

Livingston County

Community Health Assessment/Community Service Plan

2016-2018



The participating local health department in the 2016 Community Health Assessment is Livingston County Public Health. Jennifer Rodriguez, the Public Health Director, is the contact person. She may be reached at: jrodriguez@co.livingston.ny.us or 585.243.7270.

The participating hospital is Noyes Health, the only hospital located in Livingston County. Noyes Health is an affiliate hospital of the University of Rochester Medical Center. Patricia Piper, Director of Community Outreach Services, is the contact person and may be reached at ppiper@noyeshealth.org or 585.335.4359

In Livingston County, facilitation of the Community Health Assessment process was provided by the S²AY Rural Health Network, which is a partnership of eight Public Health Departments in the Finger Lakes region, and the Genesee Valley Health Partnership, which is the rural health partnership in Livingston County. The main coordinating body that oversaw the Community Health Assessment is the Livingston County Community Health Assessment (CHA) Leadership Team and Chronic Disease Committee of the Genesee Valley Health Partnership. The Livingston County CHA Leadership Team, which is a multi-disciplinary group of community organizations, which are described more fully within this document. The Livingston County CHA Leadership Team will oversee the implementation of the Community Health Improvement Plan. Please see attachment 1 for a list of members of the Livingston County CHA Leadership Team and the Chronic Disease Committee.

Executive Summary

1. Priorities and Disparities:

The Livingston County Department of Health, Noyes Health and community partners identified the following prevention agenda priorities: prevention of chronic diseases, promoting a healthy and safe environment and promoting mental health and preventing substance abuse. Higher obesity rates in the lower socio economic status is the health disparity.

2. Changes from 2013: The priorities have not changed (Prevent Chronic Diseases – Reducing Obesity in Children and Adults, and Promote Mental Health and Prevent Substance Abuse) from the 2013 CHA and CHIP, although the strategies to be used to address these priorities have evolved as will be seen in the attached CHIP. In the 2013 CHA and CHIP, pre-diabetes and diabetes were identified as specific areas to be addressed in the Prevent Chronic Disease priority area (along with obesity). Current efforts to address diabetes will be continued and future strategy will be implementation of the National Diabetes Prevention Program. New for 2017, falls among seniors rose to the top as one of the most pressing health needs, and some progress has already been made throughout the County. GVHP membership ranked the priorities, and the CHIP Leadership Committee, Chronic Disease Committee chose to continue these efforts, and identified fall prevention in the 65+ population as a priority during this CHA/CHIP cycle.

Finally, public health issues being watched include opiate use and Zika.

3. Data Reviewed and Analyzed: The data review and analysis was extensive. A data update for the county was conducted by the Finger Lakes Health Systems Agency (FLHSA). In addition to this data, the Prevention Needs Assessment (PNA) of the Healthy Communities That Care committee was also reviewed. This data collection and analysis effort focused on data related to the priorities in the 2013 CHA for the county as well as some emerging issues that the

hospital and Public Health agreed should be analyzed based on their knowledge of public health issues in their community and the needs assessment for DSRIP (also conducted by the FLHSA). Priority Areas in the region included: Obesity, Hypertension, Diabetes, Heart Disease, Tobacco Use, and falls in the 65+ population. Emerging issues included: Behavioral Health and low back pain. This data was presented to the PH Directors and the hospital representatives in the region on March 4, 2016. Per the attached presentation, the data collected and analyzed came from the following sources: Expanded Behavioral Risk Factor Surveillance Survey (EBRFSS), Census Bureau, SPARCS data, NY State Prevention Agenda data set, Aggregated Claims Data, NY State Vital Statistics, Community Health Indicator Reports, Sub-County Data Reports, Leading Causes of Death Indicators, and County Health Rankings... In addition to the primary data reviewed from the high blood pressure registry, the Prevention Needs Assessment Survey and results from focus group input were reviewed as per the MAPP process

4. Partners and Roles: While the primary partners in the assessment process include Livingston County Public Health, Noyes Health, S²AY, and the FLHSA, many sectors of the community were represented on the CHA Leadership Team and Chronic Disease Committee. A member list for both groups is attached. These groups provide oversight of both the process and implementation of the CHIP. The Genesee Valley Health Partnership also provides oversight of the CHIP activities. These groups include a diverse representation of community including FQHCs, CBOs, other County Departments, a provider of services to the developmentally disabled population, and schools. Many community partners will provide leadership and/or technical support regarding the 2016-2018 CHIP. Detailed roles in implementation are in the attached CHIP.

5. Community Engagement: The community has been engaged in a variety of different ways. After S²AY prepared a presentation on the highest needs in Livingston County, it was shared with eight diverse focus groups throughout the community by reviewing data and gathering their input and perceptions regarding the needs in the County. Additionally, focus group participants were invited to attend the priority setting meeting for community members. Again, after preliminary priority setting meeting was held, another opportunity for input from the general public was provided. Preliminary priorities were listed in a media release and also posted on the website of the hospital, Public Health and the Genesee Valley Health Partnership, which is a rural health network. The public was again asked to provide any additional input at this third opportunity.

6. Evidence-based interventions: As detailed in the CHIP, strategies to address chronic diseases include evidence based activities such as Stanford approved curriculums (e.g. Chronic Disease Self-Management Programs (CDSMP), policy/practice implementation (working with schools to develop strong Local School Wellness Policies, working with worksites to implement healthy policies), Healthy Lifestyle Program, working to increase opportunities for physical activity in the community, and working to increase the number of farmers markets. Strategies under "Promote Mental Health and Prevent Substance Abuse" include, building the capacity of the Suicide Prevention Task Force, implementing evidence based health messages and trainings, pursuing additional Social Host Laws in towns/villages, implementing evidence based interventions based on the Prevention Needs Assessment data, increasing access by co-locating behavior health into primary care, implementing best practices for anti-bullying/non-violence programming in schools, and coordinating mental, emotional, behavioral (MEB) and chronic disease efforts. To address the third priority, falls among seniors, evidence based strategies will

include: Home Safe Home, Tia Chi and Matter of Balance. The evidence based interventions/strategies were selected by sub committees which focus on the specific issues, which included: Chronic Disease, Fall Prevention, and HCTC committees.

7. Evaluation of Impact and Process Measures: The CHIP Leadership Team meets a minimum of two times per year to review updated data and progress on the CHIP, as well as to identify gaps. The Chronic Disease Committee meets a minimum of nine times per year. The agenda for the Chronic Disease Committee meetings is focused on tracking progress, identifying barriers, strategizing how to overcome barriers and measuring progress. The Genesee Valley Health Partnership also tracks progress and improvement during board and general meetings. Progress will be reported to NY State starting by December 2017 per the established schedule.

Process measures are indicated in the attached CHIP and correlate with the objectives chosen from the "Refresh Chart" for the NYS Prevention Agenda. They include such measures as the number of institutions that implement healthy policies, the number of participants enrolled in CDSMP and percent reporting increased ability to self- manage their health, biometrics and behavior change among Healthy Lifestyle Program participants, number of parks/trails providing additional physical activity opportunities, number of farmers markets, schools completing the School Health Index and number of policies/practices adopted, number of events/education held through the Suicide Prevention Task Force, number of organizations collaborating and sharing resource with other organizations regarding chronic disease and MEB, number of towns/villages that adopt the Social Host Law, number of evidence based interventions addressing PNA data results (HCTC), number of schools using best practice programming for anti-bullying/non-violence, the number of evidence based community fall prevention programs offered, and the number of home assessments/modifications for fall prevention.

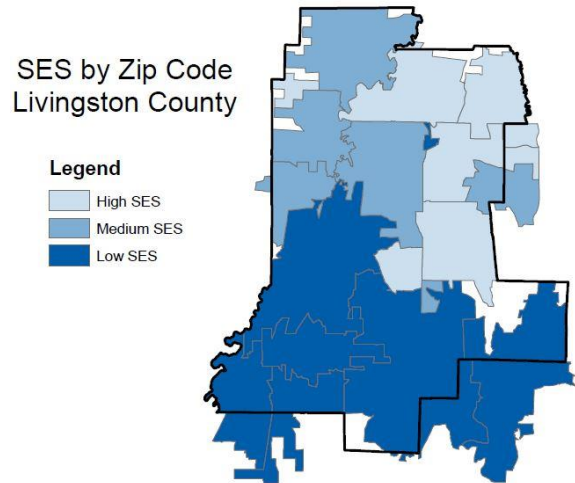
1. Community Description and Health Needs:

Community Description:

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

Livingston County is a larger rural county located in the western New York region. It is bordered by Monroe County to the north, Ontario County to the East, Allegany and Steuben Counties to the south, and Genesee and Wyoming Counties to the west. The geography of Livingston County has affected the agriculture in the area, and also the presence of a substantial migrant labor force.

The population of Livingston County is 64,717, per the Census 2015. The population is widely scattered over the 631.76 square miles, with an average population density of approximately 103.5 persons per square mile. The most populous communities in Livingston County are Dansville, Geneseo, and Mt. Morris. The population has been slightly declining each year for the last five years.



Socioeconomic Status (SES) often measures as a combination of education, income and occupation. In the provided map the majority of Livingston County population falls into the medium to low Socio-Economic Status categories. Differences in socioeconomic status are responsible for important disparities in the nutrition, housing, safety, and health of large groups of people. In general, the lower one's SES, the greater one's risk of malnutrition, heart disease, infectious diseases, and early mortality from all causes. The annual median household income is \$52,200 compared to \$53,482 for the nation and the per capita income is \$23,981 compared to \$28,555 for the nation. According to 2016 USDA data, the county poverty rate is 14.7% with 18.9% of children 0-17 years living in poverty.

In general, Livingston County has a high dependency ratio, with 18.4% of the population estimated to be under age 18 in 2015 (4.3% under age 5), and 16.3% estimated to be aged 65 or over. Approximately 93.5% of the population is white, 3.1% is Black/African American and the remainder other races. In 2015, 3.7% of the population is estimated to be Hispanic/Latino. This makes Livingston County one of the most diverse county of the Finger Lakes region.

Livingston County Population Size - Census Quickfacts					
2010	2011	2012	2013	2014	2015
65,241	64,890	64,869	64,764	64,763	64,717

In the 2010 census, 957 people indicated that they spoke English "less than very well", while the 2015 estimates indicate that 5.7% speak a language other than English at home, with 522 of these indicating that they speak Spanish at home.

Health Needs:

While each county in the eight county S²AY Network region started with a summary assessment of each county's data in the regional FLHSA presentation (attached) and each county in the region followed a fairly similar process, each county's CHA was completed separately, and each county held their own focus groups within the county. (Additionally, a sub-regional focus group was held in coordination with DSRIP through the Finger Lakes Performing Provider System (FLPPS) in each of the three Naturally Occurring Care Networks (NOCNs) that are in S²AY's region: Finger Lakes NOCN (Wayne, Seneca, Yates and Ontario Counties); S-E NOCN (Chemung and eastern Steuben Counties) and Southern NOCN (western Steuben, Livingston and Allegany Counties). Additionally, each county including Livingston held their own "priority setting meeting" and worked through county-specific committees (CHA Leadership Team, Chronic Disease, Fall Prevention, and HCTC Committees) to review data, analyze needs and develop priorities.

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

- Obesity (physical activity, nutrition, low back pain, cardiovascular disease, and diabetes)
- Substance abuse
- Dental health (especially Medicaid/low-income)
- Mental health (including suicide rate)
- Hypertension (tobacco use, cerebrovascular and heart disease)
- Cancer (lung, prostate)
- CLRD (COPD)
- Injury prevention (injuries/falls)
- Teen pregnancy

Hypertension: According to the CDC, approximately 30% of adults are diagnosed with hypertension in the United States. Livingston County has a higher rate with approximately 34% of the adult population residing in the county having been diagnosed with hypertension by a physician. Adversely Livingston County has one of the highest control rates in the region for hypertension with approximately 74% of the population registering as in-control. (FLHSA/RBA High Blood Pressure Registry, June 2015)

Obesity: In Livingston County, 60.4% of adults are classified as either overweight or obese on an age adjusted rate. Proportionally 37.5% of Livingston County children are considered overweight or obese (85th percentile or higher (2012-2014) NYSDOH data), this puts Livingston County children in the 3rd quartile for county ranking. 5.4% of adults have a diagnosis of pre-diabetes, 11.4% diabetes and 31.5% hypertension. As can be seen in the attached Focus Group presentation, the analysis shows that obesity is important due to the many related health conditions linked to obesity, including heart disease, hypertension, diabetes, lower back pain, arthritis, high cholesterol and several types of cancer. Therefore by addressing obesity, several other health-related problems may be prevented. Obesity related data and other statistics cited below can be reviewed in the Livingston County EBRSS at:

<https://www.health.ny.gov/statistics/brfss/expanded/2013/county/docs/livingston.pdf>

Behavioral Health: (mental health and substance abuse) Data revealed sharp increases in Emergency Department visits for substance abuse, heroin overdose, and mental health diagnoses, as well as admissions for heroin overdose. Please see the attached Power point presentations). Discussions of the analysis related to the opioid epidemic included mortality rates, premature loss of life, criminal behaviors related to substance abuse and the fact that substance use disorders affect entire families, often including the children of the person with the disorder.

Dental health: Unfortunately the most up to date Livingston County dental health data is from 2011 and indicates that there are 26.3% of 3rd grade children having untreated dental caries placing it in the 3rd quartile in NY State. Only 78.8% of adults have visited a dentist within the past year. Good oral health is essential to the general health of the community. Tooth decay is preventable, but continues to affect all ages. It is a greater problem for those who have limited access to prevention and treatment services. According to the NYSDOH untreated decay among children has been associated with difficulty in eating, sleeping, learning, and proper nutrition.

Injury Prevention (Falls): The elderly population in Livingston Counties continues to increase as the population, as 16.3% of the population according to 2015 census projections are age 65+ and over. According to the CDC, one in three adults aged 65+ falls each year. Falls can have an adverse effect on resident's health. Livingston County had a relatively low incident of falls, slips and trips in the region 29.6% of the population age 65+ reporting falls in the last 12 months according the EBRFSS 2012-2014. Livingston County had an average rate for ED Fall visits per 100,000 for population aged 65+ when compared against the State average. Falls are a serious health issue and can be difficult to track because of many different reasons, i.e. an individual

falls multiple times and does not go to the emergency room until after multiple falls, or an individual presents to the ED for another health related concern as the primary diagnosis and is also treated for a fall. This health concern will be continued to be monitored through future data.

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

Health Care Access

Livingston County has discussed the access gaps related to the above health needs as they analyzed the data (see attachments). As discussed above, analysis of data reveals health disparities for the low-income population in general. With designations of primary care, mental health and dental HPSAs, the capacity and distribution of health care providers is an issue. For example, transportation was repeatedly cited as a barrier in the focus groups, and was a key discussion in determining health care strategies.

The S2AY Rural Health Network, of which Livingston County Public Health is a member, helps to serve the uninsured and under-insured through the Reproductive Health Center and Cancer Services Program, both of which helps to address gaps in coverage or improve access to health care. Noyes Health addresses access to care by providing diabetes education in physician offices, CDSMP classes at multiple locations several times per year, and expanding health education programs into the community.

Emerging issues in the health care system were also discussed. Noyes Health, Livingston County Public Health and the S2AY Rural Health Network have been active participants in DSRIP, working diligently to implement alternative models of care and improved care coordination. Members also work in coordination with the FLHSA on the PHIP (Population Health Improvement Program) through Regional Leadership meetings that occur regularly, which are hosted by Yates County Public Health (as a central location for the Finger Lakes region). As the non-profit sector for the regional Public Health Departments including Livingston, the S2AY Network started a group called Finger Lakes and Southern Tier Network, which is currently transitioning into an IPA. While mostly comprised of FQHCs, S2AY is helping to lead the way for determining how to navigate the changing reimbursement structures for all types of organizations. S2AY reports progress on this development regularly to Livingston County representatives.

2. Data Reviewed and Analyzed:

The data review and analysis was extensive. In all S²AY Network Counties including Livingston, the process began with a data update for the eight county region conducted by the Finger Lakes Health Systems Agency (FLHSA) at the request of S²AY. This data collection and analysis effort focused on data related to the main priorities in the 2013 CHA for the region as well as some emerging issues that the hospitals and Public Health agreed should be analyzed based both on their knowledge of what they were seeing in their communities and what the needs assessment for DSRIP (also conducted by the FLHSA) had revealed. In addition to the DSRIP needs assessment, data sources for this review included.

- Expanded Behavioral Risk Factor Surveillance Survey
- Census Bureau
- SPARCS data
- NY State Prevention Agenda data set
- Aggregated Claims Data
- NY State Vital Statistics
- Regional High Blood Pressure Registry
- HCTC Prevention Needs Assessment

Once this data had been reviewed, the S²AY Network staff reviewed and analyzed other data to develop a summary Power Point presentation of the highest need areas particularly for the county. In addition to the above sources, this additional review of data included, among other things:

- County Prevention Agenda Dashboard
- Community Health Indicator Reports
- Sub-County Data Reports
- Leading Causes of Death Indicators
- County Health Rankings

In addition to the primary data reviewed from the high blood pressure registry, other primary data was obtained through the HCTC Prevention Needs Assessment and focus group input as described above. Finally, results from all four MAPP assessments, which includes Community Health Status, Forces of Change, Community Themes and Strengths and Local Public Health Systems were reviewed and discussed by the CHA Leadership Team and GVHP membership.

3. Priorities, Disparities and Community Engagement:

Prevention Agenda Priorities -

As detailed on the attached Community Health Improvement Plan (CHIP), the three New York State Department of Health (NYSDOH) Prevention Agenda priority areas for Livingston County for the 2016-2018 time period include:

1. **Priority Area 1: Prevent Chronic Diseases**
 - *Focus Area 1:* Reduce Obesity in Children and Adults
 - *Focus Area 3:* Increase Access to High Quality Chronic Disease Preventative Care and Management in Both Clinical and Community Settings
2. **Priority Area 2: Promote a Healthy and Safe Environment**
 - *Focus Area 4:* Injuries, Violence and Occupational Health
3. **Priority Area 4: Promote Mental Health and Prevent Substance Abuse**
 - *Focus Area 2:* Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders
 - *Focus Area 3:* Strengthen Infrastructure

Health Disparity Being Addressed -

During the 2016-2018 period, Livingston County Public Health and Noyes Health have chosen higher obesity rates in the lower SES population to address by implementing specific evidence based activities (as outlined in the CHIP chart, attached). The disparity to be addressed falls under the priority area of Prevent Chronic Diseases. The first disparity focuses on Goals 1.1 and 1.2 (Create community environments that promote and support healthy food and beverage choices and physical activity, and prevent childhood obesity through early child care and schools). This disparity will target the low socioeconomic status (SES) population by implementing strategies to increase physical activity opportunities for all populations (including the disabled population) and working on policy implementation. The second disparity focuses on Goal 1.3 (expand the role of health care and health service providers and insurers in obesity prevention). This health disparity was chosen by the CHIP Leadership Team and Chronic Disease Committee based on analysis of the data and potential to reach disparate populations.

Community Engagement

The S2AY Rural Health Network used the Mobilizing for Action through Planning and Partnership (MAPP) process to engage the community in a collaborative assessment process and collectively develop priorities.

The MAPP process is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, communities seek to achieve optimal health by identifying and using their

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

a. Organize for Success- Partner Development

This included representatives of Livingston County Public Health, Noyes Health and additional human service organizations and key stakeholders discussed above. This collaborative, multi-disciplinary group oversaw the assessment process and the development of the CHIP.

b. Assessments

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

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

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

The third assessment was the Community Themes and Strengths Assessment, which asked participants of the Taste

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of Livingston County, which is large community event attended by diverse sectors of the community including the disparate population, what would most improve the health of the community?

In addition, focus groups were conducted throughout the County and included disparate populations such as, inmates, seniors, Hispanic population, and substance abuse treatment participants. This assessment looked at the issues that affect the quality of life among community residents and the assets the County has available to address health needs.

The fourth assessment that reviewed and discussed at the “Forces of Change” that are at work locally, statewide and nationally, and what types of threats and/or opportunities are created by these changes. The Genesee Valley Health Partnership and the Continuum of Care Coalition participated in this assessment.

c. Identification of Strategic Issues

This step included both developing the list of major health issues based on all the data obtained, and prioritizing these issues. The MAPP process was utilized by completing the following steps from the MAPP guidance document “identify potential strategic issues by reviewing the findings from the Visioning process and the four MAPP Assessments, arrive at an understanding about why certain issues are strategic by considering the convergence of assessment findings, determine the consequences of not addressing certain issues by considering the urgency or immediacy of the issue, and consolidate overlapping or related issues into a manageable number. The final list should include no more than twelve issues, and arrange issues in priority order by considering how they relate to one another.

d. Formulate Goals and Strategies

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

The process of Community Engagement using MAPP

Livingston County Public Health and Noyes Health, with assistance from the S2AY Rural Health Network and GVHP, conducted a comprehensive assessment of the community, which provided the basis for the Prevention Agenda priority areas selected above. The assessment process included a thorough review of county specific data around health needs, compared to neighboring counties, the region, and the State as a whole. As noted above, this included data

collection and analysis by both the FLHSA and S²AY. The CHIP Leadership Team and Chronic Disease Committee, which includes FQHCs (Regional Primary Care Network), other Livingston County Departments (Office for the Aging, Department of Social Services, etc.), a provider of services to the developmentally disabled population, schools and CBOs, oversaw the assessment process. After the data was analyzed and prepared, this data was shared in the form of focus group presentations to county residents. Livingston County conducted eight separate focus groups with key informants throughout the county to solicit feedback. Focus groups were selected to include a broad diversity of community members from different segments of the community, including populations that experience health disparities as outlined in this report. Focus groups that were conducted include the following: a Suicide Prevention Task Force meeting, TRIAD group (senior citizens), Hand in Hand group (support group), workforce development (un/under employed population), a fatherhood group, CASA Personal Recovery Group (substance abuse), a group of migrant workers (through the Migrant Center), and the Southern NOCN. Livingston County also conducted two additional focus groups that focused on Forces of Change (part of the MAPP process). These groups included the Continuum of Care Coalition and the Community Resource Network. Livingston County chose to conduct the Forces of Change assessment in two separate focus groups, rather than the rest of the S²AY counties, which incorporated the Forces of Change assessment into all of their regularly scheduled focus groups. This can be seen in the focus group notes (attached).

After the completion of the focus groups, the CHIP Leadership Team and Chronic Disease Committee invited focus group participants, all community members, health care organizations, and human service agencies to participate in the prioritization of the most pressing health needs identified from the data collection and focus group input. Focus group participants and community members were invited to this meeting through email, media releases, and postings on websites and social media platforms (Public Health, Hospitals, S²AY Rural Health Network, and other partners). S²AY prepared another Power Point presentation for this "Priority Setting" meeting. The meeting was open to the public and focus group participants were invited. At this meeting, S²AY presented the data shared with the focus groups, along with key slides from the EBRFSS and Community Health Indicator Reports. Input from the focus groups was analyzed and considered when developing a list of priorities for the group to rank that S²AY created from all of the data reviewed and analyzed (list of issues to rank attached). The group was also offered the opportunity to add any additional issues that they believed needed to be ranked to come up with priorities.

The CHIP Leadership Team met to rank the public health issues. At this meeting, the Team completed a brainstorming by conducting a root cause analysis. The Hanlon Method was then used to rank issues, and a presentation summarizing the Hanlon Method was reviewed (attached), and participants ranked the highest priority issues to come up with a list of preliminary priorities (list of ranked issues attached). (Hanlon uses the Basic Priority Rating (BPR) System formula where $BPR = (A + 2B) \times C$ where A= the size of the problem, B= the

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

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

As fully detailed in the CHIP, strategies to address chronic diseases include evidence based activities such as Stanford approved curriculums (e.g. Chronic Disease Self-Management Program (CDSMP), Diabetes Self-Management, Chronic Pain Management), policy/practice implementation (working with schools to develop strong Local School Wellness Policies, working with worksites to implement healthy policies), working to increase opportunities for physical activity in the community, and working to increase the number of farmers markets. Strategies under "Promote Mental Health and Prevent Substance Abuse building the capacity of the Suicide Prevention Task Force, pursuing the implementation of the Social Host Law in additional towns/villages in the County, implementing best practices for anti-bullying/non-violence programming in schools, and coordinating mental, emotional, and behavioral (MEB) and chronic disease efforts. To address the third priority, falls in the 65+ population, evidence based strategies include promoting community-based programs for fall prevention (Home Safe Home program – providing home assessments, modifications, and education) and promoting physical activity opportunities through active design promotion for older adults (Tai Chi, Matter of Balance, etc.).

4. Community Health Improvement Plan (CHIP):

Please see the attached Livingston County CHIP chart, created using the template provided by the NYSDOH and the "Refresh Chart" for the Prevention Agenda.

The CHIP Leadership Team and Chronic Disease Committee conducted several meetings developing and refining the attached Community Health Improvement Plan (CHIP) chart, the overall work plan for community health improvement. This chart outlines the actions that both Livingston County Public Health and Noyes Health intend to take to address each priority area, the specific resources Livingston County Public Health and Noyes Health intend to commit (dollar amounts and/or FTEs), the roles of other partners engaged in each activity, and the chosen disparities being addressed by these efforts.

5. Maintaining Engagement and Tracking Progress:

As seen above, the Community Health Improvement Plan (CHIP) chart designates the organizations that have accepted responsibility for implementing each of the activities outlined. The Livingston County CHA Leadership Team will meet a minimum of two times per year and the GVHP Board meets regularly throughout the year. Both will monitor and track the progress of the CHIP. The Chronic Disease Committee is the group that will be leading the implementation, monitoring, and evaluation of the plan regarding the chronic disease section of the CHIP. The Chronic Disease Committee meets a minimum of nine times per year and has been meeting since before the last CHA/CHIP cycle in 2013) and has accepted this role of overseeing the CHIP. Currently, each partner organization reports CHIP updates as they are completed, to Livingston County Public Health (which facilitates the Chronic Disease Committee meetings). Livingston County Public Health then records this progress on the CHIP document, assigning each task as completed, in process, or no longer applicable. All Chronic Disease Committee partners review the CHIP chart at each meeting to ensure that all activities/progress are captured, to discuss barriers, and identify new opportunities or changes in goals or activities. The Fall Prevention Subcommittee of the GVHP will lead the implementation of the fall prevention section of the CHIP and report to the GVHP Board regarding activities, etc. HCTC and Suicide will lead the implementation of their respective areas of the CHIP and report to the GVHP Board. Furthermore, progress is also reported quarterly to the Livingston County Legislature through the Livingston County Director of Public Health (which has been done since the last CHA/CHIP cycle in 2013). Noyes Health will continue to communicate CHIP/Community Service Plan (CSP) updates to their Hospital Board annually, and activities will also be shared with the S2AY Rural Health Network Board. Activities on the CHIP will continually be assessed and modified as needed to address barriers and replicate successes. As priorities are addressed, other community partners may need to be brought to the table to effectively accomplish objectives. The Chronic Disease Committee is aware of this and experienced at this, as several new partnership members have been recruited since the 2013 CHA/CHIP cycle.

6. Dissemination:

The executive summary of the 2016-2018 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)/Community Service Plan (CSP) created in

partnership between the lead entities (Livingston County Public Health and Noyes Health) will be disseminated to the public in the following ways:

- Made publicly available on the Livingston County Public Health main website
- Made publicly available on the Noyes Health main website
- Made publicly available on the Genesee Valley Health Partnership website
- Made publicly available on the S2AY Rural Health Network website
- Made publicly available on additional partners websites (Cornell Cooperative Extension, local community based organizations, etc.)
- Shared with all appropriate news outlets in the form of a press/media release
- All partners including Livingston County Public Health, Noyes Health, S2AY Rural Health Network, and additional partners will be asked to share the publication and website links of the CHA/CHIP/CSP on their respective social media accounts (Facebook, LinkedIn, Twitter, etc.)

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

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

Noyes Health: <https://www.noyes-health.org/>

Genesee Valley Health Partnership: www.gvhp.org

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

7. CHIP Update 2016

Chronic Disease Prevention:

- The Livingston County Health Department, with support from the GVHP, continued with the Healthy Baby Cafe, which is a drop in site for breastfeeding mothers to increase breastfeeding rates.
- Three Livingston County Certified Lactation Consultants attended recertification training.

- Eight restaurants (one additional new restaurant) are participating in Healthy Dining Initiative.
- Three grocery stores (one additional new store) are participating Healthy Grocery Store initiative.
- Planning began in 2016 to create an additional walking trail in West Sparta, which will be established in 2017. The three previously established trails continued to be maintained.
- The CHANGE (CDC) assessment was completed with one worksite. A wellness committee and a walking club were created. Adoption of two policies re: increasing physical activity were implemented.
- The committee also continued to promote physical activity opportunities throughout the county through various outreach and media efforts.
- One school has completed the School Health Index and is working on policy/practice change regarding nutrition.
- The Stroke Initiative with Noyes Health included media and outreach regarding signs of stroke, seeking early medical attention and Noyes Designated Stroke Center. The annual community stroke education event was held in November with ten attendees. Plans are underway to expand community education opportunities and increase number of contacts reached in 2017 by providing 4-6 presentations to community based groups and clubs.
- The Chronic Disease Committee continued to promote the Time is Brain website and publicize Noyes becoming a certified.
- Four chronic disease self-management classes held in Wayland, Dansville, Nunda and York in 2016. 49 participants registered and 36 completed the classes. Living Healthy with Chronic Pain was newest CDSMP added in 2016 to go along with current Living Healthy NY and Living Healthy with Diabetes.
- Diabetes education enrollments at the Noyes Diabetes Education Program exceeded 2016 projections by 10% with over 370 enrollments. A new RN hired in 2016 as an additional Diabetes Educator. A Family Nurse Practitioner Noyes Creekside Family Medicine is a CDE and now providing additional diabetes management services for area diabetics to address access to care issues and provide expanded diabetes management services locally.
- Six Continuum of Care Coalition meetings were held in 2016 at Noyes Health with 25-35 area health and human service providers in attendance. This active and engaged group uses this forum as both an educational and networking opportunity. Topics presented in 2016 included: Advanced Care Planning and MOLST/eMOLST, Veterans Lifetime Electronic Record, NEW Finger Lake Caregiver Institute grant funded programs, American Red Cross Home Fire Prevention Campaign, Fidelis and VNA Home Care Options Medicaid Long Term Care Programs, CCSI Open Enrollment NY State of Health Marketplace, and new *In My Corner* web-based cancer education portal for patients, caregivers and health care providers.

- Throughout 2016, Noyes Health, in partnership with Wilmot Cancer Center, worked on building the new regional Ann and Carl Myers Cancer Center at Noyes Hospital to serve cancer patients in the region and provide patients with convenient access to state-of-the-art, comprehensive cancer care. The cancer center is scheduled to open Jan 2017 and will provide both medical and radiologic oncology services.
- In January 2016, Noyes Health officially joined the URMC health care system as an affiliate. This new collaboration allows Noyes to strengthen health care services and make them more easily accessible to patients who live in our community. The goal of this health care system is to keep patients in their own communities, to remain near their support systems, with access to medical care in Rochester if there is a need for more specialized treatment.

Promote Mental Health and Prevent Substance Abuse:

- Livingston County works to decrease stigma regarding mental health by integrating mental services into primary care and other medical settings by providing MH services at Noyes Hospital and Department of Social Services (DSS) in Mt. Morris. There are two Livingston County mental health therapists at DSS, one is bilingual and the other is a MICA specialist.
- The capacity of Livingston County Mental Health services was enhanced by increasing the number of therapists by 4% and creating a satellite clinic to decrease the number of no shows in the Mt Morris zip code from 20% to 12%.
- Capacity of Noyes Mental Health services also expanded. 15,500 visits were provided by Noyes Mental Health staff in 2016, a 19% increase over 2015. Increased utilization of crisis management services has been seen as demonstrated by increase visit volume. Staffing has expanded in response to need and they now have 3 FTE Psychiatric providers (1 MD, 2 NP's) and 18 FTE therapists. Noyes Health purchased a new building in 2016 for relocation of the Mental Health Clinic that is scheduled to open the end of December 2016.
- The Suicide Prevention Task Force completed objectives for a grant awarded through the Suicide Prevention Center of NYS to support the development of the coalition. Three additional members joined the Task Force in 2016.
- A Suicide Prevention Task Force member attended a Suicide Prevention Conference and participated in a poster presentation regarding local initiatives.
- SAFE Talk Training was conducted in Geneseo with 30 attendees from schools, law enforcement, and community.
- The 2nd Annual Candle Light Vigil regarding suicide awareness was held with almost 60 people attending, which is a 50% increase in attendance.
- A healthcare provider training was conducted which included CMEs, with 15 in attendance.

- Additional Suicide Prevention Toolkits were distributed to community partners. The Social and Emotional Health Sub-Committee continued to work with the Healthy Communities That Care Coalition (HCTC) to raise awareness around prescription misuse/substance abuse.
- Prevention Needs Assessments was administered at local schools for grades 8, 10, and 12. Four of eight schools have agreed to add ACE (Adverse Childhood Experiences) questions to their surveys. Outcomes will be reported and initiative will be implemented in 2017.
- Medication disposal boxes were placed in two additional locations, for a total of three locations in the county.
- Nalaxon (Narcan) Training is now available at Council on Alcohol and Substance Abuse (CASA) the first Tuesday of the month, which includes kits and community education.
- The Heroine Drug Amnesty Program is provided in partnership with CASA and Livingston County Sheriff's Office.
- National Recovery month activities, which included Sunset Yoga, Luminary Lighting, and a 1K walk were implemented throughout the county in September.