



Priorities for Monroe County

Adult and Older Adult Health Report Card



September
2008

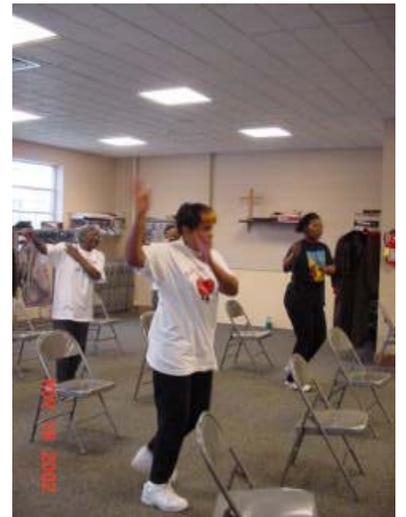


Table of Contents

INTRODUCTION.....	1
The HEALTH ACTION Process.....	1
Health Disparities	2
HEALTH ACTION Priorities for Adult/Older Adult Health 1999-2007	4
Next Steps for Adult and Older Adult Health in Monroe County.....	7
Report Card Format.....	7
Statistically Significant Differences Between Indicators.....	7
BACKGROUND DATA	8
DEMOGRAPHIC & SOCIO/ECONOMIC DATA	8
Population By Age Group.....	8
Projections By Age Group	8
Population By Residence and Age Group	9
Race/Latino Origin	9
Older Adults Living Alone.....	10
Income Below the Poverty Level.....	11
Educational Status	12
Unemployment Rate.....	13
GENERAL HEALTH DATA	14
ACCESS TO HEALTH CARE	14
Medicaid and Family Health Plus Enrollment.....	14
Health Insurance.....	14
Discontinuously Uninsured	15
Access to a Personal Health Care Provider.....	16
Could Not Afford Medical Care.....	16
Visited the Doctor for a Routine Check-up in the Past Year	17
Dental Insurance Coverage	17
HEALTH STATUS	17
Self- Reported Health Status	17
Functional Limitations Due to Physical Health.....	18
LEADING CAUSES OF DEATH.....	19
HEALTH ISSUES AND GOALS (ADULTS OF ALL AGES)	20
CHRONIC DISEASES AND CONDITIONS	20
Deaths Due to Chronic Diseases.....	20
Hospitalizations Due to Chronic Diseases.....	23
Cancer Incidence.....	25
Self Reported Prevalence of Chronic Diseases/Conditions	26
GOALS FOR CHRONIC DISEASE PREVENTION/MANAGEMENT	28
Goal: Increase Physical Activity and Improve Nutrition	28
Overweight and Obesity.....	28

No-Leisure-Time Physical Activity.....	30
Meet Recommended Physical Activity Guidelines	31
Fruit/Vegetable Intake	31
Calcium Intake	32
Purchasing/Consuming Foods High in Fat/SaturatedFat/Trans Fat.....	32
Preventive Counseling Related to Diet and Eating Habits.....	33
Goal: Reduce Cigarette Smoking.....	34
Current Smoking	34
Tried to Quit Smoking in the Past Year	35
Doctor Talked with Them About Smoking	35
Goal: Improve Management of Chronic Disease	36
Management of Chronic Conditions, Managed Care Performance.....	36
Physician Counseling Related to Physical Activity and Nutrition among those with Diabetes, High Blood Pressure and/or High Cholesterol	37
Physical Activity among those with Diabetes, High Blood Pressure, and/or High Cholesterol.....	37
Food Intake Behaviors among those with Diabetes, High Blood Pressure and High Cholesterol	38
PREVENTIVE HEALTH SERVICES	39
Goal: Promote Use of Preventive Health Services	39
Immunization Rates.....	39
Mammography Rates.....	40
Cervical Cancer Screening.....	40
Colorectal Cancer Screening	41
Blood Pressure Screening and Awareness.....	42
Cholesterol Screening.....	42
Under Doctor's Care for High Blood Pressure and High Cholesterol.....	42
MENTAL HEALTH	43
GOALS FOR MENTAL HEALTH	43
Goal: Improve Mental Health	43
Deaths Due to Suicide.....	44
Hospitalizations Due to Self-Inflicted Injuries.....	45
Self-Reported Suicide Attempts	45
Frequent Mental Distress	46
Functional Limitations Due to Emotional/Mental Health Issues.....	46
Use of Medication for Mental Health Problems	47
Preventive Counseling for Mental Health Problems.....	47
Mental Health Problems Among Older Adults Served by Eldersource...	47
Goal: Reduce Alcohol Use Disorders and Substance Abuse	48
Alcohol Use Disorders (Based on Self-Report).....	48
Past Month Marijuana Use	49
Preventive Counseling for Alcohol and Drug Use.....	49
Drinking and Driving	49
Arrests for Driving While Intoxicated	50
Drug Arrests	50

Goal: Reduce Violence	52
Homicides	52
Hospitalizations Due to Assault	53
Intimate Partner Violence	54
Sexual Abuse	55
Reported Violent Crimes.....	55
HEALTH ISSUE AND GOAL (ADULTS UNDER AGE 65 YEARS OLD)	
.....	57
SEXUALLY TRANSMITTED DISEASES (Including HIV).....	57
Goal: Reduce Sexually Transmitted Diseases (Including HIV)	57
New Cases of HIV.....	57
HIV New Case Rate.....	58
New Cases of HIV by Exposure Category	58
Gonorrhea.....	59
Chlamydia.....	61
Syphilis.....	62
Selected Risk Factors for HIV and STDs.....	62
HEALTH ISSUES AND GOALS (ADULTS AGE 65 YEARS AND OLDER)	
.....	64
DISABILITIES AND FUNCTIONAL STATUS	64
Disabilities Among Non-Institutionalized Adults Aged 65 Years and Older.....	64
Goal: Promote Optimal Level of Functioning.....	65
Self-Reported Health Status, Functional Limitations and Mental Health Indicators	65
Falls.....	66
ELDER ABUSE	68
Goal: Reduce Elder Abuse.....	68
Self-Reported Risks for Elder Abuse.....	69
Elder Abuse Referrals (LifeSpan and Adult Protective Services).....	69
APPENDIX.....	
.....	71
Data Technical Notes	71
Adult/Older Adult Health Report Card Advisory Group.....	74

**For more information about data found in this report card call the Monroe County Department of Public Health at 753-5331.

INTRODUCTION

Improving the health status of the community will require that we expand efforts to target areas that were traditionally thought to be outside of the realm of health care. The US spends more on health care than any other nation, yet ranks very low in most health status indicators. Most of our health care dollars are spent on treating health problems, but very little is spent on preventing them before they occur. There is significant scientific evidence demonstrating that as much as 70% of health is influenced by behaviors, social circumstances (income and education) and environmental exposures (toxic and microbial agents), while access to health care is only responsible for 10% of health status. When access to health care is important, those who need it often don't receive it, they receive it too late, or they receive poor quality care.¹

HEALTH ACTION began over ten years ago when several health and planning agencies in Monroe County came together to develop a strategy to improve the health status of the community. The vision for **HEALTH ACTION** is continuous, measurable improvement in health status among Monroe County residents. Two overarching goals are to increase the quality and years of healthy life and eliminate health disparities. These are also the goals for the US Department and Health and Human Services Healthy People 2010, Goals for the Nation².

The foci of **HEALTH ACTION** are prevention of disease onset and early detection/preventive care to improve health outcomes. In April of 2008, the NYS Health Commissioner launched the Prevention Agenda which requires that local health departments work with hospitals to assess community health needs, identify health priorities and develop public health programs to address the priorities. Monroe County's efforts are aligned with the New York State Health Department's Prevention Agenda. Local health systems, health insurers, the Latino and African American Health Coalitions, the Monroe County Medical Society, the Finger Lakes Health Systems Agency and the Rochester Business Alliance are represented on the **HEALTH ACTION** steering committee.

The priority areas for the Prevention Agenda include:

- Physical Activity and Nutrition
- Chronic Disease and Cancer
- Mental Health and Substance Abuse
- Healthy Mothers, Healthy Babies
- Tobacco Use
- Healthy Children
- Unintentional Injury
- Healthy Environment
- Access to Quality Health Care
- Infectious Diseases
- Community Preparedness

The **HEALTH ACTION** Process

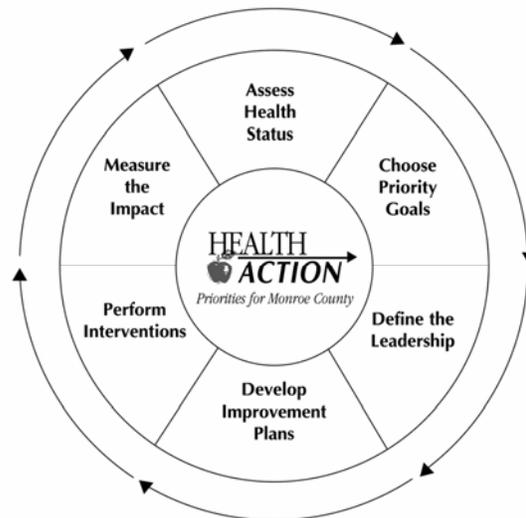
HEALTH ACTION works to improve community health by selecting priorities for action from health goals identified in community health report cards¹ in each of five focus areas:

- Maternal and Child Health
- Adolescent Health
- Adult Health
- Older Adult Health
- Environmental Health

¹ Schroder, Steven. "We can do better on Improving the Health of the American People." NEJM, 2007: 357:1221-8.

² <http://www.healthypeople.gov>

The process used by **HEALTH ACTION** for each of the five focus areas is shown in the graphic to the right and is described in detail below.



Assess Health Status

A **HEALTH ACTION** report card advisory committee representing various agencies working to address health issues within the particular focus areas is formed to steer the health assessment. For each focus area, data detailing health status, access to health care and health behaviors are analyzed to identify trends and disparities, and to compare Monroe County to other communities. The advisory committee develops 7-10 health goals based on issues supported by the data. The goals and data are published in a report card.

Choose Priority Goals

Several community forums are held with both professional groups and Monroe County residents. The goals of the forums are to: 1. educate participants about health issues in the community and 2. obtain feedback from participants about which health goals should be priorities for action for the next 4-5 years. Based on community input collected during the forums, and recommendations from the report card advisory committee, the Board of Health selects two health goals as priorities for action for each focus area.

Identify Leadership

For each health goal selected as a priority for action, an organization is identified to take the lead in addressing the health goal. Often there is an existing organization that is able to take this leadership role, and sometimes a new group is formed. These lead organizations are called **HEALTH ACTION** Partnerships.

Develop an Improvement Plan, Perform Interventions and Evaluate the Impact

Each **HEALTH ACTION** Partnership develops an improvement plan to address the health goal and then oversees the implementation and evaluation of the interventions.

Health Disparities

Eliminating health disparities is an overarching goal of **HEALTH ACTION**. Health disparities are differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions among specific population groups. This report includes descriptions of significant health disparities by residence (a proxy for socioeconomic status), race and ethnicity. Disparities in the following areas are noted in this report:

- health insurance coverage
- chronic disease prevalence, hospitalization, deaths
- functional limitations due to physical and emotional health
- sexually transmitted diseases
- violent deaths and hospitalizations
- reported health risk behavior

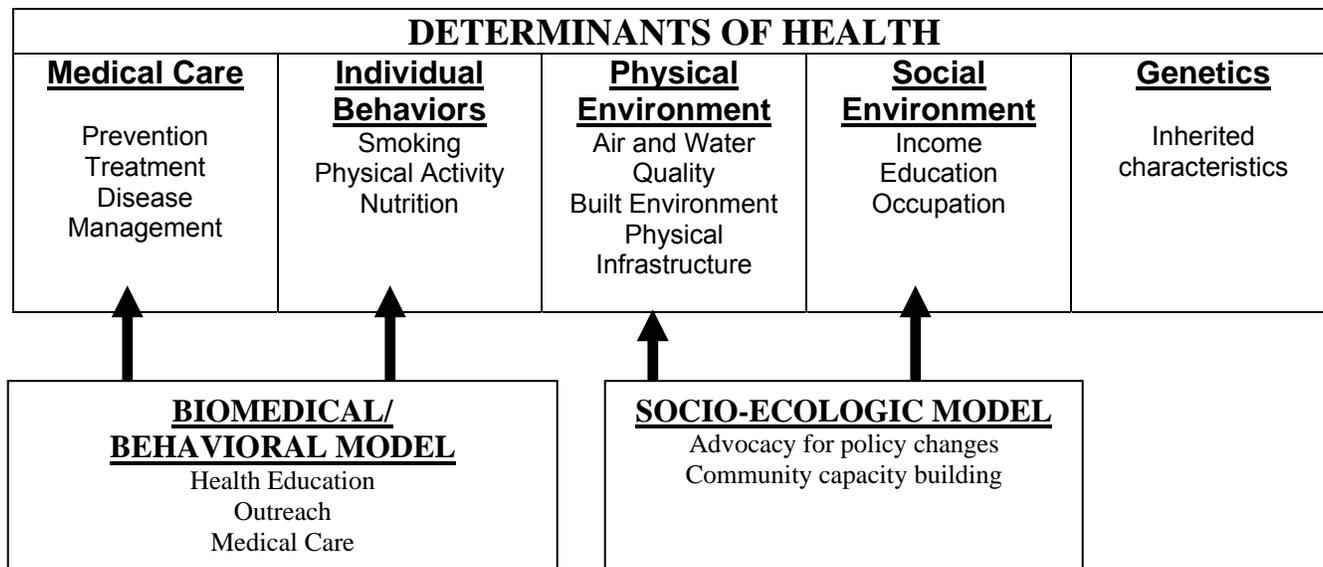
HEALTH ACTION affirms that we can not achieve our vision of community health status improvement without effectively addressing the marked health disparities in Monroe County. Historically, many of the interventions implemented by **HEALTH ACTION** partners and the Monroe County Department of Public Health have focused on eliminating health disparities. These include the Healthy Living Program, the Women’s Health Partnership and READII. **HEALTH ACTION** will continue to ensure that interventions designed to promote health AND reduce health disparities will be incorporated into health improvement plans developed for the new adult/older adult health priorities.

Stakeholders are recognizing that reducing disparities requires an expanded understanding of health to include not only the complexity of human behavior and the innovation of medical technology, but also the social and environmental settings within which people live and interact. The acknowledgement of, and appreciation for the need to consider the contextual nature of health and disease is the starting point for addressing what are called determinants of health.

The figure below shows the five determinants of health based on the Evans-Stoddart model.³ All of these determinants are modifiable with the exception of genetics (although genomics holds some promise for targeting future interventions). The determinants are listed separately, however, there are complex interactions between them and their influence on health.

For the past several decades public health interventions have used the biomedical/behavioral model and focused on addressing the medical care and behavioral determinants of health. Examples of these interventions include: health education programs, outreach to connect individuals to needed services, and the provision of medical care.

There is a growing consensus that in order to reduce health disparities, communities will need to broaden their strategies to address the physical and social determinants of health. Examples of these types of interventions would be advocacy for policy changes and community capacity building.



Local and state health departments across the nation are updating their health improvement strategies from solely biomedical/behavioral approaches to identifying and promoting interventions and strategies that are better equipped to address the social and economic issues that broadly impact community health conditions. Locally, the Finger Lakes Health System Agency, through its Latino and African

³ Evans RG, Stoddard GL. Consuming health care, producing health care. *Social Science Medicine*. 1990; 33 (12): 1347-1363.

American Health Coalitions, is looking at cultural and environmental issues that are driving the significant disparities and is developing a plan to address the priority root causes. In addition, the Greater Rochester Health Foundation has funded four neighborhood community health improvement projects within economically disadvantaged sections of the City of Rochester. **HEALTH ACTION** supports these initiatives that focus on addressing health disparities.

HEALTH ACTION Priorities for Adult/Older Adult Health 1999-2007

The first Adult and Older Adult Health Report Cards were published in 1998. In 1999, four health goals for adults and older adults were selected as priorities for action. Below are the goals:

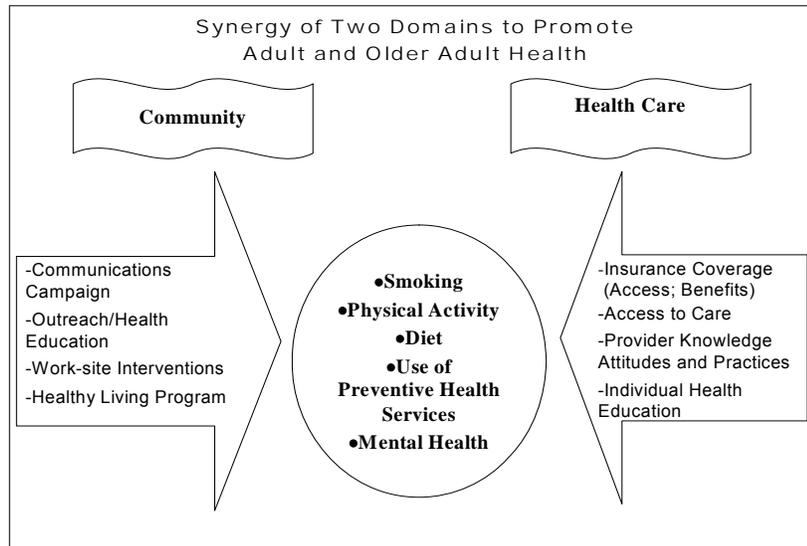
Adult:

- Promote healthy behaviors to prevent chronic disease
- Promote use of preventive health services, including screening for substance abuse and depression

Older Adult:

- Promote behaviors that prevent or delay complications from chronic disease.
- Promote use of preventive health services, including screening for substance abuse, depression, dementia and nutrition.

Since the priorities for action were very similar in both the adult and older adult age groups, the Board of Health recommended the development of a single plan to address adult and older adult health priorities. Rather than establishing four partnerships to address the goals, the group elected to develop strategies as shown in the schematic to the right.



A summary of some of the strategies/interventions in Monroe County to address these goals can be found below and on the following pages.

Healthy Living Program (HLP) (Vida en Salud)

The Healthy Living Program was designed by local health experts and targets inner city underserved populations. The twelve week, 24 session program includes physical activity classes tailored to the fitness levels of participants, and health promotion classes that focus on using the strength of social support, empowerment, and goal setting to improve the health of participants. More than 1,300 Monroe County residents have participated in the 12 week

program since its inception in 2001. The program is now supported by the Center for Community Health of the University of Rochester and has a sister program in the Latino community, Vida en Salud.

BEACTIVE ROCHESTER.COM

The Beactiverochester.com website was developed to educate the community about the benefits of physical activity, and ways to be active in the Rochester area. This website is no longer active, however, Excellus developed a similar website called STEP UP. For more information go to: <http://www.stepup.excellusbcbcs.com/>.

Worksite Health Alliance

The Worksite Health Alliance of Greater Rochester (WHAGR) was founded in 2001 as a non-profit membership organization dedicated to promoting workplace wellness. Now in collaboration with Preferred Care, WHAGR provides regular "Well Workplace Universities" to assist employers with implementing wellness activities within their organizations. Membership of the WHAGR has grown from 5 to over 70 members representing more than 25,000 employees. For more information go to: <http://www.whagr.org/whagr/history.html>.

Additional Programs to Increase Physical Activity and Improve Nutrition

There are numerous other programs that promote physical activity among Monroe County residents. Some of these programs are Eat Well/Live Well, Cornell Cooperative Extension, mall-walking programs, classes offered at community centers, fitness centers, health clubs, schools, towns, City of Rochester recreation centers, senior centers and those offered by health insurers. Program costs vary, and health insurers offer limited discounts for selected programs. In addition, the Greater Rochester Health Foundation has initiated a major initiative to address childhood obesity.

New York State Tobacco Control Program

Established in 2000, the NYTCP has established a comprehensive, aggressive and effective program built upon a foundation of community partners and evidence-based strategies from both the CDC Best Practices for Comprehensive Tobacco Control and The Community Guide to Community Preventive Services. The program seeks to promote cessation of tobacco use, reduce the social acceptability of tobacco use, prevent initiation of tobacco use and eliminate exposure to secondhand smoke. A multi-pronged strategic approach is utilized. Most recently this program implemented a strong clean indoor air law, increased support for high tobacco taxes to keep tobacco products away from children and to motivate adults to quit, increased access to effective cessation services, and worked to reduce the social acceptability of tobacco use in the community. All of these strategies have been shown to decrease smoking rates. Below is a brief discussion of but a few of the program's components.

Cessation Centers: There are 19 state funded Cessation Centers across the state including the Greater Rochester Area Tobacco Cessation Center (GRATCC), housed in the University of Rochester Medical Center. These centers offer provider training, technical assistance and follow-up to health care providers and institutions to implement tobacco screening and interventions for every patient who smokes. They assist practices with implementing effective office systems to screen for smokers and provide evidence based training and materials. A newer method is to target parents who smoke during pediatric visits. Intensive one-on-one counseling is also available through the center for a limited number of persons referred by physicians. Both the Cessation Centers and Community Partnerships (noted below) have been active in promoting Smoke-Free Campuses whereby an entire property must be tobacco-free.

Quitline and Quitsite: New York hosts both a smokers' Quitline (1866 NY QUILTS) and Quitsite (www.nysmokefree.com). Both services are free and confidential that provide effective stop smoking services to all New Yorkers. Counseling is available in English and Spanish with special arrangements available for other languages. Free nicotine replacement therapy starter kits is provided to eligible smokers. Callers can either speak with a trained quit coach or listen to recorded self help information. The Quitline is open Monday-Friday, 9-9 and Saturday and Sunday, 9-1. Similar information and content is available at the Web site including a listing of the various stop smoking programs. Various media activities drive traffic to the QuitLine. 6,268 Monroe County residents called the Quitline in 2007.

Community Partnerships: There are 29 state funded community partnerships in NY including the Smoking and Health Action Coalition of Monroe County. Partnerships engage local stakeholders, educate community leaders and the general public, mobilize the community around tobacco control policy issues such as reducing tobacco advertising and promotion and reducing exposure to secondhand smoke. Reducing the social acceptability of tobacco use is a primary goal of the community partners. This is accomplished by reducing exposure to secondhand smoke, reducing advertising and promotion of tobacco products, and more recently by advocating for smoke-free multi-unit dwellings.

Voluntary Health Organizations, Health Insurers and Other Stop Smoking Resources: For many years, most of the national voluntary health organizations (American Heart, American Cancer, and American Lung) conducted group cessation clinics. Most have now shifted their focus on other methods to promote cessation. For example, the American Cancer Society has shifted to working with worksites to both assist them in adopting smoke-free policies and to train their staff in how to conduct a stop smoking program for employees. Excellus BC/BS has implemented a 'Quit For Life' program which offers one-on-one coaching and nicotine replacement therapy for members. There are a number of other cessation services available including Nicotine Anonymous and hospital-based classes. This is not an exhaustive list.

The Health Partnership

The Health Partnership of Monroe County (HPMC), formerly the Women's Health Partnership, is a program of the University of Rochester's Center for Community Health, and is funded by NYS Department of Health Cancer Services Program. Established in 1993, HPMC is a coalition of over 40 community agencies and over 100 health care providers whose mission is to assist women and men facing barriers to optimal health by providing access to educational, clinical and supportive services.

The Health Partnership provides funding for breast, cervical and colorectal cancer screening, diagnosis, and case management services to over 2,000 uninsured or underinsured individuals annually. As a collaborative, it also offers numerous support services, such as transportation to assist clients in overcoming barriers to accessing health care. Clients diagnosed with breast, cervical, colorectal or prostate cancer through the program receive assistance with their application for the Medicaid Cancer Treatment Program, which provides for treatment of these cancers. For more information please call 585-753-5978 or 1-877-293-0822

Racial and Ethnic Adult Disparities in Immunization Initiative (READII)

READII was funded by the Centers for Disease Control and Prevention to promote adult immunizations among African American and Latino older adults. The Rochester READII program consisted of two components: a system of comprehensive intervention in medical practices and physician offices and a community-based network of outreach and education.

The READII program worked directly with eight inner-city neighborhood health clinics, hospital based clinics, and group practices, effectively targeting the majority of Monroe County's African American seniors. Outreach workers collaborated with health center staff to identify seniors who

were behind on their annual immunizations and actively and repeatedly reached out to these individuals until they came into the doctor's office for their shots. This process – called tracking, recall, and outreach – is modeled after a successful program used in Monroe County to eliminate childhood vaccine disparities in the 1990s.

READII also partnered with many community organizations, including Action for a Better Community (ABC), Lifespan, Southwest Area Neighborhood Association, and the Urban League, to raise community awareness about vaccinations and reach out directly to African American and Latino seniors.

The program's coordinated approach has had a significant impact. The Monroe County Adult Health survey conducted in 2000 revealed that influenza and pneumococcal vaccination rates for African American seniors were below 40 percent. Six years later, African American vaccination rates were 70 percent and higher – comparable to those of white seniors – and are now among the highest in the nation.

Next Steps for Adult and Older Adult Health in Monroe County

The publication of this report card marks the beginning of a new cycle of the **HEALTH ACTION** process addressing adult and older health priorities in Monroe County for the next several years.

In the fall of 2008, several forums will be held to obtain input about which health goals should be the new priorities for action. The Adult/Older Adult Health Report Card Committee will use this input to make recommendations to the Monroe County Board of Health about which goals should be selected as priorities. Once goals are selected, **HEALTH ACTION** will oversee the process of developing and implementing health improvement plans for each goal.

Report Card Format

This report card combines health issues and goals for adults and older adults. While several health issues are common among both age groups, there are certain issues that occur more frequently within specific age populations. In this report card, there are three separate sections for health issues and goals to account for these similarities and differences by age group as shown below.

- **Health Issues and Goals for Adults of All Ages**
 - Chronic Diseases and Conditions
 - GOAL: Increase physical activity and improve nutrition
 - GOAL: Reduce cigarette smoking
 - GOAL: Improve management of chronic disease
 - Preventive Health Services
 - GOAL: Promote use of preventive health services
 - Mental Health
 - GOAL: Improve mental health
 - GOAL: Reduce alcohol use disorders and substance abuse
 - GOAL: Reduce violence
- **Health Issue and Goal for Adults Under Age 65**
 - Sexually Transmitted Diseases
 - GOAL: Reduce sexually transmitted diseases including HIV
- **Health Issues and Goals for Adults Aged 65 Years and Older**
 - GOAL: Promote optimal level of functioning
 - GOAL: Reduce elder abuse

Statistically Significant Differences Between Indicators

In this report, an * is included when there is a statistically significant difference between indicators.

BACKGROUND DATA

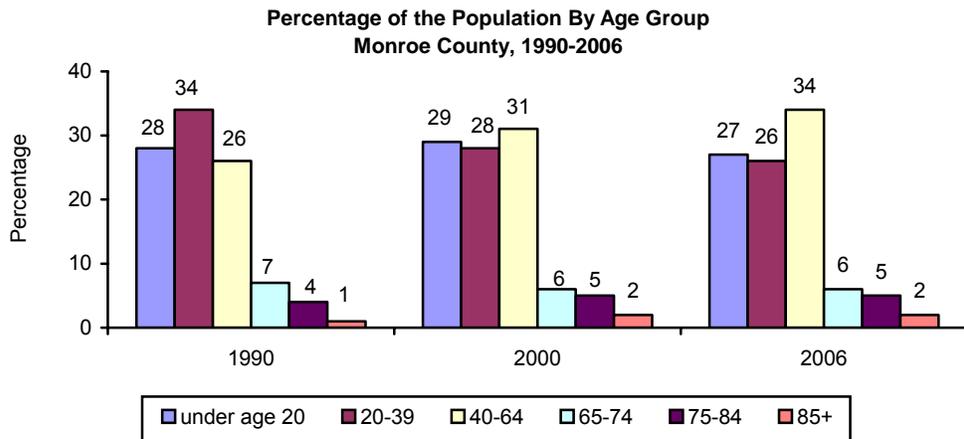
DEMOGRAPHIC & SOCIO/ECONOMIC DATA

Population By Age Group

Source: 1990 and 2006 Census Estimates.

Findings: In 2006, an estimated 436,621 adults ages 20-64 years old, and 97,097 adults aged 65 years and older were living in Monroe County.

Between 1990 and 2006, the population growth in Monroe County was nearly flat. During this time period, however there was a significant shift in the age distribution of the population. The percentage of the population aged 40 years and older increased from 38% in 1990 to 47% in 2006.

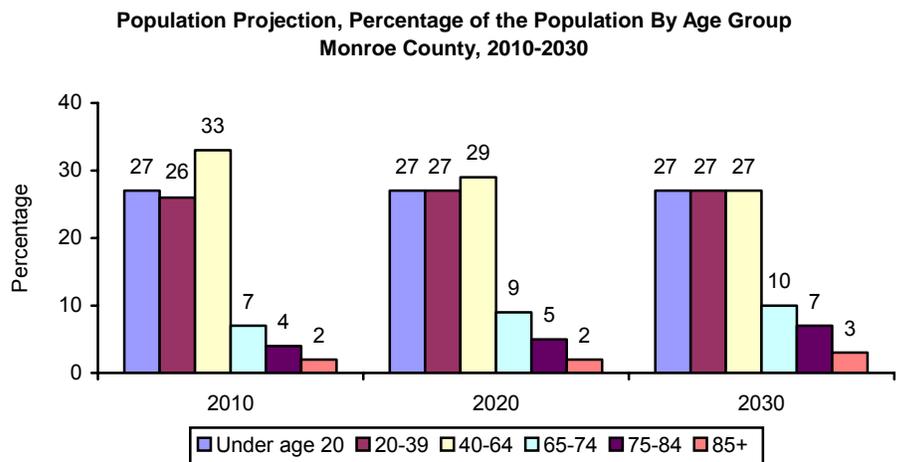


Projections By Age Group

Source: Statistical Information System, Cornell University for Social and Economic Research, September 2002.

<http://www.human.cornell.edu/che/BLC/C/pad/data/projections02.cfm>

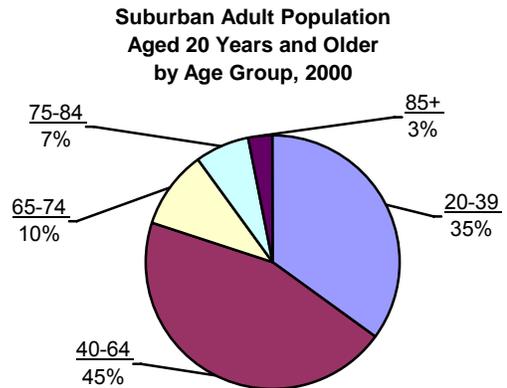
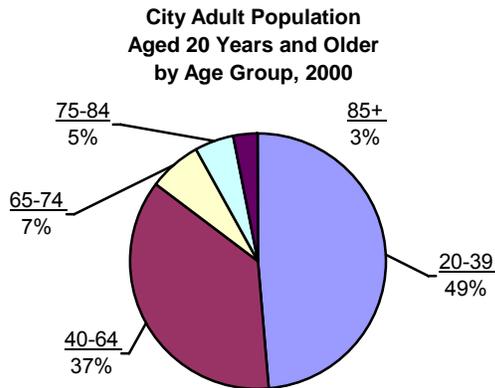
Findings: Population projections through 2030 show that the shift in the age distribution of the population will continue. By 2030, it is projected that 20% of the population will be aged 65 years and older.



Population By Residence and Age Group

Source: 2000 Census.

Findings: Twenty-nine percent (29%) of Monroe County adults reside in the city and 71% reside in the suburbs. The adult population in the city is younger than the population in the suburbs as shown in the graphics below.

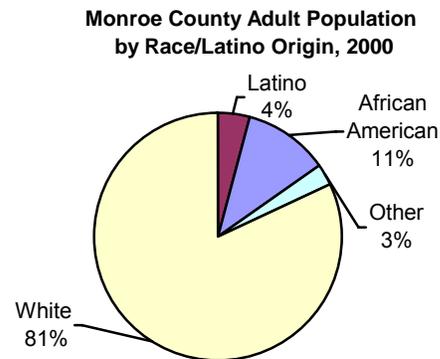


Race/Latino Origin

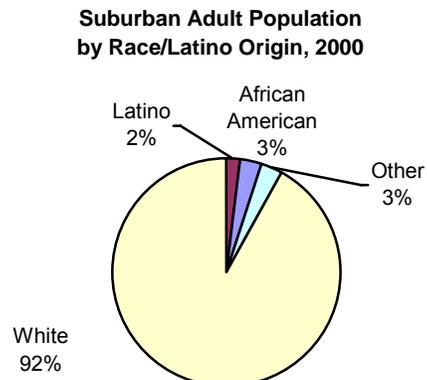
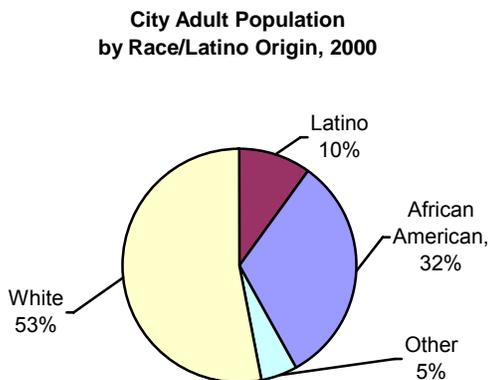
Source: 2000 Census.

About the data: Note that White, African American and Other categories do not include Latinos. Latinos can be of any race.

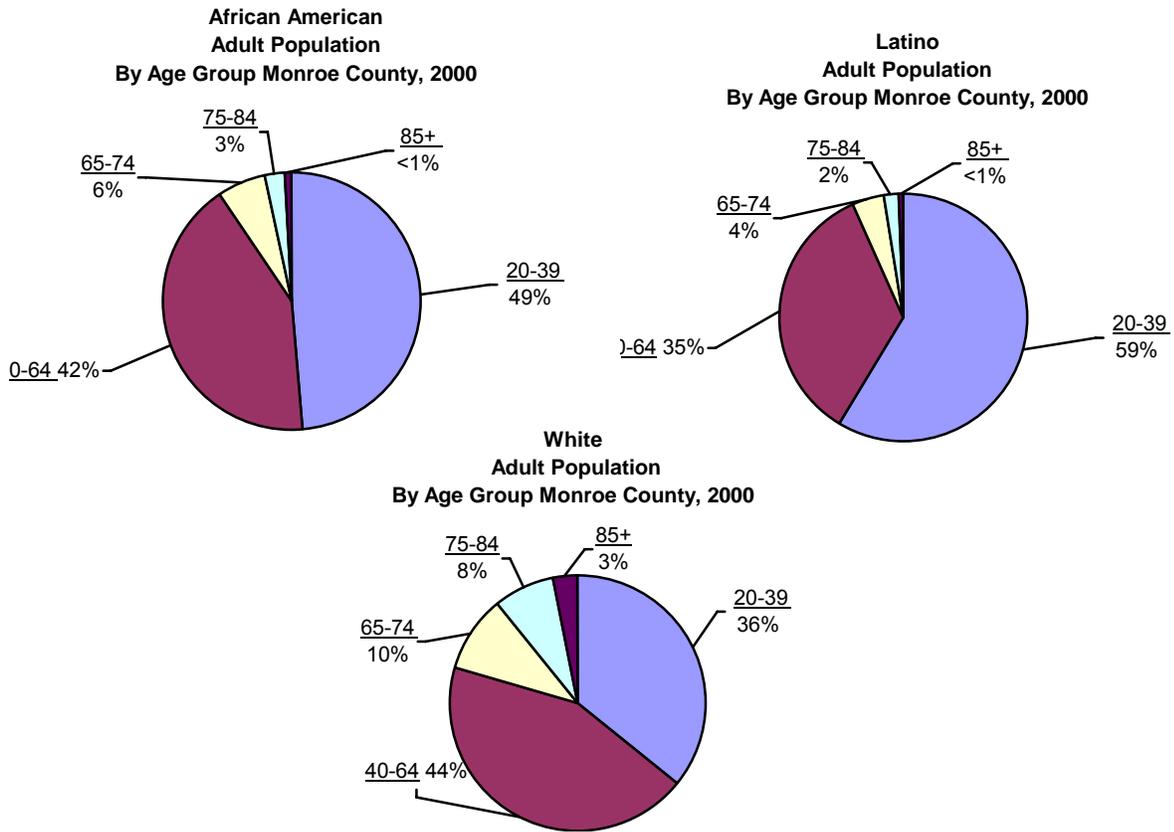
Findings: As shown in the graphic to the right, 81% of Monroe County adults are White, not Latino.



The graphics below show that the adult population in the city is more diverse compared to the population in the suburbs.



As shown in the graphics below, the adult population of African Americans and Latinos is younger compared to the adult population of Whites.

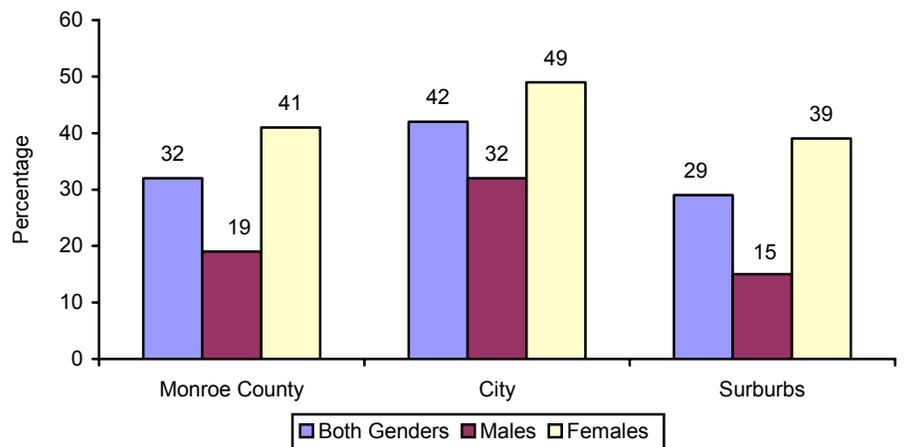


Older Adults Living Alone

Source: Census 2000.

Findings: Of community residing Monroe County adults aged 65 and older, 32% (28,276) live alone. The percentage who live alone is higher in the city compared to the suburbs. Females are more likely to live alone compared to males.

Live Alone, Community Residing Adults Aged 65 Years and Older, By Gender and Residence Monroe County, 2000



Income Below the Poverty Level

Individuals with low income are more likely to report poor physical and mental health status, and to have higher rates of morbidity and premature mortality.

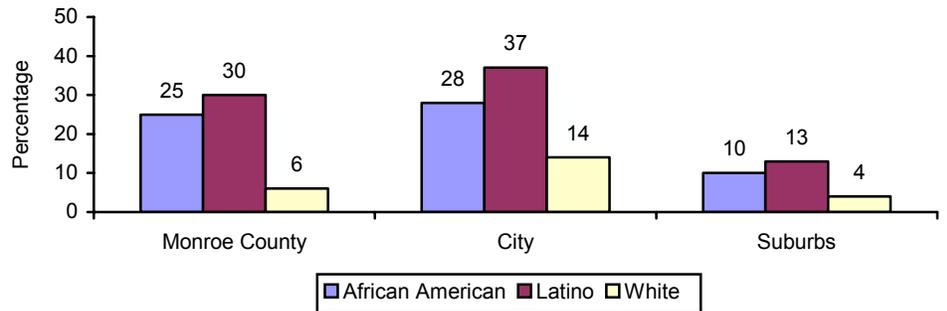
Source: Census 2000.

Findings: Ten percent (10%) of Monroe County adults age 18-64 and 7% of adults ages 65 and older had an income below the poverty level in 1999. Percentages are higher in the city compared to the suburbs.

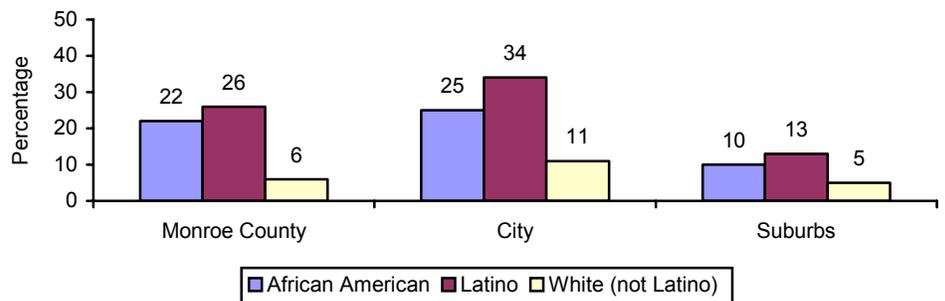
Income Below the Poverty Level By Age Group, Monroe County, 1999						
	Monroe County		City		Suburbs	
	#	%	#	%	#	%
Age 18-64	43,253	10%	28,803	22%	14,450	5%
Age 65+	6,681	7%	2,983	15%	3,698	5%

The following graphics show significant disparities in poverty status between African Americans and Latinos compared to Whites among both younger and older adults.

**Income Below the Poverty Level
Adults Aged 18-64 Years Old
By Race, Latino Origin and Residence
Monroe County, 1999**



**Income Below the Poverty Level,
Adults Aged 65+ Years
By Race, Latino Origin and Residence
Monroe County, 1999**

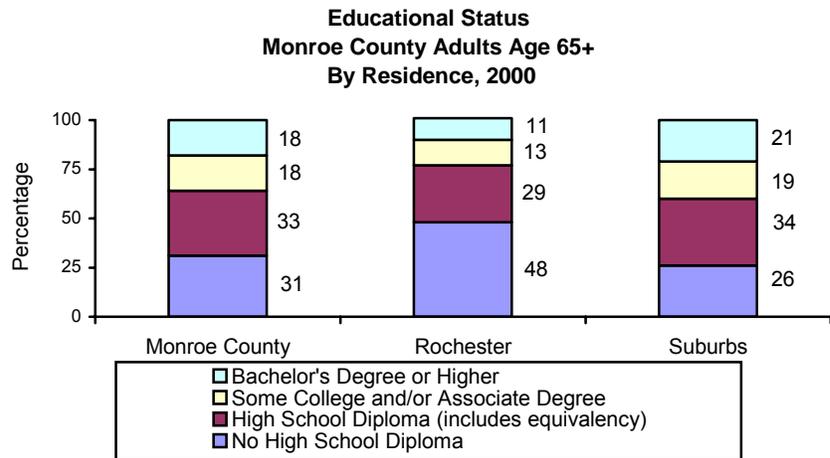
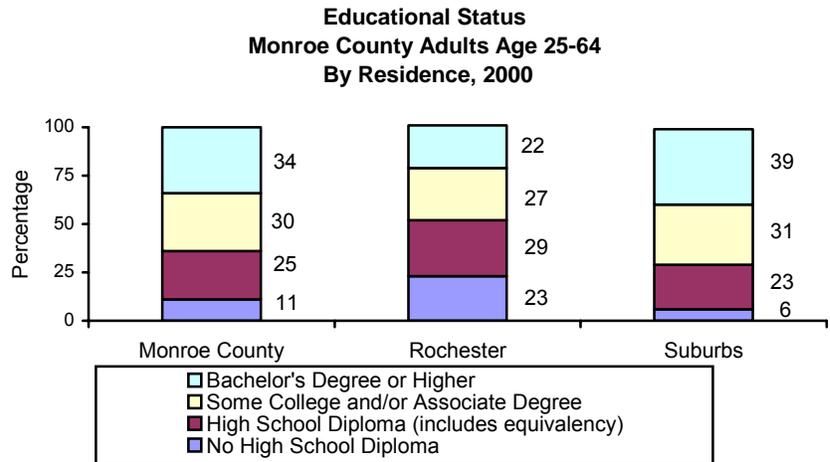


Educational Status

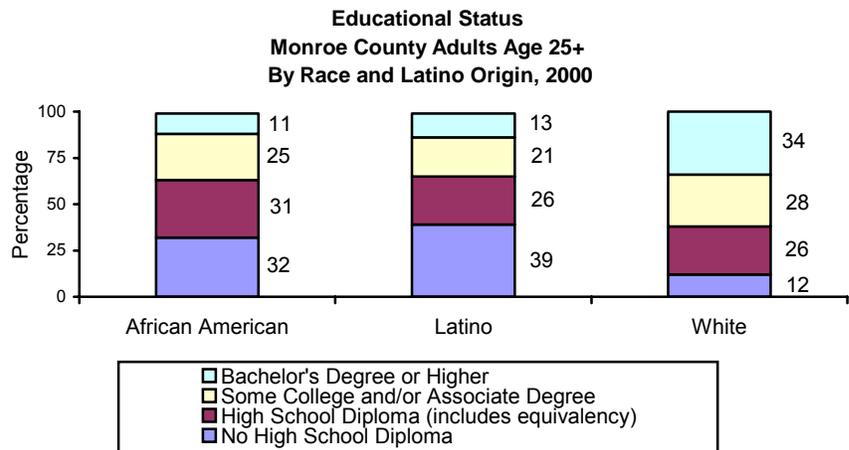
Lower educational levels are associated with poorer health outcomes. Literacy levels have a profound impact on an individual's ability to manage their health.

Source: Census 2000.

Findings: In Monroe County, 11% of adults ages 25-64 years old and 31% of adults aged 65 years and older do not have a high school diploma. Percentages are higher in the city compared to the suburbs.



A higher proportion of African Americans and Latinos do not have a high school diploma compared to Whites.

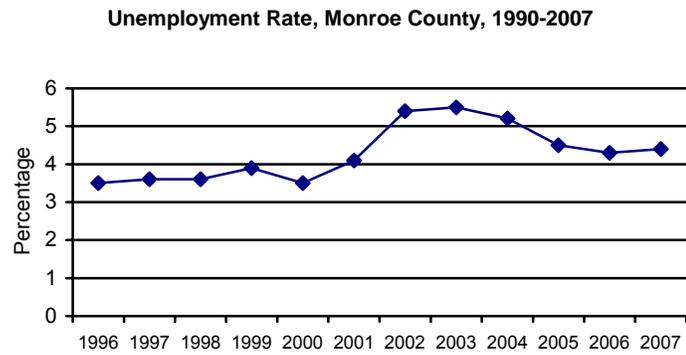


Unemployment Rate

Unemployment is associated with many health risks. Access to health insurance, comes primarily through the work place.

Source: NYS Department of Labor.

Findings: The unemployment rate in Monroe County increased between 2000 and 2003 and then declined.



GENERAL HEALTH DATA

ACCESS TO HEALTH CARE

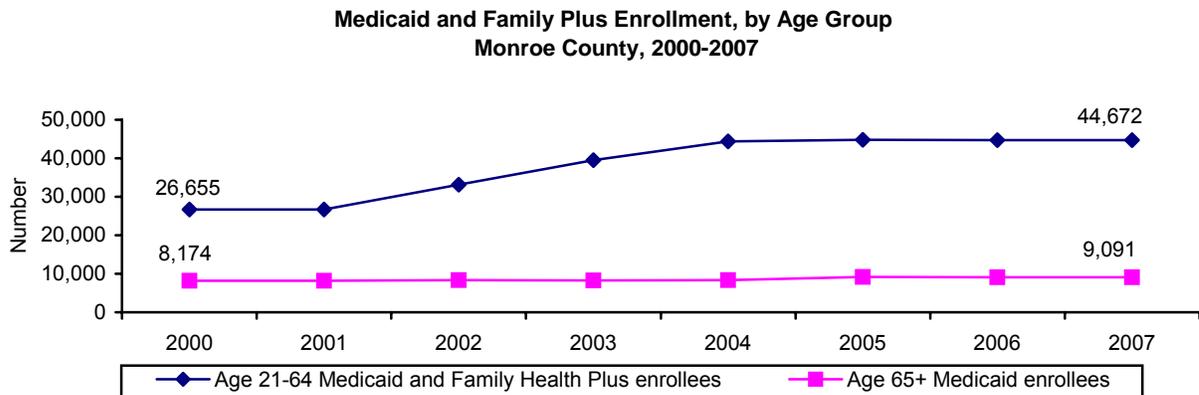
Medicaid and Family Health Plus Enrollment

Source: Monroe County Department of Human Services.

About the data: These figures are point in time enrollment at year end. Medicaid and Family Health Plus enrollment figures are combined for ages 21-64 years. Enrollment figures for ages 65+ include individuals who are enrolled in Medicaid and may also be enrolled in Medicare.

Findings: In December of 2007, 44,672 Monroe County residents ages 21-64 were enrolled in Medicaid or Family Health Plus which is about 11% of the population. Nine thousand ninety-one (9,091) adults aged 65 and older were enrolled in Medicaid which is about 9% of the population.

Since the implementation of Family Health Plus in 2001, enrollment in government funded health care coverage among those ages 21-64 years old increased significantly. Since 2001, Medicaid enrollment among adults aged 65 years increased by about 900.



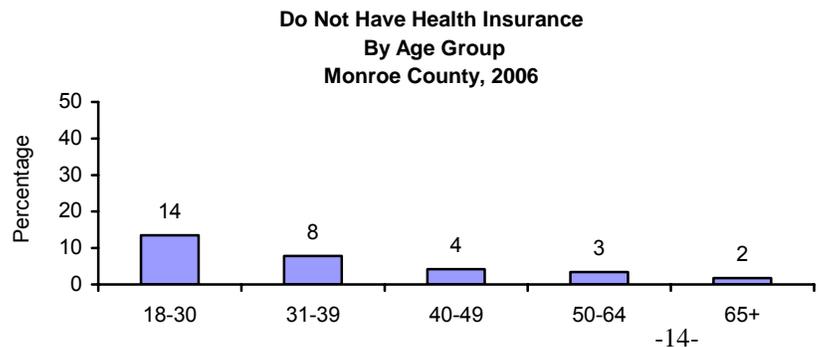
Health Insurance

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

Findings: Six percent (6%) of Monroe County adults aged 18 years and older reported they did not have health insurance in 2006, which is comparable to the percentage in 2000.

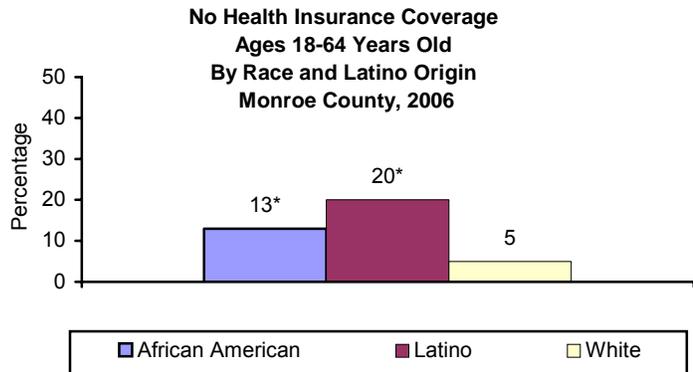
The percentage of adults who reported they lacked health insurance was higher among those ages 18-64 (7%*) compared to those aged 65 years and older (2%).

As shown in the graphic to the right the percentage of adults who are uninsured declines with increasing age.



City residents (10%*) were more likely than suburban residents (4%) to report they lacked health insurance. This difference occurred within all age groups except those aged 18-30 years old.

African Americans and Latinos were more likely to report they lacked health insurance compared to Whites.



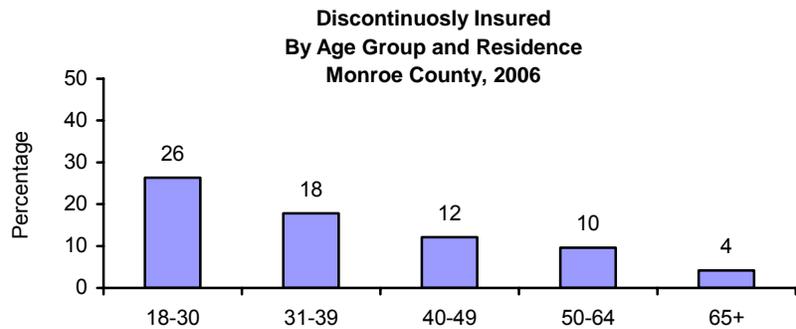
The uninsured rate in Monroe County (6%) is better than NYS (14%*), but it is not at the 2010 Goal for the Nation which is 0%.

Discontinuously Uninsured

Source: Adult Health Survey (AHS), 2006, MCDPH

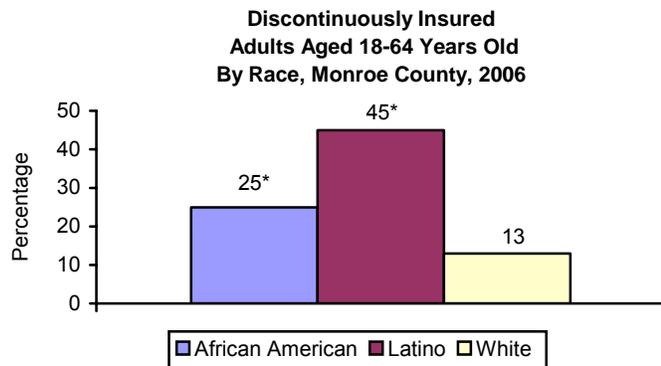
Findings: Overall, 14% of all Monroe County adults reported they were discontinuously insured (without health insurance at some point in the past 2 years). The rate was higher among adults under age 65 (16%*) compared to adults aged 65 years and older (4%).

The percentage of adults who reported they were discontinuously insured was highest among adults aged 18-30 years old.



City residents (20%*) were more likely to report they were discontinuously insured compared to suburban residents (10%*). These differences occurred within every age group except among those aged 18-30 years old.

African Americans and Latinos were more likely to report they were without health insurance at some point during the past two years compared to Whites and non-Latinos. These differences occurred in nearly all age groups.

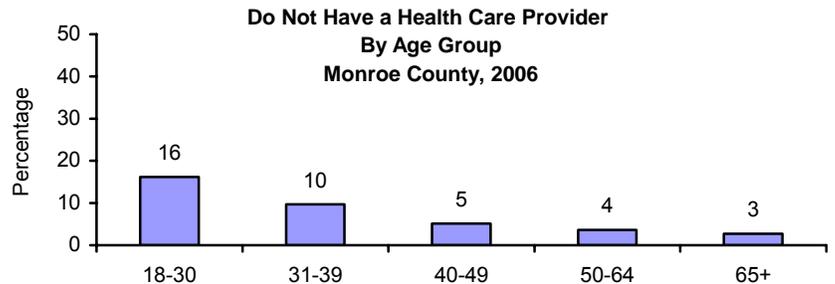


Access to a Personal Health Care Provider

Source: Adult Health Survey (AHS), 2006, MCDPH

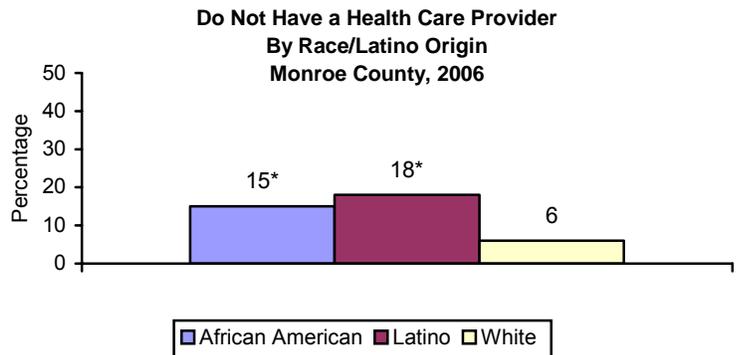
Findings: Eight percent (8%) of Monroe County adults reported they do not have a personal health care provider. The percentage was higher among adults under age 65 (9%*) compared to those aged 65 years and older (3%).

Adults aged 18-30 years old were most likely to report they do not have a health care provider.



City residents (10%*) were more likely than suburban residents (6%) to report they do not have a health care provider.

Compared to Whites, African Americans and Latinos were more likely to report they did not have a personal health care provider. These differences occurred in most age groups.



Could Not Afford Medical Care

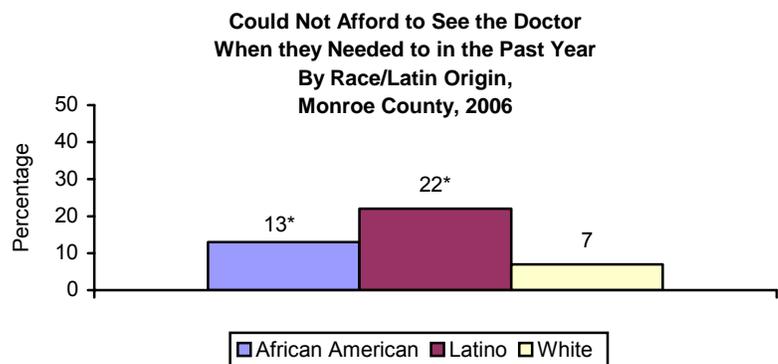
Source: Adult Health Survey, 2006, MCDPH

Findings: Nine percent (9%) of Monroe County adults reported that there was a time in the past year when they needed to see the doctor but could not because of the cost.

Adults under age 65 (10%*) were more likely to report having difficulty affording medical care compared to older adults (3%).

City residents (12%*) were more likely than suburban residents (7%) to report they couldn't afford to see the doctor in the past year.

African Americans and Latinos were more likely than Whites to report they couldn't afford to see the doctor.



Visited the Doctor for a Routine Check-up in the Past Year

Source: Adult Health Survey, 2006, MCDPH

Findings: Ninety-three percent (93%) of adults age 50 and older saw a health care provider for a checkup within the past 2 years. Ninety-two percent (92%) of adults under age 50 saw a health care provider for a checkup within the past 5 years. Within this age group, males (89%*) were less likely than females (96%) to report they received a checkup in the past 5 years. There were no other statistically significant differences by sub-populations.

Dental Insurance Coverage

Source: Adult Health Survey, MCDPH

Findings: Twenty-three percent (23%) of Monroe County adults reported they did not have dental insurance. This percentage did not change significantly between the 2000 and 2006 AHS. Adults aged 65 years and older (38%*) were more likely to report they did not have dental insurance compared to adults aged 18-64 years old (20%).

City residents (26%*) were more likely to report they lacked dental insurance compared to suburban residents (22%). There were no significant differences by race or Latino Origin.

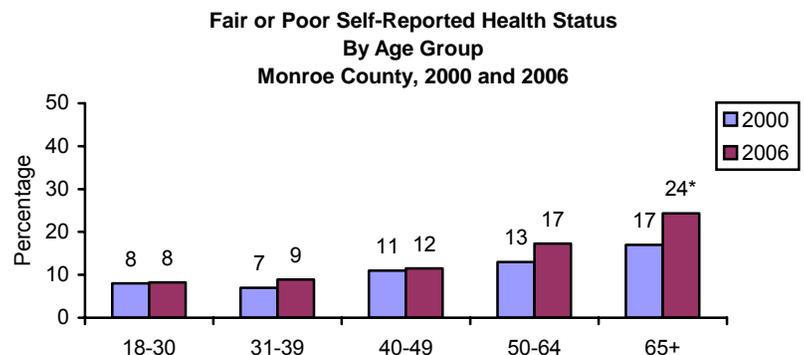
HEALTH STATUS

Self- Reported Health Status

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

Findings: A common way of measuring health is to ask individuals to rate their overall health ranging from excellent to fair/poor. In 2006, 61% of Monroe County adults reported their health was “very good to excellent”, 25% reported “good” and 14% reported their health was “fair to poor”. The percentage of Monroe County adults who reported “fair to poor” health increased from 11% in 2000 to 14% in 2006.

As shown in the graphic to the right, the increase occurred mainly among older adults.



City residents (21%*) were more likely to report fair or poor health status compared to suburban residents (10%). This difference occurred within nearly every age group.

African American (25%*) and Latinos (26%*) were more likely to report fair or poor health status compared to Whites (12%*).

The percentage of adults who reported fair to poor in Monroe County was not statistically different from the percentage in NYS.

Functional Limitations Due to Physical Health

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

Findings: The table below shows the percentage of adults in Monroe County who reported various functional limitations due to physical health. For the most part, these functional limitations were more prevalent in 2006 than in 2000.

Functional Limitations Monroe County Adults, 2000, 2006	2000	2006
1. Being limited <u>a lot</u> in doing moderate activities like moving a table, pushing a vacuum, bowling or playing golf because of their health	6	10*
2. Being limited <u>a lot</u> in climbing stairs	6	11*
3. Did not accomplish what they would have liked at work or in daily activities because of physical health – <u>all or most of the time</u> during the last 4 weeks	10	13*
4. Were limited in the kind of work or other activities because of physical health - <u>all or most of the time</u> during the last 4 weeks	8	9
5. Pain interfered <u>extremely</u> or <u>quite a bit</u> with normal work during the past 4 weeks	8	11*
6. Had a lot of energy – <u>none or a little of the time</u> during the past 4 weeks	12	14*

The increase in reported functional limitations appears to be due in part to the aging of the population because most of the significant changes only occurred among older adults. There were, however, some increases within younger age groups.

- The proportion of adults ages 18-30 who reported they accomplished less than they would like due to physical health all or most of the time within the past month increased from 4% to 11%.
- There was also an increase in the proportion of those aged 50-64 who said they have a lot of energy none or a little of the time, from 9% in 2000, to 16% in 2006.

Overall, older adults, city residents, African Americans, and Latinos were more likely to report they had functional limitations due to their physical health compared to younger adults, suburban residents and Whites.

LEADING CAUSES OF DEATH

Source: Vital Records, MCDPH

Ages 20-64 Years

Findings: Among younger adults, cancer is the leading cause of death followed by diseases of the heart, unintentional injuries and homicide.

Leading Causes of Death Monroe County Ages 20-64 2004-2006	Average Annual # deaths	% of Deaths
Cancer	406	32
Diseases of the Heart	231	18
Unintentional Injuries	92	7
Homicide	38	3
Stroke	38	3
Suicide	37	3
Diabetes	35	3
HIV/AIDS	33	3
Chronic Lower Respiratory Disease	26	2
Pneumonia and Flu	18	1

Within this age group, homicides and HIV/AIDS account for larger proportions of deaths among African Americans and Latinos, compared to Whites.

Percentage of Deaths Due to Homicides and HIV/AIDS, Monroe County Adults Aged 18-64, 2004-2006

Cause of Death	African American	Latino	White
Homicide	8%	10%	1%
HIV/AIDS	5%	8%	1%

Ages 65 Years and Older

Source: Vital Records, MCDPH

Findings: Among those age 65+ and older, heart disease, cancer and stroke are the top three leading causes of death.

Leading Causes of Death Monroe County Ages 65+ 2004-2006	Average Annual # deaths	% of Deaths
Diseases of the Heart	1336	28
Cancer	1098	23
Stroke	346	7
Chronic Lower Respiratory Disease	241	5
Alzheimer's Disease	221	5
Pneumonia and Flu	180	4
Kidney Disease	94	2
Diabetes	87	2
Unintentional Injuries	70	1
Septicemia	63	1

Among African American and Latino older adults, diabetes accounts for 4% of deaths, compared to 2% of deaths among Whites.

Alzheimer's Disease accounted for 5% of deaths among Whites, compared to 3% among African Americans and 2% among Latinos.

HEALTH ISSUES AND GOALS

(ADULTS OF ALL AGES)

CHRONIC DISEASES AND CONDITIONS

Chronic diseases are the leading causes of death in the US and account for a majority of all deaths. Eighty percent (80%) of older adults in the US have at least one chronic condition, 50% have at least two.⁴ It is estimated that one in five adults has been diagnosed with arthritis, which is the leading cause of disability in the US.⁵⁶

As the Monroe County population continues to age, we will see significant increases in the prevalence of chronic diseases. In addition to changes to the age structure, the rising rate of obesity will also contribute significantly to the increased prevalence of chronic diseases. Obesity is a risk factor for many chronic diseases and conditions including diabetes, heart disease, high blood pressure, stroke and arthritis.

Chronic diseases and conditions consume a significant proportion of health care resources. Medical care costs of people with chronic diseases account for more than 75% of the nation's \$2 trillion medical care costs.⁷ Preventing disease and preventing medical complications after disease onset are important steps to containing medical costs in Monroe County.

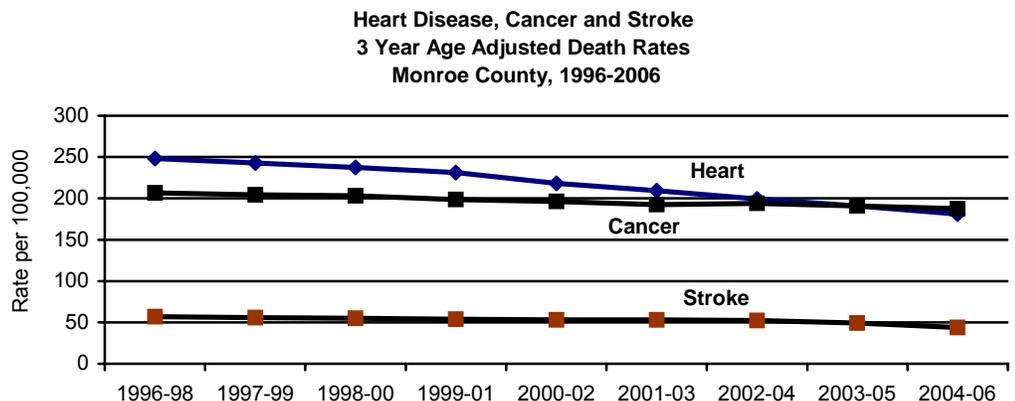
BACKGROUND DATA

Deaths Due to Chronic Diseases

Source: Vital Records, MCDPH.

About the data: It should be noted that diabetes is thought to be under-reported as a cause of death. Studies have found that of decedents with diabetes, only 35 to 40 percent had diabetes listed anywhere on the death certificate and only 0 to 15% had it listed as the underlying cause of death.⁸

Findings: The death rates due to the top three leading causes of death, heart disease, cancer and stroke, have declined in the past decade as shown in the graphic to the right.



⁴ Costs of Chronic Disease. Centers for Disease Control and Prevention. <http://www.cdc.gov/nccdphp/overview.htm> accessed 4-4-08.

⁵ The State of Aging and Health in America, 2007. Centers for Disease Control and Prevention. <http://www.cdc.gov/aging/saha.htm> accessed 4-9-08.

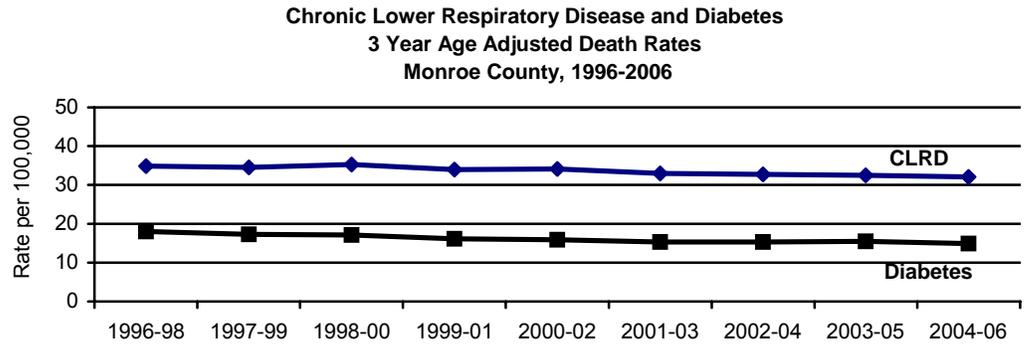
⁶ Targeting Arthritis, 2008. Centers for Disease Control and Prevention. <http://www.cdc.gov/nccdphp/publications/AAG/pdf/arthritis.pdf> accessed 4-9-08.

⁷ Costs of Chronic Disease. Centers for Disease Control and Prevention. <http://www.cdc.gov/nccdphp/overview.htm> accessed 4-4-08.

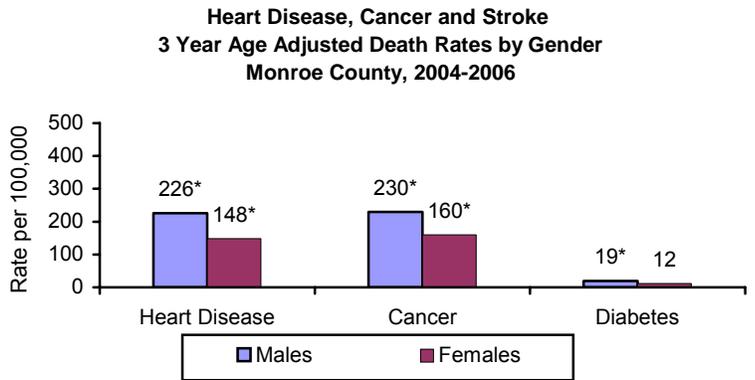
⁸ National Institutes of Health, Diabetes Statistics, <http://diabetes.niddk.nih.gov/dm/pubs/statistics/#12>

The death rate due to stroke in Monroe County has achieved the 2010 Goal (50/100,000).

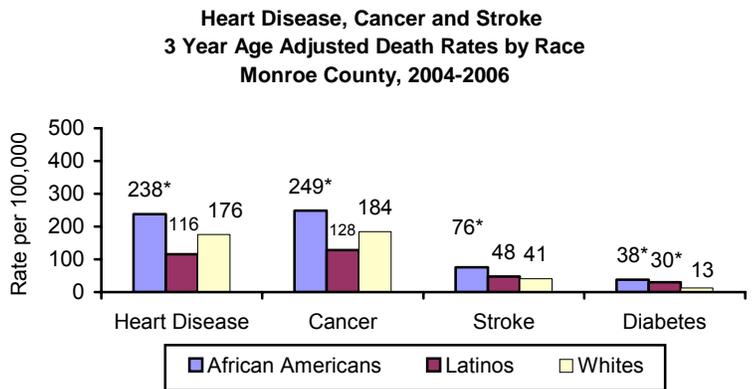
Death rates from diabetes and chronic lower respiratory diseases declined slightly in the past decade.



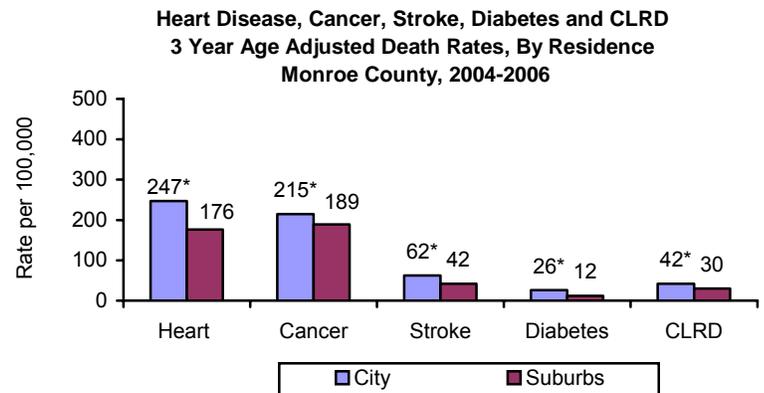
Age adjusted death rates due to heart disease, cancer and diabetes are higher among males compared to females.



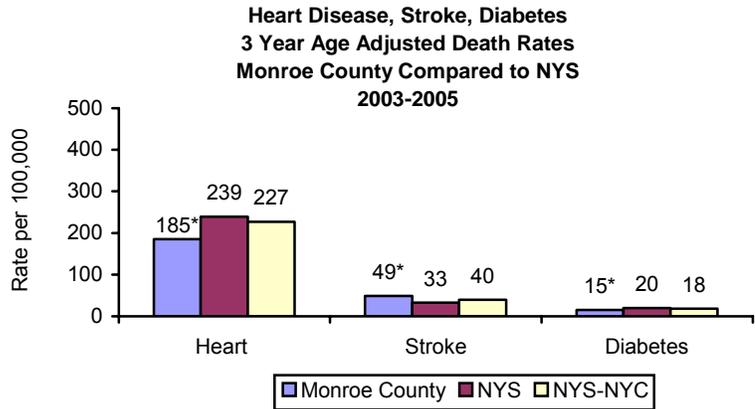
Age adjusted death rates due to heart disease, cancer and stroke, are higher among African Americans compared to Whites and Latinos. Age adjusted death rates due to diabetes are higher among African Americans and Latinos compared to Whites.



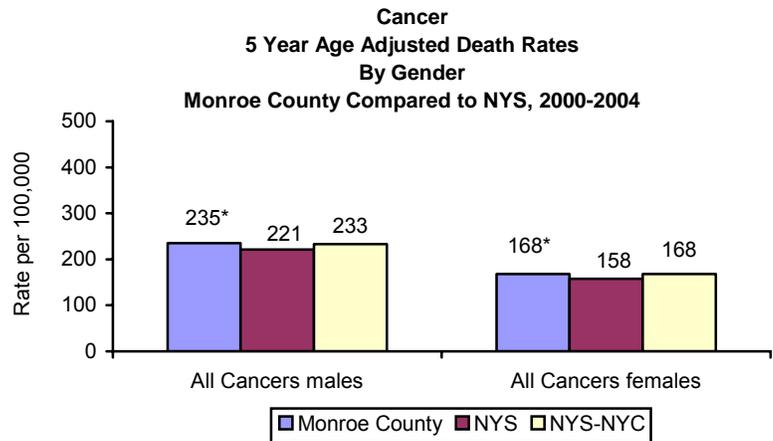
Age adjusted death rates due to heart disease, cancer, stroke diabetes and CLRD are higher among city residents compared to suburban residents.



Age adjusted death rates due to heart disease and diabetes are lower in Monroe County compared to rates in NYS and NYS minus NYC. The stroke death rate is higher in Monroe County compared to the rate in NYS and NYS minus NYC.



Age adjusted death rates due to all types of cancers combined, among males and females, are higher in Monroe County compared to rates in NYS and are comparable to rates in NYS minus NYC.



Hospitalizations Due to Chronic Diseases

Source: SPARCS, NYSDOH.

Notes about the data: These are hospitalization discharges where heart disease, stroke or chronic lower respiratory diseases (CLRD) are listed as the primary diagnosis. The diabetes hospitalizations include those discharges where diabetes is listed as the primary or secondary diagnosis.

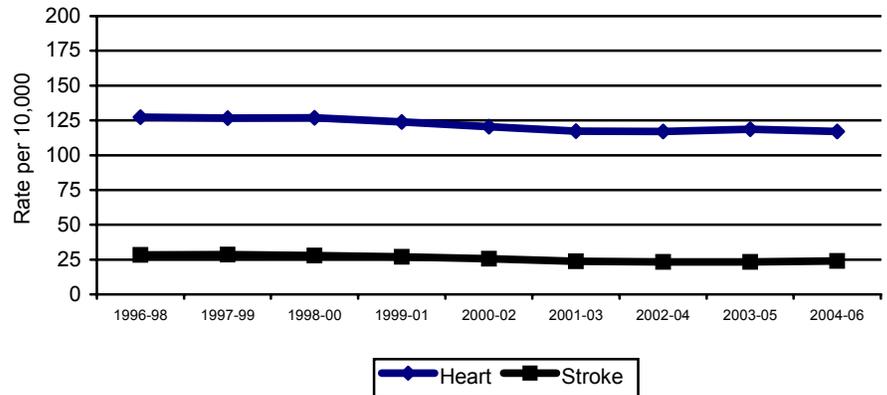
Findings:

The table to the right shows the average annual number of hospitalizations due to chronic diseases among Monroe County adults aged 19 years and older.

Hospitalization Due to	Average Annual Number 2004-2006
Heart	9,396
Stroke	1,939
Diabetes (primary and secondary)	13,844
Diabetes (primary only)	917
Chronic Lower Respiratory Disease (CLRD)	1,660
Asthma	592

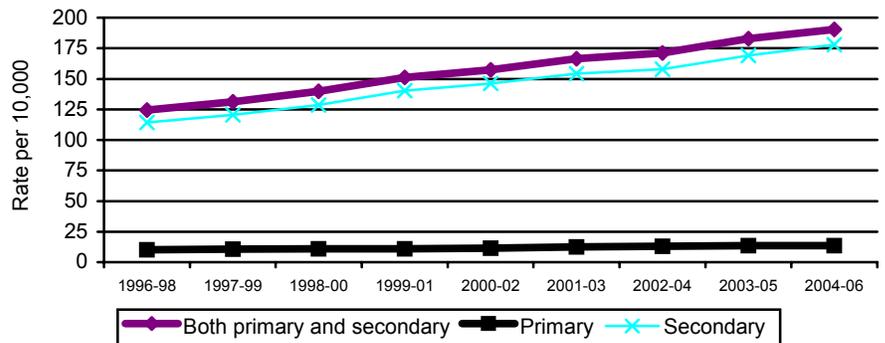
Between 1996 and 2006, the age adjusted hospitalization rates due to heart disease and stroke declined significantly.

Heart Disease, Stroke
3 Year Age Adjusted Hospitalization Rates
Monroe County, 1996-2006

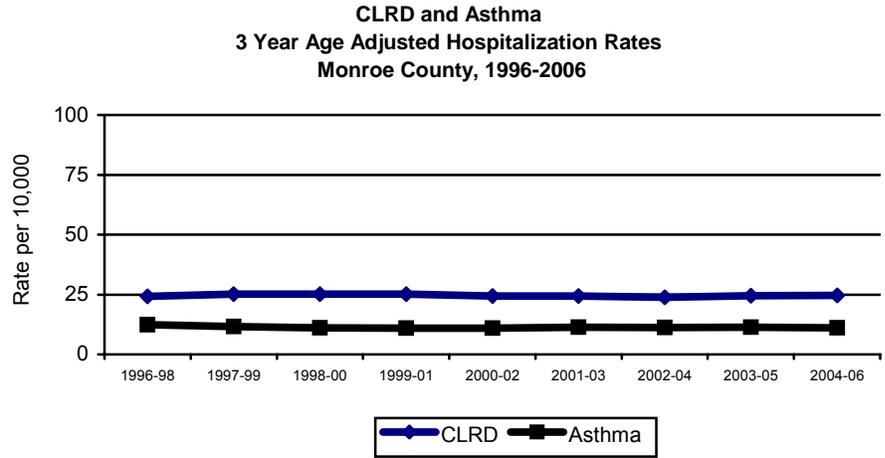


The rate of hospitalizations with diabetes as a primary and secondary diagnosis increased by 42% between 1996 and 2006. Increases were seen in both primary and secondary diagnoses.

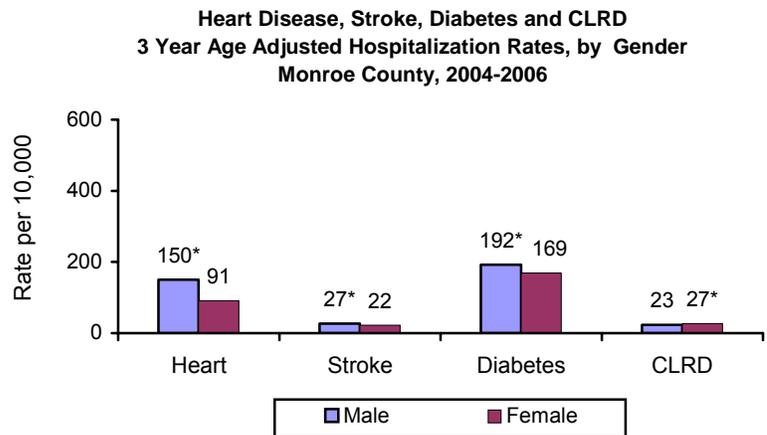
Diabetes Listed as Primary and Secondary Diagnosis
3 Year Age Adjusted Hospitalization Rates
Monroe County, 1996-2006



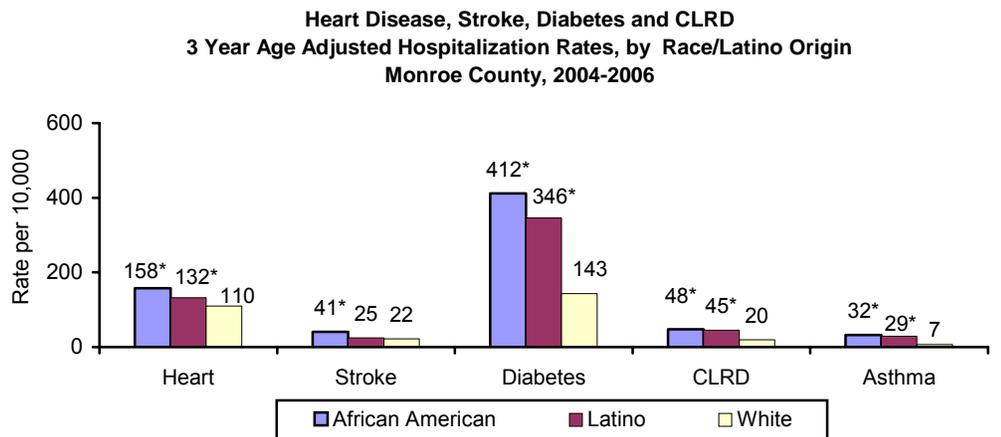
The rates of hospitalizations due to chronic lower respiratory disease and asthma remained stable.



Age adjusted rates of hospitalizations due to diseases of the heart, stroke, and diabetes are higher among males compared to females. The hospitalization rate for CLRD is higher among females compared to males.

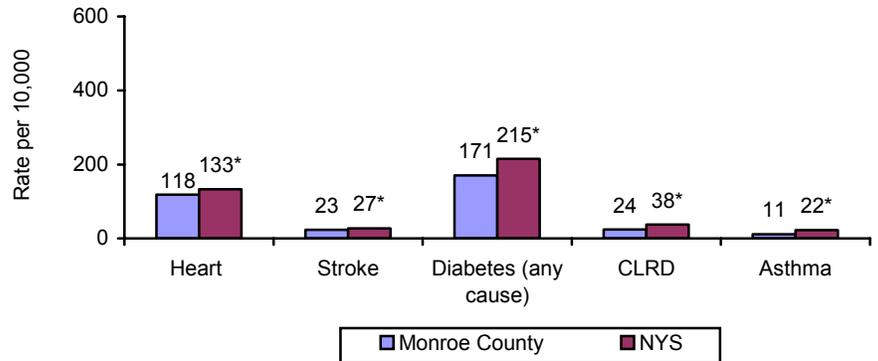


Age adjusted rates of hospitalizations due to diseases of the heart, stroke, diabetes, CLRD and asthma are higher among African Americans and Latinos compared to Whites.



Age adjusted hospitalization rates due to chronic conditions are lower in Monroe County compared to rates in NYS.

**Heart Disease, Stroke, Diabetes, CLRD, Asthma
3 Year Age Adjusted Hospitalization Rates
Monroe County Compared to NYS
2003-2005**



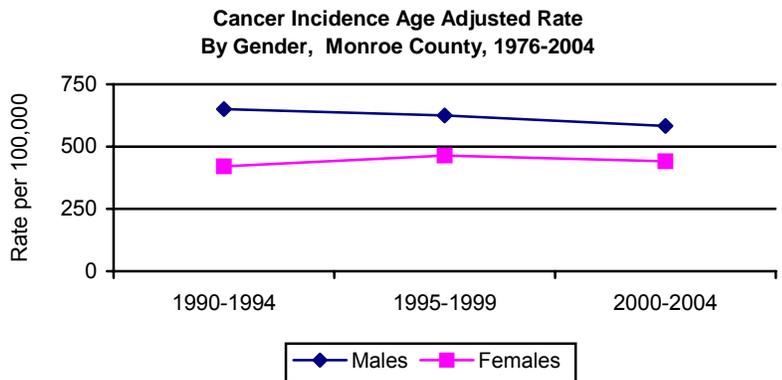
Cancer Incidence

Source: Cancer Registry, NYSDOH

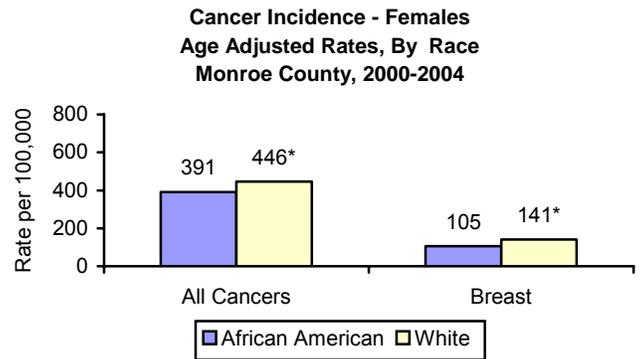
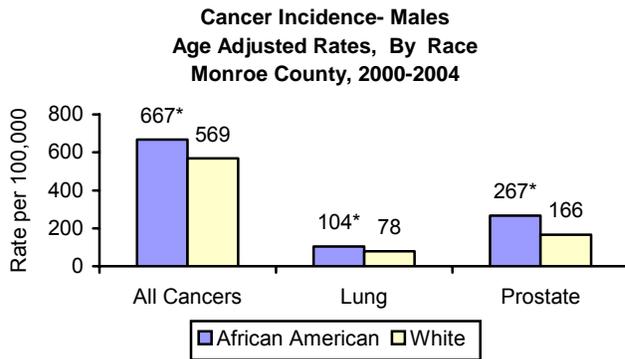
Findings: On average each year between 2000 and 2004, there were 3,828 newly diagnosed cases of cancer in Monroe County. The most common forms of cancer diagnosed in Monroe County are listed in the table to the right.

Most Common Cancers Diagnosed in Monroe County Average Annual Number and % of All Cancers, By Gender, 2000-2004					
Males	#	%	Females	#	%
Prostate	583	30	Breast	587	31
Lung and bronchus	260	14	Lung and bronchus	239	12
Colorectal	209	11	Colorectal	224	12
Urinary bladder (incl. in situ)	154	8	Uterine	119	6
Non-Hodgkin lymphomas	84	4	Non-Hodgkin lymphomas	79	4
All Cancers	1915		All Cancers	1913	

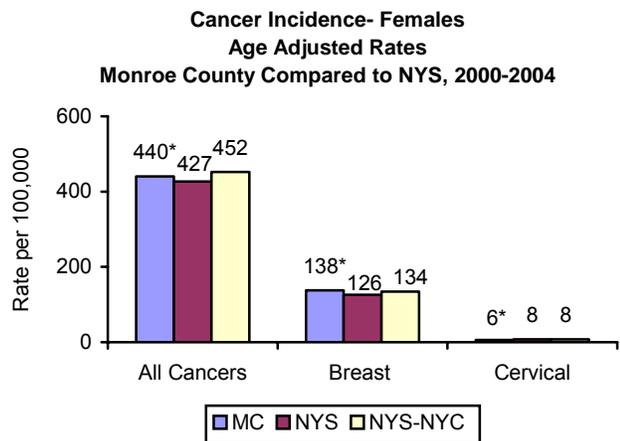
Cancer incidence rates among males declined slightly between (1990-1994) and (2000-2004). Among females, the rate increased during the 1990s and then declined.



As shown in the graphics on the next page, among males, the incidence rates of all cancers, lung and prostate cancers, are higher among African Americans compared to Whites. Among females, the incidence rates of all cancers and breast cancer, are higher among Whites compared to African Americans.



Among Monroe County females, the incidence rate of all types of cancer combined is higher than the rate in NYS and is lower than the rate in NYS minus NYC. The breast cancer incidence rate is higher in Monroe County compared to NYS and is comparable to the rate in NYS minus NYC. Cervical cancer incidence rates are lower in Monroe County compared to rates in NYS and NYS-NYC.



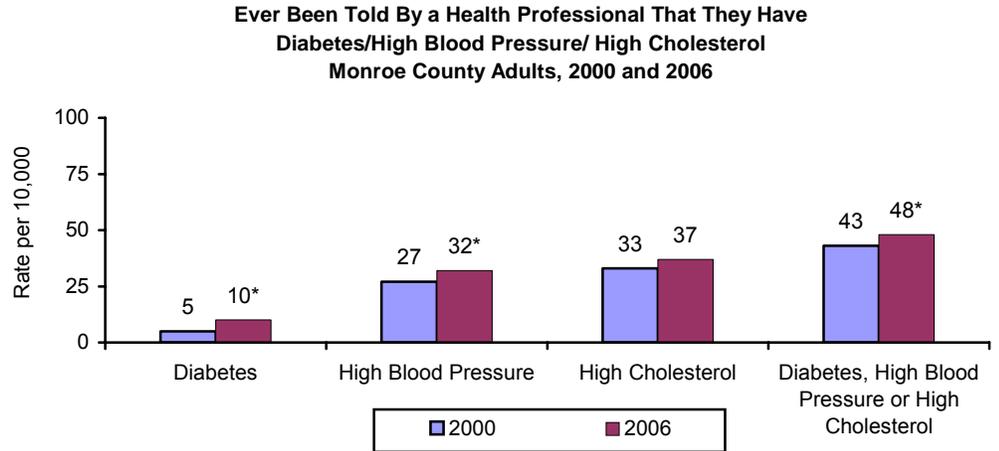
Self Reported Prevalence of Chronic Diseases/Conditions

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

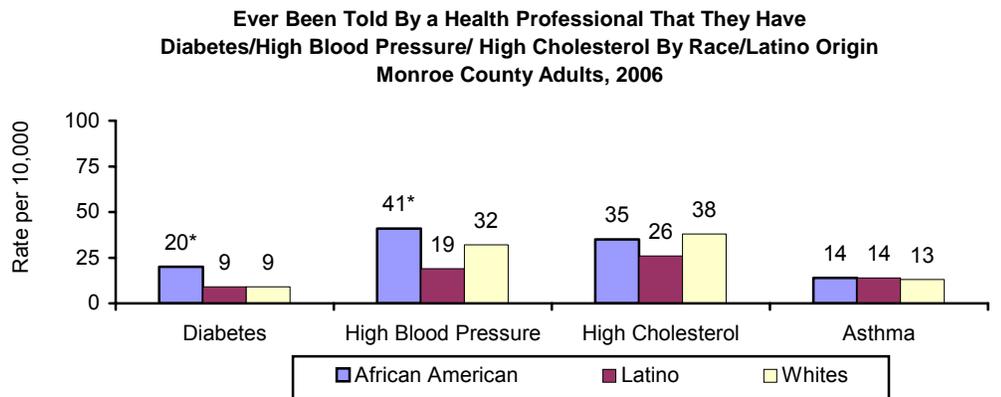
Findings: The percentages of Monroe County adults who were ever told they had a chronic condition are listed below. Older adults were more likely than younger adults to report they were told they had a chronic condition.

% of Adults Who Reported they Were Ever Told By a Health Professional That They	Age 18+	Age 18-64	Age 65+
Have Diabetes	10	8	22*
Have High Blood Pressure	32	26	61*
Have High Blood Cholesterol	37	32	57*
Have Diabetes, High Blood Pressure and/or High Cholesterol	48	42	82*
Had a Heart Attack, or Coronary Artery Disease or Angina	6	3	22*
Had a Stroke	2	0.7	9*
Have Asthma	13	14	11

The proportion of Monroe County adults who reported they were ever told they had diabetes or high blood pressure increased significantly between 2000 and 2006 as shown in the graphic to the right. The increase occurred in most age groups.

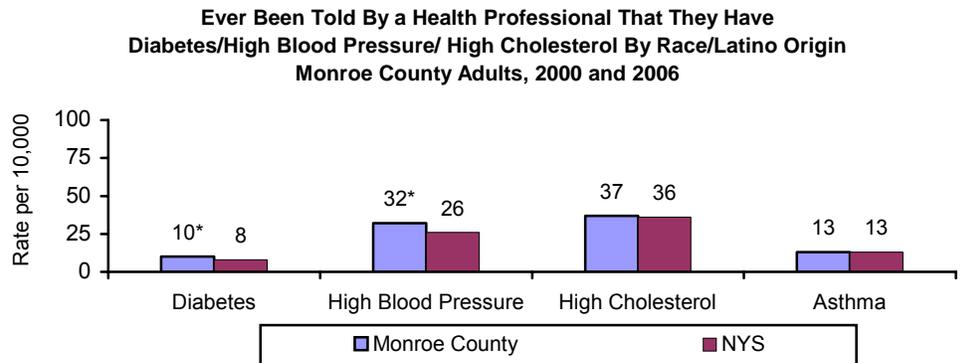


The proportion of Monroe County adults reporting they were ever told they had diabetes or high blood pressure was higher among African Americans compared to Whites. There were no differences by race/Latino origin in the percentage of adults who reported they were ever told they had asthma.



Females (16%*) and city residents (16*%) were more likely than males (10%) and suburban residents (12%) to report an asthma diagnosis.

The percentage who reported they were told they had diabetes or high blood pressure is higher in Monroe County compared to NYS.



GOALS FOR CHRONIC DISEASE PREVENTION/MANAGEMENT

Goal: Increase Physical Activity and Improve Nutrition

Increasing physical activity and improving nutrition can have a substantial impact on improving the overall health of the community. Lack of physical activity and poor nutrition are the two main factors that contribute to obesity and overweight. Obesity is a known risk factor for many chronic diseases like high blood pressure, diabetes, and heart disease. Physical activity and good nutrition play critical roles in reducing people's risk of developing chronic diseases like heart disease, stroke, diabetes, high blood pressure, arthritis and osteoporosis. Evidence suggests that one third of cancer deaths in the United States each year can be attributed to dietary choices, weight and physical activity habits,⁹

For those who already have a chronic disease or condition, physical activity and good nutrition are proven treatments for these conditions and can reduce negative consequences and symptoms from the diseases. Physical activity has been shown to decrease the pain of arthritis, reduce the symptoms of anxiety and depression and reduce falls among older adults. Physical activity also helps older adults maintain their ability to do every day activities and to continue to live independently.

Measures

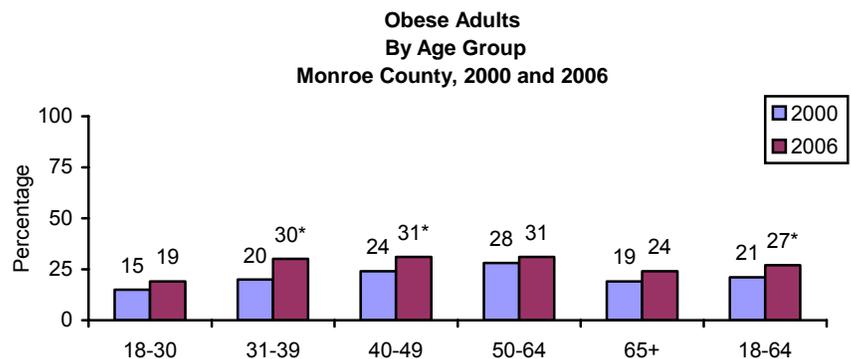
Overweight and Obesity

Source: Adult Health Survey (AHS) 2000 and 2006, MCDPH.

About the data: As part of the AHS, 2006, respondents were asked to report their height and weight (without shoes). Based on this information, body mass index (BMI) was calculated and respondents were classified into the following categories: obese, overweight, obese or overweight, and not obese or overweight.¹⁰

Findings: Between 2000 and 2006, the percentage of adults in the overweight category remained stable at 35%. During the same time period, the percentage of adults in the obese weight category increased from 24% to 27%.

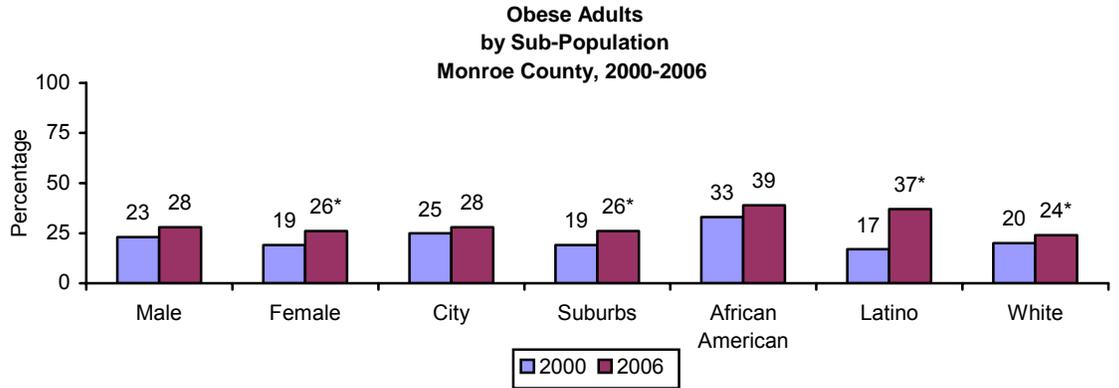
The increase in the obesity rate occurred in most age groups as shown in the graphic to the right.



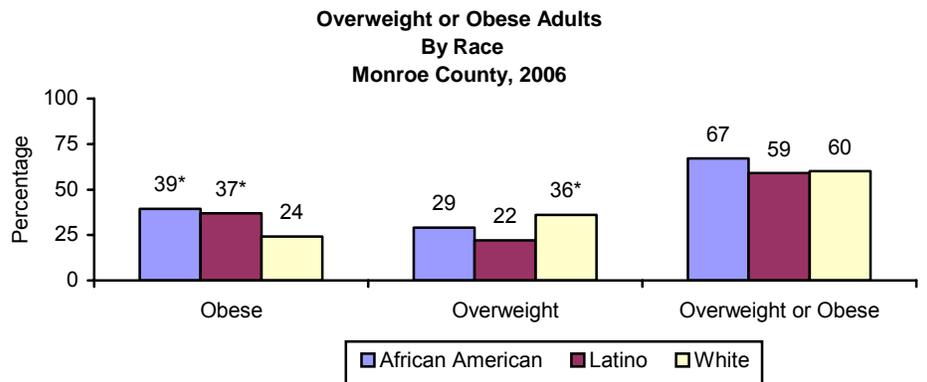
⁹ McGinnis, et al. "Actual Causes of Death in the United States, 2001. *JAMA*. 2004;291:1238-1245.

¹⁰ Obese – BMI>=30, Overweight-BMI>=25 and <30, Obese or Overweight-BMI>=25, Not obese or overweight-BMI<25

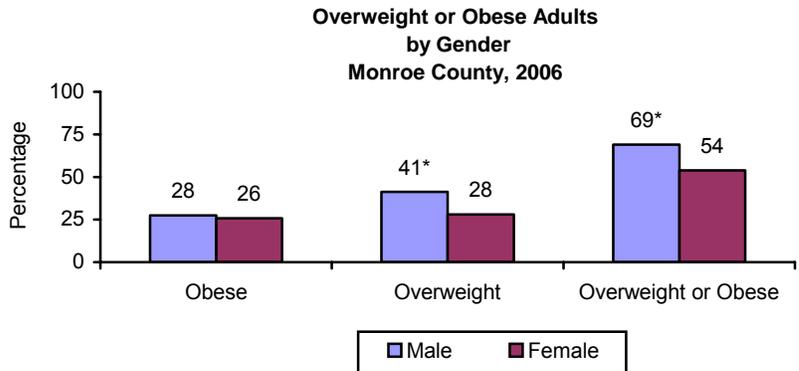
Rates of obesity also increased among most sub-populations.



As shown in the graphic to the right, African Americans and Latinos were more likely to be obese and less likely to be overweight compared to Whites.

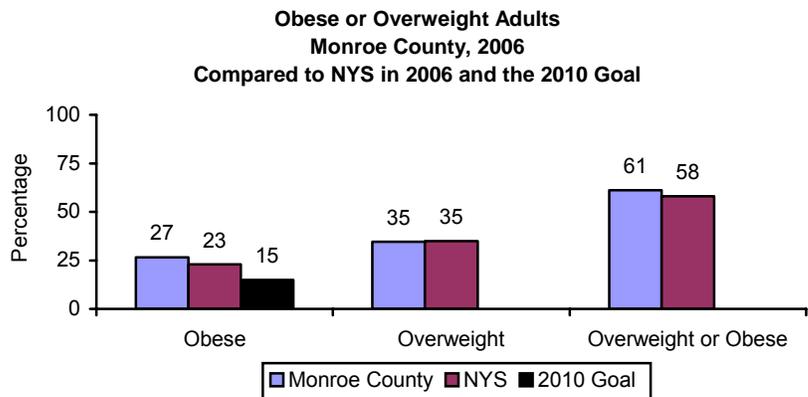


Males were more likely than females to be overweight.



There was no difference in the rate of obesity/overweight by residence.

As shown in the graphic to the right, the percentage of adults in Monroe County who are obese (27%) did not meet the 2010 Goal (15%). Rates of obesity and overweight in Monroe County are not significantly different compared to NYS.



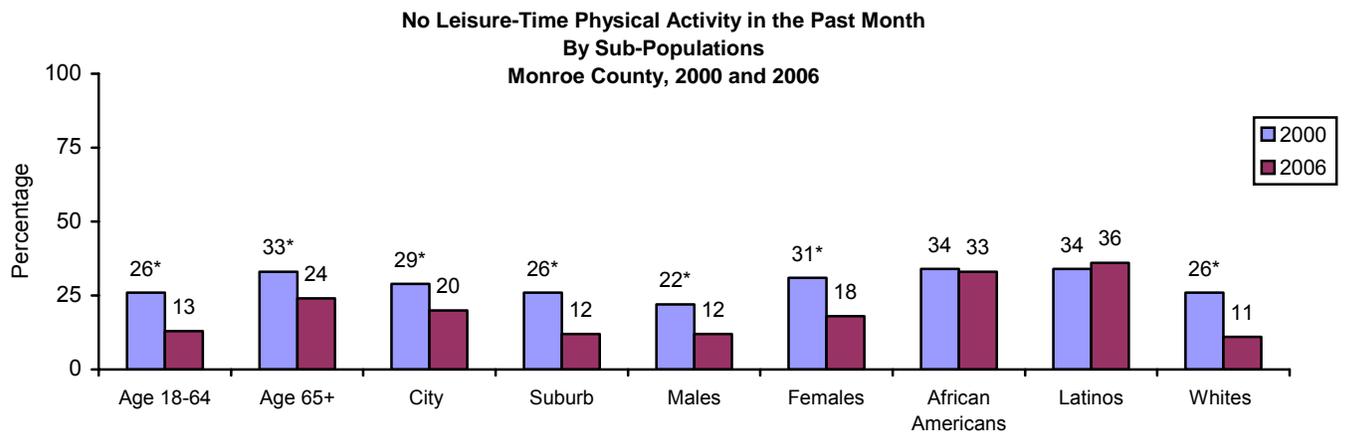
No-Leisure-Time Physical Activity

Source: Adult Health Survey (AHS) 2000 and 2006, MCDPH

About the data: Leisure-time physical activity is defined as walking for exercise, golf, gardening, running or any other exercise or physical activity done during non-work time.

It should be noted that the 2006 Monroe County AHS was conducted during the summer months, when residents tend to be more active, the 2000 AHS was conducted in the winter months, and the New York State BRFSS was conducted throughout the year. The fact that the surveys were administered during different times of the year may have contributed at least in part to the better reported rates of physical activity in the 2006 AHS compared to the 2000 AHS and the NYS BRFSS.

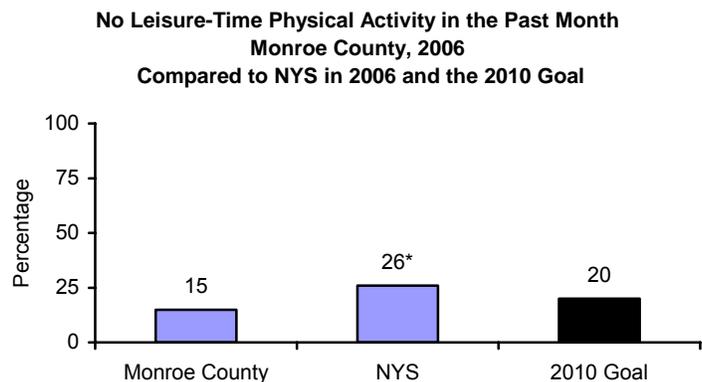
Findings: The percentage of adults reporting no past month leisure-time physical activity improved from 27% in the 2000 AHS to 15% in the 2006 AHS. Improvements were made among all sub-populations except African Americans and Latinos as shown in the graphic below.



In 2006, the proportion of adults who reported no leisure time activity was higher among

- Older adults (24%*) compared to adults under age 65 (13%)
- Females (18%*) compared to males (12%)
- City residents (20%*) compared to suburban residents (12%)
- African Americans (34%*) and Latinos (36%*) compared to Whites (11%)

The proportion of adults who reported no leisure-time physical activity in Monroe County is better than NYS and the 2010 Goal as shown in the graphic to the right.



Meet Recommended Physical Activity Guidelines

Source: Adult Health Survey, 2006, MCDPH

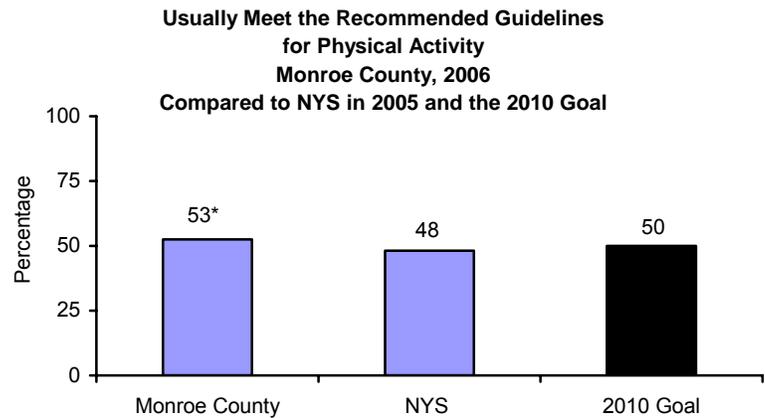
About the data: Recommended guidelines from the Centers for Disease Control and Prevention call for adults to engage in moderate-intensity physical activity for 30 minutes or more on 5 or more days of the week and/or vigorous intensity activity for 20 minutes or more on 3 or more days of the week. Respondents to the AHS were asked a series of questions about the frequency and duration at which they usually engage in moderate and vigorous activity.

Trend data on this measure is not available because the questions in the 2006 AHS are different from those in the 2000 AHS.

Findings: In 2006, 53% of Monroe County adults reported that they usually engage in the recommended amount of physical activity.

African Americans (46%*) and Latinos (43%*) compared to Whites (54%), and older adults (42%*) compared to younger adults (55%), were less likely to report they usually engage in the recommended amounts of physical activity.

The percentage of adults who reported they usually engage in the recommended amounts of physical activity in Monroe County is higher than NYS and the 2010 Goal for the Nation.



Fruit/Vegetable Intake

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

About the data: It should be noted that the 2006 AHS was conducted in the summer when consumption of fruits and vegetables might be higher, while the 2000 AHS was conducted during the winter. Respondents to the AHS were asked about their intake of fruits and vegetables on the day prior to the survey.

Findings: In 2006, 21% of adults reported they consumed five or more servings of fruits and vegetables, compared to 16% in 2000. Increases occurred among Whites and suburban residents. There were no changes among African Americans, Latinos and city residents.

As shown in the table below, males, city residents, African Americans, and Latinos were less likely to report they consumed the recommended amounts of fruits and vegetables in 2006 compared to suburban residents and Whites.

Percentage of Monroe County Adults Who Reported Consuming Five or More Servings of Fruits and Vegetables on the Day Prior to the Survey, 2006

	Age 18-64	Age 65+	Male	Female	City	Suburb	African Amer.	Latino	White
Consumed 5+ Fruits/Vegetables	20	24	16*	25	17*	23	12*	10*	22

Calcium Intake

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

Findings: In the 2006 AHS, 33% of adults reported they consumed three or more servings of milk and dairy products and twenty three percent (23%) reported they take daily calcium supplements. Forty-eight percent (48%) reported they consume three or more servings of milk and dairy products per day and/or take daily calcium supplements. These percentages are not statistically different from the percentages from the 2000 AHS.

African Americans and Latinos were less likely to report consuming three or more servings of milk and dairy products per day and/or consuming daily calcium supplements, compared to suburban residents and Whites.

Purchasing/Consuming Foods High in Fat/Saturated Fat/Trans Fat

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

Findings: In the 2006 AHS, respondents reported the following food intake behaviors:

- 10% most often use whole milk
- 42% used whole or 2% milk
- 13% use butter, stick margarine, shortening or lard most often
- 38% seldom or never choose low fat foods when eating away from home
- 18% almost always or usually choose fast food when eating away from home
- 14% seldom or never buy lean or low fat meat

As shown in the table to the right, Monroe County adults were less likely to report purchasing and/or consuming foods high in fat, saturated fat and trans fat in 2006 compared to 2000.

**Percentage of Adults Who Reported Consuming/Purchasing High Fat Foods
Monroe County, 2000 and 2006**

	2000	2006
Use whole or 2% milk	48*	42*
Seldom or never choose low fat foods when eating away from home	48*	38*
Almost always or usually choose fast food when eating away from home	22*	18*

The table below shows that males, city residents, African Americans and Latinos were more likely than females, suburban residents, and Whites to report consuming and/or purchasing foods high in fat saturated fat and trans fat.

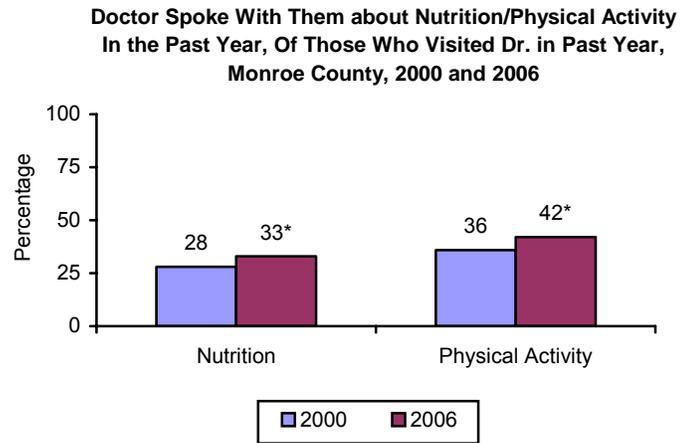
Percentage of Adults Who Reported Consuming/Purchasing High Fat Foods, Monroe County, 2006

	Age 18-64	Age 65+	Male	Female	City	Suburbs	African Amer.	Latino	White
Use whole milk	10*	5	12*	8	17*	6	28*	24*	5
Use whole or 2% milk	43	38	47*	37	55*	34	80*	63*	34
Seldom or never choose low fat foods when eating away from home	40*	33	50*	28	46*	34	52*	44	35
Almost always or usually choose fast food when eating away from home	20*	7	21*	14	22*	15	35*	25	15
Seldom or never buy lean or low fat meat	13	14	16*	11	19*	11	28*	29*	10

Preventive Counseling Related to Diet and Eating Habits

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

Findings: Of Monroe County adults who reported they visited a doctor for a routine check-up within the past year, 42% reported their doctor spoke with them about physical activity and 33% reported that they talked with them about diet and eating habits. These percentages increased since 2000 as shown in the graphic below.



Goal: Reduce Cigarette Smoking

Cigarette smoking is the number one preventable cause of disease and death in the United States.¹¹ It is a major risk factor for heart disease, stroke, cancer and chronic lung disease.¹² One third of all cancer deaths are attributed to smoking.¹³ Smoking is not only harmful to those who smoke, it has also been shown to be harmful to those exposed to secondhand smoke.¹⁴

There are significant health benefits of smoking cessation including reduced risk for developing tobacco related diseases and a slowing of the progression of these diseases among those who are afflicted.¹⁵ Studies have shown that a physician's advice to stop smoking increases the rate of smoking cessation by about 30%.¹⁶ The U.S. Public Health Service recommends that clinicians and health care delivery systems institutionalize the consistent identification, documentation and treatment of every tobacco user seen in the health care setting.¹⁷

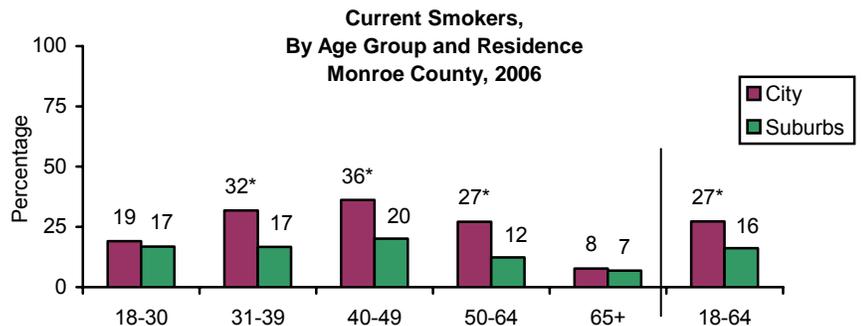
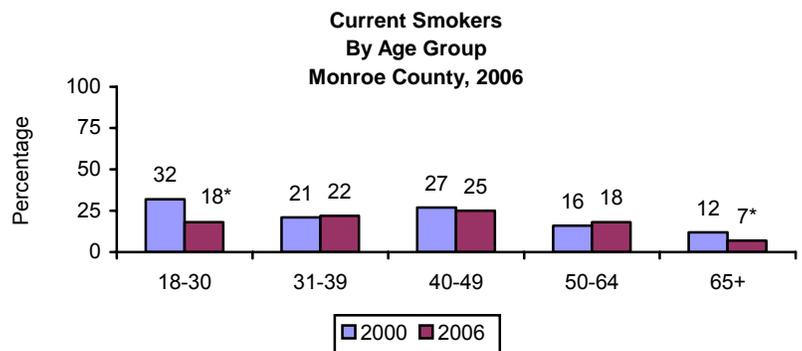
Measures

Current Smoking

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

Findings: The percentage of adults who reported they smoked declined from 22% in 2000 to 18% in 2006. During this time period, smoking rates among those ages 18-30 years old and aged 65 years and older were reduced by almost half. Rates among those aged 31-64 remained stable.

Among adults ages 31-64, city residents were more likely to report that they smoke compared to suburban residents.



¹¹ Mokdad, A., Marks, J., Stroup, D., Gerberding, J. "Actual causes of death in the United States, 2000." *JAMA*. 291 No. 10 (2004):1238-1245. <http://www.csdp.org/research/1238.pdf> <accessed April 2008>

¹² Centers for Disease Control, *At A Glance: Targeting Tobacco Use: The Nation's Leading Cause of Death*, 2002. <http://www.cdc.gov/tobacco/overview/oshag.pdf> (June 17, 2002)

¹³ McGinnis, et al. "Actual Causes of Death in the United States, 2001." *JAMA*. 2004;291:1238-1245.

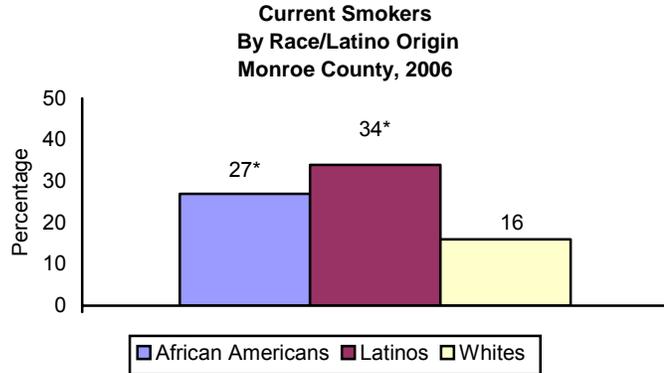
¹⁴ Glantz, SA and Parmely, WW. "Passive Smoking and Heart Disease: Mechanism and Risk." *JAMA* 273(1995):1047-53.

¹⁵ Department of Health and Human Services. "The Health Benefits of Smoking Cessation: A report of the Surgeon General." Washington, DC: Government Printing Office, 1990. DHHS publication # (CDC) 90-8416).

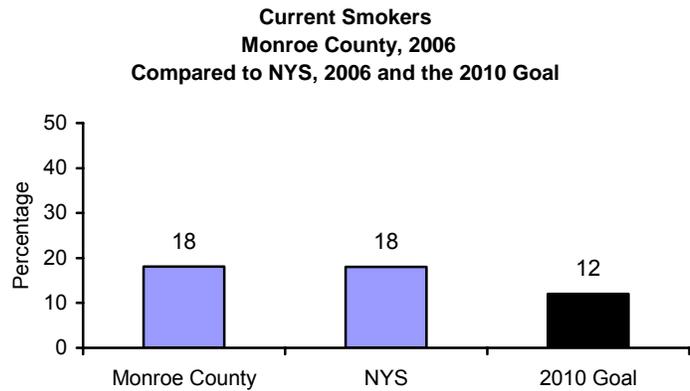
¹⁶ Fiore MC, Bailey WC, Cohen SJ et al. *Treating Tobacco Use and Dependence*. Rockville, Md: DHHS, PHS, 2000.

¹⁷ U.S. Public Health Service. *Treating Tobacco Use and Dependence: Summary*, June 2000. <http://www.surgeongeneral.gov/tobacco/smokesum.htm> (June 17, 2002)

African Americans and Latinos were significantly more likely to report that they smoke compared to Whites.



As shown in the graphic to the right the percentage of Monroe County adults who reported they smoke (18%) did not meet the 2010 Goal and was comparable to the percentage in NYS in 2006.



Tried to Quit Smoking in the Past Year

Source: Adult Health Survey, 2006, MCDPH

Findings: Of Monroe County adults who smoke, 54% reported that they quit smoking for one or more days in the past year. There were no significant differences by residence, gender, race or ethnicity.

Doctor Talked with Them About Smoking

Source: Adult Health Survey, 2006, MCDPH

Findings: Of Monroe County adults who smoke, 72% reported that a health professional advised them in the past year to quit smoking. This percentage did not change significantly since the 2000 AHS.

There were no significant differences in this measure by residence, gender, race or ethnicity.

Goal: Improve Management of Chronic Disease

Management of chronic diseases like keeping diabetes and high blood pressure under control can reduce costly complications from these conditions. Chronic disease management requires a partnership between health care providers and their patients. Health care providers can order appropriate medical tests and provide counseling and instruction about the importance of, and how to manage chronic diseases. This instruction and counseling should be tailored to an individual's culture and literacy level. Health care providers can also direct individuals to community health resources like chronic disease management education/support programs. Individuals can take steps to follow their medical treatment plan by getting appropriate medical screenings, taking medication as directed, following their diet, engaging in regular exercise, and self monitoring of their blood pressure and/or blood sugar.

Measures

Management of Chronic Conditions, Managed Care Performance

Source: Managed Care Performance Measures, QARR, NYSDOH, 2007

About the data: These data are not only measures of how well enrollees self-manage their diseases, but also measures of the medical care provided.

Included in the data are Excellus (EXC) enrollees from the Northeast, Central and Western parts of NYS, and Preferred Care (PC) enrollees from Western NYS.

The data are derived from medical record review and are dependent upon the accuracy of reporting in the medical records and variation in data collector interpretation.

The measure of "high blood pressure under control" may be an underestimate of the actual percentage of enrollees with controlled blood pressure. The measure is based on the blood pressure reading taken during the last outpatient visit in the given year. The visit may have been due to illness or pain, both of which can contribute to elevated blood pressure levels.

Findings: The tables below show the proportion of enrollees in Excellus and Preferred Care Managed Care Programs whose chronic conditions were monitored and under control in 2006.

High Blood Pressure under Control Enrollees with Hypertension (ages 18-85 years old)	Medicaid			Commercial		
	EXC	PC	NYS	EX	PC	NYS
% who have controlled blood pressure (less than 140/90 mm Hg)	64	57	60	67▲	61	58

▲ significantly better than the statewide average

Cholesterol Management Enrollees with Cardiovascular Conditions (ages 18-75 years old)	Medicaid			Commercial		
	EXC	PC	NYS	EX	PC	NYS
% who had a LDL-cholesterol screening performed	87	64▼	89	90	91	90
% whose LDL-cholesterol levels were in control (<100 md/dL)	52	53	46	61▲	66▲	54

▲ significantly better than the statewide average

▼ significantly worse than the statewide average

Diabetes Management and Control Enrollees with Diabetes (ages 18-75 years old)	Medicaid			Commercial		
	EXC	PC	NYS	EX	PC	NYS
% who received a Hemoglobin A1c (HbA1c) test within the last year	89▲	88	86	91▲	93▲	88
% whose most recent (HbA1c) test indicated good control (<7.0%)	40▲	39	35	51▲	46	43
% who had a cholesterol test done in the past year	82	79▼	85	90	86	87
% who had a cholesterol test done in the past year and whose most recent level of LDL cholesterol was controlled (LDL-C <100mg/dL)	37	40	39	51▲	40	44
% who had a blood pressure measurement of <130/80 mm Hg in the past year	38▲	32	30	38▲	29	27

▲ significantly better than the statewide average
▼ significantly worse than the statewide average

Physician Counseling Related to Physical Activity and Nutrition among those with Diabetes, High Blood Pressure and/or High Cholesterol

Source: Adult Health Survey (AHS), 2006, MCDPH

Physician Counseling About Physical Activity and Nutrition Among those With Diabetes, High Blood Pressure or High Cholesterol Who Visited Their Doctor in the Past Year
Monroe County Adults, 2006

Findings: As shown in the table to the right, about half of those with diabetes, high blood pressure and/or high cholesterol reported that within the past year, their doctor spoke with them about physical activity and 44% reported their doctor spoke with them about their eating habits.

In the Past Year Their Doctor Talked With them About	Have Diabetes/ High Blood Pressure/ High Cholesterol	Do not have one of the conditions
Physical Activity	51%*	31%
Their Eating Habits	44%*	21%

Physical Activity among those with Diabetes, High Blood Pressure, and/or High Cholesterol

Source: Adult Health Survey (AHS), 2006, MCDPH

Findings: The table below shows that those who have diabetes, high blood pressure and cholesterol are less likely to engage in physical activity compared to those without these conditions.

Reported Physical Activity Among those With Diabetes/High Blood Pressure and/or High Cholesterol, Monroe County, 2006

	Have Diabetes/ High Blood Pressure/ High Cholesterol	Do not have one of the conditions
No Past Month Leisure Time Physical Activity	18%*	12%
Meet Recommendations for Physical Activity	47%*	57%

Food Intake Behaviors among those with Diabetes, High Blood Pressure and High Cholesterol

Source: Adult Health Survey, 2006, MCDPH

Findings: Adults with diabetes, high blood pressure or high cholesterol were less likely to report they frequently consume fast food compared to adults without these conditions (14% compared to 21%). There were no other significant differences in other reported food intake behaviors.

PREVENTIVE HEALTH SERVICES

Appropriate use of preventive health services can significantly decrease rates of disability, hospitalizations and deaths. Immunizing for influenza and pneumonia among older adults reduces hospitalization rates. Early detection of breast and colon cancer has been shown to reduce mortality rates. Screening for and treatment of high blood pressure and high cholesterol can reduce the incidence of coronary artery disease.

Goal: Promote Use of Preventive Health Services

Measures

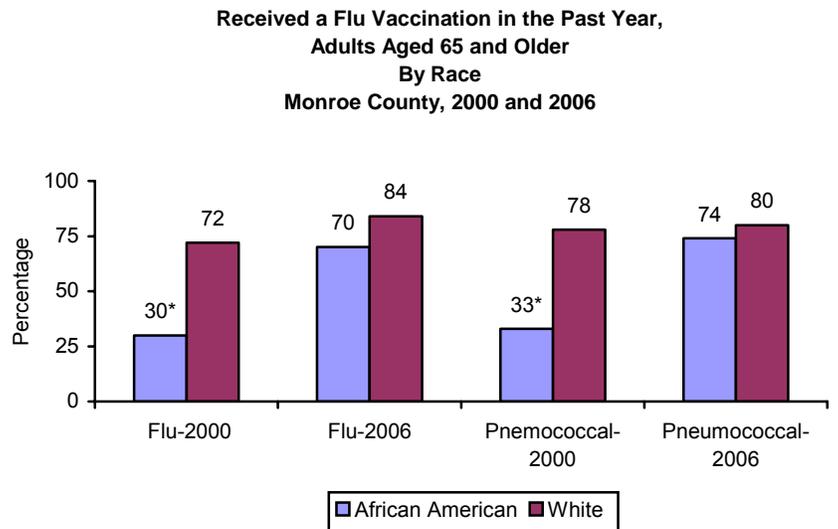
Immunization Rates

Source: Adult Health Survey, 2000 and 2006, MCDPH

About the data: The Centers for Disease Control recommends an annual influenza vaccination and a one-time pneumococcal vaccination for all adults age 65 and older, and for all adults under age 65 who have certain chronic medical conditions (including heart disease, diabetes, asthma, other chronic lung diseases, cancer, alcoholism, kidney or liver disease or any other condition that weakens the immune system).

Findings: In 2006, 83% of adults aged 65 years and older in Monroe County reported they received an influenza vaccination in the past year, and 79% reported they ever received a pneumococcal vaccination. The 2010 Goals for both of these indicators is 90%.

In 2000, there were significant disparities in immunization rates between African Americans and Whites and by 2006, these disparities were eliminated as shown in the graphic to the right.



Of adults *under age 65 who have a chronic condition* 58% reported they received a flu shot within the past year and 35% reported that they ever received a pneumococcal vaccine. These percentages are below the 2010 Goal (60%) but are better than NYS and the US as a whole.

Mammography Rates

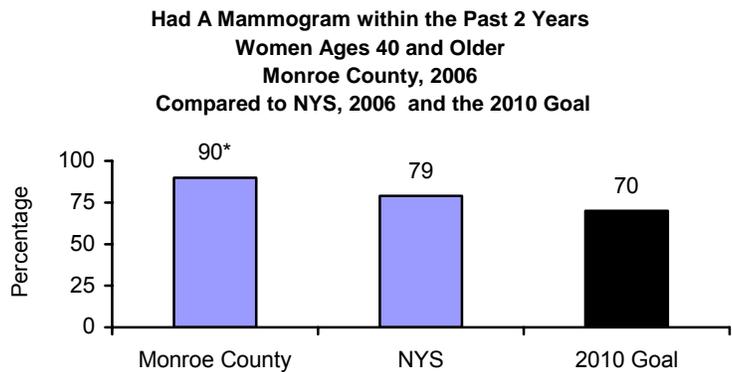
Source: Adult Health Survey, 2000 and 2006, MCDPH

About the data: The US Preventive Health Services Task Force recommends that women age 40 and older receive a mammogram every one to two years.

Findings: In 2006, 90% of women aged 40 and older report they had a mammogram within the past 2 years. This rate declined from 94% in 2000. The decline in mammography rates also occurred nationally.

There were no significant differences in reported mammography rates by residence, race, or Latino Origin.

The mammography rate in Monroe County is better than NYS and has met the 2010 Goal.



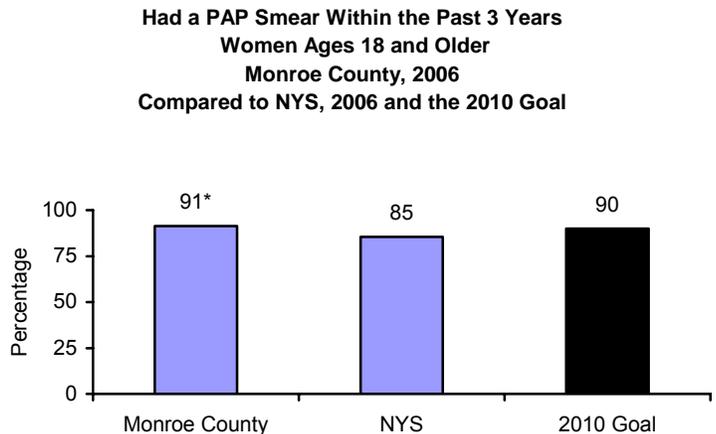
Cervical Cancer Screening

Source: Adult Health Survey, 2006, MCDPH

About the data: The US Preventive Health Services Task Force recommends that adult women have a PAP smear at least every three years to screen for cervical cancer.

Findings: Ninety-one (91%) of Monroe County women reported they had a PAP smear within the past 3 years. There were no differences by race or residence.

As shown in the graphic to the right, the percentage of Monroe County women screened for cervical cancer is better than the percentage in NYS and has met the 2010 Goal for the Nation.

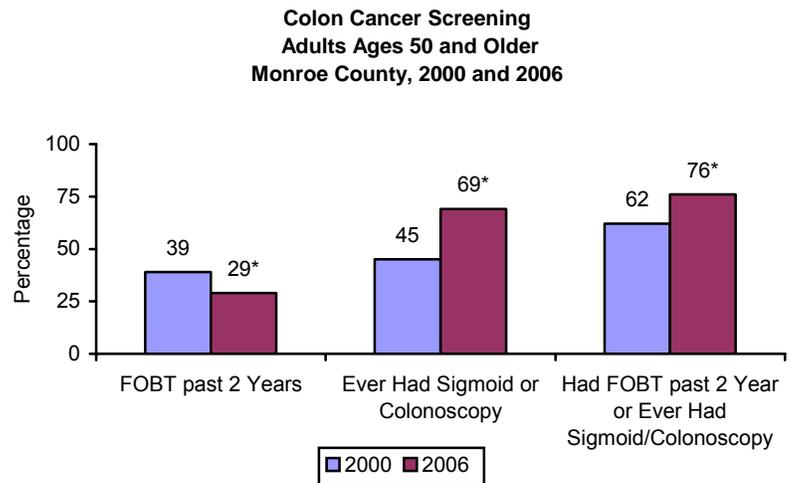


Colorectal Cancer Screening

Source: Adult Health Survey, 2000 and 2006, MCDPH

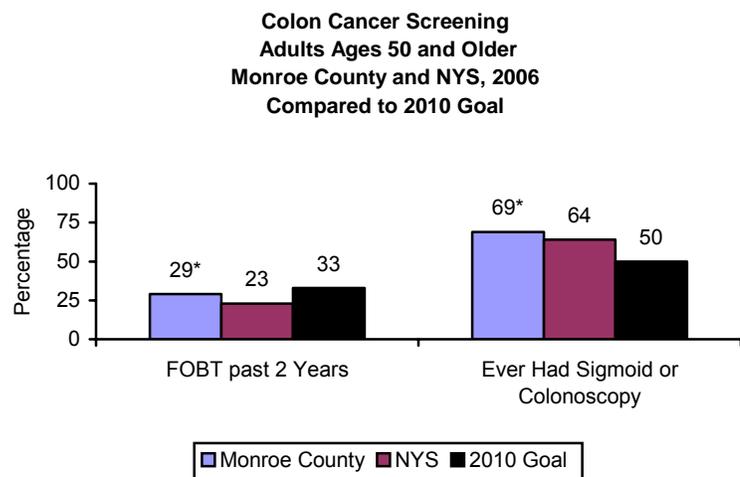
About the data: The US Preventive Services Task Force recommends colorectal cancer screening for all adults aged 50 and older. Options for screening include at-home fecal occult blood test (FOBT), flexible sigmoidoscopy, colonoscopy or double-contrast barium enema. The Task Force notes that there is insufficient evidence to recommend one method over another. Only questions about FOBT and sigmoidoscopy/colonoscopy screening were included in the AHS. Note that in the 2000 AHS respondents were asked whether they ever had a proctoscopy or sigmoidoscopy test, and in the 2006 AHS the question was changed to include sigmoidoscopy or colonoscopy tests. This change in wording contributed in part to the increased rate between 2000 and 2006.

Findings: The percentage of adults age 50+ who received a FOBT declined between 2000 and 2006, while the percentage who received a colonoscopy or sigmoidoscopy increased as shown in the graphic to the right.



In 2006, African Americans (59%*) were less likely than Whites (71%) to report they ever had a colonoscopy. (note: rates for Latinos were not available due to a small number of Latino adults over age 50 who participated in the survey).

The percentage of adults who reported they were screened for colon cancer was higher in Monroe County compared to NYS. The rate for colonoscopy screening in Monroe County and NYS met the 2010 Goal.



Blood Pressure Screening and Awareness

Source: Adult Health Survey, 2000, 2006, MCDPH

Findings: Ninety-six percent (96%) of Monroe County adults reported they had their blood pressure checked within the past two years, and knew whether their level was high, normal or low. This percentage met the 2010 Goal.

There were no differences by race/Latino origin or residence.

Cholesterol Screening

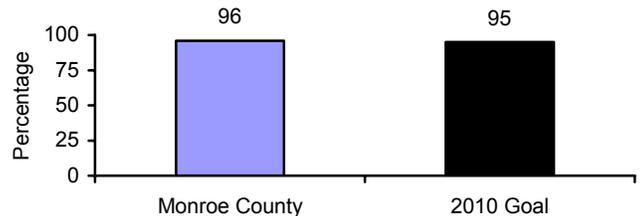
Source: Adult Health Survey, 2000 and 2006, MCDPH

Findings: In 2006, 85% of Monroe County adults reported they were screened for high cholesterol in the past 5 years. This percentage did not change significantly since 2000.

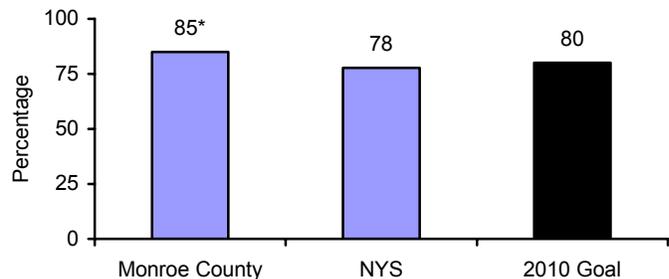
City residents (82%*) were less likely than suburban residents (87%), and African Americans (81%*) were less likely than Whites (87%) to report they were tested within the past 5 years. These differences may be due in part to the fact that the White and Suburban populations tend to be older and screening rates are higher among older adults.

As shown in the graphic to the right, the percentage of Monroe County adults who reported they were screened for high cholesterol (85%), met the 2010 Goal, and was better than the NYS percentage in 2005.

**Blood Pressure Checked in the Past 2 Years and Knew Their Level
Monroe County, 2006
Compared to the 2010 Goal**



**Had Their Cholesterol Checked in the Past 5 Years
Monroe County, 2006
compared to NYS, 2005**



Under Doctor's Care for High Blood Pressure and High Cholesterol

Source: Adult Health Survey, 2006, MCDPH

Findings: Sixty-nine percent (69%) of adults who were ever told they had high blood pressure and 59% who were ever told they had high cholesterol, reported they were currently under a doctor's care for the condition.

MENTAL HEALTH

Mental health is essential to overall health and well-being. The World Health Organization describes mental health as “a state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”¹⁸

GOALS FOR MENTAL HEALTH

Goal: Improve Mental Health

Mental problems like anxiety and depression can have a major impact on a person’s overall quality life and ability to function as a productive member of society. The onset, progression and outcome of physical illnesses can be negatively impacted by mental health problems. Individuals with mental health problems are more likely to engage in health risk behaviors like substance abuse, tobacco use, and physical inactivity.

Mental disorders account for about one fourth of the disability in the US, Canada and Western Europe.¹⁷ In any given year, approximately 22% of the US population has one or more diagnosable mental disorders.¹⁹ Of the US adult population, in any given year, about 8.5% have a mood disorder (including depression, dysthymic disorder or bi-polar) and 18.1% have an anxiety disorder.²⁰

An important gain in addressing mental health problems in NYS was the passage of Timothy’s law in 2006. The law, which went into effect in January of 2007, requires that health insurance plans sold in NYS provide comparable coverage for mental health conditions as it does for physical health ailments.

Measures

It should be noted that the only available measures for mental health in Monroe County are data about mental health problems. The Department of Psychiatry of the University of Rochester along with the Mental Health Promotion Task Force, are working to identify additional measures of mental health.

¹⁸ World Health Organization. (2001). *The World Health Report 2001 - Mental Health: New Understanding, New Hope*. Geneva: World Health Organization

¹⁹ US Department of Health and Human Services. *Mental Health: a report of the Surgeon General*. Rockville, MC: US Department of Health and Human Services;1999.

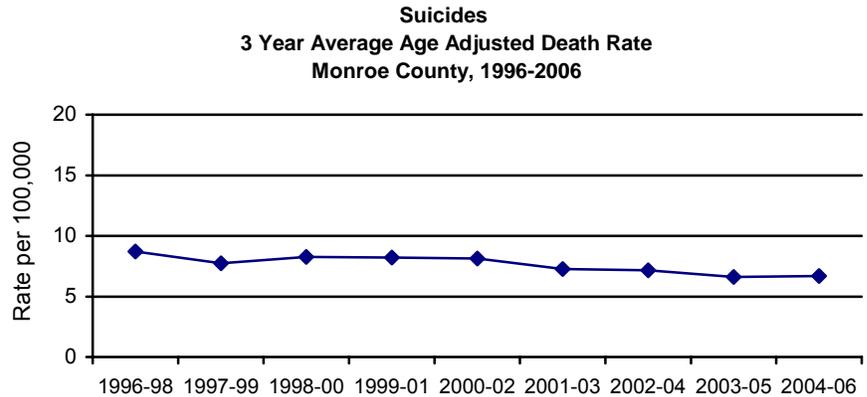
²⁰Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.

Deaths Due to Suicide

Source: Vital Records, MCDPH and NYSDOH.

Findings: On average each year between 2004 and 2006, 48 adults died from suicide. Seventy-eight percent (78%) of these adults were under age 65.

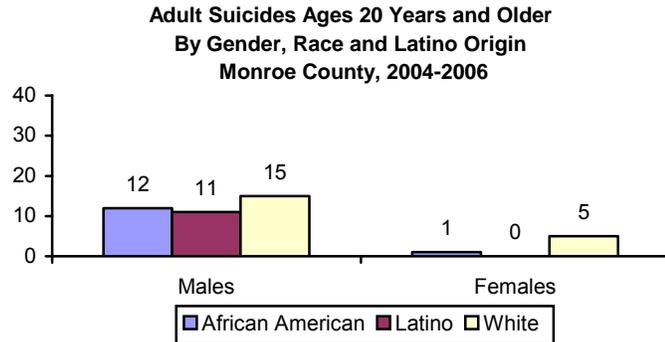
Between 1996 and 2006, the age adjusted death rate due to suicide declined slightly.



Nationally, suicide rates are significantly higher among those aged 65 years and older, compared to younger adults. This same trend is seen in Monroe County however the difference in the rates is not statistically significant due to small numbers. The rate among adults aged 20-64 years old is 8/100,000, while the rate among older adults is 11/100,000.

The adult suicide rate is nearly four times higher among males (15/100,000*) compared to females (4/100,000).

Rates among white males and females are higher than rates among African American and Latinos. However because of the small number of suicides, the rates are not statistically significant.



The age-adjusted suicide rate in Monroe County (6.7/100,000) is not different from the rate in NYS and did not meet the 2010 Goal for the Nation (4.8).

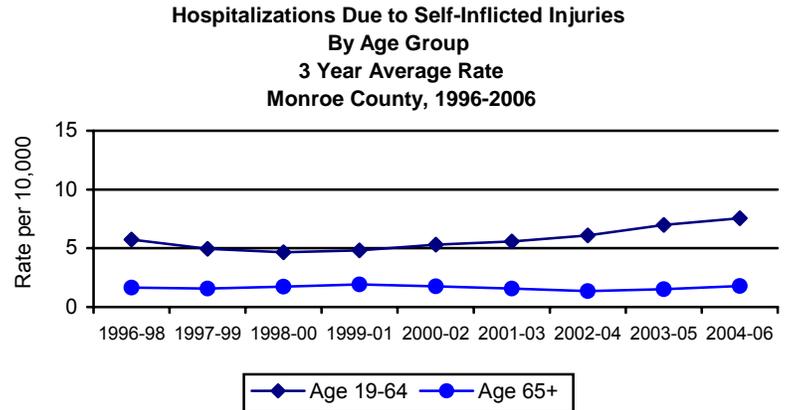
Hospitalizations Due to Self-Inflicted Injuries

Source: SPARCS, NYSDOH

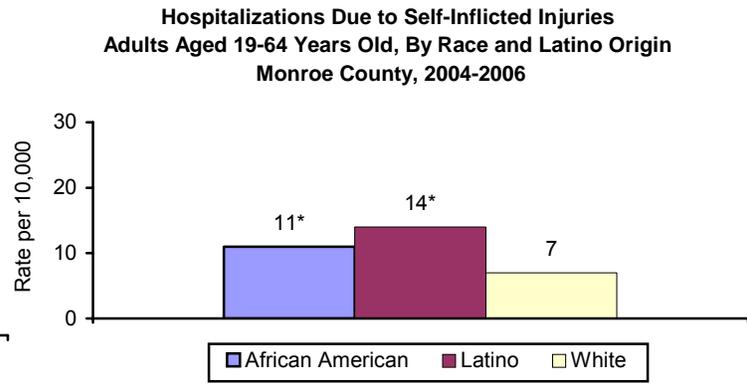
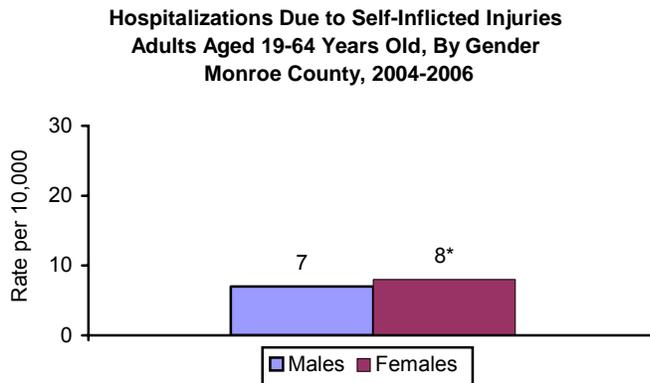
Findings: On average each year between 2004 and 2006, there were 355 hospitalizations due to self-inflicted injuries among adults aged 19 years and older. Ninety-five percent (95%) of the hospitalizations were among adults under age 65.

Between 2001 and 2006, there was a 50% increase in the number of hospitalizations due to self-inflicted injuries among adults under age 65 years old.

As shown in the graphic, the hospitalization rate among younger adults increased significantly, while the rate among those aged 65 years and older remained stable.



Of the hospitalizations due to self-inflicted injuries among those aged 19-64 years old, the rate was higher among females compared to males, and among African American and Latinos compared to Whites.



Self-Reported Suicide Attempts

Source: Adult Health Survey, 2006, MCDPH

Findings: In 2006, 0.7% of Monroe County adults reported they made a plan to attempt suicide within the past year, and 0.4% reported they attempted suicide within the past year. These percentages were similar to those in 2000.

City residents (1.4%*), Latinos (3%*) and African Americans (1.6%) were more likely than suburban residents (0.3%) and Whites (0.5%) to report they made a plan to attempt suicide in the past year.

There were no other significant differences.

Frequent Mental Distress

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

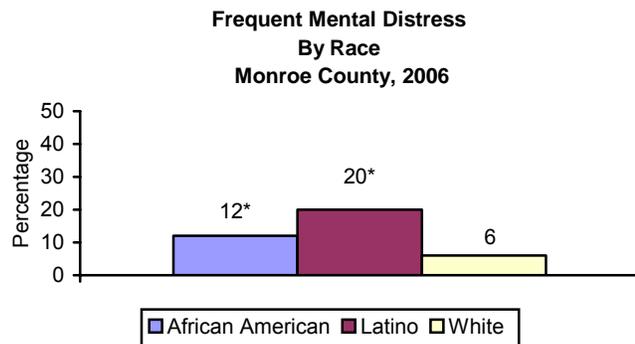
About the data: The Centers for Disease Control uses a measure called “Frequent Mental Distress” (FMD) to estimate the prevalence of mental health issues in a community. An individual is identified as having FMD when they report that their mental health was not good during 14 or more of the past 30 days. (Mental health includes stress, depression and problems with their emotions)²¹

Findings: In 2006, 8% of Monroe County adults reported they had frequent mental health distress in 2006 which is not different from the percentage in 2000.

Adults ages 18-64 years old (9%*) were more likely to report FMD compared to adults aged 65 and older (4%).

City residents (11%*) were more likely than suburban residents (6%) to report FMD. There were differences by residence in nearly every age group.

African Americans and Latinos were more likely to report FMD compared to Whites. These differences occurred in nearly all age groups.



The percentage of adults reporting frequent mental distress in Monroe County is not different from the percentage in NYS.

Functional Limitations Due to Emotional/Mental Health Issues

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

Findings: The table below shows the percentage of Monroe County and City adults who reported various functional limitations due to emotional health issues. The prevalence of most of these functional limitations increased in the city between 2000 and 2006.

Functional Limitations Monroe County and City Adults , 2000 and 2006	Monroe County		City of Rochester	
	2000	2006	2000	2006
Accomplished less than they would have liked due to emotional problems – <u>all or most of the time</u> during the past 4 weeks	4%	6%*	6%	8%*
Worked less carefully due to any emotional problems - <u>all or most of the time</u> during the past 4 weeks	4%	5%	5%	8%*
Felt calm and peaceful – <u>none or a little of the time</u> – during the past 4 weeks	10%	11%	10%	14%*
Felt downhearted and depressed - <u>all or most of the time</u> during the last 4 weeks	6%	5%	8%	7%

²¹ Morbidity and Mortality Weekly Review. CDC. May 01, 1998 / 47(16);325-331

Overall the percentages of adults reporting these functional limitations were higher among city residents compared to suburban residents, and among African Americans and Latinos compared to Whites. There were no significant differences by age group or gender.

Use of Medication for Mental Health Problems

Source: Adult Health Survey, MCDPH

Findings: Fifteen percent (15%) of Monroe County adults in 2006, reported that they were currently taking prescription medications for mental health problems such as personal or family problems, depression, anxiety or stress, an increase from 10% in 2000.

In 2006, a higher percentage of females (18%*) reported taking medication for mental health problems compared to males (12%).

Preventive Counseling for Mental Health Problems

Source: Adult Health Survey, MCDPH

Findings: Of Monroe County adults who reported they visited a doctor for a routine check-up within the past year, 35% in 2006 said their doctor talked with them about whether or not they experience depression, anxiety, or stress, an increase from 25% in 2000.

In 2006, females (40%*) compared to males (28%), and younger adults (39%*) compared to older adults (19%), were more likely to report their doctor spoke with them about mental health issues.

Mental Health Problems Among Older Adults Served by Eldersource

Source: The Senior Health and Research (SHARE) Alliance, NIMH R24 MH071604; Y.Conwell, PI.

About the Data: The University of Rochester School of Medicine and Dentistry Department of Psychiatry, Lifespan and Catholic Family Center are partners in SHARE. Through SHARE, care managers in the Eldersource Program, a joint Lifespan/Catholic Family Center care management program, were trained in the use of screening tools to recognize mental health disorders among community-dwelling older adult clients. Two hundred seventy-nine (279) older adults receiving care management services from Eldersource were screened in 2006 and 2007. It should be noted that these data are not representative of the entire community-dwelling older adult population. They only represent those accessing services through Eldersource.

Findings: Based on the screenings conducted by care managers, it is estimated that approximately 1/3 of Eldersource clients screened were depressed. Mental health problems were correlated with physical health, social support and ability to perform instrumental activities of daily living like doing housework, preparing meals, shopping, managing money and taking medication.

Goal: Reduce Alcohol Use Disorders and Substance Abuse

Alcohol use disorders and substance abuse are major public health problems that impact the community at many levels, and cost the US economy an estimated \$276 billion per year in health care expenses, lost productivity, motor vehicle crashes and crime.²² Forty-one percent of all traffic fatalities are alcohol related.²³ An estimated 60% of adults in Federal prisons are there for drug related crimes.²⁴

Measures

Alcohol Use Disorders (Based on Self-Report)

Source: Adult Health Survey (AHS), 2000 and 2006, MCDPH

About the data: Alcohol use disorders include alcohol dependence, abuse, intoxication and withdrawal. The AUDIT-C is a three-item screening tool for alcohol use disorders taken from the full Alcohol Use Disorder Identification Test.²⁵ Below are the three AUDIT-C questions that were included in the AHS:

- In the past year, how often did you have a drink containing alcohol?
- In the past year, how many drinks did you have on a typical day when drinking?
- In the past year, how often did you have six or more drinks on one occasion?

Each question was scored from 0-4 points, depending on the respondent's report of the frequency of the behavior. A score of 4 or more indicates that the respondent is at risk for an alcohol use disorder.

Findings: In 2006, 25% of Monroe County adults were estimated to be at risk for an alcohol use disorder, which is not different from the percentage in 2000.

Younger adults were more likely to be at risk for alcohol use disorders compared to older adults.



²² Substance Abuse: The Nation's Number One Health Problem," Institute for Health Policy, Brandeis University, 2001.

²³ 2006 Traffic Safety Annual Assessment, Alcohol Related Fatalities, 2006. National Highway Traffic Safety Administration. <http://www-nrd.nhtsa.dot.gov/Pubs/810821.PDF> (April 9, 2008).

²⁴ National Center on Addiction and Substance Abuse at Columbia University (CASA). Behind bars: Substance abuse and America's prison population, New York, CASA, 1998.

²⁵ Bush, et al. "The AUDIT Alcohol Consumption Questions (AUDIT-C) – An Effective Brief Screening Test for Problem Drinking," *Archives of Internal Medicine*, Vol. 158, No. 16, September 14, 1998.

Males (37%*) were more likely than females (14%) to be at risk for alcohol use disorders. This difference between genders occurred in most age groups. There were no differences by residence, race or Latino Origin.

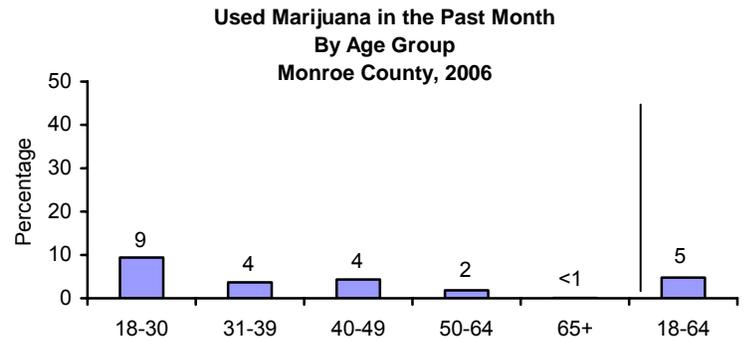
Past Month Marijuana Use

Source: Adult Health Survey (AHS), 2006, MCDPH

Findings: Four percent (4%) of Monroe County adults reported using marijuana one or more times during the past month.

Adults aged 18-30 were more likely to report marijuana use compared to all other age groups.

City residents (6%*) were more likely than suburban residents (3%), males (5%*) were more likely than females (3%), and African Americans (9%*) were more likely than Whites (3%) to report marijuana use. The percentage of Latinos reporting marijuana smoking (9%) was higher than among Whites, (3%) although the difference was not statistically significant. The differences among subpopulations occurred even after adjusting for age.



Preventive Counseling for Alcohol and Drug Use

Source: Adult Health Survey (AHS), 2006, MCDPH

Findings: Of Monroe County adults who reported they visited a doctor for a routine check-up within the past year, 25% reported that their doctor talked with them about their alcohol use and 18% reported their doctor spoke with them about drug use. Adults under age 30 were most likely to report their doctor spoke with them about alcohol use (32%) and drug use (28%)

African Americans (28%*) and Latinos (25%*) were more likely than Whites (16%), and city residents (23%*) were more likely than suburban residents (15%) to report that their doctor spoke with them about drug use.

Drinking and Driving

Source: Adult Health Survey (AHS), 2006, MCDPH

Findings: Three percent (3%) of adults in Monroe County adults reported that they drove one or more times in the past month when perhaps they had too much to drink. When this figure is applied to the population, it is estimated that 14,000 adults in Monroe County drive drunk each month.

Adults ages 18-64 (3%*) were more likely to report drinking and driving compared to older adults (0.5%). There were no differences by gender, residence, race or Latino Origin.

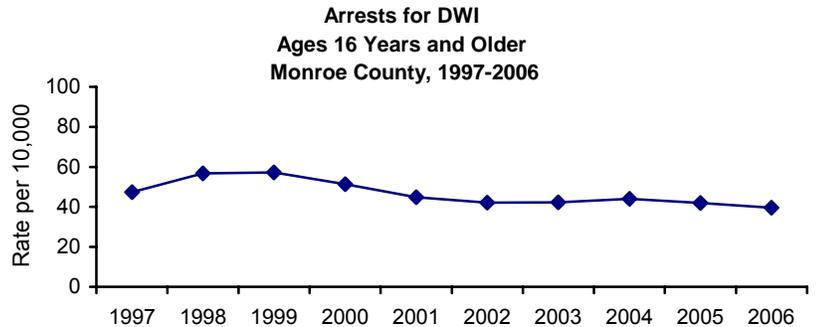
Arrests for Driving While Intoxicated

Source: Source: DCJS, Computerized Criminal History system (as of 01/12/2007).
<http://www.criminaljustice.state.ny.us/crimnet/ojsa/stats.htm>

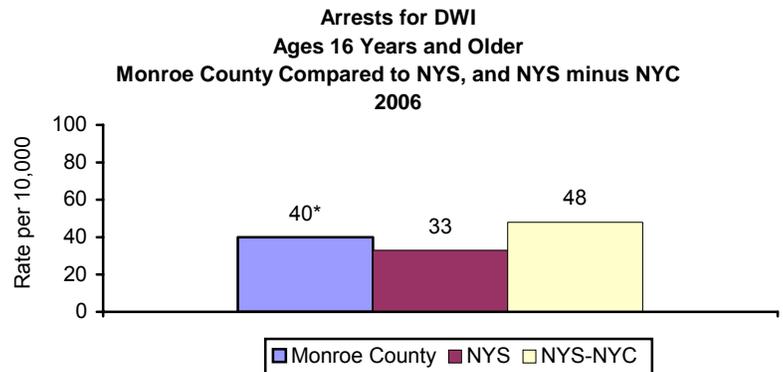
About the Data: These data include number of driving while intoxicated felony and misdemeanor arrests in Monroe County among those aged 16 years and older. It should be noted that this number is not the prevalence of driving while intoxicated. The number of arrests due to DWI is dependent on not only the number of people who drive while intoxicated, but also law enforcement response to this issue.

Findings: In 2006, there were 2,302 arrests for driving while intoxicated in Monroe County among those aged 16 years and older. Since 1999, the number of arrests declined by 29%.

The arrest rate also declined as shown in the graphic to the right.



The DWI arrest rate in Monroe County is higher than NYS, but lower than NYS minus NYC.

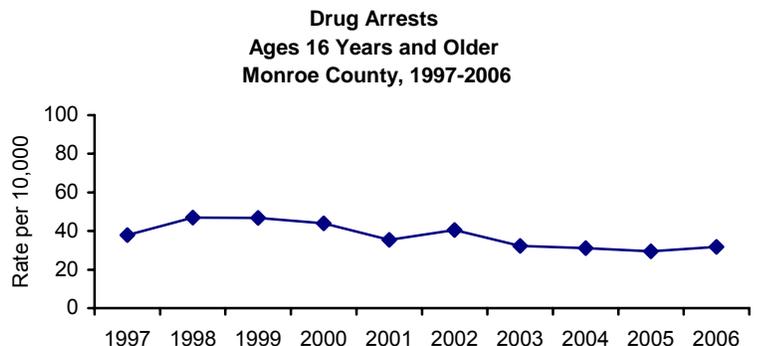


Drug Arrests

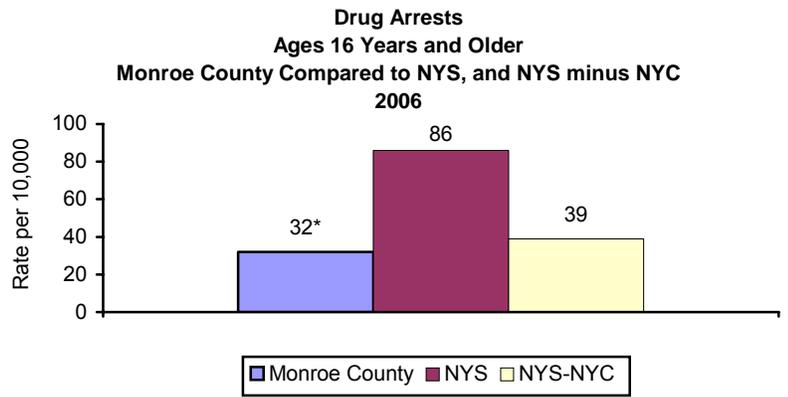
Source: Source: DCJS, Computerized Criminal History system (as of 01/12/2007).

About the data: Drug offenses include all charges listed under Penal Law Articles 220 (controlled substances) and 221 (marijuana). It includes sale and possession charges. The number of drug arrests is dependent on not only the number of people who possess and sell drugs, but also law enforcement response to this issue.

Findings: In Monroe County during 2006, there were 1,847 drug arrests. The drug arrest rate declined between 1999 and 2003 and has since leveled off.



The drug arrest rate in Monroe County is lower than NYS, and NYS minus NYC.



Goal: Reduce Violence

Violence results in significant mortality and morbidity in the US. The estimated total lifetime cost of physical injuries due to interpersonal violence occurring in 2000 was approximately \$37 billion - \$4 billion for medical treatment and \$33 billion for lost productivity.²⁶ These estimates only include the economic impact of the physical injury. Victims of violence often experience post-traumatic stress disorder, depression, anxiety, suicide ideation and substance abuse. Neighborhoods suffer significant social consequences of violence. Fear of being victimized often prevents people from being active in their community which results in social isolation. Violence also erodes communities by reducing productivity, decreasing property values, and disrupting social services.

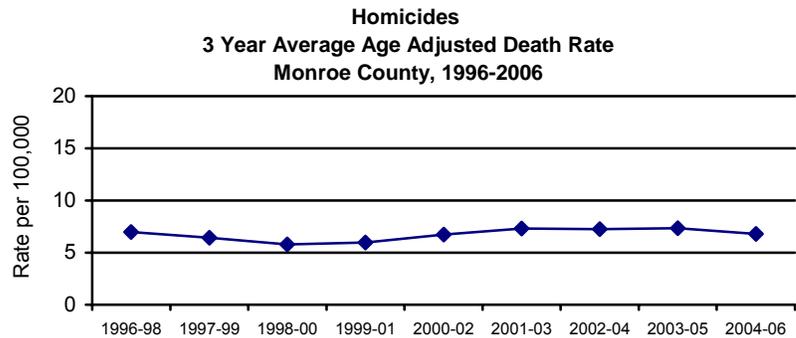
Measures

Homicides

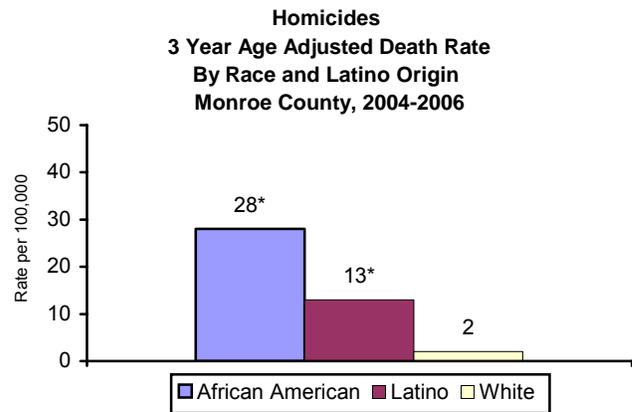
Source: Vital Records, MCDPH and NYSDOH

Findings: Homicide is the 4th leading cause of death among Monroe County adults ages 20-64 years old. On average each year between 2004 and 2006, 40 Monroe County adults were homicide victims.

Between 1996 and 2006, the age adjusted death rate due to homicide did not change significantly.

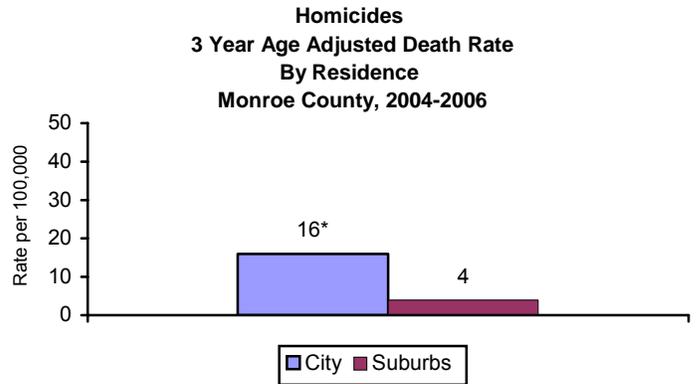


The death rate due to homicide is more than 3 times higher among males compared to females, 14 times higher among African Americans compared to Whites, and almost 7 times higher among Latinos compared to Whites.

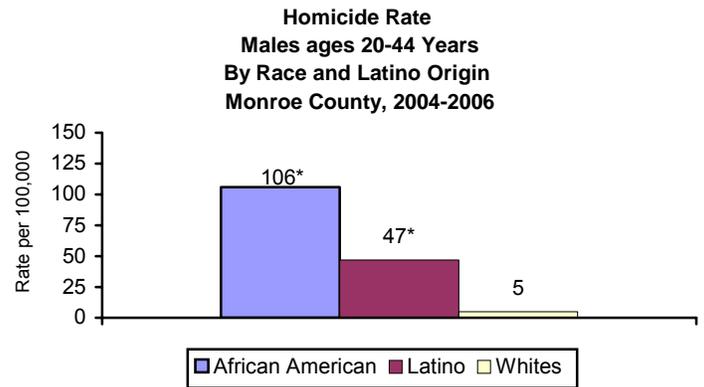


²⁶ Phadedra, C., Mercy, J., Simon, T., Finkelstein, E., and Miller, T. "Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States." *American Journal of Preventive Medicine*. 2007. Volume 32, number 6. Pg 474-482.

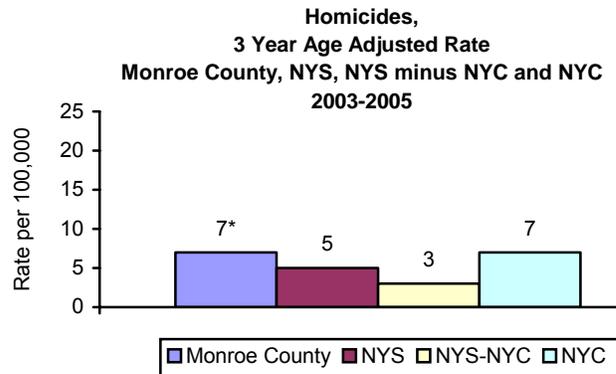
Seventy-one percent (71%) of homicide victims were city residents. The rate is 4 times higher in the city compared to the suburbs.



The homicide rate is highest among males age 20-44 years old. Within in this population, the rate among African American is 20 times higher and the rate among Latinos is 10 times higher compared to the rate among Whites.



The age adjusted homicide rate in Monroe County is higher than the rates in NYS and NYS minus NYC, and is similar to the rate in NYC. The rate is well above the 2010 Goal for the Nation (2.8/100,000).



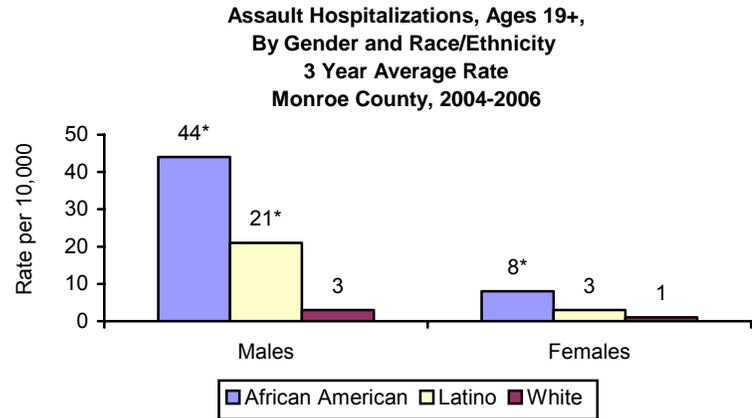
Hospitalizations Due to Assault

Source: SPARCS, NYSDOH

Findings: On average each year between 2004 and 2006, there were 267 hospitalizations due to assault among Monroe County adults. The hospitalization rate due to assault remained relatively stable between 1996 and 2006.

Eighty-percent (80%) of hospitalizations occur among males.

Rates of hospitalizations due to assault are highest among African American males.



The age adjusted hospitalization rate due²⁷ to assault in Monroe County (3.6/10,000) is higher than NYS minus NYC (2.1/10,000) and lower than NYS (4.0*/10,000).

Intimate Partner Violence

IPV includes physical, sexual, emotional and financial abuse and threats. Violence between intimates is difficult to measure because it often occurs in private, and victims are often reluctant to report incidents to anyone because of shame or fear of reprisal. When incidents are reported, there is no central registry for tracking the information. Because of the lack of a central data registry, surveys are the most widely available estimate of the prevalence of IPV.

According to the findings from the National Violence Against Women Survey nearly 25% of women and 8% of men were ever physically assaulted and/or raped by a current or former spouse, cohabiting partner, or date. About 2% of women and 1% of men reported they were raped or assaulted within the past year.²⁸

Source: Adult Health Survey (AHS), 2006, MCDPH

About the data: AHS respondents under age 65 years old were asked the following questions related to intimate partner violence:

- “Has an intimate partner EVER hit, slapped, pushed, kicked, or physically hurt you in any way?”
- IF YES, “When was the last time this happened?”

Intimate partner was defined as any current or former spouse, boyfriend, or girlfriend or a date. These data do not include the prevalence of emotional abuse, threats and/or financial abuse. This survey assumes that respondents to survey questions were free to answer honestly. This may not have been the case, and the risk of underreporting may be high.

Findings: Fourteen percent (14%) of Monroe County Adults ages 18-64 years old reported they were ever hurt physically by an intimate partner and 3% reported this occurred within the past year. Females (17%) were more likely than males (11%) and city residents (18%) were more likely than suburban residents (11%) to report they were ever victims of intimate partner physical violence.

²⁷ 2003-2005

²⁸ Extent, Nature and Consequences of Intimate Partner Violence. US Department of Justice, 2000. <http://www.ncjrs.gov/pdffiles1/nij/181867.pdf> accessed 5-23-08.

Sexual Abuse

Sexual abuse includes molestation, incest, rape, and abuse that occurs between intimate partners.

About the data: AHS respondents under age 65 years old were asked the following questions about sexual abuse:

- “Has anyone EVER had sex with you after you said or showed that you didn’t want them to or without your consent?”
- IF YES, “When was the last time this happened?”

Unwanted sex was defined as being forced to engage in sexual intercourse or engage in acts like putting anything into your vagina [*if female*], anus, or mouth or being force to do these things to someone else. It includes times when an individual may have been unable to consent, for example, when they were drunk or asleep, or they thought they would be hurt or punished if they refused.

Findings: Six percent (6%) of Monroe County Adults ages 18-64 years old reported they were ever forced to have sex and 0.7% reported this occurred within the past year. Females (10%) were more likely than males (1%) to report they were ever forced to have sex.

Reported Violent Crimes

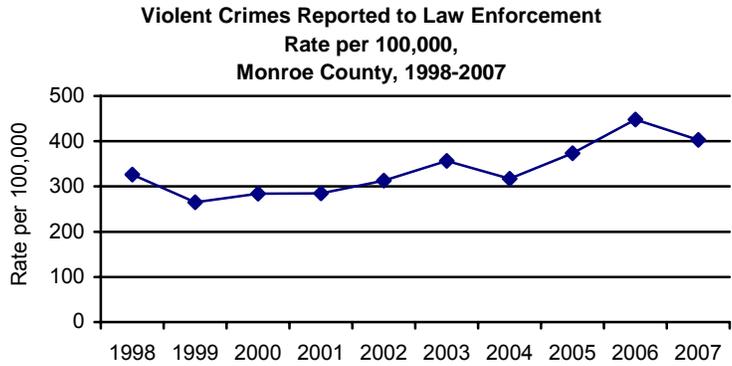
Source: NYS Division of Criminal Justice Services (DCJS)

<http://criminaljustice.state.ny.us/crimnet/ojsa/countycrimestats.htm>

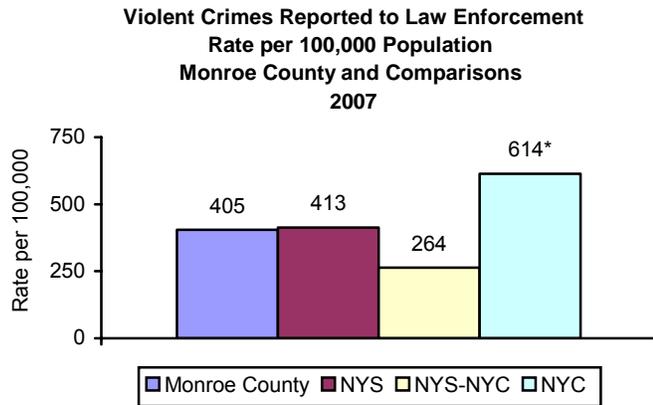
About the data: Crime counts only include those offenses reported to law enforcement agencies. All offenses are counted regardless of whether an arrested has been made. Offenses determined by investigation to be unfounded are removed from the crime counts. Violent crime is composed of four offense categories: murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. All violent offenses (excluding robbery) are considered crimes against person and are counted per victim not occurrence. Only the most serious offense is counted in incidents where more than one offense is reported. For example, if a murder occurs during a robbery, only the murder is counted.

Findings: In 2007, there were 2,947 violent crimes reported in Monroe County. Eighty-percent of reported violent crimes occur within the City of Rochester.

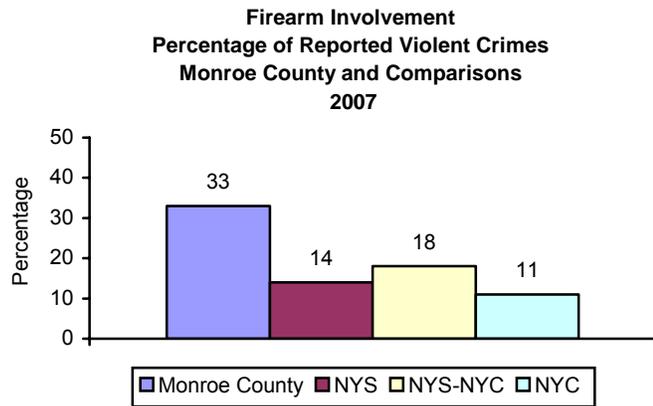
Between 1998 and 2007 the number and rate of reported violent crimes increased significantly. Increases occurred in both the city and suburbs.



The rate of reported violent crimes in Monroe County is similar to the rate in NYS, higher than the rate in NYS minus NYC and lower than the rate in NYC.



Of violent crimes reported in Monroe County in 2007, 33% involved a firearm. The percentage of violent crimes involving a firearm is higher in Monroe County compared to NYS, NYS minus NYC and NYC.



HEALTH ISSUE AND GOAL (ADULTS UNDER AGE 65 YEARS OLD)

SEXUALLY TRANSMITTED DISEASES (Including HIV)

Although rates of sexually transmitted diseases (STDs) in Monroe County have declined over the past several years, the prevalence remains high compared to other Upstate communities. Having an untreated STD can result in infertility among men and women, chronic pelvic pain, and increased risk of both transmitting and acquiring HIV. Having an STD also increases the risk of developing some forms of cancer.²⁹

Goal: Reduce Sexually Transmitted Diseases (Including HIV)

Measures

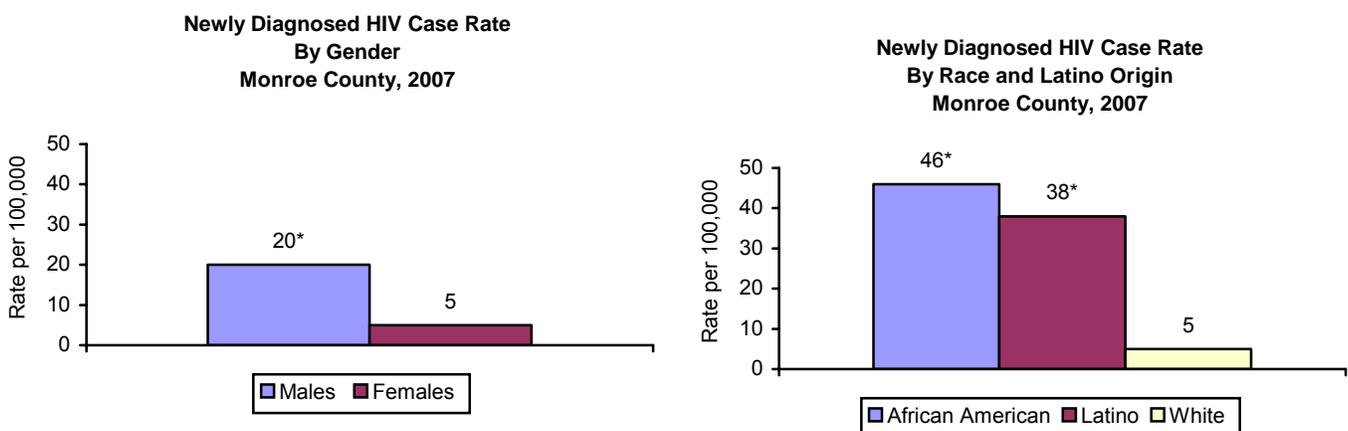
New Cases of HIV

Source: Monroe County Department of Public Health (MCDPH)

About the data: A newly diagnosed case is an individual who tests antibody positive, with no prior history of HIV on follow up investigation. These cases are investigated by the Monroe County Department of Public Health and reported to the NYSDOH. Cases among prisoners are not included in these data. HIV became reportable in 2001.

Findings: In 2007, 82 adults aged 20 years and older were newly diagnosed with HIV. Sixty-five (65) of the cases were among males and 17 were among females.

Rates are significantly higher among males compared to females and among African Americans and Latinos compared to Whites.



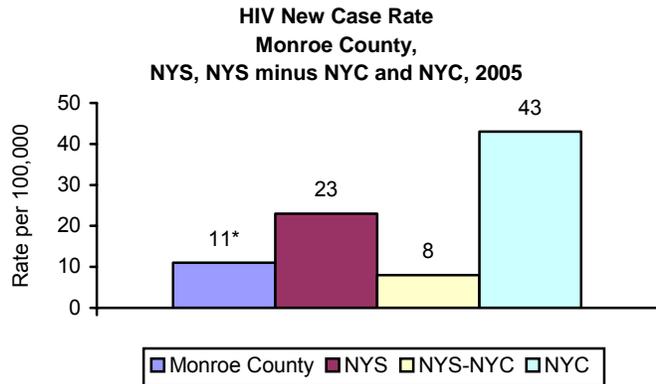
²⁹ STD Fact Sheets. Center for Disease Control and Prevention, <accessed 4-8-08> http://www.cdc.gov/std/healthcomm/fact_sheets.htm

HIV New Case Rate

Source: Monroe County data special run from NYSDOH in 3/08. NYS HIV/AIDS Surveillance Annual Report for Cases Diagnosed through December of 2005 (dated September 2007), Bureau of HIV/AIDS Epidemiology, NYSDOH.

About the data: These are crude rates and may be different from rates found in the NYS Surveillance Report which are age adjusted. NYS and NYC rates include prisoners.

Findings: The HIV case rate in Monroe County is lower than NYS and NYC, but is higher than NYS minus NYC.



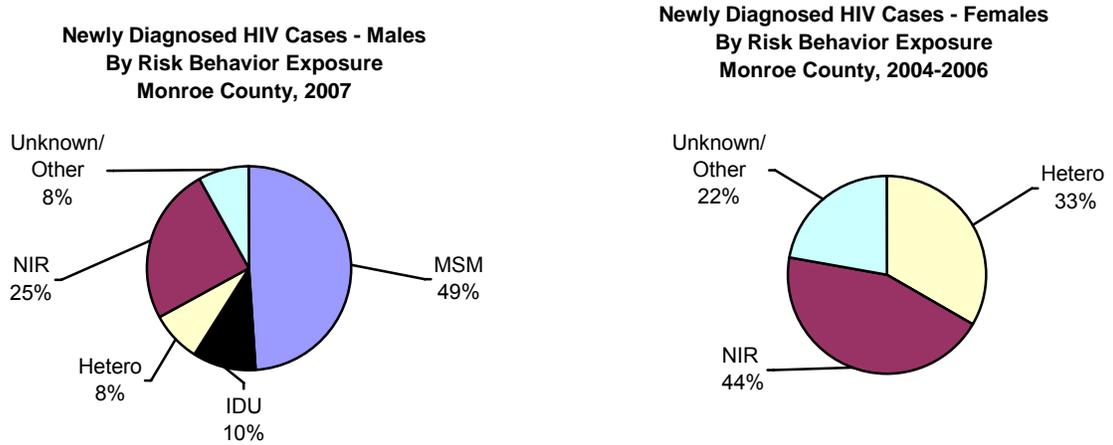
New Cases of HIV by Exposure Category

Source: Monroe County Department of Public Health (MCDPH)

About the data: These data exclude prisoners. The following categories are used to classify possible exposure to HIV by risk behaviors.

- IDU - Injection Drug User.
- MSM - Men Who Have Sex with Men.
- Hetero - The CDC definition of Hetero includes only those heterosexuals who can name a sexual partner who is bisexual, an IDU, transfusion recipient, or known to be HIV infected. All other heterosexuals are put in the NIR category.
- No Identified Risk (NIR) - No Identified Risk as defined by the CDC's HIV/AIDS surveillance case definitions. The NIR category may include heterosexuals with one or more of the following risk behaviors: cocaine use, partner of cocaine user, person exchanging sex for money/drugs, partner who exchanges sex for money/drugs, recent STD diagnosis, and unknown partners.
- UNKNOWN - Includes individuals who are currently being followed up by health department officials; and whose exposure history is missing or incomplete; including those who declined to be interviewed, died, or were lost to follow up. This category also includes those who are transfusion recipients or who have an occupational exposure.

Findings: Of new HIV cases among males, 49% were classified in the men who had sex with men (MSM) risk exposure category. Among cases diagnosed among females 44% were classified in the NIR category.



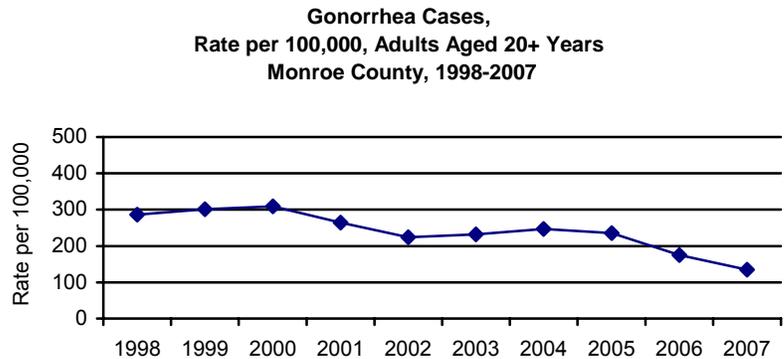
Gonorrhea

Source: MCDPH and NYSDOH. <http://www.health.state.ny.us/statistics/diseases/communicable/2006/>

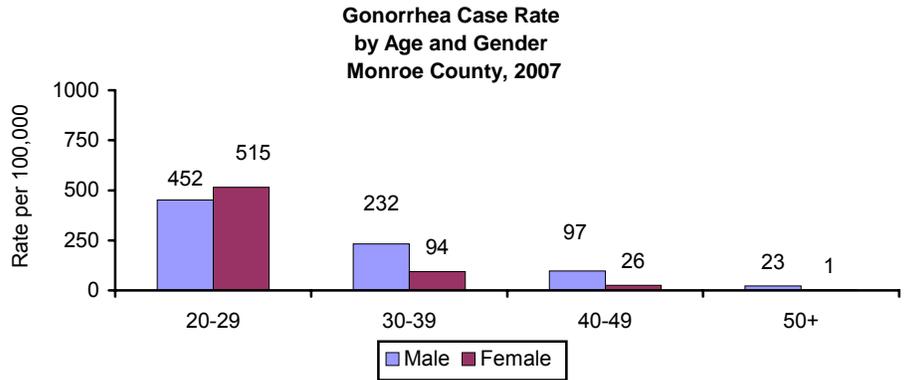
Notes about the data: Individuals may be counted multiple times in a given year, if they test positive for gonorrhea, receive treatment, and then at least 30 days after their previous diagnosis, they test positive again.

Findings: In 2007, there were 723 new cases of gonorrhea diagnosed among Monroe County adults aged 20 years and older.

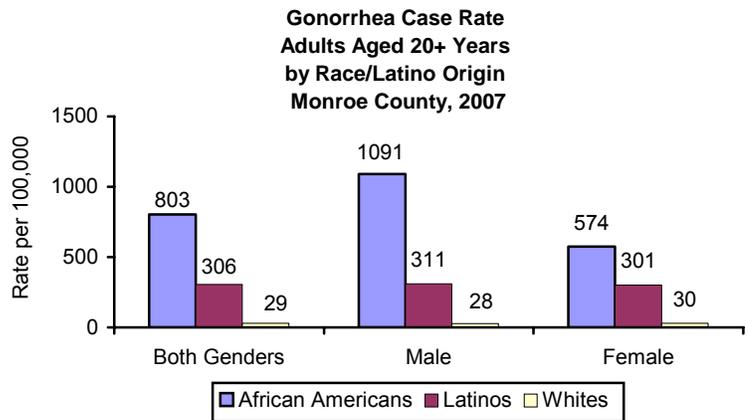
Between 1998 and 2007, the number of cases among adults declined by 52%. The rate also declined as shown in the graphic to the right



As shown in the figure to the right, the highest case rate is among females ages 20-29 years. Case rates among adults aged 30 years and older are higher among males compared to females.

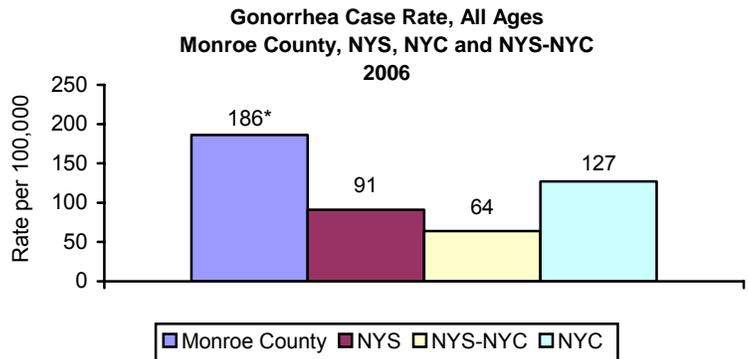


Rates are significantly higher among African Americans and Latinos compared to Whites.



Most (86%) adult cases of gonorrhea occur among City residents.

The gonorrhea case rate in Monroe County is higher than NYS, NYS minus NYC and NYC.



Chlamydia

Source: MCDPH and NYSDOH <http://www.health.state.ny.us/statistics/diseases/communicable/2006/>

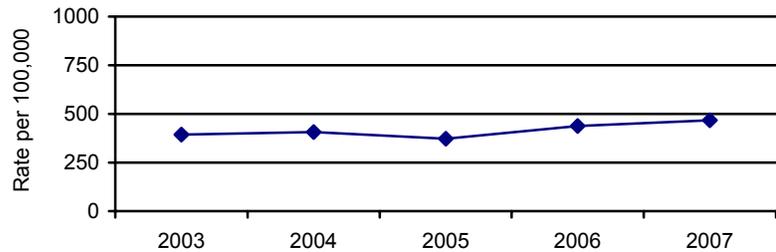
About the data: Individuals may be counted multiple times within a given year, if they test positive for Chlamydia, receive treatment, and then at least 30 days after their previous diagnosis, they test positive again. Required chlamydia reporting began in 2001. Data prior to 2003 are considered under-reported.

Findings: In 2007, there were 2,496 new cases of chlamydia diagnosed among Monroe County adults aged 20 years and older.

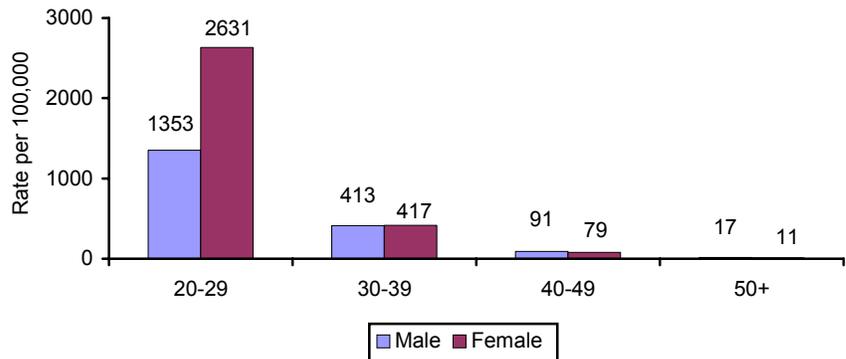
Between 2003 and 2007, the number of cases within this age group increased by 20%.

The rate also increased during this time period as shown in the graphic to the right.

**Chlamydia Case Rate
Adults Aged 20+ Years
Monroe County, 2003-2007**

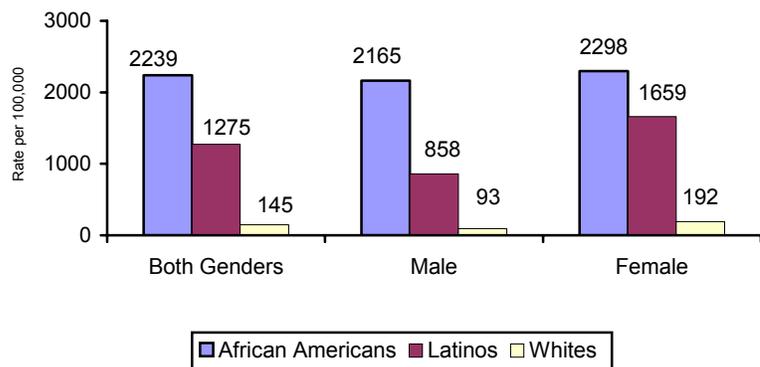


**Chlamydia Case Rate by Age and Gender
Monroe County, 2007**



The case rate is highest among females aged 20-29.

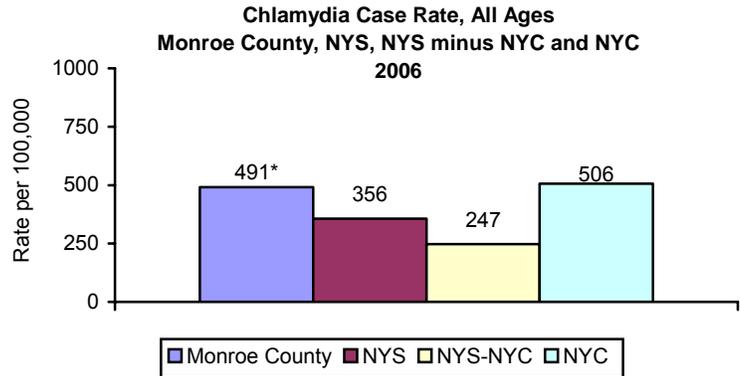
**Chlamydia Case Rate by Gender and Race/Latino Origin
Adults Aged 20 Years and Older
Monroe County, 2007**



Rates of Chlamydia are highest among African American and Latinos compared to Whites.

The majority of adult Chlamydia cases occur in the City of Rochester (73%).

The chlamydia case rate in Monroe County is higher than NYS and NYS minus NYC.



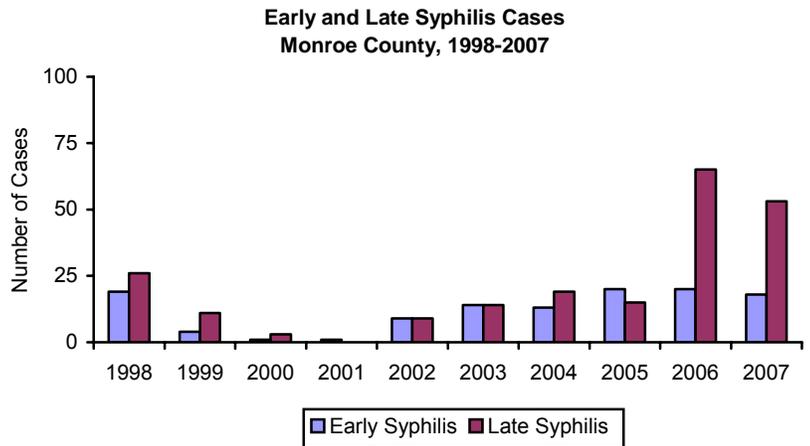
Syphilis

Source: MCDPH and NYSDOH. <http://www.health.state.ny.us/statistics/diseases/communicable/2006/>

About the data: There are different types of syphilis depending upon what stage of the disease a person is diagnosed. Early syphilis is the infectious stage of the disease. Late syphilis is not infectious, but can result in complications, including damage to the heart, neurologic system and bones, and death.

Findings:

In 2007, there were 18 cases of early syphilis and 53 cases of late syphilis diagnosed in Monroe County. The number of syphilis cases has increased since 2001. The significant increase in late syphilis cases since 2005 is due to improvements in testing sensitivity.



Selected Risk Factors for HIV and STDs

At Risk for Contracting HIV

Source: Adult Health Survey (AHS), 2006, MCDPH

About the data: In order to estimate the percentage of individuals at high risk for HIV, respondents to the AHS ages 18-64 were asked whether any of these situations applied to them:

- Have used intravenous drugs in the past year
- Have been treated for a sexually transmitted or venereal disease in the past year
- Have given or received money or drugs in exchange for sex in the past year
- Had anal sex without a condom in the past year

Findings: Four percent (4%) of Monroe County adults reported that one or more of the above situations applied to them. When this percentage is applied to the adult population aged 18-64 years old, it is estimated that approximately 16,000 are at high risk for HIV. The percentage was higher among city residents (6%*) compared to suburban residents (2%).

Multiple Sexual Partners

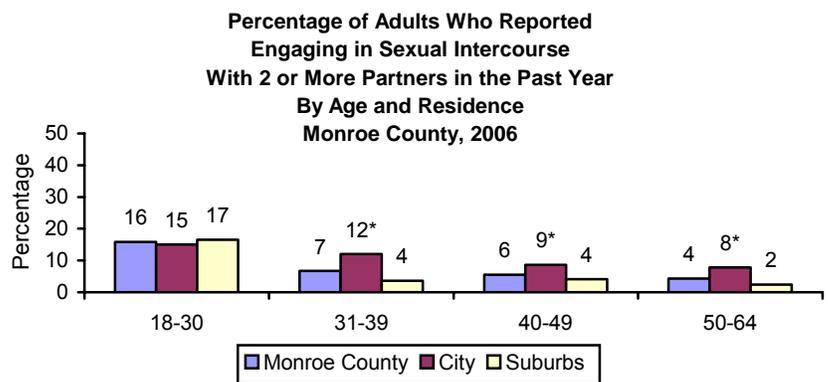
Source: Adult Health Survey (AHS), 2006, MCDPH

Adults who have multiple sexual partners are at a higher risk of contracting STDs and HIV compared to those who remain monogamous.

Findings: Eight percent (8%) of adults under age 65 years old reported they engaged in sexual intercourse with 2 or more people within the past year. When this percentage is applied to the population of adult aged 18-64 years old, it is estimated that 35,000 individuals engaged in sexual intercourse with two or more partners in the past year.

Adults ages 18-30 years old were more likely to report engaging in this behavior compared to other age groups.

There were significant differences between city and suburban residents within all age groups except age 18-30 years old.



A higher proportion of African Americans (17%*) compared to Whites (6%*) reported engaging in sexual intercourse with 2 or more partners. This disparity occurred in nearly all age groups.

Condom Use

Source: Adult Health Survey (AHS), 2006, MCDPH

Findings: Of those who reported having multiple sexual partners in the past year, only 55% reported that they used a condom the last time they had sex.

Preventive Counseling About Sexual Risks

Source: Adult Health Survey (AHS), 2006, MCDPH

Findings: Of Monroe County adults who reported they visited a doctor for a routine check-up within the past year, 28% reported that their doctor talked with them about sexual practices including sexually transmitted diseases, AIDS or condom use. This percentage increased significantly since 2000, when it was only 16%.

In the 2006 AHS, females (36%*) compared to males (20%), city residents (35%*) compared to suburban residents (24%), and African Americans (38%*) and Latinos (47%*) compared to Whites (25%) were more likely to report their doctor discussed this subject with them.

HEALTH ISSUES AND GOALS

(ADULTS AGE 65 YEARS AND OLDER)

While many of the health issues facing both younger adults and older adults are similar, there are specific health issues that are more common among adults aged 65 years and older. Disease prevalence increases with age, as do functional limitations that prevent individuals from engaging in activities of daily living. Because of these limitations, older adults often become socially isolated and suffer mental health problems because of their change in health and functional status. Cognitive decline that impacts daily functioning is also common among older adults.

DISABILITIES AND FUNCTIONAL STATUS

BACKGROUND DATA

Disabilities Among Non-Institutionalized Adults Aged 65 Years and Older

Source: 2000 Census, SF-3.

About the data: The data on disability status were derived from answers to two multiple part questions on the Census long-form questionnaire. Below are the questions and the disability classifications based on a “yes” answer to the question.

Question 1. Does this person have any of the following long-lasting conditions?	
Blindness, deafness, or a severe vision or hearing impairment	(Sensory Disability)
A condition that substantially limits one or more basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying	(Physical Disability)
Question 2. Does this person have physical, mental or emotional disabilities lasting 6 months or more that make it difficult to perform certain activities?	
Learning, remembering, or concentrating	(Mental Disability)
Dressing, bathing, or getting around inside the home	(Self-Care Disability)
Going outside the home alone to shop or visit a doctor’s office	(Going Outside the Home Disability)

Findings: Thirty-seven percent (37%) of non-institutionalized Monroe County adults aged 65 years and older have one or more disabilities. The percentage is higher in the City (48%) compared to the Suburbs (33%).

The table below shows the proportion of the population with a disability by type of disability and residence.

Disabilities-% of Non-Institutionalized Monroe County Adults Ages 65 Years and Older, 2000			
Disabilities Type	Monroe County	Rochester	Suburbs
Sensory Disability	12	16	11
Physical Disability	24	33	22
Mental Disability	8	12	7
Self-Care Disability	8	13	7
Going Outside the Home Disability	19	25	17

Goal: Promote Optimal Level of Functioning

The functional level of an older adult is impacted by many factors that are often inter-related. These include the physiological changes with aging, medical conditions, lifestyle choices, living environment, the availability of needed support services and the amount of social support. Maintaining or improving functioning plays a critical role in improving health outcomes and quality of life among older adults.

There are some interventions that have been shown to prevent functional decline in older adults including physical activity³⁰, fall prevention programs, and treatment of depression.³¹ When function does decline, it is important that care and support services be accessible to (1) recognize decline as it comes, (2) minimize it, and/or (3) compensate for it once it occurs.

Measures

Self-Reported Health Status, Functional Limitations and Mental Health Indicators

Source: Adult Health Survey (AHS), 2006, MCDPH

Findings: The table on the next page shows the percentage of older adults reporting fair or poor health status, functional limitations and mental health issues.

Functional Limitations due to Physical and Emotional Health Monroe County Adults Aged 65 Years and Older, 2000, 2006	%
Limited <u>a lot</u> in doing moderate activities like moving a table, pushing a vacuum, bowling or playing golf because of your health	15
Limited <u>a lot</u> in climbing stairs	10
Did not accomplish what they would have liked at work or in daily activities because of physical health – <u>all or most of the time</u> during the last 4 weeks	16
Were limited in the kind of work or other activities because of physical health - <u>all or most of the time</u> during the last 4 weeks	14
Pain interfered <u>extremely</u> or <u>quite a bit</u> with normal work during the past 4 weeks	13
Had a lot of energy – <u>none</u> or <u>a little of the time</u> during the past 4 weeks	17
Accomplished less than they would have liked due to emotional problems – <u>all or most of the time</u> during the past 4 weeks	6
Worked less carefully due to any emotional problems - <u>all or most of the time</u> during the past 4 weeks	5
Felt calm and peaceful – <u>none</u> or <u>a little of the time</u> – during the past 4 weeks	9
Felt downhearted and depressed - <u>all or most of the time</u> during the last 4 weeks	3
Physical or emotional health interfered with social activities <u>all or most of the time</u> during the past 4 weeks	6

³⁰ Physical Activity and Health – Older Adults, Centers for Disease Control and Prevention. <http://www.cdc.gov/nccdphp/sgr/olderad.htm> accessed June 18, 2008.

³¹ Brenda W. J. H., et al. Depressive Symptoms and Physical Decline in Community-Dwelling Older Persons. JAMA. 1998;279:1720-1726.

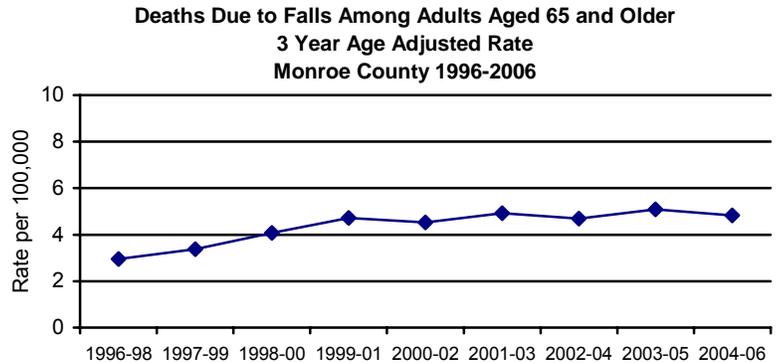
Falls

Nationally it is estimated that more than one-third of community dwelling adults aged 65 years and older fall each year.³² Most fractures among older adults are caused by falls. Of older adults who fall, 20-30% suffer moderate to severe injuries such as bruises, hip fractures, or head traumas. These injuries often make it hard to get around and limit independent living. They also can increase the risk of early death. Many people who fall, even those who are not injured, develop a fear of falling. This fear may cause them to limit their activities even more, leading to reduced mobility and physical fitness and a decline in independence.

Deaths Due to Falls

Source: Vital Records, NYSDOH.

Findings: On average each year between 2004 and 2006, there were 43 deaths due to falls among older adults. The number of deaths doubled since 1996. The rate also increased during this time period even after adjusting for age.

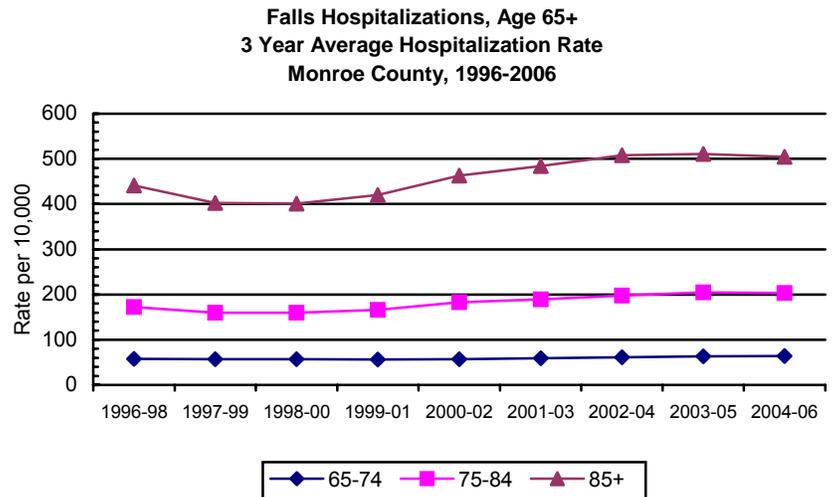


Hospitalizations Due to Falls

Source: SPARCS, NYSDOH.

Findings: On average each year between 2004 and 2006, there were 1,808 hospitalizations due to falls among adults aged 65 years and older.

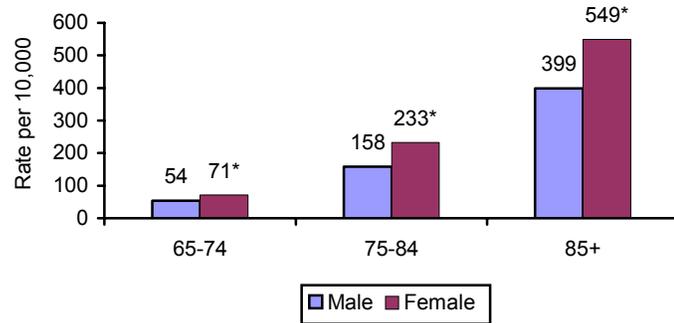
Since 2000, the rate of hospitalizations due to falls increased among those aged 75 years and older. The rate among those aged 65-74, remained relatively stable.



³² CDC, National Center for Injury Prevention and Control. Falls Among Older Adults: An Overview <http://www.cdc.gov/ncipc/factsheets/adultfalls.htm>

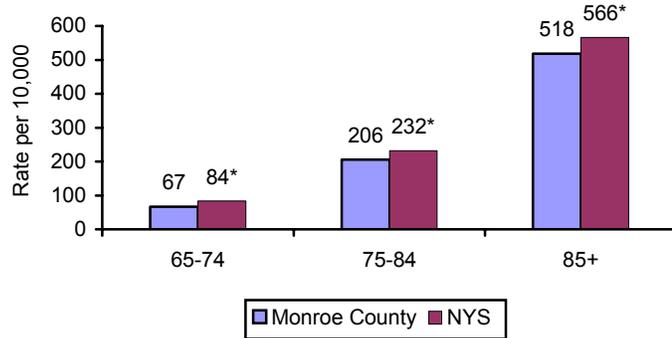
Rates are higher among females compared to males within all age groups as shown in the graphic to the right.

**Falls Hospitalization Rates
By Gender and Age Group
Monroe County, 2004-2006**



Hospitalization rates due to falls among older adults in Monroe County are lower than the rates in NYS.

**Falls Hospitalization Rates
By Age Group
Monroe County compared to NYS, 2003-2005**



ELDER ABUSE

The New York State Governor's Task Force on Elder Abuse defines elder abuse as physical, psychological and financial abuse, and active/passive neglect. "Physical abuse is defined as the infliction of physical pain or injury, or physical coercion, including confinement against one's will. Psychological abuse is defined as the infliction of mental anguish, through name-calling, infantilizing, intimidating, humiliating, threatening, or isolating. Financial abuse is the exploitation and/or improper use of funds or other resources. Active neglect is defined as the deliberate refusal or failure to fulfill a care-giving role, and passive neglect is defined as the unintentional refusal or failure to fulfill a care-giving role, because of inadequate knowledge, ability or capacity."³³ Victims of elder abuse, when compared to the general senior population, have higher mortality rates.³⁴

Goal: Reduce Elder Abuse

Measures

State and county prevalence rates of elder abuse are not known. Two of the reasons for the lack of data include varying definitions of elder abuse across organizations serving abuse victims and perpetrators, and the lack of NYS legislation mandating reporting of domestic (non-institutional) elder abuse and neglect to a central registry.

Elder abuse is thought to be grossly under-reported. The National Elder Abuse Incidence Study estimated that for every one case of elder abuse, neglect, exploitation, or self-neglect reported to authorities, about five go unreported.³⁵ Seniors who are abused are often physically isolated and are unable or unaware of how to ask for help. Since adult children and spouses are the most frequent perpetrators in elder abuse in domestic settings, abused older adults are often reluctant to report their family members because they are ashamed and/or fear retribution.

Lifespan, Cornell University and the NYS Department of Aging have been funded to conduct a statewide study in order to establish a baseline of prevalence and incidence of elder abuse, and to develop a methodology for ongoing data collection. Prevalence and incidence data for Monroe County and NYS should be available by 2010.

Until these data are available, studies conducted by independent researchers will be used to estimate prevalence rates. These studies estimate the prevalence of elder abuse to range from 2% to 10% based on various sampling and survey methods, and case definitions.¹³ Based on these percentages and the population of older adults in Monroe County, there are an estimated 1,900-9,700 victims of elder abuse in Monroe County.

³³ "The Future of Aging in NYS – Elder Abuse." NYS Office for the Aging, <http://www.aging.state.ny.us/explore/project2015/artabuse.htm> accessed on 3-23-07.
<http://aging.state.ny.us/explore/project2015/artEld.pdf>

³⁴ Lachs, Marks., and Karl Pillemer. October 2004. "Elder Abuse", the Lancet, Vol. 364: 1192-1263

³⁵ National Elder Abuse Incidence Study, 1998. Washington, DC; National Center on Elder Abuse at American Public Human Service Association. http://www.aoa.gov/eldfam/Elder_Rights/Elder_Abuse/ABuseReport_Full.pdf

Self-Reported Risks for Elder Abuse

Source: Adult Health Survey, 2006, MCDPH

About the data: The H-S/EAST is an elder abuse screening tool which has been tested and validated.³⁶ All six questions of this tool were asked of respondents to the AHS who were aged 65 and older. The table below shows the questions, and the percentage of older adults who responded yes to each question. There are several limitations to these data. Risks for abuse might be under-reported because as previously stated older adults are often reluctant to report abuse. In addition, some older adults might answer yes to one or more of these questions, and it may not be due to elder abuse. For example, an older adult may answer yes to the question “Has anyone forced you to do things you didn’t want to do?” if a family member strongly encouraged them to visit a doctor because of a health issue. This is most likely not abuse, but it is something that the family member did out of concern.

Findings: Eight percent (8%) of Monroe County older adults answered “yes” to one or more of the question below and are considered to be at risk for elder abuse. When these figures are applied to the population of older adults in Monroe County, it is estimated that approximately 7,300 are victims of elder abuse. City residents (13%*) were more likely than suburban residents (5%) to be at risk. There were no other significant differences among sub-groups.

Older Adults at Risk For Elder Abuse Monroe County AHS, 2006	%
Are you afraid of anyone in your family?	0.6
Has anyone close to you tried to hurt or harm you recently?	0.6
Has anyone close to you called you names or put you down or made you feel bad recently?	3.1
Does someone in your family make you stay in bed or tell you you're sick when you know you aren't?	0.6
Has anyone forced you to do things you didn't want to do?	0.7
Has anyone taken things that belong to you without your OK?	3.5

Elder Abuse Referrals (LifeSpan and Adult Protective Services)

Source: Lifespan and Monroe County Adult Protective Services.

About the data: Both the Monroe County Adult Protective Services Unit and the Elder Abuse Prevention Program of Lifespan provide case management services for potential cases of elder abuse. These figures represent the number of cases that meet the eligibility criteria for case management services from one of these programs. They are not an indication of cases that have been investigated and determined to have enough evidence of the presence of elder abuse.

³⁶ Schofield, M.J., Reynolds, R., Mishra, G.D., Powers, J.R., Dobson, A.J. (2002). “Screening for Vulnerability to Abuse Among Older Women: Women’s Health Australia Study.” The Journal of Applied Gerontology. Vol 21, pp-24-39.

Eligibility requirement for the programs are noted below:

- **Adult Protective Services** provides cases management services to older adults if they have a physical or mental impairment and they can no longer protect themselves from neglect, abuse or hazardous situations, or they cannot provide for their most basic needs for food, clothing, shelter or medical care and they have no one willing and able to help them in a responsible manner.
- **Lifespan** provides elder abuse prevention and case management services to community-dwelling individuals aged 60 years and older if they are in situations where there is a reported precipitating incident that puts them at high risk for elder abuse, or if there is substantial evidence that elder abuse is occurring.

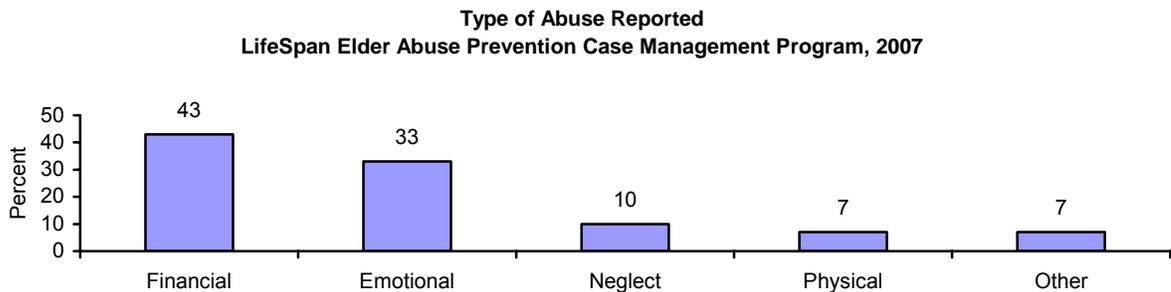
It should be noted that both of these programs often work cooperatively. Even though there are different eligibility requirements for these programs, occasionally a referral might be counted in both programs.

Findings:

Lifespan Elder Abuse Prevention Case Management Program

In 2007, Lifespan provided elder abuse prevention and case management services to 262 older adults in Monroe County.

Of all clients served in the nine-county Rochester area in 2007, financial exploitation and emotional were the most common types of abuse reported as shown in the graphic below.



Monroe County Adult Protective Services

In 2007, Adult Protective Services provided case management services to 63 adults aged 65 and older who were potential victims of elder abuse.

APPENDIX

Data Technical Notes

In this report, health data are presented for the county as a whole, and when available, by age, residence, gender, and race and Latino origin.

Race/Latino Origin

When data are presented by race and Latino origin, the following definitions are used:

- African American = African American, single race, not Latino
- Latino= Latino origin regardless of their race.
- White = White, single race, not Latino

The only exception to these definitions is for cancer incidence data. These data are only available by race.

Rate Calculation

In this report, crude rates are calculated using the following population bases:

Population	Years 1996-1999	Year 2000	Years 2001-2006
Monroe County	Intercensal Population Estimates	2000 Census	Residence Population Estimates release date 8-9-07
City/Suburb	-	2000 Census	2000 Census
Race/Latino Origin	-	2000 Census	Residence Population Estimates release

For death and hospitalization data rates are age adjusted. Age adjusting accounts for the differences in age structure that may affect rates when comparing trends overtime or between different communities.

Major Sources of Health Data in the Report Card

On the following pages are brief descriptions of major data sources found throughout the report. If a data source is only found in one particular section of the report, it is described within that section.

Death Data

Mortality data come from death certificates reported to the New York State Health Department. Cause of death is defined by the underlying cause of death, which is the disease or injury that initiated the train of events that lead directly to the death, or the circumstances of the accident or violent act which produced the fatal injury.

In 1999, the rules for coding causes of death changed from the Ninth Revision of the International Classification of Diseases (ICD-9) to the Tenth Revision (ICD-10), so death statistics prior to implementation of the new rules are not comparable. In order to account for this change, and allow statistics to be monitored over time, the National Center for Health Statistics developed comparability ratios for selected causes of death based on a sample of death certificates from 1996. The ratios were calculated by dividing the number of deaths classified to a certain cause using ICD-10 rules by the

number of deaths classified to that same cause using ICD-9 rules. Below is an example of how the comparability ratios are calculated.

1996	Number of deaths allocated according to		Comparability ratio ICD-10/ICD-9
	ICD-10	ICD-9	
Selected cause of death	99,000	100,000	0.99

By applying the comparability ratios to the death statistics prior to 1999, we can compare data overtime and be fairly confident that any changes in the statistics are actual changes and are not due to coding rule changes. In this document, comparability ratios are applied to cause of death data from 1996-1998, therefore these data will in most cases be different from cause of death data in previous report cards.

For most causes of death the comparability ratios are between 0.9 and 1.1, meaning these diseases are just about as likely to be coded as the cause of death with the ICD 9 rules as they are with the ICD-10 rules. For some diseases, however, this is not the case. With the ICD10 rules, pneumonia is less likely to be coded as the cause of death because the rule states that when pneumonia is listed on the death certificate with another cause of death, and the death is obviously a direct consequence of that other cause, the other cause is selected as the underlying cause of death. The comparability ratio for pneumonia is 0.6957.

For more information on comparability ratios, go to <http://www.cdc.gov/nchs/dataawh/nchsdefs/comparabilityratio.htm>

Hospitalization Data –Statewide Planning and Research Cooperative System- (SPARCS)

Data on hospitalizations are collected through the hospital inpatient discharge data system by the New York State Health Department. Each hospitalization receives an ICD-9 code at discharge which indicates the primary reason for the hospitalization. The principal/primary diagnosis is the condition established after study to have been chiefly responsible for occasioning the admission of the patient to the hospital for care. Since the principal/primary diagnosis represents the reason for the patient's stay, it may not necessarily have been the diagnosis which represented the greatest length of stay, the greatest consumption of hospital resources, or the most life-threatening condition. Since the principal/primary diagnosis reflects clinical findings discovered during the patient's stay, it may differ from admitting diagnosis.

Data refers to the number of hospitalizations and not to the number of individuals who have been hospitalized. An individual hospitalized multiple times during a given year will be included in the data each time they are hospitalized.

For more information go to about SPARCS data go to <http://www.health.state.ny.us/statistics/sparcs/operations/overview.htm>

Adult Health Survey

The Adult Health Survey (AHS) is a random digit phone survey of Monroe County adults conducted in both 2000 and 2006. More than 2,500 adults completed the survey in 2006. The 2000 survey data were weighted to match the Monroe County 2000 Census population and the 2006 survey data were weighted to match the 2005 population estimates produced by the US Census Bureau.

A major limitation of the data is that they are based on self-report. Respondents tend to “under-report” such behaviors as alcohol use but may “over-report” behaviors that seem desirable such as exercise or regular health screenings. The respondent’s ability to recall behaviors may also affect the accuracy of the responses. For more information about the survey go to:

<http://www.monroecounty.gov/File/Health/2006%20ADULT%20HEALTH%20SURVEY.pdf>

Cancer Incidence

These data come from the Cancer Registry which is maintained by the NYSDOH. All New York State residents diagnosed with cancer are included in the registry. Each time a person is diagnosed with a new tumor, the hospital where that person is diagnosed and/or treated reports information about the person and tumor to the Cancer Registry. Reporting is not voluntary. Data are available for five year periods. For more information go to <http://www.health.state.ny.us/statistics/cancer/registry/about.htm>.

Managed Care Performance Measures, Quality Assurance Reporting Requirements (QARR)

Quality Assurance Reporting Requirements were developed by the New York State Department of Health (NYSDOH) to enable consumers to evaluate the quality of health care services provided by New York State's managed care plans. **QARR** measures are largely adopted from the [National Committee for Quality Assurance's \(NCQA\)](#) Health Plan Effectiveness Data and Information Set (HEDIS®) with New York State-specific measures added to address public health issues of particular importance in New York. Included in this report card are several measures of management of adults living with illness, behavioral and preventive health. Measures are published annually in the NYS Managed Care Plan Performance Report. For copies of the complete reports go to: http://www.health.state.ny.us/health_care/managed_care/reports/.

Adult/Older Adult Health Report Card Advisory Group

Nancy Bennett, MD, MS
Director, Center for Community Health
University of Rochester Medical Center
Deputy Director
Monroe County Department of Public Health

Margie-Lovett-Scott, EdD,RN, FNP, BC
Associate Professor of Nursing and Director of
RN-BSN Program
The College at Brockport.
State University of NY

Gloriela Burns, RN, MS, CHIE
Director Medicare Managed Care
Excellus

Robert McCann, MD, FACP
Chief, Department of Medicine
Highland Hospital

Pat Campbell, RN, MPH
Program Officer
Rochester Area Community Foundation

Ruth McNamara, BSN
Geriatric Case Manager
ViaHealth

Linda Clark, MD, MS
Self-employed, Occupational medicine

LaRon Nelson, NP, RD, PhD(c)
Associate Director
Monroe County Department of Public Health

Irene Coveny, MPH
Associate Director
Finger Lakes Health Systems Agency

Louis Papa, MD, FACP
Physician
Olsan Medical Group

Anne Marie Cook
President, CEO
Lifespan of Greater Rochester

Jason Purnell, PhD
Research Assistant Professor
University of Rochester Medical Center

Bonnie DeVinney
V.P., Chief Program Officer
The Greater Rochester Health Foundation

Steve Ryan, MD, MPH
Regional Medical Director
Evercare
Physician at Hill Haven

Susan Fisher PhD
Department Chair,
Community & Preventive Medicine
University of Rochester Medical Center

Nick Trotto, MBA
Assistant Director
Monroe County Office of the Aging

Jeannette Flynn-Weiss, RN, MS
Associate Director Quality Management
Preferred Care

Ann Marie White, Ed.D.
Assistant Professor
Department of Psychiatry
University of Rochester Medical Center

Anne Kern, RD
Nutritionist
Community Health Improvement
Monroe County Department of Public Health

