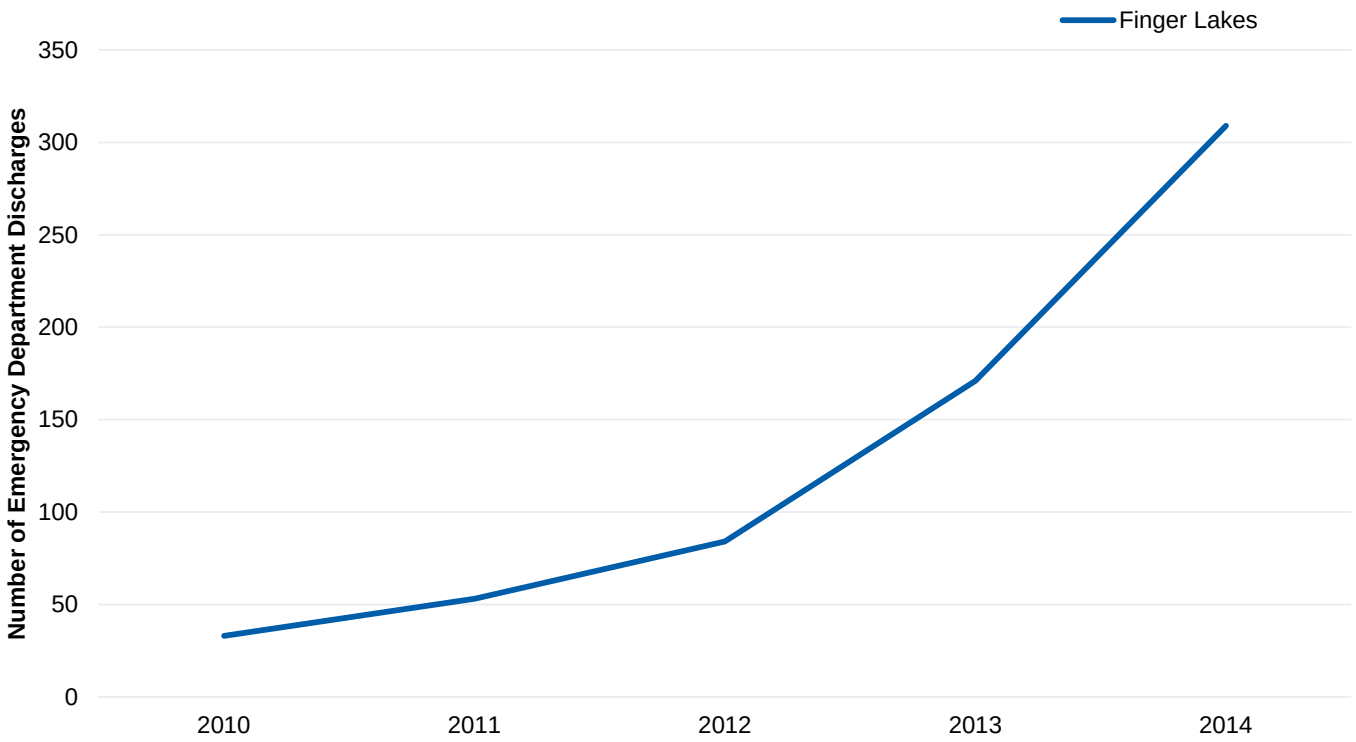


Heroin- number of heroin overdose admissions for the Finger Lakes (9 county) region



Data Source: SPARCS, 2010-2014

Heroin - Number of Heroin Related Emergency Department Overdoses for Finger Lakes Region



Data Source: SPARCS, 2010-2014

Data says… Heroin is a growing concern in the region

- 2015 data is not yet available, but this problem could potentially have doubled between 2014 and 2015. While the problem is significant because the effects can be severe and result in death, the overall numbers effected are still relatively small compared to other problems

FLPPS Community Stakeholder Forum Findings

Insurance	**High cost – premiums, copays, deductibles.** **Barriers – eligibility.** **Amish/Mennonite challenges.** **Insurance dictates healthcare availability.**
Adolescent Health	**Education around sexual health.** **More exposure to sexual health information on a consistent basis.** **Utilize forums, incentives, social media, peer education.**
Self Care	**Right to a second opinion.** **Lack of men in some health care provider fields, for example lacking male counselors.** **Doctor to patient relationship.**
Work & Employment	**Workplace danger. Discrimination/racism/sexism.** **Availability.**
Transportation	**Travel>Effect on Work.** **Trans between counties.** **Aging population and loss of ability. Disability effecting trans.**
Prejudice	**Providers need to be educated on LGTBQ needs and services.**
Education & Health Literacy	**Resources available in the community.** **Multiple points of entry.** **Addressing patients in their native language. Present information to patients at their literacy level.**

Leading Causes of Death by County, New York State, 2013
Source: Vital Statistics Data as of March 2015

County and # of Deaths	#1 Cause of Death and # of Deaths Age-adjusted Death Rate	#2 Cause of Death and # of Deaths Age-adjusted Death Rate	#3 Cause of Death and # of Deaths Age-adjusted Death Rate	#4 Cause of Death and # of Deaths Age-adjusted Death Rate	#5 Cause of Death and # of Deaths Age-adjusted Death Rate
Ontario Total: 1,005	Heart Disease 253 165 per 100,000	Cancer 244 164 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 63 41 per 100,000	Stroke 53 35 per 100,000	Unintentional Injury 31 23 per 100,000
Rest of State Total: 95,595	Heart Disease 26,539 178 per 100,000	Cancer 22,611 160 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,124 36 per 100,000	Stroke 4,226 29 per 100,000	Unintentional Injury 3,916 31 per 100,000
New York State Total: 147,419	Heart Disease 43,112 181 per 100,000	Cancer 35,074 153 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 6,977 30 per 100,000	Stroke 5,959 25 per 100,000	Unintentional Injury 5,552 26 per 100,000

Cerebrovascular disease (stroke) mortality rate per 100,000

Source:2011-2013 Vital Statistics Data as of February, 2015

Adjusted Rates Are Age Adjusted to The 2000 United States Population

	Deaths				Average population	Crude	Adjusted
Region/County	2011	2012	2013	Total	2011-2013	Rate	Rate
Reg- 10 Finger Lakes							
Chemung	49	52	28	129	88,752	48.4	34.9
Livingston	22	23	28	73	64,862	37.5	31.6
Monroe	323	340	315	978	747,681	43.6	33.6
Ontario	61	57	53	171	108,716	52.4	38.8
Schuyler	10	6	5	21	18,445	38.0	27.9
Seneca	13	16	21	50	35,304	47.2	36.0
Steuben	43	48	39	130	98,915	43.8	33.0
Wayne	39	33	49	121	92,957	43.4	36.6
Yates	15	13	5	33	25,318	43.4	32.4
Region Total	575	588	543	1,706	1,280,950	44.4	34.2
New York State	6,153	6,029	5,961	18,143	19,562,195	30.9	26.2

Chronic lower respiratory disease mortality rate per 100,000

Source:2011-2013 Vital Statistics Data as of February, 2015

Adjusted Rates Are Age Adjusted to The 2000 United States Population

	Deaths				Average population	Crude	Adjusted
Region/County	2011	2012	2013	Total	2011-2013	Rate	Rate
Reg- 10 Finger Lakes							
Chemung	76	77	63	216	88,752	81.1	59.5
Livingston	32	37	38	107	64,862	55.0	46.0
Monroe	246	264	267	777	747,681	34.6	28.0
Ontario	60	66	63	189	108,716	57.9	43.2
Schuyler	19	16	17	52	18,445	94.0	68.0
Seneca	24	19	25	68	35,304	64.2	47.1
Steuben	69	66	52	187	98,915	63.0	46.8
Wayne	51	47	39	137	92,957	49.1	41.2
Yates	14	20	23	57	25,318	75.0	56.3
Region Total	591	612	587	1,790	1,280,950	46.6	36.9
Region Total	926	911	926	2,763	1,539,754	59.8	44.6
New York State	6,902	6,986	6,977	20,865	19,562,195	35.6	30.7

Chronic lower respiratory disease hospitalization rate per 10,000

Source:2011-2013 SPARCS Data as of December, 2014

Adjusted Rates Are Age Adjusted to The 2000 United States Population

	Discharges				Average population	Crude	Adjusted
Region/County	2011	2012	2013	Total	2011-2013	Rate	Rate
Reg- 10 Finger Lakes							
Chemung	591	564	510	1,665	88,752	62.5	50.5
Livingston	135	113	120	368	64,862	18.9	16.9
Monroe	1,989	1,956	1,723	5,668	747,681	25.3	22.9
Ontario	246	199	288	733	108,716	22.5	17.6
Schuyler	92	115	91	298	18,445	53.9	39.8
Seneca	110	100	126	336	35,304	31.7	25.9
Steuben	370	329	288	987	98,915	33.3	26.8
Wayne	373	320	315	1,008	92,957	36.1	29.7
Yates	57	48	57	162	25,318	21.3	17.0
Region Total	3,963	3,744	3,518	11,225	1,280,950	29.2	25.2
Region Total	5,520	5,136	4,723	15,379	1,539,754	33.3	27.8
New York State	74,254	72,471	67,700	214,425	19,562,195	36.5	34.1

Community Input
Answer four questions:

- What are we missing in our assessment to date?
- What words would you use to define health and what terms would you use to define a healthy community?
- What factors do you think are influencing health?
- What community strengths contribute to the health of Ontario County residents?
- What do YOU think we should do to solve these problems?

What are we missing?

What's missing in our assessment to date that could help to improve the health of Ontario County residents?

Define Health

- What words would you use to define health and what terms would you use to define a healthy community?

WHAT TRENDS OR FACTORS ARE INFLUENCING HEALTH

Can be grouped into categories such as:

- Discrete elements, such as the rural setting or the proximity to the lake
- Patterns over time, such as an increased focus on exercise and healthy eating in the community
- A one-time occurrence, such as the passage of the smoke-free public building law (Clean Indoor Air Act), a major employer downsizing, or high vacancy rates in downtown

ASSETS

What assets/strengths does Ontario County have that help (or could help) to contribute to the health of community residents?

What would you do?

What are your thoughts on how we address the issues we have discussed today to improve the health of your neighbors and friends in Ontario County?

Next Steps

- Sift through and analyze data from all four assessments, including all focus group input
- Identify and prioritize strategic issues- please let your email with us if you are willing to be invited to this session!!
- Develop 2-3 strategic objectives in conjunction with the hospital, with timeframes and assigned responsibilities
- Together, improve the health of Ontario County residents!

Five Prevention Agenda Priorities

1. **Prevent Chronic Diseases**

2. **Promote a Healthy and Safe Environment**

3. **Promote Healthy Women, Infants and Children**

4. **Prevent HIV, STIs and Vaccine Preventable Diseases**

5. **Promote Mental Health and Prevent Substance Abuse**

THANK YOU

for your time and assistance in improving Ontario County Health outcomes!!

Ontario County Focus Group Summary Data

1. What are we missing in our assessment to date?
    - Heroin, law enforcement data.
    - Age specific data, drilling down to see chronic diseases that affect different age groups.
    - Where are the sources of heroin? Canandaigua, Geneva.
    - Median income.
    - Average age.
    - Education rate.
    - Breast Cancer and women's health.
    - Race.
    - Co-morbidity statistics for categories.
    - Substance and mental health abuse data.
    - Level of care and number of providers.
    - Census tract level data.
    - Birth data.
    - Stress.
    - Anorexia, bulimia, other eating disorders.
    - Depression/anxiety.
    - Violence.
    - Unemployment.
    - Cancer, and behavioral issues that relate to it.
    - Usage of primary care physician for healthcare.
    - Compare county to state to country.
    - Economic barriers.
    - Landfill.
    - Childhood obesity and type two diabetes.
    - Dementia/Alzheimer's.
    - Available preventative measures.
    - VA specific data.
    - Pollutant levels.
    - Narcan.
    - Children specific data.
    - Teen pregnancy and birth rates.
    - Availability of providers.
    - Socioeconomic factors.
    - Opiate abuse data, not just heroin.
    - Number of residents seeking care inside and outside of county.
    - Transportation specifically to the emergency room.
    - Data trends over time.

- Participation in self-management programs such as NDPP, CDSMP.
- Smoking.

2. What words would you use to define health and what terms would you use to define a healthy community?
    - Environment.
    - Full Function.
    - Accessibility.
    - Good General Health.
    - Youth.
    - Nutrition, fruit.
    - Mental health.
    - Fellowship, social health, decreasing isolation.
    - Limited screen time.
    - Active.
    - Vitality.
    - Thriving.
    - Responsive.
    - Productive.
    - Proactive.
    - Support.
    - Management.
    - Cultural.
    - Collaborative.
    - Engagement.
    - Resources.
    - Longevity of life.
    - Disparity.
    - Volunteerism.
    - Safety.
3. What trends or factors are influencing the health of the residents?
    - Rural aspect affecting access to services and preventative care.
    - Transportation.
    - Obesity and the fact that insurance doesn't cover treatment or preventative.
    - Blue Green Algae.
    - Air quality.
    - Substance abuse and mental health on the rise. Lack of care for these conditions and people.
    - System overhaul.
    - Breast cancer.
    - Inundation of processed foods.
    - Screen time.

- Generational migration transit patterns.
- Increase in focus around exercise.
- Food desserts.
- Landfills.
- Body posture and mechanics.
- Increase use in heroin.
- Fast food availability.
- Healthy food is expensive.
- Type two diabetes increasing rates.
- How much time and money people have?
- Caloric intake in prepared foods.
- High deductible health plans.
- People not paying medical bills.
- Affordability of medication.
- Behavioral barriers.
- Politics.
- Aging population.
- Smaller family size.
- Less caregivers.
- Technology.
- Awareness.
- Alternative methods of health care.
- More complexity with health issues.
- De-stigmatization.
- Both parents being required to work to support family.
- Delivery System Reform Incentive Program (DSRIP).
- Affordable Care Act – High deductible plans.
- Mennonite population.

4. What community strengths or assets contribute to the health of the residents?
    - Access to outdoor physical activity space.
    - YMCA.
    - Finger Lakes Community College.
    - Community activities.
    - Access to three hospitals and VA.
    - Walkability.
    - The Lake.
    - Rotary.
    - Public Health.
    - Clean air.
    - Geographic accessibility.
    - Geneva Hospital.

- Collaborative groups.
- Access to farm shares and good foods, transportation permitting.
- Lake, parks, trails, freshwater, physical activity.
- Beautiful scenery.
- Chiropractic center.
- Community Service Program.
- Gyms.
- Parks.
- Anger Management Program.
- Libraries.
- Salvation Army in Canandaigua.
- Office for the Aging.
- Summer concerts.
- Local mayors and their supportive nature.
- Human society.
- Non-profits.
- Quality hospitals.
- Intimate knowledge of resource availability in the community.
- Policy and system changes are easier in smaller communities.
- Lower poverty levels.
- Farm stands and farmer markets.
- Smoking prohibited areas.

5. What would you do to address some of these problems?
    - Can't help someone unless they want to be helped.
    - Social service programs need an overhaul.
    - Environment and reducing GMO's.
    - Smoking cessation.
    - Education.
    - Drill down into data, provide multiple strategies.
    - Gyms are costly.
    - Epidemic of drug use for years.
    - Incentivize employers to provide health opportunities for employees.
    - Regulations opioid prescribing.
    - System and policy changes with collaboration from law enforcement.
    - Healthy literacy, especially based on culture and race.
    - Legalize weed.
    - More daycares.
    - Job trainings.
    - Soup kitchens.
    - Animal shelters.
    - Homeless shelters.

- Domestic violence shelters.
- Lower gas prices.
- Housing.
- Mental Health services.
- Community Gatherings.
- Rehab.
- Libraries.
- Food Pantry.
- Health Clinic.
- Parenting education.
- Senior health education.
- Community blood pressure screenings.
- First aid and CPR training provided for free to seniors.
- Family support.
- Participation in sports by children.
- Early intervention and prevention.
- Addressing child bio/psycho/social factors.
- Collective provider based patient care.
- School integration.
- Champions for specific needs.
- Support for cancer survivors.
- More smoking and tobacco free places.
- Telehealth.

County:	Wayne, Ontario, Yates, Seneca & Cayuga
Group Name:	FLPPS Finger Lakes NOCN
Date and Time:	March 11, 2016 – 11:00AM

1. What are we missing in our assessment to date?
    a. Include Social determinants
    b. Community service boards are attached to the Departments of Mental Health
    c. Behavioral health is happening at the Department of Mental Health level
    d. Public health and behavioral health are at the table with each other
    e. Counties can only pick two priorities
    f. Intersection of chronic pain, pain management and substance abuse
    g. Services for the elderly on the behavioral health side it is almost non-existent (high users of medical services but low users of behavioral health services)
2. What trends or factors are influencing the health of the residents?
    a. DSRIP
    b. ACA: correlation between people choosing the bronze plan (high deductible) is not increasing access to care, acting more like catastrophe insurance
    c. Commercial insurance plans through employers are creating the same trends away from access/prevention
    d. Need to look at population trends, growing and reducing (especially the drain brain of younger folks)
    e. A lot more employers are tying wellness activities to payment contributions
    f. Mennonite population in Yates county is growing while non-Mennonite population is moving away
3. What community strengths or assets contribute to the health of the residents?
    a. Interagency cooperation
    b. DSRIP can be seen as an asset
4. What would you do to address some of these problems?
    a. DSRIP project strategies should help (including workforce, transportation, IT Infrastructure)
    b. Telehealth

County:	Ontario
Group Name:	Honeoye Firefighters
Date and Time:	March 21, 2016 - 7:00PM
# of Participants:	17

1. What are we missing in our assessment to date?
    a. Heroin problem – knowing where it is coming from. Possibly law enforcement data.
    b. Narrow down by age – 18 to 30, 31 to 60 – to see what diseases are affecting people at certain ages.
    c. Very little heroin around here, it is mainly in the cities – Canandaigua, Geneva
    d. Age groups are a huge piece of the puzzle. Being able to decipher whether these things are contributed by work or are they seniors, etc. Need age specific data.
2. What trends or factors are influencing the health of the residents?
    a. Rural - people wait a long time to call because the hospital is so far away. Closest hospital is half an hour away, people wait to the last minute to fill prescriptions, don't want to go to the doctor because it's all the way out there.
    b. Transportation – closest hospital is half an hour away.
    c. Obesity – there isn't a lot to help, insurance doesn't cover things that help with obesity. Insurance doesn't cover medicine for obesity – it covers everything for smoking cessation, but won't cover anything for obesity. Isn't much help out there for obesity.
    d. Blue green algae – is a huge problem in the summer because the water is stagnant.
    e. Air quality – not very good, especially in the summer with the blue green algae.
    f. Substance abuse and mental health are on the rise – almost every day we are going on site calls. Once taken to the hospital – there is no place to send them. Sometimes I have to take people to Buffalo or Albany for treatment – for mental health or even detox sometimes. Not enough providers. Have heard from patients that it is very hard for them to find services when they want to get help.
    g. People that get into the system never get out – the system is flawed. The system is backwards, needs an overhaul.
3. What community strengths or assets contribute to the health of the residents?
    a. Hills - outdoor places for physical activity.
    b. YMCA – a good resource.
    c. Finger Lakes Community College – a good resource, do a lot for physical activity and health.
    d. There are always runs and different activities going on.
4. What would you do to address some of these problems?

a. Can't help someone unless they want to be helped.
b. The system needs to be restructured – I lose many employees to social services because they can offer them better benefits/money than I can (I own a small business).

County:	Ontario
Group Name:	Tools For Social Change
Date and Time:	March 22, 2016 - 6:00PM
# of Participants:	30

1. What are we missing in our assessment to date?
    a. Need to break out into age, race, geography, income levels, etc. Try to read between the lines a little bit.
    b. Co-morbidity statistics within each of the categories presented.
    c. Substance abuse and mental health – access data.
    d. Quality of the hospital in your county. Some counties have more specialists, etc.
    e. Availability of services.
    f. Break data out into a map, through data points.
    g. Do by census district – 4 in the city, 2 of them we know that the statistics vary widely.
    h. Age specific data. Birth data.
2. What trends or factors are influencing the health of the residents?
    a. Food desserts – no access to healthy foods, many areas where there are just convenient stores.
    b. Transportation – can't to appointments, to stores, healthy foods, etc.
    c. Landfills – air and water quality. Leaching into water supply and lakes. Off gassing of landfill to the air quality and carcinogenic.
    d. People are sandwiched in between Ontario county landfill and Seneca county landfill – I bet health trends would be seen in those residents.
    e. Body posture and mechanics – this is not taught in schools, this could address a lot of health conditions, needs to be taught.
3. What community strengths or assets contribute to the health of the residents?
    a. Good hospital in Geneva.
    b. Good collaborative groups – interfaith council, schools, health agencies.
    c. Access to farms shares and good foods, if people have transportation.
    d. Proximity to lake, parks, trails and fresh water – increased physical activity.
    e. Beautiful scenery – a gorgeous area.
    f. Good chiropractic center, can help with lower back pain.
4. What would you do to address some of these problems?
    a. Drilling down to get data on specific areas/races/low income, etc. – then help address the highest need priorities in those areas. Not on strategy fits all – a strategy that may be working in Victor, might not work in Geneva. Needs to be tailored to each community and their needs.

b. Be honest about who is being served by current services that promote health in the community – residents in 6th ward are being underserved because there is a food dessert. Gyms are costly – so people being underserved during the winter, when they can't go outside to exercise. People care about heroin now because white kids are getting into it… there has been an epidemic of drugs for years now, but no one cares because in different populations that aren't white.
c. More focus on incentivizing employers to provide shift workers an opportunity that gives people healthy opportunities – exercise, healthy foods, etc.
d. Control of dispensing pain killers – people give out a full bottle of pain meds for minor surgery – too many being dispensed.
e. Way to have conversations at the county and state level with law enforcement around treatments for drug addiction/mental health. Law changes around drugs – people going to jail for drugs for years and years – makes them unemployable, affects health, etc. So many people incarcerated for drugs, when they should be getting help so that they can do better.
f. Tailoring information sharing to each community – a Latino community may need things in a different way than another community.

County:	Ontario
Group Name:	Thompson Health – Population Health Committee
Date and Time:	April 12, 2016 - 10:00AM
# of Participants:	10

1. What are we missing in our assessment to date?
    a. You didn't dig down into cancer data. Cancer is treatable in different ways.
    b. In the full assessment it will be done. Just the top concerns were looked at.
    c. The most prevalent cancer is lung cancer. That is a behavioral issue. Would be wanting to look at behavioral issues and cancer.
    d. In the last assessment the highest cancer rate was male lung cancer.
    e. To have an effect is to get people to primary care providers which are now moving towards the patient centered medical home.
    f. Is there data on patients who have not seen a primary care physician in a year or five years?
    g. Look at the individuals who have insurance but don't see a primary care physicians.
    h. Overlay data with age, income, etc.
    i. Compare county to the state to the country.
    j. Our skills and ability to change lifestyle is very limited. It is very tough. In some ways it feels we could do better by dealing with mammography rates as opposed to lifestyles.
    k. Education is a key component. You can't affect someone's personal choice but you can give them education. Would like to see education rates. How many fail or drop out of high school? Socioeconomic education is a part of it.
    l. A big part of it is economic. It is cheaper to buy McDonald's than it is to buy fresh vegetables and fruits.
2. What trends or factors are influencing the health of the residents?
    a. Rates of type two diabetes are climbing significance. (30% of the population in the latest data.) That falls into culture.
    b. It also falls into the time/poverty issue as well. How much time do people have to devote to personal health? How much funds?
    c. The calories in premade meals at Wegman's is astronomical.
    d. Is there any data related to single family and income? Or both parents working at income? They may be smart and know what to do but due to time they need something quick.
    e. Could create that data just by surveying the Thompson Health campus.

f. One of the big things is the high deductible health plans and high cost health plans. It helps to incentivize people to take classes related to their health. How do you do that with Medicaid? Money makes people act. Incentivize people to change to healthier habits.
g. If you have a high deductible plan, how many physicians are you seeing? People are utilizing physicians, but they are just not paying their bills.
h. Also, seeing a lot of patients without primary care physicians and not adhering to their medications due to financials.
i. Access to services such as urgent care. Need to get the community into primary care.
j. 80% of medical conditions are behavioral related, not access to care. Increasing access is important but changing behavior is important.
k. Education is a big part of it. Ex: Smoking commercials.

3. What community strengths or assets contribute to the health of the residents?

   *Due to time constraints the group was not able to offer input on this question.
   See below for further comments and discussion that occurred during the presentation.

4. What would you do to address some of these problems?

   *Due to time constraints the group was not able to offer input on this question.
   See below for further comments and discussion that occurred during the presentation.

<u>Additional Discussion</u>

- Would it help to know where the Thompson Health population comes from? Ontario County is the majority (80%) with a bit from the touching counties.
- What percentage of pregnant moms in WIC with hypertension have prenatal care? We can get that data.
- What do you call heart disease incidence? CHF, cardiac disease… Confused by hypertension rates and this data. FLHSA hypertension registry data would not be in this data set.
- Forward difference between the two data sets and collections to the group. (The one used for the slides and the one used for county rankings.)
- Do we know what other counties have done for their rates of lower back pain to go down between 2010 and 2014?
- Can you tell whether that is a result of the availability of practitioners to make the diagnosis? There is a lack of significant mental health practitioners in the region and would lead to a lack of people receiving the mental health diagnosis. There is a new psychiatrist in Farmington and that will be interesting to see if their presence affects the numbers. $23 million in a mental health grant to Clifton Springs. The VA just signed a partnership with the Rochester Health System to decompress mental health services in the area.

- The Sheriff said that there were 20 heroin overdoses in a month so it seems that number would be incorrect. This data does not include people dying out in the committee. Not all are admitted. If they are breathing after six hours they are very often let out to go home. The other data exists within the county and Mary Beer feels we can obtain it for the group.
- Do you have the data to show obesity death data versus heroin death? Not to downplay the heroin deaths, but the numbers for obesity are significantly larger and can help the group make a bigger impact in the community. Don't want to rush to focus on heroin when it is more headline and news driven as opposed to statistics.
- Would like the slides sent to them.
- Primarily comparing the county to the Finger Lakes Region and/or New York State. Is that what we should be comparing ourselves to? What do we look like compared to the national average? Would like to know the national data. Is New York State ahead of the country or behind in these issues? If we're bad in New York State and New York State is bad, then that's even worse.
- Are there people out in the community who are not being treated for CLRD? Do they have primary care physicians or do they not? Have a pretty strong hospice care. They are technically discharged from the hospital at the time of their death because of this. Have many people on Hospice during the two years being looked at.
- Will accept what the county chooses at the objectives but would like to do some of their own investigations – such as look admission rates and some of the data that seemed odd. To get traction and move the committee forward will work with the priorities. There are a lot of things the health system is doing that need to bring into the committee and reported on and connected to population health.

County:	Wayne, Ontario & Seneca
Group Name:	Senior Citizen Volunteer Group – Wayne CAP
Date and Time:	April 14, 2016 – 9:15AM
# of Participants:	44

*This group consisted of members from Ontario, Wayne & Seneca Counties.

1. What are we missing in our assessment to date?

   Wayne

   a. Ratio of teens/adults/older adults that are overdosing – is it more the young or the old?
   b. Data on public transportation
   c. Broken down by age for all of the measures
   d. Smoking rate in those under 18
   e. Information on e-cigarettes
   f. Look at reoccurrence of people with substance abuse and mental health diagnosis
   g. Data on kids being connected to technology
   h. Access to healthy foods data
   i. Unemployment data

   Seneca

   j. Concerned about the trash coming from NYS – do we have data on that? Smells horrible

   Ontario

   k. Data on the landfill
   l. Childhood obesity data and type 2 diabetes in children
   m. Data on dementia/alzheimers

2. What trends or factors are influencing the health of the residents?

   Wayne

   a. No public transportation – have to call three days ahead, can't go out of the county, need to go to a certain place, and it can be expensive
   b. Kids are not getting outdoor time – all kids do are video games, tv, etc.
   c. No access to affordable, healthy foods
   d. Parents are using technology a lot – they aren't playing with their kids, etc.
   e. Loss of industry
   f. Population is down
   g. Unemployment
   h. Mental health – a lot more people with issues
   i. Family structures have changed – parents are slacking, not disciplining their children, etc.
   j. Need to bring back respect in children

k. Children are unruly now – parents don't discipline, "kids rule their parents"
l. Divorce is much higher now
m. A lot more grandparents raising grandchildren
n. Nothing for the children (if they aren't involved in school sports), nothing to keep them occupied
o. Not many programs for people of color, African American children, etc. – library needs more programs
p. There are a lot of programs – but they aren't utilized
q. Kids only do things that are structured – kids don't take it upon themselves to play

Seneca

r. Trash being transported from NYS

Ontario

s. Trash being transported from NYS, the landfill
t. Mental health – hospitals don't treat it (my son went to the ER because he wanted to commit suicide and they just sent him home and said that there was nothing wrong with him)

3. What community strengths or assets contribute to the health of the residents?

Wayne

a. Wayne CAP
b. Headstart
c. Foster Grandparent Program
d. Canal Trail
e. A lot of programs are the libraries – after school, during school, weekend activities
f. Community Center in Palmyra – during the summer they have a lot of activities
g. High School in Palmyra has quite a bit for kids to do
h. Community Center in Newark – has an active youth program
i. Library in Newark has several programs for parents
j. Audubon Nature Center in Savannah – has a lot of programs for kids

Ontario

k. Trail pathway
l. Salvation Army in Canandaigua has a lot of programs for children, teens, and young adults
m. Libraries have a lot of programs – it's always busy, there is something there for everyone

4. What would you do to address some of these problems?

Wayne

a. Schools need to take away children's cell phones during school

b. Need more discipline in schools
c. Educate parents – bring back discipline
d. Communication between organizations needs to be better
e. Promote programs more – programs are there, but people don't know about them
f. Parents need to do things with their kids more at home and talk to them more
g. Increase and publicize programs are Home Depot and Lowes – they have programs for kids to make projects, etc.

Ontario

h. Need to educate parents more
i. More parenting education

County:	Ontario
Group Name:	Day Reporting
Date and Time:	April 18, 2016 - 9:15AM
# of Participants:	5

1. What are we missing in our assessment to date?
    a. Stress is a killer due to all the inflammation. Think about all the stressors that are in our lives. Transportation something else that we need.
    b. Why just obesity? Other areas such as anorexia or bulimia being focused on. Depression/anxiety. Hard to get jobs due to lack of experience.
    c. Violence and the acts associated with anger.
    d. Receiving unemployment is extremely difficult.
2. What trends or factors are influencing the health of the residents?
    a. Ontario County has a huge problem with heroin.
    b. There is a lot of fast food restaurants. Low quality produce.
    c. Healthy food is expensive.
3. What community strengths or assets contribute to the health of the residents?
    a. Onanda Hiking and trails for physical activity. Community Service program.
    b. Local YMCA is expensive.
    c. Accelerated fitness is a good option an inexpensive.
    d. A lot of parks in the area. Anger management is an asset that has been used.
4. What would you do to address some of these problems?
    a. Legalize weed
    b. More Daycares
    c. Trainings for jobs
    d. Soup kitchens
    e. No kill animal shelters
    f. Homeless Shelters
    g. Domestic Violence Shelters
    h. Lower Gas Prices
    i. Cheaper housing/safe
    j. More therapy/mental health awareness
    k. No pesticides/hormones
    l. Decrease carbon foot print
    m. No animal cruelty -on dairy farms-egg farms-meat farms
    n. More veggie farm
    o. Vegetarian fast food
    p. Animal Rights aware
    q. Teen Center

r. Community Gatherings
s. More job openings
t. More financial aid
u. Mental Health Center
v. Rehab
w. Rec Center
x. Health Clinic
y. Libraries
z. Food Pantry

County:	Ontario
Group Name:	Rotary
Date and Time:	April 28, 2016 – 12:00PM
# of Participants:	30+

1. What are we missing in our assessment to date?
    a. Median income of these areas.
    b. Average age of the county.
    c. Age, income and education.
    d. Breast cancer. Women's health needs and why the rates are so high.
    e. Addressing the "low hanging fruit".
2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Environment
    b. Full function
    c. Accessibility
3. What trends or factors are influencing the health of the residents?
    a. Breast cancer
    b. Inundation of processed foods
    c. Screen time
    d. Generations are becoming more transit. Moving to different areas.
    e. A lot more exercise around the lake
4. What community strengths or assets contribute to the health of the residents?
    a. 3 Hospitals and VA
    b. Walkability
    c. Office of aging
    d. The lake
    e. Rotary
    f. Director of public health
    g. Clean air
    h. Geographic accessibility
5. What would you do to address some of these problems?
    a. Environment, reducing GMO corn and soy. The poison around that and the impact on the environment that we live in and the toxins.
    b. Get rid of smoking commercials. Worst case scenario. More using the positive aspects about it.
    c. Education and incentives around this.

County:	Ontario
Group Name:	Senior Meal Site - OFA, Shortsville Fire Hall
Date and Time:	May 12, 2016 – 11:30AM
# of Participants:	16 attendees (9 females, 7 males)

1. What are we missing in our assessment to date?
    a. Data on preventative measures
    b. Data on the VA and how they are working with Ontario County
    c. Data on breast cancer
    d. Data on cancer related to environmental concerns
    e. Data on environment (water, soil, air, etc.)
    f. Pollutant levels
    g. Data on Narcan - who is carrying it, how much has it been used, etc.
    h. Data on children using drugs (abusing cough medicine, etc.)
    i. Data on teen pregnancy, birth rates

2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Good health
    b. General health
    c. Youth - I felt great when I was 30 years old
    d. Fruit, nutrition
    e. Mental health
    f. How you generally feel when you wake up in the morning, overall feeling
    g. This lunch program right here - gets people out of their homes, fellowship, social health, decreases isolations, makes people feel good for a few hours
    h. Don't sit in front of the television 20 hours a day - stay busy

3. What trends or factors are influencing the health of the residents?
    a. Environmental - a lot of poisonous substances being introduced into the community (fertilizers now being banned, etc.), pollutants in the air
    b. Too much time in front of television, screens
    c. Political aspects

4. What community strengths or assets contribute to the health of the residents?
    a. OFA groups - this meal site
    b. Summer concerts
    c. Mayor is very involved - and this village has gotten so much better in the last 10 years (more parks, concerts, etc.)

d. Ontario County Humane Society - Happy Tails
e. A very wide range of non-profits that serve the community

5. What would you do to address some of these problems?
    a. Need to give more information on what we can do as seniors to prevent/treat hypertension, diabetes, obesity, etc. - we don't care about the number of people that have heart disease, diabetes, etc... we know that we have it and want to know how we can treat it ourselves
    b. Need to have a nurse come to this gathering and take blood pressures (other screenings, etc.)
    c. Provide free trainings to the senior population on CPR and the Heimlich Maneuver
    d. Have AEDs in more places
    e. Parents being more involved with their children and grandparents being more involved with their grandchildren - more family support and love
    f. Kids to participate more in sports and organized activities

County:	Ontario
Group Name:	Stakeholders Focus Group
Date and Time:	May 27, 2016 – 8:00AM
# of Participants:	32 (27 females, 5 males)

1. What are we missing in our assessment to date?
    a. Data on providers - availability of primary care, dental, etc.
    b. Specific populations in each area (data on providers) - socioeconomic factors, demographics, ages, etc.
    c. Data on ages - say an aging population, but no data on that
    d. Data on all opiates, not just heroin
    e. How many from our region go outside of our county for care
    f. How many come in to our county for care
    g. More data on drugs - different kinds of drugs, those in treatment (not just overdoses), etc.
    h. Data on how people are getting to the emergency room (ambulance, driving, walk in, etc.)
    i. Data on transportation - especially older adults getting to care
    j. Data on mental health in the elderly - we are seeing a lot of depression in the elderly
    k. Trend the data - see what we were and where we are now
    l. Data on those participating in self management programs (CDSMP, NDPP, etc.)
    m. Data on co-morbidities with certain diagnoses
    n. Data on transient populations (students, migrant workers, etc.)
    o. More detailed data around smoking/tobacco use

2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Active
    b. Vitality
    c. Thriving
    d. Responsive
    e. Productive
    f. Proactive
    g. Supports
    h. Accessibility
    i. Management
    j. Cultural
    k. Collaborative

l. Engagement
m. Resources
n. Not having children die before their parents
o. Less disparity
p. Sense of community as a whole
q. Volunteerism
r. Environment - safe and healthy
s. Safety

3. What trends or factors are influencing the health of the residents?
    a. Aging population
    b. Children don't stay in the community they were brought up in, move away for opportunities
    c. Smaller families
    d. Less caregivers
    e. Technology
    f. Awareness
    g. Alternative methods of health care - more home-based, natural healers, etc.
    h. More complexity in peoples issues - not just one issue any more, multiple
    i. Lack of response to complex health issues
    j. Change in family structures
    k. More acceptance of certain issues - de-stigmatization
    l. Building environments that are healthier (more pathways to walk, sidewalks, etc.)
    m. Over extension of family involvements - don't have time to fix proper meals, no time to exercise, etc.
    n. Both parents required to work now

4. What community strengths or assets contribute to the health of the residents?
    a. Good hospitals
    b. Green space, parks, trails, etc.
    c. Collaboration between organizations is great
    d. Health care workers are part of our communities - so they know the resources that others might not
    e. Easier to change policies/systems in smaller areas (different than in the cities)
    f. Lower poverty levels
    g. Farm stands and farmers markets (but also a negative because not available in the winter)
    h. Safe area to live - law enforcement does a good job
    i. Smoking prohibited on county property

5. What would you do to address some of these problems?
    a. Get into earliest intervention possible with children - for all children
    b. Focusing on bio/psycho/social
    c. All providers collectively at the table talking about a patients case (child doctor, social worker, school counselor, case manager, etc. - all there and working together)
    d. Mind, body, spirit program
    e. Getting these programs into schools
    f. Better position ourselves to champion opportunities for our needs
    g. More support for cancer survivors - more programs and more local agencies willing to take on these programs
    h. More smoking/tobacco free places (need to work on municipalities, parks, etc.)

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Indicator 2: Health Promotion Activities to Facilitate Health Living in Healthy Communities					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Conducts health promotion activities for the community-at-large or for populations at increased risk for negative health outcomes	19	14	3	1	37
Develops collaborative networks for health promotion activities that facilitate healthy living in healthy communities	18	15	3	1	37
Assesses the appropriateness, quality and effectiveness of health promotion activities at least every 2 years.	20	7	5	3	35
Total Respondents	37				

Mobilize Community Partnerships to Identify and Solve Health Problems					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Has a process to identify key constituents for population based health in general (e.g. improved health and quality of life at the community level) or for specific health concerns (e.g., a particular health theme, disease, risk factor, life stage need).	24	8	3	2	37
Encourages the participation of its constituents in community health activities, such as in identifying community issues and themes and in engaging in volunteer public health activities.	24	10	3	0	37
Establishes and maintains a comprehensive directory of community organizations.	25	3	5	4	37
Uses broad-based communication strategies to strengthen linkages among LPHS organizations and to provide current information about public health services and issues.	22	11	3	1	37
Total Respondents	37				

Community Partnerships					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Establishes community partnerships to assure a comprehensive approach to improving health in the community.	21	13	2	0	36
Assure the establishment of a broad-based community health improvement committee.	21	12	1	2	36
Assesses the effectiveness of community partnerships in improving community health.	23	10	2	1	36
Total Respondents	36				

Assure a Competent Public and Personal Health Care Workforce					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 0% - 26%**	**No 25% - 0%**	**Response Count**
Assessment of workforce (including volunteers and other lay community health workers) to meet the community needs for public and personal health care services.	17	12	3	4	36
Maintaining public health workforce standards, including efficient processes for licensure/credentialing of professionals and incorporation of core public health competencies needed to provide the Essential Public Health Services into personnel systems.	21	10	2	3	36
Adoption of continuous quality improvement and life-long learning programs for all members of the public health workforce, including opportunities for formal and informal public health leadership development.	19	14	0	2	35
Total Respondents	36				

Life-long Learning Through Continuing Education, Training & Mentoring					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Identify education and training needs and encourage opportunities for public health workforce development.	21	10	3	2	36
Provide opportunities for all personnel to develop core public health competencies.	24	6	4	2	36
Provide incentives (e.g. improvements in pay scale, release time, tuition reimbursement) for the public health workforce to pursue education and training.	14	11	3	8	36
Provide opportunities for public health workforce members, faculty and student interaction to mutually enrich practice-academic settings.	16	12	4	4	36
Total Respondents	36				

Public Health Leadership Development					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Provide formal (educational programs, leadership institutes) and informal (coaching, mentoring) opportunities for leadership development for employees at all organizational levels.	18	11	3	3	35
Promote collaborative leadership through the creation of a local public health system with a shared vision and participatory decision-making.	21	13	1	1	36
Assure that organizations and/or individuals have opportunities to provide leadership in areas where their expertise or experience can provide insight, direction or resources.	18	12	3	3	36
Provide opportunities for development of diverse community leadership to assure sustainability of public health initiatives.	17	13	3	3	36
Total Respondents	36				

Access to and Utilization of Current Technology to Manage, Display and Communicate Population Health Data					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Uses state of the art technology to collect, manage, integrate and display health profile databases.	14	17	3	1	35
Promotes the use of geocoded data.	8	13	5	7	33
Uses geographic information systems.	10	14	4	6	34
Uses computer-generated graphics to identify trends and/or compare data by relevant categories (e.g. race, gender, age group).	12	15	2	6	35
Total Respondents	35				

Diagnose and Investigate Health Problems and Health Hazards in the Community					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Epidemiological investigations of disease outbreaks and patterns of infectious and chronic disease and injuries, environmental hazards, and other health threats.	23	9	3	1	36
Active infectious disease epidemiology programs.	23	9	1	3	36
Access to public health laboratory capable of conducting rapid screening and high volume testing.	21	7	3	5	36
Total Respondents	36				

Plan for Public Health Emergencies					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Defines and describes public health disasters and emergencies that might trigger implementation of the LPHS emergency response plan.	24	9	0	3	36
Develops a plan that defines organizational responsibilities, establishes communication and information networks, and clearly outlines alert and evacuation protocols.	21	11	1	3	36
Tests the plan each year through the staging of one or more “mock events.”	21	9	4	1	35
Revises its emergency response plan at least every two years.	22	6	2	5	35
Total Respondents	36				

Investigate & Respond to Public Health Emergencies					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Designates an Emergency Response Coordinator	27	6	0	2	35
Develops written epidemiological case investigation protocols for immediate investigation of:	20	9	1	4	34
Communicable disease outbreaks	25	7	2	2	36
Environmental health hazards	23	10	1	2	36
Potential chemical and biological agent threats	22	9	3	1	35
Radiological threats and	19	11	3	2	35
Large scale disasters	20	11	1	3	35
Maintains written protocols to implement a program of source & contact tracing.	19	10	2	4	35
Maintain a roster of personnel with technical expertise to respond to biological, chemical or radiological emergencies	19	11	1	4	35
Evaluates past incidents for effectiveness & continuous improvement	21	10	2	2	35
Total Respondents	36				

Laboratory Support for Investigation of Health Threats					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Maintains ready access to laboratories capable of supporting investigations.	18	10	0	6	34
Maintains ready access to labs capable of meeting routine diagnostic & surveillance needs.	18	9	0	7	34
Confirms that labs are in compliance with regs & standards through credentialing and licensing agencies.	16	8	1	9	34
Maintains protocols to address handling of lab samples–storing, collecting, labeling, transporting and delivering samples and for determining the chain of custody.	16	8	2	8	34
Total Respondents	34				

Develop Policies & Plans that support Individual and Community Health Efforts.					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
An effective governmental presence at the local level.	25	9	2	0	36
Development of policy to protect the health of the public and to guide the practice of public health.	22	12	1	1	36
Systematic community-level and state-level planning for health improvement in all jurisdictions.	21	10	3	2	36
Alignment of LPHS resources & strategies with the community health improvement plan.	19	11	3	2	35
Total Respondents	36				

Public Health Policy Development					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Contributes to the development and/or modification of public health policy by facilitating community involvement in the process and by engaging in activities that inform this process.	23	9	4	0	36
Reviews existing policies at least every 2 years and alerts policy makers and the public of potential unintended outcomes and consequences.	22	6	3	4	35
Advocates for prevention and protection policies, particularly policies that affect populations who bear a disproportionate burden of mortality and morbidity.	26	6	4	0	36
Total Respondents	36				

Community Health Improvement Process					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Establishes a community health improvement process, which includes broad based participation and uses information from the community health assessment as well as perceptions of community residents.	21	9	3	3	36
Develops strategies to achieve community health improvement objectives and identifies accountable entities to achieve each strategy.	22	7	4	3	36
Total Respondents	36				

Strategic Planning & Alignment with the Community Health Improvement Process					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Conduct organizational strategic planning activities.	23	7	3	3	36
Review its own organizational strategic plan to determine how it can best be aligned with the community health improvement process.	23	8	2	3	36
Conducts organizational strategic planning activities and uses strategic planning to align its goals, objectives, strategies and resources with the community health improvement process.	24	6	3	3	36
Total Respondents	36				

Enforce Laws & Regulations that Protect Health and Ensure Safety					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Review, evaluate and revise laws and regulations designed to protect health and safety to assure they reflect current scientific knowledge and best practices for achieving compliance.	19	13	0	3	35
Education of persons and entities obligated to obey or to enforce laws and regulations designed to protect health and safety in order to encourage compliance.	21	9	3	3	36
Enforcement activities in areas of public health concern, including but not limited to the protection of drinking water, enforcement of clean air standards, regulation of care provided in health care facilities and programs, re-inspection of workplaces following safety violations; review of new drug, biologic and medical device applications, enforcement of laws governing sale of alcohol and tobacco to minors; seat belts and child safety seat usage and childhood immunizations.	17	13	1	4	35
Total Respondents	36				

Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Identifying populations with barriers to personal health services.	20	10	3	3	36
Identifying personal health service needs of populations with limited access to a coordinated system of clinical care.	20	9	2	5	36
Assuring the linkage of people to appropriate personal health services.	18	10	2	6	36
Total Respondents	36				

Identifying Personal Health Services Needs of Population					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Defines personal health service needs for the general population. This includes defining specific preventive, curative and rehabilitative health service needs for the catchment areas within its jurisdiction.	18	12	2	4	36
Assesses the extent to which personal health services are provided.	17	11	3	5	36
Identifies the personal health service needs of populations who may encounter barriers to the receipt of personal health services.	19	9	3	5	36
Total Respondents	36				

Assuring the Linkage of People to Personal Health Services					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Assures the linkage to personal health services, including populations who may encounter barriers to care.	18	8	4	6	36
Provides community outreach and linkage services in a manner that recognizes the diverse needs of unserved and underserved populations.	19	10	3	3	35
Enrolls eligible beneficiaries in state Medicaid or Medical Assistance Programs.	17	10	2	7	36
Coordinates the delivery of personal health and social services with service providers to optimize access.	16	9	4	7	36
Conducts an analysis of age-specific participation in preventive services.	15	10	4	7	36
Total Respondents	36				

Evaluation of Population-based Health Services					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Evaluate population-based health services against established criteria for performance, including the extent to which program goals are achieved for these services.	20	8	4	4	36
Assesses community satisfaction with population-based services and programs through a broad-based process, which includes residents who are representative of the community and groups at increased risk of negative health outcomes.	19	11	2	4	36
Identifies gaps in the provision of population-based health services.	16	11	4	5	36
Uses evaluation findings to modify the strategic and operational plans of LPHS organizations to improve services and programs.	16	13	2	4	35
Total Respondents	36				

Evaluate Effectiveness, Availability and Quality of Personal and population based health services?					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Identifies community organizations or entities that contribute to the delivery of the Essential Public Health Services.	21	9	2	4	36
Evaluates the comprehensiveness of the LPHS activities against established criteria at least every five years and ensures that all organizations within the LPHS contribute to the process.	19	10	2	5	36
Assesses the effectiveness of communication, coordination and linkage among LPHS entities.	18	12	2	4	36
Uses information from the evaluation process to refine existing community health programs, to establish new ones, and to redirect resources as needed to accomplish LPHS goals.	18	10	3	5	36
Total Respondents	36				

Research for New Insights and Innovative Solutions to Health Problems					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
A continuum of innovative solutions to health problems ranging from practical field-based efforts to foster change in public health practice, to more academic efforts to encourage new directions in scientific research.	16	12	1	6	35
Linkages with institutions of higher learning and research.	18	12	1	5	36
Capacity to mount timely epidemiological and health policy analyses and conduct health systems research.	17	12	1	6	36
Total Respondents	36				

Where is your organization located?		
Answer Options	**Response Percent**	**Response Count**
Canandaigua	64.5%	20
Geneva	22.6%	7
Phelps	3.2%	1
Bloomfield	6.5%	2
Victor	6.5%	2
Clifton Springs	22.6%	7
Naples	3.2%	1
Honeoye	3.2%	1
Manchester	3.2%	1
Shortsville	3.2%	1
Other		4
Total Respondents	31	

What population do you serve? ie. elderly, low income, children	
Answer Options	**Response Count**
All	16
Elderly	4
Incarcerated	1
Mental Health/Substance Abuse	2
Youth	2
Government Employees	1
Workforce	1
Migrant/Seasonal Families	1
Town residents	1
Low income	1
Total Respondents	30

What type of organization do you work for? ie. hospital, county dept., non-profit	
Answer Options	**Response Count**
Non-profit	7
Law enforcement	3
County	14
Town	2
Hospital	3
Mental Health Service Provider	1
Healthcare	1
Cancer Services Program	1
Total Respondents	32

What is your position/job title?	
Answer Options	**Response Count**
Director	10
Commissioner	1
Lieutenant, Deputy, Sheriff	3
Nurse	3
Physician	2
Secretary	1
College Faculty	1
Supervisor	4
Coordinator	5
Total Respondents	30

Partnership for Ontario County

Partnership for Success Grant

Young Adult Survey (YAS) Results 2015

Table of Contents

The Big Picture

The use and abuse of Heroin, Opiate and Prescription drugs are on the rise and deeply affecting our community. We are one of ten coalitions to receive the Partnership for Success Grant awarded in May 2015. This grant is a five-year plan in building sustainable strategic prevention framework.

Strategic Prevention Framework

What is our data telling us

The recently collect Young Adult Survey (YAS) created though New York State Office of Alcohol and Substance Abuse Services (OASAS). OASAS created the survey using the online platform SurveyGizmo. The survey was administered both directing participating individuals to a url to complete the survey online or via a paper copy hand delivered. The Coalition Coordinator and coalition members tabled at locations both in Geneva and Canandaigua on multiple occasions. Ontario County contains many areas due accessibility the two most populous areas were employed to administer the survey.

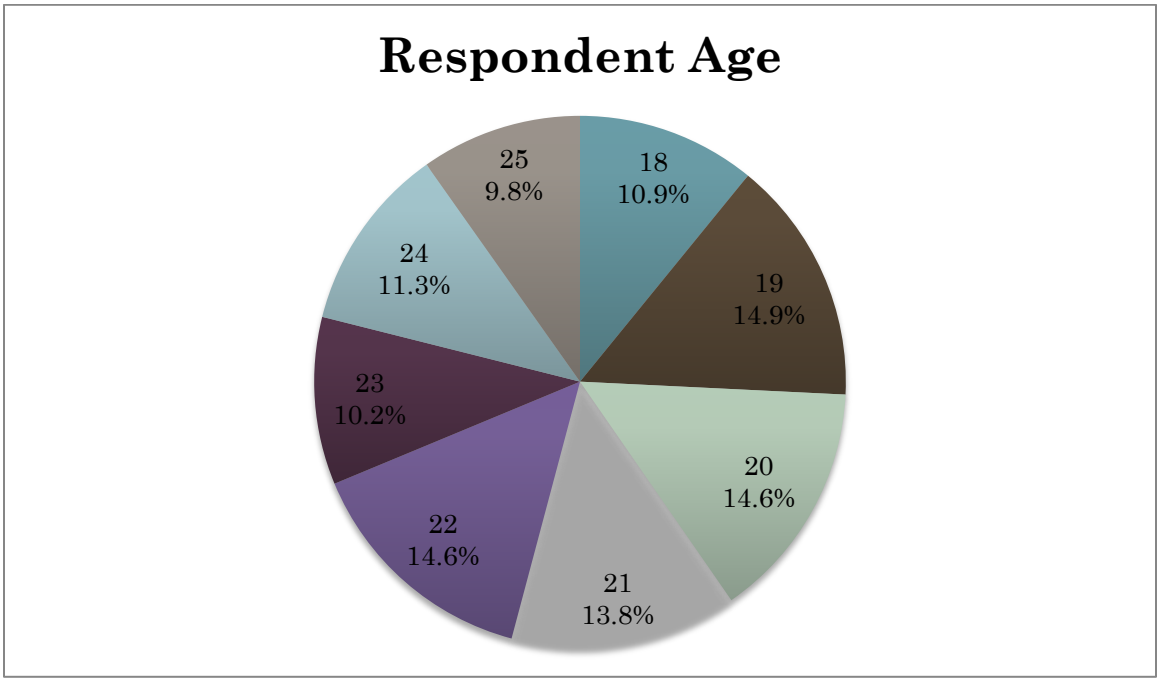
While tabling individuals could fill out paper versions in which someone was present while the respondent selected their answers, these individuals could have also included parental/guardian, peers, law enforcement, coalition members and etc. This is important to note as the climate sway respondent answer to answer what is social desirable/acceptable. The url version administered though SurveyGizmo did not provide respondents with the ability to select multiple answers, however as individuals completed the paper

copy it was noticed that several individuals chose more then one answer, those questions that have multiple selections were enter as a blank. In addition, there were some questions listed on the paper version that did not match with the online version, therefore when those questions were entered into the online survey system there were not entered. There was also a Spanish version of the YAS that would allow the coalition to capture response from those in Ontario County who spoke English as a Second Language, this paper version also had question mismatch, and other input only one answer instead of all that apply just as we had experiences with the paper version.

Moving forward the coalition would like to adopt a form of the YAS to continue to keep pulse of communities perceived activity, use/abuse of prescription drugs and heroin, as well as other vices alcohol, e-cigarettes and etc.

Demographics

The respondents (n=275) identified their sex as 43% male, 56% female, and 1% other. The average age was 21 year old, however respondents age was pretty evenly distributed between the ages of 18-25 (see Chart 1). The majority 89% (n=244) identified as non-Hispanic or Latino. Respondents were asked to check all race/ethnicities that best described them, 89% identified as white, 12% Black or African American, 2% Asian American, 2% Native American or Alaska Native, and less then .5% Native Hawaiian or Pacific Islander.



Status

When asked their employment status 51% of respondents (*n*=271) were *employed for wages (full- or part-time)*, 27% *not employed and looking for work*, 16% *not employed and not looking for work*, 5% *self-employed*, and less than .5% selected that they were *active military*. In addition, 49% of respondents selected *yes, in college or vocational school, full-time*, 42% said that *no* they were not a student, 6% answered *yes, in high school or a GED program*, and 4% in a *college or vocational school, part-time*.

Primary and Secondary Residence

Of the 111 zip codes selected as a primary residence for the individuals that responded (*n*=275) over a third resided in Geneva (14456) or Canandaigua (14424), this was consistent with the locations were individuals send the majority of their time. The main reason for spending time in the other town or city was *attending school* (45%), *working* (21%), *other* (16%), *seeing friends or family members* (14%), *dining or entertainment* (2%), and *shopping* (1%).

Parental Involvement

Respondents were asked to check all that apply and answered that *yes, they have talked with at least one parent about the dangers of tobacco* (27%), *alcohol* (36%), or *drug* (40%) *use*. However, 47% of respondents (n=272) selected ***no*** *when asked during the past 12 months, have you talked to their parent about the dangers of tobacco, alcohol, or drug abuse*.

Perceptions

The majority of individuals responded that they thought that people were at **great risk** of *harming themselves physically and in other ways when they* use heroin (90%). There were also **moderate** to **great risks** associated with *smoking one or more packs of cigarettes per day* (89%), *using prescription pain relievers* (86%), *stimulants* (77%), *tranquilizers* (84%) *not prescribed to them*. When asked how easy the respondents thought it was to obtain prescription pills, heroin, and other drugs individuals selected **very easy** to obtain 81% marijuana and 50% prescription stimulants (see Table 1).

Sixty six percent of individuals associate the risk of using marijuana regularly as having **no** to a **slight risk.** Over 80% of all respondents thought that their parents would **strongly disapprove** of their use of *prescription pain relievers, stimulants, tranquilizers that were taken only for the experience or feeling they caused***.** However over 60% of respondents said that they **strongly disapproved** of *someone their age's use of prescription pain relievers, stimulants, tranquilizers that were taken only for the experience or feeling they caused* In addition, 95% of individuals denoted that they thought their parents would **strongly disapprove**

if they were using *heroin*. This is also reflective of the way the *individuals felt about someone their age using heroin* were 91% selected that they would **strongly disapprove**.

Table 1. Question 11. Young Adult Survey

How easy do you think it is for a person your age in your community to obtain …	Very easy	Somewhat easy	Somewhat difficult	Very difficult
Prescription pain relievers (such as OxyContin, Percocet, Vicodin, or Tylox) that were not prescribed to them? (n=274)	32.8%	42.7%	22.3%	2.2%
Prescription stimulant pills (such as Ritalin, Adderall, or Concerta) that were not prescribed to them? (n=273)	**49.8%**	32.6%	13.6%	4.0%
Prescription tranquilizers or "benzos", (like Xanax, Valium, or Ativan) that were not prescribed to them? (n=271)	29.2%	37.3%	25.8%	7.7%
Marijuana? (n=274)	**81.0%**	13.1%	3.3%	2.6%
Heroin? (n=273)	26.4%	22.0%	29.3%	22.3%
Any other drug? (n=271)	29.2%	36.5%	26.9%	7.4%

Participation

The majority of respondents selected **zero** for the amount of days the *past 30 days* that they have participated in the following activities use of *prescription pain relievers* (94%), *stimulants pills* (87%), *tranquilizers or "benzos"* (93%), or *heroin* (97%) (see Table 2). During the last 30 day, 69% of respondents selected that they had consumed at least **one** drink, 43% answered that they had **five or more drinks on the same occasion** (see Table 2). Forty-one percent of individuals who were *under the age of 21 or jus turned 21 within the past year, and drank alcohol in the past year selected an adult (age 21 or older) who I know but who is not related to me gave it to me or bought it for me* as the top way they got alcohol.

Respondents when asked about use of prescription drugs not prescribed to you selected **have not ever used them without a prescription** 78% pain relievers, 67% stimulants, 68% tranquilizers (n=135). Of the ways that the individuals said that they obtained **pain relievers** not prescribe to them the following were listed as the most predominate ways:

- A friend or relative gave them to me (*n*=66)
- Found at home (*n*=60)
- Found them at a home of a relative or friend (*n*=53)

Of the ways that the individuals said that they obtained **stimulants** not prescribe to them the following were listed as the most predominate ways:

- A friend or relative gave them to me (*n*=42)
- Bought them from a friend or relative (*n*=32)
- From a drug dealer or other stranger (*n*=25)

Of the ways that the individuals said that they obtained **tranquilizers** not prescribe to them the following were listed as the most predominate ways:

- From a drug dealer or other stranger (*n*=20)
- A friend or relative gave them to me (*n*=19)
- Bought them from a friend or relative (*n*=14)

Table 2. Question 15. Young Adult Survey

During the past 30 days, on how many days did you …	Never	At least one day
Smoke part or all of a cigarette? (n=260)	63.1%	37.9%
Use e-cigarettes? (n=260)	83.5%	16.5%
Use marijuana? (n=260)	68.1%	31.9%
Drink one or more drinks of an alcoholic beverage? (n=258)	31.0%	68.9%
Have 5 or more drinks on the same occasion? (n=257)	56.8%	43.2%
Use prescription pain relievers? (n=259)	93.8%	6.2%
Use prescription stimulants? (n=259)	86.5%	13.5%
Use prescription Tranquilizers or "benzos"? (n=259)	93.4%	6.6%
Use heroin? (n=259)	96.9%	3.1%

Individuals responded that *during the last 12 months, they had experienced the following due to you use of alcohol, marijuana, prescription pain relievers or other prescription drugs*.

Table 3. Question 18.

Alcohol	Marijuana	Prescription pain relievers	Other prescription drugs
Had a hangover (95%)	Rode in a vehicle while the driver was under the influence (64%)	Thought I might have a alcohol/drug problem (35%)	Have taken advantage of another sexually (33%)
Got nauseated or vomited (89%)	Driven a vehicle while under the influence (54%)	Tried unsuccessfully to stop using (27%)	Thought I might have a alcohol/drug problem (28%)
Done something I later regretted (83.3%)	Performed poorly at school or work (31%)	Driven a vehicle while under the influence (22%)	Tried unsuccessfully to stop using (27%)

Recommendations

Cancer Indicators - Ontario County

2010-2012

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
All cancers								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	2,035	625.9	550.9	Yes	610.0	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	2,035	487.4	489.2	No	510.8	Yes	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	663	203.9	180.7	Yes	202.4	No	2nd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	663	159.0	158.6	No	165.6	No	1st
Lip, Oral Cavity, and Pharynx Cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	42	12.9	12.1	No	13.5	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	42	9.5	10.5	No	11.0	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	7	2.2*	2.5	No	2.6	No	2nd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	7	1.8*	2.2	No	2.1	No	1st
Colon and rectum cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	131	40.3	46.7	No	49.6	Yes	1st
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	131	31.0	41.4	Yes	41.2	Yes	1st
Crude mortality rate per 100,000	(Table) (Trend) (Map)	48	14.8	16.6	No	17.2	No	1st
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	48	11.1	14.4	No	13.9	No	1st
Lung and bronchus cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	303	93.2	69.6	Yes	83.0	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	303	71.6	61.6	Yes	68.6	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	194	59.7	46.4	Yes	55.9	No	2nd

Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	194	47.4	41.0	No	46.1	No	2nd
Female breast cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	272	163.8	149.1	No	164.4	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	272	123.2	127.2	No	133.2	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	38	22.9	26.3	No	28.1	No	1st
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	38	16.4	20.9	No	20.9	No	1st
Crude late stage incidence rate per 100,000	(Table) (Trend) (Map)	86	51.8	49.2	No	51.4	No	3rd
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	86	39.5	42.7	No	42.7	No	2nd
Cervix uteri cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	11	6.6	8.3	No	7.2	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	11	5.9	7.7	No	6.7	No	1st
Crude mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.7	N/A	2.4	N/A	N/A
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.3	N/A	2.0	N/A	N/A
Ovarian cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	32	19.3	14.9	No	16.2	No	4th
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	32	15.0	12.5	No	12.9	No	4th
Crude mortality rate per 100,000	(Table) (Trend) (Map)	22	13.2	9.5	No	10.4	No	4th
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	22	9.6	7.5	No	7.8	No	4th
Prostate cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	290	182.4	156.7	Yes	167.4	No	4th
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	290	140.3	145.3	No	143.8	No	3rd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	33	20.8	18.3	No	18.6	No	3rd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	33	19.7	20.0	No	18.5	No	3rd
Crude late stage	(Table) (Trend) (Map)	84	52.8	23.3	Yes	25.1	Yes	4th

incidence rate per 100,000								
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	84	38.7	21.2	Yes	21.1	Yes	4th
Melanoma cancer mortality								
Crude mortality rate per 100,000	(Table) (Trend) (Map)	12	3.7	2.5	No	3.3	No	3rd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	12	2.8	2.2	No	2.8	No	2nd
Age-adjusted % of women 18 years and older with Pap smear in past 3 years (2013-2014)	(Table) (Map)	N/A	77.9	74.2	No	76.2	No	2nd
% of women 40 years and older with mammography screening in past 2 years (2013-2014)	(Table) (Map)	N/A	87.3	77.8	Yes	77.4	Yes	1st
% of women, aged 50-74 years, who had a mammogram between October 1, 2011 and December 31, 2013 (2013)	(Table) (Map)	168	70.6	71.7	No	63.4	No	1st

N/A: Data not available

*: Fewer than 10 events in the numerator, therefore the rate is unstable

s: Data do not meet reporting criteria

Cardiovascular Disease Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Cardiovascular disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	969	297.1	272.5	Yes	297.4	No	3rd
Age-adjusted	(Table) (Trend) (Map)	969	216.3	228.0	Yes	228.2	Yes	2nd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	139	100.8	99.0	No	96.8	No	2nd
Pretransport mortality	(Table) (Trend) (Map)	514	157.6	146.7	No	162.3	No	2nd
Cardiovascular disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	4,796	147.0	163.6	Yes	165.9	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	4,796	112.8	143.5	Yes	136.0	Yes	1st
Disease of the heart mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	746	228.7	222.1	No	238.7	No	2nd
Age-adjusted	(Table) (Trend) (Map)	746	165.6	185.4	Yes	182.8	Yes	1st
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	117	84.9	80.6	No	79.9	No	2nd
Pretransport mortality	(Table) (Trend) (Map)	416	127.5	126.3	No	134.7	No	3rd
Disease of the heart hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	3,263	100.0	108.5	Yes	111.9	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	3,263	76.7	94.9	Yes	91.4	Yes	1st
Coronary heart disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	503	154.2	175.1	Yes	171.8	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	503	112.0	146.2	Yes	131.5	Yes	1st
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	92	66.7	65.5	No	60.7	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	293	89.8	103.6	Yes	100.0	No	2nd
Coronary heart disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,188	36.4	40.0	Yes	39.9	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	1,188	28.0	34.8	Yes	32.5	Yes	2nd
Heart attack (Acute Myocardial Infarction) hospitalization rate per 10,000								

Crude	(Table) (Trend) (Map)	689	21.1	17.1	Yes	19.4	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	689	16.2	14.8	Yes	15.7	No	3rd
Heart attack (Acute Myocardial Infarction) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	186	57.0	37.3	Yes	45.0	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	186	42.0	31.3	Yes	34.8	Yes	3rd
Congestive heart failure mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	77	23.6	14.7	Yes	21.6	No	3rd
Age-adjusted	(Table) (Trend) (Map)	77	16.4	12.0	Yes	16.1	No	3rd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	3	2.2*	1.9	No	2.3	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	43	13.2	8.0	Yes	12.4	No	3rd
Congestive heart failure hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	861	26.4	28.8	Yes	29.3	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	861	19.7	24.9	Yes	23.4	Yes	1st
Cerebrovascular disease (stroke) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	171	52.4	30.9	Yes	38.5	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	171	38.8	26.2	Yes	29.8	Yes	4th
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	19	13.8	10.5	No	10.1	No	4th
Pretransport mortality	(Table) (Trend) (Map)	73	22.4	11.5	Yes	17.0	Yes	4th
Cerebrovascular disease (stroke) hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	958	29.4	26.9	Yes	28.9	No	3rd
Age-adjusted	(Table) (Trend) (Map)	958	22.1	23.5	No	23.6	No	3rd
Hypertension hospitalization rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	67	2.6	7.4	Yes	5.0	Yes	1st
Hypertension hospitalization rate per 10,000 (any diagnosis) (aged 18 years and older)	(Table) (Trend) (Map)	13,256	518.0	562.1	Yes	560.8	Yes	2nd
Hypertension emergency department visit rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	539	21.1	32.9	Yes	24.9	Yes	2nd
Hypertension emergency department visit rate per 10,000 (any diagnosis) (aged 18 years and older)	(Table) (Trend) (Map)	19,298	754.1	896.6	Yes	927.7	Yes	2nd
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,272	100.3	117.7	Yes	117.1	Yes	2nd

Age-adjusted	(Table) (Trend) (Map)	3,272	78.1	103.0	Yes	95.3	Yes	1st
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,263	100.0	115.3	Yes	116.8	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	3,263	77.8	101.0	Yes	95.4	Yes	2nd
Age-adjusted % of adults with physician diagnosed angina, heart attack or stroke # (2008-2009)	(Table) (Map)	N/A	7.8	7.6	No	7.2	No	2nd
Age-adjusted % of adults with cholesterol checked in the last 5 years # (2013-2014)	(Table) (Map)	N/A	81.0	83.4	No	83.2	No	3rd
Age-adjusted % of adults ever told they have high blood pressure (2013-2014)	(Table) (Map)	N/A	32.3	27.3	No	27.8	No	4th

N/A: Data not available

*: Fewer than 10 events in the numerator, therefore the rate is unstable

#: Data not available for NYC counties

See technical notes for information about the indicators and data sources.

Child and Adolescent Health Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Childhood mortality rate per 100,000								
Aged 1-4 years	(Table) (Trend) (Map)	1	7.4*	20.0	No	21.1	No	1st
Aged 5-9 years	(Table) (Trend) (Map)	2	10.3*	10.1	No	9.7	No	3rd
Aged 10-14 years	(Table) (Trend) (Map)	4	19.0*	11.9	No	11.8	No	4th
Aged 5-14 years	(Table) (Trend) (Map)	6	14.8*	11.0	No	10.8	No	3rd
Aged 15-19 years	(Table) (Trend) (Map)	9	39.2*	33.4	No	35.2	No	3rd
Asthma hospitalization rate per 10,000								
Aged 0-4 years	(Table) (Trend) (Map)	15	9.1	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	6	1.5*	20.5	Yes	10.4	Yes	1st
Aged 0-17 years	(Table) (Trend) (Map)	23	3.3	26.6	Yes	14.2	Yes	1st
Gastroenteritis hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	6	3.6*	11.3	Yes	8.6	Yes	1st
Otitis media hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	s	s	2.5	N/A	2.0	N/A	N/A
Pneumonia hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	33	20.0	39.4	Yes	31.3	Yes	1st
% of children born in 2010 with a lead screening aged 0-8 months (2010-2013)	(Table) (Map)	144	13.9	3.5	Yes	4.2	Yes	1st
% of children born in 2010 with a lead screening - aged 9-17 months (2010-2013)	(Table) (Trend) (Map)	536	51.7	65.0	Yes	53.5	No	2nd
% of children born in 2010 with a lead screening - aged 18-35 months (2010-2013)	(Table) (Trend) (Map)	513	49.5	65.6	Yes	55.7	Yes	2nd
% of children born in 2010 with at least two lead screenings by 36 months (2010-2013)	(Table) (Trend) (Map)	395	38.1	55.1	Yes	42.1	Yes	2nd
Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) - rate per 1,000 tested children aged <72 months	(Table) (Trend) (Map)	29	6.4	4.9	No	8.8	No	2nd

% of children with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	2,723	74.1	71.6	No	70.3	Yes	1st
% of children aged 0-15 months with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	256	92.1	82.2	No	85.4	No	1st
% of children aged 3-6 years with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	1,065	85.4	83.1	No	81.2	No	1st
% of children aged 12-21 years with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	1,402	65.2	63.8	No	61.9	No	1st

*: Fewer than 10 events in the numerator, therefore the rate is unstable

s: Data do not meet reporting criteria

NOTE: Government sponsored insurance programs include Medicaid and Child Health Plus.

See technical notes for information about the indicators and data sources.

Cirrhosis/Diabetes Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Cirrhosis mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	40	12.3	7.7	Yes	8.7	No	4th
Age-adjusted	(Table) (Trend) (Map)	40	10.4	6.7	Yes	7.2	Yes	4th
Cirrhosis hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	73	2.2	2.8	No	2.5	No	2nd
Age-adjusted	(Table) (Trend) (Map)	73	1.9	2.5	Yes	2.2	No	2nd
Diabetes mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	57	17.5	20.3	No	19.6	No	1st
Age-adjusted	(Table) (Trend) (Map)	57	13.2	17.6	Yes	15.7	Yes	1st
Diabetes hospitalization rate per 10,000 (primary diagnosis)								
Crude	(Table) (Trend) (Map)	418	12.8	19.3	Yes	15.6	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	418	11.7	17.9	Yes	14.2	Yes	1st
Diabetes hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	6,784	208.0	244.1	Yes	225.8	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	6,784	163.8	215.9	Yes	188.6	Yes	1st
Diabetes short-term complications hospitalization rate per 10,000								
Aged 6-17 Years	(Table) (Trend) (Map)	7	1.4*	3.1	Yes	2.9	No	1st
Aged 18 years and older	(Table) (Trend) (Map)	153	6.0	6.3	No	5.8	No	3rd
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,272	100.3	117.7	Yes	117.1	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	3,272	78.1	103.0	Yes	95.3	Yes	1st
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,263	100.0	115.3	Yes	116.8	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	3,263	77.8	101.0	Yes	95.4	Yes	2nd
Age-adjusted % of adults with physician diagnosed diabetes (2013-2014)	(Table) (Map)	N/A	9.1	8.9	No	8.2	No	3rd

N/A: Data not available

*: Fewer than 10 events in the numerator, therefore the rate is unstable

See technical notes for information about the indicators and data sources.

Communicable Disease Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Pneumonia/flu hospitalization rate (aged 65 years and older) per 10,000	(Table) (Trend) (Map)	764	141.8	112.6	Yes	121.9	Yes	3rd
Pertussis incidence rate per 100,000	(Table) (Trend) (Map)	59	18.1	8.8	Yes	12.9	Yes	4th
Mumps incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.2	Yes	0.1	Yes	2nd
Meningococcal incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.2	Yes	0.2	Yes	1st
H. influenza incidence rate per 100,000	(Table) (Trend) (Map)	5	1.5*	1.7	No	1.7	No	2nd
Hepatitis A incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.7	Yes	0.5	Yes	1st
Acute hepatitis B incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.6	Yes	0.5	Yes	1st
Tuberculosis incidence rate per 100,000	(Table) (Trend) (Map)	3	0.9*	4.5	Yes	1.9	No	2nd
E. coli O157 incidence rate per 100,000	(Table) (Trend) (Map)	2	0.6*	0.6	No	0.8	No	2nd
Salmonella incidence rate per 100,000	(Table) (Trend) (Map)	35	10.7	12.9	No	12.2	No	2nd
Shigella incidence rate per 100,000	(Table) (Trend) (Map)	13	4.0	4.8	No	4.4	No	4th
Lyme disease incidence rate per 100,000#	(Table) (Map)	27	8.3	36.6	Yes	57.8	Yes	2nd
% of adults aged 65 years and older with flu shot in last year (2013-2014)	(Table) (Map)	N/A	89.0	72.4	Yes	77.1	Yes	1st
% of adults aged 65 years and older who ever received pneumonia shot (2013-2014)	(Table) (Map)	N/A	84.1	65.1	Yes	70.7	Yes	1st

N/A: Data not available

*: Fewer than 10 events in the numerator, therefore the rate is unstable

#: A sample of investigated positive laboratory results was used to extrapolate the total cases for several counties.

See: Technical Notes

Family Planning/Natality Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
% of births within 24 months of previous pregnancy	(Table) (Trend) (Map)	701	22.7	18.5	Yes	21.0	Yes	3rd
Percentage of births to teens								
Aged 15-17 years	(Table) (Trend) (Map)	43	1.4	1.4	No	1.5	No	2nd
Aged 15-19 years	(Table) (Trend) (Map)	179	5.8	5.2	No	5.7	No	2nd
% of births to women aged 35 years and older	(Table) (Trend) (Map)	442	14.3	20.5	Yes	18.9	Yes	3rd
Fertility rate per 1,000 females								
Total (all births/females aged 15-44 years)	(Table) (Trend) (Map)	3,093	53.3	59.0	Yes	56.8	Yes	2nd
Aged 10-14 years (births to mothers aged 10-14 years/females aged 10-14 years)	(Table) (Trend) (Map)	3	0.3*	0.3	No	0.2	No	3rd
Aged 15-17 years (births to mothers aged 15-17 years/females aged 15-17 years)	(Table) (Trend) (Map)	43	6.5	9.3	Yes	7.9	No	2nd
Aged 15-19 years (births to mothers aged 15-19 years/females aged 15-19 years)	(Table) (Trend) (Map)	179	15.7	19.5	Yes	17.3	No	2nd
Aged 18-19 years (births to mothers aged 18-19 years/females aged 18-19 years)	(Table) (Trend) (Map)	136	28.4	33.5	Yes	29.9	No	2nd
Pregnancy rate per 1,000 (all pregnancies/females aged 15-44 years) #	(Table) (Trend) (Map)	3,811	65.6	87.9	Yes	72.6	Yes	1st
Teen pregnancy rate per 1,000 #								
Aged 10-14 years	(Table) (Trend) (Map)	7	0.7*	0.9	No	0.6	No	3rd
Aged 15-17 years	(Table) (Trend) (Map)	72	10.9	22.4	Yes	14.5	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	275	24.2	41.3	Yes	28.7	Yes	1st
Aged 18-19 years	(Table) (Trend) (Map)	203	42.4	67.2	Yes	47.6	No	2nd

Abortion ratio (induced abortions per 1,000 live births) #								
Aged 15-19 years	(Table) (Trend) (Map)	87	483.3	1,050.3	Yes	624.6	Yes	2nd
All ages	(Table) (Trend) (Map)	614	198.5	412.3	Yes	233.2	Yes	2nd

*: Fewer than 10 events in the numerator, therefore the rate is unstable

#: Data for Essex and Hamilton counties were combined for confidentiality purposes.

See technical notes for information about the indicators and data sources.

HIV/AIDS and Other Sexually Transmitted Infection Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
HIV case rate per 100,000								
Crude	(Table) (Trend) (Map)	8	2.5*	19.1	Yes	7.6	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	8	2.6*	19.1	Yes	7.9	Yes	1st
AIDS case rate per 100,000								
Crude	(Table) (Trend) (Map)	3	0.9*	12.2	Yes	4.4	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	3	1.1*	12.2	Yes	4.5	Yes	1st
AIDS mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	1	0.3*	4.0	Yes	1.4	No	1st
Age-adjusted	(Table) (Trend) (Map)	1	0.3*	3.7	Yes	1.3	Yes	1st
Early syphilis case rate per 100,000	(Table) (Trend) (Map)	1	0.3*	14.4	Yes	3.6	Yes	1st
Gonorrhea case rate per 100,000								
All ages	(Table) (Trend) (Map)	41	12.6	107.7	Yes	61.1	Yes	1st
Aged 15-19 years	(Table) (Trend) (Map)	8	34.8*	368.1	Yes	203.6	Yes	1st
Chlamydia case rate per 100,000 males								
All ages	(Table) (Trend) (Map)	234	146.6	336.0	Yes	203.0	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	57	492.5	1,029.1	Yes	608.6	No	3rd
Aged 20-24 years	(Table) (Trend) (Map)	104	956.1	1,492.7	Yes	1,089.0	No	3rd
Chlamydia case rate per 100,000 females								
All ages	(Table) (Trend) (Map)	639	383.7	672.3	Yes	466.8	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	237	2,082.2	3,595.5	Yes	2,387.5	Yes	3rd
Aged 20-24 years	(Table) (Trend) (Map)	255	2,491.2	3,432.2	Yes	2,743.8	No	2nd
% of sexually active young women aged 16-24 with at least one Chlamydia test in Medicaid program (2013)	(Table) (Trend) (Map)	294	55.3	72.2	Yes	65.2	Yes	3rd
Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)	(Table) (Trend) (Map)	9	1.5*	3.0	Yes	2.1	No	1st

*: Fewer than 10 events in the numerator, therefore the rate is unstable

See technical notes for information about the indicators and data sources.

Injury Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Suicide mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	43	13.2	8.4	Yes	10.1	No	3rd
Age-adjusted	(Table) (Trend) (Map)	43	12.8	8.0	Yes	9.6	Yes	3rd
Aged 15-19 years	(Table) (Trend) (Map)	5	21.8*	5.4	Yes	6.3	No	4th
Self-inflicted injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	213	6.5	5.8	No	6.8	No	2nd
Age-adjusted	(Table) (Trend) (Map)	213	7.0	5.8	Yes	7.0	No	2nd
Aged 15-19 years	(Table) (Trend) (Map)	17	7.4	11.3	No	12.5	Yes	1st
Homicide mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	2	0.6*	3.7	Yes	2.7	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	2	0.8*	3.7	Yes	2.8	Yes	1st
Assault hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	35	1.1	4.1	Yes	2.5	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	35	1.2	4.1	Yes	2.7	Yes	1st
Unintentional injury mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	122	37.4	27.7	Yes	34.0	No	3rd
Age-adjusted	(Table) (Trend) (Map)	122	31.3	25.6	Yes	30.8	No	2nd
Unintentional injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	2,242	68.7	68.3	No	71.6	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	2,242	57.0	62.2	Yes	62.2	Yes	2nd
Aged less than 10 years	(Table) (Trend) (Map)	62	17.3	23.6	Yes	20.4	No	2nd
Aged 10-14 years	(Table) (Trend) (Map)	24	11.4	18.0	Yes	16.0	No	1st
Aged 15-24 years	(Table) (Trend) (Map)	119	27.0	28.7	No	29.7	No	3rd
Aged 25-64 years	(Table) (Trend) (Map)	713	41.6	46.0	Yes	45.8	Yes	2nd
Aged 65 years and older	(Table) (Trend) (Map)	1,324	245.8	252.3	No	262.9	Yes	2nd
Falls hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,372	42.1	39.4	Yes	42.5	No	3rd
Age-adjusted	(Table) (Trend) (Map)	1,372	32.2	34.7	Yes	34.9	Yes	2nd

Aged less than 10 years	(Table) (Trend) (Map)	21	5.9	8.9	No	7.5	No	2nd
Aged 10-14 years	(Table) (Trend) (Map)	7	3.3*	6.1	No	5.0	No	1st
Aged 15-24 years	(Table) (Trend) (Map)	18	4.1	5.7	No	5.2	No	2nd
Aged 25-64 years	(Table) (Trend) (Map)	280	16.3	18.4	Yes	18.4	Yes	2nd
Aged 65-74 years	(Table) (Trend) (Map)	221	74.2	75.2	No	75.2	No	3rd
Aged 75-84 years	(Table) (Trend) (Map)	348	218.4	220.3	No	229.4	No	3rd
Aged 85 years and older	(Table) (Trend) (Map)	477	585.2	560.2	No	590.7	No	3rd
Poisoning hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	357	10.9	11.1	No	11.0	No	2nd
Age-adjusted	(Table) (Trend) (Map)	357	11.0	10.7	No	10.9	No	2nd
Motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	36	11.0	6.3	Yes	8.4	No	3rd
Age-adjusted	(Table) (Trend) (Map)	36	10.1	6.0	Yes	8.0	Yes	3rd
Non-motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	86	26.4	21.4	No	25.6	No	3rd
Age-adjusted	(Table) (Trend) (Map)	86	21.2	19.5	Yes	22.8	Yes	2nd
Traumatic brain injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	226	6.9	10.0	Yes	10.2	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	226	5.9	9.4	Yes	9.2	Yes	1st
Alcohol related motor vehicle injuries and deaths per 100,000	(Table) (Trend) (Map)	155	47.5	33.3	Yes	44.4	No	2nd

*: Fewer than 10 events in the numerator, therefore the rate is unstable

See technical notes for information about the indicators and data sources.

Maternal and Infant Health Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Percentage of births								
% of births to women aged 25 years and older without a high school education	(Table) (Trend) (Map)	149	6.6	14.1	Yes	10.6	Yes	1st
% of births to out-of-wedlock mothers	(Table) (Trend) (Map)	1,202	38.9	40.9	No	39.1	No	2nd
% of births that were first births	(Table) (Trend) (Map)	1,296	41.9	42.6	No	40.8	No	3rd
% of births that were multiple births	(Table) (Trend) (Map)	127	4.1	3.9	No	4.1	No	3rd
% of births with early (1st trimester) prenatal care	(Table) (Trend) (Map)	2,422	81.2	73.1	Yes	75.4	Yes	1st
% of births with late (3rd trimester) or no prenatal care	(Table) (Trend) (Map)	72	2.4	5.6	Yes	4.1	Yes	1st
% of births with adequate prenatal care (Kotelchuck)	(Table) (Trend) (Map)	2,048	74.1	69.1	Yes	70.8	Yes	2nd
WIC indicators								
% of pregnant women in WIC with early (1st trimester) prenatal care (2009-2011)	(Table) (Trend) (Map)	1,240	87.8	86.5	No	86.9	No	3rd
% of pregnant women in WIC who were pre-pregnancy underweight (BMI less than 18.5) (2010-2012)	(Table) (Trend) (Map)	55	3.7	4.7	No	4.1	No	1st
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30) (2010-2012)	(Table) (Trend) (Map)	353	23.8	26.6	Yes	26.3	Yes	2nd
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher) (2010-2012)	(Table) (Trend) (Map)	450	30.4	24.2	Yes	28.0	No	2nd
% of pregnant women in WIC with anemia in 3rd trimester (2009-2011)	(Table) (Map)	91	32.7	37.3	No	36.0	No	2nd

% of pregnant women in WIC with gestational weight gain greater than ideal (2009-2011)	(Table) (Trend) (Map)	714	51.7	41.7	Yes	47.1	Yes	3rd
% of pregnant women in WIC with gestational diabetes (2009-2011)	(Table) (Trend) (Map)	79	5.6	5.5	No	5.8	No	2nd
% of pregnant women in WIC with hypertension during pregnancy (2009-2011)	(Table) (Trend) (Map)	170	12.1	7.1	Yes	9.0	Yes	4th
% of WIC mothers breastfeeding at least 6 months (2010-2012)	(Table) (Trend) (Map)	96	18.6	38.2	Yes	27.7	Yes	3rd
% of infants fed any breast milk in delivery hospital	(Table) (Trend) (Map)	2,274	80.7	83.1	No	77.9	No	2nd
% of infants fed exclusively breast milk in delivery hospital	(Table) (Trend) (Map)	1,848	65.6	40.7	Yes	49.2	Yes	1st
% of births delivered by cesarean section	(Table) (Trend) (Map)	859	27.8	34.1	Yes	35.6	Yes	1st
Mortality rate per 1,000 live births								
Infant (less than 1 year)	(Table) (Trend) (Map)	13	4.2	5.0	No	5.5	No	1st
Neonatal (less than 28 days)	(Table) (Trend) (Map)	10	3.2	3.4	No	3.9	No	2nd
Post-neonatal (1 month to 1 year)	(Table) (Trend) (Map)	3	1.0*	1.5	No	1.6	No	1st
Fetal death (20 weeks gestation or more)	(Table) (Trend) (Map)	19	6.1	6.6	No	4.4	No	3rd
Perinatal (20 weeks gestation to less than 28 days of life)	(Table) (Trend) (Map)	29	9.3	10.0	No	8.3	No	3rd
Perinatal (28 weeks gestation to less than 7 days of life)	(Table) (Trend) (Map)	14	4.5	5.4	No	5.4	No	2nd
Maternal mortality rate per 100,000 live births +	(Table) (Trend) (Map)	0	0.0*	20.0	Yes	19.4	Yes	1st
Low birthweight indicators								
% very low birthweight (less than 1.5 kg) births	(Table) (Trend) (Map)	29	0.9	1.4	Yes	1.4	Yes	1st
% very low birthweight (less than 1.5kg) singleton births	(Table) (Trend) (Map)	21	0.7	1.1	No	1.0	No	1st
% low birthweight (less than 2.5 kg) births	(Table) (Trend) (Map)	215	7.0	8.0	Yes	7.6	No	2nd
% low birthweight (less than 2.5kg) singleton births	(Table) (Trend) (Map)	154	5.2	6.0	Yes	5.6	No	2nd

% of premature births by gestational age								
less than 32 weeks gestation	(Table) (Trend) (Map)	47	1.5	1.8	No	1.8	No	1st
32 - less than 37 weeks gestation	(Table) (Trend) (Map)	275	8.9	9.1	No	9.1	No	3rd
less than 37 weeks gestation	(Table) (Trend) (Map)	322	10.4	10.9	No	10.9	No	3rd
% of births with a 5 minute APGAR less than 6	(Table) (Trend) (Map)	24	0.8	0.6	No	0.7	No	2nd
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	49	165.3	95.0	Yes	123.2	No	4th

*: Fewer than 10 events in the numerator, therefore the rate is unstable

+: Definition of Maternal Mortality has changed. See: Technical Notes

See technical notes for information about the indicators and data sources.

Obesity and Related Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
All students (elementary - PreK, K, 2nd and 4th grades, middle - 7th grade and high school - 10th grade) with weight status information in SWSCRS								
% overweight but not obese (85th-less than 95th percentile) # (2012-2014)	(Table) (Trend) (Map)	854	16.4	N/A	N/A	16.7	N/A	2nd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	769	14.8	N/A	N/A	17.3	N/A	1st
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	1,623	31.2	N/A	N/A	33.9	N/A	1st
Elementary students (PreK, K, 2nd and 4th grades) with weight status information in SWSCRS (2012-2014)								
% overweight but not obese (85th-less than 95th percentile) # (2012-2014)	(Table) (Trend) (Map)	482	15.8	N/A	N/A	16.4	N/A	1st
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	411	13.5	N/A	N/A	16.8	N/A	1st
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	893	29.3	N/A	N/A	33.1	N/A	1st
Middle and high school students (7th and 10th grades) with weight status information in SWSCRS (2012-2014)								
% overweight but not obese (85th-less than 95th percentile) # (2012-2014)	(Table) (Trend) (Map)	358	17.2	N/A	N/A	17.1	N/A	2nd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	344	16.6	N/A	N/A	18.1	N/A	1st
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	702	33.8	N/A	N/A	35.2	N/A	1st
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30)	(Table) (Trend) (Map)	353	23.8	26.6	Yes	26.3	Yes	2nd
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher)	(Table) (Trend) (Map)	450	30.4	24.2	Yes	28.0	No	2nd
% obese (95th percentile or	(Table) (Trend) (Map)	377	16.1	14.3	Yes	15.2	No	3rd

higher) children in WIC (aged 2-4 years) (2010-2012)								
% of children in WIC viewing TV 2 hours or less per day (aged 2-4 years) (2010-2012)	(Table) (Trend) (Map)	1,773	77.8	79.9	No	81.0	No	3rd
% of WIC mothers breastfeeding at least 6 months (2009-2011)	(Table) (Trend) (Map)	96	18.6	38.2	Yes	27.7	Yes	3rd
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2013-2014)	(Table) (Map)	N/A	55.6	60.5	No	62.3	No	1st
Age-adjusted % of adults obese (BMI 30 or higher) (2013-2014)	(Table) (Map)	N/A	26.8	24.6	No	27.4	No	2nd
Age-adjusted % of adults who did not participate in leisure time physical activity in last 30 days (2013-2014)	(Table) (Map)	N/A	27.2	27.1	No	26.2	No	2nd
Age-adjusted % of adults eating 5 or more fruits or vegetables per day (2008-2009)	(Table) (Map)	N/A	32.9	27.1	No	27.7	No	1st
Age-adjusted % of adults with physician diagnosed diabetes (2008-2009)	(Table) (Map)	N/A	9.1	8.9	No	8.2	No	3rd
Age-adjusted % of adults with physician diagnosed angina, heart attack or stroke # (2008-2009)	(Table) (Map)	N/A	7.8	7.6	No	7.2	No	2nd
Age-adjusted mortality rate per 100,000								
Cardiovascular disease mortality	(Table) (Trend) (Map)	969	216.3	228.0	Yes	228.2	Yes	2nd
Cerebrovascular disease (stroke) mortality	(Table) (Trend) (Map)	171	38.8	26.2	Yes	29.8	Yes	4th
Diabetes mortality	(Table) (Trend) (Map)	57	13.2	17.6	Yes	15.7	Yes	1st
Age-adjusted hospitalization rate per 100,000								
Cardiovascular disease hospitalizations	(Table) (Trend) (Map)	4,796	112.8	143.5	Yes	136.0	Yes	1st
Cerebrovascular disease (stroke) hospitalizations	(Table) (Trend) (Map)	958	22.1	23.5	No	23.6	No	3rd
Diabetes hospitalizations (primary diagnosis)	(Table) (Trend) (Map)	418	11.7	17.9	Yes	14.2	Yes	1st

N/A: Data not available

#: Data not available for NYC counties

See technical notes for information about the indicators and data sources.

Occupational Health Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Incidence of malignant mesothelioma per 100,000 persons aged 15 years and older (2010-2012)	(Table) (Trend) (Map)	s	s	1.3	N/A	1.7	N/A	N/A
Hospitalization rate per 100,000 persons aged 15 years and older								
Pneumoconiosis	(Table) (Trend) (Map)	29	10.8	10.3	No	14.0	No	2nd
Asbestosis	(Table) (Trend) (Map)	27	10.0	9.3	No	12.7	No	3rd
Work-related hospitalizations per 100,000 employed persons aged 16 years and older	(Table) (Trend) (Map)	271	172.3	156.5	No	191.1	No	2nd
Elevated blood lead levels (greater than or equal to 10 micrograms per deciliter) per 100,000 employed persons aged 16 years and older	(Table) (Trend) (Map)	32	20.3	22.3	No	22.7	No	3rd
Fatal work-related injuries per 100,000 employed persons aged 16 years and older #	(Table) (Trend) (Map)	s	s	2.3	N/A	2.7	N/A	N/A

s: Data do not meet reporting criteria

#: Data not available for NYC counties

Oral Health Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Oral health survey of 3rd grade children								
% of 3rd grade children with caries experience # (2009-2011)	(Table) (Map)	N/A	48.2	N/A	N/A	45.4	Yes	3rd
% of 3rd grade children with untreated caries # (2009-2011)	(Table) (Map)	N/A	17.4	N/A	N/A	24.0	Yes	1st
% of 3rd grade children with dental sealants # (2009-2011)	(Table) (Map)	N/A	42.8	N/A	N/A	41.9	Yes	2nd
% of 3rd grade children with dental insurance # (2009-2011)	(Table) (Map)	N/A	83.1	N/A	N/A	81.8	Yes	2nd
% of 3rd grade children with at least one dental visit in last year # (2009-2011)	(Table) (Map)	N/A	88.4	N/A	N/A	83.4	Yes	4th
% of 3rd grade children reported taking fluoride tablets regularly # (2009-2011)	(Table) (Map)	N/A	32.1	N/A	N/A	41.9	Yes	1st
Age-adjusted % of adults who had a dentist visit within the past year # (2013-2014)	(Table) (Map)	N/A	77.0	69.8	No	71.5	No	1st
Caries outpatient visit rate per 10,000 (aged 3-5 years)	(Table) (Trend) (Map)	122	113.8	79.2	Yes	93.5	Yes	3rd
Medicaid oral health indicators								
% of Medicaid enrollees with at least one dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	19,578	30.0	31.8	Yes	30.9	Yes	2nd
% of Medicaid enrollees with at least one preventive dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	15,821	24.3	26.6	Yes	25.1	Yes	2nd
% of Medicaid enrollees (aged 2-20 years) who had at least one dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	9,126	41.9	45.0	Yes	44.3	Yes	2nd
% of Medicaid enrollees (aged 2-20 years) with at	(Table) (Trend) (Map)	8,391	38.5	40.1	Yes	39.7	Yes	2nd

least one preventive dental visit within the last year # (2012-2014)								
% of children, aged 2-21 years, with at least one dental visit in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	3,152	62.0	59.2	Yes	61.4	No	2nd
Oral cancer								
Crude incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	42	12.9	12.1	No	13.5	No	2nd
Age-adjusted incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	42	9.5	10.5	No	11.0	No	2nd
Crude mortality rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	7	2.2*	2.5	No	2.6	No	2nd
Age-adjusted mortality rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	7	1.8*	2.2	No	2.1	No	1st
Mortality per 100,000 (aged 45-74 years) (2010-2012)	(Table) (Trend) (Map)	7	5.5*	4.8	No	4.6	No	3rd

N/A: Data not available

*: Fewer than 10 events in the numerator, therefore the rate is unstable

#: Data not available for NYC counties

NOTE: Government sponsored insurance programs include Medicaid and Child Health Plus.

Respiratory Disease Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Chronic lower respiratory disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	189	57.9	35.6	Yes	46.2	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	189	43.2	30.7	Yes	36.8	Yes	2nd
Chronic lower respiratory disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	733	22.5	36.5	Yes	33.0	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	733	17.6	34.1	Yes	28.6	Yes	1st
Asthma hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	119	3.6	18.2	Yes	11.1	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	119	3.4	18.2	Yes	10.9	Yes	1st
Aged 0-4 years	(Table) (Trend) (Map)	15	9.1	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	6	1.5*	20.5	Yes	10.4	Yes	1st
Aged 0-17 years	(Table) (Trend) (Map)	23	3.3	26.6	Yes	14.2	Yes	1st
Aged 5-64 years	(Table) (Trend) (Map)	68	2.7	13.8	Yes	8.5	Yes	1st
Aged 15-24 years	(Table) (Trend) (Map)	9	2.0*	6.8	Yes	3.6	No	1st
Aged 25-44 years	(Table) (Trend) (Map)	13	1.8	8.6	Yes	6.6	Yes	1st
Aged 45-64 years	(Table) (Trend) (Map)	40	4.0	19.7	Yes	11.6	Yes	1st
Aged 65 years or older	(Table) (Trend) (Map)	36	6.7	29.4	Yes	17.7	Yes	1st
Asthma mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	1	0.3*	1.4	No	0.9	No	1st
Age-adjusted	(Table) (Trend) (Map)	1	0.2*	1.3	Yes	0.8	Yes	1st
Age-adjusted % of adults with current asthma (2013-2014)	(Table) (Map)	N/A	19.6	10.1	Yes	10.5	Yes	4th

N/A: Data not available

*: Fewer than 10 events in the numerator, therefore the rate is unstable

See technical notes for information about the indicators and data sources.

Socio-Economic Status and General Health Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Total population (2013)	(Table) (Trend) (Map)	N/A	109,103.0	19,651,127.0	N/A	11,245,290.0	N/A	3rd
% of labor force unemployed (2014)	(Table) (Trend) (Map)	2,865	5.3	6.3	Yes	5.6	Yes	1st
% of population below poverty (2013)	(Table) (Trend) (Map)	N/A	10.0	16.0	Yes	N/A	N/A	1st
% of children aged less than 18 years below poverty (2013)	(Table) (Trend) (Map)	N/A	13.3	22.9	Yes	N/A	N/A	1st
Median household income in US dollars (2013)	(Table) (Trend) (Map)	N/A	57,846.0	57,255.0	N/A	N/A	N/A	1st
% of children aged less than 19 years with health insurance (2013)	(Table) (Trend) (Map)	N/A	96.1	95.9	No	N/A	N/A	2nd
% of adults aged 18-64 years with health insurance (2013)	(Table) (Trend) (Map)	N/A	89.4	84.7	Yes	N/A	N/A	1st
High school drop out rate (2012-2014)	(Table) (Trend) (Map)	216	1.3	3.3	Yes	2.3	Yes	1st
Age-adjusted % of adults who did not receive medical care because of cost # (2013-2014)	(Table) (Map)	N/A	13.8	13.6	No	12.0	No	4th
Age-adjusted % of adults with regular health care provider	(Table) (Map)	N/A	90.4	84.5	No	84.7	No	1st

(2013-2014)								
Age-adjusted % of adults who had poor mental health 14 or more days within the past month (2013-2014)	(Table) (Map)	N/A	12.0	11.1	No	11.8	No	3rd
Birth rate per 1,000 population	(Table) (Trend) (Map)	3,093	9.5	12.2	Yes	10.7	Yes	2nd
Total mortality rate per 100,000	(Table) (Trend) (Map)	3,092	948.0	753.1	Yes	854.1	Yes	3rd
Age-adjusted total mortality rate per 100,000	(Table) (Trend) (Map)	3,092	713.1	644.9	Yes	678.5	Yes	2nd
% premature deaths (aged less than 75 years)	(Table) (Trend) (Map)	1,151	37.2	39.9	Yes	37.5	No	1st
Years of potential life lost per 100,000	(Table) (Trend) (Map)	18,241	6,038.8	5,577.4	Yes	5,839.3	Yes	2nd
Total emergency department visit rate per 10,000	(Table) (Trend) (Map)	116,871	3,583.4	4,086.4	Yes	3,752.5	Yes	2nd
Age-adjusted total emergency department visit rate per 10,000	(Table) (Trend) (Map)	116,871	3,601.7	4,074.7	Yes	3,762.9	Yes	2nd
Total hospitalization rate per 10,000	(Table) (Trend) (Map)	33,496	1,027.0	1,226.2	Yes	1,168.1	Yes	1st
Age-adjusted total hospitalization rate per 10,000	(Table) (Trend) (Map)	33,496	959.5	1,167.3	Yes	1,104.3	Yes	1st

N/A: Data not available

#: Data not available for NYC counties

See technical notes for information about the indicators and data sources.

Tobacco, Alcohol and Other Substance Abuse Indicators - Ontario County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Drug-related hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	351	10.8	23.7	Yes	20.2	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	351	10.9	23.6	Yes	21.0	Yes	1st
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	49	165.3	95.0	Yes	123.2	No	4th
Alcohol related motor vehicle injuries and deaths per 100,000	(Table) (Trend) (Map)	155	47.5	33.3	Yes	44.4	No	2nd
Age-adjusted % of adults who smoke cigarettes (2013-2014)	(Table) (Map)	N/A	20.1	15.9	No	18.0	No	2nd
Age-adjusted % of adults living in homes where smoking is prohibited (2008-2009)	(Table) (Map)	N/A	79.2	80.9	No	79.3	No	2nd
Age-adjusted % of adults who binge drink (2013-2014)	(Table) (Map)	N/A	10.1	17.7	Yes	17.2	Yes	1st

N/A: Data not available

County:	Ontario
Group Name:	Ontario County Community Health Priority Setting
Date and Time:	June 09, 2016 - 2:00 PM

The following is a list of the highest priority issues that are prevalent from the data assessment that was presented during the Priority Setting meeting.

Issues to Rank based on Data Assessment

- Obesity – lifestyle, cultural, physical activity, nutrition, community gardens. (low back pain and diabetes)
- Substance abuse, especially Opioid drugs, births
- Dental health
- Mental health
- Hypertension (tobacco use, cerebrovascular, heart)
- CLRD (COPD)
- Injury Prevention (suicides, UI, Falls – 65+ population)

(Strategies: access to care issues – dental, transportation, health insurance, health disparities, target populations such as seniors, tobacco use)

Charting the Course…

Selecting Issues and Priorities

Public Health

Acknowledgement:

- *From "Setting Health Priorities", Course CB3052, Version 1.0, June 2000: Developed by Rollins School of Public Health, Emory University; Division of Media and Training Services, Public Health Practice Program Office; and Association of Schools of Public Health; materials available online at http://bookstore.phf.org/prod122.htm*
- *Adapted for use in "Building on Community Health Assessments" workshops offered in June 2002 by Cornell University under sub-contract with New York State Department of Health.*

Selecting Issues & Priorities

- Several reliable, proven methods exist for selecting and prioritizing community issues
- The Hanlon method, or BPR system, is a generally accepted, widely recognized tool.

The Hanlon Method

- Research-based and proven method for setting community priorities
- Developed by Rollins School of Public Health, Emory University (Atlanta) and Association of Schools of Public Health
- Is part of "Setting Health Priorities" from the ***Assessment Protocol for Excellence in Public Health*** (APEX-PH) program.

The Hanlon Method…

BPR – Basic Priority Rating System

$$BPR = (A + 2B) \times C$$

A = Size of the problem

B = Seriousness of the problem

C = Effectiveness of the solution

(weighted by PEARL Factors)

Component A – Size of Problem

- Score based on proportion of population directly affected
- Can be considered in terms of entire population, or that of a selected target population
- Issue is assigned a numerical rating, on a scale of 0-10

Component A: Size of Problem

% of Population Affected by Problem	Size "Rating"
25% or more	9 or 10
10% - 24.9%	7 or 8
1% - 9.9%	5 or 6
.1% - .9%	3 or 4
.01% - .09%	1 or 2
< .01%	0

Component B – Seriousness of Problem

- Estimate seriousness of problem using various factors:
  - **Urgency** – emergent nature of the concern; importance to the public
  - **Severity** – premature mortality; years of potential life lost (YPLL)
  - **Economic Loss** – loss to the community; loss to individuals
  - **Involvement of Others** – potential impact on populations or on family groups

Component B: Seriousness of Problem

How Serious Problem is Considered	Seriousness "Rating"
Very Serious	9 or 10
Serious	6, 7 or 8
Moderately Serious	3, 4 or 5
Not Serious	0, 1 or 2

Component C – Effectiveness of Intervention

- The most important component of the BPR System
- Only estimates of effectiveness are generally available
- Establish parameters for acceptable upper and lower limits
- Assess each intervention relative to those limits

Component C: Effectiveness of Intervention

Effectiveness of Available Interventions to Reduce or Eliminate the Problem	Effectiveness "Rating"
Very Effective (80-100%)	9 or 10
Relatively Effective (60-80%)	7 or 8
Effective (40-60%)	5 or 6
Moderately Ineffective (20-40%)	3 or 4
Relatively Ineffective (5-20%)	1 or 2
Almost Entirely Ineffective (Less than 5%)	0

Immunization programs are known to be highly effective…

as compared to the results of smoking cessation programs.

P.E.A.R.L.. Factors

- Follows the rating of the issue by components A, B and C
- Includes discussion process to determine if PEARL factors are changeable
- Weights the results of the mathematical formula (A + 2B) x C

PEARL Factors:

Propriety	(1) Is the problem one that falls within the overall scope of operation, and (2) is it consistent with mission statement?
Economic Feasibility	(1) Does it make economic sense to address the problem? (2) Are there economic consequences as a result of the problem NOT being addressed?
Acceptability	Will the community and/or target population accept a program to address the problem?
Resources	Are, or should, resources be available to address the problem?
Legality	Do current laws allow, favor or prohibit interventions to address the problem?

Here We Go!

- Discuss and score the issues by components A, B and C
- Use the formula to obtain the total score for each
- Factor in the PEARL outcome
- Rank your issues!

Sample Worksheet:

Issue	A (Size)	B (Seriousness)	C (Effectiveness)	Score = (A + 2B) x C	P: E: A: R: L:
Widget Wiggling	6	4	9	(6 + 8) x 9 = 126	P: ✓ ✓ E:✓ ✓ A: ✓ R: ✓ L: ✓
Tiddly-Wink Flipping	4	9	2	(4 + 18) x 2 = 44	P: ✓ E: ✓ ✓ A: ✓ R: ✓ L:
Soup Slurping	8	8	8	(8 + 16) x 8 = 192	P: E: ✓ A: ✓ R: L:

Considerations and Conclusions

- Widget wiggling may not be very widespread or serious, but our interventions would, most likely, be quite effective
- Addressing this problem DOES fall within our scope and is consistent with our mission statement
- It makes economic sense to address the problem, and there will probably be economic consequences if we DON'T
- The community and target population will, most likely, accept our intervention
- There IS grant money available to address the problem
- Public policy supports our intervention.

And…

- The severity of tiddly-wink flipping is great, but only effects a small portion of the population and interventions will, most likely, be relatively ineffective.
- Addressing this problem DOES fall within our scope and is consistent with our mission statement
- It makes economic sense to address the problem, and there will probably be economic consequences if we DON'T
- The community and target population will, most likely, accept our intervention
- There MAY be resources available to address this problem
- There are no laws to support or prohibit our interventions at this time.

And finally…

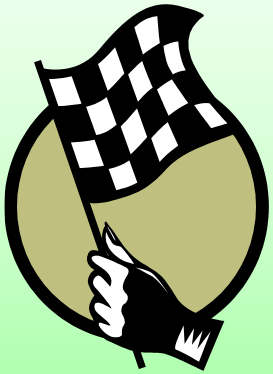
- Soup slurping is evidently quite widespread and a serious problem, and we believe the interventions could be relatively effective
- However, solutions to the problem are NOT within our scope or mission statement
- It makes economic sense to address the problem, but there will probably NOT be economic consequences if we DON'T
- The community and target population will, most likely, accept our intervention
- There is really NO grant money available to address the problem
- There are no laws to support or prohibit our interventions at this time.

Therefore…

Based on the formula, external supportive data, and our discussions:

- It would be prudent to invest resources into providing interventions for the situation with the widgets. There is a good possibility that we could leverage outside grant monies for this effort and demonstrate real success in achieving positive outcomes.
- We MAY want to consider a lesser investment in the tiddly-wink problem. We should investigate interventions that have been successful in other communities that would be reasonable locally. Advocating for public policy change in this arena may be appropriate, as well.
- We should really consider NOT investing in the soup slurping problem at this time. Intervention is NOT within our scope or mission, and it is NOT likely that additional resources will be available to assist with the intervention suggested.

Time to Get Started!



Attachment 11
County: Ontario Please enter issues in same order as on the screen Date: 06/09/2016

Issue	Size (A)	Serious-ness (B)	Effective-ness (C)	Score (A+2B) X C	PEARL
Obesity - lifestyle, cultural, physical activity, nutrition, community gardens (low back pain and diabetes)					P P E E A R L
Substance abuse, especially opioid drugs, births					P P E E A R L
Dental health					P P E E A R L
Mental health					P P E E A R L
Hypertension (tobacco use, cerebrovascular, heart)					P P E E A R L
CLRD (COPD)					P P E E A R L
Injury prevention (suicides, unintentional injury, falls - 65+population)					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L

Size (A)	
% of Population Affected	Size Rating
25% or more	9 or 10
10% - 24.9%	7 or 8
1% - 9.9%	5 or 6
.1% - .9%	3 or 4
.01% - .09%	1 or 2
< .01%	0

Score based on proportion of population directly affected
Can be considered in terms of entire population, or that of a selected target population

Seriousness (B)	
How serious problem is considered	Seriousness Rating
Very Serious	9 or 10
Serious	6, 7 or 8
Moderately Serious	3, 4 or 5
Not Serious	0, 1 or 2

Urgency – emergent nature of the concern; importance to the public.
Severity – premature mortality; years of potential life lost (YPLL).
Economic Loss – loss to the community; loss to individuals.
Involvement of Others – potential impact on populations or on family groups

Effectiveness (C)	
Effectiveness of Available Interventions to Reduce or Eliminate the Problem	Effectiveness Rating
Very Effective (80-100%)	9 or 10
Relatively Effective (60-80%)	7 or 8
Effective (40-60%)	5 or 6
Moderately Ineffective (20-40%)	3 or 4
Relatively Ineffective (5-20%)	1 or 2
Almost Entirely Ineffective (Less than 5%)	0

The most important component of the BPR System
Only estimates of effectiveness are generally available
Establish parameters for acceptable upper and lower limits
Assess each intervention relative to those limits

PEARL Factors – Check if the answer is yes	
Propriety	(1) Is the problem one that falls within the overall scope of operation, and (2) is it consistent with mission statement?
Economic Feasibility	(1) Does it make economic sense to address the problem? (2) Are there economic consequences as a result of the problem NOT being addressed?
Acceptability	Will the community and/or target population accept a program to address the problem?
Resources	Are, or should, resources be available to address the problem?
Legality	Do current laws allow, favor or prohibit interventions to address the problem?

The following are the results from the Priority Setting Meeting conducted on June 9th, 2016 from 2:00pm to 4:00pm.

#	Issue	Hanlon	Pearl
1	Hypertension (Tobacco Use)	159.45	6.40
2	Substance Abuse (Opioid)	150.55	6.15
3	Obesity	129.80	6.10
4	Mental health	128.25	5.55
5	CLRD (COPD)	113.00	5.60
6	Teen Pregnancy	105.65	5.85
7	Injury Prevention	94.00	4.80
8	Dental health	92.20	5.00

Attachment 13

(1)

Meeting: Ontario County/Priority Setting meeting

Date/Time: 06/09/16 at 2:00pm

Public Health
Prevent. Promote. Protect.

Name	Title	County/Agency	Signature
Hillary Anderson	grants specialist	S2AY RHN	Hill
Petree Rai	Coalition Coordinator	Partnership	Petree Rai
Christen Smith	Comm. Out. Coord.	FL Health	Christen Smith
Marsha Foote	Youth Bureau	Ontario	Marsha E Foote
Becky Packard	Secretary	OCPH	Rebecca S Packard
Lilah Crelley	supervising social worker	Ontario Cty Mental Health	Lilah Crelley
Barbara Roszak	DPHS	OCPH	B Roszak
Marsha Teller	Resident	Fusers Ontario	[illegible]
Mary Beer	DPH	OCPH	Mary L Beer
Julia Culver	Wellness Manager	Ontario	Julia Culver
Nancy Finger	CNM	Ontario	Nancy Finger
Kate Ott	PH Ed	OC	Kate Ott
Cathie Horan	regional health planner	FLHSA	Cathie Horan
Mary Gates	Dir of Finance	Ontario	Mary M Yates
Helen Dunlap	CCE	YOSW	Helen Dunlap
Maggie McHugh	Sr. Nutritionist	Wayne/FL Eat Smart NY	MM
Patricia Dhondt-Campbell	Dietitian	OFA	P Dhondt-Campbell
Marie Russo	Director of CR	Thompson Health	[illegible]
Jeanna Savage	PR Marketing	Clifton Springs Hospice	J. Sa
Chris Rich	RN BSN OCPH	Ontario	Chris Rich

Ellie Fradich — Thompson Health Board member — Community — Ellie Fradich; Ellie Fradich

Mitch Gruber — Foodlink

Ontario County Public Health

July 11, 2016

Community Health Assessment & Community Services Plan – Prioritization of Needs

Dear Community Member:

In preparation for the 2017 Community Health Assessment (CHA) and development of the Community Service Plan (CSP), Ontario County Public Health has been working with community partners - UR Thompson Health, Finger Lakes Health, Rochester Regional Health System, Finger Lakes Community Health, Rushville Health Clinic, and others - to assess the health needs of our community. We have reviewed population health data and solicited community input via focus groups.

This process has identified the following health priorities,

- Hypertension
- Substance abuse
- Obesity
- Mental Health

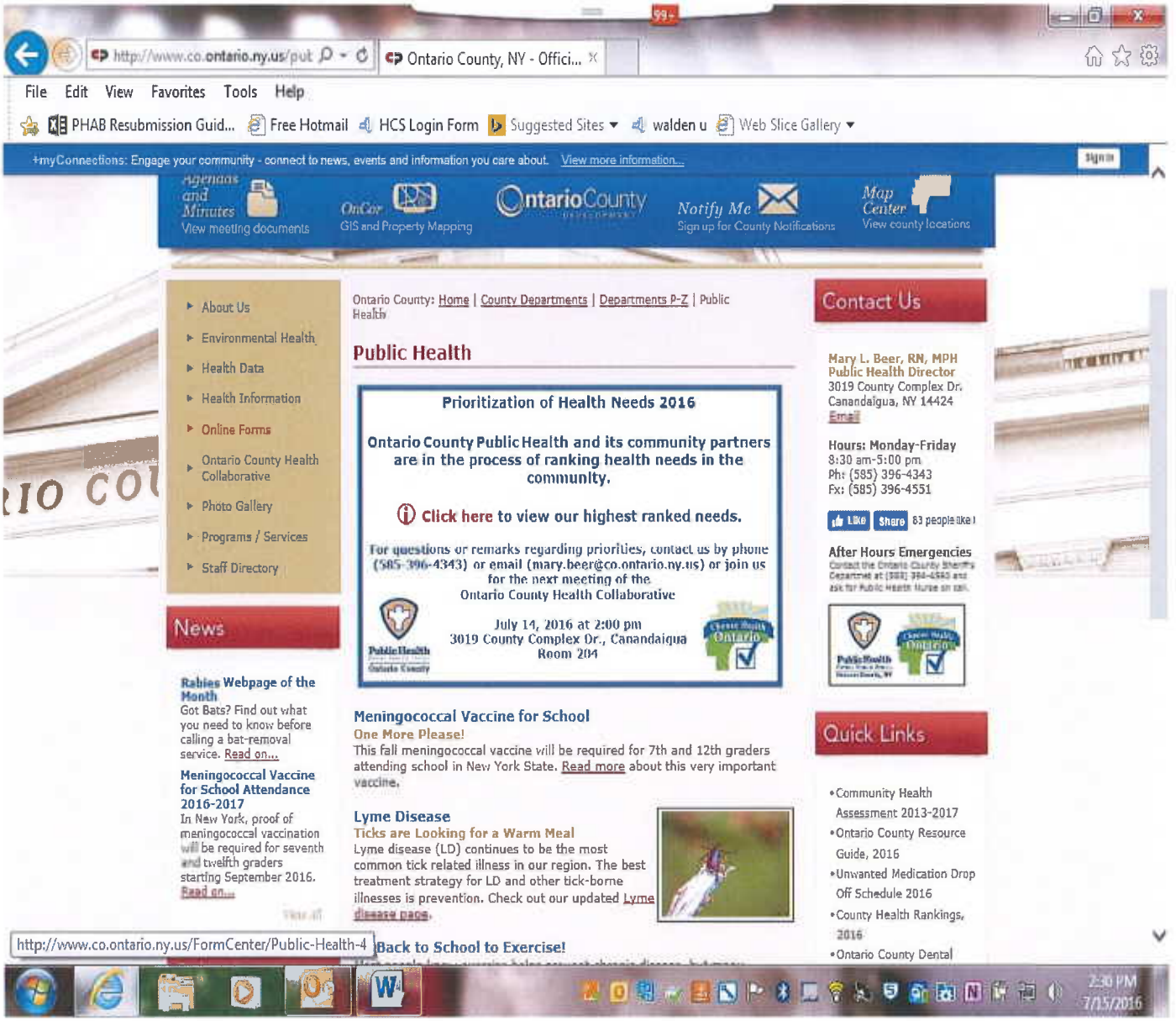
We are now soliciting public comment from residents of Ontario County. Please forward remarks to Mary Beer, Director of Public Health at 585-396-4343 or mary.beer@co.ontario.ny.us. The deadline for public comment is July 25, 2016.

Thank you in advance for your participation in this very important process.

Mary Beer, Ontario County Public Health Director

Director	Address	Telephone	Web Site
Mary L. Beer, RN, MPH Email: Mary.Beer@co.ontario.ny.us	3019 County Complex Drive Canandaigua, NY 14424-9505	585-396-4343 Fax: 585-396-4551	www.ontariocountypublichealth.com

Attachment 15



Ontario County Public Health
Revision Date: 11-23-2016

Priority: Prevent Chronic Diseases					
Focus Area 1: Reduce Obesity in Children and Adults					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 1.0.1 – Targeting Geneva area (low income) and Objective 1.3.2 – Targeting FQHCs for Breastfeeding Friendly Certification (low income population).					
Goal	**Outcome Objectives**	**Interventions/Strategies/Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#1.1 Create community environments that promote and support healthy food and beverage choices and physical activity.	**Overarching Objective 1.0.1:** By December 31, 2018, reduce the percentage of children who are obese: • By 5% from 13.1% (2010) to 12.4% among WIC children (ages 2-4 years). (Data Source: NYS Pediatric and Pregnancy Nutrition Surveillance System [PedNSS]) • By 5% from 17.6% (2010-12) to 16.7% among public school children Statewide reported to the Student Weight Status Category Reporting system. (Data Source: NYS Student Weight Status Category Reporting [SWSCR]) (Prevention Agenda [PA] Tracking Indicator)	Implementation of evidence based programs including "Get Up Fuel Up" and "Food, Fun, and Fitness". Implementation of evidence based programs such as "Rethink Your Drink" (group workshops). www.cdph.ca.gov/programs/cpns/Pages/RethinkYourDrinkCurriculum.aspx Provide food demos, classroom based lessons, afterschool workshops, presentations at school assemblies and fairs, and family and parent events. Assist schools in high need communities in implementing policies, systems, and practices that improve access to nutrition education, healthy foods, and physical activity.	Number of programs/ presentations offered. Number of participants. Pre/post test data from programs. Participant feedback.	FF Thompson (FFT) to provide "Get Up Fuel Up" program. Finger Lakes Health (FLH) to provide "Food, Fun, and Fitness" program. (CHAT) Public Health (PH) and Ontario County Health Collaborative (OCHC) – led by PH, to provide support through promotion and networking. FL Eat Smart NY (Cornell Cooperative Extension (CCE)) to Provide programming, presentations, and support to Geneva.	-FFT: 0.25 FTE/ Grant Dollars= $6,800.00 per year -FLH: 0.03 FTE per year -PH: $14,739.86 (2 years) Additional partners include FL Eat Smart NY/CCE and OCHC.

#1.3 Expand the role of health care health services providers and insurers in obesity preventio n.	**Objective 1.3.2:** By 2018, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by 10% from 43.7% (2010) to 48.1%. Data Source: Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital Records, NYC DOHMH) (Also, see: Focus Area – Maternal and Infant Health)	Recruit hospitals to participate in quality improvement efforts to increase breastfeeding exclusivity at discharge. Encourage and recruit pediatricians, obstetricians and gynecologists, Federally Qualified Health Centers (FQHCs), and other primary care provider practices and clinical offices to become New York State *Breastfeeding Friendly Practices.* Specifically target FQHCs first, to reach low income population (disparity). Encourage and recruit CACFP participating daycare centers/homes to become New York State Breastfeeding Friendly Certified. Identify location for Baby Café.	Number of breastfeeding classes offered. Data from breastfeeding classes. Number of primary care practices that are designated as *NYS Breastfeeding Friendly.* Number of women reached by policies and practices to support breastfeeding. Develop a second Baby Café in the County.	CSH, FFT, and Finger Lakes Community Health (FLCH) to participate in quality improvement efforts to increase breastfeeding exclusivity at discharge. Encourage affiliated practices to become BF Friendly Certified. Finger Lakes Health to provide breastfeeding educational materials at affiliated family doctors. PH, S2AY Rural Health Network (RHN), WIC, Child & Family Resources (CFR), and Finger Lakes Breastfeeding Partnership (FLBP) to provide training, education, and assistance to practices and daycare centers/homes to become BF Friendly Certified.	-CSH: 200 staff hours/year -FFT: 0.02 FTE per year -FLH: 0.01 FTE per year -PH: $13,475.02 (2 years) -WIC: 0.40 FTE per year -FLBP/S2AY RHN: $3,300 (2 years) Additional partners include FLCH and CFR.
	Objective 1.4.2: By December 31, 2018, increase the percentage of employers with supports for breastfeeding at the worksite by 10%. Baseline to be determined. (Data Source: NYSDOH Healthy Heart Program Worksite Survey) (Also, see: Focus Area – Maternal and Infant Health)	Use the *Business Case for Breastfeeding* to encourage employers to implement breastfeeding-friendly policies.	Number of employers that have implemented lactation support programs. Number and demographics of women reached by policies and practices to support breastfeeding.	FFT and CSH to work internally to implement breast feeding worksite strategies. FLH to distribute Business Case for Breastfeeding and CLC referral materials to practices who see new mothers. PH and FLBP/S2AY RHN/Regional Worksite Wellness Committee to reach out to and provide support to worksites in	-FFT: 0.01 FTE per year -CSH: 100 staff hours per year -FLH: 0.01 FTE per year -PH: $6,209.08 (2 years) -FLBP/S2AY RHN/Regional

				adopting breastfeeding friendly policies.	Worksite Wellness Committee: $3,300 (2 years)

Priority: Prevent Chronic Disease					
Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 2.1.3 – Low income population and youth.					
Goal	**Outcome Objectives**	**Interventions/ Strategies/Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#2.1 Prevent initiation of tobacco use by youth and young adults, especially among low socioeconomic status (SES) populations.	**Objective 2.1.3:** By December 31, 2018, increase the number of municipalities that restrict tobacco marketing (including banning store displays, limiting the density of tobacco vendors and their proximity to schools) from zero (2011) to 10. (Data Source: Community Activity Tracking, CAT)	Encourage municipalities to implement policies that protect youth from tobacco marketing in the retail environment, also known as the point-of-sale (POS).	Number of municipalities that restrict tobacco marketing in stores, including: o Tobacco display restrictions o Prohibiting the use of coupons and multi-pack discounts Number of elected officials communicated with about the impact of retail tobacco marketing on youth. Number of public hearings attended. Number of organizations/key community leaders engaged in efforts. Information, advertisements, and media utilized to educate and promote efforts.	Tobacco Action Coalition of the Finger Lakes (TACFL) to provide programming, outreach to elected officials, attendance at public hearings, and education/media outreach. OCHC – led by PH, to provide support through promotion and networking.	Efforts to be led by TACFL. Additional partners include OCHC. -PH: $661.02 (2 years)

Priority: Prevent Chronic Disease					
Focus Area 3: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings.					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☐ Yes ☒ No					
Goal	**Outcome Objectives**	**Interventions/Strategies/ Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#3.2: Promote use of evidence-based care to manage chronic diseases.	**Objective 3.2.4:** By December 31, 2018, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90)	Participation in regional blood pressure registry.	Number of primary care practices that submit patient numbers to registry.	PH, FLH, CSH, FFT, and S2AY RHN to provide assistance in recruiting practices to participate in registry. FLH and FFT to provide Data to Finger Lakes Health Systems Agency (FLHSA) through EHR transfer. FLHSA to provide programming, reports, and technical assistance to practices and partners.	-PH: $1,303.62 (2 years) -FLH: 0.02 FTE per year -CSH: 200 staff hours per year -FFT: 0.02 FTE per year -S2AY RHN: $2,475 (2 years) -FLHSA: in kind
#3.3 Promote culturally relevant chronic disease self-management education.	**Objective 3.3.1:** By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. (Data Source: BRFSS; annual	Promote the use of evidence-based interventions to prevent or manage chronic diseases.	Percent of adults with one or more chronic diseases who have attended a self-management program. Number of providers that use their EHRs to trigger them to speak to their patients about their weight, diet and exercise, and refer them to EBIs.	FFT and Wayne CAP to offer and conduct CDSMP classes. Promote and enroll members in classes. PH to coordinate training for additional CDSMP trainers. OCHC to identify additional partners that can be trained in CDSMP, promote classes and support as a county wide initiative.	-Wayne CAP: $10,211 per year -FFT: 0.04 FTE/ Grant Dollars= $7,000.00 per year -PH: $3,668.04 (2 years) -S2AY RHN/Regional

	measure, beginning 2013)			S2AY RHN / Regional Living Healthy Group to assist with coordination of evidence based programs and provide back-up peer leaders for classes.	Living Healthy Group: $1,886 (2 years) Additional partners include OCHC.

Priority: Promote Mental Health and Prevent Substance Abuse					
Focus Area 2: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☐ Yes ☒ No					
Goal	**Outcome Objectives**	**Interventions/Strategies/ Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#2.1 Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults.	**Objective 2.1.2:** December 31, 2018, reduce the percentage of youth ages 12-17 years reporting the use of non-medical use of painkillers. (Baseline: 5.26% 2009-2010, NSDUH, Target: 4.73%) - Tracking Indicator	Implement strategies to prevent overdose including • Engaging the community and coalition building • Educating prescribers • Reducing supply and diversion control through "lock your meds" campaigns, placing prescription drop boxes, and facilitating drug take back days • Harm reduction through Narcan trainings • Community based prevention education • Continued evaluation of project components/success	Number of members engaged in coalition. Number of schools and student participants. Number of trainings held for prescribers. Number of medication drop boxes placed (and drug take back days). Number of educational trainings, workshops, and forums held (number of participants).	Substance Abuse Prevention Coalition (Partnership for Ontario County) to provide programming, trainings, educational sessions, facilitate coalition, and work with law enforcement to place drop boxes (and drug take back days). PH, CSH, FLH, FFT, Ontario County Mental Health (OCMH), OCHC, and law enforcement to provide support through promotion, networking, and sending staff to trainings (NARCAN, Mental Health First Aid, etc.). CSH houses a psyche unit and providers numerous in/outpatient services for psyche and substance abuse, and case management. PH, FLH, FFT, and CSH to provide NARCAN trainings and/or education.	-PH: $2,372.13 (2 years) -CSH: 6,240 staff hours per year -FLH: 0.01 FTE per year -FFT: 0.01 FTE per year Additional partners include the Substance Abuse Prevention Coalition, OCHC, law enforcement, and OCMH.