Wayne County

Community Health Assessment/Community Service Plan

2016-2018

December 5, 2016

The participating local health department in the 2016 Community Health Assessment (CHA) is Wayne County Public Health. Diane Devlin, the Public Health Director, is the contact person. She may be reached at: ddevlin@co.wayne.ny.us or 315.946.5749.

The participating hospital is Newark-Wayne Community Hospital (NWCH), the only hospital located in Wayne County. NWCH is an affiliate hospital of Rochester Regional Health. It is a 120-bed small community hospital, located in Newark, New York. Jeanna Savage, Public Relations Advisor, is the contact person and may be reached at jeanna.savage@rochesterregional.org or 315.332.2492.

In Wayne 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 (Steuben, Seneca, Schuyler, Wayne, Ontario, Yates, Livingston, and Chemung), and has completed Community Health Assessments in this region for the last five cycles. The main coordinating body that oversaw the Community Health Assessment is the Wayne Health Improvement Partnership (WHIP), formerly known as the Wayne County Prevention Agenda Team. WHIP is a multi-disciplinary group of community organizations described more fully within this document. WHIP will oversee the implementation of the Community Health Improvement Plan (CHIP). Please see Attachment 1 for a list of members.

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Attachments:

Executive Summary

1. Priorities and Disparities:

Wayne County chose three priority areas, and five focus areas within those priorities to address.

Priority Area 1: Prevent Chronic Diseases

- *Focus Area 1:* Reduce Obesity in Children and Adults
- *Focus Area 2:* Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
- *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings

Priority Area 3: Promote Healthy Women, Infants, and Children

- *Focus Area 2:* Child Health

Priority Area 4: Promote Mental Health and Prevent Substance Abuse

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

Wayne County also chose two disparities to address:

1. Lower rates of breastfeeding among women of lower socio-economic status (SES)
2. Decreasing smoking rates in the lower SES and those reporting poor mental health populations

2. Changes from 2013: The first priority has not changed (Prevent Chronic Diseases – focusing on obesity and hypertension) from the 2013 CHA and CHIP, although the strategies to be used to address these priorities have evolved somewhat as will be seen in the attached CHIP chart. The second priority has changed however. In the review of the data and discussions with focus groups, dental health (particularly in children) continues to be of significant concern. Strides have been made in Wayne County over the last few years, with increased dental screening/ cleaning programs in local schools and access to Medicaid dental services. As dental health rose to the top as one of the most pressing health needs, and progress has already been made throughout the County, the WHIP chose to continue these efforts, and chose dental health as a priority during this CHA/CHIP cycle. Furthermore, the rates of increase in emergency department (ED) visits for substance abuse issues increased dramatically between 2013 and 2014, as did visits for mental health related issues. The opioid epidemic has also hit home locally in Wayne County as well, calling attention to the need to address this problem as a community. In the 2016-2018 CHA/CHIP process, Wayne County has chosen a fourth priority, Priority

Area 4: Promote Mental Health and Prevent Substance Abuse, in recognition of the extent and severity of behavioral health issues.

3. Data Reviewed and Analyzed: The data review and analysis was extensive. In all S²AY Network Counties, the process began with a data update for the eight county region conducted by the Finger Lakes Health Systems Agency (FLHSA) at the request of S²AY. This data collection and analysis effort focused on data related to the main priorities in the 2013 CHA for the region as well as some emerging issues that the hospitals and Public Health agreed should be analyzed based both on their knowledge of what they were seeing in their communities and what the needs assessment for Delivery System Reform Incentive Payment (DSRIP) program (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.

This data was presented to the Public Health 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: 2013-2014 Expanded Behavioral Risk Factor Surveillance Survey (EBRFSS), Census Bureau (2010 Census and 2015 American Community Survey estimates), 2010-2014 SPARCS data, NY State Prevention Agenda data set (updated 2016), 2014 Aggregated Claims Data, 2014 NY State Vital Statistics, and the 2015 Regional High Blood Pressure Registry. Once this data had been reviewed, the S²AY reviewed other data to develop a summary Power Point presentation of the highest need areas particularly for the county. This additional review of data included, among other things: County Prevention Agenda Dashboard (updated 2016, data from various dates), 2010-2014 Community Health Indicator Reports, Sub-County Data Reports (2016 report, data various years), 2012-2014 Leading Causes of Death Indicators, and County Health Rankings (2016 report, data from various years). In addition to the primary data reviewed from the high blood pressure registry, other primary data was obtained through focus group input.

4. Partners and Roles: While the primary partners in the assessment process include Wayne County Public Health, Newark-Wayne Community Hospital, S²AY, and the Finger Lakes Health Systems Agency, there are a wide variety of other partners that serve on the Wayne Health Improvement Partnership (WHIP). A member list for the WHIP is attached (Attachment 1). The WHIP provides oversight of both the process and implementation of the Community Health Improvement Plan (CHIP). The WHIP includes a good mix of community representatives including Federally Qualified Health Centers (FQHCs), Community Based Organizations (CBOs), other County Departments, a provider of services to the developmentally disabled population, and schools. Detailed roles in implementation are in the attached CHIP.

5. Community Engagement: The community has been engaged in a variety of different ways. After S²AY prepared a presentation on the highest needs in Wayne County, it was shared with eight separate and diverse focus groups throughout the community to review data with them, but also to gather their input and perceptions regarding needs in the County. Additionally, focus group participants were invited to attend the priority setting meeting. Again, after the preliminary priority setting meeting was held, another

opportunity for input from the general public was provided. Preliminary priorities were listed in a media release and also posted on the website of the hospital and Public Health. The public was again asked to provide any additional input at this third opportunity.

6. Evidence-based interventions: As fully detailed in the CHIP, strategies to address chronic diseases include evidence based activities such as Stanford approved curriculums (e.g. Chronic Disease Self-Management Program (CDSMP), policy/practice implementation (working with worksites to implement healthy policies and encouraging providers to become New York State Department of Health (NYSDOH) Breastfeeding Friendly Certified), promoting provider practice participation in the regional hypertension registry, and promoting evidence-based tobacco dependence treatments among those who use tobacco. Strategies under "Promote Mental Health and Prevent Substance Abuse" include Project Lazarus to prevent overdose deaths (project activities include community activation, prescriber education, supply reduction, drug safety, demand reduction, Narcan trainings, and community-based prevention education). In addition to Project Lazarus, the WHIP will be working to better coordinate efforts between existing coalitions/groups in Wayne County (Wayne Wellness Coalition, etc.) to implement a comprehensive approach to addressing the opioid crisis.

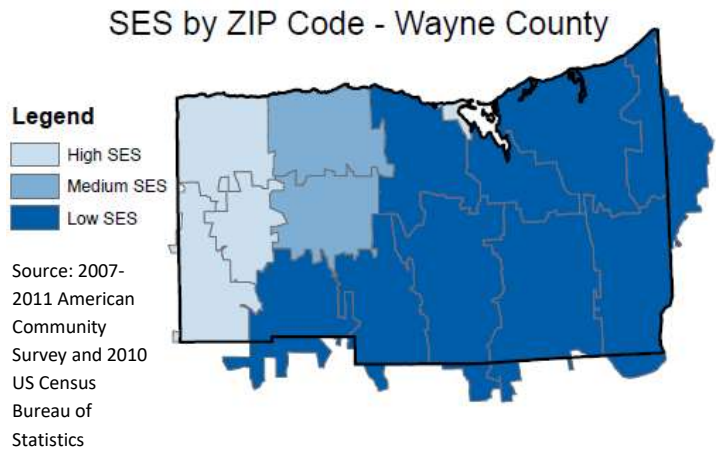
7. Evaluation of Impact and Process Measures: Process measures are indicated in the attached CHIP chart and correlate with the objectives chosen from the "Refresh Chart" for the New York State Prevention Agenda. They include such measures as the number of institutions that implement healthy policies, the number of primary care practices that become NYSDOH Breastfeeding Friendly Certified, the number of participants enrolled in Opti-Quit and Baby and Me Tobacco Free, the number of providers participating in the regional hypertension registry, the number of participants enrolled in evidence-based self-management programs, and the number of school based dental sites. The WHIP meets bi-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 New York 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 Wayne County, NY.

Wayne County is a small rural county located on the southern shore of Lake Ontario between two major cities, Rochester and Syracuse, in the Finger Lakes region of upstate New York. Sodus Bay, located about midway between these two cities, is the largest bay on the American shore of Lake Ontario. Glacier activity had a significant effect on the geography of the County. Along the norther border, south of Lake Ontario, the land rises slightly. This higher land is called the "Ridge". It is believed that it was the shore of a once bigger Lake Ontario. Much of the County is flat, except for large rounded hills which run north and south. The geography of Wayne County has affected the agriculture in the area, and also the presence of a substantial migrant labor force. The area near the lake has been the best place for farming of fruit because the temperature of the lake changes more slowly and affects the land close to it, by keeping the temperature more constant.



Socioeconomic Status (SES) measures as a combination of education, income and occupation. In the map provided above, the majority of Wayne County falls into the low Socio-Economic Status category. In general, the lower one's SES, the greater one's risk for obesity, chronic diseases, and negative health outcomes. The annual median household income is $51,597 compared to $53,482 for the nation and the per capita income is $25,643 compared to $28,555 for the nation (Census QuickFacts, 2010-2014). According to 2014 United States Department of Agriculture (USDA) poverty data, the county poverty rate is 12.9% with 18.4% of children 0-17 years living in poverty.

The population is widely scattered over the 604 square miles, with an average population density of approximately 155.3 persons per square mile (US Census 2010). The most populous communities in Wayne County are Newark and Lyons (the county seat). The population seems to have peaked in 2000, declining slightly since that time. In general, Wayne County has a high dependency ratio, with 21.9% of the population estimated to be under age 18 in 2015 (5.4% under age 5), and 17.0% estimated to be aged 65 or over (US Census Bureau, Population Estimates Program 2015). Approximately 93.6% of the population is white, 3.3% is Black/African American and the remainder other races. In 2015, 4.2% of the population is estimated to be Hispanic/Latino (US Census Bureau, Population Estimates Program). This makes Wayne the most diverse county of the 8 Network counties. In addition to migrant farm workers, County residents also include a sizeable Mennonite population. In the 2010-2014 American Community Survey, 1,391 people indicated that they spoke English "less than very well", 4.6% speak a language other than English at home, with 2,168 of these indicating that they speak Spanish at home.

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

Health Needs:

While each county in the eight county S²AY Network region started with a summary assessment of each county's data in the region in the FLHSA presentation (Attachment 2) and each county in the region followed a fairly similar process, each county's CHA was completed separately, and each county held their own focus groups within the county. (Additionally, a sub-regional focus group was held in coordination with DSRIP through the Finger Lakes Performing Provider System (FLPPS) in each of the three Naturally Occurring Care Networks (NOCNs) that are in S²AY's region: 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.)) Wayne County is 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 Wayne held their own "priority setting meeting" and worked through county-specific committees (WHIP) to review data, analyze needs and develop priorities.

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

- Obesity – lifestyle, cultural, physical activity, nutrition, community gardens. (low back pain, cardiovascular, and diabetes)

- Dental health (especially Medicaid/low-income)

- Behavioral Health
- Hypertension (tobacco use, cerebrovascular, heart)
- Cancer (lung, prostate)
- CLRD (COPD)
- Injury prevention (suicides, injuries)
- Teen pregnancy

Obesity: 69.7% of adults in Wayne County are classified as either overweight or obese on an age adjusted rate (2013-2014 EBRFSS). Proportionally 36.3% of Wayne County children are considered overweight or obese (85th percentile or higher (2012-2014) DOH health ranking data), this puts Wayne County children in the 3rd quartile for county ranking. 3.1% of adults have a diagnosis of pre-diabetes, 6.4% diabetes, and 26.5% hypertension (2013-2014 EBRFSS). As can be seen in the attached Focus Group presentation (Attachment 3), 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 Wayne County 2013-2014 EBRFSS at: https://www.health.ny.gov/statistics/brfss/expanded/2013/county/docs/wayne.pdf. Additionally, although this data was not available during the focus group/data analysis portion of the assessment process, the Wayne Health Improvement Partnership (WHIP) was provided with 2016 data from the Wayne County Kindergarten Questionnaire which supports the WHIPs chosen disparity (lower breastfeeding rates in the low SES population) and decision to include efforts around breastfeeding in the CHIP. The Wayne County Kindergarten Questionnaire is a voluntary survey completed by parents/guardians at the time they registered their child for Kindergarten. This report provides results from 554 parent surveys, in 10 of the 11 schools in Wayne County. As seen in the chart below, breastfeeding rates are low.

2016 Pre-K registration Survey How long was this child breastfed?	Total Percent	Cly-Sav Percent	Gananda Percent	Lyons Percent	Marion Percent	Newark Percent	NRW Percent	Pal-Mac Percent	Red Creek Percent	Sodus Percent	Wayne Percent
He/she was not breastfed	32.0%	37.2%	12.0%	38.6%	41.0%	33.3%	44.9%	26.5%	41.4%	40.3%	17.2%
He/she was breastfed for one(1) months	12.4%	14.0%	22.0%	20.5%	5.1%	16.0%	10.1%	11.8%	6.9%	12.9%	6.1%
He/she was breastfed for 2-3 months	12.5%	4.7%	14.0%	13.6%	12.8%	16.0%	11.6%	14.7%	13.8%	8.1%	14.1%
He/she was breastfed for 4 months or more	13.8%	14.0%	18.0%	4.5%	12.8%	14.8%	13.0%	11.8%	6.9%	16.1%	17.2%
Mother could not breast feed for medical or other reason	28.0%	30.2%	34.0%	18.2%	28.2%	18.5%	18.8%	35.3%	24.1%	22.6%	44.4%
I don't know	1.3%	0.0%	0.0%	4.5%	0.0%	1.2%	1.4%	0.0%	6.9%	0.0%	1.0%

How long was this child breastfed?	% With no College	% With Some College	Ratio
He/she was not breast fed (for medical or personal reasons)	50.4%	27.1%	0.54
He/she was breastfed for one(1) month or less	11.3%	12.6%	1.12
He/she was breastfed for 3 months or less	11.3%	12.9%	1.14
He/she was breastfed for 6 months or less	8.7%	15.2%	1.74
He/she was breastfed for more than 6 months	15.7%	31.3%	2.00
I don't know	2.6%	0.9%	0.35

Dental health: Unfortunately the most up to date Wayne County dental health data is from 2011 (Bureau of Dental Health Data) and indicates that there are 18.6% of 3rd grade children having untreated dental caries, placing it in the 1st quartile in NY State. Although the 1st quartile indicates that Wayne County is doing well in this measure, input from the focus groups conducted through this assessment (Attachments 4 and 5) and feedback from providers, school staff, Head Start, and Public Health show that child dental health is a much more significant concern. If more updated data was available, it is expected that this number would be much higher. According to the New York State Department of Health, 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. According to the 2013-2014 EBRFSS, 73.8% of adults have visited a dentist within the past year, a little higher than the NYS rate (69.8%). 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.

Behavioral Health - Mental Health and Substance Abuse: This area was identified as an emerging issue through this community health assessment process, specifically around heroin/opioid use. 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. Wayne County has been working on preventing substance abuse at the County level and will continue efforts based on interventions outlined in the CHIP chart. The data shows sharp increases in emergency department visits for substance abuse, heroin overdose, and mental health diagnoses, as well as admissions for heroin overdose (as shown in the attached power point presentations – Attachments 2 and 3). Discussions of the analysis related to the opioid epidemic included mortality rates, premature loss of

life, criminal behaviors related to substance abuse and the fact that substance use disorders affect entire families, often including the children of the person with the disorder.

Hypertension: According to the Centers for Disease Control and Prevention (CDC), approximately 30% of adults have high blood pressure in the United States. Only about half (52%) of these people have their high blood pressure under control. Wayne County is in line with those numbers with approximately 26.5% of the adult population having been diagnosed with hypertension by a physician (2013-2014 EBRFSS). Wayne County also has the second lowest control rate in the region for hypertension with approximately 63% of the population registering as in-control (FLHSA/RBA High Blood Pressure Registry, June 2016).

Cancer: According to 2010-2012 Cancer Registry, Wayne County is higher in cancer incidence, particularly for lung and prostate cancers. The age-adjusted incidence rate for all cancers was 511.4 per 100,000, compared to 489.2 per 100,000 for New York State as a whole. The age-adjusted incidence rate for lung and bronchus cancer was 68.2 per 100,000, compared to 61.6 per 100,000 for New York State as a whole. The age-adjusted incidence rate for prostate cancer was 170.2 per 100,000, compared to 145.3 per 100,000 for New York State as a whole. The age-adjusted late stage incidence rate for prostate cancer was 43.2 per 100,000, more than double the state rate of 21.2 per 100,000. This indicates that screening and early detection are areas to work on in Wayne County.

CLRD/COPD: According to the 2013-2014 EBRFSS, the percentage of adults who are smokers in Wayne County is 27.5% (age adjusted), significantly higher than the New York State rate (15.9%). The age-adjusted death rate due to Chronic Lower Respiratory Disease is 41.5 per 100,000, more than a third higher than New York State as a whole at 29.8 per 100,000 (2012-2014 Vital Statistics Data). Tobacco use is a significant contributor to this health problem. According to the 2013-2014 EBRFSS, the tobacco use rate for those with a household income under $25,000 is 35.4%, higher than the region (30.9%) and New York State as a whole (24.2%). The rates of tobacco use for adults reporting poor mental health (only available for the region as a whole) are also higher than the State.

Injury Prevention (Falls): With Wayne Counties continually aging population, 17.0% of the population being age 65 and over (US Census Bureau, Population Estimates Program 2015), falls can have an adverse effect on resident's health. Wayne County had the fourth highest incident of falls in the region with 34.6% of the population age 65+ reporting at least one fall in the last 12 months (2013-2014 EBRFSS). According to the 2012-2014 SPARCS data, the age-adjusted falls hospitalization rate for Wayne County was 34.1 per 10,000, slightly higher than New York State as a whole (34.0 per 10,000). As a growing concern in the region, this priority area will be monitored over the next two year CHIP cycle.

Teen Pregnancy: Although the data for teen pregnancy in Wayne County is not significantly different than the region or New York State as a whole (aged 10-14 years - 0.2 per 1,000, aged 15-19 years – 27.8 per 1,000, and aged 18-19 years – 63.6 per 1,000 (2012-2014 Vital Statistics Data)), teen pregnancy in the aged 18-19 years was a little higher than NYS as a whole, 63.6 per 1,000 compared to 60.8 per 1,000 (2012-2014 Vital Statistics Data).

Full descriptions of the health needs data are included in the attached presentations for the FLHSA and the focus groups (Attachments 2 and 3).

Health Care Access:

The Wayne Health Improvement Partnership (WHIP) has discussed the access gaps related to the above health needs as they analyzed the data (see Attachments 5 and 6). As discussed above, analysis of data reveals health disparities for the low-income population in general. With designations of primary care, mental and dental Health Professional Shortage Areas (HPSAs), the capacity and distribution of health care providers is an issue. For example, transportation, affordability, and access to care were repeatedly cited as barriers in the focus groups, and was a key discussion in determining health care strategies. The S^2AY Rural Health Network, of which Wayne 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, both of which help people to address gaps in coverage or find access to health care.

Wayne County has the largest migrant population in New York State which poses some additional challenges relating to health care access. With much of this population being transient, working seasonal agriculture jobs, transportation and access to primary care is a significant challenge. A focus group was held with a group of providers that work with the migrant population (Finger Lakes Migrant and Seasonal Farmworker Coalition) to gain feedback on these challenges specifically (see Attachment 4 for focus group notes). The behaviors and culture of all specific populations in the county influence reasoning and strategies in development of the CHIP.

There are many issues that affect the quality of health care in a rural county such as Wayne. 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 Centers for Disease Control and Prevention (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

Wayne County Public Health and their partners will work to address these factors as they tackle their identified health priorities. The sub-groups for these risk factors include lower-income, lower-educated and socially isolated populations, as well as those with genetic predispositions for chronic disease, mental illness and alcohol/substance abuse.

Lack of access to primary care results in poor health outcomes since prevention, early detection, early treatment and referral to other needed services eases the effects of long-term chronic conditions. In Wayne County, socioeconomic conditions limit access to health care. There is a lack of urgent care and specialty providers in the county, limiting access for those without private transportation due to limited public transportation. For the most part however, services are available, if cost, behavioral and transportation barriers do not preclude access. Wayne County residents only have access to one hospital located within county borders and must travel to Rochester for many specialty services. The County is a Health Professional Shortage Area (HPSA) for primary and mental health for the Medicaid eligible population and a dental HPSA for low income individuals in eastern Wayne County.

Physical – As stated in the demographic section, Wayne County has a population of 91,446 over 604 square miles with a population density of approximately 155.3 people per square mile. Wayne County is located on the southern shore of Lake Ontario between two major cities, Rochester and Syracuse, in the Finger Lakes Region of upstate New York. The challenge is for those residents scattered throughout other parts of our rural county where transportation is an issue. The ability to access health care, especially for the uninsured, non-Medicaid population with limited financial means and for the elderly who face hurdles in driving longer distances due to the rural-ness of the county, presents a physical barrier some cannot overcome. Wayne County has a limited public transportation system called Wayne Area Transportation Services (WATS). WATS is fairly economical to use, but requires an entire day of time to access health care due to limited bus routes. Many choose not to use it. Additionally, with older housing stock, indoor air quality issues, long winters with lake-effect snow and 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 implementation of the Affordable Care Act in 2014, the country is now closer to universal

health coverage. The challenge has been to help residents understand the complex system. Legal issues are also a concern for the illegal migrant population who defer health care until an emergency occurs for fear of legal repercussions.

Social - The social aspects of Wayne County residents are influenced by a wide variety of behavioral risk factors that affect Wayne County residents. These include low-income and thus limited means with which to purchase nutritional meals or take advantage of many social and recreational opportunities for physical activity (e.g canoeing, kayaking, backpacking, golf, etc.). Persons with limited means are also more likely to engage in unhealthy habits such as tobacco use or alcohol abuse, probably due to the fact that there are fewer other opportunities to which they have been exposed through which they can change their "state of being" than those of more substantial means, who may use exercise, music, theater, art, stimulating conversation, higher education or other venues for this stimulation. 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 possible or feasible in rural areas. The social isolation seems to also make residents more prone 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. Lower levels of education and educational aspirations are also risk factors as discussed above in the demographics section. Lack of access to dental care and lack of a fluoridated water supply in some parts of the county contribute to these factors.

Economic – The economic factors affecting the health of our residents, as previously stated in the demographics poverty section, 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. Per the census data cited earlier, the annual median household income in Wayne County is $51,597, lower than the New York State median household income of $53,482. Per capita income in Wayne County is $25,643, lower than the New York State average of $28,555 (2010-2014 American Community Survey). Among Wayne County residents 12.9% had incomes below the poverty level compared to the New York State average of 13.5% (2014 USDA Poverty Data).

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 2010-2014 American Community Survey, Wayne County does have a higher percentage high school graduates at 89.3% compared to the New York State average of 86.3%. However, Wayne County has fewer residents over the age of 25 with a Bachelor's degree compared with the New York State average (29.3%), with just 21.3% of Wayne County residents having a Bachelor's degree or higher (2010-2014 American Community Survey).

Other Health Related Components of the Environment:

Wayne County Public Health is always attempting to increase and strengthen collaborations

with coalitions, partnerships, and networks to enhance, coordinate, and provide much needed health care services to County residents.

Wayne 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. We do weekly surveillance of Wayne County school systems for disease outbreaks and daily surveillance of local hospital emergency room activity for disease outbreaks or trends. We assist school health programs on an "as needed" basis to provide up-to- date health education/information for situations that may be occurring in the school systems (such as Methicillin-resistant Staphylococcus aureus (MRSA)). Additional factors are listed below:

- State budget cuts effecting health care and government at local level, Public Health programs may be cut.
- Increases 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 as of October 2016 in Wayne County was 4.6% compared to the 5.0% for New York State.
- Hospitalists pose unique challenges for the smooth transition from inpatient status to care in the home (i.e. obtaining physician's orders; medication management)
- Regulatory changes, increased immunization costs and complicated immunization schedules is beginning to deter provider participation in adult and children immunizations
- Smoking:
    - Increase in worksites/campuses that have become smoke free
    - Increase in available nicotine replacement therapies
    - Public Health has a smoking cessation and nicotine replacement therapy program for public and staff
- Increase in population seeking medical advice from internet web sites.

Improving access to high-quality, continuous primary care and treatment services are critical in eliminating disparities in health outcomes. Unlike other medical services, the primary payment source for dental services is out-of-pocket, with access to services for persons on Medicaid particularly limited. Limited transportation in rural areas, feeling intimidated by the health care system, lack of insurance and perceived confidentiality issues are some of the factors that may keep people from appropriately accessing care. Women in abusive relationships may be so controlled by their abuser that they are not allowed to get medical or dental care. Visibly poor dental health also makes it difficult for people to obtain jobs.

Personal barriers in access to care include:

- Personal value and behavior systems on the part of some county residents (particularly older residents) who refuse to take advantage of eligibility-based

programs (such as Medicaid and Food Stamps) because they consider it a "hand-out"

- Cultural differences and fear of government officials on the part of the growing migrant population in Wayne County may inhibit their access to care
- Lack of a private vehicle for transportation
- Lack of education and personal experience regarding the value of and need for primary and preventive care. This can include feelings of intimidation that some residents may experience in the presence of health professionals, leading both to avoidance of care and lack of empowerment in managing relevant aspects of their own healthcare, along with health literacy issues. For too many residents, emergency room care may be the only type of care accessed. While there is an emergency room, there are no urgent care services in the county. For a significant portion of females, family planning services may be their only access point to primary care services.

According to 2014 Bureau of US Census Data, an estimated 9.4% of Wayne County residents between the ages of 18 and 64 lack health insurance. This is better than the New York State rate of 12.4%. Due to the implementation of the Affordable Care Act and New York State of Health Marketplace, we know that currently, these numbers are much lower. Expansion of the Medicaid income threshold through this has greatly helped many Wayne County residents. Furthermore, the creation of the Essential Plan (for those who are just over the income threshold for Medicaid) has also helped a large amount of Wayne County residents. On the other side, others have been adversely affected, as many of the health plans (for those who are above income for Medicaid and the Essential Plan) have very high deductibles, so although the consumer is now insured, they are not using their plan due to the high out of pocket costs.

Wayne County has two organizations available to assist residents with enrolling in this new system: Thompson Health and the S^2AY Rural Health Network. Public Health is a partner of S^2AY and will work closely with these organizations to ensure residents understand and sign up for health insurance.

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 have made strides in improving access to care issues.

Media Reach - Wayne County has a mixture of media outlets in the County although changes in technology bring new challenges as public health explores novel ways to reach residents. Traditional methods of health care promotion through newspapers, television and radio 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. Public health must re-invent the

way they reach their residents. 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. The challenge will be the ability to utilize these tools given the boundaries of county internet security policies. At the other end of the spectrum is the issue of effectively communicating with the increasing Amish population. Learning about the Amish culture and identifying what is acceptable and not are one of the biggest hurdles that Wayne County Public Health will have to overcome in the near future.

The Clean Indoor Act, passed more than ten years ago, continues to improve the overall environment and reduce second hand smoke statistics. New York State has led the way in creating smoke free indoor environments and is pushing policies in public outdoor areas as well. There is an increase in the number of workplaces and campuses that are now smoke-free. Throughout the last CHIP cycle, Wayne County Public Health was able to pass a smoke-free policy for all County owned property.

Poverty statistics described previously impact a resident's ability to access health care. Income levels can restrict basic needs such as heat, food, adequate shelter, medical and prescription care. Some homes still have no indoor plumbing and many county residents use wood as their main heat source. Inadequate housing can impact health outcomes. The social environment is generally conducive to accepting of health care although there is a subset of the population that does not seek preventive care and relies on the emergency room for medical necessity.

Wayne County attracts many tourists during the summer season, placing a burden on local medical services, law enforcement and the local infrastructure. This creates the potential for a health disaster as regular resources will quickly be exhausted in the event of a major health emergency. Typical seasonal visitors include those enjoying Lake Ontario, Sodus Bay, local wineries, and the Erie Canal.

The current economic situation and the budget cuts over the last few years have affected the local health care environment. Providers have a more difficult time, with a seemingly increasing number of individuals recently electing to skip routine medical and dental care due to lack of employment, resources and/or insurance. Some providers refuse to accept Medicaid.

Additionally, the high cost of fuel is still a consideration for residents as this expense reduces funds available for health related items (healthy food choices, memberships to health clubs, etc.) and the ability to get to health-related services and/or pay for prescriptions.

Emerging Issues:

Emerging issues in the health care system were also discussed, and Newark Wayne Community Hospital, Wayne County Public Health and the S^{2}AY 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 Wayne, the S^{2}AY Network started a group called Finger Lakes and Southern Tier (FLAST), which is currently transitioning into an Independent Provider Association (IPA). While mostly comprised of Federally Qualified Health Centers (FQHCs), S^{2}AY is helping to lead the way for determining how to navigate the changing reimbursement structures for all types of organizations. S^{2}AY reports progress on this development regularly to Wayne County representatives.

Furthermore, since the 2013 Community Health Assessment, Eastern Equine Encephalitis Virus (EEEV) has emerged as a public health concern, specifically in Wayne County. From 2014 - 2016 a total of seven (7) horses have tested positive for EEEV in the Towns of Rose, Galen and Macedon in Wayne County. According to the Centers for Disease Control (CDC), EEEV develops from an infected mosquito bite (in humans, horses, other mammals, some birds, reptiles and amphibians), resulting in one of two types of illness, systemic or encephalitic. The type of illness will depend on the age of the person and other host factors. Wayne County has been conducting mosquito surveillance to monitor the presences of EEEV and have found no mosquito pools testing positive for the EEEV. This emerging issue will continue to be monitored through 2016 and beyond.

2. Data Reviewed and Analyzed:

The data review and analysis was extensive. In all S^{2}AY Network Counties including Wayne, 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^{2}AY. This data collection and analysis effort focused on data related to the main priorities in the 2013 CHA for the region as well as some emerging issues that the hospitals and Public Health agreed should be analyzed based both on their knowledge of what they were seeing in their communities and what the needs assessment for DSRIP (also conducted by the FLHSA) had revealed. In addition to the DSRIP needs assessment, data sources for this review included.

- Expanded Behavioral Risk Factor Surveillance Survey (2013-2014)
- Census Bureau (2010 Census and 2015 American Community Survey estimates)
- SPARCS data (2010-2014)
- NY State Prevention Agenda data set (updated 2016)

- Aggregated Claims Data (2014)
- NY State Vital Statistics (2014)
- Regional High Blood Pressure Registry (2015-2016)

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

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

3. Priorities, Disparities and Community Engagement:

Prevention Agenda Priorities -

As detailed on the attached Community Health Improvement Plan (CHIP) chart, the three New York State Department of Health (NYSDOH) Prevention Agenda priority areas for Wayne 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 2:* Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
    - *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings
2. **Priority Area 3:** Promote Healthy Women, Infants, and Children
    - *Focus Area 2:* Child Health
3. **Priority Area 4:** Promote Mental Health and Prevent Substance Abuse
    - *Focus Area 1*: Promote Mental, Emotional and Behavioral Well-Being

Disparities Being Addressed -

During the 2016-2018 period, Wayne County Public Health and Newark-Wayne Community Hospital have chosen to address two disparities through specific evidence based activities (as outlined in the CHIP chart, attached). Both of the disparities to be addressed fall under the priority area of Prevent Chronic Diseases. The first disparity focuses on Goal 1.3 (expand the role of health care providers and insurers in obesity prevention). This disparity will target the low socioeconomic status (SES) population by implementing strategies in the hospital and affiliated practices (very high Medicaid rates) to increase breastfeeding initiation/duration/exclusivity. Breastfeeding rates among the WIC population are shown to be low in the EBRFSS. The second disparity focuses on Goal 2.2 (promote tobacco use cessation, especially among low SES populations and those with poor mental health). This disparity will target the low SES population and those with poor mental health by promoting the use of evidence based tobacco dependence treatments (Opti-Quit and Baby and Me Tobacco Free) and increasing the awareness of Medicaid benefits for smoking cessation. The EBRFSS shows that smoking rates are significantly higher among those with poor mental health in the Finger Lakes region. Disparities were chosen by the WHIP based on analysis of the data and potential to reach disparate populations.

Community Engagement –

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

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

1. **Organize for Success- Partner Development**
   This included representatives of the Wayne Health Improvement Partnership 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 Wayne 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 -

Wayne County Public Health and Newark-Wayne Community Hospital, with assistance from the S2AY Rural Health Network, conducted a comprehensive assessment of the community, which provided the basis for the Prevention Agenda priority areas selected above. The assessment process included a thorough review of county specific data around health needs, compared to neighboring counties, the region, and the State as a whole. As noted above, this included data collection and analysis by both the FLHSA and S^{2}AY. The WHIP, which includes FQHCs (Finger Lakes Community Health), other Wayne County Departments (Office for the Aging, Department of Social Services, etc.), a provider of services to the developmentally disabled population, schools and CBOs, oversaw the assessment process. After the data was analyzed and prepared, this data was shared in the form of focus group presentations to county residents. Wayne County conducted eight (8) separate focus groups with key informants throughout the county to solicit feedback. Focus groups were selected to include a broad diversity of community members from different segments of the community, including populations that experience health disparities as outlined in this report. Focus groups that were conducted include the following: a Head Start parent group, the Wayne Health Improvement Partnership, a group of physicians, a senior citizen group, the W3C (Wayne County Coordinating Council), a population health committee meeting, Finger Lakes Migrant and Seasonal Farmworker Coalition, and the Finger Lakes NOCN.

After the completion of the focus groups, the WHIP invited focus group participants, all community members, health care organizations, and human service agencies to participate in the prioritization of the most pressing health needs identified from the data collection and focus group input. Focus group participants and community members were invited to this meeting through email, media releases, and postings on websites and social media platforms (Public Health, Hospitals, S2AY Rural Health Network, and other partners). S^{2}AY prepared another Power Point presentation for this "Priority Setting" meeting. The meeting was open to the public and focus group participants were invited. At this meeting, S^{2}AY 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^{2}AY created from all of the data reviewed and analyzed (list of issues to rank, see Attachment 8). The group was also offered the opportunity to add any additional issues that they believed needed to be ranked to come up with priorities.

The Hanlon Method was used to rank issues, and a presentation summarizing the Hanlon Method was reviewed (Attachment 9), and participants ranked the highest priority issues to come up with a list of preliminary priorities (list of ranked issues, see Attachment 11). (Hanlon uses the Basic Priority Rating (BPR) System formula where BPR = (A + 2B) X C where A= the size of the problem, B= the severity of the problem and C=the effectiveness of the solution. The effectiveness of the solution is given a lot more weight than the size or seriousness of the problem, with the hope of making wise use of limited resources by targeting solutions that are known to be effective. Participants also consider the weight of the propriety, economic feasibility, acceptability, resources and legality (PEARL) of issues in this ranking system. Numerical values were determined by each participant for size, severity and effectiveness, and then plugged into the formula along with average PEARL scores. It is important to note that while the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still a method that is largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since respondents ranked each component (size, seriousness and effectiveness of the solution, as well as the PEARL factors) individually using a paper ranking form (blank rating sheet, Attachment 10), 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 (Attachment 13 and 14). The next three meetings of the WHIP 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 chart, strategies to address chronic diseases include evidence based activities such as Stanford approved curriculums (e.g. Chronic Disease Self-Management Program (CDSMP), policy/practice implementation (working with worksites to implement healthy policies and encouraging providers to become Breast Friendly Certified), promoting provider practice participation in the regional hypertension registry, and promoting evidence-based tobacco dependence treatments among those who use tobacco. Strategies under "Promote Mental Health and Prevent Substance Abuse" include Project Lazarus to prevent overdose deaths (project activities include community activation, prescriber education, supply reduction, drug safety, demand reduction, Narcan trainings, and community-based prevention education). In addition to Project Lazarus, the WHIP will be working to better coordinate efforts between existing coalitions/groups in Wayne County (Wayne Wellness Coalition, etc.) to implement a comprehensive approach to addressing the opioid crisis.

4. Community Health Improvement Plan (CHIP):

Lessons Learned/Progress on Current CHIP

Wayne County is fortunate in that many of the health and human service agencies are willing collaborative partners. Much of the work on the current CHIP has been done by many of the WHIP members coming together and applying their area of expertise to the specific activity. There were many times where Wayne County Public Health was not the lead agency overseeing a project.

Major indications of success within the CHIP include work in several priority areas. One such example being the local law prohibiting tobacco use, including e-cigarettes, on county owned and leased properties. This law was created with the public in mind, considering the harmful effects of tobacco smoke from primary and secondary sources; providing clean, second-hand smoke free grounds for clients using county agencies.

An additional example of progress within the CHIP would be the successful implementation of a policy allowing county employees time for breastfeeding and private space for pumping. Increasing breastfeeding rates is an important aspect of the prioritization of reducing obesity. The aforementioned policy allows greater access for clients and employees to provide for their children. Additionally, the creation of the Baby Café in Newark allows even greater access for expecting and current mothers to obtain resources, information, and aid regarding breastfeeding from certified lactation counselors. Finally, the transition within Newark-Wayne Community Hospital to become designated as a “Baby Friendly” hospital has created a unified message to the community that breastfeeding is a preferred, and extremely health effective method for providing nourishment to a child.

Community Health Improvement Plan

Please see the attached Wayne County CHIP chart (attachment 15), created using the template provided by the NYSDOH and the "Refresh Chart" for the Prevention Agenda. The NYSDOH Refresh Chart uses both established state and national standards/research, for example the National Prevention Strategy and Healthy People 2020 priority areas. The Refresh Chart can be located at the following link:

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 New York 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 Wayne Health Improvement Partnership (WHIP) 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 Wayne County Public Health and Newark-Wayne Community Hospital intend to take to address each priority area, the specific resources Wayne County Public Health and Newark-Wayne Community Hospital intend to commit (dollar amounts and/or full time equivalents (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 above, the Community Health Improvement Plan (CHIP) chart designates the organizations that have accepted responsibility for implementing each of the activities outlined. The Wayne Health Improvement Partnership ((WHIP) – formerly known as the "Wayne County Prevention Agenda Team") is the group that will be leading the implementation, monitoring, and evaluation of the plan. The WHIP meets on an every other month basis (and has been meeting since before the last CHA/CHIP cycle in 2013) and has accepted this role of overseeing the CHIP. Currently, each partner organization reports CHIP updates as they are completed, to Wayne County Public Health (which facilitates the WHIP meetings). Wayne County Public Health then records this progress on the CHIP document, assigning each task as completed, in process, or no longer applicable. All WHIP partners review the CHIP chart at each meeting to ensure that all activities/progress are captured, to discuss barriers, and identify new opportunities or changes in goals or activities. Furthermore, progress is also reported quarterly to the Wayne County Legislature through the Wayne County Director of Public Health (which has been done since the last CHA/CHIP cycle in 2013). Newark-Wayne Community Hospital will continue to communicate CHIP/Community Service Plan (CSP) updates to their Hospital Board annually, and activities will also be shared with the S2AY Rural Health Network Board. Activities on the CHIP will continually be assessed and modified as needed to address barriers and replicate successes. As priorities are addressed, other community partners may need to be brought to the table to effectively accomplish objectives. The WHIP is aware of this and experienced at this, as several new partnership 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 (Wayne County Public Health and Newark-Wayne Community Hospital) will be disseminated to the public in the following ways:

- Made publicly available on the Wayne County Public Health main website
- Made publicly available on the Newark-Wayne Community Hospital main website
- Made publicly available on the S^2AY Rural Health Network website

- Made publicly available on additional partners websites (Cornell Cooperative Extension, WIC, local community based organizations, etc.)
- Shared with all appropriate news outlets in the form of a press/media release
- All partners including Wayne County Public Health, Newark-Wayne Community Hospital, S2AY Rural Health Network, and additional partners will be asked to share the publication and website links of the CHA/CHIP/CSP on their respective social media accounts (Facebook, LinkedIn, Twitter, etc.)

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

Wayne County Public Health: http://web.co.wayne.ny.us/publichealth/

Newark-Wayne Community Hospital: https://www.rochesterregional.org/patients-visitors/newark-wayne-community-hospital/

S2AY Rural Health Network: http://www.s2aynetwork.org/community-health-assessments.html

Attachment 1

Wayne Health Improvement Partnership (WHIP)

Membership List 2016

- Wayne County Public Health
- S2AY Rural Health Network
- Wayne County Action Program
- Newark-Wayne Community Hospital
- Cornell Cooperative Extension
- Finger Lakes Health Systems Agency
- Finger Lakes Community Health
- Wayne County Office for the Aging
- Wayne County Mental Health
- Wayne County Rural Health Network
- Wayne County Arc
- Lyons Central School District
- Tobacco Action Coalition of the Finger Lakes
- Catholic Charities of Wayne County

Finger Lakes Health Systems Agency

Regional Leadership Meeting

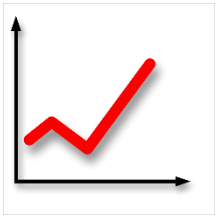
March 4, 2016

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

Research & Analysis Updates

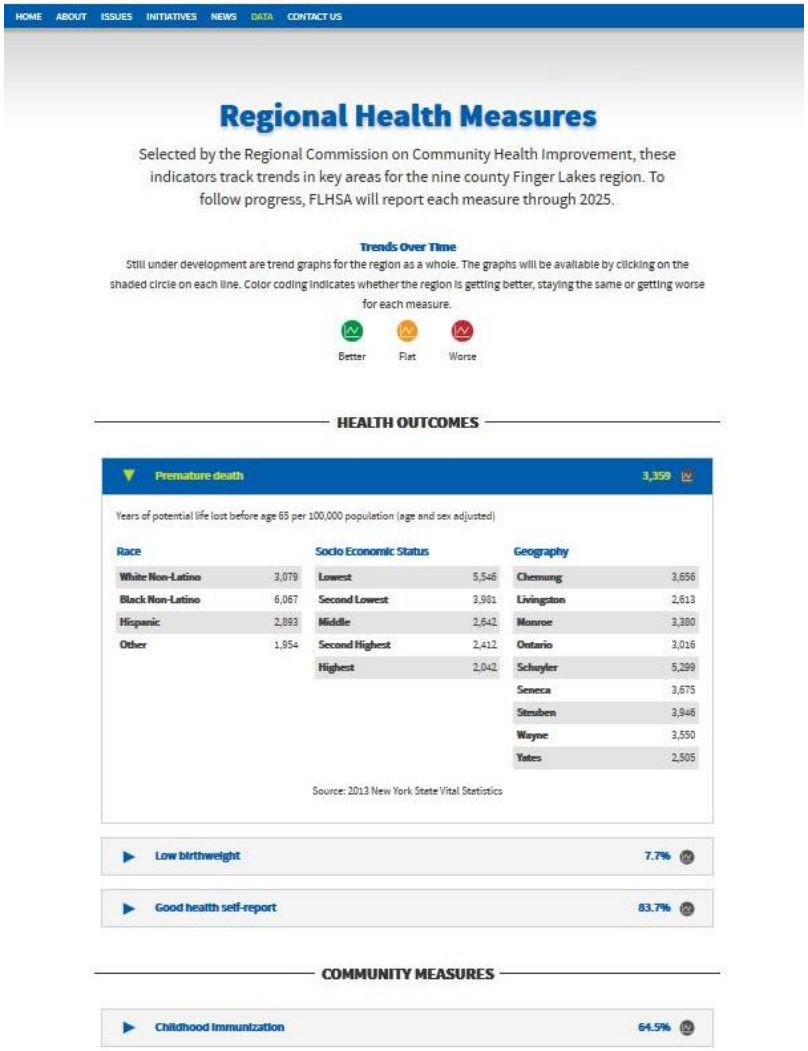
- Continuous Capability Enhancement

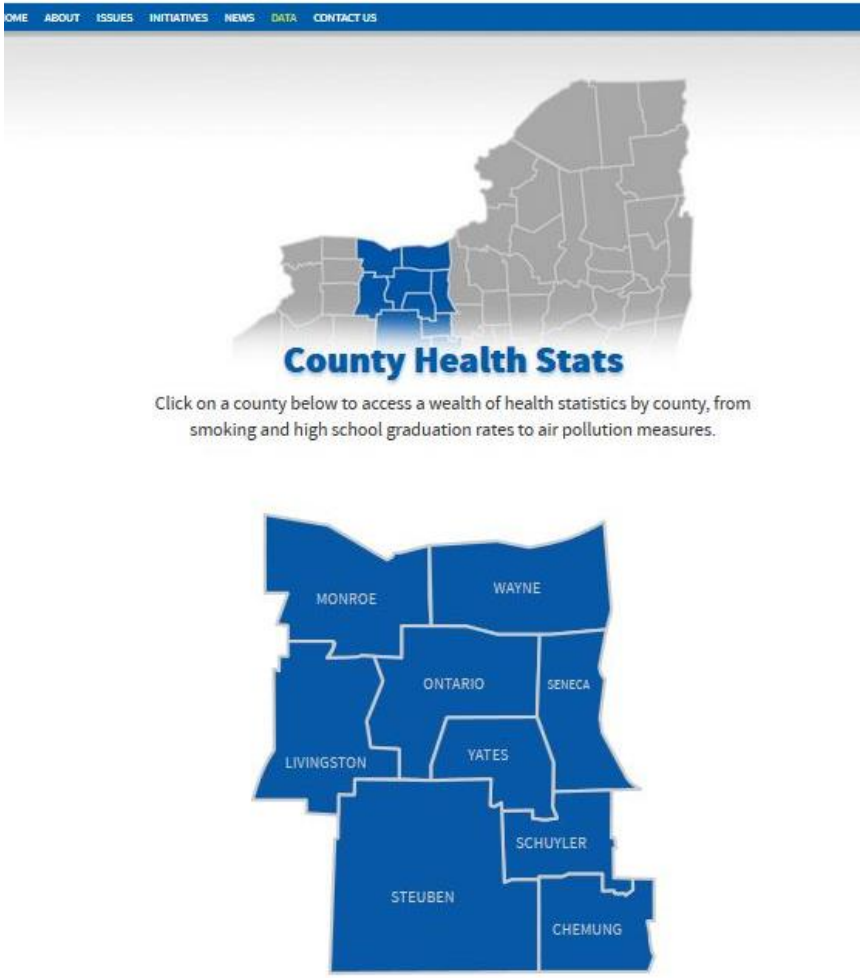
- Regional Population Health Measures



- Community Insight & Input

FLHSA Website Enhancements



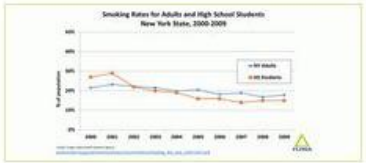


FLHSA Website Enhancements

HOME ABOUT ISSUES INITIATIVES NEWS DATA CONTACT US

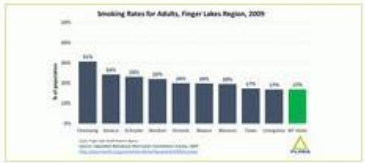
Insights

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



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

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



Smoking rates for adults, Finger Lakes Region, 2009

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

DOWNLOAD IMAGE [PPT]

DOWNLOAD IMAGE [PDF]

Rate of fruit and vegetable consumption, Finger Lakes Region

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

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

Finger Lakes Health Systems Agency

An Analytic Review of Selected Priority Areas

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

Approach & Methodology

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

2013 Community Health Assessment Priority Areas

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

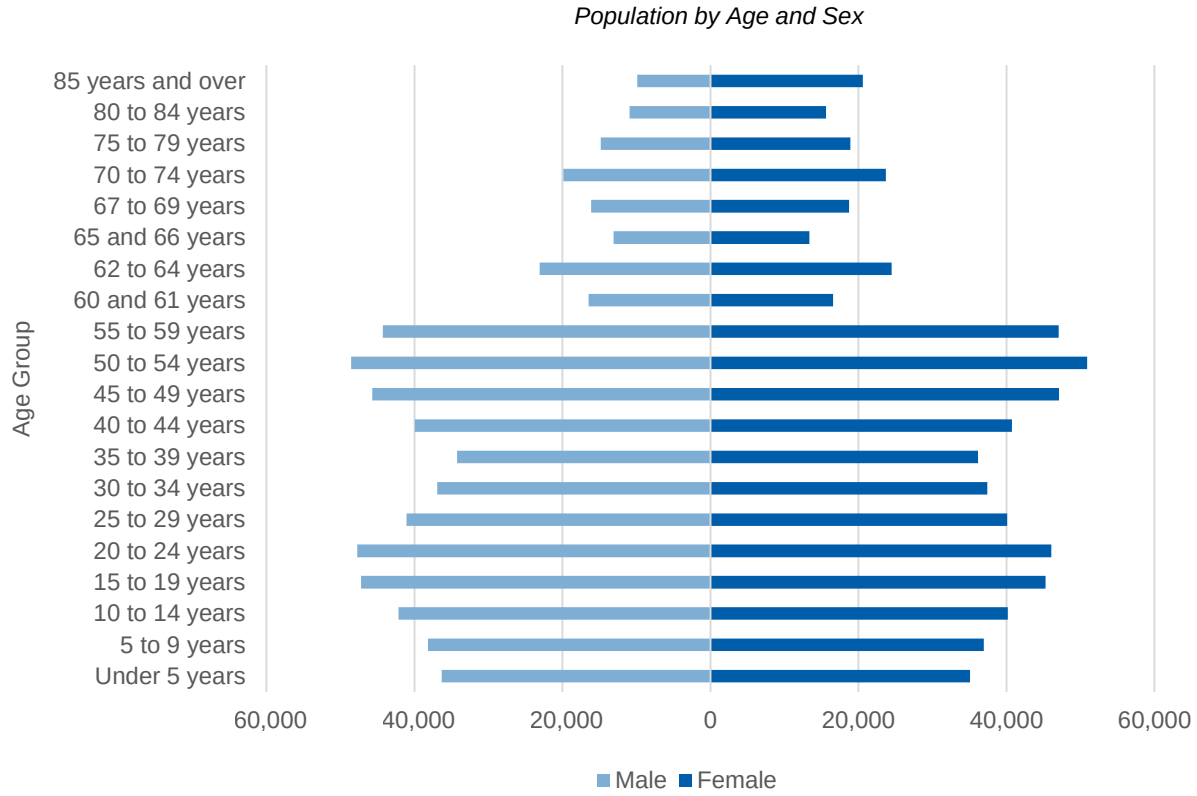
Approach & Methodology, Continued

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

THE FINGER LAKES REGION: DEMOGRAPHICS

The Finger Lakes Region

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

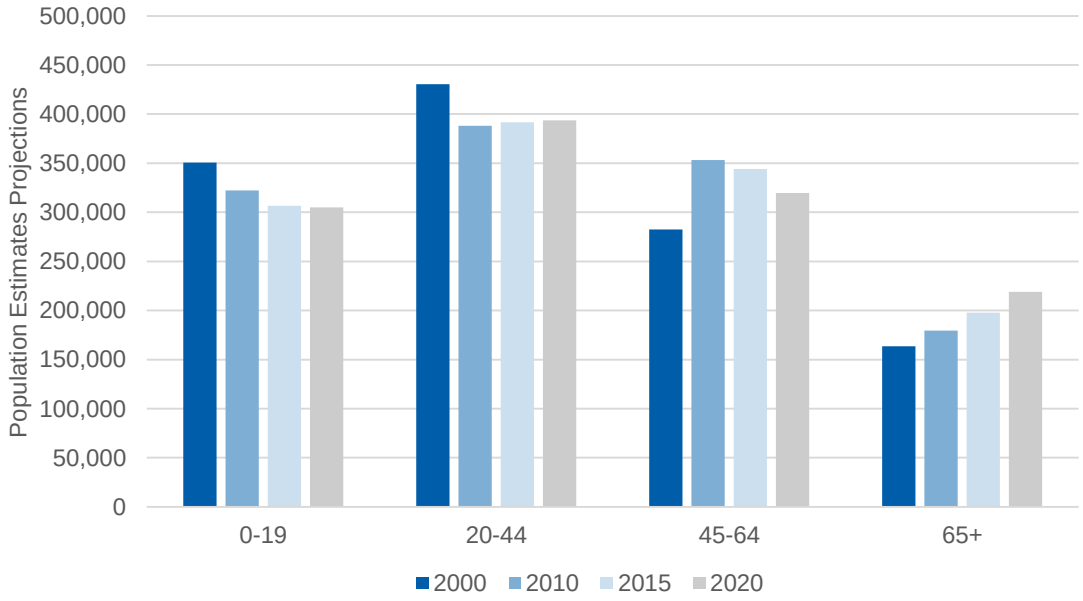


Data Source: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2010-2014

The Finger Lakes Region, Continued

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

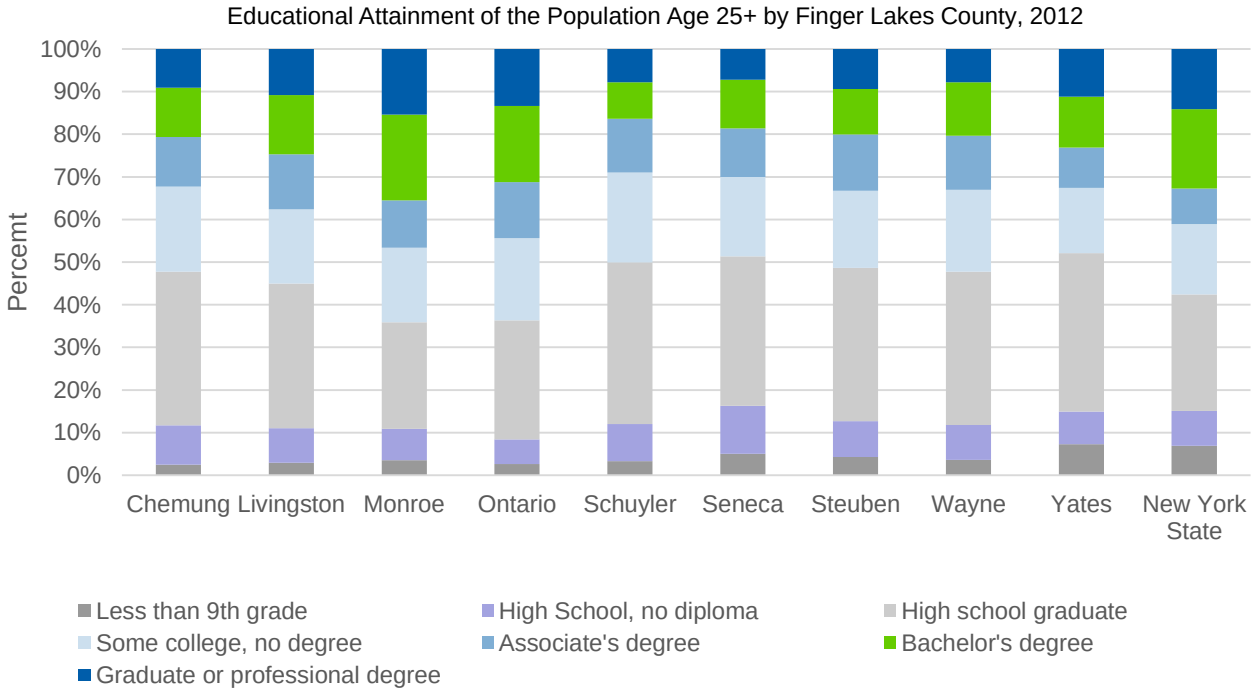
2000 to 2020 Population Trends by Age Group



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

The Finger Lakes Region, Continued

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

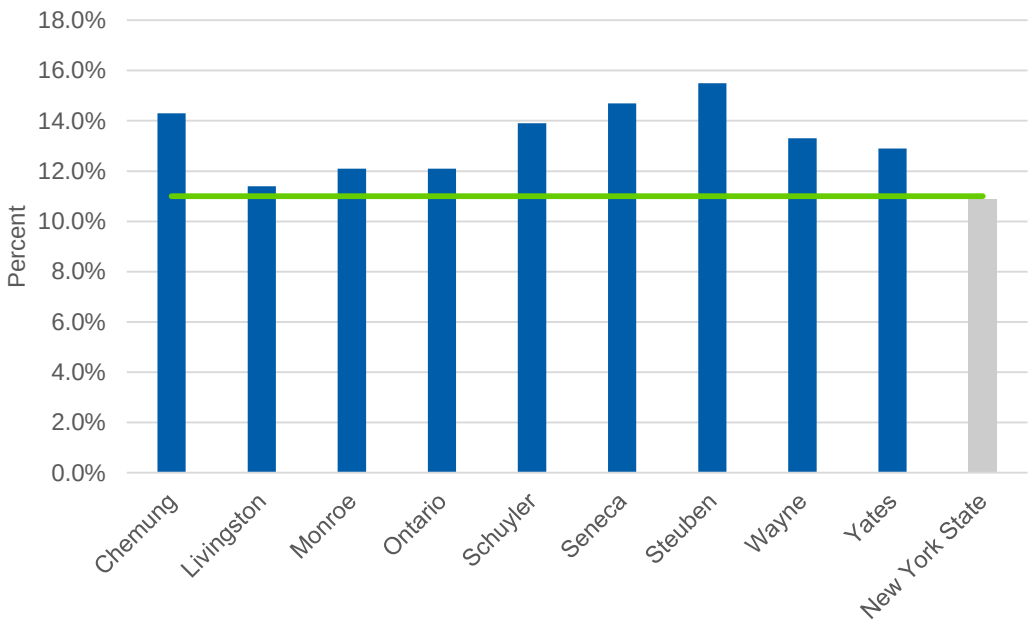


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

The Finger Lakes Region, Continued

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

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

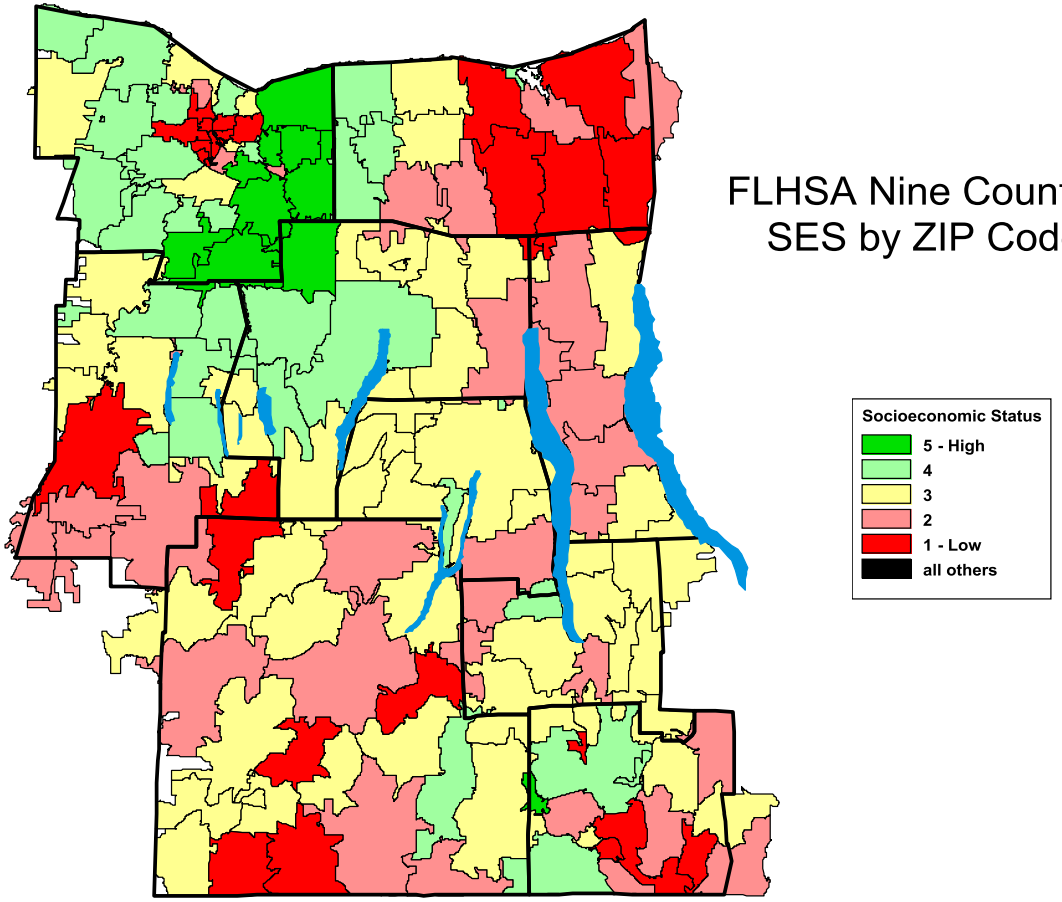


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

The Finger Lakes Region, Continued

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

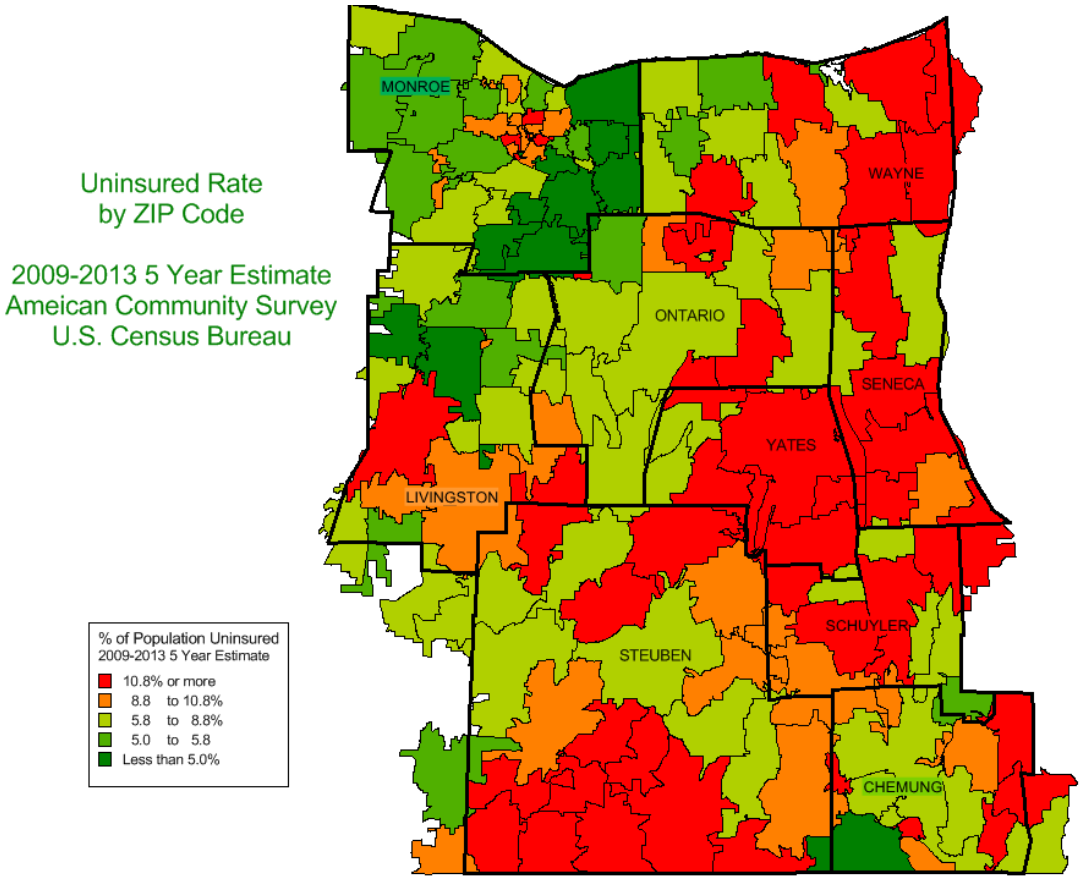
Socioeconomic Status of Finger Lakes Region based on ZIP Code



The Finger Lakes Region, Continued

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

Percent of Finger Lakes Region Uninsured by ZIP Code



DATA UPDATES:
THE EIGHT PRIORITY AREAS

The Eight Priority Areas

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

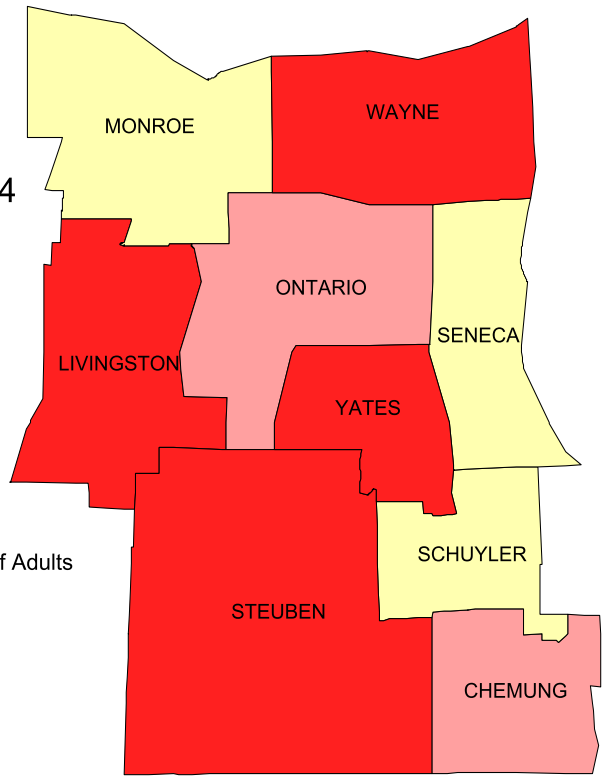
PRIORITY AREA 1: OBESITY

Obesity

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

Percent of Adults who are Obese in Finger Lakes Region

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



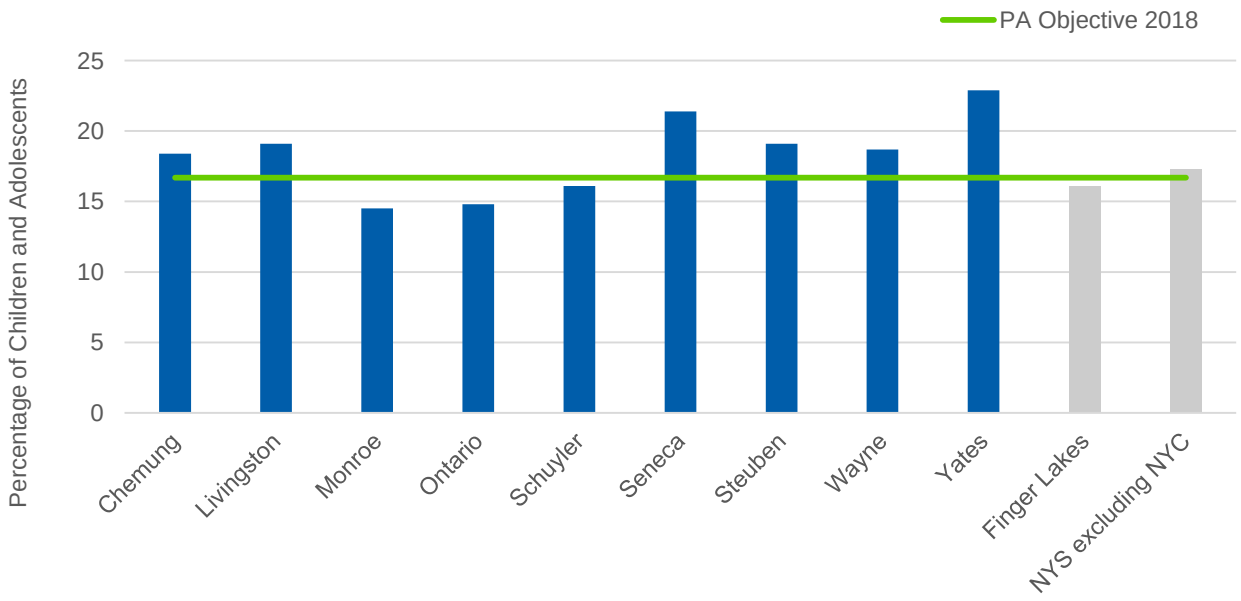
The Prevention Agenda Objective for 2018 is 23.2% of Adults

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

Obesity

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

Percentage of Children and Adolescents who are Obese



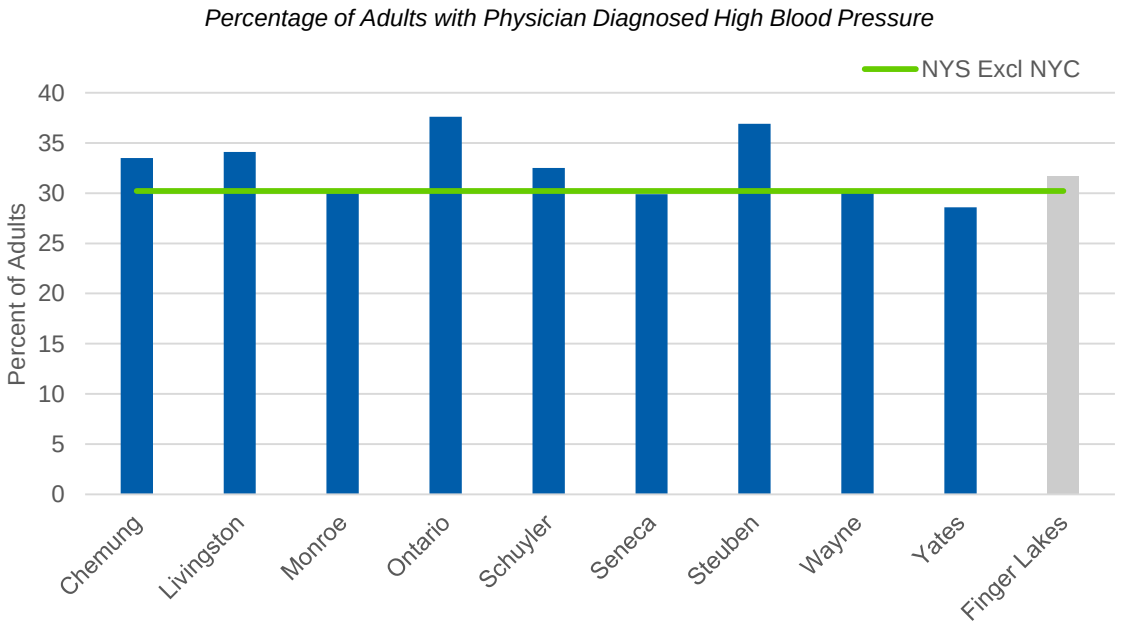
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2012-2014

PRIORITY AREAS 2-4: CHRONIC DISEASE

HYPERTENSION, DIABETES, AND HEART DISEASE

Chronic Disease- Hypertension

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

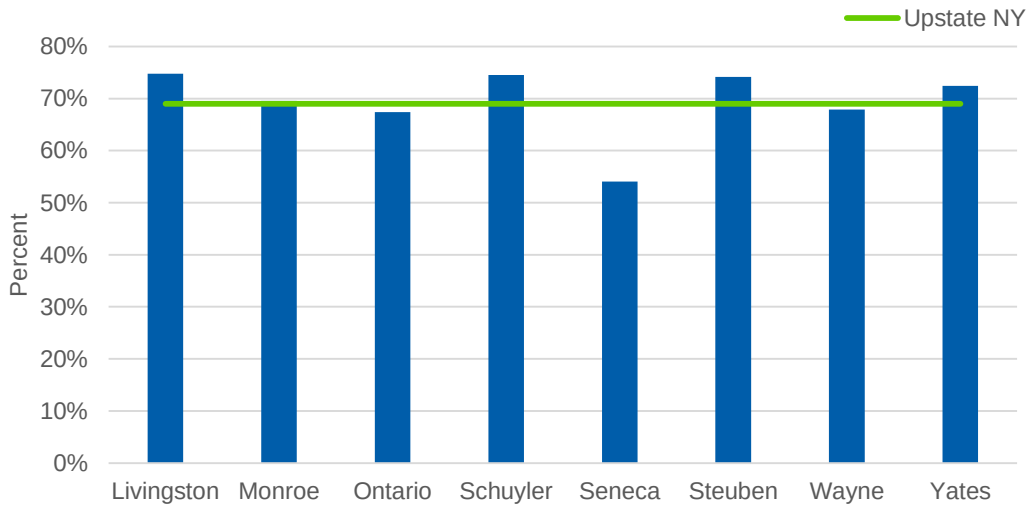


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Chronic Disease- Hypertension

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

Hypertension Control Rates, June 2015

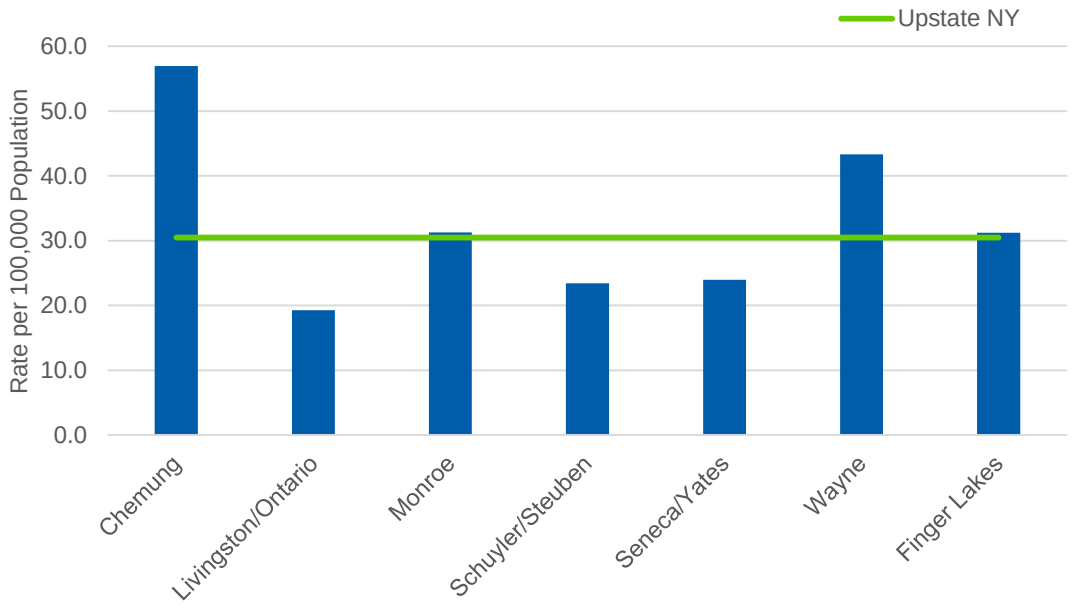


Data Source: FLHSA/RBA High Blood Pressure Registry, June 2015
Note: Chemung has been excluded due to small sample.

Chronic Disease- Hypertension

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

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

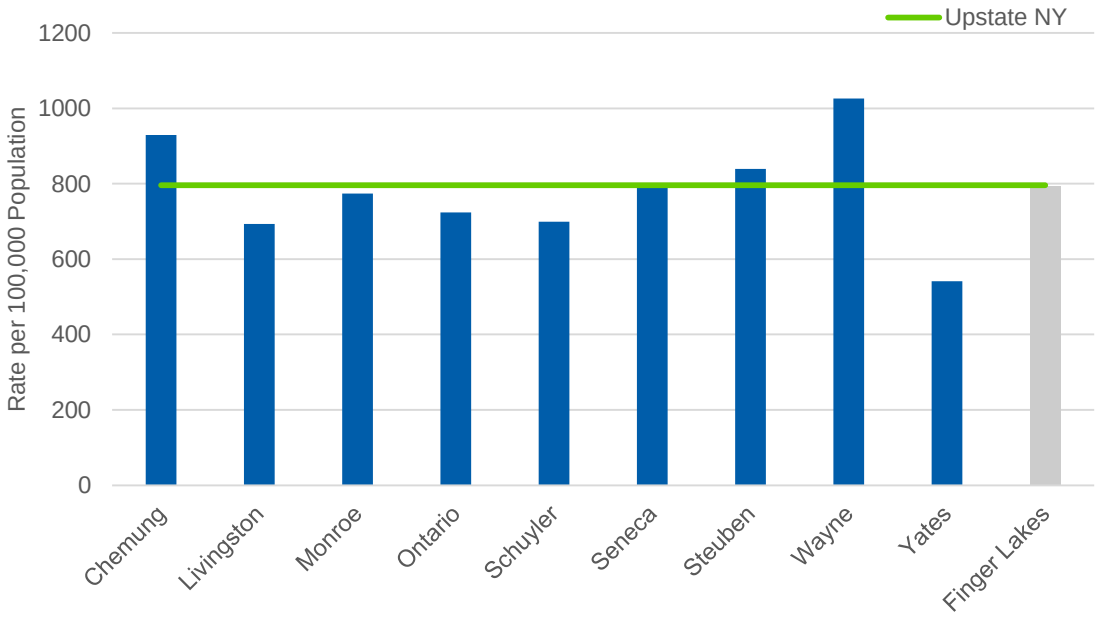


Data Source: SPARCS, 2013
Hypertension as a primary or cormorbidity diagnosis

Chronic Disease- Heart Disease

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

Rate of Inpatient Heart Disease Admissions per 100,000 Population

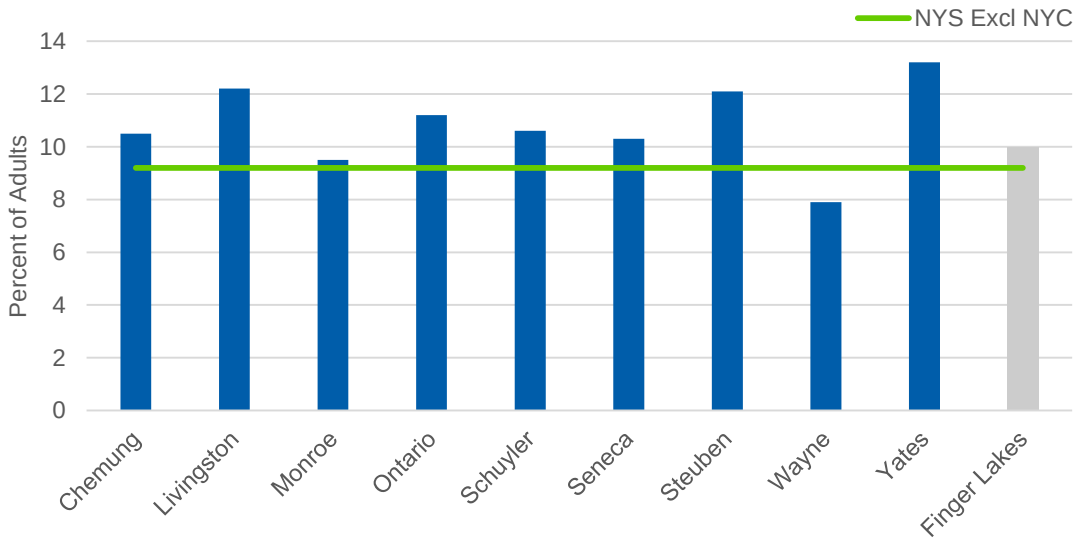


Data Source: SPARCS, 2013

Chronic Disease: Diabetes

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

Percentage of Adults with Physician Diagnosed Diabetes

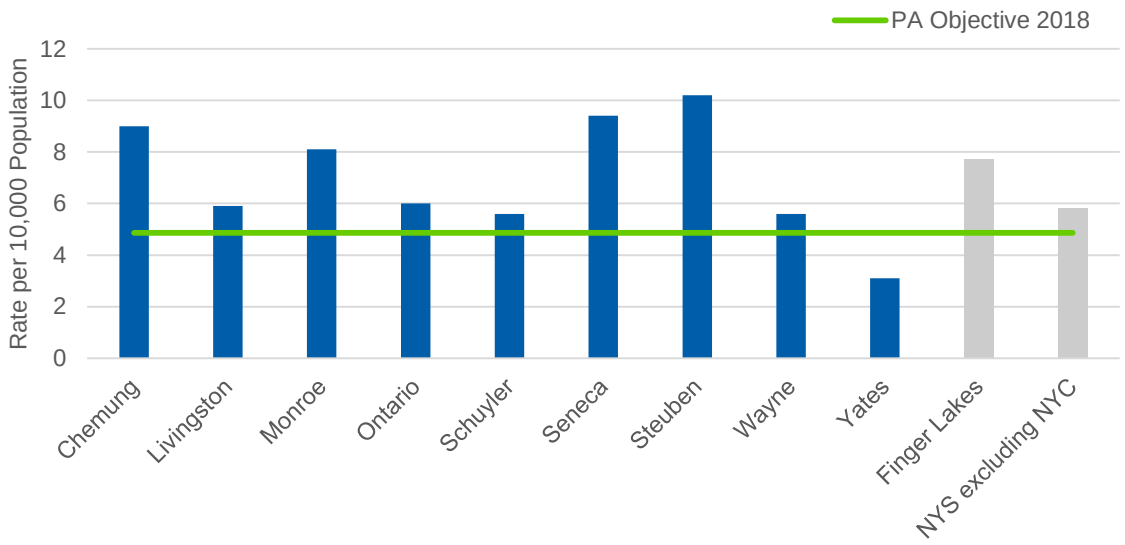


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Chronic Disease: Diabetes

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

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

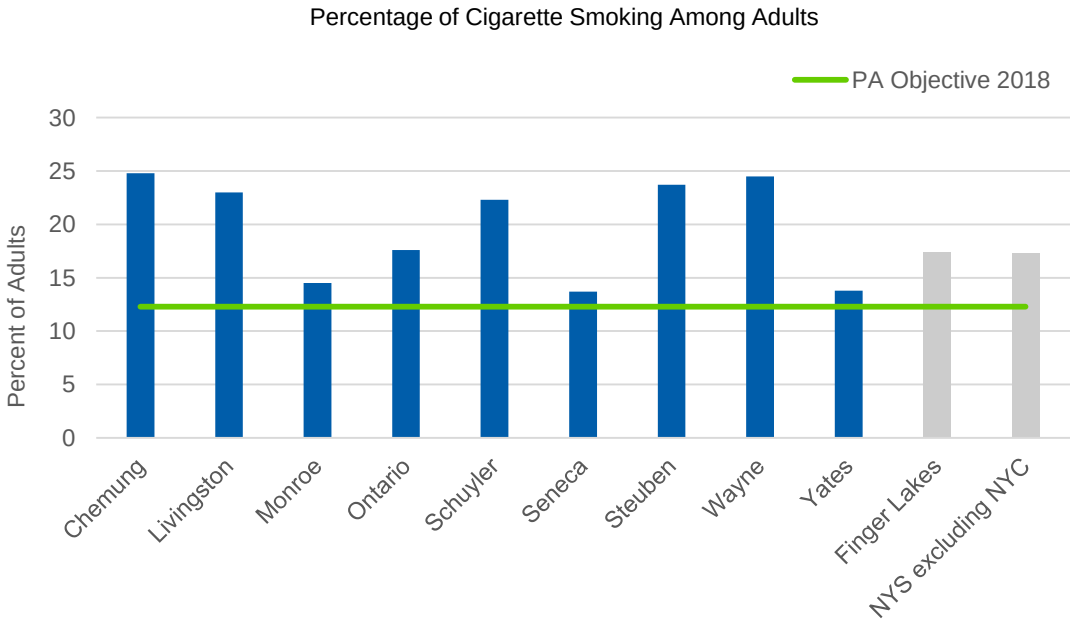


Data Source: New York State Prevention Agenda, 2011-2013

PRIORITY AREA 5: TOBACCO USE

Tobacco Use

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

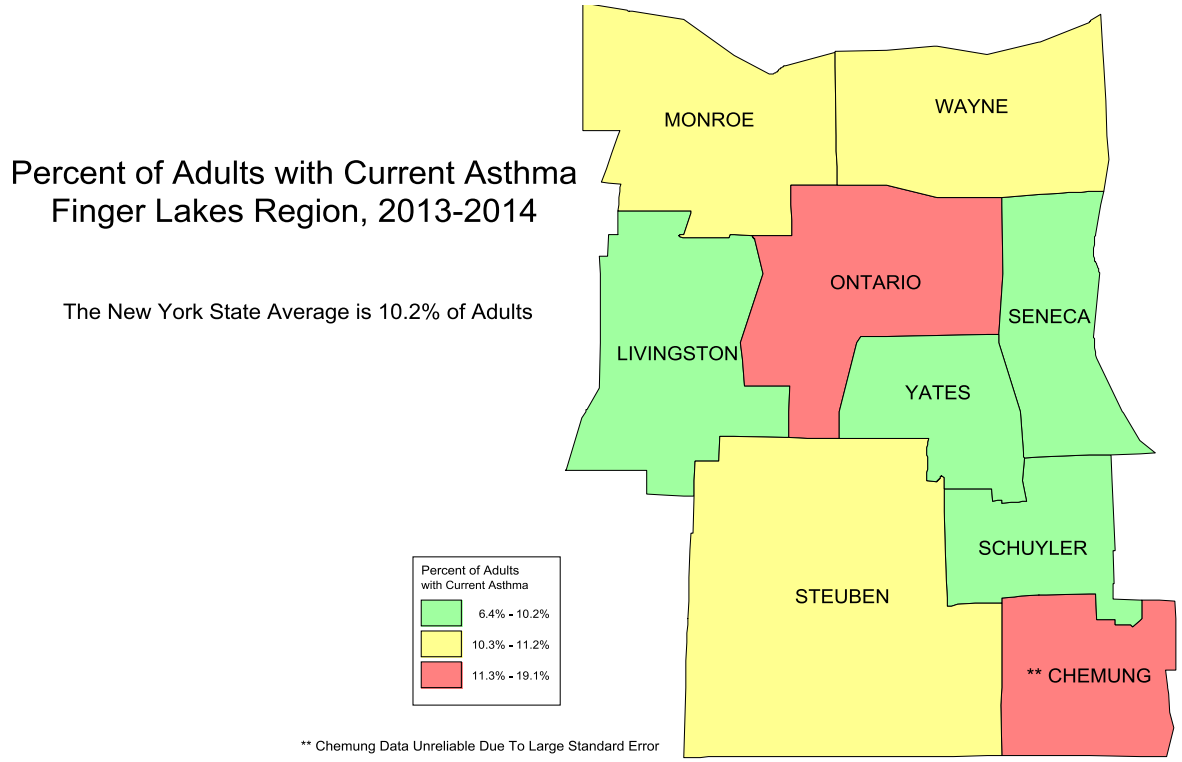


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Tobacco Use

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

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

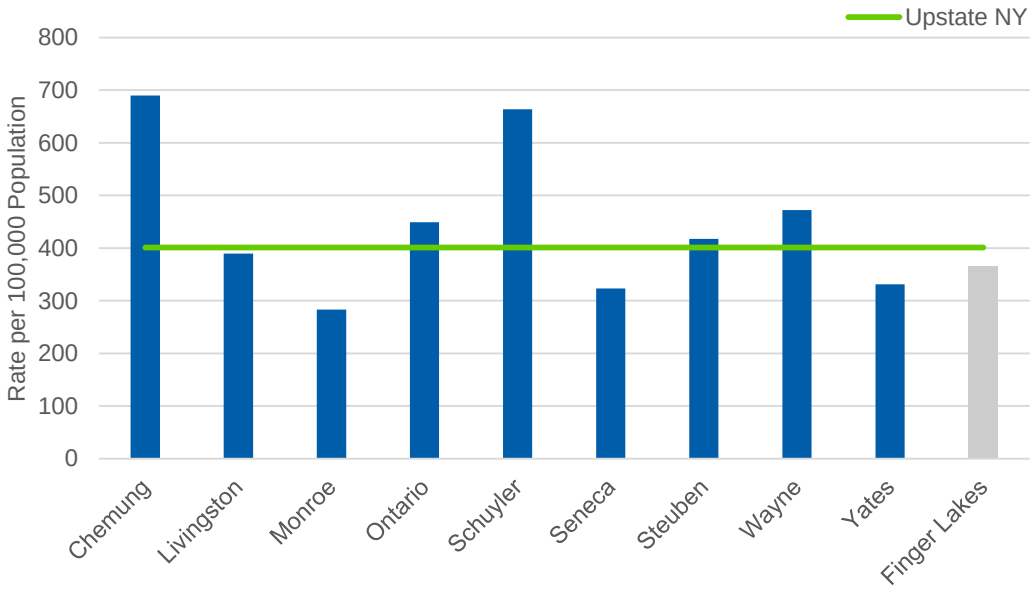


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Tobacco Use

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

Rate of Respiratory Prevention Quality Indicators

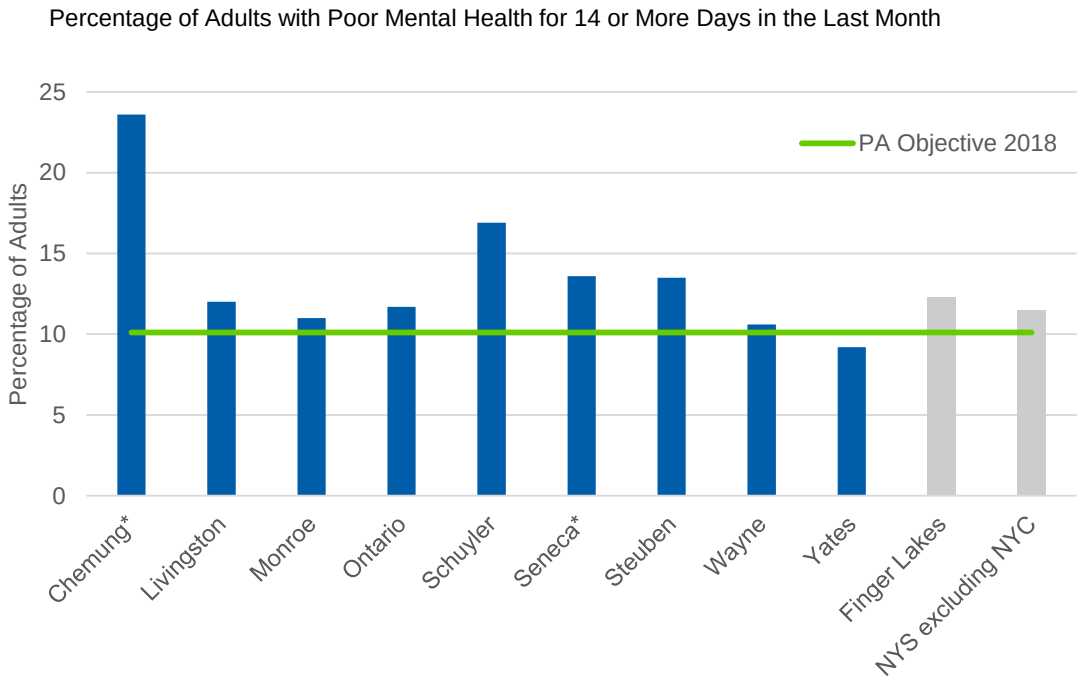


Data Source: SPARCS, 2013

PRIORITY AREA 6: BEHAVIORAL HEALTH

Behavioral Health

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

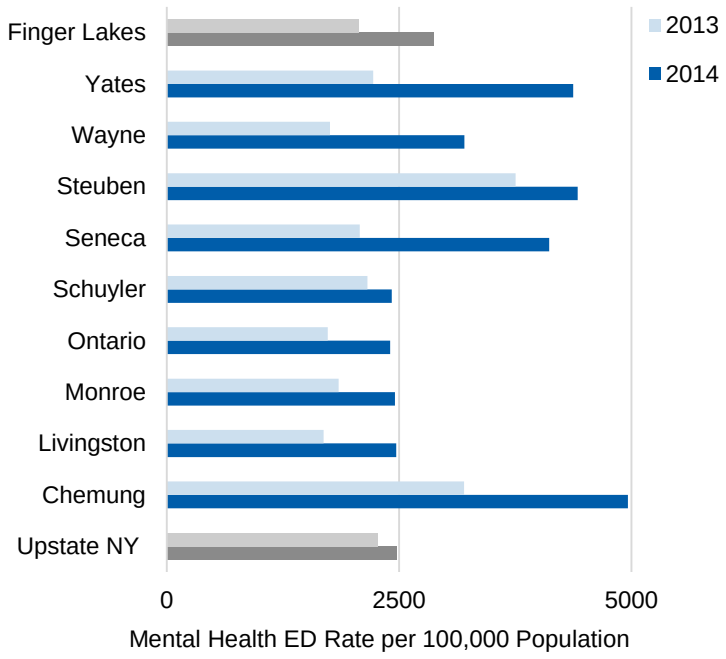


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error.

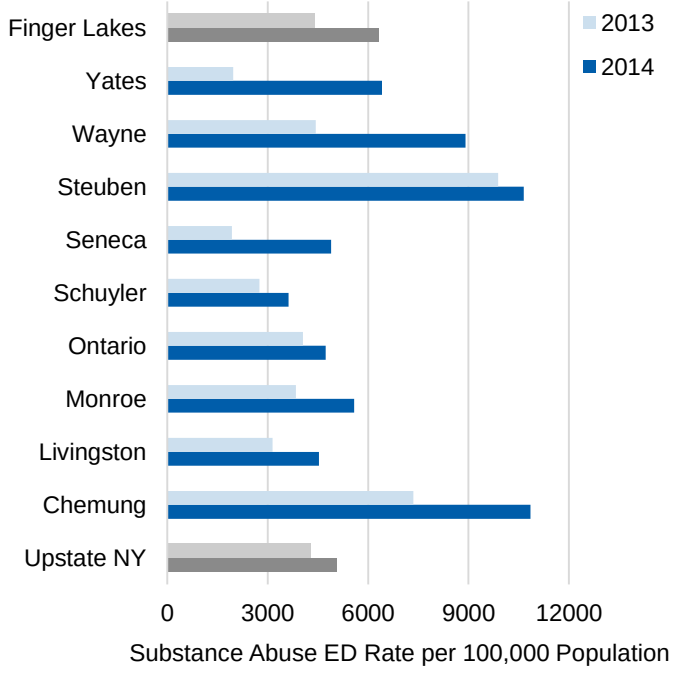
Behavioral Health

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

Rate of ED Discharges with a Mental Health Diagnosis



Rate of ED Discharges with a Substance Abuse Diagnosis

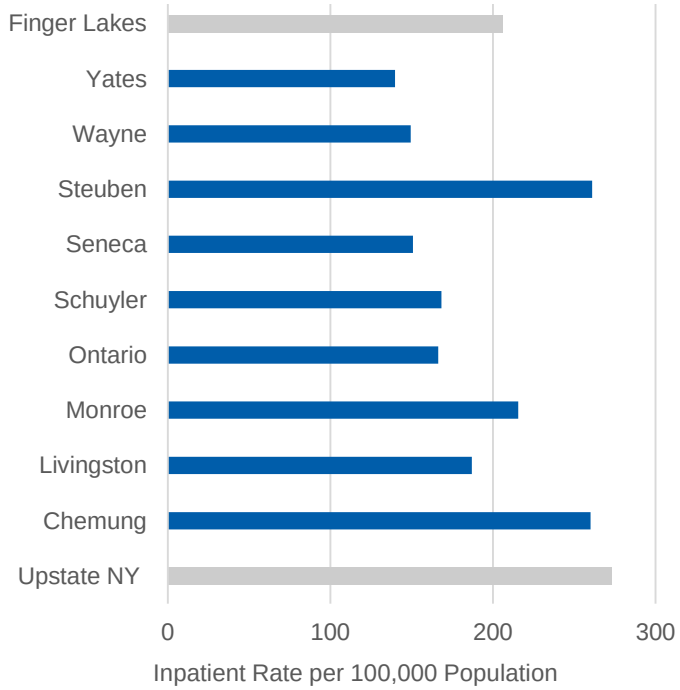


Data Source: SPARCS, 2013-2014. Diagnosis includes primary or comorbidity

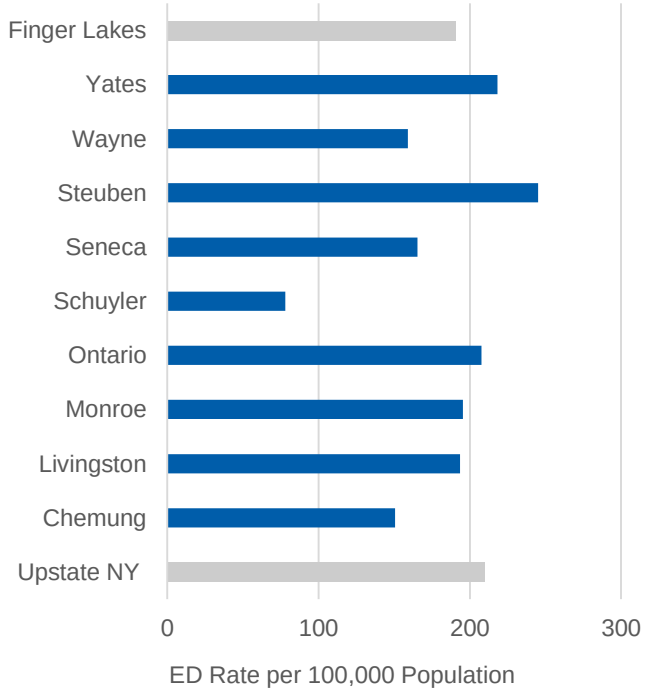
Behavioral Health

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

Rate of Inpatient Admissions with an Opiate Diagnosis



Rate of ED Discharges with an Opiate Diagnosis

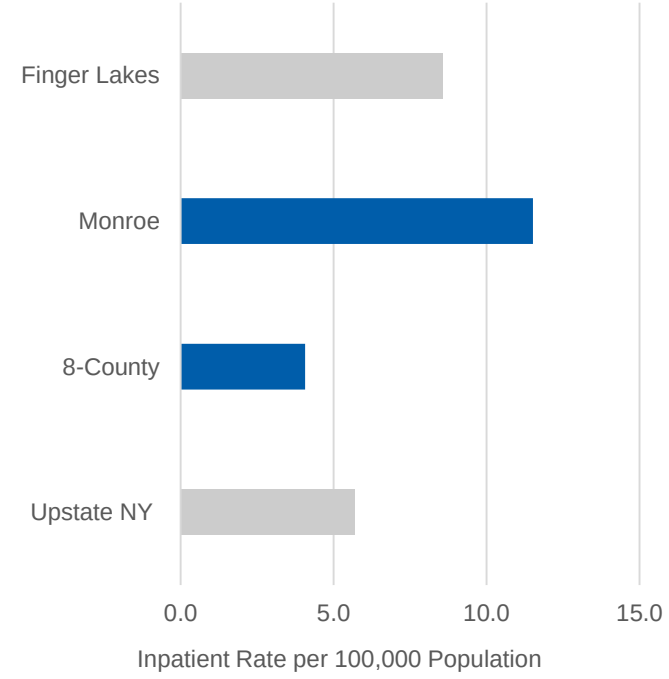


Data Source: SPARCS, 2014

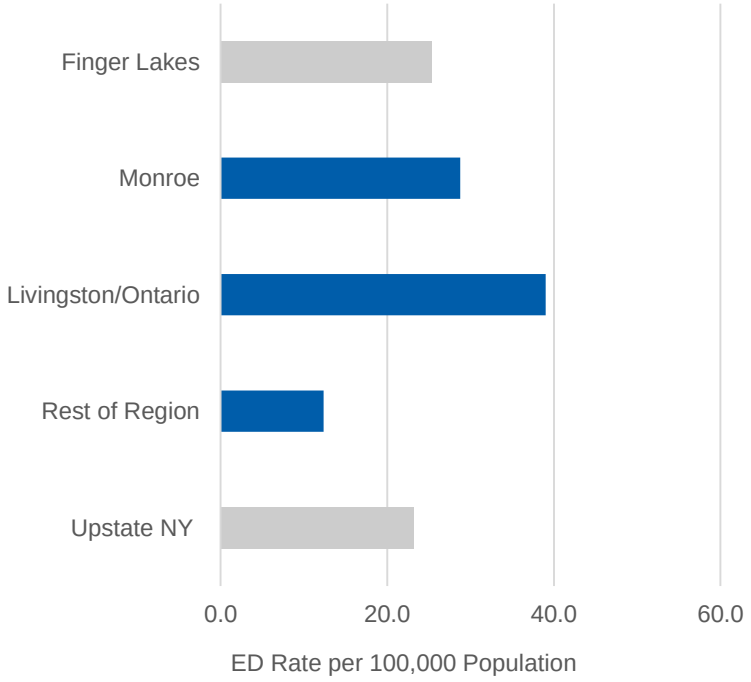
Behavioral Health

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

Rate of Inpatient Admissions with a Heroin Overdose Diagnosis



Rate of ED Discharges with a Heroin Overdose Diagnosis

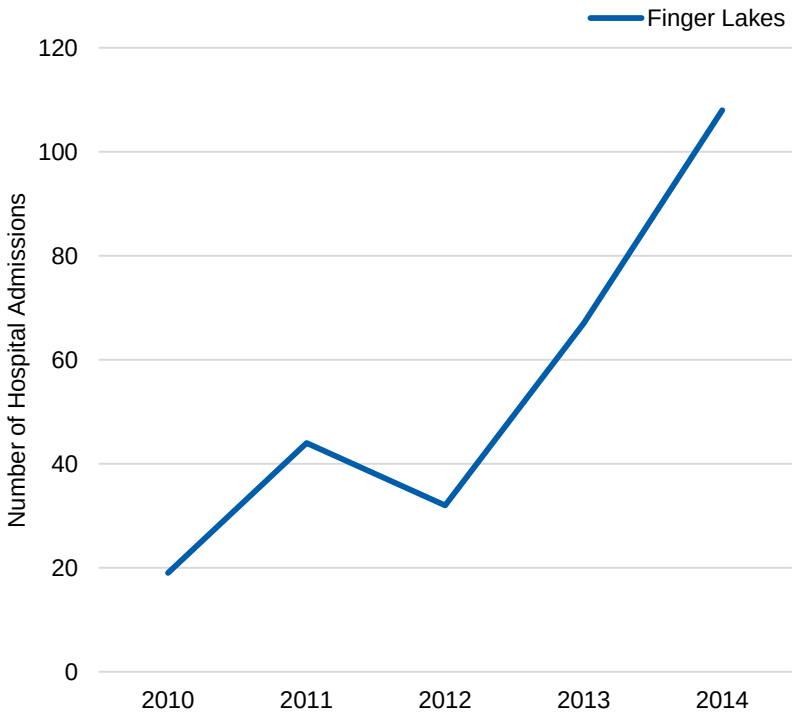


Data Source: SPARCS, 2014

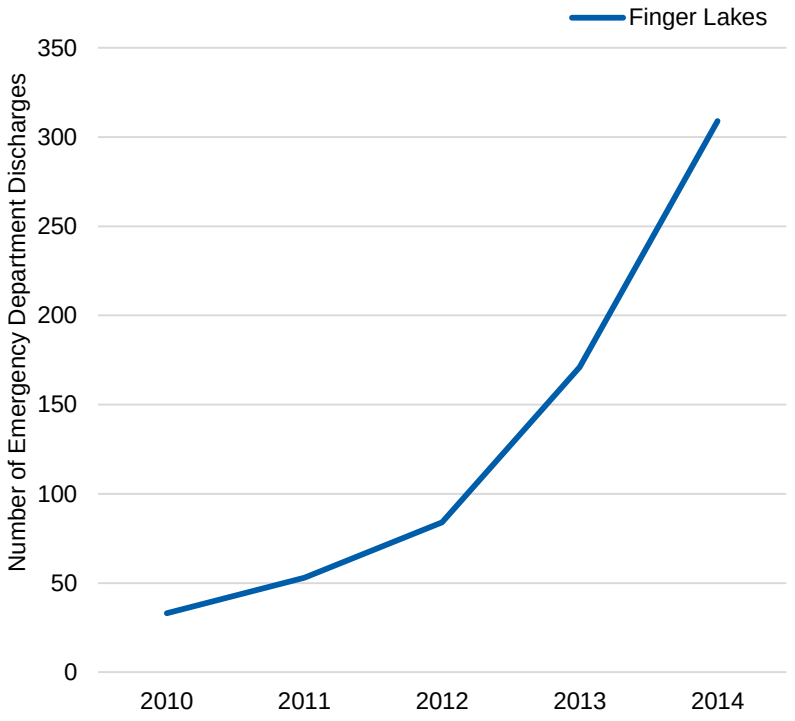
Behavioral Health

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

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



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

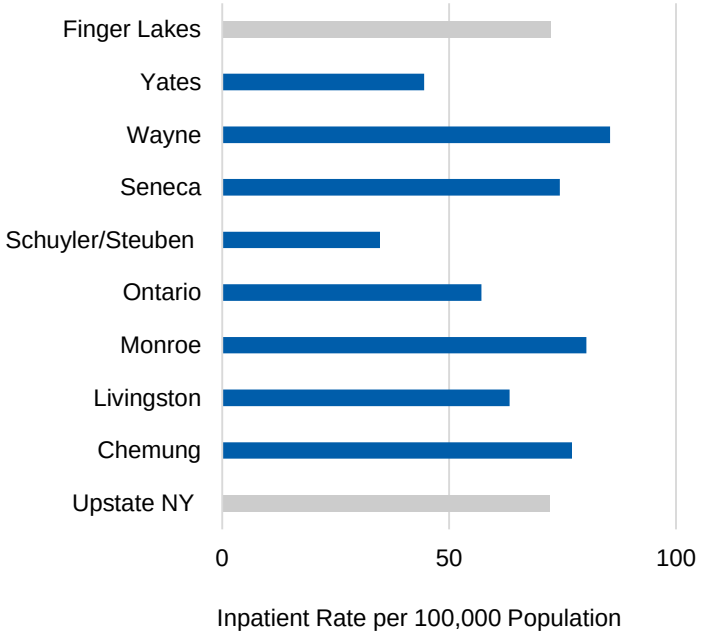


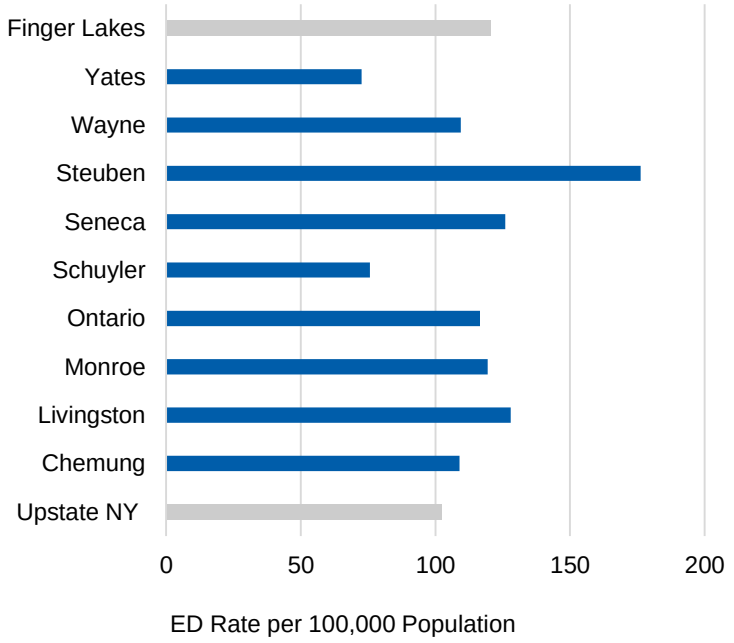
Data Source: SPARCS, 2010-2014

Behavioral Health

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

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

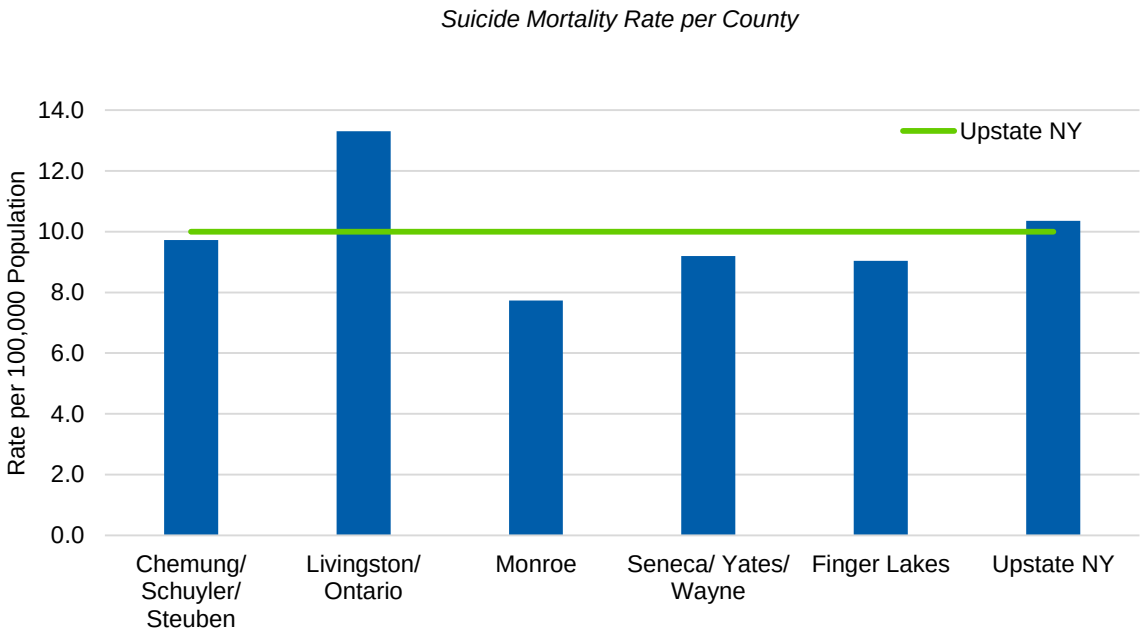




Data Source: SPARCS, 2014

Behavioral Health

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



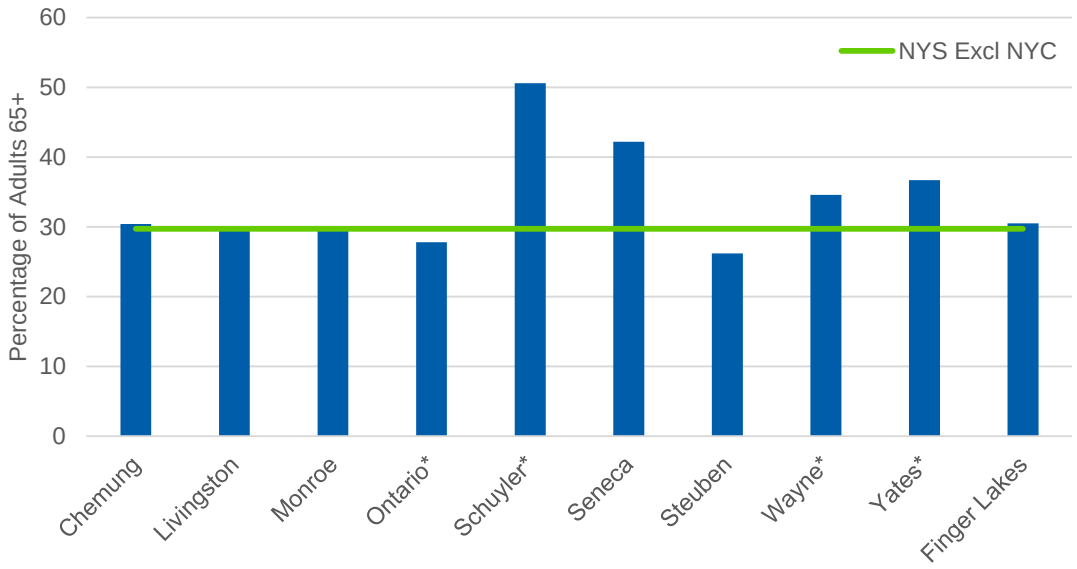
Data Source: New York State Department of Health Vital Statistics, 2013

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

Falls, Slips and Trips

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

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

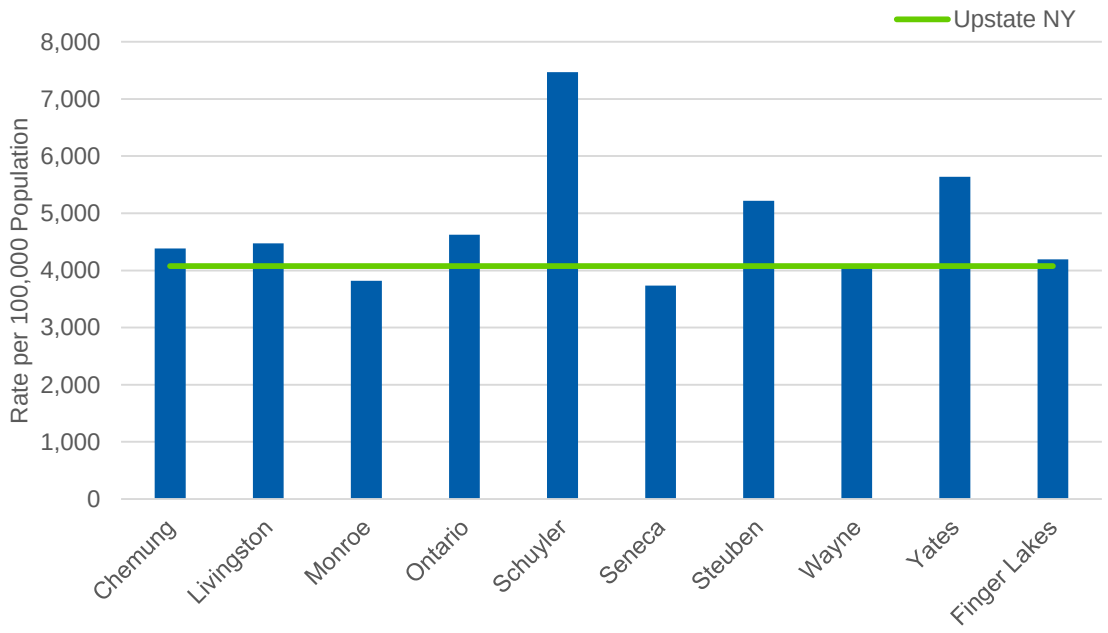


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error

Falls, Slips and Trips

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

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



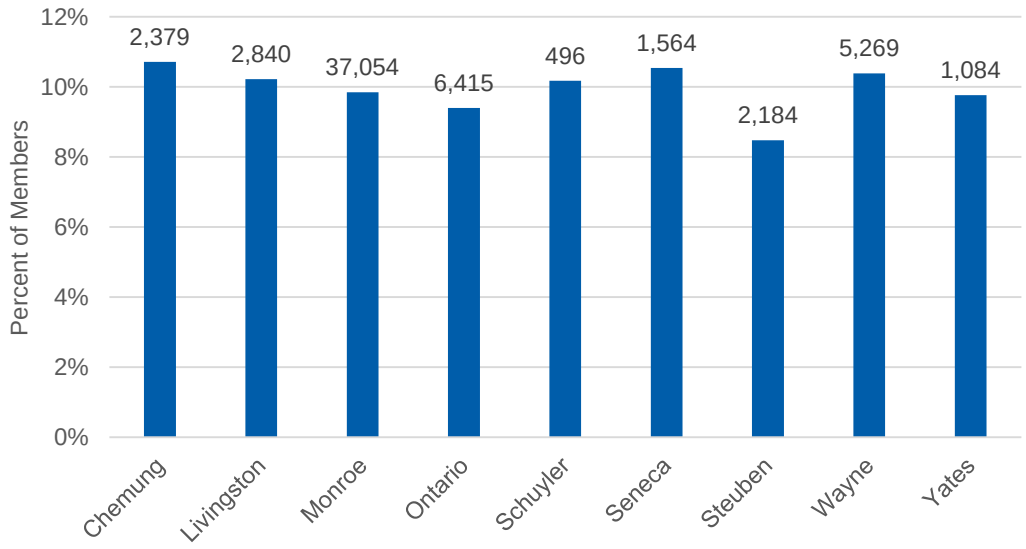
Data Source: SPARCS, 2013

PRIORITY AREA 8: LOW BACK PAIN

Low Back Pain

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

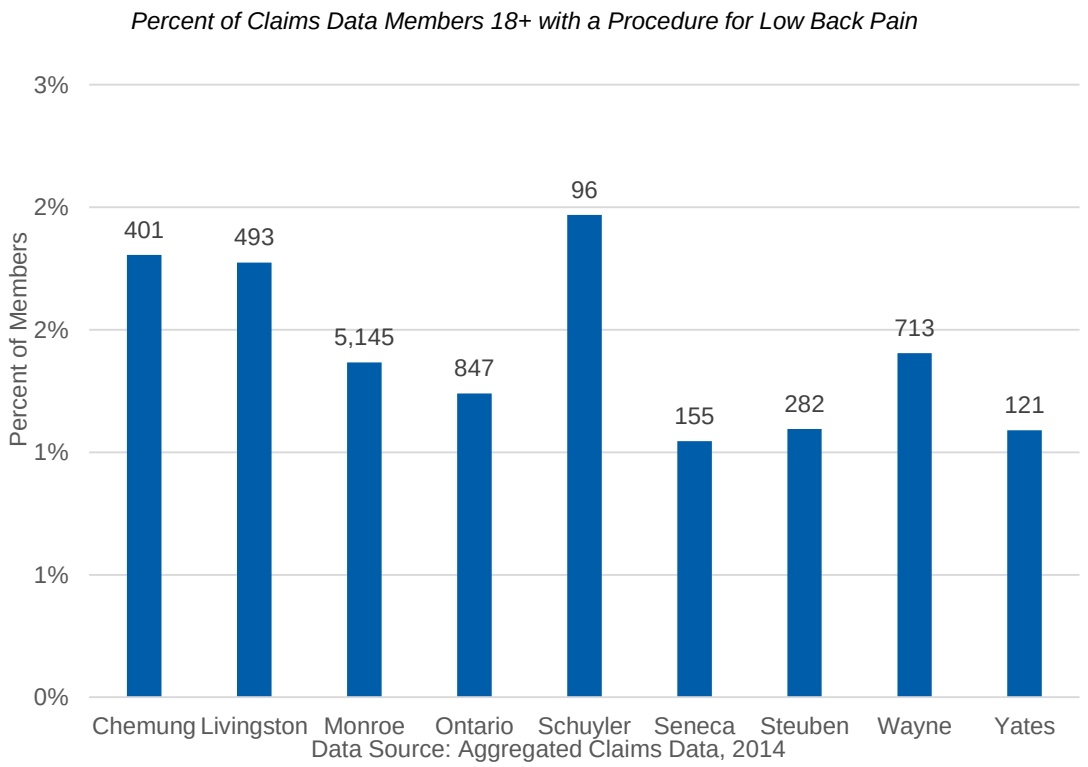
Percent of Claims Data Members 18+ with a Diagnosis for Low Back Pain



Data Source: Aggregated Claims Data, 2014

Low Back Pain

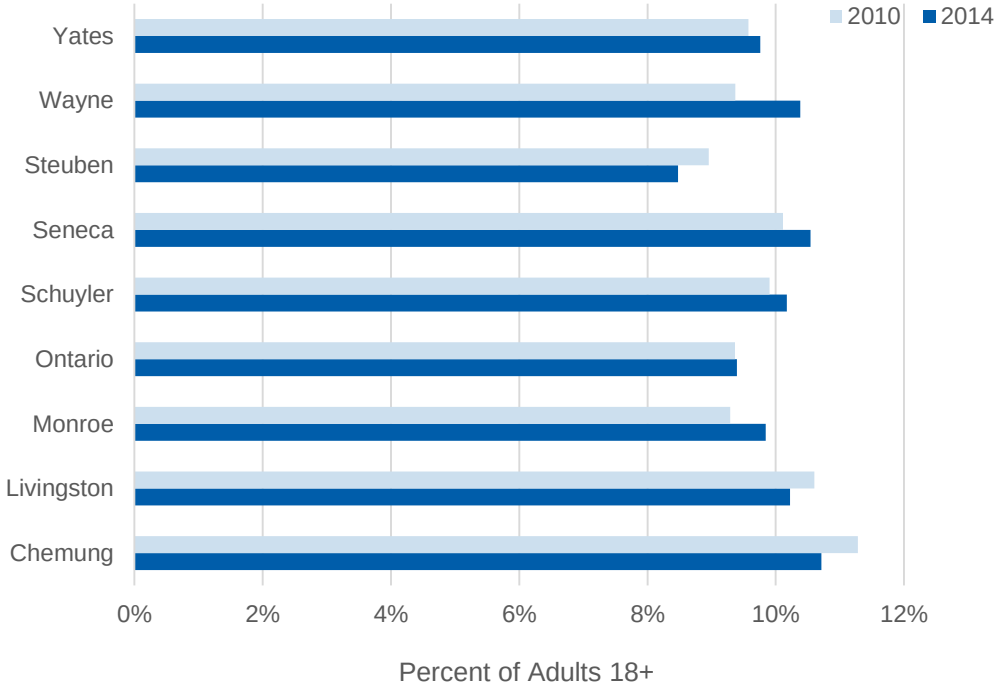
- Percent of the members in the FLHSA claims database with a procedure code for low back pain (i.e. spinal/nerve injections).



Low Back Pain

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

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



Data Source: Aggregated Claims Data, 2010-2014

KEY FINDINGS

Key Findings

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

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

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

www.flhsa.org

QUESTIONS?

Finger Lakes Health Systems Agency

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

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585.224.3101 • www.flhsa.org

Wayne County Health Needs Focus Groups

Agenda

- Welcome & Orientation
- Wayne 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)

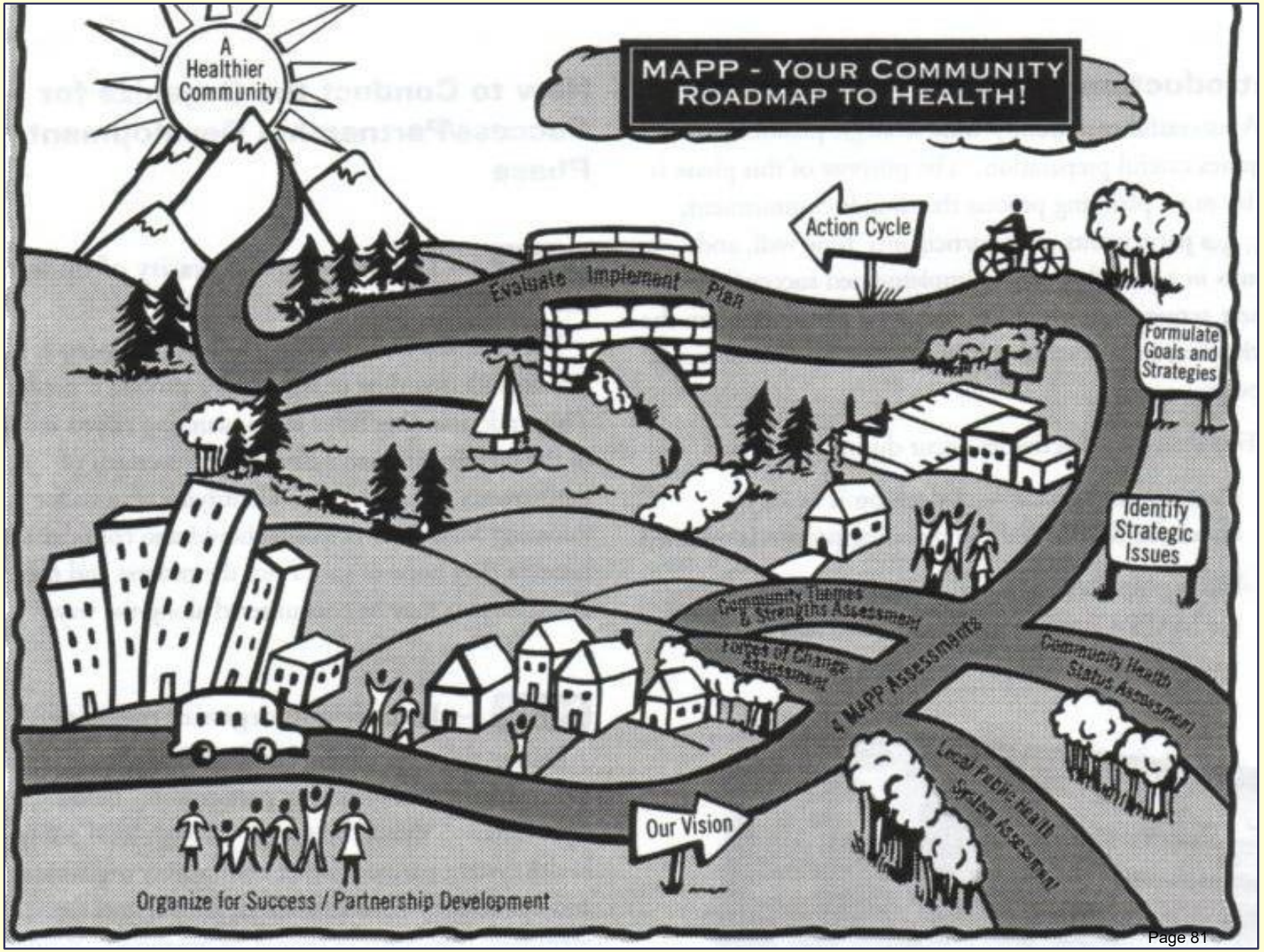
Joint CHA/CHIP/CSP

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

Help!!!!

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

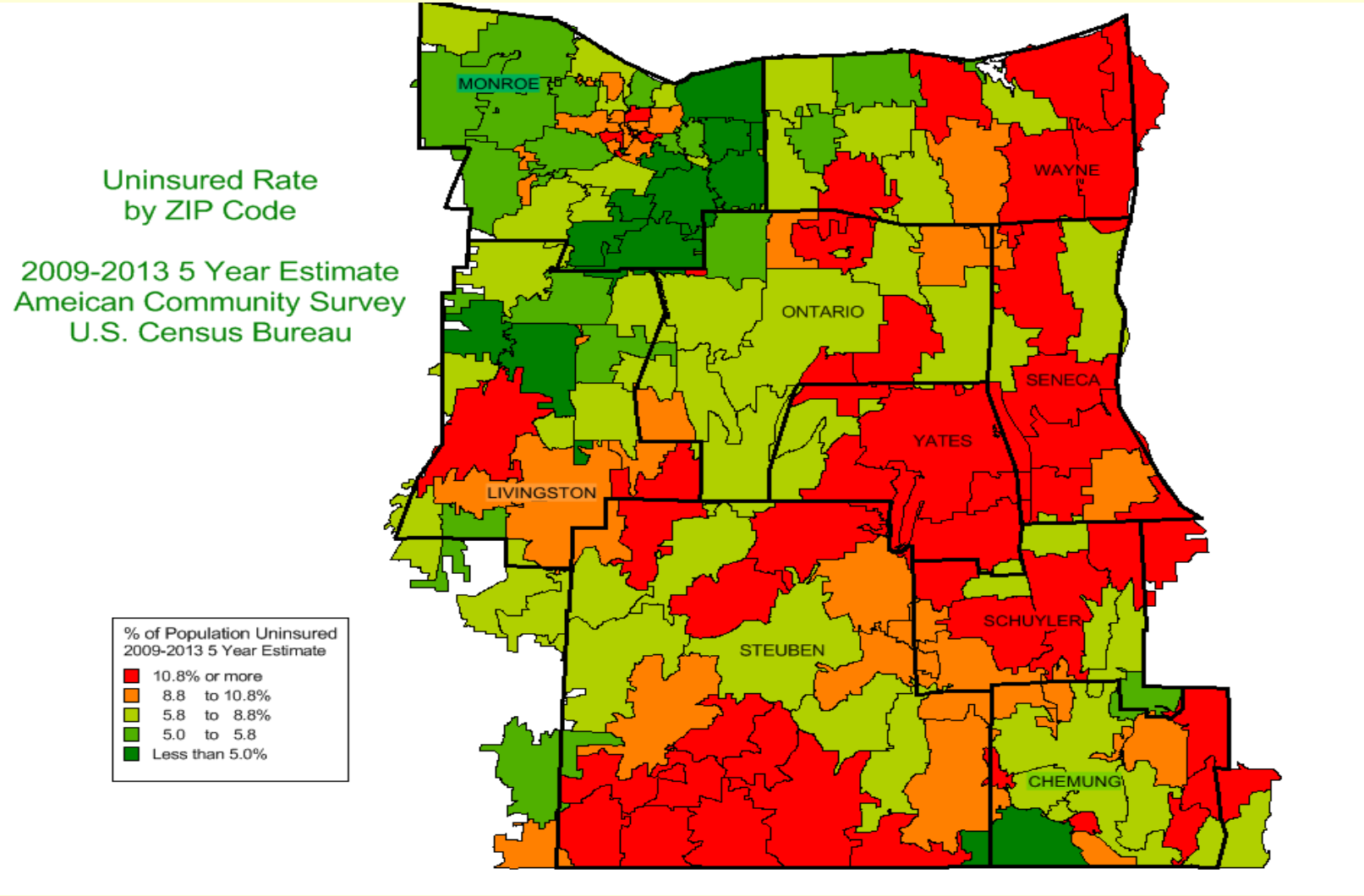
MAPP - Mobilizing for Action through Planning and Partnerships



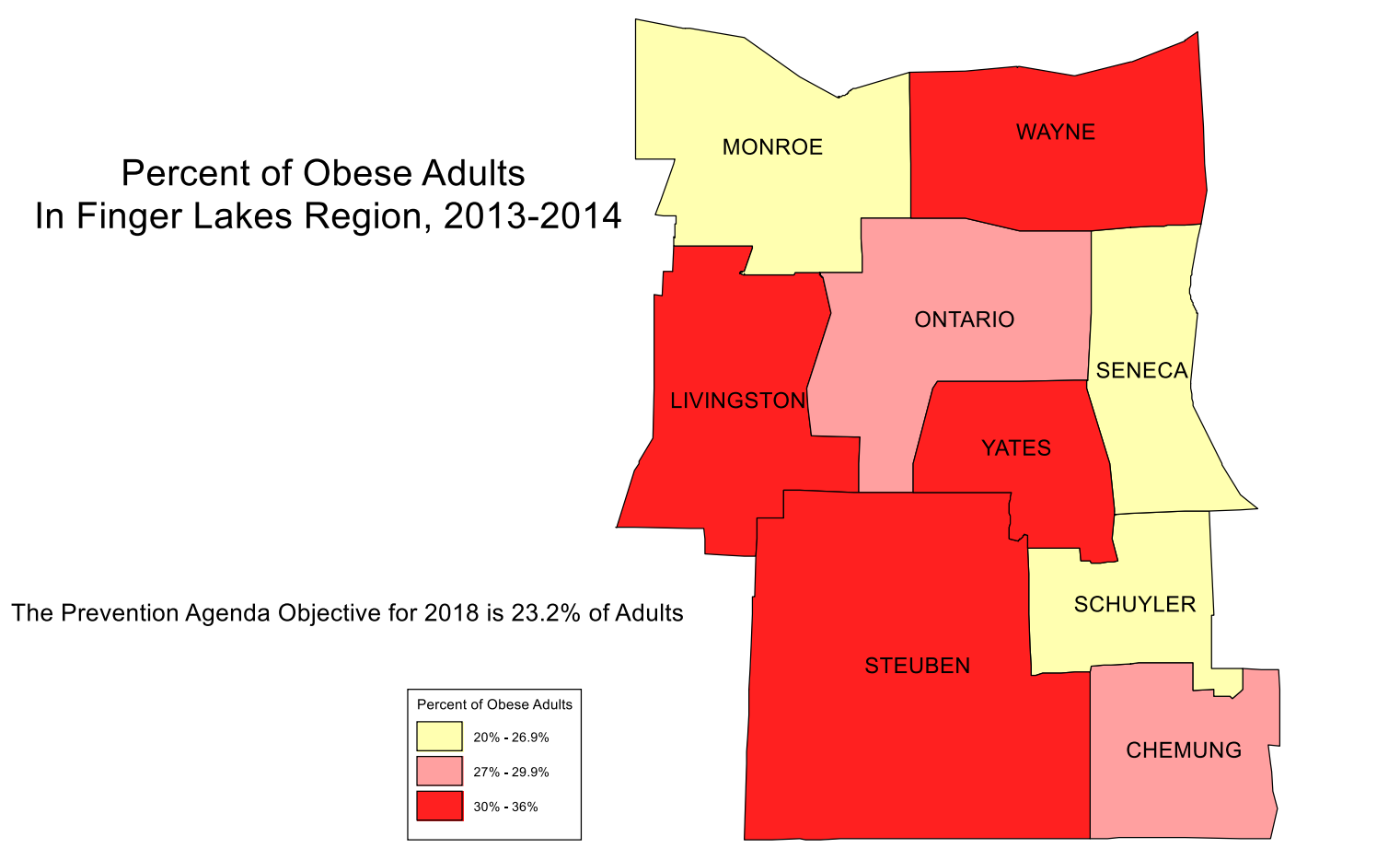
Data says…

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

Data says…high rates of uninsured



Data says: High rates of Obesity 30-36% in Wayne County

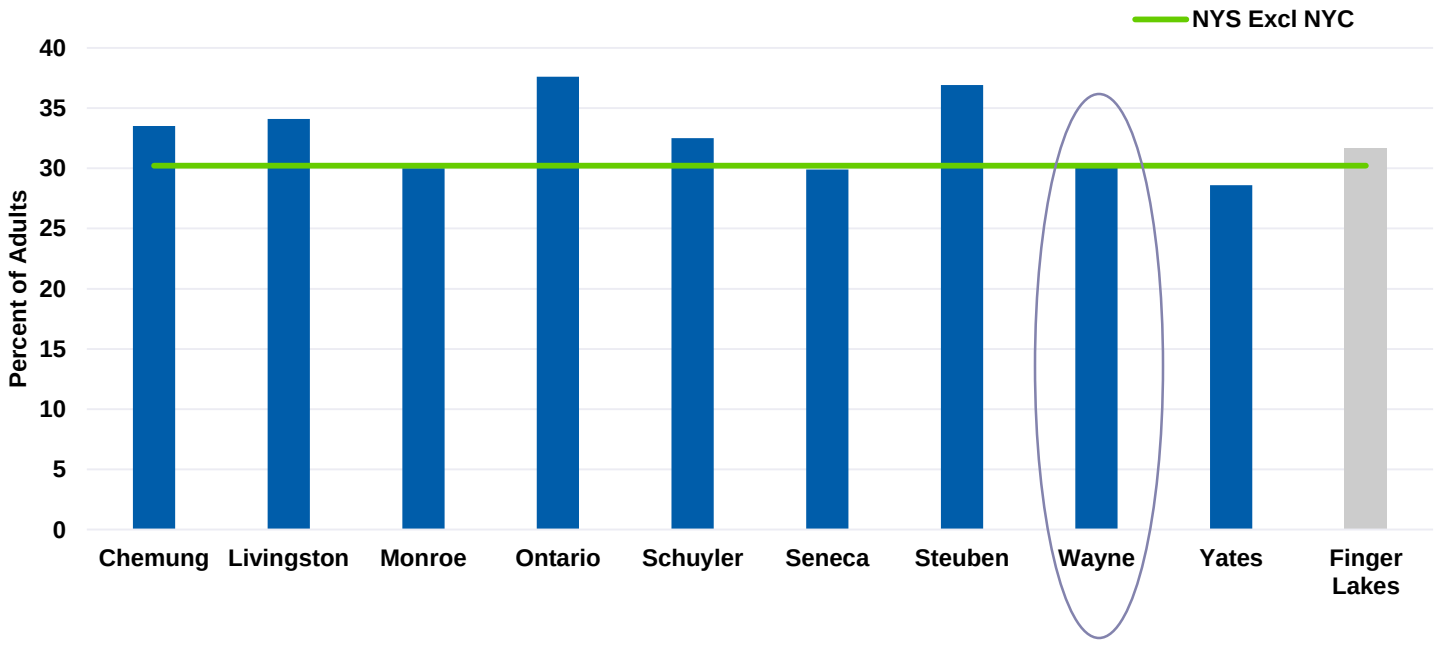


Why is obesity important?

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 Wayne County…

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



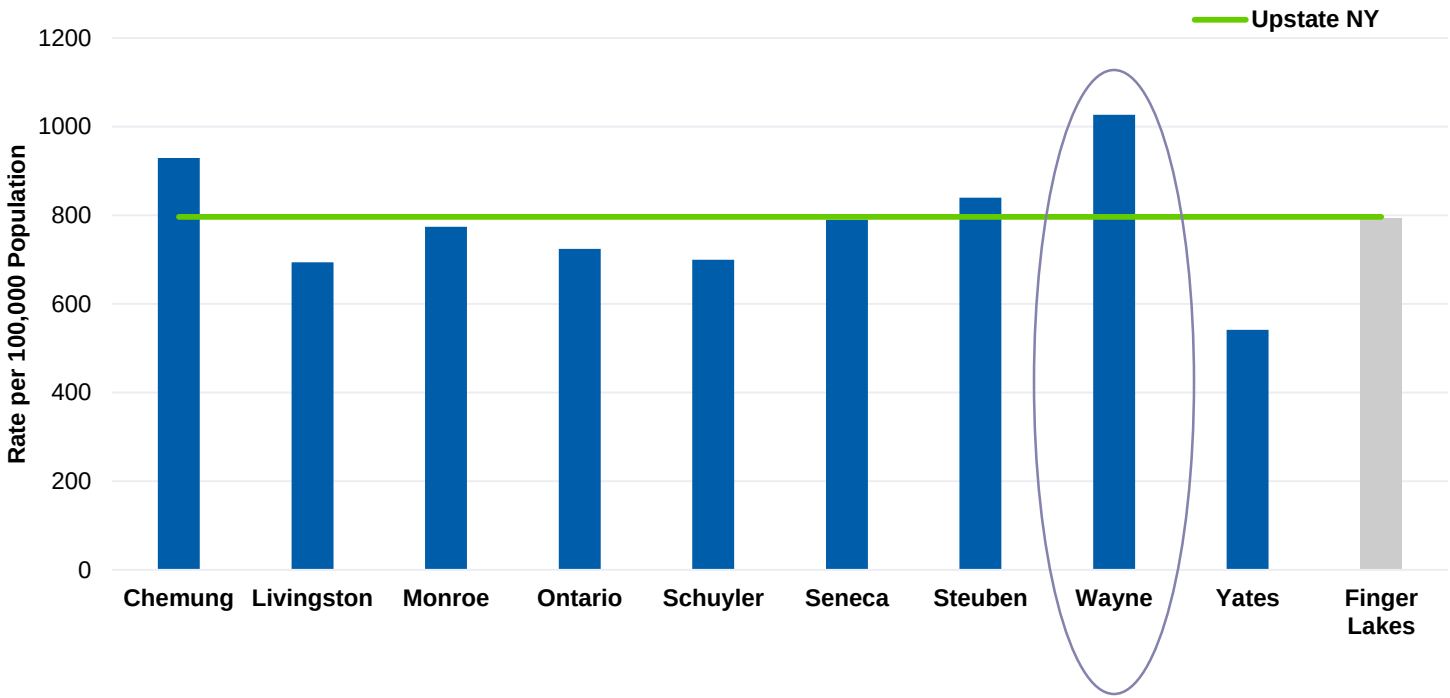
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Hypertension hospitalization rate per 10,000 (any diagnosis) - Aged 18 years and older

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

	Discharges				Average population (aged 18+)	Crude
Region/County	2011	2012	2013	Total	2011-2013	Rate
Reg- 10 Finger Lakes						
Chemung	5,402	5,285	5,204	15,891	69,263	764.8
Livingston	2,559	2,504	2,410	7,473	52,332	476.0
Monroe	32,247	31,810	30,551	94,608	583,956	540.0
Ontario	4,434	4,233	4,589	13,256	85,297	518.0
Schuyler	939	938	853	2,730	14,758	616.6
Seneca	1,305	1,411	1,369	4,085	28,028	485.8
Steuben	4,693	4,426	4,165	13,284	76,468	579.1
Wayne	4,128	3,957	4,303	12,388	71,767	575.4
Yates	1,071	993	958	3,022	19,349	520.6
Region Total	56,778	55,557	54,402	166,737	1,001,220	555.1
New York State	879,030	870,517	830,246	2,579,793	15,299,149	562.1

Data says…. worst in the region for heart disease incidence



Data Source: SPARCS, 2013

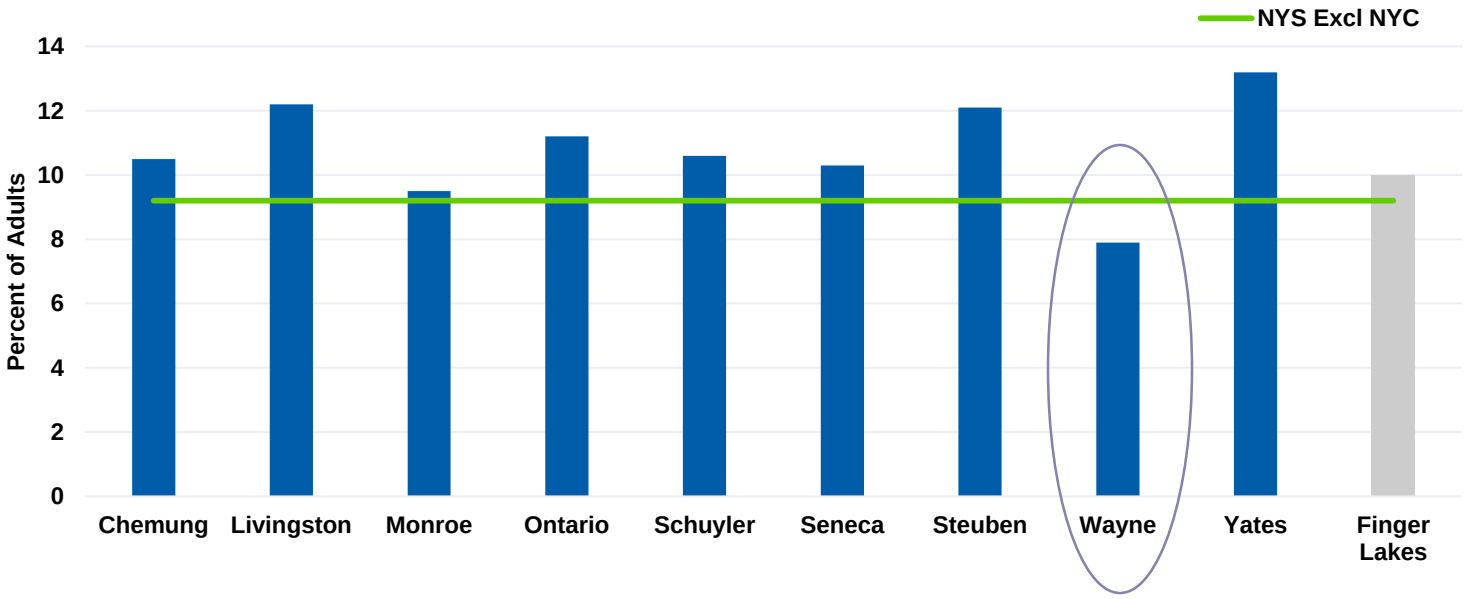
Higher in age-adjusted heart attack hospitalization rate per 10,000 overall though, 2013

Age-adjusted heart attack hospitalization rate per 10,000, 2013

Data Source: SPARCS data as of December 2014

Region/County	Hospitalizations	Population	Age-adjusted rate
Region - 10 Finger Lakes			
Chemung	205	88,506	18.3
Livingston	117	64,705	14.7
Monroe	1,168	749,606	12.9
Ontario	236	109,103	16.2
Schuyler	50	18,460	19.4
Seneca	54	35,409	11.8
Steuben	229	98,650	17.5
Wayne	229	92,473	19.4
Yates	43	25,156	12.9
Finger Lakes	**2,331**	**1,282,068**	**14.6**
New York State			
New York State (excluding NYC)	**21,245**	**11,245,290**	**15.2**
New York State	**32,445**	**19,651,127**	**14.2**

Data says….Percentage of adults with physician diagnosed diabetes – 7.9%



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

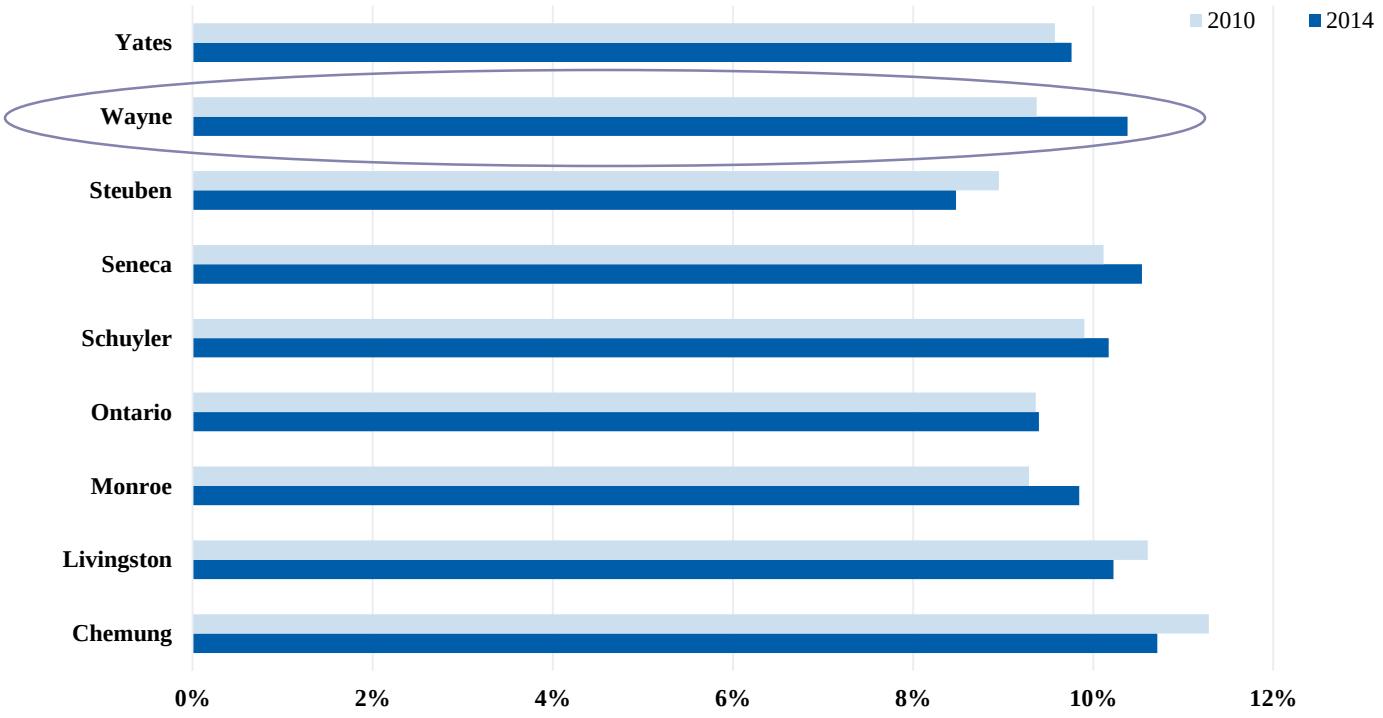
Diabetes mortality rate per 100,000

Adjusted Rates Are Age Adjusted to the 2000 United States Population

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

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

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

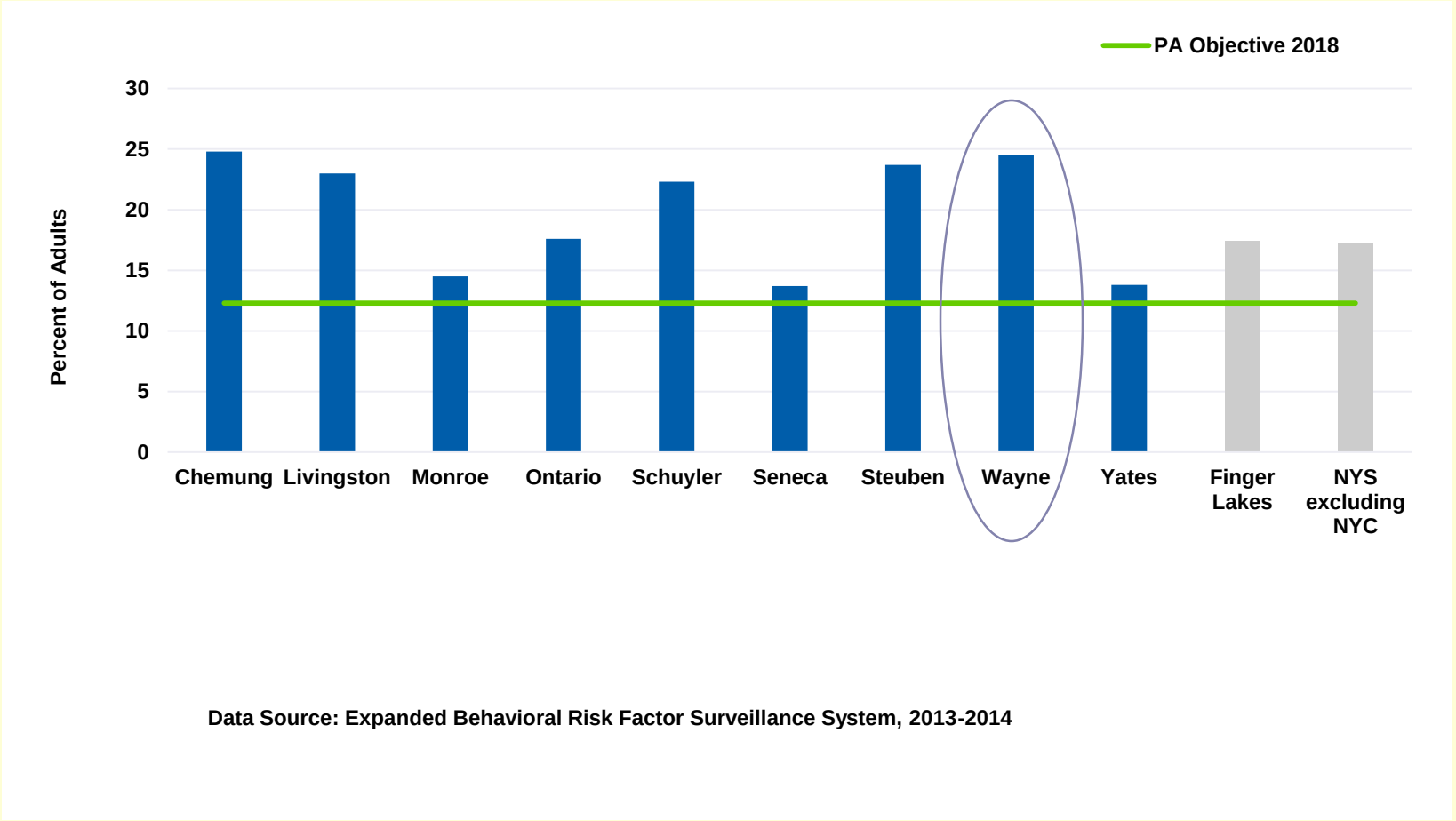


Data Source: Aggregated Claims Data, 2010-2014

Other health problems

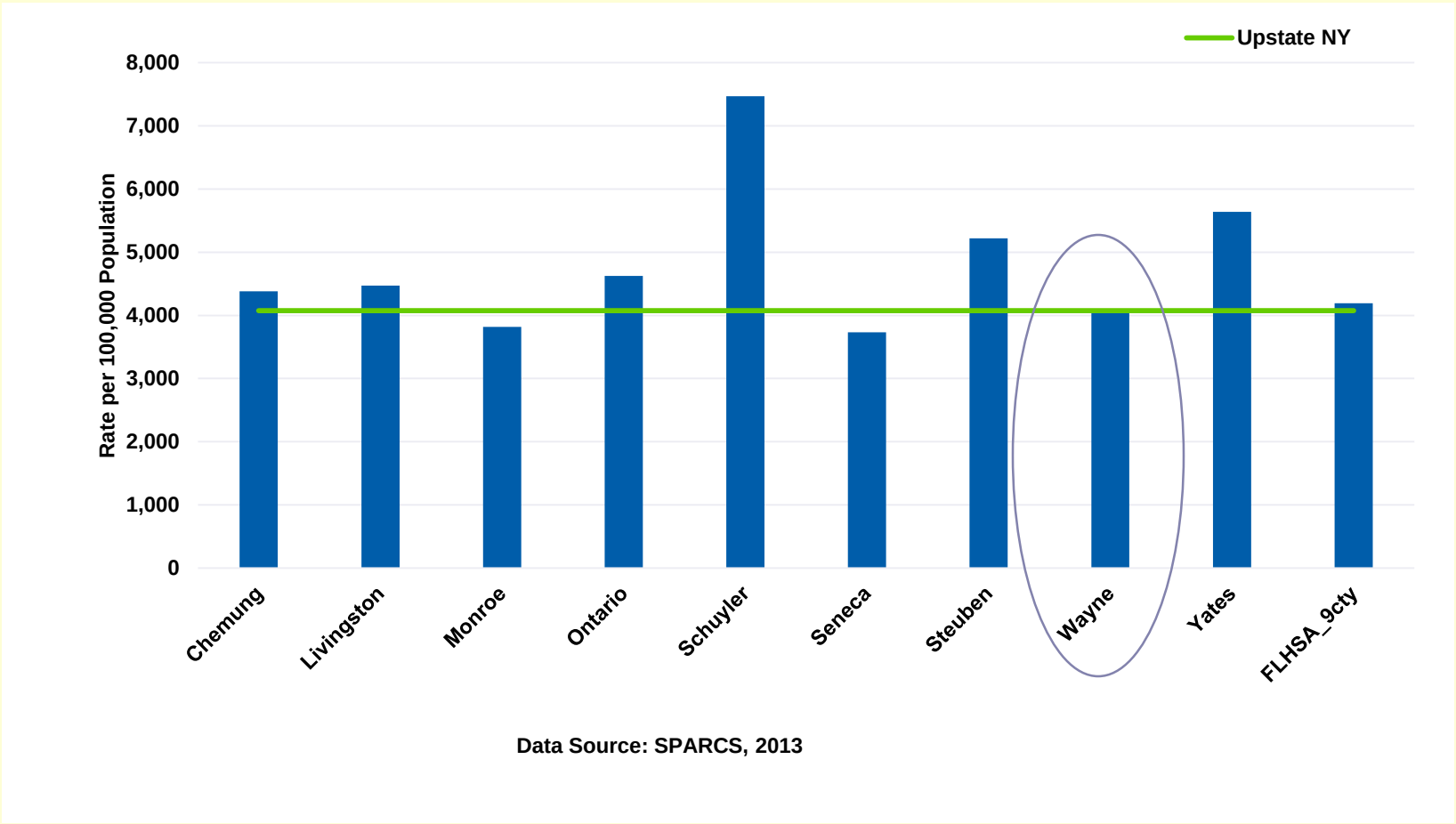
- In addition to obesity and the problems related to that (heart disease, diabetes, hypertension and lower-back pain), there are other problems in the region where we have above average rates:
- Tobacco use- related to cancer, asthma/COPD and hypertension
- Behavioral health problems
- Falls – for the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

Data says… Percentage of cigarette smokers in Wayne County = 24.5%



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

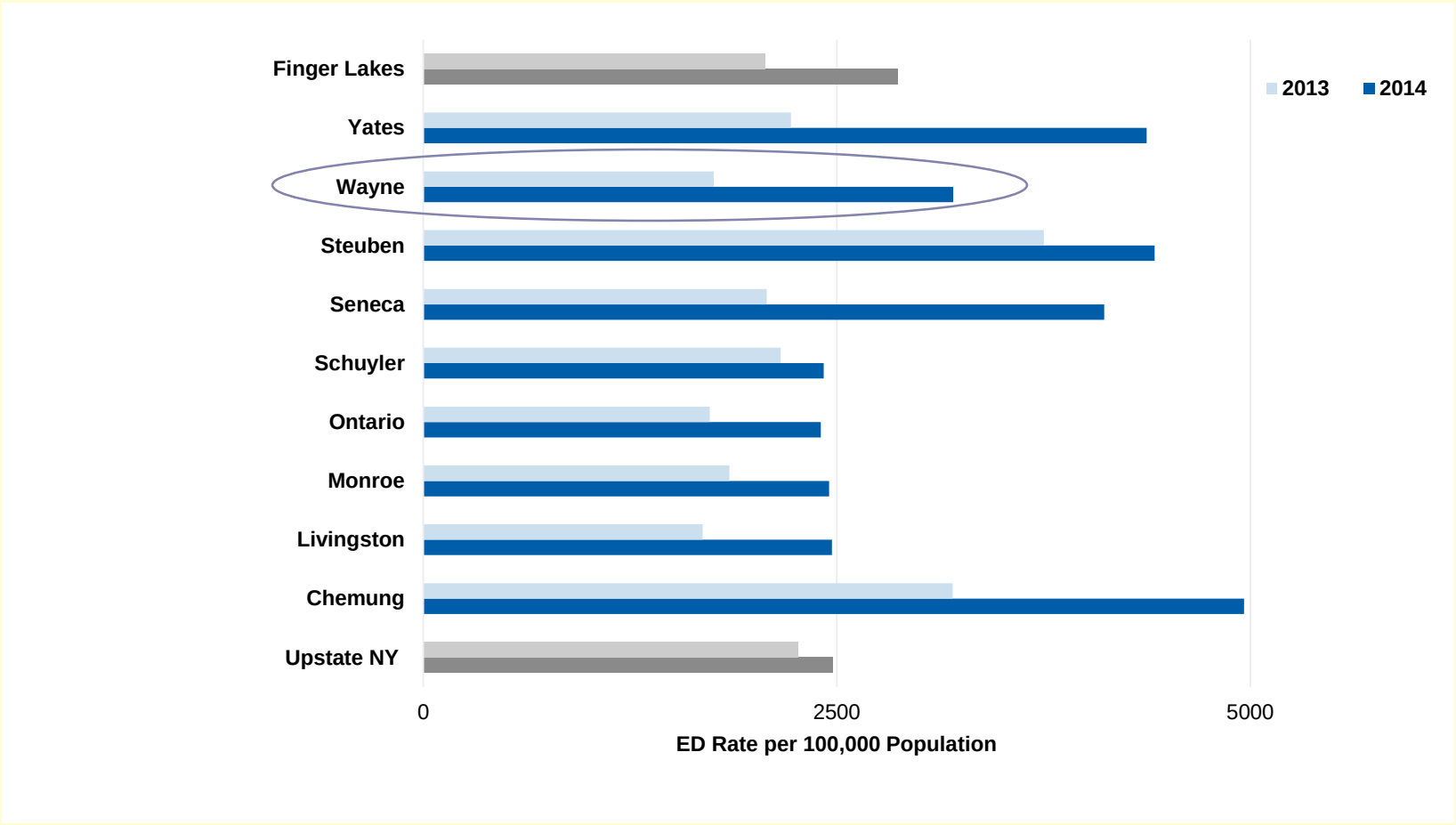
Data says…ED Visits per 100,000 for falls for those aged 65+



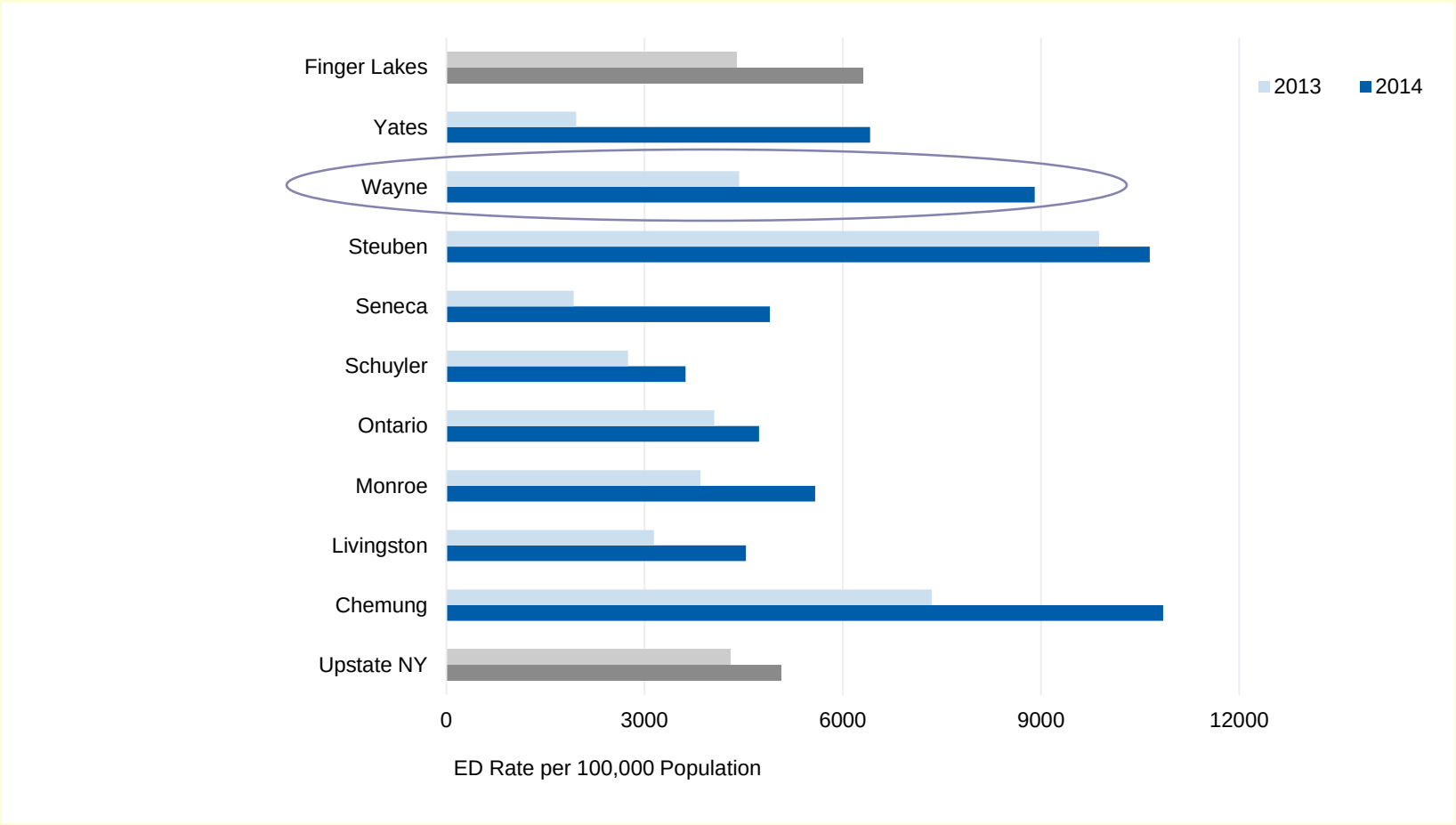
Behavioral Health

- 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

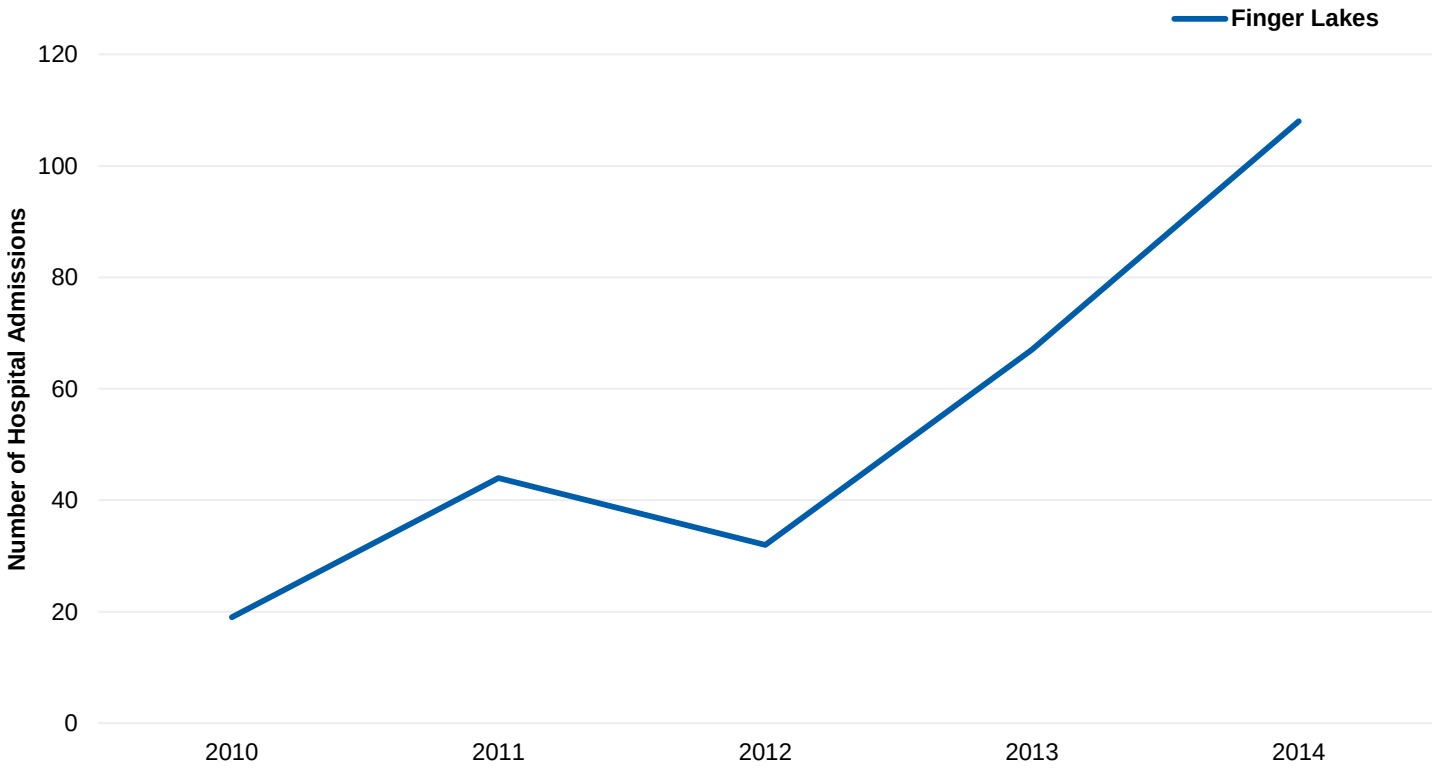
Mental health – ED discharges with a mental health diagnosis



Substance abuse- ED visits with a substance abuse diagnosis

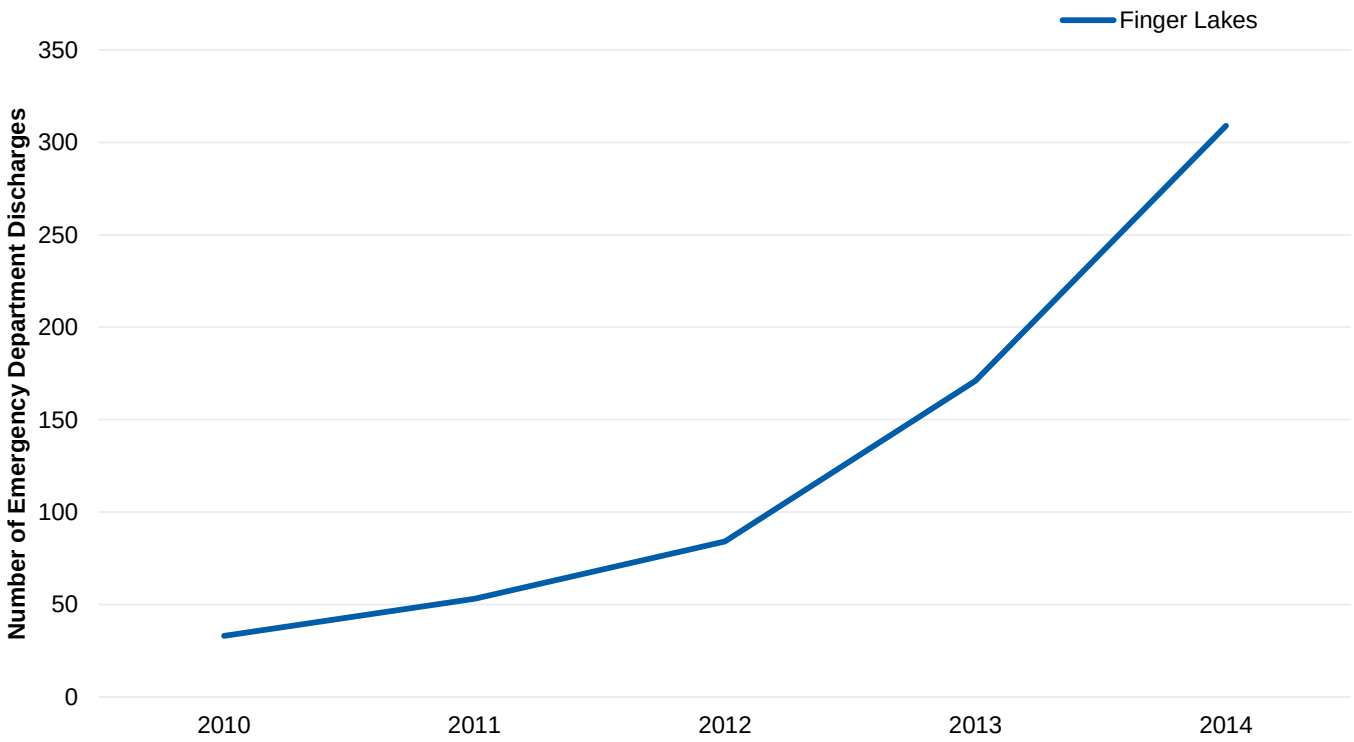


Heroin- number of heroin overdose admissions for the Finger Lakes (9 county) region



Data Source: SPARCS, 2010-2014

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



Data Source: SPARCS, 2010-2014

Data says… Heroin is a growing concern in the region

- BUT- the actual numbers are still fairly small, especially in Wayne 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
Wayne Total: 819	Cancer 221 188 per 100,000	Heart Disease 181 160 per 100,000	Stroke 49 43 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 39 35 per 100,000	Unintentional Injury 36 35 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 factors do you think are influencing health?
- What community strengths contribute to the health of Wayne 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 Wayne County residents?

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 Wayne 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 Wayne 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 Wayne 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 Wayne County Health outcomes!!

Wayne County Focus Group Summary Data

1. What are we missing in our assessment to date?
    - Dental Health.
    - Education around proper dental health.
    - Children mental health and obesity data.
    - Providers for mental health.
    - Suicide data.
    - Access to care.
    - Alcohol.
    - Firearms.
    - Input from children/youth.
    - Demographic data.
    - Seasonal workers.
    - Physical activity opportunities.
    - School data.
    - Sexually Transmitted Diseases.
    - Work related injury and illness.
    - Vaccinations.
    - Women's health issues.
    - Teen pregnancy.
    - Smoking.
    - Preventative care.
    - ED visits.
    - Physician availability.
    - High school dropout rate.
    - Education rate.
    - Unemployment.
    - Poverty.
    - Overdosing data.
    - Age specific data.
    - E-cigarettes.
    - Rehab data.
    - Screen time data.
    - Cancer.
    - Gestational diabetes.
2. What words would you use to define health and what terms would you use to define a healthy community?
    - Involved community.
    - Happy.
    - Active.

- Education.
- Healthy foods and availability.
- Affordability.
- Culture.
- Freedom from fear.
- Equity.
- Health literacy.
- Nutrition education.

3. What trends or factors are influencing the health of the residents?
    - Rural setting.
    - Transportation.
    - Lack of education.
    - Poverty.
    - Access.
    - Healthy food.
    - Schools allowing access to facilities, such as gyms.
    - Basic needs not being met.
    - Heroin.
    - Vending machine policies.
    - Public Health dept.
    - Tobacco law on county grounds.
    - Preventative care and screenings.
    - Increases screen time usage.
    - Schools offering healthy food.
    - Rise in mental health among children.
    - Substance abuse.
    - Sleep deprivation.
    - Dieting pills.
    - Money schemes.
    - Work place violence.
    - Chemical exposure.
    - Lower back pain.
    - Lower educated population.
    - Low health literacy rates.
    - Poor dieting.
    - Limited access to healthy food.
    - Poor parenting.
    - Loss of industry.
    - Family structure breakdown.
    - Higher divorce rate.
    - Autism.

- Employers offering wellness programs.
- E-cigarettes.
- Housing.
- Young people leaving the county for higher paying jobs.
- East side of county much worse than west side of county.
- Skin cancer.
- Aging community.
- Climate change.
- Tobacco advertising.

4. What community strengths or assets contribute to the health of the residents?
    - Low crime rate.
    - Sense of community.
    - Collaboration.
    - Outdoor activity opportunities.
    - Lake.
    - Safe neighborhoods.
    - Community centers.
    - Cornell Cooperative Extension.
    - Hospitals.
    - Wayne Rural Health Network.
    - Head Start program.
    - Foodlink and food pantries.
    - Walking trails.
    - Wegmans.
    - National Diabetes Prevention Program.
    - Doctor to patient involvement.
    - Counselors places in schools.
    - Mental health screenings occurring in schools.
    - Mental health first aid trainings.
    - Family Counseling Services of the Finger Lakes.
    - Delphi Counseling.
    - Cancer Services program.
    - Finger Lakes Community Health.
    - Catholic Charities.
    - Worker Justice Center of NY.
    - Finger Lakes Occupation Health Services.
    - Daycares.
    - Lifetime Care.
    - Wayne CAP.
    - Headstart.
    - Foster Grandparent Program.

- Libraries.
- Two dialysis offices.
- Urgent Care.
- Dental clinic with RPCN and FLCH.
- Farmers Markets accepting SNAP/EBT.
- United Way
- Cultural shift around healthy lifestyles.
- Physician referral.
- Wayne County resource guide.
- Community gardens.
- Baby Café to support breastfeeding.
- Network of churches.
- DSRIP.

5. What would you do to address some of these problems?
    - Education.
    - Utilize social media.
    - Partnering with schools.
    - Entice providers to the area.
    - Therapy for children.
    - Mental health treatment.
    - Reduce stigma against mental health.
    - Increase internet accessibility.
    - More community centers.
    - Recycled bike program for kids.
    - Transportation.
    - Interpretation services.
    - Outreach.
    - Literacy Competency.
    - Availability of funding.
    - Health care provider training.
    - Home care services.
    - Increased communication between agencies and patients.
    - Better utilize paramedics.
    - School nurses.
    - More discipline.
    - Promote programs.
    - Smoking cessation.
    - Economic development.
    - Address socio-determinants of health.
    - Engage younger people.
    - Embrace diversity.

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

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

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

County:	Wayne
Group Name:	Head Start
Date and Time:	March 10, 2016 – 9:00AM
# of Participants:	8

1. What are we missing in our assessment to date?
    a. Dental Health seems to be missing. Untreated dental disease can lead to heart trouble and many other health issues.
    b. See a lot of attitudes that dental is a "luxury", even if they have dental insurance. We have seen an improvement in Head Start over the last few years, but it has taken a really long time. We see more follow up now.
    c. When kids have dental pain, they don't even realize it. They can't learn, they can't pay attention, and it affects their behavior. When they get treated, a huge improvement has been seen after.
    d. We have been doing better with kids, but there is still a huge lack with adults. Getting adults treatment for dental, still seen as a "luxury" even though they may have insurance. See this in the clinic all the time.
    e. Do we have data on children mental health and obesity? Might want to include.
    f. We do not have enough providers for children's mental health. We definitely need more.
2. What trends or factors are influencing the health of the residents?
    a. Rural setting - there is public transportation, but no one is using it. Services aren't there for the families. People can't get to their appointments. Have to travel to everything.
    b. Transportation may be there, but there is a lack of education on availability/how to use/etc.
    c. Lack of education overall, especially in parents. They never had dental, so they don't see why their children need to go.
    d. Poverty - people are trying to meet their basic needs, so they can't even think about health/prevention/etc.
    e. There's nothing out in some of those really small towns (Butler, Savannah, Red Creek), there is no access to healthy food, there are no jobs out there... just increases the obesity, lack of health, etc.
    f. Schools open their gyms, pools, and halls for walking/exercising... but people can't get there, and some you have to pay for... which no one is willing to pay for. Can't meet basic needs... so not going to spend money on physical activity. Need to try to get this to be on a sliding fee scale or for free.
3. What community strengths or assets contribute to the health of the residents?
    a. No gang violence, lower crime rate.

b. Great sense of community. A lot of support in the community.
c. Agencies work together well, are very supportive and collaborative.
d. A lot of things are available... some may not know about them, but they are available. Need to get the word out more.
e. A really great trail system in the county - that are all mapped out.
f. The bay and the lake.
g. Lots of room for kids to play. Very safe, don't have to worry about kids being outside late.
h. Lots of recreation programs for kids and community centers.
i. More and more families each year that do get transportation (back in "the day" people really never left the house... they would go days without seeing people). Because of this... there is more of a sense of community - because people are seeing each other more.

4. What would you do to address some of these problems?
    a. Education - that is the biggest thing. Letting families know that we can help them, that preventative is important, what programs are out there, teach about healthy eating, and teach about physical activity. Even teachers are unaware and uneducated.
    b. Utilize social media more.
    c. Not everyone has the internet/social media... I think utilizing the schools would be better. Send flyers home with kids... parents see flyers in back packs.
    d. How can we lure more child and adult psychiatrists to this area? We need more. There just isn't enough therapists/providers. Need more prescribers (NPs, PAs, etc.). Mental Health is constantly looking for providers.
    e. Is there more that can be done at the school based level? Maybe more social workers in the schools, counselors, etc. Need more therapy for children. Many will not take their kids to the doctor because they don't want them to be "drugged up". So comes back to education... there are counselors in all of the schools, which can help.
    f. Huge lack of mental health for adults... there just isn't anything for them.
    g. Need to reduce the stigma around mental health.

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

County:	Wayne
Group Name:	Wayne Health Improvement Partnership (WHIP)
Date and Time:	March 18, 2016 – 1:30PM

1. What are we missing in our assessment to date?
    a. Childhood obesity.
    b. Breakdown numbers of mental health/substance abuse by diagnosis, etc.
    c. Include information on access.
    d. Breakdown numbers for unintentional injuries.
    e. Breakdown for other drugs (make sure we are including all).
    f. Dental.
    g. Access to PCP, dentists and mental health providers.
    h. Gestational Diabetes/pre-pregnancy diabetes.
    i. Alcohol abuse.
    j. Youth tobacco use?
    k. Skin cancer.
    l. Any information on access to care/transportation?
2. What trends or factors are influencing the health of the residents?
    a. Skin Cancer - CSP getting a lot of calls.
    b. Transportation
    c. Access to PCPs, dental, mental health
    d. Aging community, increasing
    e. Proximity to the lake - bad weather in the winter, but good for the summer
    f. Canal trail - increase physical activity
    g. Transient population
    h. No new businesses coming in
    i. Less revenue - unemployment
    j. Less uninsured - but many can't afford the insurance they have, many can't go due to high deductibles
    k. Strong collaboration
    l. Mosquitoes - climate change
    m. Education and access to healthy retail options
    n. Tobacco advertising at the cash register
    o. Increasing opioid use - access increased for dangerous drugs
    p. Casino being built - not sure how this will affect health (may increase addictive behavior, spouse abuse, income changes) - possibly an emerging issue... are we capturing data around this? Are there ways we can capture data around this?
3. What community strengths or assets contribute to the health of the residents?
    a. Collaboration

b. Free health programs - a lot
c. People are more receptive to healthy lifestyle programs
d. Getting support from local physicians to refer to healthy lifestyle programs
e. Wayne County resource guide
f. Trails system, canal path
g. Farmers markets - in all parts of the county
h. Foodlink - mobile food pantries, curbside, food distribution
i. Roadside stands, unique
j. Community gardens (15)
k. Every school has something for the community to do for exercise (free or low cost)
l. Dedicated tobacco cessation specialist in Wayne County
m. Park system
n. Existing businesses are community owned/staffed, a lot of family businesses
o. Some growing businesses
p. Healthy vending policy at the county
q. No smoking on county grounds law passed
r. County breastfeeding policy
s. Baby Cafe
t. A lot of CLCs trained
u. Baby Friendly hospital
v. County network of churches
w. DSRIP has helped to bring in more organizations/collaboration
x. Collaboration with hospital

4. What would you do to address some of these problems?
    a. Keep working on our efforts
    b. Continue to secure other agencies/individuals/volunteers - to sustain
    c. Keep building on success
    d. Build on DSRIP, keep going
    e. Involve community more in successes, take pride in successes and want to improve more (possibly a media campaign)
    f. Target young people/students that are local - a lot of young people are leaving the county
    g. Embracing the diversity of residents (a lot of Amish in the last few years), create a sense of community more

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

County:	Wayne
Group Name:	Wayne County Physicians Group
Date and Time:	April 13, 2016 – 6:45PM
# of Participants:	25+

1. What are we missing in our assessment to date?
    a. Women's health issues - breastfeeding, smoking in pregnant women
    b. Teen Pregnancy
    c. Smoking
    d. Childhood obesity
    e. Access to care - may now have coverage due to ACA, but are they using it? (high deductibles)
    f. How many are seeking preventative care?
    g. ED diagnosis of a chronic condition (ex: people getting a prescription for insulin in the ED... they shouldn't be using the ED for this), would be great to have numbers for this... to see how many are using the ED as more preventive/chronic care, rather than a PCP
    h. Per capita rate for number of physicians and for dentists
    i. Data around number of cars per family - transportation
    j. Drop-out rates
    k. Education data
    l. Unemployment
    m. Poverty
    n. Towns are getting smaller
2. What trends or factors are influencing the health of the residents?
    a. Transportation
    b. Transportation particularly for pregnant women with children
    c. Poverty
    d. Increase in drug use
    e. A lot of immigrants
    f. High drop-out rates - less educated population
    g. General health literacy
    h. We see that health literacy is learned from generation to generation (they see what their mom did, so they do that... can't break the cycle)
    i. A lot of health is related to diet - there are a lot of fast food places and unhealthy restaurants
    j. Not a lot of grocery stores
    k. No access to healthy food
3. What community strengths or assets contribute to the health of the residents?

a. Strong hospital located in the county
b. Wayne Rural Health Network and Cancer Services Program
c. Strong medical community - can often serve patients all in one area, which is very helpful
d. A sense in the community that they can come to the Newark-Wayne Campus and get all of the help they need
e. Good coordination between programs (pediatricians talked to kids about bike helmets, the hospital purchases them to give out, etc.)
f. Use local resources to solve local problems
g. If you break your ankle, I can guarantee you follow up in the next week... because rehab works really well with the ED
h. Lifetime Care is great

4. What would you do to address some of these problems?
    a. Coordinating more - taking the care to the patient, getting home care services, aid services, getting someone out to patients to do an assessment
    b. Increased communication between organizations - there is some duplication of services
    c. Have a lot of paramedics - an underused resource (they are sitting, waiting for a call) - we should utilize them more... they could go out and do things for patients (immunizations, EKGs, etc.)... they have a lot of skills and are willing to do them... but there is resistance
    d. Involving the school nurses more - expand their screening processes, help to identify issues earlier (more preventative than reactive)
    e. Different ways to reach out to residents of Wayne County - utilization of social media (the medical community is a little behind on this, could be used more/better)
    f. A lot of resources in the county, they are just not well coordinated - need to coordinate more/better
    g. Could be a lot more effective, if services were coordinated better
    h. Focus on the schools more - start young, to change the culture

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

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

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

County:	Wayne
Group Name:	W3C Group - Wayne Coordinating Council
Date and Time:	April 21, 2016 – 2:00PM
# of Participants:	11

1. What are we missing in our assessment to date?
    a. More data around mental health - need more than just hospital discharges
    b. Data on loss/addition of mental health providers - the loss/addition of just one can skew the numbers a lot
    c. Availability/access of mental health providers
    d. Age ranges and demographic information (strokes, high blood pressure, etc.) - to determine where we should focus on
    e. Data on where services are being provided - is it primarily in the county? Primarily outside of the county? What places?
    f. Data on cancer - could there be an agricultural link? COPD rates are higher... agriculture could contribute to that as well, a lot of spraying because of the fruit
    g. Data that connects high rates of substance abuse/mental health with school districts (children and adults)
    h. Data on sexually transmitted diseases
    i. Numbers for the back pack program, free and reduced lunch, food pantries, etc.
    j. Data on e-cigarettes and "vaping"
2. What trends or factors are influencing the health of the residents?
    a. Rural nature of county - don't have immediate access to medical services like in an urban area (could contribute to stroke mortality)
    b. Quantity and severity of mental health in school aged children
    c. Younger kids having mental health issues - in Pre-K
    d. A lot of autism - seeing a lot more of it
    e. More employers have wellness programs
    f. A lot more healthy choices available - healthy meals act in schools, healthier vending in schools, etc.
    g. E-cigarettes/vaping
    h. Housing
    i. Transportation
    j. Lack of work - unemployment, poverty, loss of jobs, no high paying jobs
    k. Education levels
    l. People leaving the county - losing those that are educated, professionals, etc.
    m. Elderly population is going up - the workforce is decreasing (ex: cannot keep enough CNAs for home care, huge shortage)

n. East side of the county is much worse than the west (higher poverty, unemployment, etc.)

3. What community strengths or assets contribute to the health of the residents?
    a. Two dialysis offices in the county now
    b. Urgent care just opened up in Newark
    c. Emergency room has improved
    d. Dental clinic run through RPCN and two sites through FLCH in Wayne County
    e. Farmers markets increasing - take SNAP/EBT
    f. Mental Health First Aid - many trained
    g. Nutrition programs through CCE
    h. United Way shifting their focus to poverty
    i. Several agencies trained to provide CDSMP - running on a regular basis
    j. All PCP practices owned by Rochester Regional Health all offer the community Saturday hours or Saturday options, and some night time hours
    k. PEP Grants - focus on physical fitness in Sodus and Clyde-Savannah
    l. Community Centers/school gyms that can be used - a lot of people use facilities in Ontario, Palmyra, and Lyons
    m. Trails
    n. CCE chart that shows what schools have public access to physical activity opportunities
    o. March of Dimes just gave Newark Wayne Community Hospital $70,000 to focus on smoking cessation in pregnant women
4. What would you do to address some of these problems?
    a. More smoking cessation programs
    b. Bring more resources for substance abuse, mental health, housing, transportation
    c. Address social determinants of health
    d. Using grocery stores and common access points for education/programs
    e. More communication and collaboration between schools/CBOs/agencies/etc.
    f. Increase economic development

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

County:	Wayne
Group Name:	Health Services Advisory Board
Date and Time:	April 27, 2016 – 9:00AM
# of Participants:	13

1. What are we missing in our assessment to date?
    a. Attempted suicides or suicides
    b. Access to care (insurance is not a true assessment of access)
    c. Data on alcohol
    d. Data on firearms and suicide
    e. Data or input from children/youth
    f. Demographics - income, unemployment, etc.
    g. Demographics - male, female, race/ethnicity, etc.
    h. Data on seasonal workers
    i. Data on physical activity and access to physical activity
    j. Data on physical activity in the schools

2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Good health - absence of problems
    b. Lots of festivals, 5ks, walks, etc.
    c. Opportunities to become involved in the community
    d. Happy
    e. Active
    f. Education/Educated
    g. Healthy foods are available
    h. Affordability of healthy foods

3. What trends or factors are influencing the health of the residents?
    a. Heroin - much more difficult to prescribe narcotics, many doctors will not prescribe narcotics in any large amounts - they are referring patients to pain clinics (causing people to use heroin because it is a lot cheaper than pills on the street)
    b. County vending machines now have healthy choices
    c. Public Health - leading the way with a lot of healthy choices
    d. Tobacco law on county grounds
    e. Trends in health coverage - a lot of tests are now covered (cancer screenings, blood pressure, preventative, etc.)

f. Kids don't go out and play - increases in video games, phones, television, etc. (leads to obesity and creates unhealthy adults)
g. Schools offering healthy foods
h. Increased mental health issues in children
i. Increased substance abuse
j. Transportation - people can't access services
k. Sleep deprivation/lack of sleep

4. What community strengths or assets contribute to the health of the residents?
    a. Cornell Cooperative Extension
    b. Collaboration/partnerships are strong
    c. Good health community (hospital, public health, rural health network, etc.)
    d. One of the strongest Head Start programs in the area
    e. Strong food distribution programs - usually monthly (Foodlink, food pantries, etc.)
    f. North Rose and in Newark they have the backpack program (includes healthy snacks)
    g. Long walking trails - canal
    h. We have space - don't have that in the city
    i. EMR includes questions about weight/BMI/etc. - doctors are really trying to talk to their patients more about weight/healthy eating/exercising, etc.
    j. National Diabetes Prevention Program and The Good Life Program
    k. Trail Works
    l. Wegmans is very active in the community/health
    m. Counselors in Lyons High School (have them now due to grants) - makes a huge difference
    n. Mental health screening in schools now
    o. NYSDOH has now recognized the value of Mental Health First Aid Trainings and it's link to public health
    p. Family Counseling Services of the Finger Lakes
    q. Delphi Counseling Services

5. What would you do to address some of these problems?
    a. Education - early on in life (start with the kids)
    b. Increase internet accessibility (there are a lot of pockets that do not get signal) - a lot is on the internet these days and it's difficult for some to access it (especially low income)
    More programs/access for mental health and substance abuse - especially in the schools (it is a great, safe place for families to be able to access services)

c. More community centers/areas where people can get out and be active, and socialize
d. Recycled bike program for kids

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

County:	Wayne
Group Name:	Finger Lakes Migrant and Seasonal Farmworker Coalition
Date and Time:	May 03, 2016 – 1:30PM
# of Participants:	11

1. What are we missing in our assessment to date?
    a. No mention of STD's.
    b. Widespread easy access to HIV testing that doesn't need blood draw compared to syphilis which requires a blood draw. Are people not being tested? Look at data in regards to the testing rate.
    c. Migrant farm workers are undocumented, no insurance or qualification for Obama Care. Lacking of free clinics, workers have to pay for visit out of pocket which is a barrier to access of services. No insurance = health disparity. Sliding fee scale can be used to cover the high deductible costs as well. Community isn't aware.
    d. Work related injuries and illness. Very few farm workers that receive care from clinics. Have to have social security number to file workers comp claim. Transportation barrier to get to clinic. 1 clinic that serves 9 county region.
    e. Access to healthcare and services. In the past services costed $25 or so and now they cost over $100. Mental Issues and workplace violence. Healthy and Safety's trainings to assist with these issues. Workers are fearful to report violence incidents due to fear of losing jobs. Farm workers don't have right to rest for their positions. This can affect nutrition of workers and also transportation limits their access to healthy food. Don't get to eat the food that they are farming. Exposure to chemicals and pesticides, not just workers, community as well. Can be contributing to chronic diseases such as Asthma, etc. No proper work protection.
    f. Vaccinations for farm workers, do they know where to receive vaccinations or the importance of being vaccinated.
    g. Health education. Access to care.
2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Perceptions between patients and doctors. A lot of farm workers come from different countries such as Mexico and Central America. The doctor comes to you in these cultures. Mobile clinics are very important in terms of serving the migrant farm worker population.
    b. Sense of community. Health and wellbeing is affected by how emotionally healthy an individual is, socialization aspects. Not a lot of opportunities to participate in social activities. Can lead to isolation and depression.

   c. Freedom from fear. Many families from kids to adults are fearful on many different reasons. Undocumented so they are in fear of legal authority, fear of prejudice.
   d. Equity and access to services. Transportation, proactive education for services and access to those services. Going above and beyond to serve the community. Issues with Language access.
   e. Maybe using pictures to help the population define and understand the information that is being communicated to them. Taking into account cultural competency and literacy. Attention spans are a lot shorter to for the generation and people want information fast.
   f. Food desserts and access to healthy nutrition. Survey the population to understand what food they want to eat, taking into cultural aspects.
3. What trends or factors are influencing the health of the residents?
   a. Dieting pills. Pyramid schemes of selling pills to lose weight.
   b. Schemes of people selling vitamins as a cure to some issue or disease.
   c. Trend of not getting 8 hours of sleep, such as milking for 4 hours and then sleeping for 4 hours. This can have long term effects on health.
   d. Work place violence. Places that are isolated have higher rates of work place violence, lots of farms have a higher propensity for such.
   e. Chemical exposure. Pesticides, symptoms from exposure. Long term studies not done. Farm workers should have a yearly checkup to have a better grasp on data. Some other states have done this such as California to understand the data around pesticides effects. Are pesticides contributing to chronic diseases?
   f. Relatable information. When you receive information about nutrition, it can be difficult to understand how this information can be incorporated into their lives. Worked with other agencies like CCE to help with understanding proper nutrition and prep of food. Better to have hands on experience.
   g. Lower back pain and anything relating to ergonomics especially in agricultural work.
   h. Cultural exposures, lead exposed workers. From a cultural perspective they are exposed to spices or foods that they are used to from different cultures and they bring to the country with them.
4. What community strengths or assets contribute to the health of the residents?
   a. CCE and food nutrition.
   b. Cancer Services program. 3 levels of care. Screening, diagnosis and treatment. In season up to 1/3 of the population is migrant farming workers. Only have funding for 4 most hereditary cancers, breast, cervical, colorectal and prostate.
   c. Finger Lakes Community Health. Extensive mobile program, screening at farms.

   d. Foodlink program and Catholic Charities in Ontario County, not sure if they serve Wayne or how they differ. They are in Wayne.
   e. Worker Justice Center of NY. Workplace and Health and Safety Project. Offer safety trainings at farms. On aspects such as extreme weather and chemicals. Covering worker rights and also falls from heights, and eye safety.
   f. Finger Lakes Occupation Health Services. Seeing individuals who suffer from injury or illness as a result of farm work.
   g. Daycares, a lot of education with parents. Agro Business Child Development. Two centers located in Wayne County.
5. What would you do to address some of these problems?
   a. Transfer of Health Insurance information from State to State.
   b. Transportation needs to address access to services.
   c. Having agencies provide language services.
   d. NYS has specific regulations for language access and services.
   e. Direct outreach to workers and not asking permission of employers.
   f. Partnerships with organizations that are already doing work, collaborations.
   g. Patient education that are more visual. 70/30 with text.
   h. Health care providers being trained in chemical and pesticide exposure diagnosis and treatment.
   i. Money Money Money to train bilingual interpreters for mental health.
   j. May need to consider implications of Zika. What impact is that going to have on the community? Especially with the influx of migrant workers.

Wayne 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	15	19	3	1	38
Develops collaborative networks for health promotion activities that facilitate healthy living in healthy communities	18	14	3	3	38
Assesses the appropriateness, quality and effectiveness of health promotion activities at least every 2 years.	14	14	5	5	38
Total Respondents	38				

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).	18	15	3	2	38
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.	19	13	4	2	38
Establishes and maintains a comprehensive directory of community organizations.	24	12	2	0	38
Uses broad-based communication strategies to strengthen linkages among LPHS organizations and to provide current information about public health services and issues.	14	18	4	1	37
Total Respondents	38				

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.	14	18	5	1	38
Assure the establishment of a broad-based community health improvement committee.	16	11	5	5	37
Assesses the effectiveness of community partnerships in improving community health.	14	13	5	5	37
Total Respondents	38				

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.	11	20	5	1	37
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.	16	15	4	2	37
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.	13	18	2	4	37
Total Respondents	37				

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.	15	15	3	3	36
Provide opportunities for all personnel to develop core public health competencies.	13	15	6	2	36
Provide incentives (e.g. improvements in pay scale, release time, tuition reimbursement) for the public health workforce to pursue education and training.	9	13	5	7	34
Provide opportunities for public health workforce members, faculty and student interaction to mutually enrich practice-academic settings.	8	15	4	8	35
Total Respondents	36				

Public Health Leadership Development					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Provide formal (educational programs, leadership institutes) and informal (coaching, mentoring) opportunities for leadership development for employees at all organizational levels.	9	16	6	4	35
Promote collaborative leadership through the creation of a local public health system with a shared vision and participatory decision-making.	11	17	5	3	36
Assure that organizations and/or individuals have opportunities to provide leadership in areas where their expertise or experience can provide insight, direction or resources.	11	16	3	6	36
Provide opportunities for development of diverse community leadership to assure sustainability of public health initiatives.	10	17	3	7	37
Total Respondents	37				

Access to and Utilization of Current Technology to Manage, Display and Communicate Population Health Data					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Uses state of the art technology to collect, manage, integrate and display health profile databases.	8	16	4	3	31
Promotes the use of geocoded data.	8	11	2	10	31
Uses geographic information systems.	9	10	3	10	32
Uses computer-generated graphics to identify trends and/or compare data by relevant categories (e.g. race, gender, age group).	13	10	4	8	35
Total Respondents	35				

Diagnose and Investigate Health Problems and Health Hazards in the Community					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Epidemiological investigations of disease outbreaks and patterns of infectious and chronic disease and injuries, environmental hazards, and other health threats.	19	12	4	1	36
Active infectious disease epidemiology programs.	20	8	7	0	35
Access to public health laboratory capable of conducting rapid screening and high volume testing.	14	12	3	6	35
Total Respondents	36				

Plan for Public Health Emergencies					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Defines and describes public health disasters and emergencies that might trigger implementation of the LPHS emergency response plan.	16	14	2	2	34
Develops a plan that defines organizational responsibilities, establishes communication and information networks, and clearly outlines alert and evacuation protocols.	15	14	2	3	34
Tests the plan each year through the staging of one or more “mock events.”	16	8	3	7	34
Revises its emergency response plan at least every two years.	17	9	1	7	34
Total Respondents	34				

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	22	9	0	3	34
Develops written epidemiological case investigation protocols for immediate investigation of:	19	8	0	5	32
Communicable disease outbreaks	22	10	2	1	35
Environmental health hazards	19	11	1	3	34
Potential chemical and biological agent threats	19	9	3	3	34
Radiological threats and	19	9	4	2	34
Large scale disasters	18	11	3	2	34
Maintains written protocols to implement a program of source & contact tracing.	18	11	3	2	34
Maintain a roster of personnel with technical expertise to respond to biological, chemical or radiological emergencies	16	10	4	4	34
Evaluates past incidents for effectiveness & continuous improvement	18	10	3	3	34
Total Respondents	35				

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.	13	15	0	3	31
Maintains ready access to labs capable of meeting routine diagnostic & surveillance needs.	14	14	0	3	31
Confirms that labs are in compliance with regs & standards through credentialing and licensing agencies.	10	14	2	4	30
Maintains protocols to address handling of lab samples– storing, collecting, labeling, transporting and delivering samples and for determining the chain of custody.	12	14	0	4	30
Total Respondents	31				

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.	17	10	6	2	35
Development of policy to protect the health of the public and to guide the practice of public health.	18	9	3	3	33
Systematic community-level and state-level planning for health improvement in all jurisdictions.	16	10	4	4	34
Alignment of LPHS resources & strategies with the community health improvement plan.	17	9	3	5	34
Total Respondents	35				

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.	15	14	3	3	35
Reviews existing policies at least every 2 years and alerts policy makers and the public of potential unintended outcomes and consequences.	15	13	0	7	35
Advocates for prevention and protection policies, particularly policies that affect populations who bear a disproportionate burden of mortality and morbidity.	16	10	5	3	34
Total Respondents	35				

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.	17	10	3	4	34
Develops strategies to achieve community health improvement objectives and identifies accountable entities to achieve each strategy.	18	8	4	4	34
Total Respondents	34				

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.	16	9	3	3	31
Review its own organizational strategic plan to determine how it can best be aligned with the community health improvement process.	17	9	2	3	31
Conducts organizational strategic planning activities and uses strategic planning to align its goals, objectives, strategies and resources with the community health improvement process.	17	8	3	3	31
Total Respondents	31				

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.	15	14	3	1	33
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.	13	14	6	0	33
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.	15	10	7	1	33
Total Respondents	33				

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.	19	11	3	1	34
Identifying personal health service needs of populations with limited access to a coordinated system of clinical care.	18	12	3	1	34
Assuring the linkage of people to appropriate personal health services.	16	13	4	1	34
Total Respondents	34				

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.	15	11	6	1	33
Assesses the extent to which personal health services are provided.	16	10	6	1	33
Identifies the personal health service needs of populations who may encounter barriers to the receipt of personal health services.	15	11	6	1	33
Total Respondents	33				

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.	11	18	3	2	34
Provides community outreach and linkage services in a manner that recognizes the diverse needs of unserved and underserved populations.	14	12	4	4	34
Enrolls eligible beneficiaries in state Medicaid or Medical Assistance Programs.	14	14	2	3	33
Coordinates the delivery of personal health and social services with service providers to optimize access.	12	13	4	4	33
Conducts an analysis of age-specific participation in preventive services.	13	9	5	6	33
Total Respondents	34				

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.	14	11	4	4	33
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.	12	13	2	6	33
Identifies gaps in the provision of population-based health services.	14	12	2	5	33
Uses evaluation findings to modify the strategic and operational plans of LPHS organizations to improve services and programs.	13	12	4	4	33
Total Respondents	33				

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.	16	13	2	2	33
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.	14	10	4	5	33
Assesses the effectiveness of communication, coordination and linkage among LPHS entities.	12	12	4	5	33
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.	12	13	3	5	33
Total Respondents	33				

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.	13	9	5	6	33
Linkages with institutions of higher learning and research.	12	9	6	6	33
Capacity to mount timely epidemiological and health policy analyses and conduct health systems research.	11	10	5	7	33
Total Respondents	33				

Where is your organization located?		
Answer Options	**Response Percent**	**Response Count**
Newark	27.3%	9
Lyons	45.5%	15
Ontario	12.1%	4
Marion	6.1%	2
Sodus	18.2%	6
Palmyra	15.2%	5
Clyde	9.1%	3
Wolcott	12.1%	4
Red Creek	3.0%	1
North Rose	3.0%	1
Macedon	3.0%	1
Williamson	6.1%	2
Other (Whole County, Walworth, Rochester)		3
Total Respondents	24	

What population does your organization serve? ie. elderly, low income, children	
Answer Options	**Response Count**
All	19
Elderly	2
Low income - children	3
Low income – families	2
Low income – all	2
Substance abuse	1
Probation	1
School children	3
DSS, job seekers	1
Support/consultation	1
4000	1
Total Respondents	36

What type of organization do you work for? ie. hospital, county agency, non-profit	
Answer Options	**Response Count**
Non-profit	8
Hospital	2
Medical practice	1
School	3
FQHC	1
Law enforcement	1
County/town agency	18
State agency	2
Total Respondents	36

What is your position/job title?	
Answer Options	**Response Count**
Director	10
Chief	2
Commissioner	1
Community Health Worker	1
Coordinator	3
Town supervisor	1
Supervisor/administrator	5
Physician	2
Nurse/Nurse Practitioner	4
Nutritionist	1
Historian	1
Total Respondents	31

Cancer Indicators - Wayne 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)	1,736	620.0	550.9	Yes	610.0	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	1,736	511.4	489.2	No	510.8	No	3rd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	578	206.4	180.7	Yes	202.4	No	2nd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	578	170.3	158.6	No	165.6	No	2nd
Lip, Oral Cavity, and Pharynx Cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	34	12.1	12.1	No	13.5	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	34	9.0	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)	126	45.0	46.7	No	49.6	No	1st
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	126	37.6	41.4	No	41.2	No	1st
Crude mortality rate per 100,000	(Table) (Trend) (Map)	48	17.1	16.6	No	17.2	No	2nd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	48	14.4	14.4	No	13.9	No	2nd
Lung and bronchus cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	236	84.3	69.6	Yes	83.0	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	236	68.2	61.6	No	68.6	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	176	62.9	46.4	Yes	55.9	No	2nd

Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	176	51.5	41.0	Yes	46.1	No	3rd
Female breast cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	232	164.4	149.1	No	164.4	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	232	132.6	127.2	No	133.2	No	3rd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	37	26.2	26.3	No	28.1	No	3rd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	37	20.4	20.9	No	20.9	No	3rd
Crude late stage incidence rate per 100,000	(Table) (Trend) (Map)	71	50.3	49.2	No	51.4	No	3rd
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	71	40.7	42.7	No	42.7	No	3rd
Cervix uteri cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	10	7.1	8.3	No	7.2	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	10	7.2	7.7	No	6.7	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.7	N/A	2.4	N/A	N/A
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.3	N/A	2.0	N/A	N/A
Ovarian cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	22	15.6	14.9	No	16.2	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	22	11.5	12.5	No	12.9	No	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	13	9.2	9.5	No	10.4	No	2nd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	13	6.9	7.5	No	7.8	No	2nd
Prostate cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	292	210.3	156.7	Yes	167.4	Yes	4th
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	292	170.2	145.3	Yes	143.8	Yes	4th
Crude mortality rate per 100,000	(Table) (Trend) (Map)	39	28.1	18.3	Yes	18.6	Yes	4th
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	39	28.6	20.0	No	18.5	Yes	4th
Crude late stage	(Table) (Trend) (Map)	78	56.2	23.3	Yes	25.1	Yes	4th

incidence rate per 100,000								
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	78	43.2	21.2	Yes	21.1	Yes	4th
Melanoma cancer mortality								
Crude mortality rate per 100,000	(Table) (Trend) (Map)	10	3.6	2.5	No	3.3	No	3rd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	10	2.9	2.2	No	2.8	No	3rd
Age-adjusted % of women 18 years and older with Pap smear in past 3 years (2013-2014)	(Table) (Map)	N/A	77.6	74.2	No	76.2	No	2nd
% of women 40 years and older with mammography screening in past 2 years (2013-2014)	(Table) (Map)	N/A	80.4	77.8	No	77.4	No	1st
% of women, aged 50-74 years, who had a mammogram between October 1, 2011 and December 31, 2013 (2013)	(Table) (Map)	98	45.6	71.7	Yes	63.4	Yes	4th

N/A: Data not available

s: Data do not meet reporting criteria

Cardiovascular Disease Indicators - Wayne 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)	723	259.3	272.5	No	297.4	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	723	214.5	228.0	Yes	228.2	Yes	2nd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	116	96.3	99.0	No	96.8	No	2nd
Pretransport mortality	(Table) (Trend) (Map)	387	138.8	146.7	No	162.3	Yes	1st
Cardiovascular disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	5,292	189.8	163.6	Yes	165.9	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	5,292	154.9	143.5	Yes	136.0	Yes	4th
Disease of the heart mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	569	204.0	222.1	Yes	238.7	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	569	167.9	185.4	Yes	182.8	Yes	2nd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	96	79.7	80.6	No	79.9	No	2nd
Pretransport mortality	(Table) (Trend) (Map)	320	114.7	126.3	No	134.7	Yes	2nd
Disease of the heart hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	3,700	132.7	108.5	Yes	111.9	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	3,700	108.1	94.9	Yes	91.4	Yes	4th
Coronary heart disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	401	143.8	175.1	Yes	171.8	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	401	117.6	146.2	Yes	131.5	Yes	2nd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	72	59.8	65.5	No	60.7	No	2nd
Pretransport mortality	(Table) (Trend) (Map)	241	86.4	103.6	Yes	100.0	Yes	2nd
Coronary heart disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,275	45.7	40.0	Yes	39.9	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	1,275	36.2	34.8	No	32.5	Yes	3rd
Heart attack (Acute Myocardial Infarction) hospitalization rate per 10,000								

Crude	(Table) (Trend) (Map)	710	25.5	17.1	Yes	19.4	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	710	20.3	14.8	Yes	15.7	Yes	4th
Heart attack (Acute Myocardial Infarction) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	141	50.6	37.3	Yes	45.0	No	3rd
Age-adjusted	(Table) (Trend) (Map)	141	40.3	31.3	Yes	34.8	Yes	3rd
Congestive heart failure mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	64	22.9	14.7	Yes	21.6	No	3rd
Age-adjusted	(Table) (Trend) (Map)	64	19.4	12.0	Yes	16.1	Yes	4th
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	4	3.3*	1.9	No	2.3	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	42	15.1	8.0	Yes	12.4	No	4th
Congestive heart failure hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	987	35.4	28.8	Yes	29.3	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	987	29.2	24.9	Yes	23.4	Yes	4th
Cerebrovascular disease (stroke) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	121	43.4	30.9	Yes	38.5	No	3rd
Age-adjusted	(Table) (Trend) (Map)	121	36.6	26.2	Yes	29.8	Yes	4th
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	18	14.9	10.5	No	10.1	No	4th
Pretransport mortality	(Table) (Trend) (Map)	55	19.7	11.5	Yes	17.0	No	3rd
Cerebrovascular disease (stroke) hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	946	33.9	26.9	Yes	28.9	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	946	27.6	23.5	Yes	23.6	Yes	4th
Hypertension hospitalization rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	90	4.2	7.4	Yes	5.0	No	3rd
Hypertension hospitalization rate per 10,000 (any diagnosis) (aged 18 years and older)	(Table) (Trend) (Map)	12,388	575.4	562.1	Yes	560.8	Yes	3rd
Hypertension emergency department visit rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	424	19.7	32.9	Yes	24.9	Yes	1st
Hypertension emergency department visit rate per 10,000 (any diagnosis) (aged 18 years and older)	(Table) (Trend) (Map)	18,223	846.4	896.6	Yes	927.7	Yes	2nd
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,674	131.7	117.7	Yes	117.1	Yes	4th

Age-adjusted	(Table) (Trend) (Map)	3,674	109.1	103.0	Yes	95.3	Yes	4th
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,909	140.2	115.3	Yes	116.8	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	3,909	116.5	101.0	Yes	95.4	Yes	4th
Age-adjusted % of adults with physician diagnosed angina, heart attack or stroke # (2008-2009)	(Table) (Map)	N/A	8.1	7.6	No	7.2	No	3rd
Age-adjusted % of adults with cholesterol checked in the last 5 years # (2013-2014)	(Table) (Map)	N/A	81.2	83.4	No	83.2	No	3rd
Age-adjusted % of adults ever told they have high blood pressure (2013-2014)	(Table) (Map)	N/A	26.5	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 - Wayne 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	23.5*	20.0	No	21.1	No	3rd
Aged 5-9 years	(Table) (Trend) (Map)	2	11.7*	10.1	No	9.7	No	3rd
Aged 10-14 years	(Table) (Trend) (Map)	4	21.6*	11.9	No	11.8	No	4th
Aged 5-14 years	(Table) (Trend) (Map)	6	16.9*	11.0	No	10.8	No	3rd
Aged 15-19 years	(Table) (Trend) (Map)	9	47.9*	33.4	No	35.2	No	3rd
Asthma hospitalization rate per 10,000								
Aged 0-4 years	(Table) (Trend) (Map)	20	12.6	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	21	5.9	20.5	Yes	10.4	Yes	2nd
Aged 0-17 years	(Table) (Trend) (Map)	42	6.6	26.6	Yes	14.2	Yes	1st
Gastroenteritis hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	9	5.7*	11.3	Yes	8.6	No	1st
Otitis media hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	s	s	2.5	N/A	2.0	N/A	N/A
Pneumonia hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	43	27.1	39.4	Yes	31.3	No	2nd
% of children born in 2010 with a lead screening aged 0-8 months (2010-2013)	(Table) (Map)	35	3.6	3.5	No	4.2	No	2nd
% of children born in 2010 with a lead screening - aged 9-17 months (2010-2013)	(Table) (Trend) (Map)	651	67.3	65.0	No	53.5	Yes	1st
% of children born in 2010 with a lead screening - aged 18-35 months (2010-2013)	(Table) (Trend) (Map)	547	56.5	65.6	Yes	55.7	No	2nd
% of children born in 2010 with at least two lead screenings by 36 months (2010-2013)	(Table) (Trend) (Map)	425	43.9	55.1	Yes	42.1	No	2nd
Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) - rate per 1,000 tested children aged <72 months	(Table) (Trend) (Map)	48	10.5	4.9	Yes	8.8	No	3rd

% of children with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	2,723	71.5	71.6	No	70.3	No	2nd
% of children aged 0-15 months with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	256	96.6	82.2	Yes	85.4	No	1st
% of children aged 3-6 years with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	1,130	79.9	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)	1,337	62.8	63.8	No	61.9	No	2nd

Cirrhosis/Diabetes Indicators - Wayne 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)	25	9.0	7.7	No	8.7	No	2nd
Age-adjusted	(Table) (Trend) (Map)	25	6.8	6.7	No	7.2	Yes	2nd
Cirrhosis hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	58	2.1	2.8	Yes	2.5	No	2nd
Age-adjusted	(Table) (Trend) (Map)	58	1.7	2.5	Yes	2.2	No	2nd
Diabetes mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	77	27.6	20.3	Yes	19.6	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	77	22.0	17.6	Yes	15.7	Yes	3rd
Diabetes hospitalization rate per 10,000 (primary diagnosis)								
Crude	(Table) (Trend) (Map)	391	14.0	19.3	Yes	15.6	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	391	12.5	17.9	Yes	14.2	Yes	2nd
Diabetes hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	6,932	248.6	244.1	No	225.8	Yes	3rd

Age-adjusted	(Table) (Trend) (Map)	6,932	202.3	215.9	Yes	188.6	Yes	3rd
Diabetes short-term complications hospitalization rate per 10,000								
Aged 6-17 Years	(Table) (Trend) (Map)	9	2.0*	3.1	No	2.9	No	1st
Aged 18 years and older	(Table) (Trend) (Map)	121	5.6	6.3	No	5.8	No	2nd
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,674	131.7	117.7	Yes	117.1	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	3,674	109.1	103.0	Yes	95.3	Yes	4th
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,909	140.2	115.3	Yes	116.8	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	3,909	116.5	101.0	Yes	95.4	Yes	4th
Age-adjusted % of adults with physician diagnosed diabetes (2013-2014)	(Table) (Map)	N/A	6.4	8.9	No	8.2	No	1st

N/A: Data not available

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

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

Communicable Disease Indicators - Wayne 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)	638	148.4	112.6	Yes	121.9	Yes	3rd
Pertussis incidence rate per 100,000	(Table) (Trend) (Map)	73	26.2	8.8	Yes	12.9	Yes	4th
Mumps incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.2	Yes	0.1	Yes	2nd
Meningococcal incidence rate per 100,000	(Table) (Trend) (Map)	1	0.4*	0.2	No	0.2	No	4th
H. influenza incidence rate per 100,000	(Table) (Trend) (Map)	6	2.2*	1.7	No	1.7	No	3rd
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)	2	0.7*	0.6	No	0.5	No	4th
Tuberculosis incidence rate per 100,000	(Table) (Trend) (Map)	4	1.4*	4.5	Yes	1.9	No	3rd
E. coli O157 incidence rate per 100,000	(Table) (Trend) (Map)	4	1.4*	0.6	No	0.8	No	4th
Salmonella incidence rate per 100,000	(Table) (Trend) (Map)	33	11.8	12.9	No	12.2	No	3rd
Shigella incidence rate per 100,000	(Table) (Trend) (Map)	45	16.1	4.8	Yes	4.4	Yes	4th
Lyme disease incidence rate per 100,000#	(Table) (Map)	20	7.2	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	84.1	72.4	Yes	77.1	No	1st
% of adults aged 65 years and older who ever received pneumonia shot (2013-2014)	(Table) (Map)	N/A	84.3	65.1	Yes	70.7	Yes	1st

N/A: Data not available

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

Family Planning/Natality Indicators - Wayne 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)	604	20.4	18.5	Yes	21.0	No	1st
Percentage of births to teens								
Aged 15-17 years	(Table) (Trend) (Map)	37	1.2	1.4	No	1.5	No	2nd
Aged 15-19 years	(Table) (Trend) (Map)	216	7.3	5.2	Yes	5.7	Yes	3rd
% of births to women aged 35 years and older	(Table) (Trend) (Map)	329	11.1	20.5	Yes	18.9	Yes	2nd
Fertility rate per 1,000 females								
Total (all births/females aged 15-44 years)	(Table) (Trend) (Map)	2,961	61.3	59.0	Yes	56.8	Yes	3rd
Aged 10-14 years (births to mothers aged 10-14 years/females aged 10-14 years)	(Table) (Trend) (Map)	1	0.1*	0.3	No	0.2	No	2nd
Aged 15-17 years (births to mothers aged 15-17 years/females aged 15-17 years)	(Table) (Trend) (Map)	37	6.3	9.3	Yes	7.9	No	2nd
Aged 15-19 years (births to mothers aged 15-19 years/females aged 15-19 years)	(Table) (Trend) (Map)	216	24.0	19.5	Yes	17.3	Yes	3rd
Aged 18-19 years (births to mothers aged 18-19 years/females aged 18-19 years)	(Table) (Trend) (Map)	179	57.9	33.5	Yes	29.9	Yes	4th
Pregnancy rate per 1,000 (all pregnancies/females aged 15-44 years) #	(Table) (Trend) (Map)	3,480	72.1	87.9	Yes	72.6	No	2nd
Teen pregnancy rate per 1,000 #								
Aged 10-14 years	(Table) (Trend) (Map)	2	0.2*	0.9	Yes	0.6	No	1st
Aged 15-17 years	(Table) (Trend) (Map)	65	11.0	22.4	Yes	14.5	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	293	32.6	41.3	Yes	28.7	Yes	2nd
Aged 18-19 years	(Table) (Trend) (Map)	228	73.8	67.2	No	47.6	Yes	3rd

Abortion ratio (induced abortions per 1,000 live births) #								
Aged 15-19 years	(Table) (Trend) (Map)	72	333.3	1,050.3	Yes	624.6	Yes	1st
All ages	(Table) (Trend) (Map)	453	153.0	412.3	Yes	233.2	Yes	1st

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

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

See technical notes for information about the indicators and data sources

HIV/AIDS and Other Sexually Transmitted Infection Indicators - Wayne 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)	12	4.3	19.1	Yes	7.6	No	2nd
Age-adjusted	(Table) (Trend) (Map)	12	4.0	19.1	Yes	7.9	Yes	2nd
AIDS case rate per 100,000								
Crude	(Table) (Trend) (Map)	10	3.6	12.2	Yes	4.4	No	3rd
Age-adjusted	(Table) (Trend) (Map)	10	3.6	12.2	Yes	4.5	No	3rd
AIDS mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	1	0.4*	4.0	Yes	1.4	No	1st
Age-adjusted	(Table) (Trend) (Map)	1	0.3*	3.7	Yes	1.3	Yes	1st
Early syphilis case rate per 100,000	(Table) (Trend) (Map)	5	1.8*	14.4	Yes	3.6	No	2nd
Gonorrhea case rate per 100,000								
All ages	(Table) (Trend) (Map)	47	16.9	107.7	Yes	61.1	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	7	37.3*	368.1	Yes	203.6	Yes	1st
Chlamydia case rate per 100,000 males								
All ages	(Table) (Trend) (Map)	206	148.9	336.0	Yes	203.0	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	36	367.4	1,029.1	Yes	608.6	Yes	2nd
Aged 20-24 years	(Table) (Trend) (Map)	98	1,190.0	1,492.7	Yes	1,089.0	No	4th
Chlamydia case rate per 100,000 females								

All ages	(Table) (Trend) (Map)	559	397.7	672.3	Yes	466.8	Yes	3rd
Aged 15-19 years	(Table) (Trend) (Map)	209	2,325.3	3,595.5	Yes	2,387.5	No	3rd
Aged 20-24 years	(Table) (Trend) (Map)	206	2,765.5	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)	260	52.8	72.2	Yes	65.2	Yes	3rd
Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)	(Table) (Trend) (Map)	13	2.7	3.0	No	2.1	No	3rd

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

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

Injury Indicators - Wayne 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)	30	10.8	8.4	No	10.1	No	2nd
Age-adjusted	(Table) (Trend) (Map)	30	10.0	8.0	Yes	9.6	No	2nd
Aged 15-19 years	(Table) (Trend) (Map)	1	5.3*	5.4	No	6.3	No	2nd
Self-inflicted injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	214	7.7	5.8	Yes	6.8	No	3rd
Age-adjusted	(Table) (Trend) (Map)	214	8.5	5.8	Yes	7.0	Yes	3rd
Aged 15-19 years	(Table) (Trend) (Map)	29	15.4	11.3	No	12.5	No	3rd
Homicide mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	3	1.1*	3.7	Yes	2.7	No	2nd
Age-adjusted	(Table) (Trend) (Map)	3	1.2*	3.7	Yes	2.8	Yes	2nd
Assault hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	34	1.2	4.1	Yes	2.5	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	34	1.4	4.1	Yes	2.7	Yes	2nd
Unintentional injury mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	119	42.7	27.7	Yes	34.0	Yes	4th

Age-adjusted	(Table) (Trend) (Map)	119	40.1	25.6	Yes	30.8	Yes	4th
Unintentional injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	2,004	71.9	68.3	Yes	71.6	No	3rd
Age-adjusted	(Table) (Trend) (Map)	2,004	64.3	62.2	No	62.2	No	3rd
Aged less than 10 years	(Table) (Trend) (Map)	64	19.4	23.6	No	20.4	No	2nd
Aged 10-14 years	(Table) (Trend) (Map)	33	17.8	18.0	No	16.0	No	3rd
Aged 15-24 years	(Table) (Trend) (Map)	139	40.3	28.7	Yes	29.7	Yes	4th
Aged 25-64 years	(Table) (Trend) (Map)	689	45.9	46.0	No	45.8	No	3rd
Aged 65 years and older	(Table) (Trend) (Map)	1,079	251.0	252.3	No	262.9	No	3rd
Falls hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,128	40.4	39.4	No	42.5	No	3rd
Age-adjusted	(Table) (Trend) (Map)	1,128	34.3	34.7	No	34.9	No	3rd
Aged less than 10 years	(Table) (Trend) (Map)	17	5.2	8.9	Yes	7.5	No	1st
Aged 10-14 years	(Table) (Trend) (Map)	10	5.4	6.1	No	5.0	No	3rd
Aged 15-24 years	(Table) (Trend) (Map)	19	5.5	5.7	No	5.2	No	3rd
Aged 25-64 years	(Table) (Trend) (Map)	259	17.3	18.4	No	18.4	No	2nd
Aged 65-74 years	(Table) (Trend) (Map)	208	84.9	75.2	No	75.2	No	4th
Aged 75-84 years	(Table) (Trend) (Map)	314	240.7	220.3	No	229.4	No	4th
Aged 85 years and older	(Table) (Trend) (Map)	301	554.3	560.2	No	590.7	No	3rd
Poisoning hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	301	10.8	11.1	No	11.0	No	2nd
Age-adjusted	(Table) (Trend) (Map)	301	11.3	10.7	No	10.9	No	2nd
Motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	40	14.3	6.3	Yes	8.4	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	40	14.7	6.0	Yes	8.0	Yes	4th
Non-motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	79	28.3	21.4	Yes	25.6	No	4th
Age-adjusted	(Table) (Trend) (Map)	79	25.4	19.5	Yes	22.8	Yes	4th
Traumatic brain injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	229	8.2	10.0	Yes	10.2	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	229	7.6	9.4	Yes	9.2	Yes	3rd
Alcohol related motor vehicle injuries and	(Table) (Trend) (Map)	136	48.8	33.3	Yes	44.4	No	3rd

deaths per 100,000								

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

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

Maternal and Infant Health Indicators - Wayne 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)	193	9.6	14.1	Yes	10.6	No	3rd
% of births to out-of-wedlock mothers	(Table) (Trend) (Map)	1,335	45.1	40.9	Yes	39.1	Yes	3rd
% of births that were first births	(Table) (Trend) (Map)	1,168	39.4	42.6	Yes	40.8	No	1st
% of births that were multiple births	(Table) (Trend) (Map)	102	3.4	3.9	No	4.1	Yes	2nd
% of births with early (1st trimester) prenatal care	(Table) (Trend) (Map)	2,081	73.2	73.1	No	75.4	No	3rd
% of births with late (3rd trimester) or no prenatal care	(Table) (Trend) (Map)	124	4.4	5.6	Yes	4.1	No	2nd
% of births with adequate prenatal care (Kotelchuck)	(Table) (Trend) (Map)	1,787	64.2	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)	1,237	89.6	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)	61	4.2	4.7	No	4.1	No	2nd
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30) (2010-2012)	(Table) (Trend) (Map)	343	23.4	26.6	Yes	26.3	Yes	2nd

% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher) (2010-2012)	(Table) (Trend) (Map)	459	31.4	24.2	Yes	28.0	Yes	3rd
% of pregnant women in WIC with anemia in 3rd trimester (2009-2011)	(Table) (Map)	97	42.5	37.3	No	36.0	No	4th
% of pregnant women in WIC with gestational weight gain greater than ideal (2009-2011)	(Table) (Trend) (Map)	720	53.8	41.7	Yes	47.1	Yes	4th
% of pregnant women in WIC with gestational diabetes (2009-2011)	(Table) (Trend) (Map)	70	5.1	5.5	No	5.8	No	2nd
% of pregnant women in WIC with hypertension during pregnancy (2009-2011)	(Table) (Trend) (Map)	129	9.4	7.1	Yes	9.0	No	2nd
% of WIC mothers breastfeeding at least 6 months (2010-2012)	(Table) (Trend) (Map)	75	15.6	38.2	Yes	27.7	Yes	4th
% of infants fed any breast milk in delivery hospital	(Table) (Trend) (Map)	2,050	75.8	83.1	Yes	77.9	No	3rd
% of infants fed exclusively breast milk in delivery hospital	(Table) (Trend) (Map)	1,658	61.3	40.7	Yes	49.2	Yes	2nd
% of births delivered by cesarean section	(Table) (Trend) (Map)	881	29.8	34.1	Yes	35.6	Yes	1st
Mortality rate per 1,000 live births								
Infant (less than 1 year)	(Table) (Trend) (Map)	15	5.1	5.0	No	5.5	No	2nd
Neonatal (less than 28 days)	(Table) (Trend) (Map)	9	3.0*	3.4	No	3.9	No	1st
Post-neonatal (1 month to 1 year)	(Table) (Trend) (Map)	6	2.0*	1.5	No	1.6	No	3rd
Fetal death (20 weeks gestation or more)	(Table) (Trend) (Map)	12	4.0	6.6	No	4.4	No	2nd
Perinatal (20 weeks gestation to less than 28 days of life)	(Table) (Trend) (Map)	21	7.1	10.0	No	8.3	No	2nd
Perinatal (28 weeks gestation to less than 7 days of life)	(Table) (Trend) (Map)	18	6.1	5.4	No	5.4	No	3rd
Maternal mortality rate per 100,000 live births +	(Table) (Trend) (Map)	1	33.8*	20.0	No	19.4	No	4th
Low birthweight indicators								
% very low birthweight (less than 1.5 kg) births	(Table) (Trend) (Map)	32	1.1	1.4	No	1.4	No	2nd
% very low birthweight	(Table) (Trend) (Map)	25	0.9	1.1	No	1.0	No	2nd

(less than 1.5kg) singleton births								
% low birthweight (less than 2.5 kg) births	(Table) (Trend) (Map)	203	6.9	8.0	Yes	7.6	No	2nd
% low birthweight (less than 2.5kg) singleton births	(Table) (Trend) (Map)	154	5.4	6.0	No	5.6	No	3rd
% of premature births by gestational age								
less than 32 weeks gestation	(Table) (Trend) (Map)	51	1.7	1.8	No	1.8	No	3rd
32 - less than 37 weeks gestation	(Table) (Trend) (Map)	254	8.6	9.1	No	9.1	No	2nd
less than 37 weeks gestation	(Table) (Trend) (Map)	305	10.3	10.9	No	10.9	No	2nd
% of births with a 5 minute APGAR less than 6	(Table) (Trend) (Map)	27	0.9	0.6	No	0.7	No	3rd
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	48	167.9	95.0	Yes	123.2	No	4th

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

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

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

Obesity and Related Indicators - Wayne 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)	850	17.7	N/A	N/A	16.7	N/A	3rd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	898	18.7	N/A	N/A	17.3	N/A	2nd
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	1,748	36.3	N/A	N/A	33.9	N/A	3rd
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)	437	15.8	N/A	N/A	16.4	N/A	2nd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	491	17.8	N/A	N/A	16.8	N/A	3rd
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	928	33.6	N/A	N/A	33.1	N/A	2nd
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)	346	19.0	N/A	N/A	17.1	N/A	4th
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	393	21.6	N/A	N/A	18.1	N/A	3rd
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	739	40.6	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)	343	23.4	26.6	Yes	26.3	Yes	2nd
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher)	(Table) (Trend) (Map)	459	31.4	24.2	Yes	28.0	Yes	3rd
% obese (95th percentile or	(Table) (Trend) (Map)	386	15.3	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)	1,892	80.4	79.9	No	81.0	No	3rd
% of WIC mothers breastfeeding at least 6 months (2009-2011)	(Table) (Trend) (Map)	75	15.6	38.2	Yes	27.7	Yes	4th
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2013-2014)	(Table) (Map)	N/A	69.7	60.5	No	62.3	No	4th
Age-adjusted % of adults obese (BMI 30 or higher) (2013-2014)	(Table) (Map)	N/A	36.8	24.6	Yes	27.4	No	4th
Age-adjusted % of adults who did not participate in leisure time physical activity in last 30 days (2013-2014)	(Table) (Map)	N/A	25.2	27.1	No	26.2	No	3rd
Age-adjusted % of adults eating 5 or more fruits or vegetables per day (2008-2009)	(Table) (Map)	N/A	25.8	27.1	No	27.7	No	3rd
Age-adjusted % of adults with physician diagnosed diabetes (2008-2009)	(Table) (Map)	N/A	6.4	8.9	No	8.2	No	1st
Age-adjusted % of adults with physician diagnosed angina, heart attack or stroke # (2008-2009)	(Table) (Map)	N/A	8.1	7.6	No	7.2	No	3rd
Age-adjusted mortality rate per 100,000								
Cardiovascular disease mortality	(Table) (Trend) (Map)	723	214.5	228.0	Yes	228.2	Yes	2nd
Cerebrovascular disease (stroke) mortality	(Table) (Trend) (Map)	121	36.6	26.2	Yes	29.8	Yes	4th
Diabetes mortality	(Table) (Trend) (Map)	77	22.0	17.6	Yes	15.7	Yes	3rd
Age-adjusted hospitalization rate per 100,000								
Cardiovascular disease hospitalizations	(Table) (Trend) (Map)	5,292	154.9	143.5	Yes	136.0	Yes	4th
Cerebrovascular disease (stroke) hospitalizations	(Table) (Trend) (Map)	946	27.6	23.5	Yes	23.6	Yes	4th
Diabetes hospitalizations (primary diagnosis)	(Table) (Trend) (Map)	391	12.5	17.9	Yes	14.2	Yes	2nd

N/A: Data not available

#: Data not available for NYC counties

Occupational Health Indicators - Wayne 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)	6	2.6*	1.3	No	1.7	No	4th
Hospitalization rate per 100,000 persons aged 15 years and older								
Pneumoconiosis	(Table) (Trend) (Map)	19	8.4	10.3	No	14.0	Yes	2nd
Asbestosis	(Table) (Trend) (Map)	26	11.4	9.3	No	12.7	No	3rd
Work-related hospitalizations per 100,000 employed persons aged 16 years and older	(Table) (Trend) (Map)	303	235.3	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)	16	12.4	22.3	Yes	22.7	Yes	1st
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

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

s: Data do not meet reporting criteria

#: Data not available for NYC counties

Oral Health Indicators - Wayne 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	36.2	N/A	N/A	45.4	No	1st
% of 3rd grade children with untreated caries # (2009-2011)	(Table) (Map)	N/A	18.6	N/A	N/A	24.0	Yes	1st
% of 3rd grade children with dental sealants # (2009-2011)	(Table) (Map)	N/A	31.6	N/A	N/A	41.9	No	1st
% of 3rd grade children with dental insurance # (2009-2011)	(Table) (Map)	N/A	85.3	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	77.1	N/A	N/A	83.4	Yes	1st
% of 3rd grade children reported taking fluoride tablets regularly # (2009-2011)	(Table) (Map)	N/A	33.3	N/A	N/A	41.9	No	1st
Age-adjusted % of adults who had a dentist visit within the past year # (2013-2014)	(Table) (Map)	N/A	73.8	69.8	No	71.5	No	1st
Caries outpatient visit rate per 10,000 (aged 3-5 years)	(Table) (Trend) (Map)	140	139.8	79.2	Yes	93.5	Yes	3rd
Medicaid oral health indicators								
% of Medicaid enrollees with at least one dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	17,973	28.4	31.8	Yes	30.9	Yes	2nd
% of Medicaid enrollees with at least one preventive dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	13,895	22.0	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)	8,971	40.1	45.0	Yes	44.3	Yes	3rd
% of Medicaid enrollees (aged 2-20 years) with at	(Table) (Trend) (Map)	8,037	35.9	40.1	Yes	39.7	Yes	2nd

least one preventive dental visit within the last year # (2012-2014)								
% of children, aged 2-21 years, with at least one dental visit in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	3,134	58.0	59.2	No	61.4	Yes	3rd
Oral cancer								
Crude incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	34	12.1	12.1	No	13.5	No	2nd
Age-adjusted incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	34	9.0	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

#: Data not available for NYC counties

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

Respiratory Disease Indicators - Wayne 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)	137	49.1	35.6	Yes	46.2	No	2nd
Age-adjusted	(Table) (Trend) (Map)	137	41.2	30.7	Yes	36.8	Yes	2nd
Chronic lower respiratory disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,008	36.1	36.5	No	33.0	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	1,008	29.7	34.1	Yes	28.6	No	2nd
Asthma hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	204	7.3	18.2	Yes	11.1	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	204	7.0	18.2	Yes	10.9	Yes	2nd
Aged 0-4 years	(Table) (Trend) (Map)	20	12.6	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	21	5.9	20.5	Yes	10.4	Yes	2nd
Aged 0-17 years	(Table) (Trend) (Map)	42	6.6	26.6	Yes	14.2	Yes	1st
Aged 5-64 years	(Table) (Trend) (Map)	138	6.3	13.8	Yes	8.5	Yes	2nd
Aged 15-24 years	(Table) (Trend) (Map)	10	2.9	6.8	Yes	3.6	No	2nd
Aged 25-44 years	(Table) (Trend) (Map)	37	5.8	8.6	Yes	6.6	No	2nd
Aged 45-64 years	(Table) (Trend) (Map)	70	8.1	19.7	Yes	11.6	Yes	2nd
Aged 65 years or older	(Table) (Trend) (Map)	46	10.7	29.4	Yes	17.7	Yes	2nd
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	11.5	10.1	No	10.5	No	3rd

N/A: Data not available

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

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

Socio-Economic Status and General Health Indicators - Wayne 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	92,473.0	19,651,127.0	N/A	11,245,290.0	N/A	3rd
% of labor force unemployed (2014)	(Table) (Trend) (Map)	2,748	6.2	6.3	No	5.6	Yes	2nd
% of population below poverty (2013)	(Table) (Trend) (Map)	N/A	11.4	16.0	Yes	N/A	N/A	1st
% of children aged less than 18 years below poverty (2013)	(Table) (Trend) (Map)	N/A	17.7	22.9	Yes	N/A	N/A	1st
Median household income in US dollars (2013)	(Table) (Trend) (Map)	N/A	50,603.0	57,255.0	N/A	N/A	N/A	2nd
% of children aged less than 19 years with health insurance (2013)	(Table) (Trend) (Map)	N/A	95.8	95.9	No	N/A	N/A	2nd
% of adults aged 18-64 years with health insurance (2013)	(Table) (Trend) (Map)	N/A	87.7	84.7	Yes	N/A	N/A	2nd
High school drop out rate (2012-2014)	(Table) (Trend) (Map)	284	2.0	3.3	Yes	2.3	Yes	1st
Age-adjusted % of adults who did not receive medical care because of cost # (2013-2014)	(Table) (Map)	N/A	9.0	13.6	No	12.0	No	1st
Age-adjusted % of adults with regular health care provider (2013-2014)	(Table) (Map)	N/A	79.7	84.5	No	84.7	No	4th
Age-adjusted %	(Table) (Map)	N/A	11.1	11.1	No	11.8	No	2nd

of adults who had poor mental health 14 or more days within the past month (2013-2014)								
Birth rate per 1,000 population	(Table) (Trend) (Map)	2,961	10.6	12.2	Yes	10.7	No	3rd
Total mortality rate per 100,000	(Table) (Trend) (Map)	2,473	886.8	753.1	Yes	854.1	No	2nd
Age-adjusted total mortality rate per 100,000	(Table) (Trend) (Map)	2,473	738.5	644.9	Yes	678.5	Yes	3rd
% premature deaths (aged less than 75 years)	(Table) (Trend) (Map)	1,013	41.0	39.9	No	37.5	Yes	3rd
Years of potential life lost per 100,000	(Table) (Trend) (Map)	16,781	6,444.5	5,577.4	Yes	5,839.3	Yes	2nd
Total emergency department visit rate per 10,000	(Table) (Trend) (Map)	105,734	3,791.5	4,086.4	Yes	3,752.5	Yes	2nd
Age-adjusted total emergency department visit rate per 10,000	(Table) (Trend) (Map)	105,734	3,872.2	4,074.7	Yes	3,762.9	Yes	2nd
Total hospitalization rate per 10,000	(Table) (Trend) (Map)	33,508	1,201.6	1,226.2	Yes	1,168.1	Yes	3rd
Age-adjusted total hospitalization rate per 10,000	(Table) (Trend) (Map)	33,508	1,127.7	1,167.3	Yes	1,104.3	Yes	3rd

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 - Wayne 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)	278	10.0	23.7	Yes	20.2	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	278	10.4	23.6	Yes	21.0	Yes	1st
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	48	167.9	95.0	Yes	123.2	No	4th
Alcohol related motor vehicle injuries and deaths per 100,000	(Table) (Trend) (Map)	136	48.8	33.3	Yes	44.4	No	3rd
Age-adjusted % of adults who smoke cigarettes (2013-2014)	(Table) (Map)	N/A	27.5	15.9	Yes	18.0	Yes	4th
Age-adjusted % of adults living in homes where smoking is prohibited (2008-2009)	(Table) (Map)	N/A	81.8	80.9	No	79.3	No	1st
Age-adjusted % of adults who binge drink (2013-2014)	(Table) (Map)	N/A	12.5	17.7	No	17.2	No	1st

N/A: Data not available

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

County:	Wayne
Group Name:	Wayne County Community Health Priority Setting
Date and Time:	June 30, 2016 - 8:00 AM

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

Issues to Rank based on Data Assessment

- Obesity – lifestyle, cultural, physical activity, nutrition, community gardens. (low back pain, cardiovascular and diabetes)
- Substance abuse
- Dental health (especially Medicaid/low-income)
- Mental health
- Hypertension (tobacco use, cerebrovascular, heart)
- Cancer (lung, prostate)
- CLRD (COPD)
- Injury Prevention (suicides, injuries)
- Teen pregnancy

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

Charting the Course…

Selecting Issues and Priorities

Public Health

Acknowledgement:

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

Selecting Issues & Priorities

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

The Hanlon Method

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

The Hanlon Method…

BPR – Basic Priority Rating System

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

A = Size of the problem

B = Seriousness of the problem

C = Effectiveness of the solution

(weighted by PEARL Factors)

Component A – Size of Problem

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

Component A: Size of Problem

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

Component B – Seriousness of Problem

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

Component B: Seriousness of Problem

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

Component C – Effectiveness of Intervention

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

Component C: Effectiveness of Intervention

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

Immunization programs are known to be highly effective…

as compared to the results of smoking cessation programs.

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

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

PEARL Factors:

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

Here We Go!

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

Sample Worksheet:

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

Considerations and Conclusions

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

And…

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

And finally…

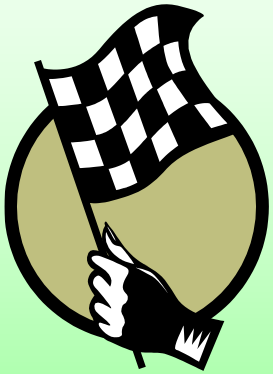
- Soup slurping is evidently quite widespread and a serious problem, and we believe the interventions could be relatively effective
- However, solutions to the problem are NOT within our scope or mission statement
- It makes economic sense to address the problem, but there will probably NOT be economic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

Therefore…

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

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

Time to Get Started!



Attachment 10

County: ___Wayne_____ Please enter issues in same order as on the screen Date: 06/30/2016_____

Issue	Size (A)	Serious-ness (B)	Effective-ness (C)	Score (A+2B) X C	PEARL
Obesity – lifestyle, cultural, physical activity, nutrition, community gardens. (low back pain, cardiovascular and diabetes)					P P E E A R L
Substance Abuse					P P E E A R L
Dental Health (especially Medicaid/low-income)					P P E E A R L
Mental Health					P P E E A R L
Hypertension (tobacco use, cerebrovascular, heart)					P P E E A R L
Cancer (lung, prostate)					P P E E A R L
CLRD (COPD)					P P E E A R L
Injury Prevention (suicides, injuries)					P P E E A R L
Teen Pregnancy					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?

ROCHESTER REGIONAL HEALTH
Newark-Wayne Community Hospital

The following are the results from the Priority Setting Meeting conducted on June 30th, 2016 from 8:00am to 10:00am.

#	Issue	Hanlon	Pearl
1	Cancer	135.50	6.32
2	Obesity	133.95	5.95
3	Dental health	133.55	5.45
4	Behavioral Health	130.95	6.36
5	Hypertension (Tobacco Use)	124.86	5.73
6	Injury Prevention	105.05	5.27
7	Teen Pregnancy	105.05	5.64
8	CLRD (COPD)	103.23	5.27

CHA: Selection Mtg.

Sign-In

6/30/2016

Wayne County Public Health
1519 Nye Road, Suite 200
Lyons, New York 14489

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Lisa O'Dell	WAPH	
Bridjette Wiefling	RRH	Bridgette.wiefling@Rochesterregional.org

Wayne County Public Health
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Tel: (315) 946-5749 • Fax: (315) 946-5762
Email: WCPH@co.wayne.ny.us
Diane Devlin, Director of Public Health

DATE: July 1, 2016

FROM: Wayne County Public Health and Newark-Wayne Community Hospital

RE: Community Health Assessment & Community Services Plan – Prioritization of Needs 2016

Dear Community Members:

As we prepare for the completion of the 2017 Community Health Assessment (CHA) and Community Service Plan (CSP) Wayne County Public Health and Newark-Wayne Community Hospital along with the S2AY Rural Health Network, with input from several other health and human service agencies throughout Wayne County, have started conducting a comprehensive assessment of community health needs. We have reviewed population health data statistics, 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 that have been identified are:

- Cancer
- Obesity
- Dental Health
- Behavioral Health
- Hypertension

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 Wayne County. Any remarks can be emailed to Diane Devlin, Wayne County Public Health Director, ddevlin@co.wayne.ny.us or Jeanna Savage, Newark-Wayne Community Hospital Public Relations Advisor, jeanna.savage@rochesterregional.org

WAYNE COUNTY PUBLIC HEALTH
&
NEWARK-WAYNE
COMMUNITY HOSPITAL

Invite you to attend the:

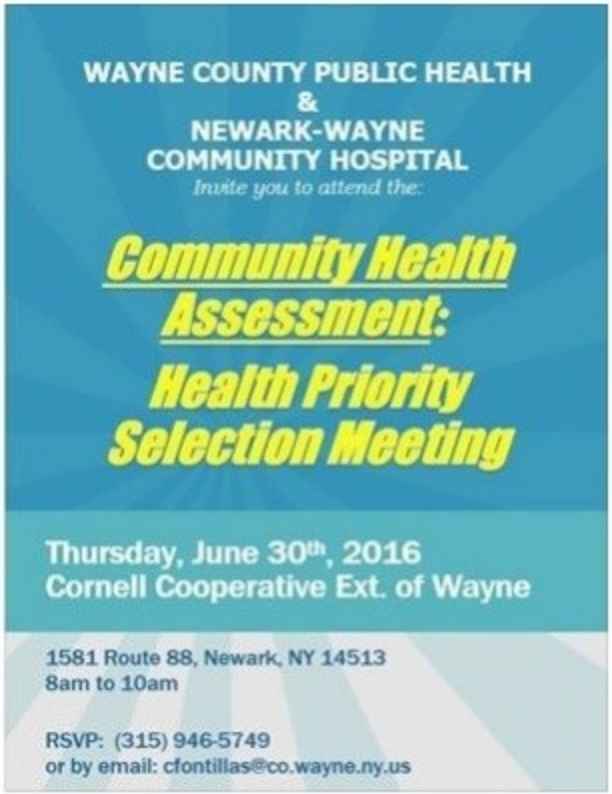
Community Health Assessment:
Health Priority Selection Meeting

Thursday, June 30th, 2016
Cornell Cooperative Ext. of Wayne

1581 Route 88, Newark, NY 14513
8am to 10am

RSVP: (315) 946-5749
or by email: cfontillas@co.wayne.ny.us

Wayne County Public Health added a new photo.
Published by Ryan Timothy Mulhern [?] · June 16 ·



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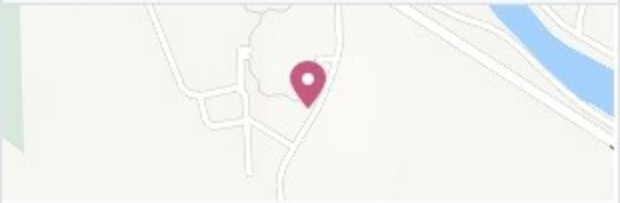

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Wayne County Public Health
Revision Date: 11.23.2016

Priority: Prevent Chronic Diseases					
Focus Area 1: Reduce Obesity in Children and Adults					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 1.3.2 – targeting the low income population (very high Medicaid rates)					
Goal	**Outcome Objectives**	**Interventions/Strategies / Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#1.1 Create community environments that promote and support healthy food and beverage choices and physical activity.	**Objective 1.1.1:** By December 31, 2018, decrease the percentage of adults ages 18 years and older who consume one or more sugary drink per day: • By 5% from 20.5% (2009) to 19.5% among all adults. (Data source: NYS BRFSS) (Health Disparities Indicator)	Increase the number of institutions with nutrition standards for healthy food and beverage procurement.	Number of municipalities, community-based organizations (CBOs), worksites, and hospitals that develop and adopt policies or practices to implement nutrition standards (cafeterias, snack bars, vending, etc.) Number of individuals potentially accessing settings that have adopted policies to implement nutrition standards for health food and beverage procurement.	Public Health (PH), Cornell Cooperative Extension (CCE), and Regional Worksite Wellness Committee/S2AY Rural Health Network (RHN) to reach out to worksites, CBOs, etc. to implement healthy policies or practices (vending, meeting guidelines, etc.). Newark Wayne Community Hospital (NWCH) and PH to work internally to adopt healthy policies and practices.	-PH – facilitation, education and coordination - $6,672 (2 years) -NWCH – 100 hours (2 years) – internal policy and execution. -Regional Worksite Wellness Committee/ S2AY RHN=$2,475 (2 years) Additional Partners: -CCE
#1.3 Expand the role of health care, health service providers, and insurers in obesity prevention.	**Objective 1.3.2:** 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%.	Recruit hospitals to participate in quality improvement efforts to increase breastfeeding exclusivity at discharge.	Number of hospitals that have joined NYS BQIH, NYC BHC, Great Beginnings NY, Latch on NYC, WHO Baby Friendly Designation, or Excellus Maternity Care Excellence Designation.	NWCH to implement efforts and maintain WHO Baby Friendly status. PH, Finger Lakes Breastfeeding Partnership (FLBP), Finger Lakes Community Health (FLCH), Wayne County Rural Health Network (WCRHN), and S2AY Rural Health Network (RHN) to support efforts of the hospital through promotion, etc. WCRHN to fund Breastfeeding Summit Activities.	-NWCH – 3,600 hours (2 years) PH – education - $12,119 (2 years) -FLBP/S2AY RHN=$3,300 (2 years) -WCRHN=$7,084.37 per year Additional Partners: -FLCH

		Encourage and recruit pediatricians, obstetricians and gynecologists, and other primary care provider practices and clinical offices to become New York State Breastfeeding Friendly Practices.	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.	FLBP, PH, S2AY RHN to work with FLCH to certify practices as Breastfeeding Friendly. NWCH to support/encourage breastfeeding during delivery and at discharge.	-PH –education - $12,119 (2 years) -FLBP/S2AY RHN=$3,300 (2 years) -NWCH – 200 hours (2 years) Additional Partners: -FLCH

Priority: Prevent Chronic Diseases					
Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke exposure					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 2.2.2 – targeting the low income population (Medicaid)					
Goal	Outcome Objectives	Interventions/Strategies / Activities	Process Measures	Partner Role	Partner Resources
#2.2 Promote tobacco use cessation, especially among low SES populations and those with poor mental health.	**Objective 2.2.2:** By December 31, 2018, decrease the prevalence of cigarette smoking by adults ages 18 years and older: • By 17% from 18.1% to 15.0% among all adults. (Data Source: NYS BRFSS) (PA Tracking Indicator) • By 28% from 27.8% (2011) to 20.0% among adults with income less than $25,000. (Data Source: NYS BRFSS) (PA Tracking Indicator; Health Disparities Indicator)	Increase awareness of Medicaid benefits for smoking cessation including counseling and medication.	Number of Medicaid enrollees who smoke and utilize the cessation benefit.	Wayne County Cancer Services Program (CSP), PH, NWCH, and Wayne County Rural Health Network (WCRHN) to offer cessation classes. Wayne Health Improvement Partnership (WHIP) and Tobacco Action Coalition of the Finger Lakes (TACFL) to promote benefit through promotion and networking.	-PH – Education - $67,553 (2 years) -NWCH – 1 FTE dedicated + 1,000 hours (2 years) Additional Partners: -WHIP -TACFL -WCRHN
		Promote use of evidence-based tobacco dependence treatments among those who use tobacco.	Number of providers who deliver evidence based assistance to their patients who smoke including brief	NWCH to identify providers using Opti-Quit and Baby and Me Tobacco Free, promote the use of Opti-Quit and Baby and	-NWCH – 1 FTE dedicated (2 years) PH – see above

	• By 17% from 29% (2011) to 24% among adults who report poor mental health. (Data source: NY Adult Tobacco Survey) (PA Tracking Indicator; Health Disparities Indicator)	• Opti-Quit (EMR Referral) • Baby and Me Tobacco Free	counseling, medications, and arrange for follow up. Tracking referrals to Opti-Quit and Baby and Me Tobacco Free through EMR.	Me Tobacco Free, and provide referral/ utilization data. WHIP and partners to promote the use of referral systems.	Additional Partners: -WHIP
Priority: Prevent Chronic Diseases					
Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Partner Role	Partner Resources
#3.2: Promote use of evidence-based care to manage chronic diseases.	**Objective 3.2.4:** By December 31, 2018, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90).	Participation in regional blood pressure registry.	Number of primary care practices that submit patient numbers to registry.	Finger Lakes Health Systems Agency (FLHSA) to provide technical support and data/reports. FLHSA, PH, and S2AY RHN to work to recruit additional practices. NWCH to provide data to FLHSA. PH to follow up with practices with information and trainings to increase control rates.	-NWCH – 100 hours (2 years) -PH – coordination, education - $4,897 (2 years) -FLHSA – in kind -S2AY RHN=$2,475 (2 years)
#3.3 Promote culturally relevant chronic disease self-management education.	**Objective 3.3.1:** By December 31, 2018, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. (Data Source: BRFSS; annual	Promote the use of evidence based interventions to prevent or manage chronic diseases.	Number and type of evidence based self-management programs offered by partners. Number of participants at EBIs offered by partners. Number of providers that use their EHRs to trigger them to speak to their patients about their weight,	Wayne CAP, Aging and Youth, and PH to offer classes (CDSMP and NDPP). Wayne CAP and Aging and Youth to offer CSDMP training. WCRHN to provide funds for Wayne CAP to promote and deliver CSDMP. WHIP and partners to promote trainings and send staff to trainings.	-Wayne CAP=$10,211 per year -PH – education, facilitation, coordination - $3,550 (2 years) -NWCH – 200 hours (2 years) -WCRHN=$5,000 per year

	measure, beginning 2013)		diet and exercise, and refer them to EBIs.	WHIP and partners working to increase referrals and the use of EHR to refer patients. S2AY RHN/Regional Living Healthy Group to assist with coordination of evidence based programs and provide back-up peer leaders for classes. NWCH to encourage providers to refer to programs and use EHR to trigger referrals.	-S2AY RHN/Living Healthy=$1,886 (2 years) Additional Partners: -Aging and Youth -WHIP

Priority: Promote Healthy women, Infants, and Children					
Focus Area 2: Child Health					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives	Interventions/Strategies/ Activities	Process Measures	Partner Role	Partner Resources
#2.2 Reduce prevalence of dental caries among children.	**Objective 5-3:** By December 31, 2018, increase the proportion of NYS children who receive regular dental care by at least 10%.	Link children and families to dental services. Offer Fluoride Varnish Training to practices.	Number of providers trained and offering fluoride varnish at pediatric visits. Number of and data from school based dental health sites. Investigate opportunities to increase school-based dental and health sites/ services.	PH to offer trainings to providers. NWCH and FLCH to encourage practices to utilize trainings and offer fluoride varnish at pediatric visits. WHIP to work with RPCN to promote school-based dental health sites and identify and remedy barriers to use of sites. Schools and WHIP to investigate opportunities to increase school-based dental and health services. WHIP and partners to promote dental health for children and families.	-PH – education, facilitation, coordination - $9,170 (2 years) -NWCH – 100 hours (2 years) -WCRHN=$2,000 per year Additional Partners: -FLCH -WHIP -RPCN -Schools

				WCRHN to provide funds for FLCH to provide dental hygiene education in schools.	

Priority: Promote Mental Health and Prevent Substance Abuse					
Focus Area 1: Promote Mental, Emotional and Behavioral Well-Being					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☐ Yes ☒ No					
Goal	Outcome Objectives	Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources
#2.1 Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults.	Increase the use of evidence-informed policies and evidence-based programs that are grounded on healthy development of children, youth and adults.	**Overdose Prevention** Project Lazarus is a public health model that asserts drug overdose deaths are preventable and communities are ultimately responsible for their own health. The model components include: 1) community activation and coalition building; 2) prescriber education and behavior; 3) supply reduction and diversion control; 4) pain patient services and drug safety; 5) drug treatment and demand reduction; 6) harm reduction including Naloxone training; 7) community-based prevention education;	Percent and/or number participating in Naloxone trainings Percent participation in safe prescription opiate disposal programs, take-back events, drop boxes, safe storage education, and law enforcement diversion efforts Investigate, coordinate, and build partnerships to develop a comprehensive approach to prevent substance abuse, overdose deaths, etc. Number of public awareness, outreach, and educational efforts to change attitudes, beliefs, and norms towards underage and excessive adult alcohol use, prescription opiates.	PH, Mental Health, and Trillium to provide Naloxone trainings. NWCH to work to place a prescription drop box at the hospital. WHIP and partners to promote take back days, drop box placement, etc. PH, WHIP, and partners to identify opportunities to partner with coalitions/ groups (Wayne Wellness Coalition, etc.) to coordinate efforts. PH and WHIP to work with schools to identify EBIs to implement. WHIP and partners to provide education and promotion of prevention efforts.	-PH – coordination, facilitation, education - $10,517 (2 years) -NWCH – 200 hours (2 years) Additional Partners: -Mental Health -Trillium -WHIP -Schools