Yates County 2019-2021
Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP)

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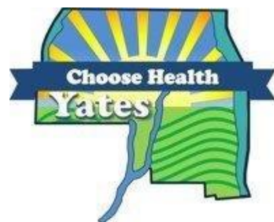


Common Ground Health

Introduction

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

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

During each new cycle, public health and hospital systems turn to key partners and community informants to help determine what the course of action ought to be to improve the population's health. For this particular cycle, eight local health departments and hospitals opted to leverage a local regional health planning agency (Common Ground Health) to conduct a community health assessment for the eight county region.

The following report summarizes Common Ground Health's assessment of local demographics and health data relating to the above priority areas for the eight county region. The report also contains a section devoted toward discussion of Yates County's local health challenges, assets and resources and selected interventions to improve community health. A copy of the complete Regional Community Health Assessment (which includes a chapter on each of the eight counties) can be found on the websites of the S2AY Rural Health Network and Common Ground Health.

www.S2AYnetwork.org

www.CommonGroundHealth.org

Key Findings

Eight County Region

The total population in the region[1] has increased since 1990. Over the next ten years, however, Cornell University's Program on Applied Demographics projects a decrease in the overall population with an increase in the aging (65+) population. The most recent American Community Survey reports that 92% of the region's residents are white non-Hispanic. However, the community is becoming more diverse. Since 1990, there has been a 63% regional growth in the Hispanic population and a 32% regional growth in the African American population. In addition, there is anecdotal evidence to suggest a growing number of Amish and Mennonite settlements within the region due to the affordability of land. In fact, it is estimated that nearly 20% of Yates County's population is Amish or Mennonite.

There are several implications that both the growing diverse and aging population will have an impact on health. Healthcare providers must be equipped to care for patients with more co-morbid conditions than ever (aging population) as well as remaining culturally competent and relatable to diverse patients (growing number of Hispanics, African Americans, Amish and Mennonites). Ensuring a competent workforce is one of public health's ten essential services, which is why it is important to consider the population shift in health planning.

As identified through several avenues of local research, lack of transportation is one of the top barriers in each of the regional counties. Access to a vehicle and/or public transportation is not a privilege that all residents have. For those living on the outskirts of the populous cities and towns, access to transportation is essentially nonexistent unless they have their own vehicle or nearby neighbors, family and friends who have vehicles. This is particularly concerning for the aging population due to their need to attend more medical appointments than the average person, which could necessitate greater transportation planning in rural communities.

In addition, when looking at food insecurity data for the Community Health Assessment, data revealed that a portion of each county's population (average of 5%) are low income and have low access to a supermarket or grocery store. According to *My Health Story 2018* survey data, a supermarket or grocery store is where the majority of residents access their fresh fruits and vegetables (75%). Ensuring access to healthy and affordable food is essential to practicing a healthy lifestyle.

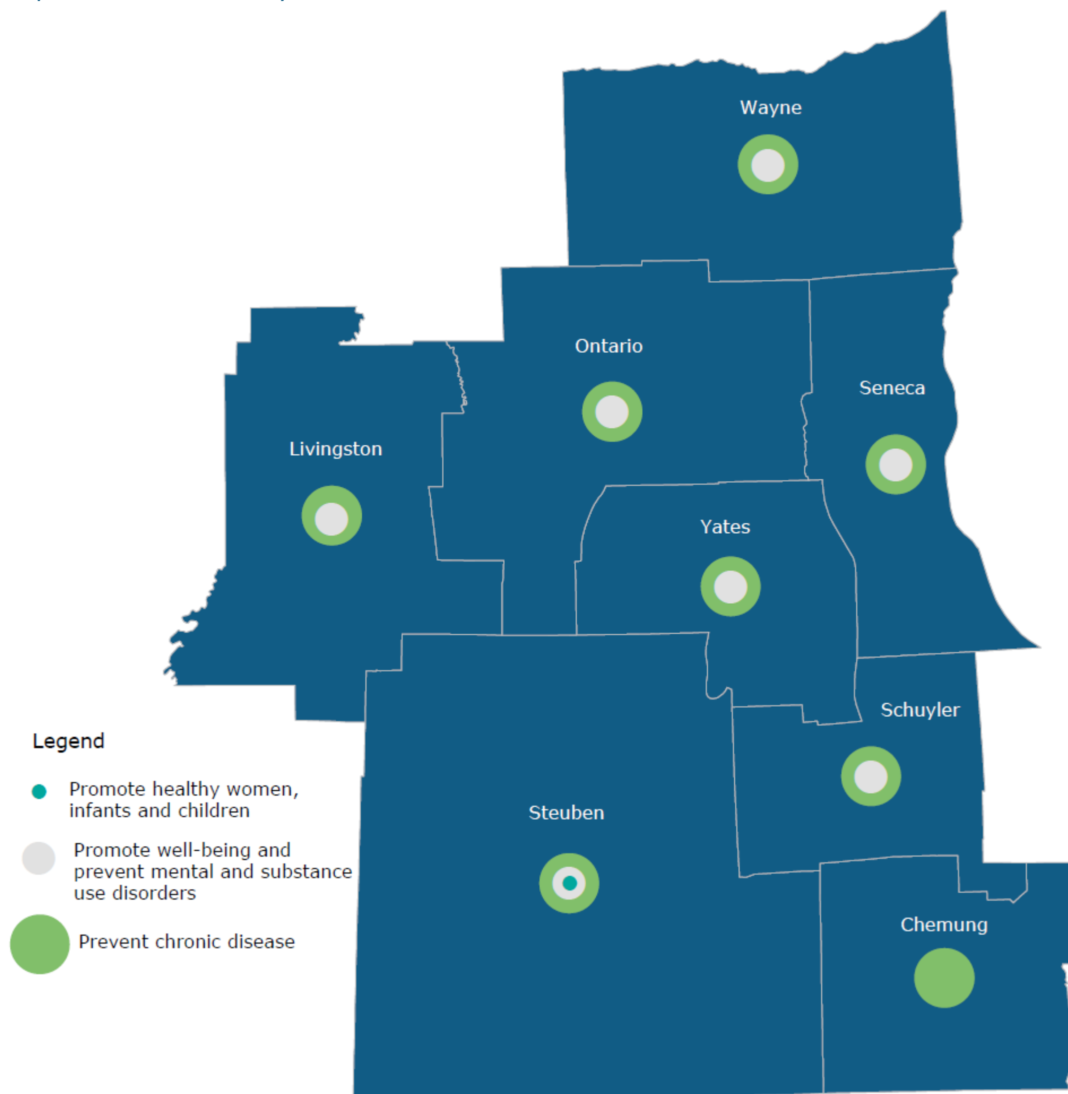
[1] Region includes Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties

Regional Priority Alignment

It is not surprising that each of the eight counties have selected Prevent Chronic Diseases as one of their priority areas to focus on through 2021. It has been an opportunity for improvement for the past several assessment periods and remains one of the top priorities for each department. The most commonly selected focus areas within Prevent Chronic Diseases are (1) chronic disease preventative care management (six out of eight counties), (2) tobacco prevention (five out of eight counties) and (3) healthy eating and food security (four out of eight counties).

Promote Well-Being and Prevent Mental and Substance Use Disorders was the second most popular priority area with seven out of eight counties selecting this area. The particular focus area the majority of counties have selected revolve around prevention (seven out of eight counties).

Map 1: Selected Priority Areas



Interventions

To address the top focus areas, counties have selected the following interventions:

Focus area	Interventions
Chronic disease preventative care and management	**4.1.2** Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting) (selected by three counties) **4.1.3** Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand (selected by four counties)
Tobacco prevention	**3.1.2** Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms (selected by four counties) **3.2.3** Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence based quitting, increasing awareness of available cessation benefits (especially Medicaid) and removing barriers to treatment (selected by three counties) **3.3.1** Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents (selected by four counties)
Healthy eating and food security	**1.0.3** Implement worksite nutrition and physical activity programs designed to improve health behaviors and results (selected by three counties)
Prevent mental and substance use disorders	**2.2.2** Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (selected by five counties) **2.2.4** Build support systems to care for opioid users at risk of an overdose (selected by three counties) **2.2.5** Establish additional permanent safe disposal sites for prescription drugs and organized take-back days (selected by three counties) **2.3.3** Grow resilient communities through education, engagement, activation/mobilization and celebration (selected by three counties) **2.5.4** Identify and support people at risk: Gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-intervention, safe reporting and messaging about suicides (selected by five counties)
*Interventions shown are those where three or more counties selected the intervention. A full list of selected interventions can be found in the county improvement plan found in appendix A.	

Several of the above interventions include communication and small-media. As several counties have selected the same interventions, this poses an opportunity to create unified regional messaging. Residents do not remain within their counties' borders, so this concept will create an opportunity for Finger Lakes residents, regardless of where they live, work and play, to receive consistent messaging on health related topics. In addition, local departments have the opportunity to work together and leverage each other's resources when creating and disseminating these communications and educational materials.

Regional Assets and Resources to be Mobilized

The Finger Lakes region already has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies which promote and facilitate collaboration: the S2AY Rural Health Network and Common Ground Health.

The S2AY Rural Health Network is a partnership of seven local health departments including Chemung, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties. The network's mission is to be a leader in improving health outcomes for rural communities and has a vision of their rural communities being among the healthiest in the nation. Common Ground Health covers the same geographic area as the network, with the addition of Livingston and Monroe Counties. The agency brings together leaders from health care, business, education and other sectors to find common ground on health challenges.

Both of these agencies together help support the work of the Community Health Improvement Plan process and continually strive towards highlighting alignment, leveraging shared resources, and creating opportunities for shared learning. With facilitation and coordination by each agency, local leaders are able to regularly meet to discuss health challenges and issues as a team and devise plans towards improving health of all Finger Lakes residents (via S2AY's Public Health Directors/Board Development Committee and Common Ground Health's quarterly Regional Leadership meeting). Regular discussions regarding challenges in health outcomes and resources take place at both of these meetings.

In addition to the resources available at both S2AY and Common Ground, there are regional workgroups and local nonprofit organizations. The S2AY Rural Health Network has helped in leading four regional workgroups designed to address health needs of residents. The workgroups include:

1. **Farm to Table**
    - *A regional workgroup that addresses increased access to healthy foods, and collaborates with schools, food pantries, farmers, and local communities to get locally grown, fresh produce and raised products to them.*
2. **Healthy Living**
    - *A regional workgroup which enhances skills in our communities through collaboration among partners to prevent and control chronic health conditions with the delivery of evidence-based and evidence-informed interventions.*
3. **Worksite Wellness**
    - *A regional workgroup to help improve worksite wellness at area businesses and organizations for employers and their employees.*

Common Ground Health

4. **Finger Lakes Breastfeeding Partnership**
    - *A regional coalition that focuses on supporting breastfeeding mothers and increasing the number of women who breastfeed in the Finger Lakes region.*

Local nonprofit organizations are additional assets and resources that Finger Lakes region leaders may mobilize when implementing their community health improvement plans. There are several organizations in addition to those already mentioned which cover several counties in their work efforts. For example, the Tobacco Action Coalition of the Finger Lakes (TACFL) and the Southern Tier Tobacco Awareness Coalition (STTAC) may be leveraged in support of tobacco prevention efforts. In relation to healthy eating and food security, local Cornell Cooperative Extension agencies and worksite wellness coordinators (such as at hospitals, school districts, etc.) are potential agencies and departments which may support initiatives outlined in the improvement plans.

In addition to the above referenced regional partners, each county has built and sustained relationships with countless partner organizations that help to support initiatives within their specific county. Within each community health improvement plan, the roles of each agency are identified in relation to the selected priority areas, focus areas and interventions.

Yates County Executive Summary

The Yates County Health Department, in partnership with Finger Lakes Health, has selected the following priority areas and disparity for the 2019-2021 assessment and planning period:

County	Priority Areas & Disparity
Yates County	**Prevent Chronic Disease** 1. Chronic Disease Preventative Care and Management **Promote Well-Being and Prevent Mental and Substance Use Disorders** 2. Prevent mental and substance use disorders **Disparity: low income (chronic disease)**

Selection of the 2019-2021 Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP) priority and disparity areas was a joint process which began in the summer of 2018 with assistance from the S2AY Rural Health Network and Common Ground Health. A variety of partners were engaged throughout the process including the public health departments and hospital staff, Community Based Organizations (CBOs), county legislation, the S2AY Rural Health Network, Common Ground Health, and more. The community at large was engaged throughout the assessment period via a regional health survey in 2018 (*My Health Story 2018*) and focus groups. Partners' role in the assessment were to help inform and select the 2019-2021 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings.

On May 8, 2019, the health department engaged key stakeholders in a prioritization meeting facilitated by the S2AY Rural Health Network. Key partners and community members were invited to attend the prioritization meetings, including all those who attended prior focus groups. Social media platforms, e-mail, news media and newsletters were utilized to help stimulate participation. Common Ground Health provided group members copies of county specific pre-read documents in advance of the meetings. The documents included information on current priority areas and progress made to date, as well as a mix of updated quantitative, qualitative, primary and secondary data on each of the five priority areas outlined in the New York State Prevention Agenda. Data were collected from a variety of different sources including, but not limited, to the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports and primary data collected from the *My Health Story 2018* Survey. A copy of the pre-read document, prioritization meeting materials and meeting attendees are available upon request.

Using the above referenced data and group discussions, participants utilized Hanlon and PEARL methods[2] to rank a list of group identified and pre-populated priorities. To address the previously mentioned priorities and disparities, the health department facilitated a CHIP planning meeting where partners discussed opportunities to leverage existing work. Existing work efforts were then compared

[2] Hanlon and Pearl are methods which rate items based on size and seriousness of the problem as well as effectiveness of interventions.

to intervention options (primarily selected from the New York State Prevention Agenda Refresh Chart) and were informally voted on and selected.

Regionally[3], Yates County aligns with nearby counties on several interventions including the following:

Focus Area	Intervention* & # of Counties Selected
Chronic disease preventative care and management	**4.1.2** Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting) (selected by three counties) **4.1.3** Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand (selected by four counties)
Prevent mental and substance use disorders	**2.2.5** Establish additional permanent safe disposal sites for prescription drugs and organized take-back days (selected by three counties) **2.3.3** Grow resilient communities through education, engagement, activation/mobilization and celebration (selected by three counties) **2.5.4** Identify and support people at risk: Gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-intervention, safe reporting and messaging about suicides (selected by five counties)
*Interventions shown are those where three or more counties selected the intervention. A full list of selected interventions can be found in the county improvement plan found in appendix A.	

Chronic Disease Preventative Care and Management was a widely selected focus area by several regional counties (six out of eight counties). Many counties, including Yates, have selected goals which revolve around increasing cancer screening rates. Leveraging region-wide all of the previously mentioned interventions will aid in reaching as many persons as possible throughout the region. In addition, wide-spread goal alignment exists among promotion of well-being and prevention of mental and substance use disorders. Several counties,

[3] The region includes eight of the nine Finger Lakes counties: Yates, Livingston, Ontario, Yates, Seneca, Steuben, Wayne and Yates Counties.

including Yates, have selected goals that revolve around prevention of suicides and addressing adverse childhood experiences (ACEs). The complete list of Yates County's selected interventions, process measures and partner roles in implementation processes can be found in the county's Community Health Improvement Plan grid (Appendix A).

The CHIP's designated overseeing body, Choose Health Yates, meets on a monthly basis. The group has historically reviewed and updated the Community Health Improvement Plan and will continue to fulfill that role. During meetings, group members will identify any mid-course actions that need to be taken and modify the implementation plan accordingly. Progress will be tracked during meetings via partner report outs and will be recorded in meeting minutes and a CHIP progress chart. Partners and the community will continue to be engaged and apprised of progress via website postings, email notification, presentations, and social media postings.

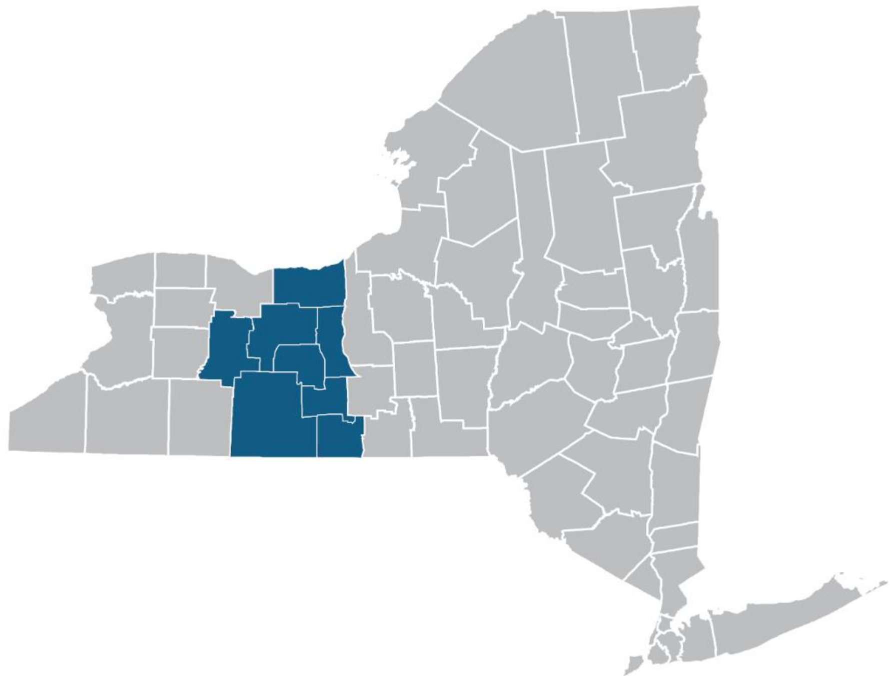
Community Health Assessment

Eight County Region

Total Population

Located in the Western half of New York State between Lake Ontario and the New York/Pennsylvania border, the Finger Lakes region is home to visions of renowned waterfront, hiking trails, thousands of acres of farmland, quaint and lively towns and villages, and active small cities (Map 2). Such a picturesque region brings in thousands of tourists each year. Despite all of its assets, residents experience health related issues and illness just like any other community in New York State. The following assessment will take a closer look at the health of Finger Lakes region residents and selected interventions to improve the health of its residents.

Map 2: The eight-county Finger Lakes region



The total population of the eight county region has increased by approximately 11,000 residents since 1990, with an estimated 528,000 total residents. Projections from Cornell University's Program on Applied Demographics expect a decrease in overall population (13,000 residents) over the next ten years, though there is an expected increase in the aging (65+) population. Implications of the growing aging population ought to be considered when health planning in the region.

According to the most recent American Community Survey data, 92% of the region's residents are white non-Hispanic. Since 1990, there has been a 63% regional growth in the Hispanic population (6,000 to 17,000 residents), and a 32% regional growth in the African American population (13,000 to 19,000 residents).

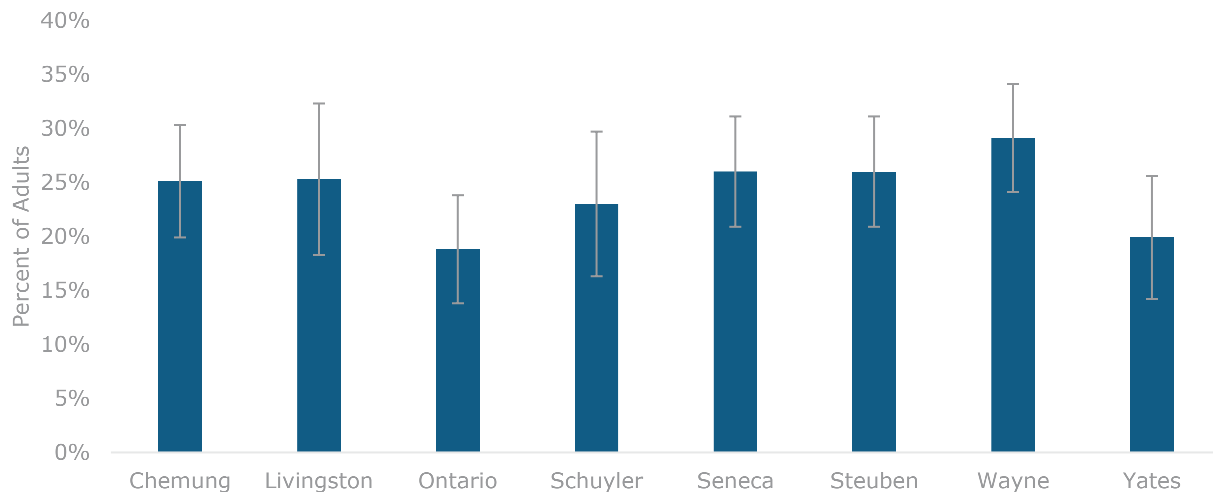
Disability

Those living with any form of disability (physical, activity or daily functioning impairments) are at greater risk for development of chronic conditions including

obesity, heart disease, and diabetes. Creating a built environment that helps eliminate structural barriers and building a culture of inclusion helps to reduce disparities in health outcomes for the disabled. Doing so requires support from a variety of change initiatives such as policy, system and environmental changes.

In the eight county region, an average of 24% of adult residents are living with a disability. The rates range from 19% in Ontario County to 29% in Wayne County (Figure 1).

Figure 1: Percent of adults living with a disability



Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016.

Household Language

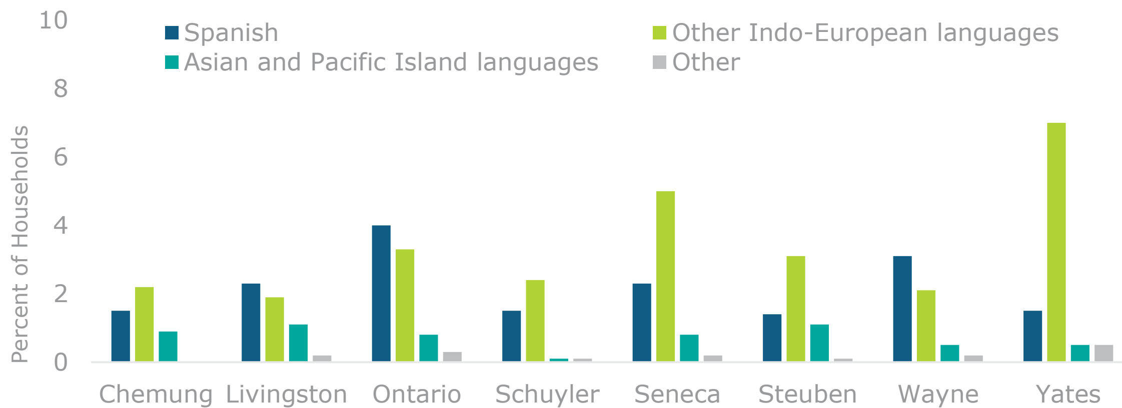
Providers of all types (medical, social service, etc.) should be aware of language and cultural differences when working with patients/clients. Being respectful of a person's cultural practices is important to building a trusting and positive relationship. A system where healthcare providers are culturally competent can help improve patient health outcomes and quality of care. In addition, it can help to eliminate racial and ethnic disparities in outcomes.[4]

The majority of residents in the eight county region speak English. A small percentage speak limited English (<1.5% of total population per county). Other popular languages spoken in the home include Spanish, Asian and Pacific Island

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

languages, and other Indo-European languages. Figure 2 shows the percent of each county's residents who speak a language other than English.

Figure 2: Percent of households speaking a language other than English



Special Populations

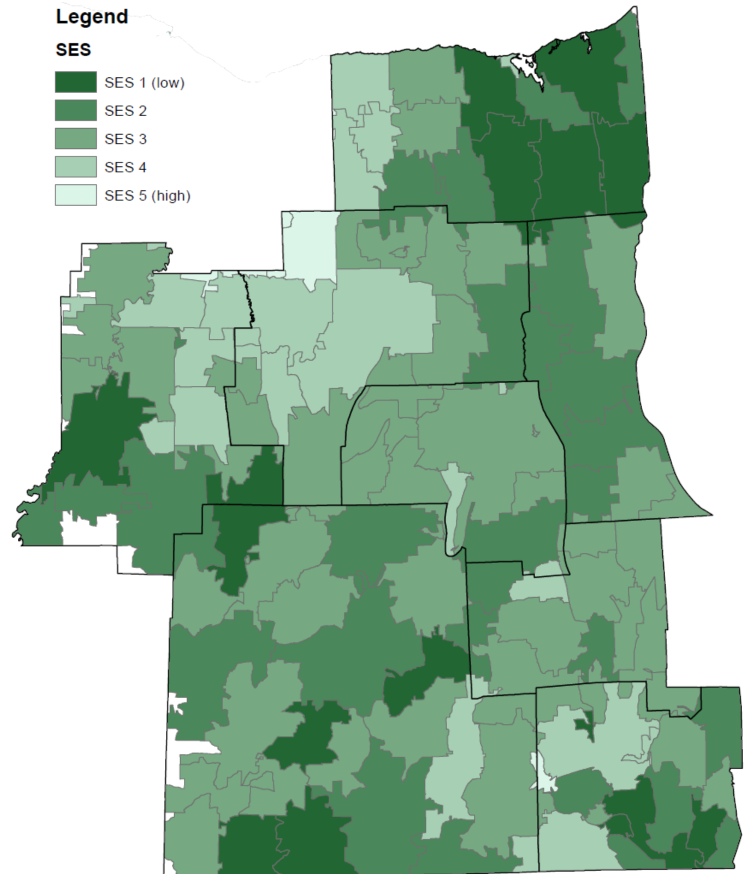
Finding accurate and up-to-date data on Amish and Mennonite populations is a challenge. This population often does not respond to surveys such as those conducted by the U.S. Census Bureau. Local churches, however, collect information on their members and may share this information with public health officials. The Groffdale Conference Mennonites (Old Order Mennonites), for instance, releases an annual map of its congregation. Groffdale Conference Mennonite families span the area between Canandaigua and Seneca Lakes (Yates County), and from Geneva (Ontario County) all the way down to Reading, NY (Schuyler County). The church reports a total of 697 Groffdale Conference Mennonite households throughout Yates, Ontario, Schuyler and Steuben Counties; the majority of whom reside in Yates County.[5] Important to note, however, is that these data do not include the Crystal Valley Mennonite and Horning Order groups- two additional congregations which are found in the region.

Cultural practices of Amish and Mennonites must be considered when reviewing data and planning health initiatives. It is customary in Amish and Mennonite cultures to practice natural and homeopathic medicine as opposed to traditional American medical care (family planning, preventative care visits, dental screenings, vaccinations, etc.). Late entrance into prenatal care and home births are common practices. Children attend school through eighth grade and learn farming and other trades throughout childhood and adolescence, creating potential for unintentional and farm-related injuries. Bikes and buggies (horse drawn) are common forms of transportation and, combined with speeding traffic on rural roads, can create the potential for road accidents. Health decision making is often based on the attitudes,

[5] Source: Groffdale Conference Mennonites in the Finger Lakes Area of New York State, March 2019 Map

beliefs and practices of church leadership. These factors with the anticipated growth in this population create unique challenges for Public Health practitioners.

Map 3: Socioeconomic status in the eight-county Finger Lakes region



Socioeconomic Status

Socioeconomic status[6] affects several areas of a person's life, including their health status. Data have revealed that low-income families are less likely to receive timely preventative services or have an established regular healthcare provider than families with higher incomes. Map 3 reveals the socioeconomic status of the Finger Lakes region based on ZIP code. Note that almost half of Wayne County was found to be in the two lowest socioeconomic statuses in the region, yet pockets of poverty exist throughout the eight counties.

One of the factors influencing socioeconomic status is income, largely driven by employment status. Having a job may afford a person the ability to maintain safe and adequate housing, purchase healthy foods, remain up to date on health visits, and more. The type of position a person holds plays a significant role in the individual's ability to become self-sufficient and is closely related to educational attainment. Higher paid jobs are directly correlated to greater self-sufficiency. The 2017 American Community Survey estimates 28% of regional residents have received a Bachelor's degree or higher, which has increased since 2012 (26%).

Unemployment

Unemployment in the Finger Lakes region has declined since 2012, as shown in the table below (Table 1). The percent of the population who are not in the labor force, however, has increased. It is important to note the percent not in the labor force

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

includes those over the age of 65. With a growing number of elderly in the region, it is not surprising that this rate has increased since 2012.

Table 1: Percent of 16+ by labor force and employment status

	2012		2017	
	% 16+ in Labor force Unemployed	% 16+ Not in Labor Force	% 16+ in Labor force Unemployed	% 16+ Not in Labor Force
Chemung	7	41	5	43
Livingston	6	39	5	43
Ontario	7	34	5	36
Schuyler	6	41	7	41
Seneca	6	44	5	43
Steuben	9	40	7	41
Wayne	8	34	6	37
Yates	6	38	6	40
8 County Region	**7**	**38**	**6**	**40**
NYS	9	35	7	37
Source: US Census Bureau American Community Survey 5-Year Estimates				

Unemployed persons under age 65 do not have access to employer-based subsidized health insurance, and are therefore more likely to be uninsured. Health insurance helps individuals access the care that they need. Like the low socioeconomic status population, the uninsured are less likely to receive or seek preventative care such as health screenings, are less likely to have an established regular healthcare provider and are more likely to use the emergency room for services that could have been rendered in a primary care provider setting. Since the implementation of the Affordable Care Act, the rate of uninsured individuals has decreased 3% over the past six years to 5% of residents. This is a step in the right direction, but health insurance attainment is not the only barrier to health care. Underinsured individuals, or those who have high deductibles that affect their ability to access healthcare, is a real concern. Transportation, lack of provider availability (including difficulty scheduling with providers) and cost (i.e. cost of care, time away from work, and childcare) were repeatedly identified as barriers and top concerns in *My Health Story 2018* survey discussions and are areas that could see improvement.

Health Assessment

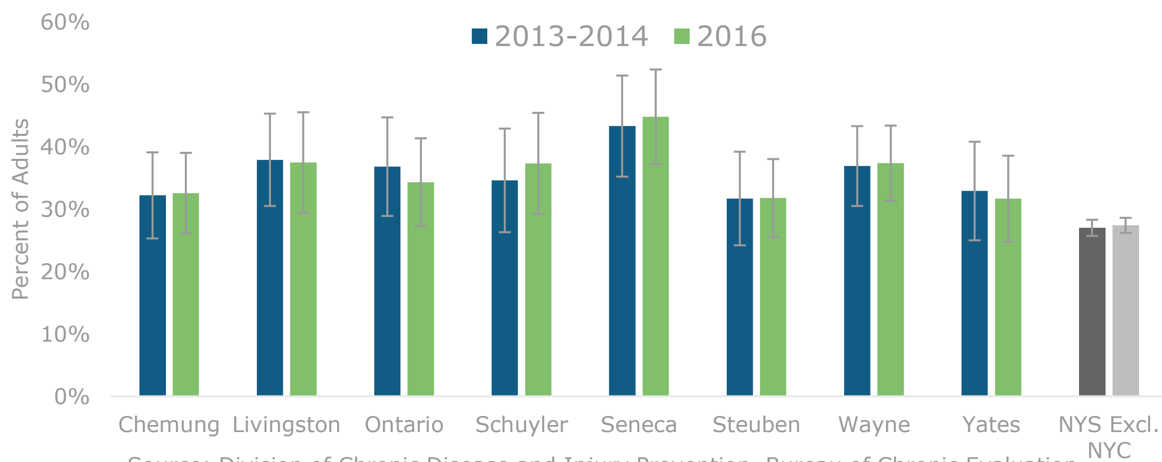
Eight County Region

At priority setting meetings, participants reviewed and discussed data from a variety of sources and five different topic areas recommended by the NYS Prevention Agenda. A summary of regional health challenges by topic area are below.

Prevent Chronic Diseases

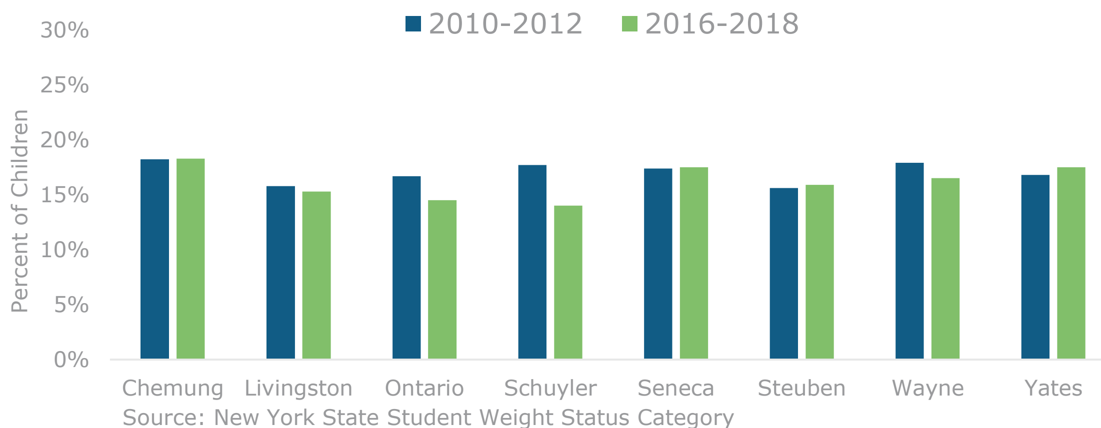
Preventing chronic disease has been a long standing priority area in the eight county region. Efforts have largely been focused on reducing illness, disability and death related to hypertension, tobacco use and second hand smoke, and reducing obesity in children and adults. Rates of obesity in the eight county region have not changed significantly in recent years. Affecting both adults (Figure 3) and children (Figure 4), long-term health complications may lead to development of diabetes, hypertension, and premature mortality due to related conditions. Regionally, respondents to the *My Health Story 2018* survey indicated that better diet, nutrition and physical activity habits would help them manage their weight better.

Figure 3: Percent of adults 18+ who are obese



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

Figure 4: Percent of children who are obese



Obesity disproportionately affects specific populations. Both the low-income population and those living with a disability have higher rates of obesity than the general population, as shown in Table 2 below.

Table 2: Obesity rates among low income and those living with a disability

	Obesity	Obesity among low-income population	Obesity among those living with a disability
Chemung	33%	45%	49%
Livingston	38%	39%	48%
Ontario	34%	41%	51%
Schuyler	37%	54%	46%
Seneca	45%	46%	46%
Steuben	32%	37%	36%
Wayne	37%	42%	45%
Yates	32%	29%	48%
8 County Region	**35%**	**41%**	**45%**
NYS	27%	33%	40%
Source: Behavioral Risk Factor Surveillance System, 2016			

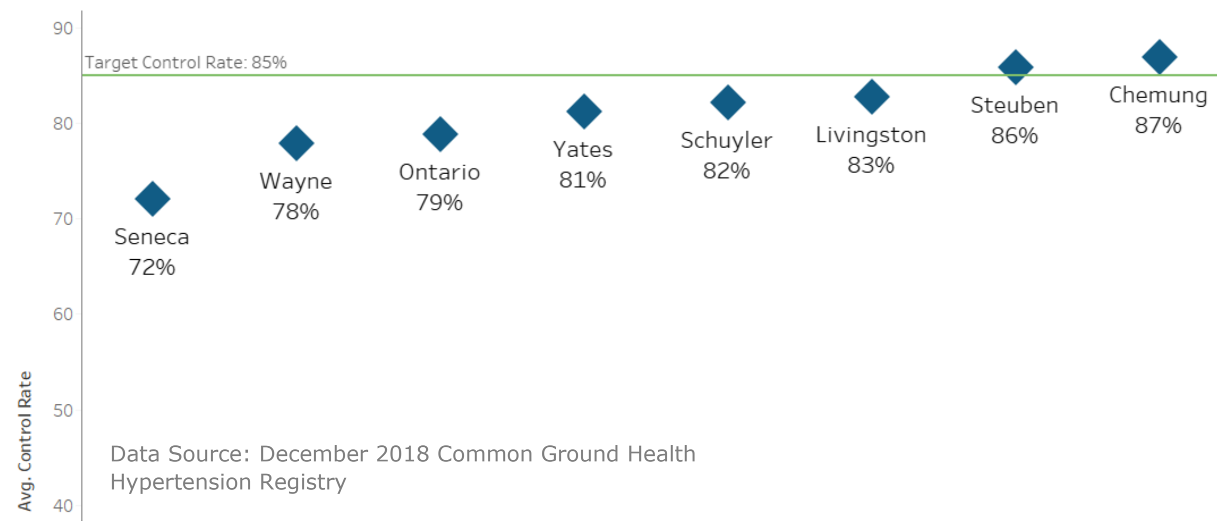
In addition, there are some stark differences in rates of obesity by sex. Data appears to demonstrate that more males are reported obese than females (Table 3).

Table 3: Obesity rates by sex

	Obesity- Males	Obesity- Females
Chemung	34%	30%
Livingston	31%	40%
Ontario	40%	36%
Schuyler	24%	42%
Seneca	56%	35%
Steuben	33%	31%
Wayne	43%	31%
Yates	31%	30%
8 County Region	**37%**	**34%**
Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health		

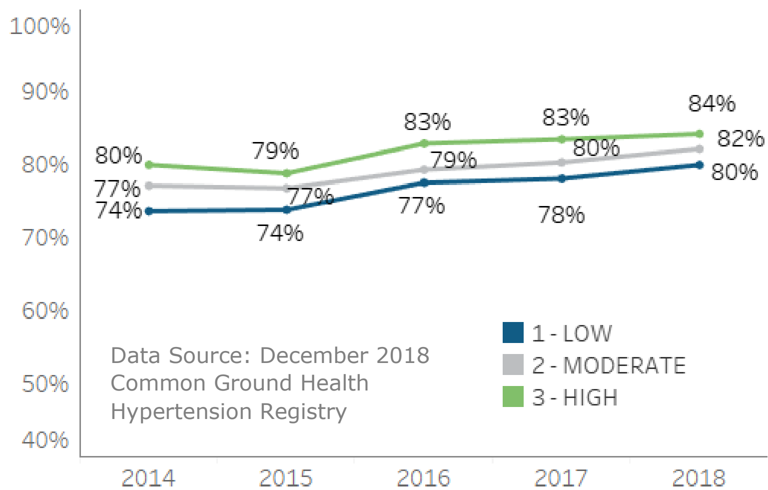
An estimated 36% of adults in the region have been diagnosed with hypertension. However, it is important to note the hypertension control rate for residents. According to the December 2018 High Blood Pressure Registry[7], 79% of hypertensive patients in the region are in control of their blood pressure. Rates of blood pressure control in the eight county region range from 72-87%, with an overall target of 85% control (Figure 5). Maintaining greater control of blood pressure can lead to lower risk of heart attack, stroke and death. Among those who reported they were not managing their high blood pressure well in the *My Health Story 2018* survey, respondents indicated that prescriptions and better diet and nutrition would help them manage their disease better.

Figure 5: Percent of patients with blood pressure controlled, December 2018 high blood pressure registry



[7] The High Blood Pressure Registry is a biannual effort led by Common Ground Health, which collects data on hypertensive patients from healthcare providers in the nine county Finger Lakes region.

Figure 6: Regional control rate by socioeconomic status over time



There is a four percent difference in hypertension control rate by socioeconomic status in the eight county region (Figure 6). Reducing the disparity requires engaging patients in taking control of their blood pressure through various methods including blood pressure medication adherence, being physically active and eating healthy. Low income patients are less able to afford medications and healthy foods and may live in circumstances that limit their ability to exercise regularly. Working with providers to prescribe generic medications covered by insurance, mitigating lack of access to healthy foods and addressing the built environment are important interventions to consider when looking to reduce disparities.

Those diagnosed with hypertension and/or obesity are at greater risk for other diseases such as chronic kidney and cardiovascular (heart) disease. In fact, heart disease is one of the top two leading causes of death in the eight county region (additional data can be found later in report). Cardiovascular disease (CVD), similar to its contributing factors (obesity, hypertension and smoking), impacts different populations at varying levels. Data have revealed that those living with a disability are at greater risk for development of cardiovascular disease (Table 4) and may be a population where health intervention ought to be focused.

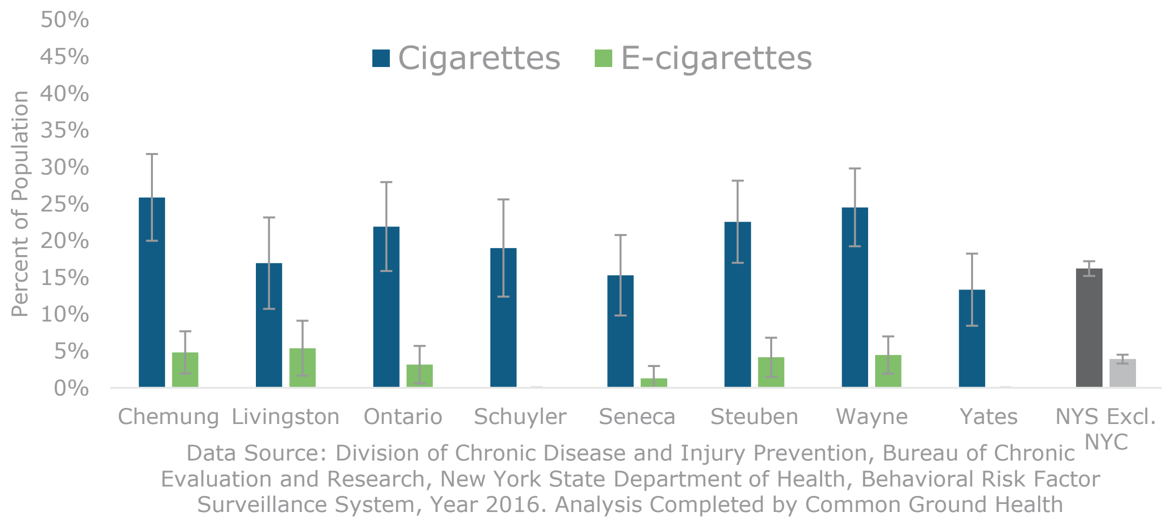
Table 4: Cardiovascular disease by demographic

	CVD	CVD- those living with a disability
Chemung	13%	24%
Livingston	9%	20%
Ontario	8%	16%
Schuyler	9%	27%
Seneca	13%	28%
Steuben	15%	37%
Wayne	10%	21%
Yates	8%	24%
8 County Region	**11%**	**25%**
NYS	9%	21%

Source: Behavioral Risk Factor Surveillance System, 2016

Tobacco use increases the risk of cardiovascular disease. An emerging issue identified in the region is the use of e-cigarettes and other nicotine delivery systems, especially among younger adults. Nicotine is addictive – regardless of the form in which it is consumed - and has deleterious effects on developing fetuses and underdeveloped brains in children and adolescents. Unregulated child-friendly flavorings and colorings found in vaping and other devices damage the oral mucosa and airway. There is much still unknown about the full health effects of electronic cigarettes. A recent NY State DOH Health Alert (August 15, 2019) of severe pulmonary disease among ten NY State residents related to vaping highlights the need for public health professionals to address this issue in the coming years. While data at this time are sparse, the popularity of these devices have grown substantially. It is likely that use is actually much higher than the estimates shown in Figure 7.

Figure 7: Percent of adults (18+) who smoke every day or some days



Smoking rates vary by demographic. For instance, the low-income population has higher rates of smoking than the general population, as shown in Table 5Table 2 below. Additionally, those living with a disability are also estimated to have higher rates than the general population.

Table 5: Smoking rates by demographic

	Current smoker	Current smoker- low income	Current smoker- those living with a disability
Chemung	26%	37%	34%
Livingston	17%	20%	20%
Ontario	22%	45%	29%
Schuyler	19%	32%	32%
Seneca	15%	33%	20%
Steuben	23%	31%	29%
Wayne	25%	32%	30%
Yates	13%	30%	27%
8 County Region	**26%**	**33%**	**28%**
NYS	16%	25%	23%
Source: Behavioral Risk Factor Surveillance System, 2016			

There are also differences in rates of smoking by sex (Table 6). Some counties, such as Chemung, Seneca and Livingston Counties, see a fairly big difference in smoking rates by sex. In these counties, males are upwards of 10% more likely to report smoking than females. Targeting public health interventions towards males and the above mentioned disparate populations may help to reduce disparities.

Table 6: Smoking rates by sex

	Current smoker- Males	Current smoker- Females
Chemung	32%	22%
Livingston	11%	19%
Ontario	22%	21%
Schuyler	18%	21%
Seneca	19%	11%
Steuben	24%	25%
Wayne	27%	21%
Yates	13%	14%
8 County Region	**21%**	**23%**
Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health		

Healthy eating habits are important when it comes to decreasing the burden of obesity in children and adults. According to *My Health Story 2018* survey data, 9% of the region's respondents reported the nearest grocery store is 20+ minutes away, where vehicles are needed to access them. Of note, the majority of residents (75%) indicated they usually get their fruits and vegetables from a supermarket or

grocery store or local grocery store (47%). A substantial amount utilize local farm stands (39%), farmers markets (29%), or grow their own in their garden (22%), with estimates higher in Schuyler, Seneca, Wayne and Yates Counties.

My Health Story 2018 respondents were also asked the biggest challenges or barriers keeping them from eating healthier. Table 7 reveals barriers reported by residents. The biggest barrier to eating healthier, particularly for those with low income, is that healthy food is too expensive. Other issues which rose to the top were not enough time and lack of knowledge of how to shop for and prepare the food.

Table 7: Barriers to eating healthy

	8 County Region				
	under $25K	**$25-50K**	**$50-75K**	**$75K+**	**Overall**
Buying healthy food is too expensive	57%	50%	43%	24%	42%
I don't enjoy the taste of healthy food	3%	6%	11%	8%	7%
I don't have any place nearby to buy healthy food	4%	5%	2%	3%	3%
I don't have the supplies and equipment I'd need to cook healthy food	8%	4%	3%	1%	4%
I don't have the time to shop for, and prepare, healthy food	15%	18%	22%	22%	19%
I don't have the transportation to go shopping for healthy food	11%	1%	0%	0%	3%
I don't know how to cook and prepare healthy meals that taste good	16%	15%	14%	9%	13%
The others in my household don't eat healthy, and we eat together	14%	13%	14%	13%	13%
I really don't have any barriers keeping me from eating healthy food	22%	33%	37%	48%	36%
I don't want or need to eat healthier than I already do	5%	6%	10%	11%	8%

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

In the eight county region, 74% of residents reported engaging in physical activity in the past month (2016 BRFSS). According to *My Health Story 2018* data, the main reason for not engaging in more physical activity is lack of time and feeling too tired to exercise (Table 8). Of note, the low income population reported inability to afford a gym membership as the biggest barrier to being physically active.

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Table 8: Barriers to being physically active

	8 County Region				
	under $25K	$25-50K	$50-75K	$75K+	Overall
I always seem to be too tired to exercise	29%	31%	33%	26%	29%
I can't afford a gym membership or other fitness opportunities	46%	31%	22%	10%	26%
I can't exercise because of a physical limitation or disability	25%	13%	12%	7%	14%
I don't have a safe place nearby to get more exercise	9%	6%	5%	3%	6%
I don't have anyone to exercise with, and don't like to exercise alone	21%	19%	17%	11%	16%
I don't have the time to get more exercise	17%	38%	46%	54%	40%
I don't have transportation to get places where I could get more exercise	11%	2%	1%	0%	3%
My life is too complicated to worry about exercise	6%	10%	9%	7%	8%
I really don't have any barriers keeping me from being physically active	16%	27%	20%	30%	24%
I don't want or need to be more active than I already am	8%	8%	10%	8%	8%

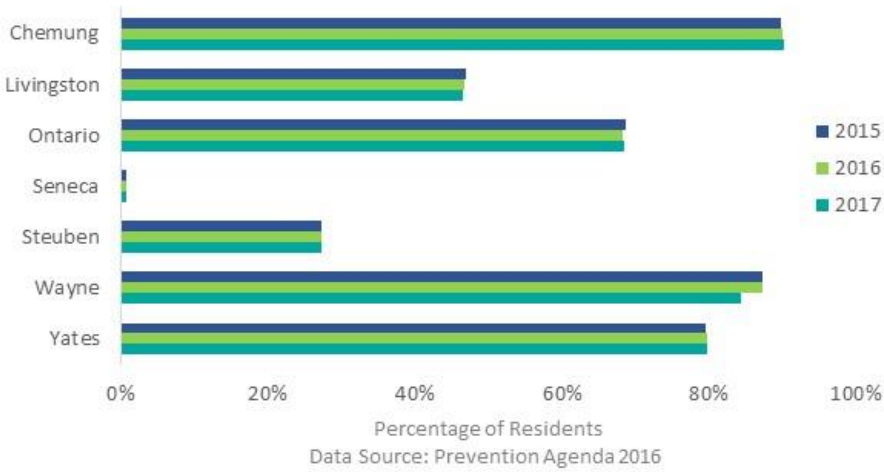
Source: My Health Story *survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.*

Promote a Healthy and Safe Environment

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

Water quality is one way to examine healthy environments and is measured by the percentage of residents served by community water systems with optimally fluoridated water. Fluoridation benefits both children and adults by rebuilding weakened tooth enamel and helping to prevent tooth decay. There are varying levels of optimal water by county as shown in Figure 8. Several counties in the region exceed 50% of residents served by optimally fluoridated water. Progress could be made in Steuben and Seneca Counties.

Figure 8: Percent of residents served by community water systems with optimally fluoridated water



Fewer than 10 events in Schuyler County, therefore the percentage is unstable.

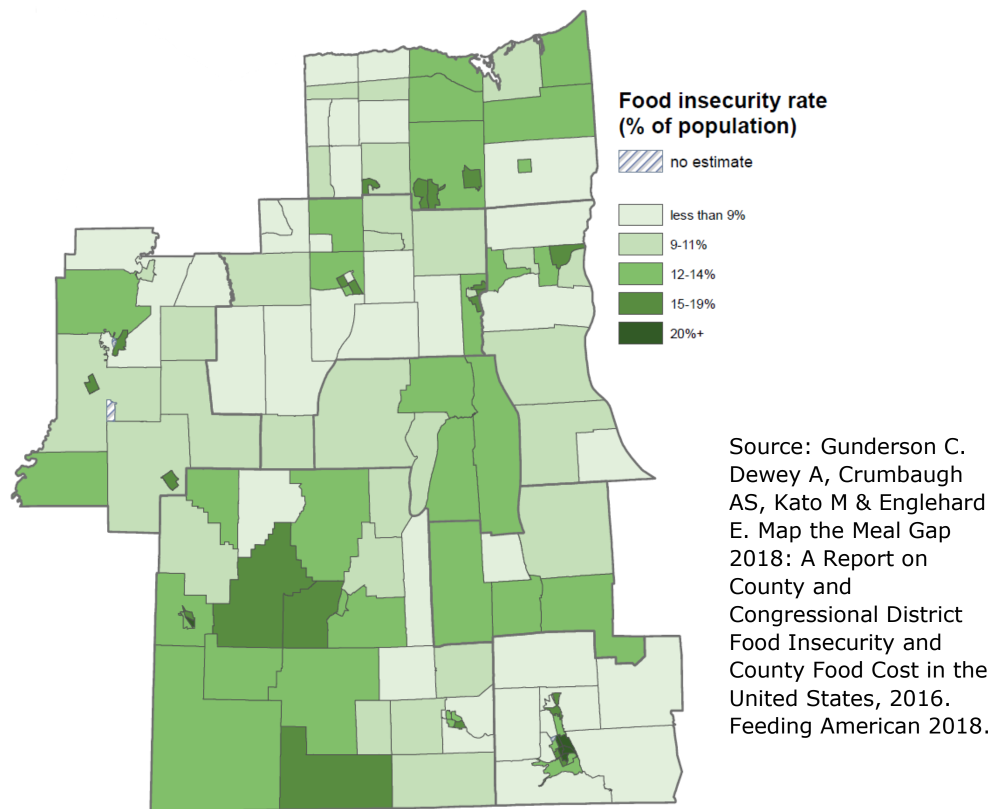
As previously discussed, access to a supermarket or grocery store is important for accessing healthy foods. In the eight county region, 9% of *My Health Story 2018* respondents indicated the nearest grocery or supermarket store was 20+ minutes away. Access to a vehicle may be particularly challenging for the low income population. Figure 9 shows the percent of residents who are low income and have low access to a grocery store.[8] NYS rates are much lower than several counties in the region with the exception of Yates County. Rates of low income and residents with low access have increased since 2010 in Ontario, Schuyler and Seneca Counties.

Figure 9: Percent of population that is low income and has low access to a supermarket or large grocery store

[8] Source: NYS Prevention Agenda Dashboard

Over 22% of the regional population reported experiencing food insecurity in the past 12 months. Of note, 14% of *My Health Story 2018* respondents reported they are always stressed about having enough money to afford healthy food. Map 4 shows the food insecurity rates by census tract in the eight county region. Higher rates of food insecurity are found in previously identified low income areas such as Geneva, Mount Morris and Elmira. In addition, Steuben County has the highest reported food insecurity rate with insecurity noted in communities throughout the county.

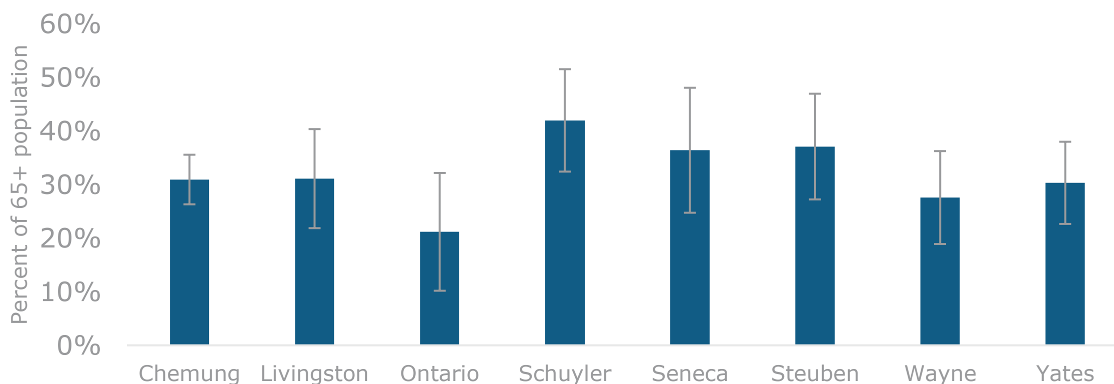
Map 4: Food insecurity rate by census tract



Source: Gunderson C. Dewey A, Crumbaugh AS, Kato M & Englehard E. Map the Meal Gap 2018: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States, 2016. Feeding American 2018.

Falls in the 65+ population are another indicator of environmental health and safety. In the eight county region, an average of 30% of residents aged 65+ have fallen in the past year though the rate varies by county (Figure 10). The results of falls in the elderly can be devastating. These may include death, decreased life expectancy, chronic pain, loss of mobility and resultant loss of independence. Several counties in the region have partnered with their Office for the Aging to offer evidence-based classes on fall prevention.

Figure 10: Reported falls in 65+ population



Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, NYSDOH, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health

Promote Healthy Women, Infants and Children

New York State collects several pieces of information on births including the number of premature and low birth weight babies. A baby born prematurely (<37 weeks gestation) is at risk for several health complications including jaundice, anemia, apnea, and more. The earlier a baby is born in pregnancy, the more likely it is that the baby will need to spend time in the neonatal intensive care unit (NICU). Long-term health complications associated with premature birth include intellectual and developmental delays, problems with communicating, getting along with others, and even taking care of him or herself. Neurological disorders, behavioral problems, and asthma may also occur.[9]

Premature birth is the primary cause of low birth weight. A child born at a low birth weight may suffer a range of health complications at birth. Some of the common issues for a low birth weight newborn include low oxygen levels, breathing complications due to immature lungs, difficulty feeding and gaining weight, neurological and gastrointestinal problems, infection, and more.[10] In the eight county region, rates of premature birth (9.5%) and low birth weight (6.8%) have remained below the NYS excluding NYC average (10.6% and 7.6%).

The rate of infant mortality (deaths that occurred less than 1 year after birth) has increased slightly over the past several years (Figure 11). Causes of infant mortality may be related to prematurity and related conditions, infections, obstetric conditions, sudden unexpected infant death and external causes such as unsafe sleep practices.

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

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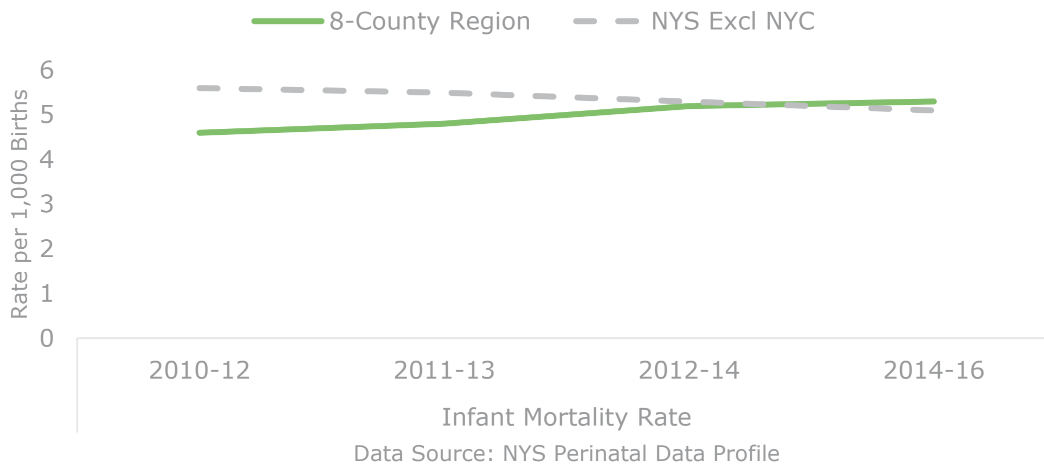
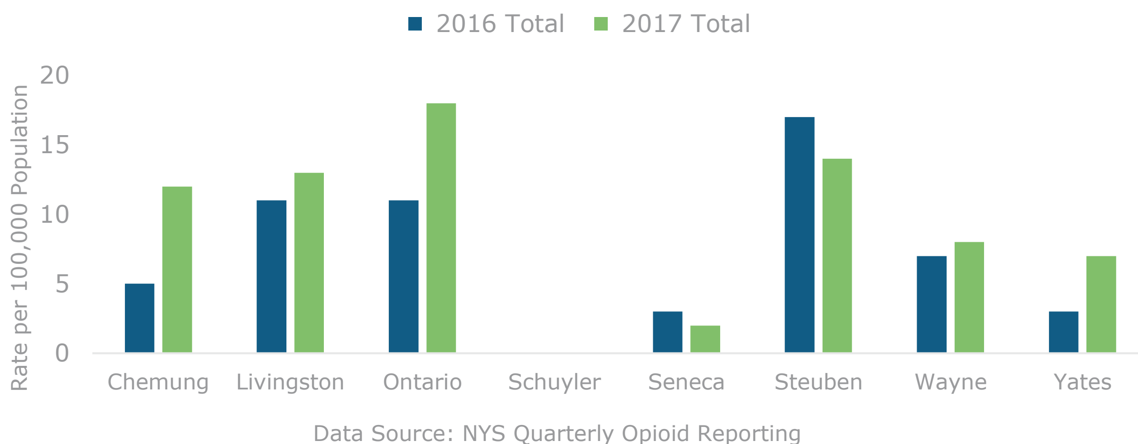
Figure 11: Rate of Infant Mortality



Promote Well-Being and Prevent Mental and Substance Use Disorders

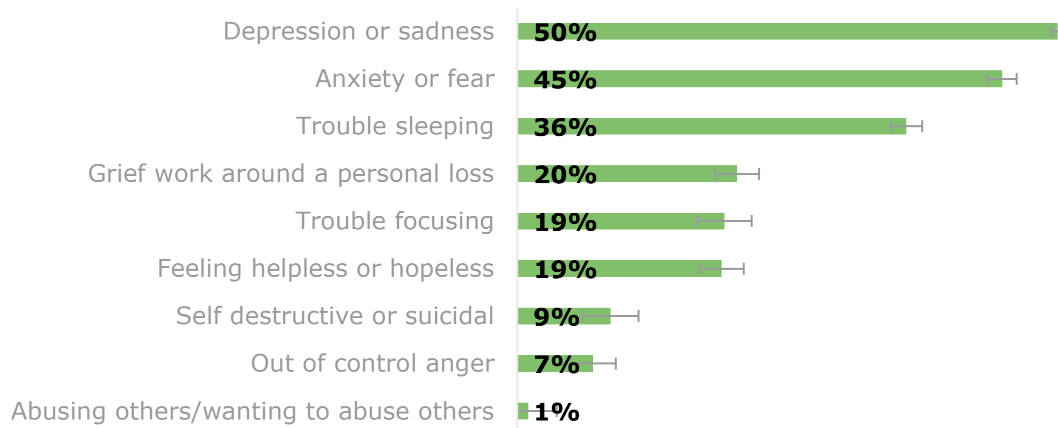
Data from New York State Opioid Reporting indicate a 23% increase in overdose deaths from 2016 (N=57) to 2017 (N= 74) (Figure 12). Notably, Seneca and Steuben Counties were the only counties that saw a decrease in deaths from 2016. The largest increases in deaths were in Chemung and Ontario Counties. No data are available for Schuyler County.

Figure 12: All opioid overdose death rates per 100,000 population



According to survey data from *My Health Story 2018*, half of the respondents indicated they have dealt with anxiety, fear, depression or sadness (Figure 13). For those who have dealt with mental or emotional health issues, 75% of survey respondents said they got the help they needed. The most commonly reported support was from doctors, counselors and other mental health professionals followed by support from friends and family.

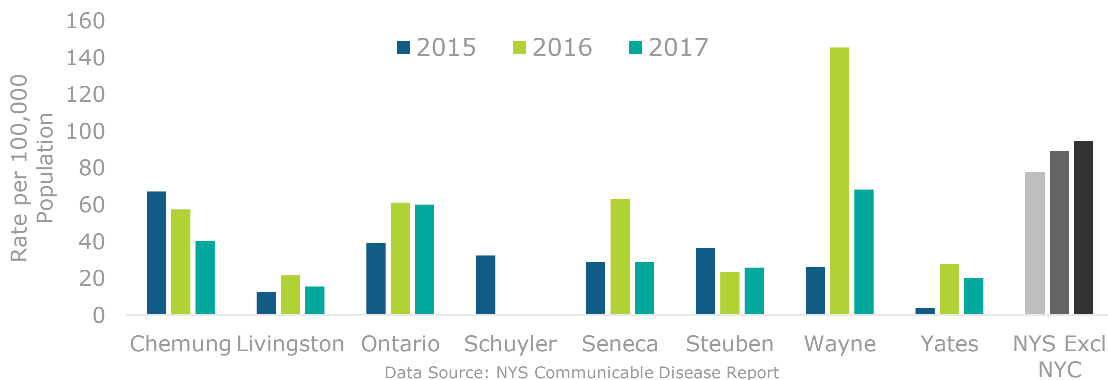
Figure 13: Percent of adults who have personally dealt with each of the following mental or emotional health issues



Prevent Communicable Diseases

Sexually transmitted diseases are a prominent issue in New York State, including all eight counties in the region. Historical data are available on the incidence of chlamydia and gonorrhea. In comparison to NYS excluding NYC, all eight counties have lower rates of chlamydia in recent years. Typically, rates of gonorrhea in the region are lower than NYS excluding NYC. However, rates spiked in 2016 for several counties in the region including Ontario, Seneca and Wayne which could be due to an outbreak or increased testing and diagnosis. (Figure 14).

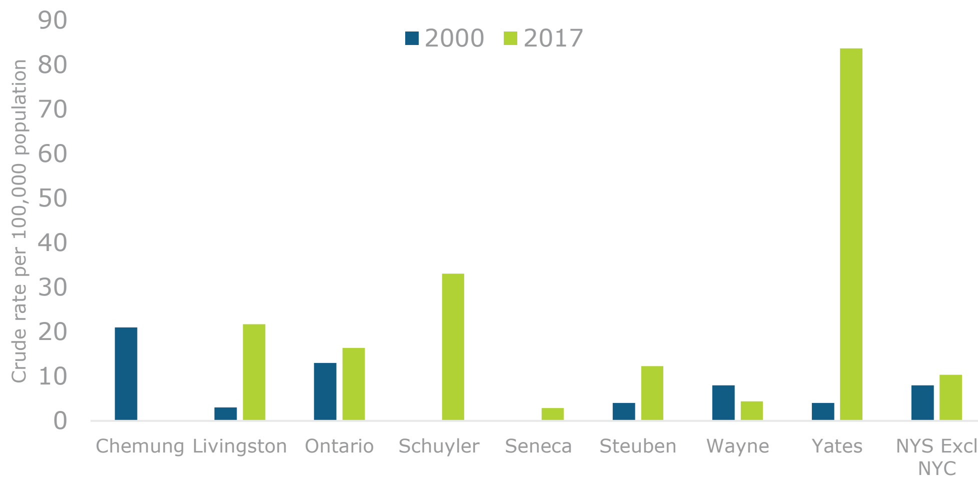
Figure 14: Rate of gonorrhea per 100,000



Vaccine preventable diseases are on the rise in the region. An average of 10 patients were diagnosed with vaccine preventable diseases in 2017 in the region with a range by county from 0 to 21 patients. In 2000, the average was 6 patients with a range of 0 to 18 by county. With the increased number of those who choose not to vaccinate, it is important now more than ever to increase education and awareness of the benefits of vaccinating children. Herd immunity occurs when the

majority of the population is immune to infection or disease. It helps to reduce risk of disease for those who are unable to be vaccinated due to age, health conditions or other factors. The rise of those who choose not to vaccinate negatively impacts the effectiveness of herd immunity. The majority of vaccine preventable diseases in the region are cases of pertussis (Figure 15).

Figure 15: Rate of vaccine preventable diseases



Source: NYS Communicable Disease Reporting, 2000 and 2017

Mortality

Each of the behavioral, environmental and socioeconomic factors previously discussed have a collective impact on one major health outcome: life expectancy. Community members who engage in risky health behaviors, are socioeconomically disadvantaged, and live in environments that negatively impact health have a greater risk of dying sooner than someone on the opposite spectrum. Within our region, we find pockets of lower life expectancy (under 75 years) in communities such Lyons, Geneva, Mount Morris, Bath and portions of Elmira (Map 5). Of note, a death which occurs before age 75 is considered premature. Therefore, communities with life expectancies under 75 years (highlighted in dark blue below) are considered as communities experiencing health inequities.

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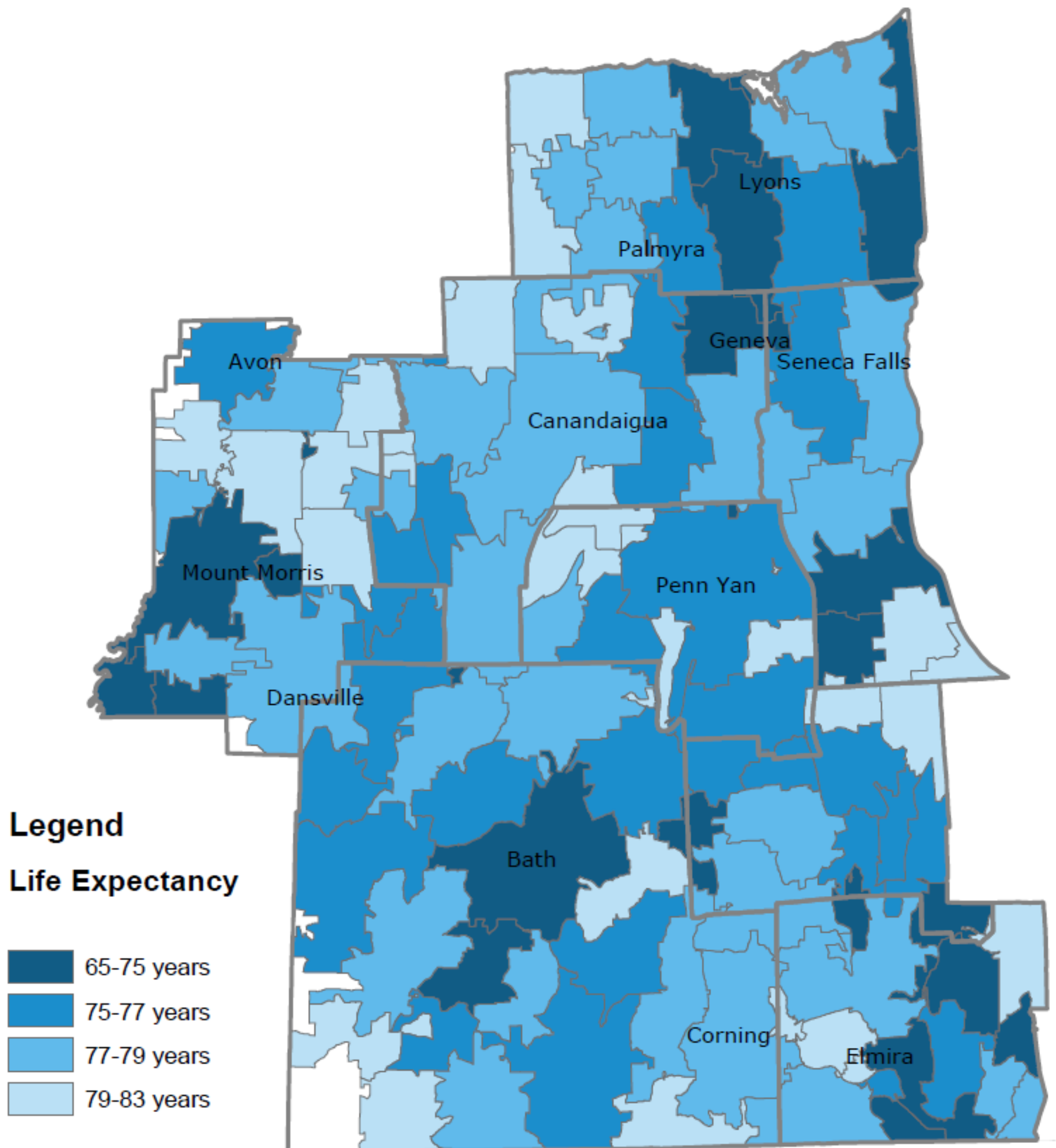
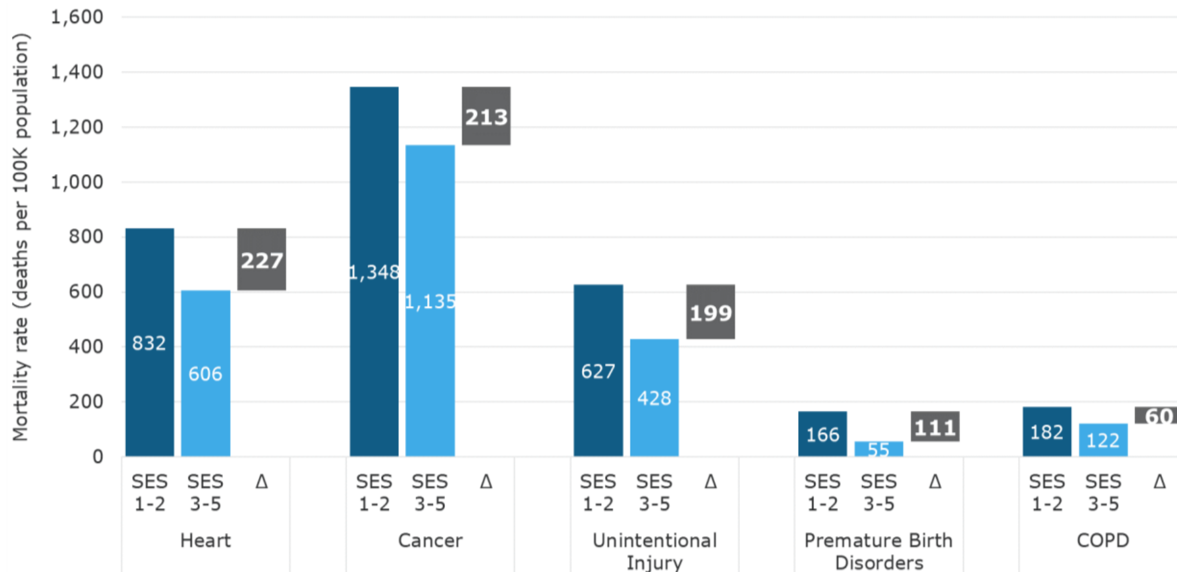
Map 5: Life expectancy by ZIP code



Source: NYSDOH Vital Statistics 2012-2014. Calculations performed by Common Ground Health.

The largest force behind health inequity relates to socioeconomic difference. Premature mortality is one measure that can be used to identify health inequities. Communities with low life expectancy also tend to be communities with higher rates of poverty. Disparities in premature mortality are the greatest in the top two causes of death – heart disease and cancer – and may be attributed back to risk factors (such as smoking, obesity, etc.) which are more commonly found in a low income population (Figure 16).

Figure 16: Rates of premature mortality disparities for eight county region



Source: NYSDOH Vital Statistics 2010-2015. Calculations performed by Common Ground Health.

In general, males have a lower life expectancy than females. This is partly attributed to biological differences, but perhaps more so behavioral tendencies differences in the two sexes. For instance, males may be more likely to drink excessively, smoke cigarettes, not follow-up with preventative care, etc. Many of these factors may play a role in development of heart disease and cancer later in life. According to New York State Department of Health Vital Statistics, males tend to have higher rates of death due to heart disease and cancer compared to their female counterparts (Table 9).

Table 9: Heart Disease and Cancer mortality by sex

	Heart Disease		Cancer	
	Male	**Female**	**Male**	**Female**
Chemung	221.9	162.4	185.2	145.9
Livingston	155.9	106.6	210.9	140.6
Ontario	217.9	93.5	213.7	156.6
Schuyler	268.5	104.9	216.4	214.8
Seneca	231.1	103.8	182.2	185.8
Steuben	188.7	165.1	187.1	138.2
Wayne	174.2	133.9	189	179.5
Yates	216.1	104.3	181.2	124.0
Source: NYSDOH Vital Statistics, 2016. Rates are per 100,000 population				

Common Ground Health

Planning and Prioritization Process

Eight County Region

The MAPP (Mobilizing for Action through Planning and Partnerships) process was used by all eight health departments to develop their health assessments and improvement plans. This process includes four community assessments. The first assessment began in the summer of 2018 when local health departments partnered with Common Ground Health to conduct a nine county regional health survey (*My Health Story 2018*).[11] This survey served as the vehicle for gathering primary qualitative and quantitative data from Finger Lakes region residents on health issues in each county. Health departments, hospitals, and other local partners were instrumental in distributing the survey to community members including disparate populations.

The second assessment was of the local public health system completed by stakeholders in each respective county. The survey sought to determine how well the public health system works together to address the ten essential services and provides an effective work-flow that promotes, supports and maintains the health of the community. Results from the survey are available in county specific prioritization pre-read documents (available upon request) and, overall, were very positive.

For additional community engagement and feedback, and the third and fourth assessments (forces of change and community themes and strengths), health departments conducted focus groups with lesser represented survey populations between the months of November and February.[12] Results from the focus groups and a list of attendees are available upon request.

After conducting each of the four assessments above with assistance from the S2AY Rural Health Network, local health departments invited key stakeholders and focus group attendees to participate in a prioritization meeting to help inform and select the 2019-2021 priority and focus areas. Participants utilized the Hanlon (PEARL) method to rank a list of group identified and/or pre-populated health department identified priorities. The method rates items based on size and seriousness of the problem as well as effectiveness of interventions. The result of each group scoring led to the selection of the priority areas and disparities and are summarized in greater detail in the county-specific chapters to follow.

As demonstrated in the health data section, each county's residents face their own unique and challenging issues when it comes to their community, yet

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[11] Common Ground Health services nine counties in the Finger Lakes region. For the purposes of this Community Health Assessment, Monroe County was excluded from data analysis.

[12] The majority of survey respondents were middle aged white women. Common Ground Health staff performed weighting calibration to align with each county's actual demographics, though, results may be biased.

commonalities remain. There are a number of demographic and socioeconomic indicators which may impact health and are consistent concerns across the region. For example:

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

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

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

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

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

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Yates County

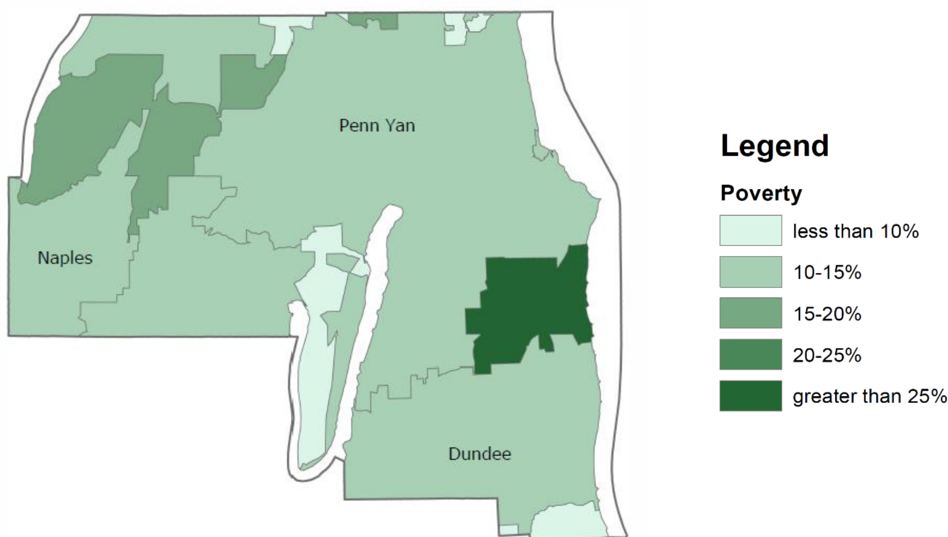
Demographic and Socioeconomic Health Indicators

Yates County is centered in the Finger Lakes region and shares county borders with Ontario, Steuben, Schuyler and Seneca Counties. The county also touches portions of several of the Finger Lakes including Canandaigua, Keuka and Seneca Lakes. A total of 25,083 persons reside in Yates County, the majority of which (97%) are White Non-Hispanic. Women of childbearing age make up 16% of the population, and 19.9% of the 18+ population are living with a disability.[13] 2017 estimates reveal 26% of the 65+ population (N=1,257) is living alone.

It is difficult to gather data on the Amish and Mennonite population, though it is a prominent demographic in Yates County. Local agencies estimate there are 916 farms in Yates County, 40% of which are owned by Mennonites. Each year, the Groffdale Conference Old Order Mennonites produces a map that lists all of their members. Per the 2018 map, it is estimated that there are 681 Old Order Mennonite households – 45 of which have been newly established (<1 year). It is important to note these data do not include estimates of the Crystal Valley or Horning Order Mennonite groups.

In Yates County, 13% of residents are living below the federal poverty level, and another 23% live near it. The distribution of poverty in the county is shown below in Map 6.

Map 6: Poverty rates by ZIP code

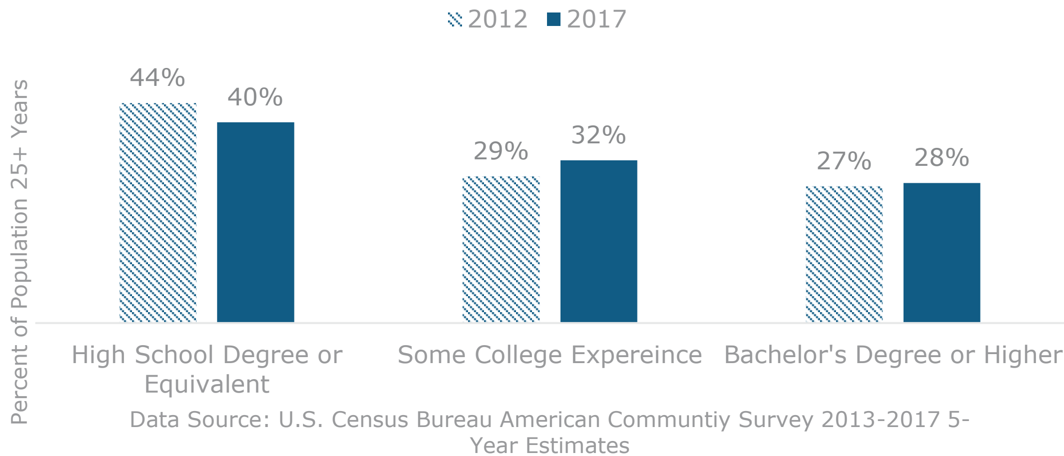


Source: U.S. Census Bureau American Community Survey 2013-2017 5-Year

[13] Disability in this context is defined as impairment to body structure or mental functioning, activity limitation such as difficulty hearing, moving or problem-solving, and participation restrictions in daily activities such as working, engaging in social/recreational activities or obtaining healthcare or preventative services.

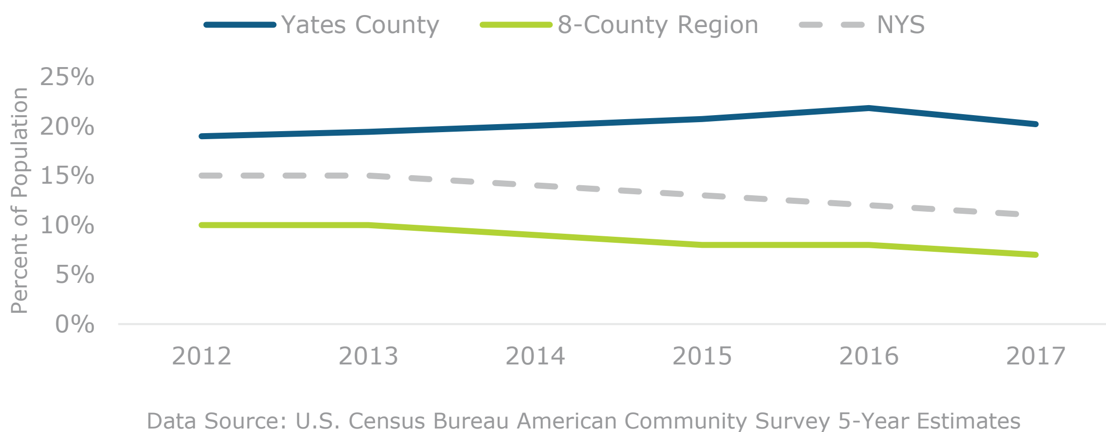
Over the past 5 years, there has been a slight shift in educational attainment where there are more residents aged 25+ who have college experience than in years past (Figure 17).

Figure 17: Educational attainment for Yates County by year



Data below show the trend in uninsured rates in Yates County over the past 5 years compared to NYS and the eight county region which has increased 6 percent since 2012 (Figure 18). This may likely be attributed to the high Amish and Mennonite populations found in Yates County.

Figure 18: Percent of population that is uninsured



Finally, 23% of Yates County residents rent vs. own their home. In addition, 13% of occupied housing units have no vehicles available. Another 31% have access to one vehicle. Of note, the average household size for occupied housing is greater than

two people. Approximately 43% of residents are paying 35% or more of their household income in rent costs.[14]

Main Health Challenges

On May 8, 2019, stakeholders and community members were invited to attend a priority setting meeting. At this meeting, participants (about 20 in total) reviewed the MAPP process, as well as relevant qualitative, quantitative, primary and secondary data. Data were reviewed from a variety of different sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports and primary data collected from the My Health Story 2018 Survey. Ultimately, using the Hanlon/PEARL method, the group selected the following as their priority areas and disparities for the 2019-2021 Community Health Improvement Plan:

Prevent Chronic Disease

1. Chronic Disease Preventative Care and Management

Promote Mental Well-Being and Prevent Substance Use Disorders

2. Mental and Substance Use Disorders Prevention

Disparity: low income

Lively group discussions took place regarding the potential priority areas. In addition to the group's thoughts, *My Health Story 2018* respondents were also asked questions relating to their top concerns for the health of themselves, loved ones, adults and children in the community (and were reviewed at the meeting). Weight and mental/emotional health issues rose to the top for three of the four categories (Figure 19). Of note, substance use and obesity indicators including exercise, weight, diet and nutrition, are concerns for children in the county. Similar items were found among concerns for adults in the county.

[14] Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

Figure 19: Yates County summary of health-related concerns for self, loved ones and county to prioritize

Biggest fear - for self	Biggest fear - for others
Weight (10.8%)	Cancer (10.9%)
Mental / emotional health issues (9.5%)	Mental / emotional health issues (10.4%)
Cancer (8.8%)	Heart conditions (8.0%)
Heart conditions (8.5%)	Cost (7.9%)
Aging (7.9%)	Diet / nutrition (6.6%)

County priority - for adults	County priority - for children
Substance abuse (27.8%)	Substance abuse (26.3%)
Weight (13.1%)	Diet / nutrition (25.0%)
Mental / emotional health issues (10.7%)	Exercise (19.9%)
Cost (10.6%)	Mental / emotional health issues (9.2%)
Diet / nutrition (10.0%)	Weight (7.5%)

Source: *My Health Story* survey 2018. Analysis by Common Ground Health incorporates weighting to normalize survey participants to demographics of each county. Top 5 issues shown for each question. Data shown are the percent of participants with responses in each category.

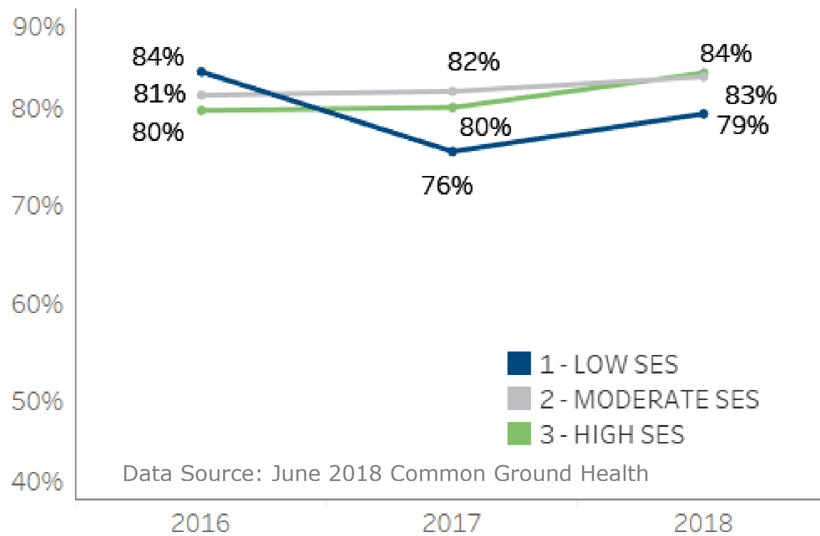
Behavioral Risk Factors

It is estimated that approximately one in three adults in Yates County are obese. Obesity affects an estimated 5,500 adults and 170 children. Long-term health complications associated with obesity include increased risk for development of diabetes, hypertension, and premature mortality due to related conditions.

Roughly 34%[15] of adults have been diagnosed with hypertension in the county, 82%[16] of whom are in control of their blood pressure. This control rate varies by income (Figure 20). Reducing the disparity requires engaging patients in taking control of their blood pressure through various methods: blood pressure medication adherence, promotion of physical activity, healthy eating, and more. Low income patients are often less likely to be able to afford medications, and it is therefore important to work with providers to prescribe generic medications that are less expensive and accepted by insurance companies.

[15] Source: Behavioral Risk Factor Surveillance System, 2016
[16] Source: Common Ground Health High Blood Pressure Registry, June 2018.

Figure 20: Yates County control rate by socioeconomic status over time

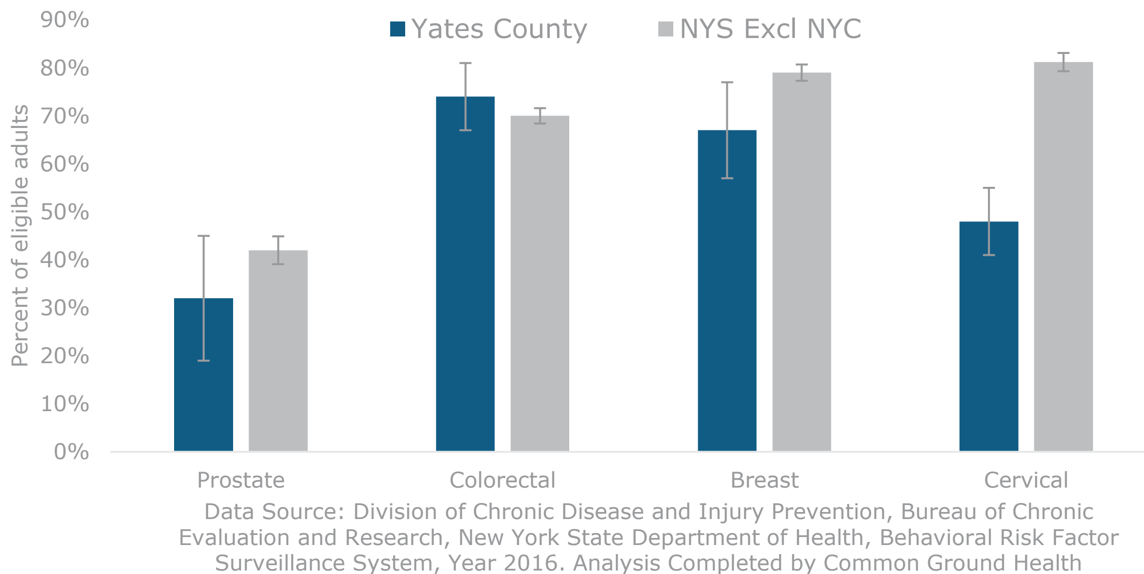


Obesity may also lead to increased risk of developing diabetes. In Yates County, rates of persons diagnosed with diabetes has remained around 14% over the past several years.[17] Regionally, respondents to *My Health Story 2018* indicated that better diet and nutrition habits would help them manage their diabetes (and hypertension) better.

Screening for cancer is another area that came up as a priority in meetings with Yates County agencies. As previously mentioned, screening for cancers is an important preventative step in primary care. Figure 21 shows the percent of the population that has received screenings for various types of cancer based on recommended guidelines in Yates County. Of note, cervical cancer screenings in the county are significantly lower than nearby counties and NYS excluding NYC.

[17] Source: Behavioral Risk Factor Surveillance System

Figure 21: Percent of population receiving cancer screenings



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

In terms of colorectal cancer screenings, an estimated 74% of county residents have received recommended screenings. However, this varies by sex and income as shown below in Table 10. Particular focus ought to be put on increasing screening rates in females and the low income population.

Table 10: Colorectal cancer screening rates by demographic

	Male	**Female**	**Low-income**
Colorectal Cancer Screening Rates	78%	65%	63%*
Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health. *low income data from 2013-2014 Behavioral Risk Factor Surveillance System			

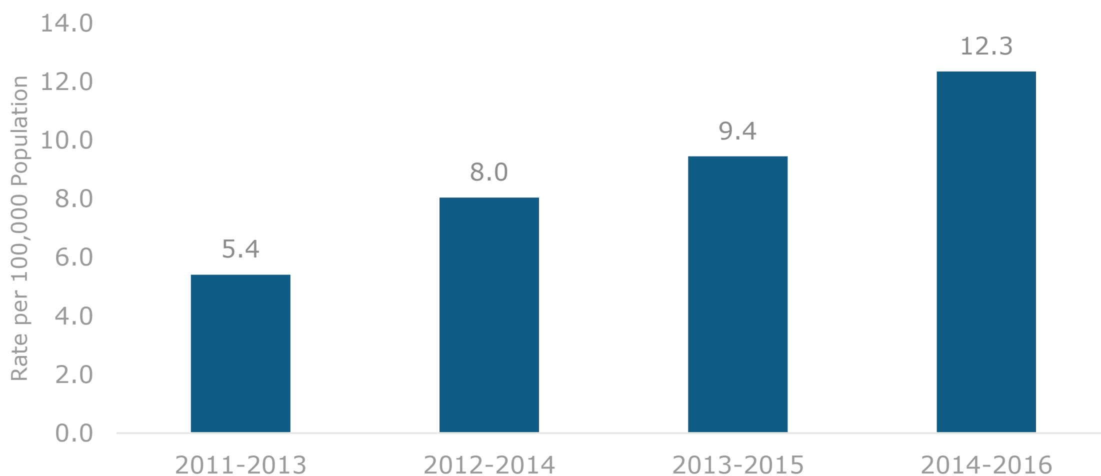
Deaths due to opioids in Yates County have increased 133% from 3 deaths in 2016 to 7 in 2017, according to reports published by New York State Quarterly Opioid Reporting. To date, data show a dip in Yates County's overdose deaths for the first two quarters of 2018. It is unknown at this time if this trend continued throughout the rest of the year. Clients being admitted to OASAS-certified chemical dependence treatment programs have continued in Yates County though have shown no increase or decrease in the number of unique clients admitted (N=126 for both 2016 and 2017). The support from these programs are likely helpful in contributing to the lower number of deaths related to opioids noted in 2018.

According to survey data from *My Health Story 2018*, almost half of the respondents indicated they have dealt with anxiety or fear (48%), depression or

sadness (47%). For those who have dealt with mental or emotional health issues, 73% of survey respondents said they got the help they needed. The most commonly reported support was from doctors, counselors and other mental health professionals followed by support from friends and family.

Suicide rates in Yates County have increased over the past several years (Figure 22). In 2011-2013, there were a total of 6 suicide deaths which occurred (rate of 5.4 per 100,000 residents). In 2014-2016, deaths doubled to 12 (rate of 12.4 per 1000,000 residents). The prevalence of mental emotional health issues reported in *My Health Story 2018* and increase in suicide rates support the county's decision to focus on mental well-being, specifically suicide prevention, in the upcoming health improvement period.

Figure 22: Suicide mortality rates per 100,000 population



Policy and Environmental Factors

Yates County recently approved a local law that prohibits tobacco and vaping use on county property including county-owned vehicles. In addition, the Village of Penn Yan has smoke-free parks.

The local environment includes several green spaces where residents and visitors can engage in outdoor recreational activities. This is encouraged by Yates County and its partners. In fact, the local Cornell Cooperative Extension has a brochure listing trails with opportunities to exercise for both residents and visitors.

While the county has worked towards bolstering natural and manmade recreational areas, there are still issues of concern that may negatively impact opportunities. For example, several villages in the county have old, broken and sometimes non-existent sidewalks making it difficult for some to use when trying to walk in the

community. In addition, the public waterline infrastructure in Penn Yan contains old pipes, which may be lead-lined and in many cases are breaking apart. This poses a public health issue.

Unique Characteristics Contributing to Health Status

The local hospital recently requested discontinuation of inpatient mental health services. This may likely present challenges for some in accessing specialist care that is not located within the county. This is a particular concern given the burden of mental and emotional health challenges expressed by Yates County residents in *My Health Story 2018* and in other secondary data sources.

To aid in the mental health and substance use epidemic, FLACRA has recently announced the launch of their new Center of Treatment Innovation (COTI). This was created to address the opioid and heroin crisis in Ontario and Yates Counties. COTI will focus on increased access to treatment, unmet treatment needs and reducing overdose related deaths. The no cost services will be available 24/7 and will aid in reducing death due to substance use.

Yates County also has a large percentage of Mennonite families and a growing birth cohort, which presents interesting implications on health related measures in Yates County. As previously discussed, the Amish and Mennonite population practices natural and homeopathic medicine vs. traditional American healthcare. This negatively affects Yates County health indicator data by causing lower reported rates of immunization and lead screening. In addition, the population has many heavy farm workers and therefore experience increased farm related injuries compared to the average resident. This population, however, also positively impacts health data as the Amish and Mennonite are more likely to initiate and extend breastfeeding, which may lead to decreased obesity rates in the longer term.

Community Assets and Resources to be Mobilized

During focus groups completed in late 2018 and early 2019, community members identified several assets and resources in Yates County. For example, focus group attendees identified food assistance programs such as Hope Center, Foodlink and Living Well as community strengths and resources. In addition, attendees identified the county's clean environment, supportive community and good quality of life as strengths. A comprehensive list of identified strengths and resources can be found in focus group summaries and is available upon request.

Through implementation of the Community Health Improvement Plan, staff will work to leverage these pre-existing agencies and services. A full description of interventions and partner roles is in the Yates County Community Health

Improvement Plan document. Partnering and leveraging the assets and resources of local community agencies will be imperative to achieving success in the plan.

Community Health Improvement Plan/Community Service Plan

As previously discussed in the executive summary, the MAPP process was used to help create the Community Health Assessment and Community Health Improvement Plan. County specific pre-read documents were provided to prioritization meeting attendees and Choose Health Yates (CHY) group members. These documents included updated data measures for each of the five priority areas outlined in the Prevention Agenda (please see executive summary for more information on pre-read documents). A variety of partners were engaged in each county's specific process including:

Yates County Prioritization Agencies		
Yates County Public Health	S2AY Rural Health Network	Common Ground Health
Dundee Our Town Rocks	Dundee Council of Churches	Child and Family Resources
Finger Lakes Health	Keuka College	Yates County Legislature
Tobacco Action Coalition of the Finger Lakes	The Living Well	Yates County Sheriff's Office
Chamber of Commerce	Council on Alcoholism	Our Lady of the Lakes Catholic Community

A regional health survey and focus groups engage the community throughout the assessment period. Community members were also invited to attend the prioritization meeting to help inform and select the 2019-2021 priority areas. Preliminary findings of the assessment were shared with the public via public service announcements in two local newspapers. In addition, preliminary results were emailed to prioritization meeting attendees and stakeholders.

Specific interventions to address the priority areas were selected at CHY meetings and were a group effort. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Yates County Community Health Improvement Plan (Appendix A). Interventions selected are evidence based and strive to achieve health equity by focusing on creating greater access for the low-income population.

The Community Health Improvement Plan progress and implementation will be overseen by Choose Health Yates, a group that meets bi-monthly and brings together diverse partners to improve the health of its residents. Progress and

relevant data on each measure will be regularly reviewed at these meetings. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

The Community Health Assessment and Community Health Improvement plan will be disseminated via email to key stakeholders and governing bodies including the Yates County Legislature, Professional Advisory Committee and County Departments. The plan will be posted to the county website at www.yatescounty.org. Hard copies will be provide to the local libraries for ease of access by members of the public that may not have internet access. Public service announcements to the local media outlets and social media posts will be used to inform the public how they can access the plan.

Yates County

Community Health Improvement Plan

Priority: Prevent Chronic Disease					
Focus Area 4: Preventive Care and Management					
Timeframe: To be completed by December 31, 2021					
Goal 4.1 Increase Cancer Screening Rates					
Disparity: Lower SES, uninsured					
Outcome Objective: 4.1.1 Increase the percentage of women with an annual household less than $25,000 who receive a **BREAST CANCER SCREENING** based on most recent guidelines.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
4.1.1 Work with health care providers/clinics to put systems in place for patient and provider screening reminders (letter, postcards, emails, recorded phone messages, electronic health records (EHRs) alerts.	Number of health systems that implement or improve provider and patient reminder systems.	Finger Lakes Health (FLH) will utilize EHR (EMR) to make patient referrals for screenings as appropriate. Staff time of .15 FTE to collect and report aggregate data	Report on mammography screening referral numbers for Yates County from primary care practices. Provide mammography raw numbers for each service year. Provide estimates of demographics to determine those of low SES	Report on mammography screening referral numbers for Yates County from primary care practices. Provide mammography raw numbers for each service year. Provide estimates of demographics to determine those of low SES	Report on mammography screening referral numbers for Yates County from primary care practices. Provide mammography raw numbers for each service year. Provide estimates of demographics to determine those of low SES

Priority: Prevent Chronic Disease					
Focus Area 4: Preventive Care and Management					
Timeframe: To be completed by December 31, 2021					
Goal 4.1 Increase Cancer Screening Rates					
Disparity: Lower SES, uninsured					
Outcome Objective: 4.1.1 Increase the percentage of women with an annual household less than $25,000 who receive a **BREAST CANCER SCREENING** based on most recent guidelines.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
4.1.2 Conduct one-on-one (by phone or in person) and group education (presentation or other interactive session in a church, home, senior center or other setting).	Number of individuals reached through education. Change in knowledge & awareness of need for cancer screenings among groups reached.	Yates County Public Health (YCPH) 0.1 FTE	Met with uninsured Mennonite women promoting mammograms through the Mobile Mammography unit. Arranged 2 "Sister's Day" events targeting uninsured Mennonite women. Surveyed local employers (targeting women of lower SES) re: cancer screenings-insurance coverage for screenings, policies in place for paid time off/flexing etc.	YCPH will conduct 1 presentation about the importance of mammograms targeting women of lower SES/uninsured. YCPH will reach out to the Yates County Chamber of Commerce to discuss best practices when targeting employers about importance of cancer screenings. YCPH will identify 1-2 employers that employ women of lower SES re: the importance of mammograms & policies to improve access to screenings. YCPH will reach out to members of the Mennonite community to arrange additional Mobile Mammography screening events.	YCPH will conduct 1 presentation about the importance of mammograms targeting women of lower SES/uninsured. YCPH will target 1-2 employers that employ women of lower SES re: the importance of mammograms & policies to improve access to screenings. YCPH will reach out to Finger Lakes Community Health & Cancer Services Program to address mammograms in the migrant population.

Priority: Prevent Chronic Disease					
Focus Area 4: Preventive Care and Management					
Timeframe: To be completed by December 31, 2021					
Goal 4.1 Increase Cancer Screening Rates					
Disparity: Lower SES, uninsured					
Outcome Objective: 4.1.1 Increase the percentage of women with an annual household less than $25,000 who receive a **BREAST CANCER SCREENING** based on most recent guidelines.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
4.1.3 Use small media such as videos, printed materials (letters, brochures, and newsletters) and health communications to build public awareness and demand	Number and type of locations where materials were distributed. Change in knowledge & awareness of need for cancer screenings among groups reached through small media dissemination	Finger Lakes Health (FLH). We will utilize direct mail and other promotional vehicles. $5,000 is estimated for development and mailing of educational materials. .2 FTEs	FLH developed flyer outlining screenings performed by FLH. FLH developed advertising their new "Walk-In" screening mammography offered once a month, starting in October in Penn Yan and Geneva locations. FLH advertised, promoted and held ribbon cutting ceremony for new 3D mammography at Soldiers & Sailors Hospital during October (breast cancer awareness month).	FLH will promote breast cancer screenings and guidelines via newspaper, radio, Facebook, Website, "Thrive" magazine.	FLH will promote breast cancer screenings and guidelines via newspaper, radio, Facebook, Website, "Thrive" magazine.
		Yates County Public Health (YCPH) 0.1 FTE $500-$1000 total for ALL cancer screening media communications.	YCPH promoted mammograms offered through FLH and Mobile Mammography at Yates Community Center via website, Facebook and posting of flyers. YCPH organized and promoted a mobile mammography event in	YCPH will promote FLH mammogram screenings, Rochester Regional Health Mobile Mammography unit, targeting low SES and uninsured. YCPH will work with Cancer Services Program (CSP) to promote mammogram screenings for low income/uninsured women.	YCPH will promote FLH mammogram screenings, Rochester Regional Health Mobile Mammography unit, targeting low SES and uninsured. YCPH will work with Cancer Services Program (CSP) to promote mammogram screenings for low income/uninsured women.

			Benton geared toward uninsured Mennonite women (15 women received screening mammograms). A second event has been plan, organized and promoted by YCPH for 11/6/19. YCPH promoted Mobile Mammography at Mosaic Health 10/18/19	YCPH will organize and promote 1 Mobile Mammography event targeting uninsured, low SES women.	YCPH will organize and promote 1 Mobile Mammography event targeting uninsured, low SES women.
		Our Town Rocks (OTR) – Community Based Organization	OTR have visited all Dundee businesses encouraging all to go PINK in October and display the breast cancer screening flyer. OTR promoted all free and walk-in screening opportunities in the area via flyers and social media platforms.	OTR, in collaboration with 4 Dundee beauty salons and Dundee Pharmacy are planning a Breast/Colon/Prostate Screening Services awareness campaign utilizing flyers & social media. OTR working with CSP to have the Mobile Mammography unit at the Annual AMBA blood drive in June '20. OTR is partnering with CSP Breast Cancer Screening Campaign in October 2020.	OTR will continue to build upon cancer screening initiatives that proved successful.

Priority: Prevent Chronic Disease					
Focus Area 4: Preventive Care and Management					
Timeframe: To be completed by December 31, 2021					
Goal 4.1 Increase Cancer Screening Rates					
Disparity: Lower SES, uninsured					
Outcome Objective: 4.1.2 Increase the percentage of women with an annual household less than $25,000 who receive a **CERVICAL CANCER SCREENING** based on most recent guidelines.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
4.1.2 Conduct one-on-one (by phone or in person) and group education (presentation or other interactive session in a church, home, senior center or other setting).	Number of individuals reached through education. Change in knowledge & awareness of need for cancer screenings among groups reached.	Yates County Public Health (YCPH) 0.1 FTE		YCPH will conduct 1 presentation about the importance of cervical cancer screening targeting women of lower SES/uninsured. YCPH will target 1 employer that employs women of lower SES re: the importance of cervical cancer screening and policies to improve access. YCPH will meet with midwives in the area to seek assistance in promoting/encouraging cervical cancer screening in low SES/uninsured clients that they see. YCPH will meet with Finger Lakes Community Health and Mosaic Health to promote cervical cancer screening among low SES, un or underinsured and migrant population.	YCPH will conduct 1 presentation about the importance of cervical cancer screening targeting women of lower SES/uninsured. YCPH will target 1 employer that employs women of lower SES re: the importance of cervical cancer screening and policies to improve access.

Priority: Prevent Chronic Disease					
Focus Area 4: Preventive Care and Management					
Timeframe: To be completed by December 31, 2021					
Goal 4.1 Increase Cancer Screening Rates					
Disparity: Lower SES, uninsured					
Outcome Objective: 4.1.2 Increase the percentage of women with an annual household less than $25,000 who receive a **CERVICAL CANCER SCREENING** based on most recent guidelines.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
4.1.3 Use small media such as videos, printed materials (letters, brochures, and newsletters) and health communications to build public awareness and demand	Number and type of locations where materials were distributed. Change in knowledge & awareness of need for cancer screenings among groups reached through small media dissemination	Yates County Public Health (YCPH) 0.1 FTE $500-$1000 total for ALL cancer screening media communications.	Promoted Cervical Cancer awareness month on Facebook.	YCPH will set up a display at 2 community locations that are visible to women of lower SES (i.e. County Office Building, library, food pantries etc). YCPH will promote Cervical Cancer Awareness month (Jan) on website, Facebook, newspaper etc. YCPH will outreach to Finger Lakes Sexual Health Coalition to promote cervical cancer screening. YCPH will outreach to Finger Lakes Community Health and Mosaic Health to promote cervical cancer screening among low SES, un or underinsured and migrant population.	YCPH will set up a display at 2 community locations that are visible to women of lower SES (i.e. County Office Building, library, food pantries etc). YCPH will promote Cervical Cancer Awareness month (Jan) on website, Facebook, newspaper etc. YCPH will outreach to Finger Lakes Sexual Health Coalition to promote cervical cancer screening. YCPH will outreach to Finger Lakes Community Health and Mosaic Health to promote cervical cancer screening among low SES, un or underinsured and migrant population.

Priority: Prevent Chronic Disease					
Focus Area 4: Preventive Care and Management					
Goal 4.1 Increase Cancer Screening Rates					
Timeframe: To be completed by December 31, 2021					
Disparity: Lower SES, uninsured					
Outcome Objective: 4.1.4 Increase the percentage of adults who receive a **COLORECTAL CANCER SCREENING** based on the most recent guidelines (adults with an annual household income less than $25,000.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
4.1.1 Work with health care providers/clinics to put systems in place for patient and provider screening reminders (letter, postcards, emails, recorded phone messages, electronic health records (EHRs) alerts.	Number of health systems that implement or improve provider and patient reminder systems.	Finger Lakes Health (FLH) will use EHR (EMR) for reminders and referrals as appropriate and report on data. Staff time of .15 FTE to collect and report aggregate data	Report on colonoscopy/colon cancer screening referral numbers for Yates County from primary care practices in FLH system. Provide colonoscopy/colon cancer screening raw numbers for each service year. Provide estimates of demographics to determine those of low SES	Report on colonoscopy/colon cancer screening referral numbers for Yates County from primary care practices in FLH system. Provide colonoscopy/colon cancer screening raw numbers for each service year. Provide estimates of demographics to determine those of low SES	Report on colonoscopy screening referral numbers for Yates County from primary care practices in FLH system. Provide colonoscopy/colon cancer screening raw numbers for each service year. Provide estimates of demographics to determine those of low SES

Priority: Prevent Chronic Disease					
Focus Area 4: Preventive Care and Management					
Goal 4.1 Increase Cancer Screening Rates					
Timeframe: To be completed by December 31, 2021					
Disparity: Lower SES, uninsured					
Outcome Objective: 4.1.4 Increase the percentage of adults who receive a **COLORECTAL CANCER SCREENING** based on the most recent guidelines (adults with an annual household income less than $25,000.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
4.1.2 Conduct one-on-one (by phone or in person) and group education (presentation or other interactive session in a church, home, senior center or other setting).	Number of individuals reached through education. Change in knowledge & awareness of need for cancer screenings among groups reached.	Yates County Public Health (YCPH) 0.1 FTE	YCPH conducted one-on-one presentations to Mennonites re: the importance of colorectal screening. As a result 5 FIT screening kits were distributed to uninsured individuals.	YCPH will conduct 1 presentation about the importance of colorectal cancer screening targeting individuals of lower SES/uninsured. YCPH will target 1 employer that employs lower SES individuals re: the importance of colorectal cancer screening and policies to improve access. YCPH, in partnership with Finger Lakes CSP will promote/distribute FIT screening kits at Mobile Mammography events. YCPH will outreach to Finger Lakes Community Health to promote CSP services to migrant population & lower SES individuals.	YCPH will conduct 1 presentation about the importance of colorectal cancer screening targeting individuals of lower SES/uninsured. YCPH will target 1 employer that employs lower SES individuals re: the importance of colorectal cancer screening and policies to improve access. YCPH, in partnership with Finger Lakes CSP will promote/distribute FIT screening kits at Mobile Mammography events. YCPH will outreach to Finger Lakes Community Health to promote CSP services to migrant population & lower SES individuals.

Priority: Prevent Chronic Disease					
Focus Area 4: Preventive Care and Management					
Goal 4.1 Increase Cancer Screening Rates					
Timeframe: To be completed by December 31, 2021					
Disparity: Lower SES, uninsured					
Outcome Objective: 4.1.4 Increase the percentage of adults who receive a **COLORECTAL CANCER SCREENING** based on the most recent guidelines (adults with an annual household income less than $25,000.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
4.1.3 Use small media such as videos, printed materials (letters, brochures, and newsletters) and health communications to build public awareness and demand	Number and type of locations where materials were distributed. Change in knowledge & awareness of need for cancer screenings among groups reached through small media dissemination	Finger Lakes Health (FLH). Resources estimated to be $3,000 for direct mail and other communication vehicles.	FLH developed flyer outlining screenings performed by FLH & distributed via website, Facebook. Advertised colon screening availability in "Thrive" magazine.	FLH will promote colorectal cancer screenings and guidelines via newspaper, radio, Facebook, Website, "Thrive" magazine.	FLH will promote colorectal cancer screenings and guidelines via newspaper, radio, Facebook, Website, "Thrive" magazine.
		Yates County Public Health (YCPH) 0.1 FTE $500-$1000 total for ALL cancer screening media communications.	YCPH promoted colorectal screenings offered by FLH. YCPH provided a display/written material at a mobile mammography event & partnered with FL Cancer Screening Program to distribute 5 FIT test kits to uninsured individuals.	YCPH will set up a display at 1- 2 community locations that are visible to men/women of lower SES (i.e. County Office Building, library, food pantries etc) re: the importance of colorectal screening. YCPH will promote colorectal screenings offered by FLH and area hospitals on website, Facebook. YCPH will partner with CSP to promote their services/funding for colorectal screening. YCPH will promote colorectal cancer screenings via paid media, website, Facebook.	YCPH will set up a display at 1- 2 community locations that are visible to men/women of lower SES (i.e. County Office Building, library, food pantries etc) re: the importance of colorectal screening. YCPH will promote colorectal screenings offered by FLH and area hospitals. YCPH will partner with CSP to promote their services/funding for colorectal screening. YCPH will promote colorectal cancer screenings via paid media, website, Facebook.

Priority: Promote Well-Being and Prevent Mental and Substance Use Disorders					
Focus Area 2: Prevent Mental and Substance Use Disorders					
Goal 2.2 Prevent Opioid Overdose Deaths					
Timeframe: To be completed by December 31, 2021					
Outcome Objective 2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
2.2.2 Increase availability of/access to overdose (Naloxone) trainings to prescribers, pharmacists and consumers	Number of Naloxone trainings completed. Number of individuals trained in Naloxone. Number of pharmacies contacted/surveyed re: N-CAP Number of educational outreaches re: N-CAP	Yates County Public Health (YCPH) 0.025 FTE	YCPH conducted one Naloxone training to CCSI (Tier 1) with 13 participants. YCPH will investigate w/Common Ground Health if claims data is available for N-CAP usage at Yates County participating pharmacies.	YCPH will promote & conduct 2 Naloxone trainings per years (i.e. Keuka College, law enforcement, fire department, uninsured, etc). YCPH will explore other community agencies providing Naloxone trainings in Yates County and promote those trainings via website & Facebook. YCPH will survey local pharmacies re: N-CAP. YCPH will increase public awareness about N-CAP (in partnership w/Yates Substance Abuse Coalition (YSAC) via website, Facebook, paid media.	YCPH will promote & conduct 2 Naloxone trainings per years (i.e. Keuka College, law enforcement, fire department, uninsured, etc). YCPH will explore other community agencies providing Naloxone trainings in Yates County and promote those trainings via website & Facebook. YCPH will increase public awareness about N-CAP (in partnership w/Yates Substance Abuse Coalition (YSAC) via website, Facebook, paid media.
Local Effort: Received research grant through Columbia University: HEALing Communities – effort to reduce opioid deaths by 40% over 3 years.	Number of meetings held. Number and types of partners involved. Current efforts in place to decrease opioid use. Improvement in number of opioid deaths	Yates County Community Services (other government agency.	HEALing (Help to End Addiction Long term) Community grant awarded through Columbia University. Yates County Community Services will provide oversight of the grant. Mtg. was held 7/30/19 with Columbia University research team, director of community	Continued work with HEALing Community grant	Continued work with HEALing Community grant

			services, DPH, Community partners to outline grant expectations & initial local efforts. Tour of jail was conducted and met w/treatment representatives who described current efforts. Two professional positions will be funded.		
		Yates County Public Health (YCPH) 0.01 FTE	YCPH will support efforts for the grant	YCPH will support efforts for the grant	YCPH will support efforts for the grant
		FLACRA (Community Based Organization)	FLACRA will participate and support efforts for grant	FLACRA will participate and support efforts for grant	FLACRA will participate and support efforts for grant

Priority: Promote Well-Being and Prevent Mental and Substance Use Disorders					
Focus Area 2: Prevent Mental and Substance Use Disorders					
Goal 2.2 Prevent Opioid Overdose Deaths					
Timeframe: To be completed by December 31, 2021					
Outcome Objective 2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days	Number of additional permanent safe disposal sites for prescription drugs and organized take-back days.	Yates County Public Health (YCPH) 0.028 FTE	YCPH will explore all current areas of safe disposal sites in Yates County and post on website. YCPH promoted "Drug Take-Back Days" in April and October 2019 on Website, Facebook, Weekly Surveillance, Sandwich Board & Electronic sign.	YCPH will identify 1 additional area of safe disposal in the county and move toward securing a new site. YCPH will outreach to Ontario County Substance Abuse Partnership to identify how they were able to secure safe disposal site/funding in Rushville. YCPH will promote "Drug Take-Back Days" in April and October 2020 on Website, Facebook, Weekly Surveillance, Sandwich Board & Electronic sign.	YCPH will identify 1 additional area of safe disposal in the county and move toward securing a new site. YCPH will promote "Drug Take-Back Days" in April and October 2021 on Website, Facebook, Weekly Surveillance, Sandwich Board & Electronic sign.
		S2AY Rural Health Network (5% of FTE)	Provide Dispose Rx bags to key community partners to assist in safe disposal of prescription drugs.	Provide Dispose Rx bags to key community partners to assist in safe disposal of prescription drugs.	Provide Dispose Rx bags to key community partners to assist in safe disposal of prescription drugs.

Priority: Promote Well-Being and Prevent Mental and Substance Use Disorders					
Focus Area 2: Prevent Mental and Substance Use Disorders					
Goal 2.3 Prevent & Address Adverse Childhood Experiences					
Timeframe: To be completed by December 31, 2021					
Outcome Objective 2.3.3 Increase communities reached by opportunities to build resilience by at least 10%					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
2.3.3 Grow resilient communities through education, engagement, activation/mobilization and celebration.	Number of community organizations/members who participated in ACE's discussions.	Yates County Public Health (YCPH) 0.025 FTE	YCPH promoted a free training on ACES on 10/22/19 offered by Family Counseling Services of the Finger Lakes. _____ YCPH staff attended the training.	YCPH will continue to become familiar with ACE's via trainings & webinars. YCPH and its partners will assemble community partners (community organizations, schools, providers, etc.) to education/address ACE's in the community setting.	YCPH will work with community partners to promote resilient communities.
		S2AY Rural Health Network	Organize workshop/conference to educate community on ACES and resilience.	Work with YCPH to establish plan for continued community engagement on ACES.	Work with YCPH to establish plan for continued community engagement on ACES.

Priority: Promote Well-Being and Prevent Mental and Substance Use Disorders					
Focus Area 2: Prevent Mental and Substance Use Disorders					
Goal 2.5 Prevent Suicides					
Timeframe: To be completed by December 31, 2021					
Outcome Objective 2.5.2: Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000.					
Intervention/ Strategies/ Activities	**Process Measures**	**Partner Role and Resources**	**2019**	**2020**	**2021**
2.5.4 Identify & support people at risk: Gatekeeper Training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, postvention, safe reporting and messaging about suicides.	Number of Gatekeeper Trainings (MHFA & YMHFA) Number of individuals trained. Number of outreach/educational events.	Yates County Community Services (other governmental unit).	Conduct MHFA & YMHFA trainings. One individual from Yates County was selected to attend the Conference of Mental Hygiene Directors Youth Mental Health First Aide “Train the Trainer” in the Fall ’19. Planning underway to provide 2 or three additional YMHFA trainings during 2019 (Nov). Participation in the Systems of Care (SOC) planning which addresses mental health issues in youth. Participate in Crisis Intervention Training (CIT), a collaborative effort between several community agencies & law enforcement.	Conduct MHFA & YMHFA trainings. Administer the biannual school survey regarding substance use and mental health issues. Participation in Systems of Care Planning. Participating in Crisis Intervention Training.	Conduct MHFA & YMHFA trainings. Participation in Systems of Care Planning. Participating in Crisis Intervention Training.
		Suicide Coalition of Yates County (Community based organization.	“Talk Saves Lives” was presented to more than 70 community members. “Train the Trainer” trained 7 community members to be “Talk Saves Lives” facilitators.	“Talk Saves Lives”, “Train the Trainer”, “It Real”, “More than Sad”, “Out of the Darkness” community walk & educational tabling will take place in 2020.	“Talk Saves Lives”, “Train the Trainer”, “It Real”, “More than Sad”, “Out of the Darkness” community walk & educational tabling will take place in 2021.

			"It's Real" (a mental health and suicide prevention program was presented to Keuka College students. "Out of the Darkness" community walk was held on 9/29/19 with 265 participants and more than $14,000 raised. Educational tabling, in honor of Suicide Prevention month (Sept) was done at the library and in the main lobby of the County Office Building. Penn Yan Schools had tabling during their open house activities. "Talk Saves Lives" was provided at 2 local churches in September. The Suicide Coalition of Yates County meets monthly.	The Suicide Coalition of Yates County meets monthly.	The Suicide Coalition of Yates County meets monthly.
		Yates County Public Health (YCPH) 0.035 FTE	YCPH attend Systems of Care Planning meetings and assist in efforts. YCPH will promote all trainings & events open to the public.	YCPH attend Systems of Care Planning meetings and assist in efforts. YCPH attend Suicide Prevention Coalition meetings and assist in efforts. YCPH will promote all trainings & events open to the public.	YCPH attend Systems of Care Planning meetings and assist in efforts. YCPH attend Suicide Prevention Coalition meetings and assist in efforts. YCPH will promote all trainings open to the public.
		Finger Lakes Health (FLH). Vice President of Nursing and other staff as appropriate will attend meetings and work as partner - 0.04 Administrator FTE	FLH will attend Systems of Care Planning meetings and assist in efforts. FLH will promote all trainings & events open to the public.	FLH will attend Systems of Care Planning meetings and assist in efforts. FLH will promote all trainings & events open to the public.	FLH will attend Systems of Care Planning meetings and assist in efforts. FLH will promote all trainings & events open to the public.