ONEIDA COUNTY 2016-2018 COMMUNITY HEALTH ASSESSMENT / COMMUNITY SERVICE PLAN & COMMUNITY HEALTH IMPROVEMENT PLAN UPDATE

UPDATE TO 2013-2017 CHA/CSP & CHIP

DECEMBER 2016

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This 2016-2018 Oneida County Community Health Assessment (CHA)/Community Service Plan (CSP) and Community Health Improvement Plan (CHIP) is an appendix and update to the comprehensive 2013-2017 Oneida County CHA/CSP and CHIP. The report summarizes the health status of the community and public health and hospital Prevention Agenda health improvement goals for the residents of the County of Oneida.

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EXECUTIVE SUMMARY

The Oneida County Community Health Assessment/Community Service Plan & Community Health Improvement Plan (CHA/CSP/CHIP) Planning Team identified the following as its top two Prevention Agenda priorities for the 2016-2018 update:

- Prevent Chronic Diseases – Disparity: Poverty
- Promote Healthy Women, Infants and Children – Disparity: Poverty

The priority areas have remained the same since 2013, however there are some additional areas identified. The Priority to Prevent Chronic Diseases is being addressed through a focus on tobacco cessation. We continue to address policies promoting use of the NYS Quitline with providers and have expanded our initiative to align with the Central New York Care Collaborative DSRIP cardiovascular disease management (CVD) initiative referencing the Tobacco Standards of Care. Within its larger goal of promoting tobacco use cessation among adults, we have expanded to preventing initiation of tobacco use by youth and young adults. Emerging issues include the use of e-cigarettes as a method to quit, the trend of youth starting with e-cigarettes, and we have found an increase in community interest in cessation classes that we have not seen in the past. In addition, poverty was added as a disparity to the Chronic Disease priority area.

A variety of data sources were used to identify and confirm priorities including: the NYS Prevention Agenda Dashboard, HealtheConnections, New York State Quitline Partners reports, Oneida County Teen Assessment Project (TAP), and the Pediatric Nutrition Surveillance System (PedNSS) reports. The Planning Team also reviewed data from the John Snow, Inc. Community Health Assessment for the Central New York Care Collaborative (CNYCC), the County Health Rankings, and BRIDGES Community Survey.

Partners include the Oneida County Health Coalition Steering Committee and the two Prevention Agenda priority area work groups that focus on tobacco use cessation and breastfeeding. The Coalition consists of community partners including hospitals, OCHD and community organizations. The Steering Committee assisted by reaffirming our priority areas and will serve as an ongoing resource for implementation efforts. Our priority area work groups include members from Oneida County hospitals, OCHD and community organization staff members who have a focus on the priority area. Both groups help with planning, implementation and ongoing monitoring of the improvement plans.

The Planning Team worked to solicit feedback from community members throughout the year. Rome Memorial Hospital hosted a community forum to solicit feedback from community members and participated in the City of Rome's HUD Community Needs Assessment; Access to specialty, primary, urgent care and behavioral health services were the main community needs identified. Additionally, the Planning Team reviewed the findings from the Central NY Care Collaborative (CNYCC) Needs Assessment in which some its key findings and recommendations are addressed in the selected CHIP interventions and target populations. Finally, the Oneida County Health Department asked specific questions at health fairs and events where its staff interacts with the public:

1) What can we do as a community to help more mothers breastfeed their babies?

2) What can we do as a community to help more people stop smoking?

In our plan, we incorporated Evidence-Based or Best Practice interventions. Interventions include:

- Activities from the DSRIP Cardiovascular Disease Management Tobacco Standards of Care, affiliated with the national Million Hearts initiative and including referrals to the NYS Quitline for tobacco dependence.
- Smoke-free worksites
- Encouraging municipality policies protecting youth
- Recruiting targeted providers for the Breastfeeding Friendly Practice Designation
- Encouraging the Breastfeeding Friendly Daycare Designation
- Providing clinical and educational support
- Participation in the New York State Breastfeeding Quality Improvement in Hospitals (BQIH) Collaborative

To continue to track our process and evaluate our impact, our Tobacco Cessation and Breastfeeding work groups meet quarterly to monitor the objectives, activities, data and process measures. The groups will continue these activities throughout 2018. Some of the major process measures for evaluating impact include (See CHIP for all process measures):

Prevent Chronic Diseases

- Number of provider referrals to the NYS Quitline
- Number of municipalities with tobacco marketing policies

Promote Healthy Women, Infants and Children

- Number of hospital staff trained in identified polices to support breastfeeding
- Number of child care providers trained in Breastfeeding Friendly Child Care.
- Number of providers receiving designation for Breastfeeding Friendly Child Care.

ONEIDA COUNTY 2016-2018 COMMUNITY HEALTH ASSESSMENT/COMMUNITY SERVICE PLAN & COMMUNITY HEALTH IMPROVEMENT PLAN UPDATE

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SERVICE AREA AND DEMOGRAPHICS

Below is a summary of the demographic profile of the community served (primarily taken from the *2010-2014 American Community Survey 5-Year Estimates*, where not otherwise indicated):

- **Service Area:**
  - The Oneida County Health Department and the hospitals serve the entire county. Hospital patient census includes residents from Herkimer and Madison as well, with approximately 80% of patients residing in Oneida County zip codes. The three hospitals in the County include: Mohawk Valley Health System which includes Faxton-St. Luke's Healthcare (FSLH) and St. Elizabeth Medical Center (SEMC), located in the City of Utica; and Rome Memorial Hospital (RMH) located in the City of Rome.
- **Geography:**
  - Oneida County is located in Central New York with a population of approximately 233,944. There are three cities in the County: Utica – population of 62,000; Rome – population of 33,000; and the small city of Sherrill. There are 45 towns and villages that cover a total of 1,257.11 square miles. Sixty-seven percent (67%) of the County's population resides in urban areas and 33% in rural areas.

- **Age**:
  - Like many other communities, Oneida County has a significant and growing aging population with a median age of 41.2 and 16.8% of the population 65 years and older.
- **Race & Ethnicity:**
  - The racial and ethnic characteristics of Oneida County is: White (84.9%); Black (5.5%); Asian (4.0%); Other (2.0%), Two or More Races (3.1%); and Hispanic or Latino (5.5%). Oneida County is the home of one of the largest refugee resettlement agencies in the country, the Mohawk Valley Resource Center for Refugees (MVRCR). Since 1981, the MVRCR has resettled over 15,000 individuals in the City of Utica of varying ethnicities and nationalities including Vietnamese, Russian, Bosnian, Somali Bantu, Burmese and Nepali to name a few (*MVRCR*):
    - 17.6% foreign-born residents constitute the population of the City of Utica
    - 26.6% households in Utica speak a language other than English
  - Within the County border is a portion of the members (~549) and territory of the Oneida Indian Nation (*NYS Office of Children and Family Services, "A Proud Heritage - Native American Services in NYS", 2001 Edition*)
  - In the County, there are pockets of Amish and Mennonite populations in rural areas (data unavailable).
- **Economic:**
  - Percentage of families and people whose income in the past 12 months is below the poverty level is 11.7% and the percentage with related children under 18 years is 20.8%; the percentage of people 65 years and older below the poverty level is 9.1% .
  - The percentage of the population 16 years and older that is unemployed is 4.8%.
  - Percent with high school graduate degree or higher is 87.5%
  - Percent of civilian noninstitutionalized population with health insurance coverage is 93.1%; 67.5% of these have private health insurance and 40.6% with public coverage. 6.9% have no health insurance coverage.
  - The eight counties of CNY have a total of 277,458 Medicaid enrollees; Onondaga and Oneida County account for 171,713 or 62% of all of the Medicaid enrollees. (*Central NY Care Collaborative Community Health Assessment*)

CHA/CSP & CHIP UPDATE PROCESS

Background:

In 2013, the Oneida County Health Department (OCHD), Hospitals, and representatives from community organizations convened to develop the 2013-2017 Community Health Assessment and Community Health Improvement Plan. The planning group met regularly to discuss the data, community input, and health priorities. Input was collected from a large community forum with stakeholder feedback on community strengths, weaknesses, and priority areas for improvement. Through this process, the focus areas of smoking and breastfeeding were collectively identified as a community need and areas in which OCHD and hospitals could influence and dedicate resources to intervene. As a result, it was collaboratively determined that the CHIP Prevention Agenda Priorities and Focus Areas for the next four years would be as follows:

Prevention Agenda Priority Area: *Prevent Chronic Disease*
Goal: *Promote Tobacco Use Cessation Among Adults*

Prevention Agenda Priority Area: *Healthy Women, Infants, and Children*
Goal: *Increase the proportion of Oneida County babies who are breastfed.*
Disparity: *Poverty*

2016-2018 CHA/CHIP Update:

A CHA/CHIP Planning Team comprised of OCHD, FSL, SEMC and RMH staff met regularly starting in early 2016. The Planning Team met to review and discuss the 2016-2018 CHA/CHIP Update process, clarify expectations, and develop a detailed work plan with team responsibilities, assigned tasks, and deadlines to develop and finalize the plan update. The Planning Team came to consensus on the approach to update the CHA and reassess priorities established in the CHIP. Data from the Oneida County Prevention Agenda Dashboard (See Appendix A), New York State Quitline Partners reports, Oneida County Teen Assessment Project (TAP), Pediatric Nutrition Surveillance System (PedNSS) reports, County Health Rankings, BRIDGES Community Survey, and the CNY Care Collaborative (CNYCC) Community Health Assessment were reviewed to assess areas for improvement

and status in achieving the goals and objectives outlined in the previous CHIP. The CNYCC Community Health Assessment and work to support the Delivery System Reform Incentive Payment Program (DSRIP), an initiative to transform the health system of New York State, were also factored into the assessment process. The focus of DSRIP is reducing avoidable hospital use by 25% over 5 years for the Medicaid and uninsured population in New York State. Some of the DSRIP goals supported in this assessment include reducing avoidable hospital use, improving health and public health measures, and implementing Patient Centered Medical Home model.

Appendix A – NYS Prevention Agenda Dashboard – Oneida County summarizes some of the data reviewed to assess the County's health status and progress in achieving the NYS Prevention Agenda Priority Areas Objectives for 2018. The Planning Team collaboratively assessed whether to change or add priorities based on progress to date and other community needs. While there were multiple areas worthy of selection for improvement, the data analysis below indicates that the focus areas identified in the existing 2013-2017 CHIP merited continued and sustained improvement efforts to address Breastfeeding and Tobacco Cessation (see Table 1). Additionally, the selected priorities and goals were initiatives that both hospitals and public health could lead and impact. The Planning Team also regularly consulted with the CHIP Work groups to assess progress and gather feedback on the data and goals. Table 1 is an extraction of Appendix A, and highlights indicators related to the focus areas and goals in the CHIP; the following is a summary and analysis of the findings:

- **Tobacco Cessation:** Although the percentage of adults smoking cigarettes decreased from 24% to 22% since the 2013 CHIP/CHA, the percentage remains high in comparison to NYS (17.3%) and the NYS Prevention Agenda Objective (12.3%), notwithstanding the fact that smoking is also linked to multiple chronic disease conditions including diabetes, heart disease, stroke and asthma.
- **Breastfeeding**: The percentage of infants exclusively breastfed in the hospital is 51.7% and near the PA Objective of 48.1%. However, there is significant difference between the ratio for at-risk populations including Blacks (0.39) and Medicaid Births (0.49) and the NYS PA Objectives of 0.57 and 0.667, respectively. Also, WIC data shows improvements are still needed for infants breastfeeding at six months (18.5% - PedNSS 2014). The initiatives in the existing 2013-2017 CHIP also target individuals with low socioeconomic status and indirectly impact other individuals with disparities

(minorities and individuals with Low-English Proficiency) identified in the demographic analysis above.

TABLE 1 - ONEIDA COUNTY CHIP PREVENTION AGENDA INDICATORS STATUS NYS PREVENTION AGENDA DASHBOARD – ONEIDA COUNTY				
Indicator	Data	Oneida County	NYS exc. NYC	2018 NYS Prevention Agenda Objective
16-Percentage of cigarette smoking among adults	2013-2014	22	17.3	12.3
33-Percentage of infants exclusively breastfed in the hospital	2014	51.7	51.1	48.1
33.1-Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	0.39	0.53	0.57
33.2-Exclusively breastfed: Ratio of Hispanics to White non-Hispanics	2012-2014	0.6	0.58	0.64
33.3-Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births	2012-2014	0.49	0.69	0.66

Additionally, findings in the *CNY Care Collaborative Community Health Assessment,* related to Oneida County, support the need for interventions targeted at Chronic Disease Prevention (Tobacco Cessation) and Promoting Healthy Women, Infants and Children (Breastfeeding). These include the following:

- **Total Prevention Quality Indicators (PQIs) -** PQIs are defined as conditions for which access to and provision of appropriate outpatient care can prevent complications of chronic disease and potentially prevent the need for hospitalization. The list of areas that require closer examination related to increased need for improved access to outpatient care in Oneida County included Utica, Rome and Waterville. These areas have total PQI rates that are two (2) to five (5) times greater than the average rates for Central and Upstate New York.
- **Diabetes PQI and Inpatient Hospitalization Rates -** The following areas had one or more diabetes indicator rates that were substantially higher than the Central and Upstate New York benchmark rates: Woodgate had the greatest need. It had the highest rates for PQI 1 (short-term complications of diabetes) and PQI 16 (lower extremity amputation) in the eight-county region. It also had the second highest rates for PQI 3 (long-term complications of diabetes). Camden, Utica and, to a lesser extent Rome and a few outlining areas, also showed up on a number of diabetes indicators.
- **Respiratory PQI and Inpatient Hospitalization Rates -** The following areas had one or more respiratory indicator rates that were substantially higher than the Central and Upstate New York benchmark rates - the cities of Utica and Rome showed up

consistently on the indicators. There were a few areas with much smaller populations in the County that also appeared.

- **Circulatory PQI and Cardiac-Related Inpatient Hospitalization Rates –** In the cities of Rome and Utica, as well as Lee Center, the rates of coronary vascular disease discharges specifically showed a very distinct pattern. Nearly all of Oneida County showed high levels of need. General conclusion: Given the distinct pattern of coronary vascular disease morbidity, it seems as though a broad-based program focusing on healthy behaviors such as proper nutrition and exercise would be very beneficial, not only for cardiovascular-related morbidity, but for diabetes, as well.

(Source: *CNYCC Needs Assessment)*

STAKEHOLDER & COMMUNITY ENGAGEMENT PROCESS

The Planning Team confirmed that the data indicated a need to continue traction toward achieving the goals outlined for 2017 in the areas of Breastfeeding and Tobacco Cessation; the change in the CHA timeline and subsequent CHA/CSP Update requirement came while still working toward those goals -- therefore it was too early to measure full impact. Moreover, team members concurred that the focus area targets were validated by recent data reviews and supported by the previous comprehensive assessment process. In order to secure stakeholder feedback on this determination, they established a plan for seeking stakeholder and community feedback as outlined below.

In March 2016, the Planning Team presented to the Oneida County Health Coalition general membership (approximately 60 people in attendance) information on the CHA and CHIP activities. The OCHC is comprised of broad representation of sectors and organizations that convene under the direction of the OCHD to discuss and analyze data on various health issues and trends. Partners were provided with a summary of the Prevention Agenda data and the selected CHIP focus areas and work group activities. Members were apprised of and invited to participate in the work groups and community health assessment activities.

As a follow up to collect more in-depth partner feedback, in May 2016, the Planning Team convened members of the Oneida County Health Coalition Steering Committee, a group of approximately 20 community agencies and organizations that oversee and guide the larger community health partnership. Partners were presented with an overview of the Community Health Assessment Update and Community Health Improvement Plan requirements, CHIP

Work group projects, timelines, and status in achieving the defined goals and objectives. The Prevention Agenda indicator data and goals were reviewed along with an overview of how each of the focus areas align with hospital DSRIP initiatives, specifically: the initiatives of the Tobacco Cessation Work Group aligned with DSRIP focus areas to DSRIP 4.d.i. - Reduce Preterm Births and DSRIP 3.b.i. - Cardiovascular Disease Management and the initiatives of the Breastfeeding Work Group indirectly align with DSRIP goals (e.g., healthy start for babies and health benefits to mother) to reduce unnecessary utilization through primary prevention. The Planning Team outlined its successes and challenges and obtained input from the Steering Committee on areas for improvement and identified other potential partners or resources that could support CHIP Work Group activities. As a result of the dialogue, the OCHC Steering Committee reaffirmed that the Planning Team and Work Groups should continue their efforts to address the CHIP focus areas and goals outlined in the 2013- 2017 CHIP.

The Planning Team also established mechanisms to collect community perspective on the CHIP focus areas. Health Department staff presented a short comment card to community members at all seven (7) public health events on needs and perceptions related to tobacco cessation and breastfeeding. The results of this feedback are in Appendix B.

Additionally, the Planning Team reviewed the findings from the *CNYCC Needs Assessment* which included a Primary Care Assessment, CNY Consumer Access Survey, CNY Safety Net Assessment (Medicaid and Self-pay populations) and Key Informant Interviews. Some key findings and recommendations from this comprehensive assessment related to the CHIP target populations, interventions and goals to *Promote Tobacco Use Cessation* and *Breastfeeding* include:

- *Finding*: Despite the dramatic growth in core safety-net provider organizations there is still substantial unmet need in the region, particularly among low-income segments of the population. In some communities, the safety-net's penetration into the low-income population may be as low as 20-30%.
- *Weakness*: Team-based approaches to providing primary care that involves physicians, nurse practitioners, physician assistants and other mid-level providers have to be very effective and efficient, yet there is limited evidence of these models being applied in the region.

- *Weakness*: Lack of primary care engagement, particularly for people with chronic illness or with risk factors.
- *Recommendation*: Promote population-based approaches to community health by addressing the social determinants of health: Communities that included primary care are working collaboratively to improve physical environments, address social/economic factors, and implement targeted community health programs.
- *Recommendation*: Promote consumer/primary care engagement in a patient-centered medical home. Communities and primary care practice sites need to collaborate to reach the community at-large including people with chronic conditions in more targeted ways to: Promote healthy behaviors; Provide education and support; Promote primary care engagement.

(Source: *CNYCC Needs Assessment)*

Additionally, all seven MVHS Medical Group primary care offices affiliated with Faxton St. Luke's Healthcare received Level 3 recognition from the National Committee for Quality Assurance (NCQA) under the 2014 Standards in December 2016. Recognized practices include: Barneveld, Boonville, Herkimer, New Hartford - Crossroads Plaza, Washington Mills, Waterville - Madison Street and Whitesboro. Each has received NCQA Patient-Centered Medical Home (PCMH) recognition for using evidence-based, patient-centered processes that focus on highly coordinated care and long-term, participative relationships. This is a renewal of a previous recognition under the 2011 Standards.

In summary, as a result of the above-mentioned processes, data findings and recommendations, the final selection for the 2016 – 2018 CHIP priority and focus areas remained the same as follows:

Prevention Agenda Priority Area: *Prevent Chronic Disease*
Goal: *Promote Tobacco Use Cessation Among Adults*
Disparity: *Poverty*

Prevention Agenda Priority Area: *Healthy Women, Infants, and Children*
Goal: *Increase the proportion of Oneida County babies who are breastfed.*
Disparity: *Poverty*

CHIP Work Groups Status

Since 2014, the Tobacco Cessation and Breastfeeding Work Groups have been meeting quarterly to review work plans and monitor data. In consultation with the Planning Team, work groups reviewed the Prevention Agenda Indicators specific to their goals, assessed current status, reaffirmed initiatives and community partners and adjusted work plans for 2017-2018. Each of the work groups' major accomplishments and challenges to date were outlined as follows:

- **Tobacco Cessation Work Group**
  - Successfully implemented fax-to-quit/opt-to-quit policies within three hospitals in the County and applicable OCHD program, contributing to the increase in cessation referrals.
  - Successfully established relationships with area schools to offer tobacco prevention education sessions.
  - Successfully developed partnerships to offer cessation classes.
  - Saw an increase in number of calls to the Quitline: *458* (2015) to *980* (2016 YTD)
  - Oneida County Health Department Clinic Staff trained in and using 5 A's with patients.

- **Breastfeeding Work Group**
  - Successfully supported community peer-to-peer supports for breastfeeding women.
  - Successfully implemented direct referral systems for two OB clinics to refer women to WIC.
  - Successfully started partnership with education for child care providers.
  - Successfully implemented the breastfeeding friendly places in the community through the Breastfeed Your Baby Here (BYBH) initiative.
  - Media promotion to support opening of additional breastfeeding café location targeting underserved populations.
  - FSLH participated in Great Beginnings Learning Collaborative.
  - Community Education and Weigh Stations provided ongoing breastfeeding support (RMH and OCHD).
  - Challenge in effectiveness of feeding counseling sessions at OB Clinics. Although a substantial amount of women were educated, significant changes in breastfeeding outcomes at delivery were not seen and it was not a sustainable model.
  - Challenge in connecting delivery patients with WIC peer counselors upon delivery. Identified indirect ways to make this timely connection, mainly through using social media.

ONEIDA COUNTY 2016-2018

COMMUNITY HEALTH IMPROVEMENT PLAN

Based on the assessment process and stakeholder feedback outlined above, the work plan for the Oneida County's CHIP was modified for 2016-2018. The following action plan represents the final 2016-2018 Oneida County CHIP which outlines each of the Prevention Agenda priorities selected in addition to the established goals, objectives, activities to be implemented, process measures and time-framed targets to measure progress. Additionally, each of the objectives is linked to evidence-based and/or promising practices in the areas of focus.

Tobacco

Community Health Improvement Plan 2016-2018* *(Developed November 2016)* **County: Oneida**

Partners: Mohawk Valley Health System (MVHS) (includes Faxton-St. Luke's Healthcare (FSLH) and St. Elizabeth Medical Center (SEMC)), Rome Memorial Hospital (RMH), Oneida County Health Department (OCHD), American Cancer Society (ACS), St. Joseph's Hospital Health Center, BRIDGES to Prevent Tobacco.

Priority Area: Prevent Chronic Diseases

Disparity: Poverty

Goal: Promote Tobacco use cessation among adults.

Objective 1: Increase the number of referrals for Oneida County to NYS Quitline from baseline (2016: 980) by 10% by Dec. 31, 2018.

Objective 2: Expand Fax-to-Quit or Opt-to-Quit to 100% of hospital associated primary care practice sites (RMH: 4, MVHS: 15) by March 31, 2017.

Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity
Identify hospital associated provider practices participating in DSRIP Cardiovascular Disease project Tobacco Standards of Care.	Number of provider practices identified	MVHS and RMH - Coordinating and Implementing	MVHS DSRIP Coordinator - staff time. RMH staff - staff time.	October 2016	This activity will benefit all patients including disparate populations
Develop Quitline referral policies	Quitline referral policies developed	MVHS and RMH - Coordinating and Implementing	MVHS Director of Quality & Performance Excellence - staff time, RMH Staff - staff time.	January 31 2017	
	Offices are prepared to implement policy	MVHS and RMH - Coordinating and Implementing	MVHS Director of Quality & Performance Excellence - staff time, RMH Staff - staff time.	February 28 2017	
Implement referral policy	Number of providers implementing Fax to Quit or Opt to Quit	MVHS and RMH - Coordinating and Implementing, NYS Quitline - implement	MVHS and RMH Staff - staff time, NYS Quitline technical support - staff time.	March 31 2017	
	Number of referrals to Quitline	OCHD, MVHS, RMH - monitor reports	OCHD health educator - staff time	December 31, 2018; Ongoing quarterly review.	
	Progress shared at Tobacco Workgroup meetings	MVHS and RMH - Coordinating and Implementing	MVHS and RMH Respiratory Care staff - staff time	Ongoing, Quarterly	

Objective 3: By December 31, 2018 increase the number of community based organizations (CBOs) by 2-3 who are using Fax-to-Quit or Opt-to- Quit					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Encourage participation in the referral program Fax to Quit/Opt to Quit	Number of meetings with CBOs	OCHD -Coordinate	Health Educator - staff time	December 2017	Yes, targeting CBOs serving a disparate population
Implement policy	The identified number of CBOs implementing Fax to Quit or Opt to Quit procedures	OCHD - facilitate, assist. Identified CBOs - implement	Health Educator - staff time, Identified CBOs - staff time	December 2018	
	Progress shared at Tobacco workgroup meetings	OCHD -Coordinate	Health Educator - staff time	Ongoing; Quarterly	
Objective 4: By December 31, 2018 increase the number of health care organizations by 2 in Oneida County that have adopted a system-level policy that improves tobacco dependence treatment as recommended in the clinical practice guidelines (2008)					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Meet with interested health care organizations. Assemble committee of staff that will implement policy, Discuss and develop a plan for change. Assist with implementation of tobacco health system policy	Health Care Organizations Identified	St. Joseph's Hospital - Coordinate	Health Systems for Tobacco Free NY Grant, St. Joseph's Hospital - Staff time, grant funding.	December 2017	These activities will benefit all patients including disparate populations
	Written timeline for change developed	St. Joseph's Hospital - Coordinate	St Joseph's Hospital - staff time.	December 2017	
	Staff trained to address tobacco cessation	St. Joseph's Hospital - Coordinate, implement.	St Joseph's Hospital Tobacco Grant Coordinator - staff time.	December 2018	
	Number of healthcare organizations who deliver evidence based assistance to patients who smoke.	St. Joseph's Hospital - Coordinate, Identified organizations - implement.	St Joseph's Hospital Staff - staff time, Identified organizations - staff time.	December 2018	
	Progress shared at Tobacco Workgroup meetings	St. Joseph's Hospital - Coordinate	St Joseph's Tobacco Grant Coordinator - staff time.	Ongoing; Quarterly	

Objective 5: Between January 1, 2017 and December 31, 2018 facilitate 3 series of smoking cessation classes in Oneida County using evidence based approach of American Cancer Society Freshstart® program.					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Determine schedule of classes.	Number of classes scheduled.	OCHD - facilitator, MVCC, MVHS, RMH - coordinate, implement	MVCC Respiratory Care Students and Faculty - staff time, OCHD Health Educator - staff time, MVHS - staff time, RMH - staff time	June 30, 2017	These activities will benefit all participants.
Apply for funding for materials	PHIP funding - applied	OCHD - coordinate, MVHS, RMH, MVCC - apply and implement	Hospital Staff - staff time, MVCC staff - staff time, OCHD Health Educator- staff time, PHIP - resources	January 2017	
Train leaders	Freshstart cessation online training completed	MVCC, MVHS, RMH - coordinate and implement	MVCC Respiratory Care Students and Faculty - staff time, Hospital Respiratory Therapists - staff time	Ongoing throughout year	
	Train- the-trainer sessions (Freshstart curriculum) completed (to MVCC Respiratory Care students and Hospital Respiratory Therapists)	OCHD - coordinate, educate, provide training, MVHS, RMH, MVCC - implement	OCHD Health Educator - staff time, MVCC Respiratory Care Students and Faculty - staff time, room location, MVHS & RMH Respiratory Therapy - staff time, room location.	Ongoing; Each September- i.e. Sept. 2016 for Sept. 2017, etc.	
Promote classes (targeted towards identified smokers)	Number of promotions and/or # of referrals.	MVHS - implement, RMH - implement	MVHS and RMH -staff time, resources	Ongoing	
Provide Classes	Number of classes provided	MVCC, MVHS, RMH - implement	MVCC, Respiratory Care students and faculty - staff time, room space, Hospital Respiratory Therapists - staff time, room space.	December 31, 2018; Ongoing	
Evaluate success of cessation classes by evaluating last class of each series	Participants indicate they plan to make quit attempt	OCHD - coordinate.	Class Facilitator, Health Educator - staff time.	Ongoing	

Objective 6: By January 1, 2018 all Oneida County Government buildings and grounds will become smoke free.					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Adopt tobacco-free outdoor policy	Press conference conducted by County Executive announcing proposed change	Oneida County	County Executive and Staff	2016 (complete)	
	Review 100% smoke-free draft local law adoption	OCHD	OCHD staff	2016 (completed ; pending public comment session)	activity to benefit all employees and visitors
	Change communicated to county staff and employees in county owned buildings	OCHD, BRIDGES	OCHD Staff and BRIDGES Staff, -signage from Tobacco Free Communities grant	2017	
Post sign at all county owned/leased buildings indicating change	Number of signs posted at all county owned/leased buildings	Oneida County - coordinate and implement	Oneida County Department of Public Works - staff time, Oneida County - resources	Q4 2017	
Inform employees of cessation options.	Cessation class information provided to employees	OCHD - coordinate, facilitate distribution	Health Educator - staff time	Ongoing- 2017- 2018	
Review county insurance policies to determine nicotine replacement therapy (NRT) coverage.	Policies reviewed.	OCHD - coordinate, review	Health Educator - staff time, Oneida County Personnel - staff time - provide policies	March 2017	
Update employee handbook regarding policy.	Handbooks updated.	Oneida County - implement	Oneida County Personnel Department - staff time.	January 2018	
Public and media promotion	Number of releases, media pieces sent	Oneida County - coordinate, implement	OCHD Health Educator and PIO - staff time, BRiDGES coordinator - TF signage through ATFC, American Cancer Society - staff time	January 2018	

Objective 7: By December 31, 2018 e-cigarettes will be included in NYS Clean Indoor Act law					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Advocate for e-cigarettes to be included in Clean Indoor Air law	Information is compiled and disseminated to local leaders at state level to advocate for this change to include e-cigarettes in Clean Indoor Air Act	American Cancer Society (ACS) - Coordinate, Advocate	American Cancer Society - staff time	December 2018	Activity will benefit all
Objective 8: By December 31, 2017 will share information with local and state leaders regarding the importance of stable and increased funding for programs that promote tobacco cessation among adults (example- NYS quitline, etc.)					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Advocate locally in County and at NYS level for stable and increased funding for programs that promote tobacco cessation among adults	Information compiled on the need for programs that promote tobacco cessation among adults.	American Cancer Society - Coordinate, implement	American Cancer Society - staff time	January 2017 and ongoing	Activity will benefit all communities.
	Information disseminated to local, state, or national decision makers during lobby days and meetings decision makers.	American Cancer Society - Coordinate, implement	American Cancer Society - staff time	January 2017 and ongoing	
Goal: Prevent initiation of tobacco use by youth and young adults, especially among low socioeconomic status (SES) populations					
Objective 1: By December 31, 2018 increase the amount of municipalities by 2 in Oneida County that have implemented policies that protect youth from tobacco marketing in retail point-of-sale environment (POS) (baseline: 216:0).					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Reduce the impact of retail tobacco product marketing on youth by encouraging municipalities to implement policies that protect youth from tobacco marketing in retail environment (POS)	Communities with higher number of tobacco retailers (particularly near schools or youth recreational areas) are identified.	BRiDGES to Prevent Tobacco/Advancing Tobacco Free Communities Grant - coordinate, implement ACS	BRiDGES - staff time and grant, Reality Check Youth - staff time, American Cancer Society - Staff time	December 2017	Yes, will target disparate communities.
Conduct tobacco product observations in communities where youth are exposed to high amount of tobacco marketing in the retail environment	Number of observations conducted.	BRiDGES to Prevent Tobacco Reality Check- coordinate and implement	Reality Check youth - staff time	June 2017	

Communicate with elected officials about the impact of tobacco marketing in communities. Youth will speak with key leaders and/or elected officials about tobacco marketing in stores.	Number of officials and key leaders addressed	BRiDGES to Prevent Tobacco - Coordinate and implement, provide communications	Reality Check staff and youth - staff time	June 30 2017	
	Number of policies implemented.	BRiDGES to Prevent Tobacco - coordinate. Municipalities Identified - implement	BRiDGES to prevent tobacco - staff time, grant. Municipalities - staff time.	December 2018	
Objective 2: By December 31, 2017, share information on the presence of tobacco imagery in youth media to 3 local, state, or national decision makers.					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Reality Check youth will advocate locally in Oneida County and in NYS for eliminating pro-tobacco imagery from youth media	Information compiled on presence of tobacco imagery in youth media	BRiDGES to Prevent Tobacco/Advancing Tobacco Free Communities Grant	BRiDGES staff, Reality Check Youth	June 2017	Activity will benefit all
Disseminate information to local, state, or national decision makers in writing and if there is an expressed interest, in person as a brief presentation	Number of decision makers receiving information or presentation	BRiDGES to prevent tobacco - coordinate and implement	Reality Check youth - staff time, grant	December 2017	
Educate community members and leaders - share findings of tobacco industry presence on the internet with local decision makers, school boards, and local media.	Number of community members and leaders reached	BRiDGES to prevent tobacco - coordinate and implement	Reality Check youth - staff time, grant	December 31 2017	
	Number of communications (target 50) sent to movie studio parent companies, the MPAA, and/or social media parent companies asking them to eliminate youth exposure to smoking and tobacco product imagery.	BRiDGES to prevent tobacco - coordinate and implement	Reality Check youth - staff time, grant	December 2017	

Objective 3: By December 31, 2017 will share information with local and state leaders regarding the importance of stable and increased funding for programs that work to prevent initiation of tobacco use by youth and young adults (example- Reality Check)					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
American Cancer Society will advocate locally in County and at NYS level for stable and increased funding towards preventing initiation of tobacco use by youth.	Information compiled (on the need for programs that prevent initiation of tobacco use by youth).	American Cancer Society - coordinate	American Cancer Society - staff time	January 2017 and ongoing	Activity will benefit all
Disseminate this information to local, state, or national decision makers during lobby days and meetings decision makers.	Amount of information disseminated	American Cancer Society - coordinate, implement	American Cancer Society - staff time	January 2017 and ongoing	

Objective 4: By December 31, 2018 have active/ongoing partnerships with 5 area schools in Oneida County whereby tobacco prevention education is provided for middle or high school students.					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Provide tobacco prevention education on health risks of smoking, use of tobacco products, and impact of tobacco marketing, to select middle and high school students in Oneida County.	Number of local secondary schools identified.	OCHD -coordinate	Health Educator - staff time	February 2017	Identify a portion of schools with disparate populations; activity will benefit all students.
	Number of sessions provided	OCHD coordinate, provide education	Health Educator - staff time. Identified schools - space for classes	December 2018	
Evaluate success of lessons	Knowledge check question conducted. Number of students indicating that they learned something new (80% target)	OCHD - coordinate, implement	Health Educator - staff time.	Ongoing- March 2017- December 31, 2018	
Link students with BRiDGES Tobacco Prevention Program/Reality Check	Number of students linked with program	OCHD, BRIDGES Tobacco Prevention Program/Reality Check	Health Educator - staff time, BRIDGES - staff time.	Ongoing- March 2017- Dec. 31, 2018	

*2016 activities part of 2013-2017 CHA/CHIP; updates included in report section

Breastfeeding

Community Health Improvement Plan 2016-2018* *(Developed Nov. 2016)* **County: Oneida**
Partners: Mohawk Valley Health System (MVHS) (includes Faxton-St. Luke's Healthcare (FSLH) and St. Elizabeth Medical Center (SEMC)), Rome Memorial Hospital (RMH), Oneida County Health Department (OCHD), Cornell Cooperative Extension (CCE), Mohawk Valley Perinatal Network (MVPN), WIC, Neighborhood Center, Community Health Worker Program (CHWP), Healthy Families. Plan Completed - November 2016.
Priority Area: Promote Healthy Women, Infants, and Children
Disparity: Poverty

Goal: Increase the proportion of Oneida County babies who are breastfed.

Objective 1: By December 2018, increase rate of exclusive breastfeeding during Rome Memorial Hospital stay from 54% (2015) to 65%.
Objective 2: By December 2018, decrease rate of elective supplementation during Rome Memorial Hospital stay from 20% (2015) to 17%.

Interventions/Strategies/Activities	Process Measures	Partner Role	Partner Resources	By When	Will action address disparity
Participate in NYSDOH BQIH Learning Collaborative.	Accepted into collaborative	RMH Maternity and BQIH team - Coordinate and Implement	RMH Maternity, BQIH Learning Collaborative Team - staff time.	December 2016	The activities will benefit all patients
Discontinue routine pacifier use for newborns; educate prenatally (at Rome OB Clinic) about pacifier use in hospital	Education conducted. Determine that bassinets are no longer routinely stocked with pacifiers.	RMH Maternity - Coordinate, Implement. RMH OB Clinic - Implement	RMH Maternity Staff and BQIH Learning Collaborative Team - staff time, RMH OB Clinic - staff time. Scripts for nurses and aides	December 2016	
Practice 24-hour rooming in (revise policy, adapt well baby nursery, educate mothers prenatally and in the hospital about rooming-in, educate mother about advantages, provide education to providers to perform infant assessments in couplet's room, scripts for nurses, aids, physicians for messaging.)	1) A revised rooming-in policy in place, 2) Adapted well baby nursery, 3) Education and scripts completed	RMH - Coordinate, Implement	RMH Staff - staff time, scripts	March 2017	
Eliminate formula-sponsored items - new educational materials and crib cards	Materials and crib cards for parents are in place.	RMH Maternity- purchase or create new supplies	RMH Staff - staff time, funds for supplies	March 2017	

Perform LATCH scores every shift on breastfeeding couplets (all RNs educated on how to perform and document LATCH assessments)	Number of RNs educated	RMH Staff - provide education	RMH Breastfeeding Staff - staff time.	February 2017	
Place healthy infants immediately skin-to-skin for one hour uninterrupted following delivery	Number of healthy infants placed skin-to-skin for one hour uninterrupted following delivery (using document review)	RMH - coordinate, implement, educate	RMH Staff - staff time	November 2017	
Objective 3: By December 2018, increase the number of babies who receive any breastmilk in the hospital (FSLHC) from baseline (2015: 68%) to 80%					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Increase level of staff knowledge on current evidence based Activity on breastfeeding through mandatory use of online educational tool Injoy e-course	Number using online tool	MVHS - coordinate, implement	MVHS Staff, FSLH OB Clinic Staff - Staff time, software	Started October 2016	Activity will benefit all patients
Train maternity and nursery staff	Number of staff trained	MVHS - coordinate, implement	FSLH Nurse Manager - staff time, Nursing staff - staff time	100% by end of 2016	
Maternity and Nursery nurses shadow	Number of nurses shadowing	MVHS - coordinate, implement	FSLH Nurse Manager - staff time, Nursing Staff - staff time	100% by 2nd quarter 2017	
	Monitor percentages through SPDS data	FSLH - facilitate, data monitoring	FSLH Nurse Manager - staff time	ongoing	
	Report out at breastfeeding workgroup	FSLH - data report	FSLH Nurse Manager - staff time	ongoing	
Objective 4: By December 2018, increase the number of providers with NYS Breastfeeding Friendly Practice designation from baseline to 4. Baseline 2016:0					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Recruit Pediatric, FP, or OBGYN offices to become NYS Breastfeeding Friendly Activity.(including at least 2 serving a vulnerable population (low income).	Providers identified	OCHD - facilitate, MVHS (FSL OB Clinic and St E's Women and Children) - facilitate, implement.	MVHS Nurse Manager - staff time, OB Clinics Staff time, OCHD - MCH Staff time	March 2017	Yes. Targeted providers serving low income.
Complete initial Assessments	Assessments completed	OCHD assist in initial, Identified providers - implement	OCHD - MCH Staff time, MVHS OB Clinic Staff time, Additional Providers -staff time	June 2017	

Providers develop implementation plan	Plan developed	Identified Providers - implement, OCHD - assist, assist training	Providers - staff time, OCHD MCH Staff time.	December 2017	
Adopt practice designation in MVHS OB Clinics and identified Provider offices	Designation received	MVHS and other designated providers - implement	Staff time.	December 2018	
Objective 5: By December 2018, increase the number of childcare providers (family and group homes) with NYS Breastfeeding-friendly childcare designation from baseline by 20%. (Baseline 2016: 13 family/10 group homes, 0 legally exempt.)					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Incorporate a breastfeeding friendly practice training segment in Child and Adult Care Food Program (CACFP) annual required training.	Number of childcare providers trained	Cornell Cooperative Extension (CCE) and Neighborhood Center - coordinate, implement. OCHD - assist	CCE and Neighborhood Center CACFP Staff - staff time. OCHD MCH and Health Educator - staff time.	December 2017, ongoing	The activities will benefit all participants. Training is available to all registered and legally exempt providers.
Promote application and designation at annual CACFP meetings and ongoing during monitoring visits; promote application and designation during new CACFP provider training. CCE - facilitate application process for legally exempt providers; track results.	Number of childcare providers with the NYS designation	CCE and Neighborhood Center CACFP staff - coordinate, implement. CCE - facilitate.	CCE and Neighborhood Center Staff - staff time	December 2017, ongoing	
Objective 6: By December 2018, increase the number of Breastfeed Your Baby Here (BYBH) locations from baseline to 24. (Baseline 2016: 20)					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Conduct outreach to new businesses, meet with sites.	Number of locations contacted and adopted	MVPN - coordinate, implement	MVPN Perinatal Program Associate - staff time	ongoing	Activity benefits all community members.
Promote website and mobile App	Number of visitors to site/app	MVPN - coordinate, implement	MPVN Perinatal Program Associate - staff time	ongoing	
Inform BYBH partners about opportunities for Business Care for Breastfeeding support.	Number of businesses expressing interest	MVPN - coordinate	MPVN Program Coordinator, Associate - staff time.	December 2018	

Objective 7: By December 2018, increase the number of individuals educated at Baby Weigh Station by 10 people annually from baseline (Baseline 2016:1) (CDC Guide to Breastfeeding Interventions, Educating Mothers)					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Provide comprehensive breastfeeding education and lactation professional support prenatal/perinatal.	monitor use of weigh station	OCHD - Coordinator, implementer	OCHD MCH Staff - staff time.	December 2018	Yes, targeted population and targeted providers.
Update outreach materials describing services to more accurately reflect CLC services available (rebranding).	Updated flier available for distribution	OCHD - implement	OCHD MCH, Health Educator - staff time.	March 2017	
Promote Services Available with general community and clients	Number of programs distributing information, referring	OCHD -coordinate. Partners (MVHS, WIC, MVPN, CCE, HF, CHWP) - implement, distribute	OCHD MCH Staff - staff time, OCHD - fliers, Partners - staff time.	Ongoing	
Promote Services Available with providers; attend MVHS Maternity Staff meetings, MVHS Physician OB & Pediatric meetings, WIC & CHWP staff meetings	Number of sessions attended	OCHD -coordinate. Partners (MVHS, WIC, MVPN, CCE, HF, CHWP) - implement, distribute	OCHD MCH Staff - staff time, OCHD - fliers, Partners - staff time.	December 2017	
Objective 8: By December 2018, increase the WIC initiation rate from baseline (2015: 67%) to 70%					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Establish Peer Counselor/participant relationships - Peer Counselor Staff see WIC participants prenatally	Visits conducted	WIC - coordinate, implement	WIC Peer Counselors - staff time	Ongoing	Yes, targeted population
Conduct staff training on how to ask breastfeeding questions	Training conducted	WIC - coordinate, implement	WIC Breastfeeding Coord. - staff time	October 2018	
Use Healthy Lifestyle Program to promote breastfeeding to prenatal clients	promoted to prenatal clients	WIC - coordinate, implement	WIC Staff - staff time	October 2017	
Provide comprehensive breastfeeding education during home visits	Number that received education (incl. Herkimer and Oneida)	CHWP - coordinate, implement	CHWP staff - staff time	Ongoing	

Objective 9: By July 2017, establish program to offer maternal, infant, child health education sessions for refugees enrolled in refugee center school program (baseline: 2016: 0). (CDC Guide to Breastfeeding Interventions: Educating Mothers)					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Determine program logistics (session type, length)	Session format outlined	OCHD coordinate, implement	OCHD MCH - Staff time	December 2016	
Seek input from local perinatal providers on curriculum	Input received	OCHD - coordinate	MCH staff - staff time, health educator - staff time, Providers - staff time.	December 2016	
Develop curriculum. Finalize topics to be included in the program (include: breastfeeding, child spacing (contraceptive) and relationship to premature births).	Curriculum developed.	OCHD - coordinate, develop curriculum	OCHD - MCH Staff time	December 2016	
Begin class sessions	number of sessions held	OCHD coordinate, implement	OCHD MCH - staff. Refugee Center - staff time interpreter, space.	January 2017	
Evaluate class sessions	evaluations completed (50% intend behavior change)	OCHD coordinate, conduct survey. Refugee Center - assist	OCHD MCH Staff - staff time, Refugee Center - staff time.	Ongoing, December 2018.	
Objective 10: By December 2018, increase number of people utilizing peer support group (Breastfeeding cafes) by 10% (baseline: 245) (CDC Guide to Breastfeeding Interventions: Peer Support)					
Interventions/Strategies/Activities	**Process Measures**	**Partner Role**	**Partner Resources**	**By When**	**Will action address disparity**
Offer peer support and provide breastfeeding management by certified lactation counselors	number of people attending cafes	Mohawk Valley Breastfeeding Network (MVBFN) - coordinate, implement. OCHD - collect data, report	MVBFN partners - staff time. OCHD - staff time.	December 2018	Yes, target populations subset
establish community relationships to increase referrals	number of people attending cafes	Mohawk Valley Breastfeeding Network (MVBFN) - coordinate, implement.	MVBFN partners - staff time.	December 2018	

*2016 activities part of 2013-2017 CHA/CHIP; updates included in report section

APPENDICES

Appendix A – NYS Prevention Agenda Dashboard - Oneida County								
		Oneida		Central NY		NYS excluding NYC		PA 2018 Objective
Prevention Agenda (PA) Indicator	Data Years	Numerator	Percentage (or) Rate (or) Ratio	Numerator	Percentage (or) Rate (or) Ratio	Numerator	Percentage (or) Rate (or) Ratio	Percentage (or) Rate (or) Ratio
Improve Health Status and Reduce Health Disparities								
1-Percentage of premature deaths (before age 65 years)	2014	518	21.3	2,186	23	21,090	22	21.8
1.1-Premature deaths: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	57.8	3.05	49.1	2.37	41.1	2.1	1.87
1.2-Premature deaths: Ratio of Hispanics to White non-Hispanics	2012-2014	56.2	2.97	56.1	2.71	43.8	2.24	1.86
2-Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years[b]	2014	2,885	130.8	11,048	119.9	108,846	106.1	122
2.1-Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	257.1	1.95	232.2	1.96	191.7	1.94	1.85
2.2-Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics	2012-2014	71	0.54	90.7	0.76	149.2	1.51	1.38
3-Percentage of adults (aged 18-64) with health insurance	2014		90.6					100
4-Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	2013-2014		85.1		84.1		84.6	90.8
Promote a Healthy and Safe Environment								
5-Rate of hospitalizations due to falls per 10,000 - Aged 65+ years	2014	908	223.2	3,166	195.3	33,951	188.7	204.6
6-Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years	2014	545	503.9	1,836	400.5	21,997	442.7	429.1
7-Assault-related hospitalization rate per 10,000	2012-2014	168	2.4	767	2.5	7,961	2.4	4.3
7.1-Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	12.4	8.37	7.2	6.9	9.4	7.68	6.69
7.2-Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics	2012-2014	1.7*	1.12+	9.4	9.02	3.1	2.55	2.75
7.3-Assault-related hospitalization: Ratio of low income ZIP codes to non-low income ZIP codes	2012-2014	5.3	4.36	7.6	6.37	6	3.24	2.92
8-Rate of occupational injuries treated in ED per 10,000 adolescents - Aged 15-19 years	2014	48	31.2	198	26.3	2,226	28.2	33
9-Percentage of population that lives in a jurisdiction that adopted the Climate Smart Communities pledge	2015	35,797	15.2	752,922	73.3	6,364,999	56.8	32
10-Percentage of employed civilian workers age 16 and over who use alternate modes of transportation to work or work from home	2010-2014	17,338	17	85,915	18.7	1,175,182	22.6	49.2

11-Percentage of population with low-income and low access to a supermarket or large grocery store	2010	13,166	5.61	48,052	4.68	474,392	4.23	2.24
12-Percentage of homes in Healthy Neighborhoods Program that have fewer asthma triggers during the home revisits[b]	2011-2014	NA	NA			196	18	25
13-Percentage of residents served by community water systems with optimally fluoridated water	2015	136,122	68.2	755,477	79.6	5,529,521	52.6	78.5
Prevent Chronic Diseases								
14-Percentage of adults who are obese	2013-2014		35		31		27	23.2
15-Percentage of children and adolescents who are obese	2012-2014		20.1		19.6		17.3	16.7
16-Percentage of cigarette smoking among adults[b]	2013-2014		22		22.2		17.3	12.3
17-Percentage of adults who received a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years[b]	2013-2014		72.6		73.7		70	80
18-Asthma emergency department visit rate per 10,000 population	2014	1,091	46.8	4,327	42.3	54,981	48.8	75.1
19-Asthma emergency department visit rate per 10,000 - Aged 0-4 years	2014	144	107.5	703	123.3	7,220	117	196.5
20-Age-adjusted heart attack hospitalization rate per 10,000	2014	429	14.2	1,685	13.2	20,944	14.7	14
21-Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	2012-2014	55	5.4	184	4	1,473	2.9	3.06
22-Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years	2012-2014	414	7.5	1,830	7.6	15,881	6	4.86
Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections								
23-Percentage of children with 4:3:1:3:3:1:4 immunization series - Aged 19-35 months	2014	2,279	60.1	11,180	68.9	100,601	59.4	80
24-Percentage of adolescent females with 3 or more doses of HPV immunization - Aged 13-17 years	2014	2,456	34.4	12,837	37.2	108,458	30.3	50
25-Percentage of adults with flu immunization- Aged 65+ years[b]	2013-2014		65.8		76.2		77.1	70
26-Newly diagnosed HIV case rate per 100,000[c]	2012-2014	29	4.1	205	6.7	2,410	7.1	16.1
26.1-Difference in rates (Black and White) of newly diagnosed HIV cases[c]	2012-2014	19.6*	17.5+	28.9	25.5	25	22	46.8
26.2-Difference in rates (Hispanic and White) of newly diagnosed HIV cases[c]	2012-2014	11.1*	8.9+	24.8	21.4	17.5	14.4	26.6
27-Gonorrhea case rate per 100,000 women - Aged 15-44 years	2014	60	144.4	495	252.6	2,949	140.1	183.4
28-Gonorrhea case rate per 100,000 men - Aged 15-44 years	2014	52	115.9	437	220.9	3,153	145.3	199.5
29-Chlamydia case rate per 100,000 women - Aged 15-44 years	2014	588	1,415.30	3,111	1,587.60	26,303	1,249.60	1,458
30-Primary and secondary syphilis case rate per 100,000 men	2014	1	0.9*	49	9.8	385	7	10.1

31-Primary and secondary syphilis case rate per 100,000 women	2014	0	0.0*	2	0.4*	16	0.3	0.4
Promote Healthy Women, Infants, and Children								
32-Percentage of preterm births	2014	317	12.7	1,150	10.5	13,025	10.8	10.2
32.1-Premature births: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	21.9	2.02	16.3	1.69	15.7	1.59	1.42
32.2-Premature births: Ratio of Hispanics to White non-Hispanics	2012-2014	17.1	1.59	13.1	1.36	12	1.21	1.12
32.3-Premature births: Ratio of Medicaid births to non-Medicaid births	2012-2014	15.2	1.53	12.5	1.37	11.7	1.12	1
33-Percentage of infants exclusively breastfed in the hospital	2014	1,178	51.7	5,532	56	55,355	51.1	48.1
33.1-Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	21.7	0.39	30.1	0.49	30.8	0.53	0.57
33.2-Exclusively breastfed: Ratio of Hispanics to White non-Hispanics	2012-2014	33.4	0.6	40.2	0.65	33.7	0.58	0.64
33.3-Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births	2012-2014	32.5	0.49	39.7	0.58	38.6	0.69	0.66
34-Maternal mortality rate per 100,000 births	2012-2014	3	38.7*	9	27.1*	65	18	21
35-Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs	2014	10,521	75.1	32,638	69.5	340,949	70.2	76.9
35.1-Percentage of children aged 0-15 months who have had the recommended number of well child visits in government sponsored insurance programs	2014	1,018	89.8	3,050	84.6	30,103	84.3	91.3
35.2-Percentage of children aged 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs	2014	4,232	86.6	12,963	81	134,763	81.4	91.3
35.3-Percentage of children aged 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs	2014	5,271	66	16,625	60.8	176,083	62	67.1
36-Percentage of children (aged under 19 years) with health insurance	2014		96.4					100
37-Percentage of third-grade children with evidence of untreated tooth decay	2009-2011		29				24	21.6
37.1-Tooth decay: Ratio of low-income children to non-low income children	2009-2011	37.1*	1.64+			35.2	2.46	2.21
38-Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	2014	83	19.7	315	16.2	2,562	11.7	25.6
38.1-Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	51	5.26	48.7	4.9	31.1	4.13	4.9

38.2-Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics	2012-2014	36.6	3.77	43.1	4.34	23.6	3.14	4.1
39-Percentage of unintended pregnancy among live births	2014	799	35.1	3,496	34.1	25,610	26.5	23.8
39.1-Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic	2014	53.8	1.73	57	1.92	47.3	2.14	1.9
39.2-Unintended pregnancy: Ratio of Hispanics to White non-Hispanics	2014	51.1	1.65	49.7	1.67	32.6	1.48	1.43
39.3-Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births	2014	49	2.42	49.8	2.33	39.6	1.97	1.54
40-Percentage of women (aged 18-64) with health insurance	2014		92.4					100
41-Percentage of live births that occur within 24 months of a previous pregnancy	2014	621	24.9	2,731	24.9	25,482	21.1	17
Promote Mental Health and Prevent Substance Abuse								
42-Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	2013-2014		14.4		14.5		11.8	10.1
43-Age-adjusted percentage of adult binge drinking during the past month	2013-2014		16.4		18.6		17.4	18.4
44-Age-adjusted suicide death rate per 100,000	2012-2014	89	12.2	368	11.4	3,397	9.5	5.9

Data downloaded November 2016

Notes

- [a]: The Prevention Agenda 2013-2017 has been extended to 2018 to align and coordinate timelines with other state and federal health care reform initiatives.
- [b]: A new target has been set for 2018. Click for more information.
- [c]: Indicator baseline data, trend data, and 2018 objective were revised and updated. Click for more information.
- See technical notes for information about the indicators and data sources.

Appendix B - OCHD Summary of Community Input	
Question	Responses (from 7 community events, not listed in any particular order)
What can we do as a community to help more mothers' breastfeed their babies?	Education • Informational classes for breast feeding • Education & support • Educate the public at work places about breast feeding • More education in schools • More education in hospitals, especially younger moms Support • More support after delivery • Don't give formula in hospital if nursing • Be allowed to pump at work Community/Awareness • Raise awareness on right to pump at work • Help public accept breastfeeding as natural • Help public accept breastfeeding should be able to be done in any location
What can we do as a community to help more people stop smoking?	Education • Education in schools, highlight dangers • More face to face education in schools, employers (with people who have suffered effects of smoking) • Remind people of reasons to quit Cessation Services and Support • Hypnosis • Acupuncture • Access to NRT (Nicotine Replacement Therapy) • Support to stay on top of quit attempt, to stay on top of it long-term – urges always there • Doctors need to address more • Supports –to just do it Other • Nothing more can be done, has to come from the person when they are ready • Tried everything, nothing left to try or I'd do it myself • Stop selling cigarettes
What are the top health issues for you and your family?	Access • Insurance – cost and confusion • Insurance – having it and keeping it • Finding Family Physicians • Therapy Services (PT, OT) • Dental Health Issues • Overweight/obesity, weight gain, exercise • Breastfeeding • Allergies • Heart disease/cardiac issues, high blood pressure • Eating, nutrition, sugar, food – preparation, time, meal planning, affordability, fast food, kids (fruits & vegetables) • Exercise, time to workout • Alzheimer's • Lyme Disease/ticks • Mental & physical health • Chronic pain • Weak bones • Contagious diseases, STDs • Smoking, Cigarettes, drugs, drugs in the street, drinking • Lead, lead testing, housing • Pollution • Anemia • Hygiene