

GENESEE VALLEY HEALTH PARTNERSHIP STRATEGIC PLAN

MAPP Demonstration

Mobilizing for Action through Planning and Partnerships

I. BACKGROUND AND SUMMARY:

A. *MAPP*

MAPP project was developed through a cooperative agreement between NACCHO (National Association of City and County Health Officials) and CDC (Center for Disease Control). Genesee Valley Health Partnership is a demonstration site for the MAPP model. Community involvement and the engagement of a broad cross-section of the community are essential for a successful planning process using MAPP.

New York State was one of several states participating in the field study offered by the Centers for Disease Control utilizing a draft version of the NPHPS. (The NPHPS were officially rolled out on June 20, 2002.) Livingston County was one of eight counties in New York State that completed the assessment through a Partnership. Genesee Valley Health Partnership is a Demonstration site for MAPP. Although the Partnership found the assessment process complicated at times, their commitment led to a completed document, and information that, combined with the results of the other three MAPP Assessments, will identify the most important public health issues facing Livingston County.

This planning document is organized using the MAPP process as implemented by GVHP. Those activities undertaken by GVHP from the original vision through the strategic issues and health opportunities stages of the planning process are restated in this document with a focus on strategy and resources. Information in this plan is organized as follows:

- MAPP description
- The Local Mission and Genesee Valley Health Partnership Profile
- Goals Statement
- Objectives
- Steps in the MAPP Planning Process and Local Planning Results
 - Community Health Assessments
 - Critical Issues
 - Healthy Opportunities and Resources
- Measuring Progress and Specific Achievements

B. *GVHP Mission:* To improve health outcomes in Livingston County through collaboration, education, prevention, and practice.

GVHP is comprised of 35 organizations, organized into 11 committees constantly working on a goal of improving health outcomes for rural residents of Livingston County. Member organizations include private human service agencies, County service agencies, health care providers, health care facilities, countywide emergency and crisis services, health maintenance organizations, private special health interest organizations such as the American Cancer Society, organizations focusing on children and health, public officials, health care practitioners, mental health agencies and organizations, alcoholism and substance abuse services, regional health networks and educational services.

The result is a diverse working partnership organized to help create a healthier community through improved health outcomes for all Livingston County residents.

C. *GVHP Overarching Goals (Healthy People 2010):*

1. Increase quality and years of healthy life
2. Eliminate health disparities

To address these goals, the community identified ten key indicators that must form the core of any strategy. Critical issues and resulting objectives have been analyzed by key indicator and health opportunities restated in 2003.

Ten Health Opportunities identified in 1997 include:

- Access to Health Care
- Chemical Dependency
- Exposure to Toxic and Infectious Agents
- Five Leading Screenable Causes of Death
- Immunizations
- Inactivity and Improper Diet
- Mental Health
- Respite Services
- Teen Pregnancy
- Violence

Leading Health Indicators for Healthy People 2010.

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality

- Immunization
- Access to Health Care

D. *GVHP Objectives:*

- To strengthen the local health system through continued coalition building.
- To improve health care access for Livingston County Residents including pre-hospital care, primary care, hospital and after-care health services.
- To improve the health status of Livingston County residents.

GVHP has identified community health opportunities that will ultimately directly link community action to stated objectives with specific programs and resources.

E. *Steps in the MAPP Planning Process:*

Steps in the MAPP planning process include organizing for action, visioning, community assessments, identifying key strategic issues, and mobilizing for action. In September 2001, GVHP set forward a work plan coordinated by the GVHP MAPP Steering Committee.

Committee Members included:

- Joan Ellison, Livingston County Department of Health;
- Joni Tiller, FF Thompson Health
- Kathy Dahl, Preferred Care
- Jim Wissler, Nicholas Noyes Hospital
- Tim Mc Mahon, Catholic Charities
- Lance Bassage, Livingston County Legislature
- Dr. Ed Black, Blue Cross & Blue Shield
- Steve Newvine, Livingston County Chamber of Commerce

Eight Process Steps drive the work plan schedule in which the “what”, “who” and “when” are specified. From the formation of the Steering Committee through the Action Plan and Evaluation there are more than 38 activities involving Steering Committee members and volunteers from the 33 GVHP members for which there are a corresponding number of scheduled completion dates.

The basic MAPP philosophy is that the community drives the process. The community must be involved to help determine the most appropriate and most accurately targeted strategy.

F. *The Vision:*

GVHP envisions a healthier community (Livingston County and the greater Genesee Valley) resulting from a collaborative community health assessment with broad participation from GVHP members, including health practitioners and other partners from which the most pressing “strategic issues” are identified. From the strategic issues, goals and strategies emerge, leading to an action plan organized by committee. Through this collaborative effort, GVHP’s healthy community issues can receive special concentration, including innovative methods.

The “vision”, therefore, goes beyond the outcomes to include a working process designed to maintain assessment and evaluate progress and, when necessary, redirect focus. In fact, it is a direct result of this visioning process that GVHP added on assessment to the standard five assessments included in the MAPP process [*Uninsured: Access to Health Care*]

II. MAPP ASSESSMENT REPORTS

MAPP encourages assessments in four major areas. These assessments include A. Community Health Status Assessment B. Forces of Change Assessment C. Local Public Health System Assessment D. Community Themes & Strengths. Adding E. “Uninsured: Access to Health Care” established 5 community health assessments required by GVHP in the MAPP process. Assessments were conducted simultaneously, providing baseline information used to identify challenges and opportunities.

A. COMMUNITY HEALTH STATUS ASSESSMENT: How healthy are our residents? What does the health status of our community look like? *The Community Health Status Assessment Committee process involved 6 meetings and data analysis from the following sources.*

NYS Department of Health
NYS Office of Alcohol and Substance Abuse
US Census 2000
Finger Lakes Regional Perinatal Database
Local Government and Agencies

The Committee identified 8 Health Indicators for which data was collected and reviewed. These Indicators include:

1. Socioeconomic/Demographic
2. Maternal Child Health
3. Adolescent Health
4. Infectious Diseases
5. Socio/Mental Health
6. Physical/Environmental Health
7. Health Status/Mortality/Morbidity
8. Health and Social Resources

Indicator #1. Socioeconomic/Demographic

Data was collected from Census 2000 and the Office of Alcohol and Substance Abuse Services. Data elements selected for analysis include Population, Education, Income/Unemployment and Housing.

Population: **64,328** (includes college students and inmates)

Age (%)	<20 yrs.= 29	20-44= 38	44-64= 22	>64 yrs.= 11	Median Age=35.3
Race (%)	White= 94	Black/AA= 3	Asian/PI= 1	Other= 2	Hispanics represent about 2.3% (all races)
Living Situation	89% live in households	Institutionalized population 5%	Noninstitutionalized (not in household) 6%		
Marital Status % (population over age 15)	Married= 51.1	Never Married= 31.6	Separated= 2.8	Divorced= 8.5	Widowed= 5.9
Household Status	Average household size=2.6	69% of all households defined as family (avg. family household size=3.05)	Female headed households (no husband present)=14% of family households	Grandparents responsible for grandchildren= 245 (39% of all grandparents living in households with grandchildren)	Children comprise approx. 31% of household members.
Disability (%) n=9950	<18yrs.= 10	12-64yrs.= 17	>64yrs.= 34.5	55.8% of disabled adults are employed	
Language (%)	English Only= 95	Spanish= 2	Other= 5		

Education:

School Enrollment n=19,552	Preschool= 3.8%	Kindergarten= 3.0%	Grades 1-8 = 38.4%	Grades 9-12 = 19.7%	College/grad. School = 35.1%		
Educational Level (population of 40,081 age 25 or older)	Less than grade 9 = 4.4%	9-12 (no diploma) = 13.2%	HS graduate/GED = 33.8%	Some College = 19.0%	Associates Degree = 10.3%	Bachelor's Degree = 11.4%	Graduate or Prof degree = 7.9%
Youth at Risk (population under age 21)	HS Dropout = 2%	HS grad. Not attending college = 25%	Non regents diploma = 50%				

Income/Poverty, Unemployment:

Median family income is higher than the median household income by approximately 20%. The number of female headed families living in poverty in the GVHP catchment area exceeds the same figure for New York State by 300.

Median Household Income \$42,066	<\$10,000 = 7%	\$10,000 to \$14,999 = 7%	\$15,000 to \$24,999 = 14%	\$25,000 to \$34,999 = 13%	\$35,000 to \$49,999 = 19%	\$50,000 to \$74,999 = 23%	\$75,000 to \$99,000 = 11%	>\$100,000 = 8%
Median Earnings	Male full time year round = \$36,599	Female full time year round = \$25,228						
Poverty Rates 2000 Census	Poverty rate for all persons = 10.4%	Children in poverty = 16.1%	Families in poverty = 5.2%	Female household in poverty = 23.2%				
Employment (2000) based on 51,247 age 16 or greater	In labor force = 63%	Employed = 59.6%	Unemployed = 3.9%	Not in labor force = 36.5%	Females in labor force = 62.1%			
Class of Worker (2000) based on 30,550 age 16 or greater	Private = 73%	Government = 20%	Self-Employed = 7%	Unpaid Family = <1%				
Occupation (2000) based on 30,550 age 16 or greater	Management / Professional = 32%	Service = 16%	Sales/Office = 24%	Farming, fishing, forestry = 1%	Construction, maintenance = 10%	Production, transportation = 17%		

Housing:

Homeownership Rate (24,023 units)	Total = 74.5%	Single Unit = 70.5%	Multi-units = 17.9%	Mobile Homes = 11.5%	
Vehicles Available	None = 6%	One = 31%	Two = 44%	Three or more = 19%	
Housing Condition Indicators	Lacking complete plumbing = 0.3% (n=76)	Lacking complete kitchen = 0.4% (n=80)	No telephone service = 1.1% (n=234)		
Heating Source (24,023 units)	Utility Gas = 47%	Bottled gas = 13%	Electricity = 13%	Fuel Oil / kerosene = 21%	Wood = 5%

Strengths: Relatively high levels: (1.) Education (2.) Homeownership (3.) Employment [broad distribution of employment (4.) Median family income (5.) Breadth of occupations (6.) Adequate housing

Opportunities: Relatively high rates of (1.) Population living in poverty (2.) Children living in poverty

Trends to Watch: (1.) Decline in free lunch participation (2.) Decline in food stamp applications (3.) Number of grandparents involved as children's care givers.

Indicator #2. Maternal Child Health

Data sources for Maternal Child Health include (1.) Finger Lakes Perinatal Data System. (2.) NYS Department of Health. (3.) Livingston County Health Department.

When the data was analyzed, the committee responsible for the community health assessment focused on the following data elements.

- Maternity
- Early prenatal care
- Late/no prenatal care
- Satisfaction with care
- Gestational age <37 weeks
- Low birthweight

Infant Mortality:

Data was examined to determine rates of (1.) Infant deaths (2.) Neonatal deaths (3.) Postneonatal deaths (4.) Spontaneous fetal deaths.

The charts available for review and comparison of data include: (1.) Rates per 1,000 (except spontaneous fetal deaths) for Livingston County Perinatal Health (2.) NYS Department of Health, County Health Indicator Profiles – Number of Infant and Fetal Deaths for Livingston County, 1995-1999. (3.) Rates per 1,000 except spontaneous fetal deaths[rates per 100,000] – Perinatal Health for Livingston and Genesee Counties. The information contained in the charts includes a caution that care should be exercised with data change interpretation due to the low numbers and variability of the data. It may be fair to suggest that the data supports no conclusions due to the high variability and low overall numbers during the five year period 1995 – 1999.

Pregnancies and Prenatal Care:

Data examined included: (1.) Number of pregnancies and births for Livingston County 1995 through 1999. (2.) First trimester entry into prenatal care. (3.) Pregnancies per 1,000 population and births per 1,000 population in Livingston County from 1995 to 1999. (4.) Late or no entry into prenatal care tracked by (n) and (%).

There has been virtually no change in the number of pregnancies and births from 1995 through 1999 in Livingston County. First trimester entry into prenatal care was relatively steady between 82% and 86% from 1995 to 1999. Late or no entry into prenatal care is calculated between 1% and 3% with adjustments for missing data.

Satisfaction with Prenatal Care:

Satisfaction with prenatal care was examined by reviewing data for (1.) Satisfaction with hours open (2.) Satisfaction with the time to get first appointment (3.) Satisfaction with the time of wait after arrival. (4.) Satisfaction with time spent by MD.

In general, women in Livingston County are more satisfied than women in Genesee County with the time to get their first appointment, but women in Livingston County are less satisfied than women in Genesee County with the hours open. Women in Livingston County are generally more satisfied with wait time after arrival than women in Genesee County, but less satisfied with the time spent by the MD.

Birthweight and Medical Risk:

Medical risk factors for pregnancies (births) include (1.) Drug/Alcohol use (2.) STD's (3.) Hypertension (4.) Smoking (5.) Prior preterm birth (6.) Diabetes (7.) Prior low birth weight birth. These indicators are tracked in the attached chart for 1999, 2000, and 2001 by the NYS Department of Health County Health Indicator Profiles for Livingston County. The percentage has risen from 30% in 1999 to 36% in 2001.

Pediatric Hospitalizations/Children with Special Needs:

Pediatric hospitalizations were tracked for Livingston County from 1995 to 1999. Rates per 10,000 were listed for ages 0-4 years. These rates were variable over the five year period ranging from 9.2 in 1998 to a high of 22.6 in 1997. No specific trend can be supported by this data.

The 1999 rate of 21 for Livingston County was then compared with Genesee County and New York State using data from NYS Department of Health. These differences for 1999 were more notable with a range from a low in Livingston County of 21 to a high for New York State of 81.6. The figure for Genesee County was still higher than Livingston County at 32.9.

The committee reviewed other measures, including rates of pediatric hospitalization (ages 0-4) in Livingston County from 1995 through 1999 specifically for (1.) Gastroenteritis (2.) Otitis Media (3.) Drug related (4.) Head injury. Once again the numbers are relatively small, but the data demonstrates a slight increase in otitis media and a decline in drug related and head injury.

The 1999 Livingston County pediatric hospitalization rates for gastroenteritis, otitis media, drug related and head injury were then compared with the same rates for Genesee County and New York State. As with the aggregate hospitalization rates, the rates in all four diagnoses were notably higher for New York State. Rates in 1999 for Genesee County were slightly higher for drug related hospitalizations.

Pediatric hospitalizations for Asthma were examined separately. Rates for Livingston County and Genesee County were reviewed for 1997, 1998 and 1999. Genesee County rates for the three years are higher than Livingston County. Livingston County rates show no significant shift up or down, but Genesee County rates appear to be trending down.

Pediatric Diagnoses:

The Committee examined percentages of children ages 6 to 10 with ADD/ADHD diagnoses for years 1998, 1999 and 2000 in Livingston and Genesee Counties. The incidence of ADD/ADHD diagnoses was relatively stable in Livingston County ranging from 7.0% to 8.5%. Although Genesee County rates were slightly lower for 1998 and 1999, the 7.1% rate for Livingston County in 2000 is slightly lower than Genesee County at 7.7% in 2000.

Opportunities: Opportunities (for action/intervention) identified by the committee include (1.) Rates of late entry or no prenatal care variable and/or unchanged. (2.) Increasing numbers of children identified with special health care needs. (3.) Number of births with at least one medical risk increasing.

Strengths: Strengths include (1.) High rates of entry into prenatal care. (2.) Rate of low birthweight births remains low. (3.) Preterm delivery rates declining. (4.) Satisfaction with care high and improving. (5.) Breastfeeding rates comparatively high. (6.) Low rates of pediatric hospitalizations.

Trends to Watch: (1.) Rates of ADHD diagnosis variable. (2.) Hospitalizations for pediatric asthma among those under age 5.

Indicator #3 Adolescent Health

Data sources for this research included: Finger Lakes Perinatal Data System; NYS Department of Health; Livingston County Health Department; and the Office of Alcohol and Substance Abuse.

Key data elements that were the focus of data collection for this Indicator included:

- Alcohol Abuse
- Drug Use
- Tobacco Use
- Youth Behavior
- Teen Pregnancy

Alcohol Abuse:

A survey of ninth graders in Livingston County asked whether the respondent (1.) Drank alcohol in the past 30 days. (2.) Got drunk using alcohol ever. (3.) Got drunk on alcohol in the past 30 days. (4.) Intend to get drunk in the next year. The data is recorded in two two-year columns, one for 1996-1997 and one for 2000-2001.

GVHP will examine the implication of a spike in the survey data that indicates a 16% increase in the number of ninth graders who said they were drunk on alcohol in the past 30 days from the 1996-1997 survey data to the 2000-2001 survey data. Declines were noted in the other three categories.

Two additional tables show a comparison of male to female ninth grade response to (1.) type of alcohol used. (2.) Ever been drunk. (3.) Been drunk in the past 30 days. Again, there appears to be a spike in the percentage of respondents who indicated they had been drunk in the past 30 days. There does not appear to be a significant difference between male and female use.

Drug Use:

Two tables show data that compares ninth grade male and female drug use in Livingston County by type of drug. The respondents identified use of marijuana, steroids, inhalants, cocaine and other illegal drugs. These tables also compare the 1996-1997 time frame with the 2000-2001 time frame. The 2000-2001 responses for females indicate a measurable decline in marijuana use. Steroid use is very small showing between 2% and 3% for male and female.

Relative rankings for ASA risk (composite scores) indicates an increased risk for alcohol use, but not drug use. Livingston County scores list 1990 and 1998. Genesee County scores are 1998 only. The data source is the New York State Office of Alcoholism and Substance Abuse Services. The Genesee County scores for drug and alcohol risk was notably higher than Livingston County.

Smoking:

The ninth grade survey information indicates a drop in tobacco use during the past five years, including one question about intention to use tobacco in the next year. 20% of the respondents indicated use in the past 30 days. 23% of the 2000-2001 respondents indicated intention to use tobacco in the next year, compared with 37% of the 1996-1997 respondents.

Females generally showed a slightly higher tobacco use than male respondents.

Youth Behavior:

ADD/ADHD diagnoses appear to be increasing in the 11-18 year age range in Livingston County from 5.8% in 1998 to 8.0% in 2000. [Preferred Care and BC/BS] Diagnoses appear to have remained relatively unchanged for the 6-10 year age range. Genesee County rates have leveled to about 5% in 2001.

Injury hospitalizations for youth age <18 have been consistently lower in Livingston County from 1997 to 1999. Genesee County numbers have dropped, however, from 345 in 1997 to 243 in 1999.

There has been a decline in youth violence/property arrests in Livingston County during the same period.

Teen Pregnancy:

There is no demonstrated change in pregnancy rates for women under age 19 in Livingston County. The number per 1,000 remains steady at about 30.

Opportunities: The Committee identifies the following “opportunities” for Adolescent Health. (1.) Alcohol risk behavior increasing. (2.) Reports of drug use unchanged. (3.) ADHD diagnoses increasing.

Strengths: Strengths for this Indicator include: (1.) Teen pregnancy continues at one of the lowest rates in the state. (2.) Female teens reported lower rates of smoking than in prior survey.

Trends to Watch: Selected aspects of smoking and alcohol use trending lower.

Indicator # 4. Infectious Disease

To review Infectious Disease as a Health Status Indicator, the following data elements were considered.

- Immunization Rates
- Communicable Diseases
- AIDS incidence and mortality

Data sources for data review included the NYS Department of Health and the Livingston County Health Department.

Immunization Rates:

Immunization completion rate in 2001-2002 for grades 1 – 3 in Livingston County was 95%, lower than 1995-1996. The rate is 98% for grades 4 – 11.

Communicable Diseases:

Frequencies of Giardia, Gonorrhea, Group B Strep and Syphilis were compared for years 1997 through 2001. Data interpretation is difficult due to low numbers. Giardia increased in 1999. Gonorrhea declined in 2001 following an increase from 1998.

Three-year rolling frequencies indicate a steady increase in all four diseases, noting that syphilis numbers are very small and appear to have leveled in 2001.

A cursory examination of the incidence of TB and Lyme Disease shows very low numbers for each. There have only been 5 cases of TB reported since 1995. Only 3 cases of Lyme disease have been reported since 1995. There have been no cases of measles reported.

AIDS incidence and mortality:

Cases of HIV/AIDS reported for 1995, 1996 and 1997 number 21, 23 and 22 respectively. No figures have yet been released for 1998 and 1999.

Strengths: Strengths for this indicator include: (1.) High rates of immunization among school age children, (2.) Number of HIV sero-positive newborns nearly zero.

Opportunities: The Committee identifies the following “opportunities” for Infectious Disease: Immunization rates among toddlers lower than rates among school age children.

Trends to Watch: (1.) STD rates trending higher. (2.) AIDS/HIV cases

Indicator #5. Social and Mental Health

Social and Mental Health was reviewed using the following data elements.

- Violence Data
 - School
 - Domestic Violence
 - Unintentional Injury
 - Homicide Suicide
- Adult Alcohol Use
- Adult Substance Use
- Mental Health diagnoses

Data sources for Social and Mental Health data review include: NYS Department of Health, NYS Office of Alcohol and Substance Abuse Services, and the Livingston County Health Department

School Based Violence:

One elementary school sample indicates that physical fighting has represented less than half of the incidents of interpersonal violence since 1997-1998. For this school, physical fighting represented a much higher percentage of interpersonal violence during the 1996-1997 year.

In a comparison of three “higher violence” schools during 1998-1999, the incidence of physical fighting was less than half of all reported interpersonal violence in all three schools. In general, the percentage of physical fighting has remained relatively steady at approximately 45%. For the three “higher violence” elementary schools in this comparison, reported incidents of interpersonal violence was still substantial, ranging from a low of 457 incidents to 1,372 incidents.

Pediatric Incidents:

Pediatric hospitalizations for injury from drug related incidents (measured as the rate per 1,000) shows a steady decline between 1995 and 1999.

Pediatric hospitalizations for head injuries (again measured as the rate per 1,000) declined sharply between 1995 and 1996 and have remained relatively steady since 1996 at about 4. Only very small changes in the data have been recorded during this period and the total numbers are small making data interpretation difficult.

Injury / Mortality:

Livingston County injury hospitalizations for ages 18-64 over a three year period (1997 – 1999) were compared with the same data for Genesee County. Livingston County numbers are consistently lower than Genesee County.

The rate of Unintentional Injury has been rising since 1997 in Livingston County. Suicide rates have also been steadily increasing during the past five years. Both the UI rates and the Suicide rates are higher than New York State. In 1999, the homicide, suicide, UI and motor vehicle rates were similar in Livingston County to Genesee County.

Adults and Alcohol:

A view of alcohol related motor vehicle accidents in 1999 shows higher rates per 100,000 in Genesee County than Livingston County, but both counties are higher than New York State rates. There appears to be a decline in DWI arrests, but there is a slight increase in the number of intoxicated adults in motor vehicles accidents.

Data from the NYS Office of Alcoholism and Substance Abuse Services indicates a notable decline in alcohol related hospital diagnoses in Livingston County from 1990 to 1998. There is a corresponding drop in OASAS treatment in Livingston County from 1990 to 1998. Livingston County has witnessed a slight increase in the rate of alcohol related probation cases for the same dates.

Smoking:

A quick look at smoking among adults shows 31.5% of adults in Livingston County smoke tobacco. This number is 28.3% for Genesee County.

Adults and Drugs:

One notable piece of data related to adults and drugs is that in Livingston County, there has been a decline in the number of drug related arrests and hospital drug diagnoses from 1990 to 1998. There is also a corresponding decline in OASAS treatment in Livingston County for the same period. These declines are similar to data recorded for adults and Alcohol.

Mental Health Diagnoses:

Genesee and Livingston County rates of female mental health diagnoses were compared in years 1998, 1999 and 2000. Livingston County rates are generally higher during the three years. When rates of mental health diagnoses among males were compared with rates among females, it can be noted that for 1998, 1999 and 2000, rates of mental health diagnoses among females not only increased but were consistently higher than the rates of mental health diagnoses among males. The same trends are apparent for older adults in Livingston County and Genesee County during the same period.

Domestic Violence:

Reported incidents of domestic violence in Livingston County increased steadily from 453 incidents in 1999 to 596 reported incidents in 2002. Domestic violence shelter hotline calls at the Chances and Changes shelter in Genesee have also increased between 1998 and 2002 with one dramatic spike in calls during 2000. The range is 886 hotline calls in 1998 to 1,456 hotline calls in 2000.

Interestingly, the number of clients who used the shelter for at least one overnight stay declined steadily from 1998 through 2002.

Strengths: Strengths for the Social and Mental Health indicator include (1.) Utilization of domestic violence services. (2.) Schools developing violence plans.

Opportunities: Opportunities cited by the committee include (1.) Adult alcohol use increasing. (2.) Domestic violence incidents increasing. (3.) Relatively high percent of adult smokers [approx. 30%]. (4.) Mental health diagnoses increasing among adult females. (5.) Suicides trending upward.

Trends to Watch: (1.) Changes in patterns of foster care use. (2.) Openings in preventive services. (3.) Variable trends in number of sex offences. (4.) School based violence data insufficient/inadequate for trend analysis. (5.) Rates of drug/chemical dependency diagnoses unchanged. (6.) declining rates of alcohol related diagnosis and treatment.

Indicator #6. Physical/Environmental Health

The Community Health Status Assessment Committee identified the following key data elements for data analysis.

- Lead Testing
- Water Supply and Test Results
- Food Service Inspections
- Town and Village Flouridation
- Rabies Reports
- West Nile Surveillance

For these six key data elements, the following data sources were accessed for analysis.

- Livingston County.

Lead Exposure:

A comparison of lead exposure testing in Livingston County between 1999 and 2001 shows a high of 731 in 1999 to a low of 652 tests in 2000. Exposure results for elevated lead levels are variable, but 1999 appears to be higher overall, especially in the highest exposure (20-44 mcg/dl). 1999 was the only year with positive results in the highest elevated level category.

Water Supply Contamination:

Since 2000, there have been 24 water contamination reports, 17 of which were municipal supplies and 7 private.

Food Service Inspection Results:

The number of hearings and stipulations from Food Service Inspections declined steadily since 1999. During 2000, there were 14 stipulations and 2 hearings in Livingston County.

Indoor Air:

Indoor air quality complaints numbered 10 in 2001 and 8 as of September 2002.

Water Flouridation:

As of February 2002, 6 of Livingston Counties 9 Towns now have fluoridated water systems. 8 of Livingston County's 18 Villages now have fluoridated water.

Rabies:

There has been a steady decline in the number of positive animals and the number of treated individuals from 1997 to 2001. The highest number of positive animals during this period was 23 in 1997. The lowest number of animals testing positive was 9 in 2001. The number of individuals receiving treatment declined from a high of 48 in 1997 to a low of 29 in 2001.

West Nile Virus:

In 2002, there were 11 positive bird reports, nine of which were crows.

Toxic Waste Sites:

There are three toxic waste sites in Livingston County. NYSEG owns a site in Dansville. Atrochem owns a site in Piffard (York). Lastly, the William Benson Landfill is located in Livonia.

Strengths: For this indicator, the Committee identified the following strengths. (Decline in food service related citations. (2.) Confirmed cases of lead exposure declining. (3.) Cases of animal rabies and exposed individuals declining.

Opportunities: Opportunities for this indicator include: (1.) Absence of fluoridation in over half of villages and some towns. (2.) Presence of three toxic waste sites.

Trends to Watch: West Nile Virus continues to be a concern.

Indicator #7. Health Status

Key data elements for the Health Status Indicator include:

- Morbidity and Mortality
 - Cardiovascular
 - Cancer
 - Cerebrovascular
 - Diabetes
 - Asthma
 - COPD

- Nutrition and Overweight

Data sources for Health Status include (1.) New York State Department of Health (2.) Livingston County Health Department.

Mortality data: Livingston County Mortality data for 1999 was analyzed. Rates for 14 separate categories are listed for per 100,000. Causes compared in this analysis include: (1) Heart Disease; (2) Lung Cancer separated by gender; (3) Cerebrovascular; (4) Breast Cancer; (5) Suicide; (6) Cervical Cancer; (7) Motor Vehicle; (8) non-motor vehicle; (9) Liver Cirrhosis; (10) Homicides and (11) AIDS

The highest mortality rate is Heart Disease at 178 per 100,000. Lung cancer ranks second at 83 per 100,000 population. Following Heart Disease, all forms of cancer constitute the largest category of mortality cause. All other causes show relatively small numbers

Cardiovascular Disease: Trends in Cardiovascular Disease as a leading cause of mortality are tracked from 1995 to 1999 in Livingston County. A small increase is noted in 1996 at 234 per 100,000 from 194 in 1995. The lowest number is 178 in 1999 marking a steady decline from 1996.

Hospitalization rates for Cardiovascular Disease are also tracked from 1997 to 1999 in both Genesee and Livingston Counties. Genesee County shows a consistently higher hospitalization rate for all age ranges during this period, although both a steady decline is noted for both counties during this period.

Cancer data:

A comparison of mortality rates in all forms of cancer notes very similar numbers for Livingston, Genesee and New York State during years 1992 to 1996 as compared with years 1994 to 1998. Rates appear relatively consistent for male and female populations. Male rates are consistently higher. The highest combined mortality rate was 223 for males in Genesee County between 1994 and 1998.

Incidence of Cancer was also analyzed for Livingston and Genesee Counties. Rates for both counties are also consistent with Statewide rates. These numbers show only a modest decline between 1992 and 1998 in Livingston County.

A small increase in **lung cancer** mortality among males in Livingston County was also noted between 1998 and 1999. Prior to 1999, a slight, but steady decline was noted.

Breast Cancer screening among un/under insured notes a steady decline between 1997 and 2001. Breast Cancer mortality rate in Livingston County doubled from 20 to 40 between 1998 and 1999.

Cerebrovascular:

Mortality rates for Cerebrovascular Disease in Livingston County between 1995 and 1999 show a slight, but steady, downward trend from 65 per 100,000 in 1995 to 48 per 100,000 in 1999.

Diabetes:

Diabetes rates per 10,000 population in Livingston and Genesee Counties between 1997 and 1999 show variability with a low in Livingston County of 7.7 in 1997 to a high of 15 in Genesee County in 1997. In general rates are consistently higher in Genesee County.

Asthma (hospitalization data):

Hospitalization data for Livingston and Genesee Counties between 1997 and 1999 show no significant trends. Rates per 10,000 range from 14 to 19.

COPD hospitalization data:

There was a slight decline in COPD hospitalization rates for those under 18 years of age between 1997 and 1999. There were no notable trends for other age groups during the same period.

Nutrition and Overweight:

Based on data from 1998 to 2000 from two area insurers, between 1% and 2% of Livingston County residents have an obesity diagnosis.

Obesity rates between 1998 and 2000 show a slight increase among males and females. The highest rate is the 2000 number among females at more than 3.5%.

Strengths: Strengths for this Health Status Indicator include: (1.) Mortality trends are improving. (2.) Cardiovascular mortality declining. (3.) Cerebrovascular mortality declining. (4.) Improved breast cancer screening [more women diagnosed]. (5.) Lung cancer deaths among women declining.

Opportunities: Opportunities identified from data include: (1.) Breast cancer deaths among women increasing. (2.) Lung cancer deaths among men increasing. (3.) Adult Asthma diagnoses increasing. (4.) Obesity rates increasing.

Trends to Watch: (1.) Inadequate data to assess dental health. (2.) Diabetes hospitalizations unchanged.

Indicator #8. Health and Social Resources

Key data elements for Health and Social Resources examination include:

- Emergency Services
- Hospital Beds
- Nursing Home Beds
- Health Plan Satisfaction
- Health Plan Performance
- Early Intervention Enrollment

Data was gathered from the following sources:

- NYS Health Accountability Foundation
- Finger Lakes Regional Trauma Center
- Emergency Medical Service providers
- Finger Lakes Health Systems Agency
- Livingston County Health Department
- New York State Health Department
- Office of Alcohol and Substance Abuse Services

Emergency Medical Services:

Emergency Medical Services response time is was analyzed in 19 Livingston County Towns and Villages. All Town response times were below target of 20 minutes. Response time in nine Villages exceeded cutoff time during the 1-9/02 study period.

Hospital Bed Use:

Bed use in local hospitals shows a notable decline between 1985 and 2000. Local hospitals listed include Noyes, St. James Mercy, Davenport, Soldiers and Sailors, and FF Thompson. All facilities show a decline.

Bed use by Livingston County residents in Monroe County hospitals, however, shows a clear increase during the past 20 years.

Nursing Home Bed Use:

Nursing Home use has declined during the past 15 years in Livingston County, while Adult Day Program use shows a steady increase in most locations throughout the central and southern NYS region, except Livingston County.

Children with Special Needs:

Active early intervention cases for Children with Special Needs in Livingston County have increased steadily between 1995 and 2001. In absolute numbers, cases have increase from a low in 1995 of 85 to a high of 198 in 2000. There is a corresponding increase in cost per Early Intervention Case during the same period.

Dental Services:

Dental services provided to children (Eastman Dental Center Satellite) between 1998 and 2001 shows a steady increase in enrollment during this period from 822 to 1,320. Enrollment for adults during the same period also increased from 238 to 310.

Access to Quality Health Care:

There appears to have been a very slight increase in prenatal care in the first trimester of pregnancy in Livingston County between 1995 and 1999 (by % of births). 1999 shows a high of 82.5%.

Total admissions for metabolic disorders (uncontrolled Diabetes Hospitalizations) remained relatively steady between 1998 and 2000, ranging from a low in 1999 of 22 to a high in 1998 of 37. It was noted that these admissions may reflect quality of care issues.

Satisfaction with Health Plan:

Two HMOs represent the majority of residents. Between 86% and 88% of residents rated their ability to get needed services high (8,9, or 10 on a scale of 10). Between 72 and 75% of respondents rated the quality of health plan high.

Between 12% and 13% of respondents indicated difficulty getting care.

In general, between 80% and 90% of respondents rated access to Preventive Services high.

Strengths: Strengths identified from data for Health and Social Resources include: (1.) Declining nursing home utilization with increasing intensity of case mix. (2.) High priority care provider ratio. (3.) Relatively high ratings of HMO provided health plans.

Opportunities: Opportunities include: (1.) Response time of emergency medical services inconsistent across county. (2.) Inadequate number of dental providers. (3.) Decreases in individuals receiving treatment at OASAS sites. (4.) Early intervention cases increasing in number and cost.

Trends to Watch: (1.) Increasing numbers of individuals receiving Medicaid. (2.) Hospital Bed utilization

B. LIVINGSTON COUNTY STUDY OF ACCESS TO HEALTH CARE AND INSURANCE COVERAGE

1. Overview

- *Community Partners:*
 - Genesee Valley Health Partnership
 - Blue Cross Blue Shield of the Rochester Area
 - Catholic Charities of Livingston County
 - Finger Lakes Health Systems Agency
 - Livingston County Health Department
 - Monroe Plan for Medical Care
 - Noyes Memorial Hospital
 - Preferred Care
 - Tri-County Family Medicine.
- *Goal:* To ensure that the people of Livingston County are continuously covered by affordable health insurance and able to access appropriate, affordable health care services when they are needed.
- *Objectives:*
 - To identify populations that are at high risk of not having health insurance and the primary factors contributing to not having health insurance.
 - To identify the populations that currently experience difficulty accessing affordable health care.
 - To evaluate the effectiveness of the current facilitated enrollment efforts of the Department of Health and Department of Social Services and identify opportunities to enhance and expand the program.
 - Determine a demographic and geographic profile of the uninsured/self-pay patients and identify trends and challenges in providing care to the uninsured population.
- *Report:*
 - The partnership will provide the GVHP with a list of recommendations and a framework for developing interventions that will reduce barriers to health insurance and access to affordable health care.

2. Activities

- *Focus Groups:*
 - Chances and Changes, Caseworkers. Nicole Sweeny, 4 Health Care Professionals
 - Catholic Charities Housing Support Group. Suzanne Bell, 1 Uninsured, 5 Publicly Insured

- Workforce Development, DSS Members. Keith Mitchell, 9 Publicly Insured
 - First Steps, Caseworkers. Gail Feathers, 4 Health Care Professionals
 - Workforce Development, Dislocated Workers Group. Keith Mitchell, 7 Uninsured
 - PEACE Parenting Support Group, Joni Nilsson, 1 Uninsured, 5 Publicly Insured, 2 Commercially Insured
 - WIC, Women’s Center, and Focus on the Children. Mary Margaret Stallone, 4 Publicly Insured
 - Home Health Aids. Bethany Wadsworth, 3 Uninsured
- *Individual Interviews*
 - Janice Page, Migrant Center; Health Care Professional
 - Sister Nancy O’Brien, Catholic Charities; Health Care Professional
 - Dee Bartholemew, Facilitated Enroller; Health Care Professional
 - Kaaren Smith, Office of the Aging; Health Care Professional
 - WIC clinic and Child Health Plus/Medicaid enrolled
 - Tri-County Family Medicine
 - Geneseo Summer Festival, Tri-County & Noyes Booth
 - Hemlock Fair, Tri-County & Noyes Booth
 - Youth Mentor Program families, Catholic Charities
 - *Employer Interviews*
 - 6 Large Employers
 - Small Employers
 - 2 Farms

3. Findings

A. Uninsured Participants

Demographics n= 21

- The majority of the uninsured participants were part-time or self-employed male, Caucasians between the ages of 18 to 30 years old.
- The uninsured participants were the only uninsured members of their household.
- All uninsured full-time employed participants worked in the service or construction job sectors and the majority of them worked for very small employers (less than five employee’s) and/or received under-the-table compensation.

Summary of Uninsured Participant Observations:

Barriers to Health Insurance Coverage – Examples/Scenarios

- Some young adults recently lost health insurance coverage from their parents’ policy.
- Some pregnant teens avoided seeking health insurance for the baby or loose Medicaid eligibility one year after baby is born (the baby will not be covered under the mother’s parent’s health insurance).

- Some employers that offer health insurance have low percent employer contribution, making the employees share unaffordable.
- Some young adults that are healthy believe it is less expensive to pay out of pocket for their healthcare than to buy health insurance.
- Purchasing health care insurance as an individual is financially prohibitive.

Access to Care

- Most uninsured participants had a primary care doctor, some of whom offered discounted fees to the uninsured.
- Many uninsured participants reported difficulty accessing a dental care provider accepting new uninsured patients.
- Few uninsured participants reported inappropriate use of the emergency department because of the high cost of care and long waiting time.
- The Women’s Health Center’s hours change often and the quality of care is perceived to be less than that of a private physician office visit.
- The Eastman Dental Clinic’s waiting list is long for new patients and adults must travel to Rochester for dental care.
- Mental Health access for uninsured participants very limited, except in hospitals.
- Few uninsured participants had any recent experience with optical care.
- Uninsured participants reported that there are not enough female OB/GYNs.
- Travel/transportation to providers (especially for the rural poor), waiting time for appointments, and in office hours are barriers to care.

Utilization of Health Care

- The majority of uninsured participants have not seen a primary care doctor, dentist or an OB/GYN in the last year.
- The majority of uninsured participants reported avoiding seeking/postponing health care until “very ill or had a lot of little ailments”, because of the cost and hassles associated with obtaining health care.
- Uninsured participants reported that they always sought health care for their children when they were ill.

B. Publicly Insured Participants

Demographics n= 26

- The majority of the publicly insured participants were young, female, Caucasian, and unemployed.
- The majority of the participants with children on Child Health Plus had employer-based health care insurance for themselves.
- Some publicly insured participants reported having uninsured household members, none of which were children.

Summary of Publicly Insured Participant Observations:

Public Health Insurance Administration

Enrollment/Eligibility

- Child Health Plus and Family Health Plus facilitated enrollment through the Department of Health (DOH) have one-on-one meetings with a Facilitated Enroller while Medicaid enrollment through the Department of Social Services (DSS) has group enrollment meetings. The majority of the publicly insured participants preferred the one-on-one meetings at the DOH.
- The DSS is open one evening per week for enrollment but the DOH is only open normal business hours.
- The facilitated enroller for Child Health Plus and Family Health Plus is hard to contact. When you call you usually get voice mail and your call is only returned during business hours. Also, appointment availability is limited to certain times and days of the week.
- Child Health Plus and Family Health Plus have less extensive benefits, but also less stigma than Medicaid.
- Child and Family Health Plus are administered by the DOH and Medicaid is administered by the DSS, making it confusing when one does not know which program they are eligible for.
- Individuals often lose public insurance coverage when they become employed, even if it is a low wage job.

Application

- Having one common application for all programs makes the application long and confusing, due to the numerous optional/group specific sections and small print.
- Publicly insured participants reported their application being rejected for inconsequential reasons (i.e. having variable income due to flexible number of hours/wk).
- When mailing documentation to the DOH and/or the DSS, some publicly insured participants reported their documents not being received by the Department. This has caused publicly insured participants to send documents by certified mail, which costs the participant extra money.

Renewal

- Renewal materials can be submitted for renewal one month prior to expiration, but the approval process takes three weeks, so if you need to send additional materials you experience a lapse in coverage due to the slow return of your paperwork.
- Many reports by publicly insured participants of at least a one-month lapse in coverage due to protocol and forms. Although Medicaid will pay retrospectively, health care is often delayed and/or prescriptions are not filled because of the large out of pocket expense of the medical care.
- A lapse in public health insurance (usually due to sending forms in late) requires a complete, new application.
- Moving is a hassle. It is hard to change residency from one county and start public insurance in another.

Medicaid Option Programs

- Few publicly insured participants knew which Medicaid Option plan they were members of.
- Publicly insured participants reported that it is a hassle to verify that their doctor participates in the Medicaid Option HMO they selected.
- It is unclear what health care is covered under the Option plan and what is under Medicaid (i.e. prescriptions).

Premiums

- Child Health Plus Part B billing for premiums is irregular and inconsistent. The bill arrives randomly within each month.

Outreach and Information

- More outreach of program and support services is needed in convenient, visible locations.
- Publicly insured participants commented that advertising Child Health Plus through employers to lower income employees would have been of great assistance to them.

Access to Care

- All publicly insured participants had a primary care physician.
- The only Hispanic speaking primary care physician in Livingston County that accepts Medicaid patients is located in Lakeville.
- The lack of convenient access to dental providers decreases care and increases out-of-pocket dental care when publicly insured individuals cannot obtain the dental care they need through their public insurance program.
- The Eastman Dental has a waiting list for new patients, long office waiting time, and some reported low quality care.
- Family Health Plus does not have dental coverage.
- The emergency department was not reported as a source of primary care for public insured participants.
- The Women's Health Center hours change daily and the quality of care is less than that of a private physician visit.
- Medicaid needs to accept Dual Diagnosis for Mental Health conditions (i.e. ADHD and Autism) in order to have more insurance covered specialty visits per year for patients with several health care needs.
- Mental Health new patients have to wait to get an appointment and often must travel to Rochester or Geneseo for specialty clinicians.
- Optical care requires travel to Rochester - the glasses covered are outdated, limited, and of poor quality.
- There are not enough female OB/GYNs.
- Some prescriptions are not covered by Medicaid and often the participant does not pick up the prescription until he or she arrives to pick up the prescription at the pharmacy. Also, each pharmacy varies slightly in what is covered (i.e. Medicaid Multivitamins, spacers for inhalers).

C. Commercially Insured

Demographics n=17

- All commercially insured participants were over age 30 and Caucasian. Two thirds of the participants were female and most were BCBS members.
- The majority of commercially insured participants worked full-time, were retired, or had a spouse that worked full-time.
- About half of the commercially insured participants had children on public health care insurance.

Summary of Commercially Insured Participant Observations:

Financing Health Care

- The majority of commercially insured participants reported that the cost of the insurance is taken directly from their paychecks and therefore the money is not missed.
- Many commercially insured participants reported having to pay the full premium if children and/or spouse were added to employer-based policy.

Access to Care

- Travel, time off work, long waits at the office, the cost of co-pay/deductible, & childcare all contributed to deter commercially insured participants from accessing health care.
- Reports of administrative hassles when changing insurance carriers between spouses or when changing to a different primary care physician.
- Most commercially insured participants had a primary care physician, although a few participants reported difficulty making well adult visit appointments with their physician.
- Most commercially plans do not include dental coverage and some employers with dental coverage lose it when they retire.
- AFLAC and other optional dental insurance plans have very few to no providers in Livingston County.
- Participants did not report the emergency department as a source of primary.
- Mental health clinicians have long waiting lists for new patient appointments and plans have strict limits on the number of allowed/covered visits per year.
- Commercial insurance provides less reimbursement for inpatient substance abuse treatment than public insurance does and it is hard to find inpatient treatment centers that will reduce the cost based on financial status.
- Optical care benefits have limited visits to as few as once every two years.
- There are not enough female OB/GYNs.
- The majority of commercially insured participants had seen a dentist and a primary care physician in the past year.

D. Unpaid Self-Pay Utilization

Noyes ER and Tri-County Family Medicine have collected data sets on the uninsured/self pay population in yr 2001. The following includes those listed as uninsured/self pay in 2001 and still have unpaid claims. Each record represents an individual - there are no duplications.

Noyes: Fields: zip code, gender, age, ICD-9 code, and primary care physician listed.

Overall	Under 19
1874 unpaid self-pay patients with claims	339/1874 < 19 years old = 18.1%
Average age = 32.88 yrs	Average age = 9.16 yrs
About ¾ had a PCP listed	About ¾ had a PCP listed

Tri County: Fields: zip code, gender, age, frequency of visits, and amount owed.

Overall	65/310 <19 year old = 21.0%
310 unpaid self-pay patients with claims	Average age = 8.31 yrs
Average age = 26.57 yrs	Average visits/yr 2001 = 1.91
\$35,232 in unpaid self-pay claims = \$113.65 each on average	\$7,472 in unpaid self-pay claims <19 yrs = 21.0% of total and \$115 per individual
Under 19	

Other Quantitative Studies:

Monroe County 2000: 10% Uninsured with significant disparities

Seneca County 2000: 21% Uninsured

Yates County 1999: 12% Uninsured

E. Employers

LARGE EMPLOYER QUALITATIVE DATA						
	1	2	3	4	5	6
<i>Offer Insurance</i>	Y	Y	Y	Y	Y	Y
<i># of FT Employees</i>	180	160	50-150, seasonal	300	180	500
<i>Zip Code</i>	14414	14454	14481	14414	14510	14414
<i>Job Sector</i>	Manufacturing	Chemical Manufacturing	Agricultural	Decline	Mining	Canning
<i>Employer Contribution (FT)</i>	70%	Decline	75%	Approx. 50%	80%	Decline
<i>Self-Insured</i>	N	N	Y	N	N	N
<i>Type/plan</i>	BCBS	BCBS	Catastrophic coverage, high deductible	BCBS, FLHP, Preferred care	BCBS	Decline
<i>Plan choices/options</i>	5, most on Blue Choice Select	Many	1	6	6, most on Blue Choice Select	Decline
<i>Employee uptake</i>	75%	Unknown	20%	75%	90%	Decline
<i>Employee family uptake (of 'ees w/ families)</i>	50%	Unknown	Approx. 0%	75%	High	Decline
<i>Why Offered</i>	Family oriented business, - important for employees, - creates healthier employees which H4helps the company, - necessary to recruit/retain, - unionization, - employees expect it in benefit package, - right thing to do					
<i>Security of coverage</i>	Security in having health insurance, but many companies concerned over the increase of premiums, - Insurance company may change which could cause employees to have to change providers, - employer contribution may decrease, - the number of plans offered may decrease to funnel employees into cheaper plans, - cost to employer likely to increase and cuts must come somewhere to make the bottom line.					
SMALL EMPLOYER QUALITATIVE DATA						
	1	2	3	4	5	
<i>Offer Insurance</i>	Y	Y	Y	Y	Y	
<i># of FT Employees</i>	8	8	11	7	5	
<i>Zip Code</i>	14592	14437	14437	14423	14414	
<i>Job Sector</i>	Dairy Farming	Dairy Farming	Manufacturing	Agricultural	Manufacturing	
<i>Employer Contribution (FT)</i>	Varies by length of service	0%	0% first year, \$160 after 1 year	80%	50%	
<i>Self-Insured</i>	N	N	N	N	N	
<i>Type/plan</i>	BCBS	BCBS	BCBS & other Chamber plans	BCBS	BCBS	
<i>Plan choices/options</i>	1, no dental	1	Yes	1, Blue Choice Select	1	
<i>Employee uptake</i>	100%	20%, others through spouse	Approx. 50%	100%	40% (note that 40% of 'ees uninsured)	
<i>Employee family uptake (of 'ees w/ families)</i>	Unknown	NA	High	Low	0%	
<i>Why Offered</i>	Valuable, - employees expect it, especially new employees, - increases retention and helps recruitment, - important, primary benefit, -increases health of employees, -increase employee attendance, -worth equivalent of \$3 hour for an employee					
<i>Security of coverage</i>	Recent trends in many small employers have been a decrease in employer contribution and this could continue if healthcare costs continue to increase premiums dramatically each year, - most small employers believe that health insurance is a critical benefit and were confident that they will offer health insurance in the future,					
<i>Other Information</i>	Small employers had a far greater proportion of male employees than female while the large employers had both males and females, - Keep employees part-time until they can afford to offer them health insurance,					

C. LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

“If you can’t measure something, you can’t understand it; if you can’t understand it, you can’t control it; if you can’t control it, you can’t improve it.”

◦ from *The Improvement Process* by H.J. Harrington

1. Background:

The National Public Health Performance Standards Program (NPHPSP) is a partnership initiative established at the Centers for Disease Control and Prevention in 1998 to improve the practice of public health, the performance of public health systems, and the infrastructure supporting public health actions. Performance and capacity standards, using the Ten Essential Services for Public Health, were developed. These national standards represent an optimal level of performance and capacity that need to exist to deliver the essential public health services within a public health system

The Local Public Health System (LPHS) can be defined as all the organizations, agencies, entities within the community, that contribute to the health of the public through the delivery of essential public health services. These public, private, and voluntary entities have differing roles, relationships, interactions with its system partners and the populations served. Each contributes to the health and well being of the residents.

The Genesee Valley Health Partnership undertook the assessment of the Local Public Health System in the spring of 2001. Most Partnership members participated in the three meetings, which entailed a comprehensive analysis and assessment of Livingston County’s local health system. The purpose of the system assessment was to identify how organizations and institutions contribute to the delivery of public health services, to understand the existing infrastructure, and to identify potential gaps or challenges in different areas.

Utilizing the National Public Health Performance Standards (NPHPS), based upon the Ten Essential Services (listed below), the Partnership “assessed” the local public health system. During the assessment process, partners realized that there were many programs and services being carried out through out the community, however, not everyone knew what was available, how to access services, or how to coordinate with each other. These discussions proved to be most helpful, resulting in enhanced communications, bridging gaps, and promoting programs sponsored by other agencies.

2. The Essential Public Health Services

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.

4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

3. Summary of findings:

The NPHPS Assessment completed in New York State compared each County with the New York State average. There are three caveats which must be kept in mind when reviewing the results:

The assessment process was completed in three meetings over two months, due to a NYS imposed time frame. Given adequate time for the assessment (six to eight months), there would have been additional opportunity for discussion and clarification, and additional partners may have participated.

The standards were still in draft form; there were ambiguities that caused confusion as to how to answer the question.

It was sometimes difficult to answer the questions for the “system” rather than an individual agency. The consensus was, if the partners didn’t know, then the system didn’t meet the standard. Consequently, there are many activities taking place, which may fully meet the standard, but the system as a whole did not.

- In 8 of the 10 Essential Services, the local public health system met the standard by more than 50%;
- In 5 of the 10 Essential Services, the local public health systems exceed the State average.
- The local public health system fully met and substantially met 59.06 % of the standards.
- The local public health system partially met 25.81 % of the model standards.

A. The local public health system excelled in the following Essential Services:

- 2. Diagnose and investigate health problems and health hazards in the community.
- 5. Develop policies and plans that support individual and community health efforts.
- 6. Enforce laws and regulations that protect health and ensure safety.
- 7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- 10. Research for new insights and innovative solutions to health problems.

B. The local public health system did well in the following Essential Services:

- 4. Mobilize community partnerships to identify and solve health issues.
- 8. Assure a competent public health and personal health care workforce.
- 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
-

C. The two areas identified in the assessment that hold opportunities for improvement are:

- 1. Monitor health status to identify community health problems.
- 3. Inform, educate, and empower people about health issues.

D. The following Indicator/Model Standards have been identified as providing opportunities

to advance the local public health system, improve the delivery of services, and enhance communications among and between partner agencies.

<u>Essential Service</u>	<u>Indicator/Model Standard Partially Met</u>	<u>Indicator/Model Standard Not Met</u>
1. Monitor Health	Population based Community Access to and Utilization of Health Profile	Current Technology
3. Inform, Educate, and Empower People	Health Promotion Activities to Facilitate Health Living	Health Education
4. Mobilize Community Partnerships	Constituency Development	
5. Develop Policies and Plans	Governmental Presence at the local level	Public Health Policy Development
7. Link people to Needed Personal Health Services	Assuring Linkage of People to Personal Health Services	
8. Assure a Competent Workforce	Public Health Leadership	Workforce Assessment Development
9. Evaluate Effectiveness, Accessibility and Quality		Evaluation of the Local Public Health System
10. Research		Capacity to initiate or participate in Research

FORCES OF CHANGE (MAPP) BRAINSTORMING SESSION

Environmental	<ul style="list-style-type: none"> • Medical Facilities • Agricultural Change • Renovation of County Jail excluding female prisoners • Threats and Emergency Preparedness • Protection versus production
Education	<ul style="list-style-type: none"> • Educational Facilities • Workforce training and capacity • Crisis in educational quality/funding/opportunities affecting labor force
Economic	<ul style="list-style-type: none"> • Employment concerns • Loss of jobs due to Plant closings • Impact of 9/11 on Manufacturing Industry • Population Increase • Tourism • Transportation • Welfare Service Reform • Changes due to Welfare Reform • More single parent heads of households working • Increased disparity between well to do and pockets of poverty in Southern portion of County • Disappearance of the Middle Class • Young people leaving the county due to lack of job opportunities • Competitive Interest – Integration • Major Industry Employment Increases/Decreases • Workforce Issues impacting access to Services • Regulatory Reform / Stricter Standards • Capacity Demands • Increase in State mandates affecting economics of Local Government

	<ul style="list-style-type: none"> • Decrease in state budget timeliness • Digital Divide/Cost of Technology/Specialization
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Societal	<ul style="list-style-type: none"> • Increase in cultural diversity, impacting service delivery • Minority Increase from 3 to 6 percent • Demographic Changes • Demographic Shifts – Aging Patterns • Changing Face of Age • Redefinition of Age • Increase in Over 50 Population • Increase in Female Population Over 80 • Increase in Aging population • Increase in second careers due to longevity • Growth of Spanish speaking population • Lack of support services for the poor/aging • Social Welfare Reform • Increase of risk behaviors in youth • Increase in violent behavior • Repeated heroin use and other drugs • Increase in drug and alcohol use in youth • Drug and Substance Abuse • Lack of transitional housing for those leaving drug treatment • No transitional living for those recovering from drugs/alcohol • Violence/Drugs/Alcohol • Access to services e.g. healthcare, cultural, social • Work more nationally
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Health	<ul style="list-style-type: none"> • Impact of 9/11 on money available for public health • Health Industry • Continuing crisis in healthcare/physician recruitment • Increased burden of the seriously ill) • Healthcare Professionals Recruitment/Retention • Lack of dental services for low income people • Medicare/Medicaid Reimbursement Formulas • Asset Divestiture – Third Party Insurance • Malpractice Insurance Rates for Specialty MD’s • Health Insurance costs to employers, subscribers • Large employers becoming self-insured for health insurance • Cost of Health Insurance • Impact of Technology / Telemedicine • Pharmacological Advances • Disease Entities e.g. Increase in Communicable
Other	<ul style="list-style-type: none"> • CHP / Family Health Plus • SWAE Grant

