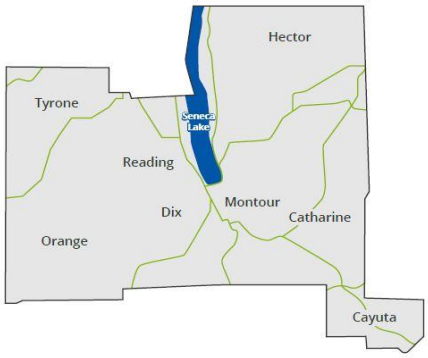
Schuyler County 2016-2018

Community Health Assessment/Community Service Plan



Schuyler County Public Health Department participated in the development of the 2016-2018 Community Health Assessment. Marcia Kasprzyk, the Public Health Director, is the contact person. She may be reached at: MKasprzyk@co.schuyler.ny.us or (607) 535-8140.

Schuyler Hospital Inc. a member of the Cayuga Health System and the only hospital located in Schuyler County participated in the development of the 2016-2018 Community Health Assessment. Deb Bailey, Executive Director of Clinical and Nursing Operations is the contact person and may be reached at baileyd@schuylerhospital.org or (607) 535-7121.

In Schuyler County, facilitation of the Community Health Assessment process was provided by leadership from the S^2AY Rural Health Network. The Network is a partnership of eight Public Health Departments in the Finger Lakes region (Steuben, Seneca, Schuyler, Wayne, Ontario, Yates, Livingston, and Chemung), and has completed Community Health Assessments in this region for the last five cycles. The Public Health Professional Advisory Committee (PAC) is the main coordinating body that oversaw the Community Health Assessment of Schuyler County. The PAC, a multi-disciplinary group of community organizations described more fully within this document, will oversee the majority of the implementation of the Community Health Improvement Plan and more detail will be provided later in this report. Please see attachment 1 for a list of PAC members.

Executive Summary

1. Priorities and Disparities:

Schuyler County chose two priority areas, an emerging priority area, and four focus areas within those priorities to address.

Priority Area 1: Prevent Chronic Diseases
- *Focus Area 1:* Reduce Obesity in Children and Adults
- *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Priority Area 3: Promote Healthy Women, Infants and Children
- *Focus Area 2:* Child Health

Priority Area 4: Promote Mental Health and Prevent Substance Abuse
- *Focus Area 2:* Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders.

Schuyler County also chose the following disparity to address:

The disparity falls under the Prevent Chronic Disease priority area and will include increasing the percentage of individuals who receive preventative screening with an annual household income of <$25,000.

Changes from 2013: The first Schuyler County priority has not changed (Prevent Chronic Diseases – focusing on obesity and hypertension) from the 2013 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), although the strategies to be used to address these priorities have evolved, as seen in the attached CHIP. The second Schuyler County priority has changed. After the review of the data and discussion with focus groups and the priority setting group, dental health and behavioral health issues were determined to be significant concerns. Dental health has been a longstanding issue that affects the health of Schuyler County, specifically young children. The regional rates for Emergency Department visits for substance abuse issues increased dramatically between 2013 and 2014 as did visits for mental health related issues. In the 2013 cycle, the second priority chosen fell again under Priority 1: Prevent Chronic Diseases, with a focus on diabetes. In the 2016-2018 CHA/CHIP process, the county will continue to work on efforts specific to diabetes screenings, but have added another main priority area and an emerging priority area. Priority Area 3: Promote Healthy Women, Infants and Children and Priority Area 4: Promote Mental Health and Prevent Substance Abuse have been added in recognition of the community's interest in dental health and substance use issues.

3. Data Reviewed and Analyzed: The data review and analysis was extensive. In all S^2AY Network Counties, the process began with a data update for the eight county region conducted by the Finger Lakes Health Systems Agency (FLHSA) at the request of S^2AY. This data collection and analysis effort focused on data related to the main priorities in the 2013 CHA for the region as well as some emerging issues that the hospitals and Public Health agreed should be analyzed. They included these emerging issues based both on their knowledge of what they were seeing in their communities and what was revealed in the Delivery System Reform Incentive Payment Program (DSRIP) needs assessment (also completed by the FLHSA). The 2013 Regional Priority Areas included: Obesity, Hypertension, Diabetes, Heart Disease, Tobacco Use, falls, slips and trips in the 65+ population. Emerging issues included: Behavioral Health and Low back pain. The collaborative Mobilizing for Action Planning and Partnership (MAPP) was used for this assessment.

The data was presented to the Public Health Directors and the hospital representatives in a regional meeting held on March 4, 2016. The data collected and analyzed came from the following sources: Expanded Behavioral Risk Factor Surveillance Survey (EBRFSS), Census Bureau, Statewide Planning and Research Cooperative System (SPARCS) data, NY State Prevention Agenda data set, Aggregated Claims Data, NY State Vital Statistics, and the Regional High Blood Pressure Registry, as can be seen in the attached copy of the presentation. Once this data had been reviewed, the S^2AY reviewed other data to develop a summary PowerPoint presentation of the highest need areas for each county. This additional review of data included, among other things: County Prevention Agenda Dashboard, EBRFSS; Community Health Indicator Reports, Sub-County Data Reports, Leading Causes of Death Indicators and County Health Rankings. The primary data reviewed originated from the Regional Hypertension Registry, the 2013 and 2015 "Communities That Care" Grades 7-12 Student Survey results Youth Survey, as well as the input from the five community focus groups.

4. Partners and Roles: The primary partners in the assessment process included Schuyler County Public Health, Schuyler Hospital, S^2AY and the FLHSA. There were also a wide variety of other community partners that serve on the Schuyler County Public Health Professional Advisory Committee (PAC) and other community based organizations and not-for-profits that participated at some point along this process and in the priority setting meeting. This list is attached. The PAC provides oversight of both the process and the implementation, while Public Health and the Hospital will coordinate the implementation of specific activities. The group includes a good mix of community representatives including Schuyler Hospital, community-based organizations, other County Departments, local business owners, a provider of indigent population services, and FLHSA. Detailed roles in implementation are in the attached CHIP.

5. Community Engagement: The community has been engaged in a variety of different ways. After S^2AY prepared a presentation on the highest needs in Schuyler County, it was shared with five separate and diverse focus groups throughout the community to review data with them and to gather their input and perceptions regarding needs and assets in the County. All focus group participants were invited to attend the priority setting meeting. Once the priority setting meeting was held, additional input from the general public was sought. The preliminary priority list was released and posted on social media and posted on the Schuyler Hospital, Public Health and the County websites. This was the third opportunity the public was asked for their input and thoughts.

6. Evidence-based interventions: Our strategies to address chronic diseases include evidence-based activities such as implementing nutrition and beverage standards, increasing the percentage of breast cancer, colorectal, and diabetes preventative screenings, and promoting provider practice participation in the regional hypertension registry (fully detailed in our CHIP document). Strategies addressing "Promote Healthy Women, Infants and Children" include linking children and families to dental services and supporting the delivery of oral health screening and preventative dental services through school-based clinics (also laid out in our CHIP). Strategies under "Promote Mental Health and Prevent Substance Abuse" include prevent underage drinking, non-medical use of prescription pain relievers by youth. Public Health is the lead agency for a Drug-Free Communities (DFC) Support Grant. The Schuyler County Coalition on Underage Drinking and Drugs (SCCUDD) implements the DFC work-plan. SCCUDD includes Public Health, Finger Lakes Addictions Counseling & Referral Agency (FLACRA), District Attorney's Office, Council on Alcoholism and Addictions of the Finger Lakes, Probation Department, Sheriff Office, Watkins Glen Village Police Department, Mental Health, Schuyler Hospital, the County School Districts, parents, youth, business people, and other dedicated community members. Strategies addressing the goal "prevent underage drinking and non-medical use of prescription pain relievers by youth" are outlined in the attached CHIP.

7. Evaluation of Impact and Process Measures: Process measures are indicated in the attached CHIP and correlate with the objectives chosen from the "Refresh Chart" for the NYS Prevention Agenda. They include such measures as number and type of key community locations that adopt and/or implement nutrition and beverage standards, number of patients navigated to and/or through screening, induction of Schuyler Hospital into regional hypertension registry, number of school-based dental sites, among other measures. The PAC meets routinely due to its responsibilities for compliance oversight of all Public Health programs and the Licensed Home Care Services Agency. The tracking CHIP of progress, identifying barriers, strategizing how to overcome barriers, and measuring CHIP progress will become one of the PAC's routine agenda items. Progress will be included in the Public Health annual report as well as reported annually to NY State starting by December 2017 per their established schedule.

1. Community Description and Health Needs:

Community Description:

The service area for this Community Health Assessment includes all of Schuyler County, NY.

Schuyler County is a rural community with a permanent estimated population of 18,186, but is a destination for over two million visitors annually. Schuyler County is the gateway to the fourteen county Finger Lakes Region of Upstate New York. Schuyler County is best known for its natural beauty, with tourism and agriculture being the largest industries. Its eastern boundary is Tompkins County; Yates and Seneca Counties form its northern boundaries; the southern border is Chemung County, and Steuben County forms its western border. Socioeconomic Status (SES) often measures as a combination of education, income and occupation. In the provided map, the majority of the Schuyler County population falls into the medium to low Socio-Economic Status category. Differences in socioeconomic status are responsible for important disparities in the nutrition, housing, safety, and health of large groups of people. In general, the lower one's SES, the greater one's risk of malnutrition, heart disease, infectious diseases, and early mortality from all causes. The annual median household income is $49,225 compared to $53,482 for the nation and the per capita income is $24,529 compared to $28,555 for the nation. According to 2016 USDA data, the county poverty rate is 15.4% with 23.9% of children 0-17 years living in poverty.

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

With a land area of 329 square miles, Schuyler County is among the smallest counties in the State. Schuyler County has about 37,396 acres of State and Federal Park lands, lowering the available amount of taxable land, and has part of the Appalachian Trail passing through it. The County has a population density of about 55.28 per square mile.

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

The population of the County has grown by about 22.9% in the last 50 years, but is estimated to have dropped by about 5.4% in the last fifteen years. Schuyler County's population according to the 2010 census was 18,343

residents. The 2015 Census Bureau estimates a population of 18,186, slightly lower than 2010. Schuyler County has a relatively high dependency ratio, with 19.3% of the population estimated to be under the age of 18 in 2015 (4.9% under age 5), and 20.1% estimated to be aged 65 or over. Approximately 96.7% of the population is white, 1.0% is Black/African American and the remainder other races. In 2015, 1.9% of the population was estimated to be Hispanic/Latino. In the 2010 census, 658 people indicated that they spoke English "less than very well". The 2015 estimates indicate that 2.8% speak a language other than English at home, with 168 of these indicating that they speak Spanish at home.

Schuyler County is nestled in the heart of the Finger Lakes Region of Upstate New York which attracts tens of thousands of tourists weekly to its small community, visiting natural attractions (e.g. the Watkins Glen State Park, the Finger Lakes National Forest, and Seneca Lake), wineries, breweries, and distilleries, various festivals, and the largest attraction - Watkins Glen International Raceway (WGI, a world-renowned road racing venue). Recently a new lake front luxury hotel and conference center and new high-end condos were built in the community. Additionally, unused buildings in the community have recently been renovated and repurposed adding more housing options (e.g. a school building that was no longer being utilized was turned in to housing for senior citizens).

Health Needs:

While each county in the eight-county S^2AY Network region started with a summary assessment of their respective data in the region in the FLHSA presentation (attached) and each county in the region followed a fairly similar process, the CHA's were completed separately and each county held their own focus groups. Additionally, each county, including Schuyler, held their own "priority setting meeting" and worked through county-specific committees to review data, analyze needs and develop priorities.

Based on analysis of all data, the major health issues based on the 2016 priority ranking in the community include:

- Dental Health
- Substance Abuse
- Obesity
- Mental health
- Early Childhood
- Tobacco Use (Hypertension, CLRD/COPD, Cancer)
- Unintentional Injury

Dental health: The most recent Schuyler County dental health data is from 2011 and indicates that there are 14.3% of 3rd grade children having untreated dental caries placing it in the 1st quartile in NY State. While this percentage indicates child dental health is not a significant issue in Schuyler County, Public Health and Schuyler Hospital in partnership with local physicians and dentists are continually monitoring dental health data and working to address issues. It remains a community priority due to the lack of dental services willing to accept Medicaid patients. Presently, no dentist within the county accepts Medicaid patients, requiring people to travel out of county for their dental care. Only 62.4% of our adults have visited a dentist within the past year. Good oral health is essential to the general health of the community. Tooth decay is preventable, but continues to affect all ages. It is a greater problem for those who have limited access to prevention and treatment services. According to

the NYSDOH untreated decay among children has been associated with difficulty in eating, sleeping, learning, and proper nutrition. Nationally an estimated 51 million school hours are lost due to cavities. Almost one fifth of all health care expenditures in children are related to dental care.

Substance Abuse-Mental Health and Substance Abuse: Data shows a sharp increase in emergency department visits for substance abuse, heroin overdose, and mental health diagnoses (as shown in the attached PowerPoint presentations). Discussions of the analysis related to the opioid epidemic included youth usage rates, mortality rates, premature loss of life, criminal behaviors related to substance abuse and the fact that substance use disorders affect entire families, often including the children of the person with the disorder. The opioid epidemic sweeping across the Nation is a significant health improvement priority and was analyzed at the national, state and local levels during the assessment. Narcan has been used in at least 16 known overdose situations so far in 2016 in Schuyler County. Along with the widespread opioid issue, Schuyler County continues to see large numbers of Methamphetamine manufacturing arrests. So far in 2016, there have been 60-70 felony drug arrests, up from the annual mean of 12-15. Schuyler County has been working on preventing substance abuse at the County level and will continue efforts based on interventions outlined in the CHIP chart.

Obesity: (61.1%) of Schuyler County adults are classified as either overweight or obese on an age- adjusted rate. Proportionally 35.7% of Schuyler County children are considered overweight or obese (85th percentile or higher in the 2012-2014 DOH health ranking data), putting Schuyler County children in the 2nd quartile for county ranking when compared to the State average. 5.4% of adults have a diagnosis of pre-diabetes, 8% diabetes and 27.6% hypertension. As can be seen in the attached focus group presentation, the analysis shows that obesity is important due to the many related health conditions linked to obesity, including heart disease, hypertension, diabetes, lower back pain, arthritis, high cholesterol and several types of cancer. Therefore by addressing obesity, several other health-related problems may be prevented. Obesity related data and other statistics cited below can be reviewed in the Schuyler County EBFRSS at:
https://www.health.ny.gov/statistics/brfss/expanded/2013/county/docs/schuyler.pdf

Behavioral Health-Injury Prevention (Falls): With Schuyler County's continually aging population (20.1% of the population according to 2015 census projections being age 65+), falls can have an adverse effect on resident's health. Schuyler County has the highest incidence of falls, slips and trips in the region with 50.6% of the population age 65+ reporting falls in the last 12 months according to the EBRFSS 2012-2014. Schuyler County also had the highest rate of ED Fall visits per 100,000 for population aged 65+ in the region, with a rate of over 7,000. This could be due to many different reasons, e.g. a single individual falls multiple times and goes to the emergency room for each fall, or an individual presents to the ED for another health related concern as the primary diagnosis and is also treated for a fall. This health concern will continue to be monitored through future data.

Hypertension: According to the CDC, approximately 30% of adults are diagnosed with hypertension in the United States. Schuyler County is in line with this percentage with approximately 27.6% of the adult population residing in the County having been diagnosed with hypertension by a physician. Schuyler County has an above average control rate in the region for hypertension with approximately 72% of the population registering as in-control (FLHSA/RBA High Blood Pressure Registry, June 2015). Schuyler Hospital has plans to start uploading data to the registry in 2017.

Early Childhood: The health and well-being of families is fundamental to overall population health. The priority of the Schuyler County community is to provide support to all families and nurture their abilities to develop their children's physical, cognitive and social emotional health. On average 40 % of our children entering Kindergarten have some kind of a delay in a developmental domain (School Kindergarten Screenings for years 2014 and 2015). 23.9% of Schuyler County children live in poverty and 26.6 % of our children live in single parent households. 85.3% of our children aged 3-6 years on government sponsored insurance have received the recommended number of well child visits. Children need a healthy start in life and the opportunity for optimal growth and development throughout their lifespan. By approaching health as a continuum, consideration is given to the impact of social, economic, environmental, biological, behavioral and psychological factors on individuals and families throughout their lives. Supporting young families has proven to strengthen families with young children by directly providing or connecting them with health, psychological, parenting and other services, depending on each family's unique needs.

Full descriptions of the health needs data are included in the attached presentations for the FLHSA and the focus groups.

Health Care Access:

Schuyler County has discussed the access gaps related to the above health needs as they analyzed the data (see attachments 2, 3, & 7). As discussed above, analysis of data reveals health disparities for the low-income population in general. Schuyler County has been designated as a Health Professional Shortage Area (HPSA) which means the capacity and distribution of primary care, mental health, and dental providers is an issue. Schuyler Hospital, as participating member of the Cayuga Health System, recently has started making some medical specialties available within the county. This was cited by focus group in the last CHA cycle as a community need.

Transportation was repeatedly cited as a barrier in the focus groups, and was a key discussion in determining health care strategies. Schuyler County has made progress on addressing transportation issues in the form of the Schuyler County Transit system. The transit system makes stops at some population dense locations in Schuyler County but coverage remains sparse in outlying areas of the county. Schuyler County is mostly rural and provides minimal transportation from pick up locations to resident's homes.

The S^2AY Rural Health Network and Access to Independence and Mobility (AIM) have Navigators to assist people to enroll in health insurance. The S^2AY Rural Health Network additionally, helps to serve the uninsured and under-insured through its Community Health Advocate program and Cancer Services Fund, both of which help people to address gaps in coverage or find access to health care.

Schuyler County has seen an increase in the Mennonite population over recent years and this poses some additional challenges related to health care access. Whenever possible, this group avoids participation in health insurance, since the Mennonite community as a whole serves as something of a safety net for unanticipated health care needs and expenses. Additionally, the population will not usually avail themselves of some typical health care services, avoiding some immunizations for example, or not seeking early prenatal care. The behaviors and cultures of all populations in the county influence reasoning and strategies used during the development of the CHIP.

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

Health Challenges:

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

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

CDC, Social Determinants of Health http://www.cdc.gov/socialdeterminants/Definitions.html

Schuyler County Public Health, Schuyler Hospital and partners will work to address these factors as they tackle their identified health priorities. The sub-groups for these risk factors include lower-income, lower-educated and socially isolated populations, as well as those with genetic predispositions for chronic disease, mental illness and alcohol/substance abuse. Trauma history also needs to be considered. Adverse childhood experiences, or ACEs, are broadly defined as incidents during childhood that harm social, cognitive and emotional functioning. Frequent or prolonged exposure to such events creates toxic stress that damages the architecture of the developing brain. The negative outcomes are serious. On the health side, they include diabetes, hypertension and heart disease, depression, morbidity and early death. On the risky-behavior side, they include smoking, overeating, alcoholism and drug use. Evidence shows that the more ACEs a person experiences, the more likely poor health outcomes become.

Lack of access to primary care results in poor health outcomes since prevention, early detection, early treatment and referral to other needed services eases the effects of long-term chronic conditions. In Schuyler County socioeconomic conditions limit access to health care as well as limited availability of services within county borders. There is still a lack of some specialty providers in the county, limiting access for those without private transportation, due to a limited public transportation system. Improving access to high-quality, continuous primary care and treatment services are critical in eliminating disparities in health outcomes. Lack of transportation in rural areas, feeling intimidated by the health care system, lack of insurance and perceived confidentiality issues are some of the factors that may keep people from appropriately accessing care. About 60 % of Schuyler County residents use Schuyler Hospital. Depending on where residents live in the County, they may

use hospitals in the adjacent counties including: Chemung County (Arnot Health), Steuben (usually Corning-Guthrie, or Ira Davenport in Bath), Tompkins (Cayuga Medical), and Yates (Soldiers and Sailors in Penn Yan) Hospitals. Schuyler Hospital is now a Critical Access Hospital (CAH). For the most part, services are available, if cost, behavioral and transportation barriers do not preclude access. The social environment is generally conducive to accepting of health care although there is a subset of the population that does not seek preventive care and relies on the emergency room for medical necessity.

Transportation Factors:

Physical and economic conditions can cause geographic isolation for some county residents. Public transportation within the county has always been an issue. After years of planning and preparation, Schuyler County Transit, operated by ARC of Schuyler in collaboration with the County, opened in 2010. This system connects the villages of Burdett, Watkins Glen, Montour Falls, and Odessa. It also incorporates a loop to Schuyler Hospital, and the hospital's Primary Care Center. Additional stops include Burdett Mini Mart, Wal-Mart in Watkins Glen, Seneca Harbor Park (near the Guthrie Offices), Franklin St. & 7th St., 12th St. and Porter St.(which is near Public Health and the Arnot Health offices), Tops/CVS, Main St. & Montour St. in Montour Falls, the Human Services Complex (where the county's Department of Social Services, Youth Bureau, Veterans Service Agency and Office for the Aging are housed as well as Schuyler HeadStart and Cornell Cooperative Extension), Broadway St. in Montour Falls as well as the Odessa Municipal Building. The Transit recently added a Dial-A-Ride capability, so people in the outlaying area of the county can order up a ride and a daily (Monday to Friday) run to the Corning Transportation Center where riders connect with other transportation to the College or worksites. The Schuyler County Transit service helps address the geographic and transportation barriers of some county residents. The population tends to heavily use the local volunteer ambulance services as a transportation option to medical services in the Emergency Department.

Behavioral Factors:

Personal barriers in access to care include:

- Personal value and behavior systems on the part of some county residents (particularly older residents) who refuse to take advantage of eligibility-based programs (such as Medicaid and Food Stamps) because they consider it a "hand-out"
- Personal belief and behavior systems on the part of the growing Mennonite population in Schuyler County may inhibit their access to care
- Lack of a private vehicle for transportation
- Lack of education and personal experience regarding the value of and need for primary and preventive care. This can include feelings of intimidation that some residents may experience in the presence of health professionals, leading both to avoidance of care and lack of empowerment in managing relevant aspects of their own healthcare, along with health literacy issues. For too many residents, emergency room care may be the only type of care accessed. While there is an emergency room, there are no urgent care services in the county. For a significant portion of females, family planning services may be their only access point to primary care services.
- Women in abusive relationships may be so controlled by their abuser that they are not allowed to get medical or dental care.
- Cultural acceptance of tobacco and alcohol use is also a factor.

A wide variety of behavioral risk factors affect Schuyler County residents including residents with low-income, and thus limited means with which to purchase nutritional meals or take advantage of many social and recreational opportunities for physical activity (e.g. canoeing, kayaking, backpacking, golf, etc.). Persons with limited means are also more likely to engage in unhealthy habits such as tobacco use or alcohol abuse, probably due to the fact that there are fewer other opportunities to which they have been exposed through which they can change their "state of being" than those of more substantial means, who may use exercise, music, theater, art, stimulating conversation, higher education or other venues for this stimulation. Recent studies have also shown that urban residents may lead less of a sedentary lifestyle than do rural (non-farming) or suburban residents, due to spending more time walking to various destinations than is possible or feasible in rural areas.

The social isolation seems to also make residents more prone to alcohol abuse, and higher rates of depression or poor mental health than their urban counterparts.

Economic Factors:

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

NY State of Health is an organized marketplace designed to help people shop for and enroll in health insurance coverage. Individuals, families and small businesses are able to use the Marketplace to help them compare insurance options, calculate costs and select coverage online, in-person, over the phone or by mail. The Marketplace helps people to check their eligibility for health care programs like Medicaid and sign up for these programs if they are eligible. The Marketplace is also able to tell what type of financial assistance is available to applicants to help them afford health insurance purchased through the Marketplace.

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

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

Unlike other medical services, the primary payment source for dental services is out-of-pocket, with access to services for persons on Medicaid particularly limited, in fact, non-existent within the County borders. Lack of access to dental care and lack of any fluoridated water supply within the county are other factors residents face. An estimated 70% of the Schuyler County population has private wells as their source of water.

Lower levels of education and educational aspirations are also risk factors. According to the US Census Quick Facts, only 18% of Schuyler County residents age 25+ have a Bachelor's degree or higher compared to the NYS average of 29.3%.

There is no daily paper within the county boarders. Three dailies in neighboring counties, the Corning Leader (Steuben County), the Star-Gazette (Chemung County), and the Ithaca Journal (Tompkins County), serve the needs of Schuyler County residents. The County also has a weekly paper, the Watkins Glen Review & Express which covers both Schuyler and Yates County news. Additionally, there is a local, online-only news site, the Odessa File, which covers Schuyler County daily news. There are also no local TV or radio stations within the county.

The Clean Indoor Air Act, passed more than ten years ago, continues to improve the overall environment and reduce secondhand smoke exposure. Many businesses are going to smoke-free work areas.

Schuyler County is somewhat unique in that it attracts over 2 million tourists annually, placing a burden on local medical services, law enforcement and the local infrastructure. This creates the potential for a health disaster as regular resources will quickly be exhausted in the event of a major health emergency. In addition to typical seasonal visitors to Seneca Lake, local wineries, breweries, and distilleries, and the Watkins Glen State Park, the area is inundated with visitors to events at the Watkins Glen International race track including NASCAR series races. This increases the chance of a mass causality situation.

2. Data Reviewed and Analyzed:

In all S^2AY Network Counties, including Schuyler, the process began with a data update for the eight county region conducted by the Finger Lakes Health Systems Agency (FLHSA) at the request of S^2AY. This data collection and analysis effort focused on data related to the main priorities in the 2013 CHA for the region as well as some emerging issues that Schuyler Hospital and Public Health agreed should be examined based both on their knowledge of what they were seeing in their communities and what the needs assessment for DSRIP (also conducted by the FLHSA) had revealed. In addition to the DSRIP needs assessment, data sources for this review included:

- Expanded Behavioral Risk Factor Surveillance Survey (EBRFSS: 2013-2014) https://www.health.ny.gov/statistics/brfss/expanded/2013/county/docs/schuyler.pdf
- U.S. Census Bureau, 2010 Census http://www.census.gov/2010census/
- Statewide Planning and Research Cooperative System (SPARCS) 2013 data https://health.data.ny.gov/Health/Hospital-Inpatient-Discharges-SPARCS-De-Identified/876q-xdbe
- NY State Prevention Agenda data set http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/indicator_map.htm
- FLHSA Aggregated Claims Data 2010-2014
- NY State Vital Statistics https://www.health.ny.gov/statistics/vital_statistics/
- Regional High Blood Pressure Registry https://www.flhsa.org/ *Internal Data Source*

Once this data had been reviewed, the S^{2}AY Network staff reviewed and analyzed other data to develop a summary PowerPoint presentation of the highest need areas for the county. In addition to the above sources, this additional review of data included, among other things:

- County Prevention Agenda Dashboard https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=44
- Community Health Indicator Reports http://www.health.ny.gov/statistics/chac/chai/chai_44.htm
- Sub-County Data Reports http://www.nysachoinfo.org/Sub-County-Health-Data-Report/Schuyler.pdf
- Leading Causes of Death Indicators http://www.health.ny.gov/statistics/leadingcauses_death/
- County Health Rankings http://www.countyhealthrankings.org/

Additionally, three primary data sources were reviewed: the high blood pressure registry, the Communities That Care Youth Survey (students in grades 7-12 were surveyed in 2013 and 2015 regarding substance use and risk factors), and the five focus groups.

3. Priorities, Disparities and Community Engagement:

Prevention Agenda Priorities:

As detailed on the attached Community Health Improvement Plan (CHIP), the two primary priorities and one emerging New York State Department of Health (NYSDOH) Prevention Agenda priority areas for Schuyler County for the 2016-2018 period include:

1. **Priority Area 1:** Prevent Chronic Diseases
    - *Focus Area 1:* Reduce Obesity in Children and Adults
    - *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings
2. **Priority Area 3:** Promote Healthy Women, Infants and Children
    - *Focus Area 2:* Child Health
3. **Priority Area 4:** Promote Mental Health and Prevent Substance Abuse
    - *Focus Area 2:* Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders.

Disparities Being Addressed:

During the 2016-2018 period, Schuyler County Public Health, Schuyler Hospital and their partners have chosen to address a disparity under the Prevent Chronic Disease priority area that relates to increasing the percentage of individuals who receive preventative screening with an annual income of <$25,000, which currently shows a health disparity in the EBRFSS. This will be achieved through specific evidence-based activities (as outlined in the attached CHIP chart.) This disparity will be addressed under Goal 3.1, through Objectives 3.1.1, 3.1.3, and 3.1.4. This includes increasing the percentage of women who receive breast cancer screening, the percentage of adults who receive colorectal cancer screening, and the percentage of adults who had a test for high blood sugar. All of the screening events and efforts around improving the health of the population will be available to all

members of the community, but the group will focus on targeting individuals of low SES; specifically providing screening and preventive services. Disparities were chosen based on analysis of the data and potential to reach disparate populations.

Community Engagement:

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

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

1. **Organize for Success- Partner Development**

This included representatives of the Public Health Professional Advisory Committee discussed above. This collaborative, multi-disciplinary group oversaw the assessment process and the development of the majority of the CHIP. The substance abuse goal was developed in collaboration with the Schuyler County Coalition on Underage Drinking and Drugs (SCCUDD), which has additional members. See list in attachments.

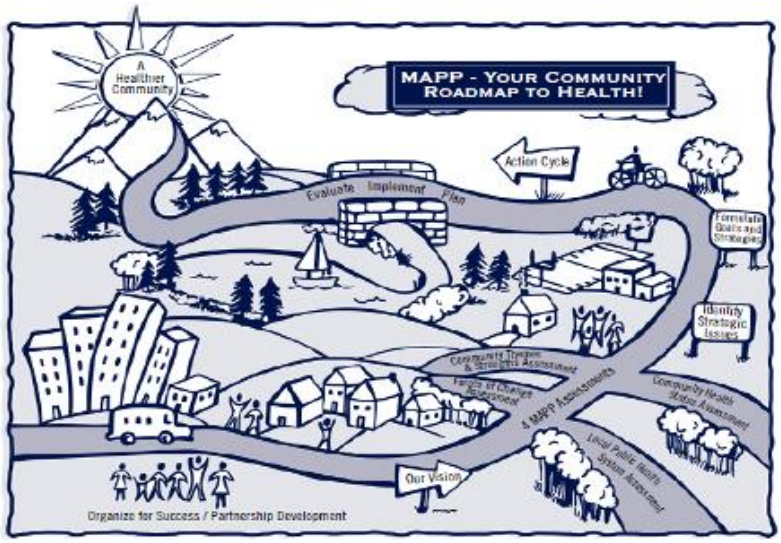
2. **Assessments**

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

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

The second assessment evaluated the effectiveness of the Public Health System and the role of Schuyler County Public Health within that system. This was done using a modification of the Local Public Health System Assessment tool developed by the CDC and NACCHO. This was conducted via an electronic survey on Survey Monkey. A diverse group of key informants were chosen to complete the survey, including community leaders who are familiar in some way with the local public health system. The assessment was completed through the use of a more user-friendly version of the CDC and NACCHO tool, Local Public Health System Assessment (LPHSA). Each of the ten essential public health services was rated by the group by ranking the series of indicators within each Essential Service to determine areas of strength and areas needing improvement within the Local Public Health System.

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



3. Identification of Strategic Issues

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

4. Formulate Goals and Strategies

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

The process of Community Engagement using MAPP

Schuyler County Public Health and Schuyler Hospital, with assistance from the S^2AY Rural Health Network, conducted a comprehensive assessment of the community, which provided the basis for the Prevention Agenda priority areas selected above. The assessment process included a thorough review and analysis of county specific data around health needs, compared to neighboring counties, the region, and the State as a whole. As noted above, this included data collection and analysis by both the FLHSA and S^2AY. The PAC, which includes Public Health, other Schuyler County Departments (County Planner and Legislator), an MD, a provider of services to the indigent population, local business owners and community-based organizations, oversaw the assessment process. After the data was analyzed and prepared, it was shared in the form of focus group presentations to county residents. Schuyler County conducted five separate focus groups with key informants throughout the county to solicit feedback. Focus groups were selected to include a broad diversity of community members from different segments of the community, including populations that experience health disparities as outlined in this report. Focus groups that were conducted in Schuyler County included the following: Environmental Management Council (a group of civic-minded community members working on environmental policy issues), the Public Health Professional Advisory Committee (the oversight committee which includes key members of the community), the Watkins-Montour Rotary Club (a volunteer organization of business and professional leaders who provide humanitarian service), Firefighter Chiefs Meeting (a collection of local firefighters, the fire chiefs and first responders that serve Schuyler County mainly consisting of males), and the Cayuga Medical Health System Physicians Group (a collection of physicians that live and work in the Schuyler County region). Additionally, a Public Health System Assessment was completed as part of the MAPP process using key informants as respondents, with this input incorporated into the decision-making process.

After the completion of the focus groups, the PAC invited focus group participants, all community members, health care organizations, and human service agencies to participate in the prioritization of the most pressing

health needs identified from the data collection and focus group input. Focus group participants and community members were invited to this meeting through email, media releases, and postings on websites and social media platforms (Public Health, Hospital, S^2AY Rural Health Network, the County and other partners). S^2AY prepared another PowerPoint presentation for this "Priority Setting" meeting. At this meeting, S^2AY presented the data shared with the focus groups, along with key slides from the EBRFSS and Community Health Indicator Reports. Input from the focus groups was analyzed and considered when developing a list of priorities for the group to rank. This list was created byS^2AY using all of the data reviewed and analyzed (list of issues to rank attached). The group was also offered the opportunity to add any additional issues to the list.

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

After the preliminary priorities were chosen, a media release was done and preliminary priorities were posted on the Public Health and hospital websites (please see attachments 13 & 14). The next three meetings of the Leadership Committee were then focused on finalizing the priorities, choosing disparities based on an additional analysis of the data within each priority area, and choosing the interventions, strategies and activities to address the selected priorities and disparities.

As detailed in the CHIP, strategies to address chronic diseases include evidence-based activities such as implementing nutrition and beverage standards, increasing the percentage of breast cancer, colorectal cancer, and diabetes preventative screenings, and promoting provider practice participation in the regional hypertension registry. Strategies to address “Promote Healthy Women, Infants and Children” include linking children and families to dental services and supporting the delivery of oral health screening and preventative dental services through school-based clinics. Strategies under "Promote Mental Health and Prevent Substance Abuse" include Goal 2.1 (prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults). Initiatives to address this priority area will be completed with leadership from the Schuyler County Coalition on Underage Drinking and Drugs which includes in its membership Public Health, Schuyler Hospital, and a variety of other community partners.

4. Community Health Improvement Plan (CHIP):

Lessons Learned/Progress on 2013-17 CHIP:

Obesity: Schuyler County's main goal is to reduce the rate of obesity in the community. Healthy Eating Active Living (HEAL) Schuyler committee includes a mix of nine agencies and businesses. Schuyler County Public Health facilitated the first three years of the work plan. Some of the interventions were more successful in making progress on the goal, while others were less effective.

HEAL Schuyler was successful in implementing 15 interventions identified for 2014 through 2016. HEAL Schuyler's Worksite Wellness interventions included "The Biggest Loser" and the Schuyler Steps Out program. Both programs have proved to be successful the past three years and HEAL Schuyler was able to expand the program to other worksites in 2015. HEAL Schuyler also saw an increase in participation in adult community activities that promoted physical activity. HEAL Schuyler published their first walking trail maps project, "Schuyler Walks" on their website as 8 X12 maps that can be printed from home and plan to distribute 11X17 maps in 2017. HEAL Schuyler has increased their promotion of healthy lifestyles, through participating in events and publishing information through social media and newspapers. HEAL Schuyler's promotion and tracking of youth activities was limited. Some youth activities were established through HEAL partners and proved to be successful.

Expanding the knowledge base of partners in obesity prevention increased in 2015 with identifying emerging best practices and implementing them. Identifying new obesity prevention work added 2 interventions in 2015 that HEAL Schuyler partners implemented. The two new interventions included the Baby Café and the Voluntary Food Standards for Eateries.

Diabetes: Schuyler County's main goal was to reduce illness, disability and death related to diabetes. Two staff members were trained and certified to deliver the evidence-based National Diabetes Prevention Program (NPP) in 2015. A group of 13 pre-diabetic individuals met weekly for 16 weeks starting in 2014 and continued to meet monthly until July of 2015. Another class began in 2015 and ended early 2016. Motivational interviewing, group participation and peer support have assisted participants with decreased fat and calorie consumption and increased exercise.

The community collaborative also planned to screen 10% of the County's 20-49 year old population for diabetes risk, as many do not have Primary Care Physicians or Health Insurance coverage, by the end of 2016. Once screened for their risk of diabetes, they would be referred to a Primary Care Physician and, if appropriate, a Navigator to be screened for Health Insurance eligibility. The group was well underway with an award from the local Lions Club allowing for the purchase of glucometers and screening sticks when, in early 2014, the FDA disallowed population screening with individual glucometers, ending the initiative. The S²AY Rural Health Network won a Guthrie award the fall of 2015 to purchase 2 glucometers and sticks that could be used for population screens. The group has been busy reinvigorating the worksite screenings and referring community members to PCPs and Navigators. Many of the original members of the group were no longer available which slowed down the re-initiation of screening events. We have hopes of recruiting the next NPP from these screenings.

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

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

The Leadership committee and Schuyler County Public Health Advisory Committee spent several meetings developing and refining the attached Community Health Improvement Plan (CHIP) chart. This chart outlines the actions that both Schuyler County Public Health and Schuyler Hospital intend to take to address each priority area, the specific resources Schuyler County Public Health and Schuyler Hospital intend to commit (dollar amounts and/or FTEs), the roles of other partners engaged in each activity, and the chosen disparities being addressed by these efforts. The investments partners make and the expected community benefits are also outlined in the CHIP.

5. Maintaining Engagement and Tracking Progress:

As seen above, the CHIP chart designates the organizations that have accepted responsibility for implementing each of the activities outlined. The PAC is the group that will be overseeing the implementation, monitoring, and evaluation of the plan. The PAC has met on a monthly basis through the process of developing the CHIP and has accepted this role of overseeing the CHIP. Schuyler County Public Health and Schuyler Hospital, who are the lead entities in this work plan, will be carrying out the activities of the CHIP with support from additional community partners and will continue reporting back to the PAC routinely. All partners review the CHIP chart to ensure that all activities/progress are captured, to discuss barriers, and identify new opportunities or changes in activities. Furthermore, progress will also be reported annually to the Board of Health Committee a.k.a. the Schuyler County Legislature. Schuyler Hospital will continue to communicate CHIP/Community Service Plan (CSP) updates to the Hospital Board annually, and activities will also be shared with the S^2AY Rural Health Network Board at their quarterly meetings. Activities on the CHIP will continually be assessed and modified as needed to address barriers and replicate successes. As priorities are addressed, other community partners may need to be brought to the table to effectively accomplish objectives. The Schuyler County Public Health PAC is aware of this and CHIP progress will be a routine agenda item at their meetings.

6. Dissemination: The Executive Summary of the 2016-2018 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)/Community Service Plan (CSP) created in partnership between the lead entities (Schuyler County Public Health and Schuyler Hospital) will be disseminated to the public in the following ways:

- Through an initial media release summarizing the results and again offering the opportunity for public involvement during the first quarter of 2017
- Made publicly available on the Schuyler County Public Health website
- Made publicly available on the Schuyler Hospital website
- Made publicly available on the S^2AY Rural Health Network website
- Made publicly available on additional partners websites
- Will be presented in person at the first Board of Health Committee meeting January 4th , 2017
- Schuyler County Public Health, Schuyler Hospital, S^2AY Rural Health Network, and additional partners will be asked to share the publication and website links of the CHA/CHIP/CSP on their respective social media accounts (Facebook, LinkedIn, Twitter, etc.)

- Additionally, as significant accomplishments or changes are noted, the information will again be shared with all appropriate news outlets in the form of a press/media release

Lists of websites that have the documents posted are included below.

Schuyler County Public Health: http://www.schuylercounty.us/166/Public-Health

Schuyler Hospital: http://schuylerhospital.org/

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