ADIRONDACK HEALTH

Community Health Needs Assessment 2019

Community Service Plan 2019-2021

Table of Contents

Appendices

Contact information

The following organizations participated in the structural development of this Community Health Needs Assessment and Improvement/Service Plan. Respective committees and boards were engaged throughout the development process.

Heidi A. Bailey
Population Health Manager
Adirondack Health
hbailey@adirondackhealth.org
518-897-2735

Annette Marshall
Director of Executive Services
UVM Health Network – Alice Hyde Medical Center
amarshall@alicehyde.com
518-483-3000

Amanda Whisher
Primary Care Data Quality Specialist
UVM Health Network – Elizabethtown Community Hospital
awhisher@ech.org
518-873-3125

Sarah Granquist
Public Health Educator
Franklin County Public Health
sgranqui@franklincony.org
518-891-4471

Jessica Darney-Buehler, MPH
Coordinator – Emergency Preparedness & Response, MRC Public Health Unit
Essex County Health Department
jdarney-buehler@co.essex.ny.us
518-873-3518

Executive Summary

Introduction to Community Health Needs Assessment and Community Service Plan

From Adirondack Health's perspective, the primary purpose of this Community Health Needs Assessment (CHNA) is to identify and prioritize the healthcare challenges currently facing residents of Essex and Franklin counties. The findings are the end result of more than 18 months spent collecting and analyzing data, while also consulting with stakeholders throughout the communities and regions served by Adirondack Health. Ultimately, the results of this assessment are intended to assist members of the community, especially healthcare providers, in collaborative efforts to improve the overall health and wellbeing of those we serve.

The Community Service Plan (CSP) that follows the CHNA lays out, in detail, the specific New York State Prevention Agenda priorities and health disparities which Adirondack Health, in partnership with county health departments, community-based organizations, and our fellow healthcare providers, is working to address for the 2019-2021 time period. Our work was greatly informed by the Adirondack Rural Health Network (ARHN), the longest running program of the Adirondack Health Institute (AHI). Since 1992, ARHN has provided "a forum for public health leaders, community health centers, hospitals, behavioral health organizations, emergency medical services, and other community-based organizations to assess regional population health needs and develop collaborative responses to priorities. As a multi-stakeholder regional coalition, ARHN informs on planning assessment, provides education and training to further the NYS DOH Prevention Agenda and Delivery System

Reform Incentive Payment (DSRIP) Program, and offers other resources that support the development of the regional health care system."[1]

The Community Health Assessment (CHA) committee, facilitated by ARHN, is composed of 13 hospitals and county health departments, from seven counties, that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA committee counts among its members representatives from Adirondack Health, the University of Vermont Health Network - Alice Hyde Medical Center, the University of Vermont Health Network - Elizabethtown Community Hospital, the Essex County Health Department and Franklin County Public Health. This multi-county, regional committee has been meeting in person every three months throughout the last assessment and planning cycle and will continue to do so during the 2019-2021 cycle. This collaboration assists partners in tracking plan progress and in making mid-course corrections, if needed.

To engage the broad community, the CHA committee created a list of 807 community stakeholders, including professionals from healthcare, social services, educational, and governmental institutions as well as community members. A stakeholder survey, developed by the CHA committee to garner constructive feedback, was sent to the 807 identified stakeholders and posed 14 community health questions and several demographic questions. The stakeholder survey was conducted to gather information from a variety of fields and perspectives, providing valuable insight as to the community's needs. The survey summary provided a regional look at the results through a wide-angle lens, focusing

[1] https://ahihealth.org/arhn/

on the ARHN service area. It provided individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties.

The results enable the CHA Committee to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties. In addition to demographic and population health data provided by ARHN, Adirondack Health collected and analyzed quantitative data from its own electronic health records and multiple state and national sources including, but not limited to, county offices for the aging, the New York State Department of Health, the New York State Office of Mental Health, the U.S. Census Bureau and the federal Drug Enforcement Agency. Qualitative data was collected from medical providers and community-based organizations serving residents of Essex and Franklin counties.

A prioritization tool, inclusive of quartile ranking, severity score, and a prioritization worksheet, in consultation with internal and external stakeholders, led Adirondack Health to the specific Prevention Agenda priorities of promoting well-being and preventing mental and substance use disorders, preventing chronic disease, and promoting healthy women, infants and children. While there are no significant health disparities based on race/ethnicity in Franklin or Essex counties, there are significant access-to-care issues in both counties. Adirondack Health and its community partners will work to address health disparities pertaining to access, income, disability, care coordination, and social/environmental contexts via the following specific strategies:

Promote Well-Being and Prevent Mental and Substance Use Disorders

- Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan

- Goal 2.2 Prevent opioid overdose deaths
- Goal 2.6 Reduce the mortality gap between those living with serious mental illness and the general population

Prevent Chronic Diseases

- Goal 3.2 Promote tobacco use cessation
- Goal 4.1 Increase cancer screening rates
- Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
- Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes, prediabetes and obesity
- Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes, prediabetes and obesity

Promote Healthy Women, Infants and Children

- Goal 1.1 Increase use of primary and preventative healthcare services by women, with a focus on women of reproductive age

Progress and improvement toward these goals will be tracked primarily via Adirondack Health's electronic medical records. All other quantitative measures and evaluation metrics will be reported by the responsible parties. Adirondack Health and its partners in Franklin and Essex counties will meet to review the community health improvement plan on a quarterly basis. Any barriers to progress will be immediately addressed via the implementation of problem-solving interventions.

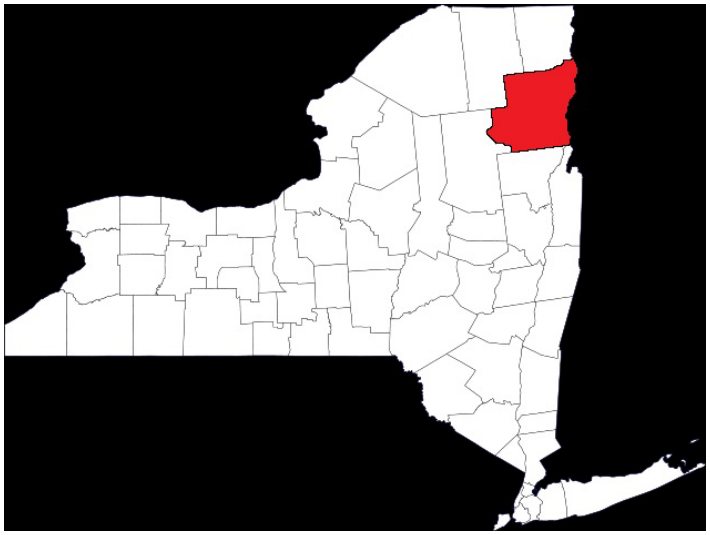
2019 Community Health Needs Assessment

Profiles of Adirondack Health's service area counties

Geographic and political profiles

Essex County is in the North Country region of northern New York (NY) and situated entirely within the Adirondack Park. The county is defined in red on the map below. In Essex County, Adirondack Health operates two primary care centers (Lake Placid and Keene), one emergency department (Lake Placid), one medically-integrated fitness center (Lake Placid) and one dental practice (Lake Placid).

Essex County is the second largest county in the state, with a land area of 1,796.80 square miles.[1] It is the third least-populated county in the state, with a population density of 21.15 people per square mile.[2] A majority of the county's land area (592,470 acres, or 48.38 percent) is state owned, while a minority (550,575 acres, or 44.94 percent) is privately owned.[3]



Essex County, NY

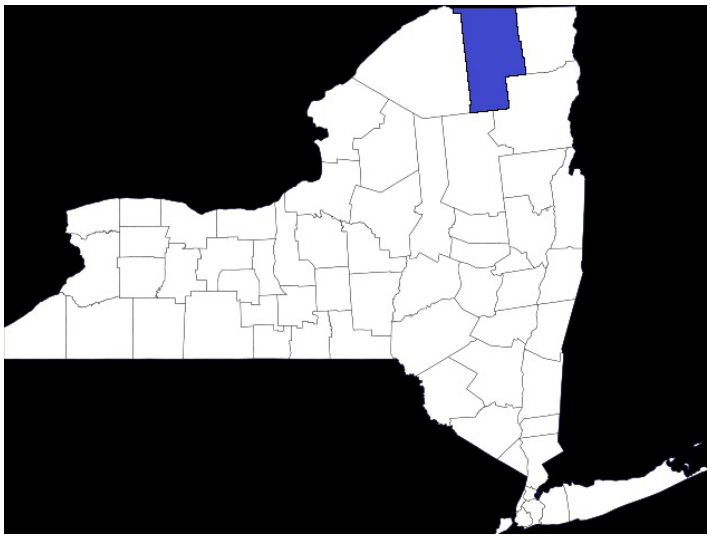
The 2018 population of Essex County was estimated to be 37,300, representing a 5.2 percent decrease from the 2010 U.S. Census estimate.[4] The county is comprised of 18 towns and two villages. Two former villages in Essex County – Keeseville and Port Henry – underwent dissolution in 2015 and 2017, respectively, and are now both classified as hamlets. The three most populous townships in Essex County are North Elba (8,957), Ticonderoga (5,042) and Moriah (4,798); the three least populous are North Hudson (240), Newcomb (436) and Essex (671).[5]

[1] https://www.health.ny.gov/statistics/vital_statistics/2017/table02.htm
[2] https://www.health.ny.gov/statistics/vital_statistics/2017/table02.htm
[3] https://www.apa.ny.gov/gis/stats/colc201803.htm
[4] https://www.census.gov/quickfacts/fact/table/essexcountynewyork,US/PST045218
[5] http://www.acapinc.org/wp-content/uploads/2019/03/2019-Community-Asmt-Report.pdf

Essex County is governed by a board of supervisors, with each supervisor elected by their respective town. Each supervisor wields a weighted vote, based on the population of the town represented. Board members select a chair and vice chair; the board chair appoints supervisors to committees of the board.[6]

Franklin County is in the North Country region of northern New York and situated mostly within the Adirondack Park. The county is defined in blue on the map below. In Franklin County, Adirondack Health operates one 95-bed acute-care hospital (Saranac Lake), one emergency department (Saranac Lake), three primary care centers (Tupper Lake, St. Regis Falls and Saranac Lake) and one 60-bed short-term rehabilitation/long-term care facility (Tupper Lake).

Franklin County is the fourth largest county in the state, with a land area of 1,629.12 square miles.[7] It is the fifth least-populated county in the state, with a population density of 31.38 people per square mile.[8] A minority of the county's land area (253,921 acres, or 34.51 percent) is state owned, while the majority (438,516 acres, or 59.60 percent) is privately owned.[9]



Franklin County, NY

The 2018 population of Franklin County was estimated to be 50,293, representing a 2.5 percent decrease from the 2010 U.S. Census estimate.[10] The county is comprised of 19 towns and six villages. The Saint Regis Mohawk reservation, *Akwesasne*, is situated in the northwestern corner of Franklin County and native residents retain the right to travel freely across the international border with Canada. The three most populous townships in Franklin County are Malone (14,139), Tupper Lake

[6] https://www.co.essex.ny.us/wp/essex-county-board-of-supervisors/
[7] https://www.health.ny.gov/statistics/vital_statistics/2017/table02.htm
[8] https://www.health.ny.gov/statistics/vital_statistics/2017/table02.htm
[9] https://www.apa.ny.gov/gis/stats/colc201803.htm
[10] https://www.census.gov/quickfacts/fact/table/franklincountynewyork,US/PST045218

(5,761) and Harrietstown (5,507); the three least populous are Duane (174), Santa Clara (345) and Brandon (577).[11]

Franklin County is governed by a board of legislators, with one legislator elected from each of the county's seven legislative districts. Each legislator wields an equal, unweighted vote. Board members select a chair and vice chair; the board chair appoints legislators to committees of the board.

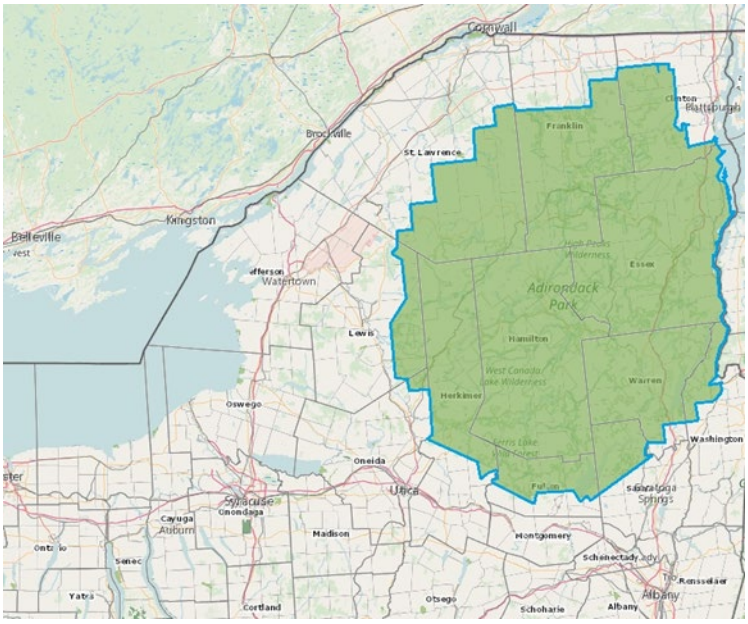
[11] https://web.archive.org/web/20150401191444/https://www.census.gov/prod/cen2010/cph-1-34.pdf

History and implications

Modern-day Essex County was the site of numerous military conflicts during the French and Indian War and the American Revolutionary War, due to the strategic value of Forts Ticonderoga and Crown Point on Lake Champlain's southwestern shore. The town of Whitehall, at the southern terminus of Lake Champlain, is considered the birthplace of the United States Navy.

Early industry in both Essex and Franklin counties included lumbering, agriculture and mining, but the Adirondack mountains were rightly viewed as rough, unforgiving wilderness until the 1870s, when wealthy New York City residents – assisted by local Adirondack guides – began vacationing and recreating in the region. Railroad lines, hotels, great camps and incorporated townships followed. Based on the work of Dr. E.L. Trudeau at his laboratory in Saranac Lake, tuberculosis patients from across the country and world began flocking to the sanatoriums of southern Franklin County to pursue the open-air "rest-cure."

At the same time, the southern Adirondacks were being heavily logged and deforested, due to the national demand for building materials that accompanied economic expansion in the post-Civil War Reconstruction Era. New York state officials eventually grew concerned that the deforestation and subsequent erosion of the southern Adirondacks would silt up the Erie Canal, threatening one of the state's premier economic drivers. In 1894, the state constitution was amended to grant perpetual protection to the New York State Forest Preserve, which halted logging and development activity on approximately three million state-owned acres of the six-million-acre Adirondack Park.



The Adirondack Park

Today, there are approximately 137,000 year-round residents inside the Adirondack Park's "Blue Line", another 200,000 seasonal residents and seven-to-ten million annual visitors.[12] Population centers in Franklin and Essex counties are oftentimes separated by expansive tracts of rugged Park land. This poses a significant challenge to transportation, particularly during the winter months with inclement weather and hazardous road conditions. In the least populated townships, isolation from even low-order goods and services can be pronounced.

These geographic barriers pose further challenges to collaboration, as do perceived cultural differences within and between counties and, in some cases, townships.

[12] https://www.roostadk.com/media-resources/media-kit

Adirondack Health service areas

Adirondack Health's primary service area (PSA) encompasses southern Franklin and northern Essex counties – Saranac Lake, Lake Placid, Tupper Lake, Paul Smiths, Bloomingdale, Gabriels, Lake Clear and Rainbow Lake. Eight of Adirondack Health's ten current patient access points are in the PSA. The estimated PSA population is 14,012.[13]

Adirondack Health's secondary service area (SSA) expands to include Long Lake, Childwood, Piercefield, Vermontville, Onchiota, Loon Lake and St. Regis Falls in Franklin County, and Keene, Ausable Forks, Jay, Upper Jay, Keene Valley and Wilmington in Essex County. Two of Adirondack Health's ten current patient access points are in the SSA. The estimated SSA population is 8,097.[14]

Adirondack Health's tertiary service area (TSA) further expands to include Malone, Constable, Brushton, Bangor, North Bangor, Colton, South Colton, Potsdam, Parishville, Star Lake, Newcomb, Elizabethtown and Saranac. Adirondack Health has no current patient access points in the TSA. Estimated TSA population is 45,473.[15]

Adirondack Health's total service area, then, contains approximately 67,582 people across four counties and 29 zip codes. However, most Adirondack Health patients reside in Essex and Franklin counties. Residents of the tertiary service area are generally in closer proximity to Canton-Potsdam Hospital or University of Vermont – Champlain Valley Physician's Hospital and tend to establish care accordingly.

[Appendix A: Franklin County CHA]

[Appendix B: Essex County CHA]

County demographics

For the purposes of this assessment, we will examine county-level data pertaining to the residents of Franklin and Essex counties, and township-level data for Adirondack Health's PSA, as appropriate and/or available.

Unless otherwise noted, all demographic data was provided by the Adirondack Rural Health Network (ARHN), a program directed by the Glens Falls-based Adirondack Health Institute. The ARHN region includes Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties.

[13] https://www.census.gov/quickfacts/
[14] https://www.census.gov/quickfacts/
[15] https://www.census.gov/quickfacts/

Population/race/ethnicity

Franklin County's population is 51,054. Like the rest of upstate New York, Franklin County's population is very limited in diversity – more than 82 percent white (non-Hispanic), six percent black (African American, non-Hispanic) and three percent Hispanic/Latino. More than 15 percent of the population is 65 years of age or older, which is slightly lower than the ARHN region (18.0 percent) and upstate New York (16.4 percent) as a whole.

Essex County's population is 38,233, making it the second-least populated county in the ARHN region. Essex County's population is also very limited in diversity – more than 92 percent white (non-Hispanic), three percent black (African American, non-Hispanic) and three percent Hispanic/Latino. More than 21 percent of the population is 65 years of age or older, which is slightly higher than the ARHN region (18 percent) and higher than upstate New York (16.37 percent) as a whole.

Household income

Average Franklin County household income is $62,870, with per capita income at $24,294; both of which are much lower than the state averages of $93,443 and $35,752, respectively. The share of individuals in Franklin County living below the Federal Poverty Level is 19.4 percent, significantly higher than the ARHN region (13.9 percent) and upstate New York (11.7 percent). In Franklin County, the unemployment rate is 4.2 percent.

Average Essex County household income is $69,488, with per capita income at $29,008; both of which are much lower than the state averages of $93,443 and $35,752 respectively. The percentage of individuals in Essex County living below the Federal Poverty Level is 8.9 percent, which is lower than the ARHN region (13.9 percent) and upstate New York (11.7 percent). In Essex County, the unemployment rate is 3.8 percent.

Asset-limited, income-constrained, employed (ALICE) profiles

In total, there are 19,299 households in Franklin County, with approximately 25 percent of residents over 65 years of age. There is a 18.2 percent poverty rate and 27.8 percent ALICE rate, with a total of 8,869 households designated as either living below the Federal Poverty Level or ALICE. Specific to ALICE households, the majority are white (5,191), which far exceeds the second-largest group of ALICE households – those whose residents are comprised of two or more races (44).

In total, there are 15,298 households in Essex County, with approximately 33.6 percent of residents over 65 years of age. There is a 10.2 percent poverty rate and 30.1 percent ALICE rate, with a total of 6,161 households designated as either living below the Federal Poverty Level or ALICE. Specific to ALICE households, the majority are white (4,449), which far exceeds the second-largest group of ALICE households – those whose residents are comprised of two or more races (49).

[Appendix C: Regional ALICE Profile]

Education and workforce

Within Franklin County, there are eight school districts and total enrollment of 7,493 students. Of the enrolled students, 57 percent are eligible for free and reduced lunch, with the majority (88 percent or 3,594 students) eligible for free lunch. The high school dropout rate is 2.0 percent, which is higher than the ARHN region (0.8 percent) and upstate New York (0.64 percent), but lower than the statewide dropout rate of three percent. There are 10.7 students per teacher in Franklin County, which is comparable to the ARHN region but slightly lower than upstate New York (12.37 per teacher).

Of the total Franklin County population, approximately 37.2 percent of individuals 25 years of age or older have a high school diploma or equivalent as the highest level of education attained, and an additional 30.4 percent have completed an associate degree, bachelor's degree or higher. Fifty two percent of the population 16 years of age or older is in the workforce, with the highest percentage of individuals in the field of education (33.2 percent), followed by public administration (12.8 percent), retail trade (10.5 percent) and arts and entertainment (10.4 percent).

Within Essex County, there are 11 school districts and total enrollment of 3,806 students. Of the enrolled students, 50 percent are eligible for free and reduced lunch, with the majority (84 percent or 1,533 students) eligible for free lunch. The high school dropout rate is two percent, which is higher than the ARHN region (0.8 percent) and upstate New York (0.64 percent), but lower than the statewide dropout rate of three percent. There are 9.1 students per teacher in Essex County, which is comparable to the ARHN region but slightly lower than upstate New York (12.37 per teacher).

Of the total Essex County population, approximately 33.3 percent of individuals 25 years of age or older have a high school diploma or equivalent as the highest level of education attained, and an additional 57.6 percent have completed an associate degree, bachelor's degree or higher. Fifty seven percent of the population 16 years of age or older is in the workforce, with the highest percentage of individuals in the field of education (29.1 percent), followed by arts, entertainment, recreation, hotel & food service (13.6 percent), retail trade (11.6 percent) and manufacturing (8.7 percent).

Health system profiles

Franklin County has two hospitals, Adirondack Medical Center in Saranac Lake and the University of Vermont Health Network-Alice Hyde Medical Center in Malone. Between them, they possess 171 hospital beds (the majority of which are other beds), resulting in a rate of 334.9 beds per 100,000 residents. This rate is higher than the ARHN region (274.2 per 100,000 residents). There are two nursing home facilities (195 total beds, or 381.9 per 100,000 residents) and two adult care facilities (60 total beds, or 176.3 per 100,000 residents).

The rate of primary care physicians in Franklin County is 101.9 per 100,000 residents and the rate of total physicians is 206.5 per 100,000 residents.

Franklin County currently contains 12 health professional shortage areas: five (5) primary care, five (5) dental care and two (2) mental health.

Essex County has one hospital, the University of Vermont Health Network-Elizabethtown Community Hospital. It possesses 25 hospital beds (the majority of which are other beds), resulting in a rate of 65.4 beds per 100,000 residents. This rate is lower than the ARHN region (274.2 per 100,000 residents). There are three nursing home facilities (340 total beds, or 889.3 per 100,000 residents) and four adult care facilities (194 total beds, or 928.5 per 100,000 residents).

The rate of primary care physicians in Essex County is 66.2 per 100,000 residents and the rate of total physicians is 108.0 per 100,000 residents.

Essex County currently contains 14 health professional shortage areas: eight (8) primary care, three (3) dental care and three (3) mental health.

Health disparities

While there are no significant health disparities based on race/ethnicity in Franklin or Essex counties, there are significant access-to-care issues in both counties.

The percentage of adults possessing health insurance in Franklin County is 92.3 percent, with 81.1 percent of the population having a regular health care provider. The rate of age-adjusted preventable hospitalizations (111.5 per 10,000 residents,18 years of age or older) is lower than the rate for upstate New York (116.8) and the Prevention Agenda benchmark rate (122.0).

The rate of emergency department visits in Franklin County (4,694.2 per 10,000 residents) is lower than the ARHN region (4,866.3) but higher than upstate New York (3,865.6).

The percentage of Franklin County residents 18 years of age or older with a disability (24.5 percent) is lower than the ARHN region (25.6 percent), but higher than upstate New York (22.8 percent) and the state as a whole (22.9 percent).

The percentage of adults possessing health insurance in Essex County is 94.0 percent, with 88.5 percent of the population having a regular health care provider. The rate of age-adjusted preventable hospitalizations (109.0 per 10,000 residents, 18 years of age and older) is lower than the rate for upstate New York (116.8) and the Prevention Agenda benchmark rate (122.0).

The rate of emergency department visits in Essex County (4,912.1 per 10,000 residents) is higher than the ARHN region (4,866.3) and significantly higher than upstate New York (3,865.6).

The percentage of Essex County residents 18 years of age or older with a disability (26.8 percent) is higher than the ARHN region (25.6 percent), upstate New York (22.8 percent) and the state as a whole (22.9 percent).

Injuries/violence/occupational health

Motor vehicle accidents (2,273.3 per 100,000 residents) and speed-related accidents (498.9 per 100,000 residents) are higher in Franklin County than in the ARHN region (2,162.0 and 364.7, respectively), and significantly higher than the state as a whole (1,558.5 and 141.6, respectively).

The rate of motor vehicle accident deaths is higher in Franklin County (7.8) than the ARHN region (7.3), upstate New York (7.1) and the state as a whole (5.0).

The rate of violent crimes (198.7) is also higher than the ARHN region (171.8), but significantly lower than that of upstate New York (214.9) and the state as a whole (355.6).

Motor vehicle accidents (2,779.5 per 100,000 residents) and speed-related accidents (685.0 per 100,000 residents) are higher in Essex County than in the ARHN region (2,162.0 and 364.7, respectively), and significantly higher than the state as a whole (1,558.5 and 141.6, respectively).

The rate of motor vehicle accident deaths is higher in Essex County (7.9) than the ARHN region (7.3), upstate New York (7.1) and the state as a whole (5.0).

The rate of violent crimes (172.6) is slightly higher than the ARHN region (171.8), but significantly lower than that of upstate New York (214.9) and the state as a whole (355.6).

Built environment

The percentage of Franklin County residents with low income and low access to supermarkets or large grocery stores (9.3 percent) is much higher than in the ARHN region (6.0 percent), upstate New York (3.9 percent), the state as a whole (2.3 percent), and the Prevention Agenda benchmark (2.2 percent).

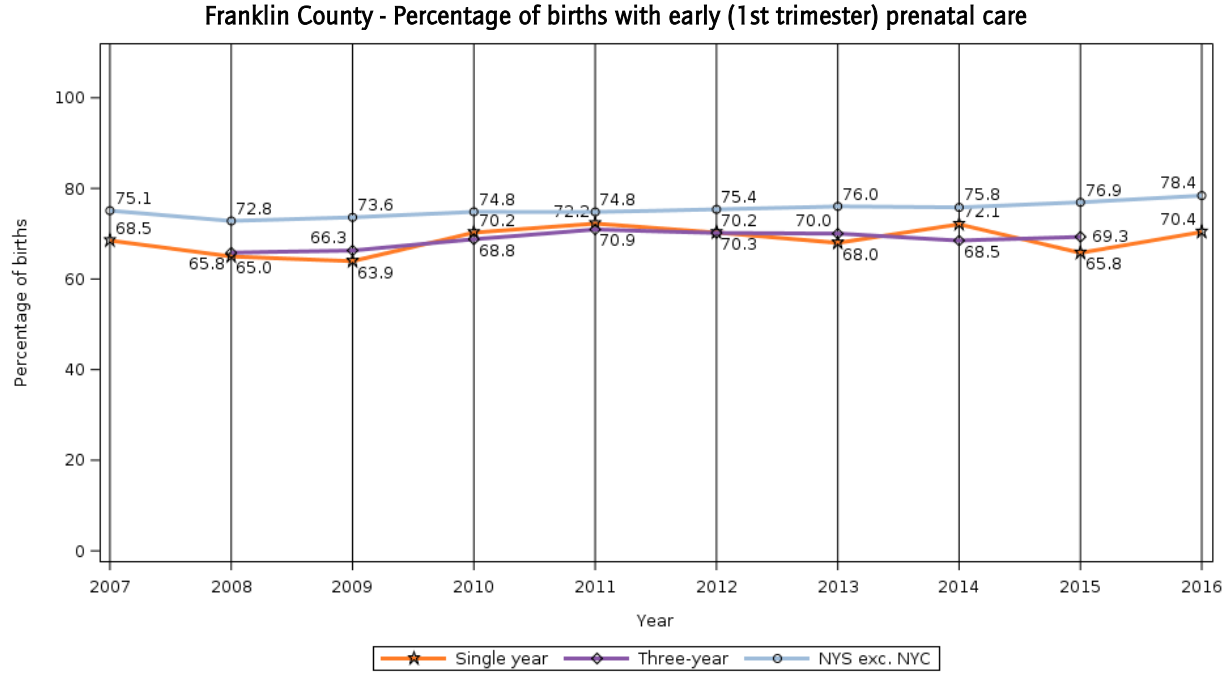
The percentage of Essex County residents with low-income and low access to supermarkets or large grocery stores (2.2 percent) is much lower than in the ARHN region (6.0 percent) and upstate New York (3.9 percent), and in line with the state as a whole (2.3 percent), and the Prevention Agenda benchmark (2.2 percent).

Women, infants and children

In Franklin County, the percentage of births within 24 months of previous pregnancies (23.4 percent) is higher than the Prevention Agenda benchmark (17 percent). The percentage of unintended pregnancies (37.3 percent) also exceeds the Prevention Agenda benchmark (23.8 percent).

The percentage of women receiving WIC in Franklin County with gestational weight gain greater than ideal (52.8 percent) is higher than the state as a whole (41.7 percent).[16] The percentage with gestational diabetes (8.7 percent) is also higher than the state as a whole (5.5 percent).[17] The percentage of pre-pregnancy obesity (32.6 percent) is lower than that of the ARHN region (33.3 percent), but higher than that of upstate New York (28 percent).

In Franklin County, the percentage of births with early (first trimester) prenatal care (69.3 percent) is lower than the North Country region (74.5 percent) and state as a whole (75.2 percent).[18]



In Essex County, the percentage of births within 24 months of previous pregnancies (23.4 percent) is higher than the Prevention Agenda benchmark (17 percent). The percentage of unintended pregnancies in Essex County (33.7 percent) also exceeds Prevention Agenda benchmark (23.8 percent).

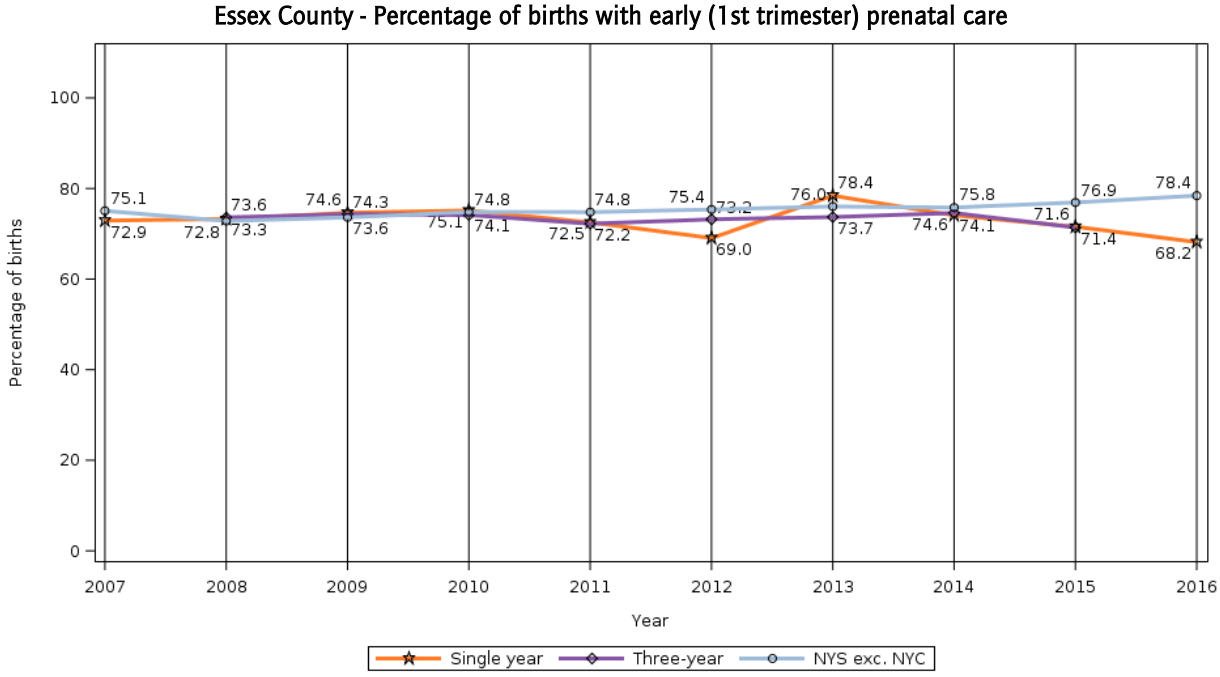
16 https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=16&ctop=9

17 https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=16&ctop=9

18 https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=16&ctop=9

The percentage of women receiving WIC in Essex County with gestational weight gain greater than ideal (52.9 percent) is higher than the state as a whole (41.7 percent).[19] The percentage with gestational diabetes (9.6 percent) is also higher than the state as a whole (5.5 percent).[20] The percentage of pre-pregnancy obesity (29.1percent) is lower than that of the ARHN region (33.3 percent), but higher than that of upstate New York (28 percent).

In Essex County, the percentage of births with early (first trimester) prenatal care (71.4%) is lower than the North Country region (74.5%) and state as a whole (75.2%).[21]



Obesity in children and adults

The percentages of obese adults (32.7 percent) and children (21.2 percent) in Franklin County are higher than their respective Prevention Agenda benchmarks (23.2 percent and 16.7 percent).

The rate of obesity in Franklin County elementary school children (20.1 percent) is higher than that of upstate New York (16 percent) and is essentially flat from 2016.

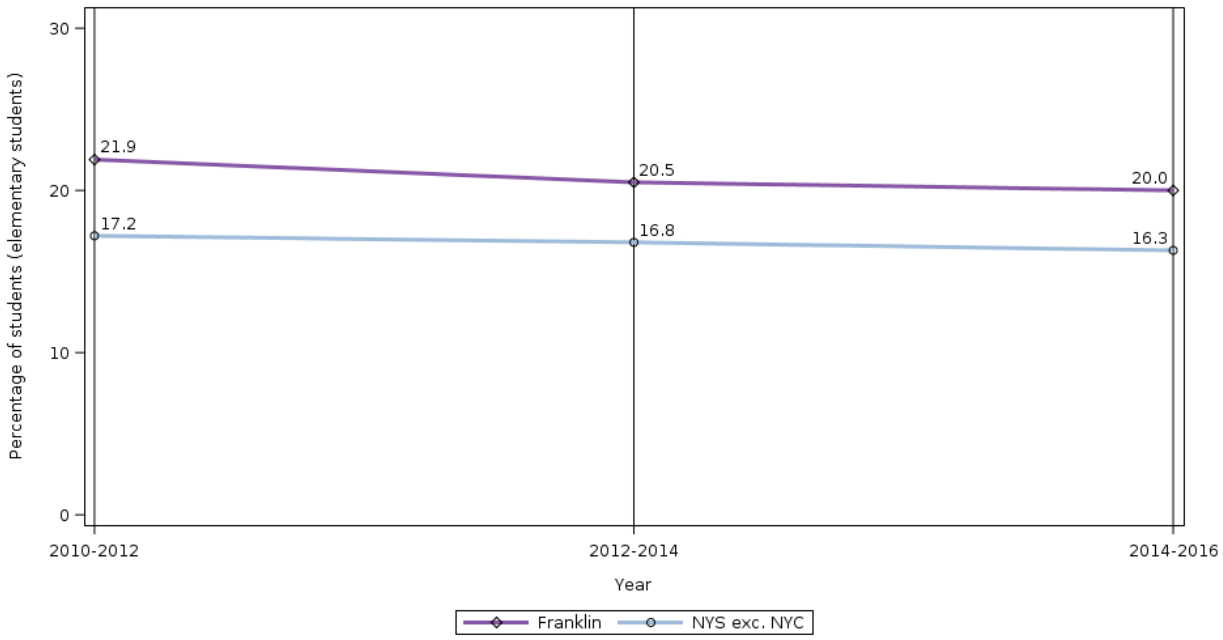
---

19 https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=15&ctop=9

20 https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=15&ctop=9

21 https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=ch&cos=16&ctop=9

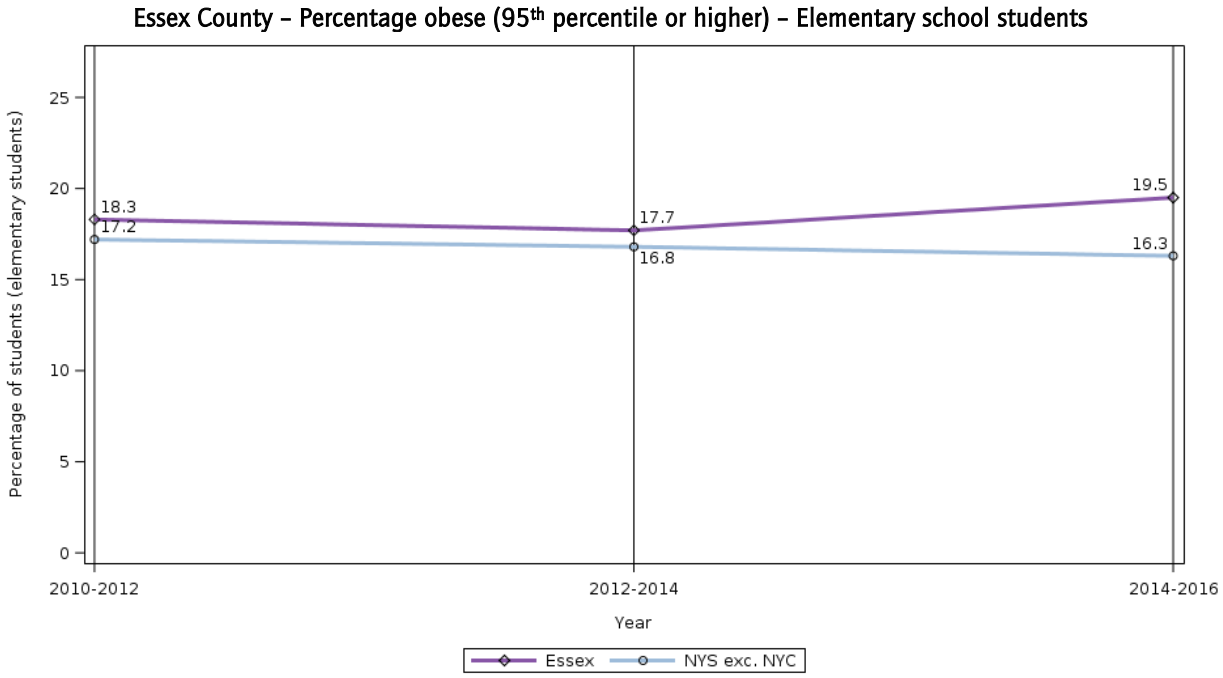
Franklin County – Percentage obese (95th percentile or higher) – Elementary school students



The burden of obesity may contribute to higher rates of death due to diabetes (any diagnosis) in Franklin County (29.5 per 100,000) than in upstate New York (15.4 per 100,000).

The percentages of obese adults (32.2 percent) and children (21.4 percent) in Essex County are higher than their respective Prevention Agenda benchmarks (23.2 percent and 16.7 percent).

The rate of obesity in Essex County elementary school children (18.7 percent) is higher than upstate New York (16 percent) but is trending downward from 2016.



The burden of obesity may contribute to higher rates of death due to diabetes (any diagnosis) in Essex County (39.9 per 100,000) than in upstate New York (15.4 per 100,000).

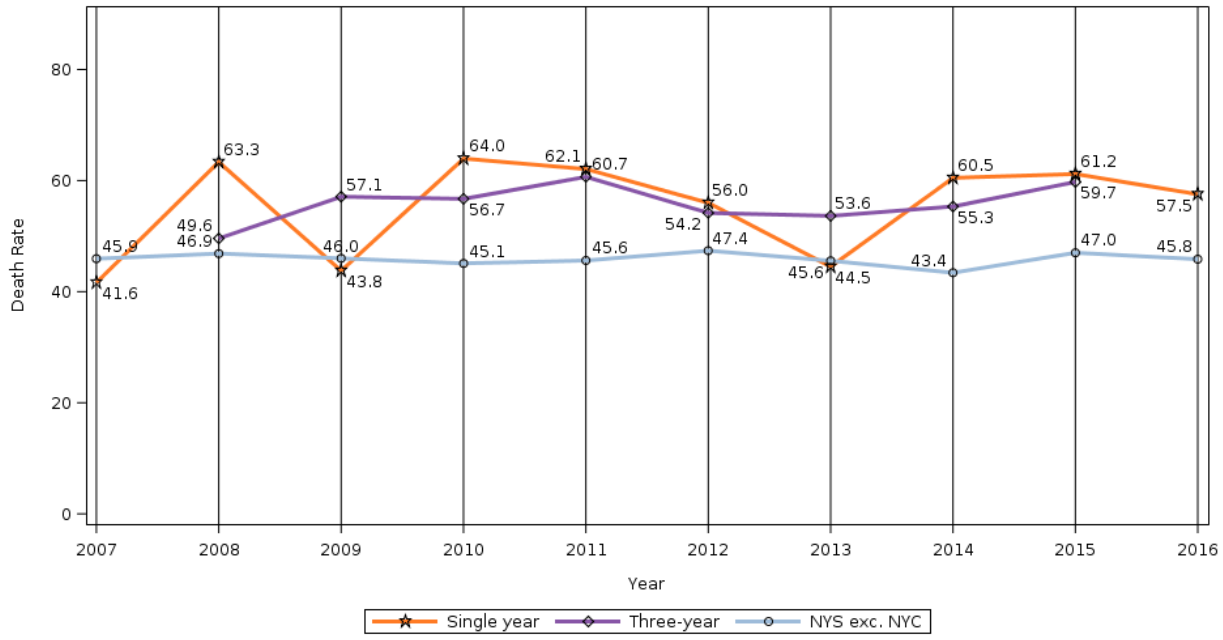
Chronic disease

Smoking and smoking-related diseases seem to pose a significant challenge for both Franklin and Essex counties.

In Franklin County, eight indicators are listed as worse than the comparison benchmark. The percentage of Franklin County adult smokers (28.8 percent) significantly exceeds the percentage of adult smokers in upstate New York (16.2 percent) and the state as a whole (14.2 percent), as well as the Prevention Agenda benchmark (12.3 percent).

Franklin County chronic lower respiratory deaths (59.7 per 100,000) are substantially higher than in upstate New York (45.4 per 100,000) and the state as a whole (34.1 per 100,000).

Franklin County - Chronic lower respiratory disease mortality rate per 100,000



At the same time, rates of hospitalization for chronic lower respiratory disease (19.6 per 100,000) are lower than in upstate New York (28.0 per 100,000) and the state as a whole (30.6 per 100,000).

The rates of lung and bronchus cancer diagnosis are lower in Franklin County (92.9 per 100,000) than in the ARHN region (112.2), but higher than upstate New York (84.3) and the state as a whole (69.7).

Lung and bronchus cancer deaths in Franklin County (67.4 per 100,000) are comparable to the ARHN region (67.4), yet higher than upstate New York (53.0) and the state as a whole (43.5).

In Franklin County, the hypertension emergency department visit rate for those 18 years of age or older (31.8 per 10,000) is higher than the North Country (27.6) but lower than the state as a whole (49.7).

The rates of colon and rectal cancer diagnosis (54.3 per 100,000) and death (19.0) in Franklin County are comparable to the ARHN region (55.0 and 18.9, respectively).

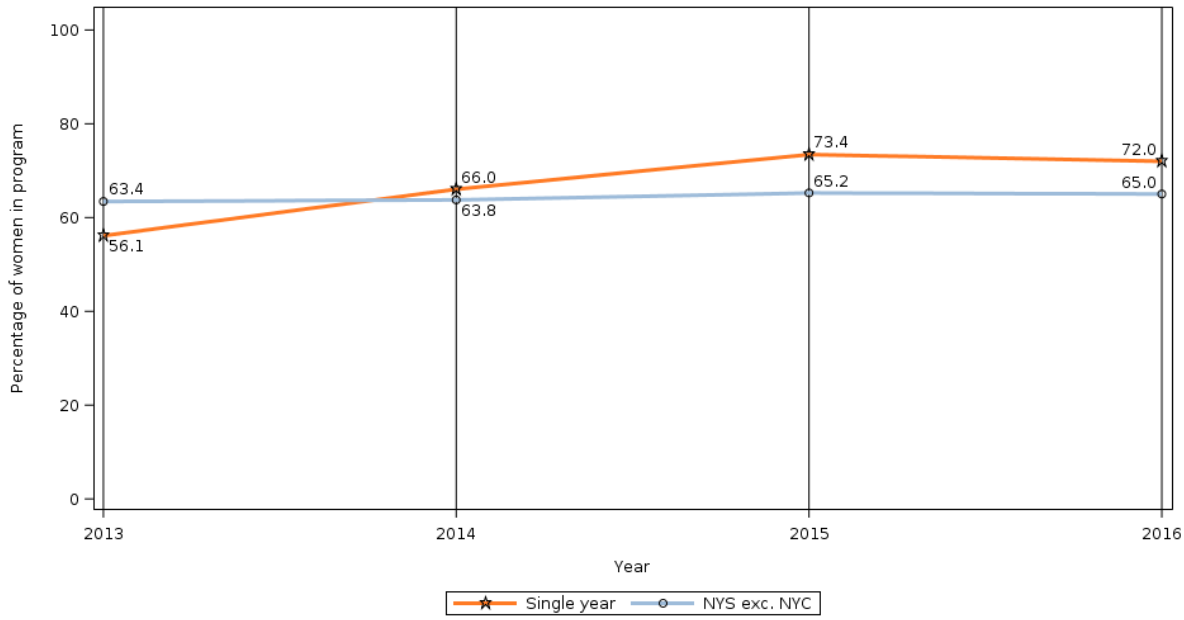
The percentage of colorectal screenings for those 50 to 75 years of age in Franklin County (74.1 percent) is somewhat higher than the ARHN region (73.6 percent), upstate New York (68.5 percent), and the state as a whole (69.7 percent).

The percentage of Franklin County women aged 21-65 years receiving cervical cancer screening based on 2012 guidelines (80 percent) is lower than the North Country (86.5 percent) and state as a whole (82.2 percent).

The percentage of Franklin County women aged 50-74 years receiving breast cancer screening based on recent guidelines (78.9 percent) is lower than the North Country (81.4 percent) and slightly lower than the state as a whole (79.7 percent).

The percentage of Franklin County women aged 50-74 years receiving mammograms between Oct. 1, 2014 and Dec. 31, 2016 (72 percent) is higher than the North Country (63.5 percent) and state as a whole (71.2 percent).

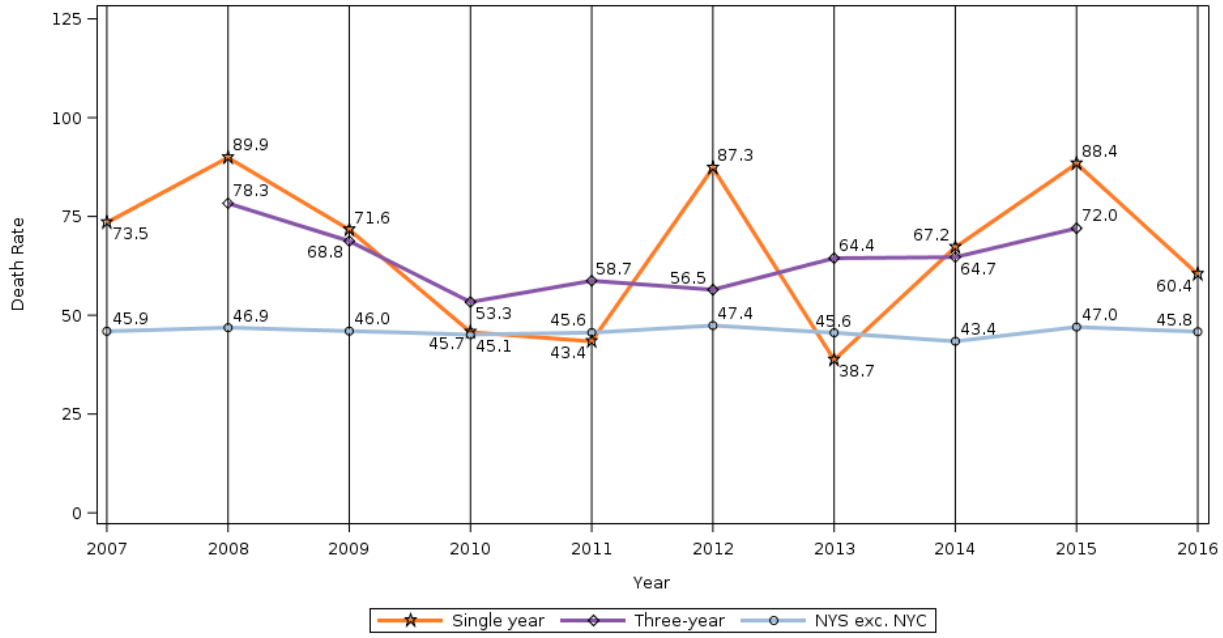
Franklin County - Percentage of women (aged 50-74 years) who had a mammogram between October 1, 2014 and December 31, 2016



In Essex County, seven indicators are listed as worse than the comparison benchmark. The percentage of Essex County adult smokers (16.8 percent) slightly exceeds the percentage of adult smokers in upstate New York (16.2 percent) and the state as a whole (14.2 percent), as well as the Prevention Agenda benchmark (12.3 percent).

Essex County chronic lower respiratory deaths (72.0 per 100,000) are substantially higher than in upstate New York (45.4 per 100,000) and the state as a whole (34.1 per 100,000).

Essex County - Chronic lower respiratory disease mortality rate per 100,000



At the same time, rates of hospitalization for chronic lower respiratory disease (22.6 per 100,000) are lower than in upstate New York (28.0 per 100,000) and the state as a whole (30.6 per 100,000).

The rates of lung and bronchus cancer diagnosis are higher in Essex County (114.0 per 100,000) than in the ARHN region (112.2), upstate New York (84.3) and the state as a whole (69.7).

Lung and bronchus cancer deaths in Essex County (70.8 per 100,000) are slightly higher than in the ARHN region (67.4), and much higher than upstate New York (53.0) and the state as a whole (43.5).

In Essex County, the hypertension emergency department visit rate for those 18 years of age or older (23.9 per 10,000) is lower than the North Country (27.6) and state as a whole (49.7).

The rates of colon and rectal cancer diagnosis (57.9 per 100,000) and death (20.7) in Essex County are slightly higher than in the ARHN region (55.0 and 18.9, respectively).

The percentage of colorectal screenings for those 50 to 75 years of age in Essex County (66.9 percent)[22] is lower than the ARHN region (73.6 percent), upstate New York (68.5 percent), and the state as a whole (69.7 percent).

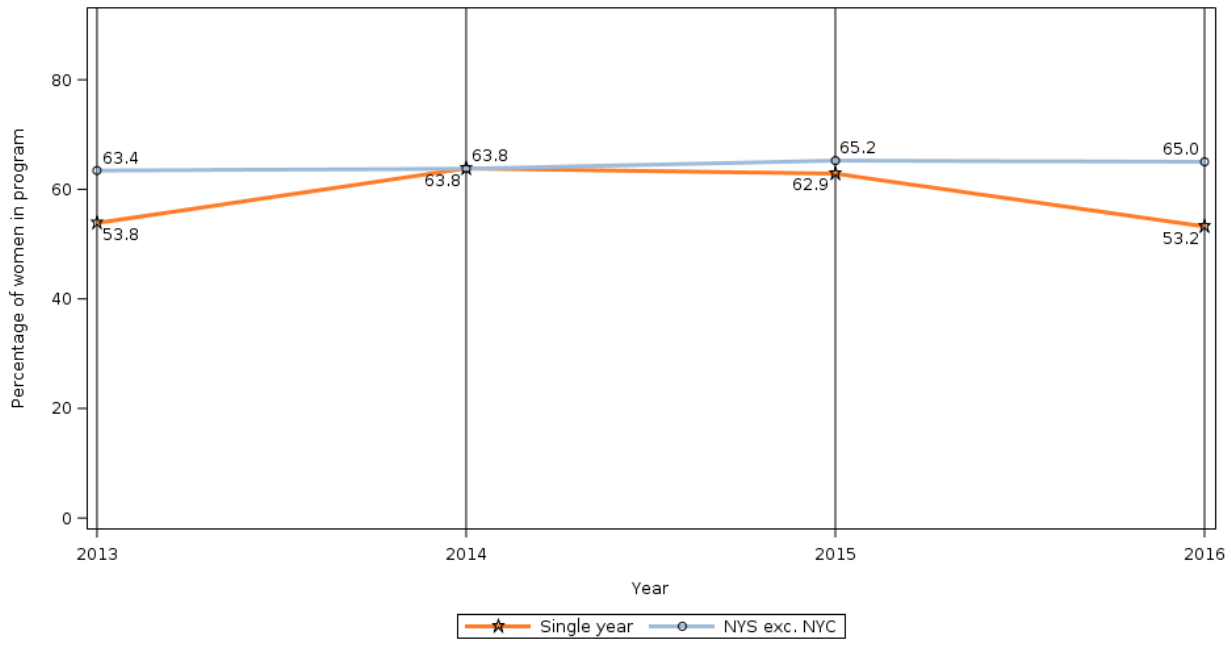
The percentage of Essex County women aged 21-65 years receiving cervical cancer screening based on 2012 guidelines (93.1 percent) is higher than the North Country (86.5 percent) and state as a whole (82.2 percent).

[22] NYS DOH Information for Action report 2019-05

The percentage of Essex County women aged 50-74 years receiving breast cancer screening based on recent guidelines (78.4 percent) is lower than the North Country (81.4 percent) and slightly lower than the state as a whole (79.7 percent).

The percentage of Essex County women aged 50-74 years receiving mammograms between Oct. 1, 2014 and Dec. 31, 2016 (53.2 percent) is substantially lower than the North Country (63.5 percent) and state as a whole (71.2 percent).

Essex County - Percentage of women (aged 50-74 years) who had a mammogram between October 1, 2014 and December 31, 2016



Vaccine-preventable disease

The 4:3:1:3:3:1:4 immunization rate for Franklin County children aged 19–35 months (66.6 percent) is lower than the Prevention Agenda benchmark (80 percent).

The percentage of Franklin County females aged 13-17 years receiving three-dose HPV vaccination (31.1 percent) is significantly lower than the Prevention Agenda benchmark (50 percent).

The rate of Pertussis cases in Franklin County (15.8 per 100,000) is higher than in the ARHN region (11.7) and is significantly higher than upstate New York (5.9) and the state as a whole (5.1).
The Franklin County rate of pneumonia/flu hospitalizations for those 65 years of age or older (84.1per 100,000) is lower than in the ARHN region (93.3), upstate New York (93.7) and the state as a whole (87.3).

The 4:3:1:3:3:1:4 immunization rate for Essex County children aged 19–35 months (73 percent) is lower than the Prevention Agenda benchmark (80 percent).

The percentage of Essex County females aged 13-17 years receiving three-dose HPV vaccination (34.2 percent) is significantly lower than the Prevention Agenda benchmark (50 percent).

The rate of Pertussis cases in Essex County (7.8 per 100,000) is lower than in the ARHN region (11.7), but still higher than upstate New York (5.9) and the state as a whole (5.1).

The Essex County rate of pneumonia/flu hospitalizations for those 65 years of age or older (98.4 per 100,000) is higher than in the ARHN region (93.3), upstate New York (93.7) and the state as a whole (87.3).

Substance abuse and behavioral health

In 2017, 42 percent of the Franklin County OMH population used tobacco – the highest percentage of any county in the state.[23]

The percentage of Franklin County adults who binge drink (17.8 percent) is lower than the Prevention Agenda benchmark (18.4 percent), while the percentage who reported 14 or more poor mental health days within the last month (13.1 percent) is higher than the Prevention Agenda benchmark (10.1 percent).

The rate of self-inflicted hospitalizations in Franklin County (3.4 per 10,000) is lower than in upstate New York (4.1) and the state as a whole (3.5).

The rate of alcohol-related crashes in Franklin County (94.8 per 100,000) is significantly higher than New York State (38.0).

Among those aged 15-19 years, the Franklin County suicide rate (0.0 per 100,000) is significantly lower than the ARHN region (10.7) and upstate New York (6.1).

In 2018, there were three documented Franklin County opioid overdoses resulting in death, a rate of 6.0 per 100,000. There were 15 documented administrations of Naloxone by EMS, law enforcement or registered COOP programs. 247 unique clients were admitted to OASAS-certified chemical dependence treatment programs.[24]

There are currently four medication drop boxes located in Franklin County (Franklin County Sheriff's Office, Saranac Lake Police Department, St. Regis Mohawk Tribal Police, Adirondack Medical Center).[25]

[23] NYS OMH Patient Characteristics Survey (2017)
[24] NYS DOH County Opioid Quarterly Report for New York State Counties
[25] https://www.health.ny.gov/professionals/narcotic/medication_drop_boxes/franklin.htm

In 2017, 28 percent of the Essex County OMH population used tobacco.[26]

The percentage of Essex County adults who binge drink (24.7 percent) is higher than the Prevention Agenda benchmark (18.4 percent).

The percentage who reported 14 or more poor mental health days within the last month (14.4 percent) is also higher than the Prevention Agenda benchmark (10.1 percent).

The rate of self-inflicted hospitalizations in Essex County (2.4 per 10,000) is lower than in upstate New York (4.1) and the state as a whole (3.5).

The rate of alcohol-related crashes in Essex County (94.8 per 100,000) is identical to the Franklin County rate and significantly higher than the state as a whole (38.0).

Among those aged 15-19 years, the Essex County suicide rate (0.0 per 100,000) is identical to the Franklin County rate, and significantly lower than the ARHN region (10.7) and upstate New York (6.1).

In 2018, there were two documented Essex County opioid overdoses resulting in death, a rate of 5.2 per 100,000. There were nine documented administrations of Naloxone by EMS, law enforcement or registered COOP programs. 135 unique clients were admitted to OASAS-certified chemical dependence treatment programs.[27]

There is currently one medication drop box located in Essex County (New York State Police Troop B – Ray Brook).[28]

Social determinants and disparities

According to the Adirondack Rural Health Network:

Inequities in external conditions referred to as social determinants of health lead to health disparities. Health disparities are measurable differences in health outcomes linked to populations living with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who've encountered systemic barriers to health due to characteristics historically linked to discrimination or exclusion. These can include race, ethnicity, religion, socioeconomic status, gender, age, disability, sexual orientation or gender identity, and geographic location among others.

While health disparities in the Adirondack region reflect some similarity to those experienced by groups across New York state, demographic differences must be considered to sufficiently address regional issues. Relative to upstate New York and New York state as a whole, the Adirondack region is characterized by lower educational

[26] NYS OMH Patient Characteristics Survey (2017)
[27] NYS DOH County Opioid Quarterly Report for New York State Counties
[28] https://www.health.ny.gov/professionals/narcotic/medication_drop_boxes/essex.htm

attainment, higher unemployment rates, an aging population, higher disability rates, lower household incomes, higher poverty rates, and a vastly rural composition.

Each of these attributes can increase the incidence of significant health disparities. Mental health and substance abuse are significant issues, affecting at least one-third of the Medicaid population, and driving significant emergency department utilization across the region. Poverty in the Adirondacks is exceptionally severe. Of those in poverty, there are greater proportions at or below 138 percent of the Federal Poverty Line (FPL) and 200 percent FPL compared to upstate New York.

Data, including that which is collected through community health assessments, can help identify health disparities and inform targeted interventions to address them. General guidelines for decreasing regional health disparities include:

- *Increasing capacity and reach of primary care and preventative services.*
- *Strengthening integration and information-sharing infrastructure across the continuum of care.*
- *Leveraging community-based interventions and resources to address patients' unmet social needs.*
- *Gathering stakeholder input to inform quality improvement initiatives.*
- *Implementing culturally competent and health literate health care practices.*

Residents of Adirondack Health's primary service area – southern Franklin and northern Essex counties – appear to benefit from the economic activity generated in the municipalities of Tupper Lake, Saranac Lake, and Lake Placid (located in the townships of Tupper Lake, Harrietstown, and North Elba, respectively). Median household incomes in Tupper Lake ($54,618) and Harrietstown ($52,629) exceed Franklin County as a whole ($50,733). The same is true in North Elba, where median household income ($60,651) exceeds Essex County as a whole ($55,294).

While 51.5 percent of Franklin County's population aged 16 years or older is in the civilian labor force, the average between Harrietstown and Tupper Lake is 60.5 percent. The corresponding Essex County civilian labor force (57.4 percent) is greater than in the Town of North Elba (51.4 percent), but this may be partially due to the increased cost of living and decreased availability of workforce housing in the resort village of Lake Placid, which leads some of the North Elba workforce to reside in neighboring communities.

The median value of owner-occupied housing units in Franklin County ($102,200) is less than in Tupper Lake ($119,300) and Harrietstown ($171,900). The same is true in North Elba ($194,200) when compared to Essex County as a whole ($146,900).

There are fewer uninsured residents of Tupper Lake (6.7 percent) and Harrietstown (5.8 percent) than of Franklin County as a whole (7.4 percent). This may be due, in part, to the relatively high concentration of institutional employers (Sunmount DDSO, Mercy Living Center, Tupper Lake Central

School District, Adirondack Health, Saranac Lake Central School District, Paul Smith's College, North Country Community College, Adirondack Adolescent Offender Facility, Federal Correctional Institute – Ray Brook, etc.) offering employer-sponsored health insurance benefits. On the other hand, the Town of North Elba's uninsured population (8.8 percent) exceeds Essex County as a whole (5.3 percent). This may be due, in part, to the high concentration of seasonal, tourism-dependent employers (hotels, restaurants, retail establishments, etc.) which do not generally offer employer-sponsored health insurance benefits to part-time and/or seasonal employees.

Regional economic resilience notwithstanding, significant health challenges are apparent: tobacco use and preventable chronic diseases are more common than across the rest of the state. Obesity levels run high. The population is aging, as young people leave the area in pursuit of greater economic opportunity. Among those who do stay, the percentages of unintended pregnancies in both counties exceed the Prevention Agenda benchmark. Select cancer screening rates are lackluster. Last year, nearly 400 residents between the two counties were admitted to opioid-based chemical dependence treatment programs.

The policy environment is generally favorable for targeted health interventions. In Sept. 2018, for example, the Essex County Board of Supervisors passed a local law to raise the legal age for tobacco purchases to 21 – more than a year before the statewide age was similarly raised.[29] Saranac Lake Central School District – the largest district, geographically, in the state – is a participant in the Community Schools initiative, which targets "school buildings as 'community hubs' to deliver co-located or school-linked academic, health, mental health, nutrition, counseling, legal and/or other services to students and their families in a manner that will lead to improved educational and other outcomes."[30]

Within the Prevention Agenda 2019-2024, Adirondack Health identified 15 specific interventions to pursue across three priority areas and five focus areas. Selection of these interventions represents the culmination of more than 18 months of meetings, calls, planning sessions, outreach and collaboration with public health partners and stakeholders in Essex and Franklin counties. External partners included the county health departments, the Adirondack Health Institute and Adirondack Rural Health Network, University of Vermont Health Network, Mercy Care for the Adirondacks, Franklin and Essex County Offices for the Aging, North Country Healthy Heart Network and St. Joseph's Addiction Treatment and Recovery Centers. Internal partners included Adirondack Health's medical and associate medical staffs, hospital board of trustees, Women's Health Center leadership, Population Health Steering Committee, Health Center leadership team, executive leadership team and department directors.

[Appendix D: Prioritization Methodology]

[29] https://www.wamc.org/post/essex-county-raises-tobacco-purchase-age
[30] http://www.nysed.gov/budget-coordination/community-schools

Adirondack Health's three priority areas are (1) promoting healthy women, infants and children, (2) preventing chronic disease and (3) promoting wellbeing and preventing mental and substance use disorders.

Promote healthy women, infants and children

The burgeoning Women's Health Center at Adirondack Medical Center in Saranac Lake is well positioned to increase the use of primary and preventative healthcare services by women, with a focus on women of reproductive age. Adirondack Health has recruited and retained two full-time and one per diem obstetricians, three advanced practice providers and a support staff with deep ties to the communities it serves. Significant capital investments were also directed to the service line, including more than $400,000 raised this past year by the Adirondack Health Foundation to help finance the acquisition of three-dimensional ultrasound and mammography technology. Next year, in concert with the Essex and Franklin county public health departments, Adirondack Health plans to provide facilitated health insurance enrollment on site at the Women's Health Center, while also implementing a policy and procedure for providers and clinical staff to encourage reproductive planning discussions with all qualifying patients.

Prevent chronic disease

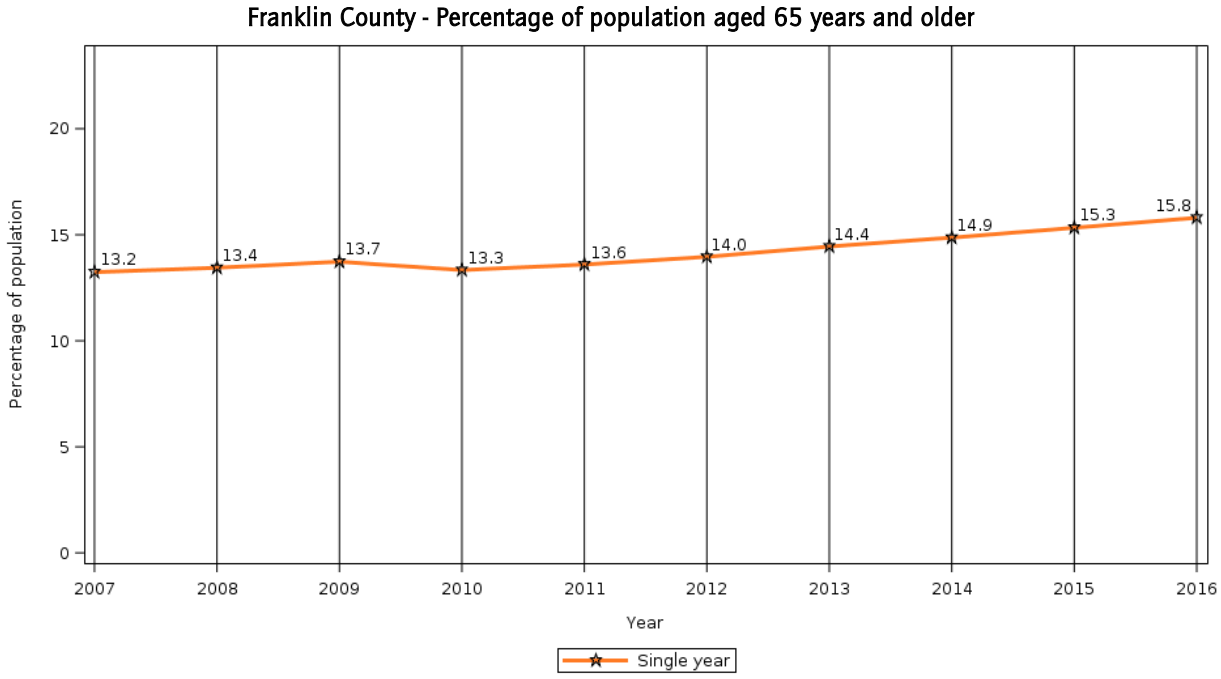
Adirondack Health believes the best way to prevent chronic disease is to provide the tools, knowledge and support needed to help our patients help themselves. With smoking rates in both Franklin and Essex counties that exceed the Prevention Agenda benchmark, it is the health system's responsibility to lean even further into the issue and continue confronting the *most* preventable of chronic diseases, which stem from tobacco use. Next year, in concert with regional behavioral healthcare providers other community-based organizations, Adirondack Health plans to assist in the establishment of baseline measures for quality improvement that focus on increasing provider delivery of an advice statement, per evidence-based guidance.

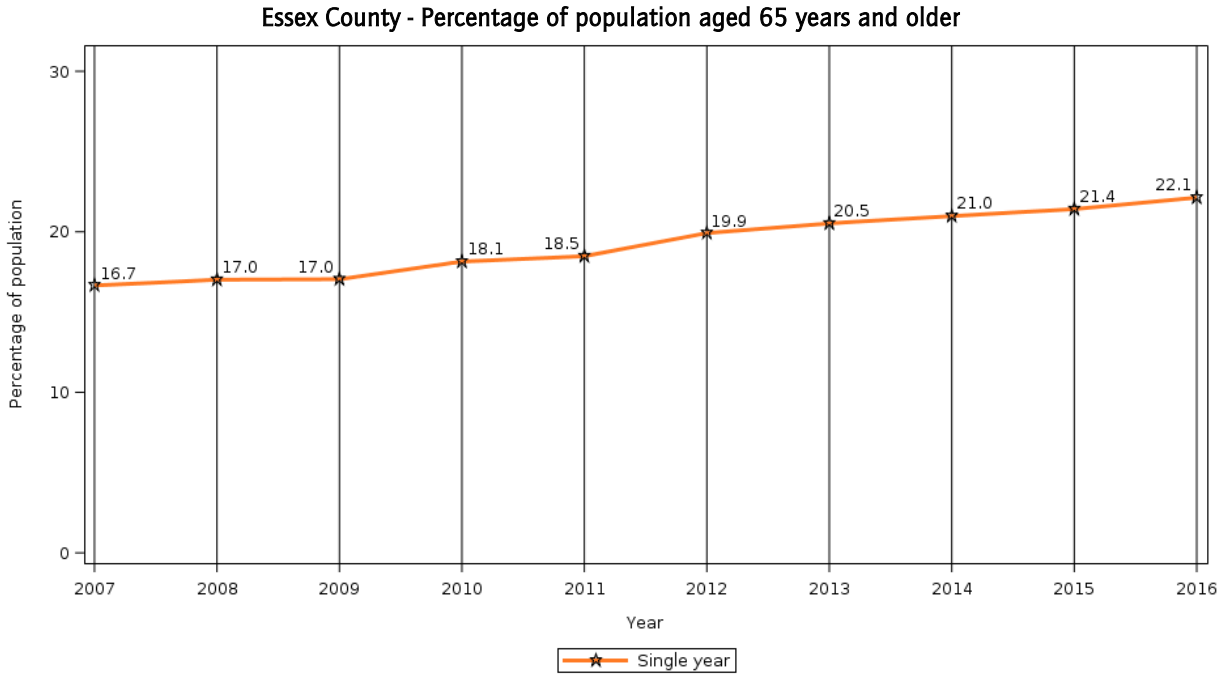
Four additional hospital-based interventions will leverage existing technology to promote increased colorectal cancer screening, the detection of undiagnosed hypertension, pre-diabetes testing and referrals to intensive behavioral lifestyle intervention programming. These interventions will be undertaken primarily via workflow revisions and new prompts in Adirondack Health's electronic health record. The health system also plans to further integrate chronic disease wellness coaches into primary care settings, thereby expanding access to chronic disease self-management and the National Diabetes Prevention Program (NDPP).

Promote wellbeing and prevent mental and substance use disorders

As young people leave to seek opportunity elsewhere and the Baby Boomer generation ages in place, rural Adirondack communities are at the crest of the "Silver Tsunami." Cornell University's Program on Applied Demographics projects that New York state's aged dependency ratio – a measure of persons aged 65 or more years per 100 persons aged 25-64 – will rise from 32.5 in 2020 to a peak of 44.0 in

2036.[31] Franklin County is projected to see a similar increase, from 34.1 in 2020 to a peak of 43.8 in 2032. Meanwhile, the Essex County aged dependency ratio *already* stands near where the whole state is expected to peak: 42.4 in 2020, projected to peak at 53.0 in 2035 – representing a majority county population aged 65 or more years. This is already the case in neighboring Hamilton County, which is projected to see an increase from 81.1 in 2020 to 170.5 in 2040.





[31] https://pad.human.cornell.edu/counties/projections.cfm

These projections represent one of many reasons why Adirondack Health has moved quickly to embrace New York State's Age-Friendly Health System Initiative. Next year, Adirondack Health plans to fully implement age-friendly policies and procedures in its Saranac Lake and Lake Placid emergency departments, establishing workflows that can be fine-tuned and scaled to all clinical and nonclinical departments throughout the health system. This will include the implementation of structured fields in hospital electronic health records to assess the "Four Ms" – **mentation**, **medication**, **mobility** and [what] **matters**.

In terms of preventing mental and substance use disorders, Adirondack Health is in the process of ensuring Naloxone [Narcan] is in supply and available at its two emergency departments and all six primary/urgent care health centers. A medication drop box has been made available to the public at Adirondack Medical Center in Saranac Lake.

This past year, Adirondack Health also partnered with St. Joseph's Addiction Treatment and Rehabilitation Centers to facilitate the establishment of a 24-hour open access clinic. Staffed by clinical and nonclinical St. Joseph's staff – including peer recovery counselors – the open access clinic provides a safe, judgment-free setting for those interested in taking the first step toward recovery. The clinic is located on the main campus of Adirondack Medical Center in Saranac Lake, approximately 100 yards from the from the emergency department entrance.

Finally, given the tobacco use challenges in both Essex and Franklin counties, Adirondack Health will continue to encourage concurrent mental health and tobacco cessation treatments in primary care settings whenever the opportunity presents.

[Appendix E: Assets and Resources]

2019 Community Service Plan

The Adirondack Rural Health Network (ARHN) region is comprised of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties. The Community Health Assessment (CHA) Committee is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment. The CHA Committee works collaboratively on interventions and develops the planning documents required by the New York State Department of Health and the Internal Revenue Service, in an effort to advance the NYS Prevention Agenda. Since 2002, ARHN has coordinated the CHA Committee, providing resources for collaborative formal community health planning.

[Appendix F: Health Systems Profile]

The region's population is older and sicker than other communities in New York state and forecast to become even more so over the next 10 years.

- In 2017, 17.9 percent of the north country's population was over age 65, compared to 15.2 percent in New York state and 14.9 percent nationally.[32]
- The region is projected to be the second oldest in the country by 2020.[33]
- The obesity rate for north country adults is 35 percent, which is 38 percent higher than New York average.
- The smoking rate is 24 percent, which is 67 percent higher than New York average.
- Franklin County has the highest smoking rate of any county in the state.
- North country adults are 22 percent more likely to be hospitalized for mental illness.
- North country residents are 88 percent more likely to die from chronic lower respiratory disease than other residents of New York state.[34]
- Chronic disease is the leading cause of death in the six counties with a high incidence of heart disease and cancer deaths.

As the population ages over the coming years, these trends are likely to become more pronounced. Given these demographic conditions, it is especially important for the regional health network to accurately identify community needs and engage essential clinical providers and community-based organizations. To improve health equity, they must take a collaborative, tactical approach to recognizing and addressing disparities through utilization of the community health needs assessment.

[32] U.S. Census Bureau, "Community Facts," 2013-17
[33] Kenneth Strike and Lorraine Duvall, Adirondack Park Regional Assessment, June 19, 2017
[34] New York State Department of Health, Community Health Assessment, 2009-2017, https://www.health.ny.gov/statistics/chac/indicators/index.htm#chai

Community Health Improvement Plan/Community Service Plan
NYS Prevention Agenda

The Prevention Agenda 2019-2024 is New York state's overarching health improvement plan. It identifies five priority areas, each with a specific action plan including focus areas, goals, objectives and measures for evidence-based interventions to track impact. These objectives are tracked on the Prevention Agenda Dashboard.[35]

[Appendix G: Prevention Agenda 2019-2024]

Prevent Chronic Disease

- Focus Area 1 – Healthy Eating and Food Security
- Focus Area 2 – Physical Activity
- Focus Area 3 – Tobacco Prevention
- Focus Area 4 – Chronic Disease Preventive Care and Management

Promote a Healthy and Safe Environment

- Focus Area 1 – Injuries, Violence and Occupational Health
- Focus Area 2 – Outdoor Air Quality
- Focus Area 3 – Built and Indoor Environments
- Focus Area 4 – Water Quality
- Focus Area 5 – Food and Consumer Products

Promote Healthy Women, Infants and Children

- Focus Area 1 – Maternal and Women's Health
- Focus Area 2 – Perinatal and Infant Health
- Focus Area 3 – Child and Adolescent Health
- Focus Area 4 – Cross Cutting Healthy Women, Infants, and Children

Promote Well-Being and Prevent Mental and Substance Use Disorders

- Focus Area 1 – Promote Well-Being
- Focus Area 2 – Mental and Substance Use Disorders Prevention

Prevent Communicable Diseases

- Focus Area 1 – Vaccine Preventable Diseases
- Focus Area 2 – Human Immunodeficiency Virus (HIV)
- Focus Area 3 – Sexually Transmitted Infections (STIs)
- Focus Area 4 – Hepatitis C Virus (HCV)
- Focus Area 5 – Antibiotic Resistance and Healthcare-Associated Infections

[35] www.health.ny.gov/prevention/prevention_agenda/2019-2024

Adirondack Health engaged with essential clinical providers, community-based organizations, local hospitals and county public health departments (Essex and Franklin) to identify priority areas for the north country region, comprised of Franklin and Essex county residents.

In addition to information gathering and regional collaboration, Adirondack Health is a partner of the Adirondack Health Institute and the Adirondack Rural Health Network in the collection of regional data via the 2019 Community Health Assessment (CHA) Regional Stakeholder Survey.

[Appendix H: 2019 CHA Regional Stakeholder Survey Summary]

The document was distributed to more than 800 stakeholders with diverse interests that nonetheless align to promote health equity in the north country region.

While race and ethnicity do not play a significant role in health disparities in the north country, a unique set of factors contributing to health disparities are the social determinants of health. These include access to care, household income, educational attainment and rates of unemployment, as outlined below.

Demographic Information	Essex	Franklin
Total population	38,233	51,054
Population 64+	8,176	7,909
Population per square mile	21.9	31.7
Uninsured rate	5.2%	7.3%
Unemployment rate	3.8%	4.6%
Median household income	$55,294	$50,733
Persons with disability who are living in poverty	22.6%	45.2%
Persons living below the Federal Poverty Level	8.9%	19.4%
Low income & low access to a grocery store	2.1%	9.1%

Stakeholder survey

The CHA 2019 Regional Stakeholder Survey information is drafted by the ARHN Ad Hoc Data subcommittee, with the final version approved by the full CHA Committee. ARHN surveyed stakeholders in the seven-county service area, in order to provide the CHA Committee with input on regional healthcare needs and priorities. Stakeholders included professionals from healthcare, social services, education and governmental institutions, among other community members.

The survey was developed via SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of community stakeholders, by county, to be surveyed. The collected distribution list totaled 807 such stakeholders.

The survey instrument asked community stakeholders to identify their top two priority areas from a list of five. They were also asked to provide additional insight regarding their individual top five health concerns and the most influential contributing factors for those specific concerns.

Survey Responses and Analysis

A total of 409 responses were received through Feb. 8, 2019, yielding a response rate of 50.68 percent. Respondents were asked to indicate the county or counties in which they provide services. The total number of responses, by county, are outlined below.

Respondents by county		
County/region	Total responses	Total responses (%)
Adirondack/North Country region	49	12.04%
Clinton	81	19.90%
Essex	129	31.70%
Franklin	82	20.15%
Fulton	50	12.29%
Hamilton	69	16.95%
Warren	92	22.60%
Washington	150	36.86%
Other	65	15.97%

Community stakeholders were asked to select one community sector which best described the organization or agency. More than 160 organizations responded to the survey, spanning multiple counties in the ARHN region:

- Education (19.0 percent)
- Health care (13.2 percent)
- Social services (12.5 percent)
- Public health (9.2 percent)
- Health-based community-based organizations (7.5 percent), among many others

Top priority areas for the ARHN region

Survey participants were asked to rank the Prevention Agenda Priority areas, from most impactful to least impactful. Overall, respondents in the ARHN region identified **Promote Well-Being and Prevent Mental and Substance Use Disorders** as their top priority (41.7 percent), followed by **Promote a Healthy and Safe Environment** (21.9 percent).

NYS Prevention Agenda Top Priority for the ARHN Region		
County	First Choice	Second Choice
ARHN Region	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

Top priorities areas by county

To further analyze priority areas, responses were totaled by county and first/second choice priority area preference.

All seven counites identified **Promote Well-Being and Prevent Mental and Substance Use Disorders** as their top priority. Franklin and Fulton counties identified **Prevent Chronic Disease** as their second choice, while Warren and Washington counties identified **Promote a Healthy and Safe Environment** as their second choice. Clinton and Hamilton counties split their second choices on identical lines. Essex County identified **Promote Healthy Women, Infants and Children** as its second choice.

NYS Prevention Agenda Top Priority Area by County		
County	First Choice	Second Choice
Clinton	Promote Well-Being and Prevent Mental and Substance Use Disorders	*Tie:* Prevent Chronic Disease Promote a Healthy and Safe Environment
Essex	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote Healthy Women, Infants and Children
Franklin	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Fulton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Hamilton	Promote Well-Being and Prevent Mental and Substance Use Disorders	*Tie:* Prevent Chronic Disease Promote a Healthy and Safe Environment
Warren	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment
Washington	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

Top five health concerns and contributing factors

Community stakeholders were asked to share their top five health concerns affecting residents in the counties they served, ranked from "one" (highest relative concern) to "five" (lowest relative concern).

Top five health concerns affecting residents of the ARHN region:

1. Mental health
2. Substance abuse
3. Opioid use
4. Overweight/obesity
5. Child/adolescent health

Top five contributing factors affecting residents of the ARHN region:

1. Poverty
2. Addiction to illicit drugs
3. Changing family structures
4. Lack of mental health services
5. Age of residents

Summary of Franklin and Essex county selections and findings

As noted above, Essex and Franklin county stakeholders identified **Promote Well-Being and Prevent Mental and Substance Use Disorders** as their top priority through stakeholder survey results. Essex county identified **Promote Healthy Women, Infant and Children** as its second-highest priority, while Franklin county identified **Prevent Chronic Disease** as its second-highest priority. Other key insights include:

- There are no practicing psychiatrists in Essex County.[36]
- There is no birthing hospital in Essex County.
- Franklin County has the highest smoking rate of any county in the state.
- Substance use-related child welfare placements have surged over the last five years, increasing by 62 percent in Essex County and 208 percent in Franklin County.
- Chronic disease is the leading cause of death in the six counties with a high incidence of heart disease and cancer deaths.

[36] NYS OMH Adirondacks DSRIP Region Needs Assessment https://www.omh.ny.gov/omhweb/special-projects/dsrip/

Adirondack Health's organizational process

Adirondack Health engaged essential medical staff providers, clinical staff and population health steering committee members, in addition to other regional hospitals and public health departments, to identify priority areas with prioritization tools, survey instruments and informational discussions. The health system also queried data from outpatient primary care providers and its two emergency departments to further identify priority areas and inventory available assets.

[Appendix I: Prioritization Worksheet]

The timeline for this internal process was closely tied to the work done by the ARHN planning group through monthly population health steering committee meetings. The committee monitors and guides Adirondack Health's population health planning and offerings. The committee roster includes representation from clinical program managers and care coordinators from Adirondack Health's inpatient and outpatient programs and service lines. The committee roster consists of the health system's:

Chief Medical Officer (committee chair)
Chief Nursing Officer
Chief Operating Officer
Chief Financial Officer
Medical Director, Emergency Department
Medical Director, Surgery
Assistant Vice President, Physician Network
Director, Transitional Care
Director, Quality and Data Analytics
Director, Patient Education Program
Director, Primary Care Clinics
Manager, Population Health
Health Center Care Coordinators
Chronic Disease Prevention Coaches

Priority area identification methodology

- Quantitative data collection from multiple state and national sources
- Quantitative data collection from Adirondack Health's electronic medical record
- Qualitative data collection from essential medical providers serving residents in Essex and Franklin county
- Prioritization tool inclusive of quartile ranking, severity score and prioritization worksheet
- Planning Committee consensus through multiple discussions and meetings with subject matter experts, including the Franklin and Essex county health departments, University of Vermont Health Network – Alice Hyde Medical Center, North Country Healthy Heart Network and University of Vermont Health Network – Elizabethtown Community Hospital.

Priority areas for Adirondack Health's service area:

Promote Well-Being and Prevent Mental and Substance Use Disorders was determined to be the area of greatest concern in Adirondack Health's primary service area, which encompasses both southern Franklin and northern Essex counties.

Prevent Chronic Disease was determined to be the second choice for Franklin County and **Promote Healthy Women, Infants and Children** was determined to be the second choice for Essex County stakeholders and partners.

Socio-cultural determinants of health and health disparities addressed

Adirondack Health's service area displays a compounding set of factors contributing to health disparities. These factors include disparate access to care, due to health professional shortages and transportation challenges; lack of supports for healthy behaviors, such as limited access to large grocery stores; lack of safe and affordable housing, lack of broadband access and limited employment opportunities.

The rural nature of the region, together with demographic characteristics including low income and an aging population, suggests the need for a well-integrated healthcare delivery system to ensure these challenges do not magnify disparities in access and, ultimately, yield poorer outcomes. The data shows that over the past decade this region has made progress in improving certain health outcomes, systems and access-to-care issues. Despite these strides, however, disparities remain:

- 24.2 percent of adults are smokers, far exceeding the statewide figure of 14.5 percent. Opioid overdoses increased seven percent between 2016 and 2017.
- Emergency department visitation rates (4,866.3 per 10,000 population) are far higher than the upstate New York rate (3,865.6 per 10,000 population).
- 25.6 percent of the regional population lives with a disability; higher than upstate New York (22.8 percent) and the state as a whole (22.9 percent).
- 35.2 percent of adults are obese, far exceeding the state as a whole (25.5 percent).
- 18.3 percent of elementary school children are obese; higher than upstate New York (16.0 percent)

Care coordination

These challenges can be better managed through an integrated healthcare delivery system focused on care coordination. Regional care coordination in the north country requires timely communication between care coordinators, across all sectors, to assist individuals who experience access-related issues. Health disparities result, in part, from care coordinators lacking the tools needed to follow the patients, rather than the facilities.

Care coordination services at Adirondack Health include:

- Care coordinators within primary care
- Peer resource navigators
- Emergency department navigators
- Breast health navigator
- Oncology navigator
- Transitional care department
- Patient care partners

Adirondack Health's care coordination model strives to incorporate the full spectrum of health and healthcare providers, including primary, behavioral and long-term care, as well as services provided by community-based providers, such as transportation, housing, care management and peer outreach to better help people manage all aspects of their health and well-being.

Adirondack Health's priority areas

Through the 18-month collaborative process described above, Adirondack Health identified three New York State Prevention Agenda priority areas – **Prevent Chronic Disease**, **Promote Healthy Women, Infants and Children** and **Promote Well-Being and Prevent Mental Health and Substance Use Disorders** – and specific objectives, as outlined below.

[Appendix J: 2019 CHIP Workplan]

Priority area: Prevent Chronic Disease

Tobacco Prevention

Goal 3.2 – New York State Prevention Agenda
Interventions 3.2.1, 3.2.2

Objective: Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1 percent from 53.1 percent (2017) to 60.1 percent.

Why it matters

- Respiratory disease is a leading cause of death in Essex County.
- Franklin County has the highest rate of smoking in the state.
- Smoking and smoking-related diseases seem to pose a significant challenge for Franklin County, with eight indicators listed as worse than the comparison benchmark.
- Smoking is the leading cause of disease including lung disease, heart disease and stroke.
- Chronic Lower Respiratory Disease (CLRD) is one of the leading causes of death in Essex County. CLRD is a group of conditions that affect the lungs: chronic obstructive pulmonary

disease (COPD), includes emphysema and chronic bronchitis; asthma; pulmonary hypertension; and occupational lung diseases. These conditions are most common among smokers.

Promoting tobacco use cessation is one of the top three goals identified in the CHA stakeholder survey for both Franklin and Essex counties. Adirondack Health will promote tobacco use cessation throughout Franklin and Essex counties by partnering with the Tobacco Health Systems grantee and local public health departments to facilitate medical and behavioral practices in delivering tobacco treatments. In addition to these efforts, partners will utilize health communications and media opportunities to promote the treatment of tobacco dependence, targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, increase awareness of available cessation benefits (especially those offered through Medicaid), and encourage healthcare provider involvement with additional assistance from the NYS Smokers' Quit line. Participation in the North Country Chronic Disease Coalition will further collaborative work efforts to reduce disparities and promote health equity in the north country region.

Priority area: Prevent Chronic Disease

Prevention and Care Management

Goal 4.1 – New York State Prevention Agenda
Intervention 4.1.1

Objective: Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years).

Why it matters

- The percentage of Franklin County women aged 21-65 years receiving cervical cancer screening based on 2012 guidelines (80.0 percent) is lower than the North Country (86.5 percent) and state (82.2 percent).
- The percentage of Franklin County women aged 50-74 years receiving breast cancer screening based on recent guidelines (78.9 percent) is lower than the north country (81.4 percent) and slightly lower than the state as a whole (79.7 percent).
- The rates of colon and rectal cancer diagnosis (54.3 per 100,000) and death (19.0 per 100,000) in Franklin County are comparable to the ARHN region (55.0 and 18.9, respectively).

Adirondack Health will support system changes for cancer screening reminders. The health system grantee, currently North Country Healthy Heart Network, will partner and support this intervention to expand services in the Tri-Lakes region. Franklin and Essex county public health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep the health system attuned to disparities in both counties and connect the public to healthcare resources. In addition, care coordination services, including breast health and

oncology nurse navigators, will help to ensure compliance with care recommendations by guiding patients through the continuum of care.

Priority area: Prevent Chronic Disease
Prevention and Care Management

Goal 4.2 – New York State Prevention Agenda
Interventions 4.2.1, 4.2.2

Objective: Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by five percent.

Why it matters

- Fourteen percent of the Essex County adult population has diabetes. This is higher than the state as a whole (9.5 percent) and, indeed, the United States (10.5 percent). Essex County's diabetes prevalence is the highest in the region and among the top five counties statewide.

The health system grantee will provide staff time to support practice enhancement activities aimed at increasing identification and diagnosis of prediabetes, offer practice facilitator staff time to support development and use of registry and provide financial support for patient education materials. Franklin and Essex counties' public health departments will increase access to care by serving as referral mechanisms for chronic disease wellness coaches.

Priority area: Prevent Chronic Disease
Prevention and Care Management

Goal 4.3 – New York State Prevention Agenda
Interventions 4.3.1, 4.3.5

Objective: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.

Why it matters

- Hypertension, obesity and diabetes are among the top diagnoses within the Adirondack Health's health centers and emergency departments.
- The burden of obesity may contribute to higher rates of death due to diabetes (any diagnosis) in Essex County (39.9 per 100,000) than in upstate New York (15.4 per 100,000).
- The burden of obesity may contribute to higher rates of death due to diabetes (any diagnosis) in Franklin County (29.5 per 100,000) than in upstate New York (15.4 per 100,000).

Improving self-management skills for individuals with chronic disease is the number one goal for working to prevent chronic disease for both Franklin and Essex county, identified in the CHA stakeholder survey. Using a team-based approach, care coordination services and chronic disease

wellness coaching, health system grantee will partner and support this intervention with staff time to support practice enhancement activities aimed at increasing referral of patients to NDPP program.

Additionally, health system grantee will assist with funds for patient education and NDPP facilitator training. Franklin and Essex County Public Health Department will assist by increasing access to care by acting as a referral mechanism for diabetes prevention program.

Priority area: Prevent Chronic Disease

Prevention and Care Management

Goal 4.4 – New York State Prevention Agenda
Interventions 4.4.2, 4.4.3

Objective: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.

Why it matters

- Adult obesity continues to be a concern in Essex County, affecting more than 32 percent of adults – a rate higher than the state as a whole and nine percent above the Prevention Agenda Benchmark. Obesity is a significant risk factor for chronic diseases including diabetes, high blood pressure and cholesterol, heart disease, stroke, asthma, arthritis and certain types of cancer.

Over the next two years, Adirondack Health and partners will expand access to chronic disease self-management via the National Diabetes Prevention Program (NDPP). The health system grantee, currently the North Country Healthy Heart Network, will provide staff time to support establishment and/or maintenance of NDPP programs. This includes facilitator training, stipends and participant materials. Health system grantee will also assist in data collection and reporting, as required by CDC to maintain recognition.

Priority area: Promote Healthy, Women, Infants and Children

Maternal and Women's Health

Goal 1.1 – New York State Prevention Agenda
Intervention 1.1.1

Objective: Increase use of primary and preventive health care services among women of all ages, with special focus on women of reproductive age.

Why it matters

- In Essex County, the percentage of births within 24 months of previous pregnancies (23.4 percent) is higher than the Prevention Agenda benchmark (17.0 percent). The percentage of

unintended pregnancies in Essex County (33.7 percent) also exceeds Prevention Agenda benchmark (23.8 percent).

- In Franklin County, the percentage of births within 24 months of previous pregnancies (23.4 percent) is higher than the Prevention Agenda benchmark (17.0 percent). The percentage of unintended pregnancies (37.3 percent) also exceeds the Prevention Agenda benchmark (23.8 percent).

Essex County Public Health has identified Promote Healthy Women Infants and Children as a main priority area in its most recent community health assessment. The county could benefit from expanded women's health programming and services. Adirondack Health will increase access to care by offering women's health services within its Lake Placid primary care setting and hold birthing, breastfeeding and post-partum care classes at the Lake Placid Health and Medical Fitness Center.

Priority area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Promote Well-Being

Goal 1.1 – New York State Prevention Agenda
Intervention 1.2.3

Objective: Reduce the percentage of adults 65+ New Yorkers reporting frequent mental distress during the past month by 10 percent to no more than 13 percent.

Why it matters

- In 2017, 17.9 percent of the north country's population was aged more than 65 years, compared to 15.2 percent in New York State and 14.9 percent nationally.[37] The region is projected to be the second oldest in the country by 2020.[38]
- Fourteen percent of Essex County adults report experiencing poor mental health days. This exceeds the state as a whole (11 percent) and the Prevention Agenda benchmark (10 percent). Trend analysis of this data demonstrates an increase of five percent over seven years: from nine percent in 2009 to 14 percent in 2016.[39]

As part of the Age-Friendly Health Systems initiative, The John A. Hartford Foundation and the Institute for Healthcare Improvement, in partnership with the American Hospital Association and the Catholic Health Association of the United States, are helping hospitals and other care settings implement a set of evidence-based interventions specifically designed to improve care for older adults. Adirondack Health now joins more than 100 health systems working to make care for older adults even more tailored to patients' goals and preferences and consistently of high quality. The Age-Friendly Health Systems initiative is an important part of our overarching vision to provide every older adult with the best care possible. Together with Mercy Care for the Adirondacks, Essex County Public Health and both the Franklin and Essex county offices for the aging, the health system will devise

[37] U.S. Census Bureau, "Community Facts," 2013-17
[38] Kenneth Strike and Lorraine Duvall, Adirondack Park Regional Assessment, June 19, 2017
[39] ARHN data

and institute age-friendly policies and program interventions that promote inclusion, integration and competence, strengthening opportunities to build well-being and resilience across the lifespan.

Priority area: Promote Well-Being and Prevent Mental and Substance Use Disorders
Promote Well-Being

Goal 2.2 – New York State Prevention Agenda
Interventions 2.2.2, 2.2.3, 2.2.5

Objective: Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20 percent to 43.8 per 1,000 population. Baseline: 36.5 per 1,000.

Why it matters

- Franklin County, sharing a more than 30-mile northern border with Canada, is designated by the federal Drug Enforcement Agency (DEA) as High Intensity Drug Trafficking Area.

The rising rate of drug-related arrests in the north country region demonstrates the growing need for opioid-related services and treatment. Opioid overdose emergency department visits in Essex and Franklin counties totaled 114 in 2017 and 64 in 2018. We estimate more than 750 emergency department visits for other emergencies related to opioid use disorder (OUD) occur annually across the region. We further estimate that more than one percent of all other healthcare visits are OUD-related. We know, for certain, that north country opioid rates for substance-related hospitalizations (30.7 per 100,000) are higher than the state average.

Working closely with St. Joseph's Addiction Treatment and Rehabilitation Centers, Adirondack Health will strive to prevent opioid and other substance misuse and deaths through continued care coordination and information sharing, ensuring patients receive appropriate levels of care. Adirondack Health will encourage educational opportunities for providers related to the prescription of buprenorphine as medication-assisted therapy for substance use disorders. Adirondack Health will also maintain safe disposal sites for prescription drugs at Adirondack Medical Center in Saranac Lake.

Priority area: Promote Well-Being and Prevent Mental and Substance Use Disorders
Promote Well-Being

Goal 2.6 – New York State Prevention Agenda
Intervention 2.6.2

Objective: Decrease by 20 percent the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4 percent.

Why it matters

- In 2017, 28 percent of the Essex County Office of Mental Health population used tobacco.[40]

[40] NYS OMH Patient Characteristics Survey (2017)

- In 2017, 42 percent of the Franklin County Office of Mental Health population used tobacco – the highest percentage of any county in the state.[41]

Adirondack Health's integrated physical and behavioral health treatment is implemented in primary care settings in Franklin and Essex counties. Both counties identified "promote tobacco use cessation, especially among populations disproportionately affected by tobacco use" as top-three goals in the CHA stakeholder survey. Concurrent therapies for mental illness and nicotine addiction are shown to have the best outcomes, with smokers in receipt of mental health treatment demonstrating higher quit rates than those lacking mental health treatment. St. Joseph's Addiction Treatment and Rehabilitation Centers will partner with Adirondack Health to provide continued care coordination and information sharing, ensuring patients receive appropriate levels of care.

Additional Adirondack Health initiatives

Adirondack Health continues to work diligently and creatively towards addressing all Prevention Agenda Priority Areas, leveraging existing resources and collaborating with essential providers to improve health equity. Because of this, many of Adirondack Health's initiatives cut across multiple Prevention Agenda areas.

Promote Healthy Women, Infants and Children

Increasing access to women's health services in Essex and Franklin counties is important to the residents of Adirondack Health's service area. Interventions will address the disparity areas of income and access to care. Of primary importance is the lack of a birthing hospital in Essex County. Adirondack Health will work over the next two years to increase access to comprehensive breastfeeding and professional lactation consulting and childbirth classes in Essex County.

- Provide structured, comprehensive breastfeeding education and professional lactation counseling and support, including use of International Board Certified Lactation Consultants (IBCLCs) - during pregnancy and in the hospital.
- Provide free childbirth education every other month, in four class sessions:
    - Class 1 – Pregnancy, labor & delivery
    - Class 2 – Breastfeeding
    - Class 3 – Postpartum care
    - Class 4 – Infant CPR and first aid
- Provides access to two certified car seat technicians who participate in monthly car seat clinics.
- Flag high-risk pregnant women upon arrival at the emergency rooms or other hospital portals to assure appropriate level of care.
- Continue NCQA patient-centered medical home certification.

[41] NYS OMH Patient Characteristics Survey (2017)

- Participate in structured, evidence-based learning collaborations to identify and address areas for improvement in clinical practice and management, such as increasing developmental screenings and reducing no-show rates.
- Enhance electronic health records and connections to regional health information systems to improve service quality and coordination.
- Maintain and expand the availability of school-based preventive dental programs in targeted high-need, underserved communities.
- Provides access to a women's health nurse navigator.
- Provides hospital-based OB/GYN services.

Prevent Communicable Diseases

- Improve efforts to educate patients, parents, children and educators about immunization and the importance of low exemption rates.
- Ensure vaccination of adults with influenza vaccine.
- Educate patients and visitors about the importance of hand washing.
- Continue organizational quality improvement programs to reduce infections.
- Ensure adequate cleaning and disinfection of patient care rooms and medical equipment.
- Ensure that sinks and alcohol-based hand rub are readily available for patients, visitors and healthcare personnel
- Continue antibiotic stewardship program and include Franklin County Public Health as committee member, to minimize the frequency and duration of antimicrobial therapy and the number of antimicrobial agents within the hospital and community.

Promote Healthy and Safe Environment

- Staff trained in recognizing human trafficking
- Participate in universal screening and refer to services within the primary care setting

Dissemination of the plan to the public

The plan will be disseminated to the public via Adirondack Health's website, (adirondackhealth.org) and also available on the Adirondack Rural Health Network's website (ahihealth.org/arhn/).

Maintaining engagement with partners

Adirondack Health maintains strong working relationships with all partners in the north country region: hospitals, local public health departments, primary care providers, behavioral health providers, community-based organizations and an accountable care organization (ACO) to collaboratively

address health challenges.[42] This area has a long history of independent entities working together to address ongoing challenges associated with access to care, an aging population and financially fragile providers.

Adirondack Health will remain an active member of the Adirondack Rural Health Network Community Health Assessment (CHA) Committee and the Population Health Network convened by the Adirondack Health Institute (AHI) as a New York State Delivery System Reform Innovation Program (DSRIP) Performing Provider System (PPS).

The multi-county, regional CHA Committee, coordinated by ARHN, has met in-person every three months throughout the last assessment and planning cycle. It will continue to do so during the 2019-2021 cycle. The committee convenes to support ongoing regional health planning and assessment, working collaboratively on interventions and sharing promising evidence-based programing.

With partners in Essex and Franklin counties, Adirondack Health will track and monitor the community health improvement plan on a quarterly basis. Any barriers to progress will be immediately addressed via the implementation of problem-solving interventions.

[Appendix K: County Health Indicators]

[42] Adirondacks ACO is an extensive provider network of more than 450 primary and specialty clinicians who coordinate care 26,000 Medicare beneficiaries; 33,000 managed Medicaid beneficiaries and 64,000 commercially insured beneficiaries. The ACO partners with all six of the region's hospitals, an academic medical center in Burlington, VT, and a large regional Federally Qualified Health Center.


WESTVILLE
CONSTABLE
BURKE
BOMBAY
CHATEAUGAY
THE
University of Vermont
HEALTH NETWORK
Alice Hyde Medical Center
FRANKLIN COUNTY
SEAL
Public Health
Prevent. Promote. Protect.
ADIRONDACK HEALTH
Better Health, Better Lives

Contents

Executive Summary

The purpose of this Community Health Assessment (CHA) or Community Health Needs Assessment (CHNA) for hospitals is to identify and prioritize the health care challenges currently faced by the residents of Franklin County. The findings in this assessment result from a year-long process of collecting and analyzing data and consulting with stakeholders throughout the community and the region. The results of this assessment are intended to help members of the community, especially healthcare providers, work together to provide programs and services targeted to improve the overall health and wellbeing of all residents of Franklin County.

Working within the framework provided by New York State's Prevention Agenda 2019-2024, Adirondack Health Medical Center Hospital, the University of Vermont Health Network Alice Hyde Medical Center and Franklin County Public Health Services collaborated in the development of this CHA/CHNA. Additionally, Adirondack Health Medical Center Hospital, the University of Vermont Health Network Alice Hyde Medical Center and Franklin County Public Health Services participated in regional health assessment and planning efforts conducted by the Adirondack Rural Health Network (AHRN).

The Adirondack Rural Health Network (ARHN) provides a forum for local public health services, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations to address rural health care delivery barriers, identify regional health needs and support the NYS Prevention Agenda to improve health care in the region. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Working collaboratively and informed by community stakeholders and residents the final selected priorities for Franklin County are:

1. Prevent Chronic Disease

2. Promote Well-Being and Prevent Mental and Substance Use Disorders

Both priorities reflect disparities of Poverty and Access to Care.

Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital work group obtained and examined data from a variety of sources; the details of which are explained in their entirety throughout the CHA. The workgroup reviewed the New York State Prevention Agenda county level dashboards, as well as data from HealthyAdk.org. Additionally, Community Stakeholder assessments contributed to our choosing of priorities.

The Community Health Assessment (CHA) Committee, facilitated by ARHN, has developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. CHA Committee members from Franklin County are Adirondack Health, The University of Vermont Health Network - Alice Hyde Medical Center, and Franklin County Public Health Services (FCPHS). The committee has been meeting in person every three months throughout the last assessment and planning cycle and will continue to do so during the 2019-2021 cycle. This collaboration assists partners in tracking plan progress and in making mid-course corrections if needed.

To engage the broad community, the CHA Committee created a stakeholder survey to garner constructive feedback. The stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The survey summary provided a regional look at the results through a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area and provided individual analyses of Franklin County.

The results enable the CHA Committee to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.

The completion of the 2019-2021 Franklin County Community Health Assessment and Community Service Plan/Community Health Improvement Plan was a collaborative effort between Franklin County Public Health Services, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital and a number of community-based organizations. These include Cornell Cooperative Extension, St. Joseph's Rehabilitation Services, Franklin County Community Housing, Harrietstown Housing Authority, Catholic Charities, Franklin County Community Services, North Country Healthy Heart Network, Franklin County Office of the Aging/NY Connects, the Department of Social Services, the Joint Council for Economic Opportunity (JCEO), Community Health Center of the North Country Federally Qualified Health Care Center (FQHC), and the Youth Advocate Program. Ongoing engagement with the Adirondack Rural Health Network will continue.

The community engagement process involved a survey of key community stakeholders conducted by the Adirondack Rural Health Network. A smaller workgroup met several times to assess the results of this survey and align it with the data. We will continue to engage the community throughout the implementation of this plan to assure that our interventions

and efforts are addressing their needs.

All implementation strategies, interventions, activities and measures are outlined in great detail within the 2019 – 2021 Implementation Plan. Evidence-based interventions were selected directly from those offered in the Prevention Agenda. Data findings suggest that the leading causes of death and illness in Franklin County can be directly linked to obesity, nutrition, physical activity, and tobacco use, as well as supports related to mental, emotional, and behavioral (MEB) well-being. Franklin County Public Health Services, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital are committed to enhancing opportunities for all residents to live more healthful lives by promoting safe, healthful behaviors and creating supportive environments.

These actions include working with other community based organization partners to provide outdoor spaces that are appropriate and available for physical activity and play; promoting accessibility and affordability of healthful foods; promoting wellness policies and hospital-based programs for tobacco cessation; and increasing early detection to prevent and manage chronic diseases. We are also committed to promoting age-friendly environments; and promoting opioid prescriber education as well as support for opioid users. Our interventions described in this Community Service Plan/Community Health Improvement Plan will decrease the incidence and burden of obesity and other chronic diseases, and contribute to the overall health – physical, social, and emotional – of our county residents.

Progress towards the identified health goals will be continually tracked with formal progress captured in annual community health plan documents. Interventions identified in our Implementation Plan have measurable outcomes, which will be reported on. Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical

Center, and Adirondack Health Medical Center Hospital will continue to meet bi—annually in June and December to assess progress and report on the measurable outcomes identified in our interventions chart.

Evaluation of Success: Progress towards the identified health goals will be continually tracked with formal progress captured in annual community health plan documents. Interventions identified in our Implementation Plan have measurable outcomes, which will be reported on. Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital will continue to meet bi—annually in June and December to assess progress and report on the measurable outcomes identified in our interventions chart.

Introduction

Message to the Community

The purpose of this Community Health Assessment (CHA) (or Community Health Needs Assessment (CHNA) for hospitals) is to identify and prioritize the health care challenges currently faced by the residents of Franklin County. The findings in this assessment result from a year-long process of collecting and analyzing data and consulting with stakeholders throughout the community and the region. The results of this assessment are intended to help members of the community, especially healthcare providers, work together to provide programs and services targeted to improve the overall health and wellbeing of all residents of Franklin County.

Working within the framework provided by New York State's Prevention Agenda 2019-2024, Adirondack Health Medical Center Hospital, the University of Vermont Health Network Alice Hyde Medical Center and Franklin County Public Health collaborated in the development of this CHA/CHNA. Additionally, Adirondack Health Medical Center Hospital, the University of Vermont Health Network Alice Hyde Medical Center and Franklin County Public Health participated in regional health assessment and planning efforts conducted by the Adirondack Rural Health Network.

The Adirondack Rural Health Network (ARHN) provides a forum for local public health services, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations to address rural health care delivery barriers, identify regional health needs and support the NYS Prevention Agenda to improve health care in the region. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments working

together utilizing a systematic approach to community health planning.

New York State's Prevention Agenda 2019 – 2024

The Prevention Agenda 2019-2024 is a blueprint for local, regional, and state action to improve the health of New Yorkers in five priority areas, and to reduce health disparities for racial, ethnic, disability, and low socioeconomic groups, as well as other populations who experience them. The Prevention Agenda serves as a guide to local health departments as they work with their community to develop mandated Community Health Improvement Plans and Community Health Assessments and to hospitals as they develop mandated Community Service Plans and Community Health Needs Assessments required by the Affordable Care Act.

The Prevention Agenda establishes goals for each priority area and defines indicators to measure progress toward achieving these goals. The plan features five priority areas, with focus areas under each priority:

- Prevent Chronic Disease
    - Focus Area 1-Healthy Eating and Food Security
    - Focus Area 2-Physical Activity
    - Focus Area 3-Tobacco Prevention
    - Focus Area 4 - Chronic Disease Preventive Care and Management

- Promote a Healthy and Safe Environment
    - Focus Area 1- Injuries, Violence and Occupational Health
    - Focus Area 2-Outdoor Air Quality
    - Focus Area 3-Built and Indoor Environments
    - Focus Area 4-Water Quality
    - Focus Area 5-Food and Consumer Products

- Promote Healthy Women, Infants and Children
    - Focus Area 1-Maternal and Women's Health
    - Focus Area 2-Perinatal and Infant Health
    - Focus Area 3-Child and Adolescent Health
    - Focus Area 4-Cross Cutting Healthy Women, Infants, and Children
- Promote Well-Being and Prevent Mental and Substance Use Disorders
    - Focus Area 1-Promote Well-Being
    - Focus Area 2 -Mental and Substance Use Disorders Prevention

- Prevent Communicable Diseases
    - Focus Area 1- Vaccine Preventable Diseases
    - Focus Area 2- Human Immunodeficiency Virus (HIV)
    - Focus Area 3- Sexually Transmitted Infections (STIs)
    - Focus Area 4- Hepatitis C Virus (HCV)
    - Focus Area 5-Antibiotic Resistance and Healthcare-Associated Infections


STRATEGY
GOAL
PLAN

Community Health Assessment

GEOGRAPHY/SERVICE AREA PROFILE

Franklin County has a total area of 1,697 square miles, of which 1,629 square miles is land and 68 square miles (4.0%) is water. It is the fourth-largest county in New York by land area. Franklin County is in the northeastern part of New York State. The northern edge is the border with Canada. Adjacent counties are Clinton County directly to the east, Essex County to the southeast, Hamilton County to the southwest, and St. Lawrence County to the west.

Franklin County has twenty towns including Hogansburg, a portion of the St. Regis Mohawk Tribe. The county seat is located in the town of Malone. Other towns are Chateaugay, Burke, Constable, Westville, Fort Covington, Bombay, Moira, Bangor, Brandon, Dickinson, Duane, Santa Clara, Waverly, Tupper Lake, Brighton, Franklin, and Harrietstown (which includes the Village of Saranac Lake).

Early industry included agriculture, mills, and iron ore mining. The southern portion of the county benefited from the founding of sanatoriums for the treatment of tuberculosis and other ailments, based on the work of Dr. E.L. Trudeau. The open-air 'rest cure' made the Adirondacks and the Saranac Lake area nationally famous.

The Adirondacks, which were once a barrier to settlement, began to serve as a draw for tourists in the late 19th century, and now serve as one of Franklin County's defining features. The Adirondack Park is 600 million acres of both public and private land, making it the largest publicly protected area in the lower forty eight states. About fifty percent of the land belongs to the residents of New York State and it protected as “forever wild”. The remaining fifty percent is made up of small towns and villages, farms, timberland and homes both summer and year round.

Franklin County's three largest population centers, the villages of Malone, Saranac Lake, and Tupper Lake, are separated by large tracts of Adirondack Park land. This poses a significant challenge to transportation, particularly during the winter months with inclement weather and hazardous road conditions. It also results in geographic barriers to collaboration, and the "North-South" distinction carries with it perceived cultural differences between the two areas.

Demographic Characteristics

Franklin County's population is 51,054. Similar to the rest of Upstate New York, Franklin County's population is very limited in its diversity, over 82% are White/non-Hispanics, followed by 5.9% Black/African American, non-Hispanics and 3.4% Hispanic/Latinos. Over 15% of the population is 65 years of age and older, which is slightly lower than the ARHN region (18.0%) and Upstate New York (16.37%).

Household income on average is $62,870, with per capita income at $24,294, which is much lower than that of New York State, $93,443 and $35,752 respectively. The percentage of individuals in Franklin County living below the Federal Poverty Level is 19.4%, which is significantly higher than the ARHN (13.9%) region and Upstate New York (11.7%). In Franklin County, the unemployment rate is 4.2%.

Of the total population in Franklin County, approximately 37.2% of individuals 25 years of age and older have a high school diploma or equivalent, and another 30.4% have an Associates or bachelor's degree or higher. Fifty two percent of the population 16 and older is in the workforce, with the highest percentage of individuals in the field of education (33.2%), followed by public administration (12.8%), retail trade (10.5%), and arts and entertainment (10.4%).

Health System Profile

Franklin County has two hospitals, Adirondack Medical Center-Saranac Lake Site and UVMHN-Alice Hyde Medical Center, with 171 hospital beds, the majority of which are other beds, resulting in a rate of 334.9 hospital beds. This rate is higher than the ARHN region (274.2). There are total of two nursing home facilities, accounting for 195 beds, and two adult care facilities, accounting for 60 beds, with rates per 100,000 population of 381.9 and 176.3, respectively. The rate of primary care physicians in Franklin County is 101.9 and a rate of 206.5 total physicians. Franklin County consists of 12 health professional shortage areas (HPSAs), 5 in primary care, 5 in dental care, and 2 in mental health.

Educational Profile

Within Franklin County, there are 7 school districts, with a total enrollment of 7,493 students. Of the enrolled students, 57% are eligible for free and reduced lunch, with majority eligible for free lunch (88% or 3,594). The total number of high school graduates is 505 with a dropout rate of 2.0%, which is higher than the ARHN (0.8%) region and Upstate New York (0.64%) dropout rates, but lower than the New York State dropout rate of 3.0%. There are 10.7 students per teacher in Franklin County, which is comparable to the ARHN region but slightly lower than Upstate New York (12.37).

Asset-Limited, Income Constrained, Employed (ALICE) Profile

In total, there are 19,299 households in Franklin County, with approximately 25% of residents over 65 years of age. There is a 18.2% poverty rate and 27.8% ALICE rate, with a total of 8,869 households designated as either poverty or ALICE. Specific to ALICE households, the majority are white (5,191), which far exceeds the second largest group of ALICE households comprised of 2+ races residents (44).

HEALTH INDICATORS

Improve Health Status and Reduce Disparities

While there are no significant health disparities based on race and ethnicity in Franklin County, there are significant access to care issues. The percentage of adults with health insurance in Franklin County is at 92.3%, with 81.1% of the population having a regular health care provider. The rate of age-adjusted preventable hospitalizations per 10,000 population among those 18 years of age and older (111.5) is lower than the rate for Upstate New York (116.8), and the Prevention Agenda benchmark (122.0) rate. The rate of ED visits per 10,000 population in Franklin County (4,694.2) is lower than the ARHN region (4,866.3) and higher than Upstate New York (3,865.6). Lastly, the percentage of adults 18 years of age and older in Franklin County with disability (24.5%) is lower than the ARHN region (25.6%), but higher than Upstate New York (22.8%), and the state as a whole (22.9%).

Promote Healthy And Safe Environment

The built environment poses several challenges in Franklin County. The percentage of the population with low-income and low access to supermarkets or large grocery stores is much higher in Franklin County (9.3%) than in the ARHN region (6.0%), Upstate New York (3.9%), the state as a whole (2.3%), and the Prevention Agenda Benchmark of 2.2%. Injuries, Violence, and Occupational Health pose a problem for Franklin County. Motor vehicle accidents and speed-related accidents are higher in Franklin County (2,273.3 and 498.9 respectively) than in the ARHN region (2,162.0 and 364.7), and significantly higher than New York State (1,558.5 and 141.6). Additionally, the rate of motor vehicle accident deaths is higher in Franklin County (7.8) than the ARHN region (7.3), Upstate New York (7.1) and the state as a whole (5.0). Lastly, the rate of violent crimes (198.7) is also higher than the ARHN region (171.8) and significantly lower than that of Upstate New York (214.9) and New York State (355.6).

Prevent Chronic Diseases

Smoking and smoking-related diseases seems to pose a significant challenge for Franklin County, with eight of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Franklin County (28.8%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Benchmark of 12.3%. Chronic lower respiratory deaths are significantly higher, and hospitalizations are lower in Franklin County (59.7 and 19.6, respectively) than in Upstate New York (45.4 and 28.0) and the state as a whole (34.1 and 30.6). The percentage of adults with asthma in Franklin County (13.7%) is slightly higher, in comparison to the ARHN region (12.0%), Upstate New York (10.1%), and New York State (9.5%). The rates of lung and bronchus cancer cases in Franklin County (92.9) higher than Upstate New York (84.3) and New York State (69.7). Lung and bronchus cancer deaths in Franklin County (67.4) are comparable to the ARHN region (67.4), yet higher than Upstate New York (53.0) and New York State (43.5). The rate of colon and rectal cancer cases and deaths in Franklin County (54.3 and 19.0) is comparable to the ARHN region (55.0 and 18.9). The percentage of colorectal screenings for those 50 to 75 years of age in Franklin County (74.1%) is somewhat higher than the ARHN region (73.6%), Upstate New York (68.5%), and New York State (69.7%). The percentages of adults (32.7%) and children who are obese (21.2%) in Franklin County is higher than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. Additionally, the rate of obesity in elementary school children (20.1%) is higher than Upstate New York (16.0%). The burden of obesity may contribute to higher rates of death due to diabetes (any diagnosis) in Franklin County (29.5) than in Upstate New York (15.4).

Promote Healthy Woman, Infants, and Children
The percentage of births within 24 months of previous pregnancies in Franklin County (23.4%) is higher than the Prevention Agenda Benchmark of 17.0%, as is the percentage of unintended pregnancies in Franklin County (37.3%), with the Prevention Agenda Benchmark being 23.8%.

The percentages of women receiving WIC in Franklin County with either gestational weight gain greater than ideal or gestational diabetes are worse than the ARHN region, Upstate New York, and New York State. The percentage of pre-pregnancy obesity (32.6%) is lower than that of the ARHN region (33.3%) and higher than that of Upstate New York (28.0%).

Promote Mental Health and Prevent Substance Abuse
The percentage of adults in Franklin County who binge drink (17.8%) is lower than the Prevention Agenda Benchmark (18.4%), while the percentage who reported 14 or more poor mental health days within the last month (13.1%) is higher than the Prevention Agenda Benchmarks of 10.1%. The rate of self-inflicted hospitalizations in Franklin County (3.4) is lower than in Upstate New York (4.1). The rate of alcohol-related crashes in Franklin County (64.6) is significantly higher than New York State (38.0). Among those who are 15 to 19-year old, the 2016 Community Health Indicator Reports listed the rate of suicides at 0.0, which is significantly lower than the ARHN region (10.7) and Upstate New York (6.1).

Other Findings
The salmonella case rate is significantly higher in Franklin County (17.1) than in the ARHN region (12.0), Upstate New York (12.0), and New York State (11.6). The rate of confirmed rabies is also higher in Franklin County (3.7) than in Upstate New York (3.3). In 2019, there were two (2) Listeriosis deaths where the source of the disease acquisition was not determined.

County Health Rankings sponsored by the Robert Wood Foundation and or published online at countyhealthrankings.org. The Rankings help counties understand what influences how healthy residents are and how long they will live. They also look at a variety of measures that affect the future health of communities, such as high school graduation rates, access to healthy foods, rates of smoking, obesity, and teen birth. These help us focus on what we can do to create healthier places to live, learn, work, and play.

In the 3 years since Franklin County Public Health has been closely tracking the County Health Rankings, our county has steadily improved in both Health Outcomes (including length of life and quality of life), and Health Factors (including health behaviors, access to care, and additional social and economic factors). The rankings include 62 counties in New York State, 1 being the best and 62 being the greatest need.

	Year 2017	Year 2018	Year 2019
Health Outcomes	46	42	36
Health Factors	61	59	56

Health is influenced by a range of factors. Social and economic factors, like connected and supportive communities, good schools, stable jobs, safe housing, access to fresh healthy foods, and safe opportunities for physical activity, are foundational to achieving long and healthy lives. When policies, programs, and systems respond to the specific needs of communities and promote inclusive and connected neighborhoods, it enables opportunity for better health for all people. While Franklin County still has a ways to go toward ensuring all of our residents have the opportunities they need to be as healthy as possible, we are making steady

improvements

Franklin County Main Health Challenges

Behavioral Risk Factors

Support Healthy Behaviors Across Systems

♦ Below Benchmarks ♦ Meets or Better than Benchmark ♦ Risk

3 Health Risk Behaviors cause…

Unhealthy Diet

- ♦ Breast Feeding rates Improved at delivery hospital
- ♦ Breast Feeding drops 50% of NYS - benchmark at 6 months
- ♦ Percentage of low income and low access to supermarket or large grocery store – 3x below benchmark
- ♦ Adult and child overweight and obese

Sedentary Lifestyle

- ♦ Number of Recreational Facilities - 2x below benchmark
- ♦ 14 or more days feeling poor physical health
- ♦ Adults who participated in leisure activities in the last 30 days

Tobacco Use

Smoking Rate 28.8% Prevention Agenda Rate 12.3%

- ♦ Lung and Bronchus Cancer

4 Chronic Conditions: Diabetes, Cancer, Heart Disease, Lung Disease

Claiming the lives of 50% of Franklin County residents

Premature Death

- Premature deaths and total deaths
- Rate of Chronic Lower Respiratory Disease deaths
- Rate of premature death due to Cardio Vascular Disease ages 35-64
- Rate of Diabetes Deaths
- Rate of Colon and Rectal cancer cases and deaths
- Cirrhosis deaths

Well Being/Prevent Substance Use Disorder

- Use of OPD Mental Health Services 17 and under, 18-64
- 14 or more days feeling poor mental health
- Rate of age adjusted suicide 10.4 - years 2014-2016; 2018 – 6 (age 24-61)
- Cirrhosis hospitalizations
- Rate of suicides ages 15-19: 2018-0
- Rate of drug related hospitalizations
- ED Visits for Mental Health Services 17 and under 18-64

Antibiotic Resistance/Antimicrobial Resistance / Vaccine Preventable Diseases

- Percentage of children with government insurance with recommended well checkups age 0-21
- Same as above Without Dental Visits age 2- 20
- Rate of pregnancies and births age 15-17; 18-19
- Percent of children with recommended vaccines (County Pertussis Outbreak-2018)
- Lead testing Screening rates
- Salmonella and Rabies cases
- Rate of Community Onset Health-Care-Facility-Associated C. Diff Infections (CDI's)

- Rate of Hospital onset CDI's

Preventive Care and Management

- Screening for Cervical and Uterine Cancer and rate of Cervical and Uterine Cancer
- HPV Vaccine prevents Cervical and Uterine Cancer; HPV Vaccinations and screenings for Cervical and Uterine Cancer need to increase
- Breast and Prostate cases and deaths – better than the benchmark
- Cardio Vascular Disease and Hypertension rate
- Rate of Diabetes hospitalizations
- Percentage of adults experiencing food and housing insecurity
- Rate of Congestive Heart Failure and Stroke
- Screening for Colorectal Cancer have increased
- Rate of Lower Respiratory Disease hospitalizations
- Percentage of Adults (16-64) without Health Insurance 2016
- Age adjusted percentage of Adults with Regular Health Care Provider – Over 18 yrs, 2016

Injuries, Violence, Occupational Health

- Alcohol related crashes
- Alcohol related MVA injuries and deaths
- Motor Vehicle Crashes, Speed related accidents, Motor Vehicle Deaths
- Rate of Emergency Room Visits – patient falls ages 1-4
- Rate of self-inflicted hospitalizations

Environmental Risk Factors

A significant contributing cause of the health challenges in Franklin County is the level of vulnerability of its residents. Social determinants of vulnerability place individuals, households and communities at higher risk for poor health outcomes. These factors specifically address the broader scope and perspective of how to view public health and safety in communities.

Healthy people 2020 describes conditions (social, economic and physical) in various environments and settings (school, church, workplace, and neighborhood) and refers to them as “place”.

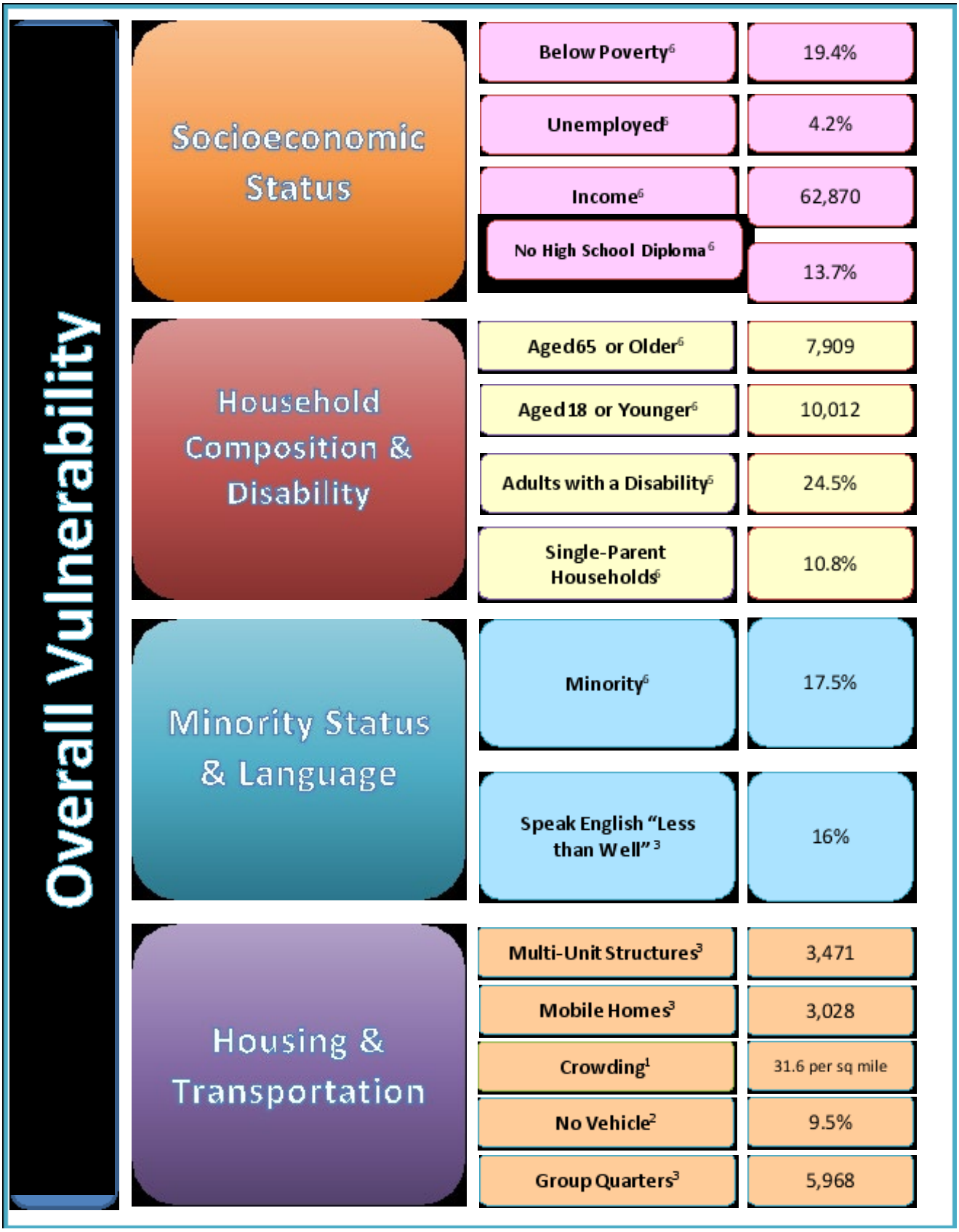
The 2019 Socio-Needs Index, created by Conduent Healthy Communities Institute is a measure of social economic need that is correlated with poor health outcomes. All zip codes, counties, and county equivalents in the United States are given an Index Value from 0 (low need) to 100 (high need). To help find areas of highest need the selected locations are ranked for 1 (low need) to 5 (high need) based on their Index Value.

Social Vulnerability Index (SVI) framework created by The Agency for Toxic Substances and Disease Registry’s (ATSDR) Geosocial Research, Analysis and Services Program (GRASP) and other data sources are utilized to rank Franklin County population on the 4 themes and 14 social factors of the SVI. Franklin County Vulnerability Profile in Disasters data is included as an indicator of overall vulnerability.

Data Sources for Vulnerability Profile

1. US Census Bureau Tracker
2. American Community Survey
3. City-Data.com
4. Comorn Assoc/Franklin County NY Comprehensive Development
5. NYSDOH BRFSS 2016 Behavioral Risk Factor Surveillance System
6. CHA 2020-2023 Franklin County Data Profile 2019-2021
7. NYS Community Health Indicator Reports (CHRIS)

Four (4) themes and 14 social factors of the SVI for Franklin County:



***Greatest Needs Zip Codes (all ranked 5 – greatest need)**

Calculated by: Conduent Health Communities Institute using data from clarities, 2019

13655	Hogansburg	12966	North Bangor
12980	St. Regis Falls	12914	Bombay

Medical Frailty Indicators

NYS Health Commerce System Empower Map Tool

Electricity Dependent	833
Cardiac Device	44
Ventilator	66
BiPap	55
O2 Concentrator	704
Internal Feeding	91
IV Infusion Pump	154
Suction Pump	55
At Home ESRD	11
Motorized Mobility device	77
Electric Bed	180

Franklin County Data

Receive Medicaid[6]	24.6%
Per Capita Medicaid Expenses[6]	$7,383

NYSDOH Behavior Risk Surveillance System - BRFSS 2016[5]

Cognitive Disability	8.3%
Hearing Difficulty	7.0%
Self-Care Difficulty	2.6%
Vision Difficulty	4.3%
Mobility Disability	11%
Independent Living Difficulty	5.4%

Emotional Health Frailty Indicators

Healthyadk.org (2014-2016)

- Age adjusted rate Emergency Room (ER) rate due to Mental Health (ER visits per 10,000 population age 18+) 88.8
- Frequent mental distress 12.5%
- Depression: Medicare population 16.6%
- Frequent physical distress 12.4%
- Insufficient sleep 35%
- Poor Mental Health (14 days or more) 13.1%
- Percentage of disconnected youth[7] 28.5%

VULNERABILITY PROFILE
FRANKLIN COUNTY SOCIO-NEEDS INDEX 64.2
What makes some people especially Vulnerable in Disasters?

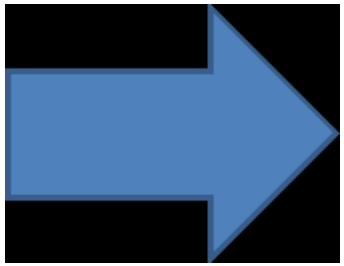
Being Dependent on Support Services –
People who depend on others or community support services to function independently or perform daily activities, may become vulnerable in disasters when these "lifelines" are disrupted.

Residing in High-Risk Areas –
People who live in the older or lower income parts of town are exposed to more of the physical structural damage from disasters.

Limited Access –
People who lack resources, trust, knowledge, or ability to access traditional systems frequently have great difficulty with recovery.

Social Status –
People lacking money, education, jobs, or other resources probably have fewer coping mechanisms with which to recover from disaster.

No Support System –
People who live on very low incomes cannot prepare for disasters and may not have adequate support systems pre or post disaster.



1. Some Senior Citizens[1] 16.2%
2. People with Disabilities[5] 24.5%
   Seniors with Disabilities 30%
3. People who are Non-English Speakers[3] 7.5%
4. People who are Culturally or Geographically Isolated[1]
   31.6 per Square Mile
   9.5% No Vehicle
5. People with Substance Abuse Issues (Residential treatment) 120
6. People who are Homeless[3] Marginally Housed or Shelter Dependent 18
7. Children (<18) with Disability[7] 6.6%
8. People Living in Poverty[6] 19.4%
   Alice & Poverty Households[6] 8,869
9. Illegal Residents N/A
10. Single-Parent Households[6] 10.8%
    Grandparents as Parents 5.2%

Franklin County residents have many indicators for what makes people vulnerable.

FCPHS data indicate social determinants, medical and mental health frailty, isolation, aging, independent living difficulty, those dependent on and without a support system have fewer coping mechanisms and resiliency among its residents.

Above indicators assist planners, community based organizations identify those most needing support. All have a shared stake to focus on the needs of vulnerable persons and the under-served community to ensure everyone gets the services they need for their health and well-being.

Franklin County Socio-Needs Index of 64.2 of 100 quantifies the "place based" conditions that affect the health and vulnerability facing our residents affecting their quality of life outcomes and risks.

The greatest need zip codes are located in the north end of Franklin County. They are:

13655	Hogansburg
12980	St. Regis Falls
12966	North Bangor
12914	Bombay

Among the greatest needs zip codes, a portion of the Hogansburg zip code 13655 belongs to the St. Regis Tribe and receives health care services from the Tribe. FCPHS provides Early Intervention services, Health Family's Home Visiting and collaborate with Emergency Prepared activities. FCPHS works with USDA to provide a rabies clinic in Hogansburg. Alice Hyde Medical Center has health center sites serving

the other three greatest need zip codes providing Family Medicine. Adirondack Medical Center maintains a health center in St. Regis Falls also with future plans to bring in specialists, telehealth and is committed to implement Women and Children interventions identified with in the Essex County Community Health Improvement Plan to its St. Regis Fall facility.

The Community Health Center of the North County (FQHC) is located in northern Malone serving many needy zip codes in Franklin County. The FQHC collaborates with FCPHS providing STD services and lead screenings, thereby increasing access and availability of those services in the county. The FQHCF houses the county WIC Program. Further collaboration potential with WIC and FCPHS is desired specifically relating to data regarding gestational diabetes, prenatal, hypertension, and obesity, along with 50% drop in county breast feeding rates at six months.

School districts in all greatest need zip codes and Chateaugay School participate in the creating Healthy Schools and Communities grant. The school districts receive multi-component school-based obesity preventions and implement the CDC's comprehensive School Physical Education activities. The North County Healthy Heart Network facilitates the grant work with schools in the greatest need zip codes with support from that grant assisting the county pass a Complete Streets Policy with future plans to outreach to municipalities which will further benefit greatest needs zip codes.

Citizen Advocates, Inc., Prevention Specialists have a presence in all greatest needs zip codes school districts.

The geographic size of the county and poor weather in winter with only 31.6 persons per square mile compounded by 9.5% of the Franklin County

population having no vehicle illustrates the need for safe reliable transportation in order to access health care services.

Department of Social Services provides transportation to medical appointments. Behavioral Health facilities offer vouchers for transportation or arrange for travel to/from appointments themselves. The ridership of the county bus system January to September 2019 is 86,503 riders who traveled 513,211 miles using the county bus system. The county provides door to door pick up/ drop off. Transportation needs will continue and contribute to the overall vulnerability of Franklin County residents.

Socioeconomic Factors

Franklin County completed a Demographic and Economic Base Analysis to better understand the existing conditions for Franklin County including age distribution, area income, educational attainment, industry trends, major employers, largest occupations, and other data points. This analysis is used to build on current strengths of the county and identifies potential emerging assets. Some of the key findings from this analysis include:

- Population of Franklin County is projected to remain steady over the next five years and gain approximately 500 new residents (+1%).
- Average household income in Franklin County is about $62,870, much lower than NYS $93,443
- 55% of Franklin County residents have a high school diploma or less as their highest level of education, compared to 42% in Upstate New York as a whole. This is important when considering the type of jobs that can be filled and the educational needs of residents in order to prepare them for employment.
- The Franklin County economy is dominated by Government, Health Care and Social Services, and Retail Trade. These are industries that tend to serve the immediate community rather than attract wealth or export goods.

- Overall the county has seen 7% growth in employment since 2003, with that growth being driven by the Health Care and Social Assistance industry (particularly hospitals, mental health facilities, and other health practitioners) and the Administrative and Support and Waste Management and Remediation Services industry.
- Compared to the national average, Franklin County has a very high concentration of employment in the Agriculture, Forestry, and Fishing industry.
- Very few of the top occupations in Franklin County require more than a high school diploma or GED. The few that require more include: Registered Nurses, Teachers and Physical/Occupational/Speech Therapists. This suggests that residents who grow up in Franklin County and get a higher education may find it difficult to stay or come back to the county for work. There are, however, many other occupations in the county that do requires some form of higher education including Accountants, Doctors, Lawyers, Physicians Assistants, Counselors, and many others. The number of these jobs is just not as great as the jobs that require less education.

The county's goals for 2020 include an expanded emphasis on road infrastructure, development of the county's workforce and improved employment opportunities, and the revitalization of the towns and villages within the county. The county also plans to be directly involved in the planned upgrade of the Malone Recreation Park.

Installation of electric car charging stations, has earned Franklin County a classification as a clean energy community. 2019 also included adoption of a Complete Streets plan and a partnership with the Joint Council for Economic Opportunity (JCEO) and the North County Healthy Heart Network (NCHHN) to address some of the health needs of county residents.

Selection of Franklin County as the “community” is consistent with regulatory requirements to assure inclusion of “medically underserved, low income or minority populations” (sec. 1.501(r) - 3(b)(3), as these populations represent a greater share of the population in Franklin County.

Policy Environment

The mission of FCPHS is to promote information and action so people can live happier and healthier lives. FCPHS has been providing visiting nurse services for over 100 years. The homecare agency became Medicare Certified in 1966. FCPHS is organized as a partial-service health department. Regulatory activities related to facility inspections identified in the NYSDOH Sanitary Code, lead safe housing, water quality related to public water systems, and beaches are conducted by NYSDOH Saranac Lake District Office.

Local towns and villages have their own health codes and officers to conduct public nuisances, health/building/electrical code violation investigations and enforcement. The Environmental Health Services conducted by FCPHS are Injury Control activities such as lead poisoning, prevention motor vehicle, bike, car seat, safety education and other public education campaign activities related to environmental health and climate change.

FCPHS has four main service units: Home Health Population Health, Family Health and the Administrative Unit that provides overall administrative oversight and financial management.

The Certified Home Health Care Agency (CHHA) provides skilled nursing and other therapeutic health services to individuals in the home implementing a physician's medical plan. Costs are covered by health insurances. The county commitment to its CHHA offers residents a choice in home health care, a referral source and safety net for Social Determinants of Health (SDOH) interventions, and allows for population health initiatives to occur at the individual level in the home. The provision of Occupational Therapy (OT), and Speech Language Therapy (SL) as a therapeutic service is a gap in service provision due to inability to recruit providers for those services.

As a partial service public health department, FCPHS is engaged in a broad range of population health services and policy interventions. The Population Health Unit communicable disease team, manages the Rabies Program and outbreaks as part of routine department activities. Tuberculosis Screenings and preventive vaccinations are offered through its clinic services. Sexually Transmitted Disease services are provided by Planned Parenthood of the North Country and most recently through collaboration with Community Health Center of the North Country Federally Qualified Health Care Facility (FQHCF) for clients without health insurance or a regular provider.

The Population Health Chronic Disease staff implement the agency chronic disease work plan and support all Community Health improvement activities. The Emergency Preparedness staff meet required NYS deliverables and all county preparedness activities. Staff support Injury Prevention and all public education campaign activities.

The Family Health staff operationalize the Children with Special Health Care Needs program activities, administers the Early Intervention Program (EI) servicing children ages 0 to 3, the Child Find Program and the Lead

Program. Lead Poisoning screening is now occurring at county WIC clinic sites facilitated by the FQHCF and at JCEO Early Head Start. Nursing staff are Certified Lactation Consultants. Referrals to the Healthy Family's Program in the county occur upon appropriate programming match.

The provision of county EI services has been affected by Provider waitlists related to lack of capacity. Current EIP services provided by the municipality will expand from Service Coordination to include all education services Providers. This expansion of services provision is hoped to carry over and assist Pre-School provider capacity issues.

Franklin County health challenges are complex and often linked with societal issues that extend beyond health care and traditional public health activities. To successfully improve the health of all communities' health improvement strategies must target social determinants of health and other complex factors that are often the responsibility of non-health partners such as housing, transportation, education and environment. Franklin County Legislature has integrated health considerations into policy making to improve community health and wellness a priority by:

- Adopting a Complete Streets policy for all projects.
- Working on Health in All Policies (HiAP) initiative
- Supporting employee Wellness Being Committee reaching 12.8% of county total workforce
- Setting standards on Workplace wellness through participation with NCHHN employer wellness program
- Supporting initiation to achieve smoke free Franklin County worksites
- Participating in St. Regis Falls Healthy Community projects

- Committing funding in county budget to expand transportation projects
- Supporting town/village housing grant applications
- Consolidating county offices in the south end of the county to one site addressing concern for the county north/south differences
- Promoting programing to increase presence and services in the south end of the county

By working to establish policies that positively influence social and economic conditions and those that support changes in individual's behaviors improvement in health for large numbers of people can be sustained over time. Improving the conditions in which we live, learn, work, and play and the quality of our relationships will create a healthier population, society and workforce.

Unique Characteristics

The Amish population in Franklin County affect the health care system and offer traffic safety challenges as well. Amish population census and density is unknown as is morbidly and mortality. The Amish pay for health care services on a sliding fee scale. Financial plans are offered by hospitals for catastrophic occurrences. Medication prescription are paid out of pocket. The majority of Amish babies are born at home. Recently vaccinations are intermittently accepted. Children are educated in Amish schools or are home schooled. Generally health care is sought after failure of all home remedy attempts or in dire emergency.

Buggy accidents occur on major highways thoroughfare's involving, low visibility and inability for car to react fast enough to avoid the buggy. Most but not all sects accept reflectors on their buggies as a safety measure, distributed by the county Traffic Safety Committee.

SUMMARY OF FRANKILIN COUNTY HEALTH ASSETS TO ADDRESS PUBLIC HEALTH ISSUES AND CHALLENGES

Franklin County identified its own assets that are available to address the five health priorities described in the Prevention Agenda's 2019-2021. The below summarize the programs and initiatives within Franklin County that have contributed to addressing each health issue at the local level.
(Abbreviations: AMC – Adirondack Medical Center; AHMC – Alice Hyde Medical Center; CVPH – Champlain Valley Physicians Hospital; FQHCF – Federal Qualified Healthcare Facility; FCPHS – Franklin County Public Health Services; FCOFA – Franklin County Office of Aging; NCHHN – North County Healthy Heart Network; FC – Franklin County; NYSDOH – New York State Department of Health; EMS – Emergency Medical Services)

Assets to Prevent Chronic Diseases

Health Issue	Franklin County Assets
Asthma	• Respiratory Therapy • Cardiopulmonary Services AHMC
Breastfeeding	• Certified Lactation Consultants (CLC) • Women, Infants and Children (WIC) • Breast Feeding Council • Nurse home visitors • Breastfeeding Rooms

Health Issue	• Franklin County Assets
Cancer	• Merrill Center for Oncology • Breast Program: Breast Health Navigator • Various Cancer Screenings Offerings • Cancer Services Program Clinton, Essex, Franklin • Reddy Cancer Treatment Center • FIT-DNA Testing
Nutrition	• Registered Dieticians Inpatient/Outpatient Consultations • Hunger prevention and Nutrition Assistance Program • Comprehensive School Policies for Physical Activity and Nutrition
Obesity	• Creating Healthy Schools and Communities • Weight Management Program (comprehensive, nutrition/physical therapy/behavioral health) • Medical Fitness Program • Fit for Life (Medically-Supervised Activity) • Health Center Wellness Coaches • Registered Tobacco Cessation Specialist
Tobacco Use Prevention and Control	• Decker Learning Center: Tobacco Cessation Program (AMC) • Health Center Wellness Coaches (AMC) • Tobacco Free Clinton, Essex, Franklin • North County Tobacco Cessation Center • NYS Smokers Quitline

Assets to Promote a Healthy and Safe Environment

Health Issue	Franklin County Assets
Foodborne Disease	• Bureau of Community Environmental Health and Food Protection (NYSDOH) • NYSDOH Saranac Lake District Office • County Communicable Disease Unit • County Immunization Program
Public Water Supply	• NYSDOH Saranac Lake District Office • Franklin County Soil and Water Department • County Communicable Disease Unit
Injuries, Violence and Occupational Health	• Physical Therapy/Occupational Therapy/Speech Therapy programs • Traffic Safety Board • Stop DWI • Domestic Violence CMTE • Sharps Disposal towns/villages/public • Crisis Intervention
Built Environment	• Franklin County Complete Streets • Lead Poisoning Prevention Programs • Franklin County Highway Department

Assets to Prevent Communicable Diseases

Health Issue	Franklin County Assets
HIV/AIDS and Sexually Transmitted infections	• Harm Reduction/Syringe Exchange – planned 2019 • HIV/STD/HCV Prevention Services • Regional Prevention and Support Programs • STD Testing and Awareness
Vaccine-preventable disease	• Immunization Action Plan • Primary Care vaccinations and immunizations
Antimicrobial resistance and healthcare-associated infections	• Antibiotic Stewardship Committee - A • Communicable Disease Surveillance in Healthcare & Community - • CDC/NYS Roapmap AR/AMR • CDC “One Health”

Assets to Promote Well-Being and Reduce Mental and Substance Use Disorders

Health Issue	Franklin County Assets
Substance Use	• Overdose Reversal • Medication drop-box • Buprenorphine Clinic • Dr. First Pharmacist-led med-reconciliation • Community Services - local services plan • Opioid Prevention Program • Community Connections Warm Line • Prevention task Force & Subcommittee's Franklin County • Crisis Stabilization\ • Pain management Program • Crisis Hotline

Assets to Promote Healthy Women, Infants and Children

Health Issue	Franklin County Assets
Maternal and Women's Health	• Neonatal Abstinence Syndrome (NAS) Collaborative - • Healthy Families Home Visiting Program • Maternal-Child Nurse Home Visiting • OB/GYN Services • Childbirth Class
Perinatal and Infant Health	• Medicaid Program • Perinatal Program • Child Find
Child and Adolescent Health	• Child Lead Poison Prevention Program • Children with Special Health Care Needs Program • Early Intervention Program/Pre School Program • Birth to 3 Collaborative • Community Intervention Partnership • Childcare Safety Education

Community needs are identified through regular and comprehensive local assessments including:

- The County Emergency Preparedness Assessment (CEPA) conducted by the Franklin County Office of Emergency Services through direction of the New York State Division of Homeland Security and Emergency Services.
- Franklin County Community Health Assessment conducted by Franklin County Public Health Department and community hospital partners.
- Franklin County Office of Aging (OFA) Annual Assessment
- Franklin County Community Services Local Services Plan

COMPLEMENTARY HEALTH INITIATIVES IN OUR REGION

Community needs assessments, service plans and strategic plans from other community sectors in the region were reviewed to identify opportunities for collaboration among local health department/hospitals and other community entities to improve health outcomes in the county and region. Efforts to build healthier communities have the potential for being more successful when agencies, programs and individuals from multiple community sectors work together. Collaboration between the health sector and other community sectors can generate new opportunities to improve health.

Below is a summary of county, regional and statewide planning documents, policy agendas, and mission statements from a variety of community sectors that address health-related issues. Links are included

to facilitate access to the documents and web sites. The contents are organized by the relevant Prevention Agenda Focus Areas; *Promote Well-Being and Prevent Mental and Substance Use Disorders* and *Prevent Chronic Disease.* The summary does not provide an exhaustive analysis of multi-sector health priorities, but is provided to illustrate the potential for collaborative health improvement efforts in the county and region.

Promote Well-Being and Prevent Mental and Substance Use Disorders

Priority Area: **Prevent Chronic Disease**
Focus Area 3: Tobacco Prevention
Goal Promote tobacco use cessation
Objective Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%.
Interventions 3.2.1 Facilitate medical/behavioral practices in delivering tobacco Tx. 3.2.2 Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline.
Implementation Partner Health system grantee will provide support on policy implementation and the development of standards of care as the Lead for this intervention.
Available resources Decker Learning Center: Tobacco Cessation Program, Chronic disease wellness coaches, bariatric program
Disparity Addressed

Priority Area: **Prevent Chronic Disease**
Focus Area 4: Prevention and Care Management
Goal Increase cancer screening rates
Objective Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years)
Intervention 4.1.1 Systems change for cancer screening reminders
Implementation Partner Health system grantee will partner and support this intervention. Franklin County Public Health Department will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the county and connect to healthcare resources.
Available resources Merrill Center for Oncology and various cancer screenings
Disparity addressed

Priority Area: **Prevent Chronic Disease**
Focus Area 4: Prevention and Care Management
Goal Increase early detection of cardiovascular disease, diabetes, pre-diabetes and obesity
Objective Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%
Interventions 4.2.1 Improve detection of undiagnosed hypertension 4.2.2 promote testing for pre-diabetes/diabetes
Implementation Partner Health system grantee will provide staff time to support practice enhancement activities aimed at increasing identification and diagnosis of pre-diabetes offer practice facilitator staff time to support use of registry and staff time to support development. Will also support with funds to pay for patient education material. Franklin County Public Health Department will assist by increasing access to care by acting as a referral mechanism for chronic disease wellness coaching.
Available resources Electronic health records, HIXNY registries Weight Management Program (comprehensive, nutrition/physical therapy/behavioral health) Medical Fitness Program- integration of health and wellness services Fit for Life (Medically-Supervised Activity) Health Center Wellness Coaches Decker Learning Center: Tobacco Cessation Program Chronic Disease prevention wellness coaches Care coordinators
Disparity addressed

Priority Area: **Prevent Chronic Disease**
Focus Area 4: Prevention and Care Management
Goal Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity
Objective Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%)
Interventions 4.3.1 Team approach to Chronic Disease Outcomes 4.3.5 Referral for those with pre-diabetes to Diabetes Prevention Program
Implementation Partner Health system grantee will partner and support this intervention with staff time to support practice enhancement activities aimed at increasing referral of patients to DPP program. Additionally, assist with funds for patient education and DPP facilitator training. Franklin County Public Health Department will assist by increasing access to care by acting as a referral mechanism for diabetes prevention program.
Available resources Electronic health records, HIXNY registries Weight Management Program (comprehensive, nutrition/physical therapy/behavioral health) Medical Fitness Program- integration of health and wellness services Fit for Life (Medically-Supervised Activity) Health Center Wellness Coaches Decker Learning Center: Tobacco Cessation Program Chronic Disease prevention wellness coaches

Care coordinators
Disparity addressed
Priority Area: **Prevent Chronic Disease**
Focus Area 4: Prevention and Care Management
Goal In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity
Objective Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition
Interventions 4.4.2 expand access to chronic disease self-management 4.4.3 expand access to National Diabetes Prevention Program
Implementation Partner Health system grantee will provide staff time to support establishment and/or maintenance of DPP programs. This includes facilitator training, stipends and participant materials. Health System grantee will also assist with data collection and reporting, as required by CDC to maintain recognition.
Available Resources Electronic health records, HIXNY registries Weight Management Program (comprehensive, nutrition/physical therapy/behavioral health) Medical Fitness Program- integration of health and wellness services Fit for Life (Medically-Supervised Activity) Decker Learning Center: Tobacco Cessation Program Chronic Disease prevention wellness coaches Care coordinators
Disparity addressed

Education, poverty

Priority Area: Promote Healthy Women, Infants and Children
Focus Area 1: Maternal and Women's Health
Goal Increase use of primary and preventive health care services among women of all ages, with special focus on women of reproductive age
Objective Increase the percentage of women ages 45 years and older with a past year preventive medical visit by 2% to 85.0% Increase the percentage of women ages 18-44 years with a past year preventive medical visit by 10% to 80.6%.
Intervention 1.1.1 health insurance enrollment 1.1.2 reproductive goal setting in routine health visits
Implementation Partner Adirondack Health will lead. Essex County Public Health Department will partner to increase access to Women's Health Services in Essex County.
Available resources Women's Health Clinic providers Certified Lactation Consultants Birthing classes Facilitated insurance enrollers
Disparity addressed Access to care- explain *(Narrative on this priority area is that we are also implementing OB/GYN time in LP and Keene)*

Priority Area: **Promote Well-Being and Prevent Mental Health/Substance Use Disorders**
Focus Area 1: Promote Well-Being
Goal Strengthen opportunities to build well-being and resilience across the lifespan
Objective Reduce the percentage of adults 65+ New Yorkers reporting frequent mental distress during the past month by 10% to no more than 13%.
Intervention 1.2.3 Policy and program interventions that promote inclusion, integration and competence (Age Friendly)
Implementation Partner Adirondack Health will lead. Mercy Care for the Adirondacks; will support by communicating efforts to the region, provide expertise. Franklin County Public Health will provide support and help identify seniors at risk of negative health outcomes that can benefit from hospital services.
Available resources Behavioral Health providers in Lake Placid, Saranac Lake and Tupper Lake. Care Coordinators
Disparity addressed Access to care, disability and poverty

Priority Area: **Promote Well-Being and Prevent Mental Health/Substance Use Disorders**
Focus Area 2: Prevent Mental Health and Substance Use Disorders
Goal Prevent opioid and other substance misuse and deaths
Objective Increase the age-adjusted *Buprenorphine* prescribing rate for substance use disorder (SUD) by 20% to 43.8 per 1,000 population. Baseline: 36.5 per 1,000
Interventions 2.2.2 availability/access to OD reversal 2.2.3 prescriber education regarding opioid guidelines/limits 2.2.5 safe disposal sites & take-back days, lobby drop off
Implementation Partner Adirondack Health
Available resources Provider to prescribe buprenorphine Safe disposal site at main campus
Disparity addressed Access, education

Priority Area: **Promote Well-Being and Prevent Mental Health/Substance Use Disorders**
Focus Area 2: Prevent Mental Health and Substance Use Disorders
Goal Reduce the mortality gap between those living with serious mental illness and the general population
Objective Decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4%
Intervention 2.6.2 Integrated treatment: Concurrent therapy for mental illness and nicotine addiction have the best outcomes. Smokers who receive mental health treatment have higher quit rates than those who do not.
Implementation Partner St. Josephs Addiction Treatment Center will partner with hospital to provide continued care coordination and information sharing to ensure patients receive the appropriate level of care.
Available resources
Disparity addressed Access, care coordination, patient education

Franklin County Community Services -2020 Local Services Plan for Mental Hygiene Services
http://www.clmhd.org/img/pdfs/brochure_dcvr0q4am7.pdf

- Create opportunities for those in need of safe and affordable housing
- Insure transportation is available to Franklin County residents to access services and employment.
- Insure crisis intervention and stabilization services are available to Franklin County residents and are supported by a skilled professional community.
- Develop strategies to assist providers in recruitment and retention of staff.
- Create and strengthen existing prevention and engagement strategies to reduce the impact of opiate, opioid and other substance use disorders through supports to individuals, families and communities.
- Provide opportunities for individuals in recovery to develop personal/professional support networks and access to services.
- Develop strategies to increase public understanding of behavioral health conditions to reduce the negative perception of individuals seeking help and who are in recovery.
- Expand the delivery of behavioral health and I/DD services provided at the Franklin County Correctional Facility.
- Franklin County System of Care will continue to develop trauma responsive practices within the community to better meet the needs of children and their families.

The Alcoholism and Substance Abuse Providers of New York State (ASAP)
http://www.asapnys.org
Working together to support organizations, groups and individuals that prevent and alleviate the consequences of alcoholism and substances in New York State.

Prevent Chronic Disease

NYS Office for the Aging State Plan 2019-2023
https://aging.ny.gov/PlanonAging/index.cfm
Empower older New Yorkers, their families and the public to make informed decisions about, and be able to access, existing health, long term care and other service options.
Enable older New Yorkers to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.
Empower older New Yorkers to stay active and healthy through Older Americans Act services and those offered under Medicare.
Embed ACL discretionary grants with OAA Title III core programs.
Ensure the rights of older New Yorkers and prevent their abuse, neglect and exploitation.
Ensure the network is prepared to respond in emergencies and disasters.
Enhance the capacity of the AAA network to develop business acumen strategies to engage with and integrate into emerging health care delivery system transformation activities that foster outcomes-driven population health approaches.

North Country Healthy Heart Network
heartnetwork.org/projects
Current projects include Creating Healthy Schools and Communities, Chronic Disease Prevention Coalition, and North Country Tobacco

Cessation Center

Joint Council for Economic Opportunity of Clinton and Franklin Counties, Inc. (JCEO)
www.jceo.org
JCEO is a private, not-for-profit human service agency that serves the residents of Clinton and Franklin Counties through its main administrative offices as well as 13 Community Outreach Centers and 10 Head Start Centers. All programs are based on JCEO's mission to alleviate poverty through practical, timely, and innovative services that emphasize and develop problem-solving skills for people.

Complete Streets Policies
https://www.dot.ny.gov/programs/completestreets
Franklin County and the Town of Malone have Complete Streets policies.

Cooperative Extension Franklin County
www. http://franklin.cce.cornell.edu/about-us
The mission of Cooperative Extension is to enable people to improve their lives and communities through partnerships that put experience and research knowledge to work. Extension staff and trained volunteers deliver education programs, conduct applied research, and encourage community collaborations. Our educators connect people with the information they need on topics such as commercial and consumer agriculture; nutrition and health; youth and families; finances; energy efficiency; economic and community development; and sustainable natural resources. Our ability to match university resources with community needs helps us play a vital role in the lives of individuals, families, businesses, and communities throughout Franklin County.

Tobacco-Free CFE (Clinton, Franklin, and Essex Counties)
www.tobaccofreecfe.com

Work includes helping businesses, organizations, property managers and municipalities: Create tobacco free grounds (parks, playgrounds and work sites), establish smoke-free units, reduce or eliminate tobacco imagery and brand identification in youth-rated media, reduce youth exposure to retail tobacco marketing

Promote Healthy Women, Infants and Children

Adirondack Birth to Three Alliance
http://www.adirondackbt3.org/about-us

The Adirondack Birth to Three (BT3) Alliance has identified the following five building blocks of services to improve outcomes for children:

- Universal home visiting for all families with newborns;
- Comprehensive home visiting with extended periods of home visits for vulnerable families;
- Family resource centers for parenting education and support, developmental screening, and other family services accessible to all;
- High quality early childhood education for all; High quality health care including mental and physical health care services accessible to all children; and
- Early literacy support emphasizing the importance of reading to infants and toddlers, providing access to free books, and providing parents with information about child development.

New York State Early Childhood Advisory Council
http://www.nysecac.org/priorities/healthy-children/

The NYS Early Childhood Advisory Council (ECAC) focus on healthy children includes training early childhood professionals to better identify health issues, establishing routine developmental screenings and promoting more nutritious meals and exercise at early childhood centers. The desired outcomes that guide the ECAC's work on Healthy Children include:

- All pregnancies are wanted, healthy, and safe, and include prenatal screening.
- Children's environments are free from preventable injury and illness.

- Children achieve optimal physical, social, emotional and cognitive development.
- Children receive early recognition and intervention services for their special needs.
- Children are enrolled in public or private health insurance programs
- Children's health, mental health, and oral health services are accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally respectful.

▪ School Wellness Policies

http://www.fns.usda.gov/tn/local-school-wellness-policy

School districts participating in the National School Lunch Program and/or the School Breakfast Program are required to establish a school wellness policy for every school building in the district. At a minimum, the wellness policy must include goals for nutrition promotion and education, physical activity, and other school-based activities that promote student wellness. The policies must include nutrition guidelines to promote student health and reduce childhood obesity for all foods available in each school district. Additionally, school districts are required to permit teachers of physical education and school health professionals, as well as parents, students, school board members, and the public to participate in the development and implementation of wellness policies. Opportunities exist for local health departments and health care providers to assist school districts develop and implement school wellness policies.

Promote a Healthy and Safe Environment

Governor's Traffic Safety Committee
http://www.safeny.ny.gov/overview.htm
Governor's Traffic Safety Committee (GTSC) awards Federal highway safety grant funds to local, state and not-for-profit agencies for projects to improve highway safety and reduce deaths and serious injuries due to crashes.

Documentation of the process and methods used to conduct the assessment, the sources and time periods of data used, how the preliminary findings of the assessment were distributed to the community-at-large, and how the community's input was sought.

COMMUNITY HEALTH ASSESSMENT PROCESS AND METHODS

The process of identifying the important health care needs of the residents of Franklin County involved both data analysis and consultation with key members of the community. The data was collected from multiple sources including publicly available health indicator data as well as the data collected from a survey conducted by the Adirondack Rural Health Network.

The health indicator data is collected and published by New York State and contains 271 different health indicators. Since 2002, The Adirondack Rural Health Network has been compiling this data for the region and producing reports to inform healthcare planning on a regional basis.

In January of 2019, the Adirondack Rural Health Network (ARHN) conducted a survey of selected stakeholders representing health care and service-providing agencies within a seven-county region. The results of the survey are intended to provide an overview of regional needs and priorities, to inform future planning and the development of a regional health care agenda. The survey results were presented at both the county and regional levels.

Using the results of the indicator analysis, the survey, and other community assessments, a group of stakeholders was convened to identify and prioritize the current healthcare challenges for the residents of Franklin County. The group consisted of representatives from Adirondack Health Medical Center Hospital, the University of Vermont Health Network Alice Hyde Medical Center and Franklin County Public Health County Public Health. The group assessed the magnitude of the health issues (number of people affected), the severity of the issues (consequences for those affected), and the community's ability to make a meaningful contribution in addressing the health need. (See Appendix… Community Health Assessment Committee Data 2019 Methodology.)

Community Health Improvement Plan/Community Service Plan

Summary of 2019 Community Stakeholder Survey

Background:

Adirondack Rural Health Network: The Adirondack Rural Health Network (ARHN) is a program of AHI -Adirondack Health Institute, Inc. Established in 1992 through a New York State Department of Health Rural Health Development Grant, ARHN is a multi-stakeholder, regional coalition that informs planning, assessment, provides education and training to further the implementation of the New York State Department of Health Prevention Agenda, and offers other resources that support the development of the regional health care system. Since its inception, ARHN has provided a forum to assess regional population health needs and develop collaborative responses to priorities. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Description of the Community Health Assessment Committee: Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities.

The CHA Committee is made up of representatives from Adirondack Health, Clinton County Health Department, University of Vermont Health Network - Alice Hyde Medical Center, University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital, University of Vermont Health Network – Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health.

Purpose of the CHA Committee: The CHA Committee, made up of the CHA service contract holders with AHI, is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment by working collaboratively on interventions and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda.

CHA Committee, Ad Hoc Data Sub-Committee: At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

The data subcommittee met seven times from mid-July through the end of October 2018. Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 subcommittee members per meeting. Meetings were also attended by AHI staff from ARHN, Population Health Improvement Program (PHIP) and Data teams.

Survey Methodology

Survey Creation: The 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at December 7, 2018 meeting.

Survey Facilitation: ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental institutions as well as community members. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington Counties.

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed

within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns. A full list of survey questions can be found under Appendix A.

Survey Responses and Analysis: A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

(What follows is a summary of Stakeholder Survey results for Franklin County. Please see Appendix B for complete Summary of 2019 Stakeholder Survey

Indicate county/counties served

Community stakeholder survey respondents were asked which county their organization/agency serves. 82 of the respondents were from Franklin County.

Top priority areas for Franklin County

- Franklin County *i*dentified ***Promote Well-Being and Prevent Mental and Substance Use***
- ***Disorders*** as their top priority and ***Prevent Chronic Diseases*** as their second choice.

As survey participants were not provided focus areas or goals associated with each priority area, it can be assumed that the answers for these priority areas were slightly swayed due to what partners believe *Promote Well-Being and Prevent Mental and Substance Use Disorders* represents or what they feel would be listed in that category.

Top five health concerns affecting the residents of Franklin County

Community stakeholders were asked to choose what they believed to be the top five health concerns affecting the residents in the counties their organization/agency served. The choices were ranked from one, being the highest health concern, to five, indicating the lowest health concern.

Franklin County survey respondents recognized **mental health conditions, overweight/obesity, substance abuse, opioid use, and adverse childhood experiences** as their top 5 health concerns.

Contributing Factors for Franklin County:

Respondents were asked to identify what they believed to be the top five contributing factors to the health concerns they chose. The contributing factors were ranked from one to five, with one being the highest contributing factor and five being the lowest.

Franklin County survey respondents identified **poverty, lack of mental health services, addiction to illicit drugs, changing family structures, and health care costs** as the contributing factors to the health concerns they chose.

Priority Selection

SELECTION BASIS AND METHOD

Selection was based primarily on the following:
1. Results of stakeholder surveys outlined above
2. Data analysis outlined above
3. Community health planning session

In order to prioritize the focus areas under the prevention agenda priorities listed above, a workgroup was established to rank the significant community needs based on criteria important to the Hospital and Health Department.

Participants: The group was chosen to represent people with community and clinical knowledge, with particular attention to include individuals who are knowledgeable about the needs assessment process, manage services to the underserved, or manage services that address an identified need. Participants included:

- Kathleen Farrell Strack, FCPH
- Sarah Granquist, FCPH
- Dan Hill , AH
- Heidi Bailey, AH
- Matt Scollin, AH
- Annette Marshall, UVMHN-AHMC
- Kaitlyn Tentis, UVMHN-CVPH

Process: The subcommittee listed above representing the public health department and hospitals convened on 9/6/2019 to finalize Priority Area and Focus Area selection. Members of the subcommittee noted the consistency in findings from the stakeholder survey and data analysis. Therefore, ***Promote Well-Being and Prevent Mental and Substance Use Disorders*** and ***Prevent Chronic Disease*** were accepted as selected Priority Areas for Franklin County.

Action Plans:
Lead staff from Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center and Adirondack Health Medical Center Hospital worked with partners to collect potential activities and interventions. Determination of specific interventions related to each priority area was based on alignment with the DSRIP goals and objectives each agency is committed to; other population health based initiatives occurring within the organization; organizational ability to make a sustained impact with the intervention; as well as Franklin County Public Health's ongoing collaborations with the Franklin County Community Services Board, Federally Qualified Health Care Facility and the North Country Healthy Heart Network.

2019-2021 PRIORITIES AND GOALS

County/Service Area Priorities and Disparities 2019-2021

Priority 1— Promote Well-Being and Prevent Mental Health and Substance Use Disorders

Focus Area – Promote Well-Being

Priority 2— Prevent Chronic Diseases

Focus Area – Healthy Eating and Food Security
Focus Area – Physical Activity

Disparities—Poverty and Access to Care

Franklin County Public Health services Community Health Improvement Plan

Priority: Prevent Chronic Disease	
Focus Area 1 – Healthy Eating and Food Security	
Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices.	
Objective 1.9: By December 31, 2021, decrease the % of adults who consume less than one fruit and less than one vegetable per day by 5% from 21.1% to 20%	
Key Actions: • Participate in Local Foods Local Places Project • Develop and provide public health messaging to educate residents on nutritional value of food • Participate in NYSDOH ASTHO ECHO Food Security and Community Wealth Building collaborative • Strengthen systems within the county that support community capacity building	**Anticipated Impact** • Increase number of people consuming 5+ servings of fruits and vegetables daily • Increased number of people with knowledge of nutritional value of food • Increased agency staff knowledge of food security community wealth building and well being • Increased agency staff ability to advocate for the needs of the community
Disparity: Access, Education	

Focus Area 2 – Physical Activity	
Goal 2.1: Improve Community environments that support active transportation and recreational physical activity for people of all ages and abilities.	
Objective 1.7: By December 31, 2021, increase the % of adults age 18 and older who participate in leisure time physical activity by 5% from 69.5% to 73%.	
Key Actions: • Support implementation of county Complete Streets Policy • Promote safe and more connected communities that prevent injury (designing safer environments fostering economic growth) and provide safe shared spaces for county residents to interact. • Initiate and develop community "Health Improvement Partnership" • Develop and implement county employee Wellness Committee wellness activities	**Anticipated Impact** • Increased ability of multisector body to leverage existing resources across systems • Increase number of individuals trained on assessing health impact in community planning and development • Increased access to safe public spaces and environments • Increased leverage of Partnership resources across systems • Increased number of programs that promote physical activity and healthy eating
Disparity: Built Environment	

Priority: Promote Well Being and Prevent Mental and Substance Use Disorders	
Focus Area 1 – Promote Well Being	
Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	
Objective 1.1: By December 31, 2021, reduce the % of adult New Yorkers reporting 14 or more days with poor mental health in the last month by 10% from 13/1% to 12%.	
Key Actions: • Promote staff training opportunities on early detection of Behavioral Health needs across the lifespan • Promote participation in Employee Assistance Program activities • Provide education in various school districts on How to Talk to your Doctor • Conduct social determinants of health screening for home care patients in the greatest need zip codes. • Provide Public Health Messaging on physical, emotional health services offered in the county • Provide overdose reversal training opportunities	**Anticipated Impact** • Improved staff early detection of behavioral health needs • Improved county employee well being • Increased youth health literacy • Early intervention for home care patients needing assistance on SDOH • Increased utilization of behavioral and health prevention services • Increase number of people able to reverse opioid overdose. • Increase number of people without provider or health insurance accessing primary health services and substance use care

Disparity: Access, Education

LHD Resources

Chronic Disease	Participate in Healthy Eating and Food Security Collaborative NYSDOH
Well Being	Provide literacy education – Community Connections (Access)
Antimicrobial Resistance/ Antibiotic Resistance	Attend hospital Infection Control Committee Meetings
Well Being	Attend Prevention Task Force Meetings North & South
Well Being	Attend Post Venation Meetings
Chronic Disease	Participate in Chronic Disease St. Regis Falls Built Environment Collaborative
Well Being	Assist government development Health in All Policy's Access
Well Being	Implement Age-Friendly elements of wellness and community revitalization into Emergency Preparedness planning and activities
Well Being	Maintain Liaison with academic affiliations

Well Being	Certified Home Health Agency (CHHA) institute Social Determents of Health screening for clients in top 5 zip codes
Age Friendly	Public Health develop comprehensive information about county supports for caregivers
Age Friendly	CHHA refer patients to Office of Aging (OFA)
Well Being	Public Health develop SDOH county Intervention info
Well Being	Public Health post SDOH screening tool American Academy Family Physicians
Chronic Disease/ Health in All Policy's	Public Health Implement 3-4-50 Framework Community Health Strategy
Built Environment	Public Health Mass media campaign against alcohol – Impaired Driving
Chronic Disease	Public Health Mass media campaign Fruits and Vegetables
Well Being	Attend TSC support Sobriety Checks and provide vehicle safety public messages

Well Being / Chronic Disease	Attend Birth to 3 Coalition Meeting
Well Being / Chronic Disease	Attend Child Coordinating Council of Franklin, Clinton and Essex
Antimicrobial Resistance/ Antibiotic Resistance	Implementing CDC AB for LHD's

Participant Rolls and Resources

<u>Unhealthy Diet</u>

- The NYSDOH will be a resource for training vice participation in the Healthy Eating and Food Security Collaboration
- The Chronic Disease Collaborative will address chronic disease in the county
- Medical, county government will support messaging campaign
- The Breastfeeding Council in northern Malone will participate in messaging on the importance of Breast feeding
- 12.8% of the government will participate as stakeholders in institution of "Wellness" Committee addressing access as a disparity and obesity/Chronic disease providing improvement
- WIC will be a focus as a potential stakeholder to improve Breastfeeding rates after six months
- North County Healthy Heart Network Franklin County Office of Aging and JCEO to increase availability of fruits and veggies facilitate and conduct actions

Sedentary Lifestyle

- The YMCA in northern Malone will be a resource to increase physical activity for government employees as well as the general community
- NCHHC will be a resource to FCPHS to build on the county Complete Streets Policy
- Media, County government will support messaging campaign to modify local environments to support physical exercise

Tobacco

- Tobacco Free Clinton, Franklin, Essex will be the resource to increase smoke free parks, beaches, playgrounds. Colleges and other public spaces
- FCPHS CHHA will screen for smoking and refer patients to quit line
- All CBO's, business and the county will be a stakeholder to receive health communications encouraging quit attempts and resources for smoking cessation.
- Tobacco Free Clinton, Franklin, Essex will be the resource to promote smoke-free policies in multi-housing, apartment complexes, multi-unit housing especially those that house low socioeconomic residents
- Tobacco Free Clinton, Franklin, Essex will be the resource to prevent initiation of tobacco use including sustainable tobacco and vaping products by NY youth and young adults.

Promote Well Being

- Community Services and all appropriate CBO's will be the resource to implement the Local Services plan and activities described in the plan.
- The county Employee Assistance Program will be a resource for 12.8% of government employees to receive mental health and well-being intervention

- County government will be a resource to develop Health in All Policy's (HiAP)and implement accordingly
- FCPHS will use "creating age Friendly Public Health System" / HiAP to address access as a disparity during Emergency Planning for Venerable Populations during recruitment for Closed Point of Distribution arrangements
- Community Connections will utilize FCPHS to address literacy/ access for school age population for training on how to talk to your doctor.
- FCPHS CHHA will be a resource to implement "The Everyone Project" Social Determents of Health screening in greatest need zip codes.
- Franklin County Traffic safety Board will be the resource to address community safety to prevent injuries from alcohol related motor vehicle crashes, injuries and death
- The Franklin County Community Intervention Partnership will address the disparity of access for children with government insurance in order to receive recommended well child and dental checkups, lead screening, vaccinations
- The county hospitals will address the disparity of access to reduce the rate of community acquired C. difficult infection and be a resource to FCPHS developing coordinated approach to reduce antibiotic resistance in the community and facilitate AB stewardship.

Addressed Health Disparity

In order to support healthy behaviors across settings and address Access to Care disparity the 3-4-50 focused framework for Community Health Improvement will be implemented to prevent Chronic Disease.

In order to promote well-being and address the disparity of access to care the framework of creating age Friendly Public Health System/Health in All Policy's will be utilized.

Maintaining Engagement and Tracking Progress

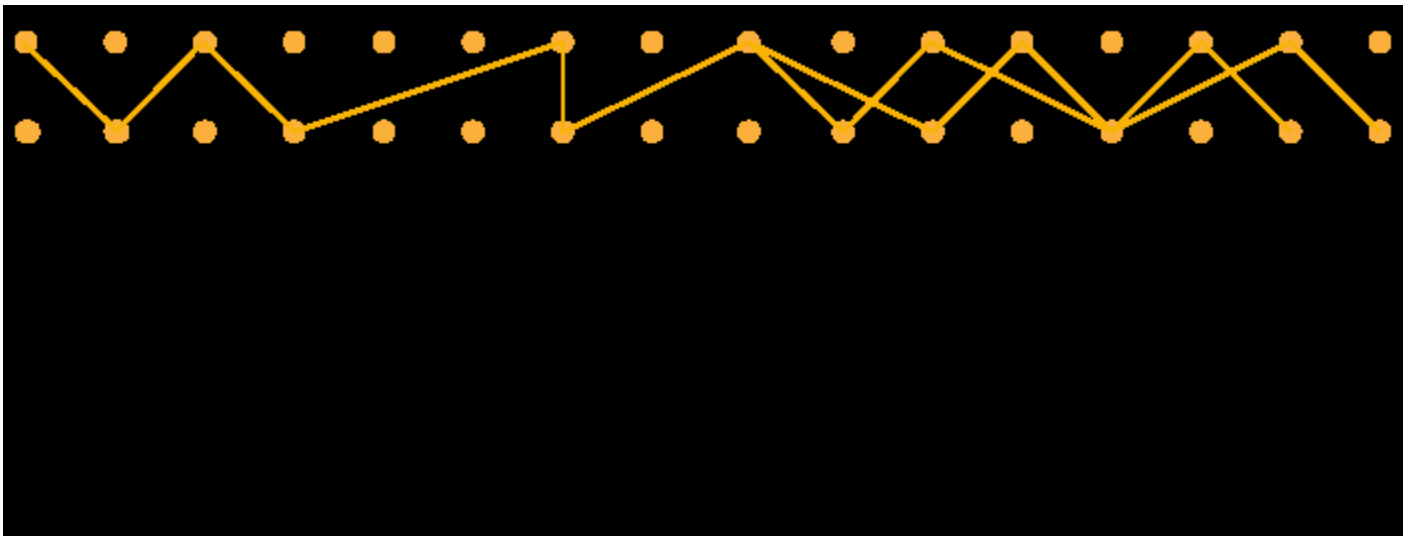
The multi-county, regional CHA Committee, coordinated by ARHN, has been meeting in person every three months throughout the last assessment and planning cycle and will continue to do so during the 2019-2021 cycle. The committee convenes to support regional ongoing health planning and assessment, working collaboratively on interventions and sharing promising evidence-based programing.

Additionally, Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital have committed to meet bi-annually to discuss progress and evaluate results. We will assess measurable outcomes identified in our interventions chart, discuss strategy updates or changes, and collaborate on additional plans. Progress towards the identified health goals will be continually tracked with formal progress captured in annual reports.

Dissemination of Plan to Public

The Community Health Needs Assessment and Community Service Plan/Community Health Improvement Plan will be disseminated to the public through the websites of Franklin County Public Health (www.franklicony.org), The University of Vermont Health Network – Alice Hyde Medical Center (www.alicehyde.com), and Adirondack Health (www.adirondackhealth.org). The plan will also be available through the website of the Adirondack Health Institute (www.ahihealth.org/arhn).

LEFT BLANK
ON PURPOSE



ARHN Resources/Appendices:

A: 2019 Data Methodology

B: 2019 Stakeholder Survey Methodology

C: Social Determinants of Health and Health Disparities

D: ALICE Profile

E. NYS Data Resources

Community Health Assessment Committee

2019 Data Methodology

Background:

The Community Health Assessment (CHA) Committee, facilitated by the Adirondack Rural Health Network (ARHN), a program of Adirondack Health Institute (AHI), is a multi-county, regional stakeholder group, that convenes to support ongoing health planning and assessment by working collaboratively on interventions, and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service to advance the New York State Prevention Agenda.

The overall goal of collecting and providing this data to the CHA Committee was to provide a comprehensive picture of the individual counties and overview of population health within the ARHN region, as well as Montgomery and Saratoga counties.

Demographic Profile:

Demographic data was primarily taken from the 2013-2017 American Consumer Survey 5-year estimates, utilizing the United States Census Bureau American FactFinder website. Other sources include the 2010-2014 American Consumer Survey 5-

year estimates, Centers for Medicaid and Medicare Services, through the CMS Enterprise Portal, NYS Department of Health, U.S. Department of Agriculture (USDA), and the National Agriculture Statistics Service.

Information incorporated into the demographic report includes square mileage, population, family structure and status, household information, education and employment status.

Health System Profile:

The vast majority of health systems data comes from the New York State Department of Health, including the NYS Health Profiles, Nursing Home Weekly Bed Census, License Statistics and Adult Care Facility Directory. Other sources include Health Resources and Services Administration (HRSA) and Center for Health Workforce Studies, Health Workforce Planning Data Guide.

Health system profile data incorporated hospital, nursing home, and adult care facilities bed counts, health professional shortage areas (HPSAs), physician data, and licensure data.

Education Profile:

The education profile is separated into two parts; education system information and school districts by county. Part one of the education profiles includes data pertaining to education systems in the ARHN region, including student teacher ratios,

english proficiency rates, and free lunch eligibility rates as well as available education programs and graduates. Data was pulled from the NYS Education Department, National Center for Education Statistics, and Center for Health Workforce Studies. Part two identifies school districts by county includes county school districts as well as regional school districts.

Data was pulled from the NYS Education Department, National Center for Education Statistics, and Center for Health Workforce Studies.

ALICE Profile:

All data provided in the ALICE profile comes from the 2016 ALICE report, which can be found at www.unitedforalice.org/new-york. Sources utilized in the report include American Consumer Survey, Bureau of Labor Statistics, Consumer Reports, IRS and U.S. Department of Agriculture.

In April 2018, the NYS Department of Health released guidance for 2019-2021 community health assessment and planning. It was suggested that local health departments and hospitals submit one plan per county and hospitals serving more than one county were strongly encouraged to select and prioritize high poverty neighborhoods for action. To address these updates, the Asset Limited, Income Constrained, Employed (ALICE) profile was added. ALICE profile data includes total households, poverty and ALICE percentages, unemployment rates, percent of residents with health insurance and average annual earnings. Please note that all data on the ALICE profile is reflective of 2016 figures.

Data Sheets:

The data sheets, compiled of 271 data indicators, provide an overview of population health as compared to the ARHN region, Upstate New York and New York State. The reports feature a status field that specifies whether indicators were met, better, or worse than their corresponding benchmarks. When indicators were worse than their corresponding benchmarks, their distances from their respective benchmarks were calculated. On the report, distances from benchmarks were indicated using quartile rankings.

Quartile 1: Less than 25%	Quartile 3: 50% - 74.9%
Quartile 2: 25% - 49.9%	Quartile 4: 75% - 100%

The report also showed the percentage of total indicators that were worse than their respective benchmarks by focus area.

- For example, if 20 of the 33 child health focus area indicators were worse than their respective benchmarks, the quartile summary score would be 61% (20/33).
- Additionally, the report identified a severity score, i.e., the percentage of those indicators that were either in quartile 3 or 4. Using the above example, if 9 of the 20 child health focus indicators that were worse than their respective benchmarks were in quartiles 3 or 4, the severity score would be 45% (9/20).

Quartile summary scores and severity scores were calculated for each focus area as well as for Prevention Agenda indicators and “other indicators” within each focus area. Both quartile summary scores and severity scores were used to understand if the specific focus areas were challenges to the counties and hospitals. In certain cases, focus areas would have low severity scores but high quartile summary scores indicating that while not especially severe, the focus area offered significant challenges to the community.

Indicators were broken out by the Prevention Agenda focus areas, across ten tabs. Tabs include *Mortality, Injuries, Violence and Occupational Health, Built Environment and Water, Obesity, Smoke Exposure, Chronic Disease, Maternal and Infant Health, HIV, STD, Immunization and Infections Substance Abuse and Mental Health,* and *Other.* Data and statistics for all indicators comes from a variety of sources, including:

- Prevention Agenda Dashboard
- Community Health Indicator Reports (CHIRs)
- NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators
- Division of Criminal Justice Services Index, Property, and Firearm Rates
- NYS Traffic Safety Statistical Repository
- Student Weight Status Category Reporting System (SWSCRS) Data
- USDA Economic Research Service Fitness Facilities Data

- NYS Department of Health Tobacco Enforcement Compliance Results
- State and County Indicators for Tracking Public Health Priority Areas
- NYS Department of Health, Asthma Dashboard – County Level
- NYS Department of Health Hospital Report on Hospital Acquired Infections
- NYS Office of Mental Health, PCS

2019 Stakeholder Survey Methodology

Background:

Adirondack Rural Health Network: The Adirondack Rural Health Network (ARHN) is a program of AHI - Adirondack Health Institute, Inc. Established in 1992 through a New York State Department of Health Rural Health Development Grant, ARHN is a multi-stakeholder, regional coalition that informs planning, assessment, provides education and training to further the implementation of the New York State Department of Health Prevention Agenda, and offers other resources that support the development of the regional health care system. Since its inception, ARHN has provided a forum to assess regional population health needs and develop collaborative responses to priorities. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Description of the Community Health Assessment Committee: Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments that have developed and implemented a sophisticated process for community health

assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from Adirondack Health, Clinton County Health Department, University of Vermont Health Network - Alice Hyde Medical Center, University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital, University of Vermont Health Network – Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health.

Purpose of the CHA Committee: The CHA Committee, made up of the CHA service contract holders with AHI, is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment by working collaboratively on interventions and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda.

CHA Committee, Ad Hoc Data Sub-Committee: At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey. The data

subcommittee met seven times from mid-July through the end of October 2018. Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 subcommittee members per meeting. Meetings were also attended by AHI staff from ARHN, Population Health Improvement Program (PHIP) and Data teams.

Survey Methodology:

Survey Creation: The 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data
Sub-Committee, with the final version approved by the full CHA Committee at December 7, 2018 meeting.

Survey Facilitation: ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental institutions as well as community members. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington Counties.

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

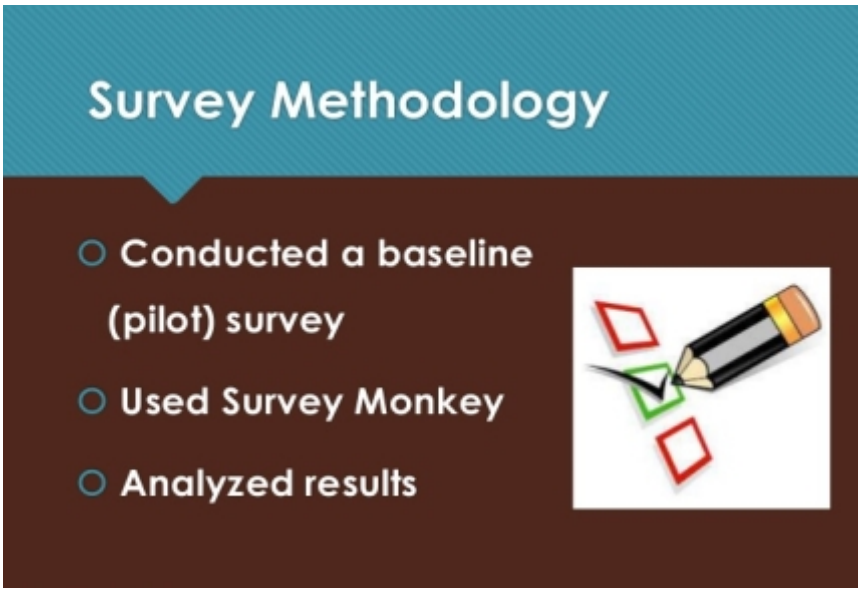
The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns. A full list of survey questions can be found at the end of this document.

Survey Responses and Analysis: A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

Analysis is sorted alphabetically and in order of how the questions were listed in the survey to make the analysis easier to comprehend. Each table is labeled to identify whether the

information is by response count or percentage. For tables containing counties, the table below indicates table is color coded to identify counties. All written analysis for each section is provided, with table below, and all written results are done in percentages.

This report provides a regional look at the results thru a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties. This stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The results enable us to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties



Addressing Social Determinants of Health and Health Disparities in the Adirondack Region Social Determinants of Health

Social determinants of health are the social and environmental factors that influence individual and population health outcomes. Shaped by policy and the resulting distribution of resources, the circumstances in which people are born, grow, live, work and age account for most factors impacting a person's health and wellness. Some of the more frequently cited unmet social needs in the Adirondack region include reduced access to health care, food insecurity, lack of reliable transportation, lack of safe and affordable housing, low income, and limited employment opportunities.

A 2017 survey conducted by the American Academy of Family Physicians found that 83% of family physicians agree they should help with identifying and addressing social factors that influence patients' health outcomes, but 56% felt unable to provide solutions to patients to resolve unmet social needs. This study indicates an ongoing need for greater education and guidance to support health care providers' efforts in this arena.

Our region is in the initial phases of implementing and standardizing processes to screen for social determinants of health and develop referral pathways between clinical providers

and community-based organizations to address identified needs. This will enable health care providers to incorporate this information and resulting processes into clinical practice, outcomes measurement, and payment models. Below are recommended steps, informed by lessons learned through our regional initiatives along with recognized best practices, to guide providers in taking steps to address the role social needs play in their patients' and clients' health and wellness:

- Identify unmet social needs through screening. Select a screening tool that's most appropriate for your patient population and that will collect information meaningful to the individual and the practice.
- Leverage patient-centered, culturally-competent patient engagement strategies, such as motivational interviewing, to understand the root cause of the identified need and build rapport with the patient.
- Manage expectations around the ability to address needs. Have a plan in place for responding to urgent needs and those that present an imminent safety risk to the patient or others.
- Refer patients to community-based service providers with the capacity to address identified needs.
- Whenever possible, have standardized care pathways in place for addressing commonly- identified needs, such as through an established partnership with a community service provider. For example, if access to healthy foods impacts many patients in your practice, consider opportunities for collaboration with food providers to create food prescription programs.

- Have a standardized referral and linkage process that includes monitoring and tracking referral outcomes (closed-loop referrals).
- Collect and analyze data from screening and referral processes to better understand needs specific to your patient population, as well as to contribute to a larger picture of population health in your region. Data can be used at the practice level to inform development of CBO partnerships and selection of interventions to implement. At the regional level, data collected can be used to advocate for policy change or support requests for funding.

Health Disparities

Inequities in external conditions referred to as social determinants of health lead to health disparities. Health disparities are measurable differences in health outcomes linked to populations living with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who've encountered systemic barriers to health due to characteristics historically linked to discrimination or exclusion. These can include race, ethnicity, religion, socioeconomic status, gender, age, disability, sexual orientation or gender identity, and geographic location among others.

While health disparities in the Adirondack region reflect some similarity to those experienced by groups across New York State,

demographic differences must be considered to sufficiently address regional issues. Relative to Upstate New York and New York State as a whole, the Adirondack region is characterized by lower educational attainment, higher unemployment rates, an aging population, higher disability rates, lower household incomes, higher poverty rates, and a vastly rural composition.

Each of these attributes can increase the incidence of significant health disparities. Mental health and substance abuse are significant issues, affecting at least one-third of the Medicaid population, and driving significant emergency department utilization across the region. Poverty in the Adirondacks is exceptionally severe. Of those in poverty, there are greater proportions at or below 138% of the Federal Poverty Line (FPL) and 200% FPL compared to Upstate New York.

Data, such as that collected through Community Health Assessments, can help identify health disparities and inform targeted interventions to address them. General guidelines for decreasing regional health disparities include:

- Increasing capacity and reach of primary care and preventative services.
- Strengthening integration and information-sharing infrastructure across the continuum of care.
- Leveraging community-based interventions and resources to address patients' unmet social needs.
- Gathering stakeholder input to inform quality improvement initiatives.
- Implementing culturally competent and health literate health care practices.

Appendix D - ALICE Profile

Adirondack Rural Health Network	County											
Summary of ALICE Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
ALICE Household Information												
[redacted]												
ALICE Households by Race/Ethnicity												
[redacted]												

*Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond).
*Data in all categories except *Two or More Races* is for one race alone. Because race and ethnicity are overlapping categories, the totals for each income category do not add to 100 percent exactly.
(n/a) Data Not Available
Sources:
(1) American Community Survey, 2016.
ALICE Demographics:
(2) American Community Survey and the ALICE Threshold, 2016.
Wages:
(3) Bureau of Labor Statistics, 2016
Budget:
(4) Bureau of Labor Statistics, 2016a; Consumer Reports, 2017; Internal Revenue Service, 2016
(5) New York State Office of Children & Family Services, 2016; Tax Foundation, 2016, 2017; U.S. Department of Agriculture; U.S. Department of Housing and Urban Development

Sources for Evidence Based Interventions

The Prevention Agenda
https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm

The Community Guide (Community Preventive Services Task Force)
https://www.thecommunityguide.org/task-force-findings

County Health Rankings – What Works for Health
http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health

CDC 6/18 Initiative https://www.cdc.gov/sixeighteen/

CDC Health Impact in Five Years
https://www.cdc.gov/policy/hst/hi5/index.html

CDC Community Health Improvement Navigator
https://wwwn.cdc.gov/chidatabase

Substance Abuse and Mental Health Services Administration
National Registry of Evidence-based Programs and Practices
https://www.samhsa.gov/nrepp?_sm_au_=iHVVZpZ0Q8L1rspF

Successful Interventions to Reduce Health Disparities
https://www.cdc.gov/mmwr/ind2016_su.html

The Cochrane Database http://www.cochranelibrary.com/

The Health Across All Policies/Age-Friendly NY (AAAP/AFNY/Roadmaps)

Examples of Assessments and Plans:

Albany County 2016-2018 Community Health Improvement Plan: http://www.albanycounty.com/Libraries/Department_of_Health/Albany_County_CHIP_123020162_0.sflb. ashx

Albany Medical Center Community Service Plan: http://www.amc.edu/aboutus/documents/Albany_Medical_Center_Community_Service_Plan_2014- 2017.pdf

Chautauqua County Community Health Improvement Plan, 2014-2017, a collaborative LHD-Hospital Plan including Chautauqua County Health Network, TLC Health Network, and Brooks Memorial, Women's Christian Association and Westfield Memorial Hospitals http://www.co.chautauqua.ny.us/DocumentCenter/View/938

2016-2018 Delaware County: Community Health Assessment and Improvement Plan and Community Service Plans, a collaborative LHD-hospital plan including UHS Delaware Valley, Margaretville, O'Connor and Tri Town Regional Hospitals http://delawarecountypublichealth.com/wp-content/uploads/2014/12/Delaware-County-Community-Health-Assessment-Update-FINAL.pdf

Orange County Department of Health: https://www.orangecountygov.com/DocumentCenter/View/162

NYU Langone Medical Center: https://nyulangone.org/our-story/community-health-needs-assessment- service-plan

Data resources:

New York State Prevention Agenda Tracking Indicator Dashboard
The New York State Prevention Agenda Dashboard is an interactive visual presentation of the most current Prevention Agenda tracking indicator data at state and county levels. It can be used to monitor progress toward meeting the Prevention Agenda 2018 objectives.

Sub-County Health Data Reports for County Health Rankings-Related Measures (2016)
These reports provide data for 11 health measures at sub-county levels, including sub-county populations (such as race/ethnicity, age group, Medicaid status, education level) and sub-county geographies (ZIP codes and minor civil divisions where data are available). These reports can be used to assess community health needs, to plan health interventions, and specifically to identify health disparities within counties.

Community Health Indicator Reports
This site links the previous Community Health Data Set (CHDS) and Community Health Assessment Indicators (CHAI), with nearly 300 health-related indicators available. State and county trend data are available for most indicators. The top part of this site allows the user to access indicator data for all counties in the state by health topic areas. The bottom part of this site provides access to individual county profiles of these health topic areas with direct links to county historical (trend) data.

County Health Indicators by Race/Ethnicity (CHIRE)
CHIRE provides selected public health indicators by race/ethnicity for New York State and counties. Data related to births, deaths, and hospitalizations are presented.

New York State 2017 Health Equity Reports

The New York State 2017 Health Equity Reports present data on health outcomes, demographics, and other community characteristics for select cities and towns with a 40% or greater non-White population throughout New York State. Each town or city specific report contains data associated with the priority areas of the Prevention Agenda, as well as social determinant indicators such as housing, educational attainment and insurance coverage.

U.S. Census Bureau

The U.S. Census Bureau webpage provides links by topic, geography or data system or survey to a vast array of information available from the U.S. Census.

US Census Bureau - American Fact Finder

The Census Bureau, through American Fact Finder, provides access to data from the Decennial Census, American Community Survey, Annual Population Estimates Program and other economic and business-related surveys. The Fact Finder data system allows a user to search for data by topic, geography (state, county, town, and city), race/ethnic groups and industrial codes.

Additional resources can be found at:
https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/sources.htm

https://www.Healthyadk.org

Essex County, NY
Community Health Assessment (CHA) 2019 and
Community Health Improvement/Service Plan 2019-2021

PART II: Community Health Assessment 2019

Essex County Health Partners
Report Date: 12/31/2019

Table of Contents

Purpose

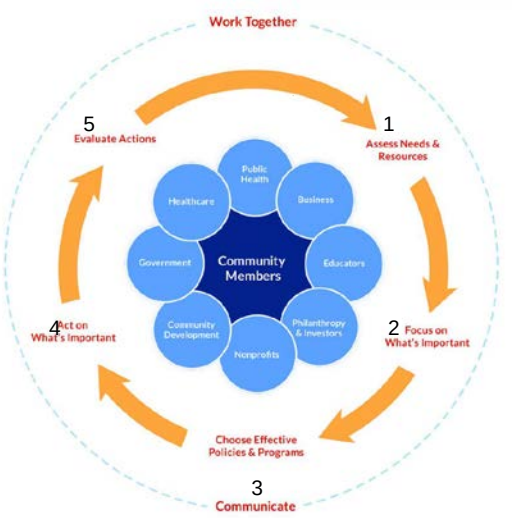
The purpose of the Essex County, NY Health Community Health Assessment (CHA) 2019 is to demonstrate an ongoing understanding of the significant health needs of Essex County residents.

Needs were identified through a comprehensive analysis of multiple-source data, community perceptions, and a solid historical knowledge of the region, cultivated after years of service to individuals and families in the county by the service agencies referenced in this report.

Collaborative Process Model

The collaborative process used to develop the Community Health Assessment (CHA) and Community Health Improvement/Service Plan (CHISP) is the **Take Action Cycle**, a model developed by **County Health Rankings and Roadmaps**[1], a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Take Action Cycle



The **Take Action Cycle** emphasizes how to create a healthier community (see diagram at left), wrapped with necessary elements of working together and communication.

Each **Take Action Cycle** step includes key steps to undertake in an intentional process of community engagement in examining health issues, analyzing social determinants of health contributing to health issues and identifying community assets that can be mobilized to address health needs.

Take Action Cycle Steps 1-2 are included in this Part II: Community Health Assessment 2019 of the full report.

[1] https://www.countyhealthrankings.org/

Step 1: Assess Needs and Resources

The Framework for conducting the assessment follows the **NYSDOH Prevention Agenda**[2] and the following two models it references:

- **County Health Rankings and Roadmaps Model** and the
- **Healthy People Social Determinants of Health**.

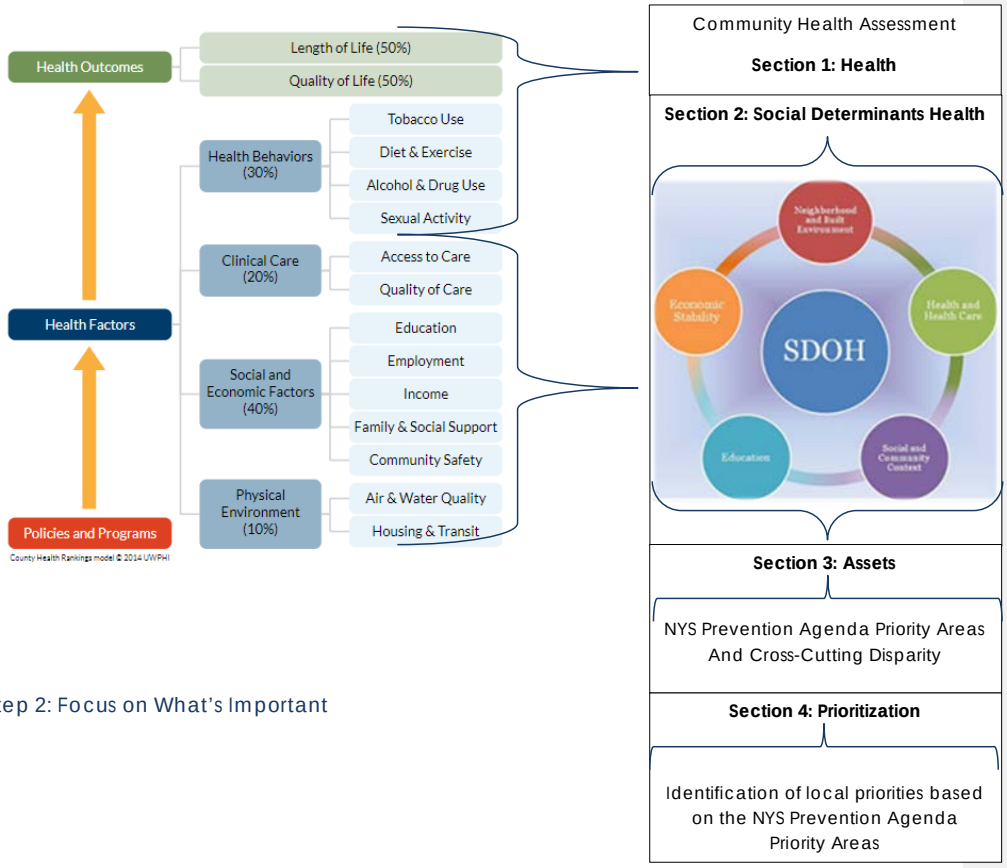
The County Health Rankings and Roadmaps Model[3] emphasizes the many factors that influence health outcomes. Healthy People Social Determinants of Health Domains[4] reveal how factors of economic stability, education, health care access, neighborhood and the environment and social and community context impact health behaviors and outcomes. Exploration of these domains make evident the need to engage the broader (beyond health partners) community in working collaboratively across domains to address the unique needs of our communities and residents.

As depicted in the diagram below, in this CHA, Health Outcomes and Behaviors are included in Section 1: Health; Health Factors/Social Determinants are included in Section 2: Social Determinants of Health; and Assets, the link between identified priority needs and improvement plans, are included in Section 3: Assets.

[2] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/overview.pdf
[3] https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model
[4] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources

Framework for Conducting the CHA

Step 1: Assess Needs and Resources



Step 2: Focus on What's Important

Reading This Report

Moving through this report readers will find data expressed as percent, rate or ratio and analysis in the form of text, tables, charts and visualizations. Following are explanations of how data is expressed and how to interpret elements of data analysis that appear in the report.

Understanding Rate Expressions
Percent are expressed as a portion of 100%.
For example, if 500 people were surveyed and 125 answered a certain way (yes), than 25% of the people said yes to this question.

Understanding Rate Expressions
Rates are expressed as per(/) 1,000 (1K); 10,0000 (10K); or 100,000 (100K).
For example, if there are 25 lung cancer deaths in one year in a population of 30,000, then the mortality rate for that population is 83 per 100,000 (83/100K).

Understanding Ratio Expressions
Ratios are expressed as a discrepancy from 1:1.
For example, a premature death ratio of Blacks to White non-Hispanics of 1:1 would mean there is no difference/discrepancy in premature deaths for these sub-populations of people.

Continuing the example, if pre-mature deaths of Blacks is 28% and that of White non-Hispanics is 15%, then the ratio is calculated as Blacks (28%) divided by White non-Hispanics (15%) resulting in a ratio expressed as 1.87. This means there is a discrepancy in premature deaths for Blacks as compared to White non-Hispanics.

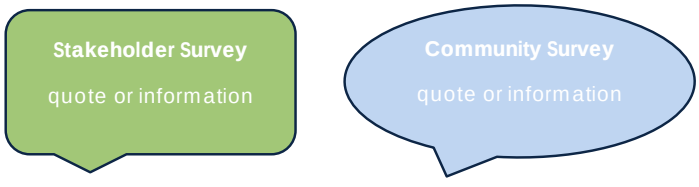
Ratios are also expressed for patients to providers.
For example, there are 1,234 patients for every 1 provider which appears as 1,234:1.

Other Notations and Symbols

NA means the data was not available or like data was not available for inclusion.

***** means the percent, rate or ratio is unreliable due to small incidence or number of occurrences. The number of occurrences may be under 10, 20 or 30 and is specific to the indicator.

N= means the number of people who answered a question in the survey
For example N=345 means 345 people answered the question in the survey.



Essex County Trend

Percent, rate or ratio of current Essex County data compared to previous Essex County data.
Previous = indicator data as available upon 2016 assessment
Current = indicator data as available upon 2019 assessment
The year or year range varies for each indicator. Specifics are available by going to the data source or upon request. This display simplifies the data view in this report.

Trends are identified as:

▲▼	On Track/Improving	EXAMPLES: % Screening increased & this is good Cancer case rate decreased & this is good
■	Stable/No Significant Change	EXAMPLE: Early prenatal enrollment was 51.2; now 51.1; stable
▲▼	Off Track/Worsening	EXAMPLES: Cancer case rate increased & this is not good % Screening decreased & this is not good

Essex County Compared to

Whenever available, the New York State Department of Health Prevention Agenda benchmark (NYS Benchmark) was used as a comparison point. If not available for the indicator, than a comparison of Upstate New York (NYS except NYC), NYS or other comparison data set is used.

Comparisons are identified as:

- ● Meets/performs better than the comparison
  EXAMPLE: 80% screening in Essex County is better than the NYS Benchmark of 70%
- ● Performing at the comparison
  EXAMPLE: % screening in Essex is 79.8 which is very close to the NYS Benchmark of 80.0
- ● Doesn't meet the comparison
  EXAMPLE: 70% screening in Essex County does not reach the NYS Benchmark of 80%

Quartile Explanation

To provide context for the distance of the given indicator data from the comparison data, a quartile ranking was used as follows:

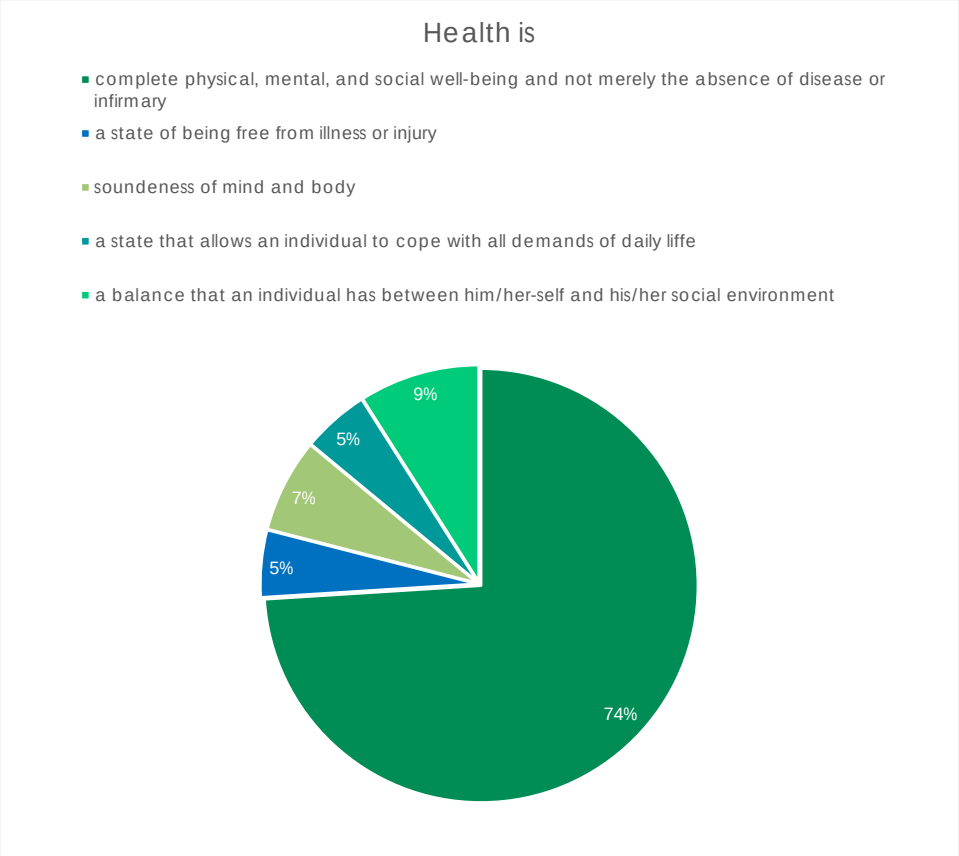
- Quartile 1: with 24.9% of comparison
- Quartile 2: between 25% and 49.9% of the comparison
- Quartile 3: between 50% and 74.9% of the comparison
- Quartile 4: 75% to 100% from the comparison

In other words, data indicators closest to the comparison are within Quartile 1; farthest in Quartile 4. For example, an indicator that is in the 4th quartile from the NYS Benchmark means it is significantly away from the benchmark.

SECTION 1: HEATH

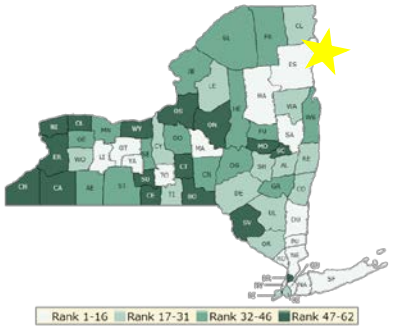
Community Definition of Health

The Community Survey asked residents to select one definition, of 5 offered, that best describes "health". Health was largely agreed upon as a state of complete well-being and not merely the absence of disease. Results of responses to this question are displayed in the chart below. This definition was important to understanding community perspective and helped inform the scope of this CHA.



Population Health Status Overview

Commented [JDB1]: Add community definition of health somewhere here



County Health Rankings[1]

Essex County ranks:

10th in Health Outcomes

13th in Contributing Factors

Standardized measures based on numerous factors show Essex County residents enjoy better health outcomes than peer residents across NY.

Health Outcomes

Commented [JDB2]: ARHN

INDICATOR	Essex County Trend	Essex County Previous	Essex County Current	North County Current	Essex County compared to NYS Benchmark	NYS Benchmark
Premature deaths (before 65 years)% [2]	▼	23.7	19.1	22.8	●	21.8
Preventable hospitalizations/10K[3]	▼	88.9	109	N/A	●	122
Adults reporting poor physical health % [4]	▲	12.0	15.4	14.3		N/A
Adults reporting poor mental health %[5]	▲	11.3	14.4	13.8	●	10.1
Babies with low birth weight %[6]	▼	7.3%	5.7%	6.5%	●	7.9%

Contributing Factors

Commented [JDB3]: County Health rankings

INDICATOR	Essex County Trend	Essex County Previous	Essex County Current	North County Current	Essex County compared to NYS Benchmark	NYS Benchmark
BEHAVIORS						
Obesity % [7]	■	32.2	32.2	25.5	●	23.2
Smokers % [8]	■	16.6	16.8	14.2	●	12.3
Binge drinking in the last month %	▲	21.9	24.7	18.3	●	18.4
Births (ages 15-19) rate /1K females	▼	19.4	20.5	14.6		N/A
CLINICAL CARE						
Uninsured %	▼	10.2	6	N/A	●	7
Primary Care Providers	▲	N/A	2,540:1	N/A	●	1,200:1
Dentist Rate	▲	N/A	3,160:1	N/A	●	1,230:1
Mental Health Providers	N/A	N/A	720:1	N/A	●	370:1
SOCIO-ECONOMIC FACTORS						
Unemployment %	▼	6.9	3.2	3.7	●	4.3
People in Poverty %	▼	11.4	8.9	13.9	●	15.1
Less than High School Education %	▼	12.0	9.1	11.6	●	13.9
Some College %	■	20.7	20.2	18.9	●	15.9

Priority Health Issue: Chronic Disease

Obesity

WHY IT MATTERS[5]

Obesity increases risk of many other physical & mental health conditions & death:

- Diabetes
- High blood pressure, cholesterol & triglycerides
- Heart disease
- Stroke
- Gall Bladder disease
- Sleep Apnea & sleeping problems
- Pain & Osteoarthritis
- Some cancers
- Depression, anxiety & other mental health disorders

Obesity itself can lead to premature death.

For children there are similar consequences[6]:

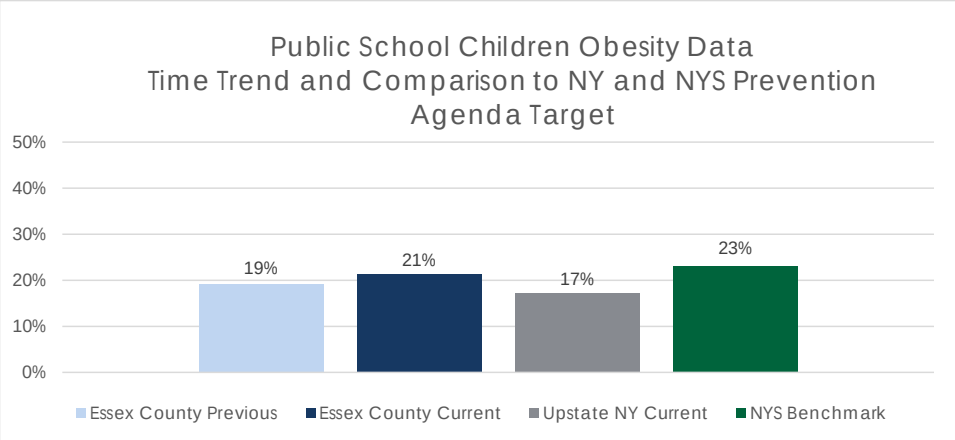
- Risk of type II Diabetes, high blood pressure, high cholesterol & heart disease
- Risk of fatty liver disease, joint pain, asthma & breathing problems
- Social problems including low self-esteem, anxiety & depression
- More likely to become obese adults & suffer more severe health outcomes

WHY IT'S A PRIORITY

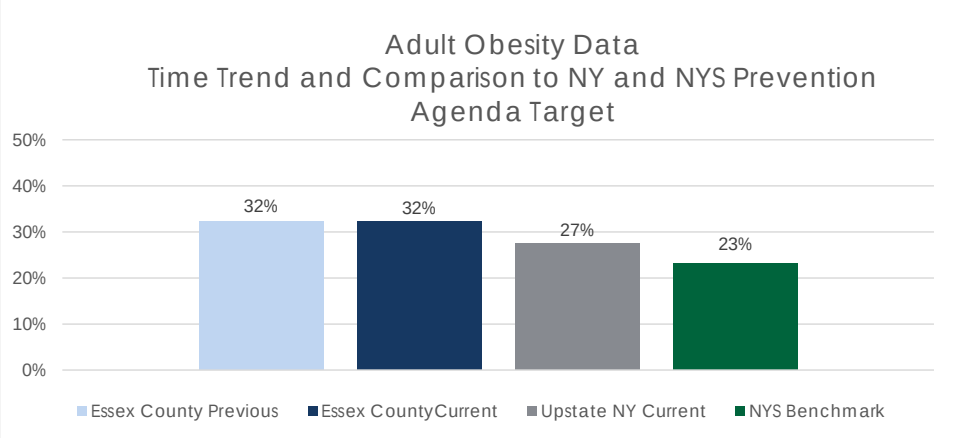
Adult obesity remains stable from the previous assessment to this current assessment; 32%. The current percent of adults with obesity is 5% higher than Upstate NY; 27%) and 9% away from the NYS Benchmark; 23%. See Figure X below.

[5] https://www.cdc.gov/obesity/adult/causes.html
[6] https://www.cdc.gov/obesity/childhood/index.html

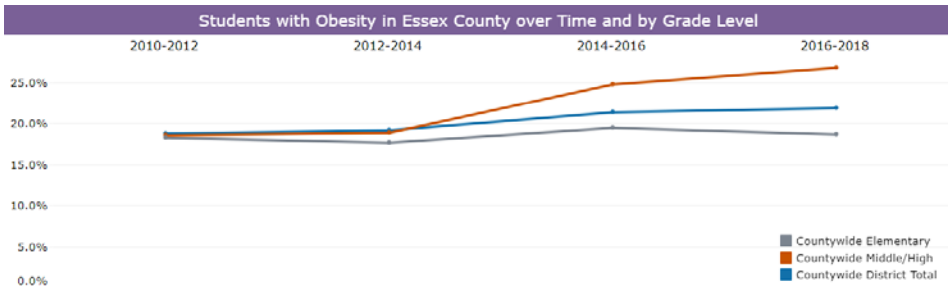
Analysis of available data for students in Elementary and Middle/High levels in Essex County demonstrates a trend of increase from the previous to current assessments as seen below.



As displayed below in Figure X[7], there are consistently more students with obesity in the Middle/High age group than the Elementary. High needs districts, as identified by NYSDOH applying five (5) elements of risk indicators included Elizabethtown-Lewis Central School District (CSD); Moriah CSD and Ticonderoga CSD.[9]



[7] https://nyshc.health.ny.gov/web/nyapd/student-weight-data-explorer


Students with Obesity in Essex County over Time and by Grade Level
2010-2012
2012-2014
2014-2016
2016-2018
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Countywide Elementary
Countywide Middle/High
Countywide District Total

Diabetes

WHY IT MATTERS[8]

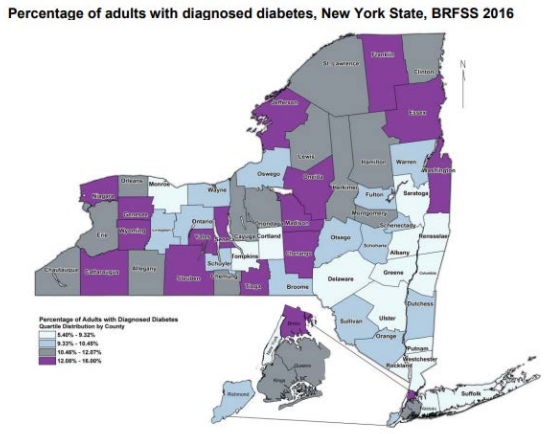
Diabetes is a leading cause of disability & death.
It causes other health conditions including

- Heart disease
- Stroke
- Kidney disease
- Vision problems
- Amputations due to circulatory problems

People with Diabetes use more healthcare & miss more work.
Diabetes is largely preventable.

WHY IT'S A PRIORITY

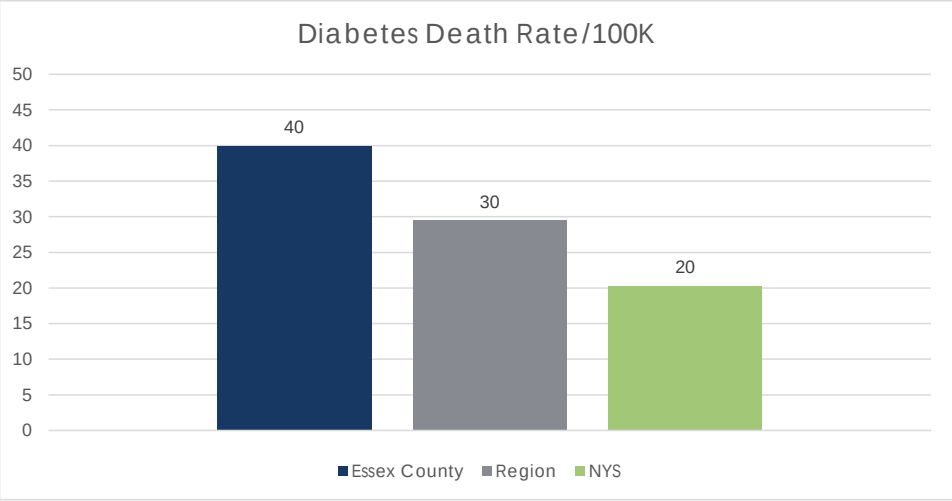
Fourteen percent (14.2%) of the adult population has Diabetes. This is higher than NYS (10.5%) and the 4th highest percent in NYS.[9]



[8] https://www.cdc.gov/diabetes/basics/index.html

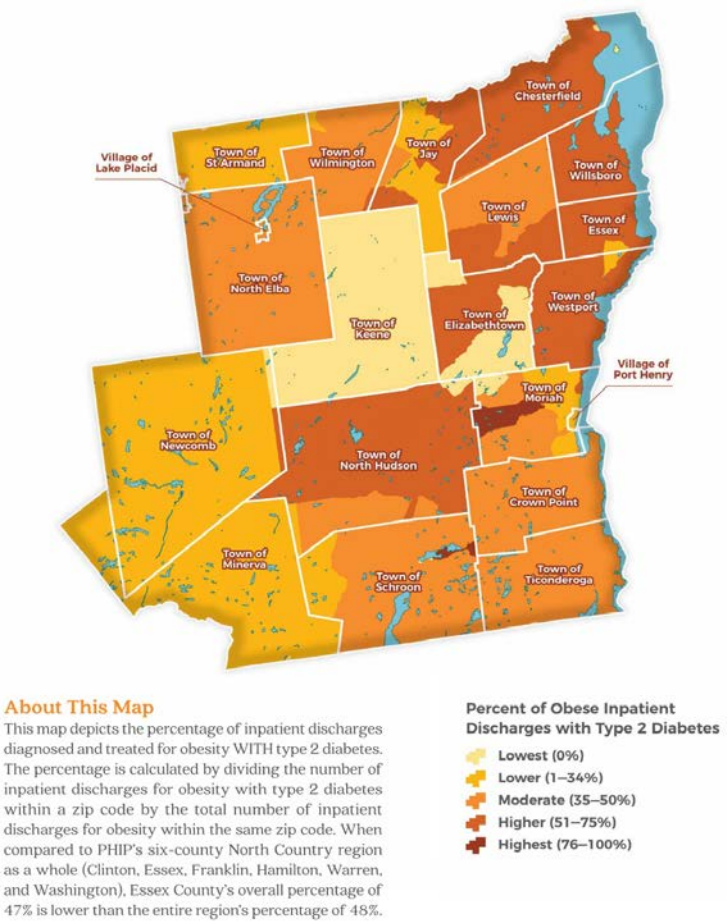
[9] NYSDOH. Information for Action Report 2018-09.
https://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2018-09_ifa_report.pdf

The death rate due to Diabetes in Essex County (40/100K) is higher than the Region (30/100K) and double that of NYS (20/100K) – see the visual aid below (Figure X). (Source: ARHN)



The Figure below, X[10], depicts hospital discharges for patients diagnosed and treated for Obesity with Diabetes by location. This visual aid demonstrates communities at greatest need.

Pockets within the Towns of Moriah and Schroon are shown below to have residents experiencing the highest percentages of these discharge totals; 76-100%. The northeastern portion of the county including the Towns of Jay, Chesterfield, Willsboro and Elizabethtown along with the central Town of North Hudson follow comprising 51-75% of these discharges.



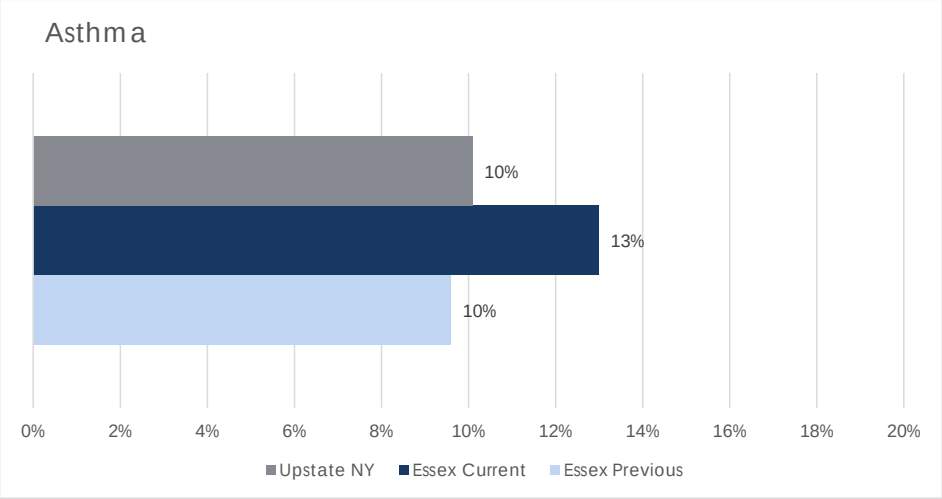
[10] Adirondack Health Institute. Obesity in the North Country Report. http://anyflip.com/biiz/sewj/

Lung Disease, Tobacco and Nicotine

WHY IT MATTERS[11]

- **Asthma** is a serious disease causing wheezing, trouble breathing & coughing
- It is a leading cause of hospitalizations for children[12]
- Over a lifetime it can cause permanent lung damage

WHY IT'S A PRIORITY



Latest available data demonstrates 13% of Essex County residents have Asthma; an increase from the previous assessment and higher than NYS (9.6%). Analysis of age groups for people with Asthma reveals that children ages 0-17 have the highest rate of Asthma in Essex County[13].

WHY IT MATTERS

- **Respiratory Disease** is a leading cause of death in Essex County
- Smoking is **the** leading cause of disease including lung disease, heart disease & stroke.

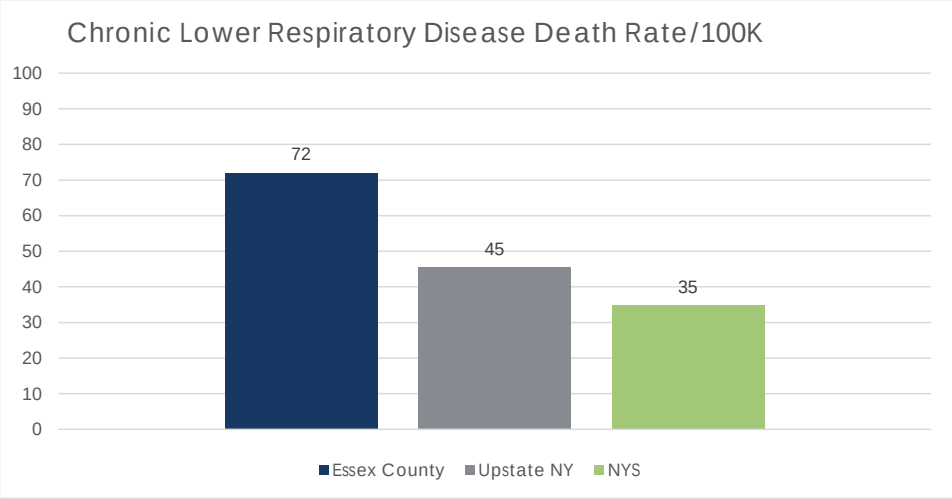
Chronic Lower Respiratory Disease (CLRD) is one of the leading causes of death in Essex County.

[11] https://www.cdc.gov/mmwr/volumes/66/ss/ss6602a1.htm
[12] https://www.cdc.gov/vitalsigns/childhood-asthma/
[13] https://www.health.ny.gov/statistics/ny_asthma/

CLRD is a group of conditions that affect the lungs: chronic obstructive pulmonary disease (COPD), includes emphysema and chronic bronchitis; asthma; pulmonary hypertension; and occupational lung diseases. These conditions are most common among smokers.[14]

WHY IT'S A PRIORITY

Figure X below demonstrates the rate of 72/100K in Essex County is higher than the Upstate rate of 45/100K and double the NY rate of 35/100K.[15]

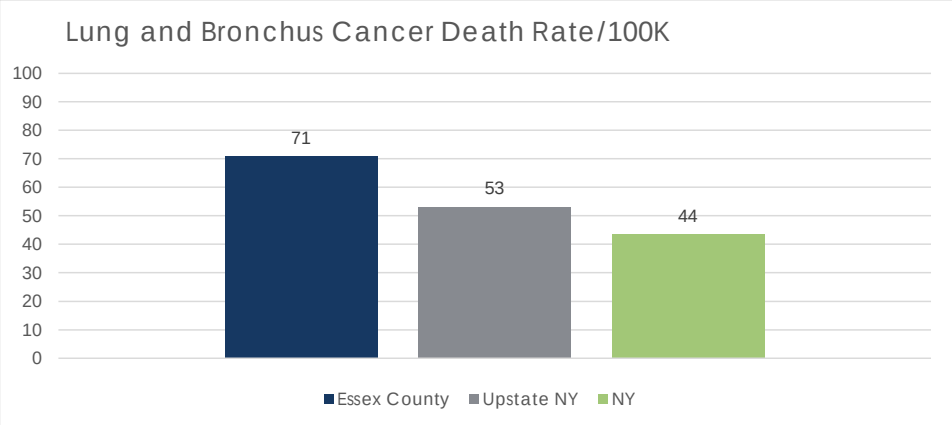


Lung and Bronchus Cancers remain the leading type of cancer causing death in the US.[16] In Essex County, the rate of this type of cancer deaths (71/100K) exceeds the Upstate NY rate (53/100K) and NYS rate (44/100K) as visualized in Figure X below. Smoking is also the greatest risk factor for these types of cancers.

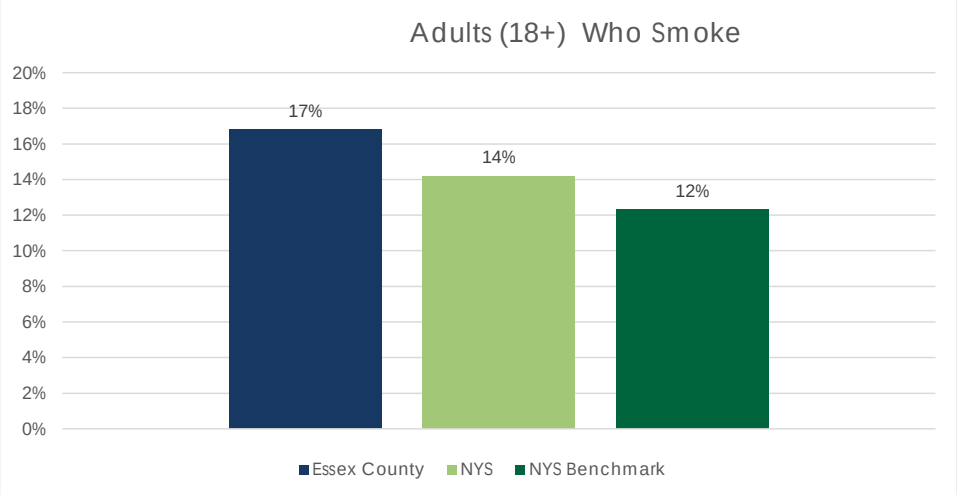
[14] https://www.cdc.gov/ruralhealth/COPD/

[15] ARHN Data Sheets

[16] https://gis.cdc.gov/Cancer/USCS/DataViz.html



These disease rates correlate with Adults Who Smoke as demonstrated in Figure X below. The percent of Smokers in Essex County, 17%, is on the decline. Yet is remains higher than NYS (14%) and the NYS benchmark (12%).[17]



[17] ARHN Data Sheets

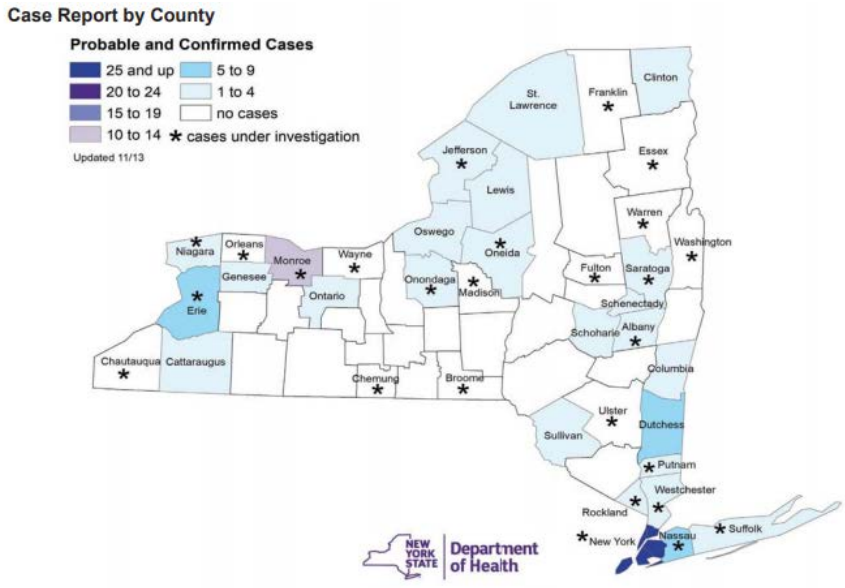
E-cigarettes/Vaping Associated Lung Injury (EVALI)

WHY IT MATTERS[18], [19]

Since 2014 e-cigarettes have become the most commonly used tobacco product among youth

- outbreak of vaping-associated pulmonary illnesses and deaths occurs in NYS & the US, 2019
- current outbreak investigation reveals 62% of patients are under the age of 25

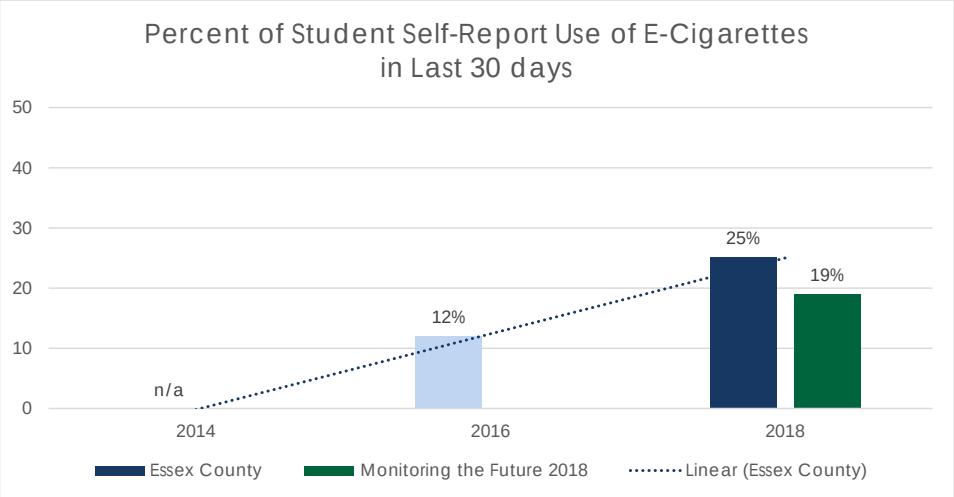
Case reports from across NYS reveal residents of Essex County are included as part of the on-going investigation of EVALI (Figure X).[20]



[18] https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html
[19] https://www.health.ny.gov/prevention/tobacco_control/campaign/e-cigarettes/
[20] https://www.health.ny.gov/prevention/tobacco_control/docs/vapireport.pdf

WHY IT'S A PRIORITY

Analysis of the local 2018 New York Prevention Needs Assessment Survey sponsored by the Essex County Youth Bureau demonstrates self-reports of use (students in grades 7-12) increased from 12% in 2016 to 25% in 2018 (Figure X). Data in this report generally demonstrates an increase in the percent of youth using these products as they age from 7th to 12 grades; 10% in 7th grade to 37.7% in 12th grade.[21]



[21] Essex County Youth Bureau. Needs Assessment Report.

Priority Health Issue: Well-Being & Substance Use Prevention

Alcohol

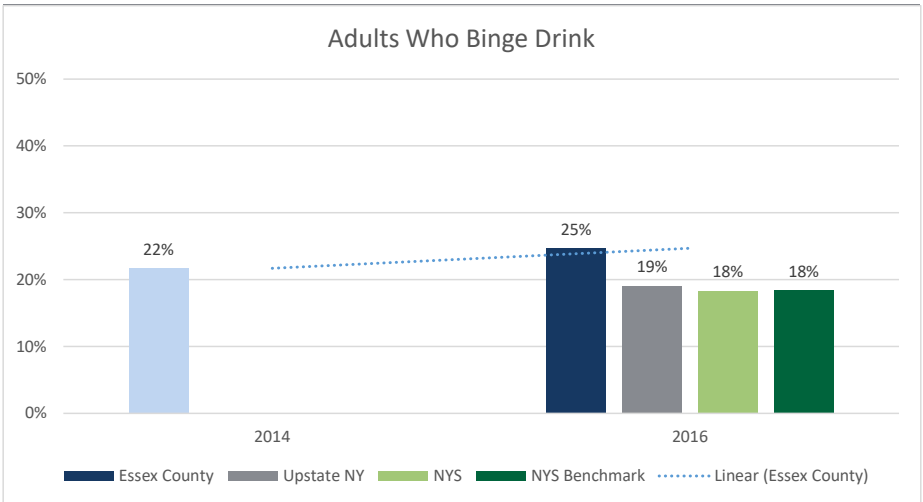
WHY IT MATTERS[22]

- Excessive alcohol use results in short & long term health effects
- Motor vehicle accidents, drownings, violence
- Risky sexual behaviors-assault & unintended pregnancy, STIs
- Chronic conditions:
  - High BP, Stroke, Liver Disease, Digestive problems & some Cancers
- Mental health problems:
  - Depression, Anxiety
- Social problems:
  - Family disputes, financial loss, legal & employment problems

WHY IT'S A PRIORITY

The most recent data available shows 25% of adults in Essex County report binge drinking. [23]

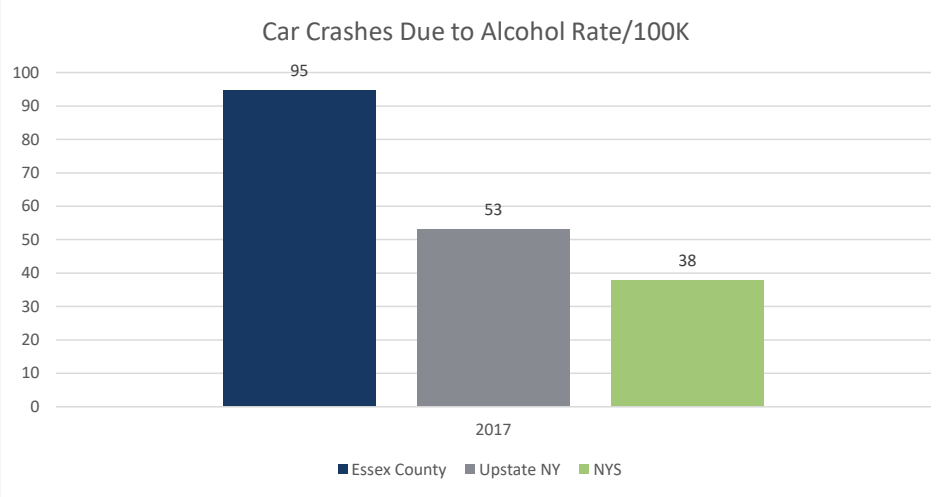
This is a slight increase from previous assessments showing 22% in 2014. As demonstrated in Figure X, when compared to Upstate NYS, NYS and the NYS Benchmark, the percent of binge drinking adults in Essex County is higher.



[22] Why It Matters Section: https://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm
[23] ARHN Data Sheets

We also know we have the highest density of liquor stores here in Essex County than anywhere else in our North Country region.

Short term negative impacts of excessive alcohol use are evident in the rate of car crashes due to alcohol in Essex County. At a rate of 95/100K; 2 ½ times the NYS rate of 38/100K.[24]



[24] ARHN Data Sheets

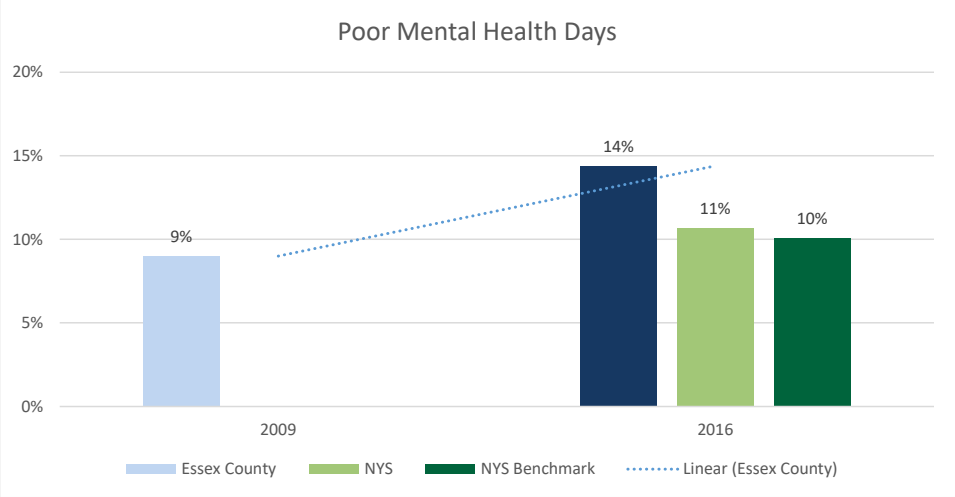
Mental Health

WHY IT Matters[25]

- Mental health impacts includes emotional, psychological & social well-being
- It affects how to think, feel and act
- It affects how we handle stress, relate to others & make choices that impact our physical health & other aspects of our lives
- It includes a range of periodic poor mental health to mental illness
- Ongoing poor mental health or poorly managed illness can lead to death by suicide

WHY IT'S A PRIORITY

Adults reporting poor mental health days is 14%. This exceeds NYS (11%) and the NYS Benchmark (10%) (See Figure X below). Trend analysis of this data demonstrate an increase of 5% over 7 years: 9% in 2009 to 14% in 2016 (See Figure X below).[26]



[25] https://www.cdc.gov/mentalhealth/learn/index.htm

[26] ARHN Data Sheets

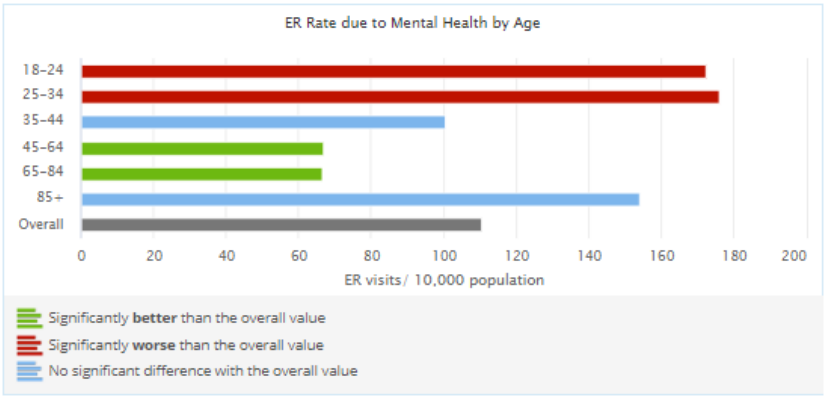
The use of Emergency Rooms for mental health visits was one indicator for which more granular data for Essex County was available.[27]

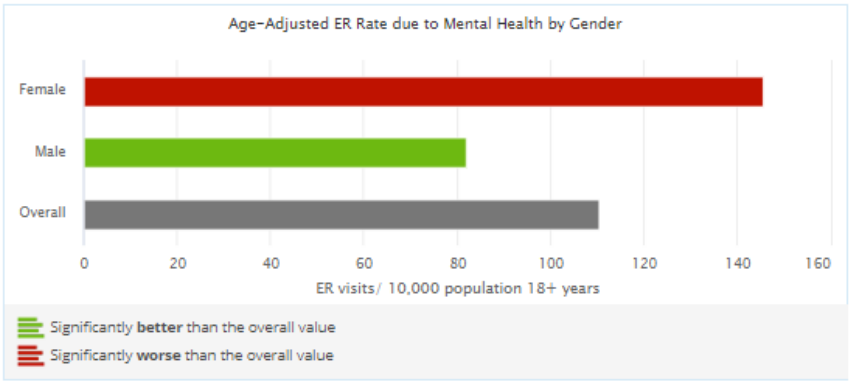
When considering age, the greatest discrepancy from the overall value is found to be in younger adults; that is, people ages 25-34 followed by people 18-24 as depicted below in Figure X.

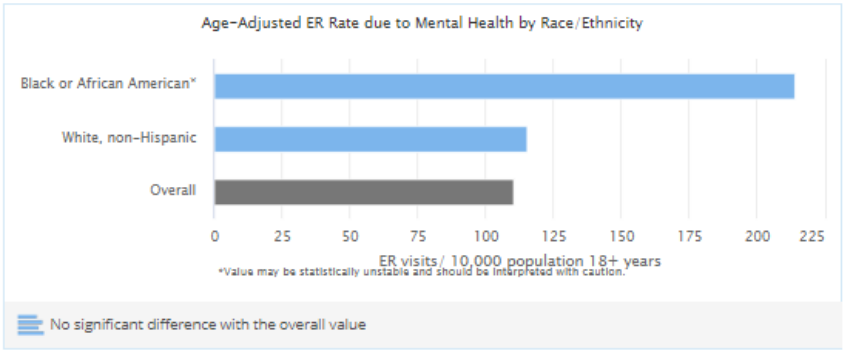
Gender analysis also reveal a statistically significant difference from the overall for females as demonstrated in Figure X.

Race/Ethnicity analysis suggests a higher rate for people that are Black/African American (see Figure X). However, it is notable that this value is statistically unstable. That is because the sub-population of Black/African Americans residents is low, a small incidence (input) within this sub-population yields an unreliable projection of race specific total (output). (help – wordsmithing needed) (Healthy ADK)

[27] Healthy Adk

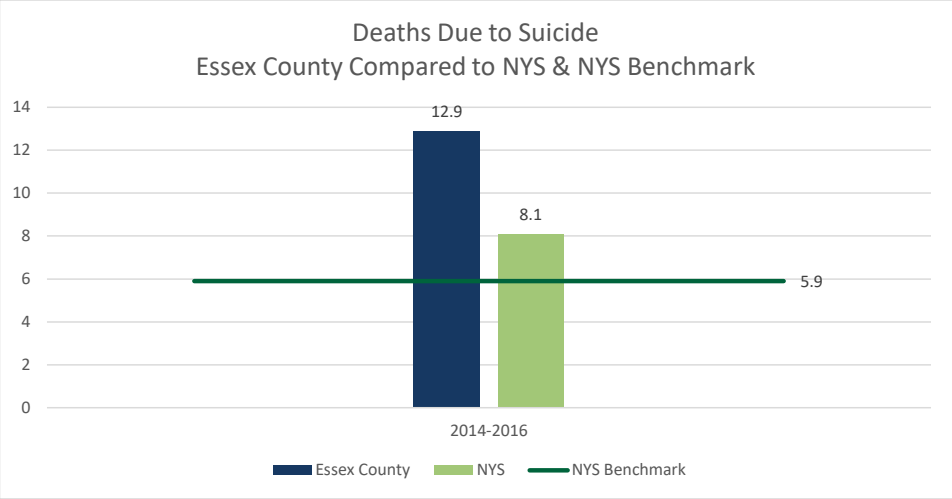

ER Rate due to Mental Health by Age
18–24
25–34
35–44
45–64
65–84
85+
Overall
0
20
40
60
80
100
120
140
160
180
200
ER visits/ 10,000 population
Significantly better than the overall value
Significantly worse than the overall value
No significant difference with the overall value


Age-Adjusted ER Rate due to Mental Health by Gender
Female
Male
Overall
0
20
40
60
80
100
120
140
160
ER visits/ 10,000 population 18+ years
Significantly better than the overall value
Significantly worse than the overall value


Age-Adjusted ER Rate due to Mental Health by Race/Ethnicity
Black or African American*
White, non-Hispanic
Overall
0
25
50
75
100
125
150
175
200
225
ER visits/ 10,000 population 18+ years
*Value may be statistically unstable and should be interpreted with caution.
No significant difference with the overall value

The most recent Vital Statistics data published (May 2018) for NYS demonstrate death due to suicide in Essex County (12.9/100K) have improved since the previous assessment. However the rate is higher than the NYS rate (8.1/100K) and consistently higher than the NYS Benchmark (5.9/100K).[28]

Examination of NYS sub-population data reveals deaths by suicide impacts more men than women, and those in the age range of 45-64.[29] Because the number of deaths by suicide is small, sub-population data is not available for Essex County. However it is reasonable to consider that men ages 45-64 are at increased risk compared to the general population if applying the NYS analysis here.



[28] ARHN Data Sheets
[29] NYS Prevention Agenda Dashboard

Opioids and Other Drugs[30]

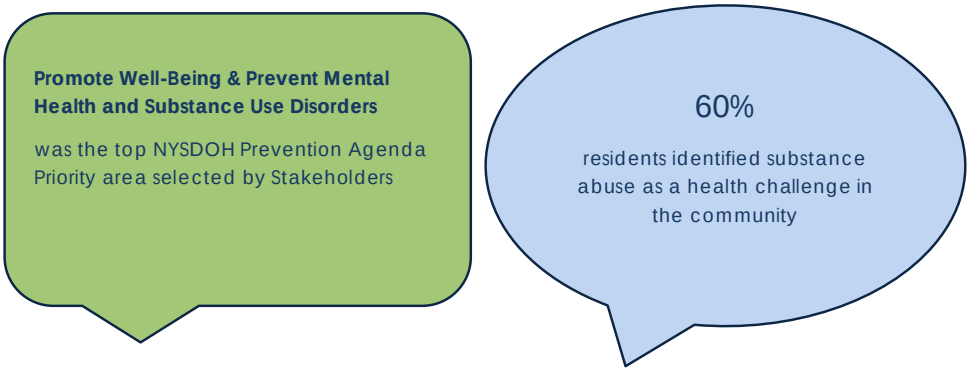
WHY IT MATTERS [31],[32]

Nationally,

- deaths involving prescription opioids have increased since 1999
- deaths involving heroin have rapidly increased since 2010
- deaths involving synthetic opioids have significantly increased in since 2013
    - o includes illicitly-manufactured fentanyl (IMF) and fentanyl analogues as found in combination with heroin, counterfeit pills, and cocaine
- most people who report prescription opioid misuse in current cohorts initiated use in their early to late 20s
- the proportion of babies born with neo-natal abstinence syndrome (NAS) increased five-fold from 2000 to 2012
- misuse of opioids and other drugs pose significant health, social and economic complications for individuals, families and communities

NYSDOH responded to the growing opioid crisis with a significant improvement in opioid-related data through the Opioid Prevention Program's Opioid Dashboard in 2019. This is data from multiple places including hospital discharge, the Prescription Monitoring Program & NYS Office if Alcohol and Substance Abuse Services (OASAS) and allows communities to better understand the local burden related to opioids and other drugs.

WHY IT'S A PRIORITY

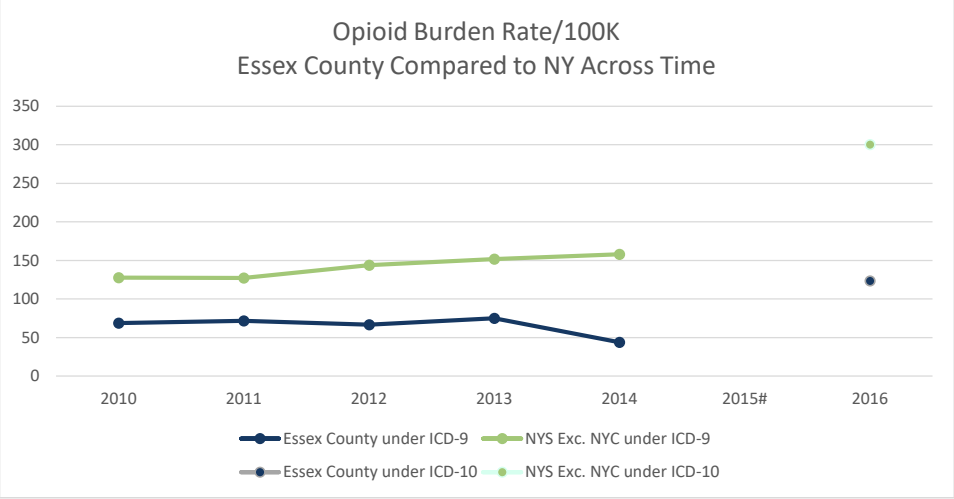


[30] NYSDOH Opioid Dashboard https://www.health.ny.gov/statistics/opioid/
[31] Centers for Disease Control and Prevention. https://www.cdc.gov/opioids/
[32] National Center for Biotechnical Information; National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK458661/

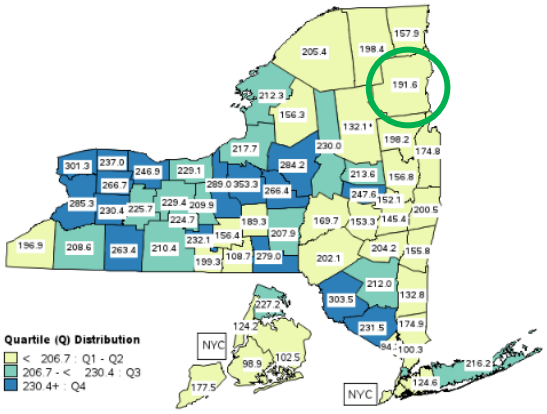
Opioid Burden is a composite indicator including outpatient ED visits and hospital discharges for non-fatal opioid overdose, abuse, dependence, and unspecified use; and opioid overdose deaths. As demonstrated in Figure X below, the opioid burden in Essex County remains consistently below that of NY excluding NYC. The 2015# year is excluded due to the data source transitioning in this year from ICD-9-CM to ICD-10-CM diagnosis codes. As these codes are not comparable, an annual rate for 2015 cannot be calculated. It is not recommended to compare 2016-and-forward data with 2014-and-prior data.

Additional data analysis reveals the Opioid Prescription Rate in Essex County shows trend improvement since 2013 to the most current rate available, 2017 of 572.6/1K. This 2017 rate is lower than the North Country rate (623.3/1K) though higher than NY (361.3/1K).

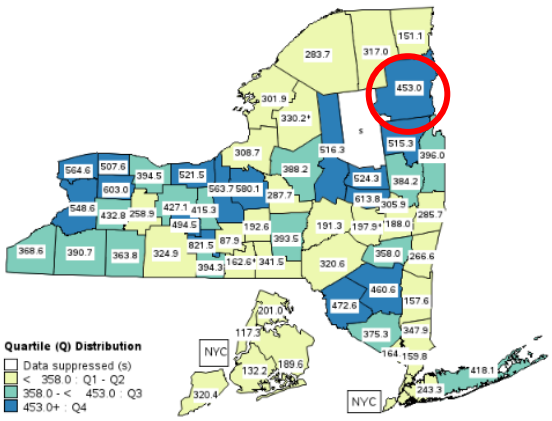
Opioid Overdose Deaths data was also examined for years 2010-2017. This data demonstrates a general trend increase though data points are considered statistically unstable with less than 10 incidents each year.



Examination of Emergency Department Visits for Any Drug data, 2016 shows the rate in Essex County (191.6/100K) to be slightly higher than the state average (171.0/100K) though within the first 2 (lowest risk) quartiles as demonstrated in Figure X below.[33]



Further analysis of this data to find sub-populations at greatest risk reveals young adults, those ages 18-24, have the highest rate of Emergency Department Visits for Any Drug as depicted below in Figure X.



[33] NYSDOH Opioid Dashboard

Priority Issue: Healthy Women, Infants and Children

Unintended Pregnancies

WHY IT MATTERS[34]

- Unintended pregnancies can contribute to physical, psychological, emotional and social woes for moms & babies
- It often means less adequate prenatal care, low birth weight, increased risk of infant mortality, child abuse and developmental deficits
- It has been associated with increased socio-economic impacts on communities as well:
  - increased need/use of healthcare and social services
  - decreased educational attainment and economic contributions of mothers & babies

WHY IT'S A PRIORITY

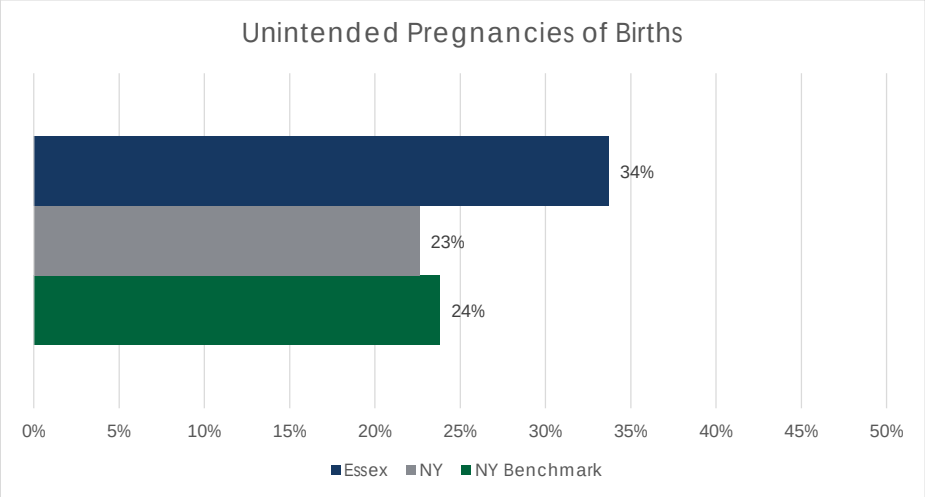
Thirty-four percent (34%) of births are the result of unintended pregnancies.[35]

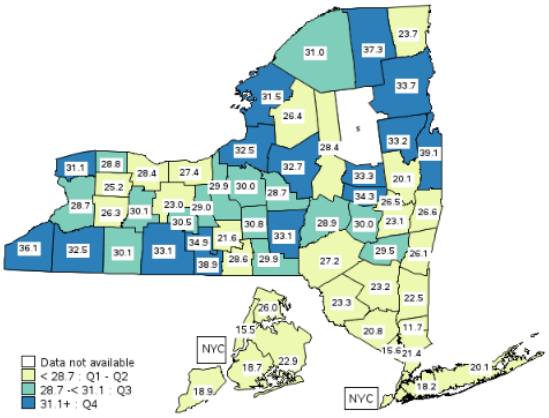
The percent of unintended pregnancies in Essex County is 10% higher than the NY benchmark (24%). As indicated in the visual aid of the map (at left/right) Essex County falls within the 4th quartile (furthest from the benchmark) for this indicator, coded as dark blue for locations with the highest rates.

Examination of this data to determine if there are disparities reveals[36]:

- Data by race is suppressed due to very small numbers (less than 10)
- Medicaid to non-Medicaid ratio in Essex County (1.10) is better than the NY average (1.71) and NY Benchmark (1.54).
- Communities with the highest rates are the towns of Moriah, Crown Point, Ticonderoga and Schroon.

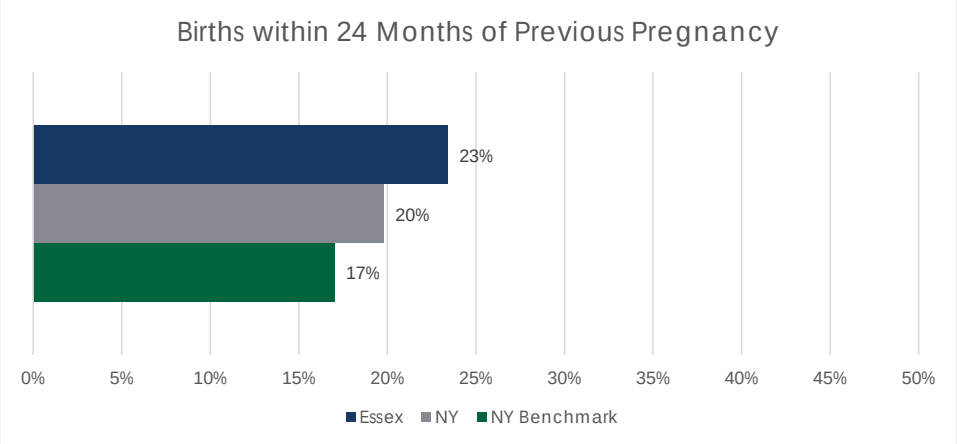
[34] https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning
[35] ARHN data Sheets
[36] NYSDOH Prevention Agenda Dashboard


Unintended Pregnancies of Births
34%
23%
24%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%
50%
Essex
NY
NY Benchmark


Data not available
< 28.7 : Q1 - Q2
28.7 -< 31.1 : Q3
31.1+ : Q4
NYC
NYC

Pregnancy timing is an important piece of family planning discussions that can be conducted during prenatal or post-natal health visits. Close proximity of births can be physically, mentally, emotionally and financially stressful for families.

In Essex County, 23% of births are within 2 years of a previous pregnancy; 5% higher than the NY benchmark.[37] Sub-population analysis demonstrates communities that fall within the 4th quartile/furthest from the benchmark, are the towns of Bloomingdale and Schroon.



[37] NYSDOH Prevention Agenda Dashboard

Teen Pregnancy

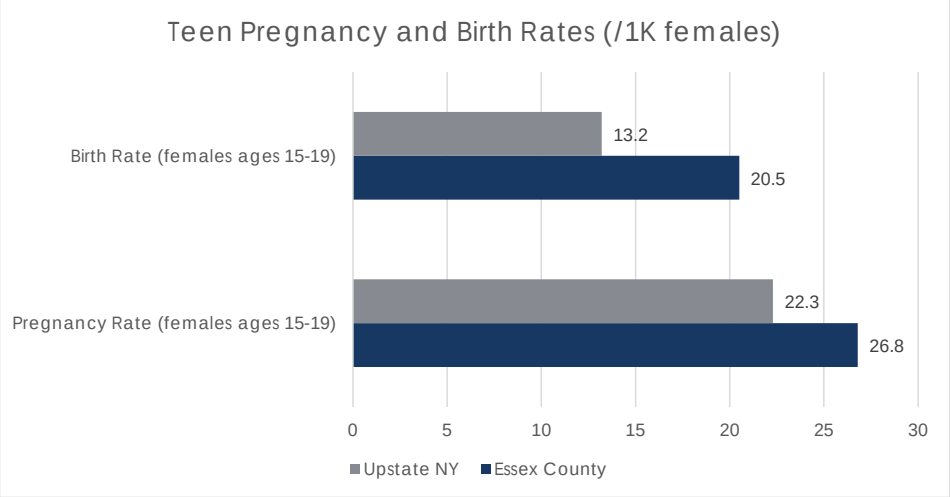
WHY IT MATTERS[38]

Teen pregnancies bring substantial social & economic impacts for mothers, their babies & communities:

- Increased health risks for moms & babies
- Negative impact on social & educational development of moms & babies
- Negative impact on earnings potential
- Increased need of social services

WHY IT'S A PRIORITY

Pregnancies include births, abortions and spontaneous fetal deaths to females ages 15-19. [39] Essex County teen pregnancy rate falls within the 4th quartile (farthest from the benchmark).[40]

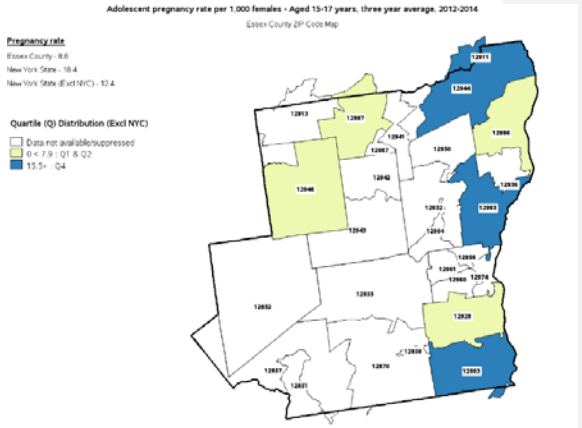


[38] https://www.cdc.gov/teenpregnancy/about/index.htm

[39] https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/essex.htm

[40] ARHN Data Sheets

Examination of sub-county data demonstrates 4th quartile rates in the communities of Chesterfield, Westport & Ticonderoga as depicted in Figure X.[41]



[41] NYSDOH Prevention Agenda Dashboard

Early Prenatal Care

WHY IT MATTERS[42]

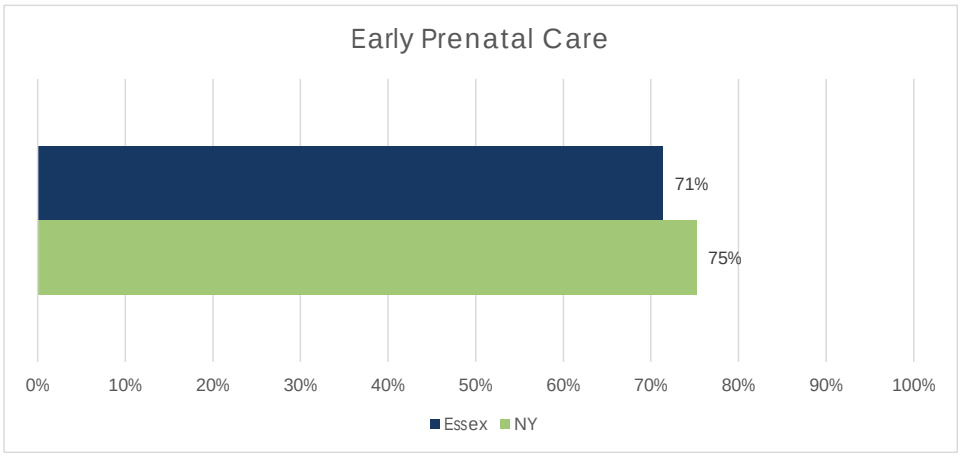
Early prenatal care

- ensures the best possible outcomes for mothers, babies and children
- allows for education and planning for preventing problems related to pregnancy:
  - vitamins, minerals & nutrition;
  - vaccinations;
  - medications & drug use;
  - environmental risks and travel exposures.
- ensures women access healthcare when needed for pregnancy related concerns:
  - high blood pressure;
  - gestational diabetes;
  - bleeding or clotting.
- ensures planning for babies' arrivals:
  - Newborn screenings, vaccinations;
  - Breastfeeding, infants and child nutrition;
  - Home and vehicle safety;
  - Child care and
- Impacts the physical and cognitive development of infants that starts during pregnancy
- Impacts the psychological and social well-being of families and
- Predicts a future public health challenges families, communities, and the health care system.

WHY IT'S A PRIORITY

[42] https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

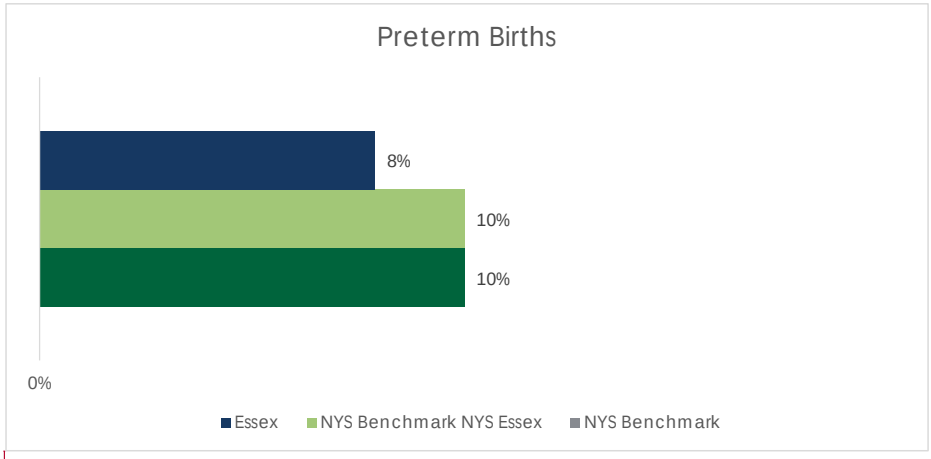
There is a lower percent of prenatal care received by women in Essex County (71%) compared to NY (75%).



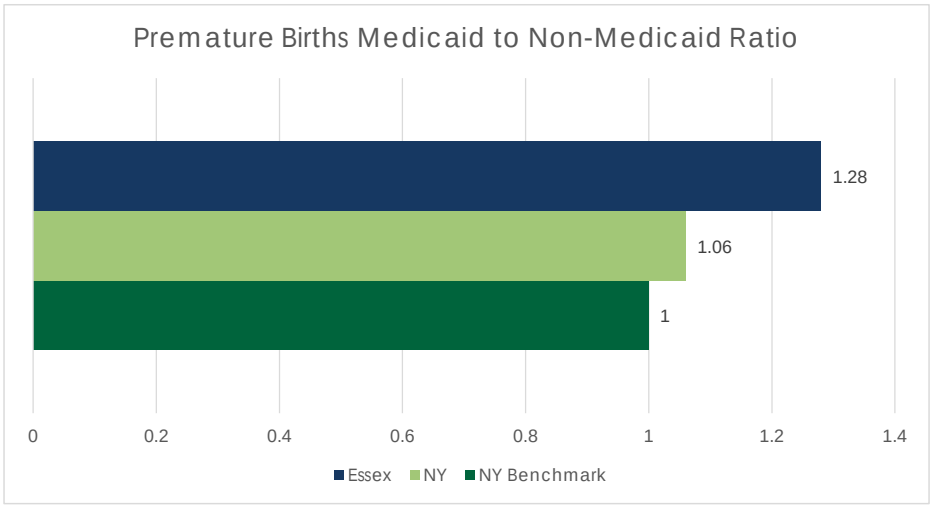
Essex County has a lower percent of Preterm Births (8%) than the NY average (10%) and performing better than the NY Benchmark (10%).[43] (Figure X below)

However, examination of the ratio of premature births Medicaid to Non-Medicaid in Essex County reveals a ratio (1.28) that exceeds the NY average (1.06) and the NY Benchmark (1.0). (Figure X below) This indicates that more babies are born prematurely to women with Medicaid than women with private insurance.

[43] ARHN Data Sheets



Commented [JDB4]: Something's up with this chart's key…



Child Health Indicators

Why It Matters[44]

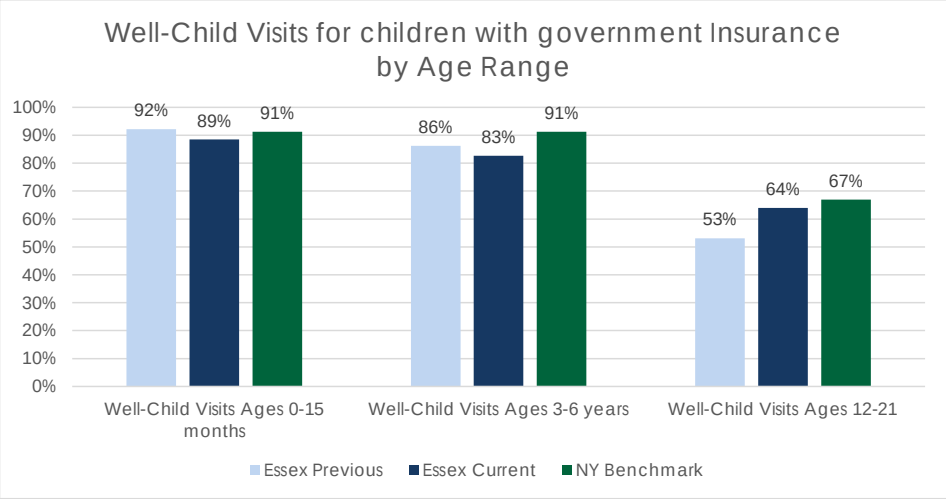
Children having a medical home and receiving annual well-child visits ensures age-specific care including:

- assessment of childhood physical & cognitive development;
- education for lifestyle and behavioral health factors;
- recommendations for preventive health care such as vaccinations & lead screening; and
- coordinated health care and/or referral for specialty care/services.

WHY IT'S A PRIORITY

Analysis of data for Essex County reveals:

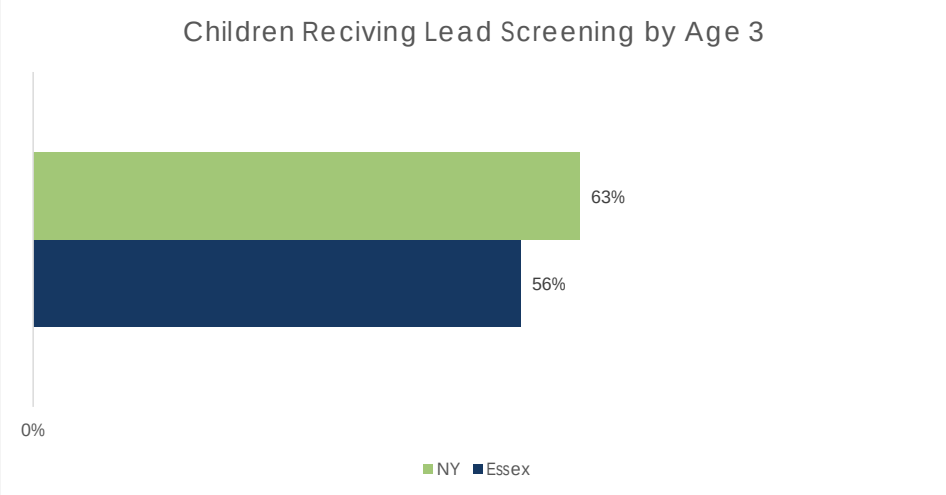
- well child visits have decreased since the previous assessment from 92% to 89% for those ages 0-15 months and 86% to 83% for those ages 3-6 years;
- well child visits for youth 12-21 increased since the previous assessment from 53% to 64%;
- NY Benchmarks for well child visits are not met for any age group as depicted in Figure X.[45]



[44] Healthy People 2020
[45] ARHN Data Sheets

Lead Screening

It is recommended that children receive lead testing at least twice by the time they are 3 to identify risk for lead poisoning exposures and risks including childhood development. While the NY average for meeting this lead screening standard is 63%, Essex County is less; 56%.[46]

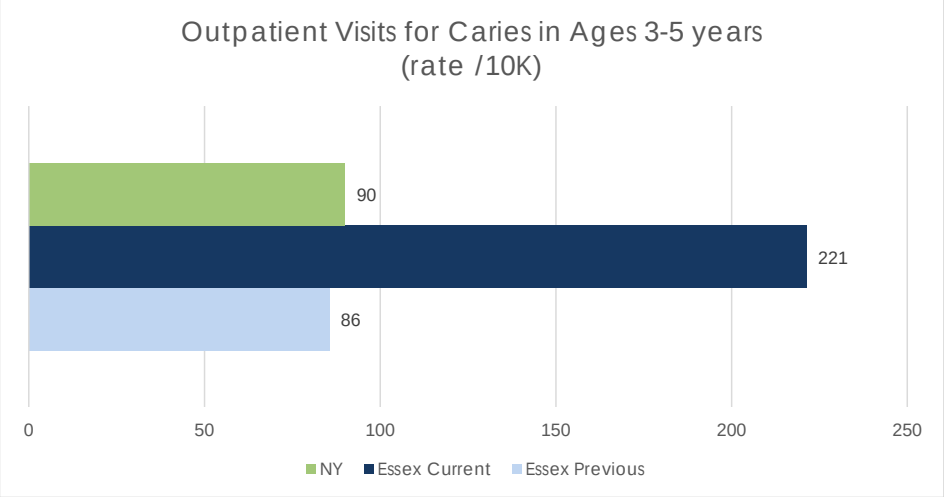


[46] ARHN Data Sheets

Dental Caries

Children are susceptible to dental caries (tooth decay) as soon as their baby teeth appear. Problems related to dental caries include pain, loss of teeth, impaired growth, and negative quality of life. Decay is primarily caused when bacteria on teeth metabolize dietary sugars and produce acids that demineralize the teeth. Water fluoridation or fluoridation treatments are recommended to improve the resistance of tooth enamel to the breakdown caused by acid decay.[47]

There are no public water systems that are fluoridated in Essex County.[48]

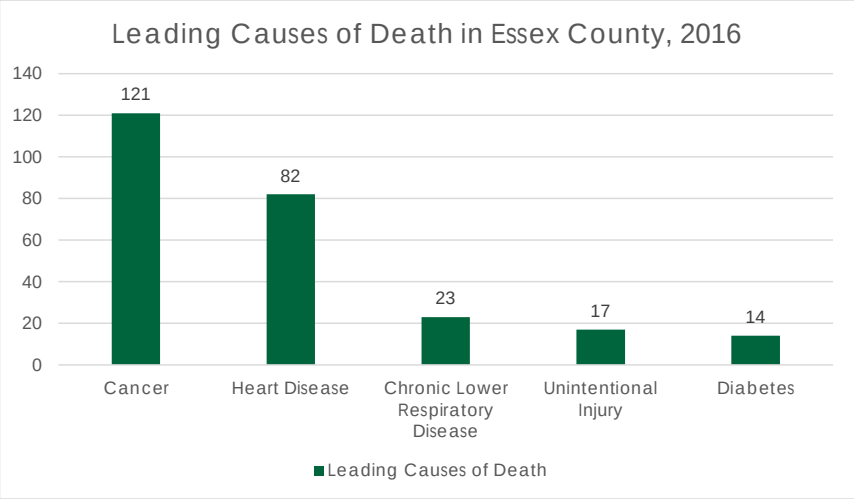


[47] https://www.ncbi.nlm.nih.gov/books/NBK202091/
[48] NYSDOH Center for Environmental Health.
https://www.health.ny.gov/environmental/water/drinking/facts_figures.htm

Leading Causes of Death[49]

There are approximately 400 deaths per year in Essex County.

The top 2 leading causes of death remain cancer and heart disease.



[49] NYSDOH. Vital Statistics.
https://apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/reports/#county

Health Indicators by Sub-Populations

This section of the report provides select indicators for 4 sub-populations of Essex County:

- Women and Infants
- Children and Adolescents
- Adults
- Older Adults.

A brief summary of issues for each sub-population followed by a selection of indicators is provided.

Women & Infants

Cancer Screenings and Cases[50]

Screenings for cancers specific to women are lower than the NYS comparison; rates are higher.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to Upstate NYS	Upstate NYS
Breast Cancer screening %	▼	83.0	78.4	●	79.2
Breast Cancer cases rate/100K	▲	151.7	201.5	●	175.9
Cervical Cancer screening %	N/A	N/A	93.1	●	83.5
Ovarian Cancer cases rate/100K	▼	15.9	14.4	●	16.0

Formatted Table

Pregnancies and Births[51]

Indicators related to pregnancies and births are generally trending poorly and are worse than NYS comparison or do not meet the NYS Benchmark.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Unintended Pregnancies of Births %	▲	31.7	33.7	●	23.8
Unintended Pregnancies of Births Medicaid to Non-Medicaid* ratio	▼	1.82	1.10	●	1.54
Births within 24 months of previous birth %	▲	19.5	23.4	●	17.0

				Essex County compared to Upstate NYS	Upstate NYS
Early prenatal care %	▼	73.3	71.4	●	77.0
Preterm Births %	▼	8.2	7.9	●	10.2
Premature Births Medicaid to Non-Medicaid ratio	▲	1.23	1.28	●	1.00
Births to women 35+ %	▲	14.4	15.6	●	20.2

[50] ARHN Data Sheets
[51] ARHN Data Sheets

Newborn Drug-related hospitalizations rate/10K	▲	101.6	106.1	●	140.8

Commented [SM5]: Why highlighted? What to do with this?

Breastfeeding[52]

The percent of women reporting breastfeeding in the delivery hospital has decreased though remain better than the NYS Benchmark.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Breastfed in delivery hospital %	▼	75.0	65.3	●	48.1
Breastfed in delivery Hospital Medicaid to Non-Medicaid** ratio	▲	.86	.87	●	.66

WIC Indicators[53]

Several WIC indicators – first trimester prenatal enrollment, breastfeeding initiation and exclusively breastfeeding demonstrate a poor trend and fair worse than NYS as a comparison.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS	NYS
Prenatal enrollment in the first trimester %	■	51.2	51.1	●	37.2
High maternal weight gain %	▼	41.4	37.3	●	35.2
Breastfeeding initiation %	▼	79.6	77.3	●	83.4
Exclusively breastfed at 6 months %	▼	17.7	6.3	●	9.6

Children and Adolescents

Household/Family

Household and family indicators demonstrate poor trends and fairing worse than the NYS.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS	NYS
Single Parent Households %[10]	▼	13.2	7.9	●	8.9
Report of Child Abuse/Maltreatment rate/1K [11]	▲	18.6	19.3	●	17.1
Children in Foster Care rate/1K [12]	▲	4	5	●	3.0

[52] ARHN Data Sheets
[53] Essex County WIC. Local Agency Compliance And Assessment Data Sheet; June 20, 2019

Healthcare

The percent of children with health insurance is closer to the NYS Benchmark than ever before.

Well child visits generally trend poorly and fair worse than the NYS comparison or benchmark. Childhood immunization rate have increased though do not yet reach NYS Benchmarks.

INDICATORS[13], [14]	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Children with Health Insurance %	▲	95.8	96.9	●	100
Well Child Visits (0-15 months) %	▼	92.2	88.5	●	91.3
Well Child Visits (ages 3-6) %	▼	86.2	82.6	●	91.3
Well Child Visits (ages 12-21) %	▲	53.1	64.0	●	67.1
Childhood Immunizations %	▲	61.5	73	●	80
Females with HPV Vaccine (ages 15-19) %	▲	24.7	34.2	●	50

				Essex County compared to Upstate NYS	Upstate NYS
Lead Screening by 3 years (2 screenings) %	▲	11.3	56.0	●	55.9

Dental Health[54]

Dental health indicators demonstrate a poor trend and close or worse when compared to NYSDOH.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County Compared to Upstate NYS	Upstate NYS
One dental visit within the year, Medicaid Enrollees ages 2-20 %	▼	58.7	47.9	●	48.0
Dental Caries (Decay) Outpatient Visits (ages 3-5) rate/10K	▼	85.5	221.3	●	119.7

Commented [JDB6]: Check to see other comparisons in previous sections – if they're Upstate or NY

Commented [SM7]: As of 12/18, I have still not checked all of these

Injuries

Commented [JDB8]: Keep inserting a 1-liner for each table or delete?

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
ED Visits for Falls (ages 1-4) rate/10K	▲	392.6	569.3	●	429.1
ED Occupational Visits (ages 15-19) rate/10K	▼	101.7	82.1	●	33.0

[54] ARHN Data Sheets

Obesity[15], [55]

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Bench mark
Public School Children Obese %	▲	19.2	21.4	🔴	16.7
				Essex County compared to Upstate NYS	Upstate NYS
Elementary Students Obese %	▲	17.7	18.7	🔴	16.0
Middle/High School Students Obese %	▲	18.9	26.8	🔴	18.8

Teen Pregnancy[56]

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to Upstate NYS	Upstate NY
Pregnancy (ages 15-19) rate/1K females	🟨	27.0	26.8	🔴	22.3
Births (ages 15-19)/ rate 1K females	▲	19.4	20.5	🔴	13.2
Abortions (ages 15-19) rate/1K births	▼	420.3	333.3	🟢	652.3

Adolescent Alcohol, Nicotine & other Drug Use Behaviors

Vaping use has more than doubled in only two years (from 2016-2018). In 2016 12% of 7th -12th graders reported vaping compared to 25.2% in 2018. This percent also exceeds the *Monitoring the Future Survey (MTF Survey) 2018 [national survey providing a large sample comparison]* of 19.3%. Very small percentages of students reported using inhalants, hallucinogens, methamphetamines, amphetamines, sedatives, tranquilizers, ecstasy, synthetic marijuana, caffeine pills, heroin or other narcotics.

INDICATORS **Last 30 Days Use (Grades 7-12)**	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to MTF	MTF *
Energy Drinks %	▲	30.2	41.8		N/A
Vaping (E-cigarette) %	▲	12.0	25.2	🔴	19.3
Cigarette Use %	▼	6.0	3.4	🟢	4.6
Chewing Tobacco %	▼	5.8	5.0	🔴	3.4
Marijuana %	▲	12.5	16.9	🔴	14.6
Alcohol Use %	▲	23.1	25.8	🔴	18.7

INDICATOR	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS	NYS Current
Young adults driving while intoxicated[16] arrest rate/10K	▼	96.1	81.7	🔴	17.5

* MTF =*Monitoring the Future Survey 2018; a national survey providing a large sample comparison*

Formatted Table

Formatted: Indent: Left: 0", Hanging: 0.25", Position: Horizontal: Center, Relative to: Margin, Vertical: -0.04", Relative to: Paragraph, Horizontal: 0.13", Wrap Around

Formatted: Indent: Left: 0", Hanging: 0.25", Position: Horizontal: Center, Relative to: Margin, Vertical: -0.04", Relative to: Paragraph, Horizontal: 0.13", Wrap Around

Formatted: Indent: Left: 0", Hanging: 0.25", Position: Horizontal: Center, Relative to: Margin, Vertical: -0.04", Relative to: Paragraph, Horizontal: 0.13", Wrap Around

Formatted: Indent: Left: 0", Hanging: 0.25", Position: Horizontal: Center, Relative to: Margin, Vertical: -0.04", Relative to: Paragraph, Horizontal: 0.13", Wrap Around

Formatted: Indent: Left: 0", Hanging: 0.25", Position: Horizontal: Center, Relative to: Margin, Vertical: -0.04", Relative to: Paragraph, Horizontal: 0.13", Wrap Around

Formatted: Indent: Left: 0", Hanging: 0.25", Position: Horizontal: Center, Relative to: Margin, Vertical: -0.04", Relative to: Paragraph, Horizontal: 0.13", Wrap Around

Deleted: Essex County Current compared to NYS current

Deleted: NYS current

Formatted: Left, Position: Horizontal: Center, Relative to: Margin, Vertical: -0.04", Relative to: Paragraph, Horizontal: 0.13", Wrap Around

Formatted: Indent: Left: 0", Hanging: 0.25", Position: Horizontal: Center, Relative to: Margin, Vertical: -0.04", Relative to: Paragraph, Horizontal: 0.13", Wrap Around

---

[55] ARHN Data Sheets

[56] ARHN Data Sheets

Adolescent Perceptions about Drug Use[17]

INDICATORS (Grades 7-12)	Essex County Trend	Essex County Previous	Essex County Current	Essex County Compared to BH Norm*	BH Norm*
Perceived availability of drugs in the community %	▼	31.1	30.2	●	28.8
Parent attitudes favor drug use %	▲	34.1	39.4	●	31.3
Peer attitudes favor drug use %	▲	29.7	37.2	●	36.2
Perceived risk of drug use %	▲	57.2	61.0	●	55.2

* BH Norm = Behavioral Health Norm; a national survey providing a large sample comparison

Adolescent Mental Health[57]

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to Upstate NYS	Upstate NYS
Children </=17 served in mental health outpatient setting rate/100K	**	521.9	1,437.3	**	642.2
Children </=17 served in mental health emergency settings rate/100K	N/A	<10	<10	●	20.0
Death by Suicide (ages 15-19) rate/100K	▼	14.2*	0.0*	●	6.1

* Unstable rate; incidence is less than 10

** This indicator can be interpreted in different ways given numerous factors, including need and access (availability of services).

More requests from schools to implement mental health in schools. Resource Officers.
Reducing stigma for mental health issues.
Children are more needy today than they used to be years ago.
Children don't have the ability to manage their emotions.

Formatted Table

Formatted: Indent: Left: 0", Hanging: 0.25"

Deleted: ●

Formatted: Font color: Auto

Formatted: Normal

[57] ARHN Data Sheets

Adult Physical Health Indicators[58]

Adult obesity continues to be a concern in Essex County affecting over 32% of adults; a rate higher than New York and 9% away from the NYS Prevention Agenda Benchmark. Obesity is a significant risk factor for chronic diseases including diabetes, high blood pressure and cholesterol, heart disease, stroke, asthma, arthritis and certain types of cancer.

With 14.2% having diagnosed diabetes in 2018, Essex County fell within the top 5 counties in NY for prevalence of Diabetes. This is a significant increase from 2015 when the prevalence was only 5.4% and among the lowest 5 counties in NY. Death due to diabetes is also nearly double that of New York.

As depicted below, other select physical health outcome indicators are trending poorly and fairing poorly when compared to NY.

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Benchmark
Obesity % [18]	■	32.2	32.2	●	27.4
Heart Attack Hospitalizations rate/10K	▼	14.8	11.9	●	14.0
Asthma ED visit rate/10K	▼	43.7	32.5	●	75.1

				Essex County compared to NYS	NYS
Arthritis %	▲	25.3	29.6	●	21.8
Diagnosed pre-diabetes % [19]	NA	NA	11.5	●	9.9
Diagnosed with diabetes % [20]	NA	NA	14.2	●	10.5

				Essex County compared to Upstate NYS	Upstate NYS
Diabetes deaths/100K	▲	31.6	39.9	●	19.8
Diagnosed with High Blood Pressure %	▲	30.8	37.2	●	33.0
Stroke deaths rate /100K	▲	36.8	40.8	●	38.1
Cardiovascular Disease death rate/100K	▲	320.8	314.1	●	295.7
Diseases of the heart deaths rate/100K	▼	258.3	251.6	●	236.5
Diseases of the heart premature death (35-64) rate/100K	▼	115.3	84.2	●	82.8
Chronic lower respiratory disease deaths[21] rate/100K	▲	56.5	72.0	●	45.4
Lung and Bronchitis Cancer Cases rate/100K	▲	112.2	114	●	84.3
Lip, Oral Cavity & Pharynx Cancer Cases rate/100K	▲	17.9	19.9	●	14.7
Asthma %	▲	9.6	12.4	●	10.1
Prostate Cancer Cases rate/100K	▼	155.9	116.3	●	151.7

Commented [SM9]: Can't find this previous rate in 2016 CHIP indicator data

Commented [JDB10]: Need to find previous

Deleted: ▲

Formatted: Font: 10.5 pt, Font color: Auto

Formatted: Font: 10.5 pt

Commented [JDB11]: Need to find previous data

Commented [SM12]: Can't find this previous rate in 2016 CHIP indicator data:
Diagnosed pre-diabetes %
Diagnosed with diabetes %

Formatted: Font: 10.5 pt, Font color: Auto

Deleted: ▲

Formatted: Font: 10.5 pt

Commented [JDB13]: Need to find previous

[58] ARHN Data Sheets

Screenings[59]

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS	NYS
Diabetes & Pre-diabetes Testing %	▲	49.2	53.6	●	57.9
Cholesterol Check % [22]	▼	78.2	70.0	●	84.2

	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Benchmark
Colorectal screening as recommended %	▼	68.3	66.9	●	80.0

Behaviors[23]

INDICATORS	Essex County Trend	Essex County Previous	Essex County Current	Essex County compared to NYS Benchmark	NYS Benchmark
Smokers % [24]	▲	16.6	16.8	●	12.3

				Essex County compared to NYS	NYS
Vapers (e-cigarette Users) %	N/A	N/A	Suppressed (small sample size)	N/A	4.3
Leisure Time Physical Activity %	▲	76.2	75.6	●	74.0
Consuming No Fruits or Vegetables %	N/A	N/A	17.3	●	31.5
Consuming Sugar Sweetened Beverages %	▼	26.8	23.4	●	24.2
Chronic Disease Self-Management %	▲	4.9	9.9	●	9.5

Social/Emotional/Mental Health & Substance Use

INDICATORS[60], [61]	Essex County Trend	Essex County Current	Essex County Previous	Essex County compared to NYS Benchmark	NYS Benchmark
Poor mental health days (14+/month) %	▲	14.4	11.3	●	10.1
Death by suicide rate/100K	▼	12.9	14.8	●	5.9
Binge drinking in the last month %	▲	24.7	21.9	●	18.4

	Essex County Trend	Essex County Current	Essex County Previous	Essex County compared to Upstate NYS	Upstate NYS
Alcohol-related Crashes rate/100K	▼	94.8	102.6	●	53.2
Alcohol-Related Injuries & Deaths rate/100K	▼	31.6	54.7	●	10.5

[59] ARHN Data Sheets
[60] ARHN Data Sheets
[61] NYSDOH Opioid Dashboard

Deleted: Benchmark
Deleted: NY
Commented [SM14]:
Commented [SM15]: Can't find this previous rate in 2016 CHIP indicator data
Commented [SM16]:
Formatted: Indent: Left: 0", Hanging: 0.25", No bullets or numbering
Deleted: 57.9
Deleted: N/A
Formatted: Font: 10.5 pt
Formatted Table
Formatted: Indent: Left: 0", Hanging: 0.25", No bullets or numbering
Deleted: 84.2
Formatted Table
Commented [SM17]: Incomplete (come back to this)
Commented [SM18]: revisit this
Deleted: Y
Formatted: Indent: Left: 0", Hanging: 0.25", No bullets or numbering
Formatted: Font: 9 pt, Font color: Red
Commented [SM19]: NYS? confirm source
Commented [SM20]: same as Leisure Activities Last 30 Days? Because that doesn't mean PA
Formatted
Formatted
Commented [SM21]: where is previous for f&v,
Commented [SM22]: where yo find Essex County
Commented [SM23]: (resolved) I have many
Formatted
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight
Formatted: Not Highlight

	Essex County Trend	Essex County Current	Essex County Previous	Essex County compared to NYS	NYS
Opioid burden (ED Visits, discharges, dependence, deaths)	Not comparable	123.4	N/A	●	295.9
ED visits involving any drug/100K (18-24 year olds)	Not comparable	453.0	N/A	●	272.2
Overdose deaths any opioid rate/100K*	▼	10.5	18.2	●	15.5
Overdose deaths any drug rate/100K*	▼	18.4	20.8	●	18.9

* Unstable rate; incidence is less than 10

Formatted: Not Highlight

Commented [SM24]: Overdose deaths any opioid rate/100K*
Overdose deaths any drug rate/100K*Look up EC prev for

Older Adults (65+)[62]

Text

INDICATORS	Essex County Trend	Essex County Current	Essex County previous	Essex County compared to NYS Benchmark	NYS Benchmark
Flu shot received in the last year %	▼	57.8	68.3	🔴	70.0
Fall hospitalizations rate/10K	▼	110.3	110.9	🟢	204.6

				Essex County compared to Upstate NYS	Upstate NYS
Served in Out Patient setting for mental health (ages 65+) rate/100K	**	62.5	88.0	**	170.3
Served in ED setting for mental health (ages 65+) rate/100K	*	*	*	Not comparable	5.7
Pneumonia shot received in the last year %	▲	73.7	59.3	🟡	73.8
Flu/Pneumonia hospitalizations rate/10K	▼	98.4	133.7	🔴	93.7
Asthma ED Visits rate/10K	▲	26.9	15.9	🔴	19.1
Unintentional Injury Hospitalizations rate/100K	▼	142.3	198.6	🟢	239.3

* Unstable rate; incidence is less than 10
** This indicator can be interpreted in different ways given numerous factors including need and access (availability of services)

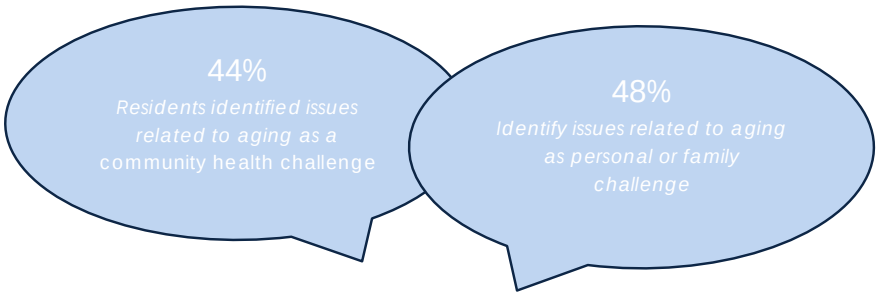
Formatted: No bullets or numbering
Formatted: Centered
Formatted: Centered, No bullets or numbering
Formatted: No bullets or numbering
Formatted: No bullets or numbering
Formatted: No bullets or numbering
Formatted: No bullets or numbering
Formatted: Normal

Alzheimer's Disease and other dementias pose significant quality of life health concerns for patients, caregivers and families. This health condition as a cause of death increased 145% from 2000-2017 and is projected to increase 15% more from 2018-2025. It is currently the 6th leading cause of death in the United States with an estimated that 1 of every 3 seniors dying with Alzheimer's or other dementia.[25]

Alzheimer's data does not currently appear as a leading cause of death in Essex County or NY. However, given the high percent of residents aged 65 years or older in Essex County it is reasonable to expect that Alzheimer's Disease and other dementias will be of increasing concern for Essex County residents.

[62] ARHN Data Sheets

Residents identified issues related to aging as a concern for their community and themselves.



The Essex County Office for the Aging (OFA) provide services to community members through several programs and services. Notable in their data is that many clients participating in their services have multiple chronic conditions. The percent of clients with chronic conditions varies by the type of service.[63]

There are 4 major categories of service for OFA clients. They are:

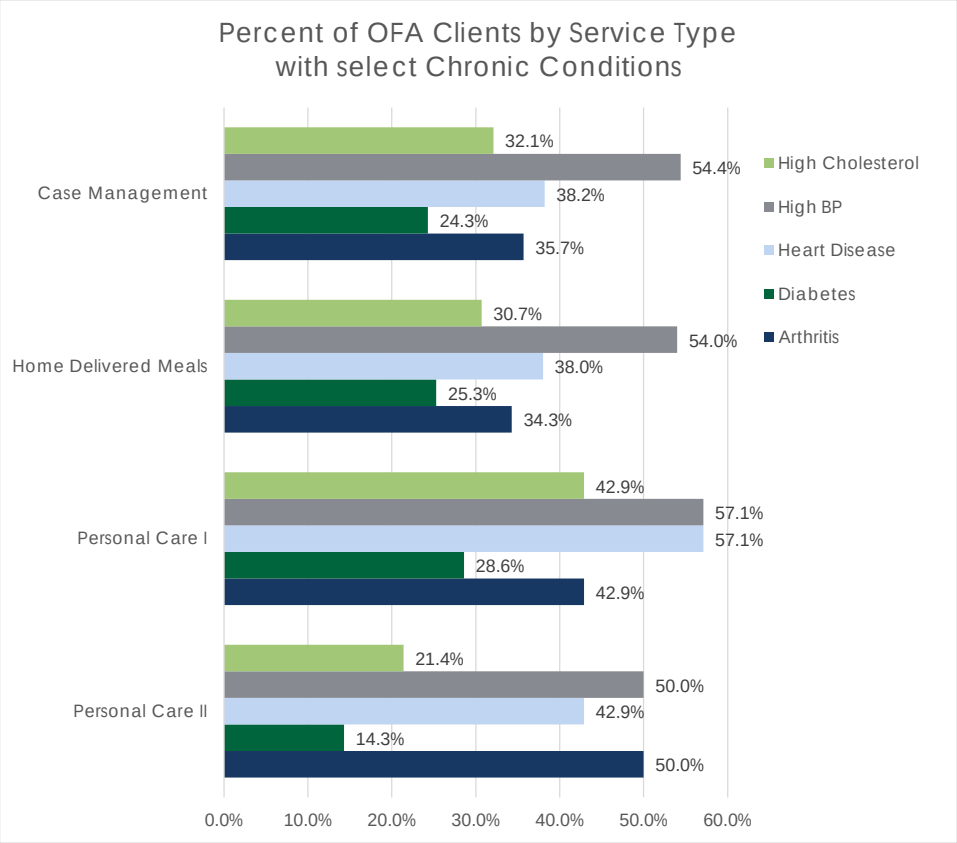
Case Management	= in-depth care planning with staff to ensure client accesses all services needed; assistance with referrals, paperwork completion; etc.
Home Delivered Meals	= receipt of "Meals on Wheels" program
Personal Care I	= non-hands on assistance (light house-keeping, shopping assistance, laundry, meals, phone, etc.)
Personal II	= hand-on assistance (bathing, hygiene, dressing, feeding)

Conditions most commonly identified by OFA clients are:

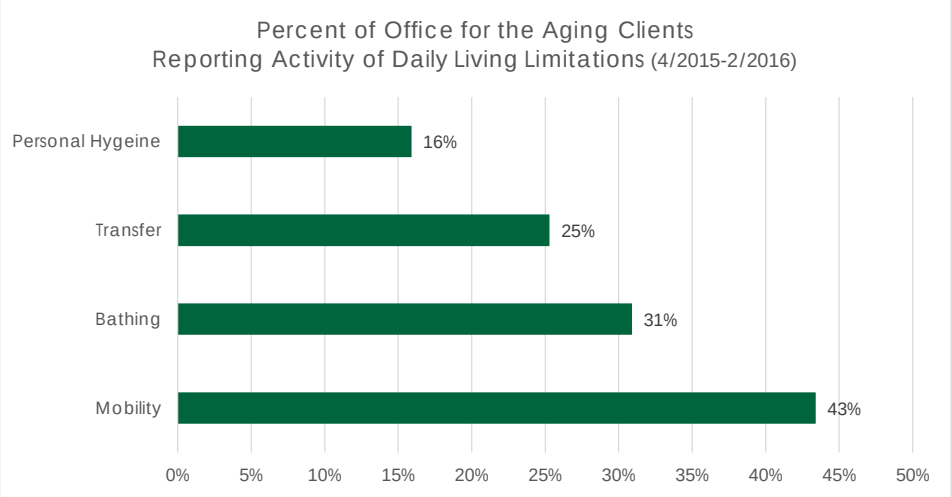
- High cholesterol,
- High blood pressure,
- Heart disease,
- Diabetes and
- Arthritis

The Figure below provides a snapshot of conditions where 25% or more of clients within 3 of the 4 major categories of services have diagnosed conditions.

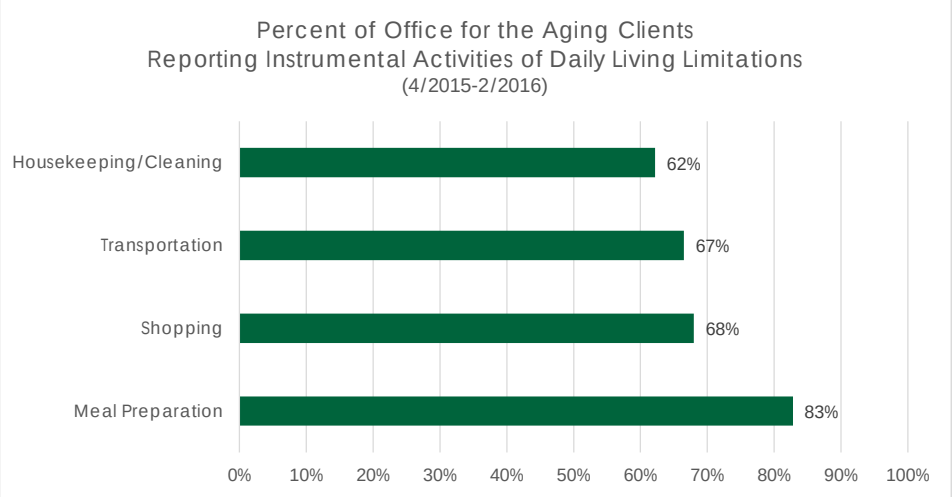
[63] Essex County Office for the Aging. Slides


Percent of OFA Clients by Service Type with select Chronic Conditions
Case Management
Home Delivered Meals
Personal Care I
Personal Care II
32.1%
54.4%
38.2%
24.3%
35.7%
30.7%
54.0%
38.0%
25.3%
34.3%
42.9%
57.1%
57.1%
28.6%
42.9%
21.4%
50.0%
42.9%
14.3%
50.0%
High Cholesterol
High BP
Heart Disease
Diabetes
Arthritis
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%

Of daily living limitations reported by Office for the Aging clients, Mobility (43%) is the highest.



Over 50% of clients report limitations in instrumental activities of daily living including meal preparation, shopping, transportation, housekeeping/cleaning.



"There should be community vans or other means of transportation for the elderly who aren't driving."

Evolving Topics in Health

The Changing Health Care Environment

Advances in Technology

The rise of telehealth services may be able to address the lack of providers, particularly specialists, in Essex County. As access to specialists and acute care services is more readily available outside of the county within an hour drive, many residents of Essex County must travel for care.

Telehealth services in Essex County, such as remote-monitoring and distant site visits, could help increase access to care for certain specialty services without having the need for residents to travel. A relaxation in regulations governing the 'originating site' for a virtual visit, as well as investment in broadband technology, can help address access to care for those in rural areas such as Essex County. Remote monitoring (where a patient has a wearable device that relays clinical information back to a health care provider) can also help healthcare providers triage those patients who are in greatest need.

Such technology use is beginning in Essex County such as through the Health Department Home Health Unit home visiting program. Expansion of telehealth across the healthcare sector is anticipated to improve access to care and health outcomes for residents.

Care Coordination

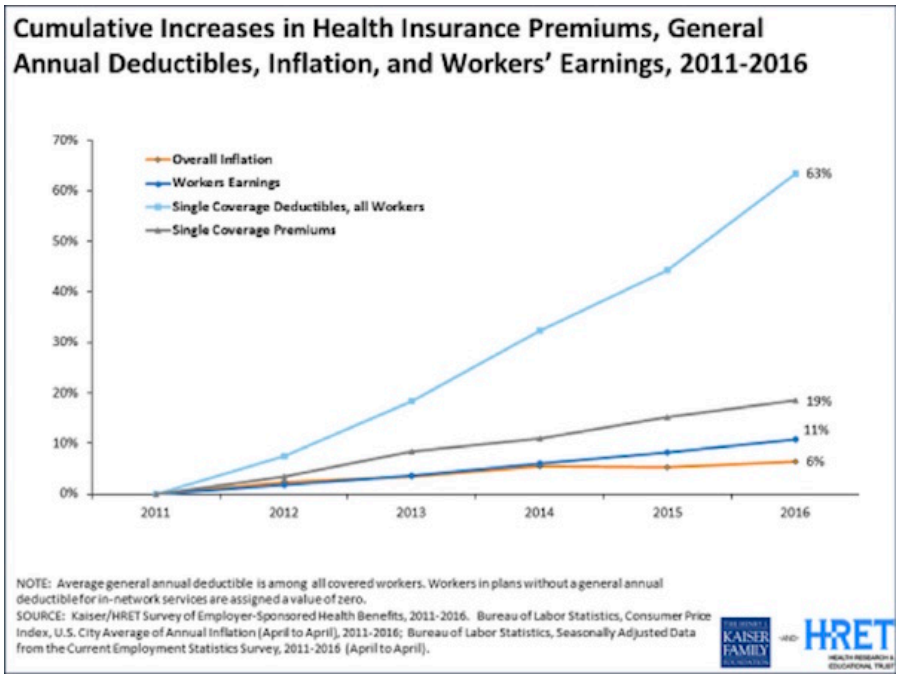
As the provider shortages in rural America continue to impact access to care, a whole-person care model continues to evolve that functions in large part through 'care coordination' provided by healthcare providers. By 2007, a patient-centered medical home model was established with a core element of coordinating care across many elements of the healthcare system. Today, the limited number of providers are supported in their care of patients by a team of nurses, health educators, nutritionists and other health professionals in the care of a patient whether it is in primary care, behavioral health or in an inpatient setting.

The previously mentioned 'remote monitoring' and other technological advances will assist in this new model of care by automating processes for delivering patient care. The future of primary care will be built upon this patient-centered, whole person care system that will be enabled by networked care coordinators working at the direction of physicians and mid-levels.

Cost of Care

The year-over-year increase in the cost of healthcare continues to outpace the rate of inflation and workers earnings nation-wide; see Figure X below.[64]

[64] Dan Hill

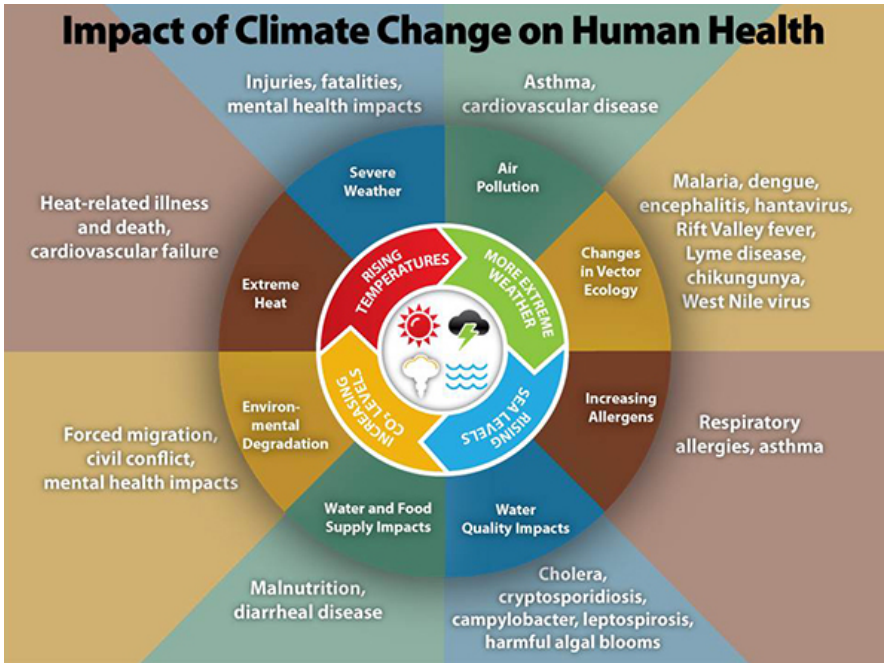


In the North Country, an effort is underway by a consortium or healthcare organizations to put patients at the center of care to improve care outcomes through alignment, integration and coordination for the region. The North Country Innovation Pilot (NCIP) aims to have these organizations collaborate rather than compete in the care of North Country residents such as the population of Essex County. Two of the NCIP organizations (Adirondack Health and the University of Vermont Health Network) have facilities in Essex County.

Among the areas of opportunity to improve patient outcomes for the NCIP are preventable complications, reduce the increase in cost for care (bend the cost curve), diagnostic intensity, treatment selection and site of care. Collaboration, quality outcomes and care coordination will be essential in the endeavor to maintain health care costs at a more sustainable rate while improving the health of the population in the North Country.

Climate and Health[65]

Climate change has been a hot topic nationally and whether naturally occurring and/or man-made, climate change has human health implications. The Centers for Disease Control and Prevention provide a visual aid to demonstrate these implications. This report highlights three locally experiences of climate change: Severe Weather; Water Quality Impacts; and Changes in Vector Ecology on page XX; devoted to Climate & Health.



State Legislation

New York State

Related to Mental Health and Substances and Communicable Diseases

- Substance Use/Misuse
  - Vaping/New Nicotine Delivery Devices
  - Opioids
  - Medical Marijuana

[65] Centers for Disease Control and Prevention. https://www.cdc.gov/climateandhealth/default.htm

SECTION 2: SOCIAL DETERMINANTS OF HEALTH

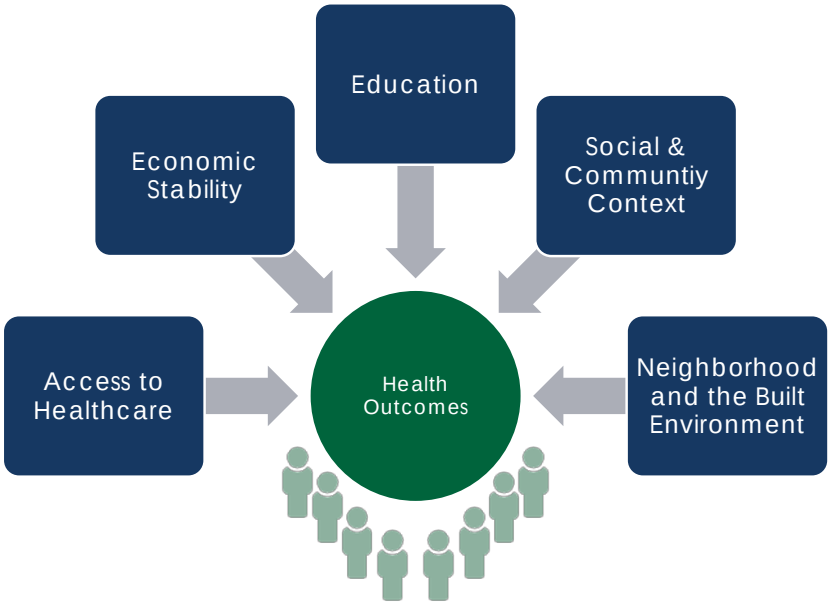
Introduction to Social Determinants

The phrase Social Determinants of Health describes the complex environment in which people live that influences their health. It includes "places" such as neighborhood, school and work as well as "conditions" including social engagement, sense of security, economic stability and access to health promoting opportunities or care services.

The section follows the Healthy People 2020 organization of social determinants into five domains[66]:

- Access to Health Care
- Economic Stability
- Education
- Social & Community Context
- Neighborhood and the Built Environment

This assessment explores the places and conditions of Essex County that influence health outcomes of residents. The WHY IT MATTERS description is continued in this section to help readers understand how these key areas influence health outcomes and that inequities in these areas lead to disparities health outcomes.



[66] US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Community Engagement Initiatives

The three local community engagement activities: the Stakeholder Survey, Distributed Focus Group and Community Survey provide perceptions of what people experience and believe. As data in the domains of social determinants of health are explored, it is evident how perceptions and realities align.

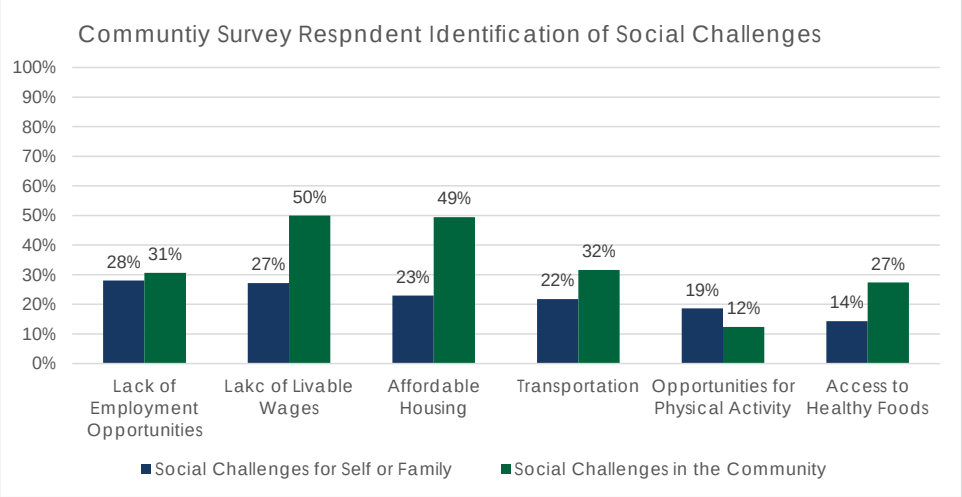
Community Perceptions

Residents were asked to identify social challenges experienced by themselves or family members as well as within their community. Most frequently identified in both of these categories (self/family or community) were:

- lack of employment opportunities,
- lack of livable wages,
- affordable housing, and
- transportation.

The 5th most frequently identified challenge was:

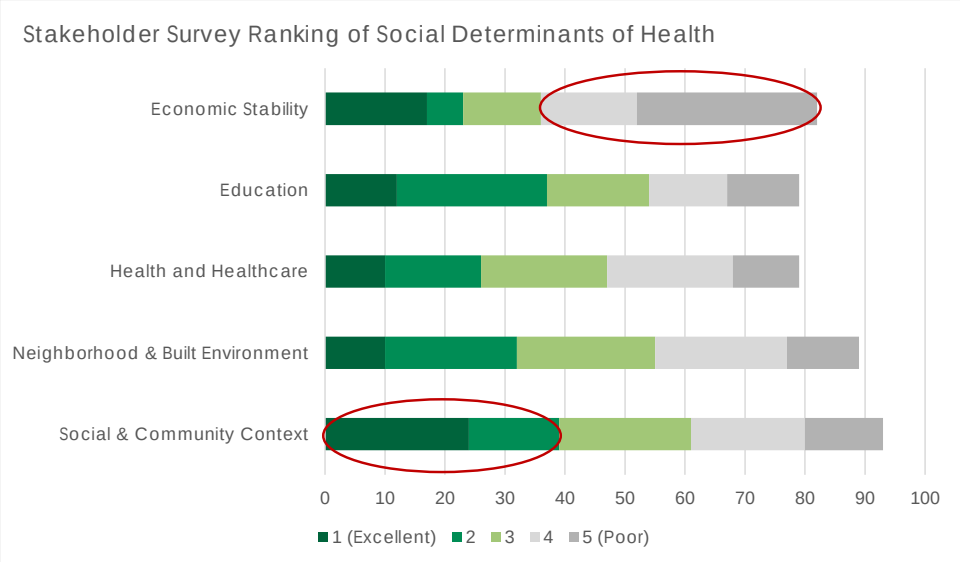
- Access to Healthy Foods within the community and
- Opportunities for Physical Activity for respondents and their families.



The Stakeholder Survey asked participants to rank how they perceived the 5 domains of social determinants of health to be impacting residents on a scale of order of 1-5 where
(1) “excellent” means that domain is positively impacting residents and
(5)”very poor” means that domain is negatively impacting residents.

Notable results of this survey indicate:

- Economic Stability was largely identified as negatively impacting residents (4 or 5);
- Social and Community Context was identified as positively impacting residents (1 or 2).



The Distributed Focus Group Initiative asked *"If you could change 1 thing about your community to make it better, what would it be?"* This word cloud visual display shows the larger the word/phrase, the more times this was identified by respondents.

Healthcare System Overview

Healthcare System Profile

1	Hospital
25	Beds
3	Nursing Homes
340	Beds
4	Adult Care Facilities
194	Beds
3	Nursing Homes
340	Beds
11	Health Centers
3	Emergency Services Sites
1	Urgent Care Site

Health Professional Shortage Areas*

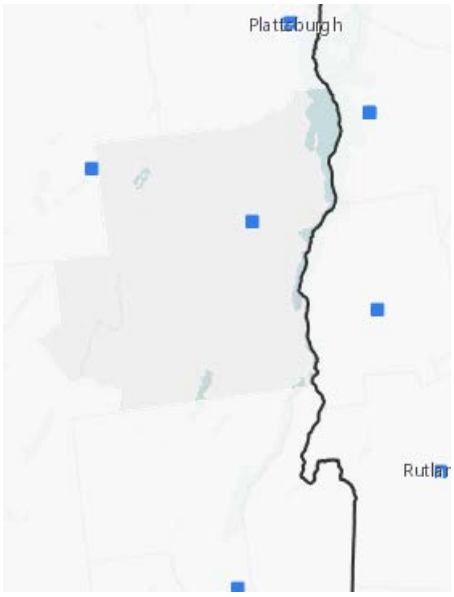
8	Primary Care	Geographic
3	Dental Care	Mediciad-eligible
3	Mental Health	Geographic

* There are 6 categories of HPSA designations.

Shortages in Essex County are related to:

- **geography** - a shortage of providers within a defined geographic region; and
- **population** – a shortage of providers for a specific sub-population (Medicaid-eligible) within a defined geographic region.

Locations of Hospitals



Regular Provider Benchmark

89%	Adults (18+)	91%

Emergency Visit Rate*- Benchmark

4,912	Essex	3,866 Upstate NY

* Rate is per 10,000, demonstrates an increase since the previous assessment and is higher than the Upstate NY rate.

Access to Healthcare

Commented [JDB25]: Why It Matters: HP2020 https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services https://www.ruralhealthinfo.org/topics/healthcare-access Telemedicine: https://www.ruralhealthinfo.org/topics/telehealth Sociocultural source: https://ahihealth.org/ahipps/dsrip-infrastructure/cultural-competency-and-health-literacy/

WHY IT MATTERS

Access to healthcare means timely use of care to achieve the best possible personal health outcomes. Healthcare includes all aspects of the care system including, and not limited to, primary care, specialty care, emergency transportation and services, rehabilitative and long term care, beyond physical health and includes behavioral and mental health.

Barriers to accessing the healthcare system can be categorized as:

- **Financial -**lack of insurance or ability to pay for care;
- **Provider Shortages** -inadequate providers for the population;
- **Geographic** -physically inaccessible care within a region or necessary to go far for care;
- **Transportation** -un-available, un-accessible, un-reliable or un-affordable; and
- **Social or cultural** -differences in social practices or acceptances, languages or health literacy.

IN ESSEX COUNTY

The top 3 barriers to care in Essex County are Geography, Provider Shortages & Transportation.

GEOGRAPHY

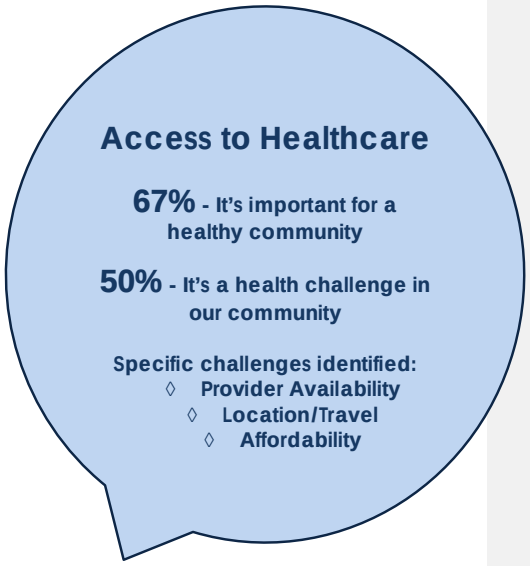
The rural nature of Essex County and small population has led to the existing healthcare system.

There are 11 community health centers throughout Essex County providing good geographical access to Primary Care.

Emergency Care is also accessible with 3 locations and 1 Urgent Care location.

There is one critical access hospital in Essex County located in the county seat, Elizabethtown.

Acute and specialty care facilities are located in the surrounding region in all directions allowing most residents to access care within an approximate 1 hour drive from any location in the county.



Provider Shortages

Community Survey respondents identified long waits for appointments and brief or rushed healthcare visits as healthcare access challenges. Health Professional Shortage Areas data and patients to provider ratios agree with resident experiences of provider shortages with Primary Health, Mental Health and Dental Health ratios all considerably worse than the NYS average.

The relatively small population in Essex County equates to a patient volume problem for acute and specialty care providers and services being more accessible. However, larger health care institutions are within an hour drive from most residents of the county. Albeit challenging for rural and aging residents, the existing system and geographic layout is the viable design.

Telemedicine services is a growing area in healthcare. Between 2006 and 2016 the utilization of Medicare distant site telehealth visits grew nearly 16 times (.6 to 9.5 per 1,000 encounters).

Telehealth services in Essex County, such as remote-monitoring and distant site visits, could help increase access to care for certain specialty services without having the need for residents to travel.

Commented [JDB26]: Transportation: ARHN Data Sheets
Provider Rations: County Health Rankings
Financial Source: ARHN Data Sheets

Primary Care Provider Ratio

2,540:1	Essex
1,200:1	NY
1,050:1	Top Performers (90th Percentile)

The Patient to Primary Care Provider Ratio in Essex County is more than double that of the NY average and fairs worse than US Top Performers.

Mental Health Provider Ratio

720:1	Essex
370:1	NY
310:1	Top Performers (90th Percentile)

The ratio of patients to mental health providers is also considerably higher in Essex County than the NY average; nearly double, and fairs worse than US Top Performers.

Dental Health Provider Ratio

3,160:1	Essex
1,230:1	NY
1,260:1	Top Performers (90th Percentile)

While NY as a whole meet Top Performer standards, this is not so in Essex County where the ratio of patients to dentists is more than 2.5 times the NY average.

TRANSPORTATION

40% Households with 0-1 vehicle

Described more completely under the Transportation section of this report (pp?) and related to other socio-demographic and economic factors, the following transportation barriers exist for Essex County residents:

- Vehicle access/availability
- Limited public transportation
- High costs for leasing/owning
- Long distances/travel time
- Aging population with driving limitations.

Financial

More Essex County residents are covered by health insurance than ever before and a smaller percent of residents report not receiving care due to costs here than in NY.

Insurance Coverage		*Benchmark*
97%	Children	100%
95%	Women	100%
94%	Adults (18-64)	100%

Didn't Receive Care Due to Cost			
7%	Essex	11%	NY

However, residents express financial barriers to healthcare.

Financial Barriers:

- lack of dental/vision insurance;
- lack of affordable prescription/ medication coverage; and
- high co-pays/deductibles.

Socio-Cultural

The need to ensure socio-cultural appreciation within the healthcare system, throughout community based organizations, our schools, communities and media continues to grow. As demonstrated in this assessment, the Essex County community continues to diversify in race, language, religion and sexual identity. Health disparities often exist within such sub-populations who experience barriers to preventive and restorative health care.

Essex County Health partners and scores of community based organizations and stakeholders have participated in cultural competency and health literacy trainings provided by the Adirondack Health Institute since 2016. Such opportunities have served to reduce socio-cultural barriers to healthcare by improving:

- the behaviors, attitudes and policies of agencies and systems allows for sensitive and effective service of all types of individuals with respect, empathy and dignity regardless of socio-cultural differences (cultural competency) and
- the ability of patients to obtain, process and understand health information (health literacy).

Social and Community Context

WHY IT MATTERS

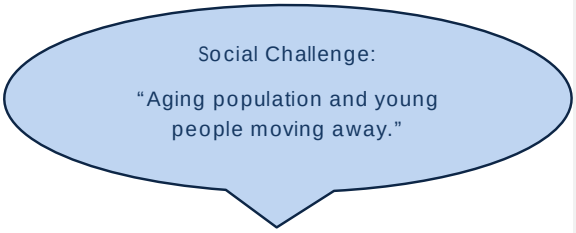
Health behaviors and outcomes along with needed services and healthcare utilization are all influenced by the composition of people within the community.

Analysis of demographic information and other social determinants of health help predict and plan for community needs. Factors include:

* age
* people living with disabilities
* veteran status
* ethnicity
* migration
* language spoken at home
* religious groups
* gender and sexual identity

And beyond including:

* Civic participation
* Discrimination
* Incarceration (d) (e)



Age

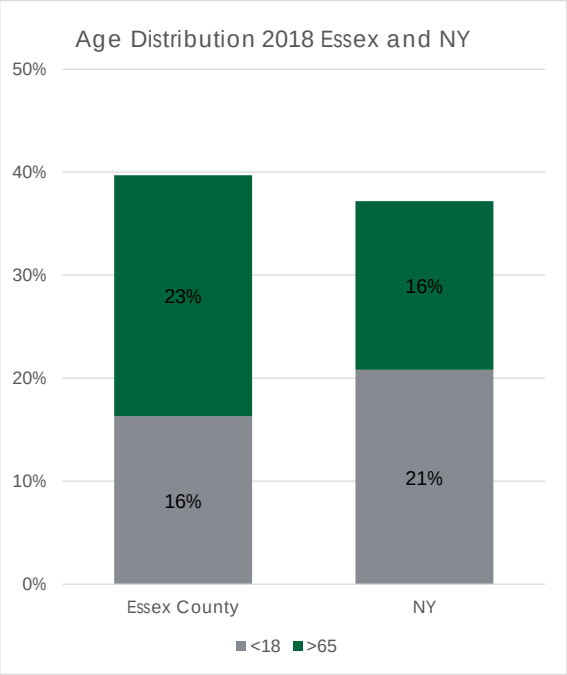
WHY IT MATTERS

It is estimated that over 60% of aging adults manage two or more chronic conditions. Such health often leads to reduced quality of life and life expectancy.

IN ESSEX COUNTY

One of the most distinguishing characteristics of Essex County demographics is age. The distribution of those under 18 and older than 65 is inverted in Essex County compared to NY and the US.

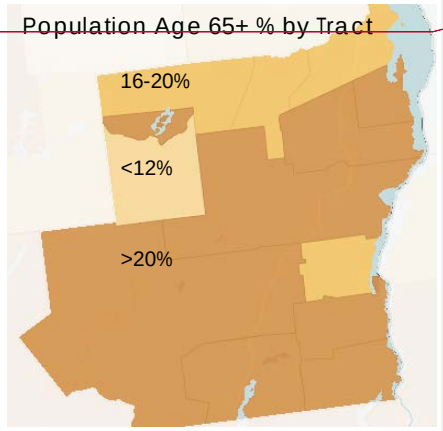
It follows that issues related to aging may impact a larger percent of the whole population in Essex County than may be found throughout the state. This includes chronic conditions often associated with aging and living with one or more disabilities.



Over 20% of the population is 65+ in almost all communities in the county.

With the exception of Moriah, these communities are closer to social and economic hubs of Plattsburgh (north) and Saranac Lake (west).

The Town of North Elba has the smallest percent (under 12.1%)



Commented [JDB27]: Source: Cares Engagement Network (ACS data)

People Living with Disabilities

WHY IT MATTERS

Our environment, culture and society often include barriers for people with disabilities in experiencing a full range of life activities. This results in higher rates of chronic conditions including obesity, diabetes and heart disease.

Interventions that remove barriers create accessible environments, and support policies and systems changes that benefit people with disabilities will help reduce disparities in health outcomes for people with disabilities.

IN ESSEX COUNTY

More of the population in Essex County (27%) report living with a disability compared to NY (23%). Effecting more than 10% of the population are mobility (16%) and cognitive (11%) disabilities.

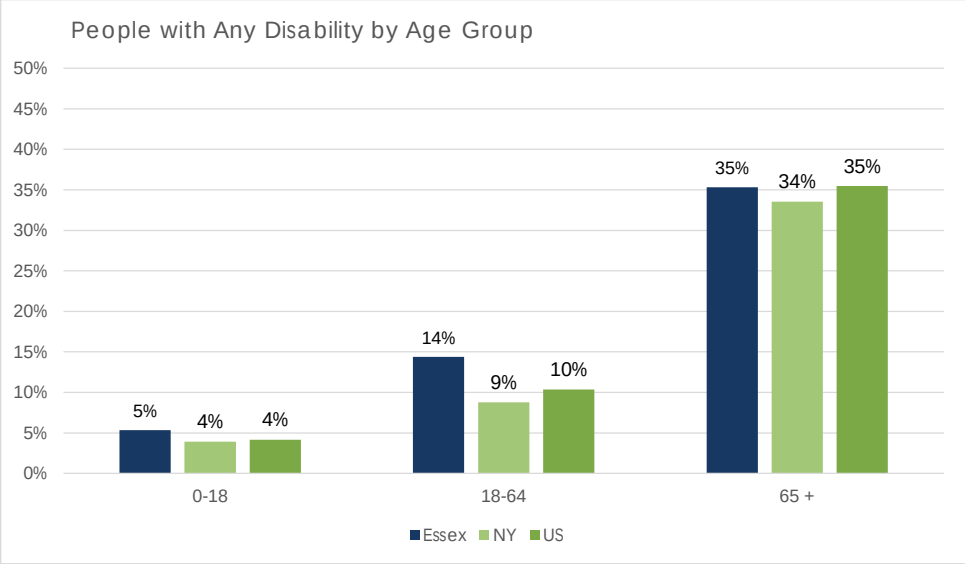
Commented [JDB28]: ARHN Data Sheet

Commented [JDB29]: By Type: Healthy ADK/BRFSS

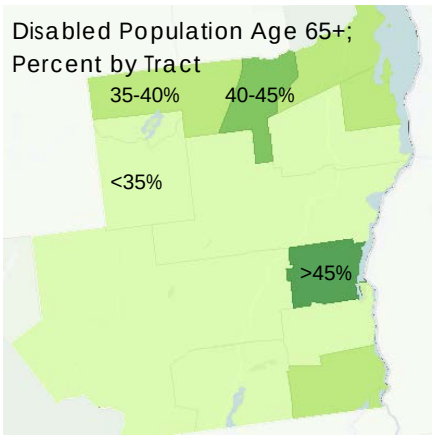
People with Disabilities, % by Type	Essex	NY
People with a disability	27%	23%
Mobility Disability	16%	13%
Cognitive disability	11%	9%
Hearing disability	8%	4%
Independent Living Disability	7%	4%
Vision disability	4%	4%
Self-Care Disability	3%	4%

Analysis of disabilities across the lifespan demonstrate an increase in the percent of the Essex County population living with a disability with the highest percent in the age range of 65+. This general trend is consistent when compared to NY and the US. It is notable that the percent of people living with disabilities in the age range of 18-64 (14%) is 5 percentage points higher than the NY 10%.

Commented [JDB30]: This whole page source = Cares Engagement Network



In examining geographic distribution of the disabled population ages 65+ reveals the highest percent on the Town of Moriah (>45%) followed by the Town of Jay (40—45%).



Veteran Status

10% Essex County
5% NY

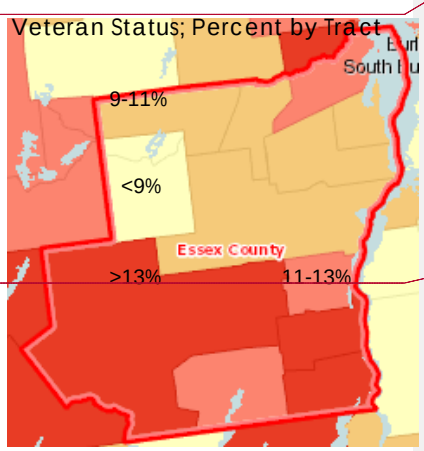
WHY IT MATTERS

Veteran status often reflects positively on the overall wellbeing of service members. However the type of service, duration, duties and experiences can also negatively impact service members' physical, mental and social wellbeing.

IN ESSEX COUNTY

An average of 10% of the population are veterans; double the NY average.

Higher than 13% of many communities in the southern portion of the county as depicted in the map (right).



Commented [JDB31]: Cares Engagement Network

Commented [JDB32]: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5747125/

Race and Migration

WHY IT MATTERS

People in minorities and migrants often experience disproportionate burdens of preventive disease, disability and death than non-minorities.

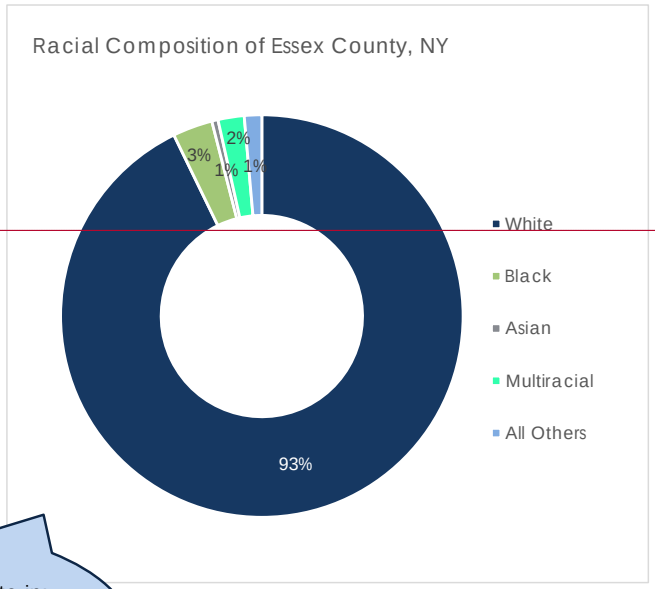
IN ESSEX COUNTY

Residents of Essex County are increasingly racially diverse.

All racial groups (other than White) represent more of the resident population than ever before.

The population remain predominantly white (93%); more than 20 percentage points higher than NY (70%).

More residents are US or US Territory Born (97%); compared to NY (70%).



Social challenge write-in:

"Lack of diversity in the neighborhood."

Commented [JDB33]: HP 2020

Commented [JDB34]: ARHN Data Sheets or US census

Commented [JDB35]: This page = Cares Engagement Network

While minority and migrant populations are increasing in Essex County, populations remain small making it more difficult to identify disparities of distinct racial or minority sub-populations. Whenever possible these distinctions were made.

Population Change (2010-2018)

- 5%	Essex County
+1%	NY

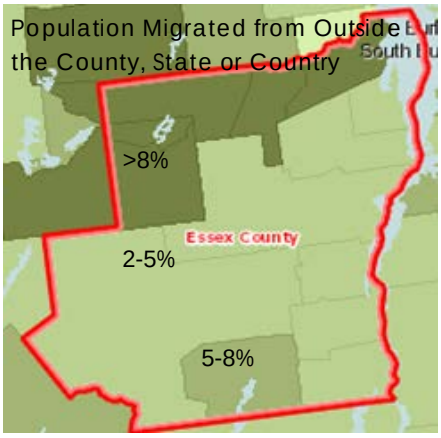
Migration, Essex County (2006-2016)

13,672	In
14,002	Out

Commented [JDB36]: Cares Enagement Network https://engagementnetwork.org/map-room/

In-Migration

Immigration has been greatest in the northern and northwestern portion of the county as displayed (right). This is consistent with larger hub communities of Plattsburgh (north) and Saranac Lake (northwest).



 # International Migrants

25	2018
70	2017
70	2016

Since the previous comprehensive assessment in 2016, Essex County has become home to a growing number of Swartzentruber Amish families. Approximately 6 families enjoy life in the Champlain Valley region of Essex County in the communities of Willsboro, Essex, Westport & Lewis. This is the largest known collective in-migration to the county.

 # Domestic Migrants

-118	2018
-32	2017
-176	2016

Young adults, ages 20-29, are the age group with the greatest percent (~17%) of out-migration.

Language

WHY IT MATTERS

Language is one piece of human communication essential to people's ability to find, understand, make decision about and act upon health information. People speaking English as a secondary language or with limited English proficiency may find challenges in connecting to preventive and care related health services.

Commented [JDB37]: HP 2020

IN ESSEX COUNTY

Non-English Speaking at Home

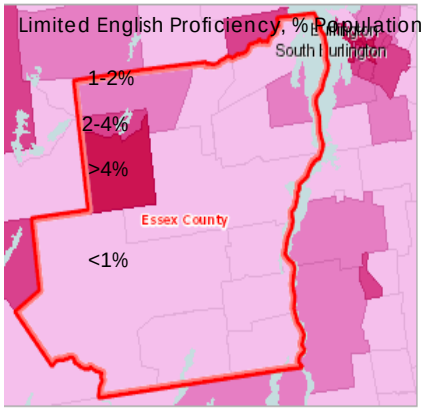
6% Essex

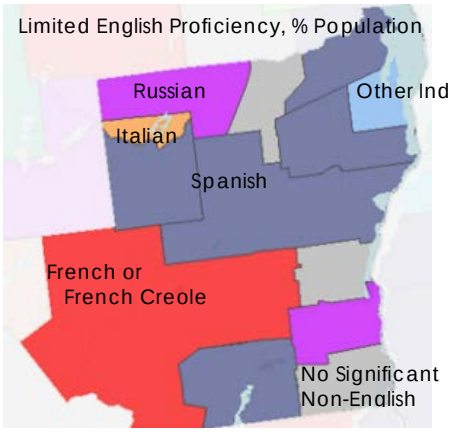
31% NY

As depicted at below, over 4% of the Lake Placid community and 1-4% of the Bloomindale, Wilmington and Willsboro communities reported limited English proficiency.

Commented [JDB38]: Cares Engagement Network, ACS Survey

Spanish, French, Russian, Italian and other Indo-European are other spoken languages in Essex County Communities as depicted in the map below.

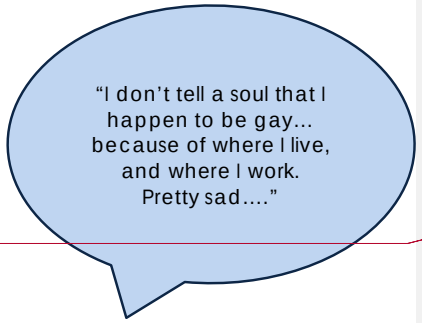




Sexual Identity

WHY IT MATTERS

People that identify as lesbian, gay, bisexual, transgender and/or queer (LGBTQ) are found in all races, religions, ethnicities and classes. People that identify as LGBTQ often face issues of social discrimination and denial of human rights. People face higher incidents of psychiatric and substance use disorders and may die by suicide.



Commented [JDB39]: HP2020

IN ESSEX COUNTY

Data systems are just beginning to collect information about sexual identification. At this time, there was no available information for Essex County except as captured in the Community Survey.

Public Safety/Crime and Violence

WHY IT MATTERS

Indicators of crime and violence can be important pieces of information in understanding community well-being and cohesion. People may be impacted by crime or violence by personally experiencing it, witnessing it, or living with the results of it.

Physical impacts include injury and death while psychological impacts encompass a range of potential results such as depression, anxiety and other stress-related disorders. These impacts can be even greater for children.

Commented [JDB40]: (HP 2020)

IN ESSEX COUNTY

Commented [JDB41]: ARHN Data Sheets

Crimes

Trend analysis [previous assessment in 2016 to now] of arrests for property and violent crimes demonstrate:

- an increase for adults
- a decrease for young adults (16-21 year olds)
- lower rates for adults & young adults than NYS.

INDICATORS (/100k)	Essex Trend	Essex County Current	NYS
Arrests Property Crimes	▲	975.6	1466.1
Arrests Violent Crimes	▲	172.6	355.6
Young Adult (16-21) Arrests Property Crime	▼	43.0	106.7
Young Adult (16-21) Arrests Violent Crime	▼	12.9	56.9

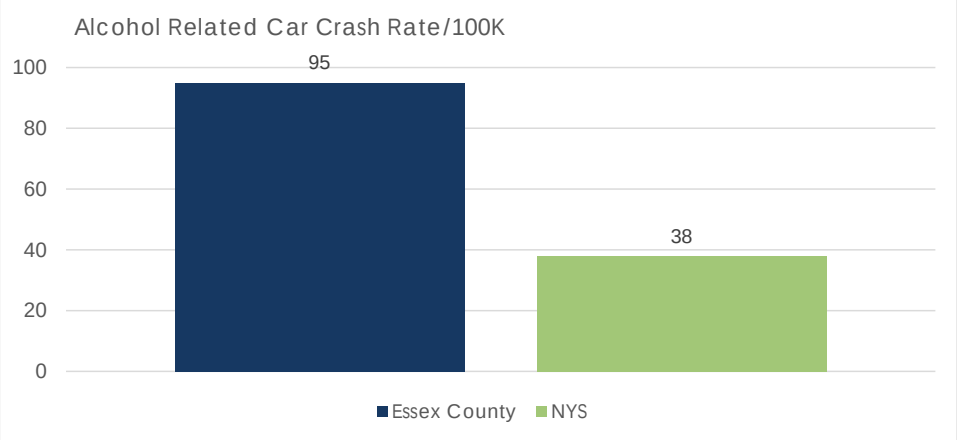
Motor Vehicle Accidents

Commented [JDB42]: ARHN Data Sheets

Trend analysis of motor vehicle crashes including hospitalizations, deaths and those related to either speed or alcohol reveal:

- Hospitalizations for young adults is increasing though less than the NY average
- Crash rate is increasing & exceeds NY average
- Speed-related crash rate is increasing & exceeds NY
- Alcohol-related crash rate (95/100K) is decreasing though 2 ½ times that of the NY (38/100K) average

INDICATORS (/100K)	Essex Trend	Essex County Current	Essex County Compared to NYS	NYS
Motor vehicle crash hospitalizations young adult	▲	45.1	●	82.5
Motor vehicle crashes	▲	2779.5	●	1558.5
Speed related accidents	▲	685.0	●	141.6
Alcohol related crashes	▼	94.8	●	38.0



Households with Children

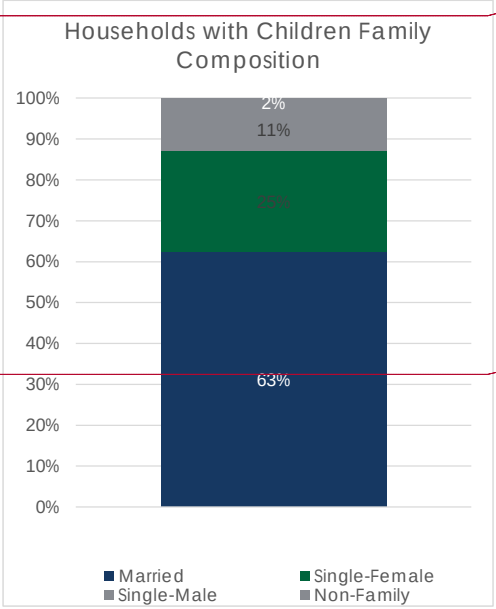
WHY IT MATTERS

Psychosocial and physical health are largely influenced by human relationships. Families are a primary means of relationships and social connectedness. Family connectedness is identified as an essential protective factor for child and adolescent health outcomes including preventive health care and guidance in behaviors that influence health.

IN ESSEX COUNTY

The average household size in Essex County (2.32) is slightly smaller than NYS (2.63).

The majority of families with children, 63% include a married couple. Single, female parents account for 25% of families with children; 11% are single, male parents. Two percent (2%) are non-family households.



Commented [JDB43]: (HP 2020/CDC/KWIC)

Commented [JDB44]: Communities Engagement Network/Census

Foster Care

WHY IT MATTERS

Children removed from families and admitted to foster care have often been exposed to health risks such as poverty, substance abuse, parental neglect and abuse. Children experience change and loss including parents, siblings, friends and community.

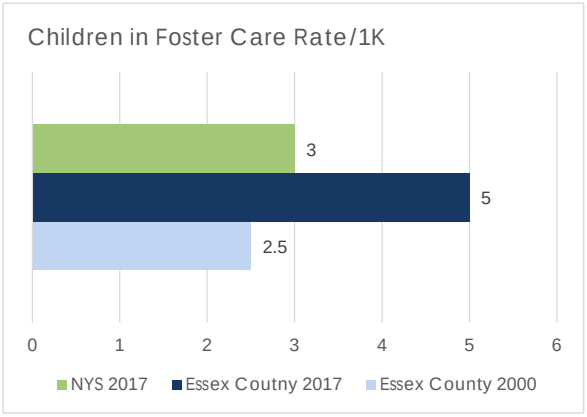
Fostering provides safety, stability & nurturing for children who often experience complex and serious problems. Yet these children still experience additional risks for medical, emotional, mental, behavioral, developmental, educational, and other health issues.

Commented [JDB45]: KWIC

IN ESSEX COUNTY

In the year 2000 there were 12 children admitted to Foster Care (a rate of 1.6/1K). Assessed again in 2017 data demonstrates 27 children admitted for Foster Care in Essex County (rate of 3.1/1K) and higher than the same-year NYS rate of 1.7/1,000.

Foster Care children in care rate increased from 2.5 in 2000 to 5.0 in 2017; double and surpassing the NYS rate of 3.0. (KWIC)



Education

Early Childhood Education and Development

WHY IT MATTERS

Early childhood education, such as provided through licensed day care and early childhood programs, is closely connected to cognitive, social and emotional development with life-long lasting impacts.

IN ESSEX COUNTY

Adirondack Community Action Program (ACAP) operates both Early Head Start and Head Start programs. These programs promote school readiness of children under 5 from low-income families through education, health, social and other services.

1,455
Children Ages 0-5

ACAP is funded to provide services for 72 Early Head Start children and 125 Head Start children.

These programs are conducted through home and center-based (Pre-K Collaboration) options.

Essex County Health Department facilitates an **Early Intervention Program** for children ages birth-3 with confirmed disability or established developmental delay. The program serves an average of 69 children each year (2015-2018) through in-home or center-based services.

The Health Department facilitates a **Preschool Program** for children ages 3-5 who continue to need interventions to support their development. The program serves an average of 117 children each year (2015-2018) through in-home or center-based services.

The Health Department also facilitates a **Children with Special Healthcare Needs Program** for children ages birth – 21 years who have a probable or diagnosed serious chronic physical, developmental, behavioral or emotional conditions needing services in an amount or type that exceeds those typically required by children. More than half of the children in the program are between the ages of 1 and 5. The program typically serves under 20 children per year.

These programs collaborate with private agencies, independent service providers, ACAP, school districts and transportation agencies to ensure youngsters receive interventions needed to progress in their whole-person development.

Commented [JDB46]: Hp2020

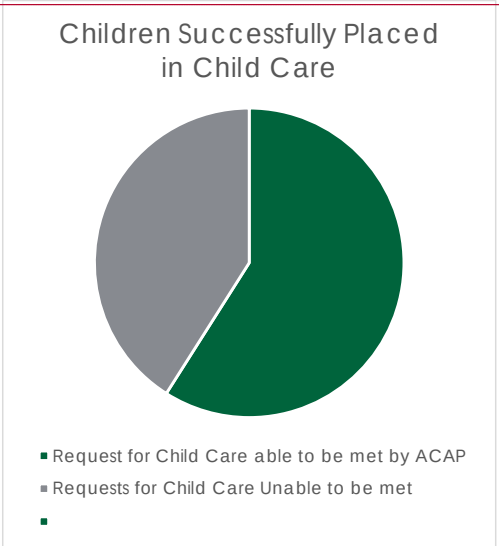
Commented [JDB47]: (ACAP Community Impact Report 2018)

Commented [JDB48]: (ECHD)

Child Care

Commented [JDB49]: ACAP CA report 2019

Adirondack Community Action Program (ACAP) is the local center for training, advocacy, education and referral management of child care.



Child Day Care Snapshot 2018

36	licensed/registered providers
21	legally exempt providers
1	small day care center
157	# children referred/need care
59%	% children successfully placed

Childcare was the 2nd most frequently identified need of community survey respondents in the 2018 Adirondack Community Action Program (ACAP) survey.

Availability and cost were identified by survey respondents as primary reasons for not using licensed/registered providers leaving those families turning to alternate care scenarios.

Preschool and Afterschool Care

Preschool and afterschool program availability was assessed by school district and reveals a combination of operationalizing this need. This includes programs operated by ACAP, the school district, and private and/or town-operated programs as depicted below.

Preschool and Afterschool Care Availability by District

Public Districts K-12	Universal PreK	Afterschool	Operated by
Ausable Valley*	✓	✓	ACAP
Boquet Valley	✓	✓	ACAP
Crown Point	✓	✓	District
Keene	✓	✓	District
Lake Placid	✓	✓	Private
Minerva	✓	✓	District
Moriah	✓	✓	ACAP
Newcomb	✓	✗	District
Saranac Lake*	✓	✓	Private
Schroon Lake	✓	✓	ACAP
Ticonderoga	✓	✓	Private & Town
Willsboro	✓	✗	District

Commented [JDB50]: ECHD – Children's Services

* Ausable Valley and Saranac Lake districts are just outside Essex County and serve Essex County residents.

Private Pre-schools include:
Lakeside School at Black Kettle Farm (a combined program for birth-3 years olds; Prek-K for 3.5-6 years olds plus early education for children in grades 1-3) and Little Peaks (for 3-5 year olds) in Keene.

K-12 Education and High School Graduation

WHY IT MATTERS

Commented [JDB51]: HP 2020

Continuous quality education supports short & long term educational attainment, earning potential, health behaviors and health outcomes. Students without basic reading proficiency, those living in poverty, and those who become pregnant during high school are less likely to achieve while in school and graduate.

IN ESSEX COUNTY

Commented [JDB52]: NYSED

K-12 Students & Schools

3,618 K-12 Aged Students

11 Public School Districts

0 Charter Schools

4 Private Schools
Lakeside School at Black Kettle Farm (K-3)
North Country School (4-9)
Mountain Lake Academy (8-11)
National Sports Academy (8-12)
Northwood School (9-12)

4 Religious Schools
Adirondack Christian School (K-11)
Mountainside Christian Academy (PreK-12) – Closed in 2019
St. Agnes School (K-6)
St. Mary's School (K-8)

ELA and Math Proficiency

Students in grades 3-8 demonstrate English Language Arts (ELA) proficiency at 41% compared to the NYS at 45% for the 2018-2019 school year.

Subpopulations with scores less than comparison counterparts include students that are:
* Male * Multi-racial, Hispanic or Latino
* Disabled * Economically Disadvantaged or
* in Foster Care.

Students in grades 3-8 demonstrate mathematics proficiency
at 39% compared to NYS at 46% for the 2018-2019 school year.

Subpopulations with scores less than comparison counterparts include students that are:
* Male * Black or Hispanic or Latino
* Disabled * Economically Disadvantaged * Homeless.

High School Graduation

WHY IT MATTERS

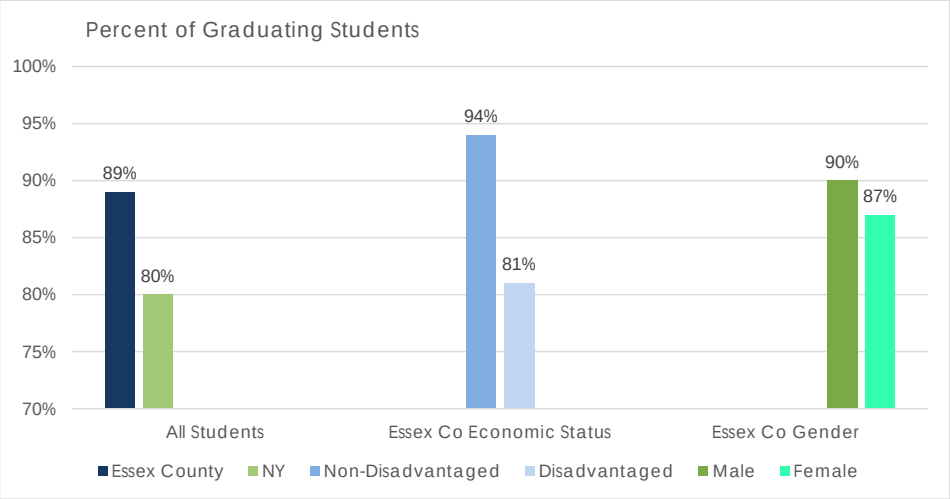
High School graduation is important for employment and earning opportunities across a lifetime. Student success is often the result of complex interactions including family, school and community context.

Commented [JDB53]: (HP2020)

IN ESSEX COUNTY

Graduation disparities in Essex County exist between economic status and gender. A higher percent of non-economically disadvantaged students graduate than economically disadvantaged students and a higher percent of male students graduate than female students.

Commented [JDB54]: NYSED



2018 Graduation Rates (2014 cohort)			
Public Districts K-12	Total # Students	Non-Economically Disadvantaged	Economically Disadvantaged
Crown Point	264	88%	85%
Elizabethtown-Lewis*	247	100%	56%
Keene	171	100%	100%
Lake Placid	647	100%	82%
Minerva**	97	100%	-
Moriah	676	96%	78%
Newcomb**	77	86%	-
Schroon Lake	237	100%	90%
Ticonderoga	745	88%	84%
Westport*	209	100%	83%
Willsboro**	248	79%	-

* Elizabethtown-Lewis CSD and Westport CSD merged to create a new district, Boquet Valley, starting the 2019-2020 school year. This merge was driven by declining enrollment, fiscal insecurity and incentives by NYS Department of Education.

** Graduation rate is listed as All for these districts because of the small number of students; no subcategories are available. Residents also attend neighboring districts of Saranac Lake and Ausable Valley.

Adult Literacy

WHY IT MATTERS

Adult Literacy includes oral, print, numeric, cultural and conceptual knowledge and communication skills. Such skills are important precursors to many aspects of life including knowledge access and higher educational attainment, employment, and ability to engage in preventive and health care across life.

Commented [JDB55]: HP 2020

IN ESSEX COUNTY

The National Assessment of Adult Literacy estimates that in 2003 (the most recent data available, 12% of Essex County residents lack basic prose literacy skills; an increase from the 1992 estimate of 11%.

Higher Educational Attainment

WHY IT MATTERS

Commented [JDB56]: HP 2020

Higher Educational Attainment is associated with improved economic security and health outcomes. Higher education equates to:

- better paying jobs with less risks
- increased ability to invest in health promoting
- goods and services
- improved ability to save for the future
- better housing in healthier communities
- more reliable transportation
- improved mental/psychological health
- increased socialization & community connection
- increased participation in leisure time activity and healthy living
- increased use of preventive health care
- increased ability to understand and follow healthcare treatment regimens.

IN ESSEX COUNTY

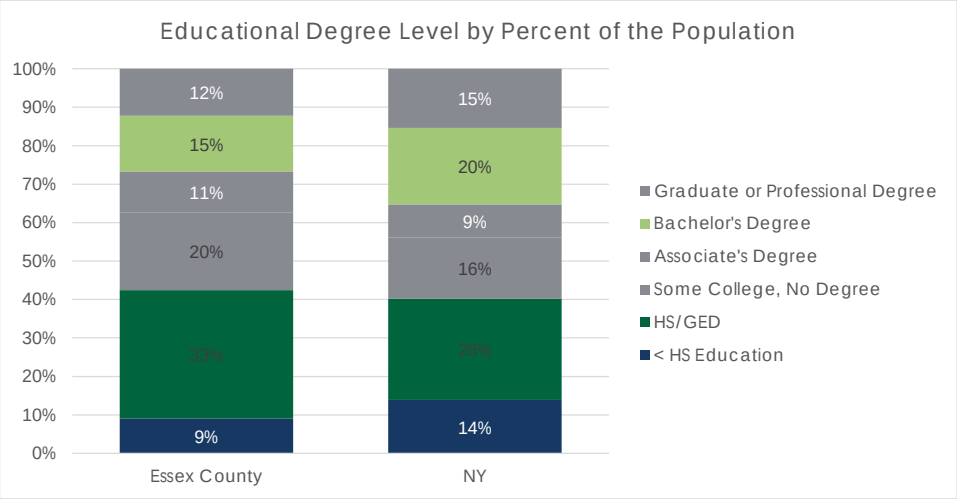
Higher Education Opportunities in the Region

The North Country Community College main campus is in Saranac Lake, a shared village of Essex and Franklin Counties, with an extension campus in Essex County's Ticonderoga.

Clinton Community College in Plattsburgh is a nearby option for students. The SUNY College of Environmental Science and Forestry has a campus in southern Essex County. Other North Country regional SUNY colleges include Adirondack to the south in Glens Falls; Plattsburgh to the north; Canton and Potsdam to the west.

Private colleges in the region include St. Lawrence University, Clarkson University, and Paul Smith's College of Arts and Science. Students also venture to nearby Vermont to colleges and universities in Burlington and Middlebury.

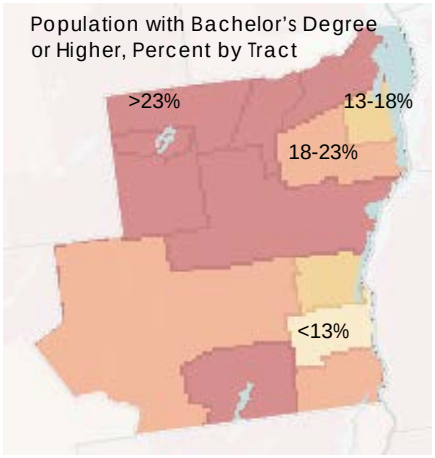
Essex County residents compare better than the state for residents aged 25 and older with less than a High School Education and Associate's Degree though not as many residents complete Bachelor's, Professional or Graduate level Degrees.



Commented [JDB57]: US Census/ACS 2013 -2017 And Cares Engagement Network map

The map to the right demonstrates the percent of the population by town.

When comparing Educational Attainment with Median Family income by community one can see a similar alignment of higher education aligning with higher income (See p. ??).



Neighborhood and the Built Environment

Housing

WHY IT MATTERS

Affordability, neighborhood context, stability, and quality are identified as housing pathways known to impact health outcomes and costs.

49%
said **Affordable Housing** is important to a strong, vibrant & healthy community.

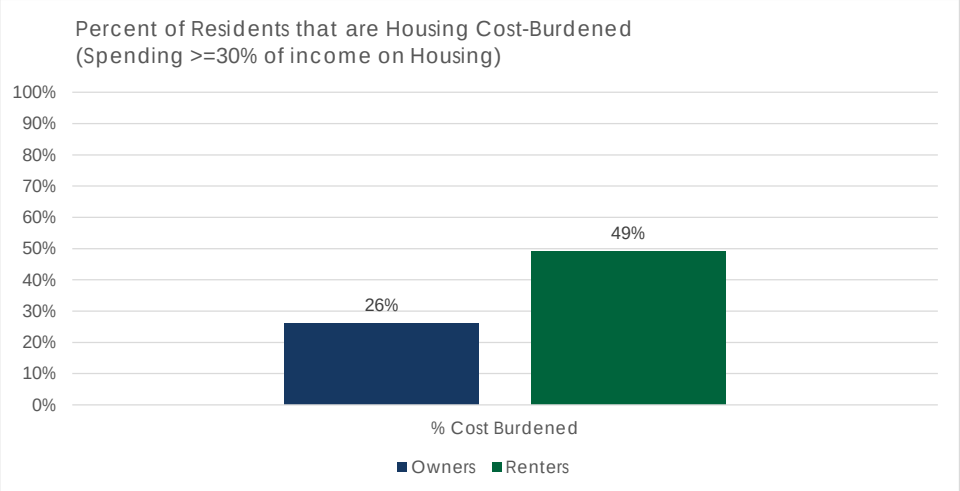
IN ESSEX COUNTY

Affordability:
Approximately ¼ of homeowners are considered cost-burdened by housing; that is, spending over 30% of income on housing. This burden is more widely experienced by renters as approximately ½ of renters are so burdened.

	Own	Rent
% Occupied	76%	24%
Cost	$15,108	$8,736
Cost ≥ 30% income	26%	49%

Housing burden equates to:

* difficulty affording basic necessities
* increased physical and mental distress
* inability to purchase health-generating goods
* inability to financially invest in the future.
* hardship in affording health care.



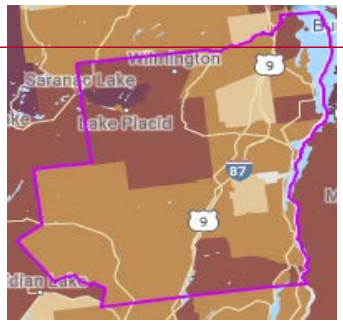
Commented [JDB58]: Source (a) from previous version

Commented [JDB59]: (b) previous doc & census.

Home sale prices increased substantially in Essex County from 2006-2016 from a median price of $140K to $175K. In the North Country region this is one of the greatest increases during this time frame. This trend negatively impacts housing ownership affordability for residents. Ownership impacts stability and security of residents and economic stability of the community as a whole.

The maps at right depict average monthly owner and renter costs by community.

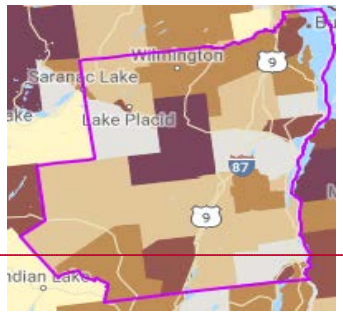
Average owner costs (map to the right top) are highest in the Village of Lake Placid and towns of North Elba, Bloomingdale, Wilmington, areas of Keeseville, Essex and Schroon; lowest in the Town of Lewis and portions of Moriah.



Owner Costs/ Community
average monthly

< $700
$700-1000
$1000-1,300
$1,300-1,800
$1,800+

The highest average renter costs (map to the right bottom) are in the Town of Keene followed by portions of Schroon and Keeseville.



Renter Costs/ Community
average monthly

< $600
$600-750
$750-925
$925-1,200
$1,200+

Neighborhood context: Discrepancies of affordability by community exist within the county for owning and renting.

56% of Stakeholders identified

Neighborhood & Built Environment to be excellent or close to excellent.

Quality: Essex County housing is younger than that of the region & NYS with 43% being under 50 years in county compared to 32% in state.

Stability: Housing vacancy in Essex County is increasing and currently estimated at 41% compared to 11% in NY state.

Security: Those experiencing housing insecurity is improving with a current rate of 29% in Essex County compared to 35% in NY. However residents identify the need for senior housing options.

"There is no housing option for HEALTHY seniors."

Commented [JDB60]: NC economic profile

Commented [JDB61]: (c) from previous version

Commented [JDB62]: Cares Engagement Network

Commented [JDB63]: (38)

Commented [JDB64]: Census

Commented [JDB65]: Census

Commented [JDB66]: Census

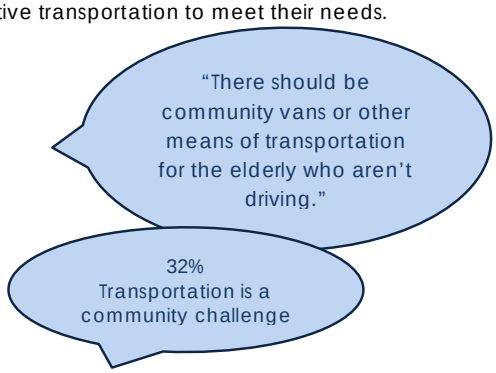
Transportation

WHY IT MATTERS

Essex County can be described as a sparsely populated, rural community with limited public transportation and ability for residents to use active transportation to meet their needs.

Transportation is tightly related to other social determinants of health including:

* access to employment & higher education
* access to resources to meet daily needs, engage in wellness & maintain community connections
* access to health services and
* costs as % of family income.



IN ESSEX COUNTY

Transportation was one of the most frequently identified social challenges by residents through the Resident Survey and Stakeholders through the Distributed Focus Group.

Average Costs and Economic Impact[26]

Annual household costs include vehicle ownership/lease, maintenance & fuel. The percent of household income that Essex County residents spend on transportation, 28%, exceeds what is considered affordable, 15% or less of income.

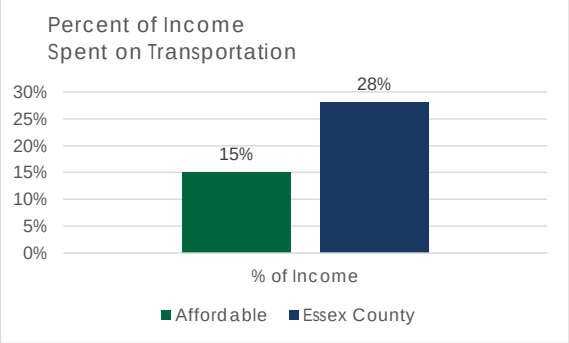
$14, 653	Annual Household Cost
2	vehicles/household average
23,791	vehicle miles travelled/year

Commented [JDB67]: (38)

Vehicle Availability[1]

Residents largely rely upon personal vehicles for transportation with about 93% of families having one or more vehicles available to them; nearly 20% higher than the NY average of 71%.

% of Households	Essex	ARHN Region	NY
0 vehicles	7.5%	8.5%	29.0%
1 + vehicle	92.5%	91.5%	71%



Public Systems- Bus and Rail

Commented [JDB68]: https://www.co.essex.ny.us/wp/transportation/

Essex County Transportation Department operates 9 buses on 4 regular routes within the county and coordinates with inter-county routes to Plattsburgh in Clinton County and Saranac Lake in Franklin County.[1] This service provides limited relief for reliance upon personal vehicles for resident needs.Long-trip, limited service passenger railway running North-South along the Lake Champlain valley and partial railway tourism routes equate to extremely limited use of railway transportation as a regular transportation option for residents.

Broadband

WHYT IT MATTERS

Access to high speed internet has increasingly become recognized as an important and even super-determinant of health. This is because it influences other social determinants of health – with education and employment at the forefront. It is also necessary for healthcare services, access to healthcare and community economic development.

It is recognized that the digital divide is severe in rural communities, such as Essex County. Those that are older, have lower levels of education and income are less likely to have broadband access at home.

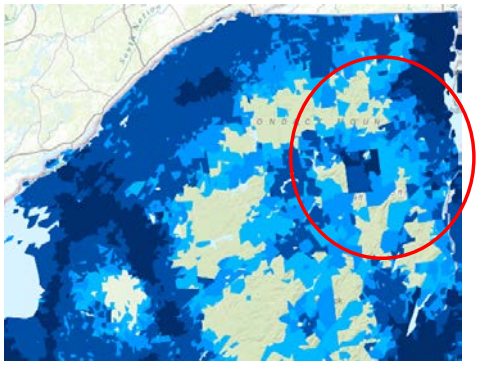
Access is complex with factors including

- Coverage
- Type of Service/Technology
- Providers
- Price
- Speed

IN ESSEX COUNTY

Availability in Essex County varies (see map on the right) with increased accessed in population hubs including the Lake Champlain and Lake Placid areas and no or limited access in the south-west region of the county.

LGE Coverage by Number of Providers-2017



Households with Computer

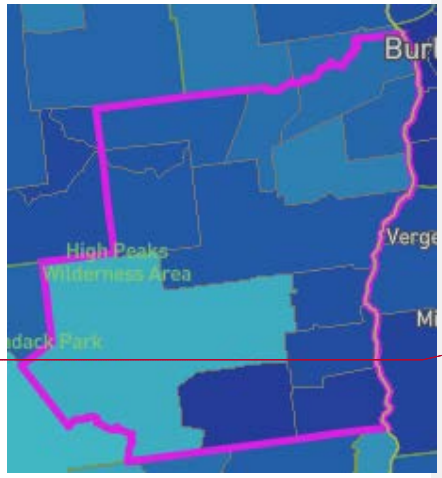
85% Essex
87% NY

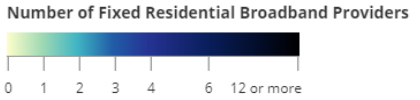
Households with Internet Subscription

Dial-up, cable, fiber optic, DSL, Satellite or other

75% Essex
79% NY

14 Providers in Essex County





The connection of broadband and health will continue as an area of exploration with further visual overlay of broadband and health data at the national, state and county levels.

Commented [JDB69]: Law = https://www.networkforphl.org/the_network_blog/2018/07/17/1017/broadband_access_as_a_super-determinant_of_health

Commented [JDB70]: Federal Communications Commission https://www.fcc.gov/reports-research/maps/

Commented [JDB71]: FCC

Food Access

WHY IT MATTERS

Access to healthy foods support health over the course of a lifetime and lower risks for chronic conditions. Conversely, inability to access healthy foods or abundant access to unhealthy foods and beverages can increase risk for chronic conditions and decrease quality of life. People that are low-income and have limited transportation experience the greatest barriers to healthy foods. Older adults living in rural communities are also identified as an at-risk sub-population.

Commented [JDB72]: (HP2020)

IN ESSEX COUNTY

More recent than data depicted in the map (right) identifies the continued closure of grocery store chains in the county; most recently in the Village of Port Henry/Town of Moriah in 2019. Newcomb, Minerva and North Hudson are considered food deserts given there are no such establishments within 10 miles. Some communities have smaller family-owned establishments that fill the gaps for residents.

Commented [JDB73]: (CaresEngagementNetwork)

3,630 Residents are Food Insecure

9.5% Essex County
11.4% NYS

Commented [JDB74]: Feeding America https://www.feedingamerica.org/

7 **Chain Grocery Stores** include Tops Market (4); Hannaford (1); Price Chopper (1); Walmart (1).

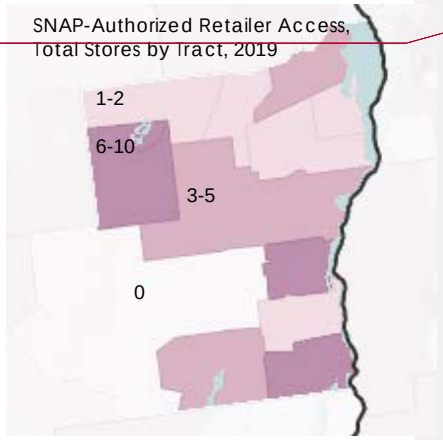
42 **SNAP Retailers** include grocery stores, convenience stores and others (Dollar stores).

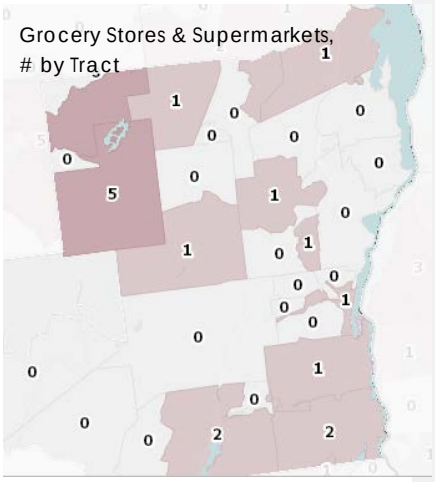
6 **WIC Vendors** are grocers that meet stocking requirements for WIC-approved healthy foods.

7 **Farmers' Markets** sell local produce, meats, dairy and artisan goods at outdoor markets.

17 **Food Pantries** are faith-based and independently operated organizations with unique policies and practices for distribution. Only a few partner with the Regional Food Bank.

10 **Better Choice Retailers** are locally owned marts that achieve minimal stocking requirements for healthy foods in a variety of food groups.





Tobacco

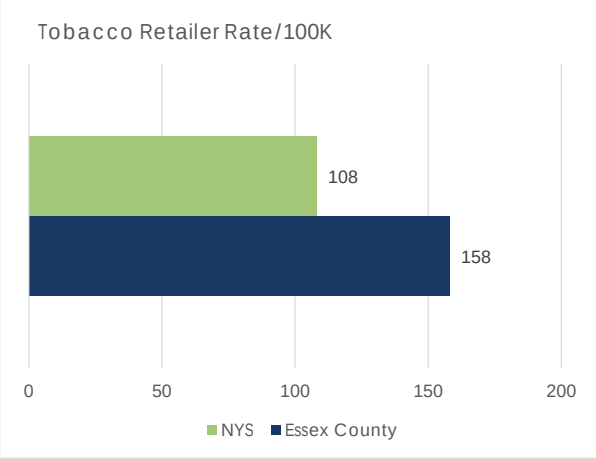
WHY IT MATTERS

Smoking is the leading cause of chronic disease including lung disease, heart disease & stroke. Retail availability supports social norms of tobacco use, increases point of sale advertising, increases accessibility and availability of products, increases brand recognition and perpetuates social environmental inequities. Limiting tobacco vendors is just one piece of a comprehensive tobacco control program.

Commented [JDB75]: Counter Tobacco https://countertobacco.org/

IN ESSEX COUNTY

There are 57 Tobacco Retailers in Essex County.
This equates to a rate/100K of 158; higher than the NY rate of 108.



Town	# Retailers
Chesterfield	1
Crown Point	1
Elizabethtown	5
Essex	0
Jay	2
Keene	2
Lewis	2
Minerva	2
Moriah	8
Newcomb	0
North Elba	14
North Hudson	1
St. Armand	1
Schroon	4
Ticonderoga	8
Westport	3
Willsboro	2
Wilmington	1
TOTAL	57

Public Water Systems

WHY IT MATTERS

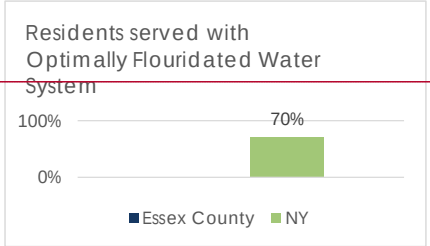
Commented [JDB76]: CDC

Public water supplies are protected from sources of contamination such as naturally occurring chemicals/minerals and biologicals, land use practice elements, manufacturing process elements and sewage. Community water fluoridation has been used for over 70 years as a means to prevent tooth decay and improve oral health.

IN ESSEX COUNTY

Commented [JDB77]: NYSDOH CEH https://www.health.ny.gov/environmental/water/drinking/

21	public water systems
0	include water fluoridation systems
31,513	people served by these systems



Natural Environment

WHY IT MATTERS

Air quality, water pollution and heat are three environmental factors identified as having significant impacts on human health with an estimated 11% of deaths in the US due to environmental causes.

Outdoor air pollutants include ozone and particulate matter; indoor air pollutants may be associated with housing-related exposures such as insects, rodents and tobacco.

Groundwater pollutants include exposure to septic, landfill and agricultural runoff and include waterborne diseases.

Hottest Days on Record have been in the most recent decade as reported the National Oceanic and Atmospheric Administration.

Commented [JDB78]: (NOAA).

Vulnerable populations including the very young and very old and those with existing chronic health conditions are at increased risk for environmental health risk exposures. Economically disadvantaged communities are at increased risk of environmental health hazards.

Commented [JDB79]: (HP2020)

IN ESSEX COUNTY

Air Quality

0 Unhealthy Ozone/ Particulate Matter Days

Commented [JDB80]: ARHN Data Sheets

Water Quality

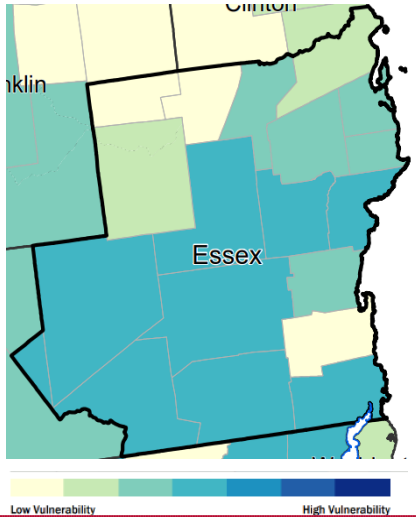
The 21 public water systems in Essex County are monitored locally with support by the NYSDOH District Office that covers Essex, Franklin and Hamilton Counties.

Heat

NYSDOH developed a Heat Vulnerability Index (HVI) to help local jurisdictions identify and map local communities where vulnerable populations exist based on 4 categories:

* Language,
* Socio-Economic,
* Environment and
* Elderly.

The map on the right depicts a combined HVI score by town in Essex County.



16 Designated cooling centers in Essex County

Commented [JDB81]: ECHD

During the 2019 year Essex County Health Department partnered with the Clinton-Essex-Franklin Library System to Designated Cooling Centers at 16 local libraries in Essex County.

Climate and Health

WHY IT MATTERS

Part of the natural environment in which we live includes climate and effects of climate change on human health. The Centers for Disease Control and Prevention (CDC) identify 8 categories in which a changing climate impacts human health:

- Severe Weather
- Extreme Heat
- Air Pollution
- Change in Vector Ecology
- Water Quality Impacts
- Increasing Allergens
- Water and Food Supply Impacts
- Environmental Degradation

Climate Change was the #3 Environmental Health issue identified in the Community Survey

Climate Smart Communities Pledge

100%	Essex County
36%	NY

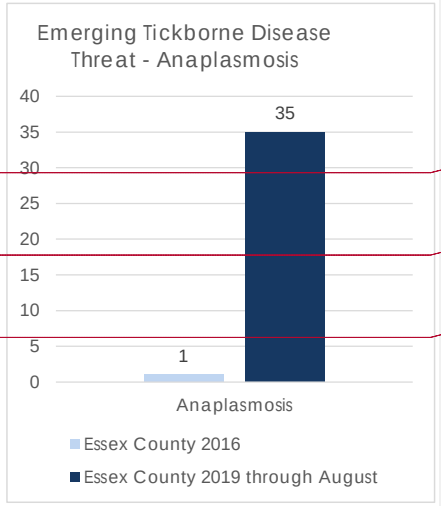
IN ESSEX COUNTY

Essex County has experienced the effects of a changing climate. Highlighted here are:

* **Change in Vector Ecology** - tick-borne diseases

* **Water Quality Impacts** - harmful algae blooms

* **Severe Weather** - disaster declarations



Tickborne diseases

Tick surveillance conducted by NYSDOH in Essex County during the 2017 year revealed that Lyme-Disease infected ticks continue to be a public health threat in Essex County.

Emerging public health threats due to pathogen-infected ticks include Anaplasmosis and Babesiosis.

With only 1 confirmed case of Anaplasmosis in 2016, the 2019 case number through only August of 2019 demonstrates this emerging threat locally. Case of Babesiosis remain less than 10.

Vector-borne diseases was the #1 Environmental Health issue identified in the Community Survey

Commented [JDB82]: Essex County Health Department & NYSDOH

Commented [JDB83]: NYSDOH

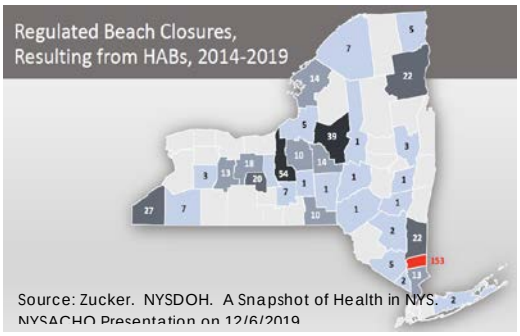
Commented [JDB84]: Community Engagement Network

Commented [JDB85]: NYSDOH Letter to ECHD Director, April 2018

Harmful Algae Blooms

Notable increases in reports of Harmful Algae Blooms (HABs) have occurred since the 2016 assessment. HABs are an increasing public health risk throughout NY and Essex County.

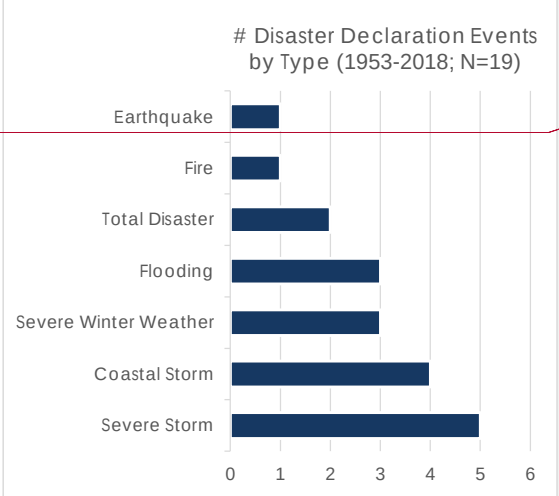
From 2014-2019 there were 22 beach closures due to HABs in Essex County. This is important for humans and economic health [given the recreation-dependent economy of Essex County].



Stream, river & lake quality was the #2 Environmental Health issue identified in the Community Survey

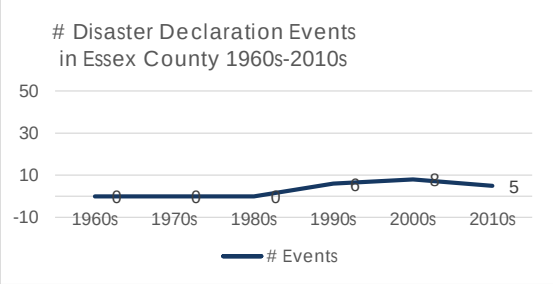
Disaster Declarations

Disaster events and declarations are only those events of a magnitude that exceeds combined capacities of local and state governments; not all severe instances of weather events able to be addressed with local/state resources.



Commented [JDB86]: Community Engagement Network

Disaster declarations have increased over an extended period of time from the 1960s through the 2010s as depicted at right with severe storms being the most common type of disaster locally.



Economic Stability

Local Economy

WHY IT MATTERS

Work is a fundamental aspect of people's lives impacting the personal physical, psychological and social well-being of workers and their families.

It influences:
* health insurance and health care access;
* food, housing and transportation resources;
* household expenses (taxes, childcare, technology and recreation) resources; and
* financial investment and savings capacity.

IN ESSEX COUNTY

The USDA Economic Research Service typology codes classifies Essex County is as economically dependent on **Government** & **Recreation** from 6 types of 1) farming, 2) mining, 3) manufacturing, 4) Federal/State government, 5) recreation, and 6) nonspecialized counties.

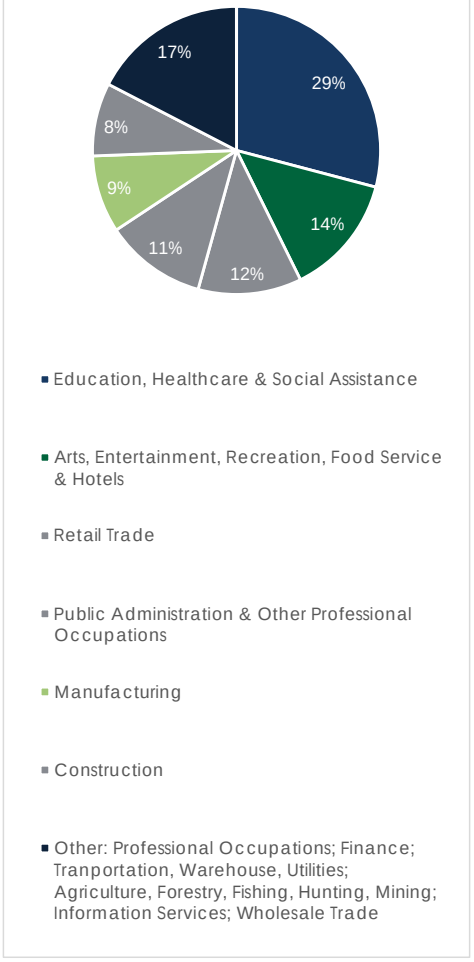
Government-dependence is based on the percent of jobs or earnings from fed/state government. Recreation-dependence is based upon measurement of jobs & earnings in relevant sectors plus dedicated seasonal housing.

Essex County does not meet thresholds for classification within any of the policy-relevant types: 1) low education, 2) low employment, 3) persistent poverty, 4) persistent child poverty, 5) population loss, and 6) retirement destination.

Economic Dependence

Government

Recreation



Commented [JDB87]: (CaresEngagementNetwork to Source: USDA)

Adequate Income and Poverty

WHY IT MATTERS

Adequate incomes help people:
* avoid stress and feel in control,
* access experiences and material resources,
* adopt and maintain healthy behaviors, and
* feel supported by a financial safety net.

It allows people to pursue higher education, engage in meaningful work, find secure housing, access healthy foods, and live with improved mental health.

Household Survival Budget - Essex, New York, 2016

	Single Adult	2 Adults, 1 Infant, 1 Preschooler
Housing	$532	$844
Child Care	$0	$1,250
Food	$182	$603
Transportation	$341	$682
Health Care	$213	$792
Technology	$55	$75
Miscellaneous	$158	$491
Taxes	$262	$664
Monthly Total	$1,743	$5,401
ANNUAL TOTAL	$20,916	$64,812
Hourly Wage	$10.46	$32.41

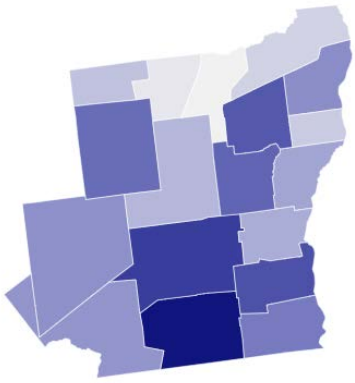
Source: U.S. Department of Housing and Urban Development; U.S. Department of Agriculture; Bureau of Labor Statistics; Internal Revenue Service; Tax Foundation; and New York State Office of Children & Family; 2016.

ALICE=

Asset Limited, Income Constrained, Employed

ALICE individuals and families are working with an income above the federal poverty level but below a sustainable wage.

The bare minimum cost of living in the modern economy, as estimated by a Household Survival Budget (depicted right) continues to increase.
The Survival Budget does not include savings making it difficult for families to cover unexpected expenses or contribute to financial investments for the future such as college or retirement.



IN ESSEX COUNTY

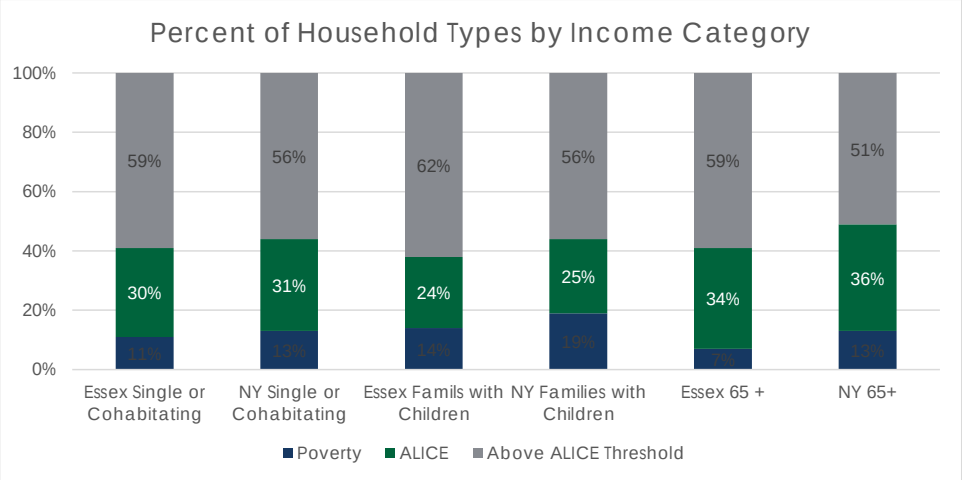
Geographic analysis demonstrates the greatest percent of ALICE households to be in the Village of Witherbee (73%) and Port Henry (53%) both in the Town of Moriah followed by the Town of Schroon at 52%.

Analysis of the percent of households by the types of income categories reveal:

- the highest percent of people living in poverty in Essex County are families with children (14%) followed by people that are single or cohabitating (11%) and seniors of age 65 and older (7%); and
- the highest percent of people meeting the ALICE threshold in Essex County are seniors of age 65 and older (34%); followed by people that are single or cohabitating (30%) and families with children (24%).

Analyzing the data by the percent of household types that are living in poverty or meeting the ALICE threshold reveals the following:

- 41% of people that are single or cohabitating
- 38% of families with children
- 41% of seniors of age 65 and older



Unemployment and Poverty

The unemployment rate demonstrates a decrease in Essex County; currently 3.8%. This is near the Adirondack Region at 3.7% and better than the NY average at 4.3% Other indicators for poverty reveal Essex County fairs better than NYS for children living below poverty, children & youth receiving SNAP or Public Assistance, the percent of individuals receiving Medicaid and the per capita Medicaid expenditures.

INDICATORS	Essex County	NY
Children & Youth Living Below Poverty	16.8%	19.9%
Children & Youth Receiving SNAP (rate)	17.7	24.5
Children & Youth Receiving Public Assistance	2.1	6.3
Individuals receiving Medicaid	20.4%	24.8%
Per capita Medicaid expenditures	$8,028	$9,670

Commented [JDB88]: ARHN Data Sheets

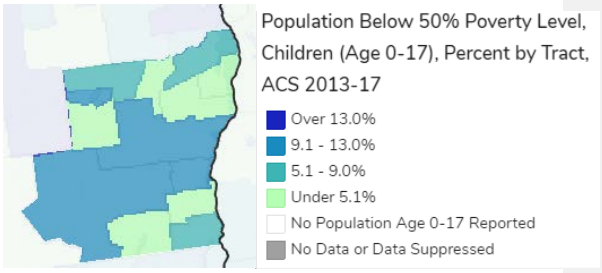
Poverty by Age Ranges and Geography

Poverty threshold levels are federally determined and vary by family size and composition.

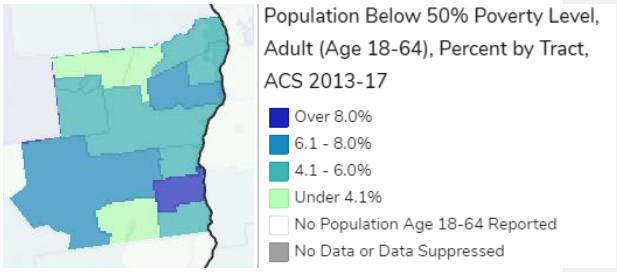
The following three figures provide a visual display of the percent of people living 50% below the federal poverty level based on township. It is notable that the use of color in these visual displays represent different percent ranges for each image. For example, the darkest color for children is equal to 13+%, for adults ages 18-64 8+% and for seniors aged 65+ over 3%.

Commented [JDB89]: CaresEngagementNetwork

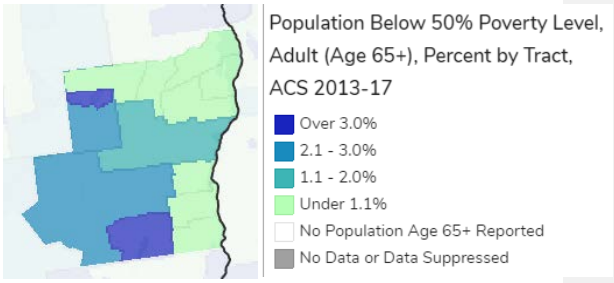
The percent of children living in poverty are lowest (under 5.1%) in the towns of North Elba, Jay, Lewis, Willsboro, Schroon and Crown Point. There are no townships where 13% or more of the children ages 0-17 are in poverty.



The lowest percent of adults ages 18-64 living in poverty (under 4.1%) are in the towns of Bloomingdale, Wilmington, Jay and Schroon Lake. The highest (over 8%) is in the Town of Crown Point.



The lowest percent (under 1.1%) of adults in poverty are in the towns of Bloomingdale, Wilmington, Jay, Chesterfield, Lewis, Willsboro, Moriah, Crown Point and Ticonderoga. The highest percent (over 3.0%) is in the Village of Lake Placid and the Town of Schroon.



SECTION 3: ASSETS

Asset identification was conducted as the final initiative of Step 1: Assess Needs and Resources of the Take Action Cycle.

Assets are identified as resources available to the community that can be mobilized to address community health needs and contributing factors.

For this Section of the CHA, ***Essex County Health Partners*** categorized assets as:

- Healthcare System
- Coalitions and Committees
- County Government Departments
- Community Based Organizations
- Media
- Law Enforcement
- Education Systems
- Religious Groups
- Local Programs and Grants, and
- New York State Health Department and Associations.

These categories were considered across NYSDOH Prevention Agenda Priority Areas and the cross-cutting disparity for Essex County residents; Access to Healthcare.

This information was organized into an Asset Matrix (following).

Essex County Health Partners recognize the benefit of additional asset mapping including broader considerations such as programs and policies directly or indirectly influencing health and as related to additional Social Determinants of Health.

Asset identification was an essential part of informing priority selection as described further in the next Section; Section 4: Focusing on What's Important.

Asset Matrix		KEY: Engaged in the development of the CHA & CHISP.	KEY: Resources available to mobilize in addressing community health.					
			Prevention Agenda Priorities & Cross-Cutting Disparity in Essex County					
Asset Type	Name	Description	Chronic Diseases	Healthy & Safe Environment	Healthy Women, Infants & Children	Well-Bring & Mental/ Behavioral Health	Communicable Diseases	Access to Healthcare
Healthcare System	Adirondack Health-Adirondack Medical Center	Population Health Committee	■	■	■	■	■	■
		Decker Learning Center for Health Education	■	■	■	■	■	■
		Health Centers - Providers & Wellness Coaches	■	■	■	■	■	■
		Physical, Occupation & Speech Therapy Programs		■				■
		Car Seat Technicians & Car Seat Clinics		■				■
		Women's Health Clinic			■			■
		Breast Program: Breast Health Navigator	■					■
		Certified Lactation Consultants			■			■
		clinics.			■			■
		Antibiotic Stewardship Program					■	■
		OD Reversal Program				■		■
		Buprenorphine Clinic				■		■
		Medication Drop Box				■		■
		Dr. First Pharmacist-Led Medication Reconciliation				■		■
		Respiratory Therapy Program	■					■
		Oncology	■					■
		Weight Management Program	■					■
		Medical Fitness Program	■					■
		Fit for Life (Medically-Supervised Activity)	■					■
	UVHN-Elizabethtown Community Hospital	Population Health Committee	■					■
		Health Centers - Providers & Social Workers	■	■	■	■	■	■
		Diabetes Educator, Prevention Program, Support Group	■					■
		Cancer Screenings & Events; Chemo infusion Therapy	■					■
		Physical, Occupation & Speech Therapy Programs	■					■
		Nutritionist, Wellness Rx Program & co-located food pantries	■		■			■
		Wellness Program	■		■			■
		Tobacco Cessation Specialists	■		■	■		■
		Pulmonary & Cardiac Rehabilitation Programs	■					■
		Breastfeeding- Friendly Health System			■			■
		Stop Domestic Violence Program			■			■
		Specialty Care Outpatient Clinics	■		■	■		■
		Opioid Stewardship & MAT				■		■
		Medication Drop Box and Community Narcan distribution				■		■
		Ryan White Grant					■	■
		Antibiotic Stewardship Program					■	■
	Hudson Headwaters Healthcare Network		■	■	■	■	■	■
	Pharmacies					■		■
	Essex County Health Department	Public Health Advisory Board	■	■	■	■	■	■
		Public Health Unit Programs	■	■	■	■	■	■
		Children's Services Unit Programs			■			■
		WIC Unit			■			■
		Home Health Unit	■	■	■		■	■
	Adirondack Health Institute (AHI)	Adirondack Rural Health Network	■	■	■	■	■	
		(PHIP)	■	■	■	■	■	
Adult Care Facilities			■	■			■	
Nursing Homes			■	■			■	
Senior Living Facilities			■	■			■	

	Adirondack Birth to Three Alliance				■			■
	Essex County Breastfeeding Coalition		■		■			
	Well Fed Essex County Collaborative		■					
	Essex County Drug Court				■	■		■
	Essex County Heroin & Opioid Prevention Coalition (ECHO)			■	■	■	■	■
	Coalition				■	■		
	Essex County Community Services Board					■		
	Essex County Human Services Committee	Sub-Committee of the Board of Supervisors				■		
	Human Services Coalition	Committee of ACAP				■		■
	Essex, Clinton, Franklin Immunization Action Plan Coalition						■	■
	Essex, Clinton, Franklin Lead Poisoning Prevention Coalition				■			
	Safe Kids Adirondack				■			
	Local Emergency Planning Committee			■	■		■	
	Housing Coalition				■	■		■
	Rural Communities Opioid Response Planning (RCORP)				■	■		
County Government Departments	Mental Health					■		■
	Department of Social Services				■	■		■
	District Attorney					■		■
	Office for the Aging		■			■		■
	Public Works & Transportation		■	■				
	Sheriff					■		
	Emergency Services & EMS			■		■		■
	Community Resources/Planning		■	■		■		
	Youth Bureau		■		■	■		
	Transportation			■				■
	Veteran's Services		■			■		■
Local Government	Towns & Villages	Boards, Planning, Zoning		■				
Media		Print, Radio, TV, Social	■	■	■	■	■	■
Law Enforcement		NYSPD, Essex County Sheriff, Local				■		
Community-Based Organizations	Alliance for Positive Health		■	■	■	■	■	■
	Adirondack Foundation		■	■	■	■	■	
	The Prevention Team					■		
	Mental Health Association in Essex County					■		■
	Planned Parenthood of the North Country				■	■	■	■
	Adirondack Community Action Program (ACAP)	Human Services Coalition	■	■	■	■		
	Families First				■	■		
	North Country Healthy Heart Network (NCHHN)		■	■	■	■		
	Retired Senior Volunteer Program (RSVP)							■
	St. Joseph's Addiction Treatment & Recovery Center					■		■
	Behavioral Health Services North					■		■
	Tri-Lakes Center for Independent Living		■					■
	Mountain Lake Services		■					■
	Cornell Cooperative Extension		■		■			
	Industrial Development Association		■	■				
	Housing Assistance Program of Essex County		■	■				
	Literacy Volunteers of Essex & Franklin Counties							■
	Chambers of Commerce	Local & Regional	■	■				
	Businesses		■		■	■		
	United Way of Clinton, Essex, Franklin County							■
	One Work Source							■
	Champlain Valley Family Center		■			■		
Schools		Public, Private, BOCES, Colleges	■	■	■	■	■	
Religious Groups	Churches, Ecumenical Societies, etc.							■
Local Programs/Grants	Cancer Services Program of Northeastern NY		■					■
New York State (NYS)	NYS Association of Counties (NYSAC)		■	■	■	■	■	■
	NYS Association of County & City Health Officials (NYSACHO)		■	■	■	■	■	■
	NYS Public Health Association (NYSPHA)		■	■	■	■	■	■
	Healthcare Association of New York State (HANYS)		■	■	■	■	■	■
	Home Care Association of New York State (HCA-NYS)		■	■	■	■	■	■
	NYS Department of Health (NYSDOH)		■	■	■	■	■	■

SECTION 4: PRIORITIZATION

Step 2: Focus on What's Important

Prioritization was informed through numerous steps as taken by ***Essex County Health Partners***:

1. ***Analyzing regional and local data and contributing factors*** as documented in this CHA:

- Health Indicators (Section 1)
- Contributing Factors (Section 2)
- Community Engagement Results (Sections 1 & 2)

2. ***Identifying Disparities*** during the data analysis process:

Within Section 1: Health, disparities were identified within each priority area specific to indicators including:

- Age
- Gender
- Geography/Communities within the county
- Socio-economics as Medicaid/Non-Medicaid.

Within Section 2: Social Determinants of Health, Access to Healthcare was identified as a cross-cutting disparity for Essex County residents and include barriers of Geography, Transportation and Provider Shortages.

3. ***Identifying local assets*** that can be mobilized to address needs & disparities (Section 3).

4. ***Using a prioritization matrix*** with internal planning groups of:

- Essex County Health Department
- University of Vermont Health Network-Elizabethtown Community Hospital
- Adirondack Health-Adirondack Medical Center.

The prioritization matrix was a locally-modified version of the Hanlon Method[67] that included criteria categories of need and feasibility. The matrix was guided by asking questions regarding the scope and severity (need) of health issue and the perceived ability to impact and community readiness (feasibility) regarding addressing those health issues.

Health issues were categorized and scored following the five (5) NYSDOH Prevention Agenda[68] areas:

- Prevent Chronic Disease
- Promote a Healthy & Safe Environment
- Promote Healthy Women, Infants & Children
- Promote Well-Being and Prevent Mental Health & Substance Use Disorders
- Prevent Communicable Diseases

Internal planning groups of ***Essex Health Partners*** identified priorities as:

- Prevent Chronic Disease (3 of 3 groups)
- Promote Healthy Women, Infants & Children (2 of 3 groups)
- Promote Well-Being and Prevent Mental Health & Substance Use Disorders (3 of 3 groups)

5. ***Sharing preliminary findings and requesting feedback*** from:

- Essex County Health Department Public Health Advisory Committee (PHAC)
- Essex County Board of Supervisors (BOS)
- Essex County Community Members

6. ***Drawing a conclusion to address 3 priorities*** in the Community Health Improvement/Service Plan (CHISP):

- **Prevent Chronic Disease**
- **Promote Healthy Women, Infants & Children**
- **Promote Well-Being and Prevent Mental Health & Substance Use Disorders**

Identification of these priorities concludes Steps 1 and 2 of the Take Action Cycle and this Part II: Community Health Assessment (CHA) 2019 of the full report.

[67] https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf
[68] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/index.htm

DELETE & INCLUDE AS SOURCES DOC

---

[1] Robert Wood Johnson Foundation. County Health Rankings.
https://www.countyhealthrankings.org/

[2] NYS DOH Prevention Agenda Dashboard.
https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

[3] NYS DOH Prevention Agenda Dashboard.
https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

[4] NYSDOH Behavioral Risk Factor Surveillance System.
https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n

[5] Healthy ADK
[6] Healthy Adk
[7] NYS DOH Prevention Agenda Dashboard.
https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

[8] NYS DOH Prevention Agenda Dashboard.
https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

[9] Creating Healthy Schools and Communities FRA

[10] US Census Bureau. American Community Survey 5-year estimates.
https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2017/

[11] Kids' Well-being Indicators Clearinghouse. KWIC County Report.
https://www.nyskwic.org/get_data/county_report_detail.cfm?countyID=36031

[12] Kids' Well-being Indicators Clearinghouse. KWIC County Report.
https://www.nyskwic.org/get_data/county_report_detail.cfm?countyID=36031

[13] NYSDOH Community Health Indicator Reports Dashboard.
https://www.health.ny.gov/statistics/chac/indicators/index.htm

[14] NYS DOH Prevention Agenda Dashboard.
https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

[15] NYSDOH Student Weight Category Status Reporting Results.
https://health.data.ny.gov/Health/Student-Weight-Status-Category-Reporting-Results-B/es3k-2aus

[16] KWIC

[17] Essex County Youth Bureau. Prevention Needs Assessment 2018

[18] NYS DOH Prevention Agenda Dashboard.
https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

[19] NYS DOH Information for Action Sheet.
https://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2018-10_ifa_report.pdf

[20] NYS DOH Information for Action Sheet.
https://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2018-09_ifa_report.pdf

[21] NYS DOH Community Health Indicator Reports Dashboard/
https://www.health.ny.gov/statistics/chac/indicators/index.htm

[22] NYSDOH Behavioral Risk Factor Surveillance System.
https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n

[23] NYS DOH. Behavioral Risk Factor Surveillance System.
https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n/data

[24] NYS DOH Prevention Agenda Dashboard.
https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

[25] Alzheimer's Association. New York Alzheimer's Statistics. https://www.alz.org/alzheimers-dementia/facts-figures

[26] Center for Neighborhood Technology. https://www.cnt.org/tools/housing-and-transportation-affordability-index

FCC = https://www.fcc.gov/about-fcc/fcc-initiatives/connect2healthfcc
https://www.fcc.gov/about-fcc/fcc-initiatives/connect2healthfcc

Counter tobacco = https://countertobacco.org/policy/restricting-product-availability/

USDSA https://www.ers.usda.gov/data-products/county-typology-codes

Leading causes of death:
https://apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/reports/#county

Appendix D: ALICE Profile

ALICE is a United Way acronym that stands for Asset Limited, Income Constrained, Employed.												
Adirondack Rural Health Network	County									ARHN	Upstate NY	NYS
Summary of ALICE Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
ALICE Household Information												
Total Households	30,624	15,298	19,299	22,450	1,239	19,540	93,703	28,841	24,027	141,778	4,101,529	7,216,340
Total Households Over 65 Years of Age	8,150	5,144	4,817	6,339	544	5,484	24,083	8,898	6,738	40,630	705,081	1,839,483
Total ALICE Households	7,350	4,589	5,404	6,511	632	6,448	19,678	6,922	7,208	38,615	1,059,036	2,222,633
ALICE Households Over 65 Years of Age	2,119	1,749	1,590	2,282	261	2,468	6,502	2,936	2,291	13,408	380,182	662,214
Poverty %	15.0%	10.2%	18.2%	15.0%	12.2%	17.6%	6.8%	11.0%	12.1%	13.6%	11.3%	14.4%
ALICE %	24.4%	30.1%	27.8%	29.3%	50.7%	33.2%	21.1%	24.0%	30.4%	27.4%	28.7%	30.8%
Above ALICE %	60.6%	59.7%	54.0%	55.7%	37.1%	49.2%	72.1%	65.1%	57.5%	59.0%	60.0%	54.8%
# of ALICE and Poverty Households	12,062	6,161	8,869	9,945	779	9,928	26,181	10,079	10,204	58,099	1,640,619	3,262,043
Unemployment Rate	5.0%	7.5%	8.5%	8.0%	9.2%	8.4%	2.9%	4.6%	8.1%	n/a	n/a	n/a
Percent of Residents with Health Insurance	95.8%	93.2%	91.3%	91.4%	90.4%	91.2%	96.1%	96.5%	91.9%	n/a	n/a	n/a
Average Annual Earnings	$36,372.00	$37,128.00	$35,148.00	$32,892.00	$32,940.00	$37,704.00	$47,604.00	$40,932.00	$38,028.00	n/a	n/a	n/a
ALICE Households by Race/Ethnicity												
White	8,119	4,449	5,191	6,683	622	6,112	19,596	6,635	7,404	39,103	922,506	1,245,865
Asian	50	n/a	2	28	n/a	28	191	65	27	172	31,141	180,688
Black	122	n/a	13	32	n/a	134	255	100	14	281	125,980	433,433
Hispanic	81	33	41	156	n/a	651	425	126	200	637	134,063	494,216
2+ races	95	49	44	71	n/a	79	278	38	64	361	22,672	54,130

*Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond).

*Data in all categories except Two or More Races is for one race alone. Because race and ethnicity are overlapping categories, the totals for each income category do not add to 100 percent exactly.

(n/a) Data Not Available

Sources:

(1) American Community Survey, 2016.

ALICE Demographics:

(2) American Community Survey and the ALICE Threshold, 2016.

Wages:

(3) Bureau of Labor Statistics, 2016

Budget:

(4) Bureau of Labor Statistics, 2016a; Consumer Reports, 2017; Internal Revenue Service, 2016

(5) New York State Office of Children & Family Services, 2016; Tax Foundation, 2016, 2017; U.S. Department of Agriculture; U.S. Department of Housing and Urban Development

Community Health Assessment (CHA) Timeline 2018-2019		
Dates	Work Effort	Responsible Party
6/15/2018	CHA MEETING: Holiday Inn Lake George * Discuss beta update and CHA indicators for data table * Review Timeline and "data updates" timeline	AHI/AHRN
9/11/2018	CHA MEETING: Six Flags Great Escape Lodge *Review Scope of Services *Review 2016 Stakeholder Survey for edits *Review cleaned 2016 distribution contact list	AHI/AHRN
12/7/2018	CHA MEETING: Adirondack Health Institute/Virtual *Finalize Stakeholder Survey questions and contact list	AHI/AHRN
3/8/2019	CHA MEETING: Lake George Holiday Inn	AHI/AHRN
6/7/2019	Adirondack Health Population Health Steering Committee Meeting: Identifying Priority Areas	AH
6/7/2019	AH meeting with Healthy Heart Network	AH/CBO
6/11/2019	CHA MEETING: Holiday Inn Lake George * Discuss beta update and CHA indicators for data table * Review Timeline and "data updates" timeline	AHI/AHRN
6/18/2019	CHA webinar with ARHN on Data Analysis	AH/AHRN
7/16/2019	Adirondack Health Population Health Steering Committee Meeting: Reviewing potential Interventions for CSP	AH
9/6/2019	CHA MEETING: Great Escape Lodge	AHI/AHRN
9/9/2019	Adirondack Health Population Health Steering Committee Meeting: CH/CSP/CHIP update	AH
9/10/2019	Adirondack Health and Franklin County Public Health CHA/CSP/CHIP	AH/AHMC/ARHN/FCPH
9/20/2019	Adirondack Health and Essex County Public Health CHA/CSP/CHIP	AH/ECPH/ECH
10/2/2019	Adirondack Health and Franklin County Public Health CHA/CSP/CHIP	AH/FCPH
10/16/2019	Adirondack Health and Franklin County Public Health CHA/CSP/CHIP	AH/FCPH
10/18/2019	Adirondack Health and Essex County Public Health CHA/CSP/CHIP	AH/ECPH/ECH
10/18/2019	AH meeting with Healthy Heart Network	AH/HHN
10/21/2019	Adirondack Health Women's Health Program meeting to go over Interventions	AH
10/24/2019	Adirondack Health Board of Trustees CHA/CSP presentation	AH
10/30/2019	Adirondack Health Population Health Steering Committee Meeting: CH/CSP/CHIP update	AH
11/5/2019	AH meeting with Healthy Heart Network	AH/HHN
11/14/2019	Adirondack Health and Franklin County Public Health CHA/CSP/CHIP	AH/FCPH
11/22/2019	Adirondack Health and Essex County Public Health CHA/CSP/CHIP	AH/ECPH/ECH
12/2/2019	Adirondack Health and Franklin County Public Health CHA/CSP/CHIP	AH/FCPH
12/4/2019	Adirondack Health Population Health Steering Committee	AH
12/6/2019	CHA MEETING: AHI and Virtual	AHI/AHRN
12/6/2019	Adirondack Health and Essex County Public Health CHA/CSP/CHIP	AH/ECPH/ECH
12/12/2019	Adirondack Health and Essex County Public Health CHA/CSP/CHIP	AH/ECPH/ECH
12/19/2019	Adirondack Health and Essex County Public Health CHA/CSP/CHIP	AH/ECPH/ECH
AH	Adirondack Health	
AHI	Adirondack Health Institute	
AHMC	Alice Hyde Medical Center	
ARHN	Adirondack Rural Health Network	
HHN	Healthy Heart Network	
ECPH	Essex County Public Health	
ECH	Elizabethtown Community Hospital	
FCPH	Franklin County Public Health	

Adirondack Health Primary Service Area List of Assets

Health Issue	**Assets**	**Agency/Organization**
Prevent Chronic Disease		
Asthma	Respiratory Therapy	Adirondack Health
Breastfeeding	Certified Lactation Consultants teach a feeding class	Adirondack Health
	Breast Feeding Council	Franklin County
	Essex County Breastfeeding Coalition	Essex County
Cancer	Merrill Center for Oncology	Adirondack Health
	Breast Program: Breast Health Navigator	Adirondack Health
	Various Cancer screenings	Adirondack Health
	Cancer Services Program Clinton, Essex and Franklin Counties	Counties
Nutrition	Decker Learning Center. Registered Dieticians Available for out-patient consults and education	Adirondack Health
	Hunger Prevention and Nutrition Assistance Program	Franklin County
	Comprehensive School Policites for Physical Activity and Nutrition	Schools
	Essex County Well Fed Collaborative	Essex County
Obesity	Weight Management Program (comprehensive, nutrition/physical therapy/behavioral health)	Adirondack Health
	Medical Fitness Program	Adirondack Health
	Fit for Life (Medically-Supervised Activity)	Adirondack Health
	Health Center Wellness Coaches	Adirondack Health
	Creating Healthy Schools and Communities	Counties
Tobacco use Prevention and Control	Decker Learning Center: Tobacco Cessasion Program	Adirondack Health
	Health Center Wellness Coaches	Adirondack Health
	Tobacco Free Clinton, Essex, Franklin	Counties
	New York State Smokers Quit Line	NYSDOH
	North Country Healthy Heart Network	CBO

Promote and Healthy and Safe Environment		
Foodbourne disease	Bureau of Comminity Environmental Health and Food Protection	NYSDOH
	County Communicable Disease Units	Counties
Public Water supply	Franklin County Soil and Water Department	Franklin County
Injuries, Violence and Occupational Health	Physical Therapy/Occupational therapy/ Speech Therapy programs at three sites (LP/SL/TL)	Adirondack Health
	Traffic Safety Board	Franklin County
	Stop DWI	Franklin County
	Domestic Violence CMTE	Franklin County
	Crisis Intervention	Franklin County
Built Environment	Franklin County Complete Streets	Franklin County
	Essex, Clinton, Franklin Lead Poisoning Prevention Programs	Counties
	County Highway Departments	Counties
Promote Healthy Women Infants and Children		Adirondack Health
Maternal and Women's Health	Adirondack Health Women's Health Center	Adirondack Health
Perinatal and Infant Health	Certified Lactation Consultants	Adirondack Health
	Certified Car Seat technicians. Car seat clinics.	Adirondack Health
	Essex County Public Health WIC Unit	Essex County
Child and Adolescent Health	Pediatricians in Health Centers	Adirondack Health
	Birth to Three Adirondack Alliance	Essex County
	Essex County Children Services Unit	Essex County
	Planned Parenthood of the North Country	CBO

Prevent Communicable Disease		
HIV/AIDS and sexually transmitted infections	Harm Reduction/Syringe Exchange	Franklin County
	HIV/STD/HCV Prevention Services	Franklin County
Vaccine-preventable diseases	Primary Care vaccinations and immunizations	Adirondack Health
	Essex, Clinton, Franklin County Immunization Program	Counties
Antimicrobial resistance and healthcare-associated infections	Antibiotic Stewardship Committee	Adirondack Health
	County Communicable Disease Unit	Counties
	CDC "One Health"	CDC
Promote Well-Being and Prevent Mental and Substance use disorders		
Substance abuse	OD reversal	Adirondack Health
	Medication drop-box	Adirondack Health
	Buprenorphine clinic	Adirondack Health
	Dr First Pharmacist-led med-reconciliation	Adirondack Health
	Opioid Prevention Program	Franklin County
	Community Connections Warm Line	Franklin County
	Prevention Task Force & Subcommittee	Franklin County
	Crisis Hotline	Franklin County
	Essex County Drug Court	Essex County
	Essex County Heroin and Opioid Prevention Coalition	Essex County
	Essex County Suicide Prevention Coalition	Essex County
	Essex and Franklin Counties Office for the Aging	Counties
	Tri-Lakes Center for Independent Living	CBO
	Mountain Lake Services	CBO
	Literacy Volunteers of Essex and Franklin Counties	CBO

Health Systems Profile

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS	New York State
Summary of Health Systems Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Population, 2013-2017	81,224	38,233	51,054	53,955	4,646	49,500	226,632	64,701	62,183	355,996	11,238,156	19,798,228
Total Hospital Beds1												
Hospital Beds per 100,000 Population	369.3		334.9	137.2	n/a	262.6	75.5	627.5	n/a	274.2	n/a	n/a
Medical/Surgical Beds	214	0	129	47	n/a	70	115	300	n/a	690.0	n/a	n/a
Intensive Care Beds	14	0	14	8	n/a	5	12	12	n/a	48.0	n/a	n/a
Coronary Care Beds	7	0	0	0	n/a	3	7	12	n/a	19.0	n/a	n/a
Pediatric Beds	10	0	3	12	n/a	0	7	14	n/a	39.0	n/a	n/a
Maternity Beds	21	0	13	7	n/a	8	14	23	n/a	64.0	n/a	n/a
Physical Medicine and Rehabilitation Beds	0	0	0	0	n/a	10	0	15	n/a	15.0	n/a	n/a
Psychiatric Beds	34	0	12	0	n/a	20	16	30	n/a	76.0	n/a	n/a
Other Beds	0	25	0	0	n/a	14	0	0	n/a	25.0	n/a	n/a
Hospital Beds Per Facility1												
Adirondack Medical Center-Lake Placid Site	-	-	-	-	-	-	-	-	-	-	-	-
Adirondack Medical Center-Saranac Lake Site	-	-	95	-	-	-	-	-	-	-	-	-
Alice Hyde Medical Center	-	-	76	-	-	-	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center	300	-	-	-	-	-	-	-	-	-	-	-
Elizabethtown Community Hospital	-	25	-	-	-	-	-	-	-	-	-	-
Glens Falls Hospital	-	-	-	-	-	-	-	406	-	-	-	-
Nathan Littauer Hospital	-	-	-	74	-	-	-	-	-	-	-	-
Saratoga Hospital	-	-	-	-	-	-	171	-	-	-	-	-
St. Mary's Healthcare	-	-	-	-	-	120	-	-	-	-	-	-
St. Mary's Healthcare-Amsterdam Memorial Campus	-	-	-	-	-	10	-	-	-	-	-	-
Total Nursing Home Beds2												
Nursing Home Beds per 100,000 Population	603.3	889.3	381.9	667.2	0.0	1191.9	317.3	616.7	849.1	-	-	-
Nursing Home Beds per Facility2												
Alice Hyde Medical Center	-	-	135	-	-	-	-	-	-	-	-	-
Capstone Center for Rehabilitation and Nursing	-	-	-	-	-	120	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center SNF	34	-	-	-	-	-	-	-	-	-	-	-
Clinton County Nursing Home	80	-	-	-	-	-	-	-	-	-	-	-
Elderwood at North Creek	-	-	-	-	-	-	-	82	-	-	-	-
Elderwood at Ticonderoga	-	84	-	-	-	-	-	-	-	-	-	-
Elderwood of Uihlein at Lake Placid	-	156	-	-	-	-	-	-	-	-	-	-
Essex Center for Rehabilitation and Healthcare	-	100	-	-	-	-	-	-	-	-	-	-
Fort Hudson Nursing Center, Inc.	-	-	-	-	-	-	-	-	196	-	-	-
Fulton Center for Rehabilitation and Healthcare	-	-	-	176	-	-	-	-	-	-	-	-
Glens Falls Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	117	-	-	-	-
Granville Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	122	-	-	-
Meadowbrook Healthcare	287	-	-	-	-	-	-	-	-	-	-	-
Mercy Living Center	-	-	60	-	-	-	-	-	-	-	-	-
Nathan Littauer Hospital Nursing Home	-	-	-	84	-	-	-	-	-	-	-	-
Palatine Nursing Home	-	-	-	-	-	70	-	-	-	-	-	-
Plattsburgh Rehabilitation and Nursing Center	89	-	-	-	-	-	-	-	-	-	-	-
River Ridge Living Center	-	-	-	-	-	120	-	-	-	-	-	-

Saratoga Center for Rehab and Skilled Nursing Care	-	-	-	-	-	-	257	-	-	-	-	-
Seton Health at Schuyler Ridge Residential Healthcare	-	-	-	-	-	-	120	-	-	-	-	-
Slate Valley Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	88	-	-	-
St Johnsville Rehabilitation and Nursing Center	-	-	-	-	-	120	-	-	-	-	-	-
The Pines at Glens Falls Center for Nursing & Rehabilitation	-	-	-	-	-	-	-	120	-	-	-	-
Warren Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	80	-	-	-	-
Washington Center for Rehabilitation and Healthcare	-	-	-	-	-	-	-	-	122	-	-	-
Wells Nursing Home Inc	-	-	-	100	-	-	-	-	-	-	-	-
Wesley Health Care Center Inc	-	-	-	-	-	-	342	-	-	-	-	-
Wilkinson Residential Health Care Facility	-	-	-	-	-	160	-	-	-	-	-	-
Total Adult Care Facility Beds3												
Adult Care Facility Beds per 100,000 Population	221.6	928.5	176.3	307.7	0.0	977.8	390.1	452.9	403.6	375.0	550.2	404.7
Total Adult Home Beds	150	194	60	114	n/a	294	483	248	142	908	38,328	49,670
Total Assisted Living Program Beds	30	30	30	52	n/a	160	0	45	69	256	7,072	12,192
Total Assisted Living Residence (ALR) Beds	0	131	0	0	n/a	30	401	0	40	171	16,434	18,255
Adult Home Beds by Total Capacity per Facility3												
Adirondack Manor HFA D.B.A Adirondack Manor HFA ALP	-	-	-	-	-	-	-	60	-	-	-	-
Adirondack Manor HFA D.B.A Montcalm Manor HFA	-	40	-	-	-	-	-	-	-	-	-	-
Ahana House	-	-	-	-	-	-	17	-	-	-	-	-
Alice Hyde Assisted Living Program	-	-	30	-	-	-	-	-	-	-	-	-
Argyle Center for Independent Living	-	-	-	-	-	-	-	-	35	-	-	-
Arkell Hall	-	-	-	-	-	24	-	-	-	-	-	-
Beacon Pointe Memory Care Community	-	-	-	-	-	-	52	-	-	-	-	-
Champlain Valley Senior Community	-	81	-	-	-	-	-	-	-	-	-	-
Cook Adult Home	-	-	-	-	-	-	13	-	-	-	-	-
Countryside Adult Home	-	-	-	-	-	-	-	48	-	-	-	-
Elderwood Village at Ticonderoga	-	23	-	-	-	-	-	-	-	-	-	-
Emeritus at the Landing of Queensbury	-	-	-	-	-	-	-	88	-	-	-	-
Hillcrest Spring Residential	-	-	-	-	-	80	-	-	-	-	-	-
Holbrook Adult Home	-	-	-	-	-	-	-	-	33	-	-	-
Home of the Good Shepherd at Highpointe	-	-	-	-	-	-	86	-	-	-	-	-
Home of the Good Shepherd	-	-	-	-	-	-	42	-	-	-	-	-
Home of the Good Shepherd Moreau	-	-	-	-	-	-	72	-	-	-	-	-
Home of the Good Shepherd Saratoga	-	-	-	-	-	-	105	-	-	-	-	-
Home of the Good Shepherd Wilton	-	-	-	-	-	-	54	-	-	-	-	-
Keene Valley Neighborhood House	-	50	-	-	-	-	-	-	-	-	-	-
Pine Harbour	66	-	-	-	-	-	-	-	-	-	-	-
Pineview Commons H.F.A.	-	-	-	94	-	-	-	-	-	-	-	-
Samuel F. Vilas Home	44	-	-	-	-	-	-	-	-	-	-	-
Sarah Jane Sanford Home	-	-	-	-	-	40	-	-	-	-	-	-
The Cambridge	-	-	-	-	-	-	-	-	40	-	-	-
The Farrar Home	-	-	30	-	-	-	-	-	-	-	-	-
The Mansion at South Union	-	-	-	-	-	-	-	-	34	-	-	-
The Sentinel at Amsterdam, LLC	-	-	-	-	-	150	-	-	-	-	-	-
The Terrace at the Glen	-	-	-	-	-	-	-	52	-	-	-	-
Valehaven Home for Adults	40	-	-	-	-	-	-	-	-	-	-	-
Willing Helpers' Home for Women	-	-	-	20	-	-	-	-	-	-	-	-

Woodlawn Commons	-	-	-	-	-	-	42	-	-	-	-	-
Health Professional Shortage Areas (HPSAs)4,5												
Number of Primary Care HPSAs4	1	8	5	1	2	1	0	3	1	21	111	181
Primary Care HPSA Population5	10,339	4,481	5,997	13,950	2,949	11,456	0	2,168	189	40,073	n/a	n/a
Number of Dental Care HPSAs4	1	3	5	1	0	1	0	1	1	12	87	139
Dental Care HPSA Population5	0	6,368	16,181	0	0	0	0	0	0	22,549	n/a	n/a
Number of Mental Health HPSAs4	2	3	2	1	1	1	0	2	2	13	96	159
Mental Care HPSA Population5	10,339	39,309	51,698	6,698	4,835	11,456	0	0	0	112,879	n/a	n/a
Population, 2013-20175												
Primary Care Physicians per 100,000 population	119.2	66.2	101.9	99	84.9	83.9	87.5	153	66.4	n/a	102.8	124.1
Subspeciality per 100,000 population												
Obstetrics/Gynecology	14.9	0.0	18.3	7.4	0.0	5.4	8.4	18.6	0.0	n/a	11.0	14.5
IM Subspeciality	34.8	7.0	13.1	9.9	0.0	37.9	21.1	60.0	0.0	n/a	31.8	49.8
General Surgery	6.6	3.5	10.5	9.9	0.0	2.7	3.6	12.4	2.1	n/a	7.9	8.8
Surgical Subspecialties	23.2	10.5	0.0	7.4	0.0	8.1	10.9	37.2	0.0	n/a	17.8	21.6
General Psychiatry	24.8	0.0	15.7	9.9	0.0	8.1	21.1	20.7	8.6	n/a	18.8	36
Other	107.6	20.9	65.3	32.2	56.6	56.9	33.8	159.2	4.3	n/a	87.8	121.1
Total Physician5												
Total Physician per 100,000 population	317.9	108.0	206.5	168.3	141.5	200.4	179.2	442.5	81.4	n/a	268.0	362.9
Licensure Data6												
Clinical Laboratory Technician	14	6	5	1	0	4	21	9	5	40	1,208	1,649
Clinical Laboratory Technologist	54	19	27	32	1	38	161	50	24	207	7,730	12,064
Dental Assistant	11	2	9	4	0	7	33	10	11	47	1,338	1,435
Dental Hygienist	42	15	16	23	2	26	241	44	38	180	8,035	10,428
Dentist	41	14	17	17	1	25	175	46	15	151	8,771	15,075
Dietition/Nutritionist, Certified	21	9	8	4	1	10	122	22	7	72	3,667	5,492
Licensed Clinical Social Worker (R/P psycotherapy)	42	24	31	21	2	15	266	72	35	227	14,629	25,254
Licensed Master Social Worker (no privileges)	34	22	26	18	2	23	267	53	26	181	14,861	26,884
Licensed Practical Nurse	382	215	321	308	10	362	895	335	438	2,009	48,582	63,082
Physician	211	49	85	59	6	87	528	265	36	711	42,475	75,565
Mental Health Counselor	59	20	32	10	1	13	147	32	13	167	4,647	6,853
Midwife	6	1	3	4	0	2	14	12	5	31	595	1,022
Nurse Practitioner	79	13	36	38	2	27	258	94	29	291	15,282	22,128
Pharmacist	106	29	41	36	2	40	484	64	44	322	13,780	21,306
Physical Therapist	64	40	48	30	3	43	395	67	30	282	13,417	19,277
Physical Therapy Assistant	17	10	18	20	0	26	55	27	16	108	3,988	5,518
Psychologist	11	15	8	10	1	5	109	28	4	77	6,018	11,519
Registered Physician Assistant	43	30	34	21	3	19	199	88	17	236	9,154	13,640
Registered Professional Nurse	1,270	494	744	643	57	714	3,769	1,145	755	5,108	172,978	243,639
Respiratory Therapist	18	3	6	17	0	18	110	21	13	78	4,107	5,763
Respiratory Therapy Technician	6	0	2	2	0	1	12	4	3	17	579	747

(n/a) Data Not Available

Sources:

(1) NYS Department of Health, NYS Health Profiles

(2) NYS Department of Health, Nursing Home Weekly Bed Census, 2018

(3) NYS Department of Health, Adult Care Facility Directory
(4) Health Resources and Services Administration, HPSA Find, 2017-2018
(5) Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014
(6) NYS Office of the Professions, License Statistics, 2019

Prevention Agenda 2019-2024

Developed by the
NYS Public Health and Health Planning Council
and the NYS Department of Health
Updated: April 25, 2019
Version: 1.3

New York's State Health Improvement Plan

The New York State Prevention Agenda 2019-2024: An Overview

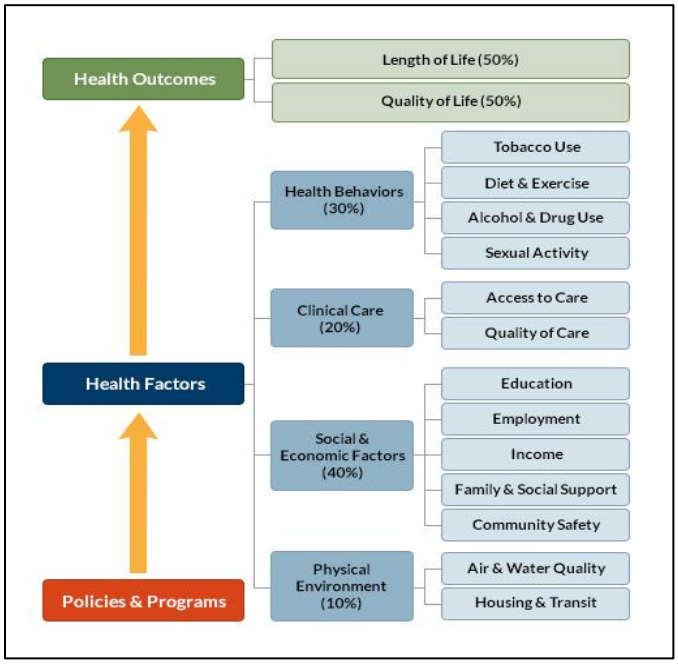
Updated: April 25, 2019

The Prevention Agenda 2019-2024 is New York State's health improvement plan, the blueprint for state and local action to improve the health and well-being of all New Yorkers and promote health equity across populations who experience disparities. In partnership with more than 100 organizations across the state, the Prevention Agenda is updated by the New York State Public Health and Health Planning Council at the request of the Department of Health. This is the third cycle for this statewide initiative that started in 2008.

The vision of the Prevention Agenda for 2019-2024 is that New York is the Healthiest State in the Nation for People of All Ages. We are proud that, since 2008, New York has moved from the 28th to 10th healthiest state on America's Health Rankings,[1] demonstrating real progress toward achieving our vision.

The Prevention Agenda is based on a comprehensive statewide assessment of health status and health disparities, changing demographics, and the underlying causes of death and diseases. We used the County Health Rankings model (*Figure 1*) as the framework for understanding the modifiable determinants of health (without discounting the role of genetics).[2] New to this 2019-2024 cycle is the incorporation of a Health Across All Policies approach, initiated by New York State in 2017, which calls on all State agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. It embraces Healthy Aging to support the State's commitment to making New York the first age-friendly state. The 2019-2024 cycle also builds on the important experiences—both successes and challenges—of local Prevention Agenda coalitions from across the state, who were formed in previous cycles of the Prevention Agenda to identify and address their local communities' health priorities.

Figure 1: County Health Rankings model © 2014 UWPHI



The overarching strategy of the Prevention Agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. This strategy includes an emphasis on social determinants of health – defined by Healthy People 2020 as the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Such determinants include social and economic opportunities, education, safety in neighborhoods and communities, the quality of physical environments (e.g., the cleanliness of our water, food, air, and housing), and social interactions and relationships. Health behaviors and access to health care are also important (*Figure 2*).

Figure 2 [3,4]

Examples of Social Determinants

- Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- Access to educational, economic and job opportunities
- Access to health care services
- Quality of education and job training
- Availability of community-based resources that support healthy lifestyles and opportunities for recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government
- Exposure to crime, violence, and social disorder (e.g., presence of trash, lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the accompanying stressful conditions)
- Residential segregation
- Language and literacy
- Access to mass media and emerging technologies (e.g., cell phones, the Internet and social media)
- Culture
- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- Built environment, such as buildings, sidewalks, bike lanes, and roads
- Worksites, schools, and recreational settings
- Housing and community design
- Exposure to toxic substances and other physical hazards
- Physical barriers, especially for people with disabilities
- Aesthetic elements (e.g., good lighting, trees, and benches)

The conditions in the environments where people live, work and play have a significant influence on health status and quality of life and are root causes of poor health and adverse outcomes. Changing these outcomes requires us to address collaboratively the social, economic, and physical conditions that contribute to poor health and well-being.

To achieve our vision, the Prevention Agenda calls for cross-sector partnerships (e.g., public health, health care, housing, education, and social services, etc.) to address social determinants of health across five key areas (*Figure 3*):

1. Economic Stability
2. Education
3. Social and Community Context
4. Health and Health Care
5. Neighborhood and Built Environment

especially by encouraging alignment of investments in primary prevention[5] and using community and policy-level interventions to have widespread and lasting positive health impacts (*Figure 4*).

Figure 3: Social Determinants of Health

Figure 4: Social Ecological Model[6]

Process for Developing the Updated Prevention Agenda

Active participation and feedback from the Ad Hoc Committee to Lead the Prevention Agenda and stakeholders across the state were essential for updating the Prevention Agenda for 2019-2024. Many organizations were engaged in developing this updated plan, including local health departments, health care providers, community-based organizations, advocacy groups, academia, employers, schools, and businesses. These organizations reviewed the data on health status and emerging health issues, participated in finalizing the Cross-Cutting Principles (*Figure 5*), updated the list of priorities and developed priority-specific action plans.

Figure 5

Cross-Cutting Principles

To improve health outcomes, enable well-being, and promote equity across the lifespan, the Prevention Agenda:

- Focuses on addressing social determinants of health and reducing health disparities
- Incorporates a Health Across All Policies approach
- Emphasizes healthy aging across the lifespan
- Promotes community engagement and collaboration across sectors in the development and implementation of local plans
- Maximizes impact with evidence-based interventions for state and local action
- Advocates for increased investments in prevention from all sources
- Concentrates on primary and secondary prevention, rather than on health care design or reimbursement

The New York State Office of Mental Health and the New York State Office of Alcoholism and Substance Abuse Services have been core partners since 2013. New in this 2019-2024 cycle is the involvement of the New York State Office for the Aging and other State agencies in identifying specific interventions that they will implement to advance the Prevention Agenda in improving the health of individuals of all ages. These collaborations are the foundation of the 2019-2024 plan.

The Prevention Agenda 2019-2024 has five priorities with priority-specific action plans developed collaboratively with input from community stakeholders (*Figure 6)*.

Figure 6: New York State Prevention Agenda 2019-2024 – Priority Areas, Focus Areas, and Goals

Priority Area: Prevent Chronic Diseases	**Focus Area 1: Healthy Eating and Food Security** Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 1.1: Increase access to healthy and affordable foods and beverages
	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
	Goal 1.3: Increase food security
	Focus Area 2: Physical Activity Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
	Goal 2.2: Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
	Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
	Focus Area 3: Tobacco Prevention
	Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults
	Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability
	Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
	Focus Area 4: Preventive Care and Management
	Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer
	Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
	Goal 4.3: Promote the use of evidence-based care to manage chronic diseases
	Goal 4.4: Improve self-management skills for individuals with chronic conditions
Priority Area: Promote a Healthy and Safe Environment	**Focus Area 1: Injuries, Violence and Occupational Health**
	Goal 1.1: Reduce falls among vulnerable populations
	Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations
	Goal 1.3: Reduce occupational injuries and illness
	Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists
	Focus Area 2: Outdoor Air Quality
	Goal 2.1: Reduce exposure to outdoor air pollutants
	Focus Area 3: Built and Indoor Environments
	Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
	Goal 3.2: Promote healthy home and school environments
	Focus Area 4: Water Quality
	Goal 4.1: Protect water sources and ensure quality drinking water
	Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
	Focus Area 5: Food and Consumer Products
	Goal 5.1: Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
	Goal 5.2: Improve food safety management

Figure 6 Continued: New York State Prevention Agenda 2019-2024 – Priority Areas, Focus Areas, and Goals

Priority Area: Promote Healthy Women, Infants and Children	**Focus Area 1: Maternal & Women's Health**
	Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age
	Goal 1.2: Reduce maternal mortality and morbidity
	Focus Area 2: Perinatal & Infant Health
	Goal 2.1: Reduce infant mortality and morbidity
	Goal 2.2: Increase breastfeeding
	Focus Area 3: Child & Adolescent Health
	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships
	Goal 3.2: Increase supports for children and youth with special health care needs
	Goal 3.3: Reduce dental caries among children
	Focus Area 4: Cross Cutting Healthy Women, Infants, & Children
	Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders	**Focus Area 1: Promote Well Being**
	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan
	Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages
	Focus Area 2: Prevent Mental and Substance Use Disorders
	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults
	Goal 2.2: Prevent opioid and other substance misuse and deaths
	Goal 2.3: Prevent and address adverse childhood experiences (ACEs)
	Goal 2.4: Reduce the prevalence of major depressive disorders
	Goal 2.5: Prevent suicides
	Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population
Priority Area: Prevent Communicable Diseases	**Focus Area 1: Vaccine-Preventable Diseases**
	Goal 1.1: Improve vaccination rates
	Goal 1.2: Reduce vaccination coverage disparities
	Focus Area 2: Human Immunodeficiency Virus (HIV)
	Goal 2.1: Decrease HIV morbidity (new HIV diagnoses)
	Goal 2.2: Increase viral suppression
	Focus Area 3: Sexually Transmitted Infections (STIs)
	Goal 3.1: Reduce the annual rate of growth for STIs
	Focus Area 4: Hepatitis C Virus (HCV)
	Goal 4.1: Increase the number of persons treated for HCV
	Goal 4.2: Reduce the number of new HCV cases among people who inject drugs
	Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections
	Goal 5.1: Improve infection control in healthcare facilities
	Goal 5.2: Reduce infections caused by multidrug resistant organisms and C. difficile
	Goal 5.3: Reduce inappropriate antibiotic use

Each priority-specific action plan includes focus areas, goals, objectives, and measures for evidence-based interventions to track their impacts – including reductions in health disparities among racial, ethnic, and socioeconomic groups, age groups, and persons with disabilities. These objectives will be tracked on the New York State Prevention Agenda Dashboard. The Prevention Agenda Action Plans provide communities with recommended evidence-based interventions, promising practices, and guidance to support implementation (e.g., by highlighting organizations that are well-positioned to take leading or supporting roles). The plans emphasize interventions that address social determinants of health, promote health equity across communities, and support healthy and active aging.

Implementing the five priority-specific action plans in the Prevention Agenda 2019-2024 will improve major cross-cutting health outcomes and reduce health disparities (*Figure 7*), as measured by the following indicators:

Figure 7: New York State Prevention Agenda 2019-2024 Cross-Cutting Objectives

Prevention Agenda (PA) Indicator	Baseline Year	Baseline	Prevention Agenda 2024 Objective	Percent Improvement from Baseline
Cross-Cutting Objectives to Improve Health Status and Reduce Health Disparities				
Percentage of premature deaths (before age 65 years)	2016	**24**	**22.8**	**-5%**
Difference in percentage (Black non-Hispanic and White non-Hispanic) of premature deaths	2016	**18.2**	**17.3**	**-5%**
Difference in percentage (Hispanic and White non-Hispanic) of premature deaths	2016	**17.1**	**16.2**	**-5%**
Age-adjusted preventable hospitalization rate per 10,000 - Aged 18+ years	2016	**123.4**	**117.2**	**-5%**
Difference in rates (Black non-Hispanic and White non-Hispanic) of preventable hospitalizations	2016	**98.2**	**93.3**	**-5%**
Difference in rates (Hispanic and White non-Hispanic) of preventable hospitalizations	2016	**25.6**	**24.3**	**-5%**
Percentage of adults (aged 18-64) with health insurance	2016	**91.4**	**97.0**	**+ 6%**
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	2016	**82.6**	**86.7**	**+ 5%**

The Prevention Agenda aims to be a dynamic plan and a catalyst for action. Key to its success will be the alignment of efforts across State agencies, working with local governments and Prevention Agenda coalitions, and facilitating active community engagement. The Ad Hoc Committee will encourage its members and partners across the state to share effective strategies for improving community health. The Public Health and Health Planning Council will oversee implementation and use lessons learned to advance the Prevention Agenda.

References

[1] United Health Foundation. America's Health Rankings Annual Report, 2017. https://www.americashealthrankings.org/about/methodology/our-reports

[2] Our Methods. County Health Rankings and Roadmaps web site. http://www.countyhealthrankings.org/explore-health-rankings/our-methods. Accessed November 2, 2018.

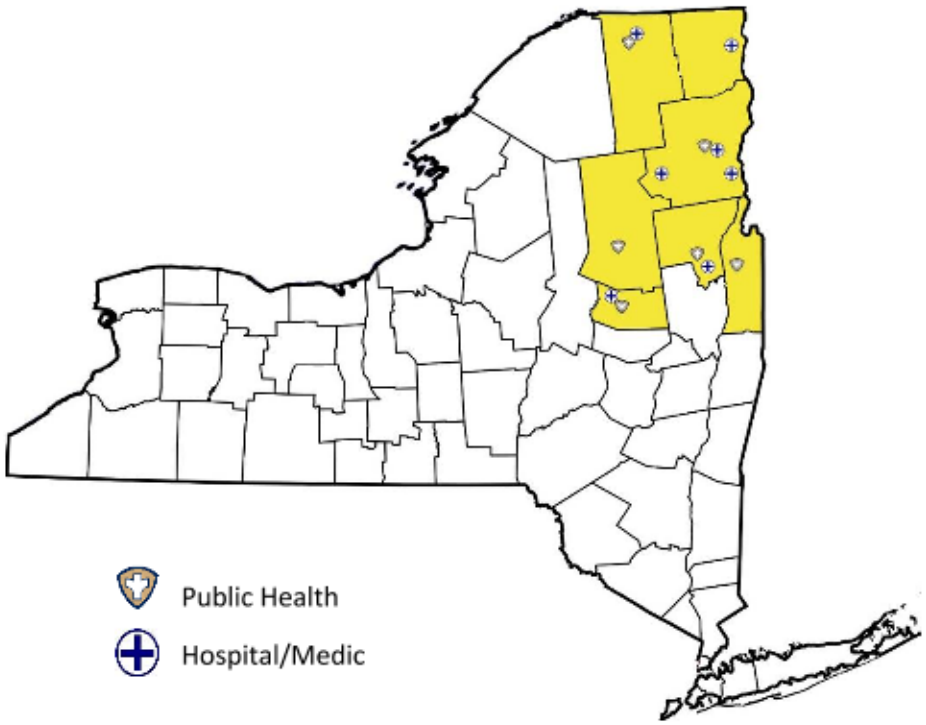
[3] US Department of Health and Human Services. Healthy People 2020. Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

[4] Social Determinants of Health, 2nd Edition. M Marmot and R Wilkinson (eds). Oxford University Press, 2006.

[5] NYS Department of Health Letter and Community Health Planning Guidance 2016-18 https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/letter_community_planning_guidance_2016_18.pdf

[6] Social Ecological Model. Centers for Disease Control and Prevention web site. Updated January 28, 2013. https://www.cdc.gov/cancer/nbccedp/sem.htm. Accessed November 2, 2018.

Summary of 2019 Community Stakeholder Survey



Adirondack Rural Health Network Service Area

Clinton, Essex, Franklin, Fulton, Hamilton,
Warren and Washington Counties

ARHN is a program of AHI-Adirondack Health Institute
Supported by the New York State Department of Health, Office of Health Systems Management,
Division of Health Facility Planning, Charles D. Cook Office of Rural Health.

April 8, 2019

Background:

Adirondack Rural Health Network: The Adirondack Rural Health Network (ARHN) is a program of AHI - Adirondack Health Institute, Inc. Established in 1992 through a New York State Department of Health Rural Health Development Grant, ARHN is a multi-stakeholder, regional coalition that informs planning, assessment, provides education and training to further the implementation of the New York State Department of Health Prevention Agenda, and offers other resources that support the development of the regional health care system. Since its inception, ARHN has provided a forum to assess regional population health needs and develop collaborative responses to priorities. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Description of the Community Health Assessment Committee: Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from Adirondack Health, Clinton County Health Department, University of Vermont Health Network - Alice Hyde Medical Center, University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital, University of Vermont Health Network – Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health.

Purpose of the CHA Committee: The CHA Committee, made up of the CHA service contract holders with AHI, is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment by working collaboratively on interventions and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda.

CHA Committee, Ad Hoc Data Sub-Committee: At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

The data subcommittee met seven times from mid-July through the end of October 2018. Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 subcommittee members per meeting. Meetings were also attended by AHI staff from ARHN, Population Health Improvement Program (PHIP) and Data teams.

Survey Methodology:

Survey Creation: The 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at December 7, 2018 meeting.

Survey Facilitation: ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental institutions as well as community

members. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington Counties.

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns. A full list of survey questions can be found under Appendix A.

Survey Responses and Analysis: A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

Analysis is sorted alphabetically and in order of how the questions were listed in the survey to make the analysis easier to comprehend. Each table is labeled to identify whether the information is by response count or percentage. For tables containing counties, the table below indicates table is color coded to identify counties . All written analysis for each section is provided, with table below, and all written results are done in percentages.

This report provides a regional look at the results thru a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties. This stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The results enable us to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.

Clinton
Essex
Franklin
Fulton
Hamilton
Warren
Washington

Summary Analysis

1. Indicate county/counties served

Respondents were asked which county their organization/agency serves. Over 68% of respondents were from Essex and Washington counties. Approximately 16% of respondents listed the county they serve as outside of the seven ARHN counties, including Montgomery, Saratoga and St. Lawrence counties. Twelve percent of respondents identified themselves as serving the Adirondack/North Country region as a whole.

It should be noted that the figures below may not add up to 100%, due to organizations with multiple county coverage areas.

Respondents by County		
County/Region	**Total Response Count**	**Total Response Percentage**
Adirondack/North Country Region	49	12.04%
Clinton	81	19.90%
Essex	129	31.70%
Franklin	82	20.15%
Fulton	50	12.29%
Hamilton	69	16.95%
Warren	92	22.60%
Washington	150	36.86%
Other	65	15.97%

*Figures do not add up to 100% due to multiple counties per organization.

2. Indicate the community sector that best describes your organization

Community stakeholders were asked to indicate one community sector that best described their organization or agency. Over 160 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including *Education (19.0%), Health Care (13.2%), Social Services (12.5%), Public Health (9.2%), and Health Based Community Based Organizations (CBO) (7.5%),* among many others.

Response Counts by Community Sector	
Community Sector	**Total**
Business	4
Civic Association	3
College/University	7
Disability Services	10
Early Childhood	9
Economic Development	6
Employment/Job Training	2
Faith-Based	3
Food/Nutrition	10
Foundation/Philanthropy	1
Health Based CBO	30
Health Care Provider	53

Health Insurance Plan	1
Housing	7
Law Enforcement/Corrections and Fire Department	10
Local Government (e.g. elected official, zoning/planning board)	29
Media	2
Mental, Emotional, Behavioral Health Provider	22
Public Health	37
Recreation	3
School (K – 12)	69
Seniors/Elderly	28
Social Services	50
Transportation	2
Tribal Government	1
Veterans	2

3. Indicate your job title

Approximately 42.64% of respondents listed themselves as an *Administrator or Director.* There was a significant number of respondents who identified their title as Other (22.69%). Of those responses, the majority included teachers or education professionals and program coordinators.

It's important to note that based off responses, there did not seem to be enough answer choices. Moving forward, a recommendation would be to broaden answer choices to incorporate more community stakeholders.

Respondent Job Titles		
Job Title	**Responses**	
	Count	**Percentage**
Community Member	5	1.25%
Direct Service Staff	94	23.44%
Program/Project Manager	40	9.98%
Administrator/Director	171	42.64%
Other	91	22.69%

4. NYS Prevention Agenda Priority Areas

Top Priority Area for the ARHN Region:

Survey participants were asked to rank the NYS Prevention Agenda Priority Areas in order of most to least impact. Overall, respondents in the ARHN region identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* (41.7%) as their top priority, followed by *Promote a Healthy and Safe Environment* (21.9%).

NYS Prevention Agenda Top Priority Area for the ARHN Region		
County	**First Choice**	**Second Choice**
ARHN Region	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

Top Priority Area by County:

To analyze the chosen priority areas, responses were totaled per county and the priority area that received the most responses is listed as the *First Choice*, followed by the second most responses listed as *Second Choice*.

All seven of the ARHN counties identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* as their top priority. Additionally, Clinton, Essex, Franklin and Fulton counties identified *Prevent Chronic Disease* as their second choice while Clinton, Essex, Warren and Washington counties identified *Promote a Healthy and Safe Environment* as their second choice. Clinton and Essex counties have an overlap due to ties.

As survey participants were not provided focus areas or goals associated with each priority area, it can be assumed that the answers for these priority areas were slightly swayed due to what partners believe *Promote Well-Being and Prevent Mental and Substance Use Disorders* represents or what they feel would be listed in that category.

NYS Prevention Agenda Top Priority Area by County		
County	**First Choice**	**Second Choice**
Clinton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Essex	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote Healthy Women, Infants and Children
Franklin	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Fulton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Hamilton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Warren	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment
Washington	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

*Overlapping in county choices is due to several ties in response totals.

5. In your opinion, what are the top five health concerns affecting the residents of the counties your organization/agency serves?

Health Concerns for the ARHN Region:

Community stakeholders were asked to choose what they believed to be the top five health concerns affecting the residents in the counties their organization/agency served. The choices were ranked from one, being the highest health concern, to five, indicating the lowest health concern.

Survey respondents felt that the top five health concerns affecting the residents within the ARHN region were *Mental Health (16.9%), Substance Abuse (12.3%), Opioid Use (9.5%), Overweight/Obesity (8.8%),* and *Child/Adolescent Emotional Health (5.7%).*

Response Counts for ARHN Region Health Concerns					
ARHN Region Health Concerns	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Adverse Childhood Experiences	20	20	19	13	8
Alzheimer's Disease/Dementia	19	17	8	5	9
Arthritis	1	0	2	3	1
Autism	2	2	2	2	4
Cancers	13	14	19	7	8
Child/Adolescent Physical Health	13	12	10	13	8
Child/Adolescent Emotional Health	20	36	20	22	14
Diabetes	10	14	14	6	16
Disability	4	7	5	5	11
Dental Health	1	5	5	10	14
Domestic Abuse/Violence	4	7	16	18	10
Drinking Water Quality	0	1	1	2	5
Emerging Infectious Diseases	2	1	5	1	8
Exposure to Air and Water Pollutants/Hazardous Materials	1	0	1	0	1
Falls	3	7	5	3	4
Food Safety	3	1	2	3	2
Heart Disease	7	11	9	16	12
Hepatitis C	0	0	1	2	1
High Blood Pressure	1	2	8	6	8
HIV/AIDS	0	0	1	0	2
Hunger	4	10	5	6	5
Infant Health	1	0	8	1	4
Infectious Disease	1	0	2	3	4
LGBT Health	0	1	0	1	2
Maternal Health	3	4	3	3	7
Mental Health Conditions	59	48	36	37	23
Motor Vehicle Safety (impaired/distracted driving)	0	0	1	0	7
Opioid Use	33	18	16	14	11
Overweight or Obesity	31	25	26	23	17
Pedestrian/Bicyclist Accidents	0	0	0	0	2
Prescription Drug Abuse	4	7	11	9	7
Respiratory Disease (asthma, COPD, etc.)	5	10	5	9	8

Senior Health	18	9	12	13	11
Sexual Assault/Rape	2	0	0	3	3
Sexually Transmitted Infections	2	0	0	4	4
Social Connectedness	2	4	9	18	16
Stroke	0	2	2	1	2
Substance Abuse	43	33	38	29	10
Suicide	1	5	2	2	7
Tobacco Use/Nicotine Addiction (smoking, vaping, chewing, etc.)	11	7	11	19	27
Underage Drinking/Excessive Adult Drinking	2	8	5	6	5
Unintended/Teen Pregnancy	2	1	1	4	10
Violence (assault, firearm related)	1	0	1	2	5

Health Concerns by County:

Overall, most of the health concerns identified per county aligned with the top five health concerns identified for the ARHN region. Several counties recognized health concerns outside the top five for the ARHN region. Three out of the seven ARHN counties listed *Adverse Childhood Experiences* as a top health concern in their county.

Warren and Washington county respondents felt that *Alzheimer's Disease* was a concern in their area, while Clinton and Hamilton counties included *Heart Disease* as a concern for their counties. Outliers include Hamilton County listing *Diabetes* and Fulton County listing *Tobacco Use* as a top concern in their county.

Top Five Health Concerns by County					
County	1st	2nd	3rd	4th	5th
Clinton	Mental Health Conditions	Overweight/Obesity	Opioid Use	Senior Health	Heart Disease
Essex	Substance Abuse	Mental Health Conditions	Child/Adolescent Emotional Health	Overweight/Obesity	Adverse Childhood Experiences
Franklin	Mental Health Conditions	Overweight/Obesity	Substance Abuse	Opioid Use	Adverse Childhood Experiences
Fulton	Mental Health Conditions	Substance Abuse	Tobacco Use	Opioid Use	Child/Adolescent Emotional Health
Hamilton	Substance Abuse	Mental Health Conditions	Overweight/Obesity	Heart Disease	Diabetes
Warren	Mental Health Conditions	Overweight/Obesity	Adverse Childhood Experiences	Substance Abuse	Alzheimer's Disease
Washington	Substance Abuse	Mental Health Conditions	Opioid Use	Alzheimer's Disease	Cancers

6. In your opinion, what are the top five contributing factors to the health concerns you chose in the previous question, affecting the residents of the counties your organization/agency serves?

Respondents were asked to identify what they believed to be the top five contributing factors to the health concerns they chose. The contributing factors were ranked from one to five, with one being the highest contributing factor and five being the lowest.

Contributing Factors for the ARHN Region:

The top five contributing factors identified by survey respondents are *Poverty (12.7%), Addiction to illicit drugs (10.9%), Changing family structures (10.6%), Lack of mental health services (10.3%), and Age of residents (8.3%).* Forty-four percent of respondents chose these factors as either the highest or second highest contributing factors for the health concerns that they had previously identified.

Response Counts for Top Contributing Factors in the ARHN Region					
ARHN Region Contributing Factors	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Addiction to alcohol	14	16	12	7	6
Addiction to illicit drugs	37	36	22	13	5
Addiction to nicotine	7	10	6	7	11
Age of residents	28	11	6	4	7
Changing family structures (increased foster care, grandparents as parents, etc.)	36	22	15	20	8
Crime/violence/community blight	0	1	2	1	4
Deteriorating infrastructure (roads, bridges, water systems, etc.)	1	0	1	0	3
Discrimination/racism	0	0	0	0	1
Domestic violence and abuse	4	6	5	4	7
Environmental quality	0	3	4	5	6
Excessive screen time	2	13	11	4	8
Exposure to tobacco smoke/emissions from electronic vapor products	1	3	5	1	3
Food insecurity	8	13	9	8	7
Health care costs	16	17	21	20	16
Homelessness	1	2	4	4	2
Inadequate physical activity	5	16	15	17	21
Inadequate sleep	0	0	2	3	3
Inadequate/unaffordable housing options	5	9	16	8	13
Lack of chronic disease screening, treatment and self-management services	3	8	7	7	4
Lack of cultural and enrichment programs	1	2	1	1	3
Lack of dental/oral health care services	1	3	0	6	7
Lack of educational opportunities for people of all ages	1	2	3	2	9
Lack of educational, vocational or job-training options for adults	1	1	0	6	1
Lack of employment options	1	3	12	7	7
Lack of health education programs	3	1	4	3	2
Lack of health insurance	3	1	4	3	3
Lack of intergenerational connections within communities	1	0	2	4	8
Lack of mental health services	35	28	27	26	9
Lack of opportunities for health for people with physical limitations or disabilities	2	0	1	4	4

Lack of preventive/primary health care services (screenings, annual check-ups)	6	5	2	3	3
Lack of social supports for community residents	4	3	10	8	9
Lack of specialty care and treatment	1	4	4	3	2
Lack of substance use disorder services	8	8	11	4	6
Late or no prenatal care	0	0	1	2	3
Pedestrian safety (roads, sidewalks, buildings, etc.)	0	0	0	0	1
Poor access to healthy food and beverage options	5	2	6	9	0
Poor access to public places for physical activity and recreation	2	3	1	3	4
Poor educational attainment	2	8	2	8	8
Poor community engagement and connectivity	6	5	4	6	14
Poor eating/dietary practices	12	15	15	17	12
Poor health literacy (ability to comprehend health information)	6	2	4	5	4
Poor referrals to health care, specialty care, & community-based support services	8	5	4	4	7
Poverty	43	18	16	16	23
Problems with Internet access (absent, unreliable, unaffordable)	0	0	0	3	2
Quality of schools	0	0	1	1	3
Religious or spiritual values	0	0	0	1	1
Shortage of child care options	0	1	3	1	3
Stress (work, family, school, etc.)	7	10	15	21	9
Transportation problems (unreliable, unaffordable)	9	13	15	13	14
Unemployment/low wages	3	6	3	8	13

Contributing Factors by County:

The majority of the ARHN counties identified contributing factors that fell in line with the overall ARHN region's top five. Another contributing factor indicated by Franklin, Hamilton and Warren counties was *Health Care Costs*.

Top Five Contributing Factors by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Poverty	Food Insecurity	Addiction to Illicit Drugs	Lack of Mental Health Services	Inadequate Physical Activity
Essex	Poverty	Lack of Mental Health Services	Changing Family Structures	Addiction to Illicit Drugs	Age of Residents
Franklin	Poverty	Lack of Mental Health Services	Addiction to Illicit Drugs	Changing Family Structures	Health Care Costs
Fulton	Lack of Mental Health Services	Poverty	Poor Eating/ Dietary Practices	Changing Family Structures	Addiction to Illicit Drugs
Hamilton	Age of Residents	Health Care Costs	Lack of Mental Health Services	Poverty	Poor Community Engagement and Connectivity
Warren	Age of Residents	Lack of Mental Health Services	Changing Family Structures	Health Care Costs	Poverty
Washington	Addiction to Illicit Drugs	Age of Residents	Poverty	Lack of Mental Health Services	Changing Family Structures

8. Please rank the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "excellent" to (5) "very poor".

This survey question asked respondents to rank the Social Determinants of Health, listed below, in order from one, excellent, to five, very poor. The table below encompasses response counts for the entire survey.

Many respondents chose *Health and Health Care (29.0%)* as the social determinant of health that they felt most impacted the residents of the counties that they serve, followed by *Economic Stability (22.4%).* Both of these specific Social Determinants of Health align with the chosen health factors and contributing factors listed previously.

Response Counts per Social Determinants of Health Ranking					
Social Determinants of Health	**1 (Excellent)**	**2**	**3**	**4**	**5 (Very Poor)**
Economic Stability (consider poverty, employment, food security, housing stability)	54	22	33	53	100
Education (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	50	67	66	49	27
Health and Health Care (consider access to primary care, access to specialty care, health literacy)	70	64	79	52	49
Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)	35	67	61	79	43
Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	32	58	73	62	38

9. In your opinion, what population in the counties your organization/agency serves experiences the poorest health outcomes?

To help determine who the target audience that has the greatest need is, we asked, in their opinion, what population, in the counties they serve, experiences the poorest health outcomes.

Every county in the ARHN region chose *Individuals living at or near the federal poverty level (33.3%)* as the population they felt had the poorest health outcomes. For six of the seven ARHN counties, excluding Hamilton, the second population with the highest responses was *Individuals with mental health issues (24.3%).* For Hamilton County, the second population believed to have the poorest health outcomes were *Seniors or Elderly (1.8%).*

Response Counts for Poorest Health Outcomes by County							
Population	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Children/Adolescents	0	5	1	1	2	5	4
Females of reproductive age	0	0	0	0	0	0	0
Individuals living at or near the federal poverty level	35	46	32	14	19	25	39
Individuals living in rural areas	5	6	7	2	8	12	17
Individuals with disability	1	2	0	0	0	1	0

Individuals with mental health issues	19	24	19	11	9	14	29
Individuals with substance abuse issues	2	8	4	1	6	7	16
Migrant workers	1	1	1	0	0	0	0
Seniors/Elderly	5	7	6	6	10	8	17
Specific racial or ethnic groups	0	0	0	0	0	0	0
Other (please specify)	0	1	0	1	1	1	2
Total per county	**68**	**101**	**70**	**37**	**56**	**74**	**126**

10. New York State Prevention Agenda Goals

Top Three Goals for the ARHN Region:

Respondents were asked to choose three goals that their organization could assist in achieving in their counties. The top three goals for each NYS Prevention Agenda priority area aligned with most of the individual county goals.

Top Three Prevention Agenda Goals for the ARHN Region			
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Increase skills and knowledge to support healthy food and beverage choices	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Promote a Healthy and Safe Environment	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Prevent Communicable Disease	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

Top Three Goals by County:

To align with the structure of the survey, county analysis is provided per NYS Prevention Agenda priority area.

Prevent Chronic Disease

Most of the responses contained two specific goals, *Promote the use of evidence-based care to manage chronic diseases* and *Improve self-management skills for individuals with chronic disease.* Five out of the seven ARHN counties also listed *Promote tobacco use cessation*. Washington County was the only county to include *Improving community environments that support active transportation,* which aligns with the top ARHN goals.

Priority Area: Prevent Chronic Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Essex	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Franklin	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Promote the use of evidence-based care to manage chronic diseases
Fulton	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Increase skills and knowledge to support healthy food and beverage choices
Hamilton	Improve self-management skills for individuals with chronic disease	Promote the use of evidence-based care to manage chronic diseases	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Warren	Improve self-management skills for individuals with chronic disease	Increase skills and knowledge to support healthy food and beverage choices	Promote the use of evidence-based care to manage chronic diseases
Washington	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	Increase skills and knowledge to support healthy food and beverage choices

Promote Healthy Women, Infants and Children

All ARHN counties choose *Support and enhance children and adolescents' social-emotional development and relationships* as their number one goal. Clinton, Fulton, Hamilton, Warren and Washington counties also listed *Reduce racial, ethnic, economic and geographic disparities in maternal and child health outcomes* as one of their top three goals.

Priority Area: Promote Healthy Women, Infants and Children			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Essex	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Franklin	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Fulton	Support and enhance children and adolescents' social-emotional development and relationships	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations	Increase supports for children with special health care needs
Hamilton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Warren	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Washington	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

Promote a Healthy and Safe Environment

Promote healthy home and schools' environments was chosen as the top goal for all seven of the ARHN counties, as well as the ARHN region as a whole. *Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change* was also listed in the top three goals for every county.

Priority Area: Promote a Healthy and Safe Environment			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce falls among vulnerable populations
Essex	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Franklin	Promote healthy home and schools' environments	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	Reduce violence by targeting prevention programs to highest risk populations
Fulton	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Hamilton	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Warren	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Washington	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change

Promote Well-Being and Prevent Mental and Substance Use Disorders

Strengthen opportunities to promote well-being and resilience across the lifespan and *Facilitate supportive environments that promote respect and dignity for all ages* were both within the top three goals for every county. Five counties also listed *Prevent opioid and other substance misuse and deaths* in their top three goals.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Essex	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Franklin	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Fulton	Prevent opioid and other substance misuse and deaths	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages
Hamilton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Warren	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Washington	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths

Prevent Communicable Diseases

All seven ARHN counties listed *Improve vaccination rates, Improve infection control in health care facilities,* and *Reduce inappropriate antibiotic use* in the top three goals that their organization can assist in improving. *Reduce the annual growth rate for Sexually Transmitted Infections (STIs)* was also included in Fulton County's top three goals.

Priority Area: Prevent Communicable Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Essex	Improve vaccination rates	Reduce inappropriate antibiotic use	Improve infection control in health care facilities
Franklin	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Fulton	Improve vaccination rates	Reduce inappropriate antibiotic use	Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
Hamilton	Reduce inappropriate antibiotic use	Improve vaccination rates	Improve infection control in health care facilities
Warren	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Washington	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

12. Based on the goals you selected, please identify the resources your organization/agency can contribute toward achieving these goals.

Respondents were asked to indicate the resources that their organization/agency would be able to contribute toward achieving the goals they listed. The table below encompasses the top ten resources listed.

Approximately 70% of all respondents identified *Participating on committees, workgroups and coalitions* and *Share knowledge of community resources* as the main resources they can contribute to help achieve the NYS Prevention Agenda goals listed above. Respondents also felt strongly that they can deliver education and counseling and provide expertise relevant to achieving the listed goals.

This is the first year that we have asked this question in the stakeholder survey. This would be a helpful resource to explore further once partners begin exacting their approved plans.

Response Counts and Percentages for Resources Organizations Can Contribute		
Resources	**Count**	**Percentage**
Participate on committees, work groups, coalitions to help achieve the selected goals	208	70.99%
Share knowledge of community resources	204	69.62%
Deliver education and counseling relevant to the selected goal(s)	189	64.51%
Provide subject-matter knowledge and expertise	182	62.12%
Promote health improvement activities/events through social media and other communication channels your organization/agency operates	164	55.97%
Facilitate access to populations your organization/agency serves	139	47.44%

Provide letters of support for planned health improvement activities	124	42.32%
Offer health related-educational materials	117	39.93%
Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals	112	38.23%
Work to promote changes to policies/laws/community environment to address selected goal(s)	111	37.88%

Appendix A. 2019 Stakeholder Survey

2019 CHA Stakeholders Survey

Introduction

To help inform a collaborative approach to improving community health, the Adirondack Rural Health Network (ARHN) seeks to identify priorities, factors and resources that influence the health of residents of the Adirondack region (Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties).

You have been identified as a key informant who can provide insight into health and well-being of the people your organization/agency serves. Please answer the survey questions in the context of your role within your organization/agency and in representing the population(s) your organization/agency serves.

All survey information will be held confidential and no responses will be attributed to any one individual or agency.

Your Organization/Agency

Please provide the following information about your organization/agency and yourself:

1. Organization/Agency name:

2. Your name (Please provide first and last name):

3. Your job title/role:

- ☐ Community Members
- ☐ Direct Service Staff
- ☐ Program/Project Manager
- ☐ Administrator/Director
- ☐ Other (please specify)

4. Your email address:

5. Indicate the **one** community sector that best describes your organization/agency:

- ☐ Business
- ☐ Civic Association
- ☐ College/University
- ☐ Disability Services

- ☐ Early Childhood
- ☐ Economic Development
- ☐ Employment/Job training
- ☐ Faith-Based
- ☐ Food/Nutrition
- ☐ Foundation/Philanthropy
- ☐ Health Based CBO
- ☐ Health Care Provider
- ☐ Health Insurance Plan
- ☐ Housing
- ☐ Law Enforcement/Corrections
- ☐ Local Government (e.g. elected official, zoning/planning board)
- ☐ Media
- ☐ Mental, Emotional, Behavioral Health Provider
- ☐ Public Health
- ☐ Recreation
- ☐ School (K – 12)
- ☐ Seniors/Elderly
- ☐ Social Services
- ☐ Transportation
- ☐ Tribal Government
- ☐ Veterans
- ☐ Other (please specify):

6. Indicate the counties your organization/agency serves. **Check all that apply.**

- ☐ Adirondack/North Country Region
- ☐ Clinton
- ☐ Essex
- ☐ Franklin
- ☐ Fulton
- ☐ Hamilton
- ☐ Warren
- ☐ Washington
- ☐ Other: _____

Health Priorities, Concerns and Factors

The NYS Prevention Agenda for 2019-2024 identifies five main priority areas that are key to improving the health of residents that you serve. These main priority areas are listed in question #7.

7. Please rank, **by indicating 1 through 5**, the priority areas that, if addressed locally, would have the greatest to the smallest impact on improving the health and well-being of the residents of the counties your organization/agency serves. (#1 ranked priority area would have the most impact; #5 ranked priority area would have the least impact.)

- ☐ Prevent Chronic Diseases
- ☐ Promote Healthy Women, Infants and Children
- ☐ Prevent Communicable Diseases
- ☐ Promote a Healthy and Safe Environment
- ☐ Promote Well-Being and Prevent Mental and Substance Use Disorders

8. In your opinion, what are the **top five (5) health concerns** affecting the residents of the counties your organization/agency serves? Please rank the health concerns from 1 (highest) to 5 (lowest).

- ☐ Adverse childhood experiences
- ☐ Alzheimer's disease/Dementia
- ☐ Arthritis
- ☐ Autism
- ☐ Cancers
- ☐ Child/Adolescent physical health
- ☐ Child/Adolescent emotional health
- ☐ Diabetes
- ☐ Disability
- ☐ Dental health
- ☐ Domestic abuse/violence
- ☐ Drinking water quality
- ☐ Emerging infectious diseases (ebola, zika virus, tick and mosquito-transmitted, etc.)
- ☐ Exposure to air and water pollutants/hazardous materials
- ☐ Falls
- ☐ Food safety
- ☐ Heart disease
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hunger
- ☐ Infant health
- ☐ Infectious disease
- ☐ LGBT health

- ☐ Maternal health
- ☐ Mental health conditions
- ☐ Motor vehicle safety (impaired/distracted driving)
- ☐ Opioid use
- ☐ Overweight or obesity
- ☐ Pedestrian/bicyclist accidents
- ☐ Prescription drug abuse
- ☐ Respiratory disease (asthma, COPD, etc.)
- ☐ Senior health
- ☐ Sexual assault/rape
- ☐ Sexually transmitted infections
- ☐ Social connectedness
- ☐ Stroke
- ☐ Substance abuse
- ☐ Suicide
- ☐ Tobacco use/nicotine addiction – smoking/vaping/chewing
- ☐ Underage drinking/excessive adult drinking
- ☐ Unintended/Teen pregnancy
- ☐ Violence (assault, firearm related)
- ☐ Other (Please specify):

9. In your opinion, what are the **top five** (**5**) **contributing factors** to the health concerns you chose in question #8? Please rank the contributing factors from 1 (highest) to 5 (lowest).

- ☐ Addiction to alcohol
- ☐ Addiction to illicit drugs
- ☐ Addiction to nicotine
- ☐ Age of residents
- ☐ Changing family structures (increased foster care, grandparents as parents, etc.)
- ☐ Crime/violence/community blight
- ☐ Deteriorating infrastructure (roads, bridges, water systems, etc.)
- ☐ Discrimination/racism
- ☐ Domestic violence and abuse
- ☐ Environmental quality
- ☐ Excessive screen time
- ☐ Exposure to tobacco smoke/emissions from electronic vapor products
- ☐ Food insecurity
- ☐ Health care costs
- ☐ Homelessness
- ☐ Inadequate physical activity
- ☐ Inadequate sleep
- ☐ Inadequate/unaffordable housing options
- ☐ Lack of chronic disease screening, treatment and self-management services

- ☐ Lack of cultural and enrichment programs
- ☐ Lack of dental/oral health care services
- ☐ Lack of educational opportunities for people of all ages
- ☐ Lack of educational, vocational or job-training options for adults
- ☐ Lack of employment options
- ☐ Lack of health education programs
- ☐ Lack of health insurance
- ☐ Lack of intergenerational connections within communities
- ☐ Lack of mental health services
- ☐ Lack of opportunities for health for people with physical limitations or disabilities
- ☐ Lack of preventive/primary health care services (screenings, annual check-ups)
- ☐ Lack of social supports for community residents
- ☐ Lack of specialty care and treatment
- ☐ Lack of substance use disorder services
- ☐ Late or no prenatal care
- ☐ Pedestrian safety (roads, sidewalks, buildings, etc.)
- ☐ Poor access to healthy food and beverage options
- ☐ Poor access to public places for physical activity and recreation
- ☐ Poor educational attainment
- ☐ Poor community engagement and connectivity
- ☐ Poor eating/dietary practices
- ☐ Poor health literacy (ability to comprehend health information)
- ☐ Poor referrals to health care, specialty care, and community-based support services
- ☐ Poverty
- ☐ Problems with Internet access (absent, unreliable, unaffordable)
- ☐ Quality of schools
- ☐ Religious or spiritual values
- ☐ Shortage of child care options
- ☐ Stress (work, family, school, etc.)
- ☐ Transportation problems (unreliable, unaffordable)
- ☐ Unemployment/low wages
- ☐ Other (please specify)

Social Determinants of Health

10. Social Determinants of Health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Please rate the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "very poor" to (5) "excellent".

- ☐ **Economic Stability** (consider poverty, employment, food security, housing stability)

- ☐ **Education** (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)

- ☐ **Social and Community Context** (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)

- ☐ **Neighborhood and Built Environment** (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)

- ☐ **Health and Health Care** (consider access to primary care, access to specialty care, health literacy)

11. In your opinion, what **population** in the counties your organization/agency serves experiences the poorest health outcomes? Please select **one** population.

- ☐ Specific racial or ethnic groups
- ☐ Children/adolescents
- ☐ Females of reproductive age
- ☐ Seniors/elderly
- ☐ Individuals with disability
- ☐ Individuals living at or near the federal poverty level
- ☐ Individuals with mental health issues
- ☐ Individuals living in rural areas
- ☐ Individuals with substance abuse issues
- ☐ Migrant workers
- ☐ Others (please specify):

Improving Health and Well-Being

The NYS Prevention Agenda 2019-2024 identifies specific goals for improving the health of New Yorkers of all ages. New York State envisions that improving the health of all New Yorkers requires strategies that can be implemented by a diverse set of health and non-health organizations and agencies.

12. Over the next 5 questions, select the top 3 goals your organization/agency can assist in achieving in the counties it serves.

13. Prevent Chronic Diseases

- ☐ Increase access to healthy and affordable food and beverages
- ☐ Increase skills and knowledge to support healthy food and beverage choices
- ☐ Increase food security
- ☐ Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
- ☐ Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
- ☐ Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
- ☐ Prevent initiation of tobacco use, including combustible tobacco and vaping products by youth and young adults
- ☐ Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low income; frequent mental distress/substance use disorder; LGBT; and disability
- ☐ Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
- ☐ Increase screening rates for breast, cervical, and colorectal cancer
- ☐ Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
- ☐ Promote the use of evidence-based care to manage chronic diseases
- ☐ Improve self-management skills for individuals with chronic disease

14. Promote Healthy Women, Infants, and Children

- ☐ Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age
- ☐ Reduce maternal mortality and morbidity
- ☐ Reduce infant mortality and morbidity
- ☐ Increase breastfeeding
- ☐ Support and enhance children and adolescents' social-emotional development and relationships
- ☐ Increase supports for children with special health care needs
- ☐ Reduce dental caries (cavities) among children
- ☐ Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

15. Promote a Healthy and Safe Environment

- ☐ Reduce falls among vulnerable populations
- ☐ Reduce violence by targeting prevention programs to highest risk populations
- ☐ Reduce occupational injury and illness

- ☐ Reduce traffic-related injuries for pedestrians and bicyclists
- ☐ Reduce exposure to outdoor air pollutants
- ☐ Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
- ☐ Promote healthy home and schools' environments
- ☐ Protect water sources and ensure quality drinking water
- ☐ Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
- ☐ Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
- ☐ Improve food safety management

16. Promote Well-Being and Prevent Mental and Substance Use Disorders

- ☐ Strengthen opportunities to promote well-being and resilience across the lifespan
- ☐ Facilitate supportive environments that promote respect and dignity for people of all ages
- ☐ Prevent underage drinking and excessive alcohol consumption by adults
- ☐ Prevent opioid and other substance misuse and deaths
- ☐ Prevent and address adverse childhood experiences
- ☐ Reduce the prevalence of major depressive episodes
- ☐ Prevent suicides
- ☐ Reduce the mortality gap between those living with serious mental illness and the general population

17. Prevent Communicable Diseases

- ☐ Improve vaccination rates
- ☐ Reduce vaccination coverage disparities
- ☐ Decrease HIV morbidity (new HIV diagnoses)
- ☐ Increase HIV viral suppression
- ☐ Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
- ☐ Increase the number of persons treated for Hepatitis C
- ☐ Reduce the number of new Hepatitis C cases among people who inject drugs
- ☐ Improve infection control in health care facilities
- ☐ Reduce infections caused by multidrug resistant organisms and C. difficile
- ☐ Reduce inappropriate antibiotic use

18. Based on the goals you selected in Questions 12-16, please identify the primary assets/resources your organization/agency can contribute toward achieving the goals you have selected.

- ☐ Provide subject-matter knowledge and expertise
- ☐ Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)
- ☐ Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals
- ☐ Participate on committees, work groups, coalitions to help achieve the selected goals
- ☐ Share knowledge of community resources (e.g. food, clothing, housing, transportation, etc.)
- ☐ Facilitate access to populations your organization/agency serves (to encourage participation in programs, provide feedback about health improvement efforts, etc.)
- ☐ Promote health improvement activities/events through social media and other communication channels your organization/agency operates
- ☐ Share program-level data to help track progress in achieving goals
- ☐ Provide in-kind space for health improvement meetings/events
- ☐ Offer periodic organizational/program updates to community stakeholders
- ☐ Provide staff time to help conduct goal-related activities
- ☐ Provide letters of support for planned health improvement activities
- ☐ Sign partnership agreements related to community level health improvement efforts
- ☐ Assist with data analysis
- ☐ Offer health related-educational materials
- ☐ Other (please specify):

19. Are you interested in being contacted at a later date to discuss the utilization of the resources you identified in Question #17?

- ☐ Yes
- ☐ No

20. Please add any other comments/recommendations you have about improving the health and well-being of the residents of the counties your organization/agency serves.

PRIORITIZATION WORKSHEET
8/27/2019

Please work through each FOCUS AREA - for Ability to Impact & Community Readiness, apply your working knowledge on our organization's capacity, pressures, etc. Apply a number (0,1, 3, 5) for each of the 8 columns (**Cope, Severity, Ability to Impact, Community Readiness**) **& then the grey SCORE column to the right of the FOCUS AREA column will populate giving how you scored each Focus Area.**

SCORE
5 = High Impact/Need
3 = Medium Impact/Need
1 = Low Impact/Need
0 = Not Applicable

			SCOPE		**SEVERITY**		**ABILITY TO IMPACT**		**COMMUNITY READINESS**	
			Breadth	**Inequities/ disparities**	**Community Cost**	**Negative outcomes**	**Resource Capacity**	**Confidence**	**Stakeholder Support**	**Prevailing Community Attitude**
		DESCRIPTION	relatively high % or rate or trending poorly	identifiable sub-population(s) with greater risk	relatively high dollars/time/ social consequences	across other aspects of life & across lifespan	funds, staff, time	evidenced-based practices available; confidence in implementing interventions to produce desired outcomes	leaders, policy makers, community collaborators	Acceptance of the issue and support for interventions
PRIORITY AREAS	FOCUS AREAS	SCORE (0-5)								
Prevent Chronic Diseases	1. Healthy Eating & Food Security	**16**	1.00	1.00	1.00	1.00	3.00	3.00	3.00	3.00
	2. Physical Activity	**38**	5.00	5.00	3.00	5.00	5.00	5.00	5.00	5.00
	3. Tobacco Prevention	**38**	5.00	5.00	3.00	5.00	5.00	5.00	5.00	5.00
	4. Preventive Care & Management	**40**	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
	5	**0**								
Promote a Healthy & Safe Environment	1. Injuries, Violence & Occupational Health	**8**	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	2. Outdoor Air Quality	**24**	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	3. Built & Indoor Environments	**8**	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	4. Water Quality	**24**	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	5. Food & Consumer Products	**24**	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	6	**0**								
Promote Healthy Women, Infants & Children	1. Maternal & Women's Health	**40**	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
	2. Perinatal & Infants Health	**40**	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
	3. Child & Adolescent Health	**40**	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
	4. Cross Cutting Healthy WIC	**24**	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	5	**0**								
Promote Well-bring and Prevent MH & SUDs	1. Promote Well-being	**40**	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
	2. Prevent Mental & Substance Use Disorders	**40**	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
	3	**0**								
Prevent Communicable Diseases	1. Vaccine-Preventable Diseases	**8**	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	2. HIV	**24**	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	3. STIs	**24**	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	4. HepC	**24**	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	5. Antibiotic Resistence & Healthcare Associated Infections	**24**	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
	6	**0**								

Adirondack Health
2019 Workplan

Planning Report Liaison Adirondack Health — Dan Hill
E-mail: dhill@adirondackhealth.org — dhill@adirondackhealth.org
Hbailey@adirondackhealth.org

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Potential Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%.	Income, Access , Disability	3.2.1 Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment	Number of patients who quit and sustained smoking cessation.	Establish baseline measures for quality improvement that focuses on increasing provider delivery of an advice statement per evidence-based guidance.	Standing orders followed and administered by health center clinical staff.	Implement and maintain workflow to ensure all essential providers are screening for tobacco use.	Community-based organizations
		Goal 3.2 Promote tobacco use cessation	Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%.	Income, Access , Disability	3.2.2 Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline.	Number of media and marketing outreach encounters. Number of providers participating in smoking cessation campaigns.	Provide guidance and education to health centers providers. Particiapte in marketing outreach.	Provide guidance and education to health centers providers. Particiapte in marketing outreach.	Provide guidance and education to health centers providers. Particiapte in marketing outreach.	Community-based organizations
	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years)	Income, Access, Disability	4.1.1 Systems change for cancer screening reminders	Number of patients reached through patient reminder system and compliance with Cancer screening guidelines.	Review current practice for reliability and timeliness to ensure reminders are being sent by all providers	Continue to track patient reminders	Continue to track patient reminders	Community-based organizations
	Focus Area 4: Preventive care and management	Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%	Income, Access, Disability	4.2.1 Promote strategies that improve the detection of undiagnosed hypertension in health systems	Policy/practices in place to identify at-risk patients .	Utilize electronic health records and HIXNY to gather patients lists to identify individuals with undiagnosed hypertension and pre-diabetes.	Policies/practices in place for providers,nurses and medical office assistants to promote and detect chronic diseases	Identify chronic disease self management educator and host education session.	Community-based organizations
		Goal 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%	Income, Access, Disability	4.2.2 Promote testing for pre-diabetes	% of patients with improved HbA1c, weight loss and physical activity measure.	Promote referrals of patients to chronic disease wellness coaches.	Promote referrals of patients to chronic disease wellness coaches.	Promote referrals of patients to chronic disease wellness coaches.	Community-based organizations
	Focus Area 4: Preventive care and management	Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%)	Income, Access, Care Coordination	4.3.1 Team based approach to chronic disease outcomes	Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote # referrals of patients to chronic disease wellness coaches.	Identify undiagnosed pre-diabetic through electronic health records. Monitor patients with quality dashboard.	Conduct in-service education to medical staff for further expansion of chronic disease prevention program.	Increase access to chronic disease wellness coaches to schools and worksites.	Community-based organizations

Adirondack Health
2019 Workplan

Planning Report Liaison Adirondack Health — Dan Hill
E-mail: dhill@adirondackhealth.org — dhill@adirondackhealth.org
Hbailey@adirondackhealth.org

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Potential Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*
		Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Decrease the percentage of adult members with diabetes whose most recent HbA1c level indicated poor control (>9%)	Income, Access, Care Coordination	4.3.5 Promote referral of patients with prediabetes to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program to achieve and maintain 5% to 7% loss of initial body weight and increase moderate-intensity physical activity (such as brisk walking) to at least 150 min/week.	Policy/practices to identify at-risk patients . % of patients with improved HbA1c, weight loss and physical activity measure. Promote # referrals of patients to chronic disease wellness coaches.	Identify undiagnosed pre-diabetic through electronic health records. Monitor patients with quality dashboard.	Conduct in-service education to medical staff for further expansion of chronic disease prevention program.	Increase access to chronic disease wellness coaches to schools and worksites.	Community-based organizations
	Focus Area 4: Preventive care and management	Goal 4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class how to learn how to manage their condition.	Income, Access, Disability	4.4.2 Expand access to chronic disease self management	Number of patients who participate in NDPP. Number of patients who complete NDPP.	Chronic disease wellness coaches certified to administer NDPP classes in 2020.	Track number of patients. Additional locations sites identified to increase access to classes.	Continue to track number of patients. Additional locations sites identified to increase access to classes.	Local health department

Adirondack Health
2019 Workplan

Planning Report Liaison Dan Hill
E-mail: dhill@adirondackhealth.org

Dan Hill
dhill@adirondackhealth.org

Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Promote Healthy Women, Infants and Children	Focus Area 1: Maternal & Women's Health	Goal 1.1: Increase use of primary and preventive health care services by women, with a focus on women of reproductive age	Objective 1.1.1: Increase the percentage of women ages 18-44 years with a past year preventive medical visit by 10% to 80.6%.	Access, Income, social and environmental context	1.1.1 Incorporate strategies to promote health insurance enrollment, well-woman visits, and age-appropriate preventive health care across public health programs serving women	Number of patients enrolled	Provide facilitated enrollment at women's health clinic.	Provide facilitated enrollment at women's health clinic.	Provide facilitated enrollment at women's health clinic.	Local health department	Franklin and Essex County Public Health Department will assist by increasing access to care by acting as a referral mechanism for women.

Adirondack Health
2019 Workplan

Planning Report Liaison Dan Hill
E-mail: dhill@adirondackhealth.org

Dan Hill
dhill@adirondackhealth.org

Priority	Focus Area	Goal	Objectives	Disparities	Interventions	Family of Measures	Projected (or completed) Year 1 Intervention	Projected Year 2	Projected Year 3 Interventions	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	Achieve Health System goal of becoming an age friendly institution with the 4M's framework from IHI; Reduce the percentage of adults 65+ New Yorkers reporting frequent mental distress during the past month by 10% to no more than 13%.	Income, Access, Disability	1.2.3 Policy and program interventions that promote inclusion, integration and competence (Age Friendly)	Number of patients with advance care planning in place, number of patients with who have had fall risk screen using STEADI assessment on all patients over 65 and referred to PT as needed.Number of patients over age 65 screened for depression using PHQ-9 assessment	Implement policy and procedure within the Emergency department. Implement structured fields in hospital electronic medical records to assess 4M's- Mentation, Medication, What Matters and Mobility	Complete assessment of health centers and identify needs. Create a plan for implementation of Age Friendly initiative and work with Nurse Manager to build annual wellness assessment to include the 4 M's. Work with medical staff to incorporate what Matters into their progress note.	Review the assessment data to ensure proper documentation is completed. Speak with staff about the effectiveness and workflow while entering assessments. Review and revise assessments and documentation based on feedback from patients and staff.	Local health department	Mercy Care for the Adirondack will support by communicating efforts to the region, provide expertise. Franklin County Public Health will provide support and help identify seniors at risk of negative health outcomes that can benefit from hospital services. Franklin and Essex County Office of the Aging will further provide expertise, referrals and assistance with programming to improve well-being.
	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	Increase the age-adjusted Buprenorphine prescribing rate for substance abuse by 20% to 43.8 per 1,000 population. Baseline 36.5 per 1,000	Income, Access, Disability	2.2.2 Availability/access to OD reversal	Number of opioid ED encounters referred to open access clinic, number of users prescribed Buprenorphine.	Narcan available at all Emergency Departments and Health Centers. Develop partnership with OASES organization. Recruit and retain prescribing provider.	Narcan available at all Emergency Departments and Health Centers.	Narcan available at all Emergency Departments and Health Centers.	Providers	St. Josephs Addiction Treatment Center will partner with hospital to provide continued care coordination and information sharing to ensure patients receive the appropriate level of care.
					2.2.3 Prescriber education regarding opioid guidelines/limits	Number of provider education classes taken.	Identify provider education.	Provide annual medical staff in service education.	Provide annual medical staff in service education.	Providers	St. Josephs Addiction Treatment Center will partner with hospital to provide continued care coordination and information sharing to ensure patients receive the appropriate level of care.
					2.2.5 Safe disposal sites & take-back days	Number of prescription drugs obtained in safe disposal boxes.	Safe Disposal site located on campus.	Safe Disposal site located on campus.	Safe Disposal site located on campus.	Providers	St. Josephs Addiction Treatment Center will partner with hospital to provide continued care coordination and information sharing to ensure patients receive the appropriate level of care.
		Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population	Decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4%	Income, Access, Disability	2.6.2 Integrated treatment: Concurrent therapy for mental illness and nicotine addiction have the best outcomes.	Number of mental health patients referred to tobacco cessation counselor, number of tobacco users referred to mental health	Implementing a referral system within health centers to increase referrals to tobacco cessation counselors	Continue to track and refer mental health patients to tobacco cessation counselors	Continue to track and refer mental health patients to tobacco cessation counselors	Hospital	St. Josephs Addiction Treatment Center will partner with hospital to provide continued care coordination and information sharing to ensure patients receive the appropriate level of care.

Essex County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
1. Percentage of Overall Premature Deaths (before age 65 years), 2016				19.1%	22.8%	22.4%	24.0%	**21.8%**	Meets/Better						
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				0.0*	1.69	2.05	1.95	**1.87**	Less than 10						
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				0.94+	2.12	2.16	1.87	**1.86**	Less than 10						
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016				109.0	N/A	116.80	124.00	**122.0**	Meets/Better						
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016				0.0+	N/A	2.04	2.07	**1.85**	Less than 10						
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016				0.0+	N/A	1.27	1.28	**1.38**	Less than 10						
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016				94.0%	N/A	N/A	91.4%	**100.0%**	Worse	X					
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016				88.5%	N/A	84.4%	82.6%	**90.8%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	25.0%	0.0%
Other Disparity Indicators															
1. Rate of Total Deaths per 100,000 Population, 2014-2016	362	452	414	1,065.4	990.5	**877.4**	769.8	N/A	Worse	X					
2. Rate of Emergency Department Visits per 10,000 Population, 2016				4,912.1	4,866.3	**3,865.6**	4,169.1	N/A	Worse		X				
3. Rate of Total Hospitalizations per 10,000 Population, 2016				708.4	1,039.9	**1,125.3**	1,154.4	N/A	Worse	X					
4. Percentage of Adults (18 and Older) Who Did Not Receive Medical Care Due to Costs, 2016				6.7%	9.9%	**9.8%**	11.2%	N/A	Meets/Better						
5. Percentage of Adults (18 and Older) Who Report 14 Days or More of Poor Physical Health, 2016				15.4%	14.3%	**12.0%**	11.3%	N/A	Worse		X				
6. Percentage of Adults (18 and Older) Living with a Disability, 2016				26.8%	25.6%	**22.8%**	22.9%	N/A	Worse	X					
Quartile Summary for Other Indicators										3	2	0	0	83.3%	0.0%
Quartile Summary for Focus Area Disparities										5	2	0	0	50.0%	0.0%

Franklin County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
1. Percentage of Overall Premature Deaths (before age 65 years), 2016				24.4%	22.8%	22.4%	24.0%	**21.8%**	Worse	X					
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				1.71+	1.69	2.05	1.95	**1.87**	Less than 10						
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				0.00+	2.12	2.16	1.87	**1.86**	Less than 10						
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016				111.5	N/A	116.80	124.00	**122.0**	Meets/Better						
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016				N/A	N/A	2.04	2.07	**1.85**	Less than 10						
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016				N/A	N/A	1.27	1.28	**1.38**	Less than 10						
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016				92.3%	N/A	N/A	91.4%	**100.0%**	Worse	X					
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016				81.1%	N/A	84.4%	82.6%	**90.8%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	37.5%	0.0%
Other Disparity Indicators															
1. Rate of Total Deaths per 100,000 Population, 2014-2016	423	494	450	897.4	990.5	**877.4**	769.8	N/A	Worse	X					
2. Rate of Emergency Department Visits per 10,000 Population, 2016				4,694.2	4,866.3	**3,865.6**	4,169.1	N/A	Worse	X					
3. Rate of Total Hospitalizations per 10,000 Population, 2016				869.3	1,039.9	**1,125.3**	1,154.4	N/A	Worse	X					
4. Percentage of Adults (18 and Older) Who Did Not Receive Medical Care Due to Costs, 2016				7.5%	9.9%	**9.8%**	11.2%	N/A	Meets/Better						
5. Percentage of Adults (18 and Older) Who Report 14 Days or More of Poor Physical Health, 2016				13.5%	14.3%	**12.0%**	11.3%	N/A	Worse	X					
6. Percentage of Adults (18 and Older) Living with a Disability, 2016				24.5%	25.6%	**22.8%**	22.9%	N/A	Worse	X					
Quartile Summary for Other Indicators										5	0	0	0	83.3%	0.0%
Quartile Summary for Focus Area Disparities										8	0	0	0	57.1%	0.0%

Essex County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
1. Rate of Hospitalizations due to Falls per 10,000 - Ages 65+, 2016				110.3	155.7	189.9	179.0	**204.6**	Meets/Better						
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children, 2016				569.3	523.8	408.5	397.3	**429.1**	Worse		X				
3. Rate of Assault-Related Hospitalizations per 10,000 Population, 2016				0.0*	1.3	2.2	3.2	**4.3**	Less than 10						
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	6.4	6.2	**6.7**	Less than 10						
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	2.1	2.8	**2.8**	Less than 10						
6. Ratio of Assault-Related Hospitalizations for Low-Income versus Non-Low Income Zip Codes, 2016				N/A	N/A	2.9	3.0	**2.9**	Less than 10						
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population, 2016				82.1	64.9	29.4	21.3	**33.0**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										0	1	0	1	28.6%	50.0%
Other Indicators															
1. Falls hospitalization rate per 10,000 - Aged <10 years, 2016				0.0*	N/A	**6.5**	7.4	N/A	Less than 10						
2. Falls hospitalization rate per 10,000 - Aged 10-14 years, 2016				0.0*	N/A	**3.6**	4.5	N/A	Less than 10						
3. Falls hospitalization rate per 10,000 - Aged 15-24 years, 2016				N/A	N/A	**4.2**	4.8	N/A	Less than 10						
4. Falls hospitalization rate per 10,000 - Aged 25-64 years, 2016				11.6	N/A	**17.4**	17.0	N/A	Meets/Better						
5. Rate of Violent Crimes per 100,000 Population, 2017				172.6	171.8	**214.9**	355.6	N/A	Meets/Better						
6. Rate of Property Crimes per 100,000 Population, 2017				975.6	1,481.8	**1,479.5**	1,466.1	N/A	Meets/Better						
7. Rate of Total Crimes per 100,000 Population, 2017				1,148.2	1,427.1	**1,694.4**	1,821.7	N/A	Meets/Better						
8. Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, '13-15				N/A	N/A	**1.6**	**1.3**	N/A	Less than 10						
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population, 2016				N/A	N/A	**8.8**	6.3	N/A	Less than 10						
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2016				N/A	N/A	**7.7**	5.5	N/A	Less than 10						
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, '14-16	19	16	15	101.8	N/A	**167.3**	133.8	N/A	Meets/Better						
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed, '14-16	3	1	4	16.3*	17.9	**18.5**	17.3	N/A	Less than 10						
13. Rate of Total Motor Vehicle Crashes per 100,000, 2017				2,779.5	2,162.0	**2,022.7**	1,558.5	N/A	Worse		X				
14. Rate of Speed-Related Accidents per 100,000 Population, 2017				685.0	364.7	**214.2**	141.6	N/A	Worse				X		
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2017				7.9	7.3	**7.1**	5.0	N/A	Worse	X					
16. Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2016				2.8	N/A	**8.6**	8.3	N/A	Meets/Better						

17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, 2016				45.9	61.8	**68.3**	63.3	N/A	Meets/Better						
18. Rate of Unintentional Injury Hospitalizations Ages 10 to 14 per 10,000 Population, 2016				N/A	N/A	**12.5**	13.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2016				142.3	198.0	**239.3**	227.9	N/A	Meets/Better						
20. Rate of Poisoning Hospitalizations per 10,000 Population, 2016				2.4*	N/A	**7.1**	7.2	N/A	Less than 10						
Quartile Summary for Other Indicators										1	1	0	1	15.0%	33.3%
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										1	2	0	2	18.5%	40.0%

Franklin County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
1. Rate of Hospitalizations due to Falls per 10,000 - Ages 65+, 2016				156.9	155.7	189.9	179.0	**204.6**	Meets/Better						
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children, 2016				547.0	523.8	408.5	397.3	**429.1**	Worse		X				
3. Rate of Assault-Related Hospitalizations per 10,000 Population, 2016				1.2*	1.3	2.2	3.2	**4.3**	Less than 10						
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	6.4	6.2	**6.7**	Less than 10						
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	2.1	2.8	**2.8**	Less than 10						
6. Ratio of Assault-Related Hospitalizations for Low-Income versus Non-Low Income Zip Codes, 2016				N/A	N/A	2.9	3.0	**2.9**	Less than 10						
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population, 2016				67.9	64.9	29.4	21.3	**33.0**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										0	1	0	1	28.6%	50.0%
Other Indicators															
1. Falls hospitalization rate per 10,000 - Aged <10 years, 2016				N/A	N/A	**6.5**	7.4	N/A	Less than 10						
2. Falls hospitalization rate per 10,000 - Aged 10-14 years, 2016				0.0*	N/A	**3.6**	4.5	N/A	Less than 10						
3. Falls hospitalization rate per 10,000 - Aged 15-24 years, 2016				N/A	N/A	**4.2**	4.8	N/A	Less than 10						
4. Falls hospitalization rate per 10,000 - Aged 25-64 years, 2016				12.7	N/A	**17.4**	17.0	N/A	Meets/Better						
5. Rate of Violent Crimes per 100,000 Population, 2017				198.7	171.8	**214.9**	355.6	N/A	Meets/Better						
6. Rate of Property Crimes per 100,000 Population, 2017				1,168.4	1,481.8	**1,479.5**	1,466.1	N/A	Meets/Better						
7. Rate of Total Crimes per 100,000 Population, 2017				1,367.1	1,427.1	**1,694.4**	1,821.7	N/A	Meets/Better						
8. Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, '13-15				N/A	N/A	**1.6**	**1.3**	N/A	Less than 10						
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population, 2016				N/A	N/A	**8.8**	6.3	N/A	Less than 10						
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2016				N/A	N/A	**7.7**	5.5	N/A	Less than 10						
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, '14-16	18	19	20	100.1	N/A	**167.3**	133.8	N/A	Meets/Better						
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed, '14-16	3	2	1	10.5*	17.9	**18.5**	17.3	N/A	Less than 10						
13. Rate of Total Motor Vehicle Crashes per 100,000, 2017				2,273.3	2,162.0	**2,022.7**	1,558.5	N/A	Worse	X					
14. Rate of Speed-Related Accidents per 100,000 Population, 2017				498.9	364.7	**214.2**	141.6	N/A	Worse				X		
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2017				7.8	7.3	**7.1**	5.0	N/A	Worse	X					
16. Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2016				3.8	N/A	**8.6**	8.3	N/A	Meets/Better						

17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, 2016				46.0	61.8	**68.3**	63.3	N/A	Meets/Better					
18. Rate of Unintentional Injury Hospitalizations Ages 10 to 14 per 10,000 Population, 2016				0.0*	N/A	**12.5**	13.6	N/A	Less than 10					
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2016				185.8	198.0	**239.3**	227.9	N/A	Meets/Better					
20. Rate of Poisoning Hospitalizations per 10,000 Population, 2016				5.8	N/A	**7.1**	7.2	N/A	Meets/Better					
Quartile Summary for Other Indicators										2	0	0	1	15.0%	33.3%
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										2	1	0	2	18.5%	40.0%

Franklin County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Outdoor Air Quality															
1. Number of Days with Unhealthy Ozone, 2015-2017				N/A	N/A	21.0	N/A	**0.00**	Less than 10						
2. Number of Days with Unhealthy Particulate Matter, 2015-2017				N/A	N/A	0.00	N/A	**0.00**	Less than 10						
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%
Focus Area: Built Environment															
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2017				0.0%	17.2%	61.6%	35.6%	**32.0%**	Less than 10						
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, 2012-2016				20.9%	19.0%	22.9%	45.7%	**49.2%**	Worse			X			
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				9.3%	6.0%	3.9%	2.3%	**2.2%**	Worse				X		
4. Percentage of Adults Experiencing Food Insecurity '13/14				21.0%	23.3%	**22.7%**	29.0%	N/A	Meets/Better						
5. Percentage of Adults Experiencing Housing Insecurity, 2016				22.9%	29.9%	**30.9%**	35.5%	N/A	Meets/Better						
6. Percentage of Homes in Healthy Neighborhoods Program that have Fewer Asthma Triggers During Home Revisits, 2013-2016				N/A	N/A	20.5%	N/A	**25.0%**	Meets/Better						
Quartile Summary for Focus Area Built Environment										0	0	1	1	33.3%	100.0%
Focus Area: Water Quality															
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2017				3.3%	26.9%	46.6%	70.8%	**78.5%**	Worse				X		
Quartile Summary for Focus Area Water Quality										0	0	0	1	100.0%	100.0%

Essex County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Outdoor Air Quality															
1. Number of Days with Unhealthy Ozone, 2015-2017				N/A	N/A	21.0	N/A	**0.00**	Less than 10						
2. Number of Days with Unhealthy Particulate Matter, 2015-2017				N/A	N/A	0.00	N/A	**0.00**	Less than 10						
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%
Focus Area: Built Environment															
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2017				100.0%	0.0%	61.6%	35.6%	**32.0%**	Less than 10						
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, 2012-2016				19.7%	19.0%	22.9%	45.7%	**49.2%**	Worse			X			
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				2.2%	6.0%	3.9%	2.3%	**2.2%**	Meets/Better						
4. Percentage of Adults Experiencing Food Insecurity '13/14				20.9%	23.3%	**22.7%**	29.0%	N/A	Meets/Better						
5. Percentage of Adults Experiencing Housing Insecurity, 2016				29.4%	29.9%	**30.9%**	35.5%	N/A	Meets/Better						
6. Percentage of Homes in Healthy Neighborhoods Program that have Fewer Asthma Triggers During Home Revisits, 2013-2016				N/A	N/A	20.5%	N/A	**25.0%**	Meets/Better						
Quartile Summary for Focus Area Built Environment										0	0	1	0	16.7%	100.0%
Focus Area: Water Quality															
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2017				0.0%	26.9%	46.6%	70.8%	**78.5%**	Worse				X		
Quartile Summary for Focus Area Water Quality										0	0	0	1	100.0%	100.0%

Essex County Revised: April 2019

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Maternal and Infant Health															
Prevention Agenda Indicators															
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2016				7.9%	9.8%	10.5%	10.3%	**10.2%**	Meets/Better						
2. Ratio of Preterm Births (< 37 wks.) Black/NH to White/NH, 2014-2016				N/A	N/A	1.65	1.64	**1.42**	Less than 10						
3. Ratio of Preterm Births (< 37 wks.) Hisp/Latino to White/NH, 2014-2016				N/A	N/A	1.28	1.29	**1.12**	Less than 10						
4. Ratio of Preterm Births (< 37 wks.) Medicaid to Non-Medicaid, 2014-2016				1.28	N/A	1.10	1.06	**1.00**	Worse		X				
5. Rate of Maternal Mortality per 100,000 Births, 2014-2016				0.0*	N/A	18.9	20.4	**21.0**	Less than 10						
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2016				65.3%	63.0%	50.9%	46.3%	**48.1%**	Meets/Better						
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	0.55	0.59	**0.57**	Less than 10						
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, 2014-2016				N/A	N/A	0.57	0.57	**0.56**	Less than 10						
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, 2014-2016				0.87	N/A	0.68	0.59	**0.66**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	11.1%	0.0%
Other Indicators															
1. Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '14-16	1	6	5	1.4%	3.9%	**1.5%**	1.5%	N/A	Meets/Better						
2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '14-16	16	16	18	5.7%	7.5%	**7.4%**	7.3%	N/A	Meets/Better						
3. Percentage of Total Births with Weights Less Than 1,500 grams, '14-16	1	5	4	1.1%	1.2%	**1.3%**	1.4%	N/A	Meets/Better						
4. Percentage of Singleton Births with Weights Less Than 1,500 grams, '14-16	1	3	3	0.8*%	0.9%	**1.0%**	1.0%	N/A	Less than 10						
5. Percentage of Total Births with Weights Less Than 2,500 grams, '14-16	14	19	18	5.7%	6.7*%	**7.6%**	7.9%	N/A	Meets/Better						
6. Percentage of Singleton Births with Weights Less Than 2,500 grams, '14-16	10	17	14	4.7%	5.1*%	**5.7%**	6.0%	N/A	Meets/Better						
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	**12.9%**	12.2%	N/A	Less than 10						
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	**7.5%**	7.7%	N/A	Less than 10						
9. Infant Mortality Rate per 1,000 Live Births, '14-16	0	0	1	1.1*	5.7*	**5.0**	4.5	N/A	Less than 10						
10. Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, '14-16	1	0	0	3.1*	3.5*	**5.3**	5.1	N/A	Less than 10						
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '14-16	220	239	180	71.4%	75.4%	**77.0%**	75.2%	N/A	Worse	X					
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '14-16				N/A	N/A	**68.5%**	64.5%	N/A	Less than 10						
13. Percentage Early Prenatal Care for Hispanic/Latino, '14-16				N/A	N/A	**71.1%**	76.7%	N/A	Less than 10						

14. Percentage APGAR Scores of Less Than Six at Five Minute Mark of Births Where APGAR Score is Known, '14-16	3	6	2	1.2%	1.1%	**0.9%**	0.7%	N/A	Worse		X				
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '13-15				106.1	0.0	**0.0**	104.8	N/A	Worse	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
16. Percentage WIC Women Breastfeeding for at least 6 months, '14-16				23.6%	N/A	**30.7%**	40.3%	N/A	Worse	X					
17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '14-16	186	207	185	85.1%	79.5%	**82.9%**	87.3%	N/A	Meets/Better						
Quartile Summary for Other Indicators										2	1	0	0	17.6%	0.0%
Quartile Summary for Focus Area Maternal and Infant Health										2	2	0	0	13.8%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Preconception and Reproductive Health															
Prevention Agenda Indicators															
1. Percent of Births within 24 months of Previous Pregnancy, 2016				23.4%	23.2%	22.5%	19.8%	**17.0%**	Worse		X				
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2016				14.7	11.1	9.9	13.3	**25.6**	Less than 10						
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	4.30	4.80	**4.40**	Less than 10						
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, 2014-2016				N/A	N/A	3.50	4.40	**4.10**	Less than 10						
5. Percent of Unintended Pregnancies among Total Births, 2016				33.7%	32.9%	24.9%	22.6%	**23.8%**	Worse		X				
6. Ratio of Unintended Pregnancies Black, non-Hispanic to White, non-Hispanic, 2016				N/A	N/A	2.08	2.12	**1.90**	Less than 10						
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2016				N/A	N/A	1.49	1.68	**1.43**	Less than 10						
8. Ratio of Unintended Births Medicaid to Non-Medicaid, 2016				1.10	N/A	1.96	1.71	**1.54**	Meets/Better						
9. Percentage of Women Ages 18- 64 with Health Insurance, 2016				95.2%	N/A	N/A	93.1%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	2	0	0	33.3%	0.0%
Other Indicators															
1. Rate of Total Births per 1,000 Females Ages 15-44, '14-16	298	336	265	52.1	53.2	**57.2**	58.5	N/A	Meets/Better						
2. Percent Multiple Births of Total Births, '14-16	9	6	10	2.8%	3.5%	**4.0%**	3.7%	N/A	Meets/Better						
3. Percent C-Sections to Total Births, '14-16	104	103	92	33.3%	34.1%	**34.2%**	33.5%	N/A	Meets/Better						
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '14-16	361	421	335	58.8	64.5	**72.8**	83.8	N/A	Meets/Better						
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	1	0	0	0.4*	0.2*	**0.2**	0.2	N/A	Less than 10						
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	1	1	0	0.7*	0.3*	**0.4**	0.6	N/A	Less than 10						
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '14-16	10	11	10	14.4	12.5	**11.0**	15.1	N/A	Worse		X				
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	26	18	18	20.5	19.3	**13.2**	14.6	N/A	Worse			X			
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	32	32	25	26.8	28.1	**22.3**	29.8	N/A	Worse	X					
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	19	12	10	38.8	36.3*	**22.9**	25.6	N/A	Worse			X			

11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	22	21	15	49.6	50.4	**37.5**	50.1	N/A	Worse		X				
12. Percent Total Births to Women Ages 35 Plus, '14-16	44	57	39	15.6%	11.7%	**20.2%**	22.1%	N/A	Meets/Better						
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '14-16				333.3	434.5	**652.3**	990.8	N/A	Meets/Better						
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '14-16	30	49	45	126.5	181.4	**231.6**	370.9	N/A	Meets/Better						
15. Percentage of WIC Women Pre-pregnancy Underweight, '10-12	12	11	11	5.4%	4.9%	**4.1%**	4.7%	N/A	Worse		X				
16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	45	38	54	21.6%	22.3%	**26.3%**	26.6%	N/A	Meets/Better						
17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	66	63	55	29.1%	33.3%	**28.0%**	24.2%	N/A	Worse	X					
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	103	105	87	52.9%	52.4%	**47.1%**	41.7%	N/A	Worse	X					
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	14	23	20	9.6%	7.2%	**5.7%**	5.5%	N/A	Worse			X			
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	31	32	23	14.5%	12.9%	**9.1%**	7.1%	N/A	Worse			X			
Quartile Summary for Other Indicators										3	3	4	0	50.0%	40.0%
Quartile Summary for Focus Area Preconception and Reproductive Health										9	4	3	0	55.2%	18.8%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Child Health															
Prevention Agenda Indicators															
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2016				88.5%	89.8%	82.8%	80.1%	**91.3%**	Worse	X					
2. Percentage of Children Ages 3 - 6 Years with Government Insuranc with Recommended Well Visits, 2016				82.6%	84.9%	82.3%	84.3%	**91.3%**	Worse	X					
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2016				64.0%	69.5%	66.5%	68.1%	**67.1%**	Worse	X					
4. Percentage of Children Ages 0 -19 with Health Insurance, 2016				96.9%	N/A	N/A	97.4%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										4	0	0	0	100.0%	0.0%
Other Indicators															
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, '14-16	0	0	0	0.0*	26.8	**19.4**	18.2	N/A	Less than 10						
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children, '14-16	0	0	0	0.0*	9.0	**9.7**	10.0	N/A	Less than 10						
3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children, '14-16	0	0	0	0.0*	15.5	**11.5**	11.4	N/A	Less than 10						
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children, '14-16	0	0	0	0.0*	12.3	**10.6**	10.7	N/A	Less than 10						
5. Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, '14-16	0	0	1	15.3*	36.7	**32.6**	31.1	N/A	Less than 10						
6. Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**27.4**	43.5	N/A	Less than 10						
7. Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2016				0.0*	N/A	**9.5**	18.7	N/A	Less than 10						
8. Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2016				N/A	N/A	**12.9**	23.5	N/A	Less than 10						
9. Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				0.0*	N/A	**8.1**	10.6	N/A	Less than 10						

10. Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				0.0*	N/A	**24.4**	2.2	N/A	Less than 10						
11. Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**24.4**	30.9	N/A	Less than 10						
12. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				60.4*	65.5	**105.8**	186.4	196.5	Less than 10						
13. Percentage of Children born in 2013 Screened for Lead by Age 0-8 months, 2013				1.0*%	0.7%	**1.2%**	1.9%	N/A	Less than 10						
14. Percentage of Children Born in 2013 Screened for Lead by Age 9-17 months, 2013				73.3%	77.5%	**71.7%**	74.8%	N/A	Meets/Better						
15. Percentage of Children Born 2013 Screened for Lead by Age 36 months (at least two screenings), 2013				56.0%	63.7%	**55.9%**	62.8%	N/A	Meets/Better						
16. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '14-16	4	0	2	5.1*	11.4	**8.3**	4.3	N/A	Less than 10						
17. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2016				N/A	N/A	**18.1**	18.9	N/A	Less than 10						
18. Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2016				N/A	N/A	**12.5**	13.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2016				14.4*	N/A	**23.1**	23.1	N/A	Less than 10						
20. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				55.7	N/A	**68.1**	137.1	N/A	Meets/Better						
21. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, '15-17	1,306	1,375	1,406	47.9%	48.0%	**48.0%**	47.5%	N/A	Worse	X					
22. Percentage of 3rd Graders with Dental Caries, '09 - 11				50.4%	N/A	N/A	N/A	N/A	Meets/Better						
23. Percentage of 3rd Graders with Dental Sealants, '09 - 11				34.5%	N/A	N/A	N/A	N/A	Meets/Better						
24. Percentage of 3rd Graders with Dental Insurance, '09 - 11				86.6%	N/A	N/A	N/A	N/A	Meets/Better						
25. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11				76.8%	N/A	N/A	N/A	N/A	Meets/Better						
26. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11				85.4%	N/A	N/A	N/A	N/A	Meets/Better						
27. Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2016				221.3	164.1	**119.7**	90.0	N/A	Worse				X		
28. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV o Less Per Day, '14-16				87.0%	85.7%	**85.0%**	85.3%	N/A	Worse	X					
Quartile Summary for Other Indicators										2	0	0	1	10.3%	33.3%
Quartile Summary for Focus Area Child Health										6	0	0	1	21.2%	14.3%

Franklin County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Maternal and Infant Health															
Prevention Agenda Indicators															
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2016				6.6%	9.8%	10.5%	10.3%	**10.2%**	Meets/Better						
2. Ratio of Preterm Births (< 37 wks.) Black/NH to White/NH, 2014-2016				N/A	N/A	1.65	1.64	**1.42**	Less than 10						
3. Ratio of Preterm Births (< 37 wks.) Hisp/Latino to White/NH, 2014-2016				N/A	N/A	1.28	1.29	**1.12**	Less than 10						
4. Ratio of Preterm Births (< 37 wks.) Medicaid to Non-Medicaid, 201 2016				1.10	N/A	1.10	1.06	**1.00**	Worse	X					
5. Rate of Maternal Mortality per 100,000 Births, 2014-2016				0.0%	N/A	18.9	20.4	**21.0**	Less than 10						
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2016				62.3%	63.0%	50.9%	46.3%	**48.1%**	Meets/Better						
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	0.55	0.59	**0.57**	Less than 10						
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, 2014-2016				N/A	N/A	0.57	0.57	**0.56**	Less than 10						
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, 2014-2016				0.63	N/A	0.68	0.59	**0.66**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	22.2%	0.0%
Other Indicators															
1. Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '14-16	6	5	7	1.3%	3.9%	**1.5%**	1.5%	N/A	Meets/Better						
2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '14-16	274	39	30	7.0%	7.5%	**7.4%**	7.3%	N/A	Meets/Better						
3. Percentage of Total Births with Weights Less Than 1,500 grams, '14-16	7	7	4	1.3%	1.2%	**1.3%**	1.4%	N/A	Meets/Better						
4. Percentage of Singleton Births with Weights Less Than 1,500 grams '14-16	6	5	1	0.9%	0.9%	**1.0%**	1.0%	N/A	Meets/Better						
5. Percentage of Total Births with Weights Less Than 2,500 grams, '14-16	35	35	24	6.7%	6.7*%	**7.6%**	7.9%	N/A	Meets/Better						
6. Percentage of Singleton Births with Weights Less Than 2,500 grams '14-16	30	30	14	5.4%	5.1*%	**5.7%**	6.0%	N/A	Meets/Better						
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	**12.9%**	12.2%	N/A	Less than 10						
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '14-16				78.9%	N/A	**7.5%**	7.7%	N/A	Less than 10						
9. Infant Mortality Rate per 1,000 Live Births, '14-16	2	3	0	3.6*	5.7*	**5.0**	4.5	N/A	Less than 10						
10. Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, '14-16	6	0	1	5.3*	3.5*	**5.3**	5.1	N/A	Less than 10						
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '14-16	315	321	328	69.3%	75.4%	**77.0%**	75.2%	N/A	Worse	X					
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '14-16				N/A	N/A	**68.5%**	64.5%	N/A	Less than 10						
13. Percentage Early Prenatal Care for Hispanic/Latino, '14-16				N/A	N/A	**71.1%**	76.7%	N/A	Less than 10						
14. Percentage APGAR Scores of Less Than Six at Five Minute Mark of Births Where APGAR Score is Known, '14-16	4	5	7	1.1%	1.1%	**0.9%**	0.7%	N/A	Worse	X					
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '13-15				58.1	110.9	**140.8**	104.8	N/A	Meets/Better						

16. Percentage WIC Women Breastfeeding for at least 6 months, '14-16				21.1%	N/A	**30.7%**	40.3%	N/A	Worse		X					
17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '14-16	279	308	318	71.9%	79.5%	**82.9%**	87.3%	N/A	Worse	X						
Quartile Summary for Other Indicators										3	1	0	0	23.5%	0.0%	
Quartile Summary for Focus Area Maternal and Infant Health										5	1	0	0	20.7%	0.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Preconception and Reproductive Health															
Prevention Agenda Indicators															
1. Percent of Births within 24 months of Previous Pregnancy, 2016				23.4%	23.2%	22.5%	19.8%	**17.0%**	Worse		X				
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2016				10.6*	11.1	9.9	13.3	**25.6**	Less than 10						
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	4.30	4.80	**4.40**	Less than 10						
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White non-Hispanic, 2014-2016				N/A	N/A	3.50	4.40	**4.10**	Less than 10						
5. Percent of Unintended Pregnancies among Total Births, 2016				37.3%	32.9%	24.9%	22.6%	**23.8%**	Worse			X			
6. Ratio of Unintended Pregnancies Black, non-Hispanic to White, non-Hispanic, 2016				N/A	N/A	2.08	2.12	**1.90**	Less than 10						
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2016				N/A	N/A	1.49	1.68	**1.43**	Less than 10						
8. Ratio of Unintended Births Medicaid to Non-Medicaid, 2016				1.69	N/A	1.96	1.71	**1.54**	Worse	X					
9. Percentage of Women Ages 18- 64 with Health Insurance, 2016				93.6%	N/A	N/A	93.1%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	1	1	0	44.4%	25.0%
Other Indicators															
1. Rate of Total Births per 1,000 Females Ages 15-44, '14-16	441	491	475	58.3	53.2	**57.2**	58.5	N/A	Worse	X					
2. Percent Multiple Births of Total Births, '14-16	6	10	17	2.3%	3.5%	**4.0%**	3.7%	N/A	Meets/Better						
3. Percent C-Sections to Total Births, '14-16	175	207	148	37.7%	34.1%	**34.2%**	33.5%	N/A	Worse	X					
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '14-16	528	539	537	66.5	64.5	**72.8**	83.8	N/A	Meets/Better						
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	0	0	1	0.2*	0.2*	**0.2**	0.2	N/A	Less than 10						
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	0	0	1	0.2*	0.3*	**0.4**	0.6	N/A	Less than 10						
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '14-16	9	8	9	10.3	12.5	**11.0**	15.1	N/A	Meets/Better						
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	27	34	36	23.2	19.3	**13.2**	14.6	N/A	Worse				X		
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	45	39	41	29.9	28.1	**22.3**	29.8	N/A	Worse		X				
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	24	28	29	48.8	36.3*	**22.9**	25.6	N/A	Worse				X		
11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	36	31	32	59.6	50.4	**37.5**	50.1	N/A	Worse			X			
12. Percent Total Births to Women Ages 35 Plus, '14-16	45	46	50	10.0%	11.7%	**20.2%**	22.1%	N/A	Meets/Better						
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Age 15-19, '14-16	18	5	5	288.7	434.5	**652.3**	990.8	N/A	Meets/Better						
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '14-16	75	45	54	123.7	181.4	**231.6**	370.9	N/A	Meets/Better						
15. Percentage of WIC Women Pre-pregnancy Underweight, '10-12	12	11	11	4.4%	4.9%	**4.1%**	4.7%	N/A	Worse	X					
16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	45	38	54	24.6%	22.3%	**26.3%**	26.6%	N/A	Meets/Better						

17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	66	63	55	32.6%	33.3%	**28.0%**	24.2%	N/A	Worse	X					
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	103	105	87	52.8%	52.4%	**47.1%**	41.7%	N/A	Worse	X					
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	14	23	20	8.7%	7.2%	**5.7%**	5.5%	N/A	Worse			X			
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	31	32	23	10.7%	12.9%	**9.1%**	7.1%	N/A	Worse	X					
Quartile Summary for Other Indicators										6	1	2	2	55.0%	36.4%
Quartile Summary for Focus Area Preconception and Reproductive Health										9	4	3	0	55.2%	18.8%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Child Health															
Prevention Agenda Indicators															
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2016				82.9%	89.8%	82.8%	80.1%	**91.3%**	Worse	X					
2. Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2016				77.2%	84.9%	82.3%	84.3%	**91.3%**	Worse	X					
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2016				57.0%	69.5%	66.5%	68.1%	**67.1%**	Worse	X					
4. Percentage of Children Ages 0 -19 with Health Insurance, 2016				96.2%	N/A	N/A	97.4%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										4	0	0	0	100.0%	0.0%
Other Indicators															
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, '14-16	2	0	0	32.2*	26.8	**19.4**	18.2	N/A	Less than 10						
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children, '14-16	1	1	0	23.3*	9.0	**9.7**	10.0	N/A	Less than 10						
3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children, '14-16	1	0	2	34.9*	15.5	**11.5**	11.4	N/A	Less than 10						
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children, '14-16	2	1	2	29.1*	12.3	**10.6**	10.7	N/A	Less than 10						
5. Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, '14-16	1	2	0	31.8*	36.7	**32.6**	31.1	N/A	Less than 10						
6. Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				0.0*	N/A	**27.4**	43.5	N/A	Less than 10						
7. Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2016				N/A	N/A	**9.5**	18.7	N/A	Less than 10						
8. Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2016				N/A	N/A	**12.9**	23.5	N/A	Less than 10						
9. Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**8.1**	10.6	N/A	Less than 10						
10. Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				0.0*	N/A	**24.4**	2.2	N/A	Less than 10						
11. Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**24.4**	30.9	N/A	Less than 10						
12. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				37.7*	65.5	**105.8**	186.4	196.5	Less than 10						
13. Percentage of Children born in 2013 Screened for Lead by Age 0-6 months, 2013				0.6*%	0.7%	**1.2%**	1.9%	N/A	Less than 10						
14. Percentage of Children Born in 2013 Screened for Lead by Age 9 17 months, 2013				55.3%	77.5%	**71.7%**	74.8%	N/A	Worse	X					
15. Percentage of Children Born 2013 Screened for Lead by Age 36 months (at least two screenings), 2013				37.3%	63.7%	**55.9%**	62.8%	N/A	Worse		X				
16. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '14-16	16	3	2	11.5	11.4	**8.3**	4.3	N/A	Worse		X				
17. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2016				N/A	N/A	**18.1**	18.9	N/A	Less than 10						

18. Rate of Unintentional Injury Hospitalizations for Children Ages 10 14 per 10,000 Population Children, 2016				0.0*	N/A	**12.5**	13.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2016				8.8*	N/A	**23.1**	23.1	N/A	Less than 10						
20. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				26.4	N/A	**68.1**	137.1	N/A	Meets/Better						
21. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, '15-17	1,553	1,860	2,063	39.4%	48.0%	**48.0%**	47.5%	N/A	Worse	X					
22. Percentage of 3rd Graders with Dental Caries, '09 - 11				54.7%	N/A	N/A	N/A	N/A	Meets/Better						
23. Percentage of 3rd Graders with Dental Sealants, '09 - 11				45.6%	N/A	N/A	N/A	N/A	Meets/Better						
24. Percentage of 3rd Graders with Dental Insurance, '09 - 11				78.7%	N/A	N/A	N/A	N/A	Meets/Better						
25. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11				69.3%	N/A	N/A	N/A	N/A	Meets/Better						
26. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11				89.7%	N/A	N/A	N/A	N/A	Meets/Better						
27. Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2016				178.2	164.1	**119.7**	90.0	N/A	Worse		X				
28. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV o Less Per Day, '14-16				81.1%	85.7%	**85.0%**	85.3%	N/A	Meets/Better						
Quartile Summary for Other Indicators										2	3	0	0	17.2%	0.0%
Quartile Summary for Focus Area Child Health										6	3	0	0	27.3%	0.0%

Franklin County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Reduce Obesity in Children and Adults															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who are Obese, 2016				32.7%	N/A	**27.4%**	25.5%	23.2%	Worse		X				
2. Percentage of Public School Children Who are Obese, '14 - 16				21.2%	N/A	17.3%	N/A	**16.7%**	Worse		X				
Quartile Summary for Prevention Agenda Indicators										1	1	0	0	100.0%	0.0%
Other Indicators															
1. Percentage of Total Students Overweight, '16-18				18.2%	17.5%	**16.5%**	N/A	N/A	Worse	X					
2. Percentage of Elementary Students Overweight, Not Obese, '16-18				17.8%	17.0%	**15.7%**	N/A	N/A	Worse	X					
3. Percentage of Elementary Student Obese, '16-18				20.1%	18.3%	**16.0%**	N/A	N/A	Worse		X				
4. Percentage of Middle and High School Students Overweight, Not Obese, '16-18				18.1%	18.1%	**17.4%**	N/A	N/A	Worse	X					
5. Percentage of Middle and High School Students Obese, '16-18				26.9%	23.6%	**18.8%**	N/A	N/A	Worse		X				
6. Percentage of WIC Children Ages 2 - 4 Obese, '14-16				14.3%	15.9%	**15.2%**	13.9%	N/A	Meets/Better						
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, 2016				71.3%	70.2%	**63.7%**	60.8%	N/A	Worse	X					
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, 2016				72.1%	73.9%	**74.6%**	73.7%	N/A	Worse	X					
9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014				5.9	5.5	**18.7**	19.2	N/A	Worse			X			
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14				70.0%	79.7%	**84.8%**	84.2%	N/A	Worse	X					
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14				36.1%	36.0%	**33.0%**	31.7%	N/A	Worse	X					
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '14-16	144	144	121	268.5	295.6	**295.7**	272.2	N/A	Meets/Better						
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	26	24	24	119.5	111.7	**101.0**	102.4	N/A	Worse	X					
14. Rate of Cardiovascular Pretransport Deaths per 100,000 Population, '14-16	88	77	55	144.4	165.4	**169.6**	153.2	N/A	Meets/Better						
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, 2016				120.0	148.7	**1539.0**	149.9	N/A	Meets/Better						
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '14-16	104	115	96	206.8	233.2	**236.5**	220.7	N/A	Meets/Better						
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	23	19	19	98.5	95.9	**82.8**	83.4	N/A	Worse	X					
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '14-16	60	60	45	193.9	134.0	**140.7**	131.0	N/A	Worse		X				
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2016				87.1	103.1	**104.9**	100.3	N/A	Meets/Better						
20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '14-16	76	83	69	149.7	154.9	**162.7**	168.7	N/A	Meets/Better						
21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	20	11	12	69.4	68.0	**60.5**	66.4	N/A	Worse	X					
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '14-16	43	43	34	78.8	91.1	**101.3**	105.0	N/A	Meets/Better						
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2016				34.5	38.6	**35.4**	35.0	N/A	Meets/Better						

24. Rate of Congestive Heart Failure Deaths per 100,000, '14-16	7	7	8	14.4	17.6	**24.4**	16.5	N/A	Meets/Better						
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	1	2	0	4.8*	4.8	**3.3**	2.5	N/A	Less than 10						
26. Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '14-16	3	5	6	9.2	10.9	**14.5**	9.4	N/A	Meets/Better						
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, 2016				21.4	24.2	**25.6**	24.8	N/A	Meets/Better						
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '14-16	18	15	16	32.2	40.2	**38.1**	31.3	N/A	Meets/Better						
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2016				18.6	23.8	**26.9**	25.4	N/A	Meets/Better						
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population, 2016				6.4	2.7	**9.4**	9.7	N/A	Meets/Better						
31. Rate of Diabetes Deaths per 100,000 Population, '14-16	12	20	13	29.5	29.5	**19.8**	20.3	N/A	Worse		X				
32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2016				11.7	14.5	**15.4**	17.5	N/A	Meets/Better						
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2016				212.3	246.1	**237.2**	248.1	N/A	Meets/Better						
Quartile Summary for Other Indicators										10	4	1	0	45.5%	6.7%
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										11	5	1	0	48.6%	5.9%

Essex County Revised: April 2019

	Number Per Year (If Available)				Comparison Regions/Data					Quartile Ranking					
	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score
Focus Area: Reduce Obesity in Children and Adults															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who are Obese, 2016				32.2%	N/A	**27.4%**	25.5%	23.2%	Worse		X				
2. Percentage of Public School Children Who are Obese, '14 - 16				21.4%	N/A	17.3%	N/A	**16.7%**	Worse		X				
Quartile Summary for Prevention Agenda Indicators										1	1	0	0	100.0%	0.0%
Other Indicators															
1. Percentage of Total Students Overweight, '16-18				16.5%	17.5%	**16.5%**	N/A	N/A	Meets/Better						
2. Percentage of Elementary Students Overweight, Not Obese, '16-18				15.2%	17.0%	**15.7%**	N/A	N/A	Meets/Better						
3. Percentage of Elementary Student Obese, '16-18				18.7%	18.3%	**16.0%**	N/A	N/A	Worse	X					
4. Percentage of Middle and High School Students Overweight, Not Obese, '16-18				15.9%	18.1%	**17.4%**	N/A	N/A	Meets/Better						
5. Percentage of Middle and High School Students Obese, '16-18				26.8%	23.6%	**18.8%**	N/A	N/A	Worse		X				
6. Percentage of WIC Children Ages 2 - 4 Obese, '14-16				16.4%	15.9%	**15.2%**	13.9%	N/A	Worse	X					
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, 2016				68.2%	70.2%	**63.7%**	60.8%	N/A	Worse	X					
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, 2016				76.6%	73.9%	**74.6%**	73.7%	N/A	Meets/Better						
9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014				5.9	5.5	**18.7**	19.2	N/A	Worse			X			
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14				70.0%	79.7%	**84.8%**	84.2%	N/A	Worse	X					
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14				37.2%	36.0%	**33.0%**	31.7%	N/A	Worse	X					
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '14-16	124	135	103	314.1	295.6	**295.7**	272.2	N/A	Worse	X					
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	19	15	11	92.4	111.7	**101.0**	102.4	N/A	Meets/Better						
14. Rate of Cardiovascular Pretransport Deaths per 100,000 Population, '14-16	83	71	58	183.9	165.4	**169.6**	153.2	N/A	Worse	X					
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, 2016				107.6	148.7	**1539.0**	149.9	N/A	Meets/Better						
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '14-16	105	103	82	251.6	233.2	**236.5**	220.7	N/A	Worse	X					
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	17	15	9	84.2	95.9	**82.8**	83.4	N/A	Worse	X					
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '14-16	73	57	44	151.0	134.0	**140.7**	131.0	N/A	Worse	X					
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2016				76.1	103.1	**104.9**	100.3	N/A	Meets/Better						

20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '14-16	80	63	55	171.8	154.9	**162.7**	168.7	N/A	Worse	X						
21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	12	11	7	61.6	68.0	**60.5**	66.4	N/A	Worse	X						
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '14-16	55	34	34	106.7	91.1	**101.3**	105.0	N/A	Worse	X						
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2016				28.1	38.6	**35.4**	35.0	N/A	Meets/Better							
24. Rate of Congestive Heart Failure Deaths per 100,000, '14-16	5	14	5	20.8	17.6	**24.4**	16.5	N/A	Meets/Better							
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	1	3	1	10.3*	4.8	**3.3**	2.5	N/A	Less than 10							
26. Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '14-16	4	12	1	14.7	10.9	**14.5**	9.4	N/A	Worse	X						
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, 2016				17.3	24.2	**25.6**	24.8	N/A	Meets/Better							
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '14-16	12	21	14	40.8	40.2	**38.1**	31.3	N/A	Worse	X						
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2016				15.7	23.8	**26.9**	25.4	N/A	Meets/Better							
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population, 2016				3.5	2.7	**9.4**	9.7	N/A	Meets/Better							
31. Rate of Diabetes Deaths per 100,000 Population, '14-16	17	15	14	39.9	29.5	**19.8**	20.3	N/A	Worse					X		
32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2016				10.5	14.5	**15.4**	17.5	N/A	Meets/Better							
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2016				161.1	246.1	**237.2**	248.1	N/A	Meets/Better							
Quartile Summary for Other Indicators										15	1	1	1	54.5%	11.1%	
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										16	2	1	1	57.1%	10.0%	

Essex County Revised: April 2019

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, 2016				66.9%	N/A	69.7%	68.5%	**80.0%**	Worse	X					
2. Rate of Asthma ED Visits per 10,000 Population, 2016				32.5	40.3	42.0	77.0	**75.1**	Meets/Better						
3. Rate of Asthma ED Visits per 10,000 Population, Ages 0 - 4, 2016				60.4*	65.5	105.8	186.4	**196.5**	Less than 10						
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, 2016				N/A	5.0	3.4	3.2	**3.06**	Less than 10						
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, 2016				N/A	5.0	4.1	4.0	**4.86**	Less than 10						
6. Age-Adjusted Rate of Heart Attack Hospitalizations per 10,000 Population, 2016				11.9	24.9	14.8	13.9	**14.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	16.7%	0.0%
Other Indicators															
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '12-14	136	74	104	43.6	52.4	**47.4**	77.3	N/A	Meets/Better						
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '12-14	33	20	11	26.9	0.0	**19.1**	35.0	N/A	Worse		X				
3. Rate of All Cancer Cases per 100,000 Population, '13-15	257	274	287	706.5	683.8	**629.8**	564.4	N/A	Worse	X					
4. Rate of all Cancer Deaths per 100,000 Population, '13-15	98	81	108	245.3	227.3	**198.7**	176.2	N/A	Worse	X					
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '13-15	35	32	45	201.5	173.3	**175.9**	158.6	N/A	Worse	X					
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	57.6	N/A	**53.1**	50.6	N/A	Worse	X					
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	28.8	N/A	**26.1**	24.6	N/A	Worse	X					
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13-14				78.4%	81.4%	**79.2%**	79.7%	N/A	Worse	X					
9. Rate of Cervix and Uterine Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	10.8*	N/A	**7.6**	8.5	N/A	Less than 10						
10. Rate of Cervix and Uterine Cancer Deaths per 100,000 Female Population, '13-15	0	0	0	0.0*	N/A	**2.3**	2.7	N/A	Less than 10						
11. Percentage of Women Aged 21-65 Years Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14				93.1%	86.0%	**83.5%**	82.2%	N/A	Meets/Better						
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	14.4*	N/A	**16.0**	14.8	N/A	Less than 10						
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**10.4**	9.1	N/A	Less than 10						
14. Rate of Colon and Rectal Cancer Cases per 100,000 Population, '13-15	20	22	25	57.9	55.0	**48.5**	45.7	N/A	Worse	X					
15. Rate of Colon and Rectal Cancer Deaths per 100,000 Population, '13-15	6	8	10	20.7	18.9	**16.7**	15.6	N/A	Worse	X					
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines				66.9%	73.6%	**68.5%**	69.7%	N/A	Worse	X					
17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '13-15	N/A	N/A	N/A	16.6	N/A	**17.7**	17.3	N/A	Meets/Better						
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '13-15	N/A	N/A	N/A	116.3	140.4	**151.7**	141.2	N/A	Meets/Better						
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '13-15	N/A	N/A	N/A	28.2	30.0	**26.8**	25.2	N/A	Worse	X					
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '13-15	N/A	N/A	N/A	N/A	N/A	**3.0**	2.3	N/A	Less than 10						

21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '15-17	2,150	2,387	2,448	24.9%	25.7%	**28.3%**	28.0%	N/A	Worse	X					
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13-14				62.7%	64.0%	**70.0%**	68.5%	N/A	Worse	X					
23. Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, '13-15	N/A	N/A	N/A	12.2*	N/A	**4.2**	4.5	N/A	Less than 10						
24. Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '13-15	9	7	7	19.9	18.9	**14.7**	12.9	N/A	Worse		X				
Quartile Summary for Other Indicators										12	2	0	0	58.3%	0.0%
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										13	2	0	0	50.0%	0.0%

Franklin County Revised: April 2019

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, 2016				74.1%	N/A	69.7%	68.5%	**80.0%**	Worse	X					
2. Rate of Asthma ED Visits per 10,000 Population, 2016				27.6	40.3	42.0	77.0	**75.1**	Meets/Better						
3. Rate of Asthma ED Visits per 10,000 Population, Ages 0 - 4, 2016				37.7*	65.5	105.8	186.4	**196.5**	Less than 10						
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, 2016				0.0*	5.0	3.4	3.2	**3.06**	Less than 10						
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, 2016				3.9	5.0	4.1	4.0	**4.86**	Meets/Better						
6. Age-Adjusted Rate of Heart Attack Hospitalizations per 10,000 Population, 2016				21.7	24.9	14.8	13.9	**14.0**	Worse			X			
Quartile Summary for Prevention Agenda Indicators										1	0	1	0	33.3%	50.0%
Other Indicators															
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '12-14	206	173	168	53.8	52.4	**47.4**	77.3	N/A	Worse	X					
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '12-14	21	19	19	26.4	22.7	**19.1**	35.0	N/A	Worse		X				
3. Rate of All Cancer Cases per 100,000 Population, '13-15	267	286	308	563.3	683.8	**629.8**	564.4	N/A	Meets/Better						
4. Rate of all Cancer Deaths per 100,000 Population, '13-15	90	93	99	184.5	227.3	**198.7**	176.2	N/A	Meets/Better						
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '13-15	25	34	31	130.4	173.3	**175.9**	158.6	N/A	Meets/Better						
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '13-15	6	10	10	37.7	N/A	**53.1**	50.6	N/A	Meets/Better						
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	15.9	N/A	**26.1**	24.6	N/A	Meets/Better						
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13-14				78.9%	81.4%	**79.2%**	79.7%	N/A	Worse	X					
9. Rate of Cervix and Uterine Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**7.6**	8.5	N/A	Less than 10						
10. Rate of Cervix and Uterine Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	0.0*	N/A	**2.3**	2.7	N/A	Less than 10						
11. Percentage of Women Aged 21-65 Years Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14				80.0%	86.0%	**83.5%**	82.2%	N/A	Worse	X					
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**16.0**	14.8	N/A	Less than 10						
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**10.4**	9.1	N/A	Less than 10						
14. Rate of Colon and Rectal Cancer Cases per 100,000 Population, '13-15	28	31	24	54.3	55.0	**48.5**	45.7	N/A	Worse	X					
15. Rate of Colon and Rectal Cancer Deaths per 100,000 Population, '13-15	9	8	12	19.0	18.9	**16.7**	15.6	N/A	Worse	X					
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines				74.1%	73.6%	**68.5%**	69.7%	N/A	Meets/Better						
17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '13-15	N/A	N/A	N/A	16.7	N/A	**17.7**	17.3	N/A	Meets/Better						
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '13-15	48	41	66	184.9	140.4	**151.7**	141.2	N/A	Worse	X					
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '13-15	10	10	9	34.6	30.0	**26.8**	25.2	N/A	Worse		X				
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '13-15	N/A	N/A	N/A	N/A	N/A	**3.0**	2.3	N/A	Less than 10						
21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '15-17	2,676	3,080	3,341	20.6%	25.7%	**28.3%**	28.0%	N/A	Worse		X				
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13-14				57.2%	64.0%	**70.0%**	68.5%	N/A	Worse	X					
23. Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, '13-15				N/A	N/A	**4.2**	4.5	N/A	Less than 10						

24. Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '13-15				12.4	18.9	**14.7**	12.9	N/A	Meets/Better							
Quartile Summary for Other Indicators										7	3	0	0	41.7%	0.0%	
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										8	3	1	0	40.0%	8.3%	

Franklin County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Human Immunodeficiency Virus (HIV)															
Prevention Agenda Indicators															
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2014-2016				3.3*	N/A	**6.9**	16.0	16.1	Less than 10						
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, 2014-2016				-4.0+	N/A	**20.1**	35.2	46.8	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of AIDS Cases per 100,000 Population, '14-16	s	s	s	N/A	N/A	**3.3**	7.7	N/A	Less than 10						
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '14-16	0	0	0	0.0*	N/A	**1.1**	3.0	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Sexually Transmitted Disease (STDs)															
Prevention Agenda Indicators															
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2016				0.0*	3.3	9.1	24.3	**10.1**	Less than 10						
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2016				0.0*	0.6	0.5	1.3	**0.4**	Less than 10						
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2016				0.0*	60.6	197.1	206.2	**183.4**	Less than 10						
4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2016				16.4*	48.2	230.0	452.5	**199.5**	Less than 10						
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2016				818.3	1170.1	1351.6	1620.7	**1458.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of Early Syphilis Cases per 100,000 Population, '14-16	0	0	0	0.0*	2.52*	**7.9**	25.1	N/A	Less than 10						
2. Rate of Gonorrhea Cases per 100,000 Population, '14-16	5	7	0	7.8	16.1	**64.6**	111.8	N/A	Meets/Better						
3. Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '14-16	3	0	0	31.8*	45.8*	**209.9**	305.8	N/A	Less than 10						
4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '14-16	19	31	31	219.5	352.5	**569.5**	857.7	N/A	Meets/Better						
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '14-16	2	6	5	248.1	403.1	**607.9**	922.5	N/A	Meets/Better						
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '14-16	8	10	15	456.7	779.1	**1,199.7**	1,638.0	N/A	Meets/Better						
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '14-16	71	86	65	920.6	1,188.4	**1,300.3**	1,577.4	N/A	Meets/Better						
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '14-16	26	26	22	1,767.4	2,131.7	**2,300.5**	3,147.6	N/A	Meets/Better						
9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '14-16	29	39	17	2,069.1	2,717.9	**2,833.9**	3,424.6	N/A	Meets/Better						
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, 2016				N/A	N/A	**1.9**	2.5	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%

Quartile Summary for Sexually Transmitted Diseases																
										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Vaccine Preventable Disease															
Prevention Agenda Indicators															
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2016				66.6%	73.9%	64.0%	N/A	**80.0%**	Worse	X					
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2016				31.1%	42.6%	41.7%	N/A	**50.0%**	Meets/Better						
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, 2016				59.1%	N/A	59.6%	59.5%	**70.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	66.7%	0.0%
Other Indicators															
1. Rate of Pertussis Cases per 100,000 Population, '13-15	23	1	0	15.8	11.7	**5.9**	5.1	N/A	Worse				X		
2. Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population Age 65 Plus, '12-14				84.1	93.3	**93.7**	87.3	N/A	Meets/Better						
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14				79.1%	75.0%	**73.8%**	69.3%	N/A	Meets/Better						
4. Rate of Mumps Cases per 100,000 Population, '13-15	0	0	1	0.0*	0.09	**0.70**	1.08	N/A	Less than 10						
5. Rate of Meningococcal Cases per 100,000 Population, '13-15	0	0	0	0.0*	0.09*	**0.1***	0.1	N/A	Less than 10						
6. Rate of H Influenza Cases per 100,000 Population, '13-15	1	1	0	1.3*	2.0	**1.7**	1.5	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	1	16.7%	100.0%
Quartile Summary for Focus Area Vaccine Preventable Diseases										2	0	0	1	33.3%	33.3%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Healthcare Associated Infections															
Prevention Agenda Indicators															
1. Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days, 2017				4.1	5.6	N/A	5.2	**5.94**	Meets/Better						
2. Rate of Community Onset, Healthcare Facility Associated CDIs pe 10,000 Patient Days, 2017				7.3	53.8	N/A	29.2	**2.05**	Worse				X		
Quartile Summary for Healthcare Associated Infections										0	0	0	1	50.0%	100.0%

Essex County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Human Immunodeficiency Virus (HIV)															
Prevention Agenda Indicators															
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2014-2016				3.9*	N/A	**6.9**	16.0	16.1	Less than 10						
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, 2014-2016				-3.3	N/A	**20.1**	35.2	46.8	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of AIDS Cases per 100,000 Population, '14-16				2.3*	N/A	**3.3**	7.7	N/A	Less than 10						
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '14-16	0	0	0	0.0*	N/A	**1.1**	3.0	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Sexually Transmitted Disease (STDs)															
Prevention Agenda Indicators															
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2016				0.0*	3.3	9.1	24.3	**10.1**	Less than 10						
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2016				0.0*	0.6	0.5	1.3	**0.4**	Less than 10						
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2016				17.7	60.6	197.1	206.2	**183.4**	Less than 10						
4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2016				13.6	48.2	230.0	452.5	**199.5**	Less than 10						
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2016				689.5	1170.1	1351.6	1620.7	**1458.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of Early Syphilis Cases per 100,000 Population, '14-16	0	0	0	0.0*	2.52*	**7.9**	25.1	N/A	Less than 10						
2. Rate of Gonorrhea Cases per 100,000 Population, '14-16	17	27	18	8.6	0.0	**0.0**	111.8	N/A	Worse	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
3. Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '14-16	2	1	0	45.9*	45.8*	**209.9**	305.8	N/A	Less than 10						

4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '14-16	16	13	10	173.8	352.5	**569.5**	857.7	N/A	Meets/Better						
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '14-16	0	1	1	56.9*	403.1	**607.9**	922.5	N/A	Less than 10						
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '14-16	7	7	4	480.3	779.1	**1,199.7**	1,638.0	N/A	Meets/Better						
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '14-16	40	29	39	626.3	1,188.4	**1,300.3**	1,577.4	N/A	Meets/Better						
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '14-16	9	11	13	1,093.1	2,131.7	**2,300.5**	3,147.6	N/A	Meets/Better						
9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '14-16	16	11	16	1,611.0	2,717.9	**2,833.9**	3,424.6	N/A	Meets/Better						
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, 2016				0.0*	N/A	**1.9**	2.5	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Sexually Transmitted Diseases										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Vaccine Preventable Disease															
Prevention Agenda Indicators															
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2016				73.0%	73.9%	64.0%	N/A	**80.0%**	Worse	X					
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2016				34.2%	42.6%	41.7%	N/A	**50.0%**	Meets/Better						
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, 2016				57.8%	N/A	59.6%	59.5%	**70.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	66.7%	0.0%
Other Indicators															
1. Rate of Pertussis Cases per 100,000 Population, '13-15	7	2	0	7.8*	11.7	**5.9**	5.1	N/A	Less than 10						
2. Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population Age 65 Plus, '12-14				98.4	93.3	**93.7**	87.3	N/A	Worse	X					
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14				73.7%	75.0%	**73.8%**	69.3%	N/A	Worse	X					
4. Rate of Mumps Cases per 100,000 Population, '13-15	0	0	1	0.4*	0.09	**0.70**	1.08	N/A	Less than 10						
5. Rate of Meningococcal Cases per 100,000 Population, '13-15	0	0	0	0.0*	0.09*	**0.1***	0.1	N/A	Less than 10						
6. Rate of H Influenza Cases per 100,000 Population, '13-15	0	3	0	2.6*	2.0	**1.7**	1.5	N/A	Less than 10						
Quartile Summary for Other Indicators										2	0	0	0	33.3%	0.0%
Quartile Summary for Focus Area Vaccine Preventable Diseases										4	0	0	0	44.4%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Healthcare Associated Infections															
Prevention Agenda Indicators															
1. Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days, 2017				N/A	5.6	N/A	5.2	**5.94**	Less than 10						
2. Rate of Community Onset, Healthcare Facility Associated CDIs pe 10,000 Patient Days, 2017				N/A	53.8	N/A	29.2	**2.05**	Less than 10						
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%

Essex County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders															
Prevention Agenda Indicators															
1. Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2016				24.7%	N/A	19.1%	18.3%	**18.4%**	Worse		X				
2. Age-adjusted Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, 2016				14.4%	N/A	11.2%	10.7%	**10.1%**	Worse		X				
3. Age Adjusted Rate of Suicides per 100,000 Adjusted Population, '14-16				12.9	N/A	9.6	8.0	**5.9**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										0	2	0	1	100.0%	33.3%
Other Indicators															
1 Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '14-16				0.0*	10.7	**6.1**	5.0	N/A	Less than 10						
2. Rate of Self-inflicted Hospitalizations 10,000 Population, 2016				2.4*	N/A	**4.1**	3.5	N/A	Less than 10						
3. Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2016				N/A	N/A	**8.7**	7.6	N/A	Less than 10						
4. Rate of Cirrhosis Deaths per 100,000 Population, '14-16				8.7	13.8	**7.4**	8.0	N/A	Worse	X					
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, 2016				2.6	1.5	**3.3**	3.0	N/A	Meets/Better						
7. Rate of Alcohol-Related Crashes per 100,000, 2017				94.8	69.1	**53.20**	38.0	N/A	Worse				X		
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2017				31.6	28.8	**10.5**	19.4	N/A	Worse				X		
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '12-14	42	43	18	8.8	14.6	**20.3**	24.0	N/A	Meets/Better						
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2015				1,437.3	1,279.4	**642.2**	682.2	N/A	Worse				X		
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				776.6	819.5	**620.5**	689.7	N/A	Worse		X				
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2015				62.5	141.7	**170.3**	311.4	N/A	Meets/Better						
13. Rate of People Served in Emergency Settings for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2015				N/A	15.6	**20.0**	18.9	N/A	Less than 10						
14. Rate of People Served in Emergency Settings for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				N/A	21.7	**20.0**	25.7	N/A	Less than 10						
15. Rate of People Served in Emergency Settings for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2015				N/A	N/A	**5.7**	7.6	N/A	Less than 10						
Quartile Summary for Other Indicators										1	1	0	3	33.3%	60.0%
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										1	3	0	4	44.4%	50.0%

Franklin County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source	Updated	AgeAdjAva	Formulas			Notes
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4						COUNTY	ARHN	Upstate NY	
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders																						
Prevention Agenda Indicators																						
1. Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2016				17.8%	N/A	19.1%	18.3%	**18.4%**	Meets/Better							0.00	Prevention Agenda Dashboard	18-Sep	Yes				
2. Age-adjusted Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, 2016				13.1%	N/A	11.2%	10.7%	**10.1%**	Worse		X					0.30	Prevention Agenda Dashboard	18-Sep	Yes				
3. Age Adjusted Rate of Suicides per 100,000 Adjusted Population, '14-16				10.4	N/A	9.6	8.0	**5.9**	Worse				X			0.76	Prevention Agenda Dashboard	18-Sep	Yes				
Quartile Summary for Prevention Agenda Indicators										0	1	0	1	66.7%	50.0%								
Other Indicators																						
1 Rate of Suicides for Ages 15 - 19 per 100,000 Population, '14-16				0.0*	10.7	**6.1**	5.0	N/A	Less than 10							0.00	Community Health Indicator Repo	19-Apr		4.46847491	5.466667		
2. Rate of Self-inflicted Hospitalizations 10,000 Population, 2016				3.4	N/A	**4.1**	3.5	N/A	Meets/Better							0.00	Community Health Indicator Repo	19-Apr	Yes	9.729584336	6.633333		
3. Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2016				N/A	N/A	**8.7**	7.6	N/A	Less than 10							0.00	Community Health Indicator Repo	19-Apr		20.98268928	12.93333		
4. Rate of Cirrhosis Deaths per 100,000 Population, '14-16				23.0	13.8	**7.4**	8.0	N/A	Worse				X			2.11	Community Health Indicator Repo	19-Apr	Yes	12.29531102	8.8		
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, 2016				4.4	1.5	**3.3**	3.0	N/A	Worse		X					0.33	Community Health Indicator Repo	19-Apr	Yes	2.717605539	2.533333		
7. Rate of Alcohol-Related Crashes per 100,000, 2017				64.6	69.1	**53.20**	38.0	N/A	Worse			X				0.70	NYS Traffic Safety Statistical Repo	19-Feb					
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2017				31.3	28.8	**10.5**	19.4	N/A	Worse				X			1.98	NYS Traffic Safety Statistical Repo	19-Feb					
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '12-14	101	35	49	12.0	14.6	**20.3**	24.0	N/A	Meets/Better							0.00	Community Health Indicator Repo	19-Apr		14.64538958	20.26667		
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2015				1,437.3	1,279.4	**642.2**	682.2	N/A	Worse				X			1.24	NYS Office of Mental Health, PCS	Yes, 2015					
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				776.6	819.5	**620.5**	689.7	N/A	Worse		X					0.25	NYS Office of Mental Health, PCS	Yes, 2015					
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2015				62.5	141.7	**170.3**	311.4	N/A	Meets/Better							0.00	NYS Office of Mental Health, PCS	Yes, 2015					
13. Rate of People Served in Emergency Settings for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2015				N/A	15.6	**20.0**	18.9	N/A	Less than 10							0.00	NYS Office of Mental Health, PCS	Yes, 2015					
14. Rate of People Served in Emergency Settings for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				N/A	21.7	**20.0**	25.7	N/A	Less than 10							0.00	NYS Office of Mental Health, PCS	Yes, 2015					
15. Rate of People Served in Emergency Settings for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2015				N/A	N/A	**5.7**	7.6	N/A	Less than 10							0.00	NYS Office of Mental Health, PCS	Yes, 2015					
Quartile Summary for Other Indicators										0	2	1	3	40.0%	66.7%								
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										0	3	1	4	44.4%	62.5%								