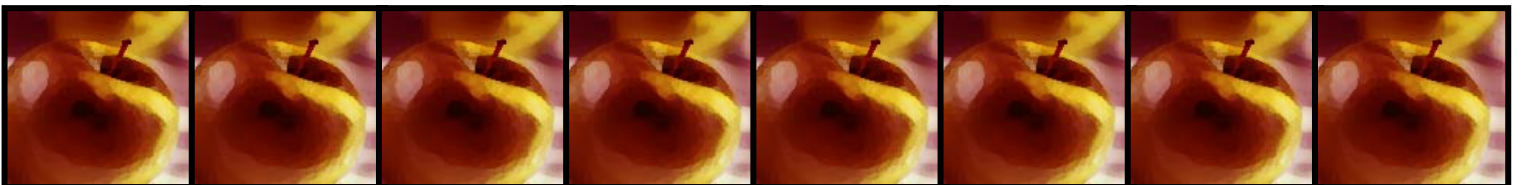




HEALTH PROFILE



HEALTH PROFILE

A. PURPOSE

A comprehensive community health assessment is foundational to our understanding, and subsequent, attention to the health needs of our County residents. An understanding of the community's health status is founded upon the basic science of public health that focuses on root causes and underlying influences (Epidemiology). Our epidemiological knowledge coupled with an ever-increasing understanding and attention to social determinants allows us to establish prevalence, analyze trends, and identify demographic, socio-economic, and other factors that contribute to our County's health status. The goal of this first component of the Oneida County Health Assessment Report is to provide an overview of the health of our community members.

B. SCOPE OF EFFORT

Data from multiple sources were assembled and organized into four (4) categories to guide our overall understanding of current health and health-related conditions in the County:

- Demographic and Socio-economic Indicators
- Health Status Indicators
- Health Perceptions and Health Related Behaviors
- Health Care Delivery and Access to Care

A broad range of data serves as the foundation for analyzing and identifying community health issues

1. DATA SOURCES

A broad range of data serves as the foundation for analyzing and identifying community health issues and determining where the community stands in relation to peer communities, state data, and national data. The Oneida County Health Department receives reports and maintains data on a variety of health conditions for the County. These data served as the baseline of the Oneida County Health Profile and were supplemented with information compiled from several additional sources including Federal, State, Regional, and non-government agencies. The aggregated data yielded both quantitative and qualitative data.

A description of the principal data sources that underlie the indicator categories is provided in the following section.

Census Data: Data regarding demographic composition and socio-economic status were obtained from the 2000 U.S. Census. The following concerns should be considered when interpreting results based on census data.

Census data is known to undercount people and that this discrepancy tends to increase with increasing poverty. The second concern has to do with changes in Oneida County's total population over time. For example, between 1990 and 2000, Oneida County's population decreased by 6.1%. Within ethnic groups, the population changed as well. The White population decreased from 92.7% to 90.2%; whereas the African American population increased from 5.4% to 5.7%; Hispanic population from 2.3% to 3.2%; and Asian population from 0.8% to 1.2% during this same timeframe. If the same trends have taken place during this decade, then the denominators used in calculating rates and the rates themselves would be affected accordingly. Since adjusting census figures for undercount poses substantial methodological and practical difficulties, this report uses the 2000 census figures and advises readers to note the cautions described above.

Vital Records: State Vital Records were used to determine the leading causes of death in Oneida County and to measure maternal and child health indicators. By ethnicity, the data are presented for African Americans, Whites, and Hispanics and where possible, Non-Hispanic others, such as American Indians and Asians at the State level, but does not facilitate further analysis at the local level.

HEALTH PROFILE

Regional Assessment: A regional, eight-county health assessment was conducted concurrently to the community health assessment conducted by the County. A short-term goal for the regional health assessment initiative was to establish, on a regional basis, a uniform county-level health assessment process. One of its initial goals was to produce a regional report focusing on regional health priorities. The initial regional report findings were evaluated and included in this document where appropriate. The data for this assessment was limited to indicators that all counties had data for.

New York State Department of Health (NYSDOH) HIN: The Health Information Network (HIN) is a closed network dedicated to secure data exchange with county health officials and NYSDOH. Data can be retrieved from several HIN-based applications such as:

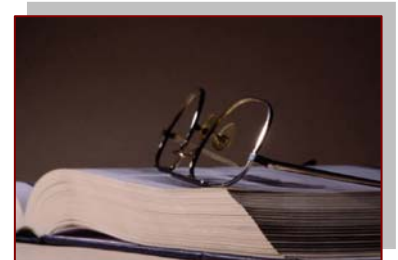
- ▣ **Statewide Planning and Research Cooperative System (SPARCS)** query displays time series patterns of historical data for counts or percentages of patients admitted to hospitals from emergency rooms (ER). That is, patients whose health status resulted in an inpatient hospital stay after being admitted to the ER. The user is provided with the ability to display these patterns by selecting and querying on a variety of factors.
- ▣ **The Communicable Disease Information System** contains data of reportable diseases in New York State. The variables in this dataset include type of disease, county of resident, patient age group, race, ethnicity, hospitalized, pregnant, sex, occupation/ setting, month of event, and year of event.
- ▣ **NYS Community Health Data Set** consists of a series of tables, maps and graphs containing health statistics organized by county of residence.

Health Provider Network (HPN): a HIPAA compliant system that currently supports reporting and information interchange pertaining to vital records and registries, disease surveillance and response, and health facilities management.

LEAdTrac Information Tracking System: A NYSDOH application to track the processes involved with childhood lead poisoning prevention and lead hazard abatement. It maintains a demographic profile of children screened, lead levels, address and inspection status, legal action, sibling/risk reduction and medical treatment tracking.

WIC Program: The Oneida County WIC Program employs a closed computer system known as WICSIS to capture all reports and pertinent data of WIC participants. These reports reflect data from all of New York State. Unfortunately the data only reflects trends in the WIC population. Financial reports, which reflect dollars spent in the county, are beneficial to the county when audits are done. Immunization reports are indicative of children enrolled in WIC only; yet give an overall reading for the area. Although there are limitations, the data is beneficial for the at risk population that WIC deals with.

Prevention Risk Indicator Services Monitoring System (PRISMS) Risk Profiles: This program assists New York counties in identifying youth alcohol and substance abuse risks and problems. The PRISMS Risk Profiles use a research-based risk framework to predict youth alcohol and substance abuse consequences.



Numerous documents, publications, and reviews were utilized in compiling this assessment including, but not limited to the following: New York State Kids Count 2002 Data Book; Mohawk Valley Perinatal Network, Perinatal Issues and Needs in Mohawk Valley-May 2004; Oneida County Department of Social Services Needs Assessment –February 2004; Communities That Care, Monitoring the Community–April 2003; Utica/Rome-Oneida County Continuum of Care – Homeless Needs Assessment, April 2004; Department of Traffic Safety Annual Report-2001; CDC - Oral Health: Preventing Cavities, Gum

HEALTH PROFILE

Disease, and Oral Cancers - At A Glance, 2004; 2003 Oneida County Teen Assessment Project Survey; Herkimer-Oneida Counties Comprehensive Planning Program, January 2004; SAMSHA Matrix: Homelessness Services. 12/2004; Darman, Stephen, Utica/Rome-Oneida County Continuum of Care. Spring 2004; National Healthcare Disparities Report; Agency for Healthcare Research and Quality, July 2003; National Healthcare Quality Report, U.S. DHHS, December 2003; 2003 Community Service Plan, Faxton-St. Luke's Healthcare, April 30, 2004; Expanded BRFSS, 2003 – New York State Department of Health; Refugee Health in New York State, 1996-1999. New York State Department of Health; Morbidity and Mortality Weekly Report "Summary of Notifiable Diseases – United States (2001, 2002) – Centers for Disease Control and Prevention; Oneida County Health Department Annual Reports (2001-2003); and Healthy People 2010.

2. CHALLENGES AND LIMITATIONS

The challenges in assembling multiple data sources to analyze health in Oneida County involve overcoming the methodological and definitional differences among them. For example, in addition to understanding the total effect of particular indicators on the entire population of Oneida County, this assessment strives to delineate the specific impact upon different population groups. While data sources at the State level provided a breakdown by ethnicity, such data at the county level is sporadic or not available for analysis.

Another challenge relates to the timeliness of available data. Where possible the most recent available data were used and then compared to previous years in order to indicate trends over time. The majority of the health status indicator data were pulled from 2000 sources, the most recent data at the time the *Health Profile* was initiated in 2004.

Other categories, however, were developed using sources that were not as recent. A final point to consider in reviewing the data that follow is that many of the health status indicators, exclusive of births and deaths, are based upon reports provided to OCHD by other providers and selective screening. The underlying objectives for collecting data, especially for data sources from providers other than the county may introduce a selective bias whereby specific conditions are under-reported, or a population not targeted for screening, the data may under-represent actual incidence or prevalence. The unique strengths and limitations of each data source must be considered when interpreting results. When combined, however, they contribute to a greater understanding of health in Oneida County.

C. DEMOGRAPHIC AND SOCIO-ECONOMIC STATUS

Oneida County is located in the heart of New York State, bordering five other counties: Herkimer, Madison, Lewis, Oswego, and Otsego Counties. It is comprised of 3 cities, Utica, Rome and, Sherrill (considered the smallest city in New York State). There are also 26 towns and 19 villages, totaling 48 different municipalities that comprise a total of 1,257.11 square miles of which, 1,212.70 square miles is land area and 44.41 square miles of water area.

1. POPULATION

Table 1 depicts Census Bureau Annual Estimates Data for 2003 for Oneida County's population from April 1, 2000 to July 1, 2003.

TABLE 1 - CITY POPULATION ESTIMATES				
CITY	2003	2002	2001	2000
Utica	59,485	59,702	59,989	60,651
Rome	34,512	34,583	34,689	34,950
Sherrill	3,109	3,110	3,118	3,147
Oneida County	234,373	234,180	234,268	235,469

Although, statistically these numbers are the best available, Census estimate numbers are not based on actual counts. The 2003 population estimate of approximately 234,373 shows a 0.5% decrease from 2000.

The three incorporated cities; Utica, Rome and Sherrill, demonstrated

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

similar population changes between 2000 and 2003. Of the County's 2000-population of 235,469, 26% reside in the City of Utica, 15% in Rome and approximately 1% in the City of Sherrill. The remaining 58% reside in the county's other 45 towns and villages. Population from 1990 to 2000 decreased by 6.1%, which may be due in part to the closing of the Griffiss Air Force Base in the early part of the 1990's. The percentage of population change for these cities from 1990 to 2000 is a 11.64% decrease for the City of Utica; 21.20% decrease for the City of Rome; and a 9.88% increase for the City of Sherrill. Town and villages with the highest and lowest population change were Clinton with a decrease by 12.78% and Florence with an increase of 27.46%.

Population projections for Oneida County, based on the New York State Statistical Information System at Cornell University predict a decline in population between 2000 and 2030. This may be attributed to the decrease among women of childbearing age and an exodus of youth from the community.

TABLE 2 - POPULATION CHANGE BY AGE (1990-2000)

AGE	ONEIDA COUNTY			NYS		
	1990	%of Total	2000	%of Total	NYS-NYC 2000	% of Total
0-4	17,488	7.0	13,348	5.7	698,539	6.4
5-19	51,369	20.5	49,443	21.0	2,359,262	21.5
20-64	143,217	57.0	133,925	56.8	6,399,883	58.4
65+	38,762	15.5	38,753	16.5	1,510,494	13.7
Total	250,836	100.0	235,469	100.0	10,968,179	100.0
Median Age			38.2			

Population by Age: Oneida County's infant population, 0-4 years of age, decreased while its senior citizen population 65+ increased. Youth population (0-19) decreased by 11.4% from 1990 to 2000. In 2000, 5.7% of the population were under 5 years of age; 23.9% under 18 years of age; and 16.5% were 65 years and older (Table 2).

Among New York State Counties with similar populations, Oneida County has the highest percentage of population 65 years and older. The 65 and older population has gone from representing about 11% of the total population in 1950 to about 17% in 2000. The City of Utica and Town of New Hartford has the highest percentage of residents in Oneida County that are 65 years and older. The median age of Oneida County's population has increased from 29 years in 1970 to 38.2 in 2000, which may in part be largely due to the influx of the "baby boomers" and the outflow of younger workers. Oneida County Office for the Aging and Continuing Care – Project 2015 reports that the Oneida County's 60 plus population will almost match our highest employment age cohort of 25-44. In 2015, the 25-44 year old population will be 59,042 and the 60 plus will be 55,263.

Population by Ethnicity: The population of Oneida County is predominantly White (90.2%) with a smaller number of minorities. Fifty-eight percent of the total Black or African American population reside in the City of Utica although 79% of the City's total population is White (Table 3). Oneida County's Hispanic and Asian population have shown the most significant increase while the White population has declined somewhat, and the African American population has increased slightly. White children and

TABLE 3 - CENSUS 2000: ONEIDA COUNTY-ETHNIC COMPOSITION BY MUNICIPALITY

Municipality	Total Pop.	SINGLE ETHNIC BACKGROUND							
		Single Race	White	Black	Am Ind	Asian	Pac Islr	Other	Multiple Race
City of Rome	34,950	34,235	30,704	2,650	93	309	6	473	715
City of Sherrill	3,147	3,130	3,084	7	19	19	0	1	17
City of Utica	60,651	58,853	48,166	7,838	170	1,341	29	1,309	1,798
Villages and Towns	136,721	135,668	130,460	3,026	267	1,053	20	842	1,053
Oneida County	235,469	231,886	212,414	13,521	549	2,722	55	2,625	3,583

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

TABLE 4-POPULATION CHANGE BY ETHNICITY (1990-2000)

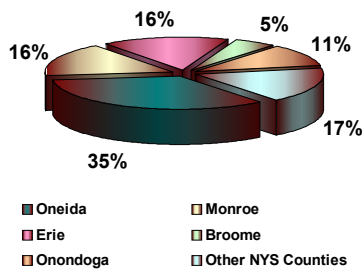
Race	Oneida County	
	1990 % of Total Population	2000 % of Total Population
White	92.7	90.2
Black	5.4	5.7
Asian	0.8	1.2
American Indian	0.2	0.2
Hispanic	2.3	3.2
Other		1.1

youth have accounted for most of the drop in population of youth in Oneida County in the 1990s; numbers of Hispanic and Asian youth have risen, and the number of black youth ages 10-19 have increased, while the number of black children ages 0-9 has declined (Table 4).

Refugee Population - A large number of refugees have settled in Oneida County due in part to having one of the largest

resettlement agencies in the country. The Mohawk Valley Resource Center for Refugees (MVRCR) has been responsible for the resettlement of 10,398 refugees in NYS (excluding NYC) between July 1996 and June 1999. Of these refugees, 35% (3,557) have settled in Oneida County; of those who remained in Oneida County, most live in the City of Utica. Among NYS Counties, Oneida County resettled the most refugees; over 1,000 per year (Figure 1). The majority of refugees (73%) came from Bosnia, Vietnam, Ukraine, Serbia and Belarus. MVRCR most recent influx of refugees are from the war-torn Southern Somalia in Africa. Since 2002, they have resettled approximately 250 Somali Bantu refugees.

Figure 1 - NYS Refugee Arrivals by County of Destination (Excluding NYC) 7/1/96 - 6/30/99



According to the MVRCR, the tragic events of September 11, 2001 drastically impacted refugee resettlement to the United States. The number of refugees resettled declined from an average of 70,000 annually before 2001 to 28,000 in 2003. The impact has been substantial. In 2003 the MVRCR resettled only 256 refugees.

Population by

Gender: For all ages in Oneida County, there are 98.6 males for every 100 females. The majority of the 65+ population of 38,753 is female (60%) while (40%) is male, which is similar to the trend nationally. For the 18 years and older population the ratio drops to 96.3 males for every 100 females. As shown in Table 5, within the 85+ population there is a significantly larger percentage (74%) of females than males (26%). National (71%) and State (72%) data show similar trends in this age group.

TABLE 5 - POPULATION BY GENDER ONEIDA COUNTY

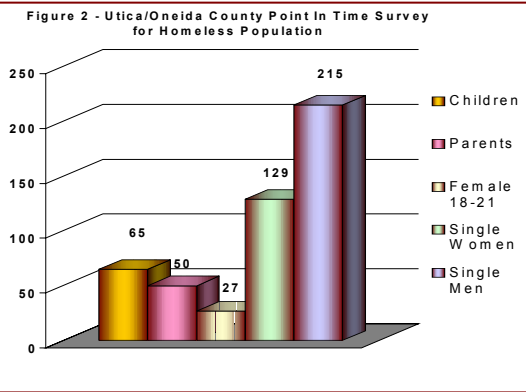
Total: 235,469			
Age:	Both:	Male:	Female:
All ages	235,469	116,913	118,556
18 years and older	179,225	87,915	91,310
65 years and older	38,753	15,462	23,291

Non-English Speaking Population: Large portions of Oneida County's immigrants are from Bosnia, the former Soviet Union, and Vietnam. Moreover, there is a large Latino population that resides within the community. Language barriers and cultural differences have made it difficult for many of these culturally and linguistically diverse residents to gain access to health and human services and pertinent medical, health and insurance information.

The population of 5 years and over totals 220,067; of these, 21,317 (9.6%) speak a language other than English of which 8,968 (4%) speak English "less than very well". The majority (65%) are between the ages of 18-64 years; 20% are in the 5-17 age group; and 15% are 65 years and older.

Homeless Population: The difficulties associated with locating individuals that are homeless create problems in determining the total number of persons within Oneida County who experience homelessness. Figure #2 reflects counts from a point-in-time survey from the Utica/Oneida County Continuum of Care Homeless Needs Assessment Survey – Spring 2004. This survey identified the

HEALTH PROFILE



highest unmet needs of homeless youths and adults to be transportation to locate housing and for work, job training and placement, life skills training, and childcare. Factors associated with and contributing to homelessness include substance abuse, domestic violence, lack of education, unemployment and poverty.

Single-parent households: There are 90,507 total households in Oneida County of which approximately one-third (30%) are one-person households. In Oneida County, 69% of total family households with

their own children under the age of 18 (27,555), are married parents. Twenty-four percent of these family households are single females raising their own children. In contrast, 7% of these family households are males raising their own children, which is higher than the statewide percentage of 5.7%.

Since the 1990 census, married family households overall decreased from 50,430 to 44,474 in 2000, while single family households have increased accordingly; male householder from 2,920 to 3,807 and female householder from 10,385 to 10,889.

2. HOUSEHOLD INCOME

Median Income: The 2000 median household income in Oneida County is \$35,909 in comparison with the New York State median household income of \$43,393. For Oneida County, this is a 26% increase from \$26,710 in 1990. There are 90,507 households in Oneida County and 48% of these earn less than the median income (\$34,999 or less). Median income for males is \$31,194 and for females is \$24,295.

The lowest median household incomes are in the City of Utica at \$24,916 and the Village of Oriskany Falls at \$24,716. Highest is in the Town of Trenton at \$49,559.

Poverty: According to the 2000 Census, 12.6% of the Oneida County population is below the poverty level, which is below the State level of 13.2% and slightly higher than the county's 11.9% level in 1990. This ranks Oneida County (along with Chemung County) as the 22nd highest poverty

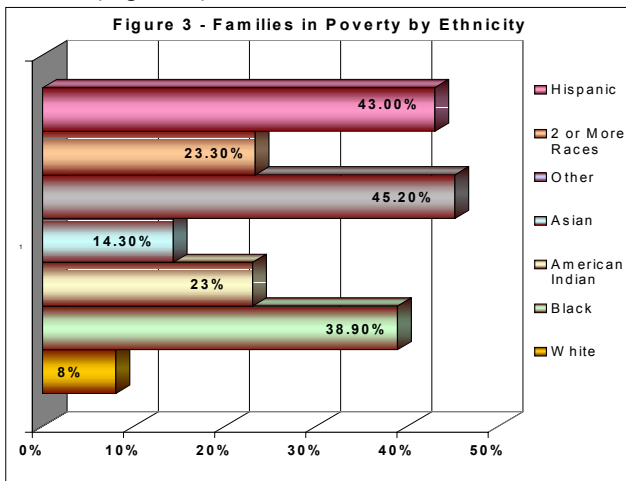
TABLE 6 - FAMILIES BELOW POVERTY LEVEL – REGIONAL COUNTIES								
	Cayuga	Cortland	Herkimer	Madison	Oneida	Onondaga	Oswego	Tompkins
Families Below Poverty Level	7.8%	9.3%	8.9%	6.3%	9.8%	8.6%	9.7%	6.8%
with related children under 18	12.5%	14.1%	14.2%	9.8%	16.5%	13.3%	14.6%	10.6%
with related children under 5	16.2%	19.4%	18.5%	13.5%	23.8%	18.6%	21.9%	15.2%

level for all ages amongst New York State's 62 counties. As indicated in Table 6, within our 8-county region, Oneida County has the highest percentage of families below the poverty level. The same applies to families with related children under 18 and under five years of age. Although high for our region, Oneida County's family poverty rate levels are below the State average of 11.3%. Poverty level for families with related children under 18 years in New York State is 16.9% for 2000. Oneida County's high rates may be due in part to several factors such as increased amount of single parent families, a shifting economy, inadequate education and training, and unemployment. Such trends

HEALTH PROFILE

tell us that there may be a need for more financial support for families in Oneida County. Approximately one out of every four children under the age of 5 lives in poverty.

According to *Communities That Care - Monitoring the Community – April 2003 Report*, Oneida County has a significantly high percentage of minority families in poverty. Within all ethnic groups there is also a substantially larger percentage of female single parent households in poverty in comparison to single male households and married couple households with children. Poverty status data is as follows for female households with children under 18; White-36%; Black – 61.6%; American Indian – 83.3%; Asian – 47%; Other – 70.5%; 2 or more races – 57.6%; and Hispanic 72.4% (Figure 3).



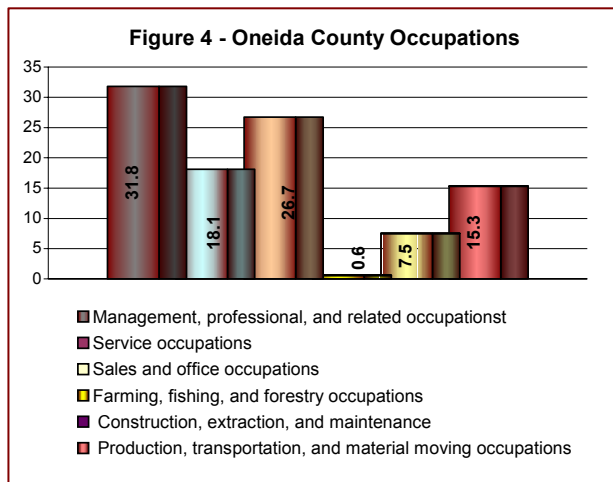
Poverty level for persons 65 and older is 8.5% for Oneida County. The rate for New York State is 11.3%. Data shows a higher amount of females 75 and over (1,311) in poverty in comparison to the number of males (504) in that age group. These numbers indicate a need for greater financial support for the elderly population.

Poverty status by municipality shows high rates for all ages in the Cities of Utica at 24.5% and Rome at 15%. Townships and villages also show high rates such as Ava – 20.1%, Remsen- 20%, Sylvan Beach –17%, and Oriskany Falls – 16.5%.

Unemployment: Census 2000 data reports that the unemployment rate for Oneida County was 5.9% for individuals 16 and over in the civilian labor force. The rate for males at 6.7% is higher than for females at 5%. Table 7 shows data from the NYS Department of Labor for average annual unemployment rate for Oneida County for 2000-2003. The rate trend indicates a steady increase between 2000 and 2003, which reflects recent losses of manufacturing industries in the county and its impact on the economy.

TABLE 7- LOCAL AREA UNEMPLOYMENT STATISTICS PROGRAM

Year	2003	2002	2001	2000
Ann Avg.	5.20%	5.20%	4.60%	3.80%



Jobs and Annual Pay:

Based on Census 2000 data, Oneida County's employed civilian and military population totals 109,496, with the highest percentage of these occupations in the management/professional and sales and office fields. Fifty-five percent of all females 16 years of age and older are in the civilian labor force whereas 63% of all males 16 years and older are in the civilian workforce. Men dominate the production, farming and construction occupations while women are more dominant in sales and office occupations and somewhat higher in management and professional occupations (14,923 vs. 17,708). There is no significant

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

difference in gender in service related occupations. Median earnings in 1999 of full-time, year-round workers was \$32,194 for males and \$24,295 for females, which is lower than for both genders for New York State for the same year - \$40,236 for men and \$31,099 for women (Figure 4).

D. HEALTH STATUS INDICATORS

1. MORTALITY

Leading Causes of Death: With 2,557 deaths, Oneida County's 2000 mortality rate was 1085.9 per 100,000 population. This rate represents an 8.5% increase from 1001.2 in 1997. Heart disease, cancer, chronic respiratory disease, stroke, pneumonia, unintentional injuries, diabetes, septicemia, cirrhosis of the liver, and suicide comprise the ten leading causes of death in 2000, accounting for 79% of all resident deaths in 2000. While the causes and rates of death vary by race and ethnicity, as reflected in Table 8, heart disease and cancer are the two leading causes within each racial/ethnic group.

TABLE 8: TEN LEADING CAUSES OF DEATH BY RACE/ETHNICITY – NUMBER AND RATE, 2000

Causes	Oneida County		White		Black		Hispanic	
	#	Rate	#	Rate	#	Rate	#	Rate
All Causes	2557	1085.9	2454	1160.0	88	650.8	18	238.6
Heart Disease	788	334.7	765	360.1	23	170.1	6	79.5
Cancer (Malignant Neoplasm)	576	244.6	551	259.4	22	162.7	2	26.5
Chronic Lower Respiratory Disease	200	84.9	197	92.7	3	22.2	0	0.0
Stroke (Cerebrovascular Disease)	179	76.0	176	82.9	3	22.2	2	26.5
Pneumonia	86	36.5	83	39.1	3	22.2	1	13.3
Unintentional Injuries	65	27.6	64	30.1	1	7.4	1	13.3
Diabetes Mellitus	54	22.9	50	23.5	4	29.6	0	0.0
Septicemia	29	12.3	27	12.7	1	7.4	0	0.0
Cirrhosis of Liver	25	10.6	21	9.9	4	29.6	0	0.0
Suicide	20	8.5	20	9.4	0	0.0	1	13.3

Diabetes and Cirrhosis of the Liver were tied as the third leading cause of death among African Americans. Also among African Americans Homicide and HIV/AIDS tied as the fourth leading cause of death. Homicide/Legal Intervention and HIV/AIDS are the eleventh and twelfth leading causes of death for Whites, respectively. Suicide tied for third, along with pneumonia and accidents, as the third leading cause of death among Hispanics. However, it must be noted that in tabulating mortality data for the County any inferences should be made with care. The statistics presented in this report are based on a small number of events are subject to a large degree of variability.

HEALTH PROFILE

By gender, the total number of deaths in 2000 did not vary greatly, with only about 4% more female deaths. However, African American males did display a higher number of deaths than African American females (55% to 45% respectively).

Data is currently not available at the county level that breaks down the causes of the deaths by gender. At this time, we can only surmise that the top two causes of death contributed to the majority of deaths for both sexes in 2000. It is possible that certain causes of death effect one gender group more than the other (e.g., prostate cancer affects only men). However, without additional information no further inferences can be made at this time.

By reviewing causes of death in 2000 to previous years, we can observe trends over time. Consistent with the 2000 data, the leading causes of death for the period of 1997 – 1999, were heart disease and cancers. HIV/AIDS, however, was the tenth leading cause of death in Oneida County in 1997, whereas in 2000 it dropped to twelfth, likely due to new drug therapies that are prolonging life for those infected. The number of homicides has tripled (1997 = 2; 2000 = 7), and suicides doubled (1997 = 11; 2000 = 20), between 1997 and 2000.

2. MATERNAL AND CHILD HEALTH STATUS

Maternal and child health status indicators are often used to reflect the overall health and well being of a population. Improvement of the health status of mothers and infants remains a national priority. This section describes birth to teens, infant mortality, low birth weight, prenatal care, maternal mortality, infants with gestational age less than 37 weeks and child mortality.



Infant mortality (death within the first year of life) is one of the most widely used markers for determining the health status of the population as a whole. As of 1995, the U.S. infant mortality rate ranked 25th among industrialized nations. In addition, the disparity in infant mortality rates between Whites and specific ethnic groups (i.e. African Americans, Hispanics and American Indians) persists. Although the overall infant mortality rate has reached record low levels, the rate for African Americans remains twice that of Whites.

Efforts, thus far, to improve the health of mothers and infants have concentrated on the prenatal/postnatal periods. This focus provides the opportunity to identify and modify risks associated with pregnancy outcomes. Major contributing factors include maternal high-risk behaviors such as smoking, alcohol consumption and illegal substance abuse. It has been proven that women who engage in these high-risk behaviors demonstrate a higher rate of poor birth outcomes including infant disease and death.

Other contributing factors include unintended pregnancies, denial of pregnancy, pregnancy occurrence before age 15, and after age 44, inadequate spacing of pregnancies (less than two years apart), poor nutrition, pre-existing medical conditions and socio-economic barriers to adequate care. Future interventions aimed toward improving birth outcomes must focus on strategies that modify those lifestyles that augment poor birth outcomes.

Infant Mortality: Nationally, in 1997, 28,045 infants died before their first birthday, for an overall rate of 7.2 deaths per 1,000 live births. In 1997, two-thirds of all infant deaths took place during the first 28 days of life (the neonatal period). The overall neonatal mortality rate in 1997 was 4.8 per 1,000 live births. The remaining one-third of infant deaths took place during the postnatal period from an infants 29th day of life until the first birthday. The U. S. post-neonatal mortality rate in 1997 was 2.4 deaths per 1,000 live births. The 1997 infant mortality rate among African American infants was 2.3 times that of White infants. Although the infant mortality rates have declined within both racial groups, the proportional discrepancy between African Americans and Whites remains largely unchanged (H. P. 2010).

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

According to U. S. Department of Health & Human Services National Vital Statistics Report, infant mortality is highest among children of teenage mothers, followed by children of mothers over age 40. Infant mortality is also higher among women who smoke during pregnancy.

NYSDOH data indicates that the primary cause of death for children less than 1 year of age is due to conditions originating in the perinatal period, especially due to immaturity or pre-term births. Sudden Infant Death Syndrome and respiratory ailments are also leading causes of death.

TABLE 9-MATERNAL AND CHILD HEALTH INDICATORS - NATALITY 2000

	Oneida County Total		White		Black		Hispanic	
	#	%	#	%	#	%	#	%
Live Births	2,499		2,253	86	18.3	7.3	105	4.2
Births to Teens Age 15 – 19	288	11.5	238	10.6	44	24.0	21	20
Infant Mortality*	27	10.8	19	8.4	8	43.7	2	19.0
		*		*		*		*
Low Birth Weight	208	8.3	184	8.2	23	12.6	10	9.5
Early Prenatal Care	1,871	75.7	1,732	77.7	111	61.0	78	75.7
No Prenatal Care	120	4.9	97	4.4	20	11.0	4	3.9
Total Pregnancy**	3,430	75.1	2,649		222		118	
		**						
Teenage Pregnancies Ages 15-19***	473	59.5	294		56		23	

Premature Births (<37 weeks)	322	13.1	284	12.8	34	18.8	17	16.3

All data based on Vital Statistics of New York 2000.

* Rate based on annual # of deaths under 1 year of age per 1000 live births occurring during the year.

** Rate based on Annual # of pregnancies per 1,000 female population 15-24.

*** Rate based on Annual # of teenage pregnancies per 1.00 female population aged 15-19.

Between 1999-2003, 109 infants in Oneida County died within the first year of life. Infant mortality rate for the same time period was 8.5 per 1,000 live births. The rate decreased from 7.7 (1998) to 6.0 (2001). This is a relatively small decrease with some fluctuations in rates between 1998 and 2001. The mortality rates for children under one year in Oneida County

TABLE 10 - INFANT MORTALITY 1999 – 2003

LOCALITY	INFANT DEATHS < 1 YR	NEONATAL DEATHS < THAN 28 DAYS	POSTNATAL DEATHS (28 DAYS TO 1 YR)	PERINATAL MORTALITY
	Rate/1,000 live births	Rate/1,000 live births	Rate	Rate
Oneida County	8.5	6.4	2.2	15.6
New York State	6.0	4.2	1.8	11.5
United States	6.9	4.6	2.3	7.0

are higher than those in New York State and the United States (Table 10). H.P. 2010 target rate is 4.5 per 1,000 live births. It is difficult to draw any conclusions from this due to the actual low number of deaths.

Mortality rates for blacks in the United States and New York State are more than twice as high as for Whites. In Oneida County, infant mortality rates for blacks are five times higher than rates for White infants (Table 11).

TABLE 11 - INFANT MORTALITY BY ETHNICITY – 1999 – 2003 DATA

LOCALITY	ETHNICITY	RATE @ < 1 YR
ONEIDA COUNTY	White	7.3
	Black	35.1
NEW YORK STATE	White	5.0
	Black	10.0
** REGIONAL	White	6.2
	Black	20.5
UNITED STATES	White	5.7
	Black	13.5

**** INCLUDES ONONDAGA, OSWEGO, TOMPKINS AND CAYUGA COUNTIES**

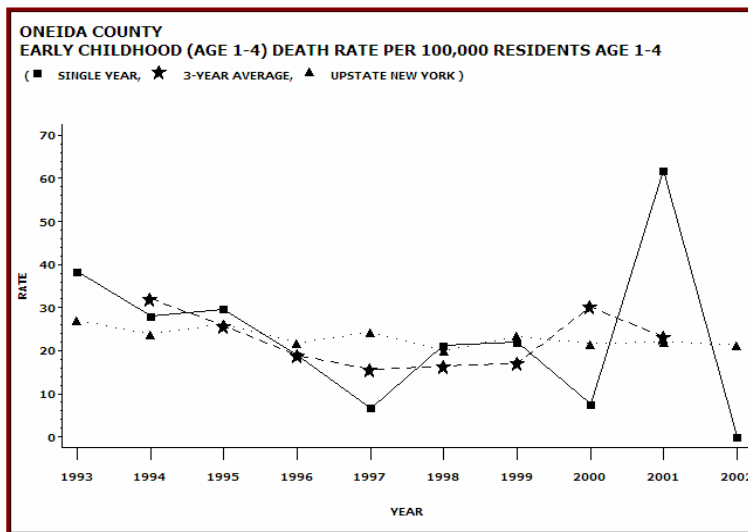
Maternal Mortality: Nationally, in 1997, 327 maternal deaths were reported. The major causes of maternal death were hemorrhage,

HEALTH PROFILE

ectopic pregnancy, pregnancy – induced hypertension, embolism, infection, and other complications of pregnancy and childbirth. The overall maternal mortality rate has fluctuated between approximately 7 and 8 per 100,000 live births since 1982. Moreover, in 1997, the maternal mortality rate for African Americans is 3.6 times higher than that of Whites. The rates among African Americans have been at least three to four times higher than those of Whites since 1940. The rate among African Americans has not declined, fluctuating between about 18 and 22 per 100,000 live births. Between 1998-200 maternal mortality for Oneida County was 0.0 per 100,000 live births and 13.1 for New York State.

Child Mortality: The deaths of children in the United States after infancy represents a public health concern and an opportunity for prevention. In 1997, 13,562 U.S. children aged 1 to 14 years died,

FIGURE 5 – EARLY CHILDHOOD (1-4) DEATH RATE



for a death rate of 25.1 per 100,000 children in that age group. The leading cause of death for children of all ages is injury, which accounts for 13.1 deaths per 100,000 preschool children (aged 1 to 4 years) and 8.7 deaths per 100,000 school-aged children (aged 5 to 14 years). Among children aged 1 to 4 years, the leading injury-related causes of death are motor vehicle crashes, drowning, fires and burns. Among those aged 5 to 14 years, the leading causes of death include motor vehicle crashes and firearms (including unintentional deaths, homicides, and suicides). These

deaths are, for the most part, preventable. Other leading causes of death among children that are less likely to be preventable include birth defects (representing 3.8 deaths per 100,000 children aged 1 to 4 years and 1.2 deaths per 100,000 children aged 5 to 14 years), malignant neoplasm's (representing 2.9 deaths per 100,000 children aged 1 to 4 years and 2.7 deaths per 100,000 children aged 5 to 14 years), and diseases of the heart (representing 1.4 deaths per 100,000 children aged 1 to 4 years and 0.8 deaths per 100,000 children aged 5 to 14 years).

In 1998, death rates for U.S. children ages 1-4 was 34.6 (rate per 100,000 population). H.P. 2010 target for this age group is 18.6. Children aged 5-9 years is 7.7 (H.P. 2010 target is 12.3). Adolescents aged 10-14 is 22.1 (H.P. 2010 target is 16.8). Adolescents aged 15-19 is 70.6 (H.P. 2010 target is 39.8).

Between 1994-1996 and 1999-2001 the average number of deaths for children between ages 1-4 declined by 29% (388 to 257) in New York State. In both time periods, non motor vehicle injury was the leading cause of death (15.5% and 16.6% respectively). Children residing outside of New York City were most frequently victims of non motor vehicle injuries (21%). In 1999-2001 non motor vehicle injuries remained the number one cause in New York State (excluding New York City) at 17.8%.

Children in New York State between the ages of 5-9 have a relatively low risk of death. In New York State, on average, 17.3 children in this age group died annually between 1999-2001 (Figure 5). This was down from the 23.8 average deaths in this age group in 1994-1996.

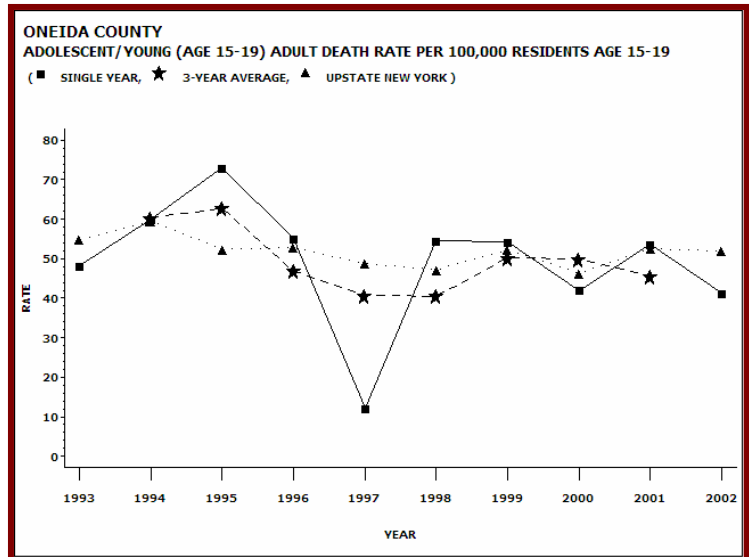
Malignant cancers, the number two causes at 15% in 1994-1996, rose to the number one cause of death in this age group for 1999-2001 at 16.2%.

HEALTH PROFILE

In 1999-2000, motor vehicle injuries were the leading cause of death among children age 5-9 (19.4%) in counties outside New York City.

The risk of death among New York State youth aged 10-14 is relatively low when compared with infants, very young children and older adolescents. In 1999-2001, malignant cancers became the leading cause of death (16%) followed by motor vehicle injuries (14.7%) among youths aged 10-14 in New York State. Motor vehicle injuries accounted for 17.0% of the deaths in 1994-1996, while malignant cancers were responsible for 13.3% of deaths in this age group. Non motor vehicle injuries were another significant cause of death in this age group, claiming 12.8% of deaths for the time period 1991-2001. The change in the leading cause of death among youth ages 10-14 in the state during 1999-2001 was driven primarily by a decline in the proportion of deaths due to motor vehicle injuries in the counties outside New York City from 23.3% in 1994-1996 to 18.6% in 1999-2001.

FIGURE 6 – ADOLESCENT/YOUNG ADULT DEATH RATE



In 2000, Oneida County had 5 deaths among children ages 1-18. The primary cause for the deaths was automobile-related injuries (4) and 1 suicide.

In 2001, 8 deaths were reported, the primary cause was due to motor vehicle crashes, the remaining deaths were related to other causes including, fire, drowning, and suicide.

In 2002 there was a total of 8 deaths (ages 1-18), 4 were related to motor vehicle crashes, 2 suicides, and 2 unknown causes.

For Oneida County in 2003, 18 deaths (ages 1-18) were reported. This demonstrates a significant increase from the previous three years. Three children, all siblings, died as a result of a house fire, 2 homicides, 2 suicides, 2 cancer related, 1 natural causes and 1 motor vehicle injury. The remaining causes of death were not documented.

Child deaths in Oneida County for the past three years were related to preventable causes. Motor vehicle injuries were the leading cause, followed by suicides and homicides.

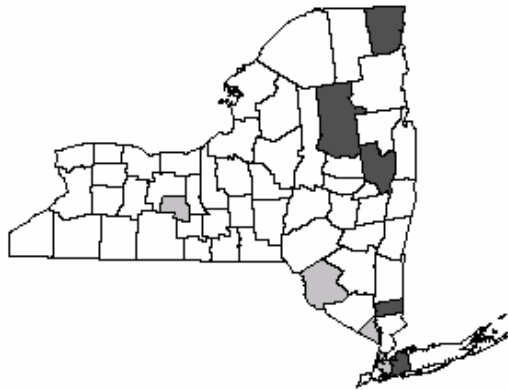
Prenatal Care: Early prenatal care is defined as pregnancy-related health care received by the mother in the first three months (first trimester) of her pregnancy.

Early high quality prenatal care can help to prevent poor birth outcomes by enabling early identification and, where possible, treatment of health problems. Such care can also provide an opportunity to educate or counsel pregnant women about the adverse effects of behaviors such as alcohol, tobacco or other drugs that increase the risks of poor outcomes for their baby. Such preventive measures as nutrition counseling and HIV testing can have important long term effects on the health and well being of the baby.

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

**FIGURE 7 - EARLY
PRENATAL CARE**



EARLY PRENATAL CARE PERCENTAGE
COUNTIES WITH 5 LOWEST AND 5 HIGHEST PERCENTAGES ARE SHADED



In 2001, the U. S. Dept. of Health and Human Services found that infants of mothers who began prenatal care after the first trimester had an infant mortality rate 37% higher than those who received early prenatal care (care starting in the first trimester). The national goal for prenatal care is to increase the percentage of infants born to pregnant women receiving prenatal care in the first trimester to 90%.

In 1998, 83% of U.S. women began prenatal care in the first trimester of pregnancy. The percentage for receiving early and adequate prenatal care was 74%.

In 2000, 72.8% of all women delivering live births received early prenatal care in New York State, an increase of 1.5% from 1999. Women receiving late or no prenatal care in New York State decreased from 8.3 in 1999 to 6.0% in 2000. Some of this decline is due to a change in the way the New York

City Health Dept. accounts for unknowns recorded for entry to prenatal care.

Over the past 5 years, 74% of women in Oneida County received early prenatal care. In Oneida County, the rates have dropped from a high of 75.5% (2000) to a low of 71.2% (2003).

The rates in Central New York have remained fairly steady. In 2002, 81.6% of women in New York State began care in the first trimester. The rate for New York State is higher than Central New York and Oneida County respectively.

According to 2003 data, teens are less likely to receive prenatal care than women over age 24. In all regions of New York State, women of color were significantly less likely to receive prenatal care than White women. Women who had private insurance were far more likely to receive prenatal care than women who had Medicaid. In Oneida County, women with private insurance, were 22.9% higher more likely to receive early prenatal care.

Adolescent Pregnancy Rates: Assuming the responsibility for parenting before one is financially, socially or emotionally prepared carries increased risks of later difficulties for the parent, the child, and the community. Adolescent mothers are less likely than their non-parenting peers to complete high school and marry. They are more likely to have large families and live in poverty. Their children are at greater risk of infant mortality, poor health, lower cognitive development, poor educational outcomes, higher rates of behavior problems and higher rates of adolescent childbearing themselves. Adolescent childbearing also places a greater financial burden on society in terms of increased supports required to assist these families.

TABLE 12 - ADOLESCENT PREGNANCIES - ONEIDA COUNTY

	2001 Rate	2000 Rate	1999 Rate	1998 Rate	1997 Rate
Ages					
10-14	0.9	1.6	0.8	1.0	1.6
15-19	57.5	59.5	58.4	64.4	64.9
New York State					
10-14	1.7	1.8	1.9	2.0	2.4
15-19	57.9	59.5	58.4	64.4	64.9
Totals	69.1	71.0	47,564	50,571	64.9

In 2000, there were 44,412 pregnancies to young women ages 15 – 19 in New York State. The pregnancy rate for this age group was 71.0 per 1,000; a 21% decline from the 1995 rate of 90.1. The rate of pregnancy for women outside New York City declined from 61.5 per 1,000 women ages 15 – 19 in 1995 to 49.7 per 1,000 in 2000.

HEALTH PROFILE

In 2000 pregnancy rates for New York State's youngest teens remained fairly low with fewer than 2 per 1,000 for girls aged 10 – 14. Pregnancy rates among young women 15 – 17 declined from 60.0 per 1,000 in 1999 to 44.4 in 2000 (Table 12).

Adolescent pregnancy rates ages 10–14 - Adolescent pregnancy rates for ages 10 – 14 fluctuated with a high of 1.6 in 2000 to a low of 0.9 in 2001. Rates by ethnicity could not be identified. Teen pregnancy rates have decreased between 1997 and 2001 for both age groups 10-14 (1.6 to 0.9) and 15-19 (64.9 to 57.5). Adolescent pregnancy rates for ages 15 – 19 ranged from a rate of 46.4 in 1995 to 31.6 in 2001. Parallel to the adolescent birth rate, the pregnancy rate also demonstrated a slight decline in rate by 6.5 per 1,000 females ages 15–44 (Table 12).

Rates of adolescent pregnancy for Oneida County are lower than New York State rates and comparable to rates in Central New York. County rates of adolescent pregnancies are actually less than the H. P. 2010 target.

Teenage Births: Teenage birth rates in this country have declined steadily since 1991. While this is good news, teen birth rates in the U.S. remain high, exceeding those in most developed countries. High teen birth rates are an important concern because teen mothers and their babies face increased risks to their health, and their opportunities to build a future are diminished.



Nationally, about 11 percent of all U.S. births in 2002 were to teens (ages 15 to 19). The majority of teenage births (about 67 percent) are to girls ages 18 and 19. About 860,000 teenagers become pregnant each year, and about 425,000 give birth. About one in three teenagers becomes pregnant before age 20.

Between 1991 and 2002, the teenage birth rate fell by 30 percent (from 61.8 per 1,000 women to 43). Still, in 2002 (the most recent year for which data are available), about 4 teenage girls in 100 had a baby. About 17 percent of teen mothers go on to have a second baby within three years after the birth of their first baby.

Nationally, teen mothers are more likely than mothers over age 20 to give birth prematurely (before 37 completed weeks of pregnancy). In 2002, the 7,315 girls under age 15 who gave birth were more than twice as likely to deliver prematurely than women ages 30 to 34 (21 vs. 9 percent). Babies born too soon face an increased risk of newborn health problems, lasting disabilities, and even death. Poor outcomes affecting the health of infants born to teens include poor eating habits, neglect to take their vitamins, smoking, drinking alcohol, and taking drugs.

Pregnant teens are more likely to smoke than pregnant women over age 25. Pregnant teens are least likely of all maternal age groups to get early and regular prenatal care. A teenage mother is at greater risk than women over age 20 for pregnancy complications such as premature labor, anemia and high blood pressure.

Teenage mothers have a higher incident of LBW infants (infants >2500gms. or 5.5lbs.). In 2002, 9.6% of mothers ages 15-19 had a low birthweight baby compared to 7.8% for mothers of all ages.

In New York State, of the 2,499 live births in 2000, 11.5% were born to mothers younger than 18 years of age. By ethnicity, 24% were African American, 20% Hispanic, 10.6% Caucasian, and 8.3% other ethnic groups.

Although not a steady decline, the number of births to girls age 15-17 in Oneida County dropped by more than 32% between 1999-2003. The trend parallels that found in the Central New York region which saw a decline of 29.5% in the number of births to 15-17 year olds.

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

The rate of adolescent births ages 15-19 is higher for Oneida County (1998-2000), 37.7 per 1,000 as compared to 36.1 per 1,000 for New York State. Focus groups conducted by Mohawk Valley Perinatal Network attributed the higher rate to lack of education in schools about the realities of pregnancy and parenthood to teenagers, lack of community support, and lack of self-esteem in this age group.

Short Gestation And Low Birth Weight: Nationally, short gestation (< 37 weeks gestational age) and low birth weight (infants weighing <than 2500 grams or 5.5 pounds) are among the leading causes of neonatal death, accounting for 20 percent of neonatal deaths. In 1998, a total of 11.6 percent of births were pre-term, and 7.6 percent were low birth weight. Included in these statistics were Very Low Birth Weight (VLBW) infants weighing less than 1,500 grams (3.3 pounds). The rate of VLBW births was 1.4 percent in 1998. The VLBW rate has increased slightly since 1990 among Whites and other population groups including African Americans, Puerto Ricans and American Indians.

Nationally, Low Birth Weight (LBW) is associated with long-term disabilities, such as cerebral palsy, autism, mental retardation, vision and hearing impairments and other developmental disabilities. Despite the low proportion of pregnancies resulting in low birth weight babies, expenditures for the care of LBW infants total more than half of the costs incurred for all newborns.

The general category of LBW infants includes both those born too early (pre-term infants) and those who are born at full term but who are too small, a condition known as intrauterine growth retardation (IUGR). Maternal characteristics that are risk factors associated with IUGR includes maternal LBW, prior LBW birth history, low pre-pregnancy weight, cigarette smoking, multiple births and low pregnancy weight gain. Cigarette smoking is the greatest known risk factor.

VLBW usually is associated with pre-term birth. Relatively little is known about risk factors for pre-term birth, but the primary risk factors are prior pre-term birth and spontaneous abortion, low pre-pregnancy weight and cigarette smoking. These risk factors account for only one-third of all pre-term births.

The low birth rate for infants weighing less than 2500 grams or about 5.5 pounds for Oneida County over a 5 year period (1999 – 2003) was 7.9 per 1,000 live births. Oneida County low birth weight births are higher than Central New York (7.3) and New York State (7.8). The H. P. 2010 target is for fewer than 5 per 1,000 of births to be lower birth weight and .9 per 1,000 to be very low birth weight (less than 1500 grams). In Oneida County, the incidence of low birth weight infants per 1,000, per ethnicity, averaged (White 8.2), (African American 12.6) and (Hispanics 9.5). In New York State the rate was 6.5 for Whites and 12.3 for African Americans.

Low birth weight is correlated by a number of factors such as high blood pressure, certain infections, and heart, kidney or lung problems. An abnormal uterus or cervix can increase the mother's risk of having a premature, low birth weight baby. The March of Dimes reports that socio-economic factors such as low income and lack of education are also associated with the risk of having a low birth weight infant.

The number of premature births (births < 37 weeks)

in Oneida County has fluctuated from 2000-2002. The percentage for premature births was higher in Oneida County (11.8%) than the Central New York region (11.3%) and the New York State (11.5%) – Table 13.

TABLE 13 - PREMATURE BIRTHS (BIRTHS < 37 WEEKS GESTATIONAL AGE)					
REGION	2000	2001	2002	BIRTHS 2000-2002 TOTAL	3 YR %
ONEIDA CO.	321	270	281	7,411	11.8%
CNY REGION	1,943	1,820	1,732	48,836	11.3%
N.Y. STATE	29,357	27,738	27,646	735,486	11.5%

HEALTH PROFILE

H. P. 2010 calls for a reduction in the number of pre term births to 7.6%. According to the March of Dimes in nearly half of all cases the reason for premature births is unknown. There are believed to be four main reasons leading to premature labor including maternal or fetal stress, infections, bleeding and stretching.

Alcohol and Substance Abuse During Pregnancy: The use of alcohol, tobacco and illegal substances during pregnancy is a major factor for low birth weight and other poor infant outcomes.

Drinking alcohol during pregnancy can cause physical and mental birth defects. Each year in the United States more than 40,000 babies are born with some degree of alcohol related damage. In general, alcohol related birth defects (such as heart defects) are more likely to result from drinking during the first trimester, while growth problems are more likely to result from drinking in the third trimester. However, drinking at any stage of pregnancy can affect the fetus. Overall rates of alcohol use during pregnancy have increased during the 1990's and the proportion of pregnant women using alcohol at higher and more hazardous levels has increased substantially. The economic cost of services to substance exposed infants is great. Nationally, health expenditures related to fetal alcohol syndrome are estimated to be from \$75 million to \$9.7 billion each year.

The American Pregnancy Association claims that marijuana, like cigarette smoke contains certain toxins that keep the fetus from getting the proper supply of oxygen that he or she needs to grow. Smoking marijuana during pregnancy can increase the chance of miscarriage, low birth weight, premature birth, developmental delays, behavioral and learning problems.

Using heroin during pregnancy increases the chance of premature birth, low birth weight and withdrawal syndromes in newborns. Withdrawal syndromes can cause abnormalities in an infant.

Reports of substance use during pregnancy are documented on birth certificates based on information provided by the mother. It is believed that self-reporting of substance use behaviors is not fully reliable and that smoking and drinking behaviors are likely under-reported.

H.P. 2010 targets call for 94% of women to report abstaining from alcohol in the month prior to being surveyed and 100% of pregnant women abstaining from binge drinking in the month prior to testing.

Smoking During Pregnancy: The U.S. Dept. of Health and Human Services has indicated that smoking during pregnancy can result in spontaneous abortion, low birth weight and sudden infant death syndrome. It has been associated with infertility, miscarriages, tubal pregnancies, infant mortality and childhood morbidity. Smoking attributed costs of complicated births in 1995 were estimated at 1.4 billion (17% of costs for all complicated births).

According to the CNY and NENY Regional Perinatal Data System Survey given to area women in hospitals and birthing centers, younger women in the region are significantly more likely to report using tobacco while pregnant; although the rate of teenagers who report smoking has dropped to more than 4% since 1999. Over the 5 year period nearly 36.6% of 15-19 year olds and 31.5% of 20-24 year olds smoked while pregnant. That dropped to 15% for 25-34 year olds and to 15.7% for those over age 34. The H.P. 2010 target is for 99% of women to abstain from smoking.

Childhood Lead Poisoning: Childhood lead poisoning is a serious health problem that can have a devastating effect on a child, and has serious repercussions for society as a whole. Human interaction with lead in the environment is most dangerous for children under age six. Lead is a common element that has no biologic function; the human body has no need or use for it. Exposure to even small amounts of lead can contribute to behavior problems and learning disabilities, and has been shown to lower intelligence. The most common source of lead exposure for children today is lead paint in older housing and the contaminated lead dust and soil it generates.

HEALTH PROFILE

Exposure to elevated levels of lead affects all socioeconomic levels, but children living in poverty tend to be at greater risk. Lower income families are more likely to live in older housing with deferred maintenance that may result in lead paint hazards. Older homes, especially homes built prior to 1950, present the greatest risk to children because these homes are most likely to contain lead – based paint. Year 2000 census data indicate that over one – third (37%) of homes in New York State, excluding NYC, were built prior to 1950. New York State has a higher percentage of pre – built 1950 housing units available for occupancy than any other state.

Statewide, 65% of children born in 1999 received a blood lead screen by the age of 24 months. This was up from 62.4% of children born in 1998.

In Oneida County, 61.5% of children born in 1999 received a blood – lead screen by the age of 24 months. This is slightly lower than the 62.2% of children born in 1998.

It is a New York State requirement that medical providers screen children at age 1 and 2 for elevated blood – leads. It was determined statewide that only 1/3 of children screened at age 1 were screened at age 2. Of those with an age 2 screen, 8% were found to have an elevated blood – lead level.

In Oneida County, of the children born between 1994 and 1998 and eligible to receive a second year screen, only 30.8% actually received it. Of those who did receive the screen, 10.8% were identified as having an elevated blood – lead level.

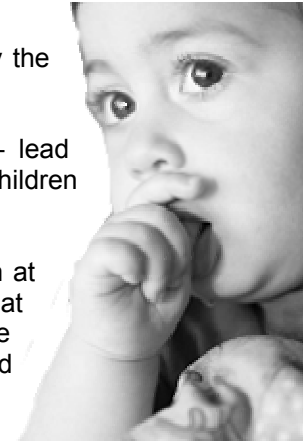
This is an important finding, as it attests to the continued need to screen children at age 2, regardless of assumed lack of risk. Children are more mobile after the age of one and often explore their world by mouthing objects, which makes them more susceptible to lead hazards.

Incidence of childhood lead poisoning (ages 0 – 72 months) - In 2001, 2,763 children were identified in New York State as having an elevated blood – lead level between 10 and 19 microgram per deciliter (ug/dL). This number is down from 3,121 in 2000, resulting in a rate decrease of 11.5%. Children identified as having a blood – lead level of < 20 ug/dL decreased from 551 in 2000 to 415 in 2001. The incident rate statewide for 2001 was 1.7 for all categories of elevated blood – leads. This is down from 1.98 in 2000.

In Oneida County, the number of children identified with elevated blood – lead levels (all categories) was 102 in 2000 and 109 in 2001. The overall incidence rate for the year 2001 was 4.16%, about equal to the 2000 rate of 4.09%.

The report also includes incidence rates based on zip code. This system allows for identification of areas where high rates of childhood lead poisoning are occurring and to target prevention efforts to those communities. There are 36 zip codes (excluding New York City) that account for 41% of all newly identified cases of childhood lead poisoning. (These zip codes represent only 2% of the state zip codes). The top four counties where these zip codes primarily reside are Erie County (9 zip codes), Monroe County (6 zip codes), Onondaga County (5 zip codes), and Albany County (5 zip codes). The rate for incidence in Oneida County for the year 2001 was 4.16%. The incidence rate for the identified zip codes in Oneida County was 7.2%. The zip codes identified in Oneida County as having high incidence are 13501 and 13502.

Prevalence of childhood lead poisoning (ages 0 – 72 months) - The overall prevalence of childhood lead poisoning in all categories fell by 18% between 2000 and 2001, from 6,385 children in 2000 to 5,258 children in 2001. The overall statewide rate for elevated blood – lead in 2001 was 2.7. In Oneida County, the prevalence rate for 2001 was 6.8, about equal to the rate in 2000 of 6.79.



HEALTH PROFILE

Housing Concerns - One of the main reasons a child is at risk for lead poisoning is the presence of lead based paint hazards, especially in those homes built prior to 1978. In New York State, 37% of the housing was built prior to 1950. Oneida County has 46.8% of its housing stock built prior to 1950. Among the high incidence zip codes in Oneida County, the rate of housing built prior to 1950 is 63%.

Poverty Issues - Children living in poverty tend to be at higher risk for lead poisoning. One major reason is because of the nature of the housing in which they live. In New York State, 13.8% of families with children under 5 live in poverty. In Oneida County, 23.8% of families with children under 5 live in poverty. In the high incidence zip codes, 40% of families with children under 5 live in poverty.

Adding to these statistics, Oneida County has 37.2% of its pre – 1950's housing occupied by people living in poverty. The high incidence zip codes have 47% of its pre – 1950's housing occupied by those living in poverty. (These statistics are inclusive of owner – occupied housing and renter – occupied housing).

Oneida County Health Department receives funding from the New York State Department of Health to support the Lead Poisoning Prevention Program. The funds support nursing and environmental services that are directed towards children birth to 6 years of age with elevated lead levels. The Health Department has recently established a county – wide Lead Poisoning Prevention Coalition. The goal of this coalition is to work with community agencies to eliminate lead poisoning. Environmental focus will be a strong point of this committee.

Oneida County Health Department's Healthy Neighborhoods, Community Health Worker, Healthy Families, and Maternal Child Health Programs all provide lead poisoning prevention education to the community through home visits and outreach programs.

Hope VI Project is remodeling and abating homes in Utica's Cornhill area, aiding in the elimination of lead from older homes in this high-risk area of Utica.

The County Lead Poisoning Prevention Program along with other Health Department programs in partnership with the health care provider coordinates efforts to prevent, detect, and treat children with elevated blood – lead levels. Environmental management is provided for children with elevated blood – lead levels (EBL) of 20 ug/dL or higher in order to identify and eliminate sources of lead exposure. By law the property owner is required to correct hazardous lead conditions when a child age six or under is identified as having an EBL of 20 ug/dL or higher.

Although there are resources in place to address lead poisoning prevention, meeting the national goal of eliminating elevated lead levels (> 10 ug/dL) in children by 2010 remains a significant challenge. The age and condition of housing stock combined with the number of children living in poverty are important factors that influence the presence and persistence of childhood lead poisoning in our community. Resources and funding for abatement is limited.

New York State regulations require health care providers to test all children for blood – lead levels at age 1 and again at age 2. Medicaid, Child Health Plus, and the majority of health insurance plans cover lead testing. Free testing is also available through the Oneida County Health Department for uninsured children. Oneida County's screening rate for children birth year cohort 1998 was 62.2. This rate is disturbing considering that by law, physicians are required to conduct blood lead screening on children. Stronger emphasis needs to be placed on universal screening of 1 and 2 year olds by local pediatricians and physicians. Health care providers need to educate the parents about the importance of obtaining the blood lead level test for their child once ordered.

Prenatal and infancy programs offer support and guidance to parents and their newborns at a critical time of physical growth and psychological development. Ensuring healthy pregnancies and healthy

HEALTH PROFILE

infants is one of the best antecedents to successful parenting. New parents are more effective if they are prepared for pregnancy and childbirth, and have adequate information about infant care and development, and guidance and support for parents after the baby is born. The most effective approaches during the prenatal and infancy periods are comprehensive in scope. The following programs are available to address Maternal and Child Health needs in this community.

The following programs are available to address Maternal and Child Health (MCH) needs in this community. Prenatal Care Assistance Programs (PCAP) and Medicaid Obstetrical Maternity Services (MOMS) serve pregnant women on Medicaid (expanded to 200% of the poverty level) in Oneida County. Area PCAP providers include St. Luke's OB Care Center, St. Elizabeth Women's and Children's Center and Family Practice Center, Rome Hospital O.B. Care, and Planned Parenthood. MOMS Program is sponsored by the Oneida County Health Department.

The Mohawk Perinatal Network provides individual outreach and support to pregnant and parenting families in Oneida and Herkimer Counties, but they especially try to target low-income women.

Oneida County Health Department Community Wellness has three programs that provide direct MCH services. Included are MCH Program that provides home visits by a registered nurse to pregnant and parenting families. Community Health Worker Program (CHWP) is a program designed to encourage pregnant women and families with young children to use primary health care and to have healthy pregnancies and healthy babies. Healthy Families Program is a program to prevent child abuse and neglect, promote optimal child health and development, and enhance parent self sufficiency. The Health Department and Family Nurturing Center of Central New York provide the services for this program. Oneida County Health Department also offers WIC and Early Intervention Programs.

Funding barriers cause programs to screen out all but those at highest risk for intervention

Planned Parenthood offers clinical services for reproductive health care and family planning and HIV counseling and testing.

Prenatal and Infancy care is available to women of all income levels with care for low-income women through PCAP clinics in Utica and Rome. More intensive home visiting services are available to those most at risk throughout the county, and there are specific services available for pregnant and parenting teenagers. Local providers indicated a gap in responding to parents requests for baby equipment and supplies that families can't afford such as, cribs, strollers, diapers and other infant items.

Although programs exist for home visiting services, they are limited in their ability to reach larger numbers of families. Many programs are designed to serve only families at highest risk, therefore falling short of a preventive program for all but the most severely impacted.

Transportation and availability of services in rural areas continues to be barriers in accessing available prenatal services.

Most programs appear to be available to any ethnic group if their primary language is English. Very few programs offer bilingual staff and our refugee community presents a challenge to most agencies due to the number of languages in which one would need to be proficient.

Funding barriers cause programs to serve fewer members than they might or screen out all but those at highest risk for intervention. Programs and funding for preventive programs and services are lacking for the ethnic population

Gaps also exist in providing family planning service to the Medicaid and underinsured women in this community. Planned Parenthood is the only provider accepting this population for services. A lack

HEALTH PROFILE

of providers who will accept Medicaid and underinsured clients for family planning services represent a substantial barrier in Oneida County.

Primary care services are available for the majority of infants and children on all forms of Medicaid. Obtaining specialty care i.e. orthopedic, gastrointestinal, oncology presents a challenge. Children in need of this service are referred to Syracuse or Albany Medical Centers for this type of follow-up care.

MATERNAL AND CHILD HEALTH GOALS AND OBJECTIVES

Goals: Improve the health and well being of women, infants, children and families in Oneida County.

Objectives:

- ▣ Reduce the rate of fetal and infant deaths in Oneida County.
- ▣ Reduce the rate of child deaths ages 1-18 years related to accidental causes.
- ▣ Increase the proportion of pregnant women in Oneida County who receive early and adequate prenatal care.
- ▣ Reduce the number of low birth weight and very low birth weight infants born in Oneida County.
- ▣ Reduce the infant mortality rate in African American infants in Oneida County.
- ▣ Reduce substance abuse and smoking in pregnant women in Oneida County.
- ▣ Increase the number of family planning services available to the Medicaid, uninsured and underinsured population.
- ▣ Increase the availability of translation services available for special population in Oneida County.
- ▣ Increase the number of available Medical Specialists in Oneida County who will provide services to children on all forms of Medicaid.

3. COMMUNICABLE DISEASE

The diagnosis, control and prevention of communicable diseases are important aspects in public health. This requires the ongoing, and often concurrent, application of epidemiological techniques; disease and infection surveillance; laboratory confirmation; accurate and rapid diagnosis; case and suspect reporting; identifying, locating and clinically evaluating individuals exposed to the diseases; prompt and accurate treatment for case and suspect management and prevention. If correctly done, this can do much to prevent the spread of communicable diseases in a community, and/or reduce the occurrence or containment of an outbreak. The application of these techniques will be of significant importance if biological agents are deliberately used to harm human populations. These techniques are an integral part of health emergency response and preparedness.

The reporting of suspect or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10). The primary responsibility for reporting rests with the physician; moreover, laboratories, school nurses, day care centers, nursing homes/hospitals and state institutions or other locations providing health services. There are 75 communicable diseases that must be reported using forms provided by the NYSDOH. Thirty-two of these warrant prompt action and should be reported immediately. In addition to these reportable diseases, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could be caused by a transmissible infectious agent or microbial toxin) or cluster or outbreak of non-reportable diseases (head lice, impetigo, pneumonia, scabies) are also reportable.

The Oneida County Health Department represents the lead agency in disease control efforts for the prevention of community and personal dysfunction, physical disability and death due to communicable diseases. OCHD's major responsibilities involve appropriate surveillance, intervention, education, prevention and outreach services.

Communicable diseases remain major causes of illness, disability, and death. Moreover, new agents and diseases are being detected, and some diseases considered under control have

HEALTH PROFILE

reemerged in recent years. In addition, antimicrobial resistance is evolving rapidly in a variety of hospital- and community-acquired infections. These trends suggest that many challenges still exist in the prevention and control of infectious diseases.

Increases in international travel, importation of foods, inappropriate use of antibiotics on humans and animals, and environmental changes multiply the potential for epidemics of all types of infectious diseases.

Some of these diseases and pathogens were unknown 20 years ago. Others are reemergent problems once thought under control. At-risk populations include persons with impaired host defenses; pregnant women and newborns; travelers, immigrants, and refugees; and older adults.

Excluding the number of active communicable disease cases followed by the clinic (sexually transmitted diseases and tuberculosis), five diseases (*Giardia*; *Salmonella* and *Campylobacteriosis*; Chronic Hepatitis B, Chronic Hepatitis C) consistently account for approximately 73% of the remaining cases in Oneida County.

Giardia: *Giardia* infection has become recognized as one of the most common causes of waterborne disease (found both in drinking and recreational water) in humans in the United States. *Giardia* are found worldwide and within every region of the United States. Anyone can get Giardiasis; however, persons more likely to become infected include international travelers, individuals who drink contaminated water.

Since 1992, the number of state reporting cases of Giardiasis to CDC has risen to CDC from 23 to 43. The annual number of Giardiasis cases reported has ranged from 12,793 in 1992 to 27,778 in 1996. In 1997, cases per 100,000 state population ranged from 0.9 to 42.3, with 10 states reporting >20.0 cases per 100,000 and a national average of 9.5 per 100,000 population. In 2003, provisional data indicate that there were 18,059 cases for a case rate of 6.9 per 100,000 population. This would represent a 14.8% decrease in morbidity than what was observed in 2002. Cases have an approximately equal sex distribution. Nationally, rates were the highest among children 0-5 years, followed closely by persons aged 31-40 years. In these two age groups, most cases were reported during the late summer and early fall—an indication that transmission occurred during the summer.

In 1997, New York State, including New York City, reported the highest number of *Giardia* cases in the United States (3,673 or 20.3 cases per 100,000 population), accounting for 14.5% of the cases nationally. Morbidity decreased by 7 % when comparing data from 2003 (1,284) to 2001 (1,383). The case rate per 100,000 decreased from 12.6 to 11.6. In 2003, 53.3% of the cases were male; 21.9% of the cases were less than 5 years of age and 10.4% were 60 years of age or older. Regionally, between 2001-2003, there was a 1.5% decrease in the number of *Giardia* cases (201 to 198); however, because of a larger decrease in the population, the case rate/100,000 population increased from 16.7 to 17.6.

In Oneida County, there was an 83% increase in morbidity when comparing data from 2001 (34) to 2003 (62). The case rate per 100,000 population increased from 14.5 to 26.5. In 2003, approximately 53% were male; 17.7% were less than 5 years of age and 14.5% were older than 60 years of age. Based on information on the case reports and the referring agencies, it appears that part of the increase is due to refugees arriving in Oneida County from countries where Giardiasis may be endemic.

Campylobacteriosis and Salmonella: *Campylobacteriosis* and *salmonella* are the most frequently reported foodborne illnesses in the United States. Both are included in the Healthy People 200 food safety objectives targeted to reducing foodborne illness.

More than 30 million people in the US are likely to be partially susceptible to foodborne disease. Very young, elderly and immunocompromised persons experience the most serious foodborne

HEALTH PROFILE

illnesses. They may become ill from smaller doses of organisms and may be more likely than other persons to die of foodborne diseases. For example, children under age 1 have the highest rate of *Campylobacter* species infections. Other high-risk populations include residents in nursing homes or chronic care facilities; hospitalized, cancer, and organ transplant patients; and individuals with AIDS, with cirrhosis, on anti-microbial treatment, or with reduced stomach acid such as due to antacid medications.



Campylobacteriosis -Nationally, in 2003 (previous annual data was not available), it was estimated that there were approximately 56,400 cases nationally for a case rate of 20 per 100,000 population. Further demographic data was not available.

In New York State, there was a 16% increase in morbidity between 2001 (1238) and 2003 (1,436). The case rate increased from 11.3 to 13.0. In 2003, approximately 53% of the cases were male; 11.8% were less than 5 years of age and 16.6% were 60 years of age or older. Regionally, there was 20.9% increase when comparing morbidity data from 2003 (185) with 2001 (153).

For Oneida County, the case rate per 100,000 population increased from 13.6 to 16.5. There was a 9.5% decrease in morbidity from 2001 (21) to 2003 (19). The case rate per 100,000 population decreased from 8.9 to 8.1. In 2003, approximately 58% of the cases were male; 15.8% were less than 5 years of age and 10.5% were 60 years of age or older.

Salmonella – Nationally, there was less than a 1 percent decrease in the number of cases reported in 2003 (provisional) when compared to 2001 (40,495 to 40,369). The case rate per 100,000 decreased from 15.5 to 15.4.

Statewide, excluding New York City, there was an 8.2% decrease in morbidity from with 2001 (1,397) to 2003 (1,282) The case rate per 100,000 population decreased from 12.7 to 11.6. In 2003, approximately 47% of the cases were male; 21.1% were less than 5 years of age and 14.7 % were 60 years of age or older. Regionally, there was a 12% increase when comparing morbidity data from 2003 (121) with 2001 (108). The case rate per 100,000 population increased from 9.6 to 10.7.

In Oneida County, there was a 12% decrease in morbidity from 2001 (25) to 2003 (22). The case rate per 100,000 population decreased from 10.6 to 9.4. In 2003, approximately 55% of the cases were male; 13.61% were less than 5 years of age and 18.2 % were 60 years of age or older.

Chronic B and C Hepatitis: Within the last three years, there have been national and state efforts to identify, diagnose, and report individuals with chronic Hepatitis B and/or Hepatitis C, to state and local health departments.

Hepatitis B virus (HBV) infection can be reduced greatly as vaccinated infants and adolescents enter young adulthood, a period when the risk of HBV infection increases.

Each year, 16,000 to 18,000 children in the United States are born to mothers infected with HBV. Without prevention programs, about 8,000 of these infants would become infected with HBV. Ninety-five percent of the infections, however, are preventable through appropriate maternal screening and infant care.

Screening pregnant women during an early prenatal visit is essential to identify those who are infected. Women at high risk should be retested late in pregnancy. In 1997, 14 states had laws or regulations to ensure such screening. To be maximally effective, steps to prevent transmission of HBV to infants born to mothers who are infected must begin as soon as the child is born. Such infants should receive a first dose of Hepatitis B vaccine within 12 hours of birth, along with hepatitis

HEALTH PROFILE

B immune globulin (HBIG), and two more doses of vaccine by age 6 months. Children need to be tested between the ages of 12 and 15 months to ensure that they are not infected and have developed immunity to the virus.

To reduce HBV transmission in the United States by 2010, vaccination programs must be targeted to adolescents and adults in high-risk groups. The primary means of achieving high levels of vaccination coverage in-groups with behavioral risk factors for HBV infection is to identify settings where these individuals can be vaccinated. Such sites include clinics that treat sexually transmitted disease (STDS), correctional facilities (juvenile detention facilities, prisons, jails), drug treatment clinics, and community-based HIV prevention sites. An estimated 1.25 million persons in the United States have chronic HBV infection. Routine infant vaccination eventually will produce a highly immune population sufficient to eliminate HBV transmission in the United States. However, high rates of acute hepatitis B continue to occur, with an estimated 65,000 cases in 1996. Most cases occur in young adult risk groups, including persons with a history of multiple sex partners, men who have sex with men, injection drug users, incarcerated persons, and household and sex contacts of persons with HBV infection. Investigation of reported cases of acute Hepatitis B indicates that as many as 70 percent of these individuals previously had been seen in settings, such as drug treatment clinics, correctional facilities, or clinics for the treatment of STD, where they could have received vaccine.

Hepatitis B vaccination has been recommended for persons with risk factors for Hepatitis B Virus infection since the vaccine was first licensed in 1981. These risk groups include the following: hemodialysis patients, men who have sex with men, incarcerated persons, health care and public safety workers who have exposure to blood in the workplace, persons with a history of sexually transmitted disease or multiple partners, injection drug users, and household and sex contacts of HBV-infected persons.

Hepatitis C Virus (HCV) is the most common chronic bloodborne viral infection in the United States. This virus usually is transmitted through large or repeated percutaneous exposures to blood-for example, through sharing equipment between injection drug users. HCV infects persons of all ages, but most new cases are among young adults aged 20 to 39 years. The highest proportion of new cases is among Whites, but the highest rates of new cases are among non-White racial and ethnic groups.

Nationally, there are no reliable national reporting data regarding individuals with chronic hepatitis. However, the Centers for Disease Control and Prevention (CDC) estimated that there are approximately 1.25 million people with chronic hepatitis B infection and 2.7 million people with chronic Hepatitis C infection. In addition, many people do not know they have either of the two conditions and don't seek medical screening or diagnosis. Thus, the number of acute infections reported is much less than what is occurring. Despite declines in the number of new infections, the reservoir of chronically infected persons are at risk for the severe consequences of chronic liver disease.

The reporting of cases became mandatory in 2002 and initiatives were taken to secure case reports in 2001 for those whose repeat blood tests yielded chronic hepatitis again in 2002. Thus, surveillance and reporting activities intensified in late 2002 in Oneida County and are part of routine communicable disease activities in 2003. Many of these individuals are reported from correctional facilities, drug treatment facilities and/or have a history of drug use.

Chronic Hepatitis B- There was a 20.4% increase in morbidity data from 2001 (49) to 2003 (59). The case rate per 100,000 population increased from 20.8 to 25.2. In 2003, approximately 68 % of the cases were male; 6.7 % were less than 5 years of age and 8.3 % were 60 years of age or older.

HEALTH PROFILE

Chronic Hepatitis C- There was a 12% decrease in morbidity between 2001 (123) and 2003 (110). The case rate per 100,000 population decreased from 52.3 to 46.9. In 2003, approximately 87% of the cases were male; none were less than 5 years of age and 6.4 % were 60 years of age or older.

Services for communicable diseases are provided by a wide variety of health care providers in the county (urgent care centers, hospitals, emergency rooms, and private physicians in group or individual private practice. Staff from the Department assist the diagnosing medical care provider arrange for the interview of the individual with a confirmed or suspected diagnosis, follow-up of those exposed to the communicable disease; provided education and consultation.

Several units/divisions within the Oneida County Health Department: the Diagnostic and Treatment Clinic in Utica provides services at its facility in Utica for Tuberculosis, Sexually Transmitted Diseases, Vaccine-preventable diseases, and other communicable diseases which are diagnosed or suspected in clinic patients; the Communicable Disease Program conducts services as listed above for the communicable diseases diagnosed or suspected in non-clinic patients. The Communicable Disease Program works with Environmental Health Staff in food or water-borne outbreaks, and vector-borne illnesses such as, West Nile Virus. Environmental Health Division staff work with other OCHD staff in rabies investigations and treatment. The New York State Department of Health Regional Epidemiology staff responsibilities include investigating nosocomial outbreaks in county nursing homes and hospitals, as well as follow-up of individuals within the state correctional facilities in Oneida County.

The Communicable Disease Program investigates individuals with diagnosed or suspected communicable diseases through laboratory reports, case and suspect reports, individual interviews or through daily emergency room surveillance. Data regarding these individuals are entered into the NYSDOH Health Information Network for each of the reportable communicable diseases. In some instances, letters are sent to the physician of record to secure information (e.g., Hepatitis B, Hepatitis C, Lyme Disease) to determine if the laboratory tests and/or symptoms are consistent with acute or chronic disease or to rule out disease altogether. The Communicable Disease Nurse calls physicians to get missing medical, symptomatology, demographic and/or treatment information. Patient information is acquired to determine other individuals who may have been exposed; to provide education about the disease; and make recommendations to prevent the spread of disease. Data regarding each case is either updated or entered into the HIN.

The Epidemiology staff is responsible for the collection and analysis of communicable disease data; coordinating the Oneida County Health Department response for communicable disease outbreaks; and developing (and/or providing input) protocols and procedures for the communicable disease and epidemiological sections of the Community Health Emergency Response and Preparedness Plan.

In the last three years, the OCHD has stepped up its efforts to strengthen its epidemiological capabilities. Collaboration with state and local agencies, stable funding, technological applications, and professional competent work staff have contributed to improvements in our local epidemiological capacity.

Continued improvements in our county's epidemiological capabilities will be necessary to 1) reduce a lack of reporting or underreporting of disease cases, 2) enhance participation of physicians in reporting and data collection, 3) provide community education regarding treatment and knowing when to seek prompt medical care and 4) improve the consistency and validity of data collected by the state and the county.

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

TABLE 14 - COMMUNICABLE DISEASE MORBIDITY

Disease	2001				2002				2003			
	Co	Reg	NYS ***	US	Co	Reg	NYS ***	US	Co	Reg	NYS ***	US ****
Campylobactr	21	153	1,238	*	17	163	1,457	*	19	185	1,436	56,400
Giardia	34	201	1,383	*	48	174	1,347	21,206	62	198	1,284	18,059
Hepatitis B **	49	*	*	*	42	*	-	*	59	*	*	*
Hepatitis C **	123	*	*	*	130	*	-	*	110	*	*	*
Salmonella	25	108	1,397	40,495	10	144	1,613	44,264	22	121	1,282	40,369

* = Data not available ** Chronic cases only ***= Exclusive of New York City **** Provisional data

TABLE 15 - COMMUNICABLE DISEASES BY CASE RATE/100,000 POPULATION

Disease	2001				2002				2003			
	Co	Reg	NYS ***	US	Co	Reg	NYS ***	US	Co	Reg	NYS ***	US ****
Campylobactr	8.9	13.6	11.3	*	7.2	14.5	13.3	*	8.1	16.5	13.0	20.0
Giardia	14.5	16.7	12.6	*	20.4	15.5	12.3	8.1	26.5	17.6	11.6	6.9
Hepatitis B **	20.8	*	*	*	17.9	*	*	*	25.2	*	*	*
Hepatitis C **	52.3	*	*	*	55.4	*	*	*	46.9	*	*	*
Salmonella	10.6	9.6	12.7	15.5	8.1	12.9	14.7	15.7	9.4	10.7	11.6	15.4

* = Data not available ** Chronic cases only ***= Exclusive of New York City **** Provisional data

COMMUNICABLE DISEASES GOALS AND OBJECTIVES

- Reduce the case rate/per 100,000 population of the most prevalent communicable diseases in Oneida County:

	2003 Base	2010 Target	HP2010 Target
▪ Campylobacteriosis	8.1	7.0	12.3
▪ Giardiasis	26.5	20.0	*
▪ Hepatitis B (Chronic)	25.2	19.5	*
▪ Hepatitis C (Chronic)	46.9	40.0	*
▪ Salmonella	10.7	6.8	6.8

- Increase the percent of case investigations initiated within:

▪ Three hours of a telephoned priority communicable disease	93	97
▪ One working day for written reportable communicable diseases	90	95

* None of these goals were included in either the Healthy People 2000 or 2010 goals

4. INFECTIOUS DISEASE

Sexually Transmitted Diseases: During the past three decades, STDs are among the few areas of infectious diseases that have changed the epidemiology and our understanding of clinical manifestations. Although the bacterial STDs declined in the 1990s in the United States and Western Europe, they remain epidemic in much of the world and in many parts of this country. The United States has many times higher rates of the classic bacterial STDs than any other industrialized country, demonstrating the influence of demographic, social, and behavioral factors on infectious diseases despite availability of effective diagnosis and treatment. Sexually transmitted diseases embody all the elements of "emerging" infections, including recognition of new or apparently new pathogens, syndromes and complications, emergence of antimicrobial resistance in formerly

HEALTH PROFILE

susceptible pathogens, the increasing importance of viral infections, and rapid international spread fostered by the increase in international travel and commerce.

STDs are hidden epidemics because many Americans are reluctant to address sexual health issues in an open way due to the biologic and social characters of these diseases.

Syphilis - The rate of *Primary and Secondary Syphilis* reported in the U.S. decreased during the 1990s and 2000 was the lowest since reporting began in 1941. However, the rate of primary and secondary syphilis has increased each year since 2001. Overall, the increases have occurred only among men. Recent increases in syphilis among men who have sex with men (MSM) highlights the importance of continually reassessing and refining surveillance, prevention and control strategies. In 2002, there were 3 cases of syphilis (primary and secondary) reported to the Oneida County Health Department. Since 1997, syphilis rates have remained relatively low. However, in 1998 the number of cases rose to 14, decreasing to 7 in 1999, and finally returning to 3 in 2000. The rates tend to be cyclical in nature, reflecting the prevalence of individual behaviors, including drug use and unsafe sex practices.

Women account for an increasing proportion of Syphilis cases. In 1997, women ages 26-66 account for 4 of the 5 cases. Fifty percent of these women were African American. Congenital syphilis was found in Oneida County with 1 case in 1997, and 1 case in 1998. No cases were found again until 2004, with one case thus far.

Gonorrhea - For Gonorrhea, the national rate in 2003 of 116.2 cases per 100,000 population is the lowest rate reported ever. Additionally, in 2003, 29.9% of GC cases were reported by STD clinics, a change from 1984 when 73.6% of GC cases were reported by STD clinics. The total number of Gonorrhea cases in Oneida County has increased steadily between 1999 and 2003. In 2003 there were 245 cases of gonorrhea reported to OCHD, up 28% from the 177 cases in 1999. In 2003, women accounted for nearly 25% of all cases (245), and women between the ages of 15-49 were particularly affected. Close to half of these cases (44%) were among African American women.

It is also interesting to look at the case distribution within ethnic groups. Among Whites, over two-thirds of all reported cases were to women 15-49 and nearly 8% of Hispanic cases were among women in this age group. However, among African Americans, 31% of reported gonorrhea cases were among women 15-44. This points to the growing numbers of African American men who are infected with this disease (90). In 2003, one out of every five case of reported gonorrhea is among African-American men between 20-29 years of age.

Although the rate of new cases of gonorrhea among persons 15 – 19 years of age has decreased significantly (by approximately 52%) between 2000 and 2002, Oneida County exhibits the second highest case rate for persons 15-19 years of age (446.5), in the Central New York Region.

According to the Central New York Regional Health Assessment report, Oneida County, along with Onondaga and Herkimer Counties, exceed the Healthy People 2010 target rate of 19 per 100,000 for new cases of gonorrhea. Oneida County, itself, exceeds this target rate five-fold (98.9 per 100,000).

Chlamydia - *Chlamydia trachomatis* are the most commonly reported notifiable disease in the United States followed by *Neisseria gonorrhoea*. This disease became reportable in New York State, in mid-2000. In 2003, a majority of cases (60%) continue to be reported among Whites, with 80% of those being female.

Chlamydia is a disease identified primarily in women, though this may be misleading as men are not often routinely screened. Nearly 50% of all cases in Oneida County in 2003 (460) were to women ages 15-44. White women in this age group comprise over three-quarters of all cases, and 55% of

ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT

HEALTH PROFILE

all African-American cases. Over one-third of all reported cases were among persons 15-19 years of age (178).

Overall, STD trends statewide and regionally follow the same trends as those seen nationally. The STD data for Oneida County must be interpreted with caution, considering the patterns of transmission and reporting. Further, nearly 10% of the Chlamydia cases and less than 1% of GC cases reported to the Oneida County Health Department could be coded by ethnicity.



Overall, STD rates have declined substantially in Oneida County since the early 1990s. Many people attribute the high rates of sexually transmitted disease in the early 1990s to the high prevalence of crack and cocaine use during this time. Additionally, changes in the healthcare marketplace and the proliferation of managed care within the past five years may also have lowered the number of screening tests completed and the subsequent identification of cases. Thus, the lower numbers of STDs in 1999 may actually be a misrepresentation of the true incidence of disease. Unfortunately, data since 1998 indicate that the rates of gonorrhea and Chlamydia are increasing in Oneida County, and preliminary reports from 2004 also identify a rise in the number of syphilis reports.

There were 165 total reported cases of primary and secondary syphilis and gonorrhea in Oneida County in 1997. Chlamydia did not become reportable until mid 2000.

HIV/AIDS - In 1999 new HIV/AIDS case rate among adolescents and adults aged 13 years and older rate was 18.6 per 100,000 population. The 8 county region, with the exception of Herkimer and Madison counties, exceed the HP 2010 target goal of 1.0 per 100,000 new HIV/AIDS infections. In Oneida newborn HIV prevalence is significant in showing a proportion of women of reproductive age who are infected with HIV/AIDS.

Through 1999, 891 cases of AIDS had been reported to the Oneida County Department of Public Health. This is a case rate of 355.2 per 100,000. While nearly 29% of these cases were diagnosed between 1996 and 1999, the number of cases has been declining in Oneida County since 1996. This decline does not represent a decrease in the epidemic, rather it is primarily due to new medications and increased and earlier access to care, resulting in fewer persons with HIV infection progressing to a clinical AIDS diagnosis. Thus, AIDS surveillance data alone are becoming less useful in describing the present nature and future trajectory of the HIV epidemic. The Oneida County Department of Public Health is moving toward integrating HIV case surveillance with AIDS case surveillance. This new method of tracking the disease commenced July 1, 1999. NYS AIDS Epidemiology 2001-2002 data reveals reported new HIV/AIDS cases among adolescents and adults aged 13 years and older at a rate of 10.1 per 100,000 population.

The face of Oneida County's AIDS epidemic has changed significantly over the past five years. African Americans comprise an increasing proportion of the cases, while the proportion of White cases has decreased significantly.

By mode of transmission, the distribution over time has shown a decreasing proportion of cases among men who have sex with men. In 1997, only 42% of cases were in this category (down from 71% in 1988). Injection drug use associated transmission, on the other hand, accounted for 44% of all 1997 diagnosed cases.

In Oneida County, several positive efforts are in place to address STD's. Clinicians that perform lab testing to diagnose STD's in Oneida County are identified through the mandated healthcare provider and laboratory reporting of STD's to OCHD. This initiates a CD report, ensures appropriate

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

treatment and assists the confidential partner notification systems, all of which assist epidemiologic analysis and improve disease control methodologies. NYSDOH mandates availability of free, walk-in STD diagnosis and treatment clinics in the county. STD testing sites provide education and counseling on behavioral based prevention measures. Fortunately, the number of local drug resistant STDs remains low in Oneida County. Several gaps remain however, that reduce our ability to respond to STD issues. Local cases of gonorrhea and chlamydia exhibit a continued increase as the county population declines. At present, this phenomenon cannot be explained. Further analysis is warranted. Decreased funding limits the availability of rapid HIV testing, free condoms, dosing of "at once" medications that avoid compliance concerns, and trained STD educators to target high risk populations. Finally, many patients with STD or at risk for STDs do not regularly attend physician offices or other traditional clinic facilities. For those patients without healthcare providers, evening and weekend treatment is limited to emergency or urgent care centers

The Oneida County Health Department's STD Program ensures provision for evaluation, diagnosis and treatment of STDs to the public during walk-in, no charge clinics held in both Utica and Rome. Patients may also be seen for treatment of infection due to referral from other facilities. Along with treatment of the individual, with assistance from the NYSDOH, efforts are made to identify, locate and ensure treatment of sexual contacts. Behavioral counseling occurs to promote healthy behaviors and to prevent future disease transmission. Planned Parenthood, Utica and Rome offices by appointment. Walk-ins accepted during Teen Night clinic in Utica. STD screening provided by appointment with primary care provider (PCP) or specialists such as OB/GYN.

TABLE 16 - COMMUNICABLE DISEASE RATE PER 100,000 POPULATION

DISEASE	2001				2002				2003			
	CO	NYS **	REG	US	CO	NYS **	REG	US	CO	NYS **	REG	US
Syphilis (P & S)	0	0.4	0.4	2.1	1.3	0.6	0.3 (00-02)	2.4	1.9	1.0	*	2.5
Gonorrhea	126.8	88.3		128.5	101.7	83.1	122.4	125.0	104.3	76.6	*	116.2
Chlamydia	175.3	153.3		278.3	156.2	165.1		296.6	195.7	197.4	*	301.3
HIV				*			10.9	*		*	*	*
TB	3.0	3.8	2.5	5.6	4.2	3.2	2.8	5.2	2.1	3.1	2.3	5.1

* = Data not available **= Exclusive of New York City **STDs in bold**

Tuberculosis: *Mycobacterium tuberculosis* and less commonly, *M bovis* and *M africanum* are the infectious agents that cause the airborne disease tuberculosis. Eight million new Tuberculosis (TB) cases occur each year in the world and 3 million people die of the disease. The United States experienced a resurgence of TB disease between 1985 and 1992. In 2003, 5.1 cases of TB per 100,000 population were seen on a national level. With infrastructure improvements and the advent of directly observed treatment (DOT), supervision of TB medication administration, as the standard of care, morbidity in the U.S. has decreased. Despite an overall reduction in cases of TB disease, among those diagnosed, an increase in foreign-born cases has continued for the past five years. The continued morbidity and mortality experienced in other parts of the world, combined with international commerce, travel and the U.S. history of welcoming immigrants and refugees account for the disease spread among these populations. Cases of multi-drug resistant disease challenge TB controllers and healthcare providers. Ensuring prompt diagnosis, patient isolation when indicated, identification and evaluation of close contacts and treatment completion remain critical factors in the control of tuberculosis.

HEALTH PROFILE

Historically, TB case rates in NYS (exclusive of NYC) have been lower than the national average, while TB case rates in NYC have exceeded national rates. The difference was most evident at the peak of the recent epidemic in 1991 and 1992 when NYC's TB incident case rates exceeded 50 per 100,000 compared to the national rate of approximately 10.5 per 100,000. For NYS as a whole, the 2003 TB case rate was 7.8 per 100,000 population (NYC, 14.2; NYS exclusively of NYC, 3.1).

In NYS, three counties- Nassau, Westchester, and Suffolk- accounted for over half of the TB cases reported in 2003. Thirty-two counties either had no cases or only one reported case of TB in 2003. Pulmonary TB was the primary site of disease in 73.4 percent of cases reported in NYS in 2003. Lymphatic TB disease was the next most frequently observed site, 10.9 percent of the total.

In 1999, 5 cases of tuberculosis were reported to the Oneida County Health Department. This number represents a decrease in reported cases since 1994, largely due to the initiation of a Directly Observed Therapy (DOT) Program in the early 90's. In 2004, year to date, 6 cases have been reported.

By gender, 5 of the 5 reported TB cases in the county in 1999 occurred in males, however only 2 (40%) of the 5 cases reported in 2003 were male. It is interesting to note that among reported TB cases in 1999, 40% were foreign born, whereas 80% of the cases reported in 2003 were foreign-born. By ethnicity, cases in 1999, 60% of cases were among Whites, and 40% were among blacks. In 2003, 40% was among Whites, 40% were among Asians, and only 20% were blacks.

Coincident HIV/TB - Since 1999, no dual cases of HIV and TB have been reported in Oneida County. Possible reasons for the apparent decline in HIV-related TB include the effectiveness of Directly Observed Therapy and advances in HIV therapies.

Oneida County Health Department's TB Clinic provides TB control services, which include treatment of TB infection and disease, consultation services and community and provider education upon request. DOT is the standard of care for TB cases in Oneida County and ensures completion of treatment for active TB disease. Recent State funding cuts in the area of TB has shifted the financial burden for this program to an already financially struggling county.

Local physicians and practitioners are aware of their responsibility, according to the NYSDOH guidelines, to report suspect and active TB cases to the county health department. They are also aware of the DOT services and contact investigation, which will be initiated by the Health Department. Ongoing communication between hospital Infection Control Nurses (ICNs) and the OCHD is key to providing continuity of TB treatment and also in avoiding TB exposure when TB clients require hospitalization or outpatient procedures.

Vaccine Preventable Diseases: Many once-common vaccine-preventable diseases now are controlled. Smallpox has been eradicated, poliomyelitis has been eliminated from the Western Hemisphere, and measles cases in the United States are at a record low. Immunizations against influenza and pneumococcal disease can prevent serious illness and death. Pneumonia and influenza deaths together constitute the sixth leading cause of death in the United States. Influenza causes an average of 110,000 hospitalizations and 20,000 deaths annually; pneumococcal disease causes 10,000 to 14,000 deaths annually.

Vaccines are among the greatest public health achievements of the 20th century. Immunizations can prevent disability and death from infectious diseases for individuals and can help control the spread of infections within communities. In 1998, 73 percent of children received all vaccines recommended for universal administration. In 1998, influenza immunization rates were 64 percent in adults aged 65 years and older—almost double the 1989 immunization rate of 33 percent. In 1998, only 46 percent of persons aged 65 years and older ever had received a pneumococcal vaccine.

HEALTH PROFILE

National coverage levels in children now are greater than 90 percent for each immunization recommended during the first 2 years of life, except for hepatitis B and varicella vaccines. The hepatitis B immunization rate in children was 87 percent in 1998—the highest level ever reported. In 1998, 70 percent of children aged 19 to 35 months from the lowest income households received the combined series of recommended immunizations, compared with 77 percent of children from higher income households.

Coverage levels for immunizations in adults are not as high as those achieved in children, yet the health effects may be just as great. Barriers to adult immunization include not knowing immunizations are needed, misconceptions about vaccines, and lack of recommendations from health care providers. Both influenza and pneumococcal immunization rates are significantly lower for African American and Hispanic adults than for White adults.

Between 1999-2004, the Oneida County Immunization Program has continued to improve the 2010 national goal of 90% coverage at 24 months of age. Concentrated efforts are ongoing with the private sector to raise their immunization rates to comply with the national goal. Efforts include in-services, PBII Provider Based Immunization Initiative through the Clinical Assessment Software Application (CASA), facilitating CDC immunization up-dates and public immunization clinics.

Cases of reported vaccine preventable disease (such as Measles, Mumps, Rubella, Pertussis, etc.) offer information about immunization coverage in the county. However, these data must be interpreted with caution given that provider recognition and identification of the diseases vary, as does reporting behavior. In 2003 there were 5 reported cases of Pertussis in Oneida County. There were no reported cases of measles or rubella.

OCHD holds walk-in immunization clinics throughout the county a minimum of four times per week. Services are available to Oneida County residents and non-county residents of all ages.

Travel immunization clinics began in November 1994 and are held, by appointment, at least once weekly at the Utica Clinic site. Available vaccines include Cholera, Typhoid, Tetanus, Diphtheria, Gamma Globulin, Yellow Fever, Meningococcal, Preexposure rabies, Hepatitis A and B.

The Federal government in conjunction with New York State continue the “Vaccine for Children Program” (VFC) by supplying vaccines to both public and private providers. The goal is to have children fully immunized according to recommended schedule by 2 years of age.

OCHD has participated in the NYS Immunization Registry program since 1996. This electronic registry supports tracking, recall and record sharing for all agency participants. Parents must consent to enrollment. As more agencies and medical practices enroll in the registry program, it may be expanded from a pediatric database to encompass all age groups. In addition to the health department, there are nine clinical practice sites, five school districts, one college and one youth agency enrolled.

OCHD along with representatives from local colleges, schools, private providers, clinics and county jails, belongs to the Regional Adult Immunization Coalition. This consortium of agencies collaborates to promote the immunization of adults through quarterly meetings to develop and implement both health care provider and patient education, health fairs and other creative initiatives.

TABLE 17 - IMMUNIZATION COVERAGE AT 24 MONTHS OF AGE PER NYSDOH AUDIT:

Year	1999	2000	2001	2002	2003	2004
NYS (total)	76%	75%	75%	75%	79%	Not available
Oneida County	77%	89%	92%	95%	93%	98%

Coverage levels for immunizations in adults are not as high as those achieved in children, yet the health effects may be just as great. Barriers to adult



**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

immunization include not knowing immunizations are needed, misconceptions about vaccines, and lack of recommendations from health care providers.

Despite the advent of Medicaid Managed care plans and some others with private insurance, private providers continue to turn some patients away due to low or no reimbursement for vaccines, missing opportunities and sending them to the local health department for vaccination.

INFECTIOUS DISEASES GOALS AND OBJECTIVES:

STDs:

Prevent sexually transmitted diseases and their associated physical and social complications.

	2003 Baseline	2010 Target
GC: Decrease morbidity to a rate of 50.0 by 2010.	104.3	19.0
CT: Decrease morbidity to a rate of 150.0 by 2010.	195.7	none listed
Syphilis: Decrease morbidity to a rate of 0.5 by 2010.	1.9	2.0

HIV: Prevent human immunodeficiency virus (HIV) infection and its related illness and death.

	2003 Baseline	2010 Target
	none listed	1.0

National data for 1999 states new cases among adolescents and adults aged 13 years and older rate per 100,000 population at 18.6. Decrease new HIV/AIDS cases among adolescents and adults aged 13 years and older to less than 7.1 per 100,000 population.

TB: Decrease TB morbidity to a rate of 1.0 per 100,000 population

	2003 Baseline	2010 Target
	2.1	

Immunizations:

- ▣ Maintain immunization efforts throughout the county.
- ▣ Promote awareness through education and publicity of the necessity of early and complete immunization and appropriate adult immunization.
- ▣ Assure easy access to immunization, especially in areas of the county where poverty is high (therefore, access to care is usually limited).
- ▣ Target children ages 0-2 for early, timely vaccination in accordance with the American Academy of Pediatrics.
- ▣ Work collaboratively with local providers, enhance partnerships to strive to maintain at least 98% coverage for the primary immunization series.

5. SELECTED CHRONIC DISEASE INDICATORS

Heart Disease: Heart disease is the leading cause of death for all people in the United States. Coronary heart disease accounts for the largest proportion of heart disease. The death rate peaked in the mid-1960s and has declined in the general population over the past 35 years. High blood cholesterol is a major risk factor for coronary heart disease that can be modified. More than 90 million adults have cholesterol levels that are higher than desirable. Life style changes that prevent or lower high blood cholesterol include eating a diet low in saturated fat and cholesterol, increasing physical activity, and reducing excess weight.

In 1996 the crude mortality rate for cardiovascular disease in Oneida County was 343.9 per 100,000. By 2002, this rate decreased (Figure 8). Cardiovascular disease, particularly coronary artery disease, is a significant cause of morbidity and mortality among New York State residents and

ONEIDA COUNTY HEALTH DEPARTMENT 2005-2010 COMMUNITY HEALTH ASSESSMENT

HEALTH PROFILE

in Oneida County as referenced by the NYS Community Health Data Set for the years 2000-2002. Cardiovascular disease is responsible for 333.3 cases per 100,000 people in the County compared to 341.0 per 100,000 in the state. The goal of HP2010 is 166 per 100,000.

Mortality rates for heart disease is somewhat lower at 217.1 per 100,000, yet Oneida County's rates remain high due to the number of elderly who live here. Additionally White females have a higher death rate from cardiovascular disease than black females, and black males have a higher death rate than White males.

Oneida County 's 2000 statistics reflect the National and New York State trends with heart disease being the number one cause of death. In Oneida County, as well as nationally the rates have demonstrated a decline since 1993.

Cerebrovascular Disease/Stroke: Stroke is the third leading cause of death for all people in the United States. In 1996, 181 deaths occurred due to cerebrovascular accidents and female deaths were 2 times higher than males. About 600,000 strokes occur each year in the United States, resulting in about 158,000 deaths. Like coronary heart disease, stroke death rates have declined over the past 30 years. This rate of decline, however, has slowed in recent years. The overall decline has occurred mainly because of improvements in the detection and treatment of high blood pressure. 1998-2000 Vital Statistics Data indicate that cerebrovascular disease is still the most prevalent of all cardiovascular diseases in the United States.

The prevalence among men and women in New York State is consistent with national data. In 200, death rates per 100,000 Oneida County residents was 76.0. Antihypertensive medications as well as dietary changes and increased physical activity can significantly reduce the risks associated with high blood pressure.

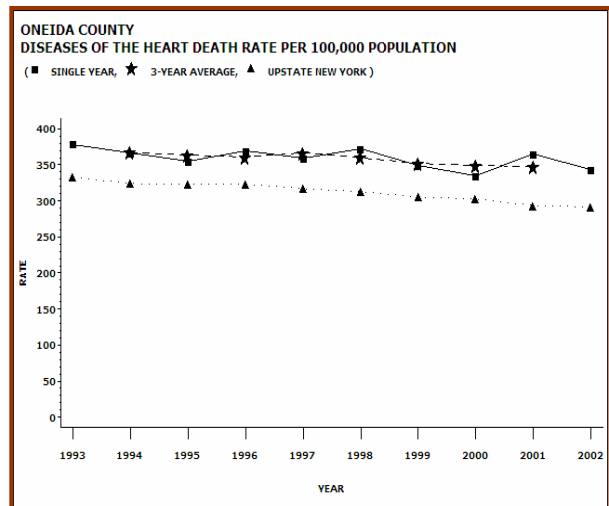
Diabetes: Diabetes is a heterogeneous group of metabolic disorders characterized by high blood glucose levels caused by a deficiency in insulin production. Most cases of diabetes fall into one of two clinical types: Insulin Dependent Diabetes Mellitus (Type 1) and Non-Insulin Dependent Diabetes Mellitus (Type 2). In general 5%-10% of diabetics have Type 1 insulin dependent diabetes and the remaining have Type 2 non-insulin dependent diabetes. In both types of diabetes, patients are treated with a regimen of diet, physical activity, medication, and blood glucose monitoring.

Nationally, the incidence of diabetes is consistently higher for females than males and for minorities than for Whites. This disorder is one of the most prevalent chronic conditions among Americans. Approximately 7 million people in the United States have been diagnosed with diabetes and each year 650,000 new cases are identified.

Approximately one in twelve New Yorkers have diabetes, about half of who are undiagnosed. State data for 2003 indicated 790,587 diabetics in New York. According to the 2003 NYS BRFSS data, 6.6% and 7.2% respectively were physician undiagnosed. The HP2010 target goal is 2.5% overall for the nation.

There were and estimated 8,835 residents of Oneida County diagnosed with diabetes between 1997-1999. Oneida County's rates of hospitalization for diabetes were also above the norm with 602.2 hospitalizations in the county compared to 420.5 hospitalizations due to diabetes in the state.

Figure 8- NYSDOH Diseases of the Heart Death Rate per 100,000 Population, 2000-2002



HEALTH PROFILE

Evidence indicates that controlling blood glucose prevents or delays the onset of complications and in turn reduces the financial burden of the disease. In New York State, in 1999, there were over 330,000 diabetes related hospital discharges, of which the average length of stay was 8.1 days with an average charge of \$16,669.99 per stay.

Respiratory Disease: Asthma is a serious chronic condition that effects 10 million Americans. For those under 18 years of age, asthma is the most frequent cause of activity limitation. Nearly 20% of all people with asthma suffer some limitations due to the disease. Asthma is much more common among children than adults. There is no difference in asthma prevalence by gender. As of August 2002, there were 525.9 cases of pediatric asthma per 100,000 hospitalized and discharged due to asthma in the 0-4 year old age group in Oneida County. Although this figure is below the state rate of 715.6 per 100,000, it does indicate a potential for concern. The overall rate for the number of people 18 years old and under is 17.8 per 10,000 which places Oneida County second among other counties in New York State. Although there was no data for hospitalization for neither the 0-17 group nor the 5-64 group, there was a discharge rate for the over 65 population of 278.5 per 100,000. A rate which was higher than the state rate of 256.2 per 100,000.

Currently there are 8.1 adults in Oneida County per 100,000 who have been diagnosed with having asthma. This figure is again higher than the state rate per 100,000. Death rates remain relatively low at 1.9 per 100,000 as reported in August 2002 Vital Statistics.

Chronic Obstructive Pulmonary Disease (COPD) has a higher rate of death in Oneida County than in New York State for 2002. Hospitalizations rates for COPD in Oneida County are also considerably higher compared to hospitalization rates for New York State in 2003. Oneida County has many elderly residents who can account for the high number of chronic disease of the lungs and respiratory system.

Chronic Liver Disease: Mortality rates for cirrhosis in Oneida County for the year 2001 were 14.1 per 100,000. The number of deaths due to chronic liver disease has been steadily rising for the past 5 years. State mortality rates are 7.7 per 100,000 are half that of Oneida County and conversely State rates have dropped over the past 5 years.

The Healthy Heart Coalition was established in 1998 to help the community understand the importance of preventing Chronic Disease. Area hospitals have a wide variety of health programs aimed at educating the community in prevention of disease. The American Heart Association, The American Lung Association, The American Diabetes Association, The Arthritis Foundation, Hospice Care, Senior Centers and Planned Parenthood of the Mohawk Valley are only a few of the many local organizations which strive to keep our residents healthier by offering programs in prevention.

Selected Cancers: Cancer is the second leading cause of death in the United States. During 2000, an estimated 1,220,100 persons in the United States were expected to be diagnosed with cancer and 552,200 persons were expected to die from cancer. About 491,400 persons who get cancer in a given year, or 4 in 10 patients, are expected to be alive 5 years after diagnosis. In addition to the human toll of cancer, the financial costs of cancer are substantial. The overall annual costs for cancer are estimated at \$107 billion, with 37 billion for direct medical costs, \$11 billion for costs of illness, and \$59 billion for costs of death. Treatment for lung, breast, and prostate cancers alone account for more than half of the direct medical costs. Evidence suggests that several types of cancer can be prevented and that the prospects for surviving cancer continue to improve. The ability to reduce cancer death rates depends, in part, on existence and application of various types of resources. There were 2,768 cancer-related deaths in Oneida County in 2001. The age adjusted mortality rates were 1179.7 per 100,000, making cancer a leading cause of death for this geographic area.

Lung Cancer - Lung Cancer is the most common and also the most preventable cancer in the United States. In 1998, there were an estimated 171,500 new cases diagnosed accounting for 14%

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

of cancer diagnosis. Cigarette smoking is the most important risk factor for lung cancer, accounting for 68-78 percent of lung cancer deaths among females and 88 to 91 percent of lung cancer deaths among males. One to two percent of lung cancer deaths are attributable to air pollution. After 10 years of abstinence, smoking cessation decreases the risk of lung cancer to 30 to 50 percent of that of continuing smokers.

The New York State data set for 1996-2000 indicates that age adjusted lung cancer in Oneida County has a rate of 53.9 per 100,000. This figure is slightly higher than the state's 51.4 per 100,000. HP2010 target is 44.9 per 100,000. Lung cancer is a purely preventable disease, which depends upon education and abstinence to lower the numbers. The percent of lung cancers diagnosed at an early stage in Oneida County indicates there is little difference in gender. There were 23.9% of men diagnosed as compared to 24.9% of women. These figures compared nearly identical to state data. There are no target goals in the HP2010 plan.

Colorectal Cancer - Colorectal cancer (CRC) is the second leading cause of cancer-related deaths in the United States. An estimated 130,200 cases of colorectal cancer and 56,300 deaths from colorectal cancer were expected to occur in 2000. Risk factors for colorectal cancer may include age, personal and family history of polyps or colorectal cancer, inflammatory bowel disease, inherited syndromes, physical inactivity (colon only), obesity, alcohol use, and a diet high in fat and low in fruits and vegetables.

TABLE 18 - COLORECTAL CANCER - CASES AND INCIDENCE RATES PER 100,000 RESIDENTS
SOURCE: 1997-2001 CANCER REGISTRY DATA AS OF AUGUST, 2004
ADJUSTED RATES ARE AGE ADJUSTED TO THE 2000 UNITED STATES POPULATION

REGION/COUNTY	CASES					POPULATION 1999	CRUDE RATE	ADJUSTED RATE	
	1997	1998	1999	2000	2001				TOTAL
			REG-3 CENTRAL NEW YORK						
CAYUGA	48	56	57	54	56	271	82,034	66.1	60.1
CORTLAND	37	28	26	32	29	152	48,734	62.4	63.3
HERKIMER	69	69	64	62	55	319	64,462	99.0	78.4
JEFFERSON	62	52	69	63	67	313	112,081	55.9	63.4
LEWIS	19	30	27	26	18	120	26,914	89.2	85.3
MADISON	40	51	44	66	45	246	69,523	70.8	71.9
ONEIDA	205	149	182	191	195	922	235,412	78.3	63.6
ONONDAGA	252	295	321	281	276	1,425	458,575	62.1	58.9
OSWEGO	56	92	81	87	84	400	122,199	65.5	72.3
ST. LAWRENCE	85	61	91	90	65	392	112,202	69.9	69.7
TOMPKINS	50	36	48	62	41	237	96,656	49.0	62.9
REGION TOTAL	923	919	1,010	1,014	931	4,797	1,428,792	67.1	64.3
NEW YORK STATE TOTAL	11,780	12,257	12,186	12,008	11,364	59,595	18,882,725	63.1	62.3

The incidence of deaths from colorectal cancers diagnosed in the later stages has decreased attributing to the decreased death rates from CRC. Cancer death rates vary by gender, race, and ethnicity. African Americans are 34% more likely to die of cancer than Whites and twice as likely to die from cancer than Asians, Pacific Islanders, American Indians, and Hispanics. African American males account for the greatest number of deaths from colon, rectum, lung and prostate cancers. Studies indicated that African American males exhibit lower survival rates due to advanced stage diagnosis. Hispanics display lower survival rates than Whites also because of later stage diagnosis. Early detection, routine screening, and early treatment play a vital role in survival rates.

The incidence of early CRC diagnosis has been increasing 0.8% per year, with the onset of improved screening methods. The decline in the age-adjusted death rate from CRC nationally, has gone beyond the year 2000 target, but declines in death rates have not been as substantial for the black population. Differences in rates among the different races pose a challenge to understand and reduce illness and death. The incidence of CRC cases per 100,000 residents for Oneida County at

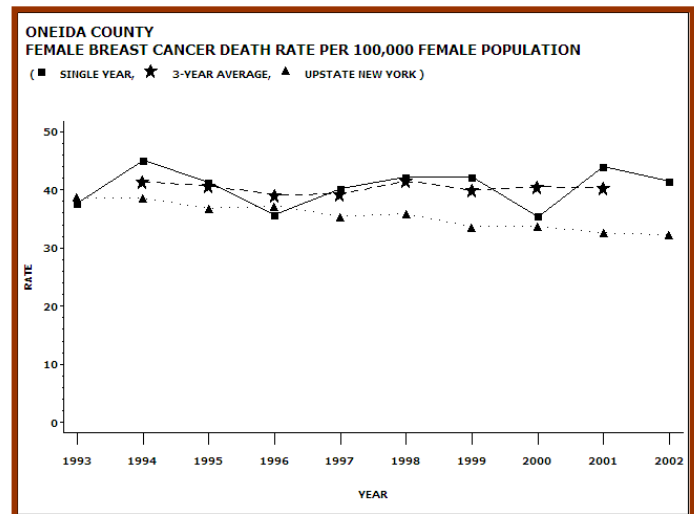
HEALTH PROFILE

63.6 is slightly below the region rate of 64.3, but is higher than 62.3, the rate for New York State (Table 18). The New York State dataset for 1996-2000 indicates that Oneida County has an above average rate for colorectal cancer as compared to the rest of the state. All counties exceed the HP2010 target rate of 13.9 deaths per 100,000. The colorectal mortality rate for Oneida County according to the 1998-2002 New York State data was 21.0 per 100,000. Early stage diagnosis numbers were 59.1 per 100,000 for the year 2002. As always, early diagnosis and treatment will lessen the impact of deaths from the disease. Detecting and removing precancerous colorectal polyps and detecting and treating the disease in its earliest stages will reduce deaths from this disease.

Breast Cancer - Breast cancer is the most common form cancer among women in the United States. An estimated 184,200 new cases were expected to be diagnosed in 2000. In 2000, it accounted for 15.2% of cancer deaths for women. Risk factors for breast cancer include age, family history of breast cancer, reproductive history, mammographic densities, previous breast disease, weight, race and ethnicity. The breast is one of the most common sites for cancer to develop in women of all racial and ethnic groups. Death rates from breast cancer decreased significantly from 1990 – 1996, especially for Whites. This decrease in rates is attributed to the use of breast cancer screening, regular medical care and testing. African American women continue to demonstrate higher death rates of 36.7 per 100,000 compared to 27.3 for Whites. New cases of breast cancer are increasing among Hispanic women who are diagnosed at later stages and result in lower survival rates. Death from breast cancer can be significantly reduced if the tumor is discovered and treated at an early stage. Mammography is the most effective method for detecting these early malignancies. Clinical trials have demonstrated that mammography screening can reduce breast cancer deaths by 20-39 percent in women aged 50 to 74 years and about 17 percent in women aged 40 to 49 years.



FIGURE 9 – FEMALE BREAST CANCER DEATH RATE



In 2001 there were 52 deaths due to female breast cancer in Oneida County at a rate of 44 per 100,000. This rate has increased since the years 1996-2000 when it was 27.8 per 100,000.

Oneida County's rate is currently double that of the HP2010 target. Approximately 69% of invasive breast cancers were diagnosed at an early stage between 1997-2001. In Oneida County, breast cancer death rates are higher than upstate New York (Figure 9).

The Oneida County Health Department obtained a grant provides screening women for breast and cervical cancer. This Healthy Women Partnership Program provides outreach, community education, and comprehensive breast cancer screening services to underserved women. The program has grown over the years and it continues to change program criteria to accommodate women as needed. The partnership consists of health care providers, Office of the Aging, the American Cancer Society, the Young Women's Christian Association, volunteers, and Planned Parenthood. A local hospital, St. Luke's Hospital offers the HERS Program for women's health education and referrals. They also offer mammography services to women at a reduced cost and without a physician referral. St Elizabeth's, Faxton and Rome hospitals also offer "no cost"

HEALTH PROFILE

mammography for those who meet the criteria for the program. The American Cancer Society offers a venue of services and educational formats for women to increase awareness to breast cancer and importance of routine screening.

Although breast cancer rates have been decreasing, increased efforts need to be addressed toward the higher risk population such as Black, Hispanic and lower income and indigent women living in Oneida County.

Cervical Cancer - Cervical cancer is the 10th most common cancer among females in the United States, with an estimated 12,800 new cases in 2000. Cervical cancer accounts for about 1.7 percent of cancer deaths among females. The 1 cervical cancer death in Oneida County in 2001 yielded a mortality rate of 0.8 per 100,000 population up 1 from the year 2000 in which the incidence was 0. Considerable evidence suggests that screening can reduce the number of deaths from cervical cancer. If cervical cancer is detected early, the likelihood of survival is almost 100 percent with appropriate treatment and follow-up.

Prostate Cancer - Prostate cancer is the most commonly diagnosed form of cancer in males and the second leading cause of cancer deaths among males in the United States. Prostate cancer is most common in men aged 65 years and older, who account for approximately 80 percent of all cases of prostate cancer.

The mortality rate for prostate cancer in males was 33.1 per 100,000 in Oneida County according to the New York State Cancer Registry data for the years 1997-2001. This rate was slightly higher than the state's value of 30.5 per 100,000 and well above the HP2010 target of 28.8 per 100,000. Oneida County had the second highest rate in the state, excluding New York City. In addition to this data the incidence of newly diagnosed invasive cancer of the prostate in Oneida County is currently 144.7 per 100,000. Although several treatment alternatives are available for prostate cancer, their impact on reducing death from prostate cancer when compared to no treatment in patients with operable cancer is uncertain. Therefore, efforts aimed at reducing deaths through screening and early detection remain controversial.

Oral Cancer - Oral and pharyngeal cancers comprise a diversity of malignant tumors that affect the oral cavity and pharynx. The overwhelming majority of these tumors are squamous cell carcinomas. In 2000, 30,200 new cases of oral cancer are expected to be diagnosed and approximately 7,800 deaths were expected to occur from the disease. Oral cancer is the 10th most common cancer among United States men and the 14th most common cancer among United States women. The five-year survival rate is only 53 percent.

Data relative to mortality rates due to oral cancers in Oneida County indicate a crude rate of 7.5 per 100,000, as well as a data rate of 2.2 per 100,000. These figures were age adjusted for ages 45-74 and include lip, oral cavity and pharynx cancers. Morbidity rates are slightly higher, 8.9 per 100,000 from the same source dataset for early stage diagnosis. Although morbidity rates are lower than the state rates, mortality rates are higher. Access to care and early diagnosis is paramount for treatment of this disease.

Currently, the Health Department offers disease prevention programs through a variety of services. Clinic services provide health education, physical assessments, and screenings. The Central New York Labor Agency offers wellness education including smoking session and weight management, general information of resources available and they sponsor a 24-hour Community Resource Information line. The American Cancer Society offers a number of venues directed toward cancer prevention, early detection, and screenings.

Faxton-St. Luke's Healthcare and the Regional Cancer Center offer a full range of Oncology outpatient services. The Regional Cancer Center at the Faxton Campus is uniquely positioned to meet the needs of cancer patients in our Community. The Cancer Center provides advanced

HEALTH PROFILE

technology services, an inpatient oncology unit, and a highly skilled staff with specialized training in cancer care.

Evidence indicates that several types of cancers can be prevented and the prospects for cancer survival rates can improve with the application of various resources and methodology's. Efforts must continue through media campaigns, networking, community partnerships and grant programs to achieve and accomplish the goals and objectives specific to Oneida County.

CHRONIC DISEASES GOALS AND OBJECTIVES:

See *Strategies for Health Improvement Section* for goals, objectives and strategies for Heart Disease, Cancer, and Diabetes.

5. DENTAL HEALTH

Although dental disease has been on the decline in the last decade, dental decay remains the most common preventable disease in children. This fact is disturbing because almost all oral diseases can be prevented. Practices that are instrumental in reducing dental caries in children include the use of optimal use of fluoride (especially community water fluoridation), dental sealant on permanent molars (and pre-molars, if indicated), a balanced diet, good personal dental hygiene and education.

Tooth decay is also a problem for adults, especially for the increasing number of older adults who have retained most of their teeth. Despite this increase in tooth retention, tooth loss remains a problem among older adults. Almost 3 of every 10 adults over age 65 have lost all of their teeth, primarily because of tooth decay and gum disease, which affects about 25% of U.S. adults. Tooth loss has more than cosmetic effects—it may contribute to nutrition problems by limiting the types of food that a person can eat.

The use of cigarettes, cigars or pipe smoking, smokeless tobacco and excess use of alcohol contribute to periodontal disease. Periodontal disease is an even greater problem for the elderly and individuals from lower socio-economic backgrounds because both groups often lack access to early and preventive dental care. Consequently, they are the least likely of any population group to either seek or complete care. National and State statistics have shown that the average number of decayed teeth increases as the household income decreases and educational attainment levels decrease. African Americans have higher rates of decay and many missing teeth and lower rates of filled teeth than Whites. Utilization of dental services is positively correlated with income and educational attainment. Immigrant children who had no benefit of fluoridated water supplies also have a high rate of tooth decay.

For children, cavities are a common problem that begins at an early age. Tooth decay affects nearly a fifth of 2–4-year-olds, more than half of 8-year-olds, and more than three-fourths of 17-year-olds. Hardest hit is low-income children. About half of all cavities among low-income children go untreated. Untreated cavities may cause pain, dysfunction, and absence from school, underweight, and poor appearance—problems that can greatly reduce a child's capacity to succeed in life. In addition, children from high-risk groups do not receive adequate fluoride exposure or adhesive sealant. Furthermore, the ability to pay for dental care is a barrier to receiving care for many children from low-income families.

Pre-school Children: In Oneida County the Low Birth Weight (<2500 Grams) Birth Percentage per 100 Live Births has gradually increased over the last decade from 6.9 in 1993 to 7.9 in 2002. Pregnant women with oral disease often give birth to pre-term low birth weight babies. The March of Dimes is focusing on low birth weight babies in 2004, periodontal disease in pregnant women as a focus for education. Dental Health materials (in immigrant languages) are given to agencies, addressing the issue of oral health during pregnancy and includes information on dental decay or Early Childhood Caries (ECC). Mohawk Valley Perinatal Networking, Concern for pre-term, low birth

HEALTH PROFILE

weight babies. Fluoride supplements should be considered for pre-school children in non-fluoridated area as part of a prevention program. MVCAA Head Start does have a fluoride supplement program in non-fluoridated areas.

School Children: Children from low socio-economic areas have higher unmet dental health needs. Studies have correlated data on participation in the free school lunch program with areas of high risk for poor dental health outcomes. These studies reveal that children who participate in the free school lunch program are more likely to be without proper dental care and, therefore, have more dental caries.



The New York State Bureau of Dental Health surveyed the oral health status of 3rd grade children in Oneida County in 2003. Receipt of a free or reduced lunch is used as an indicator for socio-economic status. In five of the six key oral health indicators (caries experience, untreated caries, 1 or more sealants on permanent molar(s), dental visit within past 12 months, insurance coverage, and use of fluoride supplements), those kids on the free or reduced lunch program fared worse for dental health. Only on the insurance coverage factor did they perform slightly better, 78% compared to 77% for kids not on a lunch program.

An elementary school fluoride rinse program exists in many of the non-fluoridated areas of Oneida County. Oneida and Madison Counties conduct a Sealant program for 2nd graders. Camden, Holland Patient, Utica School District and Westmoreland school districts do not participate in this program. Dental health (with a focus on dental sealants) was marketed through; radio, billboards, Mid-York Weekly and insert flyers.

Dental health talks with education materials & toothbrushes are made available to all school children through the Oneida – Herkimer County Dental Society (OHCDS) and the Mohawk Valley Dental Hygienists Association (MVDHA), especially during October – National Dental Hygiene Month and February – Children’s Dental Health Month.

For all under served children in the area, there is a shortage of providers of dental services. Transportation is a hindrance to getting services at the Article 28 (Medicaid Only) settings, especially for rural and inner-city children. These providers are located in the out-lying areas (New Hartford) of Utica. It appears, few dental practices see Medicaid and Child Health Plus and uninsured children in any realistic proportion.

Adults: More adults are keeping their teeth longer according to Healthy People 2010 Statistics. The major loss of teeth is attributed to periodontal disease and smoking.

According to the 2003 BRFSS survey, for adults’ ages 18 to 64 in Oneida and Oswego Counties, one-fourth, or one out of every four individuals, has not seen a dental professional within the past 12 months. In addition, fifty-three percent (53%) of this same age group indicated that they have had one or more of their permanent teeth removed because of tooth decay or gum disease.

The American Cancer Society & Faxton Hospital maintain Smoke Cessation programs on a regular basis. Dentists are mandated to do Oral Cancer Screenings, and many of them encourage smokers to stop smoking.

MVDHA participates in the Greater Utica Heart Run & Walk to educate people about periodontal disease and its contributing factors to heart disease.

Senior Citizens: According to Dental services in a number of area skilled nursing and assisted care facilities, there are many individuals admitted to these facilities that have chronic and acute dental needs. Neglect, old age and poor health contribute to the need for immediate dental attention. In

HEALTH PROFILE

Oneida County there is a lack of dentists and oral surgeons available for Medicaid and uninsured or underinsured people.

Access to Dental Care: Access to Dental Care continues to be a challenge for the poor, special needs, under insured, uninsured and Medicaid populations. According to the Central New York Dental Coalition transportation represents the most common issue that effects access to dental care. Two Article 28 dental health settings provide for Medicaid population only: Faxton – St. Luke’s Dental Health Center and Sitrin Dental Clinic. UCP Dental Center in Rome, sees Medicaid, and Child Health Plus. Sitrin has a mobile dental unit for Medicaid clients in Oneida & Herkimer Counties. Dentists in the area believe there is a shortage of dental hygienists. Reports from the office of the Professions, indicates that there are fewer dentists, with a stable dental hygiene workforce.

Dental Specialists: The 235,469 residents of Oneida County are served by only; oral surgeons –5, orthodontist –8, endodontists – 5, periodontists – 4, pediatric dentists – 2.

Water System Fluoridation: A Centers for Disease Control and Prevention (CDC) study found that, in communities with more than 20,000 residents, every \$1 invested in community water fluoridation yields \$38 in savings each year from fewer cavities treated. The Task Force on Community Preventive Services, which strongly recommends community water fluoridation, concluded that tooth decay in American children has decreased by 30%–50% because of fluoridation.

Fluoride is a significant factor in reducing dental decay. The Oneida County Environmental Health Report on the Fluoride Content of Area water supplies indicated that currently three systems provide fluoride treatment throughout the County. The three systems include the customers of the Mohawk Valley Water Authority, the Village of Clinton, and the homes along the perimeter of Oneida Lake (Verona Beach, Sylvan Beach, Hamlet of North Bay, and North Shore District) that are served by the Onondaga County Water Authority (OCWA). These three systems serve approximately sixty percent (60%) of the residents within the County.

Naturally occurring fluoride is present in many public and private water supplies throughout Oneida County. Department data suggests that areas north of NYS Route 5 have higher levels of fluoride in their water supplies. Fluoride levels in private homes in these areas may actually exceed the Maximum Contaminant Level of 2.2 mg/L.

HEALTH PROFILE

DENTAL HEALTH GOALS AND OBJECTIVES:

- Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth.
 - Target: TBD Oneida County Baseline: TBD
- Reduce the proportion of children, adolescents, and adults with untreated dental decay
 - Target: TBD Oneida County Baseline: TBD
- Increase the proportion of adults who have never had a permanent tooth extracted because of dental caries or periodontal disease.
 - Target: TBD Oneida County Baseline: TBD
- Reduce the proportion of older adults who have had all their natural teeth extracted
 - Target: TBD Oneida County Baseline: TBD
- Reduce periodontal disease.
 - Target: TBD Oneida County Baseline: TBD
- Increase the proportion of children who have received dental sealant on their molar teeth.
 - Target: TBD Oneida County Baseline: TBD
 - Strategies:
 - Expansion of the Dental Sealant Program into other school districts without fluoridated water systems.
- Increase the proportion of the Oneida County population served by community water systems with optimally fluoridated water.
 - Target: TBD Oneida County Baseline: TBD
- Increase the proportion of children, adults, and long-term care residents who use the oral health care system each year.
 - Target: TBD Oneida County Baseline: TBD
- Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.
 - Target: TBD Oneida County Baseline: TBD
 - Strategies:
 - Increased participation by area dentists in helping Medicaid clients to access

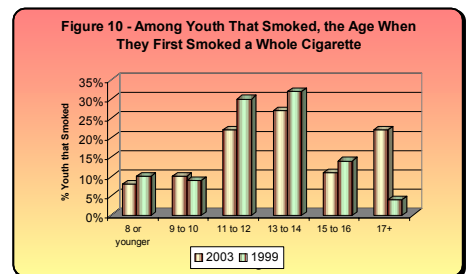
E. HEALTH-RELATED BEHAVIORS

1. SUBSTANCE ABUSE

Smoking Use: Cigarette smoking is the single most preventable cause of disease and death in the United States. Among the leading causes of death such as heart disease, stroke, lung cancer, and chronic lung diseases, smoking is identified as a major risk factor. In fact, more deaths are attributed to smoking each year than AIDS, alcohol, cocaine, heroin, homicide, suicide, motor vehicle crashes, and fires – combined. Environmental tobacco smoke (ETS), also known as second-hand smoke, increases risk of heart disease and lung conditions, such as asthma and bronchitis, especially in children

Both the Oneida-Herkimer (OH) Counties Smoking and BRFSS surveys found similar proportions of respondents who have ever smoked 100 cigarettes in their lifetime (55% and 54.7% respectively). This percentage is considerably higher than the state level of 45.9%, and places Oneida County within the top ten counties in the state (8th place).

However, in regards to current smoking practices, the two survey results varied significantly. The BRFSS survey indicated that 27.9% of the respondents currently smoke. The O-H Survey exhibited a current smoking practice of 18.8%. It should be noted that the BRFSS survey does combine Oneida with Oswego County in determining their percentages. Regardless of this discrepancy, on average one out of every 4 or 5 respondents currently smoke in Oneida County. This is similar to the state level of 20.3%.



HEALTH PROFILE

Of the O-H and BRFSS respondents who smoke, approximately 20% reported smoking every day, with over 10% of the respondents smoking more than a pack of cigarettes a day. This figure was higher for men (23%) than for women (15%) and higher for those under the age of 60 (25%) compared to those over the age of 60 (5%). No comparison could be made based on ethnicity due to a small sample size. The O-H identified that younger respondents were more likely to smoke, more likely to have children present, and less likely to have restrictions on smoking either in the home or in their vehicles.

According to the BRFSS survey, less than half of current (48.4%) and everyday smokers (42.7%) in Oneida and Oswego Counties have attempted to quit smoking. In both instances these percentages are among the lowest in state. The state percents were 58% and 51.2% respectively for those attempting to quit smoking.

In the 2003 *Teen Assessment Project* survey, over 71% of Oneida County high school students surveyed reported that they had never smoked a whole cigarette. This represents a dramatic, positive, change compared to the 1999 TAP survey results where 56% of all respondents reported they had never smoked a whole cigarette. Among those who indicated that they had smoked (29%), about 40% began smoking before the age of 13 (Figure 10). This is a decrease from the 1999 survey results of 49%. The survey further indicated that for those that ever smoked, at least one out of every four does so with some regularity (smoked at least ten out of the last 30 days).

Borrowing from someone else, having someone else purchase cigarettes for them, or purchasing cigarettes themselves were the major sources of obtaining cigarettes indicated by those surveyed, with 29%, 24%, and 15% respectively. Compared to national statistics, overall Oneida County youth are less likely to smoke. Local programs such as Reality Check, which educates teens about the tobacco industries techniques to market their products to teens, law enforcement activities to fine establishments that sell cigarettes to minors, along with the continued educational efforts of the American Lung Association, American Cancer Society, Smoke Free Mohawk Valley, and others, have contributed to the positive changes in teens regarding smoking and use of tobacco.

Alcohol Use: The use of alcohol is associated with many societal and health related problems challenging our communities including child and spouse abuse; sexually transmitted diseases, including HIV infection; teen pregnancy; school failure; motor vehicle crashes; homicides, suicides, high health care costs; low worker productivity; disruptions in family and personal life; and homelessness. In addition, long-term heavy drinking can lead to heart disease, cancer, alcohol-related liver disease, and pancreatitis. Alcohol use during pregnancy can result in fetal alcohol syndrome, a leading cause of preventable mental retardation.¹

In NY state, the risk for binge drinking decreases as the age of the respondent increases, with the highest level of risk for those respondents between 18 and 24 years of age. Whites (16.2%) tend to binge drink more, followed by Hispanics (12.7%) and Blacks (6.8%). Additionally, binge drinking levels increase as education and income levels increase. Similarly, the percent of 18 to 24 years old at risk for heavy drinking is almost two times higher than any other age group. The percent of Whites is three times higher than other ethnic groups. Again, those respondents with higher incomes and education levels tend to drink more heavily.

The 2003 BRFSS survey results indicate that approximately 17.1% of the respondents from Oneida/Oswego Counties are considered at risk for binge drinking, i.e., had 5 or more drinks per drink occasion within the past month. The Oneida/Oswego percent is higher than the state level of 14.1% and ranks among the top ten counties in the state (10th place) for at risk for binge drinking. Likewise, Oneida/Oswego county respondents tend to drink more heavily than other counties, ranking in the top ten among counties for this issue with 6.5% for Oneida/Oswego compared to a high of 9.2% for Allegany/Wyoming counties to a low of 2.5% in Westchester County. NYS was 4.8%.

HEALTH PROFILE

The NYS Office of Alcoholism and Substance Abuse Services (ASA) applies a Social Development model, focused on social bonding processes, to evaluate alcohol and substance abuse indicators, and develop profiles for each county and the state as a whole. The model employs fifteen risk constructs and two consequence indices. Community-level risk factors such as urbanicity, economic, violence and crime, accessibility, and adult alcohol and drug exposure can be used to gauge the level of risk on the county's population.

In Oneida County for year 2000, the ASA indicators - arrests for non-violent, non-property types of crimes rates were significantly higher than the NYS average (234 per 10,000 and 190.3 per 10,000 respectively). In the same way, income levels were lower and poverty levels in children and families were considerably higher than the rates in similar counties and NYS.

Although Oneida County's risky drinking behaviors rate high compared to other counties, Data from the 2002 report by the Oneida County Department of Traffic Safety demonstrate a significant decrease in DWI arrests, alcohol-related crashes, injuries, fatalities, and % alcohol involvement in motor vehicle crashes, over the last 10 to 20 years. This trend is consistent with the ASA results where the rate in Oneida County for DWI arrests per 10,000 population for adults over 21 (49.5) was lower than the rates for similar counties (52.7) and NYS (54.2).

The ASA data suggests that it is easier for Oneida County residents to access alcohol compared to similar counties and NYS. The rate of alcohol "outlets" where one can consume alcohol on the premises is 19.1 per 10,000 population compared to rates of 15.2 and 15.7 for similar counties and NYS respectively.

According to the ASA data, Oneida County experiences a slightly higher rate per 10,000 adult population of hospital discharges for alcohol-related diagnosis (15.7) than in similar counties (14.9) and the State (12.4). However, conversely, the rate for adults age 21 years old and older who were in treatment at some time during the year with alcohol as the only problem substance at admission in Oneida County (42.1) was lower than in similar counties (55.7) and the State (46.5).

In Oneida County, the rates for adults on probation for whom there was evidence of alcohol use at the time of offense (42.8), and for adults on probation who were mandated by the courts to undergo alcohol testing, abstain from alcohol, or enter treatment for alcohol (60.0), were higher than those in similar counties (17.3 and 55.5) and the State (40.2 and 57.2). The rate of adults in Oneida County mandated by the courts for alcohol-related treatment has steadily increased from 49.4 in 1994 to 60.0 in 2000.

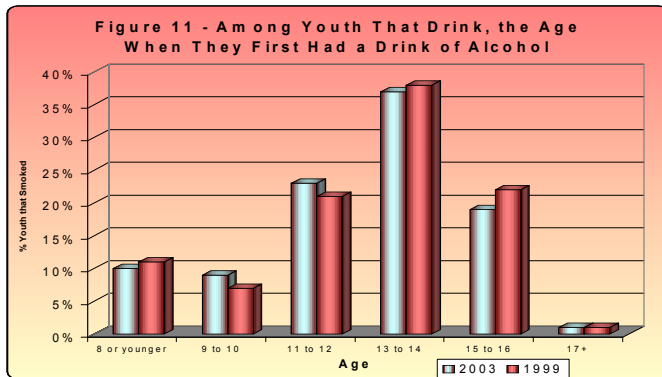
The Oneida County 2003 TAP Survey data indicate that the percentage of youth that use alcohol has remained relatively stable since the 1999 survey, with approximately 44.2% of the respondents indicating that they have used alcohol in 2003. Among those youths that currently use alcohol, 42% indicated that they drank before the age of 13, up from 39% in 1999 (Figure 11). Approximately half (49.2%) use alcohol at least a few times per month, down from 60% in 1999. Using a person of legal age to buy alcohol remains the main source of obtaining alcohol (21%), this practice is dramatically lower than in 1999 (33%). Getting their alcohol at a friend's house without the parents knowledge has increased as a source of obtaining alcohol from 9% in 1999 to 14% in 2003. Additionally, we see a slight increase in the percent of youth that indicated that they got the alcohol from their parents (12% in 1999 to 13% in 2003).

Overall, we see a significant decline in binge drinking among youths from 23% in 1999 to 14% in 2003. For such alcohol-related behavior as; at least trying a drink, one drink within the last 30 days, and binge drinking, Oneida County consistently demonstrates a lower percentage of youth engaging in such behavior.

HEALTH PROFILE

The ASA Risk Profile for Oneida County includes a Youth Risk Index incorporating youth risk factors for family environments and behaviors that are used to gauge youths at risk for alcohol and substance abuse. As the Social Development model suggests, the formation of positive social bonds during childhood and adolescence protect against alcohol and substance abuse. Family dysfunction, defined by ASA to include the following risk factors; foster care admissions, children in foster care, preventive service openings, CPS indicated cases, CPS mandated reports, CPS total reports received, and divorces, negatively impact social bonding during childhood, and thereby may lessen protection for adolescence against alcohol and substance abuse. The rates for each one of the family dysfunction risk factors are higher in Oneida County than the rates for the same factors in similar counties and for the NYS. Except for the factor – children in foster care, rates for each of the other family dysfunction indicators have increased between 1994 and 2000 in Oneida County.

For the factors of DWI arrests and youth on probation for whom there was evidence of alcohol use at the time of the offense, we find lower rates in Oneida County (38.9 and 27.4 respectively) than for similar counties (44.5, 38.1) and NYS (46.6, 28.5). However, in the case of youth probation cases whereby the court mandated some alcohol-related treatment, the Oneida County rate of 150.3 per 10,000 was significantly higher than that for similar counties (108.2) and NYS (98.3).



Correspondingly, the rate of youth age 16-20 who were in treatment at some time during the year with alcohol as the only problem substance at admission (12.2) was higher in Oneida County than in similar counties (10.9) and NYS (10.7). In fact, we observe a continual increase in the alcohol treatment rate from 8.2 in 1994 to 12.2 in 2000, in Oneida County.

Other Drug Use: Illicit drug use, like alcohol, is associated with social, as well as health-related conditions similar to

those listed in the alcohol use section. Although there has been a long-term drop in overall use, many people in the United States still use illicit drugs. Marijuana is the most commonly used illicit drug with 60 percent of users abusing marijuana only. Nationally, among persons aged 12 years and older, 35.8 percent have used an illegal drug in their lifetime. Of these, more than 90 percent used marijuana or hashish, and approximately 30 percent tried cocaine. Relatively rare in 1996, methamphetamine use began spreading in 1997. Drug use among adolescents aged 12 to 17 years doubled between 1992 and 1997.¹

According to the ASA data, the adult drug indications factors rates for Oneida County, i.e., adult drug arrests, adult DUI arrests, adult drug-related hospital diagnoses, adult OASAS drug treatment, adult probation cases: Use at offense – drugs, and adult probation cases: Court mandates – drugs, are, for the most part, consistent with similar counties and the NYS averages.

Adult drug arrests rate in Oneida County for 2000 (52.8/10,000) was slightly lower than similar counties (54.8), but substantially higher than the state average of 41.9. Between 1994 and 2000, adult drug arrests rates in Oneida County has increased from 41.6 per 10,000 population to 52.8 per 10,000, a 27% rise. Likewise, the rate of adult drug-related hospital diagnoses increased from 25.1/10,000 in 1994 to 42.8/10,000 in 2000, a 71% increase. In the areas of OASAS drug treatment (20.2) and adult probation cases: court mandates (42.9), Oneida County demonstrates substantially lower rates than similar counties (32.6; 55.5) and NYS (29.3; 48.4), respectively. However, we observe a 120% rise in OASAS drug treatment activity between 1994 and 2000. In fact, in all adult drug indications factors, rates in Oneida County have steadily increased between 1994 and 2000 (Table 19).

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

**TABLE 19- ONEIDA COUNTY ADULT DRUG INDICATIONS – 1994-2000
RATES PER 10,000 POPULATION**

INDICATION	1994	1995	1996	1997	1998	1999	2000	% CHANGE 1994-2000
Drug arrests	41.6	46.7	48.5	45.2	47.9	52.1	52.8	+27%
DUI drug arrests	1.4	1.3	0.9	1.4	2.2	1.5	1.6	+14%
Hospital diagnoses	25.1	28.9	28.4	33.4	40	37.8	42.8	+71%
OASAS drug treatment	9.2	9.3	12.2	20.3	27	18.5	20.2	+120%
Use at Offense	7.3	7.7	8.6	8.8	9.9	10.9	11.1	+52%
Court Mandates	29.2	29.8	33.4	35.9	38.2	40.5	42.9	+47%

Source: PRISM System for Alcohol and Substance Abuse, NYS-OASAS.

The ASA Risk Profile for Oneida County, Youth Risk Index Drug Consequences indicators demonstrate that rates for youth drug arrests and youth probation cases: court mandated treatment are significantly higher in Oneida County (161.1/10,000; 155.8/10,000), than in similar counties (145.6; 112.6) and NYS (117.9; 98.2) respectively. Conversely, drug consequence rates for OASAS drug treatment and hospital diagnoses were lower in Oneida County (32.1; 16.5) compared to similar counties (39.7; 19.7) and NYS (34.5; 17.9), respectively. Although the OASAS drug treatment rate is lower in Oneida County, the County has experienced a 745% increase for this indicator between 1994 and 2000 (Table 19).

The youth drug indicator rates for Oneida County rose dramatically between 1994 and 2000. Table 20 exhibits these trends. In comparison with the adult group, the youth rate for drug arrests is three times higher in 2000 (adult – 52.8/10,000; youth 161.1/10,000). Likewise, the rate for court mandated treatment is almost four times higher for youths (155.8/10,000) than for adults (42.9/10,000) in Oneida County.

**TABLE 20- ONEIDA COUNTY YOUTH DRUG INDICATIONS – 1994-2000
RATES PER 10,000 POPULATION**

INDICATION	1994	1995	1996	1997	1998	1999	2000	% CHANGE 1994-2000
Drug arrests	93.1	134.7	132.5	169.2	186.4	187.3	161.1	+73%
Hospital diagnoses	4.4	7.3	13.2	21.9	27	17.2	16.5	+275%
OASAS drug treatment	3.8	7.7	19.6	25.5	22.6	25	32.1	+745%
Use at Offense	20.6	22.3	14.5	24.5	25.7	22.9	26.2	+27%
Court Mandates	92.2	103.4	74.8	139.7	148.3	151.6	155.8	+69%

Source: PRISM System for Alcohol and Substance Abuse, NYS-OASAS.

In the 2003 Oneida County Teen Assessment Project Survey, one out of every six 7th, 9th, and 11th grader (16.5%) indicated that they had been high on alcohol, marijuana, or some other illegal drug while in school during school hours.

Compared to national statistics, Oneida County 9th and 11th graders are less likely to use illegal drugs. Although we see a slight increase in marijuana use before the age of 13 (29% in 2003, 26% in 1999), marijuana use among 9th and 11th graders in Oneida County (20%) is half of the national average for 9th and 11th graders (41%). There is a wider use of inhalants (8.5%) and other people's

HEALTH PROFILE

prescriptions (8.9%) than the “other” illegal drugs, i.e., cocaine for Oneida County youth. The National-Oneida County comparison is similar for other illegal drugs as well. These drugs include heroin, methamphetamines, ecstasy, steroids, and prescription medications.

While our percentages are lower overall, as compared to national statistics, there are some disturbing observations gleaned from the results. In Oneida County, for each of the “other” illegal drugs mentioned previously, except for prescription medications, we observe a three-fold percent increase in usage of illegal drugs for 11th graders compared to 7th graders when indicating use of an illegal drug on a daily basis. For example, 1.6% (~17 students) 11th graders indicated that they use heroin about everyday, compared to 0.5% (~6 students) 7th that use heroin about everyday. It should be noted, however, that caution should be exercised when analyzing data based on a small number of respondents.

Research links the use of cocaine, heroin, and illicit drugs other than marijuana with co-occurring chronic mental health disorders. Some of these persons can be identified by their behavior problems at the time of their entry into elementary school. Such youth tend to use substances at a young age and exhibit sensation-seeking (or “novelty-seeking”) behaviors.

Marijuana usage remains relatively unchanged since the 1993 survey was conducted, and continues to be the drug of choice among respondents. Almost 40% of the students, who responded, in 2003, indicated that they have use marijuana, at least, on a weekly basis. As pointed out by the TAP survey this percentage “is considerably higher than the “frequency of use” pattern for alcohol.” Friends and dealers are the respondents’ primary sources of obtaining marijuana as indicated by 48% and 25% of the respondents, respectively.

When queried about the helpfulness of school programs concerning drug and alcohol prevention awareness, respondents in the 2003 TAP Survey indicated that they are less helpful compared to those surveyed in 1999. In 2003, 44.2% of the respondents indicated such programs were not much help (18.5) to no help at all (25.7). This rose from 36.6% in 1999 (15.7 and 20.9, respectively). Amongst 11th grade respondents, the percentage was greater with over half (52.9%), indicating that these educational programs were not much help (24.0) to no help at all (28.9).

Across our nation, as many as 700,000 individuals are homeless on any given night. Of this amount, approximately one out of every 4 or 5 individuals suffer from a serious mental illness, and one half of this subgroup also have an alcohol and/or drug problem.

A 2004 study of homelessness in the City of Utica states that “homelessness...is a substantial, persistent, and growing social problem.” The study further indicates that homelessness “is strongly connected to substance abuse, mental health issues, domestic violence, and poverty in Utica”. Similar to the national trends, African Americans account for approximately 32% of the homeless population, although they only comprise 14% of the City of Utica’s population. In Utica, single adults comprise the majority of homeless individuals with 68%. Single men constitute 43% of the homeless population followed by single women (26%), children (13%), parents (10%), female 18-21 (5%), and male 18-21 (3%).

In Utica, chronic substance abuse among the homeless was further evaluated by single adult and in families. Among single adults, 64% are male compared to 36% female. Among families, however, nearly three out of every four individuals (74%) with chronic substance abuse were female (67% women, 7% female youth (18-21)).

In a 2001 report prepared by the Oneida County Department of Mental Health, mental health and substance abuse service customers were queried as to barriers or concerns affecting their recovery and well-being. The findings clearly identified “housing and social integration issues” such as basic living needs, rather than clinical concerns as the key issues effecting this population. Housing,



ONEIDA COUNTY HEALTH DEPARTMENT 2005-2010 COMMUNITY HEALTH ASSESSMENT

HEALTH PROFILE

available transportation and supportive services such as childcare and job training, and disability services were identified, as primary needs.

The stigma attached to substance abuse increases the severity of the problem. The hiding of substance abuse, for example, can prevent persons from seeking and continuing treatment and from having a productive attitude toward treatment.

SUBSTANCE ABUSE GOALS AND OBJECTIVES:

- For goals and objectives for **Alcohol** and **Tobacco** Use see ***Strategies for Health Improvement*** Section.

- Illicit Drug Use :**

Reduce the rate of drug-related hospital discharge of individuals.

Objective	2000 Baseline	2010 Target
Illegal drugs		Rate per 10,000 population
Adults	42.8	35.1
Youths	16.5	13.5

2. INTENTIONAL & UNINTENTIONAL INJURIES

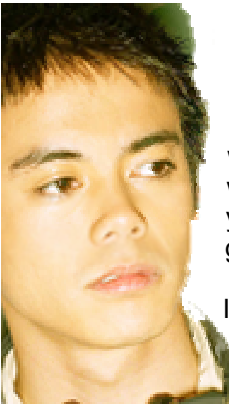
Injuries are classified into two categories "Intentional and Unintentional Injuries". Intentional injuries are injuries that occur with purposeful intent and include homicide, suicide, domestic violence, sexual assault and rape, bias related violence and firearms.

Unintentional injuries are injuries that occur without purposeful intent, and are a leading cause of death and disability. Those at risk of unintentional injuries are young people up to 24 years of age and the elderly. These injuries are caused by falls, motor vehicle injuries, fires, and sport, recreational, and occupational related injuries.

More than 400 Americans die each day from injuries due primarily to motor vehicle crashes, firearms, poisonings, suffocation, falls, fires, and drowning. The risk of injury is so great that most persons sustain a significant injury at some time during their lives.

Intentional Injuries:

Suicide - Suicide (taking one's own life) is a serious public health problem that devastates individuals, families, and communities. It is the 11th leading cause of death among Americans. Completed suicides are only part of the problem. More people are hospitalized or treated and released as a result of failed suicide attempts than are fatally injuries. While suicide is often viewed as a response to a single stressful event, it is far more complicated issue. Suicide results from complex interactions between biological, psychological, social, and environmental factors.



Suicide took the lives of 30,622 people in the United States in 2001. In 2002 132,353 individuals were hospitalized following suicide attempts. Another 116,639 were treated in emergency departments and released. In 2001 55% of suicides were committed with firearms. Suicide is the third leading cause of death among young people ages 15-24. In 2001, 3,500 suicides were reported in this age group. In 2001 firearms were used in 54% of youth suicides.

In 2001 5,393 Americans over 65 committed suicide. Firearms were used in 73% of suicides committed by adults over the age of 65.

HEALTH PROFILE

The suicide rate per 100,000 standard population (White, non- White and teen suicide) between 1998-2000 for the United States was 10.4, New York State 6.9, and Oneida County 6.4. The Healthy People 2010 target is 5.0 per 100,000. Oneida County is lower than both the United States and New York State but higher than The Healthy People 2010 target of 5.0 per 100,000.

The suicide rate per 100,000 standard population (ages 15-19) from 1998-2000 for New York State was 5.5 and Oneida County 5.9. The United States rate and Healthy People 2010 target was not identified. Oneida County is higher than the New York State rate for ages 15-19.

Homicides - Nationally, In 1997, 32,436 individuals died from firearm injuries; of this number, 42 percent were victims of homicide. In 1997, homicide was third leading cause of death among children aged 5 to 14 years, an increasing trend in childhood violent deaths. In 1996, more than 80 percent of infant homicides were considered to be fatal child abuse.

Many factors that contribute to injuries also closely associated with violent and abusive behavior, such as low income, discrimination, lack of education, and lack of employment opportunities.

Males are most often the victims and the perpetrators of homicides. African Americans are more than five times likely as Whites to be murdered. There has been a decline in the homicide of inmates, including spouses, partners, boyfriends, and girlfriends, over the past decade, but this problem remains significant.

Homicide was the cause of death for 19,491 persons in the United States (7.2 per 100,000 population) in 1997. Homicide is the second leading cause of death for young people aged 15-24 years and the leading cause of death for African Americans in this age group. Homicide rates are dropping among all groups, but the decreases are not dramatic among youths, which already exhibit the highest rates. In 1997 6,146 young persons aged 15-24 years were victims of homicide, accounting to almost 17 youth homicide victims in the United States per day. Of all homicide victims in 1997, 37 percent were under the age of 24 years. The homicide rate among males 15-24 years in the United States is 10 times higher than Canada, 15 times higher than Australia, and 28 times higher than France and Germany.

The homicide rate (age adjusted per 100,000 standard population 1998-2000) for the United States 5.9, New York State 5.1, and Oneida County 2.5. The Healthy People 2010 target is 3.0 per 100,000. Oneida County is lower than both the United States and New York State and less than Healthy People 2010 rate of 3.0 per 100,000.

Oneida County Department of Mental Health provides the planning monitoring and reviewing of services for individuals with mental illness.

Counseling services are available through the following agencies:

- Catholic Charities
- Community Health and Behavioral Services
- Family Services of the Mohawk Valley
- Planned Parenthood of Mohawk Valley/Hudson Valley
- Neighborhood Center Child Guidance Clinic.
- Samaritan Counseling Center

The Crisis Evaluation Team (CET) is the single point of entry for individuals experiencing an emotional or psychiatric crisis in Oneida County. Currently CET staff members are located at St. Elizabeth Hospital and employed by state and non-profit agencies. The goal is to provide supportive counseling and initiate services to individuals experiencing psychiatric or emotional distress and to assess eligibility for inpatient mental services.

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

Children's Mobile Assessment Team (C-MAT) sponsored by Neighborhood Center responds to emotional and psychiatric emergencies in the community with children. Trained staff respond on site if needed in a severe crisis, make an assessment for level of care needed, and try to defuse and mobilize the situation.

Crisis services and counseling services are available to respond to emotional and psychiatric crises in families. The problem is that demand exceeds services and many families may not have available resources for counseling services.

Unintentional Injuries: More persons aged 1 to 34 years of age die as a result of unintentional injuries than any other cause of death. Across all ages, 92,353 persons died in 1997 as a result of unintentional injuries. Motor vehicle crashes account for approximately half the deaths from unintentional injuries; other unintentional injuries rank second, falls third, followed by poisonings, suffocation, and drowning.

Additionally, millions of persons are incapacitated by unintentional injuries, with many suffering lifelong disabilities. These events occur disproportionately among young and elderly persons. In 1995, 29 million persons visited emergency departments as a result of unintentional injuries.

Although the greatest impact of injury is in human suffering and loss of life, the financial cost is staggering. Included in the costs associated with injuries are the costs of direct medical care and rehabilitation as well as lost income and productivity. By the late 1990's, injury costs were estimated at more than \$441 billion annually, an increase of 42 percent over the 1980's. As with other health problems, it costs far less to prevent injuries than to treat them. For example:

- Every child safety seat saves \$85 in direct medical costs and an additional \$1,275 in other costs.
- Every bicycle helmet saves \$395 in direct medical costs and other costs
- Every smoke detector saves \$35 in direct medical costs and an additional \$865 in other costs
- Every dollar spent on poison control centers saves \$6.50 in medical costs

While every person is at risk for injury, some groups appear to experience certain types of injuries more frequently. American Indians or Alaska Natives have disproportionately higher death rates from motor vehicle crashes, residential fires, and drownings. In addition, their death rates are about 1.75 times higher than the death rate for the overall U.S. population. Higher death rates from unintentional injury also occur among African Americans.

African American, Hispanic, and American Indian children are at higher risk than White children are for home fire deaths. Adults aged 65 years and older are at increased risk of death from fire because they are more vulnerable to smoke inhalation and burns and are less likely to recover. Sense impairment (such as blindness or hearing loss) may prevent older adults from noticing a fire, and mobility impairment may prevent them from escaping its consequences. Older adults also are

**FIGURE 12 – SELECTED CONTRIBUTING FACTORS IN CRASHES/
REPORTED SAFETY RESTRAINT USE IN CRUSHES**

ONEIDA COUNTY
SELECTED CONTRIBUTING FACTORS IN CRASHES*

	1998	%	1999	%	2000	%	2001	%
Total Crashes	4,454		5,129		5,885		4,645	
Alcohol involvement	167	3.7	199	3.9	242	4.1	168	3.6
Unsafe speed	581	13.0	675	13.2	964	16.4	642	13.8
Driver inattention/distraction**	607	13.6	720	14.0	867	14.7	698	15.0
Failure to yield right-of-way	807	18.1	885	17.3	896	15.2	798	17.2
Following too closely	590	13.2	629	12.3	651	11.1	518	11.2
Improper passing/lane usage	179	4.0	216	4.2	239	4.1	201	4.3
Traffic control disregarded	289	6.5	326	6.4	304	5.2	273	5.9
Unsafe lane changing	106	2.4	125	2.4	147	2.5	121	2.6

* Police-reported crashes only.
** Driver distraction was added to Police Accident Report Form MV-104, effective 7/01. Because older versions may continue to be used, driver distraction is underreported.
Note: Not all crashes have a contributing factor reported, and many crashes have multiple factors reported.

Source: 1998-2000 NYS/DMV county MV-144A, Table 13(P);
2001 NYS/DMV AIS Data Base.

ONEIDA COUNTY
REPORTED SAFETY RESTRAINT USE IN CRASHES*

	1998		1999		2000		2001	
	All Occupants	K&A Occupants %	All Occupants	K&A Occupants %	All Occupants	K&A Occupants %	All Occupants	K&A Occupants %
No restraint used	11,410	234	12,229	202	13,165	190	11,167	195
Restraint used	6.1	30.8	5.2	26.7	5.0	24.2	5.1	30.3
Restraint use unspecified	82.4	64.1	86.6	61.4	90.5	70.5	85.5	61.5
	11.5	5.1	8.2	11.9	4.5	5.3	9.4	8.2

* Police-reported crashes only.
Note: "K and A" denote occupants killed or seriously injured in a crash.
Source: 1998-2000 NYS/DMV county MV-144A, Table 29(P);
2001 NYS/DMV AIS Data Base.

C-3

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

less likely to have learned fire safety behavior and prevention information, because they grew up at a time when little fire safety was taught in schools and most current educational programs target children.

In every age group, drowning rates are almost two to four times greater for males than for females. In 1997, the overall drowning rate for African Americans was 50 percent greater than that for Whites; however, the rate was not higher for all age groups. For example, among children aged 1 through 4 years, the drowning rate for Whites was slightly higher than the rate for African Americans. For children aged 5 to 19 years, African American children are twice as likely to drown as White children.

TABLE 21- INTENTIONAL AND UNINTENTIONAL INJURIES - NEW YORK STATE AND ONEIDA COUNTY

	New York State				
	2001	2000	1999	1998	1997
	Rate	Rate	Rate	Rate	Rate
Homicides	5.2	5.2	5.1	5.0	6.0
Suicides	6.7	6.7	6.8	7.4	7.3
Unintentional Injury	23.0	20.8	22.6	21.3	22.8
Motor Vehicle	8.7	7.9	9.2	8.8	9.8
Non Motor Vehicle	14.4	12.9	13.4	12.5	13.0
Oneida County					
Homicides	4.7	3.0	2.7	1.6	N/A
Suicides	11.9	8.5	4.7	7.0	N/A
Unintentional Injury	35.8	27.6	27.4	22.2	N/A
Motor Vehicle	10.7	8.5	13.3	7.0	N/A
Non Motor Vehicle	25.1	19.1	14.1	15.2	N/A

The death rate caused by unintentional injury (age adjusted per 100,000), based on years 1998–2000 were: 34.9 per 100,000 for the U.S., 21.7 per 100,000 for New York State, and 23.5 per 100,000 in Oneida County. The Healthy People 2010 target is 17.5 per 100,000.

The Oneida County rate for unintentional injuries is significantly lower than national rates, but slightly higher than New York State rates. Higher rates of unintentional injuries in Oneida County may be related to the increase in the elderly population 65 years and older (Table 21).

Programs are available to address issues related to unintentional injuries. Infant car seat programs, bicycle helmet programs, and smoke detectors are available

through the Healthy Neighborhood Programs. Services indicated are also at no cost to those families who qualify. Demand again exceeds services available and funding streams are limited to the amount of equipment that can be provided. Culturally sensitive materials are needed to reach high risk and refugee populations and make these programs accessible to them.

Several themes become evident when examining reports on injury prevention and control, including acute care, treatment, and rehabilitation. First, unintentional injury comprises a group of complex problems involving many different sectors of society. No single force working alone can accomplish everything needed to reduce the number of injuries. Improved outcomes require the combined efforts of many fields, including health, education, transportation, law, engineering, and safety sciences. Second, many of the factors that cause unintentional injuries are closely associated with violent and abusive behavior. Injury prevention and control addresses both unintentional and intentional injuries.

HEALTH PROFILE

INTENTIONAL AND UNINTENTIONAL GOALS AND OBJECTIVES:

GOAL:

Reduce injuries, disabilities, and deaths in Oneida County due to unintentional injuries and violence.

OBJECTIVES:

- Reduce deaths caused by motor vehicle crashes.
- Reduce non-fatal unintentional injuries with focus on youth and elderly populations.
- Increase availability of counseling and other violence preventative programs to reach the at-risk and high-risk populations.
- Increase outreach and education and expand the usual venues in which information to -prevent both unintentional and intentional injuries are presented.
- Improve local surveillance systems to obtain timely and useful data.
- Increase training programs for first responders and health care professionals for assessing h victims of violence.
- Increase availability of local resources for distribution of safety equipment, i.e. car seats, smoke detectors, bicycle and other safety helmets.
- Coordinate available services to avoid duplication of services and identify gaps and services.

3. SAFETY AND INJURY CONTROL

Seat Belt Use: The seatbelt law has been in effect since 1984. Prior to that time, only 16% of individuals used their seatbelts. In 1984, according to New York statistics, 1,012 people died because of injuries related to automobile crashes and were unrestrained. In 1985, a year after the law went into effect, the death rate was reduced to almost half, to 644 deaths. The compliance rate at that time was 57%. In 2003, the compliance rate is 85%. Most unrestrained deaths happen to individuals between the ages of 16-44. In a study done by the American Academy of Pediatrics, it was shown that when the drivers buckle up, so do the children riding with them. However, if the drivers are not restrained, only 24% of the children riding with them are.

New York Safety statistics also reveal that inpatient costs are 50% higher if the individual is unrestrained during a car crash. Taxpayers pay up to 85% of those costs of care.

Motor vehicle crashes are the leading cause of injury-related deaths. In Oneida County, between 1998 and 2001, 821 people were killed or injured while not wearing their seatbelts. The decision to wear their seatbelt occurs at an individual level. The answer remains unclear as to why people refuse to wear seatbelts, despite their value and laws in place. It is clear that seatbelts save lives, especially with the combined use of airbags.

For motor vehicle crashes in Oneida County reported by police between 1998-2001, 86.3% of passengers used seat belts as compared to 5.4% of passengers that did not use seat belts (8.3% restraint use unspecified). Although seat belt usage has increased significantly there continues to be a need to reach the individuals not wearing seat belts, this is especially important when children are involved.

High schools offer drivers' education that includes a review of existing driving laws and safe driving practices. There are also private drivers' education schools throughout New York State that also instruct students on safe driving practices including the use of child passenger restraints and seatbelt use. Outreach programs that target young people and families also offer seatbelt and child passenger education.

Bike Helmet Use: Nationally, between 1984-1988, approximately 962 people died from injuries related to bicycle accidents. An astounding 557,936 people were injured. A cost to society of \$8 billion.

HEALTH PROFILE

The use of bike helmets for people of all ages is not widely accepted. The barriers include social issues related to “being different”, income related issues, and most important, lack of education surrounding the use of bike helmets. These factors lead to the limited use of helmets and increased injuries related to accidents involving cyclists of all ages.

In New York State in 1998, 6,616 injuries and 53 fatalities resulted from bicycle related injuries. In Oneida County in 1998, 78 injuries with no fatalities resulted from bicycle related accidents. In absolute numbers during the four-year period 1998-2001, injuries resulting from bicycle accidents fluctuated from a high of 84 in 2000 to a low of 63 in 2001.

The New York Governors’ Traffic Safety Commission (NYGTSC) funds local communities to educate and promote bike safety and the use of helmets for riders of all ages. This grant program has helped local communities purchase helmets and sponsor community events to promote education and provide helmets to the community as well as providing a day of family fun.

This program addresses the recommended points from CDC: 1) Identifying the problems associated with nonuse of helmets in the community; 2) Identifying resources available; 3) Implementing and overseeing the program initiatives.

Smoke Detectors: The fact that smoke detectors save lives has been proven. The majority of fatal home fires happen at night, when people are asleep. Contrary to popular belief, the smell of smoke may not wake a sleeping person. The poisonous gases and smoke produced by a fire can numb the senses and put a person into a deeper sleep.

Functioning smoke alarms on every level and in every sleeping area of a home can provide residents with sufficient warning to escape from nearly all types of fires. Therefore, functioning smoke alarms can be highly effective in preventing fire – related deaths. If a fire occurs, homes with smoke alarms are roughly half as likely to have a death occur as homes without smoke alarms. By giving you time to escape, smoke detectors cut your risk of dying in a home fire nearly in half.

In 1997, 3,220 deaths occurred as a result of residential fires. Nationally, residential property loss caused by these fires was roughly \$4.4 billion. In 1995, the cost of all fire – related deaths and injuries, including deaths and injuries to firefighters, was estimated at \$15.8 billion.

Fires are the second leading cause of unintentional injury death among children. Compared to the total population, fire death rates for children aged 4 years and under are more than twice the national averages. About 800 children aged 14 years and under die by fire each year and 65 percent of these children are under age 5 years. Children are disproportionately affected because they react less effectively to fire than adults and they also generally sustain more severe burns at lower temperatures than adults do. Two – thirds of fire – related deaths and injuries among children under age 5 years occur in homes without functioning smoke alarms.

Within Oneida County, only 2.88% of all Behavioral Risk Factor Surveillance System (BRFSS) respondents reported not having a smoke detector. Of those with detectors, only 11% reported having tested them within the last year.

Between April 2003 and September 2004 there were a total of 252 surveys completed by the Oneida County Health Department’s Healthy Neighborhoods Program (HNP). Of this number, 118 homes were actually entered. A total of 19 homes representing about 16% of the homes visited, did not have a smoke detector in the home.

Oneida County Health Department’s Healthy Neighborhoods Program provides free smoke detectors to eligible residents living in designated areas of Utica, this program also provides the community with education regarding home safety. Oneida County Health Department also provides free infant and child car seats to income eligible families.

HEALTH PROFILE

Professional liaisons within the community to promote the programs, coupled with funds available to provide helmets, infant and child car seats, and smoke detectors for low income families, and community events to educate the public on laws relating to helmet use and injury prevention education, represent positive health promotional activities currently practiced in Oneida County. We are still faced with challenges in improving health outcomes as a result of language and cultural barriers, a disregard for the seatbelt law by some individuals (believing it infringes on their personal rights), and an inadequate advertisement for promotion of helmet giveaways.

SAFETY AND INJURY PREVENTION GOALS AND OBJECTIVES:

OBJECTIVE:

Increased seatbelt use in our community

STRATEGY:

- Provide more education in our community in languages that represent the different cultures
- Show the correlation between serious injury and death with nonuse of seatbelts
- Plan to include this information with each and every health fair and health promotion event

OBJECTIVE

Will plan to target rural areas in our local community. Barriers to this population include lack of income and transportation.

STRATEGY:

- Will provide education at health fairs in rural areas
- Plan Bike Rodeo Event in the rural areas with advertisement prior to event.

OBJECTIVE:

Increase education regarding the importance of functioning smoke detectors in homes

- Provide education @ health fairs and community events
 - Provide free smoke detectors to income eligible county residents
- Seek out funding to increase smoke detector distribution to the rural areas of Oneida County

4. EXERCISE AND NUTRITION

Physical Fitness: According to the 2003 New York State BRFSS, the number of adults who engage in moderate activity appears better than average for Oneida County. While the HP 2010 target rate is at least 50% of adults who engage in moderate activity, adults over 18 in Oneida County already exceeds that goal. 77.3% of adults in Oneida County report that they have engaged in moderate leisure time activities or exercise within the past 30 days. This percentage is above the state average of 70.3%. 22.7% of the adults in Oneida County report no exercise within the past 30 days as compared to the state average of 22.4%.



Weight Control: Nationally and in New York State, overweight is a widespread problem among nearly all segments of the population and the prevalence has increased dramatically in recent years as cited in New York State's 2003 BRFSS. Only 38.3% of the population of Oneida County are considered to be at a healthy weight, while 61.7% of adults are considered to be overweight or obese. This figure is relatively high compared to state data of 36.8% being overweight and the HP 2010 target of 60%. Children however statistically are doing better in Oneida County. Only 7.6% of children ages 2-4 are considered overweight compared to the state data of 11.6%. The percentage of children ages 0-4 who are considered to be underweight is 1.6% in Oneida County compared to state data of 2.8%.

HEALTH PROFILE

Nutrition/Diet: Dietary habits are learned early in life and are strongly influenced by our social environment. Various efforts need to be made to encourage eating habits consistent with the dietary guidelines for Americans, specifically by increasing the consumption of fruits and vegetables to 5 or more per day. Only 23.8% of Oneida County residents met the goal of eating 5 or more fruits or vegetables a day according to the 2003 NYS BRFSS data, which was slightly lower than the state's rate of 27.5%.



EXERCISE AND NUTRITION GOALS AND OBJECTIVES:

For goals and objectives for, **Exercise and Nutrition** see **Strategies for Health Improvement** Section.

5. PREVENTIVE HEALTH SCREENING

Blood Pressure and Cholesterol Screening: Heart disease is the number one cause of death in all people in the United States. Heart disease is also one of the major causes of disability. Statistical studies have identified a number of factors that increase the risk of heart disease, especially Coronary Heart Disease (CHD) that accounts for the greatest proportion of heart disease. High blood pressure, which is known as the “silent killer” has been identified as one. Blood pressure is considered high if an average (among 3 blood pressures) is 140/90 or more. High blood cholesterol, total cholesterol of 240mg/dl or more is another. Screening for risk factors, specifically high blood pressure and high blood cholesterol is an important tool in identifying and preventing, illness, disability, and death from heart and other diseases.

Approximately 50 million adults in the United States have high blood pressure. High blood pressure was listed as the primary cause of death for almost 43,000 people in 1999. High blood pressure is more prevalent among older people, 50 and over. A great percentage of people afflicted with the condition are unaware of it. Approximately 90 million adults have elevated blood cholesterol levels, with 50 million requiring medical attention and treatment. Adults aged 20 and older should have cholesterol levels checked at least once every 5 years. Monitoring levels can reduce or lower CHD risks. Clinical studies have proven that lowering cholesterol reduces illness and death from CHD and reduces overall death rates.

High blood pressure rates increase with age. Forty-two percent of the population 65 and older suffers from high blood pressure. African Americans demonstrate higher rates than their counterparts. The number of existing cases of high blood pressure is nearly 40% higher in African Americans than in Whites and its effects are more frequent and severe in this population. People with the highest income and education levels had significantly lower rates. The greatest discrepancy in screening rates is seen between the White and Hispanics.

In New York State, the total adult population suffering from high blood pressure has not changed significantly since 1990: from 21% in 1990 to 23% in 1999. Nearly 23% of the population in New York State was estimated to have high blood pressure exceeding the HP2010 objective (16%) and the rate for high blood pressure screening for adults in NYS of 9.6% was just below the HP2010 objective of 95%. These findings substantiate the need to implement strategies to improve blood pressure screening rates and decrease high blood pressure disease.

In 1999, approximately 72 % of New Yorkers were screened for cholesterol. Gender had no impact on the incidence of cholesterol screening. Adults aged 18-40 are more likely to have never been

HEALTH PROFILE

tested. Screening rates were substantially lower for Hispanics than for Whites. The African American population rates were similar to the White population. The highest screening rates occur within the highest income and highest education categories.

Detecting and lowering cholesterol has been proven to reduce the risk of heart disease. A 1% decline in cholesterol results in a 2% decline in the risk of heart disease.

Locally, the Oneida County Health Department (OCHD) offers health and disease prevention programs through a variety of activities. Services include: employee physicals that include blood pressure checks, health counseling, and referrals as needed. Clinic services include health histories, laboratory tests, physical assessments, nutrition, and counseling. The OCHD also offers chronic disease education to both the public and its patients. The OCHD and community members formed the Coalition for Tobacco Concerns to promote and educate regarding smoking cessation for the purpose of disease prevention. The OCHD established the Healthy Heart Coalition in 1998 with the goal of increasing community awareness to heart disease and implement strategies to achieve a healthy heart. Other community agencies have also contributed to this cause such as the local hospitals and associated clinics. They provide patient education, screenings, support services, and sponsor programs dedicated to chronic diseases prevention. Some activities include regularly scheduled blood pressure screening clinics throughout the community, mall walks, cholesterol screening, etc. The American Heart Association (AHA) offers a large venue for outreach and education including annual health fairs with blood pressure and cholesterol screening. The AHA provides many resource materials on nutrition, fitness, hypertension, cholesterol, and other related subjects.

Colorectal Screening: A reduction in new cases and CRC deaths can be achieved through diligent efforts to promote early detection and treatment within the first stages of disease. The most commonly used methods for early detection include, the fecal occult blood test (FOBT), sigmoidoscopy, and barium enema and colonoscopy for diagnostic testing. The finding from three controlled studies indicated that biennial screening with FOBT could reduce deaths from CRC by 15 – 21% in people ages 45 – 80 years. One trial reported a 33% reduction in deaths with annual screenings for the same age group (Healthy People 2010 – Ca). Sigmoidoscopy procedure studies have proven to reduce CRC deaths by 59 – 79%, when the cancer was in reach of the sigmoid scope.

Mammography: Studies have proven that the death rates in women nationally and locally can be reduced significantly if the tumor is diagnosed and treated early. Women aged 40 and older need to comply with screening recommendations. Mammography has been found to be the most effective means of detecting and diagnosing tumors. Clinical trials demonstrated that mammography screening could reduce breast cancer deaths by 20 – 39% in women aged 50 to 74 years and 17% in women aged 40 – 49 years (Healthy People 2010 – Ca). Black females demonstrate slightly lower mammography testing rate than Whites. Hispanic women also have lower testing rates. Women with the highest education and income levels have the greatest incidence of testing.

PREVENTIVE SCREENING GOALS AND OBJECTIVES:

For goals and objectives for, **Preventive Screening** (Heart Disease and Cancer) see **Strategies for Health Improvement** Section.

HEALTH PROFILE

6. SEXUAL ACTIVITY AND RELATED SCREENING

Sexual Behaviors: Adolescent sexual activity can have life-changing or life-threatening consequences. A variety of diseases can be transmitted through sexual intimacy, including Chlamydia, trichomoniasis, gonorrhea, human papilloma virus, genital herpes, syphilis and HIV.

HIV Testing: There are currently 10.1 newly reported cases of HIV/AIDS cases per 100,000 in Oneida County as reported by NYS AIDS Epidemiology, 2001-2002 data. These figures are above the New York State rate of 8.4 per 100,000 cases. Oneida County ranks second highest to Onondaga County for newly diagnosed cases of this disease. Healthy People 2010 target goal is 1 case per 100,000. The percent of HIV positive newborns for Oneida County is 1.2%; slightly below the state rate of 3.7% nonetheless practicing safe sex is an important method in reducing transmission of HIV. Education towards that goal is imperative.

STD Testing: The Oneida County Health Department provides screening and treatment for gonorrhea, Chlamydia and syphilis. Visits are confidential and there is no charge. Walk-in clinics are available.

F. HEALTH CARE DELIVERY AND ACCESS TO CARE

Access to health care is generally considered to be an important determinant of health status in a community. An individual's ability to access quality health care represents a critical element towards eliminating health disparities and detrimental health outcomes while enhancing the quality of life for all persons within our community.

Various factors present significant implications for at risk and vulnerable populations and their ability to access quality care.

In Oneida County, as well as throughout New York State and across the country, we find ourselves faced with changing economic, social, technological, medical, cultural, political and market forces, the rise of managed care as a dominant service

delivery model, consolidation of health care services through alliances and mergers, and the trend toward privatization of public sector services. These various factors present significant implications for at risk and vulnerable populations and their ability to access quality care.

The breadth and scope of services (primary, secondary, and tertiary) within the local public health care system and the continuity of care across these system's components, coupled with financial, structural and personal barriers affect the availability, affordability, accessibility, and effectiveness of the services that our residents receive and, subsequently their overall health and well being.

Clinical preventive care, primary care, emergency services, long-term and rehabilitative care, specialty, and hospital care comprise the major components of the scope of care of the public health care system. Ample access to the programs and services provided by these key system components could increase health care system utilization and in due course improve health outcomes.

Three common barriers exist that create health disparities and impede the access and utilization of quality health care:

- Financial – the inability to pay for health care due to a lack of health insurance, or under insured or limited coverage on insurance plans,
- Structural – includes a shortage of health care providers, lack of facilities, lack of a usual source of care, and practice environments that fail to facilitate prevention
- Personal – includes a lack of knowledge about health care services, literacy level, cultural differences, language differences, skepticism about the efficacy of certain services or programs, and environmental challenges for people with disabilities.

HEALTH PROFILE

These barriers affect certain populations disproportionately. For example, nationally, among the population under 65 years of age, 33% of the individuals of Hispanic descent lack insurance coverage. Likewise, adults below the poverty level are less likely to have insurance coverage.

Additionally, adults with lower-than-average reading skills are less likely than other Americans to get potentially life-saving screening tests such as mammograms and Pap smears, to get flu and pneumonia vaccines, and to take their children for well child care visits.

1. CLINICAL PREVENTIVE SERVICES

People must have access to clinical preventive services that are effective in preventing disease (primary prevention) or in detecting asymptomatic disease or risk factors at early, treatable stages.

In Oneida County, clinical preventive services are available through the local health department, health care provider networks and independent care providers, especially in the urban areas of Utica and Rome. However, information is currently lacking to adequately determine whether or not existing clinical preventive services are accessible and sufficient to meet the needs of our residents. Although services may be available through existing clinics, access to these clinics may be hindered due to factors including a lack of insurance (16% in Oneida County), lack of awareness of available services, location of clinic sites, or cultural differences and language barriers.

A survey conducted by Hamilton College for the HOPE IV project in Utica revealed that 38% of those surveyed were not aware of services and programs, including health care, within their community. This is significant considering both the Oneida County Health Department and the St. Elizabeth Hospital's Hobart Street Clinic are located within and serve this specific community. In this same survey, 19% or approximately one out of every five individuals surveyed indicated that they would participate in a health care center if it were provide at low or no cost (HOPE IV Neighborhood Surveys, December 2003).

Numerous ambulatory care clinics (or walk-in clinics) exist in the County through such healthcare providers systems as Faxton-St. Luke's Healthcare and St. Elizabeth's Medical Center.

The Oneida County Health Department operates a Diagnostic and Treatment Clinic, performs health screening and health promotion activities, along with diagnosis and treatment or referral for treatment. In addition, education is provided to schools and colleges, healthcare providers, public safety workers and the general public from two sites (Rome & Utica).

Despite the advent of Medicaid Managed Care, the Oneida County Health Department continues to see steady client numbers. As a Medicaid Managed Care provider, the health department continues to be a referral source for agencies seeking specialty care for TB, along with immunization expertise. Oneida County healthcare providers generally are profit-driven and continue to refer both insured and uninsured patients for TB, STD and Immunization services to Oneida County Health Department.

Clients seeking new employment will appear in need of an affordable and timely (can not wait six weeks for an appointment) physical exam and vaccine in order to begin work. Mothers with sick children will appear knowing the emergency room is not the place to go, yet have not learned to access the medical system. They may be insured, through Medicare, Medicaid or Medicaid Managed Care but meet a 2-3 month waiting period before their new provider can see them. Teaching patients how to utilize their health insurance is essential. Until residents learn how to use the public health system, they continue to need alternative care.

Oneida County Health Department contains a refugee resettlement agency. It is located within blocks of the Public Health Clinic. As the first stop for medical care, the clinic becomes a comfort zone for new arrivals. Bilingual staff along with the care received makes the clinic a resource for new

HEALTH PROFILE

arrivals. They continue to return for guidance in many regards during their resettlement process. Again, one-on-one education, which requires bilingual staff, flexibility and accessibility, is key to a successful resettlement process.

2. PRIMARY CARE

Healthy People 2010 identifies that having a primary care provider as the usual source of care is a critical factor in accessing need health care services. Through a primary care provider individuals are able to avail a myriad of services.

Although there are many primary care providers in Oneida County, only 0.9 physicians per 1,000 residents accepts Medicaid as a payment source for health care. As the number of individuals on Medicaid increase, the ability for these individuals to visit a primary care provider and establish an ongoing physician/patient relationship will diminish.

Oneida County has designations for both a Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA) for several areas throughout the county, especially in the surrounding rural areas. Geographical, population-to-practitioner ratio, resource over-utilization, excessively distant or other wise inaccessible site locations represent some of the factors used to determine these designations. Remote rural populations are more at risk for having worse access and receiving poorer quality care.

The number and proportion of members of local racial and ethnic groups who are primary care providers represents an important aspect of accessing quality care. The constant influx of refugees through Mohawk Valley Refuge Resource Center presents an ongoing challenge of providing, not only health care, but also in identifying and building a local base of primary care providers representative of these diverse refugee populations.

3. EMERGENCY CARE

Emergency Medical Services: Oneida County Pre-Hospital Emergency Medical Services is provided by a combination of career, volunteer and combination agencies. Responses to medical emergencies are delivered in a tiered type response, generally the closest basic life support (BLS) agency, responds to the emergency followed by an advanced life support (ALS) ambulance. The county is divided into districts, with assigned fire / ambulance agencies responsible for responses in those areas. The placement of nearly 80 public access automatic external defibrillators (PAD sites) has also had an impact on emergency care in Oneida County. These sites include schools, industry, fire/rescue, and law enforcement.

Patients requesting EMS in Oneida County are routinely transported to Emergency Departments within the county. Faxton-St. Luke's Healthcare and St Elizabeth in Utica and Rome Memorial in Rome, all three hospitals participate in establishing pre-hospital protocols and have developed cooperative agreements for multi casualty incidents (MCI).

The Oneida County Health Department has contracted with Faxton St. Luke's to provide training and coordination of emergency medical services within the county, this is carried out in conjunction with Oneida County Emergency Services by the appointment of an EMS Coordinator and 2 Deputy Coordinators.

Oneida County Fire and EMS agencies have established an advisory committee made up of members of various levels and types of Fire and EMS agencies, County Health, and County Emergency Services. The purpose of the committee is to "cooperate with state, regional and local agencies as related to EMS issues" and has become an important part of emergency services within our county. Currently the group has addressed delays in EMS responses and mutual aid plans.

**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

TABLE 22 - COURSES IN ONEIDA COUNTY

	<u>Courses</u>	<u>Students</u>
Certified First Responder	2	18
Emergency Medical Technician	10	189
Advanced AEMT – CC	2	24
Paramedic AEMT-P	2	52
American Heat Association	384	3,116
Basic CPR		
American Heart Association ACLS	8	79
American Heart Association PALS	8	109

Oneida County EMS Agencies respond to nearly 45,000 responses annually, the exact number of responses is difficult to determine given three separate Public Safety Answering Points (PSAP) and commercial ambulances responses not tracked by any PSAP. The New York State Department of Health has determined 756 EMTs currently reside in Oneida County, of those 264 provide advanced pre-hospital care.

Currently ten ambulance services are located in Oneida County, five independent volunteer, three commercial, one fire department, and one government ambulance provide service to the county. All commercial services provide “in-house” responses and the remaining agencies provide varying levels of availability bases on volunteer responses. All Oneida County Ambulance Services are certified by the NYS Department of Health and are authorized to provide ALS service. Fifty-two, first response fire department rescues provide differing levels of care from certified first response (basic life support) to Paramedic Care. Two career Fire Departments (Utica and Rome) provide first response with in-house responses and the volunteer agencies depend on availability of members for responses.

Pre-Hospital Emergency Medical Services are coordinated through the state appointed Resource Hospital, Faxton-St. Luke’s Healthcare. Training is provided via the Faxton-St. Luke’s Course Sponsorship these courses offered include Certified First Responder, Emergency Medical Technician, Critical Care Emergency Medical Technician, and Paramedic (Table 22). These New York State Certification courses are conducted throughout the county and provide training to more than 200 students each year. St. Elizabeth Hospital, the state designated Trauma Center, offers pre-hospital trauma training throughout the year. Both Professional and community CPR is taught monthly. Specialty courses include emergency driving and emergency care of pediatric patients is provided as needed or requested.



The EMS Advisory Committee, County Health, Emergency Services and the Coordinators are monitoring recent changes in ambulance dispatch protocols, mutual aid / MCI coordination, and recruitment and retention of volunteer EMS providers. Continuing and advanced training in the following areas will be instituted this year; Incident command, haz-mat and bioterrorism in addition to drills preparing EMS responders to large scale events.

Emergency Departments: Federal law requires Emergency Departments to evaluate anyone seeking care and to at least stabilize the most severely ill and injured patients. Additionally, EDs provide walk-in care for a number of persons who face financial or other barriers to receiving care elsewhere.

On December 12, 2004, the Faxton Hospital facility converted its ED to an urgent care facility. Emergencies are now transferred to the newly enlarged St. Luke Hospital emergency room facility located nearby. With this transfer, three hospitals St. Luke’s and St Elizabeth in Utica and Rome Memorial in Rome, provide emergency services to the county.

Emergency Department visits data have remained relatively constant over the past four years as depicted in the Table 23.



**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

Age cohort further delineated the Rome Memorial Hospital emergency department visits data. Upon review of the cohort data, it was observed that emergency visits for infants have significantly decreased over the seven-year period from 629 in 1997 to 296 in 2003. In contrast, emergency department visits by individuals 65 years of age and older have increased during this same time period.

The recent conversion of the Faxton facility to an urgent care facility, shifting emergency services to the St. Luke facility will impact access to health care in Oneida County. The nature and extent of that impact will need to be determined.

4. TERTIARY AND SPECIALTY CARE

The findings presented in the December 2003 National Report of Healthcare Quality explained that although the overall health care system is performing well in many areas, there are opportunities for improvement. Two of the key findings include missed opportunities for preventive care and challenges associated with ensuring quality preventive and curative health care for chronic conditions such as cancer, diabetes, and congestive heart disease.

At all levels, national, state, and county, a considerable emphasis is placed on medical treatment of illness after it occurs, rather than preventing it before it begins. An April 2003 quote by Secretary Thompson summarizes this reality:

“Approximately 95% of the \$1.4 trillion that we spend as a Nation on health goes to direct medical services, while approximately 5% is allocated to preventing disease and promoting health. This approach is equivalent to waiting for your car to break down before you take it in for maintenance. By changing the way we view our health, the Steps initiative helps move us from a disease care system to a true health care system.”

An increase focus on prevention both in the hospitals and during office visits can save more lives and resources. For example, smoking and its relationship to chronic diseases such as cancer and heart disease is well established. Yet, national data on routine office visits in 2000 reveal that 38% of smokers were not counseled by their doctors to quit smoking. The percent was even greater for acute heart attack patients who smoke (58%). Advice to quit smoking to hospitalized acute heart attack patients is associated with a 50% quit rate at 1 year, compared to a 1 year quit rate of 8% in ambulatory settings.

Four physical hospitals, three in Utica and one in Rome, serve Oneida County. Three of the four hospitals provide acute care services, and each individual hospital has its own specialty services.

St. Elizabeth's Medical Center is a Level II area Trauma Center. Injury Prevention is a major focus of the Trauma Department. St. Elizabeth Medical Center provides the area with an array of services such as primary care facilities, emergency care services and prenatal clinics. There is a Family Practice Residency Program at St. Elizabeth.

Table 23 - Emergency Department Visits

Hospital	2000	2001	2002	2003
Rome Memorial	18,512	18,741	18,538	19,165
St. Elizabeth	NA	22,345	21,403	21,455
Faxton-St. Luke's	40,592	39,661	40,325	40,715

Rome Memorial Hospital provides general medical-surgical care, 24-hour emergency care, obstetric, pediatric, long-term care, physical therapy and rehabilitation, laboratory and medical imaging, pain management and alcohol and substance abuse services.

HEALTH PROFILE

Faxton/St. Luke's Hospital (FSLH) provides a variety of specialty services such as maternity care, pediatrics, psychiatric care, renal dialysis and long term care. They also provide a Level II nursery, which helps parents in our area access, a higher level of care. Infants who need Level I care are sent to the Perinatal Center at Crouse-Irving Hospital in Syracuse. As part of its ongoing re-organizational efforts, Faxton-St.Luke's recently decided to convert the Faxton Campus from an acute care facility to an urgent care facility. After December 12, 2004 individuals in need of emergency services after this date will need to use the St. Elizabeth Medical Center or the St. Luke's Campus, which has expanded their emergency room to accommodate the change.

The Faxton Campus operates the Cancer Center for the community, which opened in 1999. The center provides access for outpatient cancer care with state-of-the-art equipment. Both inpatient and outpatient visits at the Regional Cancer Center have increased significantly over the past few years. This trend is evidence that fewer patients are leaving the area for treatment, and recognition that the Regional Cancer Center has the components necessary to provide state-of-the-art Cancer care. These include advanced technology, inpatient oncology unit, and a highly skilled staff with specialized training in Cancer care.

The Mohawk Valley Heart Institute is a cooperative venture of Faxton-St.Luke's Healthcare (FSLH) and St. Elizabeth Medical Center. MVHI provides cardiac surgery and coronary angioplasty, cardiac catheterizations, and rehabilitation services.

Traditionally, the hospital care providers have focused on secondary and tertiary care. In recent years they are shifting more focus towards disease education and prevention activities. A FSLH market survey revealed a low level of awareness about stroke and factors contributing to this disease. In response to these findings FSLH will be focusing more efforts towards awareness and prevention-related activities regarding Stroke. The St. Elizabeth Trauma Center spearheads injury prevention education and programs aimed at senior citizens, an important preventive measure whose demand will steadily increase as our county population ages. Rome Memorial Hospital has directed prevention activities towards areas of anti-smoking and increased physical fitness and diet. Likewise, the Mohawk Valley Heart Institute, which has focused primarily on treatment, will be increasing activities aimed at prevention.



In Oneida County, as elsewhere throughout the nation, are challenge to improve the management of chronic disease will require healthcare providers to expand our examination of individual measures of quality for these diseases (e.g., annual foot exams for diabetics) to evaluate related measures as well (e.g., lack of exercise and obesity).

5. LONG-TERM & REHABILITATIVE CARE

People in the long-term care population need access to a range of services, including nursing home care, home health care, adult day care, assisted living, and hospice care.

In 2000, the U.S. Department of Health and Human Services released statistics on the changing demographics indicating "the average life expectancy for the U.S. population reached 76.9 years". In 2001, the Agency for Health Care Research and Quality estimated: "By 2011, 77 million people will turn 65; by 2025 Medicare benefits are expected to reach 69.3 million or 20% of the U.S. population, with those (people) 80 years or older being the fastest growing segment of the population". During the 2001 report of the Administration on Aging's; "A Profile of Older Americans", they found that while only "1.56 million of the 65+population lived in nursing homes, the percentage increases dramatically with age ranging from 1.1% for persons 65-74 years, to 4.7% for persons 75-84 years, and 18.2% for persons 85+"years. These demographic changes and the inherent costs associated with skilled nursing facility placement will put increased pressure on states and local governments to increase access to long term home health care programs and services.

HEALTH PROFILE

In Oneida County, 19 skilled nursing homes provide long-term care. The 60 plus population is steadily rising in Oneida County and in New York State which will increase our need for long term care beds.

Adult Care Service is provided at 12 centers around the Mohawk Valley. These programs are designed to meet supportive needs of the elderly living at home and provide respite for caregivers. Transportation is provided when needed.



Home Care Services: Emerging national trends in the home health care marketplace will create a major paradigm shift in the delivery of health care in the United States in the coming decades.

Changing demographics, financial incentives to increase the number of private Medicare Advantage plans, changes in reimbursement methodology, the continuing shortage of nurses, and the advent of new technologies will drive the changes in the National Home Care market through year 2040.

As the traditional payers for services to the elderly and disabled, Medicare for homebound patients and Medicaid for many patients in skilled nursing facilities as well as in the long term care sector; and with the predicted changes in aging demographics, it can be expected that the increasing demands for services will increase the costs of providing skilled nursing facility and home health care services at all levels of government. The Congressional Budget Office (CBO) estimates: “that inflation-adjusted expenditures for long-term care for the elderly will grow annually by 2.6 percent between 2000 and 2040”.

In 2003, the Medicare Modernization Act provided risk sharing incentives for insurance carriers to increase Medicare beneficiary enrollment in managed care programs, such as Health Maintenance Organizations (HMO), local Preferred Provider Organizations (PPO), Private Fee for Service Plans (PFFS), and Medicare Advantage (MA) plans. Further, by January 1, 2005, the Center for Medicare Services (CMS) will have established Regional MA’s defined as “ PPOs that cover an entire CMS defined region including urban and rural areas”. Regional Medicare Advantage plans will be able to offer additional services to Medicare beneficiaries along with the requirement to provide Medicare Part A and Part B coverage as well as the new prescription drug benefit. CBO estimates: “that private insurance spending for long-term care will rise during the 2000-2020 period”. The rise of private insurance carriers in the long-term care market and the development of Medical Savings Accounts (MSA) will likely increase rates of home health care service utilization as the cost to the individual health care consumer decreases.

In 2006, the current reimbursement method using the Adjusted Community Rate Proposals (ACRP), will be converted to a plan bidding process. Regional Medicare Advantage plans as well as other large long term insurance providers will have the clout and numbers to demand lower rates of reimbursements for services to its members. Home health care providers already struggling to remain profitable with the 2.4% reduction in inflation adjusted reimbursements will need to be prepared for further belt tightening as the Medicare Advantage incentives encourage more patients to enroll in managed care plans. Managed care plans which often require pre-authorized permission for a limited number of home care visits have as Carolyn Markey, President & CEO of Visiting Nurse Associations of America (VNAA) stated: “(Medicare managed care plans) offered less access to home healthcare than traditional Medicare”. Home health care agencies will need to sharpen their care planning skills to cope with the decreased number of home care visits they will be permitted during the care episode while the CMS system continues to demand accountability in the form of tracking outcome measurement data.

HEALTH PROFILE

The growing and persistent shortage of qualified registered nurses will occur at the same time there is an increased need for their services. The Bureau of Health Professions estimates “by 2020, there will be a national shortfall of 808,000 nurses”. The current nursing profession is 94% female, and primarily non-Hispanic Caucasian. Young women today have many more career choices and nursing is increasingly viewed as a high stress and thankless profession. The Baby boomer generation will turn 65 in 2011, this generation has supplied the largest number of nurses and they will retire out of the health care system along with their fellow Baby boomers at a time when there is an increased demand for healthcare in general, and home care and long term care programs specifically. Efforts to ease nursing shortages will need to be multi-faceted including recruiting all minorities and especially underrepresented members of Hispanic and African American students to attend nursing programs, recruiting more males to the profession, offering educational opportunities through incentives including interest free loans and grants, changing the work environment, and making changes in the health care market which treats nurses as commodities rather than assets.

The advent of new technologies including tele-home care, i.e., “providing monitoring (telemetry) and home health care services at a distance,” may permit access to quality health care to patients in urban and often under served rural communities while allowing for higher patient to nurse ratios, permitting continuity of care, and encouraging increased rates of patient engagement in their care and compliance with their medical and nursing regimens.

The growing and persistent shortage of qualified registered nurses will occur at the same time there is an increased need for their services.

In a report from the Workshop on Home Care Technologies for the 21st Century it stated “studies show tele-homecare can save money by decreasing unnecessary hospital and emergency room admittances”. Home care agencies that embrace tele-healthcare technologies will need to confront policy issues on what constitutes a patient visit by CMS standards and how tele-homecare visits will be reimbursed and calculated in their statistical patient outcome reports. Home health care agencies that are successful in these strategies should realize savings in direct costs through changes in staffing patterns, and improved productivity and an inherent decrease in costs incurred by travel time to patient’s homes. Home health care agencies who are unable to access these technological breakthroughs due to financial constraints may find themselves competing in an environment that judges them negatively by their non-competitive cost structures and their outcome reports which rely on measurements of emergent care, hospitalization, and length of stay rates; thus putting them at a distinct disadvantage to their more technologically proficient and endowed competitors.

The Oneida County Health Department operates a Certified Home Health Agency (CHHA), a Long Term Home Health Care Program (LTHHCP), and an AIDS Home Care Program (AHCP) providing home care services to clients throughout Oneida County.

The Certified Home Health Agency provides skilled nursing, home health aide, physical, occupational, and speech therapies, medical social work, and nutrition counseling to populations ranging from newborn to geriatric clients. Home care services are provided 24 hours per day, 7 days a week for acute and chronic health care problems. Adult client unduplicated census for the CHHA during the first three-quarters of 2004 was 379, with third quarter census of 128 clients. Maternal Child Health unduplicated census for CHHA for the first three-quarters of 2004 was 418 clients.

The Long Term Home Health Care Program serves clients with complex needs who would otherwise require skilled nursing facility placement. Services provided include nursing, therapies, and waived services. LTHHCP client unduplicated census during the first three-quarters of 2004 was 111 clients with a third quarter census of 57 clients.

The AIDS Home Care Program is part of the LTHHCP and serves clients with advanced HIV infection providing services for AIDS and related illnesses. Care is coordinated with other facilities to offer substance abuse treatment, and provide access to pastoral care, mental health services,



ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT

HEALTH PROFILE

dental health, and appropriate physician services. The OCHD's LTHHCP-AIDS census during the first three-quarters of 2004 was 2 clients.

The CHHA provides for functional assessments including the Performance Review Instrument (PRI) screen through its Assisted Living Program (ALP) for clients at the Loretto and Presbyterian Adult Homes. ALPS census for the third quarter of 2004 was 116 clients.

The CHHA is an approved provider for Early Intervention Services (EI) receiving referrals through the Early Intervention Program. The program provides services to children less than 3 years of age in the areas of nursing, therapies, and medical social work. Unduplicated census for EI clients receiving services by the CHHA was 70 clients.

The Visiting Nurse Association of Utica and Oneida County operates a Certified Home Health Agency and Long Term Home Health Care Program serving residents throughout Oneida County. With a main office in Utica, New York and their recent expansion in the city of Rome they have positioned themselves to better serve the northern and western Oneida County townships as well as the rest of Oneida County. While they have traditionally provided service to acute and chronically ill adult to geriatric populations they have recently hired a pediatric home care nurse and are accepting referrals for ill children and making home visits to at risk newborn and young children for Synagis injections. Services provided include skilled nursing, home health aide, therapies, medical social worker, and nutritionist. Services are provided 24 hours a day, 7 days a week. With an average daily census of 700 adult patients, its affiliation with the Mohawk Valley Network and its expansion into Telemedicine, the VNA is the largest provider of home care services in Oneida County.

St. Elizabeth's Home Care is a hospital based Certified Home Health Agency serving clients in the greater Utica area with recent expansion into western Oneida County. They provide nursing, home health aide, therapies, and MSW services to acute and chronically ill adult to geriatric client populations. They have recently hired a pediatric home care nurse and are accepting referrals for at risk pre-mature infants and children in need of Synagis injections for the prevention of RSV.

Acacia Home Care of the Masonic Home purchased the Certified Home Health Agency medallion from St. Regis Home Care in mid 2004. They are currently serving 14 acute and chronically ill clients in the greater Utica area with services provided 24 hours a day, 7 days a week.

Senior Network Health is a program of the Mohawk Valley Network. It serves clients who are at least 21 years of age and are in need of a managed long-term health care plan due to chronic or disabling diseases. It is located in Utica, New York and offers services throughout Oneida County. Services include case management, transportation, prescriptions, dentistry, podiatry, social/environmental supports, medical or social Adult day care services, personal care, chores, meals, optometry, audiology, and licensed home health care. Additional services coordinated by Senior Network Health include home health care- certified, medical specialists, durable medical equipment, acute care, emergency room care, primary care, rehabilitative skilled nursing facility care, radiology, laboratory and ambulance services. Personal Emergency Response Systems (PERS) are also available.

Additional agencies providing home care services in Oneida County include AmeriCare, Caregivers, Central Home Care, Family Home Care, Mohawk Valley Home Care, Oxford Home Care Services, and U.S. Care Services serving the greater Utica area. Cathie Lee's Home and Health Care servicing the Sylvan Beach, and western Oneida County areas, Comfy Care and Connie's Caring Companions serving western and southern Oneida County, and HASCA serving the northern Oneida County townships.

HEALTH PROFILE

6. DISPARITIES IN ACCESS TO CARE

Financial Barriers:

Insurance Coverage - The 2004 OCHD Health Survey included several questions on health care delivery and access to health care services.

The results of the OCHD survey are consistent with the state BRFSS results for health insurance coverage rate for individuals 18 to 64 years of age in Oneida/Oswego counties (84.6%). Within the eight-county regional assessment, only Herkimer County registered a lower rate (83.5%). However it should be noted that both the rates for Oneida and Herkimer were presented as a group rate for two or more counties. Actual rates may be slightly higher or lower than the combined average. Although the Oneida County rate was higher than the state and national rate (83% respectively), it remains significantly below the Healthy People 2010 target of 100%.

Percent uninsured under age 18 - In New York State, the percent of individuals under the age of 18 that lacked medical care insurance between 1994 and 2003 decreased from 14.1% in 1994 to 9.4% in 2003. Estimates from the 1997 Census Population Survey placed the percentage of children in Oneida County that were uninsured or underinsured at 16% (n = 10,026). The Oneida County percentage (16%) is slightly higher than the percentage for New York State (15.5%) in 1997.

Several factors contribute to the percent of insurance coverage for children under 18 years of age, including:

- age (children 16-18 less likely to be insured),
- nativity (native born more likely to have insurance than foreign born),
- ethnicity (Hispanics less likely to be insured),
- income to poverty ratio (less than 100% are more likely to be uninsured),
- urban vs. rural (children in central cities less likely to be insured),
- education level of parent (higher education attained are more likely to have insurance)
- parent's marital status (married couples most likely to have insured children)

Data is currently not available at the county level that breaks down the insurance coverage for the factors listed above.

Percent Medicaid or self pay at delivery - The proportion of women using Medicaid as the form of payment for giving birth increased steadily between 1999 and 2003 in Oneida County from 39.9% to 46.7% during this period. Furthermore, in Oneida County, women with private insurance were far more likely to obtain early prenatal care than women who used Medicaid for insurance.

Medicaid Acceptance - The total number of individuals who were Medicaid eligible in Oneida County rose from 31,277 in July 1999 to 42,098 in July 2004, representing a 35% increase.

In the Central New York region, acceptance of Medicaid as a payer source for dental services represents a major barrier to accessing oral health care. Six out of the eight counties, including Oneida County do not have dental providers who accept Medicaid. Oral diseases and conditions disproportionately burden individuals, especially children, with low socio-economic status.

In Oneida County, the ratio of primary care providers who accept Medicaid is 0.9 per 1000.

The number of doctors and dentists that accept Medicaid is difficult to determine due to the managed care contracts that give access through that mechanism. Additionally, providers may have Medicaid provider numbers, but may not be accepting patients.

Employee Insurance Trends - A 2004 report by the Kaiser Family Foundation and Health Research and Educational Trust marked another year of continued employee sponsored health

HEALTH PROFILE

insurance premium increases. Should this trend continue, businesses will likely increase employee contributions, making it more difficult for working individuals to provide insurance to themselves and their families.

7. STRUCTURAL BARRIERS

Medically Underserved Area: In Oneida County, fourteen census tract areas, thirteen (13) within the City of Utica and one in the City of Rome, are designated as Medically Underserved Areas (MUA). The ratio of primary medical care physicians per 1,000 population, infant mortality rate, percent of the population with incomes below the poverty level, and the percentage of the population age 65 and over represent the four weighted variables whose cumulative score determines its MUA designation. These variables for Oneida County are as follows:

- In Oneida County, the ratio of primary care providers who accept Medicaid is 0.9 per 1000.
- Infant mortality rates between 2000-2002 position Oneida County with the second highest rate (8.9 infant deaths per 1000 live births) behind Cortland County (9.2 infant deaths per 1000 live births) in the regional assessment. This rate is higher than the state rate of 6.3 deaths per 1000 live births, and significantly higher than the Healthy People 2010 target of 4.5 per 1000 live births.
- The percent of people with incomes below the poverty level has increased slightly between the 1990 and 2000 census reports, from 12% to 13%, respectively.
- Among New York State counties with similar populations, Oneida County has the highest percentage of population 65 years and older. The 65 and older population has gone from approximately 11% of the population in 1950 to about 17% in 2000.

Health Professional Underserved Area: Currently, nine areas in Oneida County are designated by the Bureau of Primary Health Care's Division of Shortage Designation as a Health Professional Shortage Area (HPSA). The nine areas are Boonville Town, Forestport Town, Low Income – Rome PCSA, Floyd Town, Lee Town, Rome City, Verona Town, Western Town, and St. Elizabeth Medical Center. Geographical, population-to-practitioner ratio, and resource over-utilized, excessively distant, or other wise inaccessible constitute the criteria for an HPSA designation.

Routine physical exams within last 2 years: The majority of individuals within Oneida/Oswego Counties (86.6%) report having seen their doctor for a routine physical in the past two years. This is slightly less than the New York State percentage of 89.2%. Data is currently not available at the county level that breaks this information down further by age, gender, ethnicity, education or income.

In New York State, the percentage is highest among Blacks (95.1%) and lowest among Hispanics and other ethnic groups (86%). As a person's age increases they are more likely to see their doctor. Approximately 97% of individuals over the age of 65 have seen their doctor for a routine physical in the last two years compared with only 84% of those individuals 25-34 years of age. Also, individuals with higher level of education attained and higher household incomes were more likely to have had a routine physical exam within the last two years.

Time in past year when needed medical care and could not get due to cost: In Oneida/Oswego Counties, 5.5% of individuals 18 and older indicated that they could not get medical care due to cost. The percentage is lower in Oneida/Oswego Counties than compared to New York State (7.6%). Data is currently not available at the county level that breaks this information down further by age, gender, ethnicity, education or income.



**ONEIDA COUNTY HEALTH DEPARTMENT
2005-2010 COMMUNITY HEALTH ASSESSMENT**

HEALTH PROFILE

In New York State, the percentage is highest among Hispanics (18.6%) and lowest among Whites (4.2%). As a person's age decreases they are more likely to not get medical care due to cost. Approximately 1.6% of individuals over the age of 65 do not get care due to cost compared with 11.7% of those individuals 25-34 years of age. Also, individuals with higher level of education attained and higher household incomes were less likely to not get medical care due to cost.

Admissions for specific conditions: Hospitalization rates for conditions such as pediatric asthma, and uncontrolled diabetes provides insight as to unmet need for primary care. Higher hospitalization rates indicate primary health care access or utilization problems.

Between 1993 and 2002, 3-year average pediatric asthma (<5 years of age) discharge rates have increased from 521.4 in 1994, to 563.8 in 2001. The rate in Oneida County was consistently above the upstate New York State average during this time period. Although the rate is higher in Oneida County than the rest of the upstate area, the number of discharges between 2000 and 2002 has decreased from 100 to 61, a 39% decrease.

The 2002 rate of uncontrolled diabetes is higher in Oneida County (15.2 per 10,000) compared to the other seven counties in the region, except for Cayuga County (18.7). The rate in Oneida County is dramatically higher than the rate in the United State (7.4) and the Healthy People 2010 target of 5.4 per 10,000.

Although local data is currently not available, several additional factors contribute to accessing health care. These factors include urban vs. rural areas (e.g., fewer providers and personnel, broad geographic coverage and accessibility), the availability of support services (e.g., day care and respite care), lack of transportation, especially in rural areas, and piecemeal services requiring multiple services.

Immunization Services: Immunizations are provided to some extent by most providers, however, all vaccines are not available (varicella, meningococcal) due to storage and cost issues. Healthcare providers continue to refer patients to the Health Department for immunization services despite the patient's financial and/or insurance status. At present, no providers provide walk-in immunization clinics or travel vaccines.

Flu clinics are increasingly available through other agencies/organizations, however, as evidenced during the 2003 flu season, providers do not maintain adequate vaccine supplies. Consequently, the public relies on the Health Department to meet their flu vaccine needs.

TABLE 24 - OCHD IMMUNIZATION PROGRAM		YEAR			
Total	2000	2001	2002	2003	
<i>Immunizations</i>	15,705	15,387	15,500	14,610	

In 2004, the Oneida County Health Department achieved an immunization rate of 98% for two-year-olds seen in public clinics. This compares to 96% in 2003. The OCHD administered

7,644 influenza vaccinations to Oneida County residents in 2003, which was an increase of 14% from 2002 (6,699) – Table 24. Additionally, OCHD formed an Adult Immunization Coalition with Madison County to improve influenza and pneumococcal rates of adults.

8. PERSONAL BARRIERS

Refugee Population: Between July 1996 and June 1999, 10,398 refugees arrived in New York State (exclusive of New York City). Although refugee arrivals were on the rise during this time, the number of arrivals has significantly decreased since the terrorist events of September 11, 2001. Nevertheless, Oneida County resettles the most refugees in New York State. Over one thousand per year during this time period, 1996 - 1999.

HEALTH PROFILE

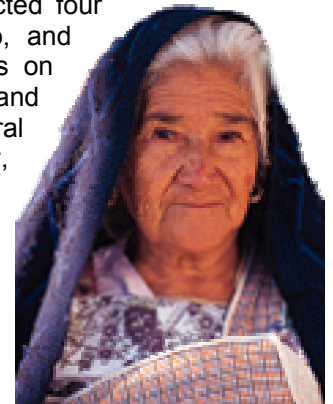
The refugee populations arrive with unique health issues, concerns, experiences and needs. A component of the refugee resettlement program necessitates an initial health screening for specific health conditions such as Tuberculosis, Hepatitis B, and Ova, Giardiasis, and Parasites.

Between 1996 and 1999, approximately 55% of the refugee population exhibited a positive TB skin test. During this same time frame, the percentage of refugee population demonstrating a positive Hepatitis B test increased from 1.9% in 1996 to 4.5% in 1999, approximately a 137% increase. Approximately 31% of the refugee population screened tested positive for ova and parasites in stool samples. Recently refugees have also been diagnosed with Giardiasis.

Refugee populations are a high-risk group for tuberculosis infection/disease. Timely health assessment and intervention can lead to periods of reduced infection and transmission of disease. Although Oneida County resettles, and subsequently provides a health assessment, to over a third of all the refugees arriving in NYS during this time period, 97% of the refugees' health are assessed within the first 120 days of arrival, with over 93% of the refugees receive a health assessment within the first 30 days of arrival.

Although Oneida County maintains a high percentage of refugees who have received an initial health assessment, individuals within these refugee populations still face challenges when accessing health care within the Oneida County Public Health System.

In February 2003, the Oneida County Health Coalition (OCHC) conducted four focus groups with four different groups (Vietnamese, Bosnian, Latino, and Russian) to find out if the health care needs of certain ethnic groups on Medicaid are being met. Three of the four groups (Vietnamese, Bosnian, and Russian) represent resettled refugee populations. Over the past several years a large Latino population has come to reside in Oneida County, moving up state predominantly from the New York City area. Each group was asked general questions about the health care they are receiving in Oneida County. The results of the focus groups are summarized in three areas below.



Healthcare in Country of Origin - In other countries, individuals would either try a home remedy or go to a doctor when they were sick. They reported that there was never a wait for a doctor's appointment. Physician care was either free or provided at low cost. Hospital care was provided at no charge by public hospitals. Individuals only went to emergency rooms for life threatening illness/injuries. They were provided care promptly in the emergency room.

Major Differences/Problems in Utica - Individuals voiced a variety of differences centered on common challenges that most Americans face in dealing with our health care system. Some included waiting to get doctors appointments, the higher cost of medical care, and long waiting in emergency rooms. Some reported having transportation problems getting to the doctor.

With regard to language barriers, some reported that the lack of interpretation and translation is a problem. They noted that medical care provided by doctors and nurses is good, but communicating with providers is often difficult because of language barriers. They also noted that telephone interpretation services are not always effective because of multiple dialects. They also reported that children are not good interpreters.

Several noted that dental services were difficult to secure because the provider was located in a different county.

Paperwork Problem -: While the suggestion was made that medical documents be written in multiple languages, three issues related to patient care were brought up. First, it was suggested that

HEALTH PROFILE

pain chart, medical history questionnaires, and other forms be written in multiple languages. Second, instructions for medications should be written in multiple languages. Lastly, it was suggested that providers be informed that although refugees/immigrants can speak English, they may not be able to read it.

Based on the knowledge gained from the focus groups discussions, the *ACCESS to Healthcare Information – For Culturally Diverse Populations* manual was developed and distributed to the various health care organizations throughout the community. The manual provides a key step towards improving access to health care services and information for culturally and linguistically diverse populations within Oneida County.

The two-part manual provides 29 important standard medical forms, Medicaid documents, and other health information translated into four languages – Bosnian, Russian, Spanish, and Vietnamese. The manual is organized to facilitate use and was made available to the health care industry in multi-media forms - a CD Disc, reproducible hard copy binder, and web-based access.

ACCESS TO HEALTHCARE GOALS AND OBJECTIVES:

For goals and objectives for, **Access to Healthcare** see *Strategies for Health Improvement* Section