Franklin County 2019-2021 Community Health Assessment and Community Health Improvement Plan and Community Service Plan

New York State 2019-2021 Community Health Needs Assessment, Community Health Improvement Plan and Community Service Plan

1. County Covered:
    Franklin County

2. Participating Local Health Department:
    Franklin County Public Health Services
    355 West Main Street
    Malone NY 12953
    518-481-1710

3. Participating Hospitals:
    University of Vermont Health Network – Alice Hyde Medical Center
    133 Park Street
    Malone NY 12953
    518-483-3000

    Adirondack Health
    2233 State Route 86
    Saranac Lake NY 12983
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Contents

A. 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 Medical Center, 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. 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.

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

B. Community Health Assessment

B1a. 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 6 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 is 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 is a 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 an 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).

B1b. 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) is 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.

B2. Franklin County Main Health Challenges

B2a. Behavioral Risk Factors

Support Healthy Behaviors Across Systems

♦ Benchmark Deviation   ♦ 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

B2b. 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)

Abbreviations:

AH – Adirondack Health
AHMC – Alice Hyde Medical Center;
AMC – Adirondack Medical Center;
CVPH – Champlain Valley Physicians Hospital;
EMS – Emergency Medical Services
FC – Franklin County;
FCOFA – Franklin County Office of Aging
FCPHS – Franklin County Public Health Services;
FQHCF – Federal Qualified Healthcare Facility;
NCHHN – North County Healthy Heart Network;
NYSDOH – New York State Department of Health;
UVMHN – University of Vermont Health Network

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

Overall Vulnerability	Theme	Factor	Value
	Socioeconomic Status	Below Poverty[6]	19.4%
		Unemployed[6]	4.2%
		Income[6]	62,870
		No High School Diploma[6]	13.7%
	Household Composition & Disability	Aged 65 or Older[6]	7,909
		Aged 18 or Younger[6]	10,012
		Adults with a Disability[5]	24.5%
		Single-Parent Households[6]	10.8%
	Minority Status & Language	Minority[6]	17.5%
		Speak English "Less than Well" [3]	16%
	Housing & Transportation	Multi-Unit Structures[3]	3,471
		Mobile Homes[3]	3,028
		Crowding[1]	31.6 per sq mile
		No Vehicle[2]	9.5%
		Group Quarters[3]	5,968

*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   88.8
  (ER visits per 10,000 population age 18+)
- 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.
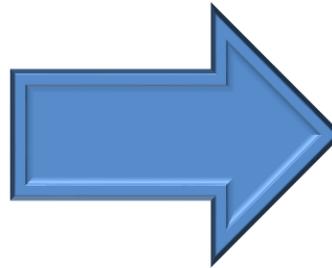
1. Some Senior Citizens[1]   16.2%

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%

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Franklin County residents have 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 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, Healthy Family's home visiting and collaborates with Emergency Preparedness activities on the Reservation. 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 Falls 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 is the sponsor of 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 district 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 Country 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. The county provides door-to-door pick up/ drop off. Transportation needs will continue and contribute to the overall vulnerability of Franklin County residents.

B2c. 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, Nurse Practitioners, 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 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 Country 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.

B2d. 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. 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, Lead 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, Child Find Activities and the Lead Poisoning Prevention 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.

B2e. 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 morbidity and mortality.   The Amish pay for health care services on a sliding fee scale. Financial plans are offered by hospitals for catastrophic occurrences. Medications are purchased 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 highway 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.

B3. Summary of Franklin 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.

Assets to Prevent Chronic Diseases

Health Issue	Franklin County Assets
Asthma	• Respiratory Therapy • Cardiopulmonary Services
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 • Health Center Wellness Coaches • 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 Division • 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 • Franklin County Community Housing Council

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 • Communicable Disease Surveillance in Healthcare & Community • CDC/NYS Roadmap 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 - Prevention Task Force & Subcommittee's - Crisis Stabilization & Recovery Center - Pain management Program - Crisis Hotline; "WarmLine" - Addiction Support Services

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 Classes
Perinatal and Infant Health	- Medicaid Program - Perinatal Program - Child Find
Child and Adolescent Health	- Child Lead Poisoning 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 - Youth Action Partnership - Child Care Coordinating Council

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.

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

The mission of the "Heart Network" is to design, develop and implement strategies to decrease the incidence of cardiac disease, stroke, and related chronic disease in Northern New York State.

All activities are aimed at reducing tobacco use and increasing physical activity and nutrition – the top 3 preventable causes of chronic disease that often disproportionately impact people living in rural communities.

The Heart Network has contributed to the establishment of numerous new, health-promoting opportunities for North Country residents. Most were the result of many years working with partners to lay the groundwork for success.

The Heart Network is funded primarily through grants, with each grant supporting evidence-based projects that help to reduce the chronic disease burden in the North Country by reducing tobacco use, increasing consumption of nutritious foods and/or increasing physical activity.

The 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
https://www.dot.ny.gov/programs/completestreets
The purpose of a Complete Streets policy is to provide guidance and/or requirements for new construction and reconstruction of roadways.

Complete Streets is a national movement towards creating streets and sidewalks with all users in mind- including pedestrians and bicyclists of all ages and abilities. Complete Streets design features such as good sidewalks, bike lanes, and safe traffic crossings are an effective intervention for increasing daily physical activity for people of all ages and abilities. Such changes help prevent obesity, a major risk factor for most chronic diseases.

New York States Complete Streets Act was signed into law and went into effect February 15, 2012.

The Act establishes Complete Streets principles that encompass the consideration of the needs of all users of our roadway as, including pedestrians, bicyclists, transit riders, motorists, and people of all ages and abilities.

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.

Catholic Charities of Franklin County
http://www.cathcharities.org
Services offered by Catholic Charities include: Counseling of individual couples, families, children, Foster Grandparent program, Pregnant and Parenting Teen Program. Services provided on a non-sectarian basis and the agency does not discriminate on the basis of race, creed, religious affiliation, ethnic background or sexual orientation.

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. 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.

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.

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 Services. 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 A Community Health Assessment Committee Data 2019 Methodology.)

C. Community Health Improvement Plan/ Community Service Plan

C1. Community Engagement Stakeholder Survey

Background

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.

Description of the Community Health Assessment Committee

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

An Ad Hoc Data Sub-Committee was 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 Appendix B.

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. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes. 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, FCPHS
- Sarah Granquist, FCPHS
- 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 Services, 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 Delivery System Reform Incentive Payment (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

Adirondack Health
Better Health, Better Lives

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 ed 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

PRIORITY AREA: PREVENT CHRONIC DISEASE
Focus Area 1:   Healthy Eating and Food Security *Overarching Goal: Reduce Obesity and the risk of chronic diseases*
Goals 1.1 Increase Access to healthy and affordable foods and beverages 1.2 Increase skills and knowledge to support healthy food and beverage choices.
Objectives 1.4 Decrease the percentage of adults ages 18 years and older with obesity (among all adults) 1.9 Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among all adults)
Intervention 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results. Local health departments, hospitals, health centers, businesses, CBOs and other stakeholders can <u>implement wellness programs at their own worksite and work with local worksites to implement nutrition and physical activity interventions as part of a comprehensive worksite wellness program.</u>
Activities • Establishment and Continued Enhancement of Employee Wellness Committee (EWC) to Promote Health and Well-Being for all employees. • Collaborate with JCEO for onsite Mobile Food Market providing access to healthy fruits and vegetables weekly during the growing season. • Partner with local orchard for onsite access to local apples, honey, and other naturally grown products
Resources AHMC Wellness Committee; local community organizations
Disparity Addressed Access; Education

PRIORITY AREA: PREVENT CHRONIC DISEASE
Focus Area 2: Physical Activity
Overarching Goal: Reduce obesity and risk of Chronic Diseases
Goals
2.2 Promote school, child care and worksite environments that increase physical activity
2.3 Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity.
Objectives
1.7 Increase the percentage of adults age 18 years and older who participate in leisure-time physical activity (among all adults
1.11 Increase the percentage of adults age 18 years and older who meet the aerobic and muscle strengthening physical activity guidelines (among all adults)
Interventions
2.2.3 Implement a combination of worksite-based physical activity policies, programs, or best practices through multi-component worksite physical activity and/or nutrition programs; environmental supports or prompts to encourage walking and/or taking the stairs; or structured walking-based programs focusing on overall physical activity that include goal-setting, activity monitoring, social support, counseling, and health promotion and information messaging 2.3.1 Implement and/or promote a combination of community walking, wheeling, or biking programs. Open Streets programs, joint use agreements with schools and community facilities, Safe Routes to School programs, increased park and recreation facility safety and decreased incivilities (i.e., litter, graffiti, dogs off leash, unmaintained equipment), new or upgraded park or facility amenities or universal design features (i.e. playgrounds and structures; walking loops, recreation fields; gymnasiums; pools; outdoor physical activity equipment, fitness stations or zones; skate zones; picnic areas; concessions or food vendors; and pet waste stations); supervised activities or programs combined with onsite marketing, community outreach, and safety education. (Note: Parks can include mini-parks, pocket parks, or parklets; neighborhood parks; community and large urban parks; sports complexes; and natural resource areas).
Activities
- AHMC Sponsored Events, Programs and Environments that support the promotion of worksite physical activity and healthy behavior   - Employee walking trails - Promote and Provide Maps (Inside hospital and around campus)   - Malone Community Fun Run Program Sponsorship (six weekly events during summer months).
Resources
AHMC Wellness Committee; Volunteer Services; Marketing and Communications
Disparity Addressed
Access; Education

PRIORITY AREA: PREVENT CHRONIC DISEASE
Focus Area 3: Tobacco Prevention
Goal
3.2 Promote tobacco use cessation
Objectives
3.2.1 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%.   3.2.2 Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among all adults)   3.2.8 Increase the utilization of smoking cessation benefits (counseling and/or medications) among smokers who are enrolled in any Medicaid* program
Interventions
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, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers, **Community Health Centers** and behavioral health providers.   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   3.2.3 Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment.
Activities
- Certified Tobacco Cessation Specialist (CTCS) embedded in AHMC Primary Care practices   - Implement workflow to ensure all primary care patients are screened and tracked for tobacco use (all forms) and referred for intervention services with onsite CTCS or NYS Quitline.   - Utilize AHMC Communications and Engagement Strategies Division to create content to promote and educate smokers about the benefits of evidence-based quitting approaches   - Promote the Great American Smokeout Initiative   - Work with primary care leadership and providers to promote the delivery of evidence-based cessation services by health care providers to patients.   - Collaborate with North Country Healthy Heart Network to create and provide education opportunities and tobacco cessation intervention materials for health care providers and patients.
Resources
AHMC Primary Care Practice; AHMC Wellness Committee; Marketing and Communications; Adirondacks ACO; North country Healthy Heart Network.
Disparity Addressed
Access; Education

PRIORITY AREA: PREVENT CHRONIC DISEASE
Focus Area 4: Chronic Disease Preventive Care and Management

Goals

4.1 Increase Cancer Screening Rates

4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity

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

Objectives

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

4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5%

4.3.4 Increase the percentage of adult members who had hypertension whose blood pressure was adequately controlled during the measurement year

Interventions

4.1.1 Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts).

4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings.

4.1.6 Ensure continued access to health insurance to reduce economic barriers to screening.

4.2.2 Promote testing for prediabetes and risk for future diabetes in asymptomatic people in adults of any age with obesity and overweight (BMI 25 kg/m2 or 23 kg/m2 in Asian Americans) and who have one or more additional risk factors for diabetes, including first degree relative with diabetes, high risk race/ethnicity, and history of cardiovascular disease. Promote testing for all other patients beginning at 45 years of age. Promote repeat testing at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.

4.3.1 Promote a team-based approach (which may include pharmacist, community health worker, registered dietitian, podiatrist, and other health workers) to chronic disease care to improve health outcomes.

4.3.2 Promote evidence-based medical management in accordance with national guidelines.

4.3.3 Promote the use of Health Information Technology for: Measurement, Registry Development, Patient Alerts, Bi-Directional Referrals, Reporting

4.3.4 Promote strategies that improve access and adherence to medications and devices.

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.

4.4.3 Expand access to the National Diabetes Prevention Program (National DPP), a lifestyle change program for preventing type 2 diabetes.

Activities

- Utilize Primary Care EMR Reminder System to ensure completion of annual patient screenings.
- Implement cancer screening partnership opportunities including education for providers.
- Implement FIT-DNA Testing Program for improved patient adherence and convenience with colorectal cancer screenings.
- Expansion of Clinic Hours being piloted at rural health clinic in Moira (Dwyer HC) to ensure additional access for patients needing care, screenings, or testing.
- Medicaid/Medicare Insurance enrollment agents onsite for patient referrals M-F from ED, Primary Care, and Walk-In Clinic.
- Utilize HIXNY Data on pre-diabetic non-diagnosed indicators by lab results to identify at-risk patients.
- Collaborate with CVPH to access and implement Diabetes Prevention Program with access to certified DPP and Health coach.

- Participate in the Adirondacks ACO Population Health Committee to ensure a team-based approach to chronic disease care management for patients at AHMC Primary Care practices.
- AHMC Primary Care EMR System established with evidence-based clinical decision support reference and guidelines for patient treatment.
- Utilize AHMC practice EMR to effectively manage patient alerts, measurement and reporting to improve care delivery.
- Implementation of Integrated Network-wide EHR (Epic) at AHMC in 2021 to enhance care coordination across the entire continuum.
- Installation of Medical Home Community Resource Specialist within AHMC Primary Care to track and report follow-through with Medication Adherence (by Target Year 2) and provide patient education and intervention as necessary.
- Participate on North Country Chronic Disease Prevention Coalition to implement the North Country Healthy Heart Network's (NC HHN) Pre-Diabetes Prevention Program through the AHMC Primary Care setting.
- Collaborate with CVPH for implementation of Certified Diabetes Prevention Program through the AHMC Occupational Health and Wellness Program, which adheres to National DPP standards.

Resources
AHMC Primary Care Practice; Reddy Cancer Treatment Center; AHMC Revenue Cycle; Marketing and Communications; Adirondacks ACO/Medical Home; North Country Healthy Heart Network/Chronic Disease Prevention Coalition; CVPH; HIXNY; UVMHN.

Disparity Addressed
Access; Education

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.

Objective
1.1.2 Reduce the age-adjusted percentage of adult New Yorkers reporting frequent mental distress during the past month by 10% to no more than 10.7%. Baseline 11.9%

Intervention
1.1.5 Enable resilience for people living with chronic illness: Strengthening protective factors include independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety.

Activities
- Investigate the opportunity for integration of behavioral health services into the AHMC primary care Rural Health Clinic practices.
- Develop a plan to construct a new AHMC Primary Care Building on campus, to develop a coordinated, multi-disciplinary approach to care delivery that includes behavioral health.
- ED Peer Navigator Program implemented in AHMC Emergency Department to provide access to and coordination of community based resources for patients frequenting the ED, who need additional services to manage their health and well-being.

Resources
 AHMC primary care; Citizen Advocates, Inc.; UVMHN; Community Connections of Franklin County.

Disparity Addressed
Access; Care Coordination; Poverty/Income level

PRIORITY AREA: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Focus Area 2:   Mental and Substance Use Disorder Prevention

Goal

2.2   Prevent opioid and other substance misuse and deaths

Objectives

2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population

2.2.3 Reduce the opioid analgesics prescription for pain, age-adjusted rate by 5% to 347 per 1,000 population

2.2.4 Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.3 per 100,000 population

Interventions

2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations

2.2.4 Build support systems to care for opioid users or at risk of an overdose

2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days

Activities

- Create Education Sessions for Primary Care providers on opioid prescribing
- Establishment of Pain Management Program with AHMC Pain Management provider to create access to specialized and appropriate care of patients dealing with chronic pain.
- Continued coordination between Crisis Intervention Center and AHMC ED to ensure patients receive the appropriate level of care.
- Investigate increased opportunities to collaborate with St. Joseph's Rehabilitation Center.
- Implementation of the NYS PSYCKES system in the AHMC Emergency Department, providing access to behavioral and mental health information as well as substance use information for Medicaid patients who are treating in the ED, in order to inform treatment plans and improve coordination of care.
- Investigate implementation of additional safe disposal boxes on AHMC Campus or in outlying health center (s).
- Create media and promotion around organized take back days to ensure public is educated.

Resources

 AHMC primary care; Citizen Advocates, Inc.; St. Joseph's Rehabilitation Center; NYS; AHMC Pharmacy; AHMC Marketing and Communications; AHMC Clinical Education.

Disparity Addressed

Access; Care Coordination; Poverty/Income level; Education

Franklin County
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:	**Anticipated Impact**
- 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	- 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:	**Anticipated Impact**
- 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	- 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	

Health Department Resources

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

Well Being Poverty	Certified Home Health Agency (CHHA) institute Social Determents of Health (SDOH) screening for clients in top 5 zip codes.
Age Friendly	Public Health develop comprehensive information about county supports for caregivers
Age Friendly Poverty	CHHA refer patients to Office of Aging (OFA) for SDOH Intervention
Well Being	Public Health develop SDOH County Intervention info
Well Being	Public Health post SDOH screening tool developed by 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 Traffic Safety Committee 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	Implement CDC AB for LHD's

Health Department Participant Rolls and Resources

Unhealthy Diet

- The NYSDOH will be a resource for training and participation in the Healthy Eating and Food Security Collaboration
- The Chronic Disease Collaborative Health Improvement Partnership 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 Country Healthy Heart Network (NCHHN), Franklin County Office of Aging (FCOFA) and JCEO to increase availability of fruits and veggies facilitate and conduct actions

Sedentary Lifestyle

- The YMCA in northern Franklin County (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.

C3. 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.

C4. 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).

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APPENDIX

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

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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

List of Sources Used for 2019 CHA Data Analysis
Demographic, Health Systems, Education and ALICE Profile Data Sources:

Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014

Centers for Medicare and Medicaid Services, CMS Enterprise Portal

Health Resources and Services Administration, HPSA Find, 2017-2018

Institute of Education Sciences, National Center for Education Statistics, District Directory Information 2016-2017

NYS Department of Health, Adult Care Facility Directory

NYS Department of Health, Nursing Home Weekly Bed Census, 2018

NYS Department of Health, NYS Health Profiles

NYS Department of Health, Vital Statistics of New York State, 2016

NYS Education Department, 3-8 ELA Assessment Data, 2017-2018

NYS Education Department, School Report Card Data, 2016-2017

NYS Office of the Professions, License Statistics, 2019

United For ALICE

US Census Bureau, 2010-2014 American Community Survey 5-year Estimates

US Census Bureau, 2013-2017 American Community Survey 5-year Estimates

US Department of Agriculture, National Agriculture Statistics Service, 2012

2019 CHA State Sheets and Written Analysis Data Sources:

Community Health Indicator Reports

Department of Health, Wadsworth Center

Division of Criminal Justice Services Index, Property, and Firearm Rates

NYS Department of Health Hospital Report on Hospital Acquired Infections

NYS Department of Health Tobacco Enforcement Compliance Results

NYS Expanded Behavioral Risk Factor Surveillance System

NYS Traffic Safety Statistical Repository

Prevention Agenda Dashboard

State and County Indicators for Tracking Public Health Priority Areas

Student Weight Status Category Reporting System (SWSCRS) Data

USDA Economic Research Service Fitness Facilities Data

2019 Stakeholder Survey Questions

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

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. **<u>Check all that apply.</u>**

⌟ 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, **<u>by indicating 1 through 5</u>**, 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.

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

ALICE is a United Way acronym that stands for Asset Limited, Income Constrained, Employed.												
Adirondack Rural Health Network	County											
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	$37,128	$35,148	$32,892	$32,940	$37,704	$47,604	$40,932	$38,028	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

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.

[US 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