Rochester
and
Monroe County

COMMUNITY PROFILE:

HOW WELL ARE WE DOING?

A partnership of
The Bruner Foundation; City of Rochester, NY; County of Monroe; Daisy Marquis Jones Foundation; Rochester Area Community Foundation; and United Way of Greater Rochester

April 2003

CGR

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Expertise to create effective solutions.

ROCHESTER AND MONROE COUNTY COMMUNITY PROFILE

HOW WELL ARE WE DOING?

Prepared for:
The Community of Rochester and Monroe County

With Guidance from:
Community Profile Advisory Team

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April, 2003

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April, 2003

EXECUTIVE SUMMARY

As the Rochester/Monroe County community invests its valuable and finite resources in priority areas, and defines the outcomes it expects as a result of those investments, it ultimately needs to be able to determine what impact the investments are having. Thus, the community needs to be able to measure progress against the desired outcomes over time, thereby allowing for an assessment of where it is on track in improving outcomes and where corrective actions may be needed in the future. This profile was designed to objectively assess changes over time in Monroe County's well-being across a variety of issues.

This 2003 document represents the second edition of the Rochester/Monroe County community profile. The first was published in July 1999. Both profiles were produced by CGR (Center for Governmental Research Inc.), under the leadership and guidance of the project's sponsoring partners: the Bruner Foundation, the City of Rochester, the County of Monroe, the Daisy Marquis Jones Foundation, the Rochester Area Community Foundation, and the United Way of Greater Rochester. Oversight of the project was provided by a Community Profile Advisory Team.

The profile is intended to be a reference document for community use. It is not designed to set community priorities, but it is intended to be a tool to provide unbiased, objective information that will give practical guidance to various community groups to use in determining possible service enhancements and needed future directions in Monroe County.

Summary Findings

Among the profile's key findings and overall conclusions are the following:

- Monroe County's overall population increased by 3% between 1990 and 2000. During that time, Rochester lost 4.6% of its population, while the suburban population increased by 6.6%.
- The population of black and Hispanic/Latino county residents increased substantially in the last decade. Between 1990 and 2000, the black population increased by more than 16,000 (+19%) to more than 100,000 residents, while Hispanics increased by 48% to more than 39,000 people in 2000.
- The population of the county is aging. The population 75 and older increased by almost 28%, while the number of children under 5 declined by 14%, and the key young adult population between the ages of 20 and 34 declined by 21%.
- Overall, across 116 separate measures, data from 1995 through the early years of this decade indicate that Monroe County has generally been at least holding its own or improving—with stability on between 15% and 20% of the measures, documented progress over the past few years on more than 40%, and movement away from desired outcomes on about 20% (on about 20% of the measures, there were questions about how the data should be interpreted). However, on a number of measures, including some where county rates have improved in recent years, the county's rates remain worse than national targets and/or worse than comparable rates for New York State, excluding New York City. Also, although there are a number of exceptions, performance on most measures is typically not as good among city residents as it is within the suburban areas of the county. More specifically, among five Impact Areas:

Success by 6

Monroe County has experienced consistent, steady and in some cases even dramatic improvements in various measures indicating readiness for school. However, in other outcome areas there has been relatively little indication of improvement, and new community initiatives may be needed if future improvements are to be realized.

- **Healthy Births:** Except for progress in reducing teen pregnancy and teen birth rates, relatively little statistical progress has been

evidenced in recent years in this outcome area; county rates are typically worse than New York-excluding-New York City rates, and typically fall short of national Healthy People 2010 goals.

- **Children Ready for School:** Consistent improvements have been evidenced since 1995 in preparing children for school.
- **Children Succeeding in School:** There have been some signs of encouragement in this outcome area among young children, but much progress remains to be made, especially in the city.
- **Family Stability:** There are some signs of encouragement in this area, but mostly reminders of work still needing to be done.

Kids on Track

There have been a number of encouraging improvements in recent years in various measures tracking progress of children and adolescents throughout Monroe County. However, other measures show less encouraging trends, and considerable improvement is still needed in many areas, including even some of those where recent progress has been indicated.

- **Children Succeeding in School:** The recent track record on children and adolescents succeeding in school is relatively discouraging, leaving considerable room for improvement within the city, but within suburban schools as well.
- **Youth Leading Healthy Lives:** Since the mid-1990s, there have been a number of encouraging signs of progress in this outcome area, although considerable improvement is still needed; on several measures county rates—even if they have improved—are consistently worse than national Healthy People 2010 goals.
- **Family Stability:** Although there are some signs of encouragement in this outcome area, considerable areas of need for improvement remain.

Strengthening Families

The stability of families in this update of the community profile appears overall to have eroded somewhat since the first edition, due in large part to declines in the economy. New community initiatives may be needed in several areas, including additional emphasis on the continuing development and strengthening of assets and resources for children, youth and families throughout the county. Such assets include expanded focus on primary prevention and early intervention services and activities designed to help youth and families make informed decisions that will

positively affect the ability of young people and adults to lead healthy, productive lives.

- **Physically and Mentally Healthy Families:** Many of the measures in this outcome area have been relatively stable in recent years, with some progress noted and some areas in which improvement is needed, especially in comparison with the rest of the state, excluding NYC, and in comparison with national Healthy People 2010 goals.
- **Personally Safe Families:** Overall trends in this outcome area have been positive, for the most part, in recent years.
- **Financially Secure Families:** In recent years, the overall financial profile of families and adults in the county has become less secure.
- **Appropriately Housed Families:** The trends in available data in this outcome area are somewhat mixed.

Helping Seniors

In general, Monroe County's growing older population appears to be relatively healthy, both physically and mentally, and to be relatively independent and self-sufficient. However, there are areas where new or expanded initiatives may be needed in the future, and additional data measures need to be developed in several areas.

- **Seniors Enjoying Mental and Physical Well-Being:** Overall, the county's older residents appear to be relatively healthy. On most of the measures in this outcome area, the county appears to be at least holding its own, with some areas of improvement needed.
- **Seniors Exercising Independence, and Productive Seniors:** Available measures are mostly encouraging, but few measures exist for these two outcome areas.
- **Financially Secure Seniors:** The available data on the financial status of seniors are somewhat mixed.
- **Personally Safe Seniors:** Although public safety data are not available for seniors, other available indicators suggest that most seniors are relatively safe.

Overcoming Disabilities

Considerable progress has been made in the past several years in improving the quality of life and providing various legal

protections for those with disabilities. However, this community and others throughout the country continue to struggle to find ways to adequately and reliably measure that progress. Among the critical next steps in assessing this community's progress in addressing the needs and aspirations of the diverse population of people with disabilities is to initiate a community process of refining the measures currently available and of developing and implementing new measures to track outcomes that cannot now be monitored in any consistent, comprehensive way.

- **People with Disabilities Enjoying Mental and Physical Well-Being:** On most of the available measures in this outcome area, recent data trends are inconclusive.
- **Personally Safe People with Disabilities:** Little good data exist to measure progress in this outcome area.
- **People with Disabilities Exercising Self-Determination:** The available data to measure progress in this outcome area are also limited.
- **Financially Secure People with Disabilities:** There are some indications of community progress in this area, but overall the data are too limited to draw definitive conclusions.

At-a-Glance Summary of Measures

Beyond the previous overall summary statements for each Impact Area and desired outcome, the "at-a-glance" table on the concluding several pages of this Executive Summary presents an overview of how Monroe County is faring on each one of the 116 measures included in this Community Profile 2003 update. The measures are presented in the order in which they appear in the full report, organized into five Impact Areas and, within those, grouped by outcomes.

The summary for each measure focuses on whether the **county as a whole** has improved in recent years. Within the county, there are often significant differences between city and suburban rates, and in many cases they are going in different directions. Any such city/suburban differences are not reflected in the summary table that follows, but they are clearly enumerated in detail in the discussion of each measure in the full report and in the data tables in the appendix.

For each measure, four columns of information are presented:

- **Column 1: Desired Direction of Rate or Number.** This column reflects the direction in which the measure should be moving in order to achieve the desired outcome. When both rates and actual numbers are available for a measure (as in most cases), the direction of the rate is used as the basis for determining the desired direction, and for the actual comparisons that follow in Columns 2-4. Three symbols are used to indicate the preferred direction:

  - An upward arrow (⬆) indicates that an **increase in rate (or number) is desired.**

  - A downward arrow (⬇) indicates that a **decrease in rate (or number) is desired.**

  - An asterisk (✸) indicates that the **desired direction is uncertain**. The reader should refer to the one-page narrative in the full profile document for further discussion of the measure.

- **Column 2: Monroe County Rates: Most Recent Year vs. Baseline Year.** This column compares Monroe County rates (or actual numbers) at two points in time. The rate or number in 1995 (or the earliest year for which data are presented) is compared with the most recent year for which data are available for the measure (typically 2000 or 2001). Whether the county has improved or not is reflected in one of three summary comments:

  - **Better** indicates that the **measure has shown improvement toward meeting the desired outcome**. Typically a small improvement reflecting little practical impact would not be considered to be better.

  - **Worse** indicates that the **measure has shown movement away from the desired outcome.** Again, a small change with little practical impact would not be considered to be worse.

  - **Comparable** indicates that the **measure has shown little practical change between the two points in time.**

- **Column 3: Monroe County Rates: Direction Over Past 3 Years.** In this column, the performance on the measure over the past three years is indicated. A measure could have improved between the baseline year and the most recent year (column 2), but might have been stable or gone in a different direction over the past three years. Comparing columns 2 and 3 would indicate whether the directions during the longer and shorter periods of time represented in the two comparisons have been consistent or not. Whether the county has improved or not over the past three years is reflected in one of four summary comments:

  - As in column 2, **Better** indicates that the **measure has shown improvement toward meeting the desired outcome**. Typically a small improvement reflecting little practical impact would not be considered to be better.

  - **Worse** indicates that the **measure has shown movement away from the desired outcome.** Again, a small change with little practical impact would not be considered to be worse.

  - **Comparable** indicates that the **measure has shown little practical change during the past three years.**

  - **Variable** indicates that the **direction of the measure has shifted up and down during the past three years**.

- **Column 4: Monroe County Rates vs. NYS-Excluding-NYC Rates.** Where possible, county data were compared to comparable rates for the rest of New York State, excluding the city of New York. This column indicates how county rates have compared to the NYS-excluding-NYC rates over the past several years, reflecting the period of time between the baseline year and the most recent year for which data were available. If no comparison data were available, the column indicates "na". Otherwise, the following terms are used to indicate how the county compares to the larger region:

  - **Better** indicates that the **county rate has been consistently better than the larger regional rate.** The difference must have been viewed as having practical significance or impact to have received this term.

- **Worse** indicates that the **county rate has been consistently worse than the larger regional rate.** The difference must have been viewed as having practical significance or impact to have received this term.

- **Comparable** indicates that the **county and larger regional rates have been similar during the comparison years.**

Note: Several measures included in this report relate to more than one Outcome Area. While the full analysis of these measures appears only once in the report—under the Outcome Area to which the measure primarily relates—in the "At-a-Glance" table below, we have listed the measure under each Outcome Area for which it has relevance. Hence, where a measure is related to an Outcome Area other than the primary area under which the measure is analyzed, the measure is listed in italics.

Monroe County At-A-Glance

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
SUCCESS BY SIX				
Healthy Births				
Low Birth Weight	⬇	Comparable	Variable	Comparable
Early Entry Into Prenatal Care	⬆	Comparable	Worse	Comparable
Live Births to Teens, Ages 15-17	⬇	Better	Comparable	Worse
Children Ready for School				
Children Fully Immunized at 24 Months of Age	⬆	Better	Better	na
Asthma Hospitalizations (Age 0–4)	⬇	Better	Variable	Better
Children with High Blood Lead Levels	⬇	Better	Variable	Worse
Pre-Kindergarten Special Education Referrals and Placements	✸	(#s down)	na	na
Quality of Pre-Kindergarten Classrooms	⬆	Better	Better	na
Children Entering Kindergarten with Problems[1]	⬇	Better	Comparable	na

[1] Data for this measure are for Rochester City Schools only.

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
Children Succeeding in School				
Student Performance on Grade 4 English Language Arts Test	⬆	Better	Better	na
Student Performance on Grade 4 Math Test	⬆	Comparable	Variable	na
Family Stability				
Children Receiving DSS Preventive Services	✸	(#s down)	na	na
Monthly Average Population on Temporary Assistance	⬇	Better	Better	na
Monthly Average Food Stamps Caseload	⬇	Worse	Worse	na
Elementary School Students Eligible for Free/Reduced Price Lunch	⬇	Worse	Worse	Worse
Children in Foster Care[2]	⬇	Comparable	Comparable	Worse
Children Admitted to Foster Care[2]	⬇	Worse	Comparable	Worse
Indicated Cases of Child Abuse and Neglect	⬇	Worse	Comparable	Better
Unemployment Rate	⬇	Worse	Worse	Better until '00

[2] Over time, OCFS has changed the population base used in its rate calculation for this measure. Therefore, as rates may not be directly comparable over time, comparisons for this measure are based on actual numbers rather than rates.

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
KIDS ON TRACK				
Children Succeeding in School				
Student Performance on Grade 8 English Language Arts Test	⬆	Worse	Worse	na
Student Performance on Grade 8 Math	⬆	Better	Variable	na
Middle School Attendance Rates	⬆	Comparable	Comparable	Comparable
High School Attendance Rates	⬆	Better	Comparable	Worse
High School Dropout Rates	⬇	Better	Variable	Worse
Graduation Destination: College	⬆	Better	Better	Comparable
Middle School Suspension Rates	⬇	Worse	Comparable	Worse
High School Suspension Rates	⬇	Better	Better	Worse
Youth Leading Healthy Lives				
Teen Pregnancy Rates (Age 10–14)	⬇	Better	Variable	Worse
Teen Pregnancy Rates (Age 15–17)	⬇	Better	Variable	Worse
Repeat Births to Teens	⬇	Better	Variable	Worse
Self-Reported Teen Cigarette Smoking	⬇	Better	Better	na
Self-Reported Teen Marijuana Use	⬇	Comparable	Comparable	na
Self-Reported Teen Cocaine Use	⬇	Comparable	Comparable	na
Self-Reported Teen Alcohol Use	⬇	Comparable	Comparable	na
Youth Arrests for Part I Crimes	⬇	Better	Variable	Better

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
Youth Arrests for Part II Crimes	⬇	Better	Better	Comparable '98-'00
PINS Cases Opened at Probation Intake	⬇	Better	Variable	Better
Juvenile Delinquency Cases Opened at Probation Intake	⬇	Better	Better	Worse('98,'00,'01)
Teen Suicide Rates (age 10–19)	⬇	Comparable	Comparable	na
Teen Gonorrhea (Age 15–19)	⬇	Better	Comparable	na
Family Stability				
Children Receiving DSS Preventive Services	✸	(#s down)	na	na
Monthly Average Population on Temporary Assistance	⬇	Better	Better	na
Monthly Average Food Stamps Caseload	⬇	Worse	Worse	na
Elementary School Students Eligible for Free/Reduced Price Lunch	⬇	Worse	Worse	Worse
Children in Foster Care[3]	⬇	Comparable	Comparable	Worse
Children Admitted to Foster Care[3]	⬇	Worse	Comparable	Worse
Indicated Cases of Child Abuse and Neglect	⬇	Worse	Comparable	Better
Unemployment Rate	⬇	Worse	Worse	Better until '00

[3] Over time, OCFS has changed the population base used in its rate calculation for this measure. Therefore, as rates may not be directly comparable over time, comparisons for this measure are based on actual numbers rather than rates.

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
STRENGTHENING FAMILIES				
Physically and Mentally Healthy Families				
Elementary School Students Eligible for Free/Reduced Price Lunch	⬇	Worse	Worse	Worse
Number of Individuals Served Emergency Food	✸	(#s down)	na	na
Teen Pregnancy Rates (Age 10 – 19)	⬇	Better	Comparable	Worse
Self-Reported Physical Activity[4]	⬇	na	na	na
Self-Reported Physical Health Status*	⬇	Comparable	na	na
Self-Reported Mental Health Status*	⬇	Comparable	na	na
Self-Reported Cigarette Smoking*	⬇	Comparable	na	na
Mortality Rates- All Causes	⬇	Comparable	Variable	Comparable
Mortality Rates- Lung Cancer	⬇	Comparable	Variable	Comparable
Mortality Rates- Heart Disease	⬇	Better	Variable	Better
AIDS Deaths	⬇	Better	na	na
Suicides	⬇	Comparable	Variable	na
Sexually Transmitted Diseases- Gonorrhea	⬇	Better	Variable	na
Self-Reported Disease Prevalence- High Blood Pressure*	⬇	Comparable	na	na
Self-Reported Disease Prevalence- Diabetes*	⬇	Comparable	na	na

4 Data for this measure are only available for a single year (2000).

* The data for this measure are self-reported survey data available only at two points in time (1997 and 2000).

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
Ambulatory Care Sensitive Hospitalizations	✸	(#s down)	na	na
New Entrants to Mental Health Treatment	✸	(#s down)	na	na
Individuals Receiving Mental Health Crisis Services	✸	(#s variable)	na	na
Individuals Admitted to Mental Health Inpatient Services	✸	(#s comparable)	na	na
Alcohol- and Drug- Related Hospital Discharges	⬇	Better	Variable	na
Alcohol-Related Motor Vehicle Crashes	⬇	Worse	Worse	Better until '99
Personally Safe Families				
Reports of Domestic Violence	⬇	Better	Better	Worse
Murder Rates	⬇	Comparable	Variable	Worse
Reported Part I Violent Crime Rates	⬇	Better	Variable	Worse until '99
Reported Part I Property Crime Rates	⬇	Better	Variable	Worse
Reported Part II Crime Rates	⬇	Better	Better	Better
Self-Reported Youth Weapon Use	⬇	Better	Variable	na
Self-Reported Youth Victimization	⬇	Worse	Worse	na
Indicated Cases of Child Abuse and Neglect	⬇	Worse	Comparable	Better
Financially Secure Families				
Per Capita Personal Income	⬆	Better	Variable	Worse
Average Annual Wages	⬆	Comparable	Worse	Better until '00
Households Experiencing Difficulty Paying Utility Bills	⬇	Better	Better	na
Unemployment Rate	⬇	Worse	Worse	Better until '00
Annual Growth in New Jobs	⬆	Worse	Worse	Worse since '97
Public Assistance Cases Closed Due to Employment	✸	(#s down)	na	na

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
Employment by Sector	✸	na	na	na
Temporary Employment	⬇	Worse	Variable	na
Self-Reported Health Insurance Coverage*	⬆	Comparable	na	na
Appropriately Housed Families				
Mortgage Foreclosures	⬇	Worse	Worse	na
Tax Foreclosures	⬇	Worse	Variable	na
Emergency Placements in Homeless Shelters	✸	(#s up)	na	na
Home Mortgage Loans	⬆	Better	Variable	na
Dispersion of Low Income Households	⬆	Better	Better	na
HELPING SENIORS				
Seniors Enjoying Mental and Physical Well-Being				
Self-Reported Senior Physical Activity (No activity)*	⬇	Better	na	na
Self-Reported Senior Health Status: Fair or Poor*	⬇	Comparable	na	na
Individuals 65+ Served Emergency Food	✸	(#s down)	na	na
Individuals 65+ Served Congregate and Home Delivered Meals	✸	(#s up)	na	na
Self-Reported Senior Influenza Immunization Rates*	⬆	Worse	na	na
Senior Mortality Rates- All Causes	⬇	Better (slightly)	Variable	na

* The data for this measure are self-reported survey data available only at two points in time (1997 and 2000).

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
Senior Suicide Rates	⬇	Comparable	Variable	na
Hospital Discharges with Primary Diagnosis of Stroke	⬇	Better (slightly)	Variable	na
Ambulatory Care Sensitive Hospitalizations for Seniors	✸	(#s down)		
Self-Reported Senior Disease Prevalence- High Blood Pressure*	⬇	Comparable	na	na
Self-Reported Senior Disease Prevalence- Diabetes*	⬇	Comparable	na	na
Seniors Entering Mental Health Treatment for the First Time	✸	(#s up)	na	na
Seniors Receiving Mental Health Crisis Services	✸	(#s up)	na	na
Seniors Admitted to Inpatient Mental Health Services	✸	(#s up)	na	na
Self-Reported Senior Mental Health Status: Frequent Mental Distress*	⬇	Comparable	na	na
Seniors Exercising Independence				
Productive Seniors				
Senior Self-Reported Feelings of Isolation*	⬇	Comparable	na	na
Financially Secure Seniors				
Seniors Receiving SSI	✸	(#s down)	na	na
Self-Reported Health Insurance Coverage*	⬆	Comparable	na	na
Personally Safe Seniors				

* The data for this measure are self-reported survey data available only at two points in time (1997 and 2000).

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
Senior Hospitalizations for Falls	⬇	Comparable	Variable	na
Senior Self-Reported Injurious Falls	⬇	Comparable	na	na
Seniors in DSS Adult Protective Services	⬇	Worse	Worse	na
OVERCOMING DISABILITIES				
People with Disabilities Enjoying Mental and Physical Well-Being				
Functional Improvement Goals	✸	na	na	na
Admissions to Alcohol and Drug Abuse Treatment	✸	(#s up)	na	na
Annual First Time Entrants to Alcohol/Substance Abuse Treatment	✸	(#s down)	na	na
Prevalence of Mentally Ill Receiving Services	✸	(#s up)	na	na
New Entrants to Mental Health Treatment Services	✸	(#s up)	na	na
Individuals Admitted to Mental Health Inpatient Treatment	✸	(#s up)	na	na
Unmet Needs of People with Disabilities as Reported by Caregivers	✸	na	na	na
Expansion of Competitive Jobs Held by People with Disabilities	⬆	Better	Better	na
Personally Safe People with Disabilities				
Abuse and Neglect Against People with Disabilities	⬇	Worse	na	na
Inventory of Accessible and Adaptable Rental Units	⬆	Better	Variable	na

OUTCOMES AND MEASURES	DESIRED DIRECTION OF RATE OR NUMBER ⬆=Increase ⬇=Decrease ✸=Uncertain	MONROE COUNTY RATES: MOST RECENT YEAR VS. BASELINE YEAR	MONROE COUNTY RATES: DIRECTION OVER PAST 3 YEARS	MONROE COUNTY RATES VS. NYS-EXCLUDING-NYC RATES
People with Disabilities Exercising Self-Determination				
RTS Lift-Equipped Bus Fleet	⬆	Better	Better	na
Progress Against Alcoholism and Substance Abuse Treatment Goals	⬆	Better	Better	na
Financially Secure People with Disabilities				
People with Disabilities Receiving SSI Payments	✸	(#s up)	na	na
Sources of Income for Mentally Ill Adults: Employment	⬆	Worse	Worse	na
Number of Job Placements by Type Among Adults with Disabilities	⬆	Better	Better	na
Number of People with Disabilities Moved from Welfare to Employment	⬆	Worse	Variable	na
Proportion of Those in Substance Abuse Treatment Who Maintain or Improve Their Employment Status	⬆	Better	Variable	na

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The partners, along with other community representatives, make up the Community Profile Advisory Team, chaired by Dr. Andrew Doniger. The Team's members are listed at the front of this document. We are grateful for their vision, continuing support and encouragement, and helpful insights and prodding throughout the process. Their suggestions have led to many improvements in the profile since its first edition in 1999.

The United Way has played an especially important support role in overseeing the process of creating, improving and reviewing this document, and in providing key support to the Community Profile Advisory Team. We particularly thank Carol Gravetter and Bill McCullough for their many contributions throughout the process of creating this profile document.

Finally, our thanks to the numerous individuals in local, regional and state agencies who assisted us in the data collection and interpretation process. Without their behind-the-scenes cooperation, this document would not have been possible. They are too numerous to mention, but we would be remiss if we did not mention the special "above and beyond" contributions of Anne Kern and Melissa Gray of the Monroe County Health Department. To all who contributed, thank you.

Staff Team

Kimberly Hood and Marilyn Klotz collected and analyzed most of the data in this profile, and collaborated in the authorship of the document.

I. INTRODUCTION AND METHODOLOGY

Background

In recent years a national movement has emerged to define and measure community-wide outcomes. The Rochester/Monroe County community has taken the lead in developing outcomes and measures to track how well it is doing in addressing selected issues and needs. This community profile was designed to objectively assess changes over time in Monroe County's well-being across a variety of issues.

In 1998, a broad coalition of six organizations committed resources to develop Monroe County's first community profile: the Bruner Foundation, the City of Rochester, the County of Monroe, the Daisy Marquis Jones Foundation, the Rochester Area Community Foundation, and the United Way of Greater Rochester. Representatives of these organizations, along with other community representatives, formed a Community Profile Advisory Team which helped determine and design the profile's goals, content and format, and which provided project oversight to assure that the profile met the funders' original goals. The Advisory Team members are listed at the beginning of this document. CGR (Center for Governmental Research Inc.) was engaged by the coalition to produce the first community profile, which was published in July 1999.[1]

This 2003 document represents the second edition of the community profile. The timing of this document is consistent with the original plan, which was to update data annually and produce updated data tables each year, but to only publish the full profile document every three or four years, including detailed analyses of data, graphs of each measure, and summaries of the implications of the data and changes over time.

Purpose of the Community Profile

The profile is intended to be a reference document for community use. It is not the role of the profile or of the Profile Advisory Team to set community priorities. Rather, the profile is designed to provide unbiased, objective information that will give practical guidance to various community groups to use in determining

[1] *Greater Rochester/Monroe County Community Profile: How Well Are We Doing?* July, 1999.

possible service enhancements and needed future directions in Monroe County. As the community invests its valuable and finite resources in priority areas, it ultimately needs to be able to determine what impact the investments are having. Thus, the community needs to be able to measure progress against desired outcomes over time, thereby allowing for an assessment of where the community is on track in improving outcomes and where corrective actions may be needed in the future.

More specifically, the purposes of the community profile include the following:

- To provide an objective assessment of how well the Monroe County community is doing in achieving desired outcomes and an improved quality of life for the county's residents;
- To educate and inform the community as a whole (and its leaders, policymakers, funders, donors, planners, service providers, etc.) about the degree of progress against desired outcomes and the implications of any changes;
- To compare local progress where possible against the rest of New York State (excluding New York City) and, in some cases, against relevant national goals; and
- To be a tool that serves as a catalyst to guide the community's use in planning, setting priorities and developing strategies to shape future community investments, policies and service provision initiatives most likely to have the greatest positive impact in bringing about needed improvements to help assure the future well-being of the community.

Project Methodology

Prior to the introduction of the baseline 1999 community profile, community leaders, service providers, and measurement experts worked closely to define desired community outcomes and measures to assess community progress in five broad Impact Areas: Success by 6, Kids on Track, Strengthening Families, Helping Seniors, and Overcoming Disabilities. These Impact Areas encompass broad substantive areas which are of concern to, and reflect priorities of, the larger community—and as such are areas in which the community is investing considerable financial and volunteer resources to effect improved outcomes throughout the Monroe County area.

Defining Terms

The term *outcome* was used in the first profile document, and continues to be used in this profile update, to mean "an inherently valued state of being," or a statement of what we want for the residents of this community. Examples of such outcomes include: healthy births, children succeeding in school, physically and mentally healthy families, family stability, financially secure seniors, people with disabilities exercising self-determination.

The term *measure* refers to "a specific and concrete source of data used to determine whether progress is being made in achieving the desired outcome." Because outcomes are broad statements of desired conditions, multiple measures are typically needed to paint a picture of whether progress is being made in a particular outcome area.

A total of 20 outcomes were defined for use in the first community profile, and those 20 continue to be included in this document. In the first document, 151 separate measures were used to assess progress against those outcomes. In this updated profile document, the number of measures has been reduced to 116.

Determination of Measures

An initial list of potential measures was determined by community leaders and experts through an extensive process guided by the United Way. That list was narrowed down to the 151 used in the 1999 profile by comparing the initial list against a set of criteria, including (1) the ready availability of, and ability to easily access and analyze the data, and (2) the practical feasibility of collecting and tracking the measure over multiple years. In addition, only measures that provided *community-wide data* were considered for inclusion; that is, data that only pertained to individual agencies or programs, and that could not be collected and analyzed for the larger community, typically were not included.

For the current edition of the profile, the original list of 151 measures was pared down by 23% to 116, based on a number of factors. Most of the measures that were deleted between the first and second profile editions were eliminated either because the data were no longer collected (such as several survey-related measures), or because CGR and the project steering committee agreed that the measure had little value on an ongoing basis. These reductions were also influenced by reactions from some users of the first

profile that the updated edition would be more useful and would receive more attention if fewer measures were included. In addition to the reduction in the number of measures included in this document, some of the remaining 116 measures were modified to reflect changes in how data were collected. Where such modifications occurred, those are indicated in the discussion of the affected measures.

Once the final list of measures was agreed upon by CGR and the steering committee, data were collected from the appropriate state and local agencies, analyzed and displayed in tables and graphs. The format for presenting the data is described below. The sources for all measures are cited at appropriate places in the report. Where possible, we used New York State sources of data rather than county sources to ensure, as much as possible, consistent definitions and reporting across counties, and to enable us to make consistent and reliable comparisons where possible with the rest of New York (exclusive of New York City).

It should be noted in reviewing the data that there are few "perfect" measures. Nearly all have some flaws and limitations. Nonetheless, CGR is comfortable that the measures, individually and collectively, have enough positive attributes and value to offset any limitations.

In that context, it is also important to note that no single measure should be reviewed in isolation without putting it into a larger context. Rarely does a single measure—or even a group of measures—in isolation tell a story that sufficiently explains the community's progress or lack of progress around a particular outcome. Without discussing the interrelationship of different measures, the presentation of the measures is likely to be relatively unhelpful to the community, and worse, some data could potentially be misinterpreted or taken out of context, resulting in misleading conclusions. Thus, it is important to keep in mind not just each individual measure under consideration, but also how combinations of measures may interact to convey a picture of progress or lack thereof in a given area. This underscores the importance of the summary interpretive discussions included at the beginning of each of the Impact Area chapters.

Contents and Format of Community Profile

Within the five Impact Areas, data for each relevant measure are presented in "reader-friendly" graphs, which emphasize documentation of trends and rates for Monroe County, the city and suburban areas of the county, and the rest of New York State excluding New York City, where such comparison data are available. More specifically, this profile includes the following:

- For each measure, the core information is presented on one page in a consistent format, with a graph and an analytical narrative which includes three brief sections: ***Definition*** of the measure; ***Findings*** focusing on trends over time; and ***Caveats*** that readers should be aware of when interpreting the data. While these caveats are essential to note, CGR is comfortable that the measures, individually and collectively, have enough positive attributes and value to offset any limitations.
- For each measure, data are always presented at least for Monroe County as a whole. In most cases, data are also available, and presented and graphed, for the City of Rochester and for a composite of the suburban portion of the county.
- Comparison data are presented where readily available for New York State excluding NYC. Additional benchmark or comparison data also include, where available, national goals or standards such as the Healthy People 2010 national goals. Healthy People 2010 refers to a set of objectives, or measurable targets, designed as part of a national strategy to improve the health of all Americans.
- More detailed data tables for each measure are presented in an appendix, which includes the raw data on which the graphs are based; detailed data tables are provided for each of the 116 measures included in this update of the profile.
- Data are presented for each measure for the most recent year available. Also, in most cases, historical data as far back as 1995, or as close to that as possible, were available and are presented in the graphs for trending purposes. (In addition, where older data existed, back as far as 1990, those data are included in the appendix data tables, even though they are not graphed in the body of the report.) It should be noted that caution should be exercised in analyzing trends, so that conclusions not be drawn based on fluctuations in data from one year to the next. ***Year-to-year fluctuations, even if substantial, typically are not***

sufficiently reliable for planning and assessment purposes. Thus we have noted cautions wherever appropriate about not attributing too much significance to changes that only occur across a year or two. For CGR to suggest that a trend exists, there must typically be a clear pattern of consistent movement of a measure in the same direction over several years.

- To assist the reader in wading through and interpreting more than 100 measures, a summary is presented at the beginning of each Impact Area chapter. These summary discussions include an overview of each area, relevant demographic trends based on Census data, summary interpretations of significant themes or directions in each Impact Area, and overall conclusions reflecting suggestions for new strategies that may need to be considered in the future. The summary statements also include arrows which indicate for the county as a whole whether the trend for a particular measure reflects overall improvement in recent years toward meeting the desired outcome, is trending away from the desired outcome, or indicates no significant change over time.

- The executive summary at the beginning of this document highlights the profile's major themes, trends and issues that cut across outcome areas. It also provides an "At-a-Glance" summary of how the community is doing on each of the measures included in this document.

Finally, a reminder that even the best combination of measures is only one of many decision-making tools, albeit a useful one, available to policymakers, service providers, planners, funders and community residents. The outcome measures presented in the subsequent chapters of this document are not meant to substitute for the experiences and judgments of community leaders, or to prescribe specific solutions for issues facing the community. Rather, the measures should be used as an important supplementary tool to help identify areas where the community appears to be doing well, along with issues needing further attention.

Value of Survey Data

A number of the measures included in the profile involve responses to various surveys. The largest and most important of these surveys, because it yields measures in several of the Impact Areas, is the community-wide health survey conducted in 1997 and 2000 for the Monroe County Health Department. Responses

to a number of the questions asked in that survey have been incorporated as measures for several outcome areas, but there are significant cautions: Only households with telephones were included in the survey. In addition, the "frail" elderly may be under-represented by the survey approach. Moreover, respondents to any type of survey may not answer all questions accurately for a variety of reasons. The most likely result of these factors is that the reported data may appear to be somewhat more favorable than is actually the case. Nonetheless, survey data, when questions are asked consistently in each survey administration, clearly add significant value to the ability to track changes over time in some areas where we otherwise would have gaps in our community measures.

Outline of Remainder of this Document

Chapter II provides a summary profile of Monroe County in 2000, based on 2000 Census data, compared with the 1990 Census profile. Chapter III provides a brief economic overview of the county in the early years of the new decade. Chapters IV through VIII present the statistical data/measures and summary discussions for each of the five Impact Areas, in the following order: Success by 6, Kids on Track, Strengthening Families, Helping Seniors, and Overcoming Disabilities. Following Chapter VIII, two indexes are presented: The first indicates the text page and table numbers for each measure, by Impact Area and Outcome, and the second categorizes information in the document by broad issue or subject area. The Appendix includes the detailed tabular data on which the graphs of the measures in Chapters IV – VIII are based. Finally, the Executive Summary that precedes the full report focuses on the major highlights of the data and the significant trends, themes, conclusions and cross-cutting issues that emerged from the analyses of the various measures.

II. Census 2000 Profile: Demographic Trends in Monroe County

The narrative and tables below offer a summary overview from the U.S. Census of key descriptive data that provide a profile of Monroe County and the City of Rochester in 2000, compared with 1990.[2] The narrative and tables summarize key information from the Census and suggest major trends and implications of the data. (Other highlights of Census data applicable to each Impact Area are presented in Chapters IV - VIII.)

- Monroe County's overall population increased by 3% during the 1990s. All of the population growth occurred in the suburban areas (an increase of almost 32,000, up almost 7% from 1990), with the city of Rochester losing almost 5% of its population (more than 10,000 people) since 1990. In 2000, about 30% of the county's inhabitants resided in the city.
- While the overall population of the county grew slightly and the population of the city of Rochester declined between 1990 and 2000, the population of certain racial and ethnic groups increased during the decade. Overall, Monroe County is still primarily white (79%, but down 3% from 1990). But the number of Blacks residing in the county increased 19% (more than 16,000 people) between 1990 and 2000, and the number of persons of Hispanic or Latino origin grew by 48% to more than 39,000 people in 2000. Over 70% of Hispanics/Latinos living in the county indicated they were of Puerto Rican origin or descent. Although the vast majority of Blacks and Hispanics continue to live in the city, the

[2] A note about the data presented in the tables below: While all U.S. households receive the "short-form" (100 percent) Census survey, only 1 in 6 households received the "long-form" (sample data). Weighting techniques were used to bring the numbers pulled from the long-forms up to the total population size indicated by responses in the short-form. However, because of the sampling, the totals at the county, city, town, and census tract levels do not always match precisely. Therefore, for each table below, we have noted whether the data are derived from sample data or 100-percent population data.

proportion of both groups living in the suburbs also increased substantially during the past decade.

- The population of the county is aging. The number of 75 – 84 year olds increased by more than 7,000 residents (a 25% increase) between 1990 and 2000, and the number of individuals age 85 and older increased by more than 3,5000 (or 35%) during the same time period.
- While Monroe County's senior population has grown to almost 95,800 individuals age 65 and over, its young adult population ages 25 – 34 declined by more than 28,500 (23%) during the 1990s, and the number of 20 – 24 year olds also declined by almost 11,000 to 47,587 in 2000 (a 19% decline).
- About a quarter of the county's population is under the age of 18. Since 1990, the number of children under age 5 has decreased countywide, with the city of Rochester experiencing a high rate of loss compared to the rest of the county. There has been an increase in the number of school-age children over the past decade; in particular, since 1990 the number of children ages 5 – 14 increased by more than 15,600 (+17%) countywide.
- The number of people living alone in the county increased by almost 10,700 (+15%) between 1990 and 2000.
- Overall household income has increased in the county. Median household and median family incomes are increasing, although Rochester's levels remain substantially below the countywide figures. In 2000, the disparity between the median household income in the city and the county as a whole was almost $18,000 (up from a disparity of about $12,500 in 1990), and the disparity between median family incomes was even greater, at more than $24,600 (it had been about $15,000 ten years earlier).
- Compared to 1990, 20% fewer households countywide in 2000 had annual incomes of less than $25,000, and the number of households countywide earning $75,000 or more increased 124%. One quarter of the county's households in 2000 (more than 71,500) earned $75,000 or more the previous year (up from 12% in 1990). The number of households in the city earning more than $75,000 increased by 147% during the 1990s, though in contrast to the larger county, only 10% of city households in 2000 earned $75,000 or more the previous year (up from 4% in 1990).

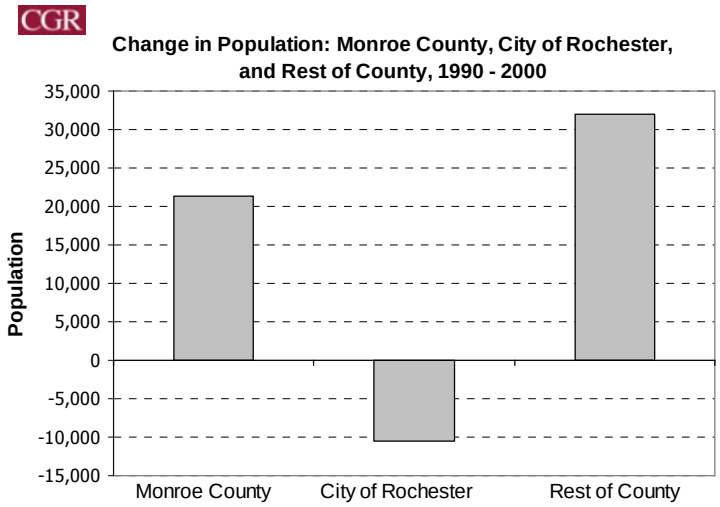
- Despite the overall increases in income levels, the numbers of county residents in poverty increased by more than 7,500 (+11%) to more than 79,000 individuals, with most of the increase in the suburbs.
- Countywide, in 2000, almost one in eight households were headed by a female. While the proportion of female-headed families living in poverty declined during the 1990s, in 2000, nearly 40% of female-headed families in the city lived in poverty.
- In 2000, about 17% of Monroe County's children under the age of 5 lived in poverty. At about 39%, the proportion of children living in the city who live in poverty is more than twice as high as the county rate.
- Adults with less than a high school education declined by almost 19,000 (-21%) between 1990 and 2000 countywide, while the number with a bachelor's degree or higher increased by more than 28,600 (+24%). Those with at least a bachelor's degree now make up 31% of the county's residents 25 and older (up from 26% ten years earlier).
- Countywide, 65% of occupied housing units countywide are owner-occupied. That proportion drops to 40% within the city. While the 1990s saw an increase in the number of owner-occupied units countywide, owner-occupied units in the city decreased by 13%. In 2000, about 53% of all renter-occupied units in the county were located in the city.

Population Data

Table 1: Total Population	1990 Census	2000 Census	% Change
Monroe County	713,968	735,343	*3.0*
Rochester	230,356	219,773	*-4.6*
Suburbs	483,612	515,570	*6.6*

Source: US Census Bureau, 1990 Summary Tape File (STF 1)-100-Percent Data and 2000 Summary File 1 (SF 1) 100-Percent Data

Total County population increased 3% from 1990 to 2000.



Source: U.S. Census Bureau

Table 2: Population by Age						
	Monroe County			City of Rochester		
	1990 Census	2000 Census	% Change	1990 Census	2000 Census	% Change
<5 years	54,587	46,977	*-13.9*	21,808	17,227	*-21.0*
5 - 9 years	50,047	54,661	*9.2*	16,722	18,733	*12.0*
10 - 14 years	44,703	55,725	*24.7*	13,847	17,233	*24.5*
15 - 19 years	48,887	52,980	*8.4*	15,377	15,699	*2.1*
20 - 24 years	58,553	47,587	*-18.7*	22,613	18,432	*-18.5*
25 - 34 years	125,988	97,480	*-22.6*	49,753	37,652	*-24.3*
35 - 44 years	110,109	118,293	*7.4*	31,036	33,057	*6.5*
45 - 54 years	73,428	102,728	*39.9*	17,852	25,014	*40.1*
55 - 59 years	29,093	36,258	*24.6*	7,092	8,395	*18.4*
60 - 64 years	29,341	26,875	*-8.4*	7,401	6,354	*-14.1*
65 - 74 years	50,514	46,468	*-8.0*	14,326	9,992	*-30.3*
75 - 84 years	28,494	35,676	*25.2*	9,773	8,179	*-16.3*
85 years and over	10,121	13,635	*34.7*	4,036	3,806	*-5.7*

Source: US Census Bureau, 1990 Summary Tape File (STF 1)-100-Percent Data and 2000 Summary File 1 (SF 1) 100-Percent Data

Table 3: Population by Race	Monroe County			City of Rochester		
	1990 Census	2000 Census	% Change	1990 Census	2000 Census	% Change
White	600,328	581,961	*-3.1*	141,503	106,161	*-25.0*
Black	85,041	101,078	*18.9*	73,024	84,717	*16.0*
American Indian/Alaskan Native	2,020	1,950	*-3.5*	1,103	1,003	*-9.1*
Asian/Pacific Islander	12,667	NA	*NA*	4,081	NA	*NA*
Other Race	13,912	NA	*NA*	11,925	NA	*NA*
Asian	NA	17,922	*NA*	NA	4,943	*NA*
Native Hawaiian, Other Pacific Islander	NA	220	*NA*	NA	104	*NA*
Other	NA	17,925	*NA*	NA	14,452	*NA*
Two+ races*	NA	14,287	*NA*	NA	8,363	*NA*

*In 2000, Census respondents were able for the first time to select more than one race. This renders 1990 and 2000 data not directly comparable.
Source: US Census Bureau, 1990 Summary Tape File (STF 1)-100-Percent Data and 2000 Summary File 1 (SF 1) 100-Percent Data

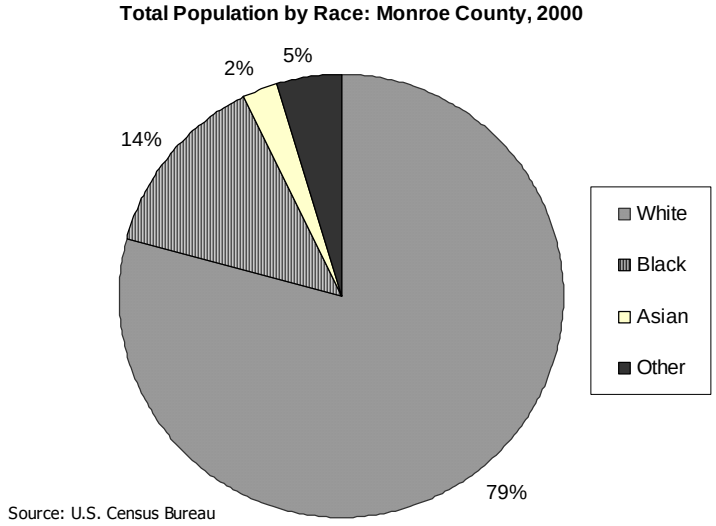


Table 4: Persons of Hispanic* Origin:	Monroe County			City of Rochester		
	1990 Census	2000 Census	% Change	1990 Census	2000 Census	% Change
Mexican	1,367	2,285	*67.2*	574	851	*48.3*
Puerto Rican	19,229	27,501	*43.0*	16,383	21,897	*33.7*
Cuban	1,051	1,893	*80.1*	519	1,177	*126.8*
Other Hispanic	4,803	7,386	*53.8*	2,579	4,107	*59.2*
Total	26,450	39,065	*47.7*	20,055	28,032	*39.8*

* People who identify their origin as Spanish, Hispanic, or Latino may be of any race.
Source: US Census Bureau, 1990 Summary Tape File (STF 1)-100-Percent Data and 2000 Summary File 1 (SF 1) 100-Percent Data

Table 5: Households and Families*	Monroe County			City of Rochester		
	1990	2000	% Change	1990	2000	% Change
Total Households	271,944	286,512	5.4	93,607	88,999	-4.9
Family Households	182,746	184,514	1.0	51,952	47,169	-9.2
With Own Children Under 18	NA	91,111	NA	NA	26,700	NA
Married-Couple Family	140,595	135,807	-3.4	29,018	22,339	-23.0
Female-Headed Family	33,993	38,393	12.9	19,283	20,737	7.5
Non-Family Households	89,198	101,998	14.4	41,655	41,830	0.4
Householder Living Alone (All Ages)	71,249	81,942	15.0	33,043	33,019	-0.1
Householder Living Alone (Age 65+)	NA	28,365	NA	NA	8,188	NA

* A household includes all the people who occupy a housing unit as their usual place of residence. A family includes a householder and one or more people living in the same household who are related to the householder by birth, marriage, or adoption. Not all households contain families ("non-family households") since a household may comprise a group of unrelated people or one person living alone.
Source: US Census Bureau, 1990 Summary Tape File (STF 1)-100-Percent Data and 2000 Summary File 1 (SF 1) 100-Percent Data

Income and Poverty Data

Table 6: Median Income*	Monroe County			City of Rochester		
	1990	2000	*% Change*	1990	2000	*% Change*
Median Household Income	$35,337	$44,891	*27.0*	$22,785	$27,123	*19.0*
Median Family Income	$42,625	$55,900	*31.1*	$27,675	$31,257	*12.9*

* The median income divides the income distribution into two equal groups, one having incomes above the median, the other having incomes below the median.
Source: US Census Bureau, 2000 Summary File 3 (SF3)-Sample data and 1990 Summary Tape File 3 (STF 3)-Sample data

Table 7: Median and Mean Family Income (1999)*	Monroe County		City of Rochester	
	Median Income	Mean Income	Median Income	Mean Income
All Families	$55,900	$68,250	$31,257	$42,213
All Families with Children under 18	$54,445	$64,320	$24,555	$33,960
Married-Couple Families	$66,405	$79,829	$48,400	$59,469
Married-Couple Families with Children under 18	$70,156	$81,413	$48,924	$55,344
Female-Headed Families	$25,265	$32,087	$17,953	$24,926
Female-Headed Families with Children under 18	$19,541	$24,690	$14,824	$18,751

* The median income divides the income distribution into two equal groups, one having incomes above the median, and other having incomes below the median. Mean household income is obtained by dividing total household income by the total number of households.
Source: US Census Bureau, 2000 Summary File 3 (SF3)-Sample data

Table 8A: Household Income	Monroe County				
	1990		2000		% Change 1990– 2000
	# of Households	% of Households	# of Households	% of Households	
Total Households:	272,193	100	286,820	100	5.4
Less than $10,000	34,364	12.6	26,223	9.1	-23.7
$10,000 to $14,999	19,520	7.2	16,528	5.8	-15.3
$15,000 to $19,999	20,574	7.6	17,651	6.2	-14.2
$20,000 to $24,999	19,693	7.2	17,549	6.1	-10.9
$25,000 to $29,999	20,091	7.4	16,744	5.8	-16.7
$30,000 to $34,999	20,404	7.5	17,569	6.1	-13.9
$35,000 to $39,999	19,648	7.2	15,932	5.6	-18.9
$40,000 to $44,999	17,792	6.5	15,497	5.4	-12.9
$45,000 to $49,999	15,630	5.7	14,084	4.9	-9.9
$50,000 to $59,999	26,058	9.6	25,909	9.0	-0.6
$60,000 to $74,999	26,525	9.7	31,571	11.0	19.0
$75,000 to $99,999	18,779	6.9	34,109	11.9	81.6
$100,000 to $124,999	7,083	2.6	17,418	6.1	145.9
$125,000 to $149,999	2,345	0.9	7,933	2.8	238.3
$150,000 or more	3,687	1.4	12,103	4.2	228.3

Source: US Census Bureau, 2000 Summary File 3 (SF3)-Sample data and 1990 Summary Tape File 3 (STF 3)-Sample data

Table 8B: Household Income	City of Rochester				
	1990		2000		% Change 1990– 2000
	# of Households	% of Households	# of Households	% of Households	
Total Households:	93,521	100	89,093	100	-4.7
Less than $10,000	22,850	24.4	17,228	19.3	-24.6
$10,000 to $14,999	9,847	10.5	8,611	9.7	-12.6
$15,000 to $19,999	9,148	9.8	8,483	9.5	-7.3
$20,000 to $24,999	7,899	8.4	7,234	8.1	-8.4
$25,000 to $29,999	7,665	8.2	6,337	7.1	-17.3
$30,000 to $34,999	7,200	7.7	6,313	7.1	-12.3
$35,000 to $39,999	6,197	6.6	4,962	5.6	-19.9
$40,000 to $44,999	4,768	5.1	4,594	5.2	-3.6
$45,000 to $49,999	4,031	4.3	3,816	4.3	-5.3
$50,000 to $59,999	5,609	6.0	6,164	6.9	9.9
$60,000 to $74,999	4,529	4.8	6,006	6.7	32.6
$75,000 to $99,999	2,505	2.7	5,202	5.8	107.7
$100,000 to $124,999	700	0.7	2,030	2.3	190.0
$125,000 to $149,999	189	0.2	809	0.9	328.0
$150,000 or more	384	0.4	1,304	1.5	239.6

Source: US Census Bureau, 2000 Summary File 3 (SF3)-Sample data and 1990 Summary Tape File 3 (STF 3)-Sample data

Table 9A: Persons Living in Poverty: Monroe County	1990 Census		2000 Census		%
	#	%	#	%	*Change*
Total Persons Living in Poverty*	71,734	10.4	79,311	11.2	*10.6*
Under 5 Years	10,319	18.9	8,096	17.2	*-21.5*
Under 18 Years	27,961	15.9	29,377	15.6	*5.1*
18 Years and Over	43,773	8.4	49,934	9.5	*14.1*
65 Years and Older	5,942	7.2	6,681	7.4	*12.4*
Family Households (Total Number)	184,572	-	185,818	-	*.7*
Families Living in Poverty**	14,303	7.7	15,236	8.2	*6.5*
Families with Children <5	7,384	17.5	6,211	17.1	*-15.9*
Female-Headed Families in Poverty***	10,586	31.8	10,228	27.3	*-3.4*
Female-Headed Families with Children <5	6,015	62.0	4,585	49.1	*-23.8*

** Percent of all persons in the specified age group*

***Percent of all families*

**** Percentage of all female-headed families*

Source: US Census Bureau, 2000 Summary File 3 (SF3)-Sample data and 1990 Summary Tape File 3 (STF 3)-Sample data

Table 9B: Persons Living in Poverty: City of Rochester	1990 Census		2000 Census		% Change
	#	%	#	%	
Total Persons Living in Poverty*	52,237	23.5	54,713	25.9	*4.7*
Under 5 Years	8,850	40.6	6,630	38.5	*-25.1*
Under 18 Years	22,752	37.8	22,927	37.1	*0.8*
18 Years and Over	29,485	18.1	31,786	21.1	*7.8*
65 Years and Older	3,349	13.3	2,983	15.4	*-10.9*
Family Households (Total Number)	52,681	-	47,713	-	-
Families Living in Poverty**	11,115	21.1	11,148	23.4	*0.3*
Families with Children <5	6,260	37.8	4,969	37.5	*-20.6*
Female-Headed Families in Poverty***	8,900	45.9	8,191	39.8	*-8.0*
Female-Headed Families with Children <5	5,381	70.8	3,930	56.6	*-27.0*

** Percent of all persons in the specified age group*

***Percent of all families*

**** Percentage of all female-headed families*

Source: US Census Bureau, 2000 Summary File 3 (SF3)-Sample data and 1990 Summary Tape File 3 (STF 3)-Sample data

- The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is poor. If a family's total income is less than that family's threshold, then that family, and every individual in it, is considered poor. The poverty thresholds do not vary geographically, but they are updated annually for inflation using the Consumer Price Index (CPI-U). In 1999, the poverty threshold for a family of four (2 children) was $16,895.

  The official poverty definition counts money income before taxes and does not include capital gains and noncash benefits (such as public housing, Medicaid, and food stamps). Poverty is not defined for people in military barracks, institutional group quarters, or for unrelated individuals under age 15 (such as foster children). They are excluded from the poverty universe—that is, they are considered neither as "poor" nor as "nonpoor."

Table 10: Households with Public Assistance Income					
	1990 Census		2000 Census		*% Change*
	#	%	#	%	
Monroe County	20,681	7.6	15,427	5.4	*-25.4*
Rochester	15,451	16.5	12,127	13.6	*-21.5*

Source: US Census Bureau, 2000 Summary File 3 (SF3)-Sample data and 1990 Summary Tape File 3 (STF 3)-Sample data

Educational Attainment Data

Table 11A: Educational Attainment	Monroe County				
	1990 Census		2000 Census		*%*
Persons 25 and older:	#	%	#	%	*Change*
Less than 9th grade	30,487	6.7	20,336	4.3	*-33.3*
9th to 12th grade, no diploma	60,797	13.3	52,074	10.9	*-14.3*
High school graduate, including equivalency	128,252	28	124,927	26.1	*-2.6*
Some college, no degree	75,934	16.6	85,255	17.8	*12.3*
Associate's degree	42,146	9.2	46,412	9.7	*10.1*
Bachelor's degree	74,493	16.3	88,191	18.5	*18.4*
Graduate or professional degree	45,810	10	60,762	12.7	*32.6*
Percent High School Graduate of Higher:	80.1		84.9		*10.6*
Percent Bachelor's Degree or Higher:	26.3		31.2		*23.8*

Table 11B: Educational Attainment	City of Rochester				
	1990 Census		2000 Census		*%*
Persons 25 and older:	#	%	#	%	*Change*
Less than 9th grade	15,581	11.0	10,048	7.6	*-35.5*
9th to 12th grade, no diploma	28,501	20.2	25,748	19.4	*-9.7*
High school graduate, including equivalency	39,124	27.7	38,008	28.6	*-2.9*
Some college, no degree	21,026	14.9	21,946	16.5	*4.4*
Associate's degree	10,209	7.2	10,234	7.7	*0.2*
Bachelor's degree	16,716	11.8	16,104	12.1	*-3.7*
Graduate or professional degree	10,107	7.2	10,619	8	*5.1*
Percent High School Graduate of Higher:	68.8		73.0		*-.3*
Percent Bachelor's Degree or Higher:	19.0		20.1		*-.4*

Source: US Census Bureau, 2000 Summary File 3 (SF3)-Sample data and 1990 Summary Tape File 3 (STF 3)-Sample data

Language Data

Table 12: Language Spoken at Home	1990 Census		2000 Census		% Change
	#	%	#	%	
Persons 5 Years and Over	659,505	-	688,804	-	*4.4*
Speak language other than English	67,419	10.2	83,632	12.1	*24.0*
Do not speak English "very well"	24,542	3.7	32,063	4.7	*30.6*
Speak Spanish	21,193	3.2	31,950	4.6	*50.8*
Do not speak English "very well"	8,557	1.3	11,936	1.7	*39.5*

Source: US Census Bureau, 1990 Summary Tape File (STF 1)-100-Percent Data and 2000 Summary File 1 (SF 1) 100-Percent Data

Housing Data

Table 13: Housing Occupancy	Monroe County			City of Rochester		
	1990	2000	% Change	1990	2000	% Change
Total Housing Units	285,524	304,388	6.6	101,154	99,789	*-1.3*
Occupied	271,944	286,512	5.4	93,607	88,999	*-4.9*
Owner Occupied	176,927	186,426	5.4	41,188	35,747	*-13.2*
Renter Occupied	95,017	100,086	5.3	52,419	53,252	*1.6*
Vacant	13,580	17,876	31.6	7,547	10,790	*43.0*

Source: US Census Bureau, 1990 Summary Tape File (STF 1)-100-Percent Data and 2000 Summary File 1 (SF 1) 100-Percent Data

III. Overview Economic Profile of Monroe County

In tracking the well-being of county residents on various measures, it is important to understand the economic context in which those residents exist, and how the economic environment is changing over time. This chapter provides an economic perspective against which to assess the changes in well-being documented in the remaining chapters of this community profile.

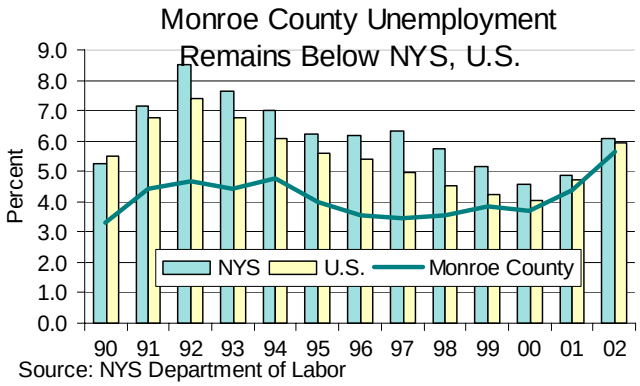
The dominant feature of Monroe County's economy during the previous 20 years has been the reduction of traditional sources of income and the birth of new firms and industries. Until the last decade, the local economy was dominated by major manufacturers employing highly skilled production workers, key scientists and technicians in research and development positions, and many headquarters staff. As companies restructured, workers who left these major employers have fueled the growth of numerous small and medium sized firms in a range of industries. In 1980, only 57% of local employment was in firms of 1,000 employees or less—and most of these firms had direct or indirect linkages to major Monroe County firms such as Kodak, Xerox or General Motors. By 1999, the share of employment in small and medium-sized firms had risen to 87%.

The regional economy's future lies with fast-growing small and medium-sized firms, such as high technology manufacturers and telecommunications and business service firms. Monroe County's higher education sector also holds significant promise for the future. The county's higher education sector is responsible for a payroll of $800 million annually and attracts a steady stream of young talent to the community.

Steady Growth in Monroe County Through 1990s

Despite the loss in the past 20 years of about $2 billion in payroll (in 2001 dollars) and more than 37,000 jobs from Kodak, the resilient Monroe County economy continued to grow through the 1990s. Annual average non-agricultural employment increased steadily from 1980 through the nationwide recession that began in 2001.

From 1980 through the first half of 2002, the Rochester metropolitan area added 107,200 net new jobs. Business service employment soared in comparison with New York State. While the transition from a manufacturing-based economy to a more service-based economy has reduced average income in many communities, **payroll per job** has remained at Rochester's historically-high level (in constant dollar terms) as wages and salaries per job have been rising both in manufacturing *and* in the service sector.



Source: NYS Department of Labor

The underlying strength of the Rochester economy is reflected in its unemployment rate. Monroe County's unemployment rate averaged 4.0% during the 1990s while NYS and the nation experienced unemployment of 6.5% and 5.7%, respectively. Since 1980 (Kodak's contraction began in 1982), county unemployment averaged 70% that of NYS, though it has increased substantially in the past two years.

High Technology and the Local Economy

While dominated by manufacturing, the Monroe County occupational mix has been weighted toward professional and managerial occupations. Educational attainment has historically led competitive Upstate economies.

Monroe County firms employ an unusual number of workers in high technology industries. In 2000, about 15% of the Rochester area workforce—earning 26% of total payroll—was employed in industries classified as "high technology" by the U.S. Bureau of Labor Statistics. Twenty-seven percent of employed county residents are in professional occupations. Monroe ranks highest among NYS urban counties in the share of workers in computer, math, architectural and engineering occupations.

The most tangible evidence of Rochester's "output" of scientific innovation is the number of patents issued to inventors living in the Rochester area. In the late 1990s, among the largest 100 metropolitan areas of the country, local patents issued per capita were second only to Silicon Valley's San Jose. The total number of patents issued per capita was more than four times the national

average. In addition, a study by the US Conference of Mayors found that Rochester ranked 20th in high-tech output among the 319 metro areas as defined by the U.S. Office of Management and Budget.

Degrees Conferred (Bachelor's and Higher) 1996-97 Field of Study & Rank (of 60 largest metros)	
All Fields	7
Biological & Life Sciences	3
Physical Sciences	3
Mathematics	3
Engineering & Related Degrees	5
Computer & Info Sciences	12
Visual & Performing Arts	1

Source: Atlanta Regional Consortium for Higher Education

The community also has a large and vital higher education sector, with 17 colleges and universities in the region granting some 10,000 degrees per year—many in key areas of technology such as mathematics, engineering, the physical sciences, the biological sciences and computer and information systems. On a *per capita* basis, Rochester ranks near the top of the 60 largest metro areas in granting degrees in many critical fields.

Monroe County's Future Economic Outlook

With Rochester emerging as the region's economic leader, Western New York offers established firms and entrepreneurs unique value as a corporate location. A strong industrial history and an emphasis on high quality public services—particularly public education—plus an unusually large higher education sector ensures a technically-sophisticated and reliable workforce. Shrinkage of the region's numerous old economy employers has dampened wage and salary inflation and depressed asset values. New firms can take advantage of the region's workforce while enjoying low labor, land, and building costs, including low housing costs for key personnel.

Monroe County is particularly well positioned to lead Western New York's resurgence. This area's emphasis on technology and the strong showing of its academic institutions in key areas such as mathematics, engineering, physical sciences and biological sciences make it the natural economic leader of the region.

However, despite a strong showing during the 1990s, recent economic performance has been disappointing. Total non-farm employment peaked in August 2000 at 558,600 but finished July 2002 at about 541,000. In the year ending July 2002, Rochester manufacturing lost 7,000 jobs. Sectors particularly targeted by the national downturn have been conspicuous sources of strength for the local regional economy, lowering near-term expectations for growth in Monroe County, although long-term vitality is likely.

- The local business services sector is closely tied into the region's small and medium-sized manufacturing firms. As manufacturing orders declined, business service employment also fell. After years of steady growth, business services employment declined for the first time in 2001, but bounced back in 2002, adding 7% more jobs between January and July.
- The bursting of the telecom "bubble" took away a significant source of employment growth in Monroe County. While communications employment is still above the average for 2000, more than 1,000 jobs added in 2001 were lost. Growth prospects for this industry are likely to be limited for the next few years, though the area's deep investment in both telecom services and equipment is likely to bear fruit when growth resumes in this quintessential 21st century sector.
- Following the Y2K buildup and the decline of the dotcoms, information technology professionals suddenly found the seller's market had become a buyer's market. Rochester's prodigious IT growth has slowed as a consequence. As with telecom, the skills so abundant among Monroe County's IT sector are likely to be in demand again as the economy recovers and investment in new IT infrastructure resumes.
- Although the 1990s brought substantial increases in the numbers of individuals and families with high-income levels, many have not kept pace. Moreover, the emphasis in the local economy on high technology, education and related high-skills sectors, while offering high promise for the future, also threatens to leave behind many with low skills. Recent economic downturns and related losses of jobs, fears of future job loss, and stock market declines have contributed to a climate of uncertainty among many.

  Overall, the local economy is likely to continue to languish during the next couple of years. Yet having made a successful transition from excessive dependence on Kodak and established a robust presence in key 21st century industries—e.g., biotechnology, telecommunications, higher education, photonics and information technology—the medium and long-term growth potential for the Rochester area economy remains very strong.

  (Throughout this profile document, additional measures of local economic performance are presented and discussed.)

IV. Success by 6 Impact Area

Context

The first Impact Area is designed to track how well the Monroe County community is doing in creating an environment in which young children can be born healthy, live in stable family settings, thrive and develop at levels appropriate to their age, and be ready for and able to succeed in school. Four specific Outcomes have been identified to track progress in these areas: Healthy Births, Children Ready for School, Children Succeeding in School, and Family Stability.

Although called Success by 6, this Impact Area might more accurately be described as Success by 9, as those who monitor progress in this area have included early school years within the scope of their area of responsibility.

For a few of the measures in this chapter, reference is made to national Year 2010 Healthy People targets or goals. Healthy People 2010 refers to a set of objectives, or measurable targets, designed as part of a national strategy to improve the health of all Americans. Although they have not necessarily been formally adopted as community-wide goals for Monroe County, these targets provide useful health-related benchmarks for the community to strive to meet.

Relevant Demographic Trends

Based on U.S. Census data:

- Monroe County's population of children under the age of 5 *declined* by 14% between 1990 and 2000, to a total of 46,977 in 2000.
- The number of city children under 5 declined at a more rapid rate, 21%, to a 2000 total of 17,227. In 1990, city children accounted for 40% of all the county's children under 5; by 2000, that proportion had dropped to 36.7% of all preschool-aged children.
- Between 1990 and 2000, the number of 5-9 year olds in the county *increased* by 9%, to a 2000 total of 54,661.
- The number of 5-9 year olds in the city increased by 12% during those years, to a total of 18,733 in 2000. About one-third of the county's children between the ages of 5 and 9 have continued to live in the city.
- The entire total of children 9 and under in the county declined by 3% between 1990 and 2000, to a total of 101,638. Of those, 35% lived in the city (35,960 in 2000, a reduction of 7% since 1990).
- The number of families with children under the age of 5 living in poverty declined countywide by 16%, a reduction of about 1,175 to a 2000 total of 6,211 families.
- The total number of children under 5 in those poverty families declined by about 2,200, a 21.5% reduction to 8,096 children countywide. This represents about 17% of all children under 5 in the county.
- About 82% of the county's children under 5 in poverty lived in the city in 2000, down from 86% in 1990. The number of city children under 5 living in poverty declined by 25% between 1990 and 2000 (to 6,630 city children). Nonetheless, 38.5% of all under-5 children in the city in 2000 were living in poverty.

Summary of Trends

In reviewing the 17 measures which are presented in this chapter, some trends and themes emerge from the data. At the end of each summary statement below, arrows indicate whether the *overall county trend* for a particular measure (irrespective of trends within city and suburbs) reflects *improvement in recent years toward meeting the desired outcome* (⬆), *movement away from the desired outcome* (⬇), or *no significant change* (⬅➡). We urge caution though, as there are many indicators where Monroe County's rates are moving in the right direction but are still not as good as the NYS-excluding-NYC comparison or the national Healthy People 2010 goals. Therefore, the reader is encouraged not to make judgments on any measure before carefully reviewing the detailed profiles that appear under each Outcome area.

Healthy Births

In this Outcome area, except in teen birth rates, relatively little statistical progress has been evidenced in recent years, and considerable improvement is still needed:

- The proportion of low birth weight births has changed very little since 1995, and remains about twice as high in the city as in the suburbs. Countywide rates are comparable to rates in NYS-excluding-NYC. Rates in both the city and suburbs remain higher than the Healthy People 2010 target. (*County progress:* ⬅➡)
- The proportion of births in which early prenatal care was provided has remained fairly constant countywide, and has declined somewhat in the city. The overall county rate is comparable to the NYS-excluding-NYC rate, but even the higher suburban proportions continue to fall below the Healthy People 2010 goal. (*County progress:* ⬅➡)
- Since 1995 there has been an encouraging reduction in the teen birth rate countywide, driven by a reduction in the city rate. However, the county rate remains higher than the NYS-excluding-NYC rate, and the city rate, although declining, remains three to four times higher than that Upstate rate. (*County progress:* ⬆)

Children Ready for School

Consistent improvements have been evidenced since 1995 in preparing children for school:

- Between 1993 and 1999, the most recent year for which data are available, significant increases occurred in the proportion of children who were fully immunized by their second birthday, and those increases were especially prominent in the city. By 1999, both city and suburbs were still short, but within reach of, the Healthy People 2010 target. (*County progress:* ⬆)
- The number of children 0-4 in the county who are hospitalized annually for asthma declined by almost 60% between 1995 and 2000. (*County progress:* ⬆)
- The proportion of children under 6 with high blood lead levels has declined steadily over the past several years, countywide and in the city, though proportions remain high in some areas of the city. (*County progress:* ⬆)
- Countywide, and particularly in the city, the number of preschool-age children with disabilities receiving special education services has declined since 1996, raising the question of whether there are fewer such children with special needs, or changes in resources to address their needs. (*County progress:* ?)
- The proportion of children in Rochester who enter kindergarten with problems in language, motor skills, cognition, vision and hearing has continued to decline slowly but surely. (*County progress:* ⬆)

Children Succeeding in School

There have been some signs of encouragement in this Outcome area, but there remains a long way to go, especially in the city:

- The proportion of 4th-grade students in the county who meet or exceed statewide standards on the English Language Arts test has increased steadily since the test was first administered in 1999. Gains have been especially pronounced in the city, although more than half of the city's students still do not meet the standards. (*County progress:* ⬆)
- There have been few changes since 1999 in the proportions of county 4th-graders meeting or exceeding the statewide Math standards. The countywide rate has been about 70%, though the city proportions have fluctuated primarily in the 40s. (*County progress:* ⬅➡)

Family Stability

Although the focus of this Impact Area is children under 9, data for some of the measures of Family Stability were only available

for children and youth of all ages. For additional measures of Family Stability, see also the Strengthening Families chapter later in this document.

There are some signs of encouragement in this Outcome area, but mostly reminders of work still needing to be done:

- Significant reductions have occurred since 1995 in the numbers of public assistance recipients, though in an average month in 2001, almost 32,000 people remained on open temporary assistance cases, including almost 20,000 children. (*County progress:* ⬆) Non-temporary assistance food stamps cases increased in 2001 (*County progress:* ⬇), and increasing proportions (over 40%) of all elementary school children in the county (and more than 80% in the city) remain eligible for free or reduced price lunches. (*County progress:* ⬇)
- On the other hand, the number of children under the age of 5 living in poverty declined by 21.5% between 1990 and 2000 countywide, with virtually the entire decline reflected in a 25% reduction among city preschool-aged children in poverty. These reductions are in part a reflection of the overall population decline among children under 5, but the percentage reductions in poverty exceeded the proportionate reductions in population both countywide and within the city. (*County progress:* ⬆)
- The number and rate of children for whom preventive service cases are opened has declined in the county since 1995, though the county rate remains consistently higher than the rate for NYS-excluding-NYC. It is unclear whether these declines reflect a reduction in needs, or changes in resources to address those needs. (*County progress:* ?)
- There has been little change in the overall number of county children placed in foster care since 1995, and the numbers of new admissions each year have actually increased, suggesting that more children are being admitted each year for shorter periods of time. Both new admission and total placement county rates consistently exceed NYS-excluding-NYC rates. (*County progress:* ⬇)
- The numbers of indicated child abuse and neglect cases have increased countywide since 1995, although the rates remain consistently below Upstate rates. (*County progress:* ⬇)

Conclusions

Monroe County has experienced consistent, steady and in some cases even dramatic improvements in various measures indicating readiness for school. However, in the following areas, there has been little indication of improvement, and increased attention may need to be given to these areas if future improvements are to be realized:

- Although there have been some encouraging reductions in births to teenagers, especially in the city, both city and county rates remain higher than in the rest of the state outside NYC. Other indicators of healthy births appear to be stagnant in the county, are no better than NYS-excluding-NYC rates, and fall short of meeting Healthy People 2010 targets. Expanded efforts are likely to be needed to significantly improve community healthy birth outcomes.
- Although school-readiness measures have shown consistent encouraging improvements, student performance on standard test measures once in elementary school has not shown as much improvement, especially within the city. Continued attention is needed to address the myriad of issues that affect academic performance, especially within high poverty areas within the city.
- Although proportions of children with high blood lead levels have declined substantially in recent years, significant concentrations remain within several city neighborhoods which need to be addressed.
- High numbers of children remain at or near the poverty levels in Monroe County, and increasing numbers of children are involved in indicated child abuse and neglect cases each year. Foster care admissions within the county remain consistently higher than comparable rates for the rest of the state outside NYC. New efforts are needed to break down the concentrations and effects of poverty, and to stabilize and strengthen families if these rates are to improve in the future.

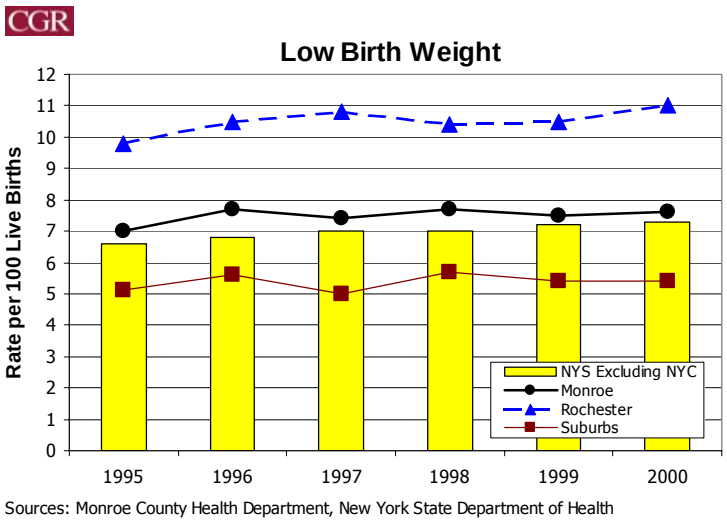
Outcome I: Healthy Births

- Low Birth Weight
- Early Entry into Prenatal Care
- Live Births to Teens, Ages 15-17

Since the mid-1990s, overall county progress in this outcome area has been mixed, with progress only in the live teen births measure.

Measure: Low Birth Weight

Definition: Percent (rate/100) of live births with birth weight less than 2,500 grams (about 5.5 pounds). The Healthy People 2010 target is a reduction in the proportion of low birth weight infants to no more than 5%.



Sources: Monroe County Health Department, New York State Department of Health

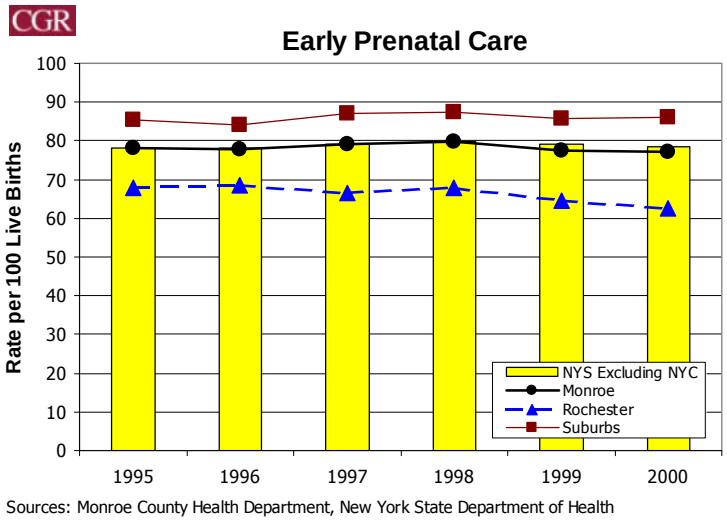
Findings: Low birth weight rates in Monroe County remained fairly constant during the latter half of the 1990s, with annual rates ranging from 7.0 to 7.7 per 100 live births (representing between 688 and 747 infants annually) between 1995 and 2000. Rates in the City of Rochester have consistently been substantially higher (worse) than the countywide rate, and about twice the suburban rate (in 2000, the city's rate was 11.0 vs. 5.4 per 100 live births in the suburbs, or 415 low birth weight infants in the city, compared to 303 in the suburbs). In recent years, the overall county rate and the larger NYS-excluding-NYC region rate have been roughly comparable. While the suburban area has historically had the lowest proportion of low birth weight births compared to the county as a whole, Rochester, and NYS excluding NYC, all of the rates presented here fail to meet the Healthy People 2010 target of 5 low birth weight births per 100 live births. Data for this measure are presented in Appendix Table 1.

Caveats: None.

Measure: Early Entry Into Prenatal Care

Definition: The number of births occurring to women who initiated prenatal care during the first trimester of pregnancy (before 13 weeks gestation), expressed as a rate per 100 live births.

The Healthy People 2010 target is to have 90% of women entering prenatal care during the first trimester.



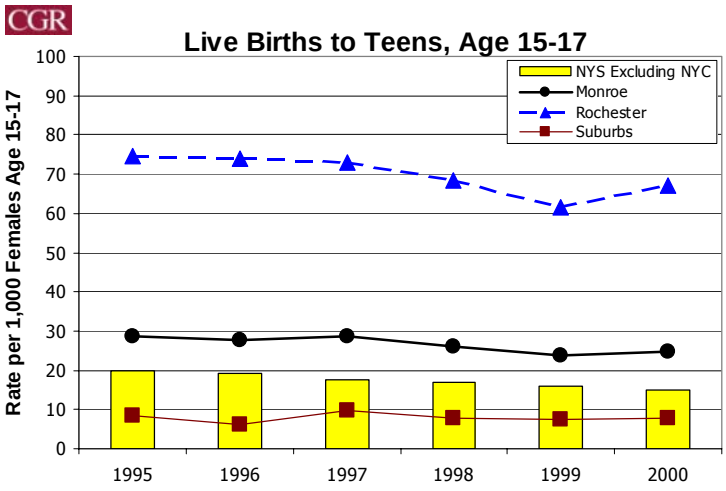
Sources: Monroe County Health Department, New York State Department of Health

Findings: From 1995 to 2000 in Monroe County, the proportion of women receiving early prenatal care fluctuated from 79.7 to 77.2/ 100 live births. However, the data reveal a geographic disparity showing that women who live in the city are less likely to initiate first trimester care compared to their suburban counterparts. In 2000, the rate of early entry into prenatal care was only 62.6 per 100 (representing 2,021 live births) in Rochester compared to 86.1 per 100 (representing 4,526 live births) in the suburbs. County and the NYS-excluding-NYC region rates have been comparable throughout the study period. It is important to note that each of the four geographic regions presented here have thus far failed to meet the Healthy People 2010 goal of increasing the proportion of women entering care during the first trimester to 90%. Data for this measure are presented in Appendix Table 2.

Caveats: The rate excludes the number of live births for which the date of entry into prenatal care is unknown.

Measure: Live Births to Teens, Ages 15-17

Definition: The number of live births to females ages 15-17, expressed as a rate per 1,000 females ages 15-17.



Sources: Monroe County Health Department, New York State Department of Health

Babies born to adolescents, particularly younger adolescents, are at higher risk of low birth weight and infant mortality compared to babies born to older mothers. Children of adolescent mothers are at increased risk of lower cognitive development and educational outcomes, and they are more likely to live in poverty and to have children during adolescence themselves. Adolescent mothers may be less likely to complete high school or obtain post secondary education than their peers, which may reduce their employment opportunities and earnings potential.

Findings: In Monroe County, from 1995 to 2000, the number of live births to teens ages 15-17 decreased by about seven percent (from 397 in 1995 to 369 in 2000). In each of the years graphed here, at least three-quarters of the total number of teen births occurring in the county were to teens who resided in the city. While the city's teen birth rate among 15 – 17 year olds has shown a decline from 74.5 in 1995 to 67.2 in 2000 (a 9% decline), throughout the period Rochester's teen birth rate remained more than eight times the suburban rate. When compared to the larger Upstate region, both the overall County rate, as well as the Rochester rate, are higher (worse), with the Rochester rate consistently about four times the NYS-excluding-NYC rate. Data for this measure, as well as for the larger 10-19 age range, are presented in Appendix Table 3.

Caveats: None.

Outcome II: Children Ready for School

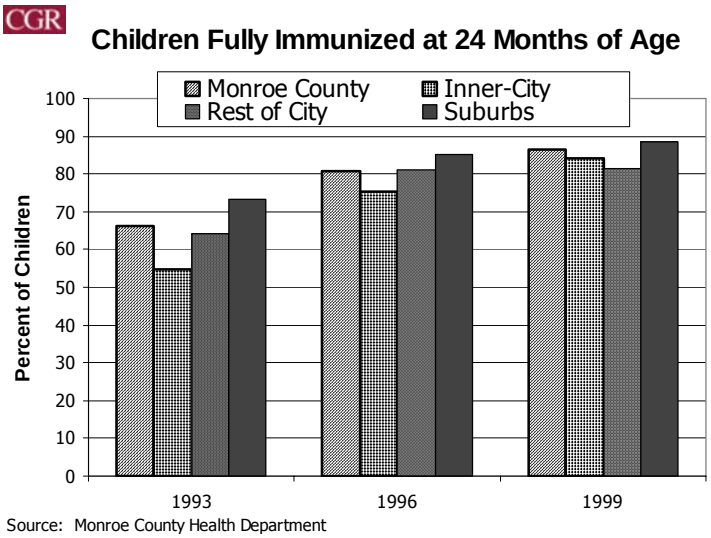
- Children Fully Immunized at 24 Months of Age
- Asthma Hospitalizations
- Children with High Blood Lead Levels
- Pre-Kindergarten Special Education Referrals and Placements
- Quality of Pre-Kindergarten Classrooms
- Children Entering Kindergarten with Problems

Since the mid-1990s, the county overall has made progress in each of the measures included in this outcome area.

Measure: Children Fully Immunized at 24 Months of Age

Definition: The number of children who have received all age-appropriate immunizations by their second birthday, expressed as a percent.

"Inner-City" is defined by those census tracts in which more than 50% of the births are covered by Medicaid. "Rest of City" is defined as the remainder of the City's census tracts. The Healthy People 2010 target is to have 90% of all children current on their immunizations by the age of 2.



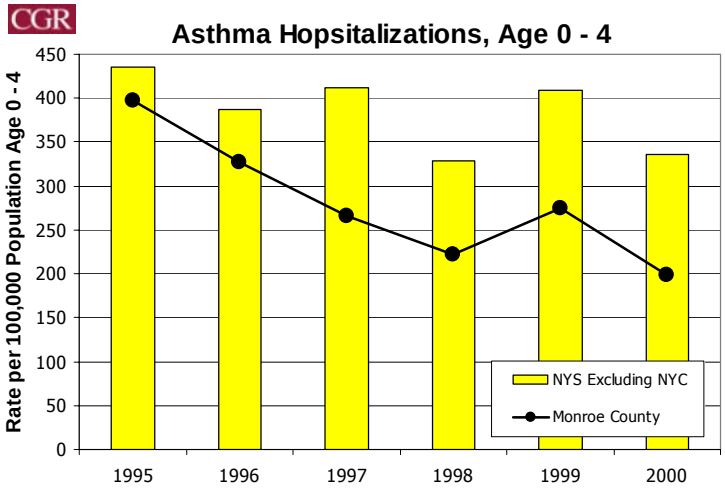
Source: Monroe County Health Department

Findings: Between 1993 and 1999, immunization rates improved in all four geographic areas graphed here, though the greatest gains occurred in the inner-city, where the proportion of children fully immunized increased from about 55% in 1993 to almost 85% in 1999. By 1999, all these primary areas of the county were approaching, but still falling slightly short of, the 90% Healthy People 2010 target. Data are presented in Appendix Table 4.

Caveats: Data for this measure are collected every three years, through a local survey of pediatricians and family practitioners. 1999 data are the most recent data available.

Measure: Asthma Hospitalizations

Definition: The number of children, age 0-4, who experience an asthma-related hospitalization, expressed as a rate per 100,000.



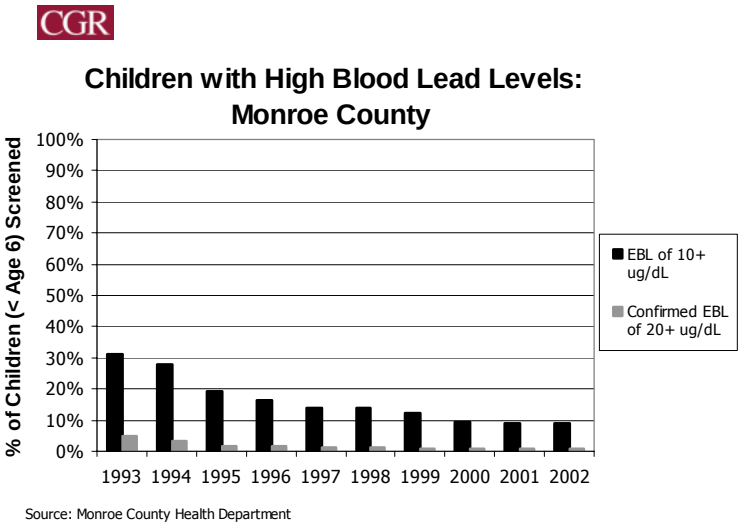
Sources: Monroe County Health Department, New York State Department of Health

Findings: Monroe County's asthma hospitalization rates decreased by 50% between 1995 and 2000. The actual number of 0-4 year olds hospitalized during this period fell from 226 to 93 (a 59% reduction). While the rates for the NYS-excluding-NYC region fluctuated during the same period, the larger region's rates were consistently above the County rates. Data for this measure are presented in Appendix Table 5.

Caveats: None

Measure: Children with High Blood Lead Levels

Definition: Of all children (counted distinctly) under age six who had a finger stick or venous blood screening lead test within the calendar year, the proportion who had elevated blood lead levels (EBL) greater than or equal to 10 micrograms per deciliter.



If a child has never been tested or is being tested after the child has been under management (active) and then was discharged, the test would be considered an initial screen (I). If the child has been tested routinely, the test is called a repeat screen or re-screen(R). The number screened reflects both the (I) and (R), or new cases of EBL as well as children who had prior EBL and continue to be tested annually. Children who are under case management are not counted in these numbers. Case management is provided for all children with a confirmed blood test greater than or equal to 20 µg/dL. These children are in case management until they have several tests below 15 or 10 µg/dL, or by age.

Findings: Between 1993 and 2002, both the number and proportion of children screened in Monroe County and determined to be lead poisoned (confirmed EBL of 20+ µg/dL) declined. In 1993, 553, or 4.8% of the children screened had blood lead levels at or above 20µg/dL. In 2002, 112, or .8% of those screened were lead poisoned, an 80% reduction from 1993. However, in 2002, 1,234 children (9.1% of those screened) had blood lead levels greater than or equal to 10µg/dL.

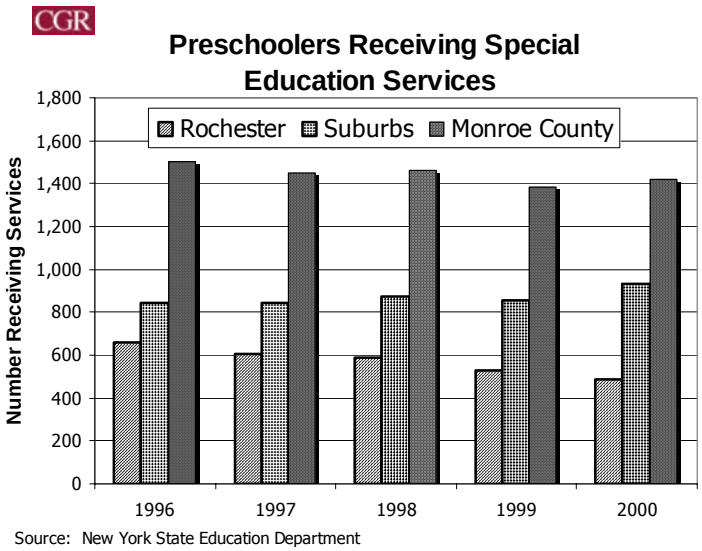
Typically, over 95% of children whose blood lead levels are confirmed at greater than 20µg/dL live in the following high-risk zip codes: 14604, 14605, 14606, 14607, 14608, 14609, 14610, 14611, 14612, 14613, 14614, 14615, 14619, 14620, 14621. Data at the county level as well as a breakout by the high-risk area are presented in Appendix Table 6.

Caveats: None

Measure: Pre-Kindergarten Special Education Referrals and Placements

Definition: The number of preschool age children ages 3-5 with disabilities receiving special education services on December 1 of the given year, as authorized by a school district's Committee on Preschool Special Education.

Preschool special education services can improve children's cognitive performance, reduce the need for special education services in grades K-12, and improve their likely success in school.



Source: New York State Education Department

Findings: The total number of children in Monroe County receiving special education services has declined between 1996 and 2000, due to the significant 27% reduction in the numbers of Rochester children receiving such services. During that time, suburban students receiving services remained stable, until a substantial increase to 934 children in 2000. Additional data will be needed to determine if that increase was the beginning of a trend. Data for this measure are presented in Appendix Table 7.

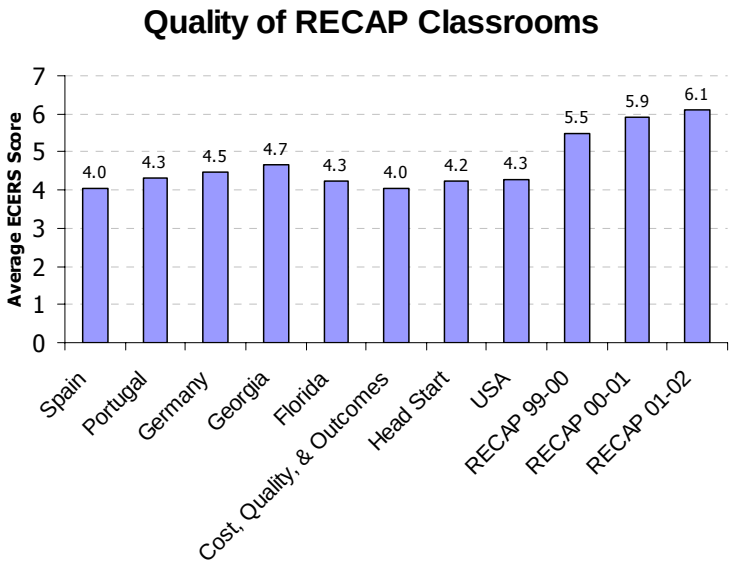
Caveats: Classification rates may vary between schools due to differing standards being applied by the various Committees on Preschool Special Education. Parents' roles, and in particular the extent to which a parent may push for his or her child to be classified, and the district's responsiveness to the parent may also impact rates. It is difficult from the data alone to determine if the reductions reflect fewer children with special needs, or changes in resources to address the needs.

Measure: Quality of Pre-Kindergarten Classrooms

Definition: The Early Childhood Environment Rating Scale (ECERS) is used in pre-school classroom settings to rate the quality of the classroom environment. Trained raters assess the quality and environment of the classroom setting on a 7-point scale, with 1 representing "inadequate," 3 meeting "minimal standards," 5 meeting "good quality standards," and 7 indicating "excellent quality." The National Association for the Education of Young Children (NAEYC) has designated an overall ECERS score of 5.0 as its benchmark standard for high quality programs.

Seven areas of classroom quality are measured by the scale: space and furnishings, personal care routines, language and reasoning, activities, interaction, program structure, and parents and staff. An overall ECERS rating is derived from the average of the seven scale scores.

Locally, the scale is used in ratings by the Rochester Early Childhood Assessment Partnership (RECAP) in all City School District and Catholic Diocese pre-K classrooms, and in a few private pre-K programs.

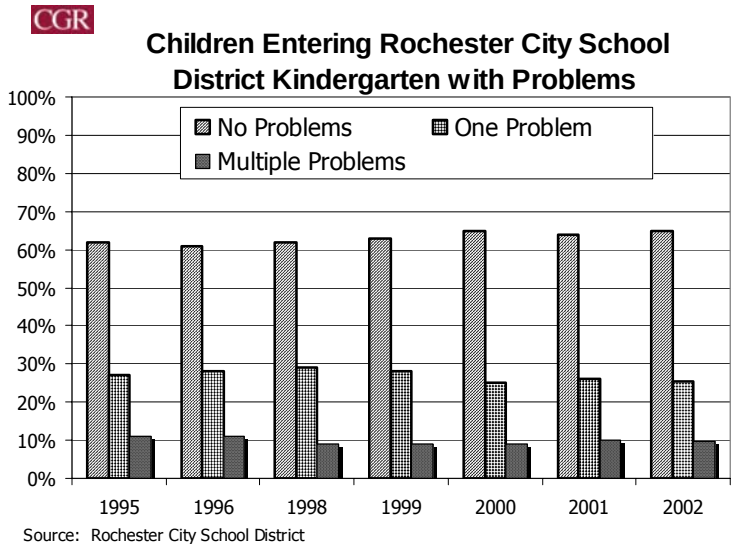


Findings: For each of the past three years, ratings across pre-K classrooms in the Rochester area have consistently substantially exceeded the NAEYC benchmark, with 83% of the classrooms meeting or exceeding that standard. Local ratings also have consistently exceeded comparable ratings in other large-scale national, international and statewide studies.

Caveats: **R**aters are carefully trained according to standard procedures, and high inter-rater reliability exists at the local level; however, there may be unknown rater biases and lower levels of reliability and consistency between raters *across* different sites. High-quality pre-K programs are thought to contribute to later success in school, but more longitudinal data are needed to show definitive correlations.

Measure: Children Entering Kindergarten with Problems

Definition: This measure reflects the proportion of children entering kindergarten in the Rochester City School District who are screened and determined to have a problem in one or more of the following areas: language, motor skills, cognition (learning), vision, and hearing.



Source: Rochester City School District

All children entering kindergarten are screened for problems within the first 90 days of the school year and the data presented here for a particular school year, e.g. 2001, reflect screening which occurred in the fall of the 2000-01 school year.

The identification of problems at entry to kindergarten has been shown to be predictive of future problems in school.

Findings: In 2002, 35% of the roughly 2,300 incoming kindergartners in the Rochester City School District were found to have one or multiple specified problem(s). In 1996, the proportion of students with one or more problems was 39%, and the proportion was 61% as recently as 1991. A reduction in the proportion of children entering Rochester City School District Kindergarten programs may be attributable to other early childhood efforts such as Early Intervention, Preschool Special Education, and quality childcare programs. Data for this measure are presented in Appendix Table 9.

Caveats: Although kindergarten screening is mandated by New York State, comparison data for this measure are not readily available as school districts are given wide latitude over the instruments they use for screening.

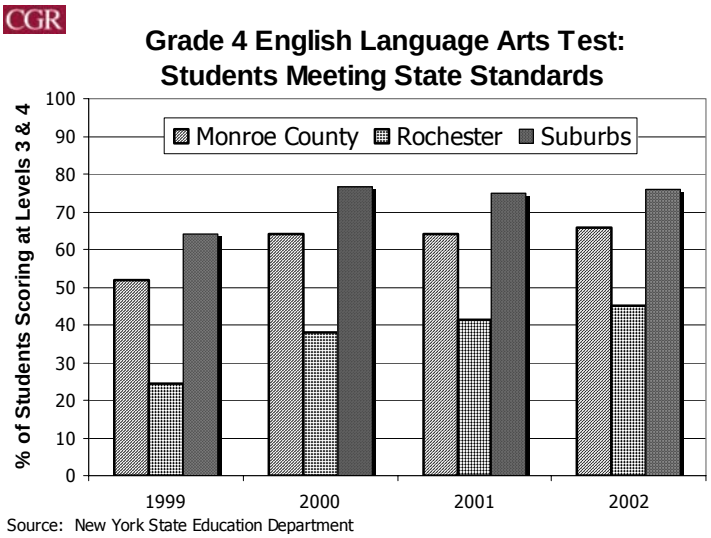
Outcome III: Children Succeeding in School

- Student Performance on Grade 4 English Language Arts Test
- Student Performance on Grade 4 Math Test

Since the initiation of these standardized state tests, progress in this outcome area has been mixed: at the county level ELA test scores have improved, while Math scores have remained comparable; in both cases, substantial disparities exist between city and suburban districts.

Measure: Student Performance on Grade 4 English Language Arts Test

Definition: Data for this measure reflect the proportion of Grade 4 students meeting state standards as measured by the English Language Arts test. Each level of scores represents a level of mastery of content and skills. At Level 4, test scores indicate student performance exceeds the standards and the student is moving toward high performance on the Regents examination. At Level 3, test scores indicate student performance at least meets the standards, and with continued steady growth, the student should pass the Regents exam. At Level 2, test scores indicate that the student will need extra help to meet the standards and pass the Regents exam. Level 1 test scores indicate serious academic deficiencies. Such students need the most help to meet the standards. The desired level of performance is level 3 or higher. The revised graduation requirements demand that all students strive to succeed at the Regents or higher levels. The Grade 4 ELA test is an early marker of students' likely success on Regents examinations.



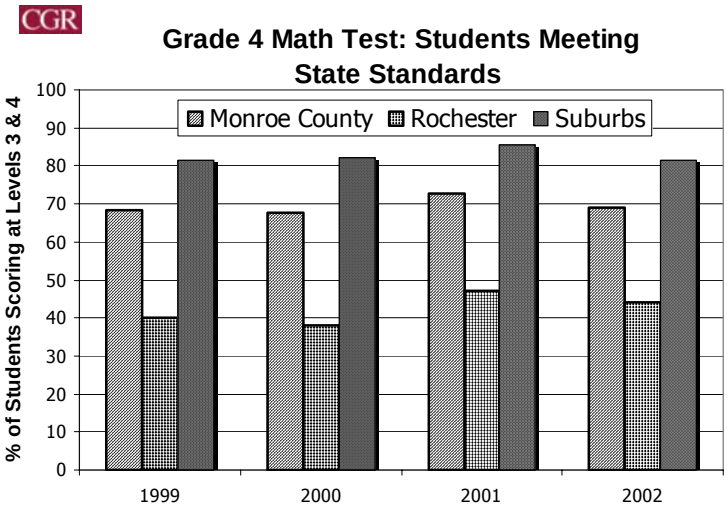
Source: New York State Education Department

Findings: The overall proportion of Monroe County students meeting state standards (scoring at levels 3 and 4) increased from 52% in 1999 to 66% in 2002. Data presented in Appendix Table 10 also show that countywide, during this same period, the proportion of students demonstrating serious academic deficiencies (those scoring at level 1) declined from 9% to 6%. When compared to the County as a whole or when compared to the suburban districts, a lower proportion of City School District youth have met state standards on the Grade 4 ELA Test. However, since the test began in 1999, the proportion of Rochester CSD students performing at levels 3 and 4 has increased from 24% in 1999 to 45% in 2002, thereby narrowing the gap between CSD and suburban district performance.

Caveats: Public schools began using this test in the 1998-1999 school year.

Measure: Student Performance on Grade 4 Math Test

Definition: Data for this measure reflect the proportion of Grade 4 students meeting state standards as measured by the Mathematics test. Each level of scores represents a level of mastery of content and skills. At Level 4, test scores indicate student performance exceeds the standards and the student is moving toward high performance on the Regents examination. At Level 3, test scores indicate student performance at least meets the standards, and with continued steady growth, the student should pass the Regents exam. At Level 2, test scores indicate that the student will need extra help to meet the standards and pass the Regents exam. At Level 1, test scores indicate that the student has serious academic deficiencies. This student needs the most help to meet the standards. The desired level of performance is level 3 or higher. The revised graduation requirements demand that all students strive to succeed at the Regents or higher levels. The Grade 4 Math test is an early marker of students' likely success on Regents examinations.



Source: New York State Education Department

Findings: Countywide, during the four years, there has been relatively little change in the profiles, as about 70% of all 4th-grade students have met or exceeded the state standards each year (scoring at levels 3 or 4), with the suburbs ranging from 82% to 85%, and the city from 38% to 47%. In 2002, 69% of 4th-grade students countywide met state standards, with 44% of City School District students scoring at levels 3 or 4, and 82% of suburban students. During the four years, city students scoring at the lowest level have declined from 19% to 14% in 2002. Data for this measure, including the proportion of students scoring at the lowest levels, levels 1 and level 2, are provided in Appendix Table 11.

Caveats: Public schools began using this test in the 1998-1999 school year.

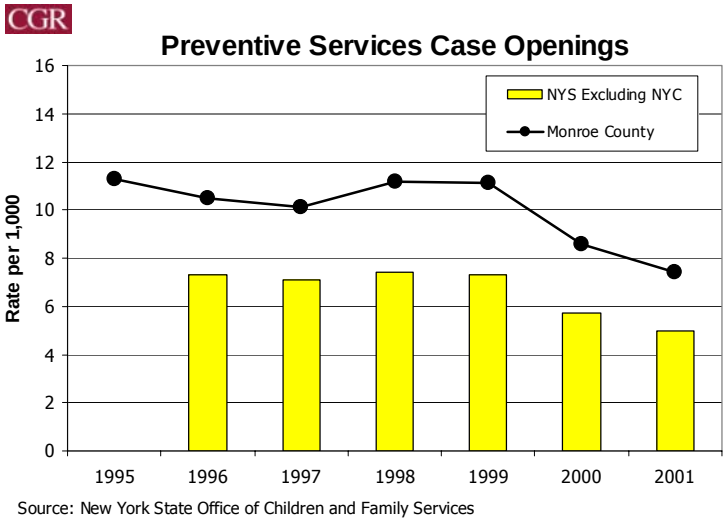
Outcome IV: Family Stability

- Children Receiving DSS Preventive Services
- Monthly Average Population on Temporary Assistance
- Monthly Average Food Stamps Caseload
- Elementary School Students Eligible for Free/Reduced Price Lunch
- Children in Foster Care
- Indicated Cases of Child Abuse and Neglect
- *Unemployment Rate (this measure appears in the Strengthening Families chapter)*

Since the mid-1990s, overall county progress in this outcome area has been mixed, with one measure improving, one showing little change, and the other measures showing movement away from the desired outcome.

Measure: Children Receiving DSS Preventive Services

Definition: The number of children under 18, expressed as a rate per 1,000, for whom a Mandated Preventive Services case was opened during the specified calendar year.



Source: New York State Office of Children and Family Services

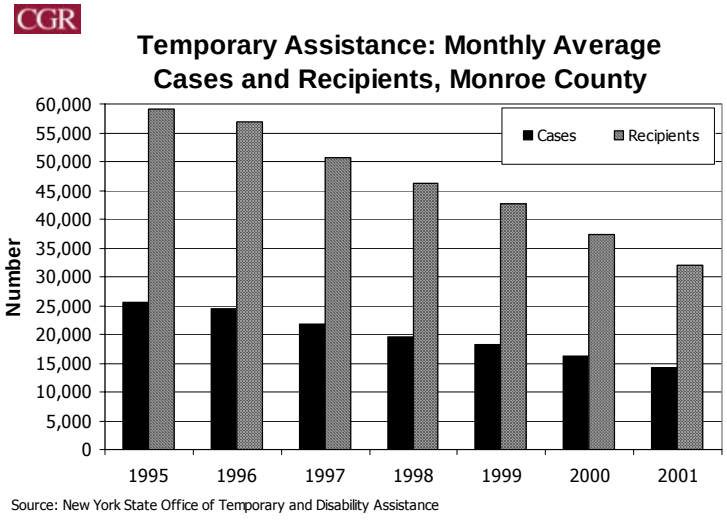
Prior to 2001, the population used to calculate rates only included children under 18 years old (all rates prior to 2001 are rates per 1,000 children under age 18). In 2001, the NYS Office of Children and Family Services (OCFS) changed its methodology, and, using 2000 Federal Census data, based its rate calculations on the population of children under age 22. Children with more than one case opened during the year are only counted once.

Findings: From 1995 to 2001, the number of Preventive Services Case Openings in Monroe County declined by 18% (2,088 in 1995 compared to 1,721 in 2001). While the County's data trend mirrored the larger NYS-excluding-NYC region's downward trend, Monroe County's rate has been consistently higher than that of the larger region. Data included in Appendix Table 12 reveal that in Monroe County, the total number of children receiving Preventive Services on December 31 of each year (active cases) remained fairly consistent during the study period, with rates consistently higher than the NYS-excluding-NYC rates.

Caveats: All data reported in OCFS' *Monitoring and Analysis Profiles* are subject to future revision by OCFS in order to account for late reporting by counties into the State database. NYS-excluding-NYC comparison data for 1995 were not readily available for this measure. It is not clear from the data alone if reductions in cases reflect a reduction in needs, or a change in resources available to address the needs.

Measure: Monthly Average Population on Temporary Assistance

Definition: Monthly average number of cases and persons receiving income maintenance assistance—Temporary Assistance to Needy Families—including Family Assistance and Safety Net.

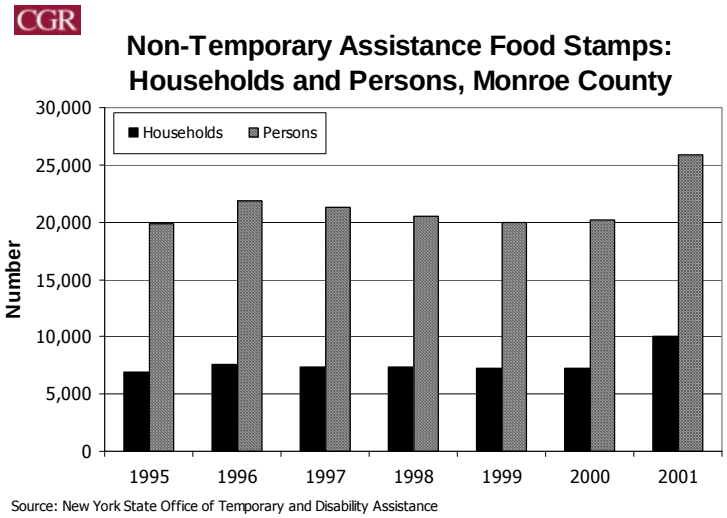


Findings: Between 1995 and 2001, the number of temporary assistance cases in Monroe County decreased by 44.5% (from 25,513 per month in 1995 to 14,170 in 2001, representing almost 32,000 individuals). During this period, the Family Assistance caseload decreased by roughly 48% and the Safety Net caseload fell by about 37%. Additional comparison data provided in Appendix Table 13 (not graphed here) reveal similar significant reductions of 55% at the larger NYS-excluding-NYC regional level. Appendix Table 13 presents caseload data by program type as well as NYS-excluding-NYC comparison data.

Caveats: December 2001 was the first month in which TANF cases in New York State began exceeding the 60-month limit on federally funded cash assistance and were transferred from federally funded assistance categories (Family Assistance) to assistance categories funded entirely by State and local dollars (Safety Net). This policy shift may affect caseloads and caseload distribution between categories of temporary assistance in the future.

Measure: Monthly Average Food Stamps Caseload

Definition: This measure reflects the monthly average numbers of households and persons who do not qualify for financial assistance/income maintenance (TANF or Safety Net) but who qualify and receive food stamp benefits.



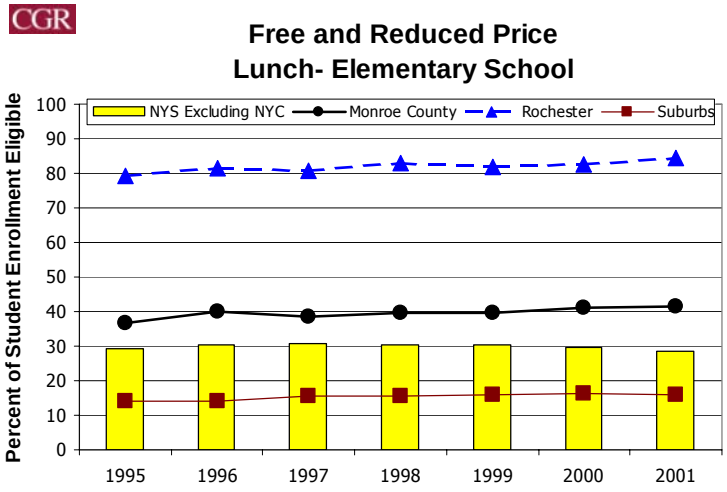
Findings: The number of Monroe County households and individuals not on temporary assistance who receive food stamps remained relatively stable between 1995 and 2000. Between 2000 and 2001, there was a 37.8% increase in the monthly average number of households receiving food stamps (7,284 households in 2000 vs. 10,034 in 2001), with a corresponding 28% increase in the number of persons receiving food stamps (to 25,826 in 2001). Additional data are needed to determine whether the increase seen in 2001 represents the beginning of an upward trend. Data for this measure are presented in Appendix Table 14.

Caveats: This indicator may not measure all of the working poor. For example, there are those who are income eligible but who do not apply for food stamps, as well as those whose incomes just exceed eligibility requirements but nevertheless are still working poor.

Measure: Elementary School Students Eligible for Free/Reduced-Price Lunch

Definition: This measure reflects the percentage of total student enrollment in both public and private elementary schools eligible (applied for and approved) for the free/reduced lunch program.

This measure is often used as a proxy for children in poverty, although it overstates the actual poverty rate since the program's income eligibility guidelines are above those used to determine poverty level. A household of four with a monthly income at or below $1,961 ($23,530 annually) is eligible for free meals, while a household of four with an income between $1,961 and $2,791 per month is eligible for reduced price meals.

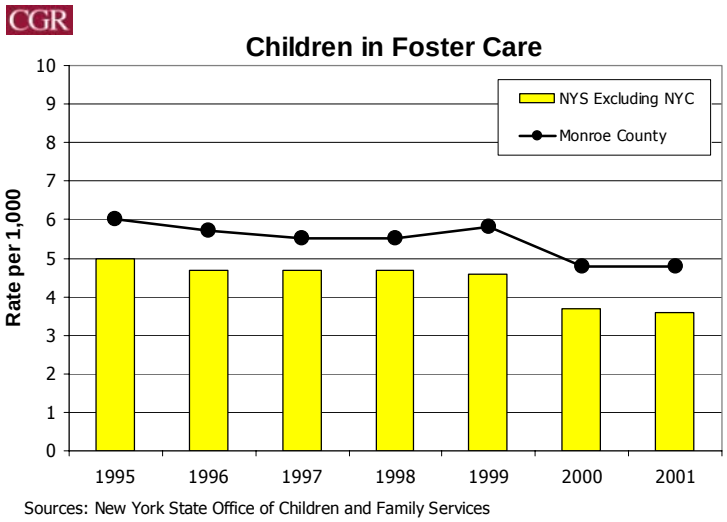


Sources: Monroe County Health Department, New York State Department of Education

Findings: The percentage of Monroe County's elementary students eligible to enroll in the free and reduced price lunch program increased somewhat from about 37% in 1995 to 41% in 2001. In the city, the proportion has slowly increased during that time from 79% to about 85% of all city elementary students, compared with about 15% of suburban students—with city rates consistently about five to six times greater than the proportion in suburban schools. Data for this measure are presented in Appendix Table 15.

Caveats: Actual program participation may be less; students enrolled in the program do not necessarily participate. School enrollment totals used to calculate the percentage of students participating include students in all school settings including BOCES, charter schools, and jail.

Measure: Children in Foster Care



Sources: New York State Office of Children and Family Services

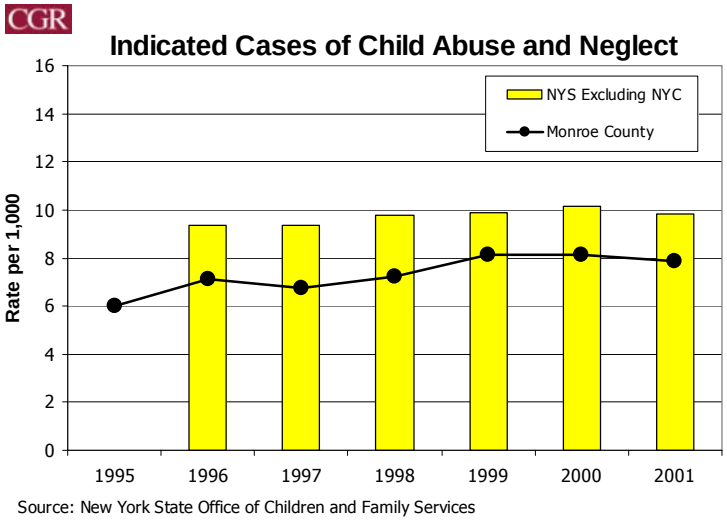
Definition: The number of children and youth under 18, expressed as a rate per 1,000, in the care and custody of the Commissioner of the local Department of Social Services. These youth may be cared for in a foster family home, group home, agency boarding home, child care institution, healthcare facility, or any combination thereof. "Children in care" is defined as the total number of children in foster care on December 31 of each year, expressed as a rate per 1,000 children under 18 (1995 –1999) or under 22 (2000 and 2001).

Findings: In 2001, the total foster care rate in Monroe County was 4.8 per 1,000 children, or 1,115 children, compared to 6.0 per 1,000 in 1995 (1,117 children). Caution is urged when comparing rates for 2000 and 2001 with earlier years. The apparent decrease in rates in those two years may be explained by a change in the way OCFS calculated the rate. Beginning in 2000, OCFS used population figures from the 2000 Federal Census that included children under age 22. Past rate calculations used a population of children under 18. Expanding the population to under 22 could make the rate appear artificially lower when comparing it to rates calculated in previous years, and not directly comparable to prior years' data. In fact, the total number of children in foster care has changed very little between 1995 and 2001, ranging from 1,079 to 1,133 during that time. However, the county rates under both approaches have remained consistently higher than the NYS-excluding-NYC rates. Also, as shown in Appendix Table 16, of the total number in foster care, the numbers of those children who were admitted during the year have gone up consistently in the county from 607 in 1995 to 756 in 2001, suggesting that more children are being admitted each year, but for shorter periods of time. New-admit county rates are also higher than comparable NYS-excluding-NYC rates.

Caveats: Capacity limitations or cost reduction policies may affect placement decisions and therefore placement rates.

Measure: Indicated Cases of Child Abuse and Neglect

Definition: The number of reports received and the number of indicated (i.e., substantiated) Child Protective Service reports expressed as a rate per 1,000 children under age 18.



Source: New York State Office of Children and Family Services

Reports are indicated as abused, neglected or maltreated when a parent or legal guardian is determined to have inflicted, created, and/or committed physical injury or a sex offense that caused or created substantial risk of death, serious or protracted disfigurement, impairment to physical or emotional health, or loss or impairment of any bodily organ. Reports of abuse and neglect are registered with the State Central Register, investigated by the county and determined to be indicated or unfounded.

Findings: Monroe County's child abuse and neglect indication rate per 1,000 children has consistently been below the NYS excluding NYC region's rate. Within Monroe County, since 1995, the indication rate increased from 6.0 (1,111 indicated cases) to 7.9 per 1,000 (1,478 indicated cases) in 2001. During this same period, the proportion of all reports received that were ultimately indicated rose from 21% to 30%. Data for this measure are presented in Appendix Table 17.

Caveats: The number of initial reports of abuse or neglect may be influenced by many factors such as outreach, education and media publicity. An indicated report or *case* may contain more than one child (e.g., siblings); therefore, the numbers and rates presented here may understate the number of *individual children* abused or neglected. Additionally, it is unknown how many cases of abuse or neglect are never reported to authorities. NYS excluding NYC comparison data for 1995 were not readily available for this measure.

Additional Resources

For additional information pertaining to the outcomes and measures included in this chapter, as well as information on related topics, see the following:

- New York State Department of Health, http://www.health.state.ny.us/
- New York State Office of Children and Family Services, http://www.ocfs.state.ny.us/
- The New York State Council on Children and Families, http://www.ccf.state.ny.us/
- The New York State Council on Children and Families *Touchstones/KIDS COUNT 2002 Data Book,* http://www.ccf.state.ny.us/Touchstones/databook02.html
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, http://www.mchb.hrsa.gov/
- U.S. Department of Health, Centers for Medicare and Medicaid Services, http://www.cms.gov
- U.S. Census Bureau, http://census.gov
- Healthy People 2010, http://www.healthypeople.gov
- Children's Defense Fund, http://www.childrensdefense.org
- America's Children: Key National Indicators of Well-Being 2002, http://www.nichd.nih.gov/publications/pubs/childstats/americas.htm

V. KIDS ON TRACK IMPACT AREA

Context

This Impact Area includes children and youth from the ages of 10 through 21, and is designed to track how well the community is doing with children in the latter years of elementary school through middle and high school, and adolescence in general. The focus is on three primary Outcomes: Children Succeeding in School, Youth Leading Healthy Lives, and Family Stability.

All of the Kids on Track measures that apply to Family Stability also appeared in the previous Success by 6 Impact Area or appear in the next chapter on Strengthening Families. To avoid repetition across Impact Areas, these Family Stability measures are only presented one time in this document. Therefore, there is no separate section of Family Stability measures presented in this chapter. However, in the summary of trends and conclusion sections which follow immediately below, a brief synopsis is provided of the Family Stability measures which are most related to the Kids on Track Impact Area, i.e., those which are most helpful in assessing the progress of the community's children and adolescents.

For a few of the measures in this chapter, reference is made to national Year 2010 Healthy People targets or goals. Healthy People 2010 refers to a set of objectives, or measurable targets, designed as part of a national strategy to improve the health of all Americans. Although they have not necessarily been formally adopted as community-wide goals for Monroe County, these targets provide useful health-related benchmarks for the community to strive to meet.

Relevant Demographic Trends

Based on U.S. Census data:

- As noted in the previous chapter, between 1990 and 2000, the number of children in Monroe County between the ages of 5 and 9 increased by 9%, to a total in 2000 of 54,661. About one-third of those lived in the city, which experienced a 12% growth in 5-9 year olds between 1990 and 2000.
- In 2000, 55,725 children between the ages of 10 and 14 lived in the county (an increase of almost 25% from 1990), and another 52,980 adolescents between the ages of 15 and 19 were county residents (up just over 8% from 1990). Both of those age groups experienced increases in numbers in the city as well as in the suburbs. In 2000, 31% of the county's 10-14 year olds, and 30% of those 15-19, lived in the city.
- In total, in 2000 there were 108,705 children and adolescents between the ages of 10 and 19 in Monroe County, an increase of 16% from 1990. Of those, 32,932 lived in the city (up 13% from 1990).
- Between 1990 and 2000, the numbers of children and adolescents under the age of 18 in poverty increased by 5% to 29,377 countywide. As noted in the previous chapter, 8,096 of those were under the age of 5, a 21.5% reduction from 1990. Thus, the remaining 21,281 were between the ages of 5 and 17, an increase of 21% in the numbers of children and adolescents in poverty between those ages.
- Of those in poverty between the ages of 5 and 17, almost 77% (16,297) lived in the city, an increase of 17% between 1990 and 2000. Suburban residents 5-17 in poverty increased at an even more rapid rate during that time, by 33%, to a total of 4,984 in 2000.

Summary of Trends

In reviewing the 20 measures which are presented in this chapter (plus additional Family Stability measures presented in other chapters), some trends and themes emerge from the data. At the end of each summary statement below, arrows indicate whether the *overall county trend* for a particular measure (irrespective of trends within city and suburbs) reflects *improvement in recent years toward meeting the desired outcome* (⬆), *movement away from the desired outcome* (⬇), or *no significant change* (⬅➡). We urge caution though, as there are many indicators where Monroe County's rates are moving in the right direction but are still not as good as the NYS-excluding-NYC comparison or the national Healthy People 2010 goals. Therefore, the reader is encouraged not to make judgments on any measure before carefully reviewing the detailed profiles that appear under each Outcome area.

Children Succeeding in School

The recent track record on children and adolescents succeeding in school is relatively discouraging, leaving considerable room for improvement within the city, but within suburban schools as well:

- Despite the steady increase from 52% to 66% from 1999 – 2002 in the proportion of the county's 4th-grade students who meet or exceed state standards in the English Language Arts test (see previous chapter), there has been a steady *decline* over the same period in the proportion of 8th-graders meeting or exceeding ELA standards (from 54% to 47%). Declines occurred in both city and suburbs. Fewer than one-fifth of city 8th-graders met the standards in 2001-02. (*County progress:* ⬇)
- Only about half the county's 8th-graders meet or exceed the state Math standards, compared with about 70% of the county's 4th-grade students. Proportions in suburban schools have increased from 58% to 65% between 1999 and 2002, while city proportions have remained between 10% and 12%. Moreover, around 55% of 8th-grade city students consistently score at the lowest of the four proficiency levels on the test. (*County progress:* slight ⬆)
- Middle school attendance has remained stable in recent years, but high school attendance has increased, especially in the city. However, city attendance rates remain substantially below suburban rates, and the overall county attendance rates have

remained consistently below comparable rates for New York State excluding New York City. (*County progress:* ⬆)

- Countywide, suburban and city dropout rates had consistently declined since the early 1990s, until a significant increase in city rates in 2000-01. It is possible that much of this apparent recent increase may be due to more accurate recent reporting by the City School District. Regardless, countywide and particularly city dropout rates are consistently higher than State-excluding-NYC rates (suburban rates are lower). (*County progress:* ⬆ until 2000-01)
- The proportion of the county's high school graduates attending post-secondary education reached a 12-year high of 85% in 2000-01. (*County progress:* ⬆)
- Middle school suspension rates, after increasing through the 1997-98 school year, have declined somewhat, but still remain higher than they were in the mid-1990s, and are consistently higher than across the Upstate region. Even after the recent declines, middle school students in city schools are suspended at a rate of more than 40 per 100 middle school students, rates that are about 10 times higher than those in the suburbs. (*County progress:* ⬇)
- More encouragingly, high school suspensions in 2000-01 were at their lowest levels in several years in both city and suburban schools. However, city rates remain three to four times higher than suburban rates. (*County progress:* ⬆)

Youth Leading Healthy Lives

Since the mid-1990s, there have been a number of encouraging signs of progress in this Outcome area, although considerable improvement is still needed:

- The number and rates of teen pregnancies have declined since 1995, for both 15-17 and especially for 10-14 year-old females in the county. The declines are even more substantial compared with 1990. As shown in the Success by 6 chapter, these reductions have been accompanied by reductions in teen births, and repeat teen births have also declined by significant amounts in both the city and suburbs. However, teen pregnancy rates still far exceed the Healthy People 2010 target. (*County progress:* ⬆)
- Among high school students throughout the county, self-reported cigarette smoking has declined since 1997, from more than 35% to

about one-quarter of all students. These rates remain well above the Healthy People 2010 target. (*County progress:* ⬆)

- Self-reported use of cocaine, marijuana and alcohol has remained fairly stable since 1997, including about one-quarter of all students consistently reporting use of marijuana and just under half of all students reporting drinking alcohol within the past 30 days. (*County progress:* ⬅➡)
- Teen suicide rates have declined countywide since 1996, and in most recent years the rate has been below (better than) the Healthy People 2010 target, in both the city and suburbs. (*County progress:* ⬆)
- Teen gonorrhea rates declined substantially from the early 1990s through 1997, especially in the city, and after a slight increase in 1998, have remained relatively stable since then. However, rates remain well above the Healthy People 2010 goal. (*County progress:* ⬆)
- Youth arrests for Part I crimes—violent and property crimes—steadily declined throughout the 1990s in both the city and suburbs. More Part I youth arrests occur in the suburbs than in the city, although youth arrest *rates* are higher in the city. Overall countywide Part I youth arrest rates are consistently lower than NYS-excluding-NYC rates. Reductions have also occurred in Part II crimes, although at a less dramatic rate, compared with the more serious Part I crimes. (*County progress:* ⬆)
- Rates of new PINS and Juvenile Delinquency case openings have generally declined in recent years. PINS rates are consistently lower than NYS-excluding-NYC rates, but JD rates have been slightly higher than those of the larger region in three of the past four reported years. (*County progress:* ⬆)
- As reported in the next chapter, the proportions of youth carrying a weapon in the past 30 days have steadily declined in recent years. (*County progress:* ⬆)
- On the other hand, relatively small but increasing proportions of youth reported feeling unsafe going to or from school. (*County progress:* ⬇)

Family Stability

As indicated in the previous Success by 6 and subsequent Strengthening Families chapters, there are some signs of

encouragement in this Outcome area, but considerable areas of need for improvement remain:

- There have been small but steady increases in the proportion of elementary school children in the county (including about 85% in the city) who remain eligible for free or reduced price lunches. Poverty rates have also increased among children under the age of 18. (*County progress:* ⬇)
- The numbers of indicated child abuse and neglect cases have increased steadily in the county since 1995, although the rates remain consistently below NYS-excluding-NYC rates. (*County progress:* ⬇)
- Numbers of new admissions to foster care have increased since 1995, and the rates of both new foster care admissions and total placements consistently exceed NYS-excluding-NYC rates. (*County progress:* ⬇)
- Reported cases of domestic violence have declined in recent years, as reflected in the next chapter. (*County progress:* ⬆)
- Many indicators of family financial stability have declined or at best held the line in recent years. (*County progress:* ⬇)

Conclusions

There have been a number of encouraging improvements in recent years in various measures tracking progress of children and adolescents throughout Monroe County. However, other measures show less encouraging trends, and considerable improvement is still needed in many areas, including even some of those where recent progress has been indicated:

- Student performance on statewide standard 8th-grade test measures has been consistently below the performance level for 4th-graders, especially among city students. Moreover, despite encouraging countywide reductions in high school suspensions and increases in attendance, middle school suspensions have increased substantially in the city. Suspension and dropout rates consistently exceed rates for the rest of the state outside NYC. Continued attention is needed to address issues affecting academic performance, especially within areas of the city with high concentrations of poverty, including issues of classroom size, reducing poverty concentrations, and assuring adequacy of resources. At the direct service-provision level, increased efforts are likely to be needed to expand tutoring, mentoring and related initiatives.
- Despite encouraging substantial reductions in self-reported smoking among the county's high school students, about one-quarter of those students report having smoked cigarettes and having used marijuana within the past 30 days, and almost half report drinking alcohol in the past 30 days. Continuing educational efforts are needed to address these issues.
- Progress has been made in reducing teen pregnancy rates, teen births, and repeat teen births. However, teen pregnancy rates continue to exceed Healthy People 2010 targets, suggesting that continuing efforts are needed to impact this measure.
- Increasing numbers of children are involved in indicated child abuse and neglect cases each year, and numbers of new admissions to foster care have increased since 1995. New efforts are needed to stabilize and strengthen children and families if these rates are to improve in the future.
- Given these trends, additional emphasis is likely to be needed on the continuing development and strengthening of assets and resources for children, youth and families throughout the county.

Such assets include expanded focus on primary prevention and early intervention services and activities designed to help youth and families make informed decisions that will positively affect the ability of young people to lead healthy, productive lives.

Outcome I: Children Succeeding in School

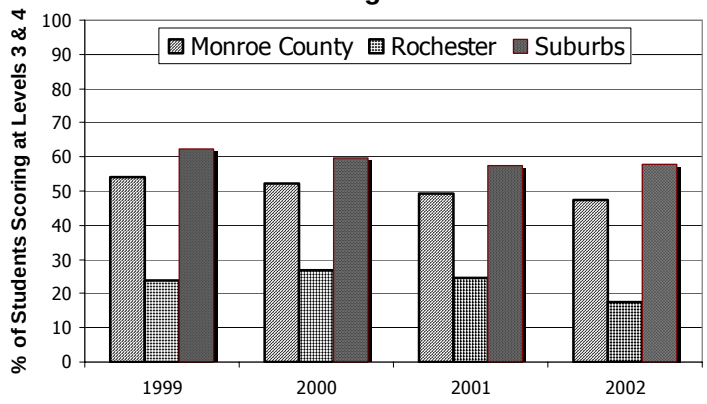
- Student Performance on Grade 8 English Language Arts Test
- Student Performance on Grade 8 Math Test
- Middle School Attendance Rates
- High School Attendance Rates
- High School Dropout Rates
- Graduation Destination
- Middle School Suspension Rates
- High School Suspension Rates

Since the mid-1990s, overall county progress in this outcome area has been mixed, with five measures showing improvement, two measures showing decline, and one showing little change.

Measure: Student Performance on Grade 8 English Language Arts Test

Definition: Data for this measure reflect the proportion of Grade 8 students meeting state standards as measured by the statewide English Language Arts test. Each level of scores represents a level of mastery of content and skills. At Level 4, test scores indicate student performance exceeds the state standards and the student is moving toward high performance on the Regents exam. At Level 3, test scores indicate student performance at least meets the standards, and with continued steady growth, the student should pass the Regents exam. At Level 2, test scores indicate that the student will need extra help to meet the standards and pass the Regents exam. At Level 1, test scores indicate that the student has serious academic deficiencies. This student needs the most help to meet the standards. The desired level of performance is level 3 or higher.

CGR



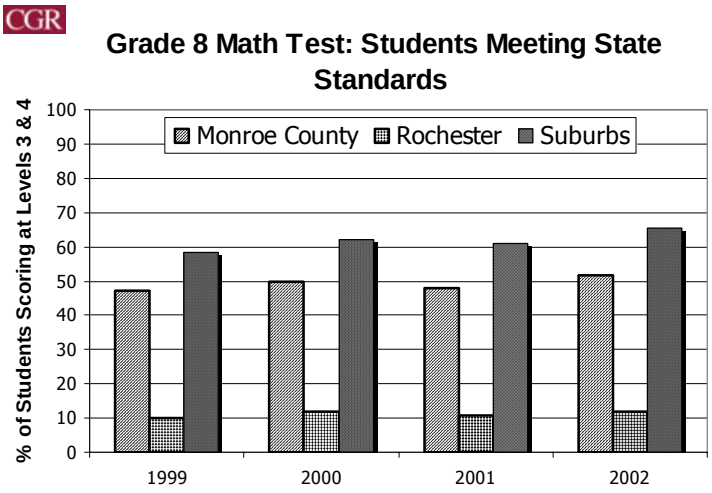
Source: New York State Education Department

Findings: Between 1999 and 2002, the overall proportion of Monroe County students meeting or exceeding state standards (scoring at levels 3 and 4) declined from 54% in 1999 to 47% in 2002. The suburban and city schools experienced similar trends, with the proportion of suburban students meeting state standards falling from 63% to 58% over the four years, and Rochester CSD students scoring at levels 3 and 4 decreasing from 24% to 18%. Data presented in Appendix Table 18 also reveal that countywide, from 1999 – 2001, the proportion of students demonstrating serious academic deficiencies (those scoring at level 1) increased from 6% to 10%, before falling to 5% in 2002.

Caveats: Public schools began using this test in the 1998-1999 school year. Concerns have been raised by many educators about the state's 8th-grade tests and their alignment with the 4th-grade tests, including issues related to some shifting of performance benchmarks from year to year.

Measure: Student Performance on Grade 8 Math Test

Definition: Data for this measure reflect the proportion of Grade 8 students meeting state standards as measured by the statewide Mathematics test. Each level of scores represents a level of mastery of content and skills. At Level 4, test scores indicate student performance exceeds the state standards and the student is moving toward high performance on the Regents exam. At Level 3, test scores indicate student performance at least meets the standards, and with continued steady growth, the student should pass the Regents exam. At Level 2, test scores indicate that the student will need extra help to meet the standards and pass the Regents exam. At Level 1, test scores indicate that the student has serious academic deficiencies. This student needs the most help to meet the standards. The desired level of performance is level 3 or 4.



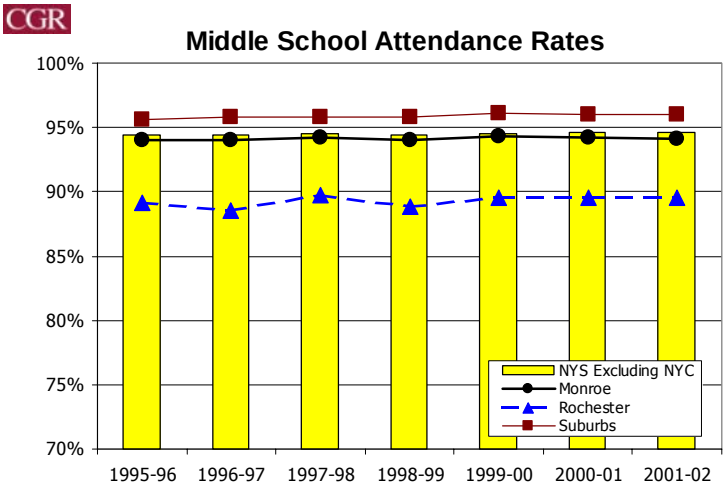
Source: New York State Education Department

Findings: In the last four years, about half of all Monroe County 8th-grade students have met or exceeded state standards for math (scoring at levels 3 and 4), ranging from 47% in 1999 to 51% in 2002. Between 10% and 12% of City School District students scored at levels 3 or 4 each of those years, while suburban proportions have increased from 58% to 65% during that time. In each year from 1999 to 2002, countywide, one in five 8th-graders has demonstrated serious academic deficiencies (level 1) in mathematical skills and knowledge expected at their grade level. In those years, between 53% and 58% of city students scored at the lowest level, with the suburbs ranging from 7% to 11% scoring at level 1. The detailed data for this measure, showing the proportion of students scoring at each of the four levels, are provided in Appendix Table 19.

Caveats: Public schools began using this test in the 1998-1999 school year. Concerns have been raised by many educators about the state's 8th-grade tests and their alignment with the 4th-grade tests, including issues related to some shifting of performance benchmarks from year to year.

Measure: Middle School Attendance Rates

Definition: Attendance rates, expressed as a percent, reflect the actual average daily attendance divided by possible average daily attendance for students in middle and junior high schools in public school districts.



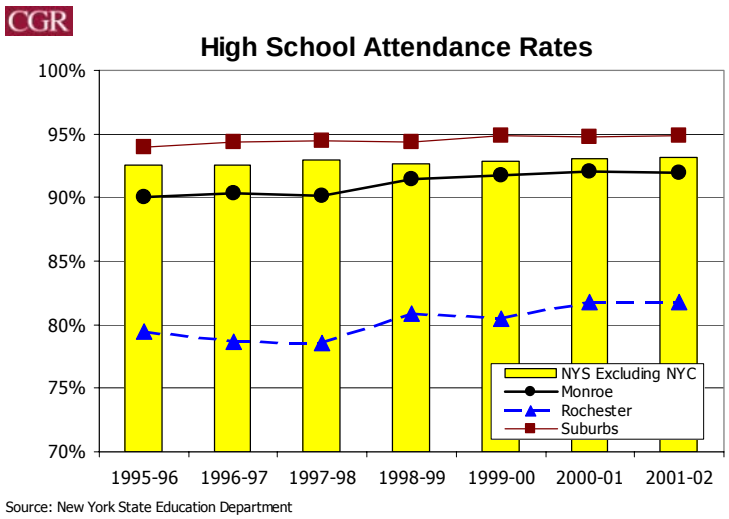
Source: New York State Education Department

Findings: Since the 1995-96 school year, middle/junior high school attendance rates have been relatively stable countywide at around 94%. Relative to the county, attendance rates in the combined suburban districts have consistently been higher by one-and-a-half to two points, and have actually increased slightly since 1996. Middle school attendance rates are consistently lower among City School District students, and while the rates have varied only slightly from year-to-year since 1995-96, the rates have consistently been just below 90%. Throughout the study period, attendance rates for the NYS-excluding-NYC region have been comparable to the countywide rate. Data for this measure are presented in Appendix Table 20.

Caveats: Data are for public school districts only. This measure shows overall attendance rates and does not measure the degree to which individual students exhibit attendance problems.

Measure: High School Attendance Rates

Definition: Attendance rates, expressed as a percent, reflect the actual average daily attendance divided by possible average daily attendance for students in public high schools.



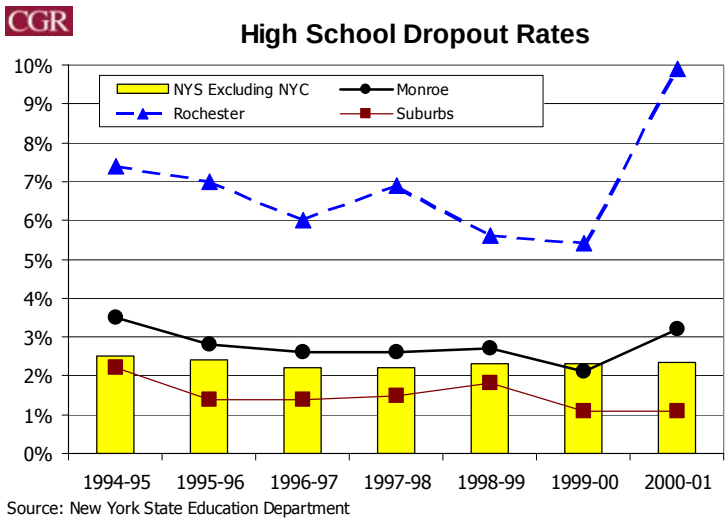
Source: New York State Education Department

Findings: From 1995-96 to 2001-02, countywide, high school attendance rates steadily increased by 1.8% from 90.1% to 91.9%, with suburban districts consistently reporting slightly higher rates, ranging from 93.9% to 94.9%. Among Rochester City School District students, attendance rates reached their highest level in 11 years during the 2000-01 and 2001-02 school years (81.8%), up from 78% in 1993-94. However, throughout the study period the substantial gap between the city and the overall county rates has been fairly constant at about ten percentage points. High schools have had the lowest attendance rates of any grade levels within Monroe County. Additionally, during the seven-year period described here, NYS-excluding-NYC rates were consistently between one and two points higher than the countywide rate. Data for this measure are presented in Appendix Table 21.

Caveats: Data are for public school districts only. This measure shows overall attendance rates and does not measure the degree to which individual students exhibit attendance problems.

Measure: High School Dropout Rates

Definition: Any pupil who leaves school prior to graduation, for any reason except death, and who does not enter another school or a program leading to a general equivalency diploma (GED). The rate, measured as a percent, is derived from the number of public school dropouts during the school year, divided by grade 9 – 12 enrollment plus a portion of ungraded secondary enrollment.



Source: New York State Education Department

Findings: Between the 1994-95 and 1999-00 school years, the number of high school dropouts in Monroe County declined by 35% (1,090, or 3.5% of enrollment in 1994-95 compared to 707, or 2.1% in 1999-00). Between 1999-00 and 2000-01 this downward trend reversed itself, and by 2000-01, the number of dropouts reached the highest level in the seven-year study period (1,093 students, a 3.2% dropout rate). Nearly all of the countywide increase in 2000-01 is attributable to the significant increase in dropouts within the City School District. From 1994 –95 to 1999-00, the number of reported dropouts in city schools fell from 586 to 432 (a 26% reduction). In 2000-01, 813, or 9.9% of CSD 9th – 12th graders dropped out. During the same period, the dropout rate in the combined suburban districts declined from 2.2% in 1994-95 to 1.1% in 2000-01. Additional data are needed to determine whether the sharp reversal in 2000-01 at the county and city levels will be sustained. The State Education Department cautioned that a substantial portion of the 2000-01 apparent increase may be due to better reporting by RCSD. Monroe County's overall rate is typically a percentage point or less above the NYS-excluding-NYC rate. Data for this measure are presented in Appendix Table 22.

Caveats: A more effective measure would be to follow a cohort of students, and determine the percentage of entering 9th-grade students who graduate. This information cannot now be consistently obtained from all school districts, but NYS Department of Education appears to be moving toward this revised approach in future years.

Measure: Graduation Destination

Definition: This measure represents the self-reported plans of public school graduates at the time of graduation, as reported by school principals in the fall following graduation.

Post-secondary education includes in-state and out-of-state 2-year and 4-year colleges or other educational institutions. Employment includes military service. Data are reported here at the countywide level.

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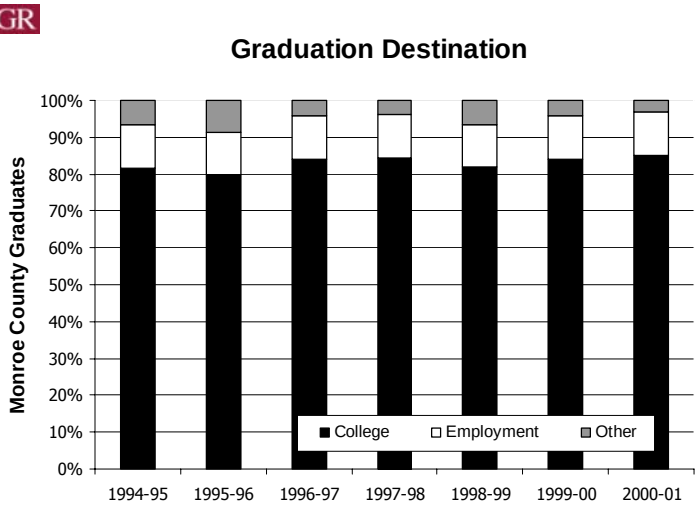


Source: New York State Education Department

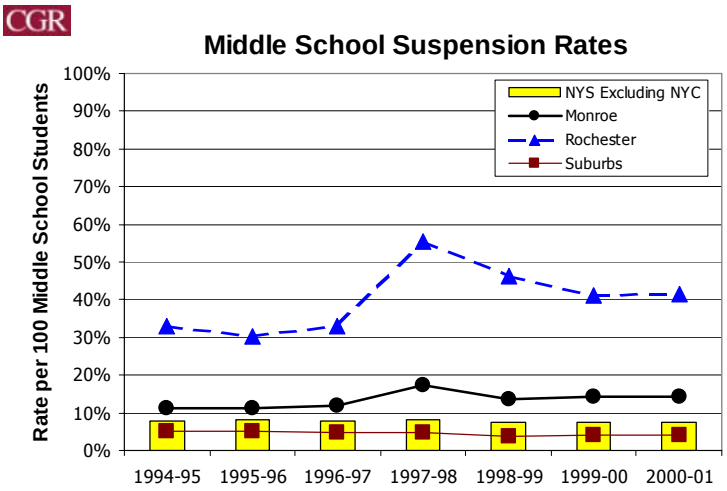
Findings: The proportion of high school graduates in Monroe County moving on to post-secondary education reached a 12-year high of 85% in 2000-01. Comparable data for the NYS-excluding-NYC region are presented in Appendix Table 23, and during the seven-year study period graphed here, the larger region had similar proportions of students pursuing post-secondary education.

Caveats: Verification of the extent to which reported plans are actualized is not conducted by school districts.

Measure: Middle School Suspension Rates

Definition: Suspension from school is a form of discipline imposed for serious or repeated infractions of school rules. This indicator is expressed as a rate per 100 students, and is obtained by dividing the number of middle/junior high school students who were suspended from school for at least one full day by the total middle/junior high school enrollment.

Per the New York State Education Department, schools are instructed to "Count each student once regardless of the number of times he or she was suspended. Do not include in-school suspensions." Data are for public schools only.



Sources: New York State Education Department

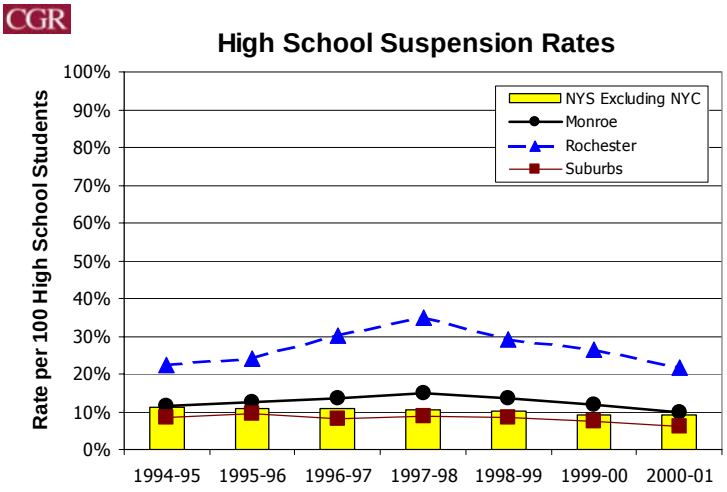
Findings: Between the 1994-95 and 2000-01 school years, middle school suspensions in Monroe County increased by 44% (to 3,644 suspensions, or 14.3% of all middle school students). Countywide, the suspension rate peaked in 1997-98 (17.3%), declined in 1998-99, and has since been relatively stable. Suspension rates in the Rochester City School District have consistently far exceeded the suburban rates, and in 2000-01, city rates were about ten times higher than suburban rates. While this difference is substantial, the gap between the city and suburban rates has narrowed in recent years. RCSD suspension rates reached a seven-year high of 55% in 1997-98 before steadily decreasing to 41.7% in 2000-01. Throughout the study period Monroe County has consistently suspended a significantly higher proportion of middle school students than the comparison NYS-excluding-NYC region. Data for this measure are presented in Appendix Table 24.

Caveats: Suspension rates may vary between schools due to differing disciplinary policies and enforcement of those policies. Breakdowns of the number of short- and long-term suspensions are not available from the State Education Department.

Measure: High School Suspension Rates

Definition: Suspension from school is a form of discipline imposed for serious or repeated infractions of school rules. This indicator is expressed as a rate per 100 students, and is obtained by dividing the number of high school students who were suspended from school for at least one full day by the total high school enrollment.

Per the New York State Education Department, schools are instructed to "Count each student once regardless of the number of times he or she was suspended. Do not include in-school suspensions." Data are for public schools only.



Sources: New York State Education Department

Findings: Following a steady increase from 1994-95 to 1997-98 (to 4,581, or 15% of all high school students), high school suspension rates in Monroe County slowly declined in the second half of the study period. By the 2000-01 school year, the proportion of students suspended (9.9%, or 3,519 students) was slightly lower than the proportion had been seven years earlier. High school suspension rates in the Rochester City School District have typically been at least twice as high as the overall county rate, though the RCSD and County trend lines have tended to follow the same increase and decline patterns. Suburban suspension rates have consistently been below both the countywide and NYS-excluding-NYC rates. Data for this measure are presented in Appendix Table 25.

Caveats: Suspension rates may vary between schools due to differing disciplinary policies and enforcement of those policies. Breakdowns of the number of short- and long-term suspensions are not available from the State Education Department.

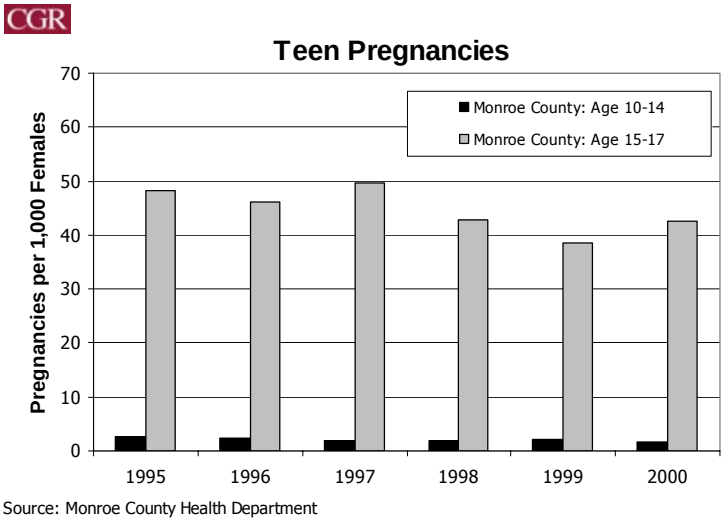
Outcome II: Youth Leading Healthy Lives

- Teen Pregnancy Rates
- Repeat Births to Teens
- Self-Reported Teen Cigarette Smoking
- Self-Reported Teen Marijuana Use
- Self-Reported Teen Cocaine Use
- Self-Reported Teen Alcohol Use
- Youth Arrests for Part I Crimes
- Youth Arrests for Part II Crimes
- PINS Cases Opened at Probation Intake
- Juvenile Delinquency Cases Opened at Probation Intake
- Teen Suicide Rates
- Teen Gonorrhea Rates

Since the mid-1990s, overall county progress in this outcome area has been mostly positive, with, one measure showing little change, one showing a slight worsening. and the rest showing improvement.

Measure: Teen Pregnancy Rates

Definition: Number of pregnancies per thousand females ages 10 – 14 and 15 - 17. Healthy People 2010 has set a target of zero pregnancies among females under the age of 15. Data are presented at the countywide level.



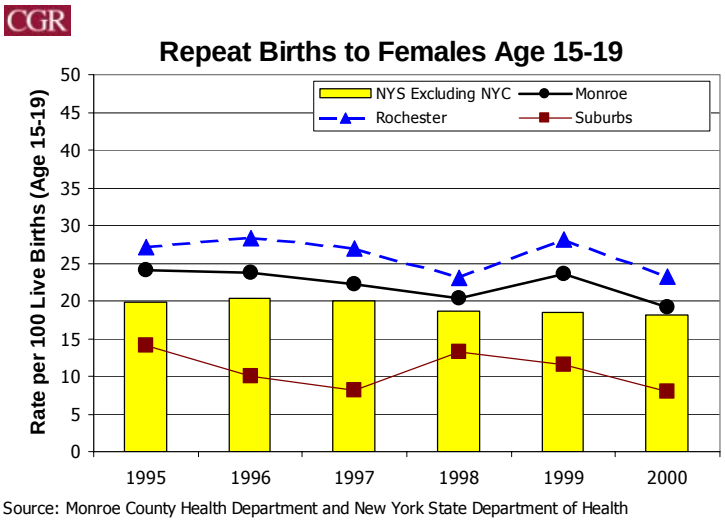
Source: Monroe County Health Department

Findings: In 2000, the most recent year for which data are available, there were 44 pregnancies among 10 - 14 year olds in Monroe County, or 28% fewer than in 1995, and 47% fewer than in 1990. While pregnancy rates also declined among 15 – 17 year olds, the extent of the decrease was not as great. In 2000, there were 638 pregnancies among 15 – 17 year olds, or 5% fewer than the 670 in 1995, and 11% fewer than the 714 pregnancies in 1997. Throughout the study period, Monroe County's teen pregnancy rates greatly exceeded the Healthy People 2010 goal. Data for this measure, including comparable NYS-Excluding-NYC data, are presented in Appendix Tables 26A and 26B.

Caveats: These data reflect teen pregnancy rates. Actual birth rates among this population are lower. Since 1992, teen pregnancy data have not been available at the sub-county level.

Measure: Repeat Births to Teens

Definition: Among adolescents age 15 – 19 giving birth during a year, the percentage that had previously given birth.



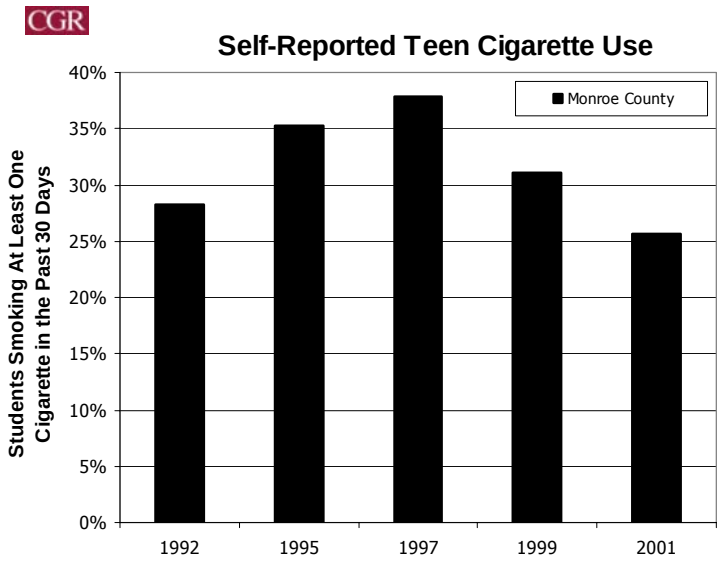
Source: Monroe County Health Department and New York State Department of Health

Findings: Repeat births to teens decreased between 1995 and 2000 in each of the geographic areas presented here. Countywide, 25% fewer repeat births occurred in 2000 compared to 1995 (238 vs. 178). Repeat births to city teens declined 20% between 1995 and 2000 while the number of suburban teens experiencing a repeat birth decreased by 41%. Repeat birth rates in the NYS-excluding-NYC comparison area have experienced a slow but steady decline since 1996, and have typically been one to five percentage points below (better than) Monroe County. Data for this measure are presented in Appendix Table 27.

Caveats: Repeat birth data do not include teens who experienced a prior pregnancy that did not result in a live birth.

Measure: Self-Reported Teen Cigarette Smoking

Definition: The proportion of Monroe County public high school students (grades 9-12) who reported having smoked at least one cigarette in the past 30 days.[3]



Source: Monroe County Health Department, Youth Risk Behavior Survey

Data are taken from the Monroe County Youth Risk Behavior Survey, conducted in 1992, 1995, 1997, 1999, and 2001. The survey is administered in all public high schools within Monroe County, and only the aggregate (countywide) findings are published. The survey will be administered again in 2003. The Healthy People 2010 target is a reduction of cigarette use (past month) among students in grades 9 through 12 to no more than 16%.

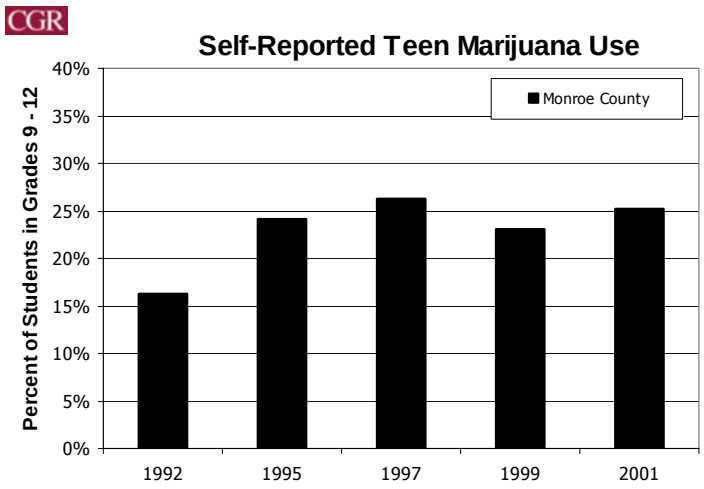
Findings: In each of the survey years between 1992 and 1997 the proportion of Monroe County students who reported smoking one or more cigarettes in the past 30 days increased. In 1995 and 1997, more than one-third of high school students reported smoking at least one cigarette in the past 30 days. Since 1997 self-reported teen cigarette smoking has steadily decreased, although in 2001 about one quarter of all high school students still reported smoking at least one cigarette in the past 30 days—above the Healthy People 2010 target. Data for this measure are presented in Appendix Table 28.

Caveats: None.

[3] In prior reports, the data for this measure reflected students who reported smoking cigarettes on 10 or more of the past 30 days. The measure has been updated for this report to be consistent with the Healthy People 2010 goal.

Measure: Self-Reported Teen Marijuana Use

Definition: The proportion of Monroe County public high school students (grades 9-12) who reported having used marijuana at least once in the past 30 days.



Source: Monroe County Health Department, Youth Risk Behavior Survey

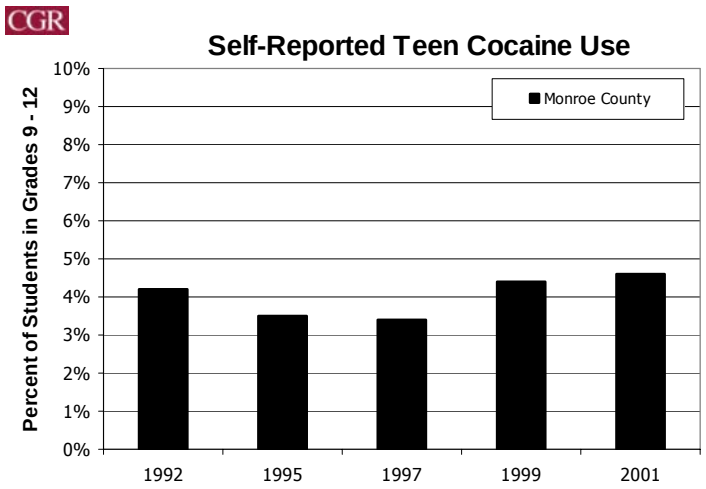
Data are taken from the Monroe County Youth Risk Behavior Survey, conducted in 1992, 1995, 1997, 1999, and 2001. The survey is administered in all public high schools within Monroe County, and only aggregate (countywide) findings are published. The survey will be administered again in 2003. The Healthy People 2010 target is reduction in the proportion of adolescents reporting past 30 day use of marijuana to no more than 0.7%.

Findings: Between 1992 and 1997 the proportion of Monroe County students who reported using marijuana at least once in the past 30 days increased. In each of the last four surveys, from 1995 through 2001, about one in four high school students have reported marijuana use within the past month. Data for this measure are presented in Appendix Table 29.

Caveats: None.

Measure: Self-Reported Teen Cocaine Use

Definition: The proportion of Monroe County public high school students (grades 9-12) who reported having used cocaine at least once in the past 30 days.



Source: Monroe County Health Department, Youth Risk Behavior Survey

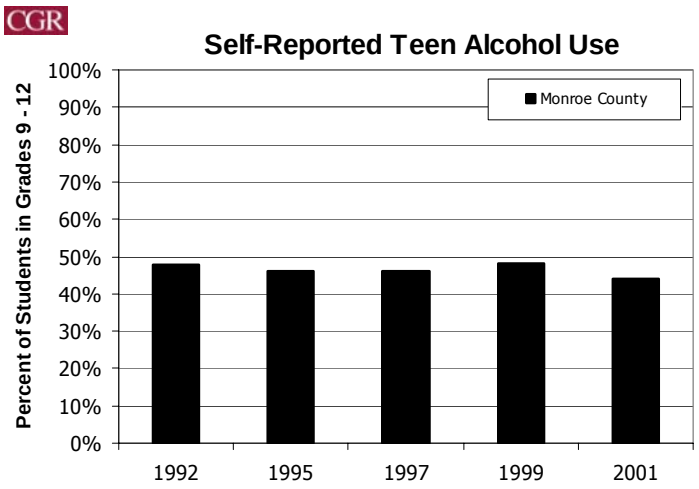
Data are taken from the Monroe County Youth Risk Behavior Survey, conducted in 1992, 1995, 1997, 1999, and 2001. The survey is administered in all public high schools within Monroe County, and aggregate (countywide) findings are published. The survey will be administered again in 2003. The Healthy People 2010 target is an increase in the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days to 89%.

Findings: Compared to cigarette, marijuana, and alcohol use, significantly fewer students reported past 30-day cocaine use. However, in 2001 4.6% of all high school students in Monroe County reported past 30-day use of cocaine. This proportion is 1.2% higher than it was in 1997. Data for this measure are presented in Appendix Table 30.

Caveats: None

Measure: Self-Reported Teen Alcohol Use

Definition: The proportion of Monroe County public high school students (grades 9-12) who reported having at least one drink of alcohol in the past 30 days.



Source: Monroe County Health Department, Youth Risk Behavior Survey

Data are taken from the Monroe County Youth Risk Behavior Survey, conducted in 1992, 1995, 1997, 1999, and 2001. The survey is administered in all public high schools within Monroe County, and only aggregate (countywide) findings are published. The survey will be administered again in 2003. The Healthy People 2010 target is an increase in the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days to 89%.

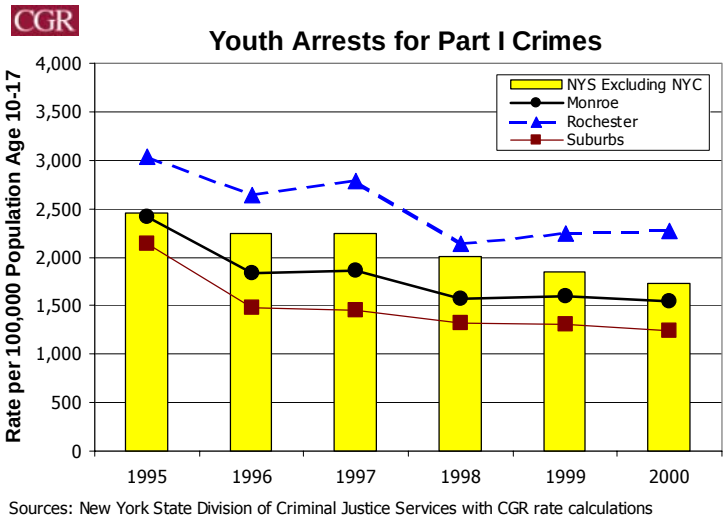
Findings: A higher proportion of Monroe County's high school students have reported having at least one drink of alcohol in the past 30 days than have reported past 30-day use of cigarettes, marijuana, or cocaine. Since 1992 there has been little change in the proportion of students engaging in this level of alcohol use, with between 44% and 48% of high school students indicating having had at least one drink in the past 30 days. Data are presented in Appendix Table 31.

Caveats: None.

Measure: Youth Arrests for Part I Crimes

Definition: The number of arrests of youth, age 10 – 17, for Part I violent and property crimes, expressed as a rate per 100,000 youth age 10 - 17.

Part I crimes, defined across jurisdictions by the FBI for consistent reporting purposes, include murder, negligent manslaughter, forcible rape, robbery, aggravated assault, burglary, larceny, and motor vehicle theft. Arrest reports are made when law enforcement officers actually take an individual into custody and charge that individual with a crime. Arrests are recorded where they occur and do not necessarily reflect the youth's residence.



Sources: New York State Division of Criminal Justice Services with CGR rate calculations

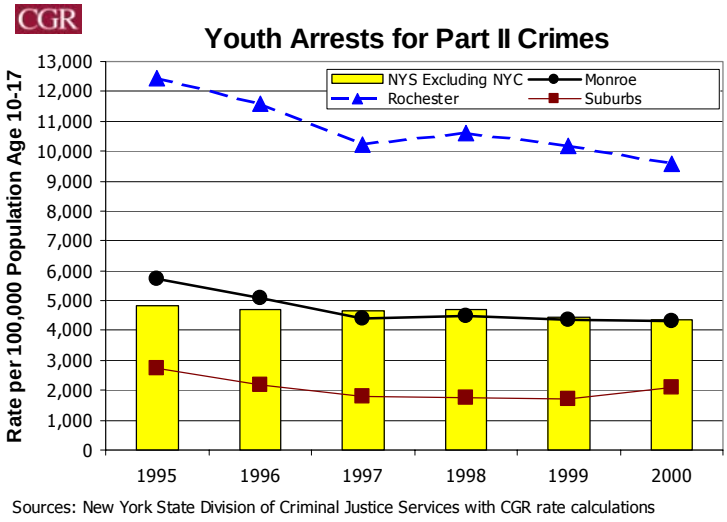
Findings: Since 1995, youth arrests for Part I crimes have steadily declined in the county, city, suburban, and NYS-excluding-NYC regions. In 2000, the most recent year for which data are available, there were 1,339 youth arrests countywide, or 29% fewer when compared to 1995, and suburban arrests were down by 35% during the same time period. From 1995 to 1998 in the City of Rochester, youth arrests for Part I crimes fell by 25% (from 730 in 1995 to 544 in 1998). Since 1998, both the number and rate of youth arrests in the city increased, with 586 arrests, or 2,274 per 100,000, made in 2000. Although city arrest rates are higher, the actual number of youth arrests are higher in the suburbs than in the city. Throughout the study period both the county and the suburban youth arrest rates have been below the NYS-excluding-NYC rates. Data for this measure are presented in Appendix Table 32.

Caveats: Many reported crimes do not result in an arrest. Arrest rates can be affected by changes in law enforcement policies, staffing patterns, etc. Data reflect the number of arrests, and some youth are arrested more than once within a year, so these arrest rates may somewhat overstate the actual number of youth arrested.

Measure: Youth Arrests for Part II Crimes

Definition: The number of arrests of youth, age 10 – 17, for Part II crimes, expressed as a rate per 100,000 youth age 10 -17.

Part II crimes, defined across jurisdictions by the FBI for consistent reporting purposes, include simple assault, disorderly conduct, DWI, sale/use of controlled substances, criminal mischief, fraud, forgery, stolen property, unauthorized possession of weapons, prostitution, sex offenses other than forcible rape, arson, kidnapping, extortion, gambling, embezzlement, family offenses, unauthorized use of motor vehicle, bribery, loitering, disturbing public order, breaking liquor laws and various other offenses. Arrest reports are made when law enforcement officers actually take an individual into custody and charge that individual with a crime. Arrests are recorded where they occur and do not necessarily reflect the youth's residence.



Sources: New York State Division of Criminal Justice Services with CGR rate calculations

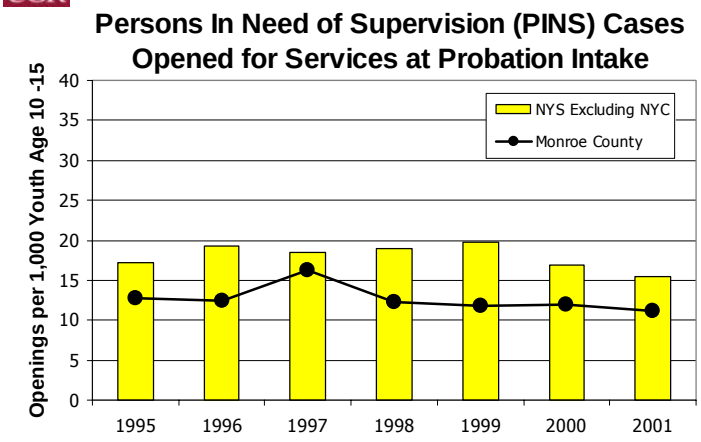
Findings: Since 1995, each of the geographic areas presented here have seen reductions in both the number and rate of youth arrests for Part II crimes. Countywide, in 2000, there were 3,757 youth arrests for Part II crimes. While the number of youth arrests in the city have decreased by 17% since 1995, in 2000 about two-thirds of all youth Part II arrests in Monroe County occurred in the City of Rochester. The youth arrest rate in the city remains more than twice the countywide rate, and almost 4.5 times the suburban rate, despite the latter's substantial increase in 2000. In recent years the NYS-excluding-NYC rate has been comparable to the overall Monroe County rate. Data for this measure are presented in Appendix Table 33.

Caveats: Many reported crimes do not result in an arrest. Arrest rates can be affected by changes in law enforcement policies, staffing patterns, etc. Data reflect the number of arrests, and some youth are arrested more than once within a year, so these arrest rates may somewhat overstate the actual number of youth arrested.

Measure: PINS Cases Opened at Probation Intake

Definition: This measure reflects the annual rate of Persons in Need of Supervision (PINS) case openings at individual county Probation Departments. PINS rates reflect the number of cases opened per 1,000 youth age 10–15; youth less than 10 years of age are excluded from rate calculations due to the low number of complaints filed for this age category.

CGR



Source: New York State Division of Probation and Correctional Alternatives, Probation Workload System, with rates calculated by CGR

A PINS is defined as a juvenile less than 16 years of age (as of July 1, 2002, less than 18 years of age) for whom complaints were filed with the local Probation Department because of non-criminal misconduct such as not attending school regularly, incorrigibility, being ungovernable or habitually disobedient and beyond lawful control of a parent or other guardian.

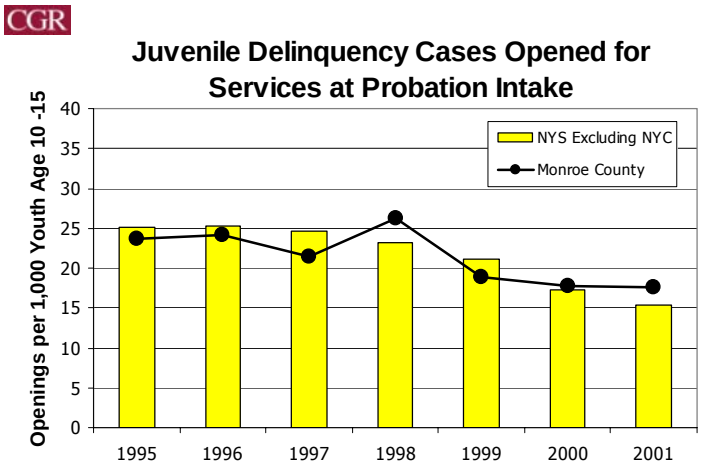
Findings: In Monroe County, in 2001, there were 741 PINS case openings at Probation Intake. This number represents a 4% increase compared to 1995, but a 19% decrease from the seven-year high of 913 openings in 1997. Additionally, it is important to note that while there were more case openings in 2001 compared to 1995, the actual rate, or number of cases opened per 1,000 youth age 10 –15, declined from 12.7 per 1,000 in 1995 to 11.2 in 2001. In each of the years presented here, the number of PINS cases opened per 1,000 youth in Monroe County has been lower than in the NYS-excluding-NYC region. Data for this measure are presented in Appendix Table 34.

Caveats: Data reflect an unduplicated count of *cases* opened at Probation Intake; an *individual* may have multiple PINS petitions filed within a single year. Also, it is important to note that these data do not reflect the ultimate disposition of the case. Finally, since 2001 county population estimates by age are not yet available, 2001 rate calculations are based on Census 2000 population data.

Measure: Juvenile Delinquency Cases Opened at Probation Intake

Definition: This measure reflects the rate of Juvenile Delinquent (JD) case openings at county Probation Departments in a given year, expressed as a rate per 1,000 youth age 10 –15; youth less than 10 years of age are excluded due to the low number of JD case openings filed for this lower age category.

A JD is a person over 7 and less than 16 years of age who has committed a crime, but because of his or her age, is tried in Family Court.



Source: New York State Division of Probation and Correctional Alternatives, Probation Workload System, with rates calculated by CGR

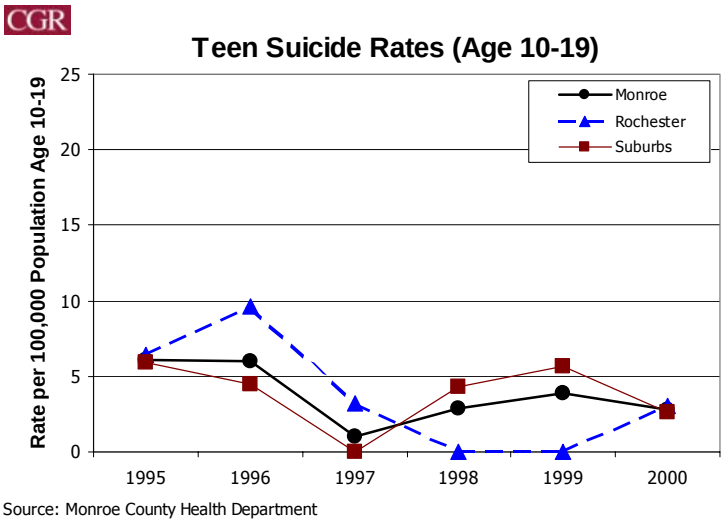
Findings: In Monroe County, in 2001, there were 1,168 JD cases opened at Probation Intake. This number represents a 12% decrease compared to 1995, and a 21% decrease from the seven-year high of 1,478 openings in 1998. JD case openings in the NYS-excluding-NYC region have steadily declined since 1996, and in both 2000 and 2001, the larger region's rate fell below the countywide rate. Data for this measure are presented in Appendix Table 35.

Caveats: These data do not reflect an unduplicated count of cases opened at Probation Intake; an individual may have multiple JD petitions filed within a single year. Also, it is important to note that these data do not reflect the ultimate disposition of the case. Finally, since 2001 county population estimates by age are not yet available, 2001 rate calculations are based on Census 2000 population data.

Measure: Teen Suicide Rates

Definition: Number of deaths from suicide per 100,000 residents age 10 –19. The Healthy People 2010 target is no more than 5 suicides per 100,000 population.

Nationally, suicide is the 3rd leading cause of death for adolescents, and there has been a greater increase in suicide among adolescents compared to the general population.



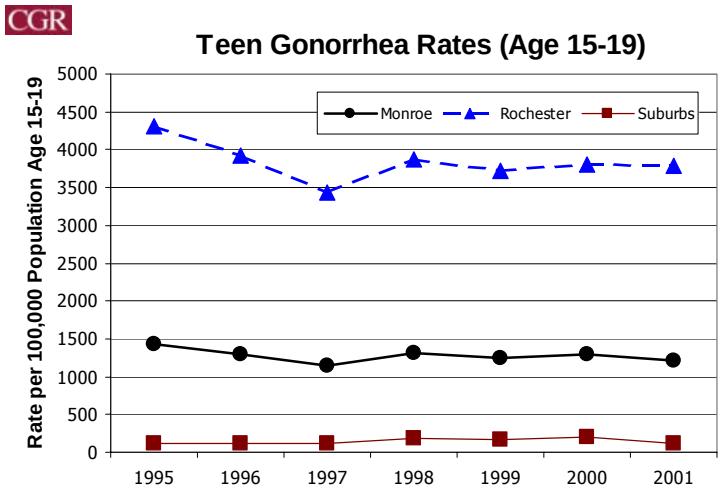
Source: Monroe County Health Department

Findings: Rates for this measure are highly variable from year to year due to a relatively small number of teen suicides, and therefore no clearly identifiable trends have been noted. Countywide, since 1995, teen suicide rates have varied from 1.0 to 6.1 per 100,000, or one to six deaths. However, in each year from 1997 through 2000, the suicide rate has been below (better than) the Healthy People 2010 target of no more than 5 suicides per 100,000 youth 10-19. Typically the goal has been reached in both the city and suburban regions. Data for this measure are presented in Appendix Table 36, and include breakdowns by age 10 – 14 and 15 – 19.

Caveats: None.

Measure: Teen Gonorrhea Rates

Definition: Reported cases of gonorrhea diagnosed annually, expressed as a rate per 100,000 youth age 15 –19. The Healthy People 2010 Target is no more than 19 new cases of gonorrhea per 100,000 total population.



Source: Monroe County Health Department

Findings: Going back to 1990, teen gonorrhea rates have declined significantly in the intervening years. Since 1998, teen gonorrhea rates have been relatively stable across each of the geographic areas presented here. In 2001, 643 new cases of gonorrhea were reported countywide. While the City of Rochester continues to have the highest rate (nearly three times higher than the countywide rate and almost 20 times higher than in the suburban areas), rates in the City have fallen by about 12% since 1995. Rates remain well above Healthy People 2010 targets. Data presented in Appendix Table 37 also provide male/female breakdowns and countywide rates for youth age 10 –14.

Caveats: None.

Additional Resources

For additional information pertaining to the outcomes and measures included in this chapter, as well as information on related topics, see the following:

- New York State Education Department:
  - http://www.nysed.gov/
  - School report cards, http://usny.nysed.gov/publications.html#schoolreport
  - No Child Left Behind Act http://www.emsc.nysed.gov/deputy/nclb/nclbhome.htm
- www.kidscount.org
- http://www.census.gov
- U.S. Department of Health, Centers for Medicare and Medicaid Services, http://www.cms.gov
- U.S. Census Bureau, http://census.gov
- Healthy People 2010, http://www.healthypeople.gov
- Children's Defense Fund, http://www.childrensdefense.org
- America's Children: Key National Indicators of Well-Being 2002, http://www.nichd.nih.gov/publications/pubs/childstats/americas.htm

VI. Strengthening Families Impact Area

Context

This Impact Area is designed to track how well the community is doing in developing and maintaining stronger, more stable family units. The focus is on four primary Outcomes: Families that are Physically and Mentally Healthy, Personally Safe, Financially Secure, and Appropriately Housed.

Several of the measures used for this Impact Area involve responses to community-wide surveys conducted in 1997 and 2000 for the Monroe County Health Department. It is important to realize in interpreting these data that the survey was conducted exclusively by telephone. Nonetheless, the self-reported survey findings remain an especially important source of information for several of the Outcomes in this Impact Area.

For a few of the measures in this chapter, reference is made to national Year 2010 Healthy People targets or goals. Healthy People 2010 refers to a set of objectives, or measurable targets, designed as part of a national strategy to improve the health of all Americans. Although they have not necessarily been formally adopted as community-wide goals for Monroe County, these targets provide useful health-related benchmarks for the community to strive to meet.

Relevant Demographic Trends

Based on U.S. Census data:

- The total number of family households in Monroe County remained virtually unchanged from 1990 to 2000, increasing by about 1,750, or 1%, to about 184,500 families in 2000.
- Of those families, 47,169 (26% of the county total) lived in the city, a 9% decline since 1990. Suburban families increased by 5% to 137,345 in 2000.
- About half the county's families included children under 18 living at home.
- Median family income in 2000 was $55,900 in the county as a whole, compared with $31,257 in the city.
- The number of families living in poverty increased 6.5% from 1990 to 2000, to a total of 15,236 in 2000 (8% of all county families). Almost three-quarters of those families lived in the city (11,148), representing 23% of all city families.
- Of the population 15 and older in 2000, 51% were currently married and not separated, 30% had never been married, 3% were separated, 7% widowed, and 9% divorced. In the city, those proportions were: 33% currently married, 44% never married, 6% separated, 7% widowed, and 11% divorced.

Summary of Trends

In reviewing the 41 measures which are presented in this chapter, some trends and themes emerge from the data. At the end of each summary statement below, arrows indicate whether the *overall county trend* for a particular measure (irrespective of trends within city and suburbs) reflects *improvement in recent years toward meeting the desired outcome* (⬆), *movement away from the desired outcome* (⬇), or *no significant change* (⬅➡). We urge caution though, as there are many indicators where Monroe County's rates are moving in the right direction but are still not as good as the NYS-excluding-NYC comparison or the national Healthy People 2010 goals. Therefore, the reader is encouraged not to make judgments on any measure before carefully reviewing the detailed profiles that appear under each Outcome area.

Physically and Mentally Healthy Families

For the most part, the measures in this Outcome area have been relatively stable in recent years, with some improvements noted and some areas in which improvement is needed, especially in comparison with the rest of the state (excluding NYC), and in comparison with national Healthy People 2010 goals:

- Teen pregnancy and teen birth rates have continued to come down, but they still remain above NYS-excluding-NYC rates, and well above the Healthy People 2010 targets. (*County progress:* ⬆)
- About 10% of the county's adults between 18 and 64 report that their health status is only fair to poor. (*County progress:* ⬅➡)
- About 26% of the county's adults aged 18 – 64 report no leisure-time physical activity in the previous month. No trend data are available, but this clearly suggests an area in which improvement is needed. The proportion is higher than the Healthy People 2010 national goal. (*County progress:* ?)
- About one in four adults consistently report cigarette smoking. Within this overall stable proportion, higher proportions of suburban adults reported smoking in 2000 than in 1997. (*County progress:* ⬅➡)
- There has been no change in the proportions of adults age 18 – 64 reporting high blood pressure or diabetes. Between 1997 and 2000, those proportions have remained about 20% and 3%-4%, respectively. Rates of high blood pressure are significantly higher

among blacks compared to white adults. While rates for diabetes among blacks are higher than whites, the difference is not statistically significant. (*County progress:* ⬅➡)

- The county's overall mortality rates for all causes of death have remained relatively stable in recent years, and similar to the NYS-excluding-NYC rates. City rates are consistently higher. Mortality for most individual causes of death exhibit similar patterns. (*County progress:* ⬅➡)
- Lung cancer mortality rates have remained relatively stable, and just below the NYS-excluding-NYC rates, with relatively little city/county differences. (*County progress:* ⬅➡) Mortality rates for heart disease have actually declined slightly but steadily over the past few years, and remain well below the Upstate rates. (*County progress:* ⬆) However, both of these rates remain well above the Healthy People 2010 rates. Both could likely be affected in helpful directions with reductions in the proportions of smokers and of adults not exercising regularly.
- The AIDS death rate has declined by about two-thirds since 1995. (*County progress:* ⬆)
- Suicide rates have shifted up and down a bit in recent years, with no discernable trend. (*County progress:* ⬅➡)
- Following a decline through 1997, the overall county rate of newly diagnosed gonorrhea cases increased in 1998 and remained stable until 2001, when it declined again. The countywide rate remains 15 times higher than the Healthy People 2010 goal. (*County progress:* ⬇)
- Hospitalizations for ambulatory care sensitive conditions have declined by 8% in the past five years, though it cannot be determined from the data whether these represent improved health or changes in how the medical care and insurance systems handle such cases. (*County progress:* ?)
- Between 1997 and 2000, there was little change in the proportion of adults in the county who reported frequently experiencing mental distress (about 10%). (*County progress:* ⬅➡) First-time entrants to the mental health system and use of mental health crisis services have both declined slightly in recent years, and there has been little change in rates of use of inpatient mental health

services. Rates may be influenced as much by changes in the mental health care and insurance systems as by changing needs. (*County progress:* ?)

- Hospital discharges related to alcohol or drug-related illnesses have declined by 29% since 1996, with a 41% reduction among city residents. Again, this reduction may represent a reduction in serious substance abuse problems in the county, or it may reflect at least in part changes in resource/system issues. (*County progress:* ?)
- There has been a significant increase of 64% since 1995 in the number of alcohol-related crashes in the county. (*County progress:* ⬇) On the other hand, there have been slight reductions in the numbers and rates of deaths and injuries resulting from those crashes. (*County progress:* ⬆)

Personally Safe Families

Overall trends in this Outcome area have been positive, for the most part, in recent years:

- Reports of domestic violence have declined by 24% since 1996, and by 32% in the city, though the majority of cases are still reported in the city. The county overall rates, despite the recent improvements, remain well above the NYS-excluding-NYC rates. (*County progress:* ⬆)
- Numbers of indicated child abuse and neglect cases have increased steadily since 1995, although the rates remain lower than (better than) the NYS-excluding-NYC rates. (*County progress:* ⬇)
- Murder rates have vacillated up and down, with no clear trend in recent years. Rates remain consistently somewhat higher than the Upstate rates each year. (*County progress:* ⬅➡)
- Violent crimes, serious property crimes, and Part II crimes have all exhibited lower rates in recent years in both city and suburban locations. Most rates are similar to, or lower than, the Upstate rates, except for major property crimes, where, despite recent reductions in local rates, they remain higher in both city and suburbs than NYS-excluding-NYC rates. (*County progress:* ⬆)
- Youth have reported reduced use of weapons in recent years. (*County progress:* ⬆)

Financially Secure Families

In recent years, the overall financial profile of families and adults in the county has become less secure:

- The number of families, children, adults between 18 and 64, and seniors in poverty all increased between 1990 and 2000. (*County progress:* ⬇)
- Per capita income, though up very slightly in recent years, has fallen farther and farther behind the NYS-excluding-NYC income levels. Similarly, average wages, though holding relatively stable locally, have not faired well compared to the larger region. (*County progress:* ⬇)
- Following years of net increases in jobs, recent years have yielded net job losses, and the last six years the local region's net job growth rates have been consistently below the NYS-excluding-NYC rates. (*County progress:* ⬇)
- Unemployment rates have increased significantly in the past two years, to rates that exceed the Upstate rates. Numbers of average monthly unemployed persons were 50% higher in 2002 than in 2000. (*County progress:* ⬇)
- There have been significant changes in the proportions of employment in various sectors of the economy, with substantial increases between 1990 and 2000 in the services sector and substantial reductions in the manufacturing sector, among others. There has also been a 45% increase in the number of people employed by temporary agencies. (*County progress:* ⬇)
- The number of public assistance cases closed due to employment has declined by 39% between 1997 and 2001. It is not clear whether the declines reflect an improved state of affairs, or changes in public assistance caseloads or in the availability of jobs for welfare recipients. (*County progress:* ?)

Appropriately Housed Families

The trends in available data in this Outcome area are somewhat mixed:

- Mortgage foreclosures and tax foreclosures have generally trended upwards in recent years. Mortgage foreclosures more than doubled from 1995 to 2002, in both the city and the suburbs. (*County progress:* ⬇)

- The number of placements made for emergency shelter has increased dramatically since 1995, for both individuals and families. (*County progress:* ⬇)
- New home mortgage loans, excluding home improvement loans or refinanced mortgages, increased by 46% between 1995 and 2001 (*County progress:* ⬆), though the proportion of mortgages written for city properties declined from 21% of the region's mortgages to 14% in 2001. (*County progress:* ⬇)
- The number of low-income Section 8 housing certificates and vouchers increased 45% countywide between 1998 and 2001, with a 57% increase in the suburbs, suggesting some slight increases in dispersion of low-income households throughout the county. (*County progress:* ⬆)

Conclusions

The stability of families in this update of the community profile appears overall to have eroded somewhat since the first edition, due in large part to declines in the economy in recent years. Special attention may need to be given in areas such as the following:

- Although teen pregnancy and teen birth rates have been declining, they remain higher than Upstate rates or national goals, suggesting that continuing efforts are needed to focus attention on this issue.
- Strengthened efforts are needed to build on existing initiatives to help more adults stop smoking and begin to engage in regular active exercise and other healthy lifestyle behaviors.
- Increased public health education efforts may be needed to retard the recent increases in the rates of gonorrhea among adults (and continuing high levels among adolescents) in the county.
- The relationship between demonstrated needs and the availability, affordability and accessibility of mental health and substance abuse treatment services needs to be examined and understood more clearly in the future.
- Current existing and expanding efforts in the county to strengthen economic development activities need to be strongly supported, in order to improve the local economy.
- Additional emphasis is needed on the continuing development and strengthening of assets and resources for children, youth and families throughout the county. Such assets include expanded focus on primary prevention and early intervention services and activities designed to help youth and families make informed decisions that will positively affect the ability of young people and adults to lead healthy, productive lives.

Outcome I: Physically and Mentally Healthy Families

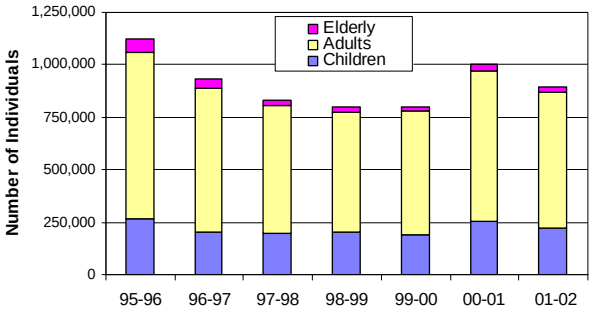
- *Elementary School Students Eligible for Free/Reduced Price Lunch (appeared previously in Success by 6 chapter)*
- Number of Individuals Served Emergency Food
- Teen Pregnancy Rates (Age 10 – 19)
- Self-Reported Physical Activity
- Self-Reported Physical Health Status
- Self-Reported Mental Health Status
- Self-Reported Cigarette Smoking
- Mortality Rates- All Causes
- Mortality Rates- Lung Cancer
- Mortality Rates- Heart Disease
- AIDS Deaths
- Suicides
- Sexually Transmitted Diseases- Gonorrhea
- Self-Reported Disease Prevalence- High Blood Pressure
- Self-Reported Disease Prevalence- Diabetes
- Ambulatory Care Sensitive Hospitalizations
- New Entrants to Mental Health Treatment
- Individuals Receiving Mental Health Crisis Services
- Individuals Admitted to Mental Health Inpatient Services
- Alcohol- and Drug- Related Hospital Discharges
- Alcohol-Related Motor Vehicle Crashes

Since the mid-1990s, overall county progress in this outcome area has been mixed. Three measures have shown movement away from the desired direction, seven measures have shown little change, five have shown some improvement, and progress of six measures is undetermined.

Measure: Number of Individuals Served Emergency Food

Definition: The total number of Monroe County residents served emergency food. This includes individuals served under the FOODLINK Supplemental Nutrition Assistance Program (SNAP) and Hunger Prevention Nutrition Assistance Program (HPNAP). New York State Department of Health regulations require a food pantry to count all people in the household receiving food each time a visit to the pantry is made, even if only one person collects the food. Soup kitchens count each person served a meal at each mealtime. For example, if a person is served breakfast and lunch at the site on the same day, they are counted as two persons served.

Individuals Served Emergency Food



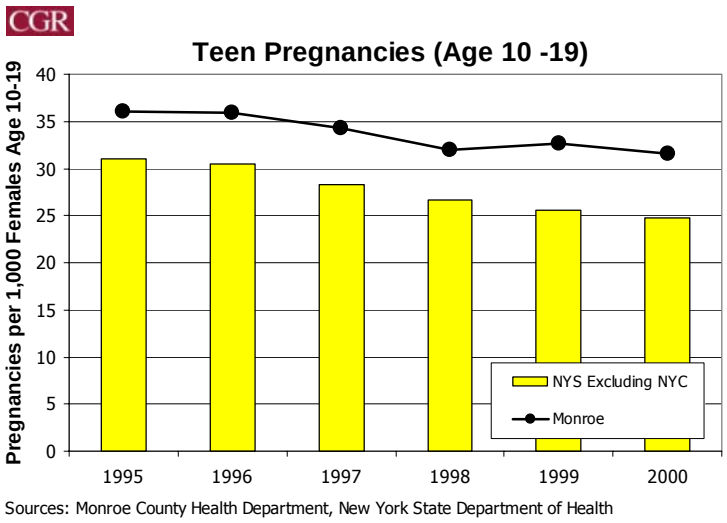
Source: FOODLINK

Findings: After an apparent decline in the late 1990's, the number of individuals served emergency food has begun to gradually increase in the past two years. The distribution has remained relatively constant over the past five years, with approximately a quarter of recipients children, and three-quarter adults, with seniors representing less than five percent of all recipients in any give year. Data for this measure are presented in Appendix Table 38.

Caveats: FOODLINK modified the data they had provided in previous years. Therefore, data in this report include corrections made to previous years, and this report will not match previous reports. A decrease in the number of individuals receiving emergency food may not mean reduced hunger in the community, as the resources available for these services may have declined. Other possible explanations for this downward trend are that between 1996 and 1997, FOODLINK provided training sessions for sites that resulted in more accurate reporting, and that during this period, several sites were reclassified from emergency to supplemental feeding sites.

Measure: Teen Pregnancy Rates

Definition: Number of pregnancies per thousand females age 10 - 19. The Healthy People 2010 goal is zero pregnancies among females under the age of 15.



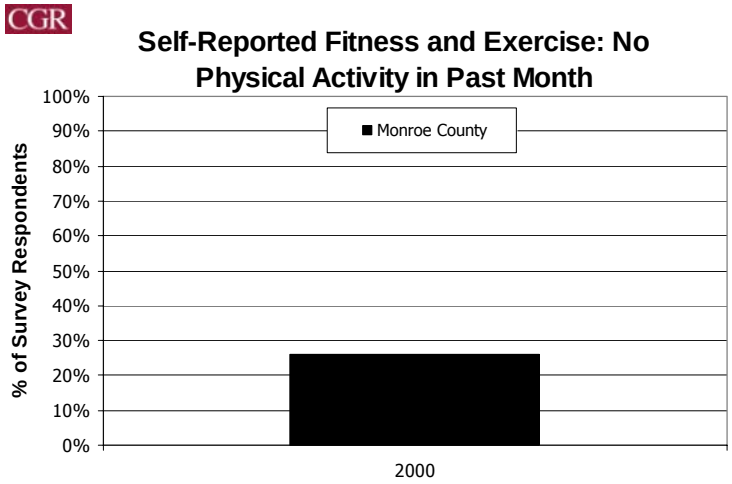
Sources: Monroe County Health Department, New York State Department of Health

Findings: From 1995 to 2000, teen pregnancy rates among 10 – 19 year olds in Monroe County declined from 36.1 to 31.6 per 1,000, representing 1,662 teen pregnancies in 2000, or 83 (5%) fewer than in 1995. During the same period, the NYS-excluding-NYC region experienced a similar downward trend, although the magnitude of the decrease was greater compared to the County's (14% vs. 5%). Throughout the study period, Monroe County's teen pregnancy rates have consistently exceeded the larger region's. Data for this measure are presented in Appendix Table 39 . Breakdowns of teen pregnancy rates for those 10-14 and 15-17 were presented in the Kids on Track chapter, and are shown in Appendix Tables 26A and 26B.

Caveats: Data at the sub-county level have not been available since 1992.

Measure: Self-Reported Physical Activity

Definition: The percentage of Monroe County Adult Health Survey respondents, age 18 – 64, who *did not* engage in any physical activities or exercises such as running, golf, calisthenics, gardening, or walking for exercise during the past month.



Source: Monroe County Health Department

The Healthy People 2010 goal is a reduction in the proportion of adults who engage in no leisure-time physical activity to no more than 20%.

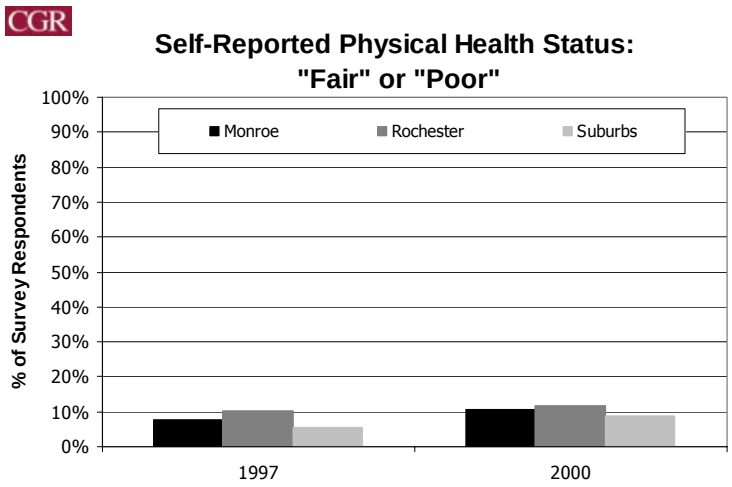
(Note: The survey question related to this measure changed from 1997 to 2000, and because the 2000 data are not comparable to 1997 data presented in earlier reports, 1997 data are no longer presented here.)

Findings: Baseline data, collected in 2000, reveal that 26% of adult survey respondents (ages 18 – 64) reported that they had not engaged in any form of physical activity for exercise in the past month. This is higher than the Healthy People 2010 target. Data for this measure are available only at the county level, and are presented in Appendix Table 40.

Caveats: See discussion of survey data.

Measure: Self-Reported Physical Health Status

Definition: The percentage of Monroe County Adult Health Survey respondents, age 18 – 64, who reported that their physical health status is "fair" or "poor".



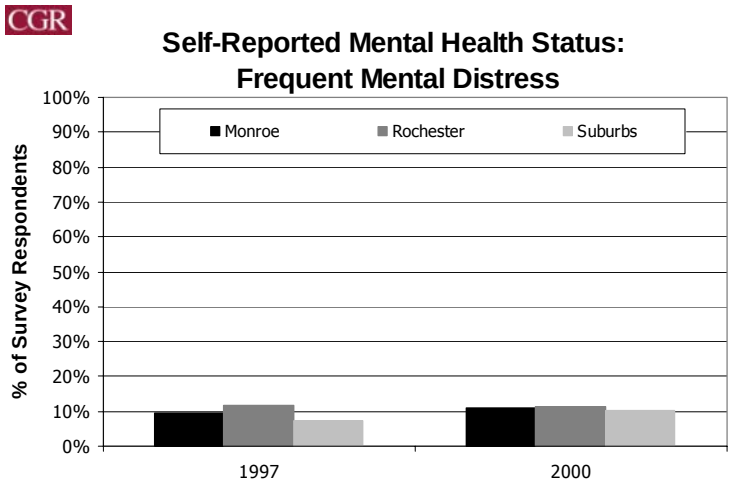
Source: Monroe County Health Department

Findings: From 1997 to 2000, the proportion of adults reporting that their physical health status was fair or poor remained relatively stable across all three geographic regions presented here. In 2000, 10.4% of respondents countywide reported fair or poor physical health status. In 1997, a higher proportion of respondents residing in the City of Rochester reported fair or poor health status compared to their suburban counterparts. In 2000, there was no statistical difference between the two areas. Caution is urged when interpreting these data. The data are presented here as a baseline for future profiles as it is too early to draw any inference of longer-term trends from only two data points. Data are presented in Appendix Table 41.

Caveats: See discussion of survey data.

Measure: Self-Reported Mental Health Status

Definition: The percentage of Monroe County Adult Health Survey respondents, age 18 – 64, who reported experiencing frequent mental distress (respondents reported that their mental health was not good on 14 or more of the last 30 days).



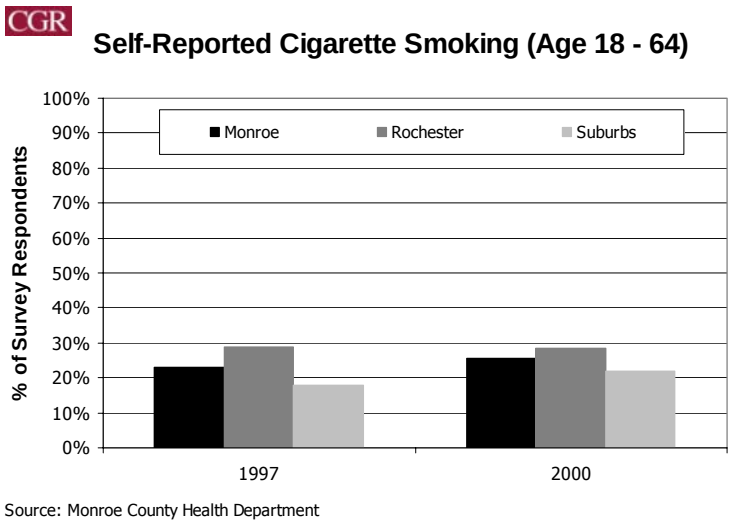
Source: Monroe County Health Department

Findings: The rate of frequent mental distress has remained relatively stable since 1997, with about one in ten respondents reporting poor mental health on 14 or more of the past 30 days. No significant differences were seen between respondents in the city and those in the suburbs. Data are presented in Appendix Table 42.

Caveats: See discussion of survey data.

Measure: Self-Reported Cigarette Smoking

Definition: The percentage of Monroe County Adult Health Survey respondents, age 18 – 64, who reported smoking cigarettes in the past 30 days.



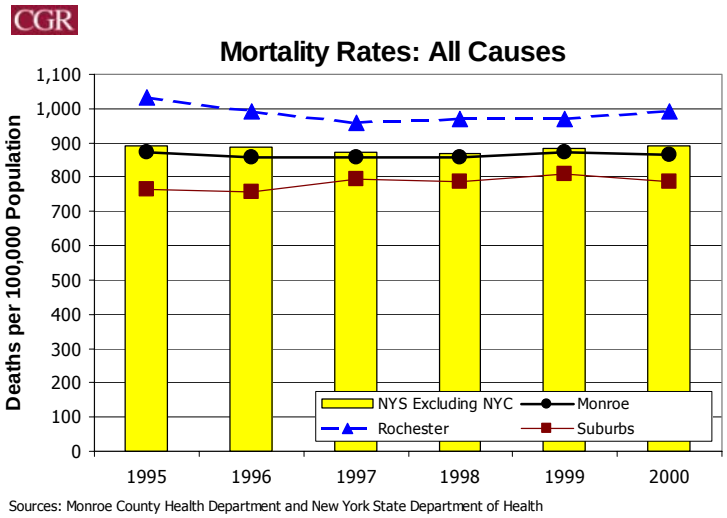
Source: Monroe County Health Department

Findings: Countywide, in both 1997 and 2000, about one in four adult respondents reported past 30-day cigarette use. In both years, a higher proportion of respondents residing in the city reported smoking cigarettes in the past 30 days compared to suburban respondents, although the gap narrowed in 2000, as somewhat higher proportions of suburban residents reported smoking than in 1997. Caution is urged in interpreting these data, as additional data points are needed to determine whether any changes between 1997 and 2000 represent a longer-term trend. Data are presented in Appendix Table 43.

Caveats: See discussion of survey data.

Measure: Mortality Rates – All Causes

Definition: Number of deaths per 100,000 residents of all ages.



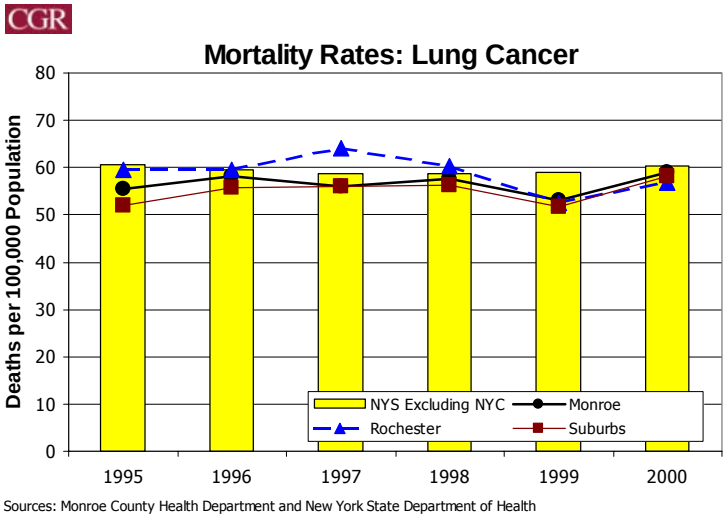
Sources: Monroe County Health Department and New York State Department of Health

Findings: From 1995 through 2000, the overall mortality rates have been stable in Monroe County, ranging between 850 and 875 deaths per 100,000 residents. During that time, county and NYS-excluding-NYC rates have been almost identical (with a difference between 10 and 28 per 100,000 annually). In 2000, the countywide mortality rate was 865 deaths per 100,000 population, and the NYC-excluding-NYC rate was 890 deaths per 100,000 population. Mortality rates in the City of Rochester have consistently been above the suburban rates, ranging from 162 to 267 per 100,000 higher during the six-year study period. Detailed trends in rates of death by specific causes (e.g., all cancers, lung cancer, breast cancer, stroke, heart disease, and unintentional injuries) are listed in Appendix Table 44. Two of these are graphed and discussed in the following pages.

Caveats: These mortality rates are for the total population and have not been adjusted for age and gender differences in the population.

Measure: Mortality Rates - Lung Cancer

Definition: Number of deaths from lung cancer per 100,000 residents of all ages.



Sources: Monroe County Health Department and New York State Department of Health

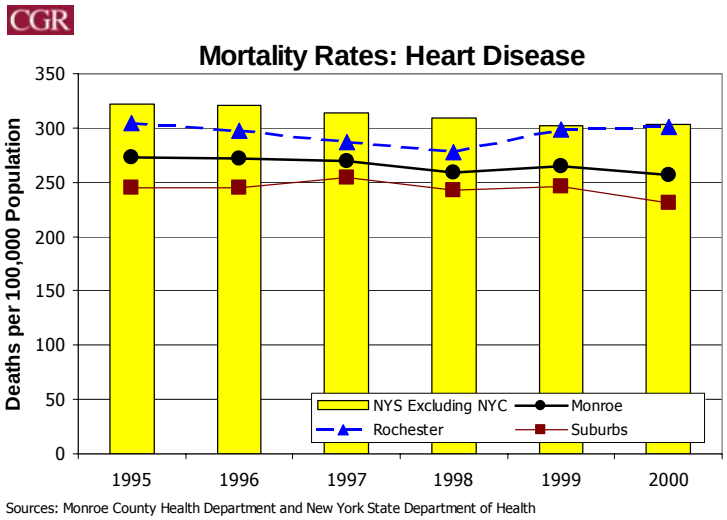
Among males and females in the United States, lung cancer is the most common cause of cancer death. Cigarette smoking is the most significant risk factor for lung cancer. The Centers for Disease Control and Prevention estimate that cancer rates overall could be reduced by as much as half through smoking cessation and improved dietary habits. The Healthy People 2010 target for the nation is 44.9 lung cancer deaths per 100,000 population.

Findings: Countywide lung cancer mortality rates remained fairly stable between 1995 and 2000, ranging between 53.1 and 59.0 deaths per 100,000 during the six-year period. In 1995, there were 55.6 lung cancer deaths per 100,000 population, in 1999 there were 53.1, and in 2000 the rate was 59 per 100,000, or 434 deaths. The countywide lung cancer mortality rate has consistently been just below the NYS-excluding-NYC rate. City rates have typically been slightly higher than suburban rates, but the suburban rate slightly exceeded the city rate in 2000. Data are presented in Appendix Table 44.

Caveats: These mortality rates are for the total population and have not been adjusted for age and gender differences in the population. Therefore, they cannot be directly compared to the Healthy People 2010 target.

Measure: Mortality Rates – Heart Disease

Definition: Number of deaths from heart disease per 100,000 residents of all ages.



Sources: Monroe County Health Department and New York State Department of Health

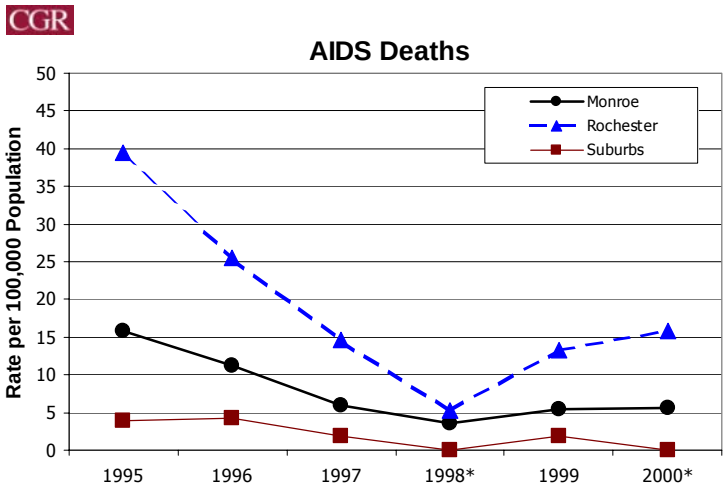
The Centers for Disease Control and Prevention report that in the United States, one out of every two males, and one out of three females, will develop coronary heart disease in his or her lifetime. Primary prevention efforts and screening for risk factors can play significant roles in reducing the incidence of heart disease. The Healthy People 2010 target for the nation is no more than 166 coronary heart disease deaths per 100,000 population.

Findings: Monroe County's heart disease mortality rate has declined gradually from 273 deaths per 100,000 population in 1995 to 257 deaths per 100,000 population in 2000. Rates are highest in the City of Rochester, and have actually increased in recent years while suburban rates have declined. The NYS-excluding-NYC comparison area's rates have consistently been above (worse than) that of the County. Data are presented in Appendix Table 44.

Caveats: These mortality rates are for the total population and have not been adjusted for age and gender differences in the population. Therefore, they cannot be directly compared to the Healthy People 2010 target.

Measure: AIDS Deaths

Definition: Number of deaths from AIDS, expressed as a rate per 100,000 Monroe County residents of all ages.



*1998 and 2000: <6 deaths reported in the suburbs
Sources: Monroe County Health Department

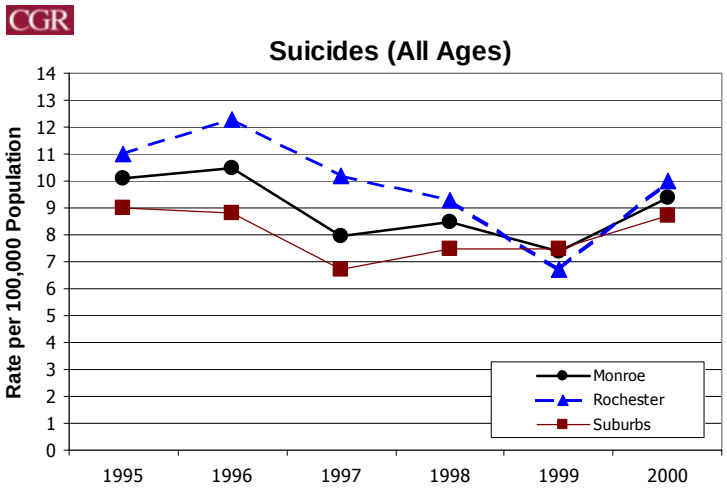
Findings: Countywide, AIDS death rates have declined by nearly two-thirds, from 15.8 per 100,000 in 1995 to 5.6 per 100,000 in 2000. Between 1995 and 1998, the rate of decline was greatest in the City of Rochester (rates fell from 39.5 to 5.3 per 100,000).

The increase in AIDS death rate seen in 1999 is most likely due to changes in the coding of causes of death (from the ICD-9 system to the ICD-10 system), and is not necessarily due to an increase in deaths due to AIDS. Data for this measure are presented in Appendix Table 45.

Caveats: Suburban data are not reported for 1998 and 2000 due to fewer than six deaths reported in each of those years. These mortality rates are for the total population and have not been adjusted for age and gender differences in the population.

Measure: Suicides

Definition: Number of deaths from suicide, expressed as a rate per 100,000 Monroe County residents of all ages. The Healthy People 2010 target is to reduce the number of suicides to no more than 5.0 per 100,000 population.



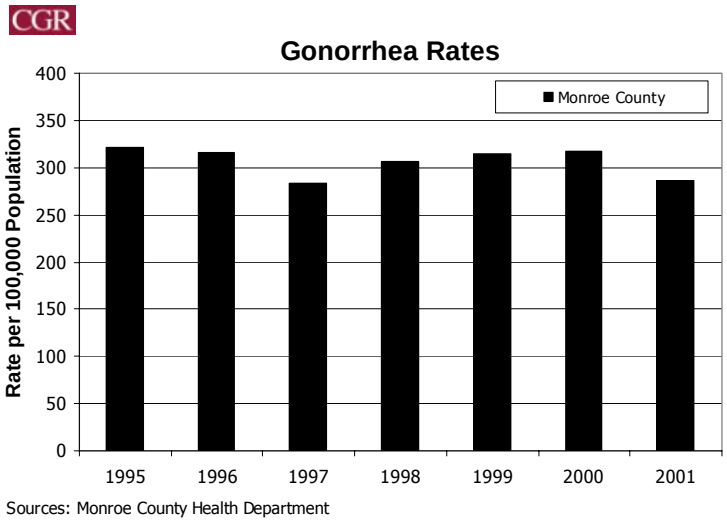
Sources: Monroe County Health Department

Findings: Rates for this measure are highly variable from year to year due to a relatively small number of suicides, and therefore no clearly identifiable trends have been noted. Countywide, since 1995, suicide rates have varied from 7.4 to 10.5 per 100,000. Data for this measure are presented in Appendix Table 46.

Caveats: These mortality rates are for the total population and have not been adjusted for age and gender differences in the population. Therefore, they cannot be directly compared to the Healthy People 2010 target.

Measure: Sexually Transmitted Diseases – Gonorrhea

Definition: The number of cases of gonorrhea diagnosed annually, expressed as a rate per 100,000 Monroe County residents of all ages. The Healthy People 2010 goal is a reduction in the number of new cases of gonorrhea to 19 per 100,000 population.



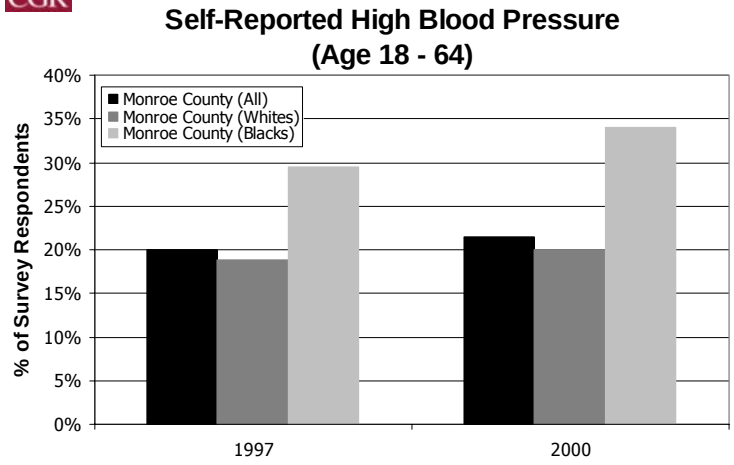
Sources: Monroe County Health Department

Findings: Between 1995 and 1997, gonorrhea rates in Monroe County declined from 322 new cases per 100,000 to 283 new cases per 100,000. The rate increased in 1998, and remained stable until 2001 when it declined back to 286/100,000, representing about 2,100 new cases (more than 200 fewer than the year before). However, even after the decline in 2001, the countywide rate remained about 15 times higher than the Healthy People 2010 goal. County level data are presented in Appendix Table 47.

Caveats: None

Measure: Self-Reported Disease Prevalence – High Blood Pressure

Definition: The percentage of Monroe County Adult Health Survey respondents, ages 18 through 64, who reported that they had ever been told they had high blood pressure.



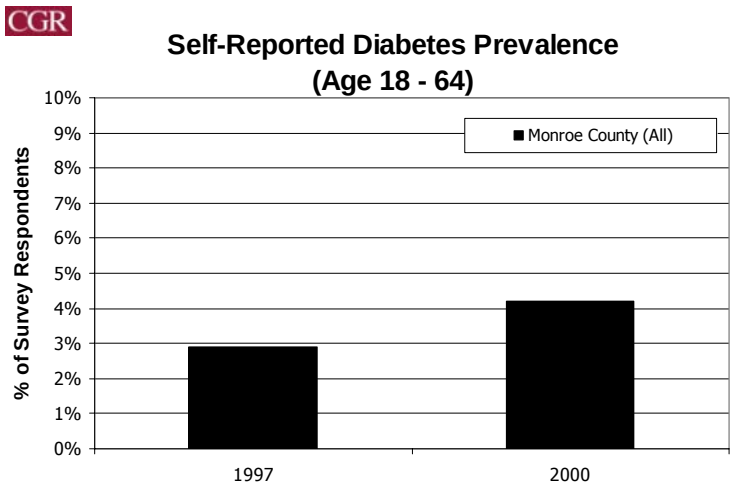
Source: Monroe County Health Department

Findings: Countywide, in both 1997 and 2000, about one in five adult respondents reported that they had ever been told they had high blood pressure. In both years a higher proportion of black respondents reported high blood pressure compared to white respondents. Data are presented in Appendix Table 48.

Caveats: See discussion of survey data.

Measure: Self-Reported Disease Prevalence – Diabetes

Definition: The percentage of Monroe County Adult Health Survey respondents, ages 18 through 64, who reported that they had ever been told by a physician that they had diabetes.



Source: Monroe County Health Department

Findings: Countywide, in 2000, about 4% of adult respondents reported that they had ever been told they had diabetes. In both 1997 and 2000, more than twice the proportion of black respondents reported having diabetes, compared to white respondents, although this difference is not statistically significant. Data are presented in Appendix Table 49.

Caveats: See discussion of survey data.

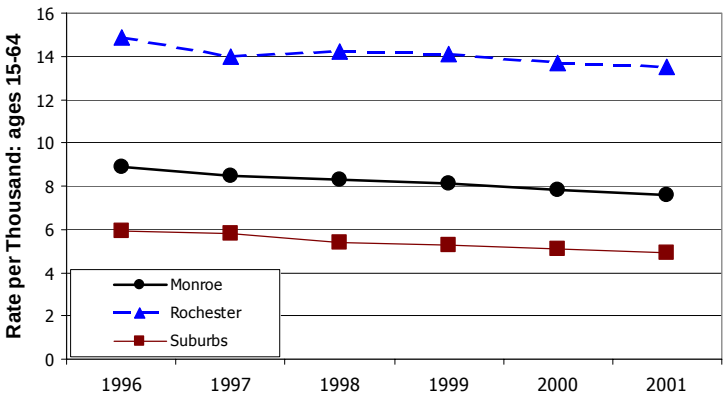
Measure: Ambulatory Care Sensitive Hospitalizations

Definition: This measure represents the rate of hospitalizations for Ambulatory Care Sensitive (ACS) conditions for adults (age 15-64). The rate is calculated as the number of hospital admissions per 1,000 persons 18-64.

ACS conditions are medical conditions that are considered to be preventable or manageable on an outpatient basis. Access to and use of timely and appropriate primary care decreases the probability that a hospitalization will occur for an ACS condition.

CGR

ACS Hospitalization Rates: Ages 15-64



Source: Finger Lakes Health Systems Agency

Findings: The rate of ambulatory care sensitive hospitalizations has decreased slightly since 1996. In 1996, 4,095 Monroe County adults (15-64) were hospitalized for ambulatory care sensitive conditions, a rate of 8.9 per 1,000 adults. In 2001, 3,748 Monroe County adults were hospitalized for the same conditions, a decrease of 8.4%. Likewise, rates have also fallen in the City of Rochester and in the suburbs. In 1996, 2,296 adult city residents were hospitalized for ambulatory care sensitive conditions, a rate of 14.9. By 2001, this had decreased by 6.7% to 2,142 city adults, a rate of 13.5 per 1,000 adult city residents. In the suburbs, the decrease was 10.8%, from 1,799 adults in 1995 to 1,606 in 2001, a change from 5.9 per 1,000 suburban adults to 4.9. Increases or decreases over time in the ACS rate may indicate changes in the availability/use/accessibility of health care services, as well as changes in financial/insurance coverage, managed care and ability to pay for services. Alternatively, changes in ACS rates may simply reflect changes in how hospitals handle such cases. For more detailed information, see Appendix Table 50.

Caveats: None.

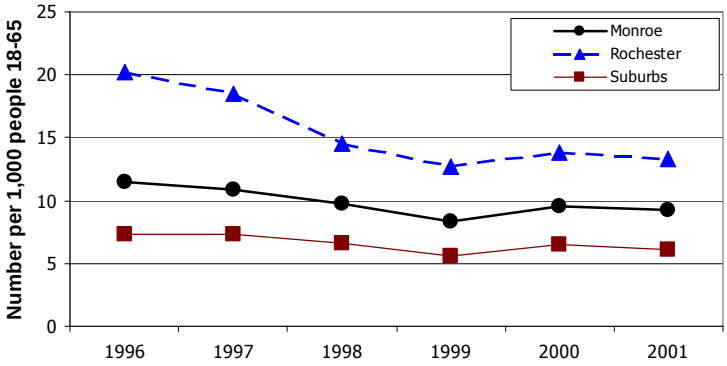
Measure: New Entrants to Mental Health Treatment

Definition: The rate per 1,000 adults (age 18-65) entering inpatient or outpatient mental health services in a hospital or community mental health center in Monroe County for the first time.

These data include only those residents served in publicly-funded and certified mental health programs reporting to the CCSI database and do not include clients of private practitioners. The data do cover a high proportion of severely and persistently mentally ill persons.

CGR

New Entrants to Mental Health Treatment: Ages 18-65



Source: Coordinated Care Services, Inc.

Findings: Because the data collection method changed beginning in 1998 and data collected in prior years is not comparable, findings focus on 1998-2001. The number of adult (18-65) new entrants to mental health treatment in Monroe County has decreased from 1998 to 2001. In Monroe County, the number fell from 4,395 adults in 1998 to 4,195 adults in 2001, a 4.5% decrease. The corresponding change in the number per 1,000 adults decreased from 9.7 in 1998 to 9.3 in 2001. Rates in the city are typically slightly more than twice the rates in the suburbs. For more detailed information, see Appendix Table 51.

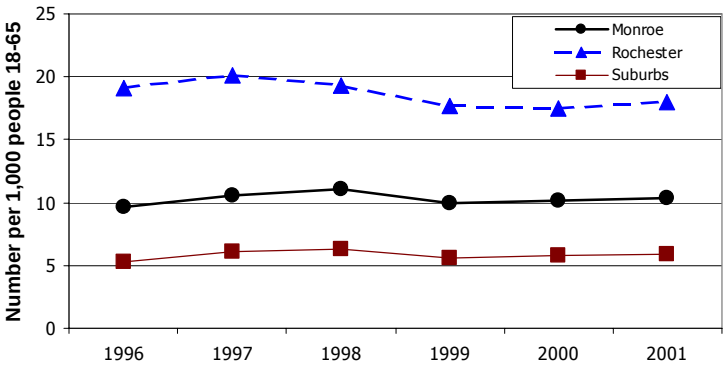
Caveats: Reported city and suburban rates from 1998-2001 are slightly undercounted, as some county residents using services those years could not be accurately allocated to city or suburban locations. Prior to 1998, data were collected in a different manner by a different firm and may not be comparable to data in subsequent years. Changes over time in the number of people receiving treatment may be attributed as much to changes in the system and to health insurance coverage as to seriousness of mental illness or the community's ability to improve the collective mental health of the population.

Measure: Individuals Receiving Mental Health Crisis Services

Definition: This measure represents the rate per 1,000 adults (18-65) receiving mental health crisis services in emergency departments or outpatient mental health crisis clinics in Monroe County.

CGR

Crisis Mental Health Services: Ages 18-65



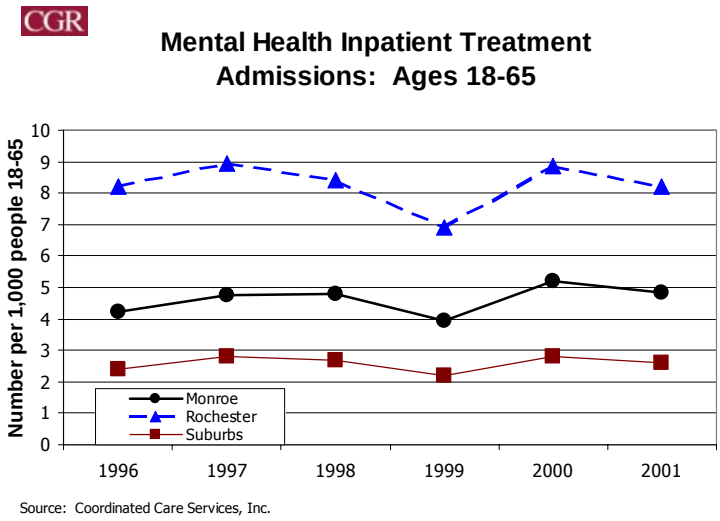
Source: Coordinated Care Services, Inc.

Findings: The number of Monroe County adults (age 18-65) receiving crisis mental health services has decreased very slightly between 1998 and 2001. For the county as a whole, the number of adults receiving crisis mental health services fell 5.9% from 1998 to 2001, from 4,989 to 4,693 people. These numbers translate to 11.1 and 10.4 adults, respectively, per 1,000 adult Monroe County residents. In the city, rates of clients receiving crisis services are typically about three times higher than among suburban residents. For more detailed information, see Appendix Table 52.

Caveats: Reported city and suburban rates for 1998-2001 are slightly undercounted, as some county residents using services those years could not be accurately allocated to city or suburban locations. Prior to 1998, data were collected in a different manner by a different firm and may not be comparable to date in subsequent years. The data do not include patients receiving services from private practitioners.

Measure: Individuals Admitted to Mental Health Inpatient Services

Definition: This measure reflects the rate per 1,000 adults (18-65) receiving mental health inpatient services in hospital psychiatric units in Monroe County.



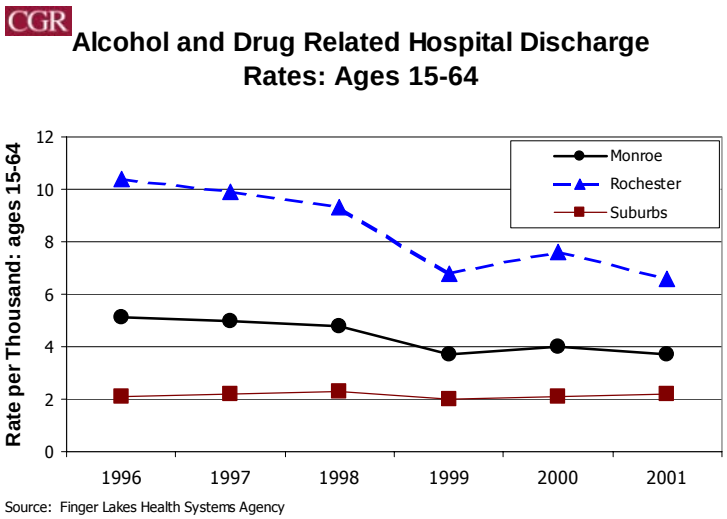
Source: Coordinated Care Services, Inc.

Findings: The number of Monroe County adults (18-65) receiving inpatient mental health treatment has varied in recent years, but with the rate typically hovering around 5 admissions per 1,000 adults. For example, in 2001, 2,182 Monroe County adults received mental health inpatient treatment, a rate of 4.8 per 1,000 adult County residents. Rates and numbers are higher in the City of Rochester than in the suburbs. In the city, rates are typically about three times higher than within the suburbs. For detailed information, see Appendix Table 53.

Caveats: Reported city and suburban rates from 1998-2001 are slightly undercounted, as some county residents using services those years could not be accurately allocated to city or suburban locations. Prior to 1998, data were collected in a different manner by a different firm and may not be comparable to data in subsequent years. The data do not include patients receiving services from private practitioners.

Measure: Alcohol and Drug-Related Hospital Discharges

Definition: This measure reflects the rate per 1,000 individuals 15-64 discharged from Monroe County hospitals due to alcohol or drug-related illnesses and/or injuries.



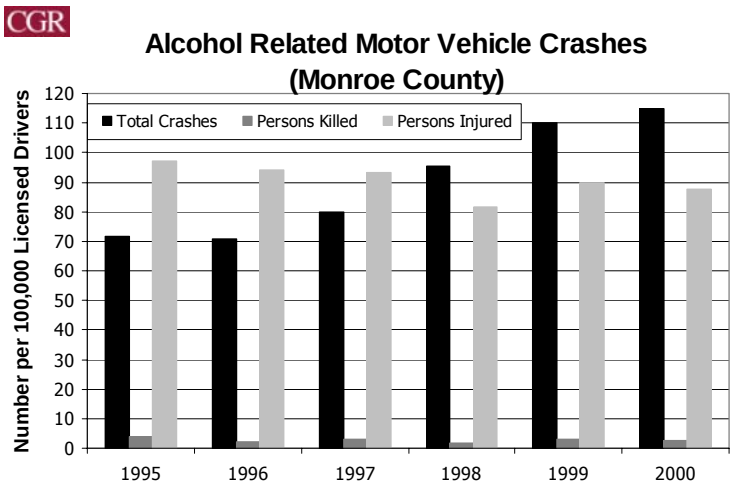
Source: Finger Lakes Health Systems Agency

Findings: The number of Monroe County adults (15-64) discharged from the hospital due to alcohol or drug-related illnesses and/or injuries has decreased in the county as a whole and in the City of Rochester, with relatively little change in the suburbs from 1996-2001. Countywide, the numbers decreased 28.6%, from 2,505 to 1,788. The rate fell from 5.1 to 3.7 per 1,000 Monroe County adults. The decrease in the City of Rochester was even more dramatic, as the number fell 41%, from 1,860 in 1996 to 1,098 in 2001. The rate fell from 10.4 to 6.6 per 1,000 city adults. In the suburbs, the numbers during this time varied from a low of 605 in 1999 to a high of 698 in 1998. During this time, the rate was consistently 2.1. or 2.2 per 1,000 suburban adults. For more detailed information, see Appendix Table 54.

Caveats: Hospital discharge numbers may be understated due to those patients who do not disclose alcohol or drug use prior to or during their hospital stay. Any changes over time in the number of cases which require hospitalization may be attributable, in part, to changes in the health care system and to health insurance coverage.

Measure: Alcohol-Related Motor Vehicle Crashes

Definition: The number of alcohol-related motor vehicle crashes, by drivers of all ages, expressed as a rate per 100,000 licensed drivers. This measure also includes the number of persons killed and number injured in alcohol-related crashes, also expressed as rates per 100,000 licensed drivers.



Source: New York State Department of Motor Vehicles

Findings: In Monroe County, the total number of alcohol related motor vehicle crashes increased 64% between 1995 and 2000. In 2000, there were 577 alcohol-related motor vehicle crashes countywide, or 114.6 per 100,000 licensed drivers, up from 352 crashes in 1995 (71.5 per 100,000). During the same period, the NYS-excluding-NYC region also experienced a significant (40%) increase in the number of alcohol-related crashes, and in 1999 and 2000, the larger region's rate was comparable to Monroe County's. In prior years, Monroe County's rate had been consistently lower than the rate for the larger region. While both regions have experienced significant increases in the number of alcohol-related crashes since 1995, the number and rate of persons killed and the number and rate of persons injured as the result of such crashes have declined. In both cases, Monroe County death and injury rates have been consistently lower than the Upstate rates. Data for this measure are presented in Appendix Table 55.

Caveats: Changes in the number of alcohol related crashes may be affected by factors such as varying levels of awareness regarding the dangers of drinking and driving, increased or decreased use of designated drivers, and targeted surveillance by law enforcement agencies.

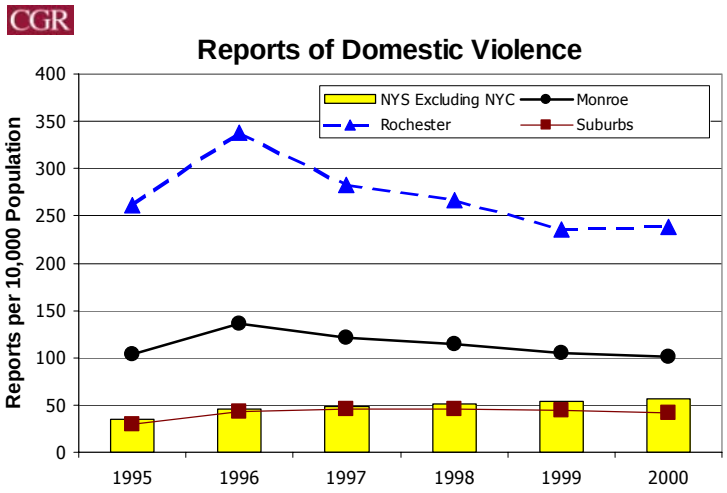
Outcome II: Personally Safe Families

- Reports of Domestic Violence
- Murder Rates
- Reported Part I Violent Crime Rates
- Reported Part I Property Crime Rates
- Reported Part II Crime Rates
- Self-Reported Youth Weapon Use
- Self-Reported Youth Victimization
- *Indicated Cases of Child Abuse and Neglect (initially presented in the Success by 6 chapter)*

Since the mid-1990s, at the overall county level, five measures in this area have improved, two have worsened, and one has shown little change.

Measure: Reports of Domestic Violence

Definition: The number of domestic violence incidents reported to law enforcement, regardless of whether a formal complaint was filed or an arrest made. This measure is expressed as a rate per 10,000 population.



Source: Information Systems Unit, Rochester Police Department and New York State Division of Criminal Justice Services

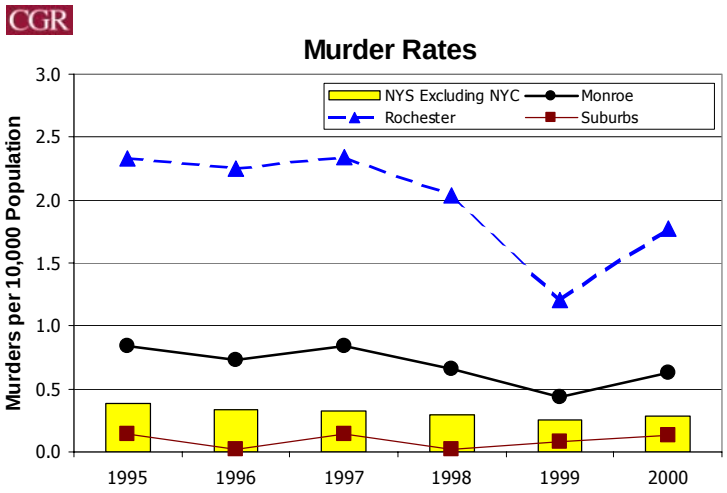
Findings: Countywide, reports of domestic violence steadily decreased from 9,748 in 1996 to 7,403 in 2000 (a 24% decline). While the number of domestic violence reports in the city has declined by nearly 32%, reporting rates in the city have consistently been several times higher than suburban rates. In 2000, 5,236, or about 71% of all reports countywide, occurred in the city.

The number of domestic violence reports occurring in suburban areas increased 53%, from 1,416 in 1995 to 2,167 in 2000. However, since 1997, both the number of suburban reports and the rate have slowly but steadily declined (from 2,272 or 46.4 per 10,000 in 1997 to 2,167 or 42.0 per 10,000 in 2000). The suburban rates have consistently been slightly below the NYS-excluding-NYC region's rates, though the overall countywide and city rates have been much higher than the larger region's rates. Data for this measure are presented in Appendix Table 56.

Caveats: For a variety of reasons, not all victims report abuse to law enforcement officers; therefore, reports of domestic violence to law enforcement understate the actual occurrence of acts of domestic violence. Reporting may also be influenced by factors such as education, outreach, and media publicity.

Measure: Murder Rates

Definition: The murder rate is the number of reported murders, expressed as a rate per 10,000 population. Excluded from this category are deaths caused by negligence, suicide, or accidents; justifiable homicides; and attempted murder.



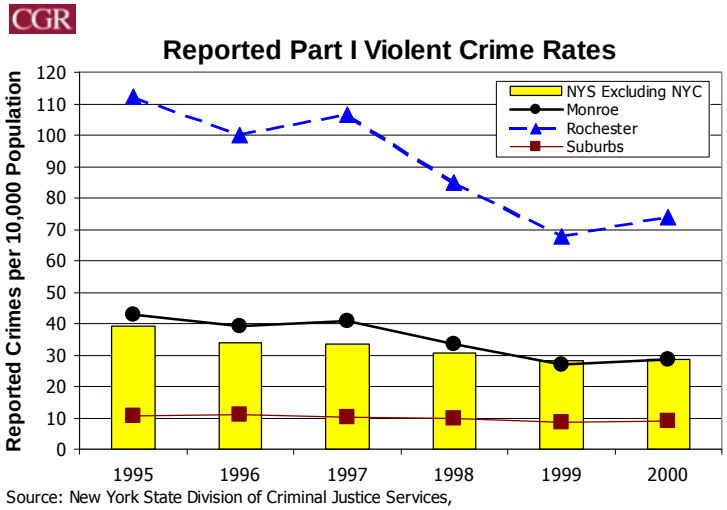
Source: New York State Division of Criminal Justice Services, Uniform Crime Reporting System

Findings: Murder rates in Monroe County have consistently been below 1 per 10,000 since 1995. However, these rates still represent between 31 and 60 murders each year countywide, with the vast majority consistently occurring in the city. While murder rates in the city declined by almost half from 1997 to 1999 (from 53 murders in 1997 to 27 in 1999), the number and rate increased in 2000 to 39 and 1.8 per 10,000 respectively. Throughout the six-year study period, murder rates in the county were consistently higher than the NYS-excluding-NYC rate (though typically less than .5 per 10,000 higher). Data for this measure are presented in Appendix Table 57.

Caveats: These rates represent reported murders and not necessarily the charges reflected in the ultimate disposition of the case.

Measure: Reported Part I Violent Crime Rates

Definition: The number of reported Part I violent crimes per 10,000 population including murder, non-negligent manslaughter, forcible rape, robbery, and aggravated assault. Part I violent crimes are defined by the FBI for consistent reporting purposes across jurisdictions and reported by law enforcement agencies on Uniform Crime Reports.



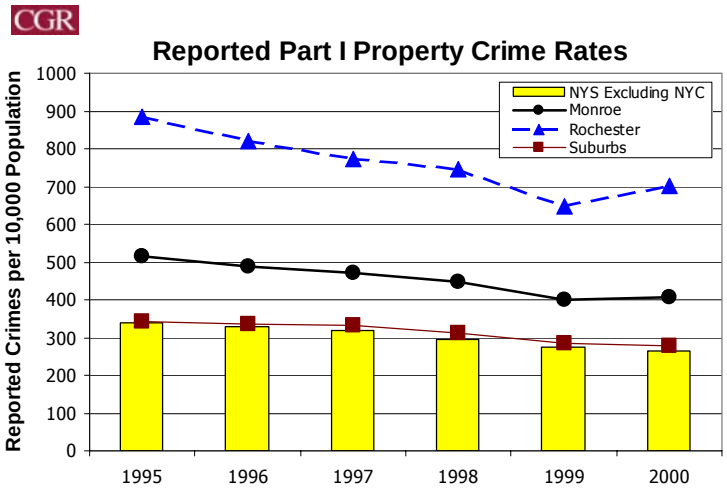
Source: New York State Division of Criminal Justice Services, Uniform Crime Reporting System

Findings: Countywide, in 2000, there were 32% fewer reports of Part I violent crimes than in 1995. While rates for the city of Rochester have been variable during the six-year study period, overall, the rate of reported violent crime in the city declined from 112.1 per 10,000 in 1995 to 74.0 per 10,000 in 2000. However, in 2000, more than three quarters of the 2,089 reports of violent crime in Monroe County occurred in the city. Suburban rates have been both significantly lower, between 8.6 and 10.8 per 10,000, and less variable over time compared to the larger regions. NYS-excluding-NYC rates have been comparable to countywide rates in recent years, and similar to Monroe County, from 1995 to 2000, the comparison region experienced a substantial (24%) decline in the number of reported Part I violent crimes. Data for this measure are presented in Appendix Table 58.

Caveats: Not all Part I crimes are reported to law enforcement; rape for example, is underreported. Kidnapping and arson numbers are not reflected in these trends although they are considered violent felony offenses in New York State. This is because the FBI considers these Part II crimes for reporting purposes.

Measure: Reported Part I Property Crime Rates

Definition: The number of reported serious, or Part I, property crimes per 10,000 population. Part I property crimes are defined by the FBI for consistent reporting purposes across jurisdictions and include burglary, larceny, and motor vehicle theft.



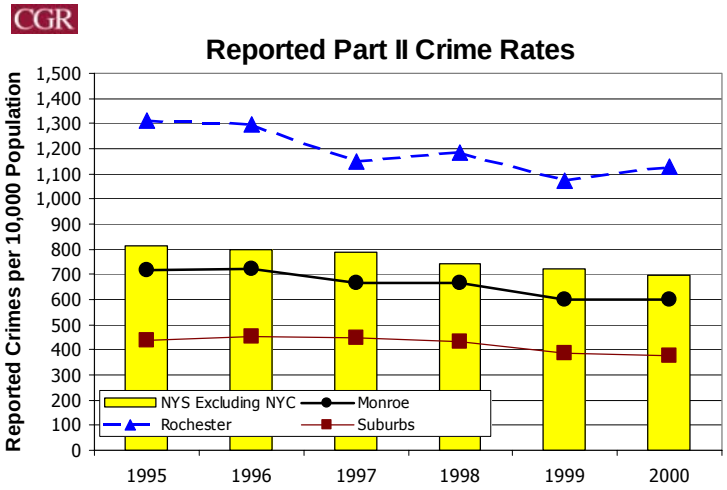
Source: New York State Division of Criminal Justice Services, Uniform Crime Reporting System

Findings: In 2000, there were 29,845 reported Part I property crimes countywide, or 19% fewer when compared to 1995 (a reduction in rate from 516 to 405.9 per 10,000 population). Suburban reports were down by 14% during the same time period. From 1995 to 1999 in the city of Rochester, reported Part I property crimes fell by 28% (from 20,169 in 1995 to 14,578 in 1999). In 2000, both the number and rate of reported property crimes in the city increased, with 15,438 reports, or 702.6 per 10,000, but still well below the 1995 city rates. Throughout the study period, the suburban and NYS-excluding-NYC rates have been comparable, with the suburbs slightly higher. Data for this measure are presented in Appendix 59.

Caveats: Not all Part I property crimes that occur are reported to the police. For example, burglary and motor vehicle theft tend to be reported more frequently than other property crimes due to insurance claim issues.

Measure: Reported Part II Crime Rates

Definition: Number of reported Part II crimes per 10,000 population, including simple assault, disorderly conduct, DWI, sale/use of controlled substances, criminal mischief, fraud, forgery, stolen property, unauthorized possession of weapons, prostitution, sex offenses other than forcible rape, arson, kidnapping, extortion, gambling, embezzlement, family offenses, unauthorized use of motor vehicle, bribery, loitering, disturbing public order, breaking liquor laws and various other offenses.



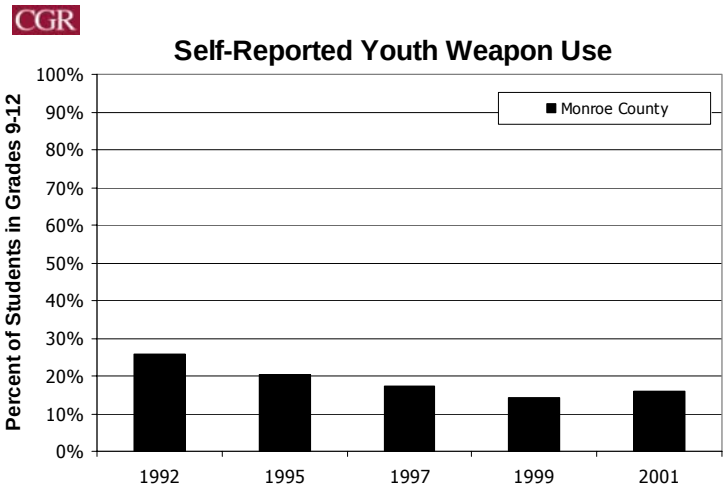
Source: New York State Division of Criminal Justice Services, Uniform Crime Reporting System

Findings: Since 1995, each of the geographic areas presented here have seen reductions in both the number and rate of reported Part II crimes. Countywide, in 2000, there were 44,156 reported Part II offenses (14% fewer than in 1995). The number of reported offenses in the city decreased by 17% between 1995 and 2000. However, while more than half of all reports countywide occurred in the city, the city's rate remains nearly two and a half times higher than the suburban rate. The NYS-excluding-NYC rate has averaged about 100 per 10,000 higher than the countywide rate throughout the study period. Data for this measure are presented in Appendix Table 60.

Caveats: As with Part I offenses, not all Part II incidents are reported to police.

Measure: Self-Reported Youth Weapon Use

Definition: The percentage of Monroe County public high school students (grades 9-12) who reported carrying a weapon in the 30 days preceding the administration of the County's Youth Risk Behavior Survey.



Sources: Monroe County Health Department, Youth Risk Behavior Survey

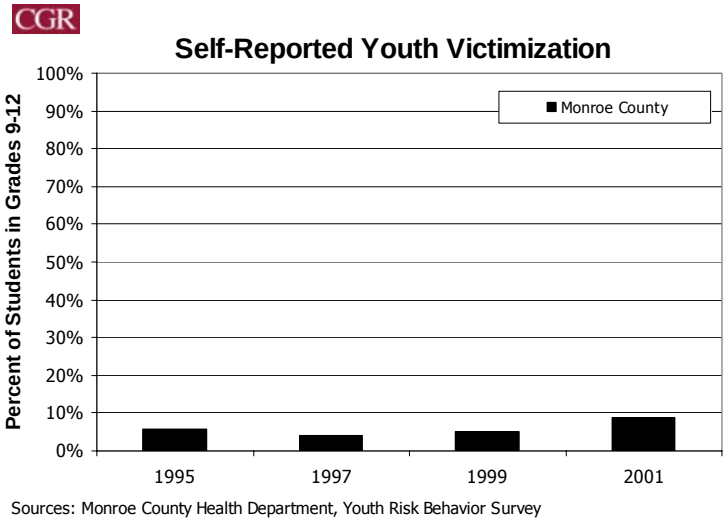
Data are taken from the Monroe County Youth Risk Behavior Survey, conducted in 1992, 1995, 1997, 1999, and 2001. The survey is administered in all public high schools within Monroe County and only aggregate (countywide) findings are published. The survey will be administered again in 2003.

Findings: The proportion of 9th – 12th-grade students who reported carrying a weapon in the past 30 days steadily declined, from 25.7% in 1992 to 14.3% in 1999, and remained stable in 2001. Data for this measure are presented in Appendix Table 61

Caveats: None.

Measure: Self-Reported Youth Victimization

Definition: The proportion of Monroe County public high school students (grades 9-12) who reported that they missed school one or more days in the month preceding the administration of the Youth Risk Behavior Survey because they felt unsafe going to or from school.



Sources: Monroe County Health Department, Youth Risk Behavior Survey

Data are taken from the Monroe County Youth Risk Behavior Survey, conducted in 1992, 1995, 1997, 1999, and 2001. The survey is administered in all public high schools within Monroe County and only aggregate (countywide) findings are published. The survey will be administered again in 2003.

Findings: From 1995 to 2001, the proportion of high school students who reported missing school one or more days in the past month because they felt unsafe going to or from school increased slightly from 5.7% to 8.7%. However, the 2001 reported rate was twice the proportion reported in 1997. Data for this measure are presented in Appendix Table 62.

Caveats: None.

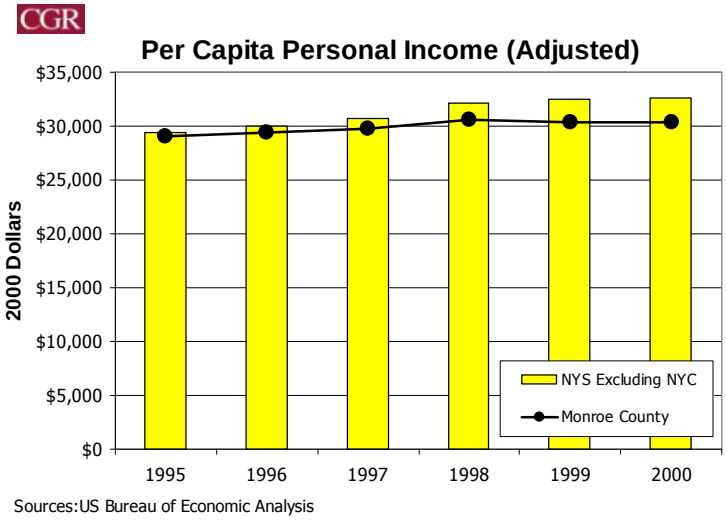
Outcome III: Financially Secure Families

- Per Capita Personal Income
- Average Annual Wages
- Households Experiencing Difficulty Paying Utility Bills
- Unemployment Rate
- Annual Growth in New Jobs
- Public Assistance Cases Closed Due to Employment
- Employment by Sector
- Temporary Employment
- Self-Reported Health Insurance Coverage

Since the mid-1990s, at the overall county level, two measures in this area have improved, three have shown decline, two have shown little change, and the progress of two measures is undetermined.

Measure: Per Capita Personal Income

Definition: Total personal income is derived from net earnings, dividends, interest, rent, and transfer payments (income maintenance, unemployment insurance, retirement, etc.) divided by the total population. Data have been adjusted to year 2000 dollars.



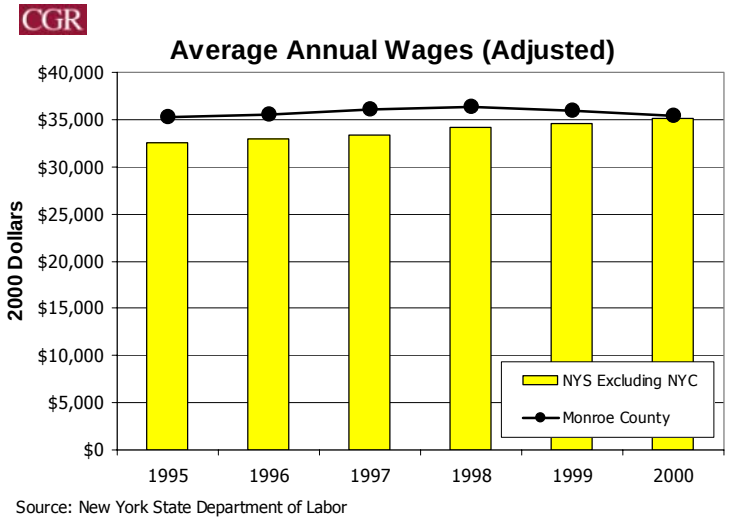
Sources:US Bureau of Economic Analysis

Findings: Since 1995, annual per capita personal income has slowly increased in Monroe County. In 2000, the per capita income level (adjusted for inflation) had risen to $30,391, or 4.5% higher than the 1995 level. In 1995 and 1996, the NYS-excluding-NYC region's per capita income level was comparable to Monroe County's level, but from 1997 through 2000, the county per capita figure has fallen increasingly behind that of the larger region (in 2000, the NYS-excluding-NYC per capita personal income level was approximately $2,200 higher than Monroe County's). Nominal and adjusted data are presented in Appendix Table 63.

Caveats: Annual per capita income data have been adjusted to year 2000 values using the Consumer Price Index.

Measure: Average Annual Wages

Definition: This measure reflects the average yearly wage paid to employees in all industry types, and is derived by dividing the total wages for the year by the average monthly employment. These data provide an average annual wage per worker (not family), and have been adjusted to 2000 dollars.



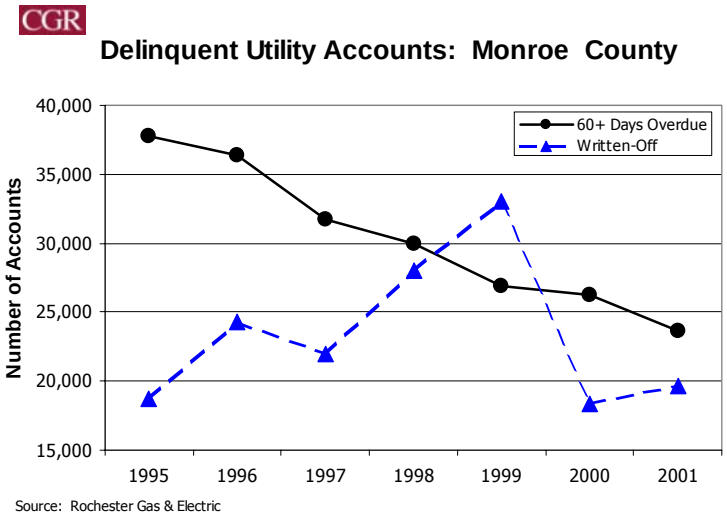
Source: New York State Department of Labor

Findings: Average annual wages in Monroe County increased 3% from 1995 to 1998 (from $35,237 to $36,305), but by 2000, the average annual wages had fallen to $35,423. Additionally, while Monroe County's average annual wage declined in the last two years of the study period, the average wage in the NYS-excluding-NYC region continued its steady upward trend. While the average annual wage amount in the larger region has not yet surpassed the County's, the gap between the two areas has lessened from more than $2,600 difference in 1995 to virtually no difference in recent years. Data for this measure are presented in Appendix Table 64.

Caveats: Data include information only for workers covered by unemployment insurance and reflect place of employment, not place of residence. Annual average wage data have been adjusted to year 2000 values using the Consumer Price Index.

Measure: Households Experiencing Difficulty Paying Utility Bills

Definition: The number of Rochester Gas & Electric customer accounts in arrears (60 days past due in August of each year) and the number of accounts written-off. RG&E is the largest power supplier for Monroe County, servicing the vast majority of the county for electricity and gas. By including both accounts in arrears and those that have been written off, the measure is shielded from changes in accounting strategies.

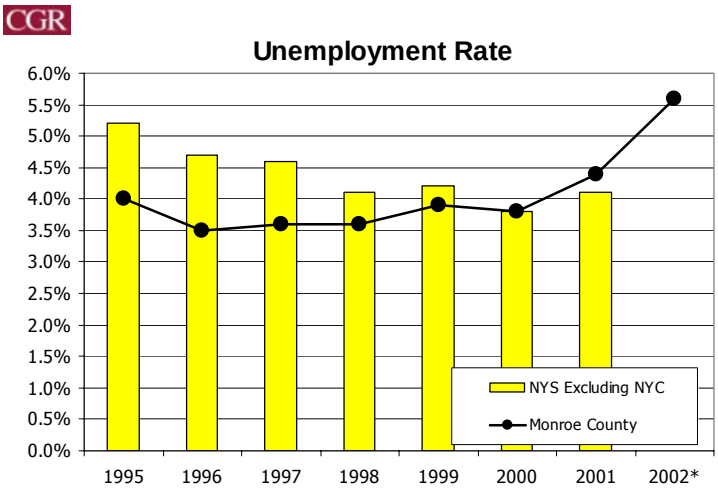


Findings: Since we began collecting data in 1990, the number of accounts in arrears trended upward, peaking in 1995 at 37,751. After 1995, the number of accounts in arrears has declined steadily, to the 2001 level of 23,685 (a 37% reduction). The number of accounts written-off has been less consistent. From 1990 to 1994, the number of accounts written-off increased gradually each year. In 1995, the number fell below 20,000, but by the following year, it had resumed its upward trend, peaking at 33,076 in 1999. For the past two years, the number of accounts written-off is once again below 20,000. For more detailed information, see Appendix Table 65.

Caveats: Although Rochester Gas & Electric is a large provider, it is not the only utility company serving Monroe County. We may need to revise this measure in the future with the deregulation of the energy market adding to the number of competitors. Delinquent accounts include both those customers unable to pay and those customers who choose not to pay. Presumably, the ratio of those unable to pay and those unwilling to pay remains constant over time.

Measure: Unemployment Rate

Definition: Unemployed individuals are those persons age 16 and older who were not employed, but were able, available and actively seeking work during the reference week. The unemployment rate is the number of unemployed per 100 persons in the labor force (the total number of employed and unemployed individuals). Rates represent the annual average.



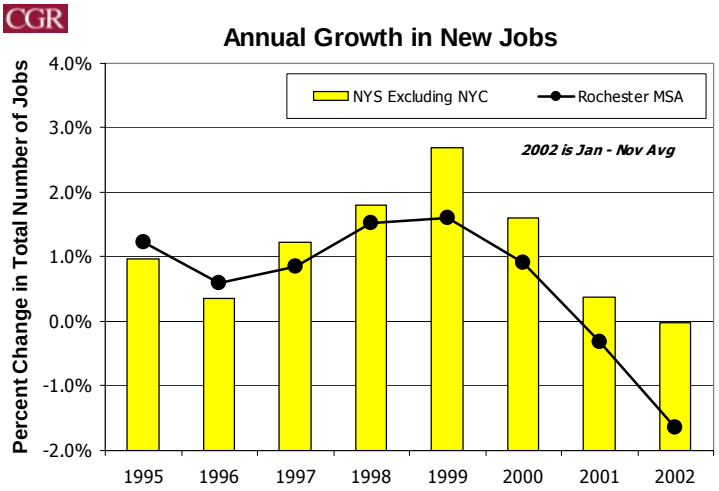
*2002 data are the Jan - Nov monthly average
Source: New York State Department of Labor

Findings: From 1995 through 2000, Monroe County's annual unemployment rate varied between 3.5% and 4%. In each year since 2000, the rate has increased substantially, and the January – November monthly average unemployment rate in 2002 reached a 13-year high of 5.6%. Additionally, in 2000, Monroe County's unemployment rate climbed above the rate for the NYS-excluding-NYC region for the first time since 1995. The 2002 January – November monthly average of 21,000 unemployed county residents represented a 50% increase over the 2000 monthly average of 14,000 individuals. Data for this measure are presented in Appendix Table 66.

Caveats: The unemployment rate represents only those individuals who are actively seeking employment, and does not count individuals who may be under-employed, or discouraged workers who are no longer actively seeking a job. 2002 data reflect the Jan – Nov average; all other data reflect average annual numbers and rates. The data presented here have not been seasonally adjusted.

Measure: Rate of Job Growth

Definition: The net number of new jobs created is calculated from annual average employment data. The graph for this measure represents the growth in new jobs, expressed as the annual percentage change in the total number of jobs.



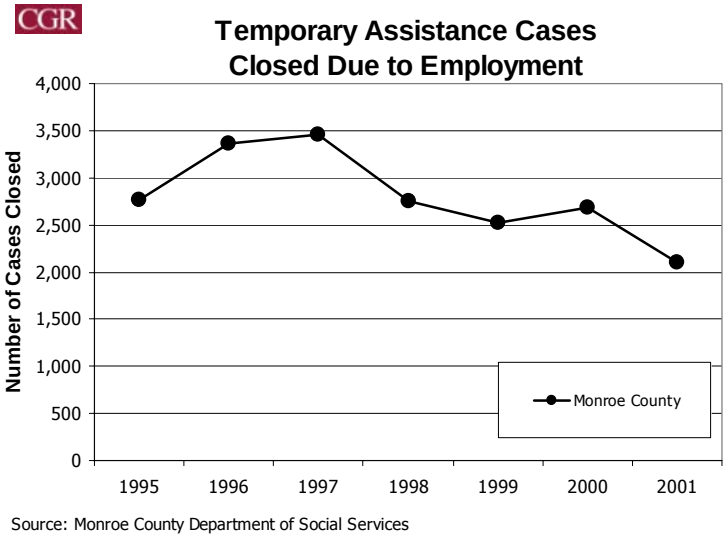
Source: New York State Department of Labor

Findings: Between 1995 and 2000, the number of jobs in the Rochester MSA grew by 5.6% (29,270 jobs). The highest levels of growth occurred in 1998 and 1999, with annual gains of 1.5% and 1.6% respectively. However, in 2001 and 2002, the Rochester MSA lost jobs, and in 2002 there were almost 11,000 fewer jobs compared to 2000. The NYS-excluding-NYC region has fared somewhat better than the Rochester region on two fronts. The larger region experienced higher levels of growth in the late 1990s, and while growth slowed from 2000 through 2002 (with no growth in 2002), the region overall did not lose jobs. Data for this measure are presented in Appendix Table 67.

Caveats: These data include full-time and part-time non-farm jobs. The Department of Labor tracks job growth at the MSA level (Metropolitan Statistical Area) rather than at the individual county level. The Rochester MSA incorporates Monroe, Livingston, Ontario, Genesee, Wayne, and Orleans Counties.

Measure: Public Assistance Cases Closed Due to Employment

Definition: This measure shows the number of temporary assistance cases closed each year as a result of job placement.



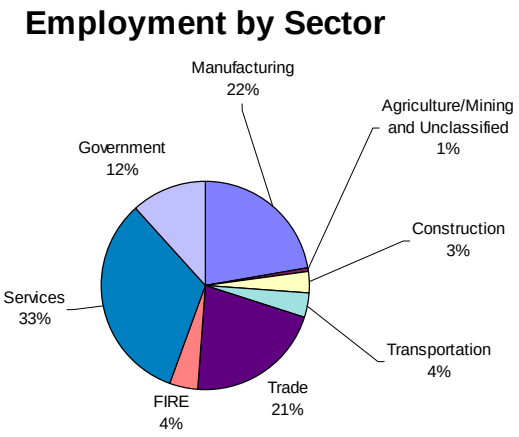
Source: Monroe County Department of Social Services

Findings: Between 1995 and 2001, in Monroe County, a total of 19,646 temporary assistance cases were closed due to employment. The number of employment-related case closings peaked at 3,464 in 1997, and by 2001, that number had fallen to 2,104 (a 39% reduction). Data for this measure are available only at the county level and are presented in Appendix Table 68.

Caveats: It is not clear whether the declines reflect some combination of fewer job placement opportunities in this economy, smaller temporary assistance caseloads, or the fact that the more skilled individuals have previously been moved from welfare to work.

Measure: Employment by Sector

Definition: This measure shows the percentage of the labor force engaged in various sectors of the economy. Data are based on SIC-codes. Beginning with 2001, the Department of Labor is replacing the SIC-codes with NAICS-codes. SIC-codes and NAICS-codes are not comparable.



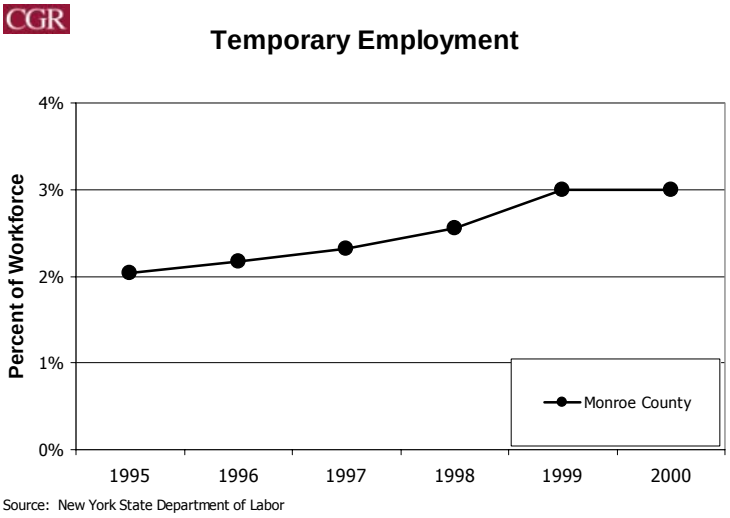
Source: New York State Department of Labor

Findings: Over the past decade, employment in the service, transportation, government, trade, and agriculture, mining and unclassified sectors has increased, while employment in the manufacturing, construction, and FIRE (financial, insurance, and real estate) sectors has fallen. The greatest percentage increases between 1990 and 2000 have taken place in services (31%), transportation (24%) and government (13%). The greatest percentage decreases have taken place in manufacturing (22%) and FIRE (11%). Manufacturing has declined from 29% of total employment in 1990 to 22% in 2000. At the same time, the service sector has increased from 26% of employment in 1990 to 33% in 2000. For more detailed information, see Appendix Table 69.

Caveats: Previous years' data were updated this year, so values in this year's report will not match values in previous reports.

Measure: Temporary Employment

Definition: This measure represents the percentage of the workforce that is employed by temporary agencies (SIC=7363). This measure does not capture contract/temporary workers on private payrolls, such as at Kodak or Xerox. It also does not capture seasonal workers.



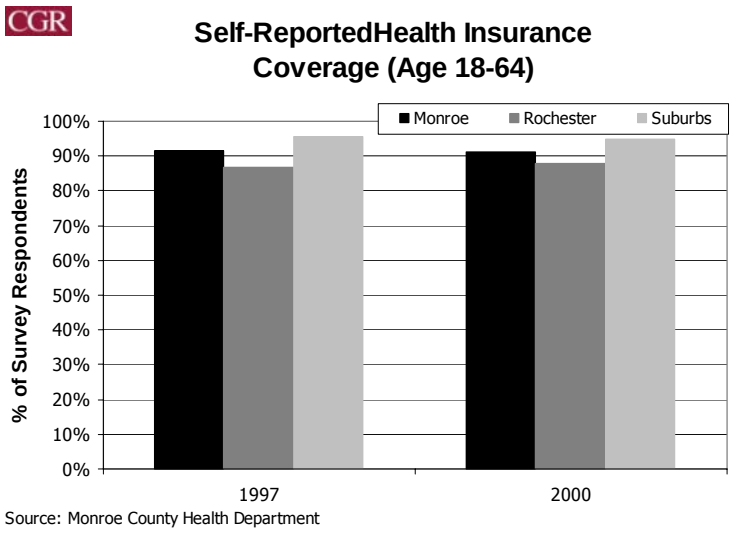
Source: New York State Department of Labor

Findings: Temporary employment increased by one percentage point of the local workforce from 1995 to 2000. In 1995, 7,373 Monroe County residents were employed by temporary agencies. By 2000, this number had increased 45.0%, to 10,694 Monroe County residents. Data is only available at the County level. For more information, see Appendix Table 70.

Caveats: Since the contract/temporary and seasonal data are not available, this measure represents only an unknown proportion of the total population of temporary workers.

Measure: Self-Reported Health Insurance Coverage

Definition: The percentage of Monroe County Adult Health Survey respondents, ages 18 through 64, who reported that they had health insurance coverage.



Source: Monroe County Health Department

Findings: Countywide, in 2000, about nine out of ten adult respondents ages 18 - 64 reported that they had health insurance coverage. In both 1997 and 2000, a slightly higher proportion of respondents residing in the suburbs reported having insurance coverage, compared to respondents living in the city. Data are presented in Appendix Table 71.

Caveats: See discussion of survey data.

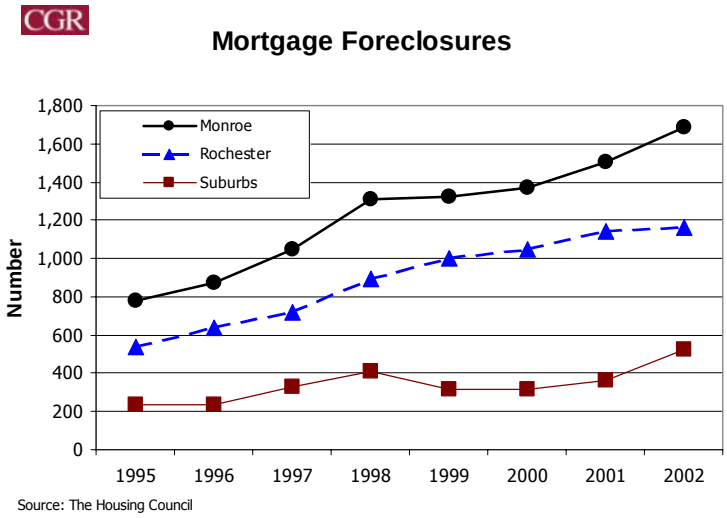
Outcome IV: Appropriately Housed Families

- Mortgage Foreclosures
- Tax Foreclosures
- Emergency Placements in Homeless Shelters
- Home Mortgage Loans
- Dispersion of Low Income Households

Since the mid-1990s, three measures in this outcome area have shown movement away from the desired outcome, and two have improved.

Measure: Mortgage Foreclosures

Definition: Annual number of mortgage foreclosures.

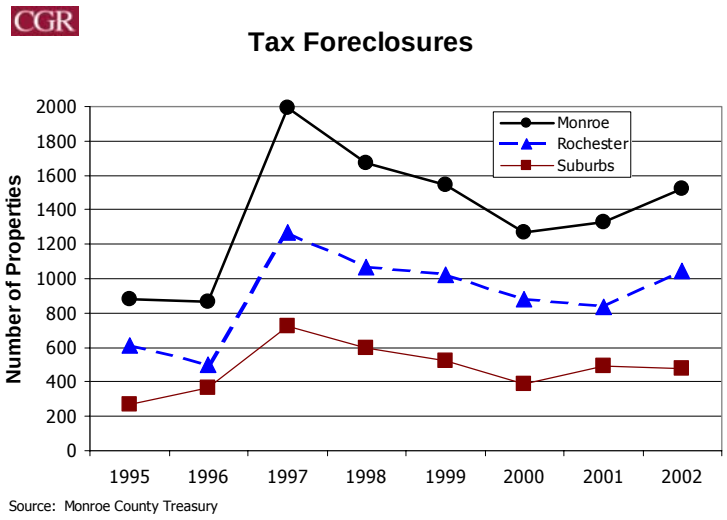


Findings: The total number of mortgage foreclosures in Monroe County has steadily increased since 1995. For Monroe County as a whole, the number of mortgage foreclosures has increased 117%, from 777 in 1995 to 1,687 in 2002. In the City of Rochester, the number of mortgage foreclosures increased 115%, from 539 in 1995 to 1,161 in 2002. In the suburbs, the number of mortgage foreclosures increased from 238 in 1995 to 526 in 2002, a 121% increase. A decrease in the number of foreclosures would reflect an increase in homeownership and financial security. For more detailed information, see Appendix Table 72.

Caveats: This measure can be affected by matters that are not strictly related to household finances such as death, marital separation, and downturns in the real estate economy. The total number of mortgage foreclosures may be slightly greater than the sum of foreclosures in the City of Rochester and the suburbs because in some years, foreclosures take place on properties for which the location is unknown to the Housing Council.

Measure: Tax Foreclosures

Definition: Properties with filings of Lis Pendens (this is the first step of the foreclosure process).



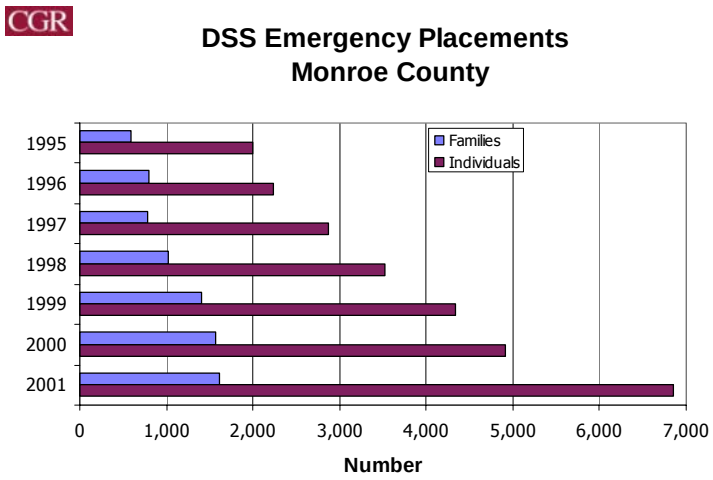
Source: Monroe County Treasury

Findings: Although there is much fluctuation over the study period, the number of tax foreclosures has generally been increasing since 1990, with a high of almost 2,000 in 1997. Since then, foreclosures have decreased, but still remain higher on average than in the early and mid-1990's. Although declining since the peak year of 1997, tax foreclosures in 2001 remained significantly higher than in the mid-1990's, in both the city and suburban areas. In the City of Rochester, the number of tax foreclosures was 36.8% higher in 2001 (836) than in 1995 (611), although there have been both increases and decreases in between. In the suburbs, the number of tax foreclosures increased 82.2%, from 270 in 1995 to 492 in 2001 with considerable variations in the intervening years. For more detailed information, see Appendix Table 73.

Caveats: This measure should be evaluated in conjunction with mortgage foreclosure data.

Measure: Emergency Placements in Homeless Shelters

Definition: The number of separate placements made each year in Rochester's emergency shelter facilities and paid for by the Department of Social Services.



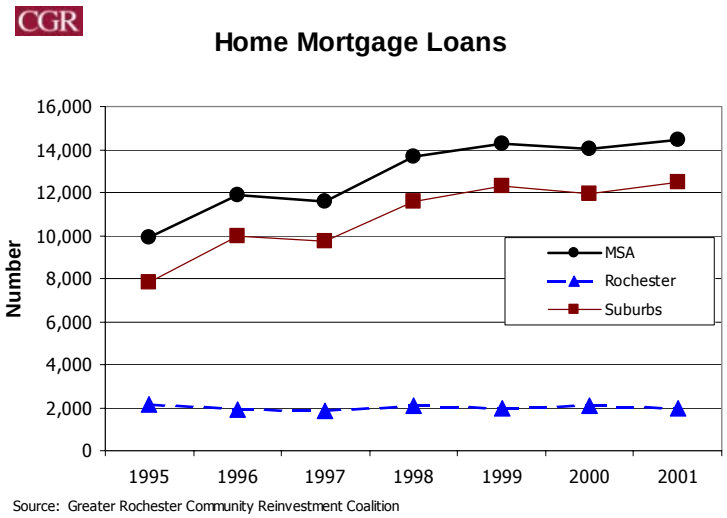
Source: Monroe County Department of Social Services

Findings: Since 1991, the total number of emergency placements has increased each year (See Appendix: Table 74); the total number of placements in 2001, 8,472, was over four times as large as the number in 1991, 1,809. Much of this increase is being driven by the large increase in the number of placements for single individuals. Since 1995, the number of single individuals receiving emergency housing has more than tripled and the number of families receiving emergency housing has more than doubled. Data were only available at the county level.

Caveats: These data reflect the total number of placements, not the individuals involved. Thus, individuals placed more than once would be counted each time, making it impossible to obtain a non-duplicated count of homeless persons. On the other hand, a family unit is counted only once per placement, as other family members are not included in the totals. Data are a product of both supply of emergency housing as well as demand for shelter. Increases in the number of shelter slots provided does not necessarily reflect increased demand. Totals also do not include significant numbers of placements in transitional housing for homeless persons, nor do they include those who are homeless but not served by any shelter. Domestic violence cases began to be included in 1992.

Measure: Home Mortgage Loans

Definition: Includes conventional and FHA loans on owner-occupied 1-4 family unit property in the Rochester metropolitan area.



Source: Greater Rochester Community Reinvestment Coalition

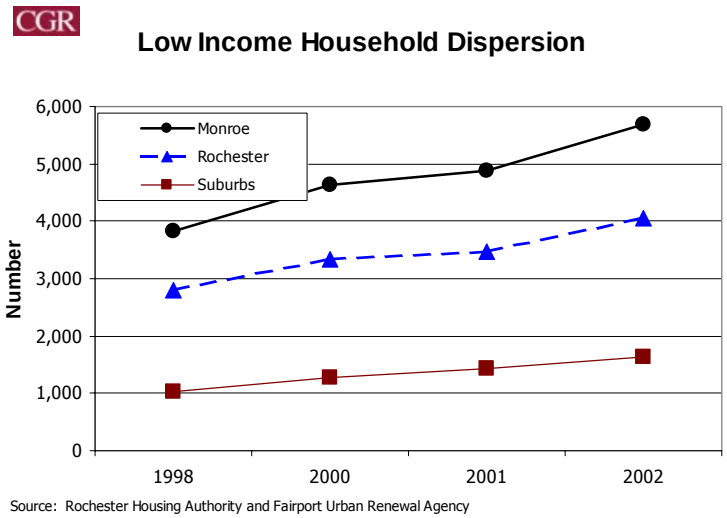
Findings: The number of home mortgages has been increasing steadily over the past few years (up 46% from 1995 to 2001), largely driven by more mortgages in the areas surrounding the city. The number of mortgages written for property in the City of Rochester has held fairly constant over these years. The percentage of all mortgages written for properties in the City of Rochester fell from a high of 21% in 1995 to 14% in 2001.

On average, about three-quarters of mortgages in the suburbs are conventional. In contrast, one-half to two-thirds of City of Rochester mortgages are conventional. Data for this measure are presented in Appendix Table 75.

Caveats: County-level data are not available, so the data is for the Metropolitan Statistical Area, which includes locations outside Monroe County. For this report, we began using mortgage data for owner-occupied homes only (not all mortgages). In addition, we only included loans for initial home purchases. We did not include home improvement loans or refinanced mortgages.

Measure: Dispersion of Low Income Households

Definition: This measure shows the distribution of households receiving Section 8 Certificates and Vouchers. To be admitted into the Section 8 program, income must be 50% or less of the area median income, adjusted for family size. Participants retain eligibility until income reaches 80% of the area median, with the subsidy decreasing as income increases. Single persons are eligible; however, preference is given to single persons who are elderly (over age 62), handicapped or disabled.



Source: Rochester Housing Authority and Fairport Urban Renewal Agency

Findings: The City of Rochester is home to more than 70% of people receiving Section 8 vouchers in Monroe County. Rochester Housing Authority vouchers can be used throughout the metropolitan area, whereas Fairport Urban Renewal Agency vouchers can only be used in the suburbs. The number of vouchers available has continued to increase over the five year period examined. Between 1998 and 2001, the number of households receiving Section 8 vouchers increased by 45% in the city, and by 57% in the suburbs, suggesting some slight increases in dispersion of low-income households throughout the county. Data for this measure are presented in Appendix Data Table 76.

Caveats: This measure does not include low income households living in all types of housing. No data were available for 1999.

Additional Resources

For additional information pertaining to the outcomes and measures included in this chapter, as well as information on related topics, see the following:

- New York State Department of Health, http://www.health.state.ny.us/
- New York State Department of Labor, http://www.labor.state.ny.us/
- New York State Office of Children and Family Services, http://www.ocfs.state.ny.us
- The New York State Council on Children and Families, http://www.ccf.state.ny.us/
- The New York State Council on Children and Families *Touchstones/KIDS COUNT 2002 Data Book,* http://www.ccf.state.ny.us/Touchstones/databook02.html
- New York State Office of Temporary and Disability Assistance, http://www.dfa.state.ny.us/
- New York State Office of Alcoholism and Substance Abuse Services, http://www.oasas.state.ny.us/
- New York State Division of Criminal Justice Services, http://www.usdoj.gov/crt/ada/adahom1.htm
- Kaiser Family Foundation, http://www.kff.org/
- Kaiser Family Foundation State Health Facts Online, http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=New+York
- http://www.census.gov
  - Census Bureau Information on Poverty, http://www.census.gov/hhes/www/poverty.html
- New York State Data Center, http://www.nylovesbiz.com/nysdc/default.asp
- U.S. Department of Health, Centers for Medicare and Medicaid Services, http://www.cms.gov
- U.S. Census Bureau, http://census.gov

❖ Healthy People 2010, http://www.healthypeople.gov

VII. HELPING SENIORS IMPACT AREA

Context

This Impact Area is designed to track how well the community is doing in helping seniors maintain healthy, independent, secure lifestyles to the greatest extent possible. Five specific Outcomes have been identified to track progress in these areas: Seniors Enjoying Mental and Physical Well-Being, Seniors Exercising Independence, Productive Seniors, Financially Secure Seniors, and Personally Safe Seniors.

It is difficult to find adequate measures of all community-wide outcomes for seniors. In Monroe County, we have developed a more complete roster of measures for seniors than have other communities throughout the country, but there are some gaps, and some of the measures are not as strong as we would prefer. In particular, there are no current measures for the Seniors Exercising Independence Outcome; only one for Productive Seniors, and none for seniors who work or volunteer; no age-specific data are available on crime affecting seniors; and no consistent data exist on needs of caregivers of the elderly. No one in the community currently maintains consistent, comprehensive annual data on the degree of institutionalization of seniors or complete data on good senior housing options. Thus, there are clearly gaps in the data for the older sector of the population, and the challenge remains, as stated in the first Community Profile in 1999, for the community to find ways to close those measurement gaps.

Several of the measures used for this Impact Area involve responses to community-wide surveys conducted in 1997 and 2000 for the Monroe County Health Department. Some of the questions asked in 1997 were eliminated from the 2000 survey, thus leading to the elimination of some of the measures that had initially been included in this Impact Area in the 1999 Profile. Nonetheless, the self-reported survey findings remain an especially important source of information about non-institutionalized seniors in the community. However, it is important to realize in interpreting these data that the survey was conducted exclusively

by telephone. There is the potential for under-representation in the survey of the non-institutionalized "frail elderly" (typically those over 85). Thus it is important not to overstate the significance or applicability of the self-reported findings to the entire universe of seniors. On the other hand, even if the findings cannot be generalized to the *entire* senior population, the Health Department is confident that they have considerable value for, and are generalizable to, the *vast majority* of seniors living in non-institutional settings in the county.

Relevant Demographic Trends

Based on U.S. Census data:

- Monroe County's population of persons 65 and older increased 7.5% between 1990 and 2000, to a total of 95,779 in 2000.
- The 75-and-older population increased by almost 11,000 people, a 25% increase to 49,311 in 2000; of that, the 85+ population increased by 35%, an increase of about 3,500, to 13,635.
- During that same 10-year period, Rochester's 65+ population *declined* by 22%, with a decrease of more than 6,000 people, to a 2000 total of 21,977. Within the overall total, the numbers of 75+ and 85+ people also declined within the city.
- Between 1990 and 2000, the numbers of people 65 and older in the suburbs grew by 21%; those 75 and older increased by 51% in the suburbs, and the suburban 85+ population grew by 62%. Whereas about two-thirds of the county's overall 65+ population in 1990 lived in the suburbs, that proportion had increased to more than three-quarters by 2000.
- Despite the increases among the older population, there was actually a slight decline of 4% in the number of seniors living in an institutionalized setting, to just under 6,000 people in 2000.
- Numbers of people 65 and older living alone increased by 10% between 1990 and 2000, an increase of about 2,500 to 28,276.
- Almost 32,750 seniors (36.5% of the non-institutionalized seniors in the county) reported some type of disability or limitation on their activities in 2000. Comparable data were not available for 1990.
- In 2000, 6,681 persons 65 and older lived in poverty in the county, an increase of 12% since 1990. This represents 7.4% of the county's non-institutionalized seniors. Of those, 2,983 (45%) lived in the city, representing a poverty rate of 15.4% of the city's seniors not living in an institutional setting.
- Among households headed by seniors, almost 90% of those 65-74 countywide have access to a vehicle/personal transportation to travel to various services and activities; even among those 75 and older, the proportion exceeds 75%. More than 90% of those owning their own homes have private transportation. However,

among seniors who rent, the proportions drop to about two-thirds of those 65-74, and just over half of those 75+. Within the city, between 40% and 45% of all senior renters, regardless of age, have access to personal transportation. Overall, more seniors had access to personal transportation in 2000 than in 1990.

Summary of Trends

In reviewing the 21 measures which are presented in this chapter, some trends and themes emerge from the data. At the end of each summary statement below, arrows indicate whether the *overall county trend* for a particular measure (irrespective of trends within city and suburbs) reflects *improvement in recent years toward meeting the desired outcome* (⬆), *movement away from the desired outcome* (⬇), or *no significant change* (⬅➡).

Seniors Enjoying Mental and Physical Well-Being

Overall, the county's older residents appear to be relatively healthy. On most of the measures in this Outcome area, the county appears to be at least holding its own, with some areas of improvement needed:

- Self-reported health status has been relatively stable among the county's seniors. In 2000, 21.6% of seniors countywide reported fair or poor health status. However, about one-third of the seniors in the city reported only fair or poor health. (*County progress:* ⬅➡)
- Perhaps helping to contribute to the improved reported health status is the fact that fewer seniors reported that they *did not* engage in any physical activity or exercise in the previous month (down from 40% in 1997 to 34.6% in 2000). (*County progress:* ⬆)
- Since 1995, there have been substantial reductions in the numbers of seniors receiving emergency food meals. These reductions have been partially offset by substantial increases during those years in the numbers of home-delivered and congregate meals served to seniors. However, these changes are at least in part a reflection of availability of resources, and may not indicate the extent of hunger among older residents of the county. (*County progress:* ?)
- In 2000, there was a delay in the availability of the flu vaccine, and this was most likely the cause of the decline of flu immunization rates between 1997 and 2000. However, in both 1997 and 2000, the proportion of seniors immunized fell substantially short of the national Healthy People 2010 target of 90%. (*County progress:* ⬇)
- There was relatively little change in the self-reported proportions of seniors saying they had been told they had high blood pressure or diabetes. However, the proportion of blacks with high blood pressure was much higher than among white seniors. (*County progress:* ⬅➡)

- Mortality rates among seniors remained relatively stable, overall and across specific diseases. There was more fluctuation from year to year within the city, and city rates remained consistently higher than in the suburbs. (*County progress:* ⬅➡)
- Rates of suicide among seniors have remained relatively stable in recent years. White males are consistently at higher risk of suicide than other seniors. (*County progress:* ⬅➡)
- Hospitalization rates have remained relatively stable for seniors for such conditions as strokes, falls and ambulatory care sensitive conditions that could be prevented or managed on an outpatient basis. Rates for strokes and ACS conditions are consistently higher among seniors in the city than in the suburbs. (*County progress:* ⬅➡)
- Self-reported poor mental health status among seniors remained relatively unchanged from 1997 to 2000, with about 5% of all seniors reporting frequent mental health difficulties. (*County progress:* ⬅➡)
- The numbers and proportions of seniors entering mental health treatment for the first time appear to be declining, but it is not clear whether the decline suggests a reduction in the extent of mental health problems or changes in the health care system and health insurance coverage. (*County progress:* ?)
- Despite reductions in new entrants to the system, and despite system efforts to reduce inpatient treatment, the number of seniors admitted to inpatient mental health services has been gradually trending upward in recent years. (*County progress:* ⬇)

Seniors Exercising Independence, and Productive Seniors

As indicated above, few measures exist for these two Outcome areas, although recent Census data add some perspective to the few existing measures. Available data are mostly encouraging:

- Between 1990 and 2000, even as the numbers of 75+ and 85+ seniors increased dramatically in the county, the numbers of seniors living in an institutionalized setting declined slightly. (*County progress:* ⬆)
- The numbers of seniors living alone increased by 10% between 1990 and 2000, a fact which may have increasing service implications for the future, as the numbers of seniors living to old

ages and remaining in community settings continues to increase. (*County progress:* ?)

- However, in both 1997 and 2000, only about 2% of all seniors reported often feeling lonely or isolated. (*County progress:* ⬅➡)
- Countywide, many seniors who rent, and between 55% and 60% of seniors who rent within the city, did not have access in 2000 to private transportation. However, these proportions represent some improvement from 1990. (*County progress:* ⬆)
- More than a third of the county's non-institutionalized seniors in 2000 reported some type of disability or limitation on their activities. No comparable data were available for earlier years. (*County progress:* ?)

Financially Secure Seniors

The available data on the financial status of seniors are somewhat mixed:

- The numbers of seniors living in poverty increased by 12% between 1990 and 2000, to almost 6,700 persons in the county. Over that period of time, however, the overall poverty rate among seniors remained about 7%, although it rose to 15% among seniors in the city. (*County progress:* ⬇)
- On the other hand, since 1995, the numbers of non-disabled seniors who obtained SSI cash assistance have declined by about 11%, to about 2,100 persons 65+ in 2001 (although not all seniors eligible for SSI assistance actually apply for it). (*County progress:* ⬆)
- Nearly all seniors in 1997 and 2000 reported being covered by some type of health insurance, though the extent of coverage varies. (*County progress:* ⬅➡)

Personally Safe Seniors

Although public safety data are not available for seniors, other available indicators suggest that most seniors are relatively safe:

- Self-reported data indicate that the proportion of seniors who were injured in a fall in the previous year increased only slightly between 1997 and 2000, from 5.8% to 6.8% (not a statistically significant difference), but from a practical perspective, when projected to the entire senior population, that would represent an increase of about 950 additional persons injured each year. (*County progress:* ⬇)

- Actual hospitalizations for falls have remained relatively stable in recent years. (*County progress:* ⬅➡)
- Relatively few seniors are served each year by the County Adult Protective Services unit, although the number appeared to increase in 2001. However, there have been some changes in ways the data are reported over time, so trends cannot be determined. (*County progress:* ?)

Conclusions

In general, Monroe County's older population appears to be relatively healthy, both physically and mentally, and to be relatively independent and self-sufficient. However, there are areas where new or expanded initiatives may be needed in the future:

- Despite the relatively good health of the senior population, 35% indicate that they do not participate in exercise or physical activity on a regular basis, and significant numbers do not receive annual flu immunizations. With health outcomes in general not as good within the city, compared to suburban locations, more emphasis may need to be placed on helping seniors access preventive services and create healthy lifestyles, diets, and opportunities for exercise and physical activity on a regular basis.
- Although only small proportions of seniors report frequent mental health problems, or report feeling lonely or isolated, relatively little is known about the overall mental health status of the senior population. Fewer seniors have been admitted for the first time to mental health services in recent years, but more have been admitted to inpatient treatment. The relationship between mental health service needs and availability, affordability and access to mental health services needs to be understood more clearly in the future.
- As more seniors live longer independently in the community, and more live alone, and slightly more live in poverty, there may be increasing needs for various services provided both by agencies and family members in the future. More will need to be known than is currently known about needs of family members and other caregivers supporting seniors; these sources of assistance for seniors are themselves likely to need greater amounts of support in the future.
- As suggested above, it will be important, as the number of seniors continues to increase, to develop additional data measures to track how the community is doing in increasing the level of independence of seniors living in the community, and in helping them remain productive, useful resources.

Outcome I: Seniors Enjoying Mental and Physical Well-Being

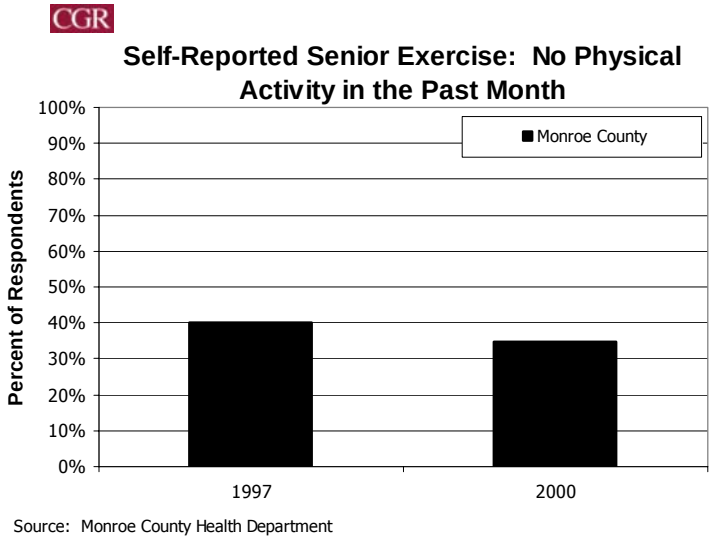
- Self-Reported Senior Physical Activity (No activity)
- Self-Reported Senior Health Status: Fair or Poor
- Individuals 65+ Served Emergency Food
- Individuals 65+ Served Congregate and Home Delivered Meals
- Self-Reported Senior Influenza Immunization Rates
- Senior Mortality Rates- All Causes
- Senior Suicide Rates
- Hospital Discharges with Primary Diagnosis of Stroke
- Ambulatory Care Sensitive Hospitalizations for Seniors
- Self-Reported Senior Disease Prevalence- High Blood Pressure
- Self-Reported Senior Disease Prevalence- Diabetes
- Seniors Entering Mental Health Treatment for the First Time
- Seniors Receiving Mental Health Crisis Services
- Seniors Admitted to Inpatient Mental Health Services
- Self-Reported Senior Mental Health Status: Frequent Mental Distress

Since the mid-1990s, at the overall county level, four of the measures above have shown slight improvement, four have shown little change, one has worsened, and the desired movement of six measures is undetermined.

Measure: Self-Reported Senior Physical Activity

Definition: The percentage of senior respondents (ages 65+) to the Monroe County Health Survey who *did not* engage in any physical activities or exercises such as running, golf, calisthenics, gardening, or walking for exercise in the month preceding the survey.

Data are reported countywide, as no statistically significant differences were found between city and suburban residents for either 1997 or 2000. Only households with telephones were surveyed.



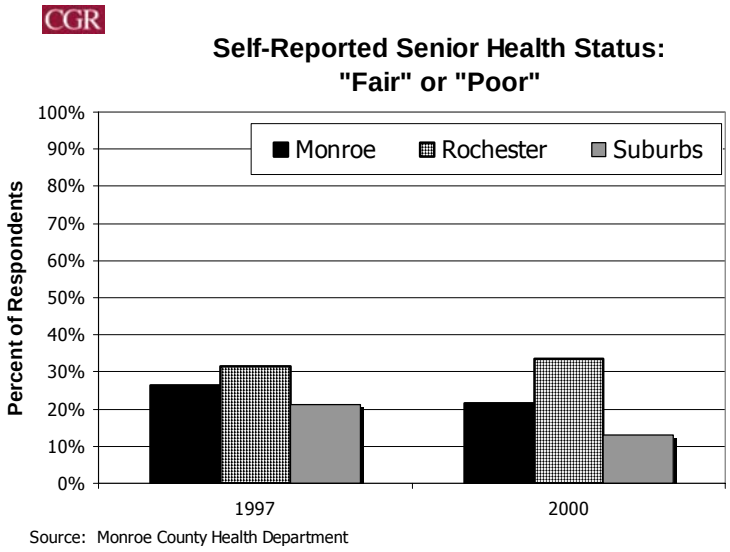
Source: Monroe County Health Department

Findings: In 2000, a lower percentage of respondents (34.6% compared to 40.0% in 1997) reported that they had not engaged in some form of physical activity or exercise in the month preceding the survey. In the 2000 survey, respondents were not asked about the intensity of their exercise or how often they exercised in the previous month. Data for this measure are presented in Appendix Table 77.

Caveats: Due to the nature of a phone survey, the "frail" elderly may be under-represented.

Measure: Self-Reported Senior Health Status

Definition: This measure represents the percentage of senior respondents (ages 65+) to the Monroe County Health Survey who reported that their physical health is "fair" or "poor".



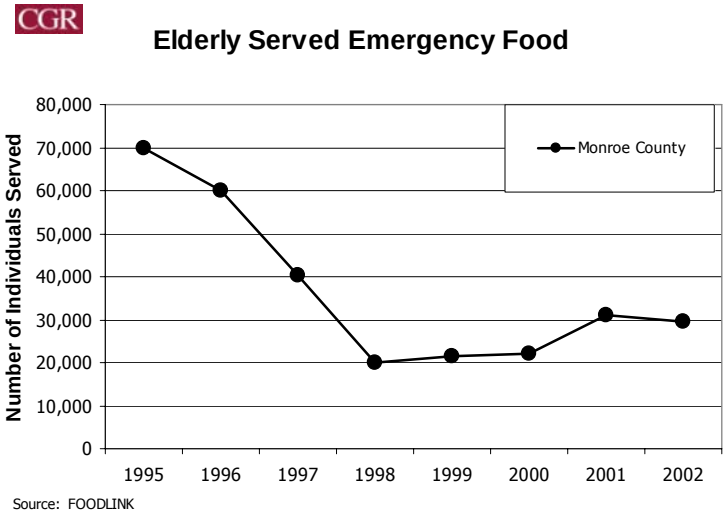
Source: Monroe County Health Department

Findings: The proportion of seniors reporting fair or poor health status remained essentially unchanged between 1997 and 2000. About one third of all city seniors reported fair or poor health, compared to about 13% of their suburban counterparts. For more detailed information, see Appendix Table 78.

Caveats: Due to the nature of a phone survey, the "frail" elderly may be under-represented.

Measure: Individuals 65+ Served Emergency Food

Definition: The total number of Monroe County residents (age 65+) served emergency food. This includes individuals served under the FOODLINK Supplemental Nutrition Assistance Program (SNAP) and Hunger Prevention Nutrition Assistance Program (HPNAP). New York State Department of Health regulations require a food pantry to count all people in the household receiving the food each time a visit to the pantry is made, even if only one person receives food at the pantry. Soup kitchens are instructed to count each person served a meal at each mealtime. For example, if a person is served breakfast and lunch at the site on the same day, they are counted as two persons served.



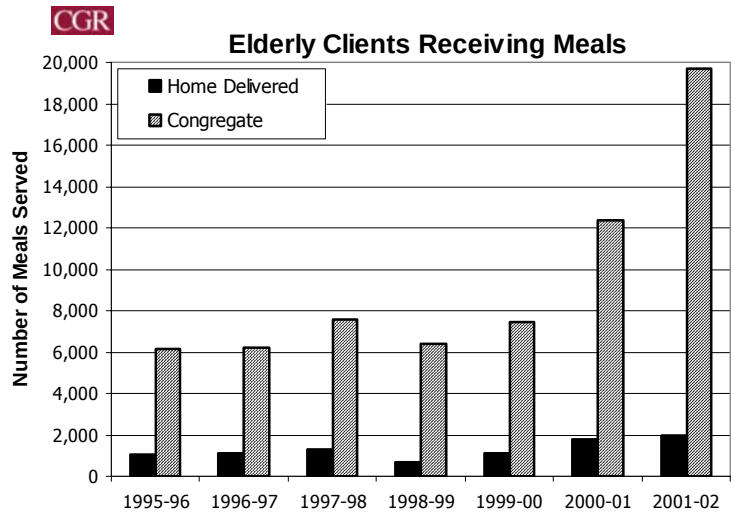
Source: FOODLINK

Findings: The number of elderly people served emergency food appears to have declined significantly since 1995. In 1995, FOODLINK served meals to 69,909 senior clients. After falling to an average of about 21,000 seniors served meals each year from 1998 through 2000, the number of elderly people receiving food increased again the past two years. By 2002, 29,409 seniors were served emergency food meals in Monroe County. This change represents a 58% decline from 1995 to 2002. A decrease in the number of seniors served emergency food may not mean reduced hunger in the community, as the resources available for these services may have declined as well. Another possible explanation for this downward trend is that between 1996 and 1997, FOODLINK provided training sessions for sites that resulted in more accurate reporting. Data are only available at the county level. Data for this measure are presented in Appendix Table 79.

Caveats: As suggested, it is difficult to know whether to interpret the decline as a sign of community progress or simply as a function of changes in resources.

Measure: Individuals 65+ Served Congregate and Home Delivered Meals

Definition: This measure represents the number of home-delivered meals or the number of meals served in congregate feeding sites funded by the New York State Office for the Aging. This total does not include meals provided by other organizations or agencies not funded by the Office for the Aging.



Source: New York State Office for the Aging

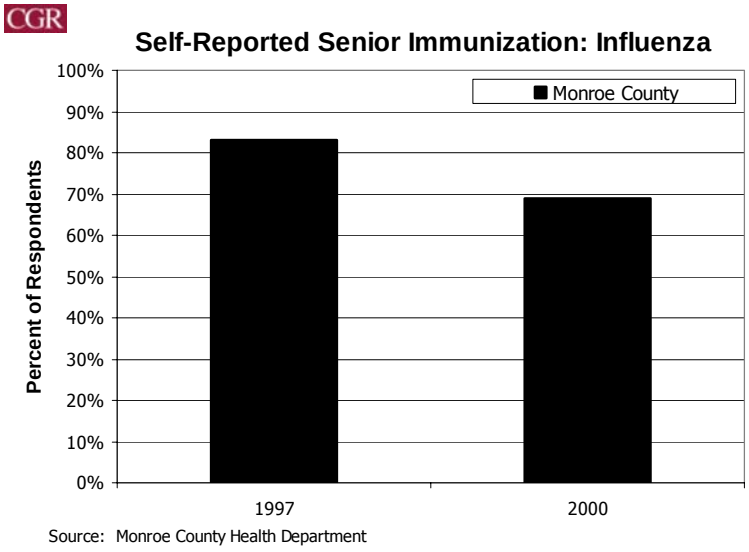
Findings: The number of meals served to elderly clients in their homes has almost doubled from 1,069 in 1995-96 to 1,980 in 2001-02. At the same time, the number of meals served to elder clients at congregate meal sites has more than tripled, increasing from 6,154 in 1995-96 to 19,709 in 2001-02. Overall, significantly more free or subsidized meals are being served to elderly people now through the Office for the Aging than was the case several years ago. Changes in the number of meals served may not mean changes in hunger in the community. Meal service is highly dependent on funding streams, with increased funding allowing for more meal service. Data for this measure are presented in Appendix Table 80.

Caveats: Totals may understate the number of meals being served to the elderly through non-OFA resources.

Measure: Self-Reported Senior Influenza Immunization Rates

Definition: This measure represents the percentage of senior respondents (ages 65+) to the Monroe County Health Survey who reported that they received an immunization for influenza in the year preceding the survey.

Data are reported countywide as no statistically significant differences were found between city and suburban residents. Only households with telephones were surveyed. The Healthy People 2010 target is a 90% influenza immunization rate for the elderly population.



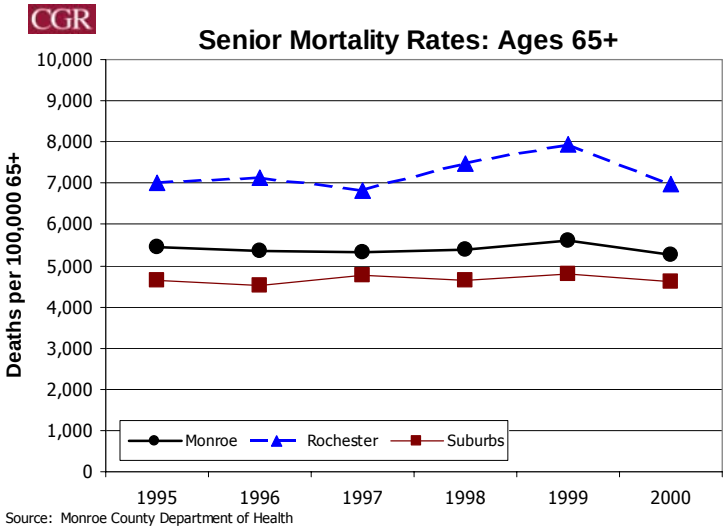
Findings: In 1997, 83% of seniors reported that they had received a flu shot in the year preceding the survey. In the 2000 Monroe County Health Survey, however, just below 70% of all senior respondents indicated that they had received a flu vaccine in the previous year, far short of the national target of 90%. This result may reflect in part the fact that the availability of the flu vaccine was delayed in 1999. For detailed information, see Appendix Table 81.

Caveats: Due to the nature of a phone survey, the "frail" elderly may be under-represented.

Measure: Senior Mortality Rates

Definition: This measure reflects the number of deaths per 100,000 Monroe County residents ages 65 and older.

The aging of the population virtually assures that the community will witness increases in *numbers* of deaths for seniors. The key objective would be to reduce the *rate* of deaths, or delay their impact to the older age ranges.



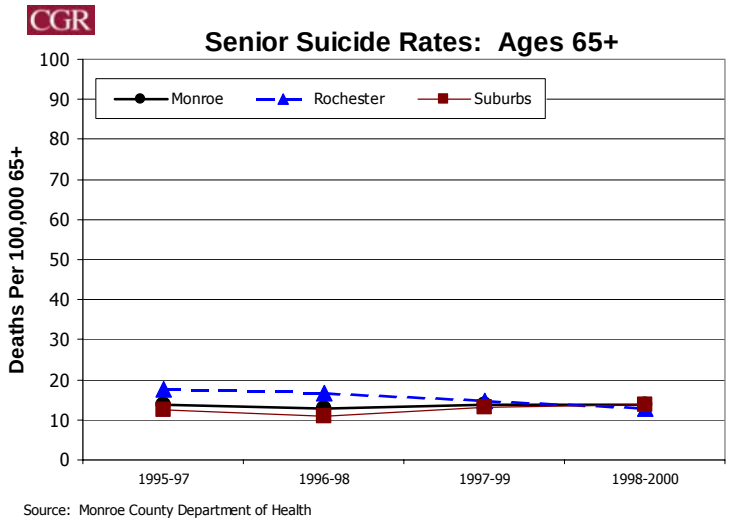
Source: Monroe County Department of Health

Findings: Rates of death among Monroe County seniors have fluctuated somewhat from year to year, but with no significant overall changes over the past decade. Senior death rates in the city are consistently higher and more variable from year to year than those in the suburbs. Chronic diseases, including heart disease, cancer, stroke, COPD (Chronic Obstructive Pulmonary Disease, which includes emphysema, asthma, and bronchitis), and diabetes consistently account for more than two-thirds of deaths among older adults in Monroe County. For trend data on disease-specific mortality rates, which have remained relatively stable from year to year, refer to Appendix Table 82.

Caveats: These are crude death rates. Rates would need to be adjusted for age and gender differences in the population to determine whether real differences exist between the county and state and national rates.

Measure: Senior Suicide Rates

Definition: This measure reflects the number of suicides per 100,000 Monroe County residents who are 65 and older.



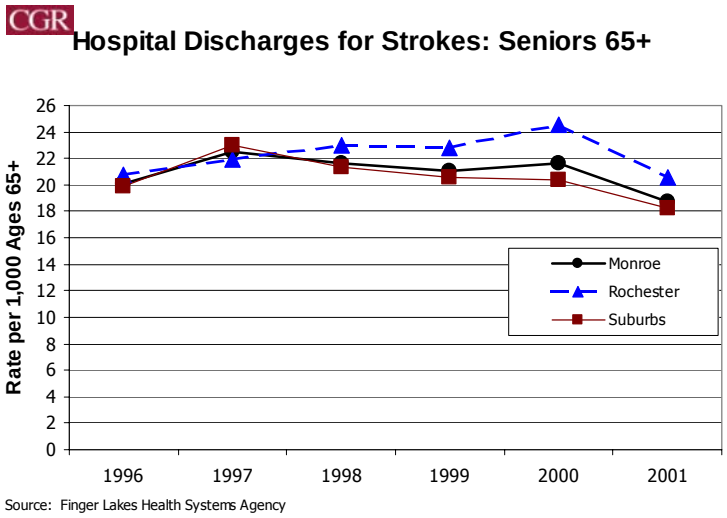
Source: Monroe County Department of Health

Findings: The numbers and rates of suicides among older adults in Monroe County have been fairly stable from year to year. White males are at higher risk of suicide than others in this age group. City and suburban rates tend to fluctuate somewhat from year to year, as the small number of suicides relative to the population results in large changes in the rate even when there is only a small change in the actual number of suicides. The three-year blended rate reflected in the graph helps control for year-to-year variations. Overall countywide numbers and rates have remained relatively consistent since 1995. In 2000, there were 13 suicides by people 65 and older in Monroe County (a rate of 13.6 per 100,000), 1 in the City of Rochester (4.6 per 100,000) and 12 in the suburbs (16.3 per 100,000). For more detailed information, see Appendix Table 83.

Caveats: None.

Measure: Hospital Discharges with Primary Diagnosis of Stroke

Definition: This measure reflects the rate of hospital discharges with injury codes for strokes per thousand people 65 years old and older.



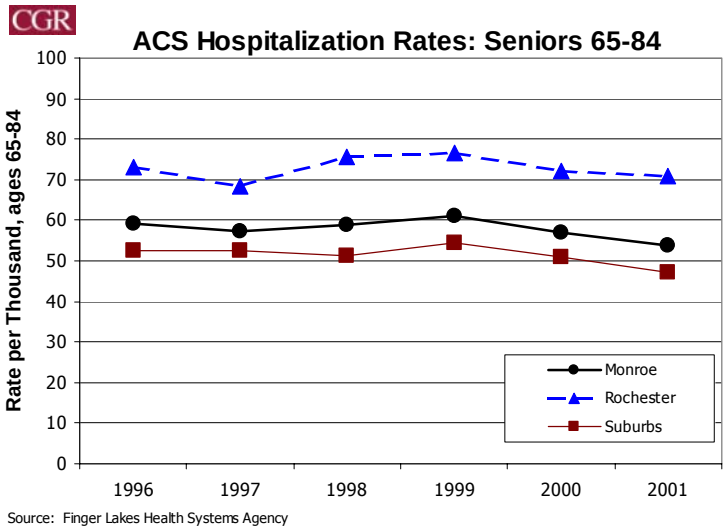
Findings: The aging of the population virtually guarantees increases in the *numbers* of seniors with health problems. The key objective would appear to be to reduce the *rate* of diseases and injuries, or delay their impact to the older age ranges. Countywide, rates of hospital discharges with primary diagnosis of stroke appear to be remaining relatively stable. Rates are typically slightly higher in the City of Rochester than in the suburbs. However, due to an overall higher senior population in the suburbs, the absolute number of discharges involving suburban residents is higher. For example, in 2001, there were 642 hospital discharges for stroke in the City of Rochester (a rate of 20.6 per 1,000), and 1,223 discharges in the suburbs (a rate of 18.2 per 1,000). For more detailed information, see Appendix Table 84.

Caveats: Hospitalization rates may reflect changes in practices and a movement to outpatient settings.

Measure: Ambulatory Care Sensitive Hospitalizations for Seniors

Definition: This measure represents the rate of hospitalizations for Ambulatory Care Sensitive (ACS) conditions for seniors ages 65-84 (rate per 1,000 persons 65-84).

ACS conditions are medical conditions that are considered to be preventable or manageable on an outpatient basis. Access to and use of timely and appropriate primary care decreases the probability that a hospitalization will occur for an ACS condition. Some of the conditions included in the standard ACS list are more prevalent in the senior population and may be indicators of failing health rather than lack of primary or preventive care.



Source: Finger Lakes Health Systems Agency

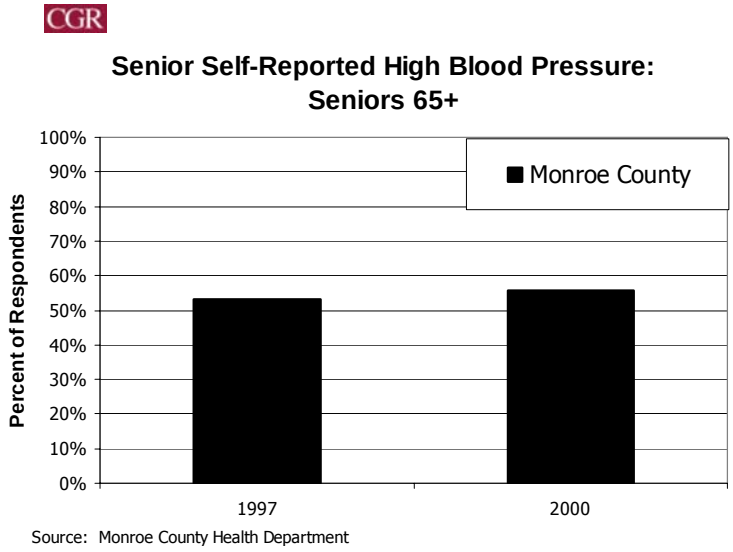
Findings: The rate of ACS hospitalizations for seniors has remained relatively constant since 1996, with a slight reduction since 1999. Increases or decreases over time in the ACS rate may indicate changes in availability/use/accessibility of health care services, as well as changes in financial/insurance coverage, managed care and ability to pay for services. Alternatively, changes in ACS rates may simply reflect changes in how hospitals handle such cases. Overall, the rate is higher in the City of Rochester than in the suburbs. However, because the suburban senior population is higher, the actual number of seniors hospitalized for ambulatory care sensitive reasons is higher in the suburbs. For example, in 2001, 4,509 seniors in Monroe County were hospitalized for ambulatory care sensitive reasons, a rate of 53.8 per 1,000. Of these seniors, 1,740 were city residents (a rate of 70.9 per 1,000), while 2,769 lived in the suburbs (rate of 47.1 per 1,000). For more detailed information, see Appendix Table 85.

Caveats: None

Measure: Self-Reported Senior Disease Prevalence – High Blood Pressure

Definition: This measure reflects the percentage of older adult respondents (ages 65+) to the Monroe County Health Survey who reported that they had ever been told that they had high blood pressure.

Data are reported countywide, as no statistically significant differences were found between city and suburban residents in either year. Only households with telephones were surveyed.



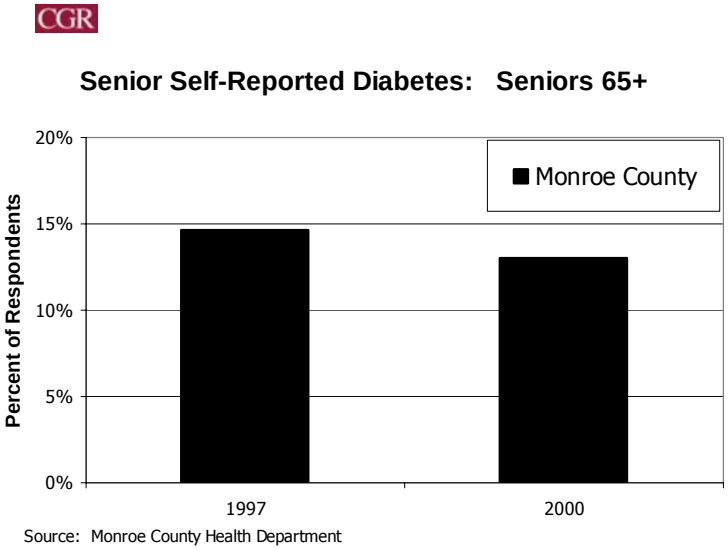
Findings: In both 1997 and 2000, about 55% of Monroe County seniors reported that they had been diagnosed with high blood pressure at some point in their life. In 2000, rates of reported high blood pressure were significantly higher among African-American seniors (78%) compared to white Monroe County seniors (54%). For detailed information, see Appendix Table 86.

Caveats: Due to the nature of a phone survey, the "frail" elderly may be under-represented.

Measure: Self-Reported Senior Disease Prevalence - Diabetes

Definition: This measure represents the percentage of older adult respondents (ages 65+) to the Monroe County Health Survey who reported that they had ever been told that they had diabetes.

Data are reported countywide, as no statistically significant differences were found between city and suburban residents. Only households with telephones were surveyed.



Source: Monroe County Health Department

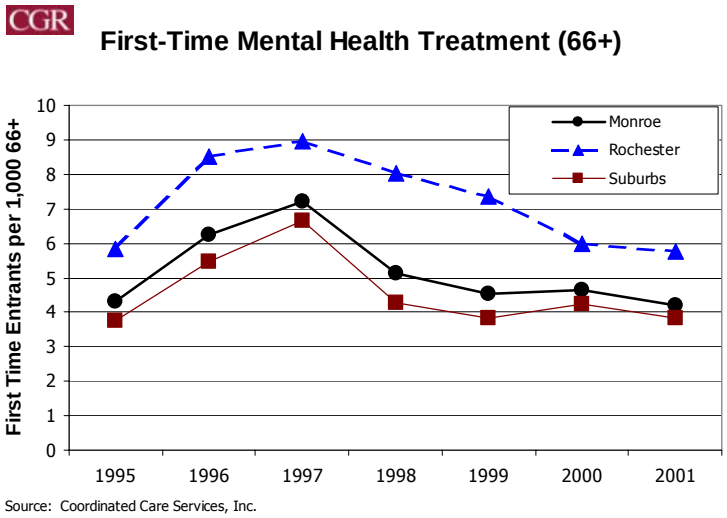
Findings: Between one in seven and one in eight (14.6% in 1997, 13.0% in 2000) reported having been informed that they had diabetes. For more detailed information, see Appendix Table 87.

Caveats: Due to the nature of a phone survey, the "frail" elderly may be under-represented.

Measure: Seniors Entering Mental Health Treatment for the First-time

Definition: This measure reflects the rate per 1,000 individuals 66 and older entering the mental health treatment system (including community mental health centers and hospital psychiatric units) for the first time.

This includes both inpatient and outpatient services. These data include only those residents served in mental health programs reporting to the CCSI database.



Source: Coordinated Care Services, Inc.

Findings: Since 1997, the number of seniors entering mental health care for the first time has been declining. Following an increase from 1995 to 1997, there has been a 33% decline in the number of first time entrants to mental health treatment in Monroe County (603 in 1997 to 402 in 2001), a reduction in the rate per 1,000 from 7.2% to 4.2%. Reductions occurred in that period of time in both the city and the suburbs. *Rates* per 1,000 seniors are higher in the city than in the suburbs (5.8 to 3.8 in 2001), though the actual *numbers* of first-time senior entrants is consistently higher in the suburbs (283 to 127 in 2001). Any changes over time in the number of seniors receiving treatment and the number of cases which require hospitalization or emergency room treatment may be attributable, in part, to changes in the health care system and to health insurance coverage. Data for this measure are presented in Appendix Table 88.

Caveats: The data do not include patients receiving services from private practitioners.

Measure: Seniors Receiving Mental Health Crisis Services

Definition: This measure represents the rate per 1,000 individuals 66 and older receiving mental health crisis services in emergency departments or outpatient mental health crisis clinics in Monroe County.

These data include only those residents served in mental health programs reporting to the CCSI database.

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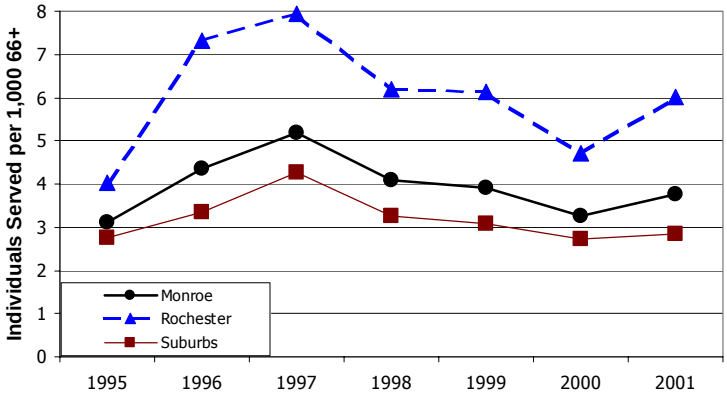


Source: Coordinated Care Services, Inc.

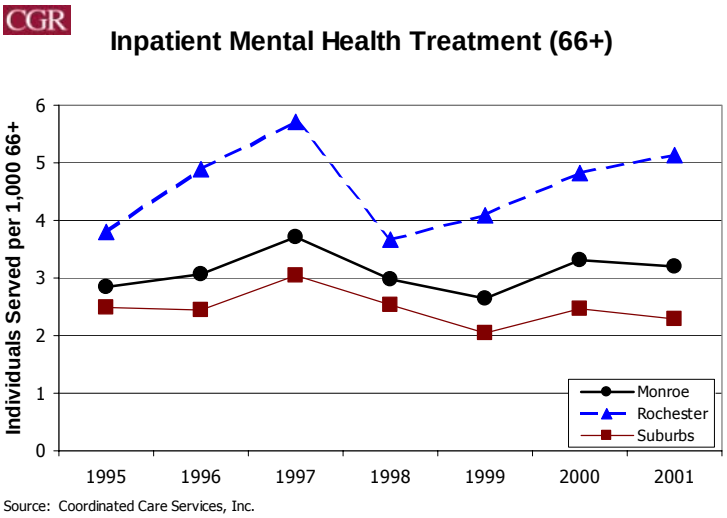
Findings: The number of seniors receiving crisis mental health treatment services over the past few years has varied considerably from year to year. From 1995 to 2001, the number of seniors receiving crisis mental health services was lowest in 1995 at 258 and peaked at 433 in 1997. The 1997 number was driven almost exclusively by a large increase in the number of suburban senior residents seeking crisis treatment that year (a 30% increase over the previous year, compared to a 4.5% increase in the City). In each year since 1997, the numbers and rates of seniors receiving crisis services (361 in 2001, a rate of 3.8 per 1,000) have been lower than the 1997 totals countywide, as well as in both the city and the suburbs. During these years, just over a third of the county's seniors receiving crisis services have lived in the city, compared with 23% of Monroe County seniors overall who reside in the city. Any changes over time may be attributable, in part, to changes in the health care system and to health insurance coverage. Data for this measure are presented in Appendix Table 89.

Caveats: The data do not include patients receiving services from private practitioners.

Measure: Seniors Admitted to Inpatient Mental Health Services

Definition: This measure reflects the rate per 1,000 individuals 66 and older receiving mental health inpatient services in hospital psychiatric units in Monroe County.

These data include only those residents served in mental health programs reporting to the CCSI database.



Source: Coordinated Care Services, Inc.

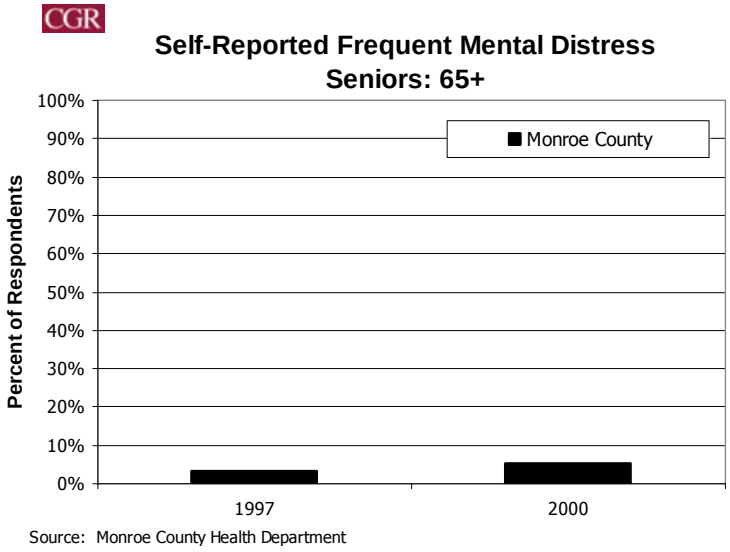
Findings: The number of Monroe County seniors receiving inpatient mental health treatment services has generally been trending upward over the past few years, although the overall rates have stayed consistently between about 3 and 4 admissions per 1,000 seniors. In 1995, there were 237 Monroe County seniors receiving inpatient mental health treatment; of these, 85 were city residents and 152 lived in the suburbs. By 2001, there were 306 Monroe County seniors receiving inpatient mental health treatment, a 29% increase. In the City of Rochester, there were 113 seniors, an increase of 33%, and in the suburbs, there were 169, an increase of 11%. Any changes over time may be attributable, in part, to changes in the health care system and to health insurance coverage. Data for this measure are presented in Appendix Table 90.

Caveats: The data do not include patients receiving services from private practitioners.

Measure: Self-Reported Senior Mental Health Status

Definition: This measure represents the percentage of older adult respondents (ages 65+) to the Monroe County Health Survey who reported that their mental health was not good on at least 14 out of the 30 days preceding the survey.

Data are presented countywide only, as there were no statistically significant differences found between city and suburban residents. Only households with telephones were surveyed.



Source: Monroe County Health Department

Findings: In 2000, about one of every 20 seniors surveyed (5.2%) reported experiencing frequent mental distress. This rate has essentially remained unchanged since 1997. Data for this measure are presented in Appendix Table 91.

Caveats: Due to the nature of a phone survey, the "frail" elderly may be under-represented.

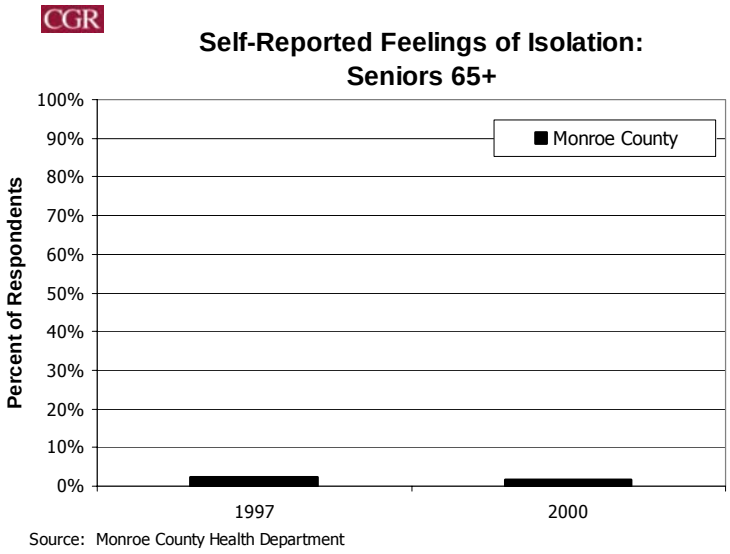
Outcome III: Productive Seniors

- Senior Self-Reported Feelings of Isolation

Since the mid-1990s there has been little change in the single measure included in this outcome area.

Measure: Senior Self-Reported Feelings of Isolation

Definition: This measure represents the percentage of older adult respondents (ages 65+) to the Monroe County Health Survey who reported very often feeling lonely or abandoned in the two weeks preceding the survey. Only households with telephones were surveyed.



Source: Monroe County Health Department

Findings: Data are presented only at the county level as no statistically significant differences were found between city and suburban residents. Countywide rates remained virtually unchanged between 1997 and 2000, with only about 2% reporting feelings of isolation. Data for this measure are presented in Appendix Table 92.

Caveats: Due to the nature of a phone survey, the "frail" elderly may be under-represented.

Outcome IV: Financially Secure Seniors

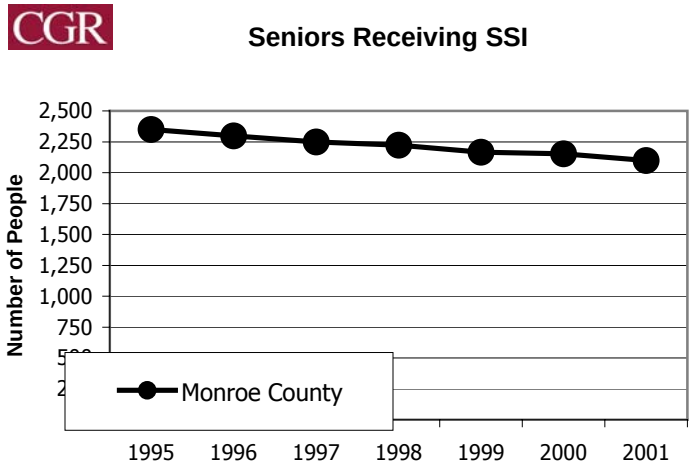
- Seniors Receiving SSI
- Self-Reported Health Insurance Coverage

Since the mid-1990s, overall county progress towards achieving this outcome has been mixed.

Measure: Seniors Receiving SSI

Definition: This measure represents people 65 and older (primarily non-institutionalized) who obtain cash assistance. For seniors, this is done through Supplemental Security Income, rather than through public assistance.

The numbers represent active recipients in December of each year. These numbers reflect only the number of non-disabled seniors who receive SSI benefits. A number of additional seniors are eligible for SSI payments because they are blind and disabled.



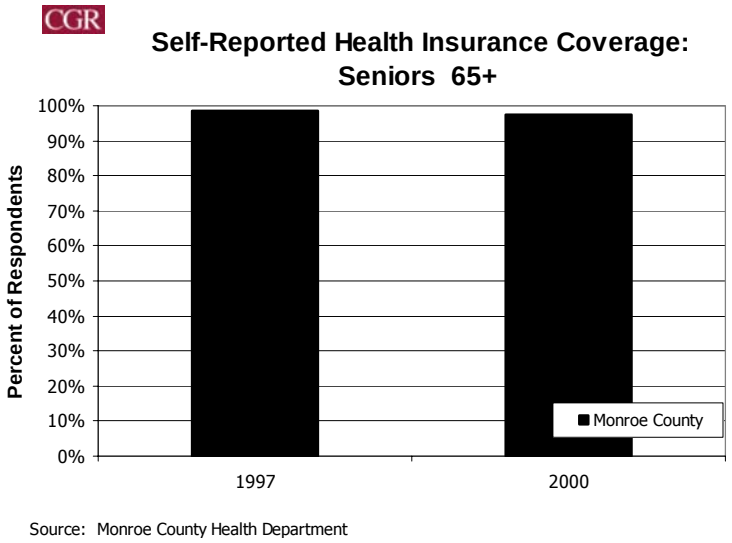
Source: Social Security Administration

Findings: Following an increase in the numbers of seniors receiving SSI payments during the first half of the 1990's, the number of seniors receiving SSI payments has declined somewhat over the past few years. In 1995, 2,349 seniors were receiving SSI in December. In 2001, this number had declined a total of 10.7%, to 2,098 seniors. This decrease may reflect improved financial status among Monroe County seniors, resulting in fewer seniors being income eligible for cash assistance. Note that not all seniors who are eligible for SSI payments apply for and receive them. For more detailed information, see Appendix Table 93.

Caveats: Ideally, SSI data would be supplemented by data on seniors receiving food stamps who do not qualify for SSI.

Measure: Self-Reported Health Insurance Coverage

Definition: This measure represents the percentage of older adult respondents (ages 65+) to the Monroe County Health Survey who reported that they have health insurance. Only households with telephones were surveyed.



Source: Monroe County Health Department

Findings: In both 1997 and 2000, virtually all seniors included in the survey report having some form of health insurance. Typically, this result means that they have Medicare coverage at a minimum and may also have private insurance to supplement their Medicare coverage. However, the extent of coverage varies. For example, in 2000, 54% of respondents indicated that they do not have dental insurance coverage. Data for this measure are presented in Appendix Table 94.

Caveats: Due to the nature of a phone survey, the "frail" elderly are under-represented.

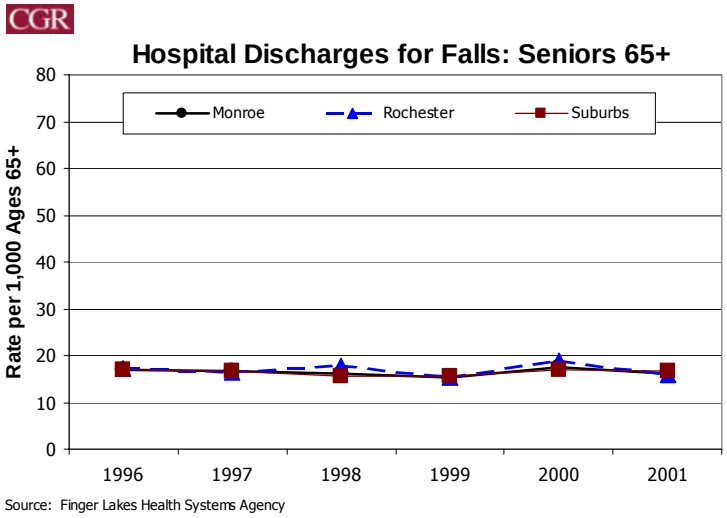
Outcome V: Personally Safe Seniors

- Senior Hospitalizations for Falls
- Senior Self-Reported Injurious Falls
- Seniors in DSS Adult Protective Services

Since the mid-1990s, overall county progress towards achieving this outcome has been mixed.

Measure: Senior Hospitalizations for Falls

Definition: This measure records hospital discharges with an injury code for falls (data include discharge by fatality). Discharges are presented as the rate per 1,000 seniors age 65 or older. The totals include both falls in the home and falls that occur in other places.



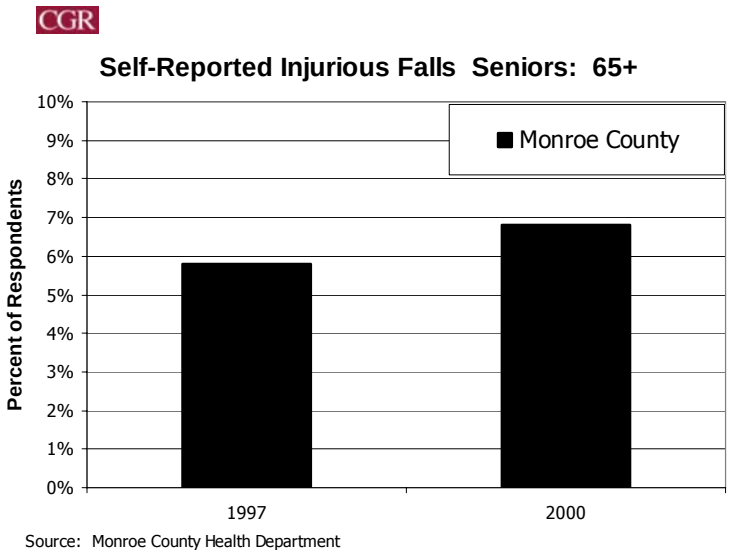
Source: Finger Lakes Health Systems Agency

Findings: Rates of hospital discharges for falls appear to be relatively stable overall, with an average of between 16 and 17 elderly people per 1,000 hospitalized for falls each year between 1995 and 2001. In 2001, there were 1,693 hospital discharges for injuries due to falls. About a third of those (570) were city residents, with 1,123 suburban seniors hospitalized for falls in 2001. There is very little difference from year to year between city and suburban residents in the rates of senior hospitalizations for falls. Rates increase with age and are higher among women. For detailed information, see Appendix Table 95.

Caveats: Any future decline in numbers hospitalized for falls may be a function of changes in hospital usage due to managed care or related health care management decisions, or may be related to increased functioning of seniors.

Measure: Senior Self-Reported Injurious Falls

Definition: This measure represents the percentage of older adult respondents (ages 65+) to the Monroe County Health Survey who reported that they were injured in a fall in the 12 months preceding the survey. Only households with telephones were surveyed.



Findings: Data are presented only at the county level, as no statistically significant differences were found between city and suburban residents. Countywide rates were comparable in 1997 and 2000, with 6.8% of respondents (or the projected equivalent of about 5,550 seniors countywide in 2000) reporting that they had been injured in a fall during the past 12 months. For more detailed information, see Appendix Table 96.

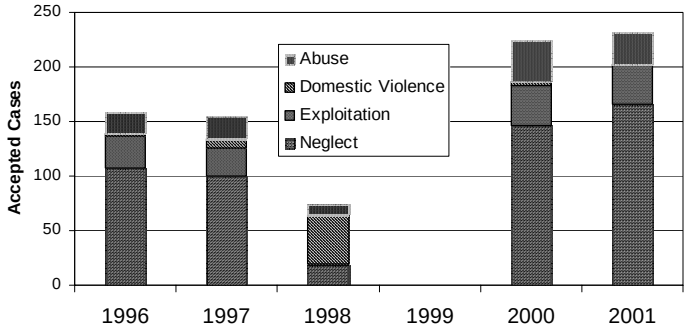
Caveats: Due to the nature of a phone survey, the "frail" elderly may be under-represented.

Measure: Seniors in DSS Adult Protective Services

Definition: This measure represents services to individuals 60 years of age and older who are unable to protect their own interests and/or who are harmed or threatened with harm.

This harm can be caused either by the individual himself or herself or through the action or inaction of another person. The harm can take the form of physical or mental injury, including domestic violence, neglect or maltreatment, failure to receive adequate food, shelter or clothing (abuse), or deprivation of entitlements due the individual or wasting their resources (exploitation). Other senior Adult Protective Service cases not considered related to domestic violence, abuse, neglect or exploitation are not shown here.

Accepted Cases of Abuse and Neglect in Monroe County: Seniors 60+



Source: Monroe County Department of Social Services - Adult Protective Services

Findings: In 2001, Monroe County Adult Protective Services accepted 232 cases involving residents 60 and older. Of those cases, 121 involved City residents and 111 lived in the suburbs. The vast majority of accepted cases, 71.6% or 166 cases, were the result of neglect, either self-neglect or neglect by a caregiver. Of these, 75 cases were in the suburbs and 91 cases were in the City of Rochester. Of the neglect cases, 45 involved clients 60-74 years of age and 121 involved clients 75 or older. An additional 15.5% (36 cases) were the result of exploitation, 12.5% (29 cases) involved abuse and one case (.4%) involved domestic violence. In general, people 75 and older are more likely than those 60-74 to be clients of adult protective services. Because there is no mandatory reporting of elder abuse, the incidence of elder abuse may be understated. For more detailed information, see Appendix Table 97.

Caveats: Note that 1998 data does not include information on clients 75 years of age and older. No data are available for 1999.

Additional Resources

For additional information pertaining to the outcomes and measures included in this chapter, as well as information on related topics, see the following:

- New York State Department of Health, http://www.health.state.ny.us/
- New York State Office for the Aging, http://aging.state.ny.us/index.htm
- Social Security Administration, *Social Security Online,* www.ssa.gov
- Department of Health and Human Services Administration on Aging, http://www.aoa.gov
- Healthy People 2010, http://www.healthypeople.gov
- U.S. Census Bureau, http://www.census.gov
- Centers for Medicare and Medicaid Services, U.S. Department of Health, http://www.cms.gov

VIII. Overcoming Disabilities Impact Area

Context

This Impact Area is designed to track how well the community is doing in helping people with a variety of disabilities maintain healthy, independent, safe and secure lifestyles to the greatest extent possible. The Impact Area typically focuses on adults 21 and older with one or more disabilities. Four specific Outcomes have been identified to track progress: People with Disabilities Enjoying Mental and Physical Well-Being, Personally Safe People with Disabilities, People with Disabilities Exercising Self-Determination, and Financially Secure People with Disabilities.

Many of the measures described in this chapter exist only for some types of disabilities, or exist only for clients associated with certain agencies. More work is needed on many of these measures, and CGR suggests that work groups be established to expand these measures and to help make them more applicable to people with a wider range of disabilities.

In short, development of appropriate measures for this Impact Area continues to be a work in progress. Compared with the other four Impact Areas, few comprehensive community-wide measures exist for people with disabilities in this community—or elsewhere in the entire country. Monroe County actually continues to be far ahead of most other communities in having created, and using, at least some outcomes and measures for people with disabilities. However, it remains nonetheless frustrating that so few good measures currently exist to accurately and comprehensively assess how well the community is doing in helping people with disabilities maintain healthy and independent lives.

For example, no good measures are known to currently exist which accurately monitor the numbers of assaults or other crimes against people with disabilities of various types; only partial data exist on the extent to which people with various types of disabilities are employed in mainstreamed/competitive jobs; no comprehensive data exist on needs of caregivers of people with all

types of disabilities; and there is little or no consistent self-reported survey data on perceptions of the disabled population.

The problems in tracking progress in meeting the needs of those with disabilities are exacerbated by the fact that there are few single measures that can define progress for the broad range of people with disabilities. Those who initially determined the measures a few years ago for this Impact Area recognized that, ideally, different types of measures would in some cases be needed for at least four broad types of disabilities: developmental disabilities, physical disabilities, mental illness, and alcohol and substance abuse. Thus no one measure or group of measures can automatically be assumed to define or reflect community-wide progress against a particular outcome for all types of disabilities.

Thus, what follows is a presentation of the best available measures of Overcoming Disabilities, in full recognition that they are not comprehensive and are far from perfect—and that better measures have been developed in some areas of disability than in others. As was noted in the first community profile report in 1999, in order for the Monroe County community to move to the next step of creating a more comprehensive set of measures that is equally applicable to all four types of disabilities, work groups with disability-specific experts will need to be established to build on and refine the measures that follow and to tailor specific measures to better meet the needs of those with diverse types of disabilities. What follows provides some insights, but is only a start in tracking how well this community is doing in addressing the needs and aspirations of our diverse population of people with disabilities.

Relevant Demographic Trends

Some information is available from the U.S. Census Bureau concerning people with disabilities in Monroe County. Because information was collected in different ways in 1990 and 2000, direct comparisons are difficult between the two years.

- Of the county's non-institutionalized population in 2000, 70,153 adults between the ages of 21 and 64 were considered, based on self-reported information, to have some type of disability or limitation on their activities. This represents 16.8% of all non-institutionalized county residents 21-64 years of age.
- Of those adults 21-64 reporting a disability, 33,407 (47.6%) reported two or more disabilities.
- Of those reporting a disability, 53.6% were employed, compared to 80.1% employed among adults 21-64 with no reported disabilities.
- The most frequently-reported types of disabilities were: physical (27,846, or 39.7% of those 21-64 who reported disabilities); mental (17,242, or 24.6%); and sensory (9,506, or 13.6%).
- Almost half of those with sensory disabilities were employed, compared with about one-third of those with mental or physical disabilities.
- Countywide, 21% of those 21-64 with disabilities had income levels in 1999 below the poverty level, compared with 7% of those 21-64 with no reported disabilities.
- Of the more than 70,000 non-senior adults in the county in 2000 with a reported disability, almost half (33,735, or 48%) were city residents. Of those, 47.7% were employed.
- In addition to those 21-64 with reported disabilities, an additional 32,747 non-institutionalized seniors 65 and older reported having one or more disabilities. Of those, more than 9,200 (28%) lived in the city in 2000.
- Of the seniors reporting disabilities, just over half (50.7%) reported two or more disability types.
- Among seniors with disabilities, 11% had 1999 income levels below the poverty level, compared with 5% of those with no disabilities.

Summary of Trends

In reviewing the 17 measures which are presented in this chapter, some trends and themes emerge from the data. At the end of each summary statement below, arrows indicate whether the *overall county trend* for a particular measure (irrespective of trends within city and suburbs) reflects *improvement in recent years toward meeting the desired outcome* (⬆), *movement away from the desired outcome* (⬇), or *no significant change* (⬅➡).

People with Disabilities Enjoying Mental and Physical Well-Being

On most of the measures in this Outcome area, recent data trends are inconclusive:

- There have been recent declines in the number of admissions of chemically-dependent people in the county to alcohol and substance abuse treatment programs, especially to inpatient facilities. The greatest declines have been among city residents, though twice as many city residents as suburban residents remain in treatment. First-time admissions have also declined in recent years. However, these declines may not indicate a decline in substance abuse problems in the county, as they are influenced at least in part by the number of treatment slots and changes in managed care treatment strategies and payment mechanisms. (*County progress:* ?)
- There has been relatively little change in the numbers of county residents receiving mental health treatment, though with some very slight increases in recent years. Rates are consistently higher among city residents. But as with alcohol and substance abuse treatment, it is difficult to reliably attribute any changes to changes in need, as opposed to changes in the system and in health insurance coverage. (*County progress:* ?)
- Limited available data on reported needs of caregivers of mentally or developmentally disabled adults suggest relatively little change in needs over time, with advocacy, case management, and benefits/entitlements assistance mentioned most frequently. (*County progress:* ⬅➡)
- Overall, there are no clear indicators of the total numbers of people in Monroe County with specific types of disabilities. There continue to be no self-reported data on the perceptions of people with disabilities concerning their health, mental health, or ability to

function and carry out routine activities within the community. (*County progress:* ?)

Personally Safe People with Disabilities

Little good data exist to measure progress in this Outcome area:

- There continue to be no consistent data on crimes against people with disabilities, and no survey data from people with disabilities concerning their perceptions of safety and feelings of victimization. Therefore, it remains difficult to draw any conclusions concerning the personal safety of those with disabilities. (*County progress:* ?)
- There have been recent increases in the numbers of HUD-funded accessible, adaptable, personal safety-conscious housing units in both the city and suburbs. (*County progress:* ⬆)

People with Disabilities Exercising Self-Determination

Here again, the available data to measure progress in this Outcome area are limited:

- The number of lift-equipped buses in the county has grown substantially since 1995, thereby creating more access to public transportation for users of wheelchairs. The increases have been in both city and suburban bus routes, but the numbers of lift-accessible buses on suburban routes remain much lower than within the city, even though more than half of the county's residents with disabilities live in the suburbs, according to 2000 Census data. (*County progress:* ⬆)
- The proportion of people achieving treatment goals at discharge from substance abuse inpatient and outpatient treatment has remained relatively constant since 1995. (*County progress:* ⬅➡)
- There continue to be no consistent survey data to assess the perceptions of people with disabilities concerning their abilities to perform basic activities of daily living; to access jobs, services and various activities; and their perceptions of independence and the extent to which they can exercise self-determination within their lives. (*County progress:* ?)

Financially Secure People with Disabilities

In this Outcome area, there are some indications of community progress, but overall the data are too limited to draw definitive conclusions:

- In recent years, the number of adults with disabilities obtaining job placements has increased significantly, at least among those who

have been through state vocational training, and most of those increases have been in competitive jobs offering at least minimum wage (compared to supported jobs or jobs in sheltered workshops). Unfortunately, comprehensive data do not exist concerning job placements for people with disabilities not involving state training. (*County progress:* ⬆)

- Of adults reporting some type of disability in the 2000 Census, 54% reported being employed, compared to 80% of adults with no reported disabilities. Within the city, that proportion was 48%. It is not known how those proportions compare with previous years, and what proportions have attempted to find work without success. (*County progress:* ?)
- Between 1996 and 2000, there were substantial increases, from 375 to 678, in the number of people with disabilities who were successfully moved each year from public assistance to employment. However, that number dropped precipitously in 2001 to 238. (*County progress:* ⬆ through 2000, uncertain beyond that)
- The number of people with disabilities who received SSI Aid to the Disabled or the Blind has remained relatively consistent in recent years, with modest increases in the past two years. It is not always clear whether increases indicate that more people with disabilities are poor, or that more people are making better use of the system. (*County progress:* ?)
- Among those served within the mental health system (other than private practitioners), many report having no regular primary source of income, though for those reporting a source of income, the most predominant is employment. (*County progress:* ⬅➡)
- The proportion of persons discharged from substance abuse treatment who maintained or improved their employment status from admission to discharge increased between 1995 and 2000 from about 16% to almost 30%. (*County progress:* ⬆)
- Data are not currently available concerning levels of pay and benefits, including health insurance coverage, among people with disabilities. (*County progress:* ?)

Conclusions

Considerable progress has been made in the past several years in improving the quality of life and providing various legal protections for those with disabilities. However, this community and others throughout the country continue to struggle to find ways to adequately and reliably measure that progress:

- It is worth reiterating that the critical next step in assessing this community's progress in addressing the needs and aspirations of the diverse population of people with disabilities is to initiate a process, such as suggested at the beginning of this chapter, of refining the measures currently available and of developing and implementing new measures to track outcomes that cannot now be monitored in any consistent, comprehensive way.
- More specifically, better data are needed on the perceptions of people with disabilities concerning a series of issues, as suggested in the summary comments above.
- Closer inspection is needed of the number of treatment slots and overall resources available in the community to address mental health service and substance abuse treatment needs. At this point, the relationship between service needs and the availability and affordability of, and access to, such services needs to be understood more clearly.
- Although there have been encouraging recent increases in the numbers of job placements involving people with disabilities, and specific increases in the numbers of people with disabilities who have been able to be moved from welfare to employment, special vigilance and focused efforts are likely to be needed to create such opportunities in the future, given changes in the economy.

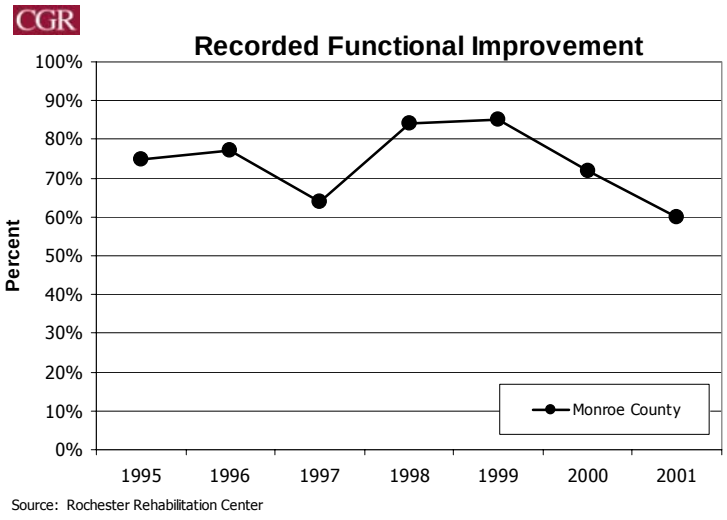
Outcome I: People with Disabilities Enjoying Mental and Physical Well-Being

- Functional Improvement Goals
- Admissions to Alcohol and Drug Abuse Treatment
- Annual First Time Entrants to Alcohol/Substance Abuse Treatment
- Prevalence of Mentally Ill Receiving Services
- New Entrants to Mental Health Treatment Services
- Individuals Admitted to Mental Health Inpatient Treatment
- Unmet Needs of People with Disabilities as Reported by Caregivers
- Expansion of Competitive Jobs Held by People with Disabilities

Since the mid-1990s, overall county progress towards achieving this outcome is largely undetermined.

Measure: Functional Improvement Goals

Definition: Used exclusively for clients in physical rehabilitation by the Rochester Rehabilitation Center (RRC), functional improvement goals are used to measure increases in mobility, speech and other areas for adults recovering from stroke, brain or spinal cord injury and serious neurological disorders. Functional status is recorded at admission and discharge. From 1995-1998, the performance measure was attaining 80% of an individual's personal recovery goals. From 1999-2000, the performance measure involved attaining 75% of an individual's goals. Beginning in 2001, the performance goal is based on comparing patients' progress to a national standard of recovery where success is defined as exceeding the national average by 5% or more.



Source: Rochester Rehabilitation Center

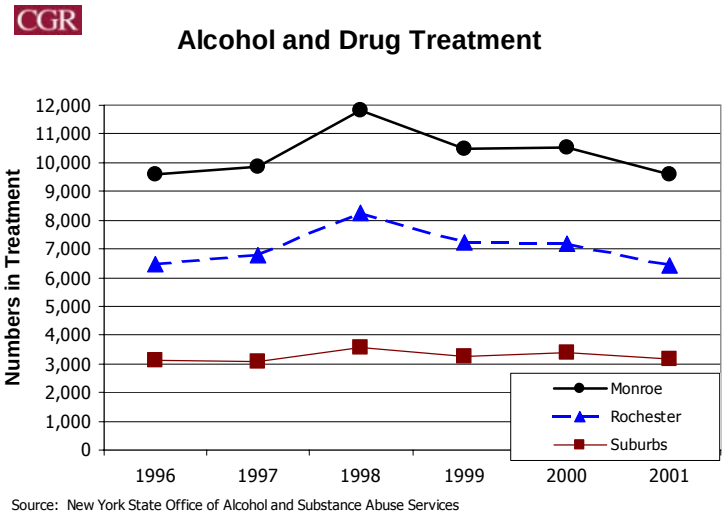
Findings: Only countywide data exist. As a result of the changes in the definition of the performance measure, it is difficult to ascertain if there is any true difference in results over time. Between 1995 and 1998, the percentage of clients attaining 80% or more of their treatment goals fluctuated between 64% and 84%. In 1999 and 2000, 85% and 72% of clients achieved at least 75% of their treatment goals. In 2001, when the measure was again redefined, with success meaning improvements exceeding the national average by 5%, 60% of RRC clients met this definition. Depression can be a major result of stroke. Individuals referred from an inpatient unit that specializes in stroke did better because depression was treated with medication. Data for this table are presented in Appendix Table 98.

Caveats: With three different definitions used for this performance measure in seven years, no clear trends can be ascertained.

Measure: Alcohol and Drug Abuse Treatment

Definition: The total number of admissions of chemically-dependent Monroe County residents to inpatient or outpatient alcohol and substance abuse treatment each year.

Some of these people may have been in treatment more than one time during the same year or during past years. Alcohol and substance abuse treatment have been figured together because 75 percent of all addicts abuse alcohol along with other drugs, according to OASAS figures.



Source: New York State Office of Alcohol and Substance Abuse Services

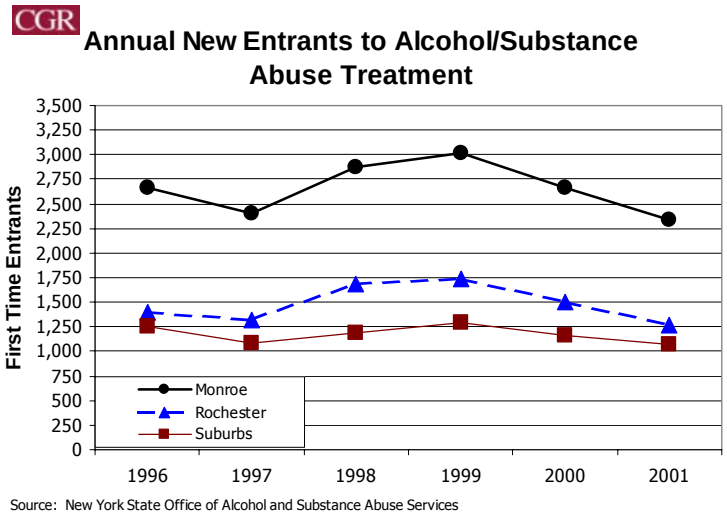
Findings: During the study period, the number of admissions of people receiving drug treatment peaked in 1998 at almost 12,000, but since then has declined to between 9,500 and 10,500 people annually. More people from the City of Rochester receive treatment than those from the suburbs, although City admissions have declined each year since 1998, while admissions involving suburban residents have remained relatively constant. As shown in the Appendix Table 99, most of the declines since 1998 have been in inpatient admissions.

Caveats: The number of admissions is influenced by changes in managed care treatment strategies and is limited by the number of treatment slots available at any given time. Data do not include out-of-county residents receiving treatment in Monroe County.

Measure: Annual First-Time Entrants to Alcohol/Substance Abuse Treatment

Definition: The number of chemically-dependent Monroe County residents entering outpatient or inpatient alcohol or substance abuse treatment for the first time. Prior treatment episodes are self-reported by clients.

Alcohol and substance abuse treatment have been figured together because about 75 percent of all addicts abuse alcohol along with other drugs, according to OASAS figures.



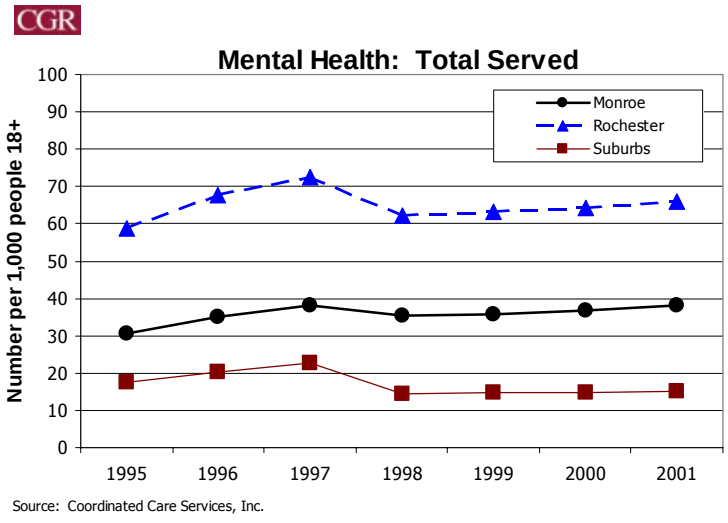
Source: New York State Office of Alcohol and Substance Abuse Services

Findings: Countywide, the number of new entrants to treatment has declined somewhat since the late 1990's. In 1999, 3,022 Monroe County residents entered treatment for the first time. In 2001, this number had declined to 2,340 first-time entrants, a decrease of 23%. The number of first-time outpatient entrants fell 22% during this time, to 2,207. Meanwhile, the number of first-time inpatient entrants fell 65% from its 1998 peak of 379 to 133 in 2001. Declines have been seen in both the City of Rochester (an overall decline of 27% since the 1998 peak) and the suburbs (an overall decline of 17% during that period). Data for this measure are presented in Appendix Table 100.

Caveats: The number of first-time admissions is influenced by changes in managed care treatment strategies and is limited by the number of treatment slots available at any given time. Data do not include out-of-county residents receiving treatment in Monroe County.

Measure: Prevalence Of Mentally Ill Receiving Services

Definition: The rate per thousand of people ages 18 and older (including adults and seniors) receiving inpatient or outpatient mental health services in a hospital or community mental health center in Monroe County. These data include only those residents served in publicly-funded and certified mental health programs reporting to the CCSI database. The CCSI database does not include clients of private practitioners, whom suburbanites may be more likely to seek out for mental health treatment. It does cover a high proportion of seriously and persistently mentally ill persons.



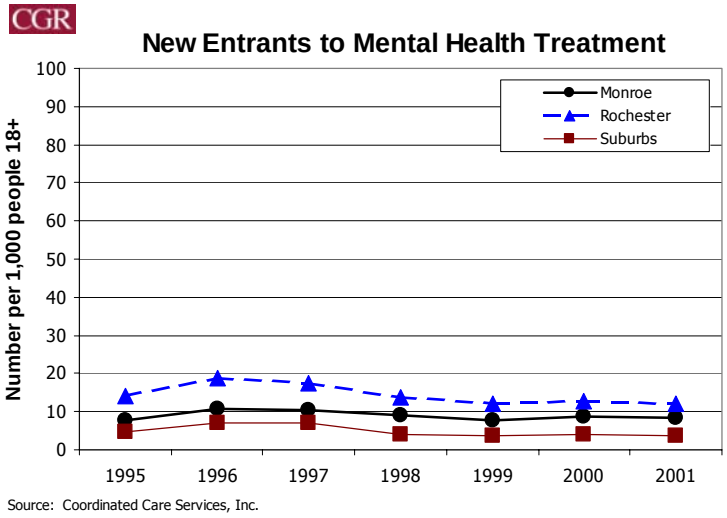
Source: Coordinated Care Services, Inc.

Findings: The number of individuals receiving mental health treatment in Monroe County has been fairly steady since 1996, with between 35 and 38 people 18 and older receiving treatment per 1,000 adults in Monroe County. This represents a low of 18,690 Monroe County residents in 1996 and a high of 20,780 people in 2001. The rate of mental health treatment is several times higher in the City of Rochester than in the suburbs. For example, in 2001, there were at least 66.1 people in mental health treatment for every 1,000 city adult residents, or 10,440 city residents in mental health treatment. In contrast, there were at least 15.1 people in mental health treatment for every 1,000 suburban adult residents, or 8,695 suburbanites. Both of these city and suburban totals are slight undercounts, as each year, between 5% and 8% of county residents receiving services cannot be accurately allocated to a city or suburban location. Also, these data do not include private practitioners, which suburbanites may be more likely to seek out for mental health treatment. For more detailed information, please see Appendix Table 101.

Caveats: Changes over time in the number of people receiving treatment may be attributed as much to changes in the system and to health insurance coverage as to seriousness of mental illness or the community's ability to improve the collective mental health of the population.

Measure: New Entrants to Mental Health Treatment Services

Definition: The rate per thousand population 18 and older (including seniors) entering inpatient or outpatient mental health services in a hospital or community mental health center in Monroe County for the first time. These data include only those residents served in publicly-funded and certified mental health programs reporting to the CCSI database and do not include clients of private practitioners. The data do cover a high proportion of severely and persistently mentally ill persons.



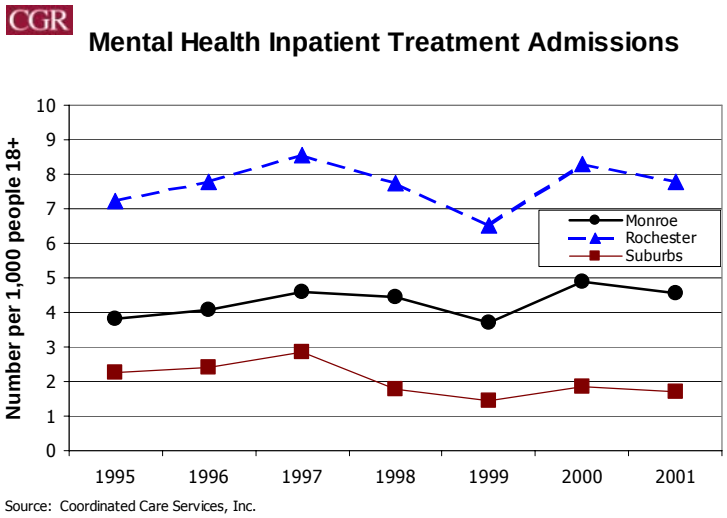
Source: Coordinated Care Services, Inc.

Findings: The rate of individuals entering mental health treatment for the first time in Monroe County has been relatively constant since 1998, varying between 7.7 and 8.9 per 1,000 adults. In the City of Rochester, the rate fluctuated between 12.0 and 13.6 new entrants per 1,000 adult city residents, or between 1,896 and 2,156 adults. In the suburbs, rates vary between 3.6 and 4.1. Rates of first-time entrants are about three times higher in the city than in the suburbs. However, in the suburbs, the *number* of first-time mental health entrants is higher than in the city, between 2,061 in 1999 and 2,390 in 1998. For more detailed information, please see Appendix Table 102.

Caveats: Reported city and suburban rates for 1998-2001 are slightly undercounted, as some county residents using services those years could not be accurately allocated to city or suburban locations. Prior to 1998, data were collected in a different manner by a different firm and may not be comparable to data in subsequent years. Changes over time in the number of people receiving treatment may be attributed as much to changes in the system and to health insurance coverage as to seriousness of mental illness or the community's ability to improve the collective mental health of the population.

Measure: Number of Individuals Admitted to Mental Health Inpatient Treatment

Definition: The rate per thousand population 18 and older (including seniors) admitted to inpatient mental health treatment services in a psychiatric unit in Monroe County. The CCSI database does not include clients of private practitioners, whom suburbanites may be more likely to seek out for mental health treatment.



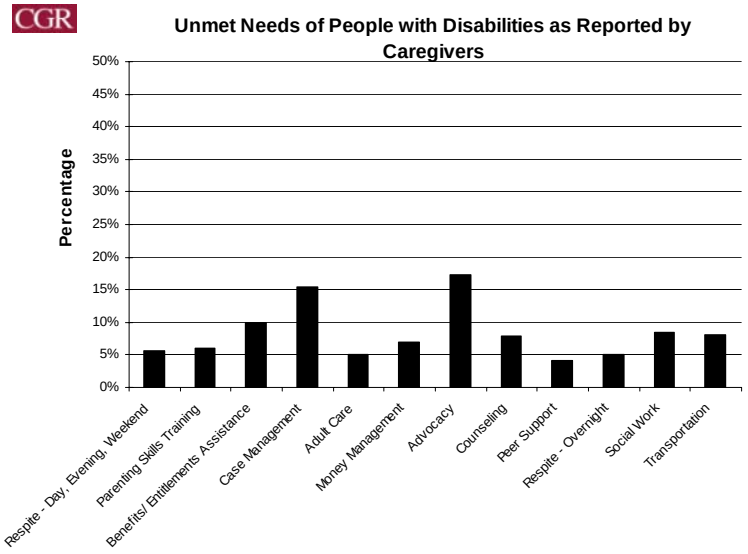
Source: Coordinated Care Services, Inc.

Findings: The number of inpatient treatment admissions has fluctuated between 2,032 and 2,667 individuals (with rates ranging between 3.7 and 4.9 per 1,000 adults) between 1995 and 2001. City rates of inpatient admission are consistently several times higher than suburban rates. For more detailed information, please see Appendix Table 103.

Caveats: Actual city and suburban rates are somewhat higher than the rates shown here for 1998-2001 as some county users of services during these years could not be accurately allocated to a city or suburban address. Changes over time in the number of people receiving treatment may be attributed as much to changes in the system and to health insurance coverage as to seriousness of mental illness or the community's ability to improve the collective mental health of the population.

Measure: Unmet Needs of People with Disabilities as Reported by Caregivers

Definition: The New York State Office of Mental Retardation and Developmental Disabilities Services annually tracks specific families' service needs. For this measure, they examine the service needs of caregivers of mentally or developmentally disabled adults age 22 and older. The caregiver needs reported here are needs which were reported to OMRDD, but which were unmet at the time of the report. The types of needs recorded include adult day care, advocacy, entitlements assistance, case management, counseling, money management, parenting skills training, peer support, respite (day, evenings, weekends), respite (overnight), social work and transportation. Data are only available at the county level.



Source: Office of Mental Retardation and Developmental Disabilities DataPack

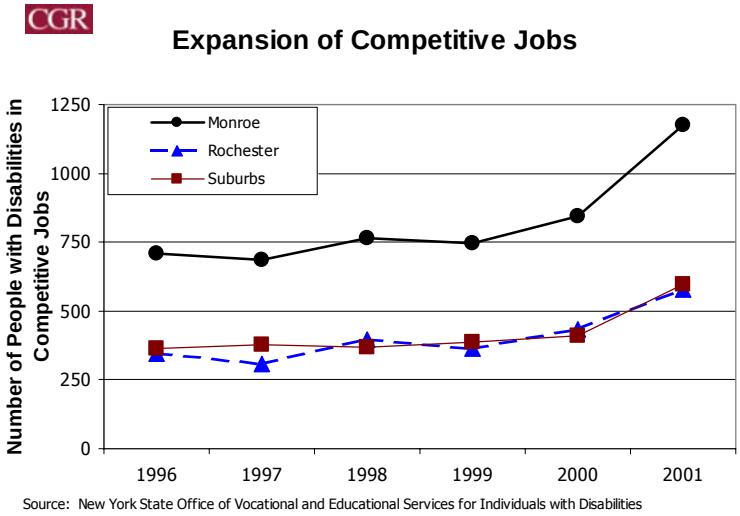
Findings: In 2001, the unmet need mentioned most frequently among families caring for people with disabilities was assistance with advocacy (18% of the identified concerns, involving 123 families). The other two most frequently-noted concerns were the need for case management assistance (109 families, or 15% of the concerns noted) and benefits/entitlement assistance (10%, representing 70 families). Families were least likely to report an unmet need for peer support. For more detailed information, including historical trends in reported needs, see Appendix Table 104. The 2001 needs data are very similar to reported needs in each of the previous few years, with one primary exception: reported needs for respite care (both overnight and day, evening and weekend) have declined since 1998 (to between 36 and 40 families, respectively).

Caveats: Outreach and better reporting may be contributing to the higher numbers over the past few years. The reported data do not indicate what proportion of all families caring for a disabled person is represented by these numbers. Families may have an unmet need in more than one category. Also, it is not clear what checks, if any, are placed on the validity of the reported needs.

Measure: Expansion of Competitive Jobs Held by People with Disabilities

Definition: The number of people with disabilities who are trained by VESID (Vocational and Educational Services for Individuals with Disabilities) and ultimately employed in competitive jobs without any special supports and earning minimum wage or higher.

Recent changes in reimbursement have resulted in the phase-out of sheltered workshops and in combining supported and competitive employment, thereby contributing to some increases in reported competitive jobs in 2001.



Source: New York State Office of Vocational and Educational Services for Individuals with Disabilities

Findings: In 1996, 709 Monroe County residents were trained by VESID and placed in competitive jobs. By 2000 that number had increased to 844 and by 2001, 1,176 Monroe County residents were trained by VESID and placed in competitive jobs (up 66% from 1996). At least a portion of this increase is a result of changes in the way data are reported, beginning in 2001. About equal numbers of people from the city and the suburbs are placed each year. In 2001, a little less than 600 residents from the suburbs and almost as many from the city were placed in competitive employment. Data are also available from the New York State Commission for the Blind and Visually Handicapped (CBVH), but since they could not be broken down by geographic area, they are not included in this narrative and graph. They are available for reference in Appendix Table 105.

Caveats: These data do not include people with disabilities hired in competitive jobs without VESID training or those placed independently by state funded agencies like DDSO and CCSI.

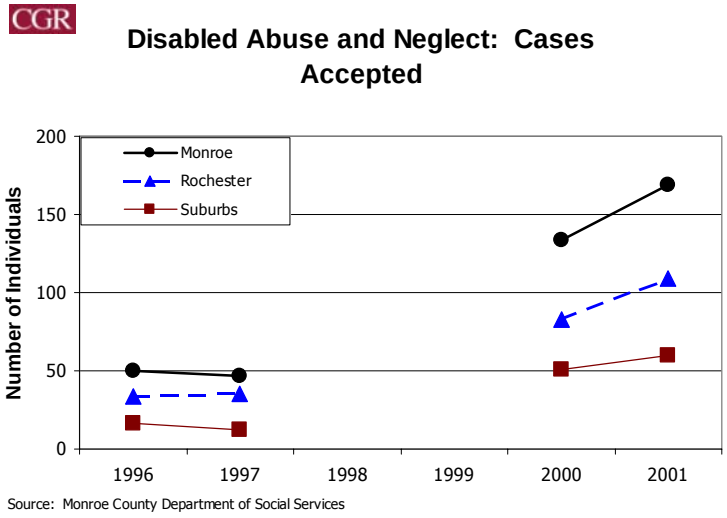
Outcome II: Personally Safe People with Disabilities

- Abuse and Neglect Against People with Disabilities
- Inventory of Accessible and Adaptable Rental Units

Since the mid-1990s, there has been some progress towards achieving this outcome.

Measure: Abuse and Neglect Against People with Disabilities

Definition: This measure reflects the number of mentally ill or developmentally disabled adults 21 and older who are served by the Adult Protective Services of the Department of Social Services. The measure reflects the number of individuals served by APS who have been harmed or are threatened by harm through their own or another's action or inaction. Harm is defined as physical or mental injury; neglect or maltreatment; failure to receive adequate food, shelter or clothing; deprivation of entitlements due to a person or wasting their resources. Cases accepted for services are a more reliable measure than reported cases, which are subject to many outside influences.

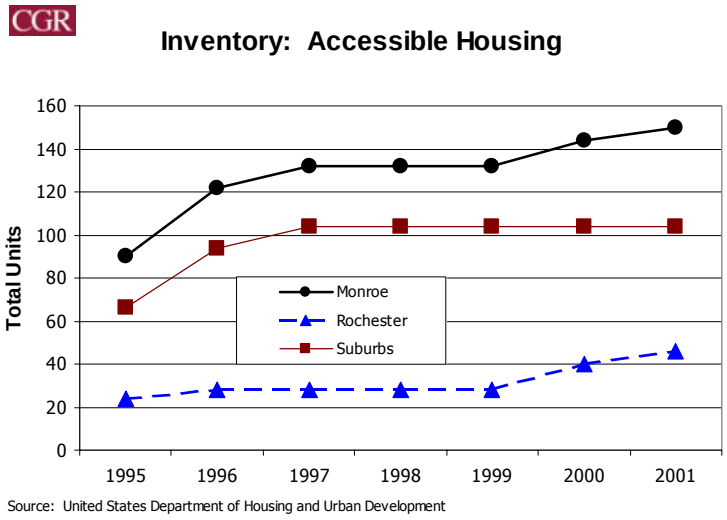


Findings: No data are available for 1998 and 1999 as of the deadline for printing this report. The graph indicates an increase in the number of accepted cases of abuse and neglect from 1997 through 2001, but without data for the intervening years, it is difficult to assess the trend. Overall, it does seem that Adult Protective Services is accepting more cases of abuse and neglect for mentally ill and disabled adults over the past few years. Data for this measure are presented in Appendix Table 106.

Caveats: This is not a particularly good measure of violence, but it is included because there are no law enforcement data on violence against people with disabilities.

Measure: Inventory of Accessible and Adaptable Rental Units

Definition: Accessible housing units are ones where public and common use spaces and facilities can be approached, entered and used by people with disabilities. A unit is considered adaptable if its interior is designed with wider doors; can accommodate the installation of grab bars around toilets and bathtubs; has light switches, electrical outlets, thermostats and other environmental controls in accessible locations; and has kitchens and bathrooms usable by people with disabilities. This measure only reflects housing construction funded by the U.S. Department of Housing and Urban Development (HUD). There may be additional accessible housing units financed through other methods.



Source: United States Department of Housing and Urban Development

Findings: These data represent a cumulative total of HUD construction in Monroe County of Section 202 subsidized housing for disabled and handicapped people. There has been an overall increase in HUD construction of affordable, accessible housing since 1995 with a greater proportional increase in the City of Rochester, although overall, more than two-thirds of the accessible units are located in the suburbs. Since 1995, there has been a 67% increase in accessible housing in Monroe County, consisting of a 92% increase in the City of Rochester and a 58% increase in the suburbs. Prior to 1993, all the affordable housing for people with disabilities in Monroe County was located in the suburbs. Now, about a third of the HUD-funded affordable housing projects for people with disabilities are located in the city. There are also two projects currently underway: a 13-unit project in Fairport and an 8-unit project in Rochester. These projects are not included in the graph above or the appendix (See Appendix Table 107), but will be added once they are completed.

Caveats: HUD housing is only a subset of the total accessible housing available in Monroe County.

Outcome III: People with Disabilities Exercising Self-Determination

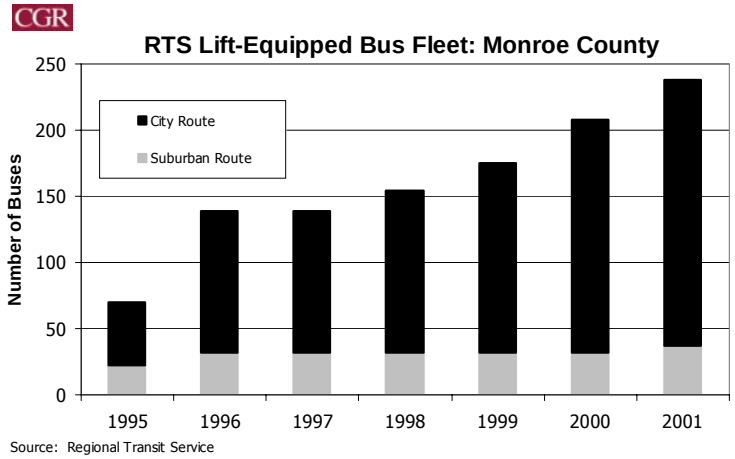
- RTS Lift-Equipped Bus Fleet
- Progress Against Alcoholism and Substance Abuse Treatment Goals

Compared to the mid-1990s, overall county progress towards achieving this outcome has improved.

Measure: RTS Lift-Equipped Bus Fleet

Definition: Number of lift-equipped buses plying RTS city and suburban routes.

City routes cover a distance of up to 10 miles from the city terminal and provide a local service. Suburban routes cover the entire county, charge a zone fare in addition to the base fare depending on the distance traveled, and operate as an express outside the city limits.



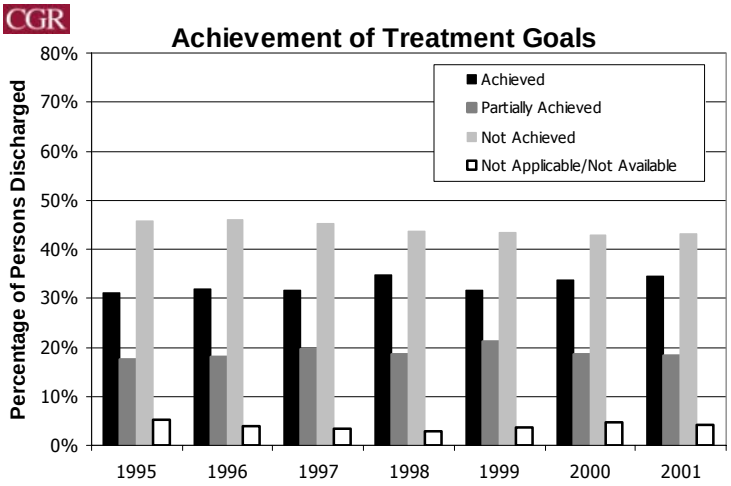
Findings: The number of lift-equipped buses operated by RTS has been increasing, implying that wheelchair users have more availability of and accessibility to public transportation. The total number of lift-equipped buses in the suburbs has remained relatively constant, while most of the increase has occurred in buses serving the City of Rochester. In 1995, there were 22 lift-accessible buses on suburban routes. By 2001, there were 37, a 68% increase. However, the number of lift-equipped buses in the suburbs remains significantly lower than the number of lift-equipped buses in the city. In 1995, there were 48 lift-equipped buses in the city. By 2001, there were 201, an increase of 319%. For the entire county, the number of lift-equipped buses increased from 70 in 1995 to 238 in 2001, a 240% increase. Data are available by County RTS network only. Data for this measure are presented in Appendix Table 108.

Caveats: None

Measure: Progress Against Alcoholism and Substance Abuse Treatment Goals

Definition: Percent of people achieving treatment goals at discharge from substance abuse inpatient and outpatient treatment.

Each person in alcoholism or substance abuse treatment defines goals in the areas of alcohol use, drug use, vocational/educational, social functioning, emotional functioning, family situation and medical. At discharge, the individual is rated by staff caseworkers as to achievement, partial achievement, or non-achievement of overall program goals.



Source: New York State Office of Alcoholism and Substance Abuse Services

Findings: The level of achievement of goals at discharge has remained relatively constant since 1995. Approximately a third of the clients (3,311 clients in 2001) achieve their goals at discharge and about a fifth (1,752 in 2001) partially achieve their goals. At the same time, between 40% and 45% of clients have not achieved any of their goals at discharge (4,137 in 2001). Data are only available at the county level. Data for this measure are presented in Appendix Table 109.

Caveats: This information does not include persons in short-term emergency or detoxification programs where treatment goals are not defined.

Outcome IV: Financially Secure People with Disabilities

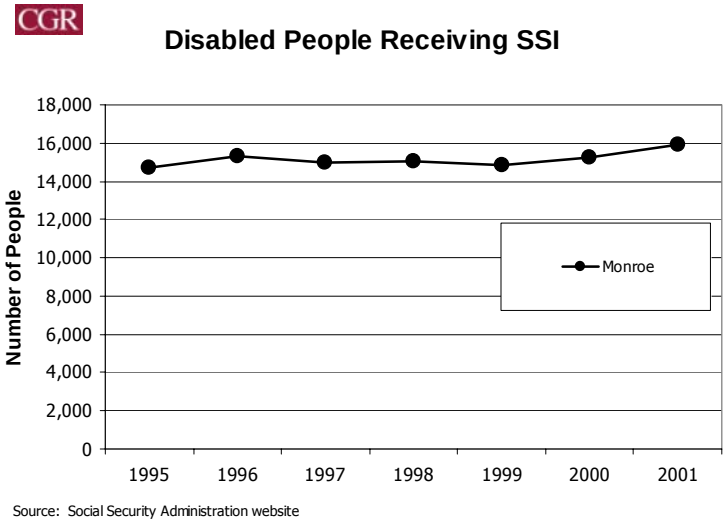
- People with Disabilities Receiving SSI Payments
- Sources of Income for Mentally Ill Adults: Employment
- Number of job Placements by Type Among Adults with Disabilities
- Number of People with Disabilities Moved from Welfare to Employment
- Proportion of Those in Substance Abuse Treatment Who Maintain or Improve Their Employment Status

Since the mid-1990s, overall county progress towards achieving this outcome has been mixed, with two measures improving, two worsening, and progress of one is undetermined.

Measure: People with Disabilities Receiving SSI Payments

Definition: People with disabilities in need of financial assistance typically obtain it through Supplemental Security Income Aid to the Disabled or the Blind. These totals are a combination of the two groups.

The numbers represent active recipients in December of each year. Only county data are available. No breakdown is available by disability type.



Source: Social Security Administration website

Findings: In the early 1990's, the number of SSI beneficiaries was increasing steadily at about 10% per year. Since the mid-1990's, the increase has leveled off considerably, with some years even seeing a minor decrease in the number of beneficiaries. In the past two years, there have been modest increases in the number of beneficiaries (from 14,875 in 1999 to 15,943 in 2001, a 7.2% increase), but it is too soon to determine if this represents a trend. Data for this measure are presented in Data Table 110.

Caveats: Not everyone who is eligible for benefits applies and receives them. It is not always clear whether increases indicate that more people with disabilities are poor, or that more people are making better use of the system.

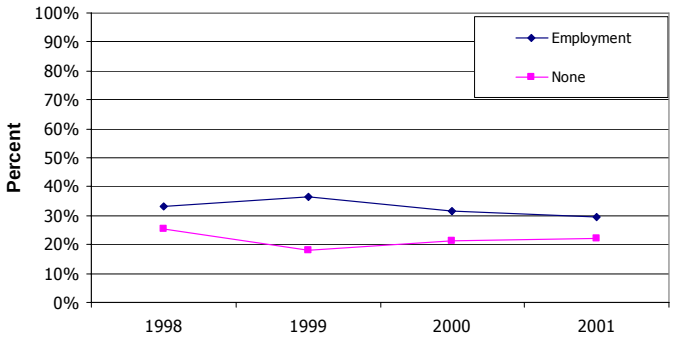
Measure: Sources of Income for Mentally Ill Adults

Definition: The sources of income for new clients entering the mental health treatment system during a given year.

This information represents only those Monroe County residents served in mental health programs reporting to the CCSI database. The data reported here are critically dependent upon the accuracy and comprehensiveness of the data collection process at participating agencies. These data do not include individuals who receive services from private mental health practitioners.

CGR

Percentage of New Entrants by Primary Income Source



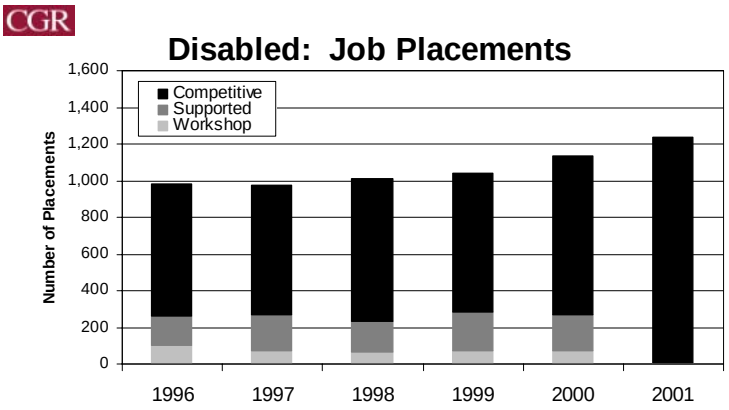
Source: Coordinated Care Services, Inc.

Findings: Since 1994, employment has consistently been the primary source of income for new mental health clients, with 1,348 (29.3% of new clients) reporting that as their primary income source in 2001. Various types of welfare payments represent the second most frequent source of income. Between 600 and 700 new clients a year typically report such primary income sources (down from around 1,000 in 1996 and 1997). Between 300 and 375 typically report family support as their primary income source. SSI/SSD is typically the least common primary source of income for new mental health clients: 3.6% in 2001. In three of the last four years, more than 1,750 new clients have reported unknown or no regular source of income (38.7% in 2001). Slightly over half of these people specifically reported no income and the remainder did not list their primary income source. It seems likely that many of the latter also have no regular source of income. Among city residents, no/unknown income is typically most prevalent, with cash assistance/welfare and employment varying from year to year as the most frequent source of income. In the suburbs, the most common primary source of income is consistently employment (35.7% in 2001). Slightly smaller proportions report no or unknown income, and relatively few report cash assistance/welfare payments. For more detailed information, see Appendix Table 111.

Caveats: Shifts in income sources may be attributable in part to a changing welfare system.

Measure: Number of Job Placements by Type Among Adults with Disabilities

Definition: The number of placements in competitive, supported or sheltered workshop settings for adults with a variety of disabilities. Competitive employment involves working in the community without any support and earning at least the minimum wage; supported employment may or may not pay the minimum wage and involves placements in jobs under the supervision of a special instructor who assists in on-the-job training and acclimation to the social environment. Sheltered employment legally allows workers to receive less than the minimum wage and involves working in a federally-certified rehabilitation facility under constant supervision. Recent changes in reimbursement have resulted in the phase-out of sheltered workshops and in combining supported and competitive employment.



Source: New York State Office of Vocational and Educational Services for Individuals with Disabilities

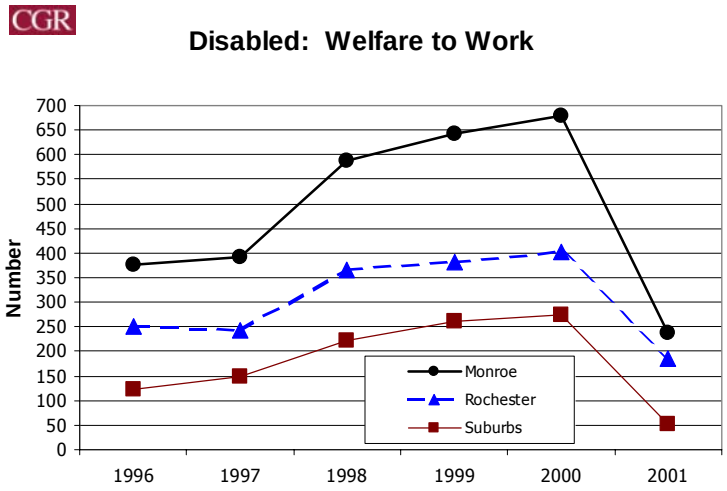
Findings: Through 2000, each year, about three-quarters of employment was competitive, with between 15% and 20% supported employment. The remainder of those people who found jobs were employed in sheltered workshops. As sheltered workshops are phased-out and supported employment is combined with competitive employment, the distinctions between the three categories will become obsolete in future years. For example, in 2001, the number of people in sheltered workshops had fallen to 7, supported employment had been completely eliminated and 1,227 were in competitive employment. The net effect of the change is that the 1,234 placements in 2001 were 26% higher than total placements in 1996. For detailed information, see Data Table 112.

Caveats: While a small percentage of these clients may be recidivists, the lengthy VESID eligibility and treatment process makes this proportion small. Also, data may be understated as they do not include direct placements by other state-funded agencies such as DDSO, or direct hires with no special training.

Measure: Number of People with Disabilities Moved From Welfare to Employment

Definition: The number of disabled people (developmental, physical, mental illness and alcohol and substance abuse) receiving SSI, Basic Assistance and AFDC/TANF who are moved from public assistance to employment.

Employment is defined as having a case closed for employment and holding a job for at least two months. These data are aggregated here across disabilities, but are broken out by specific disability in Appendix Table .



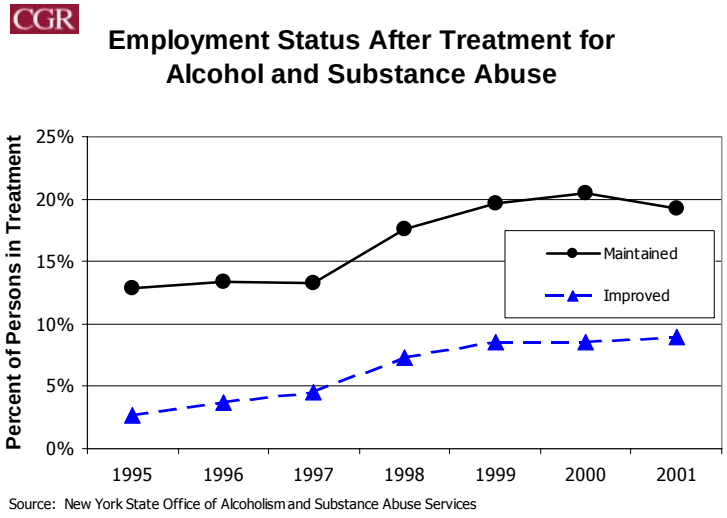
Source: New York State Education Department Office of Vocational and Educational Services for Individuals with Disabilities and Commission for the Blind.

Findings: After steady increases between 1996 and 2000, 2001 saw a large decline in the number of clients moved from welfare to work. In 2000, there were 678 disabled Monroe County residents who were moved from welfare to employment, 403 in the city and 275 in the suburbs. In 2001, these numbers fell to 185 recipients in the city and 53 in the suburbs, for a total of 238 disabled SSI recipients in Monroe County. This rapid decrease may partly reflect the phase-out of sheltered workshops. VESID believes this reduction is the result of two influences. First, welfare reform has provided strong incentives for those capable of work to find competitive employment. For many clients, their search for competitive employment was aided by a fairly strong economy. Those who remain on public assistance face multiple barriers to employment. In addition to their disability, they may face a lack of social skills or they may lack access to child care and/or suitable transportation. These barriers, combined with a declining economy and fewer people on welfare to begin with, made job placements in 2001 particularly low. Data are presented in Table 113.

Caveats: None.

Measure: Proportion of Those in Substance Abuse Treatment Who Maintain or Improve Their Employment Status

Definition: The percentage of persons discharged from alcohol or substance abuse detoxification, impatient, or outpatient treatment who either maintained their full- or part-time employment status from admission to discharge, or who moved from unemployed status at admission to full- or part-time employment at discharge. Data are available at the county level only.



Findings: The percentage of people who maintained or improved their employment status from admission to discharge increased from 1995 to 2000. The percentage in 2001 decreased somewhat, but it is too soon to determine whether this is a trend or an anomaly. From the data, it appears that it is easier to maintain employed status than it is to improve from unemployed status to employment. The total number of clients in alcohol or substance abuse detoxification, inpatient, or outpatient treatment has declined steadily over the study period, from 13,148 in 1995 to 9,591 in 2001. This decrease may reflect a reduced number of available beds and less funding, rather than a decline in the need for treatment. At the same time, the percentage of this smaller number of clients who are maintaining or improving their employment status at discharge has increased, meaning a greater proportion of clients are productively employed when they complete treatment. Data can be found in Appendix Table 114.

Caveats: Employability of any person participating in substance abuse treatment may be affected by his or her level of education, level of vocational skills, concurrent mental illness, or medical condition.

Additional Resources

For additional information pertaining to the outcomes and measures included in this chapter, as well as information on related topics, see the following:

- New York State Office of Alcoholism and Substance Abuse Services, http://www.oasas.state.ny.us/
- New York State Office of Advocate for Persons with Disabilities, http://www.advoc4disabled.state.ny.us/
- New York State Office of Temporary and Disability Assistance, http://www.dfa.state.ny.us/
- Substance Abuse and Mental Health Services Administration, http://www.samhsa.gov
- SAMHSA's National Mental Health Information Center, http://www.mentalhealth.org
- National Institute of Mental Health (NIMH) Home Page, http://www.nimh.nih.gov
- Americans with Disabilities Act, http://www.usdoj.gov/crt/ada/adahom1.htm
- Healthy People 2010, http://www.healthypeople.gov
- U.S. Census Bureau, http://www.census.gov
- Centers for Medicare and Medicaid Services, U.S. Department of Health, http://www.cms.gov

INDEX OF MEASURES – BY IMPACT AND OUTCOME AREA[4]

[4] While several measures included in this report relate to more than one Outcome Area, a full analysis of these measures appears only once in the earlier sections of the report. In this index we have listed each measure under the Impact Area for which it has primary relevance in regular font type. When a measure is related to additional Outcome Areas, but where that Outcome Area is not the area in which the in-depth analysis is found, the measure is listed in italics.

INDEX OF MEASURES – BY SUBJECT