



Public Health

Prevent. Promote. Protect.

Cortland County Health Department

Department Plan: Community Health Assessment and Improvement Plan

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Approved by: Board of Health

Cortland County Community Health Assessment And Improvement Plan 2019-2024



Public Health

Prevent. Promote. Protect.

Cortland County Health Department

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Message from the Public Health Director

December 5, 2019

Dear Friends of Public Health,

It is my pleasure to present the Cortland County Community Health Assessment and Improvement Plan 2019-2024. The Community Health Assessment presents demographic and health indicator data for Cortland County residents while also examining determinants of health and existing assets and resources in the community. The Community Health Improvement Plan establishes long range priorities for health improvement and provides a road map to assure our community that we are committed to addressing these priority health challenges.

In today's ever-changing healthcare landscape, it is important to recognize the need for accountability, transparency, and flexibility throughout our efforts to improve the public's health. These values were present throughout the entire Community Health Assessment and Improvement Plan effort. Additionally, community engagement was a foundation for identifying health priorities for improvement.

This collaborative document was thoughtfully developed by the Cortland County Health Department in partnership with Guthrie Cortland Medical Center. Input was also received from numerous community partners including Seven Valleys Health Coalition, SUNY Cortland-Institute for Civic Engagement, United Way of Cortland County, Cortland County Area Agency on Aging, Family Health Network and Cortland Area Communities that Care. I would like to thank all who were involved in this collaborative effort.

Sincerely,



Catherine Feuerherm
Public Health Director
Cortland County Health Department

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Executive Summary

Overview

The Cortland County Community Health Assessment and Improvement Plan, 2019-2024 (CHA/CHIP) presents demographic and health indicator data for Cortland County residents and describes interventions to address these challenges. The CHA/CHIP is designed to ensure that local health priorities reflect the needs of the community and ensure accountability in addressing those needs.

The CHA/CHIP is framed around the 2019-2024 New York State Prevention Agenda which has identified an overarching goal of **Improved Health Status and Reduce Disparities** along five priority areas.¹

- Prevent Chronic Disease
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Well-Being and Prevent Mental and Substance Use Disorders
- Prevent Communicable Diseases

Steering Committee

The health assessment process and the identification of interventions for the improvement plan were guided by the Community Assessment Team (CAT). The group included representatives from Cortland County Health Department (CCHD), Guthrie Cortland Medical Center, Seven Valleys Health Coalition, SUNY Cortland Institute for Civic Engagement, and the United Way of Cortland County and Area Agency on Aging.

Community Health Assessment (CHA)

The CHA provides a comprehensive overview of health indicator data for residents of Cortland County using the prevention agenda framework described above. The assessment was created following a formal data collection and analysis process which included regular review of indicators with the Community Assessment Team (CAT). Whenever possible, comparisons were made to rates for New York State (NYS) excluding New York City (NYC) as well as to Prevention Agenda objectives.

¹ New York State Department of Health. https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

In addition to the data review process, the CCHD and the CAT conducted a community engagement effort reaching over 1,560 County residents. A Community Engagement Survey was designed and distributed to reach all County residents, and focus groups were conducted to reach populations at higher risk for poor health outcomes.

Priorities for 2019-2024 Cycle

Priority areas that had been the focus for Cortland County since 2014 included both: *Prevent Chronic Disease and Promote Healthy Women, Infants and Children*, with the addition of *Promote Mental Health and Prevent Substance Abuse* in 2016. In November 2019, the Community Assessment Team (CAT) reaffirmed that two of these priority areas will be the focus for 2019-2024. These include *Prevent Chronic Disease* and *Promote Well-Being and Prevent Mental and Substance Use Disorders* (the name of this priority was changed for the new prevention agenda cycle).

Community Health Improvement Plan (CHIP)

The CHIP identifies several interventions that were selected to address health issues within the priority areas of *Prevent Chronic Disease* and *Promote Well-Being and Prevent Mental and Substance Use Disorders*. These interventions were selected based on their potential for broad impact and considerations made for the strengths and capacity of the CCHD and partners. The CHIP outlines activities, process measures, and partner agencies for each identified goal.

Within the priority area of *Prevent Chronic Disease*, focus areas include:

- Healthy Eating and Food Security
- Physical Activity
- Tobacco Prevention
- Preventative Care and Management

Within the priority area of *Prevent Chronic Disease*, interventions/activities/strategies include but are not limited to:

- Assist schools in creating policies around wellness including nutrition and physical activity
- Physicians and care coordinators use the My Plate Education program for patients aged 5 and older.
- Providers provide nutritional counseling and education during appointments to patients with BMI concerns
- Provide standardized education to primary care providers regarding ways to treat and

counsel overweight and obese patients

- Implementation of the Farm to School Program through the NYSDEC
- Participate in the Child and Adult Care Food Program (CACFP)
- Care Coordinators provide referrals for patients with limited access to healthy food or that may have food security concerns (Catholic Charities, Food Pantries, SNAP, Food Sense, etc.)
- Through the Food Policy Council, establish and implement the Food Rescue Network
- Implement the Injury Prevention and Traffic Safety Program
- Use I Am Moving, I Am Learning curriculum in all CAPCO Headstart classrooms
- Pursue policy action to reduce impact of tobacco/e-cigarettes marketing in lower-income and racial/ethnic minority communities
- Educate and communicate with elected officials about the impact of retail tobacco/e-cigarette product marketing on youth
- Present point of sale information and educate on the dangers of tobacco/e-cigarettes to youth in the community
- Use media and health communications to highlight the dangers of tobacco and promote effective tobacco/ e-cigarette control
- Increase public awareness about lung cancer including preventative measures
- Promote the importance of lung cancer screening and treatment
- Promote the health and wellness of employees, patients, and communities through tobacco cessation
- Provide Mobile Mammography van for those with and without health insurance
- Expand the role of public and Private employers in obesity prevention

Within the priority area of ***Prevent Chronic Disease***, health disparities include:

- Low Income Adults-Adults with an annual household income of < \$25,000
- Low Income Children
- Low Income Families
- Mental Health-Adults who report frequent mental distress

Within the priority area of ***Prevent Chronic Disease***, process measures include but are not limited to:

- # of patient population identified with BMI risk factor
- # of patients with BMI risk factor provided with nutrition education
- # of children provided with My Plate Education
- # of Primary Care Providers Trained in Obesity Prevention
- # of schools presented to about the Farm to School Program
- # of meetings held with school districts to educate and advocate for creating policies

around wellness, nutrition and physical activity

- # of school districts that established policies around wellness, nutrition and physical activity
- # of CAPCO Headstart classrooms with box gardens
- # of meetings held with public and private employers about the National Diabetes Prevention Program (NDPP)
- # of meetings held with public/private employers about creating nutritional standard policies for worksites
- # of bicycle safety presentations held
- # of helmets fitted and provided
- # of meetings held to educate Elected officials on the impact of tobacco/e-cigarette marketing on youth
- # of meetings held to educate and advocate for creation of policies to reduce tobacco marketing
- # of high-risk patients receiving appropriate lung cancer screenings
- # of cessation informational meetings and correspondence with major employers in Cortland County
- # of tobacco-free policies implemented
- # of people screened for breast cancer
- # of people screened for cervical cancer
- # of people screened for colorectal cancer
- # of classes held about the National Diabetes Prevention Program (NDPP)
- # of referrals made to FHN patients (by care coordinators) to the Chronic Disease Self-Management Program

Within the priority areas of ***Promote Well-Being and Prevent Mental and Substance Use Disorders***, focus areas include:

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

Within the priority areas of ***Promote Well-Being and Prevent Mental and Substance Use Disorders***, interventions/activities/strategies include but are not limited to:

- Use Patient Health Questionnaire-9 (PHQ-9) to evaluate depression
- Expand telemedicine programs and specialties to include telepsychiatry
- Promote community awareness of behavioral health and mental health care needs
- Encourage, develop and/or enhance community treatment resources to more immediately respond to urgent treatment needs with the appropriate level of care
- Promote and support community prevention efforts and education regarding: drug and

alcohol use signs and symptoms, the dangers of drugs and alcohol for individuals and available community treatment and recovery services for children, youth, parents, physicians and pharmacies

- Develop and implement a social marketing campaign targeting 11th and 12th grade students in Cortland County addressing risks and consequences associated with binge drinking Intervention
- Develop and implement a social norming campaign targeting 9-20 year olds in Cortland County utilizing available data on usage rates and perception of use from the New York Youth Development Survey. Intervention
- Implement Too Good for Drugs Programming in each of the four rural school districts. Intervention
- Provide training and implementation of Alcohol Screening and Brief Intervention for youth
- Continue drug disposal and events promoting safe drug disposal using safe disposal units MedSafe® drug disposal units are installed for use at multiple Guthrie hospitals
- Inform and educate community members on the appropriate response to opioid and/or heroin overdose and increase the availability of Narcan
- Promote access to Substance Use Disorder (SUD) services and supports for Cortland County residents
- Provide provider education for opiate prescribing and management.
- Develop the capacity to recognize and respond more immediately with behavioral health assessment and supports to address the urgent needs of all the citizens of Cortland County
- Develop and support services able to respond in the community and/or provide access to immediate services and supports to stabilize behavioral health crises
- Implementation of NYSED Mental Health Education Literacy in Schools

Within the priority areas of ***Promote Well-Being and Prevent Mental and Substance Use Disorders***, health disparities include:

- Mental Health-Adults who report frequent mental distress
- Mental Health-Adults 65 and over that report frequent mental distress
- Low Income Adults-Adults with incomes less than \$15,000
- Mental Health-Youth who felt sad or hopeless
- Mental Health-Adults aged 18 or older with past-year prevalence of major depressive episodes
- Mental Health-Adolescents aged 12-17 with past-year prevalence of major depressive episodes

Within the priority areas of *Promote Well-Being and Prevent Mental and Substance Use Disorders*, process measures include but are not limited to:

- # number of people assessed by the PHQ-9 tool
- # of patients that use telepsychiatry services
- # of COTI programs available in the community
- # of participants utilizing the COTI program
- # of referrals made to the Angel Program
- # of participants utilizing the Angel program
- # of social marketing campaigns designed (binge drinking, parents)
- # of Social norming campaign designed
- # of trainings on Alcohol Screening and Brief Intervention (ASBI)
- # of 11th and 12th grade students reached via social media channels
- # of students reached through messaging in school and social media
- # of parents reached through outreach activities (ex. quarterly mailings)
- # of students receiving prevention programming
- # screened through ASBI
- # of times in which the MedSafe drug disposal units are emptied
- # of Narcan trainings provided to organizations
- # of participants provided Narcan Training
- # of Narcan Kits distributed
- # of pounds of prescription and over-the-counter drugs recovered from the Drug Take Back events and the kiosks throughout the county
- # of peer recovery coaches, mentors and advocated (youth and adults)
- # of participants using peer services
- # of participants @ the Emotionally Disturbed Person Response Team (EDPRT) trainings
- # of students instructed by the NYSED Mental Health Education Literacy curriculum
- # of crisis and information lines available
- # of people that utilize the crisis and information line

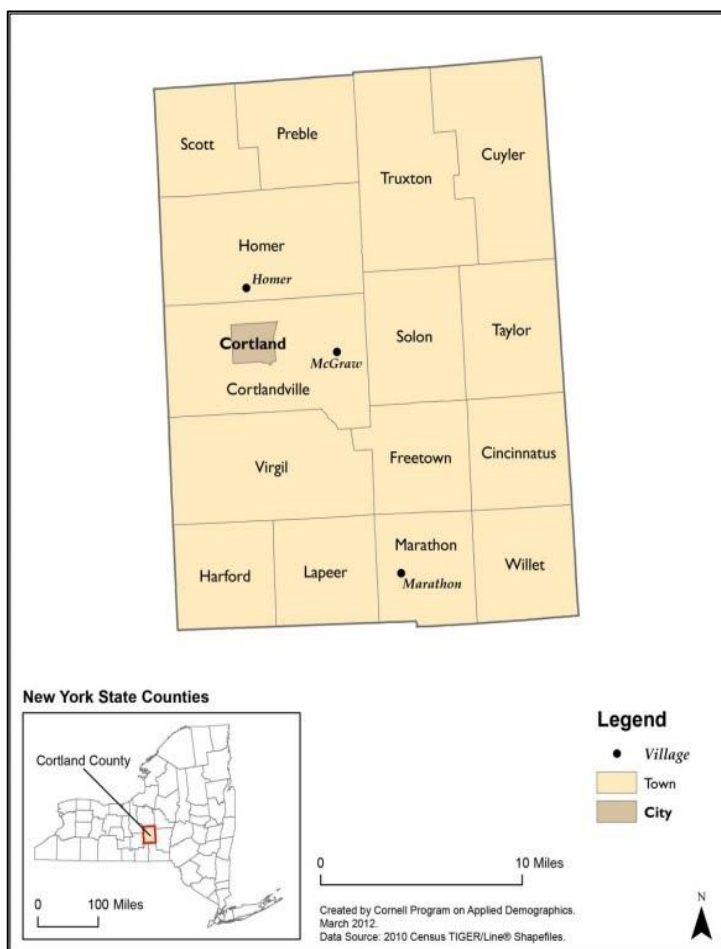
Each agency in the **Community Assessment Team (CAT)** has a role in the implementation of interventions, whether as the lead on an activity or a supporting partner. Many other community organizations, agencies and local businesses are actively involved in the CHIP activities, including but not limited to, CAPCO Headstart, WIC, Cortland County Mental Health Department, CACTC, Cortland Prevention Resources, Catholic Charities, Cortland City School District, Cortland City Youth Bureau, Cortland County Wellness Team, City of Cortland Common Council, Traffic Safety Board, Cortland Free Library, Homer Central School District, Village of Homer, St. Joseph's Hospital, Cortland County Youth Bureau, Family Health Network, Child Development Council, Mothers' and Babies Perinatal network, La Leche League, Trinity Valley, Cavity Free Cortland, Cortland County Jail, Cortland County Sheriff's

Department, Cortland Police Department, Village of Homer Police Department, SUNY Cortland Police Department, Family Counseling Services, TC3, SUNY Cortland, Care Compass Network, Dr. Mayo, Renaissance OB/GYN, Dr. Oh, Dr. Djafari Pediatrics, Dr. Clifford and many community members.

COMMUNITY HEALTH ASSESSMENT

Geographic Profile

A county’s geography and location can significantly impact the lives of its residents and affect many factors including climate and access to resources like jobs and transportation. This section explores Cortland County’s location within New York State (NYS), population density, and geographic composition. Unless otherwise noted, data in this section are from the U.S. Census Bureau, 2010 and U.S. Census Bureau American Community Survey, 2013-2017.



Cortland County has a total of 501.5 square miles of which 498.8 square miles are land and 2.8 square miles are water. The county is located in central New York State. The current population is estimated to be 47,823. Cortland County is comprised of many forests and agricultural lands, resulting in a population density of 99 persons/square mile. (Figure 1)

The County seat is in the City of Cortland, where nearly 39% of the County residents reside. In addition to the City of Cortland, there are 15 towns, and 3 villages.

Other towns within the County where high populations reside are Cortlandville with 17%, Homer with 13% and Virgil with 5%.

Figure 1: Cortland County and New York State Map

Source: <https://sites.google.com/a/steny.org/southern-tier-east-regional-planning-development-board/member-communities/cortland-county>

Population Characteristics

The demographic and socioeconomic characteristics of a population can have a significant impact on health behaviors, health care access, and utilization of health services. These factors in turn can influence health outcomes on a population level. Demographics in this section include: age, gender, race, and ethnicity. Socioeconomic characteristics covered include: poverty, education, employment, housing and transportation. Unless otherwise noted, data in this section are from the U.S. Census Bureau, 2010 and U.S. Census Bureau American Community Survey, 2013-2017.

Age and Gender

In Cortland County, the median age is 36.2 years, which is slightly lower than the NYS and CNY median ages (Figure 2). Over 80% of the County population is 18 years and older. The age ranges of 45-54 and 20-29 account for the highest percentages of the population at 12.9% and 18%, respectively. There are 2,444 children under the age of 5, which represents 5.1% of the population. In addition, there are approximately 4,359 persons aged 65-74, accounting for 9% of the total population.

Women comprise 51.5% of the population of Cortland County. Women of childbearing age (generally 15-44 years) have specific health needs and health risks. There are approximately 10,802 women in this category. Men account for 48.5 % of the population of Cortland County.

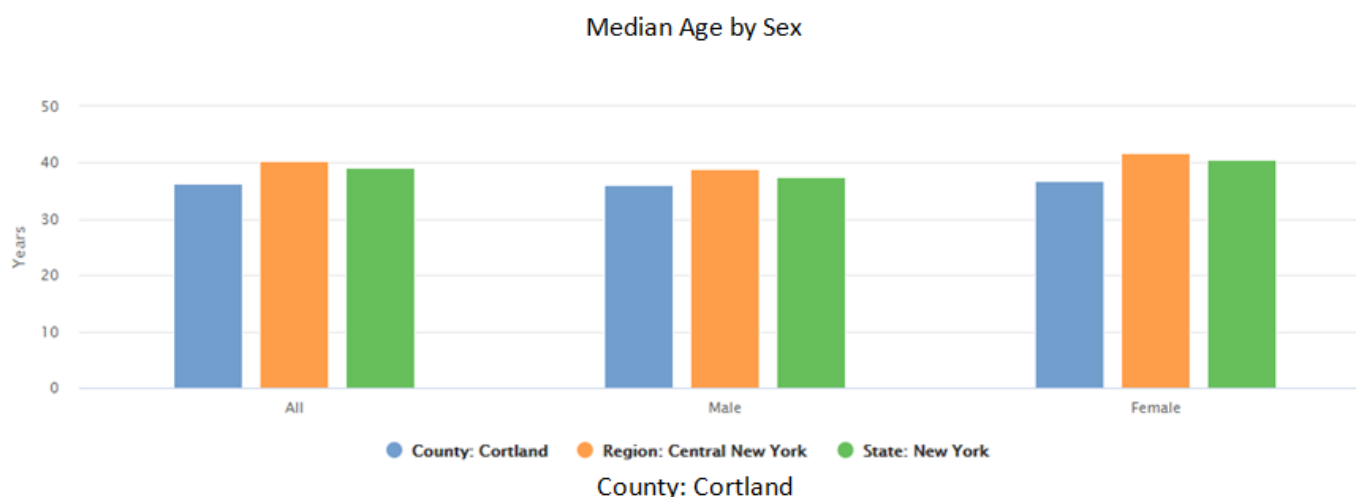


Figure 2: Cortland County Median Age by Sex Compared to NYS and Central New York

Data Source: <http://www.healthcny.org/demographicdata?id=132865§ionId=942>

Race and Ethnicity

Among Cortland County residents, 98% identified as being one race. Of these, 94.7% self-identified as white and 1.8% as Black/African American. The County population also consists of those that self-identify as Asian with 0.8% and American Indian/Alaska Native with 0.2%. Figure 3 exhibits distribution of races in Cortland County. Approximately 1,266 County residents of all races (2.6%) report Hispanic or Latino ethnicity.

98% of the population was born in the United States, with 2% being foreign born. 96.9% of residents only speak English at home, with the remaining 3.1% speaking a language other than English.

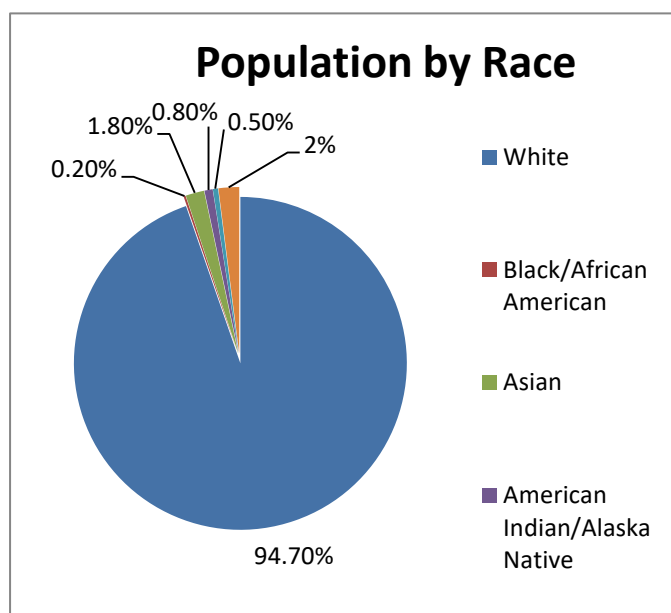
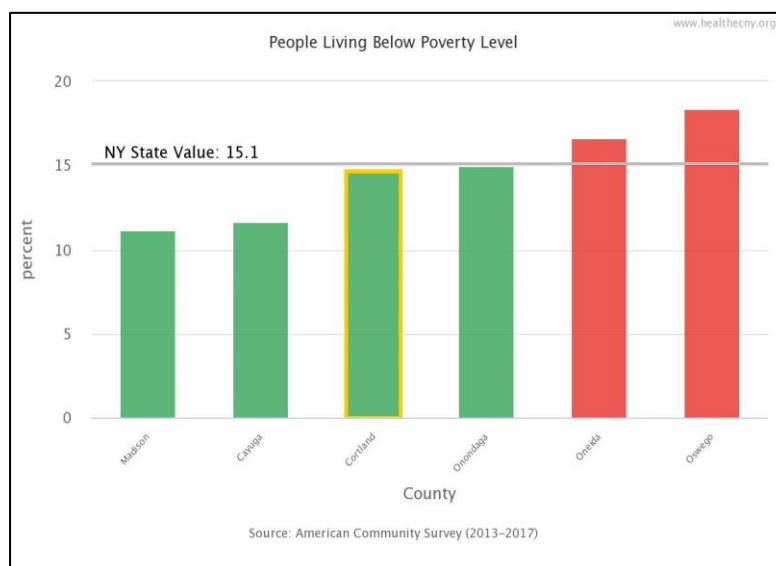


Figure 3: Distribution of population by race in Cortland County

Data Source: American Community Survey 2013-2017

Poverty

Poverty is a significant contributor to poor health outcomes. The median household income for Cortland County is \$52,451 and the estimated per capita income is \$26,271. The percentage of all Cortland County residents with incomes below the Federal Poverty Level (FPL) was reported to be 14.7%; this is slightly lower than both the statewide percentage of 15.1% and the nearby CNY counties of Onondaga, Oneida, and Oswego (Figure 4).

Figure 4: Percentage of People Living Below the FPL by CNY County and NYS

Source: <http://www.healthcny.org/indicators/index/view?indicatorId=347&localeId=1891&comparisonId=7195>

Cortland County families with children under the age of five or children between the ages of 5 and 17 have a poverty rate of 21.9%; this is currently lower than the NYS rate of 26.9%. The percentage of children and youth (birth-17) who are below the FPL is 20.1%, with approximately 23.4% of children and youth ages birth-17 years old receiving Supplemental Nutrition Assistance Program (SNAP) benefits.² Single women with children under the age of five and between the ages of five and seventeen have the highest rates of poverty in the county at 59.4%, followed by 47% of single women with children under five.

In addition to children and families, seniors living in poverty warrant special attention. In Cortland County, 19.3 % of residents ages 65 years and older who receive Supplemental Security Income (SSI) and/or cash public assistance income live in poverty. Children under six and young adults 18-24 years old have significantly higher rates of poverty than other age groups in Cortland County (Figure 5).

² Kids' Well-being Indicators Clearinghouse. http://www.nyskwic.org/get_data/county_report_detail.cfm?countyID=36023

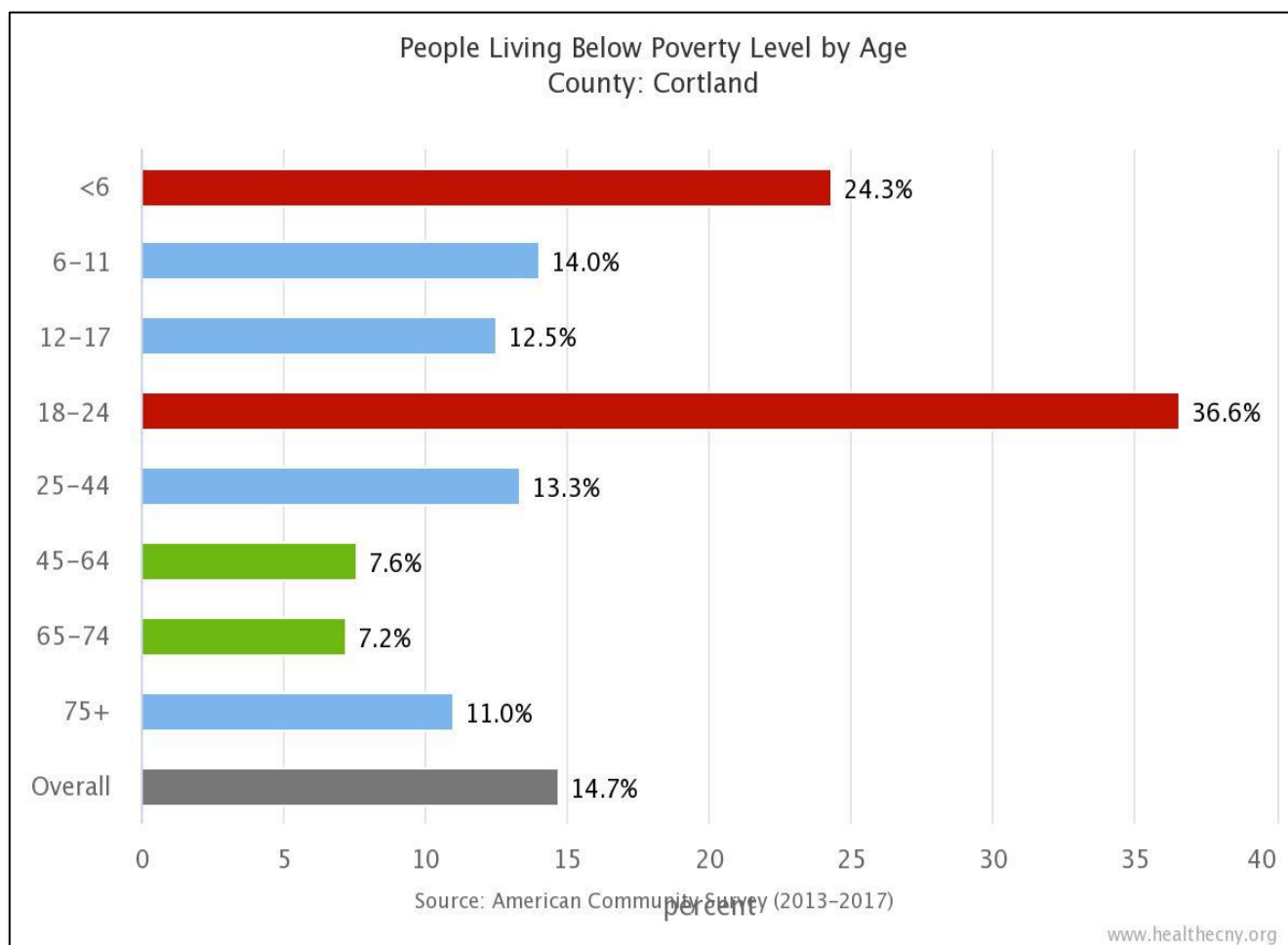


Figure 5: Percentage of Cortland County Residents Living Below the FPL by Age
 Source: <http://www.healthcny.org/indicators/index/view?indicatorId=347&localeId=1891&comparisonId=7195>

Education

Educational attainment is recognized as an important determinant of health. Early education is important for creating a foundation for learning in young children. Currently, only 43% of children (ages 3-4) in Cortland County participate in preschool programs. There are five public school districts in Cortland County with an enrollment of approximately 5,926 students.³ There are also five private schools within the County.⁴ Cortland County is also home to SUNY Cortland, for both undergraduate and graduate students totaled at 6,913 (2017-2018).³ The majority (90.4%) of Cortland County residents over the age of 25 have a high school diploma or higher, which is higher than the NYS value of 86.1% (Figure 6).

³ New York State Education Department. <https://data.nysed.gov/profile.php?county=11>

⁴ National Center for Education Statistics. https://nces.ed.gov/surveys/pss/privateschoolsearch/school_list.asp?Search=1&State=36&County=Cortland&NumOfStudentsRange=more&IncGrade=-1&LoGrade=-1&HiGrade=-1&ID=00940656

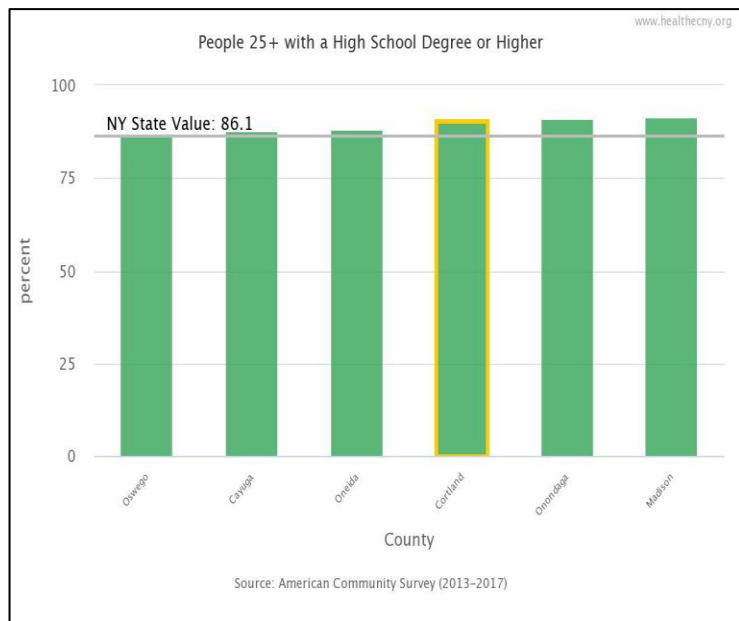


Figure 6: Percentage of People Aged 25 and over with a High School Diploma or Higher by CNY County

Source:
<http://www.healthcny.org/indicators/index/view?indicatorId=341&localeType=2>

However, only 26% of residents have attained a bachelor’s degree or higher, compared to 35.3% of NYS residents as a whole (Figure 7).

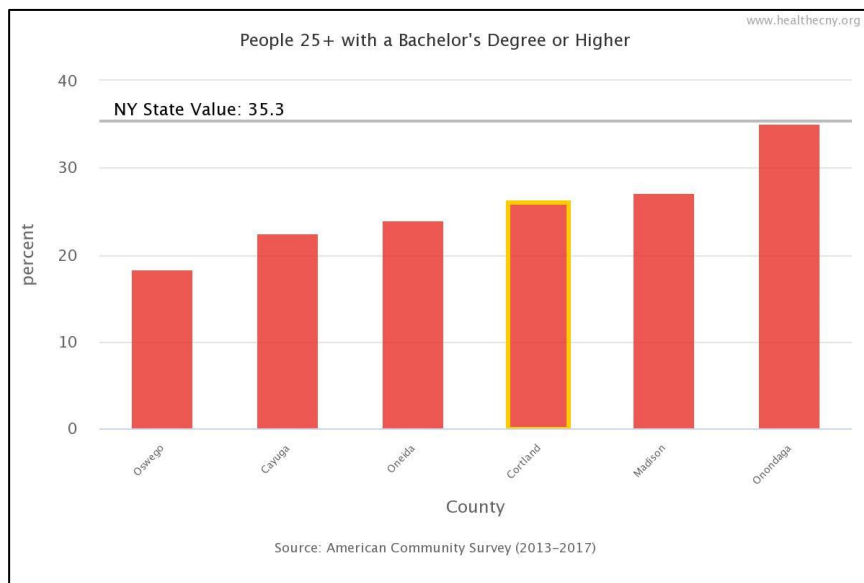


Figure 7: Percentage of People Aged 25 and over with a Bachelor’s Degree or Higher

Source:
<http://www.healthcny.org/indicators/index/view?indicatorId=340&localeType=2>

An estimated 34.1% have a high school diploma or equivalent, 17% have some college but no degree, 13.4% have an associate’s degree, 14.8% have a bachelor’s degree and 11.2% have a graduate or professional degree. The remaining 9.5% have less than 9th grade education or some high school (grades 9-12) with no degree. The median household income for an individual with a bachelor’s degree is \$44,916 as compared to \$30,806 for people with a high school diploma or equivalent. The poverty rate for people with a bachelor’s degree is lower (4.5%) than those with

a high school diploma or equivalent (10.9%).

Employment

In July 2019, the NYS Department of Labor reported that the unemployment rate in Cortland County was 4.4%, which is a decrease from the 4.8% reported in September 2017.⁵ Consequences of unemployment can include a decrease in access to employer-sponsored health insurance programs, which may lead to higher rates of uninsured persons. In Cortland County, 60.5% of residents ages 16 and older are employed. Of the percentage employed 32.7% are employed in educational services, health care and social assistance sectors. This is followed by manufacturing (11.8%), arts, entertainment, and recreation, and accommodation and food services (11.4%), retail trade (11.1%), and professional, scientific, and management, administrative and waste management services (6.1%) and construction (5.7%) (Figure 8).

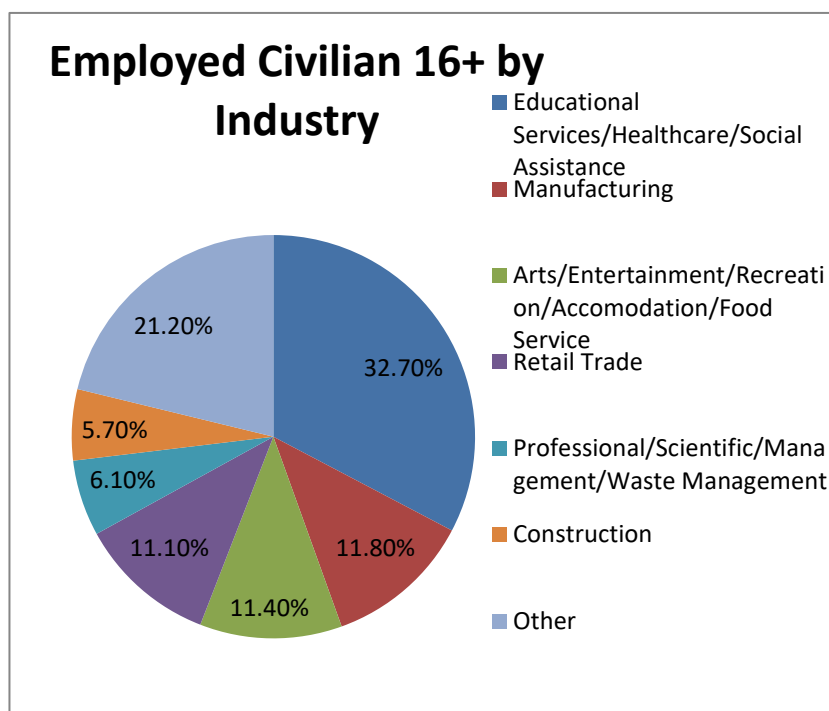


Figure 8: Employed Cortland County Civilian 16+ by Industry

Source: American Community Survey 2013-2017

⁵ U.S. Bureau of Labor Statistics. <https://labor.ny.gov/stats/lslaus.shtm>

Major employers in the County include, along with the approximate number of employees: SUNY Cortland (1000+), Cortland Regional Medical Center (700+), Cortland County (600+), Marietta Corporation (600+), Cortland City School District (600+), Paul Trinity (500+), Intertek Testing Services (300+), Suit-Kote Corporation (250+(plus seasonal)), J.M Murray Center (200+), Crown Center for Nursing and Rehabilitation (200+), City of Cortland (200+), Greek Peak Ski Resort (200+ (plus seasonal)), Gutchess Lumber (200+), Walmart Stores, Inc (100+), Cortland Community Action Program (100+), Kik Custom Products (100+), Albany International (100+), Auxiliary Services Corp (100+), Onondaga-Cortland-Madison BOCES (100+), NBT Bank (100+), Family Health Network (100)+, Lowes Home Improvement (100+).⁶

Housing

There are 20,724 housing units in Cortland County, 17,925 are occupied and 2,799 are unoccupied. 46.2% of houses in the county were built before 1939 and 79.5% were built before 1979. 64.7% of houses are owner occupied and 35.3% are rentals. 3.6% of occupied homes in the county do not have telephone service available, 1.5% lack complete kitchen facilities, and 0.6% lack complete plumbing. 52% of homes are heated using gas followed by kerosene/fuel oil and electric, at 13.5% and 12.2%, respectively.

The median value of owner occupied housing units is \$113,900 and the median monthly housing cost for all occupied units is \$817. In 2019, rent affordable at minimum wage was calculated at \$557 per month, however; fair market rent for a one bedroom in Cortland County is \$664 and for a two bedroom it is \$793 per month.⁷ Residents must work 46 hours per week at minimum wage in order to afford a one bedroom apartment and 55 hours per week at minimum wage in order to afford a two bedroom apartment in the area.⁷ The percentage of occupied units paying rent in which rent accounts for 30% of the monthly household income is calculated at 44.3%, which is lower than the NYS value of 53.5% (Figure 9). For housing units with a mortgage, 20.1% of units account for 30% or more of the owner's monthly household income in monthly housing costs.

⁶ Cortland County Business Development Corporation. <https://cortlandbusiness.com/doing-business-here/major-employers/>

⁷ National Low Income Housing Coalition. <https://reports.nlihc.org/oor/new-york>

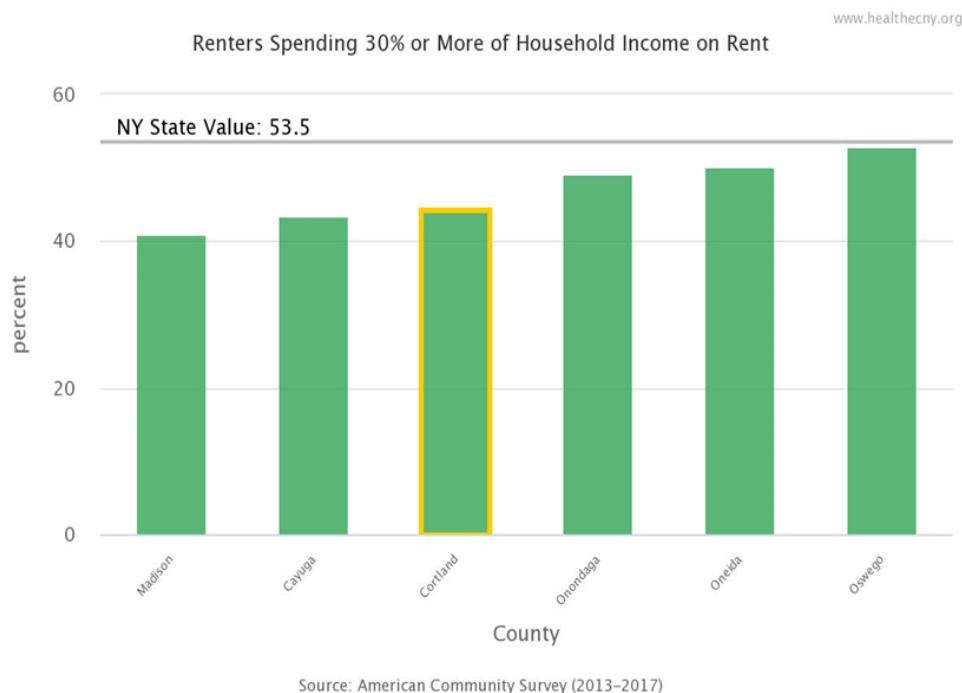


Figure 9: Renters Spending 30% or More of Household Income on Rent
 Source: <http://www.healthcny.org/indicators/index/view?indicatorId=393&localeId=1891&comparisonId=7195>

Transportation

In Cortland County, 9% of occupied housing units do not have a vehicle available for transportation, making alternative options essential. Cortland Transit provides public transportation in Cortland County.⁸ There are seven fixed routes that travel throughout the city of Cortland, village of Homer, surrounding Cortland County towns, and the Cornell University and Tc3 campuses.⁸ It costs \$45 for a monthly pass or \$1.50 to \$2.00 per ride. Special rates between 0.75 cents and \$1.00 are offered to youth, senior, and handicapped riders.⁸ Dial-a-ride curb to curb services offered in the city of Cortland cost between \$5.00 and \$6.00.⁸ In 2019, Seven Valleys Health Coalition rolled out the Lime Bike bike-sharing program which charges a \$1 base fee plus .15 cents per minute—bikes can be located via a smart phone app.⁹

Cortland county residents, on average, spend 20.5 minutes commuting to work. 77% of workers aged 16 years and older commute to work alone via car, truck, or van followed by 10.6% carpooling via car, truck or van, 6.2% walking, 4.7% working remotely from home, 0.8% use an “other” means of transportation, and 0.6% use public transportation to get to work (Figure 10).

⁸ Cortland Transit. <http://www.cortlandtransit.8m.net/index.html>

⁹ The Cortland Voice. <https://cortlandvoice.com/2019/05/01/lime-bikes-roll-into-cortland-county/>

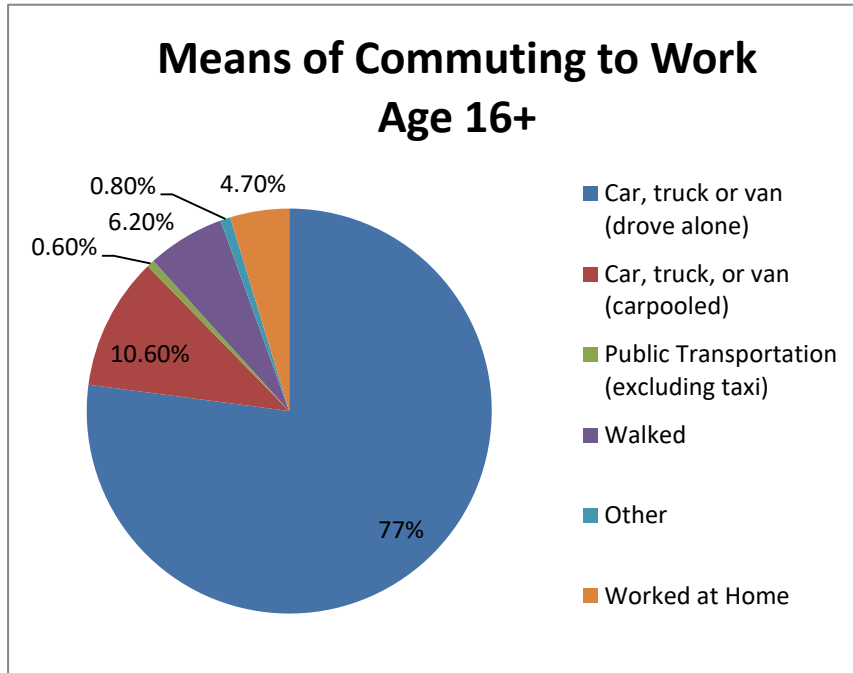


Figure 10: Means of Commuting to Work in Cortland County

Source: American Community Survey 2013-2017

Health Status and Distribution of Health Issues

The framework for the Cortland County 2019-2024 CHA/CHIP is the 2019-2024 New York State (NYS) Prevention Agenda. Through the Prevention Agenda, NYS has identified an overarching theme of **Health Across All Policies** along with five priority areas for improvement.¹⁰

- Prevent Chronic Disease
- Promote Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Well-Being and Prevent Mental and Substance Use Disorders
- Prevent Communicable Diseases

Examination of the health status and distribution of health issues with the community are framed around the priority areas shown above. As part of the Community Health Assessment, the CCHD and the CAT collected, analyzed, and interpreted comprehensive health indicator data. These data were categorized by priority area and presented in the following sections. Where available, data are presented by geography, racial and ethnic group, income and/or disability status, in order to fully understand how different populations in Cortland County are affected.

¹⁰ New York State Department of Health. https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

Improve Health Status and Reduce Health Disparities

This section presents the primary indicators that capture disparities in health outcomes and healthcare access in Cortland County. This section also provides an overall picture of the health status of Cortland County residents.

When available, rates for NYS excluding NYC are presented in place of NYS rates as these are more directly comparable for Cortland County Indicators. Prevention Agenda objectives are included as benchmarks when available.

Health Equity and Health Disparities

Understanding both health equity and health disparities is critical to fully assessing the health of a community. Definitions for each term are included below:

Health equity: “When all people have “the opportunity to ‘attain their full health potential’ and no one is ‘disadvantaged from achieving this potential because of their social position or other socially determined circumstance”¹¹

Health disparity: “A type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability.”¹²

The CCHD and CAT members are committed to addressing barriers to health equity through implementing the interventions outlined in the Community Health Improvement Plan.

Access to Care

Cortland County fares better than NYS in the percentage of adults (age 18-64 years) with health insurance; 94.6% of County residents have health insurance compared to 91.4% in NYS (Table 1). The County rate has increased since last measurement (2015) when the rate was 93.9%,¹³ however, the Prevention Agenda (2018) objective of 100% has not been met. Despite relatively

¹¹ CDC. Definitions <https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html>

¹² CDC. Definitions <https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html>

¹³ NYS Department of Health.

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=ctr&ind_id=pa3_0%20&cos=1

high insurance coverage rates, not all adults in Cortland County have a regular health care provider. Among adults, 79.8% report having a regular health care provider compared to 82.6% in NYS excluding NYC (Table 1). Both Cortland County and NYS excluding NYC do not meet the Prevention Agenda objective of 90.8%.

Table 1. Access to care, Cortland County, NYS excluding NYC, and NYSDOH Prevention Agenda Objective

Indicator	Cortland County	NYS excluding NYC	NYS 2018 Objective
Percentage of adults with health insurance – Aged 18-64 years (2016)	94.6	91.4	100.0
Age-adjusted percentage of adults who have a regular health care provider (2016)	79.8	82.6	90.8

Sources: U.S. Census Bureau, March 2018; Expanded Behavioral Risk Factor Surveillance System (BRFSS), February 2018

Premature Deaths

Premature deaths are any deaths occurring before the age of 65 years. In Cortland County, 22.4% of residents die prematurely, compared to 24.0% for NYS excluding NYC (Table 4). Both Cortland County and NYS excluding NYC did not meet the Prevention Agenda (2018) objective of 21.8%. The ratio of premature deaths is much higher for black non-Hispanic and Hispanic residents compared to white non-Hispanics (Table 4). For each white non-Hispanic premature death there are 2.52 black non-Hispanic deaths and 1.96 Hispanic deaths.

Table 2. Premature deaths, Cortland County, NYS excluding NYC, and NYSDOH Prevention Agenda Objective

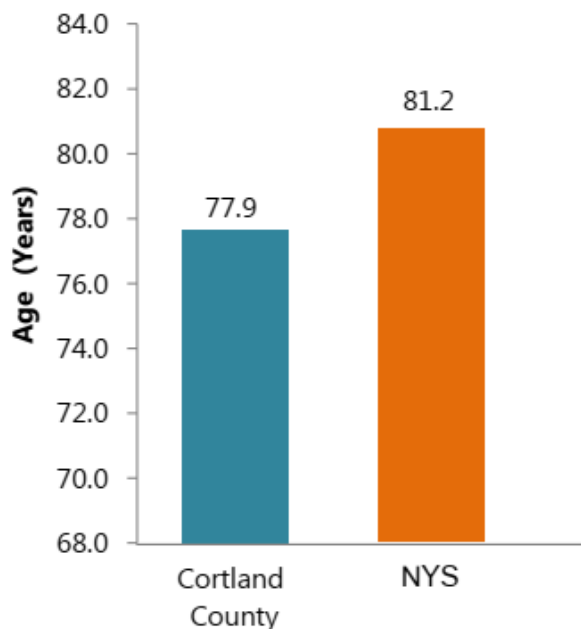
Indicator	Cortland County	NYS excluding NYC	NYS 2018 Objective
Percentage of premature deaths (before age 65 years) (2016)	22.4	24.0	21.8
Ratio of black non-Hispanic to white non-Hispanic (2014-2016)	2.52	1.95	1.87
Ratio of Hispanic to white non-Hispanic (2014-2016)	1.96	1.87	1.86

Source: NYSDOH Office of Vital Statistics, May 2018

Life Expectancy

As shown in Figure 11, Cortland County residents have a life expectancy of 77.9 years, 3.3 years shorter than the NYS average of 81.2 years.¹⁴

Figure 11. Life expectancy at birth, Cortland County and NYS, 2015-2017



Source: County Health Rankings and Roadmap, 2019

Preventable Hospitalizations

Cortland County's rate of preventable hospitalizations (137.4 per 10,000) is higher than the NYS excluding NYC rate (119.5 per 10,000). While NYS excluding NYC met the Prevention Agenda objective of 122.0 per 10,000, Cortland County did not (Table 3), although there was significant improvement shown from previous years data of 159.9 per 10,000.¹⁵ However, within Cortland County there are disparities in rates of preventable hospitalizations based upon race and ethnicity. For each white non-Hispanic preventable hospitalization, there are 0.77 preventable hospitalizations for black non-Hispanics and 0.60 preventable hospitalizations for Hispanics. Although these rates are lower than the Prevention Agenda (2018) objective, the rates for these two groups have increased from the previously reported year.¹⁶

¹⁴ County Health Rankings and Roadmap. <https://www.countyhealthrankings.org/app/new-york/2019/measure/outcomes/147/data>

¹⁵ NYS Department of Health.

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=11

¹⁶ NYS Department of Health.

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=11

Table 3. Preventable hospitalization per 10,000 aged 18 + years, Cortland County, NYS excluding NYC, and NYSDOH Prevention Agenda Objective

Indicator	Cortland County	NYS excluding NYC	NYS 2018 Objective
Age-adjusted preventable hospitalization rate (per 10,000) – Aged 18+ years (2014)	137.4	119.5	122.0
Ratio of black non-Hispanic to white non-Hispanic (2012-2014)	0.77	2.18	1.85
Ratio of Hispanic to white non-Hispanic (2012-2014)	0.60	1.54	1.38

Source: New York Statewide Planning and Research Cooperative System (SPARCS), August 2016

Additionally, there are geographic differences in preventable hospitalizations within certain Cortland County zip codes experiencing the highest rates. Table 4 depicts age-adjusted preventable hospitalization rates over a five year period in Cortland County. The zip code with the highest rate is 13863 with a rate of 194.5 per 10,000.

Table 4. Age-adjusted preventable hospitalization rate per 10,000 aged 18+ years, by select zip codes, 2010-2014

Location	Preventable hospitalization rate
Cortland County	137.4
13863	194.5
13045	185.4
13101	183.8
13158	182.7
13077	144.0

Source: SPARCS, www.healthecny.org

Disability

Within Cortland County, there are 18.7% of adults living with a disability; this is a lower percentage than in NYS excluding NYC (21.2%).¹⁷ Living with a disability is defined as reporting activity limitations due to physical, mental, or emotional problems or having health problems that require the use of special equipment.¹⁸ People living with a disability are often at increased risk for adverse health outcomes. When available, data on those living with a disability will be reported.

Leading Causes of Death

The leading causes of death provide an indication of the burden of disease. Cancer is the overall leading cause of death in Cortland County. This differs from NYS excluding NYC, where the

¹⁷ Expanded BRFSS, 2016. <https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/isy7-eb4n/data>

¹⁸ Expanded BRFSS, 2013-2014 <https://www.health.ny.gov/statistics/brfss/expanded/>

leading cause of death is heart disease.¹⁹ Table 5 depicts the top 5 leading causes of death overall for Cortland County and the leading causes of death by gender.

Table 5. Leading causes of death, by gender, Cortland County, 2016

	Overall	Female	Male
1	Cancer 90 deaths 148 per 100,000	Cancer 43 deaths 128 per 100,000	Heart Disease 51 deaths 200 per 100,000
2	Heart Disease 89 deaths 151 per 100,000	Heart Disease 38 deaths 112 per 100,000	Cancer 47 deaths 174 per 100,000
3	Stroke 31 deaths 53 per 100,000	Stroke 19 deaths 53 per 100,000	Chronic Lower Respiratory Diseases 16 deaths 62 per 100,000
4	Chronic Lower Respiratory Diseases 31 deaths 51 per 100,000	Chronic Lower Respiratory Diseases 15 deaths 45 per 100,000	Unintentional Injury 14 deaths 56 per 100,000
5	Unintentional Injury 26 deaths 53 per 100,000	Unintentional Injury 12 deaths 49 per 100,000	Pneumonia and Influenza 13 deaths 51 per 100,000

Source: NYSDOH Leading Causes of Death in New York State: https://www.health.ny.gov/statistics/leadingcauses_death/

Improve Health Status and Reduce Health Disparities Summary

Cortland County's percentage of premature deaths is lower than NYS excluding NYC while the County's rate of preventable hospitalizations is higher than NYS excluding NYC. Racial and ethnic disparities for these two indicators are prevalent. Additionally, geographic differences exist in preventable hospitalizations within certain zip codes throughout the County. While the percentage of County residents who have health insurance is higher than NYS excluding NYC, some do not have a regular health care provider. For each of the top leading causes of death, males have a higher mortality rate than females.

¹⁹ NYSDOH Leading Causes of Death In New York State. https://apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/reports/#county

Prevent Chronic Disease

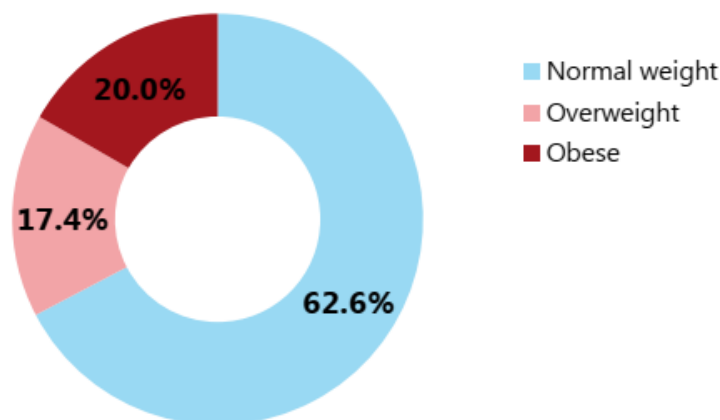
Chronic disease can significantly affect both the quality and the length of an individual's life. Of the five leading causes of death for Cortland County residents, four are chronic diseases. Chronic diseases covered in this section include: obesity, heart disease, diabetes, and cancer. This section also reports on health behaviors that can directly impact chronic disease outcomes; these include physical activity, nutrition, and cigarette smoking.

When available, rates for NYS excluding NYC are presented in place of NYS rates as these are more directly comparable for Cortland County Indicators. Prevention Agenda objectives are included as benchmarks when available.

Overweight and Obesity

Overweight and obesity presents a substantial challenge in Cortland County. Overall, 37.4% of children and adolescents in Cortland County are overweight or obese (Figure 12). The rate has not significantly changed from 37.3% at last measurement (2012-2014).²⁰ Obesity among children and adolescents (20.0%) in Cortland County is higher than in NYS excluding NYC (17.4%), and did not meet the Prevention Agenda (2018) objective of 16.7%.²¹

Figure 12. Percentage of children and adolescents who are overweight or obese, Cortland County, 2016-2018



Source: Student weight status category reporting system, 2016-2018

Note: Among children, overweight is defined as weight category $\geq 85^{\text{th}}$ and $< 95^{\text{th}}$ percentile, obesity is defined as weight category $\geq 95^{\text{th}}$ percentile

²⁰ Student Weight Status Category Reporting System, 2014-2016. <https://nyshc.health.ny.gov/web/nyapd/student-weight-data-explorer>

²¹ NYS Department of Health.

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=11

Differences do exist by school district (Table 6) with the highest obesity rates seen in the Cortland City School District (21.8%) and the Homer Central School District (20.0%).²²

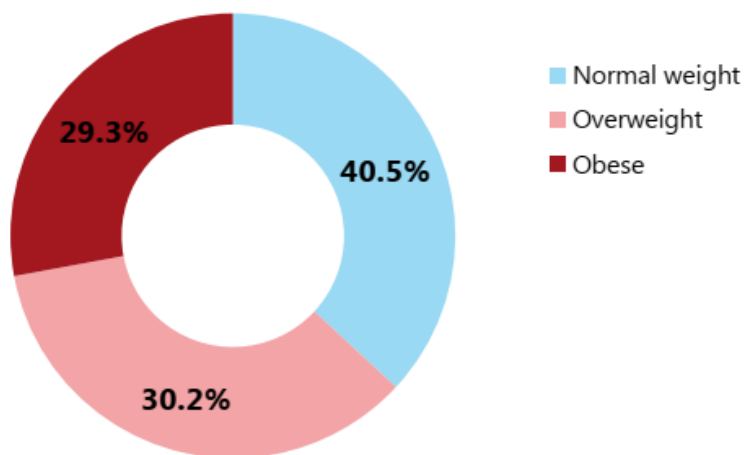
Table 6. Percentage of children and adolescents who are obese by school district, Cortland County 2016-2018

School District	Students who are obese
Cincinnatus Central School District	19.5%
Cortland City School District	21.8%
Homer Central School District	20.0%
Marathon Central School District	17.3%
McGraw Central School District	15.2%

Source: Student weight status category reporting system, 2016-2018

Among adults, the obesity rate is 29.3% with 59.5% being either overweight or obese (Figure 13). Cortland County's adult obesity rate is higher than the NYS (25.5%) and did not meet the Prevention Agenda (2018) objective of 23.2%.²³

Figure 13. Age-adjusted percentage adults who are overweight or obese, Cortland County, 2016



Source: Expanded BRFSS, 2016

Note: Among adults, overweight is defined as BMI between 25.0 and <30.0, obesity is defined as BMI \geq 30.0

²² Student Weight Status Category Reporting System, 2014-2016. <https://nyshc.health.ny.gov/web/nyapd/student-weight-data-explorer>

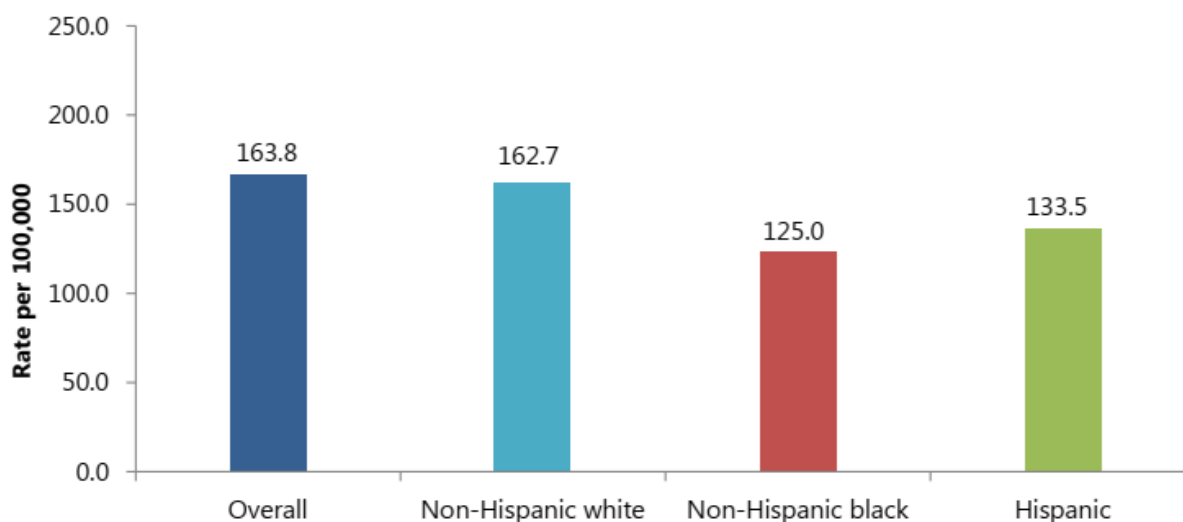
²³ NYS Department of Health.

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=11

Heart Disease

Cortland County's mortality rate for diseases of the heart (163.8 per 100,000) is lower than NYS excluding NYC (172.7 per 100,000).²⁴ However, heart disease remains an important indicator as it is the second leading cause of death in Cortland County²⁵ and there are disparities in heart disease mortality rates based upon race and ethnicity²⁶ (Figure 14).

Figure 14. Age-adjusted mortality rate for diseases of the heart, by race and ethnicity, Cortland County, 2014-2016



Source: NYSDOH County Health Indicators, by Race/Ethnicity, <https://www.health.ny.gov/statistics/community/minority/county/cortland.htm>

Diabetes

Diabetes is a leading cause of death in the United States. The prevalence of adults with diabetes in Cortland County is 8.7% which is lower than most of the surrounding Central New York (CNY) County percentages (Figure 15). The age adjusted diabetes mortality rate in Cortland County (17.6 per 100,000) is slightly higher than NYS excluding NYC (16.9 per 100,000)²⁷. Figure 16 shows the comparison of Cortland County's age-adjusted mortality rate of diabetes with surrounding CNY Counties.

²⁴ NYS Department of Health.

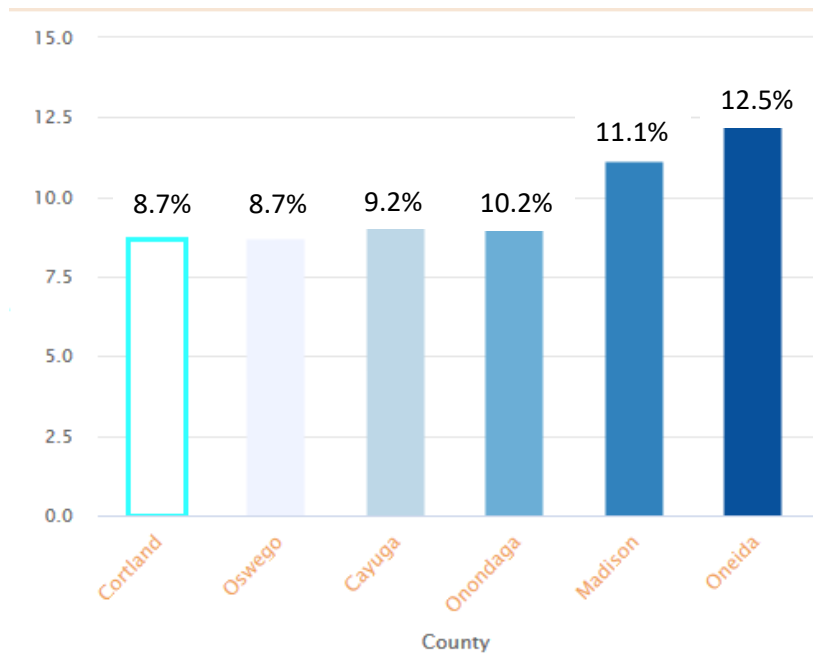
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²⁵ NYSDOH Leading Causes of Death In New York State. https://apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/reports/#county

²⁶ NYSDOH County Health Indicators, by Race/Ethnicity. <https://www.health.ny.gov/statistics/community/minority/county/cortland.htm>

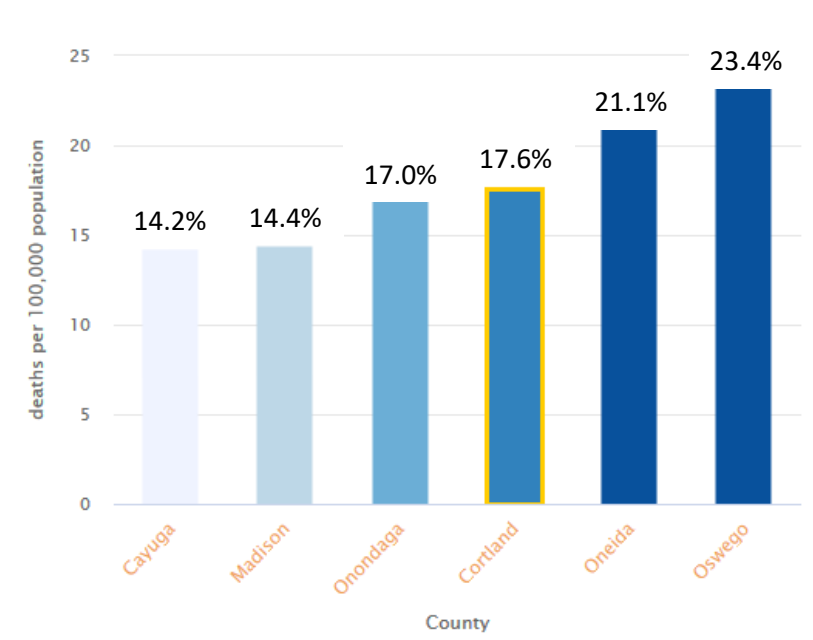
²⁷ Healthcny.org, 2015-2017 data

Figure 15. Adults with Diabetes, Cortland County compared to surrounding counties, 2016



Source: Healthcny.org and BRFSS, 2016

Figure 16. Age-adjusted diabetes mortality rate, Cortland County compared to surrounding counties, 2015-2017

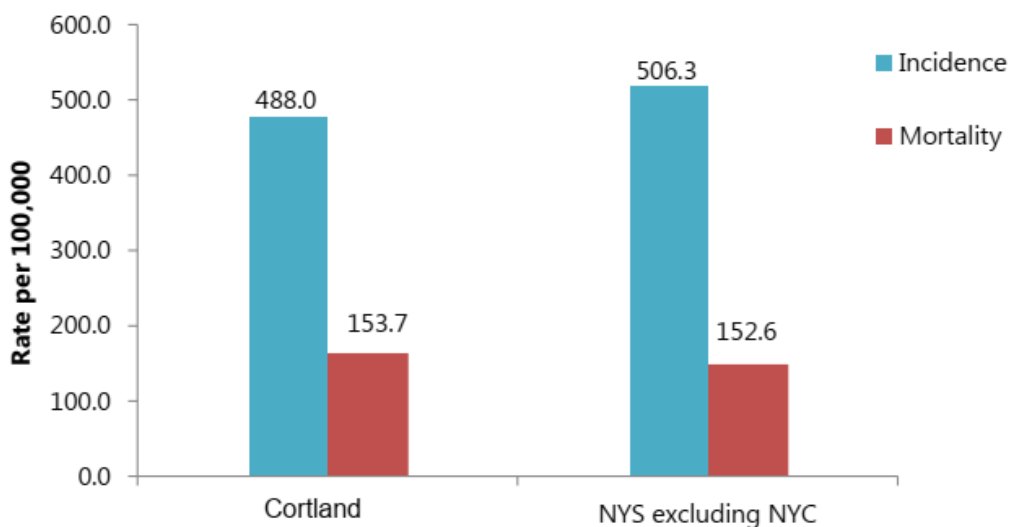


Source: Healthcny.org, CDC, 2015-2017

Cancer

Cancer is the leading cause of death in Cortland County.²⁸ Compared to NYS excluding NYC, Cortland County has a lower rate of incidence, but slightly higher mortality rate for all types of cancer (Figure 17). Within Cortland County, both the incidence and mortality rates for all types of cancer have been decreasing over time.²⁹

Figure 17. Age-adjusted incidence and mortality rates for all types of cancer, Cortland County and NYS excluding NYC, 2013-2015



Source: NYSDOH County Health Assessment Indicators, https://www.health.ny.gov/statistics/chac/cha/docs/can_31.htm

Figure 18 shows the incidence and mortality rates for three common types of cancer. Of the three types, breast, lung and bronchus, and prostate cancers, the incidence rate is highest for prostate cancer while the mortality rate is highest for lung and bronchus cancer.³⁰

²⁸ NYSDOH Leading Causes of Death In New York State. https://apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/reports/#county

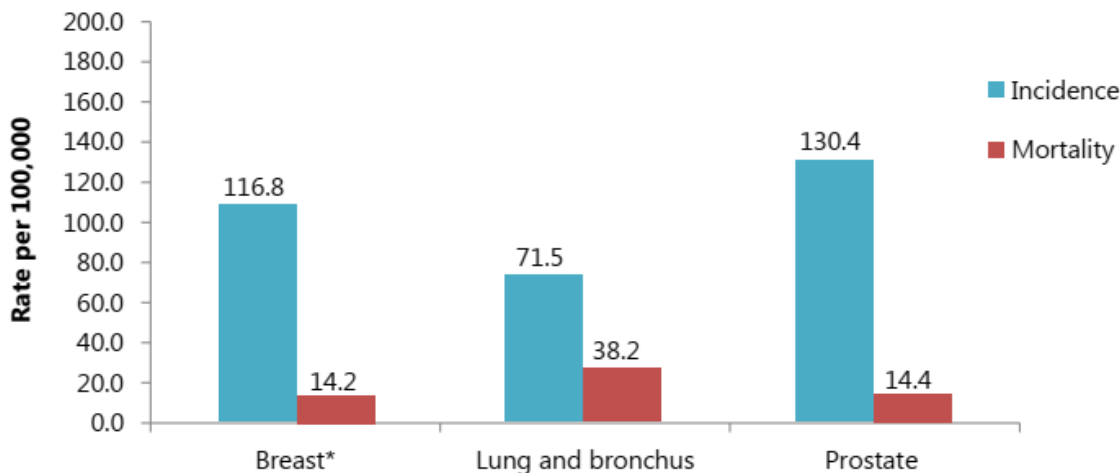
²⁹ NYSDOH.

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=11&ctop=1

³⁰ NYS Department of Health.

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=11&ctop=1

Figure 18. Age-adjusted incidence and mortality of breast, lung and bronchus, and prostate cancers, Cortland County, 2013-2015



Source: NYSDOH County Health Assessment Indicators, https://www.health.ny.gov/statistics/chac/chai/docs/can_31.htm

*Only includes female cases of breast cancer

Screening rates in Cortland County for breast, cervical, and colorectal cancer are shown in Table 7. Cortland County has higher screening rates for breast and cervical cancer than NYS excluding NYC. However, Cortland County’s screening rate for colorectal cancer did not meet the Prevention Agenda (2018) objective of 80.0%.³¹

Table 7. Cancer screening rates, Cortland County and NYS excluding NYC, 2016

Indicator	Cortland County	NYS excluding NYC
Women aged 50-74 years who received breast cancer screening	84.1%	79.2%
Women aged 21-65 years who received cervical cancer screening*	85.7%	80.6%
Adults aged 50-75 years who received colorectal cancer screening	68.5%	69.7%

Source: Expanded BRFSS, 2016

*Cervical Cancer Screening data comes from Expanded BRFSS, 2013-2014 (this is the most recent data)

³¹ NYS Department of Health.

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=11&ctop=1

Physical Activity and Nutrition

Physical activity and nutrition behaviors for Cortland County residents are presented in Figure 19. Among adults in Cortland County, 22.6% reported that they did not participate in leisure time physical activity in the past 30 days. This is lower than the rate of 25% in NYS excluding NYC.³² Compared to adults in NYS excluding NYC, Cortland County adults were slightly more likely to report consuming one or more sugary drinks daily (Cortland County:25.8%; NYS excluding NYC: 24.5%)³³ and were less likely to report that they consumed fast food three or more times per week (Cortland County: 5.0%; NYS excluding NYC: 7.1%).³⁴

Figure 19. Physical activity and nutrition behaviors, Cortland County, 2016



Source: BRFSS,2016; *Expanded BRFSS, 2013-2014

Note: Percentages are age-adjusted

Cigarette Smoking and Vaping

For adults the prevalence of cigarette smoking in Cortland County is 21.5%, higher than the prevalence of 17% in NYS excluding NYC.³⁵ Within Cortland County the prevalence of cigarette smoking is higher among adults with disabilities and the prevalence of cigarette smoking is lower among adults with annual income less than \$25,000 (Figure 20).

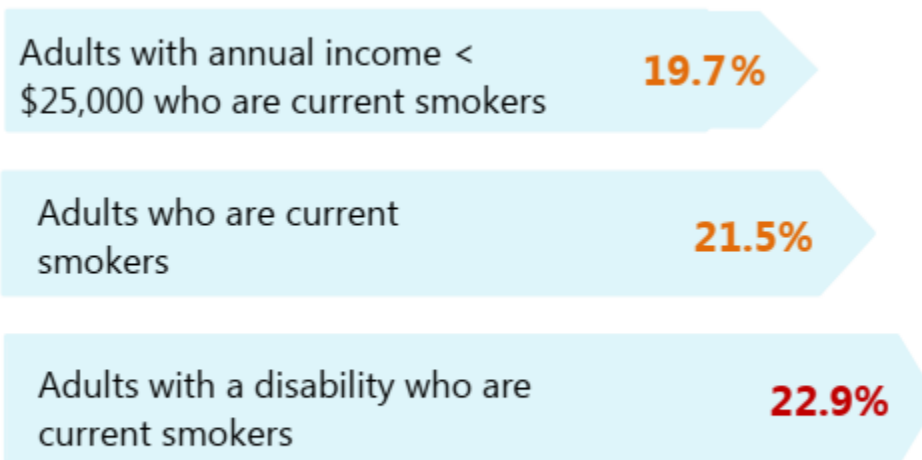
³² BRFSS,2016. <https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n/data>

³³ BRFSS,2016. <https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n/data>

³⁴ Expanded BRFSS,2013-2014. <https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n/data>

³⁵ Healthcny.org. <http://www.healthcny.org/indicators/index/view?indicatorid=8&localeid=1891>

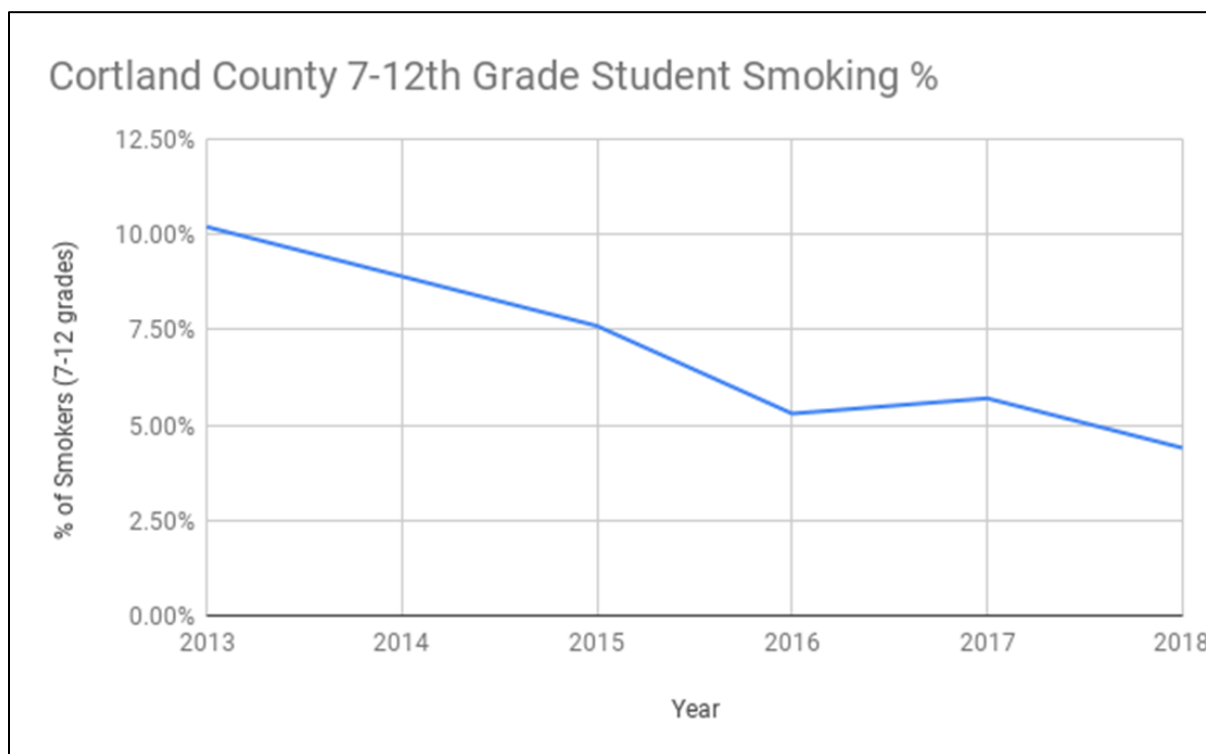
Figure 20. Disparities in cigarette smoking, Cortland County, 2016



Source: Expanded BRFSS, 2016
 Note: Percentages are age-adjusted

Figure 21 shows the significant decline in the % of smokers in 7-12th grade from 2013 to 2018.

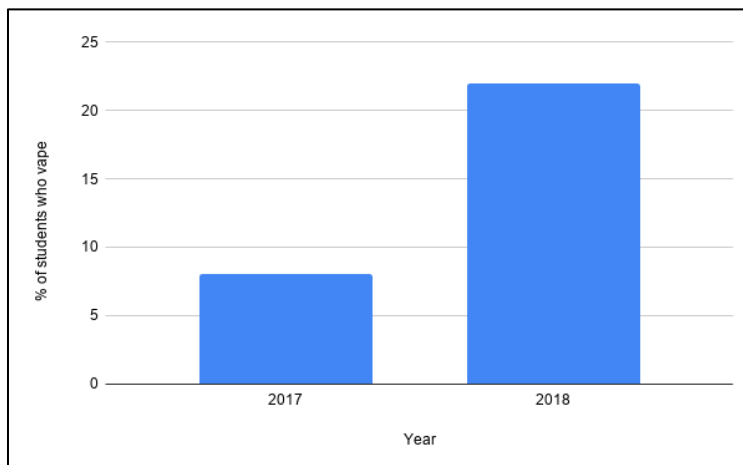
Figure 21. 7-12th grade student Smoking %, Cortland County, 2018



Source: CACTC Youth Development Survey 2018

Although there has been a significant decrease in 7-12th grade students that smoke, there has been an increase in the % of those who are vaping from 8% (2017) to 22% (2018) (Figure 22).³⁶

Figure 22. 7-12th Grade Vaping %, Cortland County, 2018



Source: CACTC Youth Development Survey, 2018

Prevent Chronic Disease Summary

Obesity remains a significant concern in Cortland County as the rates for both children and adults fail to meet the Prevention Agenda (2018) objectives. Health behaviors including lack of physical activity and adequate nutrition contribute to high rates of obesity. Within the County, cigarette smoking rates are decreasing while a growing concern is the percentage of 7-12th graders using vaping products. County screening rates for breast and cervical are higher than NYS excluding NYC, although the screening rate for colorectal cancer did not meet the Prevention Agenda (2018) objective.

³⁶ CACTC Youth Development Survey 2018. https://gallery.mailchimp.com/f9434fb32c8003867f72885a3/files/a6a180e8-b371-4afc-99c6-cb5483d2760a/2018_YDS_Report_Final_Draft_Web.01.pdf

Promote a Healthy and Safe Environment

The environment can affect several aspects of health including an individual's ability to experience optimal health and their ability to access resources to live a healthy lifestyle. Environmental indicators presented in this section include: the physical environment, asthma, radon, lead, transportation, food insecurity, homeless, crime, unintentional injury and occupational health.

When available, rates for NYS excluding NYC are presented in place of NYS rates as these are more directly comparable for Cortland County Indicators. Prevention Agenda objectives are included as benchmarks when available.

Physical Environment

Data for indicators related to the physical environment are show in Table 8. These factors can have a significant impact on health outcomes. For example, air quality can have a substantial impact on the health of those with chronic respiratory conditions like asthma. Cortland County's average daily density of fine particulate matter is 7.9 $\mu\text{g}/\text{m}^3$ compared to 8.5 $\mu\text{g}/\text{m}^3$ in NYS. House age and quality are also significant environmental factors with the potential to influence health. Cortland County has a higher percentage of housing units built in 1939 or earlier than NYS for age of housing stock, but has a lower percentage of households with severe housing problems. Cortland County also fares significantly worse than NYS excluding NYC in regards to the percentage of residents served by systems with optimally fluoridated water.

Table 8. Physical environment indicators, Cortland County, NYS, NYSDOH Prevention Agenda (2018) Objective

Indicator	Cortland County	NYS	NYS 2018 Objective
Average daily density of fine particulate matter (micrograms per cubic meter) (2019)	7.9	8.5	--
% of occupied housing units built in 1939 or earlier (2013-2017)	44.9	31.6	--
% of households with severe housing problems (2019)	15.0	24.0	--
% of residents served by community water systems with optimally fluoridated water (2017)	3.2	46.6*	78.5

Sources: County Health Rankings, 2019; U.S. Census Bureau, American Community Survey, 2013-2017; EPA Safe Drinking Water Information System, 2017.

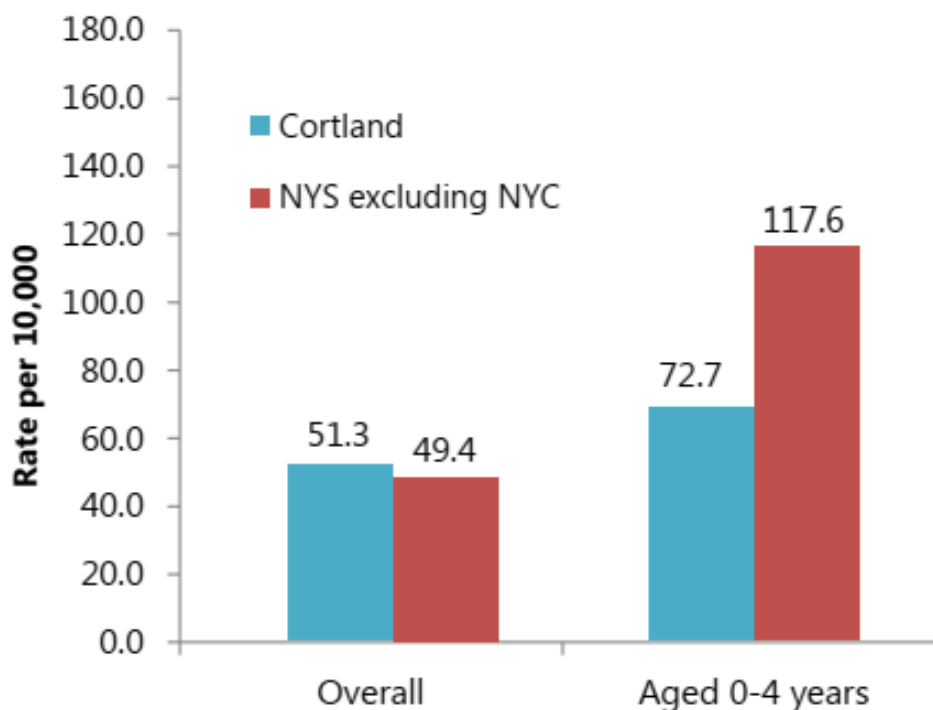
*Rate is for NYS excluding NYC.

Asthma

Although asthma is considered a chronic condition, it was included here to reflect the significant impact of the environment on disease. In Cortland County, 10.3% of adults report having physician diagnosed asthma compared to 9.6% in NYS excluding NYC.³⁷

The rate of asthma emergency room visits overall is slightly higher in Cortland County than NYS excluding NYC, however among children aged 0-4 years, the rate in Cortland County is lower (Figure 23). The mortality rate due to asthma in Cortland County is 6.9 per 1,000,000 compared to 10.7 per 1,000,000 in NYS excluding NYC.³⁸

Figure 23: Asthma emergency department visit rate, Cortland County and NYS excluding NYC, 2016



Source: SPARCS, 2016

³⁷ Expanded BRFS, 2016

³⁸ NYS DOH. https://webbi1.health.ny.gov/SASStoredProcess/guest?program=%2FEBI%2FPHIG%2Fapps%2F asthma_dashboard%2Fad_dashboard&p=ch&cos=11

Lead

Exposure to lead, typically through lead paint, is a significant environmental concern as it can negatively impact cognitive development in children. Of children tested for lead in Cortland County, 4.3% were found to have a blood lead level of 5 mcg/dl or greater (Table 9).

Table 9. Children tested for lead with blood lead level of 5 mcg/dL or greater, by blood lead level, Cortland County, 2018

Blood lead level (mcg/dL)	Cortland County
5-9	2.8%
10-14	0.8%
15-19	0.5%
≥20	0.2%
Total	4.3%

Source: Lead Tracking and Environmental Reduction Program, 2018

Radon

Radon is an invisible, tasteless and odorless gas that is found underground and can enter homes through cracks in concrete slabs and blocks, joints, loose fitting pipes, exposed soil and water. The EPA lists radon as the second leading cause of lung cancer and the number one cause of lung cancer among non-smokers, estimating it is responsible for about 20,000 lung cancer deaths every year.³⁹ Approximately 2,900 of these deaths occur among people who have never smoked.⁴⁰

Radon is measured in “Pico Curies per liter of Air” or pCi/L and New York State has determined that a level of 4.0 pCi/L or greater is considered high. In Cortland County, high radon levels are a significant concern for negative health impacts. The County has been designated as a high radon risk area by the NYS Department of health with average basement level readings over 14 pCi/L.⁴¹

³⁹ American Cancer Society: <https://www.cancer.org/cancer/cancer-causes/radiation-exposure/radon.html>

⁴⁰ EPA: <https://www.epa.gov/radon/health-risk-radon#head>

⁴¹ NYSDOH, 2019: <https://www.health.ny.gov/environmental/radiological/radon/county.htm>

Transportation

Transportation has a significant impact on an individual's access to health resources including healthy food options and health care providers. In Cortland County, 3.6% of households do not have a vehicle available which is lower than in NYS as a whole (Table 10).

Additionally, reliance on motor vehicles for transportation can increase greenhouse gas emissions which can negatively impact health, especially for individuals with chronic respiratory conditions. Nearly 23% of workers in Cortland County utilize an alternate mode of transportation to work compared to 45.7% in NYS (Table 10). Alternate modes of transportation include public transportation, carpooling, biking, walking, or telecommuting. Seventy-seven percent of the workforce in Cortland County drives alone to work and 20.3% drive alone with a commute that is more than 30 minutes.

Table 10. Transportation indicators, Cortland County, NYS, and NYSDOH Prevention Agenda (2018) Objective

Indicator	Cortland County	NYS	NYS 2018 Objective
% of households with no vehicle available (2013-2017)	3.6	21.9	--
% of workers who use alternative modes of transportation to work (2012-2016)	22.7	45.7	49.2
% of workforce that drive alone to work (2013-2017)	79.7	53.2	--
% of workforce who drive alone to work that commute more than 30 minutes (2013-2017)	20.3	26.8	--

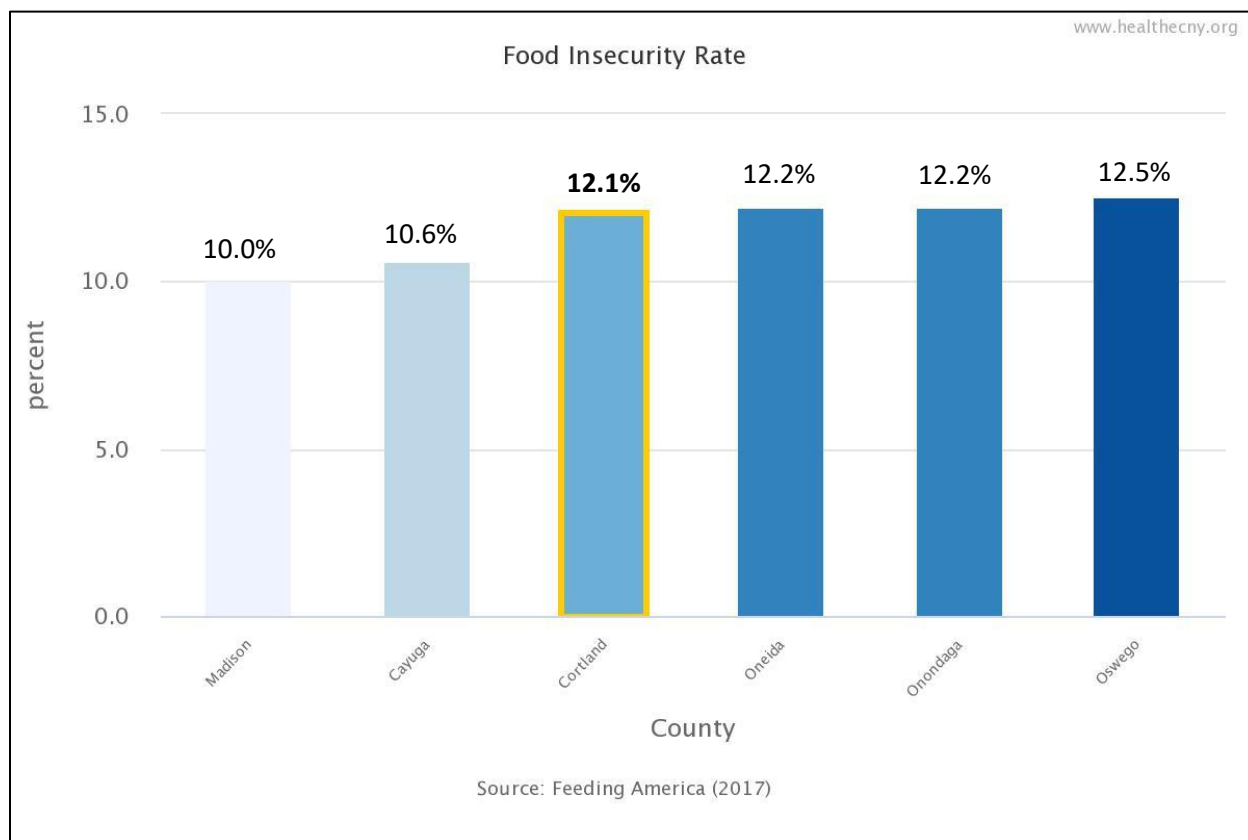
Source: U.S. Census Bureau, American Community Survey.

Food Insecurity

Food insecurity is an economic and social indicator of the health of a community. Food insecurity is defined as the disruption of food intake or eating patterns because of lack of money and other resources.⁴² Poverty and unemployment are frequently predictors of food insecurity in the United States. Food insecurity is associated with chronic health problems in adults including diabetes, heart disease, high blood pressure, obesity, and mental health issues including major depression.⁴³ Table 11 shows the food insecurity rate comparison of Cortland County with other Central New York Counties.

⁴²HealthyPeople2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity>

⁴³HealthyCNY.org. <http://www.healthecny.org/indicators/index/view?indicatorId=2107&localeTypeId=2>

Table 11. Food Insecurity Rate, Cortland County, 2017

Homeless

According to HUD, there are four categories related to defining a person homeless. These include: Category 1: Literally Homeless, Category 2: Imminent Risk of Homelessness, Category 3: Homeless under Federal Statutes, and Category 4: Fleeing/Attempting to Flee Domestic Violence.⁴⁴ In New York State, in 2018 there were over 91,000 people homeless on any given night and 46 people homeless per 10,000 in the general population.⁴⁵

Although there is no actual report on homelessness in Cortland County, some data is represented through the Cortland County Department of Social Services and Catholic Charities of Cortland. According to Cortland County Department of Social Services, in 2018 there was an increase in instances (339) where someone was housed due to homelessness compared to 246 instances in 2017.⁴⁶ Catholic Charities of Cortland provides a point in time count on a day and night at the end of January each year. In 2019, there were 73 people considered homeless (72 sheltered, one

⁴⁴ HUD Exchange, 2012: <https://www.hudexchange.info/resource/1974/criteria-and-recordkeeping-requirements-for-definition-of-homeless/>

⁴⁵ National Alliance to End Homelessness, 2018: <https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/new-york/>

⁴⁶ B. Moore, 2019, Cortland County Department of Social Services

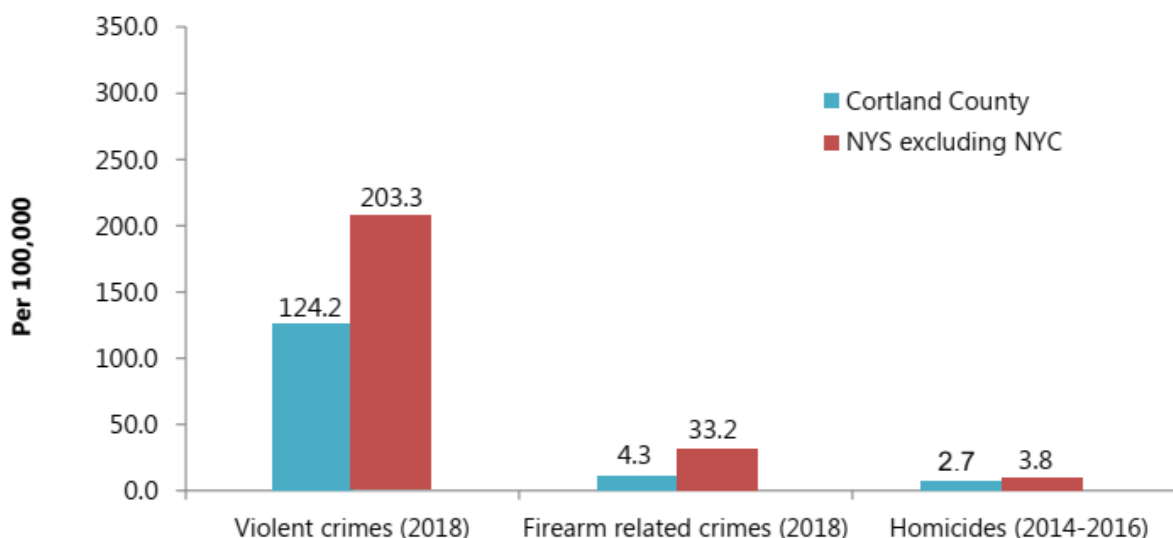
unsheltered) which is much higher than in 2018, with 35 people considered homeless.⁴⁷ The 2019 count represents a 52% increase since 2018 and is 23 % of all homeless in the regional count.

Crime

Crime can have a significant impact on population health. In addition to injury and death resulting from violent crime, high crime rates can negatively affect a community through chronic stress. Residents may also be less likely to utilize community resources for physical activity, such as parks and other green space, if the areas are perceived as unsafe.

Cortland County has lower rates of violent crimes than NYS excluding NYC (Figure 24). Violent crimes include murder, rape, robbery, and aggravated assault.⁴⁸ Cortland County's rate of firearm related crimes and homicides are also lower (Figure 24). Additionally, property crimes which include burglary, larceny, and motor vehicle theft are higher (1535.0 per 100,000) than NYS excluding NYC (1380.4 per 100,000).⁴⁹

Figure 24. Violent crimes, firearm related crimes, and homicides per 100,000 population, Cortland County and NYS excluding NYC



Sources: NYS Division of Criminal Justice Services; Uniform Crime Reporting System (2018); NYSDOH County Health Assessment Indicators, 2014-2016, https://www.health.ny.gov/chac/chai/docs/inj_31.htm

⁴⁷ T. Lockwood, 2019, Catholic Charities of Cortland

⁴⁸ NYS Division of Criminal Justice Services; Uniform Crime Reporting System, 2018. <https://www.criminaljustice.ny.gov/crimnet/ojsa/countycrimestats.htm>

⁴⁹ NYS Division of Criminal Justice Services; Uniform Crime Reporting System, 2018. <https://www.criminaljustice.ny.gov/crimnet/ojsa/countycrimestats.htm>

Unintentional Injury

Unintentional injuries are those that occur in a short period of time, with a harmful outcome that was not sought. Table 12 shows rates of unintentional injury in Cortland County and NYS excluding NYC. Cortland County did fare better than NYS excluding NYC for hospitalizations due to fall among adults aged 65+ years; and has met the 2018 NYS Prevention Agenda Objective.

For unintentional injuries, Cortland County has a lower rate of hospitalizations than NYS excluding NYC but a higher rate of mortality. Additionally, the motor vehicle mortality rate in Cortland County (11.0 per 100,000) is higher than in NYS excluding NYC (7.2 per 100,000).

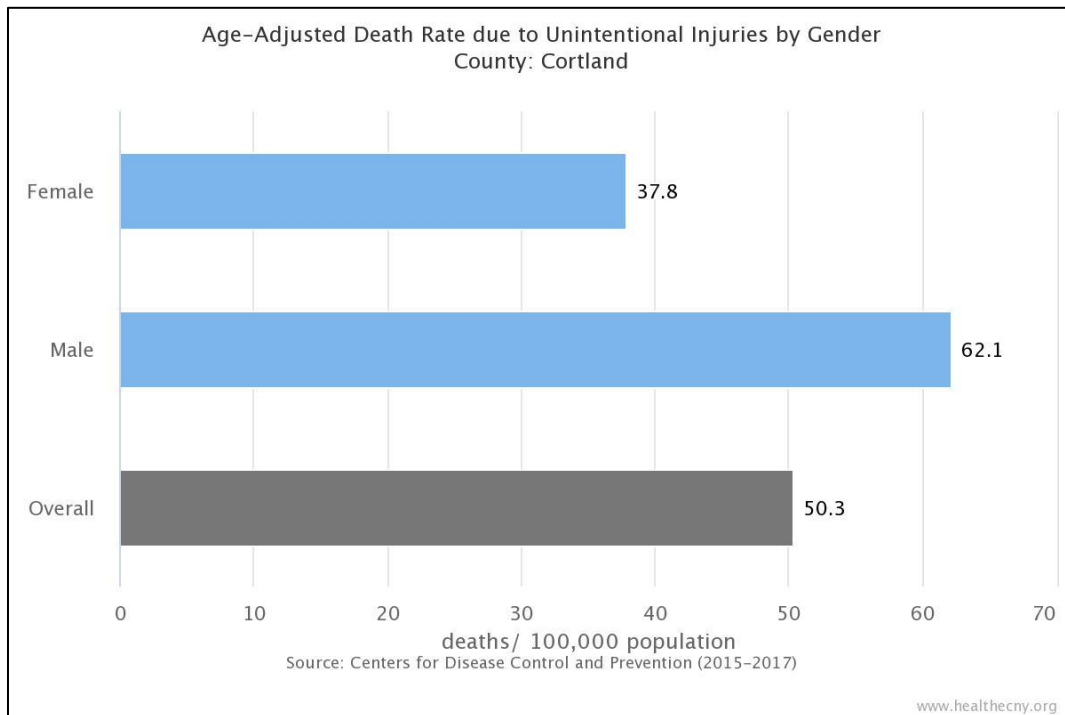
Table 12. Unintentional injury indicators, Cortland County, NYS excluding NYC, and NYSDOH Prevention Agenda Objective

Indicator	Cortland County	NYS excluding NYC	NYS 2018 Objective
Hospitalizations due to falls (per 10,000) - Aged 65+ years (2016)	130.0	189.9	204.6
Unintentional injury hospitalization rate (per 10,000) (2016)	50.4	68.3	--
Unintentional injury mortality rate (per 100,000) (2015-2017)	50.3*	41.7*	--
Motor vehicle mortality rate (per 100,000) (2014-2016)	11.0	7.2	--

Sources: SPARCS, 2016; NYSDOH County Health Assessment Indicators, 2014-2016, https://www.health.ny.gov/statistics/chac/chai/docs/inj_31.htm; CDC, 2015-2017
*age-adjusted rate

In Cortland County there is significant gender differences related to unintentional injuries. Figure 25 shows gender differences for the age-adjusted mortality rate of unintentional injuries.

Figure 25. Gender Differences, Age-Adjusted Death Rate due to Unintentional Injuries, 2015-2017



Occupational Health

Among adolescents aged 15-19 years, Cortland County has a higher rate of occupational injuries treated in emergency departments than NYS (Table 13). However, rates for hospitalizations due to work-related injury are lower in Cortland County than NYS excluding NYC. The County rate for fatal work related injuries (7.5 per 100,000) is higher than the NYS excluding NYC rate (3.5 per 100,000).

Table 13. Occupational health indicators, Cortland County, NYS excluding NYC, and NYSDOH Prevention Agenda Objective

Indicator	Cortland County	NYS excluding NYC	NYS 2018 Objective
Occupational injuries treated in emergency department (per 10,000) - Aged 15-19 years (2016)	40.3	20.6*	33.0
Work-related hospitalizations (per 100,000) (2014-2016)	117.5	152.9	--
Fatal work-related injuries (per 100,000) (2014-2016)	7.5**	3.5	--

Sources: SPARCS, 2014-2016; NYSDOH County Health Assessment Indicators, 2014-2016, https://www.health.ny.gov/statistics/chac/chai/docs/inj_31.htm; Bureau of Occupational Health and Injury Prevention, 2014-2016

*NYS Rate

**The rate/percentage is unstable

Promote a Healthy and Safe Environment Summary

Cortland County is faring better than both the State and NYS excluding NYC for many indicators in this area. However, areas of special concern include food insecurity, housing safety, unintentional injury deaths and motor vehicle deaths. The built environment in Cortland County also presents challenges, with the majority of residents utilizing personal vehicles as the primary mode of transportation. Promoting walkability and bikeability throughout the County, as well as equitable access to healthy foods, can impact health outcomes through increased physical activity and improved nutrition, but also through decreased emissions and a more accessible physical environment.

Promote Healthy Women, Infants and Children

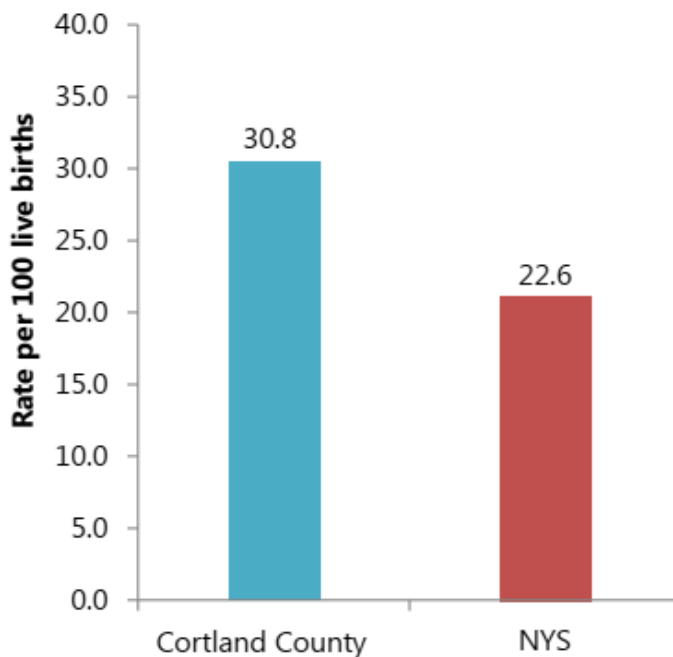
The health of women, infants and children is essential to ensuring the current and future health of our community. Topics covered in this section include: family planning and natality, prenatal care, substance use in pregnancy, preterm birth, low birth weight, infant mortality and breastfeeding.

When available, rates for NYS excluding NYC are presented in place of NYS rates as these are more directly comparable for Cortland County Indicators. Prevention Agenda objectives are included as benchmarks when available.

Family Planning and Natality

In Cortland County, almost one-third (30.8%) of births result from unintended pregnancies compared to 22.6% in NYS (Figure 26). Cortland County did not meet the 2018 Prevention Agenda Objective of 23.8%.

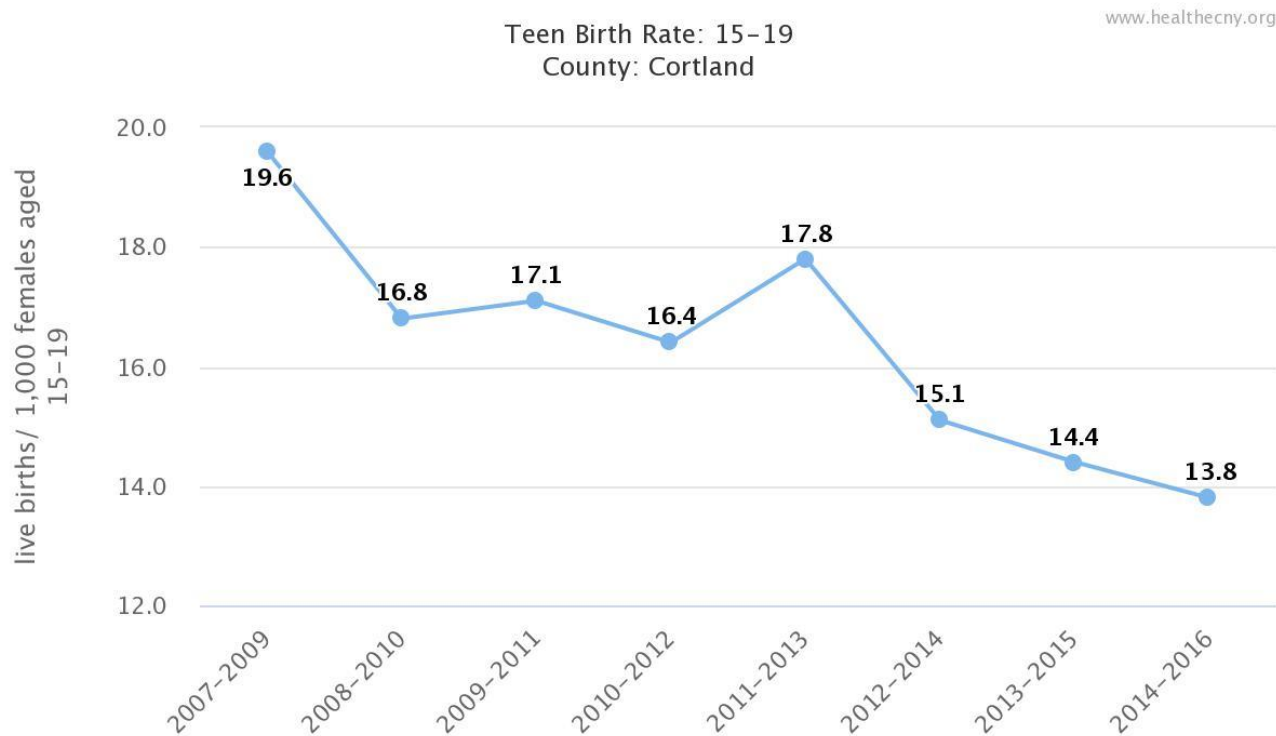
Figure 26. Unintended pregnancy rate, Cortland County and NYS, 2016



Source: NYSDOH Office of Vital Statistics, 2016

The adolescent pregnancy rate (aged 15-17 years) in Cortland County is 6.4 per 1,000; which is significantly lower than the NYS rate (13.3 per 1,000) and met the 2018 Prevention Agenda objective of 25.6 per 1,000. Overall, the adolescent pregnancy rate is 13.8 per 1,000 are to adolescents aged 15-19.⁵⁰ Since 2007, the adolescent birth rate (aged 15-19) has decreased substantially for Cortland County (Figure 27).

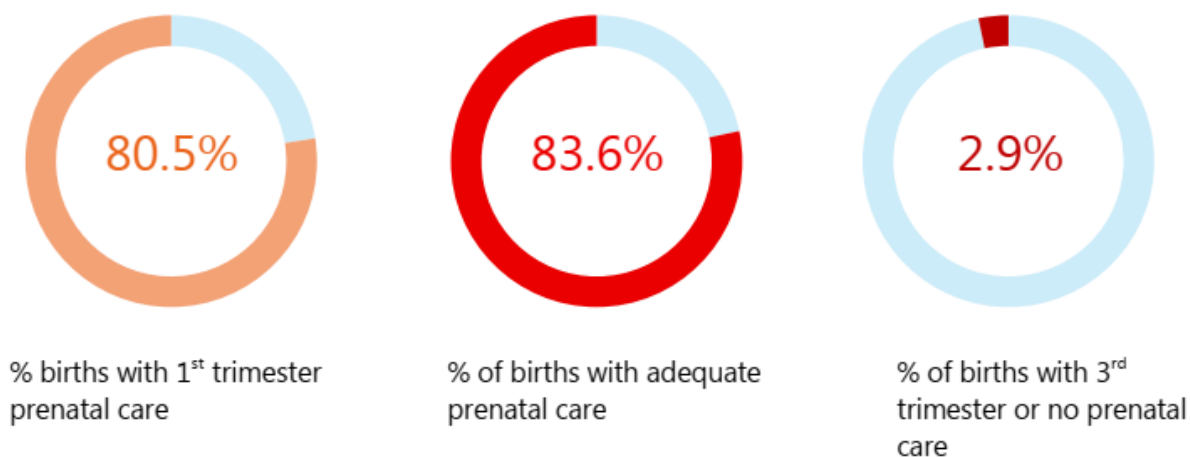
Figure 27. Teen Birth Rate, aged 15-19, 2007-2016



Prenatal Care

Cortland County fares better than NYS excluding NYC in prenatal care indicators. In Cortland County, 80.5% of mothers entered prenatal care in their first trimester compared to 78.4 % in NYS excluding NYC (Figure 28). Additionally, mothers in Cortland County had higher rates of adequate prenatal care (Cortland County: 83.6%; NYS excluding NYC: 75.7%, and a lower percentage of mother with late (3rd trimester) or no prenatal care (Cortland County: 2.9%; NYS excluding NYC: 4.4%).

⁵⁰ Healthcny.org. <http://www.healthcny.org/index.php?module=indicators&controller=index&action=view&indicatorId=430&localeId=1891>

Figure 28. Prenatal care indicators, Cortland County, 2014-2016

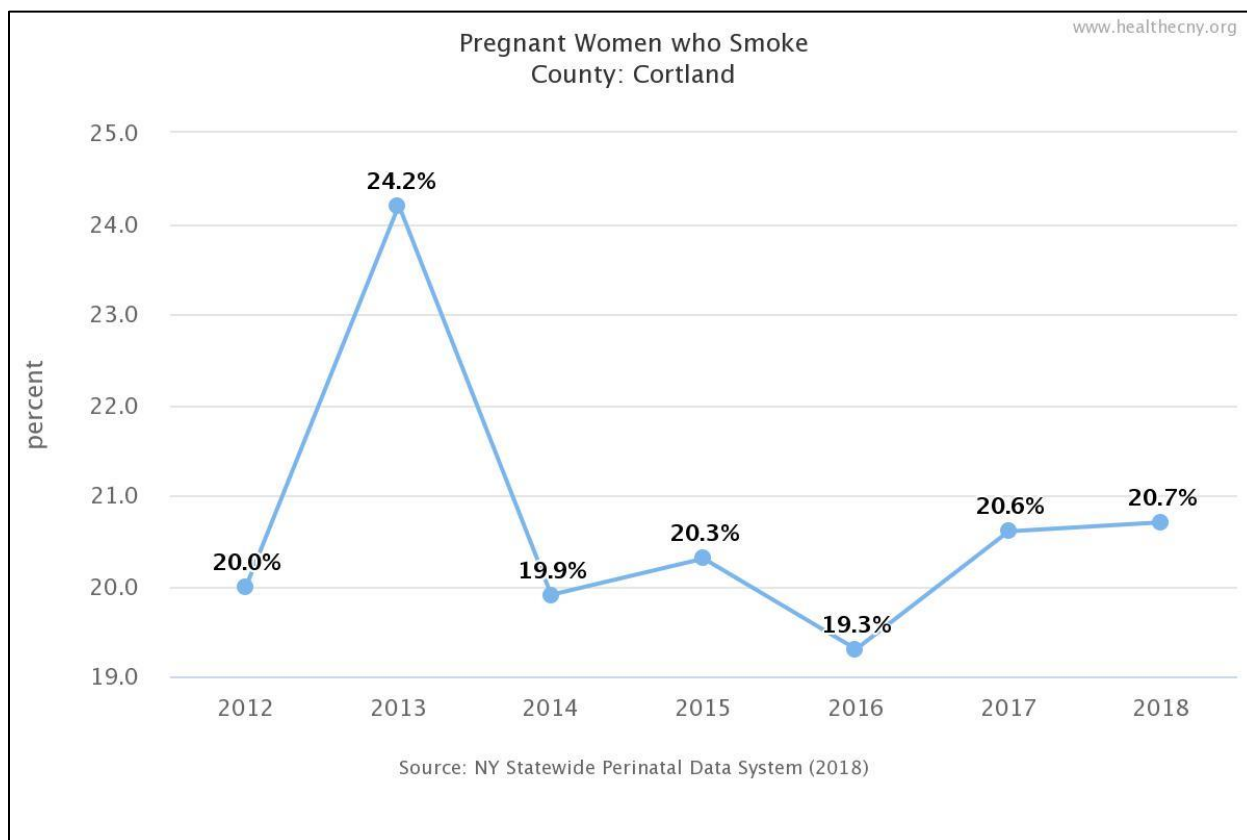
Source: NYSDOH County Health Assessment Indicators, https://www.health.ny.gov/statistics/chac/chai/docs/mih_31.htm

Substance Use in Pregnancy

Cigarette smoking and consuming drugs during pregnancy can have significant impacts on infant health. While rates of smoking in pregnancy have decreased in the last decade, many continue to smoke. Among Cortland County residents who gave birth in 2018, 20.7% reported smoking during their pregnancy.⁵¹ This rate is much higher than NYS excluding NYC (7.9%). Figure 29 shows the rate of women who smoked during pregnancy from the years of 2013-2018.

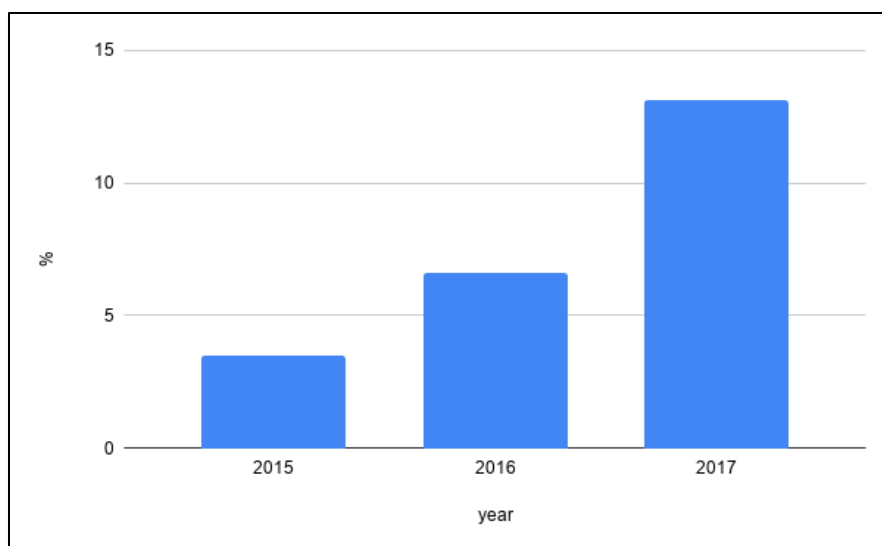
⁵¹ Healthycny.org. <http://www.healthycny.org/indicators/index/view?indicatorId=5271&localeId=1891>

Figure 29. Pregnant Women who Smoke, 2013-2018



In Cortland County, the rate of drug use during pregnancy has almost quadrupled from 3.5% (2015) to 13.1% (2017) (Figure 30).

Figure 30. Drug use During Pregnancy, Cortland County, 2015-2017

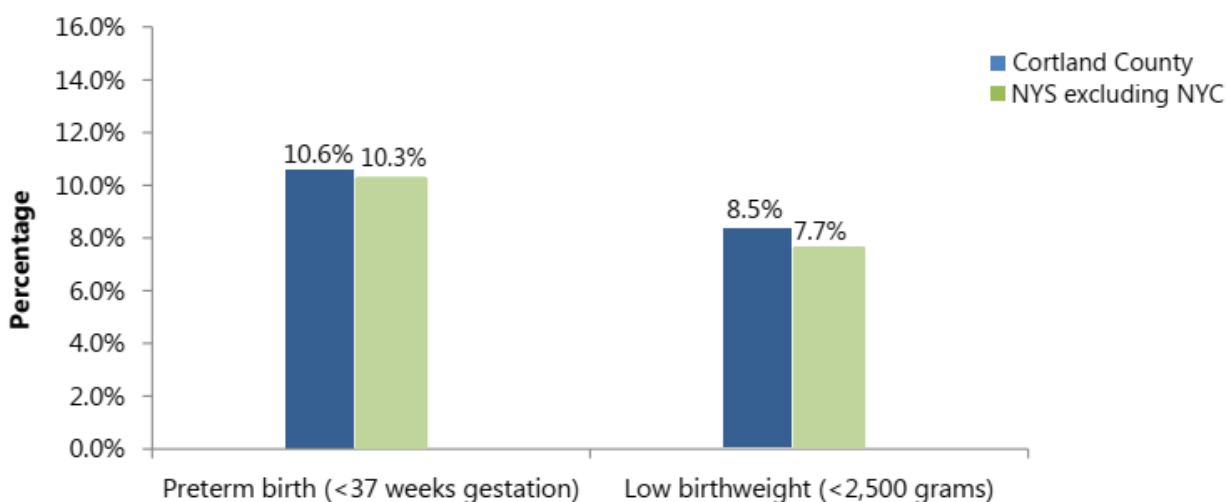


Source: Mothers and Babies Perinatal Network, 2017; <https://mothersandbabies.org/wp-content/uploads/2018/05/2017-Data-Sheets.pdf>

Preterm Birth and Low Birth Weight

In Cortland County, 10.6% of infants are born preterm compared to 10.3% in NYS excluding NYC (Figure 31).⁵² Cortland County's rate nearly met the 2018 Prevention Agenda Objective of 10.2%. The Cortland County rate for low birth weight is 8.5% which is higher than NYS excluding NYC with 7.7%.

Figure 31. Preterm births and low birth weight births, Cortland County and NYS excluding NYC, 2014-2016



Sources: NYSDOH County Health Assessment Indicators, https://www.health.ny.gov/statistics/chac/cha/docs/mih_31.htm

NYSDOH Prevention Agenda Dashboard, https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=11

Infant Mortality

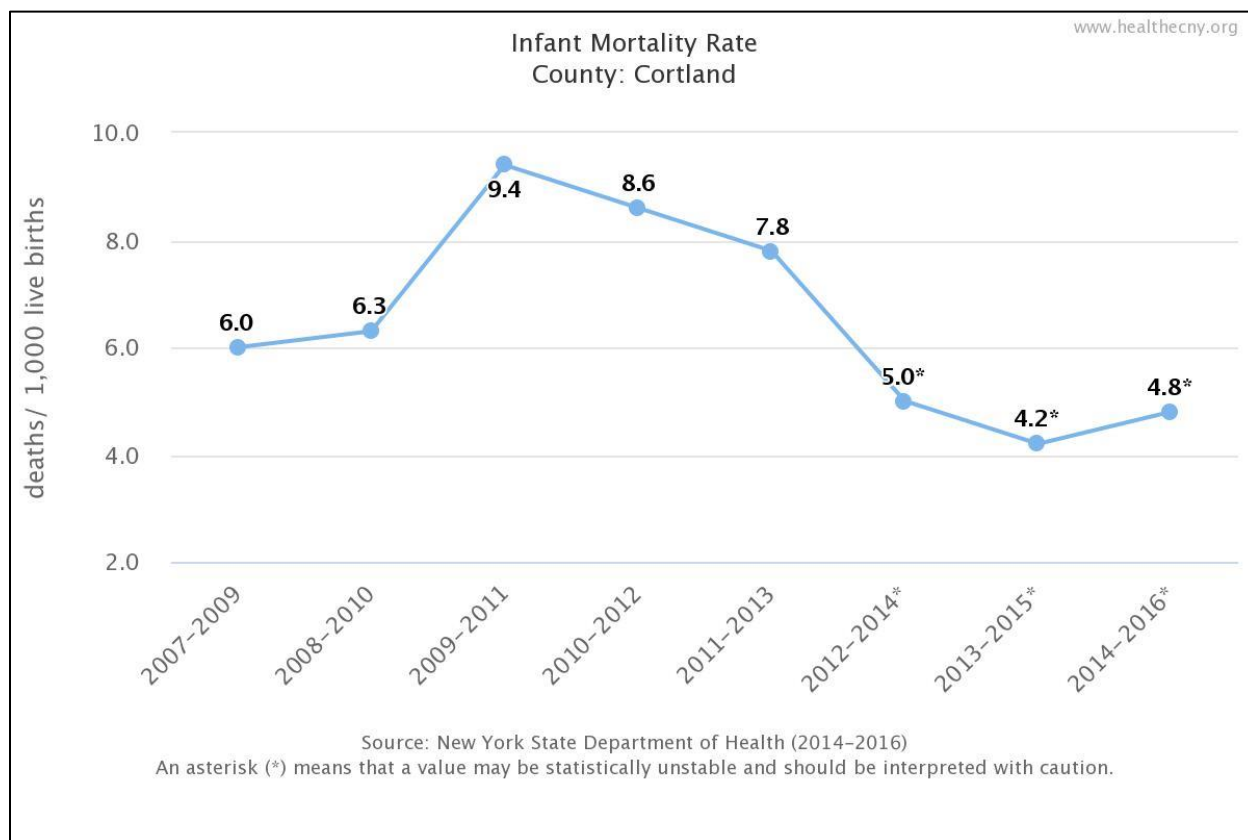
Infant mortality rate continues to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, preterm delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy.⁵³ In Cortland County the infant mortality rate is 4.8 deaths/ per 1,000 live births, this is slightly higher than the NYS infant mortality rate of 4.5 deaths/per 1,000 live births.⁵⁴ Figure 32 shows the trend of infant mortality deaths in Cortland County from 2007-2016.

⁵² NYSDOH. Prevention Agenda Dashboard,

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=11

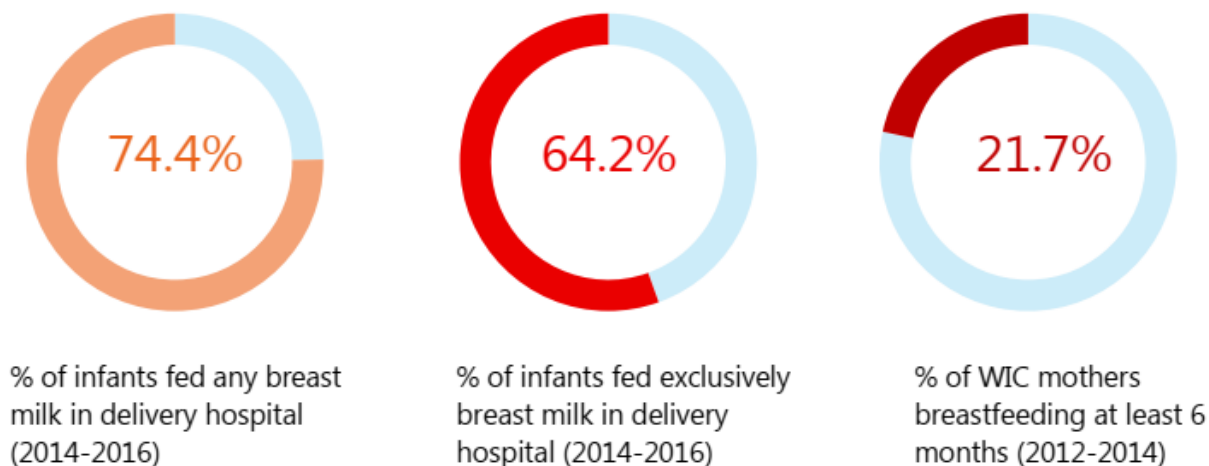
⁵³ Healthecny.org. <http://www.healthecny.org/indicators/index/view?indicatorId=289&localeId=1891>

⁵⁴ Healthecny.org. <http://www.healthecny.org/indicators/index/view?indicatorId=289&localeId=1891>

Figure 32. Infant Mortality Rate, Cortland County, 2007-2016

Breastfeeding

The percentage of infants fed any breast milk in the delivery hospital is lower in Cortland County (74.4%) than in NYS excluding NYC (83.8%). However Cortland County has a higher rate of infants exclusively breastfed at delivery than NYS excluding NYC (Cortland County: 64.2%; NYS excluding NYC: 52.4%) and met the 2018 Prevention Agenda objective of 48.1%. Among WIC program participants in Cortland County, 21.7% breastfeed for at least 6 months (Figure 33).

Figure 33. Breastfeeding indicators, Cortland County, 2014-2016

Sources: NYSDOH County Health Assessment Indicators, 2014-2016, https://www.health.ny.gov/statistics/chac/chai/docs/mih_31.htm

Promote Healthy Women, Infants and Children Summary

While some indicators in this priority area are improving over time, Cortland County continues to see almost one third of births resulting from unintended pregnancies which is higher than the NYS rate. Smoking during pregnancy continues to be a concern; the County rate is significantly higher than NYS excluding NYC and the rate of drug use during pregnancy has almost quadrupled since 2015.

Promote Well-Being and Prevent Mental and Substance Use Disorders

Optimal mental health and emotional well-being are important for achieving overall health. Preventing substance abuse is also critical as addiction can be extremely disruptive in the lives of individuals, their families, and the entire community. This section covers the following topics: mental health, suicide and self-inflicted injury, alcohol abuse, substance abuse, and drug exposed newborns.

When available, rates for NYS excluding NYC are presented in place of NYS rates as these are more directly comparable for Cortland County Indicators. Prevention Agenda objectives are included as benchmarks when available.

Mental Health

In Cortland County, 8.2% of adults reported experiencing poor mental health for 14 or more days in the last month compared to 11.2% in NYS excluding NYC.⁵⁵ While NYS excluding NYC has not met the 2018 Prevention Agenda Objective of 10.1%, Cortland County has met this objective.

Suicide and Self-Inflicted Injury

Cortland County has a comparable rate (4.3 per 10,000) to NYS excluding NYC (4.2 per 10,000) of self-inflicted injury hospitalizations (Table 14). The suicide death rate in Cortland County is also higher than NYS, and neither met the Prevention Agenda objective of 5.9 per 100,000. Particularly concerning is the increasing trend in suicide death rates in Cortland County between the years of 2008 and 2017 (Figure 34).

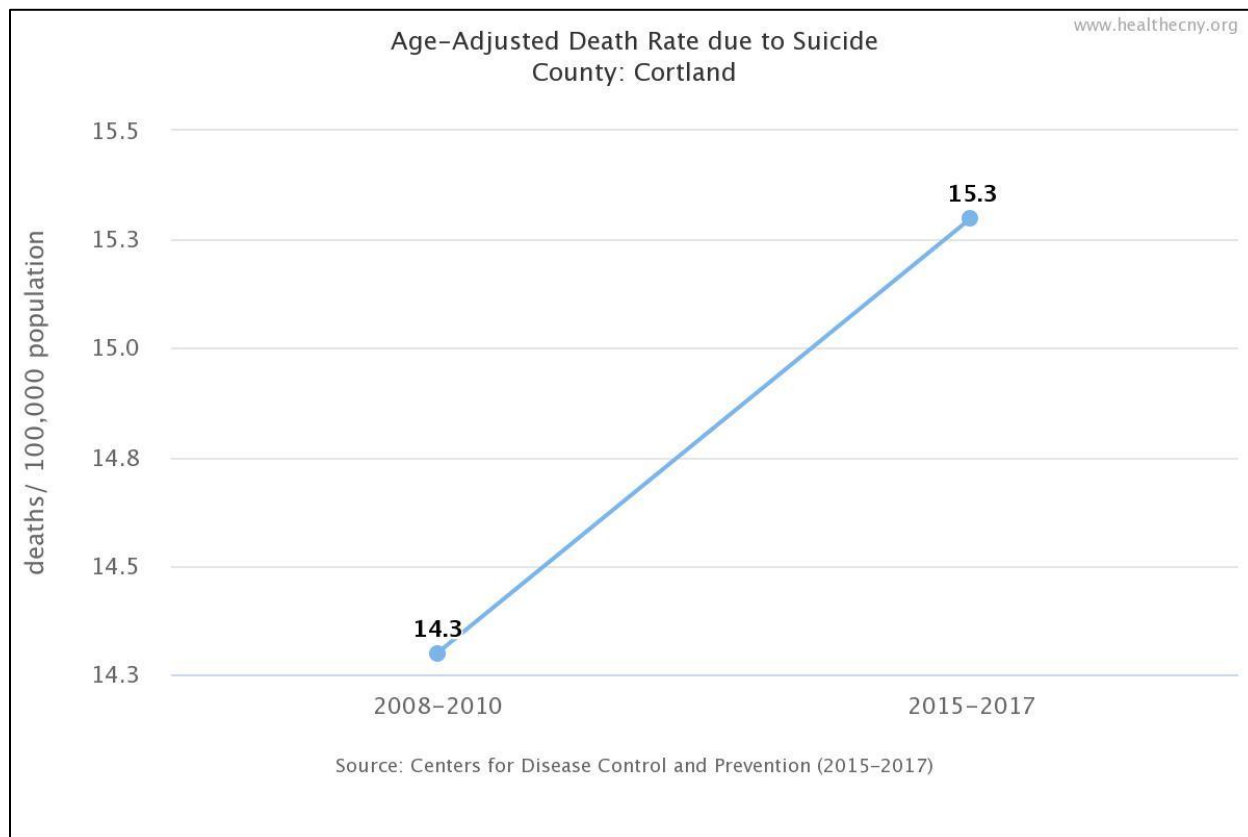
Table 14. Injury indicators, Cortland County, NYS and NYS excluding NYC

Indicator	Cortland County	NYS excluding NYC	NYS
Age-adjusted self-inflicted injury hospitalizations (per 10,000) (2014-2016)	4.3	4.2	--
Age - adjusted suicide mortality rate (per 100,000) (2015-2017)	10.6	--	8.0

Source: NYSDOH County Health Assessment Indicators, https://www.health.ny.gov/statistics/chac/cha/docs/inj_31.htm, 2014-2016; [Healthecny.org, http://www.healthecny.org/index.php?module=indicators&controller=index&action=view&indicatorId=120&localeId=1891](http://www.healthecny.org/index.php?module=indicators&controller=index&action=view&indicatorId=120&localeId=1891)

⁵⁵ Expanded BRFSS, 2016: <https://www.health.ny.gov/statistics/brfss/>

Figure 34. Age-Adjusted Death Rate Due to Suicide, Cortland County, 2008-2010 and 2015-2017



Alcohol Abuse

In Cortland County, 14.6% of adults report binge drinking during the last month compared to 19.1 in NYS excluding NYC.⁵⁶ The rate of alcohol related motor vehicle injuries and deaths occurring in Cortland County (44.2 per 100,000) is higher than the NYS excluding NYC (38.8 per 100,000).⁵⁷ Additionally, 21% of Cortland County motor vehicle deaths involve alcohol compared to 20% in NYS.⁵⁸

The rates of emergency department (ED) visits and hospitalizations due to alcohol abuse for Cortland County and NYS are presented in Table 15. Alcohol abuse is defined as alcohol dependence syndrome, nondependent alcohol abuse, alcohol psychoses, toxic effects of alcohol, and excessive blood level of alcohol and does not include diseases of the nervous system, digestive system, and circulatory system caused by alcohol.

⁵⁶ Expanded BRFSS, 2016: <https://www.health.ny.gov/statistics/brfss/expanded/>

⁵⁷ NYSDOH, Community Health Indicator Reports:

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=11&ctop=15

⁵⁸ County Health Rankings, 2019: https://www.countyhealthrankings.org/app/new-york/2019/compare/snapshot?counties=36_023

Table 15. Overall emergency department and hospitalization rates per 10,000 aged 18+ years for alcohol abuse, Cortland County and NYS, 2014-2016

Indicator	Cortland County	NYS
Age-adjusted emergency department visits due to alcohol abuse (per 10,000) – Aged 18+ years	40.8	82.7
Age-adjusted hospitalizations due to alcohol abuse (per 10,000) – Aged 18+ years	19.1	28.1

Source: *Healthecny.org*; SPARCS 2014-2016

In Cortland County, ED visits due to alcohol are highest among adults ages 25 to 44 years (53.3 per 10,000) (Figure 35) while hospitalization rates are highest among adults ages 45 to 64 years (29.2 per 10,000) (Figure 36).

Figure 35. Emergency Department Visits due to Alcohol Abuse, Age, Cortland County, 2014-2016

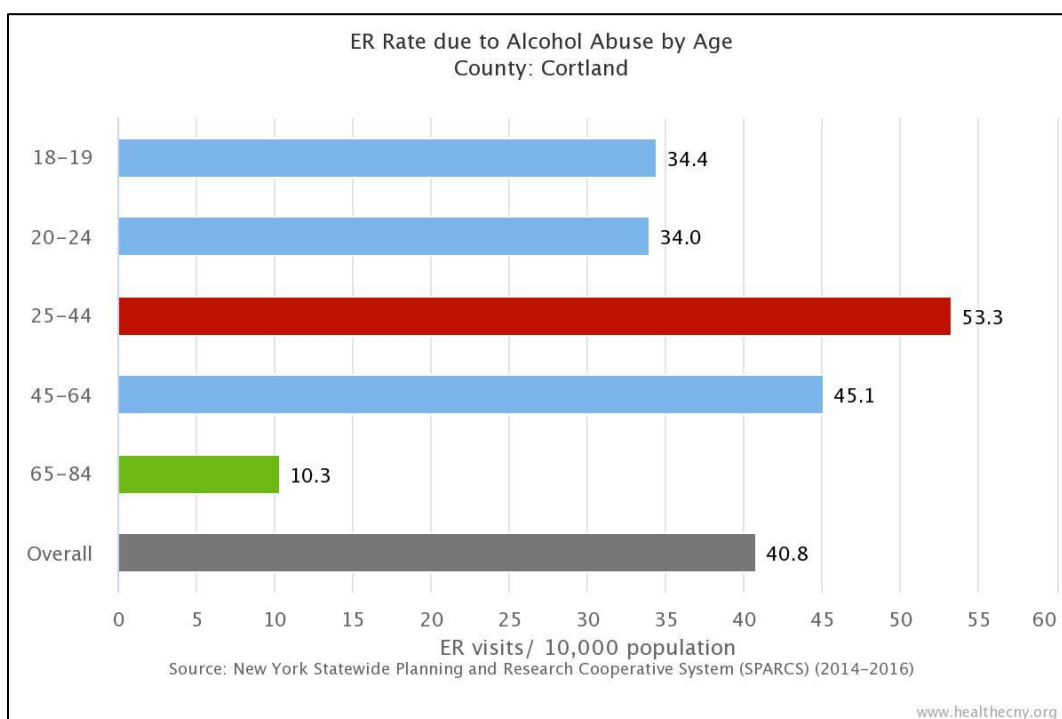
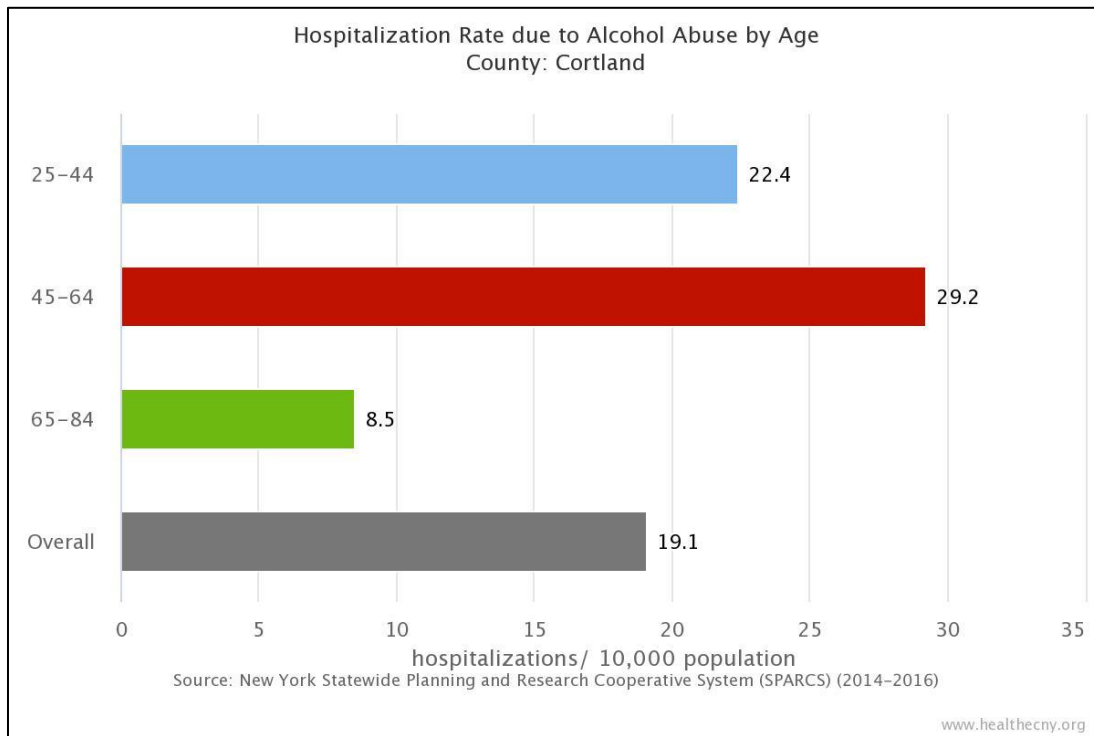


Figure 36. Hospitalization rate due to Alcohol Abuse, Age, Cortland County, 2014-2016



Additionally there are gender differences apparent for both Emergency Room (ER) visits and hospitalizations due to alcohol abuse. In Cortland County, males have higher ER visits (Figure 37) and hospitalizations due to alcohol abuse than females (Figure 38).

Figure 37. Age-Adjusted ER Rate due to Alcohol Abuse, Gender, Cortland County, 2014-2016

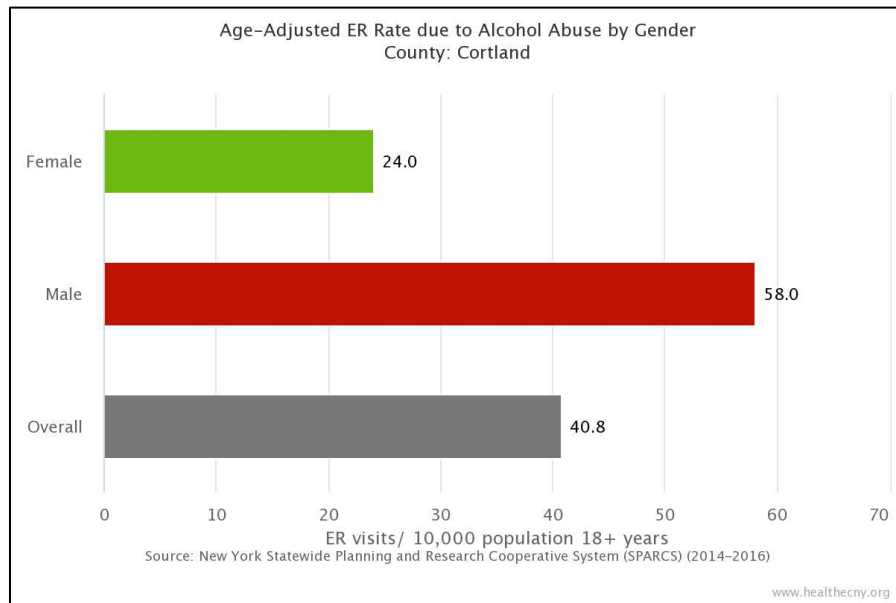
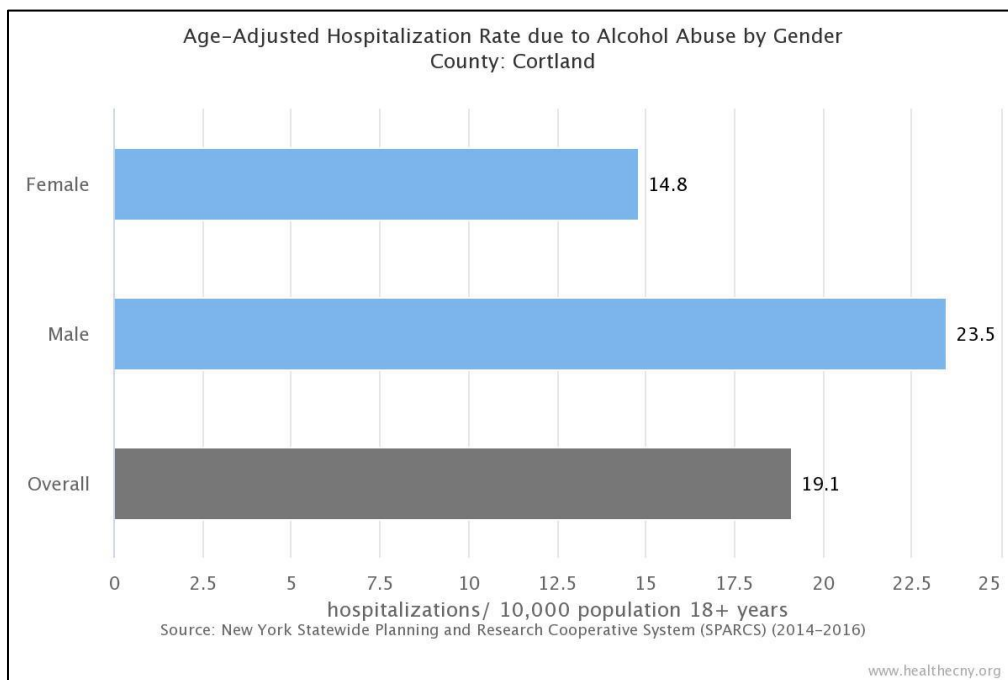


Figure 38. Age-Adjusted Hospitalization Rate, Gender, Cortland County, 2014-2016



Substance Abuse

In Cortland County, the rates of emergency visits and hospitalizations due to substance abuse are lower than the NYS rates (Table 16). These rates are for all types of substance abuse combined; however alcohol-related disorders were excluded.

Table 16. Overall emergency department and hospitalization rates per 10,000 aged 18+ years for substance abuse, Cortland County and NYS, 2014-2016

Indicator	Cortland County	NYS
Age-adjusted emergency department visits due to substance abuse (per 10,000) – Aged 18+ years	27.6	36.9
Age-adjusted hospitalizations due to substance abuse (per 10,000) – Aged 18+ years	10.5	22.0

Source: SPARCS, 2014-2016, www.healthecny.org

Within Cortland County, both emergency room visits and hospitalization rates are highest among adults aged 25 to 34 years (Figures 39 and 40).

Figure 39. ER rate due to Substance Abuse, Age, Cortland County, 2014-2016

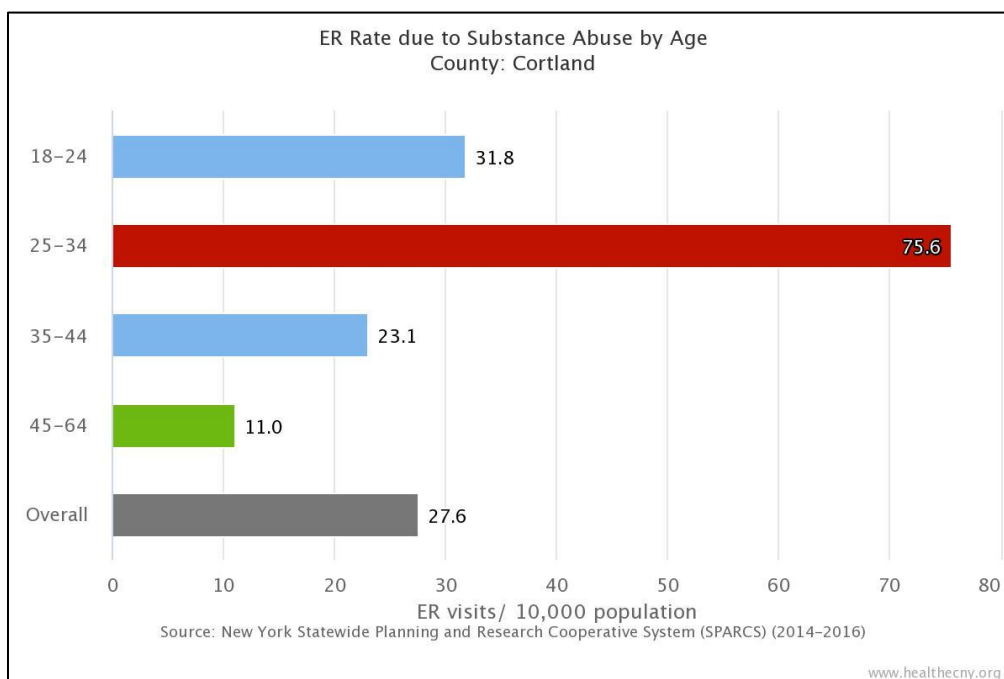
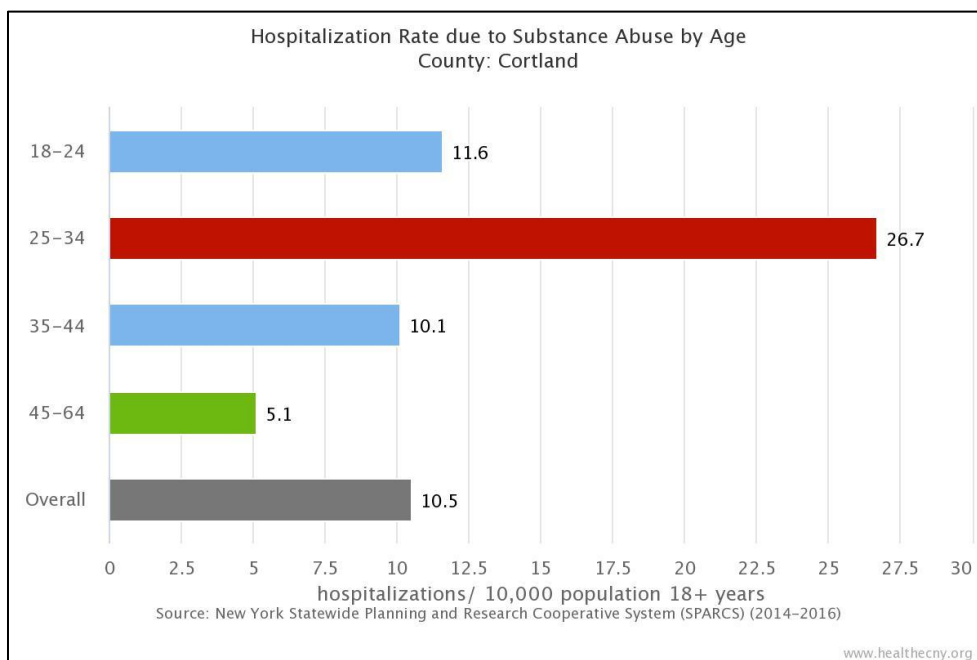


Figure 40. Hospitalization rate due to Substance Abuse, Age, Cortland County, 2014-2016



Differences based upon gender are also noted, with males having higher rates than females for both emergency room visits and hospitalizations due to substance abuse (Figures 41 and 42).

Figure 41. ER rate due to Substance Abuse, Gender, Cortland County, 2014-2016

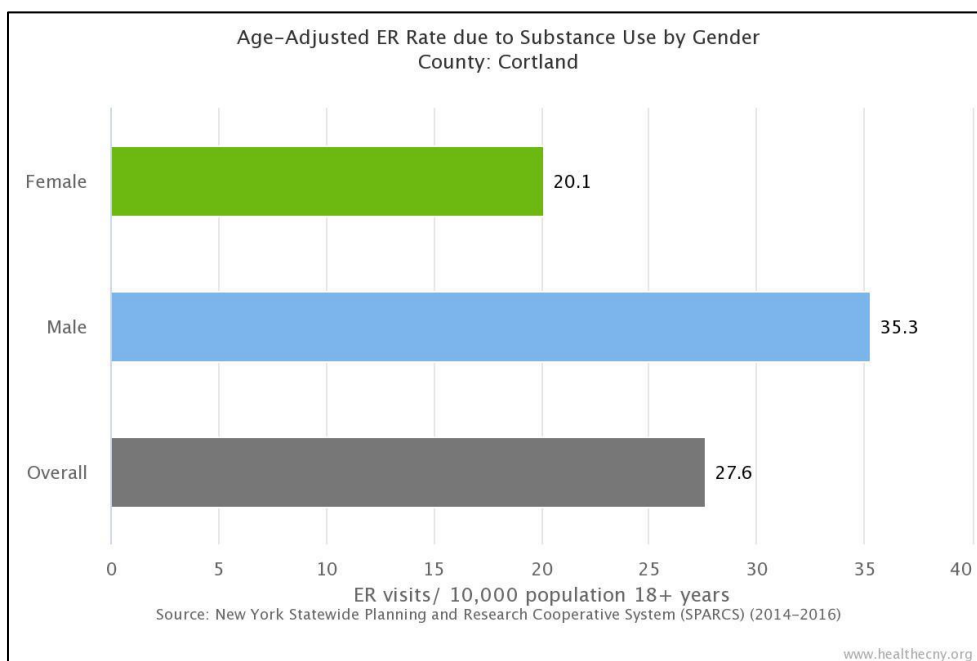
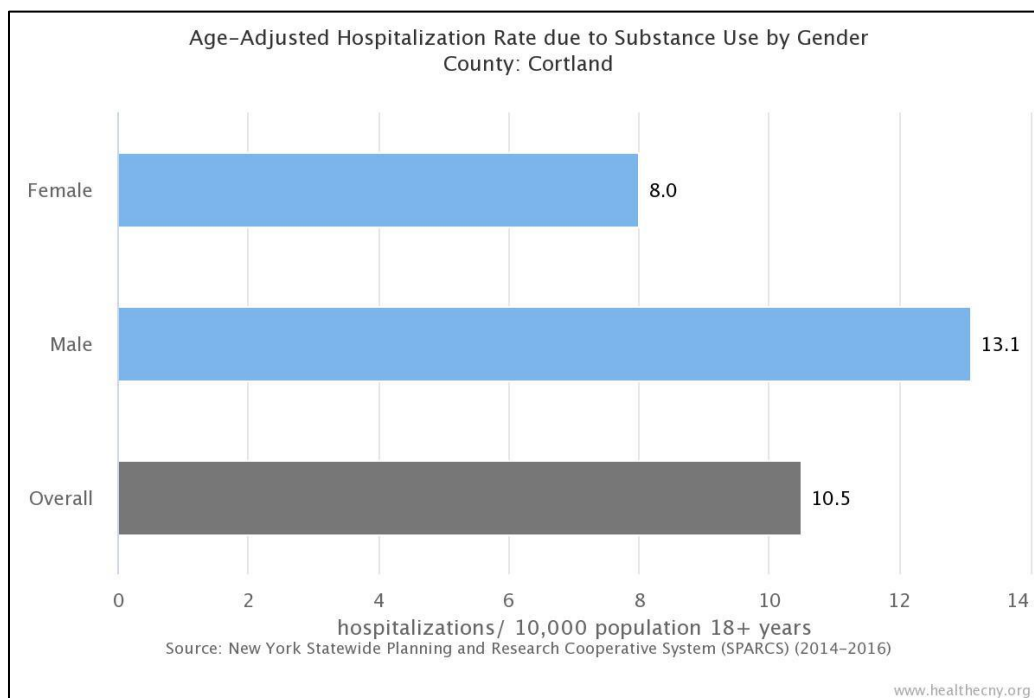


Figure 42. Hospitalization rate due to Substance Abuse, Age, Cortland County, 2014-2016

Opioid Abuse

As seen nationally, Cortland County has experienced an increase in opioid abuse and addiction in the last several years. Opioid is a term used to describe all substances with opium-like effects, including opiates, semi-synthetic opioids derived from morphine (such as heroin, hydrocodone, hydromorphone, oxycodone, and oxymorphone), and synthetic opioids which are not derived from morphine (such as fentanyl, buprenorphine, and methadone).⁵⁹

Figure 43 depicts rates of opioid overdose ED visits for the years of 2017 and 2018 in Cortland County. Across all categories (all opioid overdoses, heroin overdoses, and opioid overdoses excluding heroin), the rates have slightly decreased from 2017 to 2018. Additionally, Cortland County rates exceed rates for NYS excluding NYC in all three categories.⁶⁰

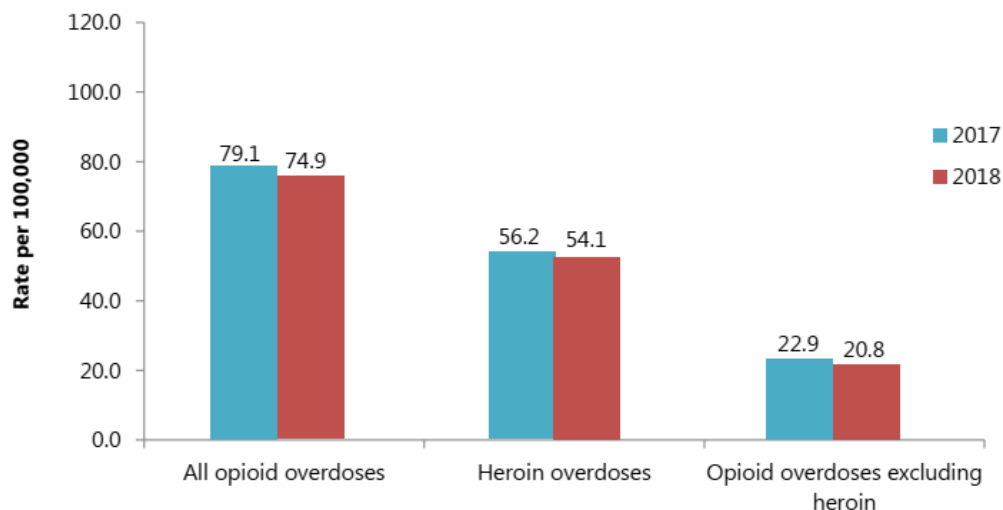
There is only reported data available for hospitalizations for all opioid overdoses in 2018 (12.5 per 100,000) which was lower than NYS excluding NYC (14.9 per 100,000). Hospitalizations for all opioid overdoses (2017), heroin overdoses (2017,2018) and opioid overdoses excluding heroin (2017,2018) was suppressed for confidentiality purposes if there were fewer than 6 discharges.⁶¹

⁵⁹ Onondaga County Health Department Combat Opioid Addiction: <http://www.ongov.net/health/opioids/>

⁶⁰ NYSDOH County Opioid Quarterly for New York State Counties, Published July 2019: https://www.health.ny.gov/statistics/opioid/data/pdf/nys_jul19.pdf

⁶¹ NYSDOH County Opioid Quarterly for New York State Counties, Published July 2019: https://www.health.ny.gov/statistics/opioid/data/pdf/nys_jul19.pdf

Figure 43. Opioid overdose outpatient emergency department visits, Cortland County, 2017 and 2018

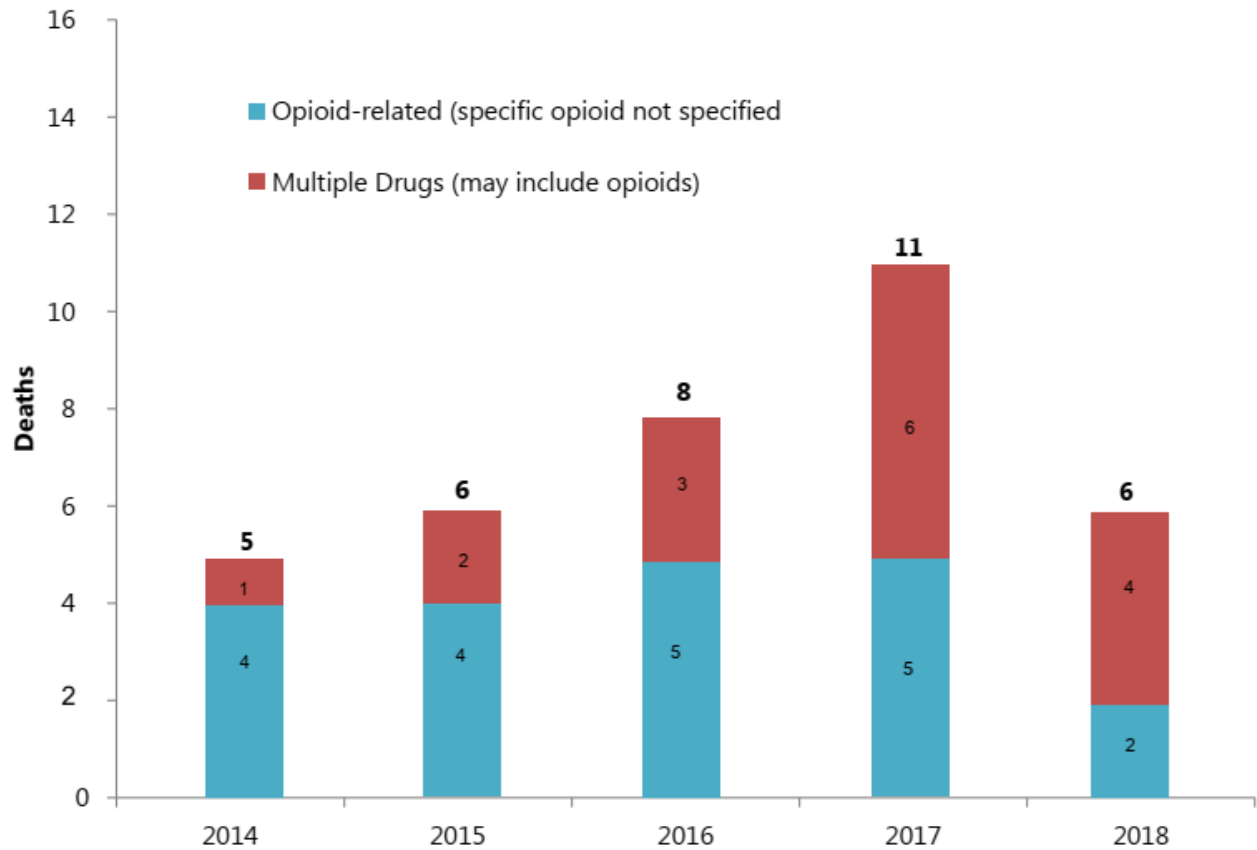


Source: Accessed from the NYSDOH County Opioid Quarterly Report for New York State Counties, Published July 2019:
https://www.health.ny.gov/statistics/opioid/data/pdf/nys_jul19.pdf

In Cortland County, overdose related deaths have increased in recent years since 2014 through 2017 with a slight decline in 2018 (Figure 44). The trend seen in Cortland County follows a broader trend that is occurring both in NYS and nationally. Overdose deaths are usually categorized as “multiple drugs” which may include opioids and “opioids” not specifying which drug.⁶² Ages have ranged from early 20’s (none under 20) to low 60’s. The median age, mid to upper thirties, has not changed since 2012.⁶³

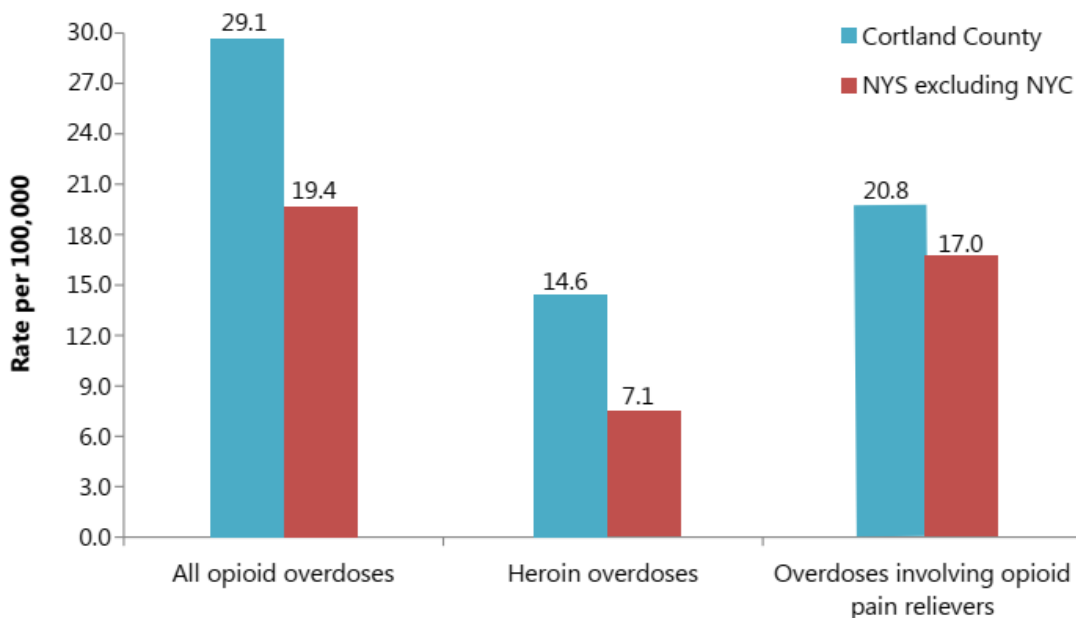
⁶² CCHD Medical Advisor, Dr. Stuart Gillim, 2019

⁶³ CCHD Medical Advisor, Dr. Stuart Gillim, 2019

Figure 44. Overdose deaths, Cortland County 2014-2018

Source: Cortland County Health Department Medical Advisor, Dr. Stuart Gillim, 2019

In 2017, the rate of deaths due to all types of opioid overdoses was higher in Cortland County than in NYS excluding NYC (Figure 45). This was also true for heroin overdoses and overdoses involving opioid pain relievers.

Figure 45. Deaths due to opioid overdoses, Cortland County and NYS excluding NYC, 2017

Source: Accessed from the NYSDOH County Opioid Quarterly Report for New York State Counties, Published July 2019:
https://www.health.ny.gov/statistics/opioid/data/pdf/nys_jul19.pdf

Note: Indicators for heroin and opioid pain relievers are not mutually exclusive as decedents may have multiple substances in their system at the time of death. Overdoses involving opioid pain relievers include pharmaceutically and illicitly produced opioids such as fentanyl.

Drug Exposed Newborns

In Cortland County, the rate of drug use during pregnancy has almost quadrupled from 3.5% (2015) to 13.1% (2017).⁶⁴ With Cortland County experiencing an increase in opioid abuse and addiction over the last several years, the rate of drug exposed newborns may increase. Neonatal abstinence syndrome (NAS) refers to cases in which newborns experience drug withdrawal shortly after birth due to drug exposure in utero. Currently, one of the most common causes of NAS is maternal use or abuse of opioids during pregnancy. In the case of opioids, NAS can result from the use of prescription drugs as legitimately prescribed, from the abuse of prescription drugs, or from the use of illegal opioids like heroin.⁶⁵

Hepatitis A Vaccination

In response to low county-wide Hepatitis A vaccination rates initiatives to increase hepatitis A vaccination among high risk populations, primarily IV drug users and the homeless are underway in Cortland County. The Cortland County Immunization Coalition is initiating a few strategies, including partnering with Guthrie Cortland Medical Center to hold an educational event for the

⁶⁴ Mothers and Babies Perinatal Network, 2017; <https://mothersandbabies.org/wp-content/uploads/2018/05/2017-Data-Sheets.pdf>

⁶⁵ March of Dimes, 2015; <https://www.marchofdimes.org/materials/NAS-Issue-Brief-February-2015.pdf>

medical community and other agencies that serve these populations. The goal for these initiatives is to increase the vaccination rate for Hepatitis A among these high risk populations from 28% in 2018.⁶⁶

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

Although our rates have slightly decreased from 2017 to 2018 for opioid overdose ED visits, they still exceed the rates for NYS excluding NYC across all three categories (all opioid overdoses, heroin overdoses, and opioid overdoses excluding heroin). The use of opioids is a concern for all of Cortland County. With the implementation of the Narcan program in October 2015, through the Cortland County Health Department and collaborations with Guthrie Cortland Medical Center, Cortland Area Communities that Care, and local law enforcement, these rates will continue to decrease.

⁶⁶ CCHD Nursing Staff, 2019: Immunization Program

Prevent Communicable Diseases

The burden of preventable communicable diseases can be reduced through a variety of public health strategies including vaccination, disease investigation, partner notification, testing and treatment, and pre-exposure prophylaxis. Topics covered in this section include: vaccine preventable diseases, HIV, and sexually transmitted infections.

When available, rates for NYS excluding NYC are presented in place of NYS rates as these are more directly comparable for Cortland County Indicators. Prevention Agenda objectives are included as benchmarks when available.

Vaccine Preventable Diseases

A vaccine-preventable disease is an infectious disease for which an effective preventive vaccine exists. If a person acquires a vaccine-preventable disease and dies from it, the death is considered a vaccine-preventable death.⁶⁷ In Cortland County, rates of vaccination against preventable diseases are generally higher than NYS excluding NYC (Table 17).

Table 17. Select vaccine-preventable disease indicators, Cortland County, NYS excluding NYC, and NYSDOH Prevention Agenda Objective

Indicator	Cortland County	NYS excluding NYC	NYS 2018 Objective
Pneumonia/influenza hospitalization rate (per 10,000) – Aged 65+years (2016)	153.6	93.7	
% of adults with an influenza immunization in the past year– Aged 65+ years (2016)	63.6	59.6	70.0
% of adults who ever received a pneumonia shot– Aged 65+years (2016)	82.7	73.8	
% of children with 4:3:1:3:3:1:4 immunization series, age 19-35 months (2018)	73.2	58.9	80.0
% of adolescents with 3-dose HPV immunization- Females aged 13-17 years (2018)	35.9	26.3	50.0

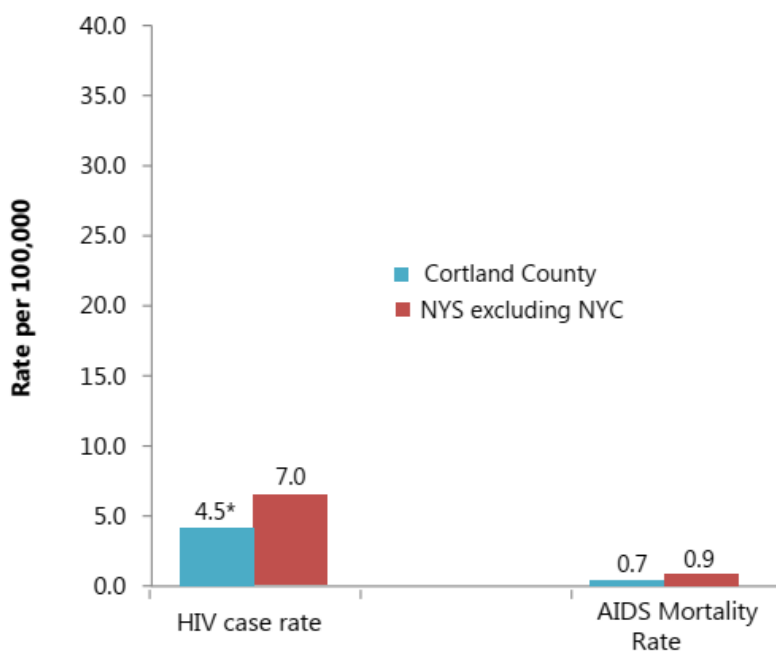
Sources: NYSDOH County Health Assessment Indicators, 2016, https://www.health.ny.gov/statistics/chac/chai/docs/com_31.htm; Expanded BRFSS, 2016; New York State Immunization Information System (NYSIIS), 2018.

⁶⁷ WHO: https://www.who.int/immunization/monitoring_surveillance/burden/VPDs/en/

HIV

Cortland County's incidence rate is lower than NYS excluding NYC for newly diagnosed HIV Cases (Figure 46). With respect to incidence of AIDS, Cortland County's rate is suppressed because it does not meet the reporting criteria.⁶⁸ The mortality rate for AIDS in Cortland County (0.7 per 100,000) is nearly equal to that for NYS excluding NYC (0.9 per 100,000).

Figure 46. Newly diagnosed HIV case and AIDS mortality rates, Cortland County and NYS excluding NYC, 2014-2016



Source: NYS HIV Surveillance System Data, 2014-2016; NYS Vital Statistics, 2014-2016

-all rates are age-adjusted

*the rate/percentage is unstable or unreliable

Sexually Transmitted Infections

Cortland County continues to have rates of sexually transmitted infections that are lower than NYS as a whole.⁶⁹ Overall, Cortland County has a lower rate of gonorrhea in NYS excluding NYC (Table 18). The gonorrhea cases rate among females in Cortland County is higher than that of males, and both are much lower than the average rate for NYS excluding NYC. Cortland County does meet the Prevention Agenda 2018 objective for gonorrhea cases among males or females.

⁶⁸ NYSDOH, County Health Assessment Indicators:

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=11&ctop=7

⁶⁹ NYSDOH County Health Assessment Indicators:

https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=11&ctop=7

The highest case rate of chlamydia in Cortland County is among females aged 15-19 years, though the rates for both males and females are lower than the rate for NYS excluding NYC (Table 18). A recent increase in diagnosed syphilis cases among males in Cortland County is reflected in an incidence rate (14.4 per 100,000) that is higher than NYS excluding NYC (9.4 per 100,000).⁷⁰

Table 18. Select sexually transmitted disease indicators, Cortland County, NYS excluding NYC, and NYSDOH Prevention Agenda 2018 Objective

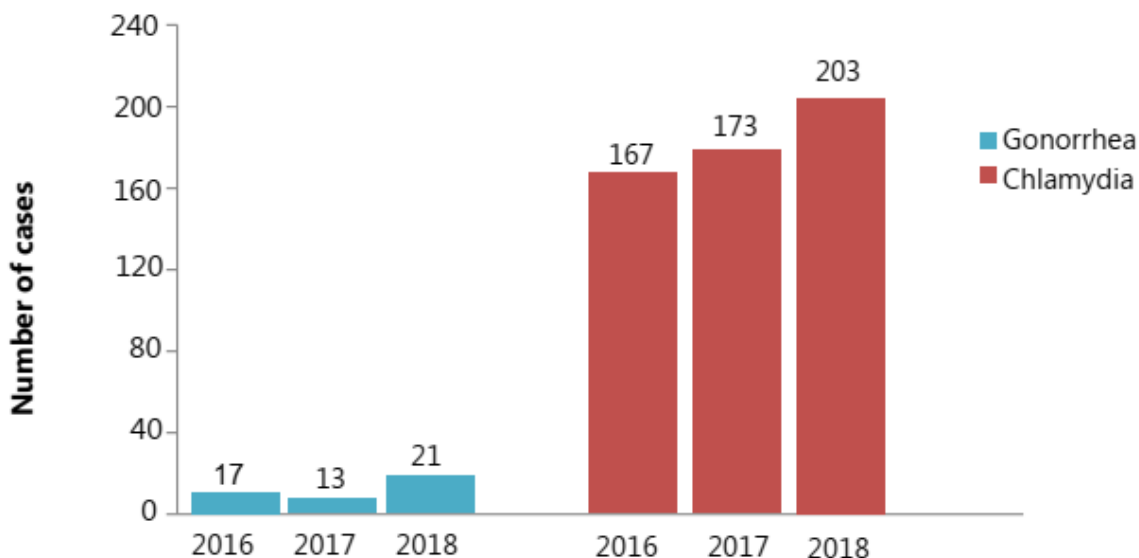
Indicator	Cortland County	NYS excluding NYC	NYS 2018 Objective
Gonorrhea case rate (per 100,000) – Females aged 15-44 years (2016)	83.7	197.1	183.4
Gonorrhea case rate (per 100,000) – Males aged 15-44 years (2016)	52.4	230.0	199.5
Chlamydia case rate (per 100,000) – Females aged 15-44 years (2014-2016)	1153.5	1351.6	--
<i>Aged 15-19 years (2017)</i>	1508.2	2493.3	--
<i>Aged 20-24 years (2017)</i>	1435.3	2996.1	--
Chlamydia case rate (per 100,000) – Males aged 15-44 (2014-2016)	533.4	618.0	--
<i>Aged 15-19 years (2014-2016)</i>	342.8	656.5	--
<i>Aged 20-24 years (2014-2016)</i>	1144.0	1271.7	--
% of sexually active females aged 16-24 years with at least one Chlamydia test in Medicaid Program (2016)	60.1	67.7	--
Early syphilis case rate (per 100,000) (2017)	16.6	10.6	--

Sources: New York State Sexually Transmitted Disease Surveillance System, 2017; NYSDOH County Health Assessment Indicators, 2014-2016, https://www.health.ny.gov/statistics/chac/chai/docs/sti_31.htm; Bureau of Sexual Health and Epidemiology, 2016; NYS Medicaid and Child Health Plus Data, 2016

⁷⁰ NYS Sexually Transmitted Infections Surveillance Report, 2017: https://www.health.ny.gov/statistics/diseases/communicable/std/docs/sti_surveillance_report_2017.pdf

Over the past three years cases of both gonorrhea and chlamydia have increased in Cortland County (Figure 47). Syphilis cases increased from 7 in 2017, to 9 in 2018.⁷¹

Figure 47. Gonorrhea and Chlamydia cases, Cortland County, 2016-2018



Sources: CCHD 2018 Annual Report, NYS Sexually Transmitted Infections Surveillance Report, 2017: https://www.health.ny.gov/statistics/diseases/communicable/std/docs/sti_surveillance_report_2017.pdf

Prevent Communicable Diseases

Cortland County fares well compared to NYS excluding NYC with respect to immunization rates. Unfortunately, Cortland County has seen an increase in gonorrhea and chlamydia cases over the last three years. New cases of syphilis are also on the rise since 2017. Overall, STIs disproportionately impact younger age groups, with the highest rates of chlamydia found in females aged 15-19 years and males aged 20-24 years.

⁷¹ CCHD 2018 Annual Report: <http://www.cortland-co.org/Archive.aspx?AMID=48>

NYS Prevention Agenda 2019-2024 and Social Determinants of Health

The Prevention Agenda is based on a comprehensive statewide assessment of health status and health disparities, changing demographics, and the primary causes of death and diseases. New to this 2019-2024 cycle is the incorporation of a Health Across All Policies approach (Figure 48) which looks for all agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. This approach embraces Healthy Aging to support the State's commitment to making New York the first age-friendly state.⁷²

The main goal of the Prevention Agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. This includes highlighting the social determinants of health – defined by Healthy People 2020 as the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.⁷³

Figure 48. NYS Prevention Agenda 2019-2024: Health Across all Policies



Sources: NYSDOH. Development Process for the NYS Prevention Agenda 2019-2024:

https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/background.htm

⁷² NYS Department of Health. Prevention agenda 2019-2024: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/overview.pdf

⁷³ Healthy People 2020. Social Determinants of Health. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> Accessed on 10/21/2019.

Healthy People 2020 organizes the social determinants of health around five key domains: (1) Economic Stability, (2) Education, (3) Health and Health Care, (4) Neighborhood and Built Environment, and (5) Social and Community Context (Figure 49).⁷⁴ To fully address Cortland County's main health challenges these contributing determinants must be understood. In order to create effective programs, Cortland County must work collaboratively across sectors to address the unique needs of the community. Within these five determinant areas, there are a number of key issues that make up the underlying factors.

Figure 49. Healthy People 2020, Social Determinants of Health, Five Key Domains



Source: Healthy People 2020: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources>

Economic Stability

The key factors included with this determinant are employment, food insecurity, housing instability and poverty. The percentage of all Cortland County residents with incomes below the Federal Poverty Level (FPL) was reported to be 14.7%.⁷⁵ Cortland County families with children under the age of five or children between the ages of 5 and 17 are faring worse, with a poverty rate of 21.9%. Poverty can impact a significant number of health determinants, including access to safe and healthy housing, availability of fresh health foods, opportunities for physical activity, access to educational and employment opportunities. Therefore, it is not surprising that many dealing with poverty may have the poorest health outcomes.

In addition, a 2016 report by the United Way of New York State⁷⁶ showed that 30 % of Cortland County households earn more than the FPL, but less than the basic cost of living for the County. Referred to as ALICE (Asset Limited, Income Constrained, Employed), these individuals may be

⁷⁴ Healthy People 2020. Social Determinants of Health. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> Accessed on 10/21/2019.

⁷⁵ American Community Survey, 2013-2017.

⁷⁶ United Way of New York State. *ALICE. Asset Limited, Income Constrained, Employed, Study of Financial Hardship. 2016.* <https://www.unitedforalice.org/national-comparison>. Accessed 10/23/2019.

struggling to make ends meet in low paying jobs. There are high proportions of households unable to meet the basic cost of living in Munson Corners (59 %), Marathon (56 %), Cortland (54 %), Cuyler (51 %), and Cincinnatus (48%).⁷⁷ These households often have to make difficult choices about where to direct limited resources, and as a result may be less likely to have access to health care, less likely to have reliable transportation and more likely to experience food insecurity.

Education

The key factors included with this determinant are early childhood education and development, enrollment in higher education, high school graduation, language and literacy. Early education is important for creating a foundation for learning in young children. In Cortland County, only 43% of children (ages 3-4) participate in preschool programs. The majority (90.4%) of Cortland County residents over the age of 25 have a high school diploma or higher, while only 26% of residents have attained a bachelor's degree or higher.⁷⁸

Basic educational expertise and skills, including fundamental knowledge, reasoning ability, emotional self-regulation, and interactional abilities, are critical components of health.⁷⁹ Closing the gaps in educational outcomes between low-income and higher-income or majority populations is needed to promote health equity.

Health and Health Care

The key factors included with this determinant are access to health care, access to primary care and health literacy. Many people face barriers that prevent or limit access to needed health care services, which may increase the risk of poor health outcomes and health disparities.⁸⁰

Inadequate health insurance coverage is one of the largest barriers to health care access and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or skip needed care (such as doctor visits, dental care, and medications).⁸¹ In Cortland County 94.6% of residents have health insurance. Despite relatively high insurance coverage rates, not all adults in Cortland County have a regular health care provider (approximately 80%).

The U.S. Department of Health and Human Services (HHS) defines health literacy as “the degree

⁷⁷ 2016 Point-in-Time. Data: American Community Survey. ALICE Demographics: American Community Survey; the ALICE Threshold.

⁷⁸ American Community Survey, 2013-2017

⁷⁹ Hahn. R. & Truman. B. (2015). Education improves public health and promotes health equity. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4691207/> Accessed 10/22/2019.

⁸⁰ HP2020: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-health>

⁸¹ HP2020: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-health>

to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.”⁸² Low or limited health literacy skills are more prevalent among certain population groups and may be linked to many poor health outcomes. Health literacy has the potential to impact a broad array of functional skills that are required to make health decisions in various settings. Improvements in health practice that address low health literacy are needed to reduce disparities in health status.

Neighborhood and Built Environment

The key factors included with this determinant are access to foods that support healthy eating patterns, quality of housing, crime and violence and environmental conditions. Health is also impacted by where people live, work, and play. This includes the built environment (sidewalks, roads, bike lanes, etc.), the natural environment (parks, green space, etc.), any potential toxins or hazards, housing conditions and physical barriers.⁸³

Regarding the built environment, much of Cortland County is rural. Throughout Cortland County there are many parks and Farmer’s Markets, located in both the rural and urban areas of the County. Increasing access to both of these attributes help to increase health equity and health outcomes for residents.

Housing characteristics play an important role in facilitating good health. In Cortland County, 58% of houses were built before 1960, and 45% were built prior to 1940.⁸⁴ Older homes are more likely to contain environmental toxins, and in areas of poverty, these homes are less likely to be maintained to healthy standards. Substandard housing can lead to higher rates of asthma and lead poisoning.

Crime and violence are also important to consider in the context of the environment. Crime can have a significant impact on population health. In addition to injury and death resulting from violent crime, high crime rates can negatively affect a community through chronic stress. Exposure to violence causes significant stress, which has been linked to many poor health outcomes.⁸⁵ Residents may also be less likely to utilize community resources for physical activity, such as parks and other green space, if the areas are perceived as unsafe. Cortland County has low rates of violent crimes (murder, rape, robbery and aggravated assault), although the County has high rates of property crimes (burglary, larceny and motor vehicle theft).

⁸² HP 2020: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/health-literacy#1>

⁸³ Healthy People 2020. Social Determinants of Health. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> Accessed on 10/21/2019.

⁸⁴ American Community Survey, 2013-2017: <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

⁸⁵ Felitti, Vincent J et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. Am. Journal of Prev. Med. 14:4, 245-58: <https://www.ncbi.nlm.nih.gov/pubmed/9635069>

Social and Community Context

The key factors included with this determinant are social cohesion, civic participation, discrimination, and incarceration. One indicator of social cohesion is the amount of social capital a community has. Social capital deals with shared group resources (ex. social networks and social relationships).⁸⁶ High levels of social support can positively influence health outcomes. Although some social support can convey negative behaviors or add stress, social isolation can be detrimental to health and increase mortality, especially for older adults.⁸⁷ In Cortland County, approximately 17% of County residents are over 65 years of age. Senior Centers offer the opportunity for social interaction with other older adults, promoting conversation, camaraderie, support and friendship.⁸⁸ Currently Cortland County has eight senior centers. These are located in Cortland, Harford, Homer, Willet/Cincinnatus, Scott, Truxton, Marathon and McGraw. Making sure that resources and social support are available is imperative for the health of those in this age group.

When compared to the general population, men and women with a history of incarceration are in worse mental and physical health. Data from the Bureau of Justice Statistics found that, in 2005, more than half of all prison and jail inmates had mental health problems.⁸⁹ Studies have also shown that when compared to general populations, jail and prison inmates of both genders are more likely to have high blood pressure, asthma, cancer, and infectious diseases, such as tuberculosis, hepatitis C, and HIV.⁹⁰ In Cortland County, the average daily population of inmates in the Cortland County Jail is approximately 59 people.⁹¹ Strategies, such as “front–end” programs (e.g., drug treatment courts), providing comprehensive health care services during incarceration, and linking people to health care services post release may help to improve the health and well–being of those who are incarcerated and those with a history of incarceration.⁹²

⁸⁶ Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/social-cohesion>

⁸⁷ Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/social-cohesion>

⁸⁸ Area Agency on Aging: <https://www.cortland-co.org/604/Senior-Centers>

⁸⁹ James DJ, Glaze LE. Mental health problems of prison and jail inmates. Bureau of Justice Statistics Special Report. Washington, DC: Bureau of Justice Statistics; 2006. Available from: <https://www.bjs.gov/content/pub/pdf/mhppij.pdf>

⁹⁰ Healthy People, 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/incarceration>

⁹¹ USA County Records. <http://www.usacountyrecords.com/state/new-york/jails/cortland-county-ny-jail-inmates/>

⁹² Healthy People. 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/incarceration>

Community Assets and Resources

Cortland County contains a variety of assets and resources available to address health challenges. Assets and resources covered in this section include: public health department, health care, academic institutions, community based agencies, and transportation.

Public Health Department

- The [Cortland County Health Department \(CCHD\)](#) has provided a wide range of public health services to the community since its creation in 1929. With a mission to promote health, prevent disease, injury, and disability while enhancing the quality of the life within our community, the CCHD has a 2019 budget of approximately \$1.6 million (including over \$1.3 million in grants) and 55 employees. For a description of all the programs and services offered by the CCHD, please see the [CCHD Annual Report](#). The CCHD is currently pursuing accreditation through the national Public Health Accreditation Board to ensure the highest level of public health service to the community.

Health Care

- According to the New York State Education Department, there are currently 59 physicians, 17 physician assistants, 568 registered professional nurses, 255 licensed practical nurses, and 52 nurse practitioners practicing in Cortland County.⁹³
- [Guthrie Cortland Medical Center \(GCMC\)](#) is an independent, nonprofit, 162-bed acute care facility with an attached 80-bed residential care facility. In fiscal year 2018, GCMC had over 4,400 inpatient visits, more than 98,850 outpatient visits, 439 inpatient surgeries, and 30,950 emergency department visits. During this same time period there were 383 births.⁹⁴
- [Family Health Network \(FHN\)](#) established in 1972, is a Federally Funded Community Health Center (FQHC), serving Cortland and contiguous counties. FHN is the only source of care in three of the five communities served, and the only source of sliding adjustments for low-income individuals and families in the Cortland County region. Programs include: family practice, women's health, perinatal program, pediatrics, occupational health, school health program and family dentistry.⁹⁵

⁹³ NYSED.org: <http://www.op.nysed.gov/prof/med/medcounts.htm>; <http://www.op.nysed.gov/prof/nurse/nursecounts.htm>

⁹⁴ Guthrie Cortland Medical Center: <https://www.guthrie.org/sites/default/files/Cortland%20Medical%20Center%20CHNA%20%28Final%29.pdf>

⁹⁵ Family Health Network: <http://www.familyhealthnetwork.org/about-us/>

Academic Institutions

- There are two academic institutions with health-related programs whose students and faculty are ready and willing to assist in addressing community health needs.
- **SUNY Cortland** was established in 1868. The college's health program prepares students for a variety of health professions. Graduates make their careers in a wide range of settings, including health departments, hospitals and other health care facilities, community health organizations, corporate and private wellness facilities and environmental agencies. Majors include: Community Health, Health Education, Healthcare Management, Human Services Studies, and Pre-Physical Therapy/Occupational Therapy. Graduate Studies include: Community Health and Health Education.⁹⁶
- **TC3** was established in 1968. The College's rigorous and highly-praised nursing program offers diverse clinical experiences in hospitals, long-term care facilities, and community settings. Courses in nursing and the liberal arts provide in-depth career preparation.⁹⁷

Community-based Health and Human Services Agencies

- **Area Agency on Aging**'s mission is to advocate, plan, develop and provide a coordinated system of programs and services on behalf of all aging citizens of Cortland County so that they might live with independence and dignity.⁹⁸
- **Cortland Area Communities that Care (CACTC)** engages the community to promote a healthy culture for positive youth development. CACTC is a community coalition - not just one organization - made up of nonprofit organizations, government agencies, law enforcement, schools, volunteers, youth, and community members working together for a common cause.⁹⁹
- **Cortland County Mental Health Department** assists individuals with mental health issues become more functional in emotional, cognitive, social, vocational, educational and/or self-care areas. The mental health clinic ensures that quality of care is improved in all areas including mental health promotion, prevention, treatment and rehabilitation.¹⁰⁰
- **Seven Valleys Health Coalition (SVHC)** is a coalition of providers and interested individuals who play an active role in promoting effective, efficient and accessible health and human services to constituents in the service area. Leaders from local health and human service agencies, working under the umbrella of SVHC, have identified gaps in services, potential funding sources, areas of collaboration, and have established a forum

⁹⁶ SUNY Cortland Health Department: <https://www2.cortland.edu/health>

⁹⁷ TC3 Nursing Program: <https://www.tompkinscortland.edu/academics/programs/nursing>

⁹⁸ Area Agency on Aging: <http://www.cortland-co.org/602/About-Us>

⁹⁹ Cortland Area Communities that Care: <https://www.cortlandareact.org/>

¹⁰⁰ Cortland County Mental health Department: <http://www.cortland-co.org/452/Mental-Health-Clinic>

for communicating on a regular basis.¹⁰¹

- **United Way of Cortland County**'s mission is to improve the lives of individuals and families in Cortland County by uniting the resources of donors, volunteers, and agencies.¹⁰²
- For a complete list of health and human service agencies in Cortland County refer to [2-1-1](#). 2-1-1 is a free, confidential, multilingual service providing an easy way to get connected with services in community.¹⁰³

Transportation

- [Cortland Transit](#) provides public transportation via bus within Cortland County. Accessible buses are available for persons with disabilities. Fixed route services are offered to many of the areas in the City of Cortland. Service is also offered to Marathon, Cincinnatus, Willet, Tompkins Cortland Community College and Cornell University.¹⁰⁴

Reports, Assessments and Plans

- Reports, assessments and plans from community partners were used to gather data for the Community Health Assessment health indicators and to highlight the health implications across many sectors within Cortland County. This collaborative effort helped to outline the goals, objectives, and strategies of the Community Health Improvement Plan.
- **Cortland Area Communities That Care:** [Cortland County PFS Youth Survey](#)
- **Cortland County Area on Aging:** 2019 Needs Assessment (*See Appendix A*)
- **Cortland County Mental Health:** Community Services Board 2019-2020 County Plan (*See Appendix B*)
- **Guthrie Cortland Medical Center:** [Community Health Needs Assessment](#) and [Annual Implementation Strategy](#)
- **Seven Valleys Health Coalition:** [Cortland Counts Report Card](#)
- **United Way of Cortland County:** ALICE in Cortland County (*See Appendix C*)

¹⁰¹ Seven Valleys Health Coalition: <https://www.sevenvalleyshealth.org/who-we-are>

¹⁰² United Way of Cortland County: <https://www.cortlandunitedway.org/>

¹⁰³ 2-1-1: <https://www.211cortland.org/>

¹⁰⁴ Cortland Transit: <http://www.cortlandtransit.8m.net/>

Community Engagement

To reaffirm existing or identify new priority areas, the Cortland County Health Department and the Community Assessment Team sought to gather feedback from the community on important health issues. This process is described below.

Survey

A Community Health Assessment Survey was designed and distributed to engage County residents, and focus groups were conducted to reach broad populations of the public and populations at a higher risk for poor health outcomes. The survey was developed by the CCHD Strategic Planning Committee, with input from the Community Assessment Team. This Community Health Assessment Survey was ten questions in length, containing questions about factors that create a healthy community, the most important health related problems impacting overall health, the top unmet health needs, top risky behaviors impacting overall health, and the top unmet non-health needs in our community. The survey also asked respondents demographic information. Space for open-ended comments was provided for each question.

The survey was made available online and in hard copy, and responses were anonymous. Surveys were circulated throughout the community by the Health Department, partnering agencies and organizations and through social media. Dissemination of the survey included many places throughout the community in order to reach a large portion of the population.

These included: the Healthy Neighborhoods Program, Traveling Tots Program, the Jacobus Center for Reproductive Health, Water Festival, Senior Enrichment Day, Senior Games, Relay for Life, Cortland County Employees, Chris's Run, Cortland County Jail, Cortland Senior Center, McGraw Senior Center, Marathon Senior Center, Scott Senior Center, New York Connects Resource Fair, Law Enforcement Day, Willet Senior Center, Harford Senior Center, Homer Senior Center, Conservation Field Days, Truxton Senior Center, Cortland High School Open House, Community Baby Shower, Loaves and Fishes, Immunization Coalition of Cortland County, Lawrence House, Family Counseling Services, Chamber of Commerce, CAPCO (Staff, Parents/Caregivers), Schools, Cortland Counts Mailing List, Area Physician Offices, 211, YWCA, Cortland Health Center, Office of Aging (Meals on Wheels, HEAP, Annual Enrollment), Access to Independence, Cortland County Health Department's Facebook, Guthrie Cortland Medical Center, and Cortland Counts Forum.

Surveys were collected through May 2018-January 2019. A total of 1,435 survey responses were received. The results of the survey can be found in *Appendix D*.

Focus Groups

Following completion of the Community Health Assessment Survey, it was determined that the CCHD would organize and facilitate community focus groups throughout Cortland County as part of the Community Health Assessment. Community focus groups would allow for continued community engagement. These focus groups provided a platform for CCHD to discuss the results of the CHA Survey and other important community health issues in order to obtain a more detailed picture of health within the county. Significant effort was placed on recruiting at-risk community members through partnering agencies and other community groups.

Leaders of community agencies were contacted via email and phone calls to gauge agency interest in hosting and participating in a CCHD Community Health Assessment focus group. If interest was expressed, agency leaders were asked to recruit employees and consumers to attend the scheduled focus group. Recruitment efforts were also made at the Cortland County Worksite Wellness Coalition Meeting and Community Health Assessment Presentation in late June 2019. Approximately 55 attendees were provided CHA focus group interest forms. Individuals who filled out the form were then contacted via email to attend one of two general community member focus groups hosted by GCMC in early August 2019. Community members were also recruited via the CCHD social media page.

From June 2019-August 2019, 22 focus groups were conducted across Cortland County. 11 of these focus groups were scheduled and facilitated by the Cortland County Health Department. An additional 11 focus groups were scheduled and facilitated by the Cortland County Area Agency on Aging in collaboration with CCHD. 132 people in total participated. The results of the focus groups can be found in *Appendix E*.

Community Feedback Summary

While Cortland County residents have a wide variety of concerns around both health status and health system issues, there was strong agreement around the top priorities of the community. Addressing **alcohol/substance abuse, chronic disease, mental health and cost/access to health care** is extremely important to residents. These concerns are confirmed by the health indicator data, reinforcing the need for a community-wide effort to address the selected priority areas through a formalized community health improvement process.

COMMUNITY HEALTH IMPROVEMENT PLAN

Overview

The comprehensive Community Health Assessment process informed the development of the Community Health Improvement Plan (CHIP). The two Prevention Agenda priority areas to be addressed in Cortland County for 2019-2021 are 1) **Prevent Chronic Disease**, and 2) **Promote Well-Being and Prevent Mental and Substance Use Disorders**. These priorities were reaffirmed by the community, as well as by health and public health professionals and community based-health and human service agencies following a thorough data review and community engagement process (community health assessment survey and focus groups, *(see Appendices D and E)* over the course of a year. While these topics were selected as priorities for the 2019-2021 CHIP, they do not reflect the full scope of work of the Cortland County Health Department (CCHD), Guthrie Cortland Medical Center (GCMC) and partners.

Note: The CHIP represented in this document covers the first three years of the 2019-2024 Prevention Agenda cycle, the CHIP will be updated in 2021 for the remaining three years.

Scope

The scope of work included in the Cortland County CHIP reflects the priority focus areas and objectives that will have a substantial impact on improving the health and wellbeing of county residents within the selected priority areas. These were determined by the Community Assessment Team (CAT) based upon their potential for broad impact, and considerations were made for the strengths and capacity of the CCHD and GCMC. Whenever possible, interventions and process measures were selected from the NYSDOH's Prevention Agenda 2019-2024 Action Plan. An email was also sent to community partners requesting input on existing efforts. These partners' provided a list of interventions, activities, and strategies that will continue to be used to reach the prevention agenda objectives and goals.

Each agency represented on the CAT has a role in the implementation of interventions whether as the lead on an activity or as a supporting partner. In addition to the commitment from CCHD and GCMC, a strong network of community partners is essential to the success of the proposed interventions.

Some of the many community partners that are actively involved in CHIP activities include but are not limited to: CAPCO Headstart, WIC, Cortland County Mental Health Department, CACTC, Cortland Prevention Resources, Catholic Charities, Cortland City School District, Cortland City Youth Bureau, Cortland County Wellness Team, City of Cortland Common

Council, Traffic Safety Board, Cortland Free Library, Homer Central School District, Village of Homer, St. Joseph's Hospital, Cortland County Youth Bureau, Family Health Network, Child Development Council, Mothers' and Babies Perinatal Network, La Leche League, Trinity Valley, Cavity Free Cortland, Cortland County Jail, Cortland County Sheriff's Department, Cortland Police Department, Village of Homer Police Department, SUNY Cortland Police Department, Family Counseling Services, TC3, SUNY Cortland, Care Compass Network, Dr. Mayo, Renaissance OB/GYN, Dr. Oh, Dr. Djafari Pediatrics, Dr. Clifford and many community members.

Partner Engagement

Partner engagement will be critical in tracking our CHIP progress and will be maintained throughout the duration of the Prevention Agenda. This will be done through the Cortland Counts process and forum (annually), the CCHD's Chronic Disease meetings (every other month) and the Community Services Board Meetings (every other month). Cortland Counts is an ongoing integrated assessment, planning, and evaluation process which recognize the interdependence of all sectors of the community. Through the Cortland Counts process, each year during the third quarter the Annual Report Card is issued about the health and well-being in the community and an annual community forum is held in January. The CCHD Chronic Disease meeting will consist of partners primarily focusing on the ***Prevent Chronic Disease Priority*** and the Community Services Board meeting will consist of partners primarily focusing on the ***Promote Well-Being and Prevent Mental and Substance Use Disorders Priority***. These meetings will help to track the progress of the CHIP initiatives and will identify the need for mid-course corrections.

Stakeholder Distribution

This plan in its entirety will be made available for the all community stakeholders after required submission to the New York State Department of Health. This document will be uploaded to the [Cortland County Health Department's Data and Report webpage](#) in early January 2020. Press releases to local media sources will be used to help disseminate this information to the community. Social media posts will also be utilized; this includes the Health Department's Facebook, Twitter and Instagram accounts.

CHIP Workplan

The workplan below describes the objectives, interventions, process measures, and partner agencies for each priority and goal being addressed in the Cortland County CHIP. This document gives a broad overview of all interventions and process measures that will be worked on over the

next few years, this is not all inclusive. For the complete Cortland County CHIP workplan refer to the [Cortland County Health Department's Data and Report webpage](#).

Note: Within the workplan below, both the efforts of the Cortland County Health Department (CCHD) and Guthrie Cortland Medical Center (GCMC) are in bolded text.

Review, Reporting, and Revision Process

In order to consider the feasibility and the effectiveness of the interventions, strategies and activities within the CHIP, annual review will be necessary. This will be done through collaboration, participation and meetings with partners and stakeholders in order to survey the status of all the interventions listed. This will help to assess the validity of our efforts in order to improve the health of the Cortland County community.

An annual update report will be completed at the end of each year, with the first new report for this Prevention Agenda cycle beginning in December 2020. This will align with requirements from the New York State Department of Health and will be disseminated to all stakeholders. This will be done through social media, local news outlets and will be available on the CCHD's website.

During the review process the Cortland County CHIP will also be revised as necessary. This includes but is not limited to updates to the interventions, implanted strategies, changing health status indicators, newly developing or identified health issues and changing resources.

Cortland County Community Health Improvement Plan 2019-2021

Priority Area: Prevent Chronic Disease

Focus Area 1: Healthy Eating and Food Security				
Overarching Goal: Reduce obesity and the risk of chronic disease				
Goal 1: Increase access to healthy and affordable foods and beverages				
Goal 2: Increase skills and knowledge to support healthy food and beverage choices				
Goal 3: Increase food security				
Objectives (combined)	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p><u>Childhood Obesity:</u></p> <ul style="list-style-type: none"> - Decrease percent of children with obesity by 5% among children ages 2-4 years participating in the WIC program by December 2021 (baseline to be set in 2020) - Decrease percent of children with obesity by 5% from 37.4% (2016-2018) to 35.5% among public school students by December 2021 <p><u>Adult Obesity:</u></p> <ul style="list-style-type: none"> - Decrease percent of adults ages 18 years and older with obesity by 5% from 29.3 % (2016 BRFSS) to 27.8% by December 2021 - Decrease the percentage of adults ages 18 years and older with obesity by 5% from 34.2% (2016 	<ol style="list-style-type: none"> 1.) BMI is monitored for all patients 2.) Physicians and care coordinators use the My Plate Education program for patients aged 5 and older (provider inputs age, weight, height and the nutrition recommendations are provided to patient) 3.) Providers provide nutritional counseling and education during appointments to patients with BMI concerns. 4.) Provide standardized education to primary care providers regarding ways to treat and counsel overweight and obese patients 5.) Implementation of the Farm to School Program through the NYSDEC 6.) Assist schools in creating policies around wellness including nutrition and physical activity 	<p># of patient population identified with BMI risk factor # of patients with BMI risk factor seen by FHN Provider # of patients with BMI risk factor provided with nutrition education # of children provided with My Plate Education</p> <p># of Primary Care Providers Trained</p> <p># of schools presented to about the Farm to School program # of students attending presentations</p> <p># of meetings held with school districts to educate and advocate for creating policies around wellness, nutrition and physical activity</p>	<p>Family Health Network (FHN)</p> <p>Guthrie Cortland Medical Center (GCMC)</p> <p>Cortland County Cornell Cooperative Extension (CCE), Seven Valleys Health Coalition (SVHC)</p> <p>Cortland County Health Department (CCHD), Cortland City School District, SVHC, Homer Central School</p>	<p>Dec 2021</p>

<p>BRFSS) to 32.5% among adults with an annual household income of <25,000 by December 2021</p>	<p>7.) Participate in the Child and Adult Care Food Program (CACFP), promoting healthy food/beverage choices using the My Plate Program.</p> <p>8.) Plant box gardens with CAPCO Headstart 0-3 year old classroom each Spring</p> <p>9.) Expand the role of public and Private employers in obesity prevention</p>	<p># of school districts that established policies around wellness, nutrition and physical activity # of students participating and taking advantage of newly established policies</p> <p># of children using the My Plate Program # of classrooms with box gardens</p> <p># of meetings held with public and private employers about the National Diabetes Prevention Program (NDPP) # of meetings held with public/private employers about creating nutritional standard policies for worksites # of public/ private employers that have Increased coverage for (NDPP) # of public/private employers adopting new nutritional standard policies # of public/private employees participating in the NDPP</p>	<p>District</p> <p>CAPCO Headstart</p> <p>SVHC</p>	
<p><u>Sugary Drink Consumption:</u></p> <ul style="list-style-type: none"> - Decrease the percent of adults who consume one or more sugary drinks per day by 5% from 25.8% (2016 BRFSS) to 24.5% among all adults by December 2021 - Decrease the percent of adults who consume one or more sugary drinks per day by 5% among adults with 	<p>1.) Nutritional newsletters are sent home monthly. This newsletter contains healthy recipes and information.</p> <p>2.) Focus on the promotion and addition of healthy options and menus in Guthrie hospital cafeterias.</p> <p>3.) In addition to serving size and nutrition facts, provide labeling and information to indicate foods that are vegetarian, appropriate</p>	<p># of families receiving newsletter # of newsletters distributed</p> <p># of healthy food options that become available</p>	<p>CAPCO Headstart</p> <p>GCMC</p>	<p>Dec 2021</p>

<p>an annual household income of <25,000 by December 2021 (baseline to be set in 2020)</p>	<p>for those with gluten sensitivity or a Guthrie Good Healthy Choice pick.</p> <p>4.) Promote healthy menus and food choices through the "Motivational Monday" initiative and other cafeteria-led initiatives designed to help patrons make healthier eating choices.</p> <p>5.) FHN Providers provide nutritional counseling and education to children and adults during appointments.</p> <p>6.) Care coordinators work with children to identify healthy goals and focus the conversation on reducing their consumption of sugary drinks.</p> <p>7.) Care Coordinators provide referrals for patients with limited access to healthy food or that may have food security concerns (Catholic Charities, Food Pantries, SNAP, Food Sense, etc.).</p>	<p># of patients with identified BMI risk factor provided with nutrition education</p> <p># of referrals made to FHN patients (by care coordinators) to community agencies providing nutritional education and financial assistance/resources to obtain health food in local community</p>	<p>FHN</p>	
<p><u>Fruit and Vegetable Consumption:</u></p> <p>- Decrease the percent of adults who consume less than one fruit and less than one vegetable per day by 5% among all adults by December 2021 (baseline to be set in 2020)</p>	<p>1.) Nutritional newsletters are sent home monthly. This newsletter contains healthy recipes and information</p> <p>2.) Focus on the promotion and addition of healthy options and menus in Guthrie hospital cafeterias.</p> <p>3.) In addition to serving size and nutrition facts, provide labeling and information to indicate foods that are vegetarian, appropriate for those with gluten sensitivity or a Guthrie Good Healthy Choice pick.</p> <p>4.) Promote healthy menus and food choices through the "Motivational Monday" initiative and other cafeteria-led initiatives designed to</p>	<p># of families receiving newsletter</p> <p># of newsletters distributed</p> <p># of healthy food options that become available</p>	<p>CAPCO Headstart</p> <p>GCMC</p>	<p>Dec 2021</p>

	Rescue Network (this will increase the # of pounds of food that is donated instead of thrown away) and continue holding Hunger Coalition Meetings	Coalition Meetings Implement the Food Rescue Network		
Focus Area 2: Physical Activity				
Overarching Goal: Reduce obesity and the risk of chronic disease				
Goal 1: <i>Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities</i>				
Goal 2: <i>Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities</i>				
Goal 3: <i>Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity</i>				
Objectives (combined)	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p><u>Childhood Obesity:</u></p> <ul style="list-style-type: none"> - Decrease percent of children with obesity by 5% among children ages 2-4 years participating in the WIC program by December 2021 (baseline to be set in 2020) - Decrease percent of children with obesity by 5% from 37.4% (2016-2018) to 35.5% among public school students by December 2021 <p><u>Adult Obesity:</u></p> <ul style="list-style-type: none"> - Decrease percent of adults ages 18 years and older with obesity by 5% from 29.3 % (2016 BRFSS) to 27.8% by December 2021 - Decrease the percentage of adults 	<ol style="list-style-type: none"> 1.) BMI is monitored for all patients 2.) Physicians and care coordinators use the My Plate Education program for patients aged 5 and older (provider inputs age, weight, height and the nutrition recommendations are provided to patient) 3.) Providers provide nutritional counseling and education during appointments to patients with BMI concerns. 4.) Assist schools in creating policies around wellness including nutrition and physical activity 	<p># of patient population identified with BMI risk factor # of patients with BMI risk factor seen by FHN Provider # of patients with BMI risk factor provided with nutrition education # of children provided with My Plate Education</p> <p># of meetings held with school districts to educate and advocate for creating policies around wellness, nutrition and physical activity # of school districts that established policies around wellness, nutrition and physical activity # of students participating and taking advantage of newly established policies</p>	<p>FHN</p> <p>CCHD, Cortland City School District, SVHC, Homer Central School District</p>	<p>Dec 2021</p>

<p>ages 18 years and older with obesity by 5% from 34.2% (2016 BRFSS) to 32.5% among adults with an annual household income of <25,000 by December 2021</p>	<p>5.) Implement the Injury Prevention and Traffic Safety Program. This includes presentations on bicycle safety with hands on instruction, as well as helmet fitting and bike rodeos. These presentations will occur at Headstart, community events, schools and camps.</p> <p>6.) Use I Am Moving, I Am Learning curriculum in all classrooms. This intervention promotes healthy choices and physical activity through song.</p>	<p># of bicycle safety presentations held # of participants participating in presentations # of Bike Rodeos held # of participants at the Bike Rodeos # of helmets fitted and provided</p> <p># of children enrolled in classrooms</p>	<p>CCHD</p> <p>CAPCO Headstart</p>	
<p><u>Leisure-time Physical Activity:</u></p> <ul style="list-style-type: none"> - Increase the percent of adults age 18 years and older who participate in leisure-time activity by 5% from 22.6% to 23.7% among all adults by December 2021 	<p>1.) Physical activity and recreation are promoted to FHN patients, as it relates to our overarching focus on improving BMI in our patient population. Care coordinators create self- management goals with patients with BMI risk factors to encourage activity, provide education, assist with applications to Y, provide lists of family friendly activities in the local community, and suggest ways to become more active around the house.</p>	<p># of FHN adult patients with BMI risk factor that have received education about increasing physical activity</p>	<p>FHN</p>	
<p><u>Physical Activity-High School Students:</u></p> <ul style="list-style-type: none"> - Increase the percent of high school students who were physically active for a total of at least 60 minutes/day on all 7 day by 5% by December 2021 (baseline to be set in 2020) 	<p>1.) Assist schools in creating policies around wellness including nutrition and physical activity</p> <p>2.) Physical activity and recreation are promoted to FHN patients, as it relates to our overarching focus on</p>	<p># of meetings held with school districts to educate and advocate for creating policies around wellness, nutrition and physical activity # of school districts that established policies around wellness, nutrition and physical activity # of students participating and taking advantage of newly established policies</p> <p># of FHN adult patients with BMI risk factor that have received education about increasing physical</p>	<p>CCHD, Cortland City School District, SVHC, Homer Central School District</p> <p>FHN</p>	

	improving BMI in our patient population. Care coordinators create self- management goals with patients with BMI risk factors to encourage activity, provide education, assist with applications to Y, provide lists of family friendly activities in the local community, and suggest ways to become more active around the house.	activity		
Focus Area 3: Tobacco Prevention				
Goal 1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p>Cigarette Use-High School:</p> <ul style="list-style-type: none"> - Decrease the prevalence of combustible cigarette use by high school students by 11.7% from 6.6% (CACTC, 2018) to 5.8% by December 2021 	<ol style="list-style-type: none"> 1.) Pursue policy action to reduce impact of tobacco/e-cigarettes marketing in lower-income and racial/ethnic minority communities 2.) Educate and communicate with elected officials about the impact of retail tobacco/e-cigarette product marketing on youth 3.) Present point of sale information and educate on the dangers of tobacco/e-cigarettes to youth in the community 4.) Use media and health communications to highlight the dangers of tobacco and promote effective tobacco/ e-cigarette control 5.) FHN asks each patient about tobacco use at each appointment. FHN providers will give information to patients on smoking cessation programs, including the NYS Quit Line. For patients that have identified tobacco use, care 	<p># of meetings held to educate and advocate for creation of policies to reduce tobacco marketing</p> <p># of tobacco marketing policies created</p> <p># of tobacco marketing policies implemented</p> <p># of meetings held to educate Elected officials on the impact of tobacco marketing on youth</p> <p># of elected officials that expressed support</p> <p># of presentations on the impact of tobacco/e-cigarettes hazards, point of sale, etc.</p> <p># of local leaders who expressed support of tobacco free areas and limiting access to youth</p> <p># of FHN patients (under age 18) that received education on smoking cessation</p>	<p>CCHD</p> <p>FHN</p>	<p>Dec 2021</p>

	coordinators work with them to establish self- management goals to reduce or quit tobacco use. Coordinators do routine follow ups and communication with patients to assist them in reaching their goals.			
<p><u>Electronic Vapor Products-High School:</u></p> <ul style="list-style-type: none"> - Decrease the prevalence of vaping products use by high school students by 11.4% from 30.8% (CACTC, 2018) to 27.3% by December 2021 	<ol style="list-style-type: none"> 1.) Pursue policy action to reduce impact of tobacco/e-cigarettes marketing in lower-income and racial/ethnic minority communities 2.) Educate and communicate with elected officials about the impact of retail tobacco/e-cigarette product marketing on youth 3.) Present point of sale information and educate on the dangers of tobacco/e-cigarettes to youth in the community 4.) Use media and health communications to highlight the dangers of tobacco and promote effective tobacco/ e-cigarette control 5.) FHN asks each patient about tobacco use at each appointment. FHN providers will give information to patients on smoking cessation programs, including the NYS Quit Line. For patients that have identified tobacco use, care coordinators work with them to establish self- management goals to reduce or quit tobacco use. Coordinators do routine follow ups and communication with patients to assist them in reaching their goals. 	<p># of meetings held to educate and advocate for creation of policies to reduce tobacco marketing</p> <p># of tobacco marketing policies created</p> <p># of tobacco marketing policies implemented</p> <p># of meetings held to educate Elected officials on the impact of tobacco marketing on youth</p> <p># of elected officials that expressed support</p> <p># of presentations on the impact of tobacco/e-cigarettes hazards, point of sale, etc.</p> <p># of local leaders who expressed support of tobacco free areas and limiting access to youth</p> <p># of FHN patients (under age 18) that received education on smoking cessation</p>	<p>CCHD</p> <p>FHN</p>	
<p><u>Retail Environment Policy:</u></p> <ul style="list-style-type: none"> - Increase the number of municipalities that adopt retail environment policies, including 	<ol style="list-style-type: none"> 1.) Pursue policy action to reduce impact of tobacco/e-cigarettes marketing in lower-income and racial/ethnic minority communities. 	<p># of meetings held to educate and advocate for creation of policies to reduce tobacco marketing</p> <p># of tobacco marketing policies created</p> <p># of tobacco marketing policies</p>	<p>CCHD</p>	

<p>those that restrict the density of tobacco retailers, keep the price of tobacco products high, and prohibit the sale of flavored tobacco products from zero to 1 by December 2021</p>		<p>implemented Increase the # of municipalities that adopt retail environment policies, including those that restrict the density of tobacco retailers, keep the price of tobacco products high, and prohibit the sale of flavored tobacco products</p>		
<p>Goal 2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES, frequent mental distress/substance use disorder; LGBT; and disability</p>				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p><u>Cigarette Use-All Adults:</u></p> <ul style="list-style-type: none"> - Decrease the prevalence of cigarette smoking by adults ages 18 year and older by 23% from 21.5 % (BRFSS, 2016) to 16.6% by December 2021 <p><u>Cigarette Use-Low Income Adults:</u></p> <ul style="list-style-type: none"> - Decrease the prevalence of cigarette smoking among adults with income less than \$25,000 by 23% from 19.7% (BRFSS, 2016) to 15.2% by December 2021 <p><u>Cigarette Use-Adults Reporting Poor Mental Health:</u></p> <ul style="list-style-type: none"> - Decrease the prevalence of cigarette smoking among adults who report frequent mental distress by 23% from 45.4% (BRFSS, 2016, data is unreliable) to 40% by 	<ol style="list-style-type: none"> 1.) Pursue policy action to reduce impact of tobacco/e-cigarettes marketing in lower-income and racial/ethnic minority communities. 2.) Use health communication to increase the utilization of the NYS Smokers' Quitline, particularly among the disparate populations. 3.) FHN asks each patient about tobacco use at each appointment. FHN providers will give information to patients on smoking cessation programs, including the NYS Quit Line. For patients that have identified tobacco use, care coordinators work with them to establish self- management goals to reduce or quit tobacco use. Coordinators do routine follow ups and communication with patients to 	<p># of meetings held to educate and advocate for creation of policies to reduce tobacco marketing # of tobacco marketing policies created # of tobacco marketing policies implemented</p> <p># of cessation informational meetings and correspondence with major employers in Cortland County # of major employees disseminating provided cessation information to their employees</p> <p># of FHN patients (over age 18) that received education on smoking cessation-</p>	<p>CCHD</p> <p>CCHD, St. Joseph's Hospital</p> <p>FHN</p>	<p>Dec 2021</p>

<p>December 2021</p> <p><u>Cigarette Use- Adults Living with a Disability:</u></p> <ul style="list-style-type: none"> - Decrease the prevalence of cigarette smoking among adults who are living with a disability by 23% from 22.9% (BRFSS, 2016) to 17.6% by December 2021 	<p>assist them in reaching their goals.</p> <p>4.) Promote the health and wellness of employees, patients, and communities through tobacco cessation. Provide smoking cessation resources to employees and community members who wish to quit, including quit aids, therapeutic counseling, relapse prevention counseling, and access to mental health professionals.</p> <p>5.) Increase public awareness about lung cancer including preventative measures. Guthrie hosts "Shine a Light on Lung Cancer" Event(s) in collaboration with the Lung Cancer Alliance. The forum promotes lung cancer awareness and remembrance for all those touched by the disease. The event will focus on community education on lung cancer, including facts, prevention, and treatment</p> <p>6.) Promote the importance of lung cancer screening and treatment. Inform and educate high-risk populations about lung cancer screenings (patients who are 55-80 years of age, have a 30-pack history of smoking, and are a current smoker or have quit within the last 15 years). Promote earlier detection of lung cancer with the goal of more successful treatment</p>	<p># of individuals receiving/accessing tobacco cessation resources # of individuals that cease use of tobacco products</p> <p># of participants attending program</p> <p># of high-risk patients receiving appropriate lung cancer screenings</p>	<p>GCMC</p> <p>GCMC</p> <p>GCMC</p>	
<p>Goal 3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products</p>				
<p>Objectives</p>	<p>Interventions</p>	<p>Process Measures</p>	<p>Lead Agency & Partners</p>	<p>Target Date</p>
<p><u>Secondhand Smoke Policies:</u></p>	<p>1.) Promote smoke-free policies in multi-unit housing including</p>	<p># of smoke-free policies implemented</p>	<p>CCHD</p>	<p>Dec 2021</p>

<p>- Increase the number of multi-unit housing units that adopt a smoke-free policy by 50-75 units each year by December 2021</p>	<p>apartment complexes, condominiums, and co-ops, especially those that house low-SES residents.</p> <p>2.) Increase the number of smoke-free parks, beaches, playgrounds, college and hospital campuses, other public spaces</p> <p>3.) Advocate organizational decision makers, conduct community education, and use paid and earned media to increase community knowledge of the dangers of secondhand smoke/vape exposure.</p>	<p># of units smoke-free # of education and advocating meetings held with municipalities/local leaders # of municipalities/local leaders supportive of smoke free parks, playgrounds, etc. # of municipalities with smoke-free public spaces policies # of established smoke-free policy areas # of presentations on the impact of tobacco hazards, specifically secondhand smoke # of local leaders who expressed support of tobacco free areas and limiting access to secondhand smoke</p>		
<p>Focus Area 4: Preventative Care and Management</p>				
<p>Goal 1: Increase cancer screening rates for breast, cervical, and colorectal cancer</p>				
<p>Objectives</p>	<p>Interventions</p>	<p>Process Measures</p>	<p>Lead Agency & Partners</p>	<p>Target Date</p>
<p><u>Breast Cancer Screening:</u></p> <p>- Increase percent of women with an annual household income less than \$25,000 who receive a breast cancer screening based on most recent guidelines by 5% by December 2021 (baseline to be set in 2020)</p>	<p>1.) Implementation of the Cancer Services Program (CSP). This includes community outreach and education about the importance of early detection and screening. Enrolling women into free cancer screening programs. One on one and group educational programming at churches, community agencies, community events, etc.</p> <p>2.) Implementation of family planning services through New State Grant funding. This includes breast and cervical cancer screenings for eligible patients.</p> <p>3.) Provide Mobile Mammography van for those with and without health</p>	<p># of one on one educational programs provided # of Group Educational Programs provided # of total participants that attended the one on one education programs # of participants attending the group educational programs # of women receiving a breast cancer screening through the CSP</p> <p># of breast cancer screenings</p> <p># of screening events held # of people screened for breast cancer</p>	<p>CCHD</p> <p>CCHD-Jacobus Center for Reproductive Health</p> <p>Marathon Central School District, Lourdes</p>	<p>Dec 2021</p>

	<p>insurance.</p> <p>4.) Breast Cancer: offer the Lourdes mammography van at each of our clinic sites 4x/year and offer a free bra incentive to patients who have their mammogram done on the mammography van. Referrals are set up for mammograms to make it easier for patients to have these done. For all cancer screenings, providers educate patients on the importance of screenings. Care coordinators identify patients appropriate for screenings to be done prior to their visit.</p>	<p># of FHN patients that are at risk or age appropriate for breast cancer screenings # of FHN patients that completed a breast cancer screening</p>	<p>Hospital</p> <p>FHN, Lourdes Hospital</p>	
<p><u>Cervical Cancer Screening:</u></p> <ul style="list-style-type: none"> - Increase the percent of women with an annual household income less than \$25,000 who receive a cervical cancer screening based on the most recent guidelines by 5% by December 2021 (baseline to be set in 2020) 	<p>1.) Implementation of the Cancer Services Program (CSP). This includes community outreach and education about the importance of early detection and screening. Enrolling women into free cancer screening programs. One on one and group educational programming at churches, community agencies, community events, etc.</p> <p>2.) Implementation of the family planning services through New State Grant funding. This includes breast and cervical cancer screenings for eligible patients.</p> <p>3.) May offer an incentive for patients that are screened for cervical cancer. For all cancer screenings, providers educate patients on the importance of screenings. Care coordinators identify patients appropriate for screenings to be done prior to their visit.</p>	<p># of one on one educational programs provided # of Group Educational Programs provided # of total participants that attended the one on one education programs # of participants attending the group educational programs # of women receiving a cervical cancer screening through the CSP</p> <p># of cervical cancer screenings</p> <p># of FHN patients that are at risk or age appropriate for cervical cancer screenings # of FHN patients that completed a cervical cancer screening</p>	<p>CCHD</p> <p>CCHD-Jacobus Center for Reproductive Health</p> <p>FHN</p>	<p>Dec 2021</p>

<p><u>Colorectal Cancer Screening:</u></p> <ul style="list-style-type: none"> - Increase the percent of adults who receive a colorectal cancer screening based on the most recent guidelines by 5% among adults with an annual household income less than \$25,000 by December 2021 (baseline to be set in 2020) - Increase the percent of adults who receive a colorectal cancer screening based on the most recent guidelines by 5% from 62.8% (2016 BRFSS) to 65.9% for adults aged 50-64 by December 2021 	<p>1.) Implementation of the Cancer Services Program (CSP). This includes community outreach and education about the importance of early detection and screening. Enrolling men and women into free cancer screening programs. One on one and group educational programming at churches, community agencies, community events, etc.</p> <p>2.) Colon cancer: Promote FIT kits and cologuard screening for patients, which is an easier way to complete a colon cancer screening. For all cancer screenings, providers educate patients on the importance of screenings. Care coordinators identify patients appropriate for screenings to be done prior to their visit.</p>	<p># of one on one educational programs provided # of Group Educational Programs provided # of total participants that attended the one on one education programs # of participants attending the group educational programs # of women receiving a colorectal cancer screening through the CSP # of men receiving a colorectal cancer screening through the CSP</p> <p># of FHN patients that are at risk or age appropriate for colorectal cancer screenings # of FHN patients that completed a colorectal cancer screening</p>	<p>CCHD</p> <p>FHN</p>	<p>Dec 2021</p>
<p>Goal 2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity</p>				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p><u>Diabetes Early Detection:</u></p> <ul style="list-style-type: none"> - Increase the percent of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% by December 2021 (baseline to be set in 2020) - Increase the percent of low-income (<25,000) adults 45+ who had a text for high blood sugar or diabetes within the past three years 	<p>1.) Providers track patients with uncontrolled diabetes and refer them to our internal endocrinologist. When chronic conditions are diagnosed, providers see patients every 3 or 6 months for follow up appointments, depending on their individual risk factors. Care coordinators identify patients with these conditions and work with them individually to develop self-management goals related to nutrition, education, and therapies. Care coordinators also refer to community agencies (Office of the Aging-BP program, YWCA-self</p>	<p>% of FHN patient population (adults) with BMI risk factors</p>	<p>FHN</p>	<p>Dec 2021</p>

	<p>individually to develop self-management goals related to nutrition, education, and therapies. Care coordinators also refer to community agencies (Office of the Aging-BP program, YWCA-self monitoring class for hypertension) as appropriate.</p>			
<p>Goal 3: Promote the use of evidence-based care to manage chronic diseases (including asthma, arthritis, cardiovascular disease, diabetes, prediabetes and obesity)</p>				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p>Adult Obesity:</p> <ul style="list-style-type: none"> - Decrease percent of adults ages 18 years and older with obesity by 5% from 29.3 % (2016 BRFSS) to 27.8% by December 2021 - Decrease the percentage of adults ages 18 years and older with obesity by 5% from 34.2% (2016 BRFSS) to 32.5% among adults with an annual household income of <25,000 by December 2021 	<ol style="list-style-type: none"> 1.) FHN closely monitors and tracks our patient population diagnosed with asthma, as it is another 330 Grant priority. Providers go through an assessment test to identify triggers for patients and track compliance with prescription medication. These health conditions are monitored at patient visits, and care coordinators focus efforts on communication, education, and motivation with patients to achieve goals and improve health. 2.) Providers track patients with uncontrolled diabetes and refer them to our internal endocrinologist. When chronic conditions are diagnosed, providers see patients every 3 or 6 months for follow up appointments, depending on their individual risk factors. Care coordinators identify patients with these conditions and work with them individually to develop self-management goals related to nutrition, education, and therapies. Care coordinators also refer to 	<p># of FHN patients provided with education and instructions for controlling asthma symptoms % of FHN adult patient population with BMI risk factors</p>	<p>FHN</p>	<p>Dec 2021</p>

	community agencies (Office of the Aging-BP program, YWCA-self monitoring class for hypertension) as appropriate.			
Goal 4: Improve self-management skills for individuals with chronic conditions				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p>Self-Management:</p> <ul style="list-style-type: none"> - Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition by 5% by December 2021 (baseline to be set in 2020) 	<ol style="list-style-type: none"> 1.) FHN care coordinators refer patients who would benefit to the Chronic Disease self-management program. Care coordinators provide an abundance of education to patients and conduct "touchpoints" with patients in between their appointments. Coordinators have been trained in motivational interviewing to encourage and motivate patients to work on their own self-management goals to improve their health and decrease risk factors related to chronic health conditions. FHN is also involved with extra projects within our cohort for diabetes and obesity. 2.) Expand the role of public and Private employers in obesity prevention 	<p># of referrals made to FHN patients (by care coordinators) to the Chronic Disease Self-Management Program</p> <p># of meetings held for the Chronic Disease Self-Management Program (CDSMP) # of patients referred by PCPs to CDSMP # of participants of the CDSMP</p>	<p>FHN</p> <p>SVHC</p>	<p>Dec 2021</p>

	<p>4.) Promote community awareness of behavioral health and mental health care needs. Host a quarterly Community Stakeholder Meeting intended as an educational forum to review best practices and identify resources for all stakeholders involved in the behavioral health of communities served throughout the region</p> <p>5.) Encourage, develop and/or enhance community treatment resources to more immediately respond to urgent treatment needs with the appropriate level of care</p>	<p># of attendees at the Community Stakeholders Meeting</p> <p># of COTI programs available in the community # of referrals made to the Angel Program # of participants utilizing the COTI program # of participants in the Angel Program</p>	<p>GCMC</p> <p>Community Services Board (CSB)</p>	
<p><u>Youth Mental Distress:</u></p> <ul style="list-style-type: none"> - Decrease the percentage of youth grades 9-12 who felt sad or hopeless by 5% from 30.4 % (2017 YRBS) to 28.9 % (combined state objective) by December 2021 	<p>1.) Use Patient Health Questionnaire-9 (PHQ-9) to evaluate depression in patients when appropriate. Use PHQ-9 as a clinical and research tool to evaluate and measure depression severity in patients. The resulting score for the questionnaire depicts a patient's clinical need for mental health care. Use PHQ-9 screening tool based on scores to determine if a mental health referral is justified</p> <p>2.) Expand telemedicine programs and specialties to include telepsychiatry</p>	<p># number of patients assessed by the PHQ-9 tool</p> <p># of patients that use telepsychiatry services</p>	<p>GCMC</p> <p>GCMC</p>	<p>Dec 2021</p>

Focus Area 2: Prevent Mental and Substance Use Disorders				
Goal 1: Prevent underage drinking and excessive alcohol consumption by adults				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p><u>Youth (Alcohol Use):</u></p> <ul style="list-style-type: none"> - Decrease the percent of youth in grades 7-12 reporting the use of alcohol on at least one occasion for the past 30 day by 5% from 20.5% (2018 CACTC) to 19.5% by December 2021 	<ol style="list-style-type: none"> 1.) Continue collaboration with CASA/Trinity. Working with CASA/Trinity, provide education to Guthrie Social Workers, Crisis Workers and Care Coordinators on local resources and other drug and alcohol topics as identified. Through enhanced collaboration and education provided by Trinity, care transitions for patients with drug and alcohol dependency needs will be improved. 2.) Promote and support community prevention efforts and education regarding: drug and alcohol use signs and symptoms, the dangers of drugs and alcohol for individuals and available community treatment and recovery services for children, youth, parents, physicians and pharmacies. 3.) Develop and implement a social marketing campaign targeting 11th and 12th grade students in Cortland County addressing risks and consequences associated with binge drinking Intervention 4.) Develop and implement a social norming campaign targeting 9-20 year olds in Cortland County utilizing available data on usage rates and perception of use from the New York Youth Development Survey. Intervention 	<p># Number of referrals</p> <p># of school presentations # of students participating in programing</p> <p># of social marketing campaigns designed (binge drinking, parents) Social norming campaign designed. Too Good for Drugs Program scheduled at rural school districts # of trainings on Alcohol Screening and Brief Intervention (ASBI) Create Training and Referral Tracking for ASBI Provide support to local law enforcement # of 11th and 12th grade students reached via social media channels # of students reached through messaging in school and social media</p>	<p>GCMC</p> <p>CSB</p> <p>Cortland Area Communities that Care (CACTC)</p>	<p>Dec 2021</p>

	<p>Trinity, care transitions for patients with drug and alcohol dependency needs will be improved</p> <p>3.) Promote and support community prevention efforts and education regarding: drug and alcohol use signs and symptoms, the dangers of drugs and alcohol for individuals and available community treatment and recovery services for children, youth, parents, physicians and pharmacies</p>	<p># of community presentations # of community members participating in programing</p>	<p>CSB</p>	
<p>Goal 2: Prevent opioid and other substance misuse and deaths</p>				
<p>Objectives</p>	<p>Interventions</p>	<p>Process Measures</p>	<p>Lead Agency & Partners</p>	<p>Target Date</p>
<p><u>Opioid Overdose Deaths:</u></p> <ul style="list-style-type: none"> - Decrease the age-adjusted rate of overdose deaths involving any opioids by 7% from 29.1 per 100,000 population (2018 NYSDOH) to 27.1 per 100,00 populations by December 2021 	<p>6.) The CAGE-AID Questionnaire is given to adult family members of children who participate in Early Intervention Services. The CAGE-AID Questionnaire is an assessment instrument used for identifying those with alcohol and other drug use problems</p> <p>7.) Continue collaboration with CASA/Trinity. Working with CASA/Trinity, provide education to Guthrie Social Workers, Crisis Workers and Care Coordinators on local resources and other drug and alcohol topics as identified. Through enhanced collaboration and education provided by Trinity, care transitions for patients with drug and alcohol dependency needs will be improved</p> <p>8.) Implement changes in discharge planning process to increase</p>	<p># of family members assessed by the CAGE-AID Questionnaire</p> <p># of referrals</p> <p># of discharges created with contact information for substance abuse</p>	<p>CCHD</p> <p>GCMC</p> <p>GCMC</p>	<p>Dec 2021</p>

	<p>patient access to substance abuse resources Implement discharge planning process changes to include contact information for substance abuse resources. Additionally, if the patient consents, staff or Social Work will initiate the appointment making process</p> <p>9.) Continue drug disposal and events promoting safe drug disposal using safe disposal units MedSafe® drug disposal units are installed for use at multiple Guthrie hospitals. MedSafe® drug disposal units allow for safe and anonymous disposal of unused or expired medications by community members. The units are available for the community during pharmacy hours. "Opioid Take Back Day" is an annual event that utilizes the MedSafe bins to encourage employees and community members to clean out unneeded medications from their medicine cabinets and drop them in the bin at the pharmacy to be disposed of properly. The focus on this day will be on the safe disposal of opioids to help prevent the misuse of these drugs in light of the recent epidemic of opioid abuse in our communities</p> <p>10.) Inform and educate community members on the appropriate response to opioid and/or heroin overdose and increase the availability of Narcan</p> <p>11.) Promote and support community prevention efforts and education regarding: drug and alcohol use</p>	<p>resources</p> <p># of times in which the MedSafe drug disposal units are emptied</p> <p># of trainings provided to organizations # of participants provided training # of Narcan Kits handed out</p> <p># of community presentations- # of community members participating in programing</p>	<p>GCMC</p> <p>CCHD</p> <p>CSB</p>	
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	<p>signs and symptoms, the dangers of drugs and alcohol for individuals and available community treatment and recovery services for children, youth, parents, physicians and pharmacies</p> <p>12.) Promote access to Substance Use Disorder (SUD) services and supports for Cortland County residents.</p>	<p># of pounds of drugs recovered from the Drug Take Back events and the kiosks throughout the county</p> <p># of peer recovery coaches, mentors and advocated (youth and adults)</p> <p># of participants using peer services</p>	CSB	
<p><u>Opioid Analgesics Prescriptions:</u></p> <ul style="list-style-type: none"> - Decrease the opioid analgesics prescription for pain, age-adjusted rate by 5% by December 2021 (baseline data to be set in 2020) 	<p>1.) Provide provider education for opiate prescribing and management. Address the appropriate prescribing practices of opiates. Education will include information such as the various types of opiates, drug duration, hazards of long term use, etc.</p>	<p># number of providers receiving education to combat the epidemic of opioid abuse in Guthrie Communities</p>	GCMC	
<p><u>Opioid Overdose Emergency Department Visits:</u></p> <ul style="list-style-type: none"> - Decrease all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% from 74.8 per 100,000 (2018 NYSDOH) to 71.2 per 100,000 by December 2021 (baseline data to be set in 2020) 	<p>1.) Implement changes in discharge planning process to increase patient access to substance abuse resources Implement discharge planning process changes to include contact information for substance abuse resources. Additionally, if the patient consents, staff or Social Work will initiate the appointment making process</p> <p>2.) Continue drug disposal and events promoting safe drug disposal using safe disposal units MedSafe® drug disposal units are installed for use at multiple Guthrie hospitals. MedSafe® drug disposal units allow for safe and anonymous disposal of unused or</p>	<p># of discharges created with contact information for substance abuse resources</p> <p># of times in which the MedSafe drug disposal units are emptied</p>	GCMC GCMC	

	<p>expired medications by community members. The units are available for the community during pharmacy hours. "Opioid Take Back Day" is an annual event that utilizes the MedSafe bins to encourage employees and community members to clean out unneeded medications from their medicine cabinets and drop them in the bin at the pharmacy to be disposed of properly. The focus on this day will be on the safe disposal of opioids to help prevent the misuse of these drugs in light of the recent epidemic of opioid abuse in our communities</p> <p>3.) Inform and educate community members on the appropriate response to opioid and/or heroin overdose and increase the availability of Narcan</p> <p>4.) Promote and support community prevention efforts and education regarding: drug and alcohol use signs and symptoms, the dangers of drugs and alcohol for individuals and available community treatment and recovery services for children, youth, parents, physicians and pharmacies</p> <p>5.) Promote access to Substance Use Disorder (SUD) services and supports for Cortland County residents.</p>	<p># of trainings provided to organizations # of participants provided training # of Narcan Kits handed out</p> <p># of community presentations- # of community members participating in programing # of pounds of drugs recovered from the Drug Take Back events and the kiosks throughout the county</p> <p># of peer recovery coaches, mentors and advocated (youth and adults) # of participants using peer services</p>	<p>CCHD</p> <p>CSB</p> <p>CSB</p>	
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Goal 3: Prevent and address adverse childhood experiences (ACEs)				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p><u>Adverse Childhood Experiences:</u></p> <ul style="list-style-type: none"> - Increase proportion of community members who are trauma-responsive by 5% by December 2021 (baseline data to be set in 2020) 	<p>1.) Develop the capacity to recognize and respond more immediately with behavioral health assessment and supports to address the urgent needs of all the citizens of Cortland County.</p>	<p># of trainings provided to the EDPRT # of participants @ the EDPRT trainings</p>	<p>CSB</p>	<p>Dec 2021</p>
Goal 4: Reduce the prevalence of major depressive disorders				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p><u>Major Depressive Disorders:</u></p> <ul style="list-style-type: none"> - Decrease the past-year prevalence of major depressive episodes among adults aged 18 or older 5% from 15% (2016) to 14.3% by December 2021 - Decrease the past-year prevalence of major depressive episodes among adolescents aged 12-17 year by 5% by December 2021 (baseline data to be set in 2020) 	<p>1.) Use Patient Health Questionnaire-9 (PHQ-9) to evaluate depression in adult family members of Early Intervention children when appropriate. Use PHQ-9 as a clinical and research tool to evaluate and measure depression severity in family members. The resulting score for the questionnaire depicts a person's clinical need for mental health care. Use PHQ-9 screening tool based on scores to determine if a mental health referral is justified</p> <p>2.) Use Patient Health Questionnaire-9 (PHQ-9) to evaluate depression in patients when appropriate. Use PHQ-9 as a clinical and research tool to evaluate and measure depression severity in patients. The resulting score for the questionnaire depicts a patient's</p>	<p># of family members screened with the PHQ-9</p> <p># number of patients assessed by the PHQ-9 tool</p>	<p>CCHD</p> <p>GCMC</p>	<p>Dec 2021</p>

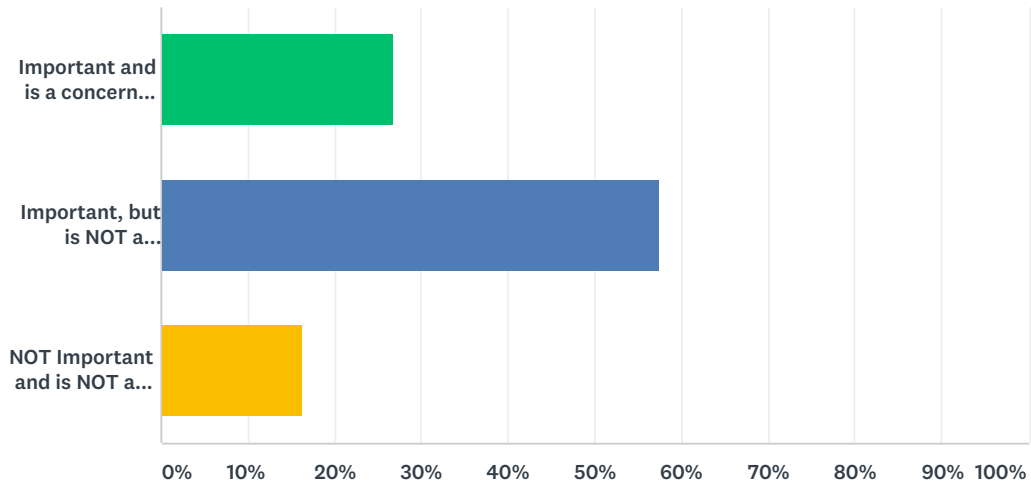
	<p>clinical need for mental health care. Use PHQ-9 screening tool based on scores to determine if a mental health referral is justified</p> <p>3.) Expand telemedicine programs and specialties to include telepsychiatry</p> <p>4.) Promote community awareness of behavioral health and mental health care needs. Host a quarterly Community Stakeholder Meeting intended as an educational forum to review best practices and identify resources for all stakeholders involved in the behavioral health of communities served throughout the region</p> <p>5.) Encourage, develop and/or enhance community treatment resources to more immediately respond to urgent treatment needs with the appropriate level of care</p> <p>6.) Implementation of NYSED Mental Health Education Literacy in Schools</p>	<p># of patients that use telepsychiatry services</p> <p># of attendees at the Community Stakeholders Meeting</p> <p># of COTI programs available in the community # of referrals made to the Angel Program # of participants utilizing the COTI program # of participants in the Angel Program</p> <p># of students instructed by this curriculum</p>	<p>GCMC</p> <p>GCMC</p> <p>CSB</p> <p>Cortland City School District, Marathon School District, Homer Central School District, McGraw Central School District and Cincinnatus Central School District</p>	
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Goal 5: Prevent Suicides				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p><u>Suicide Prevention:</u></p> <ul style="list-style-type: none"> - Decrease suicide attempts by adolescents (youth grades 9-12) who attempted suicide one or more times in the past year by 10% by December 2021 (baseline data to be set in 2020) - Decrease the age-adjusted suicide mortality rate by 10% from 10.6 per 100,000 (2015-2017 NYSDOH) to 9.5 per 100,000 by December 2021 	<ol style="list-style-type: none"> 1.) Implementation of NYSED Mental Health Education Literacy in Schools 2.) Use Patient Health Questionnaire-9 (PHQ-9) to evaluate depression in patients when appropriate. Use PHQ-9 as a clinical and research tool to evaluate and measure depression severity in patients. The resulting score for the questionnaire depicts a patient's clinical need for mental health care. Use PHQ-9 screening tool based on scores to determine if a mental health referral is justified 3.) Expand telemedicine programs and specialties to include telepsychiatry 4.) Develop the capacity to recognize and respond more immediately with behavioral health assessment and supports to address the urgent needs of all the citizens of Cortland County 5.) Develop and support services able to respond in the community and/or provide access to immediate services and supports to stabilize behavioral health crises. 	<p># of students instructed by this curriculum</p> <p># number of patients assessed by the PHQ-9 too</p> <p># of patients that use telepsychiatry services</p> <p># of trainings provided to the EDPRT # of participants @ the EDPRT trainings Develop and enhance Suicide Prevention Coalition</p> <p># of crisis and information lines available # of people that utilize the crisis and information lines Implementation of the Mobile Crisis Team through Liberty Resources</p>	<p>Cortland City School District, Marathon School District, Homer Central School District, McGraw Central School District and Cincinnatus Central School District</p> <p>GCMC</p> <p>GCMC</p> <p>CSB</p> <p>CSB</p>	<p>Dec 2021</p>

Goal 6: Reduce the mortality gap between those living with serious mental illness and the general population				
Objectives	Interventions	Process Measures	Lead Agency & Partners	Target Date
<p><u>Cigarette Use-Adults Reporting Poor Mental Health:</u></p> <ul style="list-style-type: none"> - Decrease the prevalence of cigarette smoking among adults who report frequent mental distress by 23% from 45.4% (BRFSS, 2016, data is unreliable) to 40% by December 2021 	<p>1.) Use Patient Health Questionnaire-9 (PHQ-9) to evaluate depression in patients when appropriate. Use PHQ-9 as a clinical and research tool to evaluate and measure depression severity in patients. The resulting score for the questionnaire depicts a patient's clinical need for mental health care. Use PHQ-9 screening tool based on scores to determine if a mental health referral is justified</p>	<p># number of patients assessed by the PHQ-9 tool</p>	<p>GCMC</p>	<p>Dec 2021</p>
	<p>2.) Promote the health and wellness of employees, patients, and communities through tobacco cessation. Provide smoking cessation resources to employees and community members who wish to quit, including quit aids, therapeutic counseling, relapse prevention counseling, and access to mental health professionals. Enforce and Encourage TGC Policy of tobacco-free environments on all Guthrie campuses.</p>	<p># of individuals receiving/accessing tobacco cessation resources</p>	<p>GCMC</p>	
	<p>3.) Use health communication to increase the utilization of the NYS Smokers' Quitline, particularly among the disparate populations.</p>	<p># of cessation informational meetings and correspondence with major employers in Cortland County # of major employees disseminating provided cessation information to their employees</p>	<p>CCHD</p>	

Q1 Able to perform household chores (cleaning, etc)

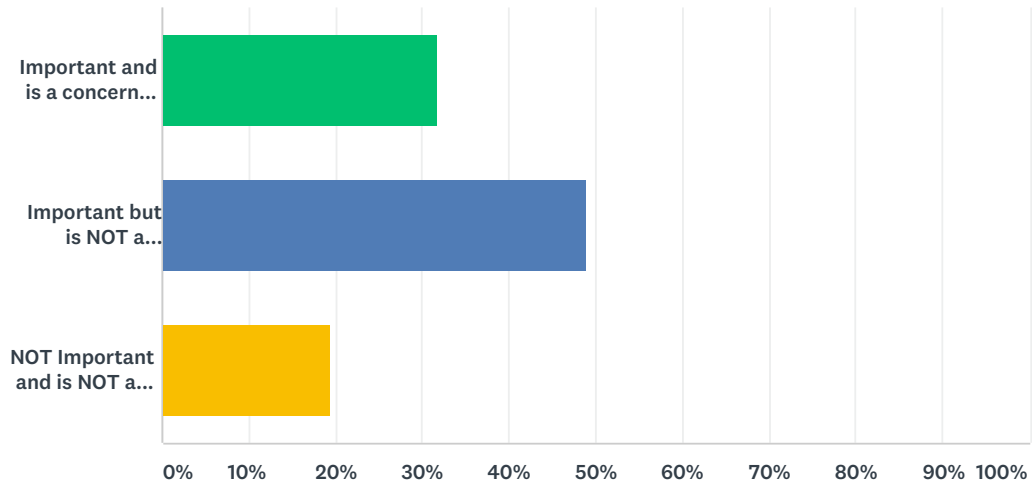
Answered: 715 Skipped: 22



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	26.71%	191
Important, but is NOT a concern for me	57.62%	412
NOT Important and is NOT a concern for me	16.22%	116
Total Respondents: 715		

Q2 Finding reliable help to perform home maintenance/repairs

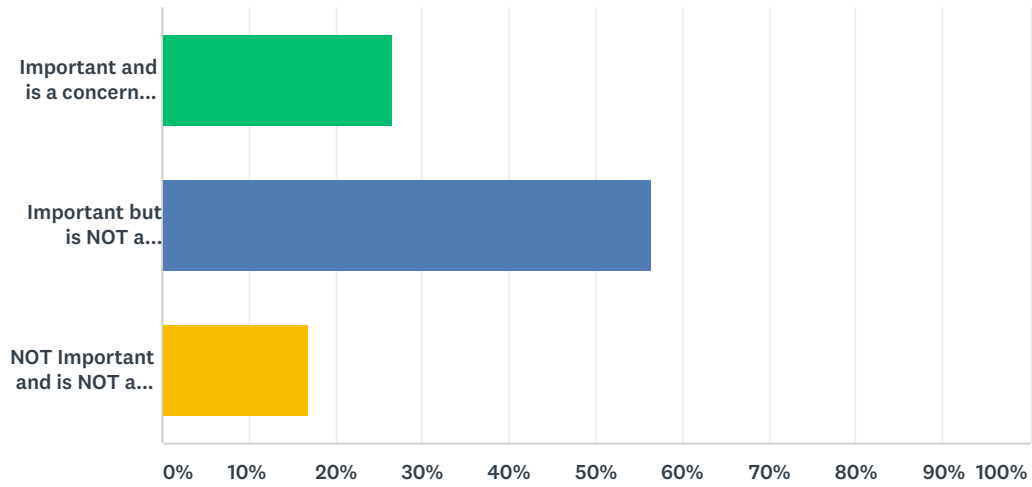
Answered: 712 Skipped: 25



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	31.74%	226
Important but is NOT a concern for me	49.02%	349
NOT Important and is NOT a concern for me	19.52%	139
Total Respondents: 712		

Q3 Ability to pay rent or taxes

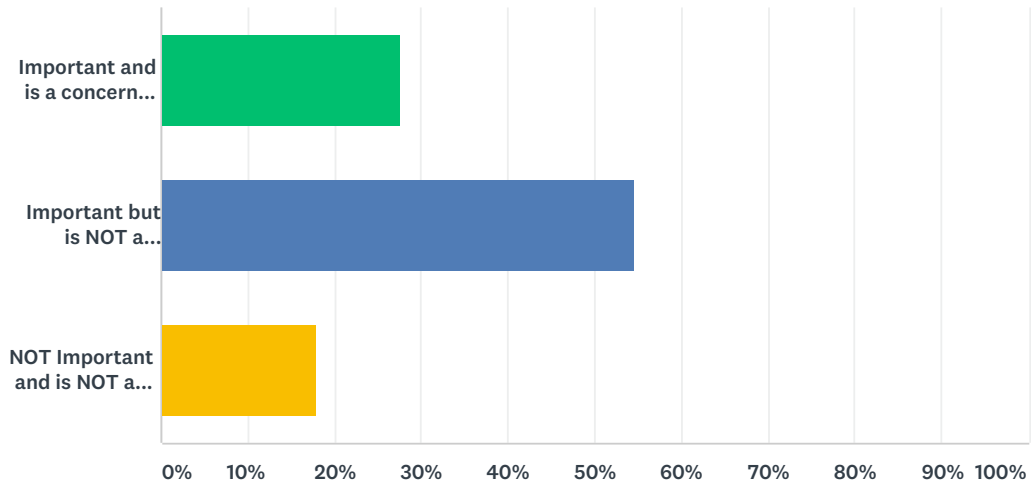
Answered: 717 Skipped: 20



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	26.64%	191
Important but is NOT a concern for me	56.49%	405
NOT Important and is NOT a concern for me	17.02%	122
Total Respondents: 717		

Q4 Able to pay for home heating

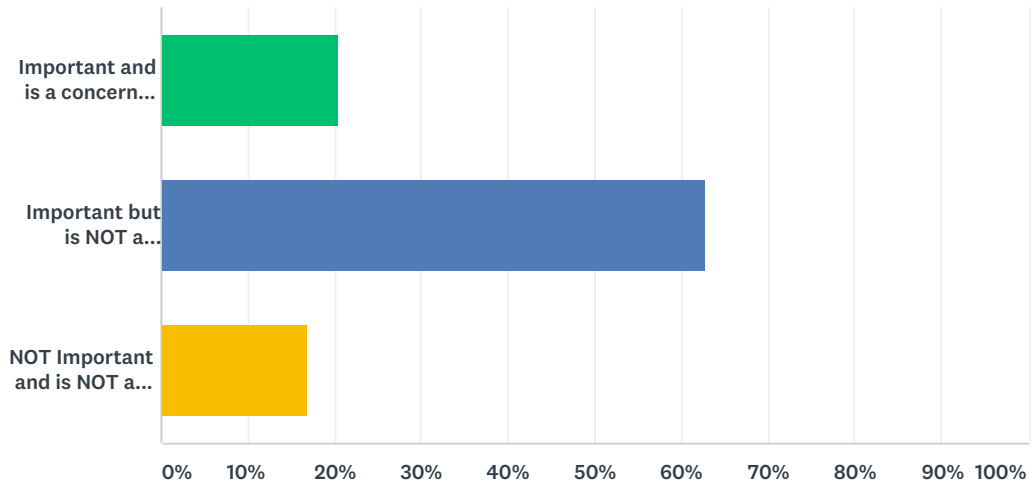
Answered: 708 Skipped: 29



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	27.68%	196
Important but is NOT a concern for me	54.66%	387
NOT Important and is NOT a concern for me	17.94%	127
Total Respondents: 708		

Q5 Transportation to medical appointments

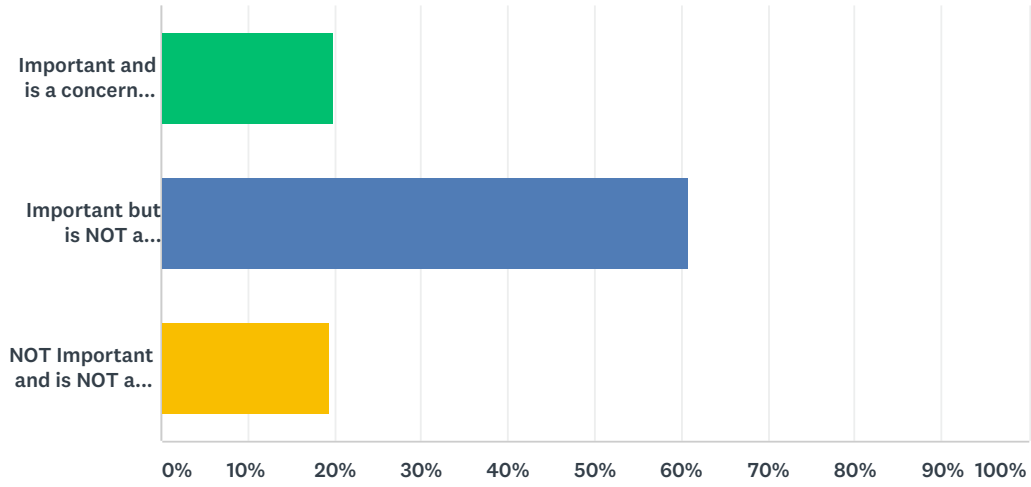
Answered: 718 Skipped: 19



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	20.47%	147
Important but is NOT a concern for me	62.81%	451
NOT Important and is NOT a concern for me	16.85%	121
Total Respondents: 718		

Q6 Transportation to out of county medical appointments

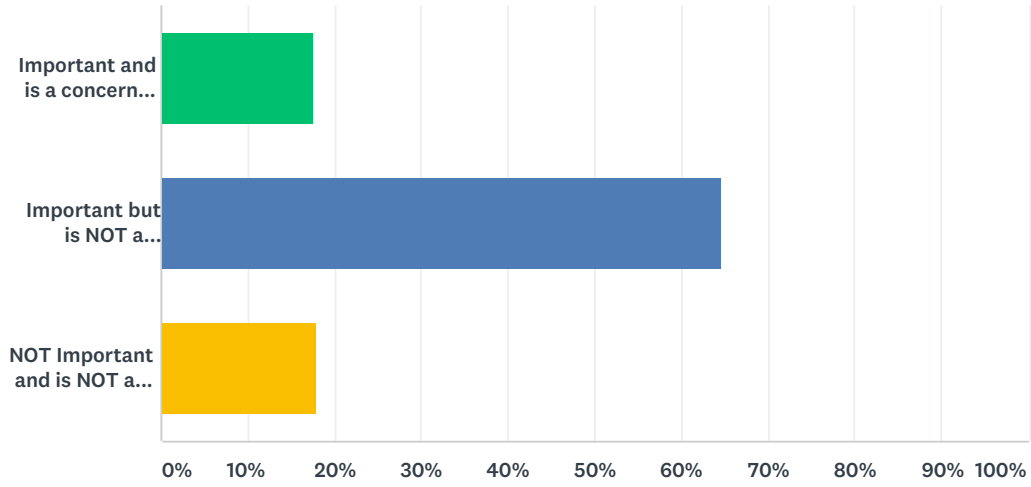
Answered: 716 Skipped: 21



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	19.83%	142
Important but is NOT a concern for me	60.89%	436
NOT Important and is NOT a concern for me	19.55%	140
Total Respondents: 716		

Q7 Transportation to the grocery store and other errands

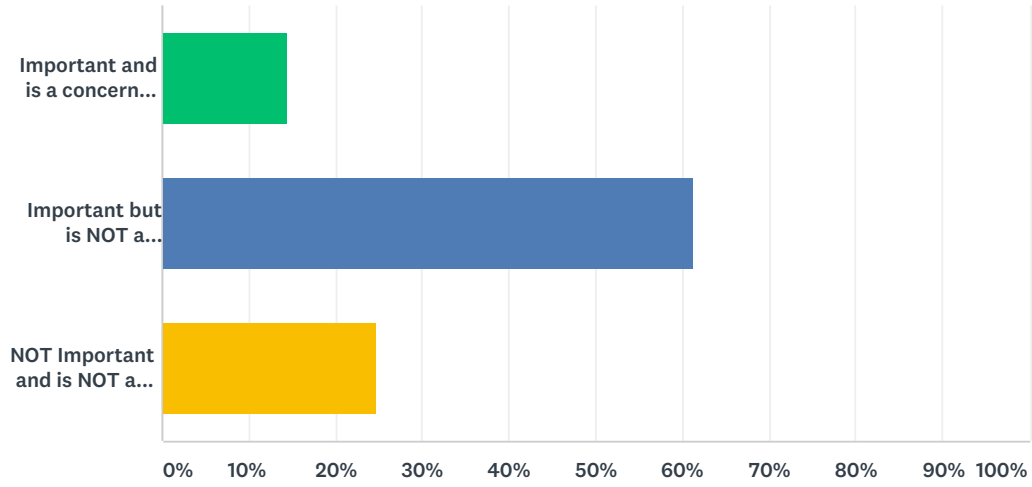
Answered: 713 Skipped: 24



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	17.67%	126
Important but is NOT a concern for me	64.66%	461
NOT Important and is NOT a concern for me	18.09%	129
Total Respondents: 713		

Q8 Driving my own car

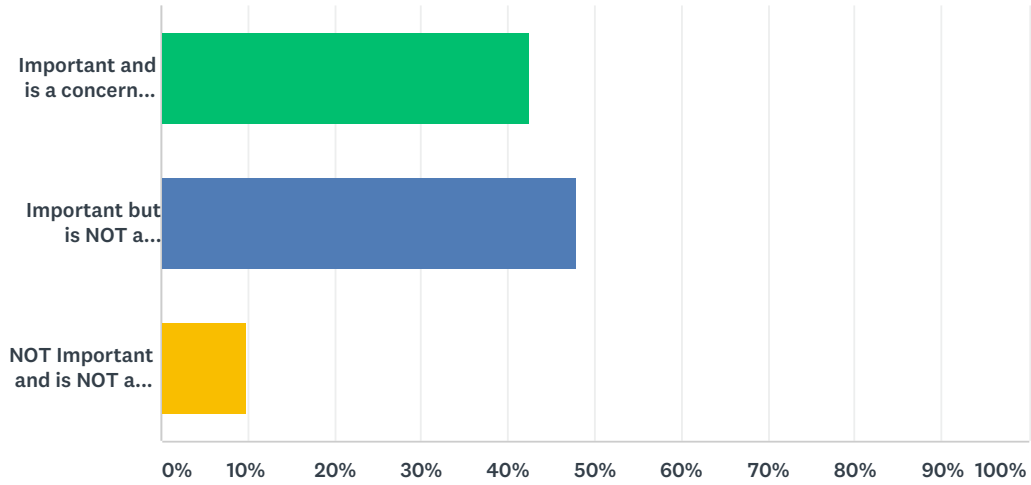
Answered: 695 Skipped: 42



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	14.39%	100
Important but is NOT a concern for me	61.29%	426
NOT Important and is NOT a concern for me	24.60%	171
Total Respondents: 695		

Q9 Understanding Medicare and various options

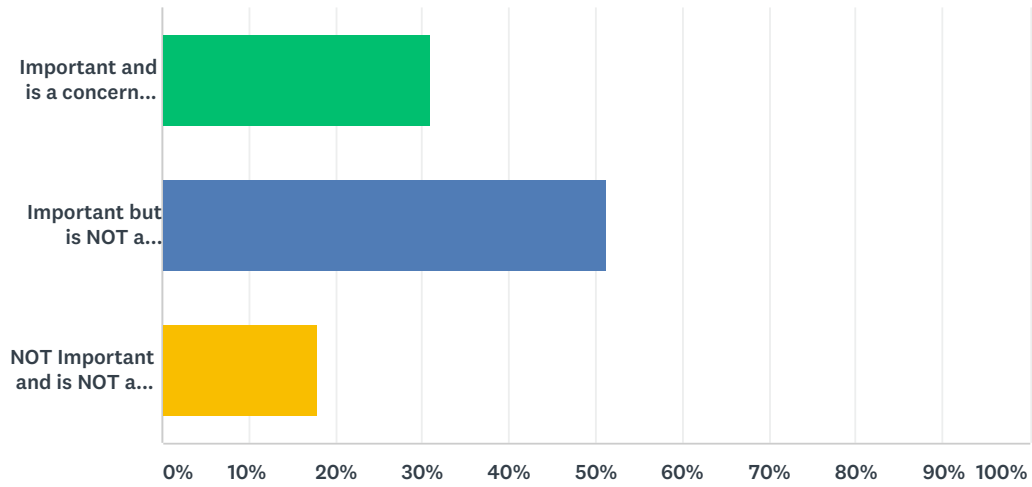
Answered: 704 Skipped: 33



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	42.47%	299
Important but is NOT a concern for me	47.87%	337
NOT Important and is NOT a concern for me	9.80%	69
Total Respondents: 704		

Q10 Understanding low-income health insurance subsidies

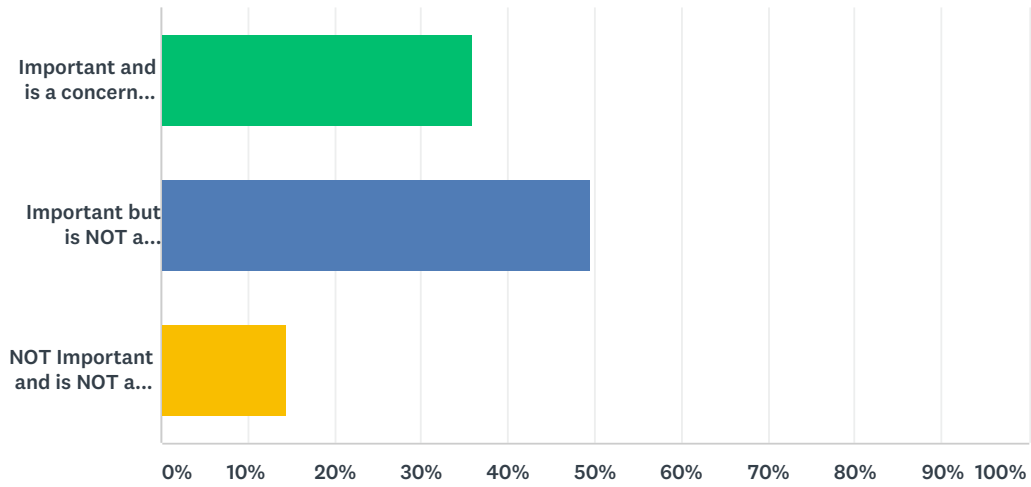
Answered: 690 Skipped: 47



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	30.87%	213
Important but is NOT a concern for me	51.16%	353
NOT Important and is NOT a concern for me	17.97%	124
Total Respondents: 690		

Q11 Understanding long term care services and support options

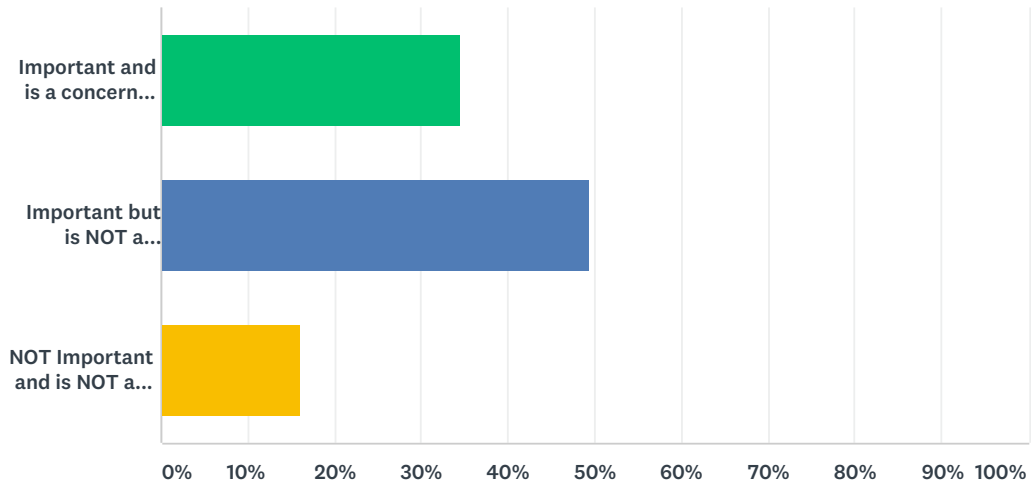
Answered: 689 Skipped: 48



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	35.99%	248
Important but is NOT a concern for me	49.49%	341
NOT Important and is NOT a concern for me	14.51%	100
Total Respondents: 689		

Q12 Understanding Long Term Care insurance options

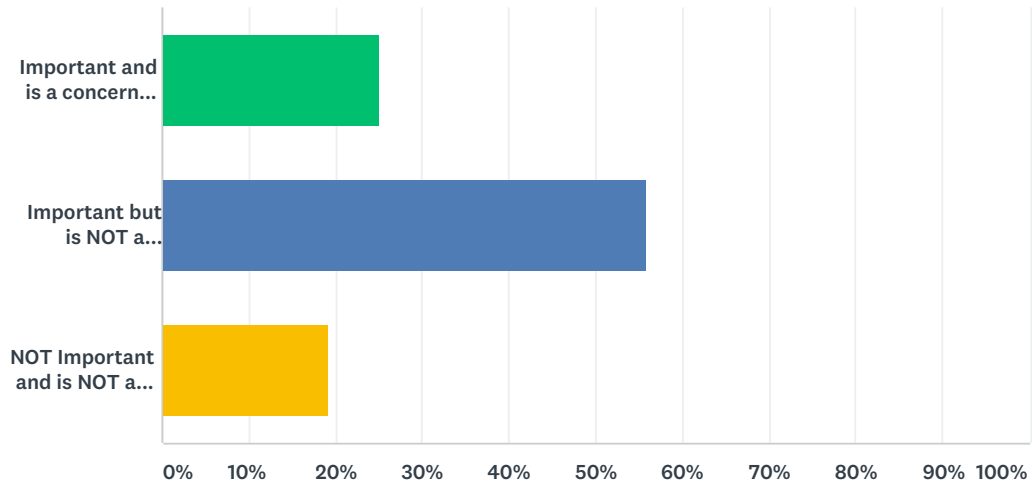
Answered: 686 Skipped: 51



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	34.55%	237
Important but is NOT a concern for me	49.27%	338
NOT Important and is NOT a concern for me	16.18%	111
Total Respondents: 686		

Q13 Recurring falls in and out of the home

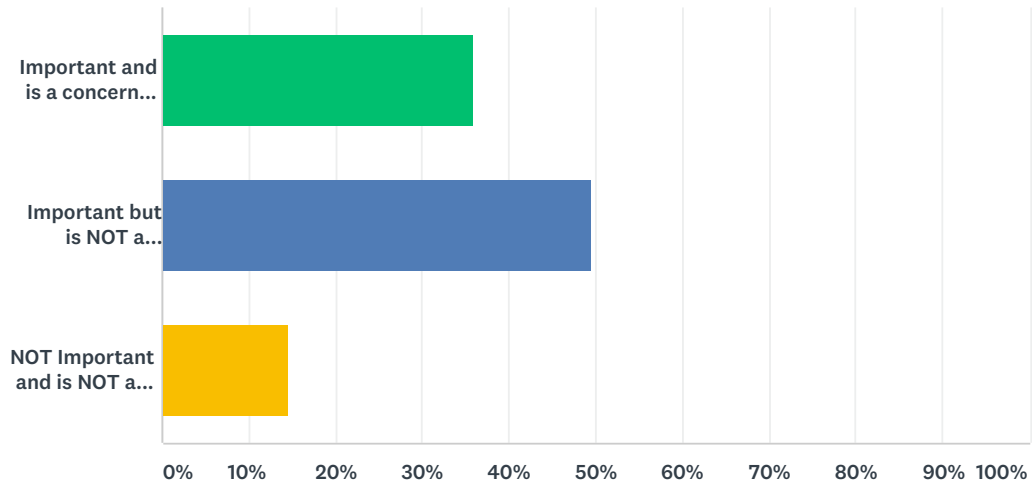
Answered: 694 Skipped: 43



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	25.07%	174
Important but is NOT a concern for me	55.76%	387
NOT Important and is NOT a concern for me	19.16%	133
Total Respondents: 694		

Q14 Managing chronic health condition(s)

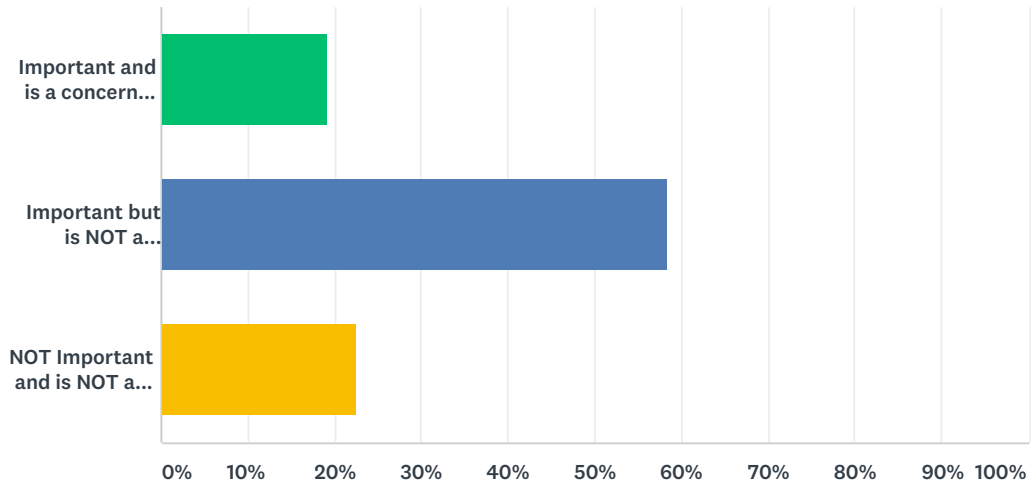
Answered: 676 Skipped: 61



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	35.95%	243
Important but is NOT a concern for me	49.56%	335
NOT Important and is NOT a concern for me	14.64%	99
Total Respondents: 676		

Q15 Accessing services for individuals with Alzheimer's or dementia and their caregivers

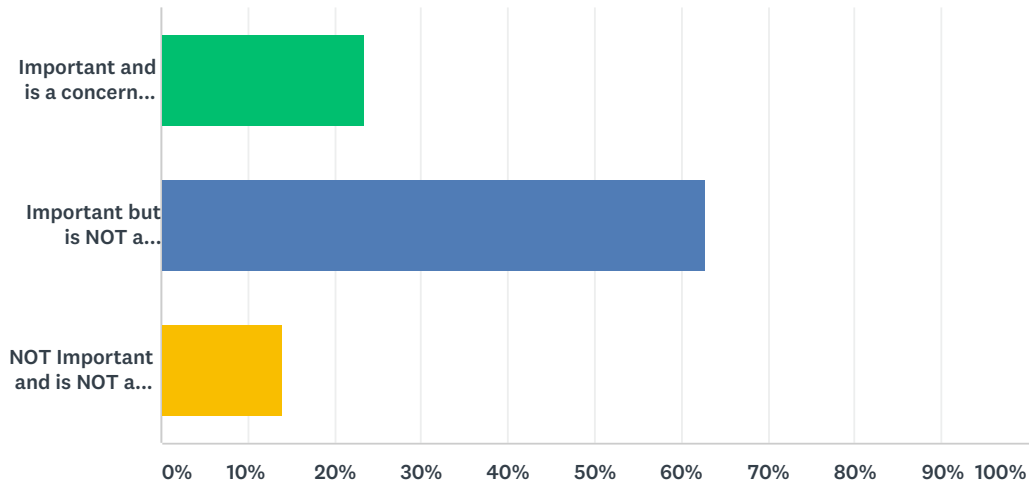
Answered: 662 Skipped: 75



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	19.18%	127
Important but is NOT a concern for me	58.46%	387
NOT Important and is NOT a concern for me	22.51%	149
Total Respondents: 662		

Q16 Having enough money for nutritious food

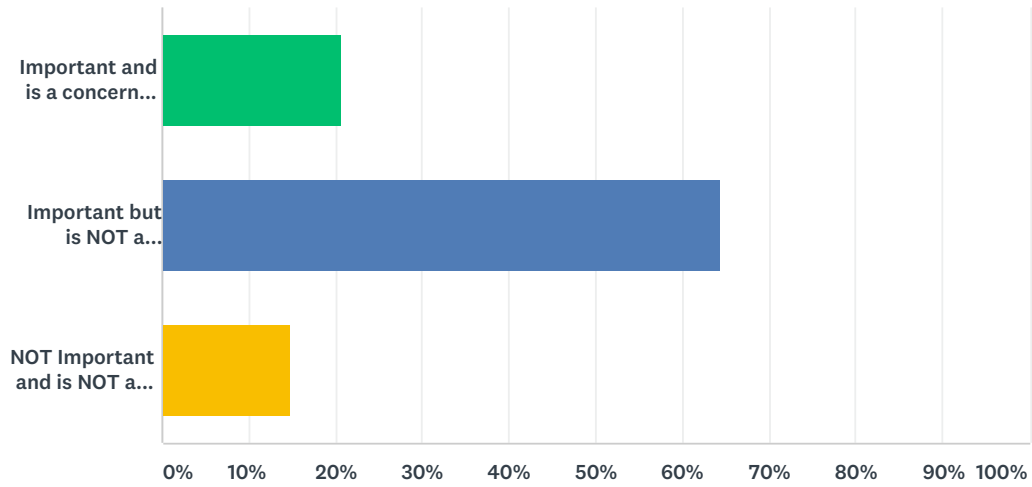
Answered: 685 Skipped: 52



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	23.36%	160
Important but is NOT a concern for me	62.77%	430
NOT Important and is NOT a concern for me	14.01%	96
Total Respondents: 685		

Q17 Being able to shop and cook for myself

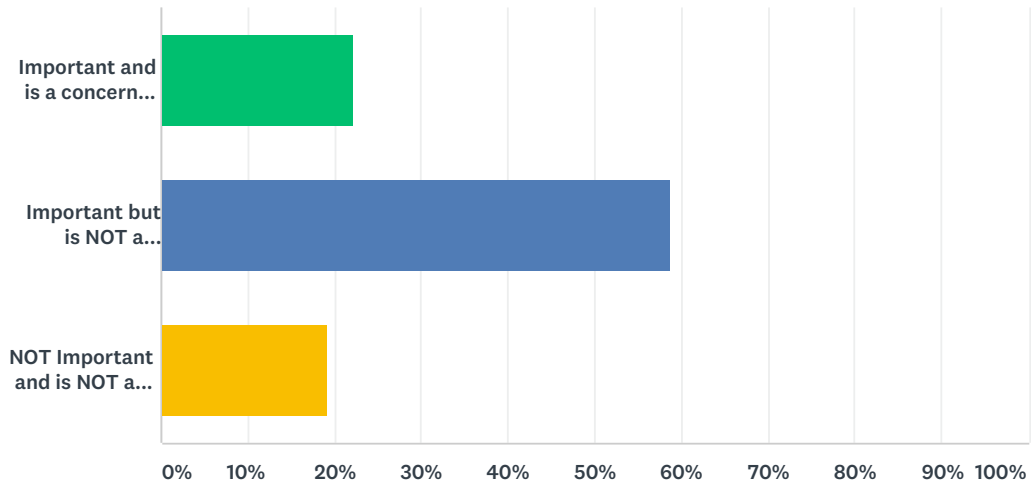
Answered: 687 Skipped: 50



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	20.67%	142
Important but is NOT a concern for me	64.48%	443
NOT Important and is NOT a concern for me	14.85%	102
Total Respondents: 687		

Q18 Able to follow a special diet recommended by my doctor

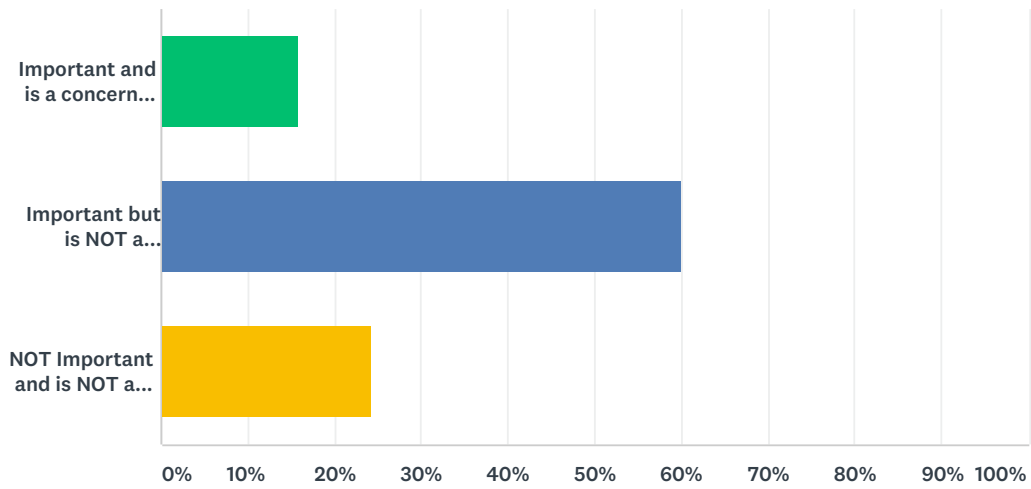
Answered: 684 Skipped: 53



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	22.22%	152
Important but is NOT a concern for me	58.77%	402
NOT Important and is NOT a concern for me	19.30%	132
Total Respondents: 684		

Q19 Respite services, such as adult day programs, for caregivers of people with dementia or other functional impairments

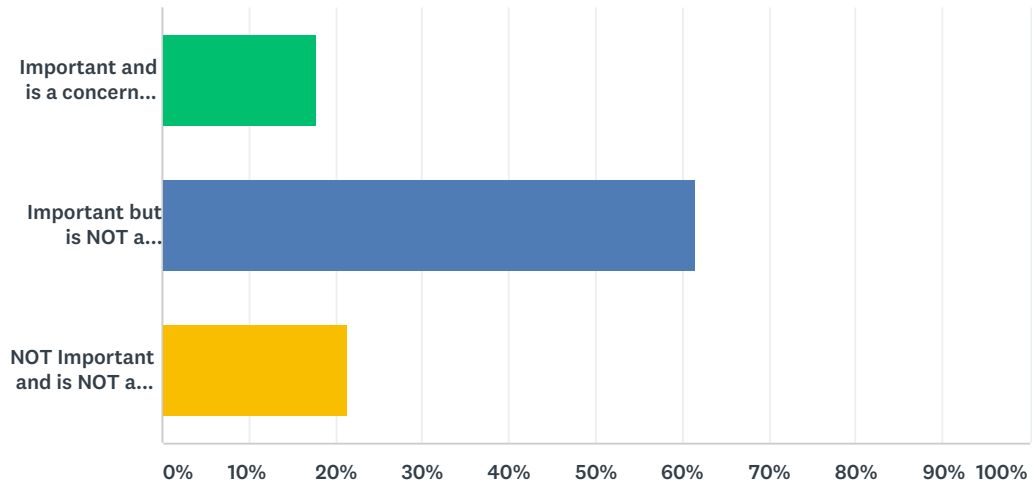
Answered: 664 Skipped: 73



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	15.96%	106
Important but is NOT a concern for me	59.94%	398
NOT Important and is NOT a concern for me	24.25%	161
Total Respondents: 664		

Q20 Access to Senior Centers

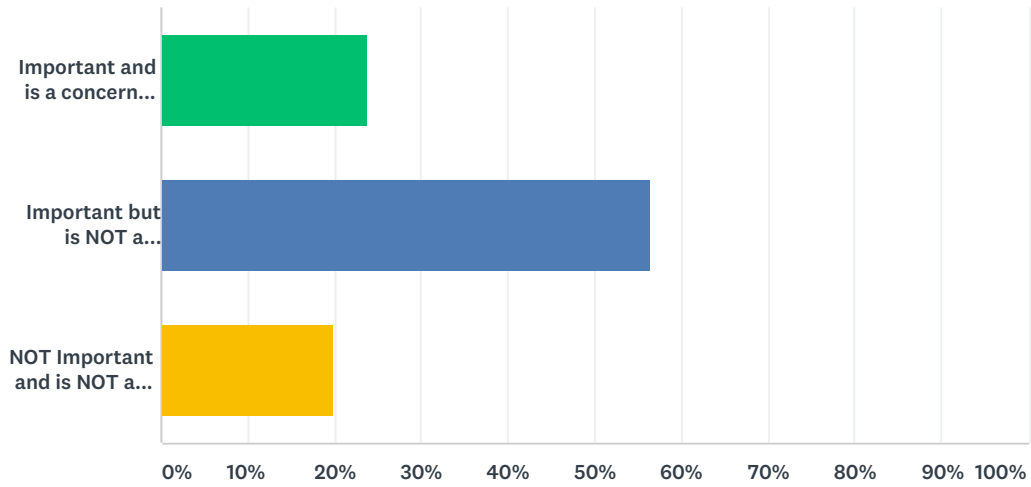
Answered: 678 Skipped: 59



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	17.70%	120
Important but is NOT a concern for me	61.50%	417
NOT Important and is NOT a concern for me	21.24%	144
Total Respondents: 678		

Q21 Transportation options for those unable to drive

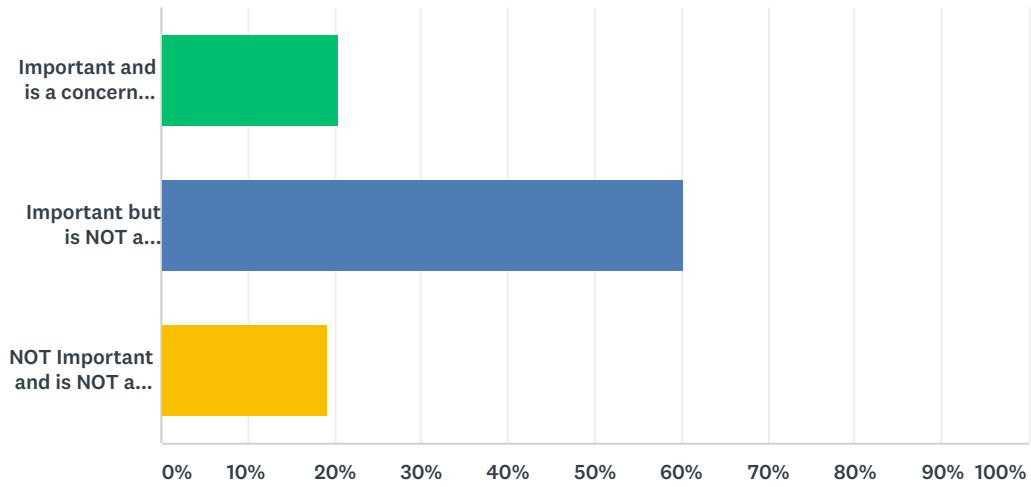
Answered: 677 Skipped: 60



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	23.93%	162
Important but is NOT a concern for me	56.57%	383
NOT Important and is NOT a concern for me	19.79%	134
Total Respondents: 677		

Q22 In-home personal care services

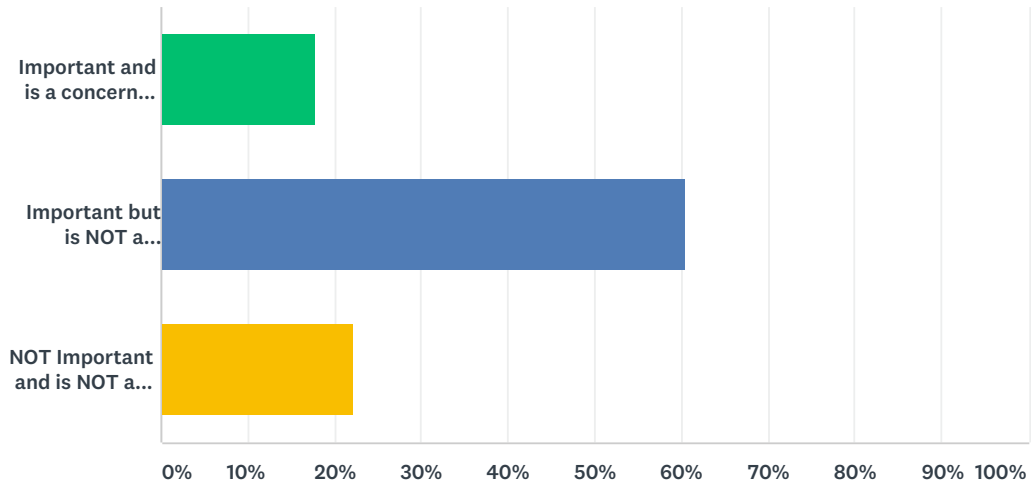
Answered: 670 Skipped: 67



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	20.60%	138
Important but is NOT a concern for me	60.30%	404
NOT Important and is NOT a concern for me	19.25%	129
Total Respondents: 670		

Q23 Ability to participate in Congregate Meal sites or receive Home Delivered meals

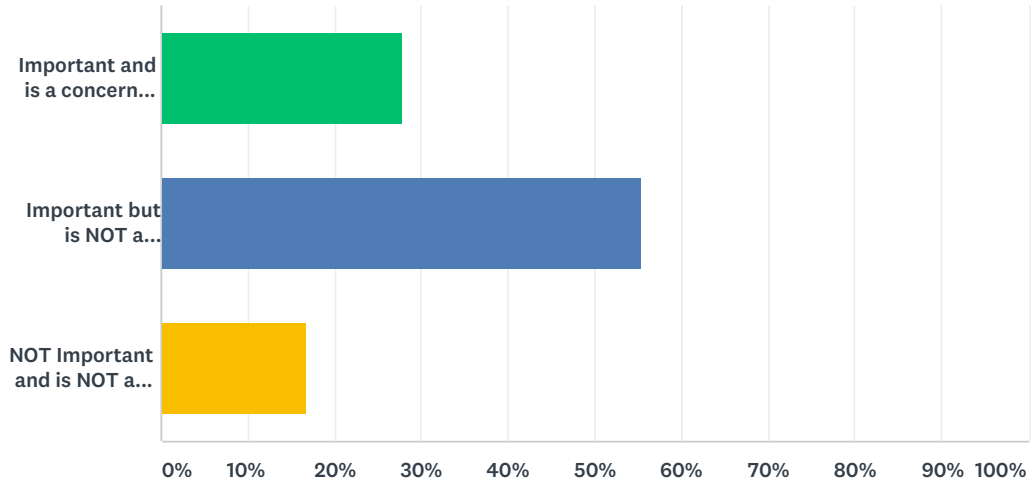
Answered: 669 Skipped: 68



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	17.79%	119
Important but is NOT a concern for me	60.39%	404
NOT Important and is NOT a concern for me	22.12%	148
Total Respondents: 669		

Q24 Ability to obtain help applying for government program(s)

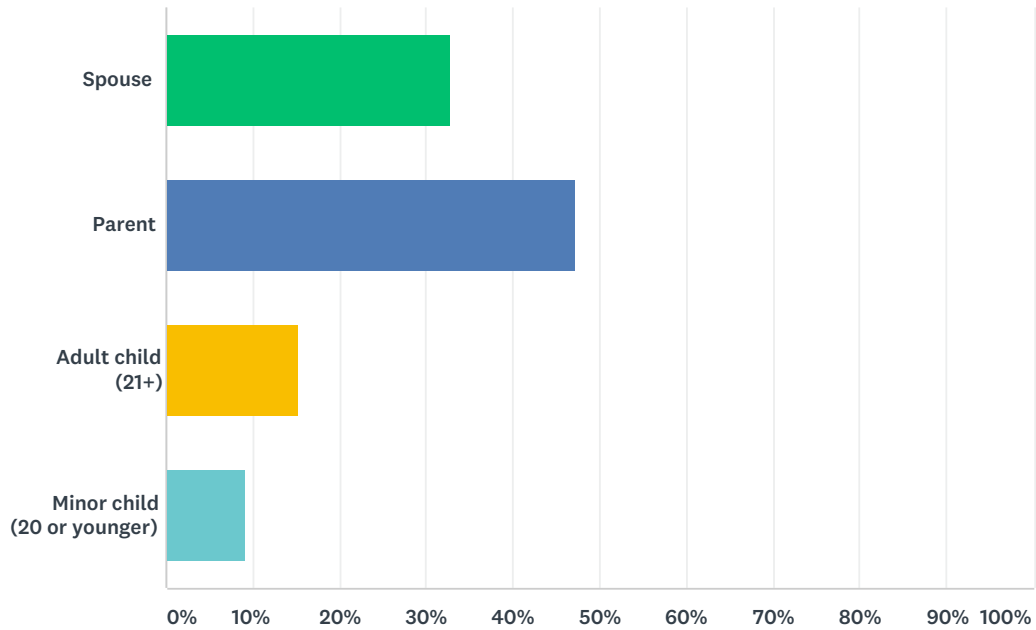
Answered: 670 Skipped: 67



ANSWER CHOICES	RESPONSES	
Important and is a concern for me	27.91%	187
Important but is NOT a concern for me	55.52%	372
NOT Important and is NOT a concern for me	16.72%	112
Total Respondents: 670		

Q25 For whom do you provide care?

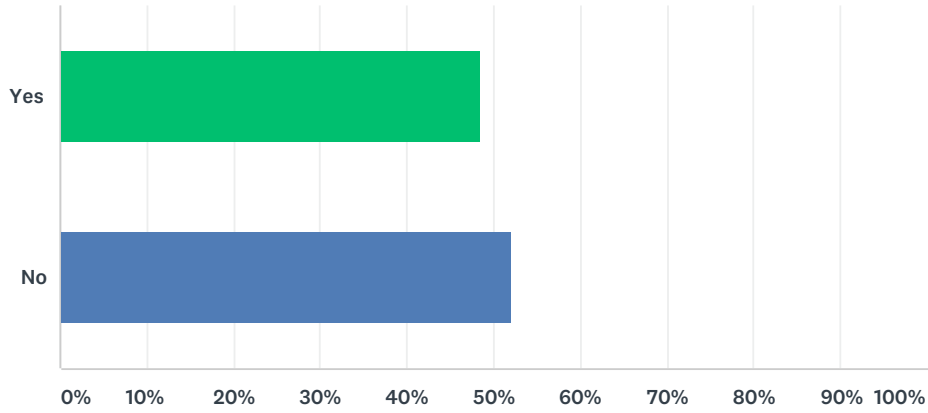
Answered: 131 Skipped: 606



ANSWER CHOICES	RESPONSES	
Spouse	32.82%	43
Parent	47.33%	62
Adult child (21+)	15.27%	20
Minor child (20 or younger)	9.16%	12
Total Respondents: 131		

Q26 Does the individual for whom you provide care live in your home?

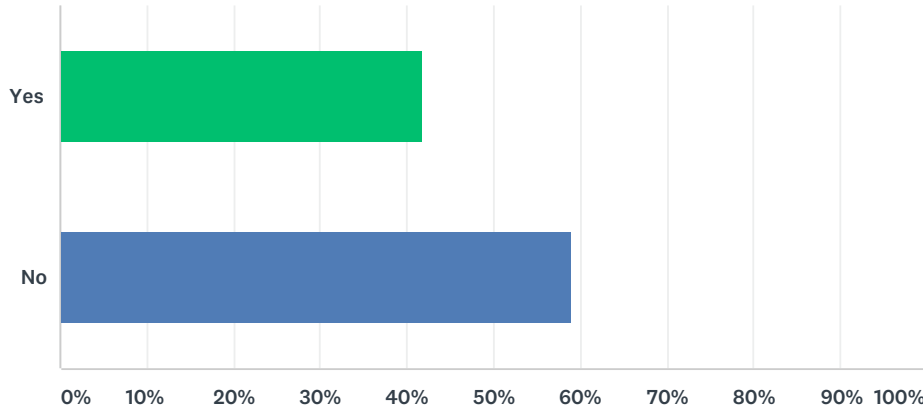
Answered: 142 Skipped: 595



ANSWER CHOICES	RESPONSES	
Yes	48.59%	69
No	52.11%	74
Total Respondents: 142		

Q27 Does the individual have memory problems and/or dementia?

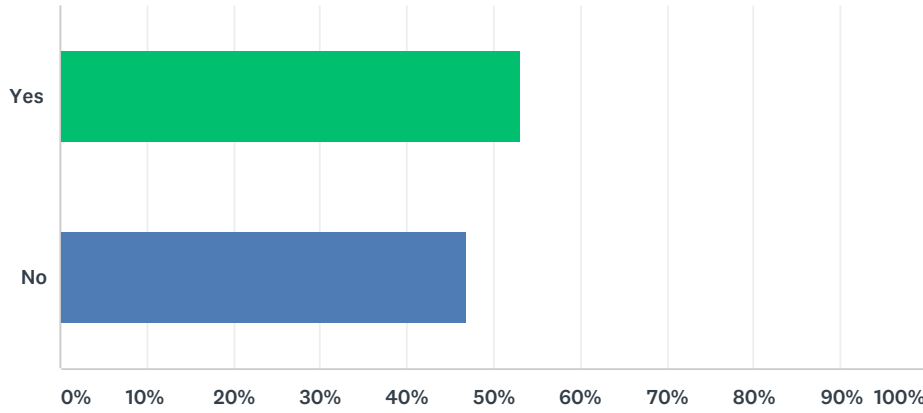
Answered: 146 Skipped: 591



ANSWER CHOICES	RESPONSES	
Yes	41.78%	61
No	58.90%	86
Total Respondents: 146		

Q28 Do you feel overwhelmed and/or stressed in providing care?

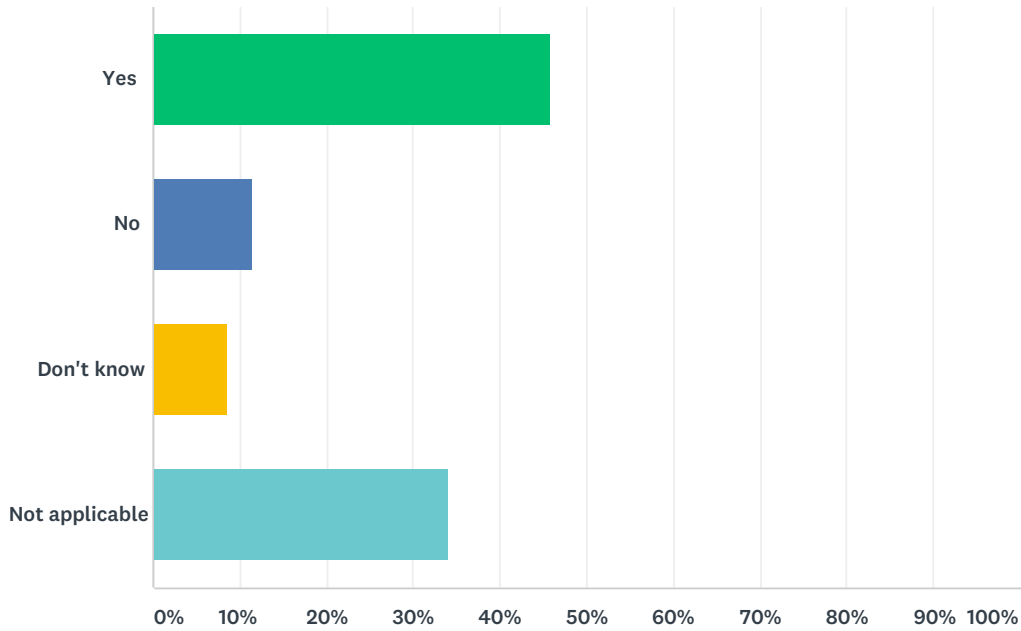
Answered: 143 Skipped: 594



ANSWER CHOICES	RESPONSES	
Yes	53.15%	76
No	46.85%	67
Total Respondents: 143		

Q29 If you or someone you know has been in the hospital in the last year, did you/they have the information and supports needed to return home?

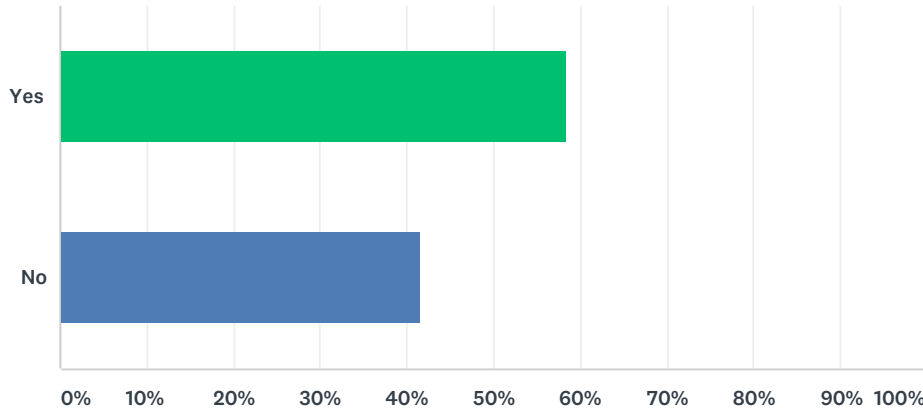
Answered: 497 Skipped: 240



ANSWER CHOICES	RESPONSES	
Yes	45.88%	228
No	11.47%	57
Don't know	8.65%	43
Not applicable	34.00%	169
Total Respondents: 497		

Q30 Have you heard of NY Connects, the local program that helps consumers with information, assistance and connections to needed long term services & supports?

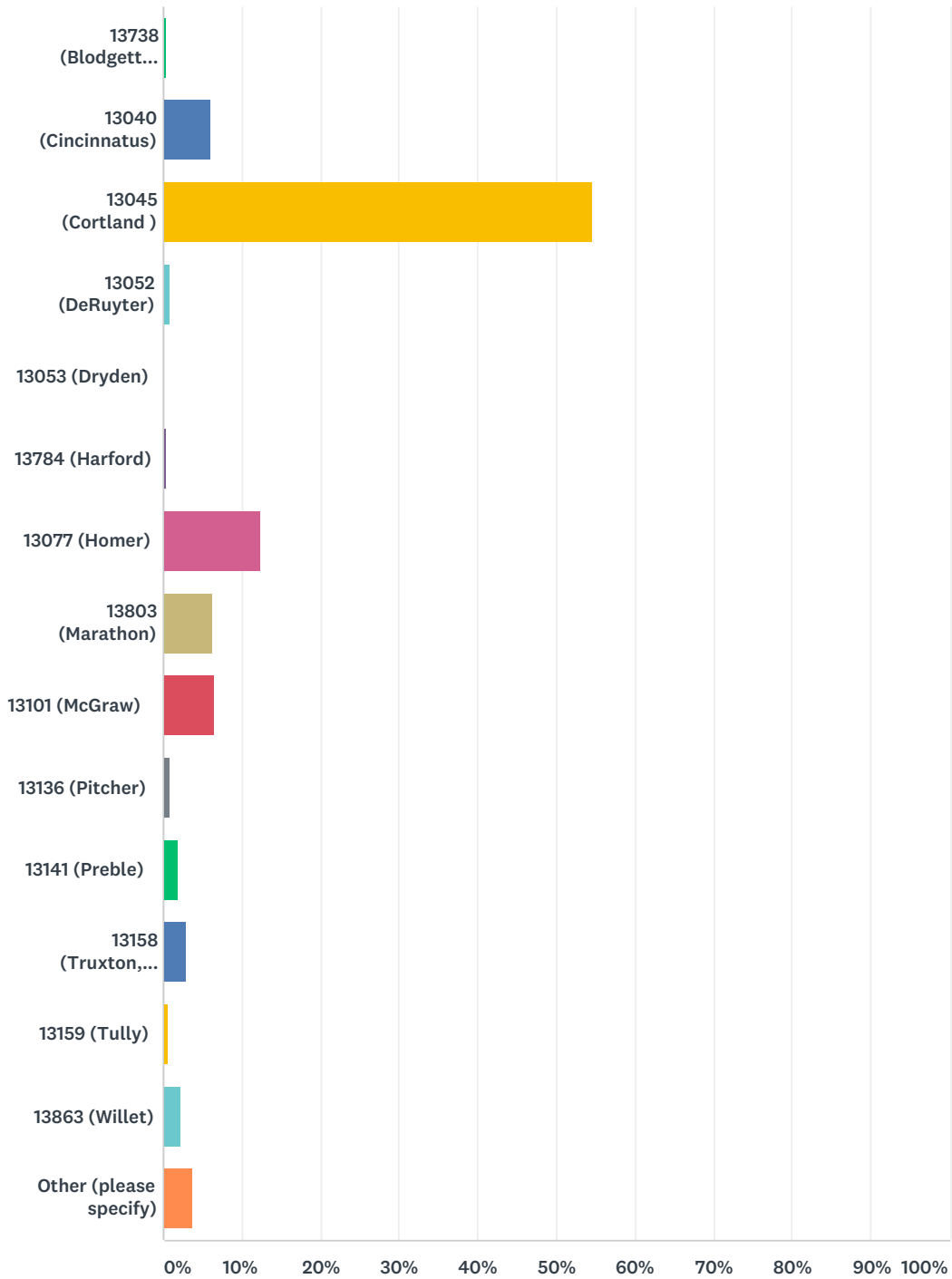
Answered: 520 Skipped: 217



ANSWER CHOICES	RESPONSES	
Yes	58.46%	304
No	41.54%	216
Total Respondents: 520		

Q31 Your zip code

Answered: 667 Skipped: 70



ANSWER CHOICES	RESPONSES	
13738 (Blodgett Mills)	0.45%	3
13040 (Cincinnatus)	6.15%	41
13045 (Cortland)	54.57%	364

Needs Assessment 2019

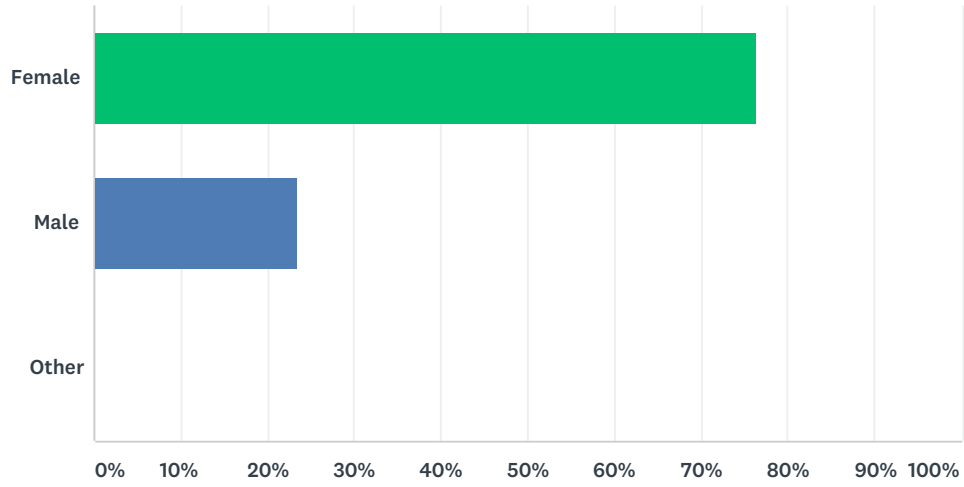
13052 (DeRuyter)	0.90%	6
13053 (Dryden)	0.30%	2
13784 (Harford)	0.45%	3
13077 (Homer)	12.29%	82
13803 (Marathon)	6.30%	42
13101 (McGraw)	6.45%	43
13136 (Pitcher)	0.75%	5
13141 (Preble)	1.80%	12
13158 (Truxton, Cuyler, E Homer)	2.85%	19
13159 (Tully)	0.60%	4
13863 (Willet)	2.40%	16
Other (please specify)	3.75%	25
TOTAL		667

Q32 What is your age?

Answered: 617 Skipped: 120

Q33 Your gender is:

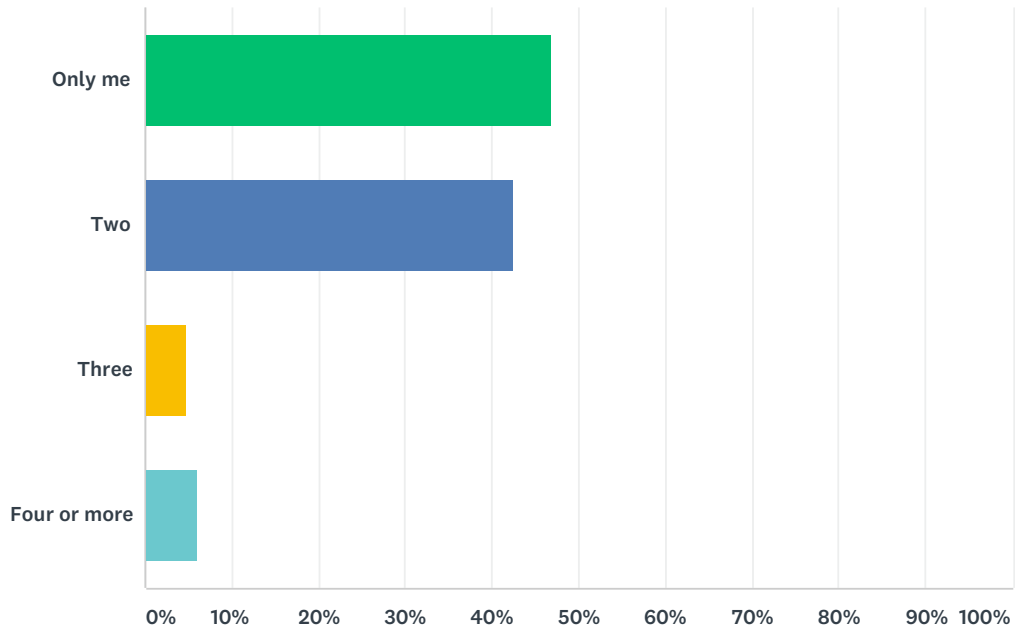
Answered: 630 Skipped: 107



ANSWER CHOICES	RESPONSES	
Female	76.35%	481
Male	23.49%	148
Other	0.16%	1
Total Respondents: 630		

Q34 How many people live in your household, including yourself?

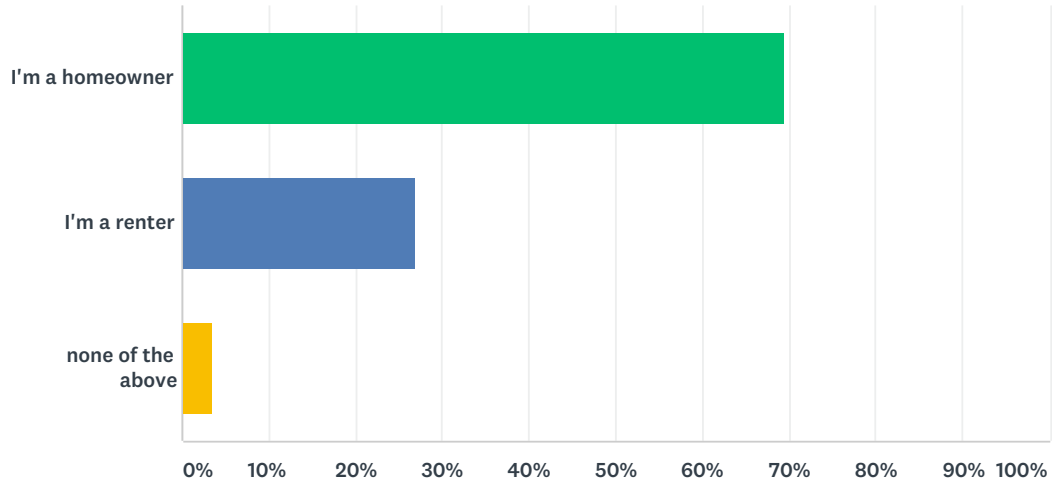
Answered: 632 Skipped: 105



ANSWER CHOICES	RESPONSES	
Only me	46.84%	296
Two	42.41%	268
Three	4.75%	30
Four or more	6.01%	38
Total Respondents: 632		

Q35 My living arrangements

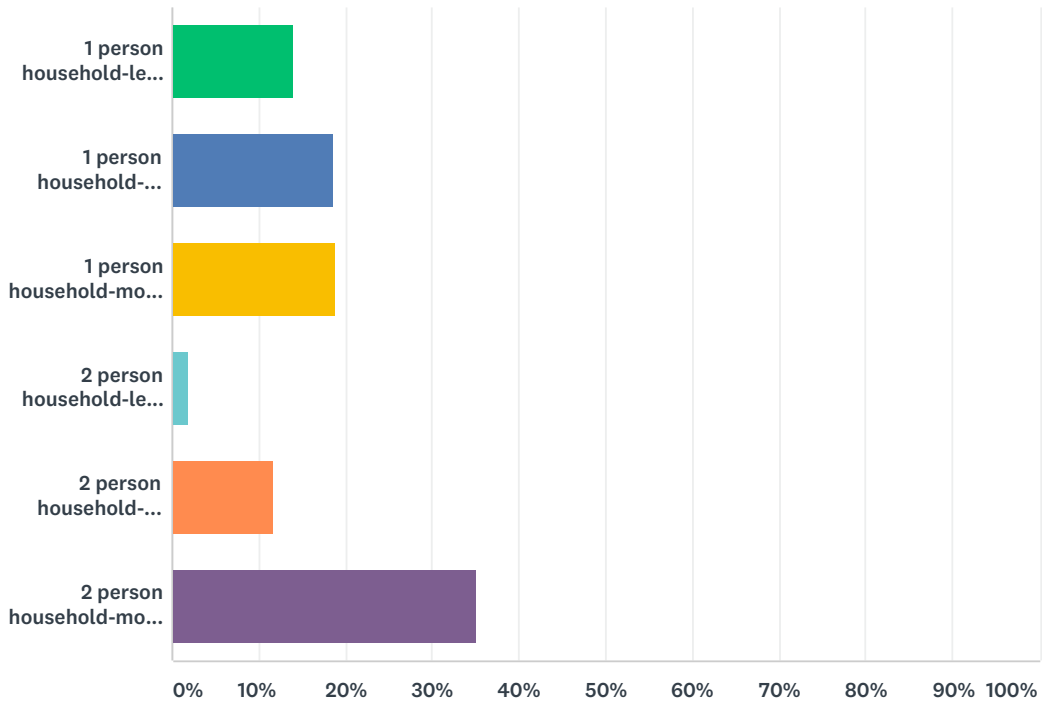
Answered: 640 Skipped: 97



ANSWER CHOICES	RESPONSES	
I'm a homeowner	69.38%	444
I'm a renter	27.03%	173
none of the above	3.59%	23
Total Respondents: 640		

Q36 My household income is:

Answered: 588 Skipped: 149



ANSWER CHOICES	RESPONSES	
1 person household-less than \$12,490 yearly	14.12%	83
1 person household- \$12,491-\$23,107 yearly	18.71%	110
1 person household-more than \$23,107 yearly	18.88%	111
2 person household-less than \$16,910 yearly	1.87%	11
2 person household- \$16,911-\$31,284 yearly	11.73%	69
2 person household-more than \$31,284	35.20%	207
Total Respondents: 588		



Cortland County
2019-2020 County Plan
Community Services Board

New York Mental Hygiene Law requires that each local government unit (LGU) annually develop and submit a comprehensive plan, establishing long term mental hygiene system goals and objectives for the county.

LGU Responsibilities:

- Determine community needs and encourage programs for prevention, assessment, treatment, social and vocational rehabilitation, education, training, and public education related to behavioral health.
- Review behavioral health services and local facilities in relation to needs.
- Establish long range goals consistent with those of the state.
- Seek to assure that all population groups are covered and sufficient services are available.
- Promote cooperation and coordination of local providers and systems serving those with behavioral health challenges.

The process to develop the county plan and priorities involved review and update over two months for each subcommittee and the monthly Community Service Board Meeting.

- Previous year goals are reviewed, progress updated, and strategies revised.
- Access and utilization data reviewed, and behavioral health needs survey will be completed by Subcommittee groups.
- New goals and strategies are added, and goals are prioritized for submission in the 2019-2020 County Plan.
- The plan is presented to a joint meeting of the CSB and Subcommittees for any final changes and approval.

Approved by Community Service Board Members June 6, 2019

2019-2020 County Plan

Priority Outcome 1: Substance Abuse Treatment (SUD) and Prevention

Develop a comprehensive plan to address issues related to Substance Abuse (broadly defined to include alcohol, opiates, methamphetamines, cocaine, etc.), with specific focus on the impact of Opioids in Cortland County, that includes prevention, treatment and crisis intervention strategies.

Goal 1.1 SUD Coordination and Oversight

A number of community groups (CD Subcommittee, CACTC) are currently focused on substance use issues with coordination happening primarily through overlapping membership integrating efforts. Recommend development of a Community Advisory Board to meet the oversight needs of the new CHASE Grant, and enhance systems integration of planning, prevention and treatment needs and services across systems.

Strategies

- Hire dedicated staff through the CHASE Grant to lead advisory board, coordinate systems integration and new service development.
- Create data dashboard to inform decision making and track outcomes.
- Support Cortland County priorities in the New York State Prevention Agenda.
- Partner with the Cortland County Health Department to access new Department of Health resources and programs targeted to substance use disorders, and integrate within the community system of care.
- Utilize ongoing Justice League / Sequential Intercept Model to foster integrated mental health, substance abuse and criminal justice system planning.

Goal 1.2 SUD Prevention and Education

Promote and support community prevention efforts and education regarding: drug and alcohol use signs and symptoms, the danger of drugs and alcohol for individuals and available community treatment and recovery resources for children and youth, parents, physicians, and pharmacies.

Strategies

- Seek resources to sustain the work of the Cortland Area Communities That Care (CACTC). The goals of the CACTC are to reduce the rates of prescription drug abuse and heroin use among the 12 to 25-year-old population in Cortland County, through the use of evidence-based environmental prevention strategies.
- Support developing coalitions such as: Central New York Regional Coalition and new prevention coalitions at SUNY Cortland and TC3 by involving them in the LGU and scheduling regular presentations to the CD Subcommittee.

- Cortland Prevention Resources and the Cortland City School District provide primary prevention and support in many schools around the county, but more resources are needed to expand to all schools in the county. Survey remaining school districts to identify needs and priorities, and provide opportunities for collaboration.
- Raise awareness of current prevention programming by scheduling regular presentations/updates by prevention providers to the CD Subcommittee.
- Enhance local visibility of Regional Family Engagement Specialist by supporting potential partnership with Cortland Prevention Resources and scheduling regular presentation to the CD Subcommittee.
- Promote prescription takeback events in Cortland County and drug disposal kiosks at Cortland City Police Department, Cortland County Sheriff's Office, Homer Police Department and Guthrie Cortland Medical Center. Explore additional harm reduction strategies such as community needle exchange and expansion of drug kiosk availability to other parts of the county.
- Explore opportunities for Community Harm Reduction Training.
- Explore new NY DOH data tracking and data systems for "hot spotting" Narcan use and emergency room presentations in real time, allowing for targeted outreach, engagement and intervention efforts, and promoting and expanding harm reduction efforts.
- Promote CACTC targeted awareness campaigns and prevention toolkits for providers, pharmacies and parents.
- Promote community training efforts of CACTC in partnership with Guthrie Cortland Medical Center, the Health Department, and Lemoyne College with primary care providers in the community to related to Opioids and prescribing practices.
- Support Prevention Agenda goals by promoting training and utilization of Screening Brief Intervention and Referral to Treatment (SBIRT) Model.
- Develop resources and strategies related to vaping.

Goal 1.3 SUD Crisis Intervention

Encourage, develop and/or enhance community treatment resources to more immediately respond to urgent treatment needs with the appropriate level of care.

Strategies

- COTI programs seek to expand access to: Medication Assisted Treatment, counseling, peer services and case management by providing outreach and mobile services to engage difficult to reach populations and individuals.
- Support the implementation of the Angel Program in Cortland County.
- Promote and develop supports to manage emergent and crisis needs through: the provision of Naloxone (Narcan) training through multiple pathways, including: Cortland County Health Department, Guthrie Cortland Medical Center and the Cortland County Jail. Encourage universal Narcan prescription with all opioid prescriptions.

- Promote and support the implementation of 24 hour Regional Open Access Center(s) in Ithaca and Syracuse to serve as a crisis stabilization, assessment and referral hub for the region.
- Coordinate access to and from new Detox beds opened by Helio Health in Binghamton in 2018, and expected new development of beds in Ithaca through Alcohol and Drug Council of Tompkins County.

Goal 1.4 SUD Treatment and Services

Promote access to SUD services and supports for Cortland County residents.

Strategies

- Expand availability and access to peer recovery coaches, mentors and advocates (youth and adult).
- Promote new programming to enhance sustainability of services in response to Cortland County inclusion in year two of Center of Treatment Innovation (COTI) funding.
- Support warm handoffs and expedited connections to community services for vulnerable individuals returning to the community from prison, jail, hospitalization or rehabilitation settings.
- Support and enhance the connection of Guthrie Cortland Medical Center to the SUD system of care in Cortland County.
- Support expansion of access to Medication Assisted Treatment (MAT) in new settings including: hospital, jail, Article 31 clinic settings.
- Promote SUD Stigma Reduction in health settings.
- Support ongoing development of mobile treatment capacity to outlying areas of the county and disconnected populations through the use of treatment in community settings and utilization of telemedicine.
- Develop and enhance SUD assessment and treatment in the Cortland County Jail.
- Develop and enhance connection to peer services to support transition coordination for inmates released from county jail.
- Support the implementation and expansion of the Cortland County Jail Vivitrol Program.
- Support opportunities to develop community peer recovery centers (youth and adult).
- Engage Family Health Network as a potential partner in service delivery and to promote connection to the community system of care.

Priority Outcome 2:

Housing

Ensure that safe affordable housing is available to all, with the appropriate supports to promote successful community living and full community integration.

Goal 2.1

Partner with DSS to identify shared needs for emergency and transitional housing in Cortland County.

Strategies

- Explore issues related to sanctions that jeopardize housing funding models for highest needs individuals, and advocate for consistent regulations that increase the likelihood of compliance and success.
- Support county efforts to find solutions to issues enhanced by Code Blue Requirements such as warming centers.
- Support efforts to expand the Transitional Housing Program at Catholic Charities.
- Support the creation of community based supports that promote and enhance housing security.
- Partner with DSS to explore alternative opportunities for highest needs individuals who are chronically homeless or unstable in their housing due to complex behavioral health needs.
- Advocate for additional OPWDD Family Support grant funds to support local opportunities for parents to develop relationships and resources that enhance the housing possibilities presented by self-directed planning.
- Advocate for planning opportunities for aging caregivers of children with developmental disabilities who need to make proactive plans that will allow their children to stay in their community and be cared for.
- Advocate and plan for new Children/Youth IRA's to be sited in Central New York, focused on children and youth who are eligible in the OPWDD System and having behavioral issues.
- Support Community Housing Coalition.
- Support Catholic Charities Empire State Supported Housing Initiative (ESHI) housing development grant opportunity.
- Support Catholic Charities proposal for Solutions to End Homelessness Grant.

Priority Outcome 3: Crisis Intervention

Develop the capacity to recognize and respond more immediately with behavioral health assessment and supports to address the urgent needs of all the citizens of Cortland County.

Goal 3.1 Training and Coordination

Provide training and support to those responding to crisis situations in Cortland County.

Strategies

- Support the Emotionally Disturbed Person Response Team (EDPRT) through ongoing training, and monthly community consultation and collaboration meetings.
- Promote coordination between community providers and Guthrie Cortland Medical Center (specifically emergency department, psychiatric unit, and case management) for high needs youth and adults. Create cross systems pathways to supports for complex needs or high risk individuals.
- Support integration of community supports and services within Guthrie Cortland Medical Center (Care Coordination, Peer, Family Support).

- Support the ongoing development and sustainability of the Community Trauma Response Team.
- Explore utilization of information sharing resources such as “Red Binder Program” across vulnerable populations.
- Support the development and enhancement of the Suicide Prevention Coalition in Cortland County, to serve as a planning and coordinating process for identification of needs, training and best practices related to Suicide Prevention.

Goal 3.2 Services

Develop and support services able to respond in the community and/or provide access to immediate services and supports to stabilize behavioral health crises.

Strategies

- Support the implementation of the Mobile Crisis Team through Liberty Resources and work in partnership with the Central New York Directors Planning Group (CNYDPG) towards the expansion of program to eventually be a 24/7 resource.
- Advocate for cross systems integration/training for crisis services supporting individuals with developmental disabilities and participate in the developing the NYSTART (Systemic, Therapeutic, Assessment, Response and Treatment) process in Central New York.
- Promote and expand access to **local** Crisis Respite opportunities for all ages and disability populations.
- Monitor impact of OPWDD Respite rate changes on access to respite services at Starry Night.
- Develop access to Family Support Services to provide education, support and advocacy to individuals supporting family members in crisis.
- Support the development of more intensive community based supports for individuals with chronic complex needs by advocating for the creation of a local ACT (Assertive Community Treatment) team, or utilizing the NY State “In lieu of services” process to create equivalent services.
- Enhance supports for the management of the Assisted Outpatient Treatment (AOT) Process.
- Explore the development and access to a “Medication Only” service for individuals refusing therapy or as a bridge service to accessing outpatient clinic medical staff.
- Advocate for greater access to inpatient psychiatric beds. Frequent shortages have resulted in long waits for placement, often hours away from parents.
- Support development of community based treatment mental health services with access to telehealth.
- Support enhanced access to skill building and community based respite services.
- Identify service gaps and support agency development of capacity to provide new Office of Mental Health Child and Family Treatment Services (CFTSS) and Home and Community Based Services (HCBS) to Cortland County residents.
- Enhance coordination of crisis and information lines to ensure consistent response and expedited access to support.

Priority Outcome 4:
Transportation

Work to reduce the impact of transportation barriers in access to services and supports across Cortland County.

Strategies

- Work with community partners to assess and document the impact of funding changes related to public transportation in Cortland County, and the associated impact on residents with behavioral health needs.
- Provide representation of behavioral health needs to the Mobility Management System through participation in the Transportation Advisory Board.
- Work with MAS to promote community understanding of process to access Medicaid transportation.
- Advocate with MAS for improvements in local systems access to transportation.
- Support efforts to integrate services in towns and villages that enhance access to care.
- Support development and expansion of access to telehealth services. OMH and OASAS are working to standardize regulations related to telehealth in ways that could make that service more of a viable resource for providers and patients potentially easing some access issues.
- Encourage and support community efforts to develop mutual aid and the CAPCO Volunteer Transportation Program.

Support access to ride sharing services.

Priority Outcome 5:
Service Access and Planning

Ensure the LGU role (consistent with Mental Hygiene Law) in the oversight, management and implementation of behavioral health plans and services to Cortland County residents across all three behavioral health service systems (OASAS, OMH, OPWDD) that promotes access to care that is timely and effective in addressing behavioral health needs.

Goal 5.1 Systems Access

Work with county systems partners to integrate processes and funding to create a "No Wrong Door" that is capable of outreaching to vulnerable populations, utilizes standardized assessment to determine eligibility for services, connects to appropriate services and monitors engagement with, and outcomes to care. Explore possibilities for an integrated setting where multiple system access points can collaborate to engage and connect county residents to appropriate supports.

Strategies

- Partner with AAA, DSS, Health, OPWDD on creation of a coordinated access point to services and cross systems planning.
- Collaborate with system partners on planning and promotion of events around access to services and community training to facilitate cross systems collaboration.

- Support Seven Valleys Health Coalition implementation and promote Cortland 211 for county information, access and referral to services. Monitor usage data and trends through the Mental Health Subcommittee.
- Support Cortland County Coordinated Children’s Initiative (CCSI) Tier 2 as a cross system process to engage families, identify service gaps, and access barriers, and provide opportunities for collaboration.

Goal 5.2 Regional and State Opportunities

Provide local leadership and leverage partnerships in regional and statewide groups to ensure that the needs of Cortland County residents are being included in resource allocation and systems planning.

Strategies

- New York State Conference of Local Mental Hygiene Directors
- Central New York Director's Planning Group
- Central New York Regional Planning Committee
- Care Compass Network (DSRIP)
- Medicaid Managed Care systems transformation, including OMH Children's System Transformation and OPWDD Transformation Agenda
- South Central Behavioral Health Care Collaborative

Goal 5.3 Supports for Transitions

Develop and operationalize protocols for transitions for youth and adults. Transitions are being defined as, but are not necessarily limited to; discharge from hospital or residential placement, transition planning for children with special needs (IEP, 504) as they move from school to post-school life, transition from child-serving to adult services or any transition impacting individuals served by behavioral health services.

Strategies

- Monitor impact of shifting OPWDD vocational service models on transitioning students.
- Develop and support opportunities to involve school districts in learning about behavioral health systems changes, and participate in needs assessment and planning.
- Develop processes to track individuals with developmental disabilities that are transitioning from lower levels of care into nursing homes and may not have natural supports.
- Develop protocols with state hospitals to notify SPOA when a local resident has been admitted to ensure good planning for discharge.
- Coordinate role of COTI Team with Regional Open Access Centers to support transitions to identified levels of care.
- Enhance relationships with NY State Residential Treatment Facility Programs to promote improved discharge planning.
- Continue to refine SPOA process in collaboration with cross system partners to identify needs and support transitions with appropriate connections to care.
- Support Community Reentry Process to enhance connection to supports for individuals released from jail and state prison system.

- Support the Early Recognition and Screening Program to integrate into non-behavioral health settings, enhance connection to SPOA and monitor reports and outcomes through the Mental Health Subcommittee.

Priority Outcome 6:
Community Engagement

Support and expand efforts to integrate services within community initiatives related to training.

- Develop and enhance relationship and connection between behavioral health systems and the Cortland Community Center.
- Monitor and assess needs for training, resources and programs that are going to be necessary to meet shifting needs related to mandates for Raise the Age.
- Develop and enhance relationships with funding entities such as the CNY Community Foundation.
- Engage Cortland County towns and villages group as a forum to advance integration of services to outlying communities of Cortland County.
- Support the development and implementation of the Cortland County Opportunity Community to move people out of poverty.
- Support the development of an Adverse Child Experiences Study (ACES) learning collaborative to promote awareness regarding the impact of trauma, and promote the coordinated training and implementation of trauma informed practices across community services and settings.
- Engage with Cortland County faith communities to identify needs and support community interventions.
- Monitor and assess the impact on community behavioral health services of "New York State Criminal Justice Reform" (bail initiative).
- Explore development of new service delivery models related to jail diversion, including the potential development/expansion of specialty courts (drug, opioid, mental health) as a resource to engage individuals in treatment and support services as an alternative to incarceration.
- Review recommendation of the 2019 VERA Institute and CRS reports and provide assistance as requested by the Cortland County Legislature to implement recommendations related to behavioral health.
- Explore unmet mental health needs for children aged 0-5. Collaborate with the Literacy Coalition and identify opportunities to intervene when behavioral health needs are impacting developmental milestones.

Priority Outcome 7:
Employment Services

Support the coordination and development of employment services and supports that allow for individuals to participate in meaningful activities in the most integrated setting that will meet their needs, regardless of disability.

Strategies

- Support the community Taskforce to Increase Disability Employment (TIDE) that seeks to mobilize community partners to raise community awareness of, build community capacity for and eliminate attitudinal and physical barriers to Employment First for people with disabilities.
- Work with business community and behavioral health providers in Cortland County to expand pre/employment services and integrated competitive employment opportunities for individuals served across all three behavioral health service systems.
- Partner with Cortland County Workforce Investment Board to match community needs to opportunities for workforce development.
- Work to identify and engage high risk and underserved populations (i.e.: homeless, post incarceration) to connect them to vocational services with the appropriate supports to encourage success.

Priority Outcome 8: Workforce

Behavioral health workforce development has been identified as a significant barrier to access to services across systems in Cortland County (and New York State). Resulting in restricted access to services, longer waiting lists, difficulties in engagement, and reduced efficacy of services.

Strategies

- Work with the Central New York Regional Planning Committee (RPC) to advocate for appropriate funding of programs to pay competitive salaries and to reduce the regulatory (paperwork and process) burdens and state guidelines that allow people to practice at the top of their license need to be explored.
- Advocate within the RPC Workforce Development Subcommittee to enhance access to tuition reimbursement and paid internship opportunities for professions in behavioral health.
- Support regional efforts to enhance internship opportunities through the development of information sharing events between college placement coordinators and agency representatives.
- Support regional efforts to develop core training programs for new staff in areas such as care management and peer services.

ALICE IN CORTLAND COUNTY

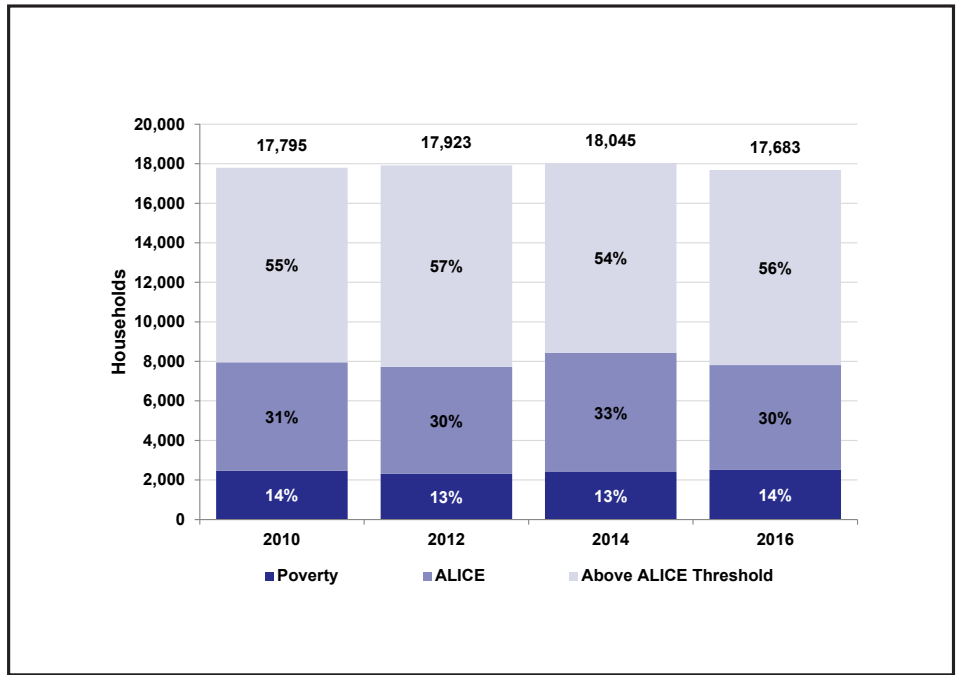
2016 Point-in-Time Data

Population: 48,713 • **Number of Households:** 17,683
Median Household Income: \$50,910 (state average: \$62,909)
Unemployment Rate: 5.2% (state average: 5.9%)
ALICE Households: 30% (state average: 31%) • **Households in Poverty:** 14% (state average: 14%)

How has the number of ALICE households changed over time?

ALICE is an acronym for **A**sset Limited, **I**ncome **C**onstrained, **E**mloyed – households that earn more than the Federal Poverty Level, but less than the basic cost of living for the county (the ALICE Threshold). Combined, the number of ALICE and poverty-level households equals the total population struggling to afford basic needs. The number of households below the ALICE Threshold changes over time; households move in and out of poverty and ALICE status as their circumstances improve or worsen. The recovery, which started in 2010, has been uneven across the state. Conditions have improved for some families, but with rising costs, many still find themselves struggling.

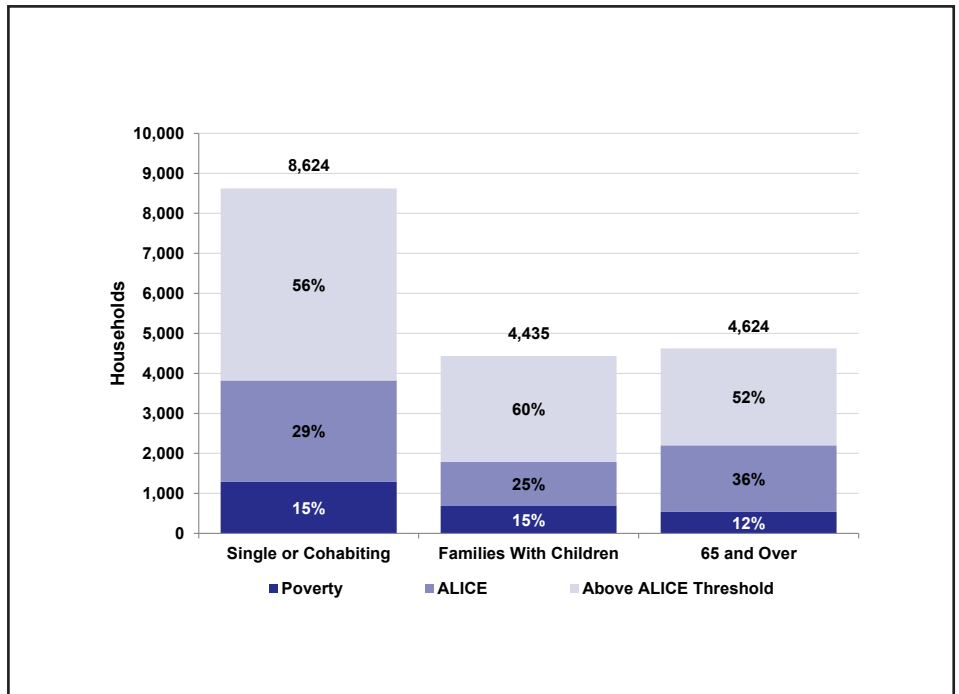
Households by Income, 2010 to 2016



What types of households are struggling?

The way Americans live is changing. There are more different family and living combinations than ever before, including more adults living alone, with roommates, or with their parents. Families with children are changing: There are more non-married cohabiting parents, same-sex parents, and blended families with remarried parents. The number of senior households is also increasing. Yet all types of households continue to struggle: ALICE and poverty-level households exist across all of these living arrangements.

Household Types by Income, 2016



Why do so many households struggle?

The cost of living continues to increase...

The Household Survival Budget reflects the bare minimum that a household needs to live and work today. It does not include savings for emergencies or future goals like college. In 2016, costs were well above the Federal Poverty Level of \$11,880 for a single adult and \$24,300 for a family of four. Family costs increased by 22 percent statewide from 2010 to 2016, compared to 9 percent inflation nationally.

Household Survival Budget, Cortland County		
	SINGLE ADULT	2 ADULTS, 1 INFANT, 1 PRESCHOOLER
Monthly Costs		
Housing	\$582	\$741
Child Care	\$-	\$1,250
Food	\$182	\$603
Transportation	\$341	\$682
Health Care	\$213	\$792
Technology	\$55	\$75
Miscellaneous	\$165	\$477
Taxes	\$280	\$623
Monthly Total	\$1,818	\$5,243
ANNUAL TOTAL	\$21,816	\$62,916
Hourly Wage	\$10.91	\$31.46

...and wages lag behind

Employment and wages vary by location; firms generally pay higher wages in areas with a higher cost of living, although those wages still do not always cover basic needs. Employment and wages also vary by firm size: Large firms tend to offer higher wages and more job stability; smaller businesses can account for more jobs overall, especially in rural areas, but may pay less and offer less stability. Medium-size firms pay more but typically employ the fewest workers.

Private-Sector Employment by Firm Size With Average Annual Wages, 2016



Sources: 2016 Point-in-Time Data: American Community Survey. ALICE Demographics: American Community Survey; the ALICE Threshold. Budget: U.S. Department of Housing and Urban Development; U.S. Department of Agriculture; Bureau of Labor Statistics; Internal Revenue Service; Tax Foundation; and New York State Office of Children & Family, 2016.

Cortland County, 2016		
Town	Total HH	% ALICE & Poverty
Blodgett Mills CDP (P)	109	40%
Cincinnatus (SD)	376	48%
Cortland (P)	6,630	54%
Cortland West CDP (P)	488	9%
Cortlandville (SD)	3,258	37%
Cuyler (SD)	280	51%
Freetown (SD)	249	45%
Harford (SD)	313	42%
Homer (P)	1,286	46%
Homer (SD)	2,360	40%
Lapeer (SD)	270	39%
Marathon (P)	355	56%
Marathon (SD)	751	43%
McGraw (P)	358	39%
Munsons Corners CDP (P)	1,056	59%
Preble (SD)	525	38%
Scott (SD)	332	28%
Solon (SD)	397	38%
Taylor (SD)	184	45%
Truxton (SD)	425	37%
Virgil (SD)	945	30%
Virgil CDP (P)	128	15%
Willet (SD)	388	42%

Note: Municipal-level data is 1 or 5-year averages for Places (P) and County Subdivisions (SD), which include Census Designated Places (CDPs). Totals do not match county-level numbers because some places cross county borders, geographies may overlap, data is not available for the smallest towns, and county-level data is often 1-year estimates.

**Cortland County
Health Department
Community Health Assessment
Survey Results (Phase 1)**



Public Health
Prevent. Promote. Protect.

Cortland County Health Department

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Purpose

Counties are required by the state to conduct a Community Health Assessment (CHA) to align with the New York State Prevention Agenda, the new cycle will cover 2019-2024. The CHA is a fundamental tool of public health practice. It describes the health of the community by presenting information on health status, community health needs, resources and current local health problems identifying target populations that may be at increased risk for poor health outcomes. The CHA enables public health professionals to gain a better understanding of their community's needs, as well as to assess the larger community environment and how it relates to the health of individuals. The CHA identifies areas where additional information is needed, especially information on health disparities among different subpopulations, quality of health care, and the occurrence and severity of disabilities in the population.

With the first Community Health Assessment in 2013, public opinion was obtained from numerous focus groups and surveys conducted. In May 2013 Seven Valleys Health Coalition also conducted two non-random sample surveys, one of business leaders, and the other of the general public, at the Business Showcase. Human service providers and key informants from the various fields of health, human service, business, and government were also surveyed by mail and email. An initial meeting was held with key leaders of Health and Human Services programs throughout community to review the data and set priority areas for our collaborative focus.

The Cortland County Health Department (CCHD) and Guthrie Cortland Medical Center (formally known as Cortland Regional Medical Center) identified in 2014; priority areas that included both: *Prevent Chronic Disease* and *Promote Healthy Women, Infants and Children*, with the addition of *Promote Mental Health and Prevent Substance Abuse* in 2016. These priorities were focused on through 2018.

In early 2018, the CCHD Strategic Planning Committee (SPC) was tasked with the creation of a new CHA Survey for the upcoming 2019-2024 cycle of the NYS Prevention Agenda, using elements of previous concepts from the 2013 CHA. A collaborative review of the survey by the Community Assessment Team (CAT) occurred in May. The members of the Community Assessment Team include CCHD, Seven Valleys Health Coalition, Guthrie Cortland Medical Center, United Way, and SUNY Cortland-Institute for Civic Engagement. By having the SPC

forefront the creation of the survey, the linkages between our strategic priorities and our priorities for our Community Health Assessment and Community Health Improvement Plan will continue to align. This was necessary not only for requirements of the NYS Prevention Agenda, but will help to foster community engagement by seeking input from those we serve.

Beginning in May 2018, the Health Department began disseminating the Cortland County Community Health Assessment Survey, to stakeholders, partners, governing bodies and the community at large. This was done through Health Department programming, partnering agencies and organization and through social media. The completed surveys were collected through May 2018-January 2019.

Survey

This Community Health Assessment Survey was ten questions in length, containing questions about factors that create a healthy community, the most important health related problems impacting overall health, the top unmet health needs, top risky behaviors impacting overall health, and the top unmet non-health needs in our community. The survey also asked respondents demographic information. (See appendix A) There were 1,435 surveys completed from May 2018-January 2019.

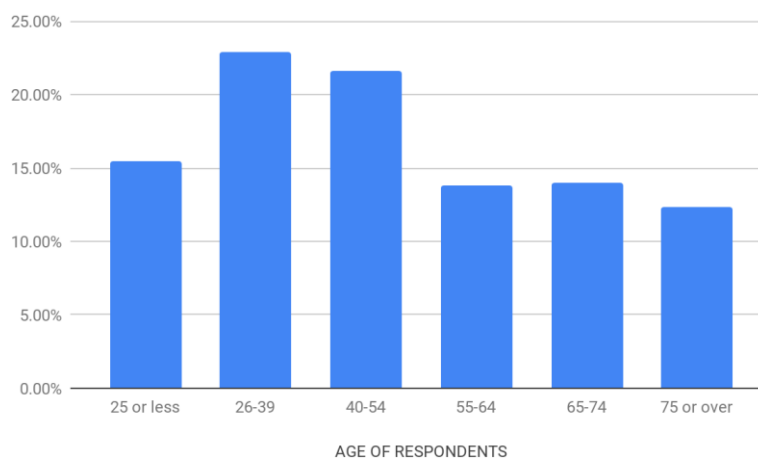
Surveys were circulated throughout the community by the Health Department, partnering agencies and organizations and through social media. Dissemination of the survey included many places throughout the community in order to reach a large portion of the population. These included: the Healthy Neighborhoods Program, Traveling Tots Program, the Jacobus Center for Reproductive Health, Water Festival, Senior Enrichment Day, Senior Games, Relay for Life, Cortland County Employees, Chris's Run, Cortland County Jail, Cortland Senior Center, McGraw Senior Center, Marathon Senior Center, Scott Senior Center, New York Connects Resource Fair, Law Enforcement Day, Willet Senior Center, Harford Senior Center, Homer Senior Center, Conservation Field Days, Truxton Senior Center, Cortland High School Open House, Community Baby Shower, Loaves and Fishes, Immunization Coalition of Cortland County, Lawrence House, Family Counseling Services, Chamber of Commerce, CAPCO (Staff, Parents/Caregivers), Schools, Cortland Counts Mailing List, Area Physician Offices, 211, YWCA, Cortland Health Center, Office of Aging (Meals on Wheels, HEAP, Annual Enrollment), Access to Independence, Cortland County Health Department's Facebook, Guthrie Cortland Medical Center, and Cortland Counts Forum.

Results

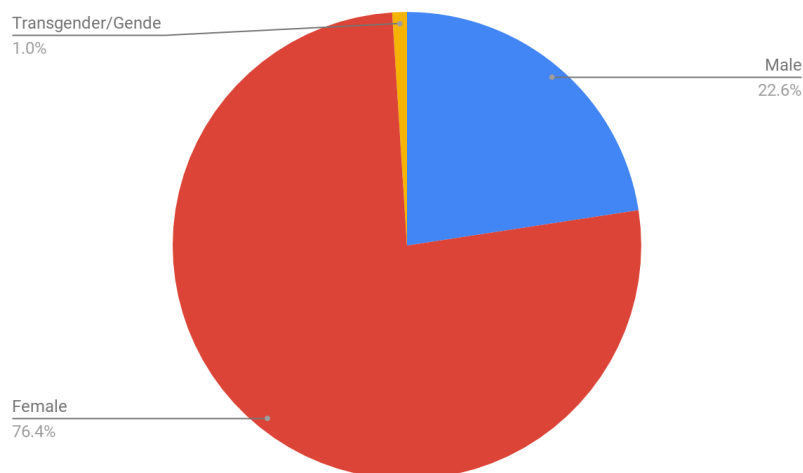
The Cortland County Health Department and community partners will use the results of this survey and other information to identify the most pressing problems which can be addressed through community action. There were 1,435 respondents that completed the survey.

Overall Results (Demographics):

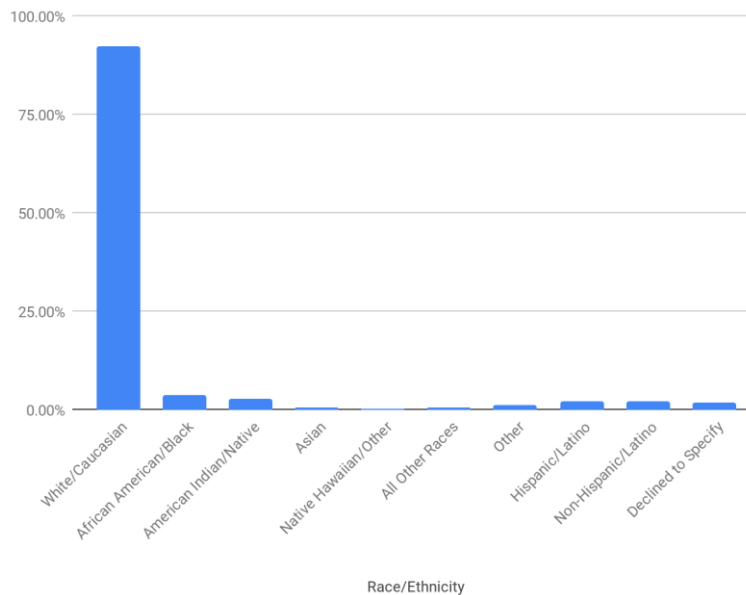
The majority of the respondents were ages 26-39 with 22.85% followed by ages 40-54 (21.62%), 25 or less (15.47%), 65-74 (14.03%), 55-64 (13.81%) and those aged 75 and older with 12.36%.



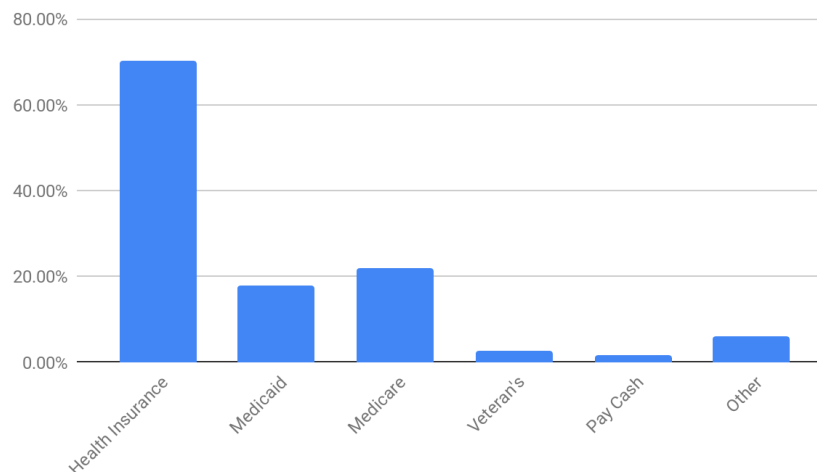
Approximately 76% of respondents were female, 23% were male and the remaining 1% identified as transgender, genderqueer, additional gender category, or none.



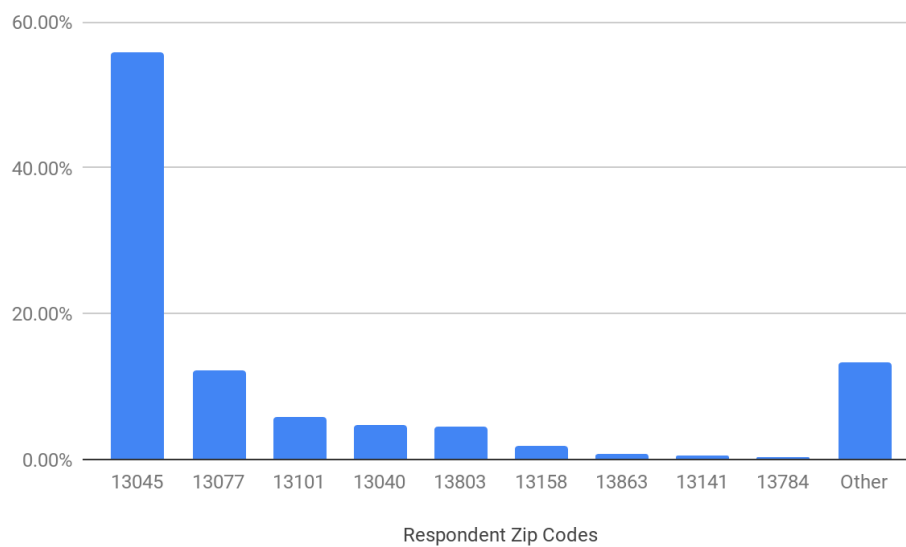
The majority of the respondents identified as White/Caucasian (92%). The remaining respondents identified as African American/Black (3.78%), 2.76% identified as American Indian/Native American, less than 1% identified as Asian, Native Hawaiian/other Pacific Islander, and 3.27% declined to specify or chose other. Approximately 2% of the respondents identified as Hispanic/Latino.



Approximately 70% of the respondents stated that they have health insurance. While 18.05% specified having Medicaid and 22.03% indicated having Medicare. 2.81% of respondents had either no health insurance or have Veteran's Administration as their coverage. 1.72% stated that they pay cash for their health care.



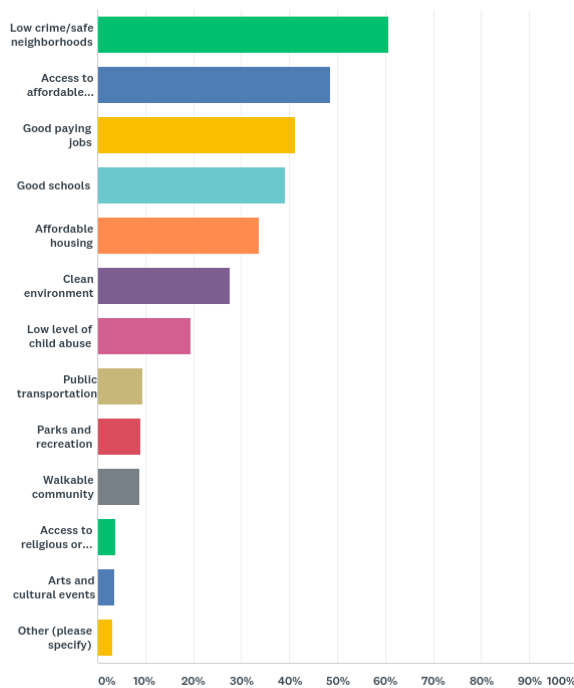
The majority of respondents reside in Cortland County (approximately 87%). The remaining respondents live outside of the County (approximately 13%). It was important to have perspective from those outside the County as well; these respondents may work, shop, and participate in events within the community. Within the County, the majority of the respondents lived within zip code 13045 (approximately 56%), zip code 13077 (approximately 12%) and zip code 13101 (approximately 6%).



Overall Results: Question #1-Three most important factors that create a healthy community

Overall respondents felt that the three most important factors that created a health community include low crime and safe neighborhoods, access to affordable health care and good paying jobs. For those in the age groups of 25 or less and 26-39, priorities included a clean environment and good schools.

Q1 In the following list, what are the three most important factors that create a healthy community? Check only three:



The following results look at the percentages of the top three choices by overall respondents, followed by a breakdown of the top three choices by age group.

Overall: Low crime and safe neighborhoods (60.58%)
 Access to affordable health care (48.62%)
 Good paying jobs (41.23%)

25 or less: Low crime and safe neighborhoods (60.28%)
 Clean Environment (44.86%)
 Good Schools (42.06%)

26-39: Low crime and safe neighborhoods (65.51%)

Good Schools (43.67%)

Good Paying Jobs (42.72%)

40-54: Low crime and safe neighborhoods (57.19%)

Access to affordable health care (52.84%)

Good Paying Jobs (45.48%)

55-64: Low crime and safe neighborhoods (46.69%)

Access to affordable health care (52.88%)

Good Paying Jobs (46.60%)

65-74: Access to affordable health care (62.18%)

Low crime and safe neighborhoods (59.59%)

Good Paying Jobs (38.34%)

75 and older: Low crime and safe neighborhoods (60.36%)

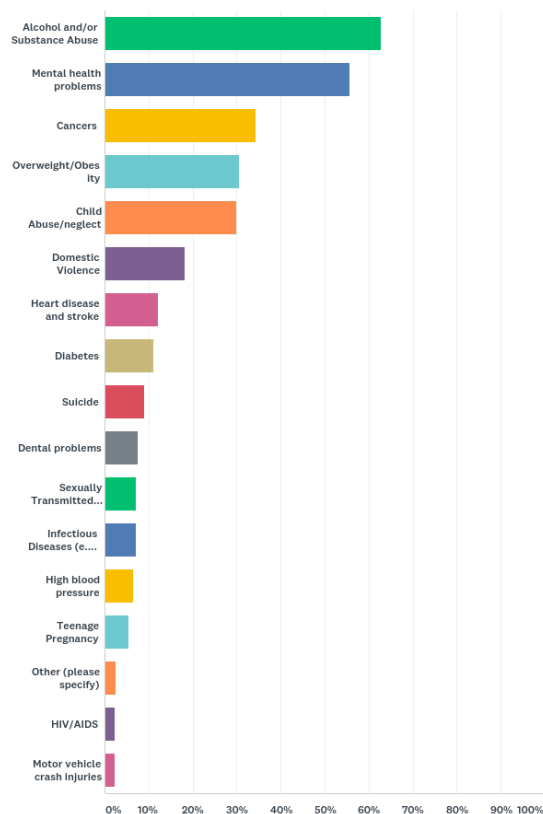
Access to affordable health care (55.62%)

Good Schools (39.64%)

Overall Results: Question #2-Three most important health related problems impacting our overall community health

Overall respondents felt that the three most important health related problems impacting our overall community health include alcohol and/or substance abuse, mental health problems and cancers. For those in the age groups of 25 or less and 26-39, child abuse/neglect was included in their top three. For ages 40-54, 55-64, and 75 and older, included overweight/obesity as an important health related problem. For ages 55-64, 65-74 and those 75 and older included cancers as one of the most important health related problems in our County.

Q2 In the following list, what are the three most important health related problems impacting our overall community health? Check only three:



The following results look at the percentages of the top three choices by overall respondents, followed by a breakdown of the top three choices by age group.

Overall: Alcohol and/or Substance Abuse (62.99%)
Mental Health Problems (56.17%)
Cancers (34.40%)

25 or less: Alcohol and/or Substance Abuse (65.42%)
Mental Health Problems (51.87%)
Child Abuse/Neglect (32.24%)

26-39: Alcohol and/or Substance Abuse (70.48%)
Mental Health Problems (61.90%)
Child Abuse/Neglect (37.46%)

40-54: Alcohol and/or Substance Abuse (70.90%)
Mental Health Problems (69.23%)
Overweight/obesity (33.11%)

55-64: Alcohol and/or Substance Abuse (68.59%)
 Mental Health Problems (61.78%)
 Cancers (35.60%)

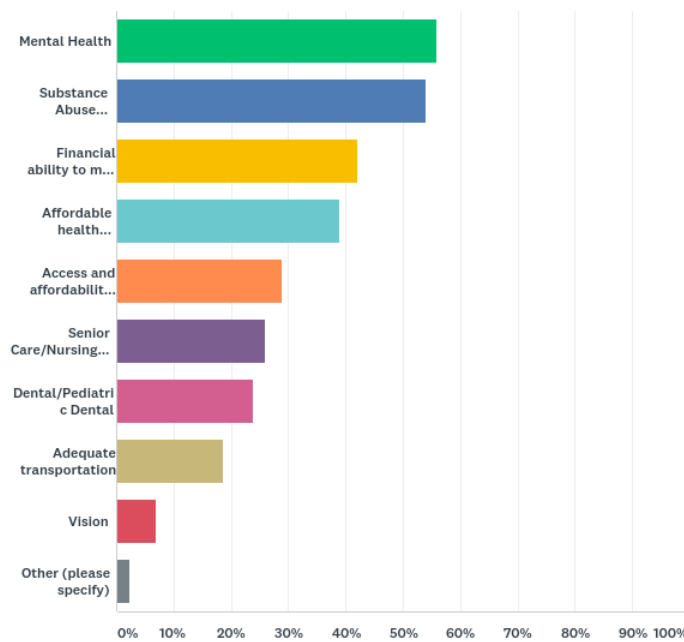
65-74: Alcohol and/or Substance Abuse (51.04%)
 Mental Health Problems (50.00%)
 Cancers (46.35%)

75 and older: Cancers (57.99%)
 Alcohol and/or Substance Abuse (39.05%)
 Overweight/obesity (31.95%)

Overall Results: Question #3- Three top unmet health needs within the community

Overall the respondents chose mental health, substance abuse rehab/counseling/prevention and financial ability to meet health care needs as the three top unmet health needs within our community. All age groups agreed with these top unmet health needs, except respondents aged 25 or less, this group felt that access and affordability of healthy food was a high priority.

Q3 In the following list, what are the three top unmet health needs within the community?
 Check only three:



The following results look at the percentages of the top three choices by overall respondents, followed by a breakdown of the top three choices by age group.

Overall: Mental Health (55.82%)
Substance Abuse Rehab/Counseling/Prevention (54.42%)
Financial ability to meet health care needs (41.75%)

25 or less: Mental Health (56.60%)
Substance Abuse Rehab/Counseling/Prevention (55.66%)
Access and Affordability of Healthy Food (43.40%)

26-39: Mental Health (59.94%)
Substance Abuse Rehab/Counseling/Prevention (56.73%)
Financial ability to meet health care needs (39.10%)

40-54: Mental Health (63.51%)
Substance Abuse Rehab/Counseling/Prevention (61.49%)
Financial ability to meet health care needs (37.50%)

55-64: Substance Abuse Rehab/Counseling/Prevention (61.50%)
Mental Health (56.15%)
Financial ability to meet health care needs (43.32%)

65-74: Affordable Health Care/Adequate Insurance (49.20%)
Mental Health (47.59%)
Financial ability to meet health care needs (47.59%)

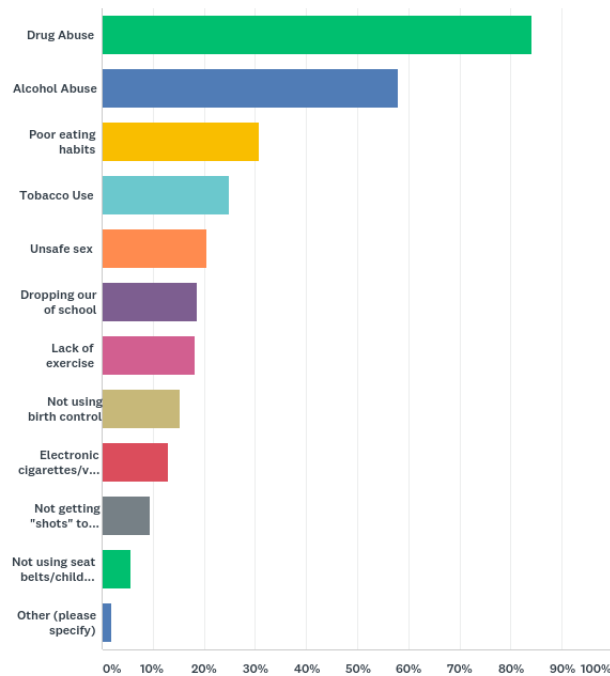
75 and older: Affordable Health Care/Adequate Insurance (51.20%)
Financial ability to meet health care needs (47.59%)
Mental Health (42.77%)
Senior Care/Nursing Homes (42.77%)

Overall Results: Question #4- The three top risky behaviors impacting our overall community health

Overall the respondents chose drug abuse, alcohol abuse and poor eating habits as the top three risky behaviors impacting our overall community health. For all of the respondents drug abuse and alcohol abuse are the top two, but there are some varying thoughts on the third risky behavior. For ages 25 or less unsafe sex is a top three risky behavior. For ages 26-39, 40-54, and 55-64 poor eating habits are part of their top three risky behaviors. For ages 65-74 and 75 and

older, tobacco use is a concern for this age group. Also a growing concern within the community is the use of Electronic Cigarettes/vaping, with 12.67% of the respondents attributing this as a risky behavior.

Q4 In the following list, what are the three top risky behaviors impacting our overall community health? Check only three:



The following results look at the percentages of the top three choices by overall respondents, followed by a breakdown of the top three choices by age group.

Overall: Drug Abuse (84.18%)
 Alcohol Abuse (57.80%)
 Poor eating habits (30.99%)

25 or less: Drug Abuse (80.75%)
 Alcohol Abuse (60.09%)
 Unsafe sex (36.15%)

26-39: Drug Abuse (91.05%)
 Alcohol Abuse (54.31%)
 Poor Eating Habits (33.55%)

40-54: Drug Abuse (88.93%)
 Alcohol Abuse (53.02%)
 Poor Eating Habits (34.56%)

55-64: Drug Abuse (82.35%)
 Alcohol Abuse (59.25%)
 Poor Eating Habits (41.71%)

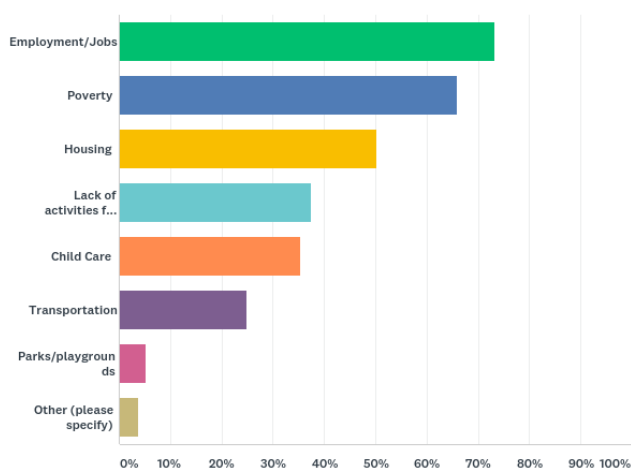
65-74: Drug Abuse (79.58%)
 Alcohol Abuse (61.78%)
 Tobacco Use (31.94%)

75 and older: Drug Abuse (74.55%)
 Alcohol Abuse (64.24%)
 Tobacco Use (29.70%)

Overall Results: Question #5- The three top unmet non-health needs within the community

Overall the respondents felt that employment/jobs, poverty and housing were the top three unmet non-health needs with our community. These three factors were top three for each individual age group as well. These social determinants can impact the health of the community; all of these factors will need to be collectively addressed in order to help provide a positive impact on the health of the community.

Q5 In the following list, what are the three top unmet non-health needs within the community?
 Check only three:



The following results look at the percentages of the top three choices by overall respondents, followed by a breakdown of the top three choices by age group.

Overall: Employment/ Jobs (73.08%)
Poverty (65.86%)
Housing (50.74%)

25 or less: Employment/ Jobs (74.29%)
Poverty (61.43%)
Housing (57.14%)

26-39: Employment /Jobs (70.38%)
Poverty (66.24%)
Housing (51.59%)

40-54: Employment /Jobs (74.83%)
Poverty (71.43%)
Housing (44.56%)

55-64: Employment/ Jobs (73.94%)
Poverty (62.77%)
Housing (55.32%)

65-74: Employment/ Jobs (73.02%)
Poverty (68.25%)
Housing (48.68%)

75 and older: Employment/ Jobs (72.39%)
Poverty (61.96%)
Housing (49.08%)

Next Steps

In December 2018, it was decided that the Cortland County Health Department would be completing a joint Community Health Improvement Plan (CHIP) with Guthrie Cortland Medical Center. This partnership will be focused on setting upcoming priorities to focus on for the NYS Prevention Agenda 2019-2024 cycle. Completing the goals and objectives of the new CHIP will be a full collaborative effort between agency partners, organizations, and stakeholders within the Cortland County community.

To continue to make an informed decision on what priorities to choose to focus on, continued community engagement is an essential building block for this. Organizing and facilitating focus groups throughout the community to discuss the results of the CHA survey and other important community health issues and concerns will be essential in completing our assessment. These focus groups will be facilitated by the Health Department, GCMC, and partnering agencies and organization, and will occur over the next few months.

Cortland County Community Health Assessment Survey

Please take a minute to complete the survey below. The purpose of this survey is to get your opinions about community health problems in Cortland County.

The Cortland County Health Department will use the results of this survey and other information to identify the most pressing problems which can be addressed through community action.

Remember... YOUR OPINION IS IMPORTANT!

Thank you and if you have any questions please contact Nicki Anjeski @ 607-758-5526 or nanjeski@cortland-co.org.

1.) In the following list, what are the **three most important factors that create a healthy community?**

Check only three:

- | | |
|---|---|
| <input type="checkbox"/> Low crime/safe neighborhoods | <input type="checkbox"/> Affordable housing |
| <input type="checkbox"/> Low level of child abuse | <input type="checkbox"/> Arts and cultural events |
| <input type="checkbox"/> Good schools | <input type="checkbox"/> Good paying jobs |
| <input type="checkbox"/> Parks and recreation | <input type="checkbox"/> Access to religious or spiritual options |
| <input type="checkbox"/> Clean environment | <input type="checkbox"/> Walkable community |
| <input type="checkbox"/> Access to affordable health care
(e.g., medical provider, medical centers, hospitals) | <input type="checkbox"/> Public transportation |
| <input type="checkbox"/> Other _____ | |

2.) In the following list, what are the **three most important health related problems** impacting our overall community health?

Check only three:

- | | |
|---|--|
| <input type="checkbox"/> Cancers | <input type="checkbox"/> Infectious Diseases (e.g., Hepatitis, TB, etc.) |
| <input type="checkbox"/> Child Abuse/neglect | <input type="checkbox"/> Mental health problems |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Motor vehicle crash injuries |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Teenage Pregnancy |
| <input type="checkbox"/> Heart disease and stroke | <input type="checkbox"/> Overweight/Obesity |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Alcohol and/or Substance Abuse |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sexually Transmitted Infections (STIs)
(e.g., Chlamydia, Gonorrhea, Syphilis) | |

3.) In the following list, what are the **three top unmet health needs** within the community?

Check only three:

- | | |
|--|--|
| <input type="checkbox"/> Dental/Pediatric Dental | <input type="checkbox"/> Substance Abuse Rehab/Counseling/Prevention |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Access and affordability of healthy food |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Affordable health care/Adequate insurance |
| <input type="checkbox"/> Senior Care/Nursing Homes | <input type="checkbox"/> Adequate transportation |
| <input type="checkbox"/> Financial ability to meet health care needs | <input type="checkbox"/> Other_____ |

4.) In the following list, what are **the three top risky behaviors** impacting our overall community health?

Check only three:

- | | |
|---|--|
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Not getting “shots” to prevent disease |
| <input type="checkbox"/> Dropping out of school | <input type="checkbox"/> Not using birth control |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Not using seat belts/child safety seats |
| <input type="checkbox"/> Lack of exercise | <input type="checkbox"/> Unsafe sex |
| <input type="checkbox"/> Poor eating habits | <input type="checkbox"/> Electronic cigarettes/vaping (e.g. JUULing) |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Other_____ |

5) In the following list, what are the **three top unmet non-health needs** within the community?

Check only three:

- | | |
|--|--|
| <input type="checkbox"/> Employment/Jobs | <input type="checkbox"/> Lack of activities for kids/teens |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Poverty |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Parks/playground |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Other_____ |

Demographics:

6.) Zip code:

7.) Age:

- 25 or less
- 26-39
- 40-54
- 55-64
- 65-74
- 75 or over

8.) Gender Identity:

- | | |
|--|---|
| <input type="checkbox"/> Male | <input type="checkbox"/> Transgender male/ Trans man/ Female-to-Male |
| <input type="checkbox"/> Female | <input type="checkbox"/> Transgender female/ Trans woman/ Male-to-Female |
| <input type="checkbox"/> Declined to Specify | <input type="checkbox"/> Genderqueer, neither exclusively male nor female |
| <input type="checkbox"/> None | <input type="checkbox"/> Additional gender category/Other_____ |

9.) Please select all that apply:

- | | |
|---|--|
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Hispanic/Latino |
| <input type="checkbox"/> American Indian/Native American | <input type="checkbox"/> Non-Hispanic/Latino |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Declined to Specify/Unknown |
| <input type="checkbox"/> Native Hawaiian/Other Pacific Islander | |
| <input type="checkbox"/> White/Caucasian | |
| <input type="checkbox"/> All Other Races | |
| <input type="checkbox"/> Other_____ | |

10.) What is your health insurance coverage? (Check all that apply)

No health insurance pay cash

Medicaid Medicare

Veterans' Administration Other

Health insurance
(e.g., private insurance, Blue Shield, HMO)

**Cortland County
Health Department
Community Health Assessment
Focus Group Results (Phase II)**



Public Health
Prevent. Promote. Protect.

Cortland County Health Department

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Background

In order for Cortland County Health Department (CCHD) and Guthrie Cortland Medical Center (GCMC) to complete the collaborative 2019-2024 Community Health Improvement Plan, NYS Prevention Agenda 2019-2024 priorities must be selected.

Following completion of Phase I of the Community Health Assessment (CHA Survey) in January 2019, it was determined that the Cortland County Health Department would organize and facilitate community focus groups throughout Cortland County as part of Phase II of the Community Health Assessment. Community focus groups would allow for continued community engagement—which is an essential building block in making an informed decision regarding what NYS Prevention Agenda priorities should be selected for the collaborative 2019-2021 Community Health Improvement Plan. These focus groups provide a platform for CCHD to discuss the results of the CHA Survey and other important community health issues in order to obtain a more detailed picture of health within the county. Significant effort would be placed on recruiting at-risk community members through partnering agencies and other community groups.

The initial planning stages for the focus groups began in June 2019, with focus group target dates throughout July and August 2019. A Focus Group Discussion Guide, comprised of 13 questions, was developed based on the CHA survey results and would be utilized at all CCHD focus groups (see Appendix A).

In early June, the Cortland County Area Agency on Aging informed CCHD that they would be completing focus groups during the same target time-frame for their agency needs assessment and four year plan. Due to their significant expertise on the aging population in Cortland County, it was determined that the best way for the CCHD to reach this at-risk population for Phase II of the Community Health Assessment would be to collaborate with the Area Agency on Aging. This subset of focus groups would be conducted in a distinctly different format from the CCHD facilitated focus groups, but would provide valuable information regarding health related concerns of the aging population in the county. These focus group discussions would emphasize what is currently working and what is needed to support “aging in place” throughout the different communities in the county. However, the CCHD would be present to co-facilitate the focus group utilizing a modified CHA Focus Group Discussion Guide.

Methods

Scope

From June 2019-August 2019, 22 focus groups were conducted across Cortland County. 11 of these focus groups were scheduled and facilitated by the Cortland County Health Department. An additional 11 focus groups were scheduled and facilitated by the Cortland County Area Agency on Aging in collaboration with CCHD. **132** people in total participated in the 22 focus groups.

Recruiting Process

Email and phone call templates, focus group interest forms, and advertising materials were developed in order to streamline the recruitment process and reach as many community members and agencies as possible (See Appendix B for email template).

Initially, leaders of community agencies were contacted via email and phone calls to gauge agency interest in hosting and participating in a CCHD CHA focus group. If interest was expressed, agency leaders were asked to recruit employees and consumers to attend the scheduled focus group.

Recruitment efforts were also made at the Cortland County Worksite Wellness Coalition Meeting and Community Health Assessment Presentation in late June 2019. Approximately 55 attendees were provided CHA focus group interest forms (see Appendix C). Individuals who filled out the form were then contacted via email to attend one of two general community member focus groups hosted by GCMC in early August 2019. Community members were also recruited via the CCHD social media page.

The Area Agency on Aging was charged with scheduling and recruitment for their focus groups. Letters were sent to community members, legislatures, and other community organizations. Flyers and social media posts were also utilized in their recruitment efforts.

Facilitation

Facilitator: The same facilitator was utilized for all CCHD focus groups in order to maintain uniformity. The Area Agency on Aging focus groups were facilitated by senior agency staff members and the CCHD facilitator was present to co-facilitate.

Recorder: A recorder was present at each focus group in order to take detailed notes.

Focus Group Discussion Guide: A discussion guide was developed based on the results of the CHA Survey and examples used by other county and healthcare system needs assessments in the past. The same guide was utilized across all CCHD focus groups. If necessary, the facilitator adjusted or omitted questions based on group dynamic. Examples of diversions from the designated CHA Discussion Guide include: omitting a question if it was already answered during the course of the discussion, clarifying a question for the group, and asking for clarification on a provided statement. Due to the differing nature of the Area Agency on Aging focus groups, a modified version of the CHA Focus Group Discussion Guide was used during those discussions, in addition to the discussion guide the Area Agency on Aging developed to facilitate their portion of the focus group.

Results

Since a modified discussion guide and different facilitation techniques were utilized at the Area Agency on Aging focus groups as compared to the CCHD focus groups; the results of the CCHD focus groups and the Area Agency on Aging focus groups are presented and analyzed separately.

Cortland County Health Department Focus Group Results

Summaries of each of the eleven Cortland County Health Department focus groups are provided in a listed format below. Table 1 displays the question aggregate overall response from the eleven CCHD focus groups. Responses were included in the Table 1 if they were mentioned more than three times across all focus groups.

1. Cortland County Wellness Committee

The Cortland County Wellness Committee is composed of Cortland County employees who are committed to fostering a healthy work environment. This focus group was conducted on 6.24.19. Male and female committee members of various ages were present.

The County Worksite Wellness Committee members enjoy that there are many outdoor and social activities to do in Cortland County (golfing, skiing, kayaking, wine trails, bowling). The group also likes the small town feel and some participants are nostalgic about the area because they were born and raised here. Cortland is also in a good location near larger cities and towns. This geographic location is also cited as a negative for the county, as the closeness to 81 and Syracuse can allow problems to come into the community. Participants do not like the ruralness, increasing drug problem, low SES of community, or lack of accessibility to transportation and services. One participant feels that community members are losing respect for themselves and the environment. Most participants agreed with the top three areas of concern identified by the CHA survey. One person felt that access was not an issue since the city of Cortland has the hospital and rural areas have Family Health Network. The group listed Family & Children's Counseling Services, Syracuse Recovery, Beacon Center, and school systems as resources for alcohol/substance abuse. The court system also plays a role. Participants feel that waiting lists at these agencies need to be reduced and more providers need to

accept more insurance. Inpatient treatment and a directory outlining what resources are available would also be beneficial to the community. The Cortland County Mental Health Department, individual therapists, mobile crisis hotline, and law enforcement officers trained to deescalate situations are all mental health resources the group named. Participants feel that more awareness regarding available resources and more pediatric mental health and inpatient services are needed. The group also mentioned that stigma surrounding mental health needs to be reduced and that mental health should be treated as a medical issue. Group members stated that they have insurance and go to the doctor. However some barriers they mentioned that may prevent people from doing so are; cost (high copays and deductibles), knowing their health insurance won't cover the appointment, people have no time to go, there are no afterhours appointments, and lack of urgent care facilities in the area. The group stated that some issues discussed could be addressed if more jobs and decent housing were available. They also stated that there is a problem with the social services system and we should not take away needed services due to income requirements.

2. Youth Community Members

Youth community members who attended a Safe Harbour event on 7.10.19 were asked to participate in a focus group for the CHA following the event. The group consisted of female and male youth ages 13-19 years old.

The youth community members present at this focus group enjoy the parks, activities for young kids, music scene, and people who want to make the community better in Cortland. However, they feel that the city of Cortland does not always feel safe and there are many places they would not go by themselves—especially Main Street and South Main. Participants felt that in order for a community to be healthy, resources need to be available to those who need them and there needs to be people who want to make the community better. One participant felt that getting businesses involved can improve community health. When asked about the results of the CHA survey; all youth felt that mental health is a problem and they were unsure whether or not access/cost is a concern for community members. The group stated that JUULing is a big problem and one

participant knew someone personally with substance abuse issues. The group was not aware of any resources in Cortland County that address substance/alcohol abuse related issues. They felt that there needs to be more education outside of the school system related to substance/alcohol abuse and that there are too many barriers in the school systems for youth to get help there. After some thought, the group was able to name Family Counseling Services and Family Health Network as resources in the community that address mental health problems. Participants felt there needs to be more and better mental health counseling in the community. They also stated they weren't sure what was available and that more education and awareness is needed about problems and programs in the community. Most participants were unsure of what prevents people from caring for their health. One participant stated that lack of transportation and disabilities has prevented a person they know from going to therapy and doctor's appointments.

3. Cortland Chenango Rural Services

Rural Services is a non-profit that serves the rural areas of Cortland and Chenango counties. On 7.10.19 a focus group was conducted at their office in Cincinnatus, NY. Participants were adult women and identified as staff members & volunteers of Rural Services or community members. Two participants live in Chenango County but utilize services and work in Cortland County.

All participants enjoy the rural beauty Cortland County has to offer. They also stated that the rural nature of the area can also be a negative as there is a lack of public transportation, long response times for volunteer emergency services, lack of resources (no free clinic or mental health providers) and difficulties with community members aging in place. One participant dislikes the lack of services for victims of domestic violence and sexual assault. They also feel there is stigma against people with mental health issues and victims of domestic violence. Participants agreed that substance/alcohol abuse, mental health, and cost/access to health care are the most pressing concerns in Cortland County. Participants said that in the rural areas, people have to be referred outside the community for alcohol/substance abuse treatment. They stated that substance abuse counselors used to come to Rural Services regularly and they would like that

program to be implemented again. One participant suggested the need for a syringe exchange programs and Narcan training in rural areas. The group felt there was a need for shelters and emergency homes for families in crisis. Participants stated that the schools in the area have mental health counselors, but that there aren't any mental health providers in the rural areas, such as Cincinnati, for adults. Affordability (high copays), transportation, and lack of specialists were all listed as barriers to seeking health care or going to doctor's appointments. One participant felt that it is unfair that Veterans have to travel very far to see the doctor. Another stated that people in the area can be stubborn and don't think they need a doctor. The group felt that insurance and Medicaid reform is needed on the national level. They also felt that people need to be able to work but not lose services due to income eligibility. Walking paths, vegetable gardens, and herbal remedies are some of the health alternatives that participants have seen implemented recently in the rural areas to address health concerns.

4. **Loaves and Fishes**

Loaves and Fishes provides free nutritious meals daily to those in need. A focus group was conducted on 7.30.19 prior to the lunchtime meal. Male and female consumers of various ages were present.

Consumers at Loaves and Fishes like that people in Cortland are generous and that there are many local agencies including; the Cortland Pregnancy Center, Loaves and Fishes, and the Jacobus Center. For many people, the meals they get at Loaves and Fishes may be all they eat the entire week. One participant, who identified as homeless, said that he likes that the cops don't bother him at Riverside Plaza. One participant stated she doesn't like anything about Cortland. Participants thought the most negative aspects of Cortland are the drugs, drama, and cops. The group felt that agencies/resources, Loaves and Fishes, friends, food pantries, Catholic Charities, taxis/busses, and DSS all make a community healthy. When asked about the results of the CHA survey, the group agreed that drugs are a problem. They also mentioned that there are mental health services, but people don't use them. Several participants stated they have been sober many years and that AA and NA are important resources to address alcohol/substance abuse. They wish

there was a Sunday afternoon AA meeting in the city. They also felt that there should be a place where people who need help immediately can go 24/7 (besides the hospital, which one person said you can get billed for). When asked what programs that address mental health the group was able to name; Cortland County Mental Health, Family & Children's Counseling Services, and the hospital. They also said family and friends are an important resource and that the cops in the area always ask how they can help. When asked what resources for mental health are needed the group suggested that people know the resources that are available, they just don't use them. The group feels that; money issues, drug addiction, insurance, transportation, and difficult paperwork are all barriers to caring for their health or the health of their families. They also stated that some people just don't want to go to the doctor either because they don't think they'll get the right help or because they are lazy. When asked how the problems discussed can be fixed one participant said that you can't push or force people to do anything, they need to want to.

5. **The Cortland LGBTQ Center**

The LGBTQ Center provides a safe place for LGBTQ individuals to socialize, get connected to community resources, and access to the LGBTQ lending library. A focus group was conducted at the Center on 8.2.19.

One participant likes that Cortland County is welcoming and more diverse than you would expect. A big negative of Cortland is that there are no bookstores. Easy access to health care and feeling safe and comfortable in the community and public spaces were listed as necessities for a healthy community. When asked about the CHA survey results, one participant felt that alcohol/drug use specifically in the teen population is a concern. Also mentioned was that access to hormones for transgender individuals and concerns that physicians in the area won't understand the LGBTQ population are issues. Cortland Prevention Resources was listed as an alcohol/substance abuse resource for youth. It was suggested that there needs to be more programs geared towards adults. Mental health resources mentioned were Family & Children's Counseling Services and Cortland County Mental Health. Liberty Resources Mobile Crisis Team was listed, however, it was suggested that this program should be expanded to 24 hours. Barriers to seeking

health care or going to doctor's appointments were listed as; cost, transportation (some people don't have cars), and hesitancy because of how medical providers will treat people who are LGBTQ. When asked how problems in the community can be fixed, it was suggested that youth community members need to be taught healthy coping mechanisms because many youth speak very negatively about themselves. Increased community gatherings revolving around health were also suggested—such as a “Monday Mile” where community members can get together one day a week and walk the same route.

6. Access to Independence

Access to Independence is a non-profit organization that provides advocacy and resources for people with disabilities. Male and female staff and consumers of various ages were present for the focus group on 8.5.19.

Participants at this focus group enjoy the rural atmosphere in Cortland County, including in the city, and that agencies work together. They find it helpful that health care providers remember you and are aware of your disability. The group feels that people in the area don't know what services are available to them. They also dislike the lack of specialists and health care professionals in general, the long wait times for appointments, and large turnover rates of providers. Attempts at telemedicine in the area have been ineffective. Transportation is a serious concern for this group. The group feels that accessibility to daily living needs and medical services, walkability, reliable transportation, and access to healthy and reasonably priced foods make a community healthy. When asked about the results of the CHA survey, participants agreed but would add access to home health aides and transportation as additional major issues. One participant also feels that the community needs to recognize that there is a homeless population in Cortland and work to solve that problem. Participants stated that the jail, Family & Children's Counseling Services, and Cortland County Mental Health are working to address alcohol/substance abuse issues. The community needs an inpatient rehab, shorter waitlists, better support and follow up services, and more choices for rehab in order to address alcohol/substance abuse. They also think there needs to be more activities for people to stay clean and more stable and affordable housing. Mental health resources in the area were listed as; EDPRT

trained police force, Catholic Charities, ATI, private psychologists, and support agencies such as CAPCO and DSS. The group expressed frustration regarding the long wait lists and high turnover rates of mental health providers—you tell your story once and a few months later you have to tell it again. They also stated that insurance and cost are a barrier to seeking mental health services and that we need to work to eliminate stigma surrounding mental health. There is also limited social support in the area. Transportation and affordability (high deductibles/copays) are major barriers to seeking health care services. Some people use a family support system—but one participant mentioned that not everyone has access to that either. The group also feels that sometimes the government works against agencies, instead of acknowledging that problems exist. Participants stated that reducing cost of public transportation, increasing access to healthy foods, finding help for elderly individuals with no families, increased funding, and better hospital discharge planning could address some of the health concerns within the community.

7. **Community Members**

A community focus group was held at Guthrie Cortland Medical Center on 8.6.19. This group consisted of all female community members of various ages. A few group members are employees of local human services agencies.

Participants in this focus group like that all the agencies in the county work together and pool resources. Cortland County was a good place to raise a family and the small size allows you to build relationships with schools and neighbors, while still having your needs met. Networking in Cortland is also easy. The participants dislike the poverty in the area and feel that it is the result of trauma, mental health and substance abuse. They feel that many people do not have their basic needs met. One participant mentioned that there are not enough specialized trauma therapists in the county. The group listed COTI (Centers of Treatment Innovation), Family & Children’s Counseling Services, Beacon Center, Syracuse Behavioral Health, and Syracuse Recovery Services as resources that are working to address alcohol/substance abuse. The group stated that there are many barriers to seeking help for alcohol/substance abuse including; insurance

costs/requirements, stigma against people with addiction, provider hours, and transportation. There needs to be a detox center in the community and more training for physicians regarding substance abuse. One participant feels there are misconceptions surrounding Narcan usage that need to be addressed. Another participant in the group stated that Liberty Resources mobile crisis unit is the best thing to come to the county to address mental health and expanding the program to 24 hours would be extremely beneficial. Cortland County Mental Health and Mark Thayer were listed as important mental health resources. The group feels that the county needs a holistic trauma center with trauma informed counselors, more providers, shorter wait times, telemedicine, and reduced provider turnover rates in order to adequately address mental health in the county. Transportation, finances (unexpected bills, high copays and deductibles), overwhelming paperwork, inability to read and write, and medical debt were all listed as reasons community members don't seek health care programs and services. This group feels that a whole systems change is needed to address the health concerns in Cortland County. They feel the community needs to make social determinants of health the basis for change.

8. Guthrie Cortland Medical Center Employees

Guthrie Cortland Medical Center (GCMC) is a nonprofit 144 bed acute care facility with an attached 80 bed residential care facility. A focus group consisting of GCMC employees was conducted on 8.9.19 and included all female employees.

This group listed the most positive aspects of Cortland County as: being near route 81, four seasons, the hometown feel and close knit community, and the sentimental attachments of raising a family here. The group does not like that large businesses have not been able to survive and that farms are struggling. They think there is a lot of poverty in rural communities and in the city of Cortland. It seems that there are more people who are struggling to access services. To this group, a healthy community is based on the school systems (making sure kids have access to food and immunizations), familial education, and making sure younger generations start life on the right foot and not graduating college with large amounts of debt. One participant said addressing social

determinants of health are important to community health. The group felt the three major areas of concern identified by the CHA survey are accurate—mental health is number one to this group and all three areas tie together. The group listed: Family & Children’s Counseling Services, Catholic Charities Halfway House, Primary Care Physicians at GCMC, Cortland County Mental Health, NA/AA, Beacon Center, and Liberty Resources as agencies who are working to address substance/alcohol abuse. They feel that alcohol/drug rehab and inpatient treatment are needed in the community. One participant stated that reimbursement rates are not high enough for facilities to provide needed services to communities. Cortland County Mental Health, Family & Children’s Counseling Services and Catholic Charities were listed as agencies working to address mental health. The group stated that the community needs more choices for mental health care, facilities and beds for pediatric mental health care, and services for people with developmental disabilities who need mental health care. Participants felt the following are barriers to accessing health care services; hours providers are available (no after hours), people do not have enough time off, and finances (copays are too high). One participant stated that some people will put off health until they have a serious condition or a minor condition exacerbates and gets worse. The group felt that in order to address the health concerns in the community we need to pressure local, state, and federal governments about regulations and reimbursement rates.

9. Community Members

A second community focus group was held at Guthrie Cortland Medical Center on 8.12.19. This group consisted of male and female community members, Legislators, and agency employees.

This focus group likes that Cortland is affordable, bikeable, safe, comfortable, and a nice place to raise a family. They feel the quality of life is high and that everyone pitches in to help. Networking is also a benefit of living in Cortland. Participants dislike the opioid crisis, loss of manufacturing/jobs, lack of accessible and convenient transportation, and the lack of low income and senior housing. One participant feels there are many people with negative attitudes and thoughts. This group thinks that looking at the social

determinants of health (healthy food options, walkability etc.), being able to age in place, and access to services and transportation in rural areas are factors that make a community healthy. When asked about the results of the CHA survey; participants thought that transportation, jail overcrowding, and daycare cost and availability are also major concerns in the county. The group was able to list: 2-1-1, Mobile Crisis Unit, chemical dependency programs, jail (as a detox center), and Beacon Center as resources for addressing substance/alcohol abuse. Participant suggested a long-term treatment center and more preventative education would help with this issue. One person mentioned that a new jail program that helps people with recovery services and rehab before resorting to jail time would be beneficial. Mental health resources that the group was able to list are: GCMC 10 bed unit, Cortland County Mental Health, Family & Children's Counseling Services, Cortland Prevention Resources, and COTI (Centers for Treatment Innovation). The group stated that high turnover of therapists due to low pay prevent people from accessing mental health services. They also stated that the area needs a child psychiatrist and more providers in the schools. Awareness and communication regarding what services are available is also needed. Lack of reliable transportation (public transit only available at certain times) and finances (high copays, high cost of medications, high cost for health insurance) are major barriers to seeking health care services that this group has seen. In order to address community health issues in Cortland, participants in this group agreed that continuing to apply for grants and having a process to use the money wisely is important. Increasing funds for the local bus system is also important to this group.

10. CAPCO

CAPCO is a community action agency that provides programs and resources that promote self-reliance and dignity. This focus group took place on 8.12.19 and included CAPCO staff and parents. All participants were female of various ages.

Participants of the CAPCO focus group like the sense of community and closeness that Cortland provides. They also appreciate the agencies within the county and that people can get referred to the services they need. The most negative aspects of Cortland County, according to this group, are the drugs, lack of accessible transportation, poor housing, and

lack of needed healthcare services (pediatric dental and walk-in clinics). The group agreed with the areas of concern identified in the CHA survey. Narcan training, community forums, Beacon Center, AA, Family & Children's Counseling Services and Cortland County Mental Health were listed as resources that address alcohol/substance abuse. This group feels there are many barriers to seeking help for alcohol/substance abuse including; insurance (too many steps to get treatment), inability/unwillingness to follow through with treatment, and lack of inpatient care in county. The on-staff mental health specialist at CAPCO is a resource that staff and children at CAPCO can utilize. Participants in this group agreed that services in the community that address alcohol/substance abuse also address mental health. The community needs more mental health providers, an open clinic for urgent needs, and more education and acceptance of people with mental health issues in order to reduce stigma. Some barriers to seeking health care services that were mentioned are: insurance not being accepted by providers, cost (high copays), lack of transportation, long waiting lists, and turnover rate for doctors (or arriving for an appointment to find out you are seeing an NP or PA instead of the doctor). The group felt some of these issues could be addressed if we incentivized providers to come to the area and stay and continue to apply for grant funding.

11. **SUNY Cortland Students**

The State University of New York at Cortland campus is located in the city of Cortland, NY. Nearly 6,000 undergraduate and graduate students attend each semester. A focus group for SUNY Cortland students was held in the Hall of Fame Room on SUNY Cortland's campus on 8.20.19.

SUNY students enjoy the sense of community in Cortland and the fact that there are people who want to improve the community. A negative aspect of living in Cortland is that the college students are sometimes ostracized from the community and locals may not necessarily see the benefits the college brings to Cortland County. Having a proper health care system, a good hospital, and trust in the health care system were suggestions for what makes a community healthy. One participant agrees that mental health is the number one issue in the county and that alcohol/substance abuse are concerns for college students. However, they were unable to name any resources that address

alcohol/substance abuse. College students need to be more aware of what resources are available outside of the campus community according to this focus group. Individual therapists and the wellness/counseling center on SUNY's campus were listed as mental health resources available. The students feel there needs to be a program that is more focused on mental health rather than just a general "wellness center" that has counselors available and that there needs to be more mental health support services that do not involve counseling. Barriers to SUNY students seeking health care services are; cost, nervousness about what to expect from health care providers in town, and previous negative experiences preventing them from seeking care again. A major concern for SUNY students is the inability to be sick from class without an outside physician's doctor's note. Professors cannot accept notes from the campus health center. Missing class without an excuse can seriously impact student's grades which they feel is unfair. In order to improve health in the community it was suggested that there needs to be a more focused mental health program, integrated mental health and substance/alcohol abuse programs, and more thoughtful planning when organizations hire health care workers. In addition, it was mentioned that community relations between the college, the hospital, and the community in general need to be improved.

Table 1

Focus Group Question	Most Common Responses
<i>What do you consider the most positive aspects of Cortland County? (What do you like best?)</i>	<ul style="list-style-type: none"> • Small town/sense of community (being recognized, knowing people, forming relationships with health care workers and schools etc.) • Agencies/people work together • Rural beauty/atmosphere • There are many activities nearby (golf, skiing, bowling, music scene, parks etc.) • Nostalgia (born & raised, raised family etc.) • Good people (generous/friendly) • Many local agencies (Loaves & Fishes, ATI etc.) • Everything you need is here

<p><i>What do you consider the most negative aspects of Cortland County? (What do you like least?)</i></p>	<ul style="list-style-type: none"> • Drugs problem/opioid crisis • Access to transportation • Failing businesses/farms/no jobs in county • Low Socioeconomic status/growing poverty • Rural (isolated) • Lack of specialist health care providers • Lack of mental health providers
<p><i>What makes a community healthy?</i></p>	<ul style="list-style-type: none"> • Access to services/resources • Fresh food/vegetable options • Agencies • Access to health care • Accessible transportation • Walkability • Schools/education/health education
<p><i>The Community Health Assessment Survey, conducted in May 2018-January 2019 identified three major areas of concern regarding health in the community: alcohol/substance abuse, mental health, and cost/access to health care. Do you feel these are the most pressing issues within Cortland County right now? If not, please indicate what issues you think should be added to this list.</i></p>	<ul style="list-style-type: none"> • Majority agreed these are major areas of concern • Transportation is also major issue • Stigma (against mental health, substance abuse, LGBTQ population etc.) • Mental health is #1 concern • All three areas tie together
<p><i>What resources (i.e agencies, institutions, programs) does the community have that address alcohol/substance abuse related issues?</i></p>	<ul style="list-style-type: none"> • Family & Children’s Counseling Services/Cortland Prevention Resources/COTI • Beacon Center • Court System/Jail • AA/NA • Cortland County Mental Health
<p><i>What other resources are needed that aren’t currently available? (Alcohol/Substance Abuse)</i></p>	<ul style="list-style-type: none"> • Inpatient/inpatient rehab/long term care • Need to eliminate insurance/cost barriers • Need a directory of resources/more advertisement of resources/more awareness • Walk-in 24 hour clinic for people in crisis
<p><i>What resources (i.e agencies, institutions, programs) does the community have that address mental health related issues?</i></p>	<ul style="list-style-type: none"> • Cortland County Mental Health • Family & Children’s Counseling Services • Trained law enforcement/cops • Liberty Resources/Mobile Crisis Unit • Primary Care Physicians/hospital • Private/individual therapists
<p><i>What other resources are needed that aren’t currently available? (Mental Health)</i></p>	<ul style="list-style-type: none"> • More providers/more choices of providers/need shorter waitlists • More education/awareness of services • Need to eliminate mental health stigma

	<ul style="list-style-type: none"> • Need less turnover of providers (need to incentivize them to stay) • Providers/agencies who specialize in childhood mental health
<i>What prevents you (or your family) from caring for their health, accessing community health programs, or going to doctor's appointments?</i>	<ul style="list-style-type: none"> • Transportation • High deductibles & copays/unexpected bills • Insurance—knowing it won't be covered/insurance not accepted/can't afford insurance • Hours providers are open/availability of appointments • Personal responsibility—People don't want to go/are stubborn/lazy/or wait until problem gets worse
<i>How does the cost of your health care influence decisions that you (or your family) make regarding your health?</i>	This question was addressed by the previous question in the majority of focus groups. Cost is a major barrier.
<i>Do you have any suggestions as to how the problems we discussed today can be addressed or fixed in order to improve health in the community?</i>	<ul style="list-style-type: none"> • Reform needed at the state/federal level/there needs to be a "whole systems" change • More focus on the social determinants of health • We need more funding/grants
<i>Is there anything anyone would like to add, or didn't have a chance to say during the discussion, that they would like to do so at this time?</i>	Responses to this question were placed in the appropriate question categories above. See individual summaries for more details.

Cortland County Area Agency on Aging Focus Group Results

Table 2 includes a list of the modified CHA Focus Group Discussion Guide questions that were asked by CCHD at the Area Agency on Aging focus groups and the aggregate responses from all groups. Table 3 summarizes the main points that were discussed during Area Agency on Aging facilitation of the focus groups.

Table 2

Focus Group Question	Responses
<i>The Community Health Assessment Survey, conducted in May 2018-January 2019 identified three major areas of concern regarding health in the community: alcohol/substance abuse, mental</i>	<p>Three Major Areas of Concern:</p> <ul style="list-style-type: none"> • Agreement with major areas of concern (but not necessarily for elderly individuals) • Substance abuse, mental health, cost/access

<p><i>health, and cost/access to health care. Do you feel these are the most pressing issues within Cortland County right now? If not, please indicate what issues you think should be added to this list.</i></p>	<p>are all related</p> <ul style="list-style-type: none"> • Substance abuse/alcohol not really “seen” or not considered a problem • Mental health is a major problem and not targeted enough • There is stigma in the community • Navigating health care and health insurance systems can be frustrating and cause people to give up. • There is stigma in the community <p>What Should Be Added:</p> <ul style="list-style-type: none"> • Cost of housing for elderly individuals on a budget • Homelessness in rural areas • No good restaurants in rural areas • Tobacco usage • Obesity • Not many high paying and fulltime jobs • Transportation
<p><i>What resources are needed that aren't currently available? (alcohol/substance abuse)</i></p>	<ul style="list-style-type: none"> • Better education/awareness on services that are available • More healthcare professionals and treatment agencies • Resources for domestic violence victims as a result of alcohol/substance abuse • Job placement and social support
<p><i>What resources are needed that aren't currently available? (mental health)</i></p>	<ul style="list-style-type: none"> • Long-term care options • Shorter wait lists • Less provider turnover • Need to eliminate stigma • More services needed at the hospital (including pediatric care) • Experts on trauma and generational poverty • Family support networks/systems • Resources to connect children to services outside of school • A larger mental health facility in Cortland • Counties should work together more to share services • More awareness/advertising for available resources

<p><i>What prevents you (or your family) from caring for their health, accessing community health programs, or going to doctor's appointments?</i></p>	<ul style="list-style-type: none"> • Transportation (many people rely on families and friends, bus schedules not reliable or inconvenient, Medicaid recipients can get free transportation but no one else) • Finances—high prescription copays/health care/insurance costs • Long wait times for appointments (routine and specialists) • Physician turnover (never seeing the same provider or seeing a PA/NP instead of physician) • No after hour or weekend appointments • Marathon has Family Health Network, but other rural areas need similar in-town clinics.
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Table 3

Focus Group Location/Description	Summary of Discussion
<p>Marathon Senior Center <i>This focus group conducted on 6.26.19 was composed of Marathon community members and local government officials. Participants were all 60 years or older.</i></p>	<ul style="list-style-type: none"> • <i>Housing</i>—need more single story homes in Marathon, senior housing has a long wait list • <i>Transportation</i>—bus only comes to town 3x a day, some seniors don't have family members to drive them • <i>Food Accessibility</i>—Food pantry is not ADA compliant, Meals on Wheels is available • <i>Home Safety/Health</i>—There is no one to check on elderly individuals who don't have family in the area • <i>Socialization</i>—numbers at senior center are declining, need more social respite programs
<p>Scott Senior Center <i>This focus group conducted on 6.1.19 was composed of community members and people who work in the towns of Scott and Preble.</i></p>	<ul style="list-style-type: none"> • <i>Food Accessibility</i>—Churches have food banks, no stores in Scott or Preble • <i>Home Safety/Health</i>—There needs to be a better system for checking on the elderly • <i>Socialization</i>—there are not many community activities in the area besides a social card club at the Preble Hotel and a summer youth program

	<ul style="list-style-type: none"> • <i>Emergency Services</i>—lack of interest in volunteering, fire department in Homer no longer does “rescue calls” for helping elderly individuals get up after a fall
<p>Cortland Community Center <i>This focus group conducted on 6.5.19 was composed of Homer and Cortland community members (of various ages), city law enforcement officials, and Legislators.</i></p>	<ul style="list-style-type: none"> • <i>Housing</i>—Need more affordable senior housing • <i>Transportation</i>—Bus in not accessible, schedule isn’t clear, there isn’t a shelter at the Homer bus stop • <i>Food Accessibility</i>—Instacart and Food Sense are in Cortland and Homer, food pantrys, • <i>Home Safety/Health</i>—More awareness needed about fraud phone calls targeting elderly individuals for money(form of elder abuse that needs to be reported) • <i>Socialization</i>—there are many social outlets in Cortland (Senior Centers & CRT), Cortland Community Center
<p>Cincinnati Central School <i>This focus group conducted on 6.5.19 was composed of Cincinnati community members and Cincinnati school leaders.</i></p>	<ul style="list-style-type: none"> • <i>Housing</i>—There aren’t enough one-story homes in Cincinnati • <i>Transportation</i>—Public transportation is limited, many people rely on neighbors or Sister Kathleen. • <i>Food Accessibility</i>—Unsure if grocery delivery is needed or would be useful. Rural Services has a food pantry. • <i>Home Safety/Health</i>—Neighbors check on each other, but many elderly people will not ask for help. • <i>Socialization</i>—there are options: bone saver program, bingo, churches. Need more social respite programs.
<p>Willet Senior Center <i>This focus group conducted on 6.6.19 was composed of Cincinnati and Willet community members (most over the age of 60).</i></p>	<ul style="list-style-type: none"> • <i>Transportation</i>—Family and friends utilized, bus is available but underutilized; some people are hesitant to volunteer to drive elderly individuals because of responsibility. Kinney drugs deliver prescriptions and mobile mammogram van comes to town. • <i>Food Accessibility</i>—Groceries can be hard to get in rural areas • <i>Home Safety/Health</i>—Shortage of home health aides, neighbors check on each other

	<ul style="list-style-type: none"> • <i>Socialization</i>—Senior Center, post office, fire station, bone saver exercise group, school newspaper for communication
<p>McGraw Senior Center <i>This focus group conducted on 6.7.19 was composed of McGraw community members (most over the age of 60).</i></p>	<ul style="list-style-type: none"> • <i>Housing</i>—McGraw needs more senior and affordable housing options • <i>Transportation</i>—Bus stop in town is helpful, but many people drive themselves • <i>Food Accessibility</i>—Reservation system for senior center meals is inconvenient. McGraw needs a dollar general since there is only one small store in town.
<p>Harford Senior Center <i>This focus group conducted on 6.7.19 was composed of Harford community members (most over the age of 60).</i></p> <p>Harford Senior Center Continued</p>	<ul style="list-style-type: none"> • <i>Housing</i>—Creamery Hills Senior Apartments are a great place to live and people are friendly and helpful. There is a waiting list. • <i>Transportation</i>—There is no bus service and transportation to grocery store is expensive (~\$30 round trip). Kinney drugs delivers prescription • <i>Food Accessibility</i>—Need a closer grocery store, like Walmart. Lunches and other meals are provided at Senior Center • <i>Home Safety/Health</i>—Showers at Creamery Hills do not have accessible showers • <i>Socialization</i>—Senior Center (& Joyce) are great resources
<p>Solon Sportsman’s Club <i>This focus group conducted on 8.8.19 was composed of Solon community members and Legislators.</i></p>	<ul style="list-style-type: none"> • <i>Food Accessibility</i>—Poor internet/cell service in the area make it difficult to access Instacart. Meals at McGraw Senior Center—breakfast should start at 7 so people can go before work. • <i>Home Safety/Health</i>—Snow removal is a concern, a licensed home care agency is needed. Many people use family members for personal care needs. • <i>Socialization</i>—Senior Center (numbers are dwindling), four score social club, need more social events in the area. • <i>Emergency Services</i>—There is no knowledge on emergency plans for the town, which is a concern.

<p>Homer Senior Center <i>This focus group conducted on 8.8.19 was composed of Homer and Cortland community members and Legislators of various ages.</i></p>	<ul style="list-style-type: none"> • <i>Housing</i>—Need more affordable housing • <i>Transportation</i>—Homer village sidewalks need repair, bus routes have been fixed to be more accessible and village is planning for a bus shelter at Homers stop. Dial a ride is also a useful resource. Prescriptions can be delivered. • <i>Food Accessibility</i>—allowing take-out meals at the Senior Center would benefit home-bound seniors. • <i>Home Safety</i>—Area Agency on Aging offers in home services (housekeeping, personal care, case management offered). • <i>Socialization</i>—Senior Center needs more food variety to bring people in, there are a few walking programs
<p>Virgil Senior Center <i>This focus group conducted on 8.21.19 was composed of Virgil community members, clergy, and Legislators.</i></p>	<ul style="list-style-type: none"> • <i>Housing</i>—there are not enough rental units or senior housing in Virgil. • <i>Transportation</i>—there is not enough interest in the bus or dial a ride services for them to stop in Virgil. There are a few Uber drivers but there hours aren't set and it is expensive. • <i>Home Safety/Health</i>—Stairs and accessibility are concerns. Insurance advisement through AAA is beneficial and advisors should come to town during open enrollment. • <i>Socialization</i>—Wi-Fi is not available in many areas. Internet access and classes on how to use computers could allow elderly to stay in touch with grandchildren through Facebook etc. There is a senior club and music offered once a month, but it can be difficult to get people to come to these events. Pets can be a good socialization tool. • <i>Emergency Services</i>— Pastors should be added to emergency call lists if someone needs help during off hours.
<p>Truxton Senior Center <i>This focus group conducted on 8.27.19 was composed of Truxton community members.</i></p>	<ul style="list-style-type: none"> • <i>Housing</i>—People want a 60 plus exclusive housing, too many full-waitlists, and lack of single story housing. People can't afford to retire-keep up with housing needs.

	<ul style="list-style-type: none">• <i>Transportation</i>—Neighbors help in assisting each other. Cortland Transit does not come out that way.• <i>Food Accessibility</i>—• <i>Home Safety/Health</i>—the SUNY Cortland Program that sends our students to help with projects was discussed and the group felt it was very positive. Neighbors help shovel/odd jobs. Difficulty finding a primary care doctor—this leads to people going to ER for treatment.• <i>Socialization</i>—Neighbors help each other out in this area. Would like classes about technology, internet at the center.
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Next Steps

With the completion of these important focus groups, focus areas and priorities for the new Community Health Improvement Plan (CHIP) will need to be determined. These priorities will be the focus over the next three years and will help to fulfil requirements for the New York State Department of Health (NYSDOH) Prevention Agenda. The NYS Prevention Agenda is based on a comprehensive statewide assessment of health status and health disparities, changing demographics, and the primary causes of death. In order to improve the health of all communities, our health improvement strategies must target the social determinants of health. These social determinates of health will focus on five key areas: economic stability, education social and community context, health and health care and neighborhood and built environment. This puts a huge emphasis on the importance of our continued partnerships across all sectors of the community. The Cortland County Health Department and Guthrie Cortland Medical Center in collaboration with the other members of the Community Assessment Team (CAT) which include Seven Valleys Health Coalition, SUNY Cortland Institute for Civic Engagement, and the United Way for Cortland County will select these priorities and focus areas. Our combined efforts will help to enhance the health of our community.

Appendix A**WELCOME**

I'd like to begin by thanking you for making the time to take part in our focus group discussion on health within the community of Cortland County. My name is _____ and I will be facilitating the discussion today. This is _____ and they will be taking detailed notes during today's discussion.

PURPOSE AND GUIDELINES**Purpose**

Our discussion should run for approximately 45 mins. Today, we will be talking about the health issues that you feel are most important in Cortland County in an attempt to obtain a detailed picture of overall health within the community. I will be asking targeted questions, but the focus group should feel conversational and I welcome you to respond not directly to me, but to your peers within the group.

We will be using the information collected today as part of our Community Health Assessment, which will ultimately determine what health priorities public health organizations within Cortland County will be focusing on for the 2019-2021 time period. Once the Community Health Assessment is complete, and priorities have been selected, the Cortland County Health Department and Guthrie Cortland Medical Center will collaborate to produce a Community Health Improvement Plan for the 2019-2021 time period.

Guidelines

Before we begin, I'd like to mention a few general guidelines:

1. The answers you provide today will be confidential and you are welcome to refuse to answer a question for any reason or excuse yourself from the discussion at any point.
2. Please put any electronic devices, including cell phones, on silent.
3. Please do not hesitate to share your point of view, even if it differs from what others have said (there are no wrong answers).
4. I may have to end discussion on a particular topic and move on to another topic in the interest of time.
5. Please be respectful of others opinions, avoid talking over people, or participating in side conversations.

****ARE THERE ANY QUESTIONS****

QUESTIONS

Opening Question

1. *Let's begin by going around the table and introducing ourselves. Please state your first name (what you go by) and why you agreed to join us for our focus group discussion today.*

General Questions

2. *What do you consider the most positive aspects of living in Cortland County (what do you like best about Cortland County)?*
3. *What do you consider the most negative aspects of living in Cortland County (what do you like least about Cortland County)?*
4. *What do you think makes a community healthy?*
5. *The Community Health Assessment Survey, conducted in May 2018-January 2019 identified three major areas of concern regarding health in the community: alcohol/substance abuse, mental health, and cost/access to health care. Do you feel these are the most pressing issues within Cortland County right now? If not, please indicate what issues you think should be added to this list.*
 - a. *Elaborate on "access" if needed (transportation, awareness etc.)*

In-Depth QuestionsAlcohol/Substance Abuse

6. *What resources (i.e agencies, institutions, programs) does the community have that address alcohol/substance abuse related issues?*
7. *What other resources are needed that aren't currently available?*

Mental Health

8. *What resources (i.e agencies, institutions, programs) does the community have to address mental health problems?*
9. *What other resources are needed that aren't currently available?*

Cost/Access

10. *What prevents you (or your family) from caring for their health, accessing community health programs, or going to doctor's appointments?*
11. *How does the cost of your health care influence decisions that you (or your family) make regarding your health?*

Closing Questions

12. *Do you have any suggestions as to how the problems we discussed today can be addressed or fixed in order to improve health in the community?*
13. *Is there anything anyone would like to add, or didn't have a chance to say during the discussion, that they would like to do so at this time?*

CLOSING

Thank you for participating in the focus group today. Your input has provided us with valuable insight into the overall status of health within Cortland County. We will use the information collected today to make an informed decision about the health priorities of Cortland County in 2019-2021.

Appendix B

Dear _____,
Good afternoon! My name is _____. Your name was provided to me by _____
as a contact for _____.

I am reaching out to see if members of your organization would be interested in participating in a focus group discussion as part of the Community Health Assessment. The results of the Community Health Assessment will help the Cortland County Health Department and Guthrie Cortland Medical Center determine which priorities Cortland County will focus on for the NYS Prevention Agenda 2019-2024 cycle.

Continued community engagement is essential for making an informed decision regarding these priorities, and the members of _____ will provide an important perspective. During the focus group, which should last approximately 45 minutes, we will discuss the results of the CHA survey and ask targeted questions in order to gain a more detailed picture of the status of community health within the county.

Please let me know if you think six to ten members of your organization would be willing to participate in a focus group. Additionally, please let me know if _____ has a space in which the focus group can be hosted. We are hoping to schedule these discussions throughout the month of July.

Please feel free to call 607-758-5526 or email me directly if you have any questions regarding the process. I look forward to hearing back from you.

Best,

Appendix C

Community Health Assessment Focus Group Interest Form

Date: _____

Name: _____

Email Address: _____

Phone Number: _____

Preferred Method of Contact (please circle one): Phone Email

Organization (If none, please write "community member"): _____

Interest (please circle one): Hosting a Focus Group Participating in a Focus Group BOTH

