

Prevention Agenda 2019-2024 Tracking Dashboard Technical Notes

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Definition of Indicators:

Improve Health Status and Reduce Health Disparities				
Indicator	Indicator Description and Note	Data Source	Program and Data Contact	Prevention Agenda Focus Area
<p>1- Percentage of deaths that are premature (before age 65 years)</p> <p>County Dashboard Tracking Indicator Number - 1</p>	<p>Percentage of deaths that occur before age 65 years</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov ov</p> <p>Data Contact: Vital Statistics Unit Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	<p>Improve Health Status and Reduce Health Disparities</p>
<p>1.1 - Premature deaths (before age 65 years), difference in percentages between Black non-Hispanics and White non-Hispanics</p> <p>County Dashboard Tracking Indicator Number - 1.1</p>	<p>The percentage of premature deaths before age 65 is calculated for both Blacks and White non-Hispanics. Then, the difference is the Black non-Hispanic rate minus the White non-Hispanic rate.</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov ov</p> <p>Data Contact: Vital Statistics Unit Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	<p>Improve Health Status and Reduce Health Disparities</p>
<p>1.2 - Premature deaths (before age 65 years), difference in percentages between Hispanics and White non-Hispanics</p>	<p>The percentage of premature deaths before age 65 is calculated for Hispanics and White non-Hispanics. Then, the difference is the Hispanic rate minus the White non-Hispanic rate.</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov ov</p> <p>Data Contact: Vital Statistics Unit Bureau of Health</p>	<p>Improve Health Status and Reduce Health Disparities</p>

<p>County Dashboard Tracking Indicator Number - 1.2</p>			<p>Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	
<p>2 - Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000</p> <p>County Dashboard Tracking Indicator Number - 2</p>	<p>The number of potentially preventable hospitalizations per 10,000 population aged 18+ years. The Prevention Quality Indicators (PQIs) are a set of measures developed by the federal Agency for Healthcare Research and Quality (AHRQ) for use in assessing the quality of outpatient care for 'ambulatory care sensitive conditions' (ACSCs). This indicator is defined as the combination of the 10 PQIs that pertain to adults: (1) Short-term Complication of Diabetes (2) Long-term Complication of Diabetes (3) Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (4) Hypertension (5) Heart Failure (6) Community-Acquired Pneumonia (7) Urinary Tract Infection (8) Uncontrolled Diabetes (9) Asthma in Younger Adults (10) Lower-Extremity Amputation Among Patients with Diabetes. Because the PQIs estimate the number of potentially avoidable hospital admissions, a lower rate is desirable. The rate is adjusted for age.</p>	<p>Statewide Planning and Research Cooperative System (SPARCS)^b</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p> <p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	<p>Improve Health Status and Reduce Health Disparities</p>
<p>2.1 - Potentially preventable hospitalizations among adults, difference in age-adjusted rates per</p>	<p>The rate of potentially preventable hospitalization is calculated for both Black and White non-Hispanics.</p>	<p>Statewide Planning and Research Cooperative System</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p>	<p>Improve Health Status and Reduce Health Disparities</p>

<p>10,000 between Black non-Hispanics and White non-Hispanics</p> <p>County Dashboard Tracking Indicator Number - 2.1</p>	<p>Then, the difference is the Black non-Hispanic rate minus the White non-Hispanic rate. Both rates are adjusted for age.</p>	<p>(SPARCS)^b</p>	<p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	
<p>2.2 - Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White non-Hispanics</p> <p>County Dashboard Tracking Indicator Number - 2.2</p>	<p>The rate of potentially preventable hospitalization is calculated for both Hispanics and White non-Hispanics. Then, the difference is the Hispanic rate minus the White non-Hispanic rate. Both rates are adjusted for age.</p>	<p>Statewide Planning and Research Cooperative System (SPARCS)^b</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p> <p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	<p>Improve Health Status and Reduce Health Disparities</p>
<p>3 - Percentage of adults with health insurance, aged 18-64 years</p> <p>County Dashboard Tracking Indicator Number - 3</p>	<p>The percentage of adults (aged 18-64 years) who reported that they had health insurance coverage.</p>	<p>U.S. Census Bureau - Small Area Health Insurance Estimates (SAHIE), http://www.census.gov/data-tools/demo/sahie/#/</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p>	<p>Improve Health Status and Reduce Health Disparities</p>
<p>4 - Adults who have a regular health care provider, age-adjusted percentage</p> <p>County Dashboard Tracking Indicator Number - 4</p>	<p>Age-adjusted percentage of adults (aged 18 years and older) who reported that they had a regular health care provider.</p>	<p>NYS Behavioral Risk Factor Surveillance System^c</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: BRFSS Program BRFSS@health.ny.gov</p>	<p>Improve Health Status and Reduce Health Disparities</p>

Prevent Chronic Diseases				
Indicator	Indicator Description and Note	Data Source	Program and Data Contact	Prevention Agenda Focus Area
5 - Percentage of children with obesity, among children aged 2-4 years participating in the WIC program County Dashboard Tracking Indicator Number - 5	Percentage of children with obesity among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	NYS Pediatric Nutrition Surveillance System	Program Contact: Division of Nutrition WICDATA@health.ny.gov	Healthy Eating and Food Security
6 - Percentage of children and adolescents with obesity County Dashboard Tracking Indicator Number - 6	The percentage of public school children with obesity. Obesity is defined as weight category greater than or equal to 95th percentile. Counties outside NYC: Grades pre-K, K, 2nd, 4th, 7th, and 10th prior to the 2019-2020 school year; grades pre-K, K, 1st, 3rd, 5th, 7th, 9th, and 11th starting with the 2019-2020 school year; data collected over two school years. NYC boroughs: Grades K-8th, data collected over one school year. Due to changes in SWSCR data collection during the 2019-2020 school year, estimates from the 2019-2021 school years may not be directly comparable to previous school years.	Student Weight Status Category Reporting System (SWSCRS)	Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov Data Contact: Student Weight Status Category Reporting schoolbmi@health.ny.gov	Healthy Eating and Food Security
7 - Percentage of children and adolescents with obesity County Dashboard Tracking Indicator Number - 6	The percentage of public school children with obesity. Obesity is defined as weight category greater than or equal to the 95th percentile. Counties outside NYC: Grades pre-K, K, 2nd, 4th, 7th, and 10th prior to the 2019-2020 school year; grades pre-K, K, 1st, 3rd, 5th, 7th, 9th, and 11th starting with the 2019-2020 school year; data collected over two school years. NYC boroughs:	NYC Fitnessgram	Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov	Healthy Eating and Food Security

	Grades K-8th, data collected over one school year.			
8 - Percentage of adults with obesity County Dashboard Tracking Indicator Number - 7	The percentage of adults (aged 18 years and older) with obesity. Obesity is defined as having a body mass index (BMI) of 30.0 or greater. BMI is calculated as weight in kilograms divided by the square of height in meters (kg/m ²).	NYS Behavioral Risk Factor Surveillance System ⁶	Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov Data Contact: BRFSS Program BRFSS@health.ny.gov	Healthy Eating and Food Security
8.1 - Percentage of adults with an annual household income less than \$25,000 with obesity County Dashboard Tracking Indicator Number - 7.1	The percentage of adults (aged 18 years and older) with an annual household income less than \$25,000 who have obesity.	NYS Behavioral Risk Factor Surveillance System ⁶	Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov Data Contact: BRFSS Program BRFSS@health.ny.gov	Healthy Eating and Food Security
9 - Percentage of adults with an annual household income less than \$25,000 who consume one or more sugary drinks per day County Dashboard Tracking Indicator Number - 8	The percentage of adults (aged 18 years and older) with an annual household income less than \$25,000 who consume one or more sugary drinks per day.	NYS Behavioral Risk Factor Surveillance System ⁶	Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov Data Contact: BRFSS Program BRFSS@health.ny.gov	Healthy Eating and Food Security
10 - Percentage of adults with an annual household income less than \$25,000 with perceived food security County Dashboard Tracking Indicator Number - 9	The percentage of adults (aged 18 years and older) with perceived food security with an annual household income less than \$25,000.	NYS Behavioral Risk Factor Surveillance System ⁶	Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov Data Contact: BRFSS Program BRFSS@health.ny.gov	Healthy Eating and Food Security
11 - Percentage of adults who participate in leisure-time physical activity County Dashboard Tracking Indicator Number - 10	The percentage of adults (aged 18 years and older) who participate in leisure-time physical activity.	NYS Behavioral Risk Factor Surveillance System ⁶	Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov Data Contact: BRFSS Program BRFSS@health.ny.gov	Physical Activity
11.1 - Percentage of adults with disabilities	The percentage of adults (aged 18 years and older)	NYS Behavioral	Program Contact: Bureau of Community	Physical

<p>who participate in leisure-time physical activity</p> <p>County Dashboard Tracking Indicator Number - 10.1</p>	<p>with disabilities who participate in leisure-time physical activity.</p>	<p>Risk Factor Surveillance System^c</p>	<p>Chronic Disease Prevention ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: BRFSS Program BRFSS@health.ny.gov</p>	<p>Activity</p>
<p>11.2 - Percentage of adults who participate in leisure-time physical activity - aged 65+ years</p> <p>County Dashboard Tracking Indicator Number - 10.2</p>	<p>The percentage of adults (aged 65 years and older) who participate in leisure-time physical activity.</p>	<p>NYS Behavioral Risk Factor Surveillance System^c</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: BRFSS Program BRFSS@health.ny.gov</p>	<p>Physical Activity</p>
<p>12 - Percentage of high school students who are physically active</p>	<p>The percentage of high school students (grades 9-12) who are physically active for a total of at least 60 minutes/day on all 7 days</p>	<p>Youth Risk Behavior Surveillance System</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: Bureau of Chronic Disease Evaluation and Research bcder@health.ny.gov</p>	<p>Physical Activity</p>
<p>13 - Prevalence of combustible cigarette use by high school age students</p>	<p>The prevalence of combustible cigarette use by high school age students</p>	<p>NYS Youth Tobacco Survey</p>	<p>Program Contact: Bureau of Tobacco Control tcp@health.ny.gov</p> <p>Data Contact: Bureau of Chronic Disease Evaluation and Research bcder@health.ny.gov</p>	<p>Tobacco Prevention</p>
<p>14 - Prevalence of vaping product use by high school age students</p>	<p>The prevalence of vaping product use by high school age students</p>	<p>NYS Youth Tobacco Survey</p>	<p>Program Contact: Bureau of Tobacco Control tcp@health.ny.gov</p> <p>Data Contact: Bureau of Chronic Disease Evaluation and Research bcder@health.ny.gov</p>	<p>Tobacco Prevention</p>
<p>15 - Prevalence of cigarette smoking</p>	<p>The prevalence of adults (aged 18 years and older)</p>	<p>NYS Behavioral</p>	<p>Program Contact: Bureau of Tobacco</p>	<p>Tobacco</p>

among adults County Dashboard Tracking Indicator Number - 11	who report currently smoking cigarettes	Risk Factor Surveillance System ⁶	Control tcp@health.ny.gov Data Contact: BRFSS Program BRFSS@health.ny.gov	Prevention
15.1 - Percentage of adults who smoke cigarettes among adults with income less than \$25,000 County Dashboard Tracking Indicator Number - 11.1	The percentage of adults (aged 18 years and older) with an annual household income less than \$25,000 who report currently smoking cigarettes	NYS Behavioral Risk Factor Surveillance System ⁶	Program Contact: Bureau of Tobacco Control tcp@health.ny.gov Data Contact: BRFSS Program BRFSS@health.ny.gov	Tobacco Prevention
16 - Utilization of smoking cessation benefits among smokers who are enrolled in Medicaid	The percentage of smokers enrolled in Medicaid who utilized smoking cessation benefits	NYSDOH Office of Quality and Patient Safety, Medicaid Program	Program Contact: Bureau of Tobacco Control tcp@health.ny.gov	Tobacco Prevention
17 - Percentage of non-smoking adults, living in multi-unit housing, who were exposed to secondhand smoke in their homes	The percentage of adults (non-smoking, aged 18 years and older) living in multi-unit housing who were exposed to secondhand smoke in their homes	NYS Adult Tobacco Survey	Program Contact: Bureau of Tobacco Control tcp@health.ny.gov Data Contact: Bureau of Chronic Disease Evaluation and Research bcder@health.ny.gov	Tobacco Prevention
18 - Percentage of adults with an annual household income less than \$25,000 who receive a colorectal cancer screening based on the most recent guidelines, aged 50-75 years	The percentage of adults (aged 50-75 years) with an annual household income less than \$25,000 who receive a colorectal cancer screening based on the most recent guidelines	NYS Behavioral Risk Factor Surveillance System ⁶	Program Contact: Cancer Services Program canserv@health.ny.gov v Data Contact: Bureau of Chronic Disease Evaluation and Research bcder@health.ny.gov	Chronic Disease Preventive Care and Management
19 - Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines, aged 50-64 years County Dashboard Tracking Indicator Number - 12	The percentage of adults (aged 50-64 years) who receive a colorectal cancer screening based on the most recent guidelines	NYS Behavioral Risk Factor Surveillance System ⁶	Program Contact: Cancer Services Program canserv@health.ny.gov v Data Contact: Bureau of Chronic Disease Evaluation and Research bcder@health.ny.gov	Chronic Disease Preventive Care and Management
20 - Percentage of adults who had a test for	The percentage of adults (aged 45 years and older)	NYS Behavioral	Program Contact: Bureau of Community	Chronic Disease

<p>high blood sugar or diabetes within the past three years, aged 45+ years</p> <p>County Dashboard Tracking Indicator Number - 13</p>	<p>who had a test for high blood sugar or diabetes within the past three years</p>	<p>Risk Factor Surveillance System^c</p>	<p>Chronic Disease Prevention ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: Bureau of Chronic Disease Evaluation and Research bcder@health.ny.gov</p>	<p>Preventive Care and Management</p>
<p>20.1 - Percentage of adults with an annual household income less than \$25,000 who had a test for high blood sugar or diabetes within the past three years, aged 45+ years</p> <p>County Dashboard Tracking Indicator Number - 13.1</p>	<p>The percentage of adults (aged 45 years and older) with an annual household income less than \$25,000 who had a test for high blood sugar or diabetes within the past three years</p>	<p>NYS Behavioral Risk Factor Surveillance System^c</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: Bureau of Chronic Disease Evaluation and Research bcder@health.ny.gov</p>	<p>Chronic Disease Preventive Care and Management</p>
<p>21 - Asthma emergency department visits, rate per 10,000, aged 0-17 years</p> <p>County Dashboard Tracking Indicator Number - 14</p>	<p>The number of emergency department visits with primary diagnosis of asthma per 10,000 population - aged 0-17 years</p>	<p>Statewide Planning and Research Cooperative System (SPARCS)^b</p>	<p>Program Contact: Asthma Surveillance Program phiginfo@health.ny.gov</p> <p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	<p>Chronic Disease Preventive Care and Management</p>

<p>22 - Percentage of Medicaid Managed Care members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year, aged 5-18 years</p> <p>County Dashboard Tracking Indicator Number - 15</p>	<p>The percentage of Medicaid Managed Care members (aged 5-18 years) who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. To be identified as having persistent asthma, individuals must have had a 3M Episode Diagnostic Category (EDC) of 138, 145 in the calendar year and year prior, and aged 5 to 18 years who were continuously enrolled in a Mainstream, HARP, or SNP MMC health plan for 24 or more months, as of the most recent reporting year. Note: NCOA HEDIS measure, the percentage of Medicaid Managed Care members (aged 5-18 years) who were identified as having persistent asthma and were dispensed appropriate asthma controller medications for at least 50% of the treatment period, retired in 2020.</p>	<p>Office of Quality and Patient Safety, QARR Report</p>	<p>Program Contact: Asthma Surveillance Program phiginfo@health.ny.gov ov</p> <p>Data Contact: Office of Quality and Patient Safety nysqarr@health.ny.gov v</p>	<p>Chronic Disease Preventive Care and Management</p>
<p>23 - Percentage of adults with hypertension who are currently taking medicine to manage their high blood pressure</p> <p>County Dashboard Tracking Indicator Number - 16</p>	<p>The percentage of adults (aged 18 years and older) with hypertension who are currently taking medicine to manage their high blood pressure.</p>	<p>NYS Behavioral Risk Factor Surveillance System⁶</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: Bureau of Chronic Disease Evaluation and Research bcder@health.ny.gov</p>	<p>Chronic Disease Preventive Care and Management</p>
<p>24 - Percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition</p>	<p>The percentage of adults (aged 18 years and older) with chronic conditions (arthritis, asthma, cardiovascular disease (CVD), diabetes, chronic kidney disease (CKD), cancer) who have taken a course or class to learn</p>	<p>NYS Behavioral Risk Factor Surveillance System⁶</p>	<p>Program Contact: Arthritis Program EBSMP@health.ny.gov v</p> <p>Data Contact: Bureau of Chronic Disease Evaluation and Research</p>	<p>Chronic Disease Preventive Care and Management</p>

County Dashboard Tracking Indicator Number - 17	how to manage their condition.		bcder@health.ny.gov	
Promote a Healthy and Safe Environment				
Indicator	Indicator Description and Note	Data Source	Program and Data Contact	Prevention Agenda Focus Area
25 - Hospitalizations due to falls among adults, rate per 10,000 population, aged 65+ years County Dashboard Tracking Indicator Number - 18	The number of hospitalizations (inpatient, aged 65 years and older) per 10,000 population aged 65 and older.	Statewide Planning and Research Cooperative System (SPARCS) ^b	Program Contact: Bureau of Occupational Health and Injury Prevention boh@health.ny.gov Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144	Injuries, Violence and Occupational Health
26 - Assault-related hospitalizations, rate per 10,000 population County Dashboard Tracking Indicator Number - 19	The number of assault-related hospitalizations per 10,000 population. As of October 1, 2015, medical data coded using the International Classification of Diseases, 10th Revision, Clinic Modification (ICD-10-CM) requires coders to assign unintentional intent when the intent is not stated in the medical record. This may lead to an overcount of unintentional injuries and an undercount of intentional injuries, such as assaults and self-harm.	Statewide Planning and Research Cooperative System (SPARCS) ^b	Program Contact: Bureau of Occupational Health and Injury Prevention boh@health.ny.gov Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144	Injuries, Violence and Occupational Health
26.1 - Assault-related hospitalizations, ratio of rates between Black non-Hispanics and White non-Hispanics County Dashboard Tracking Indicator Number - 19.1	The ratio of the rates of assault-related hospitalization for Black non-Hispanics compared to White non-Hispanics. As of October 1, 2015, medical data coded using the International Classification of Diseases, 10th Revision, Clinic Modification (ICD-10-CM)	Statewide Planning and Research Cooperative System (SPARCS) ^b	Program Contact: Bureau of Occupational Health and Injury Prevention boh@health.ny.gov Data Contact: Bureau of Health Informatics Division of Information and	Injuries, Violence and Occupational Health

	requires coders to assign unintentional intent when the intent is not stated in the medical record. This may lead to an overcount of unintentional injuries and an undercount of intentional injuries, such as assaults and self-harm.		<p>Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	
<p>26.2 - Assault-related hospitalizations, ratio of rates between Hispanics and White non-Hispanics</p> <p>County Dashboard Tracking Indicator Number - 19.2</p>	<p>The ratio of the rates of assault-related hospitalization for Hispanics compared to White non-Hispanics. As of October 1, 2015, medical data coded using the International Classification of Diseases, 10th Revision, Clinic Modification (ICD-10-CM) requires coders to assign unintentional intent when the intent is not stated in the medical record. This may lead to an overcount of unintentional injuries and an undercount of intentional injuries, such as assaults and self-harm.</p>	<p>Statewide Planning and Research Cooperative System (SPARCS)^b</p>	<p>Program Contact: Bureau of Occupational Health and Injury Prevention boh@health.ny.gov</p> <p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	<p>Injuries, Violence and Occupational Health</p>
<p>26.3 - Assault-related hospitalizations, ratio of rates between low-income ZIP Codes and non-low-income ZIP Codes</p> <p>County Dashboard Tracking Indicator Number - 19.3</p>	<p>The ratio of the rates of assault-related hospitalization in low-income ZIP Codes compared to non-low-income ZIP Codes. As of October 1, 2015, medical data coded using the International Classification of Diseases, 10th Revision, Clinic Modification (ICD-10-CM) requires coders to assign unintentional intent when the intent is not stated in the medical record. This may lead to an overcount of unintentional injuries and an undercount of intentional injuries, such as assaults and self-harm.</p>	<p>Statewide Planning and Research Cooperative System (SPARCS)^b</p>	<p>Program Contact: Bureau of Occupational Health and Injury Prevention boh@health.ny.gov</p> <p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	<p>Injuries, Violence and Occupational Health</p>

<p>27 - Firearm assault-related hospitalizations, rate per 10,000 population</p> <p>County Dashboard Tracking Indicator Number - 20</p>	<p>Firearm assault-related hospitalization rate per 10,000 people. As of October 1, 2015, medical data coded using the International Classification of Diseases, 10th Revision, Clinic Modification (ICD-10-CM) requires coders to assign unintentional intent when the intent is not stated in the medical record. This may lead to an overcount of unintentional injuries and an undercount of intentional injuries, such as assaults and self-harm.</p>	<p>Statewide Planning and Research Cooperative System (SPARCS)^b</p>	<p>Program Contact: Bureau of Occupational Health and Injury Prevention boh@health.ny.gov</p> <p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	<p>Injuries, Violence and Occupational Health</p>
<p>28 - Work-related emergency department (ED) visits, ratio of rates between Black non-Hispanics and White non-Hispanics</p> <p>County Dashboard Tracking Indicator Number - 21</p>	<p>The ratio of rates for work-related emergency department visits between Black non-Hispanics and White non-Hispanics.</p>	<p>Statewide Planning and Research Cooperative System (SPARCS)^b</p>	<p>Program Contact: Bureau of Occupational Health and Injury Prevention boh@health.ny.gov</p> <p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	<p>Injuries, Violence and Occupational Health</p>
<p>29 - Crash-related pedestrian fatalities, rate per 100,000 population</p> <p>County Dashboard Tracking Indicator Number - 22</p>	<p>Crash-related pedestrian fatalities, rate per 100,000 population.</p>	<p>Vital Records^a</p>	<p>Program Contact: Bureau of Occupational Health and Injury Prevention boh@health.ny.gov</p> <p>Data Contact: Bureau of Production Systems Management Vital Records Contact: vr@health.ny.gov</p>	<p>Injuries, Violence and Occupational Health</p>
<p>30 - Annual number of days with air quality index >100 (unhealthy levels of ozone or particulate matter)</p>	<p>Number of days each year when the air quality index is >100 (unhealthy levels of ozone or particulate matter) in at least one air quality region of the State.</p>	<p>Department of Environmental Conservation</p>	<p>Program Contact: Bureau of Toxic Substance Assessment btsa@health.ny.gov</p>	<p>Outdoor Air Quality</p>

<p>31 - Percentage of population living in a certified Climate Smart Community</p> <p>County Dashboard Tracking Indicator Number – 23</p>	<p>Percentage of population living in a certified Climate Smart Community.</p>	<p>Department of Environmental Conservation, Climate Smart Communities program</p>	<p>Program Contact: Environmental Public Health Tracking Program epht@health.ny.gov</p>	<p>Built and Indoor Environments</p>
<p>32 - Percentage of people who commute to work using alternate modes of transportation (e.g., public transportation, carpool, bike/walk) or who telecommute</p> <p>County Dashboard Tracking Indicator Number – 24</p>	<p>Proportion of people who commute to work using alternate modes of transportation (e.g., public transportation, carpool, bike/walk) or who telecommute</p>	<p>U. S. Census Bureau, American Community Survey</p>	<p>Program Contact: Environmental Public Health Tracking Program epht@health.ny.gov</p>	<p>Built and Indoor Environments</p>
<p>33 - Percentage of registered cooling towers in compliance with 10 NYCRR Subpart 4-1</p> <p>County Dashboard Tracking Indicator Number – 25</p>	<p>Percent of cooling towers registered with the NYSDOH that are in compliance (excluding towers in NYC)</p>	<p>NYS Cooling Tower Registry</p>	<p>Program Contact: Bureau of Water Supply Protection Contact: cooling.tower@health.ny.gov Phone: (518) 402-7650</p>	<p>Built and Indoor Environments</p>
<p>34 - Number of homes inspected for lead and other health hazards</p>	<p>Annual number of residential housing units inspected for the Lead Poisoning Prevention Program, Childhood Lead Poisoning Primary Prevention Program, and the Healthy Neighborhoods Program</p>	<p>NYSDOH Childhood Lead Poisoning Prevention Program Reports and other programs</p>	<p>Program Contact: Bureau of Community Environmental Health and Food Protection Contact: lppp@health.ny.gov Phone: (518) 402-7600</p>	<p>Built and Indoor Environments</p>
<p>35 - Number of radon tests performed per year, three-year average</p>	<p>Number of radon tests performed, including testing of homes, schools, daycares, and some government buildings</p>	<p>NYSDOH Radon Database/Application and Dataset per 10 NYCRR Part 16.130(b)(1)</p>	<p>Program Contact: Bureau of Environmental Radiation Protection NYS Radon Program Contact: radon@health.ny.gov Phone: (518) 402-7556</p>	<p>Built and Indoor Environments</p>
<p>36 - Number of homes mitigated per year for radon, three-year average</p>	<p>Number of homes where mitigation systems to address radon were installed</p>	<p>Dataset per 10 NYCRR Part 16.130(b)(3)</p>	<p>Program Contact: Bureau of Environmental Radiation Protection NYS Radon Program Contact: radon@health.ny.gov Phone: (518) 402-</p>	<p>Built and Indoor Environments</p>

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37 - Number of public water systems per year that were awarded infrastructure improvement assistance, three-year average	The number of public water systems awarded funding for infrastructure improvements through Drinking Water State Revolving Fund (DWSRF) and Water Infrastructure Improvement Act (WIIA)/Intermunicipal Water Infrastructure Grants (IMG). These are voluntary programs, communities choose to apply for funding.	DWSRF, WIIA/IMG Program	Program Contact: Michael Montysko, P.E., Design Section Chief Bureau of Water Supply Protection Contact: bwsp@health.ny.gov Phone: (518) 402-7650	Water Quality
38 - Number of counties with mapped waterbodies detailing contamination	Cumulative number of maps available at the county-level. The county-level maps illustrate public access waters and the applicable NYSDOH fish advisory for those waters. The maps highlight many waters where everyone in the family can eat up to four fish meals per month.	Fish Advisory Maps by County	Program Contact: Center for Environmental Health Outreach and Education Contact: HRFA@health.ny.gov Phone: (518) 402-7530	Water Quality
39 - Percentage of foodborne outbreaks where contributing factors were identified	The annual percentage of foodborne outbreaks where the contributing factor(s) is/are identified. Contributing factors are the root causes of foodborne disease outbreaks.	NYS Foodborne Disease Surveillance	Program Contact: Bureau of Community Environmental Health and Food Protection Contact: bcehfp@health.ny.gov Phone: (518) 402-7600	Food and Consumer Products

Promote Healthy Women, Infants, and Children

Indicator	Indicator Description and Note	Data Source	Program and Data Contact	Prevention Agenda Focus
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				Area
<p>40 - Percentage of women with a preventive medical visit in the past year, aged 18-44 years</p> <p>County Dashboard Tracking Indicator Number - 26</p>	<p>The number of women, aged 18 through 44 years, who had a routine preventive medical visit in the past year per 100 women aged 18 through 44 years.</p>	<p>NYS Behavioral Risk Factor Surveillance System^c</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention Contact: ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: BRFSS Program Contact: BRFSS@health.ny.gov</p>	<p>Maternal & Women's Health</p>
<p>41 - Percentage of women with a preventive medical visit in the past year, aged 45+ years</p> <p>County Dashboard Tracking Indicator Number - 27</p>	<p>The number of women, aged 45 years and older, who had a routine preventive medical visit in the past year per 100 women aged 45 years and older.</p>	<p>NYS Behavioral Risk Factor Surveillance System^c</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention Contact: ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: BRFSS Program Contact: BRFSS@health.ny.gov</p>	<p>Maternal & Women's Health</p>
<p>42 - Percentage of women who report ever talking with a health care provider about ways to prepare for a healthy pregnancy, aged 18-44 years</p> <p>County Dashboard Tracking Indicator Number - 28</p>	<p>The number of women, aged 18 through 44 years, who talked with a health care provider about ways to prepare for a healthy pregnancy per 100 women aged 18 through 44 years.</p>	<p>NYS Behavioral Risk Factor Surveillance System^c</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention Contact: ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: BRFSS Program Contact: BRFSS@health.ny.gov</p>	<p>Maternal & Women's Health</p>
<p>43 - Maternal mortality, rate per 100,000 live births</p> <p>County Dashboard Tracking Indicator Number - 29</p>	<p>The number of deaths related to or aggravated by pregnancy and occurring within 42 days of the end of pregnancy (defined as death records with causes of death ICD-10: A34, O00-O95, and O98-O99) per 100,000 live births.</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group Contact: phinfo@health.ny.gov</p> <p>Data Contact: Vital Statistics Unit Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	<p>Maternal & Women's Health</p>
<p>43.1 - Maternal mortality, ratio of rates between Black non-Hispanics and White non-Hispanics</p>	<p>The rate of maternal deaths due to pregnancy is calculated for Black non-Hispanics and White non-Hispanics. Then, the ratio is the Black non-Hispanic rate divided by</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group Contact: phinfo@health.ny.gov</p> <p>Data Contact: Vital Statistics Unit</p>	<p>Maternal & Women's Health</p>

	the White non-Hispanic rate.		Contact: bio-info@health.ny.gov Phone: (518) 473-8144	
44 - Percentage of women who report that a health care provider asked them about depression symptoms at a postpartum visit	Number of women who report a health care provider, per 100 women at a postpartum visit, asked them about feeling down or depressed following a recent live birth.	Pregnancy Risk Assessment Monitoring System (PRAMS)	Program Contact: Public Health Information Group Contact: phinfo@health.ny.gov	Maternal & Women's Health
45 - Infant mortality, rate per 1,000 live births County Dashboard Tracking Indicator Number - 30	The number of infant deaths up to 364 days of age per 1,000 live births. State estimate on the state level dashboard is provided by the Health Resources and Services Administration, a federal agency, and may be different from results that are generated by the NYS specific data sources.	National Vital Statistics System	Program Contact: Public Health Information Group Contact: phinfo@health.ny.gov	Perinatal & Infant Health
46 - Percentage of births that are preterm County Dashboard Tracking Indicator Number - 31	The number of infants born at less than 37 weeks clinically estimated gestation per 100 live births with known gestational age	Vital Records ^a	Program Contact: Public Health Information Group Contact: phinfo@health.ny.gov Data Contact: Vital Statistics Unit Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144	Perinatal & Infant Health
47 - Percentage of very low birthweight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	The number of VLBW infants born in a hospital with a level III or higher Neonatal Intensive Care Unit (NICU) per 100 VLBW infants (< 1500 grams)	Vital Records ^a	Program Contact: Public Health Information Group Contact: phinfo@health.ny.gov Data Contact: Vital Statistics Unit Bureau of Health	Perinatal & Infant Health

			<p>Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	
<p>48 - Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioid or other substance (any diagnosis), crude rate per 1,000 newborn discharges</p> <p>County Dashboard Tracking Indicator Number - 32</p>	<p>Neonatal withdrawal symptoms from maternal use of drugs of addiction, and/or newborns affected by maternal use of drugs of addiction (other than cocaine) including opiates, sedative-hypnotics and anxiolytics. ICD-10-CM: Principal Diagnosis: Z38 (liveborn infants) AND P96.1 (neonatal withdrawal symptoms from maternal use of drugs of addiction) or P04.49 (newborns affected by maternal use of drugs of addiction (other than cocaine)) or P04.14 (newborns affected by maternal use of opiates) or P04.17 (newborns affected by maternal use of sedative-hypnotics) or P04.1A (newborns affected by maternal use of anxiolytics) in any other diagnoses. (P04.14, P04.17, and P04.1A are three new codes effect 10/1/2018.)</p>	<p>Statewide Planning and Research Cooperative System (SPARCS)^b</p>	<p>Program Contact: Public Health Information Group Contact: phiginfo@health.ny.gov</p> <p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	<p>Perinatal & Infant Health</p>
<p>49 - Percentage of infants who are exclusively breastfed in the hospital among all infants</p> <p>County Dashboard Tracking Indicator Number - 33</p>	<p>The number of infants who were fed only breast milk since birth. Based on NYS residence of live born infants not admitted to the Neonatal Intensive Care Unit (NICU) or transferred to another hospital.</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group Contact: phiginfo@health.ny.gov</p> <p>Data Contact: Vital Statistics Unit Bureau of Health Informatics Division of Information and Statistics Office of Quality and</p>	<p>Perinatal & Infant Health</p>

			<p>Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	
<p>49.1 - Percentage of infants who are exclusively breastfed in the hospital among Hispanic infants</p> <p>County Dashboard Tracking Indicator Number - 33.1</p>	<p>The number of Hispanic infants who were fed only breast milk since birth. Based on NYS residence of live born Hispanic infants not admitted to the Neonatal Intensive Care Unit (NICU) or transferred to another hospital.</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group Contact: phinfo@health.ny.gov</p> <p>Data Contact: Vital Statistics Unit Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	<p>Perinatal & Infant Health</p>
<p>49.2 - Percentage of infants who are exclusively breastfed in the hospital among Black non-Hispanic infants</p> <p>County Dashboard Tracking Indicator Number - 33.2</p>	<p>The number of Black non-Hispanic infants who were fed only breast milk since birth. Based on NYS residence of live born Black non-Hispanic infants not admitted to the Neonatal Intensive Care Unit (NICU) or transferred to another hospital.</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group Contact: phinfo@health.ny.gov</p> <p>Data Contact: Vital Statistics Unit Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	<p>Perinatal & Infant Health</p>
<p>50 - Percentage of infants supplemented with formula in the hospital among breastfed infants</p> <p>County Dashboard Tracking Indicator Number - 34</p>	<p>The number of infants who were fed formula among infants fed any breast milk since birth. Based on NYS residence of live born infants not admitted to the Neonatal Intensive Care Unit (NICU) or transferred to another hospital.</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group Contact: phinfo@health.ny.gov</p> <p>Data Contact: Vital Statistics Unit Bureau of Health Informatics Division of Information and Statistics</p>	<p>Perinatal & Infant Health</p>

			Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144	
51 - Percentage of WIC enrolled infants who are breastfed at 6 months County Dashboard Tracking Indicator Number - 35	The percentage of infants enrolled in WIC who were breastfed at 6 months. Only infants who turned 6 months of age during the reporting period by/on the date of their WIC visit were included in the breastfed at least 6 months analysis. Records are excluded if date of birth and/or date of visit are unknown. Percentages are not calculated if < 100 records are available for analysis.	Pediatric Nutrition Surveillance System (PedNSS)	Program Contact: NYS Pediatric Nutrition Surveillance System (PedNSS)- WIC Program NYSWIC@health.ny.gov Data Contact: WICDATA@health.ny.gov	Perinatal & Infant Health
52 - Percentage of children who received a developmental screening using a parent-completed screening tool in the past year, aged 9-35 months	The number of children, aged 9 through 35 months, who had a health care visit in the past 12 months and whose parents completed a standardized developmental screening tool in the past 12 months per 100 children, aged 9 through 35 months, who had a health care visit in the past 12 months.	National Survey of Children's Health	Program Contact: Public Health Information Group phiginfo@health.ny.gov	Child & Adolescent Health
53 - Suicide mortality among youth, rate per 100,000, aged 15-19 years County Dashboard Tracking Indicator Number - 36	The number of deaths with an ICD-10 underlying cause of death code: X60-X84 or Y87.0, or U03 per 100,000 adolescents aged 15 through 19. State estimates on the state level dashboard are provided by the Health Resources and Services Administration, and through CDC Wonder, federal agencies, and may be different from results that are generated by the NYS-specific data sources.	State: National Vital Statistics System County: Vital Records ^a	Program Contact: Public Health Information Group phiginfo@health.ny.gov	Child & Adolescent Health

<p>54 - Percentage of infants who received diagnostic hearing test after failing most recent hearing screening</p>	<p>The number of infants who received a diagnostic hearing test that is documented in New York Early Hearing Detection and Intervention Information System (NYEHDI-IS) per 100 infants whose most recent newborn hearing screening results were abnormal.</p>	<p>Early Hearing Detection and Intervention Program (NYEHDI-IS)</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p>	<p>Child & Adolescent Health</p>
<p>55 - Percentage of families participating in the Early Intervention Program who meet the state's standard on the NY Impact on Family Scale</p> <p>County Dashboard Tracking Indicator Number - 37</p>	<p>The number of respondent families participating in Early Intervention Program (EIP) who meet the State's standard (person mean ≥ 576) on the New York Impact on Family Scale per 100 respondent families.</p> <p>Before the State Systematic Improvement Plan was submitted in 2020, the Family Outcomes Survey was analyzed using the Rasch Model to represent families' performance on a linear scale and account for the unequal difficulties across test items. Due to concerns regarding interpretability, a new method was utilized in 2020. The new method divides the total number of positive responses over the total number of positive and negative responses across all Family Outcomes survey items^{1,2}.</p> <p>1. The CAHPS Clinician & Group Survey Database: How Results Are Calculated. (2019, October.) AHRQ.gov. Retrieved January 13, 2020, from https://cahpsdatabase.ahrq.gov/CAHPSIDB/Public/Files/Doc6_How_Results_are_Calculated_CG_2019.pdf</p>	<p>Early Intervention New York Family Survey</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p>	<p>Child & Adolescent Health</p>

	<p>2. Technical Assistance Guide for Analyzing Data From the CAHPS® Home and Community-Based Services Survey. (2017, October). Medicaid.gov. Retrieved January 15, 2020 from https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbcsahps-data-analysis-guide.pdf</p>			
<p>56 - Percentage of children with special health care needs (CSHCN) whose families report that they receive care in a well-functioning system, aged 0-17 years</p>	<p>The number of children and adolescents with special health care needs (CSHCN), aged 0 through 17 years, who receive all components of a well-functioning system (family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition) per 100 CSHCN aged 0 through 17 years.</p>	<p>National Survey of Children's Health</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p>	<p>Child & Adolescent Health</p>
<p>57 - Percentage of residents served by community water systems that have optimally fluoridated water</p> <p>County Dashboard Tracking Indicator Number - 38</p>	<p>The number of residents served by community water systems with optimal fluoride levels per 100 residents served by community water systems. The Safe Drinking Water Information System (SDWIS) contains information about public water systems (PWSs) as reported to EPA by the states. This information is used by regulatory agencies to help track PWS treatment processes, facility data, and compliance with drinking water requirements.</p>	<p>Safe Drinking Water Information System (SDWIS)</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p> <p>Data Contact: NYS Bureau of Water Supply Protection Contact: bpwsp@health.ny.gov</p>	<p>Child & Adolescent Health</p>
<p>Promote Well-Being and Prevent Mental and Substance Use Disorders</p>				
<p>Indicator</p>	<p>Indicator Description and Note</p>	<p>Data Source</p>	<p>Program and Data Contact</p>	
<p>58 - Opportunity Index Score</p>	<p>At the state level, the Opportunity Index is made up of 20 indicators across</p>	<p>Child Trends and Opportunity</p>	<p>Program Contact: Office of Public Health Practice</p>	<p>Promote Well-Being</p>

<p>County Dashboard Tracking Indicator Number - 39</p>	<p>the four dimensions (Economy, Education, Health and Community). In each dimension, the rescaled values for indicators are averaged to create dimension-level Opportunity Scores, also ranging from 1 to 100. Because data for some indicators are not available at the county level, the county Opportunity Index is made up of 17 indicators. As with states, indicators in each dimension are averaged to create dimension-level Opportunity Scores ranging from 0 to 100.</p>	<p>Nation with data from Opportunity Index and American Community Survey</p>	<p>prevention@health.ny.gov</p>	
<p>59 - Frequent mental distress during the past month among adults, age-adjusted percentage County Dashboard Tracking Indicator Number - 40</p>	<p>The percentage of respondents (ages 18 or older) who reported having 14 or more days of poor mental health during the past month. The percentage is adjusted for age.</p>	<p>NYS Behavioral Risk Factor Surveillance System^c</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov Data Contact: BRFSS Program BRFSS@health.ny.gov</p>	<p>Promote Well-Being</p>
<p>60 - Economy Score County Dashboard Tracking Indicator Number - 41</p>	<p>The Economy Score is compiled from five data points: income inequality, access to banking services, affordable housing, and broadband internet subscription.</p>	<p>Child Trends and Opportunity Nation with data from Opportunity Index and American Community Survey</p>	<p>Program Contact: Office of Public Health Practice prevention@health.ny.gov</p>	<p>Promote Well-Being</p>
<p>61 - Community Score County Dashboard Tracking Indicator Number - 42</p>	<p>The Community Score is compiled from seven data sources: volunteering, voter registration, youth disconnection, violent crime, access to primary health care, access to healthy food and incarceration.</p>	<p>Child Trends and Opportunity Nation with data from Opportunity Index and American Community Survey</p>	<p>Program Contact: Office of Public Health Practice prevention@health.ny.gov</p>	<p>Promote Well-Being</p>
<p>62 - Percentage of high school students reporting alcohol use on at least one day during the past 30 days</p>	<p>The percentage of high school students (grades 9-12) reporting use of alcohol on at least one day in the past 30 days.</p>	<p>Youth Risk Behavior Surveillance System</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p>	<p>Mental and Substance Use Disorders Prevention</p>

<p>63 - Binge drinking during the past month among adults, age-adjusted percentage</p> <p>County Dashboard Tracking Indicator Number - 43</p>	<p>The percentage of adults (aged 18 years and older) reporting binge drinking on one or more occasions in the past 30 days. Binge drinking is defined as men having 5 or more drinks or women having 4 or more drinks on one occasion. The percentage is adjusted for age.</p>	<p>NYS Behavioral Risk Factor Surveillance System^c</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: BRFSS Program BRFSS@health.ny.gov</p>	<p>Mental and Substance Use Disorders Prevention</p>
<p>64 - Overdose deaths involving any opioids, age-adjusted rate per 100,000 population</p> <p>County Dashboard Tracking Indicator Number - 44</p>	<p>The number of poisoning deaths involving any opioid (all manners, using all causes of death) per 100,000 population. The rate is adjusted for age.</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov</p> <p>Data Contact: Vital Statistics Unit Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	<p>Mental and Substance Use Disorders Prevention</p>
<p>65 - Patients who received at least one buprenorphine prescription for opioid use disorder, age-adjusted rate per 100,000 population</p> <p>County Dashboard Tracking Indicator Number - 45</p>	<p>Number and rate of patients who received at least one buprenorphine prescription for opioid use disorder per 100,000 residents. The rate is adjusted for age.</p>	<p>Prescription Monitoring Program Registry</p>	<p>Program Contact: Opioid Prevention Program opioidprevention@health.ny.gov</p> <p>Data Contact: Bureau of Narcotic Enforcement Narcotic@health.ny.gov</p>	<p>Mental and Substance Use Disorders Prevention</p>
<p>66 - Opioid analgesic prescription, age-adjusted rate per 1,000 population</p> <p>County Dashboard Tracking Indicator Number - 46</p>	<p>Number and rate of opioid analgesic prescriptions per 1,000 residents. Schedule II, III and IV opioid analgesic prescriptions dispensed to state residents. The rate is adjusted for age.</p>	<p>Prescription Monitoring Program Registry</p>	<p>Program Contact: Opioid Prevention Program opioidprevention@health.ny.gov</p> <p>Data Contact: Bureau of Narcotic Enforcement Narcotic@health.ny.gov</p>	<p>Mental and Substance Use Disorders Prevention</p>
<p>67 - Emergency department visits (including outpatients)</p>	<p>All emergency department visits (including outpatients and admitted)</p>	<p>Statewide Planning and Research</p>	<p>Program Contact: Public Health Information Group</p>	<p>Mental and Substance Use Disorders</p>

<p>and admitted patients) involving any opioid overdose, age-adjusted rate per 100,000 population</p> <p>County Dashboard Tracking Indicator Number - 47</p>	<p>patients) involving opioid poisonings, all manners, principal diagnosis or first-listed cause of injury per 100,000 population. The rate is adjusted for age.</p>	<p>Cooperative System (SPARCS)^b</p>	<p>phiginfo@health.ny.gov</p> <p>Data Contact: Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: sparcs.requests@health.ny.gov Phone: (518) 473-8144</p>	<p>Prevention</p>
<p>68 - Percentage of adults who have experienced two or more adverse childhood experiences (ACEs)</p> <p>County Dashboard Tracking Indicator Number - 48</p>	<p>Adverse childhood experiences (ACEs) include eight categories of experiences: Household Dysfunction 1. Mentally ill household member 2. Substance abuse in household 3. Incarcerated household member 4. Parental separation/divorce 5. Violence between adults in household Childhood Abuse 6. Physical abuse 7. Emotional abuse 8. Sexual abuse.</p>	<p>NYS Behavioral Risk Factor Surveillance System^c</p>	<p>Program Contact: Bureau of Community Chronic Disease Prevention ManageYourHealthNY@health.ny.gov</p> <p>Data Contact: BRFSS Program BRFSS@health.ny.gov</p>	<p>Mental and Substance Use Disorders Prevention</p>
<p>69 - Indicated reports of abuse/maltreatment, rate per 1,000 children, aged 0-17 years</p> <p>County Dashboard Tracking Indicator Number - 49</p>	<p>Indicated reports of abuse/maltreatment rate per 1,000 children aged 0-17 years.</p>	<p>National Child Abuse and Neglect Data System (NCANDS)</p>	<p>Program Contact: Public Health Information Group phiginfo@health.ny.gov</p>	<p>Mental and Substance Use Disorders Prevention</p>
<p>70 - Percentage of adults with major depressive episodes during the past year</p>	<p>Percentage of adults (aged 18 years and older) with major depressive episodes during the past year.</p>	<p>National Survey on Drug Use and Health (NSDUH)</p>	<p>Program Contact: Public Health Information Group phiginfo@health.ny.gov</p>	<p>Mental and Substance Use Disorders Prevention</p>
<p>71 - Percentage of adolescents with major depressive episodes during the past year, aged 12-17 years</p>	<p>Percentage of adolescents (aged 12-17 years) with major depressive episodes during the past year.</p>	<p>National Survey on Drug Use and Health (NSDUH)</p>	<p>Program Contact: Public Health Information Group phiginfo@health.ny.gov</p>	<p>Mental and Substance Use Disorders Prevention</p>
<p>72 - Percentage of high school students who attempted suicide one or more times during the</p>	<p>Percentage of high school students (grades 9-12) who attempted suicide one or more times during</p>	<p>Youth Risk Behavior Surveillance System</p>	<p>Program Contact: Public Health Information Group phiginfo@health.ny.gov</p>	<p>Mental and Substance Use Disorders</p>

past year	the 12 months before the survey.		ov	Prevention
<p>73 - Suicide mortality, age-adjusted rate per 100,000 population</p> <p>County Dashboard Tracking Indicator Number - 50</p>	<p>The number of deaths with an ICD-10 primary cause of death code: X60-X84 or Y87.0 per 100,000 population. The rate is adjusted for age.</p>	<p>Vital Records^a</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov ov</p> <p>Data Contact: Vital Statistics Unit Bureau of Health Informatics Division of Information and Statistics Office of Quality and Patient Safety Contact: bio-info@health.ny.gov Phone: (518) 473-8144</p>	<p>Mental and Substance Use Disorders Prevention</p>
<p>74 - Percentage of adults who smoke cigarettes among adults with serious mental illness (SMI)</p>	<p>Percentage of adults who smoke cigarettes in the past month among adults (aged 18 years and older) with serious mental illness (SMI).</p>	<p>National Survey on Drug Use and Health (NSDUH)</p>	<p>Program Contact: Public Health Information Group phinfo@health.ny.gov ov</p>	<p>Mental and Substance Use Disorders Prevention</p>

Prevent Communicable Diseases				
Indicator	Indicator Description and Note	Data Source	Program and Data Contact	Prevention Agenda Focus Area
75 - Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series County Dashboard Tracking Indicator Number - 51	Percentage of 24-35 month old children with the 4:3:1:3:3:1:4* immunization series BY 2nd birthday (4 DTap, 3 polio, 1 MMR, 3 HepB, Up to date Hib, 1 varicella, up to date PCV).	NYS Immunization Information System (NYSIIS) and Citywide Immunization Registry (CIR)	Program Contact: NYS Bureau of Immunization immunize@health.ny.gov Data Contact: nysiis@health.ny.gov cir@health.nyc.gov	Vaccine Preventable Diseases
76 - Percentage of 13-year-old adolescents with a complete HPV vaccine series County Dashboard Tracking Indicator Number - 52	Percentage of 13-year-old adolescents with a complete HPV vaccine series BY 13th birthday.	NYS Immunization Information System (NYSIIS) and Citywide Immunization Registry (CIR)	Program Contact: NYS Bureau of Immunization immunize@health.ny.gov Data Contact: nysiis@health.ny.gov cir@health.nyc.gov	Vaccine Preventable Diseases
77 - Difference in the 4:3:1:3:3:1:4 immunization series coverage by federal poverty level	Difference in the 4:3:1:3:3:1:4 immunization series coverage between 19-35-month old children living in households below the federal poverty level compared with those living in households at or above the federal poverty level.	National Immunization Survey	Program Contact: NYS Bureau of Immunization immunize@health.ny.gov	Vaccine Preventable Diseases
78 - Newly diagnosed HIV cases, rate per 100,000 population County Dashboard Tracking Indicator Number - 53	The number of people newly diagnosed with human immunodeficiency virus (HIV), regardless of concurrent or subsequent AIDS diagnosis, per 100,000 population. The discrepancy in totals is due to the exclusion of prisoner cases for counties outside NYC, but not for NYC OR for the NYS total.	NYS HIV Surveillance System	Program Contact: Bureau of HIV/AIDS Epidemiology bhae@health.ny.gov	Human Immunodeficiency Virus (HIV)
79 - Percentage of all persons living with diagnosed HIV who receive care with suppressed viral load	The percentage of all persons living with diagnosed HIV (PLWDH) who are virally suppressed (<200 copies/ml) at the last VL test of the year among those in care,	NYS HIV Surveillance System	Program Contact: Bureau of HIV/AIDS Epidemiology bhae@health.ny.gov	Human Immunodeficiency Virus (HIV)

	defined as having at least one viral load, CD4, or genotype lab test result reported to the HIV surveillance system during the year.			
80 - Gonorrhea diagnoses, age-adjusted rate per 100,000 population County Dashboard Tracking Indicator Number - 54	The age-adjusted rate of gonorrhea diagnoses per 100,000 persons in the time period.	NYS STI Surveillance System	Program Contact: Office of Sexual Health and Epidemiology Phone: 518-474-3598 stdc@health.ny.gov	Sexually Transmitted Infections (STIs)
81 - Chlamydia diagnoses, age-adjusted rate per 100,000 population County Dashboard Tracking Indicator Number - 55	The age-adjusted rate of chlamydia diagnoses per 100,000 persons in the time period.	NYS STI Surveillance System	Program Contact: Office of Sexual Health and Epidemiology Phone: 518-474-3598 stdc@health.ny.gov	Sexually Transmitted Infections (STIs)
82 - Early syphilis diagnoses, age-adjusted rate per 100,000 population County Dashboard Tracking Indicator Number - 56	The age-adjusted rate of early syphilis diagnoses per 100,000 persons in the time period.	NYS STI Surveillance System	Program Contact: Office of Sexual Health and Epidemiology Phone: 518-474-3598 stdc@health.ny.gov	Sexually Transmitted Infections (STIs)
83 - Cumulative number of Medicaid enrollees treated for HCV	Data represents the number of Medicaid Fee-for-Service or Managed Care members with pharmacy claims for Direct Acting Antivirals (DAAs) used to treat hepatitis C virus (HCV).	NYS Medicaid Data Warehouse	Program Contact: Bureau of Hepatitis Health Care hepatabc@health.ny.gov	Hepatitis C Virus (HCV)
84 - Number of individuals with a syringe transaction at an AIDS Institute-registered syringe exchange program	These data only reflect individuals receiving syringes through syringe exchange programs registered with the New York State AIDS Institute. Individuals receiving syringes by prescription, or at pharmacies through the Expanded Syringe Access Program, are not included.	AIDS Institute Reporting System (AIRS)	Program Contact: Bureau of Hepatitis Health Care hepatabc@health.ny.gov	Hepatitis C Virus (HCV)

^a [Vital Records \(Vital Statistics\):](#)

Vital Event Registration:

New York State consists of two registration areas, New York City and New York State Exclusive of New York City (also referred to as Rest of State). New York City (NYC) includes the five counties of Bronx, Kings (Brooklyn), New York (Manhattan), Queens and Richmond (Staten Island); the remaining 57 counties comprise New York State Exclusive of New York City. The Bureau of Vital Records, New York State Department of Health (NYSDOH), processes data from live birth, death, fetal death and marriage certificates recorded in New York State Exclusive of New York City. Through a cooperative agreement, the New York State Department of Health receives data on live births, deaths, fetal deaths and marriages recorded in New York City from the New York City Department of Health and Mental Hygiene (NYCDOHMH). The New York State Department of Health also receives data, from other states and Canada, on live births and deaths recorded outside of New York State to residents of New York State.

Vital Event indicators for NYC geographical areas reported by NYSDOH and NYCDOHMH may be different since the former may include all NYC residents' events regardless of where they occurred and the latter reports only events to NYC residents that occurred in NYC. The indicators may also differ due to timing and/or completeness of data.

The counts of births and deaths may be influenced by specific reporting issues each year. The specific issues are reported in the NYSDOH Annual Vital Statistics Tables, in the Report Measures section of the Technical Notes.

All the vital statistics presented in this report are based on the county/borough of residence.

^b [Statewide Planning and Research Cooperative System \(SPARCS\):](#)

Information about hospitalizations is collected through the hospital inpatient discharge data system. Each hospitalization receives an ICD-10-CM code at discharge that indicates the primary reason for the hospitalization. There are also up to 24 other diagnosis codes recorded to further describe the hospitalization. Statistics presented in these tables are based on the primary diagnosis unless otherwise noted. This data system does not include information about events that did not result in a hospitalization, such as cases that were only treated in a hospital emergency room. The SPARCS data do not include visits/discharges by people who sought care from hospitals outside of New York State, which may lower numbers and rates for some counties, especially those which border other states. Numbers and rates are based on the number of hospitalizations that occurred and not the number of individuals who were hospitalized. SPARCS measures provided are generated based on patient residence county at time of discharge.

^c [Behavioral Risk Factor Surveillance System \(BRFSS\):](#)

The BRFSS is an annual statewide random telephone and cellular surveillance survey designed by the Centers for Disease Control and Prevention (CDC). The

survey is conducted in all 50 states and US territories. BRFSS monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality in the population.

County level data. The Expanded BRFSS (EBRFSS) augments the annual CDC Behavioral Risk Factor Surveillance System Survey (BRFSS). The goal of the Expanded BRFSS is to collect county-specific data on preventative health practices, risk factors, injuries and preventable chronic and infectious diseases. County level data are currently available for 2002-03, 2008-09, 2013-14, 2016 and 2018.

The New York State BRFSS [website](#) has further information.

Methodology and Limitations

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Types of Estimates

1. Percentage/age-adjusted percentage: Percentages are calculated per 100 population (e.g. the percentage of infants exclusively breastfed in the hospital represents the number of infants that were fed exclusively with breast milk among 100 live infants born in the hospital). The percentages were age-adjusted to the U.S. 2000 standard population using appropriate age distributions. ¹ Age-adjustment is a process that is performed to allow communities with different age structures to be compared. ²
2. Weighted percentage/age-adjusted weighted percentage: Weighted percentages were generated for survey data (e.g., Behavioral Risk Factor Surveillance System, Youth Tobacco Survey, Youth Risk Behavior Surveillance System, National Immunization Survey) which ensures that the data are as representative of New York's population as possible. Weighted estimates are shown as a percentage (%) and corresponding 95% confidence intervals (CI) are presented when available. The weighted percentages were age-adjusted to the U.S. 2000 standard population using appropriate age distributions. ¹ Age-adjustment is a process that is performed to allow communities with different age structures to be compared. ²
3. Rate/age-adjusted rate: A rate is a measure of the frequency with which an event occurs in a defined population over a specified period of time. Rates used for the Prevention Agenda tracking indicators are per 1,000, 10,000 or 100,000 population. The rates were age-adjusted to the U.S. 2000 standard population using appropriate age distributions. ¹ Age-adjustment is a process that is performed to allow communities with different age structures to be compared. ²

4. Ratio: A ratio is the relative magnitude of two quantities or a comparison of any two values. The ratios that are included in the Prevention Agenda are calculated by dividing the percentage or rate of one racial ethnic group (i.e., Black non-Hispanic or Hispanic) by the percentage or rate for the white non-Hispanic group.
5. Rate/percentage difference: The rate/percentage difference is the absolute difference between two rates/percentages. Among the Prevention Agenda tracking indicators, the rate/percentage difference is used as a measure when comparing the percentage of premature deaths among (a) the non-Hispanic Black population versus the non-Hispanic White population and (b) the Hispanic population versus the non-Hispanic White population.

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Population Estimates

Population estimates are developed by the US Census Bureau.

Estimates for 2020 and earlier are from [Bridged Race Categories](#) files, developed by the Census Bureau for the National Center for Health Statistics. The 2018 population estimates are used to calculate rates for 2019 and 2020.

Estimates for 2021 and later are from Special Tabulations from the [US Census Population and Housing Unit Estimates Program](#).

See [this document](#) for information about why different estimates were used, the differences in these estimates, and why 2018 estimates were used to calculate rates for 2019 and 2020.

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Unstable Estimates

Multiple years of data were combined to generate more stable estimates when the number of events for an indicator was small (i.e., rare conditions).

The relative standard error (RSE) is a tool for assessing reliability of an estimate. A large RSE is produced when estimates are calculated based on a small number of cases.² Estimates with large RSEs are considered less reliable than estimates with small RSEs. The [National Center for Health Statistics](#) recommends that estimates with RSEs greater than 30% should be considered unreliable/unstable.³ The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying that result by 100. The RSE is expressed as a percent of the estimate.

For the Prevention Agenda dashboard, an asterisk (*) or plus (+) symbol is used to indicate that a percentage, rate, or ratio is unreliable/unstable. This usually occurs when there are less than 10 events in the numerator (RSE is greater than 30%).

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Direction of Indicator Estimates

Prevention Agenda tracking indicators fall into two categories with regard to the desirable direction of their estimates. Sometimes lower estimates are better (e.g., the percentage of premature deaths before age 65 years, or the age-adjusted rate of potentially preventable hospitalizations among adults) and in other cases higher estimates are better (e.g., the percentage of the population with health insurance,

or the percentage of infants exclusively breastfed in the hospital).

The desirable direction of the Prevention Agenda tracking indicator is important to note because the county bar chart, map, concern level and visual distribution use color categories that are based on the direction of the Prevention Agenda tracking indicator. The assessment of indicator performance is also based on the direction of the Prevention Agenda tracking indicator.

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Grouping County Estimates into Three Categories for the County Visual Distributions, County Maps, and County Bar Charts

Color Categories Defined

For each Prevention Agenda tracking indicator, county visual distributions, maps and bar charts are generated when there are enough counties with data different from each other so that county visual distributions, maps and charts can show meaningful differences among the counties. In particular, county visual distributions, maps and charts are not generated if 46 or more counties have rates that are equal to 0 or are missing, or if more than half the counties have the same rate. County visual distributions, maps and charts are generated all other times. Tables are generated for all indicators in all counties, regardless of rate values. When county visual distributions, maps and charts are generated, county estimates are grouped into three categories: light green, blue-green, and dark blue. These categories are displayed consistently in the county visual distribution, the bar chart, and the New York State map for each tracking indicator.

The three colors represent the quartile distribution of estimates for the counties ordered from those doing the best to those doing the worst.

For Prevention Agenda tracking indicators where lower estimates are better (e.g., percentage of premature deaths before age 65 years or the age-adjusted rate of potentially preventable hospitalizations among adults):

- The LIGHT GREEN category includes counties that are performing the best (i.e., 50% of counties with the lowest estimates; those in quartile 1 and quartile 2) and is the most favorable category or least concern for a county's estimate to be in.
- The DARK BLUE category includes counties that are performing the worst (i.e., 25% of counties with the highest estimates; those in quartile 4) and is the least favorable or high concern category for a county's estimate to be in.
- The BLUE-GREEN category includes counties that are performing in the middle (i.e., 25% of counties or those in quartile 3).

For Prevention Agenda tracking indicators where higher estimates are better (e.g., the percentage of the population with health insurance or the percentage of infants exclusively breastfed in the hospital):

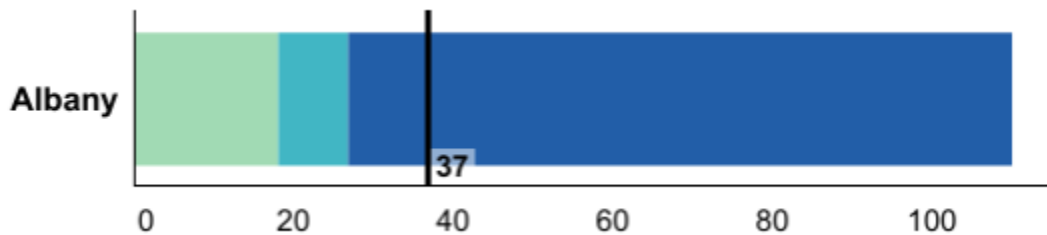
- The LIGHT GREEN category includes counties that are performing the best (i.e., 50% of counties with the highest estimates; those in quartile 3 and quartile 4) and is the most favorable or least concern category for a county's estimate to be in.
- The DARK BLUE category includes counties that are performing the worst (i.e., 25% of counties with the lowest estimates; those in quartile 1) and is

- the least favorable or high concern category for a county's estimate to be in.
- The BLUE-GREEN category includes counties that are performing in the middle (i.e., 25% of counties or those with estimates in quartile 2).

Length of Color Categories in the County Visual Distribution

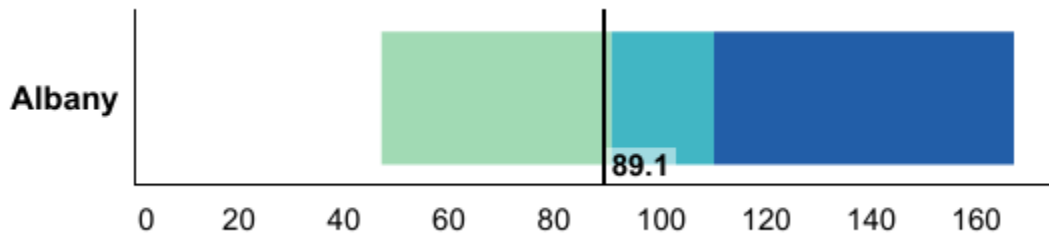
The length of each color in the county visual distribution represents the minimum and maximum values or cut-off points for the three categories. If the area is very big, this indicates that the range of county estimates is large; while a small area indicates a small range of county estimates.

For example, the county visual distribution for the asthma emergency department visit rate per 10,000 for those aged 0-17 years in Albany County in 2020 shows a very large dark blue area which ranges from 26.8 to 110.2; while the light green area ranges from 0.0-<18.1 and has a much narrower width; similarly, the blue-green area has a narrow range of estimates from 18.1-<26.8.

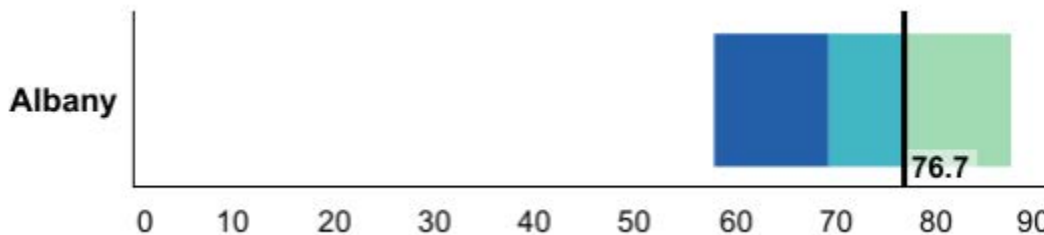


Color Switch in County Visual Distribution Based on Direction of Indicator Estimates

For Prevention Agenda tracking indicators where lower estimates are better (e.g., potentially preventable hospitalizations among adults, age-adjusted rate per 10,000), the dark blue category is displayed on the right side of the county visual distribution.



For Prevention Agenda tracking indicators where higher estimates are better (e.g., the percentage of women with a preventive medical visit in the past year, aged 18-44 years), the dark blue category is displayed on the left side of the county visual distribution.



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Comparing the Prevention Agenda Estimates with the Prevention Agenda Objectives

A green color in bar charts or for a number displayed in a data table indicates that the current value for the Prevention Agenda tracking indicator met the Prevention Agenda 2024 Objective. A red color in bar charts or for a number displayed in a data table indicates that the current value for the Prevention Agenda tracking indicator did not meet the Prevention Agenda 2024 Objective.

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Assessing the Indicator Performance

Three different methods were used to assess indicator performance.

1. Conduct one-sided z-test to assess the change (decrease/increase or improve/worsen) in estimates between the two most recent time periods. The p-value for rejecting the null hypothesis is less than or equal to 0.05 and the critical value for the one-sided test (p-value at 0.05) is 1.645. ⁴
2. A comparison of confidence intervals of estimates for the two most recent time periods was performed where this method was more appropriate. ⁴ A confidence interval is a range around an estimate that conveys how precise the estimate is. Differences between estimates are **considered "statistically significant" when the estimates being compared do not have overlapping confidence intervals**. For the purposes of this dashboard, in cases where the confidence intervals overlap, the difference is interpreted as not statistically significant at the 95% confidence level. For survey related indicators, estimates and the two-sided 95% confidence intervals were obtained and used. In some instances for count data (e.g., births, deaths, hospitalizations, and emergency department visits), we calculated the one-sided 95% confidence intervals for the estimates and used them for comparison to evaluate the indicator performance. ⁵
NOTE: This method is an approximation of a statistical test and may result in a more conservative finding. In some cases, an appropriate statistical test would indicate a statistically significant difference even though the confidence intervals overlap and falsely imply no significant difference. When two confidence intervals do not overlap, though, a comparable statistical test would always indicate a statistically significant difference. ⁶
3. Simple comparison was conducted where the two estimates were directly compared to each other based on their magnitude. This was performed when there was not a sufficient amount of data to conduct significance testing; or if confidence intervals could not be calculated; or if there is some overlap of the two time intervals being compared (e.g., 2014-2016 and 2015-2017 maternal mortality indicators).

The categories for the Indicator Performance are as follows:

- Significantly improved
- Significantly worsened
- No significant change
- Improved[^]
- Worsened[^]
- No change[^]
- Baseline data

The "[^]" sign indicates that the performance was determined using simple comparison and not statistical tests.

The most recent data available during the planning phase were used as a baseline to set the Prevention Agenda 2024 Objective/Target. **"Indicator Performance" is not assessed if there are no available data points that are more recent than the baseline data. Therefore, the "Indicator Performance" is labeled as "Baseline data" until updated data are available.**

See Table 1 below for statistical significance techniques used for each type of data source to assess the indicator performance.

Use caution when interpreting significance. For more common conditions (i.e., high incidence rates), there is a higher likelihood that a relatively small change could be detected as statistically significant. Conversely, for rare conditions, the likelihood of detecting a statistically significant change is low even for reasonable changes.

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Data Filters

Several data filters are available on state and county views to quickly select indicators based on commonly desired criteria. Multiple filters can be selected simultaneously.

1. State data filters: two data filters are available for state level indicators
 - Filter on meeting 2024 objective target: This filter displays indicators, where the most recent state level data meeting or not meeting the Prevention Agenda 2024 objectives.
 - Filter on indicator performance over time: The performance status for each indicator is generated by comparing state level data for the two most recent time periods. This filter displays indicators based on indicator performance categories selected.
2. County data filters: three data filters are available for county level indicators
 - Filter on meeting 2024 objective target: This filter displays indicators, where the most recent specific county data meeting or not meeting the Prevention Agenda 2024 objectives.
 - Filter on indicator performance over time: The performance status for each indicator is generated by comparing estimates for the two most recent time periods for a specific county. This filter displays indicators based on indicator performance categories selected.
 - Filter on **county's position of concern level**: This filter displays indicators based on how a county is doing in comparison to other counties in a quartile distribution.

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Sub-county Data

To better serve the needs for more local level data, we have assessed the availability of sub-county level data for the existing county level indicators. Depending on the availability of the information from the data sources, sub-county level data are presented in one of the following three geographic levels: ZIP Code, school district, or minor civil division (MCD)/community district (CD).

- ZIP Code: For indicators generated from SPARCS (inpatient and outpatient) data, ZIP Code refers to resident address ZIP Code. If a ZIP Code crosses county borders, the ZIP Code is assigned to the county which has the largest proportion of the population of that ZIP Code. ZIP Code level population estimates used for calculating rates were obtained by the New York State Department of Health (NYSDOH) from the Claritas Corporation.
- School District: Student weight data at the school district level (outside of New York City) came from the Student Weight Status Category Reporting System (SWSCR). A school district boundary file was generated by combining two US Census shape files – a unified school district file and a secondary school district file.
- Minor Civil Division (MCD)/Community District (CD): Birth and death certificate data for counties outside of New York City (NYC) are presented by MCD. Data for NYC boroughs are presented by CD. There are 59 CDs within the five NYC boroughs.

Note: A small percent of records did not have an assigned MCD or CD, but the records had other geographic identifiers. For NYC records with missing CD, ZIP Code information was used to look up and assign the CD location utilizing NYC Department of Planning geographic data linking ZIP Codes to CDs. This linked file contains a small number of ZIP Codes, which were completely contained within a single CD. Records with those ZIP codes were assigned to those CDs. For records of residents from the rest of the state (ROS), outside of NYC, with a missing MCD, the New York State Gazetteer code* was used to look up the MCD code. DOH staff linked the Gazetteer codes to MCDs, and the linkage was used to assign records outside of NYC to an MCD.

*The New York State Gazetteer was prepared by the New York State Department of Health (see: health.data.ny.gov/Health/New-York-State-Gazetteer/cpcx-4uew)

Based on further assessment of the stability of the estimates and the impact of data suppression, the following six indicators were selected for incorporating into the current PA tracking dashboard.

- ZIP Code level:
- Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000
- Asthma emergency department visits, rate per 10,000, aged 0-17 years
- School district level:
- Percentage of children and adolescents with obesity (NYS excluding NYC)
- MCD/CD level:
- Percentage of premature deaths (before age 65 years)

- Percentage of births that are preterm
- Percentage of infants who are exclusively breastfed in the hospital among all infants

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Data Suppression for Confidentiality

Results are not shown (i.e., suppressed) when issues of confidentiality exist. Suppression rules vary depending on the data source and the indicator.

Table 1. Summary of data suppression and statistical evaluation significance for the Prevention Agenda Indicators by data source

Data Sources	Suppression Criteria	Statistical Significance Techniques
Sample Surveys		
Pregnancy Risk Assessment Monitoring System	Denominator <30	95% CI comparison
BRFSS and Expanded BRFSS	Numerator <6 or Denominator <50	95% CI comparison
US Census		90% CI comparison
National Survey on Drug Use and Health		95% CI comparison
Youth Risk Behavior Surveillance System	Denominator <100	95% CI comparison
Youth Tobacco Survey		95% CI comparison
Population Count Data		
Death	Single Year: Denominator population <50; Three-Year Combined: Denominator population <30	Rate/percentage: one sided chi-square test with p-value <0.05 Rate difference: one sided 95% CI comparison
Birth	Single Year: Denominator total Births <50	One sided chi-square test with p-value <0.05
Sexually Transmitted Infection (STI) Surveillance		One sided chi-square test with p-value <0.05
HIV Surveillance	Numerator 1-2 cases	County level (rate): one sided 95% CI comparison; State level (rate): one sided chi-square test with p-value <0.05
SPARCS	Numerator between 1 - 5 cases	Rate/percentage: one sided chi-square test with p-value <0.05; Ratio/Rate difference: one sided 95% CI comparison
Prescription Monitoring Program (PMP)	Numerator between 1 - 5 cases	One sided chi-square test with p-value <0.05

Registry		
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CI: Confidence Interval

BRFSS: Behavioral Risk Factor Surveillance System

SPARCS: Statewide Planning and Research Cooperative System

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Data Limitations

Table 2. Summary of Limitations for Data Presented on the Prevention Agenda Dashboard

Indicator	Data Source	Limitations
Sample Surveys		
6 - Percentage of children and adolescents with obesity (NYS excluding NYC)	Student Weight Status Category Reporting System (SWSCRS)	Because of restrictions in reporting due to the Family Educational Rights and Privacy Act (FERPA), parents'/guardians' ability to request that their child's weight status data be excluded from reporting, and other sources of missing data, not all students have data in the data system. The percent of students with reported data varies from county to county. Therefore these estimates do not necessarily represent all school aged-children attending school in that county. School districts report weight status data separately for students in elementary school, middle/high school, and the school district as a whole, so that the counts of students represented in the district totals for a county will not necessarily equal the counts of students in the elementary and middle/high totals for that county.
Population Count Data		
2 - Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000	SPARCS	At the ZIP Code level, very unusual distributions in population denominator and/or numerator (possibly due to multiple hospitalizations per individual) may result in extreme age adjusted rates, therefore, these estimates are suppressed or to be interpreted with caution.
78 - Newly diagnosed HIV cases, rate per 100,000 population	HIV Surveillance	The discrepancy in totals is due to the exclusion of prisoner cases for counties outside NYC, but not for NYC OR for the NYS total.

Note: The 2018 population estimates are also used to calculate rates for 2019 and 2020.

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Revisions

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