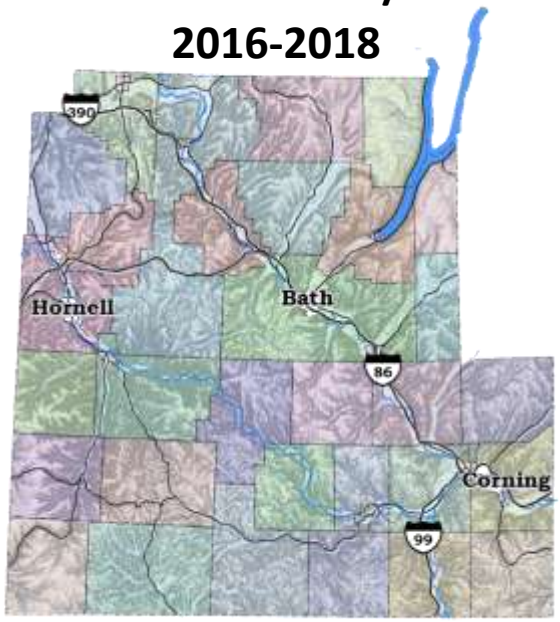
Steuben County

Community Health Assessment/Community Service Plan 2016-2018



Participating Local Health Department and Hospitals:

Steuben County Public Health
Darlene Smith
DarleneS@co.steuben.ny.us
607-664-2438

Corning Hospital
Jennifer Yartym
yartym_jennifer@guthrie.org
607-937-7097

Ira Davenport Memorial Hospital (Arnot Health)
Nykole Parks
nparks@ah.arnothealth.org
607-733-6541 ext. 6283

St. James Mercy Hospital
Laura Vetter
lvetter@sjmh.org
607-324-8147

In Steuben County, facilitation of the Community Health Assessment process was provided by leadership from the S^{2}AY Rural Health Network. The Network is a partnership of eight Public Health Departments in the Finger Lakes region (**Steuben**, Seneca, Schuyler, Wayne, Ontario, Yates, Livingston, and Chemung), and has completed Community Health Assessments in this region for the last five cycles. The main coordinating body that oversaw the Community Health Assessment is the Smart Steuben group (formerly known as the Steuben Health Priorities Team). Smart Steuben is a multi-disciplinary group of community organizations, facilitated by Steuben County Public Health, and is described more fully within this document. Please see Attachment 1 for a list of members.

Table of Contents

Attachments

Executive Summary

1. Priorities and Disparities:

Steuben County chose to address two priority areas and four focus areas within those priorities.

Priority Area: Prevent Chronic Diseases

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

Priority Area: Promote Healthy Women, Infants, and Children

- *Focus Area 1:* Maternal and Infant Health

Steuben County also chose four disparities to address:

1. Increase the number of low socioeconomic status (SES) worksites implementing healthy worksite policies.
2. Increase the number of municipalities that restrict tobacco marketing to youth and the density/proximity of tobacco retailers to schools.
3. Decrease smoking rates in the low-SES population by increasing the number of low income housing facilities to implement smoke-free policies.
4. Decrease chronic disease in the low-SES population by implementing a Community Health Worker Program.

2. Changes from 2013: Overall, one priority area for Steuben County has not changed (Prevent Chronic Diseases – focusing on obesity and heart disease/hypertension) from the 2013 CHA and Community Health Improvement Plan (CHIP), although the strategies to be used to address these focus areas have evolved, as will be seen in the attached CHIP (Attachment 16). However, a second priority or "emerging issue" has been identified. In the review of the data and discussions with focus groups, early childhood health continues to be of significant concern. In the 2016-2018 CHA/CHIP process, the group added

Priority Area – Promote Healthy Women, Infants, and Children (Focus Area 1 – Maternal and Infant Health) to the CHIP in recognition of the extent and severity of early childhood health issues in Steuben County.

3. Data Reviewed and Analyzed: The data review and analysis was extensive. In all S^2AY Network Counties, the process began with a data update for the eight county region conducted by the Finger Lakes Health Systems Agency (FLHSA) at the request of S^2AY. This data collection and analysis focused on regional data related to the main priorities in the 2013 CHA. Additionally, there were some emerging issues that the hospitals and Public Health agreed should be analyzed based on their knowledge of what they were seeing in their communities and what the needs assessment (also conducted by the FLHSA) for Delivery System Reform Incentive Payment (DSRIP) program had revealed. The 2013 priority areas in the region included: Obesity, Hypertension, Diabetes, Heart Disease, Tobacco Use, and Falls, Slips and Trips in the 65+ population. Emerging issues included: Behavioral Health and Low Back Pain.

This data was presented to the Public Health Directors and the hospital representatives in the region on March 4, 2016. As can be seen in the attached copy of the presentation (Attachment 2), the data collected and analyzed came from the following sources: 2013-2014 Expanded Behavioral Risk Factor Surveillance Survey (EBRFSS), Census Bureau (2010 Census and 2015 American Community Survey estimates), 2010-2014 SPARCS data, NY State Prevention Agenda data set (updated 2016), Aggregated Claims Data (2014), NY State Vital Statistics (2014), and the Regional High Blood Pressure Registry (2016). Once this data was reviewed, the S^2AY Network compiled other data to develop a summary PowerPoint presentation (Attachment 3) of the highest need areas for the county. This additional review of data included, among other things: County Prevention Agenda Dashboard (updated 2016, data from various dates), 2010-2014 Community Health Indicator Reports, Sub-County Data Reports (2016 report, data from various years), 2012-2014 Leading Causes of Death Indicators, and County

Health Rankings (2016 report, data from various years). In addition to this, primary data from the high blood pressure registry and other primary data were obtained through focus group input as described below (and in Attachments 4 and 5).

4. Partners and Roles: While the primary partners in the assessment process include Steuben County Public Health, Corning Hospital (Guthrie), St. James Mercy Hospital, Ira Davenport Hospital (Arnot Health), S^2AY and the FLHSA, there are a wide variety of other partners that serve on the Smart Steuben team. A list of Smart Steuben members can be found in Attachment 1. Smart Steuben provides the oversight of both process and implementation of the CHIP. The group includes a mix of Federally Qualified Health Centers (FQHCs), Community Based Organizations (CBOs), the legislature, community action organizations, and representatives who work with schools. Detailed roles in implementation are listed in the attached CHIP (Attachment 16).

5. Community Engagement: The community has been engaged in a variety of different ways. S^2AY prepared a presentation (Attachment 3) on the highest needs in Steuben County. This was shared with twelve separate and diverse focus groups throughout the community. The goals of the focus groups were to review data, and gather input and perceptions regarding needs in the county. The focus group participants were also invited to attend the priority setting meeting held on June 7th, 2016 where the preliminary priorities were established. Preliminary priorities were listed in a media release and also posted on the websites of the hospitals and Public Health (Attachments 13-15). The public was again asked to provide any additional input at this third opportunity.

6. Evidence-based interventions: Fully detailed in the CHIP, strategies to address chronic diseases include evidence-based activities such as Stanford approved curriculums (e.g. Chronic Disease Self-Management Program – CDSMP), policy/practice implementation (working with worksites to implement healthy policies, working with schools to adopt Local School Wellness Policies, encouraging providers

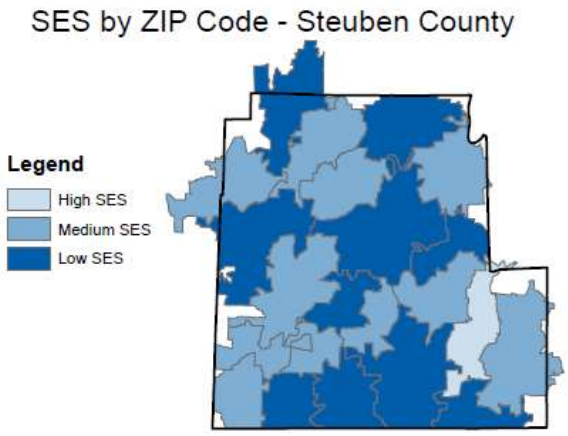
and daycares to become New York State Department of Health (NYSDOH) Breastfeeding Friendly Certified), promoting provider practice participation in the regional hypertension registry, working with hospitals to increase quality improvement efforts to increase breastfeeding exclusivity at discharge, and working with municipalities to restrict tobacco marketing to youth. Additional strategies to address early childhood health include providing evidence-based home visiting services and implementing a Community Health Worker program to provide enhanced support to women and children.

7. Evaluation of Impact and Process Measures: Process measures are indicated in the attached CHIP (Attachment 16) and correlate with the objectives chosen from the "Refresh Chart" for the New York State (NYS) Prevention Agenda. They include such measures as: the number of schools that adopt and implement comprehensive and strong Local Wellness Policies, the number of primary care practices and daycare centers/homes that become NYSDOH Breastfeeding Friendly Certified, the number of small to medium worksites that offer a comprehensive worksite wellness program, the number of municipalities that restrict tobacco marketing to youth, and the number of low income housing facilities that are smoke-free. Smart Steuben meets monthly and the agenda for this meeting is focused on tracking progress, identifying barriers, strategizing how to overcome barriers and measuring progress. Progress will be reported to New York State starting in December 2017 per the established schedule.

1. Community Description and Health Needs:

Community Description:

The service area for this Community Health Assessment includes all of Steuben County, NY. Steuben County is a rural county located in the southern portion of New York State in the lower Finger Lakes Region. One of the six Finger Lakes, Keuka Lake, borders the county in the northeast corner. Neighboring counties include Ontario, Livingston, and Yates to the north; Yates, Schuyler, and Chemung to the east; and Livingston and Allegany to the west. The entire southern border of Steuben County sits on the northern border of Pennsylvania. The county is approximately rectangular in shape, with a north-south distance of 40 miles, and an east-west distance of 40 miles in the south and 31 miles in the north. The county encompasses a total of approximately 1,397 square miles. Steuben County is the state's seventh largest county and is twice as large as any of the other counties in the nine-county Finger Lakes region. The county is part of the glaciated Allegheny Plateau with a topography of ridges and high, rolling uplands with many hilltops reaching the 2,000 foot level. The Cohocton River flows through the county and joins the Tioga and Chemung Rivers at Painted Post.



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

Socioeconomic Status (SES) measures a combination of education, income, and occupation. In the provided map above, the majority of Steuben County falls in the low to medium SES categories. In general, the lower one's SES, the greater one's risk of malnutrition, heart disease, infectious diseases, and early mortality from all causes. The annual median household income in Steuben County is $47,733 compared to $53,482 for the nation, and the per capita income is $25,696 in Steuben County compared to $28,555 for the nation (2010-2014 American Community Survey). According to 2014 United States Department of Agriculture (USDA) poverty data, the county poverty rate is 16.6% with 24.1% of children 0-17 years living in poverty.

Almost 31% of the county's population lives in its three urban areas: the cities of Corning and Hornell and the village of Bath (the county seat). The county is, however, predominately rural with more than two-thirds of its residents living in rural areas. The population is widely scattered over the 1,397 miles, with an average population density of approximately 71 persons per square mile (Census Bureau 2010). In the last 50 years, the population of the county has remained stagnant as seen in the chart below.

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

In general, Steuben County has a high dependency ratio, with 22.1% of the population estimated to be under age 18 in 2015 (5.6% under age 5) and 18.0% estimated to be aged 65 or over (US Census Bureau, Population Estimates Program 2015). Approximately 95.0% of the population is white, 1.6% is Black/African American, and the remainder is other races. In 2015, 1.6% of the population is estimated to be Hispanic/Latino (US Census Bureau, Population Estimates Program 2015). In the 2010 Census, 1,130 people indicated that they spoke English "less than very well," while the 2015 estimates indicate that 4.8% speak a language other than English at home, with 1,229 of these indicating that they speak Spanish at home.

Health Needs:

While each county in the eight county S^2AY Network region started with a summary assessment of their county's data in the FLHSA presentation (Attachment 2) and followed a fairly similar process, each county's Community Health Assessment (CHA) was completed separately, and each held their own focus groups within the county. Additionally, sub-regional focus groups were held in coordination with DSRIP through the Finger Lakes Performing Provider System (FLPPS) in each of the three Naturally Occurring Care Networks (NOCNs) that are in S^2AY 's region: 1. Finger Lakes NOCN (Wayne, Seneca, Yates and Ontario Counties); 2. S-E (southeastern) NOCN (Chemung and eastern Steuben Counties); and 3. Southern NOCN (western Steuben, Livingston, and Allegany Counties). Steuben County falls into two of the NOCNs (S-E NOCN and Southern NOCN). Data from these two focus groups is included in the assessment. Additionally, each county, including Steuben, held their own "priority setting meeting" and worked through county-specific committees (Smart Steuben here) to review data, analyze needs, and develop priorities.

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

- Obesity – lifestyle, cultural, physical activity, nutrition, community gardens (low back pain and diabetes)
- Substance abuse, especially opioid drugs
- Dental health
- Mental health
- Cancer (tobacco use)
- Hypertension (tobacco use)
- Falls – 65+ population
- Early childhood health

Obesity: 68.4% of adults in Steuben County are classified as either overweight or obese on an age adjusted rate (2013-2014 EBRFSS). Proportionally, 36.2% of Steuben County students (all grades) are considered overweight or obese, falling in the 85th percentile or higher for BMI (2012-2014 Student Weight Status Category Reporting System Data), which places Steuben County students in the 3rd quartile for county ranking. In Steuben County, 3.8% of adults have a diagnosis of pre-diabetes, 10.4% diabetes and 32.3% hypertension (2013-2014 EBRFSS). As can be seen in the attached Focus Group presentation (Attachment 3), the analysis shows that obesity is important due to the many related health conditions linked to obesity, including heart disease, hypertension, diabetes, lower back pain, arthritis, high cholesterol and several types of cancer. Therefore, by addressing obesity, several other health-related problems may be prevented. Obesity-related data and other statistics cited can be reviewed in the Steuben County 2013-2014 EBFRSS at: https://www.health.ny.gov/statistics/brfss/expanded/2013/county/docs/steuben.pdf.

Behavioral Health (mental health and substance abuse): Recent data is showing sharp increases in emergency department visits for substance abuse, heroin overdose, and mental health diagnoses, as well as for hospital admissions for heroin overdose as shown in the attached Power Point presentations (Attachments 2 and 3). The opioid epidemic sweeping across the nation is a significant health improvement priority and was analyzed at the national, state and local levels during the assessment. Steuben County has been working on preventing substance abuse at the county level and will continue these efforts throughout the next two years. Discussions of the analysis related to the opioid epidemic included mortality rates, premature loss of life, criminal behaviors related to substance abuse and the fact that substance use disorders affect entire families, often including the children of the person with the disorder.

Dental Health: The most updated Steuben County dental health data is from 2011 (2009-2011 Bureau of Dental Health Data), and it indicates that there are 23.4% of 3rd grade children having untreated dental caries, placing Steuben County in the 2nd quartile in New York State. Although the 2nd quartile indicates that Steuben County is doing somewhat well in this measure, input from the focus groups conducted through this assessment and feedback from providers, school staff, and Public Health show that child dental health is a much more significant concern. If more updated data was available, it is expected that this number would be much higher. According to the New York State Department of

Health (NYSDOH) untreated decay among children has been associated with difficulty in eating, sleeping, learning, and proper nutrition. An estimated 51 million school hours are lost due to cavities. Almost one-fifth of all health care expenditures in children are related to dental care. Among adults, untreated decay and tooth loss can also have negative effects on an individual's self-esteem and employability. Tooth decay may lead to abscess and extreme pain, blood infection that can spread, difficulty in chewing, poor weight gain, school absences and crooked teeth. According to the 2013-2014 EBRFSS, 69.1% of adults have visited a dentist within the past year, a little lower than the New York State rate (69.8%). Good oral health is essential to the general health of the community. Tooth decay is preventable, but continues to affect all ages, and it is a greater problem for those who have limited access to prevention and treatment services.

Cancer: According to 2010-2012 Cancer Registry data, Steuben County has a high mortality rate for all cancers. The age-adjusted mortality rate for all cancers was 176.7 per 100,000, compared to 158.6 per 100,000 for New York State as a whole. Incidence and mortality rates for cancers associated with tobacco use (lung/bronchus and lip/oral cavity/pharynx) were also higher. The age-adjusted incidence rate for lung and bronchus cancer was 80.5 per 100,000, compared to 61.6 per 100,000 for New York State as a whole. The age-adjusted mortality rate for lung and bronchus cancer was 80.4 per 100,000, compared to 46.4 per 100,000 for New York State as a whole. The age-adjusted incidence rate for lip/oral cavity/pharynx cancers was 12.0 per 100,000, compared to 10.5 per 100,000 for New York State as a whole. Incidence and mortality rates for colon and rectum cancer were also higher. The age-adjusted incidence rate for colon and rectum cancer was 44.3 per 100,000, compared to 41.4 per 100,000 for New York State as a whole. The age-adjusted mortality rate for colon and rectum cancer was 15.7 per 100,000, compared to 14.4 per 100,000 for New York State as a whole. This indicates that prevention (including education on tobacco use and cessation), screening, and early detection are areas for improvement in Steuben County.

Hypertension: According to the Centers for Disease Control and Prevention (CDC), approximately 30% of adults have high blood pressure in the United States. Only about half (52%) of these people have their high blood pressure under control. Steuben County is aligned with the diagnosis rate with approximately 32.3% of the adult population in Steuben County having been diagnosed with hypertension by a physician (2013-2014 EBRFSS). However, Steuben County has the second highest control rate in the region for hypertension with approximately 71% of the population registering as in-control. (FLHSA/RBA High Blood Pressure Registry, June 2016).

Injury Prevention (Falls): With Steuben County's continually aging population shown by 18.0% of the population being age 65 and over (US Census Bureau, Population Estimates Program 2015), falls can have an adverse effect on resident's health. According to the 2013-2014 EBRFSS, 26.2% of the population age 65+ reported having fallen in the last 12 months. Furthermore, as seen in the attached focus group presentation (Attachment 3), Steuben County was the third highest in the region for the number of emergency department visits per 100,000 for falls in those aged 65+. This health concern will continue to be monitored.

Early Childhood Health: From focus group input and data analysis, early childhood health was ranked as one of the top health priorities in Steuben County. According to 2012-2014 SPARCS data, Steuben County fell in the 4th quartile for pneumonia hospitalization rate in those aged 0-4 years, with 46.9 per 10,000 as compared to 34.4 per 10,000 for all of New York State. Furthermore, Steuben County fell short in lead screening measures. According to the 2011-2014 NYS Child Health Lead Poisoning Prevention Program Data, only 36.5% of children born in 2011 had a lead screening at the age of 9-17 months, as compared to 64.3% for New York State as a whole. Steuben County also shows a lower percent of children completing the recommended number of well child visits in government sponsored insurance programs with 58.8% completing compared to 72.4% for New York State as a whole (2014 NYS Medicaid and Child Health Plus Data).

Health Care Access

Smart Steuben has discussed the access gaps related to the above health needs as they analyzed the data (Attachments 3, 5, and 7). As discussed above, analysis of data revealed health disparities for the low-income population in general. With designations of Primary Care, Mental Health, and Dental Health Professional Shortage Areas (HPSAs), the capacity and distribution of health care providers is an issue in Steuben County. For example, transportation, affordability of care, and access to care were repeatedly cited as barriers in the focus groups and were instrumental in discussions to determine health care strategies. In an effort to address dental access, Steuben County Public Health played an integral role in Steuben County partnering with the New York State Association of Counties and the Health Economics Group to provide the Dental Network Card Program beginning in 2016. The Steuben County Dental Network Card enables patients to obtain dental care at reduced fees. Individuals or families without dental insurance pay a small yearly fee ($36.50 for individuals and $52 for family coverage) and receive dental services at much lower rates when visiting participating providers in the DenteMax network nationwide. Additionally, the S^2AY Rural Health Network, of which Steuben County Public Health is a part, enrolls people in health insurance through its Navigator program, and S^2AY helps to serve the uninsured and under-insured through its Community Health Advocate program, both of which help people to address gaps in coverage and find access to health care.

Steuben County has seen an increase in the Mennonite and Amish populations over recent years and this poses some additional challenges related to health care access. Traditionally, these groups avoid participation in health insurance because the community as a whole serves as a safety net for unanticipated health care needs and expenses. Furthermore, these populations abstain from some healthcare practices, including certain immunizations and early prenatal care. The behaviors and culture of the different populations of the county influenced the reasoning and strategies used to develop the CHIP.

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

Risk Factors

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

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

The Smart Steuben group will work to address these factors as they tackle the identified health priorities. The sub-groups for these risk factors include lower-income, lower-educated and socially isolated populations, as well as those with genetic predispositions for chronic disease, mental illness and alcohol/substance abuse. Lack of access to primary care results in poor health outcomes since prevention, early detection, early treatment and referral to other needed services eases the effects of long-term chronic conditions. In Steuben County socioeconomic conditions limit access to health care. There is a lack of specialty providers within the county, limiting access for those without private transportation due to the lack of public transportation covering the entire county. The county is designated as a Health Professional Shortage Area (HPSA) for dental and primary health providers for the Medicaid eligible population. For the most part, however, services are available if cost, behavioral, and transportation barriers do not preclude access. Steuben County residents are fortunate as there is a hospital located in each of the major population centers in the county.

Physical – As stated in the community description section, Steuben County has a population of 97,631 spread over 1397 square miles with a population density of 71 people per sq. mile (US Census Bureau, Population Estimates Program 2015). Steuben County is the state's seventh largest county and is twice as large as any of the other counties in the Finger Lakes region. Almost 31% of the county's population lives in its three urban areas: the cities of Corning and Hornell and the village of Bath (the county seat). The county is, however, predominately rural with more than two-thirds of its residents living in rural areas. Health challenges arise for the residents scattered throughout other parts of our rural county where transportation is an issue. The ability to access health care, especially for the uninsured, non-Medicaid population with limited financial means and for the elderly who face barriers in driving longer distances due to the rural nature of the county, presents a physical barrier some cannot overcome.

Legal – Real health care reform cannot occur without policy change. With the implementation of the Affordable Care Act in 2014, the country is now closer to universal health coverage. The challenge has been to help residents understand the complex system. Legal issues are also a concern for the migrant population who defer health care until an emergency occurs for fear of legal repercussions.

Social - The social aspects of Steuben County residents are influenced by a wide variety of behavioral risk factors. These factors include residents with a low-income and thus limited means to purchase nutritional meals or take advantage of many social and recreational opportunities for physical activity (e.g. canoeing, kayaking, backpacking, golf, etc.). Persons with limited means are also more likely to engage in unhealthy habits, such as tobacco use or alcohol abuse. These unhealthy behaviors can partly be attributed to the fact that there may be fewer opportunities that low-income individuals are exposed to in which they can change their state of being than for those of more substantial means who may use exercise, music, theater, art, stimulating conversation, higher education or other venues for stimulation and growth. Recent studies have also shown that urban residents may lead less of a sedentary lifestyle than do rural (non-farming) or suburban residents due to their ability to walk more often to various destinations than is possible or feasible in rural areas. Social isolation inherent to rural communities seems to also make residents more prone to alcohol abuse and higher rates of depression or poor mental health than their urban counterparts. Cultural acceptance of tobacco and alcohol use is also a risk factor. The growing Mennonite and Amish populations may be a mitigating factor in reducing rates of alcohol abuse and tobacco use in Steuben County, since these groups do not condone the excessive use of alcohol or the use of tobacco. Lower levels of education and educational aspirations are also risk factors. Steuben County has almost 40% fewer residents over the age of 25 with a Bachelor's degree compared with the New York State average, with just 20.8% of Steuben County residents having a Bachelor's degree or higher compared to the State average of 33.7% (2010-2014 American Community Survey). Lack of access to dental care and lack of a fluoridated water supply are other risk factors residents face.

Economic – The economic factors affecting the health of Steuben County residents, as previously stated in the community description section, are well documented. Living in poverty is associated with lower health status, an increased risk of having inadequate health insurance, and lower use of health services. The annual median household income in Steuben County is $47,733 which is almost 20% below the New York State median household income of $58,687 (2010-2014 American Community Survey). Among Steuben County residents, 16.6% had incomes below the poverty level compared to the New York State average of 15.4%.

Lack of education is a determining factor of economic stability and is also associated with a lower health status and a greater likelihood of not seeking health care, especially preventive services. According to the 2010-2014 American Community Survey, Steuben County has a higher percentage of high school graduates at 88.8% compared to the New York State average of 85.4%. However, as stated above, Steuben County has almost 40% fewer residents over the age of 25 with a Bachelor's degree as compared to New York State as a whole.

Other Health Related Components of the Environment -

Overall, the Smart Steuben group and all affiliated partners continue to collaborate with state and local officials and organizations in an effort to reduce the high costs of Early Intervention programs and at the same time provide quality service to the children who need the services. Steuben County Public Health

and partners assist school health programs on an as needed basis to provide up-to-date health education and information for situations that may be occurring in the school systems.

Other health related factors that affect us locally are listed below:

- State budget cuts affecting health care and government at local levels and cuts to public health programs.
- Increase in unemployment is reducing funds available for health related items (healthy food choices, memberships to health clubs, etc.). It limits residents' ability to access health related services and pay for health insurance, dental insurance, and prescriptions.
    - The New York State Department of Labor reported the unemployment rate in Steuben County was 5.4% (as of September 2016) compared to the NYS rate of 5.0%.
- Hospitalists pose unique challenges for the smooth transition from inpatient stay to care in the home (i.e. obtaining physician's orders, medication management).
- Regulatory changes, increased immunization costs, and complicated immunization schedules are beginning to deter provider participation in adult and children immunizations.
- Smoking:
    - Increase in worksites/campuses that have become smoke free or tobacco free.
    - Increase in available nicotine replacement therapies.
    - Steuben County Public Health offers Freedom From Smoking, a smoking cessation program, which has included distribution of nicotine replacement therapy.
- Increase in population seeking medical advice from internet websites.

Improving access to high-quality, continuous primary care and treatment services is critical in eliminating disparities in health outcomes. Many factors may keep people from appropriately accessing care. Personal access to care barriers may include:

- Personal value and behavior systems on the part of some county residents (particularly older residents) who refuse to take advantage of eligibility-based programs (such as Medicaid and Food Stamps) because they consider it a "hand-out."
- Lack of insurance.
- Perceived confidentiality issues.
- Personal belief and behavior systems on the part of the growing Amish and Mennonite populations in Steuben County may inhibit their access to care.
- Unlike other medical services, the primary payment source for dental services is out-of-pocket, with access to services for persons on Medicaid particularly limited within the county borders. A Medicaid dental clinic can be found in Hornell at Oak Orchard Health, which opened in fall 2016. One dental office in Painted Post accepts Medicaid payment from current patients but is not currently accepting new Medicaid patients.
- Lack of personal vehicle for transportation.
- Lack of education and personal experience regarding the value of and need for primary and preventive care. This can include feelings of intimidation that some residents may experience in the presence of health professionals, leading both to avoidance of care and lack of

empowerment in managing relevant aspects of their own healthcare along with health literacy issues. For too many residents, emergency rooms or urgent care facilities may be the only type of care accessed. For a significant portion of females, family planning services may be their only access point to primary care services.

According to the 2014 Bureau of US Census Data, 9.8% of Steuben County adults lack health insurance. This is better than the New York State rate of 12.4%. Due to the implementation of the Affordable Care Act (ACA) and New York State of Health Marketplace, we know that currently these numbers are much lower. Expansion of the Medicaid income threshold through the ACA has greatly helped many Steuben County residents. Furthermore, the creation of the Essential Plan (for those who are just over the income threshold for Medicaid) has also helped a large amount of Steuben County residents. Conversely, others have been adversely affected as many of the health plans (for those who are above income for Medicaid and the Essential Plan) have very high deductibles, so although the consumer is now insured, they are not using their plan due to the high out-of-pocket costs.

Steuben County has two organizations available to assist residents with enrolling in the New York State of Health Marketplace: AIM Independent Living Center and the S^2AY Rural Health Network. Public Health is a partner of S^2AY and works closely with these organizations to ensure residents understand and sign up for health insurance.

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

Media Reach - Steuben has a mixture of media outlets in the county, although changes in technology bring new challenges as public health explores novel ways to reach residents. Traditional methods of health care promotion through newspapers, television and radio are not as far-reaching as they once were. Residents now have endless cable television channel choices, satellite radio stations to choose from, vast internet options, and a wide array of apps to select from on their smart phones. Public Health must re-invent the way they reach all their residents. Conversely, technology also presents the opposite barrier as many residents reside in rural, sparsely populated areas of the county that do not have cell phone or internet access. Disparities in access to health information, services, and technology can result in lower usage rates of preventive services, less knowledge of chronic disease management, higher rates of hospitalization, and poorer reported health status. Steuben County Public Health has taken steps to address this challenge. One of the objectives from their strategic plan was to expand the use of technology for more effective external communications for those that have access. This was accomplished over the last CHA/CHIP cycle. A new logo was designed, their website was redesigned, a Facebook page was created, a Twitter account was set up, and QR codes were utilized. Steuben County Public Health and partners will continue to explore different venues for communicating with the public in the more rural, hard to reach areas.

The Clean Indoor Air Act, passed more than ten years ago, continues to improve the overall environment and reduce secondhand smoke statistics. Huge progress in creating smoke-free and tobacco-free physical environments has occurred. New York State has led the way in creating smoke-free indoor environments and is expanding policies in public outdoor areas as well. There is an increase in the number of workplaces and campuses that are now smoke-free or tobacco-free. There is also an increase in available nicotine replacement therapies. Steuben County Public Health is a partner in the Southern Tier Tobacco Awareness Coalition (STTAC) and continues to support their efforts. In the current CHIP, Smart Steuben will continue work with STTAC to target low income housing and tobacco marketing to youth.

The Socio-Economic Status and General Health Indicators from 2012-2014 state that 16.6% of Steuben County residents live in poverty. This restricts basic needs such as heat, food, adequate shelter, medical and prescription care. Inadequate housing can impact health outcomes. The social environment is generally conducive to accepting health care, although there is a subset of the population that does not seek preventive care and relies on the emergency room for medical necessity.

Tourism - Steuben County is part of the Finger Lakes region that attracts many tourists during the summer season, placing a burden on local medical services, law enforcement, and the local infrastructure. Additionally, the Corning Glass Museum welcomed over 425,000 visitors in 2015. High tourism creates the potential for a health disaster as regular resources will quickly be exhausted in the event of a major health emergency. In addition to typical seasonal visitors to Keuka Lake, local wineries, and the Corning Glass Museum, the area is inundated with visitors to events at the Watkins Glen International Race Track in neighboring Schuyler County.

An underage drinking and drug prevention campaign continues in the county aiding the efforts of our three local OASAS prevention providers – Hornell Area Concern for Youth, the Steuben Council on Addictions, and the Family Service Society. These efforts have grown into what is now the Steuben Prevention Coalition which attempts to influence the social environment by changing social norms around alcohol and drug abuse, particularly marijuana. Letters from the County District Attorney's Office to parents, publications regarding the consequences of underage drinking and drug use, focus groups and numerous educational efforts combine to change the social environment related to alcohol and drug abuse by minors. Both attitudes and behaviors are targeted.

The current economic situation and the budget cuts over the last few years have affected the local health care environment. Providers have a more difficult time with a seemingly increasing number of individuals recently electing to skip routine medical and dental care due to lack of employment, resources, and/or insurance. Some providers refuse to accept Medicaid. Additionally, the high cost of fuel is still a consideration for residents as the expense reduces funds available for health-related items (healthy food choices, memberships to health clubs, etc.) and the ability to get to health-related services and/or pay for prescriptions.

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

2. Data Reviewed and Analyzed:

The data review and analysis was extensive. In all S^2AY Network counties, including Steuben, the process began with a data update for the eight county region conducted by the Finger Lakes Health Systems Agency (FLHSA) at the request of S^2AY (Attachment 2). This data collection and analysis focused on regional data related to the main priorities in the 2013 CHA. Additionally, there were some emerging issues that the hospitals and Public Health agreed should be analyzed based on their knowledge of what they were seeing in their communities and what the needs assessment for DSRIP (also conducted by the FLHSA) had revealed. In addition to the DSRIP needs assessment, data sources for this review included:

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

Once this data was reviewed, the S^2AY Network staff compiled and analyzed other data to develop a summary PowerPoint presentation (Attachment 3) of the highest need areas particular to Steuben County. In addition to the above sources, this additional review of data included, among other things:

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

In addition to the primary data reviewed from the high blood pressure registry, other primary data was obtained through focus group input (Attachments 4 and 5) and the Public Health System Assessment (PHSA) which can be found in Attachment 6.

3. Priorities, Disparities and Community Engagement:

Prevention Agenda Priorities -

As detailed on the attached Community Health Improvement Plan (CHIP; Attachment 16), the two New York State Department of Health (NYSDOH) Prevention Agenda priority areas for Steuben County for the 2016-2018 period include:

1. **Priority Area:** Prevent Chronic Diseases
    - *Focus Area 1:* Reduce Obesity in Children and Adults
    - *Focus Area 2:* Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
    - *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings
2. **Priority Area:** Promote Healthy Women, Infants, and Children
    - *Focus Area 1:* Maternal and Infant Health

Disparities Being Addressed -

During the 2016-2018 period, Steuben County Public Health, Corning Hospital (Guthrie), St. James Mercy Hospital, and Ira Davenport Memorial Hospital (Arnot Health) have chosen to address four disparities through specific evidence-based activities (as outlined in the CHIP chart; Attachment 16). The first three disparities to be addressed fall under the priority area of Prevent Chronic Diseases and the last disparity falls under the priority area of Promote Healthy Women, Infants, and Children.

The first disparity focuses on Goal 1.4 (expand the role of public and private employers in obesity prevention). This disparity will target the low socioeconomic status (SES) population by working with worksites to implement healthy policies. An example of this disparity being addressed in action is through a partnership with the Genesee Valley BOCES and their Creating Healthy Schools and Communities Grant. The Center for Disease Control (CDC) has identified fifteen high-need school districts for enhanced monitoring. One of those fifteen districts is Campbell-Savona, and Genesee Valley BOCES has already engaged them for work around healthy policy changes.

The second disparity focuses on Goal 2.1 (prevent initiation of tobacco use by youth and young adults, especially low SES populations). This disparity will target low income populations and youth/young adults to increase the number of municipalities that restrict tobacco marketing to youth and to decrease the density/proximity of tobacco retailers to schools.

The third disparity focuses on Goal 2.3 (eliminate exposure to secondhand smoke). This disparity will target the low SES population by working with low income housing facilities to implement smoke-free policies.

The last disparity falls under the priority area of Promote Healthy Women, Infants, and Children. This disparity focuses on Goal 1.1 (reduce premature birth). This disparity targets the low SES population through implementation of a Community Health Worker program. Disparities were chosen by Smart Steuben based on analysis of the data and potential to reach disparate populations.

Community Engagement –

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

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

1. **Organize for Success- Partner Development**
   This included representatives of the Smart Steuben team discussed above. This collaborative, multi-disciplinary group oversaw the assessment process and the development of the CHIP.

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

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

   The second assessment evaluated the effectiveness of the Public Health System and the role of Steuben County Public Health within that system. This was done using a modified, user-friendly version of the Local Public Health System Assessment (LPHSA) tool developed by the CDC and NACCHO. This was conducted via an electronic survey on Survey Monkey. A diverse group of

key informants were chosen to complete the survey, including community leaders who are familiar in some way with the local public health system. Each of the ten essential public health services was rated by the survey participants by ranking the series of indicators within each Essential Service to determine areas of strength and areas needing improvement within the Local Public Health System (results from the survey summarized in Attachment 6).

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

3. Identification of Strategic Issues

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

4. Formulate Goals and Strategies

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

The Process of Community Engagement Using MAPP

Steuben County Public Health, Corning Hospital (Guthrie), St. James Mercy Hospital, and Ira Davenport Memorial Hospital (Arnot Health), with assistance from the S^2AY Rural Health Network, conducted a comprehensive assessment of the community, which provided the basis for the Prevention Agenda priority areas selected. The assessment process included a thorough review of county specific data around health needs compared to neighboring counties, the region, and the State as a whole. After the data was analyzed and prepared by FLHSA and S^2AY, it was shared in the form of focus group presentations to county residents. Steuben County conducted twelve separate focus groups with key informants throughout the county to solicit feedback. Focus groups were selected to include a broad diversity of community members from different segments of the community, including populations that

experience health disparities as outlined in this report. Focus groups that were conducted included the following: a Corning, Inc. retirees group, two Single Point of Access groups, a county-wide school counselors meeting, a Cornell Cooperative Extension Job Club group, a recovering addicts group at Arbor Housing, a class at Corning Community College, a National Diabetes Prevention Program participant group, Public Health staff, the Smart Steuben group which included all of the member organizations, and both the Southeast and Southern NOCN meetings.

After the completion of the focus groups, Smart Steuben invited focus group participants, all community members, health care organizations, and human service agencies to participate in the prioritization of the most pressing health needs identified from the data collection and focus group input. Focus group participants and community members were invited to this meeting through email, media releases, and postings on websites and social media platforms (Public Health, Hospitals, S^2AY Rural Health Network, and other partners). S^2AY prepared a PowerPoint presentation for this "Priority Setting" meeting. At this meeting, S^2AY presented the data shared with the focus groups, along with key slides from the EBRFSS and Community Health Indicator Reports (Attachment 7). Input from the focus groups was analyzed and considered when developing a list of priorities for the group to rank that S^2AY created from all of the data reviewed and analyzed (list of issues to rank found in Attachment 8). The group was also offered the opportunity to add any additional issues that they believed needed to be ranked to come up with priorities.

The Hanlon Method was used to rank issues, and a presentation summarizing the Hanlon Method was reviewed (Attachment 9). Participants ranked the highest priority issues and came up with a list of preliminary priorities (list of ranked issues found in Attachment 11). The Hanlon Method uses the Basic Priority Rating (BPR) System formula where BPR = (A + 2B) X C where A= the size of the problem, B= the severity of the problem and C=the effectiveness of the solution. The effectiveness of the solution is given a lot more weight than the size or seriousness of the problem, with the hope of making wise use of limited resources by targeting solutions that are known to be effective. Participants also consider the weight of the propriety, economic feasibility, acceptability, resources and legality (PEARL) of issues in this ranking system. Numerical values were determined by each participant for size, severity and effectiveness, and then plugged into the formula along with average PEARL scores. It is important to note that while the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still a method that is largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since respondents ranked each component (size, seriousness, and effectiveness of the solution, as well as the PEARL factors) individually using a paper ranking form (blank rating worksheet found in Attachment 10), the rankings were not heavily influenced by group dynamics.

After the preliminary priorities were chosen, a media release was distributed and preliminary priorities were posted on the Public Health and hospital websites (Attachments 13-15). The next three meetings of Smart Steuben were then focused on finalizing the priorities, choosing disparities based on an additional analysis of the data within each priority area, and choosing the interventions, strategies and activities to address the selected priorities and disparities.

Fully detailed in the CHIP, strategies to address chronic diseases include evidence-based activities such as Stanford approved curriculums (e.g. Chronic Disease Self-Management Program – CDSMP), policy/practice implementation (working with worksites to implement healthy policies, working with schools to adopt Local School Wellness Policies, encouraging providers and daycares to become Breastfeeding Friendly Certified), promoting provider practice participation in the regional hypertension registry, working with hospitals on quality improvement efforts to increase breastfeeding exclusivity at discharge, and working with municipalities to restrict tobacco marketing to youth. Additional strategies to address early childhood health include providing evidence-based home visiting and implementing a Community Health Worker program to provide enhanced support to women and children.

4. Community Health Improvement Plan (CHIP):

Lessons Learned/Progress on Current CHIP

The previous Community Health Improvement Plan, which began in 2013, focused on two of the same priority areas as the current plan: obesity and hypertension. Progress in 2016 was made on efforts that were included in the previous plan as well as some that can be found in the current plan.

Obesity –

Found in the previous plan, Steuben County Public Health strengthened ties with local media to increase awareness and information sharing about CHIP and other public health initiatives. Between February and December 2016, the Public Health Education Coordinator appeared on the Midday Makeover section of a local news show at noon 12 times. Additionally, press releases and interviews by TV, newspaper, and radio stations occurred regularly on public health and CHIP topics.

Also found in the previous plan, a guide was created in 2016 that was promoted by Smart Steuben and Public Health about the local resources available for the community to use school facilities to be active. Partnerships were formed with a couple schools to begin work on local school wellness policies which is an initiative that will continue for the next several years.

Support for current programs and the development of others focused on improving childhood fitness and reducing childhood obesity through Fit and Strong Together (FAST), a Corning Hospital-led coalition comprising community, hospital, physician, education, fitness center and public health representatives continued in 2016. "Childhood Healthy Lifestyles," a program developed by Guthrie physicians and staff with expertise in childhood obesity, health, and wellness, was piloted in the 2015-2016 school year. Third grade educators in a local elementary school incorporated the material into lesson plans comprised of 16 modules given over 16 weeks. Knowledge measures were given at weeks five, 10 and 16 as a process measure. A Tanita scale was also used to measure student progress. Results of the pilot year were very positive, and the program is being continued in the 2016-2017 school year. Additionally, there is interest in introducing the program to an elementary school in another school district in Steuben County in 2017.

In addition to the community work being done, FAST proposed to Guthrie Clinic that prompts be added to the EPIC electronic patient record to remind physicians to discuss exercise and healthy eating with overweight patients. This is part of the "Exercise is Medicine" concept, jointly proposed by the American College of Sports Medicine, the Medical Fitness Association, and the American Council on Exercise.

Arnot Health continued to be one of the major sponsors of the annual Wineglass Marathon held in Corning in 2016. The marathon draws hundreds of runners and even more spectators to the area. During the weekend-long event, Arnot Health promoted the health benefits of physical activity, including running. Information on how to avoid injury was also shared at the event along with functional screenings by physical and occupational therapists.

St. James Mercy Hospital held Healthy Kids Day and the 27th Annual Kids ¼ Miler in May 2016. Over 230 youth ages 2 - 12 participated in the event which included education and activities promoting a healthy lifestyle. St. James Mercy Hospital also sponsored a Whoville 5K in December 2016, and over 250 individuals from the community participated in the event. In addition, St. James Mercy Hospital held two in-house weight loss challenges in 2016 to promote healthy changes in diet and exercise among employees.

Efforts to increase breastfeeding rates continued, and the Bath Baby Café held at the Dormann Library in Bath was open and staffed by certified lactation consultants (CLC) from Public Health and partnering agencies every week throughout the year. In 2016, partnerships were created and strengthened to work towards increasing the number of breastfeeding friendly daycare centers and homes. In the current CHIP, Smart Steuben expects to expand the participating daycares through partnering with Child Care Aware of Steuben and Schuyler Counties, a program of ProAction. Additionally this year, a program was initiated to increase referrals from Corning Hospital to Public Health so that new moms would receive an educational home visit, free of charge, by a Public Health CLC or nurse. Ensuring that breastfeeding moms receive support quickly after delivering a child increases the chances of continued breastfeeding for a longer duration.

Arnot Health's Arnot Ogden Medical Center (AOMC) is a regional neonatal intensive care center that serves hundreds of Steuben County residents annually. Mothers who delivered their babies at AOMC received a breastfeeding resource list from across the Finger Lakes Region. Also, birth and breastfeeding classes are promoted on Arnot Health's wellness resources page of their website. Through the work of the Twin Tiers Breastfeeding Network, which Arnot Health co-chairs, a breastfeeding fax referral form is being developed to improve accessibility to support resources in the Finger Lakes Region.

In 2016, Public Health continued to offer two National Diabetes Prevention Program classes in different areas of the county. The Steuben Rural Health Network and Arnot Health partnered to have master trainers and peer leaders trained to offer the Chronic Disease Self-Management Program (CDSMP) and successfully offered a class in Steuben County. The primary care offices of Arnot Health implemented a new electronic health record, E-Clinical Works (ECW). Staff training continues on the use of the

electronic health record to promote breastfeeding and other wellness support activities, including the CDSMP.

Corning Hospital offers evidence-based interventions in self-care management in clinical and community settings. Health screenings targeted to specific populations, as well as community informational presentations/seminars are offered on important health topics. Corning Hospital also continues to offer programs like the HealthWorks Diabetes Support Group, which meets monthly and provides speakers on a variety of topics and health issues related to diabetes. Additionally, diabetes awareness education and diabetes screenings have been offered in community and industry settings.

Hypertension –

In 2016, efforts to reduce exposure to secondhand smoke continued by maintaining participation with the Southern Tier Tobacco Awareness Coalition (STTAC) and supporting their efforts. Additional smoke-free and tobacco-free grounds policies were implemented in 2016 in the Village of Riverside, the Institute for Human Services building in Bath, and the Hornell YMCA. Also in 2016, the Freedom From Smoking cessation class offered by Public Health completed a ten-session program, successfully helping individuals to quit smoking.

Information on cessation and support was distributed to a local low-income housing complex and to area organizations. Arnot Health also partnered with the Center for a Tobacco Free Finger Lakes to provide a staff train the trainer training for hospital nurses, primary care office nurse care managers, Health on Demand (regional call center) staff and respiratory therapists. The training included recognizing health risks of tobacco use and exposure, brief cessation counseling, and how to make referrals to the NYS Smokers' Quitline. Corning Hospital and St. James Mercy Hospital also continue to identify tobacco users upon hospital admission and offer cessation support services and promote the NYS Smokers' Quitline.

Guthrie and Arnot Health systems were added to the Regional Blood Pressure Registry in 2016 and will continue to contribute data to the registry in the current CHIP. According to the most recent registry report in June 2016, Steuben County had the second highest blood pressure control rate of the counties in the region.

In 2016, Arnot Health participated in three area blood pressure screening events where patients were educated on their current medications. Similarly, St. James Mercy Hospital partners with Wegmans through their Working with Wegmans program and regularly offers blood pressure screenings onsite throughout the year along with other health education and services. St. James Mercy Hospital continues to review and educate inpatients on their medication management in relation to Chronic Heart Failure (CHF). Additionally, St. James Mercy Hospital started screening for CHF and stages of CHF on their admission assessment in 2016. If a patient is at stage 3 or 4, an automatic referral notification is sent to the lead nurse of Cardiac Rehab. Monthly cardiovascular heart disease support groups continued to be held at St. James Mercy Hospital; however, only 2 people attended in 2016, so little data is available to support the goal of reducing cardiac-related complications and hospitalizations.

The Sodium Reduction in Communities Program run by Steuben County Public Health completed the 3-year grant period in 2016, successfully reducing sodium in meals offered at local hospital cafeterias and through senior meal programs. Corning Hospital and Arnot Health participated in the Sodium Reduction in Communities Program, and sodium content of meals served in their cafeterias was reduced by at least 30% over the grant period. At Corning Hospital, healthy snack food choices and reduced sugar sweetened beverages are readily available for staff, patients, and visitors. Next, Corning Hospital will be completing an analysis of all menu items for nutritional content served in the cafeteria and will be providing that information to cafeteria users.

2016-2018 CHIP

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

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

The Smart Steuben team (comprised of Public Health, all hospitals in Steuben County, the S^2AY Rural Health Network, and many additional partners) spent several meetings developing and refining the attached Community Health Improvement Plan (CHIP) chart, the overall work plan for community health improvement (Attachment 16). This chart outlines the actions that Steuben County Public Health, the hospitals—Corning Hospital (Guthrie), St. James Mercy Hospital, and Ira Davenport Memorial Hospital (Arnot Health)— and partners intend to take to address each priority area, the specific resources Steuben County Public Health, the hospitals, and partners intend to commit (dollar amounts, hours, and/or full time equivalents (FTEs)), the roles of partners engaged in each activity, and the chosen disparities being addressed by these efforts.

5. Maintaining Engagement and Tracking Progress:

The 2016-2018 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)/Community Service Plan (CSP) created in partnership between the lead entities of Steuben County Public Health, Corning Hospital (Guthrie), St. James Mercy Hospital, and Ira Davenport Memorial Hospital (Arnot Health) will be disseminated to the public in the following ways:

- Made publicly available on the Steuben County Public Health website
- Made publicly available on all of the hospitals main websites: Corning Hospital (Guthrie), St. James Mercy Hospital, and Ira Davenport Memorial Hospital (Arnot Health)
- Made publicly available on the S^2AY Rural Health Network website

- Made publicly available on additional partners' websites (Cornell Cooperative Extension, WIC, local community based organizations, etc.)
- Shared with all appropriate news outlets in the form of a press/media release
- All partners, including Steuben County Public Health, Corning Hospital (Guthrie), St. James Mercy Hospital, Ira Davenport Memorial Hospital (Arnot Health), S^2AY Rural Health Network, and additional partners, will be asked to share the publication and website links of the CHA/CHIP/CSP on their respective social media accounts (Facebook, LinkedIn, Twitter, etc.)

A list of websites where the documents are posted are included below.

Steuben County Public Health: https://steubencony.org/pages.asp?PID=419

Corning Hospital: https://www.guthrie.org/guthrie-corning-hospital-community-service-plan

St. James Mercy Hospital: http://www.stjamesmercy.org/community.shtml

Arnot Health: https://www.arnothealth.org/community-service-plans

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

Attachment 1

Smart Steuben

(Former Steuben Health Priorities Team)

Membership List 2016

- Steuben County Public Health
- Arnot Health
- Corning Hospital
- St. James Mercy Hospital
- S2AY Rural Health Network
- Genesee Valley BOCES
- Finger Lakes Health Systems Agency
- Finger Lakes Community Health
- Steuben County Legislature
- Steuben Rural Health Network
- Cornell Cooperative Extension
- ProAction of Steuben & Yates
- Southern Tier Tobacco Awareness Coalition
- Center for Tobacco Free Finger Lakes
- Cancer Services Program of Steuben County

Finger Lakes Health Systems Agency

Regional Leadership Meeting

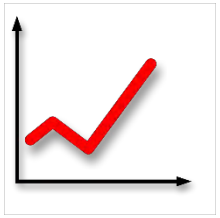
March 4, 2016

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

Research & Analysis Updates

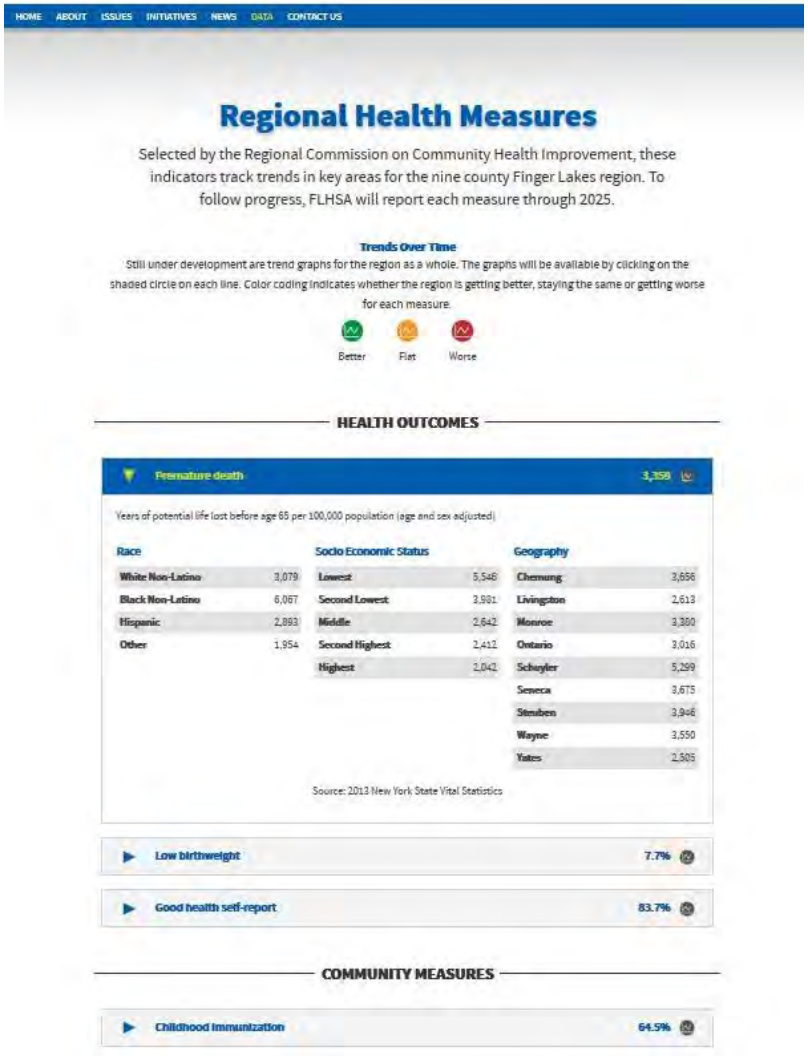
- Continuous Capability Enhancement

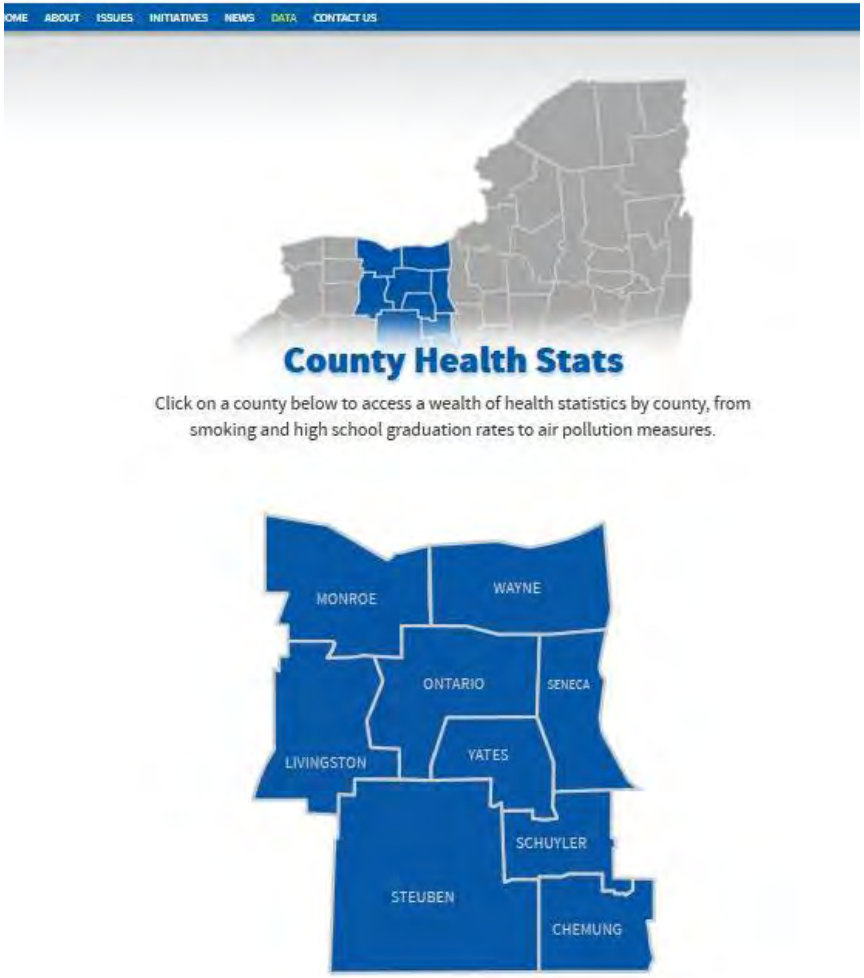
- Regional Population Health Measures



- Community Insight & Input

FLHSA Website Enhancements



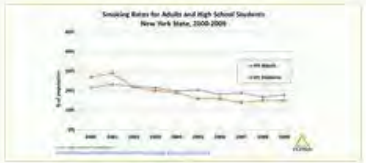


FLHSA Website Enhancements

HOME ABOUT ISSUES INITIATIVES NEWS DATA CONTACT US

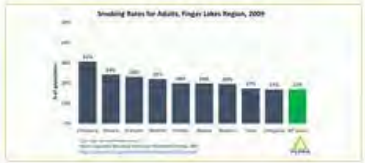
Insights

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



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

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

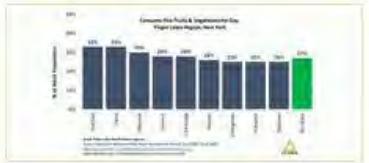


Smoking rates for adults, Finger Lakes Region, 2009

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

DOWNLOAD IMAGE [PPT]

DOWNLOAD IMAGE [PDF]



Rate of fruit and vegetable consumption, Finger Lakes Region

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

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

Finger Lakes Health Systems Agency

An Analytic Review of Selected Priority Areas

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

Approach & Methodology

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

2013 Community Health Assessment Priority Areas

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

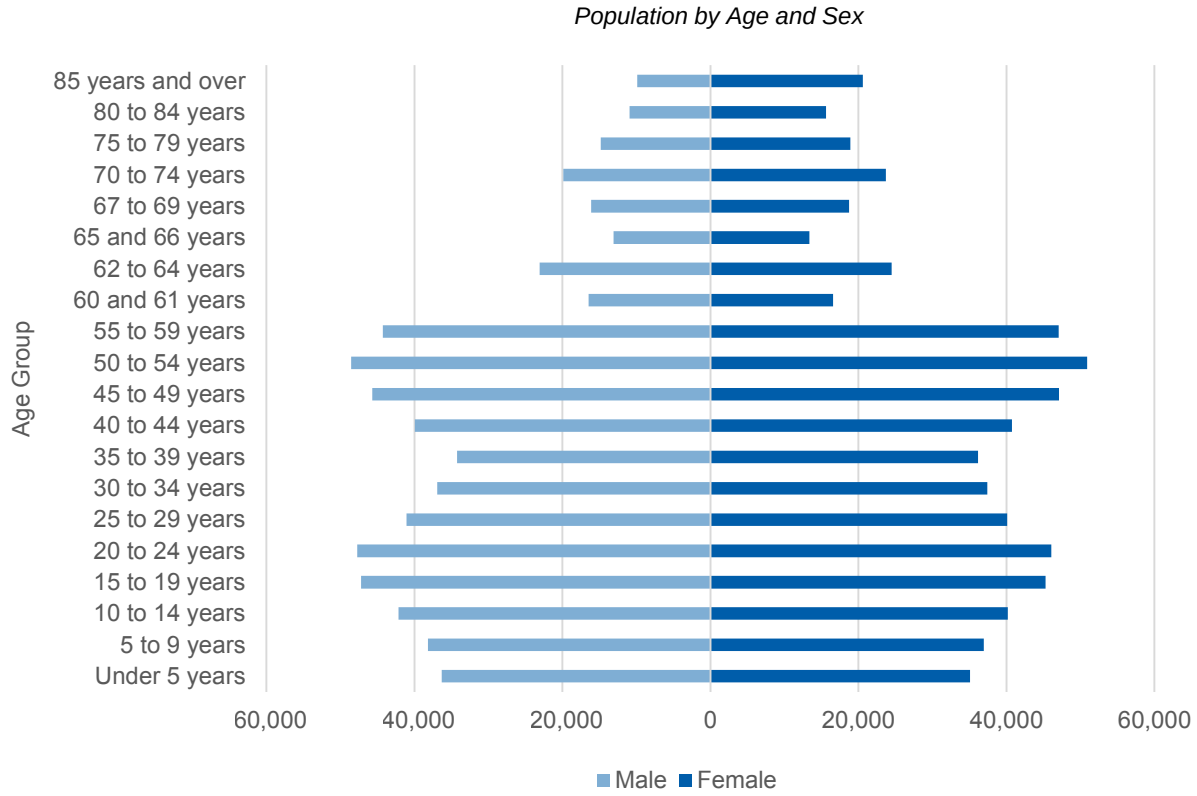
Approach & Methodology, Continued

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

THE FINGER LAKES REGION: DEMOGRAPHICS

The Finger Lakes Region

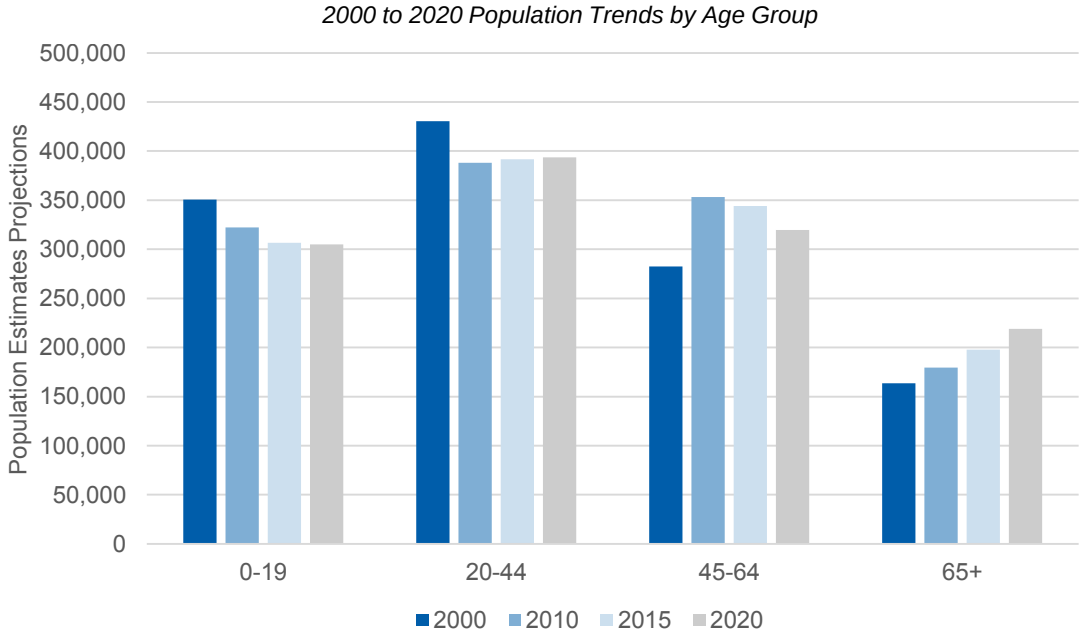
- There are approximately 1,281,374 persons living in the Finger Lakes Region. Age/Gender distributions are essentially equivalent, but begin to shift towards the female population starting at age 75.



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

The Finger Lakes Region, Continued

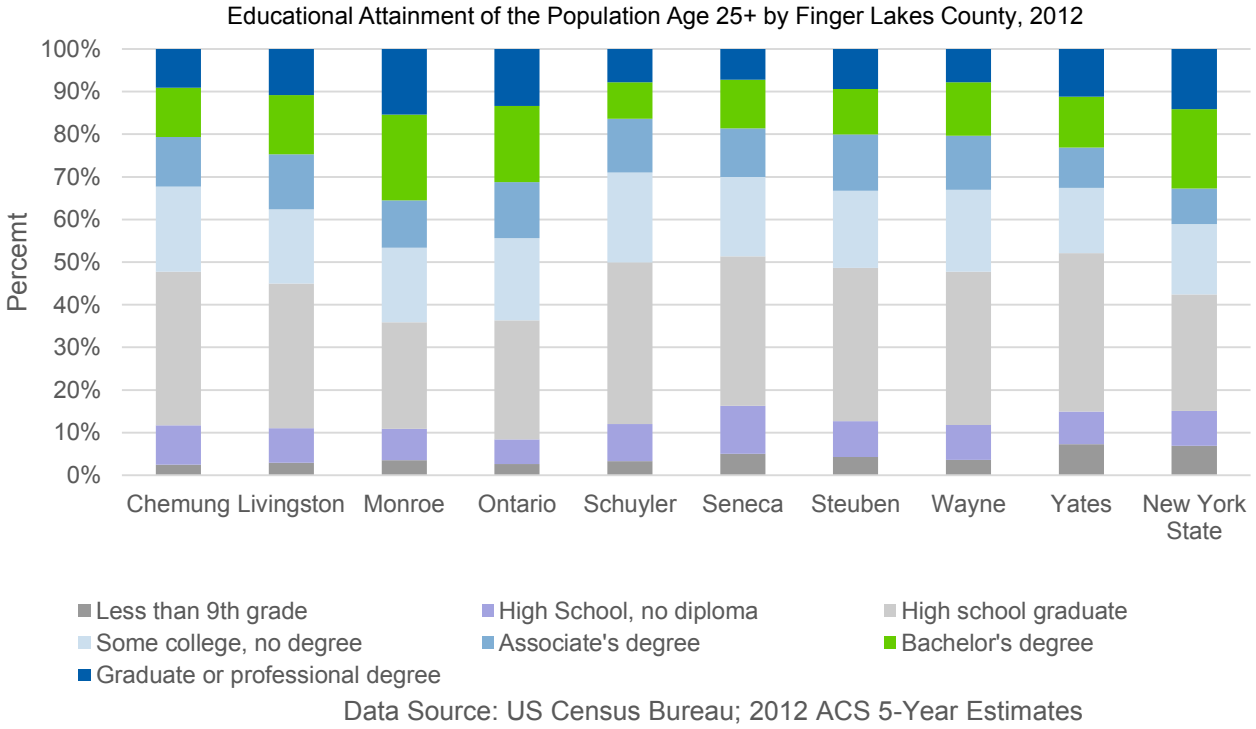
- Population projections show little change in the pre-school, school aged and adults of child bearing ages by 2020. The 45-64 population will decrease slightly, while the 65+ age group will grow.



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

The Finger Lakes Region, Continued

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

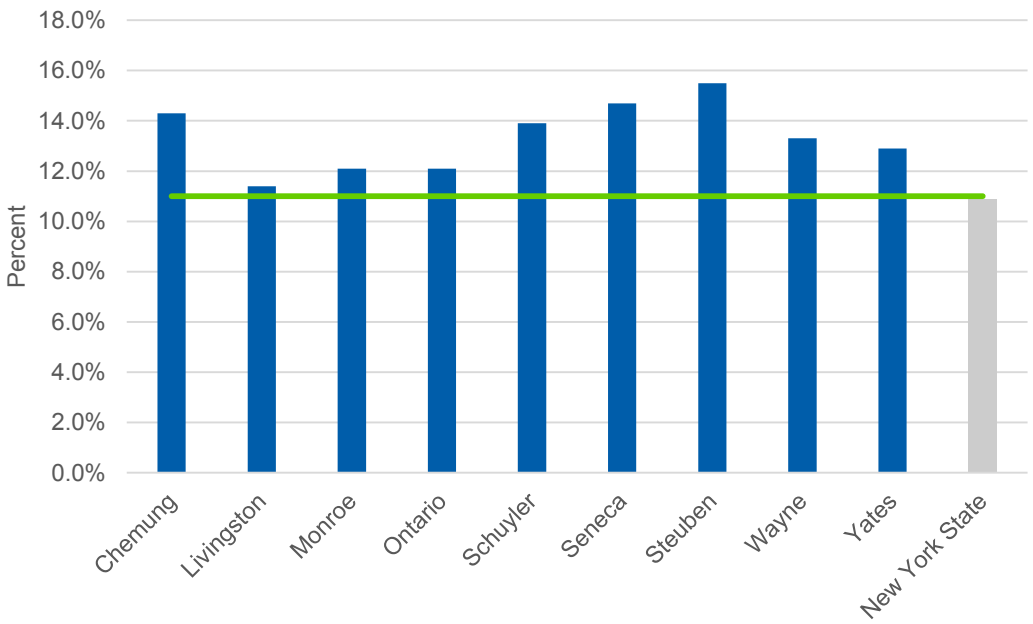


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

The Finger Lakes Region, Continued

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

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

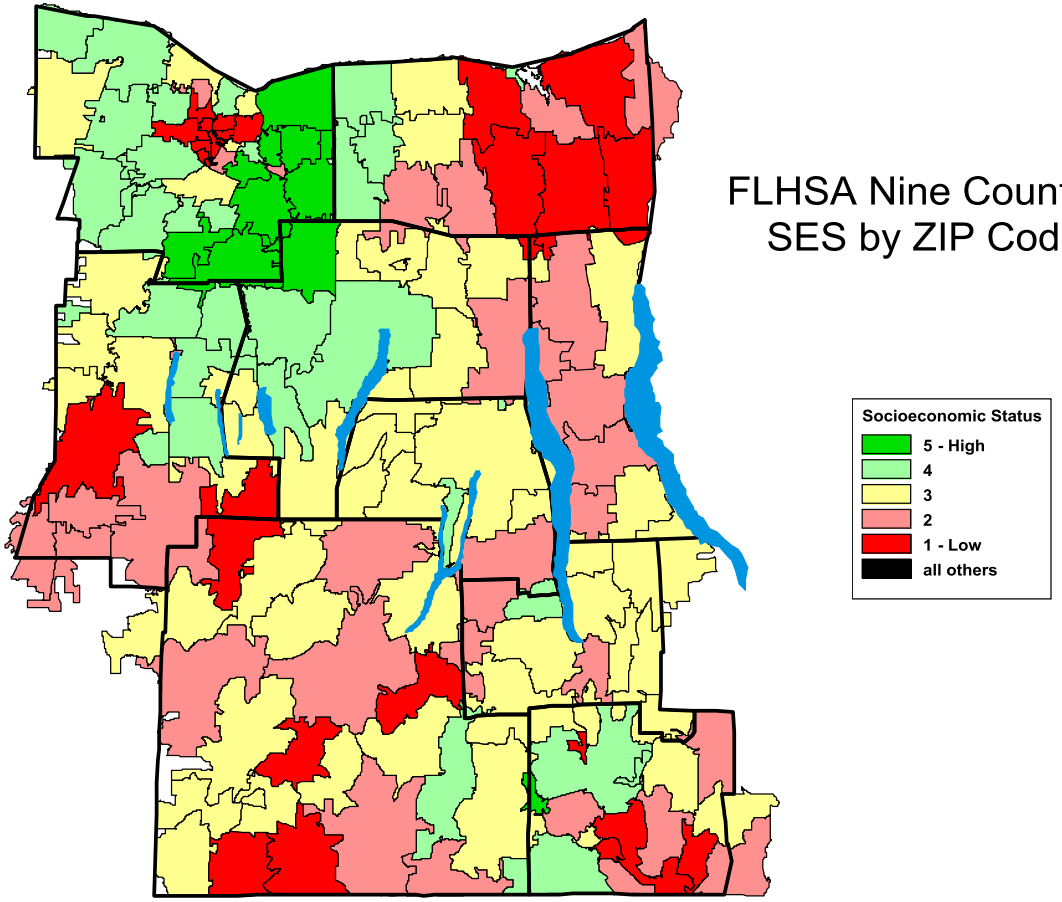


Data Source: US Census Bureau; 2012 ACS 5-Year Estimates

The Finger Lakes Region, Continued

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

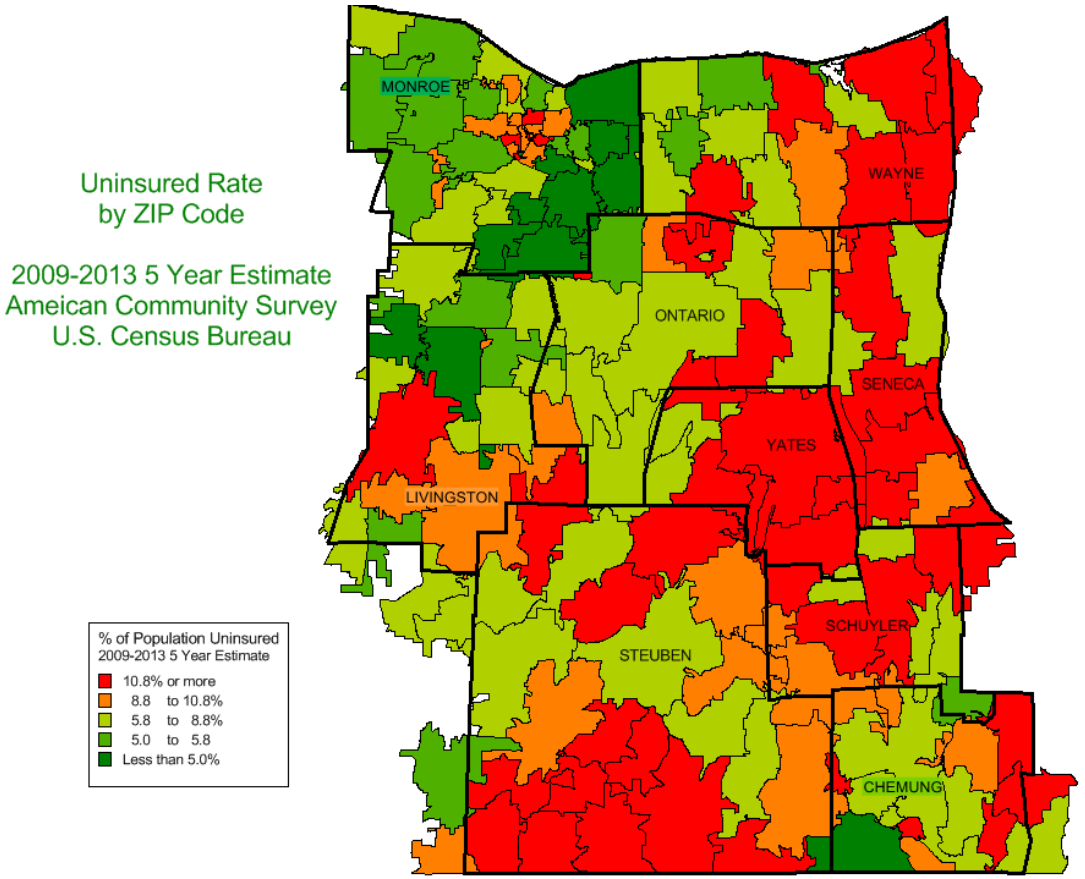
Socioeconomic Status of Finger Lakes Region based on ZIP Code



The Finger Lakes Region, Continued

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

Percent of Finger Lakes Region Uninsured by ZIP Code



DATA UPDATES:
THE EIGHT PRIORITY AREAS

The Eight Priority Areas

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

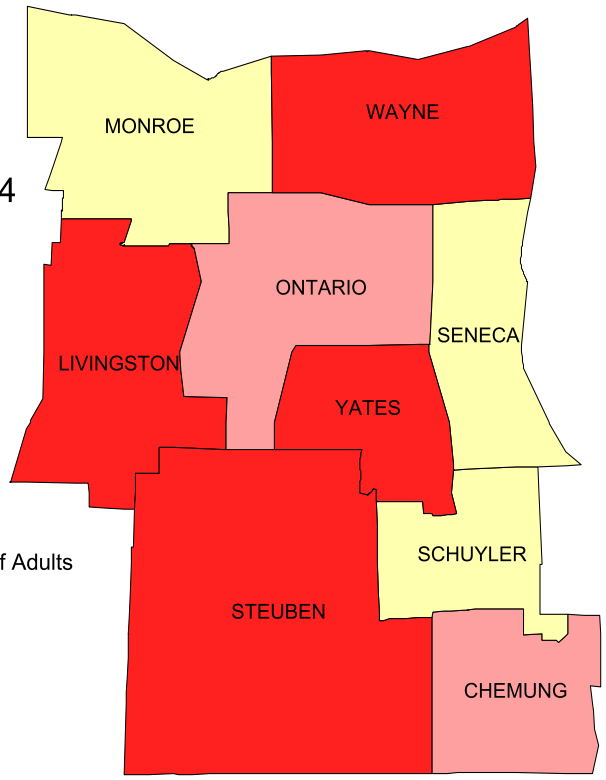
PRIORITY AREA 1: OBESITY

Obesity

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

Percent of Adults who are Obese in Finger Lakes Region

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



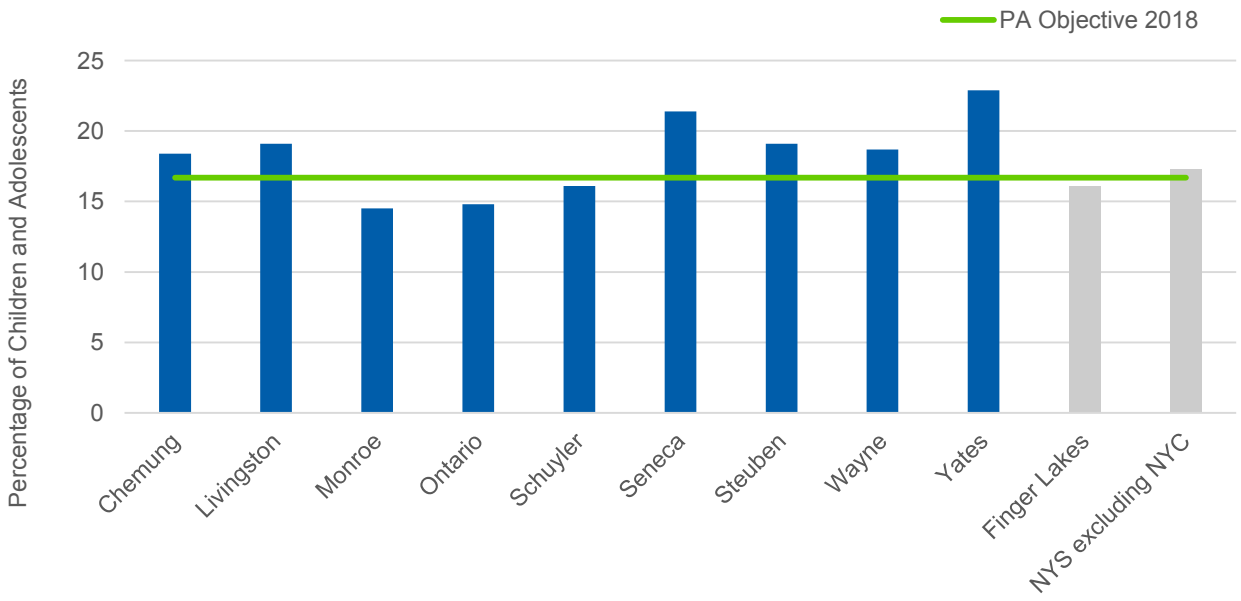
The Prevention Agenda Objective for 2018 is 23.2% of Adults

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

Obesity

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

Percentage of Children and Adolescents who are Obese



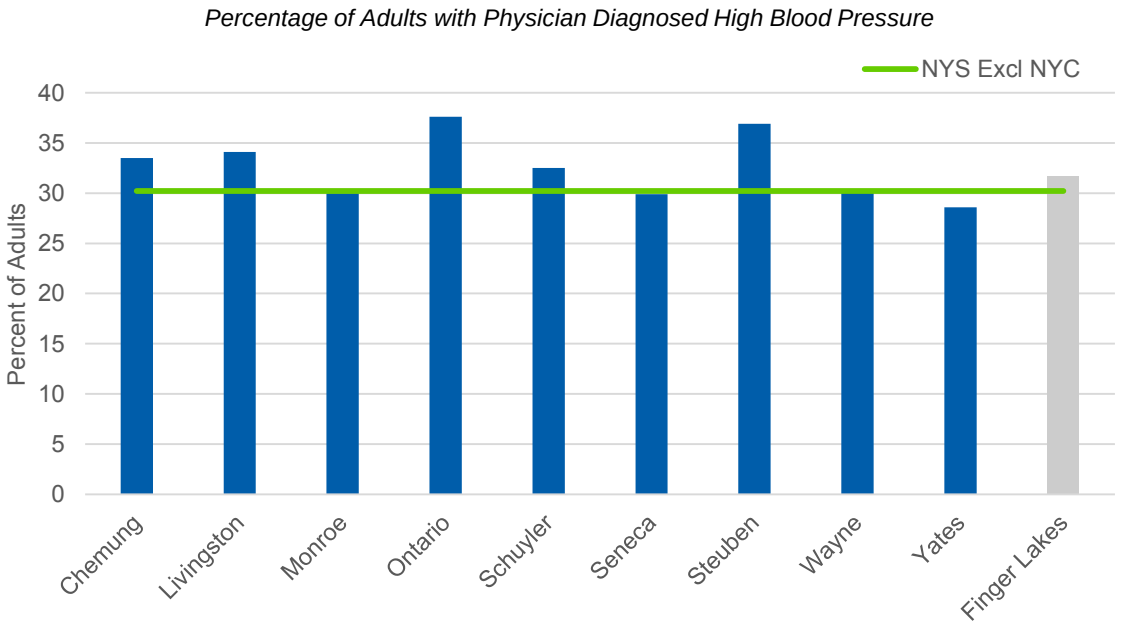
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2012-2014

PRIORITY AREAS 2-4: CHRONIC DISEASE

HYPERTENSION, DIABETES, AND HEART DISEASE

Chronic Disease- Hypertension

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

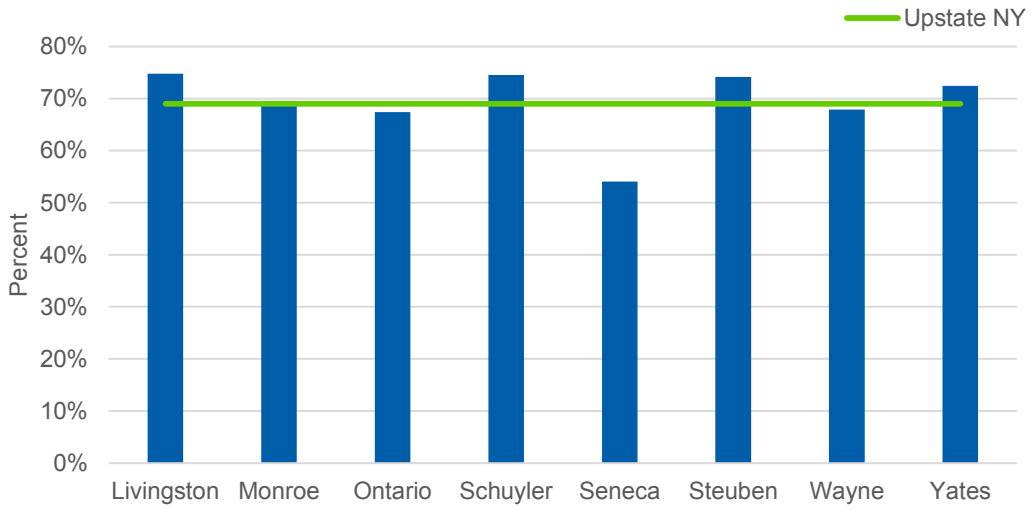


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Chronic Disease- Hypertension

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

Hypertension Control Rates, June 2015

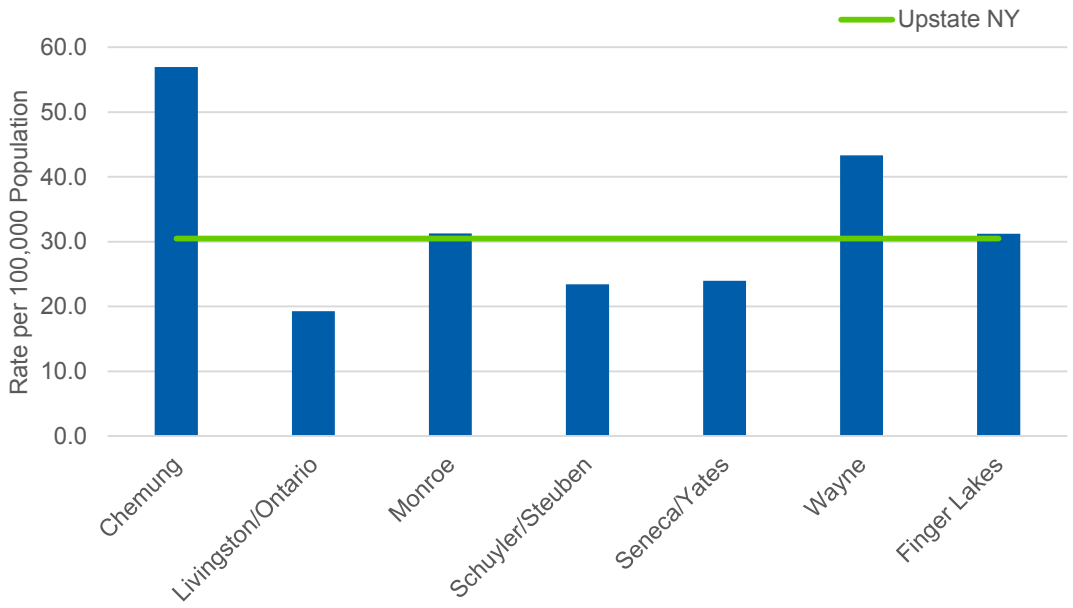


Data Source: FLHSA/RBA High Blood Pressure Registry, June 2015
Note: Chemung has been excluded due to small sample.

Chronic Disease- Hypertension

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

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

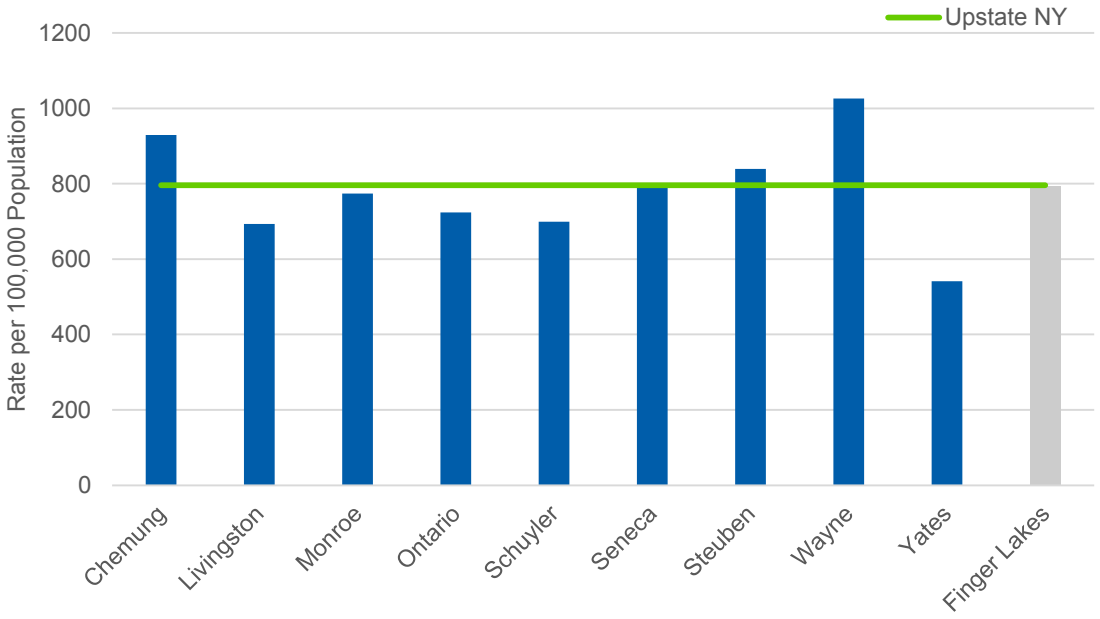


Data Source: SPARCS, 2013
Hypertension as a primary or cormorbidity diagnosis

Chronic Disease- Heart Disease

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

Rate of Inpatient Heart Disease Admissions per 100,000 Population

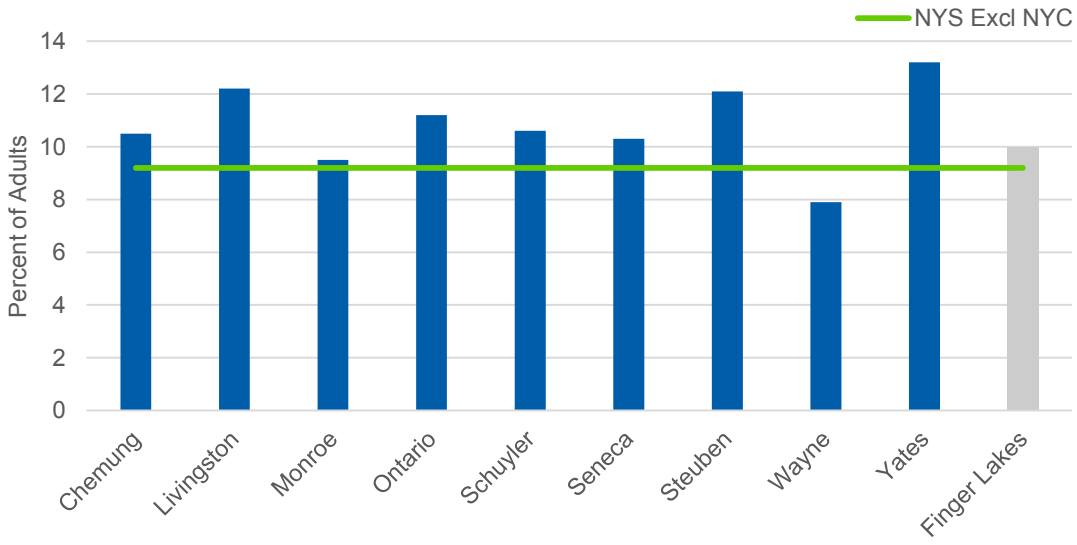


Data Source: SPARCS, 2013

Chronic Disease: Diabetes

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

Percentage of Adults with Physician Diagnosed Diabetes

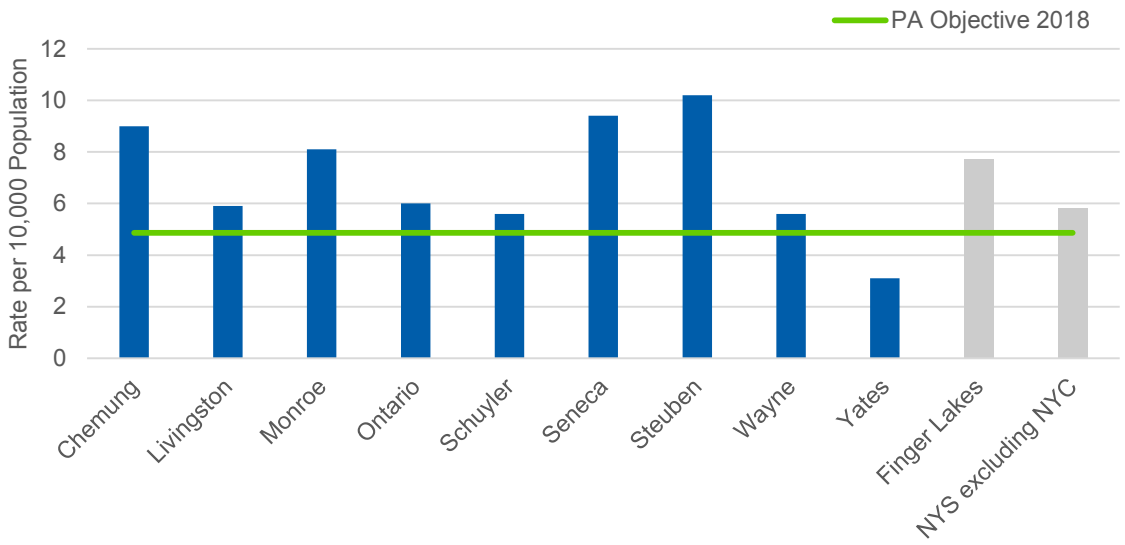


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Chronic Disease: Diabetes

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

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

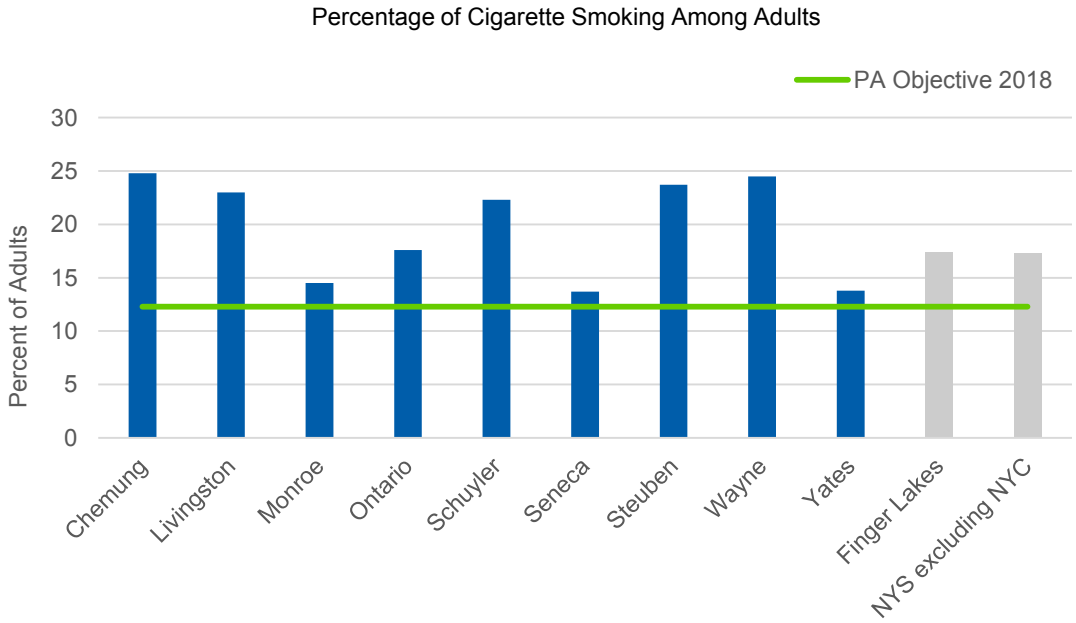


Data Source: New York State Prevention Agenda, 2011-2013

PRIORITY AREA 5: TOBACCO USE

Tobacco Use

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

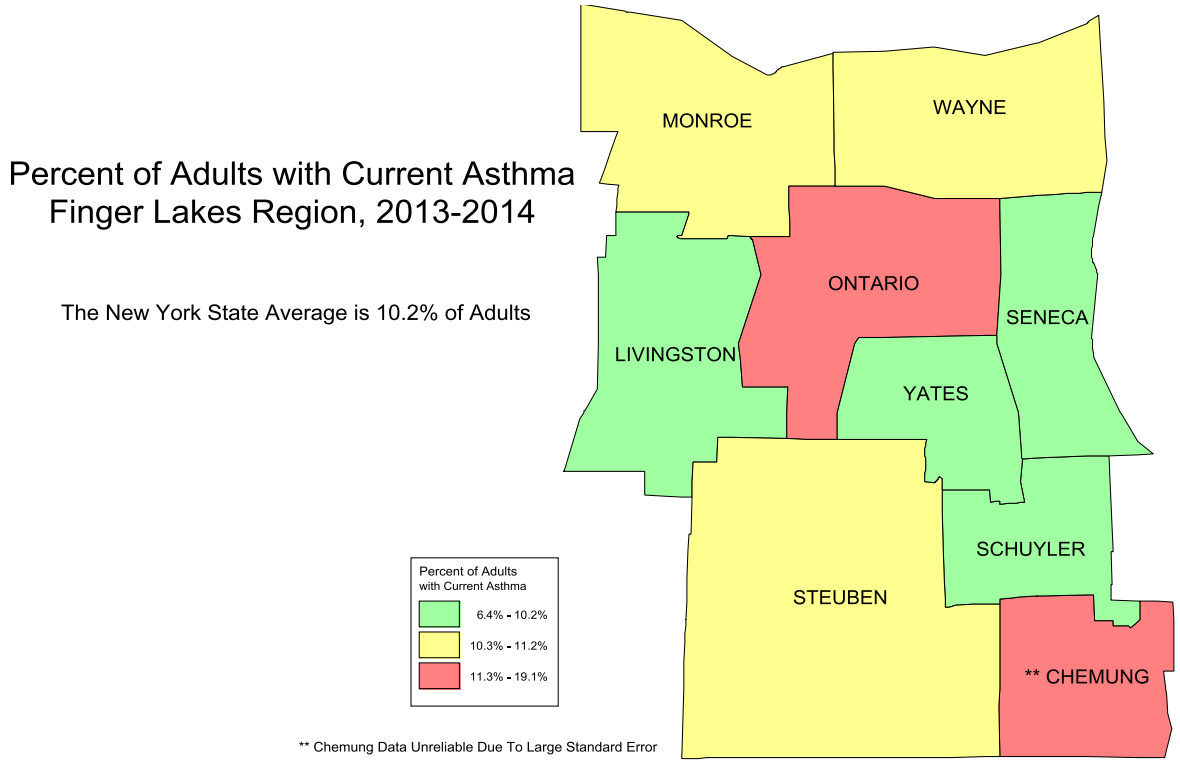


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Tobacco Use

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

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

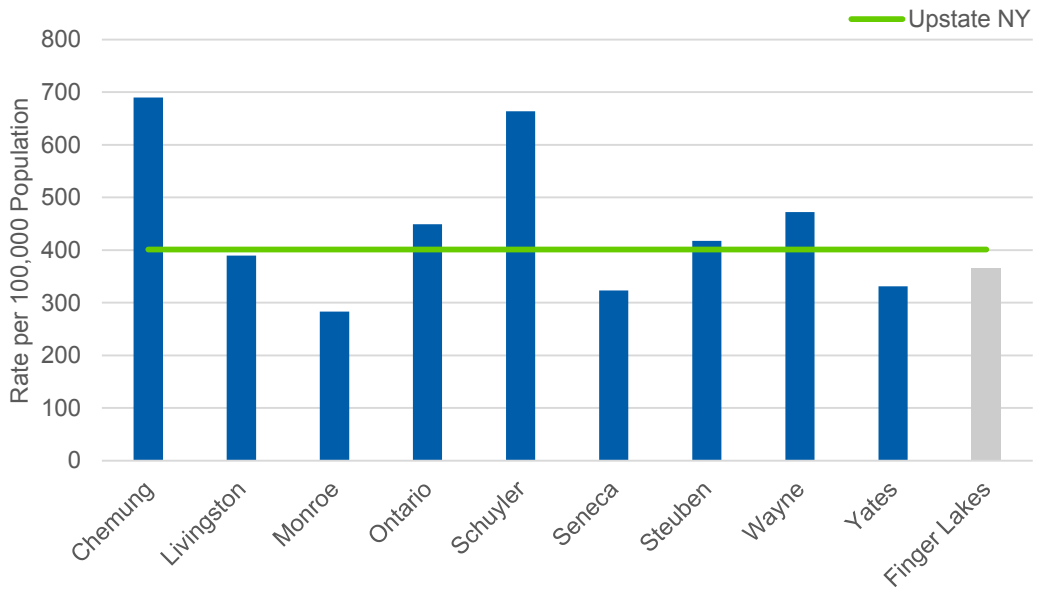


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Tobacco Use

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

Rate of Respiratory Prevention Quality Indicators

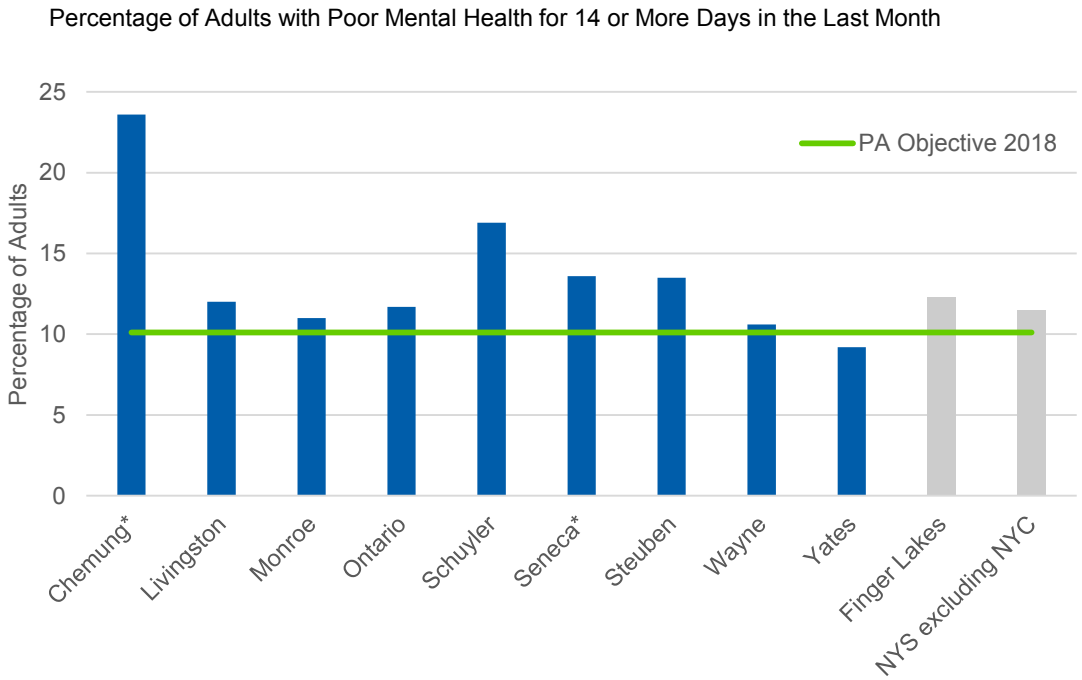


Data Source: SPARCS, 2013

PRIORITY AREA 6: BEHAVIORAL HEALTH

Behavioral Health

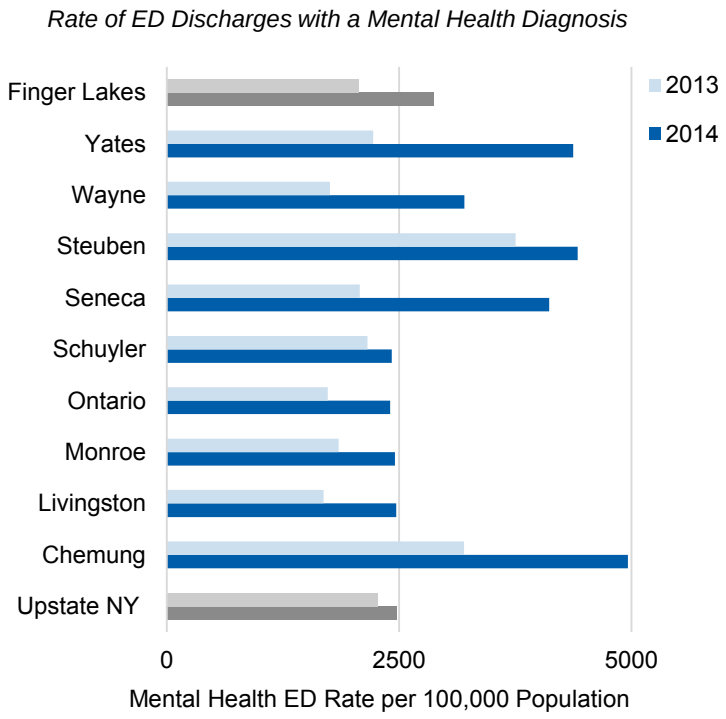
- Rates of poor mental health in the region are highest in Chemung and Schuyler County.

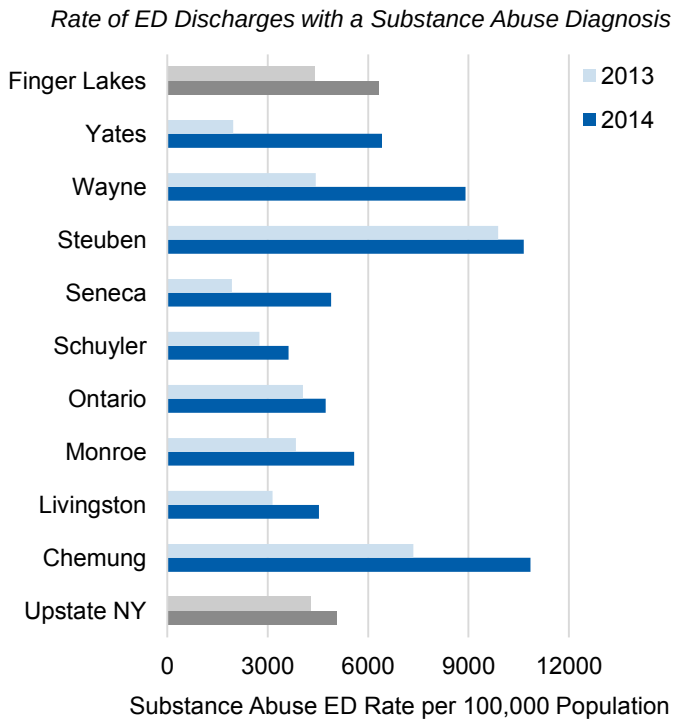


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error.

Behavioral Health

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



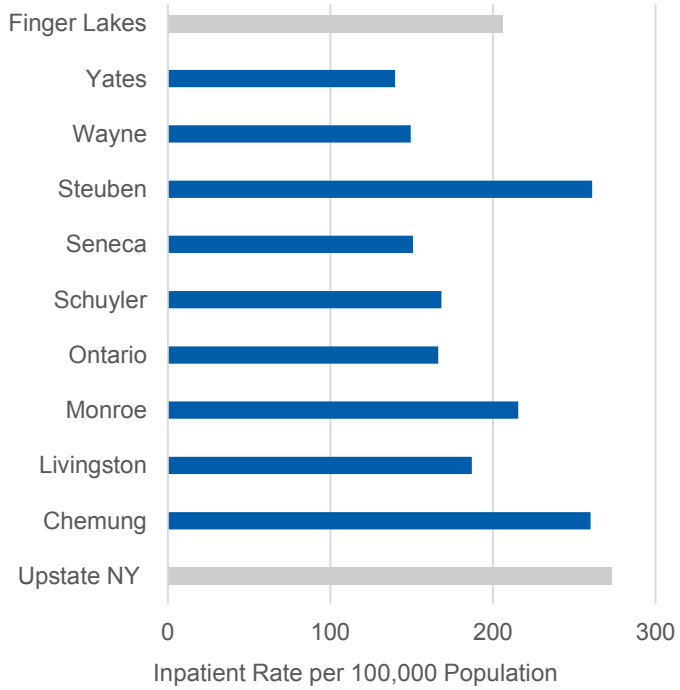


Data Source: SPARCS, 2013-2014. Diagnosis includes primary or comorbidity

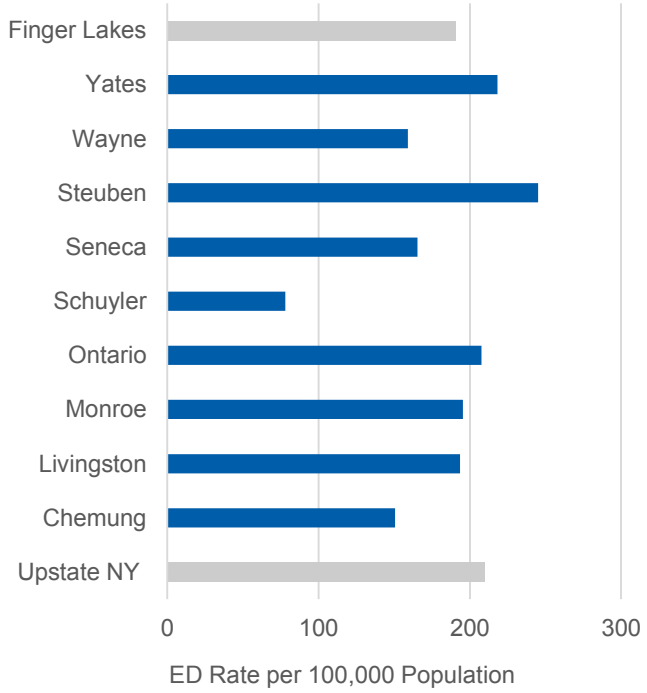
Behavioral Health

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

Rate of Inpatient Admissions with an Opiate Diagnosis



Rate of ED Discharges with an Opiate Diagnosis

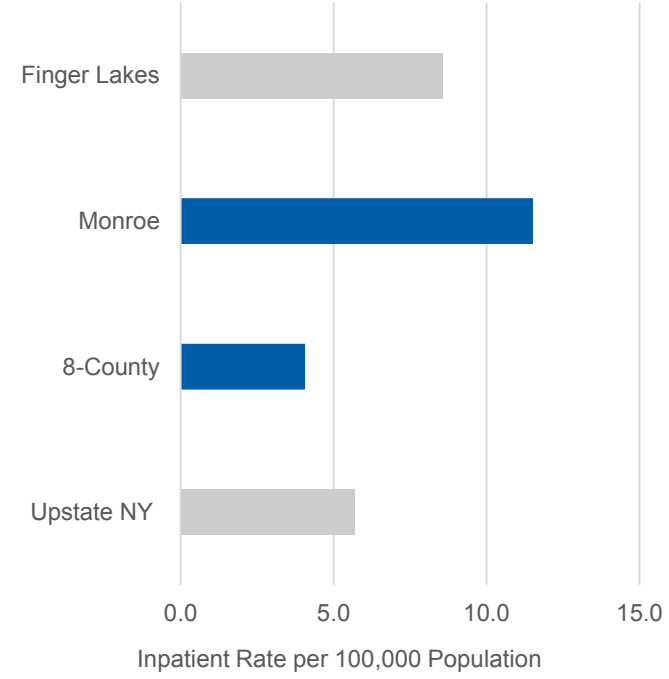


Data Source: SPARCS, 2014

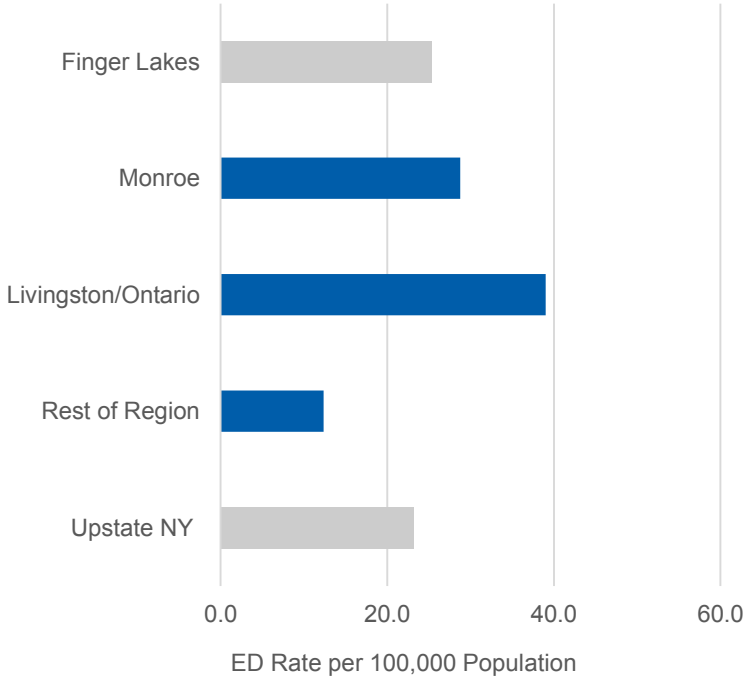
Behavioral Health

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

Rate of Inpatient Admissions with a Heroin Overdose Diagnosis



Rate of ED Discharges with a Heroin Overdose Diagnosis

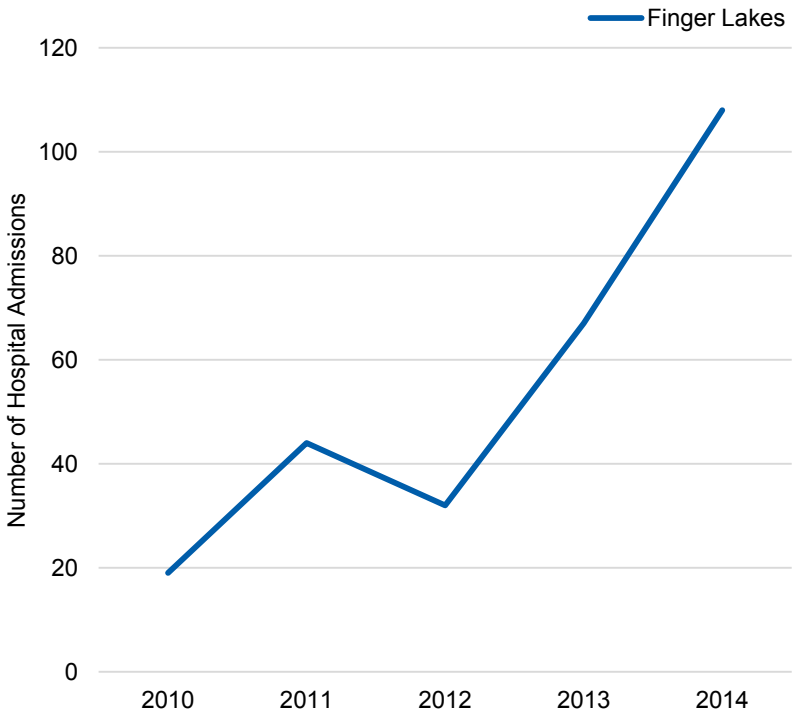


Data Source: SPARCS, 2014

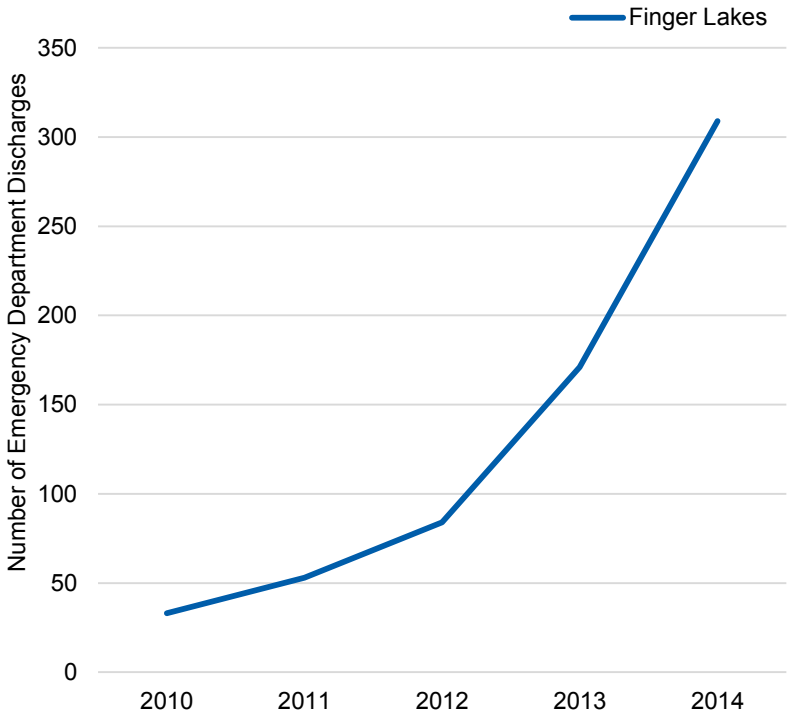
Behavioral Health

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

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



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

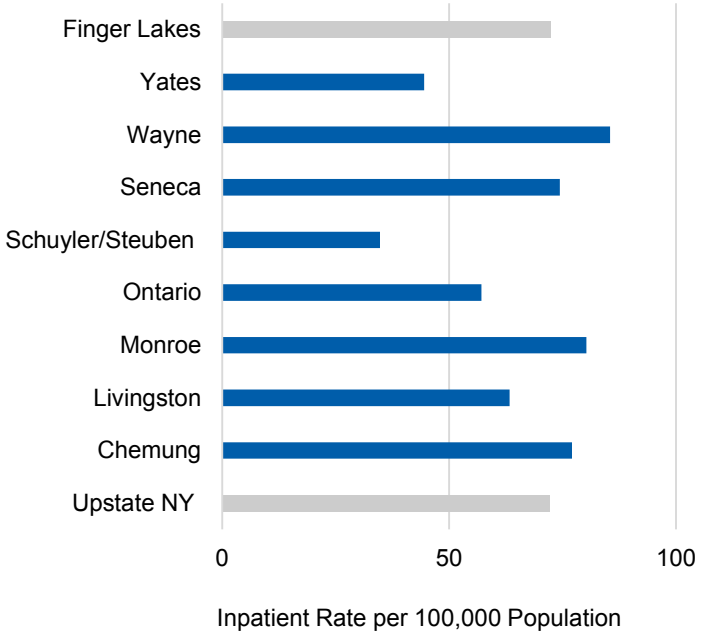


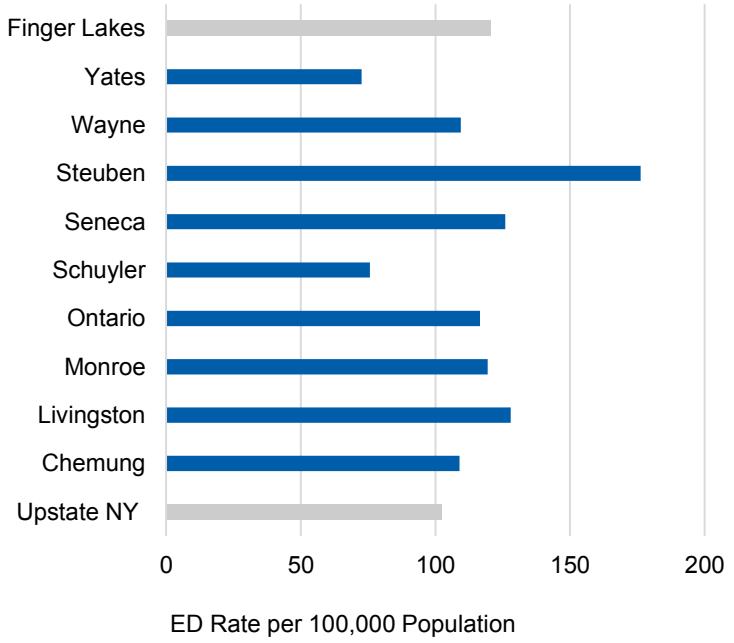
Data Source: SPARCS, 2010-2014

Behavioral Health

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

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

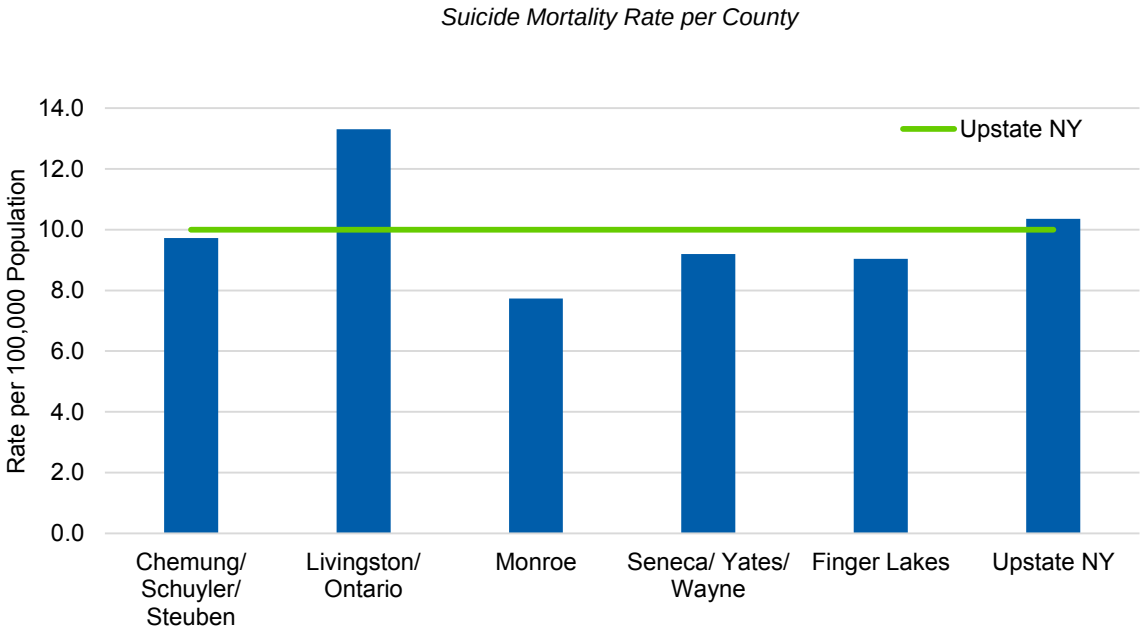




Data Source: SPARCS, 2014

Behavioral Health

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



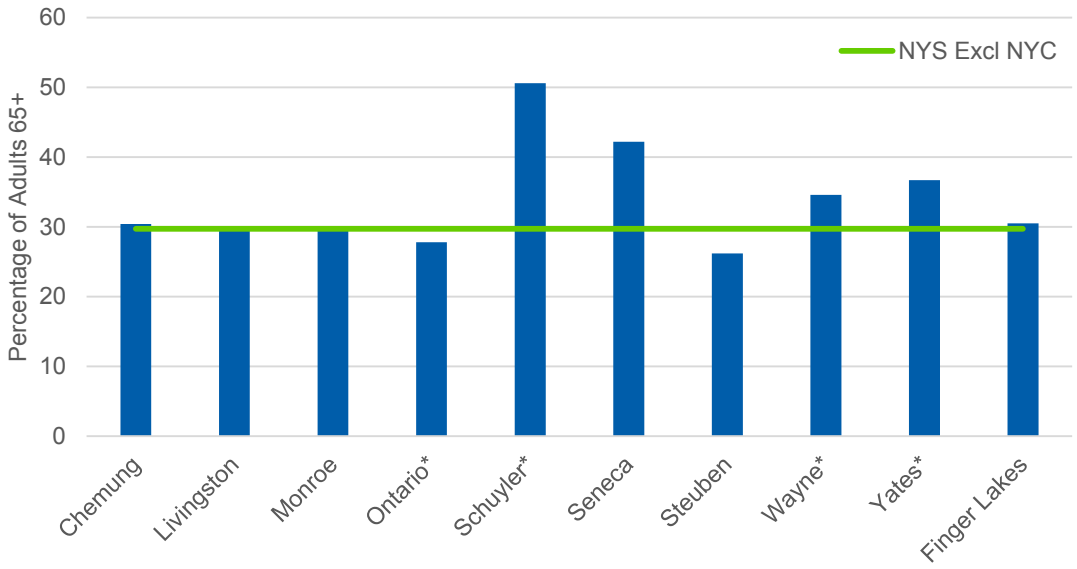
Data Source: New York State Department of Health Vital Statistics, 2013

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

Falls, Slips and Trips

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

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

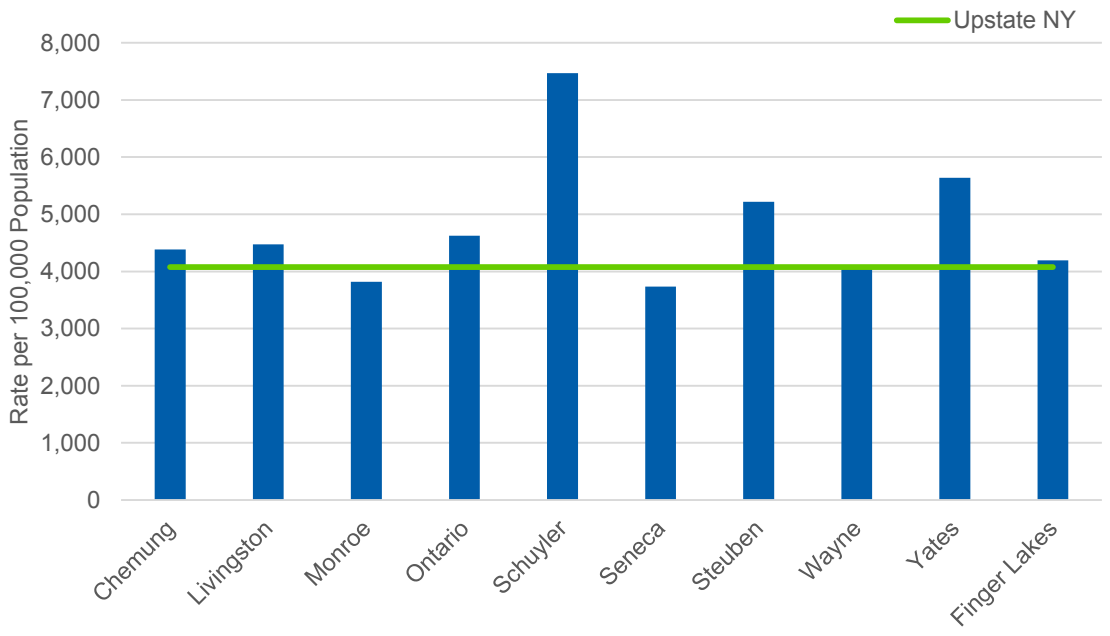


Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014
*Unreliable due to large standard error

Falls, Slips and Trips

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

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



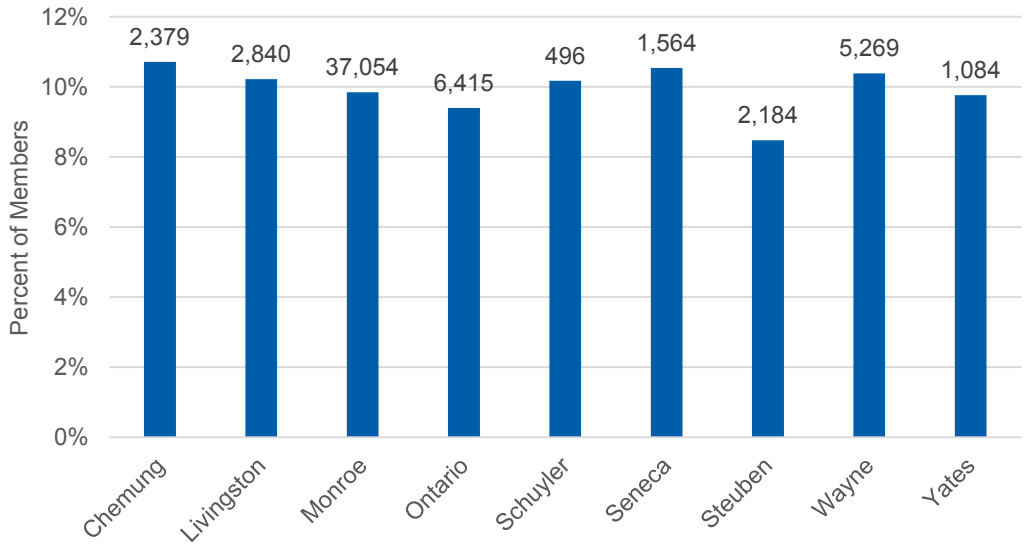
Data Source: SPARCS, 2013

PRIORITY AREA 8: LOW BACK PAIN

Low Back Pain

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

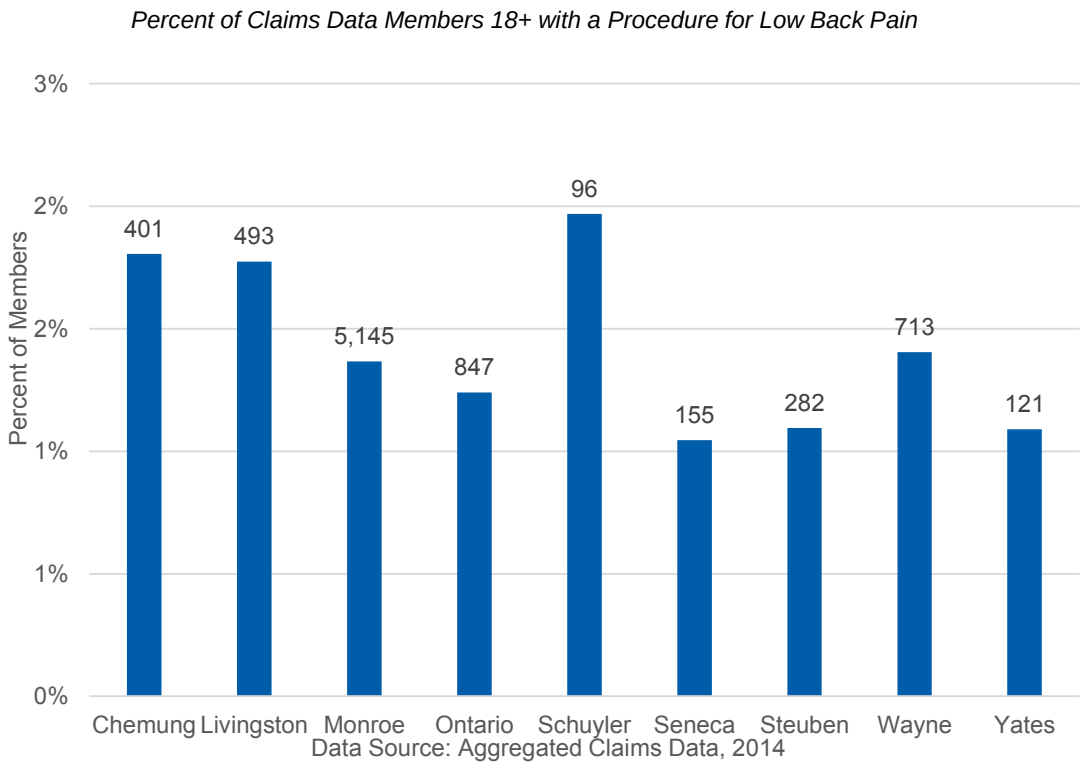
Percent of Claims Data Members 18+ with a Diagnosis for Low Back Pain



Data Source: Aggregated Claims Data, 2014

Low Back Pain

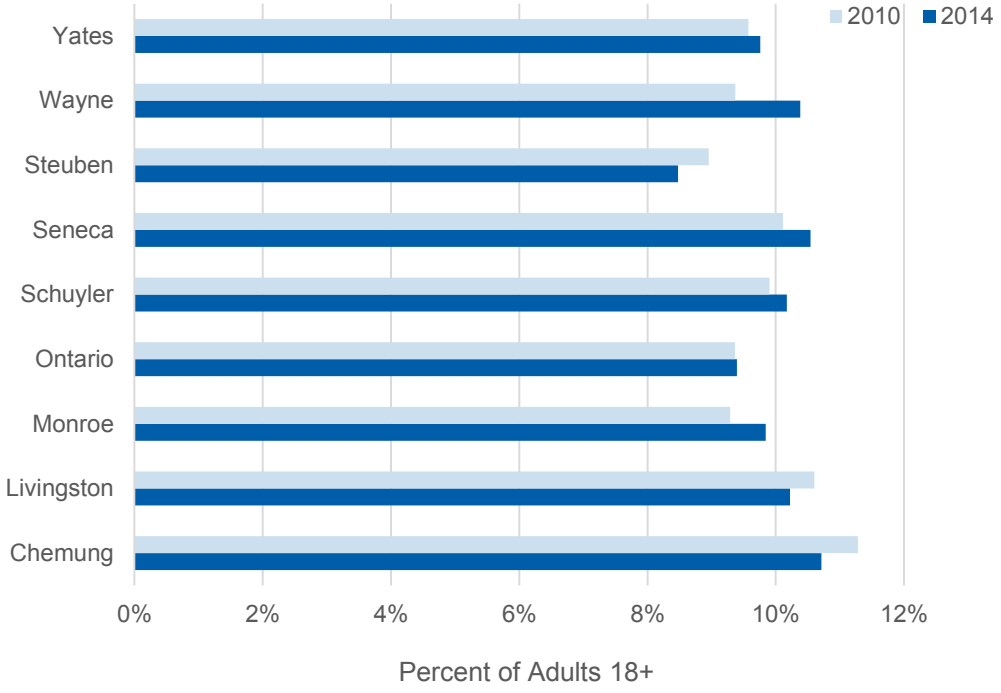
- Percent of the members in the FLHSA claims database with a procedure code for low back pain (i.e. spinal/nerve injections).



Low Back Pain

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

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



Data Source: Aggregated Claims Data, 2010-2014

KEY FINDINGS

Key Findings

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

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

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

www.flhsa.org

QUESTIONS?

Finger Lakes Health Systems Agency

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

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

Steuben County Health Needs Focus Groups

Agenda

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

S2AY Rural Health Network

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

Community Health Assessment/Community Service Plans

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

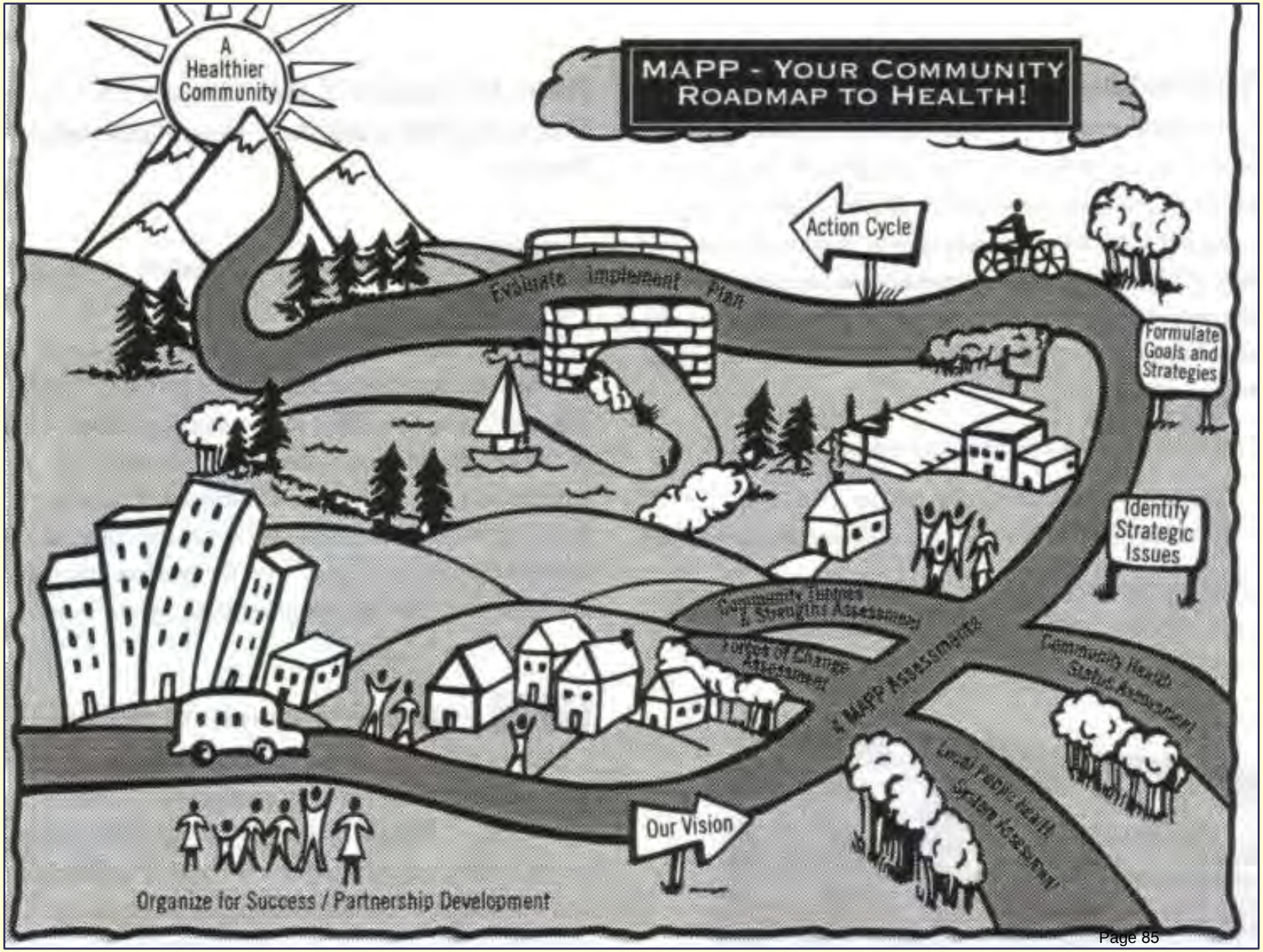
Joint CHA/CHIP/CSP

- This year, Steuben County Public Health, Corning Hospital, Ira Davenport Hospital and St. James Mercy Hospital are all working together to create one document that assesses needs and develops plans to address them over the next three years

Help!!!!

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

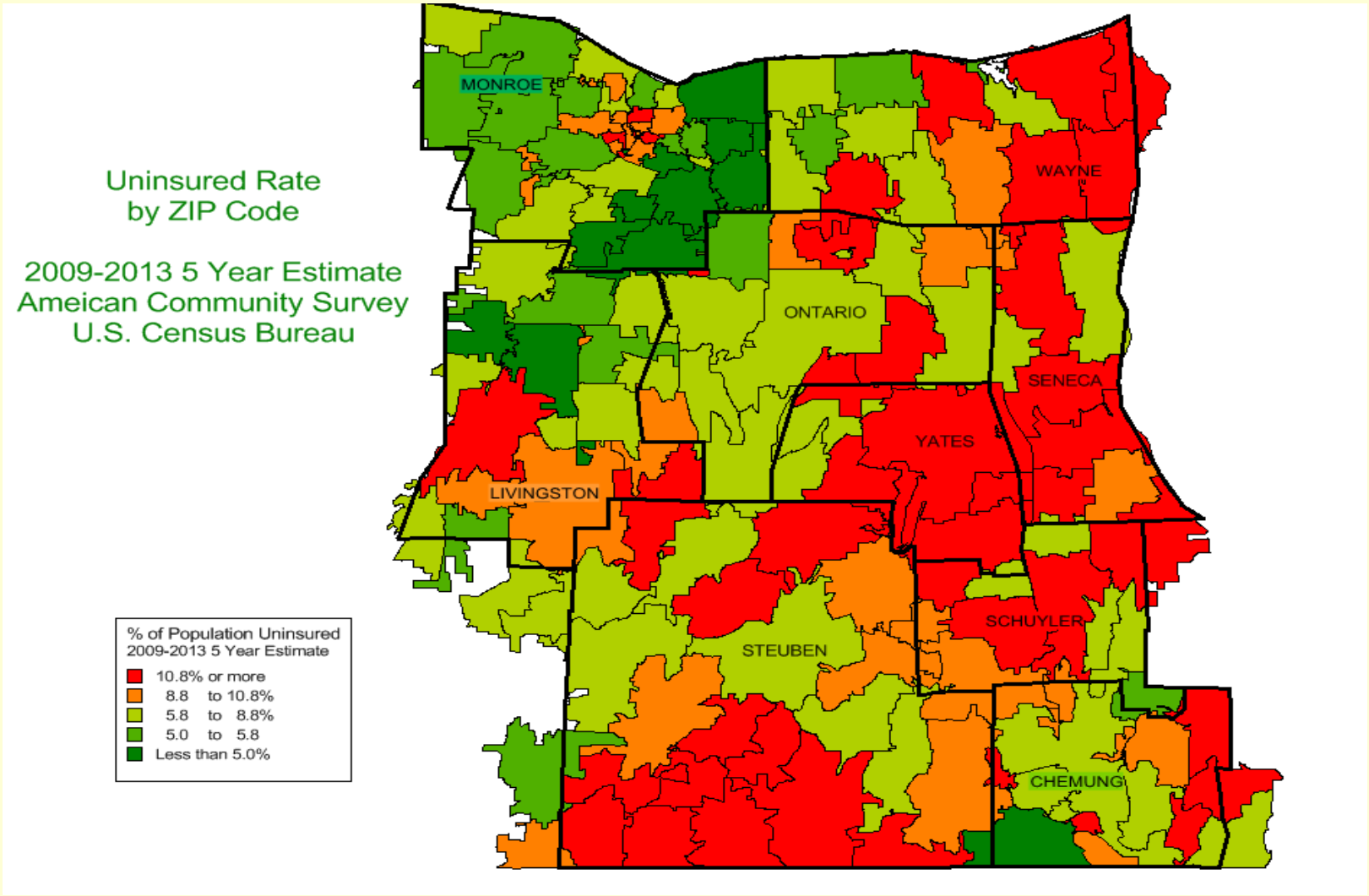
MAPP - Mobilizing for Action through Planning and Partnerships



Data says…

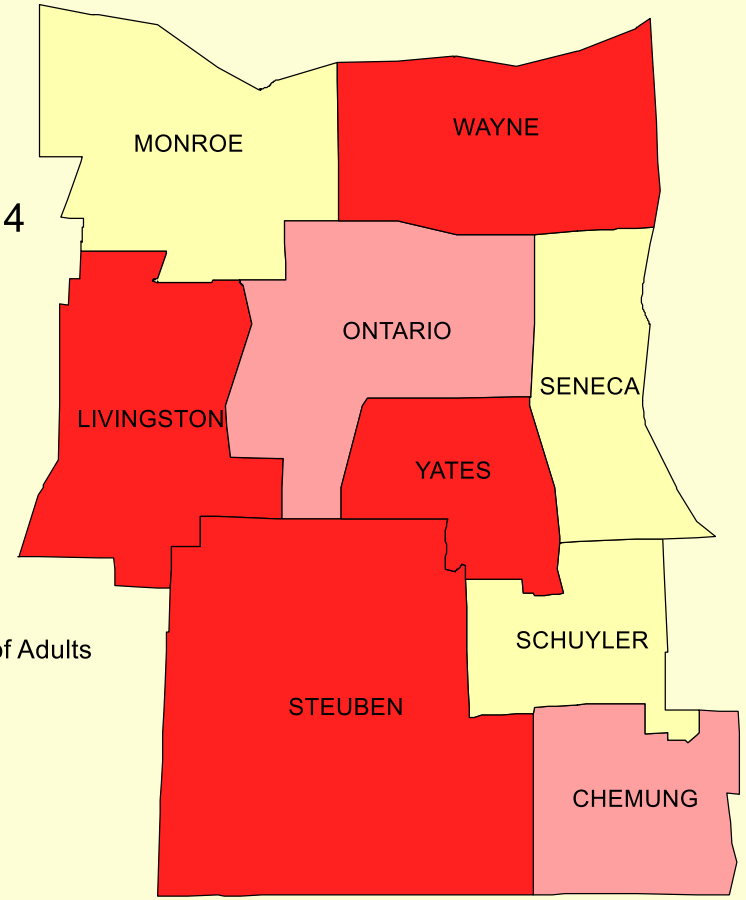
- A data report for the entire region was prepared by a Rochester-based group called the Finger Lakes Health Systems Agency (FLHSA) and is hot off the press
- We will share some of it with you here, along with a few other pieces of information, to get us started

Data says…high rates of uninsured



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

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



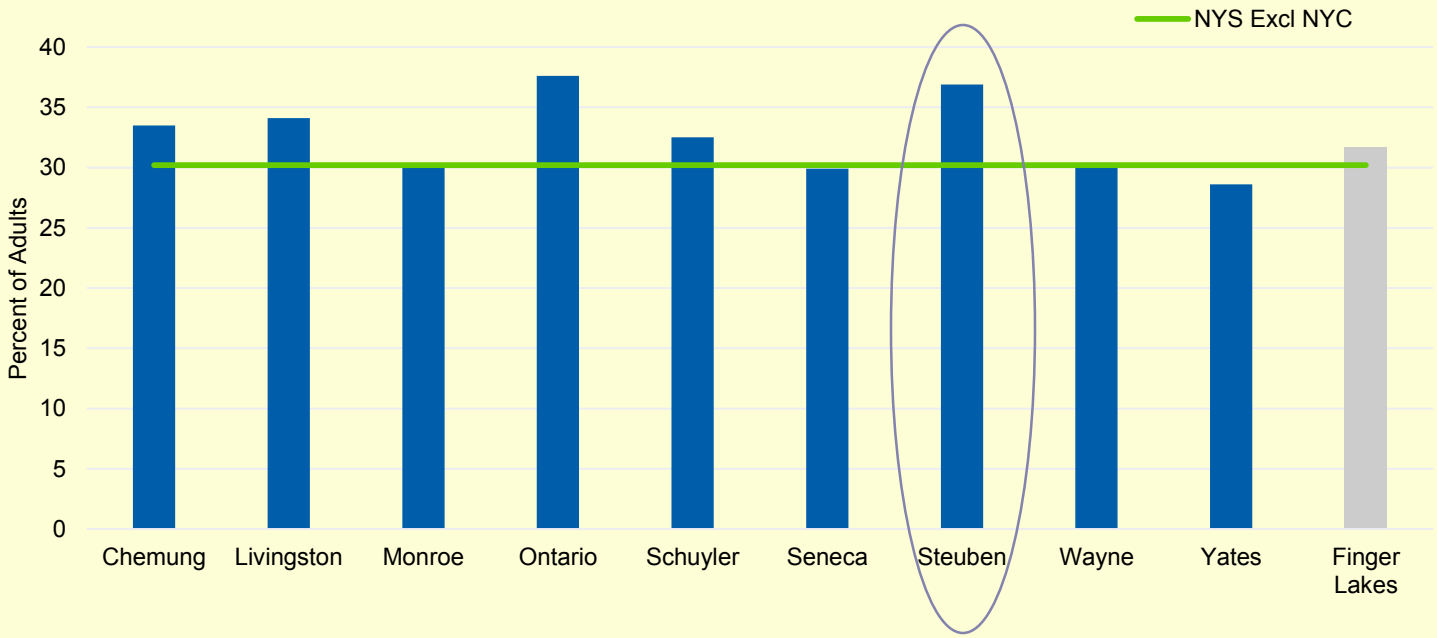
The Prevention Agenda Objective for 2018 is 23.2% of Adults

Why is obesity important?

Can lead to many other problems including:

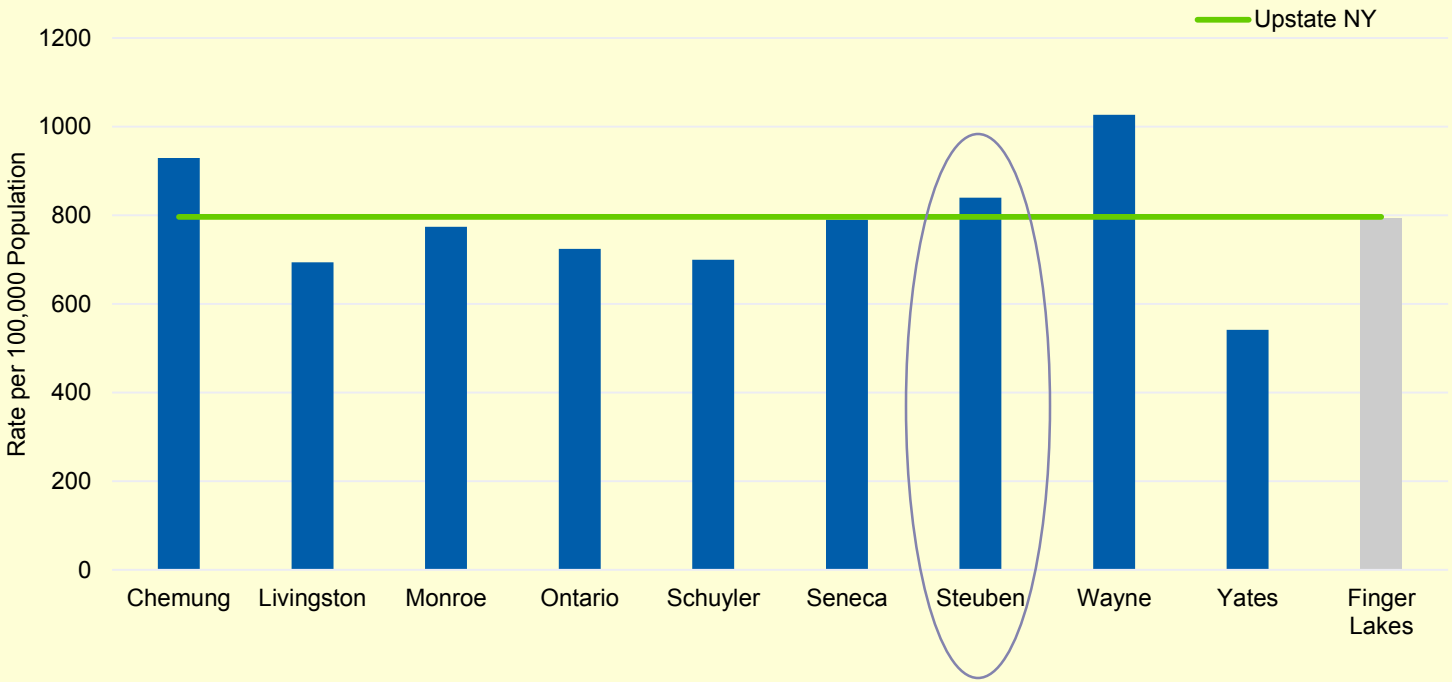
- Heart disease
- Hypertension
- Diabetes
- Lower back pain
- Arthritis
- High cholesterol
- Several forms of cancer
- And in fact, several of these things are also higher than we would like to see them in Steuben County…

Data says…high percentage (37%) of adults with physician-diagnosed high blood pressure



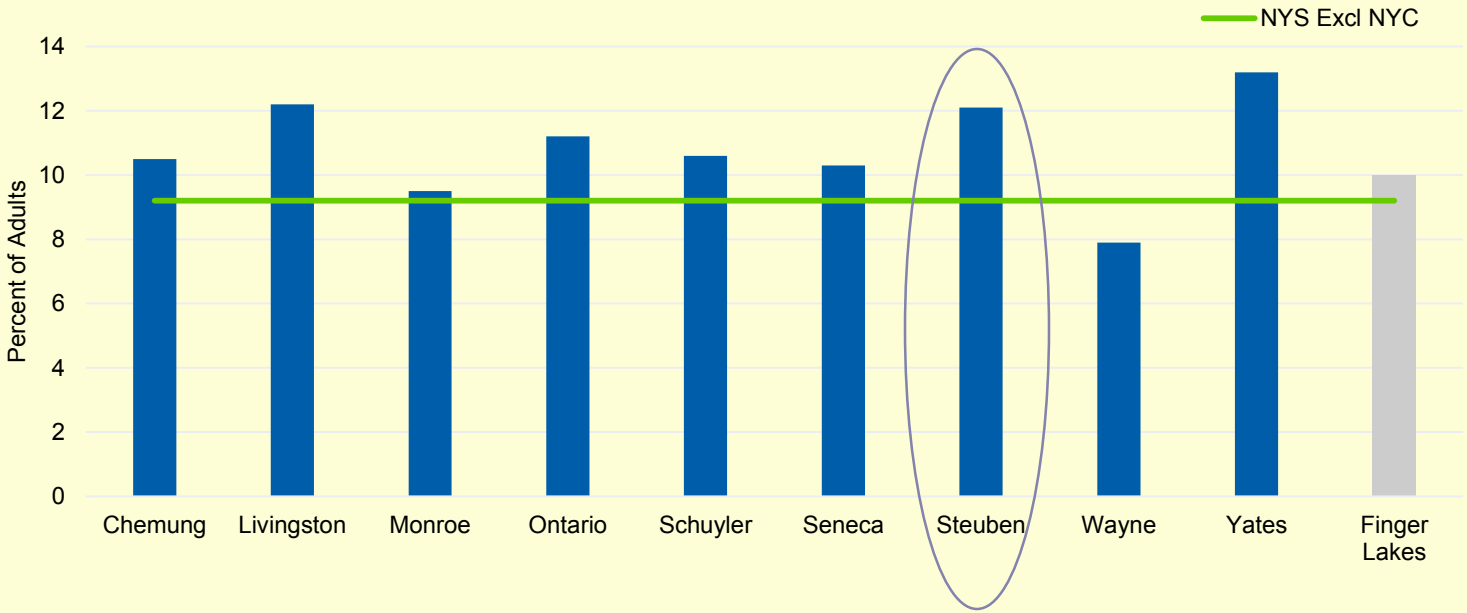
Data Source: Expanded Behavioral Risk Factor Surveillance System, 2013-2014

Data says…. Slightly above average rate for heart disease



Data Source: SPARCS, 2013

Data says….Percentage of adults with physician diagnosed diabetes – 12.1%



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

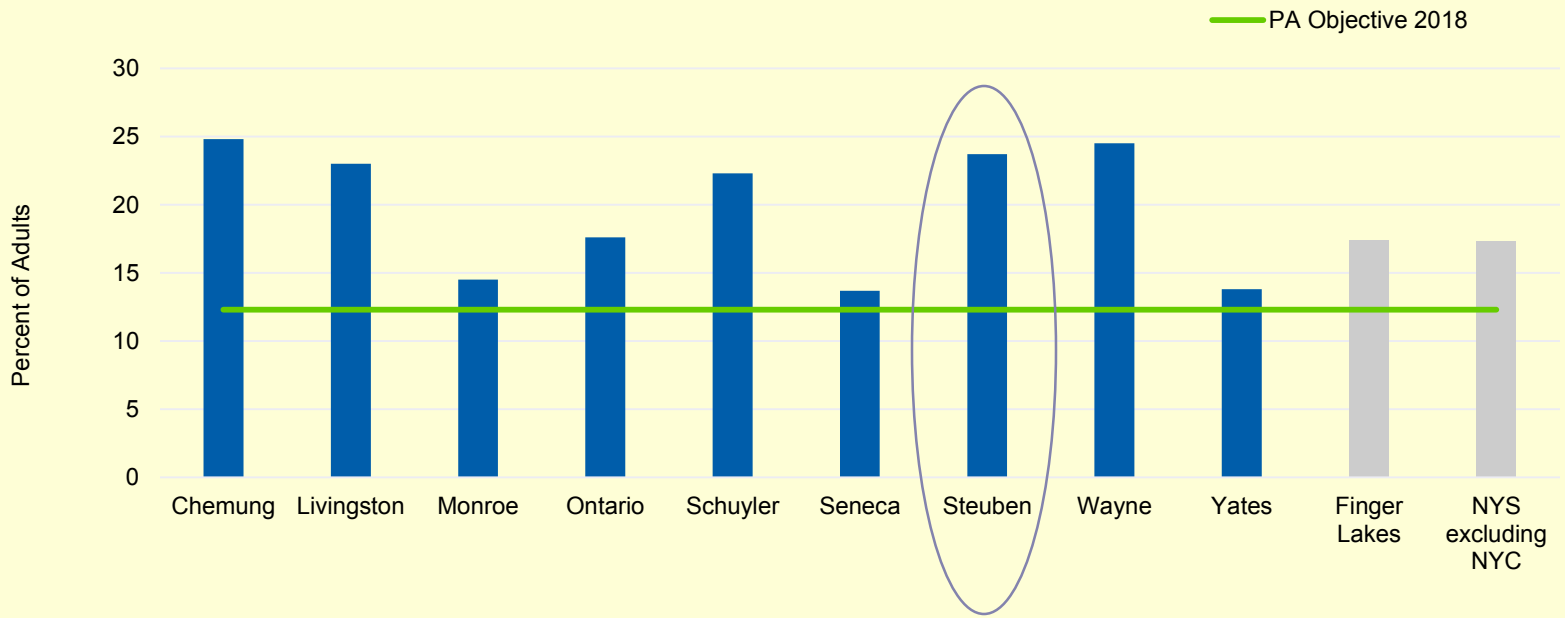
Data says…Percent of Claims Data Members 18+ with a Diagnosis for Low Back Pain, 2010-2014

Data Source: Aggregated Claims Data, 2010-2014

Other health problems

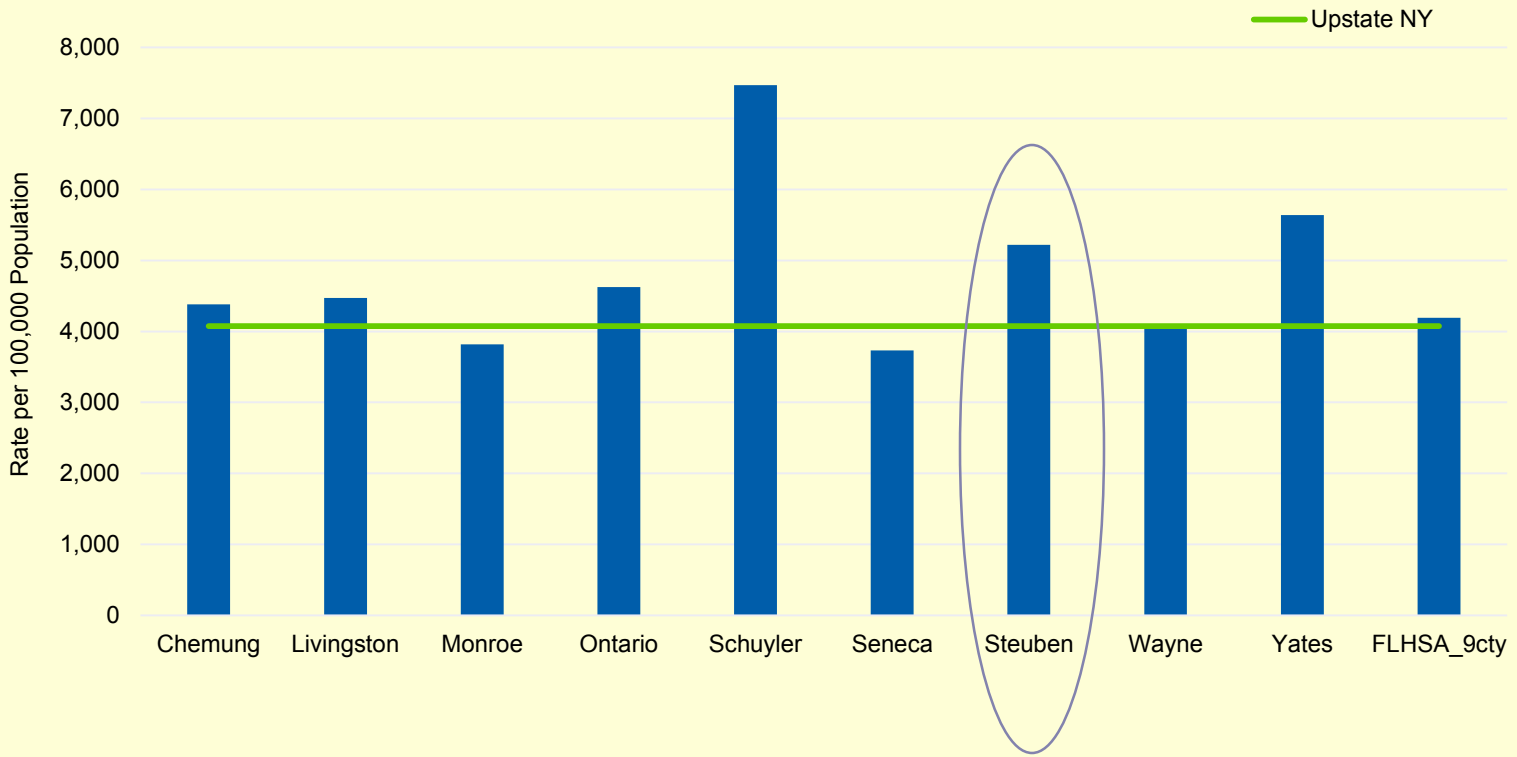
- In addition to obesity and the problems related to that (heart disease, diabetes, hypertension and lower-back pain), there are other problems in Steuben County where we have above average rates:
- Tobacco use- related to cancer, asthma/COPD and hypertension
- Behavioral health problems
- Falls – for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

Data says… Percentage of cigarette smokers in Steuben = 23.7%



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

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

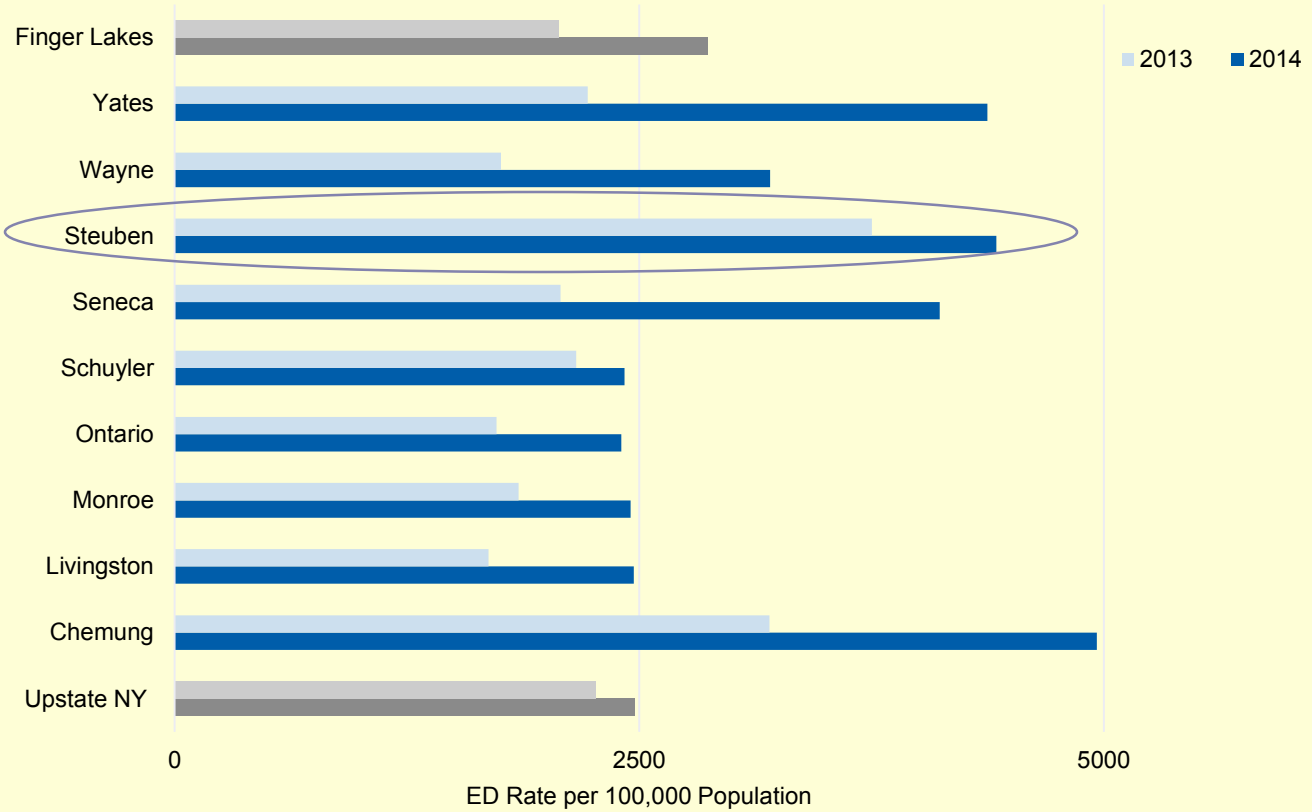


Data Source: SPARCS, 2013

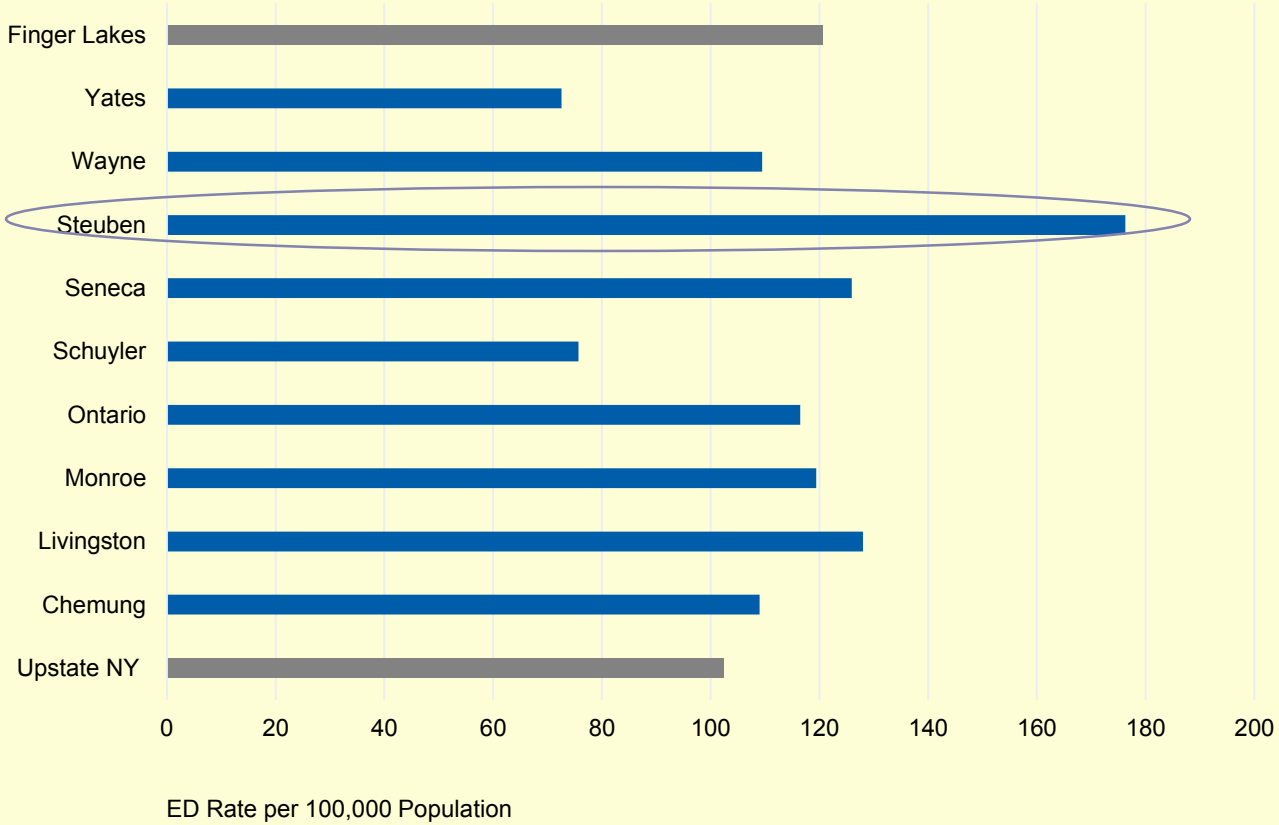
Behavioral Health

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

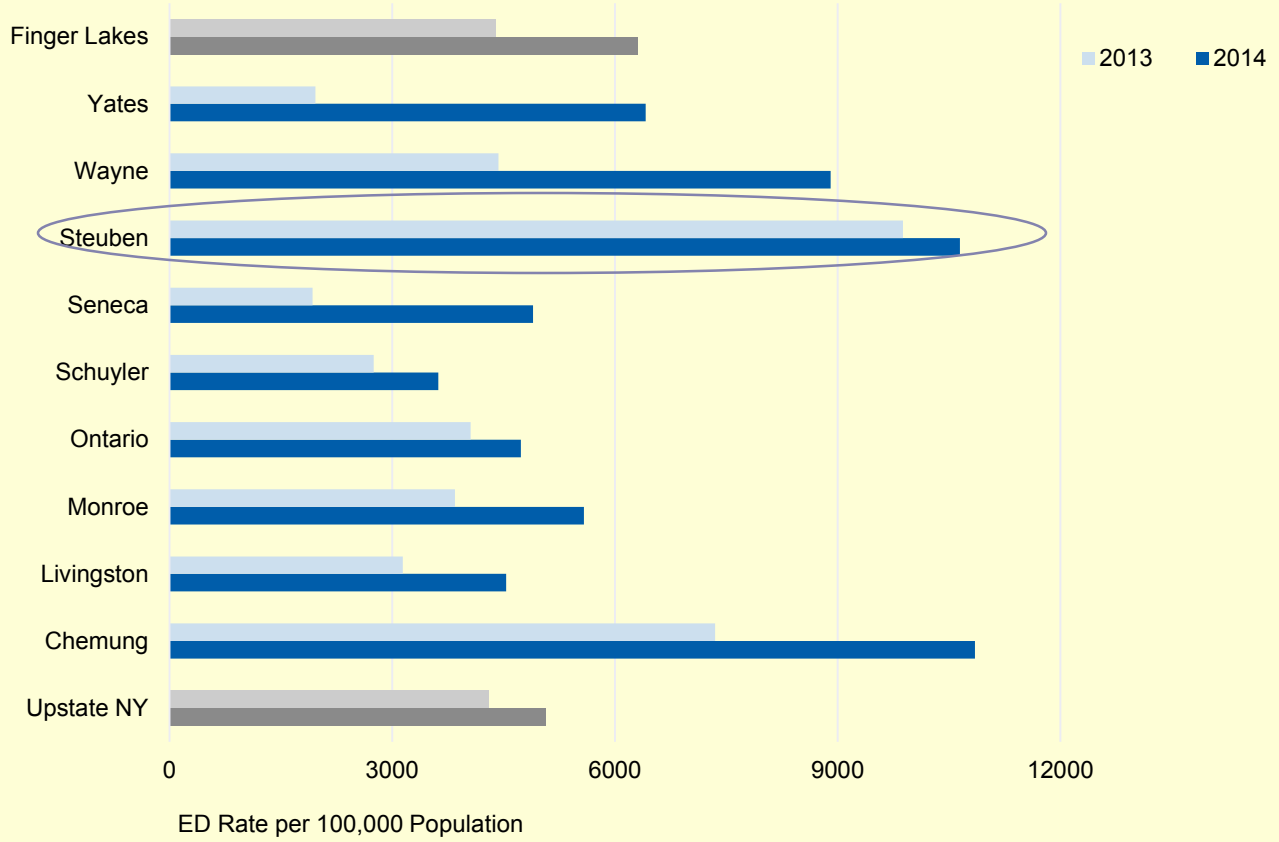
Mental health – ED discharges with a mental health diagnosis



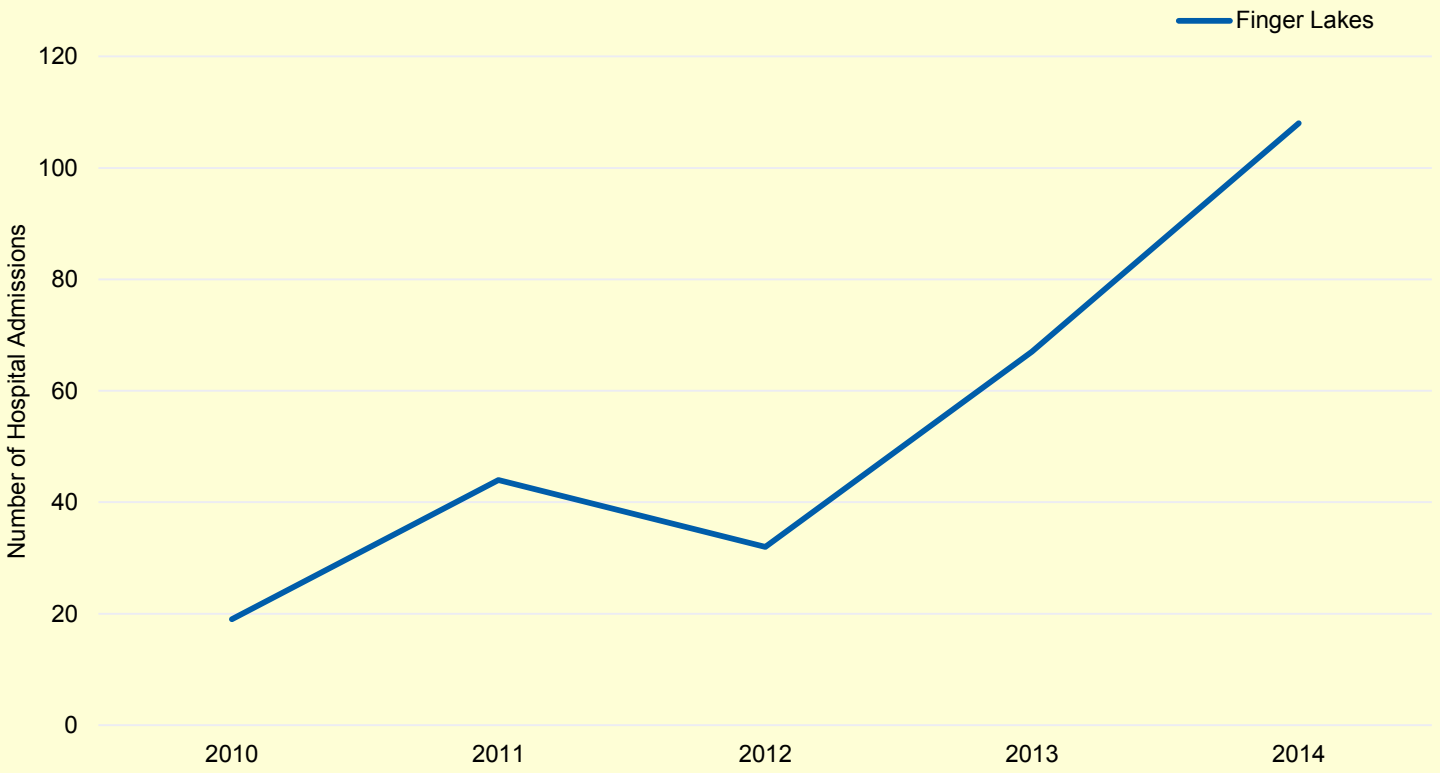
Rate of Inpatient and ED Discharges with a Self-Inflicted Injury Diagnosis



Substance abuse- ED visits with a substance abuse diagnosis

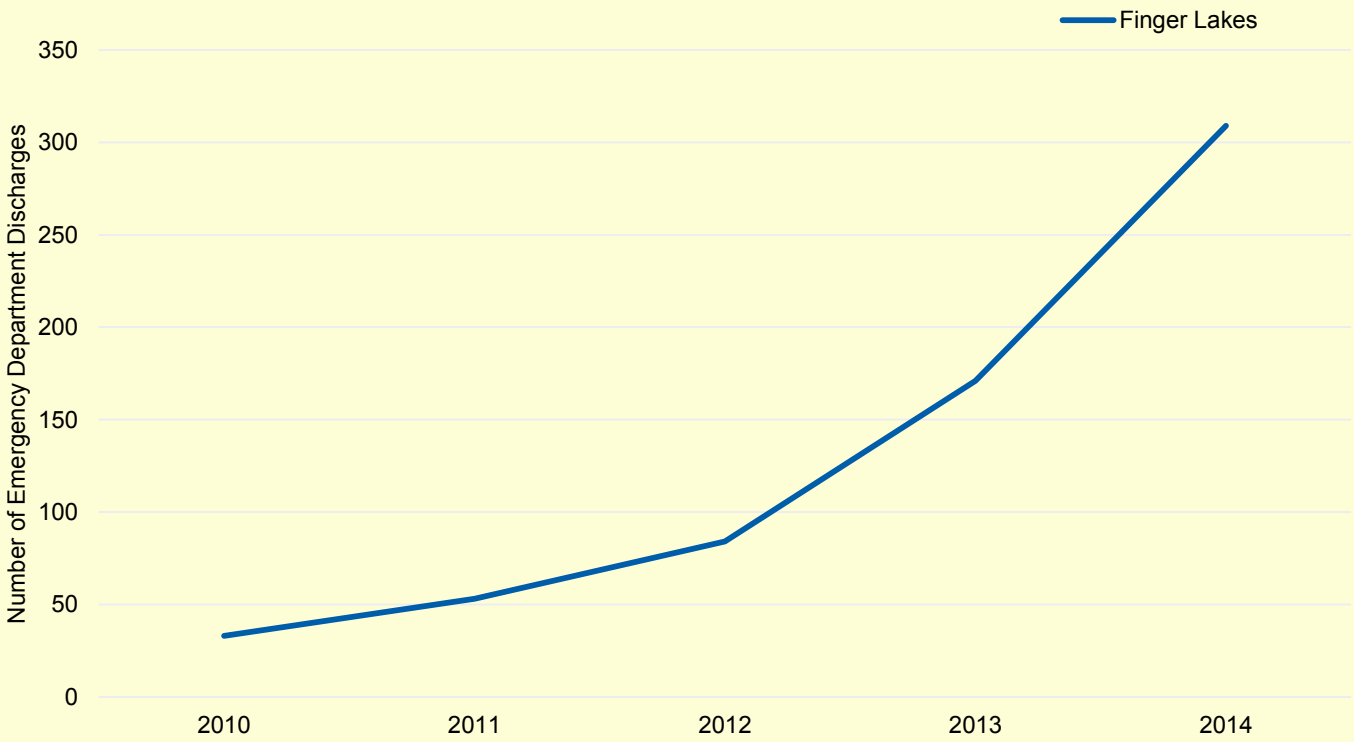


Heroin- number of heroin overdose admissions for the Finger Lakes (9 county) region



Data Source: SPARCS, 2010-2014

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



Data Source: SPARCS, 2010-2014

Leading Causes of Death by County, New York State, 2013

Source: Vital Statistics Data as of March 2015

County and # of Deaths	#1 Cause of Death and # of Deaths Age-adjusted Death Rate	#2 Cause of Death and # of Deaths Age-adjusted Death Rate	#3 Cause of Death and # of Deaths Age-adjusted Death Rate	#4 Cause of Death and # of Deaths Age-adjusted Death Rate	#5 Cause of Death and # of Deaths Age-adjusted Death Rate
Steuben Total: 924	Cancer 231 173 per 100,000	Heart Disease 207 151 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 52 38 per 100,000	Stroke 39 30 per 100,000	Unintentional Injury 35 32 per 100,000
Rest of State Total: 95,595	Heart Disease 26,539 178 per 100,000	Cancer 22,611 160 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 5,124 36 per 100,000	Stroke 4,226 29 per 100,000	Unintentional Injury 3,916 31 per 100,000
New York State Total: 147,419	Heart Disease 43,112 181 per 100,000	Cancer 35,074 153 per 100,000	Chronic Lower Respiratory Diseases (CLRD) 6,977 30 per 100,000	Stroke 5,959 25 per 100,000	Unintentional Injury 5,552 26 per 100,000

Community Input
Answer four questions:

- What are we missing in our assessment to date?
- What factors do you think are influencing health?
- What community strengths contribute to the health of Steuben County residents?
- What do YOU think we should do to solve these problems?

What are we missing?

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

WHAT TRENDS OR FACTORS ARE INFLUENCING HEALTH

Can be grouped into categories such as:

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

ASSETS

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

What would you do?

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

Next Steps

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

Five Prevention Agenda Priorities

1. **Prevent Chronic Diseases**
2. **Promote a Healthy and Safe Environment**
3. **Promote Healthy Women, Infants and Children**
4. **Prevent HIV, STIs and Vaccine Preventable Diseases**
5. **Promote Mental Health and Prevent Substance Abuse**

THANK YOU

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

Steuben County Focus Group Summary

1. What are we missing in our assessment to date?
    a. E-cigarettes
    b. Food security/insecurity
    c. Drug addicted births
    d. Gestational diabetes
    e. Tobacco use during pregnancy
    f. Self-inflicted injuries
    g. Transportation
    h. Unemployment
    i. Mental Health and Substance Abuse
    j. Incarceration
    k. Socioeconomic status
    l. Poverty
    m. Access to Doctors
    n. Available resources
    o. Cancer
    p. Dental
    q. Opioids
    r. Synthetic drug use
    s. Suicide
    t. Veterans Hospital
    u. Improper utilization of ED
2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Having energy
    b. Overall wellness
    c. Feeling optimistic
    d. Higher quality of life
    e. Disease or illness free
    f. Ability to be active
    g. Decrease in chronic conditions
    h. Normal/within range BMI
    i. Access to trails/walking/opportunities to physical activity
    j. Educated - know about being healthy
    k. Access to healthy foods
    l. Access to information on healthy foods
    m. Positive health/social norms
    n. Supportive health environment
    o. Longevity
    p. Employment
3. What trends or factors are influencing the health of the residents?
    a. Economic problems

   b. Access to health care
   c. Media attention around health/diet
   d. Access to diagnostic testing
   e. E-cigarettes
   f. Homelessness
   g. Parent education
   h. Regionalization
   i. Rural setting
   j. Transportation
   k. Behavioral health/mental health needs
   l. Housing

4. What community strengths or assets contribute to the health of the residents?
   a. Fitness Center
   b. Opportunity for outdoor activities
   c. Trails and walking paths
   d. Open to policy change
   e. Youth sports programming
   f. Progressive Public Health Department
   g. IHS and 211
   h. Medical community
   i. SMART Steuben - collaboration
   j. Having multiple hospitals within the county
   k. Having a supportive legislature
   l. Supportive Press
   m. Senior center
   n. Corning Inc.
   o. Promote available data
   p. Arbor Housing
   q. Cornell Cooperative Extension
   r. Planned Parenthood
5. What would you do to address some of these problems?
   a. Policy change
   b. Educating parents
   c. Continue with a lot of community collaborative/initiatives
   d. More intramural programs
   e. Tap into school districts more - educate parents
   f. DSRIP efforts
   g. Increase telemedicine
   h. Tele-psychiatry
   i. Incentives for children to participate in activities, etc.
   j. Volunteer
   k. Networking
   l. Develop bus system

m. Insurance incentives for healthy behaviors

County:	Steuben
Group Name:	Corning Inc. Retiree Group
Date and Time:	March 09, 2016 - 10:00AM
# of Participants:	15

1. What are we missing in our assessment to date?
    a. Dental health, Medicaid population for children. Shortage of providers that take dental insurance such as Medicaid and CHP.
    b. Health Ministry serving uninsured and lower insured, now it's closed. Huge problem still, for dental care. Article in USA Today about dental health relating to other issues around health. Fluoride in water in Painted Post and Elmira but not in Corning.
    c. Opioid problem in county and region. Getting worse and a serious issue. 7 deaths in 10 weeks from overdose.
    d. Smoking, drugs is that data broken out by age groups. Use Age level data to target programs.
    e. Food insecurities. Food bank in Steuben has grown by leaps and bounds. How much food has been distributed over the last 10 years, and is the food healthy? What are the socio-economic reasons for visiting food pantries? Hunger Coalition has data around food insecurities.
2. What trends or factors are influencing the health of the residents?
    a. Cost of housing is a huge issue, people need to spend significant amount of money for shelter leaving no money to address other needs.
    b. Good paying jobs are hard to find anymore.
    c. Opioid problem is that heroin and other drugs are a lot cheaper these days.
    d. At the food banks a lot of carpooling occurs. Seeing people come from outside the region such as Pennsylvania. Transportation issue for elderly, who can't drive or don't drive.
    e. Mental Health reasoning why younger population is overdosing and using drugs. Could it be family, jobs?
    f. Lack of providers to address multiple issues, such as mental health and crisis stabilization. Dermatologists and specialty doctors.
    g. The new Corning hospital is attracting new doctors which helps with the provider issue in the region.
3. What community strengths or assets contribute to the health of the residents?
    a. Corning Inc. is very helpful. If you look at the area, Market Street shows the influence Corning Inc. has had on the town.

b. So much info and data on the County website, but we need to do better at promoting this information to the population. The people who might need these services don't have access to computer and internet.
c. 211 service is a real asset and should be advertised more for our region. How many people here today are aware of 211 service? Only 5 people raised their hands.

4. What would you do to address some of these problems?
    a. Get involved, volunteer, find out what's going on and you can help!
    b. Networking, neighborhood – sense of community.
    c. Cornell Cooperative Extension does a lot of workshops and they are great. Maybe Public Health needs to do more workshops related to interest from the community. Example: "How to reduce clutter" Information session on the opioid problem. EDUCATION.
    d. Advocate for 211 service! Maybe have 211 present at groups in the region. Possibly Faith Based organizations. Aging in place has a huge attendance which could be used to advertise 211.
    e. Nutrition education, partner with supermarkets.

County:	Steuben
Group Name:	SPOA-Mental Health
Date and Time:	March 14, 2016 - 11:30AM

1. What are we missing in our assessment to date?
    a. Why did you just pick heroin as a problem? In this area there has been an explosion of bath salts over the past two years and that can be verified by emergency room visit data. (Chemung, Schuyler, and Steuben are known to be affected.) Meth is a large issue as well.
    b. Be interested to know age ranges and genders for the data. Poverty level or is that covered in the uninsured?
    c. What about readmissions?
    d. Would want to know if they have established primary care physicians. Can it be pulled by specific populations?
2. What trends or factors are influencing the health of the residents?
    a. Explosion of bath salts and meth resulting in long-term care needs over the last two years. Treatment versus letting them just come down from their high.
    b. Access to transportation. Those who live within public transportation system vs. those who don't.
    c. Lack of primary care. When people are linked with Medicaid they are linked with a physician but sometimes those physicians are not accepting new patients so they are unable to access the care.
    d. Kraft closing. People leaving the area due to job loss. Jobs leaving means drug use will be on the rise. Philips left. The good jobs are leaving. The new ones coming in are not offering benefits like others previously did and that puts strain on the county.
    e. Lack of electronic communication between healthcare providers in treating patients.
3. What community strengths or assets contribute to the health of the residents?
    a. Fracking/Gas was not let in.
    b. The parks are good and people are utilizing them. The YMCA is available.
    c. The main county building implemented and enforces their smoking rules. Wishes it was enforced in all buildings.
    d. This committee is an asset.
    e. There are services available and always looking to improve the services.
    f. A very collaborative county.
    g. Have the support of the county and county management as far as DSRIP goes.
    h. St. James closed their psychiatric unit but brought in a lot of home-based services.
    i. Schools allow kids to stay till 5:00 and make use of the gym. (Not Bath.)

4. What would you do to address some of these problems?
    a. We need a much better public transportation system. Bussing? Affordable taxis? This is not an area you can rely on people to walk.
    b. More recreation in Bath. There isn't much in the rural areas but especially Bath.
    c. Is there incentives for clients to get their appointments and continue treatment? Other areas you earn "Baby Bucks" that you can use to buy items for your children (bouncy seats, clothing, diapers…) for going to your appointments.
    d. Activities around the schools, getting the kids outside. Bath is missing the chance for children to stay still 5:00 and use the gym.

County:	Steuben
Group Name:	CCE – Job Readiness Training Group
Date and Time:	March 17, 2016 – 12:00PM
# of Participants:	6

1. What are we missing in our assessment to date?
    a. VA hospital could be skewing the data because the one here in Bath is for mental health/substance abuse specifically. The Dansville VA was shut down a few years ago, so all those people were shipped down here… that could be skewing the data, since it is from a few years ago.
    b. Better break down of the areas – Bath, Corning, Hornell, etc. And also by age/demographics.
    c. How much police/FBI/DEA stings are pushing drugs out of the cities, into the rural areas? Not sure how much data you could get on this, but it would be interesting to see how much is actually being pushed into here.
    d. Anabolic steroid data, "high tech" drugs that can't be found in drug screens.
    e. Correlating ED visits for drug use with mental health diagnosis.
    f. Prescription misuse data – pain medication.
    g. Data around the reasons for addiction – the different reasons why people start using (depression, losing job, pain meds for surgery, etc.).
    h. How injuries affect drug dependability. And then in turn how this affects mental health (get injured, then can't work, get pain meds, then get hooked – now have no job and are addicted to drugs, which leads to depression… it just snowballs).
    i. Over utilization of the ER and the ambulance. People don't use preventative dentist or PCP services. Clogs up the system.
2. What trends or factors are influencing the health of the residents?
    a. Loss of business in the area can be affecting a lot of the mental health/self-inflicted injury rates. Especially in people that are used to taking care of everything themselves… they have to ask for help, which they are not used to, which can make them depressed, etc.
    b. Unemployment – Mercury Aircraft closing, they employed tons of people. Also when Switzer Aircraft went out. Unemployment benefits only last so long… then you are out of work, not gaining skills… then can't get hired anywhere else.
    c. Transportation – can't get between cities. Bus is great, but it's not very useful. It doesn't run all the time… you have to either wait 2/3 hours to get on the bus when you need to or find another way home.
    d. I live in Wayland – bus leaves at 7:00am… I have to be at class at 12:00pm, so I have to wait 5 hours, and then wait after I get out… takes up the whole day.

e. The way the system works – these job classes for example… we are mandated to be here to get unemployment benefits or go to jail, but it's taking time away from actually networking with businesses.
f. There is a lot of judgement by professionals – look down on those getting services, look down on people that don't have education, etc. Doesn't help those people. People need to be more compassionate.
g. Shortage of providers.

3. What community strengths or assets contribute to the health of the residents?
   a. Bus to Addison – helps me because I live in Addison and can't get anywhere, I don't have a license.
   b. Job classes are a strength – but they do need to be expanded, need to include more real-life experience, go out to businesses.
4. What would you do to address some of these problems?
   a. Bus needs to be 24/7 and do more routes/better routes.
   b. Make these employment classes more hands on – go to job sites, see what the skills are, do mock interviews, go to businesses and show what jobs might be available, etc.
   c. Do not take away license for support – it just adds to the problem… because can't get a job without a license (I've applied to 25+ jobs… cannot get hired). Adjust laws around revoking license… people don't pay a dime of child support, but they can still have their license, etc. Or make it conditional – get your license back if you are going to classes, doing everything you can, etc.
   d. Need to change social security laws – I had a friend that worked for the town of Corning, who was an alcoholic, drank so much that he started getting seizures. He was able to get social security – didn't have to work at all… just sat and drank. That's not fair. Systematic changes to these laws are needed.
   e. Care managers in the ER to steer people out of the ER that don't need to be and into more appropriate venues (PCP, Dental, etc.).

County:	Livingston, Steuben & Allegany
Group Name:	FLPPS Southern NOCN
Date and Time:	March 18, 2016 – 11:00AM

1. What are we missing in our assessment to date?
    a. Suicide
    b. Cultural factors (Amish and Mennonite)
2. What trends or factors are influencing the health of the residents?
    a. Elderly population/aging population
    b. Increasing number of single parents, foster care, lack of support for single family homes/parents and the resulting diets in those homes, also changing homes (foster care placements are increasing)
    c. Rate of unemployment in certain areas
    d. Level of education/drop out rates
    e. Transportation: access to services
    f. Impact of the ACA and how it is impacting health outcomes
    g. People who have never had preventive care and now that they are getting it, what is the impact on statistics
    h. Primary care education of single parent families for help, support and services (referrals to services)
    i. Literacy level of served population
    j. Access to care because of hospital closures
    k. Personal behavioral choices and how we factor personal choices into our strategies
    l. Both the number and times of availability of providers in the region
3. What community strengths or assets contribute to the health of the residents?
    a. YMCA in Hornell and Wellsville
    b. Diabetes education, heart education, other chronic disease education but transportation a problem (DSRIP has helped with filling CDSMP classes)
4. What would you do to address some of these problems?
    a. Some of the strategies need to start in the schools
    b. Stress levels of school age children leads to bad eating habits, no nursing support and the schools don't support child education about healthy eating and parents don't understand all the factors to support health eating/habits
    c. Inventory by county of volunteers, faith and community volunteers,
    d. Interface of medical with social models in the community (seems like the medical and social are two different models in our communities)

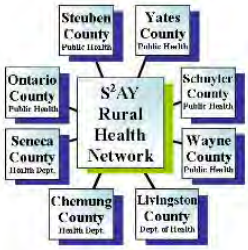
County:	Steuben & Chemung
Group Name:	FLPPS Southeastern NOCN
Date and Time:	March 22, 2016 – 11:00AM

1. What are we missing in our assessment to date?
    a. Psych center has brought people into the Chemung area and when they are discharged they become residents and that skews numbers in Chemung
    b. Very young children with severe mental and emotional issues and shortage of providers doing developmental assessments on young children
2. What trends or factors are influencing the health of the residents?
    a. Mental health and lack of addressing those needs, accessibility, is affecting their health outcomes
    b. Not getting enough education to the patient, patients don't want to take on a primary care provider, they don't think they need one (they have the ER, why primary care provider?)
    c. Lack of good jobs in the community (unemployment and underemployment)
    d. Substance abuse and outpatient services for substance abuse, not enough resources (detox, treatment) not being able to treat that population in a consistent way
    e. Exporting of young people who are more employable so concentration of people only eligible for lower paying type jobs
    f. The crackdown on prescription drugs has caused people to turn to heroin, need more resources than just detox (whole continuum of treatment)
    g. Addressing why people are getting addicted to drugs in the first place (economic and access to care, education levels)
    h. Elmira has the lowest level of educational attainment in the country outside of West Virginia
    i. That has to change the culture of competence/health literacy
3. What community strengths or assets contribute to the health of the residents?
    a. Professional resources in the community
    b. A lot of programs to educate healthcare workers
    c. Elmira working with LECOM to improve healthcare professional education
4. What would you do to address some of these problems?
    a. More outreach to people about impact of unhealthy behaviors (eating, drugs, drinking)
    b. All community groups need to reach out and do more community level organizations
    c. If you can't address mental health, you can't address obesity, unhealthy eating and other issues

d. Need to holistically address the issues of the person but if you aren't addressing their mental health issues then you are not improving that person's situation
e. Engagement of clients who are chronically mentally ill, don't just focus on how soon you can discharge them or find other ways to engage them (harm reduction)
f. Cultural engagement goes beyond race religion etc., it is about meeting the person where they are at, understanding where the person is at (without judgment), sensitivity training,
g. Addressing the culture of drug abuse, culture of mental health etc.
h. Need to look at circle of support within the patient arena, need to increase patient (including family) support
i. There comes a time when a mental health professional is needed, and within support groups or other outreach efforts they try to address everything but it needs a mental health professional (i.e. geriatric psychiatrist) and they are not available
j. Need innovative ways of provider collaboration
k. Shortages of many mental health professionals

County:	Steuben
Group Name:	SPOE-Mental Health
Date and Time:	March 23, 2016 - 9:30AM
# of Participants:	9

1. What are we missing in our assessment to date?
    a. Correlation between increase in heroin and use of Narcan. Has heard that some places are over 400% higher this year for Narcan use than in years past.
    b. Access to public water or well water.
    c. ER visits for psychiatric visits - can we see how many are duplicative (so repeat ED users)?
2. What trends or factors are influencing the health of the residents?
    a. Unemployment rate is high.
    b. Transportation for rural population - people over use the ER because they don't have a care to get to the doctor.
    c. St. James closing their services - huge factor over in Hornell. People couldn't get services - people were going out of county. Huge blow to that whole area. All places closing throughout the state is influencing it - a lot of psychiatric services closing throughout the entire region.
    d. Consolidation of ambulance corps (decentralization) - response times are not as good. EMT and police have to show up before ambulance is able to transport to hospital - people are waiting 20-30 minutes on the side of the road, it's becoming a huge problem. Puts a burden on other towns to make up response times.
    e. Substance abuse/mental health ultimately get housed in prisons - then when they get out, there is nothing for them - can't get a job, etc... so puts them right back. Need to find other ways to help these people, rather than put them in jail, which helps no one.
    f. Unfunded mandates are strangling all agencies throughout the region.
    g. State wants hospitals to get mental health/substance abuse people out to services, so that they stay out of the ER - but they are not giving us the resources to meet this need. There are too many.
3. What community strengths or assets contribute to the health of the residents?
    a. Thwarted off fracking - which would pollute our water, which is a good thing.
    b. Very collaborative - many agencies come together to network and get services out there.
4. What would you do to address some of these problems?
    a. Need to bulk up community services for mental health/substance abuse. Need more support - NYC is getting a lot of new jobs, rural upstate is getting none. We need more support to help these people.



b. Law changes for jail for substance abuse/mental health - these people end up in jail, instead of getting help, which helps no one - they get out and can't get a job, etc.
c. Transportation - need to figure that out.

County:	Steuben
Group Name:	School Counselors Meeting
Date and Time:	March 31, 2016 – 10:00AM
# of Participants:	29

1. What are we missing in our assessment to date?
    a. Dental issues, and so much the care of our health comes from the health of our teeth. If I see a student with poor dental health, they are likely to have no insurance. There are few dentists that accept Medicaid.
    b. Unemployment and income
    c. Some data referring to mental health and ED, what is missing is information pertaining to closing of adolescent and adult psych units. And also looking at what the county is providing for programs at the county level, taking into account the correlation of additional ED visits if the dept is not part of the hospital programs.
    d. Losing adolescent psych unit at St. James has been devastating. These are the students in crisis in need of immediate and intensive care that are being sent to Rochester, Elmira, Buffalo, no transportation can't get there to be a part of the family / group care.
    e. Devastating need for additional programming in county for mental health
    f. Asking if ED visits are per hospital location or resident
    g. We have a lack of preschool teams that will evaluate youngsters 2 or 3 years old. Have been greatly impacted, so they're not getting evaluated and there are not enough therapists (speech) and other to care for them.
    h. Obesity epidemic – in our school, lunches have increased dramatically. Fresh fruits, veggies, whole grains. School meals (2 per day) have been relatively healthy.
    i. Projection of what the future would look like would be very helpful. How would initiatives and specific changes impact the future rates, expectations
    j. Increase in chewing tobacco. Smoking may be going down, but chewing and vaporing is going up. What do they put in the vapes?
    k. Any data for push for CVS and Rite Aid how that's impacting rates in Steuben
    l. Alcoholism? Hillary noted this was Included in substance abuse but not broken down.
    m. Zip code level data – especially for uninsured.
    n. Steuben county jail – what's the population ending up in jail and their health data and what is the healthcare there and the link to programming and care offered after the inmates get out.
2. What trends or factors are influencing the health of the residents?

a. Transportation is huge. Even if have insurance, with local hospitals and doctors closing, how do they get there?
b. Immunizations. If kids aren't sick they're not taking them to the doctor. In the dark ages, public health would come and immunize them there. If we kept out the kids who weren't supposed to show up, they'd be out until November. Looking at big group of 6th and 7th graders who aern't going to be immunized but need to be.
c. Have to have a parent present for immunizations, there isn't a parent that will take them to Bath to get a shot.
d. Perception that public health focus and programs has shifted to geriatric population. Looking at if there's an equal distribution of public health programming to all ages.
e. See people who just don't work and are locked into that poverty. All these parents are home when doing the home visits. Even in Bath where the doctors are right there and transportation is a little easier, they still don't go and don't work. Gets passed on generation to generation. They just don't care.
f. County jail in Bath, people just get dropped off when they are released in Bath, so the area is the hardest hit. DSS, Mental Health, jail, and services are all in Bath, so the population that congregates there is made up of these groups.

3. What community strengths or assets contribute to the health of the residents?
    a. Great school counselors!
    b. Backpack programs help a lot of kids
    c. Food pantries are wonderful and utilized a lot
    d. St. James based care, if don't have insurance they will help to make ends meet to apply for insurance. Don't leave stranded
    e. Libraries in each county and a lot have developed programs to assist with breastfeeding. Utilizing those resources that are accessible in towns
    f. Community does want to help each other; we do want to see improvements in community. There are empowerment and collaboration to improve. Know what's going on but don't know how to help necessarily.
    g. Crises bring the communities together to help out the needy.
    h. Schools in general, central to the community. Giving out food, clothes, so forth. Schools are strong, see the evidence of the group coming together today is a strength.
    i. Good volunteer programs, like teen angel that supplies whatever is needed for teens in area. Primarily for Corning but will help others.
    j. More services on east side of county than west side of county.

k. Alfred state /university, local colleges help with collaboration. Lot of synergy, win – win. Taking advantage of higher ed. (Alfred is getting out of the county, but they do a lot in Steuben)
l. Beautiful area to live in with families. Relatively safe.
m. Alstom has a contract in the western area of the county, but it is not at the same level as Corning Inc. Western area seems to be the worst as far as services available; funding not there.

4. What would you do to address some of these problems?
   a. Smaller clinics in more of a rural community; clinic in Greenwood used to be there that got closed due to funding. Go out once a week into smaller areas to offer more access.
   b. Single payer health care
   c. If we are able to have quality school counselors in elementary school as recommendation or requirement means a lot of opportunities can come from that. Families that need a variety of services, the earlier we can intervene with health programming, that can directly benefit their first exposure to smoking, alcohol, marijuana, heroin. If education programs can be of true quality that can be a big benefit.
   d. Know when they leave the nursery in the hospital it is known who needs early intervention and programming.
   e. Parenting classes.

County:	Steuben
Group Name:	Corning Community College (CCC) – Human Sexuality Class
Date and Time:	April 11, 2016 – 8:00PM
# of Participants:	7

1. What are we missing in our assessment to date?
    a. Look at income data - Corning is higher than Elmira
    b. Is there an increase in the fitness industry? Seems like there has been an increase over the last few years... has that changed obesity at all? I work at the Corning YMCA... and I have seen a shift in consumer outlook on health - people coming in and wanting to get healthy
    c. Numbers going to gyms/health programs
    d. Alcohol abuse - especially with the college (can lead to obesity, liver problems, etc.)
2. What trends or factors are influencing the health of the residents?
    a. Corning Inc. hides the poverty in Corning
    b. Fast food - cost convenience, etc.
    c. Lack of education
    d. Social media, celebrities, and fads - influence the younger generations
    e. Big business in the fast food restaurants - they are poisoning us
    f. Poverty
    g. Single parents - unhealthy food is quicker and cheaper
    h. Corning Parks and Recreation - a lot of camps and activities are being utilized
    i. I do think that people are trying to eat healthier
    j. Kids don't go outside anymore - due to more video games, computers, and phones
3. What community strengths or assets contribute to the health of the residents?
    a. Planned Parenthood
    b. Sparkle in the winter
    c. The ice skating rink
    d. The college - Spencer Crest has lots of trails
    e. Corning Parks and Recreation - a lot of camps and activities
    f. 5k walks and marathons
    g. Nice basketball courts at the Alt School of Math and Science, and at Denison Park - they get utilized
    h. Wegmans - does a lot of programs and supports the community, free antibiotics and cheaper prescriptions
4. What would you do to address some of these problems?
    a. Still see people smoking all the time (even though banned in the building and so many feet from the door) - need stricter rules and more enforcement

b. Need more education - need to teach kids, start them young
c. Insurance companies need to offer more incentives to be healthy
d. More focus on consumers - making them more aware of what services are out there and what they do
e. Need to get more accurate information out there about Planned Parenthood
f. I would love to see a huge community garden through the schools - so much can be taught through that

County:	Steuben
Group Name:	Arbor Housing – Maple Leaf House
Date and Time:	April 20, 2016 – 1:00PM
# of Participants:	7

1. What are we missing in our assessment to date?
    a. Synthetics and bath salts and the admissions for psych centers. Poison control issues and the youth involved the use of these areas. This county is in an epidemic (Steuben). This is a topic that no one wants to talk about. Needs to be addressed because it can cause a lot of health issues. Age grouping around the data. Hep C-screening opportunities and diagnosis. Percentage rate of the rehabilitation success.
    b. Synthetic marijuana is highest in the area (Steuben). So few people know what's going on with this and the effects of the synthetic drugs.
    c. Hard numbers of people that are impacted from substance abuse and mental health.
    d. Suicide and the numbers surrounding that in the area.
2. What trends or factors are influencing the health of the residents?
    a. The use of the synthetic drugs use has grown and being developed. Eating disorders such as binge eating are coming up.
    b. Obesity rate (hard numbers). Availability rate of healthy foods and cheaper food is not good.
    c. Chemung county and the easy access to drugs on school property.
3. What community strengths or assets contribute to the health of the residents?
    a. D.A.R.E. program. Medical Travel
    b. Arbor Development.
    c. Self-help meetings, churches, parks.
    d. Cornell Cooperative Extensions
4. What would you do to address some of these problems?
    a. Education of drug use at a younger age. Treatment for the withdrawal process. New York City has a lot of available resources. More regulations around the process of withdrawing. Mental health assistance. Educating those who are not on drugs about how to reduce the stigma around the drug users. More programs for children. Abuse of children is not talked about enough.
    b. Trauma therapy for those in need. Can't fix the problems if you're not right in the head.
    c. All afflictions play on each other. Mental health being the main priority.

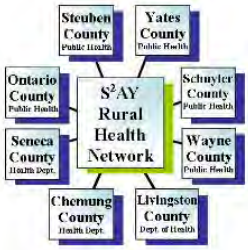
County:	Steuben
Group Name:	Steuben County Public Health Staff
Date and Time:	April 25, 2016 – 1:30 PM

1. What are we missing in our assessment to date?
    a. STD rates, esp. chlamydia
    b. Unemployment
    c. Yearly physical, preventative care
    d. Physical activity tracking
    e. Education levels
    f. Reading / literacy rates

2. What trends or factors are influencing the health of the residents?
    a. Social media
    b. Aging population, what's the mean age
    c. Businesses
    d. Rural-ness of county
    e. Weather, global warming
    f. Lack of mental health intervention / services
    g. Transportation issues
    h. St. James maternity closing and mental health

3. What community strengths or assets contribute to the health of the residents?
    a. Public Health
    b. Bike trails, hiking
    c. School readiness / pathways to success initiative
    d. Collaboration
    e. Integration of ARC
    f. Baby Café
    g. NDPP
    h. Smoking cessation programs / county smoking policy
    i. Schools offering healthier choices for lunch and encouraging more physical activity
    j. Sodium grant – effect on meal sites and hospitals
    k. Amazing partners in Emergency Preparedness
    l. S2AY

4. What would you do to address some of these problems?
    a. PR – let them know what's out there
    b. So many resources available and housed in 211 but hard to get the word and access out
    c. Educate



d. Have any specialist needed in county or primary care provider and will accept insurance / Medicaid / Fidelis
e. Insurance cover for all with low copays
f. More time for doctors to address health issues
g. Resources to do more programs that work (NDPP, car seats, prevention)
h. Better housing, better code enforcement, resources to help do lead remediation

County:	Steuben
Group Name:	SMART Steuben - Community Health Improvement Plan Group
Date and Time:	May 3, 2016 – 2:00PM
# of Participants:	12 (11 female, 1 male)

1. What are we missing in our assessment to date?
    a. E-cigarettes - any data around that (rates in youth are tripling)
    b. Food security/insecurity - access to healthy foods
    c. Births that are affected by drugs - low birth weight babies, high birth weight, etc.
    d. Gestational diabetes
    e. Tobacco use during pregnancy - see it a lot in this county
    f. More on self-inflicted injuries - what is causing them (substance abuse, suicide, etc.)?
    g. Ages of self-inflicted injury
    h. Access to healthy care - transportation

2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Having energy
    b. Overall wellness
    c. Feeling optimistic
    d. Higher quality of life
    e. Disease or illness free
    f. Ability to be active
    g. Decrease in chronic conditions
    h. Normal/within range BMI
    i. Access to trails/walking/opportunities to physical activity
    j. Educated - know about being healthy
    k. Access to healthy foods
    l. Access to information on healthy foods
    m. Positive health/social norms - policies that promote health
    n. Supportive health environment - access to support for the health issues you might have
    o. Facilities for physical activity (especially in the winter) - that people can afford

3. What trends or factors are influencing the health of the residents?
    a. Economic problems - lower incomes, unemployment, etc.
    b. Access to health care - no transportation, not enough doctors, not being able to afford it

c. Media attention around health/diet - people "perceive" things as healthy when they really aren't due to all the media
d. Access to diagnostic testing - waits are way too long
e. E-cigarettes - anything electronic is "cool"
f. Homelessness - become a big increasing trend lately (if basic needs are not met, then you aren't going to be healthy)
g. Huge trend toward social media and electronic devices - harder to get kids engaged in sports, outdoor activities, etc.
h. Getting parents to pull kids away from devices is difficult - leads to higher obesity, diabetes, bad health, etc.
i. Not enough parent education - parents don't feel as responsible for children's health
j. Consolidation of school districts/sports teams has made less opportunities for children to participate (100 kids tried out for modified, only 20 slots - so 80 kids do not get that opportunity to be active) - and the issue is just going to grow
k. Rural setting - less opportunities to have social support groups to stay connected, learn, etc.
l. Less access to community events/centers/etc. - YMCA in Hornell, but due to rural setting, not many can get there
m. Transportation - especially for poor communities
n. Increasing drug problems in all communities
o. Increase in behavioral health/mental health needs
p. Not enough mental health providers, psychiatrists, etc.

4. What community strengths or assets contribute to the health of the residents?
    a. Hornell opens fitness center for students to use for 1.5 hours after school
    b. Opportunity for outdoor activities - a lot more than cities
    c. A lot more trails and walking paths have been opened
    d. Open to policy change - a lot of businesses/places are very open to adopting smoke free policies
    e. Larger communities have decent youth sports programming
    f. Progressive Public Health Department
    g. IHS and 211
    h. A lot of infrastructure to increase programs and initiatives
    i. Medical community - both Arnot, St. James, and Guthrie have implemented patient centered medical home models
    j. DSRIP activities - more coordination between providers
    k. SMART Steuben - collaboration
    l. Having multiple hospitals within the county

m. Having a supportive legislature - a legislator that comes to meetings
n. Two newspapers that are very open to including press releases, letters to the editor, etc. (supportive)
o. County has a public relations person that has been doing a good job, we can utilize them
p. A lot of organizations that are willing to make grants to local programs
q. Senior center - is very well utilized

5. What would you do to address some of these problems?
    a. Policy change - any health policy (smoke free, etc.) - increases social norms
    b. Educating parents - great opportunity
    c. Continue with a lot of community collaborative/initiatives that are out there - utilize the school districts, utilize the senior center, use these to promote what we are going, etc.
    d. More intramural programs - utilize elementary schools (where other sports might not be using facilities)
    e. Tap into school districts more - especially smaller school districts (because those communities don't have YMCA's, community centers, etc.), the school is the hub for everything in small communities - need more partnership with schools
    f. Partner with faith communities - educate parents
    g. Group in Addison that meets to talk about heroin/drugs in the community - could be a great group to collaborate with
    h. DSRIP efforts - find ways to connect rural organizations to the larger hubs - connect electronic medical records (so that they are all speaking to each other, more information sharing)
    i. Increase telemedicine - utilize technology more, take things to the next level
    j. Tele-psychiatry - especially useful for rural areas, to meet needs
    k. Incentives for children to participate in activities, etc.

County:	Steuben
Group Name:	Hornell National Diabetes Prevention Program Group
Date and Time:	May 3, 2016 – 6:00PM
# of Participants:	10 (5 female, 5 male)

1. What are we missing in our assessment to date?
    a. Unemployment data
    b. Make correlations between mental health and substance abuse and factors that could be making these rates rise
    c. Data around incarceration and incarceration attributed to drugs (specifically heroin)
    d. Data around socioeconomic status (and this in relation to drug use)
    e. Poverty rates
    f. Access to doctors
    g. Data on what resources are available
    h. Cancer Data - correlation between that and environmental factors (the railroad, past industry, old housing, etc.)

2. What words would you use to define health and what terms would you use to define a healthy community?
    a. Longevity
    b. Vitality
    c. Energy
    d. A lot of local industry
    e. Healthy economy
    f. Employment
    g. Places for physical activity/community gathering
    h. Happy
    i. Interaction - not isolated
    j. Options - you can do things, participate in things, be active

3. What trends or factors are influencing the health of the residents?
    a. Less industry - only one now is Alstom
    b. Small communities don't have access/resources available - can't get to YMCA, stores, etc.
    c. High unemployment rates
    d. A lot of cancer and heart disease in this area - related to environment? related to industry? (the railroad, old housing, etc.)
    e. Old housing

f. The Affordable Care Act - more insured, more access, more preventative measures
g. DSRIP - a good thing for health

4. What community strengths or assets contribute to the health of the residents?
    a. The YMCA in Hornell
    b. People are very friendly
    c. A lot of social activities
    d. Space - not a crowded city
    e. Rural is a good thing - more community, people know their neighbors, more outdoor opportunities
    f. Psychological aspect - people have compassion for other people here
    g. Fraternal clubs
    h. Veteran organizations
    i. There are benefits every week for someone
    j. A lot of church and social organizations
    k. Strong schools - and people support schools long after their kids graduate
    l. 4 dance studios

5. What would you do to address some of these problems?
    a. Continue with DSRIP
    b. Promotion - getting more information out there about programs/resources/etc.
    c. Used to have a health fair twice a year, which was well attended - need to do that again
    d. Increasing awareness
    e. More buy in from hospitals/clinics/etc.- to refer to programs

S²AY Rural Health Network, Inc.

Steuben County Public Health System Assessment 2016

Health Promotion Activities to Facilitate Health Living in Healthy Communities					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Conducts health promotion activities for the community-at-large or for populations at increased risk for negative health outcomes	8	5	2	0	15
Develops collaborative networks for health promotion activities that facilitate healthy living in healthy communities	8	5	2	0	15
Assesses the appropriateness, quality and effectiveness of health promotion activities at least every 2 years.	10	3	2	0	15
Total Respondents	15				

Mobilize Community Partnerships to Identify and Solve Health Problems					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Has a process to identify key constituents for population based health in general (e.g. improved health and quality of life at the community level) or for specific health concerns (e.g., a particular health theme, disease, risk factor, life stage need).	7	7	1	0	15
Encourages the participation of its constituents in community health activities, such as in identifying community issues and themes and in engaging in volunteer public health activities.	8	5	2	0	15
Establishes and maintains a comprehensive directory of community organizations.	9	5	1	0	15
Uses broad-based communication strategies to strengthen linkages among LPHS organizations and to provide current information about public health services and issues.	9	2	3	1	15
Total Respondents	15				

Community Partnerships					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Establishes community partnerships to assure a comprehensive approach to improving health in the community.	9	5	1	0	15
Assure the establishment of a broad-based community health improvement committee.	8	5	2	0	15
Assesses the effectiveness of community partnerships in improving community health.	8	4	3	0	15
Total Respondents	15				

Assure a Competent Public and Personal Health Care Workforce					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Assessment of workforce (including volunteers and other lay community health workers) to meet the community needs for public and personal health care services.	7	7	1	0	15
Maintaining public health workforce standards, including efficient processes for licensure/credentialing of professionals and incorporation of core public health competencies needed to provide the Essential Public Health Services into personnel systems.	7	7	1	0	15
Adoption of continuous quality improvement and life-long learning programs for all members of the public health workforce, including opportunities for formal and informal public health leadership development.	6	8	1	0	15
Total Respondents	15				

Life-long Learning Through Continuing Education, Training & Mentoring					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Identify education and training needs and encourage opportunities for public health workforce development.	8	6	1	0	15
Provide opportunities for all personnel to develop core public health competencies.	7	7	1	0	15
Provide incentives (e.g. improvements in pay scale, release time, tuition reimbursement) for the public health workforce to pursue education and training.	5	8	1	1	15
Provide opportunities for public health workforce members, faculty and student interaction to mutually enrich practice-academic settings.	7	6	2	0	15
Total Respondents	15				

Public Health Leadership Development					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Provide formal (educational programs, leadership institutes) and informal (coaching, mentoring) opportunities for leadership development for employees at all organizational levels.	7	5	3	0	15
Promote collaborative leadership through the creation of a local public health system with a shared vision and participatory decision-making.	7	5	3	0	15
Assure that organizations and/or individuals have opportunities to provide leadership in areas where their expertise or experience can provide insight, direction or resources.	6	6	3	0	15
Provide opportunities for development of diverse community leadership to assure sustainability of public health initiatives.	6	6	3	0	15
Total Respondents	15				

Access to and Utilization of Current Technology to Manage, Display and Communicate Population Health Data					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Uses state of the art technology to collect, manage, integrate and display health profile databases.	6	6	3	0	15
Promotes the use of geocoded data.	5	6	2	0	13
Uses geographic information systems.	8	4	1	0	13
Uses computer-generated graphics to identify trends and/or compare data by relevant categories (e.g. race, gender, age group).	6	7	2	0	15
Total Respondents	15				

Diagnose and Investigate Health Problems and Health Hazards in the Community					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Epidemiological investigations of disease outbreaks and patterns of infectious and chronic disease and injuries, environmental hazards, and other health threats.	10	4	1	0	15
Active infectious disease epidemiology programs.	8	6	1	0	15
Access to public health laboratory capable of conducting rapid screening and high volume testing.	8	6	1	0	15
Total Respondents	15				

Plan for Public Health Emergencies					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Defines and describes public health disasters and emergencies that might trigger implementation of the LPHS emergency response plan.	12	1	2	0	15
Develops a plan that defines organizational responsibilities, establishes communication and information networks, and clearly outlines alert and evacuation protocols.	11	2	2	0	15
Tests the plan each year through the staging of one or more “mock events.”	9	5	1	0	15
Revises its emergency response plan at least every two years.	11	2	2	0	15
Total Respondents	15				

Investigate & Respond to Public Health Emergencies					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Designates an Emergency Response Coordinator	12	1	2	0	15
Develops written epidemiological case investigation protocols for immediate investigation of: Communicable disease outbreaks	11	2	2	0	15
----Environmental health hazards	11	2	2	0	15
----Potential chemical and biological agent threats	11	2	2	0	15
----Radiological threats an	10	3	2	0	15
----Large scale disasters	10	3	2	0	15
Maintains written protocols to implement a program of source & contact tracing.	11	2	2	0	15
Maintain a roster of personnel with technical expertise to respond to biological, chemical or radiological emergencies	10	2	2	0	14
Evaluates past incidents for effectiveness & continuous improvement	11	2	2	0	15
Designates an Emergency Response Coordinator	12	1	2	0	15
Total Respondents	15				

Laboratory Support for Investigation of Health Threats					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Maintains ready access to laboratories capable of supporting investigations.	7	5	2	1	15
Maintains ready access to labs capable of meeting routine diagnostic & surveillance needs.	8	4	2	1	15
Confirms that labs are in compliance with regs & standards through credentialing and licensing agencies.	8	4	2	1	15
Maintains protocols to address handling of lab samples– storing, collecting, labeling, transporting and delivering samples and for determining the chain of custody.	8	4	2	1	15
Total Respondents	15				

Develop Policies & Plans that support Individual and Community Health Efforts.					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
An effective governmental presence at the local level.	9	3	3	0	15
Development of policy to protect the health of the public and to guide the practice of public health.	8	5	2	0	15
Systematic community-level and state-level planning for health improvement in all jurisdictions.	8	5	2	0	15
Alignment of LPHS resources & strategies with the community health improvement plan.	8	4	2	1	15
Total Respondents	15				

Public Health Policy Development					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Contributes to the development and/or modification of public health policy by facilitating community involvement in the process and by engaging in activities that inform this process.	8	3	2	2	15
Reviews existing policies at least every 2 years and alerts policy makers and the public of potential unintended outcomes and consequences.	10	3	2	0	15
Advocates for prevention and protection policies, particularly policies that affect populations who bear a disproportionate burden of mortality and morbidity.	8	4	2	1	15
Total Respondents	15				

Community Health Improvement Process					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Establishes a community health improvement process, which includes broad based participation and uses information from the community health assessment as well as perceptions of community residents.	8	3	3	0	14
Develops strategies to achieve community health improvement objectives and identifies accountable entities to achieve each strategy.	8	3	3	0	14
Total Respondents	14				

Strategic Planning & Alignment with the Community Health Improvement Process					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Conduct organizational strategic planning activities.	8	5	2	0	15
Review its own organizational strategic plan to determine how it can best be aligned with the community health improvement process.	7	6	2	0	15
Conducts organizational strategic planning activities and uses strategic planning to align its goals, objectives, strategies and resources with the community health improvement process.	8	5	2	0	15
Total Respondents	15				

Enforce Laws & Regulations that Protect Health and Ensure Safety					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Review, evaluate and revise laws and regulations designed to protect health and safety to assure they reflect current scientific knowledge and best practices for achieving compliance.	9	4	2	0	15
Education of persons and entities obligated to obey or to enforce laws and regulations designed to protect health and safety in order to encourage compliance.	8	5	2	0	15
Enforcement activities in areas of public health concern, including but not limited to the protection of drinking water, enforcement of clean air standards, regulation of care provided in health care facilities and programs, re-inspection of workplaces following safety violations; review of new drug, biologic and medical device applications, enforcement of laws governing sale of alcohol and tobacco to minors; seat belts and child safety seat usage and childhood immunizations.	8	5	2	0	15
Total Respondents	15				

Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Identifying populations with barriers to personal health services.	9	4	2	0	15
Identifying personal health service needs of populations with limited access to a coordinated system of clinical care.	9	4	2	0	15
Assuring the linkage of people to appropriate personal health services.	9	4	2	0	15
Total Respondents	15				

Identifying Personal Health Services Needs of Population					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Defines personal health service needs for the general population. This includes defining specific preventive, curative and rehabilitative health service needs for the catchment areas within its jurisdiction.	9	5	1	0	15
Assesses the extent to which personal health services are provided.	9	5	1	0	15
Identifies the personal health service needs of populations who may encounter barriers to the receipt of personal health services.	9	4	2	0	15
Total Respondents	15				

Assuring the Linkage of People to Personal Health Services					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Assures the linkage to personal health services, including populations who may encounter barriers to care.	9	4	2	0	15
Provides community outreach and linkage services in a manner that recognizes the diverse needs of unserved and underserved populations.	8	5	2	0	15
Enrolls eligible beneficiaries in state Medicaid or Medical Assistance Programs.	9	5	1	0	15
Coordinates the delivery of personal health and social services with service providers to optimize access.	9	5	1	0	15
Conducts an analysis of age-specific participation in preventive services.	8	5	2	0	15
Total Respondents	15				

Evaluation of Population-based Health Services					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Evaluate population-based health services against established criteria for performance, including the extent to which program goals are achieved for these services.	9	3	3	0	15
Assesses community satisfaction with population-based services and programs through a broad-based process, which includes residents who are representative of the community and groups at increased risk of negative health outcomes.	8	3	4	0	15
Identifies gaps in the provision of population-based health services.	6	5	4	0	15
Uses evaluation findings to modify the strategic and operational plans of LPHS organizations to improve services and programs.	7	3	4	1	15
Total Respondents	15				

Evaluate Effectiveness, Availability and Quality of Personal and population based health services?					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
Identifies community organizations or entities that contribute to the delivery of the Essential Public Health Services.	9	4	2	0	15
Evaluates the comprehensiveness of the LPHS activities against established criteria at least every five years and ensures that all organizations within the LPHS contribute to the process.	7	4	3	1	15
Assesses the effectiveness of communication, coordination and linkage among LPHS entities.	8	3	3	1	15
Uses information from the evaluation process to refine existing community health programs, to establish new ones, and to redirect resources as needed to accomplish LPHS goals.	8	3	3	1	15
Total Respondents	15				

S²AY Rural Health Network, Inc.
PO Box 97 * Corning, NY 14830-0097 * (607) 962-8459 * Fax (607) 962-9755 * grantstogo@stny.rr.com

Research for New Insights and Innovative Solutions to Health Problems					
Answer Options	**Yes, met 100% - 76%**	**Mostly, 75% - 51%**	**Low 50% - 26%**	**No 25% - 0%**	**Response Count**
A continuum of innovative solutions to health problems ranging from practical field-based efforts to foster change in public health practice, to more academic efforts to encourage new directions in scientific research.	9	3	2	1	15
Linkages with institutions of higher learning and research.	8	4	2	1	15
Capacity to mount timely epidemiological and health policy analyses and conduct health systems research.	7	4	2	1	14
Total Respondents	15				

Where is your organization located?		
Answer Options	**Response Percent**	**Response Count**
Bath	54.5%	6
Corning	36.4%	4
Dansville	9.1%	1
Hornell	27.3%	3
Other		4
Total Respondents	11	

What population does your organization serve? ie. elderly, low income, children	
Answer Options	**Response Count**
Children	1
All	5
Low income	1
Elderly	2
Students	2
Total Respondents	11

What type of organization do you work for? ie. hospital, county agency, non-profit	
Answer Options	**Response Count**
School	1
Legislature	1
Non-profit	4
Higher education	1
County	1
Christian Church	1
Municipal	1
Hospital	1
County Agency	1
Total Respondents	

What is your position/job title?	
Answer Options	**Response Count**
School nurse	1
County Legislator	3
Nursing Coordinator	1
Director	3
Pastor	1
Lab IP	1
Human Resources	1
Total Respondents	11

Attachment 7

Cancer Indicators - Steuben County

2010-2012

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
All cancers								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	1,837	617.9	550.9	Yes	610.0	No	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	1,837	482.8	489.2	No	510.8	Yes	2nd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	681	229.1	180.7	Yes	202.4	Yes	3rd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	681	176.7	158.6	Yes	165.6	No	3rd
Lip, Oral Cavity, and Pharynx Cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	48	16.1	12.1	No	13.5	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	48	12.0	10.5	No	11.0	No	3rd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.5	N/A	2.6	N/A	N/A
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.2	N/A	2.1	N/A	N/A
Colon and rectum cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	168	56.5	46.7	Yes	49.6	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	168	44.3	41.4	No	41.2	No	3rd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	62	20.9	16.6	No	17.2	No	4th
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	62	15.7	14.4	No	13.9	No	3rd
Lung and bronchus cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	313	105.3	69.6	Yes	83.0	Yes	4th
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	313	80.5	61.6	Yes	68.6	Yes	4th
Crude mortality rate per 100,000	(Table) (Trend) (Map)	239	80.4	46.4	Yes	55.9	Yes	4th

Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	239	61.7	41.0	Yes	46.1	Yes	4th
Female breast cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	214	142.8	149.1	No	164.4	Yes	1st
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	214	104.6	127.2	Yes	133.2	Yes	1st
Crude mortality rate per 100,000	(Table) (Trend) (Map)	33	22.0	26.3	No	28.1	No	1st
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	33	16.7	20.9	No	20.9	No	1st
Crude late stage incidence rate per 100,000	(Table) (Trend) (Map)	67	44.7	49.2	No	51.4	No	2nd
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	67	35.2	42.7	No	42.7	No	2nd
Cervix uteri cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	13	8.7	8.3	No	7.2	No	3rd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	13	8.7	7.7	No	6.7	No	3rd
Crude mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.7	N/A	2.4	N/A	N/A
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	s	s	2.3	N/A	2.0	N/A	N/A
Ovarian cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	18	12.0	14.9	No	16.2	No	1st
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	18	9.8	12.5	No	12.9	No	1st
Crude mortality rate per 100,000	(Table) (Trend) (Map)	15	10.0	9.5	No	10.4	No	2nd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	15	7.2	7.5	No	7.8	No	2nd
Prostate cancer								
Crude incidence rate per 100,000	(Table) (Trend) (Map)	209	141.7	156.7	No	167.4	Yes	2nd
Age-adjusted incidence rate per 100,000	(Table) (Trend) (Map)	209	105.3	145.3	Yes	143.8	Yes	1st
Crude mortality rate per 100,000	(Table) (Trend) (Map)	24	16.3	18.3	No	18.6	No	1st
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	24	14.7	20.0	No	18.5	No	1st
Crude late stage	(Table) (Trend) (Map)	37	25.1	23.3	No	25.1	No	3rd

incidence rate per 100,000								
Age-adjusted late stage incidence rate per 100,000	(Table) (Trend) (Map)	37	18.7	21.2	No	21.1	No	2nd
Melanoma cancer mortality								
Crude mortality rate per 100,000	(Table) (Trend) (Map)	9	3.0*	2.5	No	3.3	No	2nd
Age-adjusted mortality rate per 100,000	(Table) (Trend) (Map)	9	2.5*	2.2	No	2.8	No	2nd
Age-adjusted % of women 18 years and older with Pap smear in past 3 years (2013-2014)	(Table) (Map)	N/A	65.6	74.2	No	76.2	No	4th
% of women 40 years and older with mammography screening in past 2 years (2013-2014)	(Table) (Map)	N/A	72.6	77.8	No	77.4	No	4th
% of women, aged 50-74 years, who had a mammogram between October 1, 2011 and December 31, 2013 (2013)	(Table) (Map)	29	56.9	71.7	No	63.4	No	4th

N/A: Data not available

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

s: Data do not meet reporting criteria

Cardiovascular Disease Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Cardiovascular disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	884	297.9	272.5	Yes	297.4	No	3rd
Age-adjusted	(Table) (Trend) (Map)	884	221.7	228.0	Yes	228.2	Yes	2nd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	127	103.6	99.0	No	96.8	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	484	163.1	146.7	Yes	162.3	No	3rd
Cardiovascular disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	5,034	169.6	163.6	Yes	165.9	No	3rd
Age-adjusted	(Table) (Trend) (Map)	5,034	131.3	143.5	Yes	136.0	Yes	3rd
Disease of the heart mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	685	230.8	222.1	No	238.7	No	2nd
Age-adjusted	(Table) (Trend) (Map)	685	171.1	185.4	Yes	182.8	Yes	2nd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	113	92.2	80.6	No	79.9	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	392	132.1	126.3	No	134.7	No	3rd
Disease of the heart hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	3,558	119.9	108.5	Yes	111.9	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	3,558	92.5	94.9	No	91.4	No	3rd
Coronary heart disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	424	142.9	175.1	Yes	171.8	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	424	104.7	146.2	Yes	131.5	Yes	1st
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	81	66.1	65.5	No	60.7	No	3rd
Pretransport mortality	(Table) (Trend) (Map)	231	77.8	103.6	Yes	100.0	Yes	1st
Coronary heart disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,156	39.0	40.0	No	39.9	No	2nd
Age-adjusted	(Table) (Trend) (Map)	1,156	30.1	34.8	Yes	32.5	Yes	2nd
Heart attack (Acute Myocardial Infarction) hospitalization rate per 10,000								

Crude	(Table) (Trend) (Map)	704	23.7	17.1	Yes	19.4	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	704	18.2	14.8	Yes	15.7	Yes	3rd
Heart attack (Acute Myocardial Infarction) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	138	46.5	37.3	Yes	45.0	No	3rd
Age-adjusted	(Table) (Trend) (Map)	138	34.1	31.3	Yes	34.8	Yes	2nd
Congestive heart failure mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	93	31.3	14.7	Yes	21.6	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	93	23.3	12.0	Yes	16.1	Yes	4th
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	5	4.1*	1.9	No	2.3	No	4th
Pretransport mortality	(Table) (Trend) (Map)	63	21.2	8.0	Yes	12.4	Yes	4th
Congestive heart failure hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,034	34.8	28.8	Yes	29.3	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	1,034	26.3	24.9	No	23.4	Yes	3rd
Cerebrovascular disease (stroke) mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	130	43.8	30.9	Yes	38.5	No	3rd
Age-adjusted	(Table) (Trend) (Map)	130	33.0	26.2	Yes	29.8	Yes	3rd
Premature death (aged 35-64 years)	(Table) (Trend) (Map)	8	6.5*	10.5	No	10.1	No	1st
Pretransport mortality	(Table) (Trend) (Map)	59	19.9	11.5	Yes	17.0	No	3rd
Cerebrovascular disease (stroke) hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	922	31.1	26.9	Yes	28.9	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	922	24.0	23.5	No	23.6	No	3rd
Hypertension hospitalization rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	77	3.4	7.4	Yes	5.0	Yes	2nd
Hypertension hospitalization rate per 10,000 (any diagnosis) (aged 18 years and older)	(Table) (Trend) (Map)	13,284	579.1	562.1	Yes	560.8	Yes	3rd
Hypertension emergency department visit rate per 10,000 (aged 18 years and older)	(Table) (Trend) (Map)	577	25.2	32.9	Yes	24.9	No	3rd
Hypertension emergency department visit rate per 10,000 (any diagnosis) (aged 18 years and older)	(Table) (Trend) (Map)	27,533	1,200.2	896.6	Yes	927.7	Yes	4th
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,326	112.1	117.7	Yes	117.1	Yes	2nd

Age-adjusted	(Table) (Trend) (Map)	3,326	84.9	103.0	Yes	95.3	Yes	2nd
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,346	112.8	115.3	No	116.8	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	3,346	85.6	101.0	Yes	95.4	Yes	2nd
Age-adjusted % of adults with physician diagnosed angina, heart attack or stroke # (2008-2009)	(Table) (Map)	N/A	7.4	7.6	No	7.2	No	2nd
Age-adjusted % of adults with cholesterol checked in the last 5 years # (2013-2014)	(Table) (Map)	N/A	78.1	83.4	No	83.2	No	3rd
Age-adjusted % of adults ever told they have high blood pressure (2013-2014)	(Table) (Map)	N/A	32.3	27.3	No	27.8	No	4th

N/A: Data not available

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

#: Data not available for NYC counties

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

Child and Adolescent Health Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Childhood mortality rate per 100,000								
Aged 1-4 years	(Table) (Trend) (Map)	2	14.5*	20.0	No	21.1	No	1st
Aged 5-9 years	(Table) (Trend) (Map)	5	27.3*	10.1	No	9.7	No	4th
Aged 10-14 years	(Table) (Trend) (Map)	2	10.2*	11.9	No	11.8	No	2nd
Aged 5-14 years	(Table) (Trend) (Map)	7	18.5*	11.0	No	10.8	No	4th
Aged 15-19 years	(Table) (Trend) (Map)	5	25.7*	33.4	No	35.2	No	1st
Asthma hospitalization rate per 10,000								
Aged 0-4 years	(Table) (Trend) (Map)	22	13.0	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	27	7.1	20.5	Yes	10.4	No	2nd
Aged 0-17 years	(Table) (Trend) (Map)	49	7.3	26.6	Yes	14.2	Yes	2nd
Gastroenteritis hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	15	8.8	11.3	No	8.6	No	3rd
Otitis media hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	s	s	2.5	N/A	2.0	N/A	N/A
Pneumonia hospitalization rate per 10,000 (aged 0-4 years)	(Table) (Trend) (Map)	87	51.3	39.4	Yes	31.3	Yes	4th
% of children born in 2010 with a lead screening aged 0-8 months (2010-2013)	(Table) (Map)	13	1.1	3.5	Yes	4.2	Yes	4th
% of children born in 2010 with a lead screening - aged 9-17 months (2010-2013)	(Table) (Trend) (Map)	470	40.1	65.0	Yes	53.5	Yes	3rd
% of children born in 2010 with a lead screening - aged 18-35 months (2010-2013)	(Table) (Trend) (Map)	501	42.7	65.6	Yes	55.7	Yes	3rd
% of children born in 2010 with at least two lead screenings by 36 months (2010-2013)	(Table) (Trend) (Map)	325	27.7	55.1	Yes	42.1	Yes	3rd
Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) - rate per 1,000 tested children aged <72 months	(Table) (Trend) (Map)	60	12.9	4.9	Yes	8.8	Yes	3rd

% of children with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	1,710	54.9	71.6	Yes	70.3	Yes	4th
% of children aged 0-15 months with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	51	86.4	82.2	No	85.4	No	3rd
% of children aged 3-6 years with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	793	69.6	83.1	Yes	81.2	Yes	4th
% of children aged 12-21 years with recommended number of well child visits in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	866	45.2	63.8	Yes	61.9	Yes	4th

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

s: Data do not meet reporting criteria

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

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

Cirrhosis/Diabetes Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Cirrhosis mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	33	11.1	7.7	No	8.7	No	3rd
Age-adjusted	(Table) (Trend) (Map)	33	8.2	6.7	Yes	7.2	Yes	3rd
Cirrhosis hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	52	1.8	2.8	Yes	2.5	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	52	1.3	2.5	Yes	2.2	Yes	1st
Diabetes mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	68	22.9	20.3	No	19.6	No	3rd
Age-adjusted	(Table) (Trend) (Map)	68	17.7	17.6	No	15.7	Yes	2nd
Diabetes hospitalization rate per 10,000 (primary diagnosis)								
Crude	(Table) (Trend) (Map)	587	19.8	19.3	No	15.6	Yes	4th
Age-adjusted	(Table) (Trend) (Map)	587	18.3	17.9	No	14.2	Yes	4th
Diabetes hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	7,541	254.1	244.1	Yes	225.8	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	7,541	202.7	215.9	Yes	188.6	Yes	3rd
Diabetes short-term complications hospitalization rate per 10,000								
Aged 6-17 Years	(Table) (Trend) (Map)	27	5.8	3.1	Yes	2.9	Yes	4th
Aged 18 years and older	(Table) (Trend) (Map)	234	10.2	6.3	Yes	5.8	Yes	4th
Chronic kidney disease hospitalization rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,326	112.1	117.7	Yes	117.1	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	3,326	84.9	103.0	Yes	95.3	Yes	2nd
Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis)								
Crude	(Table) (Trend) (Map)	3,346	112.8	115.3	No	116.8	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	3,346	85.6	101.0	Yes	95.4	Yes	2nd
Age-adjusted % of adults with physician diagnosed diabetes (2013-2014)	(Table) (Map)	N/A	10.4	8.9	No	8.2	No	3rd

N/A: Data not available

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

Communicable Disease Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Pneumonia/flu hospitalization rate (aged 65 years and older) per 10,000	(Table) (Trend) (Map)	740	149.9	112.6	Yes	121.9	Yes	3rd
Pertussis incidence rate per 100,000	(Table) (Trend) (Map)	97	32.7	8.8	Yes	12.9	Yes	4th
Mumps incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.2	Yes	0.1	Yes	2nd
Meningococcal incidence rate per 100,000	(Table) (Trend) (Map)	0	0.0*	0.2	Yes	0.2	Yes	1st
H. influenza incidence rate per 100,000	(Table) (Trend) (Map)	3	1.0*	1.7	No	1.7	No	1st
Hepatitis A incidence rate per 100,000	(Table) (Trend) (Map)	1	0.3*	0.7	No	0.5	No	3rd
Acute hepatitis B incidence rate per 100,000	(Table) (Trend) (Map)	1	0.3*	0.6	No	0.5	No	3rd
Tuberculosis incidence rate per 100,000	(Table) (Trend) (Map)	1	0.3*	4.5	Yes	1.9	No	2nd
E. coli O157 incidence rate per 100,000	(Table) (Trend) (Map)	12	4.0	0.6	Yes	0.8	Yes	4th
Salmonella incidence rate per 100,000	(Table) (Trend) (Map)	44	14.8	12.9	No	12.2	No	4th
Shigella incidence rate per 100,000	(Table) (Trend) (Map)	1	0.3*	4.8	Yes	4.4	Yes	1st
Lyme disease incidence rate per 100,000#	(Table) (Map)	33	11.1	36.6	Yes	57.8	Yes	2nd
% of adults aged 65 years and older with flu shot in last year (2013-2014)	(Table) (Map)	N/A	71.6	72.4	No	77.1	No	3rd
% of adults aged 65 years and older who ever received pneumonia shot (2013-2014)	(Table) (Map)	N/A	65.4	65.1	No	70.7	No	3rd

Family Planning/Natality Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
% of births within 24 months of previous pregnancy	(Table) (Trend) (Map)	908	27.9	18.5	Yes	21.0	Yes	4th
Percentage of births to teens								
Aged 15-17 years	(Table) (Trend) (Map)	60	1.8	1.4	No	1.5	No	3rd
Aged 15-19 years	(Table) (Trend) (Map)	289	8.9	5.2	Yes	5.7	Yes	4th
% of births to women aged 35 years and older	(Table) (Trend) (Map)	355	10.9	20.5	Yes	18.9	Yes	2nd
Fertility rate per 1,000 females								
Total (all births/females aged 15-44 years)	(Table) (Trend) (Map)	3,257	62.6	59.0	Yes	56.8	Yes	4th
Aged 10-14 years (births to mothers aged 10-14 years/females aged 10-14 years)	(Table) (Trend) (Map)	3	0.3*	0.3	No	0.2	No	3rd
Aged 15-17 years (births to mothers aged 15-17 years/females aged 15-17 years)	(Table) (Trend) (Map)	60	9.6	9.3	No	7.9	No	3rd
Aged 15-19 years (births to mothers aged 15-19 years/females aged 15-19 years)	(Table) (Trend) (Map)	289	30.6	19.5	Yes	17.3	Yes	4th
Aged 18-19 years (births to mothers aged 18-19 years/females aged 18-19 years)	(Table) (Trend) (Map)	229	71.5	33.5	Yes	29.9	Yes	4th
Pregnancy rate per 1,000 (all pregnancies/females aged 15-44 years) #	(Table) (Trend) (Map)	3,984	76.6	87.9	Yes	72.6	Yes	3rd
Teen pregnancy rate per 1,000 #								
Aged 10-14 years	(Table) (Trend) (Map)	8	0.8*	0.9	No	0.6	No	3rd
Aged 15-17 years	(Table) (Trend) (Map)	99	15.9	22.4	Yes	14.5	No	3rd
Aged 15-19 years	(Table) (Trend) (Map)	397	42.1	41.3	No	28.7	Yes	4th
Aged 18-19 years	(Table) (Trend) (Map)	298	93.1	67.2	Yes	47.6	Yes	4th

Abortion ratio (induced abortions per 1,000 live births) #								
Aged 15-19 years	(Table) (Trend) (Map)	102	354.2	1,050.3	Yes	624.6	Yes	2nd
All ages	(Table) (Trend) (Map)	591	181.4	412.3	Yes	233.2	Yes	2nd

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

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

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

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

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
HIV case rate per 100,000								
Crude	(Table) (Trend) (Map)	11	3.7	19.1	Yes	7.6	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	11	4.0	19.1	Yes	7.9	Yes	2nd
AIDS case rate per 100,000								
Crude	(Table) (Trend) (Map)	3	1.0*	12.2	Yes	4.4	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	3	0.9*	12.2	Yes	4.5	Yes	1st
AIDS mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	2	0.7*	4.0	Yes	1.4	No	2nd
Age-adjusted	(Table) (Trend) (Map)	2	0.8*	3.7	Yes	1.3	Yes	2nd
Early syphilis case rate per 100,000	(Table) (Trend) (Map)	1	0.3*	14.4	Yes	3.6	Yes	1st
Gonorrhea case rate per 100,000								
All ages	(Table) (Trend) (Map)	44	14.8	107.7	Yes	61.1	Yes	1st
Aged 15-19 years	(Table) (Trend) (Map)	8	41.2*	368.1	Yes	203.6	Yes	1st
Chlamydia case rate per 100,000 males								
All ages	(Table) (Trend) (Map)	249	169.2	336.0	Yes	203.0	Yes	3rd
Aged 15-19 years	(Table) (Trend) (Map)	48	480.8	1,029.1	Yes	608.6	No	3rd
Aged 20-24 years	(Table) (Trend) (Map)	115	1,311.4	1,492.7	No	1,089.0	No	4th
Chlamydia case rate per 100,000 females								
All ages	(Table) (Trend) (Map)	506	338.3	672.3	Yes	466.8	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	191	2,023.7	3,595.5	Yes	2,387.5	Yes	2nd
Aged 20-24 years	(Table) (Trend) (Map)	208	2,503.0	3,432.2	Yes	2,743.8	No	2nd
% of sexually active young women aged 16-24 with at least one Chlamydia test in Medicaid program (2013)	(Table) (Trend) (Map)	192	40.5	72.2	Yes	65.2	Yes	4th
Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)	(Table) (Trend) (Map)	8	1.5*	3.0	No	2.1	No	1st

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

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

Injury Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Suicide mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	31	10.4	8.4	No	10.1	No	2nd
Age-adjusted	(Table) (Trend) (Map)	31	10.3	8.0	Yes	9.6	Yes	2nd
Aged 15-19 years	(Table) (Trend) (Map)	0	0.0*	5.4	Yes	6.3	Yes	1st
Self-inflicted injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	202	6.8	5.8	Yes	6.8	No	2nd
Age-adjusted	(Table) (Trend) (Map)	202	7.5	5.8	Yes	7.0	No	3rd
Aged 15-19 years	(Table) (Trend) (Map)	23	11.8	11.3	No	12.5	No	2nd
Homicide mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	5	1.7*	3.7	No	2.7	No	2nd
Age-adjusted	(Table) (Trend) (Map)	5	2.0*	3.7	Yes	2.8	Yes	3rd
Assault hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	34	1.1	4.1	Yes	2.5	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	34	1.2	4.1	Yes	2.7	Yes	1st
Unintentional injury mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	107	36.1	27.7	Yes	34.0	No	3rd
Age-adjusted	(Table) (Trend) (Map)	107	31.7	25.6	Yes	30.8	Yes	3rd
Unintentional injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	2,255	76.0	68.3	Yes	71.6	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	2,255	64.5	62.2	No	62.2	No	3rd
Aged less than 10 years	(Table) (Trend) (Map)	74	21.0	23.6	No	20.4	No	3rd
Aged 10-14 years	(Table) (Trend) (Map)	32	16.4	18.0	No	16.0	No	3rd
Aged 15-24 years	(Table) (Trend) (Map)	113	31.0	28.7	No	29.7	No	3rd
Aged 25-64 years	(Table) (Trend) (Map)	759	48.6	46.0	No	45.8	No	3rd
Aged 65 years and older	(Table) (Trend) (Map)	1,277	258.7	252.3	No	262.9	No	3rd
Falls hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	1,110	37.4	39.4	No	42.5	Yes	2nd
Age-adjusted	(Table) (Trend) (Map)	1,110	29.5	34.7	Yes	34.9	Yes	2nd

Aged less than 10 years	(Table) (Trend) (Map)	27	7.7	8.9	No	7.5	No	3rd
Aged 10-14 years	(Table) (Trend) (Map)	s	s	6.1	N/A	5.0	N/A	N/A
Aged 15-24 years	(Table) (Trend) (Map)	10	2.7	5.7	Yes	5.2	Yes	1st
Aged 25-64 years	(Table) (Trend) (Map)	245	15.7	18.4	Yes	18.4	Yes	1st
Aged 65-74 years	(Table) (Trend) (Map)	147	55.0	75.2	Yes	75.2	Yes	1st
Aged 75-84 years	(Table) (Trend) (Map)	336	212.3	220.3	No	229.4	No	3rd
Aged 85 years and older	(Table) (Trend) (Map)	340	500.8	560.2	Yes	590.7	Yes	2nd
Poisoning hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	388	13.1	11.1	Yes	11.0	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	388	13.5	10.7	Yes	10.9	Yes	3rd
Motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	25	8.4	6.3	No	8.4	No	2nd
Age-adjusted	(Table) (Trend) (Map)	25	8.2	6.0	Yes	8.0	No	2nd
Non-motor vehicle mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	82	27.6	21.4	Yes	25.6	No	3rd
Age-adjusted	(Table) (Trend) (Map)	82	23.4	19.5	Yes	22.8	Yes	3rd
Traumatic brain injury hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	200	6.7	10.0	Yes	10.2	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	200	6.0	9.4	Yes	9.2	Yes	1st
Alcohol related motor vehicle injuries and deaths per 100,000	(Table) (Trend) (Map)	162	54.6	33.3	Yes	44.4	Yes	3rd

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

s: Data do not meet reporting criteria

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

Maternal and Infant Health Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Percentage of births								
% of births to women aged 25 years and older without a high school education	(Table) (Trend) (Map)	230	11.1	14.1	Yes	10.6	No	3rd
% of births to out-of-wedlock mothers	(Table) (Trend) (Map)	1,422	43.6	40.9	Yes	39.1	Yes	2nd
% of births that were first births	(Table) (Trend) (Map)	1,311	40.2	42.6	Yes	40.8	No	2nd
% of births that were multiple births	(Table) (Trend) (Map)	130	4.0	3.9	No	4.1	No	3rd
% of births with early (1st trimester) prenatal care	(Table) (Trend) (Map)	2,343	72.4	73.1	No	75.4	Yes	3rd
% of births with late (3rd trimester) or no prenatal care	(Table) (Trend) (Map)	193	6.0	5.6	No	4.1	Yes	4th
% of births with adequate prenatal care (Kotelchuck)	(Table) (Trend) (Map)	2,324	72.5	69.1	Yes	70.8	No	2nd
WIC indicators								
% of pregnant women in WIC with early (1st trimester) prenatal care (2009-2011)	(Table) (Trend) (Map)	1,604	91.4	86.5	Yes	86.9	Yes	1st
% of pregnant women in WIC who were pre-pregnancy underweight (BMI less than 18.5) (2010-2012)	(Table) (Trend) (Map)	112	5.7	4.7	No	4.1	Yes	4th
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30) (2010-2012)	(Table) (Trend) (Map)	449	22.9	26.6	Yes	26.3	Yes	1st
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher) (2010-2012)	(Table) (Trend) (Map)	611	31.2	24.2	Yes	28.0	Yes	3rd
% of pregnant women in WIC with anemia in 3rd trimester (2009-2011)	(Table) (Map)	64	26.2	37.3	Yes	36.0	Yes	1st

% of pregnant women in WIC with gestational weight gain greater than ideal (2009-2011)	(Table) (Trend) (Map)	834	48.8	41.7	Yes	47.1	No	2nd
% of pregnant women in WIC with gestational diabetes (2009-2011)	(Table) (Trend) (Map)	81	4.6	5.5	No	5.8	No	1st
% of pregnant women in WIC with hypertension during pregnancy (2009-2011)	(Table) (Trend) (Map)	212	12.1	7.1	Yes	9.0	Yes	4th
% of WIC mothers breastfeeding at least 6 months (2010-2012)	(Table) (Trend) (Map)	96	16.0	38.2	Yes	27.7	Yes	4th
% of infants fed any breast milk in delivery hospital	(Table) (Trend) (Map)	2,269	75.3	83.1	Yes	77.9	No	3rd
% of infants fed exclusively breast milk in delivery hospital	(Table) (Trend) (Map)	2,041	67.8	40.7	Yes	49.2	Yes	1st
% of births delivered by cesarean section	(Table) (Trend) (Map)	1,097	33.7	34.1	No	35.6	No	3rd
Mortality rate per 1,000 live births								
Infant (less than 1 year)	(Table) (Trend) (Map)	17	5.2	5.0	No	5.5	No	2nd
Neonatal (less than 28 days)	(Table) (Trend) (Map)	11	3.4	3.4	No	3.9	No	2nd
Post-neonatal (1 month to 1 year)	(Table) (Trend) (Map)	6	1.8*	1.5	No	1.6	No	3rd
Fetal death (20 weeks gestation or more)	(Table) (Trend) (Map)	20	6.1	6.6	No	4.4	No	3rd
Perinatal (20 weeks gestation to less than 28 days of life)	(Table) (Trend) (Map)	31	9.5	10.0	No	8.3	No	3rd
Perinatal (28 weeks gestation to less than 7 days of life)	(Table) (Trend) (Map)	41	12.5	5.4	Yes	5.4	Yes	4th
Maternal mortality rate per 100,000 live births +	(Table) (Trend) (Map)	1	30.7*	20.0	No	19.4	No	3rd
Low birthweight indicators								
% very low birthweight (less than 1.5 kg) births	(Table) (Trend) (Map)	42	1.3	1.4	No	1.4	No	2nd
% very low birthweight (less than 1.5kg) singleton births	(Table) (Trend) (Map)	31	1.0	1.1	No	1.0	No	3rd
% low birthweight (less than 2.5 kg) births	(Table) (Trend) (Map)	231	7.1	8.0	No	7.6	No	2nd
% low birthweight (less than 2.5kg) singleton births	(Table) (Trend) (Map)	165	5.3	6.0	No	5.6	No	2nd

% of premature births by gestational age								
less than 32 weeks gestation	(Table) (Trend) (Map)	51	1.6	1.8	No	1.8	No	2nd
32 - less than 37 weeks gestation	(Table) (Trend) (Map)	292	9.0	9.1	No	9.1	No	3rd
less than 37 weeks gestation	(Table) (Trend) (Map)	343	10.5	10.9	No	10.9	No	3rd
% of births with a 5 minute APGAR less than 6	(Table) (Trend) (Map)	35	1.1	0.6	Yes	0.7	No	4th
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	14	47.1	95.0	Yes	123.2	Yes	1st

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

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

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

Obesity and Related Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
All students (elementary - PreK, K, 2nd and 4th grades, middle - 7th grade and high school - 10th grade) with weight status information in SWSCRS								
% overweight but not obese (85th-less than 95th percentile) # (2012-2014)	(Table) (Trend) (Map)	814	17.2	N/A	N/A	16.7	N/A	3rd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	903	19.1	N/A	N/A	17.3	N/A	3rd
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	1,717	36.2	N/A	N/A	33.9	N/A	3rd
Elementary students (PreK, K, 2nd and 4th grades) with weight status information in SWSCRS (2012-2014)								
% overweight but not obese (85th-less than 95th percentile) # (2012-2014)	(Table) (Trend) (Map)	465	16.5	N/A	N/A	16.4	N/A	2nd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	491	17.4	N/A	N/A	16.8	N/A	2nd
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	956	33.9	N/A	N/A	33.1	N/A	2nd
Middle and high school students (7th and 10th grades) with weight status information in SWSCRS (2012-2014)								
% overweight but not obese (85th-less than 95th percentile) # (2012-2014)	(Table) (Trend) (Map)	334	17.9	N/A	N/A	17.1	N/A	3rd
% obese (95th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	403	21.6	N/A	N/A	18.1	N/A	3rd
% overweight or obese (85th percentile or higher) # (2012-2014)	(Table) (Trend) (Map)	737	39.5	N/A	N/A	35.2	N/A	3rd
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30)	(Table) (Trend) (Map)	449	22.9	26.6	Yes	26.3	Yes	1st
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher)	(Table) (Trend) (Map)	611	31.2	24.2	Yes	28.0	Yes	3rd
% obese (95th percentile or	(Table) (Trend) (Map)	402	14.5	14.3	No	15.2	No	2nd

higher) children in WIC (aged 2-4 years) (2010-2012)								
% of children in WIC viewing TV 2 hours or less per day (aged 2-4 years) (2010-2012)	(Table) (Trend) (Map)	2,404	88.8	79.9	Yes	81.0	Yes	1st
% of WIC mothers breastfeeding at least 6 months (2009-2011)	(Table) (Trend) (Map)	96	16.0	38.2	Yes	27.7	Yes	4th
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2013-2014)	(Table) (Map)	N/A	68.4	60.5	No	62.3	No	4th
Age-adjusted % of adults obese (BMI 30 or higher) (2013-2014)	(Table) (Map)	N/A	32.8	24.6	Yes	27.4	No	4th
Age-adjusted % of adults who did not participate in leisure time physical activity in last 30 days (2013-2014)	(Table) (Map)	N/A	23.8	27.1	No	26.2	No	3rd
Age-adjusted % of adults eating 5 or more fruits or vegetables per day (2008-2009)	(Table) (Map)	N/A	24.8	27.1	No	27.7	No	3rd
Age-adjusted % of adults with physician diagnosed diabetes (2008-2009)	(Table) (Map)	N/A	10.4	8.9	No	8.2	No	3rd
Age-adjusted % of adults with physician diagnosed angina, heart attack or stroke # (2008-2009)	(Table) (Map)	N/A	7.4	7.6	No	7.2	No	2nd
Age-adjusted mortality rate per 100,000								
Cardiovascular disease mortality	(Table) (Trend) (Map)	884	221.7	228.0	Yes	228.2	Yes	2nd
Cerebrovascular disease (stroke) mortality	(Table) (Trend) (Map)	130	33.0	26.2	Yes	29.8	Yes	3rd
Diabetes mortality	(Table) (Trend) (Map)	68	17.7	17.6	No	15.7	Yes	2nd
Age-adjusted hospitalization rate per 100,000								
Cardiovascular disease hospitalizations	(Table) (Trend) (Map)	5,034	131.3	143.5	Yes	136.0	Yes	3rd
Cerebrovascular disease (stroke) hospitalizations	(Table) (Trend) (Map)	922	24.0	23.5	No	23.6	No	3rd
Diabetes hospitalizations (primary diagnosis)	(Table) (Trend) (Map)	587	18.3	17.9	No	14.2	Yes	4th

N/A: Data not available

#: Data not available for NYC counties

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

Occupational Health Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Incidence of malignant mesothelioma per 100,000 persons aged 15 years and older (2010-2012)	(Table) (Trend) (Map)	6	2.5*	1.3	No	1.7	No	4th
Hospitalization rate per 100,000 persons aged 15 years and older								
Pneumoconiosis	(Table) (Trend) (Map)	42	17.4	10.3	Yes	14.0	No	3rd
Asbestosis	(Table) (Trend) (Map)	33	13.6	9.3	No	12.7	No	3rd
Work-related hospitalizations per 100,000 employed persons aged 16 years and older	(Table) (Trend) (Map)	292	239.9	156.5	Yes	191.1	Yes	4th
Elevated blood lead levels (greater than or equal to 10 micrograms per deciliter) per 100,000 employed persons aged 16 years and older	(Table) (Trend) (Map)	12	9.9	22.3	Yes	22.7	Yes	1st
Fatal work-related injuries per 100,000 employed persons aged 16 years and older #	(Table) (Trend) (Map)	8	6.6*	2.3	Yes	2.7	No	4th

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

#: Data not available for NYC counties

Oral Health Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Oral health survey of 3rd grade children								
% of 3rd grade children with caries experience # (2009-2011)	(Table) (Map)	N/A	23.4	N/A	N/A	45.4	Yes	1st
% of 3rd grade children with untreated caries # (2009-2011)	(Table) (Map)	N/A	23.4	N/A	N/A	24.0	Yes	2nd
% of 3rd grade children with dental sealants # (2009-2011)	(Table) (Map)	N/A	25.3	N/A	N/A	41.9	Yes	1st
% of 3rd grade children with dental insurance # (2009-2011)	(Table) (Map)	N/A	84.0	N/A	N/A	81.8	Yes	3rd
% of 3rd grade children with at least one dental visit in last year # (2009-2011)	(Table) (Map)	N/A	81.7	N/A	N/A	83.4	Yes	3rd
% of 3rd grade children reported taking fluoride tablets regularly # (2009-2011)	(Table) (Map)	N/A	71.9	N/A	N/A	41.9	Yes	4th
Age-adjusted % of adults who had a dentist visit within the past year # (2013-2014)	(Table) (Map)	N/A	69.2	69.8	No	71.5	No	3rd
Caries outpatient visit rate per 10,000 (aged 3-5 years)	(Table) (Trend) (Map)	152	143.5	79.2	Yes	93.5	Yes	3rd
Medicaid oral health indicators								
% of Medicaid enrollees with at least one dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	19,281	24.0	31.8	Yes	30.9	Yes	4th
% of Medicaid enrollees with at least one preventive dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	14,975	18.7	26.6	Yes	25.1	Yes	4th
% of Medicaid enrollees (aged 2-20 years) who had at least one dental visit within the last year # (2012-2014)	(Table) (Trend) (Map)	9,244	34.5	45.0	Yes	44.3	Yes	4th
% of Medicaid enrollees (aged 2-20 years) with at	(Table) (Trend) (Map)	7,937	29.7	40.1	Yes	39.7	Yes	4th

least one preventive dental visit within the last year # (2012-2014)								
% of children, aged 2-21 years, with at least one dental visit in government sponsored insurance programs (2013)	(Table) (Trend) (Map)	2,363	51.4	59.2	Yes	61.4	Yes	4th
Oral cancer								
Crude incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	48	16.1	12.1	No	13.5	No	3rd
Age-adjusted incidence rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	48	12.0	10.5	No	11.0	No	3rd
Crude mortality rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	s	s	2.5	N/A	2.6	N/A	N/A
Age-adjusted mortality rate per 100,000 (2010-2012)	(Table) (Trend) (Map)	s	s	2.2	N/A	2.1	N/A	N/A
Mortality per 100,000 (aged 45-74 years) (2010-2012)	(Table) (Trend) (Map)	s	s	4.8	N/A	4.6	N/A	N/A

N/A: Data not available

s: Data do not meet reporting criteria

#: Data not available for NYC counties

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

Respiratory Disease Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Chronic lower respiratory disease mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	187	63.0	35.6	Yes	46.2	Yes	3rd
Age-adjusted	(Table) (Trend) (Map)	187	46.8	30.7	Yes	36.8	Yes	3rd
Chronic lower respiratory disease hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	987	33.3	36.5	Yes	33.0	No	2nd
Age-adjusted	(Table) (Trend) (Map)	987	26.8	34.1	Yes	28.6	No	2nd
Asthma hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	206	6.9	18.2	Yes	11.1	Yes	1st
Age-adjusted	(Table) (Trend) (Map)	206	6.7	18.2	Yes	10.9	Yes	2nd
Aged 0-4 years	(Table) (Trend) (Map)	22	13.0	50.5	Yes	30.2	Yes	1st
Aged 5-14 years	(Table) (Trend) (Map)	27	7.1	20.5	Yes	10.4	No	2nd
Aged 0-17 years	(Table) (Trend) (Map)	49	7.3	26.6	Yes	14.2	Yes	2nd
Aged 5-64 years	(Table) (Trend) (Map)	140	6.1	13.8	Yes	8.5	Yes	2nd
Aged 15-24 years	(Table) (Trend) (Map)	13	3.6	6.8	Yes	3.6	No	3rd
Aged 25-44 years	(Table) (Trend) (Map)	30	4.4	8.6	Yes	6.6	Yes	1st
Aged 45-64 years	(Table) (Trend) (Map)	70	8.0	19.7	Yes	11.6	Yes	2nd
Aged 65 years or older	(Table) (Trend) (Map)	44	8.9	29.4	Yes	17.7	Yes	2nd
Asthma mortality rate per 100,000								
Crude	(Table) (Trend) (Map)	3	1.0*	1.4	No	0.9	No	3rd
Age-adjusted	(Table) (Trend) (Map)	3	0.9*	1.3	Yes	0.8	Yes	3rd
Age-adjusted % of adults with current asthma (2013-2014)	(Table) (Map)	N/A	10.5	10.1	No	10.5	No	2nd

N/A: Data not available

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

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

Socio-Economic Status and General Health Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Total population (2013)	(Table) (Trend) (Map)	N/A	98,650.0	19,651,127.0	N/A	11,245,290.0	N/A	3rd
% of labor force unemployed (2014)	(Table) (Trend) (Map)	3,064	6.9	6.3	Yes	5.6	Yes	4th
% of population below poverty (2013)	(Table) (Trend) (Map)	N/A	15.6	16.0	No	N/A	N/A	3rd
% of children aged less than 18 years below poverty (2013)	(Table) (Trend) (Map)	N/A	24.7	22.9	No	N/A	N/A	3rd
Median household income in US dollars (2013)	(Table) (Trend) (Map)	N/A	46,540.0	57,255.0	N/A	N/A	N/A	3rd
% of children aged less than 19 years with health insurance (2013)	(Table) (Trend) (Map)	N/A	94.6	95.9	No	N/A	N/A	4th
% of adults aged 18-64 years with health insurance (2013)	(Table) (Trend) (Map)	N/A	86.5	84.7	Yes	N/A	N/A	3rd
High school drop out rate (2012-2014)	(Table) (Trend) (Map)	401	2.7	3.3	Yes	2.3	Yes	3rd
Age-adjusted % of adults who did not receive medical care because of cost # (2013-2014)	(Table) (Map)	N/A	12.0	13.6	No	12.0	No	3rd
Age-adjusted % of adults with regular health care provider (2013-2014)	(Table) (Map)	N/A	89.0	84.5	No	84.7	No	1st
Age-adjusted %	(Table) (Map)	N/A	13.7	11.1	No	11.8	No	3rd

of adults who had poor mental health 14 or more days within the past month (2013-2014)								
Birth rate per 1,000 population	(Table) (Trend) (Map)	3,257	11.0	12.2	Yes	10.7	No	3rd
Total mortality rate per 100,000	(Table) (Trend) (Map)	2,823	951.3	753.1	Yes	854.1	Yes	3rd
Age-adjusted total mortality rate per 100,000	(Table) (Trend) (Map)	2,823	723.5	644.9	Yes	678.5	Yes	3rd
% premature deaths (aged less than 75 years)	(Table) (Trend) (Map)	1,113	39.4	39.9	No	37.5	No	3rd
Years of potential life lost per 100,000	(Table) (Trend) (Map)	17,944	6,545.8	5,577.4	Yes	5,839.3	Yes	3rd
Total emergency department visit rate per 10,000	(Table) (Trend) (Map)	139,542	4,702.4	4,086.4	Yes	3,752.5	Yes	4th
Age-adjusted total emergency department visit rate per 10,000	(Table) (Trend) (Map)	139,542	4,821.2	4,074.7	Yes	3,762.9	Yes	4th
Total hospitalization rate per 10,000	(Table) (Trend) (Map)	34,541	1,164.0	1,226.2	Yes	1,168.1	No	3rd
Age-adjusted total hospitalization rate per 10,000	(Table) (Trend) (Map)	34,541	1,085.3	1,167.3	Yes	1,104.3	Yes	3rd

N/A: Data not available

#: Data not available for NYC counties

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

Tobacco, Alcohol and Other Substance Abuse Indicators - Steuben County

2011-2013

Indicator	Data Links	3 Year Total	County Rate	NYS Rate	Sig.Dif.	NYS Rate exc NYC	Sig.Dif.	County Ranking Group
Drug-related hospitalization rate per 10,000								
Crude	(Table) (Trend) (Map)	648	21.8	23.7	Yes	20.2	No	3rd
Age-adjusted	(Table) (Trend) (Map)	648	24.3	23.6	No	21.0	Yes	4th
Newborn drug-related diagnosis rate per 10,000 newborn discharges	(Table) (Trend) (Map)	14	47.1	95.0	Yes	123.2	Yes	1st
Alcohol related motor vehicle injuries and deaths per 100,000	(Table) (Trend) (Map)	162	54.6	33.3	Yes	44.4	Yes	3rd
Age-adjusted % of adults who smoke cigarettes (2013-2014)	(Table) (Map)	N/A	25.1	15.9	Yes	18.0	Yes	4th
Age-adjusted % of adults living in homes where smoking is prohibited (2008-2009)	(Table) (Map)	N/A	74.5	80.9	No	79.3	No	3rd
Age-adjusted % of adults who binge drink (2013-2014)	(Table) (Map)	N/A	15.4	17.7	No	17.2	No	2nd

N/A: Data not available

Steuben County

County/ZIP Code Perinatal Data Profile - 2011-2013

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

ZIP Code	Total Births 2011-2013	Percent of Births					Infant and Neonatal Deaths, rate per 1,000 live births				Teen Rates per 1,000	
		Premature Birth	Low Birth Weight	Out of Wedlock	Medicaid or Self-pay	Late or No Prenatal Care	Infant Deaths 2011-2013	Infant Deaths Rate	Neonatal Deaths 2011-2013	Neonatal Deaths Rate	Teen Birth Rate	Teen Pregnancy Rate
14572	159	7.7	5.7	52.8	45.9	4.4	0	0.0	0	0.0	28.9	39.1
14801	234	12.2	8.1	41.1	64.7	15.9	1	4.3	1	4.3	28.8	36.4
14807	74	6.9	4.1	35.1	47.3	1.4	0	0.0	0	0.0	24.2	24.2
14808	17	12.5	5.9	70.6	58.8	0.0	0	0.0	0	0.0	*	*
14809	104	8.9	8.7	36.5	63.5	8.7	2	19.2	2	19.2	34.0	46.3
14810	395	10.6	7.8	53.8	55.7	4.1	3	7.6	1	2.5	41.0	44.6
14819	30	20.7	10.0	65.5	63.3	3.3	0	0.0	0	0.0	22.2	55.6
14820	17	17.6	5.9	52.9	52.9	5.9	0	0.0	0	0.0	0.0	0.0
14821	82	17.5	7.3	50.0	54.9	1.2	0	0.0	0	0.0	32.3	53.8
14823	122	10.7	7.4	45.1	58.2	1.6	1	8.2	0	0.0	19.5	24.3

14826	56	11.1	3.6	42.9	41.1	1.8	0	0.0	0	0.0	7.7	7.7
14830	629	11.7	7.8	39.2	40.9	1.9	1	1.6	1	1.6	20.9	31.8
14839	31	9.7	6.5	36.7	58.1	19.4	0	0.0	0	0.0	*	*
14840	58	7.0	8.6	39.7	48.3	12.1	2	34.5	2	34.5	36.1	48.2
14843	466	9.4	7.3	58.1	62.0	2.2	6	12.9	4	8.6	32.5	46.6
14855	62	6.6	3.2	16.1	82.3	35.5	1	16.1	0	0.0	23.3	38.8
14858	72	9.9	6.9	39.7	45.8	2.8	0	0.0	0	0.0	49.0	53.9
14870	312	12.3	6.4	35.7	30.8	1.9	0	0.0	0	0.0	23.0	29.0
14873	70	11.6	7.1	37.1	55.1	11.6	0	0.0	0	0.0	18.1	25.4
14877	14	14.3	21.4	23.1	42.9	0.0	0	0.0	0	0.0	*	*
14879	75	5.3	5.3	41.3	41.3	5.3	0	0.0	0	0.0	35.6	57.8
14885	31	10.3	6.5	36.7	71.0	19.4	0	0.0	0	0.0	24.4	24.4
14898	85	7.5	4.7	12.0	78.8	39.3	0	0.0	0	0.0	15.4	35.9
Total	3,199	10.6	7.1	43.9	51.9	6.0	17	5.3	11	3.4	27.7	37.3

Note:

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

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

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

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

County:	Steuben
Group Name:	Steuben County Community Health Priority Setting
Date and Time:	June 07, 2016 - 2:00 PM

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

Issues to Rank based on Data Assessment

- Obesity – lifestyle, cultural, physical activity, nutrition, community gardens. (low back pain and diabetes)
- Substance abuse, especially Opioid drugs
- Dental health
- Mental health
- Cancer (tobacco use)
- Hypertension (tobacco use)
- Falls – 65+ population
- Early childhood health

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

Charting the Course…

Selecting Issues and Priorities

Public Health

Acknowledgement:

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

Selecting Issues & Priorities

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

The Hanlon Method

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

The Hanlon Method…

BPR – Basic Priority Rating System

BPR = (A + 2B) x C

A = Size of the problem

B = Seriousness of the problem

C = Effectiveness of the solution

(weighted by PEARL Factors)

Component A – Size of Problem

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

Component A: Size of Problem

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

Component B – Seriousness of Problem

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

Component B: Seriousness of Problem

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

Component C – Effectiveness of Intervention

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

Component C: Effectiveness of Intervention

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

Immunization programs are known to be highly effective…

as compared to the results of smoking cessation programs.

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

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

PEARL Factors:

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

Here We Go!

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

Sample Worksheet:

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

Considerations and Conclusions

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

And…

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

And finally…

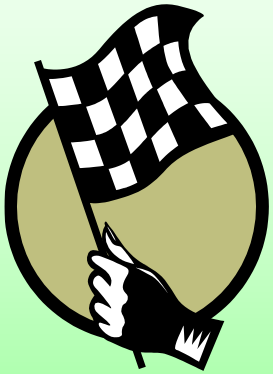
- Soup slurping is evidently quite widespread and a serious problem, and we believe the interventions could be relatively effective
- However, solutions to the problem are NOT within our scope or mission statement
- It makes economic sense to address the problem, but there will probably NOT be economic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

Therefore…

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

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

Time to Get Started!



Attachment 10

County: Steuben_____ Please enter issues in same order as on the screen Date: 06/07/2016_____

Issue	Size (A)	Serious-ness (B)	Effective-ness (C)	Score (A+2B) X C	PEARL
Obesity – lifestyle, cultural, physical activity, nutrition, community gardens. (low back pain and diabetes)					P P E E A R L
Substance abuse, especially opioid drugs					P P E E A R L
Dental health					P P E E A R L
Mental health					P P E E A R L
Cancer (tobacco use)					P P E E A R L
Hypertension (tobacco use)					P P E E A R L
Falls – 65+ population					P P E E A R L
Early childhood health					P P E E A R L
Strategies: Access to care issues – dental, maternity, ER response times, transportation, health insurance, health disparities, target populations such as seniors, tobacco use.					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L
					P P E E A R L

Attachment 10

County: Steuben_____ Please enter issues in same order as on the screen Date: 06/07/2016_____

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

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

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

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

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

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

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

The following are the results from the Priority Setting Meeting

conducted on June 7th, 2016 from 2:00pm to 4:00pm.

#	Issue	Hanlon	Pearl
1	Obesity	174.16	5.63
2	Hypertension (Tobacco Use)	169.37	5.68
3	Early Childhood health	161.05	6.11
4	Cancer (Tobacco Use)	157.84	5.84
5	Mental health	150.89	4.84
6	Alcohol abuse/Substance abuse	147.63	5.95
7	Dental health	138.78	5.00
8	Falls - 65+ population	115.89	4.26

S²AY Rural Health Network, Inc.
&
Steuben Public Health

County:	Steuben
Group Name:	Prioritization Method Meeting
Date and Time:	June 07, 2016 – 2:00PM

Sign in Sheet

Name	Organization	Email
Terry Moss	Steuben Public Health	terrym@co.steuben.ny.us
Loretei Wagner		loreleiw@co.steuben.ny.us
Hillary Anderson	S²AYRHN	
John Van Zanten	Corning Hospital	jvanzanten@cty.st.com
Laura Vetter	St. James	lvetter@sjmh.org
Cathie Heran	FLHSA	cathierckan@flhsa.org
Kate Ebersole	FLPPS	Kate.ebersole3@gmail.com
Sarah Robbins	STTAC	sarahrobbins@co.chemung.ny.us
Stacy Hills	STTAC	shills@co.chemung.ny.us
Kim Feehan	Town of Corning	supervisor@TownofCorningny.org
Jackie Woollett	SRHN	woollettj@ihsnet.org
Krystle Bertrou	SRHN	blencowek@ihsnet.org
Larkin Podsiedlik	CCE	llp36@cornell.edu
Justine Cobb	CCE and FLESNY	jec445@cornell.edu
Gail Welsh	Steuben Co Public Health	gailw@co.steuben.ny.us
Jaydee Pahlka	Arnot Health	
Rosemary Anthony	Arnot Health	
Terry Bird	Arnot Health	tbird@ah.arnothealth.org
Mildred Landon	City Leg	landoht22@gmail.com
Tina Yardani	TWC News	tyardani@twcable.com
Christine Towner	OFA / RSVP	ctowner@co.steuben.ny.us
Mary Pertram	Steuben County PHP	marypertram1@gmail.com
Darlene Smith	Steuben PH	darlenes@co.steuben.ny.us
Vicki Fuerst	Steuben Co PH	vickif@co.steuben.ny.us

SMART STEUBEN
YOUR HEALTH YOUR LIFE

Steuben County Public Health
&
Steuben County Hospitals

Invite you to attend the:

Community Health Assessment: Health Priority Setting Meeting

Tuesday, June 7th, 2016

2:00 - 4:00 pm

Civil Defense Training Center

7220 State Route 54, Bath

We are looking for community input on the health priority areas for improvement in Steuben County.

RSVP by Friday, June 3 to:

(607) 664-2438 or Loreleiw@co.steuben.ny.us

Public Health
Prevent. Promote. Protect.
Steuben County NY

ArnotHealth

GUTHRIE
Corning Hospital

St James Mercy Hospital

Attachment 13

MEMO

DATE: June 16, 2016

FROM: St. James Mercy Hospital Community Services Department

RE: Community Services Plan – Prioritization of Needs 2016

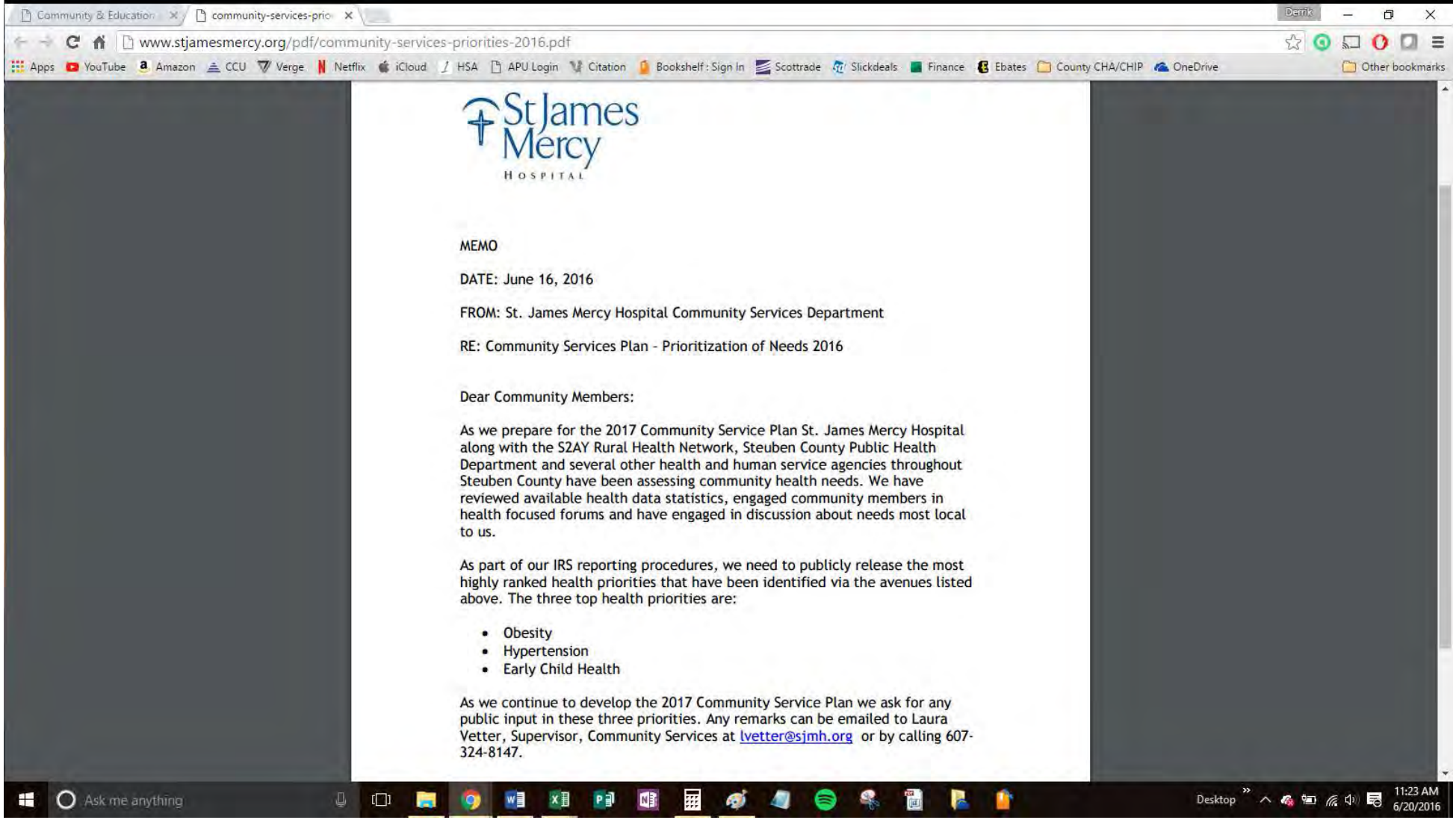
Dear Community Members:

As we prepare for the 2017 Community Service Plan St. James Mercy Hospital along with the S2AY Rural Health Network, Steuben County Public Health Department and several other health and human service agencies throughout Steuben County have been assessing community health needs. We have reviewed available health data statistics, engaged community members in health focused forums and have engaged in discussion about needs most local to us.

As part of our IRS reporting procedures, we need to publicly release the most highly ranked health priorities that have been identified via the avenues listed above. The three top health priorities are:

- Obesity
- Hypertenstion
- Early Child Health

As we continue to develop the 2017 Community Service Plan we ask for any public input in these three priorities. Any remarks can be emailed to Laura Vetter, Supervisor, Community Services at lvetter@sjmh.org or by calling 607-324-8147.



St James Mercy Hospital

MEMO

DATE: June 16, 2016

FROM: St. James Mercy Hospital Community Services Department

RE: Community Services Plan - Prioritization of Needs 2016

Dear Community Members:

As we prepare for the 2017 Community Service Plan St. James Mercy Hospital along with the S2AY Rural Health Network, Steuben County Public Health Department and several other health and human service agencies throughout Steuben County have been assessing community health needs. We have reviewed available health data statistics, engaged community members in health focused forums and have engaged in discussion about needs most local to us.

As part of our IRS reporting procedures, we need to publicly release the most highly ranked health priorities that have been identified via the avenues listed above. The three top health priorities are:

- Obesity
- Hypertension
- Early Child Health

As we continue to develop the 2017 Community Service Plan we ask for any public input in these three priorities. Any remarks can be emailed to Laura Vetter, Supervisor, Community Services at lvetter@sjmh.org or by calling 607-324-8147.

Public Health

Darlene Smith, Director

Telephone (607) 664-2438
Fax (607) 664-2166
3 East Pulteney Square
Bath, NY 14810
Emergency After Hours:1-800-836-4444

Public Health
Prevent. Promote. Protect.
Steuben County NY

SMART STEUBEN
YOUR HEALTH YOUR LIFE

Steuben County Public Health, along with Guthrie Corning Hospital, St. James Mercy Hospital, and Arnot Health, are completing a Community Health Assessment. Together, these organizations and other health-oriented community agencies form the Smart Steuben team. After reviewing data and receiving information from focus groups in the county, the following three health priorities were preliminarily chosen to focus on beginning in 2017: obesity, hypertension (high blood pressure), and early childhood health. Feedback from community members on the chosen priorities at this point will help to direct the work that we do and help to determine if these are the final priorities chosen. Please fill out the comment box below with your input. Thank you.

Steuben County Health Priority Feedback Form

Please provide feedback on the preliminary chosen health priority areas of obesity, high blood pressure, and early childhood health.

Zip Code (Required) *

Community Health Needs Assessment

Community Benefits
Community Grant Application Guidelines
Community Health Needs Assessment
Community Grants Application
History
Leadership
Mission & Values
Quality and Awards
Sponsorships
Mayo Clinic Care Network

The Patient Protection and Affordable Care Act (PPACA), requires non-profit hospitals to complete a community health needs assessment (CHNA) every three years. In line with Guthrie's vision to "improve health through clinical excellence and compassion; every patient, every time" the CHNA helps Guthrie understand community health needs. It allows Guthrie to better target its efforts to improve community health.

Each of these three community needs assessment documents include a description and supporting data of existing community needs specifically (1) demographics of the primary service area (race/ethnicity, income, education, employment); (2) insurance coverage (commercial, Medicare/Medicaid, uninsured), healthcare infrastructure (number and type of health care providers and services); and (3) key health challenges (access issues, high lung cancer rates, cancer mortality, heart disease mortality/prevalence, and obesity). The assessment will additionally include projected changes in the demographics, insurance coverage and health care infrastructure during the 3-year program period. Based on what is learned through the community needs assessment, priorities are established. Projects will be selected and implemented that address these priorities.

To review the current priorities and implementation plans for each of the Guthrie hospitals please click on the documents below.

Needs Assessments

- Guthrie Corning Hospital
- Guthrie Robert Packer Hospital
- Guthrie Towanda Memorial Hospital
- Guthrie Troy Community Hospital

2017 Implementation Plans

- Guthrie Corning Hospital

Guthrie Corning Hospital Community Service Plan

Guthrie works with the communities we serve to help each person attain optimal, life-long health and well-being.

- 2015 Annual Update
- 2014 One-Year Update

Community Service Plan for Schuyler County

- 2013 - 2015 Community Service Plan

Community Service Plan for Steuben County

- 2013 - 2015 Community Service Plan
- 2011 Community Service Plan

Steuben County Community Health Improvement Plan

11/10/16

Priority: Prevent Chronic Diseases					
Focus Area 1: Reduce Obesity in Children and Adults					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention(s) address a disparity? ☒ Yes ☐ No *Objective 1.4.1 – Working with low income population.					
Goal	**Outcome Objectives**	**Interventions/Strategies /Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#1.2 Prevent childhood obesity through early child care and schools.	**Objective 1.2.2:** By December 31, 2018, increase the number of school districts that meet or exceed NYS regulations for physical education (120 minutes per week of quality physical education in elementary grades K-6; daily physical education for children in grades K-3). • (Baseline compliance: 5% 2008) (Data Source: Office of the New York State Comptroller)	Increase the number of schools with comprehensive and strong Local School Wellness Policies (LWPs). Assist schools in developing wellness committees.	Number of schools that adopt and implement comprehensive and strong LWPs.	Public Health (PH), Corning Hospital, St. James, Genesee Valley (GV) BOCES, Cornell Cooperative Extension (CCE) working with school districts on LWPs.	CCE: $1,262.10 PH: $2,700 Corning Hospital: $1,200 St. James: $1,080 GV BOCES: In kind
#1.3 Expand the role of health care, health services providers and insurers in obesity prevention.	**Objective 1.3.2:** Increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization by 10% from 43.7% (2010) to 48.1%.	Recruit hospitals to participate in quality improvement efforts to increase breastfeeding exclusivity at discharge.	Number of efforts, practice/policy/ procedure updates, trainings, etc. implemented by birthing hospitals.	Corning Hospital to participate in/ expand efforts to increase breastfeeding exclusivity at discharge. Efforts include: • Development of standard work to educate all LDRP patients on the importance of breastfeeding (to include education to “bottle” moms re:	Corning Hospital: $2,000 / Train 6-8 FTE’s FLBP/S2AY RHN: $3,300 PH: $1,760

	Data Source: Bureau of Biometrics and Biostatistics, NYSDOH; NYC Office of Vital Records, NYC DOHMH) (Also, see: Focus Area – Maternal and Infant Health)			benefits of breastfeeding). • Change physician order sets to include Lanolin for breast feeding moms and educate on its use. • Upon admission to the hospital, identify if they have received their breast pump; if not, ensure arrangements are made prior to patient discharge. • Commitment to have all RN's within the LDRP unit to receive training on providing lactation support (currently around 50% of staff are trained). • Develop visual education materials for patient rooms Finger Lakes Breastfeeding Partnership (FLBP) and S2AY Rural Health Network (RHN) to assist hospital in increasing breastfeeding exclusivity at discharge through procurement of grants, offering trainings, networking, etc. PH serves as a member of the FLBP.	
		Encourage and recruit pediatricians, obstetricians and gynecologists, and other primary care provider practices and clinical offices to become New York State Breastfeeding Friendly Practices. Encourage daycare centers/homes	Number of primary care practices that are designated as NYS Breastfeeding Friendly. & Number and demographics of women reached by policies and practices to	PH, FLBP, S2AY RHN, Corning Hospital, and Arnot Health to assist practices with achieving NYS Breastfeeding Friendly designation. Specific efforts of Corning Hospital include: • Meet with lactation consultant at Guthrie Medical OB/GYN practice to develop a plan to collaborate and support the practice (in order to encourage pre-natal and post-partum education). • Partner with Guthrie Pediatrics and	PH: $845 FLBP / S2AY RHN: $3,300 Corning Hospital: $1,000 Arnot Health: 40 hours St. James: $300

		participating in the CACFP to become Breastfeeding Friendly Certified through the NYSDOH.	support breastfeeding. Number of daycare centers/ homes to become NYS Breastfeeding Friendly Certified.	OB/GYN practices to develop a Breastfeeding Friendly Policy. • As part of the planning for the new Medical Office Building (MOB) project, include lactation space. • Assist in the development of visual education materials for patient rooms (Guthrie Pediatrics and OB/GYN) St. James to encourage practices and daycare centers/homes in becoming Breastfeeding Friendly Certified. Efforts include sending letters and referring interested providers to the FLBP and/or ProAction/Child Care Aware for information and assistance. Child Care Aware to assist daycare centers/ homes in becoming NYS Breastfeeding Friendly Certified.	ProAction / Child Care Aware: $1484
#1.4 Expand the role of public and private employers in obesity prevention.	**Objective 1.4.1:** By December 31, 2018, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees and that is fully accessible to people with disabilities. Baseline to be determined.) (Data Source: NYSDOH Healthy Heart Program Worksite Survey)	Implement nutrition and beverage standards in public institutions, worksites, and other key locations such as hospitals.	Number and type of key community locations that adopt and or implement nutrition and beverage standards. & Number of adults that have access to key community locations that adopt and or implement	PH, Steuben Rural Health Network (SRHN), and Cancer Services Program (CSP) to reach out to worksites to promote the implementation of healthy policies/worksite wellness programs. GV BOCES and Arnot Health to work with worksites through the Creating Healthy Schools and Communities Grant. Corning Hospital, Arnot Health, and St. James to work internally to implement healthy policies. CCE to assist in worksite wellness efforts through education, programming, help set	PH: $11,000 GV BOCES: In kind Arnot Health: 50 hours Corning Hospital: $750 SRHN: $4,800 CSP / St. James: $9,040

			nutrition and beverage standards.	standards, etc. S2AY RHN/Regional Worksite Wellness Committee to assist PH and partners in worksite wellness efforts.	CCE: $1,584.22 Regional Worksite Wellness Committee / S2AY RHN: $2,475

Priority: Prevent Chronic Diseases					
Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention address a disparity? ☒ Yes ☐ No *Objective 2.1.3 and Objective 2.3.2 – Targeting low income population and low income housing.					
Goal	**Outcome Objectives**	**Interventions/Strategies /Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#2.1 Prevent initiation of tobacco use by youth and young adults, especially among low socioeconomic status (SES) populations.	**Objective 2.1.3:** By December 31, 2018, increase the number of municipalities that restrict tobacco marketing (limiting the density of tobacco vendors and their proximity to schools) from zero (2011) to 10. (Data Source: Community Activity Tracking, CAT)	Create a local environment that successfully demands passage of one or more of the following local laws or regulations that: a. Restricts the number, location, and/or type of retailers that sell tobacco products within a municipality jurisdiction b. Restricts the redemption of coupons or use of multi-pack discounts from licensed tobacco retailers	Decrease in density of tobacco vendors.	Southern Tier Tobacco Awareness Coalition (STTAC) to work toward objective through education, promotion, public hearings, trainings, etc. PH to advocate for county legislation to increase purchasing age to 21 and supporting STTAC in their efforts. Arnot Health will participate in STTAC meetings and advocacy activities. Arnot Health will provide community presentations to youth to prevent the initiation of tobacco use.	STTAC: $86,000 PH: $3,040 Arnot Health: 70 hours
#2.3 Eliminate	**Objective 2.3.2:**	Encourage adoption of	Number of units	STTAC to work with local housing authorities,	STTAC: $32,000

exposure to secondhand smoke.	By December 31, 2018, increase the number of local housing authorities that adopt a tobacco-free policy for all housing units from 3 (2012) to 12. (Data source: Community Activity Tracking, CAT)	smoke-free policies in publicly and privately operated housing.	covered by smoke free multi-unit dwelling policies.	landlords, etc. to implement smoke-free policies. Arnot Health will provide community presentations to increase awareness of the harm of secondhand smoke.	Arnot Health: 20 hours

Priority: Prevent Chronic Diseases					
Focus Area 3: Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings.					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention address a disparity? ☐ Yes ☒ No					
Goal	**Outcome Objectives**	**Interventions/Strategies/Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#3.2: Promote use of evidence-based care to manage chronic diseases.	**Objective 3.2.4:** By December 31, 2018, increase the percentage of health plan members, ages 18-85 years, with hypertension who have controlled their blood pressure (below 140/90	Participation in regional blood pressure registry.	Number of primary care practices that submit patient numbers to registry.	Finger Lakes Health Systems Agency (FLHSA) to provide technical support, compile data/reports, and recruit additional practices. PH to follow up with participating providers to offer education, training, etc. to increase control rates. Assist with recruiting additional practices. Corning Hospital and Arnot Health to provide data to FLHSA for registry. Assist with recruiting additional practices. S2AY RHN to provide support to PH in reaching out to practices, promoting programs, and offering trainings.	FLHSA: In kind PH: $1,750 Corning Hospital: $500 Arnot Health : 24 hours S2AY RHN: $2,475

#3.3 Promote culturally relevant chronic disease self-management education.	**Objective 3.3.1:** Increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.	Promote the use of evidence-based interventions to prevent or manage chronic diseases.	Percent of adults with one or more chronic diseases who have attended a self-management program. Number of providers that use their EHRs to trigger them to speak to their patients about their weight, diet and exercise, and refer them to EBIs.	PH to offer National Diabetes Prevention Program (NDPP) classes. Promote and enroll members in classes. Identify additional partners that can be trained in Chronic Disease Self-Management Program (CDSMP) and hold classes within the county. SRHN and Arnot to offer CDSMP. St. James to have peer leaders trained to offer CDSMP in Hornell. Will offer space and media promotion. Corning, St. James, and Arnot Health to refer into the programs. S2AY RHN / Regional Living Healthy Group to assist with coordination of evidence based programs and provide back-up peer leaders for classes.	PH: $12,000 SRHN: $22,293 Arnot Health: 120 hours St. James: $1,600 S2AY RHN / Regional Living Healthy Group: $1,886

Priority: Promote Healthy Women, Infants, and Children					
Focus Area 1: Maternal and Infant Health					
Timeframe: To be completed by December 31, 2018 (Ongoing)					
Do the suggested intervention address a disparity? ☒ Yes ☐ No *Objective 1-1 – Working with low income population (Medicaid).					
Goal	**Outcome Objectives**	**Interventions/Strategies /Activities**	**Process Measures**	**Partner Role**	**Partner Resources**
#1.1 Reduce Premature Birth	**Objective 1.1:** By December 31, 2018, reduce the rate of preterm birth in NYS by at least 12% to 10.2%. (This target for 2018 is in alignment with the national	Provide evidence based home visiting and community health worker program models to provide enhanced support to assist women in getting health	Number and percent of women who received evidence based home visits.	PH to conduct Community Health Worker program and screenings for other Home Visiting programs. Corning Hospital, Arnot Health, and St. James Mercy Hospital to assist with promotion and referring patients.	Public Health: 3.5 FTEs Corning Hospital: $500 St. James: $300

	ASTHO/March of Dimes target of 17.9% improvement by 2020 to achieve a national preterm birth rate of 9.6 %.)	insurance, engaging in health care services, securing basic needs assistance, and practicing healthy behaviors.			Arnot Health: 24 hours