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

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

Finger Lakes Health

Seneca County Health Department

Common Ground Health

Introduction

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

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

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

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

www.S2AYnetwork.org

www.CommonGroundHealth.org

Key Findings

Eight County Region

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

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

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

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

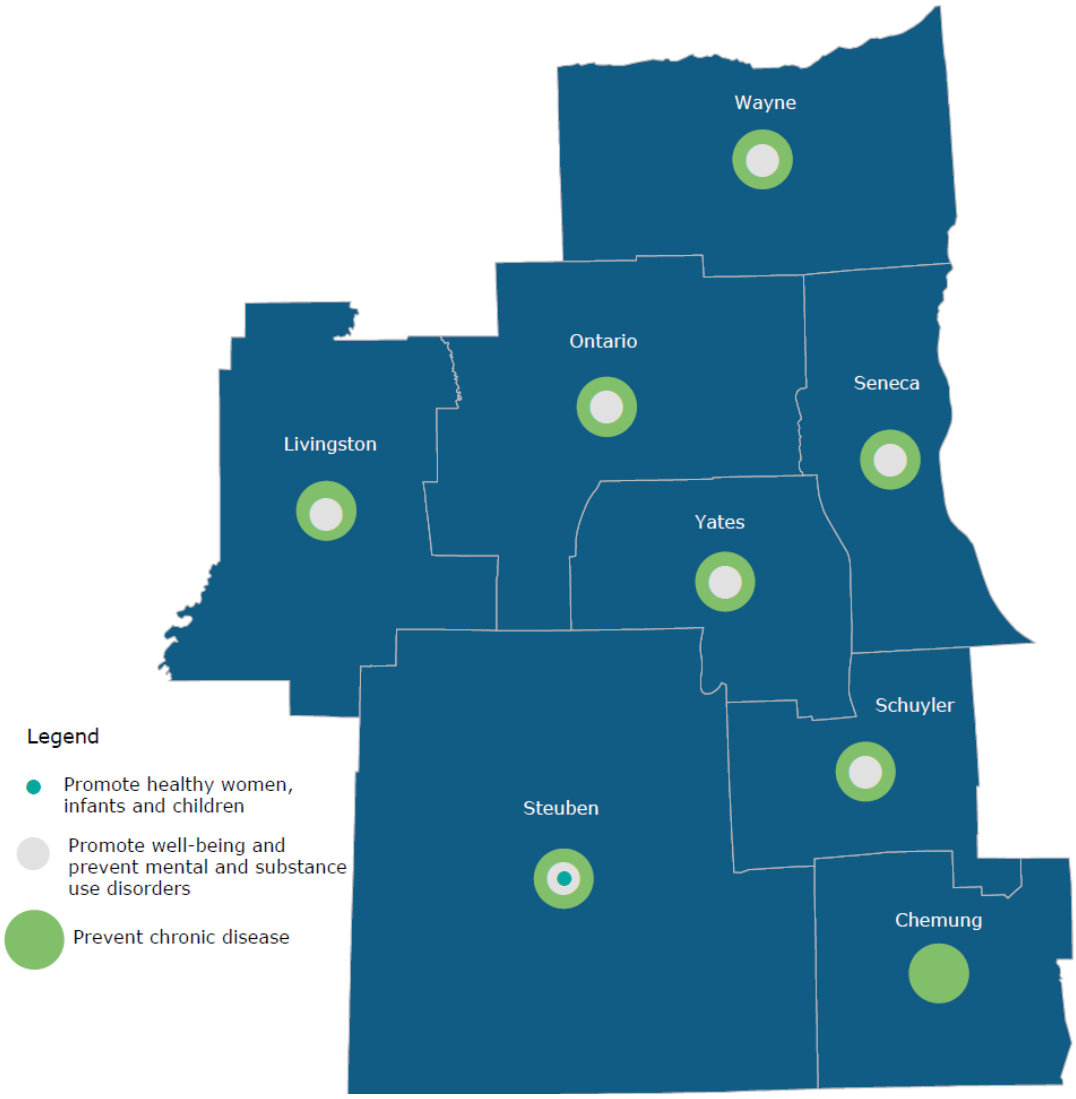
[1] Region includes Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties

Regional Priority Alignment

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

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

Map 1: Selected Priority Areas



Interventions

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

Focus Area	Intervention* & # of Counties Selected
Chronic disease preventative care and management	**4.1.2** Conduct one-on-one (by phone or in-person) and group education (presentation or other interactive session in a church, home, senior center or other setting) (selected by three counties) **4.1.3** Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand (selected by four counties)
Tobacco prevention	**3.1.2** Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms (selected by four counties) **3.2.3** Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence based quitting, increasing awareness of available cessation benefits (especially Medicaid) and removing barriers to treatment (selected by three counties) **3.3.1** Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents (selected by four counties)
Healthy eating and food security	**1.0.3** Implement worksite nutrition and physical activity programs designed to improve health behaviors and results (selected by three counties)
Prevent mental and substance use disorders	**2.2.2** Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (selected by five counties) **2.2.4** Build support systems to care for opioid users at risk of an overdose (selected by three counties) **2.2.5** Establish additional permanent safe disposal sites for prescription drugs and organized take-back days (selected by three counties) **2.3.3** Grow resilient communities through education, engagement, activation/mobilization and celebration (selected by three counties) **2.5.4** Identify and support people at risk: Gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-intervention, safe reporting and messaging about suicides (selected by five counties)
*Interventions shown are those where three or more counties selected the intervention. A full list of selected interventions can be found in the county improvement plan found in appendix A.	

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

Regional Assets and Resources to be Mobilized

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

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

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

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

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

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

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

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

Seneca County Executive Summary

The Seneca County Health Department has selected the following priority areas and disparity for the 2019-2021 assessment and planning period:

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

Selection of the 2019-2021 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) priority and disparity areas was a joint process which began in the summer of 2018 with assistance from the S2AY Rural Health Network and Common Ground Health. A variety of partners were engaged throughout the process including the public health departments and hospital staff, representatives from local Federally Qualified Health Centers (FQHCs), Community Based Organizations (CBOs), Seneca County DHS, Office for the Aging, STEPS, TACFL, Seneca County United Way, Seneca County Community Counseling Center, Genesee Valley BOCES, the S2AY Rural Health Network, Common Ground Health, and more. The community at large was engaged throughout the assessment period via a regional health survey in 2018 (*My Health Story 2018*) and focus groups. Partners' role in the assessment were to help inform and select the 2019-2021

priority areas by sharing any pertinent data or concerns and actively participating in planning meetings.

On May 15, 2019, the health department engaged key stakeholders in a prioritization meeting facilitated by the S2AY Rural Health Network. Over 100 key partners and community members were invited to attend the prioritization meetings, including all those who attended prior focus groups. Social media platforms, e-mail, news media and newsletters were utilized to help stimulate participation. Common Ground Health provided group members copies of county specific pre-read documents in advance of the meetings. The documents included information on current priority areas and progress made to date, as well as a mix of updated quantitative, qualitative, primary and secondary data on each of the five priority areas outlined in the New York State Prevention Agenda. Data were collected from a variety of different sources including, but not limited, to the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports and primary data collected from the *My Health Story 2018* Survey. A copy of the pre-read document, prioritization meeting materials and meeting attendees are available upon request.

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

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

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

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

Focus Area	Intervention* & # of Counties Selected
Tobacco prevention	**3.3.1** Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents (selected by four counties)
Healthy eating and food security	**1.0.3** Implement worksite nutrition and physical activity programs designed to improve health behaviors and results (selected by three counties)
Prevent mental and substance use disorders	**2.2.2** Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (selected by five counties) **2.2.5** Establish additional permanent safe disposal sites for prescription drugs and organized take-back days (selected by three counties) **2.5.4** Identify and support people at risk: Gatekeeper training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-intervention, safe reporting and messaging about suicides (selected by five counties)
*Interventions shown are those where Seneca County and at least two more counties selected the intervention. A full list of selected interventions can be found in the county improvement plan found in appendix A.	

Tobacco prevention was a widely selected focus area by several regional counties (five out of eight counties). Many counties, including Seneca, have selected goals designed to eliminate or reduce of exposure to secondhand smoke. Leveraging region-wide all of the previously mentioned interventions will aid in reaching as many persons as possible throughout the region. In addition, wide-spread goal alignment exists among promotion of well-being and prevention of mental and substance use disorders. Several counties, including Seneca, have selected

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

interventions and goals to reduce stigma around mental health disorders and reduce suicide. The complete list of Seneca County's selected interventions, process measures and partner roles in implementation processes can be found in the county's Community Health Improvement Plan grid (Appendix A).

The health department's designated oversight committee for the CHA/CHIP is the Seneca Health Solutions Committee. The committee meets monthly and is responsible for reviewing, updating and assessing the performance of CHIP Interventions and strategies. During meeting, the group will identify successes, challenges, changes in resources and modify the CHIP if needed. Partners and the community will be informed of CHIP progress via meeting minutes, community presentations, updates posted on our website and or reports submitted to our governing entities.

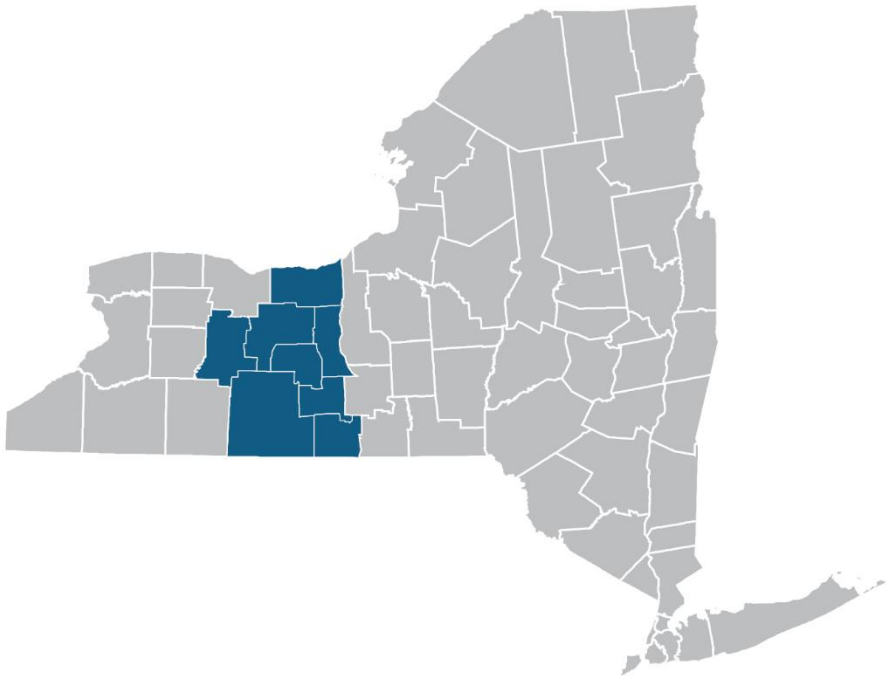
Community Health Assessment

Eight County Region

Total Population

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

Map 2: The eight-county Finger Lakes region



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

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

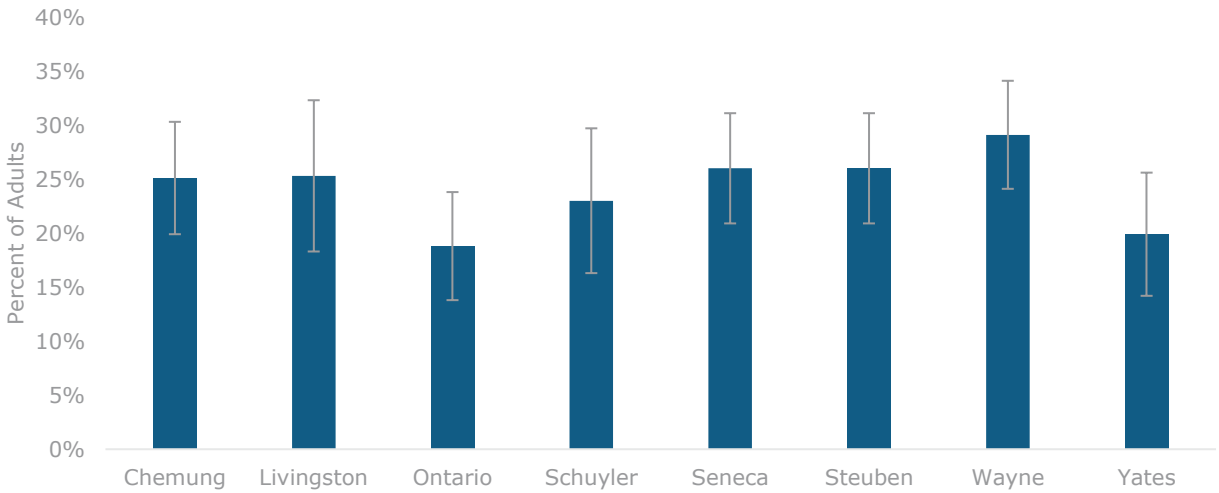
Disability

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

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

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

Figure 1: Percent of adults living with a disability



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

Household Language

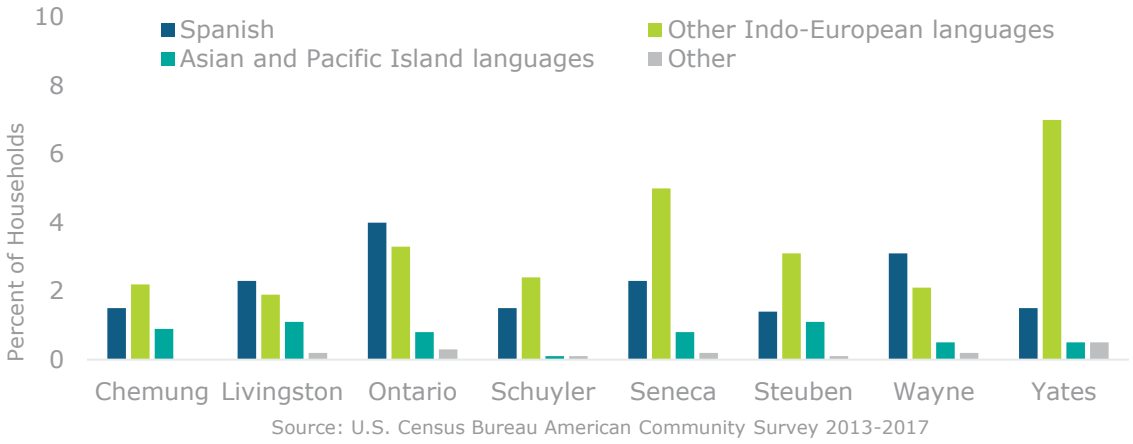
Providers of all types (medical, social service, etc.) should be aware of language and cultural differences when working with patients/clients. Being respectful of a person's cultural practices is important to building a trusting and positive relationship. A system where healthcare providers are culturally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

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

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

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

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



Special Populations

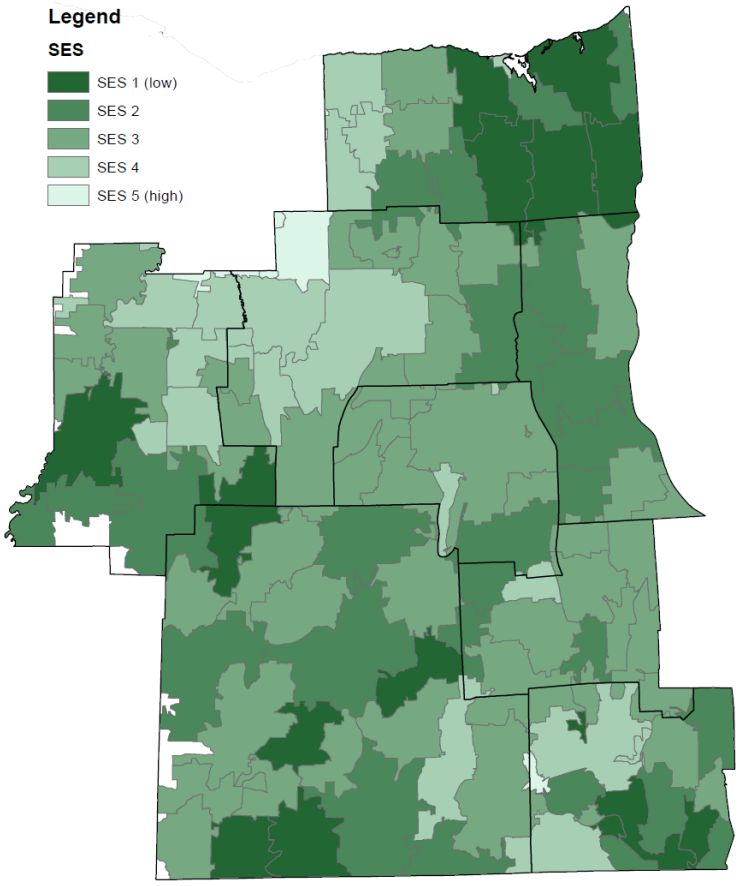
Finding accurate and up-to-date data on Amish and Mennonite populations is a challenge. This population often does not respond to surveys such as those conducted by the U.S. Census Bureau. Local churches, however, collect information on their members and may share this information with public health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

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

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

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

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



Socioeconomic Status

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

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

Unemployment

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

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

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

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

	2012		2017	
	% 16+ in Labor force Unemployed	% 16+ Not in Labor Force	% 16+ in Labor force Unemployed	% 16+ Not in Labor Force
Chemung	7	41	5	43
Livingston	6	39	5	43
Ontario	7	34	5	36
Schuyler	6	41	7	41
Seneca	6	44	5	43
Steuben	9	40	7	41
Wayne	8	34	6	37
Yates	6	38	6	40
8 County Region	**7**	**38**	**6**	**40**
NYS	9	35	7	37
Source: US Census Bureau American Community Survey 5-Year Estimates				

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

Health Assessment

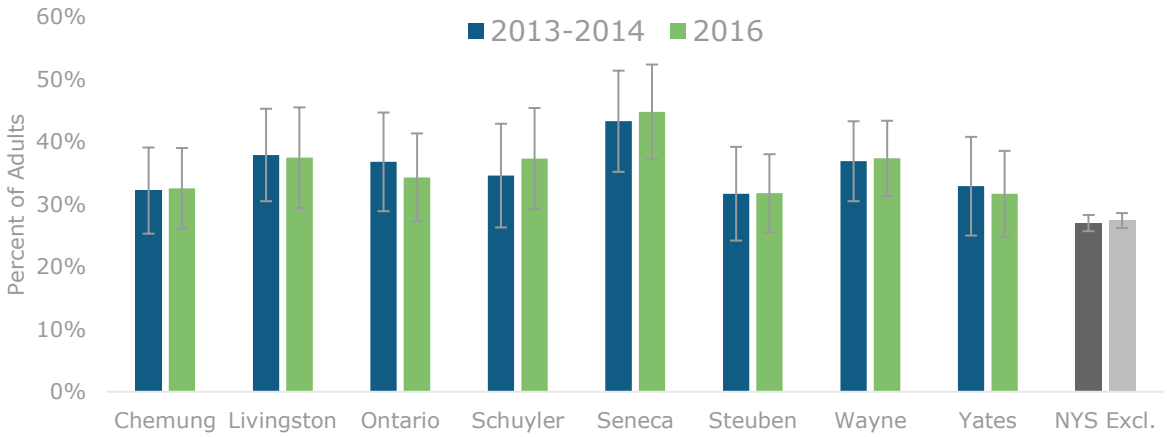
Eight County Region

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

Prevent Chronic Diseases

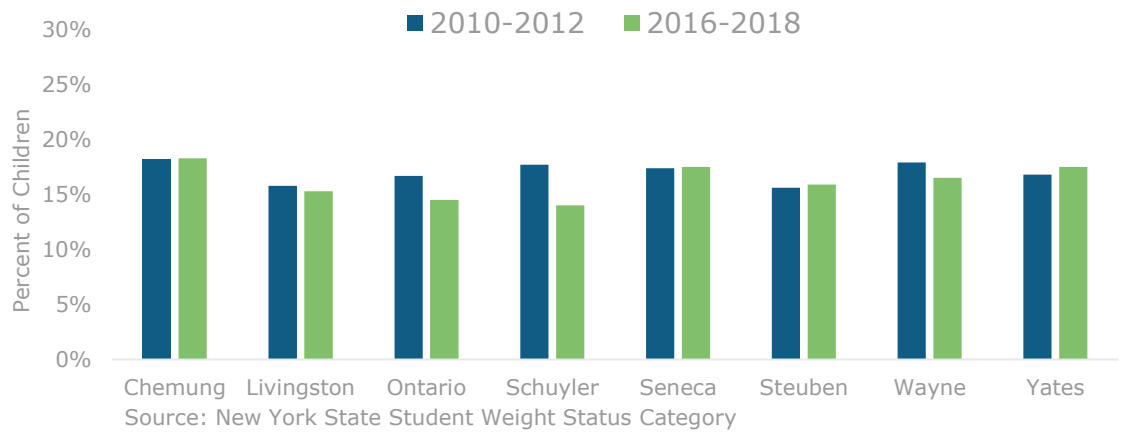
Preventing chronic disease has been a long standing priority area in the eight county region. Efforts have largely been focused on reducing illness, disability and death related to hypertension, tobacco use and second hand smoke, and reducing obesity in children and adults. Rates of obesity in the eight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

Figure 3: Percent of adults 18+ who are obese



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

Figure 4: Percent of children who are obese



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

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

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

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

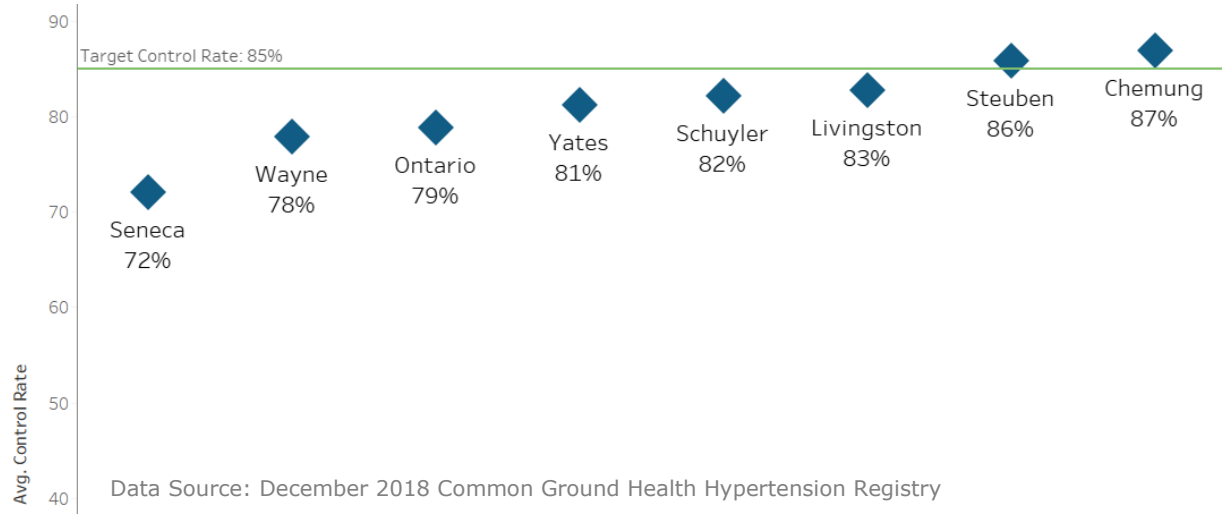
Table 3: Obesity rates by sex

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

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

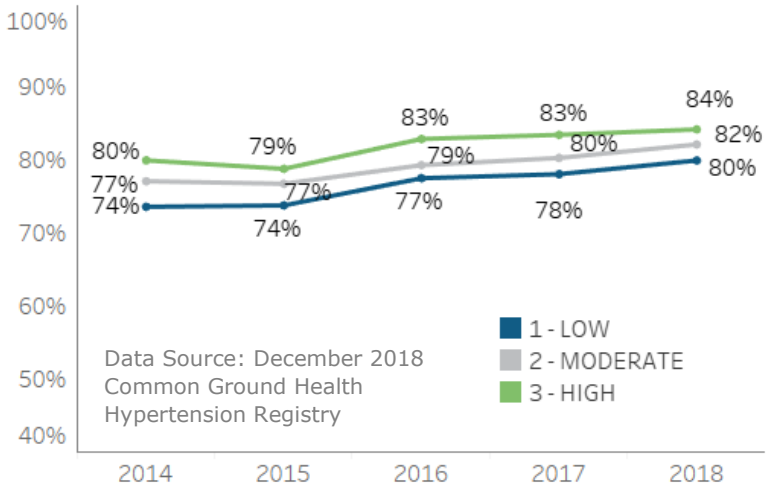
An estimated 36% of adults in the region have been diagnosed with hypertension. However, it is important to note the hypertension control rate for residents. According to the December 2018 High Blood Pressure Registry[7], 79% of hypertensive patients in the region are in control of their blood pressure.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

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



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

Figure 6: Regional control rate by socioeconomic status over time



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

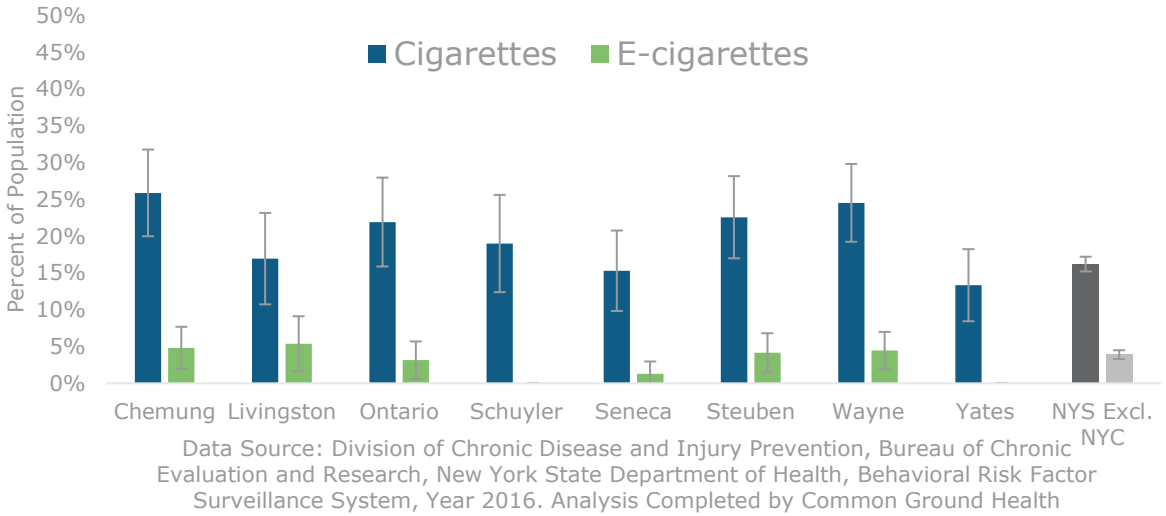
Those diagnosed with hypertension and/or obesity are at greater risk for other diseases such as chronic kidney and cardiovascular (heart) disease. In fact, heart disease is one of the top two leading causes of death in the eight county region (additional data can be found later in report). Cardiovascular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

Table 4: Cardiovascular disease by demographic

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

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

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



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

Table 5: Smoking rates by demographic

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

Source: Behavioral Risk Factor Surveillance System, 2016

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

Table 6: Smoking rates by sex

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

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

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

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

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

Table 7: Barriers to eating healthy

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

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

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

Table 8: Barriers to being physically active

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

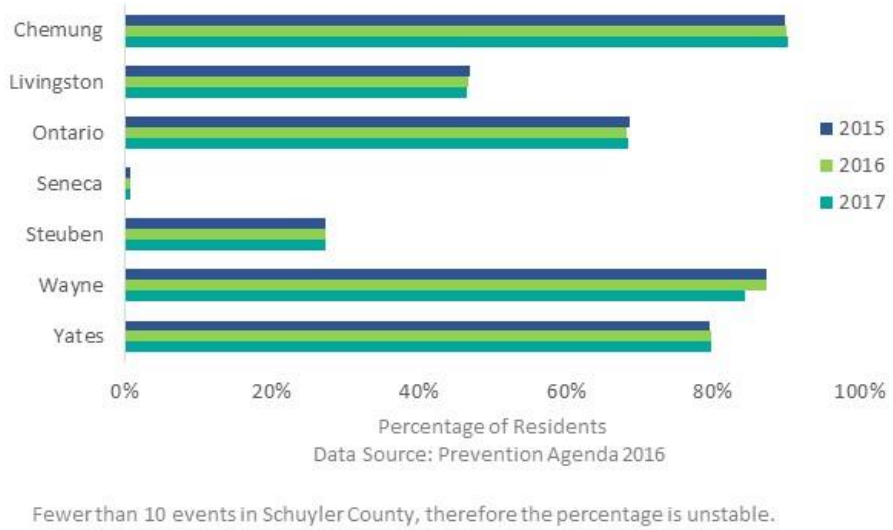
Source: My Health Story *survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.*

Promote a Healthy and Safe Environment

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

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

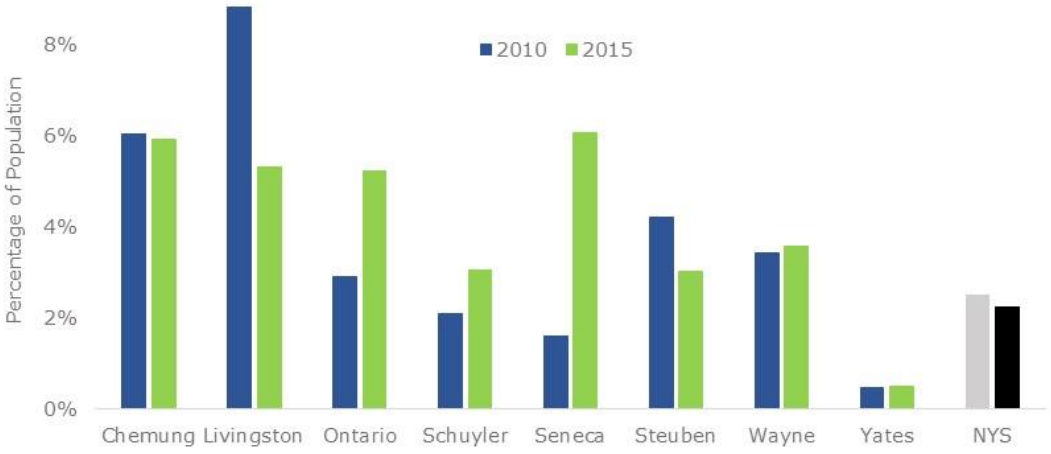
Figure 8: Percent of residents served by community water systems with optimally fluoridated water



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

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

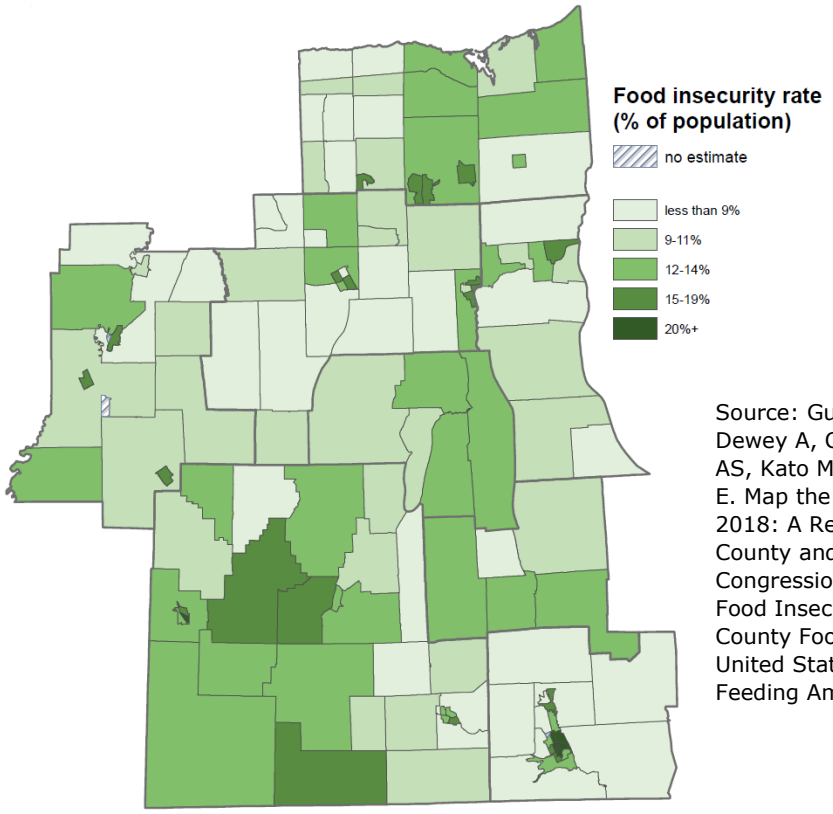
Figure 9: Percent of population that is low income and has low access to a supermarket or large grocery store



[8] Source: NYS Prevention Agenda Dashboard

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

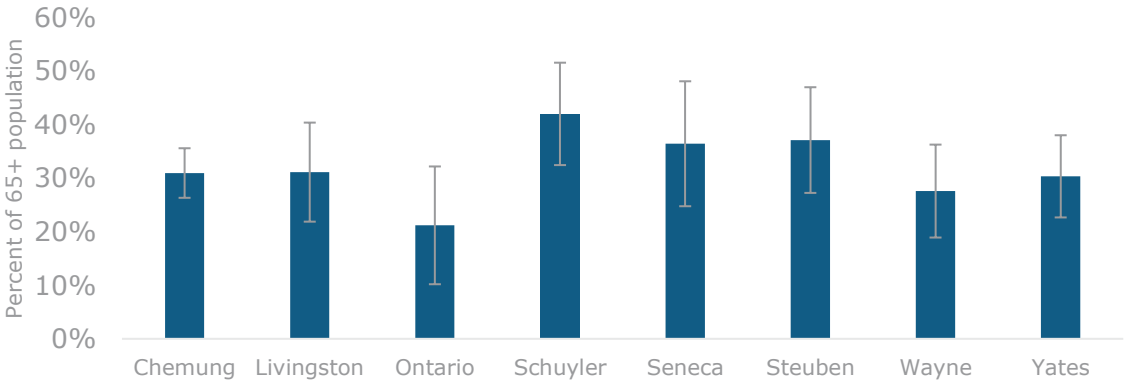
Map 4: Food insecurity rate by census tract



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

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

Figure 10: Reported falls in 65+ population



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

Promote Healthy Women, Infants and Children

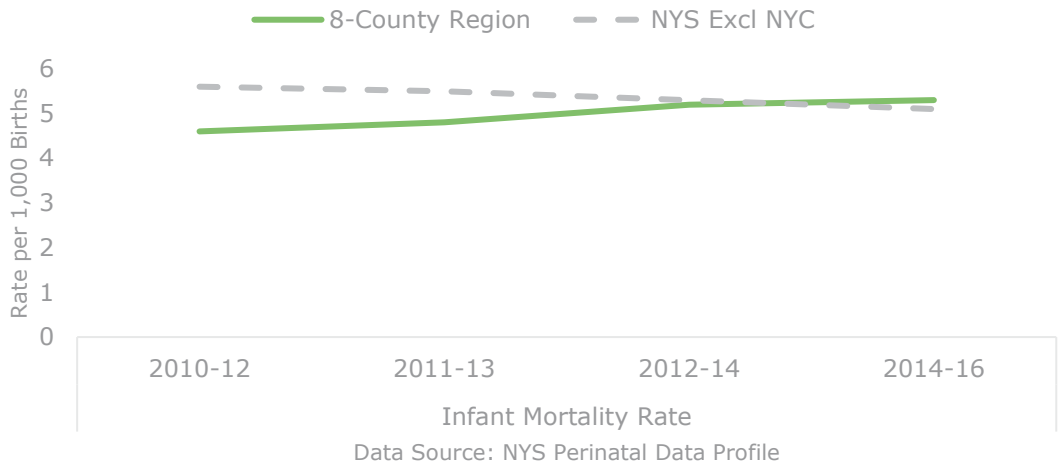
New York State collects several pieces of information on births including the number of premature and low birth weight babies. A baby born prematurely (<37 weeks gestation) is at risk for several health complications including jaundice, anemia, apnea, and more. The earlier a baby is born in pregnancy,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

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

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

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

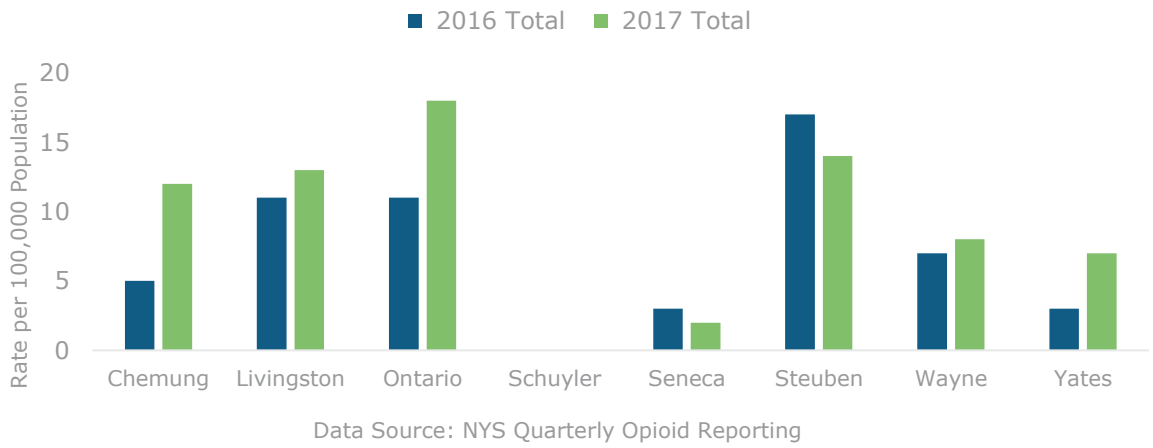
Figure 11: Rate of Infant Mortality



Promote Well-Being and Prevent Mental and Substance Use Disorders

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

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



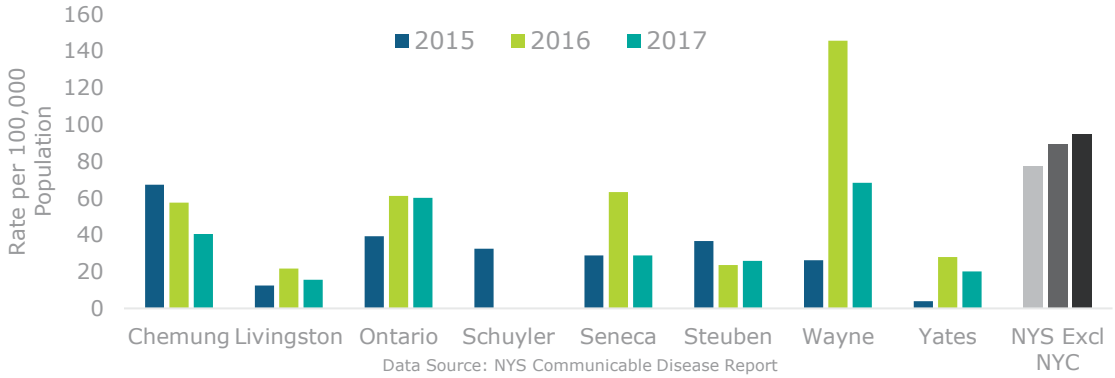
According to survey data from *My Health Story 2018*, half of the respondents indicated they have dealt with anxiety, fear, depression or sadness (Figure 13). For those who have dealt with mental or emotional health issues, 75% of survey respondents said they got the help they needed. The most commonly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

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

Prevent Communicable Diseases

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

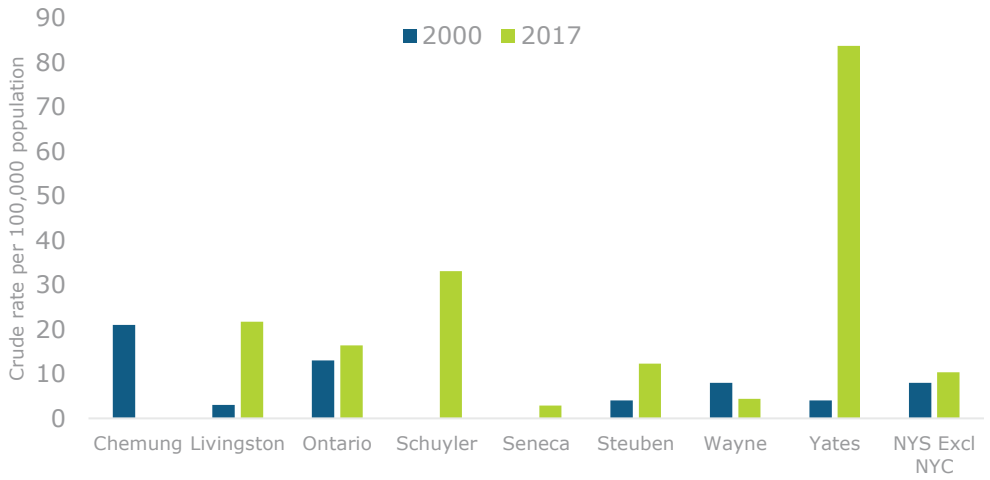
Figure 14: Rate of gonorrhea per 100,000



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

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

Figure 15: Rate of vaccine preventable diseases

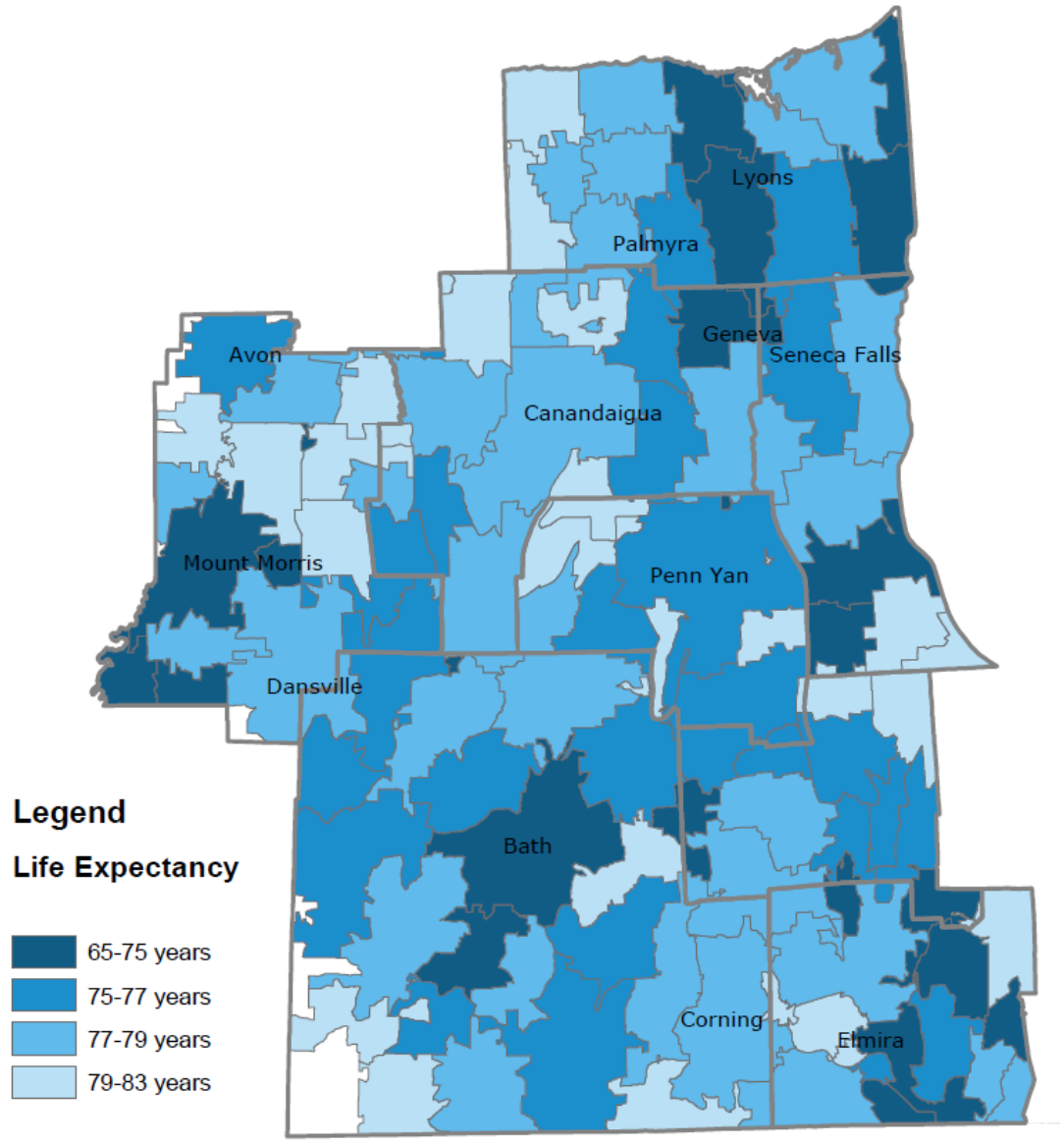


Source: NYS Communicable Disease Reporting, 2000 and 2017

Mortality

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

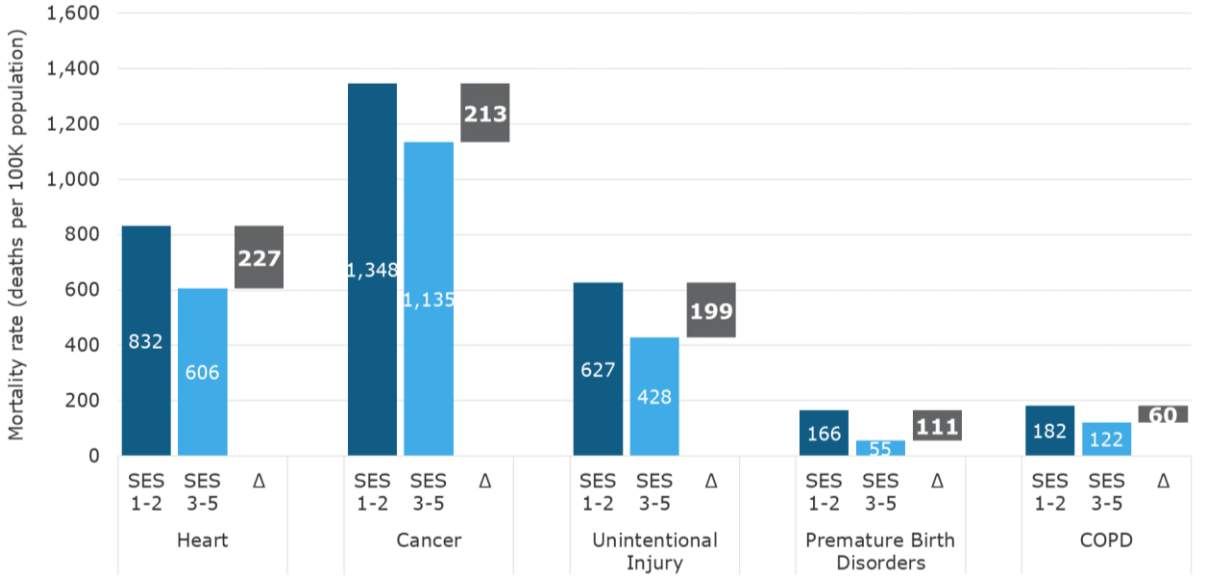
Map 5: Life expectancy by ZIP code



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

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

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



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

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

Table 9: Heart Disease and Cancer mortality by sex

	Heart Disease		Cancer	
	Male	**Female**	**Male**	**Female**
Chemung	221.9	162.4	185.2	145.9
Livingston	155.9	106.6	210.9	140.6
Ontario	217.9	93.5	213.7	156.6
Schuyler	268.5	104.9	216.4	214.8
Seneca	231.1	103.8	182.2	185.8
Steuben	188.7	165.1	187.1	138.2
Wayne	174.2	133.9	189	179.5
Yates	216.1	104.3	181.2	124.0

Source: NYSDOH Vital Statistics, 2016. Rates are per 100,000 population

Planning and Prioritization Process

Eight County Region

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

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

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

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

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

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

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

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

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

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

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

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

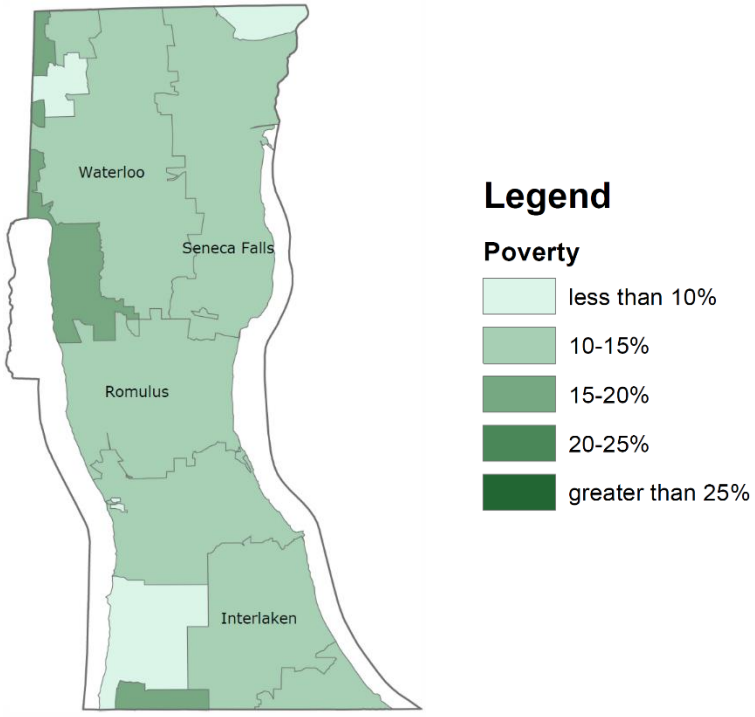
Seneca County

Demographic and Socioeconomic Health Indicators

Seneca County, also known as the county between the lakes, is bordered by Seneca and Cayuga Lakes. A total of 34,843 persons reside in the county, the majority of which (92%) are White Non-Hispanic. Women of childbearing age comprise 15% of the population, and 22.6% of the 18+ population are living with a disability.[13] 2017 estimates reveal 28% of the 65+ population (N=1,725) is living alone. This rate is down 3 percent from 2012 when 29% of the 65+ population (N=1,608) was living alone.

Of note are the rates of poverty. In Seneca County, 11.8% of residents are living below the federal poverty level, and another 21% live near it. The distribution of poverty in the county is shown below in Map 6. Of potential significance are the economic disparities in Seneca County. While not represented in the data, anecdotal evidence suggests rates of poverty are much higher than shown in the map. The presence of wealthy lake houses on the shorelines of Seneca and Cayuga Lakes likely mask some of the income disparities within a zip code.

Map 6: Poverty rates by ZIP code

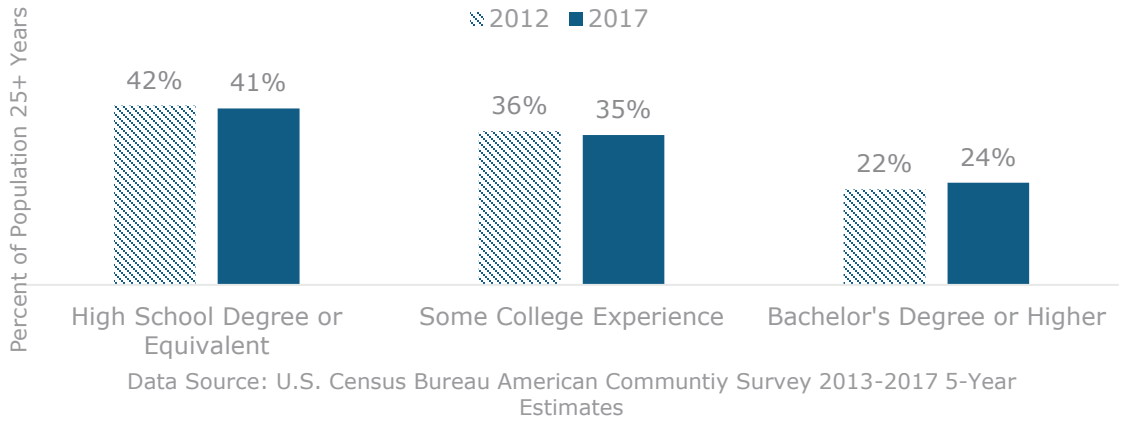


Source: U.S. Census Bureau American Community Survey 2013-2017 5-Year estimates

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

Over the past 5 years, there has been a slight shift in educational attainment where there are more residents aged 25+ with a Bachelor's degree or higher than in years past (Figure 17).

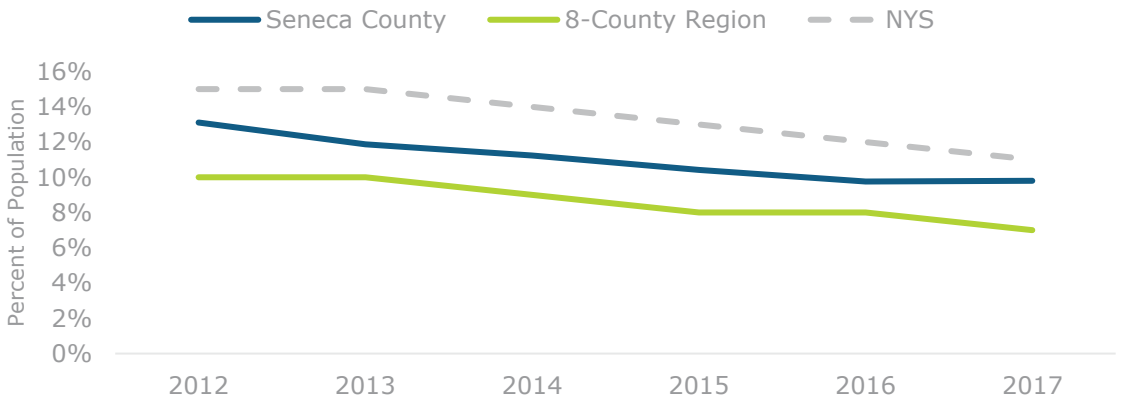
Figure 17: Educational attainment for Seneca County by year



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

Data below show the trend in uninsured rates over the past 5 years compared to the eight-county region and New York State. The percent of the Seneca County population that is uninsured has decreased 25 percent since 2012 (Figure 18).

Figure 18: Percent of population that is uninsured



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

Finally, 27% of Seneca County residents rent vs. own their home. In addition, 8% of occupied housing units have no vehicles available. Another 33% have access to one vehicle. Of note, the average household size for occupied housing is greater than two people. Approximately 40% of residents are paying 35% or more of their household income in rent costs.[14]

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

Main Health Challenges

On May 15, 2019, stakeholders and community members were invited to attend a priority setting meeting. At this meeting, participants reviewed the MAPP process, as well as relevant qualitative, quantitative, primary and secondary data. Data were reviewed from a variety of different sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports and primary data collected from the My Health Story 2018 Survey. Lively group discussions took place regarding the potential priority areas. Approximately 30 individuals attended the meeting. Ultimately, using the Hanlon/PEARL method, the group selected the following as their priority areas and disparity for the 2019-2021 Community Health Improvement Plan:

Prevent Chronic Disease

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

Promote Mental Well-Being and Prevent Substance Use Disorders

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

Disparity: low socioeconomic status

In addition to the group's thoughts, *My Health Story 2018* respondents were also asked questions relating to their top concerns for the health of themselves, loved ones, adults and children in the community (and were reviewed at the prioritization meeting). Weight and mental/emotional health issues were commonly reported concerns across the four categories (Figure 19). Of note, substance use and obesity indicators including weight, exercise, diet and nutrition, were concerns for children in the county. Heart conditions and cost of care were also highlighted as respondents' top fears for themselves and for others.

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

Biggest fear - for self	Biggest fear - for others
Weight (14.6%)	Mental / emotional health issues (13.8%)
Aging (12.2%)	Cost (8.7%)
Mental / emotional health issues (10.5%)	Diet / nutrition (7.7%)
Cost (7.4%)	Heart conditions (6.9%)
Heart conditions (6.6%)	Weight (6.4%)

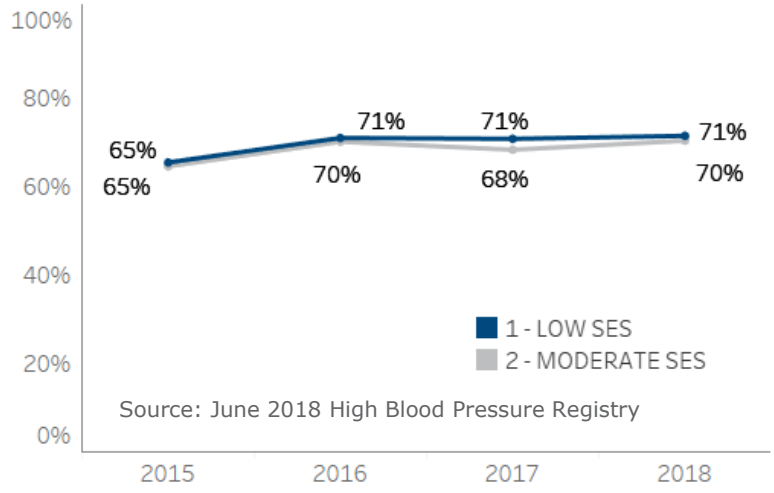
County priority - for adults	County priority - for children
Substance abuse (32.8%)	Substance abuse (29.5%)
Mental / emotional health issues (16.2%)	Diet / nutrition (16.5%)
Cost (12.4%)	Mental / emotional health issues (16.5%)
Diet / nutrition (11.9%)	Exercise (11.5%)
Weight (10.1%)	Weight (9.7%)

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

Behavioral Risk Factors

Approximately 45% of adults in Seneca County are obese. The disease affects approximately 11,460 adults and 325 children. Hypertension is a known risk factor for obese patients. In the county, 39% of adults have been diagnosed with hypertension. Common Ground Health's June 2018 Hypertension Registry estimates that 71% of hypertensive patients are in control of their blood pressure with little variation by socioeconomic status (Figure 20). This is a positive finding because reducing the disparity is a difficult task to accomplish.

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



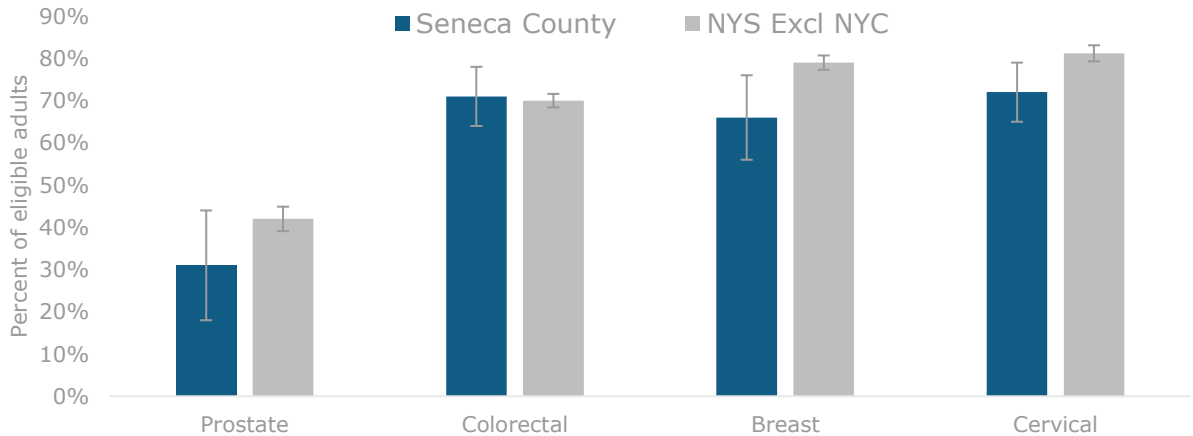
Tobacco use may increase risk of cardiovascular disease. An estimated 15% of adult residents report smoking cigarettes every day or some days. Currently, the Behavioral Risk Factor Surveillance System estimates 1% of residents use e-cigarettes in the county; however, data are sparse. It is likely that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

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

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

Screening for cancers is an important preventative step in primary care. Figure 21 below shows the percent of the population that has received screenings for various types of cancer based on recommended guidelines in Seneca County. Of note, prostate cancer screenings are the lowest in the county, which is a similar finding for each of the other counties in the region.

Figure 21: Percent of eligible population receiving cancer screening



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

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

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

Policy and Environmental Factors

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

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

Unique Characteristics Contributing to Health Status

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

Community Assets and Resources to be Mobilized

During focus groups completed in late 2018 and early 2019, community members identified several assets and resources in Seneca County. For example, focus group attendees identified local trails and recreational spaces, community agencies (i.e. Glove House, Motherhood Connection, Safe Harbors), county services and access to mental health and urgent care services as community strengths and resources. A comprehensive list of identified strengths and resources can be found in focus group summaries and is available upon request.

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

Community Health Improvement Plan/Community Service Plan

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

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

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

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

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

Dissemination

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

Appendix A

Seneca County
Community Health Improvement Plan: 2019-2021

Priority: *Prevent Chronic Disease*						
Focus Area 1: Healthy eating and food security						
Goal 1.2 Increase skills and knowledge to support						
Do the interventions address a disparity? Yes, working poor and/or employees w/o health insurance coverage						
Objectives	Interventions	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Role and Partner Resources
Decrease the percentage of Seneca County adults who consume one or more sugary drinks per day (among all adults)	1.0.3 –To engage worksites by promoting Worksite nutrition education opportunities and engagement in physical activity designed to improve health behaviors and results	-# of worksite wellness healthy eating and or physical activity programs offered in Seneca County -# of participants successfully completing nutrition education program and or physical activity programs -# of Seneca County worksites who have been engaged and have accepted nutrition education and or actively participated in physical activity program(s).	SCHD will offer at least 1 physical activity program and at least 1 nutrition education program to Seneca County employees. The Public Health Educator will actively participate in the Seneca County Employee Wellness Committee and the Regional Worksite Wellness Committee. Public Health Educator or representative will conduct outreach to encourage participation in Worksite Wellness/Healthy Nutrition/Physical Activity Programs at a minimum of 3 local businesses.	To increase physical activity offering from 1 to 2 opportunities for Seneca County employees. Public Health Educator or representative will conduct outreach to encourage participation in Worksite Wellness/ Healthy Nutrition/ Physical Activity Programs from 3-6 local businesses.	To continue to offer workplaces nutrition education offerings and opportunities to engage in physical activity while at work.	.10 FTE -Seneca County Health Department Public Health Educator will provide nutrition education to employees and other worksites as requested. Seneca County Public Health Educator will coordinate a walking challenge for County employees and one additional workplace SCHD will conduct outreach to local businesses to promote worksite wellness and healthy nutrition education and physical activity. Seneca Co. Cornell Cooperative Extension Nutrition Educator will provide nutrition education programs for Seneca County employees and other worksites.

Priority: *Prevent Chronic Disease*						
Focus Area 1: Healthy eating and food security						
Goal: 1.3 Increase Food Security						
Do the suggested interventions address a disparity? Yes, low SES and geographically isolated rural population						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Role and Partner Resources
Increase the percentage of Seneca County adults reporting they are food secure. Baseline to be developed in 2020.	Screen for food insecurity, facilitate and actively support referral	-# of seniors screened for food insecurity -# of appropriate referrals made for seniors -# of SCHD program participants (EI/MCH/Lead.) screened for food insecurity # of referrals made by SCDOH staff	To develop a food assistance resource list for clients and distribute To develop and adopt a referral form to track the number of clients referred for food assistance. To conduct food security screening and make appropriate referrals for food assistance. To sponsor the Mobile Market at the Senior Center at least 2 x a year. To promote the use of farmer's market coupons. To offer vouchers or RX to redeem for fresh fruits and vegetables at participating locations.	To routinely screen for food insecurity and make appropriate referrals to access necessary supplemental food resources. To sponsor the Mobile Market 3 x a year in Seneca County. To increase the number of farmer's markets/MD and or participating organizations redeeming fresh fruit and vegetable vouchers or Food RXs in Seneca County.	To sponsor the Mobile Market 4 x a year in Seneca County and or increase the number of stops made during visits to Seneca County. To increase the number of farmer's markets/MDs and or participating organizations/ agencies participating in redeeming fresh fruit and vegetable vouchers or Food RX program in Seneca County.	.10 RD-The Office for the Aging will conduct High Nutritional Risk Screen for Seniors who come to Congregate Meals, Home Delivered Meals, and EISEP Program. If they score at risk a referral is made to the on staff RD for follow up. Seneca County Health Department Early Intervention Service Coordinator(s) (.03 FTE) will screen families for food insecurity and will document and make appropriate referrals. The Lead Poisoning Prevention Program Coordinator (.02 FTE) will screen families of children with elevated blood lead levels for food insecurity. Families who screen positive will be referred to an appropriate agency/program and will be provided nutrition education. To promote food RX program and vouchers to access fresh fruits and vegetables for those who screened food insecure.

Priority: Prevent Chronic Disease						
Focus Area: Tobacco Use Prevention						
Goal: 3.3 Eliminate exposure to second hand smoke						
Do the suggested interventions address a disparity? Yes, low SES Seneca County residents						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Role & Resources
Decrease by 10% the number of Seneca County adults living in multi-unit housing who are exposed to second hand smoke by 2021.	3.3.1 Promote smoke-free and aerosol-free (from electronic vapor products) policies in multi-unit housing, including apartment complexes, condominiums and co-ops, especially those that house low-SES residents.	# of housing units that adopt smoke free policies # of smoke free housing presentations offered # of property owners reached through education # of tenants reached # of tenant surveys completed # of landlord surveys completed	To develop a sub-committee of TACFL to work towards smoke free housing initiatives in Seneca County. To Survey tenants and property managers/owners about their support or desire for smoke free housing policies.	To educate at least 20 landlords and/or property managers about the benefits of smoke free housing. To educate a minimum of 25 tenants about the benefits of smoke free housing. At least 1 smoke free housing policy will be passed in Seneca County.	At least 1 smoke free housing policy will be passed in Seneca County.	TACFL .015 and .05 of Seneca County Health Department Health Educators, TACFL representative and STEPS representative will form a sub-committee to work on smoke free housing initiatives in Seneca County. A landlord and tenant survey will be developed. Representatives from the committee will educate landlords about the benefits of smoke free housing and will work collaboratively with landlords and rental property managers to implement smoke free housing policies. Discuss benefits of smoke free housing with members of the Finger Lakes Landlord Association.

Seneca County
Community Health Improvement Plan: 2019-2021

Priority: Prevent Chronic Disease						
Focus Area: Tobacco Use Prevention						
Goal: Prevent Initiation of use of Tobacco Products						
Do the suggested interventions address a disparity? Yes, youth						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Role & Resources
To decrease reported 30 day-use of electronic nicotine delivery devices among youth from an average of 20.1% among 6-12th graders to 17.1% Source: 2018-2019 PRIDE survey	3.3.3 Educate organizational decision makers, conduct community education, and use paid and earned media to increase community knowledge of the dangers of secondhand smoke exposure and secondhand aerosol/emission exposure from electronic vapor products.	-# of educational presentations on vaping -# of youth in attendance at vaping presentations # of underage purchases of vaping products and/or tobacco products made by those under 21 as reported from ATUPA compliance checks.	To partner with TACFL and the Council on Alcoholism to provide at least 2 presentations for youth and /or the community. To utilize social media to increase awareness of the dangers of vaping among youth. To conduct compliance checks per ATUPA grant guidelines to ensure youth are not able to purchase vaping devices or products.	To continue compliance checks to ensure those under 21are not able to purchase nicotine delivery devices. To post at least 1 anti-vaping post per month to FB or other Social media outlets. Continue to provide education to the community and youth about the dangers associated with vaping.	To continue compliance check. To post at least 1 anti -vaping post per month to FB or other Social media outlets. Continue to provide education to the community and youth about the dangers associated with vaping.	Seneca County Health Department Health Educators (.10 FTE) will educate the public by providing informational presentations to parents, community groups, schools as requested. TACFL will provide education and resource support to educate youth and adults about the dangers of vaping. Council on Alcoholism will incorporate e-cigs into their in plain sight presentations.

Prevent Chronic Disease						
Focus Area 4: Preventive care and management						
Goal: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity						
Do the suggested interventions address a disparity? Yes, low SES						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Role & Resources
To increase the percentage of Seneca County adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition baseline to be established in 2020.	4.4.3 Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing Type 2 Diabetes.	# of NDPP workshops offered # of participants that successfully completed Core program # of provider information sessions offered about NDPP	To offer and complete at least 1 NDPP 16 week workshop in the community. Finger Lakes Health will continue to refer their patients and offer their diabetes prevention program to their patients. At least 30 patients will have taken the program by the end of year 1.	To promote and offer at least 2 NDPP programs in the community. To increase provider referrals by 15% to community based NDPP and to the FLH Diabetes Center.	To increase the number of patients completing NDPP workshops.	.05 FTE-Seneca County Health Department Health Educator will facilitate NDPP workshops. Finger Lakes Health will facilitate NDPP Workshops for their patients. Local medical providers including the FQHC will refer their pre-diabetic patients to the NDPP Program. STEPS will promote NDPP workshops offered.

Priority: Prevent Chronic Disease						
Focus Area 4: Preventive care and management						
Goal: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity						
Do the suggested interventions address a disparity? Yes, low SES						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partners & Partner Resources
To increase the percentage of Finger Lakes Health Patients with diabetes or pre-diabetes referred to the DPP and/or to see a Diabetes Educator to better control their diabetes or prevent development of Type 2 Diabetes. Baseline to be determined.	Promote referral of patients with prediabetes to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program to achieve and maintain 5% to 7% loss of initial body weight and increase moderate-intensity physical activity (such as brisk walking) to at least 150 min/week.	# of FLH practice patients referred to National DPP percentage of FLH patients who complete NDPP % of Patients who achieve 5-7% weight loss and or 150 minutes of physical activity/week	Finger Lakes Health providers will refer their pre-diabetic patients to the diabetes center and will recommend patients participate in the DPP.	Finger Lakes Health providers will promote the DPP at their practices to increase awareness about the program and will continue to refer pre-diabetic patients to the diabetes center and will recommend patients participate in the DPP.	Promote DPP and the Diabetes Center to other providers. Finger Lakes Health providers will promote the DPP at their practices to increase awareness about the program and will continue to refer pre-diabetic patients to the diabetes center and will recommend patients participate in the DPP.	Finger Lakes Health (GGH)-FLH 1.0 FTE RD/Certified Diabetes Educator and 1.0 FTE NP/Certified Diabetes Educator. Providers will make appropriate referrals for their patients to participate in the NDPP. FLH Providers and Lifestyle Coaches will offer onsite NDPP programs to their patients at the Diabetes Center.

Priority: Prevent Chronic Disease						
Focus Area 4: Preventive care and management						
Goal: Increase Cancer Screening Rates (Colorectal Cancer)						
Do the suggested interventions address a disparity? Yes, low SES						
To increase the % of Seneca County residents screened for colorectal cancer ages 50-75 from 70.0 to 80.0 according to PA dashboard.	4.1.3 Use small media such as videos, printed materials (letters, brochures, and newsletters) and health communications to build public awareness and demand.	# of 50-75 year olds screened for colorectal cancer # of Provider offices tracking screening rates among their patients. # of Seneca County referrals made to Cancer Services Program	Promote cancer screenings in accordance with the most recent guidance by conducting Public Health Detailing at Provider Offices in March annually to increase awareness for Colorectal Cancer Screenings.	Increase provider participation and the number of referrals to Cancer Services Program among Seneca County Medical Providers baseline to be determined.	Provider offices that are tracking screening will increase the number of their patients screened for Colorectal cancer by 10%.	**Finger Lakes Health:** Finger Lakes Health (GGH)- .2 FTE and $3,000 for promotion of screenings in FLH magazine. Finger Lakes Health will track colorectal cancer screening referrals from their Primary Care Offices and track the number of visits to GGH for colorectal cancer screenings. Referrals and hospital visits for colorectal cancer screenings are tracked by both zip code and healthcare payer. Finger Lakes Health will promote screening and education through direct mail newsletters to 74,000 homes 2 x years and will use social/digital media to raise awareness. **Ovid Community Health:** -Patient Navigator .10 FTE will promote cancer screening services to their patients to increase awareness for cancer

						In the community at tabling events and presentations as well as patient reminders. Navigator will make referral to CSP if patients are uninsured or underinsured and they will share practice screening rates. **Cancer Services Program:** The Outreach coordinator for the Finger Lakes CSP will conduct outreach via tabling and provider outreach in Seneca County to increase the number of uninsured or underinsured men and women who receive colorectal cancer screenings. CSP will share data with CHIP committee regarding the number of Seneca County residents enrolled in the CSP and screened for CRC.

Priority: Prevent Chronic Disease						
Focus Area 4: Preventive care and management						
Goal: Increase cancer screening (Breast Cancer)						
Do the suggested interventions address a disparity? Yes, low SES and uninsured/underinsured						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Role & Resources
To increase the % of Seneca County residents screened for breast cancer baseline to be determined.	4.1.4 Work with clinical providers to assess how many of their patients receive screening services and provide them feedback on their performance (Provider Assessment and Feedback).	Provider or clinic-level breast, cancer screening rates # Of Seneca County residents reached by FLH magazine. # of Seneca County residents enrolled in CSP who have been screened for breast cancer.	Promote the FL Cancer Services Program and work with local health systems to increase access to screenings for their patients including scheduling mobile mammogram clinics and or other screening events. FLH will promote walk in screening events.	Increase breast cancer screening rates among local providers. Increase the number of screening events and or opportunities in the community.	Increase the number of screening events and or opportunities in the community.	**Finger Lakes Health (GGH):** .2 FTE and $3,000 for promotion of screenings in FLH magazine. Finger Lakes Health will track mammogram referrals from their Primary Care Offices and track the number of visits to GGH for mammography. Referrals and hospital visits for breast cancer screenings are tracked by both zip code and healthcare payer. Finger Lakes Health will promote screening and education through direct mail newsletters to 74,000 homes 2 x a year and will use social/digital media to raise awareness. **Ovid Community Health:** (Ovid Community Health Patient Navigator .10 FTE will promote cancer screening services to their

						Finger Lakes Community Health (Ovid Community Health Patient Navigator .10 FTE will promote cancer screening services to their patients and arrange for mobile mammography clinic to be onsite to screen their patients. Patient Navigator will provide cancer screening outreach in the community to increase awareness for cancer screenings. **Cancer Service Program:** Outreach coordinator for the Finger Lakes CSP will conduct outreach via tabling and provider outreach in Seneca County to increase the number of uninsured or underinsured women who receive breast cancer screenings.

Priority: Promote Well-Being and Prevent Mental and Substance Use Disorders						
Focus Area 1: Promote Well-Being						
Goal: 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages .						
Do the suggested interventions address a disparity? Yes, low SES and uninsured/underinsured						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Role & Resources
1.1.2 Reduce the age-adjusted percentage of Seneca County adults reporting 14 or more days with poor mental health in the last month by 10% expanded BRFSS	To provide Mental Health First Aid training that teaches people how to respond to individuals who are experiencing one or more acute mental health crises (such as suicidal thoughts or behavior, an acute stress reaction, panic attacks or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (such as depressive, anxiety or psychotic disorders, which may occur with substance abuse).	# of Youth and Adult Mental Health First Aid Trainings offered # of people trained in Mental Health First Aid # of participants reporting an increase in knowledge of appropriate Mental Health first aid strategies after being trained.	Appropriate Seneca County Health Department staff will be trained in Youth Mental Health First Aid and or Adult Mental Health First Aid.	To work with the Suicide Prevention Coalition to provide Mental Health First Aid training to faith leaders and community based organizations.	To offer routine Youth and Adult Mental Health First Aid trainings in Seneca County. To train at least 50 people in either Youth and or Adult Mental Health First Aid. 100% of those trained will report increase knowledge in how and where to make appropriate referrals and increased knowledge of appropriate mental health first aid strategies.	.10 FTE from the Seneca County Health Department and .10 FTE from the Seneca County United Way and .05 FTE S2AY Rural Health Network, Seneca County Health Department, Seneca County Community Counseling Services United Way & Suicide Coalition members. The outreach sub-committee for the Seneca County Suicide Coalition and the Senior PH Educator will plan for an Adult Mental Health First Aid training to be held in Seneca County for members of the faith sector to be trained in Mental Health First Aid. Suicide Coalition and the United Way will promote appropriate trainings for the community to increase awareness of mental health and to decrease stigma.

Priority: Promote Well Being and Prevent Mental Health and Substance Use Disorders						
Focus Area 2: Prevent Mental and Substance User Disorders						
Goal 2.2: Prevent opioid overdose deaths						
Disparity? Yes uninsured or underinsured low SES						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Roles and Resources
To reduce overdose deaths involving any opioid, crude rate per 100,000 populations - Aged 18-44 years in Seneca County from 17.3 to 14.3.	To increase access and availability of Naloxone (Opioid Reversal) and trainings in the community.	# Naloxone trainings provided # people trained to administer Naloxone # of kits provided in the community % of those trained indicating increase knowledge	4 Naloxone Trainings will be provided by SCDOH staff; reaching at least 30 people. After training, 100% of those trained will indicate an increase in knowledge of how to recognize an OD and how to properly administer Naloxone for a suspected overdose. Naloxone training to be offered to FQHC staff at Ovid Community Health.	To provide Naloxone Administration and training to 100% of Seneca County School RNs and to all public Libraries in Seneca County. To provide Naloxone training for at least 1 Medical Provider office in Seneca County.	Partners: Seneca County Community Counseling Center 1% FTE dedicated to Naloxone Trainings. SCDOH Staff .05% FTE either SRPHE/PHE or RN To routinely offer Naloxone Trainings at least quarterly to members of the public. 100% of those trained will report an increase in knowledge of how to recognize an OD and how to properly administer Naloxone for a suspected overdose. To train at least 60 people annually.	.10 SRPHE, RN and or PHE- Seneca County Health Department .05 FT- Seneca County Community Counseling Center Seneca County Health Department Staff Opioid Overdose Community Trainer and Community Counseling Center Staff will provide quarterly community Naloxone Administration Trainings to the community. Seneca County Substance Abuse Coalition will promote trainings and provide information on Opioids at tabling events. How to recognize an OD palm cards will be distributed at community events.

Priority: Promote Well Being and Prevent Mental Health and Substance Use Disorders						
Focus Area 2: Prevent Mental and Substance User Disorders						
Goal 2.2: Prevent opioid overdose deaths						
Disparity? Yes uninsured or underinsured low SES						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Roles and Resources
Reduce the age-adjusted overdose deaths involving any opioid in Seneca County baseline data to be determined.	2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back events in Seneca County.	# of lbs. collected from the Med Safe drug disposal units # of Take Back events # of Dispose RX packets distributed in community	To establish at least 1 additional medication drop box in Seneca County by the end of Year 1. To work with the Substance Abuse Coalition to develop a marketing campaign and provide education to the public on safe medication storage and disposal. To provide education to seniors at 2 Senior Nutrition Sites and 1 Senior Housing Complex.	To provide proper medication storage and disposal education to seniors at 2 Senior Nutrition Sites and 1 Senior Housing Complex. To co-sponsor and or support a drug take back event in Seneca County. To provide ongoing support to the Seneca County Substance Abuse Coalition by having at least 2 staff members participate in the Coalition and coalition activities. To provide a minimum of 3 safe storage and drug disposal trainings in the community.	To establish a medication drop box in the Southern part of Seneca County by working with County and or local law enforcement and/or village or town offices. Working with the SCSAC to provide education and outreach at events in the county and to distribute at least 500 dispose RX To educate at least 150 students, adults and seniors on safe medication storage and disposal to prevent overdose and unintentional poisonings by the end of year 3.	.10 STEPS Coordinator/S2AY Rural Health Network- STEPS will work with the SCSAC to identify a location to add a medication drop box in one of the Southern Seneca County communities. Seneca County Substance Abuse Coalition will work with the SC Sheriff's Dept. for routine pick up of medication and proper disposal of medications from the drop box. S2AY Rural Health Network will provide funding for dispose RX packets approx. $1,000.00 and $800.00 for drop box. SC PH and SCSAC members will distribute dispose RX packets at informational presentations and tabling events. .02 PHE will promote drop boxes and increase awareness of safe medication disposal and use on FB.

Priority: Promote Well Being and Prevent Mental Health and Substance Use Disorders						
Focus Area 2: Prevent Mental and Substance User Disorders						
Goal 2.2: Prevent opioid overdose deaths						
Disparity? Yes uninsured or underinsured low SES						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Roles and Resources
2.2.1: Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.0 per 100,000 populations.	2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations	# of providers receiving education on opiate prescribing # of - Opioid analgesics prescription, crude rate per 1,000 population NYSDOH opioid dashboard)	To provide at least 1 provider education session on opiate prescribing for 2 Medical Provider Offices by the end of year 1.	To develop a public health detailing packet on opioid addiction and opioid prescribing for prescribers including medical, dental and pharmacist in Seneca County.	To provide ongoing outreach and detailing for prescribers regarding Opioid Addiction and prescribing guidelines to 100% of the Medical Practices in Seneca County.	.20-PHE and/or SR.PHE - Seneca County Health Department Staff Seneca County Substance Abuse Coalition will develop a detailing packet to deliver and present to local providers to censure they are aware of the prescriber guidelines for Opioids and are informed of the current state of Opioid Addiction impacting Seneca County.

Priority: Promote Well Being and Prevent Mental Health and Substance Use Disorders						
Focus Area 2: Prevent Mental and Substance User Disorders						
Goal 2.5 Prevent suicides						
Disparity? Yes, mental health disorders, youth						
Objective	Intervention	Family of Measures	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	Partner Roles and Resources
2.5.2: Reduce the number of annual suicides in Seneca County from 2016-2018 data from current data of 18 to 15 deaths by suicide.	2.5.4 Identify and support people at risk: Gatekeeper Training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, post-vention, safe reporting and messaging about suicides.	# attending Youth and Adult Mental Health First Aid trainings # of trainings held # of participants attending AFSP Presentations More than Sad and Talk Saves Lives # outreach events # of people reached at health fairs # of community engagements # of engagements for suicide prevention messaging via social media #of staff trained in Gatekeeper trainings	To have at least 1 Seneca County Staff person trained in a suicide prevention gatekeeper training by the end of year 1. Seneca County Health Department staff and Seneca County Suicide Coalition will offer at least 1 More than Sad and 1 Talk Saves Lives AFSP Gatekeeper program in Seneca County.	To work with the Seneca County Suicide Coalition to offer at least 1 annual gatekeeper training. To train at least 2 additional staff and or community members in Gatekeeper trainings. To offer gatekeeper trainings and/or awareness presentations in the community at a minimum of 2 times a year.	Seneca County United Way .25% FTE-, STEPS Coordinator .05% and SRPHE for Seneca County Health Department .10%. To continuously support the Seneca County Suicide Coalition by having at least 1 staff member participate on the Coalition. To co-sponsor at least 1 Suicide Awareness event and to provide or sponsor at least 1 Adult Mental Health First Aid Training and 1 Youth Mental Health First Aid training annually. To deliver Talk Saves Lives and More than Sad to appropriate audiences.	Partners: Seneca County Suicide Coalition United Way of Seneca County, SC Community Counseling Center and Seneca County Health Department - .25 FTE Senior PHE- is trained to deliver Gatekeeper training More than Sad and Talk Saves Lives. In addition, the SR. PHE will attend Suicide Coalition steering and outreach/education committee meetings and participate in events. .10 FTE Seneca County United Way staff for the Seneca County Suicide Coalition will provide training for coalition members to deliver gateway training such as Talk Saves Lives and More than Sad. Coalition members that are trained will deliver the programs in the community.

						The SC Suicide Coalition will participate in at least 1 awareness event each year such as Walk out of Darkness. SC Suicide Prevention Coalition is working on developing post-vention strategies including training peers who have suffered loss to suicide who could respond or be called upon to assist family and loved ones of those who die by suicide.