FINGER LAKES REGIONAL COMMUNITY HEALTH ASSESSMENT

PREPARED FOR: Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties

PREPARED BY: COMMON GROUND HEALTH | FEBRUARY 2020

Common Ground Health

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Canandaigua Lake, Ontario

The purpose of the following assessment is to fulfill the needs of eight local health departments and hospitals in the Finger Lakes region for completion of their 2019-2021 Community Health Assessments (CHA), Community Service Plans (CSP), and Community Health Improvement Plans (CHIP). Below are the staff who prepared the report.

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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. The following report summarizes pertinent information relating to the above priority areas and contains eight county chapters, which discuss local health challenges, assets and resources and selected interventions to improve community health.

Photo courtesy of Livingston County Department of Health

KEY FINDINGS

EIGHT COUNTY REGION

The total population in the region 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. Health care 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 10 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.

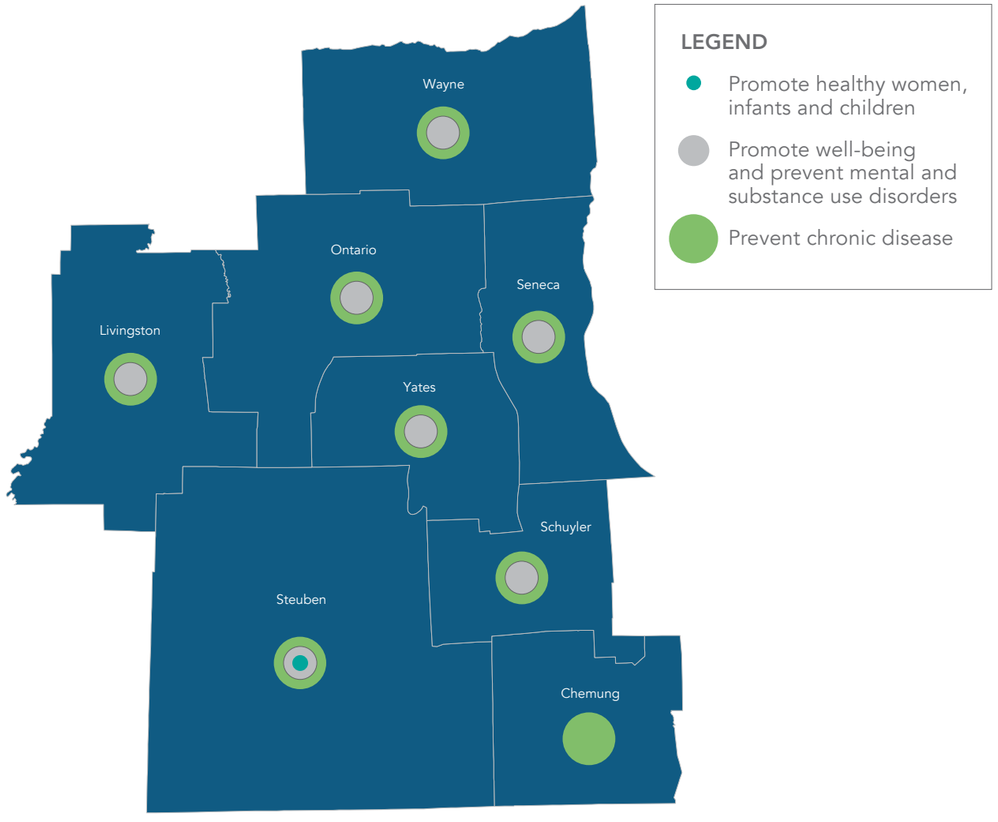
In addition, when looking at food insecurity data for the Community Health Assessment, data revealed that a portion of each county's population (average of 5%) are low income and have low access to a supermarket or grocery store. According to *My Health Story 2018* survey data, a supermarket or grocery 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.

Regional Priority Alignment

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

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

MAP 1: Selected Priority Areas



Interventions

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

FOCUS AREA	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) 3.2.3 Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence based quitting, increasing awareness of available cessation benefits (especially Medicaid) and removing barriers to treatment (selected by three counties) 3.3.1 Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents (selected by four counties)
Healthy eating and food security	1.0.3 Implement worksite nutrition and physical activity programs designed to improve health behaviors and results (selected by three counties) 1.0.4 Multi-component school-based obesity prevention interventions (selected by three counties)
Prevent mental and substance use disorders	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (selected by five counties) 2.2.4 Build support systems to care for opioid users at risk of an overdose (selected by three counties) 2.3.3 Grow resilient communities through education, engagement, activation/ mobilization and celebration (selected by three counties) 2.5.4 Identify and support people at risk: Gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-intervention, safe reporting and messaging about suicides (selected by five counties)

*Interventions shown are those where three or more counties selected the intervention.
A full list of selected interventions can be found in the county improvement plan found in appendix A.

Several of the above interventions include communication and small-media. As several counties have selected the same interventions, this poses an opportunity to create unified regional messaging. Residents do not travel only 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 that 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 its vision is to be among the healthiest communities in the nation. Common Ground Health covers the same geographic area as the network, with the addition of Livingston and Monroe Counties. The agency brings together leaders from health care, business, education and other sectors to find common ground on health challenges.

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

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

1. **Farm to Table**
   A regional workgroup that addresses increased access to healthy foods, and collaborates with schools, food pantries, farmers, and local communities to get locally grown, fresh produce and raised products to them.

2. **Healthy Living**
   A regional workgroup which enhances skills in our communities through collaboration among partners to prevent and control chronic health conditions with the delivery of evidence-based and evidence-informed interventions.

3. **Worksite Wellness**
   A regional workgroup to help improve worksite wellness at area businesses and organizations for employers and their employees.

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

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

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

Photo courtesy of Livingston County Department of Health

EXECUTIVE SUMMARY

Development of the 2019-2021 Community Health Assessment, Community Service Plans and Community Health Improvement Plans was a joint process, which began in the summer of 2018. While submission of the Regional Community Health Assessment is on behalf of the eight counties, each health department managed their own county's prioritization and planning meetings with assistance from the S2AY Rural Health Network, Common Ground Health and the Genesee Valley Health Partnership.[1] Regional check-ins occurred on a monthly basis.[2]

A variety of partners were engaged in each county's specific process including the respective public health departments and local hospital staff, representatives from local Federally Qualified Health Centers (FQHCs), Community Based Organizations (CBOs), local legislatures and other county government employees, school district representatives, the S2AY Rural Health Network, Common Ground Health, Genesee Valley Health Partnership and more. A regional health survey and county focus groups engaged the community at large throughout the assessment period. County public health departments invited community members to weigh in on selected priority areas by participating in the priority setting meetings or by providing feedback on publicly available postings. Partners' roles 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.

In the months of April, May and June of 2019, each health department engaged key stakeholders in prioritization meetings facilitated by the S2AY Rural Health Network.[3] Key stakeholders and community members were invited to attend the prioritization meetings, including all those who attended prior focus groups. Social media platforms, e-mail and news media were used to help promote participation by each local health department. Common Ground Health provided group members copies of county specific pre-read documents in advance of the meetings. The documents included information on current priority areas and progress made to date, as well as a mix of updated quantitative, qualitative, primary and secondary data on each of the five priority areas outlined in the New York State Prevention Agenda. Data were collected from a variety of different sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, primary data collected from the *My Health Story 2018* survey, and local data sources such as Livingston County's Prevention Needs Assessment, Ontario County's PRIDE survey and Wayne County's school student survey. Copies of the county specific pre-read documents, prioritization meeting materials and meeting attendees are available upon request.

1. Livingston County received support from the Genesee Valley Health Partnership and Common Ground Health.

2. Livingston County did not engage in the monthly check-ins and facilitated their own process. Common Ground Health served as the bridge to keep all parties apprised of updates

3. Livingston County facilitated their own prioritization meeting with assistance of Common Ground Health.

Participants used the Hanlon method and the PEARL test to prioritize a list of group-identified and/or pre-populated health department priorities based on size and seriousness of the problem and effectiveness of interventions. Data relating to high-risk populations were reviewed at priority setting meetings and group discussions took place regarding selection of each county's disparity. The result of the groups' scoring and discussions led to the selection of the priority areas and disparities and are as follows:

COUNTY	PRIORITY
Chemung County	**Prevent Chronic Diseases** 1. Healthy eating and food security 2. Physical activity 3. Tobacco prevention **Disparity: reduce tobacco use among pregnant women**
Livingston County	**Prevent Chronic Diseases** 1. Healthy eating and food security 2. Physical activity 3. Chronic disease preventative care and management **Promote Well-Being and Prevent Mental and Substance Use Disorders** 4. Promote well-being 5. Mental and substance use disorders prevention **Disparity: low socioeconomic status and older adults**
Ontario County	**Prevent Chronic Diseases** 1. Chronic disease preventative care and management 2. Tobacco prevention 3. Healthy eating and food security **Promote Well-Being and Prevent Mental and Substance Use Disorders** 4. Promote well-being 5. Strengthen opportunities to build well-being and resilience across the lifespan **Disparity: low income**
Schuyler County	**Prevent Chronic Diseases** 1. Chronic disease preventative care and management **Promote Well-Being and Prevent Mental and Substance Use Disorders** 2. Prevent mental and substance use disorders **Disparity: low income**
Seneca County	**Prevent Chronic Diseases** 1. Chronic disease preventative care and management 2. Healthy eating and food security 3. Tobacco prevention **Promote Well-Being and Prevent Mental and Substance Use Disorders** 2. Promote well-being 3. Prevent mental and substance use disorders **Disparity: low socioeconomic status**

COUNTY	PRIORITY
Steuben County	**Prevent Chronic Diseases** 1. Tobacco prevention **Promote Healthy Women, Infants and Children** 2. Child and adolescent health **Promote Well-Being and Prevent Mental and Substance Use Disorders** 3. Prevent mental and substance use disorders **Disparity: low socioeconomic status and pregnant women**
Wayne County	**Prevent Chronic Diseases** 1. Tobacco prevention 2. Chronic disease preventative care and management **Promote Well-Being and Prevent Mental and Substance Use Disorders** 3. Prevent mental and substance use disorders 4. Promote well-being **Disparity: low income**
Yates County	**Prevent Chronic Diseases** 1. Chronic Disease Preventative Care and Management **Promote Well-Being and Prevent Mental and Substance Use Disorders** 2. Prevent mental and substance use disorders **Disparity: low income (chronic disease)**

To address the above priorities and disparities, each local health department facilitated a CHIP planning meeting where partners discussed ways to leverage existing work. Existing work efforts were then compared to intervention options (primarily selected from the New York State Prevention Agenda Refresh Chart) and were informally voted on and selected. The selected interventions, process measures and partner roles in implementation processes can be found in each county's Community Health Improvement Plan grid (Appendixes A-H).

Each local health department has a designated overseeing CHIP body, which meets on an either monthly or bimonthly basis to review and update the Community Health Improvement Plan. During meetings, group members identify any mid-course actions that need to be taken and modify the implementation plan accordingly. Progress is be tracked during meetings via partner report outs and is recorded in meeting minutes and a CHIP progress chart. Partners and the community at large are engaged and apprised of progress via website postings, email notifications, presentations, and social media postings.

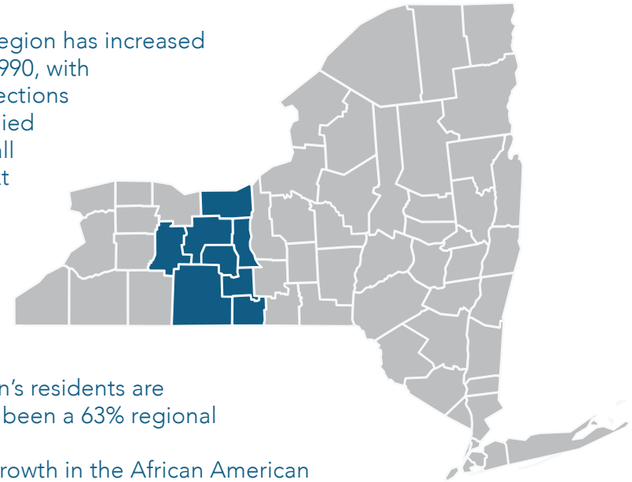
COMMUNITY HEALTH ASSESSMENT

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.

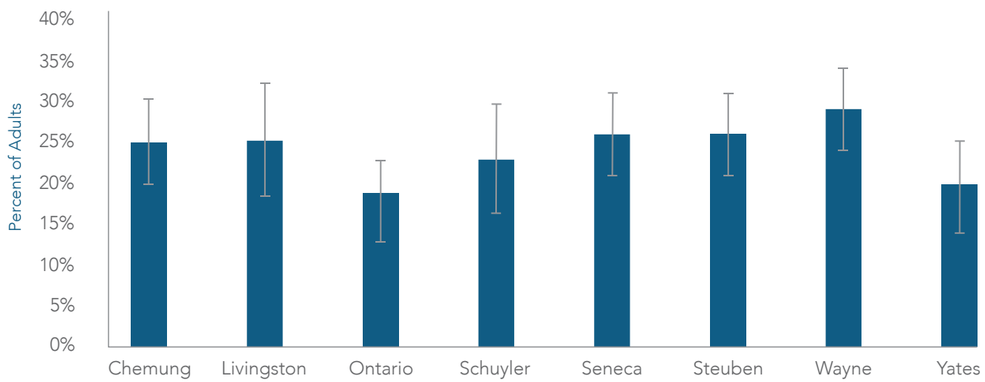
According to the most recent American Community Survey data, 92% of the region's residents are white non-Hispanic. Since 1990, there has been a 63% regional growth in the Hispanic population (6,000 to 17,000 residents), and a 32% regional growth in the African American population (13,000 to 19,000 residents).

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



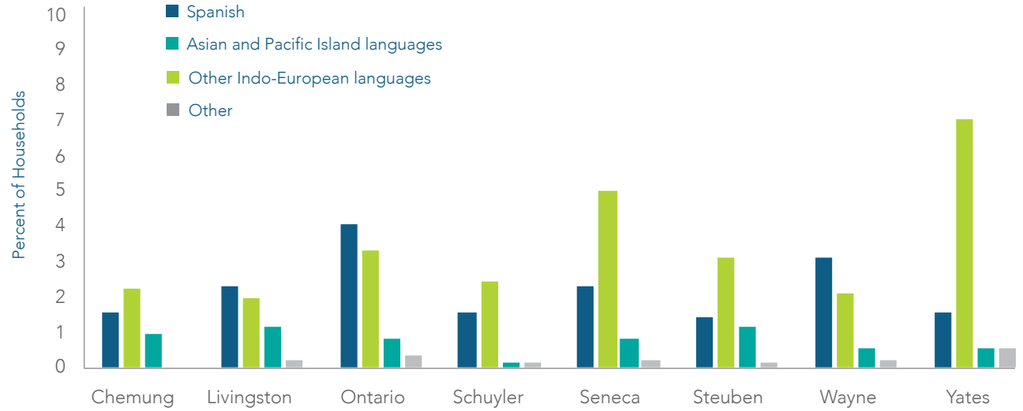
Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016.

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 responsive 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 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



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

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

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

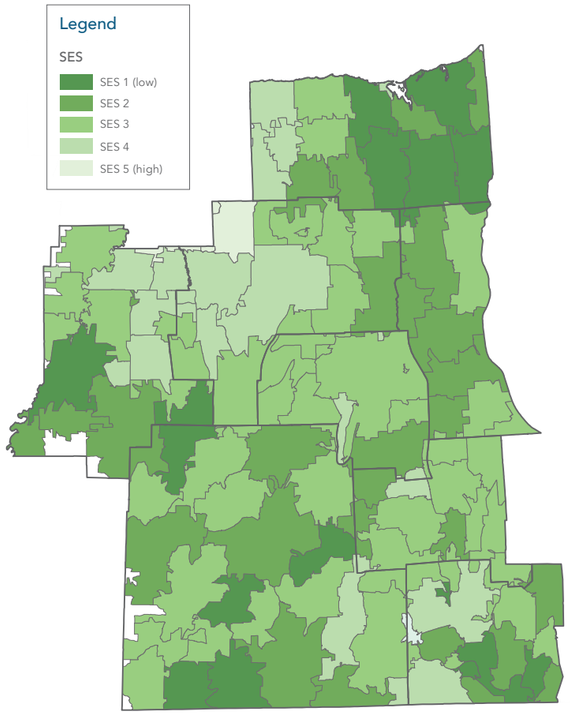
5. Source: Groffdale Conference Mennonites in the Finger Lakes Area of New York State, March 2019 Map

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%).

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



Unemployment

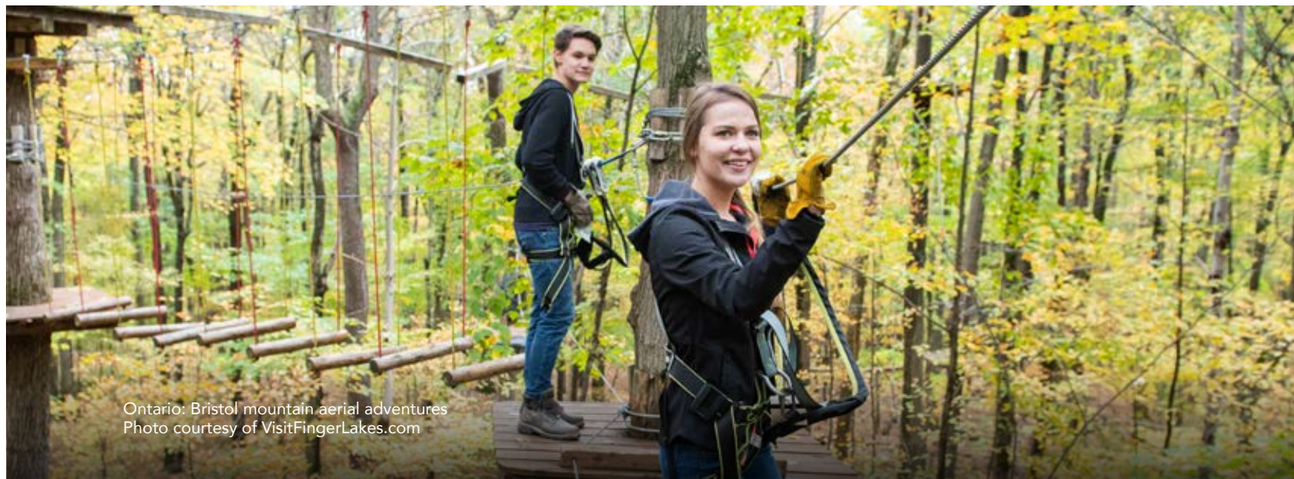
Unemployment in the Finger Lakes region has declined since 2012, as shown in Table 1. The percent of the population who are not in the labor force, however, has increased. It is important to note the percent not in the labor force includes those over the age of 65. With a growing number of elderly in the region, it is not surprising that this rate has increased since 2012.

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

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

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

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 three percentage points 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.



Ontario: Bristol mountain aerial adventures
Photo courtesy of VisitFingerLakes.com

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.

HEALTH ASSESSMENT

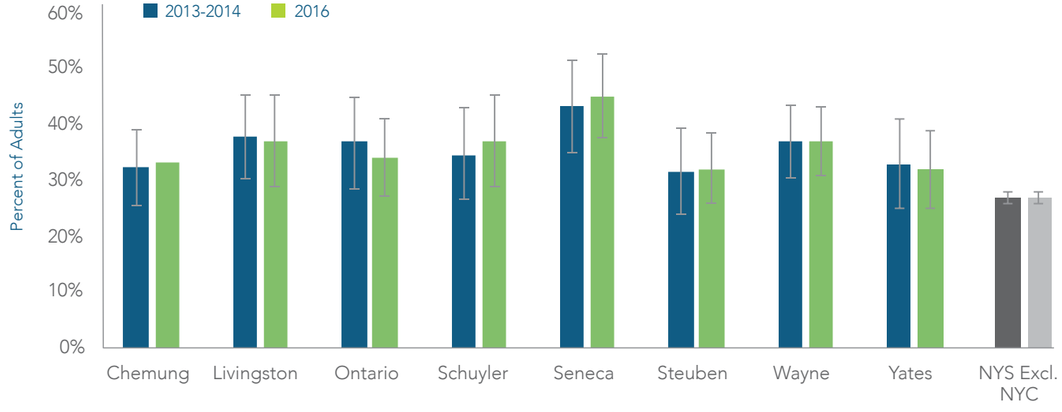
EIGHT COUNTY REGION

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

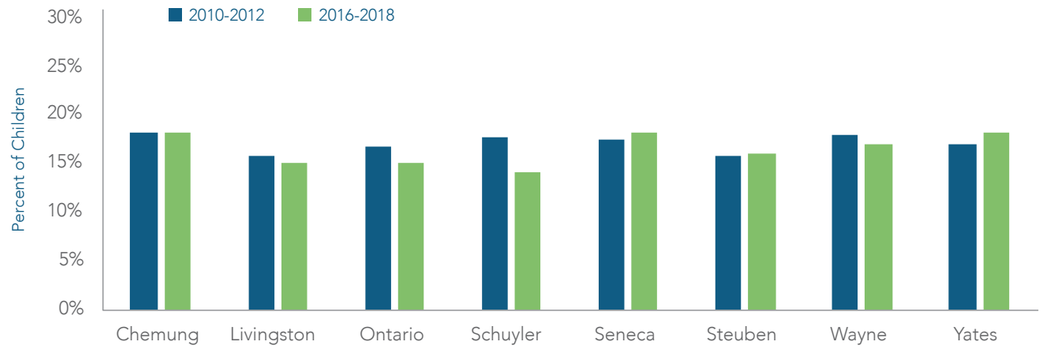
Preventing chronic disease has been a long standing priority area in the eight county region. Efforts have largely been focused on reducing illness, disability and death related to hypertension, tobacco use and second hand smoke, and reducing obesity in children and adults. Rates of obesity in the eight 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



Source: New York State Student Weight Status Category

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 appear to demonstrate that more males are reported obese than females (Table 3).

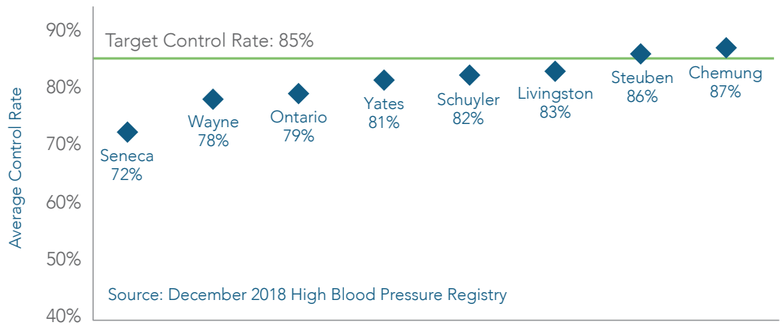
TABLE 3: Obesity rates by sex

	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

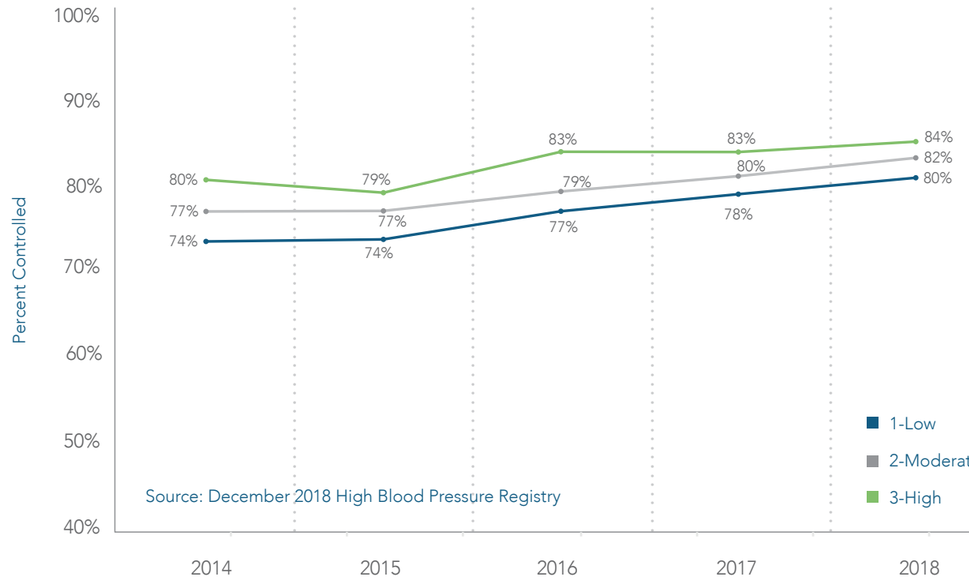
An estimated 36% of adults in the region have been diagnosed with hypertension. However, it is important to note the hypertension control rate for residents. According to the December 2018 High Blood Pressure Registry[7], 79% of hypertensive patients in the region are in control of their blood pressure. 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



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.

FIGURE 6: Regional control rate by socioeconomic status over time



Canandaigua boat houses in winter
Photo courtesy of VisitFingerLakes.com

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.

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.

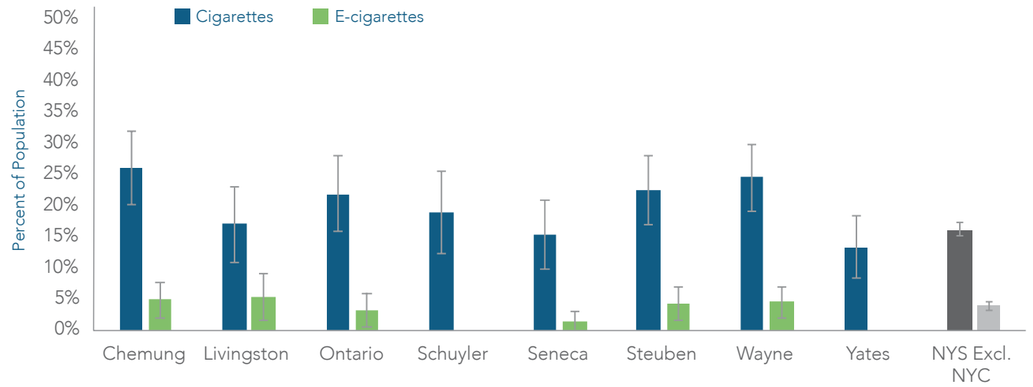
TABLE 4: Cardiovascular disease by demographic

	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 the estimates shown in Figure 7.

FIGURE 7: 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

Smoking rates vary by demographic. For instance, the low-income population has higher rates of smoking than the general population, as shown in Table 5 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: 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

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				
	8 County: under $25K	8 County: $25-50K	8 County: $50-75K	8 County: $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.

Photo by Chelsie Renae
Photo courtesy of Livingston County Department of Health

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				
	8 County: under $25K	8 County: $25-50K	8 County: $50-75K	8 County: $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%

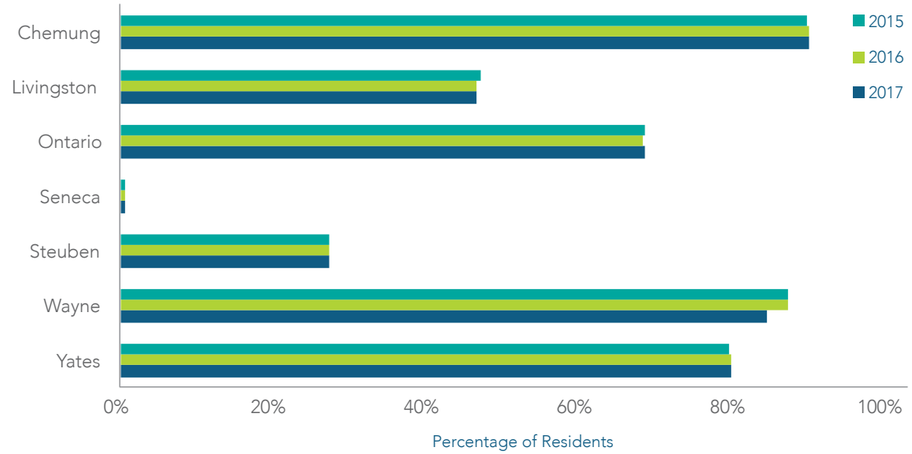
Source: My Health Story survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.

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.

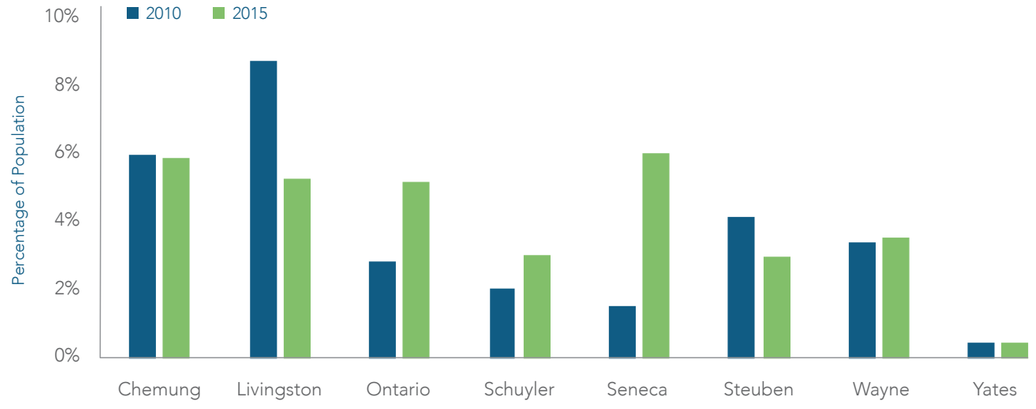
FIGURE 8: Percent of residents served by community water systems with optimally fluoridated water



Data Source: Prevention Agenda 2016
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

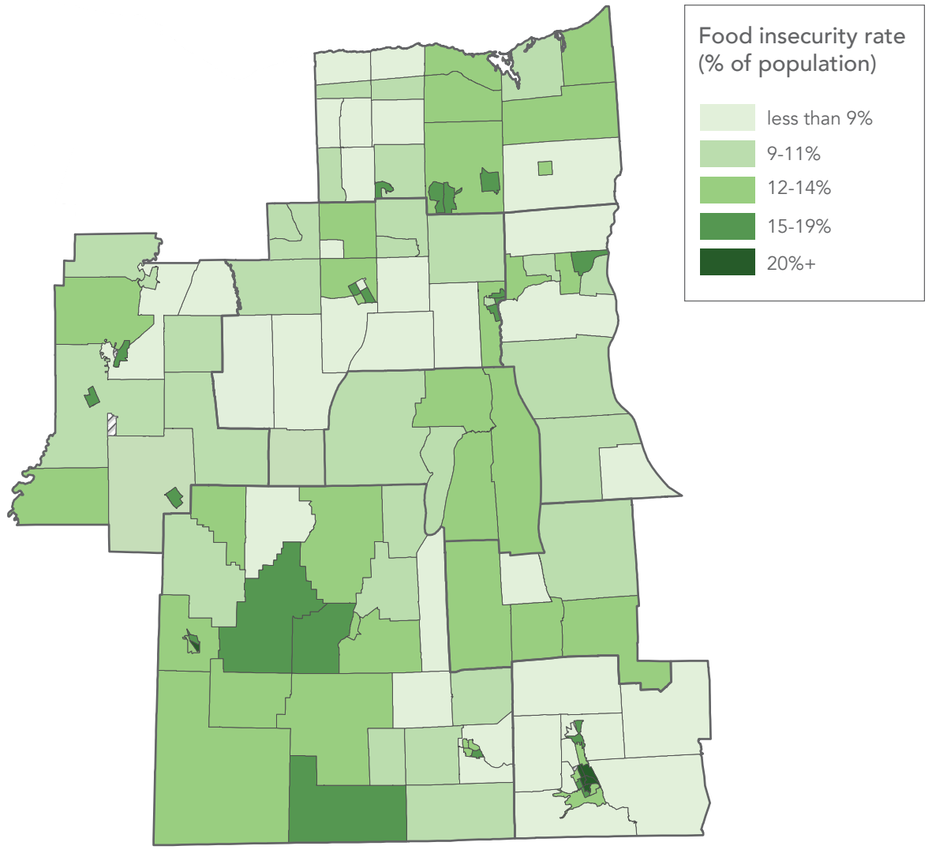


Data Source: Prevention Agenda, 2016

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.

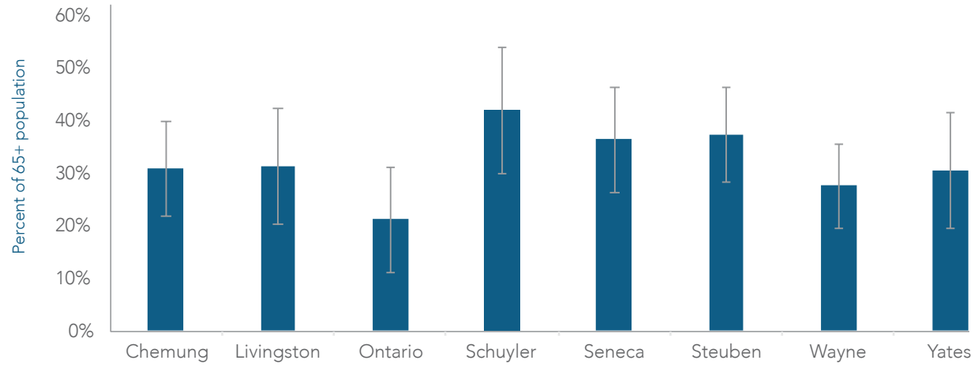
MAP 4: Food insecurity rate by census tract



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.

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

FIGURE 10: Reported falls in 65+ population



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

Promote Healthy Women, Infants and Children

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

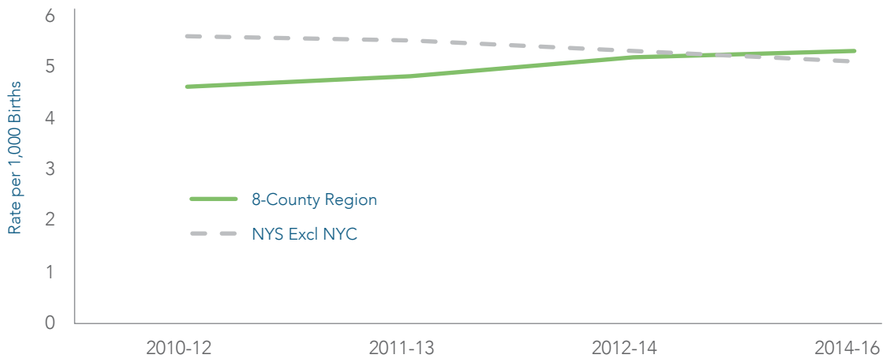
Premature birth is the primary cause of low birth weight. A child born at a low birth weight may suffer a range of health complications at birth. Some of the common issues for a low birth weight newborn include low oxygen levels, breathing complications due to immature lungs, difficulty feeding and gaining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

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

9. March of Dimes, Premature Babies and Long-Term Health Effects of Premature Birth, www.marchofdimes.org.

10. Stanford Children's Health, Low Birthweight

FIGURE 11: Rate of Infant Mortality

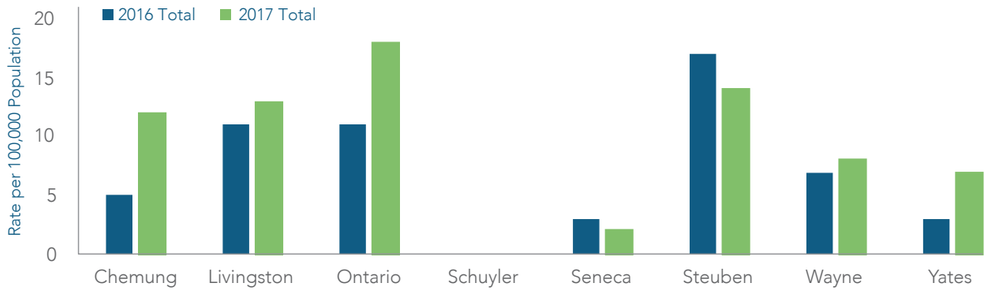


Source: NYS Perinatal Data Profile

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.

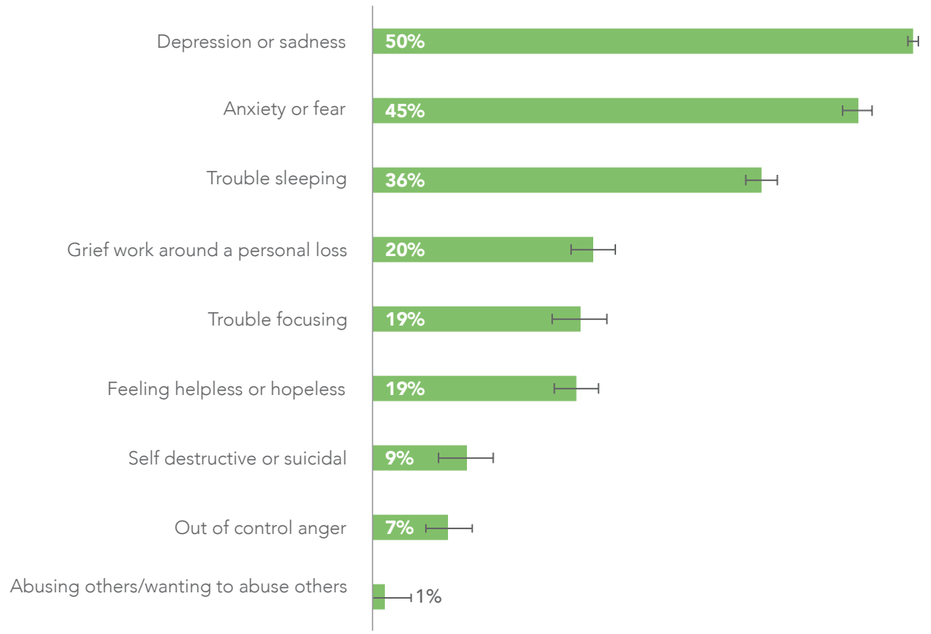
FIGURE 12: All opioid overdose death rates per 100,000 population



Data Source: NYS Quarterly Opioid Reporting

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



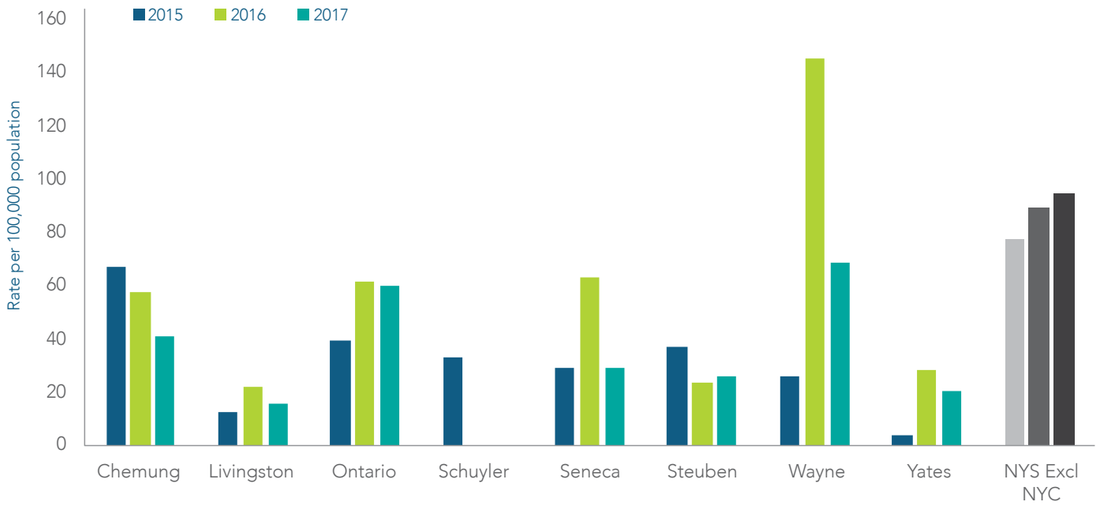
Source: My Health Story survey 2018. Analysis by Common Ground Health incorporates weighting to normalize survey participants to demographics of each county. Estimates shown with 95% confidence intervals.

Photo by Stu Gallagher
Courtesy of the CorningFingerLakes.com

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).

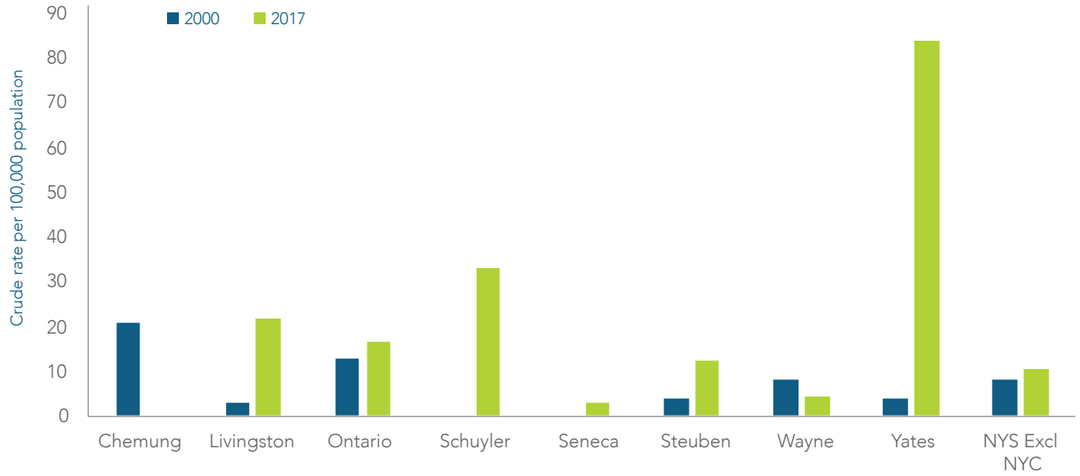
FIGURE 14: Rate of gonorrhea per 100,000



Data Source: NYS Communicable Disease Report

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

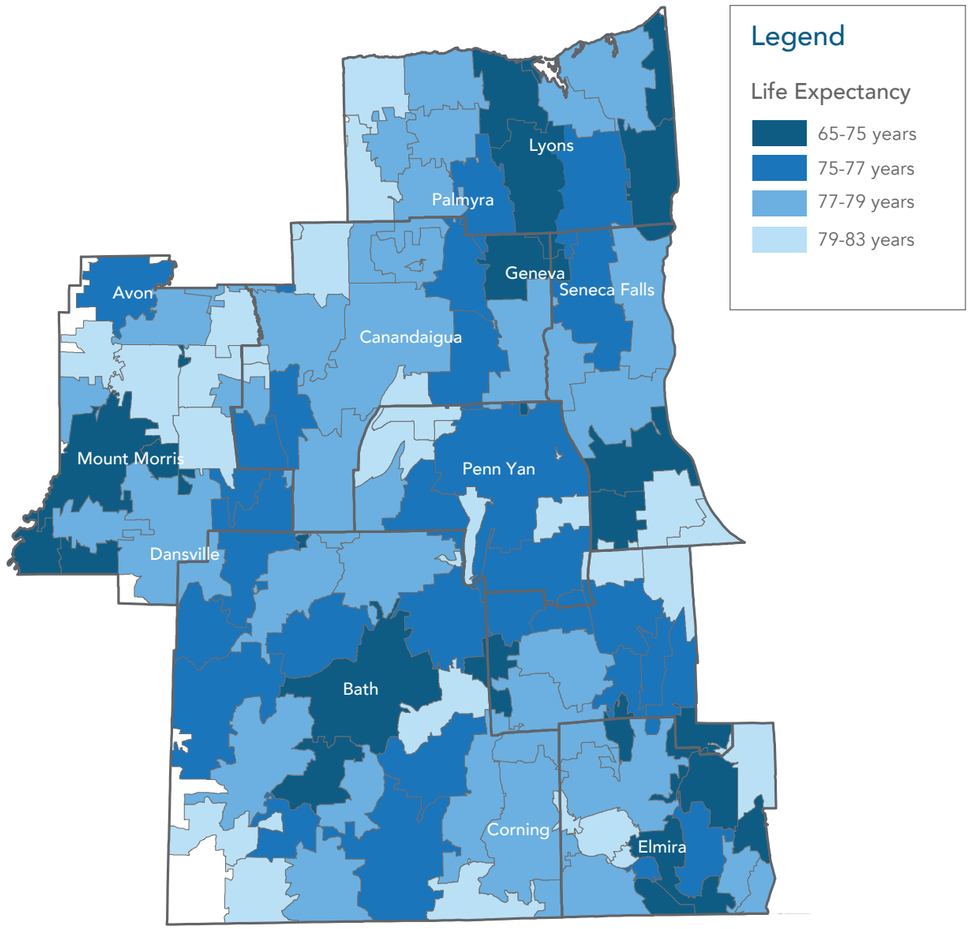


Source: NYS Communicable Disease Reporting 2000 and 2017

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.

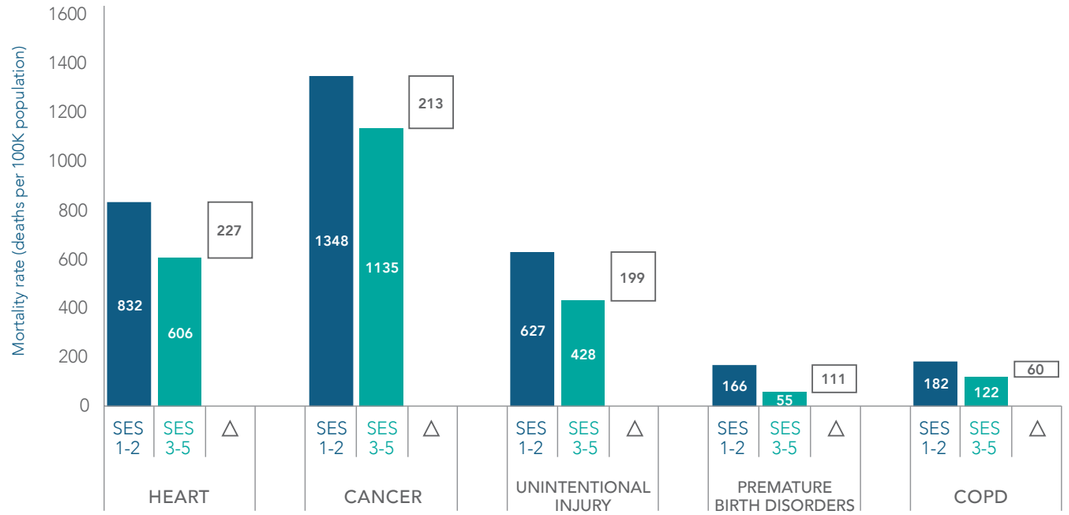
MAP 5: Life expectancy by ZIP code



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

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

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



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

In general, males have a lower life expectancy than females. This is partly attributed to biological differences, but perhaps more so behavioral tendency 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	1 40.6
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 either the S2AY Rural Health Network or Genesee Valley Health Partnership, 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 and PEARL methods 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.

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.

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 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 several sections take a closer look at these demographic and socioeconomic indicators but also include a review of county level behavioral and political environments impacting the health of residents. Finally, each chapter will highlight the community assets and resources that may be leveraged to improve health through identified evidence-based interventions.

CHEMUNG COUNTY

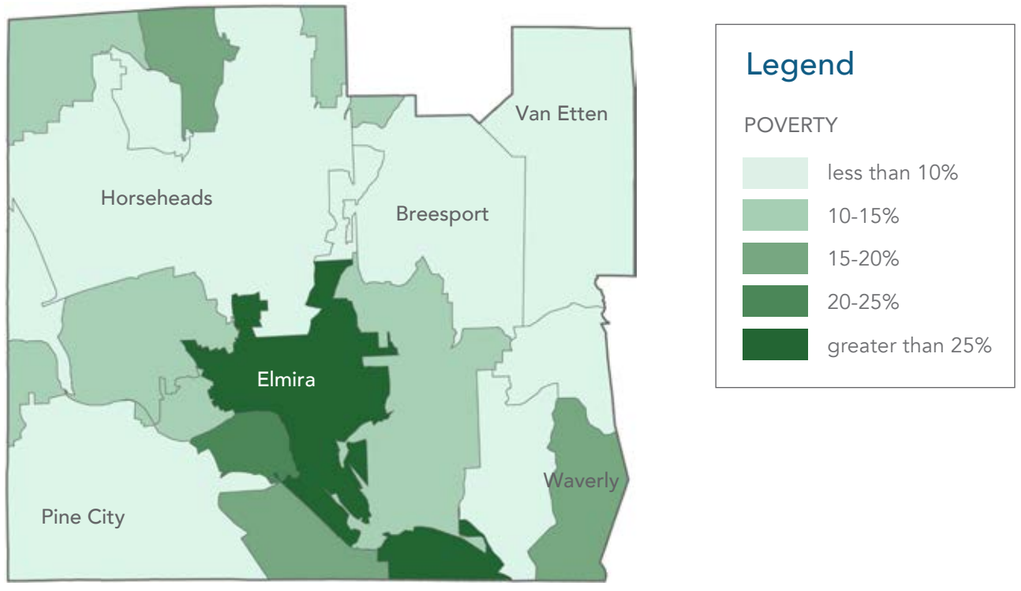
Demographic and Socioeconomic Health Indicators

Chemung County is home to one city, eleven towns and five villages and is located in the southeastern border of the Finger Lakes region. It borders the New York/Pennsylvania state line and has an estimated 86,883 residents. The majority of its residents (88%) are White Non-Hispanic and the population is heavily centered in the City of Elmira. It is estimated that 16% of the population are women of childbearing age, and 25% of the 18+ population are living with a disability.[13]

2017 estimates reveal 30% of the 65+ population (N=4,492) are living alone. This rate is down 9 percent from 2012 when 33% of the 65+ population (N=4,562) was living alone.

In Chemung County, 16% of residents are living below the federal poverty level, and another 19% live near it. The distribution of poverty in the county is shown below in Map 6. Interestingly, the two ZIP codes which make up the City of Elmira are polar opposites when it comes to income- one half of the City is very poor, while the other half is rather wealthy.

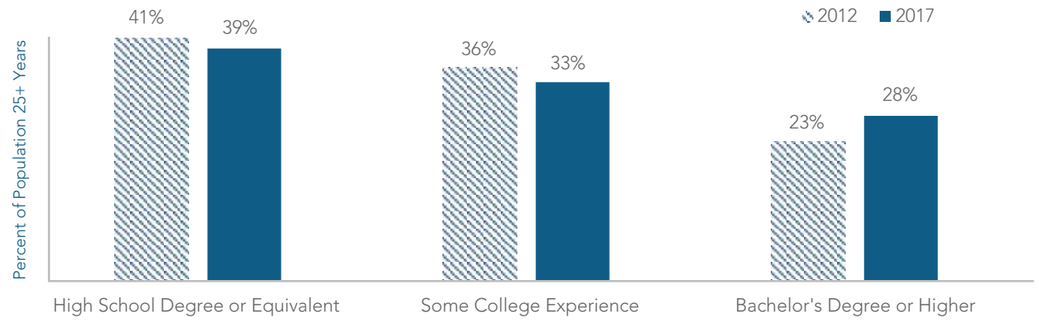
MAP 6: Poverty rates by ZIP code



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 where there are more residents aged 25+ with a Bachelor's degree or higher than in years past (Figure 17).

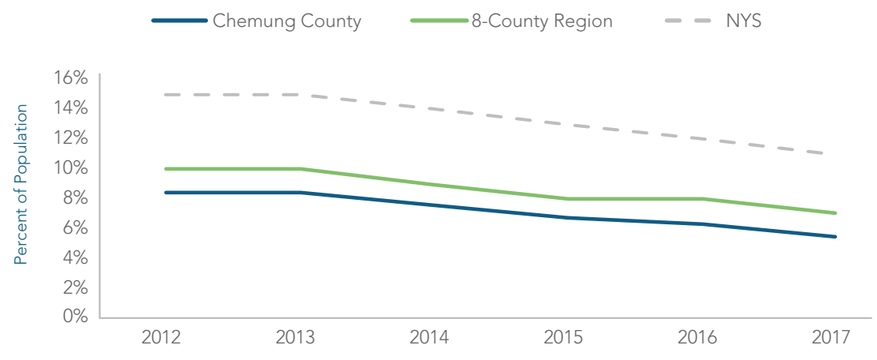
FIGURE 17: Educational attainment for Chemung County by year



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

Data below show the trend in uninsured rates over the past 5 years compared to the eight county region and NYS which has decreased 35% since 2012 for Chemung County (Figure 18).

Figure 18: Percent of population that is uninsured



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

Finally, 32% of Chemung County residents rent vs. own their home. In addition, 11% of occupied housing units have no vehicles available. Another 34% have access to one vehicle. Of note, the average household size for occupied housing is greater than two people. Approximately 44% of residents are paying more than 35% or more of their household income in rent costs.[14]

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

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

Main Health Challenges

On April 9, 2019, stakeholders and community members were invited to attend a priority setting meeting. 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 and primary data collected from the *My Health Story 2018* survey. Lively group discussions took place regarding the potential priority areas. The meeting was very well attended with multiple agencies represented. Ultimately, using the Hanlon and PEARL methods, the group selected the following as their priority areas and disparity for the 2019-2021 Community Health Improvement Plan:

PREVENT CHRONIC DISEASES

1. Healthy eating and food security
2. Physical activity
3. Tobacco prevention

DISPARITY: REDUCE TOBACCO USE AMONG PREGNANT WOMEN

In addition to the group's thoughts, *My Health Story 2018* respondents were also asked questions relating to their top concerns for the health of themselves, loved ones, adults and children in the community (and were reviewed at the prioritization meeting). Weight and mental/emotional health issues rose to the top for each of the four categories. Exercise, education and diet/nutrition were concerns for children in the county. Tobacco appeared to be a concern for adults in the county. Chronic conditions such as cancer and heart conditions were also highlighted as respondents' top fears for themselves and for others. All of these findings help support the decision to move forward with the above mentioned priority areas.

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

BIGGEST FEAR - FOR SELF
Weight (14.1%)
Cost (8.9%)
Mental / emotional health issues (8.6%)
Cancer (7.0%)
Aging (6.8%)

BIGGEST FEAR -FOR OTHERS
Weight (9.3%)
Cancer (7.1%)
Mental / emotional health issues (6.7%)
Heart conditions (6.3%)
Cost (6.0%)

COUNTY PRIORITY - FOR ADULTS
Substance abuse (21.9%)
Weight (21.2%)
Mental / emotional health issues (17.4%)
Cost (14.3%)
Tobacco (12.1%)

COUNTY PRIORITY - FOR CHILDREN
Diet / nutrition (19.0%)
Weight (17.7%)
Education (16.5%)
Mental / emotional health issues (13.8%)
Exercise (13.4%)

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

Approximately one in three adults in Chemung County are obese. The disease affects an estimated 20,000 adults and 625 children, and a higher percentage of the low income population (45%) and those living with a disability (49%).[15] Long-term health complications associated with obesity include increased risk for development of diabetes and hypertension and premature mortality due to related conditions.[16] Respondents to the *My Health Story 2018* survey revealed 15% of Chemung County residents reported poor or fair general health and one in five reported poor or fair physical health.

Two contributing factors to poor health are poor diet and lack of physical activity. Data retrieved from the 2016 Behavioral Risk Factor Surveillance System estimates that only two out of five residents reported eating fruits and three out of five reported eating vegetables on a regular basis. Approximately one in three reported daily sugary drink consumption. *My Health Story 2018* respondents were asked the biggest challenges or barriers keeping them from eating healthier. The biggest barrier to eating healthier, particularly for low income populations, 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.

In Chemung County, 77% of residents engaged in physical activity in the past month. According to *My Health Story 2018* data, the main reason for not engaging in more physical activity are lack of time and feeling too tired to exercise. Of note, the low income population reported that their biggest barrier to being physically active is that they cannot afford a gym membership.

Further evidence to support the priority area decisions are the rates of tobacco use in Chemung County. Rates of tobacco use among adults in the county are the highest in the eight-county region (26% of adults) and are particularly high among the low-income population (38%).[17] Reported use of e-cigarettes is also highest in Chemung County where 5% of adults report using e-cigarettes. It is important to note that e-cigarette use is frequently seen more often in youth and data are relatively new. In actuality, rates of use are likely much higher than 5%.[18]

Of particular concern in Chemung County are the rates of reported tobacco use among pregnant women. Almost one in three pregnant women have reported smoking during pregnancy (Figure 20). Smoking during pregnancy poses significant risks to the baby's health in the womb as exposure to smoke increases rates of premature birth, low birth weight, birth defects, and infant death. Rates of reported tobacco use are substantially higher than New York State and significantly higher than the Healthy People 2020 objective of less than 1.4%.

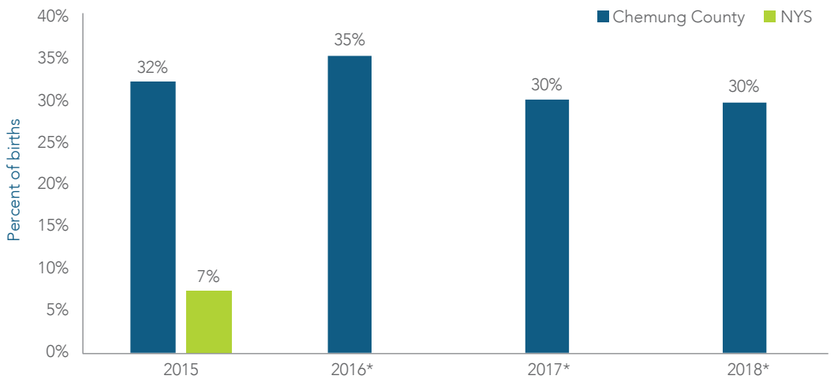
15. Source: Behavioral Risk Factor Surveillance System 2016 and Student Weight Categorizing Reporting System 2016-2018. Note: low income data are unreliable due to large standard error.

16. Source: Behavioral Risk Factor Surveillance System 2016 and Student Weight Categorizing Reporting System 2016-2018

17. Data are unreliable due to large standard error. Source: Behavioral Risk Factor Surveillance System 2013-2014.

18. Source: Behavioral Risk Factor Surveillance System 2016.

FIGURE 20: Percent of births with reported tobacco use during pregnancy



Data Source: NYS SPDS Data Child Abuse.
*Preliminary data. Note NYS data are not available past 2015 at the time of this report.

Policy and Environmental Factors

Current policies in the county help to deter smoking in public places. The Southern Tier Tobacco Awareness Coalition (STTAC) has done tremendous work in tobacco free outdoor policies. Over 50 agencies located in the county have documented tobacco free outdoor policies dating back to 2005. Part of the agency's success may be due to resident support for tobacco free outdoor policies. According to the agency's 2017 Community Tobacco Survey of Adult Residents of Chemung, Schuyler and Steuben Counties, 80% of Chemung County residents favor policies prohibiting smoking cigarettes in entrances of public buildings and workplaces. The majority of respondents also reported favoring policies prohibiting smoking in public parks or outdoor recreational areas (49%), at outdoor public community events (55%), in apartment buildings (49%), on workplace grounds (55%), and in cars with children (82%). Of note, 54% favor policies prohibiting use of electronic cigarettes inside all public places. Significantly, 72% of respondents indicated they would support raising the tobacco purchasing age to 21, a law that was recently signed by Governor Cuomo.

Walkability is another environmental factor which may impact resident health. In January 2017, the Empire State Poverty Reduction Initiative released a report on Elmira, New York – "The Community Resources and Opportunities are Aligned. It's a new day in Elmira, New York." Within the report, residents stated their concerns with walkability in the City of Elmira. While many residents reported they do not feel safe walking in certain areas of the City, the total number of crimes in the area has decreased, which is positive and may help to improve perceived neighborhood safety. To further assist in ensuring a safe and welcoming built environment, the local zoning board is working to help implement the 2016 Comprehensive Plan recommendations. One of those recommendations is to "revise its zoning ordinance to implement the community's vision and encourage healthy urban growth." The new vision will encourage "walkable urbanism over suburban-style more vehicle-centric development." Greater opportunity for physical activity will occur when the plans are put into place.

Unique Characteristics Contributing to Health Status

Chemung County has experienced nursing and other staff shortages over the past several years at its local health department. Staff note they are currently in short supply and state it is difficult to attract new employees for a variety of different reasons. Most notably, all local healthcare providers are fighting for the same staff and some agencies are unable to compete with external wages. As part of the ten essential public health services, it is necessary to ensure a competent public and personal healthcare workforce. The inability for healthcare agencies to remain fully staffed negatively impacts the community by inadvertently creating decreased access to services.

Another unique challenge Chemung County faces is the decline in brick and mortar stores. The area was once a booming shopping area with a variety of entry-level, managerial, and executive job opportunities, though the rise in online shopping has dramatically decreased the need for shopping plazas and malls. Brick and mortar stores which have now closed leave large empty and unused space- each one a missed opportunity for job creation and economic gain for the area. It is important for entry-level positions to be sustained to help those entering the workforce learn generic job skills training and, eventually, obtain greater responsibilities in new positions.

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 Chemung County. For example, focus group attendees identified local farmers' markets, supplemental food programs (i.e. backpack programs, Meals on Wheels, etc.), school based programming (Guess Club and SADD), Special Olympics, and Planned Parenthood as community strengths and resources. 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, staff will work to leverage these pre-existing agencies and services. A full description of interventions and partner roles can be found in the Chemung 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 Health Planning Partnership (HP2) 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 Chemung County's specific process including:

CHEMUNG COUNTY PRIORITIZATION AGENCIES		
Chemung County Public Health	S2AY Rural Health Network	Common Ground Health
Able 2	Anglican Health Ministries	Mothers and Babies Perinatal Network
WIC	EOP	FSCC
Man2Man	Guthrie Hospital	EPC
Elmira CSD	AIM	Finger Lakes Eat Smart NY/CDD
Creating Healthy Schools and Communities	CASA-Trinity	Arnot Health
Foodbank of the Southern Tier	Chemung County Office of Aging	Chemung County Youth Bureau
CIDS	Chemung County Mental Health	CCP

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. Preliminary findings of the assessment were shared with partners at Health Priority Partnership meetings and were shared at coalition meetings that the health department sits on. The public were invited to attend Health Priority Partnership meetings via Facebook.

Specific interventions to address the priority areas were selected at HP2 meetings and were a group effort. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Chemung County Community Health Improvement Plan (Appendix A). Interventions selected are evidence based. Special focus will be placed on reducing tobacco use among pregnant women.

The Community Health Improvement Plan progress and implementation will be overseen by HP2, a group that meets bi-monthly and brings together diverse partners to improve the health of its residents. Progress and relevant data on each measure will be regularly reviewed at these meetings. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

This Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) was created in partnership between the Chemung County Health Department and Arnot Health. It will be disseminated to the public in the following ways:

- Through a media release summarizing the results and offering the opportunity for the public to attend Health Priority Partnership meetings.
- It will be made publicly available on the Chemung County Health Department, Arnot Health, and S2AY Rural Health Network websites.
- It will be made publicly available via a shared link on Health Priorities Partnership partner websites.
- Chemung County Health Department and Arnot Health will share the link for the CHA on their social media accounts.
- It will be presented to and reviewed by the Chemung County Board of Health and the governing board of Arnot Health.

The websites that will have the Chemung County Community Health Assessment 2018 – 2021 posted are:

Chemung County Public Health: http://www.chemungcountyhealth.org/

Arnot Health: https://www.arnothealth.org/

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

Elmira, Chemung County
Photo credit: iStock.com/DenisTangneyJr

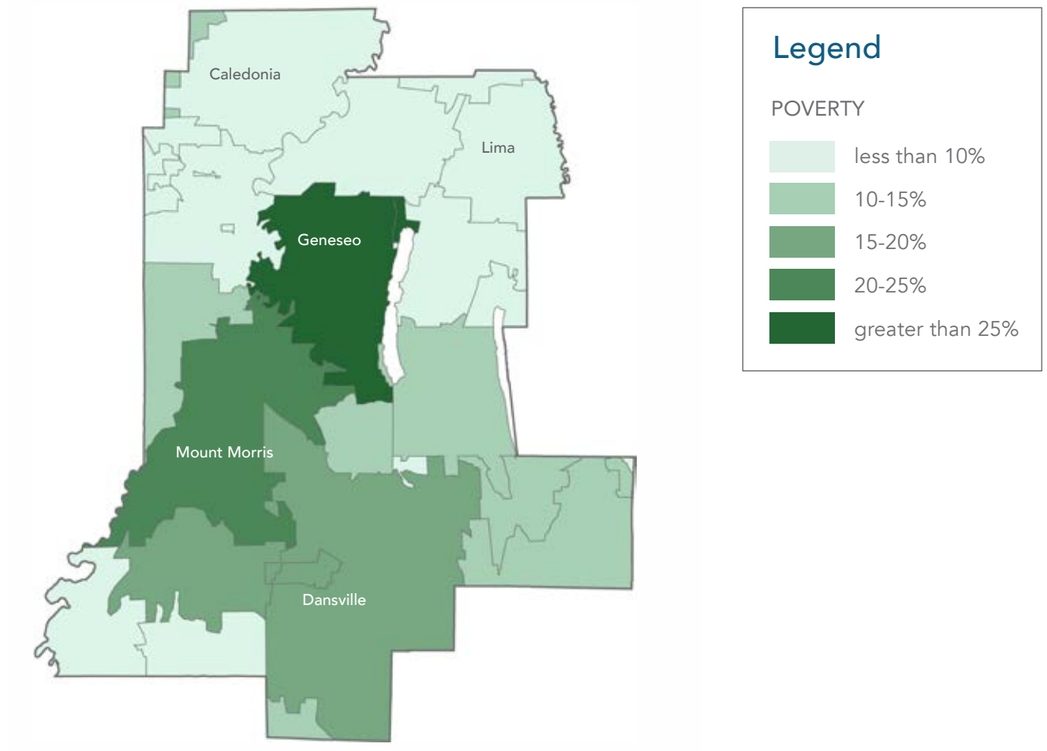
LIVINGSTON COUNTY

Demographic and Socioeconomic Health Indicators

Livingston County is home to Conesus and Hemlock Lakes and Letchworth State Park. It is located south of Monroe County and north of Steuben and Allegany Counties. The northern portion of the county's proximity to the City of Rochester makes it easily accessible for jobs for those able to commute. A total of 64,373 persons reside in the county, the majority of which (94%) are White Non-Hispanic. Women of childbearing age make up 18% of the population, and 25.3% of the 18+ population are living with a disability.[19] 2017 estimates reveal 31% of the 65+ population (N=3,188) is living alone. This rate is up 19% from 2012 when 26% of the 65+ population (N=2,397) was living alone.

A significant number - 14.6% - of Livingston County residents are living below the federal poverty level, and another 16% live near it. The rates are higher in communities such as Geneseo, Mount Morris and Dansville. The distribution of poverty in the county is shown below in Map 7.

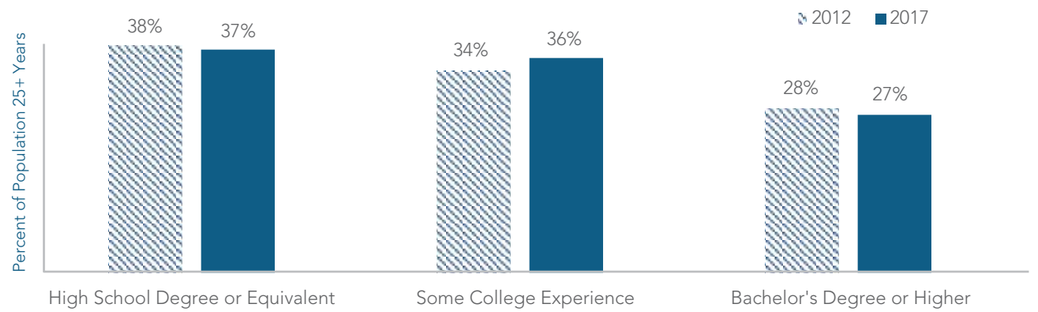
MAP 7: Poverty rates by ZIP code



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

Over the past 5 years, there has been a slight shift in educational attainment where there are more residents aged 25+ with a Bachelor's degree or higher than in years past (Figure 21).

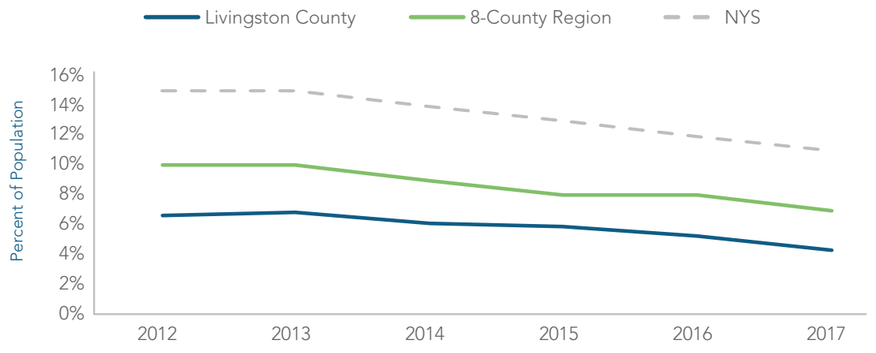
FIGURE 21: Educational attainment for Livingston County by year



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

Data below show the trend in uninsured rates over the past 5 years, which has decreased 33% since 2012 in Livingston County (Figure 22). Of note, uninsured rates in Livingston County are lower than both the eight county and NYS averages.

FIGURE 22: Percent of population that is uninsured



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

Finally, 27% of Livingston 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 50% of residents are paying 35% or more of their household income in rent costs.[20]

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

20. Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

Main Health Challenges

On June 11, 2019, stakeholders and community members were invited to attend a priority setting meeting. At this meeting, participants reviewed the MAPP process, as well as relevant qualitative, quantitative, primary and secondary data. Lively group discussions took place regarding the potential priority areas. The meeting was very well attended with multiple agencies and a community member represented. Data were collected and 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 Livingston County's Prevention Needs Assessment. Ultimately, using the Hanlon and PEARL methods, the group selected the following as their priority areas and disparity for the 2019-2021 Community Health Improvement Plan:

PREVENT CHRONIC DISEASES

1. Healthy eating and food security
2. Physical activity
3. Chronic disease preventative care and management

PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

4. Promote well-being
5. Mental and substance use disorders prevention

DISPARITY: LOW SOCIOECONOMIC STATUS AND OLDER ADULTS

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 and mental/emotional health issues have risen to the top for each of the four categories. Of note, substance use, mental/emotional health and obesity related issues are concerns respondents had for children in the county. Cancer and cost of care rose to the top five for respondents' fears for themselves and for others.

Photo courtesy of Livingston County Department of Health

FIGURE 23: Livingston County summary of health-related concerns for self, loved ones and county to prioritize

BIGGEST FEAR - FOR SELF
Mental / emotional health issues (17.3%)
Weight (9.8%)
Cancer (7.0%)
Heart conditions (6.2%)
Cost (5.8%)

BIGGEST FEAR -FOR OTHERS
Mental / emotional health issues (14.9%)
Cost (10.0%)
Cancer (9.5%)
Weight (6.7%)
Diet / nutrition (6.0%)

COUNTY PRIORITY - FOR ADULTS
Mental / emotional health issues (22.2%)
Substance abuse (20.5%)
Weight (16.4%)
Cost (10.9%)
Diet / nutrition (9.7%)

COUNTY PRIORITY - FOR CHILDREN
Diet / nutrition (21.5%)
Mental / emotional health issues (17.1%)
Substance abuse (15.9%)
Weight (15.4%)
Exercise (15.1%)

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

The 2016 Behavioral Risk Factor Surveillance System estimates that 38% of Livingston County adults are obese with rates slightly higher in the low-income population (40%) and those living with a disability (39%).[21] The chronic condition affects an estimated 17,890 adults and 490 children. Long-term health complications associated with obesity include increased risk for development of diabetes, hypertension and premature mortality due to related conditions. Respondents to *My Health Story 2018* indicated that better diet and nutrition and physical activity habits would help them to manage their weight better.

In terms of diet and nutrition, data demonstrate that 45% and 57% of the county's population reported eating fruits and vegetables, respectively, on a regular basis. Of note, 33% also report daily sugary drink consumption, which is higher than the eight county region (25%).[22] The majority of *My Health Story 2018* respondents (78%) reported that their primary source of healthy foods are from a supermarket or grocery store, though a substantial amount grow their own or utilize farm stands (38%) and local farmers markets (28%).

21. Source: Behavioral Risk Factor Surveillance System, 2016. Low-income data are unreliable due to large standard error. Standard error between 26% and 54%.

22. Source: Behavioral Risk Factor Surveillance System, 2016

Challenges and barriers to accessing healthy foods in the county are similar to other nearby communities. *My Health Story 2018* respondents identified expense as a barrier to eating healthier (43%), particularly among the low income population (53%). Other issues which rose to the top were eating habits of other family members and not having enough time to shop and prepare healthy foods (Table 10).

TABLE 10: Barriers to healthy eating

	LIVINGSTON Income up to $50K	LIVINGSTON Overall	8 COUNTY Overall
Buying healthy food is too expensive	53%	43%	42%
The others in my household don't eat healthy, and we eat together	18%	16%	13%
I don't have the time to shop for, and prepare, healthy food	13%	17%	19%
I don't have any place nearby to buy healthy food	11%	6%	3%
I don't know how to cook and prepare healthy meals that taste good	11%	12%	13%
I don't have the supplies and equipment I'd need to cook healthy food	5%	2%	4%
I don't have the transportation to go shopping for healthy food	4%	2%	3%
I don't enjoy the taste of healthy food	1%	5%	7%
I really don't have any barriers keeping me from eating healthy food	20%	32%	36%
I don't want or need to eat healthier than I already do	4%	8%	8%

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

Physical activity is another contributing factor to obesity rates. Livingston County is home to an abundance of parks, trails and recreational opportunities which residents can take advantage of all year round. The most recent Behavioral Risk Factor Surveillance System (2016) estimated that 81% of residents engaged in physical activity in the past month, which is higher than the average for the region (75%). For those who did not partake in physical activity, *My Health Story 2018* alludes to inability to afford a gym membership (31%), lack of time (40%) and feeling too tired to exercise (26%) as reasons they did not engage. The low income population was more likely to report in the survey inability to afford a gym membership (43%).

During focus groups and leadership team meetings, mental well-being and substance use were noted as hot topics and areas of concern for Livingston County residents. Data from the quarterly New York State Opioid Reporting indicated a 15% increase in opioid overdose deaths in the county from 2016 (N=11) to 2017 (N=13). To date, data show an increase in deaths for the first two quarters of 2018. It is unknown at this time if this trend continued throughout the rest of the year. However, it should be noted that this is different from surrounding counties where many have seen a decrease in deaths in the first two quarters.

Two areas that may help to alleviate substance use disorders and deaths are chemical dependence treatment programs and Naloxone administrations. In terms of treatment centers, the New York State Department of Health tracks and reports the number of OASAS-certified chemical dependence treatment program admissions and reports this data through quarterly reports. In Livingston County, admissions increased from 288 in 2016 to 298 in 2017. The increase in support for residents may help to alleviate the number of deaths that occur in the future. In addition, documented Naloxone administrations have increased from 43 in 2016 to 57 in 2017. Important to note, however, is that these reports do not include undocumented administrations, which may be completed by family, friends or bystanders.

The Livingston County Health Department and its partners have worked diligently over the past several years to help reduce mental and substance use disorders. The Suicide Prevention Coalition of the Genesee Valley Health Partnership formed in 2013 and continues to enhance capacity of the coalition, provide post-invention services, conduct evidence-based trainings in the community, and enhance awareness of services to reduce suicides in the county. Their work, however, is not yet done as mental well-being remains a concern in the county. Rates of adults reporting poor mental health days in the past month have increased from 12% in 2013-2014 to 14% in 2016.[23] Almost half of county respondents to *My Health Story 2018* indicated they have personally dealt with depression or sadness. Many others also reported they have personally dealt with mental or emotional health issues, and 79% of them said they received the help they needed. The most commonly reported support was from doctors, counselors and other mental health professionals (80%) followed by support from friends (52%) and family (51%).

Policy and Environmental Factors

Livingston County health officials and partners have worked to promote healthy living through various systems. Be Well in Livingston, a workgroup comprised of community members and community partners, continues to focus on chronic disease prevention by working to decrease obesity rates among residents in high need areas of the county through policy, systems and environmental change. The slogan of the initiative is "Eat Better, Move More and Stress Less."

In 2016, the group started planning for community centered health improvement planning where they began to focus their health improvement efforts one municipality at a time. The Greater Nunda Area was chosen based on data review, community resources, and willingness to change efforts. This work is referred to as "Be Well in Nunda." 2017 was spent doing focus groups, and assessing. A community committee was then established and continues to be sustained.

23. Source: Behavioral Risk Factor Surveillance System

The Be Well in Nunda initiative works to implement a strategic plan; develop and implement media and outreach plans including a blog titled Get Healthy with the Mayor; develop a nutrition initiative as per CHIP and community input to focus on CATCH training for school which was conducted in September 2019 for Keshequa and Mt. Morris School staff; work with Foodlink and Finger Lakes Eat Smart New York (FLESNY) to increase education and access regarding healthy foods through churches and community as a whole; and continued discussion on sustainability.

In addition, Nunda community members voiced a concern about a lack of physical activity opportunities and awareness of opportunities. Media and outreach titled Fun and Fitness include ads and flyers to increase awareness and utilization of local physical activity opportunities. In 2018, and in partnership with the Nunda Historical Society, group members created a historical walking tour, which was promoted by Fun and Fitness ad/flyers. Upon evaluation of the trail, 26 individuals completed a survey with 87% stating the trail increased their community led physical activity opportunities. The walking tour is open to the public and not only increases knowledge regarding the history of Nunda but promotes physical activity among its patrons.

In addition to the tour, a walking trail and three outdoor exercise stations were added to Kiwanis Park located within the town to help further engage and entice residents to participate in activity and utilize community resources. Evaluation of the trail and stations will occur in 2020. Those involved in Be Well in Nunda initiatives indicated the need for creating a sidewalk from the Town of Nunda to Kiwanis Park, however, this was later found to be a challenge to pursue as it is designated as a State Route. The town recently applied for a grant to build a sidewalk to fulfill the need but unfortunately did not receive funding. Connecting the town to the park would help to increase physical activity, universal accessibility, and recreational use of the park. Funding will continue to be pursued through other avenues.

In the years to come, Be Well in Livingston partners plan to expand and enhance the reach of their initiatives. The workgroup has already begun connections to expand their work in the Town of Mount Morris and, eventually, the Village of Dansville. Both of these communities have been identified as areas with lower life expectancies and high poverty rates.

In relation to cancer screenings, the Mobile Mammography Unit (Rochester Regional Health) and mammography screening days (provided by the Finger Lakes Cancer Services Program, UR Medicine/Noyes Health and The Elizabeth Wende Breast Care) have increased access to breast cancer screenings among Livingston County residents. The availability and flexibility of screenings encourages use of preventative care and the potential of early diagnosis and treatment of breast cancer. Doing so would result in less likelihood of long-term chemotherapy for the individual and the chance for a better quality of life.

Main Streets Go Blue is a NYSDOH initiative, which has been implemented in Livingston County since 2011 to increase colon cancer screening rates. The County received a model practice award from the National Association of County and City Health Organizations as evaluation of the initiative showed an increase in colon cancer screenings among Livingston County residents. This initiative also led to the County being one of three in the State to achieve 80% colon cancer screening rates by 2018.

Livingston County's environment can be quite rural and for those without a vehicle, it can be challenging to get from place to place. As such, transportation is often a reported issue for residents. Livingston County respondents to *My Health Story 2018* indicated transportation is an issue in terms of accessing healthy and wholesome foods (14% report it is a barrier), medical services (14% report it as a barrier), picking up necessary prescriptions (11%), and more. To address these issues in the county, Ride Livingston was created and is coordinated by the Livingston County Planning Department in collaboration with community partners. The mobility management website provides information on transportation resources and options available to county residents. There is a specific emphasis on providing information to assist at-risk populations such as older adults, people with disabilities and individuals with lower incomes in need of specialized transportation services. Improving access to transportation for the higher risk populations may help to improve the health and well-being of the community.

As previously mentioned, mental health well-being remains a concern for residents based on data found in state reporting, *My Health Story 2018* survey results, and anecdotal stories. Several initiatives have taken place to combat this. First, the county's 25-bed inpatient residential facility was recently established, and it has operated at full capacity since its opening. The addition of the facility helps provide local access to necessary services for residents, though additional services may be required. Second, the Suicide and Overdose Grief Support Group provides support for family members and friends to those who have lost someone due to suicide or overdose. The group meets monthly and coordinates an annual Suicide Awareness Candlelight Vigil.

In addition, Noyes Wellness and Mental Health Services have responded to growing mental health needs of residents in its rural service area. They provided 16,500 visits in 2017, 20,000 visits in 2018 (a 23% increase), and are projecting 22,500 visits in 2019 (12.5% increase). In response to this growing need, they will be adding two psychiatric nurse practitioners to their current team of 25 full-time therapists with three current psychiatric providers. Walk-in Crisis hours have been expanded to 8 a.m. to 4 p.m. five days per week resulting in a 50% increase of visits. The clinic has also expanded satellite locations by adding the May Center (BOCES) in Mt. Morris and Canaseraga School district. They have also purchased land in the northern part of Livingston County to open up a new Noyes Mental Health Clinic in Avon. Building construction will start in 2020.

Livingston County Mental Health increased capacity to serve the Livingston County community to 13 clinicians. There was an increase in the Nurse Practitioner Psychiatric by 7 hours per week with a 12% increase in the number of visits. Open access which provides services on a walk-in basis at the Mental Health clinic continues to increase accessibility. In addition, Livingston County Mental Health continues to increase access and decrease stigma by integrating services at the Department of Social Services and the Livingston County Jail. Mental Health also partners with Public Health to provide media and outreach to the community regarding overall health which includes physical, mental and social well-being.

Community members and partners can take part in evidence-based trainings at CASA-Trinity, including Narcan administration, Shawna Has a Secret for parents/guardians, Peer Navigator programs, and community forums/town hall meetings.

A voluntary drug amnesty program also continues to be available for county residents. Community members can voluntarily drop off drugs and/or paraphernalia at the Sheriff's Office, Livingston County Mental Health Services, CASA-Trinity or Livingston County DSS. Residents will avoid arrest and be scheduled for an immediate appointment at CASA-Trinity in either Geneseo or Dansville. Only a few individuals have utilized the program to date.

Systems change initiatives are also helping to improve mental health access. The Livingston County Mental Health clinic now offers open access for walk-in clients. This service improves the accessibility of services for those in immediate need.

Another systems change example is the creation of the Mobile Crisis Response, which strives to reduce mental health arrests and ED visits. Livingston County Mental Health Services, UR Medicine/ Noyes Health Mental Health, and CASA-Trinity of Livingston County have collaborated since October 2018 to deploy behavioral health clinicians to attend crisis calls after hours with law enforcement officers, to conduct on-site behavioral health and substance use evaluations, and potentially avoid

unnecessary hospital admissions. Safety plans are developed during the crisis encounters, and follow-up appointments are scheduled at Noyes or Livingston County Mental Health Clinics, or at CASA Trinity's outpatient clinic. Transportation to and from follow-up appointments can be arranged through CASA-Trinity's Peer Advocate Program. The effort is funded through Behavioral Health Community Crisis Stabilization funds using Finger Lakes Performing Provider System monies. In 2019, the program's first full year of funding, the team is on track to respond and assist with 160 municipal calls by year end.

Finally, Livingston County also has access to geographic information system (GIS) data mining regarding opioids, which provides a snapshot of arrests, overdoses and deaths in the county provided and complied by the county police department. These data assist community partners plan overdose prevention efforts. All of these services help to increase local access to services, which may help to reduce the burden of mental health diseases and substance use disorder.

Other unique characteristics contributing to health status

Similar to other local communities in the Finger Lakes are the accessibility of wineries and breweries. Within Livingston County, the number of breweries has increased to eight (8) and has revived the local economy. While the presence of the businesses provides economic boosts and helps to generate tourism, it is important to consider the implications of access to alcohol has on things such as underage drinking and alcohol-related accidents. To assist with the challenge, a local community health coalition (Healthy Communities That Care (HCTC)) aims at bringing the community together to implement strategies to reduce youth alcohol and drug use. HCTC implements three strategies to prevent underage drinking in the county: Parents Who Host Lose the Most, Project Sticker Shock, and Reducing Underage Drinking Social Marketing Campaign.

In addition, Tobacco 21 was not passed locally in Livingston County, yet the law will go into effect in New York State in 2019. This law will raise the age to legally purchase cigarettes and electronic cigarette products to age 21, which will decrease access for minors and, hopefully, reduce initiation and continuation of cigarette and e-cigarette usage.

Finally, Skybird Landing Apartments provide quality, affordable housing opportunities for severe and persistent mental health/low income individuals and families. The benefits of quality affordable housing profit the individual and/or family, as well as community at large by improving neighborhood and community appeal. In addition, lower rents potentially free up resources for medications, preventative care, healthy foods, recreational activities and childcare.

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 Livingston County. For example, focus group attendees identified county programs (falls and chronic disease prevention), collaboration between agencies, sense of community and volunteerism as community strengths. In addition, access to health care and food (via farmers' markets and grocery stores) were noted as assets in the area that help a person live healthier. A comprehensive list of identified strengths and resources can be found in focus group summaries and are available upon request. In addition, the CHA Leadership Team implemented a community asset mapping process which included a list of individuals, groups, agencies and natural resources in the county. This was also utilized to identify gaps in the community such as lack of inpatient mental health facilities and a community center (YMCA).

Through implementation of the Community Health Improvement Plan, staff will work to leverage these pre-existing agencies and services. A full description of interventions and partner roles can be found in the Livingston County Community Health Improvement Plan document. Partnering and leveraging the assets and resources of local community agencies will be imperative to achieving success in the plan.

Community Health Improvement Plan/Community Service Plan

As previously discussed in the executive summary, the MAPP process was used to help create the Community Health Assessment and Community Health Improvement Plan.

A variety of partners were engaged in Livingston County's specific process including:

LIVINGSTON COUNTY PRIORITIZATION AGENCIES		
Livingston County Public Health	UR Noyes Health	Common Ground Health
Excellus Blue Cross Blue Shield	Arc of Livingston and Wayne	LCCNR
Health and Wellness	Tri-County Family Medicine	Office for Aging
Veterans	Genesee Valley Health Partnership	Noyes Wellness and Mental Health
Livingston County Mental Health	CASA/Trinity	Livingston County Planning Department
Cancer Services	UR Center for Community Health and Prevention	Livingston County Sheriff Department
Community member		

The community at large was engaged throughout the assessment period via a regional health survey and focus groups. Focus groups were conducted with diverse populations, which included law enforcement, seniors, veterans, disabled individuals, Hispanic families and community partners to ensure social determinants of health were considered. Discussions regarding public health priorities occurred with "Conversations around the County," which is facilitated by the County Administrator in various locations of the county throughout the year. Information regarding the results of the MAPP process and prioritization was posted on the Livingston County Department of Health and UR Medicine Noyes Health websites and social media for the community's input.

Specific interventions to address the priority areas were selected at CHA Leadership meetings, GVHP committees (Trauma Informed Communities and Be Well in Livingston), and were a group effort. Each member highlighted where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives took place via public meetings including conversations with the County Administrator and the community was asked for input via a press release, social media posts and various postings on websites. A full description of objectives, interventions, process measures, partner roles and resources are available in the Livingston County Community Health Improvement Plan (Appendix B). Root cause analyses were discussed while developing the CHIP. Interventions selected are evidence based. Special focus will be placed on increasing food security among older adults and residents with low socioeconomic status.

The Community Health Improvement Plan progress and implementation will be overseen by CHA Leadership and GVHP, a group that meets a minimum of twice per year and brings together diverse partners to improve the health of its residents. Progress and relevant data on each measure will be regularly reviewed at these meetings. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

The executive summary of the 2019-2021 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) created in partnership between the Livingston County Department of Health and UR Medicine Noyes Health) will be disseminated to the public in the following ways:

- Made publicly available on the Livingston County Public Health main website and social media sites
- Made publicly available on the UR Medicine Noyes Health main website and social media sites
- Made publicly available on the Genesee Valley Health Partnership website
- Made publicly available on the S2AY Rural Health Network website
- Made publicly available on additional partners websites (Cornell Cooperative Extension, local community based organizations, etc.)
- Shared with all appropriate news outlets in the form of a press/media release
- All partners including CHA Leadership Team and GVHP members will share the document via their organizations' websites as well.

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

Livingston County Public Health: http://www.livingstoncounty.us/doh.htm

UR Medicine Noyes Health: https://www.noyeshealth.org

Genesee Valley Health Partnership: www.gvhp.org

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

Common Ground Health: www.commongroundhealth.org

Letchworth State Park
Photo courtesy of Livingston County Department of Health

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 11 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 11: 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%

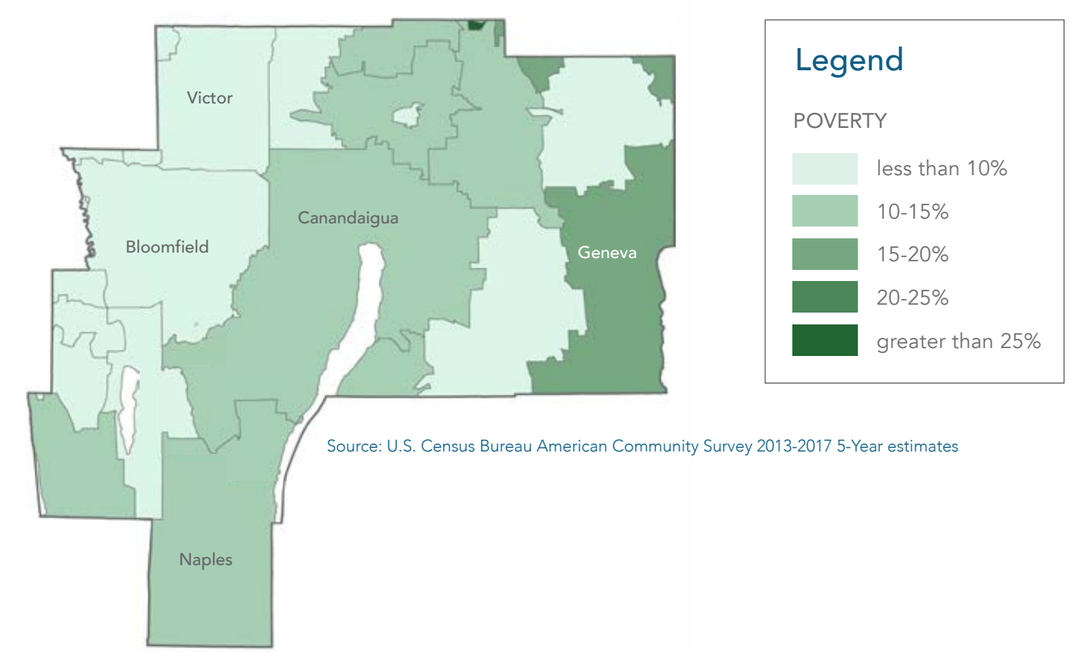
Source: US Census Bureau 2010 Decennial and 2018 Population Estimates Program

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.[24] However, socioeconomic status varies widely in the county by zip code (Map 7). 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.

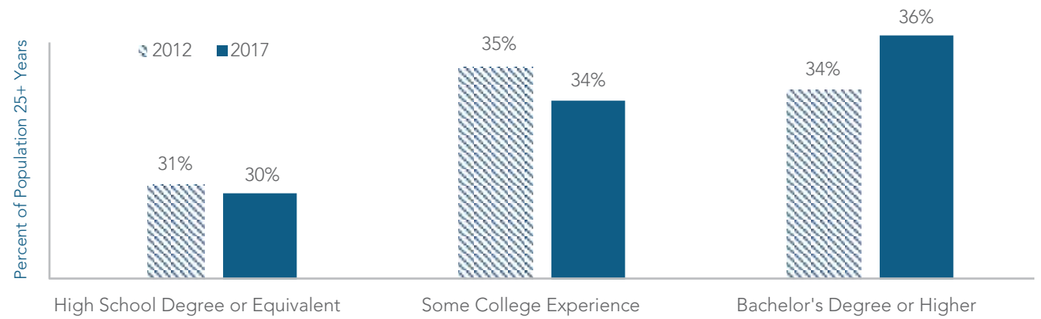
MAP 8: Poverty rates by ZIP code



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 24). 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.

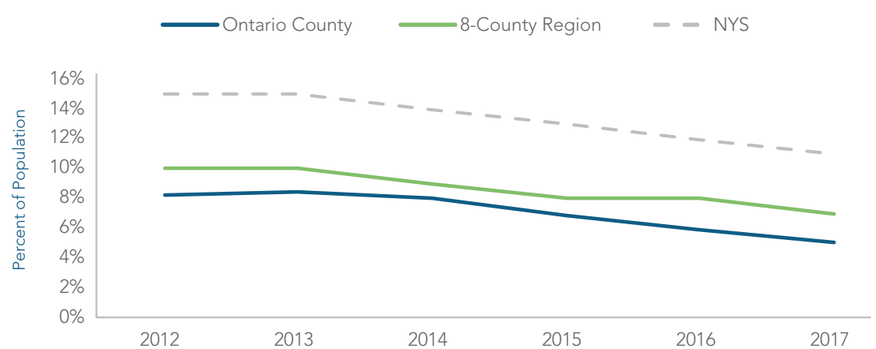
FIGURE 24: Educational attainment for Ontario County by year



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

As shown below, the uninsured rate in Ontario County has decreased 39 percent since 2012 (Figure 25). 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 25: Percent of population that is uninsured



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

24. 2013-2017 American Community Survey 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.[25]

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 DISEASES

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 26). 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 26: Ontario County summary of health-related concerns for self, loved ones and county to prioritize

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 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%).[26] 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.[27] 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%[28] of adults have been diagnosed with hypertension, 79%[29] of whom are in control of their blood pressure. Control rate varies by income level (Figure 27). 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

25. Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

26. Data are unreliable due to large standard error. Source: Behavioral Risk Factor Surveillance System 2013-2014.

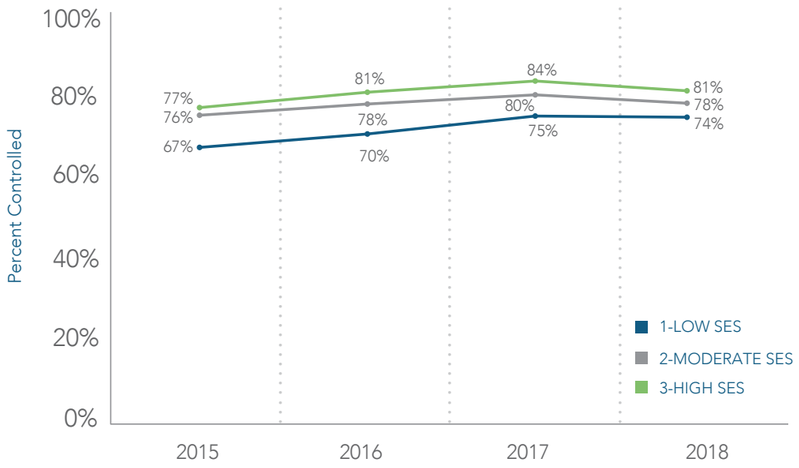
27. Source: Behavioral Risk Factor Surveillance System 2016.

28. Source: Behavioral Risk Factor Surveillance System 2016.

29. Source: Common Ground Health High Blood Pressure Registry, June 2018.

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 27: Ontario County control rate by socioeconomic status over time



Data Source: June 2018 Common Ground Health Hypertension Registry

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 28 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 28: 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

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 surrounding 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.

Canadice Lake, Ontario County
Photo courtesy of VisitFingerLakes.com

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 Ontario 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
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 C). 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.

Ontario County
Photo courtesy of VisitFingerLakes.com

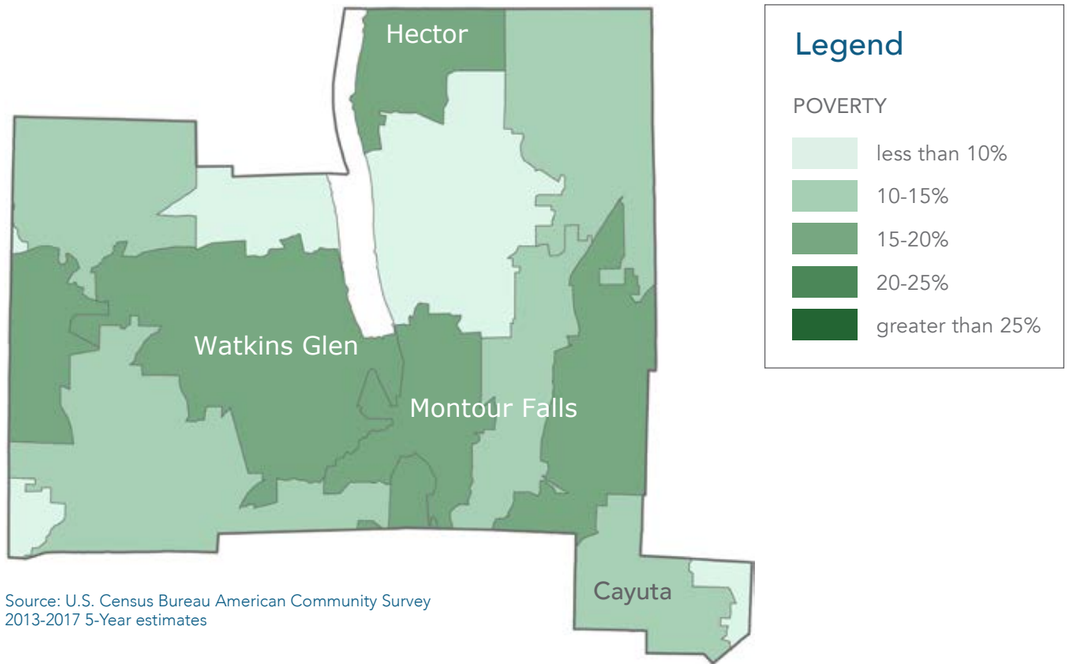
SCHUYLER COUNTY

Demographic and Socioeconomic Health Indicators

Schuyler County is home to the southern tip of Seneca Lake and Watkins Glen State Park and has the smallest county population in the region. A total of 18,112 people permanently live in the county, the majority of which (97%) are White Non-Hispanic. Women of childbearing age comprise 14% of the population, and 23% of the 18+ population are living with a disability.[30] 2017 estimates reveal 26% of the 65+ population (N=896) is living alone. This rate is down 7 percent from 2012 when 28% of the 65+ population (N=898) was living alone.

In Schuyler County, 15% of residents are living below the federal poverty level, and another 22% live near it. The distribution of poverty in the county is shown below in Map 7. While not represented in the data, anecdotal evidence suggests rates of poverty are much higher than shown in the map. Similar to other counties, the presence of wealthy lake houses on the shorelines of Seneca Lake likely mask income disparities within a zip code.

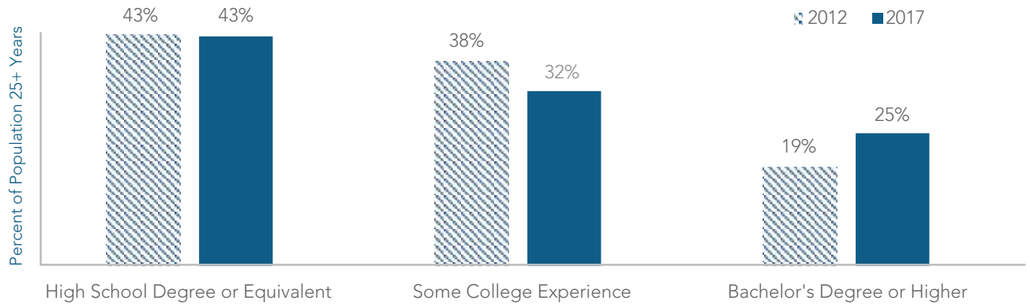
MAP 9: Poverty rates by ZIP code



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

Over the past 5 years, there has been a slight shift in educational attainment where there are more residents aged 25+ with a Bachelor's degree or higher than in years past (Figure 29).

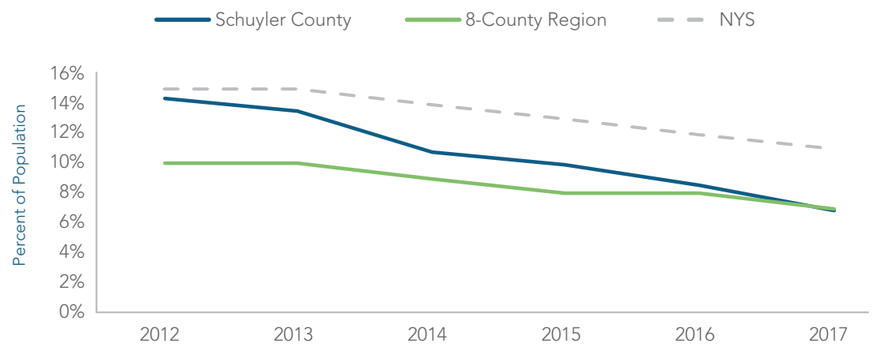
FIGURE 29: Educational attainment for Schuyler County by year



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

Data below show the trend in uninsured rates over the past 5 years compared to the eight county region which has decreased 52 percent since 2012 for Schuyler County (Figure 30).

FIGURE 30: Percent of population that is uninsured



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

In terms of housing and vehicle access, 24% of Schuyler County residents rent vs. own their home. Of the occupied housing units, 7% have no vehicle available, and 33% have access to one vehicle. The average household size for occupied housing is greater than two people. Approximately 38% of residents are paying 35% or more of their household income in rent costs.[31]

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

31. Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

Main Health Challenges

On April 10, 2019, stakeholders and community members were invited to attend a priority setting meeting. 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 and primary data collected from the *My Health Story 2018* survey. Lively group discussions were had regarding the potential priority areas. Over 30 participants attended the meeting. Ultimately, using the Hanlon and PEARL methods, the group selected the following as their priority areas and disparity for the 2019-2021 Community Health Improvement Plan:

PREVENT CHRONIC DISEASES

1. Chronic disease preventative care and management

PROMOTE MENTAL WELL-BEING AND PREVENT SUBSTANCE USE DISORDERS

2. Prevent mental and substance use disorders

DISPARITY: LOW INCOME

In addition to the group's thoughts, *My Health Story 2018* respondents were also asked questions relating to their top concerns for the health of themselves, loved ones, adults and children in the community (and were reviewed at the prioritization meeting). Weight and mental/emotional health issues rose to the top for each of the four categories. Of note, diet/nutrition, exercise and substance abuse and well-being were concerns for children in the county. Substance abuse appeared to be more of a concern for adults in the county, however. Mental emotional health and chronic disease such as obesity, cancer and heart conditions were highlighted as concerns for respondents' fears for themselves and for others.

FIGURE 31: Schuyler County summary of health-related concerns for self, loved ones and county to prioritize

BIGGEST FEAR - FOR SELF
Mental / emotional health issues (12.6%)
Cost (10.7%)
Weight (9.9%)
Aging (8.8%)
Cancer (7.6%)

BIGGEST FEAR -FOR OTHERS
Cancer (12.8%)
Cost (11.7%)
Mental / emotional health issues (9.6%)
Diet / nutrition (6.4%)
Heart conditions (6.3%)

COUNTY PRIORITY - FOR ADULTS
Substance abuse (19.3%)
Weight (14.4%)
Mental / emotional health issues (14.2%)
Cost (13.5%)
Diet / nutrition (11.1%)

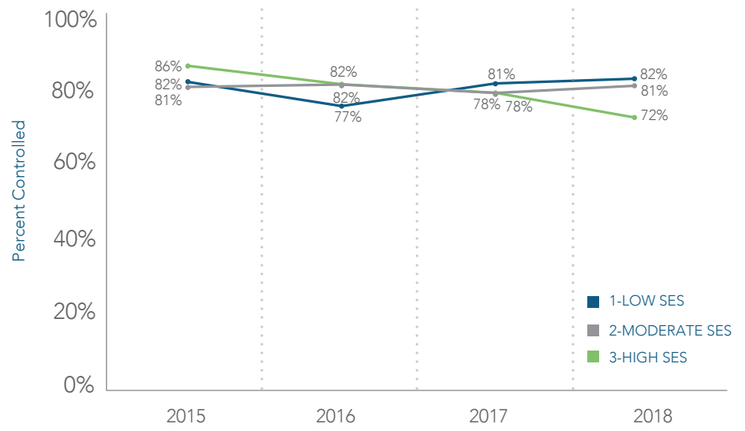
COUNTY PRIORITY - FOR CHILDREN
Diet / nutrition (23.2%)
Exercise (19.0%)
Substance abuse (16.5%)
Mental / emotional health issues (13.0%)
Weight (13.0%)

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

An estimated 23% of adults in the county have been diagnosed with hypertension. Data from the June 2018 Common Ground Health Hypertension Registry reveal that 81% of county hypertensive residents are in control of their blood pressure. Historically, county residents have varied very little in control rate by socioeconomic status, though a gap has begun to form in the most recent data (Figure 32). Interestingly, we see a reverse scenario than typically expected or seen in other areas where higher socioeconomic patients have a lower control rate, though, only 4% of Schuyler County patients fall within the high SES category. The small numbers may contribute to this finding.

FIGURE 32: Schuyler County control rate by socioeconomic status over time



Source: June 2018 high blood pressure registry

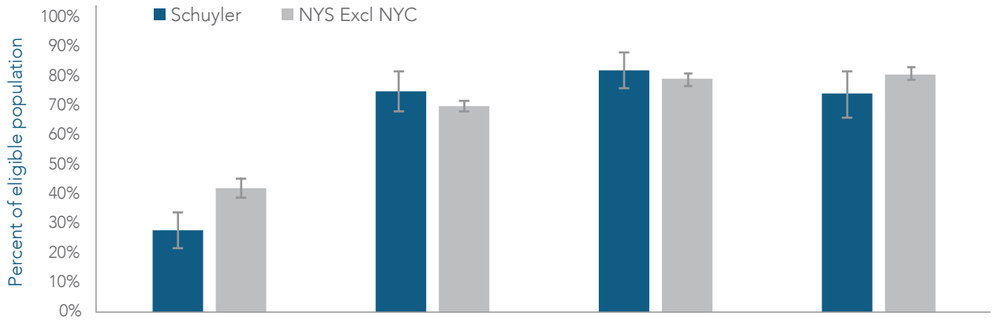
Tobacco use increases risk for cardiovascular disease. An estimated 19% of adult residents report cigarette smoking every day or some days. Currently, the Behavioral Risk Factor Surveillance System does not have an estimate for use of e-cigarettes in Schuyler County despite it being identified as an emerging health issue. This is likely due to data and analytic constraints due to small sample sizes in the survey and the inability to appropriately extrapolate the estimates to county-wide. Regionally, it is estimated that 4% of adults are currently using e-cigarettes, though it is likely the true rate is much higher (particularly among youth).

Proper diet, nutrition and physical activity are necessary components for maintaining a healthy weight and lifestyle. In terms of access to healthy foods, many respondents to the *My Health Story 2018* survey indicated that they purchase their fruits and vegetables from a supermarket or grocery store (76%). However, Schuyler County residents are significantly more likely to access these same foods from a local farm stand (44%) or from their own garden (33%) compared to the region. Data from the Behavioral Risk Factor Surveillance System reveal 39% and 62% of county adults reported eating fruits and vegetables, respectively, on a regular basis. Of note, one fourth of the population also report daily sugary drink consumption.

In terms of barriers to eating healthy, *My Health Story 2018* respondents indicated that the cost of food is the biggest barrier for them (38%). For lower income residents, the rate of reporting cost as a concern jumps to 50% of the responses. Cost is also an issue to those reporting barriers to being physically active. 20% of all residents report they cannot afford a gym membership (28% for lower income populations). On a positive note, survey respondents also indicated that the built environment is conducive to physical activity. 88% of respondents indicated that their neighborhood was good or great for children to play outdoors, which is higher than the regional rate of 81%.

Screening for cancers is an important preventative step in primary care. Figure 33 below shows the percent of the population that has received screenings for various types of cancer based on recommended guidelines in Schuyler County. Of note, prostate cancer screenings are the lowest in the county, which is a similar findings for each of the other counties in the region.

FIGURE 33: Percent of population receiving cancer screenings, Schuyler County



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

In terms of colorectal cancer screenings, an estimated 75% of county residents have received recommended screenings. However, this varies by sex and income as shown below in Table 12. Particular focus ought to be put on increasing screening rates in the low income population.

Table 12: Colorectal cancer screening rates by demographic

	MALE	FEMALE	LOW-INCOME
Colorectal Cancer Screening Rates	72%	76%	60%*

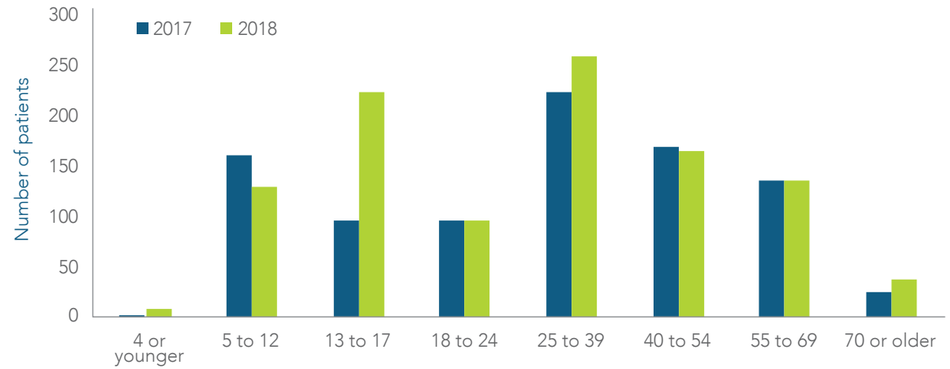
Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health. *low income data from 2013-2014 Behavioral Risk Factor Surveillance System

Rates of substance use are growing in the region. 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 13% of Schuyler County adult residents reported binge drinking in the past month. This has increased slightly from prior years (10% in 2013-2014 estimates).

Regionally, rates of adults who have been told they have a depressive disorder range from 11-22% of populations. Rates reach almost 20% of adults in Schuyler County, which is higher than average for the region. In addition, almost half of *My Health Story 2018* respondents indicated they have personally dealt with depression or sadness. Many others also reported they have dealt with anxiety, fear, and trouble sleeping. For those who have dealt with mental or emotional health issues, 79.3% said they got the help that they needed. The most commonly reported support was from doctors, counselors, and other mental health professionals followed by support from friends and family.

A local support system for mental health and well-being is the Schuyler County Mental Health Clinic. In 2018, 1,054 patients sought care at the clinic (up from 941 in 2017). The majority were aged 25 to 39, though a growing number of patients between the ages of 13 and 17 are being seen (Figure 34).

FIGURE 34: Schuyler County Mental Health Clinic age status of patients



Source: Schuyler County Mental Health

Policy and Environmental Factors

Schuyler County's political and physical environment play a role in resident health. Local residents and tourists are encouraged to make healthier decisions when visiting Schuyler County. Local restaurants have the option to engage in a voluntary food standard program (Choose HEALth) that helps to encourage healthy and tasty meals for patrons. A total of 8 restaurants in the county participated in the program in 2018. For the first two quarters of 2019, 9 restaurants have participated.

The local environment is also supportive of physical activity engagement. During the summer months, the county is bustling with tourists and local residents taking advantage of its beautiful scenery. Watkins Glen State Park is a popular attraction as well as the Finger Lakes National Forest and local county, town and village parks. Seneca Lake intersects the center of Schuyler County. Waterfront redevelopment projects will help to increase physical activity opportunities and accessibility for seniors, veterans and handicapped patrons. A recently awarded downtown revitalization grant in the Village of Watkins Glen will help to create a sustainable environment for year-round innovation and a prosperous economy. All of these things and more help to boost overall well-being in the community.

Transportation, however, is a significant issue that impacts many residents of Schuyler County in a negative way. In fact, the location affordability index in the 2015 Schuyler County Comprehensive Plan shows that housing and transportation costs add up to about 57% of the median household income in Schuyler County, compared to the ideal of 45%. Of note, affordable housing developments, including the recent conversion of the Watkins Glen middle school into affordable housing for 55+, have occurred to address this issue. Being a high tourist area, policies seeking to control the imbalances between short-term vacation rentals and long-term housing have increased over the past several years to help protect long-term residents. In fact, in August of 2019 the Village of Watkins Glen enacted a short-term moratorium on short term rental properties in the village due to the growth in rentals in the community and its impact on resident housing plans. The law will help to protect long-term housing opportunities for residents.

Transportation in the county, however, remains an issue. There is limited access to public transportation to outlying towns, including transportation to medical facilities. It has been noted several times that there are not enough affordable dental care options that accept Medicaid in the county, and patients without access to vehicles have a difficult time accessing services outside of the county. Over time, this negatively affects a person's health as that person may be unable to access medical services, a job, education opportunities, etc.

Unique Characteristics Contributing to Health Status

An interesting caveat to the booming tourist season is its effect on social norms. Throughout the Finger Lakes there is a strong tourism presence, particularly in the summer months where tourist and residents alike visit parks, hiking/walking paths and tour the county's cheese trails. Local wine and craft beer trails are also quite popular yet bring about a sort of social norm around drinking. Schuyler County leadership is aware of the phenomenon and addresses it through Schuyler County Coalition on Underage Drinking and Drugs (SCCUDD). This is a group of dedicated community members, businesses and agencies working to prevent, reduce and delay the onset of substance use among Schuyler County youth. The group achieves its goals by collaborating with community partners, promoting prevention education and substance-free activities, and implementing environmental strategies.

Another unique project in the county is the initiative currently taking place to upgrade an old gymnasium and auditorium (part of the old Watkins Glen Middle School) into the Watkins Glen Performing Arts Center. It is hopeful that the upgrade will attract internationally-known performers to the Arts Center, which will help boost the economy for the community.

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 Schuyler County. For example, focus group attendees identified accessibility to local agency offices (mental health, Office of Aging, fire department, etc.), remodeling of unused buildings to create affordable housing opportunities, and SCCUDD as community strengths and resources. In addition, attendees identified the county's good access to primary care for those able to find transportation as a strength. 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, staff will work to leverage these pre-existing agencies and services. A full description of interventions and partner roles can be found in the Schuyler 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 Professional Advisory Committee (PAC) 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 Schuyler County's specific process including:**

SCHUYLER COUNTY PRIORITIZATION AGENCIES		
Schuyler County Public Health	S2AY Rural Health Network	Common Ground Health
Cancer Services Program	Odessa Montour CSD	Schuyler County Legislature
Care First	Schuyler Hospital	Community Members
Office for Aging	Fidelis Care	Montour Falls Library
SUNY Empire State College	Seneca View	Bradford School
Schuyler Hospital PCC	University of Rochester Center for Community Health and Prevention	Cornell Cooperative Extension
Schuyler County Department of Social Services	Southern Tier Tobacco Awareness Coalition (STTAC)	Fresh Start Church
Schuyler County Coalition on Underage Drinking and Drugs	Schuyler County Mental health	Arnot Health
Independent Living Center	Schuyler County Partnership for Economic Development	

The community at large were 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. Preliminary findings of the assessment were shared with the public on the public health website, Facebook page and were shared with partners that attended the priority setting meeting via email.

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

The Community Health Improvement Plan progress and implementation will be overseen by the Professional Advisory Committee and the Community Health Assessment/Community Health Improvement Plan group at monthly meetings which bring together diverse partners to improve the health of its residents. Progress and relevant data on each measure will be regularly reviewed at these meetings. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

Schuyler County Public Health will do a press release to local media upon completion of the Community Health Assessment/Community Health Improvement Plan. The department will also email the report to local stakeholders and participants of the Community Health Assessment. They will also have it available on their county website and social media pages listed below. Hard copies of the report will be sent to local libraries and will be presented to the Board of Health.

Public Health Website: http://www.schuylercounty.us/621/About-Schuyler-County-Public-Health

Facebook: https://www.facebook.com/SchuylerPublicHealth/

Twitter: https://twitter.com/schuylercoph

Schuyler Hospital Community Page: https://schuylerhospital.org/wp-content/uploads/2017/07/Community-Health-Assessment-Community-Service-Plan-2016-18.pdf

Schuyler County Watkins Glen
Photo courtesy of Schuyler County Public Health

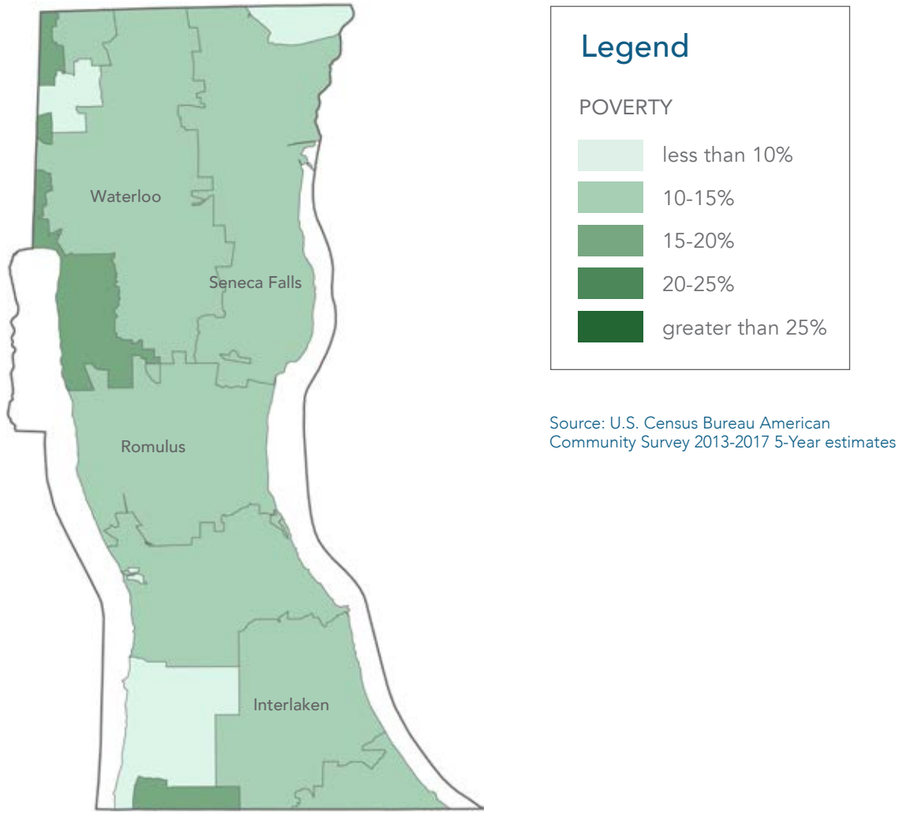
SENECA COUNTY

Demographic and Socioeconomic Health Indicators

Seneca County, also known as the county between the lakes, is bordered by Seneca and Cayuga Lakes. A total of 34,843 persons reside in the county, the majority of which (92%) are White Non-Hispanic. Women of childbearing age comprise 15% of the population, and 22.6% of the 18+ population are living with a disability.[32] 2017 estimates reveal 28% of the 65+ population (N=1,725) is living alone. This rate is down 3% from 2012 when 29% of the 65+ population (N=1,608) was living alone.

Of note are the rates of poverty. In Seneca County, 11.8% of residents are living below the federal poverty level, and another 21% live near it. The distribution of poverty in the county is shown below in Map 10. Of potential significance are the economic disparities in Seneca County. While not represented in the data, anecdotal evidence suggests rates of poverty are much higher than shown in the map. The presence of wealthy lake houses on the shorelines of Seneca and Cayuga Lakes likely mask some of the income disparities within a zip code.

MAP 10: Poverty rates by ZIP code

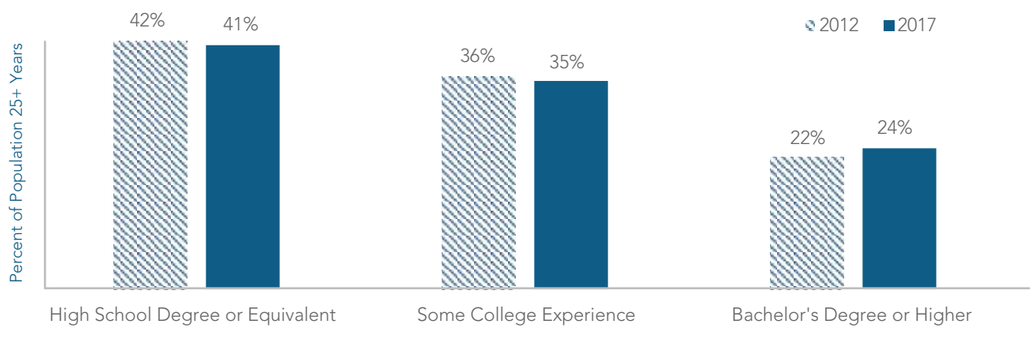


Source: U.S. Census Bureau American Community Survey 2013-2017 5-Year estimates

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

Over the past 5 years, there has been a slight shift in educational attainment where there are more residents aged 25+ with a Bachelor's degree or higher than in years past (Figure 35).

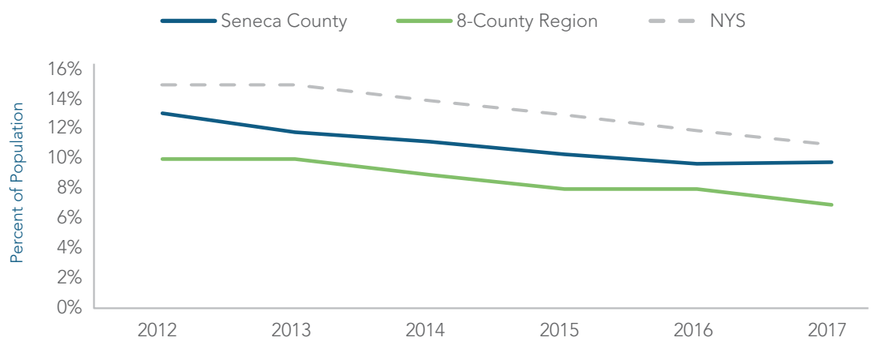
FIGURE 35: Educational attainment for Seneca County by year



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

Data below show the trend in uninsured rates over the past 5 years compared to the eight-county region and New York State. The percent of the Seneca County population that is uninsured has decreased 25% since 2012 (Figure 36).

FIGURE 36: Percent of population that is uninsured



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

Finally, 27% of Seneca County residents rent vs. own their home. In addition, 8% of occupied housing units have no vehicles available. Another 33% 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.[33]

Main Health Challenges

On May 15, 2019, stakeholders and community members were invited to attend a priority setting meeting. 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 and primary data collected from the *My Health Story 2018* survey. Lively group discussions took place regarding the potential priority areas. Approximately 30 individuals attended the meeting. Ultimately, using the Hanlon and PEARL methods, the group selected the following as their priority areas and disparity for the 2019-2021 Community Health Improvement Plan:

PREVENT CHRONIC DISEASE

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

PROMOTE MENTAL WELL-BEING AND PREVENT SUBSTANCE USE DISORDERS

2. Promote well-being
3. Prevent mental and substance use disorders

DISPARITY: LOW SOCIOECONOMIC STATUS

In addition to the group's thoughts, *My Health Story 2018* respondents were also asked questions relating to their top concerns for the health of themselves, loved ones, adults and children in the community (and were reviewed at the prioritization meeting). Weight and mental/emotional health issues were commonly reported concerns across the four categories. Of note, substance use and obesity indicators including weight, exercise, diet and nutrition, were concerns for children in the county. Heart conditions and cost of care were also highlighted as respondents' top fears for themselves and for others.

BIGGEST FEAR - FOR SELF
Weight (14.6%)
Aging (12.2%)
Mental / emotional health issues (10.5%)
Cost (7.4%)
Heart conditions (6.6%)

BIGGEST FEAR -FOR OTHERS
Mental / emotional health issues (13.8%)
Cost (8.7%)
Diet / nutrition (7.7%)
Heart conditions (6.9%)
Weight (6.4%)

COUNTY PRIORITY - FOR ADULTS
Substance abuse (32.8%)
Mental / emotional health issues (16.2%)
Cost (12.4%)
Diet / nutrition (11.9%)
Weight (10.1%)

COUNTY PRIORITY - FOR CHILDREN
Substance abuse (29.5%)
Diet / nutrition (16.5%)
Mental / emotional health issues (16.5%)
Exercise (11.5%)
Weight (9.7%)

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.

33. Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

Behavioral Risk Factors

Approximately 45% of adults in Seneca County are obese. The disease affects approximately 11,460 adults and 325 children. Hypertension is a known risk factor for obese patients. In the county, 39% of adults have been diagnosed with hypertension. Common Ground Health's June 2018 Hypertension Registry estimates that 71% of hypertensive patients are in control of their blood pressure with little variation by socioeconomic status (Figure 38). This is a positive finding because reducing the disparity is a difficult task to accomplish.

FIGURE 38: Seneca County control rate by socioeconomic status over time

Source: June 2018 Common Ground Health HBP Registry

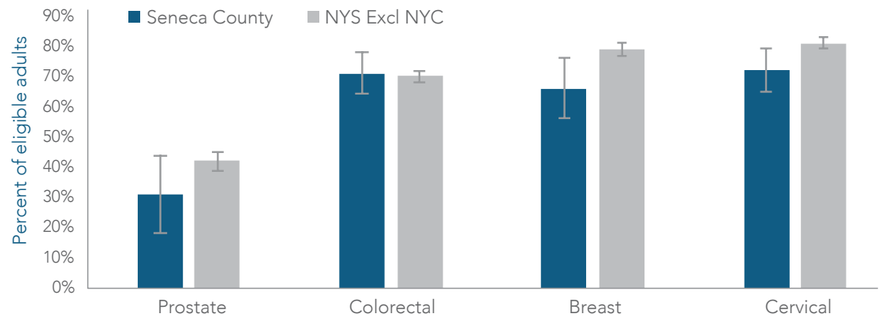
Tobacco use may increase risk of cardiovascular disease. An estimated 15% of adult residents report smoking cigarettes every day or some days. Currently, the Behavioral Risk Factor Surveillance System estimates 1% of residents use e-cigarettes in the county; however, data are sparse. It is likely that uses of the devices are actually much higher.

Proper diet, nutrition and physical activity are necessary components for maintaining a healthy weight and lifestyle. In terms of access to healthy foods, many respondents to the *My Health Story 2018* survey indicated that they purchase their fruits and vegetables from a supermarket or grocery store (74%). However, Seneca County residents are significantly more likely to access these same foods from a local farm stand (43%) or from their own garden (27%) compared to the region. Data from the Behavioral Risk Factor Surveillance System reveal 51% and 76% of county adults reported eating fruits and vegetables, respectively, on a regular basis. Of note, one fourth of the population also report daily sugary drink consumption.

In terms of barriers to eating healthy, *My Health Story 2018* respondents indicated that the cost of food is the biggest barrier for them (46%). For lower income residents, that rate jumps to 53% of the respondents. Cost is also an issue to those reporting barriers to being physically active; 21% of all residents report they cannot afford a gym membership (31% for lower income populations).

Screening for cancers is an important preventative step in primary care. Figure 39 below shows the percent of the population that has received screenings for various types of cancer based on recommended guidelines in Seneca County. Of note, prostate cancer screenings are the lowest in the county, which is a similar finding for each of the other counties in the region.

FIGURE 39: Percent of eligible 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

Substance use has been an area of concern for Seneca County residents for the past several community health improvement cycles. On a positive note, however, Seneca County was one of two counties in the region that saw a decrease in overdose deaths from 2016 to 2017. The county had a 50% reduction in deaths (down 3 deaths to 2) while many other local counties saw an increase. Documented Naloxone administrations have increased in the county, which may help contribute to the lower number of deaths. In 2016, 33 reported administrations occurred, while there were 48 in 2017.

According to survey data from *My Health Story 2018*, 44% of respondents indicated they have dealt with anxiety or fear. Many others reported they personally dealt with depression or sadness (40%) and trouble sleeping (37%). For those who have dealt with mental or emotional health issues, 75% of survey respondents got the help they needed. The most commonly reported support was from doctors, counselors and other mental health professionals (63%) followed by support from family (62%) and friends (43%).

Policy and Environmental Factors

Seneca County has worked to create a healthy environment for residents and tourists all year round. The Department of Public Health has partnered with Tobacco Action Coalition of the Finger Lakes (TACFL), the Housing Coalition and the Landlord Association to create smoke free housing initiatives throughout the county. Reducing and preventing tobacco use in the home will help to reduce both substance use and risk for chronic diseases such as cardiovascular disease.

In addition, an initiative in the southern part of the county led by Seneca Towns Engaging People for Solutions (STEPS) are helping to kick off complete streets work, which will help to create better access for individuals of all ages and abilities to engage in physical activity.

Unique Characteristics Contributing to Health Status

Mental health and well-being has been identified as a concern in Seneca County. The suicide coalition has worked over the past several years to increase awareness about suicide and offer training opportunities such as Talk Saves Lives and More than Just Sad. The coalition also supports the need for increased funding for suicide and mental health interventions. If secured, funding could help to broaden the coalition's reach, thereby positively impacting more individuals and, hopefully, creating a healthier Seneca County.

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 Seneca County. For example, focus group attendees identified local trails and recreational spaces, community agencies (i.e. Glove House, Motherhood Connection, Safe Harbors), county services and access to mental health and urgent care services as community strengths and resources. A comprehensive list of identified strengths and resources can be found in focus group summaries and is available upon request.

Through implementation of the Community Health Improvement Plan, staff will work to leverage these pre-existing agencies and services. A full description of interventions and partner roles can be found in the Seneca County Community Health Improvement Plan document. Partnering and leveraging the assets and resources of local community agencies will be imperative to achieving success in the plan.

Community Health Improvement Plan/Community Service Plan

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

SENECA COUNTY PRIORITIZATION AGENCIES		
Seneca County Public Health	S2AY Rural Health Network	Common Ground Health
New York Chiropractic College	Seneca County Division of Human Services	Greater Rochester Health Foundation
Catholic Charities	Finger Lakes Health	Seneca County Planning Dept.
Tobacco Action Coalition of the Finger Lakes	Finger Lakes ARC	Seneca County Workforce Development
Seneca County Youth Bureau	Seneca County Probation	Office for Aging
Harmony Food Pantry	1st Presbyterian Church of Seneca Falls	Seneca Towns Engaging People for Solutions (STEPS)
Finger Lakes Community Health	Romulus Central School District	Seneca County Mental Health
United Way	Board of Health	Cayuga/Seneca CAP
Cornell Cooperative Extension	Genesee Valley BOCES	

A regional health survey and focus groups engaged the community at large throughout the assessment period. Invitations and pre-read materials were sent to 112 key stakeholders and community partners to attend the priority setting meeting. Pre-read materials provided an opportunity to share preliminary CHA findings with stakeholders and partners prior to the priority setting meeting. Preliminary findings were also shared with the Ovid Willard Lions Club, the Seneca County Chamber of Commerce and shared on the health department's website and Facebook Page.

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

Seneca Health Solutions, a group that meets monthly and brings together diverse partners to improve the health of its residents, will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings 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 Seneca County Community Health Assessment and Community Health Improvement Plan will be made available to community agencies and partners by email and/or hard copy. Members of the public will be able to pick up a copy of the CHA at their local libraries and it will posted on the county website at https://www.co.seneca.ny.us/departments/community-services/public-health/. Links will also be posted on the health department's Facebook Page. In addition, electronic copies will be sent to the Seneca County Chamber of Commerce and requests for posting on Seneca County School District websites will also be made. Copies will also be available on the websites of the S2AY Rural Health Network, Common Ground Health and Seneca Towns Engaging People for Solutions.

Seneca Lake, Ontario County
Photo courtesy of VisitFingerLakes.com

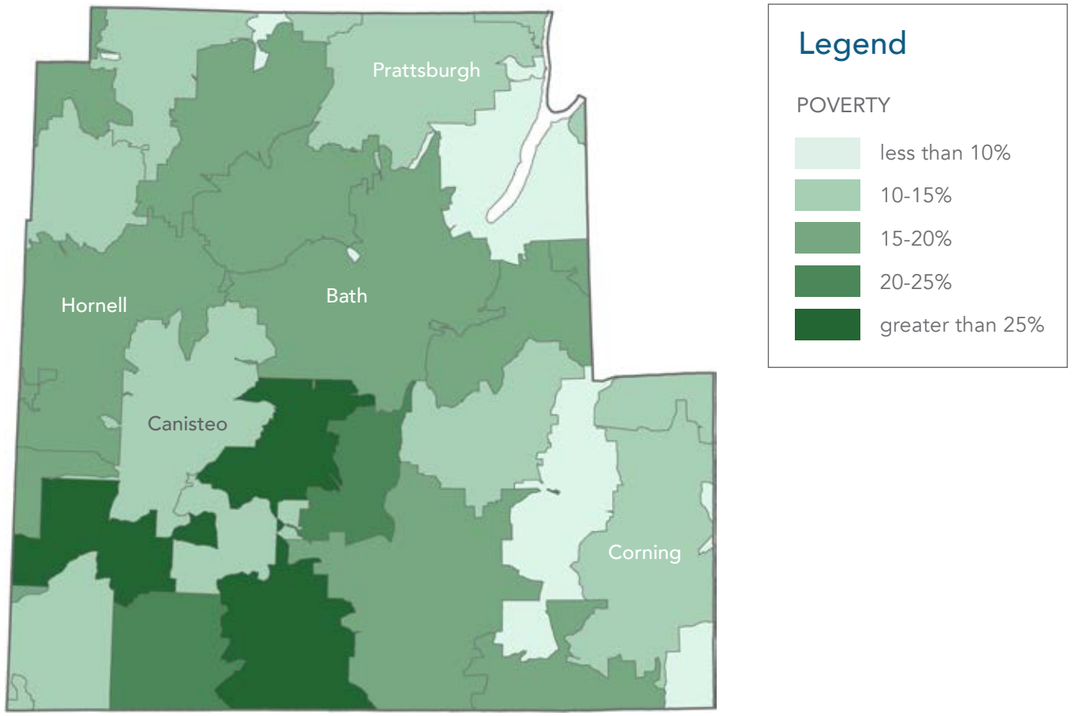
STEUBEN COUNTY

Demographic and Socioeconomic Health Indicators

Steuben County is home to popular tourist attractions including the Corning Museum of Glass and portions of Keuka Lake. It is located west of Chemung County and borders the New York/ Pennsylvania state lines. A total of 97,539 people live in the county, the majority of which (95%) are White Non-Hispanic. Women of childbearing age make up 15% of the population, and 26% of the 18+ population live with a disability.[34] 2017 estimates reveal 26% of the 65+ population (N=4,623) is living alone. This rate is down 13 percent from 2012 estimates when 30% of the 65+ population (N=4,675) was living alone.

Of note is the rate of poverty in the county. Residents living below the federal poverty level make up 14.5% of the population, and another 22% live near it. The distribution of poverty in the county is shown below in Map 11.

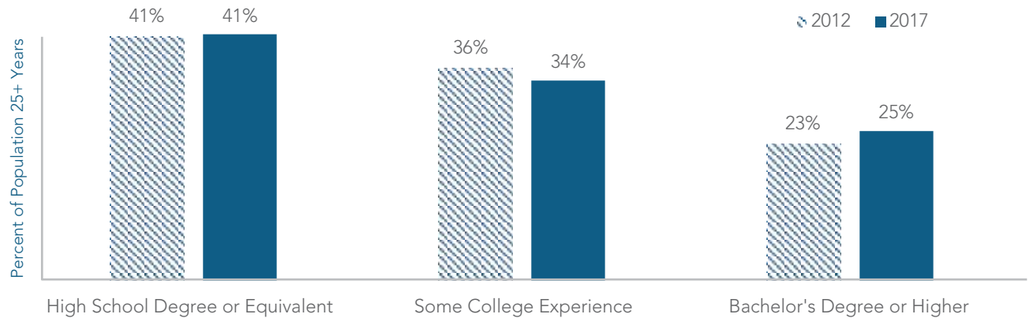
MAP 11: Poverty rates by ZIP code



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

Over the past 5 years, there has been a slight shift in educational attainment where there are now more residents aged 25+ with a Bachelor's degree or higher than in years past (Figure 40). Of note, there has been no change in high school degree or equivalent attainment.

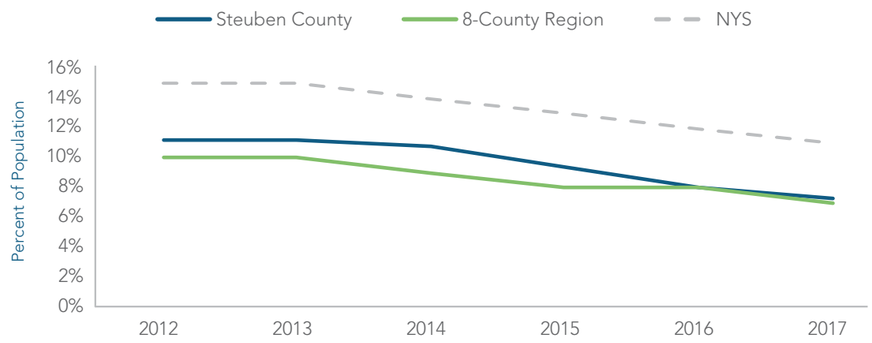
FIGURE 40: Educational attainment for Steuben County by year



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

Data below show the trend in uninsured rates over the past 5 years for Steuben County compared to the eight county region and NYS. There has been a 38 percent decrease since 2012 for Steuben County (Figure 41).

FIGURE 41: Percent of population that is uninsured



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

Finally, 28% of Steuben County residents rent vs. own their home. In addition, 9% of occupied housing units have no vehicles available. Another 35% have access to one vehicle. Of note, the average household size for occupied housing is greater than two people. Approximately 35% of residents are paying 35% or more of their household income in rent costs.[35]

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

35. Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

Main Health Challenges

On May 7, 2019, stakeholders and community members were invited to attend a priority setting meeting. 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 and primary data collected from the *My Health Story 2018* Survey. Lively group discussions occurred regarding the potential priority areas. The meeting was well attended with nearly 60 individuals. Ultimately, using the Hanlon and PEARL methods, the group selected the following as their priority areas and disparity for the 2019-2021 Community Health Improvement Plan:

PREVENT CHRONIC DISEASES

1. Tobacco prevention

PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

2. Child and adolescent health

PROMOTE MENTAL WELL-BEING AND PREVENT SUBSTANCE USE DISORDERS

3. Mental and substance use disorders prevention

DISPARITY: LOW SOCIOECONOMIC STATUS AND PREGNANT WOMEN

My Health Story 2018 respondents were asked questions related to their top concerns for the health of themselves, loved ones, adults and children in the community. Their responses were reviewed at the priority setting meeting (Figure 42). Weight and mental/emotional health issues rose to the top for each of the four categories. Of note, substance use and obesity indicators including exercise, diet and nutrition were concerns for children in the county. Aging and cost of care were also highlighted as respondents' top fears for themselves and for others.

Corning Museum of Glass
Courtesy of the CorningFingerLakes.com

FIGURE 42: Steuben County summary of health-related concerns for self, loved ones and county to prioritize

BIGGEST FEAR - FOR SELF
Weight (12.6%)
Mental / emotional health issues (9.2%)
Exercise (9.2%)
Aging (9.0%)
Cost (7.8%)

BIGGEST FEAR -FOR OTHERS
Cost (9.5%)
Weight (8.8%)
Mental / emotional health issues (8.1%)
Cancer (7.0%)
Aging (6.6%)

COUNTY PRIORITY - FOR ADULTS
Substance abuse (23.6%)
Weight (20.3%)
Mental / emotional health issues (18.6%)
Cost (11.0%)
Aging (9.7%)

COUNTY PRIORITY - FOR CHILDREN
Diet / nutrition (25.2%)
Mental / emotional health issues (20.5%)
Weight (18.5%)
Substance abuse (15.5%)
Exercise (13.4%)

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

Rates of tobacco use in Steuben County (23%) are similar to the average in the eight-county region (22%). E-cigarette use has recently emerged as an issue across many counties and New York State. Data at this time are sparse, though 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," and others are now using both cigarettes and e-cigarettes, consuming more nicotine than before. This perception that vaping is harmless is erroneous. Nicotine is addictive and has an impairing effect on the development of childhood and adolescent brains. Chemical flavorings and colorings, as yet unregulated, 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. The prevalence of smoking is more commonly seen in vulnerable populations. Estimates of usage among those whose income is less than $25,000 annually (33%) and those living with a disability (28%) are higher than general population estimates (23%).[36]

As mentioned, persons who smoke are at greater likelihood of developing chronic conditions such as hypertension. In Steuben County, it is estimated that 32%[37] of adults have been diagnosed with hypertension, 84%[38] of whom are in control of their blood pressure. However, this varies by income level (Figure 43). Reducing the disparity by income requires engaging patients to take control of their blood pressure through various methods: blood pressure medication adherence, promotion of physical activity, healthy eating, and more.

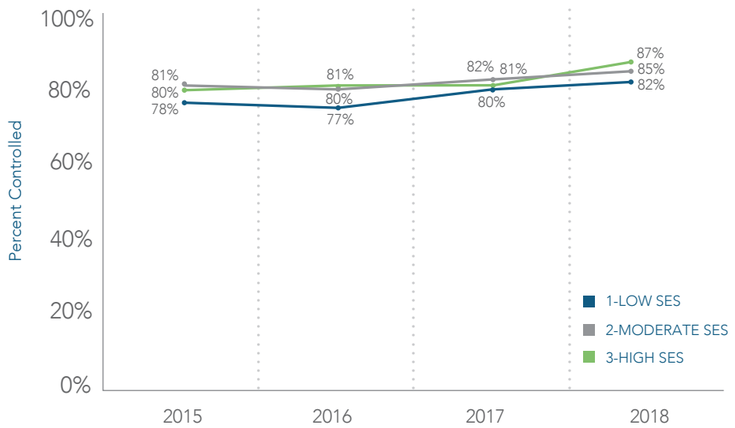
36. Source: Behavioral Risk Factor Surveillance System, 2016. Data on low-income are unreliable due to large standard error: standard error between 19.3% and 43.3%.

37. Source: Behavioral Risk Factor Surveillance System 2016.

38. Source: Common Ground Health High Blood Pressure Registry, June 2018.

Low-income patients are often less likely to be able to afford medications, and it is therefore important to work with providers to prescribe generic medications that are less expensive and accepted by insurance companies. In addition, encouraging and assisting patients in quitting smoking (if applicable) could help to improve control.

FIGURE 43: Steuben County control rate by socioeconomic status over time



Data Source: June 2018 Common Ground Health Hypertension Registry

Social-emotional health is an important developmental skill that is learned in early childhood. It encompasses a child's ability to control his or her own feelings and behaviors, build positive relationships, and understand feelings of others. The World Health Organization defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Therefore, ensuring good health of Steuben County's community warrants its leaders to include mental health as an issue. It was noted in Steuben County's priority setting meeting that access to mental health providers and supports for very young children and adults is limited, and there are barriers to accessing timely care and follow up.

Rates of adults reporting poor mental health days in the past month have improved in the county, though they still impact a large portion of the county. Estimates reveal that 18% of adult residents have been told they have a depressive disorder.[39] According to survey data from *My Health Story 2018*, half of the respondents (50%) indicated they have dealt with depression or sadness, however Many others also reported they have personally dealt with anxiety or fear (43%) and trouble sleeping (36%).

Substance use, particularly use of opioids, has increased in the past several years. Deaths due to opioids in the county have decreased 21% from 2016 to 2017, though this does not mean the issue has been resolved. Documented Naloxone administrations have increased from 69 in 2016 to 88 in 2017, which does not include undocumented administrations by family, friends or bystanders.

In addition, clients admitted to OASAS-certified chemical dependence treatment programs have increased in Steuben County from 2016 (N=418) to 2017 (N=477). The increased support from these programs is likely helpful in contributing to the lower number of deaths related to opioids noted in 2017.[40]

Several efforts have taken place focused on youth prevention in the county. The Steuben Prevention Coalition also holds a youth summit each year to engage student leaders in discussions around drugs and alcohol and how to reduce youth use. Youth Drug Court recently started in Hornell, and a new office for youth counseling will be opening on the Ira Davenport campus in the fall.

Corning-Painted Post School District has implemented programming to educate students on various health topics during the school day and then expands that same education to parents and the community in the evening throughout the school year. Topics have included teen mental health, teen suicide, and vaping among others. The former principal of Columbine even came to speak at one forum.

Finally, transportation poses a problem in Steuben County. Limited public transportation or odd bus scheduling makes it difficult for residents without access to a personal vehicle to traverse the county. Head Start and Early Head Start families noted that the distance between resources and lack of transportation prevents families from getting to doctors' offices on a regular basis for routine exams. Additionally, there is a very limited number (2) of dental offices accepting Medicaid patients or pediatric Medicaid patients. For any extensive dental treatment, families get referred to offices in or near Buffalo, Binghamton, or Rochester, posing further problems for those with already limited transportation options. Luckily, it was noted in the priority setting meeting that many schools have dental assistants make onsite preventative oral health visits for students covered by Medicaid.

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 Steuben County. For example, focus group attendees identified local agencies and support groups in the community, including mental health services/clinics, Planned Parenthood, Meals on Wheels, schools and after school programming, libraries, food pantries and YMCAs as community strengths and resources. In addition, attendees identified the county's clean environment as a strength. 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, staff will work to leverage these pre-existing agencies and services. The Steuben County Community Health Improvement Plan document has a full description of interventions and partner roles. Partnering and leveraging the assets and resources of local community agencies will be imperative to achieving success in the plan.

39. Source: 2016 Behavioral Risk Factor Surveillance System

40. Source: NYS Quarterly Opioid Reporting

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 Smart Steuben and prioritization 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 Steuben County's process including:**

STEUBEN COUNTY PRIORITIZATION AGENCIES		
Steuben County Public Health	S2AY Rural Health Network	Common Ground Health
Canisteo Valley Family Practice	Bath School District	Steuben County Mental Health
Steuben Rural Health Network at the Institute for Human Services, Inc.	211	Finger Lakes Community Health
UR St. James Hospital	Guthrie Corning Hospital	County Legislature
Arc of Steuben	Southern Tier Library System	Office for the Aging
Steuben Prevention Coalition	Steuben County Youth Bureau	Retired and Senior Volunteer Program (RSVP)
Healthy Families Steuben	Genesee Valley BOCES	Pregnancy Resource Center of the Valleys
Southern Tier Tobacco Awareness Coalition	UR Center for Community Health and Prevention	ProAction
Cornell Cooperative Extension of Steuben / Finger Lakes Eat Smart NY	Hornell Area Concern for Youth	Arnot Health
Food Bank of the Southern Tier	Steuben County DSS	Guthrie Home Care
Steuben County Alcoholism & Substance Abuse Services (SCASAS)	Prattsburgh CSD	Steuben Council on Addictions
Oak Orchard Health	Family Service Society	County Administration
City of Corning Health Board	WIC	URMC Primary Care Hornell

Throughout the assessment period, the community at large was engaged 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. Preliminary findings of the assessment were shared with the public via social and traditional media, on Public Health's website, by newsletter, and in Public Health's monthly report.

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

Smart Steuben, a group of diverse partners who meet monthly to improve the health of Steuben residents, will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings 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 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) will be posted to Steuben County Public Health's website (www.steubencony.org/publichealth) and social media pages:

- Facebook: www.facebook.com/SCNYPublicHealth and www.facebook.com/smartsteuben
- Instagram: @steubenpublichealth
- Twitter: @steubencohealth

Additionally, a press release will be submitted to traditional media sources sharing where to find the published documents. Public Health's bimonthly newsletter Wellness Matters will also provide a link to the completed CHA and CHIP. This newsletter is distributed to healthcare providers, libraries, food pantries, schools, county departments and legislators, municipalities, and local service agencies and partners. It is also shared on the website and social media pages, reaching well over 1,000 individuals.

Vineyard on Keuka Lake
Photo by Luke Petrinec
Courtesy of the CorningFingerLakes.com

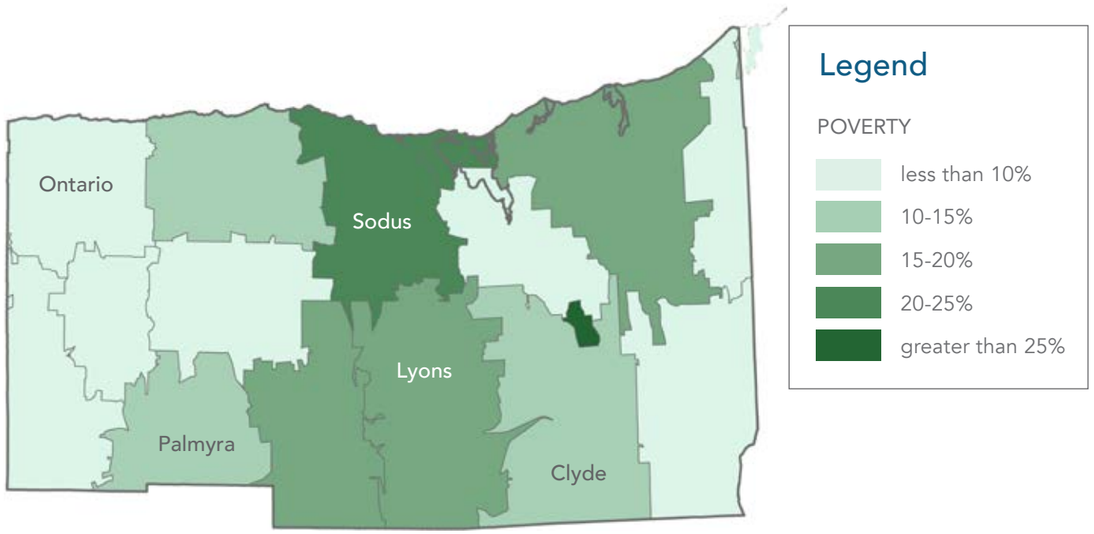
WAYNE COUNTY

Demographic and Socioeconomic Health Indicators

Wayne County is located east of Monroe County and shares its northern borderline with Lake Ontario. The western portion of the county's proximity to the City of Rochester makes it easily accessible to jobs for those able to commute. A total of 91,422 persons live in the county, the majority of which (94%) are White Non-Hispanic. Women of childbearing age make up 15% of the population, and 29.1% of the 18+ population are living with a disability.[41] 2017 estimates reveal 28% of the 65+ population (N=4,413) is living alone. This rate is up 2 percentage points from 2012 when 26% of the 65+ population (N=3.504) was living alone.

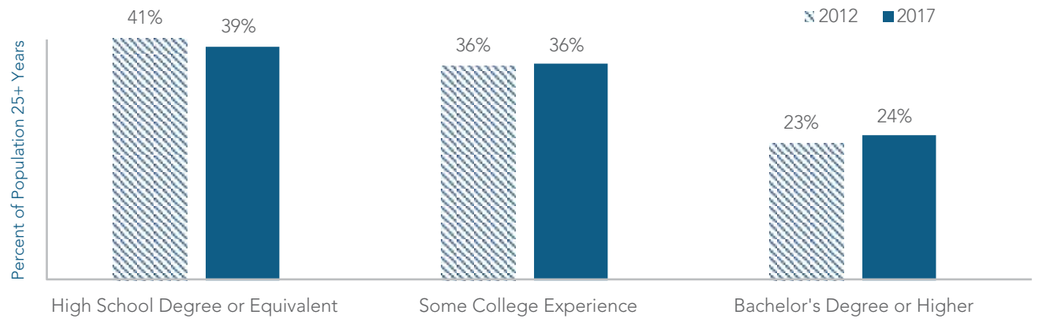
Of note is the density of poverty in the county. Of Wayne County's residents, 11.7% live below the federal poverty level, and another 17% live near it. The distribution of poverty in the county is shown below in Map 12.

MAP 12: Poverty rates by ZIP code



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

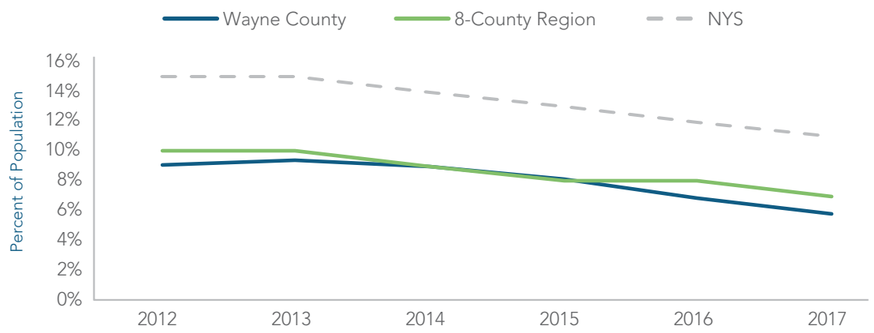
Over the past 5 years, there has been a slight shift in educational attainment where there are more residents aged 25+ with a Bachelor's degree or higher than in years past (Figure 44).



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

Data below show the trend in uninsured rates over the past 5 years compared to the region which has decreased more than 38 percent since 2012 for Wayne County (Figure 45).

FIGURE 45: Percent of population that is uninsured



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

Finally, 23% of Wayne County residents rent vs. own their home. In addition, 7% of occupied housing units have no vehicles available. Another 33% 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.[42]

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

42. Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

Main Health Challenges

On May 17, 2019, stakeholders and community members were invited to attend a priority setting meeting. 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 Wayne County's school student survey. Ultimately, using the Hanlon and PEARL methods, the group selected the following as their priority areas and disparities for the 2019-2021 Community Health Improvement Plan:

PREVENT CHRONIC DISEASES

1. Tobacco prevention
2. Chronic disease preventative care and management

PROMOTE MENTAL WELL-BEING AND PREVENT SUBSTANCE USE DISORDERS

3. Prevent mental and substance use disorders
4. Promote well-being

DISPARITY: LOW INCOME

Lively group discussions took place regarding the potential priority areas. In addition to the group's thoughts, *My Health Story 2018* respondents were also asked questions relating to their top concerns for the health of themselves, loved ones, adults and children in the community (and were reviewed at the meeting). Weight and mental/emotional health issues rose to the top for each of the four categories (Figure 46). Of note, mental health, substance abuse and education were concerns for children in the county. Cost of care and heart conditions were also highlighted as respondents' top fears for themselves and for others.

Chimney Bluffs, Wayne County
Courtesy of Wayne County Tourism

FIGURE 46: Wayne County summary of health-related concerns for self, loved ones and county to prioritize

BIGGEST FEAR - FOR SELF
Cost (14.5%)
Weight (12.9%)
Heart conditions (9.3%)
Mental / emotional health issues (9.1%)
Cancer (8.9%)

BIGGEST FEAR -FOR OTHERS
Cost (12.0%)
Mental / emotional health issues (10.7%)
Cancer (9.4%)
Heart conditions (8.4%)
Weight (6.4%)

COUNTY PRIORITY - FOR ADULTS
Mental / emotional health issues (19.4%)
Weight (16.4%)
Diet / nutrition (15.9%)
Substance abuse (15.0%)
Cost (10.9%)

COUNTY PRIORITY - FOR CHILDREN
Diet / nutrition (25.8%)
Mental / emotional health issues (16.9%)
Weight (14.6%)
Substance abuse (13.4%)
Education (13.2%)

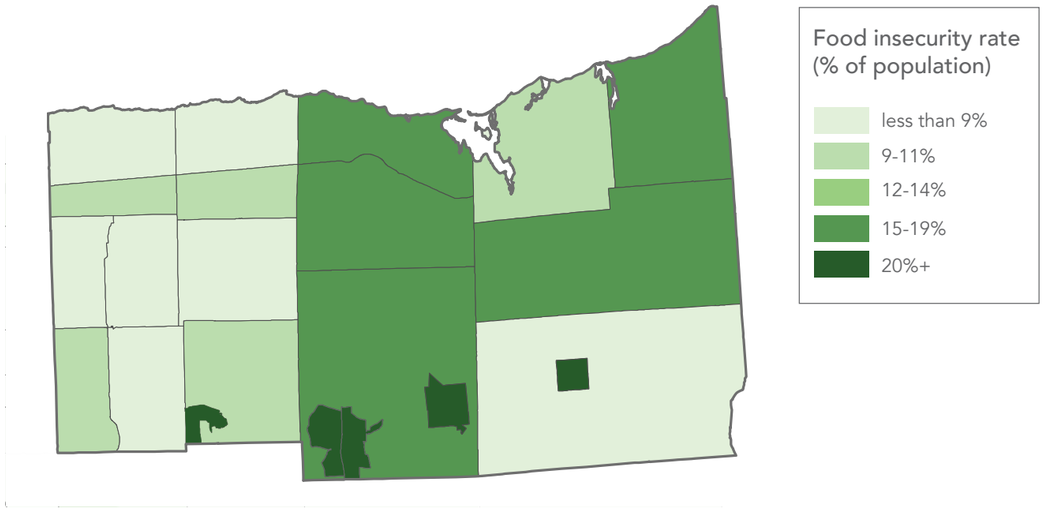
Source: My Health Story survey 2018. Analysis by Common Ground Health incorporates weighting to normalize survey participants to demographics of each county. Top 5 issues shown for each question. Data shown are the percent of participants with responses in each category.

Behavioral Risk Factors

Approximately 37% of adults in Wayne County are obese, which affects more than 24,450 adults and 990 children. Long-term health complications of obesity include increased risk for development of diabetes, hypertension, and premature mortality due to related conditions. Regionally, respondents to *My Health Story 2018* indicated that better diet and nutrition and physical activity habits would help them manage their weight better.

In terms of nutrition, ease of access to healthy foods is an important factor in a person's ability to adopt healthy eating behaviors. According to data from the 2013-14 Behavioral Risk Factor Surveillance System, over 21% of Wayne County's population reported experiencing food insecurity in the past 12 months. Additionally, 16% of Wayne County's *My Health Story 2018* survey respondents reported they are always stressed about having enough money to afford healthy food. Map 13 shows the food insecurity rates by census tract for Wayne County. Higher rates of food insecurity are present in eastern Wayne County including Lyons and Newark.

MAP 13: Food insecurity rate by census tract, Wayne 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.

Rates of tobacco use in Wayne County (25%) are similar to the average in the eight county region (22%). E-cigarette use has recently emerged as an issue across many counties and New York State. Data at this time are sparse, though 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 as harmless is erroneous. Nicotine is addictive and has an impairing effect on the development of child and adolescent brains. Chemical flavorings and colorings, as yet unregulated, 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. The prevalence of smoking is more commonly seen in vulnerable populations. Estimates of usage among those whose income is less than $25,000 annually (32%) and those living with a disability (30%) are higher than general population estimates (25%).[43]

As mentioned, persons who smoke are at greater likelihood of developing chronic conditions such as hypertension. In Wayne County, it is estimated that 40%[44] of adults have been diagnosed with hypertension (the highest in the region), 77%[45] of whom are in control of their blood pressure, though this varies by income level. Of those residents with the highest socioeconomic status, 81% are in control of their blood pressure, while only 75% of low socioeconomic status residents are in control of their blood pressure. Reducing the disparity in control rate by socioeconomic status requires engaging patients in taking control of their blood pressure through various methods: blood pressure medication adherence, promotion of physical activity, healthy eating, and more. Low income patients are often less likely to be able to afford medications, and it is therefore important to work with providers to prescribe generic medications that are less expensive and accepted by insurance companies. In addition, encouraging and assisting patients in quitting smoking (if applicable) could help to improve control.

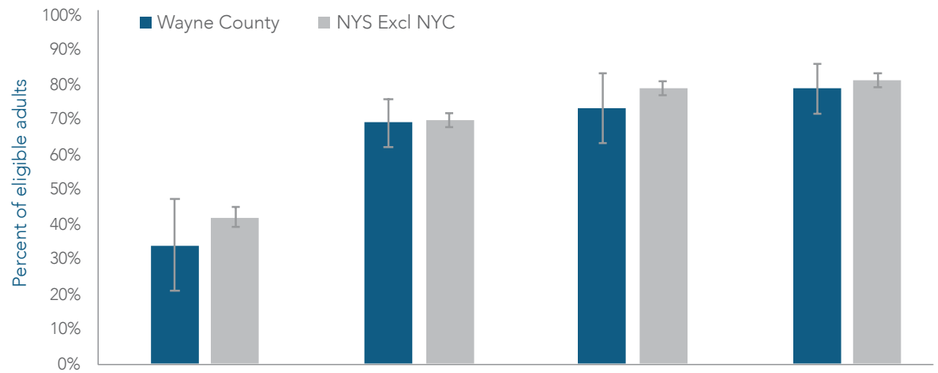
43. Source: Behavioral Risk Factor Surveillance System, 2016. Data on low-income and those with a disability are unreliable due to large standard error: standard error between 24% and 41% for low-income and 20% and 40% for those living with a disability.

44. Source: Behavioral Risk Factor Surveillance System 2016.

45. Source: Common Ground Health High Blood Pressure Registry, June 2018.

Smoking not only increases risk of development for hypertension, but it is also the number one cause of lung cancer. The leading cause of premature death in cancer patients is lung cancer. Of note, screening for different types of cancer can greatly impact the likelihood of early diagnosis and is an important preventative step in primary care. During prioritization meetings, cancer screenings were identified as a priority area. Figure 47 below shows the percent of that population that has received screenings for various types of cancer based on recommended guidelines in Wayne County. Of note, prostate cancer screenings have the lowest screening rate, which is similar to each of the other counties in the eight county region.

FIGURE 47: Percent of eligible population receiving cancer screening



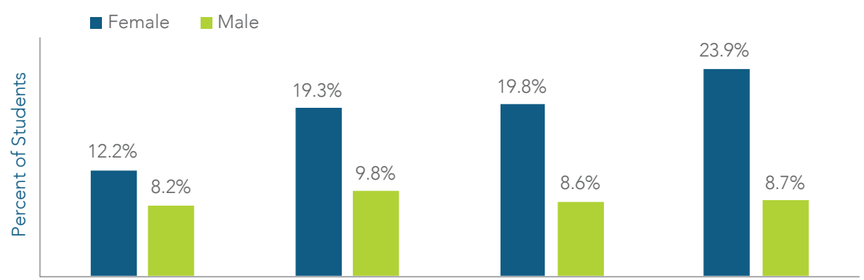
Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health

According to survey data from My Health Story, more than half of the respondents indicated they have dealt with depression or sadness (54%). Many others also reported they personally dealt with anxiety or fear (43%) and trouble sleeping (37%). For those who have dealt with these mental or emotional health issues, 70.9% of 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.

Chimney Bluffs, Wayne County
Courtesy of Wayne County Tourism

The 2019 Wayne County Evalumetrics Youth Survey reports more than half of 8th, 10th and 12th grade female students report feeling depressed or sad most days, which is 38 to 40% higher than male reports of the same age. These rates have increased since 2015. Of greatest concern for those experiencing depression and other poor mental health factors is suicide attempts. According to the 2019 report, 10th and 12th grade females were twice as likely to report making a plan about how they would attempt suicide than males. Rates were particularly high among 8th and 10th graders (12%). Of significance, these rates have decreased from the 2015 report across all grade years and particularly for 10th graders (21%). Finally, the 2019 report revealed females were also more likely to report self-injury over males, with some age groups reaching rates of almost 3x the male rate (Figure 48).

FIGURE 48: Percent of students reporting they have cut or burned themselves when they were upset



Source: 2019 Wayne Coutny Evalumetrics Youth Survey

Wayne County has an Opioid Task Force, which works to address issues around substance misuse, especially opioids. In addition to this relatively new resource, the county is using a program called ODMAP, short for Overdose Detection Mapping Application Program. ODMAP is used by select agencies in the county, including 911, to show overdoses in Wayne County in as close to real-time as possible. Eventually, the data will show "hot spots," areas where overdoses are happening at higher rates, and responders may be able to have a greater presence in those areas in order to shorten response times to overdoses, reduce/prevent fatalities, and introduce affected persons to resources that can help them.

The Wayne Behavioral Health Network (WBHN) also runs the Open Access Center, located on Nye Road in Lyons, to serve community members from Wayne and surrounding counties experiencing addiction or mental health crises. The center will eventually operate 24/7 providing greater accessibility for those seeking help.

County officials have also been proactive in evaluating the potential consequences of the likely upcoming legalization of recreational marijuana, and in April 2019 passed a resolution requesting a moratorium to the legalization of recreational marijuana, until "further non biased research has been conducted on the potential and known health and social ramifications" and "all areas of concern are critically analyzed."

Efforts to curb the rise in vaping and possible vaping related illnesses in Wayne County have been ongoing, if only just beginning to gain traction. Students surveyed within several Wayne County Districts indicated a rise in vaping among their peers, and as part of breakout sessions within a Youth Leadership Forum, focus groups (unrelated to the focus groups used as part of the CHA process) were held with students of the same ages as the survey takers. It was determined that educational efforts and interventions were necessary, as students were choosing to vape based on incorrect and/or incomplete information. A couple of schools offered community forum-style events, open to students, their families, and community members, and included panel discussions among area agencies that work in the realm of tobacco prevention and education. These agencies included Wayne County Public Health, Finger Lakes Alcohol and Substance Abuse Prevention, school administration, The Tobacco Action Coalition of the Finger Lakes (TACFL), and student advocates. Additionally, several specific instances of vaping-related school interventions allowed the Health Educator for Wayne County Public Health to be brought into the school to speak with students individually regarding tobacco and vaping education, as well as cessation, using the American Lung Association's "NOT on Tobacco" curriculum, which the Health Educator is certified in. Wayne County Public Health, along with TACFL, organized a "NOT on Tobacco" training at the end of August 2019, which was attended by 9 individuals representing 3 school districts, and other local agencies. The goal of this training was to provide interested school districts the opportunity to have a cessation counselor trained in the "NOT on Tobacco" curriculum in-house, to use as part of any other intervention and alternative-to-suspension practices currently in use for tobacco and vape related transgressions.

Policy and Environmental Factors

Although Wayne County continues to experience high rates of smoking and vaping, the communities within the county are becoming increasingly proactive by adopting smoke-free policies to protect residents, patrons, and tenants from secondhand smoke. Libraries throughout Wayne County, along with several businesses, have implemented smoke-free policies to protect their customers and employees. Throughout the county, it is forbidden to smoke in a park if children 12 or under are present. However, the Village of Newark has taken things one step further by implementing Tobacco-Free Outdoor policies in its many parks. Most importantly, several apartment complexes, covering hundreds of units, have adopted smoke-free policies – protecting their tenants from secondhand smoke and reducing the risk of fires. All Wayne County-owned and leased properties are smoke-free by law, and although enforcement has been a challenge since its implementation, law enforcement has become increasingly engaged in 2019.

Residents of some villages in Wayne County also benefit from Complete Streets policies. Complete Streets policies make the roads safer for pedestrians and cyclists, increasing opportunities for physical activity where they live. Although a minority of villages have implemented this so far, there is support for Complete Streets from Wayne County Public Health and the Wayne Health Improvement Partnership (WHIP). Any interested village has access to technical support and letters of support through these entities.

Schools continue to implement their local wellness policies, however some have reported difficulty adhering to it. Public Health and WHIP are available to assist in identifying and addressing barriers to successful implementation of these policies. Multiple agencies within WHIP are skilled in developing, implementing and assessing policies/curriculums affecting nutrition and physical activity, such as Genesee Valley BOCES and Cornell Cooperative Extension.

Other unique characteristics contributing to health status

Wayne County has the largest migrant population in New York State, and growing Amish and Mennonite communities as well. These populations each have unique characteristics impacting health behaviors and outcomes. This finding supports the need for growing awareness of and support for cultural competency and health literacy in order to sustain a successful health and human services workforce.

As previously mentioned, Amish and Mennonite populations interact with the health care system differently, often not seeking conventional health care until they feel it is necessary. Many do not have conventional health insurance and instead pay out of pocket or have something conceptually similar to health insurance through their churches. Persons working with these groups should take extra care to learn and respect their social norms and cultural values in order to make health care inviting and inclusive for them.

In Wayne County, many Amish and Mennonite families receive information from a publication called The Flame, which may be a valuable outlet for persons hoping to connect with those groups. Many of the Amish and Mennonite population do not drive cars, instead using horse and buggy, and inconvenience of transportation should be considered when trying to promote preventive care. Mobile options, such as home visits, may be more appealing. Even for those who do drive cars, there is often a preference to be seen in their own communities. For example, they may prefer to assemble in a location convenient for them and then all learn about a particular service or screening at the same time. Amish and Mennonite families often have many children, which can make travel and scheduling more difficult. Wayne County Public Health is able to provide at-home immunizations, lactation counseling, and more in these communities; and mobile mammography is available through Rochester Regional Health.

Wayne County's migrant population includes both documented and undocumented individuals and their families. Not all migrant workers come from other countries. A large portion of this population has little or no English language proficiency, often having Spanish as a first language. It is difficult to quantify this population, but there is an estimated need for between eight thousand and ten thousand workers during harvest season. In recent history, more workers are seasonal than migrant, and a greater proportion of this population is documented than in years past (H2A visas).

Agencies interacting with farms and other worksites employing migrant employees are encouraged to be prepared to communicate in both English and Spanish. Many Wayne County agencies participate in the Finger Lakes Coalition of Farm Worker Serving Agencies, working together to best meet the needs of this population. This Coalition occasionally holds events, such as the annual Harvest Festival usually held in Sodus, and clinics where workers can connect with consulates from different countries to ask questions and get assistance with documentation. Finger Lakes Community Health, a network of federally qualified health centers (FQHCs), provides bilingual medical and dental care in Wayne County and has a long history of serving this population. Undocumented migrants are at higher risk of certain health and safety outcomes, including unsafe and unfair working conditions and refusal to seek medical care, due to fear of being targeted by the government and/or losing their jobs. Fears of deportation and family separation are especially high at this time due to the political climate.

The transient population within Wayne County includes, but is not limited to, the migrant population. The 2019 Evalumetrics survey results from Wayne County schools showed that 7.4% of high school students scored above the risk level for transition and mobility. Compared to non-transient students, these students were:

- 2.45 times more likely to report bullying another student
- 2.63 times more likely to report being depressed or sad most days
- 2.52 times more likely to report suicide ideation, that is, made a plan for committing suicide
- 2.34 times more likely to report self-injury

Finally, all eleven Wayne County school districts have implemented Life Skills curriculum for middle school students. Life Skills is an evidence-based curriculum to reduce suicide ideation and other adverse outcomes among students. Transient students who move around within the county will receive this curriculum regardless of which districts they attend.

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 Wayne County. For example, focus group attendees identified local agencies such as libraries, hospitals, schools and the health department as community strengths and resources. Local programs such as Relay for Life, Green Thumb Thursday and the Justice Org of Youth were also highlighted as strengths as was the county's local environment (including trails and parks). A comprehensive list of identified strengths and resources can be found in focus group summaries and is available upon request.

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

Apart from Life Skills curriculum mentioned in the Special Populations section, which applies to every school, there are other school-based initiatives in Wayne County in place to improve health outcomes in various districts. CATCH, an evidence-based curriculum designed to reduce childhood obesity by enabling children to identify healthy foods and engage in more physical activity, is in place at Clyde-Savannah Elementary and Middle Schools and Lyons Elementary and Middle Schools.

Community Schools is an initiative impacting four Wayne County school districts at the time of this publication; that number is likely to increase over time. A community school is a school which has been transformed into a resource hub where educators, cross-sector and community partners are able to offer an array of connected services, supports, and opportunities to children, families, and communities (U.S. Department of Education, 2018; New York State Education Department, 2018; Coalition for Community Schools, 2018; Binghamton University, 2018). A goal of a community school is to attain collective impact by bringing together various community partners to collaborate in meeting the needs of their community, especially for students and families in high need. The main difference between a traditional public school and a community school is that a community school follows the collective impact model, which focuses on aligning various systems for increasing the efficient use of services and resources. Research and evaluations around the community schools strategy has indicated gains in academic achievement, improved attendance, reduced

suspensions, reduced high-risk behaviors, better access to services, increased parent involvement, and reduced violence rates for students and families in public schools that function as community schools.[46] Although much of the research on community schools has been in urban communities, the community schools strategy has the potential to deliver a variety of supports and services that would be strategically provided by community and county-based service providers in rural areas. The premise of the community school strategy is to coordinate vital resources within a school district, county, and across a region.

Community Health Improvement Plan/Community Service Plan

As previously discussed in the executive summary, the MAPP process was used to help create the Community Health Assessment and Community Health Improvement Plan. County specific pre-read documents were provided to prioritization and Wayne Health Improvement Partnership (WHIP) 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 Wayne County's specific process including:

WAYNE COUNTY PRIORITIZATION AGENCIES		
Cancer Services Program	Finger Lakes Area Counseling & Recovery Agency	Wayne County Action Program
Catholic Charities	Finger Lakes Community Health	Wayne County Department of Social Services
Common Ground Health	Genesee Valley BOCES	Wayne County Prioritization Agencies
Community Members	Mosaic Health	Wayne County Public Health
Cornell Cooperative Extension (Wayne)	RRH Newark-Wayne Community Hospital	Wayne County Rural Health Network
Council on Alcoholism & Addictions of the Finger Lakes	S2AY Rural Health Network	Tobacco Action Coalition of the Finger Lakes
Dentistry	Evalumetrics Research	Wayne Behavioral Health Network
Wayne County Aging and Youth		ProAction

A regional health survey and focus groups engaged the community at large throughout the assessment period. Community members were also invited to attend the prioritization meeting to help inform and select the 2019-2021 priority areas. Preliminary findings of the assessment were shared with Wayne Health Improvement Partnership members, prioritization meeting attendees and the Health and Medical Committee (public health's governing entity).

Specific interventions to address the priority areas were selected at WHIP meetings and were a group effort. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will take place. Wayne County plans to leverage resources from several different agencies including, but not limited to local hospitals and government agencies, community based organizations and school districts. A full description of objectives, interventions, process measures, partner roles and resources are available in the Wayne County Community Health Improvement Plan (Appendix G). Interventions selected are evidence based and strive to achieve health equity by focusing on creating greater access for the low-income population.

The Community Health Improvement Plan progress and implementation will be overseen by WHIP, a group that meets monthly and brings together diverse partners to improve the health of its residents. Progress and relevant data on each measure will be regularly reviewed at these meetings. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

This document will be shared by Wayne County Public Health and Rochester Regional Health (RRH) Newark-Wayne Community Hospital, and collaborating partners will be encouraged to share it and/or promote awareness of it on their platforms as well. Both Wayne County Public Health and RRH Newark-Wayne will post the document to their websites.

- Public Health's website: https://web.co.wayne.ny.us/index.php/publichealth/
- Facebook: https://www.facebook.com/WayneCountyPublicHealth/
- Instagram: @waynecountypublichealth or https://www.instagram.com/waynecountypublichealth/
- RRH Newark-Wayne Community Hospital's Community Investment Page: https://www.rochesterregional.org/about/community-investment

To promote awareness that the document is available, Wayne County Public Health – in partnership with RRH Newark-Wayne – will release public service announcements and press releases. Health and human service agencies, health care providers, municipalities, chambers of commerce, and elected officials will receive correspondence via email and/or mail notifying them of the new document and how it may be useful to them.

46. Dryfoos, 2002; Blank, Melaville, & Shah, 2003

YATES COUNTY

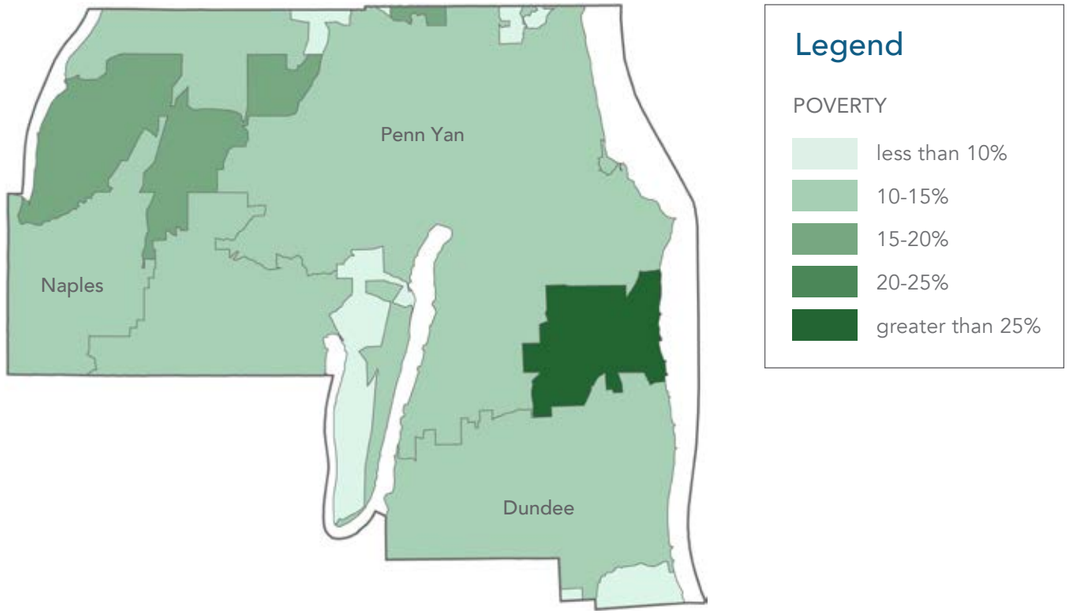
Demographic and Socioeconomic Health Indicators

Yates County is centered in the Finger Lakes region and shares county borders with Ontario, Steuben, Schuyler and Seneca Counties. The county also touches portions of several of the Finger Lakes including Canandaigua, Keuka and Seneca Lakes. A total of 25,083 persons reside in Yates County, the majority of which (97%) are White Non-Hispanic. Women of childbearing age make up 16% of the population, and 19.9% of the 18+ population are living with a disability.[47] 2017 estimates reveal 26% of the 65+ population (N=1,257) is living alone.

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

In Yates County, 13% of residents are living below the federal poverty level, and another 23% live near it. The distribution of poverty in the county is shown below in Map 14.

MAP 14: Poverty rates by ZIP code

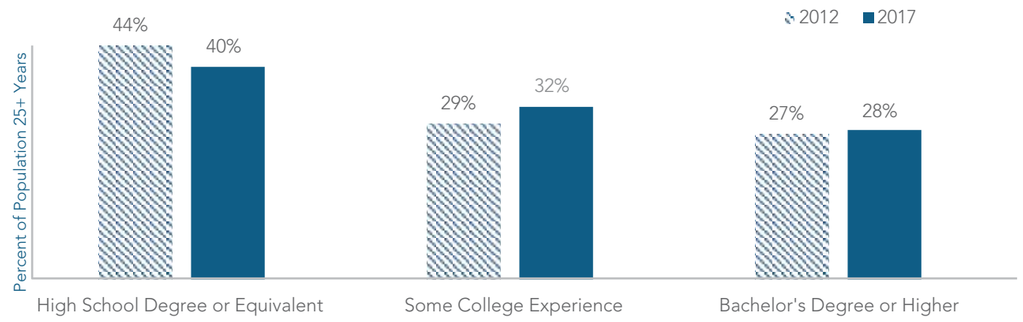


Source: U.S. Census Bureau American Community Survey 2013-2017 5-Year estimates

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

Over the past 5 years, there has been a slight shift in educational attainment where there are more residents aged 25+ who have college experience than in years past (Figure 49).

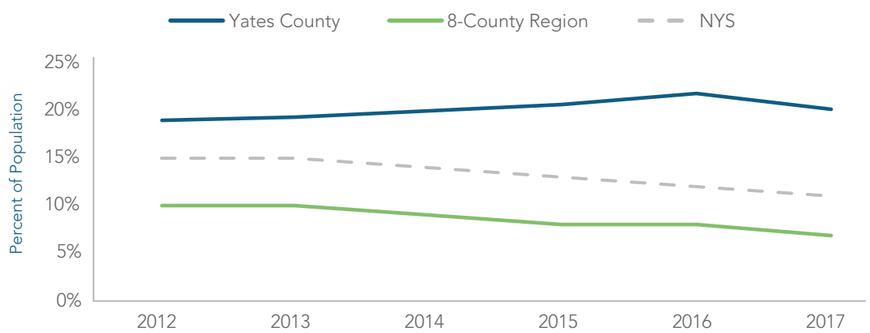
FIGURE 49: Educational attainment for Yates County by year



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

Data below show the trend in uninsured rates in Yates County over the past 5 years compared to NYS and the eight county region which has increased 6 percent since 2012 (Figure 50). This may likely be attributed to the high Amish and Mennonite populations found in Yates County who do not utilize traditional health insurance.

FIGURE 50: Percent of population that is uninsured



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

Finally, 23% of Yates County residents rent vs. own their home. In addition, 13% of occupied housing units have no vehicles available. Another 31% have access to one vehicle. Of note, the average household size for occupied housing is greater than two people. Approximately 43% of residents are paying 35% or more of their household income in rent costs.[48]

48. Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

Main Health Challenges

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

PREVENT CHRONIC DISEASES

1. Chronic Disease Preventative Care and Management

PROMOTE MENTAL WELL-BEING AND PREVENT SUBSTANCE USE DISORDERS

2. Mental and Substance Use Disorders Prevention

DISPARITY: LOW INCOME (CHRONIC DISEASE)

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

FIGURE 51: Yates County summary of health-related concerns for self, loved ones and county to prioritize

BIGGEST FEAR - FOR SELF
Weight (10.8%)
Mental / emotional health issues (9.5%)
Cancer (8.8%)
Heart conditions (8.5%)
Aging (7.9%)

BIGGEST FEAR -FOR OTHERS
Cancer (10.9%)
Mental / emotional health issues (10.4%)
Heart conditions (8.0%)
Cost (7.9%)
Diet / nutrition (6.6%)

COUNTY PRIORITY - FOR ADULTS
Substance abuse (27.8%)
Weight (13.1%)
Mental / emotional health issues (10.7%)
Cost (10.6%)
Diet / nutrition (10.0%)

COUNTY PRIORITY - FOR CHILDREN
Substance abuse (26.3%)
Diet / nutrition (25.0%)
Exercise (19.9%)
Mental / emotional health issues (9.2%)
Weight (7.5%)

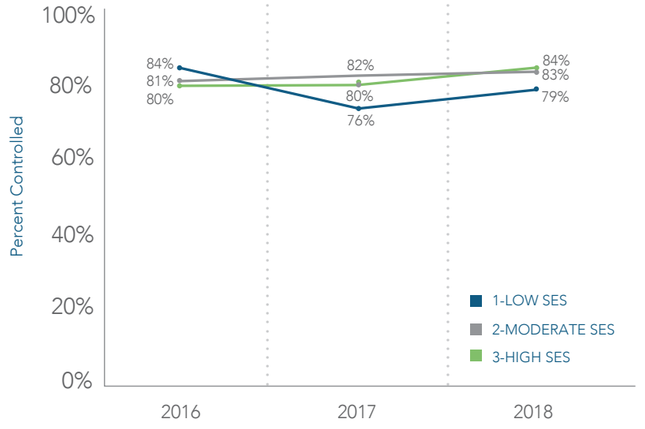
Source: My Health Story survey 2018. Analysis by Common Ground Health incorporates weighting to normalize survey participants to demographics of each county. Top 5 issues shown for each question. Data shown are the percent of participants with responses in each category.

Behavioral Risk Factors

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

Roughly 34%[49] of adults have been diagnosed with hypertension in the county, 82%[50] of whom are in control of their blood pressure. This control rate varies by income (Figure 52). Reducing the disparity requires engaging patients in taking control of their blood pressure through various methods: blood pressure medication adherence, promotion of physical activity, healthy eating, and more. Low income patients are often less likely to be able to afford medications, and it is therefore important to work with providers to prescribe generic medications that are less expensive and accepted by insurance companies.

Figure 52: Yates County control rate by socioeconomic status over time



Data Source: June 2018 Common Ground Health Hypertension Registry

Obesity may also lead to increased risk of developing diabetes. In Yates County, rates of persons diagnosed with diabetes has remained around 14% over the past several years.[51] Regionally, respondents to *My Health Story 2018* indicated that better diet and nutrition habits would help them manage their diabetes (and hypertension) better.

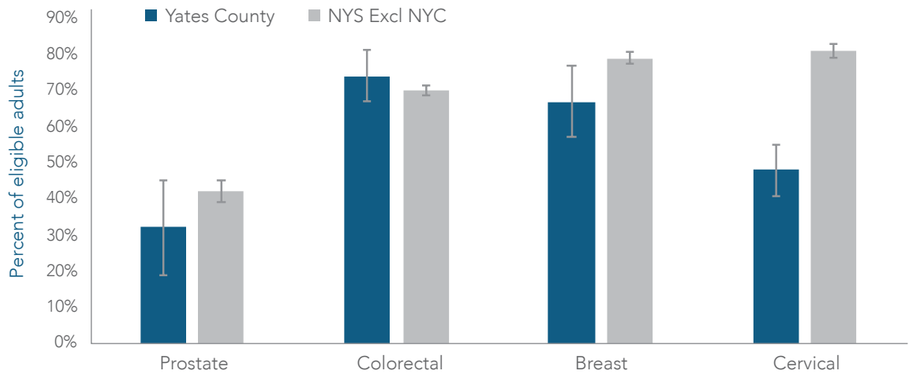
Screening for cancer is another area that came up as a priority in meetings with Yates County agencies. As previously mentioned, screening for cancers is an important preventative step in primary care. Figure 53 shows the percent of the population that has received screenings for various types of cancer based on recommended guidelines in Yates County. Of note, cervical cancer screenings in the county are significantly lower than nearby counties and NYS excluding NYC.

49. Source: Behavioral Risk Factor Surveillance System, 2016

50. Source: Common Ground Health High Blood Pressure Registry, June 2018.

51. Source: Behavioral Risk Factor Surveillance System

FIGURE 53: Percent of population receiving cancer screenings



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

In terms of colorectal cancer screenings, an estimated 74% of county residents have received recommended screenings. However, this varies by sex and income as shown below in Table 13. Particular focus ought to be put on increasing screening rates in females and the low income population.

TABLE 13: Colorectal cancer screening rates by demographic

	MALE	FEMALE	LOW-INCOME
Colorectal Cancer Screening Rates	78%	65%	63%*

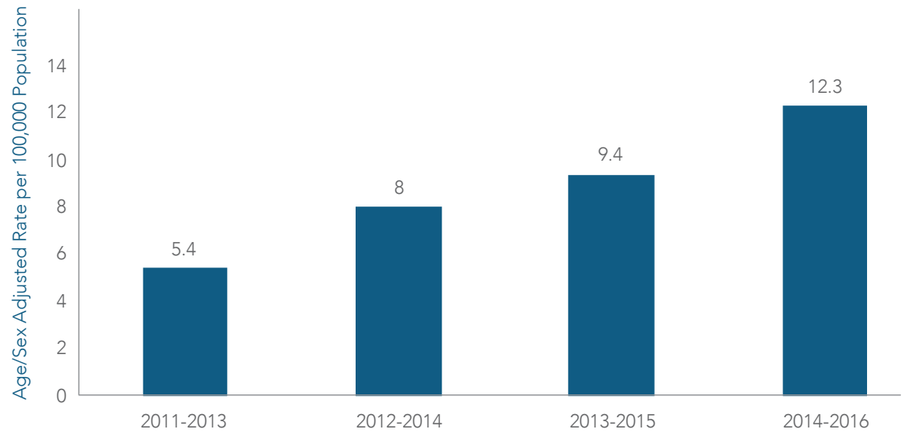
Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health. *low income data from 2013-2014 Behavioral Risk Factor Surveillance System

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

According to survey data from *My Health Story 2018*, almost half of the respondents indicated they have dealt with anxiety or fear (48%), depression or sadness (47%). For those who have dealt with mental or emotional health issues, 73% of survey respondents said they got the help they needed. The most commonly reported support was from doctors, counselors and other mental health professionals followed by support from friends and family.

Suicide rates in Yates County have increased over the past several years (Figure 54). In 2011-2013, there were a total of 6 suicide deaths which occurred (rate of 5.4 per 100,000 residents). In 2014-2016, deaths doubled to 12 (rate of 12.4 per 1000,000 residents). The prevalence of mental emotional health issues reported in *My Health Story 2018* and increase in suicide rates support the county's decision to focus on mental well-being, specifically suicide prevention, in the upcoming health improvement period.

FIGURE 54: Suicide mortality rates per 100,000 population



Policy and Environmental Factors

There are several policies and environmental factors that impact the health of Yates County residents. For example, Yates County recently approved a local law that prohibits tobacco and vaping use on county property including county-owned vehicles. In addition, the Village of Penn Yan has smoke-free parks. Both of these examples aid in reducing primary and secondary exposure to tobacco products.

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

While the county has worked towards bolstering natural and manmade recreational areas, there are still issues of concern that may negatively impact opportunities. For example, several villages in the county have old, broken and sometimes non-existent sidewalks making it difficult for some to use when trying to walk in the community. In addition, the public waterline infrastructure in Penn Yan contains old pipes, which may be lead-lined and in many cases are breaking apart. This poses a public health issue.

Unique Characteristics Contributing to Health Status

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

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

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

Community Assets and Resources to be Mobilized

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

Through implementation of the Community Health Improvement Plan, staff will work to leverage these pre-existing agencies and services. A full description of interventions and partner roles is in the Yates County Community Health Improvement Plan document. Partnering and leveraging the assets and resources of local community agencies will be imperative to achieving success in the plan.

Yates County
Photo by Lisa Heartman
Courtesy of Yates County Public Health

Community Health Improvement Plan/Community Service Plan

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

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

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

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

The Community Health Improvement Plan progress and implementation will be overseen by Choose Health Yates, a group that meets bi-monthly and brings together diverse partners to improve the health of its residents. Progress and relevant data on each measure will be regularly reviewed at these meetings. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

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

Chemung County Appendix A

PRIORITY: PREVENT CHRONIC DISEASES, HEALTHY EATING

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices	Objective 1.1: Decrease the percentage of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC])	Low income	Intervention 1.0.2 Quality nutrition (and physical activity) in early learning and child care settings	WIC provides nutrition education at every appointment Secondary nutrition education contact also made Education provided at annual breastfeeding and community baby shower events Refers to Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) Nutrition and breastfeeding assessments conducted. Education on reducing sugar sweetened beverages included Obesity rate of children, daily consumption of fruits and vegetables, and high maternal weight gain tracked	Obesity NYS 10.1 Chemung 9.7 High Maternal Weight Gain NYS 35.0% Chemung 41.8% Fruits/Veggies NYS 82.8 Chemung 78.5%	Obesity NYS 10.1 Chemung 9.7 High Maternal Weight Gain NYS 35.0% Chemung 41.8% Fruits/Veggies NYS 82.8 Chemung 78.5%	Obesity NYS 10.1 Chemung 9.7 High Maternal Weight Gain NYS 35.0% Chemung 41.8% Fruits/Veggies NYS 82.8 Chemung 78.5%	Local health department	CCHD/WIC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed

Chemung County Appendix A

PRIORITY: PREVENT CHRONIC DISEASES, HEALTHY EATING

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices	Objective 1.2: Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC])	Low income	Intervention 1.0.2 Quality nutrition (and physical activity) in early learning and child care settings	Economic Opportunity Program (EOP) Birth to Five School Readiness supports five locations as well as a Home Based Program They utilize the I am Moving, I am Learning (IMIL) Program. The goals of IMIL are: 1) Increase Physical Activity in the Classroom 2) Improve the Quality of Nutrition Provided 3) Improve Staff Wellness 4) Improve Family Engagement Nutrition education is provided daily to the children, quarterly in a newsletter to families, and monthly to families at meetings at their site The Eat Well Play Hard curriculum will be added to three sites in October and two others in the spring of 2020. It includes these initiatives: 1) Make nutrition and movement lessons part of a child's daily routine 2) Provide nutrition and physical activity education to families 3) Offer fruits, vegetables, and low-fat dairy more often 4) Create or enhance nutrition and physical activity policies 5) Make family-style dining an everyday practice 6) and provides education workshops/trainings for families	Five Head Start sites and a home based program serving 204 center based Head Start children, 27 center based Early Head Start children, 50 Early Head Start home based children and 12 pregnant mothers in the home based program for a total of 293 students and their families 40-60 minutes of active indoor or outdoor play, as well as several 15 minute sessions of movement throughout the day such as circle time dance & songs, and Zumba Kids Jr. for 30 minutes 1-2 times per week provided In year one children's BMI was reduced by 3% and the number of children in the obese category was decreased by 2% Children participated in a "Food Experience" monthly learning about and cooking a healthy food Child and Adult Care Food Program (CACFP) guidelines followed In addition, we have done away with all canned foods and the children only receive fresh vegetables and as much local organic produce as possible We do serve fresh-frozen, but we try not to. In addition, children are taught how to self-serve in specialty portioned cups and scoops. They learn what a serving is, and what it should look like. The children eat whole grains, vegetables, fruits, protein, and dairy at each meal. Allergies are always accommodated. Families receive a quarterly newsletter with fresh healthy recipes on a budget. They are invited to education events surrounding nutrition & health. We recently hosted Dr. Zama with Arnot Health who discussed Heart Health. Our Health Educator also attends monthly meetings with the parents and delivers health information that is current and addresses issues they may have (for example changes with immunizations)	We would like to increase the physical activity to 1.5 hours per day and increase Zumba Kids Jr. to 2 times per week as well as explore other options such as children's YOGA and Mindfulness	We would like to increase the physical activity to 1.5 hours per day and increase Zumba Kids Jr. to 3 times per week as well as explore other options such as children's YOGA and Mindfulness	Headstart	EOP responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed

Chemung County Appendix A

PRIORITY: PREVENT CHRONIC DISEASES, HEALTHY EATING

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices	Objective 1.2: Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC])		Intervention 1.0.2 Quality nutrition (and physical activity) in early learning and child care settings	Comprehensive Interdisciplinary Developmental Services (CIDS) encourages healthy eating and breastfeeding during home visits	# of home visits	# of home visits	# of home visits	Community-based organizations	CIDS responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
					Intervention 1.0.2 Quality nutrition (and physical activity) in early learning and child care settings	Chemung County Health Department (CCHD), Arnot Health, and community partners provide education at free summer meal sites	CCHD tabled at 7 meal sites. Arnot Health was at 7 locations serving 107 children	# of sites # reached	# of sites # reached	Local health department	CCHD, Arnot Health, and HP2 members responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
					Intervention 1.0.4 Multi-component school-based obesity prevention interventions	Steuben Rural Health Network; Girls on the Run of the Southern Tier: 80% of participants in Girls on the Run of the Southern Tier will show an increase of physical activity outside of participating in the program during the weekday and weekend 80% of participants in Girls on the Run of the Southern Tier will show a decrease in screen time after participating in the program (These measured by completion of pre and post survey asking 2 questions on physical activity) 90% of participants will complete a 5K Open rate for "Nutrition tips and tricks" sent weekly to families via email and posted on social media	80% of participants will show an increase of physical activity outside of the program 80% of participants will show a decrease in screen time after participating in the program (completion of pre and post survey asking 2 questions on physical activity) 90% of participants will complete a 5K Open rate of 35 % for the nutrition fact email	85% of participants will show an increase of physical activity outside of participating in the program during the weekday and weekend 85% of participants will show a decrease in screen time after participating in the program 90% of participants will complete a 5K Open rate of 40 % for the nutrition fact email	90% of participants will show an increase of physical activity outside of participating in the program during the weekday and weekend 90% of participants will show a decrease in screen time after participating in the program 90% of participants will complete a 5K Open rate of 45% for the nutrition fact email	Community-based organizations	SRHN responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed

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PRIORITY: PREVENT CHRONIC DISEASES, HEALTHY EATING

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices	Objective 1.2: Decrease the percentage of children with obesity (among public school students in NYS exclusive of New York City [NYC])		Intervention 1.0.4 Multi-component school-based obesity prevention interventions	Finger Lakes Eat Smart NY (FLESNY) and Cornell Cooperative Extension (CCE) work with local elementary and middle schools to implement the Coordinated Approach To Child Health (CATCH) program Quality nutrition and physical activity is provided in seven area schools serving 2,851 students The Elmira City School District (ECSD) adopted CATCH in their wellness policy for all elementary schools, CATCH is used school wide (classroom, PE, brain breaks, MBE minutes, cafeteria)	7 schools trained in CATCH with 2,851 students impacted ECSD adopted CATCH in their wellness policy for all elementary schools, CATCH is used school wide (classroom, PE, brain breaks, MBE minutes, cafeteria)	8 schools trained in CATCH 3,157 students impacted in CATCH schools	8 schools trained in CATCH 3,157 students impacted in CATCH schools	Community-based organizations	FLESNY responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
			Objective 1.5: Decrease the percentage of adults ages 18 years and older with obesity (among adults with an annual household income of <$25,000)		Intervention 1.0.4 Multi-component school-based obesity prevention interventions	Creating Healthy Schools and Communities (CHSC) work with Elmira School District staff and partners to build capacity for assessing, developing and implementing Local Wellness Policy (LWP) aligned with USDA Healthy, Hunger-Free Kids Act	Providing ongoing support to assist with implementation of 2017 updated LWP, impacting the 6,000+ students. Support provided for using the 2017 School Health Index, self-assessment planning tool at the school level to guide: - daily recess for elementary students - access to physical activity facilities outside of school day - prohibit using physical activity as punishment and taking away physical activity as punishment - using food as reward or punishment - access to drinking water - all foods/beverage sold and served during the school day meet USDA's Smart Snacks in Schools nutrition standards -implicitly addresses sugar sweetened beverages	Ongoing support to assist with assessing and enhancing 2017 LWP in 2020 as well as ongoing support to assist with implementation of 2017 LWP and 2020 updated LWP, impacting the 6,000+ students		Community-based organizations	CHSC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed

Chemung County Appendix A

PRIORITY: PREVENT CHRONIC DISEASES, HEALTHY EATING

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices	Objective 1.4: Decrease the percentage of adults ages 18 years and older with obesity (among all adults)		Intervention 1.0.3: Worksite nutrition and physical activity programs designed to improve health behaviors and results	Creating Healthy Schools and Communities (CHSC) # of engaged worksites # of engaged small retailers # of policies adopted Education provided and distributed	Arnot Health: new Community Supported Agriculture program CIDS: new Healthy Vending Machine EOP: new Healthy Vending, Wellness Newsletter, & Employee Wellness Activities Perry & Carrol: new Healthy Snack options being offered to employees. Riverside Elementary: Smoothie blenders purchased for staff break rooms; indoor walking path floor decals with motivational posters Parley Coburn: Yoga materials to offer classes for staff Able2: Community Garden and Produce Cart, distribution of educational materials to all work sites 3 small retail locations adding fresh fruit stand to their stores. 2 small retailers signing up to accept Fruit & Vegetable Prescription Program vouchers, which will increase access to healthy options in low income neighborhoods CHSC signage outside location advertising that fruit is now being sold here	# of engaged worksites # of engaged small retailers # of policies adopted Education provided and distributed		Community-based organizations	CHSC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
					Intervention 1.0.3: Worksite nutrition and physical activity programs designed to improve health behaviors and results.	EOP, CCHD, Arnot Health, and other partners participate in the CHSC program	EOP recently put in a “healthy vending” machine that offers more healthy choices and promotes health. They have instituted a Wellness Program for staff educating and encouraging them to make healthier choices They provide healthy snacks at meetings and gatherings CCHD provides monthly wellness tips and provides activities to encourage physical activity Arnot Health started a Community Supported Agriculture program and holds a weekly farmers market. Many others listed above	Continue to provide education and opportunities Increase education to families and employees Implement Healthy food Policies		Community-based organizations	CCHD and partners responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed

Chemung County Appendix A

PRIORITY: PREVENT CHRONIC DISEASES, PHYSICAL ACTIVITY

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.2: Promote school, child care and worksite environments that increase physical activity	Objective 1.1: Decrease the percentage of children with obesity (among WIC children ages 2-4 years)		2.2 Promote school, child care and worksite environments that increase physical activity	WIC - Decrease the percentage of TV and Screen Time to less than 2 Hours daily (currently 83%)	1 earned media activity 3 social media posts 2 community outreach disseminating information on reducing screen time	1 earned media activity 3 social media posts 2 community outreach disseminating information on reducing screen time	1 earned media activity 3 social media posts 2 community outreach disseminating information on reducing screen time	Local health department	CCHD/WIC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
			Objective 1.1: Decrease the percentage of children with obesity (among WIC children ages 2-4 years)		2.2 Promote school, child care and worksite environments that increase physical activity	Economic Opportunity Program (EOP) - Head Start provides structured physical activity opportunities every day In the Family Support Services program the monthly events offered occasionally offer opportunities for physical activity which may include swimming, walking in a park or at the YMCA, going to the Zoo, bowling, etc.	EOP provides 40-60 minutes per day of structured indoor-outdoor play, as well as 30 minutes of Zumba Kids Jr. and movement/ dance breaks throughout the day of 15 minutes or so	Continue to provide	Continue to provide	Headstart	EOP responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
		Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities	Objective 1.15: Increase the percentage of adults age 18 and over who walk or bike to get from one place to another (among all adults)		2.1.1 Implement a combination of one or more new or improved pedestrian, bicycle, or transit transportation system components (i.e., activity-friendly routes)	Creating Health Schools and Communities (CHSC) and Chemung County Planning - # Complete Streets policies adopted	Town of Elmira: Complete Streets Traffic Calming Signage Town of Southport: Complete Street Implementation Project to increase community physical fitness – fit stations Walking College - planning a Complete Streets implementation project to increase community physical fitness and boost economic development	# Complete Streets policies adopted	# Complete Streets policies adopted	Community-based organizations	CHSC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed

Chemung County Appendix A

PRIORITY: PREVENT CHRONIC DISEASES, PHYSICAL ACTIVITY

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities	Objective 1.7: Increase the percentage of adults age 18 years and older who participate in leisure-time physical activity (among all adults)		2.3.1 Implement and/or promote a combination of community walking, wheeling, or biking programs, Open Streets programs, joint use agreements with schools and community facilities, Safe Routes to School programs, increased park and recreation facility safety and decreased incivilities, new or upgraded park or facility amenities or universal design features; supervised activities or programs combined with onsite marketing, community outreach, and safety education	Chemung County Health Department (CCHD), Arnot Health, and community partners: # participating in Gold Shoe # participating in Park Prize Pursuit # social media posts # reached through newsletter	278 people at final event for Gold Shoe 65 screenings done by Arnot Health 95% visited one or more parks for the first time, 84% said they felt healthier, and 82 participated in scheduled walks CCHD newsletter goes out to 593 people	# participating in Gold Shoe # participating in Park Prize Pursuit # social media posts # reached through newsletter	# participating in Gold Shoe # participating in Park Prize Pursuit # social media posts # reached through newsletter	Local health department	Arnot, HP2, and CCHD responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed

Chemung County Appendix A

PRIORITY: PREVENT CHRONIC DISEASES, TOBACCO PREVENTION

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.1: Prevent initiation of tobacco use	3.1.1: Decrease the prevalence of any tobacco use by high school students		3.1.2: Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms	Southern Tier Tobacco Awareness Coalition (STTAC) # of media outreaches (radio, TV, newspapers) # of paid ads in Chemung County # of educational presentations provided to youth focused organizations # of Reality Check activities in Chemung County	YTD - 57 earned media outreaches (March - Kick Butts Day, May - World No Tobacco Day, November - Great American Smokeout) 4 - paid ads completed - April -Newspaper?, May - Radio, June -Tobacco-free pharmacies, June - Reality Check recruitment 3 - presentations to youth focused organizations completed 3 - Reality Check activities in Chemung County	6- earned media outreaches 1 - paid ad 5 - presentations to youth focused organizations completed 3 - Reality Check activities in Chemung County	6 - earned media outreaches 1 - paid ad 5 - presentations to youth focused organizations completed 3 - Reality Check activities in Chemung County	Local health department	CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
			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 areas	Low income Minorities Rural	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	STTAC - # of community events hosted or attended in Chemung County # of stakeholders educated # of retail observations completed # of community members mobilized to write or spread about tobacco marketing	5 - community events hosted or attended (March – Kick Butts Day, March – Neighborhood Conversations , April – Earth Day, April – Neighborhood Conversations, May – World No Tobacco Day) 19 - stakeholders were educated - (Feb – Legislative Education Day (2), March – Neighborhood Conversations (1), May – World No Tobacco Day (15)) 2 - retail observations completed , (June – Dollar General, AA Mart) 4 - community members wrote or spoke about tobacco marketing	5 - community events hosted or attended 3 - stakeholders were educated 2 - retail observations completed 5 - community members wrote or spoke about tobacco marketing	5 - community events hosted or attended 3 - stakeholders were educated 2 - retail observations completed 5 - community members wrote or spoke about tobacco marketing	Local health department	CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
	Focus Area 3: Tobacco prevention	Goal 3.2: Promote tobacco use cessation	3.2.1 Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%		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	Arnot Health - Percentage of patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user (MIPS quality measure) # of referrals to NYS Quitline # of prescriptions to address tobacco dependency	Currently all PCP show a rate of 91% compliance of screening for tobacco use Jan. - July 2019 3,842 unique patients (19,000 scripts) receiving prescription and non-prescription medications (Nicotrol, Nicorette, Nicoderm, RA Gum, Chantix, Buproprion, etc.). Approximately 1,211 referrals to NYS Quitline during this time	Percentage of patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user (MIPS quality measure) # of referrals to NYS Quitline # of prescriptions to address tobacco dependency	Percentage of patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user (MIPS quality measure) # of referrals to NYS Quitline # of prescriptions to address tobacco dependency	Hospital	Arnot responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed

Chemung County Appendix A

PRIORITY: PREVENT CHRONIC DISEASES, TOBACCO PREVENTION

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2: Promote tobacco use cessation	3.2.3: Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among adults with income less than $25,000)	Pregnant mothers	3.2.2 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. (among all adults focusing on pregnant moms)	Mothers & Babies Perinatal Network, CCHD, CIDS, and community partners - # of referrals to Quit Kit Program's phone based, smoking cessation program for pregnant and parenting women & family members or anyone caring for young children based on American Lung Association materials URMC Center for Community Health & Prevention Stop Smoking program available for others, in addition to the NYS Quitline # of social media posts, outreach, etc. promoting these programs STTAC – concentrate on policies for those serving pregnant moms	Increase referrals to Quit Kit smoking program by 10% 2 tobacco free outdoor policies by 6/30/20 # referrals to NYS Quitline	Increase referrals to Quit Kit smoking program by 10% 2 tobacco free outdoor policies by 6/30/20 # referrals to NYS Quitline	Increase referrals to Quit Kit smoking program by 10% # referrals to NYS Quitline	Community-based organizations	Mothers & Babies, CCHD,CIDS, STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
		Goal 3.3: Eliminate exposure to secondhand smoke	3.3.1: Decrease the percentage of adults (non-smokers) living in multi-unit housing who were exposed to secondhand smoke in their homes	Low income	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	STTAC - # of earned media outreaches # venues/events information disseminated # stakeholders educated # new units covered by policies	3 earned media outreaches (February - legislative education day, June - grant renewal, July - HUD anniversary) # venues/events/stakeholders educated (February - St. Joseph's and St. Patrick's, April & June - Libertad) 107 new units covered by smoke free policies - (St. Joseph's, St. Patrick's, and Skip Mills)	3 earned media outreaches # venues/events information disseminated 1 stakeholder educated 15 new units covered by policies	3 earned media outreaches # venues/events information disseminated 1 stakeholder educated 15 new units covered by policies	Local health department	CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed
			Decrease the percentage of residents (non-smokers) exposed to secondhand smoke in the community		3.3.2: Increase the number of smoke-free parks, beaches, playgrounds, college and other public spaces	STTAC - # of earned media outreaches # venues/events information disseminated # stakeholders educated # tobacco free major employer or municipal policies adopted	8 earned media outreaches # venues/events information disseminated 6 stakeholders educated 3 tobacco free policies adopted	6 earned media outreaches # venues/events information disseminated 3 stakeholders educated 2 tobacco free major employer or municipal policies adopted	6 earned media outreaches # venues/events information disseminated 3 stakeholders educated 2 tobacco free major employer or municipal policies adopted	Local health department	CCHD/STTAC responsible for intervention providing needed staff and resources to meet measures with assistance from Health Priorities Partners as needed

Livingston County Appendix B

PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles Resources	Projected Year 1,2, and 3
Prevent Chronic Diseases	Focus Area 1: Healthy Eating and Food Security	1.1 Increase access to healthy and affordable foods and beverages	1.2 By December 2021, decrease the percentage of children with obesity (among Livingston County public school students) by 1%	Low SES	1.0.4 Multi-component school-based obesity prevention interventions, including: completion of School Health Index (SHI), CATCH, providing healthy eating learning opportunities and participating in Farm to School Programs	Increase number of SHI assessments completed NYSDOH Prevention Agenda Increase number of policy/practices implemented Increase number of schools that implement CATCH (Baseline: 0-2018) Baseline: Free and reduced lunch Dalton Sch - 52%; Mid/High Sch Nunda-46%; Primary Sch Mt Morris 53%; Mid/High Sch Mt Morris 64%- 2019	Genesee Valley Health Partnership (GVHP/Be Well Committee) LCDOH UR Med Noyes Cornell Coop Ext URMC Fingerlakes Eat Smart NY Schools Farmers	LCDOH to complete SHI with school Genesee Valley Health Partnership (GVHP/Be Well Committee) to provide resources to improve nutrition/physical activity areas of improvement identified by SHI Fingerlakes Eat Smart NY to provide training/tech support Schools to complete assessment, dev and implement policy/practice including CATCH Farmers to work with schools on Farm to School Programs	Minimum of two schools to complete SHI by year 3 Minimum of two schools which adopts policy/ practice by year 3 A minimum of two which implement CATCH by year 3
			1.5 By December 2021, decrease the percentage of adults ages 18 years and older with obesity (among adults with an annual household income of <$25,000) by 1%	Low SES	1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results	Increase the number of assessments (from NYSDOH Prevention Agenda) completed Increase number of practices and/or policies implemented Baseline: 22 Liv Co worksites have adopted and implemented policies as of 2018-LCDOH Baseline: 44.2% with obesity among adults with an annual household income of <$25,000, 2013-2014 e-BRFSS	Genesee Valley Health Partnership (GVHP/Be Well Committee) LCDOH UR Med Noyes Cornell Coop Ext URMC American Lung Association Worksites	Genesee Valley Health Partnership (GVHP/Be Well Committee including LCDOH, UR Med Noyes, Cornell Coop Ext) to assist with development, implementation and eval of policy/practice change GVHP- $1,000 American Lung assist with tobacco free policy/practice Worksite to adopt and implement policy/practice change	A minimum of one worksite which adopts a policy or implements a practice per year
			1.7 By December 2021, decrease the percentage of adults who consume one or more sugary drinks per day by 2%		1.0.1 Adopt policies and implement practices to reduce (over) consumption of sugary drinks Sugar-sweetened beverages (SSBs) are the largest source of added sugar and an important contributor of calories in the U.S. diet	Increase the number of entities which adopts policies or implement practices to reduce consumption of sugary drinks NYSPrevAgenda Baseline: 33.3% for 2016 BRFSS Baseline: Free and reduced lunch Dalton Sch - 52%; Mid/High Sch Nunda-46%; Primary Sch Mt Morris 53%; Mid/High Sch Mt Morris 64%- 2019 Baseline: 25.9% of adults who consume one or more sugary drinks daily 2013-2014- eBRFSS	Genesee Valley Health Partnership (GVHP/Be Well Committee) LCDOH UR Med Noyes Cornell Coop Ext NYSDOH Worksites Schools	Genesee Valley Health Partnership (GVHP/Be Well Committee including LCDOH, UR Med Noyes, Cornell Coop Ext) to assist with development, implementation and eval of policy/practice change GVHP- $700 NYSDOH materials Worksites and schools to adopt and implement	A minimum of one school and one worksite which adopts a policy or implements a practice per year

Livingston County Appendix B

PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles Resources	Projected Year 1,2, and 3
Prevent Chronic Diseases	Focus Area 1: Healthy Eating and Food Security	1.3 Increase Food Security	1.14 By December 2021, increase the percentage of adults with perceived food security (among adults with an annual household income of <$25,000) by 2%	Low SES and older adults	1.0.6 Screen for food insecurity, facilitate and actively support referral.	Monitor number of education sessions with focus on low income, high need area Baseline: 34 adult direct ed. sessions with 468 adults participants, 22 adult indirect education sessions with 500 adult participants, 240 youth participants reached with direct education- FLESNY; and 6 sessions of nutrition education at Senior Nutrition Sites - CCE- 2018 Baseline: 5.2%of population with low income and low access to supermarket or grocery store- 2015 NYSCHIRS Monitor utilization of Curbside Markets Baseline: 39 sites for 13 days with 338 people served, total sales $3,057.19- Curbside; 90 SNAP transitions with $668.76 in SNAP sales- Foodlink Create service guide re: food security, promote 2-1-1 and NY Connects and distribute to community partners including HCPs	GVHP LCDOH UR Med Noyes Office for Aging Food Security Coalition (Office for Aging, Local Food Pantries, Cornell Cooperative Extension) Fingerlakes Eat Smart NY Foodlink Legal Assistance of WNY Food Security Coalition	GVHP - $700 LCDOH WIC -4 FTEs-screen and refer clients LCDOH and UR Med Noyes- coordinate and promote UR Med Noyes-.05 FTE Food Security Committee info sharing, collaboration, networking Office for Aging- 12 hrs FLESNY conduct education CCE-18 hrs. provide recipes/ information at Nutrition Sites and Curbside, provide technical assistance, promote Farmers Markets Foodlink provide Curbside Markets and develop promotions/ Legal Assistance- pre screening potential SNAP participants, referrals to appropriate resources Food Security Coalition to develop and distribute guide	Increase by %5 number of education sessions by year 3 Increase utilization re: Foodlink by 3% by year 3 Number of completed guides distributed
	Focus Area 2. Physical Activity	Reduce obesity and the risk of chronic diseases	1.2 By December 2021, decrease the percentage of children with obesity (among Livingston County public school students) by 1%	Low SES	2.2 Promote school, child care and worksite environments that increase physical activity by implementing CATCH	Increase the number of evidence based assessments (SHI) completed	LCDOH Schools	LCDOH assist with SHI School to complete SHI	A minimum of two assessments completed by year 3
						Increase the number of practices/ policies implemented Baseline: Obesity data Keshequa School obesity rate 13.9, overweight and obese rate 42.3; Mt. Morris School obesity rate17.7, overweight and obese rate 34.9 per NYSDOH 2016-2018; (Baseline: Free and reduced lunch Dalton Sch - 52%, Mid/High Sch Nunda - 46% Primary Sch Mt Morris53%, Mid/High Sch Mt Morris 64% -2019) (Baseline: 18.2 percentage of obese Liv Co children 2014-2016- NYSCHIRS)	LCDOH UR Med Noyes CCE GVHP Schools	LCDOH, UR Med Noyes, GVHP, CCE assist with implementation and evaluation Schools develop, implement and evaluate	A minimum of two practices/policies implemented by year 3
						Increase number of schools implementing CATCH (Baseline: 0- 2018)	Schools Fingerlakes Eat Smart NY	School staff to attend training, implement CATCH FLESNY to provide training and tech support	A minimum of two schools implementing CATCH by year 3

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles Resources	Projected Year 1,2, and 3
Prevent Chronic Diseases	Focus Area 2: Physical Activity	Reduce obesity and the risk of chronic diseases	1.2 By December 2021, decrease the percentage of children with obesity (among Livingston County public school students) by 1%	Low SES	2.2.3 Implement a combination of worksite-based physical activity policies, programs, or best practices through multi-component worksite physical activity and/or nutrition programs; environmental supports or prompts to encourage walking and/or taking the stairs; or structured walking-based programs focusing on overall physical activity that include goal-setting, activity monitoring, social support, counseling, and health promotion and information messaging	Increase the number of assessments (from NYSDOH Prevention Agenda) completed Increase number of practices and/or policies implemented (BASELINE: 22 Livingston County Worksites have adopted and implemented policies as of 2018-LCDOH) (Baseline: 80.5 age-adjusted percentage of adults who participated in leisure time physical activity in the past 30 days- 2016, NYSCHIRS)	GVHP / Be Well LCDOH UR Med Noyes Worksites	GVHP- $1,000 GVHP/Be Well to assist with policy development, implementation and evaluation LCDOH complete assessment with worksite UR Med Noyes to provide education at worksites per needs Worksites complete assessment, implement policy/practice change	A minimum of one worksite which adopts a policy or implements a practice per year
			1.7 By December 31, 2021, increase the percentage of adults ages 18 years and older who participate in leisure-time physical activity		2.1.1 - Implement a combination of one or more new or improved pedestrian, bicycle, or transit transportation system components (i.e., activity-friendly routes), with new or improved land use or environmental design components (i.e., connecting everyday destinations) through comprehensive master/transportation plans or Complete Streets resolutions, policies, or ordinances to connect sidewalks, multi-use paths and trails, bicycle routes, and public transit with homes, early care and education sites, schools, worksites, parks, recreation facilities, and natural or green spaces	Increase number of municipalities which adopt Complete Streets resolution (Baseline: 0-2018) LC Planning Dept Baseline: 805 age-adjusted percent of adults who participated in leisure-time activity in past 30 days-2016, NYSCHIRS)	Municipalities LC Planning NYSDOT	Municipalities to work with community partners to adopt Complete Street resolution LC Planning work with municipalities and NYSDOT to assist with resolution by providing tech support	One municipality to adopt resolution by year 3
						Complete assessment re: transportation and/or connectivity plans	Municipalities LC Planning NYSDOT	Municipalities to complete assessment Planning and NYSDOT to conduct and analyze assessment	Minimum of one assessment completed per year
						Increase utilization of *Ride LivINgston* (transportation) Baseline: 2,330 dashboard users, 1,767 planned trips-LC Planning 2/1/2019-7/31/2019	Transportation Assistance Committee (LC Planning, LCDSS, OFA, Workforce Dev, ARC, UR Med Noyes, Rochester Transportation Services)	Transportation Assistance Committee increase use through promotion and education, and assess data to identify high need areas	Increase utilization of Ride LivINgston by 5% per year
						Increase number of ordinances/ environmental changes to connect sidewalks, multi-use paths and trails, bicycle routes, and public transit with homes, early care and education sites, schools, worksites, parks, recreation facilities, and natural or green spaces	Municipalities Private Property Owners LC Planning NYSDOH NYSDEC GVHP/Be Well	Municipalities to identify areas of enhancement Private Property owners to collaborate re: access issues NYSDOH, NYSDEC to work with municipalities LC Planning to assist with mapping and tech support GVHP/Be Well to coordinate and promote	Minimum of one ordinance/env. change by year 3

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles Resources	Projected Year 1,2, and 3
Prevent Chronic Diseases	Focus Area 4: Chronic Disease Preventive Care and Management	4.4 In the community setting, improve self-management skills for individuals with chronic diseases including asthma, arthritis, cardiovascular disease, diabetes, pre-diabetes and obesity	4.4.1 By December 31, 2021, increase the percentage of adults with chronic conditions (arthritis, asthma, cardiovascular disease, diabetes, chronic kidney disease, cancer) who have taken a course or class to learn how to manage their condition		4.4.2 - Expand access to evidenced-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone.	Number and type of evidence-based/ evidence informed programs and participants attending certified programs offered by UR Med Noyes Health, URMC and Office for the Aging Increased ability of participants to self-manage their health condition (Baseline: Living Healthy 2018:4 classes: 2 CDSMP, 1 CPSMP, and 1 DSMP Total of 41 participants enrolled and 32 completed (78%)-UR Med Noyes (Baseline: Diabetes Ed - 336 Individual Visits, 12 Insulin Pump Starts, 7 Continuous Glucose Monitoring Screening, 49% Weight loss range was 2-70 lbs UR Med. UR Med Noyes Diabetes) (Baseline: Matter of Balance, 5 classes with 80 completers, Tai Chi 4 classes with 61 completers, Aging Mastery 1 class with 15 completers Healthy Living Livingston-Increased physical activity level reported Increased fruit and vegetable consumption reported (Baseline: 2018: Healthy Living Nunda, 6 completers 10 wks, 50% increased daily veg. consumption, 67% increased daily fruit consumption, 33% increased weekly medium intensity physical activity -URMC, 33% increased weekly vigorous intensity physical activity) (Baseline: 7.7 percentage of adults with chronic conditions who have taken course/ class to learn how to manage their condition 2014-2014- eBRFSS)	UR Med Noyes GVHP/Be Well Office for the Aging	UR Med Noyes to offer classes FTEs- .5 $3,500 for Living Healthy classes Be Well/GVHP to assist with community linkage and promotion of classes Office for the Aging offer evidence informed programs (Aging Mastery) URMC offer classes $1,500 for Healthy Living classes Be Well/GVHP to assist with community linkage and promotion of classes	Number of participants completing Minimum of 60% will report increased ability to self-manage their health condition/ year Number of participants completing Healthy Living Minimum of 25% with increased physical activity level Minimum of 25% with increased fruit and vegetable consumption

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles Resources	Projected Year 1,2, and 3
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	1.2 Facilitate supportive environments that promote respect and dignity for people of all	1.2 By December 31, 2021, increase LC's Health Scores by 2% per the Opportunity Index		1.2.2 Mental Health First Aid is an evidence- based public education program that teaches people how to respond to individuals who are experiencing one or more acute mental health crises (such as suicidal thoughts or behavior, an acute stress reaction, panic attacks or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (such as depressive, anxiety or psychotic disorders, which may occur with substance abuse)	Increase number of community partners trained in Mental Health First Aid Increase number of community partners trained in Youth Mental Health First Aid School and Youth Serving Organizations to develop/ implement a policy/practice change regarding Youth Mental Health First Aid Community Partners to develop/implement a policy/practice change regarding Mental Health First Aid Baseline: 65.2 (2018) Opportunity Index	CASA-Trinity GVHP CASA-Trinity, UR Med Noyes Mental Health and LCDOH-Mental Health Schools/ Youth Serving Organizations	CASA-Trinity to offer and conduct Youth and Adult Mental Health First Aid Training GVHP to promote trainings to community partners CASA-Trinity, UR Med Noyes Mental Health and LCDOH-Mental Health to assist community partners with policy development and implementation Schools/ Youth Serving Organizations to work with CASA-Trinity, UR Med Noyes Mental Health and LCDOH-Mental Health to develop and implement policy/practice change	Conduct a total of 2 Mental Health First Aid trainings per year Conduct a total of 2 Youth Mental Health First Aid trainings per year A minimum of 2 schools/Youth Serving organizations to develop/ implement a policy regarding Youth Mental Health First Aid A minimum of 2 community partners to develop/implement a policy regarding Youth Mental Health First Aid
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Mental and Substance Use Disorders Prevention	Prevent underage drinking among youth and excessive alcohol consumption by adults	2.1.1 By December 2021, reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days to 14% or less		2.1.1 Implement environmental approaches, including reducing alcohol access, implementing responsible beverage services, reducing risk of drinking and driving, and underage alcohol access 2.1.2 Implement School based prevention: Implement/Expand School-Based Prevention Services. 2.1.3 Integrate trauma-informed approaches into prevention programs by training staff, developing protocols and cross-system collaboration. 2.1.5 Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) 2.1.6 Integrate trauma-informed approaches and responses into prevention programs by training staff, developing protocols and engaging in cross-system collaboration	Number of sessions Number of schools participating Number of Participants Number of policies (Baseline: State data only available for 9-12 grade 27.1%, students in grades 8,10 and 12 past 30 day use of alcohol 15% -2018, HCTC Prevention Needs Assessment) Note: only local data available for this objective	CASA-Trinity Retail Stores Livingston County Sheriff's Office Healthy Communities That Care Coalition Schools SUNY Geneseo GVHP/Trauma Informed Committee Schools/youth serving orgs	CASA-Trinity and Sheriff's Office to provide training and retailer scans Retail Stores to have staff attend training HCTC to conduct PNA survey, work with youth/schools, coordinate evidence based school prevention strategies Schools work with HCTC assist with PNA survey, implement evidence based school programming and policy Implement SBIRT with students SUNY Geneseo- implement SBIRT GVHP/Trauma Informed Committee- Coordinate training and assist schools/ organizations with approaches/ policies Schools/youth serving organizations staff trained and implement approaches/ policies	Implement at least one responsible server training per year Implement retailer scans and compliance checks at least 1 time per year At least 3 schools participating in evidence based school prevention strategies At least 80% of required sessions being implemented for Evidence Based School programming At least 700 youth participating in school based programming per year At least 60 youth (ages 12-18) participating in SBIRT each year At least 1,200 SUNY Geneseo students participating in SBIRT each year At least 6 new staff trained in TIC by end of year 3 At least 3 new orgs/schools engaged in Trauma Informed approaches and policies by Dec 2021

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles Resources	Projected Year 1,2, and 3
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Mental and Substance Use Disorders Prevention	2.2 Prevent opioid and other substance misuse and deaths	2.2.1 By December 2021, reduce the percentage of youth in grades 9-12 reporting the use of prescription drug misuse on at least one day for the past 30 days to 14% or less		2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine xs	Offer MAT training/certification to providers (Baseline: 3 MAT prescribers-2019 Casa-Trinity)	CASA-Trinity	CASA- Trinity, Inc. Treatment Medical staff- providing MAT and Peer Support Services supporting recovery	At least 1 additional MAT prescriber by year 3
					2.2.2 Increase availability of/ access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	Number of sessions Number of participants	CASA-Trinity CBOs Community members	CASA- Trinity- promote and provide Narcan Training CBOs -promote and attend training Community members attend training	Conduct at least 10 Narcan trainings per year
					2.2.4 Build support systems to care for opioid users or at risk of an overdose	Number of sessions Number of Peer Navigators Number of clients in-patient treatment (Baseline: 3 Peer Navigators-CASA 2019, clients in-patient baseline in 2019)	Opioid Task Force CASA-Trinity ROCovery	Opioid Task Force -use track data via GIS, implement Drug Amnesty Program CASA-Trinity implement and evaluate Peer Navigator Program ROCovery- provide physical activity programs for those w/ 48 hrs of sobriety	Increase number of Peer Navigators by 5% by year 3
					2.2.6 Integrate trauma informed approaches in training staff and implementing program and policy	Number of trainings Number of schools Number of policy / practice changes Baseline: 23.3Livingston County: Opioid overdoses and crude rates per 100,000 population-2018 NYSDOH quarterly Opioid report)	GVHP/Trauma Informed Committee Schools	GVHP/Trauma Informed Committee- provide training and assist with program and policy in schools Schools - staff attend training and implement approaches/ policies	At least 2 new organizations implementing Trauma Informed policies and Approaches by end of year 3
		2.3 Prevent and Address ACES	2.3.3 By December 2021, increase communities reached by opportunities to build resilience by at least 10%		2.3.1 Integrate principles of trauma-informat approach in governance and leadership, policy, physical environment, engagement and involvement, cross sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing and evaluation 2.3.3 Grow resilient communities through education, engagement, activation/mobilization and celebration	Number of sessions Number of Schools Participating Number of Participants Amount of materials distributed Presentations and trainings conducted Number of policy changes (Baseline: Administration in 4 schools received training in ACE's information (Avon, Keshequa, Dansville, Mt.Morris) – 2018 TIC/ GVHP)	GVHP/Trauma Informed Committee (TIC) CASA-Trinity Trauma Informed Care Champions/ Agencies/Schools	GVHP/TIC to conduct training and provide technical support agencies/schools GVHP- $10,000 CASA-Trinity to coordinate TIC workplan Trauma Informed Care Champions/Agencies/Schools to collaborate with TIC to integrate trauma informed approaches via practice/policy changes	A minimum of 10% increase in the opportunities to build resilience by year 3

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles Resources	Projected Year 1,2, and 3
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Mental and Substance Use Disorders Prevention	2.5 Prevent suicides	2.5.2 By December 2021, reduce the age-adjusted suicide mortality rate by 1% and decrease suicide rate to maximum of 10 per 100,000		2.5.1 Strengthen economic supports: strengthen household financial security; policies that stabilize housing	Increase housing options for the target population (Baseline: 2- Skybird Landing, CASA-Trinity In Patient TX Facility-2019)	GVHP/Suicide Prevention Task Force LCDOH- LCMH UR Med Noyes MH CASA-Trinity Housing and Homelessness Task Force	GVHP: $4,500 GVHP/Suicide Prevention Task Force LCDOH- LCMH UR Med Noyes MH CASA-Trinity Housing and Homelessness Task Force - all above to collaborate to increase housing options	A minimum of 1 additional options by year 3
					2.5.2 Strengthen access and delivery of suicide care - Zero Suicide: Zero Suicide is a commitment to comprehensive suicide safer care in health & behavioral health care systems.	Number of sessions Number of participants	GVHP/Suicide Prevention Task Force	Conduct workshops/ presentations	Minimum of 10 participants in CALM 100% increase knowledge among Talk Saves Lives completers
					2.5.3 Create protective environments: Reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches, reduce excessive alcohol use to include education at voluntary firearms safety courses and implement media campaign using Means Matters (NYS Prevention Agenda) resources target firearms retailers and sportmen's clubs	Number of sessions Number of participants (Baseline: established in 2020) Number of earned media Number of paid media (Baseline:10 suicide deaths 2018, Liv Co Coroner's report) Baseline: 10.3 age-adjusted suicide death rate per 100,000	GVHP/Suicide Prevention Task Force LC Sheriff's Office	Conduct training and post training survey with LCSO Assist with coordination of staff training Implement media campaign	100% of participants to complete survey to show increase in knowledge Media campaign implemented and evaluated annually (number of website hits, impressions)

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
Prevent Chronic Diseases	Focus Area 1: Healthy Eating & Food Security	Goal 1.1: Increase access to healthy and affordable foods and beverages	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 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 1.5 Decrease the percentage of adults ages 18 years and older with obesity (among adults with an annual household income of <$25,000) Target: 29.0% Baseline: 30.5% (2016) 31% (2017) Data Source: BRFSS Data Level: State and County 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		Intervention 1.0.4 Multi-component school-based obesity prevention interventions, including: -Providing healthy eating learning opportunities -Participating in Farm to School Programs Ontario County Specific Intervention: Increase availability of fruits, vegetables and other healthy foods in the community and at food pantries	1. # Healthy eating learning sessions held in schools 2. # students reached with nutrition/exercise programming 3. # schools engaged on Farm to Table Coalition 4. % eligible schools trained in CATCH 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	UR Thompson Health (URTH) Ontario County Public Health (OCPH) Finger Lakes Eat Smart New York (FLESNY) Regional Farm to Table Coalition Finger Lakes Community College (FLCC) Regional Transit System (RTS)	URTH: Provide healthy eating learning opportunities in schools and daycares: Get Up! Fuel Up! (GUFU) and Eat Your Colors (EYC) OCPH: Provide healthy eating learning opportunities in the community, including schools Finger Lakes Eat Smart New York: 1. Provide school-based healthy eating learning opportunities 2. Train eligible schools in CATCH Regional Farm to Table Coalition: Engage schools re utilization of locally grown foods OCPH: 1. Participate in regional Farm to Table Coalition 2. Participate in Food Pantry Committee 3.Provide health/nutrition education at 2 food pantries 4. Provide Nourish Your Neighbor (NYN) materials to food pantries, Scouts and United Way URTH: Provide on-site mobile food pantries FLCC: 1. Host healthy food prep classes 2. Food Pantry Committee 3. Utilize "food rescue opportunities" 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	URTH: GUFU $1,420/yr EYC $,2300/yr OCPH: Staff 0.25 FTE $13,918 Finger Lakes Eat Smart New York: Total $12,232 Time $11.232, 0.3 FTE Supplies $1,000 OCPH: Total: $8,360 Farm to Table $360 Food Pantry Committee & Ed $2000 NYN time & materials-$6,000 FLCC: 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

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
Prevent Chronic Diseases	Focus Area 1: Healthy Eating & Food Security	Goal 1.1: Increase access to healthy and affordable foods and beverages	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: -Providing healthy eating learning opportunities -Participating in Farm to School Programs	1. # Healthy eating learning sessions held in schools 2. # students reached with nutrition/exercise programming 3. # schools engaged on Farm to Table Coalition 4. % eligible schools trained in CATCH	Regional Transit System Churches Food Pantries S2AY Rural Health Network Food Justice of Geneva, Inc. FLESNY	Regional Transit System: Provide designated routes to food pantries & grocery stores for those in food desserts or with other barriers to accessing healthy foods Churches: Host food pantries Food Pantries: Distribute gleaned foods to congregants Participate in educational programming, display NYN materials and accept/distribute healthy foods provided S2AY Rural Health Network: Seek out funding to: 1. Support Farm to Table Coalition, including work with schools 2. Provide Nourish Your Neighbor, regionally Food Justice of Geneva, Inc: Glean fruits and vegetables and make available to food pantries, churches and low income neighborhoods FLESNY : 1. Participate in regional Farm to Institution Coalition 2. Provide community education and demos Participate in Food Pantry Committee 3. Provide health/nutrition education and food demonstrations at food pantries and in the community. 4. Provide the Fruit and Vegetable Rx program	Regional Transit System: $15,000-$20,000 S2AY Rural Health Network: 1. 0.1 FTE 2. 1 FTE Food Justice of Geneva, Inc.: Total: $83,350 $5250 Rent & electric $3100 Insurance $12000 Van & gas $1000 Supplies $2000 Stipends $60,000 Labor FLESNY: See intervention 1.0.4
			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		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			
			1.5 Decrease the percentage of adults ages 18 years and older with obesity (among adults with an annual household income of <$25,000) Target: 29.0% Baseline: 30.5% (2016) 31% (2017) Data Source: BRFSS Data Level: State and County						
			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						

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco Prevention	Goal 3.1: Prevent initiation of tobacco use	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 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		3.1.2 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 Public service announcements (PSEs), interviews, Letters to the Editor (LTEs) TACFL OC Public Health Schools Local government Tobacco Action Coalition of the Finger Lakes (TACFL) OC Public Health	Media: Respond to PR's , print LTE's and guest essays, air PSA's. TACFL : Write LTE's, participate in interviews, use social media, work with youth and schools OC Public Health : Develop unified messaging, educate community members/schools use social media, write PR's and PSA's Schools : Provide venues for community and youth education Local government: Adoption of local laws regulating the availability of flavored vaping liquids TACFL: Education of local government officials regarding vaping & assistance with development of legislation OC Public Health: Education of local government officials and advocacy for regulation of flavored vaping products	TACFL: 0.5 FTE's for all interventions related to Goal 3.1. OC Public Health: 0.10 FTE TACFL: See Intervention 3.1.2
					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. # Government officials educated			
					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. # Government officials educated	Local government TACFL OC Public Health	Local government: Adoption of local laws regulating the availability of flavored vaping liquids. TACFL: Education of local and state government officials regarding tobacco marketing. OC Public Health: Education of local government officials and advocacy for regulation of tobacco marketing.	TACFL: See Intervention 3.1.2

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco Prevention	Goal 3.2: Promote tobacco use cessation (Adults)	3.2.1 Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%		3.2.2 Use health communications/media to 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	1. # of times smokers are targeted with messages to encourage 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	NYSDOH OC Public Health Media TACFL	NYSDOH: NYS Quit Line OC Public Health: Outreach, education, public health detailing Media: Respond to PR's , print LTE's and guest essays, air PSA's. TACFL: Outreach, education, earned media	OCPH: 0.05 FTE TACFL: 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 evidence-based assistance, including NYS Smokers' Quitline referrals	URTH FLH Rochester Regional Health/Clifton Springs Hospital and Clinic (RRH/CSHC) NYSDOH Center for a Tobacco Free Finger Lakes (CTFFL)* Greater Rochester Area Tobacco Cessation Center (GRATCC)** Healthcare providers	URTH: Encourage HCP involvement with quit attempts at affiliated practices. Provide smoking cessation classes. FLH: Encourage HCP involvement with quit attempts at affiliated practices. RRH/CSHC: Encourage HCP involvement with quit attempts at affiliated practices NYSDOH: NYS Quit Line CTFFL*: Engage for assistance with reaching the healthcare provider community GRATCC**: Engage for assistance with reaching the healthcare provider community Healthcare providers: Provide evidence-based assistance to patients' quit attempts	URTH: $1,150

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

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco Prevention	Goal 3.3: Eliminate exposure to secondhand smoke (and vaping products)	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: TBD Baseline: Year 2018 Data Source: CAT Data Level: State, municipality. Ontario County Goal: 20		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 TACFL OCPH	Housing agencies: Development of policies TACFL: Promotion and assistance with policy development OCPH: Education and cessation support	TACFL: See Intervention 3.1.2 OCPH: .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	Municipalities Colleges TACFL	Municipalities: Development of policies Colleges: Development of policies TACFL: Promotion and assistance with policy development	TACFL: 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 OCPH Ontario County Health Collaborative (OCHC) Members Schools	TACFL: Education of decision makers, press releases, LTE's, social media, earned media, tabling events, school events OCPH: Education of decision makers, press releases, LTE's, social media, earned media, tabling events, school events OCHC Members: Press releases, LTE's, social media, earned media, tabling events, school events Schools: Venues to reach children, adolescents and college students	TACFL: See Intervention 3.1.2 OCPH: 0.05 FTE

Ontario County Appendix C

PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
Prevent Chronic Diseases	Focus Area 4: Chronic Disease Preventive Care & Management	Goal 4.1: Increase cancer screening rates	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 4.1.4 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		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) OCPH Hospitals & affiliated practices OC Probation Dept. OC Jail Churches Worksites	CSP: Provide one-on-one & community education re cancer/cancer screening & services available, including assistance for those with high deductible insurance plans. OCPH: Provide community education on cancer and cancer screening. Refer residents to CSP. Hospitals & affiliated practices: Provide education to patients and families. Refer residents to CSP. Contract with CSP. OC Probation Dept: Provide venue for education OC Jail: Provide venue for education. Potentially host a mobile mammography unit. Churches: Potential venues for community education Worksites: Potential venues for tabling (work-sponsored health fairs)	CSP: .125 FTE OCPH: .10 FTE
					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	CSP of the FL Regional Transit System (RTS) OC Public Health URTH FLH RRH-CSHC Breast Cancer Coalition Health Insurers (Fidelis)	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. RTS: Distribute printed materials on buses. OC Public Health: Distribute CSP materials at community events & via social media. Use social marketing & community education to raise awareness. URTH: Display CSP materials on site. Provide community education re cancer and cancer screening. FLH: Display CSP materials on site. Provide community education re cancer and cancer screening. RRH-CSHC: Display CSP materials on site. Provide community education re cancer and cancer screening. Breast Cancer Coalition: Provide support, education and advocacy to Ontario County residents affected by breast or gynecologic cancers. Health Insurers (Fidelis): Provide cancer and cancer screening education and printed materials in public venues.	CSP of the FL: $1,100.00 OC Public Health: Staff time 1 hour/ month x 12 = $360
					4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics)…..	1. # of facilities engaged re having Mobile Mammography Unit on site 2. # of mammograms provided via mobile unit in Ontario County	OCPH Rochester Regional Health (RRH) Employers Ontario County Jail CSP of the FL	OCPH: Investigate the feasibility and assess the interest of worksites and the County Jail in hosting Rochester Regional Health's Mobile Mammography Unit. RRH: Provide Mobile Mammography to Ontario County residents. Employers: Allow RRH's Mobile Mammography Unit on-site Ontario County Jail: Allow RRH's Mobile Mammography Unit on-site CSP of the FL: Determine feasibility for CSP reimbursement for mobile mammography at jail.	OCPH: Staff time $500 RRH: 40 hours(1wk)/ year=0.14 FTE

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
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	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 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		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 URTH RRH/CSHC Medical Providers	FLH: Cardiac Re-Hab Diabetes Management Program URTH: Cardiac Re-Hab (Mended Hearts) Community Diabetes Support Group RRH/CSHC: Cardiac Re-Hab (5 days/week) Diabetes Education and Management (3day/week) Medical Providers: Refer to programs offered by local hospitals	FLH: TBD URTH: In kind RRH/CSHC: Cardiac: 1 FTE, Diabetes: 0.6 FTE
			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) URTH & affiliated practices FLH & affiliated practices RRH/CSHC & affiliated practices OCPH	Common Ground Health & RHIO: Maintain the Hypertension Registry & report out to partners& participating healthcare providers 2x/year. Provide education on best practices for monitoring and treatment of hypertension. URTH, FLH, RRH/CSHC & affiliated practices: Provide data to the Hypertension Registry. OCPH: Assist & support education of healthcare community re control rates.	Common Ground Health & RHIO: In kind

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
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	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	# 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 RRH-CSHC OCPH Community sites OCHC Medical Providers Office for the Aging	URTH: Offer CDSMP in community settings & provide flyers for partner-sponsored EBI's to clients RRH-CSHC: Consider feasibility of offering CDSMP in Clifton Springs community & provide flyers for partner-sponsored EBI's to clients OCPH: Offer CDSMP at OC Jail and assist URTH, as needed with staffing CDSMP groups, provide flyers for partner-sponsored EBI's to clients Community sites: Provide venues for CDSMP courses OCHC: Develop method to determine if CDSMP participants experience ED or hospital admissions in the 6-12 period after completion of program. Medical Providers: Refer patients to CDSMP in the community Office for the Aging: Provide EBI's: Matter of Balance & Powerful Tools for Caregivers, distribute CDSMP flyers at OFA programming	URTH: $5156.40 (Salary 5 programs $3600.00; 50 Books & CD's $1278; Mileage $278.40) RRH-CSHC: CDSMP delivery in planning process: Resources to be determined OCPH: Staff time x 2: 2 sessions/year $1,440 Office for the Aging: $7,125

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PRIORITY: PROMOTE WELL-BEING, PREVENT MENTAL & SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
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	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 conversations addressing building community-wide well-being and resilience across the lifespan. 2. Community partners enlisted, including roles (informative, advisory, transactional, decision-making).	OCPH S2AY RHN	OCPH: Begin community conversation about strengthening opportunities to build well-being & resilience. S2AY RHN: Grant opportunities to support community work	OCPH: TBD S2AY RHN: 1 FTE
							Community Partners to Consider		
							Schools Municipalities Legislators Churches Mental Health Service organizations YMCA's, Health insurers Employers Hospitals	Food pantries Food Justice Department Soc Serv Ontario County Jail Regional Transit System Office for the Aging CBO's NY Kitchen Hospitals VA	Farm Bureau CCE Ontario County Pathways Wegmans OC Substance Abuse Coalition OC Planning Rochester Comm. Foundation
		Goal 2.2: Prevent opioid and other substance misuse and deaths	2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population Target: 14.0 per 100,000 Baseline: 15.1 per 100,000 (2016) Data Source: CDC WONDER Data Level: County		2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	1. # Narcan trainings held 2. # of community members trained in the administration of Narcan.	OC Public Health S2AY Rural Health Network	OC Public Health: Participate in the NYSDOH's Opioid Overdose Prevention Program. Provide and use earned media to raise community awareness about availability of Narcan Trainings in the community. Participate on the Regional Opioid Task Force. S2AY: Continue to lead the Regional Opioid Task Force	OC Public Health: $5,000 S2AY: 0.1 FTE
							Community Partners: - Employers - Colleges - Libraries - Fire Dpts. - Sheriffs - Churches Sheriff's Media Trillium Health	Community Partners: Provide venues and audiences for Narcan trainings Sheriff's: Create OD Maps Media: Respond to PR's and LTE's Trillium Health: Provide Narcan and education at mobile syringe exchange program	

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PRIORITY: PROMOTE WELL-BEING, PREVENT MENTAL & SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Implementation Partner	Partner Roles	Partner Resources
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			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 sites	Trillium Health OC Public Health FL Area Counseling & Recovery Agency (FLACRA) Canandaigua Fire Department Ontario County Opioid Court	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. OC Public Health: Assist Trillium Health with outreach to elected officials and community leaders re needle exchange sites FLACRA: Host mobile SEP. Provide emergency Opioid Response Team services. Canandaigua Fire Department: Host mobile SEP Ontario County Opioid Court: Provide option for treatment prior to arraignment	
		Goal 2.5: Prevent suicides	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 suicide, 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. # Comprehensive Psychiatric Emergency Program (CPEP) responses (if determined to be feasible to obtain and track) 4. # Lifeline Counseling calls	Suicide Prevention Coalition of Ontario County Ontario County Public Health OC Mental Health CBOs, human services, residents, businesses, schools, colleges Healthcare systems RRH/CSHC Ontario County Sheriff's 911 center YANA (You Are Not Alone) VA Lifeline 211/Lifeline National Suicide Hot Line	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. Ontario County Public Health: Provide expertise to Suicide Prevention Coalition OC Mental Health: Provide expertise to Suicide Prevention Coalition Participate in Suicide Prevention Coalition; become trained in suicide prevention strategies; provide venues for suicide prevention trainings Healthcare systems: Screen patients for suicidal ideation and provide or refer for mental health care RRH/CSHC: 1. Provide CPEP teams to respond to emergency mental health situations 24/7. Estimate-150/month. 2. Determine feasibility of providing data to OCHC. 911 center: Partner with CPEP in responding to calls for mental health emergencies YANA: Provide support to LGBTQ youth VA, 2/Lifeline Lifeline, National Suicide Hot Line: Provide suicide-prevention hotline counseling	Suicide Prevention Coalition of Ontario County: $25,000

Schuyler County Appendix D

PRIORITY: PREVENT CHRONIC DISEASES, PREVENTATIVE CARE AND MANAGEMENT

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1: Increase cancer screening rates	4.1.3 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (age 50-75 years)	Adults with an annual household income less than $25,000	4.1.3 Use small media such as videos, printed materials (letters, brochures, newsletters) and health communication to build public awareness and demand	Number of advertisements promote cancer screenings Percent of Cancer Resource Center (CRC) promotions that target low income	Receive social media toolkit from NY CSP	Run ad in primary care center, lobbies of hospital (ER and main hospital), Facebook, brochures	Schuyler Hospital does interviews with Doctors for live videos on Facebook. Run ad in primary care center, lobbies of hospital (ER and main hospital), Facebook, brochures	Hospital	Schuyler Hospital 2% FTE
							NY CSP will continue to provide social media toolkit, that can be shared to Facebook for daily and weekly post, Press releases, Commercials Investigate if they NYCSP can provide billboard Post billboard	NY CSP will continue to provide social media toolkit, that can be shared to Facebook for daily and weekly post, Press releases, Commercials Billboard for March 2020	NY CSP will continue to provide social media toolkit, that can be shared to Facebook for daily and weekly post, Press releases, Commercials	Other (please describe partner and role(s) in column D)	Southern Tier Cancer Services Program - cost of billboard and time of employee spent on campaigning
							Promotion of Healthy Living Classes in local media and hold Healthy Living Classes	Promotion of Healthy Living Classes in local media Facebook live events with doctors to promote cancer screening awareness	Promotion of Healthy Living Classes in local media	Community-based organizations	U of R-Center for Community Health & Prevention-2% FTE and $330/year
							Receive social media tool kit from NYCSP to be used in the region Use Inflatable colon at local event to promote colorectal cancer screenings and do social media post to increase awareness for screenings Promote Health Living Class in Watkins Glen	Public Health will do paid media along with social media path, use inflatable colon at events Investigate billboard for Public Health to run Ad. Promotion of materials on colorectal cancer screening with Montour Festival, Food pantries, OFA Meal Sites	Public Health will do paid media along with social media path, use inflatable colon at events Run the Ad for a billboard Promotion of materials on colorectal cancer screening with Montour Festival, Food pantries, OFA Meal Sites	Local health department	Schuyler Public Health 2-4% of Full time public health employee

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PRIORITY: PREVENT CHRONIC DISEASES, PREVENTATIVE CARE AND MANAGEMENT

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1: Increase cancer screening rates	4.1.3 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (age 50-75 years)	Adults with an annual household income less than $25,000	4.1.3 Use small media such as videos, printed materials (letters, brochures, newsletters) and health communication to build public awareness and demand	Number of advertisements promote cancer screenings Percent of CRC promotion that target low income	S2AY will promote Living Healthy Classes in Schuyler County	S2AY will promote Living Healthy Classes in Schuyler County	S2AY will promote Living Healthy Classes in Schuyler County	Community-based organizations	S2AY Rural Health Network 5% of Full time staff towards social media promotion, website maintenance and email distribution for promotion
			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)		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		Use inflatable colon to promote awareness about colorectal cancer at festival	Use inflatable colon to promote awareness about colorectal cancer at festivals. Attend 3 service clubs, churches and OFA meal sites. Attend local school events	Attend food pantries and mobile food pantries to increase awareness for screenings Use inflatable colon to promote awareness about colorectal cancer at festivals	Local health department	Schuyler Public Health 2-4% of Full time public health employee
							Conduct Health Living Class through U of R	Conduct Health Living Class through U of R. Provider webinar about colorectal cancer by U of R	Conduct Health Living Class through U of R	Community-based organizations	U of R- Center for Community Health & Prevention- 5% FTE and $1010/ye
							Attend Harvest Festival to promote NYCSP program	Provide referral service for NYCSP to local providers and local referral agencies	Provide referral service for NYCSP to local providers and local referral agencies	Community-based organizations	Southern Tier Cancer Services Program - time spend on outreach and requirement

Schuyler County Appendix D

PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal	Objectives	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention - 2019	Projected Year 2 - 2020	Projected Year 3 Interventions - 2021	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.3: Prevent and address adverse childhood experiences	2.3.2 Reduce indicated reports of abuse/ maltreatment rate per 1,000 children and youth ages 0-17 years by 9% to 15.6 per 1,000 children and youth ages 0-17 years (Current rate: 45.2 per 1,000 - 2017)	2.3.1 Integrate principles of trauma-informat approach in governance and leadership, policy, physical environment, engagement and involvement, cross sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing and evaluation	Completion of training; change in policies or implementation of policies	Evaluate grant opportunities for Adverse Childhood Experiences (ACES) community support Evaluate community readiness from government and leaders in the community	Evaluate grant opportunities for ACES community support Training on ACEs for mental health professional Bring ACES to Schuyler County government and leaders with the community and evaluate readiness for integration into protocols, etc. Set up referral system for Mental Health Clinic Add ACES category to monthly Quality Assurance meeting with Mental Health	Implement screening tool for ACES at the Mental Health Clinic Review and update policies/ protocol as it pertains to ACES Set up a baseline of ACES scores and determine an evaluation process for effectiveness of processes addressing ACES Full implementation of ACES intervention together Collect data on ACES to review impact on community Discuss with community partners about sustaining efforts with ACES intervention	Local governmental unit	Mental Health Clinic 2% of FTE of Mental Health Clinic.
						Use existing protocols to maintain patient privacy in waiting areas and check-in	Start training on ACES with primary care providers, hospital social work providers and emergency room providers Strengthen and increase coordination of care with referral services for behavioral health Develop policies and procedures for integrating trauma informed approaches and follow-up	Integrate behavioral telehealth services with primary care Implement updated policies and procedures for integrating trauma-informed approaches and follow-up Look at integrating behavioral telehealth services with Emergency Department	Hospital	2% of FTE Schuyler Primary Care Center, 2% of FTE for Schuyler Hospital ER
						Identify training needs for Public Health staff on trauma informed care and ACES	Start training for ACES and trauma informed care Partner with and support Mental Health Clinic in discussion with government leaders and community on determining community readiness for ACES and trauma informed care	Evaluate internal practices to determine whether they are aligned with trauma informed approaches and ACES Update internal practices as necessary	Local Health Department	2% FTE Public Health Employee

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal	Objectives	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention - 2019	Projected Year 2 - 2020	Projected Year 3 Interventions - 2021	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.3: Prevent and address adverse childhood experiences	2.3.2 Reduce indicated reports of abuse/ maltreatment rate per 1,000 children and youth ages 0-17 years by 9% to 15.6 per 1,000 children and youth ages 0-17 years (Current rate: 45.2 per 1,000 - 2017)	2.3.1 Integrate principles of trauma-informat approach in governance and leadership, policy, physical environment, engagement and involvement, cross sector collaboration, screening, assessment and treatment services, training and workforce development, progress monitoring and quality assurance, financing and evaluation	Completion of training; change in policies or implementation of policies	Conduct regional ACES community presentations for awareness and education	Continue to promote informational events on ACES and Resilience in communities	Continue to promote informational events on ACES and Resilience in communities	Community-based organizations	5% FTE
				2.3.2 Address Adverse Childhood Experiences and other types of trauma in the primary care setting	Percent of primary care settings that screen for ACES	Coordinate with community partners to address ACES in primary care setting	Offer and provide education about ACES and referral system	Implement screening tool for ACES at the mental health clinic Coordinate with community partners to address ACES in primary care setting Work with primary care on evaluation of ACES intervention	Local governmental unit	Mental Health Clinic 2% of FTE
						Start conversation with EMR on getting ACES screening questions entered into ECW	Training for ACES, end of year start using ACES screening tool Work with Mental Health Clinic on strengthening the referral process and follow through Start working on processes and protocols for ACES screening	Evaluate ACES Screening process and update protocols as needed	Hospital	2% of FTE Schuyler Primary Care Center
						Identify and share resources on ACES screening with Schuyler Primary Care and other organizations participating in the CHIP	Identify and share resources on ACES screening with Schuyler Primary Care and other organizations participating in the CHIP	Identify and share resources on ACES screening with Schuyler Primary Care and other organizations participating in the CHIP	Local health department	2% FTE Public Health Employee

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal	Objectives	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention - 2019	Projected Year 2 - 2020	Projected Year 3 Interventions - 2021	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.3: Prevent and address adverse childhood experiences	2.3.2 Reduce indicated reports of abuse/ maltreatment rate per 1,000 children and youth ages 0-17 years by 9% to 15.6 per 1,000 children and youth ages 0-17 years (Current rate: 45.2 per 1,000 - 2017)	2.3.2 Address Adverse Childhood Experiences and other types of trauma in the primary care setting	Percent of support referrals followed through on within six month of being screened for ACEs	Assemble community partners to address ACES in primary care setting	Offer and complete education about ACES and referral system	Implement screening tool for ACES in the mental health clinic Conduct ongoing outreach about ACES and referral system. Work with Schuyler Primary Care on evaluation of ACES intervention, looking at referrals and ACES scores	Local governmental unit	Mental Health Clinic
						Use existing referral process for mental health services	Work with Mental Health Clinic on strengthening the referral process and follow through Develop policies and procedures for integrating trauma informed approaches and follow-up	Evaluate ACES follow up process and update protocols as needed	Hospital	Funds for changes in E.H.R system 2% of FTE Schuyler Primary Care Center
		Goal 2.5: Prevent suicides	2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000	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, postvention, safe reporting and messaging about suicides	Proportion who felt comfortable applying suicide prevention skills, active listening, problem-solving, anger management, and stress management skills to identify and refer individuals at risk for suicide to appropriate care; Proportion who were knowledgeable about the signs and symptoms of suicide as well as the mental health problems associated with suicide, such as depression and substance use	Continue following policy on clients who may be at risk Continue training with Youth Mental Health First Aid and exploring other partners who would like to be trained or be trained as trainers Continue support and participation with SAFE coalition Evaluate with internal mental health clinic staff and community partners effectiveness of intervention on suicide prevention activities Adapt interventions as necessary based on evaluation findings	Continue following policy on clients who may be at risk Continue training with Youth Mental Health First Aid and exploring other partners who would like to be trained or be trained as trainers Continue support and participation with SAFE coalition Evaluate with internal mental health clinic staff and community partners effectiveness of intervention on suicide prevention activities Adapt interventions as necessary based on evaluation findings.	Continue following policy on clients who may be at risk Continue training with Youth Mental Health First Aid and exploring other partners who would like to be trained or be trained as trainers Continue support and participation with SAFE coalition Evaluate with internal mental health clinic staff and community partners effectiveness of intervention on suicide prevention activities Adapt interventions as necessary based on evaluation findings	Local governmental unit	Mental Health Clinic- Meeting space for SAFE meetings, 5% of FTE for Mental Health Clinic

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal	Objectives	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention - 2019	Projected Year 2 - 2020	Projected Year 3 Interventions - 2021	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.5: Prevent suicides	2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000	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, postvention, safe reporting and messaging about suicides	Proportion who felt comfortable applying suicide prevention skills, active listening, problem-solving, anger management, and stress management skills to identify and refer individuals at risk for suicide to appropriate care; Proportion who were knowledgeable about the signs and symptoms of suicide as well as the mental health problems associated with suicide, such as depression and substance use	Identifying need for mental health crisis training for staff at Schuyler Primary Care, Schuyler Hospital social workers and Schuyler Emergency Providers	Identify specific trainings to complete (for example, Mental Health First Aid or QPR) Identify additional resources in the community that can be used during crisis interventions	Finalize and implement written protocol for mental health first aid in Schuyler Primary Care Center Review and revise written protocols in the Emergency Department regarding mental health first aid	Hospital	2% of FTE Schuyler Primary Care Center, 2% of FTE for Schuyler Hospital
						Continue to invest time in participating in local, regional and state wide suicide prevention efforts (e.g., SAFE, annual regional and statewide meetings) Identify and share resources and best practices for suicide prevention Collaborate with community organizations to promote trainings Sharing information about resources in the community about suicide prevention resources	Continue to invest time in participating in local, regional and state wide suicide prevention efforts (e.g., SAFE, annual regional and statewide meetings) Identify and share resources and best practices for suicide prevention Collaborate with community organizations to offer and promote trainings Explore means reduction intervention for possible implementation in 2021 Sharing information about resources in the community about suicide prevention resources	Continue to invest time in participating in local, regional and state wide suicide prevention efforts (e.g., SAFE, annual regional and statewide meetings) Identify and share resources and best practices for suicide prevention Collaborate with community organizations to offer and promote trainings Potentially implement means reduction intervention depending on 2020 findings Sharing information about resources in the community about suicide prevention resources	Local Health Department	2%-4% FTE Public Health Employee

Schuyler County Appendix D

PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal	Objectives	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention - 2019	Projected Year 2 - 2020	Projected Year 3 Interventions - 2021	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.5: Prevent suicides	2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000	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, postvention, safe reporting and messaging about suicides	Proportion who felt comfortable applying suicide prevention skills, active listening, problem-solving, anger management, and stress management skills to identify and refer individuals at risk for suicide to appropriate care; Proportion who were knowledgeable about the signs and symptoms of suicide as well as the mental health problems associated with suicide, such as depression and substance use	Attend four to five local festivals/events to promote suicide awareness SAFE member trained as a Youth Mental Health First Aid trainer Youth Mental Health First Aid training provided in Dundee School District. Attend annual regional suicide prevention meeting Fundraise for Suicide Prevention awareness at Waterfront Festival. Advocating for Schuyler County to partner with another county for Suicide Prevention Coordinator	Attend four to five local festivals/events to promote suicide awareness Attend annual regional and statewide suicide prevention meetings Fundraise for Suicide Prevention awareness at Waterfront Festival Offer Youth Mental Health First Aid training for staff at one school each year. Work with County Coroner on accurate reporting of suicide deaths	Attend four to five local festivals/events to promote suicide awareness Attend annual regional and statewide suicide prevention meetings Fundraise for Suicide Prevention awareness at Waterfront Festival Offer Youth Mental Health First Aid training for staff at one school each year Work with County Coroner on accurate reporting of suicide deaths.	Community-based organizations	SAFE- time spent on tabling, trainings, advocating.
						Attend three to four local festivals/events to promote suicide awareness Individual received training to be a QPR trainer. Offer youth and adult QPR trainings Organize "Saving Space": informal support group to support people dealing with mental health issues in their lives, including but not limited to suicide Organize six "Too Late for Taboo" discussions focused on suicide prevention Individual is Peer Specialist certified and offering individual and group peer support services	Attend three to four local festivals/events to promote suicide awareness Individual received training to be a QPR trainer, Offer youth and adult QPR trainings Organize "Saving Space": informal support group to support people dealing with mental health issues in their lives, including but not limited to suicide Organize six "Too Late for Taboo" discussions focused on suicide prevention Individual is Peer Specialist certified and offering individual and group peer support services Offer youth QPR training for school-aged youth Organize youth suicide awareness/suicide prevention dance Organize Push Through 5k race	Attend three to four local festivals/events to promote suicide awareness Individual received training to be a QPR trainer, Offer youth and adult QPR trainings Organize "Saving Space": informal support group to support people dealing with mental health issues in their lives, including but not limited to suicide Organize six "Too Late for Taboo" discussions focused on suicide prevention Individual is Peer Specialist certified and offering individual and group peer support services Offer youth QPR training for school-aged youth Organize youth suicide awareness/suicide prevention dance Organize Push Through 5k race	Community-based organizations	M. R. Hess Home Works Time spent on trainings, running groups, fundraising

Schuyler County Appendix D

PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal	Objectives	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention - 2019	Projected Year 2 - 2020	Projected Year 3 Interventions - 2021	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.5: Prevent suicides	2.5.2 Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000	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, postvention, safe reporting and messaging about suicides	Proportion who felt comfortable applying suicide prevention skills, active listening, problem-solving, anger management, and stress management skills to identify and refer individuals at risk for suicide to appropriate care; Proportion who were knowledgeable about the signs and symptoms of suicide as well as the mental health problems associated with suicide, such as depression and substance use	Attend local festivals and events together with other local suicide prevention and awareness organizations Offer Survivor Meetings starting in October Fundraise and promote suicide awareness and prevention with gala Reach out to families affected by suicide to offer support Adopt a family for the holidays Partner with other community organizations to assist with postvention efforts Committee members will complete QPR training Offer a scholarship for a Watkins Glen student.	Attend local festivals and events to together with other local suicide prevention and awareness organizations Offer Survivor Meetings Fundraise and promote suicide awareness and prevention with gala Reach out to families affected by suicide to offer support Adopt a family for the holidays Partner with other community organizations to assist with postvention efforts Committee members will complete QPR training Offer two scholarships: one each for a Watkins Glen and an Odessa-Montour student	Attend local festivals and events to together with other local suicide prevention and awareness organizations Offer Survivor Meetings Fundraise and promote suicide awareness and prevention with gala Reach out to families affected by suicide to offer support Adopt a family for the holidays Partner with other community organizations to assist with postvention efforts Committee members will complete QPR training Offer three scholarships: one each for a Watkins Glen student, an Odessa-Montour student, and a Bradford student	Community-based organizations	Ryan Pruitt Awareness 24 (RPA 24) Time spent on tabling, trainings, working on postventions and fundraising

Seneca County Appendix E

PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices	Decrease the percentage of adults who consume one or more sugary drinks per day (among all adults)	Low SES, disability	1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results	Number of worksite wellness healthy eating and or physical activity program participants # of worksites who have received nutrition education and or participated in physical activity program	SCHD will offer at least 1 physical activity program and at least 1 nutrition education session to Seneca County employees The Public Health Educator will actively participate in the Seneca County Employee Wellness Committee and the Regional Worksite Wellness Committee	To expand physical activity and or nutrition offerings to other Seneca County Employers To offer 2 physical activity opportunities for Seneca County employees	To increase the number of / workplaces offering and participating in worksite wellness programs and activities	Business	.10 FTE -Seneca County Health Department Public Health Educator will provide nutrition education to county employees and other worksites as requested Seneca County Public Health Educator will coordinate a walking challenge for County employees and at least one additional workplace Cornell Cooperative Extension Nutrition Educator will provide nutrition education programs for Seneca County employees and other worksites
		Goal 1.3: Increase food security	1.13 Increase the percentage of adults with perceived food security (among all adults)	Low SES/ Geographically isolated	1.0.6 Screen for food insecurity, facilitate and actively support referral	# of seniors screened for food insecurity # of appropriate referrals made for seniors # of health department patients (EI/MCH/Lead.) screened for food insecurity # of patients screened for food insecurity and # of referrals by health department staff	To develop a food assistance resource list for clients and a referral form to access food assistance To begin to implement food security screening and appropriate referrals to access food assistance To sponsor the Mobile Market at the Senior Center at least 2 x a year To promote farmer's market coupons	To routinely screen for food insecurity and make appropriate referrals to access necessary supplemental food resources	To routinely screen for food insecurity and make appropriate referrals to access necessary supplemental food resources	Community-based organizations	.10 RD-The Office for the Aging will conduct High Nutritional Risk Screen for Seniors who come to Congregate Meals, Home Delivered Meals, EISEP Program If they score at risk a referral is made to the on staff RD for follow up. Seneca County Health Department Early Intervention Service Coordinator will screen (.03 FTE) their families for food insecurity and will document and make an appropriate referral The Lead Poisoning Prevention Program Coordinator (.02)FTE) will screen families of children with elevated blood lead levels for food insecurity Families who screen positive will be referred to an appropriate agency/ program and will be provided nutrition education

Seneca County Appendix E

PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.3: Eliminate exposure to secondhand smoke	3.3.1 Decrease the percentage of adults (non-smokers) living in multi-unit housing who were exposed to secondhand smoke in their homes	Low SES	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	# of housing units that adopt smoke free policies	To work with TACFL, Seneca County Housing Authority and Finger Lakes Landlord Association to increase the number of multi-unit housing complexes to adopt smoke free housing policies	To provide outreach and education to landlords and managers about the benefits of smoke free housing policies At least 1 multi-unit housing complex will adopt a smoke free policy	At least 1 multi-unit housing complex will adopt a smoke free policy	Housing	TACFL .015 and .05 of Seneca County Health Department health educators, TACFL representative and STEPS representative will form a sub-committee to work on smoke free housing initiatives in Seneca County A landlord and tenant survey will be developed Representatives from the committee will educate landlords about the benefits of smoke free housing and will work collaboratively with landlords and rental property managers to implement smoke free housing policies
			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	Low SES/ Youth	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	# of educational presentation on vaping # of youth in attendance at vaping presentations # of youth reporting they were in a room with someone who was smoking or that they had smoked in the last 7 days # of underage purchases of vaping products by minors from ATUPA compliance checks	To partner with TACFL and the Council on Alcoholism to provide at least 2 presentations 1 for youth and 1 for parents To utilize social media to increase awareness of the dangers of vaping among youth To conduct compliance checks per ATUPA grant guidelines to ensure youth are not able to purchase vaping devices or products	To continue compliance checks to ensure those under 18 are not able to purchase nicotine delivery devices To post at least 1 anti vaping post per month to FB or other Social media outlets Continue to provide education to the community and youth about the dangers associated with vaping	To continue compliance check To post at least 1 anti vaping post per month to FB or other Social media outlets Continue to provide education to the community and youth about the dangers associated with vaping	K-12 School	Seneca County Health Department Health Educators (.10 FTE) will educate the public by providing informational presentations to parents, community groups, schools as requested TACFL will provide education and resource support to educate youth and adults about the dangers of vaping Council on Alcoholism will incorporate e-cigs into their in plain sight presentations
	Focus Area 4: Preventive care and management	Goal 4.4: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	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	Low SES/ minority populations	4.4.3 Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes	# of NDPP workshops offered # of participants # of provider information sessions offered about NDPP	To offer and complete at least 1 NDPP in the community Finger Lakes Health will continue to refer their patients and offer the diabetes prevention program to their patients At least 30 patients will have taken the program by the end of year 1	To promote NDPP programs in the community by reaching out to groups Offering classes in a variety of settings To increase provider referrals to community based NDPP and to the FLH Diabetes Center	To increase the number of patients completing NDPP workshops	Providers	.05 FTE-Seneca County Health Department Health Educator will facilitate NDPP workshops Finger Lakes Health will facilitate NDPP Workshops for their patients. Local medical providers including the FQHC will refer their pre-diabetic patients to the NDPP Program STEPS will promote NDPP workshops offered

Seneca County Appendix E

PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1: Increase cancer screening rates	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	Women income less than $25,000	4.1.4 Work with clinical providers to assess how many of their patients receive screening services and provide them feedback on their performance (Provider Assessment and Feedback)	Provider or clinic-level breast, cancer screening rates	Promote cancer screenings in accordance with the most recent guidance	Increase screening rates among local providers	Increase screening rates among local providers	Hospital	Finger Lakes Health (GGH)-.2 FTE and $3,000 for promotion of screenings in FLH magazine. Finger Lakes Health will track colorectal cancer screening referrals from their Primary Care Offices and track the number of visits to GGH for colorectal cancer screenings Referrals and hospital visits for colorectal cancer screenings are tracked by both zip code and healthcare payer Finger Lakes Health will promote screening and education through direct mail newsletters to 74,000 homes 2 x year and will use social/digital media to raise awareness (Ovid Community Health Patient Navigator .10 FTE) will promote cancer screening services to their patients Patient Navigator will provide cancer screening outreach in the community to increase awareness for cancer screenings Outreach coordinator for the Finger Lakes CSP will conduct outreach via tabling and provider outreach in Seneca County to increase the number of uninsured or underinsured men and women who receive colorectal cancer screenings
		Goal 4.3: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	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	Low SES/ minority populations	4.3.5 Promote referral of patients with prediabetes to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program to achieve and maintain 5% to 7% loss of initial body weight and increase moderate-intensity physical activity (such as brisk walking) to at least 150 min/week	Number of National DPP programs in community settings Number of patients referred to National DPP percentage of patients who complete National DPP Number of patients who participate in National DPP	Promote the FL Cancer Services Program and work with local health systems to increase access to screenings for their patients including scheduling mobile mammogram clinics and or other screening events	Increase screening rates among local providers	Increase screening rates among local providers	Hospital	Finger Lakes Health (GGH)- .2 FTE and $3,000 for promotion of screenings in FLH magazine Finger Lakes Health will track mammogram referrals from their Primary Care Offices and track the number of visits to GGH for mammography. Referrals and hospital visits for breast cancer screenings are tracked by both zip code and healthcare payer Finger Lakes Health will promote screening and education through direct mail newsletters to 74,000 homes 2 x year and will use social/digital media to raise awareness Finger Lakes Community Health (Ovid Community Health Patient Navigator .10 FTE will promote cancer screening services to their patients and arrange for mobile mammography clinic to be onsite to screen their patients Patient Navigator will provide cancer screening outreach in the community to increase awareness for cancer screenings Outreach coordinator for the Finger Lakes CSP will conduct outreach via tabling and provider outreach in Seneca County to increase the number of uninsured or underinsured women who receive breast cancer screenings

Seneca County Appendix E

PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	1.1.2 Reduce the age-adjusted percentage of Seneca County adults reporting 14 or more days with poor mental health in the last month by 10% expanded BRFSS	Individuals with Substance Use and or Mental Health Disorder	1.2.2 Mental Health First Aid is an evidence- based public education program that teaches people how to respond to individuals who are experiencing one or more acute mental health crises (such as suicidal thoughts or behavior, an acute stress reaction, panic attacks or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (such as depressive, anxiety or psychotic disorders, which may occur with substance abuse)	# of Youth and Adult Mental Health First Aid Trainings offered # of people trained in Mental Health First Aid # of participants reporting an increase in knowledge of appropriate Mental Health first aid strategies	To train staff in Youth Mental Health First Aid and or Adult Mental Health First Aid	To work with faith leaders and community based organizations to provide or co-sponsor a Youth and an Adult Mental Health First Aid training in Seneca County	Resources: Seneca County United Way .25 FTE Seneca County SRPHE/ PHE .10 FTE each To offer routine Youth and Adult Mental Health First Aid trainings in Seneca County To train at least 50 people in either Youth and or Adult Mental Health First Aid 100% of those trained will report increase knowledge in how and where to make appropriate referrals and increased knowledge of appropriate mental health first aid strategies	Faith	.10 FTE from the Seneca County Health Department and .10 FTE from the Seneca County United Way and .05 FTE S2AY Rural Health Network, Seneca County Health Department, Seneca County Community Counseling Services United Way & Suicide Coalition members The outreach sub-committee for the Seneca County Suicide Coalition and the Senior PH Educator will plan for an Adult Mental Health First Aid training to be held in Seneca County for members of the faith sector to be trained in Mental Health First Aid Suicide Coalition and the United Way will promote appropriate trainings for the community to increase awareness of mental health and to decrease stigma
		Goal 2.2: Prevent opioid overdose deaths	To reduce overdose deaths involving any opioid, crude rate per 100,000 population - Aged 18-44 years in Seneca County from 17.3 to 14.3	Uninsured or no RX coverage	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers	# Narcan trainings provided # people trained to administer Narcan % of those trained indicating increase knowledge	4 Nalaxone Trainings will be provided by SCDOH staff; reaching at least 30 people After training, 100% of those trained will indicate an increase in knowledge of how to recognize an OD and how to properly administer narcan for a suspected overdose Narcan training to be offered to FQHC staff at Ovid Community Health	To provide Narcan Administration and training to 100% of Seneca County School RNs and to all public Libraries in Seneca County To provide Narcan training for at least 1 Medical Provider office in Seneca County	Partners: Seneca County Community Counseling Center 1% FTE dedicated to Narcan Trainings SCDOH Staff .05% FTE either SRPHE/PHE or RN To routinely offer Narcan Trainings at least quarterly to members of the public 100% of those trained will report an increase in knowledge of how to recognize an OD and how to properly administer narcan for a suspected overdose. To train at least 60 people annually	Hospital	.10 SRPHE, RN and or PHE-Seneca County Health Department .05 FT- Seneca County Community Counseling Center, Seneca County Health Department Staff, Opioid Overdose Community Trainer and Community Counseling Center Staff will provide quarterly community Narcan Administration Trainings to the community Seneca County Substance Abuse Coalition will promote trainings and provide information on Opioids at tabling events How to recognize an OD palm cards will be distributed at community events

Seneca County Appendix E

PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2: Prevent opioid overdose deaths	2.2.1: Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population		2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days	# of lbs. collected from the Med Safe drug disposal units # of Units collected Opioid Take Back Day # of Dispose RX packets distributed in community	To establish at least 1 additional medication drop box in Seneca County by the end of Year 1 To work with the Substance Abuse Coalition to develop a marketing campaign and provide education to the public on safe medication storage and disposal To provide education to seniors at 2 Senior Nutrition Sites and 1 Senior Housing Complex	To co-sponsor and or support a drug take back event in Seneca County To provide ongoing support to the Seneca County Substance Abuse Coalition by having at least 2 staff members participate in the Coalition and coalition activities To provide a minimum of 3 safe storage and drug disposal trainings in the community	STEPS Coordinator .05% and SRPHE .01% To establish a medication drop box location in the Southern part of Seneca County by working with County and or local law enforcement and/or village or town offices To provide education and outreach events in the county and distribute at least 500 dispose RX packets in the community To provide education to at least 150 students, adults and seniors on safe medication storage and disposal to prevent overdose and unintentional poisonings	Neighborhood leader	.10 STEPS Coordinator/S2AY Rural Health Network- STEPS will work with the Seneca County Substance Abuse Coalition to identify a possible location to locate a medication drop box in one of the Southern Seneca County communities Seneca County Substance Abuse Coalition will work with the Seneca County Sheriff's Dept. for routine pick up of medication and proper disposal of medications from the drop box S2AY Rural Health Network will provide funding for the dispose RX packets Seneca County PH and Substance Abuse Coalition committee will distribute packets during informational presentations and tabling events .02 Seneca County Health Educator and/or Senior Public Health Educator will promote drop boxes and increase awareness of safe medication disposal and use
					2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations	# of providers receiving education on opiate prescribing NYSDOH opioid dashboard # of - Opioid analgesics prescription, crude rate per 1,000 population	To provide at least 1 provider education session on opiate prescribing for 2 Medical Provider Offices by the end of year 1	To develop a public health detailing packet on opioid addiction and opioid prescribing for prescribers including medical, dental and pharmacist in Seneca County	To provide ongoing outreach and detailing for prescribers regarding Opioid Addiction and prescribing guidelines to 100% of the Medical Practices in Seneca County	Providers	.20-PHE and/or SR.PHE -Seneca County Health Department Staff Seneca County Substance Abuse Coalition will develop a detailing packet to deliver and present to local providers to censure they are aware of the prescriber guidelines for Opioids and are informed of the current state of Opioid Addiction impacting Seneca County

Seneca County Appendix E

PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.5: Prevent suicides	2.5.2: Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000		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, postvention, safe reporting and messaging about suicides	# attending Youth and Adult Mental Health First Aid trainings # of trainings and 3 of participants attending AFSP Presentations More than Sad and Talk Saves Lives # outreach events # of people reached at health fairs # of community engagements # of engagements for suicide prevention messaging via social media # of staff trained in Gatekeeper trainings	To have at least 1 Seneca County Staff person trained in a suicide prevention gatekeeper training by the end of year 1 Seneca County Health Department staff and Seneca County Suicide Coalition will offer at least 1 More than Sad and 1 Talk Saves Lives AFSP Gatekeeper program in Seneca County	To work with the Seneca County Suicide Coalition to offer at least 1 annual gatekeeper training To train at least 2 additional staff and or community members in Gatekeeper trainings To offer gatekeeper trainings and/ or awareness presentations in the community at a minimum of 2 times a year	Seneca County United Way .25% FTE-, STEPS Coordinator .05% and SRPHE for Seneca County Health Department 10% To continuously support the Seneca County Suicide Coalition by having at least 1 staff member participate on the Coalition To co-sponsor at least 1 Suicide Awareness event and to provide or sponsor at least 1 Adult Mental Health First Aid Training and 1 Youth Mental Health First Aid training annually To deliver Talk Saves Lives and More than Sad to appropriate audiences	Community-based organizations	Partners: Seneca County Suicide Coalition, United Way of Seneca County, SC Community Counseling Center and Seneca County Health Department - .25 FTE Senior PHE-will be trained to deliver Gatekeeper training More than Sad and Talk Saves Lives In addition, the SR. PHE will attend Suicide Coalition steering and outreach/education committee meetings and participate in events .10 FTE Seneca County United Way staff for the Seneca County Suicide Coalition will provide training for coalition members to deliver gateway training such as Talk Saves Lives and More than Sad Coalition members that are trained will deliver the programs in the community The SC Suicide Coalition will participate in at least 1 awareness event each year such as Walk out of Darkness SC Suicide Prevention Coalition is working on developing postvention strategies including training peers who have suffered loss to suicide

Steuben County Appendix F

PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco Prevention	Goal 3.1: Prevent initiation of tobacco use	3.1.1: Decrease the prevalence of any tobacco use by high school students	Pregnant women; low SES, Mental and Substance Use disorders; those with disabilities	3.1.2: Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms	# of Reality Check activities in Steuben County # of Reality Check social media activities (posts and paid media ads) # of education presentations provided to youth-focused organizations, such as school districts # of media outreaches (radio, TV, newspaper, etc.) completed by Smart Steuben partners # of social media or other communications provided by Smart Steuben team members related to tobacco	STTAC Completed as of 7/12/19 23 - Reality Check activities in Steuben County 95 posts and 1 paid media ad - Reality Check social media activities (posts and paid media ads) 2 - education presentations provided to youth-focused organizations, such as school districts 57 - media outreaches (radio, TV, newspaper, etc.) completed by STTAC PH, Oak Orchard Health, and FLCH to provide messaging related to the dangers of tobacco	STTAC Projections 30 - Reality Check activities in Steuben County 125 posts and 1 paid media ad - Reality Check social media activities (posts and paid media ads) 5 - education presentations provided to youth-focused organizations, such as school districts 75 - media outreaches (radio, TV, newspaper, etc.) completed by STTAC PH to provide at least 12 monthly social media messages related to the dangers of tobacco FLCH and Oak Orchard Health to provide social media messages related to the dangers of tobacco	STTAC Projections 30 - Reality Check activities in Steuben County 125 posts and 1 paid media ad - Reality Check social media activities (posts and paid media ads) 5 - education presentations provided to youth-focused organizations, such as school districts 75 - media outreaches (radio, TV, newspaper, etc.) completed by STTAC PH to provide at least 12 monthly social media messages related to the dangers of tobacco FLCH and Oak Orchard Health to provide social media messages related to the dangers of tobacco	Advocates	STTAC oversees the Reality Check program, a youth advocacy program to reduce the impact of tobacco. STTAC will continue to provide and track education and outreach regarding the dangers of tobacco, effective tobacco control policies, and reshaping social norms. 1 FTE PH, FLCH and Oak Orchard Health will provide education and outreach through social and traditional media outlets and other opportunities as they arise

Steuben County Appendix F

PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco Prevention	Goal 3.2: Promote tobacco use cessation	3.2.1: Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%	Pregnant women; low SES, Mental and Substance Use disorders; those with disabilities	3.2.1: Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) 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, Community Health Centers and behavioral health providers	# people trained in Baby & Me Tobacco Free program delivery % of individuals enrolled in program % of individuals who successfully quit by time of delivery % remaining quit for 1st year of baby's life	PH to identify partner healthcare organizations to provide Baby & Me Tobacco Free program through PH funds	PH to pay for training for Baby & Me TF and program costs. Start implementation through partner organization(s)	PH to continue funding Baby & Me through partners and collecting data	Hospital	PH to provide funding to train and implement Baby and Me Tobacco Free Program and to help with data collection needs
						# of individuals who receive tobacco cessation resources and quit within one year % those assisted who successfully quit	CH continued commitment to smoking cessation discussion with each admission CH to partner with Guthrie Medical group (GMG) to evaluate and determine feasibility of implementing Baby and Me Tobacco Free Program for OB/GYN patients	CH continued commitment to smoking cessation discussions with each admission CH/GMG principal training to be completed for Baby and Me Facilitators identified, trained and workflows developed	Full implementation and monitoring of Baby and Me Tobacco Free program through CH/GMG		CH/GMG staff to conduct Baby and Me Tobacco Free Program and cessation assistance Provide education and support materials required for patient education
						% of inpatient admission tobacco cessation offered to	St James Hospital is in the process of hiring patient care partners who could offer education on cessation for inpatient/urgent care and ER	Continue to offer tobacco cessation education to inpatients and prepare to expand to outpatient	Expand to outpatient cessation assistance SJH		St James Hospital and St. James Primary Care assess patients for tobacco use and provide tobacco cessation education and also refer patients to NY Quits if patient is agreeable Treatment options are discussed and offered to patient. 2 FTE

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco Prevention	Goal 3.2: Promote tobacco use cessation	3.2.1: Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%	Pregnant women; low SES, Mental and Substance Use disorders; those with disabilities	3.2.1: Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) 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, Community Health Centers and behavioral health providers	# smokers assisted in quitting % of smokers attending 3 or more counseling sessions who identify as having quit smoking	Publicizing Tobacco Dependence Counseling through UR Center for CHP and expanding to 15 counties	Continuing to offer counseling	Continue to offer counseling and support to 15 county area for those interested in quitting	Hospital	Center for Community Health and Prevention to offer free tobacco cessation telephone guidance and track Steuben outreach. 1.5 FTE
						% patients aged 18+ who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as tobacco user	Arnot Health primary and specialty care providers screen all patients for tobacco use All patients who are identified as a tobacco user receive cessation intervention	Arnot Health primary and specialty care providers screen all patients for tobacco use All patients who are identified as a tobacco user receive cessation intervention	Arnot Health primary and specialty care providers screen all patients for tobacco use All patients who are identified as a tobacco user receive cessation intervention		Arnot Health primary and specialty care providers screen all patients for tobacco use All patients who are identified as a tobacco user receive cessation intervention
						# of patients screened for tobacco use # of patients who receive tobacco cessation interventions	All patients are screened for tobacco use All patients screening positive for tobacco use will be offered tobacco cessation assistance	All patients are screened for tobacco use All patients screening positive for tobacco use will be offered tobacco cessation assistance	All patients are screened for tobacco use All patients screening positive for tobacco use will be offered tobacco cessation assistance		OOH Medical has an established protocol to screen for tobacco use in all patients 12+ at every visit The system recently received tobacco/nicotine cessation training from a NYSDOH sponsored program run by URMC and Roswell Park Cancer Institute OOH utilizes the Fax to Quit program

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco Prevention	Goal 3.2: Promote tobacco use cessation	3.2.1: Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%	Pregnant women; low SES, Mental and Substance Use disorders; those with disabilities	3.2.1: Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) 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, Community Health Centers and behavioral health providers	# of clients assessed for tobacco use	Refer clients to group or individual cessation sessions Assess every client for tobacco use Admitted clients go through Healthy Living group which includes tobacco education	Refer clients to group or individual cessation sessions Assess every client for tobacco use Admitted clients go through Healthy Living group which includes tobacco education	Refer clients to group or individual cessation sessions Assess every client for tobacco use Admitted clients go through Healthy Living group which includes tobacco education	Hospital	SCASAS and Mental Health assess for tobacco dependence in all clients SCASAS treats and counsels those with tobacco dependence alongside their other addictions
						# of medical and behavioral health care organizations and provider groups approached # of above to establish policies, procedures and workflows to facilitate tobacco cessation info	CTFFL will offer its services to the following FQHCs in Steuben County at least twice per year Finger Lakes Community Health and Oak Orchard Health	CTFFL will offer its services to the following FQHCs in Steuben County at least twice per year Finger Lakes Community Health and Oak Orchard Health	CTFFL will offer its services to the following FQHCs in Steuben County at least twice per year Finger Lakes Community Health and Oak Orchard Health		Center for Tobacco Free Finger Lakes, CTFFL, is a program that provides free tobacco-cessation training and technical assistance to health care systems and to health care professionals

Steuben County Appendix F

PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	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, pharmacists and consumers	# Narcan trainings provided # people trained to administer Narcan % of those trained indicating increase knowledge # of trainings provided # of employees in the Hornell office who are trained in Narcan administration	4 Trainings provided by PH; reaching at least 20 people 100% of those trained indicating an increase in knowledge after training Oak Orchard Health has narcan in emergency kits in all medical sites OOH is a recognized narcan training provider All sites are in the process of being trained to administer Narcan Hornell office currently has 1 employee trained	4 Trainings provided by PH; reaching at least 20 people 100% of those trained indicating an increase in knowledge after training All medical staff will be trained to administer Narcan in OOH Hornell office	4 Trainings provided by PH; reaching at least 20 people 100% of those trained indicating an increase in knowledge after training All staff in Hornell office will be trained to administer Narcan	Local health department	PH to provide Naloxone trainings in the community Oak Orchard Health RN Care Managers were trained to recognize opioid overdose and to administer Narcan by CASA 2 years ago
					2.2.4: Build support systems to care for opioid users or at risk of an overdose	# controlled drugs dispensed during open pharmacy hours monthly # times providers enter data into NYSPMP # patients seen in ED by PAO who are referred to CASA	St James Hospital is linking ED providers with I-STOP SJH/OOH Providing education re: CASA and info to providers	All ED providers expected to be linked with I-STOP this year SJH Enforcing providers accessing I-STOP and continuing partnership with CASA	SJH Enforcing providers accessing I-STOP and continuing partnership with CASA	Community-based organizations	St. James Hospital is working with CASA Trinity to identify patients with substance abuse concerns whether new or chronic St James reaches out to CASA's case worker who comes directly on-site at the hospital to get them linked with their program (either inpatient or outpatient, whichever is determined to be best for that patient) If the patient is in withdrawal at the time of arrival to SJH, they are admitted and provided care to safely get through the acute detox/withdrawal phase They are linked with CASA from the time they arrive which gives ample time to get them the resources through CASA that they need 2 beds guaranteed to CASA for detox. Education and training to ED providers for opiate prescribing

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

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Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.2: Prevent opioid and other substance misuse and deaths	2.2.1: Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population		2.2.4: Build support systems to care for opioid users or at risk of an overdose	# of ODMAP inputs % of ODMAP inputs followed up on	ODMAP program adopted in Steuben County and partner agencies identified and roles delineated	PH to continue as ODMAP an administrator PH may run daily reports related to ODs and connect with peer specialists	PH to continue as ODMAP an administrator PH may run daily reports related to ODs and connect with peer specialists	Community-based organizations	PH and Steuben County departments will work together to bring ODMAP to the county to address overdoses and try to prevent future ODs
						# CPSMP classes offered % participants completing CPSMP	Living Healthy of the Southern Tier -Provide 1 Chronic Pain Self-Management Workshop with a completion rate of 75%	Living Healthy of the Southern Tier -Provide 1 Chronic Pain Self-Management Workshop with a completion rate of 75%	Living Healthy of the Southern Tier -Provide 1 Chronic Pain Self-Management Workshop with a completion rate of 75%		SRHN to provide support and/or CPSMP workshops (FTE)
						# cans filled and returned to the processing facility for the MedSafe drug disposal (50 lbs each) # of patients that allow social work to initiate resource contact # of providers receiving education on opiate prescribing	CH will utilize MedSafe Drug Disposal units at their annual Opioid Take Back Day CH plans to address the appropriate prescribing practices of opiates	Implement discharge planning process changes to include contact information for substance abuse resources Address the appropriate prescribing practices of opiates. Work with CASA/Trinity for education support for patients	Evaluation of data and opportunity for growth and continue		Staff to implement education and training components of prescribing appropriately
						# assessed for opioid use % accepting treatment	Mental Health assesses for opioid SSE and offers treatment, counseling and referrals SCASAS treats opioid use through individual counseling and group education and therapy	Mental Health assesses for opioid use and offers treatment, counseling and referrals SCASAS treats opioid use through individual counseling and group education and therapy. In addition, peer services are expected to be offered	Mental Health assesses for opioid use and offers treatment, counseling and referrals SCASAS treats opioid use through individual counseling and group education and therapy Peer services are expected to be continued		Mental Health assesses for opioid use and offers treatment, counseling and referrals SCASAS treats opioid use through individual counseling and group education and therapy

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.5: Prevent suicides	2.5.2: Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000		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, postvention, safe reporting and messaging about suicide	# providers receiving training related to suicide prevention (OOH) \# of behavior health referrals made from the office (including in-house BH and outside referrals)	Oak Orchard completed suicide prevention training, "Suicide Safer Care" and this training was skyped out to all locations Behavioral Health department implemented in office. Psychiatrist in office	Implement / continue to review policy for depression screening All patients are screened for depression Continue to implement "warm hand off" with in-house behavioral health providers and offer this service or future appointment or outside referral to any patient screening positive for depression	Implement / continue to review policy for depression screening. All patients are screened for depression Continue to implement "warm hand off" with in-house behavioral health providers and offer this service or future appointment or outside referral to any patient screening positive for depression	Community-based organizations	Oak Orchard Health has an established protocol to screen for depression using PHQ-2, reflex to PHQ-9 in all patients 12+ Peds providers are asking at well visits age 12-17 and nurses are asking all patients 18+ at any visit Patients with depression/ anxiety are automatically given the GAD-7 or PHQ-9 (depending on diagnosis) at follow up visits Their collaborative care model with Behavior Health is available at most locations for a warm hand off if needed
						# clients disclosing struggles with substance use/abuse # clients disclosing or expressing suicidal ideation # staff/volunteers trained to assess for suicide risk # staff trained to assess for substance use/abuse risks # of referrals for substance abuse services # of referrals for MH support services	5 staff/volunteers trained in best practice suicide risk assessment 5 staff/volunteers trained in best practice assessment for substance use/abuse	10 additional staff/volunteers trained in best practice suicide risk assessment 10 additional staff/volunteers trained in best practice assessment for substance use/ abuse	10 additional staff/volunteers trained in best practice suicide risk assessment 10 additional staff/volunteers trained in best practice assessment for substance use/ abuse		PRCV uses standardized assessments to identify the additional need for substance abuse or mental health services for pregnant and parenting families across Steuben County
						# patients seen by PAO	SJH's Psychiatric Assessment Officer (PAO) is located in the Emergency Department The PAO connects mental health patients and substance abuse patients with community resources The PAO works with a telepsych psychiatrist to identify the need for inpatient treatment as well This helps to keep patients within their own community and not to travel outside the community unless the need for further services is available	PAO to continue to see patients and assess need for psychiatric inpatient of telepsych SJH exploring opportunity to fund an additional PAO in medical office building (MOB)	PAO to continue to see patients and assess need for psychiatric inpatient of telepsych If financing available begin expansion of PAO services to MOB		PAO housed in ED, able to see patients in ER and on inpatient unit. St James contracted with URMC for telepsych

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

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Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders	Goal 2.5: Prevent suicides	2.5.2: Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000		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, postvention, safe reporting and messaging about suicide	# 211 callers referred to appropriate Mental Health/Substance Abuse Counseling Services in Steuben County (based on age)	2-1-1 will refer at least 50 callers per quarter to the appropriate Mental Health/Substance Abuse Counseling Services in Steuben County (reporting will be based on age)	2-1-1 will refer at least 50 callers per quarter to the appropriate Mental Health/Substance Abuse Counseling Services in Steuben County (reporting will be based on age)	2-1-1 will refer at least 50 callers per quarter to the appropriate Mental Health/ Substance Abuse Counseling Services in Steuben County (reporting will be based on age)	Community-based organizations	SRHN/IHS: referrals
						% of BSU patients followed up by PCP within 7 days from discharge # utilizing telepsych services	Baseline established for PCP follow up from BSU	Increase % of follow up by PCP by 10%	Increase % follow up by PCP by 10%		Because Ira does not have a BSU, any patients requiring this service may be referred to Arnot Patients would remain in the BSU until they are ready to discharge, then the DSRIP goal is that all BSU discharged patients be contacted by their PCP within 7 days Ira utilizes telepsych for adult patient consults with Arnot Health Psychiatrists

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PRIORITY: PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Healthy Women, Infants and Children	Focus Area 3: Child and Adolescent Health, including children with special health care needs (CSHCN)	Goal 3.1: Support and enhance children and adolscents' social-emotional development and relationships	3.1.2: Increase the percentage of children and adolescents, age 3-17 years, with a mental/ behavioral health condition who received treatment or counseling by 10% to 49.8%	Low SES, women	3.1.1: Increase awareness, knowledge and skills of providers serving children, youth and families related to social-emotional development, adverse childhood experiences (ACES), and trauma-informed care	# ACES trained participant by sector (ProAction) # ACES master trainers # ACES trainings provided	ProAction to provide 10 screenings of Resilience: The Biology of Stress and the Science of Hope followed by ACES information on brain development to more than 400 providers Hold Resilience Symposium for providers with national level speakers on ACES science	ProAction staff to attend ACE Interface Master training (train the trainer) Train trainers throughout Steuben County to educate providers, health care, education, law enforcement, and community at large on ACEs Hold 2nd Annual Resilience Symposium for providers on topics related to ACES and TIC Continue to host Resilience screenings	ProAction to continue to train and educate providers on ACES Train more ACES trainers Begin Healthy Communities work regionally Hold 3rd Annual Symposium on Resilience for providers on ACES and TIC related topics	Community-based organizations	ProAction: Facilitate film screenings, ACES Interface Master Trainer, Train the Trainer, Resilience Symposiums, Resilience film screening, Healing Communities work
						# of PH staff trained in ACES % of PH staff indicate increased knowledge of ACES	PH Staff to receive ACES training	PH staff begin to implement ACES work in their interactions with youth, families, providers, etc.	PH staff to continue using ACES principles In their work		Public Health staff will be trained in ACES and will use their understanding of ACES to enhance the interactions they have with the public 15 FTE
						# CH staff trained in trauma informed care % of staff reporting increased knowledge	Corning Hospital (CH) - Investigate and develop education plan for patient facing staff in regard to Trauma Informed Care	Guthrie Corning Hospital patient facing staff in ED, LDRP Social Work and Case Management to complete Trauma Informed Care Training	Completion and/or ongoing education for CH staff		CH: Education Staff to conduct training and any materials required

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PRIORITY: PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

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						# staff/volunteers trained in ACES # staff/volunteers trained in Youth Mental Health First Aid % client evaluations reflecting car received as trauma informed # or % intakes and assessments reflecting trauma informed language	25% of staff/volunteers will be trained in ACES. 4 staff/volunteers will be certified in Youth Mental Health First Aid. PRCV will continue using existing evaluation forms and will implement updates in 2020	60% of staff/volunteers will be trained in ACES. 2-6 additional staff/ volunteers will be certified in Youth Mental Health First Aid. Begin using the updated evaluation and intake and assessment forms. Update through 2020 as needed.	85% of staff/volunteers will be trained in ACES 3-6 additional staff/ volunteers will be certified in Youth Mental Health First Aid Begin using the updated evaluation and intake and assessment forms		PRCV will provide mentors and support through the Real Essentials curriculum PRCV will provide community support groups facilitated through a network of trained volunteers and donors Sites will be identified through our ministry partners across identified Steuben county communities

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PRIORITY: PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

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Promote Healthy Women, Infants and Children	Focus Area 3: Child and Adolescent Health, including children with special health care needs (CSHCN)	Goal 3.1: Support and enhance children and adolscents' social-emotional development and relationships	3.1.2: Increase the percentage of children and adolescents, age 3-17 years, with a mental/behavioral health condition who received treatment or counseling by 10% to 49.8%	Low SES, pregnant and parenting teens, dual diagnosed pregnant/parenting mothers	3.1.2: Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families	# children served % of growth in social emotional development # of parents receiving parenting education % parents gaining new knowledge about expected social and emotional well being and developmental milestones % parents gaining parenting skills # staff trained in evidence based models	ProAction Resilient Children and Families (RCF) Programs include 12 Head Start / Early Head Start sites, 3 Family Resource Centers, and multiple RCF Home Visitors All utilize the Pyramid Model, Conscious Disciple, Parents as Teachers, Your Journey Together, Flip It, Strengthening Families and the Dial Assessment to work with children and their families on social and emotional development, resulting in 400 children's growth in social and emotional milestones, and 150 parents increasing their knowledge of social and emotional well being milestones, developmental milestones and increased parenting skills	ProAction Resilient Children and Families (RCF) Programs include 12 Head Start / Early Head Start sites, 3 Family Resource Centers, and multiple RCF Home Visitors All utilize the Pyramid Model, Conscious Disciple, Parents as Teachers, Your Journey Together, Flip It, Strengthening Families and the Dial Assessment to work with children and their families on social and emotional development, resulting in 400 children's growth in social and emotional milestones, and 150 parents increasing their knowledge of social and emotional well being milestones, developmental milestones and increased parenting skills	ProAction Resilient Children and Families (RCF) Programs include 12 Head Start / Early Head Start sites, 3 Family Resource Centers, and multiple RCF Home Visitors All utilize the Pyramid Model, Conscious Disciple, Parents as Teachers, Your Journey Together, Flip It, Strengthening Families and the Dial Assessment to work with children and their families on social and emotional development, resulting in 400 children's growth in social and emotional milestones, and 150 parents increasing their knowledge of social and emotional well being milestones, developmental milestones and increased parenting skills	Community-based organizations	ProAction: Resilient Children and Families Programs and staff will deliver social and emotional learning using the Pyramid Model Framework, Conscious Discipline, Flip It, Your Journey Together, Dial Assessment, Parents as Teachers, and Strengthening Families

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PRIORITY: PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

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Promote Healthy Women, Infants and Children	Focus Area 3: Child and Adolescent Health, including children with special health care needs (CSHCN)	Goal 3.1: Support and enhance children and adolscents' social-emotional development and relationships	3.1.2: Increase the percentage of children and adolescents, age 3-17 years, with a mental/ behavioral health condition who received treatment or counseling by 10% to 49.8%	Low SES, pregnant and parenting teens, dual diagnosed pregnant/ parenting mothers	3.1.2: Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families	# schools piloting Cope to Thrive program \# instructors completing and passing training for Cope to Thrive program \# participants completing Cope to Thrive % participants showing improvement in understanding and managing stress, increasing healthy behaviors, reducing negative thoughts and emotions, building problem solving skills or improving communication skills \# sites hosting Girls on the Run of the Southern Tier program in Steuben County \# girls signed up for GOTRST in Steuben sites % average attendance across sites in Steuben % of participants completing 5K % of participants increased their confidence in physical activity, self-worth, managing emotions, resolving conflicts, and making healthy choices	Steuben Rural Health Network: Cope to Thrive -2 schools will implement the 7 session program in Steuben -4 instructors will complete a 2.5 hour training and pass with a 80% or higher -At least 15 participants will complete the program -Students will show improvements through pre and post survey in the following areas: understanding and managing stress, increase healthy behaviors, reduce negative thoughts and emotions, build problem solving skills, and improve communication skills by 80% Girls on the Run of the Southern Tier (3rd-8th grade) -3 sites will implement the GOTRST program (heart and sole or GOTR) in Steuben County with 70% attendance rate -80% of participants will complete a 5K -Pre and Post survey will show that 75% of participants increased their confidence in physical activity, self-worth, managing emotions, resolving conflicts, and making healthy choices	Steuben Rural Health Network: Cope to Thrive -1 class of 15 students will pilot the COPE Teen Online Program -Students will show improvements through pre and post survey in the following areas: understanding and managing stress, increase healthy behaviors, reduce negative thoughts and emotions, build problem solving skills, and improve communication skills by 80% Girls on the Run of the Southern Tier -3 sites will implement the GOTRST program (heart and sole or GOTR) in Steuben County with 80% attendance rate -85% of participants will complete a 5K -Pre and Post survey will show that 80% of participants increased their confidence in physical activity, self-worth, managing emotions, resolving conflicts, and making healthy choices	Steuben Rural Health Network: Girls on the Run of the Southern Tier -4 sites will implement the GOTRST program (heart and sole or GOTR) in Steuben County with 85% attendance rate -90% of participants will complete a 5K -Pre and Post survey will show that 82% of participants increased their confidence in physical activity, self-worth, managing emotions, resolving conflicts, and making healthy choices	Community-based organizations	SRHN: Providing programming and planning for Cope 2 Thrive and Girls on the Run (GOTR and Heart and Sole) SRHN's Role: FTE's, cost of curriculum/training

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PRIORITY: PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Healthy Women, Infants and Children	Focus Area 3: Child and Adolescent Health, including children with special health care needs (CSHCN)	Goal 3.1: Support and enhance children and adolscents' social-emotional development and relationships	3.1.2: Increase the percentage of children and adolescents, age 3-17 years, with a mental/ behavioral health condition who received treatment or counseling by 10% to 49.8%	Low SES, pregnant and parenting teens, dual diagnosed pregnant/ parenting mothers	3.1.2: Identify and integrate evidence-based and evidence-informed strategies to promote social-emotional wellness through public health programs serving children, youth, and families	# of Real Essentials participants identified by gender \# of Real Essentials participants identified by zip code \# of Real Essentials participants identified by DOB % showing an increase in knowledge from participating in Real Essentials \# of Childbirth Education participants identified by gender \# of Childbirth Education participants identified by zip code \# of Childbirth Education participants identified by DOB % showing an increase in knowledge from participating in Childbirth Education \# staff trained in Real Essentials \# staff trained to be Birth and Beyond Educators (BABE)	Pregnancy Resource Center of the Valleys (PRCV): Report data outcomes for 2018-2019 school year on Real Essentials with community participants Schedule and implement 3 Childbirth Education classes to take place in Steuben County 1 staff certified and 3 additional staff trained in childbirth education by 12/31/19. 5 staff/volunteers certified with the Academy of Certified Birth Educators (ACBE) in 2019 Continue offering services in existing Steuben County venues and increase community awareness and involvement	PRCV: Continue gathering and reporting data for each established Real Essentials site Increase Childbirth Education class opportunities by 50% 1-3 additional staff trained/certified in childbirth education by 12/31/20 Maintain staff/CE in childbirth education Maintain and increase existing sites in Steuben County for childbirth education Maintain or increase community awareness and involvement	PRCV: Continue gathering and reporting data for each established Real Essentials site Increase Childbirth Education class opportunities by 50% from 2020 1-3 additional staff trained/certified in childbirth education by 12/31/21 Increase trained staff/ volunteers by 1-2 in childbirth education program Maintain and increase existing sites in Steuben County for childbirth education Maintain or increase community awareness and involvement	Community-based organizations	PRCV oversees implementation of the Real Essentials curriculum in multiple community and center based locations across Steuben County PRCV connects multiple partners to provide safe community space for service provision PRCV is able to partner with other organizations to fill in gaps based on funder requirements PRCV provides trained/ certified medical and educational staff, certified Birth and Beyond Educators, and a variety of support groups

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.1: Prevent initiation of tobacco use	3.1.2 Decrease the prevalence of combustible cigarette use by high school students; 3.1.3 Decrease the prevalence of vaping product use by high school students		Intervention 3.1.2: Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms	Metrics/Goals by Year Year 1: 2+ unified messages Year 2: 4+ unified messages Year 3: 4+ unified messages	Share unified messages around tobacco and vaping prevention and cessation Tobacco Action Coalition of the Finger Lakes (TACFL) will be lead agency for creating majority of messages, although any agency can request to have a tobacco/vaping-related message shared through Partnership agencies Center for a Tobacco-Free Finger Lakes (CTFFL) will produce messages, including monthly letters to the editor, which can be shared and/or promoted by Partnership agencies CTTFL specializes in educating professionals, including mental health professionals, about tobacco cessation	Share unified messages around tobacco and vaping prevention and cessation TACFL will be lead agency for creating majority of messages, although any agency can request to have a tobacco/vaping-related message shared through Partnership agencies CTFFL will produce messages, including monthly letters to the editor, which can be shared and/or promoted by Partnership agencies CTTFL specializes in educating professionals, including mental health professionals, about tobacco cessation	Share unified messages around tobacco and vaping prevention and cessation Tobacco Action Coalition of the Finger Lakes (TACFL) will be lead agency for creating majority of messages, although any agency can request to have a tobacco/vaping-related message shared through Partnership agencies Center for a Tobacco-Free Finger Lakes (CTFFL) will produce messages, including monthly letters to the editor, which can be shared and/or promoted by Partnership agencies CTTFL specializes in educating professionals, including mental health professionals, about tobacco cessation	Community-based organizations	For partner roles, see projected year columns Resources: messages, media connections, sharing platforms
				Low SES		Metrics/Goals by Year Year 1: 4+ total documented interactions per year educating providers and health/human service entities on TFO Year 2: Number of agencies providing letters of support (goal of 2+); Number of instances where technical assistance was provided (goal 1+); Number of local level decision makers reached (goal 4+); Number or percent of decision makers reached who expressed support for TFO (goal 2+)	Promote tobacco-free outdoor spaces TACFL will provide Tobacco-Free Outdoor toolkits to Public Health to share with service provider agencies serving low SES mothers involved with Head Start type programs, and to Newark Wayne Community Hospital (NWCH) to share in communications to health care providers, within a year	Promote tobacco-free outdoor spaces to local decision makers Public Health and partners will support TACFL's initiatives to present to local level decision makers at least once on the benefits of Tobacco-Free Outdoor (TFO) public spaces, targeting low SES communities This may include letters of support, other correspondence, compiling data in support of TFO, or in-person attendance with TACFL at their presentation		Community-based organizations	For partner roles, see projected year 1 and 2 columns Resources: toolkits, letters of support, data

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.1: Prevent initiation of tobacco use	3.1.2 Decrease the prevalence of combustible cigarette use by high school students; 3.1.3 Decrease the prevalence of vaping product use by high school students	Low SES	Intervention 3.1.2: Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms	Metrics/Goals by Year Year 1: No target, pending data Year 2: Number of referrals made to CDSM courses using the Rx pad (2020 goal: 100 referrals) Minutes showing discussion of barriers for practices which do not use the Rx pad or do not use it consistently Year 3: Number of provider offices in NWCH's network consistently using the Rx pad (target TBD pending 2020 findings) Minutes like those described in Year 2	Increase tobacco cessation referrals through communication with health providers NWCH to continue to encourage providers to consistently refer smoking patients to evidence-based tobacco cessation programs, such as Public Health's tobacco cessation program and Baby & Me Tobacco Free, available through both NWCH and Public Health	Increase tobacco cessation referrals through communication with health providers NWCH and CTFFL, with the support of WHIP, will create a "prescription pad" for providers to use with their smoking patients who are interested in quitting This may be part of the same prescription pad in Intervention 1.1.5 for increasing referrals to CDSM courses The prescription pad is a small sheet distributed to providers' offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly	NWCH, CTTFL, and WHIP agencies with access to health care providers to continue promoting the "prescription pad"; and address barriers to its use identified in 2020 The prescription pad is a small sheet distributed to providers' offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly	Hospital	For partner roles, see projected year columns Resources: coordination, access to providers, prescription pads
		Goal 3.2: Promote tobacco use cessation	3.2.8 Increase the utilization of smoking cessation benefits (counseling and/or medications) among smokers enrolled in any Medicaid program		Intervention 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	Metrics/Goals for Each Year: Number of Quit Line callers who heard about the Quit Line from their provider; Number of Quit Line callers with Medicaid, number of referrals to Public Health's tobacco cessation program resulting from a provider recommendation; Number of referrals to Baby & Me Tobacco Free resulting from a provider recommendation; Note: Baseline data will be available soon	Continue to promote tobacco cessation referrals to health care providers to increase the number of persons who are connected to quitting resources through their health care provider. NWCH to continue to encourage their network of providers to connect their smoking patients to the Quit Line (Opt-to-Quit), Baby & Me Tobacco Free (available through NWCH and Public Health), and Public Health's tobacco cessation program CTFFL to continue to encourage health and mental health providers to connect their patients to the Quit Line and available cessation services	Continue to promote tobacco cessation referrals to health care providers to increase the number of persons who are connected to quitting resources through their health care provider. NWCH to continue to encourage their network of providers to connect their smoking patients to the Quit Line (Opt-to-Quit), Baby & Me Tobacco Free (available through NWCH and Public Health), and Public Health's tobacco cessation program. CTFFL to continue to encourage health and mental health providers to connect their patients to the Quit Line and available cessation services	Continue to promote tobacco cessation referrals to health care providers to increase the number of persons who are connected to quitting resources through their health care provider. NWCH to continue to encourage their network of providers to connect their smoking patients to the Quit Line (Opt-to-Quit), Baby & Me Tobacco Free (available through NWCH and Public Health), and Public Health's tobacco cessation program. CTFFL to continue to encourage health and mental health providers to connect their patients to the Quit Line and available cessation services	Hospital	For partner roles, see projected year columns Resources: Baseline data on how many providers consistently refer smoking patients to resources, Quit Line reports provided by CTFFL

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.3: Eliminate exposure to secondhand smoke	3.3.1 Decrease the percentage of adults (non-smokers) living in multi-unit housing who were exposed to secondhand smoke in their homes	Low SES	Intervention 3.3.1: Promote smoke-free and aerosal-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially among those that house low-SES residents	Metrics/Goals for Each Year: 1+ letter to the editor; 1+ local media articles on smoke-free housing	Share unified messages around smoke-free housing TACFL will produce messages around smoke-free housing which will be shared by Public Health and partners	Share unified messages around smoke-free housing TACFL will produce messages around smoke-free housing which will be shared by Public Health and partners	Share unified messages around smoke-free housing TACFL will produce messages around smoke-free housing which will be shared by Public Health and partners	Community-based organizations	For partner roles, see projected year columns Resources: messages
						Metrics/Goals by Year: Year 1: 1+ housing entity without a smoke-free policy surveyed (include number of units); 1+ housing entity with existing smoke-free policies surveyed (include number of units) Year 2: 1+ housing entity assisted with implementation of smoke-free policies (including number of units); Number of housing entities assisted with upholding existing smoke-free policies (including number of units)	Compile information and prepare to assist housing units with implementing and/or upholding smoke-free policies TACFL and Public Health to collaboratively survey tenants and landlords in housing units without smoke-free policies to learn barriers to implementing such policies TACFL and Public Health will collaboratively survey tenants and landlords in housing units with smoke-free policies to identify strengths and challenges in upholding smoke-free policies	Assist housing units in implementing and/or upholding smoke-free policies. TACFL and Public Health to collaboratively assist housing units in implementing new smoke-free policies and/or upholding existing smoke-free policies		Community-based organizations	For partner roles, see projected year 1 and 2 columns Resources: surveys, policy development guidance (TACFL resources)

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1: Increase cancer screening rates	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 the most recent guidelines; 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; 4.1.5 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines	Uninsured and underinsured	Intervention 4.1.3: Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand	Metrics/Goals by Year: Year 1: 1+ unified message Year 2: 1+ unified message per awareness month; 1+ unified message per public screening event Year 3: same as Year 2	Use unified messaging to promote awareness and utilization of breast, cervical, and colorectal cancer screenings through cancer services program (for the uninsured and underinsured)	Use unified messaging to promote awareness and utilization of breast, cervical, and colorectal cancer screenings through cancer services program (for the uninsured and underinsured)	Use unified messaging to promote awareness and utilization of breast, cervical, and colorectal cancer screenings through cancer services program (for the uninsured and underinsured)	Community-based organizations	For partner roles, see projected year columns Resources: messages and promotional materials
					Intervention 4.1.3: Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand	Metrics/Goals by Year: Year 1: Increase participation 10% by end of 2020; January-June baseline=288 patients (155 program, 133 non-program); 4+ unified messages Year 2: Increase participation by 10% from January-June baseline data shown above; 4+ unified messages Year 3: Increase participation, set goal based on 2020 data; 4+ unified messages	Use unified messaging to promote awareness and utilization of lung cancer screening services available at NWCH Note: Some messages may overlap with unified messages for tobacco/vaping prevention/ cessation	Use unified messaging to promote awareness and utilization of lung cancer screening services available at NWCH Note: Some messages may overlap with unified messages for tobacco/vaping prevention/ cessation	Use unified messaging to promote awareness and utilization of lung cancer screening services available at NWCH Note: Some messages may overlap with unified messages for tobacco/vaping prevention/ cessation	Hospital	For partner roles, see projected year columns Resources: messages and promotional materials
			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 the most recent guidelines	Transportation	Intervention 4.1.5: Remove structural barriers to cancer screening such as providing flexible clinical hours, offering cancer screening in non-clinical settings (mobile mammography Vvans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings	Metrics/Goals by Year: Year 1: 1+ unified message promoting Mobile Mammography unit; 1+ unified message per public Mobile Mammo screening event with openings left Years 2 & 3 each: 2+ unified messages promoting Mobile Mammography unit; 1+ unified message per public Mobile Mammo screening event	Increase access to mammography by coordinating with RRH's Mobile Mammography unit and Cancer Services Program to schedule screening events and promote them via unified messaging Promote to the community and worksites to generate awareness of and demand for screening events	Increase access to mammography by coordinating with RRH's Mobile Mammography unit and Cancer Services Program to schedule screening events and promote them via unified messaging. Promote to the community and worksites to generate awareness of and demand for screening events	Increase access to mammography by coordinating with RRH's Mobile Mammography unit and Cancer Services Program to schedule screening events and promote them via unified messaging. Promote to the community and worksites to generate awareness of and demand for screening events	Hospital	For partner roles, see projected year columns Resources: availability, messages and promotional materials, relationships with businesses/ networks

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	1.1.1 Increase Wayne County's Opportunity Index Score; 1.1.3 Reduce the number of youth grades 9-12 who felt sad or hopeless	Low SES families (food insecurity)	Intervention 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	Metrics/Goals by Year: Year 1: successful creation of a pantry toolkit within 2019 Year 2: 4+ unified messages, letters of support as requested Year 3: 4+ unified messages, letters of support as requested	Promote food security for children and their families through the schools Assist Community Schools Director, serving 4 districts (Sodus, North Rose-Wolcott, Lyons, Clyde-Savannah), in making the impact of the evidence-based Community Schools program sustainable beyond the grant period and replicable in other Wayne County school districts by assisting in developing a food pantry toolkit to create a path for schools to improve food security for students WHIP agencies (including Public Health, Aging & Youth, CCE, Wayne CAP, school districts) to assist with promotion of food drives to stock the pantry as requested Note: Multiple types of unified messages may be appropriate to go home in student backpacks; school food pantries may eventually serve as referral access points for other services	Continue to support elements of community schools which address food insecurity by providing unified messaging around food drives and letters of support for continued funding, as applicable At least 4 unified messages per year, letters of support as requested Agencies: Public Health, Aging & Youth, WCRHN, CCE, participating school districts, Wayne CAP	Continue to support elements of community schools which address food insecurity, by providing unified messaging around food drives and letters of support for continued funding, as applicable At least 4 unified messages per year, letters of support as requested Agencies: Schools, Public Health, WCRHN, Aging & Youth, Wayne CAP, CCE	K-12 School	For partner roles, see projected year columns Resources: toolkit, unified messages, letters of support
						Metrics/Goals by Year: Year 1: 1 plan, formal or informal, showing how agencies will roll out this initiative; 1+ community with a school receiving nutritious donations as a result of NYN/ similar initiative; baseline of need established for each of the 4 schools with food pantries Year 2: 4+ communities with a school receiving nutritious donations as a result of NYN/ similar initiative; assessment of pantry inventories versus need Year 3: 4+ communities with a school receiving nutritious donations as a result of NYN/ similar initiative; 100% of pantries receiving 100% of the donations needed to meet needs of students and their families; 1 plan, formal or informal, showing how agencies will roll out this initiative	Implement evidence-based/promising practice solution to ensure school food pantries are stocked with nutritional foods Public Health is seeking to implement Nourish Your Neighbor (NYN) or a similar initiative to solicit healthy food donations from the community while simultaneously educating county residents about nutrition, in collaboration with: schools, CCE/ FLESNY, and WCRHN	Continue to: Implement evidence-based/promising practice solution to ensure school food pantries are stocked with nutritional foods Public Health will continue to implement Nourish Your Neighbor (NYN) or a similar initiative to solicit healthy food donations from the community while simultaneously educating county residents about nutrition, in collaboration with: schools, CCE/ FLESNY, and WCRHN	Continue to: Implement evidence-based/promising practice solution to ensure school food pantries are stocked with nutritional foods Public Health will continue to implement Nourish Your Neighbor (NYN) or a similar initiative to solicit healthy food donations from the community while simultaneously educating county residents about nutrition, in collaboration with: schools, CCE/FLESNY, and WCRHN	Community-based organizations	For partner roles, see projected year columns Resources: NYN or similar framework, advertising budget/ promotional resources/media coverage, supplies budget, WHIP agency staff and/or volunteer time

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	1.1.1 Increase Wayne County's Opportunity Index Score; 1.1.3 Reduce the number of youth grades 9-12 who felt sad or hopeless	Low SES families (food insecurity)	Intervention 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	50 participants completing program	Rochester Regional Health (NWCH) piloting a prescription food program with foodlink as of July 1, serving patients at Canal Park Family Medicine (Macedon), Newark Internal Medicine, Sodus Internal Medicine, and ElderOne (Newark) Patients will be given $30/month to use at Foodlink's mobile unit to purchase fresh fruit and vegetables. Education to the patients will be provided by Care Managers at the practices CCE/FLESNY to do demonstrations and education at sites when FoodLink comes.	Rochester Regional Health (NWCH) piloting a prescription food program with foodlink as of July 1, serving patients at Canal Park Family Medicine (Macedon), Newark Internal Medicine, Sodus Internal Medicine, and ElderOne (Newark) Patients will be given $30/month to use at Foodlink's mobile unit to purchase fresh fruit and vegetables Education to the patients will be provided by Care Managers at the practices. CCE/FLESNY to do demonstrations and education at sites when FoodLink comes. Ends June 30, 2020		Hospital	For partner roles, see projected year 1 and 2 columns Resources: funding
						Metrics/Goals by Year: Year 2: 1 unified letter (or form letter sent by multiple agencies) sent to each district not participating in CATCH within 2020 (likely 9 districts); a compilation of any barriers identified by schools as a result of these letters; 2 unified messages Year 3: 1 unified letter (or form letter sent by multiple agencies) sent to each district not participating in CATCH within 2021 (number of districts TBD); discussion about school-identified barriers and plans to address them recorded in WHIP minutes; 2+ unified messages		Support CCE in their 2020 goal to train one new elementary or middle school with at least 50% of students qualifying for free/reduced meals in CATCH Promote the effectiveness of the evidence-based physical activity program, CATCH, to increase demand for the program beyond the 2 school districts which have already implemented it with targeted, unified messaging to school district decision-makers and the public At least one unified letter to schools within the year and at least 2 unified messages around the effectiveness of CATCH to the public per year. Gather data on any barriers preventing schools from adopting this curriculum Agencies: CCE, participating school districts, Public Health, agencies sharing unified messages	Continue to promote the effectiveness of CATCH through targeted, unified messaging to school district decision-makers and the public, and attempt to address any barriers to implementation which have been identified by the school districts At least one unified letter to schools within the year and at least 2 unified messages around the effectiveness of CATCH to the public per year Agencies: Public Health, CCE, participating school districts	Community-based organizations	For partner roles, see projected year columns Resources: personnel, time, unified messages

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	1.1.1 Increase Wayne County's Opportunity Index Score; 1.1.3 Reduce the number of youth grades 9-12 who felt sad or hopeless	Low SES families (food insecurity)	Intervention 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	60%+ redemption rate of Rx vouchers, number of vouchers distributed per site		Improve access to nutritional foods through the fruit & vegetable prescription program FLESNY collaborating with Finger Lakes Community Health (FLCH, a network of FQHCs) to provide Fruit & Vegetable Prescription Program through 2 sites The pilot of this program produced promising results. Providers at these sites write produce "prescriptions" to qualifying patients		Community-based organizations	For partner roles, see column projected year 1 Resources: funding, vouchers, participating retailers (farmers market)
			1.1.1 (Modified from State to County) Increase Wayne County's Opportunity Index Score		Intervention 1.1.4: integrate social and emotional approaches across the lifespan Support programs that establish caring and trusting relationships with older people Examples include the village model, intergenerational community, integrating social emotional learning in schools, community schools, parenting education	2+ unified messages per year	Promote the impact of LifeSkills (evidence-based middle school curriculum reducing substance abuse risk and suicide risk) in the eleven school districts to increase awareness of and support for the program through unified messaging at least twice within the year	Promote the impact of LifeSkills (evidence-based middle school curriculum reducing substance abuse risk and suicide risk) in the eleven school districts to increase awareness of and support for the program through unified messaging at least twice within the year	Promote the impact of LifeSkills (evidence-based middle school curriculum reducing substance abuse risk and suicide risk) in the eleven school districts to increase awareness of and support for the program through unified messaging at least twice within the year	K-12 School	For partner roles, see projected year columns Resources: unified messages
							Promote the impact of Community Schools in the 4 Community Schools districts to increase awareness of and support for Community Schools through unified messaging at least twice within the year	Promote the impact of Community Schools in the 4 Community Schools districts to increase awareness of and support for Community Schools through unified messaging at least twice within the year	Promote the impact of Community Schools in the 4 Community Schools districts to increase awareness of and support for Community Schools through unified messaging at least twice within the year	K-12 School	For partner roles, see projected year columns Resources: unified messages

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	1.1.1 (Modified from State to County) Increase Wayne County's Opportunity Index Score	Low SES families (food insecurity)	Intervention 1.1.4: integrate social and emotional approaches across the lifespan Support programs that establish caring and trusting relationships with older people Examples include the village model, intergenerational community, integrating social emotional learning in schools, community schools, parenting education	Assistance provided as requested	Appropriate partners to provide letters of support and/or technical assistance to optimize likelihood of continued funding for Community Schools and/or LifeSkills, or other evidence-based programming, as requested by program director(s)	Appropriate partners to provide letters of support and/or technical assistance to optimize likelihood of continued funding for Community Schools and/or LifeSkills, or other evidence-based programming, as requested by program director(s). (My mistake)	Appropriate partners to provide letters of support and/or technical assistance to optimize likelihood of continued funding for Community Schools and/or LifeSkills, or other evidence-based programming, as requested by program director(s). (My mistake)	K-12 School	For partner roles, see projected year columns Resources: collaboration
						Metrics/Goals by Year: Year 1: percentage of school districts participating (ideal 100%, but initial 8 of 11 districts (~73%)) Years 2 & 3 each: 100% of trained schools successfully implement N-O-T If not, identify barriers 100% of schools without successful implementation; WHIP minutes showing discussion of potential funding sources for an additional training, if needed; Percentage of N-O-T facilitators saying they are able to accommodate all students interested in the program, number of students enrolled in the academic year per district Target: 100%. If less than 100%, identify barriers for 100% of schools unable to accommodate all interested students	Implement Not-on-Tobacco (N-O-T) and INDEPTH in schools to improve student access to tobacco/vaping cessation Public Health and school districts will receive training on August 27th allowing them to implement an evidence-based program, N-O-T and INDEPTH in the schools to help students stop smoking/vaping Per the American Lung Association, it is much more expansive than cessation – covering lifestyle behaviors in physical activity and nutrition, self-control, stress management and decision-making	Promote N-O-T within the schools by distributing unified messages increasing family awareness of and demand for this service Evaluate reach of N-O-T in the schools and possible funding for more districts to have staff trained in N-O-T	Promote N-O-T within the schools by distributing unified messages increasing family awareness of and demand for this service. Evaluate reach of N-O-T in the schools and possible funding for more districts to have staff trained in N-O-T	Community-based organizations	For partner roles, see projected year columns Resources: funding, school staff time

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	1.1.2.1 Reduce the percentage of adults 65+ New Yorkers reporting 14 or more days with poor mental health in the last month		Intervention 1.1.5: Enable resilience for people living with chronic illness: strengthening protective factors include independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety	WHIP minutes showing compilation of barriers and plans to address	Re-evaluate previously identified barriers to implementation of certain chronic disease self-management programs to see which are still in effect and which are resolved; update 2020 work under this initiative to address those barriers to extent possible Agencies: Public Health, Aging & Youth, Wayne CAP, WCRHN, FLCH, any agency offering any type of evidence-based CDSM course			Community-based organizations	For partner roles, see projected year columns Resources: collaboration
				Transportation		Metrics/Goals by Year: Year 1: draft of directory Years 2 and 3 each: quarterly emails to distribution of providers promoting the directory; 4+ unified messages per year	Begin developing a directory of wellness classes so that Wayne County residents and their health care providers have a comprehensive list of everything available to them This directory will include courses such as Chronic Disease Self-Management, National Diabetes Prevention Program, and more Agencies: all Note: WCRHN has a similar task in their work plan	Complete the directory of wellness classes, including at-home classes, and promote it to the public and health care providers to increase Wayne county participation in chronic disease self-management programs	Continue to boost awareness of the wellness class directory among the public and providers through unified messaging. Increase awareness of any chronic disease self-management programs which are covered by insurance.	Community-based organizations	For partner roles, see projected year columns Resources: unified messages, distribution lists, insurance information

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	1.1.2.1 Reduce the percentage of adults 65+ New Yorkers reporting 14 or more days with poor mental health in the last month	Transportation	Intervention 1.1.5: Enable resilience for people living with chronic illness: strengthening protective factors include independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety	Metrics/Goals by Year: Year 1: Wayne CAP goal: 100 people completing course per year; 1+ unified message within 2019, depending on course availability; Aging & Youth to collect data on how registrants heard about program(s); use to evaluate effectiveness of unified messaging; Percent of classes hitting their attendance goal (for CDSMP via WCAP, A&Y, 8 persons per class) Year 2: Unified messaging to public 4+ times per year; Percent of classes hitting their attendance goal (for CDSMP via A&Y, 8 persons per class); Wayne CAP goal: 100 people completing course per year; Aging & Youth to collect data on how registrants heard about program(s) and use it to evaluate effectiveness of unified messaging Year 3: Unified messaging to public 4+ times per year; Percent of classes hitting their attendance goal (for CDSMP via A&Y, 8 persons per class); Wayne CAP goal: 100 people completing course per year	Use unified messaging to promote upcoming chronic disease self-management programs, especially home-based and work place programs which alleviate the transportation barrier experienced by many Wayne County residents At least once within the year. In 2019, WHIP can, at a minimum, promote the remaining 2019 Aging & Youth and Wayne CAP CDSMP class. One has already occurred, taught by both Aging & Youth and Wayne CAP	Use unified messaging to promote upcoming chronic disease self-management programs, especially home-based programs which alleviate the transportation barrier experienced by many Wayne County residents 4+ times per year, depending on courses. In 2020, WHIP can, at a minimum, promote Aging & Youth's 2 CDSMP classes	Use unified messaging to promote upcoming chronic disease self-management programs, especially home-based programs which alleviate the transportation barrier experienced by many Wayne County residents 4+ times per year, depending on courses. In 2021, WHIP can, at a minimum, promote Aging & Youth's 2 CDSMP classes	Community-based organizations	For partner roles, see projected year columns Resources: unified messages

Wayne County Appendix G

PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	1.1.2.1 Reduce the percentage of adults 65+ New Yorkers reporting 14 or more days with poor mental health in the last month	Transportation	Intervention 1.1.5: Enable resilience for people living with chronic illness: strengthening protective factors include independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety	Number of provider offices in NWCH's network consistently using the prescription pad Minutes showing discussion of barriers for practices which do not use the prescription pad or do not use it consistently		Increase provider referrals to cdsm courses throughout the county NWCH to collaborate with all WHIP agencies offering evidence-based CDSM courses to revamp and promote the "prescription pad" The prescription pad is a small sheet distributed to providers' offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly	Increase provider referrals to cdsm courses throughout the county NWCH to collaborate with all WHIP agencies offering evidence-based CDSM courses to continue promoting the "prescription pad"; and address barriers to its use identified in 2020 The prescription pad is a small sheet distributed to providers' offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly	Hospital	For partner roles, see projected year 2 and 3 columns Resources: coordination, access to providers, Rx pads
	Focus Area 2: Mental and Substance Use Disorders Prevention	Goal 2.3: Prevent and address adverse childhood experiences (ACES)	2.3.3 Increase communities reached by opportunities to build resilience		Intervention 2.3.3: grow resilient communities through education, engagement, activation/ mobilization and celebration	Assistance provided, funding awarded	Public health and partners to support school application for a tier 3 wrap and renew grant impacting children in 5th-8th grade RENEW focuses specifically on increasing effective school engagement, employment, post-secondary education and high school completion RENEW has shown success in reducing school dropout and school push out, while increasing high school participation and completion for students with emotional and behavioral challenges–midwestpbis.org Support may include letters of support and/or technical assistance on the grant application			K-12 School	For partner roles, see projected year 1 column Resources: collaboration, data

Wayne County Appendix G

PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Mental and Substance Use Disorders Prevention	Goal 2.3: Prevent and address adverse childhood experiences (ACES)	2.3.3 Increase communities reached by opportunities to build resilience		Intervention 2.3.3: grow resilient communities through education, engagement, activation/ mobilization and celebration	4+ unified messages in both 2020 and 2021		Increase public awareness of and support for trauma-informed care in the schools by highlighting effectiveness of Community Schools, 4 unified messages per year	Increase public awareness of and support for trauma-informed care in the schools by highlighting effectiveness of Community Schools, 4 unified messages per year	K-12 School	For partner roles, see projected year 2 and 3 columns Resources: unified messages
						WHIP minutes showing discussion of initiatives		Continue to support evidence-based or promising practice trauma-informed care in the schools by providing letters of support and/ or technical assistance for funding applications, such as helping to map programs	Continue to support evidence-based or promising practice trauma-informed care in the schools by providing letters of support and/or technical assistance for funding applications, such as helping to map programs	K-12 School	For partner roles, see projected year 2 and 3 columns Resources: information
						WHIP minutes or emails showing discussion of opportunities		Identify opportunities to increase public awareness of and demand for resilience initiatives, such as the Finger Lakes Resiliency Network, within the overall community	Identify opportunities to increase public awareness of and demand for resilience initiatives, such as the Finger Lakes Resiliency Network, within the overall community	Community-based organizations	For partner roles, see projected year 2 and 3 columns Resources: information
						2+ unified messages in both 2020 and 2021		Increase provider and community awareness of mental health's mobile response team(s) through unified messaging	Increase provider and community awareness of mental health's mobile response team(s) through unified messaging	Local governmental unit	For partner roles, see projected year 2 and 3 columns Resources: unified messages
						1+ unified message per course offered		Use unified messaging to promote aging & youth's evidence-based powerful tools for caregivers course	Use unified messaging to promote aging & youth's evidence-based powerful tools for caregivers course	Office for the Aging	For partner roles, see projected year 2 and 3 columns Resources: unified messages, promotional materials

Yates County Appendix H

PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1: Increase cancer screening rates	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	Low SES, un or under-insured	4.1.1 Work with health care providers/ clinics to put systems in place for patient and provider screening reminders (letter, postcards, emails, recorded phone messages, electronic health records (EHRs) alerts	Number of health systems that implement or improve provider and patient reminder systems	Report on mammography screening referral numbers for Yates County from primary care practices Provide mammography raw numbers for each service year Provide estimates of demographics to determine those of low SES	Report on mammography screening referral numbers for Yates County from primary care practices Provide mammography raw numbers for each service year Provide estimates of demographics to determine those of low SES	Report on mammography screening referral numbers for Yates County from primary care practices Provide mammography raw numbers for each service year Provide estimates of demographics to determine those of low SES	Hospital	Finger Lakes Health (FLH) will utilize EHR (EMR) to make patient referrals for screenings as appropriate Staff time of .15 FTE to collect and report aggregate data
					4.1.2 Conduct one-on-one (by phone or in person) and group education (presentation or other interactive session in a church, home, senior center or other setting)	Number of individuals reached through education Change in knowledge & awareness of need for cancer screenings among groups reached	Met with uninsured Mennonite women promoting mammograms through the Mobile Mammography unit Arranged 2 "Sister's Day" events targeting uninsured Mennonite women Surveyed local employers (targeting women of lower SES) re: cancer screenings - insurance coverage for screenings, policies in place for paid time off/ flexing etc.	YCPH will conduct 1 presentation about the importance of mammograms targeting women of lower SES/ uninsured YCPH will reach out to the Yates County Chamber of Commerce to discuss best practices when targeting employers about importance of cancer screenings YCPH will identify 1-2 employers that employ women of lower SES re: the importance of mammograms & policies to improve access to screenings YCPH will reach out to members of the Mennonite Community to arrange additional Mobile Mammography screening events	YCPH will conduct 1 presentation about the importance of mammograms targeting women of lower SES/uninsured YCPH will target 1-2 employers that employ women of lower SES re: the importance of mammograms & policies to improve access to screenings YCPH will reach out to Finger Lakes Community Health & Cancer Services Program to address mammograms in the migrant population	Local health department	Yates County Public Health 0.1 FTE
					4.1.3 Use small media such as videos, printed materials (letters, brochures, and newsletters) and health communications to build public awareness & demand	Number & type of locations where materials were distributed Change in knowledge & awareness of need for cancer screenings among groups reached through small media dissemination	FLH developed & distributed flyer outlining screenings performed by FLH FLH developed advertising their new "Walk-In" screening mammography offered once a month, starting in October in Penn Yan & Geneva locations FLH advertised, promoted & held ribbon cutting ceremony for new 3D mammography at Soldiers & Sailors Hospital during October (Breast Cancer Awareness month)	FLH will promote breast cancer screenings and guidelines via newspaper, radio, Facebook, website, "Thrive" magazine	FLH will promote breast cancer screenings and guidelines via newspaper, radio, Facebook, website, "Thrive" magazine	Hospital	Finger Lakes Health (FLH) will utilize direct mail and other promotional vehicles $5,000 is estimated for development and mailing of educational materials 0.2 FTE

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	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	Low SES, un or under-insured	4.1.3 Use small media such as videos, printed materials (letters, brochures, and newsletters) and health communications to build public awareness & demand	Number & type of locations where materials were distributed Change in knowledge & awareness of need for cancer screenings among groups reached through small media dissemination	YCPH promoted mammograms offered through FLH & Mobile Mammography at Yates Community Center and Mosaic Health via website, Facebook & posting of flyers YCPH organized & promoted a mobile mammography event in Benton geared toward uninsured Mennonite women (15 women received screening mammograms) A second event has been planned, organized & promoted by YCPH for 11/6/19	YCPH will promote FLH mammogram screening, Rochester Regional Health Mobile Mammography unit, targeting low SES & uninsured YCPH will work with Cancer Services Program (CSP) to promote mammogram screenings for low income/ uninsured women YCPH will organize and promote 1 Mobile Mammography event targeting uninsured, low SES women	YCPH will promote FLH mammogram screening, Rochester Regional Health Mobile Mammography unit, targeting low SES & uninsured YCPH will work with Cancer Services Program (CSP) to promote mammogram screenings for low income/ uninsured women. YCPH will organize and promote 1 Mobile Mammography event targeting uninsured, low SES women	Local health department	Yates County Public Health 0.1 FTE $500-$1000 total for ALL cancer screening media communications.
							Our Town Rocks (OTR) has visited all Dundee business encouraging all to go PINK in October and display the breast cancer screening flyer OTR promoted all free and walk-in screening opportunities in the area via flyers and social media platforms	OTR, in collaboration with 4 Dundee beauty salons & Dundee Pharmacy are planning a Breast/ Colon/Prostate Screening Services awareness campaign utilizing flyers & social media OTR working with CSP to have the Mobile Mammography unit at the Annual AMBA blood drive in June '20. OTR is partnering with CSP Breast Cancer Screening Campaign in October 2020	OTR will continue to build upon cancer screening initiatives that proved successful	Community-based organizations	

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	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 most recent guidelines	Low SES, un or under-insured	4.1.3 Use small media such as videos, printed materials (letters, brochures, and newsletters) and health communications to build public awareness & demand	Number & type of locations where materials were distributed. Change in knowledge & awareness of need for cancer screenings among groups reached through small media dissemination.	Promoted Cervical Cancer Awareness month on Facebook.	YCPH will set up a display at 2 community locations that are visible to women of lower SES (i.e. County Office Building, library, food pantries, etc.) YCPH will promote Cervical Cancer Awareness moth (Jan) on website, Facebook, newspaper, etc. YCPH will outreach to Finger Lakes Sexual Health Coalition to promote cervical cancer screening YCPH will outreach to Finger Lakes Community Health to promote cervical cancer screening among low SES, un or underinsured and migrant population	YCPH will set up a display at 2 community locations that are visible to women of lower SES (i.e. County Office Building, library, food pantries, etc.) YCPH will promote Cervical Cancer Awareness moth (Jan) on website, Facebook, newspaper, etc. YCPH will outreach to Finger Lakes Sexual Health Coalition to promote cervical cancer screening YCPH will outreach to Finger Lakes Community Health to promote cervical cancer screening among low SES, un or underinsured and migrant population	Local health department	Yates County Public Health 0.1 FTE $500-$1000 total for ALL cancer screening media communications
							Promoted Cervical Cancer Awareness month on Facebook.			Local health department	

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	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)	Low SES, un or under-insured	4.1.1 Work with health care providers/ clinics to put systems in place for patient and provider screening reminders (letter, postcards, emails, recorded phone messages, electronic health records (EHRs) alerts	Number of health systems that implement or improve provider and patient reminder systems	Report on colonoscopy, colon cancer screening referral numbers for Yates County from primary care practices Provide colon cancer screening raw numbers for each service year. Provide estimates of demographics to determine those of low SES	Report on colonoscopy, colon cancer screening referral numbers for Yates County from primary care practices Provide colon cancer screening raw numbers for each service year Provide estimates of demographics to determine those of low SES	Report on colonoscopy, colon cancer screening referral numbers for Yates County from primary care practices Provide colon cancer screening raw numbers for each service year. Provide estimates of demographics to determine those of low SES	Hospital	Finger Lakes Health (FLH) will utilize EHR (EMR) to make patient referrals for screenings as appropriate Staff time of .15 FTE to collect and report aggregate data
					4.1.2 Conduct one-on-one (by phone or in person) and group education (presentation or other interactive session in a church, home, senior center or other setting)	Number of individuals reached through education Change in knowledge & awareness of need for cancer screenings among groups reached	YCPH conducted one-on-one presentations to Mennonites re: the importance of colorectal cancer screening As a result 5 FIT screening kits were distributed to uninsured individuals	YCPH will conduct 1 presentation about the importance of colorectal cancer screening targeting individuals of lower SES/ uninsured YCPH will target 1 employer that employs lower SES individuals re: the importance of colorectal cancer screening and policies to improve access YCPH, in partnership with CSP will promote/distribute FIT screening kits at Mobile Mammography events YCPH will outreach to Finger Lakes Community Health to promote CSP services to migrant population & lower SES individuals	YCPH will conduct 1 presentation about the importance of colorectal cancer screening targeting individuals of lower SES/uninsured YCPH will target 1 employer that employs lower SES individuals re: the importance of colorectal cancer screening and policies to improve access YCPH, in partnership with CSP will promote/distribute FIT screening kits at Mobile Mammography events YCPH will outreach to Finger Lakes Community Health to promote CSP services to migrant population & lower SES individuals	Local health department	Yates County Public Health 0.1 FTE

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PRIORITY: PREVENT CHRONIC DISEASES

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1: Increase cancer screening rates	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)	Low SES, un or under-insured	4.1.3 Use small media such as videos, printed materials (letters, brochures, and newsletters) and health communications to build public awareness & demand	Number & type of locations where materials were distributed Change in knowledge & awareness of need for cancer screenings among groups reached through small media dissemination	FLH developed flyer outlining screenings performed by FLH and distributed via website, Facebook Advertised colon cancer screening availability in "Thrive" magazine	FLH will promote colorectal cancer screenings and guidelines via newspaper, radio, Facebook, Website, "Thrive" magazine	FLH will promote colorectal cancer screenings and guidelines via newspaper, radio, Facebook, Website, "Thrive" magazine	Hospital	Finger Lakes Health (FLH) Resources estimated to be $3,000 for direct mail and other communication vehicles
							YCPH promoted colorectal cancer screenings offered by FLH via website and Facebook YCPH provided a display/written material at a mobile mammography event & partnered with CSP to distribute 5 FIT test kits to uninsured individuals	YCPH will set up a display at 1-2 community locations that are visible to men/ women of lower SES (i.e. County Office Building, library, food pantries etc.) re: the importance of colorectal screening YCPH will promote colorectal screenings offered by FLH and area hospitals on website and Facebook YCPH will partner with CSP to promote their services/ funding for colorectal screening YCPH will promote colorectal cancer screenings via paid media, website, Facebook	YCPH will set up a display at 1-2 community locations that are visible to men/women of lower SES (i.e. County Office Building, library, food pantries etc.) re: the importance of colorectal screening YCPH will promote colorectal screenings offered by FLH and area hospitals on website and Facebook YCPH will partner with CSP to promote their services/funding for colorectal screening YCPH will promote colorectal cancer screenings via paid media, website, Facebook	Local health department	Yates County Public Health 0.1 FTE $500-$1000 total for ALL cancer screening media communications

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2 Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	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 (Nalaxone) trainings to prescribers, pharmacists and consumers	Number of Naloxone trainings completed Number of individuals trained in Naloxone administrations Number of pharmacies contacted/surveyed re: N-CAP Number of educational outreaches re: N-CAP	YCPH conducted one Naloxone trained to CCSI (Tier 1) with 13 participants YCPH will investigate w/ Common Ground Health if claims data is available for N-CAP usage at Yates County participating pharmacies	YCPH will promote & conduct 2 Naloxone trainings per year (i.e. Keuka College, law enforcement, fire department, uninsured, etc.) YCPH will explore other community agencies providing Naloxone trainings in Yates County and promote those trainings via website & Facebook YCPH will survey local pharmacies re: N-CAP. YCPH will increase public awareness about N-CAP (in partnership w/ Yates Substance Abuse Coalition (YSAC) via website, Facebook paid media	YCPH will promote & conduct 2 Naloxone trainings per year (i.e. Keuka College, law enforcement, fire department, uninsured, etc.) YCPH will explore other community agencies providing Naloxone trainings in Yates County and promote those trainings via website & Facebook YCPH will survey local pharmacies re: N-CAP. YCPH will increase public awareness about N-CAP (in partnership w/ Yates Substance Abuse Coalition (YSAC) via website, Facebook paid media	Local health department	Yates County Public Health (YCPH) 0.025 FTE
					Local Effort: Received research grant through Columbia University: HEALing Communities - effort to reduce opioid deaths by 40% over 3 years	Number of meetings held. Number and types of partners involved Current efforts in place to decrease opioid use Improvement in number of opioid deaths	HEALing (Help to end Addiction Long Term) Community grant awarded through Columbia University Yates County Community Services will provide oversight of the grant Mtg. was held 7/30/19 with the Columbia University research team, director of community services, DPH, Community partners to outline grant expectations & initial local efforts Tour of jail was conducted and met with treatment representatives who described current efforts Two professional positions will be funded.	Continued work with HEALing Community grant	Continued work with HEALing Community grant	Local governmental unit	Yates County Community Services
							YCPH will support efforts for the grant	YCPH will support efforts for the grant	YCPH will support efforts for the grant	Local health department	Yates County Public Health 0.01 FTE

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 population		Local Effort: Received research grant through Columbia University: HEALing Communities - effort to reduce opioid deaths by 40% over 3 years	Number of meetings held. Number and types of partners involved Current efforts in place to decrease opioid use Improvement in number of opioid deaths	Finger Lakes Area Counseling and Recovery Agency (FLACRA) will participate and support efforts for the grant	FLACRA will participate and support efforts for the grant	FLACRA will participate and support efforts for the grant	Community-based organizations	FLACRA
					2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take back days	Number of additional permanent safe disposal sites for prescription drugs and organized take-back days	YCPH will explore all current areas of safe disposal sites in Yates County and post on website YCPH promoted "Drug Take-Back Days" in April and October 2019 on website, Facebook, Weekly Surveillance, Sandwich Board & Electronic sign	YCPH will identify 1 additional area of safe disposal in the county and move toward securing a new site YCPH will outreach to Ontario County Substance Abuse Partnership to identify how they were able to secure safe disposal site/funding in Rushville YCPH will promote "Drug Take Back Days" in April & October 2020 on website, Facebook, Weekly Surveillance, Sandwich board & Electronic sign	YCPH will identify 1 additional area of safe disposal in the county and move toward securing a new site YCPH will promote "Drug Take Back Days" in April & October 2020 on website, Facebook, Weekly Surveillance, Sandwich board & Electronic sign	Local health department	Yates County Public Health (YCPH) 0.028 FTE
							Provide Dispose Rx bags to key community partners to assist in safe disposal of prescription drugs.	Provide Dispose Rx bags to key community partners to assist in safe disposal of prescription drugs	Provide Dispose Rx bags to key community partners to assist in safe disposal of prescription drugs	Community-based organizations	S2AY Rural Health Network 5% of FTE
		Goal 2.3 Prevent & Address Adverse Childhood Experiences	2.3.3 Increase communities reached by opportunities to build resilience by at least 10%		2.3.3 Grow resilient communities through education, engagement, activation/ mobilization and celebration	Number of community organizations/ members who participated in ACE's discussions	YCPH promoted a free training on ACES on 10/22/19 offered by Family Counseling Services of the Finger Lakes. YCPH staff attended the training.	YCPH will continue to become familiar with ACE's via trainings & webinars YCPH and its partners will assemble community partners (community organizations, schools, providers, etc.) to education/address ACE's in the community setting	YCPH will work with community partners to promote resilient communities	Local health department	Yates County Public Health (YCPH) 0.025 FTE

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PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.5: Prevent Suicides	.5.2: Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000		2.3.3 Grow resilient communities through education, engagement, activation/mobilization and celebration	Number of community organizations/ members who participated in ACE's discussions	Organize workshop/conference to educate community on ACES and resilience	Work with YCPH to establish plan for continued community engagement on ACES	Work with YCPH to establish plan for continued community engagement on ACES	Community-based organizations	S2AY Rural Health Network 5% of FTE
			2.5.2: Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000		2.5.4 Identify & support people at risk: Gatekeeper Training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, postvention, safe reporting and messaging about suicides	Number of Gatekeeper Trainings Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) Number of individuals trained Number of outreach/ educational events	Conduct MHFA & YMHFA trainings One individual from Yates County was selected to attend the Conference of Mental Hygiene Directors Youth Mental Health First Aide "Train the Trainer" in the Fall '19 Planning underway to provide 2 or three additional YMHFA trainings during 2019 (Nov). Participation in the Systems of Care (SOC) planning which addresses mental health issues in youth Participate in Crisis Intervention Training (CIT), a collaborative effort between several community agencies & law enforcement	Conduct MHFA & YMHFA training Administer the biannual school survey regarding substance use and mental health issues Participation in Systems of Care Planning Participating in Crisis Intervention Training	Conduct MHFA & YMHFA trainings. Participation in Systems of Care Planning Participating in Crisis Intervention Training	Local governmental unit	Yates County Community Services
							"Talk Saves Lives" was presented to more than 70 community members "Train the Trainer" trained 7 community members to be "Talk Saves Lives" facilitators "It's Real" (a mental health and suicide prevention program was presented to Keuka College students "Out of the Darkness" community walk was held on 9/29/19 with 265 participants and more than $14,000 raised Educational tabling, in honor of Suicide Prevention month (Sept) was done at the library and in the main lobby of the County Office Building Penn Yan Schools had tabling during their open house activities "Talk Saves Lives" was provided at 2 local churches in September The Suicide Coalition of Yates County meets monthly	"Talk Saves Lives", "Train the Trainer", "It Real", "More than Sad", "Out of the Darkness" community walk & educational tabling will take place in 2020 The Suicide Coalition of Yates County meets monthly	"Talk Saves Lives", "Train the Trainer", "It Real", "More than Sad", "Out of the Darkness" community walk & educational tabling will take place in 2021 The Suicide Coalition of Yates County meets monthly	Community-based organizations	Suicide Coalition of Yates County

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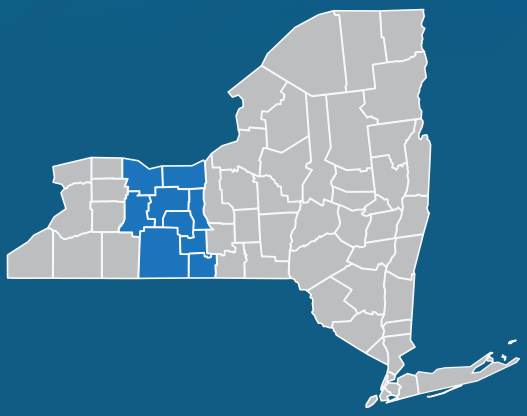
PRIORITY: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Priority	Focus Area	Goal Focus Area	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.5: Prevent Suicides	.5.2: Reduce the age-adjusted suicide mortality rate by 10% to 7 per 100,000		2.5.4 Identify & support people at risk: Gatekeeper Training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, postvention, safe reporting and messaging about suicides	Number of Gatekeeper Trainings (MHFA & YMHFA) Number of individuals trained Number of outreach/ educational events	YCPH attends Systems of Care Planning Meetings and assists in efforts YCPH will promote all trainings & events open to the public	YCPH will attend Systems of Care Planning meetings and assist in effort YCPH will attend Suicide Prevention Coalition meetings and assist in efforts YCPH will promote all trainings & events open to the public	YCPH will attend Systems of Care Planning meetings and assist in effort YCPH will attend Suicide Prevention Coalition meetings and assist in efforts YCPH will promote all trainings & events open to the public	Local health department	Yates County Public Health (YCPH) 0.035 FTE
							FLH will attend Systems of Care Planning meetings and assist in efforts FLH will promote all trainings & events open to the public	FLH will attend Systems of Care Planning meetings and assist in efforts. FLH will promote all trainings & events open to the public	FLH will attend Systems of Care Planning meetings and assist in efforts FLH will promote all trainings & events open to the public	Hospital	Finger Lakes Health (FLH) Vice President of Nursing & other staff as appropriate will attend meeting and work as partner 0.04 Administrator FTE

Common Ground Health

ABOUT COMMON GROUND HEALTH

Founded in 1974, Common Ground Health is the health planning organization for the nine-county Finger Lakes region. We bring together health care, education, business, government and other sectors to find common ground on health issues. Learn more about our community tables, our data resources and our work improving population health at www.CommonGroundHealth.org.



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