SCHUYLER COUNTY

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Schuyler County, Watkins Glen
Photo courtesy of Schuyler County Public Health

EXECUTIVE SUMMARY

Through the use of Results Based Accountability, Schuyler County in partnership with Schuyler Hospital has chosen to focus their 2022-2024 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) on the following priority areas, with the low income population as their identified disparity to address.

PRIORITY AREAS & DISPARITY	
Promote Well-Being and Prevent Mental and Substance Use Disorders	
Focus Area	Prevent mental and substance use disorders
Prevent Chronic Diseases	
Focus Area	Preventive care and management
Disparity	**Low income population**

The Schuyler County CHA/CHIP team, a group of diverse partners who span all sectors of the community, participated in the prioritization process and disparity and intervention identification. While a complete list of partners is available within the Schuyler County Chapter under "Community Health Improvement Plan/Community Service Plan," agencies present represented academia, not-for-profits and community organizations, businesses, the general public, and local government. They included the Schuyler County Public Health Department, Schuyler Hospital, Cancer Services Program, Mental Health, MR Hess Home Works, and more. Partners' roles in the assessment were to help inform and select the 2022-2024 priority areas by sharing any pertinent data or concerns and actively participating in planning meetings. Community members were involved in the 2018 My Health Story survey, and inclusion of community was considered as part of the oversight committee. The 2022 My Health Story survey took place in the summer and fall of 2022, and this will help gain community insight on key health matters in the county and surrounding areas. Both primary and secondary data were reviewed including, but not limited to, the US Census Bureau American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, data collected from Pivital Public Health Partnership (formerly known as S2AY Rural Health Network) and Common Ground Health's My Health Story 2018 survey, 211 Lifeline, and the Statewide Planning and Research Cooperative System (SPARCS).

The process of Results Based Accountability included evaluation of a pre-read document, which contained detailed county-specific analyses related to the five Prevention Agenda priority areas, followed by a multi-voting technique to select the priority areas. Participants were asked to consult with other members of their organizations and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Partners came to a consensus to address the top priority areas identified by the survey, then additional county-specific data was collected, shared and evaluated to help determine which objectives, disparity, and interventions should be selected. Interventions selected included, but were not limited to:

- 2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations.
- 2.4.2 Strengthening resources for families and caregivers.
- 2.5.2 Strengthen access and delivery of suicide care - Zero Suicide: Zero Suicide is a commitment to comprehensive suicide safer care in health & behavioral health care systems.
- 4.1.6 Ensure continued access to health insurance to reduce economic barriers to screening.

A complete list of interventions and process measures is available in the CHIP.

The Schuyler County CHA/CHIP team, outside of CHA/CHIP development, meets bi-monthly to improve the health of Schuyler residents and will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings. Partners and the community will continue to be engaged and apprised of progress via these meetings.

Schuyler County
Photo courtesy of Schuyler County Public Health

PLANNING AND PRIORITIZATION PROCESS

Schuyler County followed a process called Results Based Accountability to develop their needs assessment and improvement plans. There are several components to Results Based Accountability, some of which include defining the community, engagement of a diverse group of stakeholders (including organizations representing underserved, low-income and minority populations), data collection and analysis, prioritization of health issues and disparity identification, and discussion of root causes for selected health issues to help identify appropriate and effective interventions. For additional information on Results Based Accountability, this process is described in its entirety in Appendix 2. To pinpoint root causes of selected health concerns, the committee evaluated behavioral, environmental, social determinants of health, and policy causes that may be contributing to the current status of those concerns.

As demonstrated in the health indicator section, each county's residents face their own unique and challenging issues when it comes to their community, yet commonalities remain. There are a number of demographic and socioeconomic indicators which may impact health and are consistent concerns across the region. For example:

AGE:

Variances in age can impact a community's health status. Older adults require more frequent medical check-ins, are more prone to illness, falls and unintentional injuries, and often experience more co-morbid conditions than younger adults and children. In addition, aging adults may not have access to a vehicle and rely on family, friends or public transportation for accessing basic needs and medical appointments. The strain of caring for an elderly adult may also negatively affect the caregiver. A community with higher rates of elderly adults may have worse reported health outcomes than a younger community.

POVERTY:

Low income residents are more likely to experience a breadth of health issues not seen as often in wealthier residents. For example, lower socioeconomic status is linked to higher incidence of chronic disease, shorter life expectancy, and lower rates of good social, emotional and physical health. Low income may also force a person to choose between basic needs (such as housing, food, clothing, etc.) and preventative medical care. Often, and not surprisingly, the person will choose the basic need over preventative medical care. A community with higher rates of impoverished residents is likely to have worse health outcomes than wealthier communities.

EDUCATION:

Education levels have been known to be a predictor of life expectancy. The Centers for Disease Control and Prevention reports that adults aged 25 without a high school diploma can expect to die nine years sooner than college graduates. Persons who attain higher education levels are more likely to seek health care, preventative care services, and earn higher wages. A more educated community may, therefore, have better health outcomes than a low educated community.

HOUSING:

Access to quality and affordable housing is imperative to ensuring basic needs are met. Housing structures that are safe, clean, up to code and affordable help to improve community health. When incomes are consumed on rent or mortgages, residents may lack funds for preventative care services, medications, and healthy foods. Additionally, outdated, substandard housing puts tenants at risk for asthma and lead poisoning (especially children).

Each of the above indicators impacts the health of the community. The next section takes a closer look at these demographic and socioeconomic indicators and also includes a review of behavioral and political environments in Schuyler County that impact the health of its residents. Finally, the section will highlight the community's assets and resources that may be leveraged to improve health through identified evidence-based interventions.

COUNTY CHAPTER – SCHUYLER COUNTY

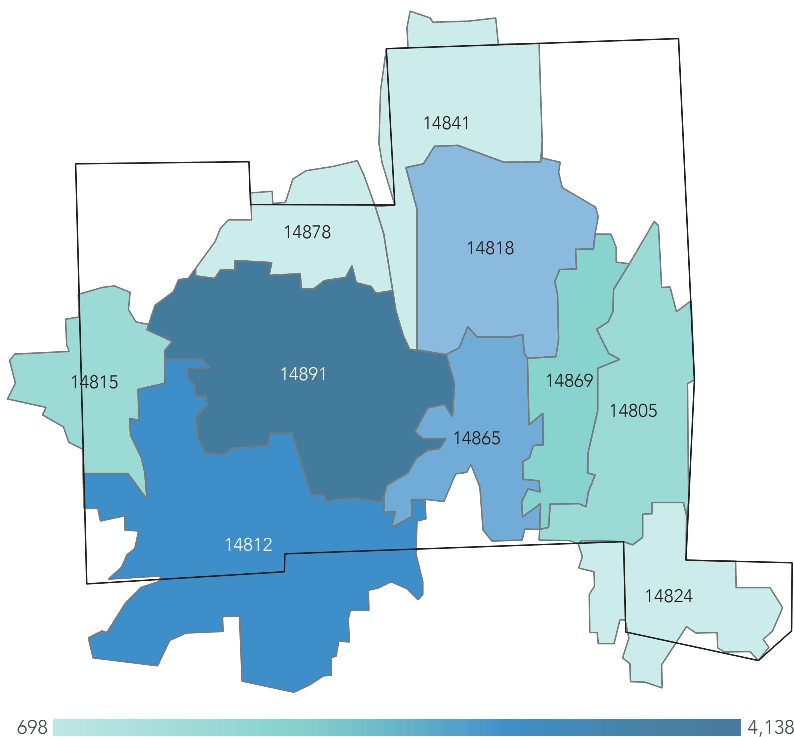
Demographic and Socioeconomic Health Indicators

Schuyler County is located in the southern portion of the Finger Lakes Region, at the base of Seneca Lake. It is home to the popular state park, Watkins Glen, which attracts both residents and tourists. There are 17,898 total residents spread throughout the county, but areas with the densest population include the Village of Watkins Glen (zip code 14891, population 4,138) and Beaver Dams (zip code 14812, population 3,149) (Figure 1). The population is primarily white non-Hispanic (95%), followed by the black non-Hispanic (2%), Hispanic (2%), and other racial and ethical groups (1%), respectively. Of note, there is a congregation of Amish and Mennonite families who reside in the county; the 2022 Old Groffdale and Midwest Horse and Buggy map shows approximately 32 households in Schuyler County (yet does not capture the driving Mennonite population). The cultural implications that this population has on the Schuyler County community must be considered when analyzing and reviewing any of the data contained in the chapter. The population often turns to natural and homeopathic medicine when it comes to family planning, preventative and dental care, vaccinations, etc. Children also only attend school through the eighth grade before turning to farming and other trades to support their families. These cultural practices directly influence the public health assessments; examples include health insurance estimates, educational attainment, poverty, vaccination rates, prenatal care, and more. Additionally, women of childbearing age (aged 15 to 50 years) comprise approximately 20% of the population, and about 18% of individuals are living with some form of disability.[1]

Schuyler County, Catherine Creek
Photo courtesy of Schuyler County Public Health

1. American Community Survey (ACS) 2019 5-Year Estimates

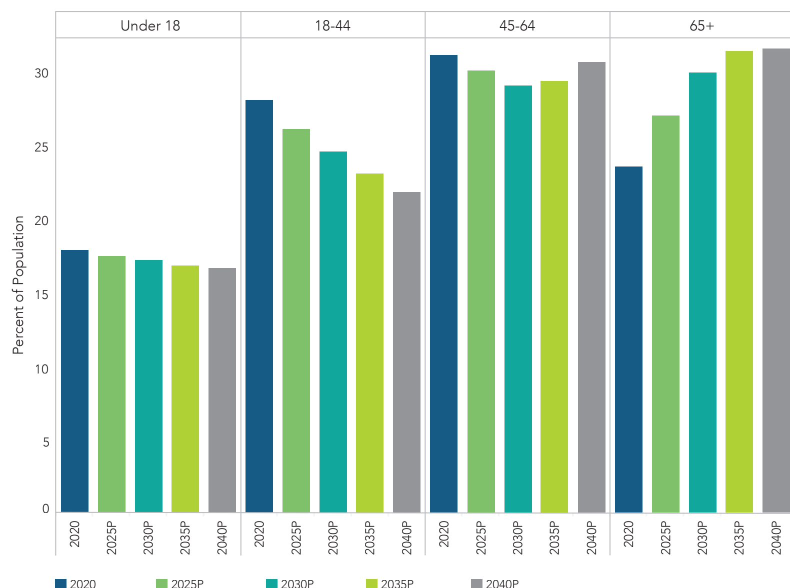
Map SC1: Schuyler County Population by ZIP Code



Source: Claritas zip-level estimates and CDC Bridged-Race county-level estimates, Year 2020. Population data and allocation methods developed by Common Ground Health.

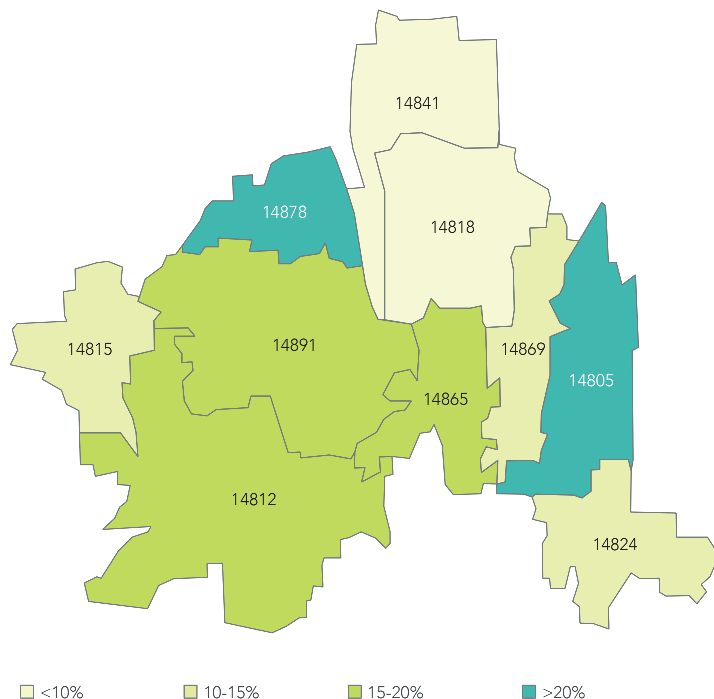
The majority of residents living with a disability in Schuyler County are 65 years of age or older (about 70%). The three types of disabilities most prevalent to this age group are independent living difficulty (about 13%), hearing difficulty (about 15%), and ambulatory difficulty (about 20%). Additionally, around 27% of the population aged 65 years or older are living alone, which may increase the potential of loneliness and emotional challenges, falls and physical safety difficulties, and financial difficulties. Population projections from Cornell University's Program on Applied Demographics (Figure SC2) show that the largest age group within Schuyler County currently are the residents aged 45-64, followed by the 18-44 age bracket. Based on the current population age structure we can infer that, within the next few decades, the 18-44 population will decrease and the 65+ population is expected to grow. As the 65+ population grows, there will be a greater demand on health care services, including chronic disease management and geriatric care.

Figure SC2: Population Projections for Schuyler County



Source: Cornell University - Program on Applied Demographics, County Projections Exploer, Year 2020
Analysis Completed by Common Ground Health

Map SC3: Percent of Population Living in Poverty

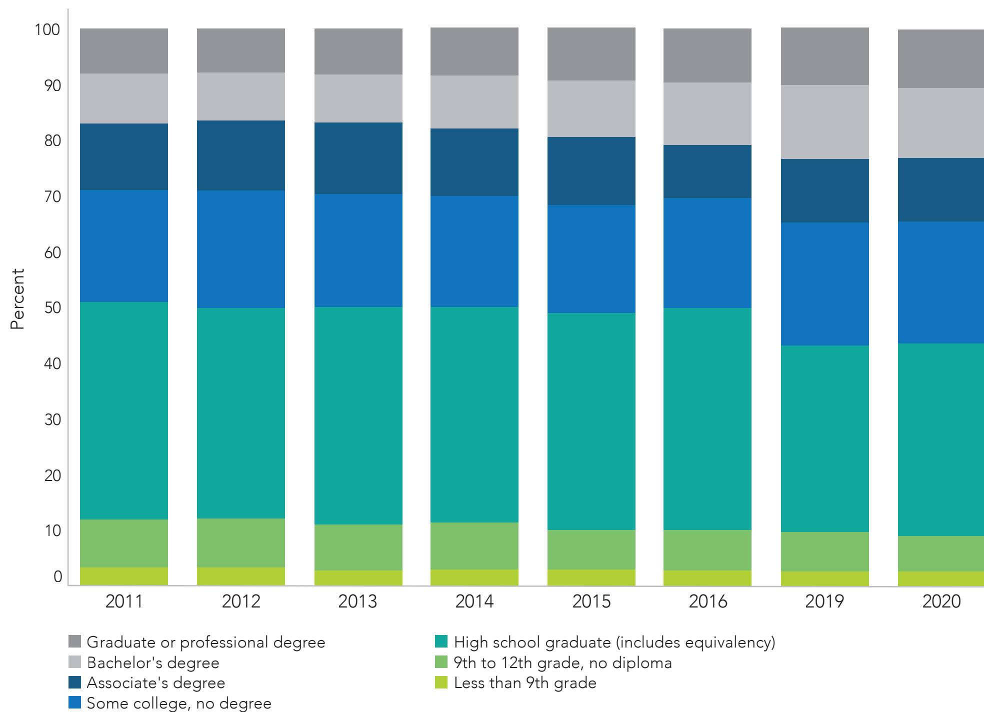


Source: US Census Bureau, American Community Survey, Year 2020
Analysis Completed by Common Ground Health

An estimated 1 in 6.5 individuals (about 15%) within Schuyler County is living below the poverty level. As shown in Map SC3, the highest poverty rates are seen within Rock Stream (14878, about 21% of the population) and Alpine (14805, about 23% of the population). Moreover, the most densely populated area (Watkins Glen, Beavers Dam, and Montour Falls) falls within the second highest poverty rate bracket (about 15%, about 15%, and about 19% respectively) in Schuyler County.

As seen in Figure SC4, educational attainment within Schuyler County has experienced a few slight improvements over recent years. From 2015 to 2020, the percent of residents who either graduated high school (or equivalency) or had a lower level of educational attainment decreased by about 6% (from about 49% to about 44%).

Figure SC4: Educational Attainment of Residents Aged 25+

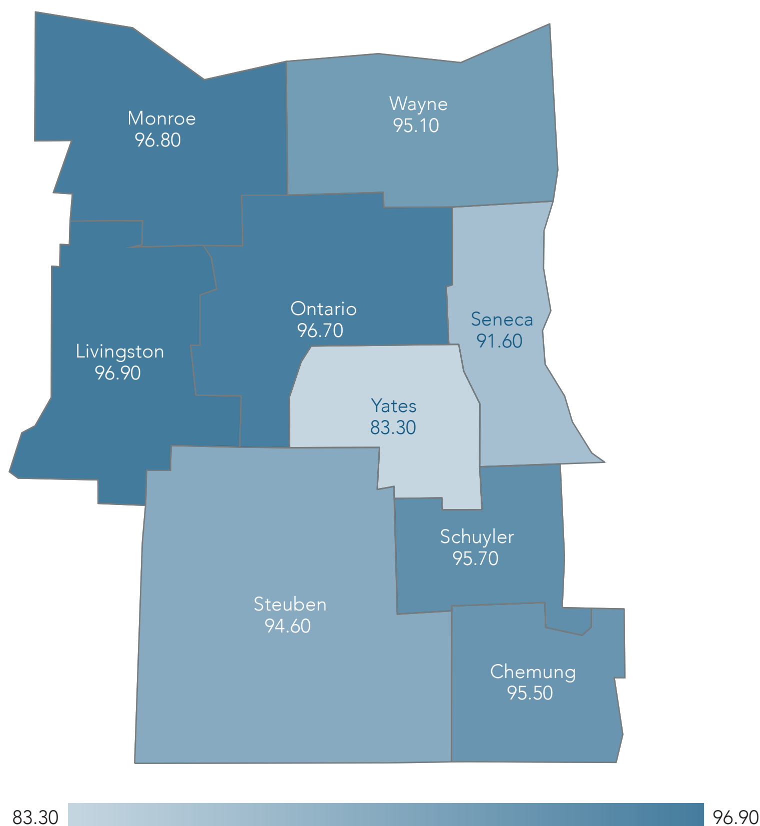


Data Source: US Census Bureau, American Community Survey (ACS), Year 2020.
Analysis Completed by Common Ground Health

On the other hand, the percentage of those who participated in some college (with no degree) increased by about 3% and residents with higher education (associates, bachelors, or graduate/professional degree) increased by about 3%. This can positively affect the community as higher educational attainment generally equates to greater health outcomes.[2]

2. Hahn, R. A., & Truman, B. I. (2015). Education Improves Public Health and Promotes Health Equity. International journal of health services: planning, administration, evaluation, 45(4), 657–678. https://doi.org/10.1177/0020731415585986

Map SC5: Percent of Population with Health Insurance



Source: US Census Bureau, ACS, Year 2020
Analysis Completed by Common Ground Health

Availability and accessibility to providers are equally important considerations regarding accessing healthcare. The Department of Health and Human Services states that nearly 32% of Schuyler County is living within a health professional shortage area (HPSA) compare to 27% of New York State residents. For each segment of health listed below, providers tend to be centered in Watkins Glen or on the perimeter of Seneca Lake. However, the majority of dental health, mental health, nurse practitioners and primary care providers in Schuyler County are on the local transit schedule, and there is also a Dial to Ride program that brings residents to providers as well. However, Schuyler County does not have any birthplaces. Labor and delivery occur outside of Schuyler County, with greater transportation barriers to accessing services.

Dental Health Providers: Dental health providers are available at a rate of 2.8 per 10,000 population[3] within Schuyler County, which is lower than New York State's rate of 3.7.

Mental Health Providers: Schuyler County has a ratio of one mental health provider to 540 residents, if all residents were divided evenly among providers. This is compared to a ratio of one provider to 310 residents for New York State.[4] Mental health providers are defined here, as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care.

Nurse Practitioners: Nurse practitioners are accessible at a rate of 1.7 providers per 10,000 population, which is approximately half the rate of New York State (3.5).

Primary Care Providers: Though still below New York State's rate of 10.9 providers per 10,000 population, primary care providers are more plentiful than nurse practitioners within Schuyler County at a rate of 10.0. Primary care providers play a critical role in preventive services and screenings.

3. Centers for Medicare and Medicaid Services, CMS – National Plan and Provider Enumeration System (NPPES), 2021
4. 2022 County Health Rankings (using 2021 data for this measure)

With regard to housing, about 25% of residents rent versus own their home. The average household size is greater than two people for both renter- and owner-occupied units. Of note, about 40% of residents are paying 35% or more of their household income in rent costs, which is considered an overburdened household. The demand for available housing to own and rent is high in Schuyler County because the housing stock is insufficient (across all market segments – high, medium and low income), poor quality of housing, conversion of long term housing into short term vacation rentals, and long term housing is used as vacation (second) homes.[5] The seasonal vacancy rate for Schuyler County is 16.7%, indicating many vacation or second homes.[6] The Village of Watkins Glen adopted a zoning law in January 2022 to cap the amount of short-term vacation rentals within the Village of Watkins Glen, to help maintain permanent housing for long-term residents.[7] Other communities in Schuyler County are looking into if they have to have a similar zoning law. Schuyler County has also converted and built some housing, but this has not helped decrease the demand for long-term housing for residents.

Out of all occupied housing units, about 6% have no vehicles available and an additional 34% have access to one vehicle. Schuyler County Transit Transportation Link-Line noted some challenges with regard to transportation throughout the county for residents: 1) buses run Monday through Friday but not on the weekends; 2) most bus routes run until 6PM but there have been requests for later routes; 3) rural locations that are spread out throughout the county present a logistical and economical challenge with regard to how to best serve residents. More funding is needed to be able to expand these routes. Meanwhile, Schuyler County does not have local taxis, Lyft or Uber. Dial to Ride is available to residents, but has limited hours and days of operation.

Main Health Challenges

On February 10, 2022, a diverse group of stakeholders, representing various aspects of the community as well as underserved and minority populations, were invited to attend a health priority setting meeting (a complete list of stakeholders can be found in the Community Health Improvement Plan/Community Service Plan section). At this meeting, participants reviewed the overarching goals of the New York State Prevention Agenda and relevant qualitative, quantitative, primary and secondary data. A pre-read document containing detailed county specific analyses relating to the five Prevention Agenda priority areas was sent to all participants for review in advance. Primary and secondary data were collected from a variety of sources including, but not limited to, the American Community Survey, the enhanced Behavioral Risk Factor Surveillance System, Vital Statistics, communicable disease and dental reports, Pivital Public Health Partnership (previously S2AY Rural Health Network), Common Ground Health's My Health Story survey, and 211 Lifeline. My Health Story 2018 was a regional survey completed on behalf of nine counties in the Finger Lakes Region. Its primary purpose was to gather qualitative and quantitative data from Finger Lakes Region residents on health issues in each county. Health departments, hospitals and other local partners were instrumental in distributing the survey to community members including disparate populations. The survey was updated in the summer and fall of 2022 and will be used to help inform potential shifts in strategies to improve the priority areas selected by Schuyler County.

5. Schuyler Countywide Comprehensive Plan Amended June 2015
6. National Association of Counties (NACo), Housing Solutions Matchmaker Tool – A Diagnostic Tool for Local Officials, March 2022
7. Village of Watkins Glen Zoning Law, NY, Section 23.17 Short Term Rentals (STRS), January 18, 2022

After initial review of the priority areas, a multi-voting technique was used to select the priority areas. Participants were asked to consult with other members of their organization and complete an online survey which matrixed a combination of the magnitude of the problem, impact on other health outcomes, social determinant of health considerations, and capacity to address the issue for each priority and focus area discussed. Schuyler County had fifteen members from their committee participate in the survey. As a result, the following areas were selected for the 2022-2024 Community Health Improvement Plan:

PRIORITY AREAS & DISPARITY	
Promote Well-Being and Prevent Mental and Substance Use Disorders	
Focus Area	Prevent mental and substance use disorders

Prevent Chronic Diseases	
Focus Area	Preventive care and management
Disparity	**Low income**

Following this selection, Common Ground Health gathered data on all objectives from the New York State Prevention Agenda within the chosen priority areas, including data that identified differences in health status and health behavior rates among demographic and geographic factors, as available. Objectives were color coded based on data status to help focus attention where it was needed most; red objectives were neither meeting the Prevention Agenda goal nor trending in a favorable direction, yellow objectives were either not meeting the Prevention Agenda goal or not trending in a favorable direction, and green objectives had both met the goal as well as trended in a favorable direction. Objectives that were color coded as gray represented a lack of current and/or reliable data. Color coded data on objectives were presented to the team during April's CHA/CHIP meeting and partners utilized the data, as well as potential scope and interest of the group, to determine which objectives they would pursue. Color-coding of selected objectives can be found in the appendix.

Risk and Protective Factors Contributing to Health Status

Schuyler County has selected two focus areas on which to anchor their 2022-2024 Community Health Improvement Plan. This section will take a closer look at the behavioral, environmental, political and unique risk and protective factors contributing to the health status of those areas.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Prevent Mental and Substance Use Disorders

The opioid overdose epidemic has been a significant public health concern for several decades now. The CDC stated that the number of drug overdose deaths has quadrupled since 1999,[8] and provisional data from November 2021 showed an estimated 100,306 drug overdose deaths in the United States from April 2020-April 2021. This represented an approximately 29% increase from the previous year.[9] One method of decreasing access and, therefore, possible addiction and adverse outcomes, is by prescribing less opioid analgesics and utilizing other options for pain management instead. Trended data for Schuyler County showed a rate of 688.3 opioid analgesic prescriptions per 1,000 population in 2012 compared to 422.1 per 1,000 population in 2020, decreasing by about 39%. In 2020, the opioid analgesic prescription rate in Schuyler County is nearly 1.2 times higher[10] than in the Finger Lakes Region (349.5 per 1,000 population) and New York State, excluding New York City (342.6 per 1,000 population).

8. CDC: Understanding the Opioid Overdose Epidemic, March 2021
9. CDC: Drug Overdose Deaths in the US Top 100,000 Annually, November 2021
10. New York State Department of Health – Opioid Data Dashboard (County Level: Schuyler County)

The rate consistently decreased within Schuyler County between 2012-2020, which is a positive feat that community partners attribute to initiatives taken within the county. First, primary care clinic patients sign a drug contract before beginning any controlled medications, which helps to inform the patient about the medication as well as hold them accountable for its use. Most prescribers are also required to consult the Prescription Monitoring Program Registry when writing scripts for controlled substances as part of the I-STOP Program, which helps them to identify patient treatment history and any red flags for substance abuse.[11] Secondly, providers are now recommending either physical therapy or alternative pain medications as first line of therapy as opposed to opioid analgesics. Additionally, insurance companies are limiting scripts for seven days, making it more difficult for patients to get access, and pharmacies have a policy in place that they cannot switch the prescription to another pharmacy but rather the prescriber would need to do so. Beginning in the spring of 2022, Schuyler Hospital began using an opioid risk assessment tool as well.

While there are already effective interventions in place which have helped to decrease the rate of opioid analgesic prescriptions over the past decade, the rate still remains above the Prevention Agenda goal of 350 prescriptions per 1,000 population. Areas where community partners identified continued challenges with further decreasing opioid analgesic prescriptions included certain diagnoses that typically use these medications (such as back pain), the fact that opioid anelgesics are an easy treatment for providers to prescribe, and certain patients come into clinics asking for these medications specifically. Additionally, should physical therapy be used as a treatment for pain rather than an opioid analgesic prescription, it is possible that the patient may encounter barriers to obtaining physical therapy (such as access, coverage, transportation, etc.).

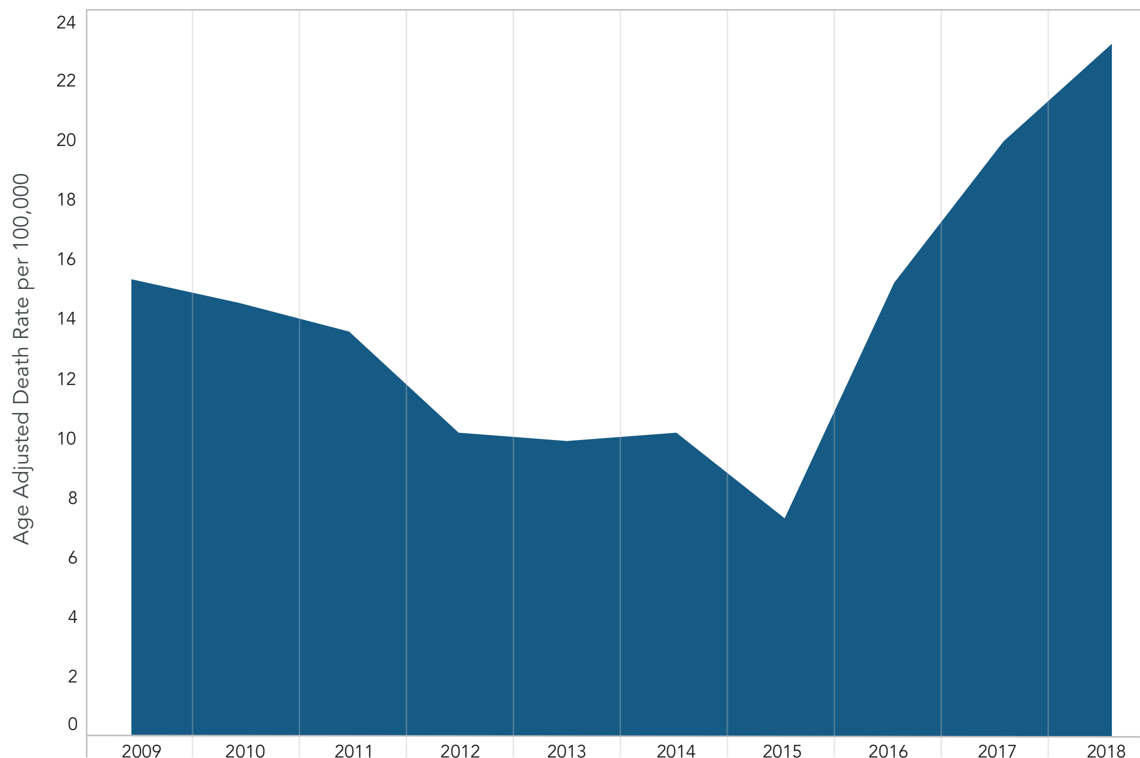
Rates of depressive disorders among adults increased within Schuyler County from 16% in 2016 to 24% in 2018. These percentages specifically reference depression, major depression, dysthymia, and minor depression. New York State excluding New York City in comparison increased from 13% of adults with depressive disorders in 2016 to about 17% in 2018.[12] Percent change for Schuyler County during that timeframe was an increase of 50%, whereas NYS excluding NYC was approximately an increase of 28%; this indicated a strong need for depression interventions. With the occurrence of the COVID-19 pandemic and the current state of mental health within the nation, it is likely that this percentage has increased since then. Depression affects a person's entire wellbeing, including both mental and physical health. It could lead to adverse outcomes such as difficulty sleeping, heart disease, worsening of chronic conditions, substance use disorders and, in more extreme cases, suicide. The CHA/CHIP committee discussed how depression affected residents within Schuyler County, as well as potential contributing factors to the increase the county has witnessed over recent years. Partners felt stigma surrounding mental health and fears regarding treatment for mental health.

High levels of adverse childhood experiences (ACES) were some of the behavioral causes of the increased depression prevalence. Also contributing to this concern were environmental issues such as fewer activities in which the public can participate, limited public transportation, a high patient to provider ratio, the climate and impact of seasonal depression, the COVID-19 pandemic, increased social isolation, and lack of support groups for those experiencing depression. Social determinants of health also contribute via low income, job insecurity, un/underinsured with regard to healthcare, disability status, substance misuse, history of abuse, age, and family history. Partners also voiced how different policies may be worsening the situation. For example, there are a lack of incentives for providers in underserved areas. There are also no grants to provide training for officers or EMTs in crisis intervention involving people with depressive disorder. Additionally, there is a lack of access to inpatient treatment facilities within Schuyler County.

11. NYS Department of Health: I-STOP/PMP - Internet System for Tracking Over-Prescribing - Prescription Monitoring Program, September 2021
12.Behavioral Risk Factor Surveillance System (BRFSS) 2016 & 2018

Decreasing rates of suicide mortality is a third objective for Schuyler County. Suicide rates within Schuyler County were on a gradual decline from 2009 to 2015 (as shown in Figure SC6),[13] but began to increase again in 2016 and continued to climb to an even higher rate of 23.2 per 100,000 in 2018. The 2022 County Health Rankings (which used data from 2016-2020) showed the age-adjusted number of deaths due to suicide per 100,000 population for Schuyler County was 21 (error margin of 15-38), compared to 8 (error margin of 5-25) within New York State.

Figure SC6: Four-Year Average of Age-Adjusted Suicide Mortality Rate per 100,000 Population



Data Source: New York State Vital Statistics Data, 2009 - 2018.
Analysis Completed by Common Ground Health

Partners attributed the suicide rates within Schuyler County to a number of factors. These include the stigma surrounding mental health and asking for help, a lack of a "sense of belonging," people no longer feeling like they are part of something bigger (possibly due to technology and busy lifestyles), and lost connections and isolation (leaving fewer close relationships in which their "signs" could be noticed). The COVID-19 pandemic has only furthered the latter. Additionally, some people have concerns around confidentiality should they decide to seek mental health services, while others experience the "it won't happen to me" mentality.

13. Note: 4-year average utilized instead of 3-year as rates were unstable due to small numerators.

Environmental causes noted included a lack of education around mental health and suicide, lack of resources, providers and funding, untreated depression or manic episodes, social economics, and lack of diversity and inclusion. Furthermore, there is a high incidence of adverse childhood experiences within the community, no in-patient clinics, high availability of alcohol, barriers to transportation, and isolation associated with the rural geography. Current initiatives within Schuyler County that are effective at addressing these root causes consist of support groups, gatekeeper trainings, evidence-based therapies, depression screenings, education on mental health and resources, trained crisis staff within healthcare, normalizing going to doctors and medical providers, as well as having those providers be approachable and client-oriented. Coordination of mental health services with services to support individuals has also been helpful, as has telehealth capabilities (more readily available for local providers); there is flexible scheduling with current mental health clinic hours in Schuyler County. Not only can local providers assist residents, but there are national telehealth mental health providers available to residents as well, and a new national suicide number to call.

Priority Area: Prevent Chronic Diseases

Preventive Care and Management

Cancer screenings are an essential preventive care service that help to detect cancers earlier on when they are more treatable. Pre-pandemic, in 2018 in Schuyler County, about 81% of women aged 40 and older and about 85% of women aged 50-74 completed breast cancer screenings,[14] as well as about 62% of adults aged 50-75 completed colorectal cancer screenings.[15] During the same year, the Finger Lakes region as a whole reported about 71% of women aged 40 and older and about 80% of women aged 50-74, who had an annual household income of less than $25,000, participated in breast cancer screenings.[16] More recent data from the Cancer Services Program shows that, between September 1, 2018 and July 20, 2022, the following screenings were conducted within Schuyler County: Schuyler Hospital Primary Care Center completed 29 clinical breast exams (CBEs) for 16 clients and 7 pap smears for 7 clients, Schuyler Hospital completed 35 mammograms for 21 clients, 4 diagnostics and 4 HPVs, and Schuyler Hospital Montour Falls Extension Clinic completed 2 CBEs and 1 pap smear. With the onset of the COVID-19 pandemic, the nation noticed a troublesome decline in cancer screenings. A paper published in March 2022 showed that cancer screening rates are generally still below pre-pandemic levels (at least through early 2021), especially with colorectal screenings.[17] A study from JAMA Oncology in April 2021 estimated (through July 2020 alone) that disruptions from the pandemic caused more than 9 million breast, colorectal and prostate cancer screenings to be missed.[18]

Not only had the pandemic deterred individuals, but additional challenges to cancer screenings were identified by Schuyler County community partners. The Cancer Services Program (CSP) noted that patients are, often times, afraid of having the screenings completed because they lack an understanding of the procedure itself. Many have also reported that they cannot afford a screening nor treatment if the screening returned with a positive cancer diagnosis. While programs exist in the county to help with such matters, not all are aware of these services and benefits.

14. Behavioral Risk Factor Surveillance System 2018
15. CDC PLACES 2018
16. Behavioral Risk Factor Surveillance System 2018
17. American Cancer Society Journals: Cancer – A national quality improvement study identifying and addressing cancer screening deficits due to the COIVD-19 pandemic, March 2022
18. TODAY: After cancer screenings fell during COVID-19, an effort to reverse the trend, March 2022

Other behavioral factors noted included fear of the unknown and the treatments, lack of an established relationship with a primary care provider, unknowns for the transgender community, as well as being unaware of the need for screenings (screenings may not be seen as important by the patient until symptoms arise). Some members of the public are also unaware of their family history, which can play a major role in their own health. Lack of transportation is another barrier that prevents residents from attaining timely preventive screenings; Medicaid transportation services are available but are not always reliable, and there is limited public transportation. Other social determinants of health considerations include being un/underinsured, a Health Professional Shortage Area for the Medicaid population (for both primary care and mental health care) in Schuyler County, limited childcare, limited employment opportunities that offer benefits, and many individuals living in "survival mode" which places screenings lower on their priorities.

Currently, there are several positive policies in place to promote cancer screenings. First, there are alerts within the electronic medical record at Schuyler Hospital to discuss screenings with patients, for breast cancer screenings specifically; this system was updated in 2022 with quick order sets as well. Second, same day breast cancer screening scheduling is available at the hospital. Third, with regard to colorectal cancer screening, Cologuard is available in offices for patients to utilize. Fourth, the hospital now has Rural Health designation that allows general surgeons to conduct screenings, which increases access to specialty services regardless of insurance type. Schuyler Hospital also has campaigns going out currently along with care coordinators to close gaps based on their payer noncompliant reports. Lastly, the No Surprise Act requires that the patient is provided a quote that is within $400 of the cost incurred. Schuyler County Public Health held educational sessions using an inflatable colon to educate people at community events about colorectal cancer screenings and local resources prior to the pandemic, and also completed focus groups with community members to understand why they have not been screened. In addition, they developed educational campaigns with NYCSP and a local survivor, which were used on social media. One policy that is negatively impacting the goal of increased screenings is when a "screening" is determined to be "diagnostic," as diagnostic brings with it additional costs.

Community Assets and Resources to be Mobilized

The Finger Lakes Region already has a long-standing reputation of collaboration and coordination among its partners. The region also has two designated agencies that promote and facilitate collaboration: Pivital Public Health Partnership (previously the S2AY Rural Health Network) and Common Ground Health. Pivital is a partnership of eight rural health departments in the Finger Lakes Region. The network's focus is on improving the health and well-being of Finger Lakes residents. Common Ground Health covers the same geographic footprint, with the addition of Monroe County, and focuses on bringing together leaders from all sectors – hospitals, insurers, universities, business, nonprofit, faith communities and residents – to collaborate on strategies for improving health in the region. Both agencies provide support, collaboration and resources to improving health of Schuyler County residents.

During brainstorming sessions at the May 12 and June 9, 2022, CHA/CHIP meetings, the following partners were identified to assist with the Prevent Mental and Substance Use Disorders objectives: Department of Social Services, Catholic Charities, school districts, the Chamber of Commerce, local community-based organizations, Schuyler County transit, Mental Health, fitness centers, VA Finger Lakes Healthcare System, MR Hess Home Works, SAFE, RPA #24, the Public Health Department, medical providers, Schuyler Hospital, insurance companies, pharmacies, libraries and churches. The CHA/CHIP team also identified a number of community partners who can assist in increasing cancer screening rates. Family and friends of patients can be resources when it comes to some of the behavioral causes identified previously, and partners such as primary care providers, the hospital, Public Health, Department of Social Services, Office for the Aging, food pantries, New York Cancer Services Program, The ARC of Chemung-Schuyler, and the Medicaid transport program could all partake in this initiative to work toward better outcomes.

Through implementation of the Community Health Improvement Plan, Schuyler County CHA/CHIP partners will work to leverage these pre-existing agencies and services. The Schuyler County Community Health Improvement Plan document has a full description of interventions and partner roles.

Community Health Improvement Plan/Community Service Plan

As previously discussed in Main Health Challenges, a multi-voting technique was used to select the priority areas for the Community Health Assessment and Community Health Improvement Plan. County specific pre-read documents were provided to the Schuyler County CHA/CHIP team which included updated data measures for each of the five priority areas outlined in the Prevention Agenda. This was followed with additional county specific data on objectives within the chosen priority areas to help identify objectives, disparities and interventions to include within the plan. A concerted effort took place during the month of November to ensure the governing Community Health Assessment and Community Health Improvement Plan body was equipped with a diverse and inclusive group which represented all areas of health and well-being in the county. The following organizations were engaged in Schuyler County's planning and prioritization process:

SCHUYLER COUNTY PLANNING AND PRIORITIZATION AGENCIES		
Southern Tier Cancer Services Program	ProAction	VA Finger Lakes Healthcare System
Schuyler Hospital	Cornell Cooperative Extension	Foodbank
Pivital Public Health Partnership	Schuyler County Public Health	Schuyler County Coalition on Underage Drinking and Drugs (SCCUDD)
Schuyler County Social Services	Schuyler County Chamber of Commerce	Schuyler Hospital Primary and Convenient Care (PCC)
Common Ground Health	Community Services	Schuyler County Mental Health
Schuyler County Sheriff	Schuyler County Office of the Aging	MR Hess Home Works
URMC Wilmot Cancer Institute	The Falls Home	University of Rochester Medical Center
Catholic Charities		

The public health department and their team of community partners at Schuyler County CHA/CHIP meetings discussed and determined interventions to target the selected priority areas. Each member was expected to highlight where resources already existed and could be leveraged. Coordinated efforts to promote and engage community members in selected initiatives will continue to take place. A full description of objectives, interventions, process measures, partner roles and resources are available in the Schuyler County Community Health Improvement Plan. All interventions selected are evidence based or evidence-informed and strive to achieve health equity by focusing on creating greater access for the low-income population, the disparity identified by Schuyler County.

The Schuyler County CHA/CHIP team, a group of diverse partners who meet bi-monthly to improve the health of Schuyler residents, will oversee the Community Health Improvement Plan progress and implementation. Attendees at these meetings will regularly review progress and relevant data on each measure. Group members will identify and address any mid-course corrections in interventions and processes that need to take place during these meetings.

Dissemination

The Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) will be shared via Schuyler County Public Health's website and social media pages:

- Website: https://schuylercounty.us/621/About-Schuyler-County-Public-Health
- Facebook: https://www.facebook.com/SchuylerPublicHealth
- Instagram: https://www.instagram.com/schuyler_ph/
- Twitter: https://twitter.com/SchuylerCoPH

Schuyler County, Vineyard
Photo courtesy of Schuyler County Public Health

APPENDIX 1

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APPENDIX 2

RESULTS BASED ACCOUNTABILITY™

Results Based Accountability™ is a disciplined way of thinking and acting to improve entrenched and complex social problems. To facilitate CHA/CHIP development, resulting in a CHIP that measurably improves health, the following steps were followed:

1. **Define the Community:** Data collection is an important first step. In this step, it is important to gather data for the community at large (county-level data) as well as data that identified vulnerable populations within the community who are at risk for poorer health outcomes. This can happen by collecting and analyzing data that shows differences in rates of illness, death, chronic conditions and more in relationship to demographic factors. The planning committee brainstormed specific potential vulnerable populations in the county to be considered with data collection.
2. **Engage Stakeholders:** Population health requires engagement from many sectors. Complex social, economic and environmental factors are all determinants of health; therefore, there is no one organization, department or program that can be held solely responsible for the health of a population. Diverse engagement began in November/December 2021, early in the CHA development process. Committee partners completed an exercise to brainstorm potential new partners from the following sectors: Local Government, Businesses, Not-for-Profit and Community Organizations, Academia and the General Public. The following questions were used to assist brainstorming:
   - Who are those with potential interest and influence who can contribute to the CHA/CHIP process?
   - What population do they represent? (including vulnerable populations identified in Step 1)
   - Identify their potential level of interest and influence (High Interest/High Influence, Low Interest/High Influence, High Interest/Low Influence, Low Influence/Low Interest)
   - Who would be the best person on the committee to extend an invitation to the selected potential new partner?

After an assessment of brainstormed information, personal invitations were made to selected potential new partners to address any gaps on the committee and the need for diverse engagement.

3. **Engage in Comprehensive Data Collection:** Both primary and secondary data were collected. Disaggregated data was collected by race, gender, income and geography as available to identify vulnerable populations and to assist in strategy development. Data sources included, but were not limited to:
   - Common Ground Health: My Health Story
   - County Health Rankings
   - Vital Statistics
   - Behavioral Risk Factor Surveillance Survey (BRFSS)
   - United States Census Bureau
   - Cornell University Program on Applied Demographics
   - Statewide Planning and Research Cooperative System (SPARCS)
   - New York State Department of Health Perinatal Data Profile
   - S2AY Rural Health Network Inc,: The Impact of COVID-19 on Food Security and Healthy Eating
   - Outreach to county committee partners for data from their respective organizations.

4. **Prioritize Health Issues:** Data was analyzed and presented by Common Ground Health. After a review of analyzed health outcome data for trends, current state against benchmarks or Prevention Agenda targets, and differences among populations, a multi-voting tool was used by committee members to rank the health issues using selected criteria to identify top Focus Areas, which identified Prevention Agenda Priority Areas.

5. **A Deeper Dive of data was conducted by Common Ground Health.** To enhance the picture of the selected Focus Areas, related Prevention Agenda objective data was presented. A table with objectives and their status colors was created to help with the selection of objectives for this CHA/CHIP cycle.
   - Green Status – the prevention goal metric has been met and the trend of that metric is in the correct direction of the goal or steady
   - Yellow Status – either the prevention goal has not been met but the trend is in the correct direction or the goal has been met but the trend is in the wrong direction
   - Red Status – the goal has not been met and the trend is in the wrong direction
   - Gray Status – there is limited data on this metric available at this time

   In addition, person, place and time was analyzed:
   - Person - Are there certain populations at higher risk for poor outcomes?

   For example, are outcomes different based on age, race/ethnicity, education, or socio-economic status?
   - Place - Are the outcomes in the county higher or lower than neighboring counties and the rest of the state? Are there high-risk neighborhoods in the county?
   - Time - Do the trends over time show the outcomes improving, remaining the same, or declining?

If multiple objectives were identified, additional consideration was given to objectives that may have a greater impact on long term health and also have a good chance of positively impacting other objective indicators.

6. **Develop the Story Behind the Data:** Understanding the story behind the data ("WHY" the data looks the way it does) contributes to an increased understanding of the factors that impact the current state, as well as identifies contributing causes and potential solutions designed to have maximum impact. Results Based Accountability's Turn the Curve Thinking was conducted for selected CHIP objectives/indicators to examine:
   - What is the story? What are the contributing causes to the trend of the selected CHIP objectives, including behavioral, environmental, policy and social determinant of health factors? 5 WHYS was conducted to help identify root causes.
   - Who are the partners that have a role in impacting contributing causes? What community assets or resources can be mobilized to impact identified causes?
   - What works to address identified contributing causes (including evidenced based interventions)?

Turn the Curve Thinking also determined a data development agenda, where counties identified if any additional data was needed on selected objectives and/or disparities, as well as a plan on how to collect that data.

7. **Select CHIP Interventions:** Upon completion of Turn the Curve Thinking, criteria was used to select interventions that will be included on the CHIP. Criteria used included:
   - How strongly will the proposed strategy impact progress as measured by the baselines?
   - Is the proposed strategy feasible?
   - Is it specific enough to be implemented?
   - Is the strategy consistent with the values of the community and/or agency?

Turn the Curve Thinking resulted in interventions which were linked with contributing causes and partners who could have an impact. It is our goal that, with successful implementation of diverse strategies by diverse partners, there will be a collective impact on Turning the Curve for the better on our CHIP objectives.

8. **Engage in Continuous Improvement:** To effectively monitor progress and effectiveness of each organization's contribution to selected CHIP objectives, intervention performance measures were identified that answer the questions:
   - How much did we do?
   - How well did we do it?
   - Is anyone better off?

Monitoring these intervention specific performance measures will identify if any focused quality improvement projects are required to improve intervention effectiveness and/or if revisions to CHIP interventions are required.

Schuyler County, Seneca Lake from Clute Park
Photo courtesy of Schuyler County Public Health

APPENDIX 3

PREVENT MENTAL & SUBSTANCE USE DISORDERS: SUMMARY

OBJECTIVE	OBJECTIVE DESCRIPTION	STATUS	NOTES
2.1.2	Reduce the age-adjusted percentage of adult (age 18 and older) binge drinking (5 drinks or more for men during one occasion, and 4 or more drinks for women during one occasion) during the past month		
2.2.4	Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate		
2.4.1	Reduce the prevalence of major depressive disorders		
2.5.2	Reduce the age-adjusted suicide mortality rate		
2.2.3	Reduce the opioid analgesics prescription for pain, age-adjusted rate		
2.2.1	Reduce the age-adjusted overdose deaths involving any opioid		
2.2.2	Increase the age-adjusted rate of patients who received at least one Buprenorphine prescription for opioid use disorder		
Note: Objectives 2.1.1, 2.1.3, 2.3.1, 2.3.2, 2.3.3, 2.4.2, 2.5.1, and 2.6.1 had limited/unreliable data.			

PREVENTIVE CARE & MANAGEMENT: SUMMARY

OBJECTIVE	OBJECTIVE DESCRIPTION	STATUS	NOTES
4.3.2	Decrease the percentage of adult Black Medicaid members with diabetes whose most recent HbAlc level indicated poor control (>9%)		NYS Data Only
4.3.5	Increase the percentage of adult Black Medicaid members who had hypertension whose blood pressure was adequately controlled during the measurement year		NYS Data Only

PREVENTIVE CARE & MANAGEMENT: SUMMARY

OBJECTIVE	OBJECTIVE DESCRIPTION	STATUS	NOTES
4.1.1	Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines - Age 40+		FLR Data Only
4.1.1	Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines - Age 50-74		FLR Data Only
4.1.3	Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 5O to 75 years)		
4.2.1	Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%		
4.2.2	Increase the percentage of low-income (<$25,000) adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%		FLR Data Only
4.3.3	Decrease the percentage of adult Medicaid members aged 18-44 with diabetes whose most recent HbAlc level indicated poor control (>9%)		NYS Data Only
4.3.6	Increase the percentage of adult Medicaid members 18-44 who had hypertension whose blood pressure was adequately controlled during the measurement year		NYS Data Only
4.3.8	Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups - All		
4.3.9	Increase the percentage of members (ages 5-64) who were Identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 5-18 (MMC)		Western NY Data Only
4.3.9	Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 19-64 (MMC)		Western NY Data Only
4.3.10	Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year - 19-64 (MMC)		Western NY Data Only
4.3.11	Increase the percentage of adults with HTN who are currently taking medicine to manage their high blood pressure		

PREVENTIVE CARE & MANAGEMENT: SUMMARY

OBJECTIVE	OBJECTIVE DESCRIPTION	STATUS	NOTES
4.1.4	Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (adults with an annual household income less than $25,000)		FLR Data Only: Age 50-75
4.1.5	Increase the percentage of adults aged 50-64 who receive a colorectal cancer screening based on the most recent guidelines		FLR Data Only
4.2.3	Increase the percentage of children and adolescents ages 3 - 17 years with an outpatient visit with a primary care provider or OB/GYN practitioner during the measurement year who received appropriate assessment for weight status during the measurement year by 5% - HMO		Western NY Data Only
4.2.3	Increase the percentage of children and adolescents ages 3 -17 years with an outpatient visit with a primary care provider or OB/GYN practitioner during the measurement year who received appropriate assessment for weight status during the measurement year by 5% - MMC		Western NY Data Only
4.3.1	Decrease the percentage of adult members with diabetes whose most recent HbAlc level indicated poor control (>9%) - HMO		
4.3.1	Decrease the percentage of adult members with diabetes whose most recent HbAlc level indicated poor control (>9%) - MMC		
4.3.4	Increase the percentage of adult members who had hypertension whose blood pressure was adequately controlled during the measurement year - HMO		
4.3.4	Increase the percentage of adult members who had hypertension whose blood pressure was adequately controlled during the measurement year - MMC		
4.3.7	Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups - 0-4		
4.3.7	Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups - 0-17		
4.3.7	Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups - All		
4.3.8	Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups - 0-4		

PREVENTIVE CARE & MANAGEMENT: SUMMARY

OBJECTIVE	OBJECTIVE DESCRIPTION	STATUS	NOTES
4.3.8	Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups - 0-17		
4.3.9	Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 5-18 (Commercial HMO)		Western NY Data Only
4.3.9	Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 5-18 (Commercial PPO)		Western NY Data Only
4.3.9	Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 19-64 (Commercial HMO)		Western NY Data Only
4.3.9	Increase the percentage of members (ages 5-64) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period during the measurement year - 19-64 (Commercial PPO)		Western NY Data Only
4.3.10	Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year- 5-18 (Commercial HMO)		Western NY Data Only
4.3.10	Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year- 5-18 (Commercial PPO)		Western NY Data Only
4.3.10	Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of a.so or greater during the measurement year- 5-18 (MMC)		Western NY Data Only
4.3.10	Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year - 19-64 (Commercial HMO)		Western NY Data Only

PREVENTIVE CARE & MANAGEMENT: SUMMARY

OBJECTIVE	OBJECTIVE DESCRIPTION	STATUS	NOTES
4.3.10	Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year - 19-64 (Commercial PPO)		Western NY Data Only
4.4.1	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		Western NY Data Only
*Note: Objectives 4.1.2, 4.3.12, and 4.4.2 had limited/unreliable data.			

SCHUYLER COUNTY: SELECTED OBJECTIVES

2.2.3	Reduce the opioid analgesics prescription for pain, age-adjusted rate		
2.4.1	Reduce the prevalence of major depressive disorders		
2.5.2	Reduce the age-adjusted suicide mortality rate		
4.1.1	Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines - Age 40+		FLR Data Only
4.1.1	Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines - Age 50-74		FLR Data Only
4.1.3	Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years)		