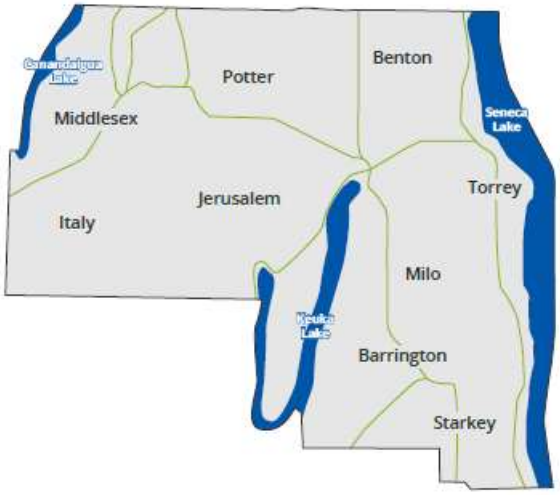
Yates County
Community Health Assessment/Community Service Plan
2016-2018
December 2, 2016



The participating local health department in the 2016 Community Health Assessment is Yates County Public Health. Deborah Minor, the Public Health Director, is the contact person. She may be reached at: dminor@yatescounty.org or 315.536.5160.

The participating hospital is Soldiers and Sailors Memorial Hospital (SSMH), the only hospital located in Yates County. Geneva General Hospital (GGH) and SSMH are part of a multi-institutional health system, Finger Lakes Health, located in Ontario County, New York. Loree K. MacKerchar, Manager, Community Relations is the contact person and may be reached at Loree.MacKerchar@flhealth.org or 315.531.2053

In Yates County, facilitation of the Community Health Assessment process was provided by leadership from the S²AY Rural Health Network. The Network is a partnership of eight Public Health Departments in the Finger Lakes region (Steuben, Seneca, Schuyler, Wayne, Ontario, Yates, Livingston, and Chemung), and has completed Community Health Assessments in this region for the last five cycles. The main coordinating body that oversaw the Community Health Assessment is the Yates County Health Planning Council. Yates County Health Planning Council, a multi-disciplinary group of community organizations described more fully within this document, together with a similar group called "Choose Health Yates" also will oversee the implementation of the Community Health Improvement Plan (CHIP). Please see Attachment 1 for a list of members.

Table of Contents

Executive Summary

1. Priorities and Disparities:
Yates County choose two priority areas, and three focus areas within those priorities to address.

Priority Area 1: Prevent Chronic Diseases

- *Focus Area 1:* Reduce Obesity in Children and Adults
- *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Priority Area 4: Promote Mental Health and Prevent Substance Abuse

- *Focus Area 1:* Promote Mental, Emotional and Behavioral Well-Being

Yates County also chose three disparities to address:

1. Lower rates of breastfeeding among women of lower socio-economic status (SES)
2. Lower rates of compliance with hypertension management among low-SES, specifically targeting patients of the Federally Qualified Health Centers (FQHCs)
3. Lower rates of chronic disease self-management among un- or under-employed, low SES, male population

2. Changes from 2013: The first priority has not changed (Prevent Chronic Diseases – focusing on obesity and hypertension) from the 2013 CHA and CHIP, although the strategies to be used to address these priorities have evolved as will be seen in the attached CHIP. The second priority has changed however. In the review of the data and discussions with focus groups, behavioral health issues continue to be of significant concern. The rates of increase in ED visits for substance abuse issues increased dramatically between 2013 and 2014 for example, as did visits for mental health related issues. The opioid epidemic has also hit home locally in Yates County as well, calling attention to the need to address this problem as a community. In the 2013, the second priority chosen was Priority 2: Promote a Health and Safe Environment, with a focus on

falls prevention. In the 2016-2018 CHA/CHIP process, this changed to Priority Area 4: Promote Mental Health and Prevent Substance Abuse, in recognition of the extent and severity of behavioral health issues.

3. Data Reviewed and Analyzed: The data review and analysis was extensive. In all S²AY Network Counties, the process began with a data update for the eight county region conducted by the Finger Lakes Health Systems Agency (FLHSA) at the request of S²AY. This data collection and analysis effort focused on data related to the main priorities in the 2013 CHA for the region as well as some emerging issues that the hospitals and Public Health agreed should be analyzed based both on their knowledge of what they were seeing in their communities and what the needs assessment for DSRIP (also conducted by the FLHSA) had revealed. 2013 Priority Areas in the region included: Obesity, Hypertension, Diabetes, Heart Disease, Tobacco Use, Falls, Slips and Trips in the 65+ population. Emerging issues included: Behavioral Health and Low back pain. This data was presented to the PH Directors and the hospital representatives in the region on March 4, 2016. As can be seen in the attached copy of the presentation (Attachment 2), the data collected and analyzed came from the following sources: Expanded Behavioral Risk Factor Surveillance Survey (EBRFSS), Census Bureau, SPARCS data, NY State Prevention Agenda data set, Aggregated Claims Data, NY State Vital Statistics, and the Regional High Blood Pressure Registry. Once this data had been reviewed, S²AY reviewed other data to develop a summary Power Point presentation of the highest need areas particularly for the county (Attachment 3). This additional review of data included, among other things: County Prevention Agenda Dashboard, EBRFSS, Community Health Indicator Reports, Sub-County Data Reports, Leading Causes of Death Indicators and County Health Rankings. In addition to the primary data reviewed from the high blood pressure registry, other primary data was obtained

through focus group input as described below (a focus group summary can be found in Attachment 4 and a full list of focus group notes can be found in Attachment 5).

4. Partners and Roles: While the primary partners in the assessment process include Yates County Public Health, Finger Lakes Health (Soldiers and Sailors Hospital), S²AY and the FLHSA there are a wide variety of other partners that serve in the Yates Community Health Planning Council (YCHPC) and the Choose Health Yates Committee. These lists are attached (Attachment 1). For the most part, the YCHPC provides the oversight of both process and implementation, while Choose Health Yates provides much of the implementation of specific activities. Each group includes a good mix of community representatives including FQHCs, CBOs, other County Departments, a substance abuse treatment provider (FLACRA), provider of services to the developmentally disabled population, and schools. Detailed roles in implementation are in the attached CHIP (Attachment 16).

5. Community Engagement: The community has been engaged in a variety of different ways. After S²AY prepared a presentation on the highest needs in Yates County, it was shared with eight separate and diverse focus groups throughout the community to review data with them, but also to gather their input and perceptions regarding needs in the County. Additionally, focus group participants were invited to attend the priority setting meeting. After the preliminary priority setting meeting was held, another opportunity for input from the general public was provided. Preliminary priorities were listed in a media release and also posted on the website of the hospital and Public Health (Attachments 13 and 14). The public was again asked to provide any additional input at this third opportunity.

6. Evidence-Based Interventions: As fully detailed in the CHIP, strategies to address chronic diseases include evidence based activities such as Stanford approved curriculums (e.g. Chronic

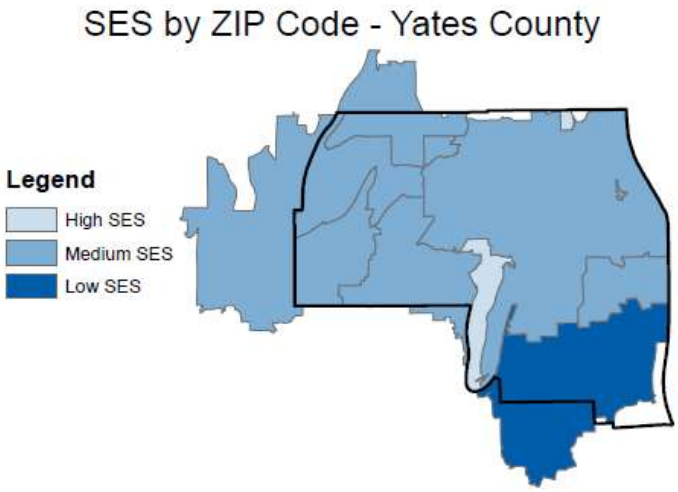
Disease Self-Management Program (CDSMP), policy/practice implementation (working with worksites to implement breastfeeding-friendly policies), and promoting provider practice participation in the regional hypertension registry. Strategies under "Promote Mental Health and Prevent Substance Abuse" include Goal 1.1 (promote mental, emotional and behavioral well-being in communities) and Goal 2.1 (prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults). The Yates Community Health Planning Council is working with the Yates County Substance Abuse Coalition (YSAC), Community Services, and the Yates County Suicide Coalition to offer and promote Mental Health First Aid/Youth Mental Health First Aid trainings, the QPR Gatekeeper Training, Too Good for Drugs program in schools, and offering NARCAN trainings to increase harm reduction.

7. Evaluation of Impact and Process Measures: Process measures are indicated in the attached CHIP (Attachment 16) and correlate with the objectives chosen from the "Refresh Chart" for the NYS Prevention Agenda. They include such measures as the increase in number of employers that have implemented lactation support programs, the percentage of patients in the participating FQHC diagnosed with HTN that are controlled and the percentage of patients in the participating FQHC diagnosed with HTN that have been screened for pre diabetes and diabetes, among other measures. The YCHPC meets bi-monthly and Choose Health Yates meets monthly, and the agenda for these meetings is focused on tracking progress, identifying barriers, strategizing how to overcome barriers and measuring progress. Progress will be reported to NY State starting by December 2017 per the established schedule.

1. Community Description and Health Needs:

Community Description:

The service area for this Community Health Assessment includes all of Yates County, NY. Yates County is a small rural county located in the western portion of New York State in the Central Finger Lakes. Three of the six Finger Lakes form part of the county's border, including Seneca on the east, Keuka on the south and Canandaigua on the west. Neighboring counties include Ontario to the north and west, Seneca on the east, Schuyler on the east and south, and Steuben to the south. The county is only 22 miles wide and encompasses a total of 338 square miles. The scenic lakes and extensive wine industry make Yates County a popular tourist destination. There are four incorporated villages and nine townships situated within the County. Penn Yan, the largest of four villages, is the County seat and is located at the north end of the east branch of Keuka Lake. The topography varies from steep hills and valleys in the western townships of the county to relatively flat land in the northern townships to gently rolling hills and valleys in the south, east and central portions. The County is host to a large agricultural base that also includes a thriving and growing Mennonite population. Agriculture, including dairy and crop farms, vineyards and wineries; remains a major source of employment for the county. The annual median household income is $50,061 compared to $54,482 for the nation and the per capita income is $25,436 compared to $28,555 for the nation. According to 2016 USDA data, the county poverty rate is 14.5% with 23.7% of children 0-17 years living in poverty. In the last 50 years, the population of the county has grown by almost 36%, climbing steadily throughout this time period. Much of this growth can be attributed to the Mennonite Community which currently comprises greater than 10% of the overall population and greater than 40% of all annual live births in the county. The population is widely scattered throughout the county with an average population density of approximately 75 persons per square mile.



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

Census Year	Yates County Population
1960	18,614
1970	19,831
1980	21,459
1990	22,810
2000	24,621
2010	25,348
2015 est.	25,048

In general, Yates County has a high dependency ratio, with 22.8% of the population estimated to be under age 18 in 2015 (6% under age 5), and 18.9% estimated to be aged 65 or over. Additionally, Yates County has a higher rate of people living with a disability (20.2%) compared to the state and national rates, and 30.6% of adults in the county have experienced housing insecurity in the past 12 months. Approximately 97.2% of the population is white, 1% is Black/African American and the remainder other races. In 2015, 2.2% of the population is estimated to be Hispanic/Latino. In the 2010 census, 149 people indicated that they spoke English "less than very well", while the 2015 estimates indicate that 12.2% (about 3,000 people) speak a language other than English at home, with 340 of these indicating that they speak Spanish at home.

Health Needs:

While each county in the eight county S²AY Network region started with a summary assessment of each county's data in the region in the FLHSA presentation (Attachment 2) and each county in the region followed a fairly similar process, each county's CHA was completed separately, and each county held their own focus groups within the county (summary can be found in Attachment 4). (Additionally, a sub-regional focus group was held in coordination with DSRIP through the Finger Lakes Performing Provider System (FLPPS) in each of the three Naturally Occurring Care Networks (NOCNs) that are in S²AY's region: Finger Lakes NOCN (Wayne, Seneca, Yates and Ontario Counties); S-E NOCN (Chemung and eastern Steuben Counties) and Southern NOCN (western Steuben, Livingston (and Allegany) Counties.)) Additionally, each county including Yates held their own "priority setting meeting" and worked through county-specific committees (YCHPC and Choose Health Yates Committees) to review data, analyze needs and develop priorities.

Based on analysis of all data, the major health issues in the community include:

Obesity: with 62.7% of Adults identified as overweight or obese, and over 20% of Children identified as obese. Additionally 4.7% of adults have a diagnosis of pre-diabetes, 13.2% diabetes and 29% hypertension. As can be seen in the attached Focus Group presentation, the analysis shows that obesity is important due to the many related health conditions linked to obesity, including heart disease, hypertension, diabetes, lower back pain, arthritis, high cholesterol and several types of cancer. Therefore by addressing obesity, several other health-related problems may be prevented. Obesity related data and other statistics cited below can be reviewed in the Yates County EBFRSS at:
https://www.health.ny.gov/statistics/brfss/expanded/2013/county/docs/yates.pdf
A disparity is shown in relationship to obesity in the data as well. The Community Health Indicator Reports show that Yates County is in the 4th quartile for the pre-pregnancy percentage of women in WIC who were obese (39%), while the EBRFSS shows that Yates County obesity rates are almost 17% higher for persons in households with incomes under $25,000.

Behavioral Health: (mental health and substance abuse) with data showing sharp increases in ED visits for substance abuse, heroin overdose, and mental health diagnoses, as well as admissions for heroin overdose (as shown in the attached PowerPoint presentations, Attachments 2 and 3). Discussions of the analysis related to the opioid epidemic included mortality rates,

premature loss of life, criminal behaviors related to substance abuse and the fact that substance use disorders affect entire families, often including the children of the person with the disorder. Yates County is a mental health HPSA.

Dental Health: with 34.2% of 3rd grade children having untreated dental caries placing it in the 4th quartile in NY State. Only 65.7% adults having visited a dentist within the past year. Good oral health is essential to the general health of the community. Tooth decay is preventable, but continues to affect all ages. It is a greater problem for those who have limited access to prevention and treatment services. According to the NYSDOH untreated decay among children has been associated with difficulty in eating, sleeping, learning, and proper nutrition. An estimated 51 million school hours are lost due to cavities. Almost one fifth of all health care expenditures in children are related to dental care. Among adults, untreated decay and tooth loss can also have negative effects on an individual's self-esteem and employability. Tooth decay may lead to abscess and extreme pain, blood infection that can spread, difficulty in chewing, poor weight gain, school absences and crooked teeth. Each year the S^2AY Network updates an inventory of which dentists accept Medicaid and Child Health Plus. While Yates County is fortunate to have dental care available to low-income and Medicaid patients through Finger Lakes Community Health and Regional Primary Care Network/Rushville Health Center (both of which are FQHCs that provide dental care to those with Medicaid or no insurance), it is a dental HPSA and dental care is in short supply.

CLRD/COPD (tobacco use): with the current percentage of adults who are smokers at 13.3% (age adjusted). The age-adjusted death rate due to Chronic Lower Respiratory Disease is 68 per 100,000, more than double that of NYS as a whole at 30 per 100,000. Tobacco use is a significant contributor to this health problem. While the tobacco use rate is lower than the rest of the region and the State as a whole, the tobacco use rate for those with household income under $25,000 is 28.9%. The rates of tobacco use for those reporting poor mental health (only available for the region as a whole) are also higher than the State.

Cerebrovascular Disease (and underlying hypertension issues): with an age-adjusted death rate of 32.4 per 100,000 is significantly higher than both NY State and the Finger Lakes region. The Emergency Department visit rate for adults is higher than NY State as a whole for hypertension. The percentage of adults who have taken a course or class to learn how to manage their chronic disease or condition (including hypertension, diabetes and arthritis) is lower in Yates County than in the region and NY State (age-adjusted basis). The percentage of pregnant women in WIC with hypertension during pregnancy also exceeds the State rate and placed Yates County in the 4th quartile for this measure.

Unintentional Injuries: with 36.7% of adults 65+ experiencing at least one fall in the past 12 months compared to the NYS percentage of 30.8%, and an age- adjusted death rate due to unintentional injury of 32 per 100,000 compared to that of NYS at 26 per 100,000, unintentional injuries are an area of concern in Yates County.
Full descriptions of the health needs data are included in the attached presentations for the FLHSA and the focus groups.

Health Care Access

YCHPC has discussed the access gaps related to the above health needs as they analyzed the data (Attachments 2 and 3). As discussed above, analysis of data reveals health disparities for the low-income population in general. With designations of primary care, mental health and dental Health Professional Shortage Areas (HPSAs), the capacity and distribution of health care providers is an issue. For example, transportation was repeatedly cited as a barrier in the focus groups, and was a key discussion in determining health care strategies. The YCHPC has helped support the development of a transportation system in the county to address some of these barriers. The S^{2}AY Rural Health Network, of which Yates County Public Health is a part, enrolls people in health insurance through its Navigator program. Additionally, it helps to serve the uninsured and under-insured through its Community Health Advocate program and Cancer Services Fund, both of which help people to address gaps in coverage or find access to health care.

The Mennonite population in Yates County poses somewhat of a challenge as well. Whenever possible, this group avoids participation in health insurance, since the Mennonite community as a whole serves as something of a safety net for unanticipated health care needs and expenses. Additionally, the population will not usually avail themselves of some typical health care services, avoiding some immunizations for example, or not seeking early prenatal care. The behaviors and culture of all specific populations in the county influence reasoning and strategies in development of the CHIP.

There are many issues that affect the quality of health care in a rural county such as Yates. Factors such as lower income levels, greater number of uninsured, poorer health, high prevalence of chronic conditions, lack of access to health care services, lower educational levels, and a lack of transportation can have a negative impact on health outcomes.

Risk Factors

Behavioral, environmental and socioeconomic factors all affect health outcomes. According to the CDC, scientists generally recognize five determinants of health of a population:

- Biology and genetics. Examples: sex and age
- Individual behavior. Examples: alcohol use, injection drug use (needles), unprotected sex, and smoking
- Social environment. Examples: discrimination, income, and gender
- Physical environment. Examples: where a person lives and crowding conditions
- Health services. Examples: Access to quality health care and having or not having health insurance[1]

These factors all entered into discussions when determining CHIP strategies and objectives. The sub-groups for these risk factors include lower-income, lower-educated and socially isolated

[1] CDC, Social Determinants of Health http://www.cdc.gov/socialdeterminants/Definitions.html

populations, as well as those with genetic predispositions for chronic disease, mental illness and alcohol/substance abuse.

Lack of access to primary care results in poor health outcomes since prevention, early detection, early treatment and referral to other needed services eases the effects of long-term chronic conditions. In Yates County socioeconomic conditions limit access to health care as well as limited availability of services within county borders. There is a lack of specialty providers within the county, limiting access for those without private transportation, although a new Public Transportation system is being tested on a pilot basis. For the most part however, services are available, if cost, behavioral and transportation barriers do not preclude access. Yates County residents may use Soldiers and Sailors Memorial Hospital, or depending on where they live in the County, they may also use hospitals in the adjacent counties including: Schuyler County (Schuyler Hospital), Steuben (usually Corning- Guthrie, or Ira Davenport in Bath), Tompkins (Cayuga Medical) or Ontario (FF Thompson, Geneva General or Clifton Springs) Hospitals.

Physical and economic conditions can cause geographic isolation for a portion of county residents. Public transportation within the county has always been an issue that is now being addressed on a pilot basis. Improving access to high-quality, continuous primary care and treatment services is critical in eliminating disparities in health outcomes. Unlike other medical services, the primary payment source for dental services is out-of-pocket. Yates County is fortunate to have dental services within county borders on a sliding fee scale as discussed below. Lack of transportation in rural areas, feeling intimidated by the health care system, lack of insurance and perceived confidentiality issues are some of the factors that may keep people from appropriately accessing care. Women in abusive relationships may be so controlled by their abuser that they are not allowed to get medical or dental care. Visibly poor dental health also makes it difficult for people to obtain jobs.

Personal barriers in access to care include:

- Personal value and behavior systems on the part of some county residents (particularly older residents) who refuse to take advantage of eligibility-based programs (such as Medicaid and Food Stamps) because they consider it a “hand-out”
- Personal belief and behavior systems on the part of the Mennonite population in Yates County may inhibit their access to care
- Lack of a private vehicle for transportation
- Lack of education and personal experience regarding the value of and need for primary and preventive care. This can include feelings of intimidation that some residents may experience in the presence of health professionals, leading both to avoidance of care and lack of empowerment in managing relevant aspects of their own healthcare, along with health literacy issues. For too many residents, emergency room care may be the only type of care accessed. While there is an emergency room, there are no urgent care services in the county. For a significant portion of females, family planning services may be their only access point to primary care services.

While access issues are present for some members of the community, the public health system partners regularly assesses these issues and strategies to reduce or eliminate them. See Attachment 15 for a listing of services.

Emerging issues in the health care S²AY system were also discussed, and Finger Lakes Health, Yates County Public Health and the S²AY Rural Health Network have all been active participants in DSRIP, working diligently to implement alternative models of care and improved care coordination. All also work in coordination with the FLHSA on the PHIP (Population Health Improvement Program) through Regional Leadership meetings that occur regularly, which are hosted by Yates County Public Health. As the non-profit arm for the regional Public Health Departments including Yates, the S²AY Network started a group called FLAST (Finger Lakes and Southern Tier) that is currently transitioning into an IPA (Independent Provider Association). While mostly comprised of FQHCs, S²AY is helping to lead the way for determining how to navigate the changing reimbursement structures for all types of organizations. S²AY reports progress on this development regularly to Yates County representatives.

2. Data Reviewed and Analyzed:

The data review and analysis was extensive. In all S²AY Network Counties including Yates, the process began with a data update for the eight county region conducted by the Finger Lakes Health Systems Agency (FLHSA) at the request of S²AY. This data collection and analysis effort focused on data related to the main priorities in the 2013 CHA for the region as well as some emerging issues that the hospitals and Public Health agreed should be analyzed based both on their knowledge of what they were seeing in their communities and what the needs assessment for DSRIP (also conducted by the FLHSA) had revealed. In addition to the DSRIP needs assessment, data sources for this review included:

- Expanded Behavioral Risk Factor Surveillance Survey (2013-2014)
- Census Bureau (2010 Census and 2015 American Community Survey estimates)
- SPARCS data (2010-2014)
- NY State Prevention Agenda data set (updated 2016)
- Aggregated Claims Data (2014)
- NY State Vital Statistics (2014)
- Regional High Blood Pressure Registry (2015)

Once this data had been reviewed, the S²AY Network staff reviewed and analyzed other data to develop a summary Power Point presentation of the highest need areas particularly for the county (Attachment 3). In addition to the above sources, this additional review of data included, among other things:

- County Prevention Agenda Dashboard (updated 2016, data from various dates)
- Community Health Indicator Reports (2010-2014)
- Sub-County Data Reports (2016 report, data various years)
- Leading Causes of Death Indicators (2012-2014)

- County Health Rankings (2016 report, data from various years)

In addition to the primary data reviewed from the high blood pressure registry, other primary data was obtained through focus group input as described above, and the Public Health System Assessment (PHSA) (Attachments 5 and 6).

3. Priorities, Disparities and Community Engagement:

Prevention Agenda Priorities -

As detailed on the attached Community Health Improvement Plan (CHIP), the two New York State Department of Health (NYSDOH) Prevention Agenda priority areas for Yates County for the 2016-2018 period include:

1. **Priority Area 1: Prevent Chronic Diseases**
    - *Focus Area 1:* Reduce Obesity in Children and Adults
    - *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings

2. **Priority Area 4: Promote Mental Health and Prevent Substance Abuse**
    - *Focus Area 1:* Promote Mental, Emotional and Behavioral Well-Being

Disparities Being Addressed –

During the 2016-2018 period, Yates County Public Health, Finger Lakes Health and their partners have chosen to address three disparities through specific evidence based activities (as outlined in the attached CHIP chart, Attachment 16). All of the disparities to be addressed fall under the Prevention Agenda priority area of Prevent Chronic Diseases. The first disparity focuses on Goal 1.4 (expand the role of public and private employers in obesity prevention). This disparity will target lower socioeconomic status (SES) female employees at county-located worksites by working with employers to adopt breastfeeding-friendly policies. The second disparity focuses on Goal 3.2 (promote evidence-based care to manage chronic disease). This disparity will target lower-SES patients receiving primary care through Federally Qualified Health Centers (FQHCs), by using decision/support tools/reminder systems in electronic medical records (EMRs) and promoting provider participation in the regional hypertension registry. The last disparity focuses on Goal 3.2 (promote culturally relevant chronic disease self-management education). This disparity will target clients of Workforce Development's Job Club (un or under-employed individuals with a high percentage being lower SES and male) to participate in evidence based interventions to prevent or manage chronic disease (Stanford approved Chronic Disease Self-Management Program (CDSMP)). Disparities were chosen by the YCHPC based on analysis of the data and potential to reach disparate populations.

Community Engagement –

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

MAPP –

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

1. **Organize for Success- Partner Development**
   This included representatives of the Yates County Health Planning Council (YCHPC) and the Choose Health Yates Committee discussed above. These collaborative, multi-disciplinary groups oversaw the assessment process and the development of the CHIP.

2. **Assessments**
   Four assessments inform the entire MAPP process. The assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods. The use of four different assessments is a unique feature of the MAPP process. Most planning processes look only at quantitative statistics and anecdotal data. MAPP provides tools to help communities analyze health issues through multiple lenses. The first assessment examined the Community Health Status Indicators. This includes relevant secondary statistical data as well as some primary data.

   The second assessment evaluated the effectiveness of the Public Health System and the role of Yates County Public Health Department within that system. This was done using a modification of the Local Public Health System Assessment tool developed by the CDC and NACCHO. This was also conducted via an electronic survey on Survey Monkey. A diverse group of key informants were chosen to complete the survey, including community leaders who are familiar in some way with the local public health system. The assessment was completed through the use of a more user-friendly version of the CDC and NACCHO tool, Local Public Health System Assessment (LPHSA). Each of the ten essential public health services was rated by the group by ranking the series of indicators within each Essential Service to determine areas of strength and areas needing improvement within the Local Public Health System (see Attachment 6).

The third assessment was the Community Themes and Strengths Assessment that was conducted through focus groups which were held throughout the County. This assessment looked at the issues that affect the quality of life among community residents and the assets the County has available to address health needs. These were held in conjunction with the fourth assessment that looked at the "Forces of Change" that are at work locally, statewide and nationally, and what types of threats and/or opportunities are created by these changes (see Attachments 4 and 5).

3. Identification of Strategic Issues

This step included both developing the list of major health issues based on all the data obtained, and prioritizing these issues (Attachment 8).

4. Formulate Goals and Strategies

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

The process of Community Engagement using MAPP –

Yates County Public Health and Finger Lakes Health, with assistance from the S²AY Rural Health Network, conducted a comprehensive assessment of the community, which provided the basis for the Prevention Agenda priority areas selected above. The assessment process included a thorough review and analysis of county specific data around health needs, compared to neighboring counties, the region, and the State as a whole. As noted above, this included data collection and analysis by both the FLHSA and S²AY. The YCHPC, which includes FQHCs (Finger Lakes Community Health and Regional Primary Care Network (RPCN), other Yates County Departments (Office for the Aging, Department of Social Services, Community Services, Veterans Services Agency) a substance abuse treatment provider (FLACRA), provider of services to the developmentally disabled population, schools and CBOs, oversaw the assessment process. (Choose Health Yates consists of the same types of groups, although the staff members representing each agency may be different than the person serving on the YCHPC, also assisted with the assessment process and CHIP development, and oversees the implementation process.) After the data was analyzed and prepared, this data was shared in the form of focus group presentations to county residents. Yates County conducted eight separate focus groups with key informants throughout the county to solicit feedback. Focus groups were selected to include a broad diversity of community members from different segments of the community, including populations that experience health disparities as outlined in this report. Focus groups that were conducted in Yates County included the following: a Tier II meeting (agencies working with children/families), Workforce Development Job Club (unemployed and under-employed

residents, most of whom were low income), the Penn Yan Baby Café (young parents, many of whom are also low income), a Bone Builder Class (mostly seniors), the Long Range Planning Committee of the Yates County Chamber of Commerce (business community), the Penn Yan Lions Club (community residents), and the Finger Lakes NOCN (meeting held in Ontario County).

After the completion of the focus groups, the YCHPC invited focus group participants, all community members, health care organizations, and human service agencies to participate in the prioritization of the most pressing health needs identified from the data collection and focus group input. Focus group participants and community members were invited to this meeting through email, media releases, and postings on websites and social media platforms (Public Health, Hospitals, S²AY Rural Health Network, and other partners). S²AY prepared another Power Point presentation for this "Priority Setting" meeting. The meeting was open to the public and focus group participants were invited. At this meeting, S²AY presented the data shared with the focus groups, along with key slides from the EBRFSS and Community Health Indicator Reports. Input from the focus groups was analyzed and considered when developing a list of priorities for the group to rank that S²AY created from all of the data reviewed and analyzed (list of issues to rank attached). The group was also offered the opportunity to add any additional issues that they believed needed to be ranked to come up with priorities.

The Hanlon Method was used to rank issues, and a presentation summarizing the Hanlon Method was reviewed (Attachment 9), and participants ranked the highest priority issues to come up with a list of preliminary priorities (Attachment 11). (Hanlon uses the Basic Priority Rating (BPR) System formula where BPR = (A + 2B) X C where A= the size of the problem, B= the severity of the problem and C=the effectiveness of the solution. The effectiveness of the solution is given a lot more weight than the size or seriousness of the problem, with the hope of making wise use of limited resources by targeting solutions that are known to be effective. Participants also consider the weight of the propriety, economic feasibility, acceptability, resources and legality (PEARL) of issues in this ranking system. Numerical values were determined by each participant for size, severity and effectiveness, and then plugged into the formula along with average PEARL scores. It is important to note that while the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still a method that is largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since respondents ranked each component (size, seriousness and effectiveness of the solution, as well as the PEARL factors) individually using a paper ranking form (blank rating sheet attached), the rankings were not heavily influenced by group dynamics.) After the preliminary priorities were chosen, a media release was done and preliminary priorities were posted on the Public Health and hospital websites (see Attachments 13 and 14). The next three meetings of the YCHPC were then focused on finalizing the priorities, choosing disparities based on an additional analysis of the data within each priority area, and choosing the interventions, strategies and activities to address the selected priorities and disparities. At these meetings, all of the data discussed above was available and used to guide discussions, including sub-county level data from the NYS Department of Health:
http://www.nysacho.org/i4a/pages/index.cfm?pageID=3810

As fully detailed in the CHIP, strategies to address chronic diseases include evidence based activities such as Stanford approved curriculums (e.g. Chronic Disease Self-Management Program (CDSMP), policy/practice implementation (working with worksites to implement breastfeeding-friendly policies), and promoting provider practice participation in the regional hypertension registry. Strategies under "Promote Mental Health and Prevent Substance Abuse" include Goal 1.1 (promote mental, emotional and behavioral well-being in communities) and Goal 2.1 (prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults). The Yates Health Planning Council is working with the Yates County Substance Abuse Coalition (YSAC), Community Services, and the Yates County Suicide Coalition to offer and promote Mental Health First Aid/Youth Mental Health First Aid trainings, the QPR Gatekeeper Training, Too Good for Drugs program in schools, and offering NARCAN trainings to increase harm reduction.

Additionally, a Public Health System Assessment was completed as part of the MAPP process using key informants as respondents, with this input incorporated into the decision-making process. The Public Health System Assessment looks at how the whole public health system is functioning, and its strengths and weaknesses. The results of this primary data collection are included in Attachment 6, and the data was analyzed and discussed at the "priority setting meeting" and was used in formulating the CHIP.

4. Community Health Improvement Plan (CHIP):

Lessons Learned/Progress on Current CHIP –

Progress in reducing childhood and adulthood obesity rates, preventing chronic disease through a reduction in hypertension and reducing fall risk in vulnerable populations has been slow throughout the 2013-2015 CHIP period, in part due to the difficulty in effecting behavior change. However, efforts have not been entirely unsuccessful.

A few highlights include the opening of a Breastfeeding Café in Yates County, trained Certified Lactation Counselors available to assist women both thru home visits and phone consultation and efforts with local employers to adopt breastfeeding policies including the County which now has a dedicated, comfortable room for both employees and visitors to the county complex to use for breastfeeding and pumping. Through the restaurant initiative, eleven restaurants are currently utilizing the table tents to encourage selection of healthy menu options, and through a Sodium Reduction Grant the local hospital and senior meal program have implemented sustainable changes to food selection and preparation aimed at reducing sodium content. Efforts were successful in bringing Foodlink to the county for a trial basis during the summer of 2015, making affordable produce available in three convenient locations.

The Finger Lakes High Blood Pressure Registry was successfully expanded to providers serving Yates County patients with currently 3,363 county patients included. This is approaching 90% of the patient volume estimated to have a diagnosis of hypertension. While control rates have not yet reached the target of 85%, this initiative has had preliminary success in providing meaningful data to the provider practices which can be used to explore practice level

improvement opportunities. Future efforts will place a focus on assisting practices to identify those patients who have not been seen in the last 12 months and those with Stage 2 hypertension. Partnering agencies were able to expand fitness programs aimed at reducing falls in the elderly such as Bone Builders and Tai Chi. These have been well attended by seniors and be will continued.

Key lessons learned through the 2013-2015 CHIP are the difficulty in effecting behavior change and challenges in keeping partner engagement, especially when time and funding are limited or reduced. We anticipate that these challenges will continue in the upcoming CHIP period.

Community Health Improvement Plan –

Please see the attached Yates County CHIP chart (Attachment 16), created using the template provided by the NYSDOH and the "Refresh Chart" for the Prevention Agenda. The Refresh Chart includes both NY State and National standards and research and can be found here: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/nysdoh_prevention_agenda_updated_evidence_based_interventions_2015.pdf

The Prevention Agenda itself is based on the development of NY State standards and measures and National standards and measures and may be found here: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/tracking_indicators.htm

The Yates Health Planning Council (YHPC) and Choose Health Yates Coalition (CHY) spent several meetings developing and refining the attached Community Health Improvement Plan (CHIP) chart, the overall work plan for community health improvement. This chart outlines the actions that both Yates County Public Health and Finger Lakes Health intend to take to address each priority area, the specific resources Yates County Public Health and Finger Lakes Health intent to commit (dollar amounts and/or FTEs), the roles of other partners engaged in each activity, and the chosen disparities being addressed by these efforts. Both the investment partners make and the expected community benefits are outlined in the CHIP.

5. Maintaining Engagement and Tracking Progress:

As seen above, the CHIP chart designates the organizations that have accepted responsibility for implementing each of the activities outlined. The YCHPC is the group that will be overseeing the implementation, monitoring, and evaluation of the plan. The YCHPC meets on a bi-monthly basis (and has been meeting since about 2006) and has accepted this role of overseeing the CHIP. The Choose Health Yates Coalition (CHY), which includes Yates County Public Health, Finger Lakes Health, and several additional partners (community based organizations, Cornell Cooperative Extension, Yates County Youth Bureau, etc.), is the work group that will be carrying out the activities of the CHIP, reporting back to the YCHPC. CHY meets on a monthly basis (and has been meeting since before the last CHA/CHIP cycle in 2013) and has accepted this role as the work group for the plan. Currently, each partner organization reports CHIP updates to CHY on a bi-monthly basis. Progress is recorded on the CHIP document, which is then shared with the YCHPC. All partners review the CHIP chart to ensure that all activities/progress are captured, to discuss barriers, and identify new opportunities or changes in

activities. Furthermore, progress will also be reported quarterly to the Yates County Legislature through the Yates County Human Services Committee (which has been done since the last CHA/CHIP cycle in 2013). Finger Lakes Health will continue to communicate CHIP/Community Service Plan (CSP) updates to the Health Systems Board annually, and activities will also be shared with the S²AY Rural Health Network Board at their quarterly meeting. Activities on the CHIP will continually be assessed and modified as needed to address barriers and replicate successes. As priorities are addressed, other community partners may need to be brought to the table to effectively accomplish objectives. The YCHPC and CHY are aware of this and experienced at this, as several new council/coalition members have been recruited since the 2013 CHA/CHIP cycle.

6. Dissemination:

The Executive Summary of the 2016-2018 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)/Community Service Plan (CSP) created in partnership between the lead entities (Yates County Public Health and Finger Lakes Health) will be disseminated to the public in the following ways:

- Through an initial media release summarizing the results and again offering the opportunity for public involvement during the first quarter of 2017
- Made publicly available on the Yates County Public Health main website
- Made publicly available on the Finger Lakes Health main website
- Made publicly available on the S²AY Rural Health Network website
- Made the CHA and CHIP publically available to our partners so that they may share and disseminate the information as well
- Publicly available on additional partners websites (Cornell Cooperative Extension, WIC, local community based organizations, etc.)
- All partners including Yates County Public Health, Finger Lakes Health, S²AY Rural Health Network, and additional partners will be asked to share the publication and website links of the CHA/CHIP/CSP on their respective social media accounts (Facebook, LinkedIn, Twitter, etc.)
- Additionally, as significant accomplishments or changes are noted, the information will again be shared with all appropriate news outlets in the form of a press/media release

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

Yates County Public Health: http://www.yatescountypublichealth.org/
Finger Lakes Health: https://www.flhealth.org/
S²AY *Rural Health Network:* http://www.s2aynetwork.org/community-health-assessments.html

Yates Community Health Planning Council (YCHPC)

Membership List 2016

Amy Miller, Commissioner of **Social Services**

Caryl Sutterby, Coordinator **Our Town RoCKS Dundee Neighborhood Project**

Catie Kunecki, Regional Health Planner and Data Analyst **Finger Lakes Health Systems Agency**

Christine Ayers, **Regional Primary Care Network**

Daniele Lyman, President & CEO **ARC of Yates**

Deb Fabris-Coon, Chief Program Officer **ARC of Yates**

Deborah Minor, Director of **Public Health**

George Roets, **Community Services Director**

Hillary Anderson, **S2AY Rural Health Network**

Katie Smeenk, Director **Office of the Aging**

Kelly Houck, Superintendent **Dundee Central School**

Lara Turbide, **Finger Lakes Health**

Loree MacKerchar, Manager, Community Relations **Finger Lakes Health**

Martin Teller, Executive Director **Finger Lakes Addictions Counseling & Referral Agency**

Mary Zelazny, CEO **Finger Lakes Community Health**

Melissa Copella, Dental Director **Regional Primary Care Network**

Michael Leary, Executive Director **Rochester Primary Care Network**

Philip Rouin, Director Yates **County Veterans Services Agency**

Sarah Simons, Rushville Practice Manager **Regional Primary Care Network**

Taryn Windheim, **ARC of Yates**

Tori Oliver, **Finger Lakes Health Systems Agency**

Trilby deJung, **Finger Lakes Health Systems Agency**

Choose Health Yates Coalition (CHY)

Membership List 2016

Caryl Sutterby, **Our Town RoCKS Dundee Neighborhood Project**

Catie Kunecki, **Finger Lakes Health Systems Agency**

Deborah Minor, **Public Health**

Kathy Swarthout, **Public Health**

Anne Murphy, **Public Health**

Karen Brennan, **Head Start**

Pam Strong, **ProAction of Steuben and Yates**

Pam Griffith, **Yate County Cultural and Recreational Center**

Alicia Avellaneda, **Yates County Youth Bureau**

Amy Miller, **Social Services**

Autumn White, **S2AY Rural Health Network**

Barb McGuffie, **Cornell Cooperative Extension**

Becky Bennet-Tears, **ProAction of Steuben and Yates**

Kim Arnold, **S2AY Rural Health Network**

Dana Burton, **Penn Yan Central School**

Deb Fabris-Coon, **Arc of Yates**

George Roets, **Community Services**

Jen Hutches, **Dundee Central School**

Katie Peterson, **Yates County Cultural and Recreational Center**

Lauren Snyder, **Community Member**

Mary Zelazny, **Finger Lakes Community Health**

Penny Gugino, **Tobacco Action Coalition of the Finger Lakes**

Brigid Heenan, **Tobacco Action Coalition of the Finger Lakes**

Sara Christensen, **Public Health**

Sara Crevelling, **Penn Yan Library**

Hillary Anderson, **S2AY Rural Health Network**

Katie Smeenk, **Office of the Aging**

Kelly Houck, **Dundee Central School**

Loree MacKerchar, **Finger Lakes Health**

Phil Rouin, **Veterans Services**

Finger Lakes Health Systems Agency

Regional Leadership Meeting

March 4, 2016

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

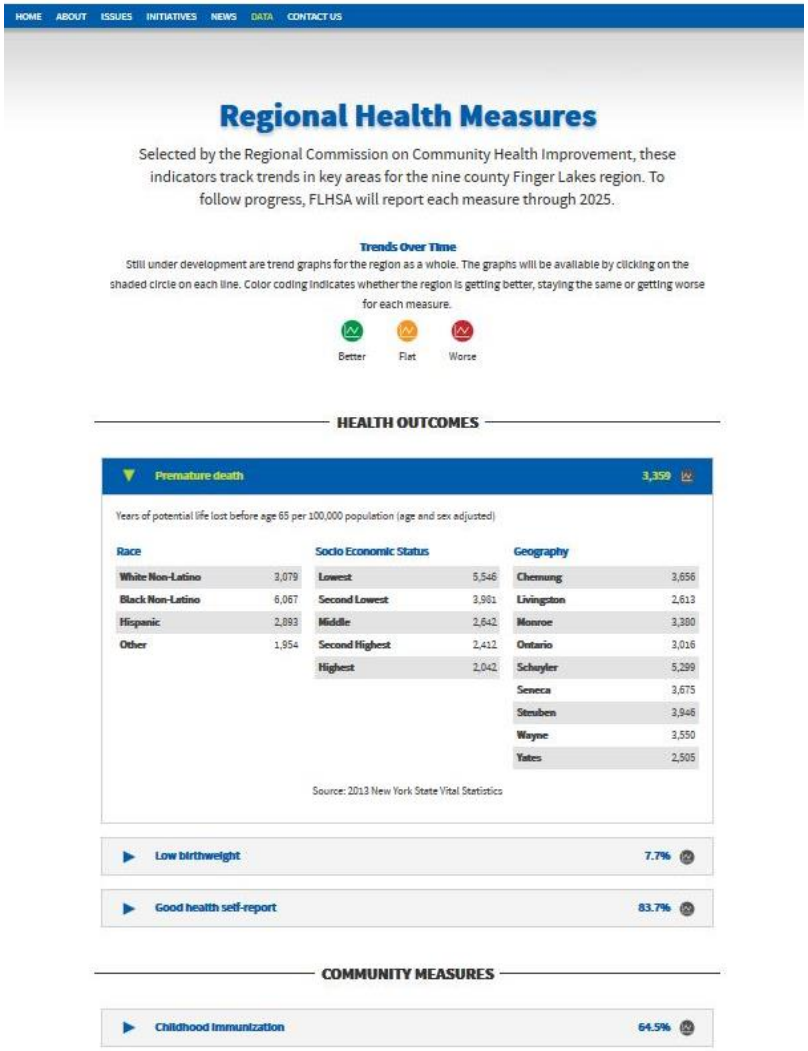
Research & Analysis Updates

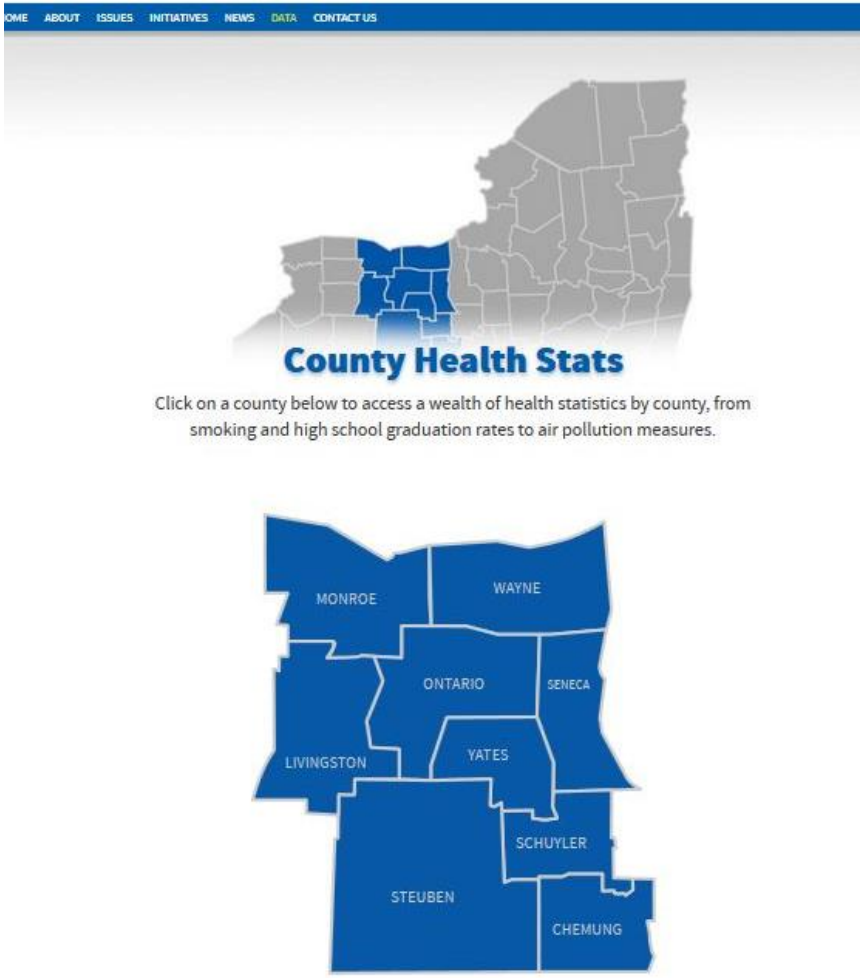
- Continuous Capability Enhancement

- Regional Population Health Measures

- Community Insight & Input

FLHSA Website Enhancements



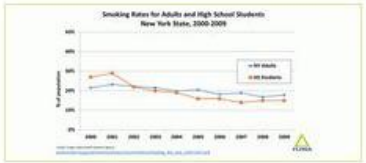


FLHSA Website Enhancements

HOME ABOUT ISSUES INITIATIVES NEWS DATA CONTACT US

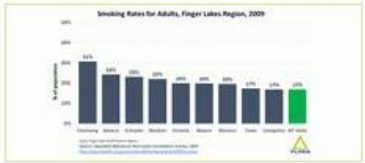
Insights

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



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

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

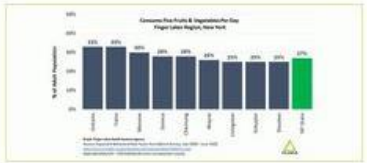


Smoking rates for adults, Finger Lakes Region, 2009

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

DOWNLOAD IMAGE [PPT]

DOWNLOAD IMAGE [PDF]



Rate of fruit and vegetable consumption, Finger Lakes Region

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

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

Finger Lakes Health Systems Agency

An Analytic Review of Selected Priority Areas

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

Approach & Methodology

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

2013 Community Health Assessment Priority Areas

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

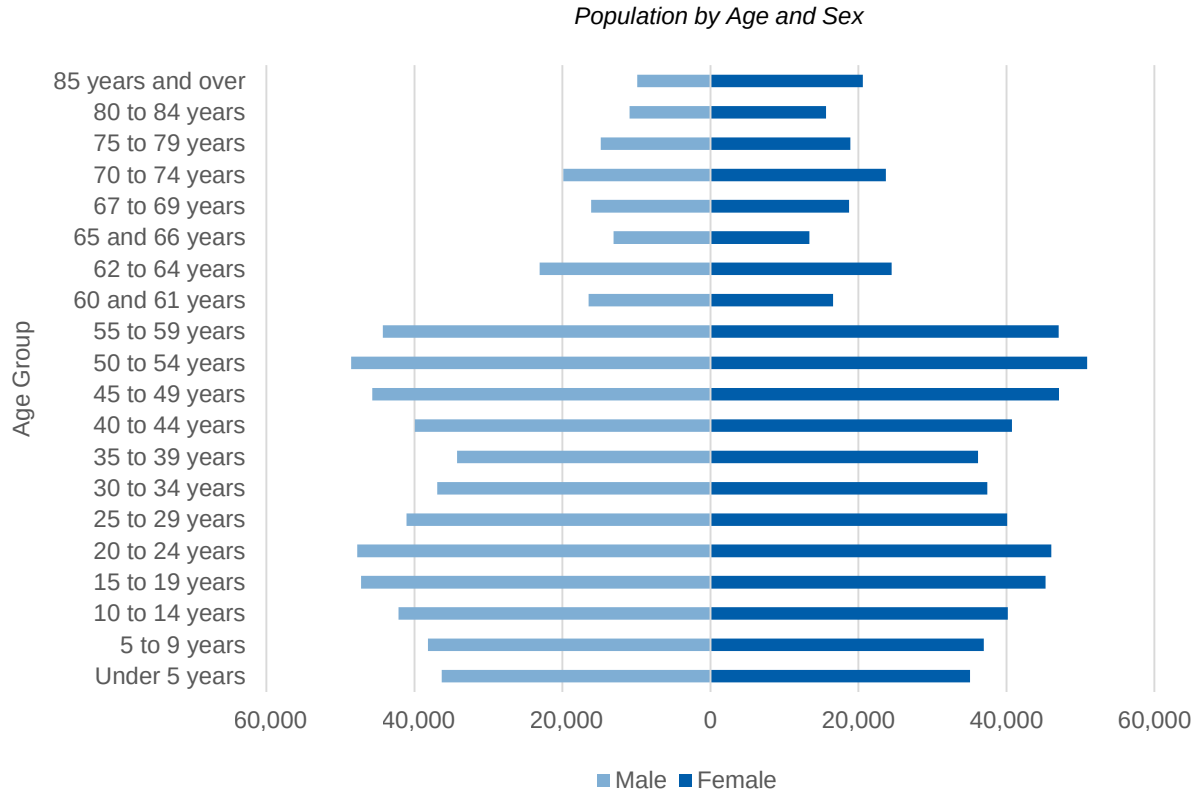
Approach & Methodology, Continued

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

THE FINGER LAKES REGION: DEMOGRAPHICS

The Finger Lakes Region

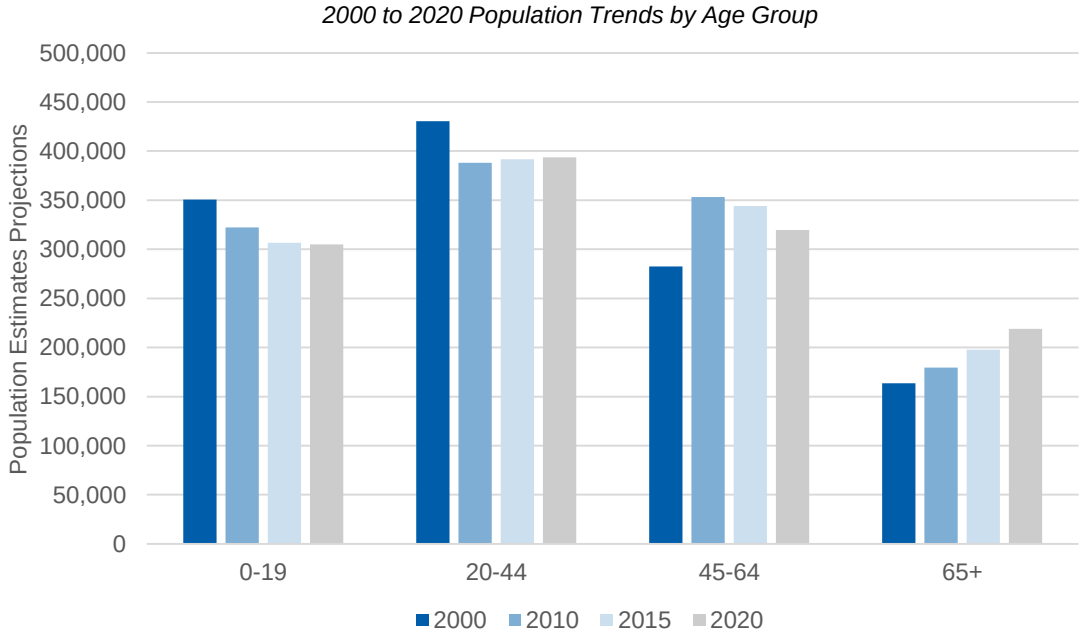
- There are approximately 1,281,374 persons living in the Finger Lakes Region. Age/Gender distributions are essentially equivalent, but begin to shift towards the female population starting at age 75.



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

The Finger Lakes Region, Continued

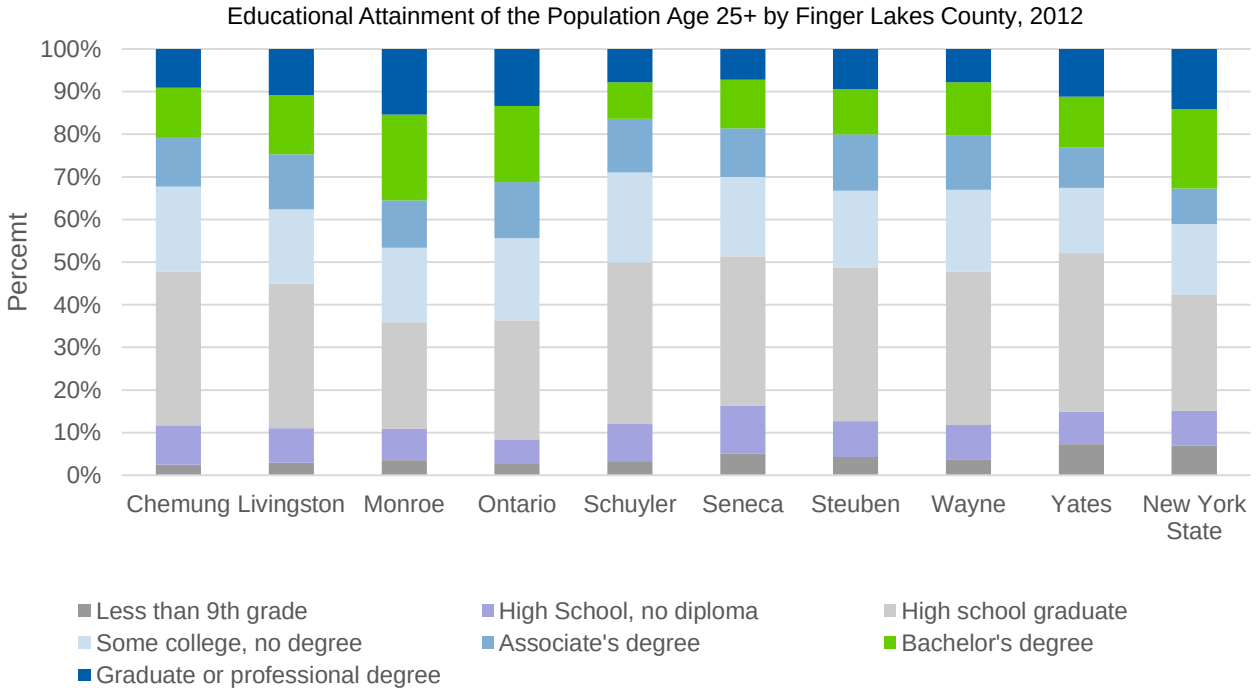
- Population projections show little change in the pre-school, school aged and adults of child bearing ages by 2020. The 45-64 population will decrease slightly, while the 65+ age group will grow.



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

The Finger Lakes Region, Continued

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

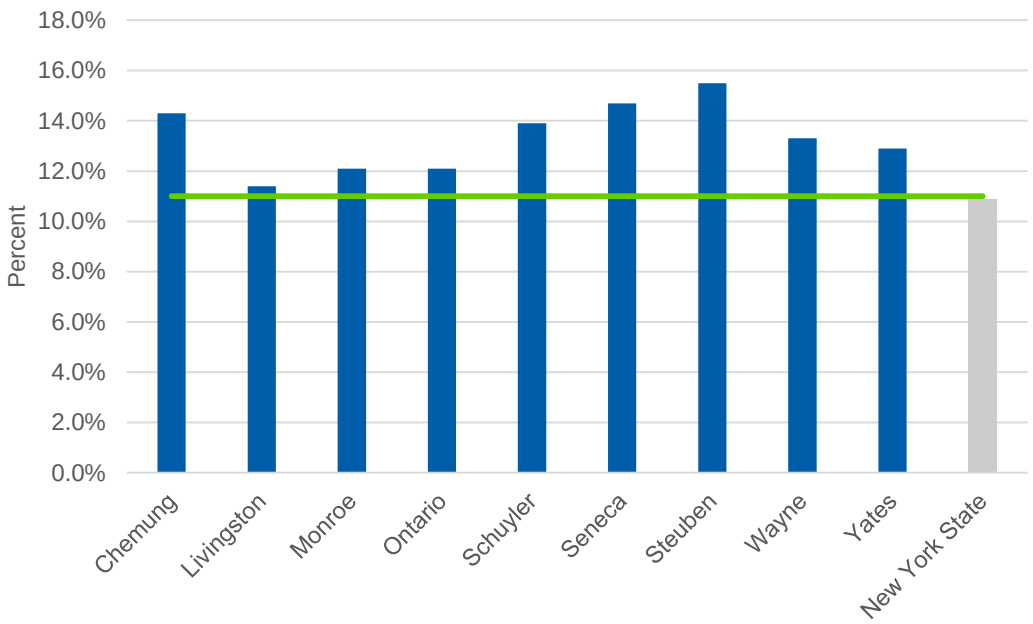


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

The Finger Lakes Region, Continued

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

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

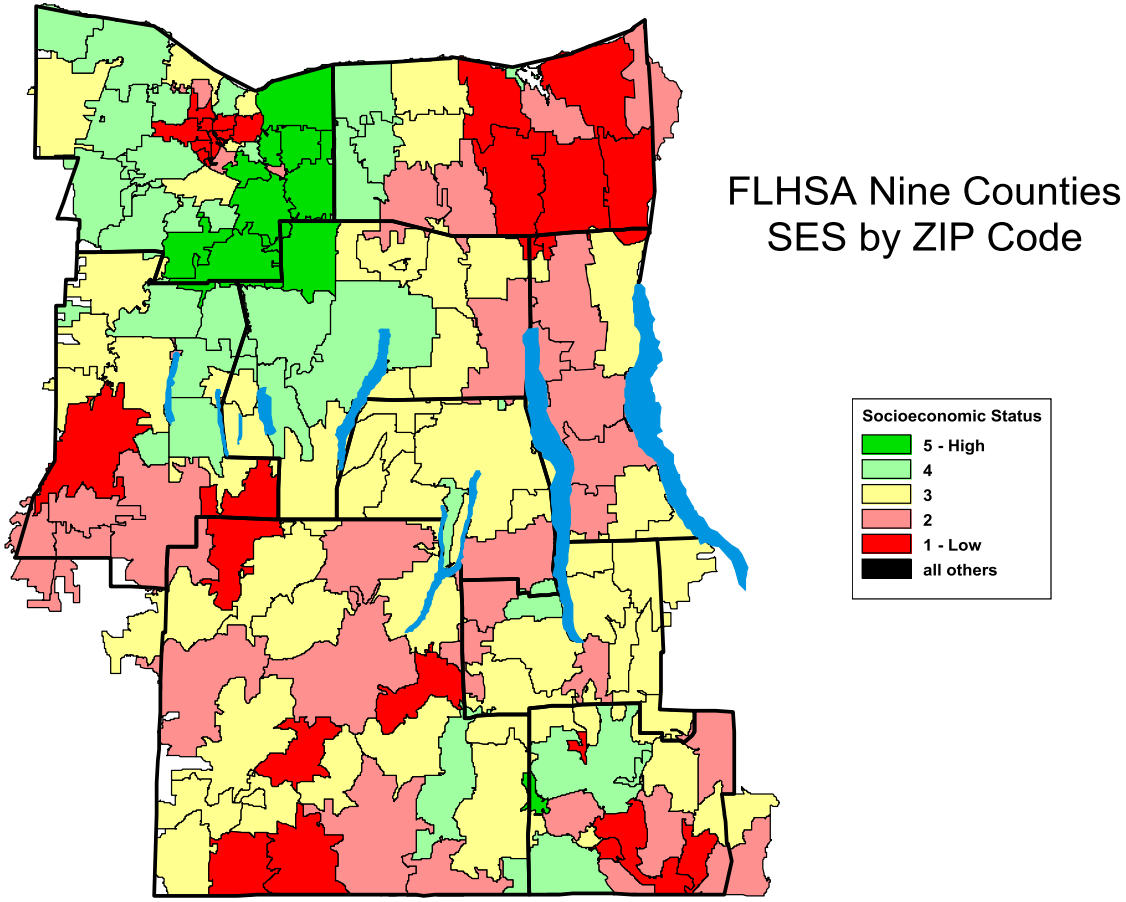


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

The Finger Lakes Region, Continued

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

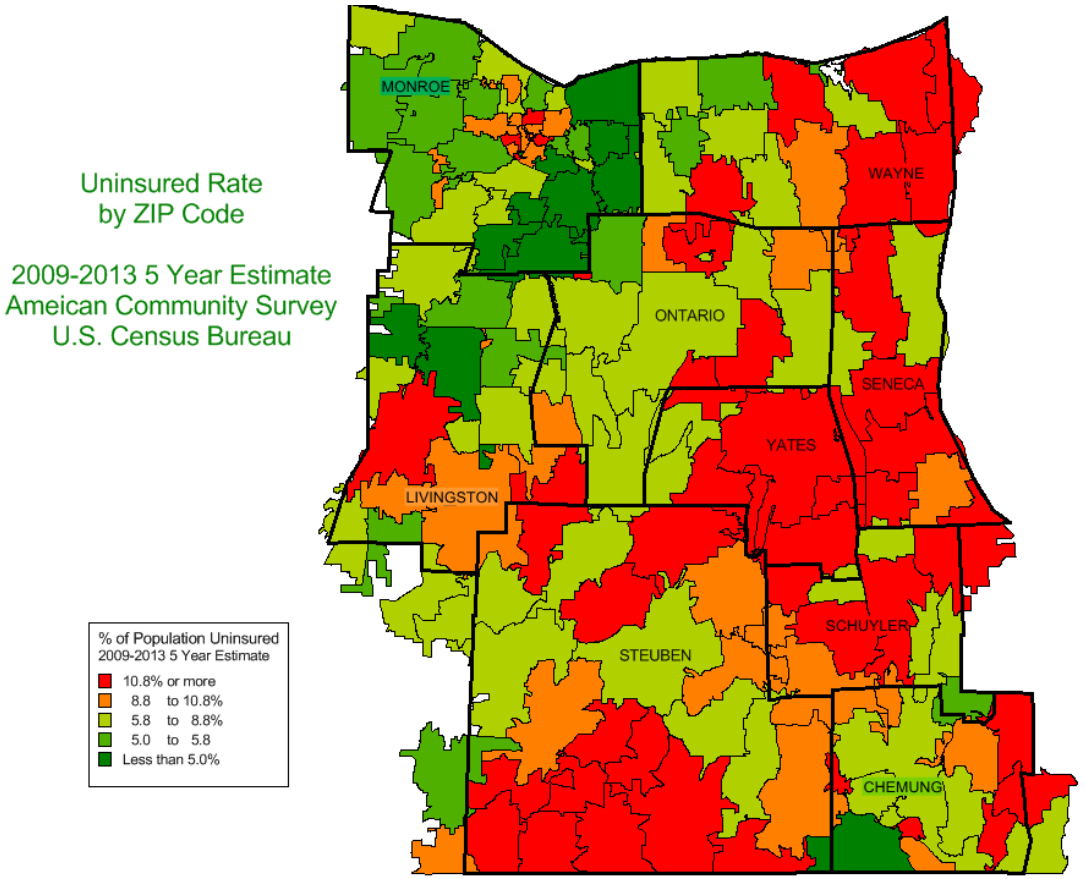
Socioeconomic Status of Finger Lakes Region based on ZIP Code



The Finger Lakes Region, Continued

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

Percent of Finger Lakes Region Uninsured by ZIP Code



DATA UPDATES:
THE EIGHT PRIORITY AREAS

The Eight Priority Areas

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

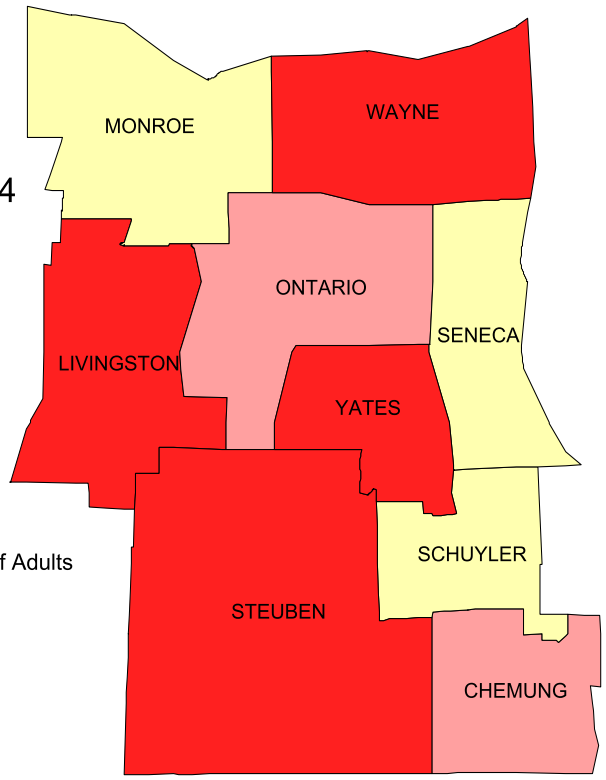
PRIORITY AREA 1: OBESITY

Obesity

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

Percent of Adults who are Obese in Finger Lakes Region

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



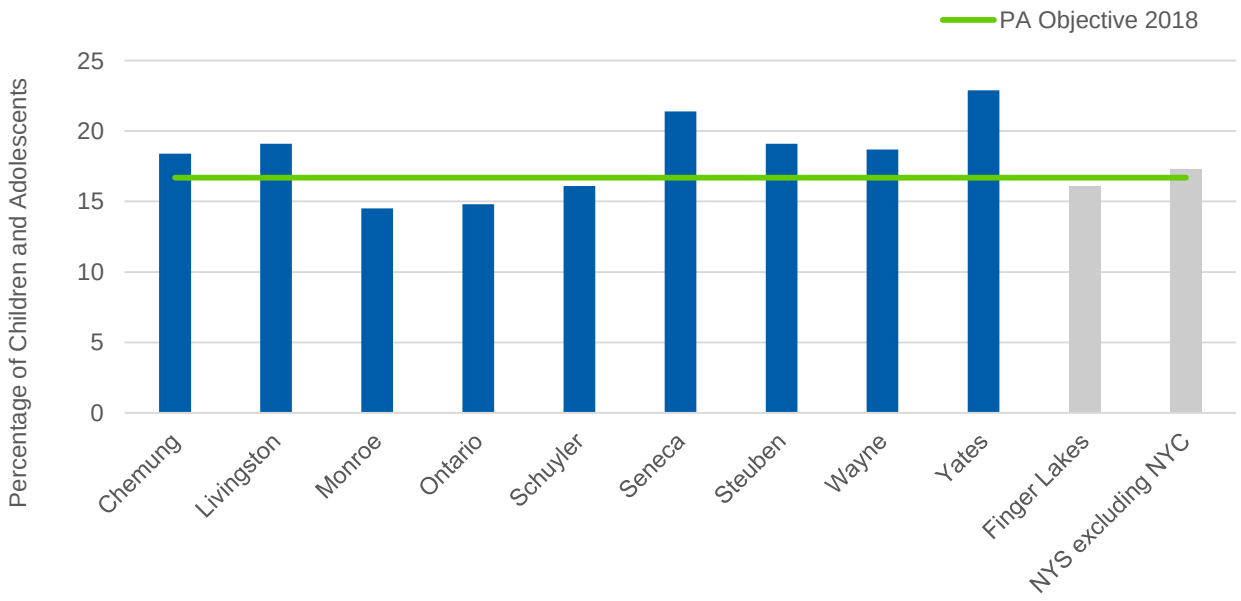
The Prevention Agenda Objective for 2018 is 23.2% of Adults

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

Obesity

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

Percentage of Children and Adolescents who are Obese



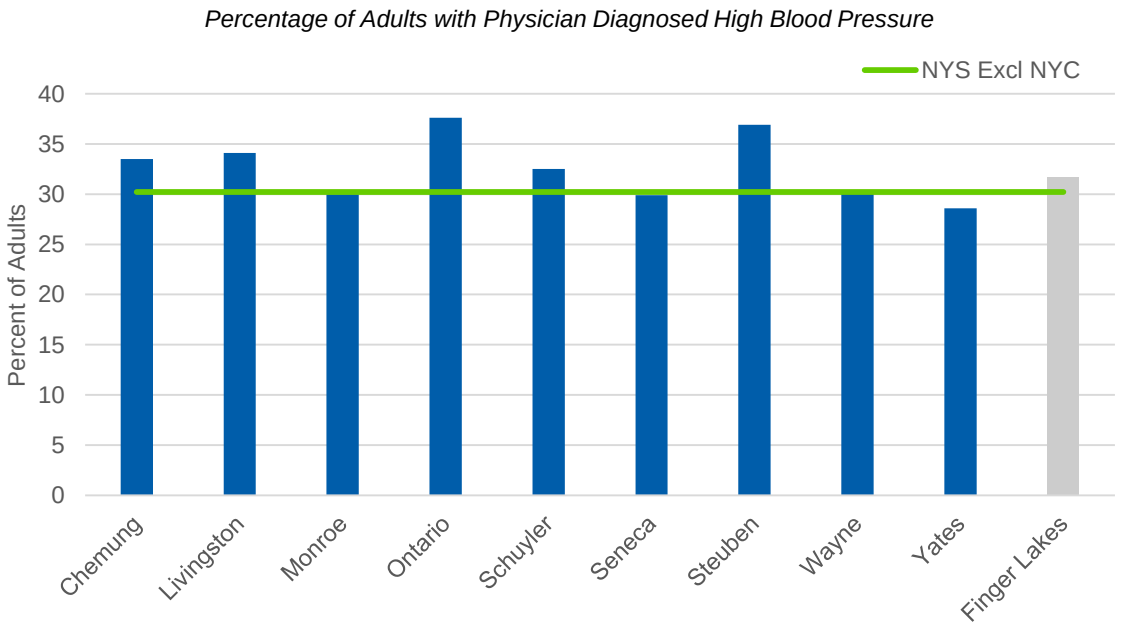
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2012-2014

PRIORITY AREAS 2-4: CHRONIC DISEASE

HYPERTENSION, DIABETES, AND HEART DISEASE

Chronic Disease- Hypertension

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

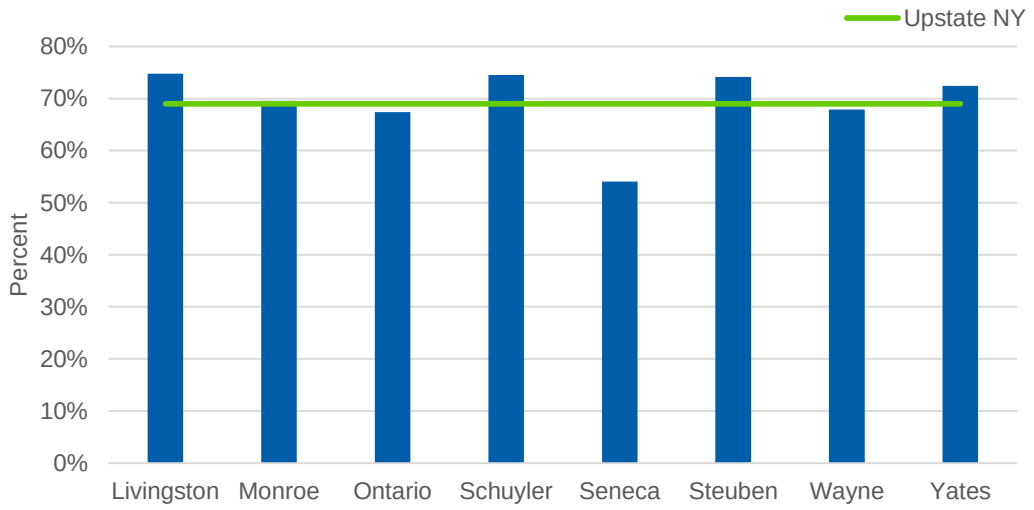


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Chronic Disease- Hypertension

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

Hypertension Control Rates, June 2015

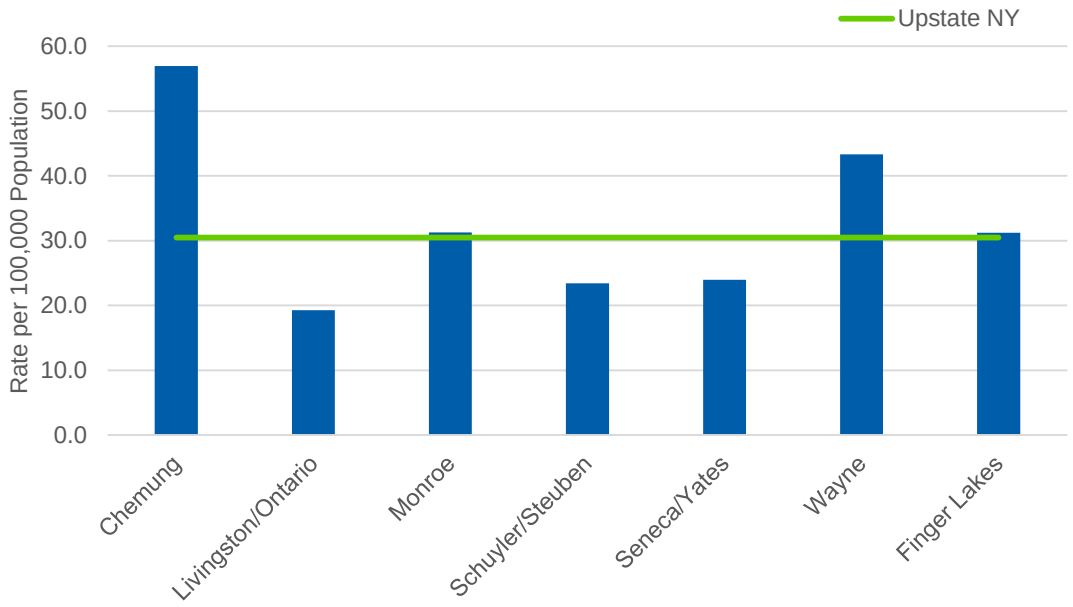


Data Source: FLHSA/RBA High Blood Pressure Registry, June 2015
Note: Chemung has been excluded due to small sample.

Chronic Disease- Hypertension

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

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

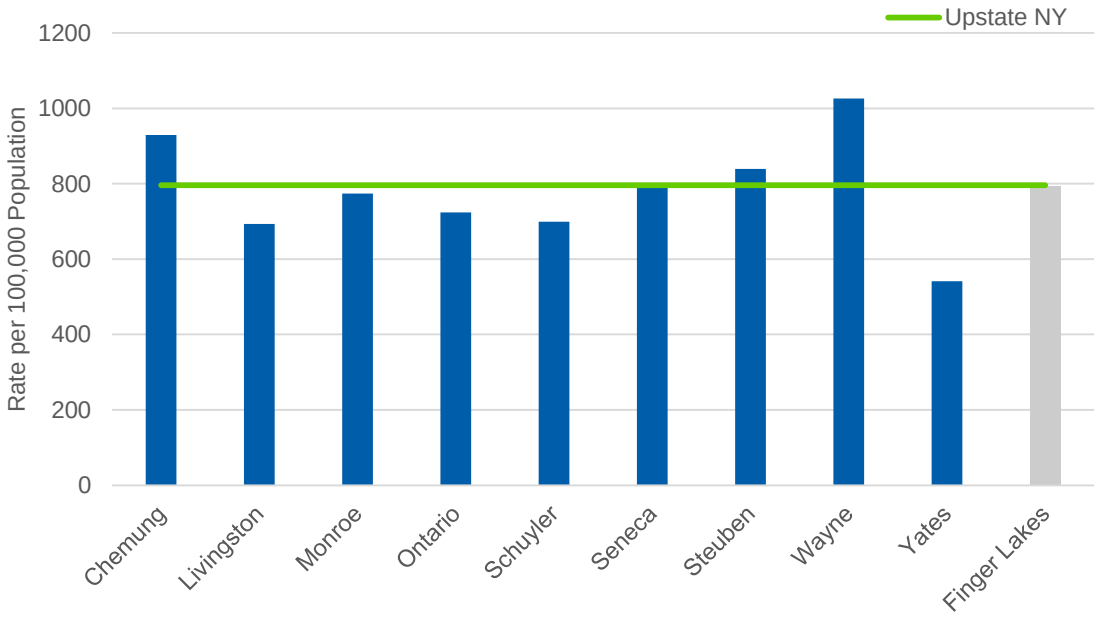


Data Source: SPARCS, 2013
Hypertension as a primary or cormorbidity diagnosis

Chronic Disease- Heart Disease

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

Rate of Inpatient Heart Disease Admissions per 100,000 Population

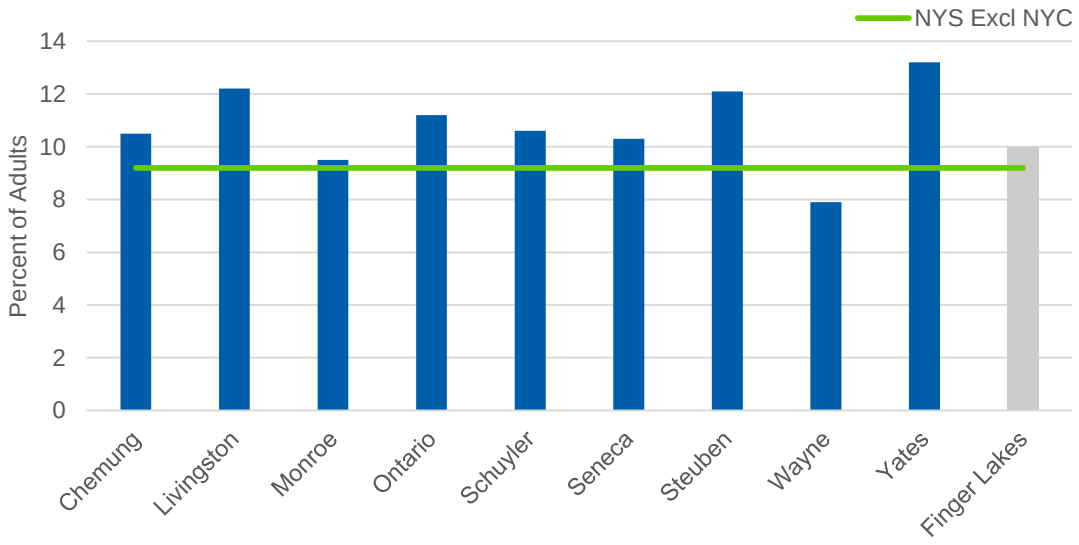


Data Source: SPARCS, 2013

Chronic Disease: Diabetes

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

Percentage of Adults with Physician Diagnosed Diabetes

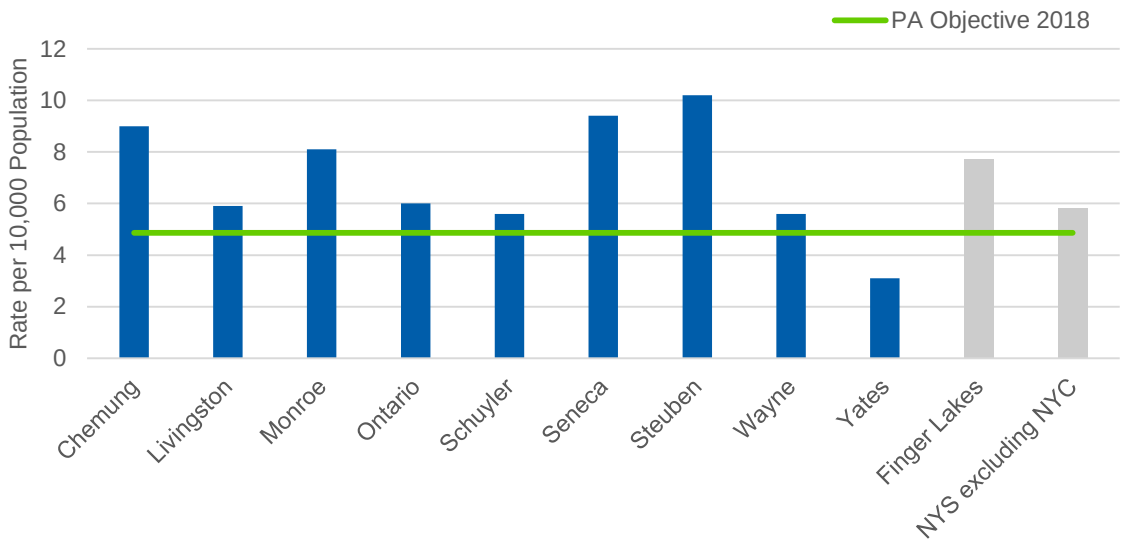


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Chronic Disease: Diabetes

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

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

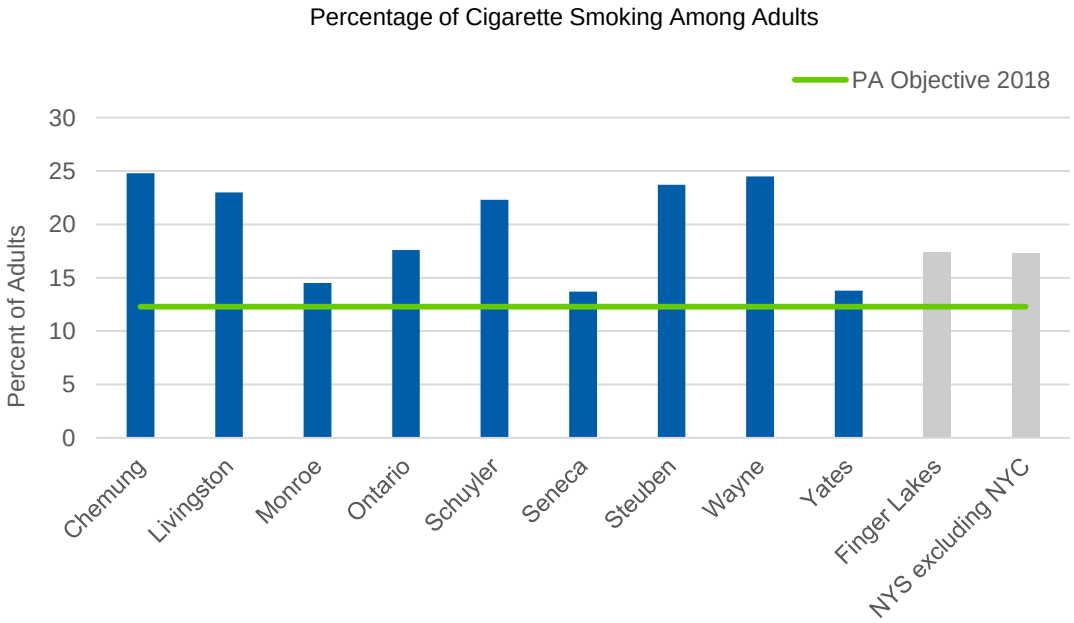


Data Source: New York State Prevention Agenda, 2011-2013

PRIORITY AREA 5: TOBACCO USE

Tobacco Use

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

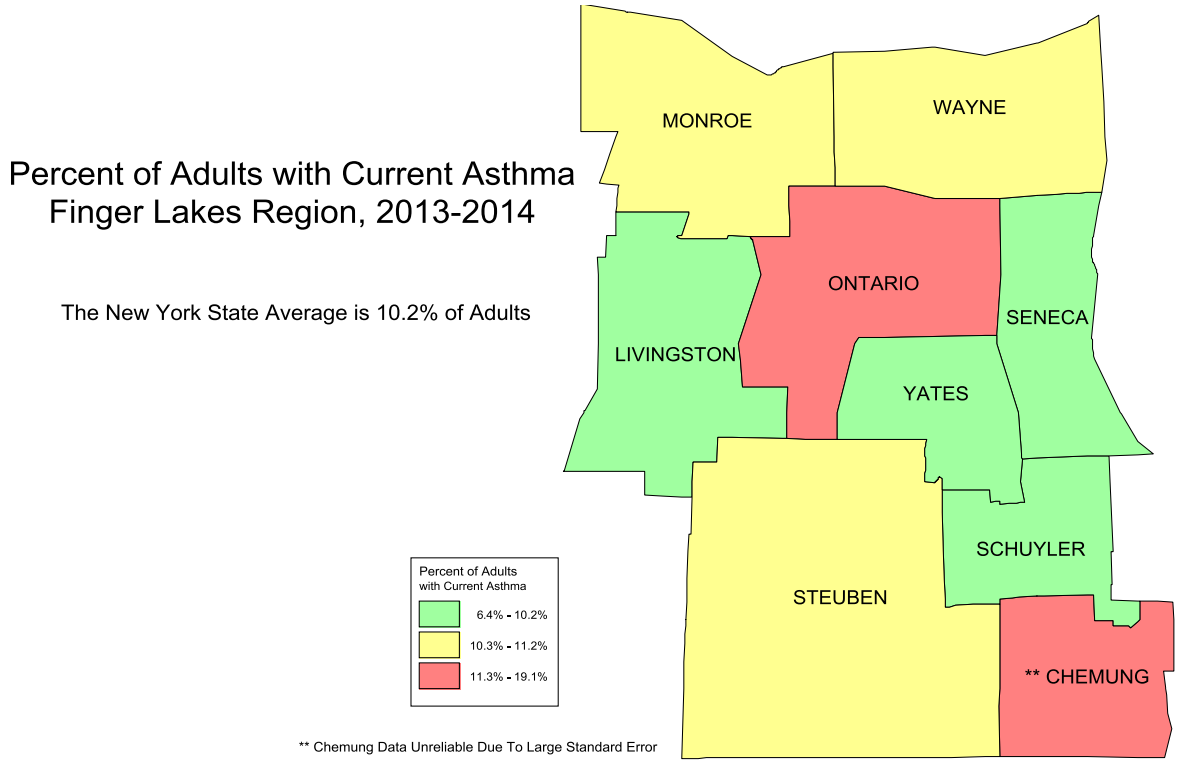


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Tobacco Use

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

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

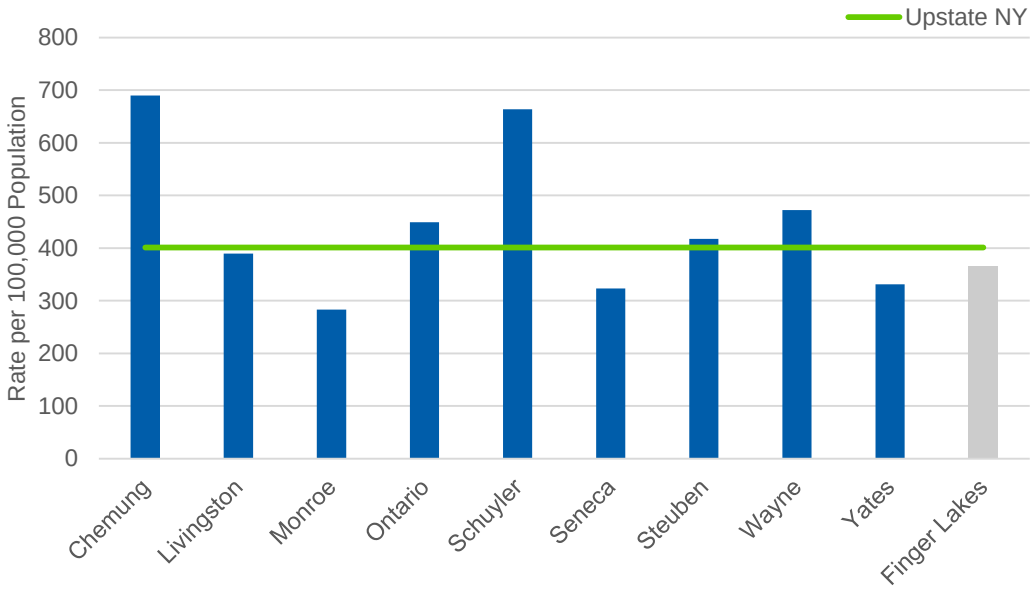


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Tobacco Use

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

Rate of Respiratory Prevention Quality Indicators

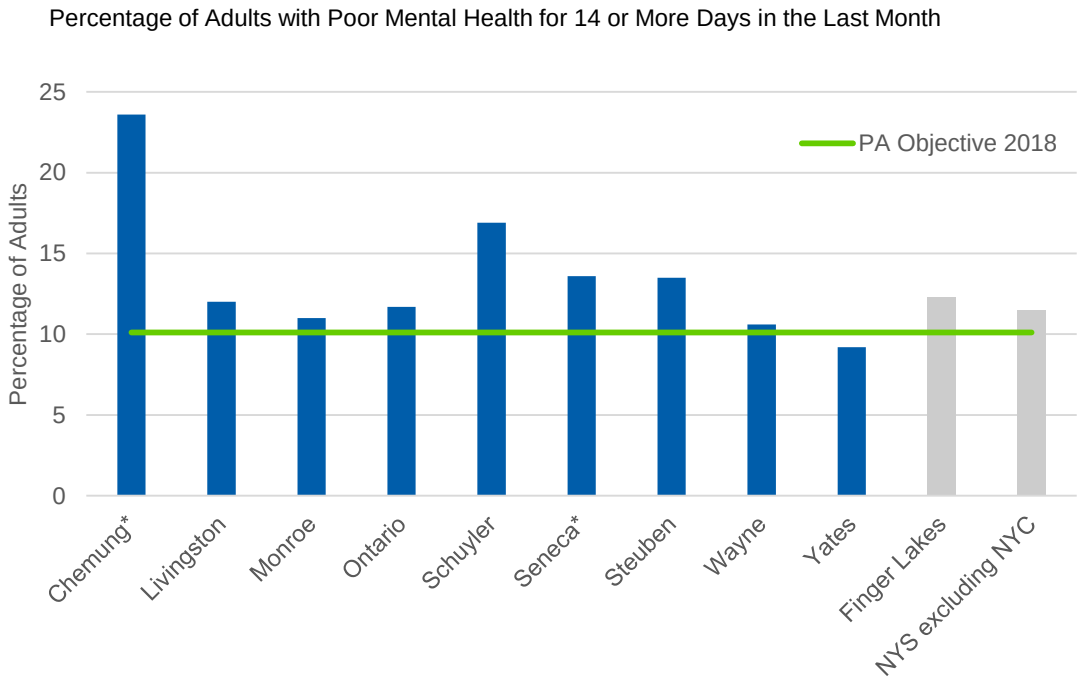


Data Source: SPARCS, 2013

PRIORITY AREA 6: BEHAVIORAL HEALTH

Behavioral Health

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

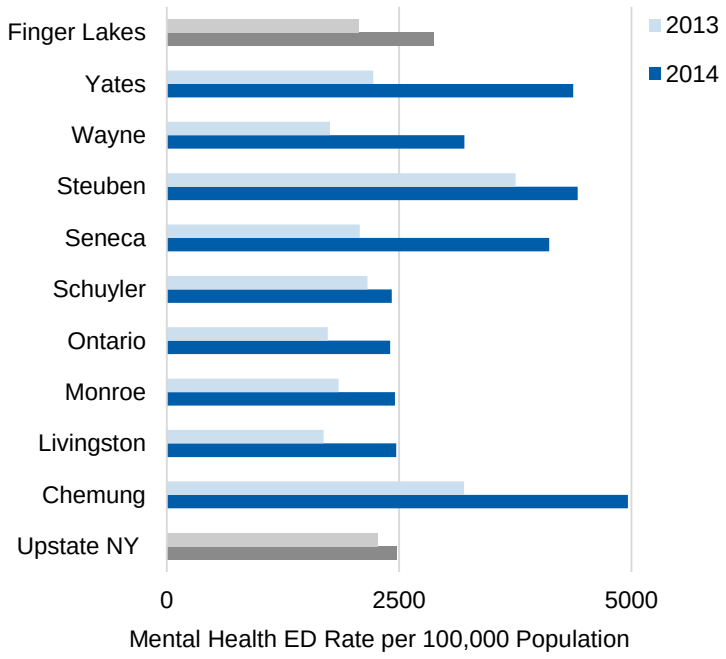


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error.

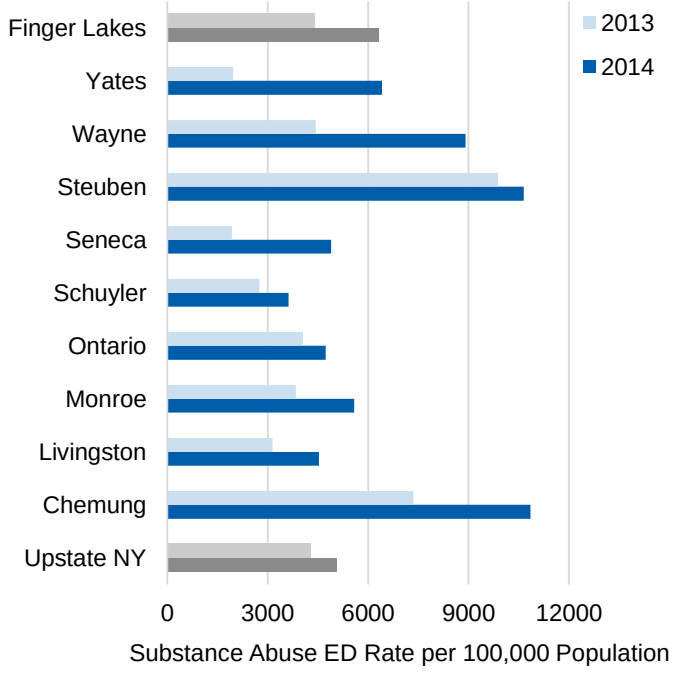
Behavioral Health

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

Rate of ED Discharges with a Mental Health Diagnosis



Rate of ED Discharges with a Substance Abuse Diagnosis

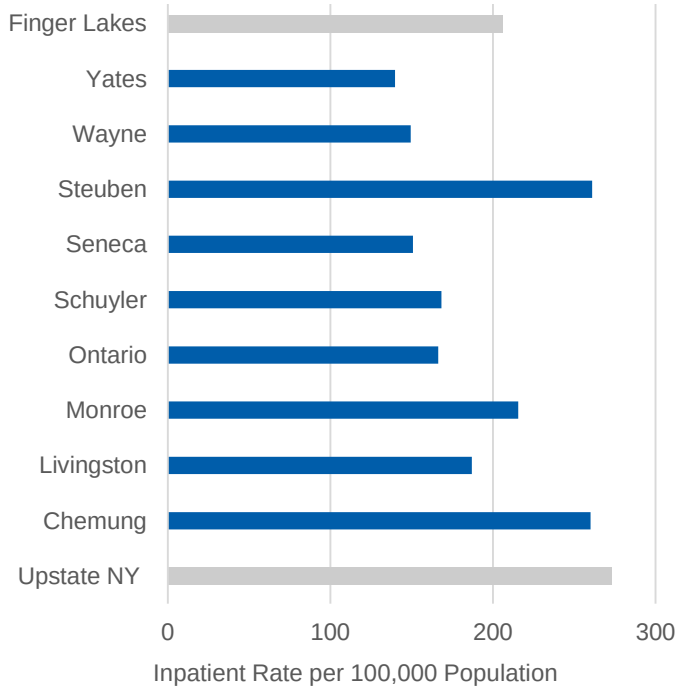


Data Source: SPARCS, 2013-2014. Diagnosis includes primary or comorbidity

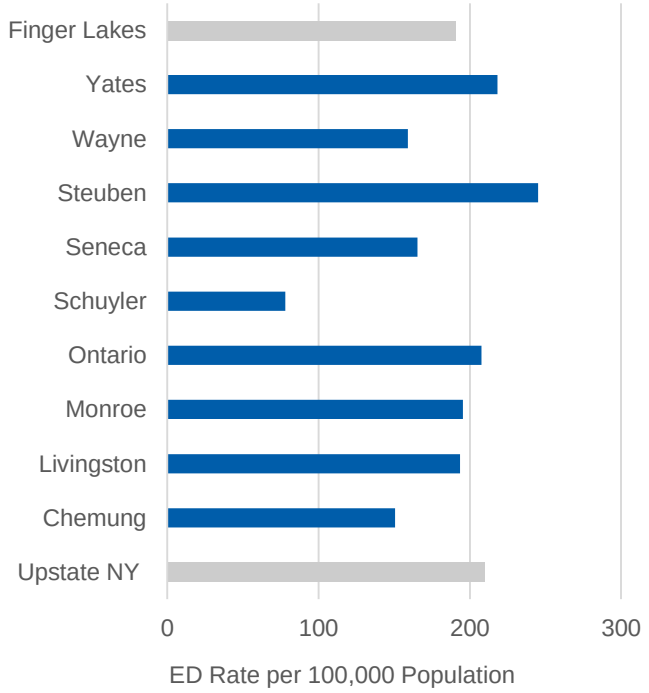
Behavioral Health

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

Rate of Inpatient Admissions with an Opiate Diagnosis



Rate of ED Discharges with an Opiate Diagnosis

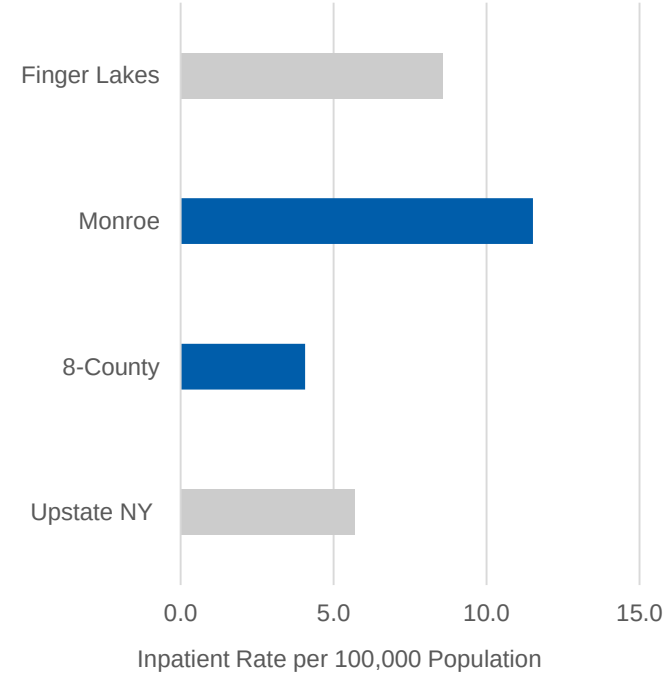


Data Source: SPARCS, 2014

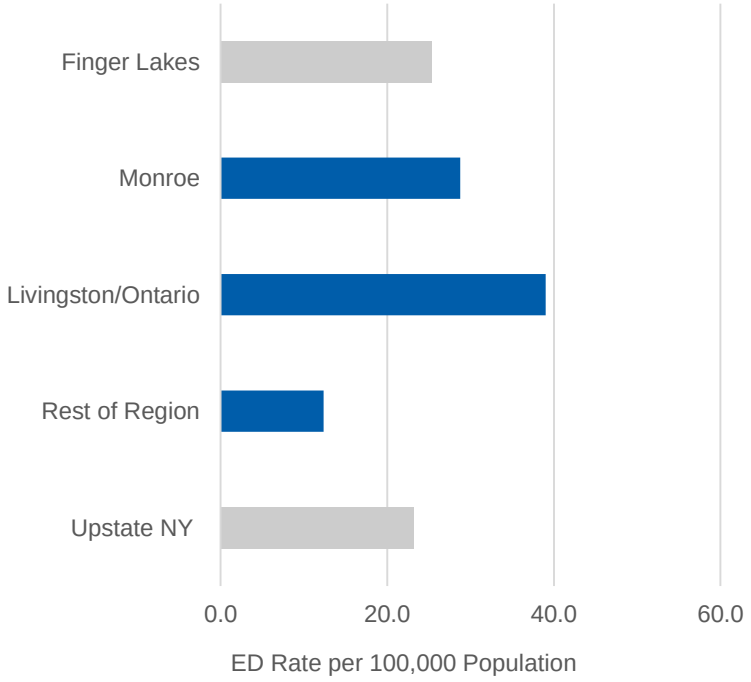
Behavioral Health

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

Rate of Inpatient Admissions with a Heroin Overdose Diagnosis



Rate of ED Discharges with a Heroin Overdose Diagnosis

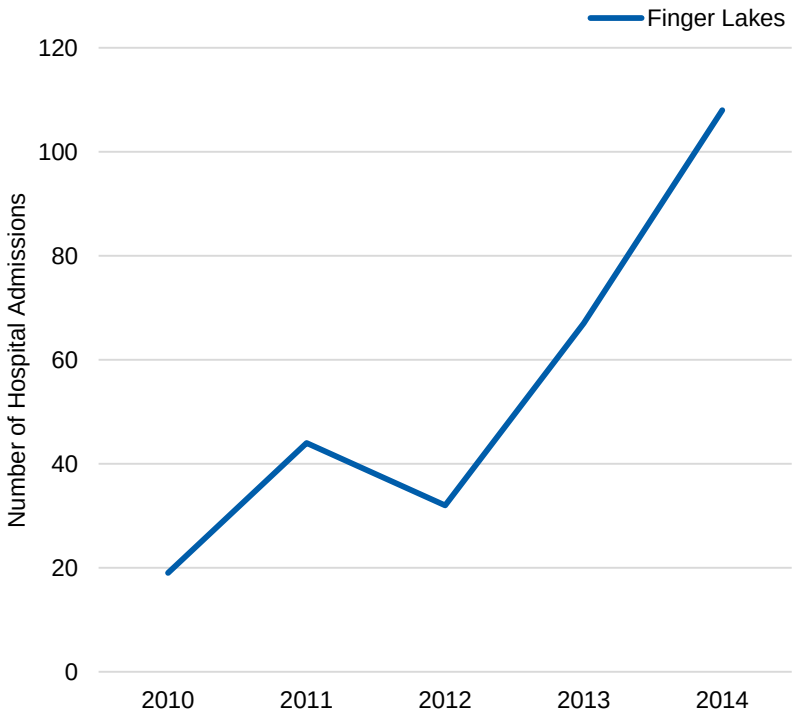


Data Source: SPARCS, 2014

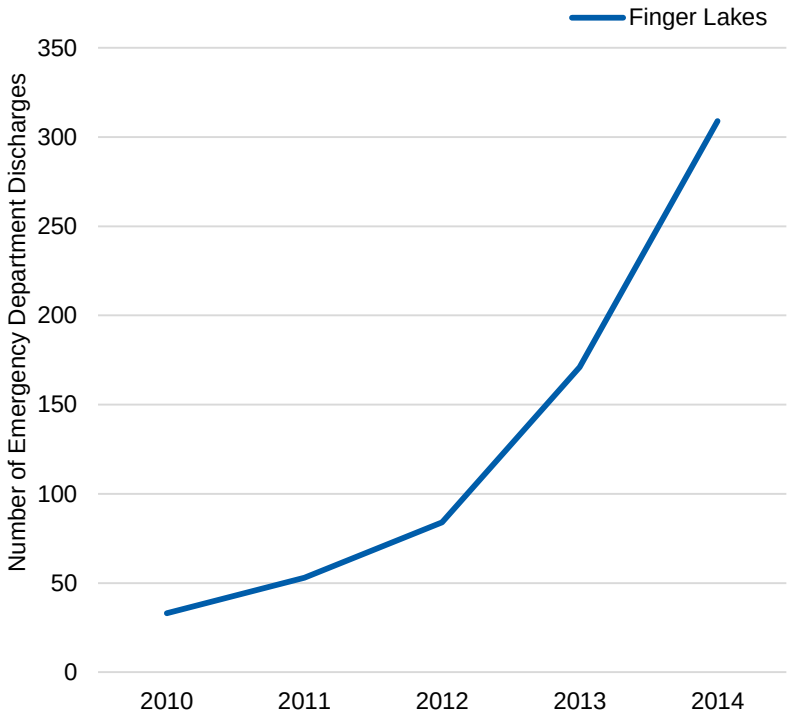
Behavioral Health

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

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



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

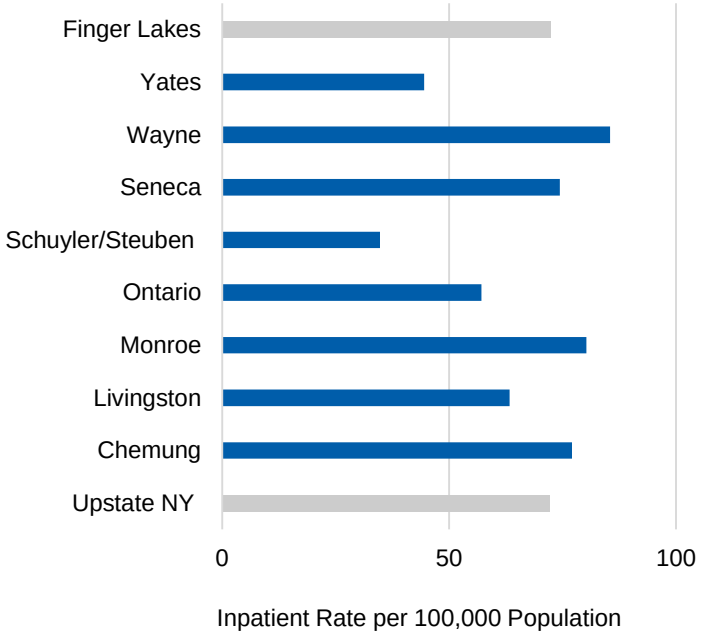


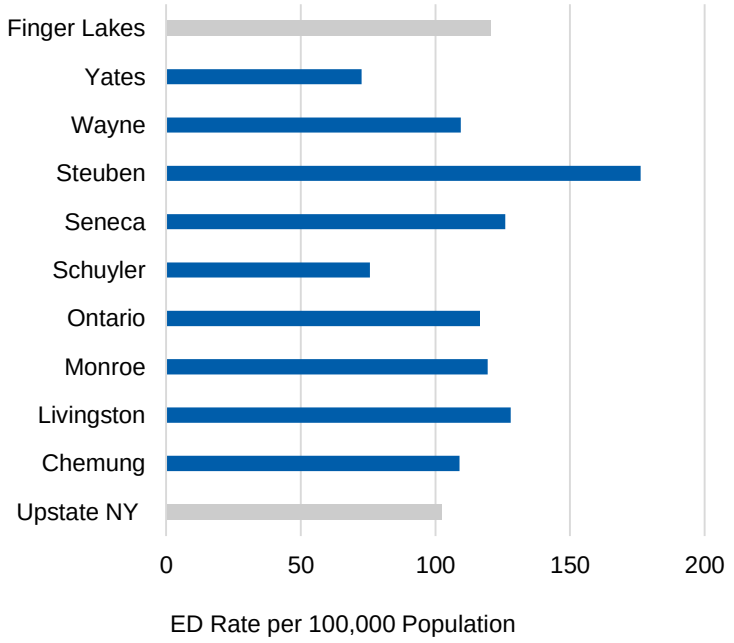
Data Source: SPARCS, 2010-2014

Behavioral Health

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

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



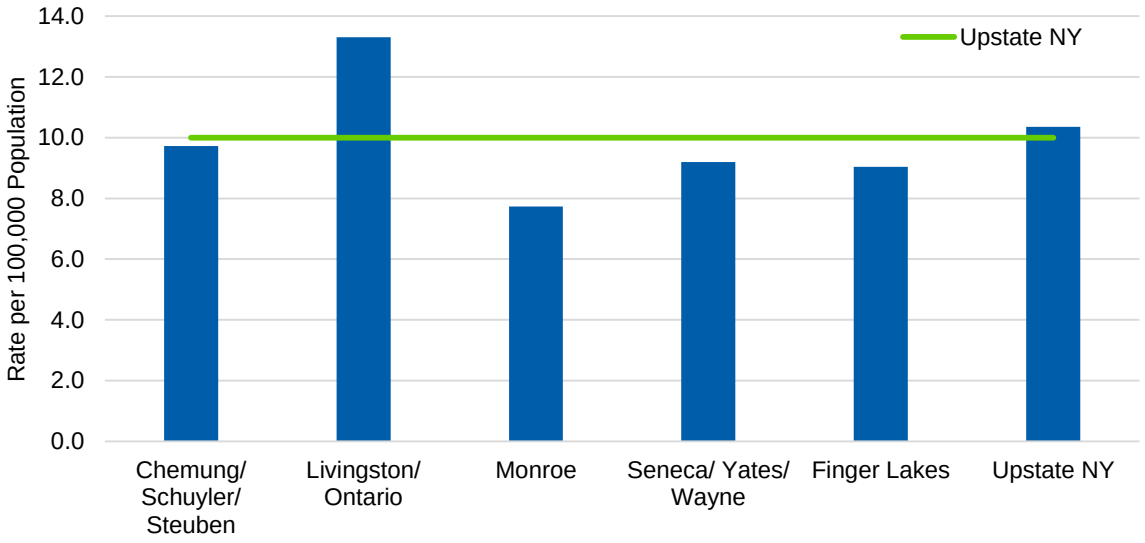


Data Source: SPARCS, 2014

Behavioral Health

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

Suicide Mortality Rate per County



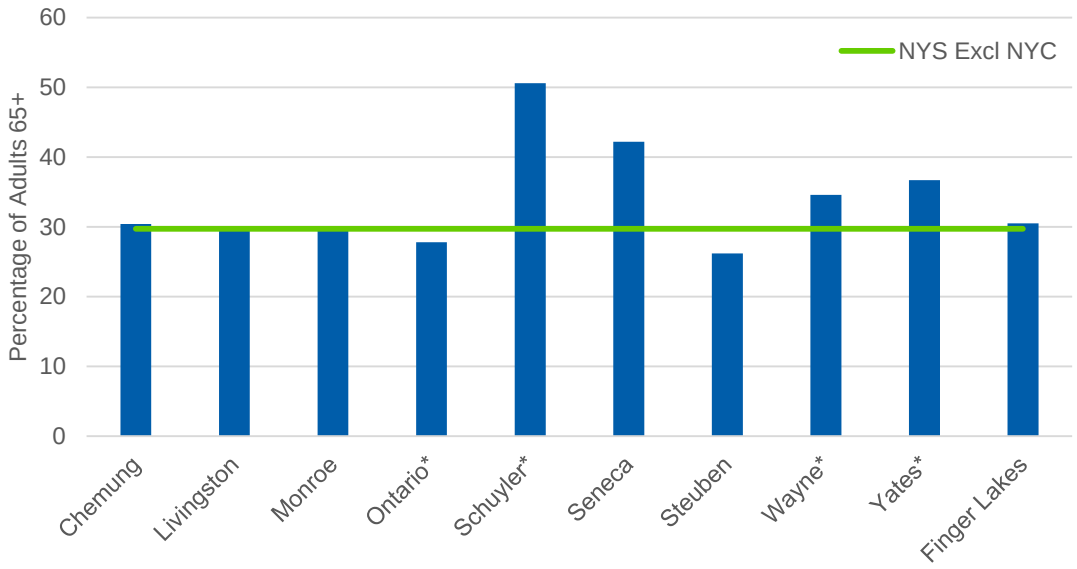
Data Source: New York State Department of Health Vital Statistics, 2013

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

Falls, Slips and Trips

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

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

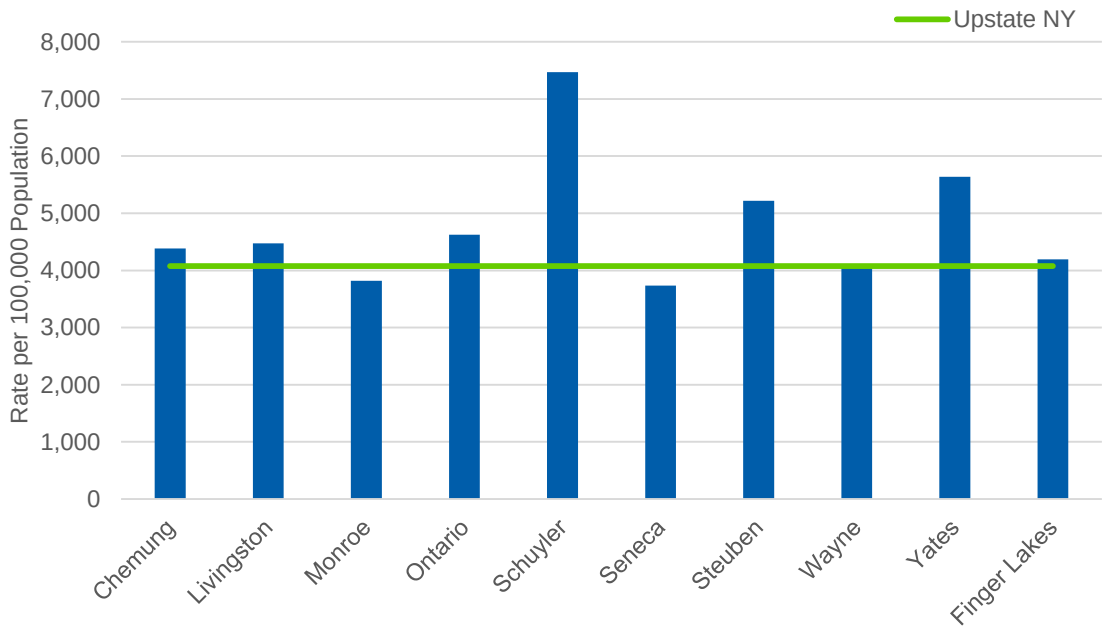


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error

Falls, Slips and Trips

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

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



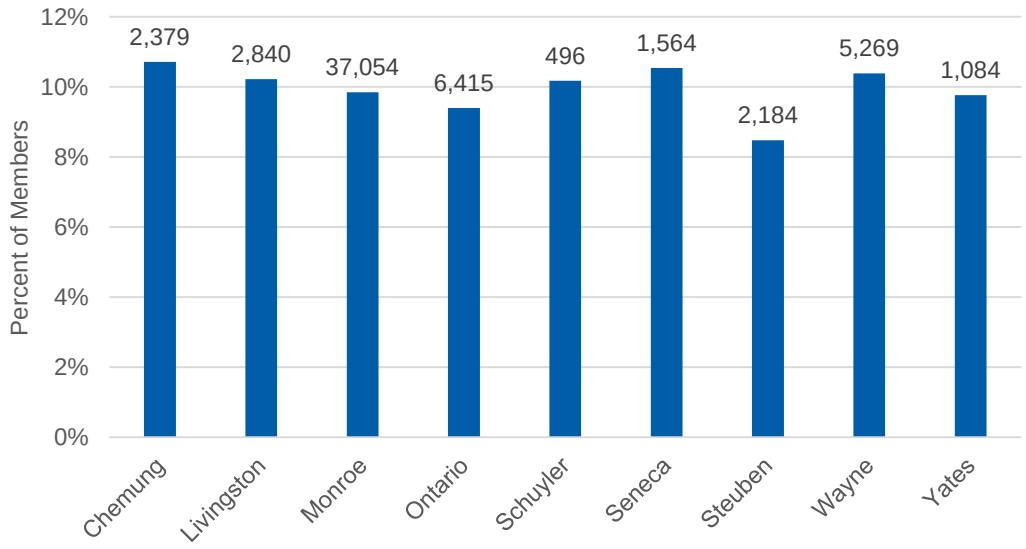
Data Source: SPARCS, 2013

PRIORITY AREA 8: LOW BACK PAIN

Low Back Pain

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

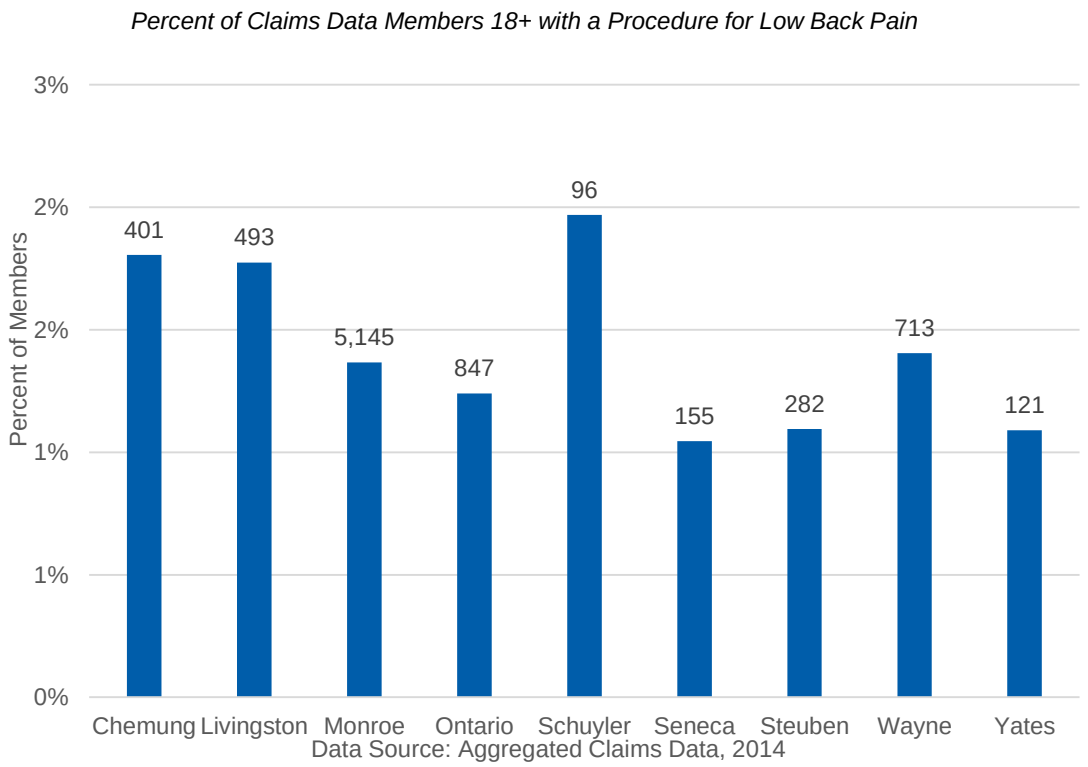
Percent of Claims Data Members 18+ with a Diagnosis for Low Back Pain



Data Source: Aggregated Claims Data, 2014

Low Back Pain

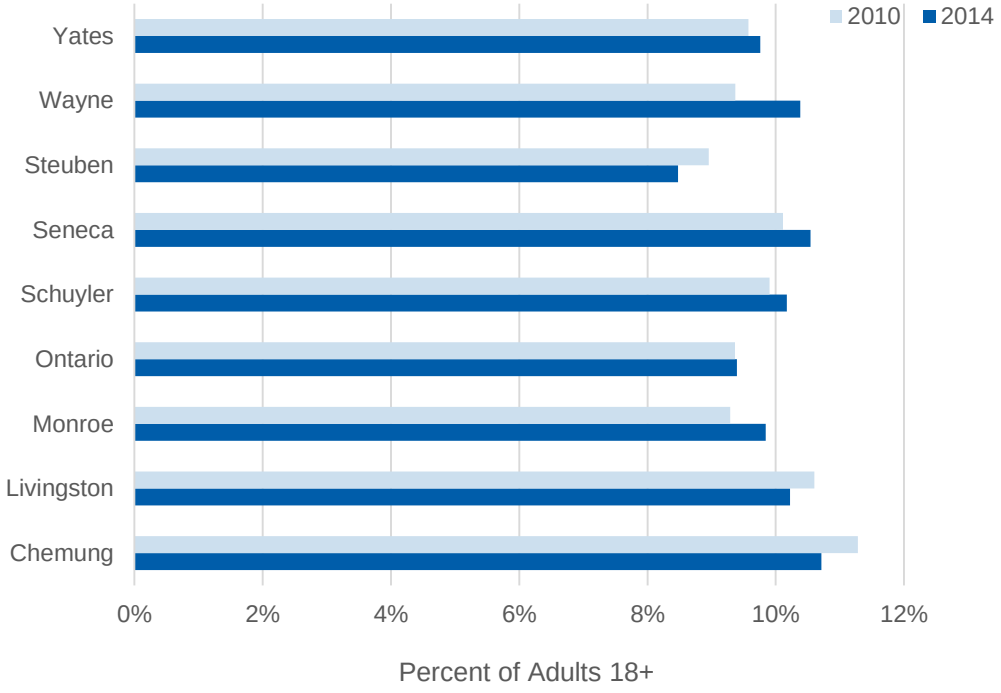
- Percent of the members in the FLHSA claims database with a procedure code for low back pain (i.e. spinal/nerve injections).



Low Back Pain

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

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



Data Source: Aggregated Claims Data, 2010-2014

KEY FINDINGS

Key Findings

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

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

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

www.flhsa.org

QUESTIONS?

Finger Lakes Health Systems Agency

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

1150 University Avenue • Rochester, New York • 14607-1647
585.224.3101 • www.flhsa.org

Yates County Health Needs Focus Groups

Agenda

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

S2AY Rural Health Network

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

Community Health Assessment/Community Service Plans

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

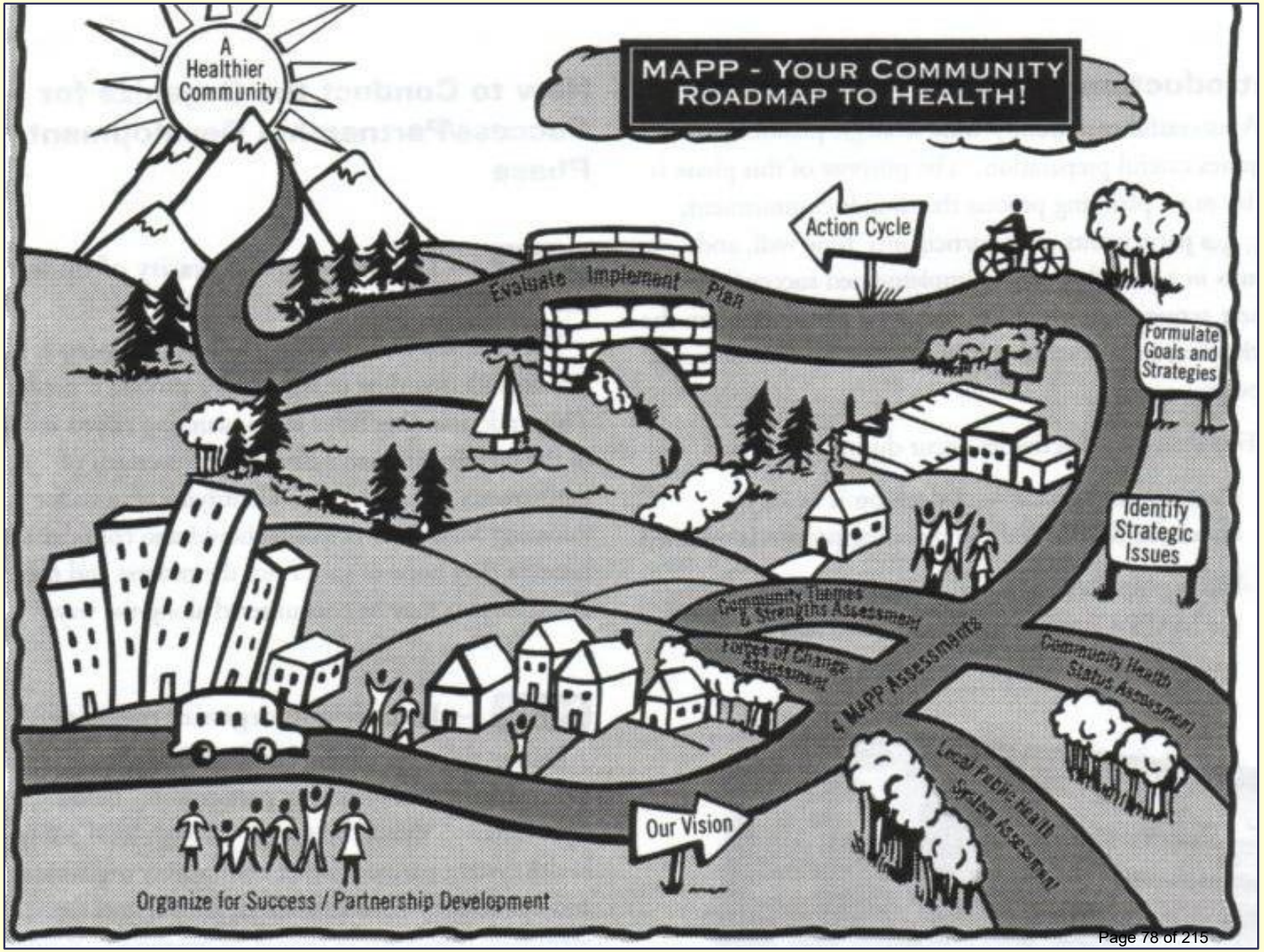
Joint CHA/CHIP/CSP

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

Help!!!!

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

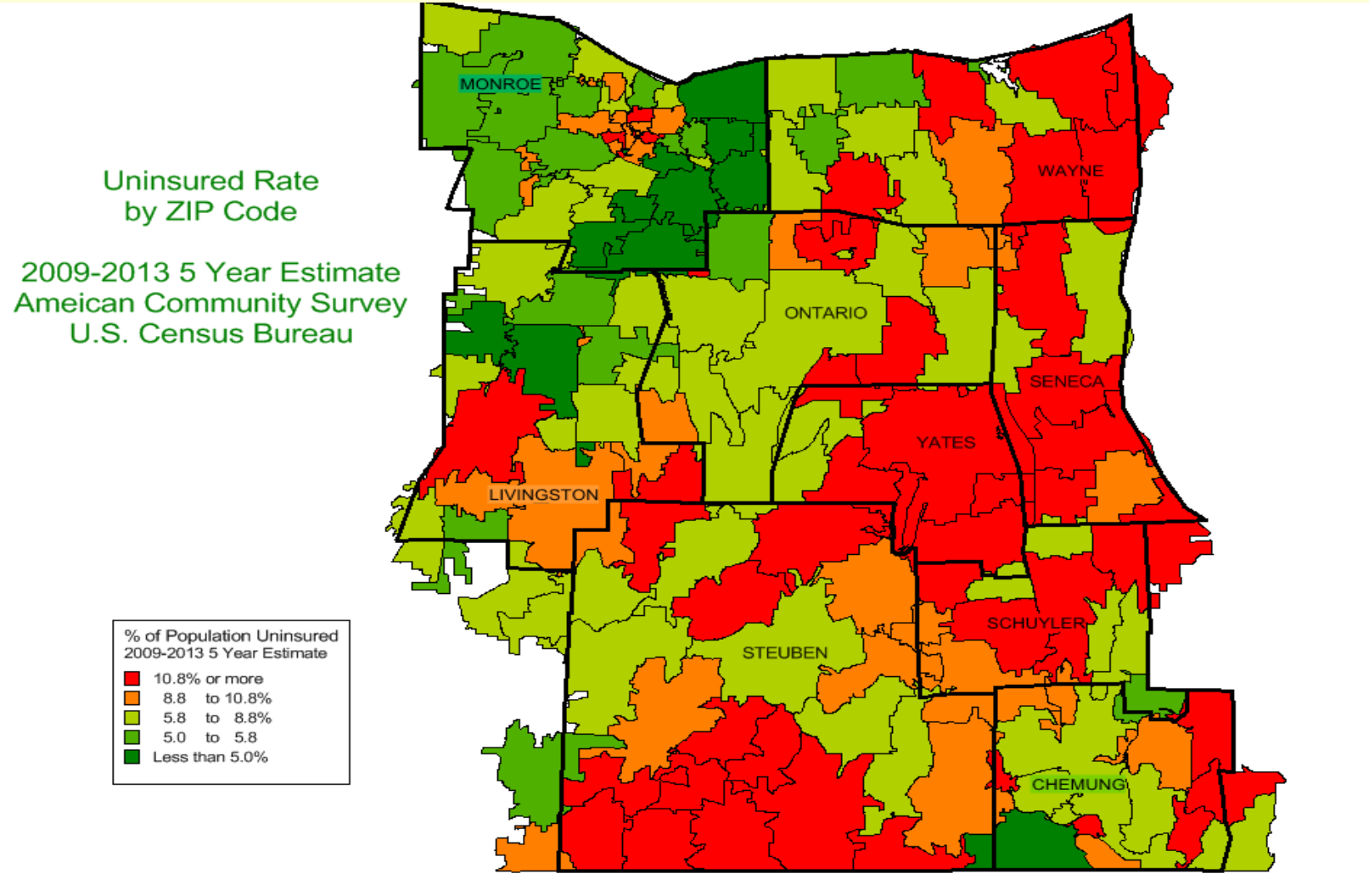
MAPP - Mobilizing for Action through Planning and Partnerships



Data says…

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

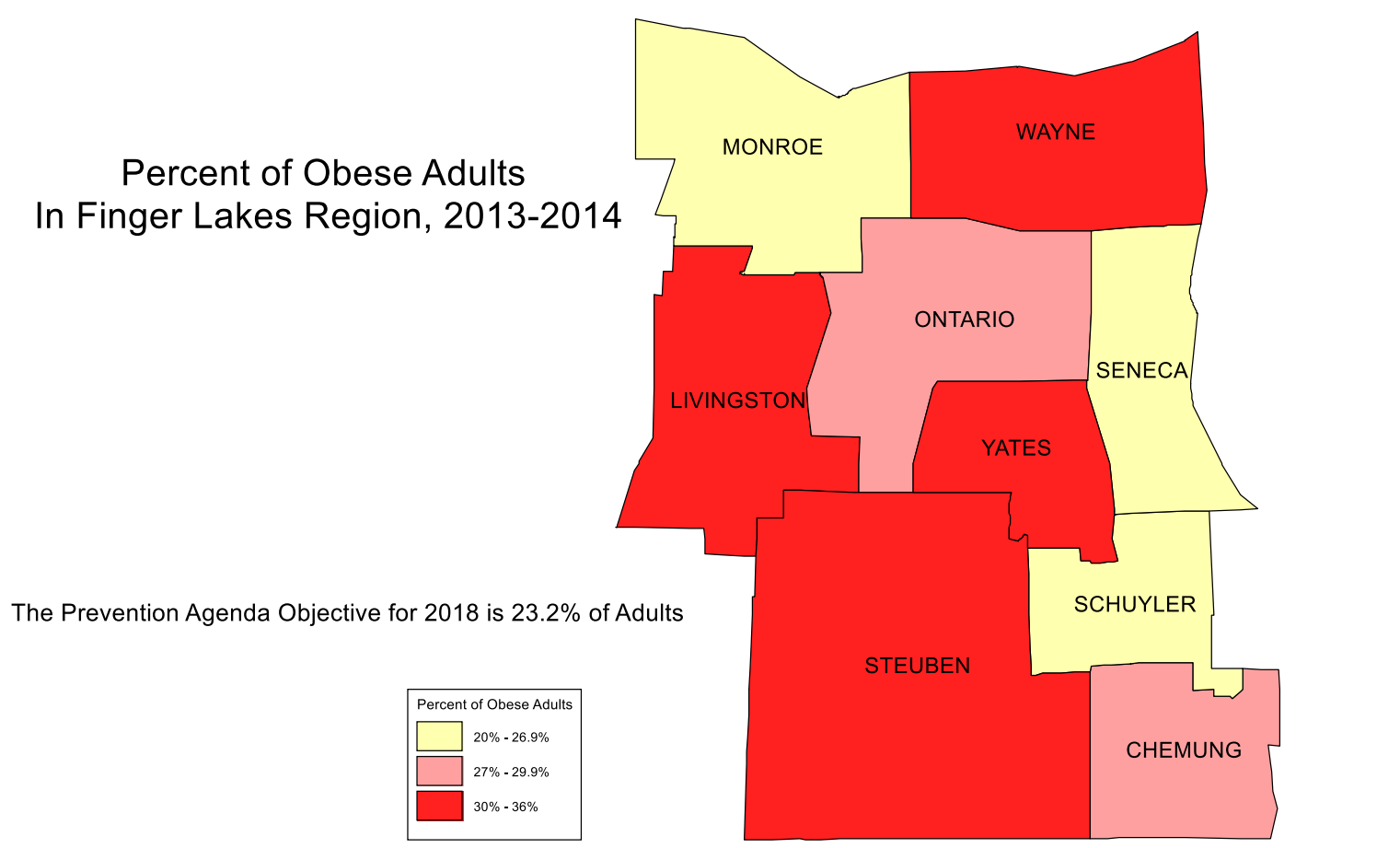
Data says…high rates of uninsured



- In 2013 before the first open enrollment period, New York's uninsured rate of 11.7% was 4.7% lower than the national uninsured rate.
- In 2015, New York's uninsured rate of 6.3% is 4.4% lower than the current national uninsured rate.

Source: Kaiser Family Foundation 2015

Data says: High rates of Obesity - over 30% of adults in Yates County are obese

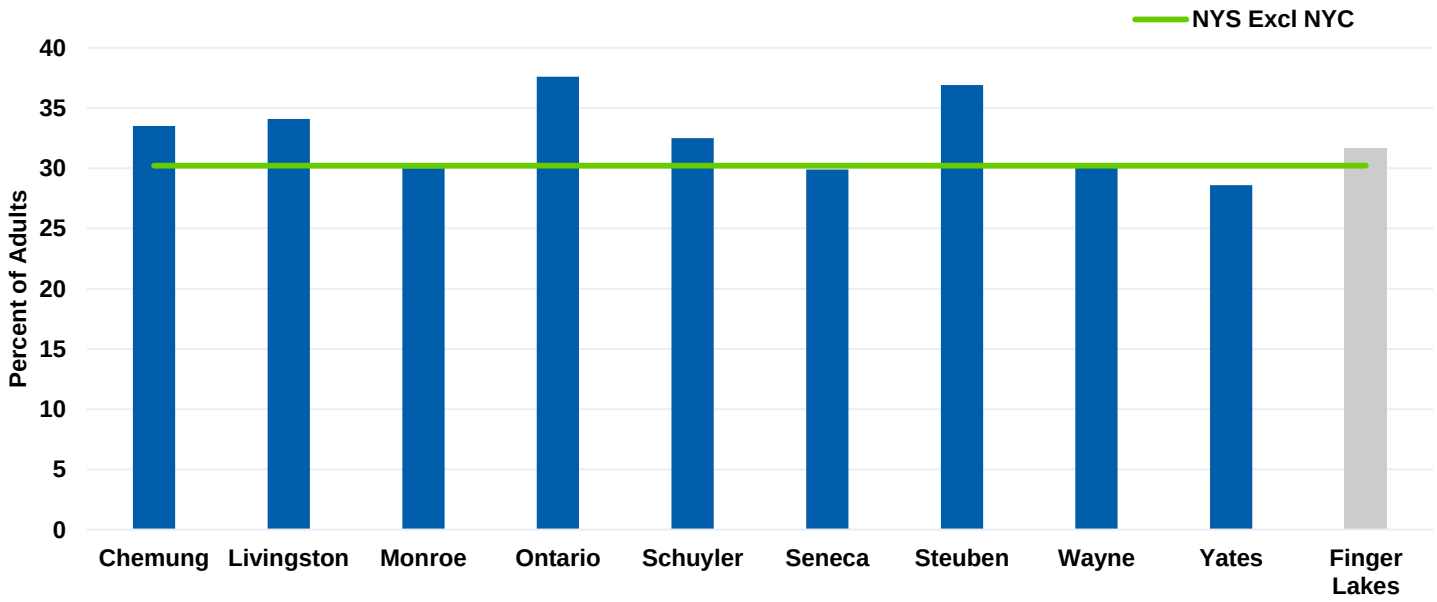


Why is obesity important?

Can lead to many other problems including:

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

Data says…Yates is a little better than the region but still has 29% of adults with physician-diagnosed high blood pressure



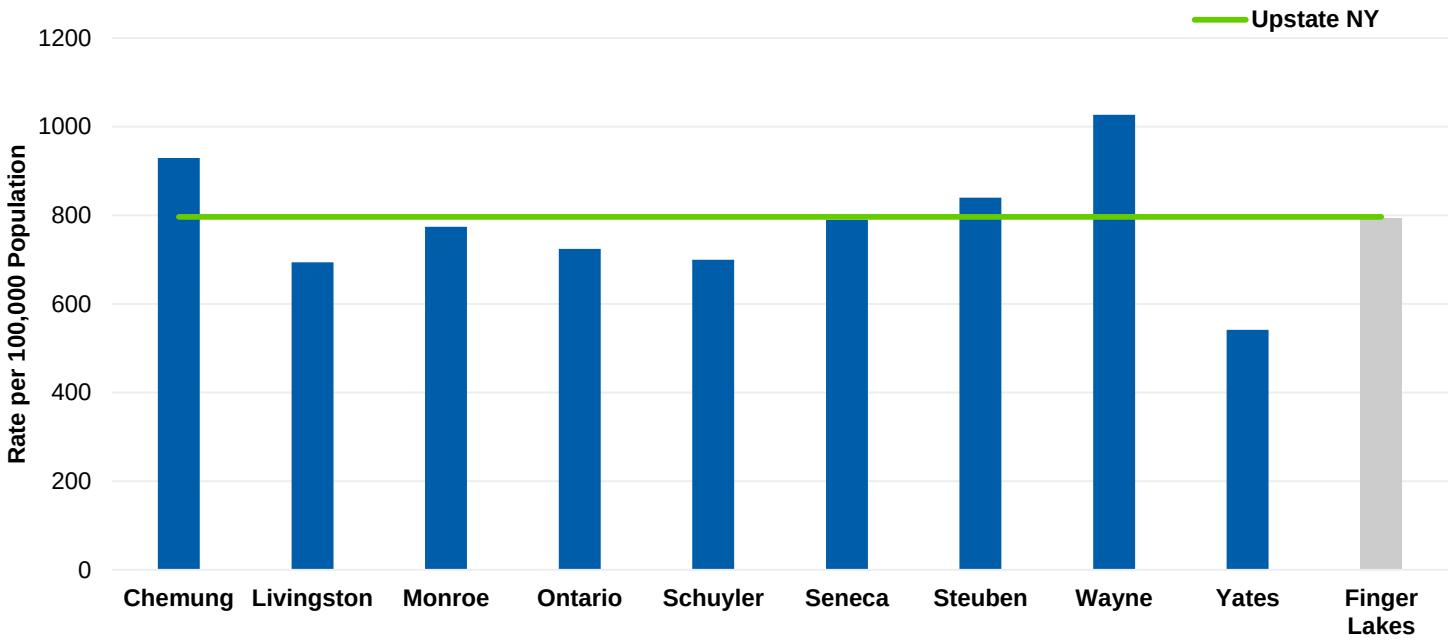
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Percentage of pregnant women in WIC with hypertension during pregnancy

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

	Women with gestational hypertension				Average WIC births	Crude
Region/County	2009	2010	2011	Total	2009-2011	Rate
Reg- 10 Finger Lakes						
Chemung	57	71	64	192	665	9.6
Livingston	41	40	31	112	272	13.7
Monroe	450	437	438	1,325	3,797	11.6
Ontario	51	57	62	170	469	12.1
Schuyler	s	16	s	16	94	5.7
Seneca	8	10	12	30	138	7.2
Steuben	69	84	59	212	586	12.1
Wayne	43	47	39	129	456	9.4
Yates	17	14	10	41	110	12.4
Region Total	736	776	715	2,227	6,527	11.4
Region Total	769	849	815	2,433	8,560	9.5
New York State	9,103	9,242	8,850	27,195	127,077	7.1

Data says…. Best in region for heart disease incidence



Data Source: SPARCS, 2013

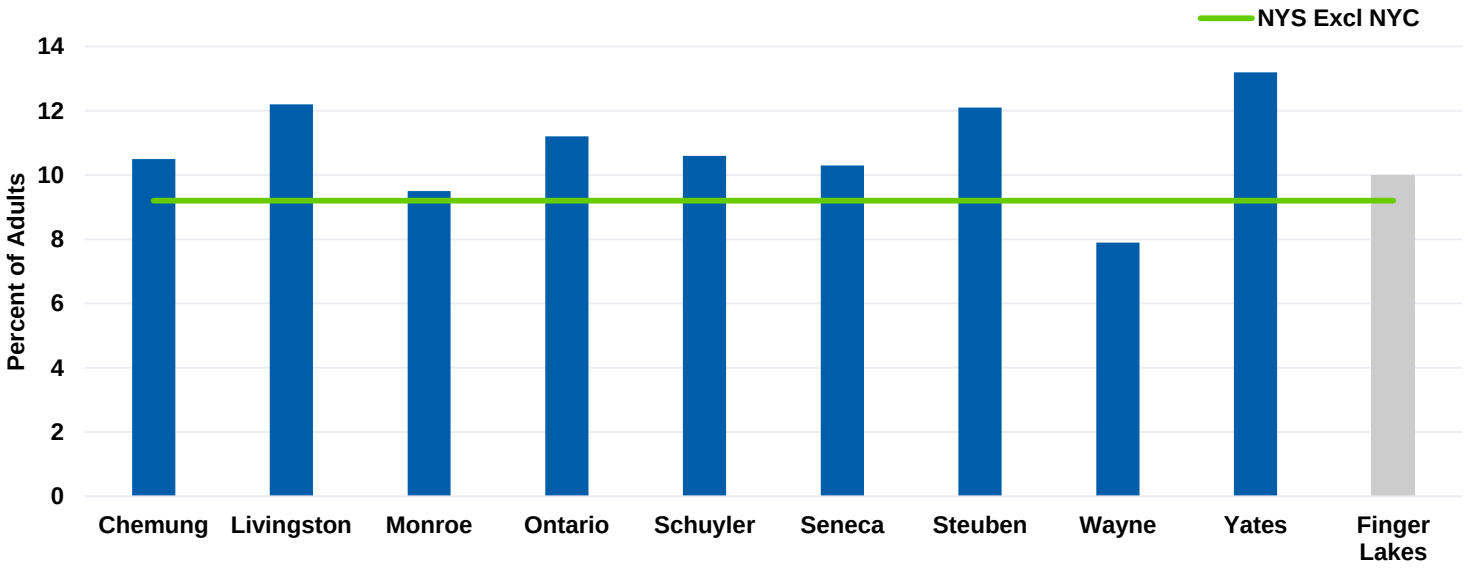
Heart attack mortality rate per 100,000

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

Adjusted Rates Are Age Adjusted to The 2000 United States Population

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

Data says….Percentage of adults with physician diagnosed diabetes – 13.2%



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

Diabetes mortality

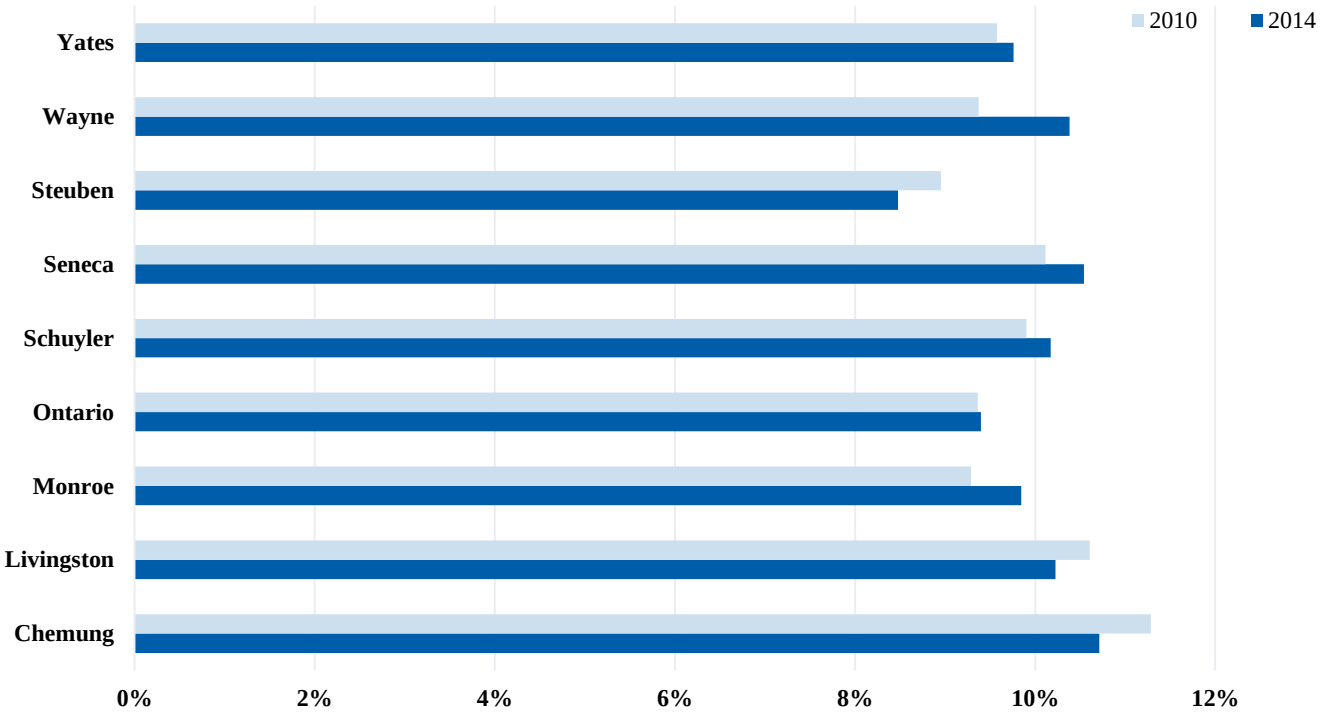
Diabetes mortality rate per 100,000

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

Adjusted Rates Are Age Adjusted to The 2000 United States Population

	Deaths				Average population	Crude	Adjusted
Region/County	2011	2012	2013	Total	2011-2013	Rate	Rate
Reg- 10 Finger Lakes							
Chemung	18	25	12	55	88,752	20.7	16.4
Livingston	12	10	13	35	64,862	18.0	15.6
Monroe	101	107	120	328	747,681	14.6	12.4
Ontario	20	18	19	57	108,716	17.5	13.2
Schuyler	10	5	4	19	18,445	34.3	24.4
Seneca	6	7	10	23	35,304	21.7	17.3
Steuben	20	17	31	68	98,915	22.9	17.7
Wayne	28	25	24	77	92,957	27.6	22.0
Yates	4	6	4	14	25,318	18.4	14.7
Region Total	219	220	237	676	1,280,950	17.6	14.4
New York State	3,921	3,970	4,035	11,926	19,562,195	20.3	17.6

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

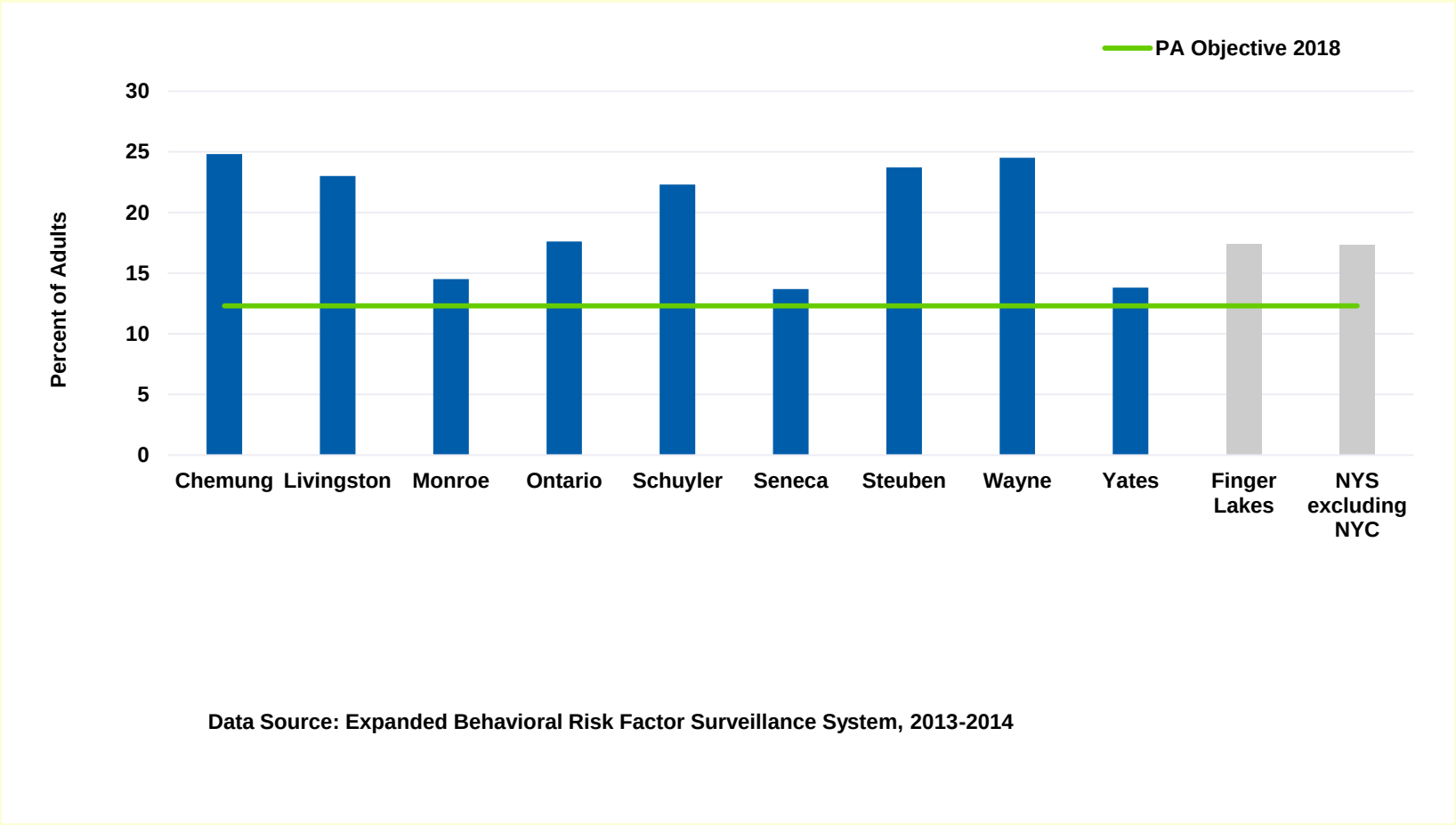


Data Source: Aggregated Claims Data, 2010-2014

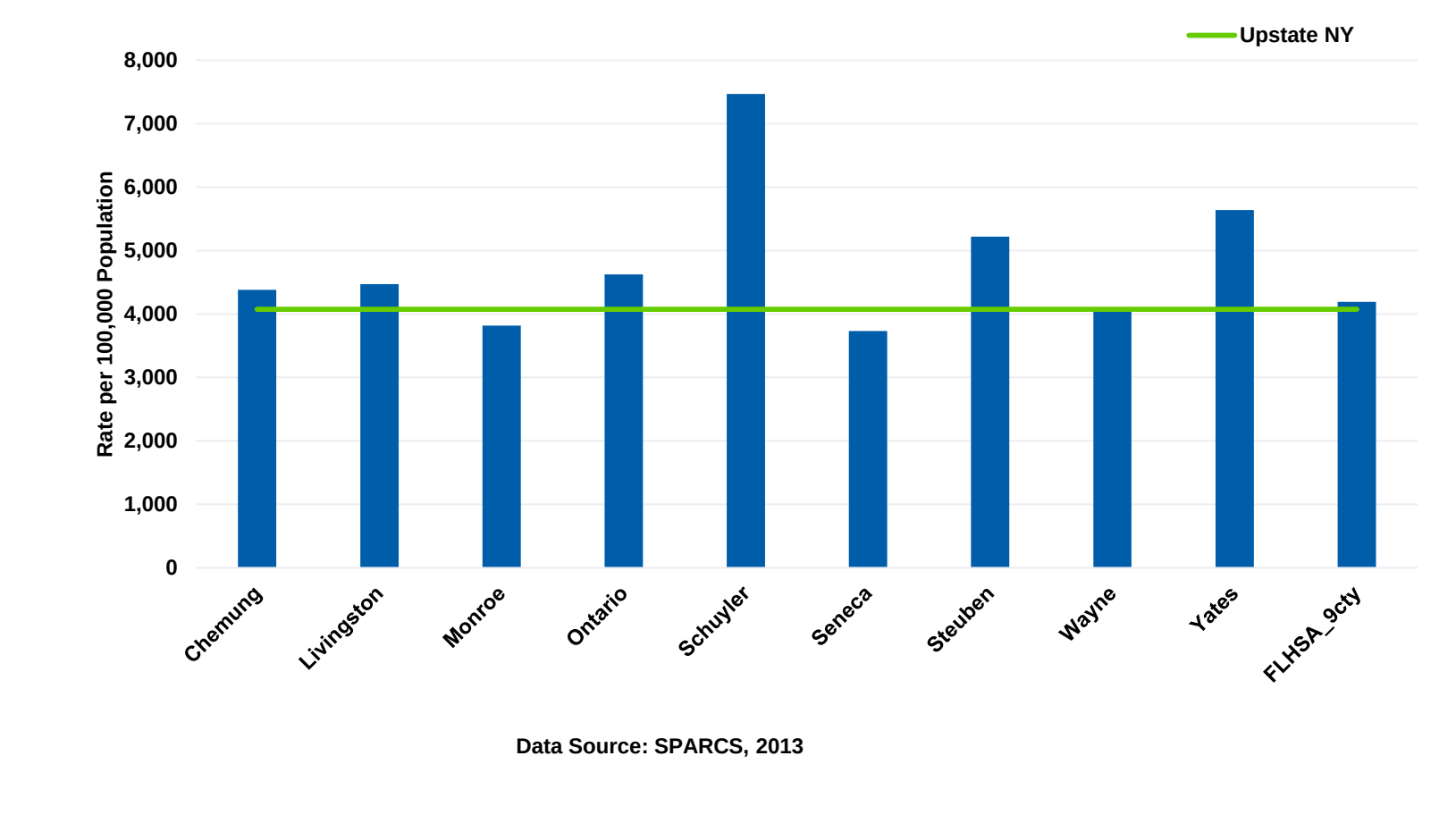
Other health problems

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

Data says… Percentage of cigarette smokers in Yates County = 13.8%



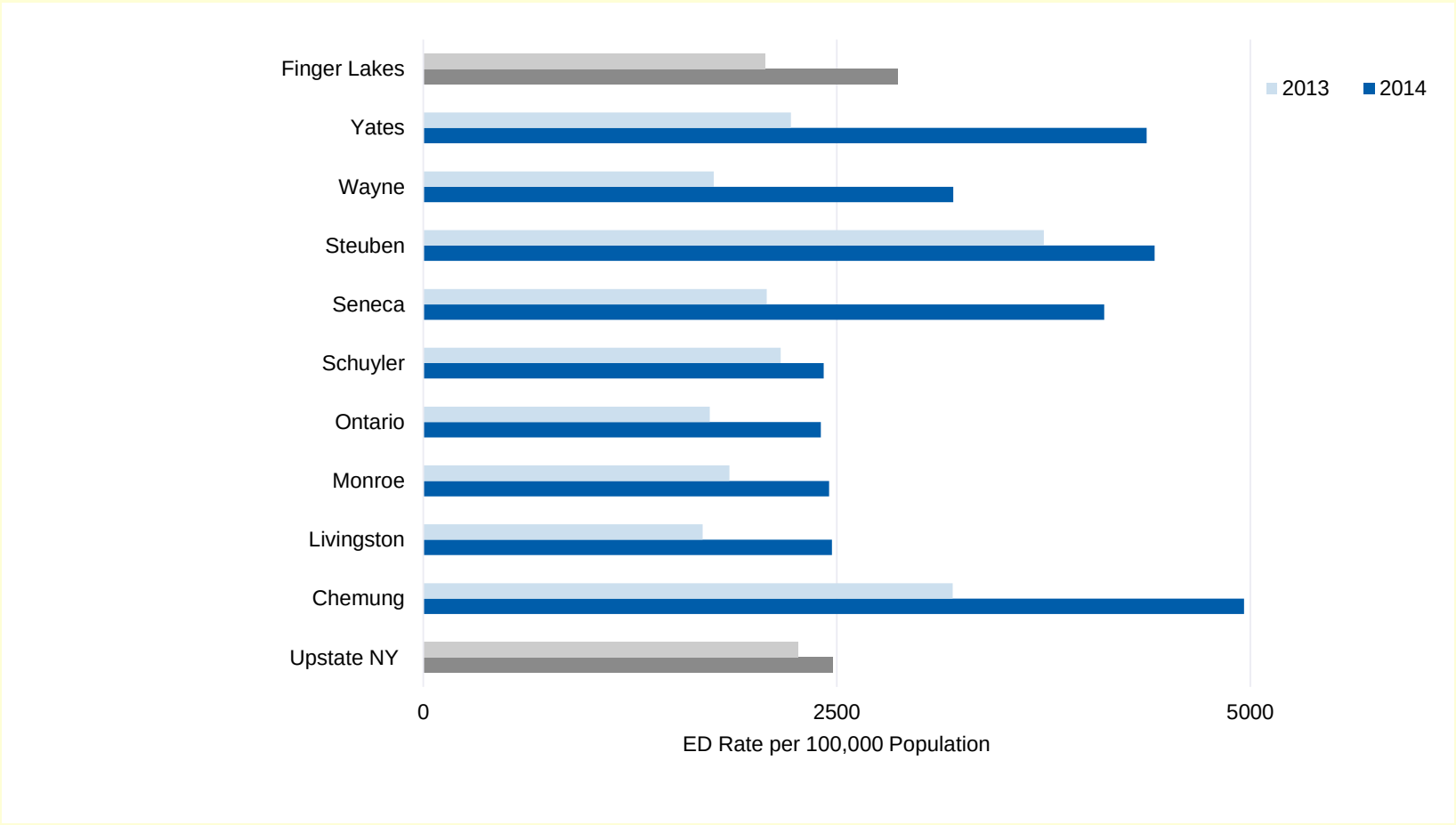
Data says…ED Visits per 100,000 for falls for those aged 65+



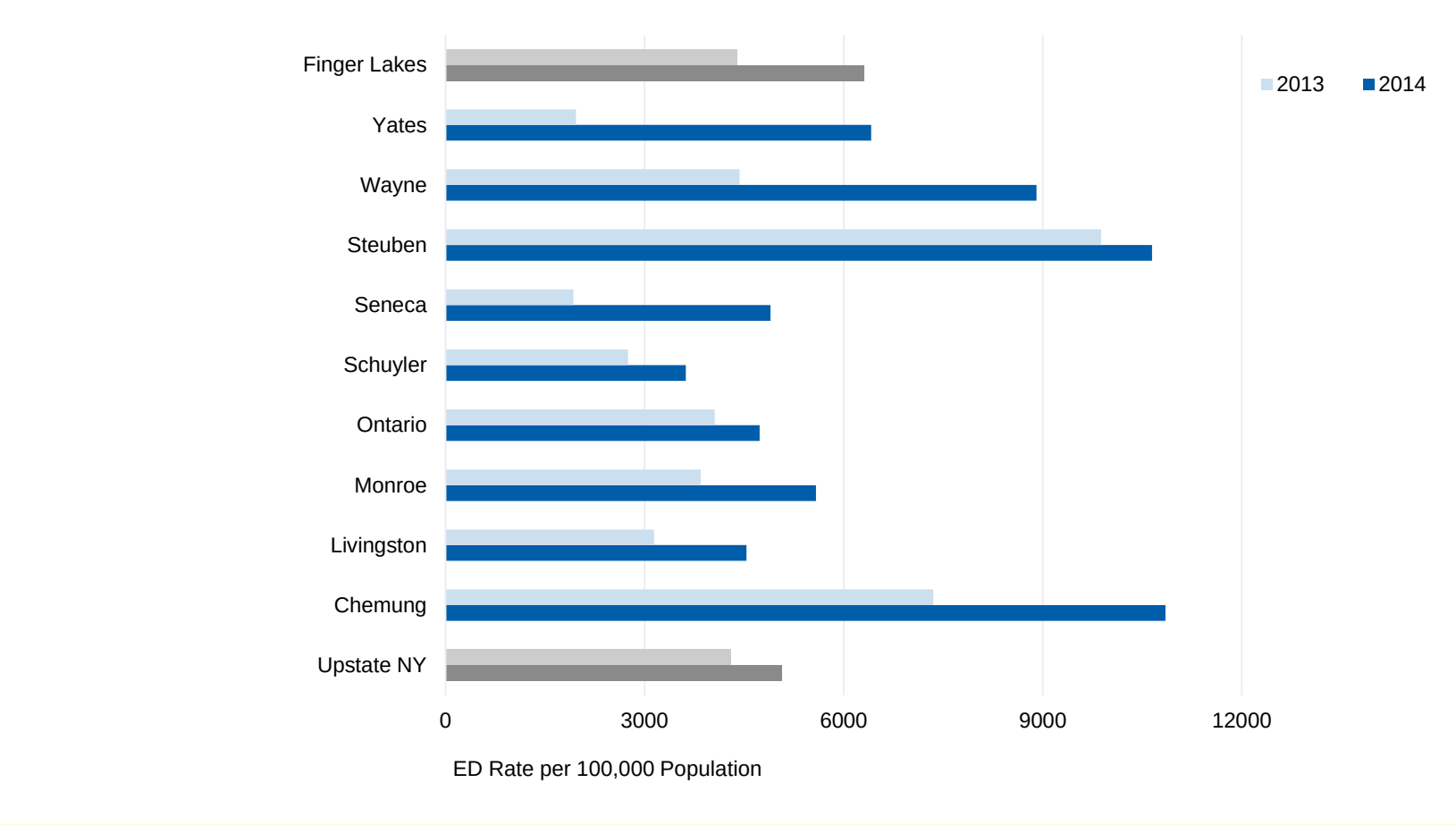
Behavioral Health

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

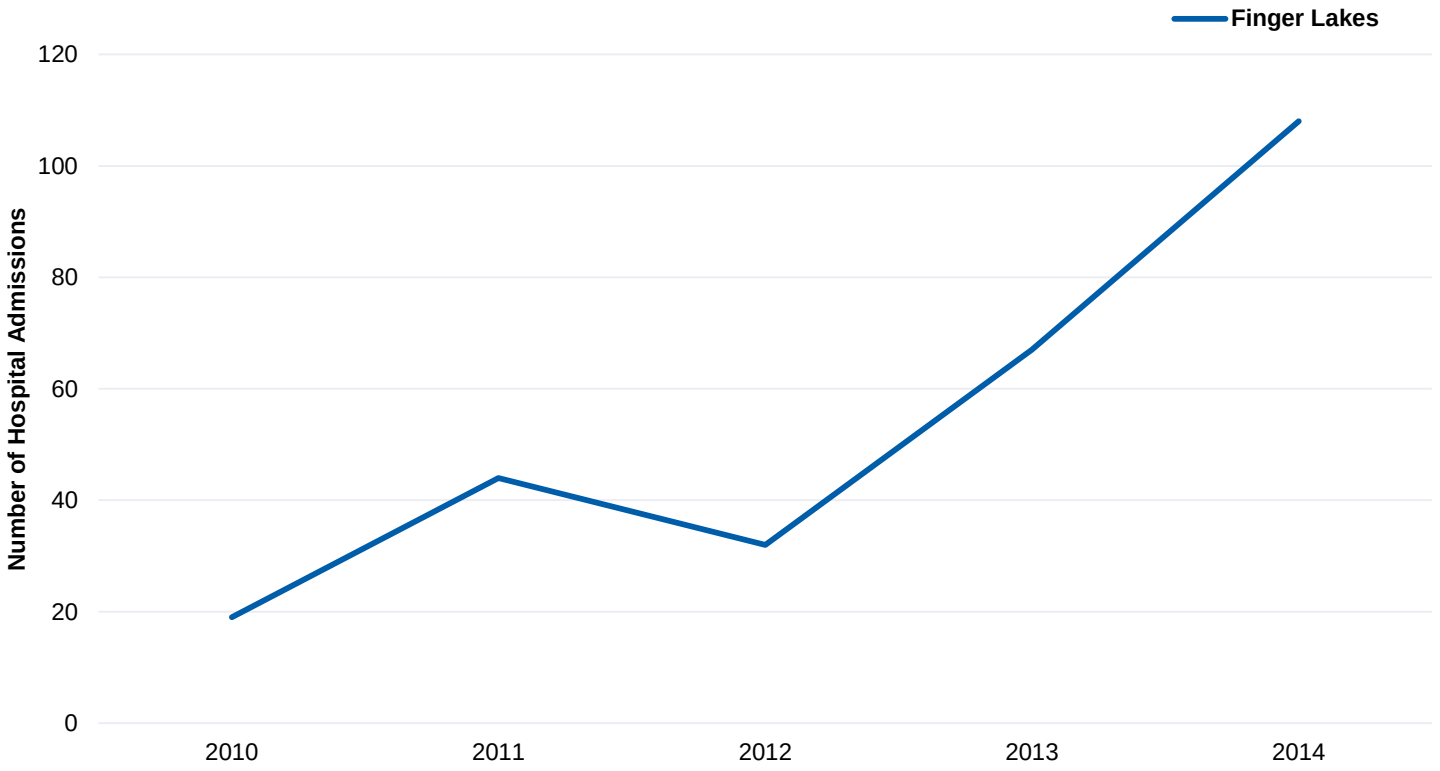
Mental health – ED discharges with a mental health diagnosis



Substance abuse- ED visits with a substance abuse diagnosis

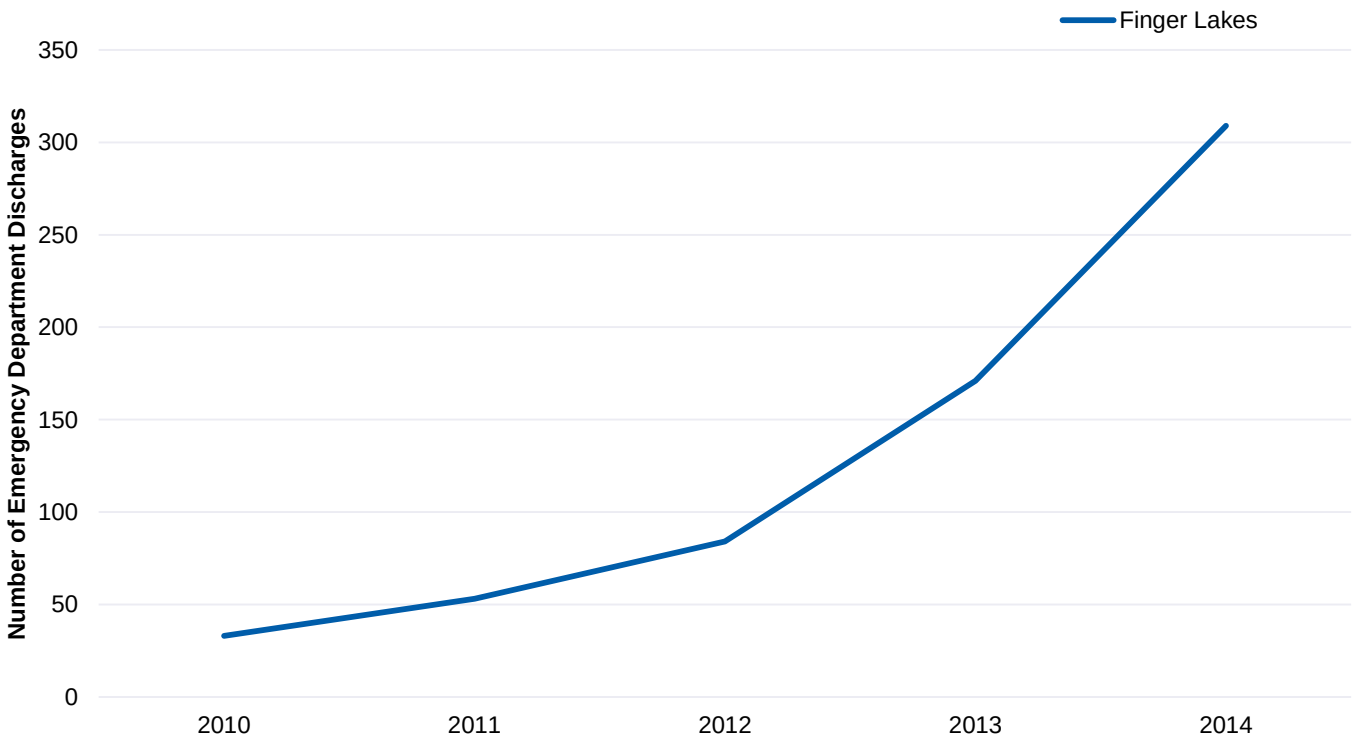


Heroin- number of heroin overdose admissions for the Finger Lakes (9 county) region



Data Source: SPARCS, 2010-2014

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



Data Source: SPARCS, 2010-2014

Data says… Heroin is a growing concern in the region

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

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

County and # of Deaths	#1 Cause of Death and # of Deaths Age-adjusted Death Rate	#2 Cause of Death and # of Deaths Age-adjusted Death Rate	#3 Cause of Death and # of Deaths Age-adjusted Death Rate	#4 Cause of Death and # of Deaths Age-adjusted Death Rate	#5 Cause of Death and # of Deaths Age-adjusted Death Rate
Yates Total: 246	Cancer 61 186 per 100,000	Heart Disease 57 160 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 23 68 per 100,000	Unintentional Injury 10 32 per 100,000*	Stroke 5 14 per 100,000*
Rest of State Total: 95,595	Heart Disease 26,539 178 per 100,000	Cancer 22,611 160 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,124 36 per 100,000	Stroke 4,226 29 per 100,000	Unintentional Injury 3,916 31 per 100,000
New York State Total: 147,419	Heart Disease 43,112 181 per 100,000	Cancer 35,074 153 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 6,977 30 per 100,000	Stroke 5,959 25 per 100,000	Unintentional Injury 5,552 26 per 100,000

Community Input
Answer four questions:

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

What are we missing?

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

Define Health

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

WHAT TRENDS OR FACTORS ARE INFLUENCING HEALTH

Can be grouped into categories such as:

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

ASSETS

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

What would you do?

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

Next Steps

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

Five Prevention Agenda Priorities

1. **Prevent Chronic Diseases**

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

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

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

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

THANK YOU

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

Yates County Focus Group Summary Data

1. What are we missing in our assessment to date?
    - Data on breastfeeding – practice and policies
    - Data on children – diabetes and asthma
    - Information on childcare services and early childhood education
    - Data on access to care (or lack of care)
    - Data by age
    - More data on tobacco use and marijuana use
    - Data on adult mental health services
    - Data on Mennonites
    - Data by income levels
    - Data on cancer
    - Data on environmental health (agriculture, clean water, clean air, etc.)
    - Data on the anorexic population
    - Ratio of fast food restaurants to actual restaurants
    - Data on availability of nutritious food and fitness centers
    - Data on facilities/programs available for substance abuse
    - Data on eye health
    - Data on the homeless population/housing
    - Data on social services
    - Access to care
    - Data on pollution
    - Assessment of walkability of the community
    - Childhood obesity data
    - Correlation between adults being obese and their children being obese
    - Correlation between breastfeeding and health outcomes
    - Physical activity data

2. What words would you use to define health and what terms would you use to define a healthy community?
    - Blood pressure is normal
    - No obese
    - Have a job
    - Geography
    - Healthy community with not a lot of substance abuse
    - Economic health and the wealth of the community

3. What trends or factors are influencing the health of the residents?
    - Lack of transportation
    - Availability of information
    - Lack of childcare services and early childhood education

- Lack of adequate housing
- Lack of healthcare providers
- Lack of dental care
- Lack of programs for school-aged children that are not involved in sports
- No place for children to play outside
- High number of lonely and isolated senior citizens
- Technology – leads to increased screen time and sedentary lifestyles
- Hospital does not offer many services (no birthing unit, etc.)
- Video games are in most households – increased screen time
- A lot of drugs in the county – scares people, children don't go outside as much
- There are no recreation centers for children – youth don't have anything to do, so they get into trouble
- Budgets affect the hospitals and the public's health
- Nutritious food is expensive
- Smoking allowed in apartment buildings
- Lack of education on nutrition
- Lack of time
- Increased use of electronics in all ages
- There is a trend in people starting to realize that they need to focus more on their health

4. What community strengths or assets contribute to the health of the residents?
    - Many programs available to help (agencies, libraries, schools, PH, Living Well, Milly's Pantry, etc.)
    - People are passionate about the community and want to fix these problems
    - Good sidewalks in the village
    - Milly's Pantry provides snacks for children
    - School districts are community and health oriented
    - Safe Harbor is connecting well with kids
    - Kids are getting more outside views due to technology
    - Kids Adventure Time is very successful
    - Outlet trail
    - Wineries (vineyards)
    - Less industrial waste
    - Access to good food sources
    - No dump (landfill)
    - Plenty of playgrounds for kids
    - Volunteerism is very active in the county
    - There is a hospital in the county
    - Keuka College

- Can volunteer at the Community Center and get a free membership
- Workforce Development
- The Living Well Center
- Food pantries, churches give out free food
- Community Café dinner every last Tuesday of the month
- Choose Health Yates Coalition
- Arc of Yates
- The Community Center
- Availability of outdoor recreation activities
- Cardiac rehab is available
- Keuka Comfort Care Home
- EMS Volunteers
- Good people
- ProAction
- Office for the Aging
- Walking trails
- Farmers markets
- Vouchers for the elderly and low income for farmers markets
- A lot of coalitions doing good work

5. What would you do to address some of these problems?
    - Provide more grant money for early childhood education and programming for families
    - Solve the transportation issue
    - Increase awareness of programs and activities that are already being offered
    - Start a staffed boys/girls club
    - Start a program with seniors mentoring children on life skills
    - Discontinue programs that are no utilized
    - Start a community bulletin or resource that goes out to all families
    - Public swimming pool
    - Delivering hospital in the county
    - More sports fields for kids to play games
    - Bring an urgent care center to the county
    - Bring a YMCA to the county
    - Educate the community more
    - More support for families
    - Encourage parents to talk to their kids more
    - Lessen regulations for first responders
    - Pay first responders more
    - Anything to get people outdoors more
    - Get people more involved in the community

- Have cooking classes for children
- More programs to reduce the number of isolated seniors
- Make the Outlet Trail safer
- Restaurants that offer more healthy options and smaller portions
- Offer affordable cooking classes
- Make farmers market coupons more accessible
- More support for grandparents that are raising grandchildren
- Support a safer community
- Educate people on using chemicals in their households

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

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

County:	Yates
Group Name:	Tier II Meeting
Date and Time:	March 18, 2016 – 9:30AM
# of Participants:	15

1. What are we missing in our assessment to date?
    a. There were a few things that said adults, was it all adults? Because most of us serve children. For the purposes of this group, youth data is missing.
    b. Yes. In full assessment it will include breakout of age. Diane explained local data related to children. Schools are seeing decrease in tobacco products and increase in marijuana. Not certain if the tobacco use includes cigarettes.
    c. Knowing the health status of the adults is helpful because it gives you a better picture of the family life of the children being served.
    d. Seeing demand for treatment up, still not numbers that are estimated that should be seen. Seeing children diagnosed sooner. Broader behavioral health assessment is being done.
    e. Adult mental health services have waiting lists in the area. Adults are also seeking services that are not available in this area and are unwilling or unable to travel to receive these services outside of the area. This trend is alarming.
    f. What is the link between lower heart disease rates and higher death from heart attack rates? Want to know if it is the same people dying. Is it health insurance related? Late diagnosis or not being diagnosed? Ability to access treatment quickly?
    g. Would like assessment broken down by groups. Ex: Mennonites. Would like to know how accurate the death certificates are in identifying cause of death in Mennonite community.
2. What trends or factors are influencing the health of the residents?
    a. Continued lack of public transportation and lack of adequate housing. Continued lack of health care providers. Dental services are included. Ex: Woman from FL Community Health noted she is booked full until September. Medicaid transportation is getting better according to one, has not improved according to another. It may be education on the system is needed for both the provider and the person receiving services.
    b. There are some programs offered in the area. Transportation is an issue. Ex: High school has sports but kids cannot be transported home after the sports. Schools no longer have the sports buses. There is some help from Big Brother/Big Sister but with how spread out they are and times are so varied, it's difficult. Would like to know how many children don't participate due to transportation. Might be more

of the adult not signing the children up because they know they can't transport them.

c. Sports does not provide an outlet for all kids. Dundee has a drop-in youth center and Penn Yan lacks this. It also needs to be well-run. The rates of children using the Dundee center has dropped. It also is not centrally located.
d. Kids are going to the library and bringing footballs. They want to play but it isn't an appropriate place for it. Playing football in the courthouse yard. There is no other centrally located place for them to play.
e. Would love to see a shuttle that runs to the community center from the schools or library. There are open fields there.
f. See a lot of lonely and isolated seniors.
g. Important meetings that decide community issues go on and you don't hear about it until too late or even after it has happened.

3. What community strengths or assets contribute to the health of the residents?
    a. The county works really well and really hard for the children. People are passionate about the community and want to fix the problems themselves.
    b. If you live within one of the villages you can walk to what you need on sidewalks.
    c. Do have access to healthy foods. May not always be affordable but it is more accessible than in other communities.
    d. Millie's Pantry has been providing snacks for children. Kids who are hungry can access snacks all day. Bagged food at the end of the week too.
    e. School districts are community and health oriented. They understand the children's and families' needs.
    f. Safe Harbor is connecting well with the kids. The children are receptive to the information they have to offer on healthy relationships.
    g. Kids are getting more outside views due to technology. Ex: Recognizing homophobia. Will call out other children.
    h. Kids Adventure Time has been a very successful program and helped with the children.
    i. Arc of Yates is always out in the community.
4. What would you do to address some of these problems?
    a. Would love to see transportation brought to the forefront again. Even the beginnings of a public transportation program can make a difference. Will make a huge difference with getting individuals to their appointments. Transportation is a top issue in the community.
    b. More public awareness of what is going on and how to get there.
    c. A staffed Boys/Girls Club.
    d. A program with seniors mentoring children on life skills. Could benefits parents as well. Parents want to know what to do, especially related to substance abuse.

(There is a Parenting for Life program and it is not being used. Served only 3 parents in 2015 even though it runs every Wednesday. Have childcare if you call ahead. Inviting to the next meeting.)

e. Get people more motivated to walk the sidewalks and use what is around.
f. Look at existing programs and see what is not being utilized.
g. Have a community bulletin or resource that goes out to families saying what is offered and when over the next year. There should be an app. Information is probably already available digitally, just need to get it to the right people.

County:	Yates
Group Name:	Workforce Development-Job Club
Date and Time:	April 15, 2016 – 2:00PM
# of Participants:	16

1. What are we missing in our assessment to date?
    a. Data on anorexic population
    b. Ratio between fast food restaurants and actual restaurants
    c. Data around availability of nutritious food
    d. Data on number of fitness centers
    e. Data on facilities/programs available for substance abuse
    f. There are a lot of addicts here, but there is nowhere for them to get treatment (no detox or rehab here)
    g. Eye or teeth health data
    h. Data on the homeless/housing
    i. Data on transportation
2. What trends or factors are influencing the health of the residents?
    a. Hospital isn't good and they don't offer many services (no birthing unit, etc.)
    b. Transportation - a lot of people that can't get to the doctor or work
    c. Cars/transportation costs too much money
    d. Video games are everywhere, kids don't go outside anymore
    e. Increase in technology can be bad - especially for children
    f. Don't see kids outside as much
    g. A lot of drugs, overdoses, drug dealers, etc. - scares people, kids don't go outside
    h. Parents are afraid to let their kids outside alone - don't want to be turned in for child abuse
    i. There are no recreation programs/centers - kids/youth and adults don't have anything to do
3. What community strengths or assets contribute to the health of the residents?
    a. Can volunteer at the Community Center and get a free membership
    b. Workforce Development - help you get a job or help you get what you need
    c. The Living Well Center
    d. Community support - if you have a problem, there are places that will help you (like when we had the flood, everyone came together and helped out)
    e. The churches give out free food
    f. Food pantries
    g. Community Cafe dinner every last Tuesday of the month
    h. Choose Health Yates Coalition reduce screen time initiative

4. What would you do to address some of these problems?
    a. Need to bring a YMCA here
    b. Education - availability of resources and health
    c. More support to help people, keeping them going on getting healthy
    d. Support families more - parents don't have sit down dinners with their family anymore, parents don't play with their kids anymore, parents don't discipline their kids anymore
    e. Parents need to talk with their kids more - they are so busy nowadays, they don't take the time to sit down and talk to their kids

County:	Yates
Group Name:	Bone Builders Class
Date and Time:	April 21, 2016 – 10:30AM
# of Participants:	23

1. What are we missing in our assessment to date?
    a. Mentioned dredging Outlet channel – pollution present – coming downstream from Keuka Lake (source of drinking water for community)
    b. Need for safe sidewalks to use when walking
    c. No place to sit down when out walking in village and surrounding area. Mentioned because person has had knee surgery and needs to sit regularly when exercising. Also, would like trail/sidewalk distance markers (perhaps identified on a walking trail map) with locations to sit and rest.
    d. Penn Yan community does not know that inside walking is available at the Penn Yan Elementary School, like Dundee has at their school.
    e. Perhaps a correlation between economic groups of people in community regarding education about what is healthy living.
    f. Younger generation does not cook – need education on healthy eating and need to develop physical activity habits.
    g. Yates County needs more physicians
    h. Young adults not feeding children properly. Also lack of activity in schools. Children need to learn to relax with yoga and other exercises. Too much screen time of all sorts. If you work the "physical", then it helps work the "mental".
2. What trends or factors are influencing the health of the residents?
    a. Good food requires money – food pantries have long wait lines on distribution day. Not much nutritious food given out. Elderly have trouble waiting in long line during distribution. Much of the food is processed food, canned food. Suggest using vouchers for food choices.
    b. Smoking allowed at apartment buildings. People smoke around and in apartments and the smoke residue affects others.
    c. Advertise about where people can go to get help when they need food, or other items.
    d. Use "Living Well" for needed items. Needs more advertising outreach.
3. What community strengths or assets contribute to the health of the residents?
    a. ProAction/Yates Office for the Aging has transportation for anyone over the age of 60 and are income eligible.
4. What would you do to address some of these problems?
    a. Have cooking classes for children.

b. Build a pool for the community.
c. Focus informational pieces for seniors who are isolated and have limited resources. They especially have a hard time if they have a disability on top of their other issues. A walking map with walking opportunities and targeted areas for rest and distance.
d. More safety on Outlet Trail. One shared a scary story of young man threatening her while she walked alone. When reporting to law enforcement – was asked what young man's name was? - Need for more patrols on foot or bike on Outlet Trail at various intervals.
e. Restaurants that offer more healthy options and smaller portions. List calorie content and nutritional value on items on menu.
f. Cooking classes that are affordable.
g. Senior citizens are providing care and nutrition for grandchildren because many are raising the grandchildren due to the absence or neglect of parents. Need more help for them.
h. Continue coupons offered for farm markets or stores. Make them more accessible.
i. Bus service – (Yates OFA provides transport for people over age 60 with income eligibility for medical appointments or shopping). Need bus service for others to get to work our travel outside county for various reasons.
j. Need safer community – many dog attacks are occurring, with some going unreported. Need to push for more follow-up on these attacks. Animal Control Officer through Yates County Sheriff needs to follow through more on reported attacks. Presently some victims have to go to Court to get help needed after such an attack.

County:	Yates
Group Name:	Penn Yan Baby Café
Date and Time:	April 21, 2016 – 9:30AM
# of Participants:	2

1. What are we missing in our assessment to date?
    a. Childhood obesity data
    b. Correlation between adults being obese and their children being obese
    c. Correlation between breastfeeding and reduced obesity (and reduced sickness, allergies, better digestion, better overall health for mom and baby)
    d. Physical activity data and opportunities for physical activity
    e. Access to healthy foods
2. What trends or factors are influencing the health of the residents?
    a. Lack of education around nutrition, etc.
    b. Cost of healthy foods - or perceived cost of healthy foods (people think that it's a lot more expensive, but often times it's not)
    c. Lack of time - people don't have time to make foods
    d. Increased screen time in kids
    e. Use of electronics in all ages - parents are on their phones, watching tv, connected all the time
    f. Have seen a trend in people starting to realize that they need to focus more on their health
3. What community strengths or assets contribute to the health of the residents?
    a. Recreation center - great for youth
    b. Walking trails
    c. Playgrounds
    d. Local produce, farmers markets (Branchport and Main Street), Mennonites
    e. Vouchers for the elderly and low income for farmers markets
    f. Farmers donate a lot to food pantries, etc.
    g. A lot of coalitions doing good work (substance abuse, reducing screen time, increasing reading, etc.)
4. What would you do to address some of these problems?
    a. More education around nutrition - how to pack a healthy lunch, how to cook healthy meals, sugar in juice, being a role model for your children
    b. Educate people on using chemicals in your household
    c. Be positive role models for the rest of the community

County:	Yates
Group Name:	Long Range Planning Committee of the Yates Chamber of Commerce
Date and Time:	April 28, 2016 – 8:30AM
# of Participants:	10

1. What are we missing in our assessment to date?
    a. Cost is not covered. What does it cost to get care?
    b. Access to care. Not enough providers.
    c. How many people are on social services? Based on income and the relation to disease?
    d. As the government is taking on the cost of some of the care how is this going to change the data we have seen today?
    e. Access to care. Availability of resources around the emergency responders.
2. What words would you use to define health and in what terms would you define community health?
    a. Blood pressure is okay Obesity is in check. Work availability.
    b. Quality of life
    c. Geography
    d. Healthy community which has limited substance abuse
    e. Economic health and the wealth of the community.
3. What trends or factors are influencing the health of the residents?
    a. Budgets affect the hospitals and the public's health.
4. What community strengths or assets contribute to the health of the residents?
    a. ARC of Yates and the daily services that they provide. Senior Housing.
    b. The Community Center
    c. Outdoor recreation due to the Geography.
    d. The hospital, cardiac rehab.
    e. Keuka Comfort Care Home. When there is a need the community comes together when there is a need.
    f. EMS Volunteers. People step up and help each other.
    g. People here are great.
5. What would you do to address some of these problems?
    a. Review and lessen regulations and requirements for first responders. Possibly more pay.
    b. Anything to get people outdoors. Places to walk and bike on.
    c. County has to get active as whole, such as volunteering for patrolling.

County:	Yates
Group Name:	Lions Club
Date and Time:	May 09, 2016 – 6:30PM

1. What are we missing in our assessment to date?
    a. Question was asked about data on income levels for gathering health statistics.
    b. Question was asked regarding heroin overdoses and if there is any identifying information about who the doctor is for an overdose patient.
    c. Question was asked how do those who gather the health data accurately know if only 51% of the people in Yates County are going to a provider. Deb Minor answered by saying the surveys are done by landline/cell phone calls.
    d. Question was asked if patients with a diagnosed illness are being monitored regularly. Alice MacKerchar (employee of Keuka Health Care), stated that patients with a diagnosed illness are monitored every 3 to 6 months to ensure compliance with medications and monitor for changes.
    e. Question was asked if co-pay is an issue for some who do not go to a doctor (provider). Deb answered that currently not as many people are choosing not to go to a doctor, but that number may increase as more are insured with high deductible insurance plans. This should not be an issue for insured children however as preventive visits are typically
    f. Question was asked on how dowe define obesity/overweight in the population. Deb spoke about providers using BMI number (ratio between height & weight) to indicate whether or not someone is underweight, normal weight, overweight, obese, or morbidly obese.
    g. Question was asked once we find a health "category" (deficiency) we realize needs attention, how do we begin to address the issue. Deb spoke about the "Priority-setting meeting" that is coming on June 24th at 8:30 Am in the County Auditorium and asked if anyone in the audience would like to attend. From this meeting, decisions are made that help develop the CHIP (Community Health Improvement Plan) and choose best-practices programming that will address the issue in our community.
    h. Question was asked about the health assessment survey – does the questionnaire ask about sleep apnea?
    i. Question was asked about how we determine the health needs of the Mennonite community.
    j. Question was asked about the cancer data rates and do we look at agriculture as a possible cause of these increased rates?
2. What trends or factors are influencing the health of the residents?
    a. Do we have fewer or more health care providers in our community? Officials believe we have enough care for our population because we can travel outside the county to find a provider.
    b. We have an access issue for dental health care.

c. Audience member felt that our younger population watches too much TV (screen time), living a more sedentary lifestyle than the Mennonite children do.
d. Transportation is missing for those who want to go to and from a doctor's appointment and for other transportation needs

3. What community strengths or assets contribute to the health of the residents?
    a. Outlet Trail
    b. Wineries (vineyards)
    c. Less industrial waste
    d. Access to good food sources
    e. No dump (landfill)
    f. Plenty of playgrounds for kids
    g. Volunteerism is alive and well in Yates County
    h. We have a hospital in our community
    i. Access to benefits from Keuka College
4. What would you do to address some of these problems?
    a. Need for a swimming pool for kids & adults
    b. Women have to travel a long distance to deliver a baby
    c. We need "increased light" to counterbalance the "SAD" effect
    d. More sports fields for kids to play games
    e. Urgent care needed in community so people who are not needing emergency care don't have to travel to another county for "urgent care"

County:	Yates
Group Name:	Yates County Youth Bureau Director
Date and Time:	May 16, 2016 – 10:00AM
# of Participants:	1

1. What are we missing in our assessment to date?
    a. More data on breastfeeding and practice/policies impact on families
    b. No health concerns included in data regarding children with diabetes or asthma or health status of children within Yates County (understanding that when info is gathered it probably is something that adults would be reluctant to provide to someone they do not know)
    c. No information about childcare services or early childhood education (programming) for kids. Funding may be an issue for families and setting up programming may be the financial issue for agencies.
    d. Large number of families who are unserved.
2. What trends or factors are influencing the health of the residents?
    a. All of the issues listed above influence the health of children and families
    b. Lack of transportation impacts health of families.
    c. Availability of information (getting info out) to families regarding interests, needs, and opportunities affects health of family members.
3. What community strengths or assets contribute to the health of the residents?
    a. Many agencies/libraries/schools/Public Health Dept./Living Well/Milly's Pantry – all have programs for families and provide information regarding availability and awareness of programs being offered.
4. What would you do to address some of these problems?
    a. More grant money available for early childhood education (birth – age 4) and programming for families. Lack of transportation affects this. Need public transportation.
    b. Finding ways to spread awareness of programs and activities that are already being offered within Yates County.

S²AY Rural Health Network, Inc.

Yates County Public Health System Assessment 2016

Health Promotion Activities to Facilitate Health Living in Healthy Communities					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Conducts health promotion activities for the community-at-large or for populations at increased risk for negative health outcomes	8	12	1	0	21
Develops collaborative networks for health promotion activities that facilitate healthy living in healthy communities	10	9	2	0	21
Assesses the appropriateness, quality and effectiveness of health promotion activities at least every 2 years.	10	6	3	3	22
Total Respondents	22				

Mobilize Community Partnerships to Identify and Solve Health Problems					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Has a process to identify key constituents for population based health in general (e.g. improved health and quality of life at the community level) or for specific health concerns (e.g., a particular health theme, disease, risk factor, life stage need).	12	7	2	1	22
Encourages the participation of its constituents in community health activities, such as in identifying community issues and themes and in engaging in volunteer public health activities.	12	9	1	0	22
Establishes and maintains a comprehensive directory of community organizations.	13	5	3	1	22
Uses broad-based communication strategies to strengthen linkages among LPHS organizations and to provide current information about public health services and issues.	10	10	2	0	22
Total Respondents	22				

Community Partnerships					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Establishes community partnerships to assure a comprehensive approach to improving health in the community.	13	8	1	0	22
Assure the establishment of a broad-based community health improvement committee.	13	5	2	2	22
Assesses the effectiveness of community partnerships in improving community health.	11	5	3	3	22
Total Respondents	22				

Assure a Competent Public and Personal Health Care Workforce					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Assessment of workforce (including volunteers and other lay community health workers) to meet the community needs for public and personal health care services.	9	7	3	3	22
Maintaining public health workforce standards, including efficient processes for licensure/credentialing of professionals and incorporation of core public health competencies needed to provide the Essential Public Health Services into personnel systems.	10	7	2	3	22
Adoption of continuous quality improvement and life-long learning programs for all members of the public health workforce, including opportunities for formal and informal public health leadership development.	11	7	1	3	22
Total Respondents	22				

Life-long Learning Through Continuing Education, Training & Mentoring					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Identify education and training needs and encourage opportunities for public health workforce development.	8	8	1	4	21
Provide opportunities for all personnel to develop core public health competencies.	6	9	1	5	21
Provide incentives (e.g. improvements in pay scale, release time, tuition reimbursement) for the public health workforce to pursue education and training.	5	8	3	5	21
Provide opportunities for public health workforce members, faculty and student interaction to mutually enrich practice-academic settings.	4	10	2	5	21
Total Respondents	21				

Public Health Leadership Development					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Provide formal (educational programs, leadership institutes) and informal (coaching, mentoring) opportunities for leadership development for employees at all organizational levels.	7	7	4	3	21
Promote collaborative leadership through the creation of a local public health system with a shared vision and participatory decision-making.	7	8	3	3	21
Assure that organizations and/or individuals have opportunities to provide leadership in areas where their expertise or experience can provide insight, direction or resources.	8	10	2	1	21
Provide opportunities for development of diverse community leadership to assure sustainability of public health initiatives.	5	10	5	1	21
Total Respondents	21				

Access to and Utilization of Current Technology to Manage, Display and Communicate Population Health Data					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Uses state of the art technology to collect, manage, integrate and display health profile databases.	8	7	3	3	21
Promotes the use of geocoded data.	4	7	2	7	20
Uses geographic information systems.	6	8	1	6	21
Uses computer-generated graphics to identify trends and/or compare data by relevant categories (e.g. race, gender, age group).	9	7	1	4	21
Total Respondents	21				

Diagnose and Investigate Health Problems and Health Hazards in the Community					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Epidemiological investigations of disease outbreaks and patterns of infectious and chronic disease and injuries, environmental hazards, and other health threats.	13	5	1	3	22
Active infectious disease epidemiology programs.	13	5	2	2	22
Access to public health laboratory capable of conducting rapid screening and high volume testing.	11	6	1	4	22
Total Respondents	22				

Plan for Public Health Emergencies					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Defines and describes public health disasters and emergencies that might trigger implementation of the LPHS emergency response plan.	18	2	0	2	22
Develops a plan that defines organizational responsibilities, establishes communication and information networks, and clearly outlines alert and evacuation protocols.	17	2	0	3	22
Tests the plan each year through the staging of one or more “mock events.”	14	4	0	4	22
Revises its emergency response plan at least every two years.	14	3	0	5	22
Total Respondents	22				

Investigate & Respond to Public Health Emergencies					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Designates an Emergency Response Coordinator	16	1	0	4	21
Develops written epidemiological case investigation protocols for immediate investigation of:	13	2	0	6	21
Communicable disease outbreaks	13	2	1	5	21
Environmental health hazards	11	2	1	7	21
Potential chemical and biological agent threats	11	4	1	5	21
Radiological threats and	11	2	2	6	21
Large scale disasters	12	3	0	6	21
Maintains written protocols to implement a program of source & contact tracing.	11	4	0	6	21
Maintain a roster of personnel with technical expertise to respond to biological, chemical or radiological emergencies	13	3	0	5	21
Evaluates past incidents for effectiveness & continuous improvement	11	4	0	5	20
Total Respondents	21				

Laboratory Support for Investigation of Health Threats					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Maintains ready access to laboratories capable of supporting investigations.	11	6	0	4	21
Maintains ready access to labs capable of meeting routine diagnostic & surveillance needs.	11	5	0	5	21
Confirms that labs are in compliance with regs & standards through credentialing and licensing agencies.	11	6	0	4	21
Maintains protocols to address handling of lab samples– storing, collecting, labeling, transporting and delivering samples and for determining the chain of custody.	9	6	0	5	20
Total Respondents	21				

Develop Policies & Plans that support Individual and Community Health Efforts.					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
An effective governmental presence at the local level.	14	5	0	3	22
Development of policy to protect the health of the public and to guide the practice of public health.	12	6	0	4	22
Systematic community-level and state-level planning for health improvement in all jurisdictions.	12	5	0	5	22
Alignment of LPHS resources & strategies with the community health improvement plan.	11	5	0	6	22
Total Respondents	22				

Public Health Policy Development					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Contributes to the development and/or modification of public health policy by facilitating community involvement in the process and by engaging in activities that inform this process.	11	7	1	3	22
Reviews existing policies at least every 2 years and alerts policy makers and the public of potential unintended outcomes and consequences.	11	6	0	5	22
Advocates for prevention and protection policies, particularly policies that affect populations who bear a disproportionate burden of mortality and morbidity.	14	6	0	2	22
Total Respondents	22				

Community Health Improvement Process					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Establishes a community health improvement process, which includes broad based participation and uses information from the community health assessment as well as perceptions of community residents.	12	4	1	5	22
Develops strategies to achieve community health improvement objectives and identifies accountable entities to achieve each strategy.	11	6	0	4	21
Total Respondents	22				

Strategic Planning & Alignment with the Community Health Improvement Process					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Conduct organizational strategic planning activities.	11	6	0	5	22
Review its own organizational strategic plan to determine how it can best be aligned with the community health improvement process.	12	4	1	5	22
Conducts organizational strategic planning activities and uses strategic planning to align its goals, objectives, strategies and resources with the community health improvement process.	12	4	1	5	22
Total Respondents	22				

Enforce Laws & Regulations that Protect Health and Ensure Safety					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Review, evaluate and revise laws and regulations designed to protect health and safety to assure they reflect current scientific knowledge and best practices for achieving compliance.	11	6	1	4	22
Education of persons and entities obligated to obey or to enforce laws and regulations designed to protect health and safety in order to encourage compliance.	15	5	0	2	22
Enforcement activities in areas of public health concern, including but not limited to the protection of drinking water, enforcement of clean air standards, regulation of care provided in health care facilities and programs, re-inspection of workplaces following safety violations; review of new drug, biologic and medical device applications, enforcement of laws governing sale of alcohol and tobacco to minors; seat belts and child safety seat usage and childhood immunizations.	13	3	1	5	22
Total Respondents	22				

Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Identifying populations with barriers to personal health services.	14	4	1	2	21
Identifying personal health service needs of populations with limited access to a coordinated system of clinical care.	13	5	1	2	21
Assuring the linkage of people to appropriate personal health services.	12	5	1	3	21
Total Respondents	21				

Identifying Personal Health Services Needs of Population					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Defines personal health service needs for the general population. This includes defining specific preventive, curative and rehabilitative health service needs for the catchment areas within its jurisdiction.	14	4	2	1	21
Assesses the extent to which personal health services are provided.	11	5	2	3	21
Identifies the personal health service needs of populations who may encounter barriers to the receipt of personal health services.	14	4	2	1	21
Total Respondents	22				

Assuring the Linkage of People to Personal Health Services					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Assures the linkage to personal health services, including populations who may encounter barriers to care.	14	5	2	0	21
Provides community outreach and linkage services in a manner that recognizes the diverse needs of unserved and underserved populations.	13	5	3	0	21
Enrolls eligible beneficiaries in state Medicaid or Medical Assistance Programs.	11	7	1	2	21
Coordinates the delivery of personal health and social services with service providers to optimize access.	13	3	2	3	21
Conducts an analysis of age-specific participation in preventive services.	11	3	2	5	21
Total Respondents	21				

Evaluation of Population-based Health Services					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Evaluate population-based health services against established criteria for performance, including the extent to which program goals are achieved for these services.	10	4	3	4	21
Assesses community satisfaction with population-based services and programs through a broad-based process, which includes residents who are representative of the community and groups at increased risk of negative health outcomes.	10	5	2	4	21
Identifies gaps in the provision of population-based health services.	10	5	2	4	21
Uses evaluation findings to modify the strategic and operational plans of LPHS organizations to improve services and programs.	9	3	2	6	20
Total Respondents	21				

Evaluate Effectiveness, Availability and Quality of Personal and population based health services?					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Identifies community organizations or entities that contribute to the delivery of the Essential Public Health Services.	12	4	2	3	21
Evaluates the comprehensiveness of the LPHS activities against established criteria at least every five years and ensures that all organizations within the LPHS contribute to the process.	9	6	1	5	21
Assesses the effectiveness of communication, coordination and linkage among LPHS entities.	9	4	2	6	21
Uses information from the evaluation process to refine existing community health programs, to establish new ones, and to redirect resources as needed to accomplish LPHS goals.	9	3	3	6	21
Total Respondents	21				

Research for New Insights and Innovative Solutions to Health Problems					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
A continuum of innovative solutions to health problems ranging from practical field-based efforts to foster change in public health practice, to more academic efforts to encourage new directions in scientific research.	8	4	3	6	21
Linkages with institutions of higher learning and research.	8	4	4	5	21
Capacity to mount timely epidemiological and health policy analyses and conduct health systems research.	8	6	1	6	21
Total Respondents	21				

Where is your organization located?		
Answer Options	**Response Percent**	**Response Count**
Dundee	15.0%	3
Naples	0.0%	0
Penn Yan	80.0%	16
Rushville	0.0%	0
Canandaigua	0.0%	0
Geneva	10.0%	2
Bath	0.0%	0
Watkins Glen	0.0%	0
Other (Keuka Park, Yate County)		2
Total Respondents	23	

What population does your organization serve? ie. elderly, low income, children	
Answer Options	**Response Count**
All	9
Elderly	1
Elderly, Low Income	1
Elderly, Low Income, Veterans	1
Low Income Adults	1
Substance Abuse	1
Students, Later Adolescence	1
Animal Owners	1
Agricultural Community	1
DD	1
Total Respondents	18

What is your position/job title?	
Answer Options	**Response Count**
Coordinator	2
Commissioner	1
Director/Administrator	5
County Legislator	1
Veterinarian	1
Manager/Supervisor	2
Pastor	1
Environmental Prevention Specialist	1
Human Resources	1
Former ED Retired, Therapist	1
Outreach	1
Total Respondents	17

What type of organization do you work for? ie. hospital, county agency, non-profit	
Answer Options	**Response Count**
Non-profit	7
College/University	2
Government	1
Hospital	3
County agency	4
Veterinary hospital	1
Total Respondents	18

Cancer Indicators - Yates County

2010-2012

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
All cancers								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	487	640.0	550.9	Yes	610.0	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	487	501.2	489.2	No	510.8	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	173	227.3	180.7	Yes	202.4	No	3rd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	173	171.3	158.6	No	165.6	No	2nd
Lip, Oral Cavity, and Pharynx Cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	s	s	12.1	N/A	13.5	N/A	N/A
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	s	s	10.5	N/A	11.0	N/A	N/A
Crude mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.5	N/A	2.6	N/A	N/A
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.2	N/A	2.1	N/A	N/A
Colon and rectum cancer								

Crude incidence rate per 100,000	(Table) (Trend) (Map)	43	56.5	46.7	No	49.6	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	43	45.4	41.4	No	41.2	No	3rd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	19	25.0	16.6	No	17.2	No	4th
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	19	18.4	14.4	No	13.9	No	4th
Lung and bronchus cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	74	97.2	69.6	Yes	83.0	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	74	72.0	61.6	No	68.6	No	3rd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	58	76.2	46.4	Yes	55.9	Yes	4th
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	58	56.3	41.0	Yes	46.1	No	4th
Female breast cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	69	176.1	149.1	No	164.4	No	4th
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	69	141.9	127.2	No	133.2	No	4th
Crude mortality rate per 100,000	(Table) (Trend) (Map)	7	17.9*	26.3	No	28.1	No	1st

Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	7	11.6*	20.9	No	20.9	No	1st
Crude late stage incidence rate per 100,000	(Table) (Trend) (Map)	15	38.3	49.2	No	51.4	No	1st
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	15	28.9	42.7	No	42.7	No	1st
Cervix uteri cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	6	15.3*	8.3	No	7.2	No	4th
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	6	13.1*	7.7	No	6.7	No	4th
Crude mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.7	N/A	2.4	N/A	N/A
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.3	N/A	2.0	N/A	N/A
Ovarian cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	10	25.5	14.9	No	16.2	No	4th
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	10	18.4	12.5	No	12.9	No	4th
Crude mortality rate per 100,000	(Table) (Trend) (Map)	s	s	9.5	N/A	10.4	N/A	N/A
Age-	(Table) (Trend) (Map)	s	s	7.5	N/A	7.8	N/A	N/A

adjusted mortality rate per 100,000								
Prostate cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	64	173.4	156.7	No	167.4	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	64	124.4	145.3	No	143.8	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	8	21.7*	18.3	No	18.6	No	3rd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	8	19.0*	20.0	No	18.5	No	2nd
Crude late stage incidence rate per 100,000	(Table) (Trend) (Map)	21	56.9	23.3	Yes	25.1	Yes	4th
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	21	40.2	21.2	Yes	21.1	Yes	4th
Melanoma cancer mortality								
Crude mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.5	N/A	3.3	N/A	N/A
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.2	N/A	2.8	N/A	N/A
Age-adjusted % of women 18 years and older with Pap smear in past 3 years (2013-	(Table) (Map)	N/A	53.5	74.2	Yes	76.2	Yes	4th

2014)								
% of women 40 years and older with mammography screening in past 2 years (2013-2014)	(Table) (Map)	N/A	69.5	77.8	No	77.4	No	4th
% of women, aged 50-74 years, who had a mammogram between October 1, 2011 and December 31, 2013 (2013)	(Table) (Map)	41	64.1	71.7	No	63.4	No	2nd

N/A: Data not available

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

s: Data do not meet reporting criteria

Cardiovascular Disease Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Cardiovascular disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	221	291.0	272.5	No	297.4	No	2nd
Age-adjusted	(Table) (Trend) (Map)	221	210.8	228.0	Yes	228.2	Yes	1st
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	25	86.4	99.0	No	96.8	No	1st
Pretransport mortality	(Table) (Trend) (Map)	114	150.1	146.7	No	162.3	No	2nd
Cardiovascular disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,016	133.8	163.6	Yes	165.9	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	1,016	102.5	143.5	Yes	136.0	Yes	1st
Disease of the heart mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	179	235.7	222.1	No	238.7	No	3rd
Age-adjusted	(Table) (Trend) (Map)	179	169.7	185.4	Yes	182.8	Yes	2nd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	19	65.7	80.6	No	79.9	No	1st
Pretransport mortality	(Table) (Trend) (Map)	95	125.1	126.3	No	134.7	No	2nd
Disease of the heart hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	684	90.1	108.5	Yes	111.9	Yes	1st
Age-	(Table) (Trend) (Map)	684	68.8	94.9	Yes	91.4	Yes	1st

adjusted								
Coronary heart disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	120	158.0	175.1	No	171.8	No	2nd
Age-adjusted	(Table) (Trend) (Map)	120	113.6	146.2	Yes	131.5	Yes	2nd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	15	51.9	65.5	No	60.7	No	1st
Pretransport mortality	(Table) (Trend) (Map)	66	86.9	103.6	No	100.0	No	2nd
Coronary heart disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	235	30.9	40.0	Yes	39.9	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	235	24.1	34.8	Yes	32.5	Yes	1st
Heart attack (Acute Myocardial Infarction) hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	130	17.1	17.1	No	19.4	No	2nd
Age-adjusted	(Table) (Trend) (Map)	130	13.4	14.8	No	15.7	No	1st
Heart attack (Acute Myocardial Infarction) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	50	65.8	37.3	Yes	45.0	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	50	46.9	31.3	Yes	34.8	Yes	4th
Congestive heart failure mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	10	13.2	14.7	No	21.6	No	1st
Age-adjusted	(Table) (Trend) (Map)	10	9.4	12.0	Yes	16.1	Yes	1st
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	0	0.0*	1.9	Yes	2.3	Yes	1st
Pretransport mortality	(Table) (Trend) (Map)	4	5.3*	8.0	No	12.4	No	1st
Congestive heart failure hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	193	25.4	28.8	No	29.3	Yes	1st

Age-adjusted	(Table) (Trend) (Map)	193	19.0	24.9	Yes	23.4	Yes	1st
Cerebrovascular disease (stroke) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	33	43.4	30.9	No	38.5	No	3rd
Age-adjusted	(Table) (Trend) (Map)	33	32.4	26.2	Yes	29.8	Yes	3rd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	5	17.3*	10.5	No	10.1	No	4th
Pretransport mortality	(Table) (Trend) (Map)	17	22.4	11.5	Yes	17.0	No	4th
Cerebrovascular disease (stroke) hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	199	26.2	26.9	No	28.9	No	2nd
Age-adjusted	(Table) (Trend) (Map)	199	20.2	23.5	Yes	23.6	Yes	2nd
Hypertension hospitalization rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	25	4.3	7.4	Yes	5.0	No	3rd
Hypertension hospitalization rate per 10,000 (any diagnosis) (aged 18 years and older)	(Table) (Trend) (Map)	3,022	520.6	562.1	Yes	560.8	Yes	2nd
Hypertension emergency department visit rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	138	23.8	32.9	Yes	24.9	No	3rd
Hypertension emergency department visit rate per	(Table) (Trend) (Map)	5,417	933.2	896.6	Yes	927.7	No	3rd

10,000 (any diagnosis) (aged 18 years and older)								
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	625	82.3	117.7	Yes	117.1	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	625	61.9	103.0	Yes	95.3	Yes	1st
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	511	67.3	115.3	Yes	116.8	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	511	50.9	101.0	Yes	95.4	Yes	1st
Age-adjusted % of adults with physician diagnosed angina, heart attack or stroke # (2008-2009)	(Table) (Map)	N/A	5.8	7.6	No	7.2	No	1st
Age-adjusted % of adults with cholesterol checked in the last 5 years # (2013-2014)	(Table) (Map)	N/A	66.0	83.4	Yes	83.2	Yes	4th
Age-adjusted % of adults ever told they have high blood pressure (2013-2014)	(Table) (Map)	N/A	24.3	27.3	No	27.8	No	1st

N/A: Data not available

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

#: Data not available for NYC counties

Child and Adolescent Health Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Childhood mortality rate per 100,000								
Aged 1-4 years	(Table) (Trend) (Map)	3	78.7*	20.0	No	21.1	No	4th
Aged 5-9 years	(Table) (Trend) (Map)	0	0.0*	10.1	Yes	9.7	Yes	1st
Aged 10-14 years	(Table) (Trend) (Map)	2	39.1*	11.9	No	11.8	No	4th
Aged 5-14 years	(Table) (Trend) (Map)	2	20.6*	11.0	No	10.8	No	4th
Aged 15-19 years	(Table) (Trend) (Map)	2	32.2*	33.4	No	35.2	No	2nd
Asthma hospitalization rate per 10,000								
Aged 0-4 years	(Table) (Trend) (Map)	0	0.0*	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	s	s	20.5	N/A	10.4	N/A	N/A
Aged 0-17 years	(Table) (Trend) (Map)	s	s	26.6	N/A	14.2	N/A	N/A
Gastroenteritis hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	s	s	11.3	N/A	8.6	N/A	N/A
Otitis media hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	0	0.0*	2.5	Yes	2.0	Yes	1st

Pneumonia hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	7	14.6*	39.4	Yes	31.3	Yes	1st
% of children born in 2010 with a lead screening aged 0-8 months (2010-2013)	(Table) (Map)	8	2.6*	3.5	No	4.2	No	2nd
% of children born in 2010 with a lead screening - aged 9-17 months (2010-2013)	(Table) (Trend) (Map)	141	45.2	65.0	Yes	53.5	Yes	3rd
% of children born in 2010 with a lead screening - aged 18-35 months (2010-2013)	(Table) (Trend) (Map)	115	36.9	65.6	Yes	55.7	Yes	3rd
% of children born in 2010 with at least two lead screenings by 36 months (2010-2013)	(Table) (Trend) (Map)	73	23.4	55.1	Yes	42.1	Yes	4th
Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) - rate per 1,000 tested children aged <72 months	(Table) (Trend) (Map)	15	16.6	4.9	Yes	8.8	Yes	4th
% of children with recommended number of well child visits in	(Table) (Trend) (Map)	670	61.3	71.6	Yes	70.3	Yes	4th

government sponsored insurance programs (2013)								
% of children aged 0-15 months with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	69	94.5	82.2	No	85.4	No	1st
% of children aged 3-6 years with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	244	68.9	83.1	Yes	81.2	Yes	4th
% of children aged 12-21 years with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	357	53.6	63.8	Yes	61.9	Yes	4th

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

s: Data do not meet reporting criteria

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

Cirrhosis/Diabetes Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Cirrhosis mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	5	6.6*	7.7	No	8.7	No	1st
Age-adjusted	(Table) (Trend) (Map)	5	4.9*	6.7	Yes	7.2	Yes	1st
Cirrhosis hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	7	0.9*	2.8	Yes	2.5	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	7	1.0*	2.5	Yes	2.2	Yes	1st
Diabetes mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	14	18.4	20.3	No	19.6	No	2nd
Age-adjusted	(Table) (Trend) (Map)	14	14.7	17.6	Yes	15.7	Yes	2nd
Diabetes hospitalization rate per 10,000 (primary diagnosis)								
Crude	(Table) (Trend) (Map)	55	7.2	19.3	Yes	15.6	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	55	6.3	17.9	Yes	14.2	Yes	1st
Diabetes hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	1,462	192.5	244.1	Yes	225.8	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	1,462	151.3	215.9	Yes	188.6	Yes	1st
Diabetes short-term complications hospitalization rate per 10,000								
Aged 6-17 Years	(Table) (Trend) (Map)	s	s	3.1	N/A	2.9	N/A	N/A
Aged	(Table) (Trend) (Map)	18	3.1	6.3	Yes	5.8	Yes	1st

18 years and older								
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	625	82.3	117.7	Yes	117.1	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	625	61.9	103.0	Yes	95.3	Yes	1st
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	511	67.3	115.3	Yes	116.8	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	511	50.9	101.0	Yes	95.4	Yes	1st
Age-adjusted % of adults with physician diagnosed diabetes (2013-2014)	(Table) (Map)	N/A	11.1	8.9	No	8.2	No	4th

N/A: Data not available

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

s: Data do not meet reporting criteria

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

Communicable Disease Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Pneumonia/flu hospitalization rate (aged 65 years and older) per 10,000	(Table) (Trend) (Map)	186	140.3	112.6	Yes	121.9	No	3rd
Pertussis incidence rate per 100,000	(Table) (Trend) (Map)	8	10.5*	8.8	No	12.9	No	3rd
Mumps incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.2	Yes	0.1	Yes	2nd
Meningococcal incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.2	Yes	0.2	Yes	1st
H. influenza incidence rate per 100,000	(Table) (Trend) (Map)	1	1.3*	1.7	No	1.7	No	2nd
Hepatitis A incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.7	Yes	0.5	Yes	1st
Acute hepatitis B incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.6	Yes	0.5	Yes	1st
Tuberculosis incidence rate per 100,000	(Table) (Trend) (Map)	2	2.6*	4.5	No	1.9	No	4th
E. coli O157 incidence rate per 100,000	(Table) (Trend) (Map)	2	2.6*	0.6	No	0.8	No	4th

Salmonella incidence rate per 100,000	(Table) (Trend) (Map)	10	13.2	12.9	No	12.2	No	3rd
Shigella incidence rate per 100,000	(Table) (Trend) (Map)	4	5.3*	4.8	No	4.4	No	4th
Lyme disease incidence rate per 100,000#	(Table) (Map)	23	30.3	36.6	No	57.8	Yes	3rd
% of adults aged 65 years and older with flu shot in last year (2013-2014)	(Table) (Map)	N/A	80.2	72.4	No	77.1	No	1st
% of adults aged 65 years and older who ever received pneumonia shot (2013-2014)	(Table) (Map)	N/A	79.8	65.1	Yes	70.7	No	1st

N/A: Data not available

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

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

Family Planning/Natality Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
% of births within 24 months of previous pregnancy	(Table) (Trend) (Map)	271	29.0	18.5	Yes	21.0	Yes	4th
Percentage of births to teens								
Aged 15-17 years	(Table) (Trend) (Map)	7	0.8*	1.4	No	1.5	No	1st
Aged 15-19 years	(Table) (Trend) (Map)	39	4.2	5.2	No	5.7	No	1st
% of births to women aged 35 years and older	(Table) (Trend) (Map)	128	13.7	20.5	Yes	18.9	Yes	3rd
Fertility rate per 1,000 females								
Total (all births/females aged 15-44 years)	(Table) (Trend) (Map)	933	68.0	59.0	Yes	56.8	Yes	4th
Aged 10-14 years (births to mothers aged 10-14 years/females aged 10-14 years)	(Table) (Trend) (Map)	0	0.0*	0.3	Yes	0.2	Yes	1st
Aged 15-17 years (births to mothers aged 15-17 years/females aged 15-17 years)	(Table) (Trend) (Map)	7	4.3*	9.3	Yes	7.9	No	1st
Aged 15-19 years (births to mothers aged 15-19 years/females	(Table) (Trend) (Map)	39	12.2	19.5	Yes	17.3	Yes	1st

aged 15-19 years)								
Aged 18-19 years (births to mothers aged 18-19 years/females aged 18-19 years)	(Table) (Trend) (Map)	32	20.6	33.5	Yes	29.9	Yes	1st
Pregnancy rate per 1,000 (all pregnancies/females aged 15-44 years) #	(Table) (Trend) (Map)	1,063	77.4	87.9	Yes	72.6	Yes	3rd
Teen pregnancy rate per 1,000 #								
Aged 10-14 years	(Table) (Trend) (Map)	1	0.4*	0.9	No	0.6	No	2nd
Aged 15-17 years	(Table) (Trend) (Map)	13	8.0	22.4	Yes	14.5	Yes	1st
Aged 15-19 years	(Table) (Trend) (Map)	64	20.1	41.3	Yes	28.7	Yes	1st
Aged 18-19 years	(Table) (Trend) (Map)	51	32.8	67.2	Yes	47.6	Yes	1st
Abortion ratio (induced abortions per 1,000 live births) #								
Aged 15-19 years	(Table) (Trend) (Map)	23	589.7	1,050.3	Yes	624.6	No	3rd
All ages	(Table) (Trend) (Map)	112	120.0	412.3	Yes	233.2	Yes	1st

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

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

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

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

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking - Group
HIV case rate per 100,000								
Crude	(Table) (Trend) (Map)	0	0.0*	19.1	Yes	7.6	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	0	0.0*	19.1	Yes	7.9	Yes	1st
AIDS case rate per 100,000								
Crude	(Table) (Trend) (Map)	s	s	12.2	Yes	4.4	Yes	N/A
Age-adjusted	(Table) (Trend) (Map)	s	s	12.2	Yes	4.5	Yes	N/A
AIDS mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	0	0.0*	4.0	Yes	1.4	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	0	0.0*	3.7	Yes	1.3	Yes	1st
Early syphilis case rate per 100,000	(Table) (Trend) (Map)	0	0.0*	14.4	Yes	3.6	Yes	1st
Gonorrhea case rate per 100,000								
All ages	(Table) (Trend) (Map)	19	25.0	107.7	Yes	61.1	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	7	112.8*	368.1	Yes	203.6	No	3rd
Chlamydia case rate per 100,000 males								
All ages	(Table) (Trend) (Map)	45	121.9	336.0	Yes	203.0	Yes	2nd

Aged 15-19 years	(Table) (Trend) (Map)	11	364.1	1,029.1	Yes	608.6	No	2nd
Aged 20-24 years	(Table) (Trend) (Map)	21	795.5	1,492.7	Yes	1,089.0	No	2nd
Chlamydia case rate per 100,000 females								
All ages	(Table) (Trend) (Map)	153	392.0	672.3	Yes	466.8	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	56	1,757.7	3,595.5	Yes	2,387.5	Yes	2nd
Aged 20-24 years	(Table) (Trend) (Map)	63	2,038.8	3,432.2	Yes	2,743.8	Yes	1st
% of sexually active young women aged 16-24 with at least one Chlamydia test in Medicaid program (2013)	(Table) (Trend) (Map)	72	41.6	72.2	Yes	65.2	Yes	4th
Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)	(Table) (Trend) (Map)	s	s	3.0	N/A	2.1	N/A	N/A

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

s: Data do not meet reporting criteria

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

Injury Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Suicide mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	7	9.2*	8.4	No	10.1	No	1st
Age-adjusted	(Table) (Trend) (Map)	7	8.2*	8.0	No	9.6	Yes	1st
Aged 15-19 years	(Table) (Trend) (Map)	0	0.0*	5.4	Yes	6.3	Yes	1st
Self-inflicted injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	34	4.5	5.8	No	6.8	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	34	4.9	5.8	No	7.0	Yes	1st
Aged 15-19 years	(Table) (Trend) (Map)	s	s	11.3	N/A	12.5	N/A	N/A
Homicide mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	0	0.0*	3.7	Yes	2.7	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	0	0.0*	3.7	Yes	2.8	Yes	1st
Assault hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	s	s	4.1	N/A	2.5	N/A	N/A
Age-adjusted	(Table) (Trend) (Map)	s	s	4.1	N/A	2.7	N/A	N/A
Unintentional injury mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	36	47.4	27.7	Yes	34.0	No	4th
Age-adjusted	(Table) (Trend) (Map)	36	41.8	25.6	Yes	30.8	Yes	4th
Unintentional injury hospitalization rate per 10,000								

Crude	(Table) (Trend) (Map)	600	79.0	68.3	Yes	71.6	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	600	67.1	62.2	No	62.2	No	4th
Aged less than 10 years	(Table) (Trend) (Map)	28	29.8	23.6	No	20.4	No	4th
Aged 10-14 years	(Table) (Trend) (Map)	8	15.6*	18.0	No	16.0	No	3rd
Aged 15-24 years	(Table) (Trend) (Map)	18	15.1	28.7	Yes	29.7	Yes	1st
Aged 25-64 years	(Table) (Trend) (Map)	202	55.7	46.0	Yes	45.8	Yes	4th
Aged 65 years and older	(Table) (Trend) (Map)	344	259.5	252.3	No	262.9	No	3rd
Falls hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	358	47.1	39.4	Yes	42.5	No	4th
Age-adjusted	(Table) (Trend) (Map)	358	37.3	34.7	No	34.9	No	4th
Aged less than 10 years	(Table) (Trend) (Map)	7	7.4*	8.9	No	7.5	No	3rd
Aged 10-14 years	(Table) (Trend) (Map)	s	s	6.1	N/A	5.0	N/A	N/A
Aged 15-24 years	(Table) (Trend) (Map)	s	s	5.7	N/A	5.2	N/A	N/A
Aged 25-64 years	(Table) (Trend) (Map)	87	24.0	18.4	Yes	18.4	Yes	4th
Aged 65-74 years	(Table) (Trend) (Map)	47	63.5	75.2	No	75.2	No	2nd
Aged 75-84 years	(Table) (Trend) (Map)	92	226.7	220.3	No	229.4	No	3rd
Aged 85 years and older	(Table) (Trend) (Map)	118	658.8	560.2	No	590.7	No	4th
Poisoning hospitalization rate per 10,000								

Crude	(Table) (Trend) (Map)	57	7.5	11.1	Yes	11.0	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	57	7.7	10.7	Yes	10.9	Yes	1st
Motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	5	6.6*	6.3	No	8.4	No	1st
Age-adjusted	(Table) (Trend) (Map)	5	6.4*	6.0	No	8.0	Yes	1st
Non-motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	31	40.8	21.4	Yes	25.6	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	31	35.4	19.5	Yes	22.8	Yes	4th
Traumatic brain injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	55	7.2	10.0	Yes	10.2	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	55	6.7	9.4	Yes	9.2	Yes	2nd
Alcohol related motor vehicle injuries and deaths per 100,000	(Table) (Trend) (Map)	47	61.9	33.3	Yes	44.4	Yes	4th

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

s: Data do not meet reporting criteria

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

Maternal and Infant Health Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Percentage of births								
% of births to women aged 25 years and older without a high school education	(Table) (Trend) (Map)	265	43.1	14.1	Yes	10.6	Yes	4th
% of births to out-of-wedlock mothers	(Table) (Trend) (Map)	272	29.2	40.9	Yes	39.1	Yes	1st
% of births that were first births	(Table) (Trend) (Map)	292	31.3	42.6	Yes	40.8	Yes	1st
% of births that were multiple births	(Table) (Trend) (Map)	34	3.6	3.9	No	4.1	No	2nd
% of births with early (1st trimester) prenatal care	(Table) (Trend) (Map)	488	52.6	73.1	Yes	75.4	Yes	4th
% of births with late (3rd trimester) or no prenatal care	(Table) (Trend) (Map)	65	7.0	5.6	No	4.1	Yes	4th
% of births with adequate prenatal care	(Table) (Trend) (Map)	420	47.6	69.1	Yes	70.8	Yes	4th

(Kotelchuck)								
WIC indicators								
% of pregnant women in WIC with early (1st trimester) prenatal care (2009-2011)	(Table) (Trend) (Map)	298	89.5	86.5	No	86.9	No	2nd
% of pregnant women in WIC who were pre-pregnancy underweight (BMI less than 18.5) (2010-2012)	(Table) (Trend) (Map)	20	5.7	4.7	No	4.1	No	4th
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30) (2010-2012)	(Table) (Trend) (Map)	62	17.7	26.6	Yes	26.3	Yes	1st
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher) (2010-2012)	(Table) (Trend) (Map)	137	39.0	24.2	Yes	28.0	Yes	4th
% of pregnant women in WIC with anemia in 3rd trimester (2009-2011)	(Table) (Map)	s	s	37.3	N/A	36.0	N/A	N/A
% of pregnant	(Table) (Trend) (Map)	171	52.8	41.7	Yes	47.1	No	4th

women in WIC with gestational weight gain greater than ideal (2009-2011)								
% of pregnant women in WIC with gestational diabetes (2009-2011)	(Table) (Trend) (Map)	13	3.9	5.5	No	5.8	No	1st
% of pregnant women in WIC with hypertension during pregnancy (2009-2011)	(Table) (Trend) (Map)	41	12.4	7.1	Yes	9.0	No	4th
% of WIC mothers breastfeeding at least 6 months (2010-2012)	(Table) (Trend) (Map)	22	16.7	38.2	Yes	27.7	Yes	3rd
% of infants fed any breast milk in delivery hospital	(Table) (Trend) (Map)	763	86.2	83.1	No	77.9	Yes	1st
% of infants fed exclusively breast milk in delivery hospital	(Table) (Trend) (Map)	699	79.0	40.7	Yes	49.2	Yes	1st
% of births delivered by cesarean section	(Table) (Trend) (Map)	174	18.6	34.1	Yes	35.6	Yes	1st
Mortality rate per 1,000 live births								
Infant (less than 1 year)	(Table) (Trend) (Map)	8	8.6*	5.0	No	5.5	No	4th

Neonatal (less than 28 days)	(Table) (Trend) (Map)	6	6.4*	3.4	No	3.9	No	4th
Post-neonatal (1 month to 1 year)	(Table) (Trend) (Map)	2	2.1*	1.5	No	1.6	No	4th
Fetal death (20 weeks gestation or more)	(Table) (Trend) (Map)	2	2.1*	6.6	No	4.4	No	1st
Perinatal (20 weeks gestation to less than 28 days of life)	(Table) (Trend) (Map)	8	8.5*	10.0	No	8.3	No	2nd
Perinatal (28 weeks gestation to less than 7 days of life)	(Table) (Trend) (Map)	7	7.5*	5.4	No	5.4	No	3rd
Maternal mortality rate per 100,000 live births +	(Table) (Trend) (Map)	0	0.0*	20.0	Yes	19.4	Yes	1st
Low birthweight indicators								
% very low birthweight (less than 1.5 kg) births	(Table) (Trend) (Map)	7	0.8*	1.4	No	1.4	No	1st
% very low birthweight (less than 1.5kg) singleton births	(Table) (Trend) (Map)	3	0.3*	1.1	Yes	1.0	Yes	1st
% low birthweight (less than 2.5 kg) births	(Table) (Trend) (Map)	47	5.1	8.0	Yes	7.6	Yes	1st
% low birthweight	(Table) (Trend) (Map)	28	3.1	6.0	Yes	5.6	Yes	1st

(less than 2.5kg) singleton births								
% of premature births by gestational age								
less than 32 weeks gestation	(Table) (Trend) (Map)	8	0.9*	1.8	Yes	1.8	Yes	1st
32 - less than 37 weeks gestation	(Table) (Trend) (Map)	50	5.4	9.1	Yes	9.1	Yes	1st
less than 37 weeks gestation	(Table) (Trend) (Map)	58	6.2	10.9	Yes	10.9	Yes	1st
% of births with a 5 minute APGAR less than 6	(Table) (Trend) (Map)	11	1.2	0.6	No	0.7	No	4th
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	6	102.6*	95.0	No	123.2	No	2nd

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

s: Data do not meet reporting criteria

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

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

Obesity and Related Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking - Group
All students (elementary - PreK, K, 2nd and 4th grades, middle - 7th grade and high school - 10th grade) with weight status information in SWSCRS								
% overweight but not obese (85th-less than 95th percentile) # (2012-2014)	(Table) (Trend) (Map)	127	16.3	N/A	N/A	16.7	N/A	1st
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	178	22.9	N/A	N/A	17.3	N/A	4th
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	305	39.3	N/A	N/A	33.9	N/A	4th
Elementary students (PreK, K, 2nd and 4th grades) with weight status information in SWSCRS (2012-2014)								
% overweight but not obese (85th-less than 95th percentile) # (2012-2014)	(Table) (Trend) (Map)	69	16.7	N/A	N/A	16.4	N/A	3rd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	92	22.2	N/A	N/A	16.8	N/A	4th
% overweight or	(Table) (Trend) (Map)	161	38.9	N/A	N/A	33.1	N/A	4th

obese (85th percentile or higher) # (2012-2014)								
Middle and high school students (7th and 10th grades) with weight status information in SWSCRS (2012-2014)								
% overweight but not obese (85th-less than 95th percentile) # (2012-2014)	(Table) (Trend) (Map)	59	16.2	N/A	N/A	17.1	N/A	1st
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	86	23.6	N/A	N/A	18.1	N/A	4th
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	145	39.8	N/A	N/A	35.2	N/A	3rd
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30)	(Table) (Trend) (Map)	62	17.7	26.6	Yes	26.3	Yes	1st
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher)	(Table) (Trend) (Map)	137	39.0	24.2	Yes	28.0	Yes	4th
% obese (95th percentile or higher) children in WIC (aged 2-4 years) (2010-2012)	(Table) (Trend) (Map)	79	16.6	14.3	No	15.2	No	4th
% of children in WIC viewing TV	(Table) (Trend) (Map)	347	71.7	79.9	Yes	81.0	Yes	4th

2 hours or less per day (aged 2-4 years) (2010-2012)								
% of WIC mothers breastfeeding at least 6 months (2009-2011)	(Table) (Trend) (Map)	22	16.7	38.2	Yes	27.7	Yes	3rd
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2013-2014)	(Table) (Map)	N/A	62.7	60.5	No	62.3	No	2nd
Age-adjusted % of adults obese (BMI 30 or higher) (2013-2014)	(Table) (Map)	N/A	31.9	24.6	No	27.4	No	3rd
Age-adjusted % of adults who did not participate in leisure time physical activity in last 30 days (2013-2014)	(Table) (Map)	N/A	37.4	27.1	Yes	26.2	Yes	1st
Age-adjusted % of adults eating 5 or more fruits or vegetables per day (2008-2009)	(Table) (Map)	N/A	33.2	27.1	No	27.7	No	1st
Age-adjusted % of adults with physician diagnosed diabetes (2008-2009)	(Table) (Map)	N/A	11.1	8.9	No	8.2	No	4th
Age-adjusted % of adults with physician diagnosed	(Table) (Map)	N/A	5.8	7.6	No	7.2	No	1st

angina, heart attack or stroke # (2008-2009)								
Age-adjusted mortality rate per 100,000								
Cardiovascular disease mortality	(Table) (Trend) (Map)	221	210.8	228.0	Yes	228.2	Yes	1st
Cerebrovascular disease (stroke) mortality	(Table) (Trend) (Map)	33	32.4	26.2	Yes	29.8	Yes	3rd
Diabetes mortality	(Table) (Trend) (Map)	14	14.7	17.6	Yes	15.7	Yes	2nd
Age-adjusted hospitalization rate per 100,000								
Cardiovascular disease hospitalizations	(Table) (Trend) (Map)	1,016	102.5	143.5	Yes	136.0	Yes	1st
Cerebrovascular disease (stroke) hospitalizations	(Table) (Trend) (Map)	199	20.2	23.5	Yes	23.6	Yes	2nd
Diabetes hospitalizations (primary diagnosis)	(Table) (Trend) (Map)	55	6.3	17.9	Yes	14.2	Yes	1st

N/A: Data not available

#: Data not available for NYC counties

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

Occupational Health Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking - Group
Incidence of malignant mesothelioma per 100,000 persons aged 15 years and older (2010-2012)	(Table) (Trend) (Map)	s	s	1.3	N/A	1.7	N/A	N/A
Hospitalization rate per 100,000 persons aged 15 years and older								
Pneumoconiosis	(Table) (Trend) (Map)	s	s	10.3	N/A	14.0	N/A	N/A
Asbestosis	(Table) (Trend) (Map)	s	s	9.3	N/A	12.7	N/A	N/A
Work-related hospitalizations per 100,000 employed persons aged 16 years and older	(Table) (Trend) (Map)	61	171.5	156.5	No	191.1	No	2nd
Elevated blood lead levels (greater than or equal to 10 micrograms per deciliter) per 100,000 employed persons aged 16 years and older	(Table) (Trend) (Map)	4	11.2*	22.3	No	22.7	No	1st
Fatal work-related injuries	(Table) (Trend) (Map)	7	19.7*	2.3	Yes	2.7	Yes	4th

per 100,000 employed persons aged 16 years and older #								

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

s: Data do not meet reporting criteria

#: Data not available for NYC counties

Oral Health Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Oral health survey of 3rd grade children								
% of 3rd grade children with caries experience # (2009-2011)	(Table) (Map)	N/A	35.8	N/A	N/A	45.4	Yes	1st
% of 3rd grade children with untreated caries # (2009-2011)	(Table) (Map)	N/A	34.2	N/A	N/A	24.0	Yes	4th
% of 3rd grade children with dental sealants # (2009-2011)	(Table) (Map)	N/A	34.2	N/A	N/A	41.9	Yes	2nd
% of 3rd grade children with dental insurance # (2009-2011)	(Table) (Map)	N/A	82.3	N/A	N/A	81.8	Yes	2nd
% of 3rd	(Table) (Map)	N/A	86.4	N/A	N/A	83.4	Yes	4th

grade children with at least one dental visit in last year # (2009-2011)								
% of 3rd grade children reported taking fluoride tablets regularly # (2009-2011)	(Table) (Map)	N/A	55.1	N/A	N/A	41.9	Yes	3rd
Age-adjusted % of adults who had a dentist visit within the past year # (2013-2014)	(Table) (Map)	N/A	65.7	69.8	No	71.5	No	3rd
Caries outpatient visit rate per 10,000 (aged 3-5 years)	(Table) (Trend) (Map)	31	110.0	79.2	No	93.5	No	3rd
Medicaid oral health indicators								
% of Medicaid enrollees with at least one dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	5,626	31.1	31.8	No	30.9	No	1st
% of Medicaid enrollees with at least one preventive dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	4,418	24.4	26.6	Yes	25.1	No	2nd
% of Medicaid enrollees	(Table) (Trend) (Map)	2,807	43.7	45.0	No	44.3	No	2nd

(aged 2-20 years) who had at least one dental visit within the last year # (2012-2014)								
% of Medicaid enrollees (aged 2-20 years) with at least one preventive dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	2,516	39.2	40.1	No	39.7	No	2nd
% of children, aged 2-21 years, with at least one dental visit in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	895	61.5	59.2	No	61.4	No	2nd
Oral cancer								
Crude incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	s	s	12.1	N/A	13.5	N/A	N/A
Age-adjusted incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	s	s	10.5	N/A	11.0	N/A	N/A
Crude mortality rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	s	s	2.5	N/A	2.6	N/A	N/A
Age-adjusted	(Table) (Trend) (Map)	s	s	2.2	N/A	2.1	N/A	N/A

mortality rate per 100,000 (2010-2012)								
Mortality per 100,000 (aged 45-74 years) (2010-2012)	(Table) (Trend) (Map)	s	s	4.8	N/A	4.6	N/A	N/A

N/A: Data not available

s: Data do not meet reporting criteria

#: Data not available for NYC counties

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

Respiratory Disease Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Chronic lower respiratory disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	57	75.0	35.6	Yes	46.2	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	57	56.3	30.7	Yes	36.8	Yes	4th
Chronic lower respiratory disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	162	21.3	36.5	Yes	33.0	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	162	17.0	34.1	Yes	28.6	Yes	1st
Asthma hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	24	3.2	18.2	Yes	11.1	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	24	3.0	18.2	Yes	10.9	Yes	1st
Aged 0-4 years	(Table) (Trend) (Map)	0	0.0*	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	s	s	20.5	N/A	10.4	N/A	N/A
Aged 0-17 years	(Table) (Trend) (Map)	s	s	26.6	N/A	14.2	N/A	N/A
Aged 5-64 years	(Table) (Trend) (Map)	17	2.9	13.8	Yes	8.5	Yes	1st
Aged 15-24 years	(Table) (Trend) (Map)	s	s	6.8	N/A	3.6	N/A	N/A
Aged 25-44 years	(Table) (Trend) (Map)	s	s	8.6	N/A	6.6	N/A	N/A
Aged	(Table) (Trend) (Map)	9	4.2*	19.7	Yes	11.6	Yes	1st

45-64 years								
Aged 65 years or older	(Table) (Trend) (Map)	7	5.3*	29.4	Yes	17.7	Yes	1st
Asthma mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	0	0.0*	1.4	Yes	0.9	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	0	0.0*	1.3	Yes	0.8	Yes	1st
Age-adjusted % of adults with current asthma (2013-2014)	(Table) (Map)	N/A	6.8	10.1	No	10.5	Yes	1st

N/A: Data not available

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

Socio-Economic Status and General Health Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Total population (2013)	(Table) (Trend) (Map)	N/A	25,156.0	19,651,127.0	N/A	11,245,290.0	N/A	1st
% of labor force unemployed (2014)	(Table) (Trend) (Map)	651	5.6	6.3	Yes	5.6	No	2nd
% of population below poverty (2013)	(Table) (Trend) (Map)	N/A	16.5	16.0	No	N/A	N/A	3rd
% of children aged less than 18 years below poverty (2013)	(Table) (Trend) (Map)	N/A	27.3	22.9	No	N/A	N/A	4th
Median household income in US dollars (2013)	(Table) (Trend) (Map)	N/A	45,509.0	57,255.0	N/A	N/A	N/A	3rd
% of children aged less than 19 years with health insurance (2013)	(Table) (Trend) (Map)	N/A	93.1	95.9	Yes	N/A	N/A	4th
% of adults	(Table) (Trend) (	N/A	83.3	84.7	No	N/A	N/A	4th

aged 18-64 years with health insurance (2013)	Map)							
High school drop out rate (2012-2014)	(Table) (Trend) (Map)	70	2.8	3.3	No	2.3	No	3rd
Age-adjusted % of adults who did not receive medical care because of cost # (2013-2014)	(Table) (Map)	N/A	4.0	13.6	Yes	12.0	Yes	1st
Age-adjusted % of adults with regular health care provider (2013-2014)	(Table) (Map)	N/A	91.8	84.5	Yes	84.7	Yes	1st
Age-adjusted % of adults who had poor mental health 14 or more days within the past month (2013-2014)	(Table) (Map)	N/A	8.3	11.1	No	11.8	No	1st
Birth rate per 1,000 population	(Table) (Trend) (Map)	933	12.3	12.2	No	10.7	Yes	4th
Total mortality rate per	(Table) (Trend) (Map)	767	1,009.8	753.1	Yes	854.1	Yes	3rd

100,000								
Age-adjusted total mortality rate per 100,000	(Table) (Trend) (Map)	767	756.6	644.9	Yes	678.5	Yes	3rd
% premature deaths (aged less than 75 years)	(Table) (Trend) (Map)	266	34.6	39.9	Yes	37.5	No	1st
Years of potential life lost per 100,000	(Table) (Trend) (Map)	4,391	6,263.6	5,577.4	Yes	5,839.3	Yes	2nd
Total emergency department visit rate per 10,000	(Table) (Trend) (Map)	30,113	3,964.6	4,086.4	Yes	3,752.5	Yes	3rd
Age-adjusted total emergency department visit rate per 10,000	(Table) (Trend) (Map)	30,113	4,062.1	4,074.7	No	3,762.9	Yes	2nd
Total hospitalization rate per 10,000	(Table) (Trend) (Map)	7,272	957.4	1,226.2	Yes	1,168.1	Yes	1st
Age-adjusted total hospitalization rate per 10,000	(Table) (Trend) (Map)	7,272	861.4	1,167.3	Yes	1,104.3	Yes	1st

N/A: Data not available

#: Data not available for NYC counties

Tobacco, Alcohol and Other Substance Abuse Indicators - Yates County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Drug-related hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	63	8.3	23.7	Yes	20.2	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	63	8.5	23.6	Yes	21.0	Yes	1st
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	6	102.6*	95.0	No	123.2	No	2nd
Alcohol related motor vehicle injuries and deaths per 100,000	(Table) (Trend) (Map)	47	61.9	33.3	Yes	44.4	Yes	4th
Age-adjusted % of adults who smoke cigarettes (2013-2014)	(Table) (Map)	N/A	13.3	15.9	No	18.0	No	1st
Age-adjusted % of adults living in homes where smoking is prohibited (2008-2009)	(Table) (Map)	N/A	77.7	80.9	No	79.3	No	2nd
Age-adjusted % of adults who binge drink (2013-	(Table) (Map)	N/A	8.5	17.7	Yes	17.2	Yes	1st

2014)								

N/A: Data not available

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

Yates County

County/ZIP Code Perinatal Data Profile - 2011-2013

Source: 2011-2013 New York State Vital Statistics Data as of June, 2015

ZIP Code	Total Births 2011-2013	Percent of Births					Infant and Neonatal Deaths, rate per 1,000 live births				Teen Rates per 1,000	
		Premature Birth	Low Birth Weight	Out of Wedlock	Medicaid or Self-pay	Late or No Prenatal Care	Infant Deaths 2011-2013	Infant Deaths Rate	Neonatal Deaths 2011-2013	Neonatal Deaths Rate	Teen Birth Rate	Teen Pregnancy Rate
14418	49	4.1	2.0	28.6	69.4	4.2	0	0.0	0	0.0	19.2	32.1
14478	24	4.3	8.3	41.7	54.2	12.5	0	0.0	0	0.0	0.0	3.2
14507	36	5.9	0.0	44.4	80.0	8.3	1	27.8	1	27.8	5.6	5.6
14527	513	5.6	4.5	26.6	72.3	8.0	4	7.8	2	3.9	11.4	19.3
14544	77	6.7	3.9	36.4	59.7	1.3	0	0.0	0	0.0	12.5	25.0
14837	217	8.3	6.5	33.2	75.1	5.5	3	13.8	3	13.8	21.8	30.8
14842	28	0.0	0.0	3.7	75.0	10.7	0	0.0	0	0.0	7.4	7.4

Total	955	6.3	4.6	29.5	71.7	6.9	8	8.4	6	6.3	11.5	18.6

Note:

This table does not display the results for ZIP Code areas with fewer than 10 births during the 3-year period.
However, the total does reflect all births in the county.

*ZIP codes with a population of less than 30 teenage women are suppressed for reasons of confidentiality.

Note: Some 2011 ZIP code level data from New York City for teen pregnancy indicator were not originally included in previous published tables. Currently, data for three periods: 2009-2011, 2010-2012 and 2011-2013 include complete 2011 records. This only impacted teen pregnancy rates for New York City and individual boroughs.

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

County:	Yates
Group Name:	Yates County Community Health Priority Setting
Date and Time:	June 24, 2016 - 8:30 AM

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

Issues to Rank based on Data Assessment

- Obesity – lifestyle, cultural, physical activity, nutrition, food preparation. (low back pain, diabetes, hypertension)
- Behavioral health (Substance abuse, especially alcohol and Opioid drugs and Mental health (esp. suicide, self-inflicted injury)
- Dental health
- CLRD/COPD
- Cerebrovascular disease (hypertension)
- Unintentional Injuries

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

Charting the Course…

Selecting Issues and Priorities

Public Health

Acknowledgement:

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

Selecting Issues & Priorities

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

The Hanlon Method

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

The Hanlon Method…

BPR – Basic Priority Rating System

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

A = Size of the problem

B = Seriousness of the problem

C = Effectiveness of the solution

(weighted by PEARL Factors)

Component A – Size of Problem

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

Component A: Size of Problem

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

Component B – Seriousness of Problem

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

Component B: Seriousness of Problem

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

Component C – Effectiveness of Intervention

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

Component C: Effectiveness of Intervention

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

Immunization programs are known to be highly effective…

as compared to the results of smoking cessation programs.

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

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

PEARL Factors:

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

Here We Go!

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

Sample Worksheet:

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

Considerations and Conclusions

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

And…

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

And finally…

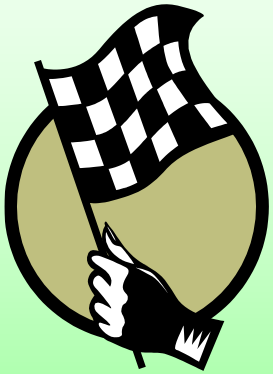
- Soup slurping is evidently quite widespread and a serious problem, and we believe the interventions could be relatively effective
- However, solutions to the problem are NOT within our scope or mission statement
- It makes economic sense to address the problem, but there will probably NOT be economic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

Therefore…

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

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

Time to Get Started!



Issue	Size (A)	Seriousness (B)	Effectiveness (C)	Score (A+2B) X C	PEARL
Obesity (low back pain, diabetes, hypertension)					P P E E A R L
Behavioral health (Substance abuse, especially alcohol and Opioid drugs and Mental health (esp. suicide, self-inflicted injury)					P P E E A R L
Dental Health					P P E E A R L
Chronic Lower Respiratory Disease (COPD)					P P E E A R L
Cerebrovascular Disease (Hypertension)					P P E E A R L
Unintentional Injuries					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L

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

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

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

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

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

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

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

The following are the results from the Priority Setting Meeting conducted on June 24th, 2016 from 8:30am to 10:30am.

#	Issue	Hanlon	Pearl
1	Cerebrovascular Disease (Hypertension)	145.94	5.88
2	Behavioral Health (Substance and Mental)	133.56	6.06
3	Obesity	130.38	5.50
4	Dental health	115.69	4.56
5	CLRD (COPD)	103.06	5.19
6	Unintentional Injuries	101.25	5.06

S²AY Rural Health Network, Inc. & Yates Public Health

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

County:	Yates
Group Name:	Priority Setting Meeting
Date and Time:	June 24, 2016 – 8:30 AM

Sign in Sheet		
Name	Organization	Email
Deborah Minor	Yates Co Public Health	dminor@yatescounty.org
Ann Murphy	YC Public Health	amurphy@yatescounty.org
Kathy Swarthout	YC Public Health	Kswarthout@yatescounty.org
CARYL SUTTERBY	OUR TOWN ROCK	csutterby@gmail.com
Lauren Snyder	S2AY/ OUR TOWN ROCKS	laurensnyder@gmail.com
Deb Fabris-Coon	Arc of Yates	dfabriscoon@arcofyates.org
Cathe Horan	FLHSA	catherinerane@finger.edu
Kate Ebersole	FLPPS	Kate.ebersole3@gmail.com
Harold Gray	Chamber of Commerce	hgray715@yahoo.com
Christine Ayers	RPCN@ Rushville Health Center	cayers@rpcn.org
Amy Miller	YC DSS	amy.miller@dfa.state.ny.us
ALICIA AVELLANEDA	YC YOUTH BUREAU	alicia.avellaneda@dfa.state.ny.
Loree Mackerchar	Soldiers & Sailors Hosp	loree.mackerchar@flhealth.us
George A. Roets	Yates Co Com Ser	groets1@rochester.rr.com org
KATIE SMEENK	PROACTION YATES OFFICE FOR THE AGING	SMEENKK@proactionmc.org
Penny Gugino	TACFL	PennyGugino@lung.org
PHIL ROUIN	YC VETERANS SERVICES	prouin@yatescounty.org
BARB McGuffie	CCE-Yates	bjm21@cornell.edu

Deborah Minor, R.N. MPH
Public Health Director

Prioritization of Health Needs in Yates County

June 30, 2016

As we work to the completion of the 2017 Community Health Assessment and Community Service Plan; Soldiers & Sailors Hospital, part of Finger Lakes Health, the Yates County Public Health Department and the S2AY Rural Health Network have been conducting a comprehensive assessment of community needs. We have reviewed population health data statistics. We have sought input from several other health and human service agencies throughout Yates County, and have conducted focus groups for members of the public to provide us with their thoughts.

As a result of the work to date, the most highly ranked health priorities that have been identified are:

- Cerebrovascular Disease (Stroke) with a focus on hypertension
- Behavioral Health (Substance Abuse and Mental Health)
- Obesity

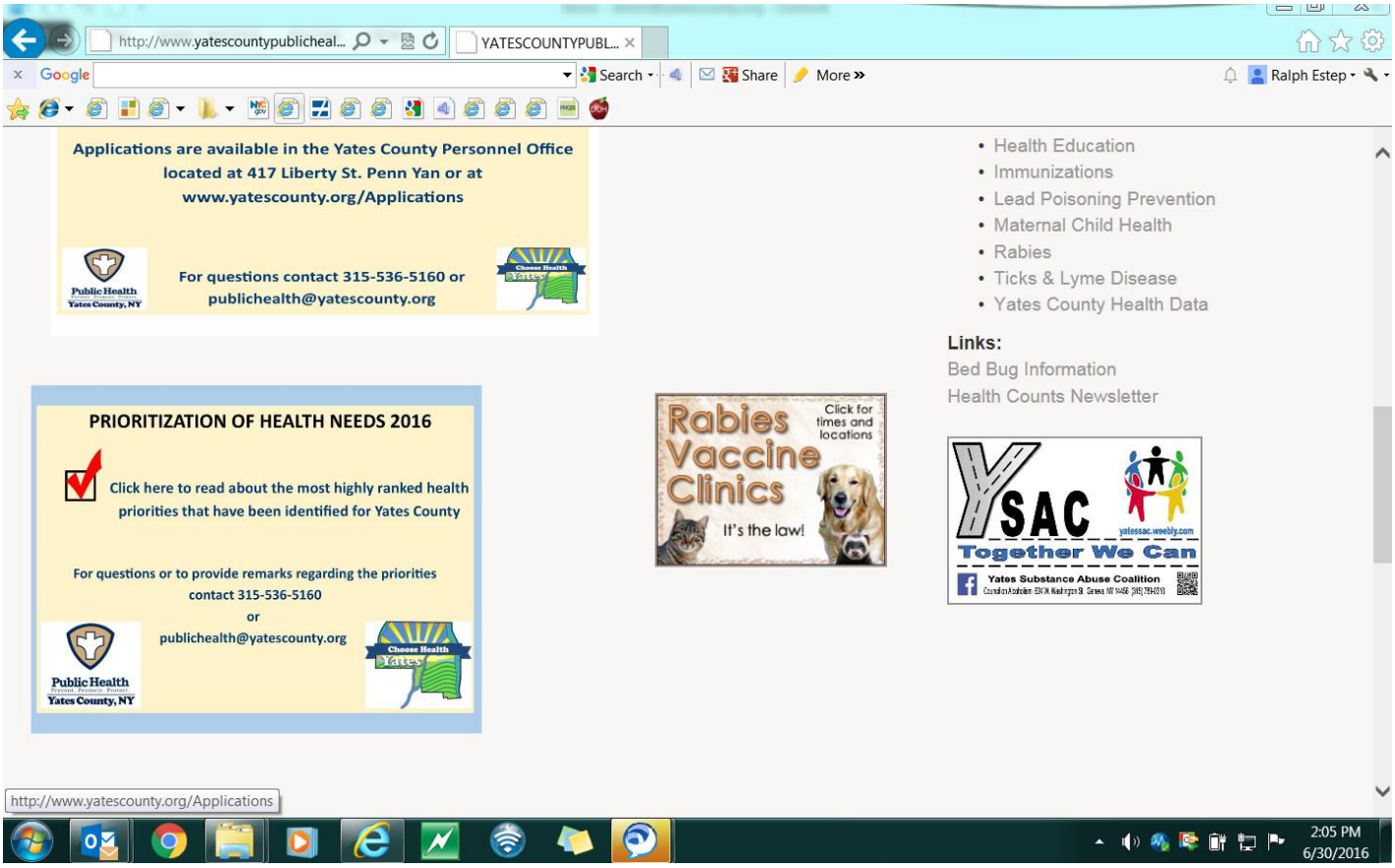
As we continue our assessment and begin to develop the Community Health Improvement Plan and Community Services Plan, we ask for public input related to the identified health priorities and possible strategies which will result in health improvements for the members of the community.

Your remarks can be emailed to Deborah Minor, Director of Public Health, at publichealth@yatescounty.org or by calling the office at 315-536-5160.

The deadline to submit remarks is Monday, July 25, 2016

YATES COUNTY PUBLIC HEALTH
417 Liberty Street, Suite 2120
Penn Yan, New York 14527
Phone: 315-536-5160
Fax: 315-536-5146
Email: publichealth@yatescounty.org
http://www.yatescountypublichealth.org

Deborah Minor, R.N. MPH
Public Health Director



Yates County Health Services

Hospital and Long Term Care

Soldiers & Sailors Memorial Hospital, part of Finger Lakes Health, operates an emergency department, a 25-bed general acute care hospital, and a 10-bed in-patient psychiatric unit. The hospital is one of New York State's Critical Access Hospitals (CAHs). During 2015, the intensive care unit was closed, with those needing this level of care now transferred to Geneva General Hospital or a tertiary hospital in Rochester or Syracuse.

- In-patient Obstetrical Care is not available within the county. Patients travel to FF Thompson Hospital located in Ontario County, Newark-Wayne Hospital located in Wayne County or to the Elmira area.

The Homestead at Soldiers & Sailors Memorial Hospital, located adjacent to the hospital in Penn Yan houses 130 skilled nursing beds, 20 behavioral beds and one respite bed for scheduled short-term stays. The Respite programs offers families who need temporary relief from caregiving an option when the primary caregiver is ill or would like to take a business trip or vacation. Respite Care provides temporary, 24-hour skilled nursing care, nutritious meals, and recreational activities.

Penn Yan Manor Nursing Home, Inc, established in 1971 provides twenty four hour skilled nursing care to 46 residents.

Clinton Crest Manor is a not-for-profit adult home offering residency to 42 older adults. Residents receive case management, assistance with personal cares, medication supervision, meals and recreation.

St Mark's Terrace in Penn Yan and Dundee, are not-for-profits located in the 2 most populated villages of the county, offering both an independent living facility and an assisted living facility for older adults. The site in Dundee offers 39 one- bedroom apartments while that in Penn Yan offers 63 efficiency apartments, 30 one-bedroom and 7 suites. Meals, laundry, housekeeping and assistance with personal care are available.

Lifetime Care with a satellite office located in Dundee, provides certified and licensed homecare services to residents of the county

Finger Lakes Visiting Nurse Services with its office located in neighboring Ontario County, provides certified homecare, licensed homecare and hospice services to residents of Yates County.

Keuka Comfort Care Home located in the village of Penn Yan, is a two bed facility offering end of life care and family support.

Behavioral Health Services

Finger Lakes Health, services include a 10-bed inpatient unit located at Soldiers and Sailors Memorial Hospital and out-patient services for both adults and children at the John D Kelly Center. Out- patient services include individual and family therapy, continuing day treatment, outreach services, therapy groups, psychiatric consultation and 24-Crisis Services.

Finger Lakes Addictions Counseling & Referral Agency (FLACRA) offers comprehensive treatment for those with alcohol and substance abuse. Services include outpatient clinics, a crisis intervention and a 4 bed residential facility.

Crestwood Children's Center (Hillside Family of Agencies) provides mental health, behavioral and family-development services to children birth to 21 and their families. Services can include crisis intervention, individual/family/group psychotherapy, diagnostic evaluation and assessment, and outreach and linkage to community resources.

Primary Care

Finger Lakes Health operates three primary care practices; Dundee Family Health Center, Pre-Emption Family Medicine and Keuka Health Care in addition to an array of specialty providers with part time office hours in Penn Yan. These include cardiology, orthopedic surgery, and surgery. Additional services including dermatology, physiatry, psychiatry are offered at their Ontario County location in Geneva, NY.

Two additional independent Primary Care Providers are Main Street Family Medicine, Penn Yan NY, and Valley View Family Practice, Rushville, NY. Both offer services to children and adults by Family Practitioners and Valley View also offers prenatal/postpartum care. Finger Lakes Medical Associates under Rochester Regional health offers gynecology, obstetrical, internal medicine and pediatric care at its satellite office in Penn Yan.

Federally Qualified Health Center

Penn Yan Community Health/Finger Lakes Community Health (formerly Finger Lakes Migrant Health) is a 330 *Migrant* & *Community Health Center* (FQHC), as well as a 330g funded *Migrant Voucher Program*, which allows them to function as a conduit for the federal funds to other independent established health care sites providing services to migrants. FLCH was originally established in 1989 to provide health services to area migrant and seasonal farm workers, with the main offices located in Penn Yan. In 2012, a private primary care practice merged with FLCH, expanding the patient base to include a wide range of SES. FLCH provides medical, dental and behavioral services at its clinic location in Penn Yan, and offers a part time dental clinic in Dundee. Services include comprehensive and culturally competent case management, outreach, transportation, Spanish interpretation and health education. These locations will accept any patient who attends for services, regardless of insurance coverage on the day of arrival. Both Rushville Health Center (below) and the Finger Lakes Community Health both accept disabled patients for dental health services.

The Family Planning Center, part of Finger Lakes Community Health, is located in Penn Yan, and provides an outreach clinic at Keuka College as well. The Family Planning Center provides reproductive health services to men and women including STD diagnosis and treatment, confidential HIV testing, pregnancy testing, birth control prescriptions and supplies, emergency contraception, annual exams, testicular exams and hormone therapy. They also provide community outreach and education.

Rushville Health Center is located in the rural northwestern part of Yates County. It is a Federally Qualified Health Center that is part of the Regional Primary Care Network (RPCN). Rushville provides medical, dental, behavioral, and outreach services to residents of this rural area. Dental services also include preventive dental services through an in-school program in Yates and surrounding counties.

Dental Care

In addition to dental services offered through the two FQHCs, three private practices exist in the County; Eaves Family Dental, Charles Whitmer, DDS and Lakes Dental PLLC.

Emergency Care

Emergency Medical Services are a program of Yates County Public Health (YCPH). Emergency Medical Service program is designed to provide recruitment, retention and training to high quality volunteers who provide pre-hospital patient care throughout the county. Offering classes within the county borders to both current and new volunteers meets the needs of the community, especially from the Mennonite Community which have had an increased presence in the fire and emergency services. Courses provided include: Certified First Responder (CFR) Original, CFR Refresher, Emergency Medical Technician (EMT) Core and EMT Refresher, as well as other targeted trainings such as Grain Bin Rescue techniques.

Soldiers & Sailors Memorial Hospital provides an Advanced Life Support Unit called the Medic 55 fly-car, based in the Emergency Department. This unit is staffed by paramedics and Critical Care Technicians (emergency medical technicians or EMTs). It's often the first vehicle on the scene of an accident or critical injury or illness transporting necessary equipment and trained personnel.

Volunteer Ambulance Services located within the county include: Branchport/Keuka Park Fire Department, Penn Yan Volunteer Ambulance Corp, Dundee Emergency Squad, and the Middlesex Valley Volunteer Ambulance.

Medical Examiner and Coroners

The Yates County Sheriff's Office contracts with Monroe County to provide the services of a Medical Examiner. Four part time Coroners are employed by the Yates County Sheriff's Office.

Jail Services

Public Health continues to work collaboratively with the jail's medical director and nurse to address the immediate health concerns of inmates and medication management that is related to inmates with Latent Tuberculosis Infection. A public health nurse visits the jail 2-3 times per week to screen inmates for tuberculosis, and offer Hepatitis A and Hepatitis B vaccination for those at high risk. To address the increased prevalence of inmates with opioid addiction, inmates are now offered the option of in house addictions counseling and pre and post release Vivitrol injections thru FLACRA.

Priority: Prevent Chronic Diseases					
Focus Area 1: Reduce Obesity in Children and Adults					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 1.4.2 – Lower socioeconomic status (SES) female employees at county located worksites.					
Goal	**Outcome Objectives**	**Interventions/Strategies / Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#1.4 Expand the role of public and private employers in obesity prevention	**Objective 1.4.2:** By 12/31/18 increase the percentage of employers with supports for breastfeeding at the worksite by 10%.	Use the Business Case for Breastfeeding to encourage employers to implement breastfeeding-friendly policies.	* Number of employers that have implemented lactation support programs * Number and demographics of women reached by policies & practices to support breastfeeding.	Finger Lakes Health (FLH) to provide Business Case for Breastfeeding and CLC referral materials to practices who see new mothers. LHD to actively participate in the Finger Lakes Breastfeeding Partnership (FLBP). LHD will identify worksites employing women and will prioritize those likely employing women of lower SES. LHD will outreach to a minimum of 2 worksites per year and will offer training, resource materials, & assistance to facilitate the implementation of policies. LHD will maintain 1 staff with current Certified Lactation Counselor (CLC) status who can provide technical expertise to employers and their workforce. FLBP, Regional Worksite Wellness Committee, and S2AY Rural Health Network (RHN) to support efforts of LHD and FLH.	FLH: 0.01 FTE to support efforts. LHD Resources: Full Time Maternal Child Health/CLC Nurse devoting approximately 0.25FTE to Breastfeeding initiatives. FLBP/Regional Worksite Wellness Committee/S2AY RHN: $3,300 (2 years)

Priority: Prevent Chronic Diseases					
Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 3.2.4 – Lower SES patients receiving primary care through the Federally Qualified Health Center (FQHC). *Objective 3.3.1 – Clients of Workforce Development Job Club are un or under employed individuals with a higher percentage being lower SES and male.					
Goal	**Outcome Objectives**	**Interventions/Strategies /Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#3.2 Promote evidence-based care to manage chronic diseases.	**Objective 3.2.4:** By 12/31/18 increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90).	Promote the use of evidence-based interventions (EBIs) to prevent or manage chronic diseases, including the use of decision support tools/reminder systems in EMRs. Promote provider practice participation in the regional blood pressure registry. Promote participation of FQHCs in the Health Systems Learning Collaborative (HSLC) efforts. Offer technical assistance & quality improvement training to providers.	*Number of primary care practices that submit patient numbers to the regional registry. *Number of follow-up contacts made with participating providers following biannual practice level registry reports. *Percentage of patients in the participating FQHC diagnosed with HTN that are controlled. *Percentage of patients in the participating FQHC diagnosed with HTN that have been screened for pre diabetes and diabetes.	FLH provider offices to provide data to the registry & "My Reminder Campaign" materials to patients, as needed. LHD to actively participate in the HSLC and offer training/assistance with quality improvement/practice change to FQHCs and provider practices. Other Partners include: Finger Lakes Health Systems Agency (FLHSA), CHY (Choose Health Yates) Coalition, S2AY RHN, Finger Lakes Community Health (FLCH)/Penn Yan Community Health (PYCH), and HCCNY. The FLHSA will administer Hypertension (HTN) Registry Program including technical assistance, data & report compilation and outreach to provider practices. FLCH/PYCH will provide data to the HTN registry 2x/year & will continue to participate in the HSLC. CHY Coalition and S2AY RHN will promote & support the program.	FLH: 0.02 FTE LHD: Full time Chronic Disease Nurse and full time Health Educator. Each devoting approximately 0.25 FTE to chronic disease initiatives. FLHSA: In kind support S2AY RHN: $2,475 (2 years)
#3.3 Promote culturally relevant chronic disease	**Objective 3.3.1:** By 12/31/18 increase by at least 5% the percentage of adults with arthritis,	Promote the use of evidence-based interventions to prevent or manage chronic	*Number & type of evidence-based self-management programs offered by partners.	FLH to provide care managers in physician practices with information to facilitate referral into Chronic Disease Self-Management programs (CSDMP).	FLH: 0.01 FTE LHD: Full time Chronic Disease

self-management education.	asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.	diseases, including the use of decision support tools/reminder systems in EHRs.	* Number of participants at EBIs offered by partners. * Number of providers that use EHRs to trigger patient education/referrals. * Number of referrals to EBIs made by providers. * Percent of adults with one or more chronic diseases who have attended a self-management program.	LHD will promote and offer the National Diabetes Prevention Program (NDPP). LHD will explore opportunities with Workforce Development Office to offer NDPP or CDSMP to their clients. LHD will promote & assist with referral to CDSMP. LHD will encourage provider practice use of EHRs support tools. Other partners include: ProAction Office for the Aging & PYCH which provide CDSMP classes. S2AY RHN and Living Healthy group to assist in coordination of classes and provide extra peer leaders for classes. CHY Coalition will provide support & promote programs.	Nurse and Full time Health Educator, each devoting approximately 0.25 FTE to chronic disease initiatives. S2AY RHN/ Living Healthy group: $1,886 (2 years)

Priority: Promote Mental Health and Prevent Substance Abuse					
Focus Area 1: Promote Mental, Emotional and Behavioral Well-Being					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☐ Yes ☒ No					
Goal	**Outcome Objectives**	**Interventions/Strategies/Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#1.1 Promote mental, emotional and behavioral well-being in communities.	**Objective 1.1.1:** Increase the use of evidence-informed policies & evidence-based programs that are grounded on healthy development of children, youth & adults.	Offer and promote the Mental Health First Aid and Youth Mental Health First Aid program to community members, schools and worksites. Offer and promote QPR	* Number of Mental Health First Aid & Youth Mental Health First Aid trainings offered. * Number of QPR Gatekeeper trainings offered.	FLH to support trainings through promotion to employees and participation in Yates Substance Abuse and Suicide Prevention Coalitions. LHD to actively participate in the Yates County Substance Abuse Coalition (YSAC) and the Yates County Suicide Coalition. LHD will encourage county workforce attendance at EBI training programs and will promote training opportunities	FLH: 0.01 FTE LHD: LHD Director serves on the YSAC Steering Committee and the Suicide

		Gatekeeper Training opportunities to community members.	* Number of individuals that have attended trainings.	for members of the public & professionals via website, social media and media releases. Other partners include: Community Services, YSAC, Suicide Coalition, and CHY Coalition. Community Services provides training at no cost to attendees. The Coalitions assist by promoting the training opportunities.	Coalition, each meeting monthly. Public Health Educator serves on YSAC and the Community Education Subcommittee, each meeting monthly.
#2.1 Prevent underage drinking, non-medical use of prescription pain relievers by youth, & excessive alcohol consumption by adults.	**Objective 2.1.1:** Reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days to no more than 34.6% Reduce the percentage of youth indicating substance use on the Yates County youth survey.	Too Good for Drugs program offered in the Dundee & Penn Yan School districts for the 2016-2017 school year.	* Number of program sessions offered. * Number of youth participating in each school district. * Data and review from youth survey.	FLH to support through creating awareness of programs to employees and providers; representation on YSAC, and Narcan training for employees. LHD to participate in review/analysis of Youth Survey data, support awareness campaigns, serve on YSAC and operate OOP Program. Other partners include: Community Services which administers and pays for the biannual youth survey, local school districts, Council on Alcoholism & Addictions of the Finger Lakes which conduct the program, YSAC which covers the cost of student materials for the program	FLH: 0.01 FTE LHD: LHD Director serves on the YSAC Steering Committee and the Suicide Coalition, each meeting monthly. Public Health Educator serves on YSAC and the Community Education Subcommittee, each meeting monthly. SPHN conducts Narcan training events.