



Madison County Community Health Needs Assessment

*Working to Build a
Healthy Community*

2005 Edition

Madison County Priorities Council

David W. Dorrance
Public Health Director
Co-Chairperson

Stacy Alvord
Executive Director CAP
Co-Chairperson

MADISON COUNTY DEPARTMENT OF HEALTH DEPARTMENT
P.O. BOX 605, WAMPSVILLE, NEW YORK 13163-0605
• **PHONE: (315) 366-2361** • **FAX: (315) 366-2207**

Dear Colleagues:

The Madison County Priorities Council is pleased to present this Community Health Needs Assessment. It is an update of the first assessment produced in 1998 and is revised based on comments received from the community and agencies that have used the previous document. The new format reflects the growing need and interest of our community for documentation of need in Madison County.

The Priorities Council is a collaboration of governmental and non-governmental Human Service agencies in Madison County. Meeting bi-monthly, the Council has continued in existence due to the interest in working together to make Madison County a “healthy” community. Sharing of ideas, working together on grant applications, and participation in community projects is the “heart and soul” of this dedicated group of people. This assessment is a product of that collaboration.

A special “thank you” goes to Colgate University’s Upstate Institute for their assistance and guidance provided for this project. Jill Tiefenthaler worked closely with our staff to guide us through out the entire project. Sabah Rabbi, a Colgate senior economics major, did the lion’s share of the statistical gathering and data analysis for the assessment. Her efforts definitely need to be recognized in this process. Cathy Baksa, director of Community Health for the County Health Department, deserves recognition for her involvement in the project. Susan Mulcahey, a student intern, assisted in the provider survey under Cathy Baksa’s supervision. Without the help of these individuals, this product would not have been produced.

We hope that you find this report informative and useful as a planning document. The next step is for all of us to establish our priorities for program development, and we are pleased to present this document as a resource for that purpose.

Sincerely,

David W. Dorrance

Stacy Alvord

**Community Health Assessment
Madison County Department of Health
2005**

Project Team

David Dorrance
**Public Health Director
Madison County Department of Health**

Cathy Baksa
**Director of Community Health Services
Madison County Department of Health**

Susan Mulcahey
**Student Intern
Madison County Department of Health**

Sabah Rabbi
**Upstate Institute Student Intern
Colgate University**

Jill Tiefenthaler
**Professor of Economics
Director, Upstate Institute
Colgate University**

Blank Page

Table of Contents

Introduction	7
Priorities Council	8
Map of Madison County	9
Methodology	11
Background Data	11
A. Population.....	11
Employment and Income.....	12
Education.....	12
Nativity.....	13
Mortality.....	13
Disease Mortality.....	14
Unfavorable Disease Mortality Rates.....	14
Favorable Disease Mortality Rates.....	15
Disease Morbidity.....	16
Unfavorable Disease Morbidity Rates.....	16
Favorable Disease Morbidity Rates.....	16
Maternal and Child Health.....	17
B. Access to Care.....	18
Resources in Madison County.....	18
C. Behavioral Risk Factors.....	19
Unfavorable Behavioral Risk Factors.....	19
Favorable Risk Factors.....	20
Needs and Priorities	22
A. Needs Identified.....	22
B. Priorities.....	23
Summary and Recommendations	27
Appendix: Tables	
1.1: Total Population , 2002.....	28
1.2: Total Population Breakdown by Age, 2002.....	28
1.3: Total Population Breakdown by Sex: Males, 2002.....	29
1.4: Total Population Breakdown by Sex: Females, 2002.....	30
1.5: Total Population Breakdown by Race, 2000.....	31
1.7: Income Level, 1999.....	32
1.8: Per-Capita Income 1999.....	32
1.9: Poverty Status, 1999.....	33
1.11: Percent of Children Living Below Poverty, 2000.....	33
1.12: Education Attainment, 2000.....	34
1.14: Language Spoken at Home, 2000.....	34
1.15: School Dropouts, 2001/2002.....	35

1.18: Unemployed— Percent per 100 people in labor force, 2003.....	35
3.1: Cancer— death and death rates per 100,000 residents, 1998-2002	36
3.2: Cancer Incidence rates per 100,000 residents, 1997-2001.....	36
3.5: Women Aged 40 Years and Older who Have Received a Mammogram within the preceding 2 years, 2003	36
4.1: Diabetes—deaths and death rates per 100,000 residents, 2000-2002.....	36
4.2: Uncontrolled Diabetes—Rate per 10,000 population, 2002.....	36
6.1: Pregnancies—rate per 1,000 females age 15-44, 2000-2002.....	37
6.2: Births—rate per 1,000 females, 2000-2002.....	37
6.3: Teenage Births (age 15-17)—percentage per 100 live births, 2000-2002.....	37
6.4: Induced Abortions—ratio per 1,000 live births, 2000-2002.....	37
6.5: Out-of-Wedlock Births—percentage per 100 live births, 2000-2002.....	38
7.1: Communicable Disease—rate per 100,000 population, 2003.....	38
8.1: Heart Disease—deaths and death rates per 100,000 residents, 2000-2002.....	38
9.1: AIDS—deaths and death rates per 100,000 residents, 2000-2002	38
10.1: Sexually Transmitted Diseases—rate per 100,000 population, 2000-2002.....	39
11.1:Deaths and death rates per 100,000 residents, 2000-2002.....	39
12.1: Ambulatory Sensitive Conditions (age 0-4)—discharge rate per 100,000 population age <5, 2000-2002	39
12.2: Asthma (age 5-14)—discharge rate per 100,000 population age 5-14, 2000-2002	40
12.3: Asthma—discharge rate per 100,000 population, 2000-2002	40
12.4: COPD Mortality—rate per 100,000 population, 2000.....	40
13.1: Communicable Diseases—rate per 100,000 population, 2003	41
14.1: Infant Mortality—rate per 1,000 live births, 2000-2002	41
14.2: Maternal Child Health—percentage per 100 live births, 2000-2002.....	42
14.3: Newborn Drug Related—discharge rate per 10,000 newborn discharges, 2000-2002...42	
15.2: Children (age 0-4) who are Underweight—percent per 100 children tested, 2000-2002	43
15.3: Percentage of Obese Adults, 2003	43
16.1: Binge Drinking, 2003	43
16.2: Drug Related—discharge rate per 10,000 population, 2000-2002	43
16.3: Cirrhosis Mortality: deaths and death rates per 100,000 residents, 2000-2002	43
16.4: Alcohol Related Motor Vehicle Deaths and Injuries—rate per 100,000 population, 1999-2001	43
17.1: Cigarette Smoking Adults, 2003.....	44
17.2: Women who Smoke During Pregnancy, 2003.....	44
18.1: Suicide Mortality Rates per 100,000 residents, 2000-2002	44
18.2: Homicide Mortality Rates per 100,000 residents, 2000-2002	44
18.3: Adolescent/Young Adult Suicide (age 15-19)—deaths and death rates per 100,000 Residents age 15-19, 2000-2002.....	44
18.4: Self-inflicted Injury—discharge rate per 100,000 population, 2000-2002	45
18.5: Assault—discharge rate per 100,000 population, 2000-2002.....	45
18.6: Unintentional Injury—deaths and death rates per 100,000 residents, 2000-2002	45
18.7: Unintentional Injury—discharge rate per 100,000 population, 2000-2002	45
Report Card.....	46

* for a full list of tables included in the report, please visit <http://upstate.colgate.edu>

Introduction

Since the early 1990's the United States has focused its interest on developing and following prevention initiatives to improve the health of all Americans. The production of Healthy People 2000 Goals and Objectives was the first work in this area. New York State followed suit in 1996 with incentives to Local Health Departments to assess and prioritize actions related to the national goals.

Madison County produced the first Community Health Needs Assessment in 1998 through a coalition of governmental and non-governmental agencies interested in human services. Since that time, the coalition has evolved into the Madison County Priorities Council. The council has representatives from a wide variety of human service agencies, and is an informal group that working together with the express purpose of improving the "health" of the community.

While the Madison County Department of Health has a requirement and a responsibility to conduct an assessment of health needs every six years in order to qualify for State Aid, the Community Health Needs Assessment goes beyond those requirements. This document can be used by all agencies in support of program development in Madison County. The health indicators reviewed are of interest to participating agencies, with a statistical comparison to neighboring counties and New York State.

We hope this information is of interest and helpful to the reader. Any one of the agencies involved is available for additional information or assistance to direct inquiries to the appropriate source. We all work together toward "building a healthy community."

There is more data and a full Community Needs Assessment on the Madison County website at <http://www.madisoncounty.org> and the Upstate Institute website at <http://upstate.colgate.edu>.

Madison County Priorities Council

BRiDGES, Madison County Council on Alcoholism and Substance Abuse, Inc.
Colgate University
Community Action Program for Madison County
Community Memorial Hospital
Consumer Services
Cornell Cooperative Extension of Madison County
Family Ties Network, Inc.
Liberty Resources, Inc.
Madison-Cortland ARC
Madison County Department of Health
Madison County Department of Social Services
Madison County Employment and Training
Madison County Head Start
Madison County Mental Health Department
Madison County Office for the Aging, Inc.
Madison County Planning Department
Madison County Youth Bureau
Madison-Herkimer WIC
Oneida Healthcare Center
Planned Parenthood of the Mohawk Valley, Inc.
The Retired and Senior Volunteer Program

Project Team

David Dorrance, Public Health Director
Madison County Department of Health

Cathy Baksa, Director of Community Health Services
Madison County Department of Health

Susan Mulcahey, Student Intern
Madison County Department of Health

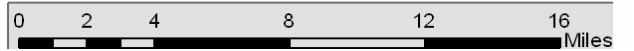
Sabah Rabbi, Upstate Institute Student Intern
Colgate University

Jill Tiefenthaler, Professor of Economics
Director, Upstate Institute
Colgate University

Madison County



E



Blank Page

Methodology

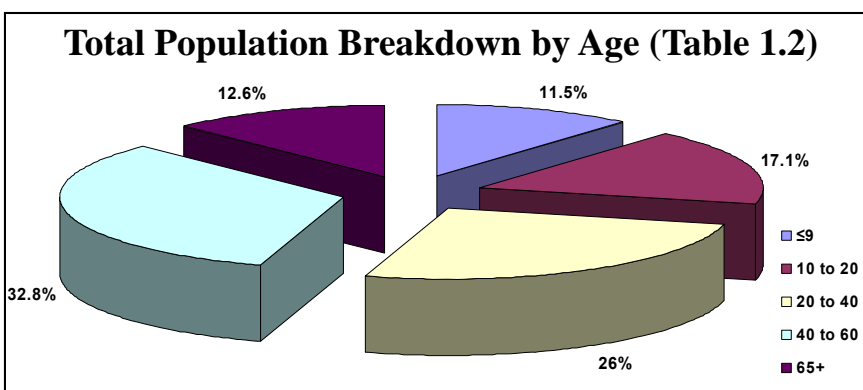
The objective of the Community Health Assessment is to evaluate the health status and resources of Madison County in order to identify the priority areas for focus for the next five years. The background data collected includes demographic and social indicators, environmental health indicators, behavioral indicators, maternal and child health indicators, infectious disease indicators, data on access to health, and an inventory of health resources in the community. Our methodology is to compare Madison County data with state and peer county indicators, as well as data from the 1998 Madison County Community Health Assessment. The peer counties, selected by the Priorities Council, are Herkimer, Oswego, and Chenango. These counties are similar to Madison County in population and rural character. Data was collected from a variety of sources and the most recent data available were included. All secondary data referenced in the report is included in the tables in Appendix A. In addition to collecting existing data, primary data was generated from a survey of health care and dental care providers. The results from these surveys are presented in the tables in the appendix. Data and conclusions from the Madison County 2003 Teen Assessment Project (TAP) survey and the Community Assessment Report 2003 are also referenced in the report. The full report is available at <http://upstate.colgate.edu>.

Background Data

A. Population

The Brookings Institute's "Upstate New York's Populations Plateau" shows that the Upstate region experienced stagnant population growth during the 1990s compared with the national increase of 13%¹. Central New York and Madison County are no exceptions. The Central New York region saw its population decline by 2.3% in the 1990s. In the same time period, Madison County's total population decreased from 71,508 in 1996 to 69,789 in 2002 (See Table 1.1). The current population of Madison County is comparable to the populations of both Herkimer (63,741) and Chenango (51,324) counties.

The age distribution of Madison County is comparable to those of its peer counties (See Table 1.2). About 23.4% of the population in Madison County is less than 18 years old. Oswego and Chenango both have a higher percentage of population under 18 with 28.9% and 27.2%, respectively. Herkimer, on the other hand, is more comparable to Madison County with 22.8% of its population being under 18. New York State has 26.6% of its population under 18. The percentage of the population that is



50 years or older in Madison County is 29.5%, which is comparable to the state rate of 28.9%. Herkimer (34.5%) and Chenango (32.8%) have higher percentages of those over 50 while Oswego is similar to Madison at 27.6%.

As the Upstate and Madison County populations have stagnated, the senior citizen

¹ Brookings Institute, August, 2003.

population has increased in size and share. The Brookings report shows that the percentage of senior citizens in Upstate New York was 14% in 2000 compared to 12.1% nationally. The median age for Madison County is 36.1, compared to 31 years as reported in the 1998 study. The state median age has also increased to 35.9 in 2002 from 33.8 as was reported in the 1998 study.

About 49% of the population is male and 51% is female in Madison County (see Table 1.3 and 1.4). Herkimer has 48% males and 52% females, 49% of Oswego's populations are males and 51% are females and 49% of Chenango's population is males and 51% females. In New York State, 48% of the population is male and 52% is female.

Madison County, along with the selected peer counties, differs significantly from the state when the population is broken down by race. Unlike the state, the upstate counties have very few non-white residents. More than 95% of the population of the selected counties is white whereas for New York State only about 68% of the population is white (see Table 1.5).

Employment and Income

The most recent annual unemployment rate in Madison County (see Table 1.18) is 5.9%. Both Chenango and Oswego counties have higher rates of unemployment at 6.3% and 8.8%, respectively. The state rate is 6.3%. It is therefore not surprising that both the median household and family income is higher for Madison County than for its peer counties (see Table 1.7). Median household income for Madison County is \$40,184 compared with \$32,924 for Herkimer, \$37,598 for Oswego, \$33,679 for Chenango, and \$43,393 for New York State. According to the data in the 2000 Census summary form (see Table 1.7), only 8.4% of the population in Madison County earns less than \$10,000 per year compared 10.4% in Oswego County, 11.4% in Chenango County, and 11.5% in New York State. The Census data also shows that the per capita income for Madison County is much higher than the per capita income for the peer counties (see Table 1.8). However, it is lower than the New York State per capita income.

Madison County also has a lower percentage of its population living below the poverty level than the selected peer counties (see Table 1.9). About 9.8% of the population in Madison County has household income below the poverty level compared with 12.5% in Herkimer, 14% in Oswego, 14% in Chenango, and 14.6% in New York State. In addition, about 12.1% of the children in Madison County live in poverty as compared to 16.8% of the children in Herkimer, 17.5% in Oswego, and 20.4% in Chenango County (see Table 1.11). In New York State, 19.1% of all children live in poverty.

Education

The Brookings Institution's report "Transition and Renewal: The Emergence of a Diverse Upstate Economy," points out that higher education is an important part of the Upstate economy². There are 206 colleges and universities in Upstate. In addition to playing an important role in contributing to Upstate's economy, the importance of higher education results in a higher-than-average percentage of residents in college and a higher level of educational attainment for the region relative to the national average. In 2000, 7% of Upstate residents were enrolled in college or graduate school compared to 6.5% nationally. In addition, 32.8% of Upstate residents have attained a college degree (including Associate's degrees) compared with 30.7% nationally.

²The Brookings Institution, January, 2004.

Madison County enjoys the strong education statistics of the entire Upstate region. According to the Census data (see Table 1.12), 83.3% of the population in Madison County has completed high school or more, compared with 79.4% in Herkimer County, 80.4% in Oswego County, 80.6% in Chenango County, and 79.1% in New York State. Madison County has a significantly higher percentage of its residents with college degrees than other Central New York counties with 21.6% of residents completing a bachelor's degree or higher. Comparative numbers for Herkimer, Oswego, and Chenango are 15.7%, 14.4%, and 14.4%, respectively. All of these statistics indicate that Madison County has strong educational attainment.

When compared with New York State averages, Madison County's school districts fare quite well. Only 2.5% of the high school students in Madison County dropped out, compared with 3.1% of students in Herkimer County, 3.3% in Oswego County, 2.8% in Chenango County and 3.7% in New York State (see Table 1.14). Impressively, about 81.5% of Madison County High School graduates (see Table 1.15) intend to enroll in college; whereas 85.4% of Herkimer High School graduates, 79% of Oswego High School graduates, 73.1% of Chenango High School graduates, and 80.8% of all New York State High School graduates have such intentions.

Natality

Data show that Madison County has a lower birth rate compared to both the State rate and peer county rates (see Table 6.2). The birth rate (per 1000 females) in Madison County is 48.9 which is much lower than the rates in Herkimer County, Oswego County, and Chenango County at 53, 51.9, and 57.2, respectively. It is also much lower than the New York State rate of 60.4. The low birth rate is one cause of the increase in the median age group for Madison County as compared to its peer counties. The birth rate in Madison County has increased since the 1998 rate, even though it is much lower than the state rate and the peer county rates.

While the overall birth rate is relatively low, the teenage birth (see Table 6.3) rate is high compared to the state rate, but is comparable to the peer county rates. However, teenage pregnancy rates (see Table 6.1) are relatively low compared to the state rate and peer county rates. The percentage of low birth weight babies for Madison County is 7.2% (see Table 14.2), which is comparable to both state and peer county rates. However, Madison County has a higher "very low birth weight," compared to both the State and peer counties.

The induced abortion rate (see Table 6.4) is much lower compared to the state rate. Only Oswego has a lower rate among peer counties. The out-of-wedlock birth rate (see Table 6.5) in Madison County is lower than both the state rate and peer county rates. The newborn drug related discharge rate (see Table 14.3) is much lower for Madison County compared to both the state and peer county rates.

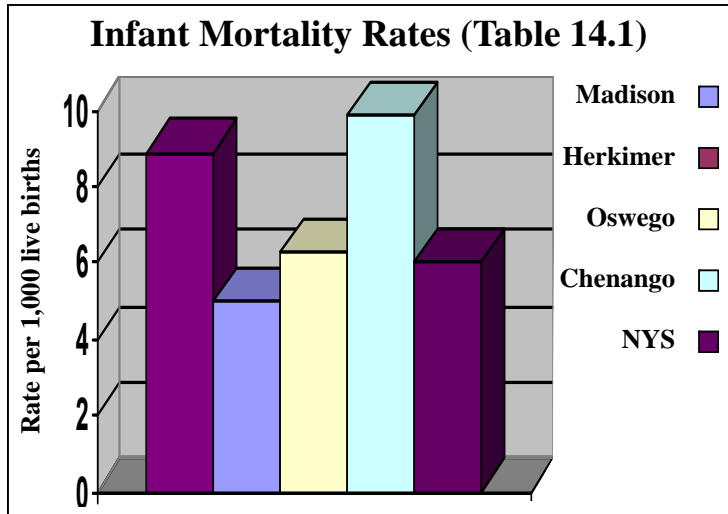
Mortality

Infant mortality in Madison County (see Table 14.1) is 8.9 per 1,000 live births, which is slightly higher than the rates for most peer counties; Herkimer and Oswego have infant mortality rates of 5 per 1,000 live births and 6.3 per 1,000 live births, respectively. Only Chenango County has a higher rate at 9.9 per 1,000 live births. New York State has a lower rate as compared to Madison County at 6 per 1,000 live births. Infant mortality rate is slightly higher in Madison County compared to both state and peer county; however, the overall numbers are very small with only an average of 25 deaths per year (2000-2002). While the neonatal mortality rate is comparable to other counties and the state at 4.4 per 1000 live births, the post-neonatal mortality rate is also higher than the state and peer county rates. Once

again, only Chenango County has a higher rate. In contrast, spontaneous fetal deaths are quite low in Madison County relative to both the state and the peer county rates.

Disease Mortality

Due to limited access to health care and limited resources, disease mortality and morbidity are concerns in Madison County. Financial constraints sometimes discourage residents from going for preliminary checkups that often delay the diagnosis of fatal diseases in their early, curable stages. In the following two sections, those rates that are unfavorable relative to our peer counties and the state and those that are relatively favorable are discussed.

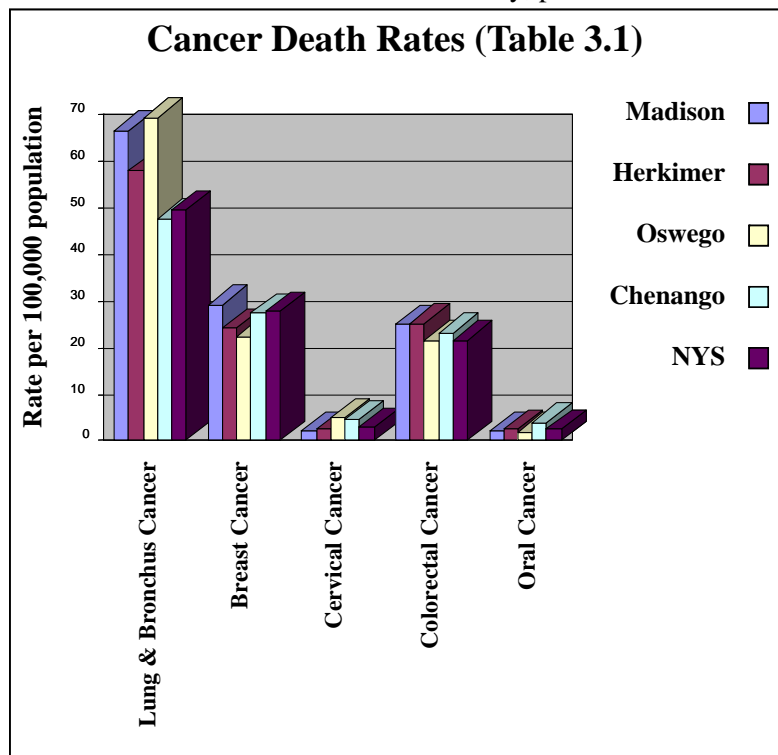


Unfavorable Disease Mortality Rates

The lung cancer mortality rate (see Table 3.1) is higher for Madison County as compared to the state rate and those for peer counties except Oswego County. In Madison County, the lung cancer mortality rate increased significantly both in absolute value and in relative terms since the 1998 study. As discussed in the 1998 study, lung cancer used to be lower than both the state rate and most of the peer county rates. In contrast, the adjusted lung cancer mortality rate for 2002 is 66.5 per 100,000 residents, while the New York State adjusted rate is 49.5 per 100,000 residents. Since the lung cancer mortality rate has increased both in absolute and relative terms since the 1998 study, prevention and treatment for lung cancer should be given a high priority.

According to present data, the breast cancer mortality rate is slightly higher for Madison County as compared to the state rate and peer county rates. As for the lung cancer mortality rate, the breast cancer mortality rate has increased in absolute terms since the 1998 study. It was lower than both the state rate and the peer county rates in 1998 and now it exceeds both. The breast cancer incidence rate has experienced a similar shift in the wrong direction.

The colorectal cancer mortality rate in Madison County is slightly higher than the state rate. As for the peer counties, only Herkimer County has a higher rate than Madison



County. Even though colorectal cancer mortality seems to be high in comparison to the state rate and some of its peer county rates, it has decreased in absolute terms since the 1998 study; from a rate of 41.9 to 24.9 per 100,000 population. Both the state and peer county rate have also declined over this time period. In general, colorectal cancer mortality rates have drastically improved statewide. However, the Madison County rate still remains higher than the state and peer county rates, which implies that there is still room for further improvement.

The diabetes mortality rate (see Table 4.1) is slightly lower than both the state rate and peer county rates. However, the rate has not declined significantly compared with the 1998 study's reported value. Given that the 1998 study indicated that diabetes was a major concern in Madison County, it can thus be deduced that diabetes continues to be a cause of concern among Madison County residents.

For Madison County, the cerebro-vascular mortality rate (see Table 8.1) is higher than both the state and peer county adjusted rates. The rate has also increased slightly from 51.0 per 100,000 population to an adjusted rate of 55.9 per 100,000 population since the 1998 study.

Although Madison County's chronic lower respiratory disease mortality rate (see Table 11.1) is higher than the state rate, it is lower than that for most of the other peer counties. Even though it is lower than most of the peer counties, the rate is significantly higher than the state rate; which implies that there is the possibility for improvement. The asthma discharge rate (see Table 12.3) is higher in Madison County relative to the peer county rates, but lower than the state rate. Madison County has an asthma discharge rate of 120.4 per 100,000 population compared with 120, 97.3, and 82 per 100,000 for Herkimer County, Oswego County, and Chenango County, respectively. New York State has a much higher discharge rate at 205.9 per 100,000 population.

The cirrhosis mortality rate (see Table 16.3) remains more or less at the same level since the 1998 report, declining from 7.2 per 100,000 population to 7.0 per 100,000 population. The state and the other peer counties enjoy a much lower cirrhosis mortality rate at present compared to their 1998 rates. Madison County, in contrast, saw no significant reduction in the cirrhosis rate since the 1998 study.

Favorable Disease Mortality Rates

The cervical cancer mortality rate is lower for Madison County as compared to both the state and peer county rates. Both the cervical cancer mortality rate and the incidence rate have fallen slightly since the 1998 study, which moves them to being a favorable indicator for Madison County, whereas these were relatively unfavorable in the 1998 study.

The oral cancer mortality rate in Madison County is slightly lower than the state rate and the peer county rates. Only Oswego County has a lower rate. However, surveys show that dental resources are very limited in Madison County and oral hygiene is still a source of major concern.

The cardiovascular disease mortality rate (see Table 8.1) is lower than both the state and peer county rates. The diseases of the heart mortality rate also are relatively lower in Madison County as compared to both the state and the peer county rates.

The state AIDS rate (see Table 9.1) significantly exceeds the Madison County rate. Chenango County has a slightly higher rate than Madison County, with the remaining peer counties having a lower rate. The AIDS mortality rate has increased for Madison County since 1998, even though it currently looks favorable when compared to its peer counties and the state.

The COPD mortality rate (see Table 12.4) for Madison County compares favorably with the peer counties; however, the rate exceeds the state rate. Data show (see Table 8.1) that Madison County also enjoys relatively lower rates of diseases of the heart mortality rate as compared to both the peer counties and the state.

Disease Morbidity

As is the case with the mortality rates for the diseases, some of the disease morbidity rates are higher for Madison County and some are lower, with respect to the state and peer county rates. The morbidity rates for certain diseases have also been divided into favorable and unfavorable categories based on how they compare to the state and the peer counties and how the rates have changed since the 1998 study.

Unfavorable Disease Morbidity Rates

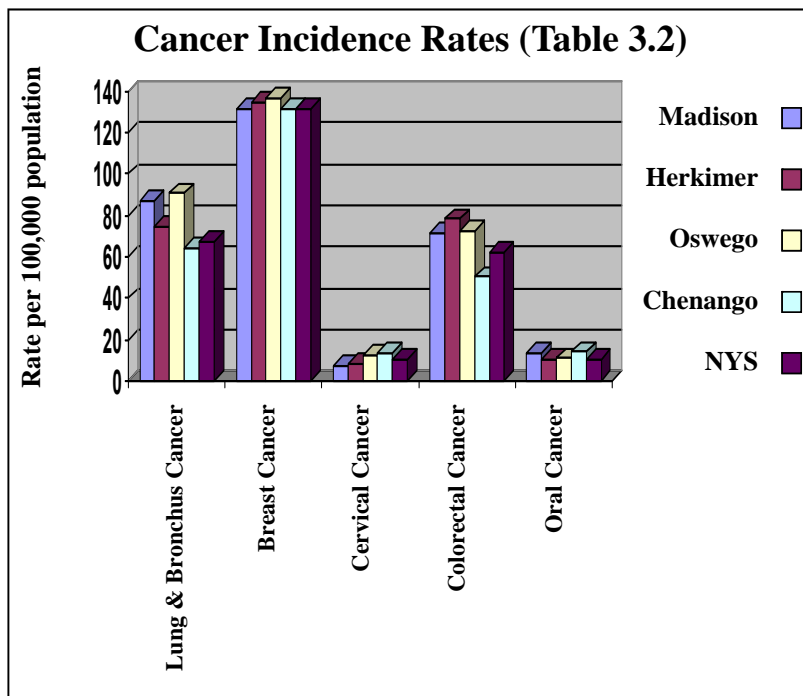
Lung cancer incidence (see Table 3.2), like lung cancer mortality rate, is quite high in Madison County, compared to the state rate. In relation to the peer counties, only Oswego County has a higher rate. Prevention of lung cancer should clearly be a high priority in Madison County.

The oral cancer incidence rate is high in Madison County compared to the state rate and peer county rates except for Chenango County. Dental resources are very limited in Madison County.

Only Herkimer County has a higher gonorrhea rate than Madison County (see Table 10.1). However, data comparison shows that the gonorrhea rate has decreased marginally in Madison County from 12.6 per 100,000 population to 11 per 100,000 population since 1995. The giardiasis rate (see Table 13.1) for Madison County is high compared to both the state and peer county rates. Madison County also has a relatively high pertussis rate. Most of the other communicable disease rates are comparable to both the state rates and the peer county rates. E. Coli incidence in Madison County (see Table 7.1) is also unfavorable when compared to the state and peer county rates.

Favorable Disease Morbidity Rates

The cervical cancer incidence rate in Madison County (see Table 3.2), as was the case with the cervical cancer mortality rate, is lower than both the state rate and the peer county rates. Data show that this indicator has improved measurably since the 1998 study.



Madison County compares favorably with the State and the peer counties for the uncontrolled diabetes rate (see Table 4.2). The younger age group, 5-14 years of age, in Madison County has a lower asthma discharge rate (see Table 12.2) compared to the state rate, even though the total asthma discharge rate exceeds the peer county rates.

The AIDS case rate is low compared to the state rate and most of the peer county rates. Only Herkimer County has an AIDS case rate as low as Madison County's rate. This is consistent with the fact that the HIV positive newborn rate is low in Madison County compared to the state rate. All the peer counties have similar rates. Other STD rates in Madison County also seem to be generally lower than the state rate.

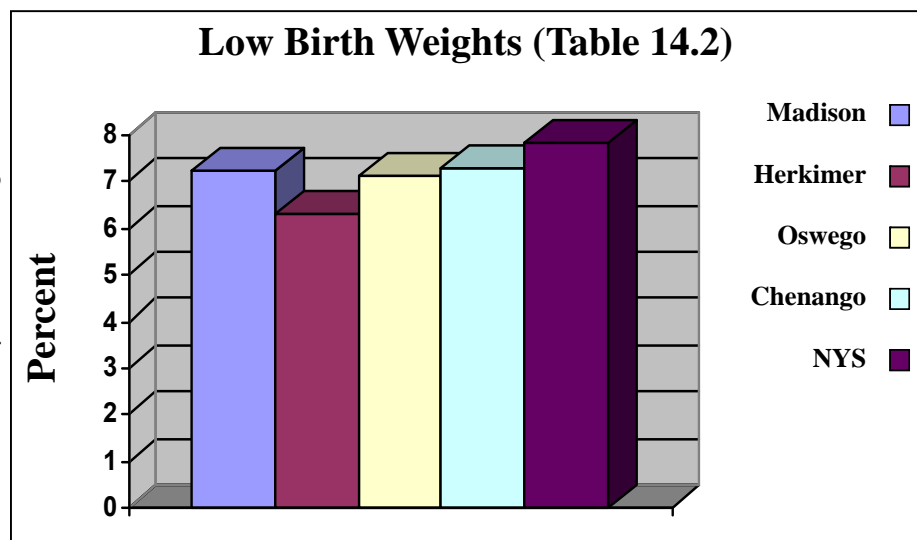
Maternal and Child Health

The 1998 study identified maternal and child health as an area of marked disadvantage. Recent data also follows similar patterns with exceptions in a few indicators. The infant mortality rate is high relative to the state rate. Even though the infant mortality rate for Madison County is still higher than the state rate and most of the peer county rates, it has decreased since 1998. All three infant mortality rates have decreased since the 1998 study; the infant mortality rate is down to 8.9 from 11.9 per 1,000 live births, and both the neonatal and post neonatal mortality rates have also declined. However, as stated earlier, the post-neonatal mortality rate is still relatively high for Madison County while spontaneous fetal deaths are low for Madison County. The child mortality rate has also increased somewhat since 1998.

The asthma discharge rate (see Table 12.1) among 0-4 year olds is higher than the peer county rates. The gastroenteritis discharge rates among 0-4 year olds is higher than the state rate, although all the peer counties have higher rates than Madison County. The pneumonia discharge rate among the 0-4 year age group is also much higher compared to the state and peer county rates. The 1998 report indicated that the rates of child hospitalization for asthma, pneumonia, and otitis media were all low for Madison County. Except for otitis media, this is not the case currently. Both the asthma discharge rate and the pneumonia discharge rate for Madison County are higher.

Data show that the percentage of children with low birth weight has increased since the 1998 study, while the percentage of very low birth weight babies exceeds the peer county and state rates. The

percentage of births with short gestation (<37 weeks) (see Table 14.2) per 100 live births is 11.9, which is slightly higher than the state rate. It is also relatively higher than all the peer county rates. However, the percent of births per 100 live births with prenatal care is higher for Madison County compared to both state and peer county rates. The percentage of live births with late/no prenatal care



is also lower than state. Only Chenango and Herkimer Counties have lower rates than Madison County. The newborn drug related discharge rate is also much lower for Madison County compared to both state and peer county rates, except for Herkimer County. Although the percentage of children with elevated blood lead levels is slightly lower than the state rate and only higher than the Oswego County rate, data comparison shows that the percentage has increased since the 1998 report.

The maternal mortality rate for Madison County over 2000-2002 is zero. As many of the indicators suggest, child health care and prevention should continue be a major concern in the next five years for Madison County.

B. Access to Care

Resources in Madison County

Access to health care, especially for low-income families, is a concern in Madison County. Given that the elderly (age 65+) make up 12.6% of the population in Madison County, adequate health care facilities will be a growing issue in the region. There are only two hospitals, four nursing homes, one diagnostic and treatment center, and eight hospital-based clinics in Madison County. In addition, there are only two adult homes. There are very few practicing physicians with only 6 pediatricians and 5 OB-GYNs, and 4 general surgeons. Twenty-seven family practitioners serve Madison County residents³.

Dental resources in Madison County are limited with only 33 licensed dentists (2003) and 55 licensed dental hygienists (2003). The ratio of population to dental hygienists is 4340:1, which is quite high. About 55.8% of the population in Madison County had a permanent tooth removed due to tooth decay or gum disease⁴. Data indicate that only about 68.7% of the population had seen a dental profession in the past 12 months⁵.

There are no Medicaid Managed Care Organizations in Madison County, with about 12.9% of the total population being Medicaid eligible⁶. Many of the local health care providers do not accept Medicaid. There are 6 commercial Managed Care Organizations operating in the county, only 2 of which accept CHP and only 1 of which accepts Medicaid. In contrast, of the 7 Commercial Managed Care Organizations in Herkimer County, 4 accept CHP, 3 accept FHP, and 3 accept Medicaid. In Madison County, there are 3 CHP plans available⁸.

Eighty-four percent of the Madison County population has health insurance, which is comparable to both the state and peer county rates. Of the 5,549 individuals who are eligible for Medicaid enrollment in Managed Care, none were enrolled. Only 0.8 per 1000 of the total number of primary care providers accept Medicaid even though 12.9% of the population is eligible for Medicaid (Regional Assessment Data; 2003 4th Quarter Report-Provider Network/NYS HIN). These data indicate that Madison County residents who qualify to receive Medicaid may have a difficult time taking advantage of the benefits of the program.

³ Madison County Profile

⁴ Expanded BRFSS, 2003; Chenango, Madison

⁵ Expanded BRFSS, 2003, Chenango, Madison

⁶ Madison County Profile

⁷ MCO's serving; Central New York Counties

⁸ Madison County Profile

Service providers throughout the county express concern about health insurance coverage, particularly Medicaid, in the county. For example, advocates at BRiDGES, Madison County Council on Alcoholism and Substance Abuse find that about 15% of the customers they provide assessment and referral services to do not have private health insurance or Medicaid. In addition, the Welfare to Work study completed in 2004 by the Community Action Program of Madison County found that among a sample of 150 former welfare/food stamp recipients, only 70% of those eligible received Medicaid.

The data on delivery of preventive health care for Madison County are mixed. Only about 4.8% of the school entrants are not fully immunized (Regional Assessment Data; NYS CHA Data Set, 1998-2000 data). However, only 44.5% of Madison County population aged 50 years and older received a sigmoidoscopy or colonoscopy, which is lower than the rates in the peer counties (Herkimer - 48.6% and Oswego - 49.6%) and New York State (52.4%)⁹. More residents should be encouraged to go for this test to avoid colon cancer, which was previously identified as a concern for Madison County.

Data (See Table 3.5) shows that 76.3% of women aged 40 years and over received a mammogram within the preceding 2 years. In New York State, 77.6% received a mammogram while the percentages are 89.5% and 75.9% for Oswego and Herkimer Counties, respectively. Relatively speaking, a smaller percentage of women in Madison County are receiving mammograms. With the breast cancer rate being relatively high for Madison County, increasing the number of women who receive mammograms should be a priority.

C. Behavioral Risk Factors

Risky behavior is a major concern in Madison County that needs to be addressed. In the following two sections, those rates that are unfavorable relative to our peer counties and the state and those that are relatively favorable are reviewed. In addition to reviewing the behavioral risk indicators in Madison County, the Teen Assessment Project (TAP) survey, and the 2003 Community Assessment Report are referenced.

Unfavorable Behavioral Risk Factors

As the data show (see Table 16.1), binge drinking among Madison County adults is higher than the state rate, even though it is lower than peer county rates. This result is consistent with the relatively high alcohol-related motor vehicle mortality rate in Madison County. As indicated in the TAP survey, a large number of the TAP teen respondents claimed that they had ridden in a car with adults who were intoxicated. As presented in Table 16.4, the alcohol related motor vehicle death rate is higher than the state rate but lower than peer county rates. The 1998 report indicated that alcohol related motor vehicle mortality rate was only 0.4 per 10,000 population while 2001 data show that the rate has increased to 91.2 per 100,000 population.

Suicide mortality (see Table 18.1) is comparatively high for Madison County. Herkimer is the only peer county with a higher rate. When compared to data presented in the 1998 report, it is evident that the suicide mortality rate has increased in recent years. It has almost doubled from a rate of 6.5 to 12.9 per 100,000 populations in 2002. Suicide cases have thus become a major concern in Madison County since the 1998 study. Adolescent suicide mortality has also increased as shown by the TAP and the Community Assessment Report. As data shows (see Table 18.3) adolescent suicide rate is high relative to the state rate. Only Herkimer has a higher rate amongst the chosen peer counties.

⁹2003 NYS BRFS

The motor vehicle mortality rate (see Table 18.6) is higher than the state rate and Herkimer County's rate. It is however, lower than the rates for both Oswego and Chenango Counties. The overall motor vehicle mortality rate has increased in recent years. Motor vehicle related deaths were also a cause of major concern in the 1998 study.

The percentage of cigarette smoking adults (see Table 17.1) is also higher for Madison County relative to both the state and peer county rates. This statistic is related to the increased lung cancer incidences in Madison County. Cigarette smoking among adolescents, however, has declined since 1999 as indicated in the TAP survey report.

Obesity in adults (see Table 15.3) is higher in Madison County relative to New York State and Herkimer County but is lower than the rate for Oswego County. Approximately 42.7% of Madison County residents are actively trying to lose weight¹⁰. 72.4% of adults in Madison engaged in moderate leisure time activity or exercise during the past 30 days, whereas 77.3% of the population in Oswego County did so¹¹. The state rate is also higher than the Madison County rate. Data from the New York State CVD Risk Factor Prevalence Rates by County: 1994-1998 show that 82.8% of Madison County residents engage in no regular and sustained physical activity. As the data show, the percentage of overweight children (see Table 15.2) is also very high in Madison County as well as in the peer counties and New York State. About 27.3% of the Madison County population is reported to have high blood pressure by a medical professional¹².

Only 20.6%¹³ (21.7% according to the New York State CVD Risk Factor Prevalence Rates by County 1994-1998) of the population of Madison County eat five fruits or vegetable servings per day. As the New York State CVD Risk Factor Prevalence Rates by County 1994-1998 data shows this is lower than other county rates, except for the rate for Oswego County (1998 data).

The unintentional injury mortality rate for Madison County, at 34.9 per 100,000 population is quite high compared to the state rate, which is only 21.5 per 100,000 population (see Table 18.6). Oswego and Chenango Counties both have even higher rates. According to the Expanded BRFSS, 2003 data, 5.8% of Madison County residents reported to have a fall with injury in the past three months. As was noted in the 1998 study, home safety and personal safety should be made a priority in Madison County.

Favorable Behavioral Risk Factors

Some indicators for Madison County, however, compare favorably with both the state rate and the peer county rates. The drug-related discharge rate (see Table 16.2) for Madison County is much lower than both the state rate and the peer county rates. In Madison County, women who smoke during pregnancy is lower compared to Herkimer and Oswego Counties (see Table 17.2).

The homicide mortality rate for Madison County (see Table 18.2), at 0.5 per 100,000 residents, is significantly lower than the state rate of 5 per 100,000 residents. The homicide mortality in Madison County has fallen since 1998 when the rate was 1.4 per 100,000 residents. Table 18.5 shows that the

¹⁰ Expanded BRFSS, 2003; Chenango, Madison

¹¹ 2003 NYS BRFSS

¹² Expanded BRFSS, 2003 – New York State Department of Health

¹³ Expanded BRFSS, 2003 – New York State Department of Health

assault hospitalization rate is also quite low for Madison County as compared to its peer counties and the state rate. Comparing current figures with the 1998 report, it is also apparent that the assault hospitalization rate has fallen significantly since 1998.

Hospitalization due to unintentional injury (see Table 18.7) is much lower for Madison County relative to both the peer county rates and the state rate. Madison County also has a significantly lower self-inflicted injury hospitalization rate (see Table 18.4) in relation to both the state and peer county rates. This, however, contradicts the fact that Madison has a relatively high suicide rate.

Needs and Priorities

A. Needs Identified:

1. Access to health care
 - Oral surgeons accepting Medicaid and uninsured patients
 - Need for orthodontists accepting Medicaid and the Physically Handicapped Children's Program
 - Many of health and human service agencies are located in the north end of the county, which is more populated. The lack of extensive public transportation exacerbates this problem and suggests that satellite sites be developed for services in the southern end of the county
 - Need to improve referral system for uninsured with dental emergencies
 - Need to increase awareness regarding the important of age and sex appropriate screenings such as mammograms, colorectal occult blood testing, and colonoscopy

2. Need to change social norms related to tobacco use, physical activity, drinking, substance abuse, nutrition, driving while intoxicated
 - Many of areas data show unfavorable health outcomes - cancer, heart disease, etc. are related to unhealthy behaviors and lifestyle
 - Need to address the underlying causes of chronic disease
 - Increase awareness of need to eat fruits and vegetables and the benefits of regular physical activity

3. Need for environmental and behavioral changes that encourage healthy lifestyles such as less fast food, higher enrollments in the school lunch program and food stamps, getting rid of vending machines in schools, making more of our communities walkable, and increasing opportunities to be physically active.

4. Need for change in attitudes regarding the Medicaid population. The provider survey shows that dentists and providers turn Medicaid patients away because of failure to keep appointments, poor attitudes about preventive health, and the administrative hassles of the Medicaid system.

5. Need to continue to educate eligible families about the availability of Medicaid, Child Health Plus, and Family Health Plus

6. Need to educate governmental representatives and the community on the benefits of fluoridation of water and fluoride supplements

7. Need for central storage of data that is accessible to all Madison County organizations

8. Need for improved transportation services and more services offered in satellite offices in the southern part of the county.

9. Need for addressing risky youth behaviors.

10. Need for more resources available to children 0-5 years including mental health, and social and emotional issues and for their parents and providers working for them.

11. Need to assess future needs of the aging population in terms of housing and health care services.

12. Need to explore reasons for relatively high infant mortality rates.

Improving and sustaining access to high-quality, continuous primary care and treatment services are critical to eliminating health disparities in health outcomes and in the achievement of many of the public health priorities identified. There is a need to provide prevention, early intervention and continuity of care through a “medical home” for all residents in Madison County. This is difficult to achieve due to the uninsured population in Madison County. Despite the availability of Medicaid, Child and Family Health Plus, some residents still do not avail themselves of these resources due to personal beliefs. Many families lack dental insurance and cannot afford to pay out of pocket for dental treatment. There is a need to improve the referral process for dental treatment for uninsured. Dental providers have indicated they are reluctant to set aside times to treat the uninsured or Medicaid populations because many times patients do not show for appointments. Part of the no show may be related to transportation issues. If a more formal system was set up, there may be a need for an agency to coordinate appointments and to schedule transportation. In addition, education regarding the importance of preventive dental care and its importance to overall health, needs to continue to be targeted to low income population groups. Staffing and funding issues which would make it difficult to set up a system for providing dental care to the uninsured or Medicaid population through private providers, even if dental providers were willing to set up services on a regular basis. Some of the issues related to treating the Medicaid population are billing issues and the “administrative hassle” and reimbursement rates for Medicaid which need to be addressed at the state and federal levels.

As stated, transportation to medical and other services is a barrier in Madison County. As part of the planning process there is a need to look at under served areas of the county to identify if health and human services can be expanded to the more isolated areas of the county, in a cost effective manner. The southern part of Madison County remains the most under served. The hospitals have opened family health centers in parts of the county to help address some of these issues with primary care services. It is still difficult to provide all of the specialty health care services which may be needed by few residents in a small rural county.

B: Local Health Priorities

The preceding evaluation of Madison County’s health indicators relative to the state and its peer counties, along with the inventory of current available resources in the county, paints a clear picture of the needs in Madison County. The Department of Health discussed these needs with the Priorities Council in October and December of 2004 and asked members to prioritize the public health needs in the county for the next five years. The council members reviewed the indicators assessed for Madison County for the Community Health Assessment process, data from the TAP Survey, regional assessment, and the Communities That Care data on needs and resources collected to determine priorities. In addition, many of the agencies provided anecdotal information and client reports that substantiated many of the findings. The Priorities Council, in consultation with the Department of Health, recommended two main areas of focus: (1) Address unhealthy behaviors in Madison County that lead to poor health outcomes. These include daily choices such tobacco use, diet, exercise, and alcohol use as well as preventive health decisions such as having a mammograms, lead screening, and immunization. (2) Address the health care access issues that are highlighted throughout the study. These include making health care more accessible in the southern end of the county and increasing access to providers for Medicaid patients. The first of these issues affects many lower-income and working near-poor residents in the County while the second focuses more specifically on the lowest income households. The remainder of this section addresses these two main areas of concern.

Objective I: To reduce mortality and morbidity due to diseases that result from unhealthy lifestyles and to improve wellness in Madison County.

As both the outcomes data and survey data indicate, Madison County residents exhibit high rates of certain diseases that are related to lifestyle choices. Some of the relatively high rates of mortality and morbidity identified in this study were lung cancer, breast cancer, diabetes, heart disease, colorectal cancer, oral cancer, cerebra-vascular disease, and asthma and chronic respiratory diseases. Most of the cases of deaths and incidences of the aforementioned diseases either exceeded the state rate and/or the peer county rates.

Obesity, diet, and exercise are a major concern for Madison County and likely contribute to the unfavorable disease outcomes outlined above. The Priorities Council has long been concerned about lifestyle choices among many Madison County residents and reviewing the data compiled for the Community Health Assessment reaffirmed these concerns. The percentage of cigarette smoking adults in Madison County is higher than both the state and peer county rates. In addition, binge drinking and alcohol related motor vehicle deaths among Madison county adults are higher than the state rate (these are also high in the peer counties). Obesity in adults is higher in Madison County relative to New York State and Herkimer County and the percentage of overweight children is also very high in Madison County. Data from the New York State CVD Risk Factor Prevalence Rates by County: 1994-1998 show that 82.8% of Madison County residents engage in no regular and sustained physical activity.

Health education must be a top priority in Madison County. Public health programs to improve lifestyle choices should focus on decreasing cigarette smoking, reducing alcohol abuse, and promoting exercise and healthy food choices for both adults and children. The county has active coalitions already addressing many of these issues, who will be continuing ongoing interventions and changing strategies as needed. They will also seek additional grant funding to address these issues. Madison County's Promise has formed task forces to work on substance abuse issues in the county.

Promoting preventive health care would also improve health outcomes in the county. The breast cancer incidence and mortality rates are relatively high and have increased since the 1998 report. Although 76.3% of women aged 40 years and over received a mammogram within the preceding two years in Madison County, there is room for improvement as 89.5% of Oswego County women received mammograms. Efforts should be made to encourage more women to have mammograms. The colorectal cancer mortality rate is also relatively high in Madison County, although it has declined since the 1998 report. Colonoscopy rates among Madison County residents are also very low and increased prevention should be a priority. The health department and its partners in the Healthy Women Partnership and Colorectal and prostate education and screening programs must continue to educate Madison County residents on the importance of preventive care and sex and age appropriate screening. These coalitions must continue to promote the availability of free screening and treatment for the un- and underinsured populations in the county available through these programs.

Suicide mortality among both adults and adolescents is relatively high in Madison County. The isolation of a rural area and the limited mental health resources in the County may contribute to the elevated suicide rate. The TAP survey also identified suicide as a problem for teens in Madison County and suggested that limited resources and social activities for teens may contribute to adolescent isolation and depression. Improving mental health resources must also be priority for the county in the next five years. Madison County's Promise has identified this as an area for intervention and formed a task force to address this important issue. The task forces will begin working on interventions in December 2004. The Early Childhood workgroup of the priorities council is seeking funding to address mental health,

social emotional and behavioral issues in the 0-6 year old populations. It is hoped that addressing mental health issues with families at earlier ages would help in improving the mental health of adolescents and adults, through more timely interventions.

Two groups - the elderly and mothers – have health care needs that require special attention. As mentioned in Section I, the elderly are increasing as a percentage of the population in Madison County (as well as nationwide). With 12.6% of the Madison County population being 65 years of age and over and this number forecasted to increase continually over the next decade, it is essential for the county to plan adequately to meet the health needs of this population. Maternal and infant health must also be a priority area for Madison County in the next five years. The 1998 study identified maternal health as an area of priority. However, although it has decreased, the infant mortality rate remains relatively high in Madison County. In addition, the percentage of low birth weight babies has increased since the 1998 study and remains relatively high. Given that Madison County mothers are more likely to seek prenatal care than all mothers in the state, the low birth weight and high infant mortality rates may be related to other behavioral indicators such as smoking and drinking. Maternal and infant health should continue to be a priority area for the next five years. The Family Ties Perinatal Network Sub-council in Madison County seeks to ensure access to health and social services needed to improve pregnancy outcomes and infant health. This group of providers can be enlisted to assess the current status of maternal and child health in the county and suggest possible interventions to help improve this area. The aging workgroup of the priorities council is already looking at issues surrounding access for the aging and must continue to look at the needs of the aging population and how to address access issues for this group.

Objective II: Improve access to healthcare, especially for Medicaid recipients and the uninsured.

The provider survey helped identify some important access to care issues in Madison County that resonated with the members of the Priorities Council. The prime concern was the lack of availability of efficient and affordable healthcare. A large portion of Madison County’s population is uninsured. About 16% of Madison County residents do not have any type of health insurance. Several of the health care providers indicated that better coordination among the practitioners might increase the rate and quality of charity care. Helping to coordinate charity care should be a priority in the next five years.

Providers also indicate that the lack of public transportation creates health access problems for Madison County residents. The lack of services in the southern end of the county is also an important problem, exacerbating the transportation problem. While several governmental and non-profit organizations do have satellite services in the southern end of the county, there is clearly a need for more. Addressing this access to care issue must be a priority for the next five years. The 1998 Community Health Assessment identified a need for services to be available to county residents in the southern part of Madison County. The current effort by several non-profit agencies for find funds for shared office space in the southern end of the county must be vigorously supported. In addition, improving public transportation must be a priority in Madison County. Not only would this improve health care access, but a reliable system of public transportation would also improve employment options for Madison County residents.

There are significant barriers to health care for Medicaid recipients in the county. As indicated by the providers, few of them accept Medicaid cases. While 12.9% of the total Madison County population is eligible for Medicaid, there are no Medicaid Managed Care Organizations. Many private physicians are unable to serve Medicaid patients due to financial constraints and specialized care providers that accept Medicaid are few in the county. Improving access to care for Medicaid recipients is a priority for the next five years in the county. While increasing Medicaid reimbursements would provide finan-

cial incentives for providers, this option does not seem likely given the pressures on state and local budgets. Again, coordination and education among providers to distribute the burden might improve access.

Access to dental services is also limited in Madison County. Both high incidences of oral cancer and the data collected from dental care providers, as well as the concerns of the Priorities Council membership, suggest that improvements in dental care should be a priority for the next five years. About 25% of the dental providers reported that they accept Child Health Plus, while only 12.5% indicated that they currently accept Family Health Plus. The major concerns expressed by dental providers when asked to identify the most important dental care issues in Madison County included the need for more oral surgeons, endodontists, and providers who accept Medicaid. The dental providers' recommendations for improving dental health in the County included setting up dental clinics specifically for Medicaid patients, encouraging more providers to work on charity cases, and encouraging providers to work with each other so that they can coordinate their services and charity care to ensure as many residents as possible receive service. Again, helping to facilitate such coordination should be a priority. The multi-county dental coalition continues to assess dental needs and methods to improve access. Access to quality dental care was identified as a need in the regional assessment. As regional priorities are set in the spring of 2005, regional interventions may be identified.

Summary and Recommendations

According to the “The Communities Working Together for a Healthier New York” 1996 Report from the New York State Public Health Commission, local communities have the greatest impact on improving the health of their residents by intervening in the causes of poor health, rather than focusing on the health problems themselves. The greatest improvements in the health of New Yorkers can be achieved by focusing on the causes of ill health for which there are effective interventions that involve the whole community and the individual. Effective public health interventions require community involvement and commitment to changing social norms. Priority health issues must address those conditions that result in the greatest morbidity, mortality, disability, and years of productive life lost. Because community involvement is essential to successful public health action, the priority health areas should reflect problems of greatest health concerns to local communities. Progress should be measurable though specific, quantifiable, and practical objectives.

As previously discussed Madison County has an active Priorities Council currently addressing priority issues. This Council continues to be responsible for setting and reassessing priority issues and evaluating the effectiveness of interventions. Workgroups continue to address specific health issues. Workgroups may be added as needed to address new priority issues. Current workgroups are responsible for examining the interventions and objectives they are working on and change them as needed and to recruit new members for workgroups as needed. Workgroups will continue to determine the needed resources to initiate interventions to address the priority areas and seek funding for these resources.

Other priority areas will be addressed through the coalitions which have been discussed previously. In some cases, the coalitions may need to look for additional members and need to examine their interventions and seek funding and resources to meet the addressed needs.

Colgate University’s Upstate Institute is a valuable resource that can be utilized in improving the health of Madison County residents. The Priorities Council has identified the need to have a web-based centralized site for Madison County data that could be accessed by groups needing Madison County data for projects and grant writing and assistance with evaluation. The Priorities Council is working with the Upstate Institute to begin to outline the data to be included. Work will begin in summer 2005. The Institute could also be a great resource to assist with designing and implementing evaluations of the local public health interventions. In addition to Colgate University, the county has Morrisville College and Cazenovia College. Both colleges have worked with county agencies and coalitions on specific projects and this collaboration should continue. Faculty and students at all of these institutions can be a great resource for the county agencies.

Madison County participated in the Regional Health Assessment. In the spring of 2005, those counties who participated in the regional assessment will be meeting to set regional priorities and look at regional approaches to address these issues.

The Madison County Health Department needs to explore avenues in which businesses/ worksites, colleges and universities, community based organizations, health care providers, media, and schools, and the food industry can be involved in improving the health of Madison County residents. Representation from these various groups on the Priorities Council and existing workgroups and coalitions needs to be examined and fostered.

Table 1.1: Total Population, 2002

	Madison	Herkimer	Oswego	Chenango	NYS
Age group	Number	Number	Percent	Number	Number
Total	69,789	63,741	122,932	51,324	19,157,532

Source: NYS Department of Health website; <http://www.health.state.ny.us/nysdoh/chac/cha/em.htm>
 NYS Department of Labor Data; New York State Community Health Data Set - 2002; revised in July 2004.

Table 1.2: Total Population Breakdown by Age, 2002

Age group	Madison		Herkimer	Oswego	Chenango	NYS
	Number	Percent	Percent	Percent	Number	Percent
<1	681	1	0.9	1.2	1.1	1.3
1	711	1	1	1.1	1	1.3
2	753	1.1	1	1.2	1.1	1.3
3	817	1.2	1	1.2	1.1	1.2
4	812	1.2	1.1	1.2	1.2	1.2
5-9	4,305	6.2	6.2	6.7	6.6	6.6
10-14	4,978	7.1	7.1	7.9	7.8	7
15-17	3,186	4.6	4.5	4.7	4.7	4
18-19	3,741	5.4	2.5	3.7	2.6	2.7
20-24	5,448	7.8	7.1	8.4	5.9	6.8
25-29	3,239	4.6	5	5.4	4.9	6.6
30-34	4,224	6.1	5.8	6.3	6.1	7.5
35-39	5,240	7.5	7	7.7	7.3	8
40-44	5,692	8.2	7.8	8.3	8.1	8
45-49	5,365	7.7	7.6	7.4	7.7	7.3
50-54	4,733	6.8	7.1	6.7	7	6.6
55-59	3,981	5.7	5.9	5.4	6.1	5.3
60-64	3,103	4.4	4.8	4	4.8	4.1
65-69	2,381	3.4	3.8	3.1	3.9	3.4
70-74	2,141	3.1	3.7	2.8	3.6	3.1
75-79	1,823	2.6	3.6	2.4	3.1	2.7
80-84	1,307	1.9	3	1.8	2.3	1.9
85+	1,128	1.6	2.6	1.4	2	1.8

Source: NYS Department of Health website; http://www.health.state.ny.us/nysdoh/chac/cha/pop/p2002_65.htm
 National Center for Health Statistics; New York State Community Health Data Set – 2002; revised in July 2004.

Table 1.3: Total Population Breakdown by Sex: Males, 2002

Age group	Madison		Herkimer	Oswego	Chenango	NYS
	Number	Percent	Percent	Percent	Percent	Percent
Total	34,409	100	100	100	100	100
<1	347	1	1	1.3	1.1	1.4
1	361	1	1	1.2	1	1.4
2	379	1.1	1.1	1.2	1.1	1.3
3	405	1.2	1.1	1.2	1.1	1.3
4	418	1.2	1.2	1.3	1.1	1.3
4-9	2,224	6.5	6.5	6.8	6.7	7
10-14	2,514	7.3	7.3	8.3	8.2	7.5
15-17	1,632	4.7	4.6	4.9	4.8	4.2
18-19	1,808	5.3	2.8	3.7	2.9	2.8
20-24	2,795	8.1	7.6	8.5	6.1	7.1
25-29	1,625	4.7	5.1	5.5	5	6.7
30-34	2,094	6.1	5.8	6.2	6.1	7.7
35-39	2,636	7.7	7.3	7.7	7.3	8.1
40-44	2,851	8.3	7.8	8.5	8.4	8.2
45-49	2,622	7.6	7.6	7.7	7.9	7.3
50-54	2,379	6.9	7.1	6.7	7.2	6.5
55-59	1,984	5.8	6.1	5.4	6.1	5.2
60-64	1,527	4.4	4.7	4	4.7	4
65-69	1,147	3.3	3.8	3.1	3.9	3.2
70-74	991	2.9	3.5	2.6	3.4	2.8
75-79	796	2.3	3.1	2	2.7	2.2
80-84	540	1.6	2.3	1.3	1.8	1.5
85+	334	1	1.6	0.8	1.4	1.1

Source: NYS Department of Health website; http://www.health.state.ny.us/nysdoh/chac/cha/pop/p2002_65.htm
National Center for Health Statistics; New York State Community Health Data Set – 2002; revised in July 2004.

Table 1.4: Total Population Breakdown by Sex: Female, 2002

Age group	Madison		Herkimer	Oswego	Chenango	NYS
	Number	Percent	Percent	Percent	Percent	Percent
Total	35,380	100	100	100	100	100
<1	334	0.9	0.9	1.2	1.1	1.3
1	350	1	0.9	1.1	1.1	1.3
2	374	1.1	1	1.1	1	1.2
3	412	1.2	1	1.1	1.1	1.2
4	394	1.1	1	1.1	1.2	1.2
4-9	2,081	5.9	6	6.6	6.4	6.3
10-14	2,464	7	6.9	7.5	7.5	6.6
15-17	1,554	4.4	4.3	4.5	4.6	3.8
18-19	1,933	5.5	2.3	3.8	2.3	2.5
20-24	2,653	7.5	6.7	8.2	5.6	6.5
25-29	1,614	4.6	4.8	5.3	4.7	6.5
30-34	2,130	6	5.8	6.4	6.1	7.4
35-39	2,604	7.4	6.7	7.7	7.2	7.8
40-44	2,841	8	7.7	8.2	7.8	7.9
45-49	2,743	7.8	7.5	7.1	7.6	7.3
50-54	2,354	6.7	7	6.8	6.9	6.7
55-59	1,997	5.6	5.6	5.3	6.2	5.5
60-64	1,576	4.5	4.9	4	4.8	4.3
65-69	1,234	3.5	3.9	3.1	3.9	3.6
70-74	1,150	3.3	4	3	3.8	3.5
75-79	1,027	2.9	4	2.8	3.5	3.1
80-84	767	2.2	3.5	2.2	2.9	2.4
85+	794	2.2	3.5	1.9	2.7	2.4

Source: NYS Department of Health website; http://www.health.state.ny.us/nysdoh/chac/cha/pop/p2002_65.htm
National Center for Health Statistics; New York State Community Health Data Set – 2002; revised in July 2004.

Table 1.5: Total Population Breakdown by Race, 2000

Total population by race	Madison ¹		Herkimer ²	Oswego ³	Chenango ⁴	NYS ⁵
	Number	Percent	Percent	Percent	Percent	Percent
One race	68,861	99.2	99.2	99.1	99.3	96.9
White	67,006	96.5	97.8	97.2	97.7	67.9
Black or African American	916	1.3	0.5	0.6	0.8	15.9
American Indian and Alaska Native	358	0.5	0.2	0.4	0.3	0.4
Asian	387	0.6	0.4	0.4	0.3	5.5
Asian Indian	66	0.1	0.1	0.1	0.1	1.3
Chinese	95	0.1	0.1	0.1	0.1	2.2
Filipino	27	-	0.1	0.1	0.1	0.4
Japanese	63	0.1	0.1	-	-	0.2
Korean	59	0.1	0.1	0.1	0.1	0.6
Vietnamese	32	-	-	-	-	0.1
Other Asian	45	0.1	-	-	-	0.6
Native Hawaiian and other Pacific Islander	10	-	-	-	-	-
Native Hawaiian	-	-	-	-	-	-
Guamanian or Chamorro	3	-	-	-	-	-
Samoan	1	-	-	-	-	-
Other Pacific Islander	6	-	-	-	-	-
Some other race	184	0.3	0.2	0.5	0.2	7.1
Two or more races	580	0.8	0.8	0.9	0.7	3.1
Race alone or in combination with one or more other races:						
White	67,527	97.2	98.6	98.0	98.4	70.0
Black or African American	1,094	1.6	0.7	0.8	1.0	17.0
American Indian and Alaska Native	617	0.9	0.6	0.8	0.7	0.9
Asian	505	0.7	0.5	0.6	0.4	6.2
Native Hawaiian and other Pacific Islander	32	-	-	-	-	0.2
Some other race	310	0.4	0.4	0.7	0.4	9.1
Hispanic or Latino and race						
Hispanic or latino	734	1.1	0.9	1.3	1.1	15.1
Mexican	112	0.2	0.2	0.3	0.2	1.4
Puerto Rican	267	0.4	0.4	0.6	0.5	5.5
Cuban	47	0.1	-	-	0.1	0.3
Other Hispanic or Latino	308	0.4	0.3	0.4	0.3	7.9
Not Hispanic or Latino	68,707	98.9	99.1	98.7	98.9	84.9
White alone	66,564	95.9	97.3	96.5	96.9	62.0

Source: US Bureau of the Census, Census 2000 Summary Form

¹<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036053.pdf>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036043.pdf>

³<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036075.pdf>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036017.pdf>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/census/04036.pdf>

Table 1.7: Income Level, 1999

	Madison ¹		Herkimer ²	Oswego ³	Chenango ⁴	NYS ⁵
	Number	Percent	Percent	Percent	Percent	Percent
Households	25,392	100	100	100	100	100
Less than \$10,000	2,139	8.4	11.4	10.4	10	11.5
\$10,000 to \$14,000	1,632	6.4	10.2	8.2	9	6.4
\$15,000 to \$24,999	3,373	13.3	16.7	14.4	17.1	11.7
\$25,000 to \$34,999	3,599	14.2	14.2	14.7	15.7	11.4
\$35,000 to \$49,999	4,754	18.7	19.2	17.4	18.3	14.8
\$50,000 to \$74,999	5,211	20.5	17.6	19.9	17.8	18.4
\$75,000 to \$99,999	2,386	9.4	6.9	8.8	7.0	10.6
\$100,000 to \$149,999	1,495	5.9	2.8	4.8	3.7	9.1
\$100,000 to \$149,999	418	1.6	0.5	0.7	0.9	2.9
\$200,000 or more	385	1.5	0.4	0.6	0.5	3.3
Median household income(dollars)	40,184		32,924	36,598	33,679	43,933
Families	17,582	100	100	100	100	100
Less than \$10,000	665	3.8	5.3	6	6.3	7.7
\$10,000 to \$14,000	730	4.2	5.8	4.8	6.4	4.6
\$15,000 to \$24,999	1,858	10.6	14.7	12.9	15.0	9.9
\$25,000 to \$34,999	2,327	13.2	15	14.9	15.2	10.8
\$35,000 to \$49,999	3,607	20.5	22.3	18.9	20.8	15.1
\$50,000 to \$74,999	4,318	24.6	22.3	23.5	21.3	20.5
\$75,000 to \$99,999	2,082	11.8	9.5	11.1	8.6	12.7
\$100,000 to \$149,999	1,340	7.6	3.8	6.2	4.5	11.2
\$150,000 to \$199,999	362	2.1	0.7	1.0	1.4	3.5
\$200,000 or more	293	1.7	0.5	0.7	0.6	4.0
Median family income(dollars)	47,889		40,750	43,821	39,711	51,691

Source: US Bureau of the Census, Census 2000 Summary Form;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036053.pdf>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036043.pdf>

³<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036075.pdf>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036017.pdf>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/census/04036.pdf>

Table 1.8: Per-Capita Income, 1999

	Madison ¹	Herkimer ²	Oswego ³	Chenango ⁴	NYS ⁵
Per-capita income	19,105	16,141	16,853	16,427	23,389

Source: US Bureau of the Census, Census 2000 Summary Form;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036053.pdf>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036043.pdf>

³<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036075.pdf>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036017.pdf>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/census/04036.pdf>

Table 1.9: Poverty Status, 1999

	Madison ¹		Herkimer ²	Oswego ³	Chenango ⁴	NYS ⁵
	Number	Percent	Percent	Percent	Percent	Percent
Income below poverty level	6313	9.8	12.5	14	14.4	14.6
Under 5 years	599	14.9	19.4	23.6	21.1	21.2
5 years	135	16.8	15.8	18.2	17.5	21.1
6 to 11 years	593	10.1	16.5	16.6	22	20.6
12 to 17 years	611	9.7	13.7	15	18.2	18.3
18 to 64 years	3644	9.3	11.7	13.1	13.2	13.1
64 to 75 years	312	6.8	8.8	7.8	8.2	10.4
75 years and over	419	11.3	12	11.7	9.4	12.4
Income at or above poverty level	58238	90.2	87.5	86	85.6	85.4
Under 5 years	3434	85.1	80.6	76.4	78.9	78.8
5 years	667	83.2	84.2	81.8	82.5	78.9
6 to 11 years	5265	89.9	83.5	83.4	78	79.4
12 to 17 years	5706	90.3	86.3	85	81.8	81.7
18 to 64 years	35624	90.7	88.3	86.9	86.8	86.9
64 to 75 years	4252	93.2	91.2	92.2	91.8	89.6
75 years and over	3290	88.7	88	88.3	90.6	87.6

Source: US Bureau of the Census, Census 2000 Summary Form;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036053.pdf>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036043.pdf>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036075.pdf>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036017.pdf>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/census/04036.pdf>

Table 1.11: Percentage of Children Living Below Poverty, 2000

	Madison		Herkimer	Oswego	Chenango	NYS
	Number	Percent	Percent	Percent	Percent	Percent
Children living below poverty	2001	12.1	16.8	17.5	20.4	19.1

Source: NYS Kids' Well-Being Indicator Clearinghouse;

http://www.nyskwic.org/access_data/ind_profile.cfm?subIndicatorID=1&indicator2.x=1&indicator2.y=4;

Small Area Income and Poverty Estimates Program (SAIPE); U.S. Bureau of the Census; data compiled in October 2003

Table 1.12: Education Attainment, 2000

Profile of selected social characteristics	Madison ¹		Herkimer ²	Oswego ³	Chenango ⁴	NYS ⁵
	Number	Percent	Percent	Percent	Percent	Percent
School enrollment						
Population 3 years and over enrolled in school	20630	100	100	100	100	100
Nursery school; preschool	1080	5.2	5.4	4.3	5.7	6.4
Kindergarten	915	4.4	6.2	4.6	5.7	5.2
Elementary school (grades 1-8)	8228	39.9	45.3	45.5	51	42.3
High school (grades 9-12)	4308	20.9	24.2	20.7	25.4	21.1
College or graduate school	6099	29.6	18.9	24.8	12.1	24.9
Educational attainment						
Population 25 years and over	43762	100	100	100	100	100
Less than 9th grade	1781	4.1	5.4	5	5.6	8
9th to 12th grade; no diploma	5510	12.6	15.2	14.5	13.8	12.9
High school graduate (includes equivalency)	14519	33.2	35.4	41.2	39.9	27.8
Some college; no degree	7780	17.8	17.5	17.2	17.3	16.8
Associate degree	4717	10.8	10.8	7.6	9	7.2
Bachelor's degree	5647	12.9	9.9	9.2	8.4	15.6
Graduate or professional degree	3808	8.7	5.8	5.3	6	11.8
Percent high school graduate or higher	N/a	83.3	79.4	80.4	80.6	79.1
Percent bachelor's degree or higher	N/a	21.6	15.7	14.4	14.4	27.4

Source: US Bureau of the Census, Census 2000 Summary Form;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036053.pdf>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036043.pdf>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036075.pdf>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036017.pdf>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/census/04036.pdf>

Table 1.14: Language Spoken at Home, 2000

Language spoken at home	Madison ¹		Herkimer ²	Oswego ³	Chenango ⁴	NYS ⁵
	Number	Percent	Percent	Percent	Percent	Percent
Population 5 years and over	65323	100	100	100	100	100
English only	62076	95	94.8	95.8	96.2	72
Language other than English	3247	5	5.2	4.2	3.8	28
Speak English less than very well	944	1.4	1.6	1.2	1.1	13
Spanish	1241	1.9	1.2	1.7	1.2	13.6
Spanish-speak English less than very well	414	0.6	0.3	0.6	0.3	6.7
Other indo-European languages	1384	2.1	3.7	2.1	2.2	9.3
Other indo-European languages-speak English less than very well	353	0.5	1.2	0.6	0.6	3.7
Asian and pacific island languages	281	0.4	0.2	0.2	0.2	3.8
Asian and pacific island languages-speak English less than very well	112	0.2	0.1	0.1	0.1	2.2

Source: US Bureau of the Census, Census 2000 Summary Form;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036053.pdf>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036043.pdf>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036075.pdf>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/census/05036017.pdf>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/census/04036.pdf>

Table 1.15: School Dropouts, 2001/2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Number	Percent	Percent	Percent	Percent	Percent
High school dropouts	27	2.5	3.1	3.3	2.8	3.7
High school graduates intending to enroll in college - public schools	640	81.5	85.4	79.0	73.1	80.8
High school graduates receiving regents diplomas - public schools	477	60.8	61.2	59.3	59	55.6

*Total number of cases over 2001-2002 were taken to calculate the respective percentages

Source: NYS Kids' Well-being Indicator Clearinghouse;

http://www.nyskwic.org/access_data/ind_profile.cfm?subIndicatorID=25&indYear1=1996&indYear2=2002&go.x=9&go.y=5

NYS Education Department; Office of Information; Reporting and Technology Services.

Table 1.18: Unemployed - percent per 100 people in labor force, 2003

	Madison		Herkimer	Oswego	Chenango	NYS
Unemployment rate	2,100	5.9	5.9	8.8	6.3	6.3

Source: NYS Department of Labor; <http://64.106.160.140:8080/lmi/laus.html>

Local Area Unemployment Statistics Program; Unemployment Rates and Labor Force (LAUS)

Table 3.1: Cancer - deaths and death rates per 100,000 residents, 1998-2002*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2002)	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate
Lung & Bronchus cancer¹	39	66.8	66.5	73.6	57.9	64.8	69.4	55.6	47.6	50.6	49.5
Breast cancer²	15	32.2	29.3	32.6	24.1	23.2	22.4	34.5	27.3	311.6	27.7
Cervical cancer³	1	2.3	2.1	3	2.4	4.8	4.8	5.4	4.4	3.1	2.8
Colorectal⁴	22	24.8	24.9	33.2	25.1	19.6	21.5	27.2	23.1	22.2	21.6
Oral⁵	2	2	2	2.8	2.4	1.6	1.8	4.3	3.8	2.6	2.5

Note: Adjusted rates are age adjusted to the 2000 United States population

*Total deaths over 1998-2002 are considered to calculate the respective rates;

Source: NYS Department of Health website;

¹http://www.health.state.ny.us/nysdoh/chac/cha/ca_lun.htm;

²http://www.health.state.ny.us/nysdoh/chac/cha/ca_bre.htm;

³http://www.health.state.ny.us/nysdoh/chac/cha/ca_utc.htm;

⁴http://www.health.state.ny.us/nysdoh/chac/cha/ca_col.htm;

⁵http://www.health.state.ny.us/nysdoh/chac/cha/ca_orx.htm;

New York State Community Health Data Set – 2002; 1998-2002 Vital Statistics Data. Published in August, 2004

Table 3.2: Cancer Incidence rates per 100,000 residents, 1997-2001*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2001)	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate
Lung & bronchus cancer¹	50	86.6	86.9	93.1	74.9	84	90.8	73.3	64.1	68	67.2
Breast cancer²	54	137.9	131.6	167	134.6	135.5	136.7	152.1	131.8	141.8	131.4
Cervical cancer³	1	7.3	7.2	9.6	8.2	12.6	12.8	13.8	13.7	10.5	10.1
Colorectal⁴	45	70.8	71.9	99	78.4	65.5	72.3	57.7	50.3	63.1	62.3
Oral⁵	8	13.5	13.5	11.8	10.2	10.3	11	15.6	14.1	10.5	10.4

Note: Adjusted rates are age adjusted to the 2000 United States population;

*Total incidence rates over 1997-2001 are taken to calculate the respective rates;

Source: NYS Department of Health website

¹http://www.health.state.ny.us/nysdoh/chac/cha/ci_lun.htm

²http://www.health.state.ny.us/nysdoh/chac/cha/ci_bre.htm;

³http://www.health.state.ny.us/nysdoh/chac/cha/ci_utc.htm;

⁴http://www.health.state.ny.us/nysdoh/chac/cha/ci_col.htm;

⁵http://www.health.state.ny.us/nysdoh/chac/cha/ci_ora.htm

New York State Community Health Data Set – 2002; 1997-2001 Cancer Registry Data. Published in August, 2004

Table 3.5: Women Aged 40 Years and Older who Have Received a Mammogram within the preceding 2 years, 2003

	Madison	Herkimer	Oswego	NYS
Percentage of women who received a mammogram	76.3	75.9	89.5	77.6

Source: Regional Assessment Data; 2003 NYS BRFSS4.

Table 4.1: Diabetes - deaths and death rates per 100,000 residents, 2000-2002*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2002)	Crude rate	Adj. rate	Crude rate	Adjusted rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate
Diabetes mortality	10	17.7	17.6	24.4	18.7	22.6	24.6	21.5	17.9	20.5	19.7

Note: Adjusted rates are age adjusted to the 2000 United States Population

*Total deaths over 2000-2002 are taken to calculate the respective rates

Source: NYS Department of Health website; <http://www.health.state.ny.us/nysdoh/chac/cha/diabet.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data published in 2004

Table 4.2: Uncontrolled Diabetes-Rate per 10,000 population, 2002

	Madison	Herkimer	Oswego	NYS
Uncontrolled diabetes	13.5	15.2	13.9	16.6

Source: Regional Assessment Data; NYS HIN/SPARCS

Table 6.1: Pregnancies - rate per 1,000 females age 15-44, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Total female age 15-44¹	854	58.3	64.2	60	69.4	90.3
Age 15-19²	118	35.7	51.4	44.1	54.6	67.1
Age 10-14³	1	0.4	1	0.8	0.5	1.6
Age 15-17⁴	39	30.5	27.4	24.3	25.1	41.2
Age 18-19⁵	79	40	92.4	67.4	110.8	105.5

Note: *Total pregnancies over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health website;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/tpreg.htm>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/tp1519.htm>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/tp1014.htm>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/tp1517.htm>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/tp1819.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 6.2: Births - rate per 1,000 females, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Total female age 15-44¹	710	48.9	53	51.9	57.2	60.4
Age 15-19²	67	21.7	31.9	33.2	39.3	31.7
Age 10-14³	0	0	0.6	0.6	0.3	0.5
Age 15-17⁴	16	16.8	17.6	16.9	16.9	17.3
Age 18-19⁵	51	25.6	56.4	52.4	81.9	53

Note: *Total births over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health website;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/births.htm>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/tb1519.htm>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/tb1014.htm>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/tb1517.htm>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/tb1819.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 6.3: Teenage Births (age 15-17) - percentage per 100 live births, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Percentage	Percentage	Percentage	Percentage	Percentage
Teenage births age 15-17	16	3.4	3.7	3.3	3.5	2.5

Note: *Total births over 2000-2002 are considered to calculate the respective percentages

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/pct1517.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 6.4: Induced Abortions - ratio per 1,000 live births, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Induced abortions	138	185	202.2	151.8	206	486

Note: *Total births over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/abratio.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 6.5: Out-of-Wedlock Births - percentage per 100 live births, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Out-of-wedlock births	220	30.7	35	38.7	37.9	36.3

Note: *Total births over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/outwed.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 7.1: Communicable Diseases – rate per 100,000 population, 2003

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
E.coli 0157	2	2.9	0	2.4	0	0.6
Salmonellosis	8	11.5	18.8	8.1	11.7	13.5
Shigellosis	1	1.4	0	1.6	0	5.6

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/cdc/2003/index.htm>;

2003 Communicable Disease Annual Rates; data was published in august 3, 2004 (excludes inmates)

Table 8.1: Heart Disease - deaths and death rates per 100,000 residents, 2000-2002*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2002)	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate
Cardio-vascular disease mortality¹	228	318.6	317.9	484.1	342.8	315	348.5	466.2	378.9	358.6	341
Cerebro-vascular disease mortality²	41	55.9	55.9	64.4	44.7	48.7	54.8	61.2	49.3	40.3	38.4
Disease of the heart mortality³	164	235.9	235.2	390.6	276.8	250.6	276.3	365.9	298.7	298.3	283.6

Note: Adjusted rates are age adjusted to the 2000 United States population

*Total deaths over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website;

1 <http://www.health.state.ny.us/nysdoh/chac/cha/cardio.htm>;

2 <http://www.health.state.ny.us/nysdoh/chac/cha/cerebr.htm>;

3 <http://www.health.state.ny.us/nysdoh/chac/cha/dishrt.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 9.1: AIDS - deaths and death rates per 100,000 residents, 2000-2002*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2000-2002)	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate
Aids Deaths	3	1.4	1.5	0	0	0.5	0.5	2	1.9	11.1	10.9

Note: Adjusted rates are age adjusted to the 2000 United States population

*Total deaths over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/aids.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 10.1: Sexually Transmitted Diseases - rate per 100,000 population, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2000-2002)	Rate	Rate	Rate	Rate	Rate
Early syphilis¹	0	0	0	0	0	4.7
Early syphilis(age 15-19)²	0	0	0	0	0	3.7
Gonorrhea³	23	11	26	10.6	5.2	112.6
Gonorrhea (age 15-19)⁴	5	24.3	108.1	38.9	26.3	390.3
Congenital syphilis⁵	0	0	0	8	0	13.6
Pelvic inflammatory disease hospitalization⁶	13	28.1	26.3	37.8	40.2	62.4

Note: *Total cases over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health website;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/sb.htm>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/sa.htm>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/gb.htm>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/ga.htm>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/cs.htm>;

⁶<http://www.health.state.ny.us/nysdoh/chac/cha/pidp.htm>

New York State Community Health Data Set – 2002; 2000-2002 Bureau of STD Control Data; published in August, 2002

Table 11.1: Deaths and death rates per 100,000 residents, 2000-2002*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2002)	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate
Chronic lower respiratory disease¹	43	48.2	48.3	62.9	45.3	60.6	66.5	67.7	56	36.1	34.8
Asthma mortality²	0	1	1	1.6	1.4	0.3	0.3	1.3	1	1.8	1.7

Note: Adjusted rates are age adjusted to the 2000 United States population.

*Total deaths over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health website;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/clrd.htm>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/ast0.htm>

New York State Community Health Data Set– 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 12.1: Ambulatory Sensitive Conditions - age 0-4- discharge rate per 100,000 population age <5, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Asthma¹	18	467.6	432.8	340.3	450.3	661
Gastroenteritis²	8	153	255.7	441.5	184.7	139.7
Otitis media³	0	17	29.5	59.8	34.6	64.5
Pneumonia⁴	23	586.6	472.1	542.7	738.9	506.7

Note: *Total deaths over 2000-2002 are considered to calculate the respective rates.

Source: NYS Department of Health website;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/asthma0.htm>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/gastro0.htm>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/otitis0.htm>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/pneumo0.htm>

New York State Community Health Data Set – 2002; 2000-2002 SPARCS Data. Published in August, 2004

Table 12.2: Asthma (age 5-14) - discharge rate per 100,000 population age 5-14, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Asthma	3	48.6	75.8	75.1	96.7	223

Note: *Total cases over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health website; <http://www.health.state.ny.us/nysdoh/chac/cha/asthma1.htm>

New York State Community Health Data Set – 2002; 2000-2002 SPARCS Data. Published in August, 2004

Table 12.3: Asthma - discharge rate per 100,000 population, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total	Rate	Rate	Rate	Rate	Rate
Total¹	85	120.4	120	97.3	82	205.9
Age 15-24²	2	30.8	50.3	48.2	41.8	90.3
Age 25-44³	13	75.8	75.7	75.2	43.6	135.1
Age 45-64⁴	19	123.7	83.9	112.6	56.8	206.1
Age 65+⁵	30	255.9	235.9	95.4	73.9	247.8

Note: *Total cases over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health website;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/asthma6.htm>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/asthma2.htm>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/asthma3.htm>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/asthma4.htm>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/asthma5.htm>

New York State Community Health Data Set – 2002; 2000-2002 SPARCS Data. Published in August, 2004

Table 12.4: COPD Mortality - rate per 100,000 populations, 2000

	Madison	Herkimer	Oswego	NYS
	Rate	Rate	Rate	Rate
COPD deaths for persons 45+	137.9	182.7	195.7	100.6

Source: Regional Assessment Data; NYS HIN, 2000 SPARCS Data

Table 13.1: Communicable Diseases – rate per 100,000 population, 2003

Diseases	Madison		Herkimer	Oswego	Chenango	NYS
	Reported cases	Rates	Rate	Rate	Rate	Rate
Amebiasis	0	0	0	0	0	3.4
Babesiosis	0	0	0	0	0	0.4
Campylobacteriosis	9	12.9	15.7	14.6	13.6	11.3
Cryptosporidiosis	4	5.7	6.3	0.8	3.9	1.4
Cyclospora	0	0	0	0	0	0.1
Ehrlichiosis	0	0	0	0	0	0.4
Encephalitis	1	1.4	0	0.8	2	1.3
Giardiasis	13	18.6	12.6	10.6	5.9	13
Haemophilus influenzae	0	0	4.7	0.8	5.9	1.2
Hepatitis a	1	1.4	0	0	0	0.1
Hepatitis b	0	0	0	0	0	3.1
Hepatitis c	0	0	3.1	2.4	0	1.6
Hemolytic uremic syndrome	0	0	3.1	0	0	
Legionellosis	1	1.4	1.6	0.8	0	1.3
Malaria	0	0	0	0	0	1.4
Measles	0	0	0	0	0	0.04
Meningitis/aseptic	3	4.3	0	3.3	3.9	6.1
Mumps	0	0	0	0	0	0.1
Pertussis	15	21.5	1.6	1.6	31.2	6.4
Rubella						
Strep group a invasive	1	1.4	18.9	1.6	9.7	2.7
Strep group b invasive	0	0	0	1.6	9.7	4.6
Strep pneumonia invasive	8	11.5	0	10.6	15.6	10.8
Toxic shock syndrome	0	0	0	0	0	0.04
Typhoid fever	0	0	0	0	0	
Yersiniosis	0	0	0	0	0	0.3

Source: NYS Department of Health; <http://www.health.state.ny.us/nysdoh/cdc/2003/index.htm>;
2003 Communicable Disease Annual Rates; data was published in August 3, 2004 (excludes inmates)

Table 14.1: Infant Mortality- Rate per 1,000 live births, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total(2002)	Rate	Rate	Rate	Rate	Rate
Infant mortality ¹	25	8.9	5	6.3	9.9	6
Neonatal mortality ²	3	4.4	4.5	4.5	5.3	4.2
Post-neonatal mortality ³	0	2.7	0.5	1.9	4.7	1.8
Spontaneous fetal deaths 20+ week ³	6	5.7	7.4	4.2	7	7.7

Note: *Total deaths over 2000-2002 were considered to calculate the respective rates

Source: NYS Department of Health website;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/infmort.htm>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/neomort.htm>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/postmort.htm>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/sfd20.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 14.2: Maternal Child Health - percentage per 100 live births, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total(2002)	Percentage	Percentage	Percentage	Percentage	Percentage
Low birth weight¹	53	7.2	6.3	7.1	7.3	7.8
Very low birth weight²	13	1.9	1.2	1.3	1.3	1.5
Short gestation <37 weeks³	83	11.9	10	10.6	10.7	11.5
Early prenatal care⁴	590	81.7	77.1	77.8	79.4	73.3
Late/no prenatal care⁵	15	3.7	3.4	4	2	6.2

Note: *Total cases over 2000-2002 were considered to calculate the respective rates

Source: NYS Department of Health website;

¹<http://www.health.state.ny.us/nysdoh/chac/cha/lowbwt.htm>;

²<http://www.health.state.ny.us/nysdoh/chac/cha/vlowbwt.htm>;

³<http://www.health.state.ny.us/nysdoh/chac/cha/shtges.htm>;

⁴<http://www.health.state.ny.us/nysdoh/chac/cha/pnce.htm>;

⁵<http://www.health.state.ny.us/nysdoh/chac/cha/pncl.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data. Published in August, 2004

Table 14.3: Newborn Drug Related - Discharge rate - per 10,000 Newborn discharges, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total(2002)	Rate	Rate	Rate	Rate	Rate
Newborn drug related discharges	1	19.1	0	41.9	23.6	58

Note: *Total cases over 2000-2002 were considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/v3drug.htm>

New York State Community Health Data Set – 2002; 2000-2002 SPARCS Data. Published in August, 2004

Table 15.2: Children (age 0-4) who are Overweight - percent per 100 children tested, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total(2002)	Rate	Rate	Rate	Rate	Rate
Overweight children	45	14.5	14.5	14.2	13	16.3

Note: *Total cases over 2000-2002 were considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/ow.htm>

New York State Community Health Data Set – 2002; 2000-2002 Division of Nutrition Data, Published in August, 2004

Table 15.3: Percentage of Obese Adults, 2003:

	Madison	Herkimer	Oswego	NYS
Percentage of obesity in adults, age 18 years and over(age adjusted)	23.5	22.3	25.7	20.6
Percentage of obesity in adults, age 18+ and over	38.4	40.6	36	36.1

Source: Regional Assessment Data; 2003 NYS BRFSS

Table 16.1: Binge Drinking, 2003

	Madison	Herkimer	Oswego	NYS
Percentage of binge drinking adults (aged 18 years and over)	15.8	17	17.1	14.1

Source: Regional Assessment Data; 2003 NYS BRFSS

Table 16.2: Drug Related - Discharge Rate – per 10,000 population, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total	Rate	Rate	Rate	Rate	Rate
Drug-related hospitalization	38	5	9.1	6.6	6.8	30.5

Note: *Total cases over 2000-2002 were considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/drug.htm>

New York State Community Health Data Set – 2002; 2000-2002 SPARCS Data, published in August, 2004

Table 16.3: Cirrhosis Mortality: deaths and death rates - per 100,000 residents, 2000-2002*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2002)	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate
Cirrhosis mortality	6	7.2	7.2	8.3	7.1	10.1	10.4	7.2	6.3	7.4	7.2

Note: Adjusted rates are age adjusted to the 2000 United States Population;

*Total cases over 2000-2002 were considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/cirrho.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics. Data, published in August, 2004

Table 16.4: Alcohol Related Motor Vehicle Deaths and Injuries - rate per 100,000 population, 1999-2001*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2001)	Rate	Rate	Rate	Rate	Rate
Alcohol related motor vehicle deaths/injuries	39	91.2	80.2	102.8	103.7	49.2

Note: *Total deaths over 1999-2001 were considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/al.htm>

New York State Community Health Data Set – 2002; 1999-2001 NYS Department of Motor Vehicles Data, published in August, 2004

Table 17.1: Cigarette Smoking Adults, 2003

	Madison	Herkimer	Oswego	NYS
	Percent	Percent	Percent	Percent
Cigarette smoking-adults (aged 18 years and over)	29.3	25.7	27.9	20.3

Source: Regional Assessment Data; 2003 BRFSS Data

Table 17.2: Women who Smoke During Pregnancy, 2003

	Madison	Herkimer	Oswego	NYS
	Percent	Percent	Percent	Percent
Percentage of pregnant women who smoke during pregnancy	22.3	23.5	29	

Source: Regional Assessment Data; Perinatal Data System

Table 18.1: Suicide Mortality Rates per 100,000 residents, 2000-2002*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2002)	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate
Suicide mortality	7	13.4	12.9	14.5	14.5	10.6	10.6	7.2	6.6	6.7	6.6
Homicide mortality	0	0.5	0.5	1	1.1	2.4	2.5	2	2.1	5.1	5

Note: *Total cases over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/suicid.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data, published in August, 2004

Adjusted rates are age adjusted to the 2000 United States population

Table 18.2: Homicide Mortality Rates per 100,000 Residents, 2000-2002*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2002)	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude Rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adjusted rate
Homicide mortality	0	0.5	0.5	1	1.1	2.4	2.5	2	2.1	5.1	5

Note: *Total cases over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/homici.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data, published in August, 2004

Adjusted rates are age adjusted to the 2000 United States population

Table 18.3: Adolescent/Young Adult Suicide (age 15-19) - deaths and death rates per 100,000 residents age 15-19, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Adolescent/young adult (age 15-19) suicide mortality	1	9.7	28.8	9.7	8.8	5.5

Note: *Total cases over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/suicad.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data, published in August, 2004

Table 18.4: Self-inflicted Injury - discharge rate per 100,000 population, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Self-inflicted injury hospitalization(total)	30	35.8	56.6	51.9	41.7	41.9
Self-inflicted injury hospitalization(age 15-19)	9	82.6	129.7	113.5	114	92.1

Note: *Total cases over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/selfall.htm>,
<http://www.health.state.ny.us/nysdoh/chac/cha/self1519.htm>

New York State Community Health Data Set – 2002; 2000-2002 SPARCS Data, published in August, 2004

Table 18.5: Assault - discharge rate per 100,000 population, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Assault hospitalization	3	6.7	10.4	16	13	44

Note: *Total cases over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/assault.htm>
New York State Community Health Data Set – 2002; 2000-2002 SPARCS Data, published in August, 2004

Table 18.6: Unintentional Injury - deaths and death rates per 100,000 residents, 2000-2002*

	Madison			Herkimer		Oswego		Chenango		NYS	
	Total (2002)	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate	Crude rate	Adj. rate
Unintentional injury mortality	29	34.4	34.9	29.6	25.4	38.6	39.2	39.1	37.4	22	21.5
Motor vehicle mortality	9	14.3	14.6	13	12.1	20.7	20.6	22.1	21.6	8.4	8.3

Note: Adjusted rates are age adjusted to the 2000 United States population;

*Total deaths over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/totacc.htm>;
<http://www.health.state.ny.us/nysdoh/chac/cha/mvacc.htm>

New York State Community Health Data Set – 2002; 2000-2002 Vital Statistics Data, published in August, 2004

Table 18.7: Unintentional Injury - discharge rate per 100,000 population, 2000-2002*

	Madison		Herkimer	Oswego	Chenango	NYS
	Total (2002)	Rate	Rate	Rate	Rate	Rate
Hospitalization due to unintentional Injury (total)	371	494.3	829.6	646.6	688.3	593
Due to unintentional injury(age<10)	11	195.1	271.3	251.1	248.8	285.6
Due to unintentional injury(age 10-14)	11	226.2	335.7	288.4	280.6	261.6
Due to unintentional injury(age 15-24)	29	274.2	421.7	362.7	470.4	348
Due to unintentional injury(age 25-64)	138	329.4	451.6	465.5	424.9	400.5
Due to unintentional injury(age 65+)	182	1913.4	2911	2572.2	2368.8	2147.7
Traumatic brain injury hospitalization	50	70.2	62.9	90.8	84.6	66.3

Note: *Total cases over 2000-2002 are considered to calculate the respective rates

Source: NYS Department of Health Website; <http://www.health.state.ny.us/nysdoh/chac/cha/uitot.htm>

New York State Community Health Data Set – 2002; 2000-2002 SPARCS Data, published in August, 2004

MADISON COUNTY COMMUNITY HEALTH REPORT CARD

Key:

F- Favorable compared to state or peer counties

U- Unfavorable compared to state or peer counties

-- Neither favorable nor unfavorable

Indicator	Madison County compared to peer counties	Madison County compared to NYS
Socioeconomic:		
• Median household income	F	U
• Per Capital income	F	U
• Income below the poverty level	F	F
• Families below the poverty level	F	F
• High school graduate including equivalency	U	F
• Bachelors degree	F	U
• High school dropouts	F	F
• Children living below poverty	F	F
• Unemployment rate	F	F
• Total % population enrolled in Medicaid	F	F
Access to care		
• Medicaid or self pay births	F	F
• People with health insurance	--	--
• Children and youth receiving SSE	F	F
• Children and youth receiving public assistance	F	F
• Prenatal care 1 st trimester	F	F
• # PCP who accept Medicaid	F	U

Chronic disease		
• Lung and bronchus cancer death rates	U	U
• Breast cancer death rates	U	U
• Cervical cancer death rates	F	F
• Colorectal cancer death rates	U	U
• Oral cancer death rates	--	--
• Lung and bronchus cancer incidence	U	U
• Breast cancer incidence	F	--
• Cervical cancer incidence	F	F
• Oral cancer incidence	U	U
• % women receiving pap test	--	--
• % women receiving mammogram	--	--
• Diabetes mortality	F	F
• Uncontrolled diabetes	F	F
• Cardiovascular disease mortality	F	F
• Cerebrovascular disease mortality	U	U
• Disease of heart mortality	F	F
• AIDS deaths	--	F
• AIDS cases	F	F
• Cirrhosis Mortality	--	--
• Chronic lower resp disease	F	U
• Asthma mortality	--	--
• COPD mortality 45 years and +	F	U
• % adults age 50+ using blood stool test at home within last 2 years	U	U
• Adults age 50+ ever receiving a sigmoidoscopy or colonoscopy	U	U
Environmental health		
• Percent of children with elevated blood leads	--	--
• Percent of children screened for blood lead level	F	F
• Number of days ozone monitors exceeded concentration of 1 or 8 hours NAAQS	--	F
Physical Activity and Nutrition		
• % adults engaging in moderate exercise during past 30 days	U	U
• % Underweight children 0-4 years	U	F
• % Overweight children 0-4	--	F
• % obese in adults 18 + years age adjusted	--	U
• % of obesity in adults age 18+	--	U

Family Planning <ul style="list-style-type: none"> • Pregnancy rate age 15-44 • Birth rate age 15-44 • Pregnancy rate age 15-19 • Birth rate age 15-19 • Teenage births 15-17 years • Out of Wedlock births 	F F F F -- F	F F F F U F
Sexually Transmitted diseases <ul style="list-style-type: none"> • Rates of early syphilis age 15-19 • Gonorrhea all ages • Gonorrhea ages 15-19 • Pelvic inflammatory Disease hospitalization 	-- -- F F	F F F F
Ambulatory sensitive conditions discharge rates <ul style="list-style-type: none"> • Asthma age 0-4 • Asthma age 5-14 • Asthma age 15-24 • All ages • Age 65 + • Gastroenteritis age 0- 4 years • Otitis Media age 0-4 • Pneumonia age 0-4 	U F F U U F F U	F F F F U U F U
Communicable disease Rates immunizations <ul style="list-style-type: none"> • Campylobacteriosis • Cryptosporidiosis • Giardiasis • Pertussis • Not fully immunized school entrants • TB rates 	F U U U F F	U U U U F F

Maternal Child Health <ul style="list-style-type: none"> • Infant mortality • Neonatal mortality • Post-neonatal mortality • Spontaneous fetal deaths 20+weeks • % Low birth weight • % very low birth weight • % short gestation < 37 weeks • Early prenatal care • Late or no prenatal care • Newborn drug related discharges 	U -- U U -- U U F -- F	U -- U F -- U -- F F F
Substance Abuse <ul style="list-style-type: none"> • % binge drinking adults • Drug related hospitalizations • Cirrhosis mortality adjusted rate • Alcohol related motor vehicle deaths and injuries • DWI arrests ages 16-20 years 	F F -- F --	U F -- U U
Tobacco Use <ul style="list-style-type: none"> • % Cigarette smoking adults 18 + • % Women smoking during pregnancy 	U F	U N/A
Violent and Abusive Behavior <ul style="list-style-type: none"> • Suicide mortality all ages • Suicide rates age 15-19 • Homicide mortality • Self-inflicted injury hospitalization total • Self-inflicted injury hospitalization age 15-19 years • Assault hospitalizations • Unintentional injury death rates adjusted • Motor vehicle mortality rate adjusted 	U -- F F F F F F U	U U F F F F U U
Childhood Mortality <ul style="list-style-type: none"> • Early childhood age 1-4 years • Childhood/adolescent age 5-14 years • Adolescent/young adult 15-19 years 	F F F	F F F