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

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Introduction

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

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

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

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

www.S2AYnetwork.org

www.CommonGroundHealth.org

Key Findings

Eight County Region

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

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

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

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

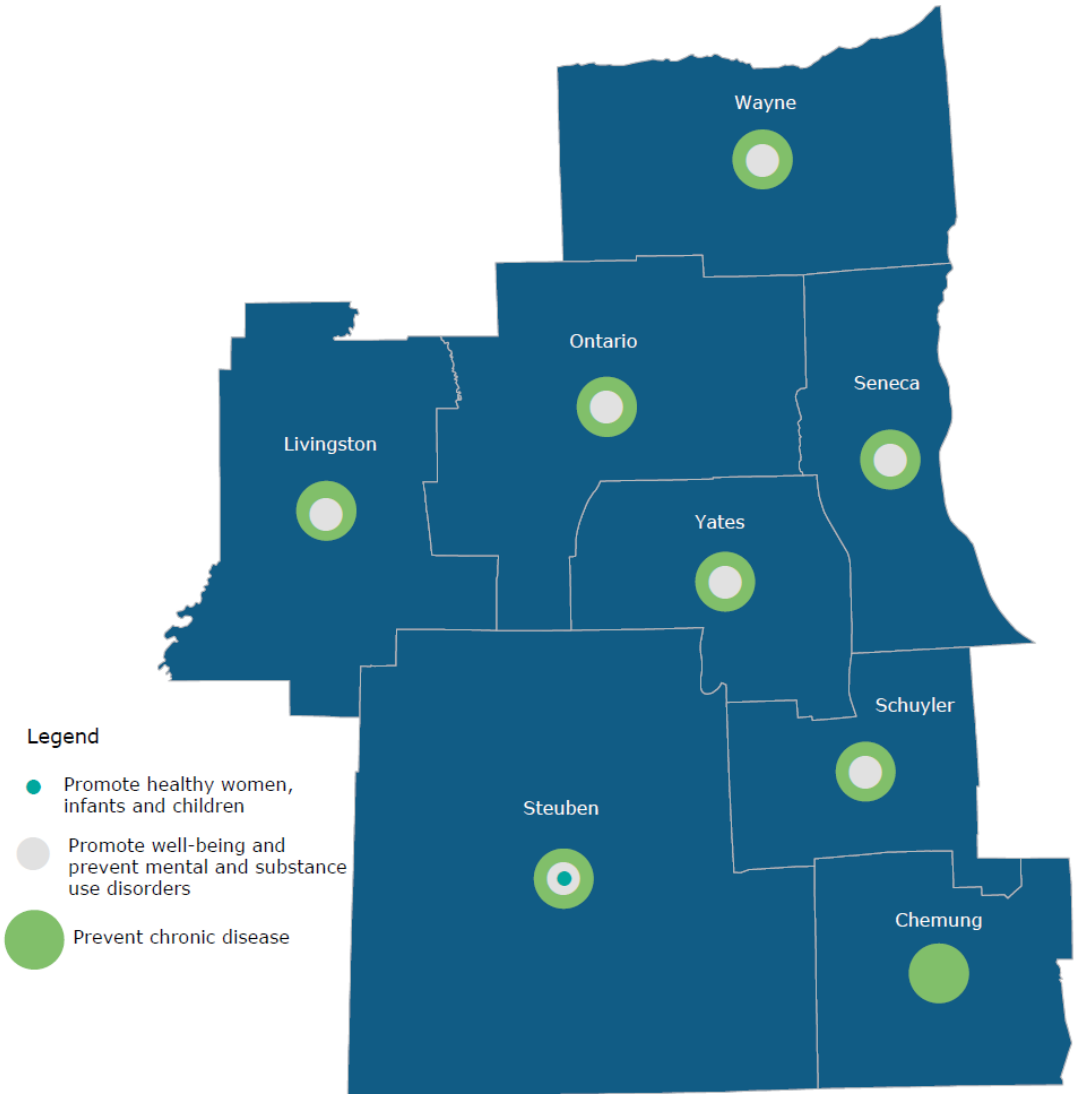
[1] Region includes Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties

Regional Priority Alignment

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

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

Map 1: Selected Priority Areas



Interventions

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

Focus Area	Intervention* & # of Counties Selected
Chronic disease preventative care and management	**4.1.2** Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting) (selected by three counties) **4.1.3** Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand (selected by four counties)
Tobacco prevention	**3.1.2** Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms (selected by four counties) **3.3.1** Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents (selected by four counties)
Healthy eating and food security	**1.0.3** Implement worksite nutrition and physical activity programs designed to improve health behaviors and results (selected by three counties) **1.0.4** Implement multi-component school-based obesity prevention interventions, including: providing healthy eating learning opportunities and participating in Farm to School programs (selected by three counties)
Prevent mental and substance use disorders	**2.2.2** Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (selected by four counties) **2.2.4** Build support systems to care for opioid users at risk of an overdose (selected by three counties) **2.2.5** Establish additional permanent safe disposal sites for prescription drugs and organized take-back days (selected by three counties) **2.3.3** Grow resilient communities through education, engagement, activation/mobilization and celebration (selected by three counties) **2.5.4** Identify and support people at risk: Gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-intervention, safe reporting and messaging about suicides (selected by five counties)
*Interventions shown are those where three or more counties selected the intervention. A full list of selected interventions can be found in the county improvement plans found in appendixes A-H.	

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

Regional Assets and Resources to be Mobilized

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

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

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

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

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

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

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

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

Ontario County Executive Summary

The Ontario County Health Department, in partnership with UR Thompson Health, Rochester Regional Health Clifton Springs Community Hospital, and Finger Lakes Health, has selected the following priority areas and disparity for the 2019-2021 assessment and planning period:

County	Priority Areas & Disparity
Ontario County	**Prevent Chronic Disease** 1. Chronic disease preventative care and management 2. Tobacco prevention 3. Healthy eating and food security **Promote Mental Well-Being and Prevent Substance Use Disorders** 4. Promote well-being 5. Prevent mental and substance use disorders **Disparity: low income**

Selection of the 2019-2021 Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP) priority and disparity areas was a joint process which began in the summer of 2018 with assistance from the S2AY Rural Health Network and Common Ground Health. A variety of partners were engaged throughout the process including the public health departments and hospital staff, representatives from local Federally Qualified Health Centers (FQHCs), Community Based Organizations (CBOs), county government employees, school district and local college representatives, the S2AY Rural Health Network, Common Ground Health, and others. The community at large was engaged throughout the assessment period via a regional health survey in 2018 (*My Health Story 2018*) and focus groups. Partners' role in the assessment

were to help inform and select the 2019-2021 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings.

On May 10, 2019, the health department engaged key stakeholders in a prioritization meeting facilitated by the S2AY Rural Health Network. Key partners and community members were invited to attend the prioritization meetings, including all those who attended prior focus groups. Social media platforms, e-mail and newspaper ads were utilized to help promote participation. At the meeting, data were reviewed which included a mix of quantitative, qualitative, primary and secondary data on each of the five priority areas outlined in the New York State Prevention Agenda. Data were collected from a variety of different sources including but not limited to the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, primary data collected from the *My Health Story 2018* Survey, and local data sources such as Ontario County's PRIDE survey. A copy of the focus group summaries, Ontario County pre-read document, prioritization meeting PowerPoint and meeting attendees are available in Appendixes A-D.

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

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

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

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

Focus Area	Intervention* & # of Counties Selected
Chronic disease preventative care and management	**4.1.2** Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting) (selected by three counties) **4.1.3** Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand (selected by four counties)
Tobacco prevention	**3.1.2** Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms (selected by four counties) **3.1.3** Pursue policy action to reduce the impact of tobacco marketing in lower-income and racial/ethnic minority communities, disadvantaged urban neighborhoods and rural areas (selected by three counties) **3.2.3** Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment (selected by three counties) **3.3.1** Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents (selected by three counties)
Healthy eating and food security	**1.0.4** Implement multi-component school-based obesity prevention interventions, including: providing healthy eating learning opportunities and participating in Farm to School programs (selected by three counties)
Prevent mental and substance use disorders	**1.1.3** Create and sustain inclusive, healthy public spaces: Ensure space for physical activity, food access, sleep; civic engagement across the lifespan (selected by three counties) **2.2.2** Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (selected by three counties) **2.5.4** Identify and support people at risk: Gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-intervention, safe reporting and messaging about suicides (selected by five counties)
*Interventions shown are those where Ontario County and at least two additional counties selected the intervention. A full list of selected interventions can be found in the county improvement plan found in appendix E.	

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

Tobacco prevention was a widely selected focus area by several counties (five out of eight counties). Many counties, including Ontario, have selected goals which revolve around prevention of initiation of tobacco use as well as tobacco cessation efforts. A regional effort will aid in reaching a larger audience with consistent messaging. In addition, wide-spread goal alignment exists among promotion of well-being and prevention of mental and substance use disorders. Several counties, including Ontario, have selected goals that revolve around prevention of suicides and addressing adverse childhood experiences (ACEs). The complete list of Ontario County's selected interventions, process measures and partner roles in implementation processes can be found in the county's Community Health Improvement Plan grid (Appendix E).

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

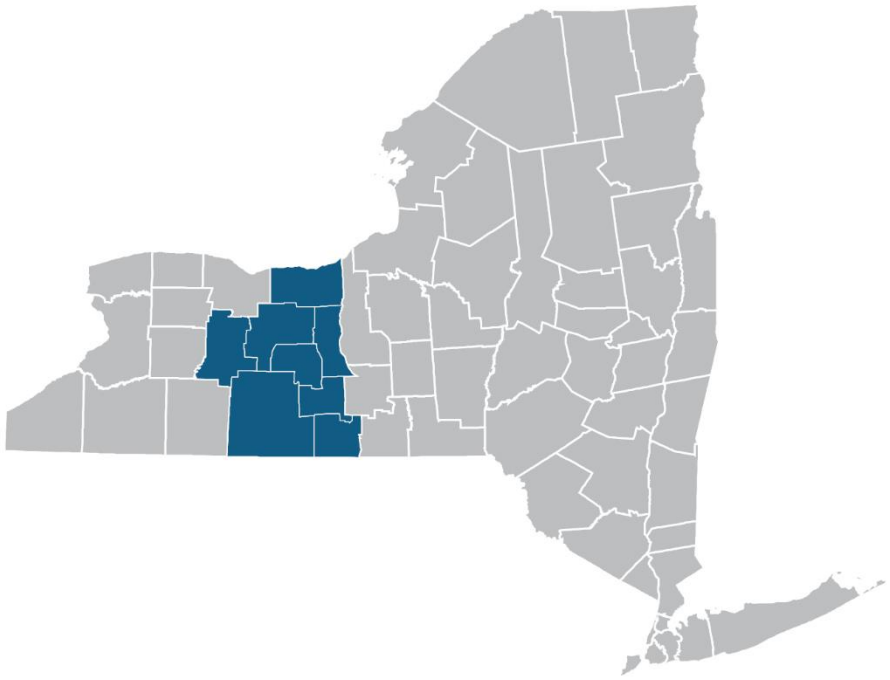
Community Health Assessment

Eight County Region

Total Population

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

Map 2: The eight-county Finger Lakes region



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

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

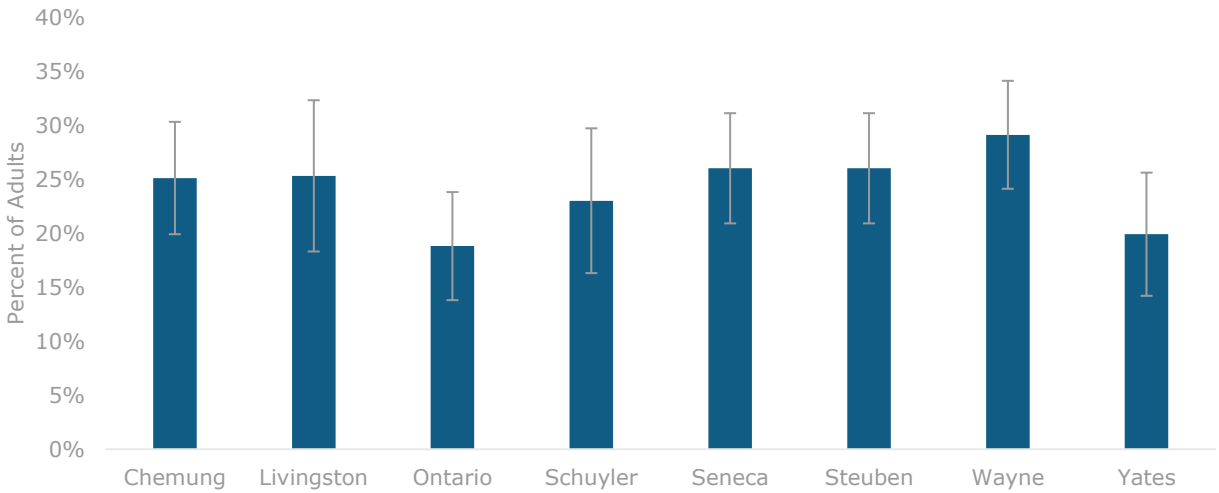
Disability

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

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

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

Figure 1: Percent of adults living with a disability



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

Household Language

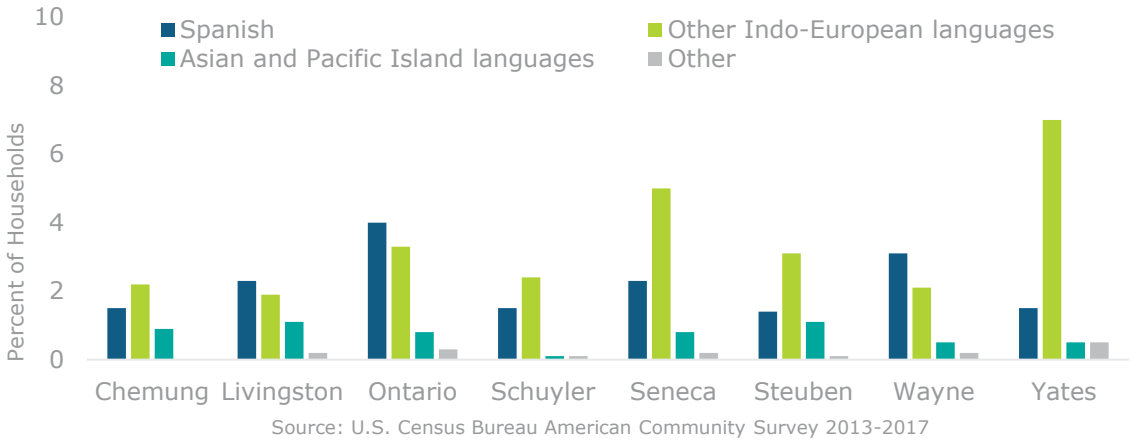
Providers of all types (medical, social service, etc.) should be aware of language and cultural differences when working with patients/clients. Being respectful of a person's cultural practices is important to building a trusting and positive relationship. A system where healthcare providers are culturally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

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

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

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

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



Special Populations

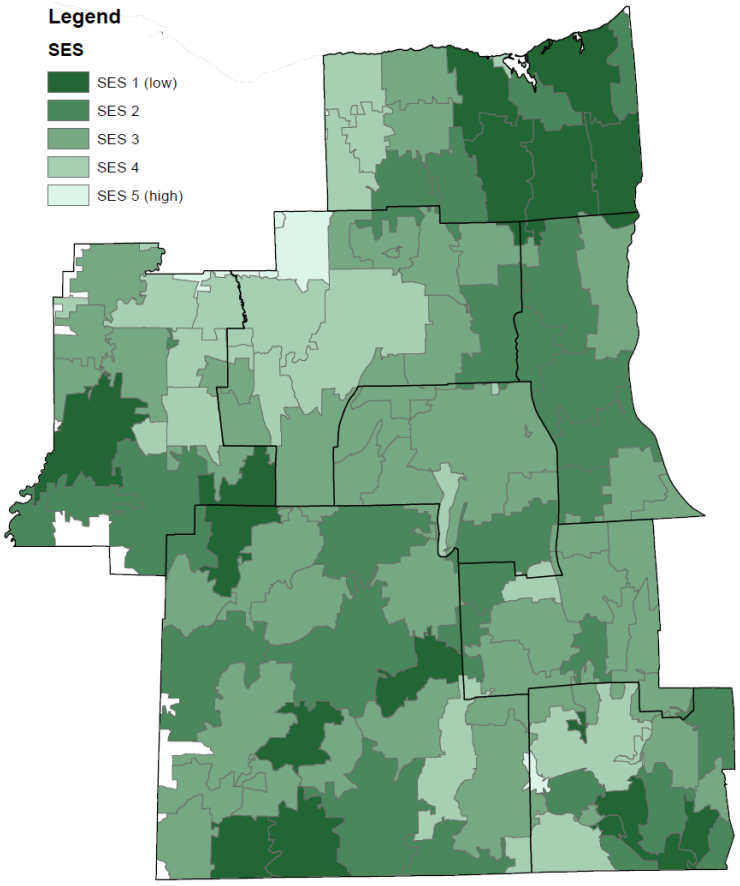
Finding accurate and up-to-date data on Amish and Mennonite populations is a challenge. This population often does not respond to surveys such as those conducted by the U.S. Census Bureau. Local churches, however, collect information on their members and may share this information with public health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

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

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

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

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



Socioeconomic Status

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

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

Unemployment

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

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

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

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

	2012		2017	
	% 16+ in Labor force Unemployed	% 16+ Not in Labor Force	% 16+ in Labor force Unemployed	% 16+ Not in Labor Force
Chemung	7	41	5	43
Livingston	6	39	5	43
Ontario	7	34	5	36
Schuyler	6	41	7	41
Seneca	6	44	5	43
Steuben	9	40	7	41
Wayne	8	34	6	37
Yates	6	38	6	40
8 County Region	**7**	**38**	**6**	**40**
NYS	9	35	7	37

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

Health Assessment

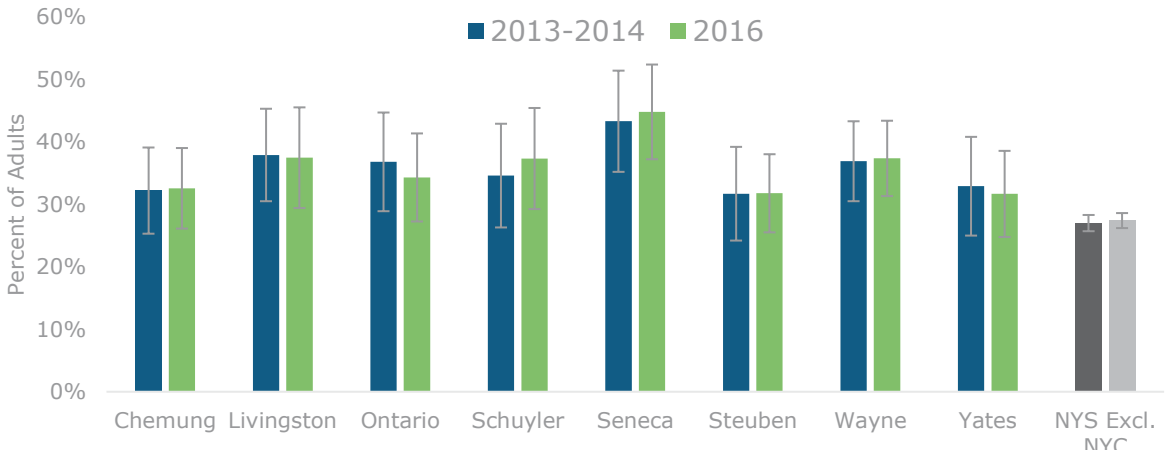
Eight County Region

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

Prevent Chronic Diseases

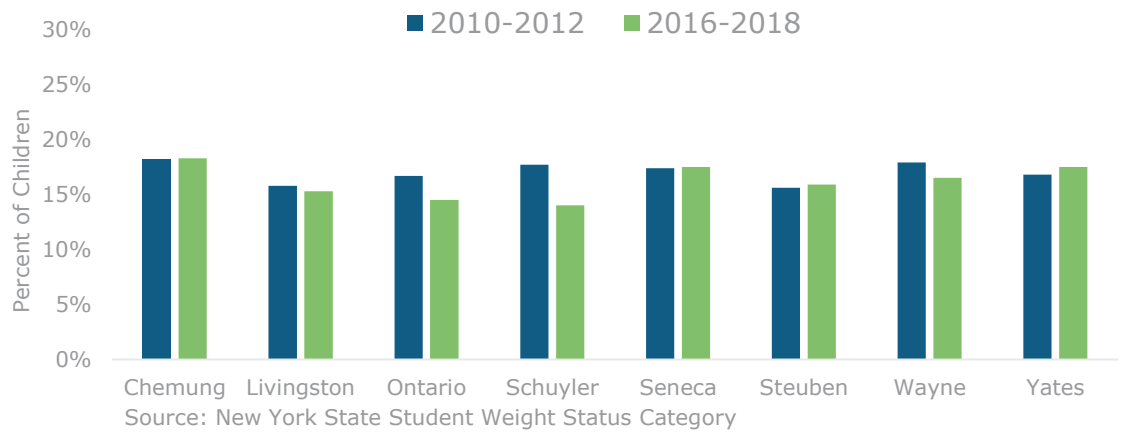
Preventing chronic disease has been a long standing priority area in the eight county region. Efforts have largely been focused on reducing illness, disability and death related to hypertension, tobacco use and second hand smoke, and reducing obesity in children and adults. Rates of obesity in the eight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

Figure 3: Percent of adults 18+ who are obese



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

Figure 4: Percent of children who are obese



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

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

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

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

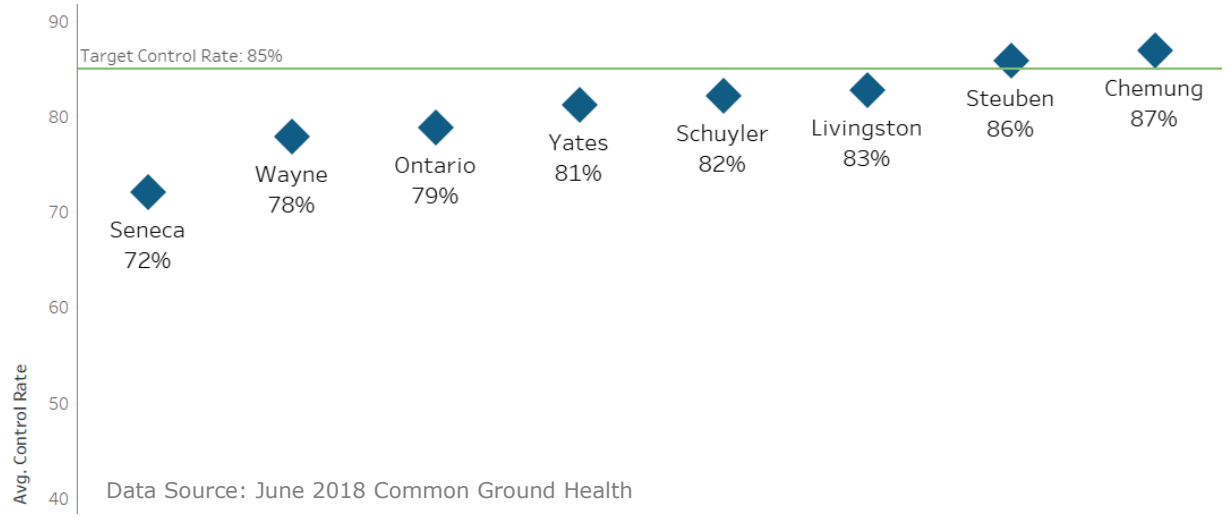
Table 3: Obesity rates by sex

	Obesity- Males	Obesity- Females
Chemung	34%	30%
Livingston	31%	40%
Ontario	40%	36%
Schuyler	24%	42%
Seneca	56%	35%
Steuben	33%	31%
Wayne	43%	31%
Yates	31%	30%
8 County Region	**37%**	**34%**

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

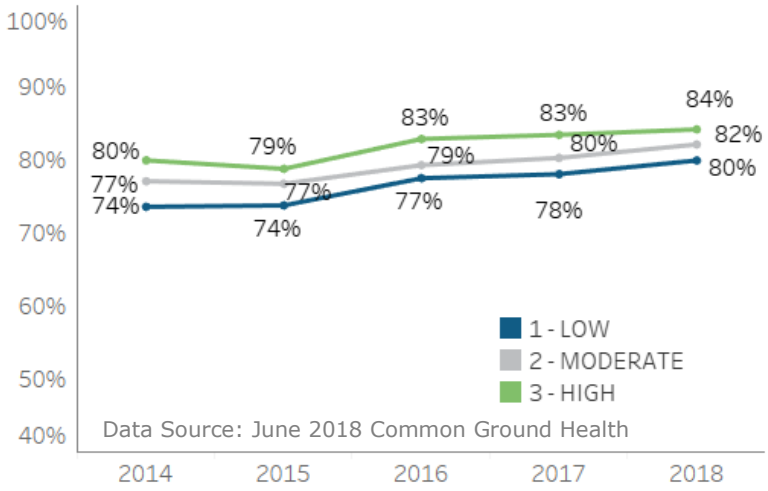
An estimated 36% of adults in the region have been diagnosed with hypertension. However, it is important to note the hypertension control rate for residents. According to the December 2018 High Blood Pressure Registry[7], 79% of hypertensive patients in the region are in control of their blood pressure.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

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



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

Figure 6: Regional control rate by socioeconomic status over time



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

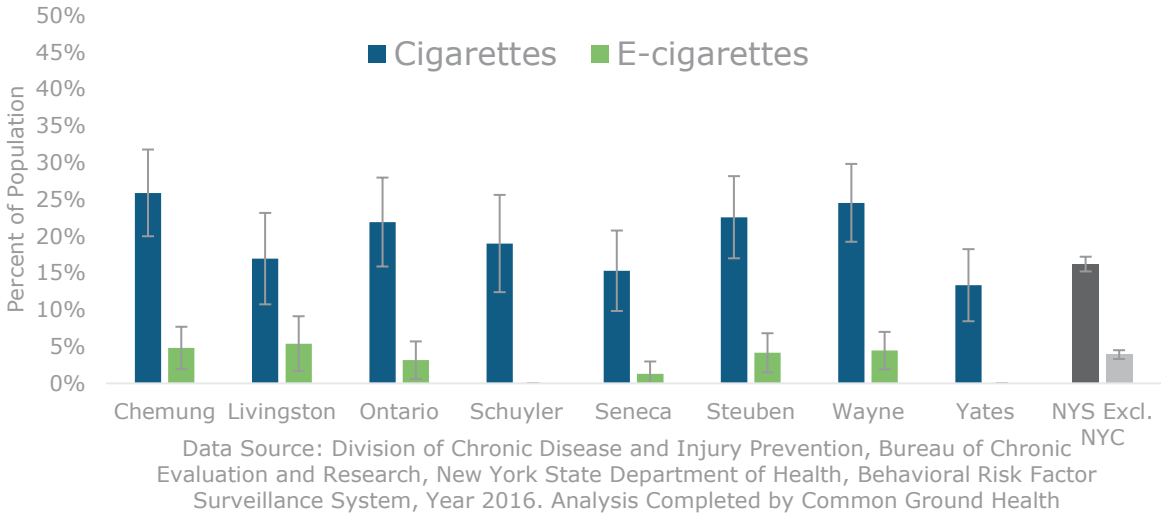
Those diagnosed with hypertension and/or obesity are at greater risk for other diseases such as chronic kidney and cardiovascular (heart) disease. In fact, heart disease is one of the top two leading causes of death in the eight county region (additional data can be found later in report). Cardiovascular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

Table 4: Cardiovascular disease by demographic

	CVD	CVD- those living with a disability
Chemung	13%	24%
Livingston	9%	20%
Ontario	8%	16%
Schuyler	9%	27%
Seneca	13%	28%
Steuben	15%	37%
Wayne	10%	21%
Yates	8%	24%
8 County Region	**11%**	**25%**
NYS	9%	21%
Source: Behavioral Risk Factor Surveillance System, 2016		

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

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



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

Table 5: Smoking rates by demographic

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

Source: Behavioral Risk Factor Surveillance System, 2016

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

Table 6: Smoking rates by sex

	Current smoker- Males	Current smoker- Females
Chemung	32%	22%
Livingston	11%	19%
Ontario	22%	21%
Schuyler	18%	21%
Seneca	19%	11%
Steuben	24%	25%
Wayne	27%	21%
Yates	13%	14%
8 County Region	**21%**	**23%**

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

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

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

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

Table 7: Barriers to eating healthy

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

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

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

Table 8: Barriers to being physically active

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

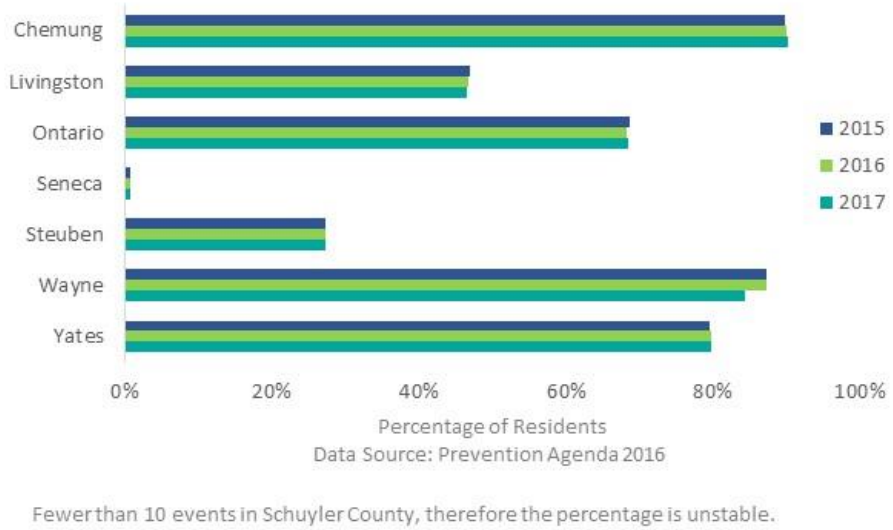
Source: My Health Story *survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.*

Promote a Healthy and Safe Environment

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

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

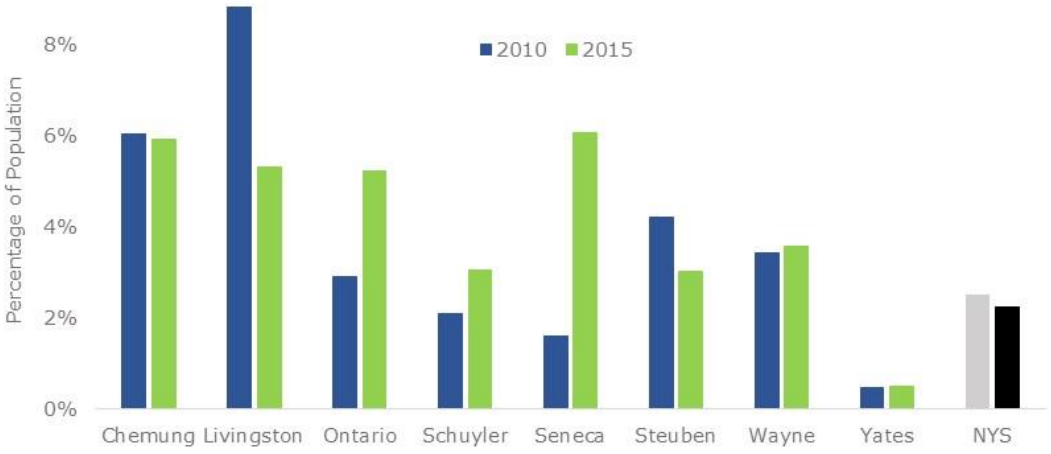
Figure 8: Percent of residents served by community water systems with optimally fluoridated water



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

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

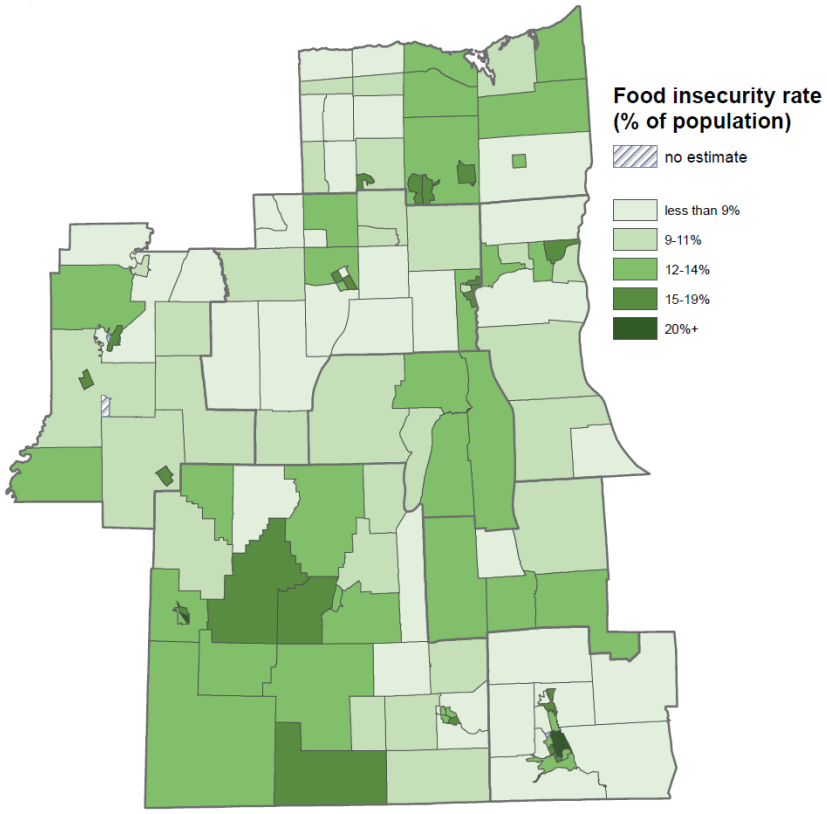
Figure 9: Percent of population that is low income and has low access to a supermarket or large grocery store



[8] Source: NYS Prevention Agenda Dashboard

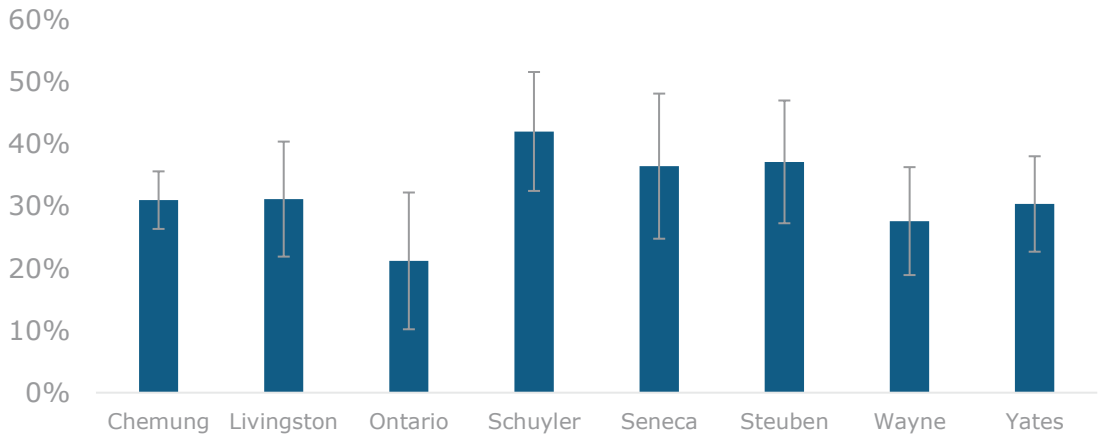
Over 22% of the regional population reported experiencing food insecurity in the past 12 months. Of note, 14% of *My Health Story 2018* respondents reported they are always stressed about having enough money to afford healthy food. Map 4 shows the food insecurity rates by census tract in the eight county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

Map 4: Food insecurity rate by census tract



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

Figure 10: Reported falls in 65+ population



Promote Healthy Women, Infants and Children

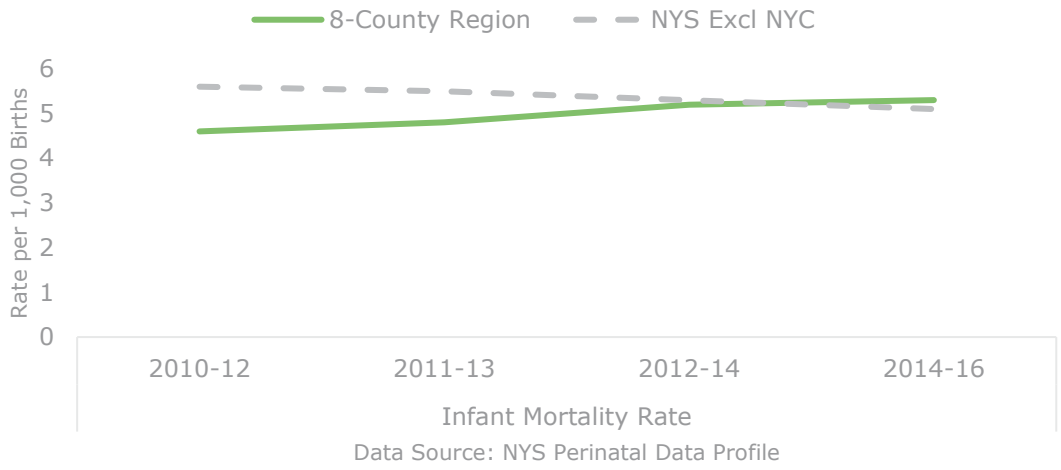
New York State collects several pieces of information on births including the number of premature and low birth weight babies. A baby born prematurely (<37 weeks gestation) is at risk for several health complications including jaundice, anemia, apnea, and more. The earlier a baby is born in pregnancy,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

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

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

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

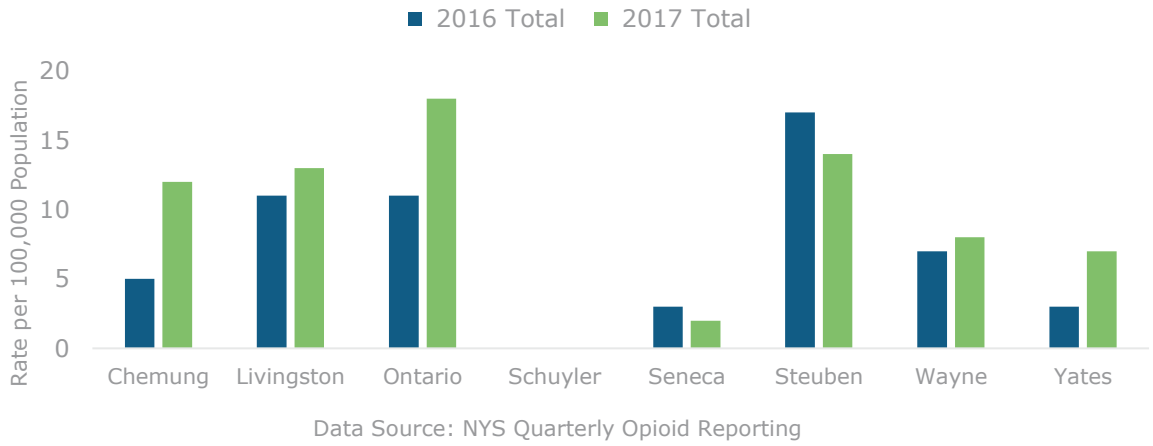
Figure 11: Rate of Infant Mortality



Promote Well-Being and Prevent Mental and Substance Use Disorders

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

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



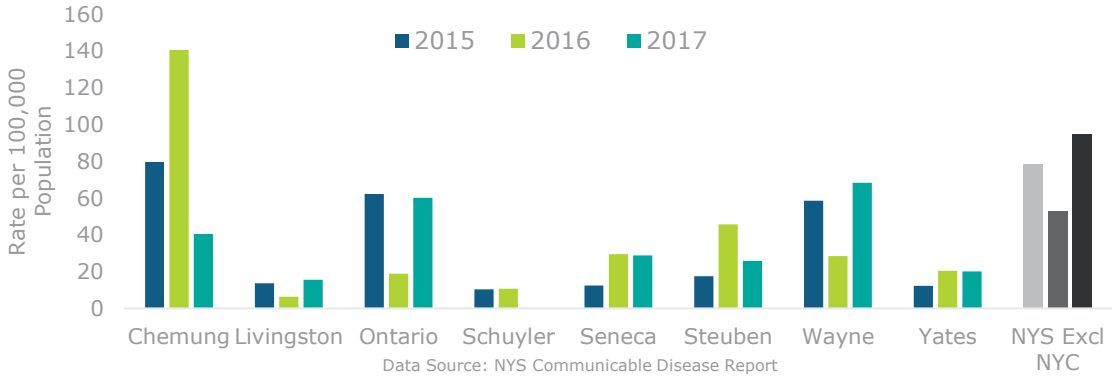
According to survey data from *My Health Story 2018*, half of the respondents indicated they have dealt with anxiety, fear, depression or sadness (Figure 13). For those who have dealt with mental or emotional health issues, 75% of survey respondents said they got the help they needed. The most commonly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

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

Prevent Communicable Diseases

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

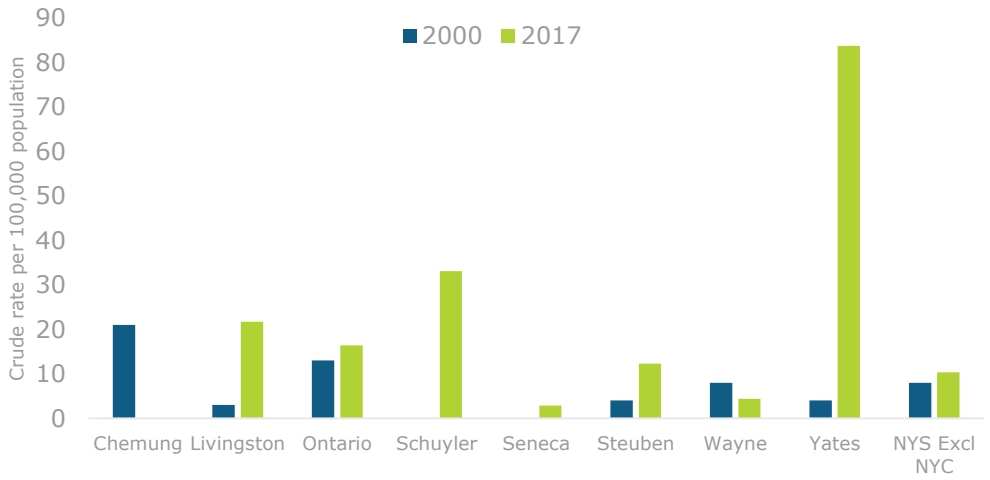
Figure 14: Rate of gonorrhea per 100,000



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

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

Figure 15: Rate of vaccine preventable diseases

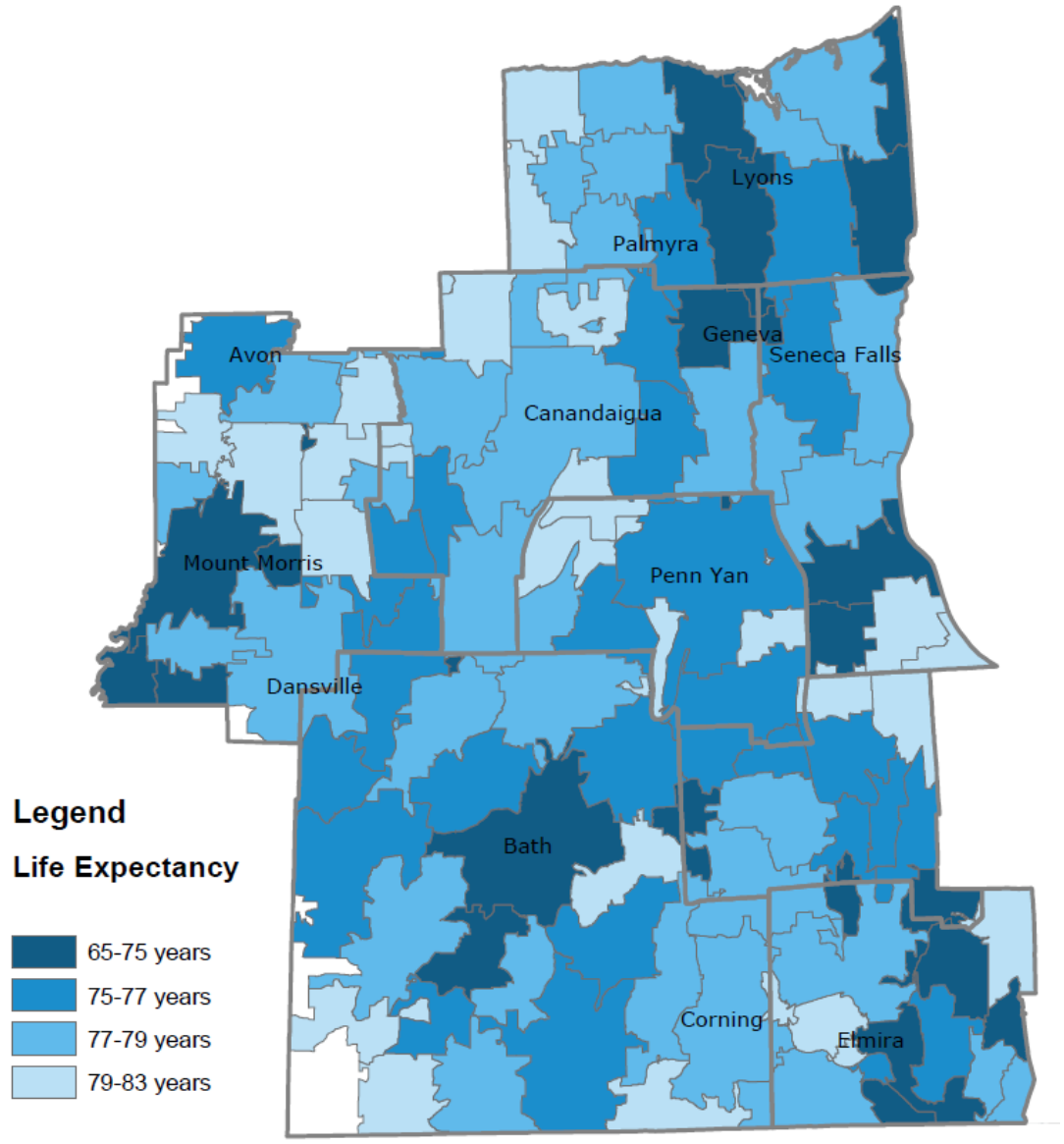


Source: NYS Communicable Disease Reporting, 2000 and 2017

Mortality

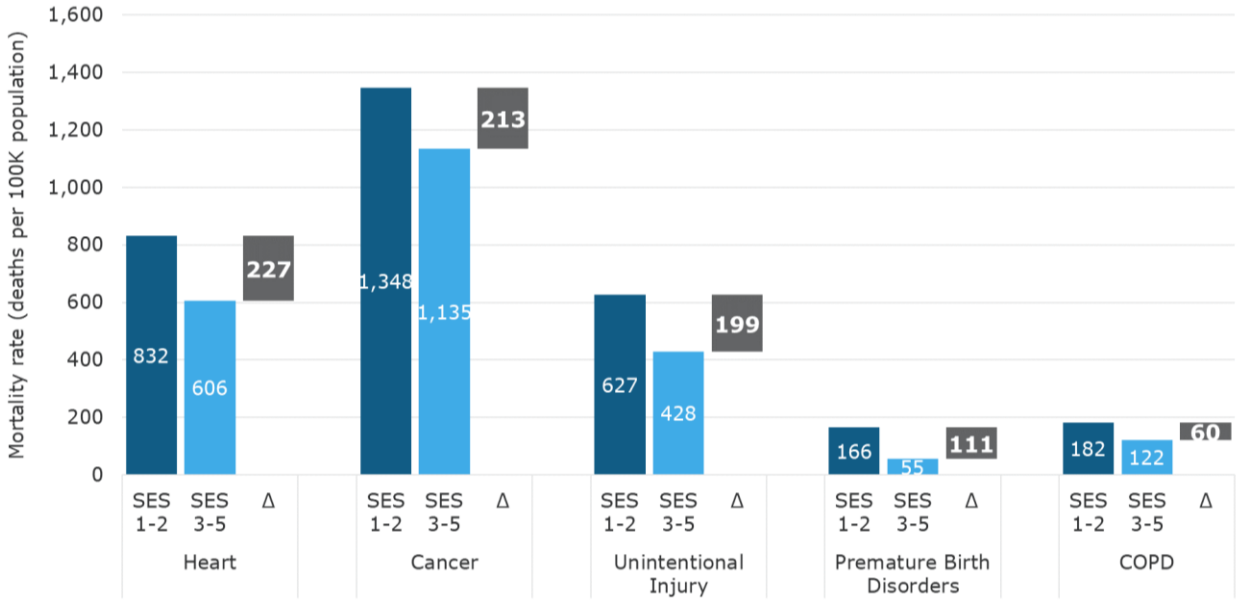
Each of the behavioral, environmental and socioeconomic factors previously discussed have a collective impact on one major health outcome: life expectancy. Community members who engage in risky health behaviors, are socioeconomically disadvantaged, and live in environments that negatively impact health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

Map 5: Life expectancy by ZIP code



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

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



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

Table 9: Heart Disease and Cancer mortality by sex

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

Planning and Prioritization Process

Eight County Region

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

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

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

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

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

[11] Common Ground Health services nine counties in the Finger Lakes region. For the purposes of this Community Health Assessment, Monroe County was excluded from data analysis.
[12] The majority of survey respondents were middle aged white women. Common Ground Health staff performed weighting calibration to align with each county's actual demographics, though, results may be biased.

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

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

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

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

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

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

Ontario County

Demographic and Socioeconomic Health Indicators

Ontario is the most urban of the counties in the S2AY Rural Health Network due to its proximity to Rochester, but is still predominantly rural with a land mass of 644 square miles. The county is home to Canandaigua, Honeoye and Canadice Lakes and is located south of Wayne County and southeast of Monroe County. The west side of Seneca Lake provides its eastern border and Hemlock Lake is shared with Livingston County on its southwestern border.

Ontario County is only one of a few New York counties experiencing growth. Residents living in the northwestern part of the county are proximal to the City of Rochester, which creates easy access to higher paying jobs for those able to commute. In recent years, the northwestern area has experienced an influx of residents which has significantly contributed to Ontario County's population and has impacted its socioeconomic profile.

A total of 109,491 persons reside in the county, the majority of which (94%) are White Non-Hispanic. Though Ontario County appears to be racially homogenous, there are significant differences in the racial and cultural composition of the county by location as evidenced in Table 10 below. Since 2010, there has been growth in the Latino/Hispanic population in the City of Geneva. This creates the need for practitioners to be culturally sensitive and tailor prevention strategies to each community.

Table 10: Ontario County race/ethnicity by county and minor civil division

	2010	2018
Ontario County		
White	93.7%	93.6%
Black/African American	2.3%	2.8%
Latino/Hispanic	3.4%	5.0%
Geneva City		
White	77.3%	75.9%
Black/African American	10.5%	10.2%
Latino/Hispanic	13.2%	17.4%
Victor Town		
White	95.1%	95.2%
Black/African American	0.8%	1.0%
Latino/Hispanic	1.9%	0.5%
Source: US Census Bureau 2010 Decennial and 2018 Population Estimates Program		

The migrant population in Ontario County is also growing. Migrant farm and seasonal workers support many farms in the county, as well as the horseracing

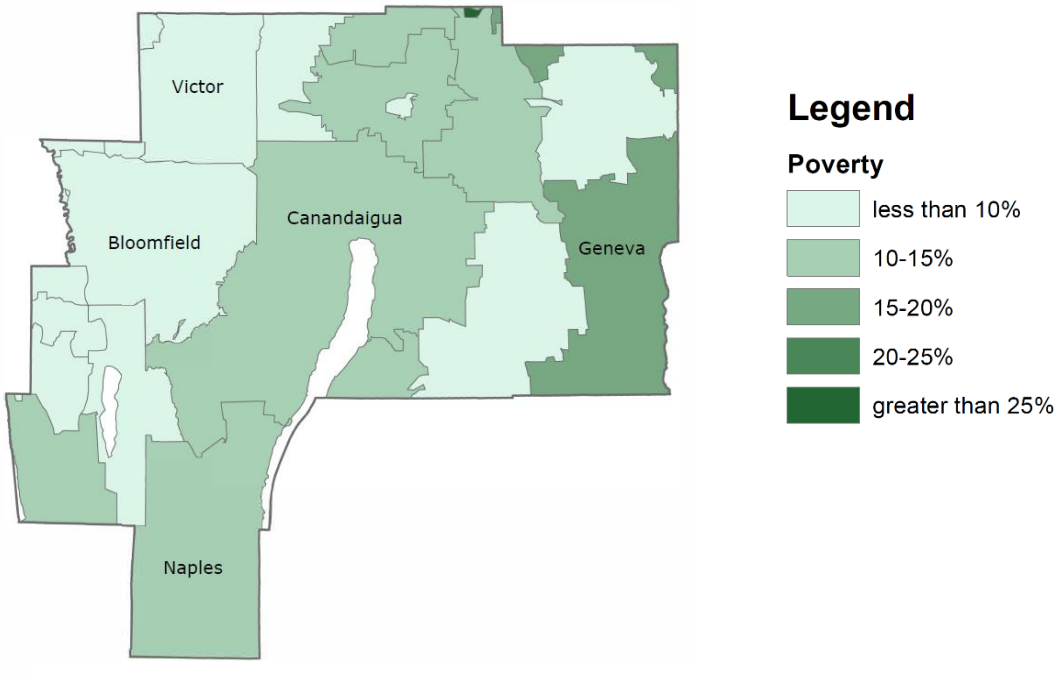
track in Farmington. Migrant workers are often hard to reach and have unique needs in relationship to health promotion and disease prevention. Additionally, language and cultural differences must be addressed during program development and delivery.

Aging of the population must also be considered in planning population health strategies. Of potential significance, the City of Canandaigua was voted one of AARP's top places to live for under $40,000 a year in 2018, indicating the potential for an increase in individuals of this demographic in future years. 2017 estimates reveal 30% of the 65+ population (N=6,044) is living alone. The rate has increased slightly from 2013 (29%) but the overall number of 65+ living alone has increased fairly substantially (N=4,860 in 2013). These findings highlight the need for development of additional strategies and services for this growing demographic. It will be challenging to meet the demand for services needed if members of this population are to maintain their independence.

The median household income in Ontario County ($61,710) is similar to that of New York State ($62,765) and higher than the eight county regional average of $52,704.[13] However, socioeconomic status varies widely in the county by zip code (Map 6). Median household income varies widely in the county geographically from a low of $40,920 (City of Geneva; population, 12,762) to $98,167 in the town of Victor (population, 15,069). Pockets of substantial wealth surrounding the lakes and an influx of high income families on the western border (Victor and parts of Farmington) account for much of the wealth in the county. Conversely, those on the eastern edge of the county experience fewer job options, more racial diversity, lower high school graduation rates and higher rates of poverty. This division of wealth creates unique public health challenges in addressing the needs of very economically and culturally diverse communities.

[13] 2013-2017 American Community Survey estimates

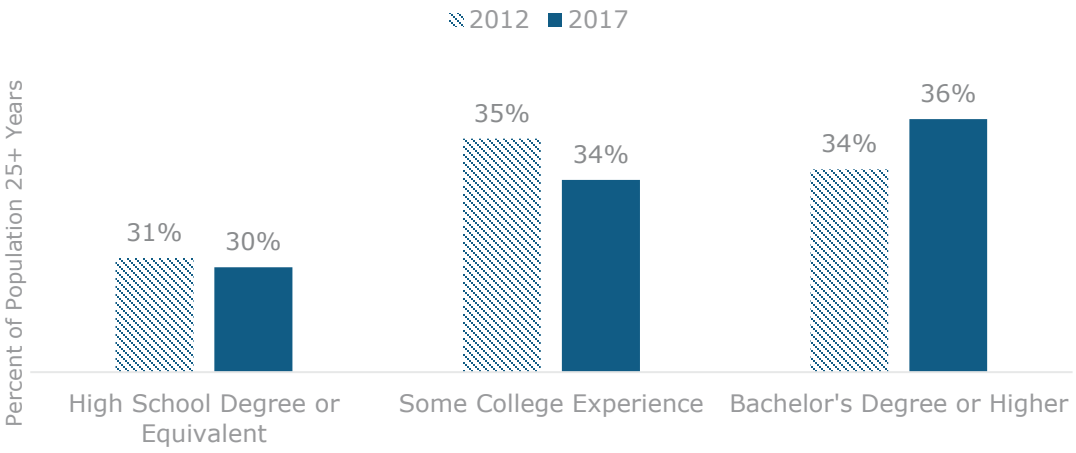
Map 6: Povertv rates bv ZIP code



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

Over the past 5 years, there has been a shift in educational attainment in Ontario County. There are more residents aged 25+ attaining a Bachelor's degree or higher than in years past (Figure 17). Additionally, the high school graduation rate is 89% which is higher than the state rate of 80%. Unfortunately, educational inequity is evident moving east across the county. Graduation rates vary by community/school district with lowest rates among those living in the Geneva area. In 2018, 78% of economically disadvantaged students graduated while 94% of non-disadvantaged students graduated. Additionally, graduation rates are lower and drop-out rates higher among the Latino/Hispanic population.

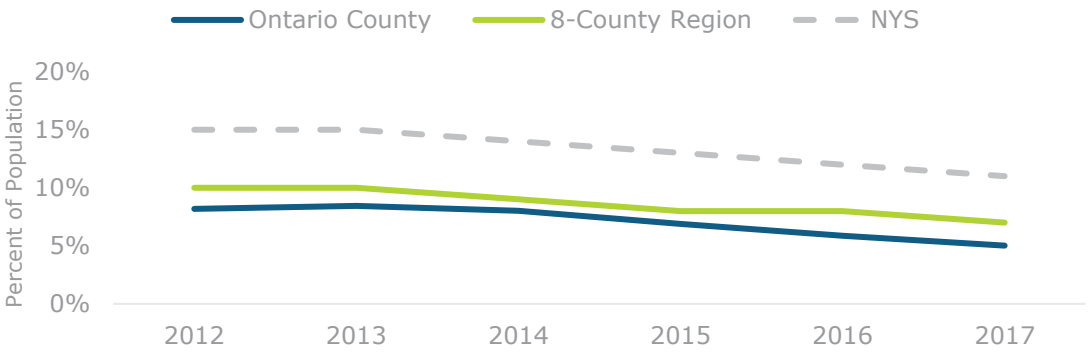
Figure 17: Educational attainment for Ontario County by year



Data Source: U.S. Census Bureau American Communtiy Survey 2013-2017 5-Year Estimates

As shown below, the uninsured rate in Ontario County has decreased 39 percent since 2012 (Figure 18). County estimates are lower than both the eight county region and New York State. The Affordable Care Act and availability of Health Navigators and Facilitated Enrollers in the county likely help with the reduction in uninsured.

Figure 18: Percent of population that is uninsured



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

Finally, 27% of Ontario County residents rent vs. own their home. In addition, 8% of occupied housing units have no vehicles available. Another 32% have access to one vehicle. Of note, the average household size for occupied housing is greater than two people. Approximately 40% of residents are paying 35% or more of their household income in rent costs.[14]

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

Main Health Challenges

On May 10, 2019, stakeholders and community members were invited to attend a priority setting meeting. There were approximately 50 people in attendance. At this meeting, participants reviewed the MAPP process, as well as relevant qualitative, quantitative, primary and secondary data. Data were reviewed from a variety of different sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, primary data collected from the My Health Story 2018 Survey and local data sources such as Ontario County's PRIDE survey. Lively group discussions took place regarding the potential priority areas. Ultimately, using the Hanlon and PEARL methods, the following priority areas and disparity were identified for inclusion in the 2019-2021 Community Health Improvement Plan:

Prevent Chronic Disease

1. Chronic disease preventative care and management
2. Tobacco prevention
3. Healthy eating and food security

Promote Mental Well-Being and Prevent Substance Use Disorders

4. Promote well-being
5. Strengthen opportunities to build well-being and resilience across the lifespan

Disparity: low income

In addition to the group's thoughts, *My Health Story 2018* respondents were asked questions relating to their top concerns for the health of themselves, loved ones, adults and children in the community (and were reviewed at the prioritization meeting). Weight was among the top five concerns for each of the four categories (Figure 19). Substance use and obesity indicators including exercise, weight, diet and nutrition, were concerns for children in the county. Similar items, with the addition of cost of care, were found to be concerns for adults in the county.

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

Biggest fear - for self	Biggest fear - for others
Mental / emotional health issues (14.7%)	Mental / emotional health issues (12.1%)
Weight (13.5%)	Cost (9.7%)
Cost (10.6%)	Cancer (8.8%)
Cancer (8.5%)	Aging (7.6%)
Heart conditions (8.4%)	Weight (7.6%)

County priority - for adults	County priority - for children
Mental / emotional health issues (21.8%)	Diet / nutrition (22.7%)
Substance abuse (21.2%)	Mental / emotional health issues (19.7%)
Cost (17.9%)	Substance abuse (18.2%)
Weight (12.3%)	Exercise (12.1%)
Diet / nutrition (12.3%)	Weight (11.4%)

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

Behavioral Risk Factors

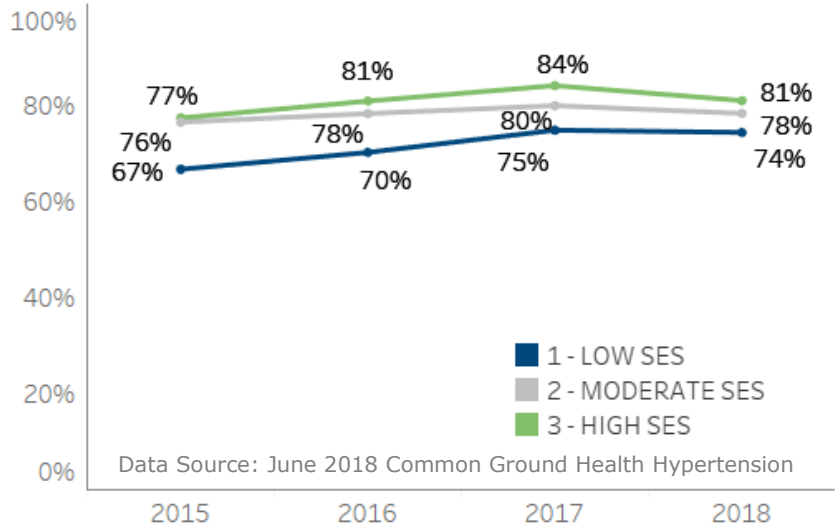
Evidence to select tobacco use as a priority area in Ontario County is supported through the data. Rates of tobacco use among adults in the county are one of the highest in the eight-county region (22% of adults) and are particularly high among the low-income population (45%) and those living with a disability (51%)[15]. Reported use of e-cigarettes as well as other nicotine delivery systems (vape pens, JUUL, etc.) has been identified as an emerging issue in the county and surrounding areas, especially among younger adults. It is estimated that 3% of residents are utilizing e-cigarettes, though in actuality the rates of use are likely much higher.[16] Data at this time are sparse, yet anecdotal evidence suggests an inverse relationship between cigarette and e-cigarette smoking. Many persons have switched from cigarette to e-cigarette usage under the impression that e-cigarettes are "safer." This perception that vaping is harmless is erroneous. Nicotine is addictive and has an impairing effect on the underdeveloped child and adolescent brain. Unregulated child-friendly chemical flavorings and colorings may damage the oral mucosa and airway. In addition, usage of both items increases the likelihood for development of lung cancer, hypertension, risk of strokes and heart attacks, and premature mortality.

In Ontario County, it is estimated that 32%[17] of adults have been diagnosed with hypertension, 79%[18] of whom are in control of their blood pressure. Control rate

[15] Data are unreliable due to large standard error. Source: Behavioral Risk Factor Surveillance System 2013-2014.
[16] Source: Behavioral Risk Factor Surveillance System 2016.
[17] Source: Behavioral Risk Factor Surveillance System 2016.
[18] Source: Common Ground Health High Blood Pressure Registry, June 2018.

varies by income level (Figure 20). Reducing the disparity by socioeconomic status requires engaging patient populations through various methods including providing education about blood pressure medication adherence, promoting physical activity, mitigating barriers to healthy eating, etc. Low income patients are less able to afford medications. Routine use of inexpensive, generic medications covered by insurance is a strategy local providers must be encouraged to embrace. Additionally, providing education, encouragement and evidence-based assistance in smoking cessation has the potential to improve hypertension control among all populations.

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



Healthy eating habits is another important factor contributing to the health of residents. According to *My Health Story 2018* survey data, the majority of residents (71%) usually get their fruits and vegetables from a supermarket or grocery store (44%), though a substantial amount utilize local farm stands (42%), farmers markets (30%), or grow their own in their garden (21%). Data from the Behavioral Risk Factor Surveillance System revealed 54% and 69% of the population reported eating fruits and vegetables, respectively, on a regular basis. Of note, 29% report daily sugary drink consumption. *My Health Story 2018* respondents were asked what are the biggest challenges or barriers that are keeping them from eating healthy. The biggest barrier in Ontario County, particularly for those with low income, is that healthy food is too expensive. Other issues which rose to the top were not enough time and lack of knowledge of how to shop for and prepare the food.

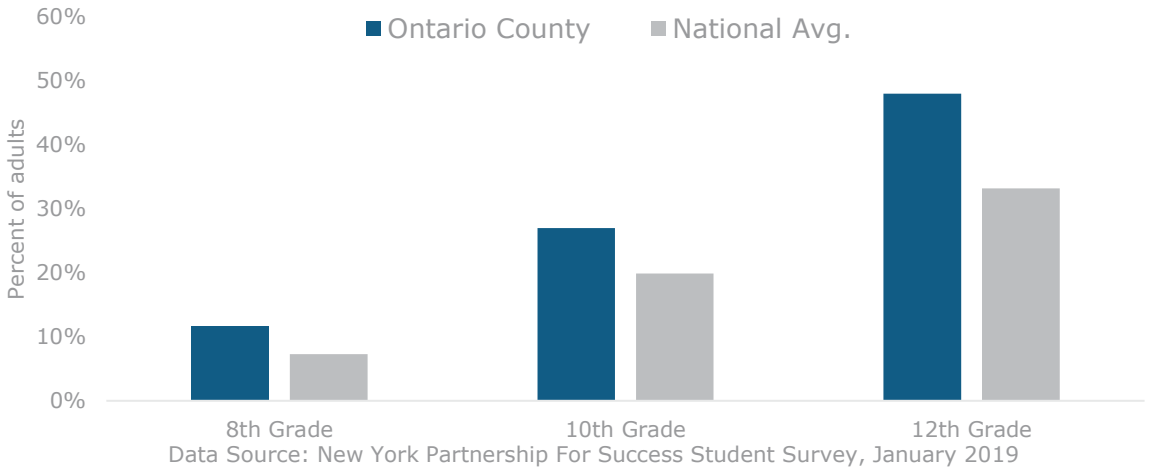
Substance use is another main health concern for Ontario County residents. An autopsy report audit conducted by Ontario County Public Health identified 17 opioid overdose deaths in 2016; 30 in 2017; and 31 in 2018. The first half of 2019 results indicate a reduction of 50% from the previous year. The reduction is most likely resultant of access to Narcan by first responders and community members. In

addition, clients admitted to OASAS-certified chemical dependence treatment programs increased in Ontario County from 575 in 2016 to 647 in 2017. The support from these programs and the increase in the number of programs available may be contributing factors to the lower number of deaths from opioids in the first two quarters of 2019. Unfortunately, law enforcement continues to see and address high drug use in our communities.

According to the January 2019 New York Partnership for Success Student Survey, the percent of 7-12th graders who misuse prescription drugs decreased from 2.7% in 2015 to 1.7% in 2017. The reduction was greatest in 10th graders (4.3% in 2015 to 1.4% in 2018). The survey also reported that 51% of students talked with at least one parent in the past year about the dangers of drug use. Rates among older youth (11-12th graders) were higher (52%) than younger students (7-8th graders, 48%).

Binge drinking is a measure used to help gauge substance abuse in communities. According to data retrieved from the 2016 Behavioral Risk Factor Surveillance System, approximately 23% of Ontario County adult residents reported binge drinking in the past month, which has risen since 2013-2014 estimates (10%). Figure 21 demonstrates the prevalence of alcohol use among youth compared to the national average. You will see that rates for each grade year are higher than the average. According to the survey data, 46% of students reported talking with at least one parent about the dangers of alcohol use in the past year. Similar to findings of talking about drug use, older youth (11-12th graders) were more likely to report talking to parents (48%) as opposed to 7-8th graders (43%).

Figure 21: Past 30-day prevalence of alcohol use in Ontario County compared to national average



Substance use and poor mental health are linked. It is impossible to address one without the other. According to survey data from *My Health Story 2018*, almost half of the respondents indicated they have dealt with anxiety, fear, depression or sadness. For those who have dealt with mental or emotional health issues, 77% of

survey respondents said they got the help they needed. The most commonly reported support was from doctors, counselors and other mental health professionals followed by support from friends and family. Suicides in Ontario County have increased over the last three years. In response, a suicide prevention coalition has been created in partnership with Public Health, Mental Health and the Partnership for Ontario County (non-profit). Activities have included community and professional education and outreach.

Policy and Environmental Factors

Ontario County stakeholders and leaders have long recognized the burden of poor mental health and substance use on residents. Continuing to focus on these issues remains important to the health department, hospital systems and partners. The Partnership for Ontario County worked diligently during the previous CHIP to ensure medication drop boxes were present in all Ontario County communities for disposal of unused or undesired medications.

The Ontario County Health Collaborative has also worked with the Tobacco Action Coalition of the Finger Lakes and other partners to ensure smoke free indoor and outdoor spaces including HUD and senior housing areas, parks, playgrounds and workplace campuses. These local laws help to decrease smoking in public spaces. New locations in the county will be pursued throughout the next health improvement cycle.

Located throughout the county are outdoor recreational spaces available to residents for walking, biking, playing and more. A 9.6 mile walking trail project is currently underway which will connect the Towns of Victor, Farmington and Canandaigua, bolstering community access to outdoor recreational activity opportunities.

Expensive housing developments are underway in Victor, located on the western edge of the county proximal to Monroe County and the City of Rochester and will lure in high-income residents. Affordable housing projects have begun in Farmington, located just south of Victor. Quality affordable housing benefits the community by improving neighborhood appeal, creating jobs (through construction efforts), and fulfilling the community's needs for low-cost housing. In addition, lower rents potentially free up resources for medications, preventative care, healthy foods, recreational activities and childcare.

The eastern side of Ontario County fares less well in regard to housing. In the Geneva area, private homes and rentals tend to be older and less well maintained. Numbers of lead poisoned children are higher in Geneva. Additionally, some Geneva residents live in a food desert, with inadequate access to grocery stores. Partners have improved access with new bus routes, free neighborhood produce stands, gleaning and delivery of fresh produce to churches and food pantries. Food Justice

of Geneva NY, Inc. has been instrumental in this process and has begun to expand to other Ontario County communities. In 2018, the Ontario County Health Collaborative began Nourish Your Neighbor, an initiative to raise community awareness and increase healthy food donations to food pantries across Ontario County.

Lead contamination from an old foundry located in Geneva is also a concern for residents. Mitigation is currently pending. To address this, several revitalization grants received from New York State will help regenerate the city over the next several years, which may bring in additional tourism and boost community pride. Nevertheless, the socioeconomic conditions residents live in are impacting their overall health status.

Unique Characteristics Contributing to Health Status

Other characteristics in Ontario County that are impacting health status include the presence of two local colleges and a nursing school and the abundance of tourism due to the beautiful lakes, wineries and craft breweries. These resources provide opportunities for education, employment, recreation and healthy living. In addition, many seasonal positions are generated to account for the increased volume of patrons that visit (particularly during the summer months).

Another resource Ontario County residents thrive on is the availability of fresh, local produce thanks to a robust farming community. Farming is an important asset to residents and migrant farmworkers are an integral part of that process. Of note, the migrant workers accept jobs, wages and hours that permanent residents will not. Laws regarding fair wages and work hours need to be developed and implemented thoughtfully with consideration of the narrow financial margins of independent local farmers.

In recent years two of Ontario County's hospitals (Thompson Health and Clifton Springs Hospital and Clinic) have joined larger hospital systems. The third (Finger Lakes Health) began this process in 2019. Affiliations with large, urban systems provide financial stability for local hospitals and greater local access to tertiary and specialized care on the part of county residents. The Canandaigua VA Hospital remains an asset and provides a plethora of services to veterans and their families, as well as, a national suicide prevention hotline.

Finally, Finger Lakes Area Counseling and Recovery Agency (FLACRA) has recently announced the launch of their new Center of Treatment Innovation (COTI) which was created to address the opioid and heroin crisis in Ontario and Yates counties. COTI will focus on increased access to treatment, unmet treatment needs and reducing overdose related deaths. The no-cost services will be available 24/7 and will aid in reducing death due to substance use.

Community Assets and Resources to be Mobilized

During focus groups completed in late 2018 and early 2019, community members identified several assets and resources in Ontario County. For example, focus group attendees identified local area hospitals, social service departments, and treatment of transitioning and transgender individuals as community strengths and resources. Community meal sites and numerous food pantries were cited as assets during focus groups as well as pre-release programming provided at the jail, good schools and an increased number of urgent care centers. In addition, attendees identified the county's environment and surroundings areas as strengths. A comprehensive list of identified strengths and resources can be found in focus group summaries and are available upon request.

Through implementation of the Community Health Improvement Plan, Public Health workers will seek to leverage community assets and resources and mitigate environmental factors that lead to inequity among county residents. A full description of interventions and partner roles can be found in the Ontario County Community Health Improvement Plan document. Partnering and leveraging the assets and resources of local community agencies will be imperative to achieving success in the plan.

Community Health Improvement Plan/Community Service Plan

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

Ontario County Prioritization Agencies		
Ontario County Public Health	S2AY Rural Health Network	Common Ground Health
Ontario County Administration	UR Medicine/Thompson Health	Finger Lakes Community College
Health & Human Services Ontario County	Ontario County Mental Health	Finger Lakes Health
City of Canandaigua	Smola Consulting	Lifespan
Stop DWI	Cancer Services	Geneva Head Start
Tobacco Action Coalition of the Finger Lakes	Fidelis Care	Substance Abuse Prevention Coalition
Private medical professionals	City of Geneva	LawNY
Office for Aging	Chamber of Commerce	Ontario ARC

Ontario County Prioritization Agencies (continued)		
United Way	Geneva CSD	URMC Center for Community Health and Prevention
Pioneer Library	New York Kitchen	Rochester Regional Health
Community member	GW Lisk	Finger Lakes Prevention Resource Center
Finger Lakes Area Counseling and Recovery Agency (FLACRA)	Clifton Springs YMCA	Catholic Charities

The community at large was engaged throughout the assessment period via a regional health survey and focus groups. Community members were also invited to attend the prioritization meeting to help inform and select the 2019-2021 priority areas. Findings of the assessment were shared with the public via social media and press release.

Specific interventions to address the priority areas were selected at Ontario County Health Collaborative meetings by stakeholders who will be directly involved and affected by the Community Health Improvement Plan/Community Service Plan. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Ontario County Community Health Improvement Plan (Appendix E). Interventions selected are evidence based, address health across all ages, and strive to achieve health equity by focusing on creating greater access for those of low socioeconomic status.

The Ontario County Health Collaborative, a monthly convening that brings together diverse partners to improve the health of its residents, will oversee Community Health Improvement Plan progress and implementation. Members will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

The completed Ontario Community Health Assessment and Community Health Improvement Plan/Community Service Plan will be shared with the public on the Ontario County Public Health website at www.OntarioCountyPublicHealth.com and via the Public Health Facebook Page. Ontario County Health Collaborative members will share the document via their organizations' websites as well. The full Regional CHA will be shared on the S2AY Rural Health Network website.

Appendix A

October 18, 2018 Epic Zone- Teen after school program in Geneva

5 Teens Participated and 1 intern from Hobart

What are we missing in terms of health priorities?

- Better healthy food choices mentioned twice
- Smoking and Weed- The teens shared that they were confused with the mixed messages between illegal marijuana and medicinal marijuana
- Drugs- Crack
- Drinking and Alcohol
- Need more and nicer police
- Texting and Driving
- Cleaner environment
- Entertainment- rollercoasters

What are the trends and factors influencing health?

- Trash and litter everywhere
- Vandalism and loitering
- Drugs
- Discrimination
- Robbery
- School shootings- kids are scared
- Bullying
- Stated that they will not jog because they are afraid of kidnapping (girls) and being robbed (boys)
- Parks, basketball courts and the YMCA has a positive effect on health
- Tobacco 21- the group thought that the legislation passed. They were very disappointed

Emerging Issues

JUULES and Vapes "Enter the school and 5 JUULS will be in your pocket when you leave." "You just need friends that are over 18 to buy one."

Donald Trump- Worried about war with Russia and North Korea

Addiction to video games and internet (Ninja and ForteNite)

Assets	Gaps
• New drug treatment • Probation program- for kids in school	• No birth center anymore- travel all the way to Rochester

• Hotline for drugs • Epic Zone • School • Programs at School • School Sports • Youth Court • Urgent Care- fast • Home-cooked meals at moms	• Waiting list for doctors (Primary Care) • Need more entertainment • Need more dance opportunities • Need kids yoga • Need more gyms • Need water fountains at local basketball courts- parks • Too many junk food options- fast, easy and cheap food

Gaps and Barriers to Healthcare Services

- Addicted to internet, Video Games (no services for them)
- Can't do homework without internet (Keeps them from being successful in school)
- Bullying Issues
- Need more adult and teen jobs (for insurance)

November 9, 2018 Population Health Focus Group - UR Thompson Health

Missing Priorities:

- Lung cancer screenings are underutilized (largest killer- needs to be top priority)
- Lack of resilience in kids
    - Need help with parenting and teaching coping skills
    - Resulting in alcohol and drugs to cope (high anxiety levels)
    - Over use of technology
    - Lack of family communication
    - Missing data- how many people in our population are on anxiety meds-
    - Burnout at young ages
- Lack of physical exercise and sedentary lifestyle

Emerging Issues and Trends:

- Legalization of marijuana
- Fortenite and videos of killing people/violence in our society.
    - Normalize violent behaviors
- Huge amount of screen time between school and home
- Sleep cycle disturbances
- Lack of resilience in kids
- Vaping products are too available, cool, can't control what Vape Shops open

- Chlamydia

Barriers to Care:

- Cost and economics
- Lack of mental health providers
- Lack of primary care providers
- Population doesn't take their own care serious until it is too late
- Need more home care resources to see pregnant moms only 1 agency will see pregnant mothers

Strengths:

- FF Thompson Hospital and their services
- Primary Care
- Activities- Lake and trail system
- Large percentage of people in Ontario County are covered by FFT's Primary Care so quality of care can be assessed and the quality of MD visits improved through FFT's QI systems
- Ontario County Schools care about the kid (schools are taxed with state mandates and struggling)

November 7, 2018 Jail Focus Group

1) Missing health priorities:

- Alcohol- Educating people about the dangers of alcohol, symptoms of being an alcoholic
- STD's- Many people don't know that they have an STD. Getting treatment is difficult.
- Healthy sexual relationships- everyone is sleeping around
- HIV- more HIV prevention education is needed

2) Emerging issues and trends/ factors that are creating them:

- It is now "cool" to be transgendered even if you are not/ social media
- It is cool to be gay and have gender dysmorphia/ It has become a trend among teenagers in school
- Drug trends-
- Carfentanyl "gray death" is in Ontario County/ comes from the city
- Flakka- new drug similar to bath salts, cheaper form of crack/ cheaper drug coming out of Florida
- Krokodil- new opioid drug, can cause flesh eating bacteria/new drug coming from Florida

- Bath salts- new forms of synthetic marijuana- can purchase them at local smoke shops
- CBD oil- very popular right now, no THC so it will not show on a drug test/ used for pain and seizures

3) Community Strengths:

- Jail, outpatient rehab- FLACRA "stepping up their game", Medicaid insurance, Pregnancy CareNet Center, CCIA "one-stop-shop," Narcan trainings "in the community but we need more at local worksites"

Gaps in Services:

- Hard to find oral surgeons that take Medicaid.
- Medicaid office (DSS) "doesn't call back and they help only the people they want to help," "DSS doesn't help with housing," "we can't work and participate in Workforce Development classes," "there is no childcare help in Ontario County."

Barriers to getting health care

- Transportation
- Medicaid doesn't cover everything
- The VA makes me travel to Syracuse or Buffalo for care

December 12, 2018 Ontario County Public Health Focus Group (CHIP/CHA)

Location: CAAST: Geneva

Presenter/ Scribe: Christy Richards

What is Missing?

- Addiction to screen time (video games, TV, phones, ipads) this leads to sleep deprivation, school absence, less physical activity. Cumulative screen time (school, home, home, homework, games, TV)
- Promoting physical activity (open spaces for kids to ply, physical activity isn't a priority, more activities like street dances, ninja warrior needed)
- Lack of social connected ness and healthy relationships with positive communication
- Adverse childhood Experiences
- SES: Financial stress linked to mental health

Emerging Issues/Trends

- Screen addiction
    - Cumulative screen time at school and home
- Technology
    - Apps- used to exploit kids sexually, mobile on the go fast food (poor nutrition becomes easier)
    - Phones used as babysitter
- Increasing chlamydia rates
    - Lack of sexual education and family planning education, lack of LGBTQ sexual education and disease prevention, lack of information of consent for sex and lack of education on healthy relationships

Strengths

- Cohesive agencies, programs and coalitions in Ontario County
- Strong FQHC programs
- Telehealth and technology usage to connect people to specialty services (Endocrinology)
- Strong and caring Public Health workforce

Gaps and Barriers

- Most elderly aren't technology savy, can't get services
- Specialist offices all the way in Rochester with long wait times and some residents cannot take time off of work or do not have transportation
- Finger Lakes Community Health Pharmacy is closing at the Geneva site (home delivery still available)
- Less places to take your family for physical activity (Canandaigua Kershaw verses Geneva's New York State Park)
- Must improve technology and apps to improve health
- Lack of knowledge about hearing and vision screenings in the younger populations
- Barriers to health care appointments
    - Kids, transportation, copay, lack of time off work, MD running late
- MD/NP/PA not talking or screening for sexually transmitted infection, no sexual health education in doctors offices

Ontario County Planning Document for 2019-2021 Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP)

April 2019

Executive Summary

The Ontario County Health Department, in partnership with Thompson Health, Finger Lakes Health and Rochester Regional Health Clifton Springs Hospital and Clinic, is updating their Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP). They are seeking input from stakeholders and community members to decide on the health priority areas to focus on through 2021. The intent of this report is to serve as a planning document to help make informed decisions on selection of the new priority areas.

Based upon the scope of public health services, as well as the breadth and workflow of other public health system entities, consideration must be made to determine what priority areas Public Health and Hospitals' ought to select for the 2019-2021 Community Health Improvement Plan. At prioritization meetings, participants will be asked their opinions regarding potential priority areas based upon data and community input already received. Throughout this document you will find all of the tools necessary to help inform the public health and hospital action plan including:

- A brief summary of the Prevention Agenda (the guiding document for CHA/CSP/CHIP planning);
- Public Health and Hospital's role in community health;
- A summary of community input already received; and
- Data regarding county demographics and health indicators.

More data are available on the Common Ground Health website at www.CommonGroundHealth.org.

The New York State Prevention Agenda

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

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

During each new cycle, public health and hospital systems turn to key partners and community informants to help determine what the course of action ought to be to improve the population's health. In the 2016-2018 Community Health Improvement Plan, Ontario County selected as their priority areas: (1) prevent chronic disease and (4) promote mental health and prevent substance abuse. These priority areas were selected based on input from public health and hospital staff, key stakeholders and community members. The following chart demonstrates a summary of the progress made for each of the priority areas in the past cycle.

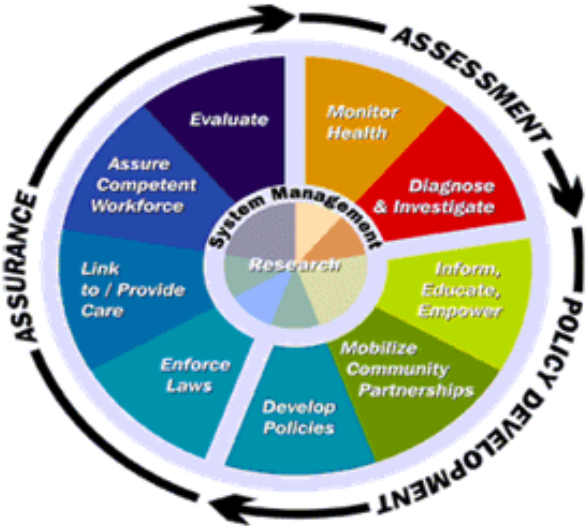
Priority Area	Progress
1. Prevent Chronic Disease	Strategies in this priority area included implementing an evidence based programs, developing a food pantry program, piloting a county-wide initiative, encouraging and promoting breastfeeding, and encouraging implementation of policies to protect youth from tobacco marketing. Activities undertaken to support these strategies are described below. Ontario County and its partners offered more than 300 programs reaching more than 2,000 Ontario county residents and more than 1,600 pre-school and school-aged children. Nearly 500 individuals received education on healthy eating and a county-wide initiative, "Nourish Your Neighborhood", had nine food pantries participating and resulted in increased donations of healthy foods. In addition, over 30,000 lbs of fruits and vegetables were gleaned (a 36% increase from 2017), and distributed to 30 sites. Twelve breastfeeding classes were offered, reaching 147 individuals. More than 1,200 women were reached by policies and practices to support breastfeeding. In addition, childcare centers implemented lactation support programs. Thirteen elected officials were communicated with about the impact of retail tobacco marketing on youth and monthly press releases were used to educate and promote these efforts. Fifteen primary care practices in Ontario County participated in the high blood pressure registry in 2018. The average rate of blood pressure under control in Ontario County increased from 77% in June, 2015 to 79% in June, 2018.
4. Promote Mental Health and Prevent Substance Abuse	Strategies in this focus area included implementing plans to prevent overdoses, identifying and strengthening opportunities for collaborating, and partnering with an existing Syringe Exchange Program (SEP) provider to provide a mobile SEP in Ontario County. Activities undertaken to support these strategies are described below. Ontario County Substance Abuse Prevention Coalition has 28 active members and held 67 events in 2018 reaching nearly 1,200 residents. Drug take-back events occurred, with more than 3,300 lbs collected. Twelve Narcan trainings were conducted, with 200 trained. A county-wide Suicide Prevention Coalition was formed which meets monthly and has 127 engaged stakeholders from multiple agencies, schools, hospitals, and the faith-based community. A mobile SEP unit was established at two locations in the county. The unit had 4 clients with 6 encounters between 3/2018 and 10/2018.

Public Health's Role

The Public Health System comprises of all public, private and voluntary agencies and entities which contribute to delivery of services that protect and promote the health of its community. The system includes public health departments, healthcare providers, human service agencies, education and youth organizations, environmental agencies, mental health, and more. All entities strive to work together in their efforts to improve the health of the community. One agency simply cannot do it alone.

There are ten essential services that the system strives to conduct. Its direct services and programs may range from county to county but their principles remain the same. Listed in the wheel below are the ten essential services including the three major themes: assessment, policy development and assurance.

The ten essential services include:



1. **Monitor health** status to identify and solve community health problems
2. **Diagnose and investigate** health problems and health hazards in the community
3. **Inform**, **educate**, and **empower** people about health issues
4. **Mobilize community partnerships** and action to identify and solve health problems
5. **Develop policies** and plans that support individual and community health efforts
6. **Enforce laws** and regulations that protect health and ensure safety
7. **Link people** to needed personal health services and assure the provision of health care when otherwise unavailable
8. **Assure competent** public and personal health care **workforce**
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services
10. **Research** for new insights and innovative solutions to health problems[1]

[1] Centers for Disease Control and Prevention, The Public Health System & the 10 Essential Public Health Services 2018

A public health system assessment was recently completed by stakeholders in Ontario County. The survey sought feedback on how well the public health system, including health and non-health sectors, work together to address the ten essential services and provide an effective work flow that promotes, supports and maintains the health of the community. Results from the survey help to identify areas for improvement for addressing the needs of the community. A total of 64 people responded to the survey.

Overall, respondents indicated that they believe the healthcare community is effective at working together to conduct (52%), update (53%) and promote use of the Community Health Assessment (46%) in the community. 83% of respondents indicated that the healthcare community actively seeks to improve the health of its residents. Of note, 67% of respondents reported that the healthcare community is quick to respond to health hazards and is effective in its endeavors.

Collaboration was identified as a strength for the community both among partners (81% agreed collaboration was present) and the community (71% agreed collaboration was present). In addition, 80% of respondents agreed that the healthcare community assists residents in accessing healthcare.

When specifically asked about ways to meet needs of all community members, respondents indicated the need to increase communication with the public and mental health services including provider access (i.e. counseling and drug treatment). The need for more affordable healthcare was also specifically identified as a need.

Community Feedback – Potential Priority Areas

In the summer of 2018, Common Ground Health oversaw a broad effort to collect health-related insights from across the Finger Lakes region. Residents were encouraged to participate in the *My Health Story* survey and share their health experiences via a series of closed and open ended questions. Over 3,800 adults participated within the eight-county region[2]. 1,052 residents participated from Ontario County.

Within the survey, participants were asked questions about their top concerns for the health of themselves, loved ones, and adults and children in the community. Listed below are the most common concerns listed for each of the categories. Weight and mental/emotional health issues have risen to the top for all four categories. Of note, substance use and obesity indicators including exercise, weight, diet and nutrition, are concerns or children in the county. In addition to these, cost of care was found to be a concern for adults in the county.

Figure 1: Ontario County summary of health-related concerns for self, loved ones and county to prioritize

Biggest fear - for self	Biggest fear - for others
Mental / emotional health issues (14.7%)	Mental / emotional health issues (12.1%)
Weight (13.5%)	Cost (9.7%)
Cost (10.6%)	Cancer (8.8%)
Cancer (8.5%)	Aging (7.6%)
Heart conditions (8.4%)	Weight (7.6%)

County priority - for adults	County priority - for children
Mental / emotional health issues (21.8%)	Diet / nutrition (22.7%)
Substance abuse (21.2%)	Mental / emotional health issues (19.7%)
Cost (17.9%)	Substance abuse (18.2%)
Weight (12.3%)	Exercise (12.1%)
Diet / nutrition (12.3%)	Weight (11.4%)

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

[2] The eight county region includes Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties.

The Ontario County Public Health Department conducted focus groups in the winter of 2018 to gain additional community input on potential priority areas. Focus groups were selected based upon population that were under-represented in the My Health Story survey. At the focus groups, participants were asked a series of questions relating to their thoughts on potential health priorities, trends influencing health, emerging issues, and assets/strengths of the county. A summary of respondent answers is shown in the chart below.

Ontario County Focus Group Summary	
What are we missing in terms of health priorities?	Missing priorities identified included: mental health; air and water quality; access to health insurance; sex, drugs and nutrition education.
What trends and factors are influencing health?	E-cigarette use and vaping, substance abuse (including CBD oil), and poor transportation were identified as trends influencing health.
What are the emerging issues you are seeing in your community?	New recreational drugs, violence, and increasing screen time were identified as emerging issues.
What assets and/or strengths does your county have that help to contribute to the health of residents?	Strengths identified included the environment/surrounding area, area hospitals, social services available, and treatment of transitioning/trans-gender individuals.
What barriers to service do we have?	Lack of access to health/dental care and to health insurance, poor transportation, lack of childcare for 2nd and 3rd shifts, and lack of affordable housing were noted as being barriers.
What gaps in service do we have?	Mental health providers for youth, recreational resources, and no Narcan training at worksites were identified as being gaps in service.

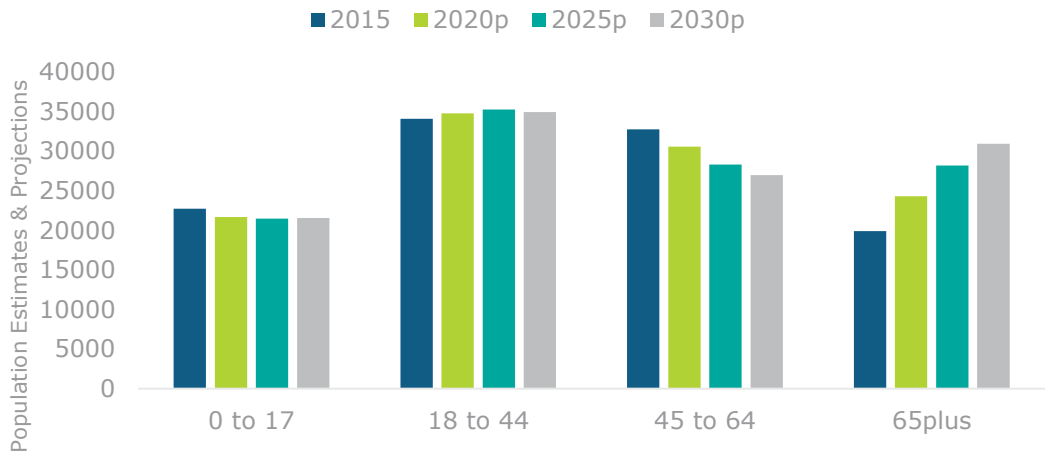
Demographic Data

Ontario County

Ontario County Demographics

A total of 109,491 persons reside in Ontario County, the majority of which (94%) are White Non-Hispanic. Population projections show a growing number of residents aged 65+ (Figure 2). Most recent estimates (2017) reveal 30% of the 65+ population (6,044 residents) live alone which may be a cause for concern, particularly with the increased risk of falls in this age group. In 2013, 29% of those over the age of 65 were living alone (4.860 residents).

Figure 2: Total population and projections



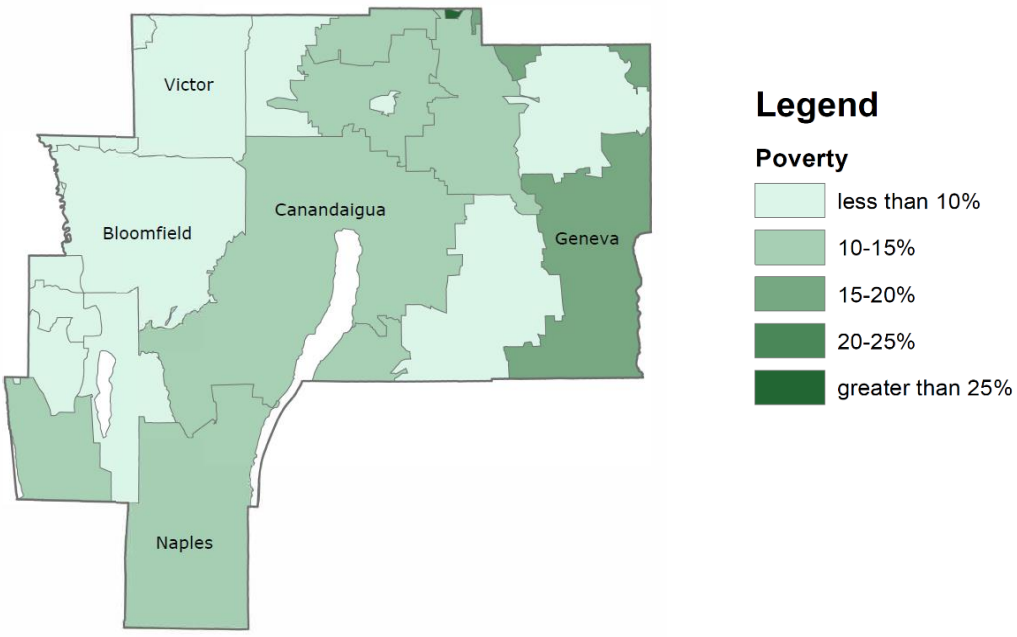
Data Source: U.S. Census Bureau, 2013-2017 American Community Survey Population Estimates; Cornell University, Program on Applied Demographics 2018 Population Projections

Of note is the density of poverty in the county. 10% of residents are living below the federal poverty level, and another 16% living near it. Living in poverty creates challenges in accessing, maintaining and prioritizing basic needs such as adequate housing, medical and dental care, healthy food and more.

Ontario County is growing and enjoys proximity to the City of Rochester on its western border, with easy access to jobs for those able to commute. This has resulted in the need for new homes and businesses and has positively affected the socioeconomics of this part of the County. Average income, the number of single family dwellings and the high school graduation rate, however, decrease significantly moving eastward and pockets of poverty exist throughout the County. Where you live matters. Life expectancy is lower in the areas of low socioeconomic status.

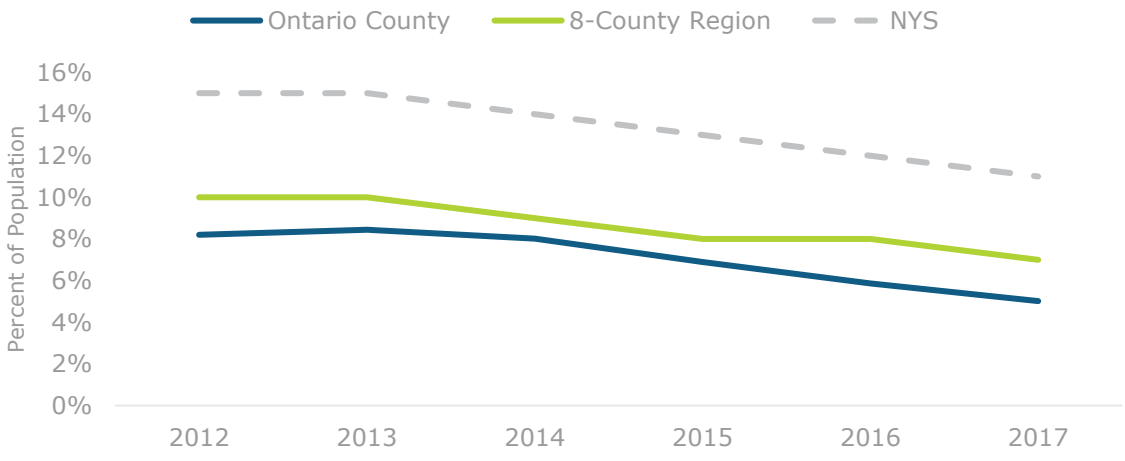
The distribution of poverty in the county is shown in Map 1.

Map 1: Poverty rates by ZIP code



With the implementation of the Affordable Care Act, rates of uninsured individuals have decreased over the past several years. Data below show the trend in uninsured over the past 5 years compared to NYS and the 8-County Region. The rate has decreased 3% since 2012 in Ontario County (Figure 3). Lack of insurance may lead to a person being unable to access or afford medical and/or dental services which will decrease preventative care accessibility and potentially early diagnosis of any acute or chronic diseases.

Figure 3: Percent of population that is uninsured



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

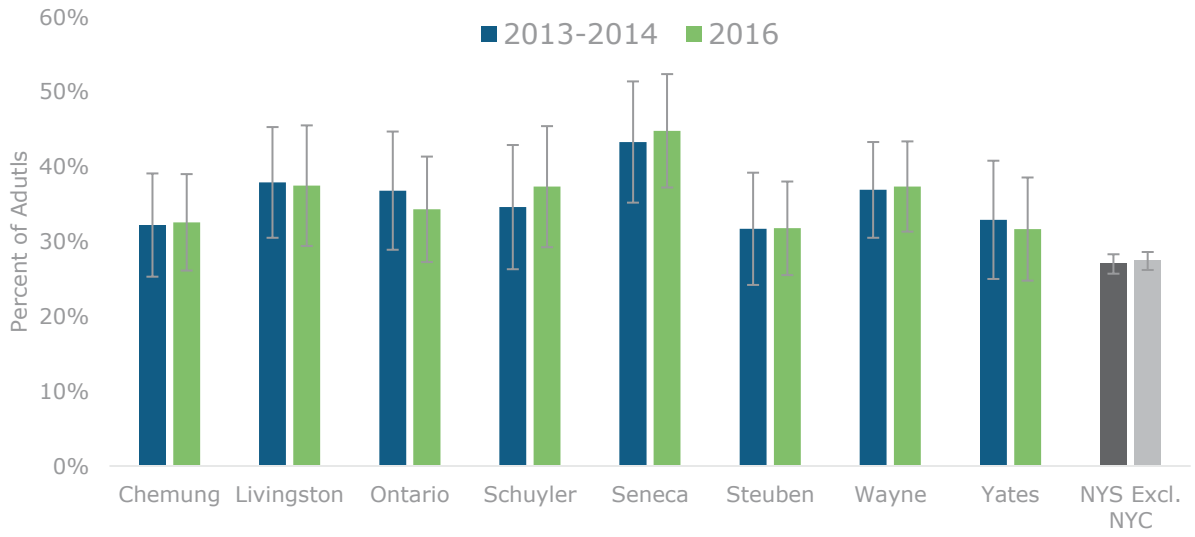
Health Indicator Data

Ontario County

Chronic Disease

Approximately 1 in 3 adults in Ontario County are obese (Figure 4). Obesity affects an estimated 26,490 adults and 800 children and can lead to the development of diabetes, hypertension (high blood pressure), and premature mortality (death). Regionally, respondents to the My Health Story survey indicated that better diet and nutrition and physical activity habits would help them manage their weight better.

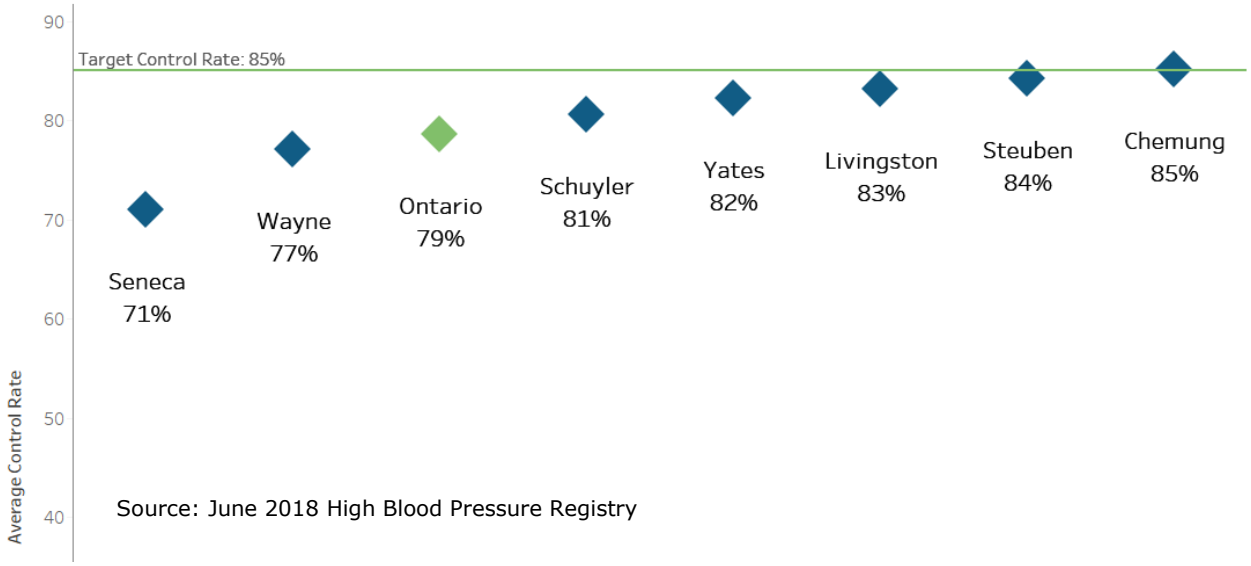
Figure 4: Percent of adults 18+ who are obese



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

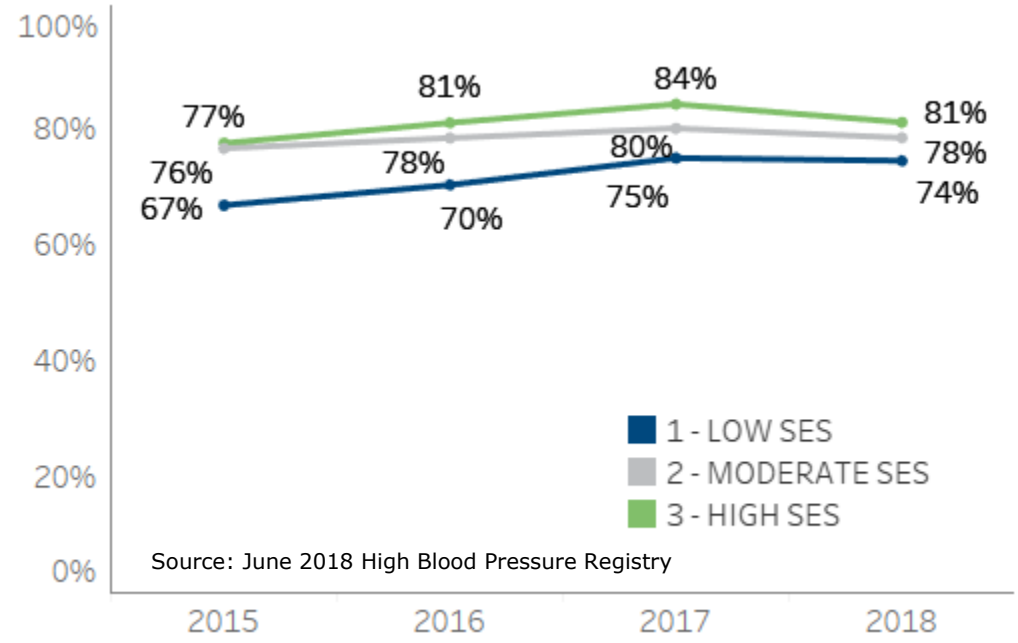
An estimated 28% adults in the county have been diagnosed with hypertension. However, important to note is the hypertension control rate for Ontario County residents. An estimated 79% of hypertensive patients in Ontario County are in control of their blood pressure based upon the June 2018 High Blood Pressure Registry produced by Common Ground Health. Rates of control in the 8-county region range from 71-85%, with an overall target of 85% control (Figure 5).

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



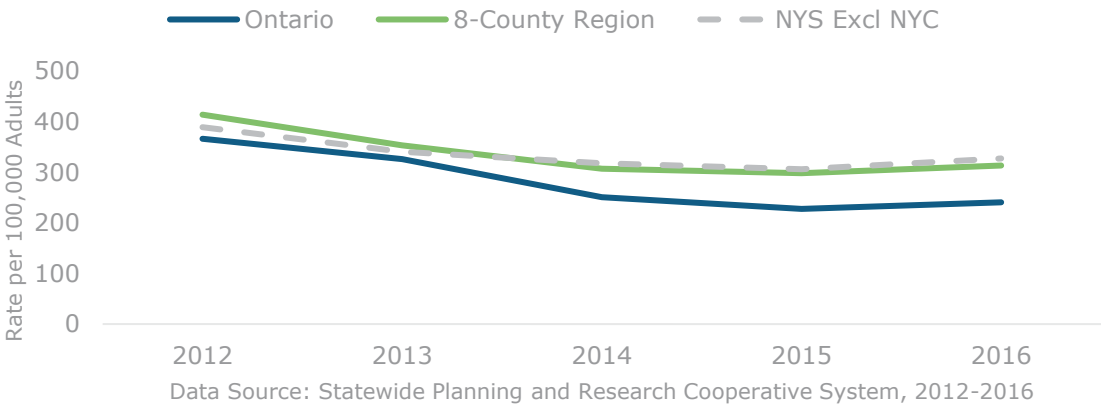
Of note is the difference in control rate by socioeconomic status- a difficult disparity to eliminate (Figure 6). Reducing the disparity requires engaging patients in taking control of their blood pressure through various methods- blood pressure medication adherence, promotion of physical activity, healthy eating, and more. Low income residents may lack reliable transportation for doctor's appointments, may lack access to or be unable to afford healthy food and may have trouble paying for prescribed medications.

Figure 6: Ontario County control rate by socioeconomic status over time



The rate of heart attacks has decreased in Ontario County since 2012, but has remained stable (Figure 7). The occurrence of cardiovascular issues such as heart attacks can be directly related to the high rates of obesity, hypertension and diabetes.

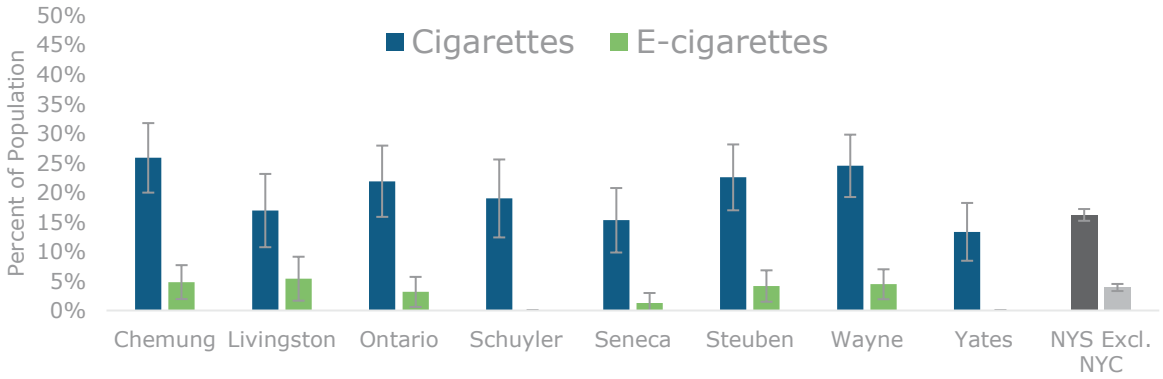
Figure 7: Age/Sex adjusted inpatient heart attack discharge rates per 100,000 adults



Data Source: Statewide Planning and Research Cooperative System, 2012-2016

Tobacco increases the risk of cardiovascular disease. An emerging issue identified in the Finger Lakes is the use of e-cigarettes, especially among younger adults. It is likely that estimates of use is actually much higher than shown in Figure 8. According to data from the January 2019 New York Partnership For Success Student Survey, approximately 28% of Ontario County middle and high school students reported using e-cigarettes. The most common age of reported first use of the device was 13-14 years. The rising popularity of vaping devices has shown a concurrent decrease in rates of reported cigarette use, however. The survey results reported 41% of students reported talking with at least one parent in the past year about the dangers of tobacco use.

Figure 8: Percent of adults (18+) who smoke every day or some days



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

The perception that vaping is harmless is erroneous. Nicotine is addictive and has an impairing effect on the underdevelopment childhood/adolescent brain. Chemical flavorings and colorings, as yet unregulated, may damage the oral mucosa and airway. Ontario County schools report vaping is rampant among students, causing frequent interruptions during the school day and interfering with learning.

The effort to reduce the burden of obesity and its related diseases is no small feat and has been a long standing initiative in Ontario County. According to My Health Story survey data, 17% of county respondents report the nearest grocery store is 20+ minutes away, requiring vehicles to access them. The majority of residents (71%) usually get their fruits and vegetables from a supermarket or grocery store (44%), though a substantial amount utilize local farm stands (42%), farmers markets (30%), or grow their own in their garden (21%).

Data from the Behavioral Risk Factor Surveillance System revealed 54% and 69% of the population reported eating fruits and vegetables respectively on a regular basis. Of note, 29% report daily sugary drink consumption.

My Health Story respondents were asked the biggest challenges or barriers keeping them from eating healthier. Table 1 reveals barriers reported by Ontario County residents. The biggest barrier to eating healthier in Ontario County, particularly those of low income, is that healthy food is too expensive. Other issues which rose to the top were not enough time and knowledge of how to shop and prepare the food.

Table 1: Barriers to eating healthy

	Ontario Income up to $50K	Ontario Overall	8 County Overall
Buying healthy food is too expensive	57%	39%	42%
I don't know how to cook and prepare healthy meals that taste good	18%	14%	13%
I don't have the time to shop for, and prepare, healthy food	17%	21%	19%
The others in my household don't eat healthy, and we eat together	9%	11%	13%
I don't have the transportation to go shopping for healthy food	7%	3%	3%
I don't have the supplies and equipment I'd need to cook healthy food	6%	4%	4%
I don't enjoy the taste of healthy food	5%	8%	7%
I don't have any place nearby to buy healthy food	4%	2%	3%
I really don't have any barriers keeping me from eating healthy food	31%	38%	36%
I don't want or need to eat healthier than I already do	5%	9%	8%

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

In Ontario County, 78% of residents who responded to My Health Story reported engaging in physical activity in the past month; the main reason for not exercising being lack of time and feeling too tired to exercise (Table 2). Of note, the low income population reported inability to afford a gym membership as their biggest barrier to being physically active.

Table 2: Barriers to being physically active

	Ontario Income up to $50K	Ontario Overall	8 County Overall
I can't afford a gym membership or other fitness opportunities	43%	27%	26%
I don't have the time to get more exercise	37%	47%	40%
I always seem to be too tired to exercise	31%	29%	29%
I don't have anyone to exercise with, and don't like to exercise alone	24%	18%	16%
I can't exercise because of a physical limitation or disability	22%	13%	14%
I don't have transportation to get places where I could get more exercise	8%	4%	3%
My life is too complicated to worry about exercise	8%	8%	8%
I don't have a safe place nearby to get more exercise	7%	4%	6%
I really don't have any barriers keeping me from being physically active	20%	24%	24%
I don't want or need to be more active than I already am	8%	8%	8%

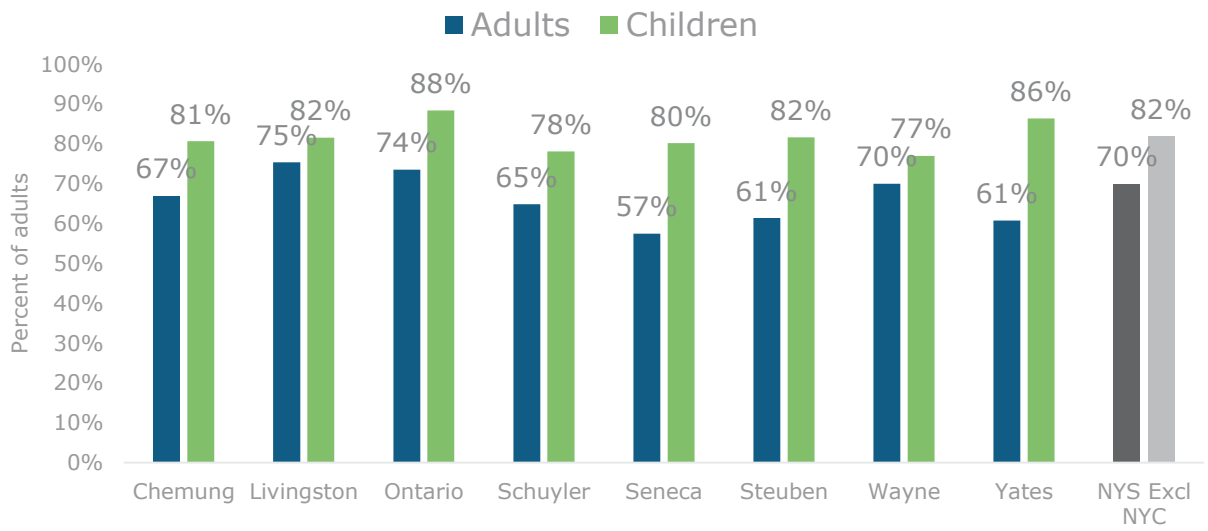
Source: My Health Story *survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.*

Poor diet and exercise habits may lead to increased risk of developing diabetes. In Ontario County, rates of persons diagnosed with diabetes has remained around 10% over the past several years.[3] Regionally, respondents to the My Health Story survey indicated that better diet and nutrition habits would help them manage their diabetes better.

Dental health is another issue of concern. Untreated dental problems may lead to gum disease, tooth decay, or teeth loss, all which impact a person's ability to eat and drink and may put them at risk for dental and systemic infections. 74% of Ontario County adults and 88% of children have visited a dentist in the past year (Figure 9). Of note, an estimated 43% of adults have had permanent teeth removed due to tooth decay or gum disease (Figure 10). In addition, 48% of third grade children in the county have experienced dental caries- 17% of which have not been treated.[4]

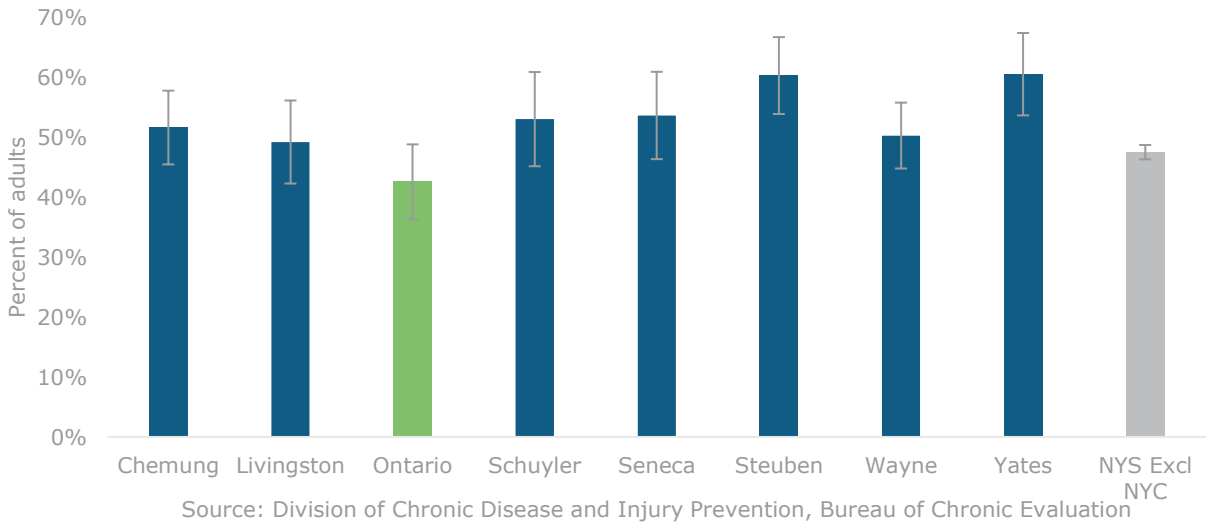
[3] Source: Behavioral Risk Factor Surveillance System
[4] 2009-2011 Bureau of Dental Health Data as of August, 2012

Figure 9: Percent of residents who have visited the dentist in the past year



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

Figure 10: Percent of adults 18+ with permanent teeth removed due to tooth decay or gum disease

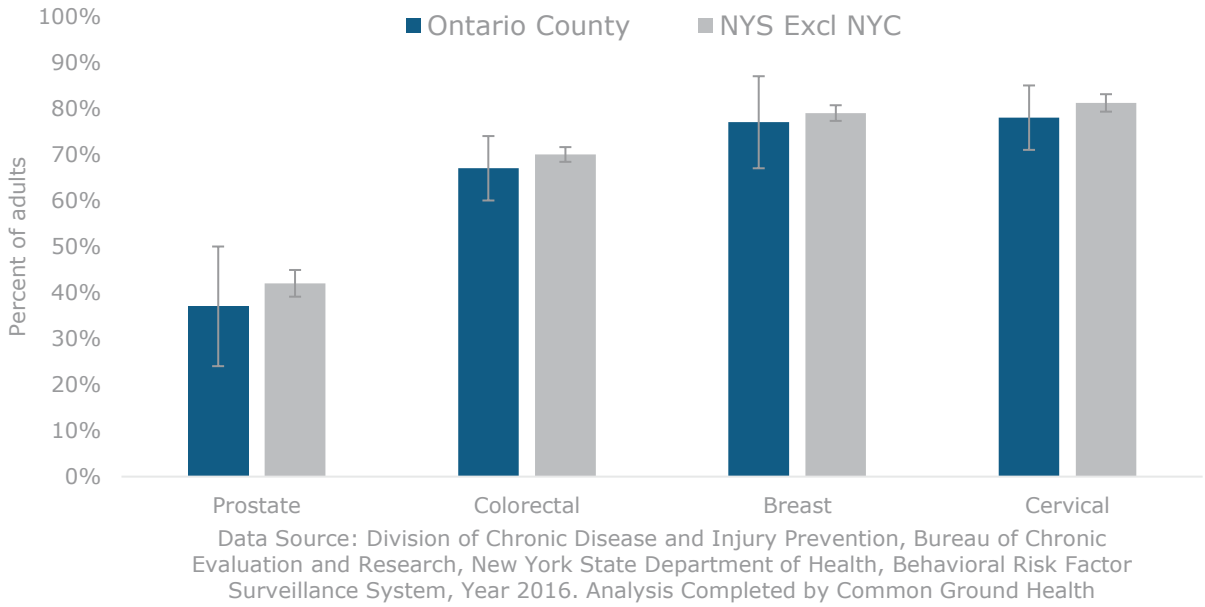


Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health

Screening for cancers is an important preventative step in primary care. Figure 11 below shows the percent of the Ontario County population which has received screenings for various types of cancer based on recommended guidelines. Of note, Ontario County is generally on par with NYS excluding NYC rates. The prostate

cancer screening rate is the lowest. This is consistent with surrounding counties and New York State.

Figure 11: Percent of population receiving cancer screening



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

Maternal and Child Health

Total births in Ontario County have remained stable over the past several years. From 2010-12, there were 3,104 total births and 3,091 from 2014-16. This is different from nearby counties where total birth rates have been decreasing. This 8-County regional rate has reduced 4% since 2010.

New York State collects several pieces of information on births including the number premature and low birth weight babies. A baby born prematurely (<37 weeks gestation) is at risk for several health complications including jaundice, anemia, apnea, and more. The earlier a baby is born in pregnancy, the more likely it is that the baby will need to spend time in the neonatal intensive care unit (NICU). Long-term health complications associated with premature birth include intellectual and developmental delays, neurological and behavioral disorders and asthma.[5]

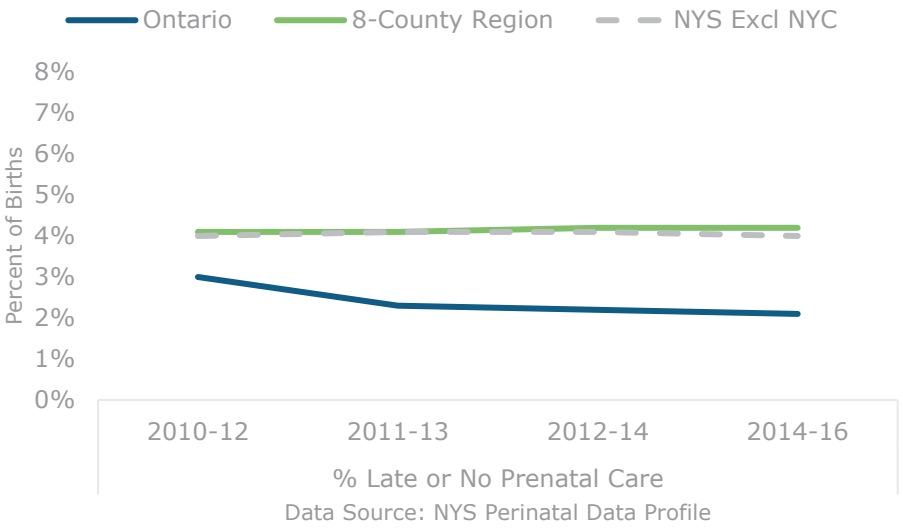
Premature birth is the primary cause of low birth weight. A child born at a low birth weight may suffer a range of health complications at birth. Some of the common issues for a low birth weight newborn include low oxygen levels, breathing complications due to immature lungs, difficulty feeding and gaining weight, neurological and gastrointestinal problems, infection, and more.[6] In Ontario County, rates of both premature birth and low birth weight have remained below the NYS excluding NYC average, consistent with the 8-county regional average.

Data on maternal access to prenatal care is also collected by New York State. Receiving early and adequate prenatal care is important for ensuring a healthy pregnancy. During prenatal care visits, health care providers will order certain vaccinations and tests and help with managing maternal chronic diseases that may have an impact on pregnancy. In addition, health care providers will inform women about steps they can take to prevent complications.[7]

In Ontario County, rates of late or no prenatal care (care sought after the third trimester or not at all) are lower than average (2.5% of total births) in the 8-county region and NYS excluding NYC (4% of total births) (Figure 12).

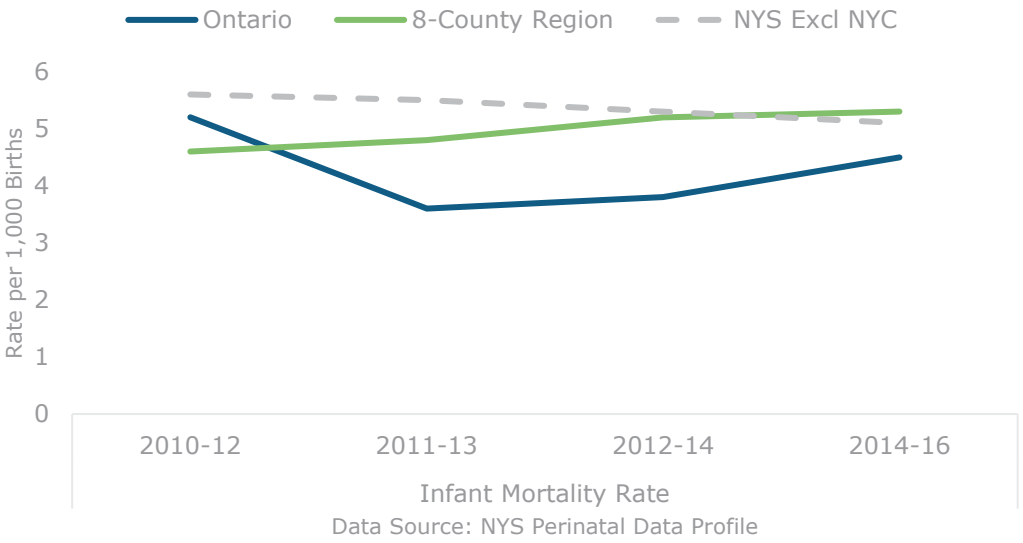
[5] March of Dimes, Premature Babies and Long-Term Health Effects of Premature Birth, www.marchofdimes.org.
[6] Stanford Children's Health, Low Birthweight
[7] New York State Department of Health, Prenatal Care in New York State, 2015

Figure 12: Percent of births that received late or no prenatal care



The rate of infant mortality (deaths that occurred less than 1 year after birth) have decreased over the past several years with an average of 13 deaths per 3-year period (Figure 13). Causes of infant mortality may be related to prematurity and related conditions, infections, obstetric conditions, sudden unexpected infant death and external causes such as unsafe sleep. For the past several years, rates of infant mortality in Ontario County are lower than its nearby counties and NYS excluding NYC.

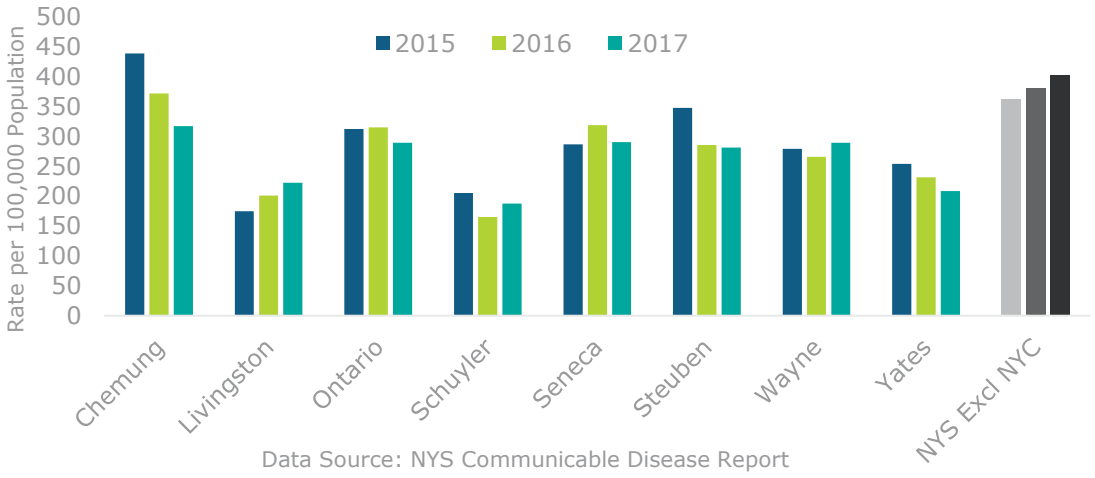
Figure 13: Rate of Infant Mortality



Communicable Disease

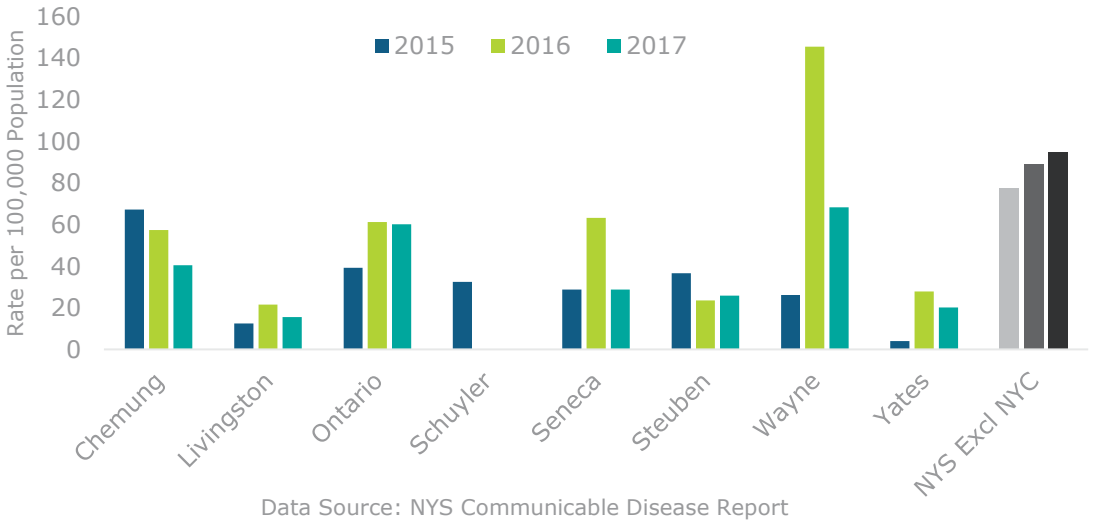
Sexually transmitted diseases are a prominent issue in New York State, including all 8 counties in the region. Historical data are available on the incidence of Chlamydia and Gonorrhea. Rates in the county have steadily decreased since 2015 (Figure 14). In comparison to NYS excluding NYC, Ontario County has lower rates.

Figure 14: Rate of chlamydia per 100,000



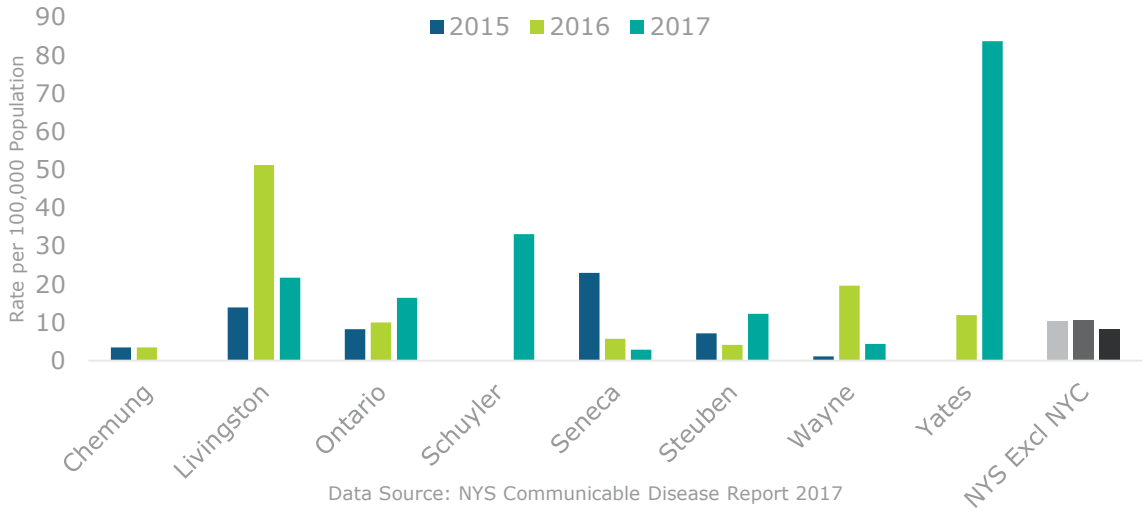
Ontario County's rates of Gonorrhea, however, have increased since 2015. Of note, smaller numbers may greatly impact the rate over time. The rates in the county are lower than NYS excluding NYC, however (Figure 15).

Figure 15: Rate of gonorrhea per 100,000



Vaccine preventable diseases, including Hepatitis A, Hepatitis B, Measles, Meningococcal, Mumps, and Pertussis are on the rise for the 8-county region. The number of patients diagnosed with vaccine preventable diseases range from 0 to 21 cases annually per county in the 8-county region. With the increased number of those who choose not to vacciante, it is important now more than ever to increase education and awareness of the benefits of vaccinating children. Of note, there are several instances where children cannot be vaccinated due to age, health conditions or other factors. Herd immunity – where the majority of the population is immune to infection or disease – helps to reduce risk of disease to those who are unable to be vaccinated. The rise of those who choose not to vaccinate negatively impacts the effectiveness of herd-immunity. The majority of vaccine preventable diseases in the 8-county region and in Ontario County are cases of Pertussis (Figure 16).

Figure 16: Rate of vaccine preventable diseases

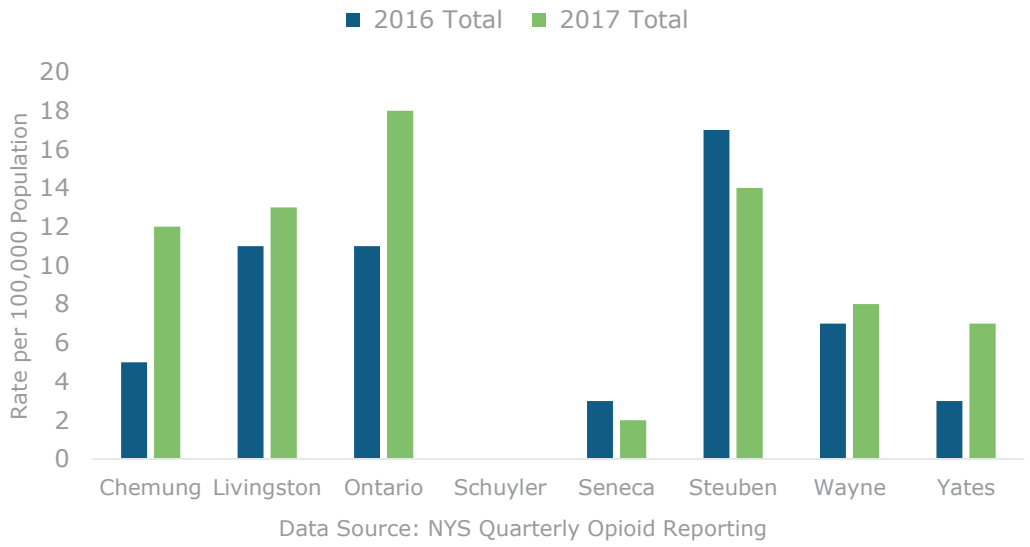


On average, 69% of the region's children have recommended immunizations by 36 months of age. The percentage of children receiving recommended immunizations range from 53% to 76% by county. In Ontario County, fully immunized 36 month olds have increased since 2015 from 53% in 2011 to 69% in 2016.

Mental Health and Substance Abuse

Overall, rates of substance use is growing in the 8-county region. Data from New York State Opioid reporting indicate a 39% increase (the highest in the 8-county region in 2017) in opioid overdose deaths in Ontario County from 2016 to 2017 (Figure 17). Total deaths in the county increased from 11 cases in 2016 to 18 in 2017. Notably, Seneca and Steuben County were the only counties which saw a decrease in deaths from 2016.

Figure 17: All opioid overdose death rates per 100,000 population

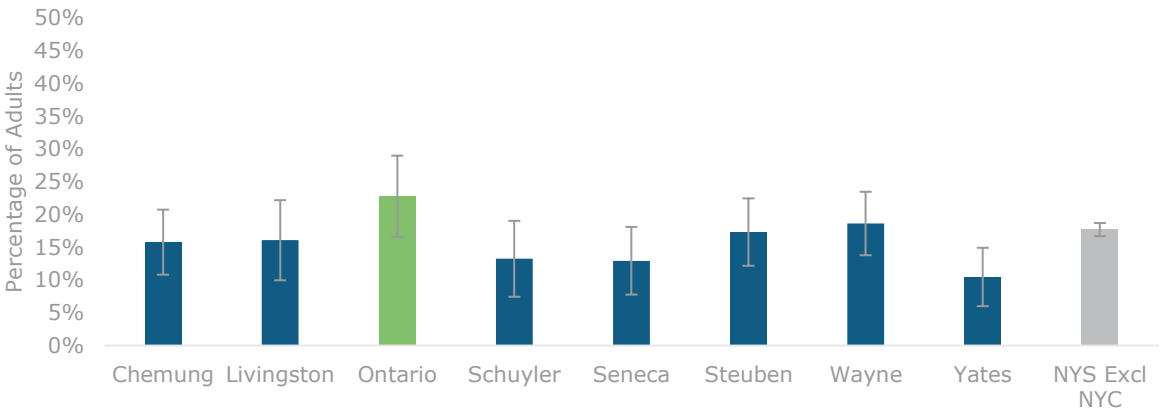


To date, data shows a dip in Ontario County overdose deaths for the first two quarters of 2018 (N=5). It is unknown at this time if this trend continued throughout the rest of the year. In addition, clients admitted to OASAS-certified chemical dependence treatment programs have increased in Ontario County from 575 in 2016 to 647 in 2017. The support from these programs are likely helpful in contributing to the lower number of deaths relating to opioids noted in the first two quarters of 2018.

According to the January 2019 New York Partnership For Success Student Survey, the percent of 7-12th graders who misuse prescription drugs decreased from 2.7% in 2015 to 1.7% in 2017. The reduction was greatest in 10th graders (4.3% in 2015 to 1.4% in 2018). The survey also reported that 51% of students talked with at least one parent in the past year about the dangers of drug use. Rates among older youth (11-12th graders) were higher (52%) than younger students (7-8th graders, 48%).

Binge drinking is another measure used to help gauge substance abuse in communities. According to data retrieved from the 2016 Behavioral Risk Factor Surveillance System, approximately 23% of Ontario County adult residents reported binge drinking in the past month (Figure 18). This has risen since 2013-14 (10%).

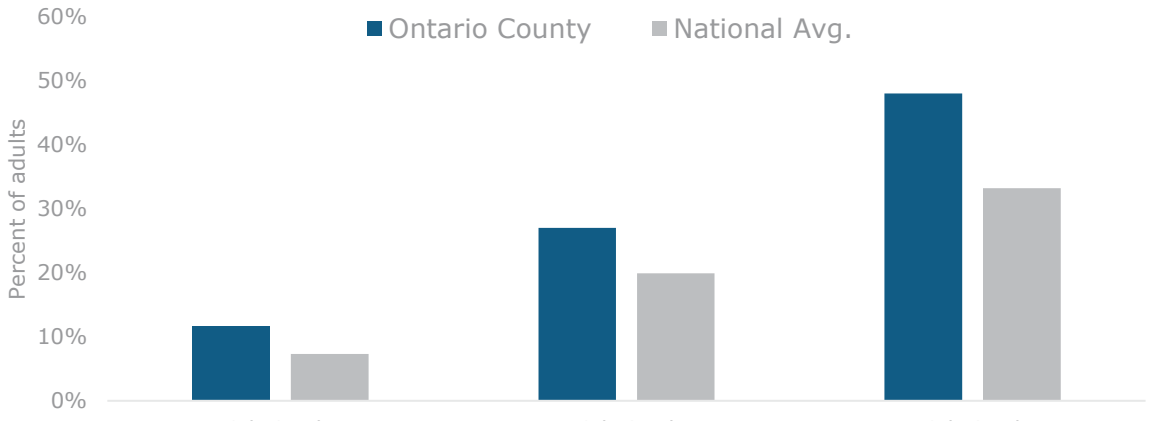
Figure 18: Percent of adults 18+ who reported binge drinking in past month



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

Figure 19 demonstrates the prevalence of alcohol use among youth compared to the national average. You will see that rates for each grade year are higher than the average. According to the survey data, 46% of students reported talking with at least one parent about the dangers of alcohol use in the past year. Similar to findings of talking about drug use, older youth (11-12th graders) were more likely to report talking to parents (48%) as opposed to 7-8th graders (43%).

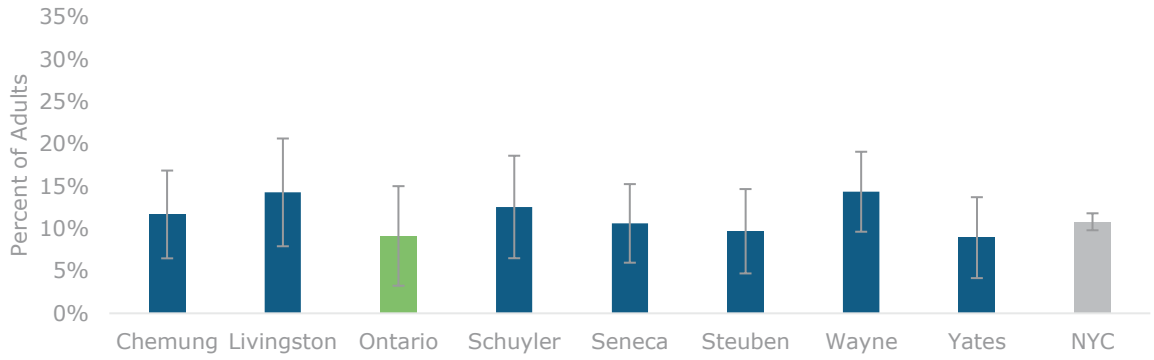
Figure 19: Past 30-day prevalence of alcohol use in Ontario County compared to national average



Data Source: New York Partnership For Success Student Survey, January 2019

Rates of adults reporting poor mental health days in the past month have decreased over the past few years in Ontario County. According to 2016 self-reported data, 9% of its adult residents reported 14+ days with mental health reported as not good in past month (down from 11.7% in 2013-14) Figure 20).

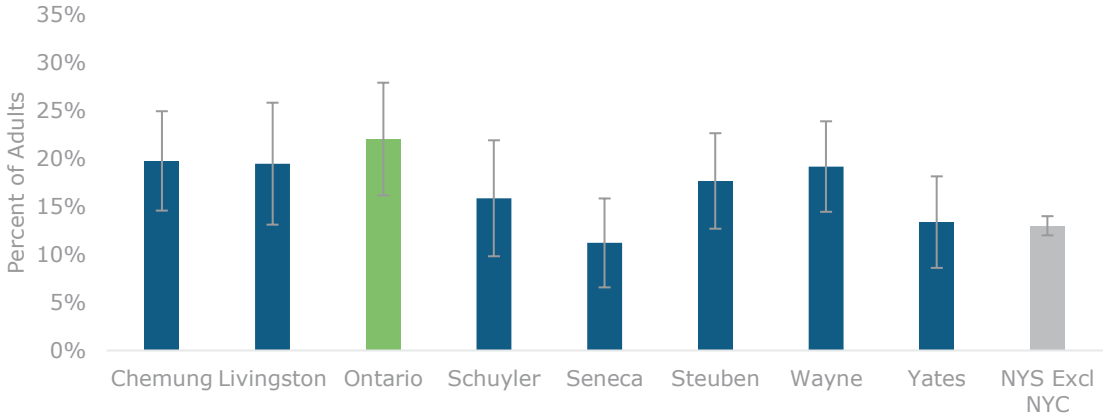
Figure 20: Percent of adults with 14+ days with mental health reported as not good in past month



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

Rates of depressive disorders in Ontario County (22%) are higher than nearby counties (17%) and the rest of NYS excluding NYC (13%). The regional county rates range from 11.2% to 22.0% (Figure 21).

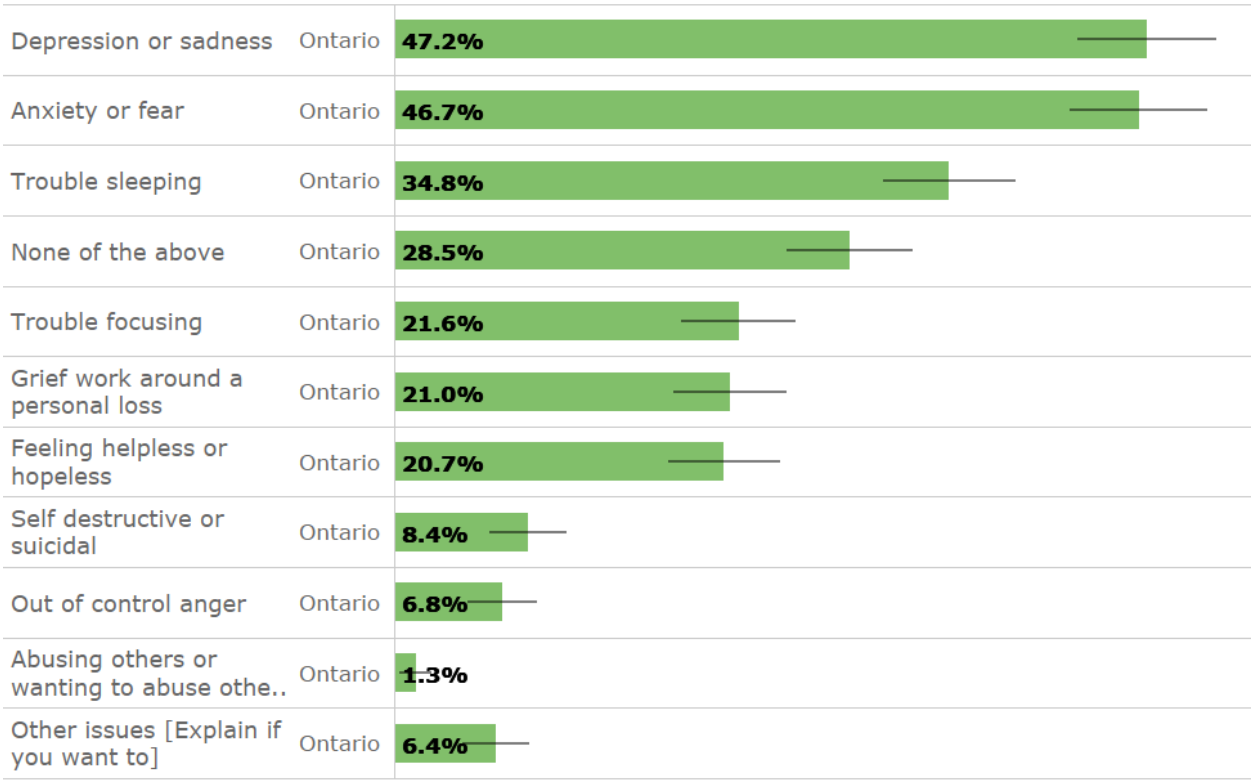
Figure 21: Percent of adults 18+ who have been told they have a depressive disorder



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

According to survey data from My Health Story, almost half of the respondents indicated they have dealt with anxiety, fear, depression or sadness (Figure 22). For those who have dealt with mental or emotional health issues, 77% of survey respondents said they got the help they needed. The most commonly reported support was from doctors, counselors and other mental health professionals followed by support from friends and family.

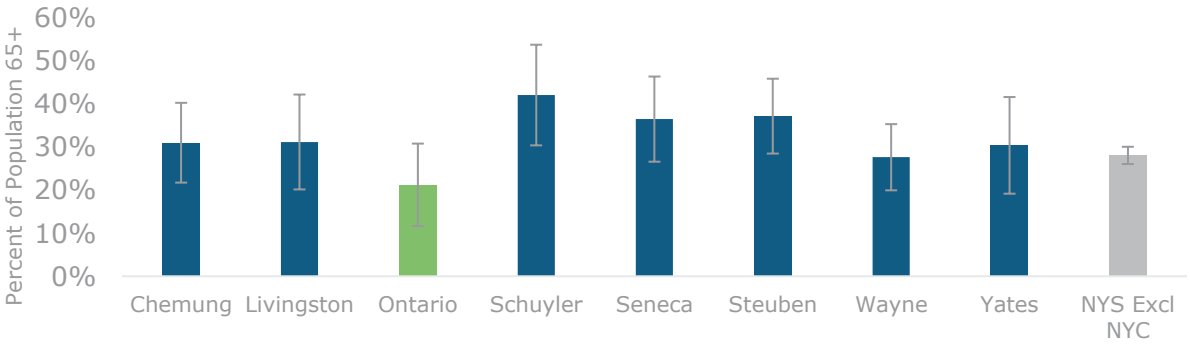
Figure 22: Percent of adults who have personally dealt with each of the following mental or emotional health issues



Built Environment

In Ontario County, falls in the 65+ population decreased from 28% in 2013-14 to 21% in 2016 (Figure 23). Of note, Ontario County had the lowest rate of falls in the 8-county region. The results of falls in the elderly can be devastating. These may include death, decreased life expectancy, chronic pain, loss of mobility and resultant loss of independence. In Ontario County, the Office for the Aging offers evidence-based classed on fall prevention.

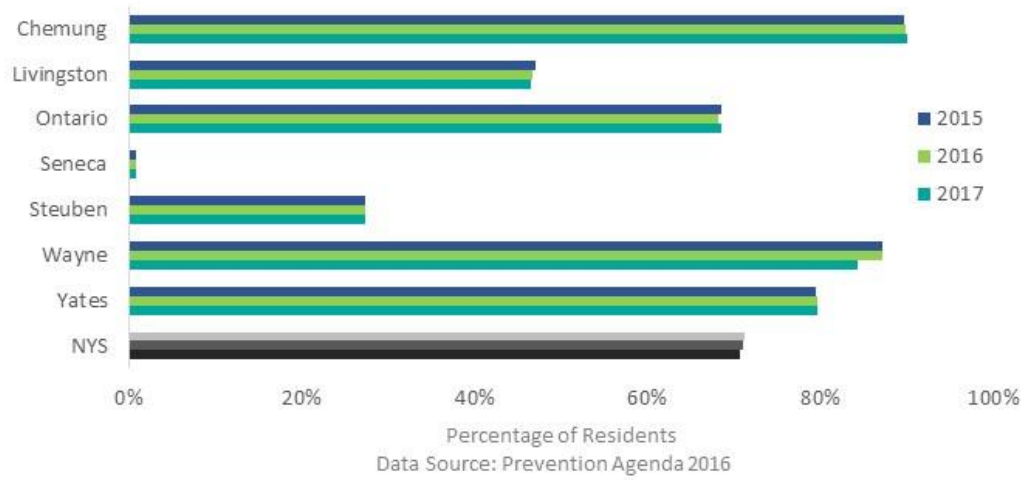
Figure 23: Percent of 65+ population that reported a fall within past 12 months



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

Water quality, as measured by the percentage of residents served by community water systems with optimally fluoridated water has remained at or near 68% for the last three years (Figure 24).

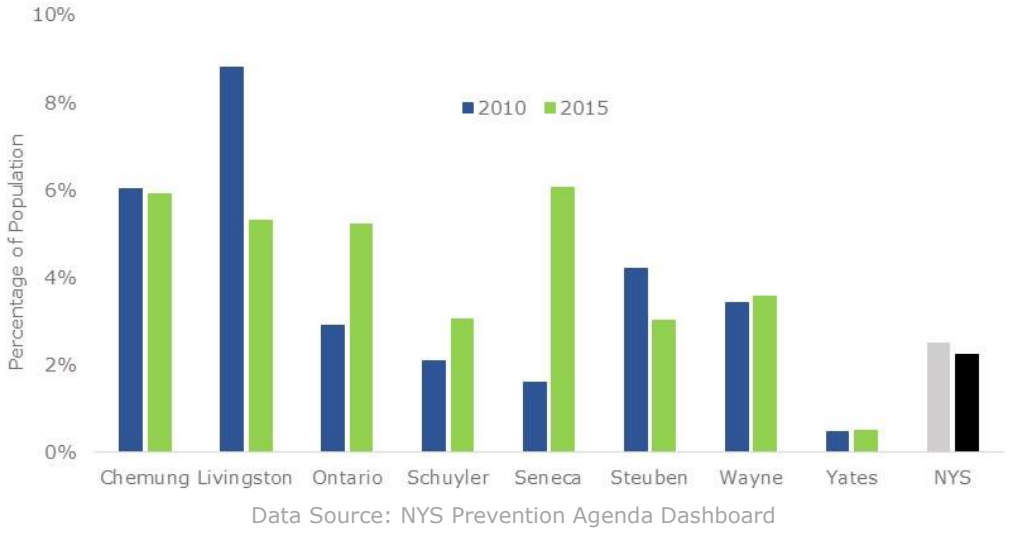
Figure 24: Percent of residents served by community water systems with optimally fluoridated water



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

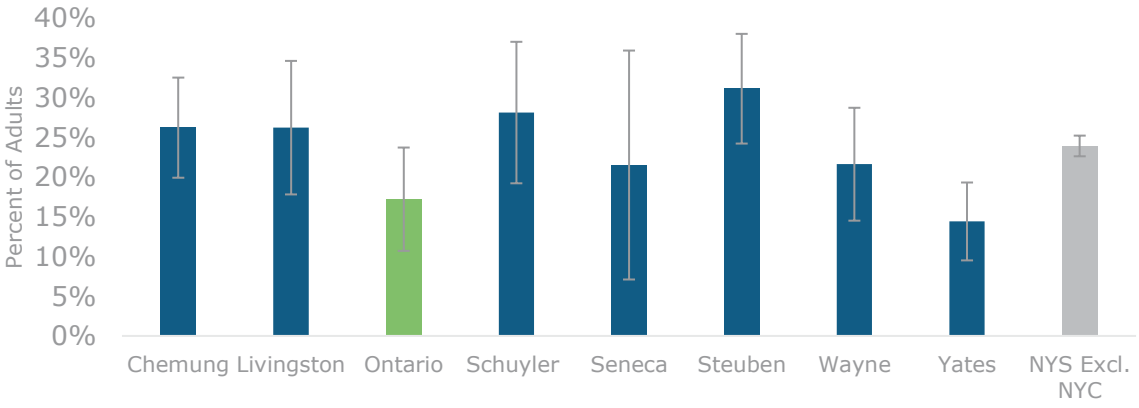
As previously discussed, access to a supermarket or grocery store is important for accessing healthy foods. In Ontario County, 17% of My Health Story respondents indicated the nearest grocery or supermarket store was 20+ minutes away. Estimates reveal that 5% of Ontario County residents are low income and have low access to a grocery store (Figure 25). This has not changed significantly since 2010 (3%). Of note, this is higher than the NYS rates.

Figure 25: Percent of population that is low income and has low access to a supermarket or large grocery store



Reported food insecurity is an identified issue in Ontario County. Over 17% of the population reported experiencing food insecurity in the past 12 months (Figure 26). Of note, 13% of Ontario County's My Health Story survey respondents reported they are always stressed about having enough money to afford healthy food.

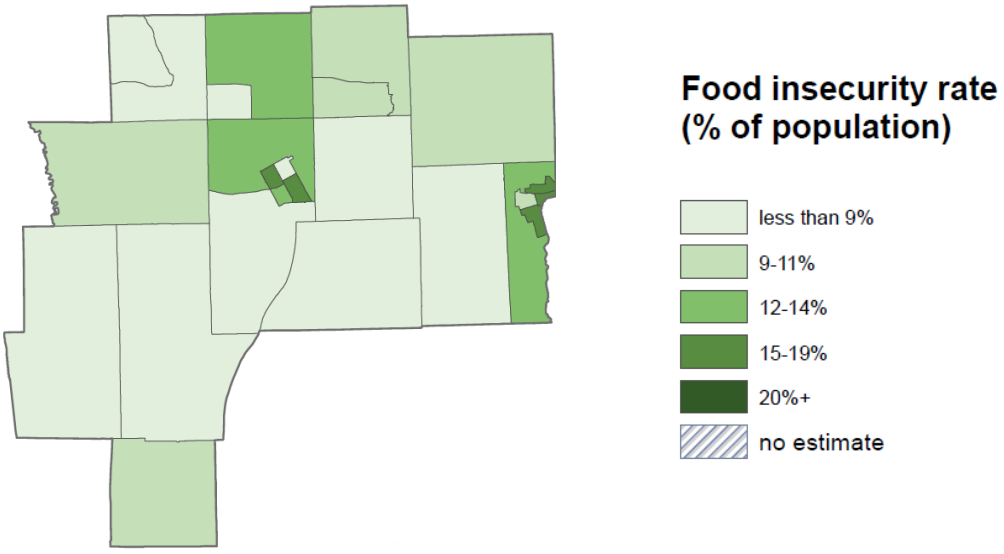
Figure 26: Percent of adults who reported food insecurity in past 12 months



Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2013-2014.

Map 2 shows the food insecurity rates by census tract for Ontario County. Higher rates of food insecurity are found in Geneva and Canandaigua.

Map 2: Food insecurity rate by census tract, Ontario County



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

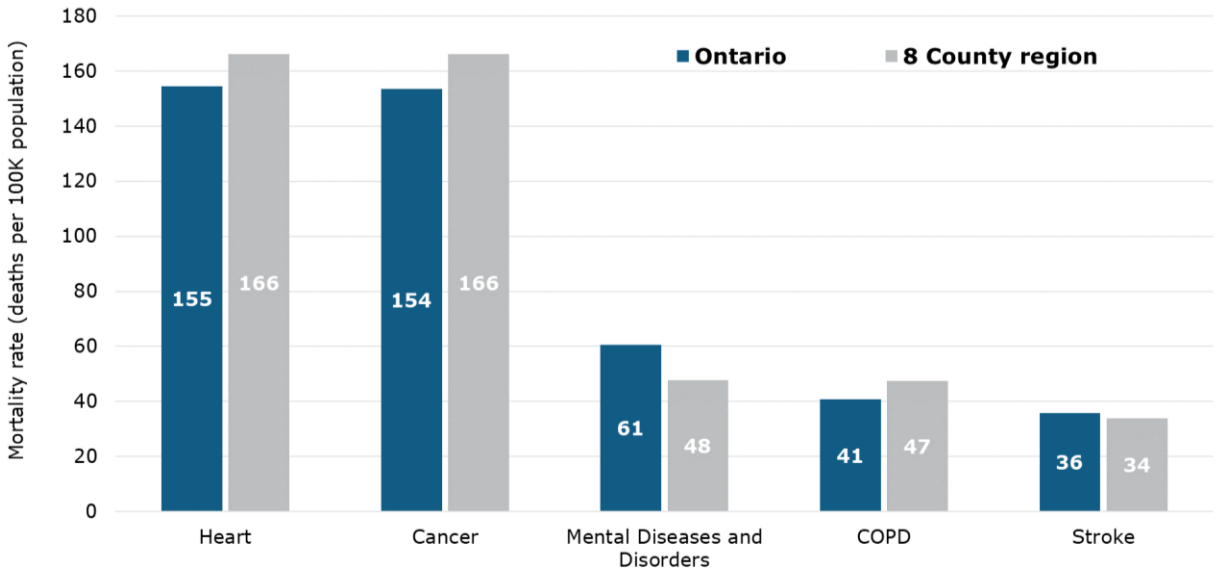
Finally, 27% of Ontario County residents rent vs. own their home. In addition, 8% of occupied housing united have no vehicles available. Another 32% have access to only one vehicle. Of note, the average household size for occupied housing is greater than two people. Approximately 40% of residents are paying 35% of their household income on rent costs. Spending such a significant portion of ones income on housing leaves little room for covering the remainder of basic needs such as healthy foods, medical and dental care.[8]

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

Mortality

The leading causes of death in Ontario County are heart disease and cancer. This is consistent with the 8-county region. Of note, Ontario County has a higher rate of death due to mental diseases and disorders than other counties (Figure 27).

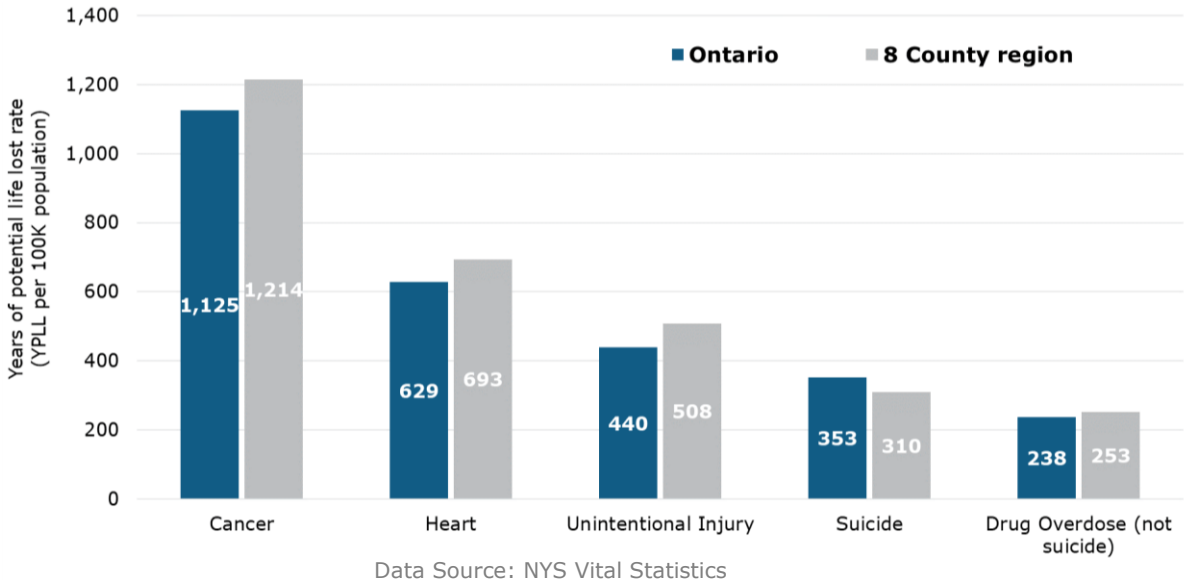
Figure 27: Top 5 causes of mortality within Ontario County (2010-2015)



Data Source: NYS Vital Statistics

Causes of premature mortality in Ontario County are also largely attributed to Cancer and heart conditions (Figure 28).

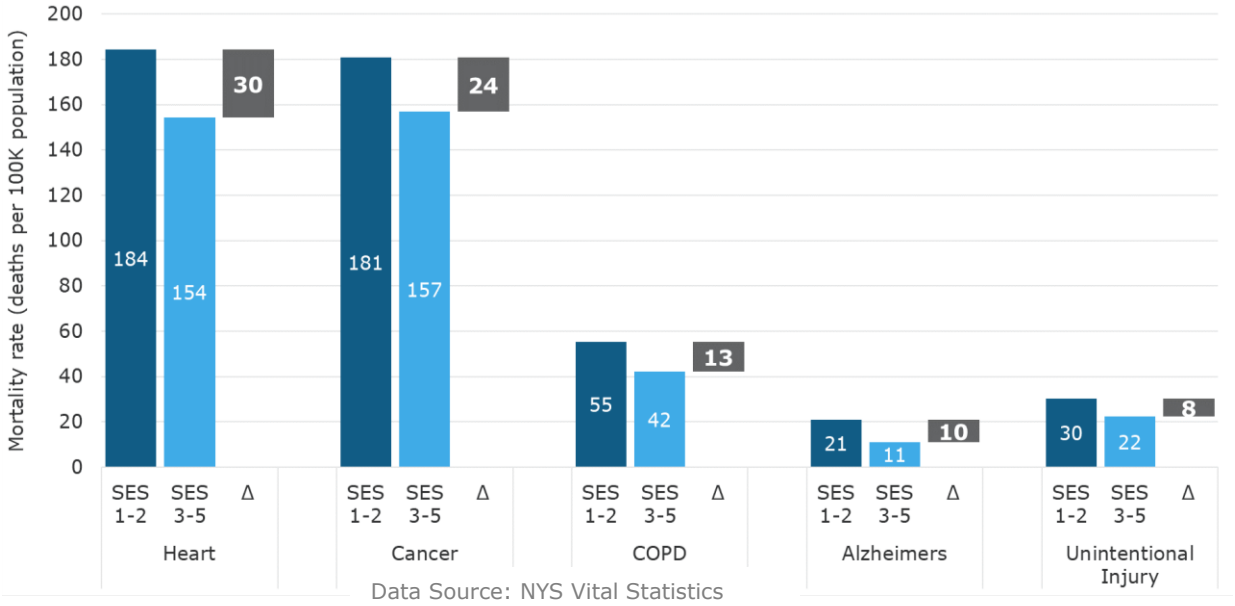
Figure 28: Top 5 causes of premature mortality within Ontario County (2010-2015)



Data Source: NYS Vital Statistics

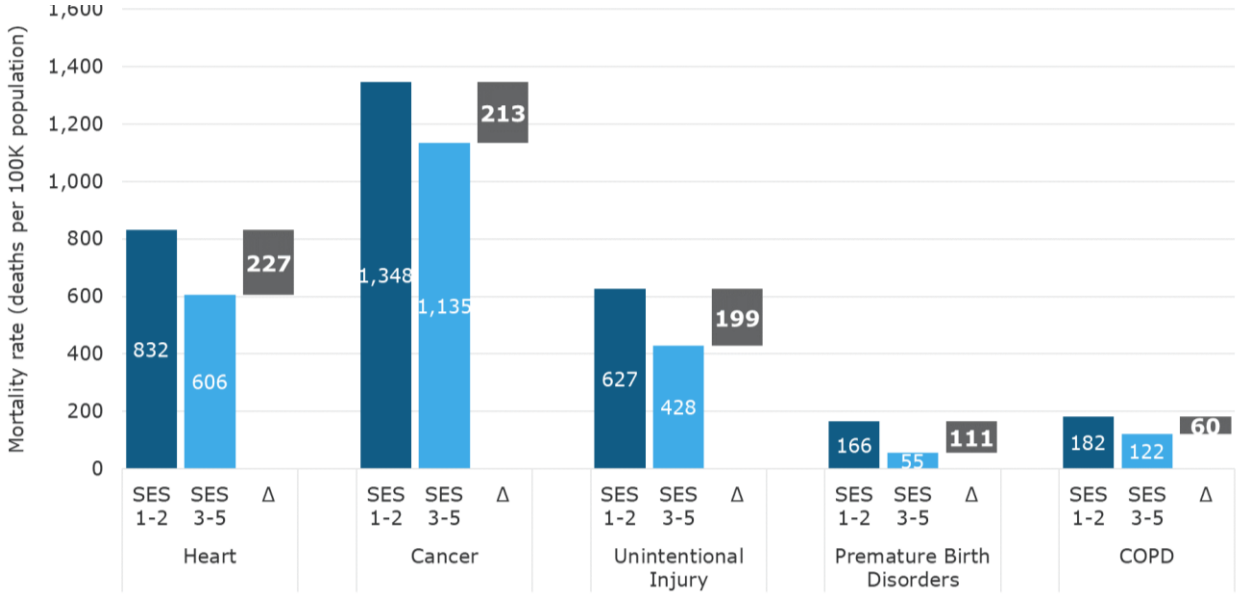
Regionally, there are large disparities in the top causes of mortality and premature death by socioeconomic status as shown in Figure 29 and Figure 30 below. Persons of low socioeconomic status are likely to die earlier than those of higher socioeconomic status. The greatest disparity exists in heart conditions and cancer for both mortality and premature mortality. Of note, cancer mortality is largely driven by lung cancer.

Figure 29: Top 5 causes of mortality rate disparity within 8-county region (2010-2015)



Data Source: NYS Vital Statistics

Figure 30: Top 5 causes of premature mortality rate disparity within 8-county region (2010-2015)



Data Source: NYS Vital Statistics

Summary

New York State has requested an update to the 2016-2018 Community Health Assessment, Community Service Plan and Community Health Improvement Plans. Utilizing the Prevention Agenda, a blueprint to help improve the health and well-bring of NYS residents, local health departments and hospitals have been asked to work together to create updated plans for their community. Local health departments and hospitals are required to select two priority areas from at least one of the five focus areas listed below:

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

In years past, Ontario County has gained insight from key partners, hospital and public health staff, and community members when selecting priority areas. In the 2016-2018 cycle, Ontario County selected as their priority areas: (1) prevent chronic disease and (2) promote mental health and prevent substance abuse.

The update for the 2019-2021 cycle has already begun. Data have been made available in this report for each of the five focus areas. Community members have already begun to provide their input via the *My Health Story 2018* and focus groups conducted by Ontario County Health Department. Results revealed Ontario County residents remain concerned about chronic disease and mental emotional well-being (including weight, substance abuse, and mental health). During focus groups, new recreational drugs, violence, and increasing screen time were all identified as emerging issues.

Keeping in mind the scope of public health services, as well as the breadth and workflow of other public health system entities, consideration must now be made to determine what priority areas Public Health and Hospitals' ought to select for the 2019-2021 Community Health Improvement Plan.

Appendix C

Community Health Assessment: Prioritization Meeting

Finger Lakes Health

ROCHESTER REGIONAL HEALTH

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

UR MEDICINE | THOMPSON HEALTH

Public Health
Prevent. Promote. Protect.

REPRESENTING THE NYS COUNTIES OF:

CHEMUNG, ONTARIO, SCHUYLER, STEUBEN, SENECA, WAYNE & YATES

Common Ground Health

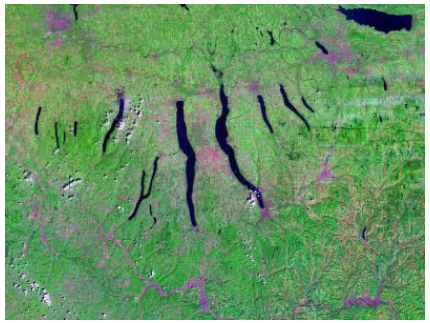
Agenda for Today

- Welcome and Introduction of Participants
- Overview of the Community Health Assessment Process
- Review and Discuss Ontario County Data
- Review of the Process of Prioritization
- Prioritize!
- What Happens Next

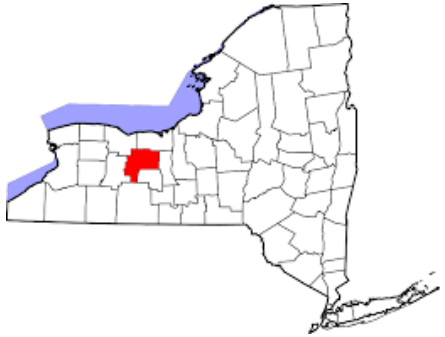
Overview of the Community Health Assessment Process

Why a Community Health Assessment?

New York State Department of Health creates the state plan (“Prevention Agenda”) to set the goals for Public Health.



County Health Departments, health systems and other organizations assess regional and county-specific data in relation to the Prevention Agenda.



Ontario County Public Health Department and the health systems use a Community Health Assessment group to make informed decisions on selection of the new priority areas.

Many Agencies – Working Together under Health & Human Services

NYS Prevention Agenda 2019 - 2024

- Prevent Chronic Diseases
- Promote a Healthy & Safe Environment
- Promote Well-Being & Prevent Mental and Substance Use Disorders
- Prevent Communicable Diseases
- Promote Healthy Women, Infants and Children

The vision - New York is the Healthiest State in the Nation for People of All Ages

The MAPP Process

Organize & Engage Partners

- Bring together key partners

Visioning

- Through NYS DOH “NYS is the Healthiest State in the Nation for People of All Ages”

Collecting & Analyzing Data

- Local Public Health System Assessment
- Community themes & Strengths and Community Health Assessment: My Health Story
- Forces of Change – Focus Groups
- Pre-read overview for Ontario County – Common Ground Health

Identify and Prioritize Strategic Issues

- Hanlon/Pearl Method for Prioritization

Formulate Goals and Strategies and Action Plan

- Using Evidenced-Based programs

Taking and Sustaining Action

- Commit resources and follow through

The NYS Prevention Agenda

Prevent Chronic Diseases

- Physical Activity
- Healthy Eating & Food Security
- Tobacco Prevention
- Preventive Care & Management

Healthy & Safe Environment

- Injuries, Violence and Occupational Health
- Outdoor Air Quality
- Built and Indoor Environments
- Water Quality
- Food and Consumer Products

Well-Being & Prevent Mental and Substance Use Disorders

- Promote Well-Being
- Prevent Mental & Substance Use Disorders

Prevent Communicable Diseases

- Antibiotic Resistance and Healthcare-Associated Infections
- Hepatitis C Virus (HCV)
- Sexually Transmitted Infections (STIs)
- Human Immunodeficiency Virus (HIV)
- Vaccine-Preventable Diseases

Promote Healthy Women, Infants and Children

- Maternal & Women's Health
- Perinatal & Infant Health
- Child & Adolescent Health
- Cross Cutting Healthy Women, Infants & Children

Review and Discuss Ontario County Data

Let's Talk About The Data

- What does the community say about its concerns?
- What does the community say about the public health system in Ontario County?
- What does the community say about issues & concerns needing more attention?
- What does the DATA say about those issues and concerns?

Summary of Health-Related Concerns

Biggest fear - for self
Mental / emotional health issues (14.7%)
Weight (13.5%)
Cost (10.6%)
Cancer (8.5%)
Heart conditions (8.4%)

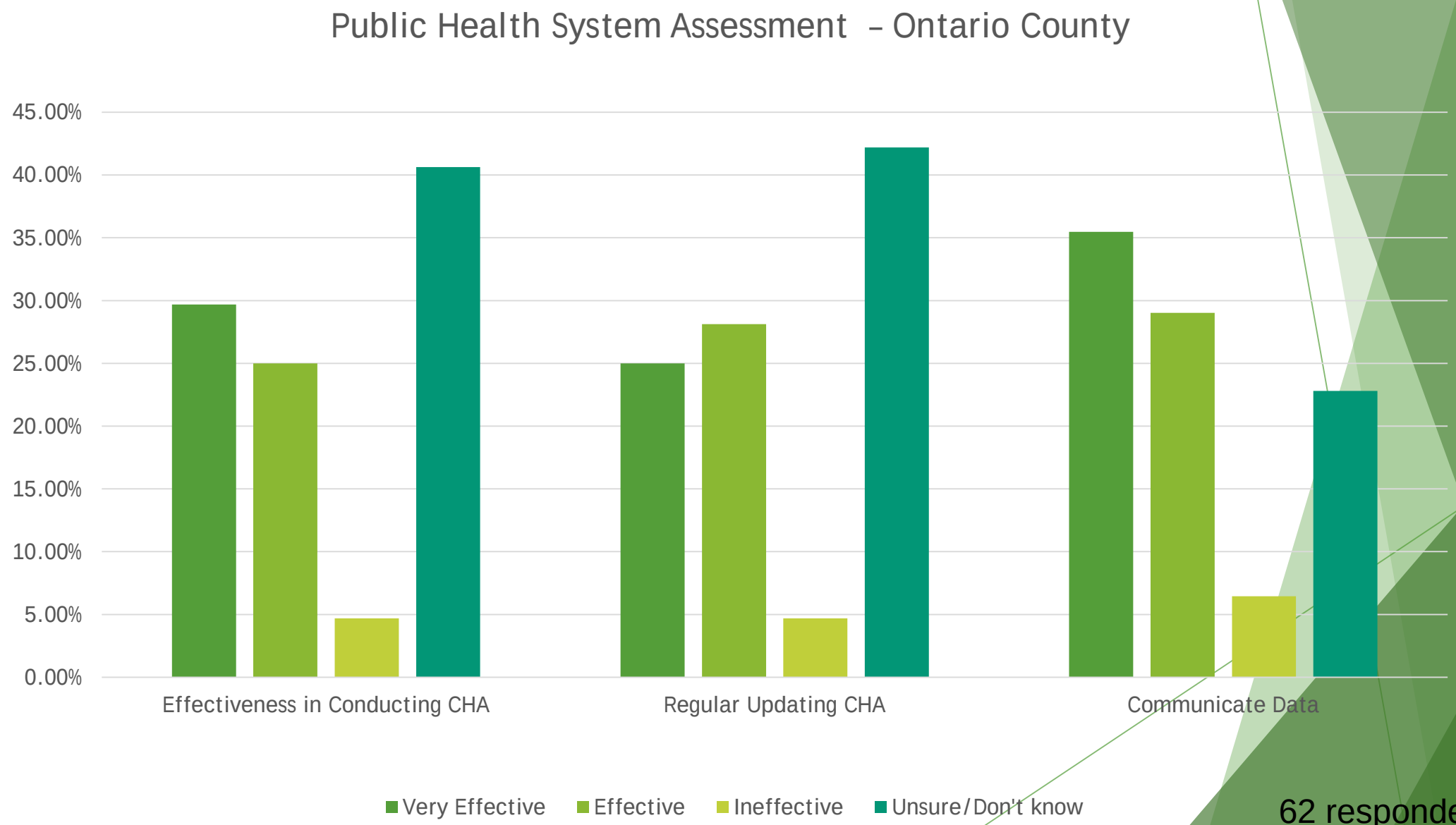
Biggest fear - for others
Mental / emotional health issues (12.1%)
Cost (9.7%)
Cancer (8.8%)
Aging (7.6%)
Weight (7.6%)

County priority - for adults
Mental / emotional health issues (21.8%)
Substance abuse (21.2%)
Cost (17.9%)
Weight (12.3%)
Diet / nutrition (12.3%)

County priority - for children
Diet / nutrition (22.7%)
Mental / emotional health issues (19.7%)
Substance abuse (18.2%)
Exercise (12.1%)
Weight (11.4%)

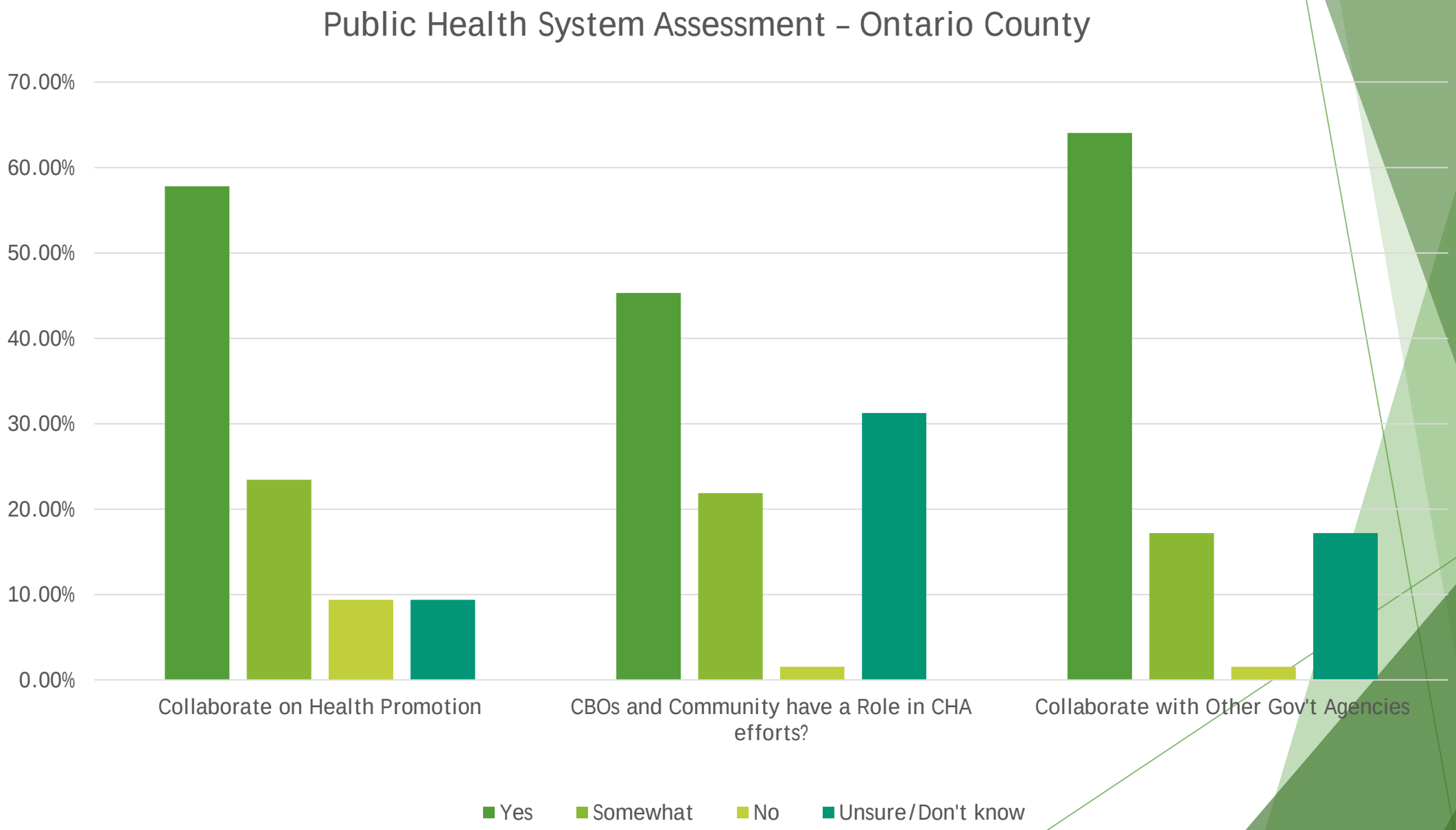
Source: *My Health Story* survey 2018. Analysis by Common Ground Health incorporates weighting to normalize survey participants to demographics of each county. Top 5 issues shown fore each question. Data shown are the percent of participants with responses in each category.

Community Input



62 respondents

Community Input (cont'd)



Summary of Focus Group Feedback

Missing

- Mental health; air and water quality; access to health insurance; sex, drugs and nutrition education.

Trends & Factors

- E-cigarette use and vaping, substance abuse (including CBD oil), and poor transportation

Emerging Issues

- New recreational drugs, violence, and increasing screen time

Assets & Strength

- Environment/surrounding area, area hospitals, social services available, and treatment of transitioning/trans-gender individuals

Barriers

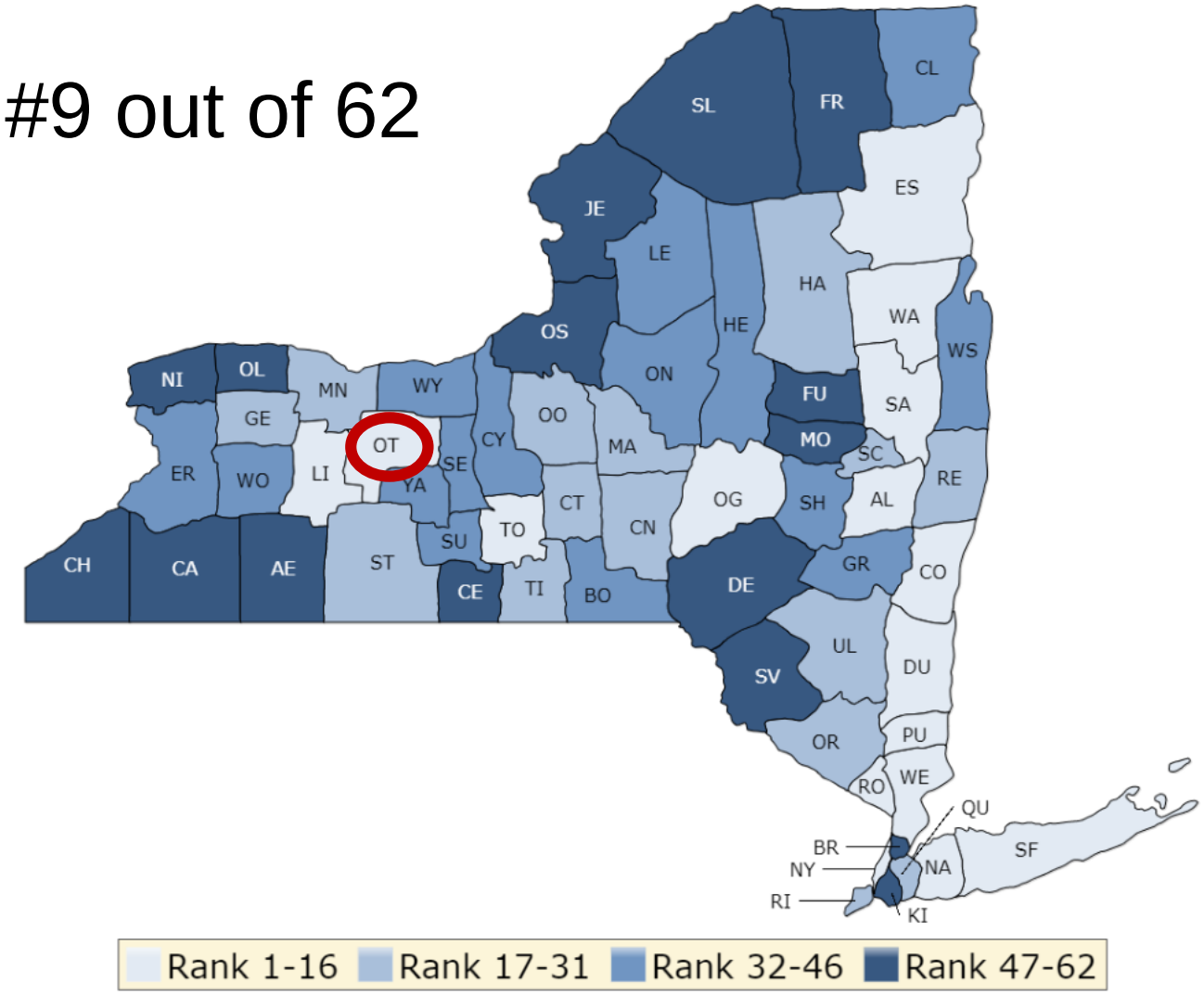
- Lack of access to health/dental care and to health insurance, poor transportation, lack of childcare for 2nd and 3rd shifts, and lack of affordable housing

Gaps

- Mental health providers for youth, recreational resources, and no Narcan training at worksites

Ontario County Health Factor

#9 out of 62



"Health factors in the County Health Rankings represent the focus areas that drive how long and how well we live, including health behaviors (tobacco use, diet & exercise, alcohol & drug use, sexual activity), clinical care (access to care, quality of care), social and economic factors (education, employment, income, family & social support, community safety), and the physical environment (air & water quality, housing & transit)."

Source: Countyhealthrankings.org published March 2019

Quality of Life

From County Health Rankings 2019

	Ontario County	Trend	Error Margin	Top U.S. Performers	New York	Rank (of 62)
Quality of Life						6
Poor or fair health	13%		13-14%	12%	16%	
Poor physical health days	3.2		3.1-3.4	3.0	3.6	
Poor mental health days	3.7		3.5-3.9	3.1	3.6	
Low birthweight	7%		6-7%	6%	8%	

Other Health Outcomes

From County Health Rankings 2019

	Ontario County	Trend	Error Margin	Top U.S. Performers	New York
Life expectancy	80.0		79.5-80.5	81.0	81.2
Premature age-adjusted mortality	290		280-310	280	280
Child mortality	40		30-50	40	40
Infant mortality	4		3-6	4	5
Frequent physical distress	10%		9-10%	9%	11%
Frequent mental distress	11%		11-11%	10%	11%
Diabetes prevalence	11%		9-13%	9%	10%
HIV prevalence	104			49	769

Health Behaviors

From County Health Rankings 2019

	Ontario County	Trend	Error Margin	Top U.S. Performers	New York
Adult smoking	18%		17-18%	14%	14%
Adult obesity	32%		29-36%	26%	26%
Food environment index	8.6			8.7	9.1
Physical inactivity	22%		19-25%	19%	25%
Access to exercise opportunities	81%			91%	93%
Excessive drinking	21%		21-22%	13%	19%
Alcohol-impaired driving deaths	22%		15-29%	13%	21%
Sexually transmitted infections	314.9			152.8	552.8
Teen births	12		11-14	14	16

Other Health Behaviors

From County Health Rankings 2019

	Ontario County	Trend	Error Margin	Top U.S. Performers	New York
Food insecurity	9%			9%	12%
Limited access to healthy foods	5%			2%	2%
Drug overdose deaths	16		12-21	10	17
Motor vehicle crash deaths	10		8-13	9	6
Insufficient sleep	32%		32-33%	27%	37%

Social & Economic Factors

From County Health Rankings 2019

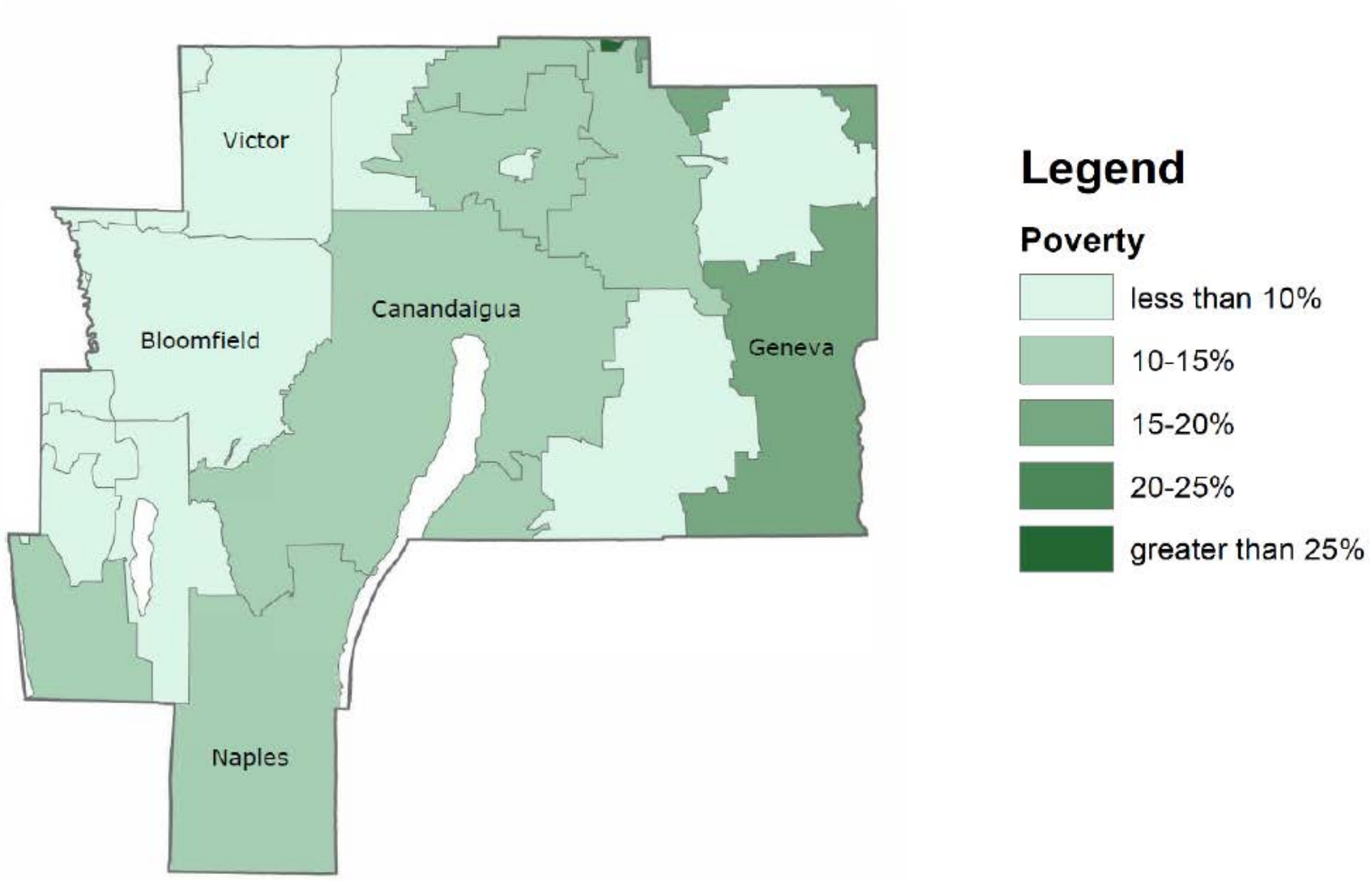
	Ontario County	Trend	Error Margin	Top U.S. Performers	New York	Rank (of 62)
Social & Economic Factors						5
High school graduation	90%			96%	82%	
Some college	73%		69-76%	73%	68%	
Unemployment	4.5%			2.9%	4.7%	
Children in poverty	13%		10-17%	11%	20%	
Income inequality	4.2		3.9-4.4	3.7	5.7	
Children in single-parent households	30%		27-34%	20%	34%	
Social associations	9.6			21.9	8.0	
Violent crime	153			63	379	
Injury deaths	56		50-62	57	47	

Physical Environment

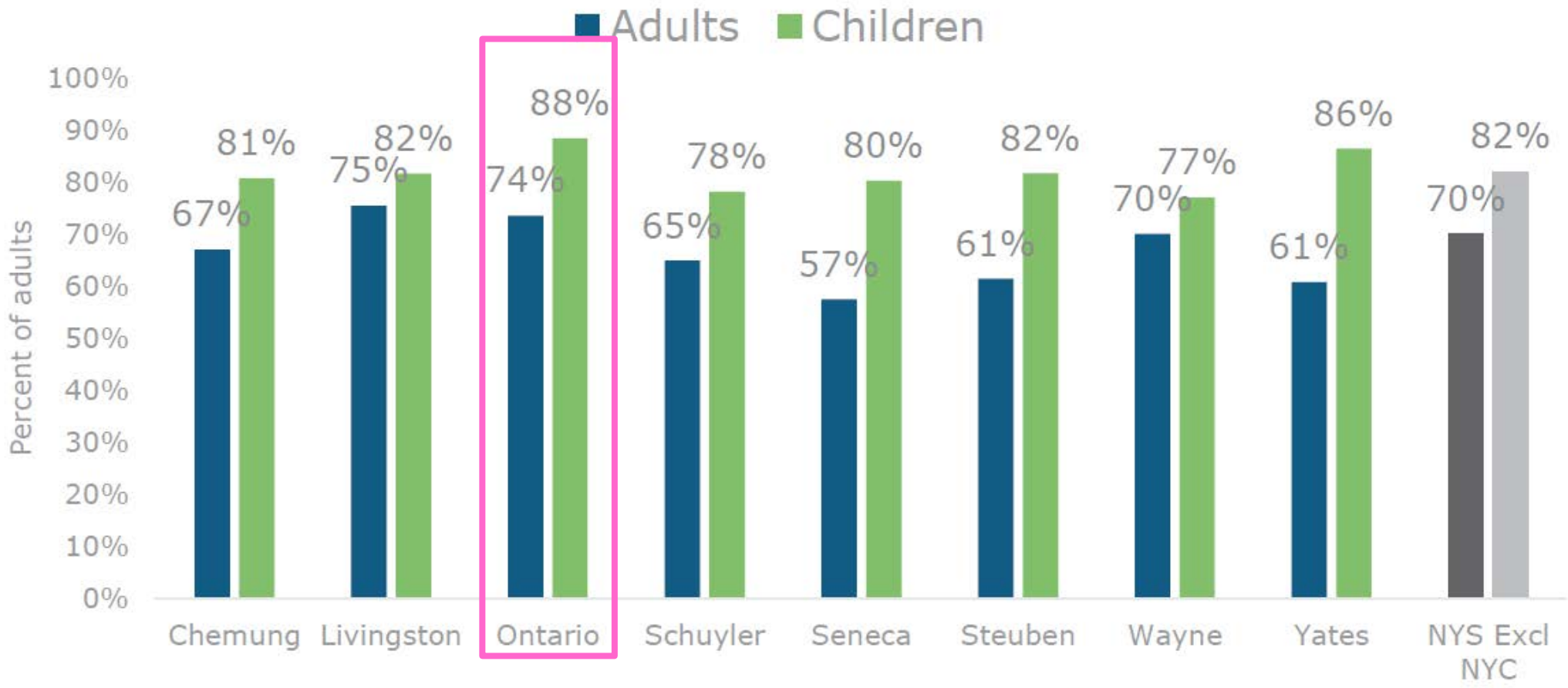
From County Health Rankings 2019

	Ontario County	Trend	Error Margin	Top U.S. Performers	New York	Rank (of 62)
Physical Environment						**39**
Air pollution - particulate matter	8.5			6.1	8.5	
Drinking water violations	Yes					
Severe housing problems	14%		12-15%	9%	24%	
Driving alone to work	83%		82-84%	72%	53%	
Long commute - driving alone	34%		32-36%	15%	38%	

Poverty Rates by ZIP Code

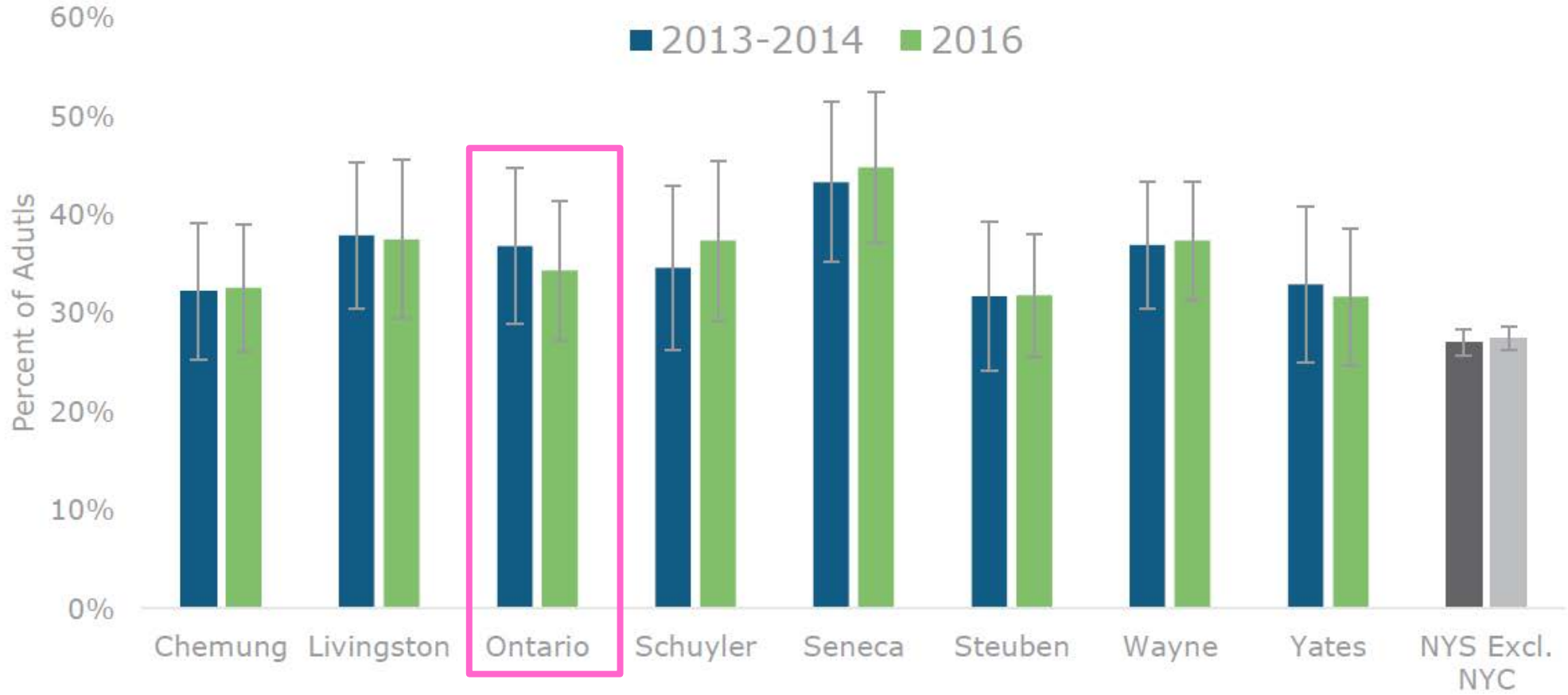


% of Residents Visiting Dentist – Last 12 months



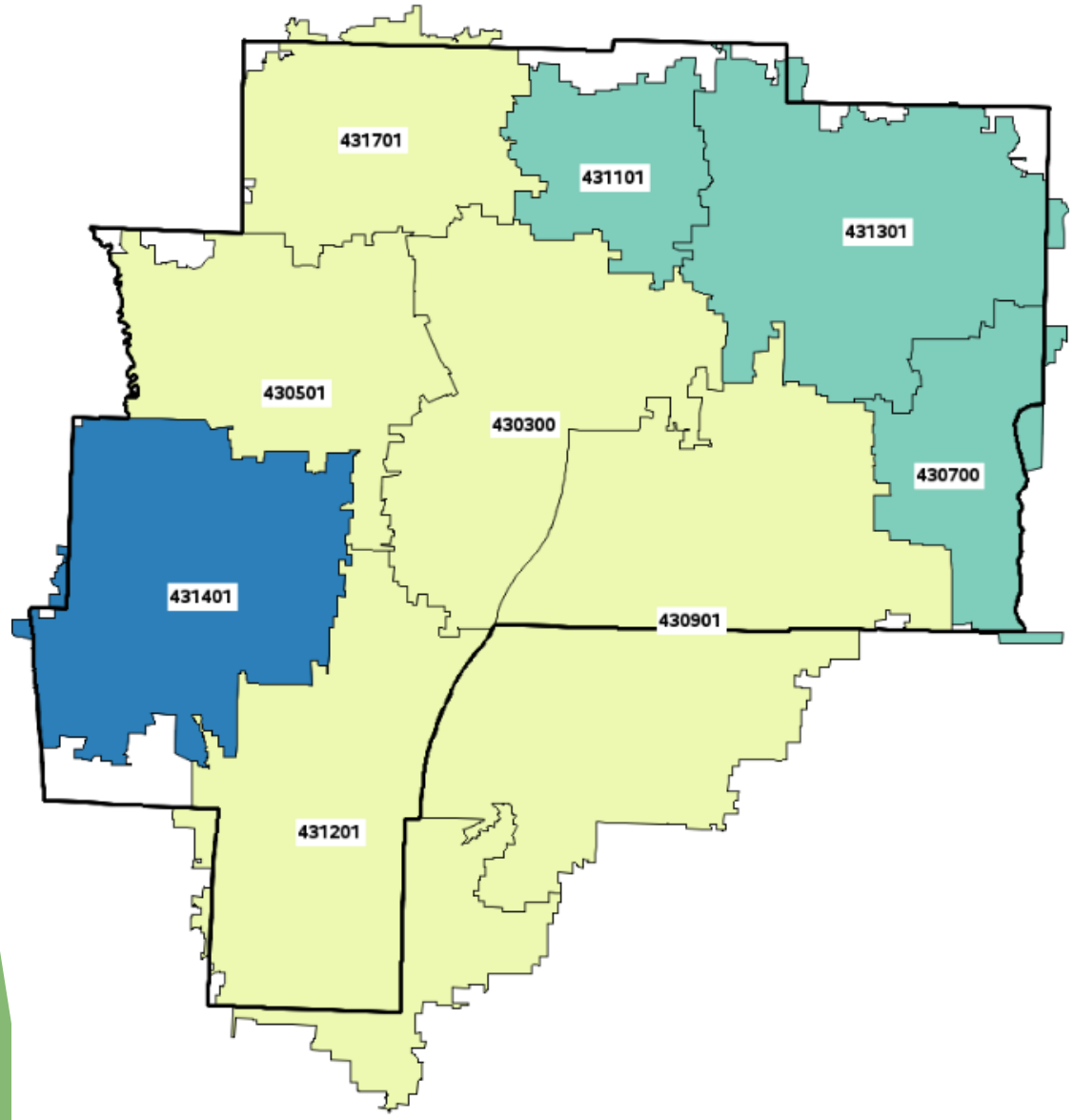
Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health. Children's data

% of Adults Classified as Obese



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

Percentage of Children Who Are Obese



Children and adolescents obesity rate

Ontario County - 15.5

New York State (Excl NYC) - 17.3

Quartile (Q) Distribution (Excl NYC)

- 0 < 17.6 : Q1 & Q2
- 17.6 -< 21.5 : Q3
- 21.5+ : Q4

Student Weight Status Category Reporting System (SWSCRS) data as of May 2017; NYC: NYC Fitnessgram data as of January 2018

New York State County Comparison - Prevention Agenda Indicators Table

Prevention Agenda (PA) Indicator	Data Years	PA 2018 Objective	Ontario		Finger Lakes	
			Count	Rate	Count	Rate
			Rate	Ratio	Rate	Ratio
			Percentage	Percentage	Percentage	Percentage
Improve Health Status and Reduce Health Disparities						
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	2016	90.8		**89.6**		87.3
Promote a Healthy and Safe Environment						
Rate of occupational injuries treated in ED per 10,000 adolescents - Aged 15-19 years	2014	33	38	**51.5**	209	23.6
Percentage of residents served by community water systems with optimally fluoridated water	2017	78.5	61,970	**68.5**	1,012,536	87.1
Prevent Chronic Diseases						
Percentage of adults who are obese	2016	23.2		**34.3**		33.5
Percentage of cigarette smoking among adults[b]	2016	12.3		**21.9**		18.4
Percentage of adults who received a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years[b]	2016	80		**67**		74
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years	2012-2014	4.86	166	**6.4**	2,537	8.4

New York State County Comparison - Prevention Agenda Indicators Table

Prevention Agenda (PA) Indicator	Data Years	PA 2018 Objective	Ontario		Finger Lakes	
			Count	Rate	Count	Rate
			Rate	Ratio	Rate	Ratio
			Percentage	Percentage	Percentage	Percentage
Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections						
Percentage of children with 4:3:1:3:3:1:4 immunization series - Aged 19-35 months	2016	80	953	**68.6**	13,546	71.1
Percentage of adolescent females that received 3 or more doses of HPV vaccine - Aged 13-17 years	2016	50	1,566	**47.6**	22,779	52
Gonorrhea case rate per 100,000 women - Aged 15-44 years	2016	183.4	36	**189.7**	1,099	458.8
Promote Healthy Women, Infants, and Children						
Percentage of children aged 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs	2016	91.3	1,141	**85.1**	16,092	82.4
Promote Mental Health and Prevent Substance Abuse						
Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	2016	10.1		**12.4**		12.2
Age-adjusted percentage of adults binge drinking during the past month	2016	18.4		**23.3**		18.6
Age-adjusted suicide death rate per 100,000 population	2014-2016	5.9	47	**12.4**	422	10.6

Review of the Process of Prioritization

Your Role in this Meeting

- You will be asked your input based on your *experience* regarding potential priority areas based upon data and community feedback
- You were provided a document with all the tools necessary to participate in the meeting including:
  - Public Health's and hospitals role in community health
  - A brief summary of the Prevention Agenda
  - A summary of community input already received; and
  - Data regarding county demographics and health indicators
- Before we begin the prioritization process – are there any questions on the information provided?

The NYS Prevention Agenda

Prevent Chronic Diseases

- Physical Activity
- Healthy Eating & Food Security
- Tobacco Prevention
- Preventive Care & Management

Healthy & Safe Environment

- Injuries, Violence and Occupational Health
- Outdoor Air Quality
- Built and Indoor Environments
- Water Quality
- Food and Consumer Products

Well-Being & Prevent Mental and Substance Use Disorders

- Promote Well-Being
- Prevent Mental & Substance Use Disorders

Prevent Communicable Diseases

- Antibiotic Resistance and Healthcare-Associated Infections
- Hepatitis C Virus (HCV)
- Sexually Transmitted Infections (STIs)
- Human Immunodeficiency Virus (HIV)
- Vaccine-Preventable Diseases

Promote Healthy Women, Infants and Children

- Maternal & Women's Health
- Perinatal & Infant Health
- Child & Adolescent Health
- Cross Cutting Healthy Women, Infants & Children

The Hanlon Method Overview

- 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

(A + 2B) x C

A = Size of the problem

B = Seriousness of the problem

C = Effectiveness of the solution

(weighted by PEARL Factors)

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.

The Hanlon Method – How It's Used

(A + 2B) x C

A

% 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

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

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

“C” – Effectiveness of Interventions

- The Community Health Improvement Plan must use EVIDENCE-BASED programs to address the priorities chosen
- Example: If we choose Tobacco Cessation – here are the interventions we can choose from:
  - Assist medical and behavioral health care organizations and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers, Community Health Centers and behavioral health providers
  - Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline.
  - Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment.
  - Promote Medicaid and other health plan coverage benefits for tobacco dependence counseling and medications.

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?

Prioritize!

The NYS Prevention Agenda

Prevent Chronic Diseases

- Physical Activity
- Healthy Eating & Food Security
- Tobacco Prevention
- Preventive Care & Management

Healthy & Safe Environment

- Injuries, Violence and Occupational Health
- Outdoor Air Quality
- Built and Indoor Environments
- Water Quality
- Food and Consumer Products

Well-Being & Prevent Mental and Substance Use Disorders

- Promote Well-Being
- Prevent Mental & Substance Use Disorders

Prevent Communicable Diseases

- Antibiotic Resistance and Healthcare-Associated Infections
- Hepatitis C Virus (HCV)
- Sexually Transmitted Infections (STIs)
- Human Immunodeficiency Virus (HIV)
- Vaccine-Preventable Diseases

Promote Healthy Women, Infants and Children

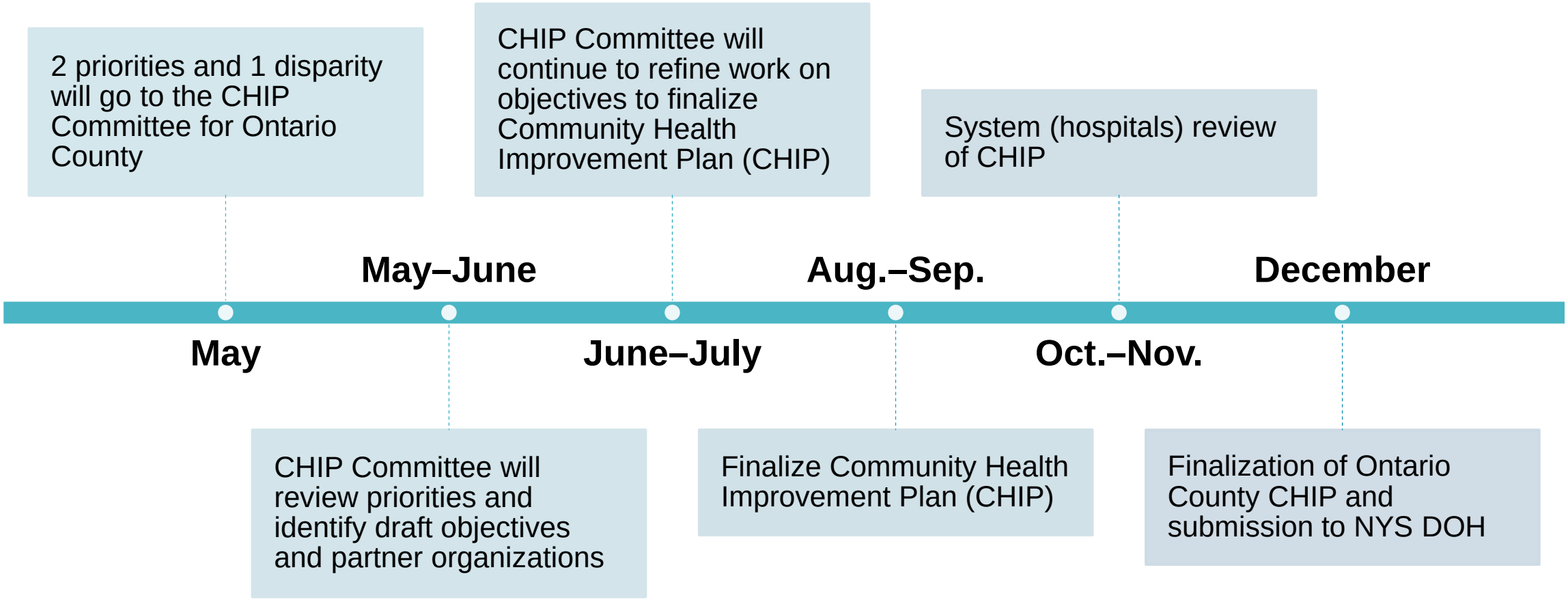
- Maternal & Women's Health
- Perinatal & Infant Health
- Child & Adolescent Health
- Cross Cutting Healthy Women, Infants & Children

Now It's Time To Prioritize...

- Use your best judgment
- Ask questions
- Use the Prevention Agenda Overview

What Happens Next?

What happens from here?



THANK YOU!

Public Health
Prevent. Promote. Protect.
Ontario County

Appendix D

Priority Setting Meeting
May 10, 2019

Choose Health Ontario

Name	Affiliation + email
Kate Ott	OC Pub. Health Kate.Ott@co.ontario.ny.us
Mary Krause	OC County Administrator mary.krause@co.ontario.ny.us
Tina Acevedo	UR Medicine / Thompson Health
Janette Aruck	FLCC Janette.aruck@FLCC.edu
Kathi Lynch	Common Ground Health
Christine Lotz Ciewski	OC Pub. Health
Holly Adams	holly.adams@co.ontario.ny.us
Danielle Tilden	danielle.tilden@flacra.org
Todd Freelove	Todd@CSAYnet.org
Ellen Wayne	ellen.wayne@dor.org (Coth. Health)
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David Halter	dhalter@GWCSC.com
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Kristy Wells	Kwells@gwLisk.com
Lora Turbide	VP Community Engagement Finger Lakes Health lora.turbide@fingerlakeshealth.org
John Shanahan MD	
Ellen Polimeni	City Canandaigua Ellen.Polimeni@Canandaiguanewyork.gov

OVER

Public Health
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Ontario County

Choose Health Ontario

Priority Setting Meeting
May 10, 2019

Please include Email

Name	Affiliation + email
Michael Tyman	Finger Lakes Health Michael.Tyman @flhealth.org
Jean Jackson	Thompson Hosp
Jerry Bennett	FL- Prevention Res-Ctr
Rick Ammoson	Smola Consulting
Annie Wells	Lifespan
Patricia Dhanti-Campbell	Ontario County
Christy Richards	OCPH
Vivian Russell STOPDWI	STOP DWI VIVIAN.RUSSELL@CO.ONTARIO.NY.US
Hannah Farley	Cancer Services Program FLR
Sue Mook	Geneva Head Start smook@genevacsd.org
Kristina Hawes	UR CCHP
Brigid Heenan	TACFL brigid.heenan@tangi.org
Tracey Clark	Fidelis Care
Marcy Lenhardt	Substance Abuse Prevention Coalition
Angela Allen	Private Therapist atallen26@gmail.com
Stephanie Chalupa	URMHC Stephanie-Chalupa@URMC.Rochester.edu
Jim Sutton	RRH

OVER

PublicHealth
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Ontario County

Priority Setting Meeting
May 10, 2019

Choose Health Ontario

Name	Affiliation (EMAIL at)
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David Sharman	City of Geneva dsharman@geneva.ny.us
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Kim Ferguson	DOPH
Andrea Snyder	asnyder@pls-net.org Pioneer Library System
Bethany DiSanto	New York Kitchen bethany.disanto@cbrands.com
Kerry Graff	Rochester Regional Health

OVER

ONTARIO COUNTY CHIP/CSP CHART 2019

Priority Area: Prevent Chronic Diseases					
Focus Area 1. Healthy Eating & Food Security					
Goal 1.1 Increase access to healthy and affordable foods and beverages					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No					**Timeframe**: To be completed 12/31/22
Outcome Objectives - NYSPA	**NYSPA Interventions**	**Process Measures**	**Partners and Roles**		**Partner Resources**
Objective 1.2 Decrease the percentage of children with obesity (among public school students in NYS exclusive of NYC) Target 16.4% Baseline 17.3% (2014-16) Data Source SWSCR Data Level State, school district	**Intervention 1.0.4 Multi-component school-based obesity prevention interventions, including:** o **Providing healthy eating learning opportunities** o **Participating in Farm to School Programs**	1. # Healthy eating learning sessions held in schools 2. # students reached with nutrition/exercise progrmaming 3. # schools engaged on Farm to Table Coalition 4. % eligible schools trained in CATCH	UR Thompson Health (URTH)	Provide healthy eating learning opportunities in schools and daycares: Get Up! Fuel Up! and Eat Your Colors	GUFU $1,420/yr EYC $,2300/yr
			Ontario County Public Health (OCPH)	Provide healthy eating learning opportunities in the community, including schools	Staff 0.25 FTE $13,918
			Finger Lakes Eat Smart New York (FLESNY)	1. Provide school-based healthy eating learning opportunities 2. Train eligible schools in CATCH.	Total $12,232 Time $11.232, 0.3 FTE Supplies $1,000
			Regional Farm to Table Coalition	Engage schools re utilization of locally grown foods	N/A
Objective 1.4 Decrease the percentage of adults ages 18 years and older with obesity (among all adults) Target 24.2% Baseline 25.5% (2016) **25.7% (2017)** Data Source BRFSS Data Level State and County Objective 1.5 Decrease the percentage of adults ages 18 years and older with obesity (among adults with an annual household	**Ontario County Specific Intervention: Increase availability of fruits, vegetables and other healthy foods in the community and at food pantries**	1. # food pantry patrons reached with messages about healthy food choices (2 sites) 2. # food pantries participating in Nourish Your Neighbor 3. # pounds fruits and vegetables gleaned and distributed 4. # served by RTS food pantry/grocery store routes	OCPH	1. Participate in regional Farm to Table Coalition 2. Parrticipate in Food Pantry Committee 3. Provide heatlth/nutrition education at 2 food pantries 4. Provide Nourish Your Neighbor (NYN) materials to food pantries, Scouts and United Way	**Total: $8,360** Farm to Table $360 Food Pantry Committee & Ed $2000 NYN time & materials-$6,000
			URTH	Provide on-site mobile food pantries	N/A
			Finger Lakes Health (FLH)	Provide seasonal farmers markets, weekly at the Jim Dooley Child Care Center (FLH Campus)	

income of <$25,000) Target 29.0% Baseline 30.5% (2016) **31% (2017)** Data Source BRFSS Data Level State and County Objective 1.9 Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among all adults) Target 29.6% Baseline 31.2% (2016) Data Source BRFSS Data Level State and County			Finger Lakes Community College (FLCC)	1. Host healthy food prep classes 2. Food Pantry Committee 3. Utilize "food rescue opportuities" 4. Campus food pantry for students 5. Consider grants to support efforts in food insecurity among students 6. Coordinate with Food Justice of Geneva, Inc. re opportunities for fresh produce	**Total: 1.04 FTE's** Classes 0.01 Committee 0.50 "food rescue" 0.01 Campus pantry 0.50 Consider grants 0.01 Coordinate with Food Justice of Geneva 0.01
			Regional Transit System (RTS)	Provide designated routes to food pantries & grocery stores for those in food desserts or with other barriers to accessing healthy foods	$15,000-$20,000
			Churches	Host food pantries Distribute gleaned foods to congregants	N/A
			Food Pantries	Participate in educational programming, display NYN materials and accept/distribute healthy foods provided	N/A
			S2AY Rural Health Network	Seek out funding to: 1. Support Farm to Table Coalition, including work with schools 2. Provide Nourish Your Neighbor, regionally	1. 0.1 FTE 2. 1 FTE
			Food Justice of Geneva, Inc.	Glean fruits and vegetables and make available to food pantries, churches and low income neighborhoods	**Total: $83,350** $5250 Rent & electric $3100 Insurance $12000 Van & gas $1000 Supplies $2000 Stipends $60,000 Labor

			FLESNY	1. Participate in regional Farm to Instituion Coalition 2. Provide community education and demos Participate in Food Pantry Committee 3. Provide heatlth/nutrition education and food demonstrations at food pantries and in the community. 4. Provide the Fruit and Vegetable Rx program	See intervention 1.0.4

Priority Area: Prevent Chronic Diseases					
Focus Are 3: Tobacco Prevention					
Goal 3.1 Prevent initiation of tobacco use					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No				**Timeframe**: To be completed 12/31/22	
Outcome Objectives - NYSPA	**NYSPA Interventions**	**Process Measures**	**Partners and Roles**		**Partner Resources**
3.1.1 Decrease the prevalence of any tobacco use by high school students Target: 19.7% Baseline: 25.4% (2016) Data Source: NYS YTS Data Level: State 3.1.3 Decrease the prevalence of vaping product use by high school students Target: 15.9% Baseline : 20.6% (2016) Data Source: NYS YTS	**3.1.2 Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.**	1. #Press releases related to dangers of tobacco 2. #PSA's, interviews, LTE's 3. #Community education sessions on tobacco 4. #Schools whose students received tobacco and vaping education	Media	Respond to PR's , print LTE's and guest essays, air PSA's.	N/A
			Tobacco Action Coaltion of the Finger Lakes (TACFL)	Write LTE's, participate in interviews, use social media, work with youth and schools	0.5 FTE's for all interventions related to Goal 3.1.
			OCPH	Develop unified messaging, educate community members/schools use social media, write PR's and PSA's	0.10 FTE
			Schools	Provide venues for community and youth education	N/A

Data Level: State 3.1.6 Increase the number of municipalities that adopt retail environment policies, including those that restrict the density of tobacco retailers, keep the price of tobacco products high, and **prohibit the sale of flavored tobacco products** Target 30 Baseline 15 (2018) Data Source CAT Data Level State	**3.1.5 Decrease the availability of flavored tobacco products including menthol flavors used in combustible and non-combustible tobacco products and flavored liquids including menthol used in electronic vapor products.**	1. #Local laws/policies passed related to tobacco retail environment, including sale of flavored tobacco products (ENDS/EDDs) 2. # Governement officials educated	Local government	Adoption of local laws regulating the availability of flavored vaping liquids	N/A
			TACFL	Education of local government officials regarding vaping & assistance with development of legislation	See Intervention 3.1.2
			OCPH	Education of local government officials and advocacy for regulation of flavored vaping products	N/A
	3.1.3 Pursue policy action to reduce the impact of tobacco marketing in lower-income and racial/ethnic minority communities, disadvantaged urban neighborhoods and rural areas.	1. #Local laws passed 2. # Governement officials educated	Local government	Adoption of local laws regulating the availability of flavored vaping liquids.	N/A
			TACFL	Education of local and state government officials regarding tobacco marketing.	See Intervention 3.1.2
			OCPH	Education of local government officials and advocacy for regulation of tobacco marketing.	N/A

Priority Area: Prevent Chronic Diseases

Focus Are 3: Tobacco Prevention

Goal 3.2 Promote tobacco use cessation (Adults)

Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No **Timeframe**: To be completed 12/31/22

Outcome Objectives - NYSPA	NYSPA Interventions	Process Measures	Partners and Roles		Partner Resources
3.2.1 Increase the percentage of smokers who received assistance	**3.2.2 Use health communications/media to**	1. # of times smokers are targeted with messages to encourage	NYSDOH	NYS Quit Line	N/A

from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%. Target 60.1% Baseline 53.1% (2017) Data Source NYS ATS Data Level State	**promote the treatment of tobacco dependence by targeting smokers with emotionally evocative & graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits & to encourage health care provider involvement with additional assistance from the NYS Quitline.**	evidence-based quit attempts including seeking assistance from their healthcare providers and utilizing the NYS Smokers' Quitline (educational events, earned media, LTE, etc.) 2. Determine feasibility of referring/partnering with U or R Quit Line via the Ctr. For Com. Health & Prevention	OCPH	Outreach, education, public health detailing	0.05 FTE
			Media	Respond to PR's , print LTE's and guest essays, air PSA's.	N/A
			TACFL	Outreach, education, earned media	See Intervention 3.1.2
3.2.2 Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among all adults) Target 11.0% Baseline 14.2% (2016) Data Source BRFSS Data Level state and by county when expanded	**3.2.3 Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment.**	1. # agencies enlisted to assist with outreach to the healthcare provider community (CTFFL, GRATCC, etc.) 2. # healthcare providers approached regarding provision of evidentce-based assistance, including NYS Smokers' Quitline referrals	URTH	Encourage HCP involvement with quit attempts at affiliated practices. Provide smoking cessation classes.	$1,150
			FLH	Encourage HCP involvement with quit attempts at affiliated practices.	N/A
			Rochester Regional Helath/Clifton Springs Hopsital & Clinic (RRH)	Encourage HCP involvement with quit attempts at affiliated practices	N/A
			NYSDOH	NYS Quit Line	N/A
			CTFFL*	Engage for assistance with reaching the healthcare provider community	N/A
			GRATCC**	Engage for assistance with reaching the healthcare provider community	N/A
			Healthcare providers	Provide evidence-based assistance to patients' quit attempts	N/A

***Center for a Tobacco-Free Finger Lakes** ****Greater Rochester Tobacco Cessation Center**

Priority Area: Prevent Chronic Diseases

Focus Are 3: Tobacco Prevention

Goal 3.3 Eliminate exposure to secondhand smoke (and vaping products)

Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No **Timeframe**: To be completed 12/31/22

Outcome Objectives - NYSPA	NYSPA Interventions	Process Measures	Partners and Roles		Partner Resources
3.3.1 Decrease the percentage of adults (non-smokers) living in multi-unit housing who were exposed to secondhand smoke in their homes Target 27.2% Baseline 35.2% (2017) Data Source NYS ATS Data Level State 3.3.2 Decrease the percentage of youth (middle and high school students) who were in a room where someone was smoking on at least 1 day in the past 7 days Target 17.9% Baseline 23.1% (2016) Data Source NYS YTS Data Level State 3.3.3 Increase the number of multi-unit housing units (focus should be on housing with higher number of units) that adopt a smoke-free policy by 5000 units each year Target TBD Baseline	**3.3.1 Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents.**	1. #multi-unit housing complexes engaged 2. # multi-unit housing complexes to institute smoke/vape – free policies	Housing agencies	Development of policies	N/A
			TACFL	Promotion and assistance with policy development	See Intervention 3.1.2
			OCPH	Educaton and cessation support	.05 FTE
	3.3.2 Increase the number of smoke-free parks, beaches, playgrounds, college and other public spaces.	1. #municipalities engaged 2. # public spaces to institute smoke/vape – free policies	Municipali-ties	Development of policies	N/A
			Colleges	Development of policies	N/A
			TACFL	Promotion and assistance with policy development	See Intervention 3.1.2
	3.3.3 Educate organizational decision makers, conduct community education, and use paid and earned media to increase community knowledge of the dangers of secondhand smoke exposure and secondhand aerosol/emission exposure from electronic vapor products.	1. # decision-makers educated 2. # community educational events held that include smoking/vaping messaging 3. #paid and earned media provided that include smoking/vaping messaging	TACFL	Education of decision makers Press releases, LTE's, social media, earned media, tabling events, school events	See Intervention 3.1.2
			OCPH	Education of decision makers Press releases, LTE's, social media, earned media, tabling events, school events	0.05 FTE
			Ontario County Health Collaborative (OCHC)	Press releases, LTE's, social media, earned media, tabling events, school events	N/A

TBD Baseline Year 2018 Data Source CAT Data Level State, municipality. Ontario County Goal: 20			Members		
			Schools	Venues to reach children, adolescents and college students	N/A

Priority Area: Prevent Chronic Diseases

Focus Area 4: Chronic Disease Preventive Care & Management

Goal 4.1 Increase cancer screening rates

Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No **Timeframe**: To be completed 12/31/22

Outcome Objectives - NYSPA	NYSPA Interventions	Process Measures	Partners and Roles		Partner Resources
4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines Target 79.7% Baseline 75.9% (2016) Data Source BRFSS Data Level-State and County 4.1.2 Increase the percentage of women with an annual household income less than $25,000 who receive a cervical cancer screening based on the most recent guidelines Target 80.0% Baseline 76.1% (2016) Data Source BRFSS Data Level-State and County	**4.1.2 Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting).**	1. # presentations/sessions in which information on cancer and cancer screening was provided to residents of Ontario County	Cancer Services Program of the Finger Lakes (CSP)	Provide one-on-one & community education re cancer/cancer screening & services available, including assistance for those with high deductible insurance plans.	.125 FTE
			OCPH	Provide community education on cancer and cancer screening. Refer residents to CSP.	.10 FTE
			Hospitals & affiliated practices	Provide education to patients and families. Refer residents to CSP. Contract with CSP.	N/A
			FLH	Track # mammo referrals made by PCP's (by zip code and provider) Track # mammo screenings completed at hospital (by zip code and provider)	
			OC Probation Dept.	Provide venue for education	N/A
			OC Jail	Provide venue for education. Potentially host a mobile mammograhy unit.	N/A

4.1.4 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (adults with an annual household income less than $25,000) Target 63.7% Baseline 60.7% (2016) Data Source BRFSS Data Level – State and County			Churches	Potential venues for community education	N/A
			Worksites	Potential venues for tabling (work-sponsored health fairs)	N/A
	4.1.3 Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand.	1. # of locations at which materials were distributed re cancer and cancer screening 2. # of unified messages created by OCHC around cancer and cancer screening	Cancer Sercices Program (CSP) of the FL	Advertise in OC. Provide printed materials to OCHC to distribute at events & via RTS. Use social marketing to raise community awareness.	$1,100.00
			RTS	Distribute printed materials on buses.	N/A
			OCPH	Distribute CSP materials at community events & via social media. Use social marketing & community education to raise awareness.	Staff time 1 hour/month x 12 = $360
			URTH	Display CSP materials on site. Provide community education re cancer and cancer screening.	N/A
			FLH	Display CSP materials on site. Provide community education re cancer and cancer screening.	N/A
			RRH-CSHC	Display CSP materials on site. Provide community education re cancer and cancer screening.	N/A
			Breast Cancer Coalition	Provide support, education and advocacy to Ontario County residents affected by breast or gynecologic cancers.	N/A
			Health Insurers (Fidelis)	Provide cancer and cancer screening education and printed materials in public venues.	N/A
	4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer	1. # of facilities engaged re having Mobile Mammography Unit on site 2. # of mammograms provided	OCPH	Investigate the feasibility and assess the interest of worksites and the County Jail in hosting Rochester Regional Health's Mobile Mammography Unit.	Staff time $500

	screening in non-clinical settings (mobile mammography vans, flu clinics)…..	via mobile unit in Ontario County	RRH	Provide Mobile Mammography to Ontario County residents.	40 hours(1wk)/year=0.14 FTE
			Employers	Allow RRH's Mobile Mammography Unit on-site	N/A
			Ontario County Jail	Allow RRH's Mobile Mammography Unit on-site	N/A
			CSP of the FL	Determine feasibility for CSP reimbursement for mobile mammography at jail.	N/A
			FLH	Assess for barriers to cancer screening: Track # mammo and coloalrect screeing referrals made by PCP's (by zip code and provider) Track # mammo and colorectal screenings completed at hospital (by zip code and provider)	N/A

Priority Area: Prevent Chronic Diseases

Focus Area 4: Chronic Disease Preventive Care & Management

Goal 4.3 Promote evidence-based care to prevent & manage chronic diseases: asthma, arthritis, cardiovascular disease, diabetes & prediabetes & obesity

Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No **Timeframe**: To be completed 12/31/22

Outcome Objectives - NYSPA	NYSPA Interventions	Process Measures	Partners and Roles		Partner Resources
4.3.1 Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%) Target 26.6% [HMO]; 31.4% [MMC] Baseline 28% [HMO]; 33% [MMC] (2016) Data Source QARR	**4.3.4 Promote strategies that improve access and adherence to medications and devices.**	# of health systems that implement policies/practices to encourage self-management behaviors, including adherence to medication	FLH	Cardiac Re-Hab Diabetes Management Program	Cardiac Rehab: 1.0 FTE , Nurse Practitioner Diabetes Management: 1.0 FTE, Registered Dietician
			URTH	Cardiac Re-Hab (Mended Hearts) Community Diabetes Support Group	In kind
			RRH/CSHC	Cardiac Re-Hab (5 days/week) Diabetes Education and Management (3day/week)	Cardiac: 1 FTE Diabetes: 0.6 FTE

Data Level state 4.3.11 Increase the percentage of adults with HTN who are currently taking medicine to manage their high blood pressure Target 80.7% Baseline 76.9% (2016) Data Source BRFSS Data Level State and County			Medical Providers	Refer to programs offered by local hospitals	**N/A**
4.3.4 Increase % of adult who had HTN whose blood pressure was adequately controlled during the measurement year Target 66.2% [HMO]; 65.1% [MMC] Baseline 63% [HMO]; 62% [MMC] (2016) Data Source QARR Ontario County Specific, 2018: 79% Goal: 85%	**4.3.3 Promote the use of Health Information Technology for: Measurement, Registry Development, Patient Alerts, Bi-Directional Referrals, Reporting.**	1. # patients in registry 2. % patients with BP under control	Common Ground Health (until 12/31/19) RHIO (after 1/1/20)	Maintain the Hypertension Registry & report out to partners& participating healthcare providers 2x/year. Provide education on best practices for monitoring and treatement of hypertension.	In kind
			URTH & affiliated practices	Provide data to the Hypertension Registry.	N/A
			FLH & affiliated practices	Provide data to the Hypertension Registry.	N/A
			RRH/CSHC & affiliated practices	Provide data to the Hypertension Registry.	N/A
			OCPH	Assist & support education of healthcare community re control rates.	N/A

Priority Area: Prevent Chronic Diseases
Focus Area 4: Chronic Disease Preventive Care & Management
Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases - asthma, arthritis, cardiovascular disease, diabetes and prediabetes & obesity
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No **Timeframe**: To be completed 12/31/22

ONTARIO COUNTY CHIP/CSP CHART 2019

Outcome Objectives - NYSPA	NYSPA Interventions	Process Measures	Partners and Roles		Partner Resources
4.4.1 Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition. Target 10.60% Baseline 10.1% (2016) Data Source BRFSS Data Level: State and County	**4.4.2 Expand access to evidence-based self-management interventions for individuals with chronic disease whose condition is not well-controlled with medical management alone.**	1. # and type of EBSMP programs in community settings • CDSMP ○ # groups held (goal=6) ○ # participants (goal=60) ○ % participants completing program (goal 60%) • Matter of Balance and Powerful Tools for Caregivers ○ # groups held ○ # participants ○ % participants completing program	URTH	Offer CDSMP in community settings & provide flyers for partner-sponsored EBI's to clients	**$5156.40** (Salary 5 programs $3600.00; 50 Books & CD's $1278; Mileage $278.40)
			RRH-CSHC	Consider feasibility of offering CDSMP in Clifton Springs community & provide flyers for partner-sponsored EBI's to clients	CDSMP delivery in planning process: Resources to be determined
			OCPH	Offer CDSMP at OC Jail and assist URTH, as needed with staffing CDSMP groups Provide flyers for partner-sponsored EBI's to clients	Staff time x 2: 2 sessions/year **$1,440**
			Commuity sites	Provide venues for CDSMP courses	N/A
			OCHC	Develop method to determine if CDSMP partidipants experience ED or hospital admissions in the 6-12 period after completion of program.	N/A
			Medical Providers	Refer patients to CDSMP in the community	N/A
			Office for the Aging (OFA)	Provide EBI's: Matter of Balance & Powerful Tools for Caregivers. Distribute CDSMP flyers at OFA programming	**$7,125**

Priority Area: Promote Well-Being, Prevent Mental & Substance Use Disorders

Focus Area 1: Promote Well-Being

Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan

Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No **Timeframe**: To be completed 12/31/22

Outcome Objectives - NYSPA	NYSPA Interventions	Process Measures	Partners and Roles		Partner Resources
1.1.1 Increase New York State's Opportunity Index Score by 5% Target 59.2/100 Baseline 56.4/100 (2017) Data Source Child Trends & Opportunity Nation, Opportunity Index, American Community Survey Data Level County 1.1.2 Reduce the age-adjusted % of adult New Yorkers reporting 14 or more days with poor mental health in the last month by 10% to no more than 10.7%. Baseline: 11.9% Target 10.7% (2017) Data Source Expanded BRFSS Data Level County	**1.1.3 Create and sustain inclusive, healthy public spaces: Ensure space for physical activity, food access, sleep; civic and community engagement across the lifespan** Evidence base: Oxford Brookes University. William K and Green S. Literature Review of Public Space and Local Environments for the Cross-Cutting Review	1. # of community conversatoins addressing building community-wide well-being and resilience across the lifespan. 2. Community partners enlisted, including roles (informative, advisory, transactional, decision-making).	OCPH	Begin community conversation about strengthening opportunities to build well-being & resilience.	TBD
			S2AY RHN	Grant oopportunities to support community work	1 FTE
			Community Partners to Consider		
			Schools Municipalities Legislators Churches Mental Health Service orgnaizations YMCA's, Health insureres Employers Hospitals	Food pantries Food Justice Department Soc Serv Ontario County Jail Regional Transity System Office for the Aging CBO's NY Kitchen Hospitals VA	Farm Bureau CCE Ontario County Pathways Wegmancs OC Substance Abuse Coalition OC Planning Rochester Comm. Foudation

Priority Area: Promote Well-Being, Prevent Mental & Substance Use Disorders

Focus Area 1: Promote Well-Being

Goal 2.2 Prevent opioid and other substance misuse and deaths

Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No **Timeframe**: To be completed 12/31/22

Outcome Objectives - NYSPA	NYSPA Interventions	Process Measures	Partners and Roles		Partner Resources
2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population	**2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers,**	1. # narcan trainings held 2. # of ncommunity members trained in the administration of	OCPH	Participate in the NYSDOH's Opioid Overdose Prevention Program. Provide and use earned media to raise community awareness about	$5,000

Target 14.0 per 100,000 Baseline 15.1 per 100,000 (2016) Data Source CDC WONDER Data Level County	**pharmacists and consumers**	Narcan.		availability of Narcan Trainings in the community. Participate on the Regional Opioid Task Force.	
			S2AY Rural Health Network	Continue to lead the Regional Opioid Task Force	0.1 FTE
			Community Partners: – Employers – Colleges – Libraries – Fire Dpts. – Sheriffs – Churches	Provide venues and audiences for Narcan Trainings	N/A
			Sheriff's	Create OD Maps	
			Media	Respond to PR's and LTE's	N/A
			Trillium Health	Provide Narcan and education at mobile syringe exchange program	**N/A**
	2.2.4 Build support systems to care for opioid users at risk of an overdose **Evidence Base SAMHSA. Recovery and Recovery Support**	1. # Mobile SEP sites 2. # Clients served at Mobile SEP stites	Trillium Health	Determine the feasibility of continuing to offer needle exchange, HIV & Hep C testing and referral to treatment via a mobile syringe exchange unit in Ontario County.	N/A
			OCPH	Assist Trillium Health with outreach to elected officials and community leaders re needle exchange sites	N/A
			FL Area Counseling & Recovey Agcy (FLACRA)	Host mobile SEP. Provide emergency Opioid Response Team services.	N/A
			Canandaigua Fire Department	Host mobile SEP	N/A

			Ontario County Opioid Court	Provide option for treatment prior to arraignment	NA

Priority Area: Promote Well-Being, Prevent Mental & Substance Use Disorders					
Focus Area 1: Promote Well-Being					
Goal 2.5 Prevent suicides					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No			**Timeframe**: To be completed 12/31/22		
Outcome Objectives - NYSPA	**NYSPA Interventions**	**Process Measures**	**Partners and Roles**		**Partner Resources**
2.5.1 Reduce suicide attempts by New York adolescents (youth grades 9 to 12) who attempted suicide one or more times in the past year by 10% to no more than 9.1%. Target 9.1% Baseline 10.1% (2017) Data Source YRBS Data Level State 2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000. Target 7 per 100,000 Baseline 7.8 per 100,000 (2015) Data Source Vital Statistics Data Level County	**2.5.4 Identify and support people at risk: Gatekeeper Training, crisis intervention, treatment for people at risk of sucide, treatment to prevent re-attempts, postvention, safe reporting and messaging about suicides**	1. # individuals trained in suicide-prevention skills 2. # of individuals trained to deliver suicide-prevention trainings in the community 3. # CPEP responses (if determined to be feasible to obtain and track) 4. # Lifeline Counseling calls	Suicide Prevention Coalition of Ontario County	Facilitate provision of suicide prevention trainings for members & the community (ASSIST, Safe Talk, Talk Saves Lives). Provide post-vention services/tools in the community.	$25,000
			Ontario County Public Health	Provide expertise to Suicide Prevention Coalition	N/A
			OC Mental Health	Provide expertise to Suicide Prevention Coalition	N/A
			CBOs, human services, residents, businesses, schools colleges	Participate in Suicide Prevention Coalition; become trained in suicide preventnion strategies; provide venues for suicide prevention trainings	N/A
			Healthcare systems	Screen patients for suicidal ideation and provide or refer for mental health care	N/A
			RRH/CSHC	1. Provide Comprehensive Psychiatric Emergency Program (CPEP) teams to respond to emergency mental health situations 24/7. Estimate-150/month.	1 FTE

				2. Determine feasiblity of providing data to OCHC.	
			Ontario County Sheriff's 911 center	Partner with CPEP in responding to calls for mental health emergencies	N/A
			YANA (You are not alone)	Provide support to LGBTQ youth	N/A
			VA Lifeline	Provide suicide-prevention hotline counseling	N/A
			211/Lifeline	Provide suicide-prevention hotline counseling	N/A
			National Suicide Hot Line	Provide suicide-prevention hotline counseling	N/A