

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

**County Name:**

**Wayne County**

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Newark-Wayne  
Community Hospital

**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 Wayne 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](http://www.S2AYnetwork.org)

[www.CommonGroundHealth.org](http://www.CommonGroundHealth.org)

## Key Findings

### Eight County Region

The total population in the region<sup>1</sup> 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%). Having access to healthy and affordable food is essential to practicing a healthy lifestyle.

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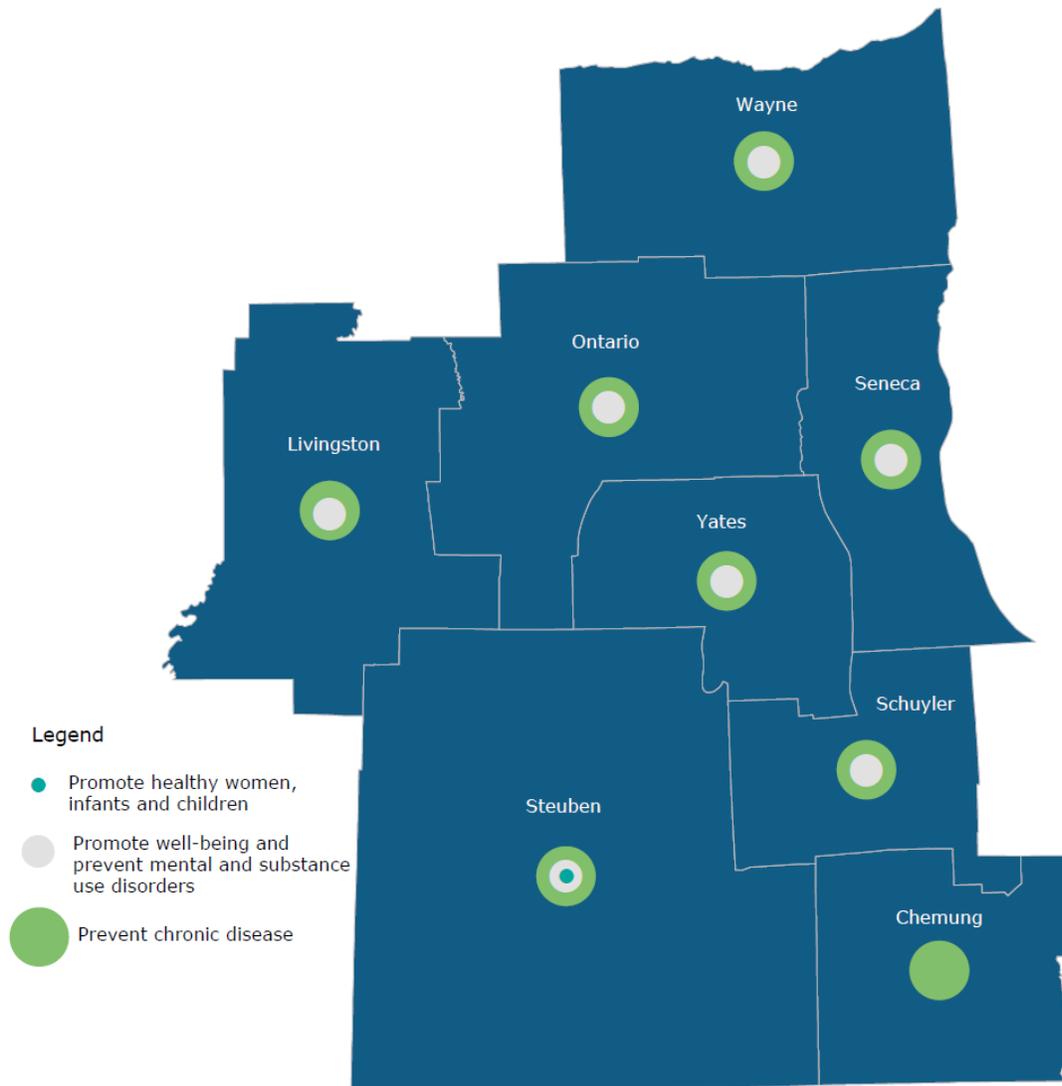
<sup>1</sup> Region includes Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates Counties

*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 (four 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*



Chronic disease preventative care and management	<p><b>4.1.2</b> 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)</p> <p><b>4.1.3</b> Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand (selected by four counties)</p>
Tobacco prevention	<p><b>3.1.2</b> Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms (selected by four counties)</p> <p><b>3.2.3</b> 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)</p> <p><b>3.3.1</b> 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)</p>
Healthy eating and food security	<p><b>1.0.3</b> Implement worksite nutrition and physical activity programs designed to improve health behaviors and results (selected by three counties)</p>
Prevent mental and substance use disorders	<p><b>2.2.2</b> Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers (selected by five counties)</p> <p><b>2.2.4</b> Build support systems to care for opioid users at risk of an overdose (selected by three counties)</p> <p><b>2.2.5</b> Establish additional permanent safe disposal sites for prescription drugs and organized take-back days (selected by three counties)</p> <p><b>2.3.3</b> Grow resilient communities through education, engagement, activation/mobilization and celebration (selected by three counties)</p> <p><b>2.5.4</b> 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)</p>
<p>*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.</p>	

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.

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.

## Wayne County Executive Summary

The Wayne County Health Department, in partnership with Newark Wayne

Community Hospital, has selected the following priority areas and disparity for the 2019-2021 assessment and planning period:

County	Priority Areas & Disparity
Wayne County	<p><b>Prevent Chronic Disease</b></p> <ol style="list-style-type: none"> <li>1. Tobacco prevention</li> <li>2. Chronic disease preventative care and management</li> </ol> <p><b>Promote Well-Being and Prevent Mental and Substance Use Disorders</b></p> <ol style="list-style-type: none"> <li>3. Promote well-being</li> <li>4. Prevent mental and substance use disorders</li> </ol> <p><b>Disparity: low income</b></p>

Selection of the 2019-2021 Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP) priority and disparity areas was a joint process which began in the summer of 2018 with assistance from the S2AY Rural Health Network and Common Ground Health. A variety of partners were engaged throughout the process including the public health departments and hospital staff, Community Based Organizations (CBOs), school district representatives, local federally qualified health centers (FQHCs), Aging and Youth, 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 17, 2019, the health department engaged key stakeholders in a prioritization meeting facilitated by the S2AY Rural Health Network. Key partners and community members were invited to attend the prioritization meetings, including all those who attended prior focus groups. Social media platforms, e-mail, 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, primary data collected from the *My Health Story 2018* Survey and local data sources such as Wayne County's school student 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<sup>2</sup> to rank a list of group identified priorities. To address the previously mentioned priorities and disparities, the health department facilitated

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<sup>2</sup> Hanlon and Pearl are methods which rate items based on size and seriousness of the problem as well as effectiveness of interventions.

CHIP planning meetings where partners discussed opportunities to leverage existing work. Existing work efforts were then compared to intervention options (primarily selected from the New York State Prevention Agenda Refresh Chart) and were informally voted on and selected.

Regionally<sup>3</sup>, Wayne County aligns with nearby counties on several interventions including the following:

Focus Area	Intervention* & # of Counties Selected
Tobacco prevention	<p><b>3.1.2</b> Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms (selected by four counties)</p> <p><b>3.2.3</b> 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)</p> <p><b>3.3.1</b> 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)</p>
Prevent mental and substance use disorders	<p><b>2.3.3</b> Grow resilient communities through education, engagement, activation/mobilization and celebration (selected by three counties)</p>
<p>*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.</p>	

Tobacco prevention was a widely selected focus area by several regional counties (five out of eight counties). Many counties, including Wayne, have selected goals which revolve around prevention of initiation of tobacco use as well as tobacco cessation efforts. The complete list of Wayne 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).

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

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

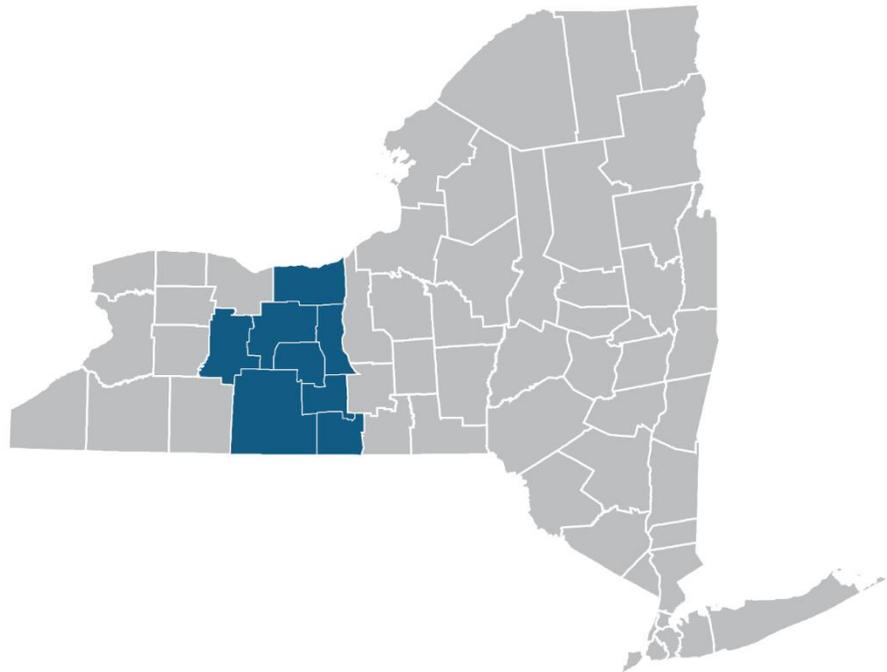
## Community Health Assessment Eight County Region

### *Total Population*

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

*Map 2: The eight-county Finger Lakes region*

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



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

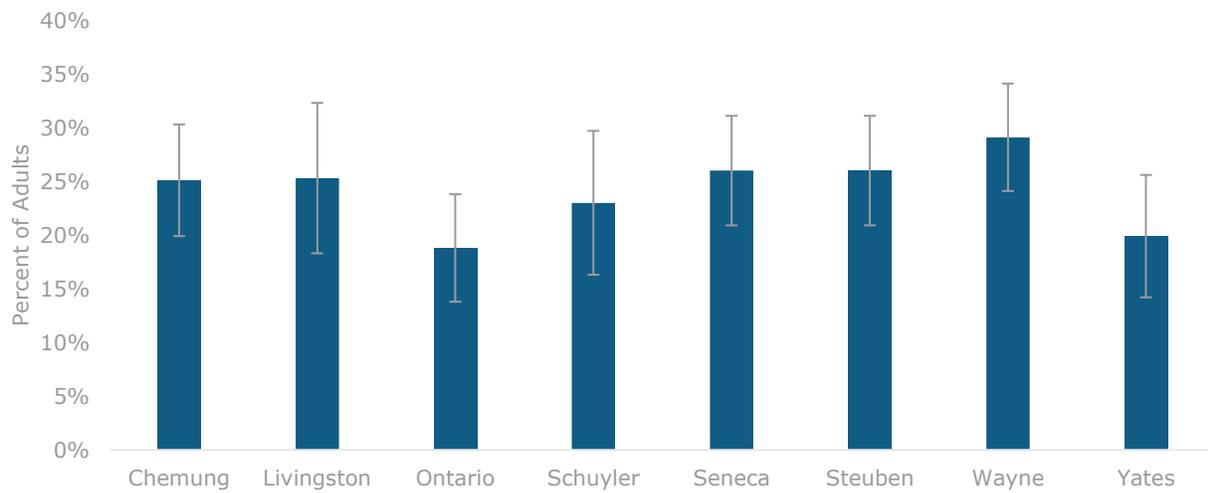
### *Disability*

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

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

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

*Figure 1: Percent of adults living with a disability*



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

### *Household Language*

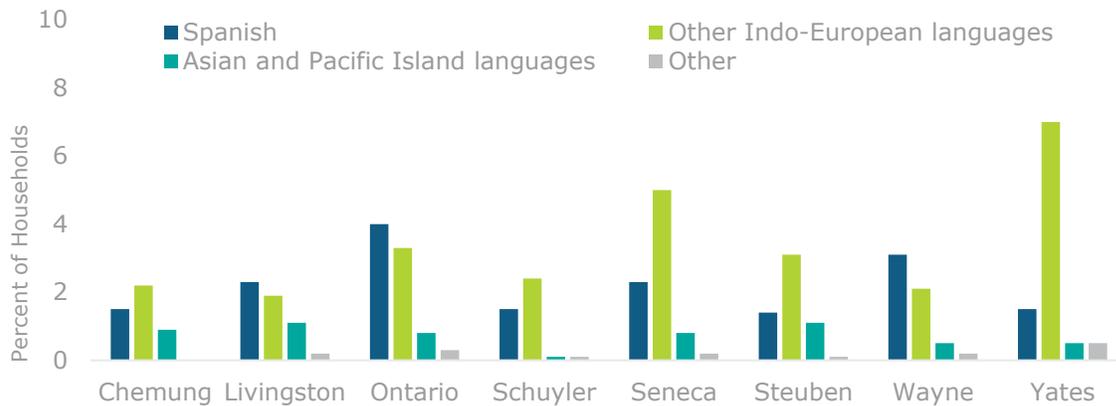
Providers of all types (medical, social service, etc.) should be aware of language and cultural differences when working with patients/clients. Being respectful of a person’s cultural practices is important to building a trusting and positive relationship. A system where healthcare providers are culturally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

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

<sup>4</sup> 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*



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

### *Special Populations*

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

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,

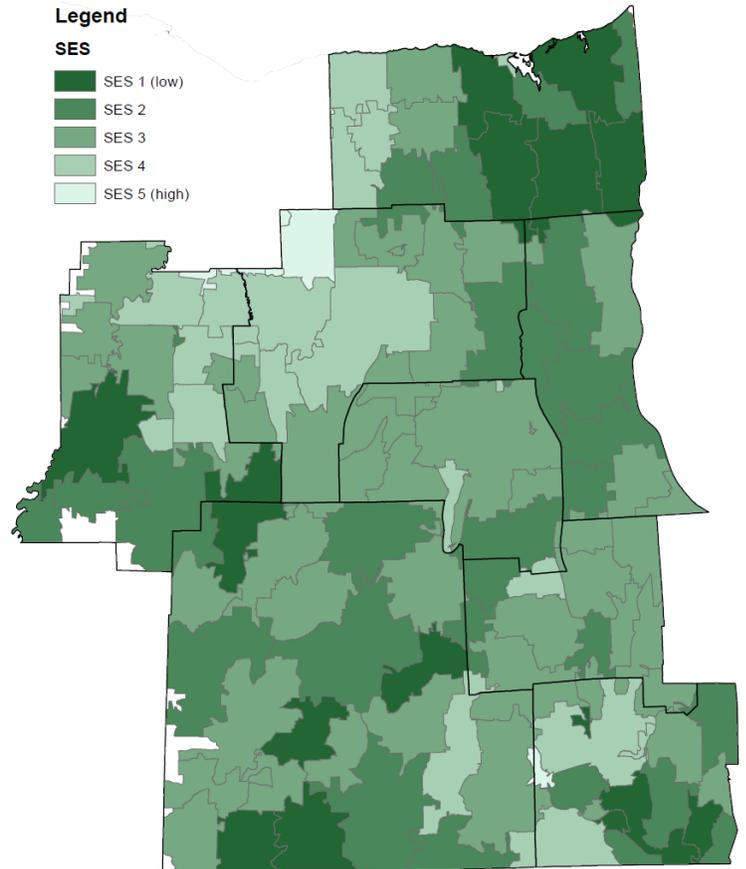
<sup>5</sup> Source: Groffdale Conference Mennonites in the Finger Lakes Area of New York State, March 2019 Map

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<sup>6</sup> 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

<sup>6</sup> 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
<b>8 County Region</b>	<b>7</b>	<b>38</b>	<b>6</b>	<b>40</b>
NYS	9	35	7	37

Source: U.S. 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, the rate of uninsured individuals has decreased 3% over the past six years to 5% of residents. This is a step in the right direction but, health insurance attainment is not the only barrier to health care. Underinsured individuals, or those who have high deductibles that affect their ability to access healthcare, are 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

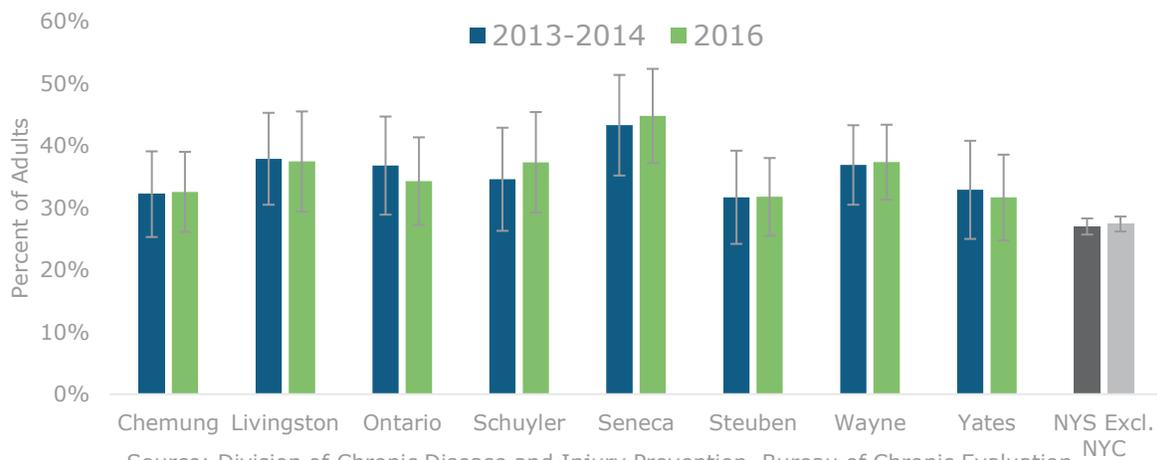
### Eight County Region

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*

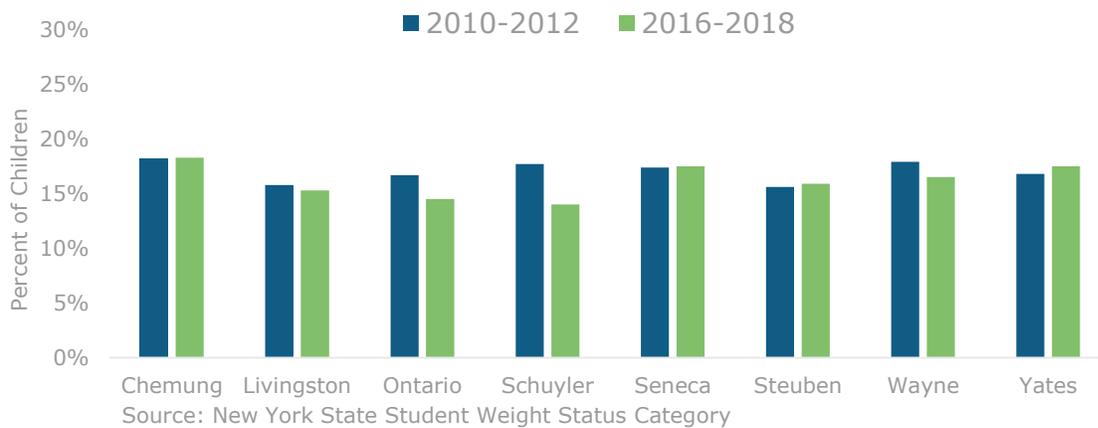
Preventing chronic disease has been a long standing priority area in the eight county region. Efforts have largely been focused on reducing illness, disability and death related to hypertension, tobacco use and second hand smoke, and reducing obesity in children and adults. Rates of obesity in the eight 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%
<b>8 County Region</b>	<b>35%</b>	<b>41%</b>	<b>45%</b>
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).

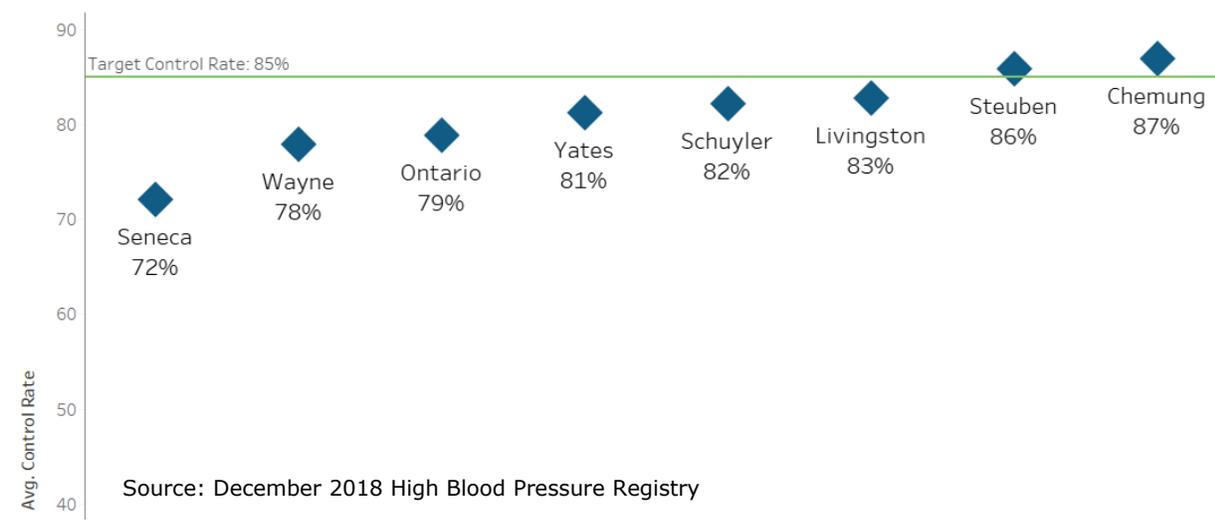
Table 3: Obesity rates by sex

	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%
<b>8 County Region</b>	<b>37%</b>	<b>34%</b>

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<sup>7</sup>, 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.

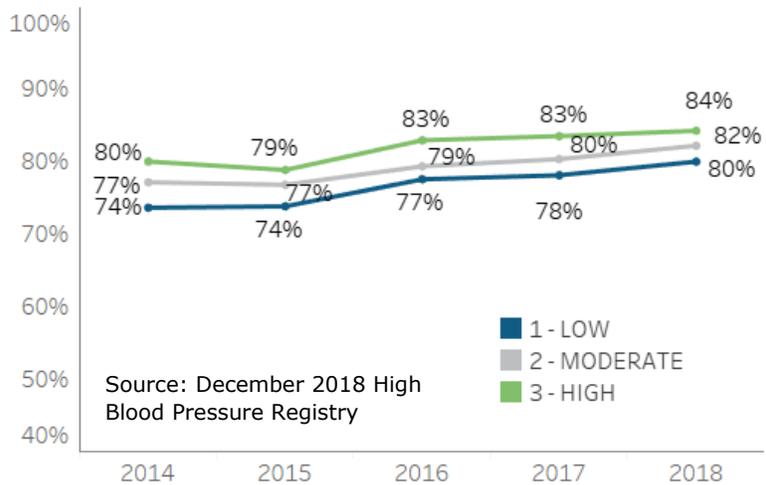
Figure 5: Percent of patients with blood pressure controlled, December 2018 high blood pressure registry



<sup>7</sup> 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.

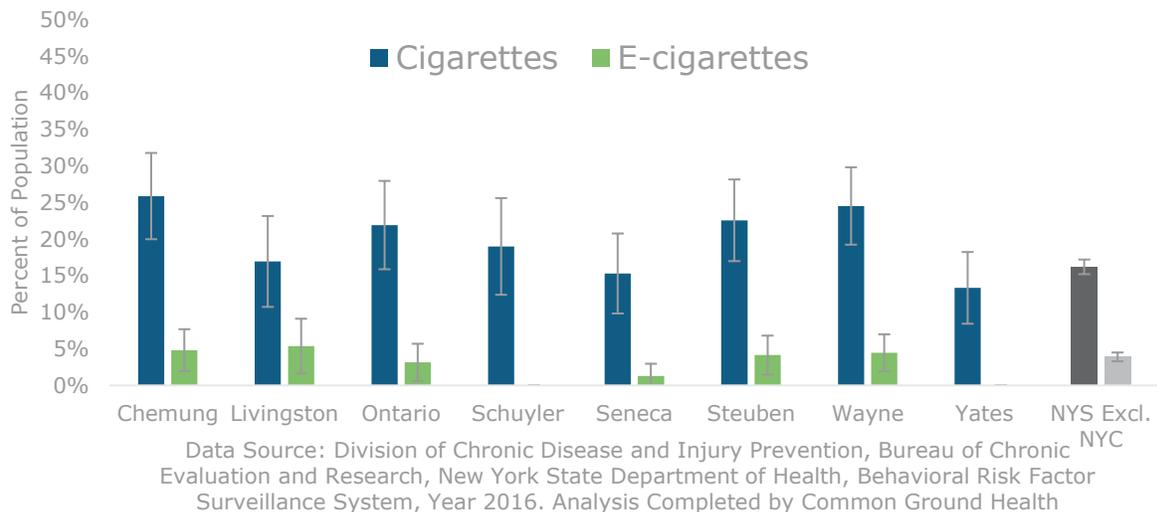
Table 4: Cardiovascular disease by demographic

	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%
<b>8 County Region</b>	<b>11%</b>	<b>25%</b>
NYS	9%	21%

Source: Behavioral Risk Factor Surveillance System, 2016

Tobacco use increases the risk of cardiovascular disease. An emerging issue identified in the region is the use of e-cigarettes and other nicotine delivery systems, especially among younger adults. Nicotine is addictive – regardless of the form in which it is consumed - and has deleterious effects on developing fetuses and underdeveloped brains in children and adolescents. Unregulated child-friendly flavorings and colorings found in vaping and other devices damage the oral mucosa and airway. There is much still unknown about the full health effects of electronic cigarettes. A recent NY State DOH Health Alert (August 15, 2019) of severe pulmonary disease among ten NY State residents related to vaping highlights the need for public health professionals to address this issue in the coming years. While data at this time are sparse, the popularity of these devices has grown substantially. It is likely that 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%
<b>8 County Region</b>	<b>26%</b>	<b>33%</b>	<b>28%</b>
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%
<b>8 County Region</b>	<b>21%</b>	<b>23%</b>

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*

	<b>8 County Region</b>				<b>Overall</b>
	<b>under \$25K</b>	<b>\$25-50K</b>	<b>\$50-75K</b>	<b>\$75K+</b>	
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*

	<b>8 County Region</b>				<b>Overall</b>
	<b>under \$25K</b>	<b>\$25-50K</b>	<b>\$50-75K</b>	<b>\$75K+</b>	
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%

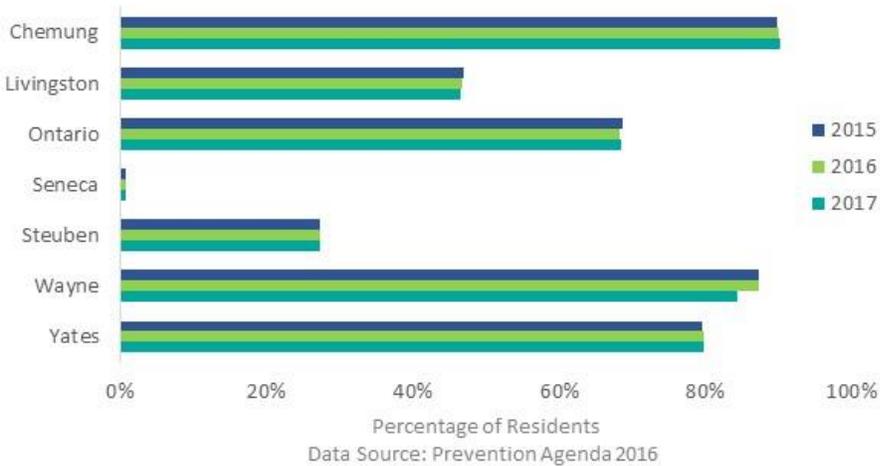
Source: My Health Story survey 2018. Analysis by Common Ground Health incorporates weighting to reflect demographics of each county and the region.

*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.<sup>8</sup> 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.

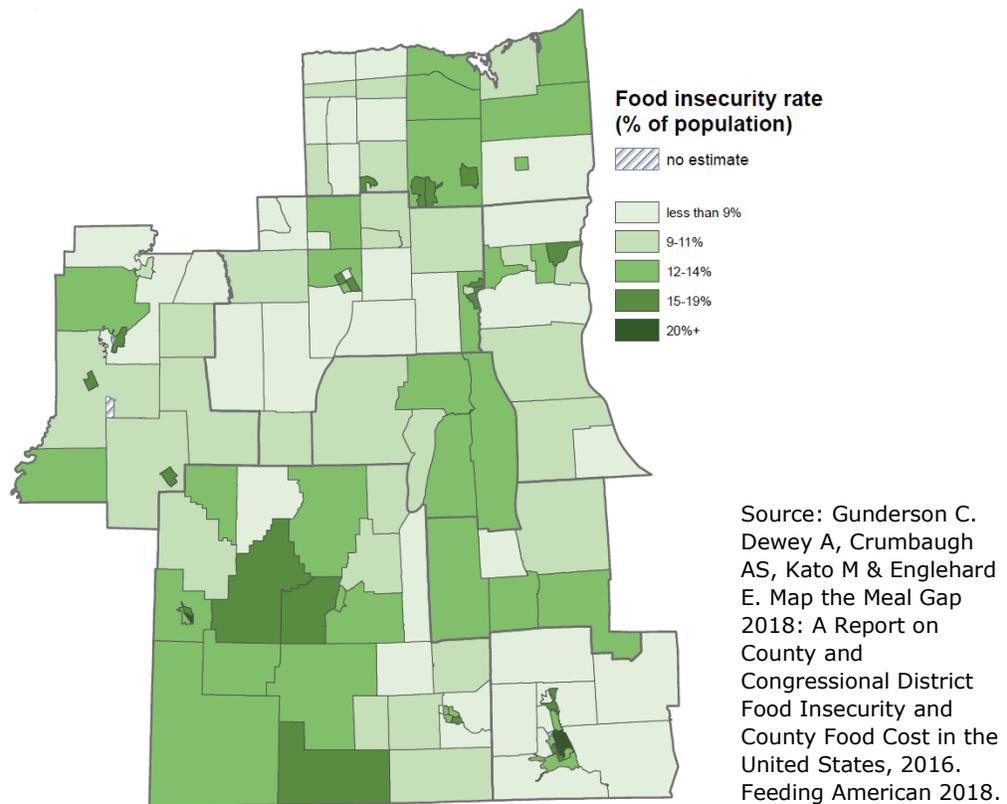
Figure 9: Percent of population that is low income and has low access to a supermarket or large grocery store



<sup>8</sup> Source: NYS Prevention Agenda Dashboard

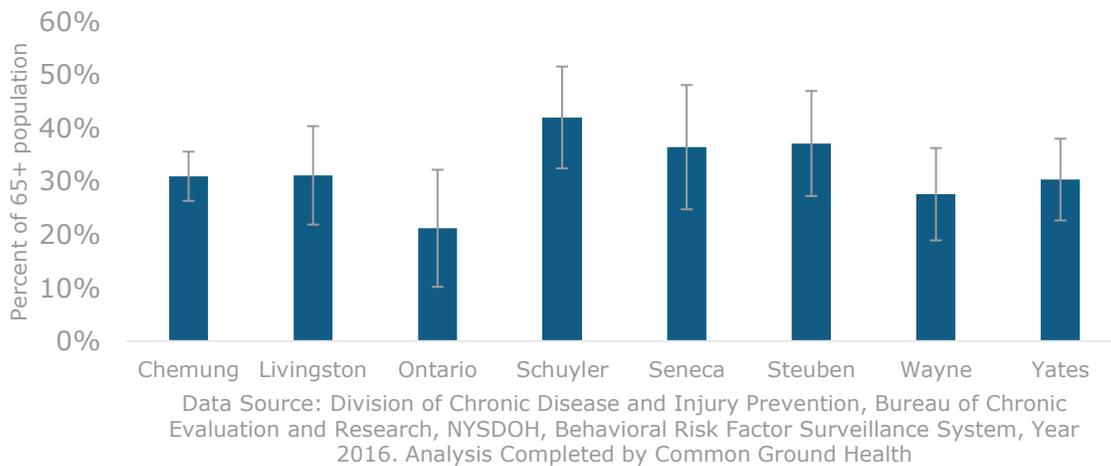
Over 22% of the regional population reported experiencing food insecurity in the past 12 months. Of note, 14% of *My Health Story 2018* respondents reported they are always stressed about having enough money to afford healthy food. Map 4 shows the food insecurity rates by census tract in the eight county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

Map 4: Food insecurity rate by census tract



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

Figure 10: Reported falls in 65+ population



*Promote Healthy Women, Infants and Children*

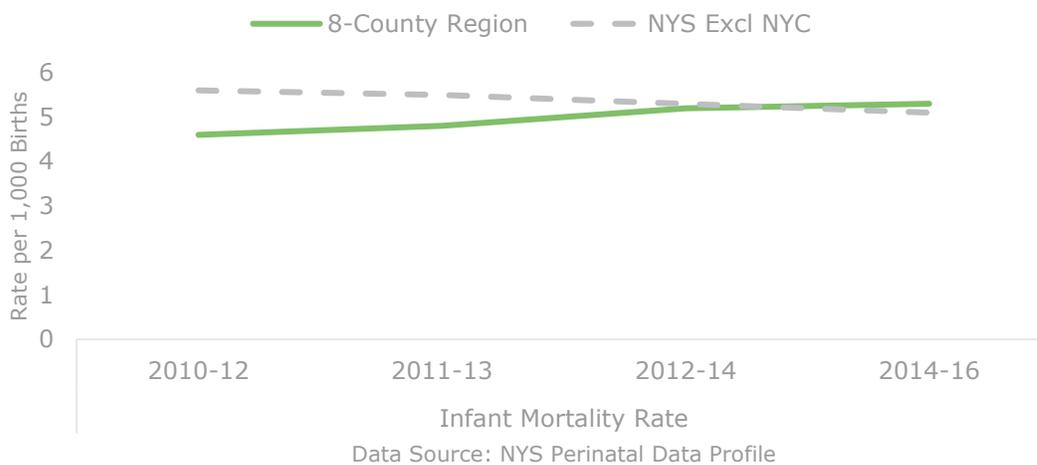
New York State collects several pieces of information on births including the number of premature and low birth weight babies. A baby born prematurely (<37 weeks gestation) is at risk for several health complications including jaundice, anemia, apnea, and more. The earlier a baby is born in pregnancy,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

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.<sup>10</sup> 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.

<sup>9</sup> March of Dimes, Premature Babies and Long-Term Health Effects of Premature Birth, [www.marchofdimes.org](http://www.marchofdimes.org).  
<sup>10</sup> Stanford Children’s Health, Low Birthweight

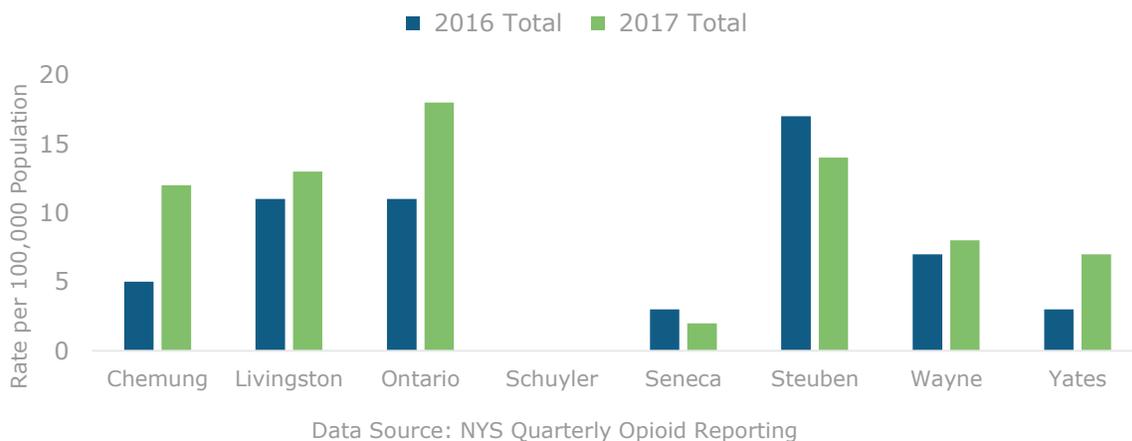
Figure 11: Rate of Infant Mortality



*Promote Well-Being and Prevent Mental and Substance Use Disorders*

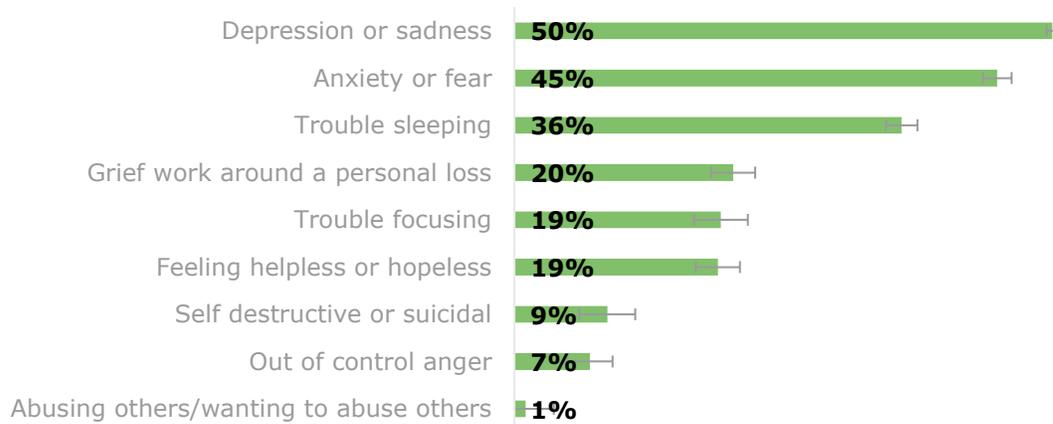
Data from New York State Opioid Reporting indicate a 23% increase in overdose deaths from 2016 (N=57) to 2017 (N= 74) (Figure 12). Notably, Seneca and Steuben Counties were the only counties that saw a decrease in deaths from 2016. The largest increases in deaths were in Chemung and Ontario Counties. 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.

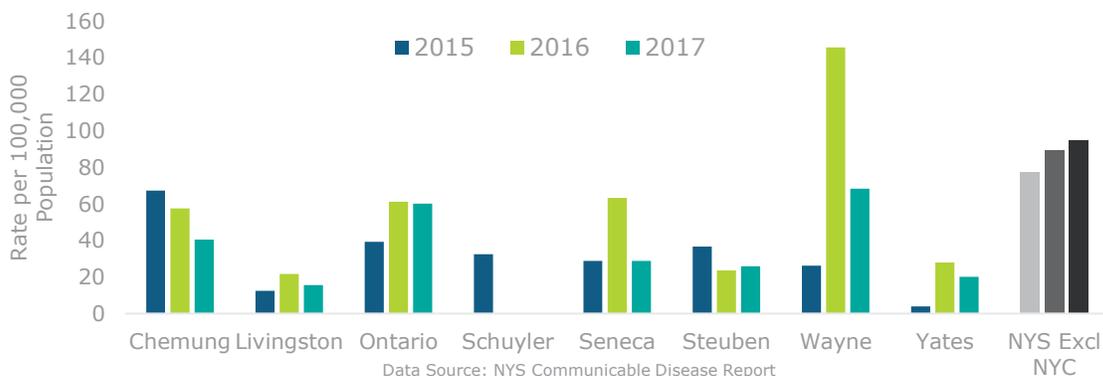
*Figure 13: Percent of adults who have personally dealt with each of the following mental or emotional health issues*



### *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).

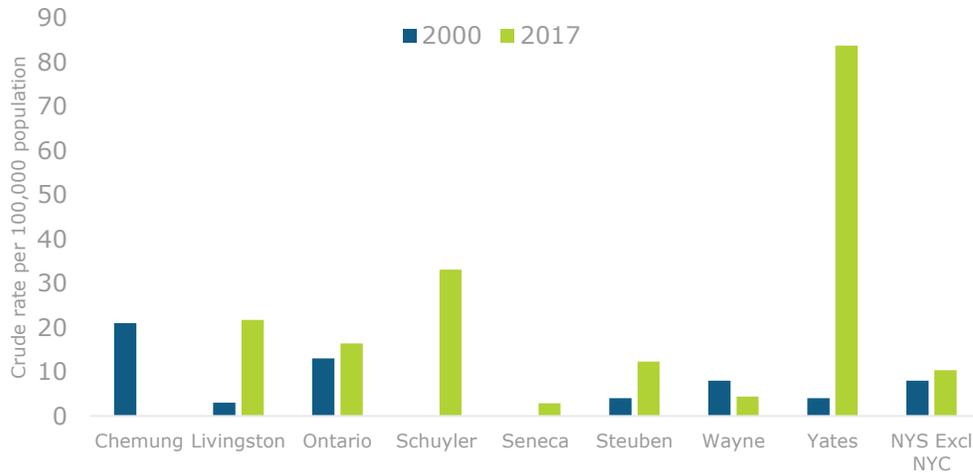
*Figure 14: Rate of gonorrhea per 100,000*



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*

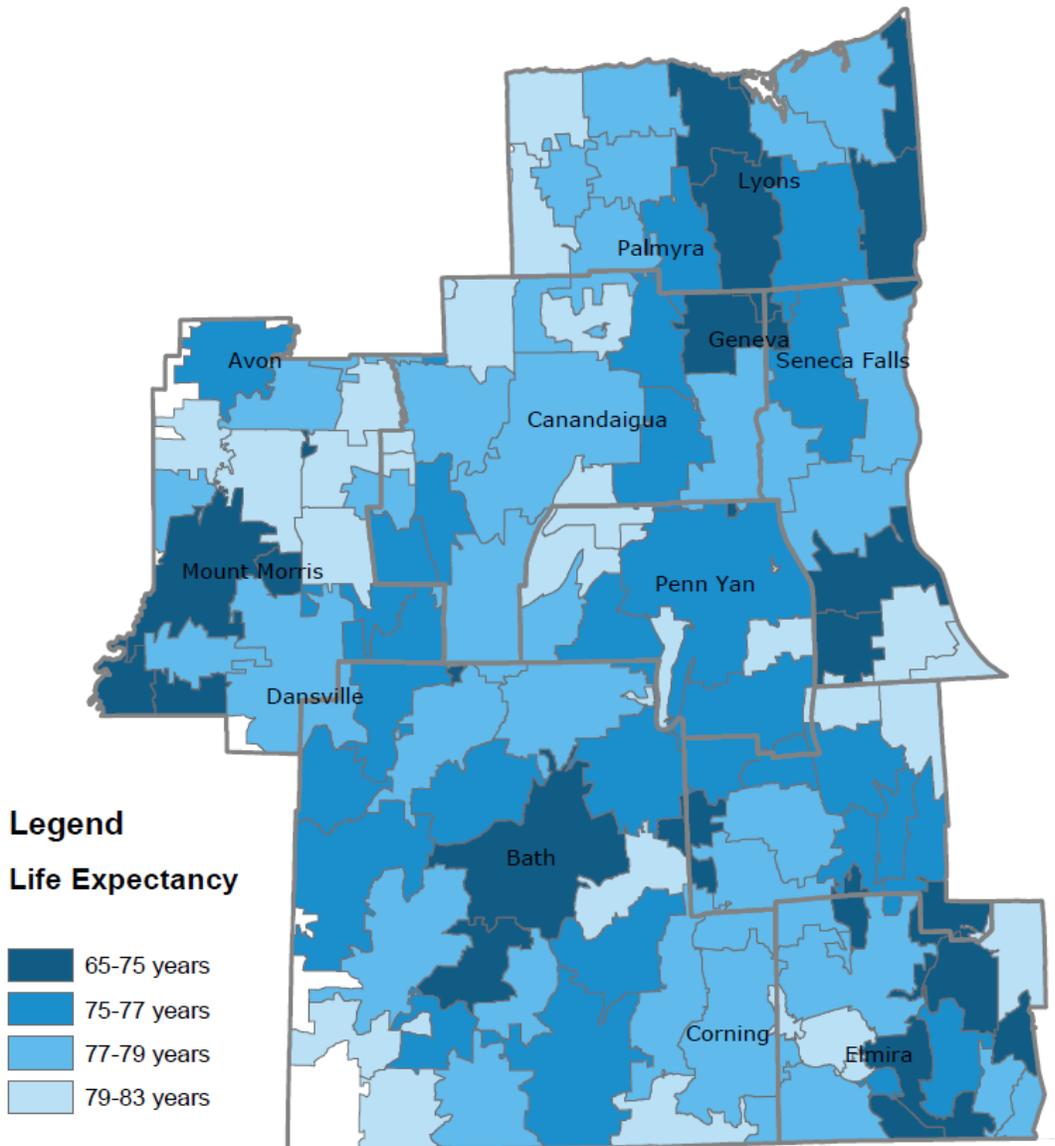


Source: NYS Communicable Disease Reporting, 2000 and 2017

### *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 as 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.

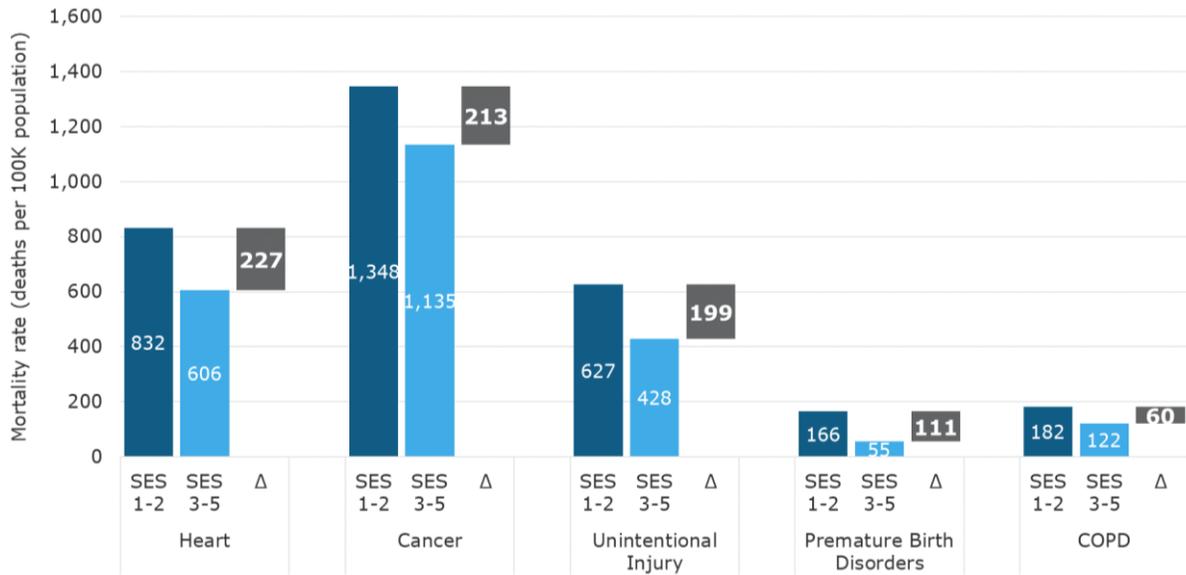
Map 5: Life expectancy by ZIP code



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 differ between 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
<b>Chemung</b>	221.9	162.4	185.2	145.9
<b>Livingston</b>	155.9	106.6	210.9	140.6
<b>Ontario</b>	217.9	93.5	213.7	156.6
<b>Schuyler</b>	268.5	104.9	216.4	214.8
<b>Seneca</b>	231.1	103.8	182.2	185.8
<b>Steuben</b>	188.7	165.1	187.1	138.2
<b>Wayne</b>	174.2	133.9	189	179.5
<b>Yates</b>	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*).<sup>11</sup> 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.<sup>12</sup> 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

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<sup>11</sup> 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.

<sup>12</sup> 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 Wayne 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.

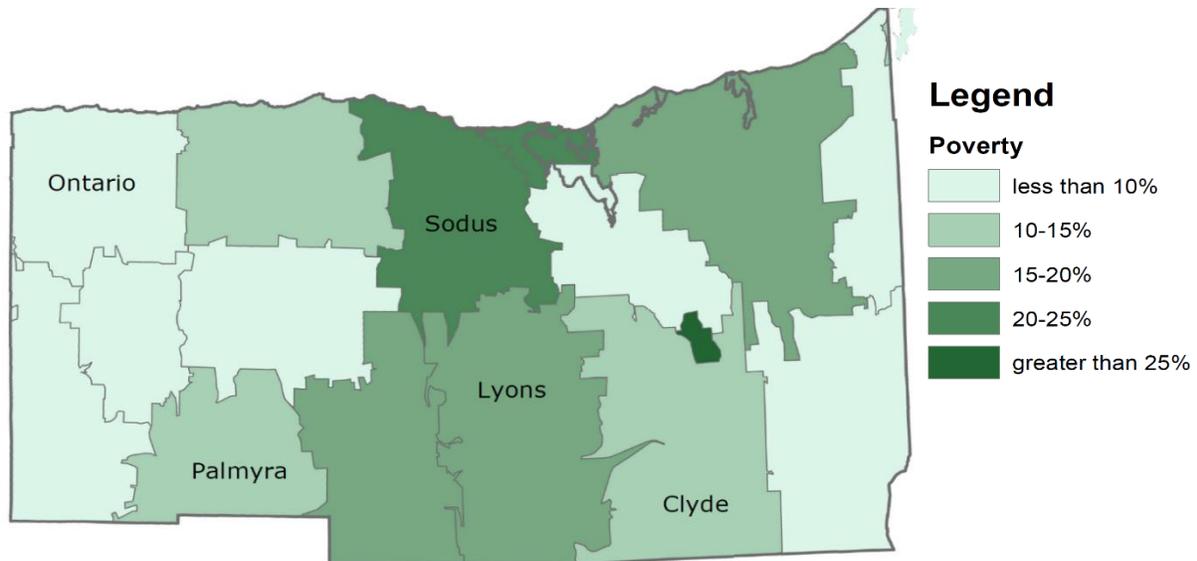
## Wayne County

### *Demographic and Socioeconomic Health Indicators*

Wayne County is located east of Monroe County and shares its northern borderline with Lake Ontario. The western portion of the county's proximity to the City of Rochester makes it easily accessible to jobs for those able to commute. A total of 91,422 persons live in the county, the majority of which (94%) are White Non-Hispanic. Women of childbearing age make up 15% of the population, and 29.1% of the 18+ population are living with a disability.<sup>13</sup> 2017 estimates reveal 28% of the 65+ population (N=4,413) is living alone. This rate is up 2 percentage points from 2012 when 26% of the 65+ population (N=3,504) was living alone.

Of note is the density of poverty in the county. Of Wayne County's residents, 11.7% live below the federal poverty level, and another 17% live near it. The distribution of poverty in the county is shown below in Map 6.

*Map 6: Poverty rates by ZIP code*

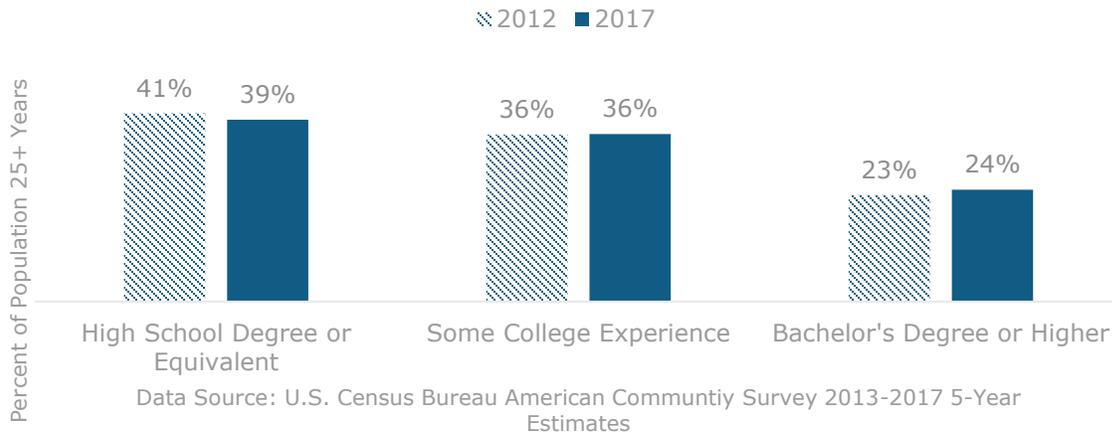


Source: U.S. Census Bureau American Community Survey 2013-2017 5-Year estimates

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

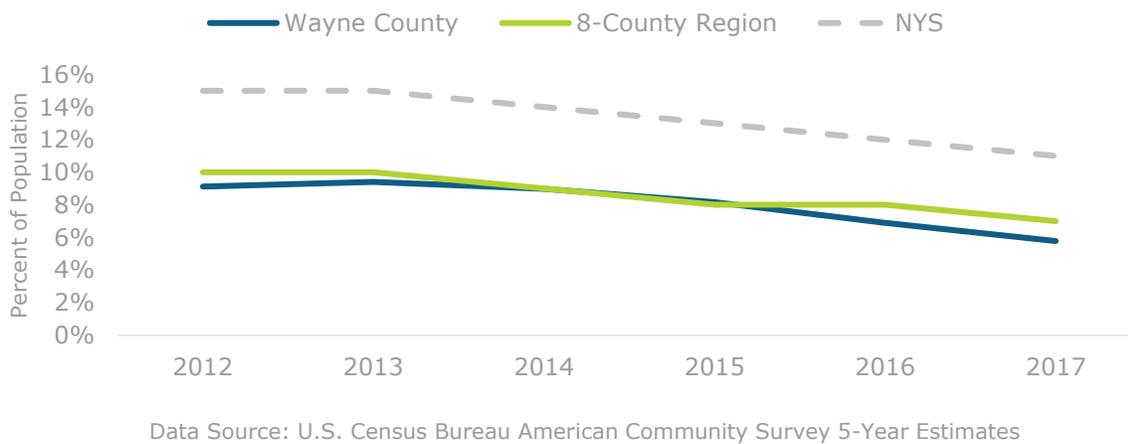
Over the past 5 years, there has been a slight shift in educational attainment where there are more residents aged 25+ with a Bachelor’s degree or higher than in years past (Figure 17).

Figure 17: Educational attainment for Wayne County by year



Data below show the trend in uninsured rates over the past 5 years compared to the region which has decreased more than 38 percent since 2012 for Wayne County (Figure 18).

Figure 18: Percent of population that is uninsured



Finally, 23% of Wayne County residents rent vs. own their home. In addition, 7% of occupied housing units have no vehicles available. Another 33% have access to one vehicle. Of note, the average household size for occupied housing is greater than two people. Approximately 40% of residents are paying 35% or more of their household income in rent costs.<sup>14</sup>

<sup>14</sup> Source: US Census Bureau American Community Survey 2013-2017 5-Year Estimates

### *Main Health Challenges*

On May 17, 2019, stakeholders and community members were invited to attend a priority setting meeting. At this meeting, participants reviewed the MAPP process, as well as relevant qualitative, quantitative, primary and secondary data. Data were reviewed from a variety of different sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, primary data collected from the My Health Story 2018 Survey and local data sources such as Wayne County's school student survey. Ultimately, using the Hanlon/PEARL method, the group selected the following as their priority areas and disparities for the 2019-2021 Community Health Improvement Plan:

#### **Prevent Chronic Disease**

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

#### **Promote Mental Well-Being and Prevent Substance Use Disorders**

4. Prevent mental and substance use disorders

#### **Disparity: low income**

Lively group discussions took place regarding the potential priority areas. In addition to the group's thoughts, *My Health Story 2018* respondents were also asked questions relating to their top concerns for the health of themselves, loved ones, adults and children in the community (and were reviewed at the meeting). Weight and mental/emotional health issues rose to the top for each of the four categories (Figure 19). Of note, mental health, substance abuse and education were concerns for children in the county. Cost of care and heart conditions were also highlighted as respondents' top fears for themselves and for others.

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

<b>Biggest fear - for self</b>	<b>Biggest fear - for others</b>
Cost (14.5%)	Cost (12.0%)
Weight (12.9%)	Mental / emotional health issues (10.7%)
Heart conditions (9.3%)	Cancer (9.4%)
Mental / emotional health issues (9.1%)	Heart conditions (8.4%)
Cancer (8.9%)	Weight (6.4%)

<b>County priority - for adults</b>	<b>County priority - for children</b>
Mental / emotional health issues (19.4%)	Diet / nutrition (25.8%)
Weight (16.4%)	Mental / emotional health issues (16.9%)
Diet / nutrition (15.9%)	Weight (14.6%)
Substance abuse (15.0%)	Substance abuse (13.4%)
Cost (10.9%)	Education (13.2%)

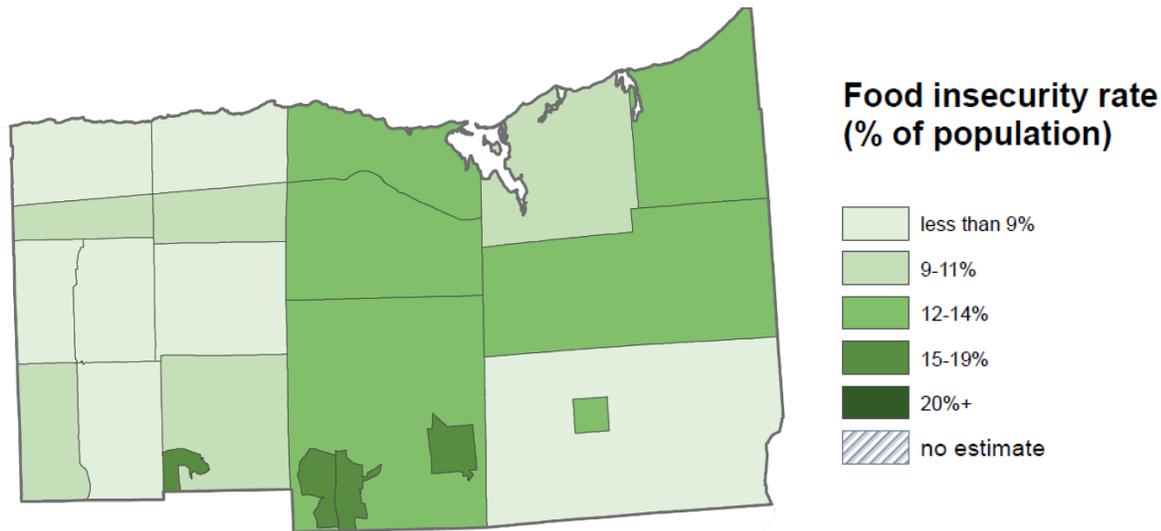
Source: *My Health Story* survey 2018. Analysis by Common Ground Health incorporates weighting to normalize survey participants to demographics of each county. Top 5 issues shown for each question. Data shown are the percent of participants with responses in each category.

### Behavioral Risk Factors

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

In terms of nutrition, ease of access to healthy foods is an important factor in a person’s ability to adopt healthy eating behaviors. According to data from the 2013-14 Behavioral Risk Factor Surveillance System, over 21% of Wayne County’s population reported experiencing food insecurity in the past 12 months. Additionally, 16% of Wayne County’s *My Health Story 2018* survey respondents reported they are always stressed about having enough money to afford healthy food. Map 7 shows the food insecurity rates by census tract for Wayne County. Higher rates of food insecurity are present in eastern Wayne County including Lyons and Newark.

Map 7: Food insecurity rate by census tract, Wayne County



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

Rates of tobacco use in Wayne County (25%) are similar to the average in the eight county region (22%). E-cigarette use has recently emerged as an issue across many counties and New York State. Data at this time are sparse, though anecdotal evidence suggests an inverse relationship between cigarette and e-cigarette smoking. Many persons have switched from cigarette to e-cigarette usage under the impression that e-cigarettes are “safer.” This perception that vaping as harmless is erroneous. Nicotine is addictive and has an impairing effect on the development of child and adolescent brains. Chemical flavorings and colorings, as yet unregulated, may damage the oral mucosa and airway. In addition, usage of both items increases the likelihood for development of lung cancer, hypertension, risk of strokes and heart attacks, and premature mortality. The prevalence of smoking is more commonly seen in vulnerable populations. Estimates of usage among those whose income is less than \$25,000 annually (32%) and those living with a disability (30%) are higher than general population estimates (25%).<sup>15</sup>

As mentioned, persons who smoke are at greater likelihood of developing chronic conditions such as hypertension. In Wayne County, it is estimated that 40%<sup>16</sup> of adults have been diagnosed with hypertension (the highest in the region), 77%<sup>17</sup> of whom are in control of their blood pressure, though this varies by income level. Of

<sup>15</sup> Source: Behavioral Risk Factor Surveillance System, 2016. Data on low-income and those with a disability are unreliable due to large standard error: standard error between 24% and 41% for low-income and 20% and 40% for those living with a disability.

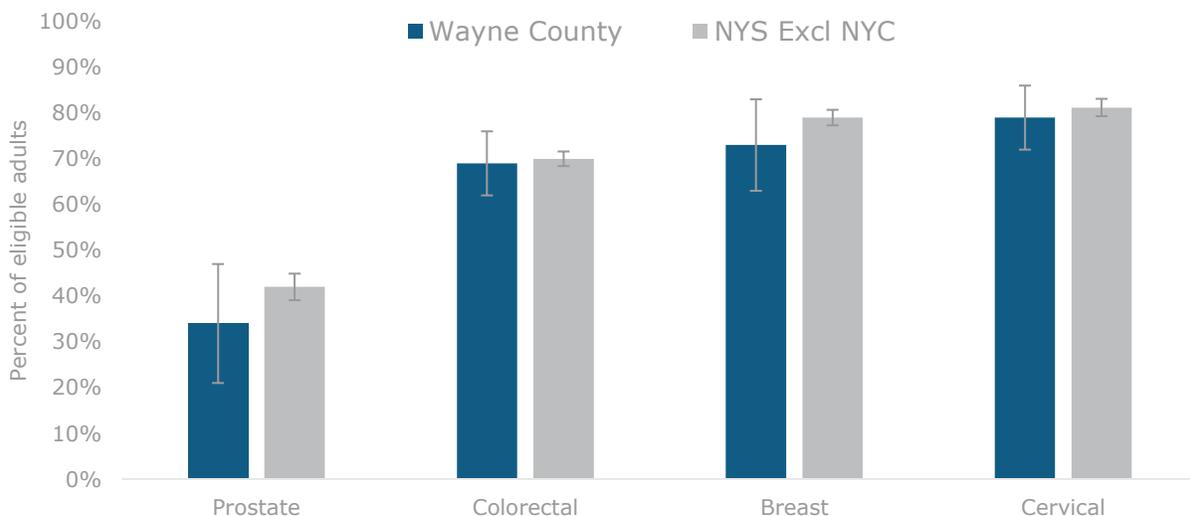
<sup>16</sup> Source: Behavioral Risk Factor Surveillance System 2016.

<sup>17</sup> Source: Common Ground Health High Blood Pressure Registry, June 2018.

those residents with the highest socioeconomic status, 81% are in control of their blood pressure, while only 75% of low socioeconomic status residents are in control of their blood pressure. Reducing the disparity in control rate by socioeconomic status requires engaging patients in taking control of their blood pressure through various methods: blood pressure medication adherence, promotion of physical activity, healthy eating, and more. Low income patients are often less likely to be able to afford medications, and it is therefore important to work with providers to prescribe generic medications that are less expensive and accepted by insurance companies. In addition, encouraging and assisting patients in quitting smoking (if applicable) could help to improve control.

Smoking not only increases risk of development for hypertension, but it is also the number one cause of lung cancer. The leading cause of premature death in cancer patients is lung cancer. Of note, screening for different types of cancer can greatly impact the likelihood of early diagnosis and is an important preventative step in primary care. During prioritization meetings, cancer screenings were identified as a priority area. Figure 20 below shows the percent of that population that has received screenings for various types of cancer based on recommended guidelines in Wayne County. Of note, prostate cancer screenings have the lowest screening rate, which is similar to each of the other counties in the eight county region.

Figure 20: Percent of eligible population receiving cancer screening



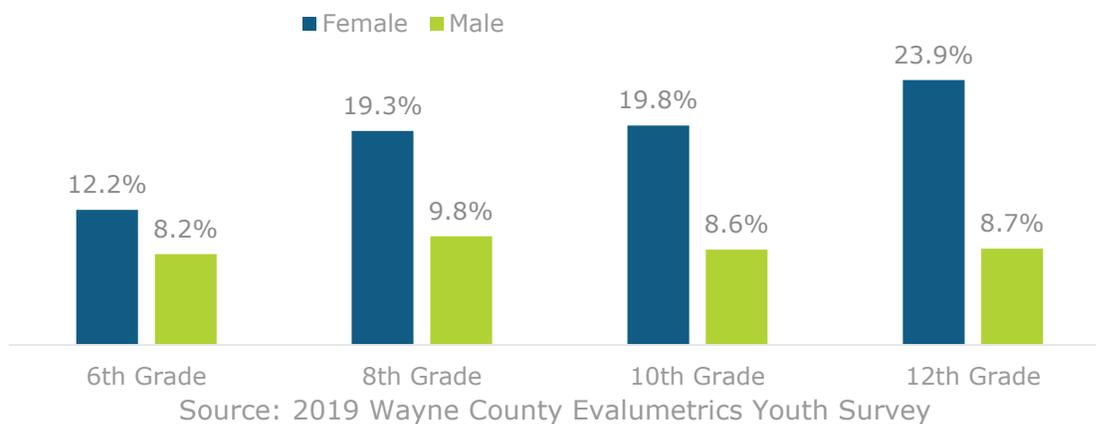
Data Source: Division of Chronic Disease and Injury Prevention, Bureau of Chronic Evaluation and Research, New York State Department of Health, Behavioral Risk Factor Surveillance System, Year 2016. Analysis Completed by Common Ground Health

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

70.9% of respondents said they got the help they needed. The most commonly reported support was from doctors, counselors and other mental health professionals followed by support from friends and family.

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

*Figure 21: Percent of students reporting they have cut or burned themselves when they were upset*



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

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

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

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

### Policy and Environmental Factors

Although Wayne County continues to experience high rates of smoking and vaping, the communities within the county are becoming increasingly proactive by adopting smoke-free policies to protect residents, patrons, and tenants from secondhand smoke. Libraries throughout Wayne County, along with several businesses, have implemented smoke-free policies to protect their customers and employees. Throughout the county, it is forbidden to smoke in a park if children 12 or under are present. However, the Village of Newark has taken things one step further by implementing Tobacco-Free Outdoor policies in its many parks. Most importantly,

several apartment complexes, covering hundreds of units, have adopted smoke-free policies – protecting their tenants from secondhand smoke and reducing the risk of fires. All Wayne County-owned and leased properties are smoke-free by law, and although enforcement has been a challenge since its implementation, law enforcement has become increasingly engaged in 2019.

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

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

#### Other unique characteristics contributing to health status

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

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

In Wayne County, many Amish and Mennonite families receive information from a publication called *The Flame*, which may be a valuable outlet for persons hoping to connect with those groups. Many of the Amish and Mennonite population do not drive cars, instead using horse and buggy, and inconvenience of transportation should be considered when trying to promote preventive care. Mobile options, such as home visits, may be more appealing. Even for those who do drive cars, there is often a preference to be seen in their own communities. For example, they may prefer to assemble in a location convenient for them and then all learn about a particular service or screening at the same time. Amish and Mennonite families

often have many children, which can make travel and scheduling more difficult. Wayne County Public Health is able to provide at-home immunizations, lactation counseling, and more in these communities; and mobile mammography is available through Rochester Regional Health.

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

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

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

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

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

### *Community Assets and Resources to be Mobilized*

During focus groups completed in late 2018 and early 2019, community members identified several assets and resources in Wayne County. For example, focus group attendees identified local agencies such as libraries, hospitals, schools and the health department as community strengths and resources. Local programs such as Relay for Life, Green Thumb Thursday and the Justice Org of Youth were also highlighted as strengths as was the county's local environment (including trails and parks). A comprehensive list of identified strengths and resources can be found in focus group summaries and is available upon request.

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

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

Community Schools is an initiative impacting four Wayne County school districts at the time of this publication; that number is likely to increase over time. A community school is a school which has been transformed into a resource hub where educators, cross-sector and community partners are able to offer an array of connected services, supports, and opportunities to children, families, and communities (U.S. Department of Education, 2018; New York State Education Department, 2018; Coalition for Community Schools, 2018; Binghamton University, 2018). A goal of a community school is to attain collective impact by bringing together various community partners to collaborate in meeting the needs of their community, especially for students and families in high need. The main difference between a traditional public school and a community school is that a community school follows the collective impact model, which focuses on aligning various systems for increasing the efficient use of services and resources. Research and evaluations around the community schools strategy has indicated gains in academic achievement, improved attendance, reduced suspensions, reduced high-risk behaviors, better access to services, increased parent involvement, and reduced violence rates for students and families in public schools that function as community schools.<sup>18</sup> Although much of the research on community schools has

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<sup>18</sup> Dryfoos, 2002; Blank, Melaville, & Shah, 2003

been in urban communities, the community schools strategy has the potential to deliver a variety of supports and services that would be strategically provided by community and county-based service providers in rural areas. The premise of the community school strategy is to coordinate vital resources within a school district, county, and across a region.

*Community Health Improvement Plan/Community Service Plan*

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

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

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

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

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

#### *Dissemination*

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

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

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

## Wayne County Community Health Improvement Plan 2019-2021

### Glossary of Acronyms:

CCE – Cornell Cooperative Extension (of Wayne)	FLESNY – Finger Lakes Eat Smart New York	TFO – Tobacco-Free Outdoors
CDSM – Chronic Disease Self-Management	FQHC – Federally Qualified Health Center	Wayne CAP – Wayne Community Action Program
CHIP – Community Health Improvement Plan	N-O-T – Not-On-Tobacco (evidence-based program)	WCRHN – Wayne County Rural Health Network
CTFFL – Center for a Tobacco-Free Finger Lakes	NWCH – Newark-Wayne Community Hospital	WHIP – Wayne Health Improvement Partnership
	TACFL – Tobacco Action Coalition of the Finger Lakes	

### Priority Area: Prevent Chronic Disease

**Focus Area 3 Tobacco Prevention, Goal 3.1 Prevent initiation of tobacco use**

**INTERVENTION 3.1.2: USE MEDIA AND HEALTH COMMUNICATIONS TO HIGHLIGHT THE DANGERS OF TOBACCO, PROMOTE EFFECTIVE TOBACCO CONTROL POLICIES AND RESHAPE SOCIAL NORMS**

Corresponding PA objective(s): 3.1.2 Decrease the prevalence of combustible cigarette use by high school students; 3.1.3 Decrease the prevalence of vaping product use by high school students

**This intervention addresses a disparity: low SES**

*Note: We can also collect data on vaping and tobacco use/attitudes through the school surveys, over time.*

<b>2019</b>	<p>SHARE UNIFIED MESSAGES AROUND TOBACCO AND VAPING PREVENTION AND CESSATION.</p> <p><u>Tobacco Action Coalition of the Finger Lakes (TACFL)</u> will be lead agency for creating majority of messages, although any agency can request to have a tobacco/vaping-related message shared through Partnership agencies.</p> <p><u>Center for a Tobacco-Free Finger Lakes (CTFFL)</u> will produce messages, including monthly letters to the editor, which can be shared and/or promoted by Partnership agencies. CTFFL specializes in educating professionals, including mental health professionals, about tobacco cessation.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages, media connections, sharing platforms</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 2+ unified messages from WHIP agencies</li> <li>○ For agencies using Facebook and Instagram, please share your analytics for how your post performed (these are provided by the platforms). We may identify patterns in types of posts that get more engagement.</li> </ul> </li> </ul>
	<p>PROMOTE TOBACCO-FREE OUTDOOR SPACES.</p> <p><u>TACFL</u> will provide Tobacco-Free Outdoor toolkits to <u>Public Health</u> to share with service provider agencies serving <b>low SES</b> mothers involved with Head Start type programs, and to <u>NWCH</u> to share in communications to health care providers, within a year.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> toolkits</li> </ul>

	<ul style="list-style-type: none"> <li>● <b>Metrics/Goals:</b> 4+ total documented interactions per year educating providers and health/human service entities on TFO</li> </ul> <p>INCREASE TOBACCO CESSATION REFERRALS THROUGH COMMUNICATION WITH HEALTH PROVIDERS.  <u>NWCH</u> to continue to encourage providers to consistently refer smoking patients to evidence-based tobacco cessation programs, such as <u>Public Health’s</u> tobacco cessation program and Baby &amp; Me Tobacco Free, available through both NWCH and Public Health.</p>
2020	<p>SHARE UNIFIED MESSAGES AROUND TOBACCO AND VAPING PREVENTION AND CESSATION.  <u>TACFL</u> will be lead agency for creating majority of messages, although any agency can request to have a tobacco/vaping-related message shared through Partnership agencies.  <u>CTFFL</u> will produce messages, including monthly letters to the editor, which can be shared and/or promoted by Partnership agencies. CTFFL specializes in educating professionals, including mental health professionals, about tobacco cessation.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> Messages, media connections, sharing platforms</li> <li>● <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 4+ unified messages from WHIP agencies</li> <li>○ For agencies using Facebook and Instagram, please share your analytics for how your post performed (these are provided by the platforms). We may identify patterns in types of posts that get more engagement.</li> </ul> </li> </ul>
	<p>INCREASE TOBACCO CESSATION REFERRALS THROUGH COMMUNICATION WITH HEALTH PROVIDERS.  <u>NWCH</u> and <u>CTFFL</u>, with the support of WHIP, will create a “prescription pad” for providers to use with their smoking patients who are interested in quitting. This may be part of the same prescription pad in Intervention 1.1.5 for increasing referrals to CDSM courses. The prescription pad is a small sheet distributed to providers’ offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> coordination, access to providers, prescription pads</li> <li>● <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Number of referrals made to Chronic Disease Self-Management Courses (CDSM, NDP, Etc.) using the Prescription Pads; goal is 100 for 2020.</li> <li>○ Minutes showing discussion of barriers for practices which do not use the prescription pad or do not use it consistently</li> </ul> </li> </ul>
	<p>PROMOTE TOBACCO-FREE OUTDOOR SPACES TO LOCAL DECISION MAKERS.  <u>Public Health and partners</u> will support <u>TACFL’s</u> initiatives to present to local level decision makers at least once on the benefits of Tobacco-Free Outdoor (TFO) public spaces, <b>targeting low SES communities</b>. This may include letters of support, other correspondence, compiling data in support of TFO, or in-person attendance with TACFL at their presentation.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> Letters of support, data</li> <li>● <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Number of agencies providing letters of support (goal of 2+)</li> <li>○ Number of instances where technical assistance was provided (goal 1+)</li> <li>○ Number of local level decision makers reached (goal 4+)</li> <li>○ Number or percent of decision makers reached who expressed support for TFO (goal 2+)</li> </ul> </li> </ul>
2021	<p>SHARE UNIFIED MESSAGES AROUND TOBACCO AND VAPING PREVENTION AND CESSATION.</p>

<p><u>Tobacco Action Coalition of the Finger Lakes (TACFL)</u> will be lead agency for creating majority of messages, although any agency can request to have a tobacco/vaping-related message shared through Partnership agencies.</p> <p><u>Center for a Tobacco-Free Finger Lakes (CTFFL)</u> will produce messages, including monthly letters to the editor, which can be shared and/or promoted by Partnership agencies. CTFFL specializes in educating professionals, including mental health professionals, about tobacco cessation.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages, media connections, sharing platforms</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 4+ unified messages from WHIP agencies</li> <li>○ For agencies using Facebook and Instagram, please share your analytics for how your post performed (these are provided by the platforms). We may identify patterns in types of posts that get more engagement.</li> </ul> </li> </ul>
<p><u>NWCH, CTFFL, AND WHIP AGENCIES WITH ACCESS TO HEALTH CARE PROVIDERS</u> TO CONTINUE PROMOTING THE “PRESCRIPTION PAD”; and address barriers to its use identified in 2020. The prescription pad is a small sheet distributed to providers’ offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> coordination, access to providers, prescription pads</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Number of provider offices in NWCH’s network consistently using the prescription pad (target TBD pending 2020 findings)</li> <li>○ Minutes showing discussion of barriers for practices which do not use the prescription pad or do not use it consistently</li> </ul> </li> </ul>

**Focus Area 3 Tobacco Prevention, Goal 3.2 Promote tobacco use cessation**

**INTERVENTION 3.2.3: USE HEALTH COMMUNICATIONS TARGETING HEALTH CARE PROVIDERS TO ENCOURAGE THEIR INVOLVEMENT IN THEIR PATIENTS' QUIT ATTEMPTS ENCOURAGING USE OF EVIDENCE-BASED QUITTING, INCREASING AWARENESS OF AVAILABLE CESSATION BENEFITS (ESPECIALLY MEDICAID), AND REMOVING BARRIERS TO TREATMENT.**

Corresponding PA objective(s): 3.2.8 Increase the utilization of smoking cessation benefits (counseling and/or medications) among smokers enrolled in any Medicaid program

<p><b>2019</b></p>	<p>CONTINUE TO PROMOTE TOBACCO CESSATION REFERRALS TO HEALTH CARE PROVIDERS TO INCREASE THE NUMBER OF PERSONS WHO ARE CONNECTED TO QUITTING RESOURCES THROUGH THEIR HEALTH CARE PROVIDER.  <u>NWCH</u> to continue to encourage their network of providers to connect their smoking patients to the Quit Line (Opt-to-Quit), Baby &amp; Me Tobacco Free (available through <u>NWCH and Public Health</u>), and <u>Public Health</u>'s tobacco cessation program.  <u>CTFFL</u> to continue to encourage health and mental health providers to connect their patients to the Quit Line and available cessation services.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> baseline data on how many providers consistently refer smoking patients to resources, Quit Line reports provided by CTFFL</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Number of Quit Line callers who heard about the Quit Line from their provider</li> <li>○ Number of Quit Line callers with Medicaid, number of referrals to Public Health's tobacco cessation program resulting from a provider recommendation</li> <li>○ Number of referrals to Baby &amp; Me Tobacco Free resulting from a provider recommendation</li> <li>○ Note: Baseline data will be available soon.</li> </ul> </li> </ul>
<p><b>2020</b></p>	<p>CONTINUE TO PROMOTE TOBACCO CESSATION REFERRALS TO HEALTH CARE PROVIDERS TO INCREASE THE NUMBER OF PERSONS WHO ARE CONNECTED TO QUITTING RESOURCES THROUGH THEIR HEALTH CARE PROVIDER.  <u>NWCH</u> to continue to encourage their network of providers to connect their smoking patients to the Quit Line (Opt-to-Quit), Baby &amp; Me Tobacco Free (available through <u>NWCH and Public Health</u>), and <u>Public Health</u>'s tobacco cessation program.  <u>CTFFL</u> to continue to encourage health and mental health providers to connect their patients to the Quit Line and available cessation services.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> baseline data on how many providers consistently refer smoking patients to resources, Quit Line reports provided by CTFFL</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Number of Quit Line callers who heard about the Quit Line from their provider</li> <li>○ Number of Quit Line callers with Medicaid, number of referrals to Public Health's tobacco cessation program resulting from a provider recommendation</li> <li>○ Number of referrals to Baby &amp; Me Tobacco Free resulting from a provider recommendation</li> </ul> </li> </ul>
<p><b>2021</b></p>	<p>CONTINUE TO PROMOTE TOBACCO CESSATION REFERRALS TO HEALTH CARE PROVIDERS TO INCREASE THE NUMBER OF PERSONS WHO ARE CONNECTED TO QUITTING RESOURCES THROUGH THEIR HEALTH CARE PROVIDER.  <u>NWCH</u> to continue to encourage their network of providers to connect their smoking patients to the Quit Line (Opt-to-Quit), Baby &amp; Me Tobacco Free (available through <u>NWCH and Public Health</u>), and <u>Public Health</u>'s tobacco cessation program.  <u>CTFFL</u> to continue to encourage health and mental health providers to connect their patients to the Quit Line and available cessation services.</p>

<ul style="list-style-type: none"><li>• <b>Resources:</b> baseline data on how many providers consistently refer smoking patients to resources, Quit Line reports provided by CTFFL</li><li>• <b>Metrics/Goals:</b><ul style="list-style-type: none"><li>○ Number of Quit Line callers who heard about the Quit Line from their provider</li><li>○ Number of Quit Line callers with Medicaid, number of referrals to Public Health’s tobacco cessation program resulting from a provider recommendation</li><li>○ Number of referrals to Baby &amp; Me Tobacco Free resulting from a provider recommendation</li></ul></li></ul>
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- **NOTE: Prevention Agenda does not provide an intervention for assisting youth with tobacco/vaping cessation under the Tobacco Prevention section; but please see an evidence-based tobacco/vaping cessation intervention under Intervention 1.1.4 in Promote Mental Health and Prevent Substance Use Disorders, Focus Area 1 Promote Well-Being.**

**Focus Area 3 Tobacco Prevention, Goal 3.3 Eliminate exposure to secondhand smoke**

**INTERVENTION 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 AMONG THOSE THAT HOUSE LOW-SES RESIDENTS.**

Corresponding PA objective: 3.3.1 Decrease the percentage of adults (non-smokers) living in multi-unit housing who were exposed to secondhand smoke in their homes

**This intervention addresses a disparity: low SES**

	<p>SHARE UNIFIED MESSAGES AROUND SMOKE-FREE HOUSING.  <u>TACFL</u> will produce messages around smoke-free housing which will be shared by <u>Public Health and partners</u>.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1+ Letter to the editor</li> <li>○ 1+ Local media articles on smoke-free housing</li> </ul> </li> </ul>
2019	<p>COMPILE INFORMATION AND PREPARE TO ASSIST HOUSING UNITS WITH IMPLEMENTING AND/OR UPHOLDING SMOKE-FREE POLICIES.  <u>TACFL</u> and <u>Public Health</u> will collaboratively survey tenants and landlords in housing units without smoke-free policies to learn barriers to implementing such policies. <u>TACFL</u> and <u>Public Health</u> will collaboratively survey tenants and landlords in housing units with smoke-free policies to identify strengths and challenges in upholding smoke-free policies.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Surveys</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1+ housing entity without a smoke-free policy surveyed (include number of units)</li> <li>○ 1+ housing entity with existing smoke-free policies surveyed (include number of units)</li> </ul> </li> </ul>
	<p>SHARE UNIFIED MESSAGES AROUND SMOKE-FREE HOUSING.  <u>TACFL</u> will produce messages around smoke-free housing which will be shared by <u>Public Health and partners</u>.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1+ Letter to the editor</li> <li>○ 1+ Local media articles on smoke-free housing</li> </ul> </li> </ul>
2020	<p>ASSIST HOUSING UNITS IN IMPLEMENTING AND/OR UPHOLDING SMOKE-FREE POLICIES.  <u>TACFL</u> and <u>Public Health</u> to collaboratively assist housing units in implementing new smoke-free policies and/or upholding existing smoke-free policies.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Policy development guidance (TACFL Resources)</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1+ housing entity assisted with implementation of smoke-free policies (include number of units)</li> <li>○ Number of housing entities assisted with upholding existing smoke-free policies (include number of units)</li> </ul> </li> </ul>
2021	<p>SHARE UNIFIED MESSAGES AROUND SMOKE-FREE HOUSING.</p>

	<p>TACFL will produce messages around smoke-free housing which will be shared by <u>Public Health and partners</u>.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1+ Letter to the editor</li> <li>○ 1+ Local media articles on smoke-free housing</li> </ul> </li> </ul>
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**Focus Area 4 Chronic Disease Preventive Care and Management, Goal 4.1 Increase cancer screening rates.**

**INTERVENTION 4.1.3: USE SMALL MEDIA SUCH AS VIDEOS, PRINTED MATERIALS (LETTERS, BROCHURES, NEWSLETTERS) AND HEALTH COMMUNICATIONS TO BUILD PUBLIC AWARENESS AND DEMAND.**

Corresponding PA objectives: 4.1.1 Increase the percentage of women with an annual household income less than \$25,000 who receive a breast cancer screening based on the most recent guidelines; 4.1.2 Increase the percentage of women with an annual household income less than \$25,000 who receive a cervical cancer screening based on the most recent guidelines; 4.1.5 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines

**This intervention addresses a disparity: un/under-insured**

2019	<p>USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF BREAST, CERVICAL, AND COLORECTAL CANCER SCREENINGS THROUGH CANCER SERVICES PROGRAM (for the uninsured and underinsured).</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages and promotional materials</li> <li>• <b>Metrics/Goals:</b> 1+ unified message for Breast Cancer Awareness Month in October</li> </ul>
	<p>USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF LUNG CANCER SCREENING SERVICES AVAILABLE AT NWCH. Note: Some messages may overlap with unified messages for tobacco/vaping prevention/cessation.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages and promotional materials</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Increase participation by 10% by end of 2020; January-June 2019 baseline = 288 patients (155 program, 133 non-program)</li> <li>○ 4+ unified messages</li> </ul> </li> </ul>
2020	<p>USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF BREAST, CERVICAL, AND COLORECTAL CANCER SCREENINGS THROUGH CANCER SERVICES PROGRAM (for the uninsured and underinsured).</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages and promotional materials</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1+ unified message for per awareness month (cervical cancer – January, colorectal cancer – March, breast cancer – October)</li> <li>○ 1+ unified message per public screening event</li> </ul> </li> </ul>
	<p>USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF LUNG CANCER SCREENING SERVICES AVAILABLE AT NWCH. Note: Some messages may overlap with unified messages for tobacco/vaping prevention/cessation.</p>

	<ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages and promotional materials</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Increase participation by 10% from January-June baseline data shown above</li> <li>○ 4+ unified messages</li> </ul> </li> </ul>
2021	<p>USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF BREAST, CERVICAL, AND COLORECTAL CANCER SCREENINGS THROUGH CANCER SERVICES PROGRAM (for the uninsured and underinsured).</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages and promotional materials</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1+ unified message for per awareness month (cervical cancer – January, colorectal cancer – March, breast cancer – October)</li> <li>○ 1+ unified message per public screening event</li> </ul> </li> </ul>
	<p>USE UNIFIED MESSAGING TO PROMOTE AWARENESS AND UTILIZATION OF LUNG CANCER SCREENING SERVICES AVAILABLE AT NWCH. Note: Some messages may overlap with unified messages for tobacco/vaping prevention/cessation.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Messages and promotional materials</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Increase participation, set goal based on 2020 data</li> <li>○ 4+ unified messages</li> </ul> </li> </ul>

**Focus Area 4 Chronic Disease Preventive Care and Management, Goal 4.1 Increase cancer screening rates.**

**INTERVENTION 4.1.5: REMOVE STRUCTURAL BARRIERS TO CANCER SCREENING SUCH AS PROVIDING FLEXIBLE CLINIC HOURS, OFFERING CANCER SCREENING IN NON-CLINICAL SETTINGS (MOBILE MAMMOGRAPHY VANS, FLU CLINICS), OFFERING ON-SITE TRANSLATION, TRANSPORTATION, PATIENT NAVIGATION AND OTHER ADMINISTRATIVE SERVICES AND WORKING WITH EMPLOYERS TO PROVIDE EMPLOYEES WITH PAID LEAVE OR THE OPTION TO USE FLEX TIME FOR CANCER SCREENINGS.**

Corresponding PA objective: 4.1.1 Increase the percentage of women with an annual household income less than \$25,000 who receive a breast cancer screening based on the most recent guidelines

**This intervention addresses a disparity: Transportation**

2019	<p>INCREASE ACCESS TO MAMMOGRAPHY by coordinating with RRH’s Mobile Mammography unit and Cancer Services Program to schedule screening events and promote them via unified messaging. Promote to the community and worksites to generate awareness of and demand for screening events.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Availability, messages and promotional materials, relationships with businesses/networks</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1+ unified message promoting Mobile Mammography unit</li> <li>○ 1+ unified message per public Mobile Mammo screening event with openings left</li> </ul> </li> </ul>
2020	<p>INCREASE ACCESS TO MAMMOGRAPHY by coordinating with RRH’s Mobile Mammography unit and Cancer Services Program to schedule screening events and promote them via unified messaging. Promote to the community and worksites to generate awareness of and demand for screening events.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Availability, messages and promotional materials, relationships with businesses/networks</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 2+ unified messages promoting Mobile Mammography unit</li> <li>○ 1+ unified message per public Mobile Mammo screening event</li> </ul> </li> </ul>
2021	<p>INCREASE ACCESS TO MAMMOGRAPHY by coordinating with RRH’s Mobile Mammography unit and Cancer Services Program to schedule screening events and promote them via unified messaging. Promote to the community and worksites to generate awareness of and demand for screening events.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Availability, messages and promotional materials, relationships with businesses/networks</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 2+ unified messages promoting Mobile Mammography unit</li> <li>○ 1+ unified message per public Mobile Mammo screening event</li> </ul> </li> </ul>

## Priority Area: Promote Well-Being and Prevent Mental Health and Substance Use Disorders

### *Focus Area 1 Promote Well-Being, Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan*

#### **INTERVENTION 1.1.3: CREATE AND SUSTAIN INCLUSIVE, HEALTHY PUBLIC SPACES: ENSURE SPACE FOR PHYSICAL ACTIVITY, FOOD ACCESS, SLEEP; CIVIC AND COMMUNITY ENGAGEMENT ACROSS THE LIFESPAN**

Corresponding PA objective(s): 1.1.1 Increase Wayne County's Opportunity Index Score; 1.1.3 Reduce the number of youth grades 9-12 who felt sad or hopeless  
 Note: The opportunity index score includes a "community score" in the more detailed data, and the community score considers availability of healthy foods (among several other factors).

**This intervention addresses a disparity: Low SES families (food insecurity)**

	<p>PROMOTE FOOD SECURITY FOR CHILDREN AND THEIR FAMILIES THROUGH THE SCHOOLS.                  Assist Community Schools Director, serving 4 districts (Sodus, North Rose-Wolcott, Lyons, Clyde-Savannah), in making the impact of the evidence-based Community Schools program sustainable beyond the grant period and replicable in other Wayne County school districts by assisting in developing a food pantry toolkit to create a path for schools to improve food security for students. WHIP agencies (including Public Health, Aging &amp; Youth, CCE, Wayne CAP, school districts) to assist with promotion of food drives to stock the pantry as requested. <i>Note: Multiple types of unified messages may be appropriate to go home in student backpacks; school food pantries may eventually serve as referral access points for other services.</i></p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> food pantry toolkit</li> <li>● <b>Metrics/Goals:</b> successful creation of a food pantry toolkit within 2019</li> </ul>
<p><b>2019</b></p>	<p>IMPLEMENT EVIDENCE-BASED/PROMISING PRACTICE SOLUTION TO ENSURE SCHOOL FOOD PANTRIES ARE STOCKED WITH NUTRITIONAL FOODS.  <u>Public Health</u> is seeking to implement Nourish Your Neighbor (NYN) or a similar initiative to solicit healthy food donations from the community while simultaneously educating county residents about nutrition, in collaboration with: <u>schools, CCE/FLESNY, and WCRHN.</u></p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> NYN or similar framework, advertising budget/promotional resources/media coverage, supplies budget, WHIP agency staff and/or volunteer time</li> <li>● <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1 plan, formal or informal, showing how these agencies will roll out this initiative</li> <li>○ 1+ community with a school receiving nutritious donations as a result of NYN/similar initiative</li> <li>○ Baseline of need established for each of the 4 schools with food pantries</li> </ul> </li> </ul>
	<p>ROCHESTER REGIONAL HEALTH (NWCH) PILOTING A PRESCRIPTION FOOD PROGRAM WITH FOODLINK AS OF JULY 1, serving patients at Canal Park Family Medicine (Macedon), Newark Internal Medicine, Sodus Internal Medicine, and ElderOne (Newark). Patients will be given \$30/month to use at Foodlink's mobile unit to purchase fresh fruit and vegetables. Education to the patients will be provided by Care Managers at the practices. CCE/FLESNY to do demonstrations and education at sites when FoodLink comes.</p> <ul style="list-style-type: none"> <li>○ <b>Resources:</b> Funding</li> <li>○ <b>Metrics/Goals:</b> 50 participants completing program</li> </ul>

	<p>CONTINUE TO IMPLEMENT EVIDENCE-BASED/PROMISING PRACTICE SOLUTION TO ENSURE SCHOOL FOOD PANTRIES ARE STOCKED WITH NUTRITIONAL FOODS.  <u>Public Health</u> will continue to implement Nourish Your Neighbor (NYN) or a similar initiative to solicit healthy food donations from the community while simultaneously educating county residents about nutrition, in collaboration with: <u>schools, CCE/FLESNY, and WCRHN.</u></p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> NYN or similar framework, advertising budget/promotional resources/media coverage, supplies budget, WHIP agency staff and/or volunteer time</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 4+ communities with a school receiving nutritious donations as a result of NYN/similar initiative</li> <li>○ Assessment of pantry inventories versus need (are they fully stocked, is anyone going without)</li> </ul> </li> </ul>
<p><b>2020</b></p>	<p>SUPPORT CCE IN THEIR 2020 GOAL TO TRAIN ONE NEW ELEMENTARY OR MIDDLE SCHOOL WITH AT LEAST 50% OF STUDENTS QUALIFYING FOR FREE/REDUCED MEALS IN CATCH. Promote the effectiveness of the evidence-based physical activity program, CATCH, to increase demand for the program beyond the 2 school districts which have already implemented it with targeted, unified messaging to school district decision-makers and the public. At least one unified letter to schools within the year and at least 2 unified messages around the effectiveness of CATCH to the public per year. Gather data on any barriers preventing schools from adopting this curriculum. Agencies: <u>CCE, participating school districts, Public Health,</u> agencies sharing unified messages</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> personnel, time, unified messages</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1 unified letter (or form letter sent by multiple agencies) sent to each district not participating in CATCH within 2020 (likely 9 districts)</li> <li>○ A compilation of any barriers identified by schools as a result of these letters</li> <li>○ 2 unified messages shared within 2020 – those of us who can get analytics data from social media posts, please report engagement statistics so we can see which types of posts have the best performance and reach.</li> </ul> </li> </ul>
	<p>CONTINUE TO SUPPORT ELEMENTS OF COMMUNITY SCHOOLS WHICH ADDRESS FOOD INSECURITY, by providing unified messaging around food drives and letters of support for continued funding, as applicable. At least 4 unified messages per year, letters of support as requested. Agencies: <u>Public Health, Aging &amp; Youth, WCRHN, CCE, participating school districts, Wayne CAP</u></p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> unified messages, letters of support</li> <li>• <b>Metrics/Goals:</b> 4+ unified messages per year, letters of support as requested. Those of us sharing unified messages on social media, please provide post reach and engagement stats.</li> </ul>
	<p>IMPROVE ACCESS TO NUTRITIONAL FOODS THROUGH THE FRUIT &amp; VEGETABLE PRESCRIPTION PROGRAM.  <u>FLESNY</u> collaborating with Finger Lakes Community Health (FLCH, a network of FQHCs) to provide Fruit &amp; Vegetable Prescription Program through 2 sites. The pilot of this program produced promising results. Providers at these sites write produce “prescriptions” to qualifying patients.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> funding, vouchers, participating retailers (farmers markets)</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 60%+ redemption rate of prescription vouchers, number of vouchers distributed per site</li> </ul> </li> </ul>
	<p>ROCHESTER REGIONAL HEALTH (NWCH) PILOTING A PRESCRIPTION FOOD PROGRAM WITH FOODLINK AS OF JULY 1, serving patients at Canal Park Family Medicine (Macedon), Newark Internal Medicine, Sodus Internal Medicine, and ElderOne (Newark). Patients will be given \$30/month to use at Foodlink’s mobile unit to purchase fresh fruit and vegetables. Education to the patients will be provided by Care Managers at the practices. CCE/FLESNY to do demonstrations and education at sites when FoodLink comes. Ends June 30, 2020.</p>
<p><b>2021</b></p>	<p>CONTINUE TO IMPLEMENT EVIDENCE-BASED/PROMISING PRACTICE SOLUTION TO ENSURE SCHOOL FOOD PANTRIES ARE STOCKED WITH NUTRITIONAL FOODS.</p>

	<p><u>Public Health</u> will continue to implement Nourish Your Neighbor (NYN) or a similar initiative to solicit healthy food donations from the community while simultaneously educating county residents about nutrition, in collaboration with: <u>schools, CCE/FLESNY, and WCRHN.</u></p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> NYN or similar framework, advertising budget/promotional resources/media coverage, supplies budget, WHIP agency staff and/or volunteer time</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1 plan, formal or informal, showing how these agencies will roll out this initiative</li> <li>○ 4+ communities with a school receiving nutritious donations as a result of NYN/similar initiative</li> <li>○ 100% of pantries receiving 100% of the donations needed to meet needs of students and their families</li> </ul> </li> </ul>
	<p>CONTINUE TO PROMOTE THE EFFECTIVENESS OF CATCH THROUGH TARGETED, UNIFIED MESSAGING TO SCHOOL DISTRICT DECISION-MAKERS AND THE PUBLIC, AND ATTEMPT TO ADDRESS ANY BARRIERS TO IMPLEMENTATION WHICH HAVE BEEN IDENTIFIED BY THE SCHOOL DISTRICTS. At least one unified letter to schools within the year and at least 2 unified messages around the effectiveness of CATCH to the public per year. Agencies: <u>Public Health, CCE, participating school districts</u></p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> unified messages, collaborative problem-solving</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1 unified letter (or form letter sent by multiple agencies) sent to each district not participating in CATCH within 2021 (number of districts TBD)</li> <li>○ Discussion about school-identified barriers and plans to address them recorded in WHIP minutes</li> </ul> </li> </ul> <p>2 unified messages shared within 2020 – those of us who can get analytics data from social media posts, please report engagement statistics so we can see which types of posts have the best performance and reach.</p>
	<p>CONTINUE TO SUPPORT ELEMENTS OF COMMUNITY SCHOOLS WHICH ADDRESS FOOD INSECURITY, by providing unified messaging around food drives and letters of support for continued funding, as applicable. At least 4 unified messages per year, letters of support as requested. Agencies: <u>Schools, Public Health, WCRHN, Aging &amp; Youth, Wayne CAP, CCE</u></p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> unified messages, letters of support</li> <li>• <b>Metrics/Goals:</b> 4+ unified messages per year, letters of support as requested. Those of us sharing unified messages on social media, please provide post reach and engagement stats.</li> </ul>

**INTERVENTION 1.1.4: INTEGRATE SOCIAL AND EMOTIONAL APPROACHES ACROSS THE LIFESPAN. SUPPORT PROGRAMS THAT ESTABLISH CARING AND TRUSTING RELATIONSHIPS WITH OLDER PEOPLE. EXAMPLES INCLUDE THE VILLAGE MODEL, INTERGENERATIONAL COMMUNITY, INTEGRATING SOCIAL EMOTIONAL LEARNING IN SCHOOLS, COMMUNITY SCHOOLS, PARENTING EDUCATION.**

Corresponding PA objective(s): 1.1.1 (Modified from State to County) Increase Wayne County’s Opportunity Index Score  
 This intervention does not address a disparity.

<p><b>2019</b></p>	<p>PROMOTE THE IMPACT OF LIFESKILLS (evidence-based middle school curriculum reducing substance abuse risk and suicide risk) in the eleven school districts to increase awareness of and support for the program through unified messaging at least twice within the year.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Unified messages</li> <li>• <b>Metrics/Goals:</b> 2+ unified messages within 2019</li> </ul>
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	<p>PROMOTE THE IMPACT OF COMMUNITY SCHOOLS IN THE 4 COMMUNITY SCHOOLS DISTRICTS to increase awareness of and support for Community Schools through unified messaging at least twice within the year.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Unified messages</li> <li>• <b>Metrics/Goals:</b> 2+ unified messages within 2019</li> </ul>
	<p>APPROPRIATE PARTNERS TO PROVIDE LETTERS OF SUPPORT AND/OR TECHNICAL ASSISTANCE TO OPTIMIZE LIKELIHOOD OF CONTINUED FUNDING FOR COMMUNITY SCHOOLS AND/OR LIFE SKILLS, OR OTHER EVIDENCE-BASED PROGRAMMING, AS REQUESTED BY PROGRAM DIRECTOR(S).</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> collaboration, staff time</li> <li>• <b>Metrics/Goals:</b> Assistance provided as requested</li> </ul>
	<p>IMPLEMENT N-O-T AND INDEPTH IN SCHOOLS TO IMPROVE STUDENT ACCESS TO TOBACCO/VAPING CESSATION. Public Health and school districts will receive training on August 27<sup>th</sup> allowing them to implement an evidence-based program, Not On Tobacco (N-O-T) and INDEPTH in the schools to help students stop smoking/vaping. Per the American Lung Association, it is much more expansive than cessation – covering lifestyle behaviors in physical activity and nutrition, self-control, stress management and decision-making.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> funding for training (PH), school staff time</li> <li>• <b>Metrics/Goals:</b> Percentage of school districts participating (ideal 100%, but initial 8 of 11 districts (~73%))</li> </ul>
<p><b>2020</b></p>	<p>PROMOTE THE IMPACT OF LIFE SKILLS (evidence-based middle school curriculum reducing substance abuse risk and suicide risk) in the eleven school districts to increase awareness of and support for the program through unified messaging at least twice within the year.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Unified messages</li> <li>• <b>Metrics/Goals:</b> 2+ unified messages within 2019</li> </ul>
	<p>PROMOTE THE IMPACT OF COMMUNITY SCHOOLS IN THE 4 COMMUNITY SCHOOLS DISTRICTS to increase awareness of and support for Community Schools through unified messaging at least twice within the year.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Unified messages</li> <li>• <b>Metrics/Goals:</b> 2+ unified messages within 2019</li> </ul>
	<p>PROMOTE N-O-T WITHIN THE SCHOOLS BY DISTRIBUTING UNIFIED MESSAGES INCREASING FAMILY AWARENESS OF AND DEMAND FOR THIS SERVICE. Evaluate reach of N-O-T in the schools and possible funding for more districts to have staff trained in N-O-T.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Staff time, funding, data</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 100% of trained schools successfully implement N-O-T. If not, identify barriers 100% of schools without successful implementation.</li> <li>○ WHIP minutes showing discussion of potential funding sources for an additional training, if needed.</li> <li>○ Percentage of N-O-T facilitators saying they are able to accommodate all students interested in the program, number of students enrolled in the academic year per district. Target: 100%. If less than 100%, identify barriers for 100% of schools unable to accommodate all interested students.</li> </ul> </li> </ul>
<p><b>2021</b></p>	<p>Same as 2020</p>

**INTERVENTION 1.1.5: ENABLE RESILIENCE FOR PEOPLE LIVING WITH CHRONIC ILLNESS: STRENGTHENING PROTECTIVE FACTORS INCLUDE INDEPENDENCE, SOCIAL SUPPORT, POSITIVE EXPLANATORY STYLES, SELF-CARE, SELF-ESTEEM, AND REDUCED ANXIETY.**

Corresponding PA objective(s): 1.1.2.1 Reduce the percentage of adults 65+ New Yorkers reporting 14 or more days with poor mental health in the last month

**This intervention addresses a disparity: transportation**

	<p>RE-EVALUATE PREVIOUSLY IDENTIFIED BARRIERS TO IMPLEMENTATION OF CERTAIN CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS TO SEE WHICH ARE STILL IN EFFECT AND WHICH ARE RESOLVED; UPDATE 2020 WORK UNDER THIS INITIATIVE TO ADDRESS THOSE BARRIERS TO EXTENT POSSIBLE. Agencies: <u>Public Health, Aging &amp; Youth, Wayne CAP, WCRHN, FLCH</u>, any agency offering any type of evidence-based CDSM course</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> collaboration</li> <li>• <b>Metrics/Goals:</b> WHIP minutes showing compilation of barriers and plans to address</li> </ul>
<p><b>2019</b></p>	<p>Begin developing a directory of wellness classes so that Wayne County residents and their health care providers have a comprehensive list of everything available to them. This directory will include courses such as Chronic Disease Self-Management, National Diabetes Prevention Program, and more. Agencies: all   Note: WCRHN has a similar task in their work plan</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> collaboration</li> <li>• <b>Metrics/Goals:</b> draft of directory within 2019</li> </ul>
	<p>USE UNIFIED MESSAGING TO PROMOTE UPCOMING CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS, especially home-based and work place programs which alleviate the transportation barrier experienced by many Wayne County residents. At least once within the year. In 2019, WHIP can, at a minimum, promote the remaining 2019 Aging &amp; Youth and Wayne CAP CDSMP class. One has already occurred, taught by both Aging &amp; Youth and Wayne CAP.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Unified message(s)</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Wayne CAP goal: 100 people completing course per year</li> <li>○ 1+ unified message within 2019, depending on course availability</li> <li>○ Aging &amp; Youth to collect data on how registrants heard about program(s); use to evaluate effectiveness of unified messaging</li> <li>○ Percent of classes hitting their attendance goal (for CDSMP via WCAP, A&amp;Y, 8 persons per class)</li> </ul> </li> </ul>
<p><b>2020</b></p>	<p>COMPLETE THE DIRECTORY OF WELLNESS CLASSES, INCLUDING AT-HOME CLASSES, AND PROMOTE IT TO THE PUBLIC AND HEALTH CARE PROVIDERS TO INCREASE WAYNE COUNTY PARTICIPATION IN CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> Unified messages, distribution lists</li> <li>• <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Quarterly emails to distribution list of providers promoting the directory</li> <li>○ Unified messaging to public 4+ times per year</li> </ul> </li> </ul>
	<p>USE UNIFIED MESSAGING TO PROMOTE UPCOMING CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS, especially home-based programs which alleviate the transportation barrier experienced by many Wayne County residents. 4+ times per year, depending on courses. In 2020, WHIP can, at a minimum, promote Aging &amp; Youth’s 2 CDSMP classes.</p> <ul style="list-style-type: none"> <li>• <b>Resources:</b> unified messages, distribution lists</li> <li>• <b>Metrics/Goals:</b></li> </ul>

	<ul style="list-style-type: none"> <li>○ Unified messaging to public 4+ times per year</li> <li>○ Percent of classes hitting their attendance goal (for CDSMP via A&amp;Y, 8 persons per class)</li> <li>○ Wayne CAP goal: 100 people completing course per year</li> <li>○ 1+ unified message within 2019, depending on course availability</li> <li>○ Aging &amp; Youth to collect data on how registrants heard about program(s); use to evaluate effectiveness of unified messaging</li> </ul>
	<p>INCREASE PROVIDER REFERRALS TO CDSM COURSES THROUGHOUT THE COUNTY.  <u>NWCH to collaborate with all WHIP agencies offering evidence-based CDSM courses to revamp and promote the “prescription pad”</u>. The prescription pad is a small sheet distributed to providers’ offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> coordination, access to providers, prescription pads</li> <li>● <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Number of provider offices in NWCH’s network consistently using the prescription pad</li> <li>○ Minutes showing discussion of barriers for practices which do not use the prescription pad or do not use it consistently</li> </ul> </li> </ul>
2021	<p>CONTINUE TO BOOST AWARENESS OF THE WELLNESS CLASS DIRECTORY AMONG THE PUBLIC AND PROVIDERS THROUGH UNIFIED MESSAGING. Increase awareness of any chronic disease self-management programs which are covered by insurance.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> unified messaging, insurance plan information</li> <li>● <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Quarterly emails to distribution list of providers promoting the directory</li> <li>○ Unified messaging to public 4+ times per year</li> </ul> </li> </ul>
2021	<p>CONTINUE TO INCREASE PROVIDER REFERRALS TO CDSM COURSES THROUGHOUT THE COUNTY.  <u>NWCH to collaborate with all WHIP agencies offering evidence-based CDSM courses to continue promoting the “prescription pad”</u>; and address barriers to its use identified in 2020. The prescription pad is a small sheet distributed to providers’ offices which makes it convenient for them to check off the appropriate program(s) for their patient, fill in their information (including consent to share it), and then fax the form to the appropriate agency so that the agency with the service can reach out to the patient directly.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> coordination, access to providers, prescription pads</li> <li>● <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Number of provider offices in NWCH’s network consistently using the prescription pad (target TBD pending 2020 findings)</li> <li>○ Minutes showing discussion of barriers for practices which do not use the prescription pad or do not use it consistently</li> </ul> </li> </ul>
2021	<p>USE UNIFIED MESSAGING TO PROMOTE UPCOMING CHRONIC DISEASE SELF-MANAGEMENT PROGRAMS, especially home-based programs which alleviate the transportation barrier experienced by many Wayne County residents. 4+ times per year, depending on courses. In 2021, WHIP can, at a minimum, promote Aging &amp; Youth’s 2 CDSMP classes.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> Unified message(s)</li> <li>● <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ Unified messaging to public 4+ times per year</li> <li>○ Percent of classes hitting their attendance goal (for CDSMP via A&amp;Y, 8 persons per class)</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ Wayne CAP goal: 100 people completing course per year</li> <li>○ 1+ unified message within 2019, depending on course availability</li> <li>○ Aging &amp; Youth to collect data on how registrants heard about program(s); use to evaluate effectiveness of unified messaging</li> </ul>
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**Focus Area 2 Mental and Substance Use Disorders Prevention, Goal 2.3 Prevent and address adverse childhood experiences (ACEs)**

**INTERVENTION 2.3.3: GROW RESILIENT COMMUNITIES THROUGH EDUCATION, ENGAGEMENT, ACTIVATION/MOBILIZATION AND CELEBRATION**

Corresponding PA objective(s): 2.3.3 Increase communities reached by opportunities to build resilience

Community Schools also fits under this intervention but is reported under other CHIP interventions already. We can revise the CHIP down the line to better reflect the work of Finger Lakes Resiliency Network.

<b>2019</b>	<p>PUBLIC HEALTH AND PARTNERS TO SUPPORT SCHOOL APPLICATION FOR A TIER 3 WRAP AND RENEW GRANT IMPACTING CHILDREN IN 5<sup>TH</sup>-8<sup>TH</sup> GRADE. “RENEW focuses specifically on increasing effective school engagement, employment, post-secondary education and high school completion. RENEW has shown success in reducing school dropout and school push out, while increasing high school participation and completion for students with emotional and behavioral challenges.” – midwestpbis.org Support may include letters of support and/or technical assistance on the grant application.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> collaboration, data</li> <li>● <b>Metrics/Goals:</b> assistance provided, funding awarded</li> </ul>
<b>2020</b>	<p>INCREASE PUBLIC AWARENESS OF AND SUPPORT FOR TRAUMA-INFORMED CARE IN THE SCHOOLS by highlighting effectiveness of Community Schools, 4 unified messages per year.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> unified messages</li> <li>● <b>Metrics/Goals:</b> 4+ unified messages per year</li> </ul>
	<p>CONTINUE TO SUPPORT EVIDENCE-BASED OR PROMISING PRACTICE TRAUMA-INFORMED CARE IN THE SCHOOLS by providing letters of support and/or technical assistance for funding applications, such as helping to map programs.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> information</li> <li>● <b>Metrics/Goals:</b> WHIP minutes or emails showing discussion of initiatives</li> </ul>
	<p>IDENTIFY OPPORTUNITIES TO INCREASE PUBLIC AWARENESS OF AND DEMAND FOR RESILIENCE INITIATIVES, such as the Finger Lakes Resiliency Network, within the overall community.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> information</li> <li>● <b>Metrics/Goals:</b> WHIP minutes or emails showing discussion of opportunities</li> </ul>
	<p>INCREASE PROVIDER AND COMMUNITY AWARENESS OF MENTAL HEALTH’S MOBILE RESPONSE TEAM(S) THROUGH UNIFIED MESSAGING.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> unified messages</li> <li>● <b>Metrics/Goals:</b> 2+ unified messages</li> </ul>
	<p>USE UNIFIED MESSAGING TO PROMOTE AGING &amp; YOUTH’S EVIDENCE-BASED POWERFUL TOOLS FOR CAREGIVERS COURSE.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> unified messages, promotional materials</li> <li>● <b>Metrics/Goals:</b></li> </ul>

	<ul style="list-style-type: none"> <li>○ 1+ unified message per course offered</li> <li>○ Generate enough enrollment to maintain course offering</li> </ul>
<b>2021</b>	<p>INCREASE PUBLIC AWARENESS OF AND SUPPORT FOR TRAUMA-INFORMED CARE IN THE SCHOOLS by highlighting effectiveness of Community Schools, 4 unified messages per year.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> unified messages</li> <li>● <b>Metrics/Goals:</b> 4+ unified messages per year</li> </ul>
	<p>CONTINUE TO SUPPORT EVIDENCE-BASED OR PROMISING PRACTICE TRAUMA-INFORMED CARE IN THE SCHOOLS by providing letters of support and/or technical assistance for funding applications, such as helping to map programs.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> information</li> <li>● <b>Metrics/Goals:</b> WHIP minutes or emails showing discussion of initiatives</li> </ul>
	<p>IDENTIFY OPPORTUNITIES TO INCREASE PUBLIC AWARENESS OF AND DEMAND FOR RESILIENCE INITIATIVES, such as the Finger Lakes Resiliency Network, within the overall community.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> information</li> <li>● <b>Metrics/Goals:</b> WHIP minutes or emails showing discussion of opportunities</li> </ul>
	<p>INCREASE PROVIDER AND COMMUNITY AWARENESS OF MENTAL HEALTH'S MOBILE RESPONSE TEAM(S) THROUGH UNIFIED MESSAGING.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> unified messages</li> <li>● <b>Metrics/Goals:</b> 2+ unified messages</li> </ul>
	<p>USE UNIFIED MESSAGING TO PROMOTE AGING &amp; YOUTH'S EVIDENCE-BASED POWERFUL TOOLS FOR CAREGIVERS COURSE.</p> <ul style="list-style-type: none"> <li>● <b>Resources:</b> unified messages, promotional materials</li> <li>● <b>Metrics/Goals:</b> <ul style="list-style-type: none"> <li>○ 1+ unified message per course offered</li> <li>○ Generate enough enrollment to maintain course offering</li> </ul> </li> </ul>