Seneca County

Community Health Assessment/Community Service Plan

2016-2018

The participating local health department in the 2016 Community Health Assessment is Seneca County Public Health. Vickie Swinehart, the Public Health Director, is the contact person. She may be reached at: vswinehart@co.seneca.ny.us or (315) 539-1925.

Seneca County is a unique county in New York State as it does not have a single hospital present within its borders. However the participating hospital that primarily serves Seneca County is Geneva General Hospital which is a member of Finger Lakes Health a multi-institutional health system serving Seneca, Ontario and Yates counties. Representatives from Geneva General Hospital were active in the development of this assessment. Christen Smith, the Community Outreach Coordinator of Community Services, is the contact person. She may be reached at christen.smith@flhealth.org or (315) 787-4065.

In Seneca County, facilitation of the Community Health Assessment process was provided by leadership from the S^{2}AY Rural Health Network. The Network is a partnership of eight Public Health Departments in the Finger Lakes region (Seneca, Steuben, 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 Seneca County Health Solutions Team. Health Solutions is a multi-disciplinary group of community organizations, facilitated by Seneca County Public Health, and is described more fully within this document. Please see attachment 1 for a list of members.

Executive Summary

1. Priorities and Disparities:

Seneca County chose 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 Preventative Care and Management in Both Clinical and Community Settings

Priority Area 4: Promote Mental Health and Prevent Substance Abuse

- *Focus Area 1:* Prevent Substance Abuse and Other Mental emotional Behavioral Disorders

Seneca County also chose to address the following disparity:

1. Providing evidence based interventions to prevent chronic diseases in the form of Chronic Disease Self-Management Program classes to behavioral health clients, low socioeconomic populations and the elderly.

2. Changes from 2013: Overall, the priorities areas of Seneca County have not changed (Prevent Chronic Diseases – focusing on obesity and Promote Mental Health and Prevent Substance Abuse) from the 2013 CHA and CHIP, although the strategies to be used to address these priorities have evolved somewhat as will be seen in the attached CHIP. In the constantly changing health care field there has been a significant shift in post treatment to preventive treatment. Healthcare providers and human service agencies are shifting focus from disease management to disease prevention. Therefore the Seneca Health Solutions Team will be concentrating on expanding the scope of activities to increase access to chronic disease prevention care and management in both the clinical and community settings.

3. Data Reviewed and Analyzed: The data review and analysis was extensive. In all S^2AY 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 S^2AY. 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 the Delivery System Reform Incentive Payment Program (DSRIP) (also conducted by the FLHSA) had revealed. 2013 Priority Areas in the region included: Obesity, Hypertension, Diabetes, Heart Disease, Tobacco Use, and Falls, slips and trips in the 65+ population. Emerging issues included: Behavioral Health and Low back pain. The collaborative MAPP process was again used for this assessment.

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, 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, the S^2AY Network reviewed other data to develop a summary Power Point presentation of the highest need areas specifically for the county. 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.

4. Partners and Roles: While the primary partners in the assessment process include Seneca County Public Health, Finger Lakes Health (Geneva General Hospital), S^2AY and the FLHSA there are a wide variety of other partners that serve on the Health Solutions Team. A list of Seneca County member organizations is attached. Health Solutions provides the oversight of both process and implementation of the CHIP. The group includes a mix of Federally Qualified Health Centers (FQHC), Community Based Organizations (CBO), other County Departments, the legislature, local primary care physicians, addictions agencies, Office for the Aging, community action organization, and schools. Detailed roles in implementation are listed in the attached CHIP.

5. Community Engagement: The community has been engaged in a variety of different ways. After S^2AY prepared a presentation on the highest needs in Seneca County, it was shared with nine 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 websites of the hospitals and Public Health. The public was again asked to provide any additional input at this third opportunity.

6. Evidence-based interventions (EBI): 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 to increase the number of CLC's integrated into the community, support designation to become NYS Breastfeeding Friendly, worksites to implement healthy policies), promoting provider

practice participation in the regional hypertension registry, working with business and hospitals to increase breastfeeding support and lactation counseling. Strategies to address mental health and preventing substance abuse include school based programs including “Project Towards No Drug Abuse” and “Project Success,” which targets direct participation from students in the local county schools.

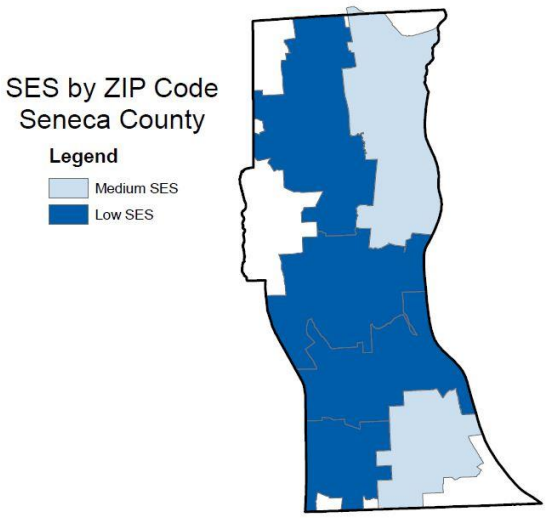
7. Evaluation of Impact and Process Measures: Process measures are indicated in the attached CHIP and correlate with the objectives chosen from the "Refresh Chart" for the NYS Prevention Agenda. They include such measures as number of primary care practices designated as NYS Breastfeeding Friendly, number of community locations that adopt or implement nutrition and beverage standards, number of employers that have implemented lactation support programs, number of primary care practices that submit patient numbers to hypertension registry, percent of adults with one or more chronic disease who have attended a self-management program, number and percent of adults among population(s) of focus (E.g., communities of color, persons with disability, low-income neighborhoods) who have attended EBIs, and number of students that participate in EBI substance abuse preventative programs, to name a few. Seneca Health Solutions meets monthly and the agenda for this meeting 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 Seneca County, NY.

Seneca County is located in the Central Finger Lakes Region of New York State. It is the smallest of the nine counties that comprise the Finger Lakes region at 324 square miles (390 sq. miles including water). Seneca County is Upstate New York's fifth smallest county and is bounded on the north by Wayne County, on the south by Tompkins and Schuyler Counties, on the east by Cayuga County, and on the west by Yates and Ontario Counties. It is located midway between Rochester (50 miles to the west) and Syracuse (50 miles to the east). Sandwiched between Seneca and Cayuga Lakes, it is rectangular in shape with a north south distance of 33 miles and varies from 12-16 miles east to west.



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

Socioeconomic Status (SES) often measures as a combination of education, income and occupation. In the provided map the majority of Seneca County population fall into the medium to low Socio-Economic Status categories. Differences in socioeconomic status are responsible for important disparities in the nutrition, housing, safety, and health of large groups of people. In general, the lower one's SES, the greater one's risk of malnutrition, heart disease, infectious diseases, and early mortality from all causes. The annual median household income is $48,932 compared to $54,482 for the nation and the per capita income is $23,823 compared to $28,555 for the nation. According to 2016 USDA data, the county poverty rate is 14.2% with 21.1% of children 0-17 years living in poverty.

Seneca County has a population of 34,833, or approximately 107.5 persons per square mile. The population has been relatively stagnant over the last 50 years, as shown in the table below, at approximately 35,000 people. Nearly half of the county's population (about 47.3% percent or 16,682 according to the 2010 census) lives in the two most northern towns of Waterloo and Seneca Falls, while the rest of the County's population is sparsely distributed to the south among the four towns of Ovid, Covert, Romulus and Lodi.

Seneca County's population according to the 2010 census was 35,251 residents. The 2015 Census Bureau estimates a population of 34,833, slightly lower than 2010. In general, Seneca County has a high dependency ratio, with 20.2% of the population estimated to be under age 18 in 2015 (5.3% under age 5), and 17.6% estimated to be aged 65 or over. Approximately 91.9%

of the population is white, 5.4% is Black/African American and the remainder other races. In 2015, 3.3% of the population is estimated to be Hispanic/Latino. In the 2010 census, 584 people indicated that they spoke English "less than very well", while the 2015 estimates indicate that 6.6% speak a language other than English at home, with 219 of these indicating that they speak Spanish at home.

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

Health Needs:

While each county in the eight county S^2AY Network region started with a summary assessment of each county's data in the region in the FLHSA presentation (attached) 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. (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 S^2AY's region: These included the 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.)) Seneca County is a part of the Finger Lakes NOCN and included focus group responses from that meeting in the list of attachments (attachment 5). Additionally, each county including Seneca held their own "priority setting meeting" and worked through county-specific committees (Health Solutions) to review data, analyze needs and develop priorities.

Based on analysis of all data, the major health issues based on the 2015 priority ranking (from highest to lowest) in the community include:

1. Hypertension (cerebrovascular, tobacco use and lung cancer)
2. Obesity – lifestyle, cultural, physical activity, nutrition, (low back pain and diabetes)
3. Substance abuse
4. Mental health
5. Dental health
6. Injury Prevention (falls)

Hypertension: According to the CDC, approximately 30% of adults are diagnosed with hypertension in the United States. Seneca County is in line with those numbers with approximately 29.9% of the adult population residing in the county having been diagnosed with hypertension by a physician. Seneca County also has the lowest control rate in the region for hypertension with approximately 52% of the population registering as in-control. (FLHSA/RBA High Blood Pressure Registry, June 2015)

Obesity: 61.7% of adults in Seneca County are classified as either overweight or obese on an age adjusted rate. Proportionally 38.6% of Seneca County children are considered overweight or obese (85th percentile or higher (2012-2014) DOH health ranking data), this puts Seneca County children in the 4th quartile for county ranking. 4.5% of adults have a diagnosis of pre-diabetes, 9.8% diabetes and 29.9% 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 Seneca County EBFRSS at:
https://www.health.ny.gov/statistics/brfss/expanded/2013/county/docs/seneca.pdf

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. 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. The opioid epidemic sweeping across the Nation is a significant health improvement priority and was analyzed at the national, state and local levels during the assessment. Seneca County has been working on preventing substance abuse at the County level and will continue efforts based on interventions outlined in the CHIP chart.

Dental health: Unfortunately the most up to date Seneca County dental health data is from 2011 and indicates that there are 18.1% of 3rd grade children having untreated dental caries placing it in the 1st quartile in NY State. While these percentages indicate child dental health is not a significant issue in Seneca County, Public Health, Finger Lakes Health in partnership with local physicians and dentists are continually monitoring dental health data and working to address issues. Only 67% of adults have 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.

Injury Prevention (Falls): with Seneca Counties continually aging population, 17.6% of the population according to 2015 census projections being age 65+ and over, falls can have an adverse effect on resident's health. Seneca County had the second highest incident of falls, slips and trips in the region 42% of the population age 65+ reporting falls in the last 12 months according the EBRFSS 2012-2014. However interestingly Seneca County had the lowest rate of ED Fall visits per 100,000 for population aged 65+ in the region. This can be subject to many different reasons, i.e. an individual falls multiple times and does not go to the emergency room until after multiple falls, or an individual presents to the ED for another health related concern as the primary diagnosis and is also treated for a fall. This health concern will be continued to be monitored through future data.

As a result of interactions that Seneca County Public Health department staff have on a daily basis with community members and from the focus group responses, a prominent theme emerged around the perception that Seneca County residents suffer from a high rate of deaths from cancer. According to Vital Statistics data from 2013 the number one cause of death in Seneca County is cancer, with a rate of 159 per 100,000. However when compared to the rest of the State, Seneca County is actually lower by one point, 160 per 100,000. While cancer continues to be a prominent focus for Public Health and health care organizations the rate of deaths associated to cancer is not significantly different than the rest of NYS. (https://www.health.ny.gov/statistics/leadingcauses_death/deaths_by_county.htm).

Cancer Indicators - Seneca 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)	655	618.7	550.9	Yes	610.0	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	655	494.2	489.2	No	510.8	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	218	205.9	180.7	No	202.4	No	2nd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	218	163.8	158.6	No	165.6	No	2nd

*****Cancer data showing Seneca County with higher rates than NYS but not significantly different when age adjusted to Census Data. Seneca County falls within the 2nd quartile for all cancer related data.

Birth Data:

Public Health monitors and evaluates birth data for the County to identify trends. This data is included below for informational purposes and includes zip code level data for all zip codes in Seneca County's borders.

County/ZIP Code Perinatal Data Profile - 2012-2014

Source: 2012-2014 New York State Vital Statistics Data as of June, 2015

ZIP Code	Total Births 2012-2014	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 2012-2014	Infant Deaths Rate	Neonatal Deaths 2012-2014	Neonatal Deaths Rate	Teen Birth Rate	Teen Pregnancy Rate
13148	334	9.6	7.2	45.5	59.3	2.1	0	0.0	0	0.0	23.9	30.4
13165	388	11.6	8.5	49.4	58.5	6.3	3	7.7	2	5.2	18.7	27.2
14521	121	8.3	6.6	24.8	64.5	13.8	0	0.0	0	0.0	16.7	26.7
14541	97	7.2	3.1	24.7	70.1	8.5	1	10.3	1	10.3	6.9	13.7
14847	80	11.3	5.0	38.8	47.5	16.7	0	0.0	0	0.0	5.2	5.2
14860	39	15.4	5.1	43.6	56.4	12.8	0	0.0	0	0.0	39.2	68.6
Total	1,059	10.3	7.0	42.0	59.6	7.1	4	3.8	3	2.8	18.8	26.8

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.

Health Care Access

Seneca Health Solutions Team has discussed the access gaps related to the above health needs as they analyzed the data (see attachments 2, 3, & 7). 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. Recently the resident participants of Seneca Towns Engaging People for Solutions (STEPS) organized and implemented a volunteer transportation system to serve Seneca County residents, STEPS representation is actively involved as a member of the Seneca Health Solutions Team. The S^2AY Rural Health Network, of which Seneca 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.

Seneca County has seen an increase in the Mennonite and Amish populations over recent years and this poses some additional challenges relating to health care access. 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.

Emerging issues in the health care system were also discussed, and Finger Lakes Health, Seneca County Public Health and the S^2AY Rural Health Network have all been active participants in DSRIP, working diligently to implement alternative models of care and improved care coordination. Members also work in coordination with the FLHSA on the Population Health Improvement Program (PHIP) through Regional Leadership meetings that occur regularly, which are hosted by Yates County Public Health (as a central location for the Finger Lakes region). As the non-profit arm for the regional Public Health Departments including Seneca, the S^2AY Network started a group called Finger Lakes and the Southern Tier (FLAST), which is currently transitioning into an Independent Practice (or Provider) Association. While mostly comprised of FQHCs, S^2AY is helping to lead the way for determining how to navigate the changing reimbursement structures for all types of organizations. S^2AY reports progress on this development regularly to Seneca County representatives.

Health Challenges

There are many issues that affect the quality of health care in a rural county such as Seneca. 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

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

The Seneca Health Solutions Team will work to address these factors as they undertake activities designed to improve the identified health priorities. The sub-groups for these risk factors include those with lower-income, a lower level of education and those that are socially isolated, as well as those with genetic predispositions for chronic disease, and those with a mental emotional behavioral diagnosis and/or alcohol/substance abuse problem.

The County is a Health Professional Shortage Area (HPSA) for primary care for low income populations, dental HPSA for the Five Points Correctional Facility and mental health HPSA for Five Points and the Medicaid-eligible population in Seneca County.

The lack of access to primary care results in poor health outcome. Prevention, early detection, early treatment and referral to other needed services ease the effects of long-term chronic conditions. In Seneca County, socioeconomic conditions limit access to health care as well as the limited availability of services within county borders. There is no hospital located in Seneca County and a lack of specialty providers in the county. These two factors limit access for those without private transportation and Seneca County also has limited public transportation. For the most part however, services are available, if cost, behavioral and transportation barriers do not preclude access. A large barrier to Seneca County residents is the absence of a hospital within the county. Residents must utilize hospitals in the adjacent counties including those located in Ontario, Wayne, Tompkins, Schuyler, Yates and Cayuga Counties. The majority of hospitalizations for Seneca County residents occurs in Geneva General Hospital.

In May 2013, Geneva General Hospital, due to a lack of medical providers, ceased to deliver babies at their facility. Subsequently, many Seneca County residents are now delivering their

babies at Newark Wayne Hospital in Wayne County or FF Thompson Hospital in Ontario County.

Physical – As stated in the demographic section Seneca County has a population of 34,833 in 330 square miles with a population density of 107.5 people per sq. mile. Seneca County is sandwiched between Seneca and Cayuga Lakes which can lead to social isolation. Social service agencies are located in the northern part of the county with limited access in the southern part of the county. This poses a challenge for residents who must travel from one end of the county to the other to access services. This is a significant burden when primary transportation is an issue. The ability to access health care, especially for the uninsured, non-Medicaid population with limited financial resources; and for the elderly who face barriers in driving longer distances presents a physical barrier some find difficult to overcome. Additionally, with older housing stock, indoor air quality issues, long winters with limited opportunities for indoor physical activity, the physical environment is a major consideration.

Legal – Real health care reform cannot occur without policy change. With the current implementation of the Affordable Care Act 2014 ushered in significant changes to the health insurance landscape. All residents of the country have access to affordable health care, but this process has not been without challenges to overcome. The challenge will be to help residents understand this complex system. Legal issues are also a concern for the migrant population who defer health care until an emergency occurs for fear of the legal repercussions. Ongoing land claim issues between the County and the Native American Indian Tribes results in financial hardship to municipalities and schools. The lack of property and school tax revenues has had a substantial impact on the tax payers of Seneca County.

Social - Behavioral risk factors and social determinants impact Seneca County resident's health. Key social determinants for residents include; low-income, lower educational levels, higher proportion of elderly residents, lack of transportation and social isolation. Social isolation experienced by rural residents may lead to alcohol abuse, and higher rates of depression or poor mental health than their urban counterparts. Cultural acceptance of tobacco and alcohol use is also a risk factor, and proximity to cheaper and un-taxed cigarettes from the nearby American Indian reservation may enhance this proclivity. Lack of access to dental care and the lack of a fluoridated water supply are additional risk factors. Recent studies have also shown that urban residents may lead less of a sedentary lifestyle than do rural (non-farming) or suburban residents, due to spending more time walking to various destinations than is feasible in rural areas.

Economic – The economic factors affecting the health of residents are well documented. Living in poverty is associated with lower health status, an increased risk of having inadequate health insurance, and lower use of health services. The annual median household income is $48,932 compared to $54,482 for the nation and the per capita income is $23,823 compared to $28,555 for the nation. According to 2016 USDA data, the county poverty rate is 14.2% with 21.1% of children 0-17 years living in poverty.

Lack of education is a determining factor of economic stability and also associated with a lower health status and a greater likelihood of not seeking health care, especially preventive services. According to the US Census Bureau Quick Facts, Seneca County has a lower percentage high school graduates at 85.4% compared to the NYS average of 86.3%. Additionally individuals 25+ with a Bachelor's degree or higher in Seneca County is 19.6% which is significantly lower than the State average of 29.3%.

Other Health Related Components of the Environment

Seneca County Public Health participates in ongoing efforts to increase and strengthen collaborations with local and regional coalitions, partnerships, and networks to enhance, coordinate, and provide health care services to County residents. In addition to the Seneca Health Solutions Team members involved in the community health assessment process a list of existing partners and collaborations can be found in attachment 1.

Seneca County Public Health continues to collaborate with state and local officials and organizations in an effort to reduce the high costs of Early Intervention programs and at the same time provide quality service to the children who need the service. Public Health conducts weekly surveillance of Seneca County school systems, childcare centers, long-term care facilities, veterinarian offices and local medical providers to monitor for disease outbreaks and assess community trends. Public Health assists school districts on an "as needed" basis to provide up-to-date health education/information for a variety of topics encountered in the public school systems (such as lice, bed bugs, MRSA).

Additional challenges faced by Public Health include:

- State and local budget cuts effecting health care and government at local level, PH programs may be cut or eliminated.
- Increase in unemployment is reducing funds available for health related items (healthy food choices, memberships to health clubs, etc.) ability to get health related services and/or pay for health insurance and prescriptions
- The New York State Dept. of Labor reported the unemployment rate in Seneca County was 5.4% as of April 2015, compared to the NYS rate of 5.7%.
- Hospitalists pose unique challenges for the smooth transition from inpatient stays to care in the home (i.e. obtaining physician's orders; medication management). This is especially challenging for Seneca County given the lack of a hospital within County borders.
- Inability to attract and retain medical providers and specialty care
- Regulatory changes, increased immunization costs and complicated immunization schedules are beginning to deter provider participation in adult and children immunizations
- Smoking:

    - Inability to collect tax revenue from cigarettes sold by Native American business owners
    - The lack of funding to support cessation services including the purchase of nicotine replacement therapy for residents
    - The high prevalence of cigarette smoking among adults who report poor mental health
    - Delivery methods: i.e. E-cigarettes and the danger posed by those devices
- Access to high-quality, continuous primary care and treatment services
- Lack of Dental Providers accepting Medicaid for payment. The recent opening of the FQHC in Ovid offering lower cost and Medicaid reimbursable dental care has improved access and utilization of preventative dental services, but still has a way to go.
- Transportation in rural areas, lack of knowledge about how to navigate the health care system, lack of insurance and perceived confidentiality issues are also some of the factors that may keep people from appropriately accessing care.

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 held by the Amish/Mennonite population in Seneca 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. Seneca County is fortunate in that Finger Lakes Health has an urgent care center in Waterloo. Residents in the south end of the county have access to local care through the Federally Qualified Health Center in Ovid, which provides access to dental health, behavioral health services as well as primary care, and access to specialty services through telehealth.

According to the BRFSS Report (2013-2014) only 69.5% of adults aged 18-64 years have health care coverage. This percentage has increased since the implementation of the Affordable Care Act with the advent of the New York State of Health Marketplace, but still poses a significant barrier.

NY State of Health is an organized marketplace designed to help people shop for and enroll in health insurance coverage. Individuals, families and small businesses are able to use the

Marketplace to help them compare insurance options, calculate costs and select coverage online, in-person, over the phone or by mail. The Marketplace helps people to check their eligibility for health care programs like Medicaid and sign up for these programs if they are eligible. The Marketplace also informs the individual what type of financial assistance is available to applicants to help them afford health insurance purchased through the Marketplace.

Seneca County has assistance available to help residents enroll in this new system including the S^2AY Rural Health Network, Cayuga/Seneca Community Action Agency, Inc. and the newly opened Ovid Community Health Center. Public Health is a partner of S^2AY and will work closely with these organizations to ensure residents better understand and enroll in a health insurance plan.

Seneca County has a limited number of media outlets in the County. Advances in technology offer additional challenges and opportunities for public health to explore novel ways to reach residents. Traditional methods of health promotion such as through print ads and articles in newspapers and television and radio spots are not as effective as they once were. Residents now have endless cable television channel choices, satellite radio stations to choose from, vast internet options, and a wide array of apps to select from on their smart phones and devices. Public health must have the ability to utilize the new avenues offered through social media outlets such as Facebook and will explore the use of Twitter in the near future to reach their populations. Technology presents another barrier as many residents reside in rural, sparsely populated areas of the County that do not have cell phone or internet access. For many of those that do have access to new technology the internet presents new hurdles as they have limited computer skills and/or literacy levels. The internet can be extremely frustrating, stressful and overwhelming especially for older residents. Disparities in access to health information, services, and technology can result in lower usage rates of preventive services, less knowledge of chronic disease management, higher rates of hospitalization, and poorer reported health status. Seneca County Public Health and partners will take steps to address this. The challenge will be how to make the best use of these new tools.

These and other barriers pose opportunity for improvements in the public health delivery system. Promising initiatives such as the New York Medicaid Redesign, the Centers for Medicare and Medicaid Services Triple Aim, the Affordable Care Act, New York State of Health and Patient Centered Medical Homes should help to address access to care issues.

Policy development is having a positive impact on improving health in Seneca County. The Clean Indoor Act, passed ten years ago, continues to improve the overall environment and reduce exposure to second hand smoke. Many businesses are implementing smoke-free policies. Seneca County passed a law in October of 2011 banning smoking on all county owned and leased properties. A Social Host Law to prevent underage drinking was successfully passed in July 2013.

2. Data Reviewed and Analyzed:

The data review and analysis was extensive. In all S²AY Network Counties including Seneca, 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 (EBRFSS: 2013-2014)
  https://www.health.ny.gov/statistics/brfss/expanded/2013/county/docs/seneca.pdf
- U.S. Census Bureau, 2010 Census.
  http://www.census.gov/2010census/
- Statewide Planning and Research Cooperative System (SPARCS) 2013 data
  https://health.data.ny.gov/Health/Hospital-Inpatient-Discharges-SPARCS-De-Identified/876q-xdbe
- NY State Prevention Agenda data set
  http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/indicator_map.htm
- FLHSA Aggregated Claims Data 2010-2014
- NY State Vital Statistics
  https://www.health.ny.gov/statistics/vital_statistics/
- Regional High Blood Pressure Registry
  https://www.flhsa.org/ *Internal Data Source*

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. In addition to the above sources, this additional review of data included, among other things:

- County Prevention Agenda Dashboard
  https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=45
- Community Health Indicator Reports
  http://www.health.ny.gov/statistics/chac/chai/chai_45.htm
- Sub-County Data Reports
  http://www.nysachoinfo.org/Sub-County-Health-Data-Report/Seneca.pdf
- Leading Causes of Death Indicators
  http://www.health.ny.gov/statistics/leadingcauses_death/
- County Health Rankings
  http://www.countyhealthrankings.org/

In addition to the primary data reviewed from the high blood pressure registry, other primary data was obtained through focus group input.

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 Seneca 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:* Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

Disparities Being Addressed –

During the 2016-2018 period, Seneca County Public Health, Finger Lakes Health (Geneva General Hospital) and community partners have chosen to address a disparity under the Prevent Chronic Diseases priority area. This will be done through evidenced based activities such as Stanford approved Chronic Disease Self-Management Program classes (as outlined in the CHIP chart below). The disparity focuses on Goal 3.3 (promote culturally relevant chronic disease self-management education). This disparity will target behavioral health clients, low socioeconomic status (SES) populations and elderly by partnering with Mental Health, Office for the Aging and Wayne CAP for referrals to and provision of CDSMP classes in Seneca County. This will be measured through tracking of the number and percent of adults among populations of focus, (e.g. communities of color, persons with disability, low-income neighborhoods) who have attended EBIs (specifically CDSMP). The disparity was chosen by Seneca Health Solutions based on analysis of the data and potential to reach disparate populations.

Community Engagement –

The S^2AY Rural Health Network used the Mobilizing for Action through Planning and Partnership (MAPP) process to engage the community in a collaborative assessment process and collectively develop priorities.

The MAPP process is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs, and forming effective partnerships for strategic action. The MAPP tool was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Public

Health Practice Program Office, Centers for Disease Control and Prevention (CDC). A work group comprised of local health officials, CDC representatives, community representatives, and academicians developed MAPP between 1997 and 2000. The vision for implementing MAPP is: *"Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action".* The MAPP process encompasses several steps.

1. **Organize for Success- Partner Development**

This included representatives of the Seneca Health Solutions Team discussed above. This collaborative, multi-disciplinary group oversaw the assessment process and the development of the CHIP.

2. **Assessments**

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

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

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

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

3. **Identification of Strategic Issues**

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

4. **Formulate Goals and Strategies**

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

The process of Community Engagement using MAPP

Seneca County Public Health, and Finger Lakes Health (Geneva General Hospital), with assistance from the S^2AY Rural Health Network, conducted a comprehensive assessment of the community, which provided the basis for the Prevention Agenda priority areas selected above. The assessment process included a thorough review of county specific data around health needs, compared to neighboring counties, the region, and the State as a whole. As noted above, this included data collection and analysis by both the FLHSA and S^2AY. After the data was analyzed and prepared, this data was shared in the form of focus group presentations to county residents. Seneca County conducted nine separate focus groups with key informants throughout the county to solicit feedback. Focus groups were selected to include a broad diversity of community members from different segments of the community, including populations that experience health disparities as outlined in this report. Focus groups that were conducted included the following: community champion members part of the Seneca Towns Engaging People for Solutions (STEPS) partnership (general cross section of the community), a senior citizen volunteer group through Wayne CAP, a collection of law enforcement officials as part of the Criminal Justice Advisory Board, human service organizations serving Seneca County,

Office for the Aging nutrition site, the Seneca County Health Advisory Committee which includes key human service informants and physicians that live and work in Seneca County, Seneca County Board of Health which is the governing body for Seneca County Public Health Department, the Ovid/Willard-Lyons Club which is a group of like-minded community members working to better the community they live in, and the FLPPS Finger Lakes NOCN meeting. Additionally, a Public Health System Assessment was completed as part of the MAPP process using key informants as respondents, and input incorporated into the decision-making process. (See attachments 4 & 5)

After the completion of the focus groups, the Health Solutions Team 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, hospital, S^2AY Rural Health Network, and other partners). S^2AY prepared another Power Point presentation for this "Priority Setting" meeting. The meeting was open to the public and focus group participants were invited via direct invitation. At this meeting, S^2AY 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 S^2AY 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 (attached), and participants ranked the highest priority issues to come up with a list of preliminary priorities (list of ranked issues attached). (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 & 14). The next three meetings of Health Solutions 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 to increase the number of CLC's integrated into the community, support designation to become NYS Breastfeeding Friendly, worksites to implement healthy policies), promoting provider practice participation in the regional hypertension registry, working with business and hospitals to increase breastfeeding support and lactation counseling. Strategies to address mental health and preventing substance abuse include school based programs including "Project Towards No Drug Abuse" and "Project Success", which targets direct participation from students in the local county schools.

4. Community Health Improvement Plan (CHIP):

Lessons Learned/Progress on CHIP 2013 –

As mentioned in the above explanation the priority areas for Seneca County have not changed significantly. However the interventions have evolved in ways to better address the priority areas utilizing either Evidence Based Interventions (EBIs) or promising interventions. The following interventions from the 2013 CHIP cycle for Seneca County have changed in their approaches for the 2016 CHIP work-plan.

1) Healthy Food and Beverage Choices – will focus on implementing nutrition and beverage standards in public institutions such as worksites and key locations such as hospitals, i.e. healthy vending at county locations, and sodium reduction efforts at hospital locations.
2) Breastfeeding – will focus on supporting breastfeeding friendly designations, specifically in the FQHC that serves Seneca County, Business Case for Breastfeeding education and support, etc.
3) Manage Chronic Disease – participation in promising intervention known as regional blood pressure hypertension registry, distribute "My Reminder Campaign" materials to assist with medication adherence (specific to high blood pressure medication), continuing to support implementation of Chronic Disease Self-Mgmt Program (CDSMP).
4) Substance Abuse – continue to support and offer education around school based programs targeting substance abuse.

While this is a list of interventions that have changed as a result of the 2016 assessment, other activities identified in the 2013 CHIP cycle will not be abandoned entirely, the Seneca Health Solutions Team felt that these interventions would provide better results for positive population health outcomes for the future CHIP cycle.

Please see the attached Seneca County CHIP chart, 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 Seneca Health Solutions Team (comprised of Public Health, Finger Lakes Health (Geneva General Hospital), the S^2AY Rural Health Network, and many additional partners) 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 Seneca County Public Health and Geneva General (Finger Lakes Health) intend to take to address each priority area, the specific resources Seneca County Public Health and Geneva General (Finger Lakes Health) intend 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.

5. Maintaining Engagement and Tracking Progress:

As seen in the attached CHIP, the chart designates the organizations that have accepted responsibility for implementing each of the activities outlined. The Seneca Health Solutions Team is the group that will be overseeing the implementation, monitoring, and evaluation of the plan. Health Solutions meets on a monthly basis (and has been meeting since about 2006) and has accepted the role of oversight and implementing the work as detailed in the activities of the CHIP. Representatives from the Seneca Health Solutions Team will report updates on activities to the Seneca County Board of Health on a quarterly basis. Progress will be recorded on a dashboard developed by the Seneca Health Solutions Team which includes all aspects of the CHIP document, and then shared with all members of the Health Solutions Team. 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. Finger Lakes Health will continue to communicate CHIP/Community Service Plan (CSP) updates to the Hospital Board annually, and activities will also be shared with the S^2AY 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. Seneca Health Solutions Team is 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 (Seneca County Public Health, Finger Lakes Health (Geneva General Hospital)) will be disseminated to the public in the following ways:

- Made publicly available on the Seneca County Public Health main website
- Made publicly available on Geneva General (Finger Lakes Health) main website
- Made publicly available on the S^2AY Rural Health Network website
- Made publicly available on additional partners websites (Cornell Cooperative Extension, STEPS, local community based organizations, etc.)
- Shared with all appropriate news outlets in the form of a press/media release
- All partners including Seneca County Public Health, Geneva General (Finger Lakes Health), S^2AY 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.)

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

Seneca County Public Health: http://www.co.seneca.ny.us/departments/community-services/public-health/

Geneva General (Finger Lakes Health): http://www.flhealth.org/GenevaGeneralHospital

S^2AY Rural Health Network: http://www.s2aynetwork.org/community-health-assessments.html

Seneca Health Solutions Team

Membership 2016

Seneca County Public Health

Finger Lakes Health (Geneva General Hospital)

Cornell Cooperative Extension

Finger Lakes Addictions Counseling & Referral Agency (FLACRA)

Local School Districts

Primary Care Physicians

Seneca Towns Engaging People for Solutions (STEPS)

Tobacco Action Coalition of the Finger Lakes (TACFL)

Lifecare Medical Associates, PC

Finger Lakes Community Health

Wayne CAP

Finger Lakes Health Systems Agency

Seneca County Environmental Health

Local Law Enforcement

Council on Alcoholism and Addictions of the Finger Lakes

Office for the Aging

S^2AY Rural Health Network

Seneca County Substance Abuse Coalition

FLHSA

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

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Regional Health Measures

Selected by the Regional Commission on Community Health Improvement, these indicators track trends in key areas for the nine county Finger Lakes region. To follow progress, FLHSA will report each measure through 2025.

Trends Over Time

Still under development are trend graphs for the region as a whole. The graphs will be available by clicking on the shaded circle on each line. Color coding indicates whether the region is getting better, staying the same or getting worse for each measure.

Better Flat Worse

HEALTH OUTCOMES

Premature death 3,359

Years of potential life lost before age 65 per 100,000 population (age and sex adjusted)

Race		Socio Economic Status		Geography	
White Non-Latino	3,079	Lowest	5,546	Chemung	3,656
Black Non-Latino	6,067	Second Lowest	3,901	Livingston	2,613
Hispanic	2,893	Middle	2,642	Monroe	3,380
Other	1,954	Second Highest	2,412	Ontario	3,016
		Highest	2,042	Schuyler	5,299
				Seneca	3,675
				Steuben	3,946
				Wayne	3,550
				Yates	2,505

Source: 2013 New York State Vital Statistics

Low birthweight 7.7%

Good health self-report 83.7%

COMMUNITY MEASURES

Childhood Immunization 64.5%

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County Health Stats

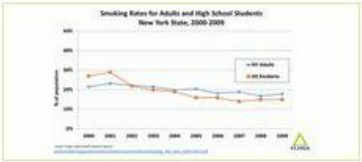
Click on a county below to access a wealth of health statistics by county, from smoking and high school graduation rates to air pollution measures.

FLHSA Website Enhancements

HOME ABOUT ISSUES INITIATIVES NEWS DATA CONTACT US

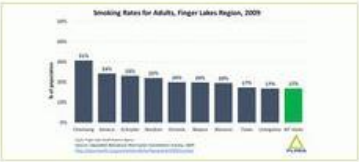
Insights

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

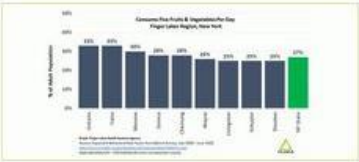


Smoking rates for adults, Finger Lakes Region, 2009

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

FLHSA

Finger Lakes Health Systems Agency

An Analytic Review of Selected Priority Areas

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

Approach & Methodology

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

2013 Community Health Assessment Priority Areas

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

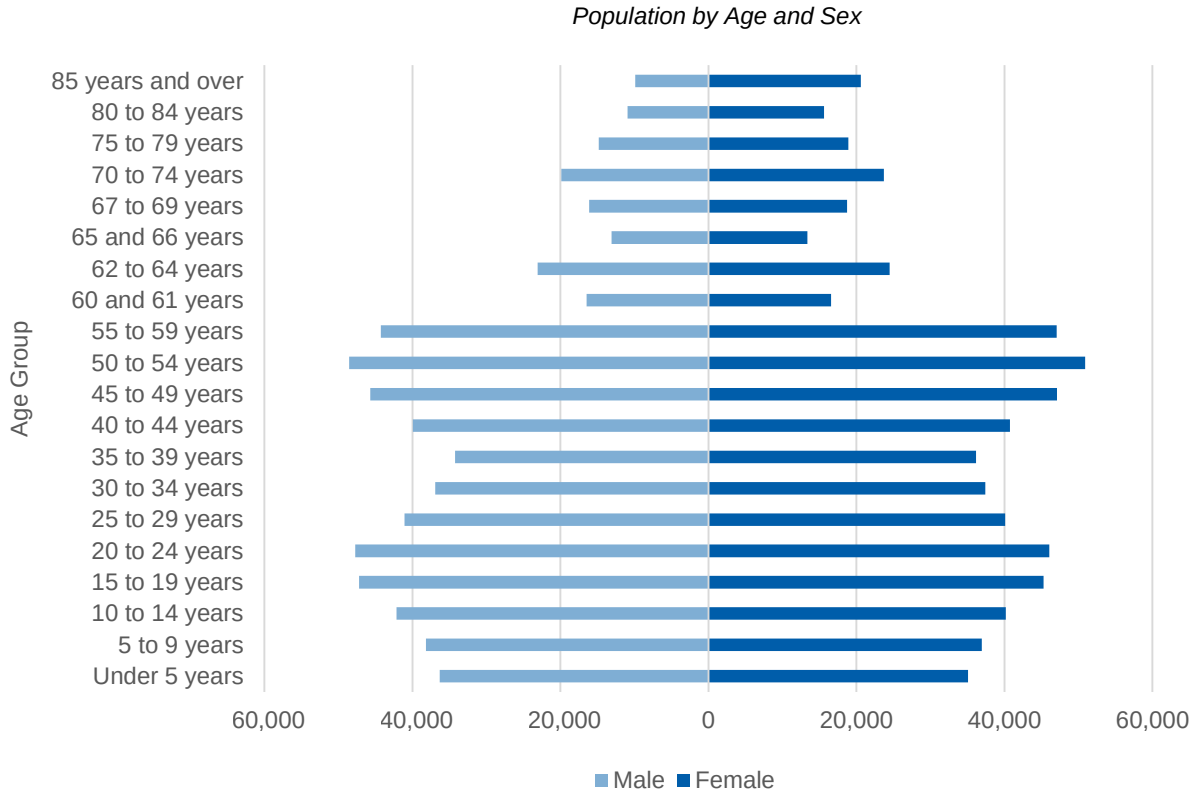
Approach & Methodology, Continued

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

THE FINGER LAKES REGION: DEMOGRAPHICS

The Finger Lakes Region

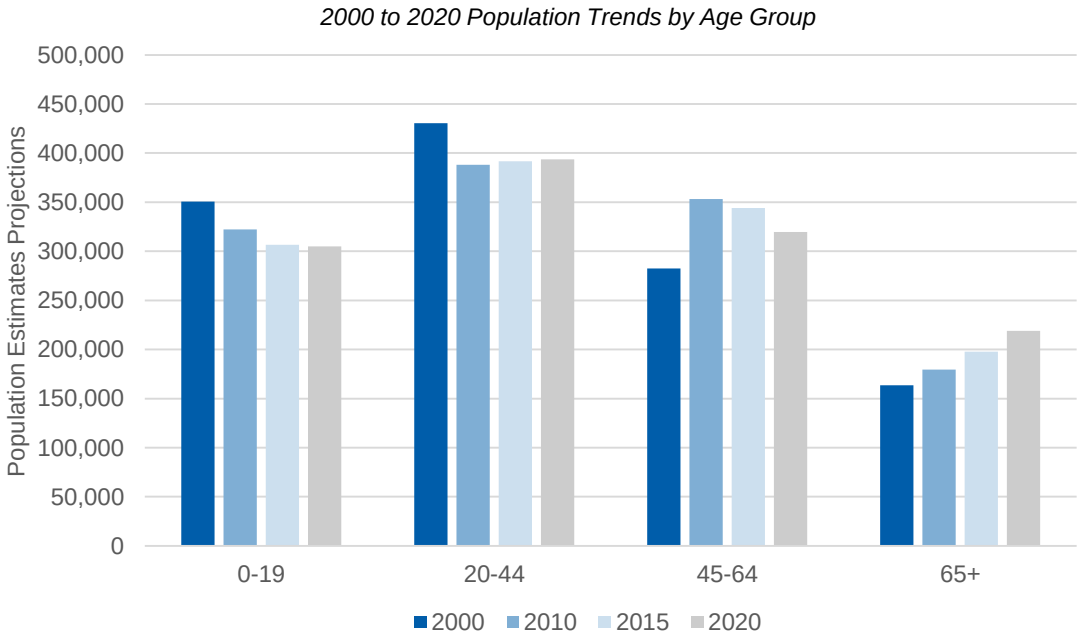
- There are approximately 1,281,374 persons living in the Finger Lakes Region. Age/Gender distributions are essentially equivalent, but begin to shift towards the female population starting at age 75.



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

The Finger Lakes Region, Continued

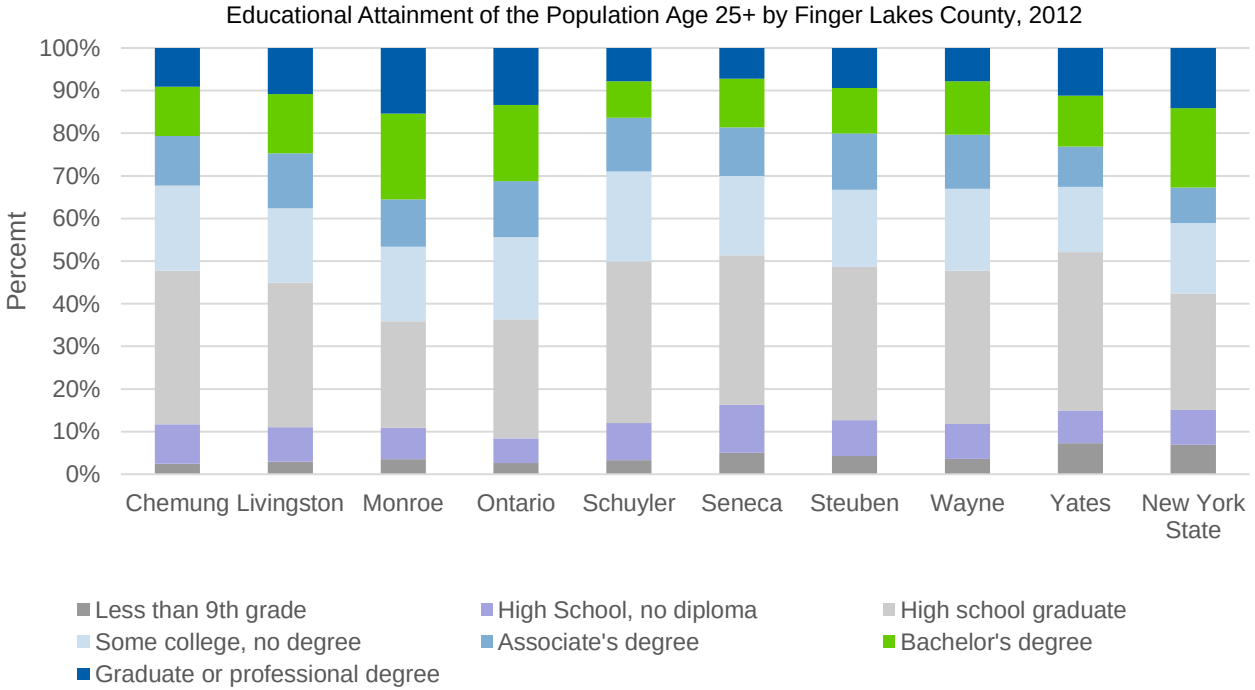
- Population projections show little change in the pre-school, school aged and adults of child bearing ages by 2020. The 45-64 population will decrease slightly, while the 65+ age group will grow.



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.

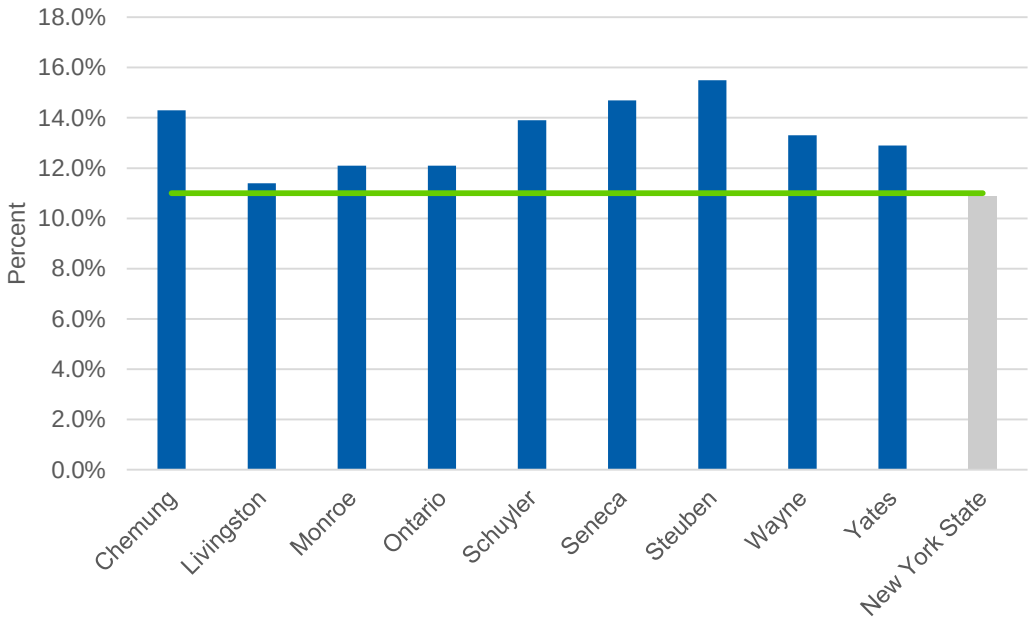


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

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

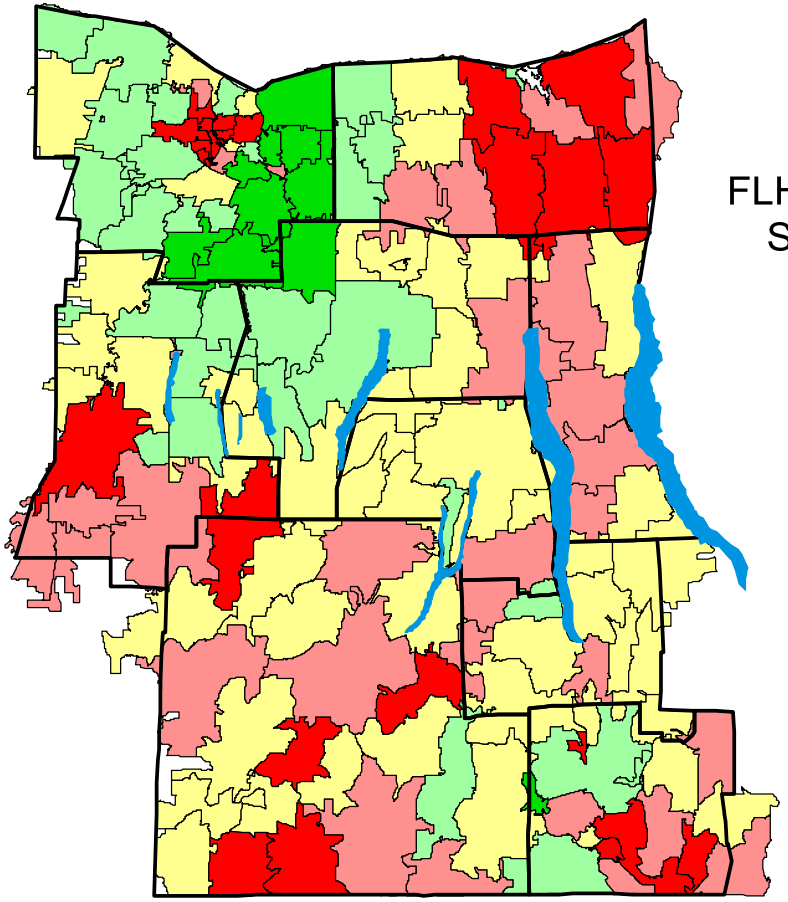


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

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

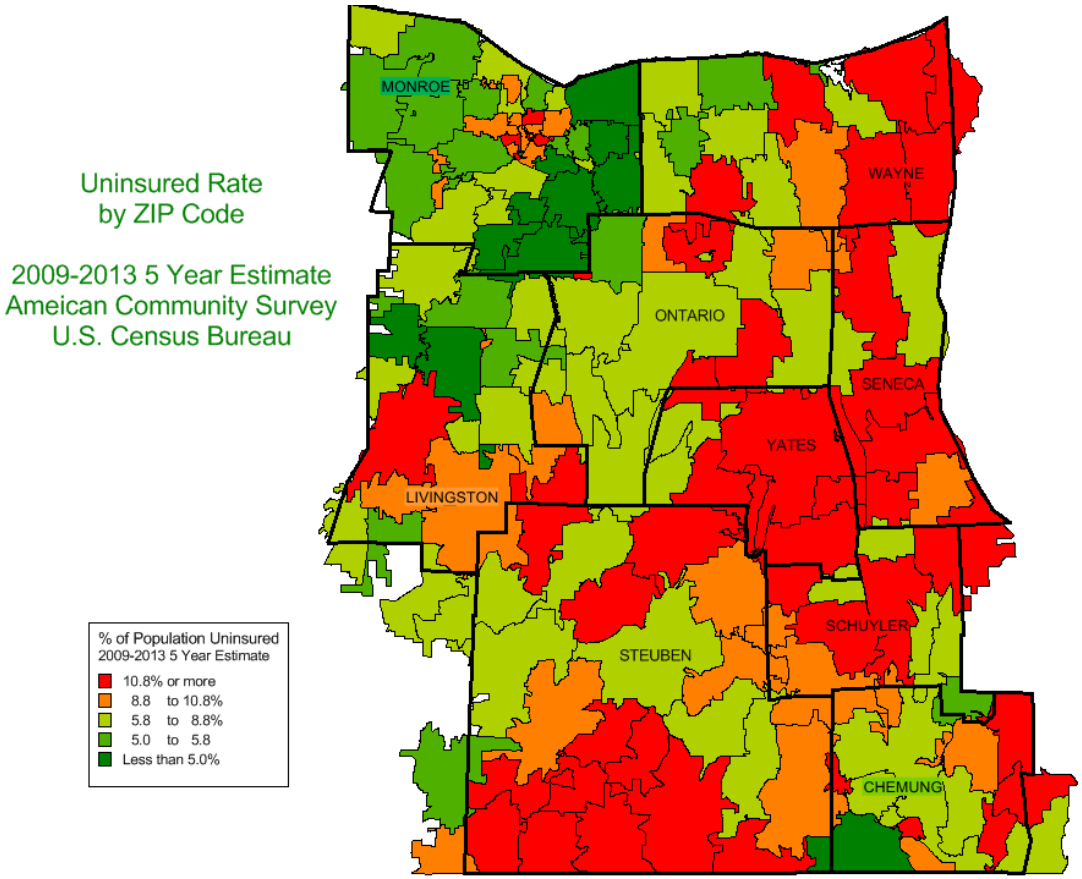


FLHSA Nine Counties SES by ZIP Code

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

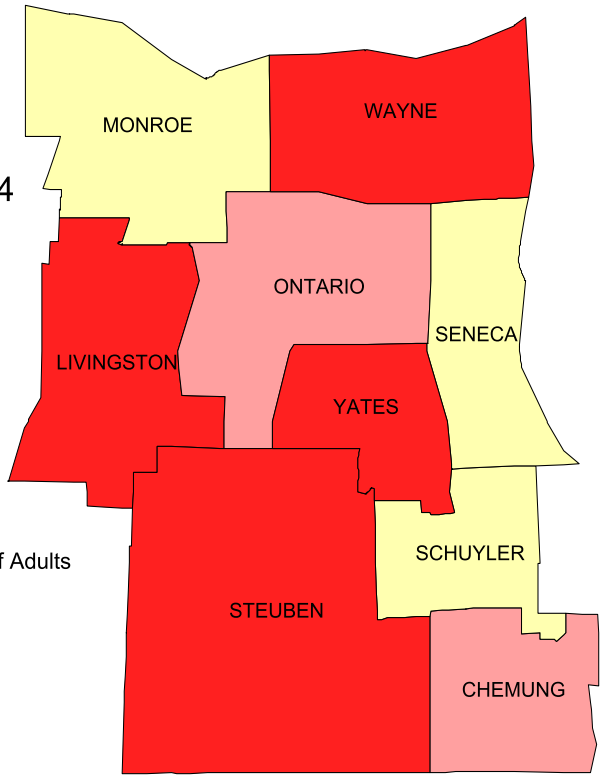
PRIORITY AREA 1: OBESITY

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



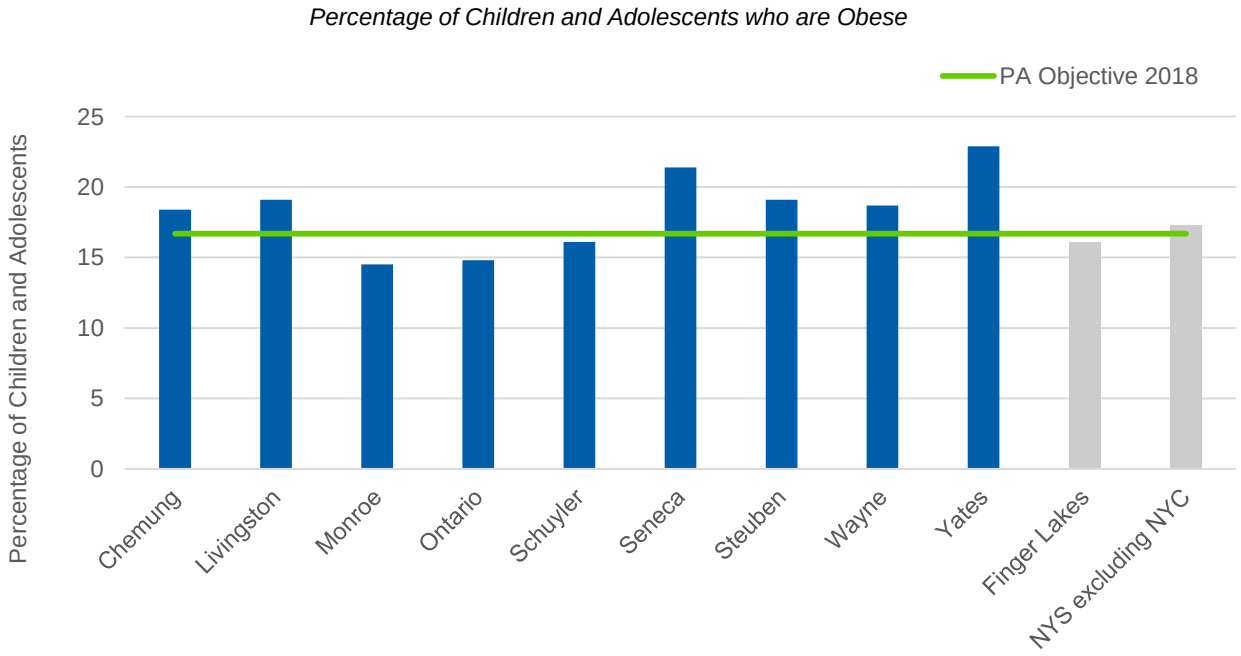
The Prevention Agenda Objective for 2018 is 23.2% of Adults

Percent of Obese Adults
20% - 26.9%
27% - 29.9%
30% - 36%

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.



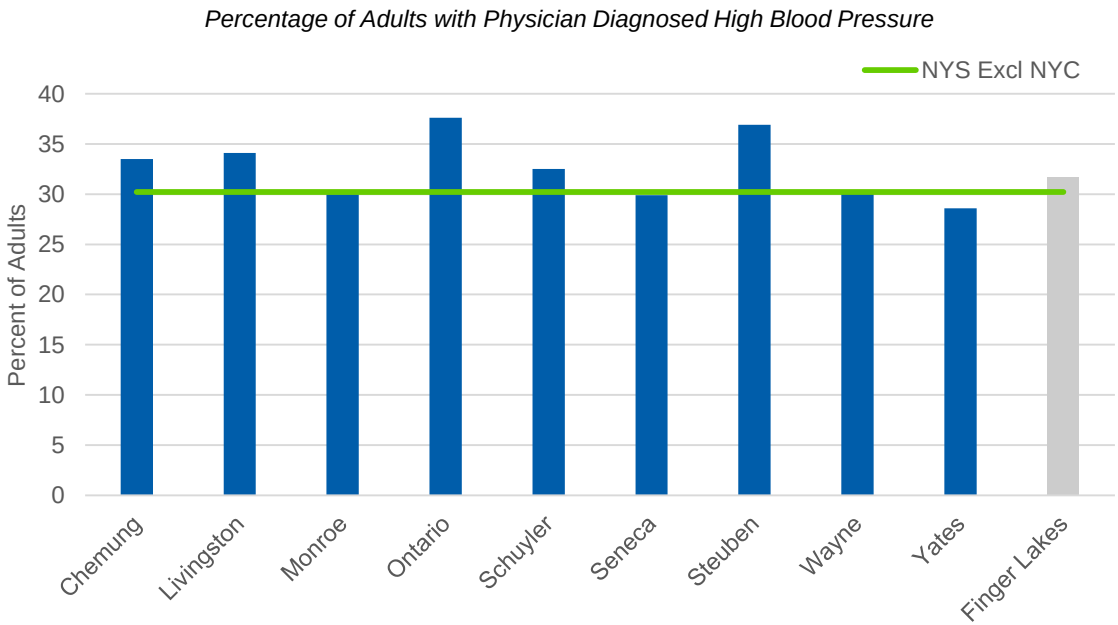
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2012-2014

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.

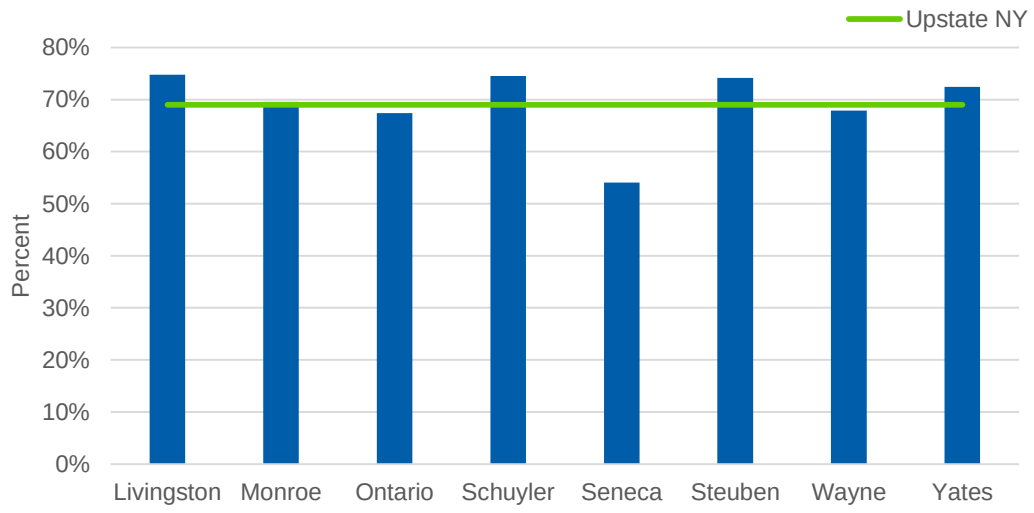


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Chronic Disease- Hypertension

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

Hypertension Control Rates, June 2015

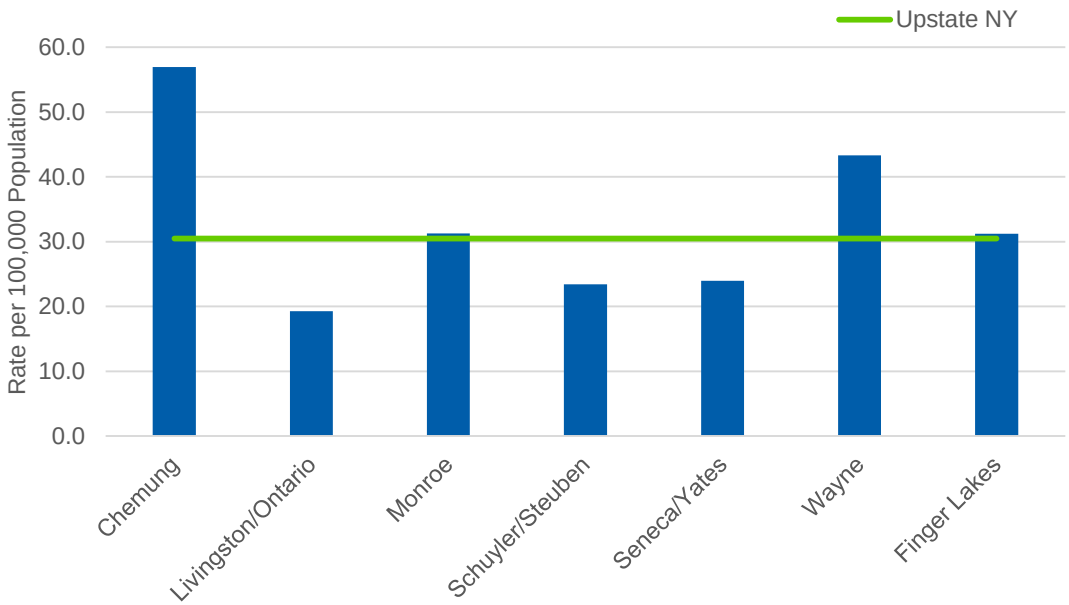


Data Source: FLHSA/RBA High Blood Pressure Registry, June 2015
Note: Chemung has been excluded due to small sample.

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

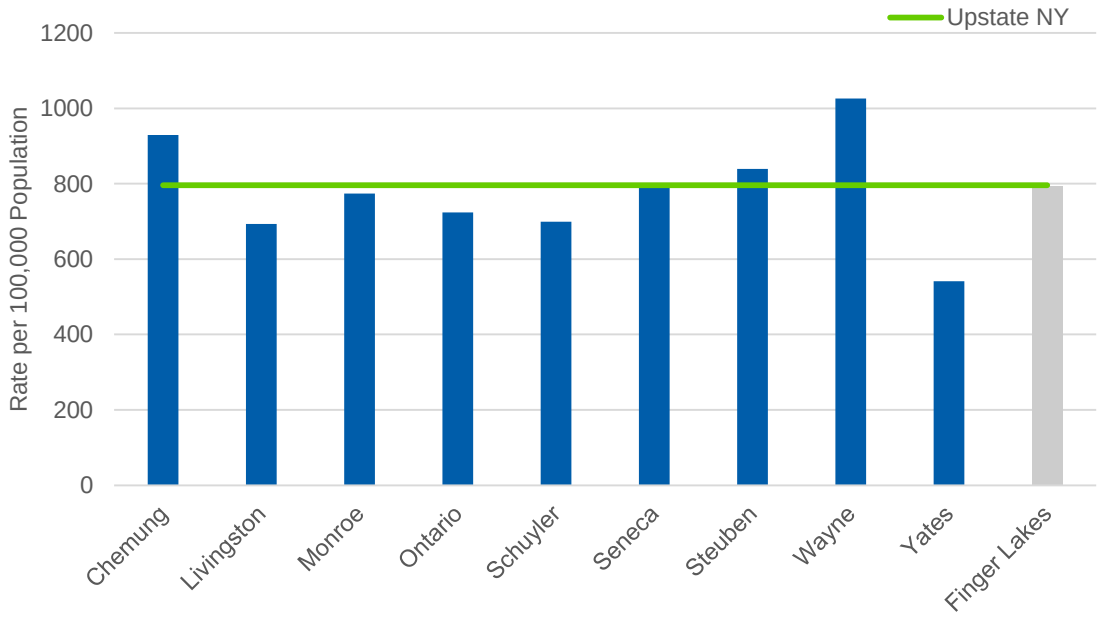


Data Source: SPARCS, 2013
Hypertension as a primary or cormorbidity diagnosis

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

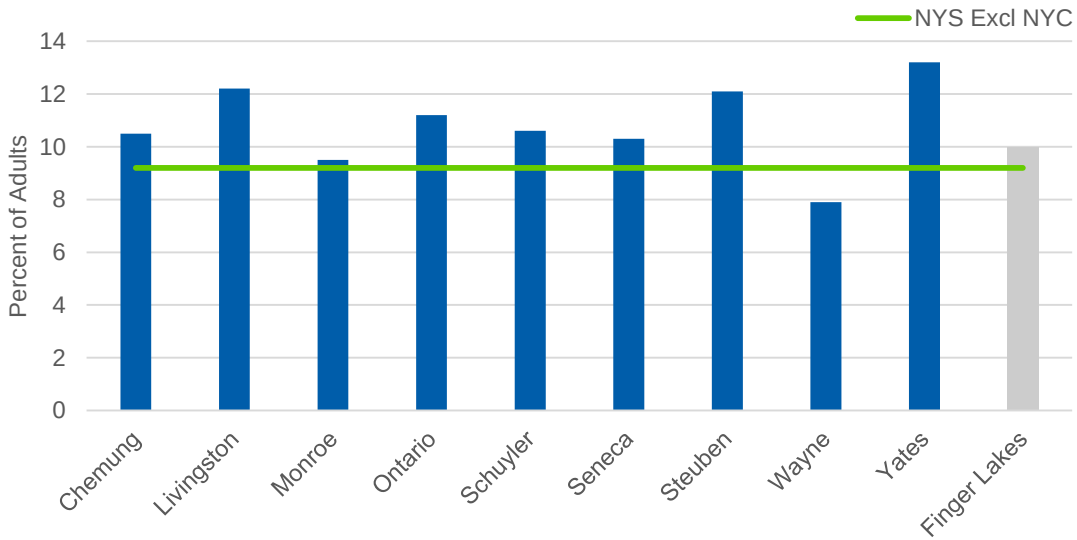


Data Source: SPARCS, 2013

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

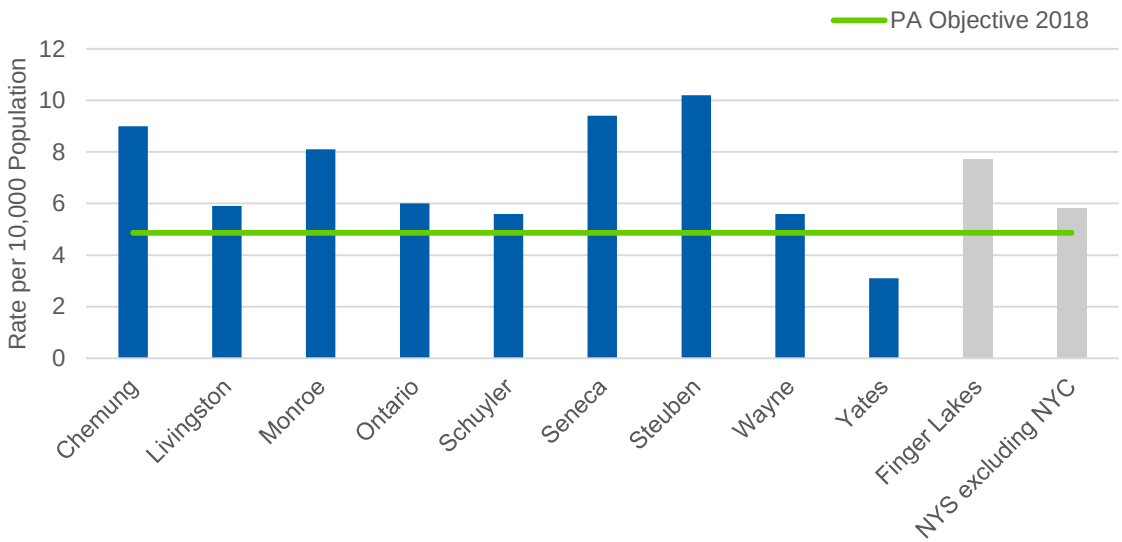


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

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

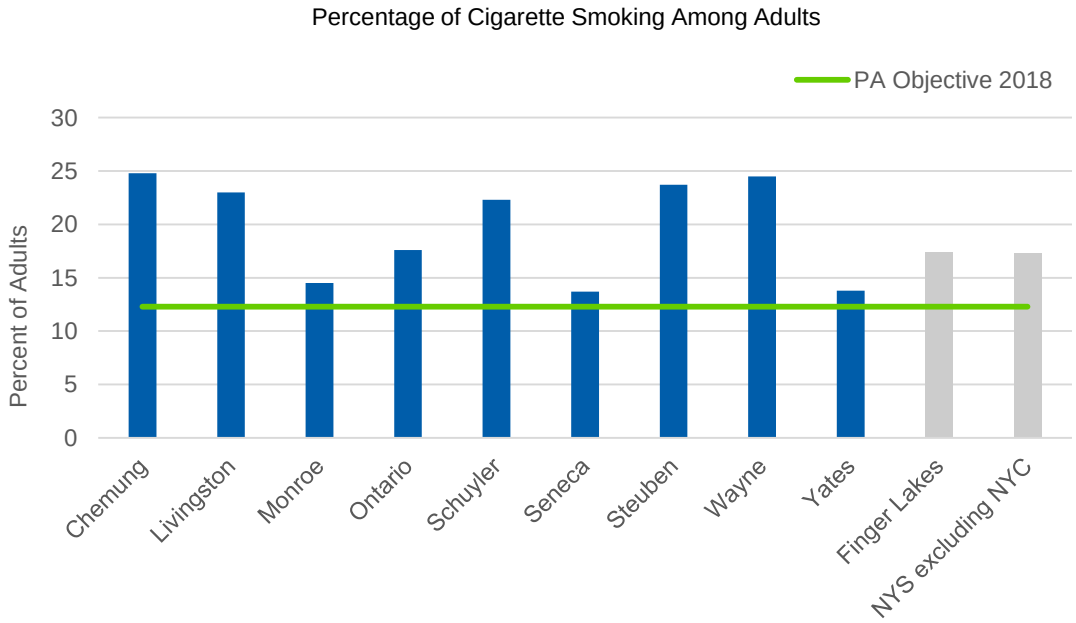


Data Source: New York State Prevention Agenda, 2011-2013

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

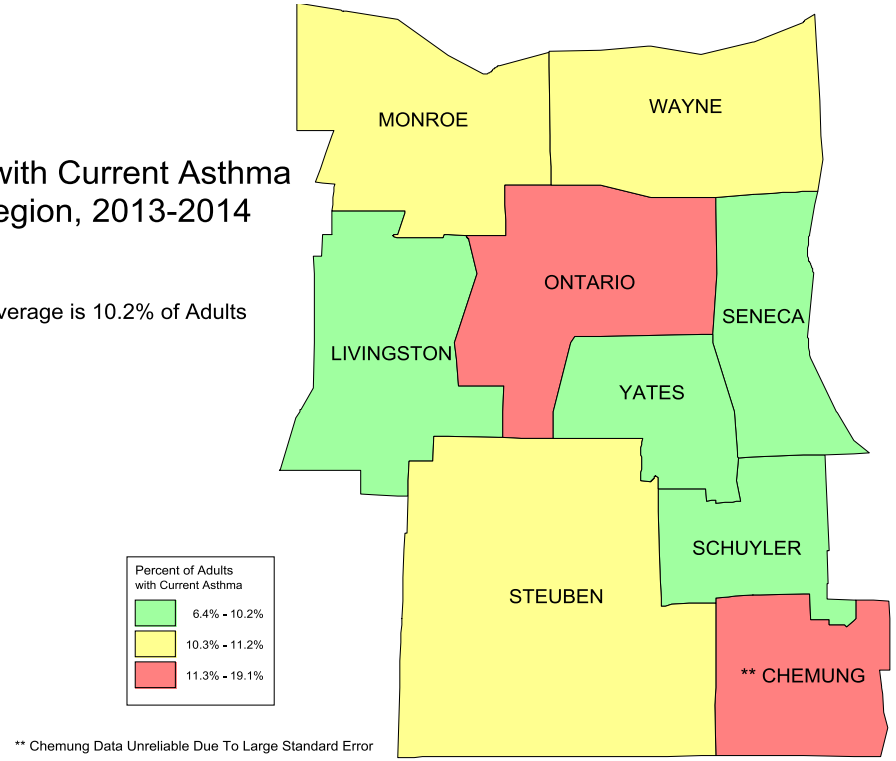
Tobacco Use

- 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

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

The New York State Average is 10.2% of Adults



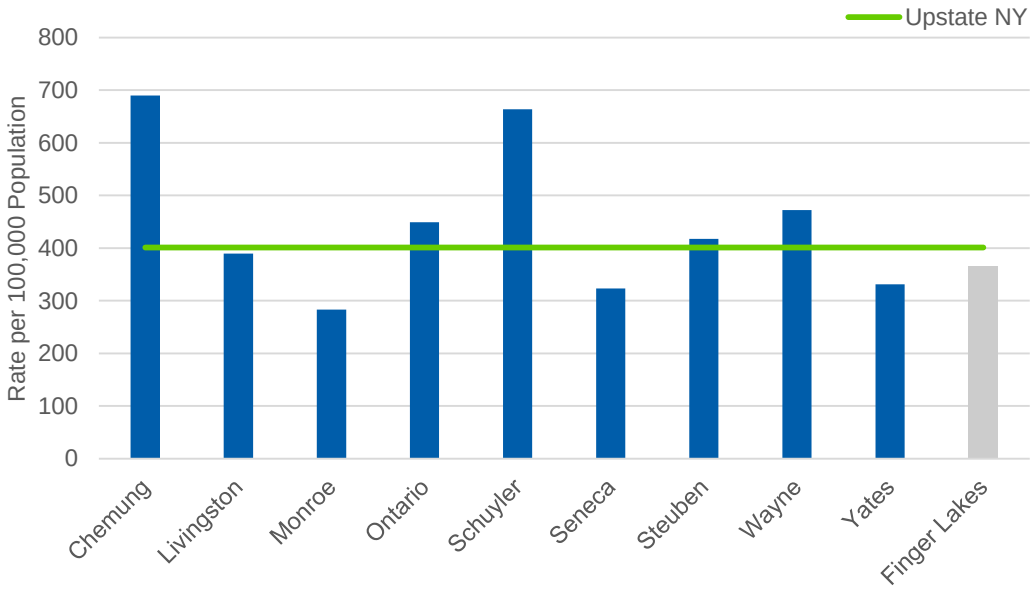
** Chemung Data Unreliable Due To Large Standard Error

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

Tobacco Use

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

Rate of Respiratory Prevention Quality Indicators

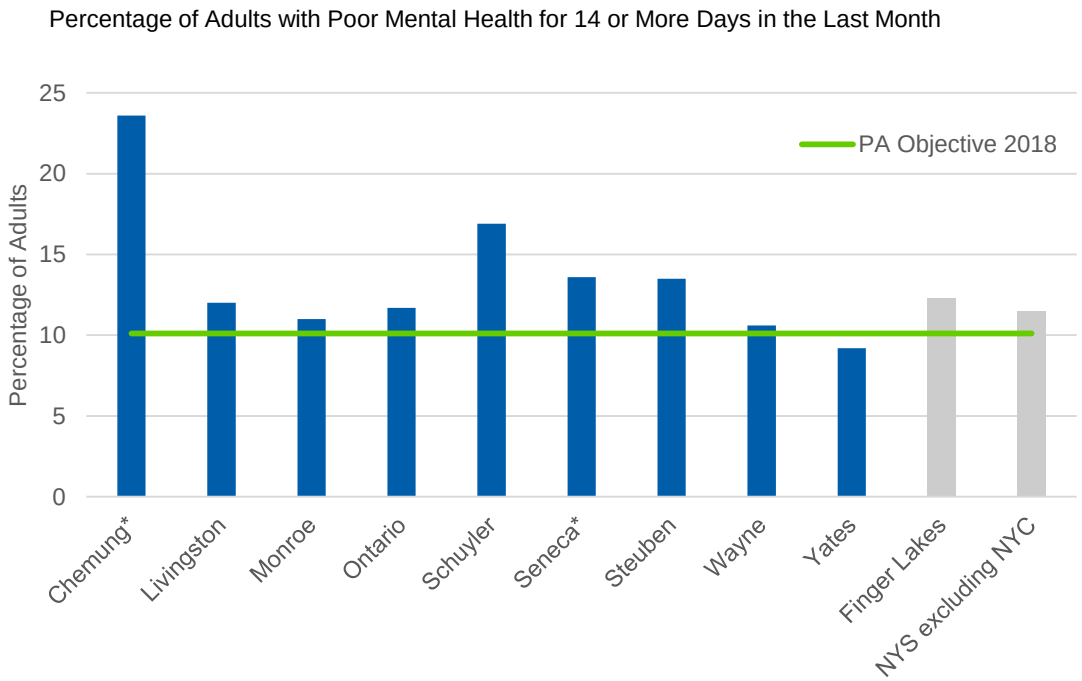


Data Source: SPARCS, 2013

PRIORITY AREA 6: BEHAVIORAL HEALTH

Behavioral Health

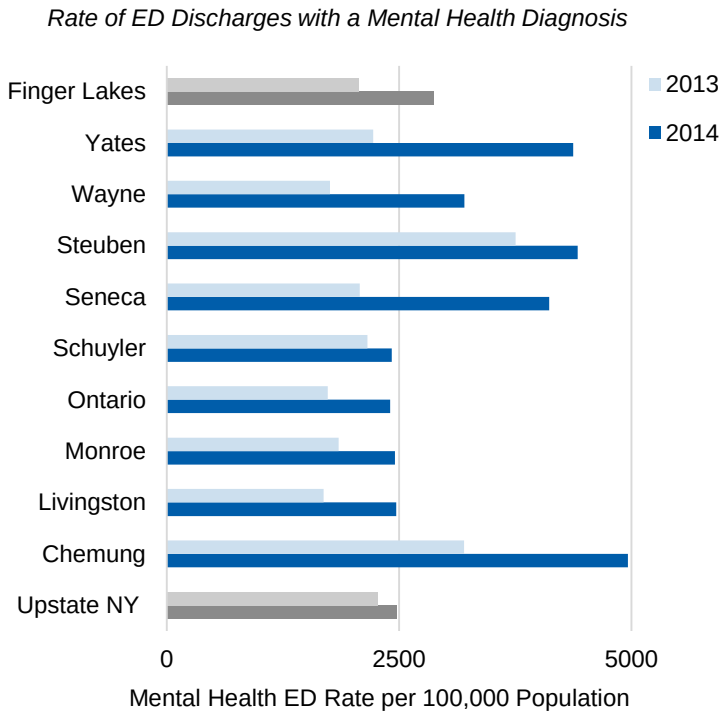
- Rates of poor mental health in the region are highest in Chemung and Schuyler County.

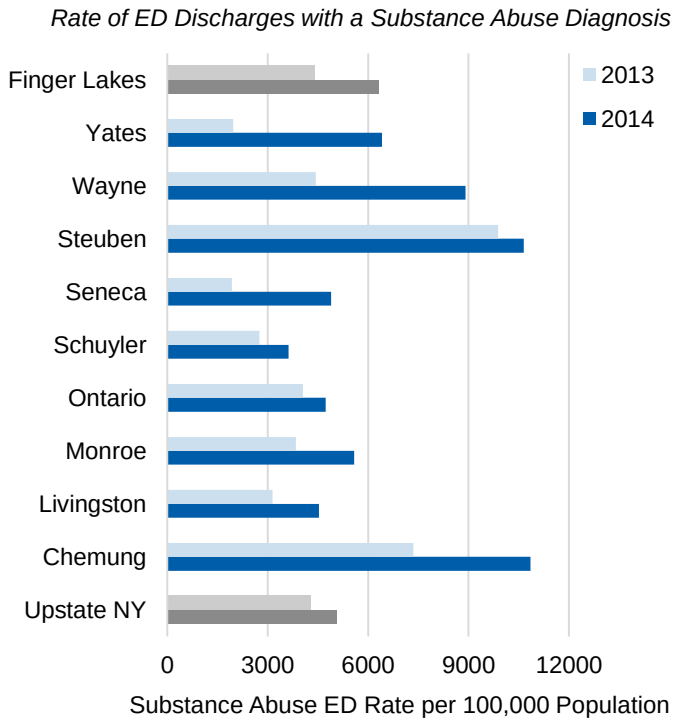


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error.

Behavioral Health

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

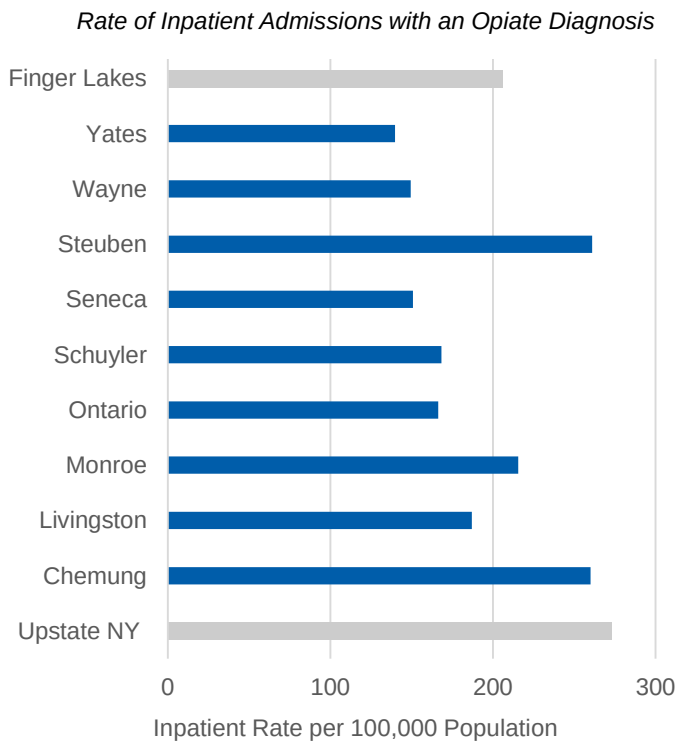


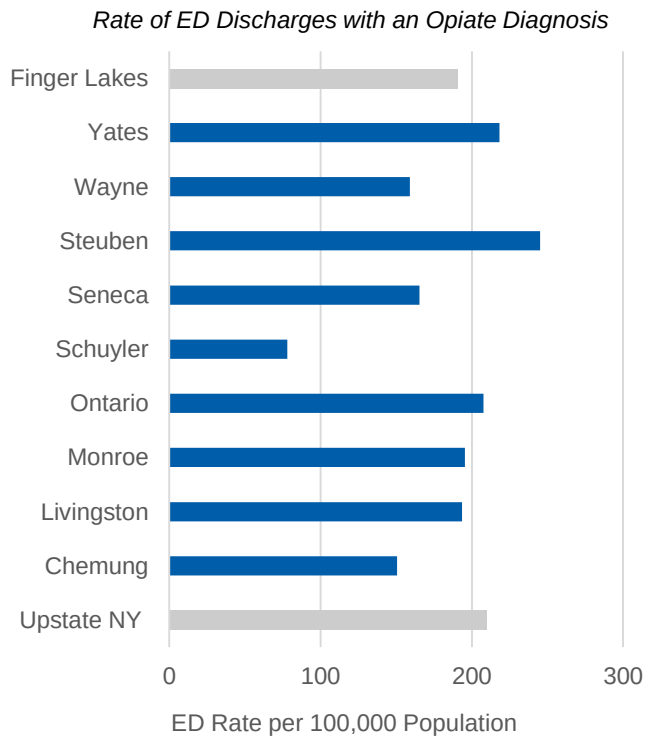


Data Source: SPARCS, 2013-2014. Diagnosis includes primary or comorbidity

Behavioral Health

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

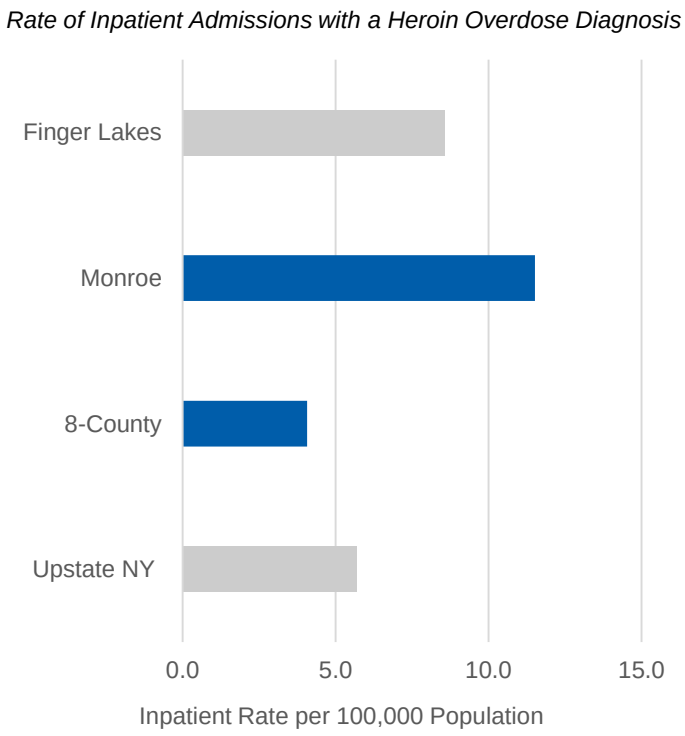


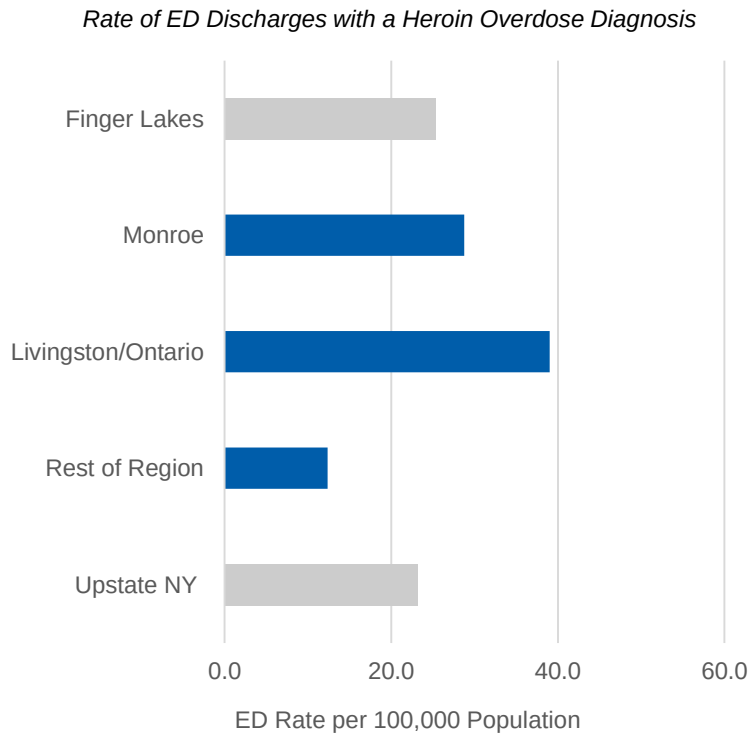


Data Source: SPARCS, 2014

Behavioral Health

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

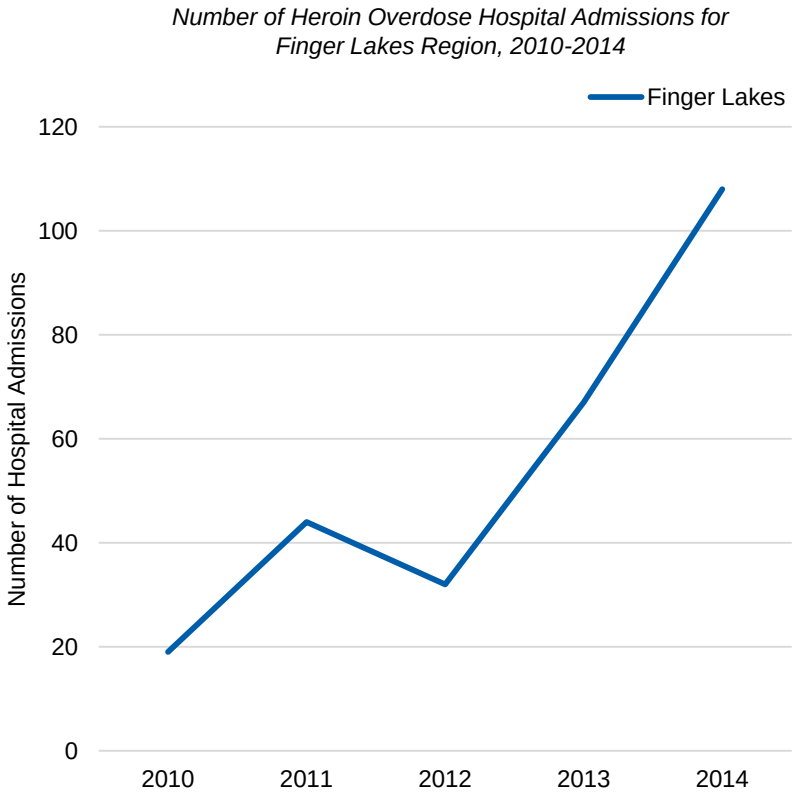


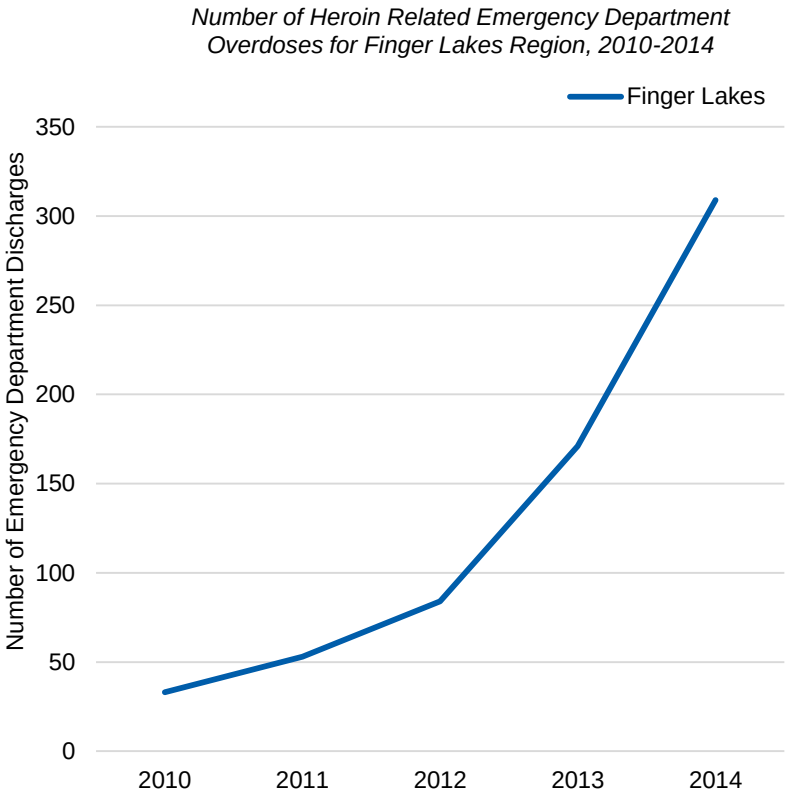


Data Source: SPARCS, 2014

Behavioral Health

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



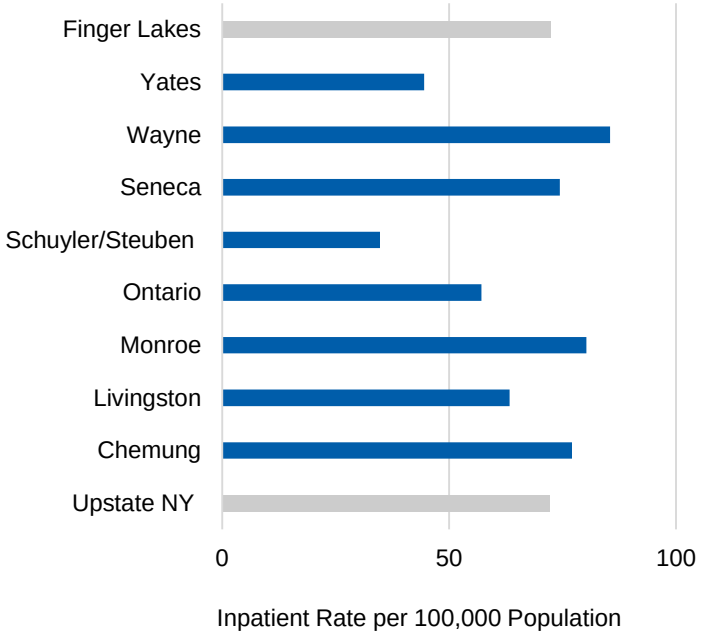


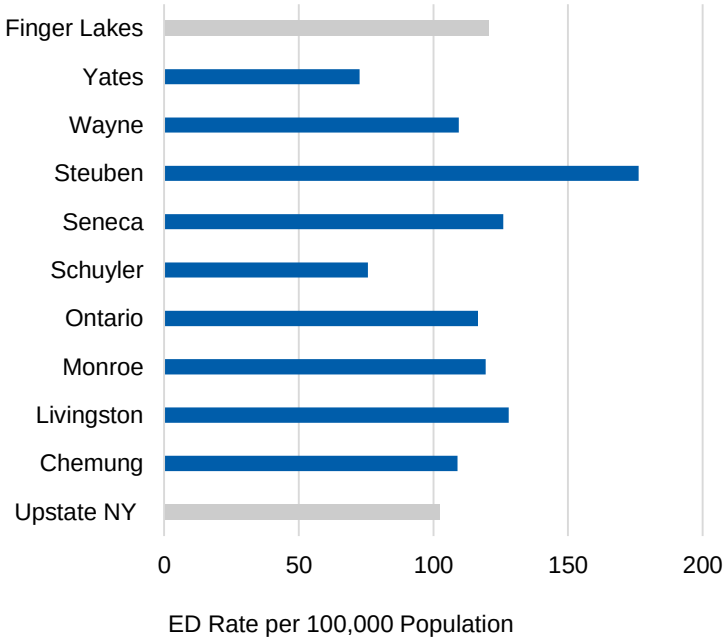
Data Source: SPARCS, 2010-2014

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

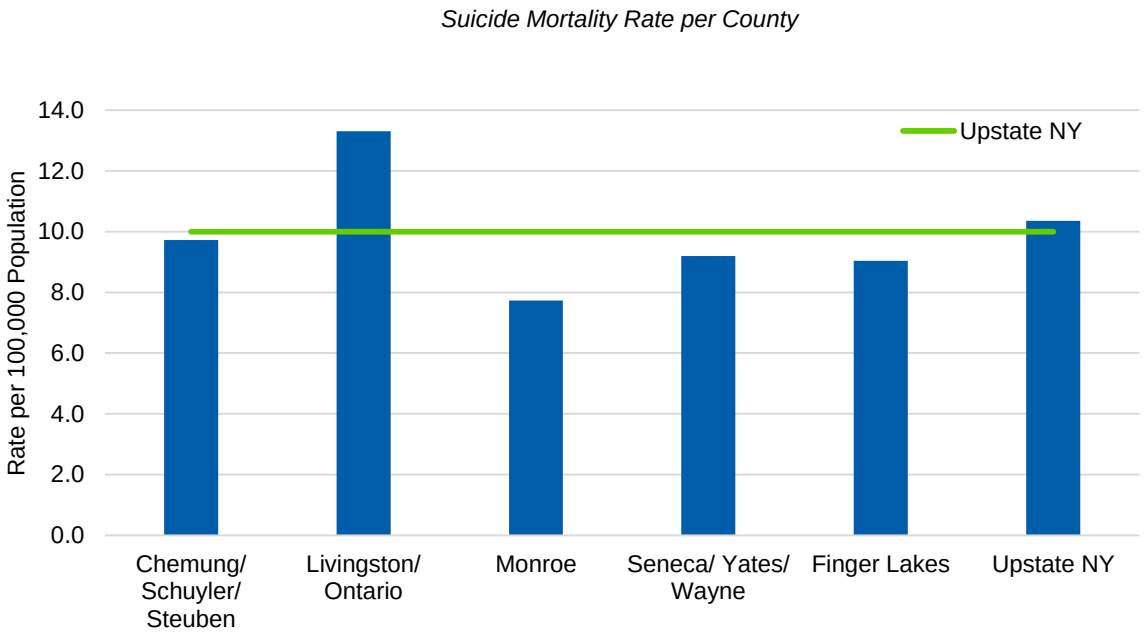




Data Source: SPARCS, 2014

Behavioral Health

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



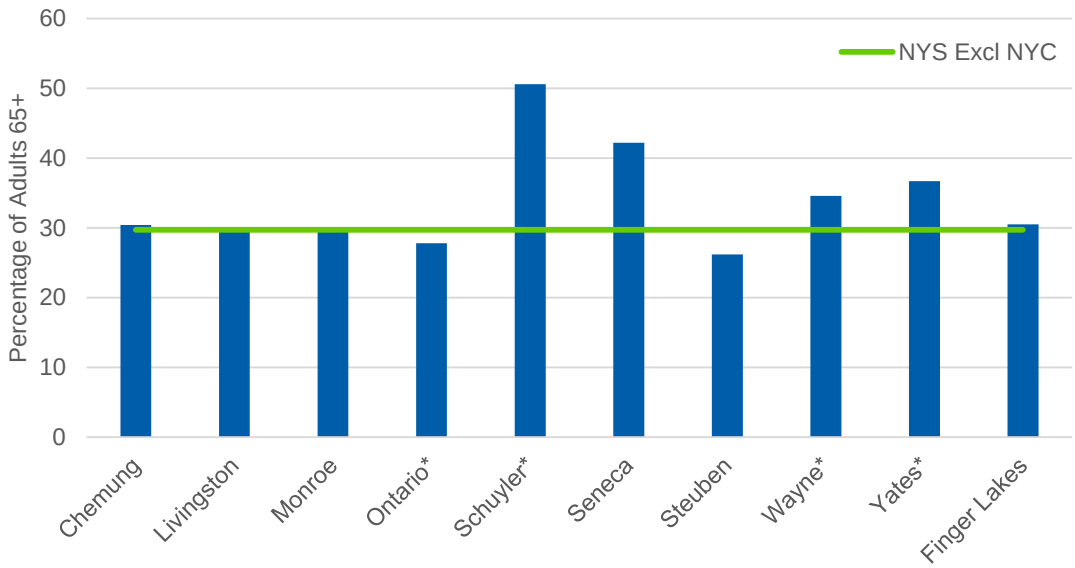
Data Source: New York State Department of Health Vital Statistics, 2013

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

Falls, Slips and Trips

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

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

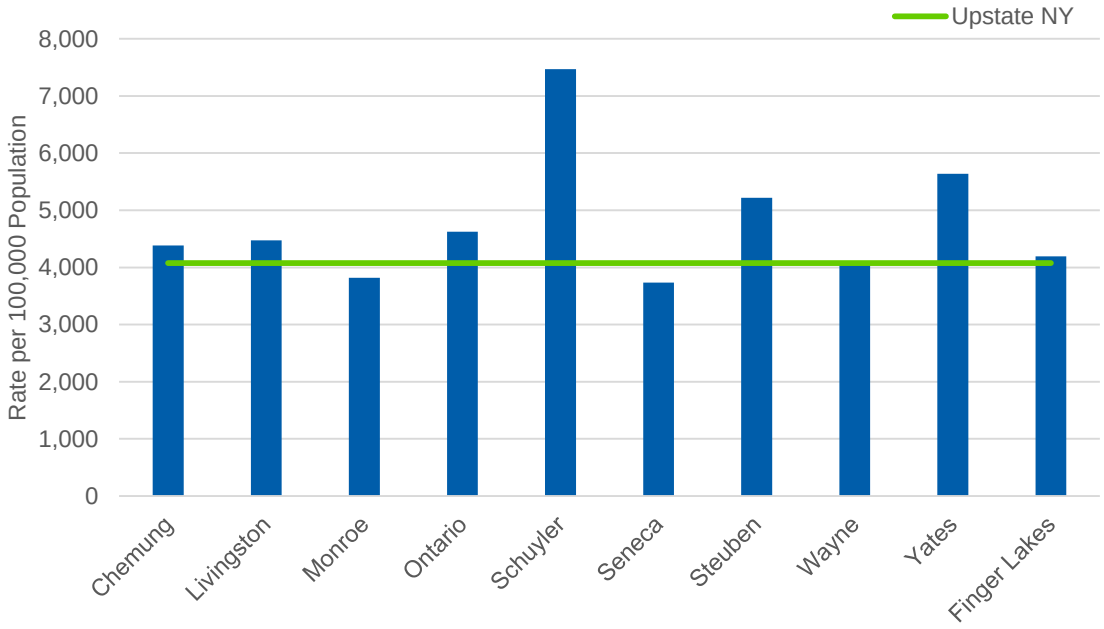


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error

Falls, Slips and Trips

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

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



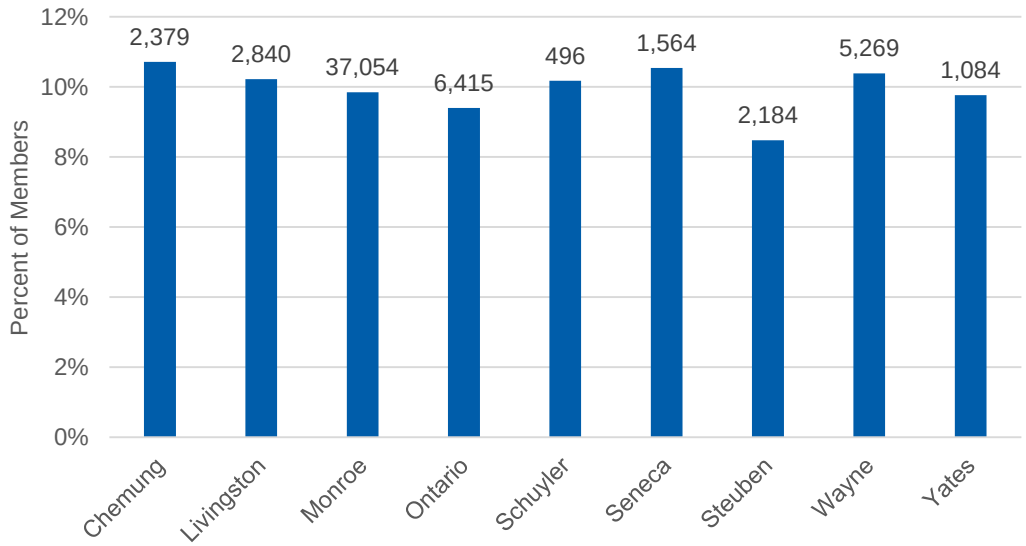
Data Source: SPARCS, 2013

PRIORITY AREA 8: LOW BACK PAIN

Low Back Pain

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

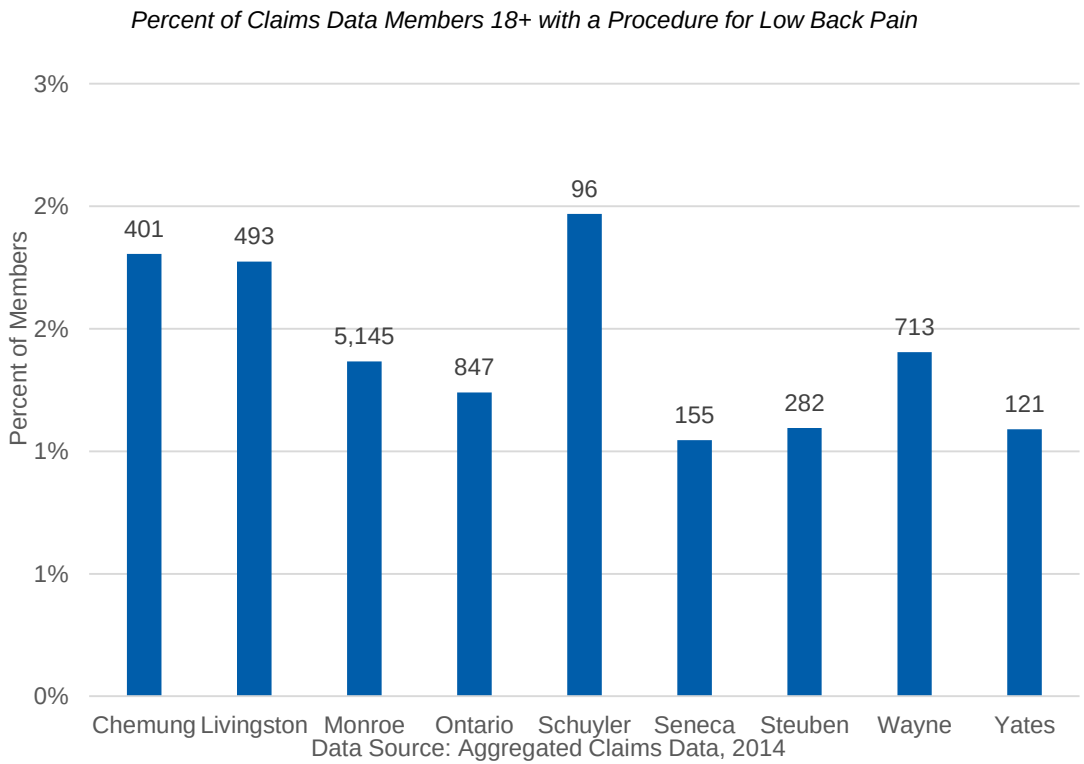
Percent of Claims Data Members 18+ with a Diagnosis for Low Back Pain



Data Source: Aggregated Claims Data, 2014

Low Back Pain

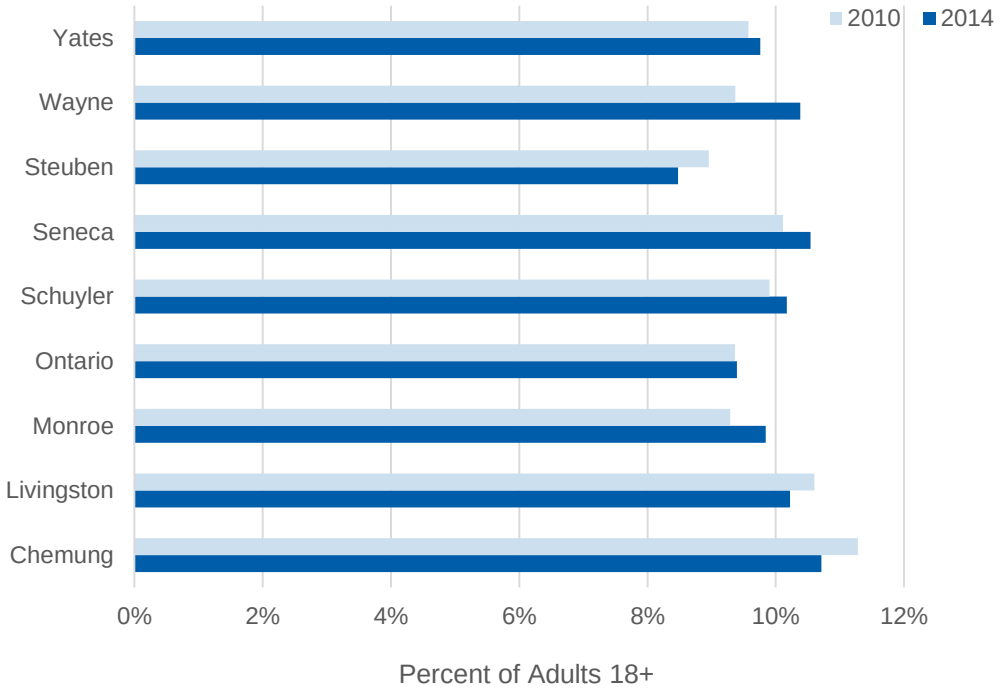
- Percent of the members in the FLHSA claims database with a procedure code for low back pain (i.e. spinal/nerve injections).



Low Back Pain

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

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



Data Source: Aggregated Claims Data, 2010-2014

KEY FINDINGS

Key Findings

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

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

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

www.flhsa.org

QUESTIONS?

FLHSA

Finger Lakes Health Systems Agency

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

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585.224.3101 • www.flhsa.org

Seneca County Health Needs Focus Groups

Agenda

- Welcome & Orientation
- Seneca 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)

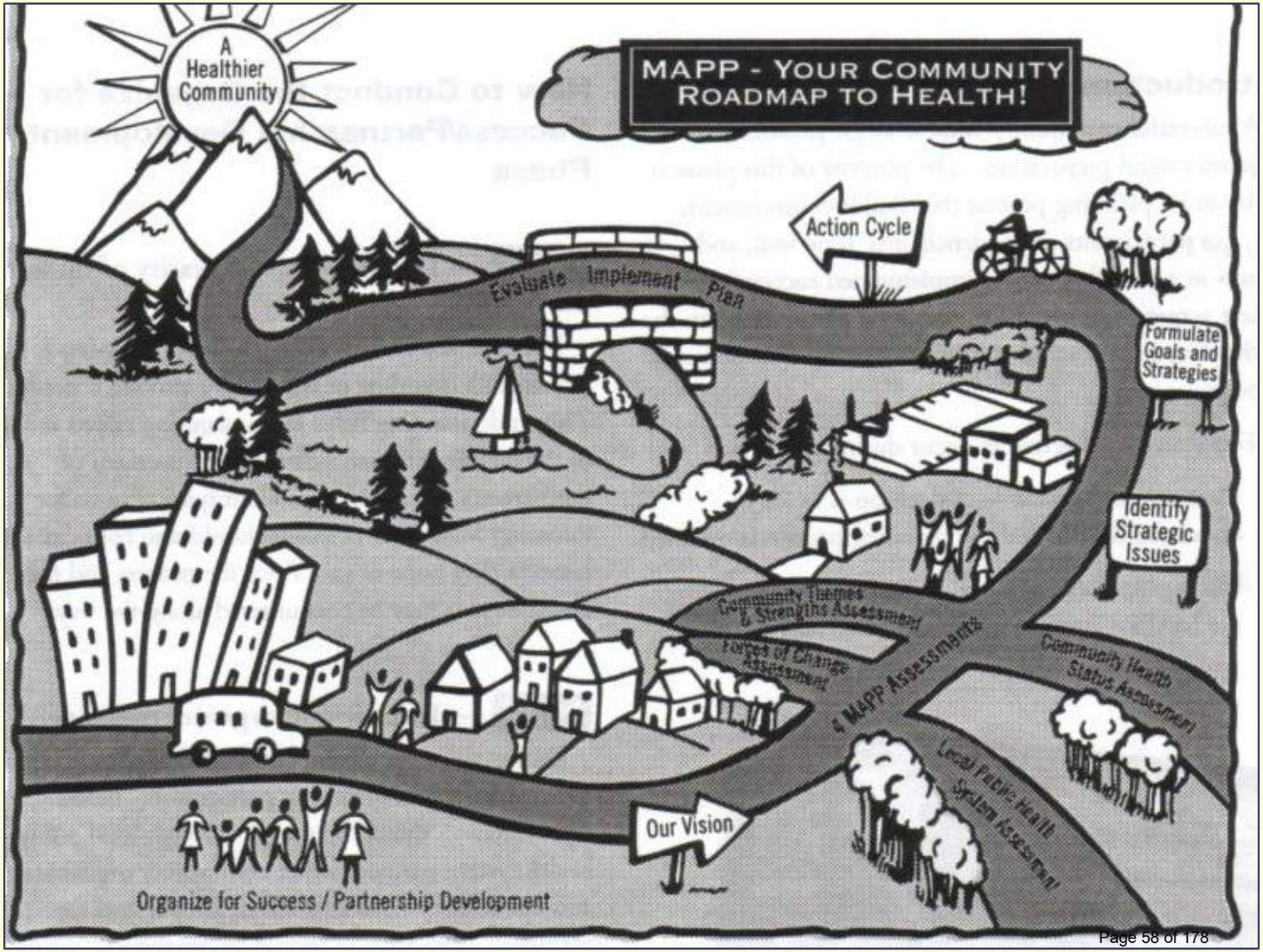
Joint CHA/CHIP/CSP

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

Help!!!!

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

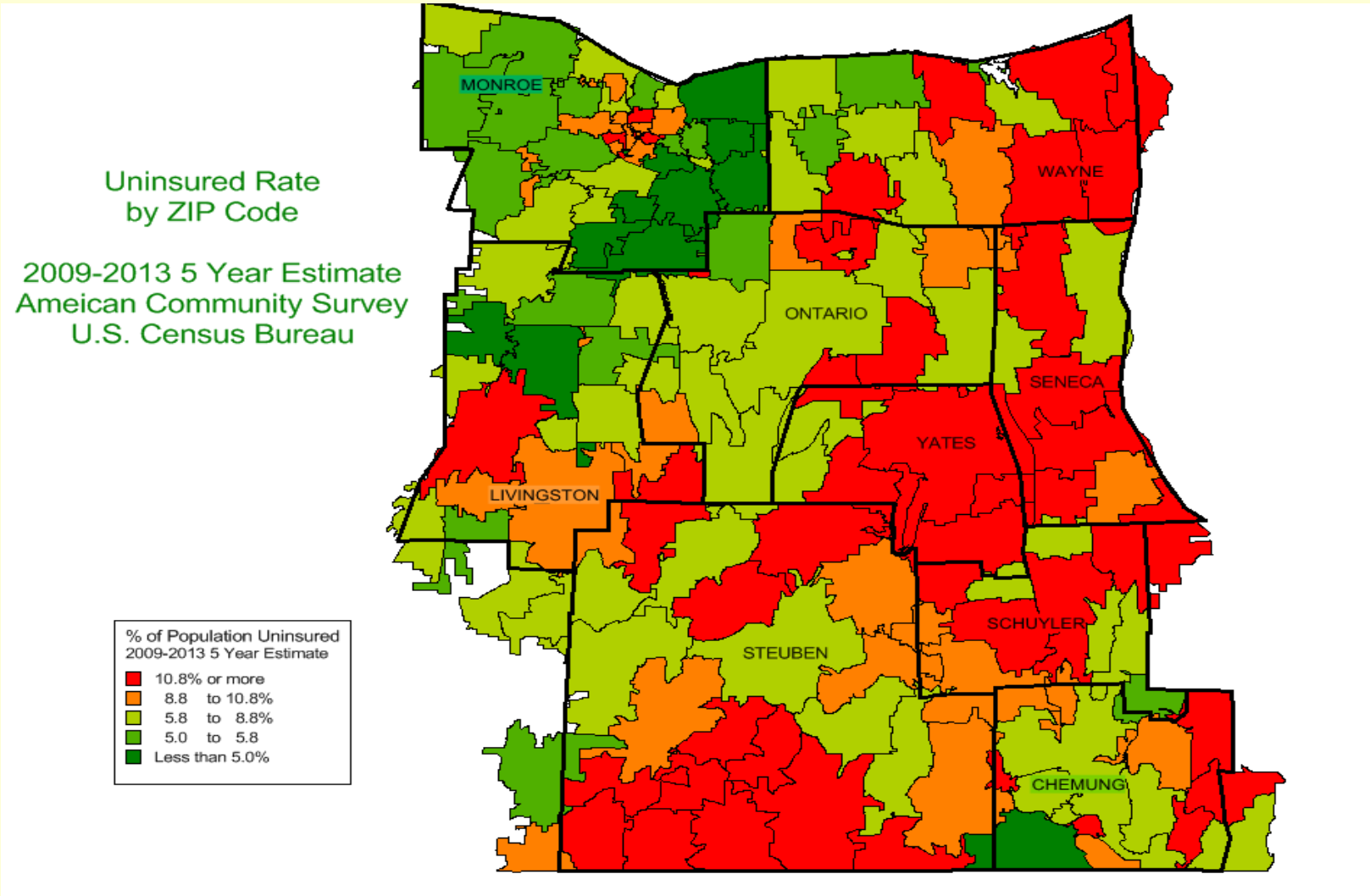
MAPP - Mobilizing for Action through Planning and Partnerships



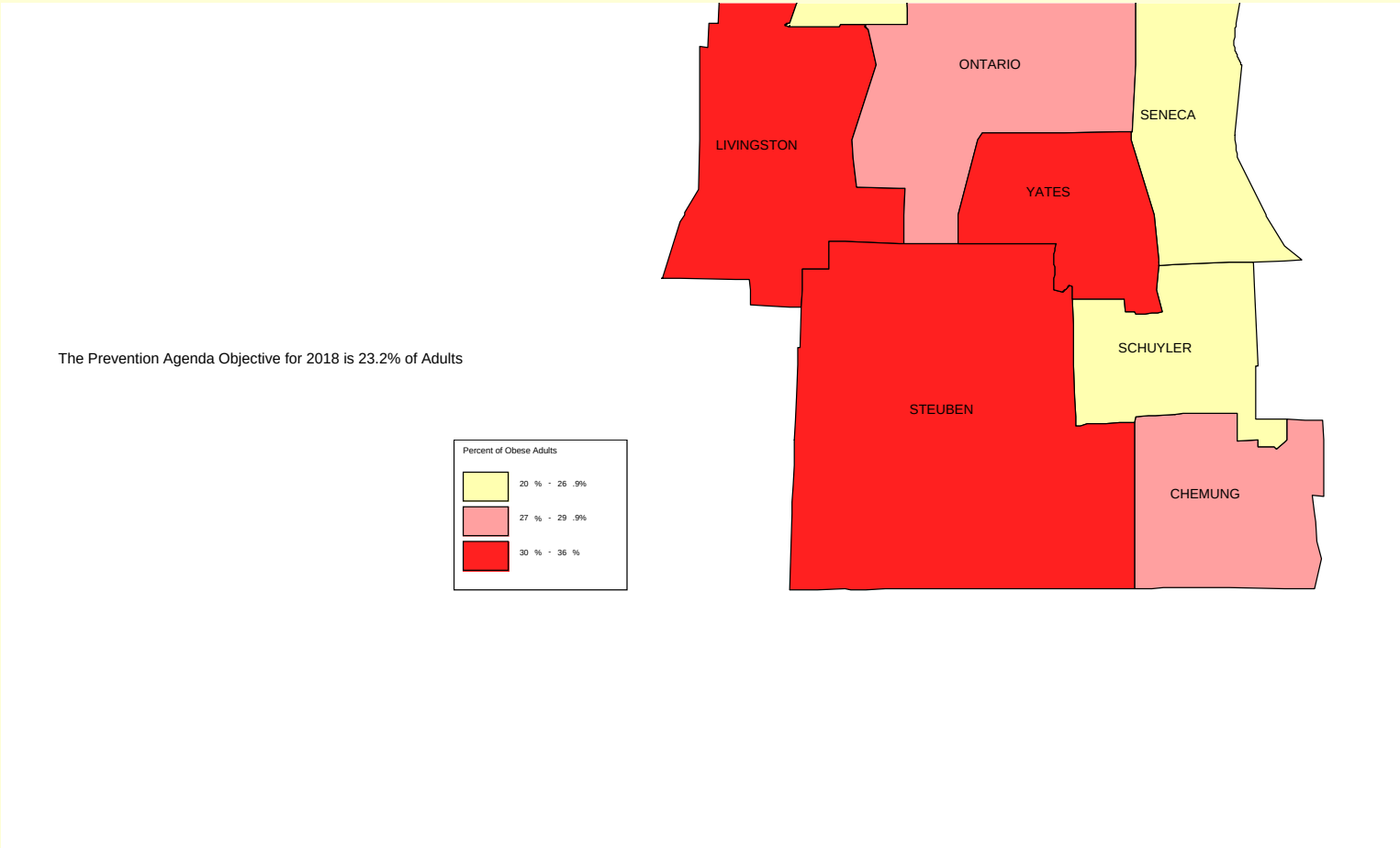
Data says…

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

Data says…high rates of uninsured



Data says: High rates of Obesity 26.9% in Seneca County

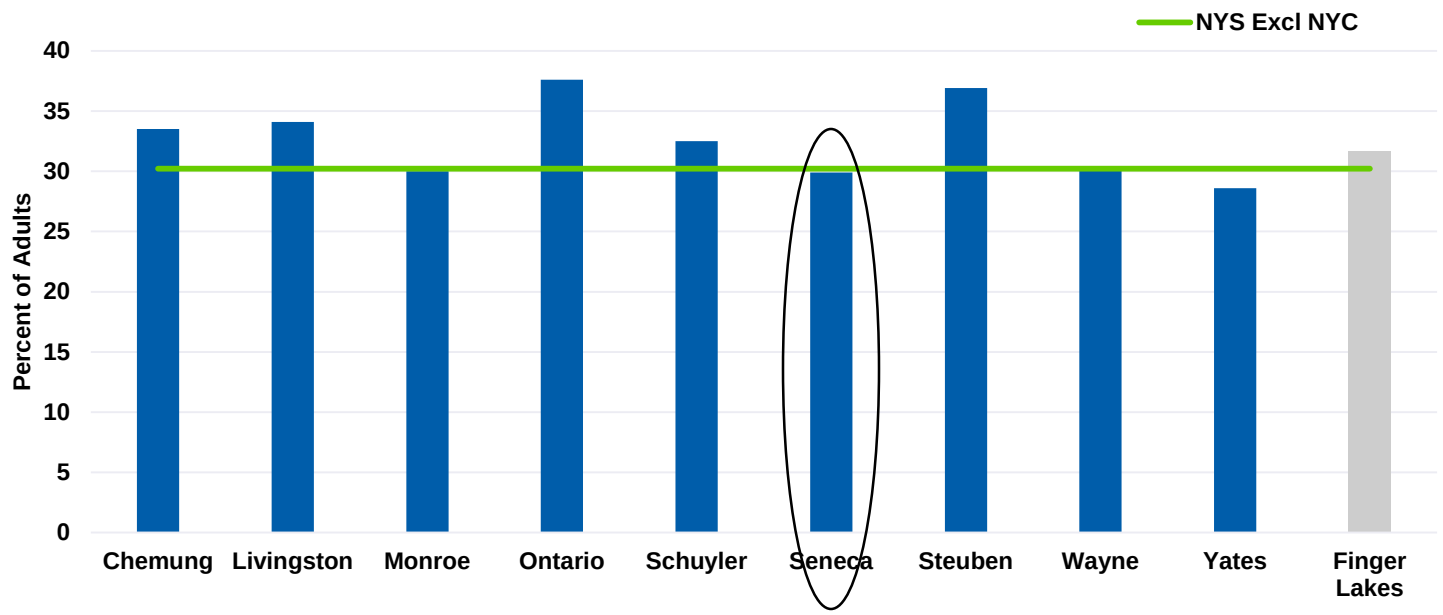


Why is obesity important?

Can lead to many other problems including:

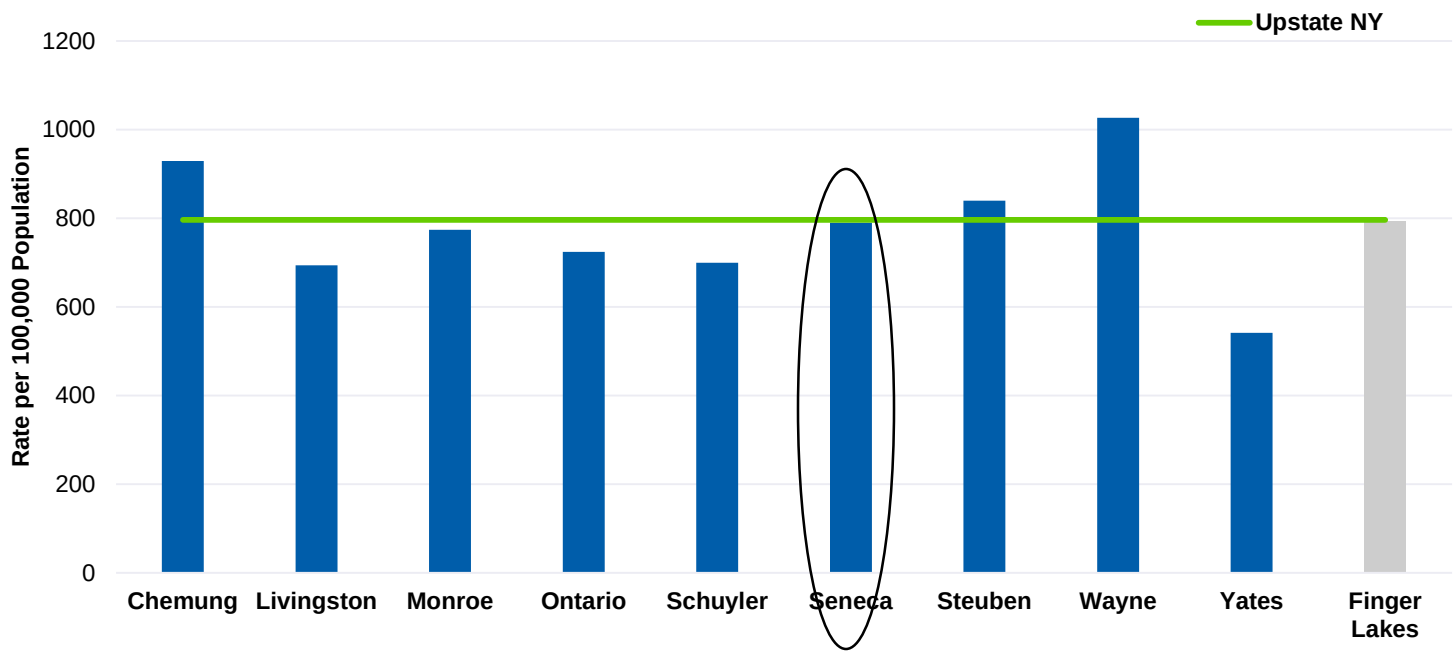
- Heart disease
- Hypertension
- Diabetes
- Lower back pain
- Arthritis
- High cholesterol
- Several forms of cancer
- And in fact, several of these things are also higher than we would like to see them in Seneca County…

Data says…high percentage (30%) of adults with physician-diagnosed high blood pressure



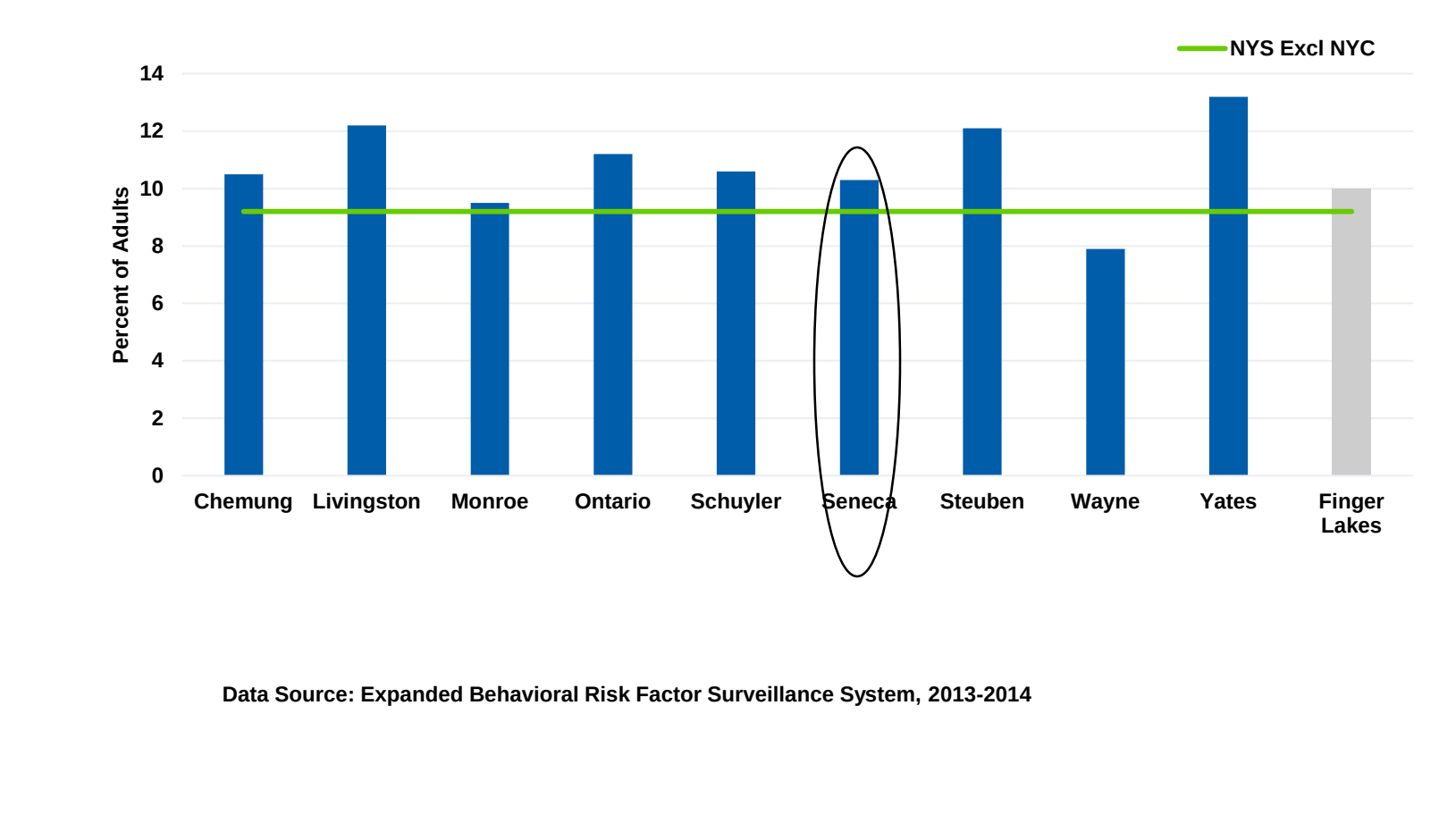
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Data says…. About average for the region for heart disease incidence

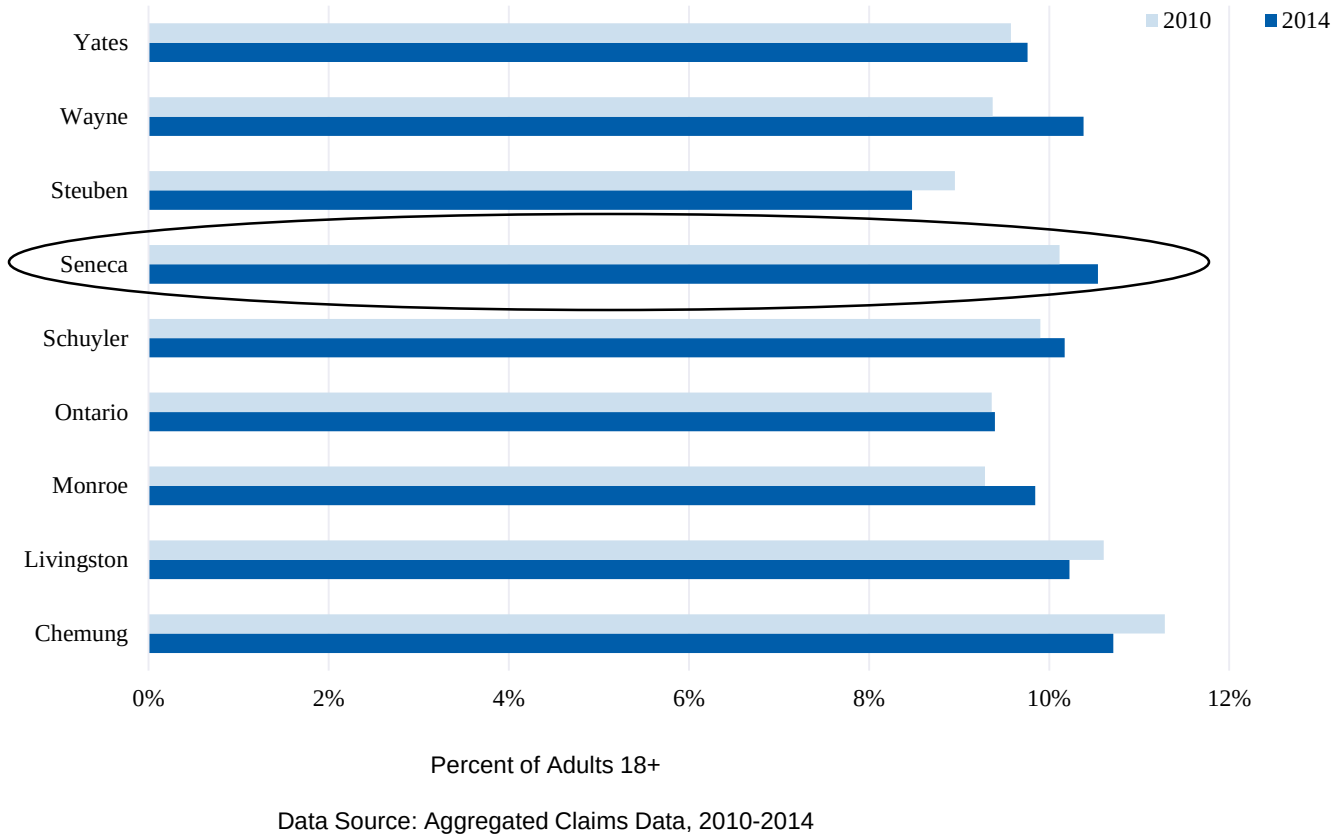


Data Source: SPARCS, 2013

Data says….Percentage of adults with physician diagnosed diabetes – 10.3%



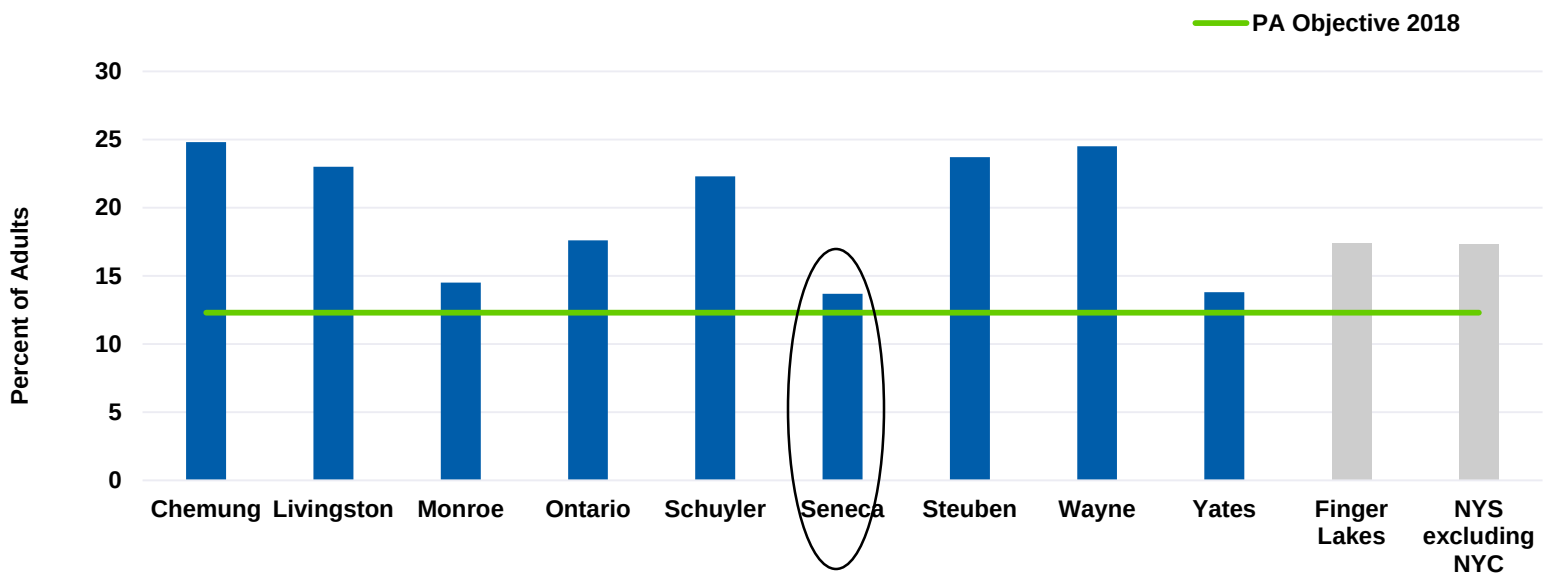
Data says…Percent of Claims Data Members 18+ with a Diagnosis for Low Back Pain, 2010-2014



Other health problems

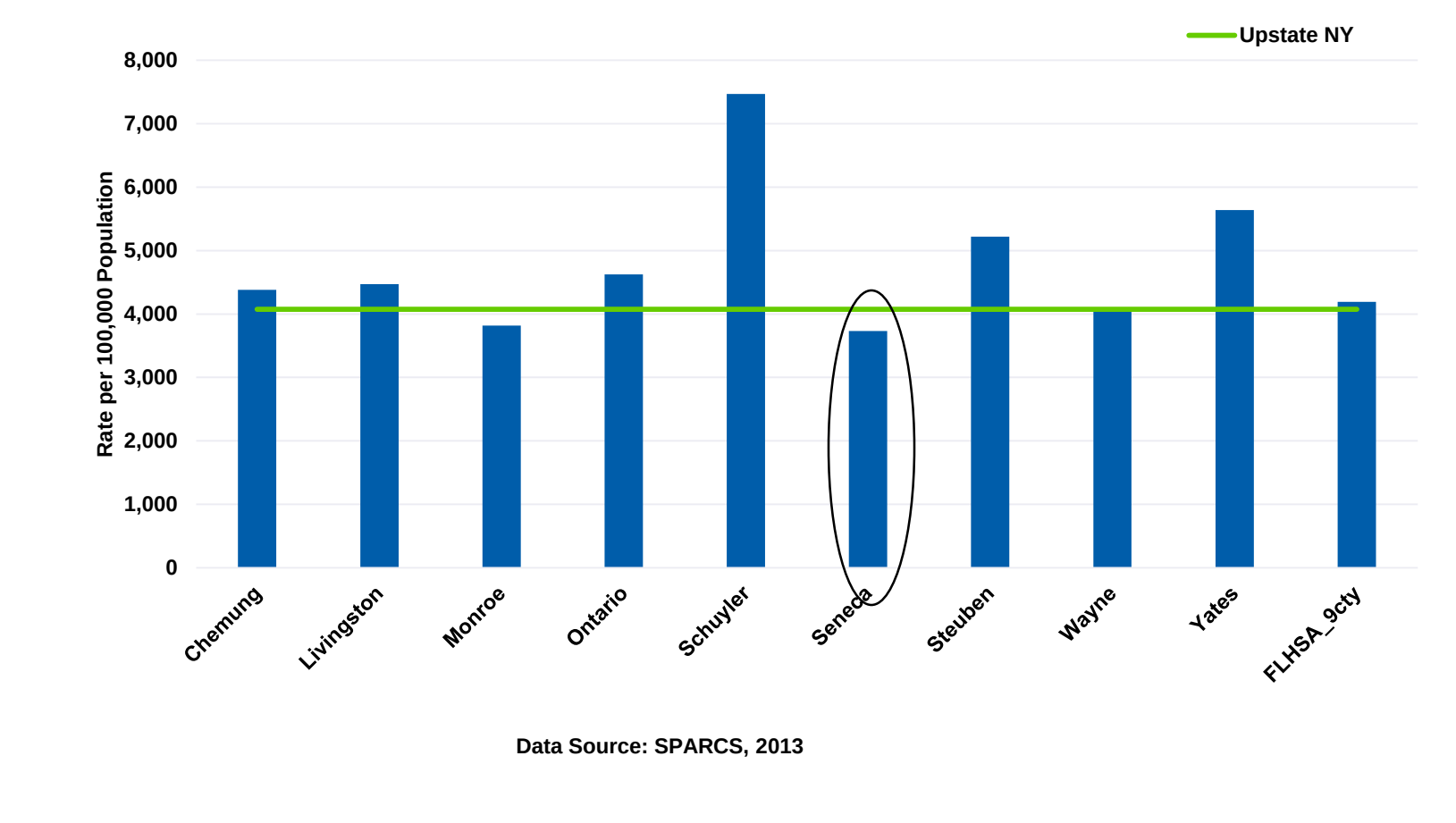
- In addition to obesity and the problems related to that (heart disease, diabetes, hypertension and lower-back pain), there are other problems in the region where we have above average rates:
- Tobacco use- related to cancer, asthma/COPD and hypertension
- Behavioral health problems
- Falls – for the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

Data says… Percentage of cigarette smokers in Seneca County – above objective



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

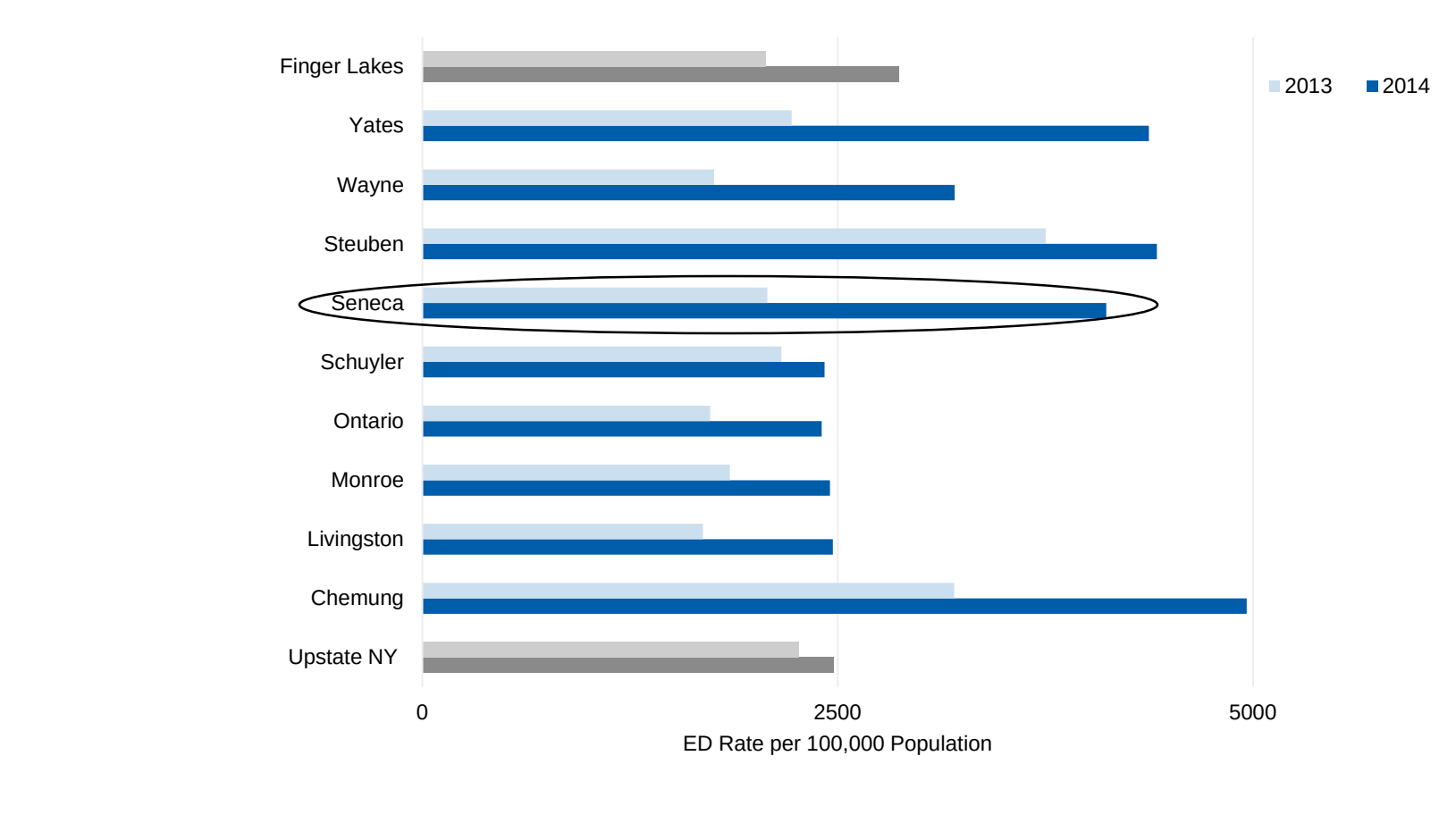
Data says…ED Visits per 100,000 for falls for those aged 65+



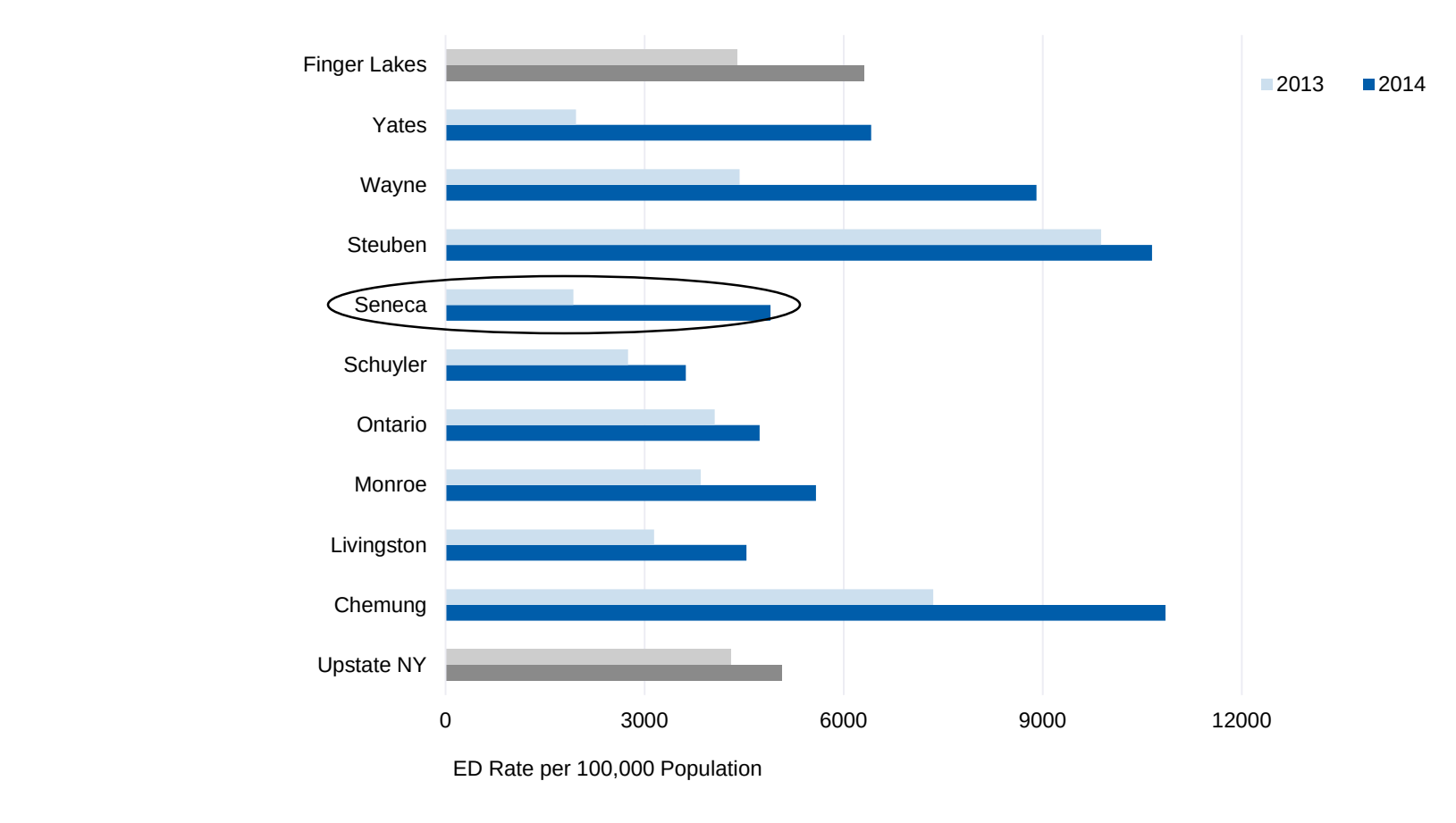
Behavioral Health

- 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

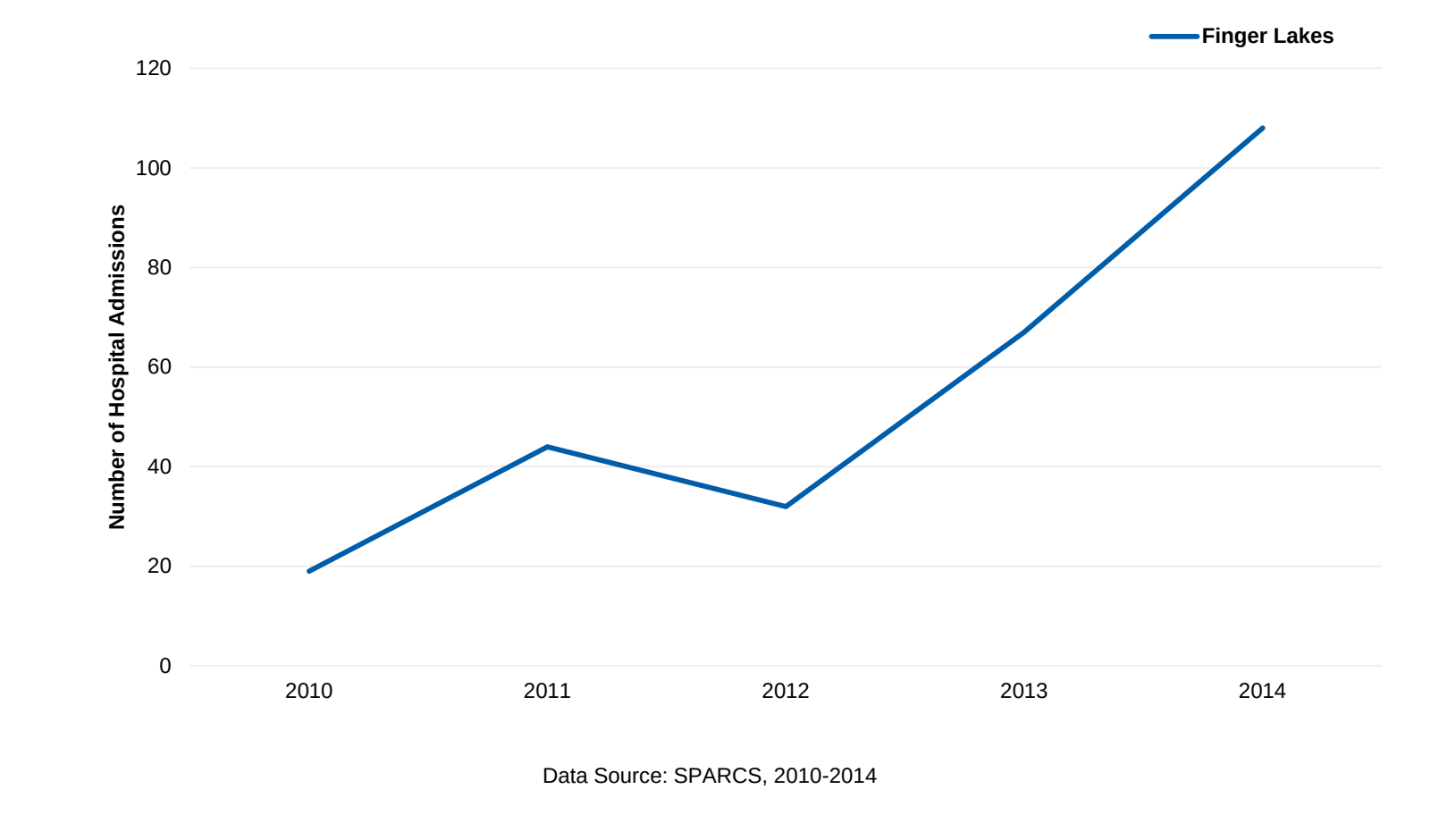
Mental health – ED discharges with a mental health diagnosis



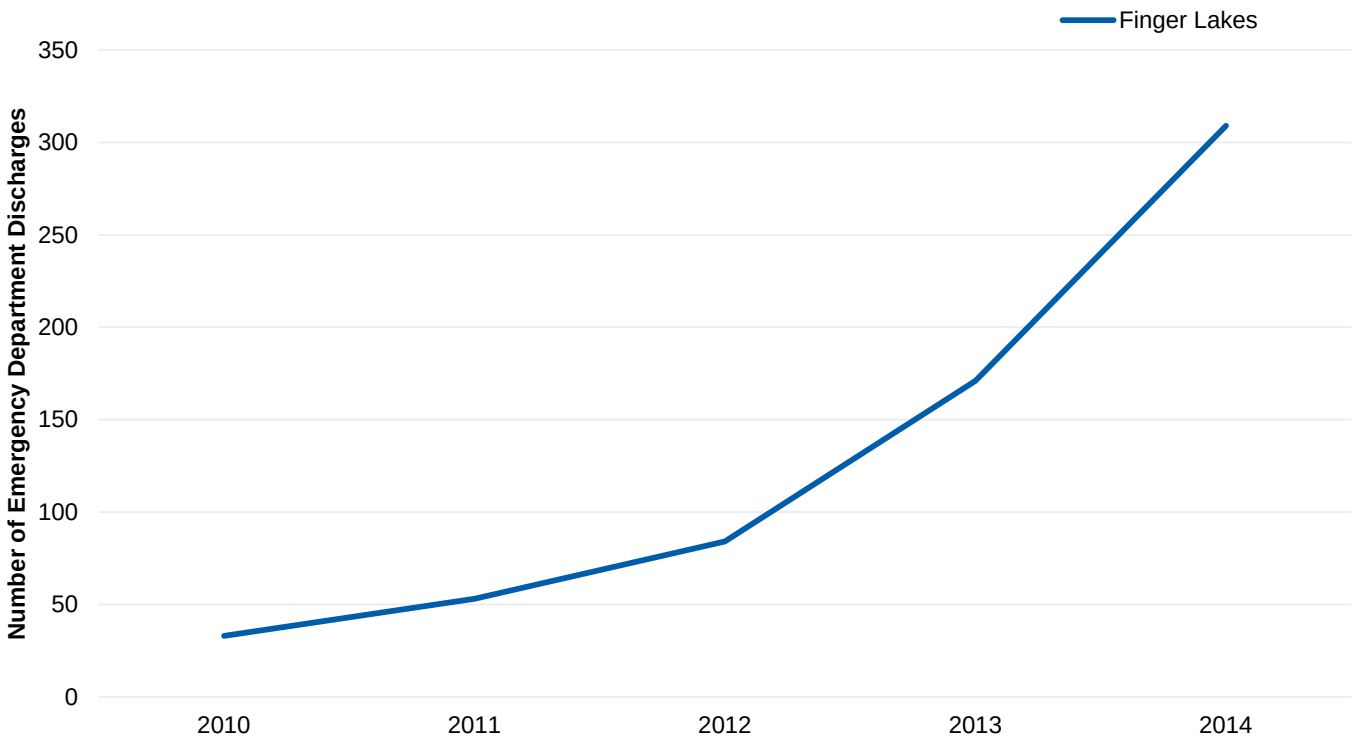
Substance abuse- ED visits with a substance abuse diagnosis



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



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

- BUT- the actual numbers are still fairly small in Seneca County.

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
Seneca Total: 314	Cancer 75 159 per 100,000	Heart Disease 67 134 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 25 51 per 100,000	Stroke 21 45 per 100,000	Unintentional Injury 14 36 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 Seneca 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 Seneca 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 Seneca 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 Seneca 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 Seneca 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 Seneca County Health outcomes!!

Attachment 4

S²AY Rural Health Network, Inc. & Seneca County Public Health

Seneca County Focus Group Summary Data

1. What are we missing in our assessment to date?
    - Birth rates, pediatric data.
    - Return to substance abuse after ED visit.
    - Specific Mental Health diagnosis.
    - STD by age
    - Hepatitis C
    - Breastfeeding
    - Demographic information.
    - Mental Health and Substance Abuse correlation.
    - Pediatric dentistry.
    - Aging population.
    - Heroin use.
    - Physical Activity opportunities.
    - Nutrition.
    - Food deserts.
    - Distance to travel for work.
    - Chronic back pain and correlations.
    - Stress.
    - Drugs.
    - Education level.
    - Smoking rate correlation.
    - Depression.
    - Unintentional injury.
    - Consumption of sugar.
    - Aging disease, Alzheimer's, Dementia.
    - Landfill and effect on health, air quality.
    - Unemployment.
    - Transportation.
    - Amish population.
    - Narcan and its use.
    - Housing.
    - Access to internet.
    - WIC data.
    - Lead data.
    - Vaccinations and immunizations.

2. What words would you use to define health and what terms would you use to define a healthy community?
    - Public Health Department.
    - Attitude.
    - Wellness.
    - Nutrition.
    - Exercise.
    - Doctors.
    - Access to services.
    - Social connectedness.
    - Safety.
    - Nurses.
    - Resources.
    - Schools.
    - Socio-determinants of health.
    - Economy.
    - Crime.
    - Employment.
    - Insurance.
    - Education.
    - Motivation.
    - Outdoors.
3. What trends or factors are influencing the health of the residents?
    - Transportation
    - Mental Health
    - Crack Cocaine usage.
    - Homeless specifically youth.
    - Transient nature of population.
    - Housing
    - Psychiatric
    - Availability of drugs.
    - Public Health.
    - Prevention focus.
    - De-stigmatization.
    - Affordable Care Act.
    - Marijuana legalization.
    - Heroin.

- Lack of information.
- Advertising for sugar and smoking.
- Cost of healthy foods.
- Technology.
- Economic disparities.
- Nutrition.
- Misinformation around health.
- Grow local, eat local.
- Cultural competency.
- Location.
- No hospital in Seneca County.
- Limited providers.
- Water quality.

4. What community strengths or assets contribute to the health of the residents?
    - Collaboration
    - Rural county nature.
    - State parks and outdoor recreation.
    - Gym
    - Law enforcement training for Mental Health.
    - Public Health dept.
    - Non-Profit community health system.
    - Access to specialist care.
    - Telemedicine.
    - Trillium Health.
    - FQHC's.
    - Bilingual staff at providers.
    - Accepting Medicaid for Dental in the County.
    - Agra-education.
    - Farmers markets.
    - Seneca Towns Engaging People for Success (STEPS) Program.
    - Finger Lakes Community Health.
    - Tobacco Education.
    - United Way.
    - Literacy efforts.
    - Youth programs.
    - Cornell Cooperative Extension.
    - Office for the Aging.

- Bus services.
- Forums on community issues.
- WIC expanding program.
- Local dentist through FLCH.
- Libraries.
- Seneca County Substance Abuse Coalition.

5. What would you do to address some of these problems?
    - Raise budgets of organizations and programs.
    - Immediate rehab.
    - Invest in Law enforcement.
    - Community Involvement.
    - Education.
    - Local solutions.
    - Mental Health.
    - More treatment programs.
    - Integrated care for Primary and Behavioral health.
    - Social community groups and activities.
    - Family support.
    - Lower co-pays.
    - Parenting resources.
    - Water testing.
    - Internet use education.

Attachment 5

S²AY Rural Health Network, Inc. & Seneca Public Health

County:	Seneca
Group Name:	STEPS Risers
Date and Time:	March 15, 2016 - 6:00PM
# of Participants:	24

1. What are we missing in our assessment to date?
    a. Unemployment - can contribute to many of the data sets presented.
    b. Transportation is a huge issue. Especially in South Seneca - the issue is critical. There is no public transportation and most people here do not have money to pay for transportation. Many people do not have cars, they cannot afford it. We are putting together a report on transportation, which will be available later this year. Dial a ride is what people use here, you have to call a day ahead... doesn't always work, doesn't help when you need a ride right now.
    c. Demographic issues, there is a large age gap - more elderly. A large Amish population.
    d. As people can more easily get Narcan, the numbers for heroin will go down... due to less being reported. There may be more overdoses, but we will not know about them.
    e. Communication - a lot of people just don't know about resources. Need more education overall - health related. Many people do not have true interest in health education/getting more healthy/etc. Need to get more information to them that is helpful. Need to get information to the general population more effectively.
    f. Community Action Agency is working on a needs assessment as well - could be a great way to collaborate.
    g. General perception that the county puts a roadblock up to getting services/benefits - many feel like it is not "worth the trouble to apply". People always hit hurtles, it's a pain in the neck to apply, so people don't do it. A general feeling that you are not being treated well (when applying for food stamps, Medicaid, etc.). People shy away from even trying to get help because there are always roadblocks and human services does not treat them well.
    h. Housing - took over 10 years to bring more housing to the county. I've tried for years and years, and it's just roadblock after roadblock. We desperately need more affordable, adequate housing.
    i. In general, the southern part of the county has been neglected.
    j. We need a paid advocate - someone to navigate people in the right direction for services. Lead them to the services they need, facilitate their enrollment, etc... and it absolutely has to be local.
    k. Communication - especially access to the internet/cell phones, most people don't have land lines - the cost of cell phones/track phones is expensive (hard for people

to pay). Not everyone has access to the internet (expensive) - and that is where the health information is, people can't get the information.

l. Food - what food is accessible (kinds, types, etc.)? There is nothing in this county for rural populations, particularly south Seneca. There is no where to get fresh, healthy food. Access to food.
m. No place for people in Ovid to use WIC - no stores will take WIC (must go to Trumansburg or Seneca Falls). Very frustrating for young mothers. Many don't have cars - they can't get to the stores that take WIC.
n. Lead - water issues, old plumbing, salinity of the lakes rising. Need to test water and fix the issues.
o. Level of vaccinations in the county - needs to be part of the assessment.

2. What trends or factors are influencing the health of the residents?
   a. Location matters - you only have north and south, no east and west - so half gone. The lake cuts us off from anything east or west, which is a huge factor. Anything you want to do, you have to go north and south.
   b. Seneca County doesn't really have a hospital to go to. We don't deliver babies any more.
   c. We don't have enough doctors. Limited availability of providers. Need a one-stop shop like Lifecare (can get everything done at one facility).
   d. Increase in the number of produce stands. I see more people exercising - bicycling, walking, etc.
   e. Levels of literacy - very low.
   f. Water issues - salinity is rising in the water. Lakes are both an asset and a threat.
   g. People don't know how to cook healthy food. Ned to be taught. Need more classes.
3. What community strengths or assets contribute to the health of the residents?
   a. Local farm stands. Access to outdoors. Physical activity.
   b. WIC - up to $12 for fruits and vegetables, they are expanding - great thing.
   c. Amazing as a rural county - sense of community and social ties are much greater.
   d. Mobile WIC is an asset.
   e. A lot of people have benefited from having the dentist (Community Health Center) in the area - is actually a really good place to get resources, easy to use, and very helpful. There is more than just dental - which is great.
   f. The STEPS Program - it is addressing our health (nutrition, exercise), economy, and environment. We have a tremendous amount of resources and information for you. People need to just get more involved.
   g. Seneca County has some really good public libraries. Libraries have classes on internet use.
   h. Some gyms and yoga classes available.

i. Have a Seneca County substance abuse coalition - tremendous organization. Has been working tirelessly to help.

4. What would you do to address some of these problems?
   a. People have to read - there is a lot of information published. People need to take time to read. We give out a lot of information, but people don't take the initiative to read.
   b. Getting water tested and knowing what your plumbing is - could really influence health.
   c. Need literacy in the internet - teach people how to use the internet, how to do searches, what to search for - the information is there, but many don't know how to get it.

S²AY Rural Health Network, Inc. & Public Health

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

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

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

   Wayne

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

   Seneca

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

   Ontario

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

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

   Wayne

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

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

Seneca

r. Trash being transported from NYS

Ontario

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

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

Wayne

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

Ontario

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

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

Wayne

a. Schools need to take away children's cell phones during school
b. Need more discipline in schools

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

Ontario

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

S²AY Rural Health Network, Inc.
&
Seneca Public Health

County:	Seneca
Group Name:	Criminal Justice Advisory Board
Date and Time:	April 18, 2016 - 12:00PM
# of Participants:	16

1. What are we missing in our assessment to date?
    a. Birth rates. Things we run into with young children.
    b. People who went to ED for substance abuse overdoes but went back to using.
    c. Mental health and the diagnosis.
    d. STD's and the age correlation.
    e. Hep C and the usage /diagnosis. Trillium has been great in the education part for working in jails. Going forward data surrounding Hep C would be essential.
2. What trends or factors are influencing the health of the residents?
    a. Transportation is a barrier for the clientele I serve. It's a barrier for services to be received. Mental Health services are really low.
    b. Crack has been coming up again. Mental Health has been huge amongst young kids these days. Interested in the data surrounding mental health.
    c. Homeless youth. 16, 17, 18 technically adults but not quite. A lot of couch surfing. Coming from outside the county. Some come out of Hillside.
    d. Transient families. Younger families constantly moving around. Kids that are enrolled in EI and CPSE which have to be changed between counties causing the kids to become lost in the program.
    e. Housing is a huge need in this area. Psychiatric care is lacking.
3. What community strengths or assets contribute to the health of the residents?
    a. Partners that are willing to collaborate in successful programs.
    b. It is beneficial to be a small rural county due to knowing other resources.
    c. State Parks and outdoor recreation.
    d. Gym memberships are free to community members.
    e. The trend of law enforcement being trained around helping folks with mental health issues and handing them off with a warm hand.
4. What would you do to address some of these problems?
    a. Health Department does a great job with what they have. Raising the budget of the Public health department. More inpatient treatment for drug abuse.
    b. Need immediate action for folks that need rehabilitation. Need the ability for the treatment within the state.
    c. Limited in the amount of law enforcement surrounding narcotics. An investment in the law enforcement is an area that should be looked at.

S²AY Rural Health Network, Inc.
&
Seneca Public Health

County:	Seneca
Group Name:	OFA Nutrition Site
Date and Time:	April 21, 2016 – 11:30AM
# of Participants:	13

1. What are we missing in our assessment to date?
    a. Nothing, covered everything
    b. Data around memory loss - dementia and Alzheimer's
2. What trends or factors are influencing the health of the residents?
    a. Education on dementia and Alzheimer's - is it normal memory loss due to aging or is it something more?
    b. Heroin affecting families - it affects everyone in a person's life
    c. If you don't have a computer, you are almost at a disadvantage nowadays - don't get the online advertisements, can't looks things up as easily
    d. Many people are not motivated to get out
    e. Parents giving children things they aren't supposed to have - cool aid in their bottles, bad foods, etc
3. What community strengths or assets contribute to the health of the residents?
    a. OFA and their programs
    b. Line dancing at the OFA
    Physical activity programs through the OFA
    c. Case workers at OFA
    d. Bus service is great for me
    e. Forums on heroin
4. What would you do to address some of these problems?
    a. Increase the price of heroin
    b. Lower co-pays - more people would go to the doctor before they get sick
    c. Increase access and availability of health services
    d. Law enforcement to go into the schools and teach the younger children about the drugs - need more programs like that - more engagement from law enforcement
    e. Need to start teaching the kids young about drugs
    f. Have someone in recovery come to the school to talk to the kids
    g. Need separate forums for adults and children on heroin
    h. Education on proper nutrition, parenting, starting at a young age

S²AY Rural Health Network, Inc.
&
Seneca Public Health

County:	Seneca
Group Name:	Seneca Health Solutions Meeting
Date and Time:	May 05, 2016 - 2:00PM
# of Participants:	13

1. What are we missing in our assessment to date?
    a. Physical Activity information or lack of.
    b. Pediatrics data and how it affects health.
    c. Fruit and vegetable intake? Nutrition.
    d. Access to fresh food. Good food.
    e. Distance to drive to work. Sedentary lifestyle issues. Use of opioids related to chronic back pain. How does that relate or correlate with Heroin and Opioid use?
    f. Stress and mental health.
    g. Drug seeking and behaviors related to those.
    h. Educational percentage of individuals with advanced degrees such as college. Availability of educational materials and how those correlate with socioeconomic factors.
    i. High school graduation rates.
    j. Higher education correlates with lower smoking rates.
    k. Depression among children and adults.
    l. Unintentional injury.
    m. Consumption of sugar sweetened beverages and how they correlate with chronic diseases. Adult and children.
    n. Senior health and the issues they face.
    o.
2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Access
    b. Socio-determinants of health.
    c. Overall wellness.
    d. Economy.
    e. Low crime rates.
    f. Employment.
    g. Insured.
    h. Education.
    i. Motivation to be healthy.
    j. Outdoor recreation.
    k.
3. What trends or factors are influencing the health of the residents?

a. Heroin usage and opioids.
b. Lack of information around drug use.
c. Lack of services for mental health.
d. Advertising of sugar sweetened beverages and junk food, and the amount of funding for those rather than proper nutrition.
e. Advertising for tobacco use.
f. Cost of healthy nutrition alternatives.
g. Technology.
h. Economic disparities and equity.
i. Lack of knowledge around how to cook/prepare food.
j. Misinformation and education, overcoming bias or prejudice. Specific to obesity and medical providers not acknowledging that it is a disease and issue.
k. Local food kick. Grow local eat local. Farmers markets.
l. Growing environmental awareness.
m. Good technology such as wearables and physical activity apps. Agra-education.
n. Language and communication. Cultural competency.

4. What community strengths or assets contribute to the health of the residents?
    a. Agra-education.
    b. Farmers markets and road side stands, local growers.
    c. STEPS, Substance Abuse coalition and the funding that supports those.
    d. Access to care, Finger Lakes Community Health Ovid Center.
    e. Tobacco education.
    f. United Way.
    g. Public Health.
    h. Transformation and community impact that organizations are having. Collaboration between organizations and efforts.
    i. Literacy efforts, Women's Leadership Council. Resulting to higher education.
    j. Strong Youth based sports community in Seneca County. Baseball, football, etc.
    k. CCE and state grants that bring money into programs, Farm 2 School and Creating Schools and Healthy Communities.
    l. Strong independent community health system.
5. What would you do to address some of these problems?
    a. Educational programs around nutrition and physical activity. And Cooking.
    b. Focusing on local solutions.
    c. Better environment for people to seek out mental health services.
    d. Less waiting list for treatment programs, whether or not mental or addiction treatment. Insurance buy-in to cover these programs.
    e. Do we have efficient number of doctors to treat these issues?
    f. Integrated care from behavioral health and primary care.

g. More social community groups or events for support. Less people are attending church or social events.
h. Youth involvement and family involvement. Youth as problem solvers.

S²AY Rural Health Network, Inc.
&
Seneca Public Health

County:	Seneca
Group Name:	Seneca Health Advisory Committee
Date and Time:	May 19, 2016 - 12:00PM
# of Participants:	7

1. What are we missing in our assessment to date?
    a. Breakdown of mental health diagnosis, in regards to MCH, psychosis and post-partum depression.
    b. Breastfeeding and how it correlates.
    c. Demographic information, specifically aging population.
    d. Identify number of people with mental health illness and are also suffering from substance abuse.
    e. Pediatric dentistry data.
    f. Senior aging issues.
    g. Opiate abuse specifically, Heroin.
2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Public Health Department.
    b. Attitude about Health. What does it mean to you?
    c. Wellness.
    d. Nutrition.
    e. Exercise.
    f. Doctors.
    g. Access to services.
    h. Social connectedness.
    i. Safety.
    j. Nurses.
    k. Resources.
    l. Schools.
3. What trends or factors are influencing the health of the residents?
    a. Availability of narcotics.
    b. Department of Public Health, has had a tremendous change over the years and increased community engagement. Efforts towards wellness and collaboration.
    c. Focusing on Population Health rather than direct services. Prevention focus rather than treatment focused.
    d. Stigma around provided services and prevents people from accessing these services. Prejudice from providers towards patients.
    e. Affordable Care Act and lack of coverage. Access to services.

   f. Social norms around acceptance of Marijuana, No Big Deal attitude, legalization is creating issues with education.
4. What community strengths or assets contribute to the health of the residents?
   a. Public Health Department.
   b. Strong non-profit community health system.
   c. Access to specialists at a local level.
   d. Telemedicine.
   e. Collaborative efforts within the county.
   f. Trillium Health being in close proximity.
   g. FQHC's.
   h. Bilingual staff at providers.
   i. Accepting Medicaid Dental in this county.
5. What would you do to address some of these problems?
   a. More community involvement.
   b. More education provided to the community, not aware of provided services.
   c. More funding and resources.

S²AY Rural Health Network, Inc.
&
Seneca County Public Health

County:	Seneca
Group Name:	Board of Health - Seneca County Public Health
Date and Time:	May 18, 2016 at 4:00PM
Attendees:	10 attendees (5 males, 5 females)

1. What are we missing in our assessment to date?
   -Rates of insurance - how much they have increased over time (Excellus proposing over an 11% increase for next year)
   -Data on oral health
   -Data on access to dentists, particularly pediatric dentists
   -Data on air quality - COPD rates are very high, look more into that (a lot of concern around the dump/landfill)
   -Data on cancer - leading cause of death, look at zip code specific data, and by types of cancers (particularly types across zip codes)

2. What words would you use to define health and what terms would you use to define a healthy community?
   -Walkability
   -Neighborliness
   -Farmers markets
   -Bikeability
   -Access to physical activity opportunities (pools, centers, etc.)
   -Repaired sidewalks, benches, etc.
   -Useable space
   -Effective public transportation - routes that work for people, goes where they need to go, etc.
   -No traffic concerns
   -Network of support for home health - keeping people healthy and in their homes
   -Educated community
   -Less school bullying
   -No access to untaxed cigarettes

3. What trends or factors are influencing the health of the residents?
   -Access - getting people to see specialists is difficult (have to go to Rochester a lot)
   -Proximity to dump
   -Access to untaxed cigarettes
   -No fluoridated water
   -Increased organized crime (gangs, trafficking routes, etc.)
   -Community attitudes around underage drinking/drug use - social norms

-Safety concerns - increased drug use and crime on the trails

4. What community strengths or assets contribute to the health of the residents?
   -Wetlands
   -A lot of outdoor space and trails
   -Has a decent public transportation system for such a rural, small county
   -Rural setting is an asset - pastoral
   -Schools and churches
   -Health department
   -A lot of volunteer groups to support the community
   -Chiropractic College - great to have here, big employer
   -Employment opportunities in health
   -A lot of collaboration around issues that impact health - food pantries, housing, substance abuse, etc.
   -People are waking up some lately - more people are getting involved, advocating, understanding the need to be an advocate in a positive and productive way

5. What would you do to address some of these problems?
   -Increase funding for the health department
   -Fluoridated water
   -More specialists - increased access
   -Close the dump/landfill
   -More education
   -Funding for things that influence health - physical activity programs, smoking cessation, weight loss programs - all evidence based and work, but have to find someone to pay for them
   -Creating an active community - changing the culture of health
   -Facilitate the growth/expansion of trails - offering tax breaks to property owners that are right next to the trail

S²AY Rural Health Network, Inc. & Seneca County Public Health

County:	Seneca
Group Name:	Lyons Club - Ovid Federated Church
Date and Time:	May 18, 2016 at 7:00PM
Attendees:	23 (18 males, 5 females)

1. What are we missing in our assessment to date?
   -Data by drug- separate them out
   -Data on the incarcerated
   -Data on the Mennonite/Amish population
   -Data on unemployment
   -Data on STDs

2. What words would you use to define health and what terms would you use to define a healthy community?
   -Age
   -Physical health
   -Well being
   -Nutrition
   -Education

3. What trends or factors are influencing the health of the residents?
   -Lead in the water - old pipes
   -Unemployment
   -STEPS - positive impact on social, mental, and physical health
   -Hazardous fumes coming out of Seneca metals
   -Aging population - "retirement county"
   -Health insurance as a system - we have to pay for everything, inmates/incarcerated get everything for free

4. What community strengths or assets contribute to the health of the residents?
   -STEPS
   -Finger Lakes Community Health Center in Ovid
   -Lyons Club - eye screenings for young children
   -Air quality good in this part of Seneca county

5. What would you do to address some of these problems?
   -Open psych center - would employ people, would get people off the streets, get people out of jails
   -Take a look at graduating classes - see how many stay in Seneca County

-Change the system as a whole - inmates/incarcerated get everything for free (health insurance, etc.), we have to pay for everything

S²AY Rural Health Network, Inc. & Public Health

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

Seneca 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	9	3	0	0	12
Develops collaborative networks for health promotion activities that facilitate healthy living in healthy communities	9	2	1	0	12
Assesses the appropriateness, quality and effectiveness of health promotion activities at least every 2 years.	10	1	1	0	12
Total Respondents	12				

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).	9	3	0	0	12
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.	7	5	0	0	12
Establishes and maintains a comprehensive directory of community organizations.	8	3	1	0	12
Uses broad-based communication strategies to strengthen linkages among LPHS organizations and to provide current information about public health services and issues.	7	4	1	0	12
Total Respondents	12				

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.	9	3	0	0	12
Assure the establishment of a broad-based community health improvement committee.	11	1	0	0	12
Assesses the effectiveness of community partnerships in improving community health.	10	2	0	0	12
Total Respondents	12				

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.	7	4	1	0	12
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	2	0	0	12
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.	9	3	0	0	12
Total Respondents	12				

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.	7	3	1	1	12
Provide opportunities for all personnel to develop core public health competencies.	8	2	1	1	12
Provide incentives (e.g. improvements in pay scale, release time, tuition reimbursement) for the public health workforce to pursue education and training.	2	4	3	3	12
Provide opportunities for public health workforce members, faculty and student interaction to mutually enrich practice-academic settings.	6	1	3	2	12
Total Respondents	12				

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.	5	3	3	1	12
Promote collaborative leadership through the creation of a local public health system with a shared vision and participatory decision-making.	6	4	1	1	12
Assure that organizations and/or individuals have opportunities to provide leadership in areas where their expertise or experience can provide insight, direction or resources.	6	4	1	1	12
Provide opportunities for development of diverse community leadership to assure sustainability of public health initiatives.	3	8	0	1	12
Total Respondents	12				

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.	5	6	0	1	12
Promotes the use of geocoded data.	4	7	0	2	12
Uses geographic information systems.	5	6	0	2	12
Uses computer-generated graphics to identify trends and/or compare data by relevant categories (e.g. race, gender, age group).	5	4	1	2	12
Total Respondents	12				

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.	9	3	0	0	12
Active infectious disease epidemiology programs.	11	1	0	0	12
Access to public health laboratory capable of conducting rapid screening and high volume testing.	7	5	0	0	12
Total Respondents	12				

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.	11	1	0	0	12
Develops a plan that defines organizational responsibilities, establishes communication and information networks, and clearly outlines alert and evacuation protocols.	11	1	0	0	12
Tests the plan each year through the staging of one or more “mock events.”	11	1	0	0	12
Revises its emergency response plan at least every two years.	11	1	0	0	12
Total Respondents	12				

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	12	0	0	0	12
Develops written epidemiological case investigation protocols for immediate investigation of:	10	1	0	1	12
Communicable disease outbreaks	11	0	0	1	12
Environmental health hazards	10	1	0	1	12
Potential chemical and biological agent threats	10	1	0	1	12
Radiological threats and	11	0	0	1	12
Large scale disasters	11	0	0	1	12
Maintains written protocols to implement a program of source & contact tracing.	11	0	0	1	12
Maintain a roster of personnel with technical expertise to respond to biological, chemical or radiological emergencies	11	0	0	1	12
Evaluates past incidents for effectiveness & continuous improvement	10	1	0	1	12
Total Respondents	12				

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.	10	1	0	1	12
Maintains ready access to labs capable of meeting routine diagnostic & surveillance needs.	10	1	0	1	12
Confirms that labs are in compliance with regs & standards through credentialing and licensing agencies.	8	3	0	1	12
Maintains protocols to address handling of lab samples– storing, collecting, labeling, transporting and delivering samples and for determining the chain of custody.	9	2	0	1	12
Total Respondents	12				

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.	10	2	0	0	12
Development of policy to protect the health of the public and to guide the practice of public health.	10	2	0	0	12
Systematic community-level and state-level planning for health improvement in all jurisdictions.	9	3	0	0	12
Alignment of LPHS resources & strategies with the community health improvement plan.	10	1	0	1	12
Total Respondents	12				

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.	10	2	0	0	12
Reviews existing policies at least every 2 years and alerts policy makers and the public of potential unintended outcomes and consequences.	11	1	0	0	12
Advocates for prevention and protection policies, particularly policies that affect populations who bear a disproportionate burden of mortality and morbidity.	12	0	0	0	12
Total Respondents	12				

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.	11	1	0	0	12
Develops strategies to achieve community health improvement objectives and identifies accountable entities to achieve each strategy.	11	1	0	0	12
Total Respondents	12				

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.	10	2	0	0	12
Review its own organizational strategic plan to determine how it can best be aligned with the community health improvement process.	9	3	0	0	12
Conducts organizational strategic planning activities and uses strategic planning to align its goals, objectives, strategies and resources with the community health improvement process.	9	2	1	0	12
Total Respondents	12				

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	1	0	0	12
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.	11	1	0	0	12
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.	11	1	0	0	12
Total Respondents	12				

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.	9	3	0	0	12
Identifying personal health service needs of populations with limited access to a coordinated system of clinical care.	8	4	0	0	12
Assuring the linkage of people to appropriate personal health services.	7	5	0	0	12
Total Respondents	12				

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.	8	4	0	0	12
Assesses the extent to which personal health services are provided.	9	3	0	0	12
Identifies the personal health service needs of populations who may encounter barriers to the receipt of personal health services.	9	3	0	0	12
Total Respondents	12				

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.	7	5	0	0	12
Provides community outreach and linkage services in a manner that recognizes the diverse needs of unserved and underserved populations.	9	3	0	0	12
Enrolls eligible beneficiaries in state Medicaid or Medical Assistance Programs.	6	5	0	1	12
Coordinates the delivery of personal health and social services with service providers to optimize access.	9	3	0	0	12
Conducts an analysis of age-specific participation in preventive services.	7	3	0	1	11
Total Respondents	12				

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.	7	3	0	1	11
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.	4	5	1	1	11
Identifies gaps in the provision of population-based health services.	6	5	0	0	11
Uses evaluation findings to modify the strategic and operational plans of LPHS organizations to improve services and programs.	7	3	0	1	11
Total Respondents	11				

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.	9	2	0	1	12
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.	6	4	0	2	12
Assesses the effectiveness of communication, coordination and linkage among LPHS entities.	7	2	1	2	12
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.	8	2	1	1	12
Total Respondents	12				

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.	5	5	2	0	12
Linkages with institutions of higher learning and research.	3	5	2	2	12
Capacity to mount timely epidemiological and health policy analyses and conduct health systems research.	4	4	2	2	12
Total Respondents	12				

Where is your organization located?		
Answer Options	**Response Percent**	**Response Count**
Waterloo	81.8%	9
Seneca Falls	9.1%	1
Ovid	9.1%	1
Romulus	0.0%	0
Geneva	0.0%	0
Other	0.0%	0
Total Respondents	25	

What population does your organization serve? ie. elderly, low income, children	
Answer Options	**Response Count**
All	6
Low income, elderly	1
Elderly	1
Youth	1
Total Respondents	9

What type of organization do you work for? ie. hospital, county agency, non-profit	
Answer Options	**Response Count**
Non-profit	2
County department	4
State	1
Law Enforcement	1
Total Respondents	

What is your position/job title?	
Answer Options	**Response Count**
Project Coordinator	1
Program Director	2
Chief of Police	1
Executive Director	1
Nursing Coordinator	1
Social Worker	1
PH Educator	1
Total Respondents	8

Cancer Indicators - Seneca 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)	655	618.7	550.9	Yes	610.0	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	655	494.2	489.2	No	510.8	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	218	205.9	180.7	No	202.4	No	2nd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	218	163.8	158.6	No	165.6	No	2nd
Lip, Oral Cavity, and Pharynx Cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	13	12.3	12.1	No	13.5	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	13	8.7	10.5	No	11.0	No	1st
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)	58	54.8	46.7	No	49.6	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	58	41.7	41.4	No	41.2	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	11	10.4	16.6	No	17.2	No	1st
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	11	8.0	14.4	No	13.9	No	1st
Lung and bronchus cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	109	103.0	69.6	Yes	83.0	Yes	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	109	82.1	61.6	Yes	68.6	No	4th
Crude mortality rate per 100,000	(Table) (Trend) (Map)	63	59.5	46.4	No	55.9	No	2nd

Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	63	48.0	41.0	No	46.1	No	2nd
Female breast cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	74	146.6	149.1	No	164.4	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	74	121.9	127.2	No	133.2	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	16	31.7	26.3	No	28.1	No	4th
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	16	23.0	20.9	No	20.9	No	4th
Crude late stage incidence rate per 100,000	(Table) (Trend) (Map)	18	35.7	49.2	No	51.4	No	1st
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	18	30.0	42.7	No	42.7	No	1st
Cervix uteri cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	6	11.9*	8.3	No	7.2	No	4th
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	6	10.5*	7.7	No	6.7	No	4th
Crude mortality rate per 100,000	(Table) (Trend) (Map)	0	0.0*	2.7	Yes	2.4	Yes	1st
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	0	0.0*	2.3	Yes	2.0	Yes	1st
Ovarian cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	13	25.8	14.9	No	16.2	No	4th
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	13	20.1	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-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	s	s	7.5	N/A	7.8	N/A	N/A
Prostate cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	78	140.8	156.7	No	167.4	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	78	113.9	145.3	Yes	143.8	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	7	12.6*	18.3	No	18.6	No	1st
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	7	12.3*	20.0	No	18.5	No	1st
Crude late stage	(Table) (Trend) (Map)	20	36.1	23.3	No	25.1	No	4th

incidence rate per 100,000								
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	20	28.6	21.2	No	21.1	No	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 (2013-2014)	(Table) (Map)	N/A	68.9	74.2	No	76.2	No	4th
% of women 40 years and older with mammography screening in past 2 years (2013-2014)	(Table) (Map)	N/A	75.6	77.8	No	77.4	No	3rd
% of women, aged 50-74 years, who had a mammogram between October 1, 2011 and December 31, 2013 (2013)	(Table) (Map)	54	65.9	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 - Seneca 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)	279	263.4	272.5	No	297.4	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	279	195.4	228.0	Yes	228.2	Yes	1st
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	49	113.2	99.0	No	96.8	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	141	133.1	146.7	No	162.3	Yes	1st

Cardiovascular disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,627	153.6	163.6	Yes	165.9	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	1,627	120.6	143.5	Yes	136.0	Yes	2nd
Disease of the heart mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	212	200.2	222.1	No	238.7	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	212	147.3	185.4	Yes	182.8	Yes	1st
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	42	97.0	80.6	No	79.9	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	110	103.9	126.3	Yes	134.7	Yes	1st
Disease of the heart hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,173	110.8	108.5	No	111.9	No	2nd
Age-adjusted	(Table) (Trend) (Map)	1,173	87.0	94.9	Yes	91.4	No	2nd
Coronary heart disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	133	125.6	175.1	Yes	171.8	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	133	91.5	146.2	Yes	131.5	Yes	1st
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	31	71.6	65.5	No	60.7	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	75	70.8	103.6	Yes	100.0	Yes	1st
Coronary heart disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	427	40.3	40.0	No	39.9	No	3rd
Age-adjusted	(Table) (Trend) (Map)	427	31.5	34.8	Yes	32.5	No	3rd
Heart attack (Acute Myocardial Infarction) hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	204	19.3	17.1	No	19.4	No	2nd
Age-adjusted	(Table) (Trend) (Map)	204	15.4	14.8	No	15.7	No	2nd
Heart attack (Acute Myocardial Infarction) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	44	41.5	37.3	No	45.0	No	2nd
Age-adjusted	(Table) (Trend) (Map)	44	29.9	31.3	Yes	34.8	Yes	2nd
Congestive heart failure mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	15	14.2	14.7	No	21.6	No	2nd
Age-adjusted	(Table) (Trend) (Map)	15	10.8	12.0	Yes	16.1	Yes	1st
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	1	2.3*	1.9	No	2.3	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	7	6.6*	8.0	No	12.4	No	1st
Congestive heart failure hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	322	30.4	28.8	No	29.3	No	3rd
Age-adjusted	(Table) (Trend) (Map)	322	23.7	24.9	No	23.4	No	3rd

Cerebrovascular disease (stroke) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	50	47.2	30.9	Yes	38.5	No	4th
Age-adjusted	(Table) (Trend) (Map)	50	36.0	26.2	Yes	29.8	Yes	4th
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	4	9.2*	10.5	No	10.1	No	2nd
Pretransport mortality	(Table) (Trend) (Map)	24	22.7	11.5	Yes	17.0	No	4th
Cerebrovascular disease (stroke) hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	267	25.2	26.9	No	28.9	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	267	19.4	23.5	Yes	23.6	Yes	1st
Hypertension hospitalization rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	19	2.3	7.4	Yes	5.0	Yes	1st
Hypertension hospitalization rate per 10,000 (any diagnosis) (aged 18 years and older)	(Table) (Trend) (Map)	4,085	485.8	562.1	Yes	560.8	Yes	1st
Hypertension emergency department visit rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	174	20.7	32.9	Yes	24.9	Yes	2nd
Hypertension emergency department visit rate per 10,000 (any diagnosis) (aged 18 years and older)	(Table) (Trend) (Map)	6,168	733.6	896.6	Yes	927.7	Yes	2nd
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	861	81.3	117.7	Yes	117.1	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	861	64.0	103.0	Yes	95.3	Yes	1st
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	785	74.1	115.3	Yes	116.8	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	785	58.6	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	9.1	7.6	No	7.2	No	4th
Age-adjusted % of adults with cholesterol checked in the last 5 years # (2013-2014)	(Table) (Map)	N/A	67.4	83.4	Yes	83.2	Yes	4th
Age-adjusted % of adults ever told they have high blood pressure (2013-2014)	(Table) (Map)	N/A	29.4	27.3	No	27.8	No	2nd

N/A: Data not available

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

#: Data not available for NYC counties

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

Child and Adolescent Health Indicators - Seneca 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	64.6*	20.0	No	21.1	No	4th
Aged 5-9 years	(Table) (Trend) (Map)	1	17.2*	10.1	No	9.7	No	4th
Aged 10-14 years	(Table) (Trend) (Map)	0	0.0*	11.9	Yes	11.8	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	1	8.3*	11.0	No	10.8	No	1st
Aged 15-19 years	(Table) (Trend) (Map)	4	60.7*	33.4	No	35.2	No	4th
Asthma hospitalization rate per 10,000								
Aged 0-4 years	(Table) (Trend) (Map)	6	10.5*	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	11	9.2	20.5	Yes	10.4	No	3rd
Aged 0-17 years	(Table) (Trend) (Map)	18	8.2	26.6	Yes	14.2	Yes	2nd
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)	6	10.5*	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	2.0*	3.5	No	4.2	Yes	3rd
% of children born in 2010 with a lead screening - aged 9-17 months (2010-2013)	(Table) (Trend) (Map)	169	42.7	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)	100	25.3	65.6	Yes	55.7	Yes	4th

% of children born in 2010 with at least two lead screenings by 36 months (2010-2013)	(Table) (Trend) (Map)	65	16.4	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)	11	9.0	4.9	No	8.8	No	2nd
% of children with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	818	66.3	71.6	Yes	70.3	No	3rd
% of children aged 0-15 months with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	83	88.3	82.2	No	85.4	No	3rd
% of children aged 3-6 years with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	331	80.5	83.1	No	81.2	No	3rd
% of children aged 12-21 years with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	404	55.5	63.8	Yes	61.9	Yes	3rd

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

s: Data do not meet reporting criteria

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

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

Cirrhosis/Diabetes Indicators - Seneca 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)	10	9.4	7.7	No	8.7	No	2nd
Age-adjusted	(Table) (Trend) (Map)	10	6.9	6.7	No	7.2	No	2nd
Cirrhosis hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	17	1.6	2.8	Yes	2.5	No	1st
Age-adjusted	(Table) (Trend) (Map)	17	1.3	2.5	Yes	2.2	Yes	1st
Diabetes mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	23	21.7	20.3	No	19.6	No	2nd
Age-adjusted	(Table) (Trend) (Map)	23	17.3	17.6	No	15.7	Yes	2nd
Diabetes hospitalization rate per 10,000 (primary diagnosis)								
Crude	(Table) (Trend) (Map)	168	15.9	19.3	Yes	15.6	No	3rd
Age-adjusted	(Table) (Trend) (Map)	168	15.5	17.9	No	14.2	No	3rd
Diabetes hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	2,281	215.4	244.1	Yes	225.8	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	2,281	174.8	215.9	Yes	188.6	Yes	2nd
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 18 years and older	(Table) (Trend) (Map)	79	9.4	6.3	Yes	5.8	Yes	4th
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	861	81.3	117.7	Yes	117.1	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	861	64.0	103.0	Yes	95.3	Yes	1st
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	785	74.1	115.3	Yes	116.8	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	785	58.6	101.0	Yes	95.4	Yes	1st
Age-adjusted % of adults with physician diagnosed diabetes (2013-2014)	(Table) (Map)	N/A	9.8	8.9	No	8.2	No	3rd

Communicable Disease Indicators - Seneca 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)	168	97.3	112.6	Yes	121.9	Yes	1st
Pertussis incidence rate per 100,000	(Table) (Trend) (Map)	4	3.8*	8.8	No	12.9	Yes	1st
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	0.9*	1.7	No	1.7	No	1st
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	1.9*	4.5	No	1.9	No	3rd
E. coli O157 incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.6	Yes	0.8	Yes	1st
Salmonella incidence rate per 100,000	(Table) (Trend) (Map)	11	10.4	12.9	No	12.2	No	2nd
Shigella incidence rate per 100,000	(Table) (Trend) (Map)	1	0.9*	4.8	No	4.4	No	2nd
Lyme disease incidence rate per 100,000#	(Table) (Map)	16	15.1	36.6	Yes	57.8	Yes	2nd
% of adults aged 65 years and older with flu shot in last year (2013-2014)	(Table) (Map)	N/A	73.4	72.4	No	77.1	No	3rd
% of adults aged 65 years and older who ever received pneumonia shot (2013-2014)	(Table) (Map)	N/A	77.4	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 - Seneca 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)	278	24.3	18.5	Yes	21.0	Yes	3rd
Percentage of births to teens								
Aged 15-17 years	(Table) (Trend) (Map)	13	1.1	1.4	No	1.5	No	2nd
Aged 15-19 years	(Table) (Trend) (Map)	60	5.2	5.2	No	5.7	No	2nd
% of births to women aged 35 years and older	(Table) (Trend) (Map)	166	14.5	20.5	Yes	18.9	Yes	3rd
Fertility rate per 1,000 females								
Total (all births/females aged 15-44 years)	(Table) (Trend) (Map)	1,143	65.3	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)	13	6.2	9.3	No	7.9	No	2nd
Aged 15-19 years (births to mothers aged 15-19 years/females aged 15-19 years)	(Table) (Trend) (Map)	60	18.8	19.5	No	17.3	No	2nd
Aged 18-19 years (births to mothers aged 18-19 years/females aged 18-19 years)	(Table) (Trend) (Map)	47	42.6	33.5	No	29.9	Yes	3rd
Pregnancy rate per 1,000 (all pregnancies/females aged 15-44 years) #	(Table) (Trend) (Map)	1,333	76.1	87.9	Yes	72.6	No	3rd
Teen pregnancy rate per 1,000 #								
Aged 10-14 years	(Table) (Trend) (Map)	1	0.3*	0.9	No	0.6	No	2nd
Aged 15-17 years	(Table) (Trend) (Map)	31	14.9	22.4	Yes	14.5	No	2nd

Aged 15-19 years	(Table) (Trend) (Map)	95	29.8	41.3	Yes	28.7	No	2nd
Aged 18-19 years	(Table) (Trend) (Map)	64	58.0	67.2	No	47.6	No	2nd
Abortion ratio (induced abortions per 1,000 live births) #								
Aged 15-19 years	(Table) (Trend) (Map)	34	566.7	1,050.3	Yes	624.6	No	3rd
All ages	(Table) (Trend) (Map)	178	155.7	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 - Seneca 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)	3	2.8*	19.1	Yes	7.6	No	1st
Age-adjusted	(Table) (Trend) (Map)	3	3.0*	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)	2	1.9*	14.4	Yes	3.6	No	2nd
Gonorrhea case rate per 100,000								
All ages	(Table) (Trend) (Map)	27	25.5	107.7	Yes	61.1	Yes	3rd
Aged 15-19 years	(Table) (Trend) (Map)	2	30.4*	368.1	Yes	203.6	Yes	1st
Chlamydia case rate per 100,000 males								
All ages	(Table) (Trend) (Map)	109	196.7	336.0	Yes	203.0	No	3rd
Aged 15-19 years	(Table) (Trend) (Map)	26	764.3	1,029.1	No	608.6	No	3rd

Aged 20-24 years	(Table) (Trend) (Map)	41	895.6	1,492.7	Yes	1,089.0	No	2nd
Chlamydia case rate per 100,000 females								
All ages	(Table) (Trend) (Map)	177	350.5	672.3	Yes	466.8	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	58	1,818.8	3,595.5	Yes	2,387.5	Yes	2nd
Aged 20-24 years	(Table) (Trend) (Map)	78	2,631.6	3,432.2	Yes	2,743.8	No	3rd
% of sexually active young women aged 16-24 with at least one Chlamydia test in Medicaid program (2013)	(Table) (Trend) (Map)	103	52.0	72.2	Yes	65.2	Yes	3rd
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 - Seneca 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)	13	12.3	8.4	No	10.1	No	3rd
Age-adjusted	(Table) (Trend) (Map)	13	13.4	8.0	Yes	9.6	Yes	3rd
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)	69	6.5	5.8	No	6.8	No	2nd
Age-adjusted	(Table) (Trend) (Map)	69	6.9	5.8	No	7.0	No	2nd
Aged 15-19 years	(Table) (Trend) (Map)	10	15.2	11.3	No	12.5	No	3rd
Homicide mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	2	1.9*	3.7	No	2.7	No	2nd
Age-adjusted	(Table) (Trend) (Map)	2	1.4*	3.7	Yes	2.8	Yes	2nd
Assault hospitalization rate per 10,000								

Crude	(Table) (Trend) (Map)	17	1.6	4.1	Yes	2.5	No	2nd
Age-adjusted	(Table) (Trend) (Map)	17	1.6	4.1	Yes	2.7	Yes	2nd
Unintentional injury mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	46	43.4	27.7	Yes	34.0	No	4th
Age-adjusted	(Table) (Trend) (Map)	46	37.6	25.6	Yes	30.8	Yes	4th
Unintentional injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	755	71.3	68.3	No	71.6	No	3rd
Age-adjusted	(Table) (Trend) (Map)	755	60.9	62.2	No	62.2	No	3rd
Aged less than 10 years	(Table) (Trend) (Map)	35	30.3	23.6	No	20.4	Yes	4th
Aged 10-14 years	(Table) (Trend) (Map)	8	13.0*	18.0	No	16.0	No	2nd
Aged 15-24 years	(Table) (Trend) (Map)	49	34.7	28.7	No	29.7	No	3rd
Aged 25-64 years	(Table) (Trend) (Map)	254	44.7	46.0	No	45.8	No	2nd
Aged 65 years and older	(Table) (Trend) (Map)	409	236.9	252.3	No	262.9	Yes	2nd
Falls hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	454	42.9	39.4	No	42.5	No	3rd
Age-adjusted	(Table) (Trend) (Map)	454	33.4	34.7	No	34.9	No	3rd
Aged less than 10 years	(Table) (Trend) (Map)	9	7.8*	8.9	No	7.5	No	4th
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)	7	5.0*	5.7	No	5.2	No	3rd
Aged 25-64 years	(Table) (Trend) (Map)	108	19.0	18.4	No	18.4	No	3rd
Aged 65-74 years	(Table) (Trend) (Map)	66	69.8	75.2	No	75.2	No	2nd
Aged 75-84 years	(Table) (Trend) (Map)	104	194.5	220.3	No	229.4	No	2nd
Aged 85 years and older	(Table) (Trend) (Map)	159	647.1	560.2	No	590.7	No	4th
Poisoning hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	110	10.4	11.1	No	11.0	No	2nd
Age-adjusted	(Table) (Trend) (Map)	110	10.7	10.7	No	10.9	No	2nd
Motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	16	15.1	6.3	Yes	8.4	No	4th
Age-adjusted	(Table) (Trend) (Map)	16	13.1	6.0	Yes	8.0	Yes	4th
Non-motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	30	28.3	21.4	No	25.6	No	4th
Age-adjusted	(Table) (Trend) (Map)	30	24.5	19.5	Yes	22.8	Yes	3rd

Traumatic brain injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	89	8.4	10.0	No	10.2	No	3rd
Age-adjusted	(Table) (Trend) (Map)	89	7.2	9.4	Yes	9.2	Yes	2nd
Alcohol related motor vehicle injuries and deaths per 100,000	(Table) (Trend) (Map)	60	56.7	33.3	Yes	44.4	No	3rd

*: 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 - Seneca 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)	179	23.5	14.1	Yes	10.6	Yes	4th
% of births to out-of-wedlock mothers	(Table) (Trend) (Map)	475	41.6	40.9	No	39.1	No	2nd
% of births that were first births	(Table) (Trend) (Map)	406	35.5	42.6	Yes	40.8	Yes	1st
% of births that were multiple births	(Table) (Trend) (Map)	42	3.7	3.9	No	4.1	No	3rd
% of births with early (1st trimester) prenatal care	(Table) (Trend) (Map)	748	67.0	73.1	Yes	75.4	Yes	4th
% of births with late (3rd trimester) or no prenatal care	(Table) (Trend) (Map)	83	7.4	5.6	Yes	4.1	Yes	4th
% of births with adequate prenatal care (Kotelchuck)	(Table) (Trend) (Map)	679	63.0	69.1	Yes	70.8	Yes	4th
WIC indicators								
% of pregnant women in WIC with early (1st trimester) prenatal care (2009-2011)	(Table) (Trend) (Map)	377	90.4	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)	12	3.8	4.7	No	4.1	No	1st
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30) (2010-2012)	(Table) (Trend) (Map)	75	23.8	26.6	No	26.3	No	2nd
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher) (2010-2012)	(Table) (Trend) (Map)	118	37.5	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 women in WIC with gestational weight gain greater than ideal (2009-2011)	(Table) (Trend) (Map)	201	49.6	41.7	Yes	47.1	No	2nd
% of pregnant women in WIC with gestational diabetes (2009-2011)	(Table) (Trend) (Map)	13	3.1	5.5	Yes	5.8	Yes	1st
% of pregnant women in WIC with hypertension during pregnancy (2009-2011)	(Table) (Trend) (Map)	30	7.2	7.1	No	9.0	No	1st
% of WIC mothers breastfeeding at least 6 months (2010-2012)	(Table) (Trend) (Map)	21	14.0	38.2	Yes	27.7	Yes	4th
% of infants fed any breast milk in delivery hospital	(Table) (Trend) (Map)	838	78.2	83.1	No	77.9	No	2nd
% of infants fed exclusively breast milk in delivery hospital	(Table) (Trend) (Map)	729	68.1	40.7	Yes	49.2	Yes	1st
% of births delivered by cesarean section	(Table) (Trend) (Map)	273	23.9	34.1	Yes	35.6	Yes	1st
Mortality rate per 1,000 live births								
Infant (less than 1 year)	(Table) (Trend) (Map)	7	6.1*	5.0	No	5.5	No	3rd
Neonatal (less than 28 days)	(Table) (Trend) (Map)	5	4.4*	3.4	No	3.9	No	3rd
Post-neonatal (1 month to 1 year)	(Table) (Trend) (Map)	2	1.7*	1.5	No	1.6	No	3rd
Fetal death (20 weeks gestation or more)	(Table) (Trend) (Map)	3	2.6*	6.6	No	4.4	No	1st
Perinatal (20 weeks gestation to less than 28 days of life)	(Table) (Trend) (Map)	8	7.0*	10.0	No	8.3	No	1st
Perinatal (28 weeks gestation to less than 7 days of life)	(Table) (Trend) (Map)	5	4.4*	5.4	No	5.4	No	1st
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)	12	1.1	1.4	No	1.4	No	1st
% very low birthweight (less than 1.5kg) singleton births	(Table) (Trend) (Map)	11	1.0	1.1	No	1.0	No	3rd
% low birthweight (less than 2.5 kg) births	(Table) (Trend) (Map)	84	7.4	8.0	No	7.6	No	3rd
% low birthweight (less than 2.5kg) singleton births	(Table) (Trend) (Map)	58	5.3	6.0	No	5.6	No	2nd

% of premature births by gestational age								
less than 32 weeks gestation	(Table) (Trend) (Map)	22	1.9	1.8	No	1.8	No	4th
32 - less than 37 weeks gestation	(Table) (Trend) (Map)	97	8.5	9.1	No	9.1	No	2nd
less than 37 weeks gestation	(Table) (Trend) (Map)	119	10.4	10.9	No	10.9	No	3rd
% of births with a 5 minute APGAR less than 6	(Table) (Trend) (Map)	5	0.4*	0.6	No	0.7	No	1st
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	9	102.4*	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 - Seneca 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)	316	17.2	N/A	N/A	16.7	N/A	3rd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	395	21.4	N/A	N/A	17.3	N/A	4th
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	711	38.6	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)	154	17.4	N/A	N/A	16.4	N/A	3rd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	181	20.5	N/A	N/A	16.8	N/A	4th
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	335	37.9	N/A	N/A	33.1	N/A	4th
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)	105	17.4	N/A	N/A	17.1	N/A	2nd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	153	25.3	N/A	N/A	18.1	N/A	4th
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	258	42.7	N/A	N/A	35.2	N/A	4th
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30)	(Table) (Trend) (Map)	75	23.8	26.6	No	26.3	No	2nd
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher)	(Table) (Trend) (Map)	118	37.5	24.2	Yes	28.0	Yes	4th
% obese (95th percentile or	(Table) (Trend) (Map)	101	14.8	14.3	No	15.2	No	3rd

higher) children in WIC (aged 2-4 years) (2010-2012)								
% of children in WIC viewing TV 2 hours or less per day (aged 2-4 years) (2010-2012)	(Table) (Trend) (Map)	570	83.6	79.9	No	81.0	No	2nd
% of WIC mothers breastfeeding at least 6 months (2009-2011)	(Table) (Trend) (Map)	21	14.0	38.2	Yes	27.7	Yes	4th
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2013-2014)	(Table) (Map)	N/A	61.7	60.5	No	62.3	No	2nd
Age-adjusted % of adults obese (BMI 30 or higher) (2013-2014)	(Table) (Map)	N/A	28.9	24.6	No	27.4	No	2nd
Age-adjusted % of adults who did not participate in leisure time physical activity in last 30 days (2013-2014)	(Table) (Map)	N/A	23.6	27.1	No	26.2	No	4th
Age-adjusted % of adults eating 5 or more fruits or vegetables per day (2008-2009)	(Table) (Map)	N/A	28.2	27.1	No	27.7	No	1st
Age-adjusted % of adults with physician diagnosed diabetes (2008-2009)	(Table) (Map)	N/A	9.8	8.9	No	8.2	No	3rd
Age-adjusted % of adults with physician diagnosed angina, heart attack or stroke # (2008-2009)	(Table) (Map)	N/A	9.1	7.6	No	7.2	No	4th
Age-adjusted mortality rate per 100,000								
Cardiovascular disease mortality	(Table) (Trend) (Map)	279	195.4	228.0	Yes	228.2	Yes	1st
Cerebrovascular disease (stroke) mortality	(Table) (Trend) (Map)	50	36.0	26.2	Yes	29.8	Yes	4th
Diabetes mortality	(Table) (Trend) (Map)	23	17.3	17.6	No	15.7	Yes	2nd
Age-adjusted hospitalization rate per 100,000								
Cardiovascular disease hospitalizations	(Table) (Trend) (Map)	1,627	120.6	143.5	Yes	136.0	Yes	2nd
Cerebrovascular disease (stroke) hospitalizations	(Table) (Trend) (Map)	267	19.4	23.5	Yes	23.6	Yes	1st
Diabetes hospitalizations (primary diagnosis)	(Table) (Trend) (Map)	168	15.5	17.9	No	14.2	No	3rd

N/A: Data not available

#: Data not available for NYC counties

Occupational Health Indicators - Seneca 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)	115	250.0	156.5	Yes	191.1	Yes	4th
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)	27	58.7	22.3	Yes	22.7	Yes	4th
Fatal work-related injuries per 100,000 employed persons aged 16 years and older #	(Table) (Trend) (Map)	s	s	2.3	N/A	2.7	N/A	N/A

s: Data do not meet reporting criteria

#: Data not available for NYC counties

Oral Health Indicators - Seneca 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	30.1	N/A	N/A	45.4	Yes	1st
% of 3rd grade children with untreated caries # (2009-2011)	(Table) (Map)	N/A	18.1	N/A	N/A	24.0	Yes	1st
% of 3rd grade children with dental sealants # (2009-2011)	(Table) (Map)	N/A	23.0	N/A	N/A	41.9	Yes	1st
% of 3rd grade children with dental insurance # (2009-2011)	(Table) (Map)	N/A	84.7	N/A	N/A	81.8	Yes	3rd
% of 3rd grade children with at least one dental visit in last year # (2009-2011)	(Table) (Map)	N/A	80.2	N/A	N/A	83.4	Yes	2nd
% of 3rd grade children reported taking fluoride tablets regularly # (2009-2011)	(Table) (Map)	N/A	54.9	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	67.0	69.8	No	71.5	No	3rd
Caries outpatient visit rate per 10,000 (aged 3-5 years)	(Table) (Trend) (Map)	52	146.4	79.2	Yes	93.5	Yes	3rd
Medicaid oral health indicators								
% of Medicaid enrollees with at least one dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	6,696	27.8	31.8	Yes	30.9	Yes	3rd
% of Medicaid enrollees with at least one preventive dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	5,247	21.8	26.6	Yes	25.1	Yes	3rd
% of Medicaid enrollees (aged 2-20 years) who had at least one dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	3,101	38.2	45.0	Yes	44.3	Yes	3rd
% of Medicaid enrollees (aged 2-20 years) with at least one preventive dental visit	(Table) (Trend) (Map)	2,813	34.7	40.1	Yes	39.7	Yes	3rd

within the last year # (2012-2014)								
% of children, aged 2-21 years, with at least one dental visit in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	905	52.4	59.2	Yes	61.4	Yes	4th
Oral cancer								
Crude incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	13	12.3	12.1	No	13.5	No	2nd
Age-adjusted incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	13	8.7	10.5	No	11.0	No	1st
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 mortality rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	s	s	2.2	N/A	2.1	N/A	N/A
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

Respiratory Disease Indicators - Seneca 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)	68	64.2	35.6	Yes	46.2	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	68	47.1	30.7	Yes	36.8	Yes	3rd
Chronic lower respiratory disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	336	31.7	36.5	Yes	33.0	No	2nd
Age-adjusted	(Table) (Trend) (Map)	336	25.9	34.1	Yes	28.6	No	2nd
Asthma hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	57	5.4	18.2	Yes	11.1	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	57	5.7	18.2	Yes	10.9	Yes	1st
Aged 0-4 years	(Table) (Trend) (Map)	6	10.5*	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	11	9.2	20.5	Yes	10.4	No	3rd
Aged 0-17 years	(Table) (Trend) (Map)	18	8.2	26.6	Yes	14.2	Yes	2nd
Aged 5-64 years	(Table) (Trend) (Map)	45	5.4	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)	12	4.6	8.6	Yes	6.6	No	1st
Aged 45-64 years	(Table) (Trend) (Map)	17	5.5	19.7	Yes	11.6	Yes	1st
Aged 65 years or older	(Table) (Trend) (Map)	6	3.5*	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	10.5	10.1	No	10.5	No	2nd

N/A: Data not available

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

Socio-Economic Status and General Health Indicators - Seneca 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	35,409.0	19,651,127.0	N/A	11,245,290.0	N/A	1st
% of labor force unemployed (2014)	(Table) (Trend) (Map)	880	5.7	6.3	Yes	5.6	No	2nd
% of population below poverty (2013)	(Table) (Trend) (Map)	N/A	13.1	16.0	No	N/A	N/A	2nd
% of children aged less than 18 years below poverty (2013)	(Table) (Trend) (Map)	N/A	21.7	22.9	No	N/A	N/A	3rd
Median household income in US dollars (2013)	(Table) (Trend) (Map)	N/A	45,265.0	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	95.4	95.9	No	N/A	N/A	3rd
% of adults aged 18-64 years with health insurance (2013)	(Table) (Trend) (Map)	N/A	87.6	84.7	Yes	N/A	N/A	2nd
High school drop out rate (2012-2014)	(Table) (Trend) (Map)	135	3.3	3.3	No	2.3	Yes	4th
Age-adjusted % of adults who did not receive medical care because of cost # (2013-2014)	(Table) (Map)	N/A	9.3	13.6	No	12.0	No	1st
Age-adjusted % of adults with regular health care provider (2013-2014)	(Table) (Map)	N/A	84.3	84.5	No	84.7	No	3rd
Age-adjusted % of adults who had	(Table) (Map)	N/A	12.6	11.1	No	11.8	No	3rd

poor mental health 14 or more days within the past month (2013-2014)								
Birth rate per 1,000 population	(Table) (Trend) (Map)	1,143	10.8	12.2	Yes	10.7	No	3rd
Total mortality rate per 100,000	(Table) (Trend) (Map)	956	902.6	753.1	Yes	854.1	No	3rd
Age-adjusted total mortality rate per 100,000	(Table) (Trend) (Map)	956	695.4	644.9	Yes	678.5	Yes	2nd
% premature deaths (aged less than 75 years)	(Table) (Trend) (Map)	397	41.5	39.9	No	37.5	No	3rd
Years of potential life lost per 100,000	(Table) (Trend) (Map)	6,492	6,617.3	5,577.4	Yes	5,839.3	Yes	3rd
Total emergency department visit rate per 10,000	(Table) (Trend) (Map)	36,664	3,461.7	4,086.4	Yes	3,752.5	Yes	2nd
Age-adjusted total emergency department visit rate per 10,000	(Table) (Trend) (Map)	36,664	3,471.7	4,074.7	Yes	3,762.9	Yes	1st
Total hospitalization rate per 10,000	(Table) (Trend) (Map)	10,669	1,007.3	1,226.2	Yes	1,168.1	Yes	1st
Age-adjusted total hospitalization rate per 10,000	(Table) (Trend) (Map)	10,669	922.7	1,167.3	Yes	1,104.3	Yes	1st

N/A: Data not available

#: Data not available for NYC counties

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

Tobacco, Alcohol and Other Substance Abuse Indicators - Seneca 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)	118	11.1	23.7	Yes	20.2	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	118	11.1	23.6	Yes	21.0	Yes	1st
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	9	102.4*	95.0	No	123.2	No	2nd
Alcohol related motor vehicle injuries and deaths per 100,000	(Table) (Trend) (Map)	60	56.7	33.3	Yes	44.4	No	3rd
Age-adjusted % of adults who smoke cigarettes (2013-2014)	(Table) (Map)	N/A	14.7	15.9	No	18.0	No	1st
Age-adjusted % of adults living in homes where smoking is prohibited (2008-2009)	(Table) (Map)	N/A	74.2	80.9	No	79.3	No	3rd
Age-adjusted % of adults who binge drink (2013-2014)	(Table) (Map)	N/A	20.1	17.7	No	17.2	No	4th

N/A: Data not available

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

Attachment 8

S²AY Rural Health Network, Inc. & Seneca Public Health

County:	Seneca
Group Name:	Seneca County Community Health Priority Setting
Date and Time:	June 22, 2016 - 2:00 PM

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

Issues to Rank based on Data Assessment

- Obesity – lifestyle, cultural, physical activity, nutrition, (low back pain and diabetes)
- Substance abuse
- Dental health
- Mental health
- Hypertension (cerebrovascular, tobacco use and lung cancer,)
- Injury Prevention (falls)

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

Charting the Course…

Selecting Issues and Priorities

Public Health

Acknowledgement:

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

Selecting Issues & Priorities

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

The Hanlon Method

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

The Hanlon Method…

BPR – Basic Priority Rating System

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

A = Size of the problem

B = Seriousness of the problem

C = Effectiveness of the solution

(weighted by PEARL Factors)

Component A – Size of Problem

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

Component A: Size of Problem

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

Component B – Seriousness of Problem

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

Component B: Seriousness of Problem

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

Component C – Effectiveness of Intervention

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

Component C: Effectiveness of Intervention

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

Immunization programs are known to be highly effective…

as compared to the results of smoking cessation programs.

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

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

PEARL Factors:

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

Here We Go!

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

Sample Worksheet:

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

Considerations and Conclusions

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

And…

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

And finally…

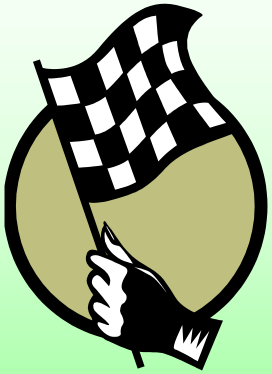
- Soup slurping is evidently quite widespread and a serious problem, and we believe the interventions could be relatively effective
- However, solutions to the problem are NOT within our scope or mission statement
- It makes economic sense to address the problem, but there will probably NOT be economic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

Therefore…

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

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

Time to Get Started!



Attachment 10

County: __Seneca_____ Please enter issues in same order as on the screen Date: 06/22/2016_____

Issue	Size (A)	Serious-ness (B)	Effective-ness (C)	Score (A+2B) X C	PEARL
Obesity (Low back pain and Diabetes)					P P E E A R L
Substance Abuse					P P E E A R L
Dental Health					P P E E A R L
Mental Health					P P E E A R L
Hypertension (Cerebrovascular, tobacco use and lung cancer)					P P E E A R L
Injury Prevention (falls)					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?

Attachment 11

S²AY Rural Health Network, Inc. & Seneca Public Health

County:	Seneca
Group Name:	Seneca County Community Health Priority Setting
Date and Time:	June 22, 2016 - 2:00 PM

The following are the ranking results from the Priority Setting

Meeting conducted on June 22nd, 2016 from 2:00pm to 4:00pm.

#	Issue	Hanlon	Pearl
1	Hypertension	176.93	4.53
2	Obesity	155.40	4.87
3	Substance Abuse	145.87	4.53
4	Mental health	135.40	4.13
5	Dental health	135.27	3.67
6	Injury Prevention	106.40	4.20

Attachment 12

Seneca County
Health Department
31 Thurber Drive
Waterloo, NY 13165
Director: Vickie Swinehart RN, MS
vswinehart@co.seneca.ny.us
Phone: 315-539-1920
Fax: 315-539-9493
www.co.seneca.ny.us

Seneca County Health Department
Community Health Assessment Priority Setting Meeting
June 22, 2016

Sign in Sheet

Name	Title	Signature
Barb Buttrey	Community member	Barbara A Buttrey
Kate Ebersole	FLPPS	[illegible]
Lynne Doyle	STEPS	Lynne M. Doyle
Angela Reardon	OPA	[illegible]
Carrie Heran	FLHSA	[illegible]
John Shepard	Municipal Seneca	jshepard@co.seneca.ny.us
Kerry VanAuken	SK. PH Educator	Kerry VanAuken
Megan Peters	PHN	[illegible]
Anne Wilkes	CSCAA Seneca Phys. Director	Anne Wilkes
Penny Guglino	Director-TACFL	Penny Guglino
Melissa Brand	PHS	Melissa Brand
Mo Tidball	Nutr. Ed. CCE	[illegible]
Theresa Sahr	STEPS	Theresa Sahr
[illegible]	VP. Community Engagement Finger Lakes Hta	[illegible]

Kate Ebersole
Kate.ebersole3@gmail.com
(716)499-0963

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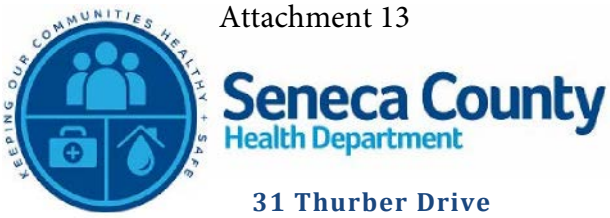
Kim Lucianovic	Wayne CAP	[illegible]
Vickie Swinehart	Seneca County DOH	[illegible]

Attachment 13



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Prioritization of Health Needs in Seneca County

June 22, 2016

As we work to the completion of the 2017 Community Health Assessment and Community Service Plan; Geneva General, part of Finger Lakes Health, the Seneca 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 Seneca 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:

- Hypertension
- Obesity
- Substance Abuse

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 Vickie Swinehart, Director of Public Health, at vswinehart@co.seneca.ny.us or by calling the office at 315-539-1920.

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

"Creating safe, healthy communities and environments for all generations."

Seneca County Health Department

Published by SenecaHealth Kerry [?] · July 5 at 1:09pm ·

The Seneca County Health Deparment is requesting public feedback on health priorities preliminarily identified through data reviews, public focus groups and input collected from health and human service agencies. As a result of the work completed to date, the highest ranked health priorities are Hypertension, Obesity and Substance Abuse. Do you agree? Provide your comments below in the link. Thank you
https://form.jotform.com/61865250362152

The Seneca County Health Department, Finger Lakes Health and the S2AY Rural Health Network are...

Please click the link to complete this form.

JOTFORM.US

25 people reached

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Like Comment Share

Finger Lakes Health

Prioritization of Health Needs 2016

As we prepare for the completion of the Community Health Assessment (CHA) and Community Service Plan (CSP) Geneva General and Soldiers & Sailors Memorial Hospitals, part of Finger Lakes Health, and the County Departments of Health in Ontario, Seneca and Yates counties, along with the S2AY Rural Health Network, with input from several other health and human service agencies throughout the three counties, have been conducting a comprehensive assessment of community health needs. We have reviewed population health data statistics, and engaged community members through soliciting input around local community health concerns by way of focus groups.

As a result of all the work to date, the most highly ranked health priorities have been identified for each county. Please see those priorities below.

As we continue our assessment and begin to develop the Community Health Improvement Plan and Community Services Plan, we ask for any public input related to health priorities in Ontario, Seneca and Yates counties. Any remarks can be emailed to Loree MacKerchar, Manager, Community Relations, Finger Lakes Health, at **loree.mackerchar@flhealth.org**.

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

The most highly ranked health priorities that have been identified for **Ontario County** are:

- Hypertension (Tobacco Use)
- Substance Abuse (Opioid)
- Obesity

The most highly ranked health priorities that have been identified for **Seneca County** are:

- Hypertension
- Obesity
- Substance Abuse

The most highly ranked health priorities that have been identified for **Yates County** are:

- Cerebrovascular Disease (Hypertension)
- Behavioral Health (Substance Abuse and Mental Health)
- Obesity

Click here to read about the most highly ranked health priorities that have been identified for

Ontario County

Seneca County

Yates County

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 interventions address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
#1.3 Expand the role of health care, health services providers and insurers in obesity prevention.	**Objective 1.3.2:** by 2018, increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by 10% from 43.7% (2010) to 48.1%. Data Source: Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital Records, NYC DOHMH) (Also, see: Focus Area – Maternal and Infant Health)	Link health care-based efforts with community prevention activities such as comprehensive school-based obesity prevention programs; community-based, nationally recognized diabetes prevention programs; and breastfeeding counseling and support systems. (IOM Obesity Prevention)	Number of primary care practices that are designated as NYS Breastfeeding Friendly Number and demographics of women reached by policies and practices to support breastfeeding	Public Health and Finger Lakes Breastfeeding Partnership to increase number of CLC's trained and integrated into the community of Seneca County. Increase support for breastfeeding (i.e. develop baby café, education etc.) Work in partnership with Finger Lakes Community Health (FQHC) on designation to become NYS Breastfeeding Friendly. Finger Lakes Health to provide breastfeeding educational materials at affiliated family doctors.	- Public Health commits .10 FTE/year ($4,795.00) - Finger Lakes Health commits .01 FTE/year. <u>Additional Community Partners</u> - Primary Care Physicians - Finger Lakes Breastfeeding Partnership/S2AY RHN: $3,300 for CHIP Cycle - Finger Lakes Community Health

Focus Area 1: Reduce Obesity in Children and Adults					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested interventions address a disparity? ☐ Yes ☒ No					
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 1.4.1:** By December 31, 2018, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees and that is fully accessible to people with disabilities. Baseline to be determined.) (Data Source: NYSDOH Healthy Heart Program Worksite Survey)	Implement nutrition and beverage standards in public institutions, worksite s and other key locations such as hospitals.	Number and type of key community locations that adopt and/or implement nutrition and beverage standards Number of adults that have access to locations.	Public Health to work towards Healthy Vending efforts at County Locations. Finger Lakes Health continues to use standards identified in the NYS DOH Cutting the Salt: Addressing Sodium Reduction. S2AY RHN/Regional Worksite Wellness Committee to assist PH and partners in worksite wellness efforts.	- Public Health commits .07 FTE PH Educators/year ($ 3,000.00) - Finger Lakes Health commits .05 FTE/year. <u>Additional Community Partners</u> - Vendors - Human Resource Departments - Risk Management Departments - Worksite Wellness Committee/S2AY RHN: $2,475 for CHIP Cycle
	Objective 1.4.2: By December 31, 2018, increase the percentage of employers with supports for breastfeeding at the worksite by 10%. Baseline to be determined. (Data Source: NYSDOH Healthy Heart Program Worksite Survey) (Also, see: Focus Area – Maternal and Infant Health)	Use the Business Case for Breastfeeding to encourage employers to implement breastfeeding-friendly policies.	Number of employers that have implemented lactation support programs. & Number and demo of women reached by policies and practices to support breastfeeding.	PH in partnership with Finger Lakes Breastfeeding Partnership to train additional and retrain existing CLCs. Support and implement breastfeeding friendly policies. Finger Lakes Health to distribute Business Case for Breastfeeding and CLC referral materials to practices who see new mothers. PH and FLBP/S2AY RHN/Regional Worksite Wellness Committee to reach out to and provide support to worksites in adopting breastfeeding friendly policies.	- Public Health commits .10 Public Health Nurse/year ($4,795.00) - Finger Lakes Health commits .01 FTE/year. <u>Additional Community Partners</u> - Finger Lakes Breastfeeding Partnership/Worksite Wellness Committee/S2AY RHN: $3,300 for CHIP Cycle

Focus Area 3: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings.					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested interventions address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Partner Role	Partner Resources
#3.2: Promote use of evidence-based care to manage chronic diseases.	**Objective 3.2.4:** By December 31, 2018, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90)	Participation in regional blood pressure registry. "My Reminder Campaign" to assist with hypertension medication adherence.	Number of primary care practices that submit patient numbers to registry. Number of materials distributed for "My Reminder Campaign."	FLHSA to provide hypertension registry data to partners every 6 months. Supply PH and FLH with "My Reminder Campaign" materials for distribution. Participating registry partners to send registry data to FLHSA. PH and S2AY to follow up with providers bi-annually after publication of registry data to offer education and blood pressure screening training.	- Public Health: $1,750 for CHIP Cycle. Additional cost for PH .08% FTE/year ($3,500.00) - Finger Lakes Health commits .02 FTE/year. <u>Additional Community Partners</u> - Primary Care Physicians - Finger Lakes Health System Agency – In kind contribution. - S2AY Rural Health Network: $2,475 for CHIP Cycle -Finger Lakes Community Health

Focus Area 3: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings.					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested interventions address a disparity? ☒ Yes ☐ No *Disparity is addressed through CDSMP classes being offered to Behavioral Health Clients, low income populations and elderly.					
Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Partner Role	Partner Resources
#3.3 Promote culturally relevant chronic disease self-management education.	**Objective 3.3.1:** By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. (Data Source: BRFSS; annual measure, beginning 2013)	Promote the use of evidence-based interventions to prevent or manage chronic diseases.	Percent of adults with one or more chronic diseases who have attended a self-management program. Number and percent of adults among population(s) of focus (E.g., communities of color, persons with disability, low-income neighborhoods) who have attended EBIs	PH and Wayne CAP to offer and conduct CDSMP classes. Promote and enroll members in classes. Identify additional partners that can be trained in CDSMP and hold classes within the county. PH to provide detailing to physicians to encourage referral to and knowledge of EBI to manage chronic disease (i.e. CDSMP). Finger Lakes Health to provide care managers information to facilitate referral into CDSMP. Office for the Aging to provide data for number of adults who attend CDSMP. S2AY RHN / Regional Living Healthy Group to assist with coordination of evidence based programs and provide back-up peer leaders for classes.	- Public Health .08%FTE for implementation and promotion of CDSM Programs/year ($3,500.00) - Finger Lakes Health commits .01 FTE/year. <u>Additional Community Partners</u> - Wayne CAP: $10,211.00/year - Office for the Aging (referral and data source) - S2AY RHN / Regional Living Healthy Group: $1,886

Priority: Promote Mental Health and Prevent Substance Abuse					
Focus Area 2: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested interventions address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Partner Role	Partner Resources
#2.1 Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults.	**Objective 2.1.1:** December 31, 2018, 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%. (Baseline: 38.4 per 100, 2011 YRBS) - Tracking Indicator	**School-based programs: Project towards No Drug Abuse**, and **Project Success** target social and psychological factors that promote the initiation of substance use, and build student resiliency by teaching social competency, autonomous problem-solving, developing self-control and communication skills, improving decision-making strategies, and acquiring resources to resist drug use.	Number of students that participate in program. Percent of youth below age 21 who report drug use in the last 30 days. Number of public awareness, outreach, and educational efforts to change attitudes, beliefs, and norms towards underage and excessive adult alcohol use, prescription opiates.	COA to conduct SPORT – Evidence Based Intervention in Romulus and South Seneca. Seneca Substance Abuse Coalition to provide data for percent of youth below age 21 who report drug use in last 30 days. Seneca Addictions to conduct Project Success intervention in Waterloo, South Seneca and Seneca Falls Schools. PH and Finger Lakes Health support and education around the efforts of the partners to reduce underage drinking and non-medical use of prescription pain relievers. FLHSA to provide data around substance abuse. Additional partners to work to create universal referral system to substance abuse and mental health services.	- Public Health commits .02% FTE ($ 1,750.00) - Finger Lakes Health commits .02 FTE/year. <u>Additional Community Partners</u> - Council on Alcoholism and Addictions of the Finger Lakes - Waterloo School - Romulus School - Seneca Falls School - South Seneca School - Seneca Substance Abuse Coalition - Seneca Addictions - FLHSA -Seneca County Community Counseling