**Community Health Improvement Plan**

**Ontario County**

**Community Health Improvement Plan**

**November 2013**

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**1. CHIP Process**

**Mobilizing for Action through Planning and Partnership**

Led by the S2AY Rural Health Network, Ontario County Public Health Department in collaboration with local hospitals and community partners utilized the Mobilizing for Action through Planning and Partnership (MAPP) process to determine two priorities and a disparity from the 2013 – 2017 Prevention Agenda. The MAPP process is a strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide strategic planning. Using MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs, and forming effective partnerships for strategic action.  The MAPP tool was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Public Health Practice Program Office, Centers for Disease Control and Prevention (CDC). A work group comprised of local health officials, CDC representatives, community representatives, and academicians developed MAPP between 1997 and 2000. The vision for implementing MAPP is: *"Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action”.* The MAPP process encompasses several steps.

**Organize for Success-Partner Development**

The goal of this step is to bring together key partners and familiarize them with the MAPP process and determine key local questions. To accomplish this Ontario County Public Health Department invited participants from a wide range of organizations throughout the county. Organizations that participated in the community health assessment process were:

* Ontario County Public Health Department
* Clifton Springs Hospital and Clinic
* FF Thompson Hospital
* Geneva General Hospital
* S2AY Rural Health Network
* Geneva Housing Authority
* Churches in Action
* Ontario County Youth Bureau
* Ontario County Office of the Aging
* Ontario County DSS
* Ontario County Sheriff's Office
* Ontario County Mental Health Department
* Ontario United Way
* Ontario County Workforce Development
* Ontario County Correctional Facility
* Finger Lakes Visiting Nurse Services
* Courts of Ontario County
* Canandaigua Red Cross
* The Salvation Army
* Rushville Health Center (RPCN)
* Geneva Head Start
* Canandaigua Veterans Affairs Medical Center
* Finger Lakes Cerebral Palsy/Happiness House
* NAACP - Geneva
* Geneva Community Health
* Ontario County ARC
* Catholic Charities
* The Monroe Plan for Medical Care
* Lifetime Care
* Finger Lakes Addictions Counseling and Referral Agency (FLACRA)
* Cornell Cooperative Extension
* Partnership for Ontario County
* Council on Alcoholism & Addictions in the Finger Lakes
* Council of Churches, Our Lady of Peace Parish
* Success for Geneva's Children
* Finger Lakes Community College
* Finger Lakes WIC Program
* Town of Hopewell
* Tobacco Coalition of the Finger Lakes
* Youth for Youth
* Wayne Finger Lakes BOCES
* Hobart William Smith Colleges, Hubbs Health Center
* Finger Lakes Health
* Child and Family Resources, Inc.

The Ontario County Health Collaborative included organizations committed to improving the health of Ontario County residents. This group has met on a monthly basis in the development of the Ontario County Health Collaborative Work Plan. The members of the Ontario County Health Collaborative have agreed to meet on a regular basis to ensure that the initiatives outlined in the plan are implemented, monitored and evaluated.

**Assessments**

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

The first assessment examined the Community Health Status Indicators. Two methods were used to examine indicators. The first was to collect relevant statistical data using the NYSDOH Community Health Indicator Reports and a variety of other secondary sources. This was completed by S2AY Rural Health Network staff. The second method was to collect primary data by conducting a comprehensive survey among a random sample of community residents to determine their opinions, health-related behaviors and health needs. A total of 472 (statistically valid) completed surveys were returned in Ontario County. Surveys were conducted electronically through a Survey Monkey link, along with paper copies which were distributed to the public through employers; health, educational, and human services agencies; and other community groups. The survey was designed to encompass questions addressing the five Prevention Agenda areas the New York State Department of Health (NYSDOH) identifies as high priority issues for the State.

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

The third assessment was the Community Themes and Strengths Assessment, conducted via focus groups held throughout the County. This assessment looked at the issues affecting the quality of life among community residents and the assets the County has available to address health needs. This was held in conjunction with the fourth assessment that looked at the “Forces of Change” that are at work locally, statewide and nationally, and what types of threats and/or opportunities are created by these changes. The focus groups conducted in Ontario County included the Bloomfield Fire Department - Fire Chiefs Meeting, the Geneva African American Association, the Canandaigua Rotary and the Finger Lakes Addictions Counseling and Referral Agency (FLACRA). These groups also helped to ensure that adequate representation of the public was included in the assessments.

**Identification of Strategic Issues**

Once these results were tallied, a finalized list of the top issues from all components of the assessment process was compiled. A series of meetings was held with the Ontario County Health Collaborative to present the data and pick priorities. Members of the Collaborative were charged with ranking the priorities based on their knowledge of health needs and available services, and in light of the data presented, to select two priorities and one disparity. In order to accomplish this, the Hanlon Method was used. This method of ranking focuses most heavily on the anticipated effectiveness of proposed interventions. The Hanlon Method utilizes the following formula to rank priorities:

**(A & 2B) X C**

where A= the size of the problem, B= the severity of the problem and C=the effectiveness of the solution. The effectiveness of the solution is weighted heavily with the hope of making wise use of limited resources by targeting solutions known to be effective. Participants also consider the propriety, economic feasibility, acceptability, resource availability, and legality (PEARL) of issues in this ranking system. Numerical values were determined by each participant for size, severity, and effectiveness, and then plugged into the formula along with average PEARL scores.

It is important to note that while the Hanlon Method offers a numerical and systematic method of ranking public health priorities, it is still a method that is largely subjective, but which represents a quantitative way to rank qualitative and non-comparable quantitative information. Since respondents ranked each component (size, seriousness and effectiveness of the solution) individually using a paper ranking form, the rankings were not heavily influenced by group dynamics. Based upon the ranking through the Hanlon Method, Ontario County’s scores on the top health related issues in the county were:

|  |  |  |
| --- | --- | --- |
| **Issues** | **Hanlon** | **PEARL** |
| Cerebrovascular Disease (stroke, hypertension) | 141.63 | 5.88 |
| Cancer (lung, ovarian, prostate) | 131.25 | 5.75 |
| Poor Nutrition (unhealthy eating) | 124.63 | 6.25 |
| Obesity (including lack of physical activity & fitness) | 122.63 | 6.00 |
| Behavioral Problems in Children | 104.25 | 5.38 |
| Dental HealthDepression/Other Mental IllnessesSmoking/Tobacco Use/Secondhand Smoke | 103.38 | 5.38 |
| Depression/Other Mental Illness | 102.50 | 5.75 |
| Smoking/Tobacco Use/Secondhand Smoke | 80.50 | 5.00 |
| Access to Specialty Health Care | 75.38 | 4.63 |
| Drug & Alcohol Abuse/Abuse of Prescription Drugs or Illegal Drugs | 73.75 | 4.71 |
| CLRD (COPD) | 72.75 | 5.25 |
| Unintentional Injuries | 69.43 | 4.00 |

Community partners discussed all these issues, but concentrated on the top ranked issues. After reviewing, discussing and considering county assessments, data and previous initiatives the group decided to focus on the top two priorities of:

1. Reducing obesity in children and adults

2. Reducing the rate of hypertension

The following disparity was chosen: Reducing obesity among the low-income population.

**Formulate Goals and Strategies**

During this stage, research and evidence-based best practices were considered by the Health Collaborative from many sources including the NY State 2013-2017 Prevention Agenda, the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020. The Health Impact Pyramid developed by Thomas R. Frieden, MD, MPH was utilized. This is a pyramid approach to describe the impact of different types of public health interventions and provides a framework to improve health. The base of the pyramid indicates interventions with the greatest potential impact. Built on the base in ascending order are interventions that change the context to make individuals' default decisions healthy; clinical interventions that require limited contact but confer long-term protection; on-going direct clinical care; and health education and counseling. Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort.

Our partnership worked to develop a broad based plan to address our chosen priorities of obesity and hypertension. The Ontario County Health Collaborative Work Plan places emphasis on three key areas: 1) health promotion activities to encourage healthy living and limit the onset of chronic diseases, including environment and policy changes; 2) early detection opportunities that include screening high risk populations; and 3) successful management strategies for existing diseases and related complications. These were chosen as evidence-based strategies with potential to address health inequities, reach broad populations and measure success, while strengthening partnerships and remaining politically feasible. Decision making was based on findings from such organizations as the Institute of Medicine of the National Academies and their report, *Accelerating Progress in Obesity Prevention: Solving the Weight of the Nation* or the CDC’s, *Recommended Community Strategies and Measurements to Prevent Obesity in the United States.*

Obesity is one of the leading causes of preventable deaths in the United States. It increases the risk of diabetes, cancer, heart disease, stroke, arthritis and other illnesses. We have included many interventions to encourage increased physical activity and better nutrition thus reducing our obesity rates and lowering chronic disease rates. These initiatives include pursuing joint use agreements with local school districts, promoting breast feeding policies in the workplace, and urging members of community organizations to consider health during project development. We will promote our county's resource guide to highlight opportunities for healthy living, including local farmer’s markets, parks and hiking trails.

As mentioned above cardiovascular Disease (CVD) is the leading cause of death in New York State. Hypertension is a major contributing factor to cardiovascular disease. The age adjusted cardiovascular disease mortality rate in Ontario County is 251.9 compared to the upstate New York rate of 244.7.[[1]](#footnote-1) Failing to win the battle against obesity and hypertension will mean premature death and disability for an increasingly large segment of Ontario County residents. Without targeted action to reverse the obesity epidemic, for the first time in U.S. history children may face a shorter lifespan than their parents. Ontario County Public Health along with their partners has developed the Ontario County Health Collaborative Work Plan to address these issues.

An exciting aspect of the Ontario County Health Collaborative Work Plan is the unlimited possibilities offered by technological advances. Area hospitals and other local providers are beginning to implement Electronic Health Records (EHR). These EHRs will create a sea of change in how providers manage their patients. When fully functional, the benefits of EHRs include improved [quality and convenience](http://www.healthit.gov/providers-professionals/health-care-quality-convenience) of patient care, accuracy of [diagnoses, better health outcomes](http://www.healthit.gov/providers-professionals/improved-diagnostics-patient-outcomes), and coordination of care, increased [patient participation](http://www.healthit.gov/providers-professionals/patient-participation) in care, improved efficiency and cost savings. We will utilize this technology to give our residents one more, vital tool to improve their health outcomes. EHRs will give providers decision support tools with available resources at their fingertips, leading to disease management discussions with patients and better chronic disease case management.

Primary care providers will be encouraged to talk to their patients about their weight, physical activity, blood pressure, diet and tobacco use. Professional training programs in prevention, screening, diagnosis and treatment of overweight, obesity and diabetes will be provided and reach across the spectrum of health care providers. The updated resources mentioned above will be available to providers through a link in the EHR. Through the use of this new technology follow-up calls will be able to be made to check on patient compliance. Additionally, the EHRs will provide the opportunity and documentation necessary to evaluate and measure their use. EHRs provide one more important connection in the network to support residents to fight obesity, heart disease and hypertension.

The strategies outlined in the work plan are supported and will be implemented in multiple sectors, including schools, worksites, businesses, community organizations, and medical offices to make the easy choice also the healthy choice. We will create an environment that is conducive to physical activity and good nutrition through our network of partnerships with these diverse organizations.

Maintenance of Engagement

The Ontario County Health Collaborative Work Plan designates the organizations that have accepted responsibility for implementing each of the activities outlined in the work plan. Measurement and evaluation techniques are provided for each activity with starting target dates provided. As mentioned above, the members of the Ontario County Health Collaborative have agreed to meet on a regular basis to ensure that the initiatives outlined in this plan are implemented, monitored and evaluated. Progress will also be reported quarterly to the Ontario County Legislature through the Health and Medical Services Committee. Hospital partners will communicate Community Service Plan updates to their respective Hospital Boards, annually. Activities on the work plan will be assessed and modified as needed to address barriers and replicate successes. As priorities are addressed, other community partners may need to be brought to the table to effectively accomplish objectives.



Community Health Improvement Plan

The Ontario County Health Collaborative spent several meetings developing and refining the attached CHIP Chart, the overall work plan for community health improvement. While many objectives will only focus on program-related measures, there are three measures that will specifically lead to improved health outcomes and help achieve the goals of reducing obesity and hypertension in a very measurable way. These include:

* Increase in WIC mothers breastfeeding at 6 months
* 10% increase (72.4% to 79.64%) among women exclusively breastfeeding in the hospital
* Increase in percent of women who institute breastfeeding after delivery and are still breastfeeding at time of discharge
* Reduce sodium content in meals for patients, visitors, and staff at hospitals, nursing homes and senior meal sites by 30% over 3 years (November 2017)
* Increase in the percentage of people managing their hypertension to 75% by December 2017 (hypertension reduction program)

It is expected that continued and collaborative efforts will lead to a healthier Ontario County.



**Section 2. – CHIP Workplan**

| **Prevention Agenda Focus Area: Prevent Chronic Disease****Priority 1: Reduce Obesity in Children and Adults** |
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| **Strategy Area** | **Objective** | **Activities** | **Partners** | **Timeframe** | **Measurement/ Evaluation** |
| 1. Reduce Obesity in Children and Adults1. Reduce Obesity in Children and Adults | A. Create community environments that promote and support healthy food and beverage choices and physical activityA. Create community environments that promote and support healthy food and beverage choices and physical activity | 1 - A1. Research existing use of fruits and vegetables and other healthy options at food pantries and food distribution program (e.g. soup kitchens, back pack programs, summer feeding programs, etc.) Identify barriers to providing healthier meals. Determine how we can help to increase use of produce/healthy food options in these venues. | Ontario County Health Collaborative (OCHC), Salvation Army, faith based community, food pantries, CCE, Food Link, schools, participating YMCAs, OFAs | June 2014 – On-going | Research and assessment completed. # Food pantries using local produce# clients educated |
| 1 - A2. Contact 10 county restaurants to mark healthy choices on menus. (Adopt committee definition of healthy choices) | OCHC, Chamber of Commerce, FLH, FL Visitors Connection | Dec. 2014 – On-going | # restaurants participating |
| 1 - A3. Determine who else needs to be involved in OCHC and invite their participation (Food Link, CCE, Salvation, schools, faith-based community, OFA, Mental Health, WIC) | OCHC | Nov 15, 2013 | % of needed partners recruited |
| 1 - A4. Work together to increase breastfeeding in Ontario County. Support hospitals in becoming baby friendly by supporting the 10 steps to successful breastfeeding  | Ontario County Public Health, FF Thompson,Breastfeeding coalitionOCHC, WIC | June 2014 – On-going | EHR documentation of education, document # of women who are still breastfeeding upon discharge from hospital, % increase of WIC mothers breastfeeding at 6 months, 10% increase (72.4% to 79.64%) among women exclusively breastfeeding in the hospital, % breastfeeding at all in the hospital |
| 1 - A5. Annually encourage 10 OCHC member organizations, non-profits, schools and local businesses to adopt breast feeding policies. | OCPHD, Hospitals, Breastfeeding CoalitionOCHC, United Way, Chamber of Commerce | June 2014 – On-going | # of policies implemented.  |
| 1 - A6. Investigate further initiatives to support breastfeeding within the county. (Work with Doctors on EHR to track persistence of breastfeeding at 1, 3, 6 and 12 months) | OCPHD, Hospitals, Breastfeeding CoalitionOCHC, PCPs/Pediatricians | Jan 2014 – On-going | Initiatives implemented |
| 1 - A7. Advocate/promote/sustain the implementation of healthier vending policy in County facilities, hospitals and OCHC members. | OCPHD, Hospitals, OCHC | Jan 2015 – Oct 2017 | # organizations with healthy vending policies |
| 1 - A8. Annually encourage 10 OCHC member organizations, non-profits, schools and local businesses to adopt Healthy Meeting guidelines. | OCHC, United Way, Chamber of Commerce | Jan. 2015 – Oct 2017 | # organizations/worksites that adopt policy |
| 1 - A9. Encourage OCHC members, non-profits and local businesses to adopt and expand sugar sweetened beverage policies. Provide sample policies to 10 worksites | OCHC, United Way, Chamber of Commerce | Jan. 2015 – Oct 2017 | # organizations/worksites that adopt policy |
| 1 - A10. Investigate the feasibility of promoting use of EBT cards at Farmer's Markets through WIC Clinics.  | OCHC, Cornell Cooperative Extension, Ontario Cty. DSS, WIC | March 2014 On-going | Feasibility determined. Next steps taken is appropriate. |
| 1 - A11. Promote the visitors guide and online resource of county hiking, biking and walking trails and other natural resources to promote physical activity within the community. Include stroller and handicapped accessible references. Investigate the possibility of using interactive media using existing apps. | Parks and Recreation, PH, FL Visitors Connection, OCHC | June 2015 - Updated on an annual basis | Guide promoted, online resource created, link provided to partners, app/interactive guide promoted |

| **Prevention Agenda Focus Area: Prevent Chronic Disease****Priority 1: Reduce Obesity in Children and Adults** |
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| **Strategy Area** | **Objective** | **Activities** | **Partners** | **Timeframe** | **Measurement/ Evaluation** |
| 1. Reduce Obesity in Children and Adults | A. Create community environments that promote and support healthy food and beverage choices and physical activity | 1 - A12. Investigate creating an annual county-wide competition centered around the promotion of physical activity and fitness (i.e. "Walk-Off" between Canandaigua/Geneva, Wegmans Eat Well Live Well, Walk and Talk for Health, Staff Steps, Step Up, TRY-athalon) | OCHC, PH, FLH, Local Employers, hospitals, FL Visitors Connection | December 2014 - Annually thereafter  | Annual contest created and held, # of participants |
| 1- A13. Investigate the use of and work on promoting 5-2-1-0 in the after-school programs, backpack program, community centers, day cares, Head Start, C&FRC, Foodlink, YMCA, Boys and Girls Club, Sal Army  | OCHC, YMCA, Foodlink, Boys and Girls Club, Sal Army, etc. | June 2015 | Number of organizations participating; number of people educated,; number of policies adopted |
| 1 - A14. Increase the use of and engage local media and online resources (i.e. social media, county/community/PH websites, online news websites, radio, television, local publications) to promote the importance of good nutrition and physical activity using consistent measurements. Include examples of ways to increase physical activity and county resources that are available to community members to increase physical activity. | OCHC, PH, Local Media, Local Hospitals, Other non-profits, FL Visitors Connection | Dec 2014 – Ongoing | # of media outlets reached out to, # of communications published/posted, |
| 1 - A15. Educate municipal officials regarding how to improve the built environment and keep them informed and educated about good nutrition and physical activities as outlined in the CHIP- at least 5 municipal officials. | Ontario County Public Health, OCHC | December 2014 | # of municipal officials educated  |

| **Prevention Agenda Focus Area: Prevent Chronic Disease****Priority 1: Reduce Obesity in Children and Adults** |
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| **Strategy Area** | **Objective** | **Activities** | **Partners** | **Timeframe** | **Measurement/ Evaluation** |
| 1. Reduce Obesity in Children and Adults1. Reduce Obesity in Children and Adults | B. Prevent childhood obesity through early-care and schoolsC. Expand the role of health care, health service providers, and insurers in obesity prevention | 1 - B1. Attempt to have committee members on the Wellness Committees at each school district in the County. | OCHC/Hospitals | By June 2015 | Adherence to wellness standards |
| 1 - B2. Partner with local schools and after school programs to promote reducing screen time, healthy living, healthy eating and physical activity. Continue and expand the "Get Up! Fuel Up!” and “Food, Fun, Fitness” programs. Explore program with Midlakes. Explore homeschoolers and parochial schools. | OCPHD, Hospitals, OCHC, schools, YMCA, Boys and Girls Club | Dec 2016 On-going | # of students reached # of new students reached |
| 1 - B3. Work with farms, food service directors and Seeking Common Ground to encourage use of local produce and farms in schools, restaurants, healthcare facilities, etc. Including promoting the use of the Ontario County "Local Food Guide" - CCE.  | Cornell Cooperative Extension, OCHC, Hospitals, School Food Independence Committee, OFA  | July 2014 On-going | # of schools, restaurants and health care facilities utilizing local produce |
| 1 - B4. Create and annually update inventory of existing opportunities for physical activities available to community members at schools. Continue to encourage, develop and expand opportunities for physical activity for community members in school facilities.  | OCHC, Schools | April 2014 – and annually thereafter | # of schools expanding use |
| 1 - C1. Ensure providers are discussing obesity and providing resources – provide resource list to providers  | Hospitals | July 2015 – On-going | EMR link to resources – measure use |

| **Prevention Agenda Focus Area: Prevent Chronic Disease****Priority 2: Decrease Hypertension Rates** |
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| **Strategy Area** | **Objective** | **Activities** | **Partners** | **Timeframe** | **Measurement/ Evaluation** |
| 2. Increase access to high quality chronic disease preventive care and management in clinical and community settings  | A. Decrease Hypertension Rates | 2 - A1. Work to prevent hypertension by assisting hospitals, nursing homes and senior meal providers in reducing sodium content in all meals served including to patients, visitors, staff and public.  | OCHC, Hospitals, Nursing Homes, Office for the Aging, RHIO, S2AY | January 2014 On-going | Reduce sodium content by 30% over 3 years, by November 2017 |
| 2 - A2. Work with the FLHSA to bring the hypertension reduction program down to Ontario County. This involves increased focus on enhanced clinical management of hypertension, enhanced community awareness and community supports. | FLHSA/S2AY RHN | January 2014 On-going | Implementation of program and at least 300 people enrolled by December 2015. Increase percentage of people managing their hypertension to 75% by December 2017. |
| B. Promote culturally relevant chronic disease self-management education | 2 - B1. Offer at least one class of the Stanford Chronic Disease Self-Management Program. | SCHD, RSVP/Wayne CAP, Seneca County OFA, Rural Health Network | Annually Starting January 2014 | At least 10 people with chronic disease (arthritis, asthma, CVD or diabetes) annually will have taken a course and demonstrate improved management of their condition. |

Ontario County has also created an Activity Workplan which breaks down each activity into specific, measurable goals and milestones. Ontario County Public Health will use this Activity Workplan to assure that activities and goals are being met and timeframes are being adhered to. The Activity Workplan will also help to predict if an activity or objective needs to be reassessed and adjusted to overcome barriers and meet timeframe goals.

**Ontario County Indicators For Tracking Public Health Priority Areas, 2013-2017**

**3.**

[Technical Notes About the Indicators For Tracking Public Health Priority Areas - New York State - 2013-2017](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/about.htm)

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| **Improve Health Status and Reduce Health Disparities** |
| **Indicator** | **Data Years** | **Ontario County**  | **New York State** | **Data Links** | **NYS 2017 Objective** |
| 1.  | Percentage of premature death (before age 65 years) | 2008-2010 | 22.2 | 24.3 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p1.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p1.pdf) | 21.8 |
| 2.  | Ratio of Black non-Hispanics to White non-Hispanics |  | 2.50 | 2.12 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p2.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p2.pdf) | 1.87 |
| 3.  | Ratio of Hispanics to White non-Hispanics |  | 2.52 | 2.14 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p3.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p3.pdf) | 1.86 |
| 4.  | Age-adjusted preventable hospitalizations rate per 10,000 - Ages 18+ years | 2008-2010 | 122.1 | 155.0 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p4.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p4.pdf) | 133.3 |
| 5.  | Ratio of Black non-Hispanics to White non-Hispanics |  | 1.36 | 2.09 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p5.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p5.pdf) | 1.85 |
| 6.  | Ratio of Hispanics to White non-Hispanics |  | 0.85 | 1.47 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p6.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p6.pdf) | 1.38 |
| 7.  | Percentage of adults with health insurance - Ages 18-64 years | 2010 | 87.1 (85.8-88.4) | 83.1 (82.9-83.3) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p7.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p7.pdf) | 100 |
| 8.  | Age-adjusted percentage of adults who have a regular health care provider - Ages 18+ years | 2008-2009 | 92.0 (88.1-96.0) | 83.0 (80.4-85.5) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p8.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p8.pdf) | 90.8 |

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| **Promote a Healthy and Safe Environment** |
| **Indicator** | **Data Years** | **Ontario County**  | **New York State** | **Data Links** | **NYS 2017 Objective** |
| 9.  | Rate of hospitalizations due to falls per 10,000 - Ages 65+ years | 2008-2010 | 234.8 | 204.6 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p9.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p9.pdf) | Maintain |
| 10.  | Rate of emergency department visits due to falls per 10,000 - Ages 1-4 years | 2008-2010 | 595.7 | 476.8 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p10.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p10.pdf) | 429.1 |
| 11.  | Assault-related hospitalization rate per 10,000 | 2008-2010 | 1.5 | 4.8 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p11.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p11.pdf) | 4.3 |
| 12.  | Ratio of Black non-Hispanics to White non-Hispanics |  | 8.59+ | 7.43 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p12.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p12.pdf) | 6.69 |
| 13.  | Ratio of Hispanics to White non-Hispanics |  | 2.49+ | 3.06 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p13.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p13.pdf) | 2.75 |
| 14.  | Ratio of low income ZIP codes to non-low income ZIP codes |  | 0.00+ | 3.25 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p14.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p14.pdf) | 2.92 |
| 15.  | Rate of occupational injuries treated in ED per 10,000 adolescents - Ages 15-19 years | 2008-2010 | 74.8 | 36.7 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p15.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p15.pdf) | 33.0 |
| 16.  | Percentage of population that lives in a jurisdiction that adopted the Climate Smart Communities pledge | 2012 | 2.5 | 26.7 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p16.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p16.pdf) | 32.0 |
| 17.  | Percentage of commuters who use alternate modes of transportation1 | 2007-2011 | 18.1 | 44.6 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p17.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p17.pdf) | 49.2 |
| 18.  | Percentage of population with low-income and low access to a supermarket or large grocery store2 | 2010 | 2.9 | 2.5 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p18.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p18.pdf) | 2.24 |
| 19.  | Percentage of homes in Healthy Neighborhood Program that have fewer asthma triggers during the home revisits | 2008-2011 | NA | 12.9 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p19.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p19.pdf) | 20 |
| 20.  | Percentage of residents served by community water systems with optimally fluoridated water | 2012 | 78.2 | 71.4 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p20.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p20.pdf) | 78.5 |

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| **Prevent Chronic Diseases** |
| **Indicator** | **Data Years** | **Ontario County**  | **New York State** | **Data Links** | **NYS 2017 Objective** |
| 21.  | Percentage of adults who are obese | 2008-2009 | 23.5 (19.2-27.8) | 23.2 (21.2-25.3) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p21.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p21.pdf) | 23.2 |
| 22.  | Percentage of children and adolescents who are obese | 2010-2012 | 16.1 | 17.6 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p22.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p22.pdf) | NYC: 19.7 ROS: 16.7 |
| 23.  | Percentage of cigarette smoking among adults | 2008-2009 | 19.8 (15.5-24.1) | 16.8 (15.1-18.6) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p23.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p23.pdf) | 15.0 |
| 24.  | Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Ages 50-75 years | 2008-2009 | 69.7 (63.3-75.4) | 66.3 (63.5-69.1) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p24.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p24.pdf) | 71.4 |
| 25.  | Asthma emergency department visit rate per 10,000 | 2008-2010 | 41.7 | 83.7 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p25.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p25.pdf) | 75.1 |
| 26.  | Asthma emergency department visit rate per 10,000 - Ages 0-4 years | 2008-2010 | 88.3 | 221.4 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p26.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p26.pdf) | 196.5 |
| 27.  | Age-adjusted heart attack hospitalization rate per 10,000 | 2010 | 14.0 | 15.5 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p27.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p27.pdf) | 14.0 |
| 28.  | Rate of hospitalizations for short-term complications of diabetes per 10,000 - Ages 6-17 years | 2008-2010 | 2.4 | 3.2 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p28.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p28.pdf) | 3.06 |
| 29.  | Rate of hospitalizations for short-term complications of diabetes per 10,000 - Ages 18+ years | 2008-2010 | 5.0 | 5.6 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p29.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p29.pdf) | 4.86 |

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| **Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections** |
| **Indicator** | **Data Years** | **Ontario County**  | **New York State** | **Data Links** | **NYS 2017 Objective** |
| 30.  | Percentage of children with 4:3:1:3:3:1:4 immunization series - Ages 19-35 months3 | 2011 | 53.1 | 47.6 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p30.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p30.pdf) | 80 |
| 31.  | Percentage of adolescent females with 3-dose HPV immunization - Ages 13-17 years | 2011 | 34.3 | 26.0 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p31.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p31.pdf) | 50 |
| 32.  | Percentage of adults with flu immunization - Ages 65+ years | 2008-2009 | 82.2 (76.7-87.7) | 75.0 (71.5-78.5) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p32.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p32.pdf) | 66.2 |
| 33.  | Newly diagnosed HIV case rate per 100,000 | 2008-2010 | 2.2\* | 21.6 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p33.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p33.pdf) | 14.7 |
| 34.  | Difference in rates (Black and White) of new HIV diagnoses |  | s | 59.4 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p34.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p34.pdf) | 45.7 |
| 35.  | Difference in rates (Hispanic and White) of new HIV diagnoses |  | s | 31.1 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p35.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p35.pdf) | 22.3 |
| 36.  | Gonorrhea case rate per 100,000 women - Ages 15-44 years | 2010 | 61.6 | 203.4 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p36.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p36.pdf) | 183.1 |
| 37.  | Gonorrhea case rate per 100,000 men - Ages 15-44 years | 2010 | 31.0\* | 221.7 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p37.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p37.pdf) | 199.5 |
| 38.  | Chlamydia case rate per 100,000 women - Ages 15-44 years | 2010 | 836.9 | 1619.8 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p38.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p38.pdf) | 1,458 |
| 39.  | Primary and secondary syphilis case rate per 100,000 males | 2010 | 0.0\* | 11.2 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p39.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p39.pdf) | 10.1 |
| 40.  | Primary and secondary syphilis case rate per 100,000 females | 2010 | 0.0\* | 0.5 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p40.htm)  | 0.4 |

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| **Promote Healthy Women, Infants, and Children** |
| **Indicator** | **Data Years** | **Ontario County**  | **New York State** | **Data Links** | **NYS 2017 Objective** |
| 41.  | Percentage of preterm births | 2008-2010 | 10.9 | 12.0 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p41.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p41.pdf) | 10.2 |
| 42.  | Ratio of Black non-Hispanics to White non-Hispanics |  | 1.53+ | 1.61 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p42.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p42.pdf) | 1.42 |
| 43.  | Ratio of Hispanics to White non-Hispanics |  | 1.04 | 1.25 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p43.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p43.pdf) | 1.12 |
| 44.  | Ratio of Medicaid births to non-Medicaid births |  | 1.09 | 1.10 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p44.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p44.pdf) | 1.00 |
| 45.  | Percentage of infants exclusively breastfed in the hospital | 2008-2010 | 72.4 | 42.5 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p45.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p45.pdf) | 48.1 |
| 46.  | Ratio of Black non-Hispanics to White non-Hispanics |  | 0.44 | 0.50 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p46.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p46.pdf) | 0.57 |
| 47.  | Ratio of Hispanics to White non-Hispanics |  | 0.58 | 0.55 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p47.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p47.pdf) | 0.64 |
| 48.  | Ratio of Medicaid births to non-Medicaid births |  | 0.68 | 0.57 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p48.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p48.pdf) | 0.66 |
| 49.  | Maternal mortality rate per 100,000 births | 2008-2010 | s | 23.3 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p49.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p49.pdf) | 21.0 |
| 50.  | Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs4 | 2011 | 66.1 | 69.9 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p50.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p50.pdf) | 76.9 |
| 51.  | Percentage of children ages 0-15 months who have had the recommended number of well child visits in government sponsored insurance programs |  | 84.6 | 82.8 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p66.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p66.pdf) | 91.3 |
| 52.  | Percentage of children ages 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs |  | 75.0 | 82.8 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p67.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p67.pdf) | 91.3 |
| 53.  | Percentage of children ages 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs |  | 58.0 | 61.0 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p68.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p68.pdf) | 67.1 |
| 54.  | Percentage of children with any kind of health insurance - Ages 0-19 years | 2010 | 95.1 (93.9-96.3) | 94.9 (94.5-95.3) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p51.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p51.pdf) | 100 |
| 55.  | Percentage of third-grade children with evidence of untreated tooth decay | 2009-2011 | 17.4 (11.4-23.4) | 24.0 (22.6-25.4) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p52.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p52.pdf) | 21.6 |
| 56.  | Ratio of low-income children to non-low income children |  | 16.38 | 2.46 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p53.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p53.pdf) | 2.21 |
| 57.  | Adolescent pregnancy rate per 1,000 females - Ages 15-17 years | 2008-2010 | 11.7 | 31.1 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p54.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p54.pdf) | 25.6 |
| 58.  | Ratio of Black non-Hispanics to White non-Hispanics |  | 5.11 | 5.74 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p55.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p55.pdf) | 4.90 |
| 59.  | Ratio of Hispanics to White non-Hispanics |  | 8.31 | 5.16 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p56.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p56.pdf) | 4.10 |
| 60.  | Percentage of unintended pregnancy among live births | 2011 | 29.7 | 26.7 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p57.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p57.pdf) | 24.2 |
| 61.  | Ratio of Black non-Hispanics to White non-Hispanics |  | 2.56 | 2.09 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p58.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p58.pdf) | 1.88 |
| 62.  | Ratio of Hispanics to White non-Hispanics |  | 1.72 | 1.58 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p59.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p59.pdf) | 1.36 |
| 63.  | Ratio of Medicaid births to non-Medicaid births |  | 2.72 | 1.69 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p60.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p60.pdf) | 1.56 |
| 64.  | Percentage of women with health coverage - Ages 18-64 years | 2010 | 89.6 (88.0-91.2) | 86.1 (85.8-86.4) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p61.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p61.pdf) | 100 |
| 65.  | Percentage of live births that occur within 24 months of a previous pregnancy | 2008-2010 | 22.7 | 18.0 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p62.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p62.pdf) | 17.0 |
| **Promote Mental Health and Prevention Substance Abuse** |
| **Indicator** | **Data Years** | **Ontario County**  | **New York State** | **Data Links** | **NYS 2017 Objective** |
| 66.  | Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month | 2008-2009 | 11.0 (7.5-14.6) | 10.2 (8.7-11.7) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p63.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p63.pdf) | 10.1 |
| 67.  | Age-adjusted percentage of adult binge drinking during the past month | 2008-2009 | 21.0 (15.8-26.2) | 18.1 (16.1-20.2) | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p64.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p64.pdf) | 18.4 |
| 68.  | Age-adjusted suicide death rate per 100,000 | 2008-2010 | 9.1 | 6.8 | [(Table)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p65.htm)[(Map)](http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/pdf/p65.pdf) | 5.9 |

\* Fewer than 10 events in the numerator, therefore the rate is unstable
+ Fewer than 10 events in one or both rate numerators, therefore the ratio is unstable
s Data do not meet reporting criteria

1- Alternate modes of transportation include public transportation, carpool, bike, walk, and telecommute
2- Low access is defined as greater than one mile from a supermarket or grocery store in urban areas or greater than ten miles from a supermarket or grocery store in rural areas
3- The 4:3:1:3:3:1:4 immunization series includes: 4 DTaP, 3 polio, 1 MMR, 3 hep B, 3 Hib, 1 varicella, 4 PCV13
4- Government sponsored insurance programs include Medicaid and Child Health Plus

Questions or comments: phiginfo@health.state.ny.us

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[Accessibility](http://www.health.ny.gov/contact/accessibility.htm)

1. New York State Dept. of Health New York State Community Health Indicator Reports <http://www.health.ny.gov/statistics/chac/indicators/> [↑](#footnote-ref-1)