Community Health Assessment 2016

Community Health Improvement & Service Plan 2016-2018

Adopted December 2016

Contact Information

The following organizations participated in the development of this Community Health Assessment and Improvement/Service Plan.

Respective Committees and Boards of these organizations reviewed and approved the Assessment & Plan before it was adopted by each participating organization and submitted to the New York State Department of Health (NYSDOH).

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Executive Summary

Community Health [Needs] Assessment Purpose

Community Health [Needs] Assessment (CHA) is the ongoing and systematic process of examining the health of a population. CHA is conducted by compiling and analyzing indicators and statistics from a variety of sources. Data includes demographics, morbidity and mortality (quality and longevity of life outcomes) and contributing health factors including health behaviors, environmental conditions, and the health system available to the population. CHA is used to:

- *determine* the overall health and disease-specific health of the community,
- *assess* underlying causes or conditions detracting from health or contributing to disease,
- *plan* for resource utilization to address health needs, and
- *implement* and *evaluate* targeted initiatives to improve population health.

Data Types and Sources

Much of the data collected was quantitative including rates and percentages. Indicators from numerous data sources including bureaus, divisions and reports of the New York State Department of Health (NYS DOH) along with other national sources such as the Census Bureau and County Health Rankings, a Robert Wood Johnson Foundation project. Most recent data available was compared to NYS for the same time period to provide perspective and previous time periods whenever possible to allow for trend analysis. See **Appendix A** for a summary of data consultants, methodology and sources.

Qualitative data collected was a Community Stakeholder Survey (**Appendix B**). The Survey served to provide input on community health needs and perceived priorities from a diverse group of community stakeholders. It was conducted with healthcare, social service, educational, governmental and others serving a wide variety of populations within the county.

Assessment Partners

This report is the product of a year-long process of collecting and analyzing data and consulting with stakeholders throughout the community and the region facilitated by the Adirondack Rural Health Network (ARHN), a program of the Adirondack Health Institute (AHI).   See **Appendix C** for the ARHN Community Health Assessment Committee list and meeting dates. The Center for Health Workforce Studies (CHWS) at the University at Albany School of Public Health was engaged for quantitative and qualitative data collection.

Essex County Health Department, the University of Vermont Health Network -Elizabethtown Community Hospital and Moses Ludington Hospital- and Adirondack Health [hereafter referred to as Essex County Health Partners] participated in this regional health assessment and planning effort and in crafting this Report. The New York State Department of Health (NYS DOH) Prevention Agenda framework[1] was used to categorize and prioritize. See **Appendix D** for more information about the NYS DOH Prevention Agenda.

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[1] New York State Department of Health (NYS DOH) Prevention Agenda framework. Available online at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Prioritization Process

A weighted prioritization tool was used to provide a score for each NYS DOH Prevention Agenda Focus Area. The tool was developed locally following guidance from the National Association of County and City Health Officials (NACCHO)[2] and included consideration of **need** in categories of *Demonstrated Need* (percent or rate of the population affected); *Variance* (comparison to NY or benchmark); *Trend* (comparison to data for the last assessment) and *Perceived Need* (stakeholder survey results) and **feasibility** in categories of *confidence* (perceived ability to engage stakeholders to address the issue), *resources* (availability of evidenced based intervention, staffing & funding) and *capacity* (perceived ability to do more than is currently being done to address the issue). See **Appendix E** for complete prioritization results.

Priorities 2016-2018

Identified priorities for 2016-2018 are a continuation from those last selected in 2013:

Preventing Chronic Disease

>   *Reducing Obesity in Children and Adults &*
>   *Increasing Access to Chronic Disease Preventive Care and Management.*

Interventions for these common priorities will be both independently and collaboratively conducted by Essex County Health Partners with a broad range of community stakeholders. The scope of interventions span broad through narrow to have both community through individual level impacts.

About Health Disparities

Health disparities may be identified when health-related outcomes are found to a greater or lesser extent within different groups of a population. Disparities in achieving optimal health are often found related to race and ethnicity, gender, sexual identity, disability and geography. Health disparities in Essex County have been identified as related to *rural geography*, *income*, *lack of higher education (Bachelor's or Professional Degree level attainment levels), an aging population, and limited access to health care.*

Disparities of Focus 2016-2018

The first two disparities of focus for 2016-2018 are a continuation from those last selected in 2013; the third is an addition:

Access to care,

Income &

Aging population.

Identifying these issues guides the work of public health (prevention), health care (treatment), and all community stakeholders in an effort to reduce the impact of these disparities on health outcomes.

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[2] National Association of County and City Health Officials. Community Health Assessments and Community Health Improvement Plans for Accreditation Preparation Demonstration Project. Tip Sheet: Prioritizing Issues in a Community Health Improvement Process. Available online at http://archived.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf

Interventions and Community Engagement

Targeted interventions support the continuation of the work started in 2014 and align with the NYS DOH Prevention Agenda Action Plan[3] of evidence-based strategies and interventions. Refer to **Appendix F** for summaries of previously adopted Improvement/Service Plans of each Essex County Health Partner.

Priority 1. Reduce obesity in children and adults

Strategies   1.1 Create **community environments** that promote and support healthy food and beverage choices and physical activity.

1.2 Prevent childhood obesity through **early child-care and schools**.

1.3 Expand the role of **health care and health service providers and insurers** in obesity prevention.

1.4 Expand the role of **public and private employers** in obesity prevention.

Priority 2. Increase access to high quality chronic disease preventive care and management
in clinical & community settings.

Strategies   2.1 Increase **screening rates** for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.

2.2 Promote use of **evidence-based care to manage** chronic diseases.

2.3 Promote culturally relevant **chronic disease self-management** education.

Lead organizations in these activities include Essex County Health Partners. Community sectors to be engaged in these goals include (and are not limited to) business owners, municipalities, child-care providers, schools, the WIC program, healthcare providers, health and human service providers, employers, Office for the Aging, senior and community centers, trail groups, the media & community members.

Emerging Issues

Other emerging issues identified through the assessment process are important to highlight. Though not identified as priorities for Essex County Health Partners for 2016-2018, they require the attention of Essex County Health Partners and community stakeholders.

Mental, Emotional, Behavioral Health and Substance Abuse

Rates of binge-drinking, alcohol-related injuries and deaths, and death by suicide are identified as higher in Essex County than the 2018 Benchmark or Upstate NY comparisons. Specific data may be found in the Mental, Emotional, Behavioral Health and Substance Abuse section. The 2017 Local Services Plan for Mental Hygiene Services (**Appendix G**) developed by the Essex County Community Services Board (CSB), details nine (9) priority outcomes including ensuring readily accessible care; integrating mental health, substance abuse and primary care health services; improving housing for those with diseases of mental health or addiction; addressing issues of marijuana and opioid use; decreasing deaths by suicide; increasing consumer participation in the service system and reducing tobacco use and its impacts. Essex County Health Partners, though not lead organizations in these priorities, are active partners in collaborative efforts to advance this Plan.

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[3] New York State Department of Health. Prevention Agenda 2013-2018: Preventing Chronic Diseases Action Plan. Available online at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/focus_area_1.htm#goals

Climate Change & Human Health

Climate changes has a varied and significant impact on human health. There are numerous health consequences – un-predictable and disastrous weather; changes in drinking water and food security, shift and emergence of infectious diseases and numerous other health consequences that influence both individual and population health. Certain populations such as the elderly, those with pre-existing health conditions and children are more vulnerable and generally less capable of adapting. Following are two climate change issues identified as emerging in Essex County.

Extreme weather events including flooding and winter storms were identified as highly probable for Essex County through the County Emergency Preparedness Assessment last conducted in 2015[4]. Geography, land use, aging population and pre-existing health conditions (chronic diseases) increases the population's vulnerability to negative health outcomes related to these events.

Change in infectious agents are occurring both due to global and local climate change. Infectious agents originating across the globe, such as *Ebola* and *Zika viruses*, are cause for local preparedness and response efforts to prevent local disease spread. Locally, *tick-borne bacterial illnesses* including *Lyme Disease* and recent documentation of *Anaplosmosis* cases have increased; data found in the Zoonoses sub-section of the Communicable Disease section.

Continue Reading

Refer to the *Community Health Assessment 2016* section for a comprehensive display of data, comparisons, trends, assets and current activities.

Refer to the *Community Health Improvement & Service Plan 2016-2018* for a comprehensive action plan including specific activities, impact targets, partners, and performance measures to evaluate and document progress of intervention.

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[4] New York State Division of Homeland Security and Emergency Services. County Emergency Preparedness Assessment, Essex County.

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Appendices*

* Appendices reports were modified from their original format to fit this report. They are available in original format upon request.

Community Health Assessment 2016

Community Profile

Unless otherwise noted through a footnote, see **Appendix H, Demographics** & **Appendix I, Education System** for additional data indicators & sources.

Geographic & Political Profile

Essex County is in the North Country region of Upstate New York (NY) and situated entirely within the Adirondack Park.

It is the 2nd most geographically large county in NY and 3rd least populated with only 21.56 people per square mile.[5] A large portion of the county is state land (45.82%) with the remainder (47.95%) being private.[6]
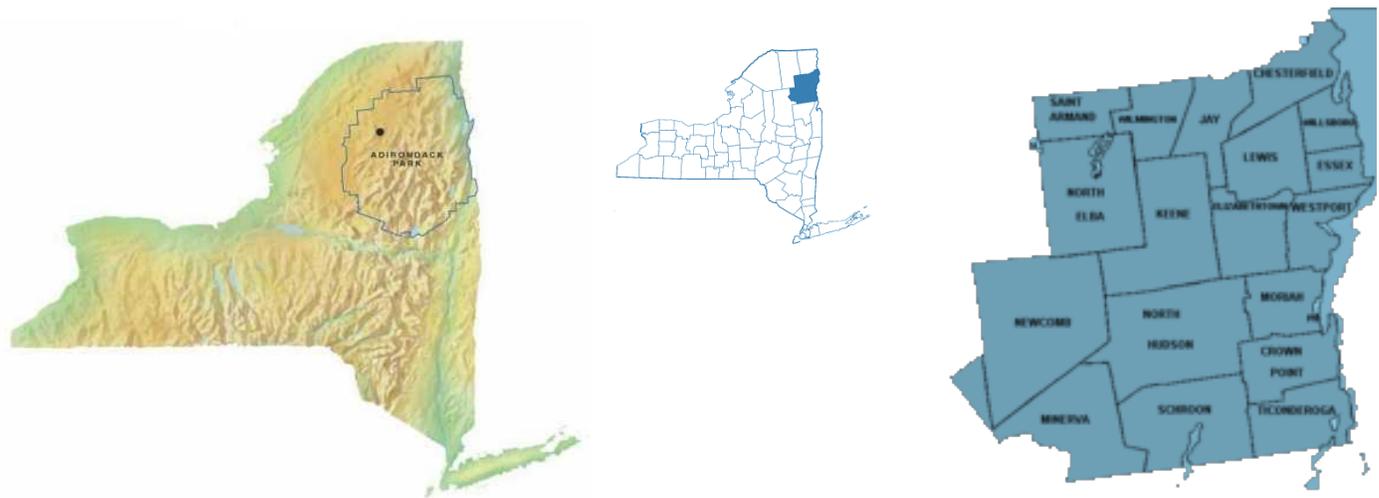
The population is estimated to be 39,370 in April 1, 2010 dropping 2.2% to an estimated 38,478 July 1, 2015.[7] There are 18 Towns and 4 Villages. Two (2) Villages are partially situated within Essex County; 1 bordering Franklin County (Lake Placid) on the west and 1 (Keeseville) bordering Clinton county to the north. Two (2) Villages, Port Henry in the Town of Moriah and Keeseville in the Town of Chesterfield, are currently undergoing dissolution processes. The Towns with the largest populations are North Elba, Ticonderoga and Moriah; the smallest are North Hudson, Newcomb & Essex. Essex County is governed by a Board of Supervisors comprised of each Town Supervisor who is provided a weighted vote based on the Town's Population.

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[5] New York State Department of Health. Vital Statistics. Table 2: Population, Land Area, and Population Density by County, New York State-2014. Retrieved from https://www.health.ny.gov/statistics/vital_statistics/2014/table02.htm

[6] Adirondack Park Agency. Adirondack Park Land Use Classification Statistics-May 21, 2014. Retrieved from http://apa.ny.gov/gis/stats/colc201405.htm

[7] United States Census Bureau. Essex County Quick Facts. Retrieved from http://www.census.gov/quickfacts/table/PST120215/36031

Economic Profile

Broadband Access

Broadband internet access, through cable or wireless services, has become not a luxury, but a necessity. It is an essential piece of economic development, commerce, education, healthcare and social connectedness.   As of August 2016 approximately 30% of Essex County homes & businesses have access at the NYS benchmark speed of at least 100 Mbps. Governor Cuomo has identified broadband access as a key component of New York's infrastructure and launched a new NY Broadband Program in January of 2016 to expand access across NY.[8]

Income

Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have more educated residents and lower unemployment rates. Higher employment rates lead to better access to healthcare and better health outcomes, since many families get their health insurance through their employer. Areas with higher median household incomes also have higher home values and their residents enjoy more disposable income. Essex County residents continue to have lower incomes compared to the rest of NYS.

Median Household Income Time Series[9]

VALUE	COMPARED TO:			
Median Household Income	$50322 (2010-2014)	NY Counties	U.S. Counties	NY Value ($58,687)	US Value ($53,482)
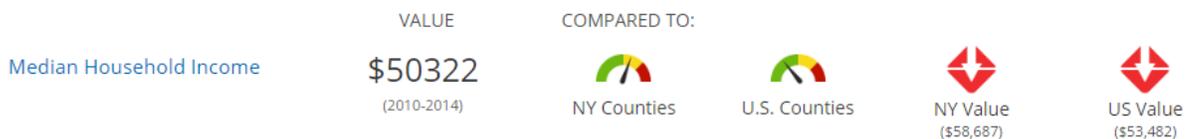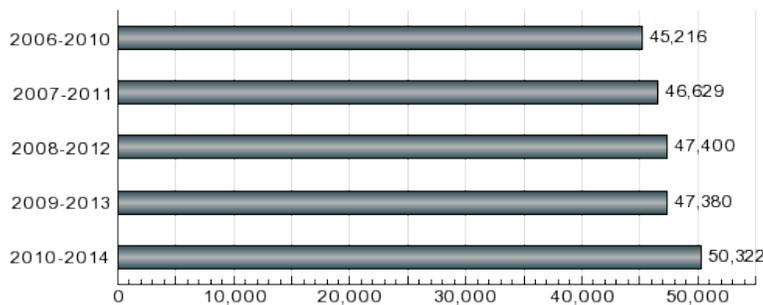
Income Indicator	Essex County 2011	Essex County 2014	NY 2014
Mean Household Income	$60,171	$64,341	$85,736
Per Capita Income	$24,915	$26,755	$32,829

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[8] New York State. Empire State Development Agency. Broadband Program Office. Available online at http://nysbroadband.ny.gov/
[9] Healthy ADK. Community Dashboard/American Community Survey Data. Available Online at http://www.healthyadk.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=20326145

Poverty

Households receiving general assistance or temporary assistance to Needy Families (TANF) is 2.7%.[10]

A time series review of poverty indicators for all sub-populations demonstrate a decreasing percent from the time period 2006-2010 and 2010-2014.   A smaller percentages of individuals are living under the federal poverty and receiving Medicaid compared to percentages in 2011 and 2014 as detailed in the table below.

Poverty Indicator	Essex County 2011	Essex County 2014	NY 2014
% Individuals Under Federal Poverty Level	12.2%	11.4%	15.6%
% Individuals Receiving Medicaid	16.4%	15.2%	24.7%

Sub-population examination for the time period of 2010-2014 demonstrate the sub-population with the highest percent living in poverty is children as demonstrated in the table below.[11]

Sub-Population Living Below Poverty	Essex County 2006-2010	Essex County 2010-2014
People	12.9%	11.4%
Families	8.1%	7.2%
Children	19.2%	16.1%
People 65+	7.7%	5.8%

Public School District Free & Reduced Lunch Program Percent Eligibility to Enrollment (all January of the year) demonstrate a general increase from 2005 through 2016 as shown in the table below.[12]

School District	2005	2010	2014	2015	2016
Crown Point	46.5	49.4	51.7	53.1	54.6
Elizabethtown-Lewis	30.8	41.5	45.4	48.6	55.7
Keene	18.1	31.0	39.6	43.0	37.4
Lake Placid	22.5	25.7	33.1	33.9	37.6
Minerva	38.2	40.0	41.7	42.2	47.3
Moriah	60.6	62.9	55.4	52.9	53.8
Newcomb	30.9	24.7	23.9	40.6	40.2
Schroon Lake	45.2	46.9	50.7	60.9	89.8
Ticonderoga	48.6	45.4	53.6	55.6	66.1
Westport	34.9	33.1	36.6	41.8	44.7
Willsboro	37.9	44.1	45.5	49.4	52.6
COUNTY TOTAL	40.8	43.1	46.1	48.1	53.5

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[10] Healthy ADK. Custom Report of Economic Indicators/Bureau of Labor Statistics. Available Online at http://www.healthyadk.org/
[11] Healthy ADK. Custom Report of Poverty Indicators for Sub-populations/American Community Survey Data. Available Online at http://www.healthyadk.org
[12] New York State Education Department. Child Nutrition Management System. Child Nutrition Knowledge Center. Eligibles to Enrollment Report. Available Online at http://portal.nysed.gov/pls/cn_port/mel3_pkg.elig_enroll_query

Childcare, Education & Employment Profile

Early Childhood/Preschool

Adirondack Community Action Program (ACAP) operates Early Head Start and Head Start Programs in Essex County with 72 slots available for Early Head Start; 125 for Head Start. These programs function at 100% capacity and are unable to meet community demand. ACAP is also the local Child Care Resource and Referral Agency. They have 38child Registered/Licensed Child Care Providers and 16 Legally exempt Child Care providers in the county and continue to note insufficient providers and slots to meet community demand.[13]

Schools

There are 11 public school districts entirely within the county and 2 bordering districts, Saranac Lake to the north-west and Ausable Valley to the North that serve Essex County student populations. Student to teacher ratio is lower than NY (9.0 in Essex County; 13.8 in NY) and the percent of students that dropped out of high school (8.6%) is also lower than the region (12.7%) and the state (12.8%). There are 3 private boarding schools: Mountain Lake Academy, North Country School and North Woods School located in Lake Placid; and two Christian schools: St. Agnes in Lake Placid and St. Mary's in Ticonderoga.

There is 1 community College, North Country Community College, located just inside the county in Saranac Lake (North-West corner of the county) and 1 satellite campus of that college in Ticonderoga.

Educational Attainment

Educational attainment indicators remain similar to the previous assessment as demonstrated in the table below.

Education Indicators (as Percent)	Essex County 2007-2011	Essex County 2010-2014	NY 2010-2014
Less than High School Diploma/GED	12.1	12.0	14.6
HS Graduate/GED	34.1	33.6	26.9
Some College, No Degree	18.1	20.7	16.3
Associate Degree	10.8	9.9	8.5
Bachelor's Degree	14.6	13.4	19.1
Professional Degree	10.3	10.4	14.6

Employment

Education, Healthcare and Social Assistance is the largest employment sector (30.3%); Higher than upstate NY (28.3%) and NYS (27.5%). Other large sectors include Arts, Entertainment, Recreation, Hotel & Food Service at 12.7% and Retail Trade at12.0%.

The most recent percent of unemployed, 2014, is 6.9%, lower than the 2011 percent of 7.2%. This percent is slightly higher than Upstate NY (5.6%) and NY (6.3%).

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[13] Adirondack Community Action Program. Child Care Annual Report. Available Online at http://www.acapinc.org/wp-content/uploads/2012/02/Child-Care-Annual-Report-2014-2015.pdf

Family & Social Profile

Age

The median age in Essex County is 45.6 compared to that of NY at 38.1. Essex County continues to experience a shrinking percent of younger citizens and growing percent of aged citizens compared to the relatively stable age

Age Distribution Comparisons

	Essex County 2000	Essex County 2010	Essex County 2014	New York 2014
65 Years and Older	16	17.8	19.6	14
45-64 Years	24.5	30.6	31.1	26.8
20-44 Years	34.6	30.2	29.1	34.4
5-19 Years	19.8	16.8	16	18.7
Under 5 Years	5	4.6	4.2	6
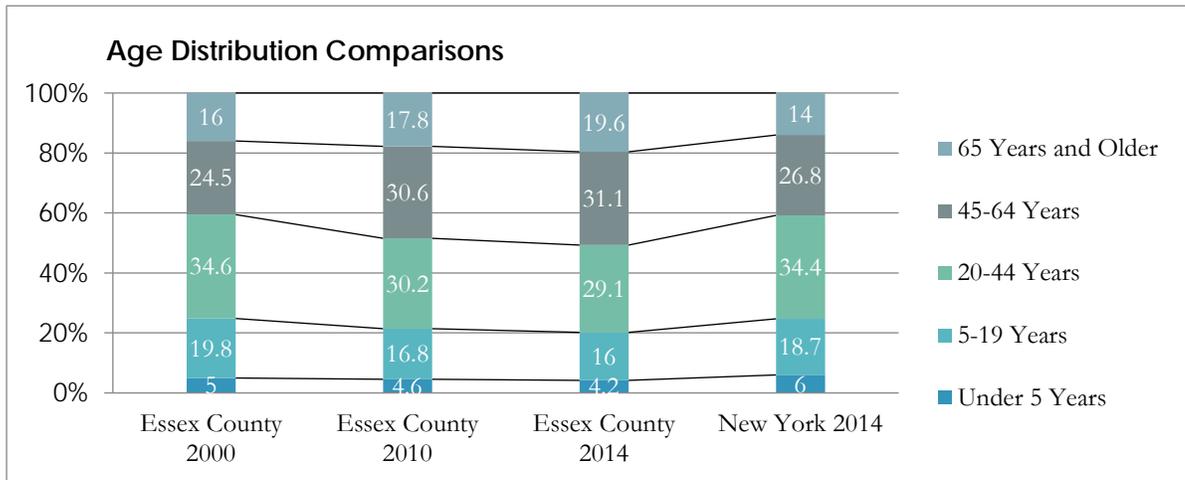
distribution of NY as demonstrated in the chart below.[14]

Race, Language & Family

The racial distribution in Essex County continues to be limited with the majority (92.5%) being white compared to NY (57.3%). There are 2.8% each Black and Hispanic/Latino population compared to NY with 14.4% Black; 18.2% Hispanic/Latino. A small percent, 6.3% of residents speak a language other than English at home; much smaller than the 30.2% in NY. Average household size is approximately 2.5 people, slightly smaller than the 2.7 of NY. Single parent households account for 13.2% of families (compared to 19.8% in NY) and a small, 1.3% of households are comprised of grandparents as parents, similar to the 1.8% in NY. A fair amount of those ages 65+ live alone (28.8%).[15]

Disabilities

The percent of adults with disabilities is 21.1%, a decrease from the 24.7% noted in the previous assessment and less than comparisons for the region (25.2%) and Upstate NY (22.4%).

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[14] US Census Bureau. American Fact Finder. Available Online at http://factfinder.census.gov/

[15] Healthy ADK. Community Dashboard/American Community Survey. Available Online at http://www.healthyadk.org/

Health System Profile

Unless otherwise noted, complete data and sources for the Health Systems Profile section may be found in **Appendix J**.

Clinical Care Ranking[16]

> This indicator shows the ranking of the county in clinical care according to the County Health Rankings. The ranking is based on a summary composite score calculated from the following measures: uninsured, primary care physicians, mental health providers, dentists, preventable hospital stays, diabetic monitoring, and mammography screening.

VALUE

41

COMPARED TO

NY Counties

Clinical Care Ranking
Source: County Health Rankings (2016)

Licensed Provider Rates

> Essex County has a significantly lower Total Physician per 100,000 population (93.5) compared to the region (214.2) and NY (307.0). Rates of all subspecialty licensed providers are much lower in Essex County compared to the region and NY. Of particular note are rates of Primary Care Providers (54.5/100,000) compared to the region (81.5) and NY (94.5). There is 1 full time Pediatric provider, no (0) Obstetrics/Gynecology providers and no (0) Psychiatry providers.

Primary Care Provider Rate — **41** Providers per 100,000 population (2013) — NY Counties — U.S. Counties — NY Value (83 providers/100,000 population) — Prior Value (41 providers/100,000 population)

Health Professional Shortage Areas (HPSAs)

> There are 5 Primary Care HPSAs in Essex County (covering 8,080 people); 1 Dental Care HPSA (covering 6,395 people); and 1 Mental Health HPSA (covering 35,299 people).

Hospitals

> There are a total of 40 hospital beds in Essex County. Hospital Beds by facility are Elizabethtown Community Hospital (25); Inter-lakes Health (ILH)/Moses Ludington Hospital (MLH) (15).

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[16] Healthy Communities Inc. Community Dashboard. Clinical Care Ranking. Available online at
http://www.healthyadk.org/index.php?module=indicators&controller=index&action=view&indicatorId=213&localeId=1895

Healthcare Transformation

Adirondack Health, Adirondack Medical Center

Adirondack Health has embarked on a healthcare transformation project called the Future of Care Campaign. The campaign has two major projects: 1) a new surgical services department for Adirondack Medical Center, and 2) the construction of Lake Placid Health and Medical Fitness Center. The surgical services upgrade of an existing suite [that is over 50 years in service] allows for the continuation and growth of vital surgical services to patients in the region accommodating an increasing number of seniors and ensuring faster, more comfortable and convenient care. The Lake Placid Health and Medical Fitness Center embraces healthy lifestyle promotion and the philosophy of exercise as medicine. These projects are also projected to support the recruitment and retention of qualified health care professionals to the region.

Inter Lakes Health, Moses Ludington Hospital AND University of Vermont Health Network, Elizabethtown Community Hospital

Since 2014, Moses Ludington Hospital has been an organization in transition. The organization is complex; and the challenges it faces are even more so. ILH (its parent organization) has had a number of issues plaguing it over the years. As a result, it must enact changes that will impact its structure, the services it offers and the manner in which it does so.

Along with providing essential healthcare to the people within the Moses Ludington service area, the primary focus of Moses Ludington has been a transition plan. There are two organizational transformations that are taking take place in relative unison: the Inter Lakes Health (ILH) organization will be restructured, along with Moses-Ludington Hospital, one of ILH's member organizations. Inter Lakes Health will be reconfigured; and will become a part of a medical village campus in Ticonderoga. Almost simultaneously, Moses-Ludington Hospital is also being reorganized; and will become part of the same medical village campus. There are 4 main parts that compose the medical village:

- Transformed hospital services operated by University of Vermont Health Network - Elizabethtown Community Hospital
- Long term care (operated by Post Acute Partners under its Elderwood brand of nursing homes)
- Primary care (working with Hudson Headwaters Health Network to develop primary care on-site.) and
- Senior housing (Lord Howe Estates and Moses Circle Senior Housing) already in place.

Central to the changes, transformations and plans for the future of health care in the Ticonderoga region is the commitment to the community by board members, management and staff at ILH – driven by the desire to provide health care to residents of, and visitors to, the entire region.

Community Health Centers

A greater percent of the Essex County population (19.0%) receive medical care at a Community Health Center compared with the region (16.84%) and NY (8.69%).

UVHN Elizabethtown Community Hospital (ECH) is working to improve Community Health Center based access to primary care by recruiting physicians and establishing primary care centers within Essex County. ECH owns a network of community-based health centers throughout Essex County including Ausable Forks, Elizabethtown, Westport, Willsboro and Wilmington. This year (2016) Elizabethtown Community Hospital expanded its network of health centers within the county by welcoming into its network the practice of Dr. Peter Sayers in Crown Point; formerly a single-provider private practice, Mountain Family Care. The health centers are supported by the hospital and its services,

assuring residents have easy access to primary care services with physicians and physician assistants and additional health services as necessary through the hospital.

Adirondack Health continues to provide primary care through health centers located in Keene and Lake Placid. Hudson Headwaters Health Centers continue to provider primary care through centers located in Moriah, Schroon Lake and Ticonderoga. Residents may also access primary care at Mountain Medical Services in Lake Placid and a limited number of single-provider practices.

Birthing Care

There are no prenatal classes, birthing facilities or beds in Essex County. As described above under Licensed Providers there are no OB/GYN providers in the county. Essex County Health Department provides at least 1 prenatal home visit for families, regardless of income, to provide birthing and breastfeeding education.

Emergency Care

Essex County residents and visitors may access emergency care through Adirondack Health Emergency Department in Lake Placid, Elizabethtown Community Hospital Emergency Department in Elizabethtown, Interlakes Health/Moses Ludington Hospital Emergency Department in Ticonderoga. Urgent care is also provided by mountain Medical Services in Lake Placid.

EMS

EMS agencies in Essex County include 2 privately owned (Elizabethtown Community Hospital Transport and International Paper) and 13 publicly owned (located in Ausable Forks, Elizabethtown, Keene, Keene Valley, Lake Placid, Minerva, Moriah, Newcomb, Schroon Lake, Ticonderoga, Westport, Willsboro and Wilmington).[17] Most of these rely solely on volunteers. Areas of coverage for certified services vary and are determined by a Certificate of Need (CON) process. Essex County appointed an EMS Coordinator in 2016.

Dental Care

There are 9 Dental Health Centers in Essex County; only 1 of these providers accepts Medicaid and 3 of these providers accept Child Health Plus. Seven (7) are known to accept private insurance. Essex County Health Department maintains a listing of Dentists in Essex County and the surrounding region to provide to the public.

Dentist Rate	31 Dentists per 100,000 population (2014)	NY Counties	U.S. Counties	NY Value (78 dentists/ 100,000 population)	Prior Value (34 dentists/ 100,000 population)

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[17] New York State Department of Health. Bureau of EMS. EMS Agency Information by County. Available online at http://www.health.ny.gov/professionals/ems/counties/map.htm

Adult Care Centers

There are a total of 194 Adult Care Facility beds in Essex County. This is a per 100,000 population rate of 497; higher than the region (252) and NY (239) though necessary given the aging population. There are 20 Assisted Living Program beds and 131 assisted living residence beds. Adult home beds by facility are 40 at Adirondack Manor (DBA Montcalm Manor) and 23 at Moses Ludington Adult Care Facility [both in Ticonderoga] and 50 at Keene Valley Neighborhood House.

Nursing Homes

There are a total of 340 Nursing Home beds in Essex County. This is a per 100,000 population rate of 870; higher than the region (775) and NY (580) though justified given the aging population. Nursing Home Beds by facility are the Essex Center for Rehabilitation and Healthcare (100) in Elizabethtown, Heritage Commons Residential Health Care facility (84) in Ticonderoga and Uihlein Living Center (156) in Lake Placid.

Mental Health

Essex County Mental Health Services serves residents through its clinic for a range of diagnoses. The Clinic provides case management as well as individual, group, school, and crisis services on an out-patient basis to Essex County residents of all ages. The Mental Health Association provides a crisis hotline and support, case management and classes. There are a limited number of private clinical psychologists and social workers. Families First in Essex County raises awareness of issues for children with mental illness, provides case management and helps families become more connected in their communities and access resources.

Mental Health Provider Rate	142 Providers per 100,000 population (2015)	NY Counties	U.S. Counties	NY Value (238 providers/ 100,000 population)	Prior Value (142 providers/ 100,000 population)

Substance Abuse

The Prevention Team is an Office of Alcohol and Substance Abuse Services (OASAS) OASAS funded, prevention focused program serving Essex County whose mission is to build relationships to promote healthy social environments for families, schools and communities leading to healthy choices by individuals. St. Joseph's Addiction & Treatment and Recovery Centers provide out-patient alcohol and substance abuse services at 2 locations in Essex County-Ticonderoga, Elizabethtown- and nearby out of county – Keeseville and Saranac Lake. Inpatient services are available in Saranac Lake, Franklin County. There are currently no detox programs in Essex County.

Community Services Board

The Community Service Board (CSB) is a coalition of mental health, substance abuse and developmental disability providers governed by NYS Mental Hygiene Law designated to assure joint planning and financing of mental health services. Responsibilities include assuring the population is adequately covered by services, that there is coordination and cooperation of providers and other community support services and that there is continuity of care among providers. The CSB Local Service Plan, with a focus on issues related to mental health and substance abuse, is similar to the Community Health Improvement Plan, the responsibility of the local health department, and the Community Services Plan, the responsibility of hospitals. Essex County's Local Service Plan in available in **Appendix G**.

NYS Prevention Agenda Priority Area Indicators

Unless otherwise noted, complete health indicator data and sources for the NYS Prevention Agenda Priority Area Indicators section may be found in **Appendix K**.

Health Status & Disparities

Death Rates for Selected Causes of Death[18]

The age-sex adjusted death rates for selected causes of death has remained fairly consistent from 2000-2014 with Diseases of the Heart and Malignant Neoplasms (Cancer) being leading causes of death. Cerebrovascular Disease rates demonstrate a general decline over this time period; Diabetes an increase.
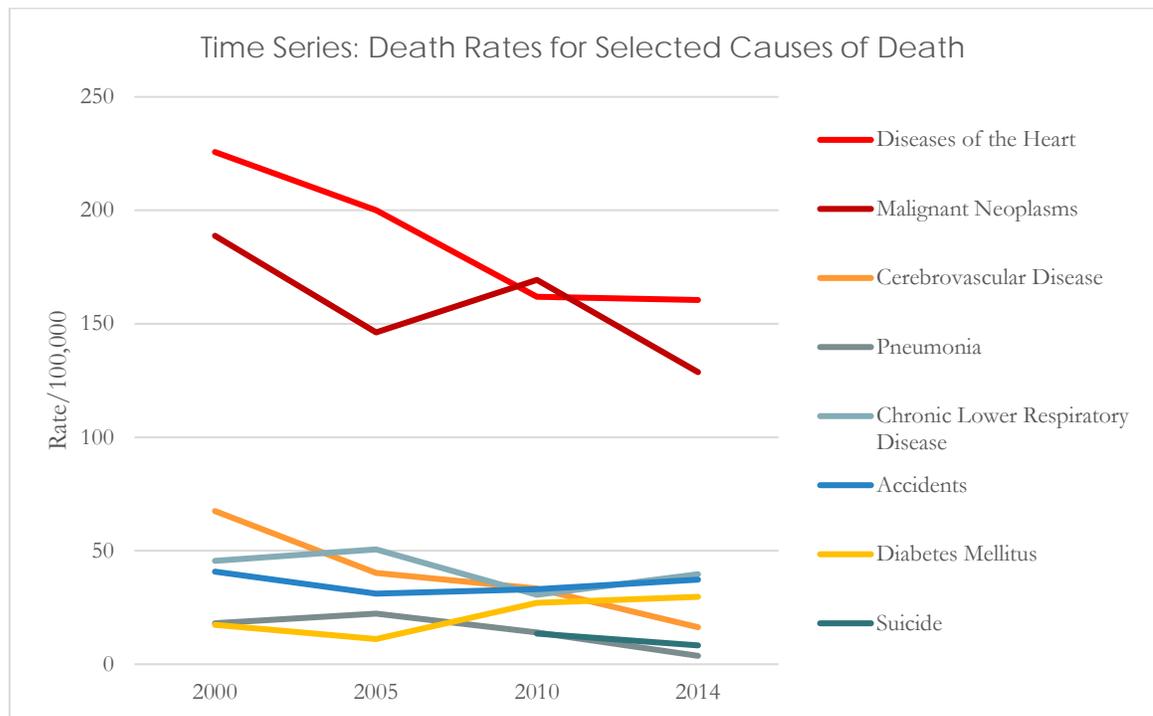
Chronic conditions remain a priority in Essex County. Diseases of the heart and cancer remain predominant causes of morbidity and mortality. And while these align with an aging population (20% of residents are 65 years and older), indicators for overweight, obesity and diabetes also continue to rise, including those for children. For more complete information, see the Chronic Diseases section.

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[18] New York State Department of Health. Vital Statistics. Available online at https://www.health.ny.gov/statistics/vital_statistics/

Healthcare Utilization & Death

Indicator	Essex (Previous)	Essex (Current)	NY (Same as (Essex Current))	2018 Benchmark
Emergency Department Visits/10,000	4,611.8 ('08-'10)	4,484.8 ('11-'13)	4,086.4	NA
Adult Preventable Hospitalizations/100,000	134.9% ('08-'10)	88.9 (2014)	119	122
Premature (Ages 35-64) Death Percent	19.9% ('08-'09)	23.7% (2013)	23.7%	21.8%

Premature Death by Zip Code[19]

A zip code view of age-adjusted premature death demonstrates a correlation of socioeconomic status with years of potential life lost (figure below).

Age-adjusted years of potential life lost before age 75 per 100,000 population
ZIP codes, 2009-2013
County: Essex

Years of potential life lost
Essex County: 5,555
New York State: 5,352
New York State excluding NYC: 5,528

Quartile Distribution: NYS excl. NYC
Data do not meet reporting criteria
0 <= Q1 & Q2 < 5,187
5,187 <= Q3 < 6,850
6,850 <= Q4

*: Less than 10 deaths, therefore rate may not be stable (RSE > 30%).
Data Source: New York State Vital Records

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[19] NYS DOH. Office of Public Health Practice. Bureau of Chronic Disease Evaluation and Research. Sub-County Health Data Report. Available online at http://www.nysachoinfo.org/Sub-County-Health-Data-Report/Essex.pdf

Access to Healthcare

People who lack a regular source of health care may not receive the proper medical services, including routine check-ups and screenings, when they need them. When they become ill, they generally delay seeking treatment until the condition is more advanced and therefore more difficult and costly to treat. Maintaining regular contact with a health care provider is especially difficult for low-income people, who are less likely to have health insurance. This often results in emergency room visits, which raises overall costs and lessens the continuity of care.

The percent of children, women and adults with health insurance have all increased since the last assessment though they do not yet meet the NYS 2018 Prevention Agenda benchmark of 100%. The percent of adults with a regular healthcare provider has decreased since the last assessment, though so has the percent of adults unable to receive care due to costs.

Indicator	Essex (Previous)	Essex (Current)	NY (Same as (Essex Current))	2018 Benchmark
Adults (18-64) with Health Insurance	84.0% ('08/'09)	89.8% (2013)	87.6%	100.0%
Women (18-64) with Health Insurance	85.7% ('08/'09)	91.7% (2014)	89.7%	100.0%
Children (0-19) with Health Insurance	93.6% (2010)	95.8% (2014)	96.6%	100.0%
Adults with a regular health care provider	83.7% ('08/'09)	77.8% ('13-'14)	84.4%	90.8%
Adults who did not receive care due to costs	11.1% ('08/'09)	10.0% ('13/'14)	13.1%	NA

Disparities

Healthcare Providers/Professional Access

While the percent of residents with health insurance has been increasing, residents continue to be at a healthcare provider access disadvantage as described in detail in the Health System Profile section. Of particular note are that there remains no OB/GYN or Psychiatry providers in county, primary care providers are considerable less than the region and NY and that there are Health Professional Shortage Areas (HPSAs) for Primary Care, Dental Care and Mental Health.

Income

Data available supports additional health risks for lower income populations such as those eligible for Medicaid or WIC. Residents continue to experience lower mean household incomes and per-capital incomes than NY. The higher percent of sub-populations living in poverty are children at 16.1%. An increasing percent of children are eligible for free and reduced lunches (40.8% in 2005 to 53.5% in 2016). Refer to the Economic Profile section for more detailed information.

Age

The age distribution in Essex County continues to display an aging population with almost 20% aged 65+; higher than the 14% in NYS; those 45-64 about 31% compared to the approximate 27% of NYS. Refer to the Family & Social Profile section for more detailed information.

Healthy & Safe Environment

Air and Water Quality

Data for the number of days with unhealthy ozone or particulate matter is unavailable.

Public Water

Of Essex County's 18 Towns, all but 1, North Hudson, have municipal water supplies. There are a total of 25 water districts. Most (10) Towns have 1 water district; 6 have 2 districts; 1 has 3 districts. None of the public water supplies are fluoridated.

Accidents/Injuries

The rates of falls for both children and aged adults continues to be lower than Upstate NY and the benchmark. Occupational injuries for those 15-19 has increased since the last assessment and is higher than Update NY & Benchmark levels.

Total Motor Vehicle Crashes, speed-related accidents and alcohol-related crashes and deaths have all continued to increase and exceed Upstate NY levels.

Select Indicators	Essex	Essex (Current)	Upstate NY (Same as Essex Current)	2018 Prevention Agenda Benchmark
ED Visits Due to Falls, Children Ages 1-4/10,000	537.9 ('08-'10)	392.6 ('14)	442.7	429.1
ED Occupational Injuries, Ages 15-19/10,000	98.4 ('08-'10)	101.7 ('13)	28.2	33.0
Hospitalizations Due to Falls, Ages 65+/10,000	205.0 ('08-'10)	110.9 ('13)	188.7	204.6
Total Motor Vehicle Crashes/100,000	2,550.2 ('09-'11)	2,661.2 ('09-'11)	2,061.9	NA
Speed-Related Accidents/100,000	588.4 ('09-'11)	635.6 ('11-'13)	217.1	NA
Alcohol-Related Crashes	Change in data reporting	102.6 ('11-'13)	43.4 (NY; not Upstate)	NA
Motor Vehicle Accident Deaths/100,000	7.0 ('08-'10)	12.8 ('11-'13)	7.4	NA

Crime

Crime data, including total crimes, property crimes & violent crimes are all less than those of the compared region, Upstate NY and NY State.

Grocery/Food Access[20]

> The grocery store (including grocery & supermarkets; excluding convenience stores or supercenters) density in Essex County is .62/1000; this rate fairs well compared to other counties in the US. Households with no car and low access to a grocery store account for only 3.7% of the population. Those with low income and limited access to a grocery store is 2.0%. Subpopulation with limited access to a grocery store include 1.4% of children and 1.2% of people ages 65+.

> The farmer's market density is .18/1,000 population which is also considered to fair well when measured against other counties in the US.

Recreation & Fitness Access

> All of Essex County is within the Adirondack Park so access to exercise opportunities are often documented as highly accessible. However communities are comprised on public and private lands and access to park lands that provide opportunities for physical activity to most are not well documented. Efforts are underway to better assess local opportunities for physical activity and market these to the public. Fitness facility availability has decreased over time from .21/1,000 in 2007 to .08/1,000 in 2012.[21]

Housing

Percent of Renters Spending Over 30% on Housing

> There is a higher percent of owner-occupied housing, 73.5% compared to that of NY, 53.8%. However the percent of renters that spend more than 30% of their income on housing is high, 49% overall with a significant burden exhibited for young adults (81.3%) and those aged 65+ (56%), as demonstrated by the chart to the right.

Category	Percent
15-24	81.3
25-34	40.5
35-64	43.2
65+	56.0
Overall	49.0
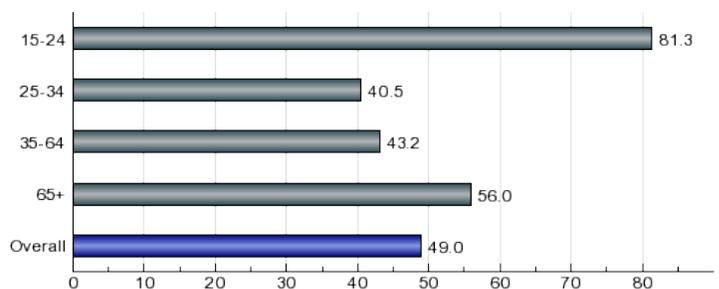
Transportation

> Residents rely heavily on personal vehicles for transportation though an increasing percent of households, 8.5% in 2016, report having no vehicle available. Public transportation is limited to the county transportation system that offers limited routes throughout the county and a trolley in the Village of Lake Placid primarily geared towards visitors. The percent of commuters who use alternate modes of transportation to work is 20.7% compared with 22.6% for Upstate NY and less than the 2018 benchmark of 49.2%.

> Vehicle ownership is directly related to the ability to travel. In general, people living in a household without a car make fewer than half the number of journeys compared to those with a car. This limits their access to essential local services such as supermarkets, post offices, doctors' offices and hospitals. Most households with above-average incomes have a car while only half of low-income households do.

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[20] Healthy ADK. Community Dashboard/US Department of Agriculture. Available Online at http://www.healthyadk.org/
[21] Healthy ADK. Community Dashboard/ US Department of Agriculture. Available Online at http://www.healthyadk.org/

Chronic Diseases

Chronic diseases- diseases of the heart & circulatory system, cancer, diabetes, arthritis and asthma – are the leading causes of reduced quality and length of life in Essex County and New York State. Yet these conditions are among the most preventable and can be largely delayed, reduced or eliminated by living healthfully. This section will examine chronic disease **outcomes** (quality & length of life) along with contributing health factors including personal health **behaviors** and **environmental conditions** that lead to these outcomes.

Heart Disease and Cancer continue to be leading causes of death in Essex County. Respiratory Disease and Diabetes also remain notable causes of death.

Heart & Circulatory System

Outcomes

Rates of premature death due to heart & circulatory conditions has increased since the last assessment and is higher than comparison rates for NY as demonstrated in the table below. Males experience a higher death rate than females.

Heart & Circulatory System Indicators/100,000	Essex ('08-'10)	Essex ('11-'13)	Upstate NY ('11-'13)	NY ('11-'13)
Cardiovascular Disease Premature (Ages 35-64) Deaths	50.5	127.2	96.8	99.0
Diseases of the Heart Premature (Ages 35-64) Deaths	45.3	115.3	79.9	80.6
Coronary Heart Disease Premature (Ages 35-64) Deaths	33.1	75.5	60.7	65.5
Cerebrovascular (Stroke) Deaths/100,000	53.1	36.8	38.5	30.9

Age-Adjusted Death Rate due to Coronary Heart Disease by Gender
County: Essex | Source: Centers for Disease Control and Prevention (2012-2014)
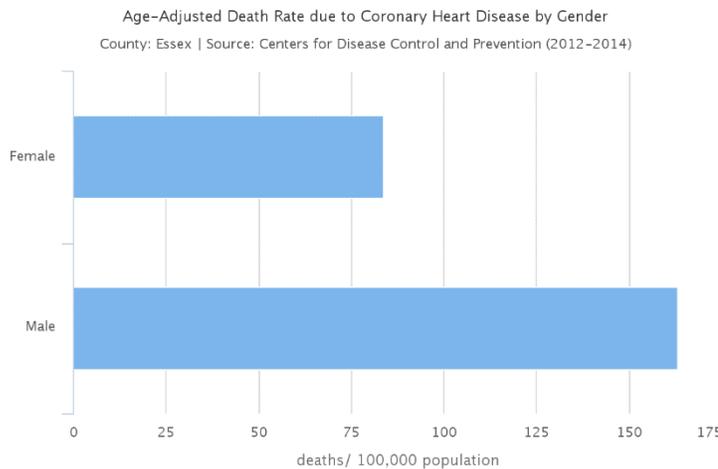
Coronary heart disease (also called coronary artery disease) is the most common type of heart disease. It occurs when the coronary arteries become narrowed or clogged by fat and cholesterol deposits (plaques) and cannot supply enough blood to the heart. As the arteries narrow, or as the plaques rupture, the flow of blood to the heart can slow or stop.

Screening Behaviors/Diagnosis

Screenings based on the most recent clinical guidelines has improved since the last assessment

Screening/Diagnosis Indicators	Essex ('08/'09)	Essex ('13/'14)	Upstate NY ('13/'14)	NY ('13/'14)
Adults with Cholesterol Check	71.3%	78.2%	79.7%	84.2%
Adults with Diagnosed High Blood Pressure	28.2%	30.8%	30.2%	28.3%

Cancer

Outcomes

Cancer remains one of the leading causes of death in Essex County. Since the last assessment, most cancer death rates have increased (all but colon & rectum) and compared to NY most (all but Prostate) most rates are higher.

Cancer Outcome Indicators	Essex ('07-'09)	Essex ('10-'12)	Upstate NY ('10-'12)	NY ('10-'12)
Cancer Cases/100,000	689.4	664.8	610.5	550.9
Cancer Deaths 100,000	263.9	244.0	202.4	180.7
Breast Cancer Deaths/100,000 female pop.	9.7 ('07)	31.8	28.1	26.3
Ovarian Cancer Deaths/100,000 female pop.	5.3	12.3	10.4	9.5
Colon & Rectum Cancer Deaths/100,000	27.4	20.4	17.2	16.6
Prostate Cancer Deaths/100,000 male pop.	6.2	14.8	21.2	18.6
Melanoma Cancer Deaths/100,000	5.3	6.0	3.3	2.5
Oral Cavity & Pharynx Cases/100,000	14.1	17.9	13.5	12.1
Lung & Bronchus Cancer Deaths/100,000	72.4	75.7	55.9	46.4

Colorectal Cancer Incidence Rate

44.1
Cases per 100,000 population
(2009-2013)

NY Counties   U.S. Counties

NY Value (41.5 cases/ 100,000 population)   US Value (40.6 cases/ 100,000 population)

Age-Adjusted Death Rate due to Colorectal Cancer

15.4
Deaths per 100,000 population
(2009-2013)

NY Counties   U.S. Counties

NY Value (14.6 deaths/ 100,000 population)   US Value (15.1 deaths/ 100,000 population)

Screening Behaviors

The percent of women having received breast cancer screening is better than NY comparisons. The percent of adults having received colorectal screening is similar to that of NY though does not meet the NYS Prevention Agenda Benchmark set at 80%.

Cancer Screening	Essex ('07-'09)	Essex ('13/'14)	Upstate NY ('13/'14)	NY ('13/'14)
Breast Cancer Screening, Women 50-74	689.4 ('07-'09)	83.0%	80.5%	80.9%
Colorectal, Adults 50-75	263.9 ('07-'09)	68.3%	70.0%	69.3%

Diabetes

Outcomes

Diabetes can have a harmful effect on most of the organ systems in the human body; it is a frequent cause of end-stage renal disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working age adults. Persons with diabetes are also at increased risk for ischemic heart disease, neuropathy, and stroke. Diabetes disproportionately affects the elderly and its incidence is likely to increase as the population ages.

The rate of Diabetes deaths has increased since the last assessment and remains higher than Upstate and NY rates.

Diabetes Indicators (per 100,000)	Essex ('08-'10)	Essex ('11-'13)	Upstate NY ('11-'13)	NY ('11-'13)
Deaths	28.7	31.6	19.6	20.3
Hospitalization, Primary Diagnosis	12.4	11.0	15.6	19.3

Overweight & Obesity

Outcomes

Obese and overweight children and adolescents are at risk for multiple health problems during their youth and are likely to be more severe as adults. Obese and overweight youth are more likely to have risk factors associated with cardiovascular diseases, such as high blood pressure, high cholesterol, and Type 2 diabetes. The percent of children and adults who are obese continue to increase as demonstrated below.

Middle and High School Students who are Overweight or Obese

38.3% (2012-2014)

NY Counties

NY Value (35.2%)

Prior Value (34.9%)

Obesity Indicator	Essex ('08-'09)	Essex ('13-'14)	Upstate NY ('13-'14)	2018 NYS Prevention Agenda Benchmark
Adults, Obese	24.8%	32.2%	27.0%	23.2%
Adults, Overweight or Obese	64.3%	68.6%	62.2%	60.9%
School-Age Children, Obese	18.8% ('10-'12)	19.2% ('12-'14)	17.3% ('12-'14)	16.7%

Behaviors/Environmental Conditions

Obesity is a complex health condition both physiologically and socially. Certain behaviors including dietary and physical activity practices of individuals contribute to weight. However there are many environmental circumstances that either contribute or detract from an individual's behaviors and ability to maintain a healthy weight such as access to fruits, vegetables and other naturally whole foods; access to nutritionally limited/void food products; marketing and social norms related to food and eating; and access to and opportunities for a variety of physical activities. These circumstances are much more difficult to assess and measure, though limited pieces of local data are available such as those detailed already under the Prevention Agenda >Healthy & Safe Environment>Grocery/Food Access and the Recreation/Fitness Access sections .

Tobacco Use

Outcomes

Rates of Lung and Bronchus cancer cases and deaths (both per 100,000 population) have increased since the last assessment and are worse than NY comparisons. The rate of chronic lower respiratory disease deaths has decreased since the last assessment though remains higher than NY comparisons.

Tobacco Use Related Indicators (Rate/100,000)	Essex ('07-'09)	Essex ('10-'12)	Upstate NY ('10-'12)	NYS ('10-'12)
Lung & Bronchus Cancer Cases	102.4	112.2	83.0	69.6
Lung & Bronchus Cancer Deaths	72.4	75.7	55.9	46.4
Chronic Lower Respiratory Deaths	68.8 ('08-'10)	56.5 ('11-'13)	46.2 ('11-'13)	35.6 ('11-'13)

Behaviors/Environmental Conditions

Smoking tobacco is linked to asthma and breathing complications including lung and bronchus cases along with diseases of the heart. Adult smoking and access indicators are described in the table below and demonstrate a decrease in adult smoking and vendors. The percent of adult smokers does not reach the NYS Prevention Agenda Benchmark for 2018 of 12.3%. The percent of vendors with sales to minors is 3.8%; an increase from the previous assessment. A continued decrease in access to and use of tobacco products are predicted to lead to reduced rates of lung & bronchus cancer cases in the future.

Tobacco Access & Use Indicators	Essex ('09-'10)	Essex ('10-'12)	Upstate NY ('10-'12)	NYS ('10-'12)
Tobacco Vendors (rate/100,000)	135.8	54.4	22.7	41.4
Vendor Sales to Minors	1.9%	3.8%	5.5%	8.9%
Adults who Smoke	23.0% ('08-'09)	16.6% ('13-'14)	22.5% ('13-'14)	17.3% ('13-'14)

Asthma

Asthma ED visits hospitalization and death rate indicators are better in Essex County than Upstate NY and NY.

Women, Infants and Children

Health Insurance

The percent of women ages 18-64 with health insurance is 91.7% (2014).

Pregnancy, Birth

The rate of pregnancies for women ages 15-17 decreased from the last assessment (21.2 to 10.3); the rate of pregnancies for women ages 18-19 decreased from the last assessment (from 79.8 to 58.2). The percent of women receiving early prenatal care has remained fairly consistent from the previous to current assessment.

The rate of abortions for Ages 15-19 and All Ages is less than those of Upstate NY comparisons. The percent of unintended births (31.7%) has remained consistent from the last assessment and exceeds Upstate NY (26.5%) and the 2018 benchmark comparison (23.8%). The ratio of unintended births Medicaid to Non-Medicaid populations increased from the last assessment and exceeds the 2018 benchmark. The ratio of pre-term birth data for the Medicaid to Non-Medicaid population is 1.23, slightly worse than the Upstate NY (1.12) and 2018 (1.00) benchmarks.

The rate of newborn drug related hospitalizations increased from 37.6 at the last assessment to 101.9 though the total patient number is less than 10.

Select Indicators	Essex ('08-'10)	Essex ('11-'13)	Upstate NY	2018 Benchmark
Rate of Pregnancies Ages 15-17/1,000	21.2	10.3	11.7	25.6
Rate of Pregnancies Ages 18-19/1,000	79.8	58.2	47.6	NA
Early Prenatal Care	74.2%	73.3%	75.4%	NA
Unintended Births to Total Births	31.5% (2011)	31.7% (2013)	26.5%	23.8%
Ratio of Unintended Births Medicaid to Non-Medicaid	1.26	1.82	1.97	1.54
Births Within 24 Months of Previous Pregnancy	24.5%	19.5%	21.1%	17.0%
Rate of Newborn Drug Related Hospitalizations/10,000 Births	37.6 (less than 10)	101.9 (less than 10)	12.2	

WIC Pregnancy Spotlight

Examination of select indicators identifies increased risk for pregnant women and their babies. Of note is the increase of gestational diabetes for WIC Women that has continued to increase since the last assessment (from 7.9% to 9.6%) and is higher than the Upstate NY comparison (5.7%).

Select WIC Women Indicators	Essex ('08-'10)	Essex (Current)	Upstate NY (Essex Current)
Pre-Pregnancy Underweight	5.9%	5.4% ('10-'12)	4.1%
Pre-Pregnancy Obese	32.5%	29.1% ('10-'12)	28.0%
Gestational Weight Gain Greater Than Ideal	54.3%	52.9% ('09-'11)	47.1%
Gestational Diabetes	7.9%	9.6% ('09-'11)	5.7%
Gestational Hypertension	15.5%	14.5% ('09-'11)	9.1%

Breastfeeding

Indicators for breastfeeding have generally improved since the last assessment and meet or exceed Upstate NY and 2018 benchmark comparisons with the exception of WIC Women Breastfeeding at 6 Months which demonstrates a slightly lower local percent compared to Upstate NY.

Select Indicators	Essex ('08-'10)	Essex ('11-'13)	Upstate NY (Essex Current)	2018 Benchmark
Infants Exclusively Breastfed in Delivery Hospital	66.8%	75.0%	51.1%	48.1%
Ratio Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid	.80	.86	.69	.66
Infants Receiving Any Breastmilk in Delivery Hospital	69.3%	80.1%	78.0%	NA
WIC Women Breastfeeding at 6 Months	20.0%	19.9%	27.8%	NA

Child Health

Indicators for children including having health insurance and receiving recommended well child visits has improved from 2010-2014 as demonstrated in the data below though some do not yet meet the 2018 benchmark comparison.

Select Indicators	Essex (2010)	Essex (2014)	Upstate NY (Same as Essex Current)	2018 Benchmark
Children with Health Insurance	93.6%	95.8%	96.6%	100%
Children with Recommended Child Health Visits, Ages 0-15 Months, Government Months, Health Insurance	62.5%	92.2%	84.3%	91.3%
Children with Recommended Child Health Visits, Ages 3-6 Years, Government Months, Health Insurance	77.1%	86.2%	81.4%	91.3%
Children with Recommended Child Health Visits, Ages 12-21 Years, Government Months, Health Insurance	46.3%	53.1%	62.0%	67.1%

Lead Screening

The percent of children screened for lead levels has decreased, at both By 18 months at By 36 months, and is less than the Upstate NY comparison.

Oral Health

The percent of Medicaid Enrollees Ages 2-20 with at least One Dental Visit increased from the previous to current assessment. The percent of 3rd Graders with dental sealants is 34.5% ('09-'11). The rate of Caries ED visits for children ages 3-5 increased from 48.9 ('08-'10) to 85.5 ('11-'13).

Mental, Emotional, Behavioral Health and Substance Abuse

Mental Health

Psychological distress can affect all aspects of our lives. Men are more likely than women to suffer death by suicide. Repercussions of suicide include the emotional toll on family and friends and combined medical and lost work costs on the community.
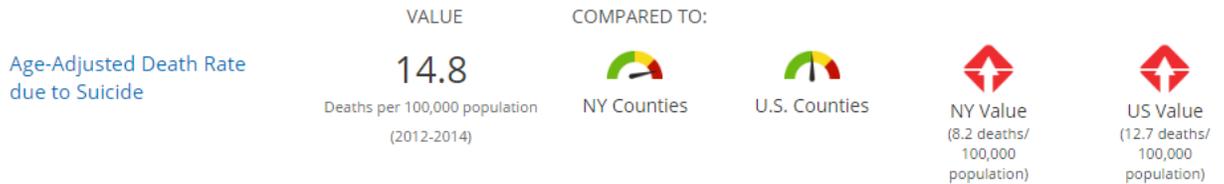
Outcome Indicators	Essex (Previous)	Essex (Current)	Upstate NY (Same as Essex Current)	2018 Benchmark
Age-Adjusted Suicides/100,000	6.8 ('08-'10)	14.8 ('11-'13)	9.5	5.9
Self-Inflicted Hospitalizations/10,000	8.4 ('08-'10)	6.8 ('11-'13)	6.8	NA
Adults with Poor Mental Health (14+ days) in the Last Month	8.8% ('08/'09)	11.3% ('13-'14)	11.8%	10.1%

Alcohol

High alcohol outlet density has been shown to be related to increased rates of drinking and driving, motor vehicle-related pedestrian injuries, and child abuse and neglect. In addition, liquor stores frequently sell food and other goods that are unhealthy and expensive. Setting rules that mandate minimum distances between alcohol outlets, limiting the number of new licenses in areas that already have a high number of outlets, and closing down outlets that repeatedly violate liquor laws can all help control and reduce liquor store density.
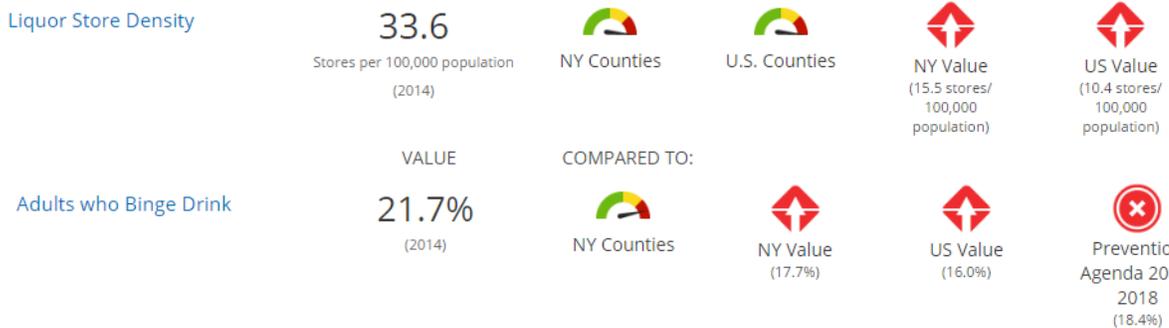
Select Indicators	Essex ('08-'10)	Essex ('11-'13)	Upstate NY	2018 Benchmark
Cirrhosis Deaths/100,000	13.9	12.0	8.7	NA
Alcohol-Related Injuries & Deaths/100,000	67.9	54.7	44.4	NA
Alcohol-Related Crashes	Change in data reporting	102.6	43.4 (NY)	NA

Opioids/Drugs

Opioids and all drugs, having devastating health and social consequences on the population, is a public health and health care issue. Prescription opioid misuse and heroin related morbidity and mortality (overdose/drug poisoning and death) has been increasing across the US, NY and Essex County. NYS DOH and the AIDS Institute, *Opioid Poisoning, Overdose and Prevention; 2015 Report to the Governor and NYS Legislature[22]*(used for all data in this section), describes over 47,000 lives lost in 2014; 61% attributed to prescription opioids and heroin and that heroin-related overdoses have tripled in the US from 2011-2014. Essex County opioid-related ED Admission have increased by 44.8% from 2010-2014 compared to NY state-wide increase of 73.1%. The inpatient hospital admission decreased by 37.1% for this same time period.

Opioid-Related ED and Inpatient Hospital Admissions

	2010	2011	2012	2013	2014
Opioid-Related ED Admissions	29	39	31	51	42
Opioid-Relared Inpatient Hospital Admissions	36	61	61	60	39
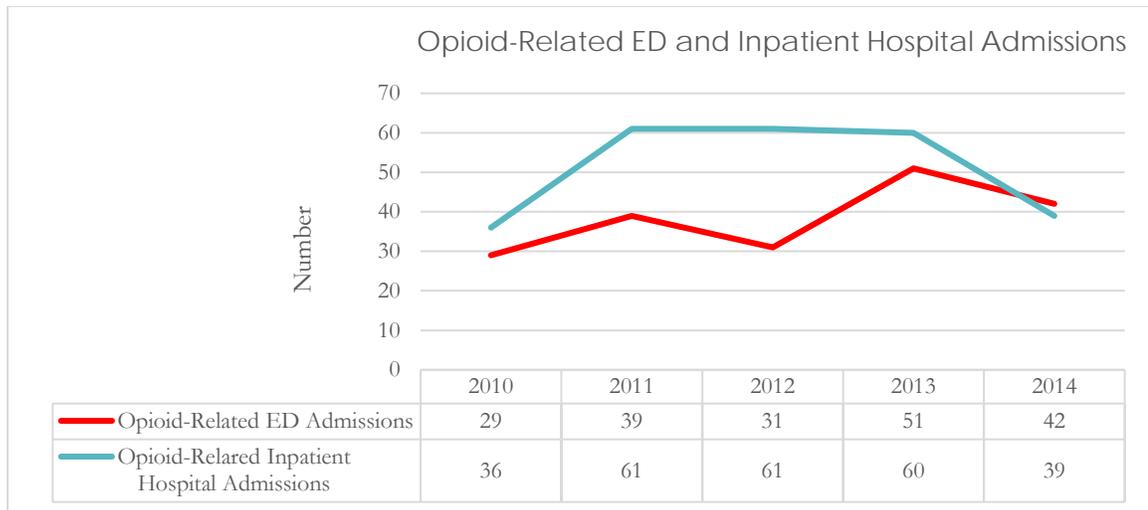
Overdose/Death Data

From 2009 to 2013, the percent of heroin-related deaths increased by 163% in NY; opioid-related deaths by 30%. NY data available for 2013 demonstrate four-times as many men died to heroin-related overdoses than women, and whites at twice the rate of blacks. For the same year the data demonstrates twice as many men compared to women died of opioid-related overdose; whites at a rate twice that of blacks and Hispanics.

Select Indicators	Essex	Essex	Upstate NY	NY
Drug-Related Hospitalizations/10,000	13.9 ('08-'10)	10.5 ('11-'13)	20.4	23.9
Deaths Due to Overdose (2009-2013) Mean Annual Frequency	Unknown	3	1,099	1,755
Deaths Due to Drug Overdose: Heroin (2009-2013) Mean Annual Frequency 5-Year Total	Unknown	less than 6 – not reported	223	368
Deaths Due to Drug Overdose: Opioids (2009-2013) Mean Annual Frequency 5-Year Total	Unknown	less than 6 – not reported	543	844

The reported number of law-enforcement Naloxone administrations through the end of 2015 is 3 for Essex County. For all Naloxone administered by Law Enforcement in NY, the greatest percent (42.4%) was administered to 25-34 year olds, followed by 30.9% to 15-24 year olds.

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[22] NYS DOH and the AIDS Institute. Opioid Poisoning, Overdose and Prevention; 2015 Report to the Governor and NYS Legislature. Available online at http://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf

Communicable Diseases

Zoonoses

Communicable diseases of concern in Essex County include tick-borne diseases (Lyme Disease and Anaplasmosis) and rabies. Lyme Disease case rates increased from 79.2(/100,000) from the last assessment ('08-'10) to 103.5 in the current assessment ('11-'13); higher than Upstate and NY comparisons. Anaplasmosis has recently been documented in Essex County and is considered an emerging concern with 2 confirmed and 3 probable cases in 2015. The rabies rate is 28.2 (per 100,000 for '11-'13); significantly higher than the upstate rate of 1.9 and an increase from the previously assessed rate of 7.8 (per 100,000 for '08-'10).

Lyme Disease Incidence Rate — 103.5 Cases per 100,000 population (2011-2013) — NY Counties — NY Value (36.6 cases/100,000 population) — Prior Value (52.8 cases/100,000 population)

Vaccine-Preventable Diseases

The percent of children ages 19-35 months with recommended immunizations increased from the previous to current assessment though this percent (61.5%) does not yet meet the 2018 benchmark of 70.7%. However the percent of females ages 13-17 with 3 doses of HPV increased from 15.7% to 24.7%. The percent of adults ages 65+ with flu and pneumonia vaccines decreased since the last assessment, though so did hospitalizations for those illnesses.

Select Indicators	Essex (Previous)	Essex (Current)	Upstate NY (Same as Essex Current)	2018 Benchmark
Children Ages 19-35 months with 4:3:1:3:3:1:4	46.0% (2011)	61.5% (2014)	59.4%	70.7%
Pertussis Cases/100,000	5.2 ('08-'10)	16.3 ('11-'13)	12.9	NA
Females Ages 13-17 with 3 Dose HPV	15.7% (2011)	24.7% (2014)	30.3%	50.0%
Adults Ages 65+ with Flu Shot in the Last Year	72.6% ('08/'09)	68.3% ('13-'14)	77.1%	70.0%
Adults Ages 65+ Ever Received Pneumonia Shot	76.2% ('08/'09)	59.3%	70.7%	NA
Pneumonia/Flu Hospitalizations Ages 65+/100,000 Ages 65+	188.5 ('08-'10)	133.7 ('11-'13)	121.9	NA

Healthcare Associated Infections

Healthcare-associated infections including both hospital onset and community onset indicators demonstrate values less than 10.

HIV/AIDS

Essex County data continues to demonstrate less than 10 cases of newly diagnosed HIV and AIDS cases.

STDs

Essex County data demonstrates rates of selected sexually transmitted diseases (Syphilis, Gonorrhea and Chlamydia) that are considerably less than comparison Upstate and NY state rates.

Community Health Improvement & Service Plan 2016-2018

The Improvement & Service Plan describes interventions based on evidence based programs, policies and practices as described in the NYS DOH Prevention Agenda Prevention Agenda 2013-2018: Preventing Chronic Diseases Action Plan.[23] Goals are set based on indicators from the Community Health Assessment. Ongoing analysis of these indicators will be used to evaluate the long-term outcomes of these plans. Interim performance measures will capture progress of activities related to each strategy. The tables in this section detail how priority health issues will be addressed by Lead organizations and through Partner (broader community) engagement. Lead organizations assume responsibility for facilitating, coordinating and evaluating (using performance measures) each activity as described in the Plan. Lead organizations will ensure Partner engagement through established and ad-hoc groups; formal and informal meetings and communications.

Summary of Priorities, Strategies & Lead Organizations 2016-2018

1. Reduce obesity in children and adults		Public Health	Hospitals
Strategy 1.1:	Create **community environments** that promote and support healthy food and beverage choices and physical activity.	X	
Strategy 1.2:	Prevent childhood obesity through **early child-care and schools**.	X	
Strategy 1.3:	Expand the role of **health care and health service providers** and insurers in obesity prevention.	X	X
Strategy 1.4:	Expand the role of **public and private employers** in obesity prevention.	X	X
2. Increase access to high quality chronic disease preventive care and management in clinical & community settings		Public Health	Hospitals
Strategy 2.1:	Increase **screening rates** for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.	X	X
Strategy 2.2:	Promote **evidence-based care** to manage chronic diseases.		X
Strategy 2.3:	Promote culturally relevant **chronic disease self-management education**.	X	X

Summary of Disparities of Focus 2016-2018

For each priority, interventions and activities are designed to reduce disparities and improve social justice. This is accomplished by:

- determining individuals and communities at increased risk;
- targeting these populations for interventions;
- partnering with community-based stakeholders;
- assuring culturally-relevant interventions that consider **priority disparities** including **income (socioeconomic status)**, **an aging population** and **access to care**.

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[23] NYS DOH. Prevention Agenda 2013-2018: Preventing Chronic Diseases Action Plan. Available online at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/

Reduce Obesity in Children and Adults

Goal: Reduce the percent of school-age children and adults who are obese to meet 2018 NYS Prevention Agenda Benchmarks:

School age children:	**19.2%** to	**16.7%**
Adults:	**32.2%** to	**23.2%.**

Strategy 1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.			
Intervention: Improve retail availability of nutritious foods and beverages & educate consumers on how to select the healthiest options.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Improve offerings at small stores; improve visibility and access through store layout & displays by implementing *Better Choice Retailer* or other similar on-site marketing/cues for healthier choices.	Income Target communities that met socioeconomic indicators making them eligible for the Creating Health Schools & Communities (CHSC) grant program.	Public Health with- Creating Health Schools & Communities (CHSC) grant program small store operators grocery stores Community Action Program (CAP) participants Office for the Aging (OFA) existing social groups (faith, parent, senior)	Number of stores that have improved offerings. Number of stores that improve visibility & access
Educate consumers about food shopping assistance systems (such as NuVal or the Stars Program) to encourage purchase of healthier options when shopping in grocery stores.	Income & Aging Population Target education to income-eligible Community Action Program (CAP) participants and OFA senior clients.		Number of education sessions offered. Number of participants reached.
Intervention: Adopt, strengthen & implement local policies & guidelines that facilitate increased physical activity for residents of all ages & abilities.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Adopt, improve or implement *Complete Streets* principles through: • policies or resolutions • land use planning (comprehensive; local use local law) • projects • education & encouragement activities.	Income Target low-income communities for policy adoption, land use planning and projects to ensure residents of these neighborhoods are afforded living conditions that follow complete streets principles. Income & Aging Ensure housing developments/units that serve low-income and aging populations are well-served through complete streets projects.	Public Health • CHCS Grant program • Local Government • Office for the Aging (OFA) • Trail Groups	Number of policies or resolutions adopted. Number of land use planning documents impacted.

Strategy 1.2:	Prevent childhood obesity through early child care and schools.		
Intervention: Increase the number of schools that establish strong nutritional standards for all foods & beverages sold and provided through the school.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with public schools to update school wellness policies and practices to include: • School meals • Concessions • Fundraising.	<u>Income</u> Target schools that met socioeconomic indicators making them eligible for the Creating Health Schools & Communities (CHSC) grant program. Target additional schools that meet similar socio-economic standards such as the percent of students eligible for free & reduced lunches.	<u>Public Health</u> with- • Creating Health Schools & Communities (CHSC) grant program • Public schools • Farmers and farm groups • Parent groups	Number of districts with updated wellness policies that meet target criteria.
Intervention: Increase the number of schools that meet NYSED regulations to increase activity before, during & after the school day.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with public schools to update school wellness policies and practices to include: • active recess • classroom activity breaks.	<u>Income</u> Target low-income communities for policy adoption, land use planning and projects to ensure residents of these neighborhoods are afforded living conditions that follow complete streets principles. <u>Income & Aging</u> Ensure housing developments/units that serve low-income and aging populations are well-served through complete streets projects.	<u>Public Health</u> with- • CHCS Grant program • Local Government • Office for the Aging (OFA) • Trail Groups	Number of districts with updated wellness policies that meet target criteria.

Intervention: Increase the number of and awareness of day breastfeeding friendly child care providers.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with the CAP to: • encourage breastfeeding friendly child care providers • update breastfeeding friendly provider lists.	Access & Income Target child care providers to ensure breastfeeding friendly providers are available across geographic areas & provider fee ranges.	Public Health with- • Adirondack CAP • WIC	Number and location of breastfeeding friendly child care providers is made available through Adirondack Community Action Program, WIC & websites.

Strategy 1.3: Expand the role of health care and health service providers and insurers in obesity prevention.			
Intervention: Link health care with community-based programs and services for breastfeeding counseling and support.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with health care providers on the adoption of breastfeeding friendly clinic practices & environmental supports.	<u>Access</u> Target provider practices across the geographic region.	<u>Public Health</u> with – • Hospitals (All) • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers	Number of provider practices that have adopted breastfeeding friendly policies and implemented environmental supports.
Conduct Public Health Detailing with primary care providers regarding locally available breastfeeding counseling and support resources including the Certified Lactation Consultant (CLC) available to WIC participants and Internationally Certified Lactation Consultant (IBCLC) available through the LHD to anyone in the county.	<u>Income</u> Assure providers are aware of resources available to WIC-eligible families and all families in Essex County.		Number of public health detailing sessions with providers. Number of women who use locally available breastfeeding support resources.
Provide a Women's Health Navigator, reprint Women's Guidebook and operate the associated phone line.	<u>Access</u> Target women and provide necessary information for any and all health needs for her and her family.	<u>Hospital</u> Adirondack Health • Hospital-owned health centers	Number of referrals
Intervention: Increase the capacity of primary care providers to implement screening, prevention and treatment measures for obesity in children and adults.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Expand access to and consistency of primary patient care to implement screening prevention & treatment for obesity.	<u>Access</u> Construct a new primary care center in an underserved area and add a mid-level provider.	<u>Hospital</u> UVHN Elizabethtown Community Hospital	Complete the move of the health center into new building. Number of new patients served.
Conduct Public Health detailing with primary care providers regarding locally available chronic disease self-management and other community-based prevention programs and opportunities to assist with patient measure to reduce weight.	<u>Access & Age</u> Ensure community opportunities are geographically accessible. Ensure age-appropriate opportunities are available & promoted.	<u>Public Health</u> and <u>Hospitals</u> (All) with – • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers	Number of sessions & providers reached through public health detailing sessions.
Providers at primary care clinics will document patient BMI, develop a plan with the patient & document in the patient EMR.	<u>Access</u> Target population will have discussion with provider and referral to community-based opportunities.	<u>Hospital</u> UVHN Elizabethtown Community Hospital	Number of patients with BMI >25 with documented discussion with provider twice yearly regarding plan for overweight/obesity.

Strategy 1.4: Expand the role of public and private employers in obesity prevention.			
Intervention: Strengthen business practices that align with the NYS Labor Law to support breastfeeding at work.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Increase the number of employer sites that have policies and practices to support breastfeeding friendly work environments.	Income Target lower-wage employers.	Public Health with- • WIC • Small business owners • Franchise owners	Number of worksites that have adopted breastfeeding friendly policies and practices.
Intervention: Increase adoption of food procurement and vending policies based on the Dietary Guidelines for Americans.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with local farmers on a farm to employer initiative to allow employees to pre-order goods to be delivered to worksites for pick-up.	Access Target large employers to increase access to farm-fresh produce and goods.	Hospital UVHN Elizabethtown Community Hospital and MLH with- • Farmers • Farmer organizations/representatives • Employers (potential employers include schools, Mountain Lakes Services, Ticonderoga Mill)	Number of employers that have implemented a farm to employer initiative. 2018 goal is to extend this to MLH campus as well.
Improve vending options at hospitals, health centers & employers to support employee health & wellness and role modeling for patients and visitors.	Aging Provide consistent messaging for aging patients.	Public Health and Hospitals (All) with- • Health care systems (FQHCs; others) • Local vending company • Employers (potential employers include schools, Mountain Lakes Services, Ticonderoga Mill)	Number of hospitals/health care systems that have improved vending options. 2018 goal to improve vending choices as MLH cafeteria closes.
Offer lifestyle modification workshops to local employers to prevent obesity.	Partner with community employers to offer on-site lifestyle modification workshops.	Hospital UVHN Elizabethtown Community Hospital and MLH	Number of worksites which have taken part in program. Extend to MLH campus as it comes under ECH (projected for 2017).

Increase access to high quality chronic disease preventive care and management in clinical and community settings.

Goal: Reduce morbidity & mortality due to chronic conditions including cardiovascular disease, diabetes and cancers to meet or be less than Upstate NY comparisons:

Cardiovascular Disease, Premature (Ages 35-64) Deaths/100,000	**127.2 to**	**<=96.8**
Diseases of the Heart, Premature (Ages 35-64) Deaths/100,000	**115.3 to**	**<=79.9**
Diabetes Deaths/100,000	**31.6 to**	**<=19.6**
Cancer Cases/100,000	**664.8 to**	**<=610.5**

Strategy 2.1: Increase screening rates for chronic conditions, especially among disparate populations.			
Intervention: Use media and health communications to build public awareness and demand.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Use paid and earned print media, social media and community outreach to raise awareness of need and demand for screening for chronic conditions.	Income Target those without health insurance/eligible for the Cancer Services Program.	Public Health & Hospitals (All) with- • Franklin & Essex Cancer Screening Program (CSP) • Media • OFA/NY Connects • Food pantries	Number of media and outreach activities conducted. Number of individuals served through the CSP.
Intervention: Ensure consumer access to screening, intervention and coverage for chronic disease.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Offer cancer screening events at least twice per year at different locations in the county.	Income, Access & Aging Target people eligible for the CSP to ensure screening is available to those ages 50+ without health insurance.	Public Health & Hospitals (All) with- • Franklin & Essex Cancer Screening Program • Media • OFA/NY Connects • Food pantries	Number of events offered. Number of individuals served through screening events.
Offer diabetes screenings at community health events	Access Target those without health insurance and increase ability of diabetes screening	Hospital UVHN Elizabethtown Community Hospital and MLH	Number of screenings completed. Extend to MLH campus in 2017/2018.
Screen all adult patients with a history of tobacco use for COPD.	Patients will complete tobacco use survey. Spirometry testing will be available at each health center for those identified as 'at risk' by survey.	Hospital UVHN Elizabethtown Community Hospital	Number of new patients and current patients screened.

Intervention: Expand the use of health information technology to remind clinicians to screen for pre-diabetes and diabetes.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Use public health detailing to increase the number of health care practices that adopt policies and a system for identifying & referring patients with pre-diabetes & diabetes.	Access & Income Adoption of policies and systems ensures universal screening and referral.	Public Health & Hospital UVHN Elizabethtown Community Hospital Diabetes Educator at ECH	Number of practices that adopt a policy for identification and referral system for care.

Strategy 2.2 Promote evidence-based care to manage chronic diseases.			
Intervention: Establish clinical-community linkages that connect patients to self-management education and community resources.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Establish an Outreach Coordinator position & a Chronic Disease Care Coordinator position to facilitate care & link of patients to care & community resources.	Access Facilitate access to care & community resources for patients.	Hospital UVHN Elizabethtown Community Hospital & Public Health	Positions established & filled.
Offer at least two (2) Better Breathers program to community annually.	Access ALA sponsored pulmonary exercise and education program.	Hospital UVHN Elizabethtown Community Hospital	Number of programs provided each year.
Establish a system for identifying & referring patients for Smoking Cessation.	Access, Income Universal screening likely to identify income-limited patients eligible for smoking cessation services.	Hospital UVHN Elizabethtown Community Hospital	Referral built into GE (EMR).
Offer cardiac or pulmonary rehab to any patient who qualifies.	Access, Income Universal screening likely to identify income-limited patients eligible for smoking cessation services.	Hospital UVHN Elizabethtown Community Hospital	Number of patients served through these programs.

Strategy 2.3 Promote culturally relevant chronic disease self-management education.

Intervention: Develop infrastructure for widely accessible, readily available lifestyle intervention professionals and opportunities.

Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Assure instructors for chronic disease self-management (CDSM) classes are trained.	Access, Aging, Income Provide classes at no or low cost	Hospital UVHN Elizabethtown Community Hospital, MLH, & Public Health with- • Eastern Adirondack Health Care Network • Office for the Aging/NY Connects Low-income housing facilities	At least 3 instructors trained. Extend to MLH campus in 2018.
Provide CDSM classes at least twice per year in Essex County.	Access, Aging, Income Provide classes at no or low cost. Target low-income/high risk communities. Target seniors.	Hospitals (All) & Public Health • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers • OFA/Senior Nutrition Sites • Community Centers	Number of classes conducted and participants completed in CDSM.
Assure trained lifestyle intervention professionals are available in clinical and community settings.	Access, Aging, Income Provide classes at no or low cost. Target low-income/high risk communities. Target seniors.	Hospitals (All) & Public Health • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers • OFA/Senior Nutrition Sites • Community Centers	Professional resource list of Chronic Disease Self-Management (CDSM) professionals is developed.

Intervention: Establish clinical-community linkages that connect patients to self-management education and community resources.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Maintain a community resource list of Chronic Disease Self-Management (CDSM) opportunities including multi-session education series, support groups, etc.	Income Assure there are no or low cost options available. Access, Income Assure opportunities are easily accessible to those with limited income & transportation. Aging Assure opportunities are offered at times and locations and content is targeted for the aging population.	Public Health with- • Eastern Adirondack Health Care Network • Office for the Aging/NY Connects • Low-income housing facilities	Create and make available to clinicians & the public community based CDSM opportunities.
Use public health marketing & communication to share opportunities for CDSM in the community setting.	Income Target community outreach efforts to those with limited income or transportation.	Public Health with- • Franklin & Essex Cancer Screening Program (CSP) • Media • OFA/NY Connects • Food pantries • Low-income housing facilities	Number of marketing/communications promoting CDSM in the community.
Use public health detailing to increase the number of health care practices that adopt policies and a system for identifying & referring patients to chronic disease self-management opportunities in the community setting.	Access & Income Adoption of policies and systems ensures universal screening and referral.	Public Health and Hospitals (All)	Number of hospital healthcare systems that have an established system in place.

Crosswalk of Other Initiatives of Essex County Health Partners with CHIP/CSP Priorities, Emerging Issues & Disparities

This section serves to identify how other initiatives of Essex County Health Partners align with Priorities & Disparities identified in the CHIP/CSP.

These initiatives support, not supplant, efforts to achieve shared community health improvement goals.

Initiatives

TYPE	DESCRIPTION	CHIP/CSP Priorities		Emerging	Disparities			Essex County Health Partners			
		Obesity	Chronic Disease	MEB/SA	Income	Aging	Access	AH	ECH	MLH	ECHD
DSRIP	2ai Integrated Delivery System	X	X		X		X	X	X	X	
	2aii Advancing Primary Care	X	X		X		X	X	X		
	2aiv Medical Village		X		X	X	X			X	
	2bviii Hospital-Home Collaboration Solutions	X	X		X	X		X			
	2di Patient Activation	X	X	X	X	X	X	X			X
	3ai Integrate Behavioral Health with Primary Care		X	X	X		X	X	X		
	3aii Crisis Stabilization				X		X				
	3aiv Withdrawal Management				X		X				
	3gi Integrate Palliative Care into the PCMH Model			X	X	X		X			
	4aiii Mental Health & Substance Abuse Infrastruct.			X	X		X				X
	4bii Chronic Care: COPD		X		X	X	X	X	X		X
Grants	Vital Access Providers (VAP) Program						X	X	X	X	
	MAX Program: Medicaid Accelerated eXchange Series				X		X	X			
	Essential Provider Medical Village Grant		X			X	X		X	X	
	Creating Healthy Schools & Communities Grant										X
	Linking Interventions For Total (LIFT) Population Health grant (pending approval/funding)	X	X		X		X		X	X	X
Community Benefit	Diabetes Self-Management Program	X	X				X	X	X		
	Diabetes Support Group	X	X		X		X		X		
	Integrative Healthcare (Yoga, meditation, etc.)		X	X				X			
	Walk/Run Health Events	X		X				X	X		
	Chronic Disease Self-Management Resources List		X		X	X	X	X	X	X	X
	Health Symposiums, Monthly Community Health Outreach Series, Screening & Other Health Events	X	X	X	X	X	X	X	X	X	X
	Women's Guidebook & Navigator						X	X			
	Respecting Choices Palliative Care			X				X			
	Employee Wellness Programs/Open Enrollment Ed.	X	X				X	X	X	X	X

Regional Priority

The Community Health Assessment (CHA) Committee identified and selected **Chronic Disease Prevention and Management** as a regional priority in support of the NYS Prevention Agenda 2013-2018. Essex County Health Partners, through active participation in the ARHN and with all the regional CHA partners, will work to identify interventions that have the potential for a regional impact on Chronic Disease Prevention and Management. The Committee's initial discussions about how best to support the regional priority included:

- Identifying a subject matter expert speaker(s) for the region;
- Implementing a media campaign;
- Creating Prevention Agenda projects;
- Using social media outlets and websites to raise awareness of initiatives and programs currently in place from partners and others in the region; and
- Creating a new page on the ARHN website to house resources and links to evidence-based strategies.

The Committee will continue to explore strategies on how to best support a regional priority through its regular meetings.

Resource Allocation to Achieve Goals

Essex County Health Partners will work collaboratively to allocate staff and resources (data, meeting rooms, educational materials & more) to implement these identified strategies and achieve established goals. Additional resources available through other initiatives and grant-funded projects including those described in the above chart may be used to support these goals.

Essex County Health Partners are involved in regional initiatives that support these priorities, address disparities, and engage a broad range of community stakeholders to improve health. The independent not-for-profit, Adirondack Health Institute, plays a large role in regional health through its Community Health and Health System Transformation projects.
Community Health

- Adirondack Rural Health Network (ARHN) - regional health assessment & planning facilitation;,
- Enrollment Assistance Services and Education (EASE) - health insurance navigation & enrollment services; and
- Population Health Improvement Program (PHIP) stakeholder engagement to advance the NYS Triple Aim of improving health, enhancing quality & reducing costs

Health System Transformation

- Adirondack Health Home - care coordination for high-risk Medicaid individuals;
- Adirondack Medical Home Initiative (AMHI) -provider and insurer partnership to assure quality, effective care while reducing costs, enhanced management of chronic conditions and assurance of close provider-patient relationships; and
- Performing Provider System (PPS)/Delivery System Reform Incentive Payment Program (DSRIP) - restructure the health care delivery system by reinvesting in the Medicaid program & addressing social factors that impact health. See **Appendix L** for details of AHI PPS DSRIP Projects.

Dissemination of this Plan

The engagement of community partners is essential to positively influencing the entire health system. The dissemination of this document is one piece of community awareness of health issues and engagement in addressing health priorities. Essex County Health Partners will each make this document available on their respective websites by March 31, 2017. This document will be made available to Adirondack Rural Health Network for posting on that website for regional access.

Appendix A

Data Consultants, Methodology and Sources

Community Health Assessment Process – Data Consultants

Center for Health Workforce Studies, University at Albany School of Public Health

Rochel Rubin, PhD, Graduate Research Assistant

Robert Martiniano, MPA, MPH, Senior Program Manager

Databases used for the Community Health Assessment

- Bureau of Communicable Disease Control Data
- Bureau of HIV/AIDS Epidemiology Data
- Cancer Registry
- Community Health Indicator Reports
- Division of Criminal Justice Services
- Governor's Traffic Safety Committee Data Report
- Motor Vehicle Crash Data
- New York State Expanded Behavioral Risk Factor Surveillance System Data (BRFSS)
- New York State Immunization Information System Data
- New York State Medicaid Program Data
- New York State Office of Mental Health Patient Characteristics Survey
- New York State Pregnancy Nutrition Surveillance System – WIC Program Data
- Office of Mental Health County Profiles Data
- Statewide Planning and Research Cooperative System (SPARCS) data
- Vital Statistics Data

The Center for Health Workforce Studies (CHWS) at the University at Albany School of Public Health under contract with the Adirondack Rural Health Network, a program of the Adirondack Health Institute, identified and collected data from a variety of sources on the seven counties in the Adirondack region and two adjacent counties to assist in developing individual county community needs assessments. Those counties include: Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren, and Washington.

The initial step in the process was determining which data elements from the 2013 community needs assessment were still available. In 2013, CHWS staff received an initial list of potential data elements from the ARHN Data Subcommittee and then supplemented that information with data from other sources. Since most of the health behavior, status, and outcome data were only available at the county level, the data for both 2013 and 2016 were displayed by county and aggregated to the ARHN region.[24] Additionally, other data was collected to further enhance already identified data. For example, one Prevention Agenda indicator was assault-related hospitalizations. That indicator was augmented by other crime statistics from the New York State Division of Criminal Justice.

The overall goal of collecting and providing this data to ARHN members was to provide a comprehensive picture of the individual counties within the Adirondack region as well as for two adjacent counties, including providing an overview of population health as well as an environmental scan. In total, counties and hospitals were provided with about 400 data elements across the following four reports:

- Demographic Data;
- Educational Profile;
- Health Behaviors, Health Outcomes, and Health Status; and
- Health Delivery System Profile.

All sources for the data were listed and made available to the counties and hospitals. The sources for the data elements in the Health Behaviors, Health Outcomes, and Health Status report were listed in a separate file and included their respective internet URL links. The data in each of the four reports were aggregated, when feasible, into the ARHN region, Upstate New York (all counties but the five in New York City), and statewide.

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[24] Aggregated data for the ARHN region included Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties but did not include Montgomery and Saratoga counties.

Demographic Data

Demographic data was primarily taken from the 2010 - 2014 American Community Survey, and supplemented with data from the Bureau of Labor Statistics, Local Area Unemployment Statistics for 2014; the New York State Department of Health (NYSDOH) Medicaid Data for 2014; and employment sector data also from American Community Survey. Among the information incorporated into the demographic report included:

- Race/Ethnicity;
- Age by groups (0 – 4, 5 – 17, 18 – 64, and 65 plus);
- Income and poverty, including the percent who received Medicaid;
- Housing stock;
- Availability of vehicles;
- Education status for those 25 and older;
- Employment status; and
- Employment sector.

Educational Profile

The education profile was taken mainly from the New York State Education Department (NYSED), School Report Card for 2013 – 2014, supplemented with data from the National Center for Education Statistics, Integrated Post-Secondary Data System on Post-Secondary graduations for 2014 and registered nurse graduation data from CHWS. Among the data displayed in the educational profile included:

- Number of school districts;
- Total school district enrollment;
- Number of students on free and reduced lunch;
- Dropout rate;
- Total number of public school teachers;
- Number of and graduations from licensed practical nurse programs; and
- Number of and graduations from registered nurse programs.

The vast majority of health behaviors, outcomes, and status data come from NYSDOH. Data sources included the:

- Community Health Indicators Report (http://www.health.ny.gov/statistics/chac/indicators/);
- County Dashboards of Indicators for Tracking Public Health Priority Areas, 2013 - 2018 (https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard); and
- 2013 – 2014 Behavioral Risk Factor Surveillance System (BRFSS) (http://www.health.ny.gov/statistics/brfss/expanded/).

Information on NYSDOH's methodologies used to collect and display data from the above sources can be found on their respective data pages.

NYSDOH data was also supplemented from other sources such as the County Health rankings, the New York State Division of Criminal Justice Services, the New York State Institute for Traffic Safety Management and Research, and the New York State Office of Mental Health Patient Characteristics Survey, among others. To the extent possible, Center staff used similar years for the additional data that was collected. Over 270 data elements are displayed in this report broken out by the Prevention Agenda focus areas. The availability of data elements did change from the 2013 community needs assessment analysis, and certain data was reported differently between the two time periods.

Data were downloaded from their various sources and stored in separate Excel files, based on their respective focus area. The Health Behaviors, Health Outcomes, and Health Status report was created in Excel and linked to the raw data, and population rates were recalculated based on the number of cases as well as the population listed in the data source.

Data in the report were organized by the six priority areas as outlined by NYSDOH at
http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/. The data was also separated into two subsections, those that were identified as Prevention Agenda indicators and those that were considered "other indicators." The data elements were organized by 17 focus areas as outlined in the table below.

Focus Area	Number of Indicators	
	Prevention Agenda	Other
Health Disparities	8	6
Injuries, Violence, and Occupational Health	7	20
Outdoor Air Quality	2	0
Built Environment	6	0
Water Quality	1	0
Obesity in Children and Adults	2	33
Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure	1	13
Increase Access to High Quality Chronic Disease Preventive Care and Management	6	24
Maternal and Infant Health	9	17
Preconception and Reproductive Health	9	20
Child Health	4	29
HIV	2	1
STDs	5	10
Vaccine Preventable Diseases	3	6
Healthcare Associated Infections	2	0
Substance Abuse and other Mental, Emotional, and Behavioral Disorders	3	15
Other Illnesses	0	8

The data elements that were Prevention Agenda indicators were compared against their respective Prevention Agenda benchmarks. "Other indicators" were compared against either Upstate New York benchmarks, when available or then New York State benchmarks when Upstate New York benchmarks were not available. The report also included a status field that indicated whether indicators were met, were better, or were 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 quartiles rankings, i.e., if distances from their corresponding benchmarks were less than 25%, indicators were in quartile 1, if distances were between 25% and 49.9% from their respective benchmarks, indicators were in quartile 2, etc.

The Health Behaviors, Health Outcomes, and Health Status Report also indicated 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 compared to all indicators which were worse than their corresponding benchmarks. 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 for "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.

Health Delivery System Profile

The data on the health system came from NYSDOH list of facilities, NYSED licensure file for 2015, the Health Resources and Services Administration Data Warehouse for health professional shortage (HPSAs) areas for 2016, the Uniform Data System (UDS) for 2014, and Center data on 2014 physicians. Among the data incorporated into this report included:

- Hospital, nursing home, and adult care facility beds;
- Number of community health center patients;
- Number of and population within primary care, mental health, or dental care HPSAs;
- Total physicians and physicians by certain specialties and sub-specialties; and
- Count of individuals licensed.[25]

Community Stakeholder Survey

A survey of stakeholders was conducted by CHWS in April and May of 2016. The purpose of the survey was to provide the Community Health Assessment (CHA) Committee with stakeholder input on regional and/or county health care needs and priorities. Stakeholders included health care, social services, educational, governmental and other agencies in the ARHN region. Results were presented for each of the seven ARHN counties[26] and aggregated for the region.

The initial survey in 2013 included 81 questions. The data subcommittee in 2016 felt that the previous survey was too extensive, and CHWS, working in conjunction with AHI and the data subcommittee, reduced the survey to 15 questions. The survey requested that the respondent identify the two priority areas from a list of five which they believe need to be addressed with their county or counties, and then respondents were also asked to rank the focus areas within each priority area and identify potential barriers to that addressing that focus area. Stakeholder responses were assessed in multiple counties if there service area covered more than one county.

The survey was administered electronically using the web-based Qualtrics software and distributed to stakeholders based on an email contact list of 658 individuals that were identified by AHI working in conjunction with county health departments. CHWS sent out the initial notification of the survey as well as two reminder notices to those who had not yet completed the survey. Additionally, participation was also incentivized through an opt-in gift card drawing, with 20 entrants randomly selected to receive a $10 Stewart's gift card at the conclusion of the survey. Ultimately, 217 surveys were completed during the six-week survey period for a response rate of 33%. Response rates varied by individual county, with certain respondents being counted in more than one county depending on the extent of their service area.

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[25] County is determined by the main address listed on the licensure file. The address listed may be a private residence or may represent those with active licenses but not actively practicing patient care. Therefore, the information provided may not truly reflect who is practicing in a profession in the county.

[26] Montgomery and Saratoga counties was not included in the survey.

Sources

Data Element	Data Source	Hyperlink
Focus Area: Disparities		
Prevention Agenda Indicators		
1 Percentage of Overall Premature Deaths (Age 35-64), 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2 Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3 Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4 Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5 Ratio of Black, Non-Hispanic Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
6 Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
7 Percentage of Adults (Ages 18 - 64) with Health Insurance, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
8 Age Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2013-2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Disparity Indicators		
1 Rate of Total Deaths per 100,000 Population, '11 - 13	New York State Department of Health; Vital Statistics of New York State	Community Health Indicator Reports
2 Rate of Emergency Department Visits per 10,000 Population, '11 - 13	New York State Department of Health; Vital Statistics of New York State	Community Health Indicator Reports
3 Rate of Total Hospital Discharges per 10,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4 Percentage of Adults (18 and Older) Who Did Not Receive Care Due to Costs, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
5 % of Adults (18 and Older) with 14 Days or More of Poor Physical Health, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
6 Percentage of Adults (18 and Older) with Disabilities, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
Focus Area: Injuries, Violence, and Occupational Health		
Prevention Agenda Indicators		
1 Rate of Hospitalizations due to Falls for Ages 65 Plus per 10,000 Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2 Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children Ages 1 - 4, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3 Rate of Assault-Related Hospitalizations per 10,000 Population, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4 Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5 Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
6 Ratio of Assault-Related Hospitalizations for Low-Income versus non-Low Income Zip Codes, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
7 Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators		
1 Rate of Hospitalizations for Falls for Children Ages Under 10 per 10,000 Population Children Ages Under 10 , '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2 Rate of Hospitalizations for Falls for Children Ages 10 - 14 per 10,000 Population Children Ages 10 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3 Rate of Hospitalizations for Falls for Individuals Ages 15 - 24 per 10,000 Population Individuals Ages 15 - 24, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4 Rate of Hospitalizations for Falls for Adults Ages 25 - 64 per 10,000 Population Adults Ages 25 - 64, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5 Rate of Violent Crimes per 100,000 Population, 2014	NY State Division of Criminal Justice, 2014 Crime Statistics	Department of Criminal Justice County Index Crime Counts and Rates
6 Rate of Property Crimes per 100,000 Population, 2014	NY State Division of Criminal Justice, 2014 Crime Statistics	Department of Criminal Justice County Index Crime Counts and Rates
7 Rate of Total Crimes per 100,000 Population, 2014	NY State Division of Criminal Justice, 2014 Crime Statistics	Department of Criminal Justice County Index Crime Counts and Rates
8 Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population Ages 15 Plus, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
9 Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population Ages 15 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10 Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population Ages 15 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

11	Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed Ages 16 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
12	Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed Ages 16 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
13	Rate of Total Motor Vehicle Crashes per 100,000, '11-13	Safe New York: Governor's Traffic Safety Committee	NYS Department of Motor Vehicles Traffic Safety Data
14	Rate of Speed-Related Accidents per 100,000 Population, '11 - 13	Safe New York: Governor's Traffic Safety Committee	NYS Department of Motor Vehicles Traffic Safety Data
15	Rate of Motor Vehicle Accident Deaths per 100,000 Population, '11 - 13	Safe New York: Governor's Traffic Safety Committee	NYS Department of Motor Vehicles Traffic Safety Data
16	Rate of TBI Hospitalizations per 10,000 Population, '11 - 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17	Rate of Unintentional Injury Hospitalizations per 10,000 Population, '11 - 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Rate of Unintentional Injury Hospitalizations Ages 14 and Under per 10,000 Population Ages 10 - 14, '11 - 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population Ages 65 Plus, '11 - 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
20	Rate of Poisoning Hospitalizations per 10,000 Population, '11- 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
Focus Area: Outdoor Air Quality			
1	1. Number of Days with Unhealthy Ozone, 2011/2013	County Health Rankings and Roadmaps	County Health Rankings
2	2. Number of Days with Unhealthy Particulate Matter, 2011/2013	County Health Rankings and Roadmaps	County Health Rankings
Focus Area: Built Environment			
1	Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2015	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Percentage of Commuters Who Use Alternative Modes of Transportation to Work, '10-14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2010	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Percentage of Adults Experiencing Food Insecurity '13/14	New York State Expanded Behavior Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
5	Percentage of Adults Experiencing Housing Insecurity	New York State Expanded Behavior Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
6	Percentage of Homes in Vulnerable Neighborhoods that have Fewer Asthma Triggers During Home Revisits, '11-14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Focus Area: Water Quality			
1	Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2015	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard

Focus Area: Reduce Obesity in Children and Adults			
Prevention Agenda Indicators			
1	Percentage of Adults Ages 18 Plus Who are Obese, '13/14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Percentage of Public School Children Who are Obese, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Student Weight Status Category Reporting System (SWSCRS) Data
Other Indicators			
1	Percentage of Total Students Overweight, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Student Weight Status Category Reporting System (SWSCRS) Data
2	Percentage of Elementary Students Overweight, Not Obese, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Student Weight Status Category Reporting System (SWSCRS) Data
3	Percentage of Elementary Student Obese, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Student Weight Status Category Reporting System (SWSCRS) Data
4	Percentage of Middle and High School Students Overweight, Not Obese, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Student Weight Status Category Reporting System (SWSCRS) Data
5	Percentage of Middle and High School Students Obese, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Student Weight Status Category Reporting System (SWSCRS) Data
6	Percentage of WIC Children Ages 2 - 4 Obese, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
8	Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
9	Number of Recreational and Fitness Facilities per 100,000 Population, 2014	United States Department of Agriculture, Food, Environment Atlas Data File	USDA Economic Research Service Fitness Facilities Data
10	Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
11	Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
12	Rate of Cardiovascular Disease Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
13	Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
14	Rate of Pre-transport Deaths per 100,000 Population, '12-14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
15	Rate of Cardiovascular Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

16	Rate of Diseases of the Heart Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17	Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Rate of Disease of the Heart Pre-transport Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Rate of Disease of the Heart Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
20	Rate of Coronary Heart Diseases Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
21	Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
22	Rate of Coronary Heart Disease Pre-transport Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
23	Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
24	Rate of Congestive Heart Failure Deaths per 100,000, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
25	Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
26	Rate of Congestive Heart Failure Pre-transport Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
27	Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
28	Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
29	Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
30	Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population Ages 18 Plus, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
31	Rate of Diabetes Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
32	Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
33	Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure			
	Prevention Agenda Indicators		
1	1. Percentage of Adults Ages 18 Plus Who Smoke '13/14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
Other Indicators			
1	Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of Asthma Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Asthma Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population Ages 25 - 44, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population Ages 45 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population Ages 65 Plus, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
8	Percentage of Adults with Asthma, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013 - 2014 NYS Expanded Behavioral Risk Factor Surveillance System
9	Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Lung and Bronchus Cases per 100,000 Population, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
11	Number of Registered Tobacco Vendors per 100,000 Population, '10 - 12	NYSDOH; Tobacco Enforcement Program Annual Report	NYS Department of Health Tobacco Enforcement Program Annual Report
12	Percentage of Vendors with Sales to Minors Violations, '10 - 12	NYSDOH; Tobacco Enforcement Program Annual Report	NYS Department of Health Tobacco Enforcement Program Annual Report
13	Percentage of Vendors with Complaints, '10 - 12	NYSDOH; Tobacco Enforcement Program Annual Report	NYS Department of Health Tobacco Enforcement Program Annual Report

Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings		
Prevention Agenda Indicators		
1	Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, '2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Rate of Asthma ED Visits per 10,000 Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Rate of Asthma ED Visits Ages 0 - 4, per 10,000 Population Ages, 0 - 4, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, Ages 6 - 17, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5	Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, Ages 18 Plus, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
6	Rate of Heart Attack Hospitalizations per 10,000 Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators		
1	Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '11 - 13	New York State Department of Health; Information on Asthma in New York State	Asthma Summary Report
2	Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '11-13	New York State Department of Health; Information on Asthma in New York State	Asthma Summary Report
3	Rate of All Cancer Cases per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of all Cancer Deaths per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Female Breast Cancer Cases per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Female Breast Cancer Deaths per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
8	Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13/14	NYSDOH; New York State Community Health Indicator Reports	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
9	Rate of Cervix and Uteric Cancer Cases per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Cervix and Uteric Cancer Deaths per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
11	of Less than $25,000 Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
12	Rate of Ovarian Cancer Cases per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
13	Rate of Ovarian Cancer Deaths per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
14	14. Rate of Colon and Rectum Cancer Cases per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
15	Rate of Colon and Rectum Cancer Deaths per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
16	Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
17	Rate of Prostate Cancer Deaths per 100,000 Male Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Rate of Prostate Cancer Cases per 100,000 Male Population, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
20	Rate of Melanoma Cancer Deaths per 100,000 Population, '10 - '12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
21	Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
22	Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
23	Oral Cavity and Pharynx Cancer Deaths per 100,000 Population, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
24	Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

Focus Area: Maternal and Infant Health		
Prevention Agenda Indicators		
1 — Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2 — Ratio of Preterm Births (< 37 wks) Black/NH to White/NH, '12- 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3 — Ratio of Preterm Births (< 37 wks) Hisp/Latino to White/NH, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4 — Ratio of Preterm Births (< 37 wks) Medicaid to Non-Medicaid, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5 — Rate of Maternal Mortality per 100,000 Births, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
6 — Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
7 — Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
8 — Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
9 — Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators		
1 — Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2 — Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3 — Percentage of Total Births with Weights Less Than 1,500 grams, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4 — Percentage of Singleton Births with Weights Less Than 1,500 grams, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5 — Percentage of Total Births with Weights Less Than 2,500 grams, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6 — Percentage of Singleton Births with Weights Less Than 2,500 grams, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7 — Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '11 - 13	NYSDOH; State and County Indicators for Tracking Public Health Priority Areas	State and County Indicators for Tracking Public Health Priority Areas
8 — Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '11 - 13	NYSDOH; State and County Indicators for Tracking Public Health Priority Areas	State and County Indicators for Tracking Public Health Priority Areas
9 — Infant Mortality Rate per 1,000 Live Births, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10 — Rate of Deaths (28 Weeks Gestation to Seven Days) per 1,000 Live Births and Perinatal Deaths, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
11 — Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
12 — Percentage Early Prenatal Care for Black, Non-Hispanic, '11 - 13	NYSDOH; State and County Indicators for Tracking Public Health Priority Areas	State and County Indicators for Tracking Public Health Priority Areas
13 — Percentage Early Prenatal Care for Hispanic/Latino, '11 - 13	NYSDOH; State and County Indicators for Tracking Public Health Priority Areas	State and County Indicators for Tracking Public Health Priority Areas
14 — Percentage APGAR Scores of Less Than Five at Five Minute Mark of Births Where APGAR Score is Known, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
15 — Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
16 — Percentage WIC Women Breastfed at Six months, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17 — Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
Focus Area: Preconception and Reproductive Health		
Prevention Agenda Indicators		
1 — Percent of Births within 24 months of Previous Pregnancy, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2 — Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3 — Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4 — Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5 — Percent of Unintended Births to Total Births, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
6 — Ratio of Unintended Births Black, non-Hispanic to White, non-Hispanic, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
7 — Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
8 — Ratio of Unintended Births Medicaid to Non-Medicaid, '2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
9 — Percentage of Women Ages 18- 64 with Health Insurance, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard

Other Indicators			
1	Rate of Total Births per 1,000 Females Ages 15-44, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Percent Multiple Births of Total Births, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Percent C-Sections to Total Births, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Total Pregnancies per 1,000 Females Ages 15-44, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
8	Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
9	Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 5-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
11	Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
12	Percent Total Births to Women Ages 35 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
13	Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
14	Rate of Abortions All Ages per 1000 Live Births to All Mothers, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
15	Percentage of WIC Women Pre-pregnancy Underweight, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
16	Percentage of WIC Women Pre-pregnancy Overweight but not Obese, ' 10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17	Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Percentage of WIC Women with Gestational Diabetes, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
20	Percentage of WIC Women with Gestational Hypertension, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

Focus Area: Child Health			
Prevention Agenda Indicators			
1	Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Percentage of Children Ages 0 -19 with Health Insurance, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators			
1	Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children Ages 1 - 4, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children Ages 1 - 4, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children ages 10 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children Ages 5 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Children Deaths Ages 15 - 19 per 100,000 Population Children Ages 15 - 19 , '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Children Deaths Ages 1 - 19 per 100,000 Population Children Ages 1 - 19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
8	Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children Ages 5 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
9	Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children Ages 0 - 17, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
11	Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

12	Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
13	Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
14	Percentage of Children Screened for Lead by Age 9 months	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
15	Percentage of Children Screened for Lead by Age 18 months	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
16	Percentage of Children Screened for Lead by Age 36 months (at least two screenings)	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17	Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children Under Age 10, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children Ages 10 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
20	Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population Ages 15 - 24, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
21	Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children Ages 0 - 17, '11 - 13	New York State Department of Health; Information on Asthma in New York State	Asthma Summary Report
22	Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit, 12 - 14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
23	Percentage of 3rd Graders with Dental Caries, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
24	Percentage of 3rd Graders with Dental Sealants, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
25	Percentage of 3rd Graders with Dental Insurance, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
26	Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
27	Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
28	Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population Children Ages 3 - 5, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
29	Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

Focus Area: Human Immunodeficiency Virus (HIV)			
Prevention Agenda Indicators			
1	Rate of Newly Diagnosed HIV Cases per 100,000 Population, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators			
1	Rate of AIDS Cases per 100,000 Population, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of AIDS Deaths per 100,000 Adjusted Population, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

Focus Area: Sexually Transmitted Disease (STDs)			
Prevention Agenda Indicators			
1	Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5	Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators			
1	Rate of Early Syphilis Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Gonorrhea Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Chlamydia Cases All Males per 100,000 Male Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Chlamydia Cases All Females per 100,000 Female Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

8	Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
9	Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

Focus Area: Vaccine Preventable Disease			
Prevention Agenda Indicators			
1	Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Percent females 13 - 17 with 3 dose HPV vaccine, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System

Other Indicators			
1	Rate of Pertussis Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Pneumonia/flu Hospitalizations Ages 65 Plus per 100,000 Population Age 65 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
4	Rate of Mumps Cases per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Meningococcal Cases per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of H Influenza Cases per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

Focus Area: Healthcare Associated Infections			
Prevention Agenda Indicators			
1	Rate of Hospital Onset CDIs per 10,000 Patient Days, 2011	NYSDOH; Hospital Report on Hospital Acquired Infections	NYS Department of Health Hospital Report on Hospital Acquired Infections
2	Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2011	NYSDOH; Hospital Report on Hospital Acquired Infections	NYS Department of Health Hospital Report on Hospital Acquired Infections

	Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavioral Disorders		
Prevention Agenda Indicators			
1	Percent of Adults Binge Drinking within the Last Month, '13/14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, '13-14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Rate of Age Adjusted Suicides per 100,000 Adjusted Population, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators			
1	Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Self-inflicted Hospitalizations 10,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Cirrhosis Deaths per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Cirrhosis Hospitalizations per 10,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Alcohol-Related Crashes, 11 - 13	Safe New York: Governor's Traffic Safety Committee Report	NYS Department of Motor Vehicles Traffic Safety Data
7	Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, '11 - 13	Safe New York: Governor's Traffic Safety Committee Report	NYS Department of Motor Vehicles Data
8	Rate of Drug-Related Hospitalizations per 10,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
9	Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2013	NYS; Office of Mental Health, PCS Planning Reports	NYS Office of Mental Health, PCS Summary Report
10	Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2013	NYS; Office of Mental Health, PCS Planning Reports	NYS Office of Mental Health, PCS Summary Report
11	Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2014	NYS; Office of Mental Health, PCS Planning Reports	NYS Office of Mental Health, PCS Summary Report
12	Rate of People Served in ED for Mental Health Ages 17 and under per 100,000 Population Ages under 17 and under, 2013	NYS; Office of Mental Health, PCS Planning Reports	NYS Office of Mental Health, PCS Summary Report
13	Rate of People Served in ED for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2013	NYS; Office of Mental Health, PCS Planning Reports	NYS Office of Mental Health, PCS Summary Report
14	Rate of People Served in ED for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2014	NYS; Office of Mental Health, PCS Planning Reports	NYS Office of Mental Health, PCS Summary Report
Other Non-Preventive Agenda Indicators			
1	Rate of Hepatitis A Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Acute Hepatitis B Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of TB Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of e. Coli 157 Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Salmonella Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Shigella Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Lyme Disease Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
8	Rate of Confirmed Rabies Cases per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

Essex County Community Health Assessment 2016. Community Health Improvement & Service Plan 2016-2018.

Appendix B

Summary of the ARHN Community Stakeholder Survey For Essex County

Prepared for AHI by

CHWS
Center for Health Workforce Studies

June 10, 2016

Executive Summary

A. Background

Under contract with the Adirondack Health Institute (AHI) and as part of the Adirondack Rural Health Network (ARHN) coordination of community needs assessment, the Center for Health Workforce Study (CHWS) surveyed health care, social services, educational, governmental and other community stakeholders in the ARHN region to provide the Community Health Assessment (CHA) Committee with stakeholder input on regional health care needs and priorities. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington Counties.

B. Methods

The survey was developed using Qualtrics Software that included 15 questions. In working with the participating counties, ARHN provided CHWS a list of health care, social service, educational, governmental, and other community stakeholders (hereafter referred to as service providers) by county to be surveyed. Using these lists, CHWS staff created an unduplicated list of providers numbering 658. An initial email was sent to this list explaining the survey and providing an electronic link to the survey. The survey was available to potential respondents for approximately six weeks.

The survey requested that the respondent identify the two priority areas from a list of five which they believe need to be addressed with their county or counties, and then respondents were also asked to rank the focus areas within each priority area and identify potential barriers to that addressing that focus area.

C. Survey Responses

A total of 217 completed responses were received to the survey through May 31, 2016 for a response rate of 33%. Respondents were asked to indicate in which counties they provided services, and respondents indicated that their service areas included multiple counties as outlined in Exhibit 1.

Exhibit 1: Respondents by County

County	Counts
Clinton	53
Essex	79
Franklin	56
Fulton	51
Hamilton	44
Warren	53
Washington	43
Other	39

D. Findings

Over 200 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including education (122), prevention and wellness (115), health care (96), healthy environment (65), and social services among others. Survey respondents also served a wide range of individuals, including school-aged children (163), individuals living at or near the federal poverty level (149), adults (146), individuals with behavioral health issues (123), individuals who are senior citizens (122), and individuals with disabilities (121).

Overall, respondents in the ARHN region identified "promoting mental health and preventing substance abuse" (40%) as their top priority of respondents, followed by "prevent chronic disease" (32%). "Promoting mental health and preventing substance abuse" was also identified as a second priority by 33% of respondents, followed by "providing a healthy and safe environment" by 29% of respondents.

Five of the seven ARHN counties identified "promoting mental health and preventing substance abuse" as their top priority, one identified "preventing chronic diseases" as their top priority, and one had a tie between the two.

Exhibit 2: Summary of County Selections of Top and Second Priority

County	Top Priority		Second Priority	
	First Choice	Second Choice	First Choice	Second Choice
Clinton	Promoting mental health	Preventing chronic disease	Providing a healthy and safe environment	Preventing chronic disease
Essex	**Promoting mental health**	**Preventing chronic disease**	**Providing a healthy and safe environment**	**Preventing chronic disease**
Franklin	Promoting mental health	Preventing chronic disease	Preventing chronic disease (tied)	Providing a healthy and safe environment (tied)
Fulton	Preventing chronic disease	Promoting mental health	Promoting mental health	Providing a healthy and safe environment
Hamilton	Preventing chronic disease (tied)	Promoting mental health (tied)	Providing a healthy and safe environment (tied)	Promoting mental health (tied)
Warren	Promoting mental health	Preventing chronic disease	Promoting mental health	Providing a healthy and safe environment
Washington	Promoting mental health	Preventing chronic disease	Promoting mental health	Providing a healthy and safe environment

The top focus area identified to address "promoting mental health and preventing substance abuse" for the ARHN region was "strengthening (the mental health) infrastructure across systems" (39), followed by "preventing substance abuse and other mental and emotional disorders" (27). Survey respondents in the ARHN indicated that the top barriers to addressing this priority include "shortage of professionals and staff" (62), "travel distance and the geography of the Adirondacks" (44), "lack of financial resources/reimbursement in the long-term" (40), and "lack of financial resources/ reimbursement in the short-term" (37).

Survey respondents indicated that the focus area to address for "preventing chronic disease" was "increasing access to high quality chronic disease care and management" (38), followed by "reducing obesity in children and adults" (21). Major barriers identified to addressing this priority include "travel distance and the geography of the Adirondacks" (33), "lack of financial resources/ reimbursement in the short-term" (29), "shortage of professionals and staff" (26), and "lack of financial resources/reimbursement in the long-term" (25).

Overview

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A. Background
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Under contract with the Adirondack Health Institute (AHI) and as part of the Adirondack Rural Health Network (ARHN) coordination of community needs assessment, the Center for Health Workforce Study (CHWS) surveyed health care, social services, educational, governmental and other community stakeholders in the ARHN region to provide the Community Health Assessment (CHA) Committee with stakeholder input on regional health care needs and priorities. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington Counties.

This survey is part of a larger effort by ARHN to assist its members in developing their community needs assessments for 2016 that included an analysis of outcome data, profiles of the demographic, educational, and health system characteristics of the ARHN region, and an understanding of what other counties are doing around community engagement.

This report represents a summary of the findings from the service provider survey and outlines identified priorities for the ARHN region and for Essex County.

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B. Methods
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The survey was developed using Qualtrics Software that included 15 questions and a number of sub questions based on an initial response. A pdf of the survey is attached as Appendix 1 to this report. In working with the participating counties, ARHN provided CHWS a list of health care, social service, educational, government and other community stakeholder s by county. Using these lists, CHWS staff created an unduplicated list of 658 providers that cut across all seven counties. An initial email was sent to this list explaining the survey and providing an electronic link to the survey. The survey was available to potential respondents for approximately six weeks.

As follow-up, CHWS sent an additional email reminding potential respondents of the survey. CHWS also provided ARHN with a list of those who responded, and county staff also followed up with non- respondents. As an incentive, respondents were told there would be a random drawing of 20 $10 gift cards from Stewart's for participating in the survey. A total of 217 completed responses were received to the survey through May 31, 2016 for a response rate of 33%. CHWS staff also provided technical assistance as requested by survey respondents.

The survey requested that the respondent identify their top two priority areas from a list of five following areas which they believe needed to be addressed within their service area:

- Preventing chronic disease;
- Providing a healthy and safe environment;
- Promoting healthy women, infants, and children;
- Promoting mental health and preventing substance abuse; and
- Preventing HIV, sexually transmitted diseases,, vaccine preventable diseases, and health care associated infections.

Once respondents identified their top two priorities, they were also asked to rank the focus areas within each priority area and identify potential barriers to that addressing that focus area.

Analysis for this report was conducted by county. Many health care, social service, and educational providers deliver services in multiple counties. Their opinions are reflected in each county they provide services.

C. Survey Responses

1. By County

While there were 217 respondents as discussed previously, service areas for certain stakeholders cut across multiple counties. Respondents were asked to indicate in which counties they provided services, and a large number of respondents provided services in multiple counties. Essex County had the largest number of respondents with 79, followed by Franklin (56), Clinton and Warren, both at 53. Additionally, 39 respondents indicated they delivered services outside of the seven county ARHN region, and those counties include Herkimer, Jefferson, Lewis, Montgomery, Rensselaer, St. Lawrence, Saratoga, Schenectady, and Schoharie as well as counties further west and south of the Adirondacks and the immediate surrounding counties.

Exhibit 2: Respondents by County

County	Counts
Clinton	53
Essex	79
Franklin	56
Fulton	51
Hamilton	44
Warren	53
Washington	43
Other	39

2. By Services Provided

Respondents indicated a wide range of services provided, including education (122), followed by prevention/wellness (115), health care services (96), and other (65).

Exhibit 3: Respondents by Services Delivered

Types of Services Delivered	Counts
Day Program Services	29
Education	122
Employment and Training	50
Health Care Services	96
Prevention/Wellness Services	115
Healthy Environment	65
Housing/Residential Services	34
Social Services	53
Other	69

2.1.1   Health Care Services

For respondents who indicated they provided health care services, 43 respondents indicated specialty care, including psychiatry, cancer treatment, infectious disease, women's health, orthopedics, substance abuse services, among others; 40 indicated primary care; and 26 indicated reproductive health. Another 43 indicated "other" that included home care services, inpatient and hospital care, long-term care, and other specialized health care.

2.1.2.   Prevention and Wellness

For respondents who indicated they provided prevention and wellness services, 61 respondents indicated child health, followed by diabetes and related diseases management (57), and immunizations (51).

Exhibit 4: Type of Prevention/Wellness Services Provider

Type of Prevention/Wellness Services Provided	Counts
Alcohol/Substance Abuse	39
Asthma	33
Birth Outcomes	31
Cancer	38
Child Health	61
Diabetes and Related Diseases Management	57
Heart Disease and Related Diseases Management	45
HIV and Other Sexually Transmitted Diseases	32
Immunizations	51
Mental Health Screenings	27
Obesity/Weight Management	54
Occupational Health/Safety	27
Oral Health	35
Reproductive Health	36
Smoking	44
Other	34

3. By Populations Served

Respondents indicated that they deliver their services to a wide variety of populations within the ARHN region, including school aged children (163), individuals living at or near the federal poverty level (149), adults, excluding the elderly (146), individuals with behavioral health issues (123), individuals who are senior citizens (122), and individuals with development disabilities (121).
Populations least serviced include racial/ethnic minorities (50) and migrant workers (59). For   organizations which service racial/ethnic minorities, 47 indicated they serve individuals who are Black/African American, non-Hispanic, 45 indicated they serve individuals who are Hispanic/Latino,   and 39 indicated they serve individuals who are Native American/Alaskan Native.

Exhibit 5: Respondents by Population Serviced

Type of Prevention/Wellness Services Provided	Counts
Babies (less than 3 years of age)	87
Pre-School Children (ages 3 and 4)	117
School Aged Children/Adolescents (ages 5 to 17)	163
Adults, Ages 18–64	146
Farmers	73
Individuals Living at or Near the Federal Poverty Level	149
Individuals who are Senior Citizens/Elderly	122
Individuals with Behavioral Health Issues	123
Individuals with Development Disabilities	121
Individuals with Substance Abuse Issues	104
Migrant Workers	59
Specific Racial/Ethnic Minorities	50
Women of Reproductive Age	101
Other	46

4. By Population Served and by Services Provided

Exhibit 6: Respondents by Population Serviced and by Services Provided

Type of Prevention/Wellness Services Provided	Day Program Services	Education	Employment and Training	Health Care	Prevention & Wellness	Healthy Environment	Housing/Residential	Social Services
Babies (less than 3 years of age)	9	41	22	52	58	32	14	26
Pre-School Children (ages 3 and 4)	15	46	28	62	67	41	18	36
School Aged Children/Adolescents (ages 5 to 17)	22	101	36	79	93	56	21	41
Adults, Ages 18–64	23	72	43	77	88	43	29	40
Farmers	8	39	22	47	48	30	11	20
Individuals Living at or Near the Federal Poverty Level	16	76	39	75	87	48	28	42
Individuals who are Senior Citizens/Elderly	20	54	33	65	71	37	26	37
Individuals with Behavioral Health Issues	15	65	36	66	70	41	20	36
Individuals with Development Disabilities	14	66	35	64	67	41	20	36
Individuals with Substance Abuse Issues	11	48	30	58	63	34	16	29
Migrant Workers	6	28	14	37	37	21	8	17
Specific Racial/Ethnic Minorities	7	25	12	32	32	18	10	13
Women of Reproductive Age	9	54	25	60	61	34	14	30

I.   ARHN Region

A.   ARHN's Priorities

Service providers in the ARHN region identified "promoting mental health and preventing substance abuse" as both their top priority and second priority. "Preventing chronic disease" was the second choice for top priority. "Preventing HIV, sexually transmitted diseases, vaccine preventable diseases, and health care associated infections" was selected the least as a top or second priority.

Exhibit I.1: Identification of Priority Areas for the ARHN Region

PriorityArea	Count	
	Top Priority	Second Priority
Prevent Chronic Disease	69	39
Provide a healthy and safe environment	33	61
Promote Healthy Women, Infants, and Children	27	30
Promote Mental Health and Prevent Substance Abuse	87	71
Prevent HIV, Sexually Transmitted Diseases, Vaccine Preventable Diseases, and Health Care Associated Infections	1	12

B.   Identifying the Top Priority

B.1.   Ranking the Focus Areas for Chronic Diseases Prevention when Chronic Disease Prevention is the Top Priority

For those service providers who identified "preventing chronic disease" as their top priority, they ranked "increasing access to high quality chronic preventive care and management" as the top focus area (38), followed by "reducing obesity in children and adults" (21).

Exhibit I.2: Ranking the Focus Areas for Chronic Diseases Prevention when Chronic Disease Prevention is the Top Priority for the ARHN Region

	Rank		
	1st	2nd	3rd
Reduce Obesity in Children and Adults	21	25	19
Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure	9	19	36
Increase Access to High Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings	38	23	7

B.2. Barriers to Addressing Chronic Diseases Prevention as the Top Priority for the ARHN Region

A number of barriers were identified by service providers in the ARHN region who indicated that "preventing chronic disease" was their top priority, including "travel distance and geography of the Adirondacks" (33), "lack of financial resources/reimbursement in the short-term" (29), "shortage of professionals and staff" (26), and lack of financial resources/ reimbursement in the long-term" (25).

Exhibit I.3. Barriers to Addressing Chronic Diseases Prevention as the Top Priority for the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	3
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	10
Existing Strategies Have Not Been Effective	16
Lack of Financial Resources/Reimbursement in the Short-Term	29
Lack of Financial Resources/Reimbursement in the Long-Term	25
Lack of Evidenced-Based Strategies	5
There is a Shortage of Professionals/Staff	26
The Existing Population Does Not Believe that My Top Priority is an Issue	15
There are Other Priorities More Important to Address	7
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	33
Other	12

B.3. Ranking the Focus Areas for Providing a Healthy and Safe Environment when Providing a Healthy and Safe Environment is the Top Priority

Service providers in the ARHN who identified "providing a healthy and safe environment" as their top priority ranked "injuries, violence, and occupational health" as their top focus area (18), followed by the "built environment" (10).

Exhibit I.4: Ranking the Focus Areas for Providing a Healthy and Safe Environment when Providing a Healthy and Safe Environment is the Top Priority for the ARHN Region

	Rank			
	1st	2nd	3rd	4th
Outdoor Air Quality	1	3	10	16
Water Quality	4	7	14	5
Built Environment	10	13	1	6
Injuries, Violence, and Occupational Health	18	7	5	3

B.4. **Barriers to Providing a Healthy and Safe Environment as the Top Priority for the ARHN Region**

The biggest barrier to "providing a healthy and safe environment" identified by service providers in the ARHN region was "the existing population does not believe that (providing a healthy and safe environment) is an issue" (31), followed by "lack of financial resources/reimbursement in the long- term" (14) and the "short-term" (13).

Exhibit I.5. Barriers to Providing a Healthy and Safe Environment as the Top Priority for the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	4
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	6
Existing Strategies Have Not Been Effective	2
Lack of Financial Resources/Reimbursement in the Short-Term	13
Lack of Financial Resources/Reimbursement in the Long-Term	14
Lack of Evidenced-Based Strategies	2
There is a Shortage of Professionals/Staff	8
The Existing Population Does Not Believe that My Top Priority is an Issue	31
There are Other Priorities More Important to Address	1
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	4
Other	5

B.5. **Ranking the Focus Areas for Promoting Healthy Women, Infants, and Children when Promoting Healthy Women, Infant, and Children is the Top Priority**

For service providers in the ARHN region that identified "promoting healthy women, infant, and children" as their top priority, they ranked "child health" (14) as the top focus area, followed by "maternal and infant health" (11).

Exhibit I.6: Ranking the Focus Areas for Promoting Healthy Women, Infants, and Children when Promoting Healthy Women, Infant, and Children is the Top Priority for the ARHN Region

	Rank		
	1st	2nd	3rd
Maternal and Infant Health	11	14	1
Child Health	14	8	4
Reproductive, Preconception, and Inter-conception Health	2	4	20

B.6.   Barriers to Promoting Healthy Women, Infants, and Children as the Top Priority for   the ARHN Region

A number of barriers were identified by service providers in the ARHN region who indicated that "healthy women, infant, and children" were their top priority, including "lack of financial resources/reimbursement in the short-term" (13), "travel distance and geography of the Adirondacks" (12), "lack of financial resources/ reimbursement in the long-term" (12), and "a shortage of professionals and staff" (10).

Exhibit I.7. Barriers to Promoting Healthy Women, Infants, and Children as the Top Priority for   the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	2
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	7
Existing Strategies Have Not Been Effective	5
Lack of Financial Resources/Reimbursement in the Short-Term	12
Lack of Financial Resources/Reimbursement in the Long-Term	13
Lack of Evidenced-Based Strategies	2
There is a Shortage of Professionals/Staff	10
The Existing Population Does Not Believe that My Top Priority is an Issue	7
There are Other Priorities More Important to Address	3
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	12
Other	4

B.7.   Ranking the Focus Areas for Promoting Mental Health and Preventing Substance Abuse when Promoting

Mental Health and Preventing Substance Abuse is the Top Priority

As indicated previously, "promoting mental health and preventing substance abuse" was ranked 1st and 2nd regionally as priorities. For those service providers that ranked it first as priority, they ranked   the top focus area as "strengthening infrastructure across systems" (39), followed by "preventing substance abuse and other mental and emotional disorders" (27).

Exhibit I.8. Ranking the Focus Areas for Promoting Mental Health and Preventing Substance Abuse when Promoting Mental Health and Preventing Substance Abuse is the Top Priority for the ARHN Region

	Rank		
	1st	2nd	3rd
Promote Mental, Emotional, and Well-Being in Communities	19	37	28
Prevent Substance Abuse and other Mental and Emotional Disorders	27	31	27
Strengthen Infrastructure Across Systems	39	17	28

B.8. Barriers to Promoting Mental Health and Preventing Substance Abuse as the Top Priority for the ARHN Region

For those service providers in the ARHN region that identified "promoting mental health and preventing substance abuse" as their top priority, they indicated that the biggest barriers to addressing this priority included "a shortage of professionals and staff" (62), "travel distance and geography of the Adirondacks" (44), "lack of financial resources/reimbursement in the long-term" (40), and "lack of financial resources/reimbursement in the short-term" (37).

Exhibit I.9. Barriers to Promoting Mental Health and Preventing Substance Abuse as the Top Priority for the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	4
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	16
Existing Strategies Have Not Been Effective	31
Lack of Financial Resources/Reimbursement in the Short-Term	37
Lack of Financial Resources/Reimbursement in the Long-Term	40
Lack of Evidenced-Based Strategies	7
There is a Shortage of Professionals/Staff	62
The Existing Population Does Not Believe that My Top Priority is an Issue	4
There are Other Priorities More Important to Address	8
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	44
Other	16

B.9. Ranking the Focus Areas for Preventing HIV, Sexually Transmitted Diseases, Vaccine- Preventable Diseases, and Health Care Associated Infections when Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections is the Top Priority

One service provider in the ARHN region identified "preventing HIV, sexually transmitted diseases, vaccine-preventable diseases, and health care associated infections" as their top priority, and that organization ranked "preventing HIV and sexually transmitted diseases" as its top focus area.

Exhibit I.10. Ranking the Focus Areas for Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections when Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections is the Top Priority for the ARHN Region

	Rank		
	1st	2nd	3rd
Prevent HIV and Sexually Transmitted Diseases	1	0	0
Prevent Vaccine-Preventable Diseases	0	1	0
Prevent Health Care Associated Infections	0	0	1

B.10. Barriers to Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections as the Top Priority for the ARHN Region

Barriers identified by the organization that selected "preventing HIV, sexually transmitted diseases, vaccine-preventable diseases, and health care associated infections" included "a shortage of professionals and staff" and "travel distance and geography of the Adirondacks."

Exhibit I.11. Barriers to Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections as the Top Priority for the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	0
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	0
Existing Strategies Have Not Been Effective	0
Lack of Financial Resources/Reimbursement in the Short-Term	0
Lack of Financial Resources/Reimbursement in the Long-Term	0
Lack of Evidenced-Based Strategies	0
There is a Shortage of Professionals/Staff	1
The Existing Population Does Not Believe that My Top Priority is an Issue	0
There are Other Priorities More Important to Address	0
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	1
Other	0

C. Identifying the Second Priority

C.1. Ranking the Focus Areas for Chronic Diseases Prevention when Chronic Disease Prevention is the Second Priority

Service providers in the ARHN region that indicated "preventing chronic disease" was their second priority ranked "increasing access to high quality chronic disease care and management" (22) as their top focus area followed by reducing "obesity in children and adults" (15).

Exhibit I.12: Ranking the Focus Areas for Chronic Diseases Prevention when Chronic Disease Prevention is the Second Priority for the ARHN Region

	Rank		
	1st	2nd	3rd
Reduce Obesity in Children and Adults	15	11	12
Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure	2	17	19
Increase Access to High Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings	22	11	6

C.2. **Barriers to Addressing Chronic Diseases Prevention as the Second Priority**

For service providers in the ARHN region that identified "preventing chronic disease" as their second priority, barriers to addressing this priority included "travel distance and geography of the Adirondacks" (20) and "a shortage of professionals and staff" (15).

Exhibit I.13. Barriers to Addressing Chronic Diseases Prevention as the Second Priority for the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Second Priority	4
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	2
Existing Strategies Have Not Been Effective	10
Lack of Financial Resources/Reimbursement in the Short-Term	10
Lack of Financial Resources/Reimbursement in the Long-Term	12
Lack of Evidenced-Based Strategies	3
There is a Shortage of Professionals/Staff	15
The Existing Population in My Service Area Does Not Believe that My Second Priority is an Issues	8
There are Other Priorities More Important to Address	6
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	20
Other	9

C.3. **Ranking the Focus Areas for Providing a Healthy and Safe Environment when Providing a Healthy and Safe Environment is the Second Priority**

Service providers in the ARHN region that indicated that "providing a healthy and safe environment" was their second priority ranked the "built environment" (26) as their top focus are followed closely by "injuries, violence, and occupational health" (25).

Exhibit I.14: Ranking the Focus Areas for Providing a Healthy and Safe Environment when Providing a Healthy and Safe Environment is the Second Priority for the ARHN Region

	Rank			
	1st	2nd	3rd	4th
Outdoor Air Quality	3	7	13	27
Water Quality	3	12	24	11
Built Environment	26	14	9	4
Injuries, Violence, and Occupational Health	25	17	4	8

C.4. Barriers to Providing a Healthy and Safe Environment as the Second Priority

For service providers that identified "a healthy and safe environment" as their second priority, financial issues were the top barriers to addressing this priority, including the "lack of financial resources/reimbursement in the short-term" (27) and in the "long-term" (22).

Exhibit I.15. Barriers to Providing a Healthy and Safe Environment as the Second Priority for the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Second Priority	16
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	5
Existing Strategies Have Not Been Effective	5
Lack of Financial Resources/Reimbursement in the Short-Term	27
Lack of Financial Resources/Reimbursement in the Long-Term	22
Lack of Evidenced-Based Strategies	5
There is a Shortage of Professionals/Staff	10
The Existing Population in My Service Area Does Not Believe that My Second Priority is an Issues	10
There are Other Priorities More Important to Address	10
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	9
Other	7

C.5. Ranking the Focus Areas for Promoting Healthy Women, Infants, and Children when Promoting Healthy Women, Infant, and Children is the Second Priority

For service providers in the ARHN region that identified "promoting healthy women, infants, and children" as their second priority, they ranked "child health" (18) as their top focus area followed by "maternal and infant health" (7), and "reproductive, preconception, and inter-conception health" (5).

Exhibit I.16: Ranking the Focus Areas for Promoting Healthy Women, Infants, and Children when Promoting Healthy Women, Infant, and Children is the Second Priority for the ARHN Region

	Rank		
	1st	2nd	3rd
Maternal and Infant Health	7	18	4
Child Health	18	7	5
Reproductive, Preconception, and Inter-conception Health	5	4	16

C.6. Barriers to Promoting Healthy Women, Infants, and Children as the Second Priority

Service providers in the ARHN region that identified "promoting healthy women, infants, and children" as their second priority indicated that the biggest barriers to addressing this priority included "lack of financial resources/reimbursement in the long-term" (14), "travel distance and geography of the Adirondacks" (14), "lack of financial resources/reimbursement in the short-term" (12), and "a shortage of professionals and staff" (10).

Exhibit I.17. Barriers to Promoting Healthy Women, Infants, and Children as the Second Priority for the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Second Priority	4
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	4
Existing Strategies Have Not Been Effective	5
Lack of Financial Resources/Reimbursement in the Short-Term	12
Lack of Financial Resources/Reimbursement in the Long-Term	14
Lack of Evidenced-Based Strategies	1
There is a Shortage of Professionals/Staff	10
The Existing Population in My Service Area Does Not Believe that My Second Priority is an Issues	3
There are Other Priorities More Important to Address	3
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	14
Other	3

C.7. Ranking the Focus Areas for Promoting Mental Health and Preventing Substance Abuse when Promoting Mental Health and Preventing Substance Abuse is the Second Priority

Service providers in the ARHN region that identified "promoting mental health and preventing substance abuse" as their second priority ranked "preventing substance abuse and other mental and emotional disorders" (27) as their top focus area, followed by "promoting mental, emotional, and well-being in communities" (25).

Exhibit I.18. Ranking the Focus Areas for Promoting Mental Health and Preventing Substance Abuse when Promoting Mental Health and Preventing Substance Abuse is the Second Priority for the ARHN Region

	Rank		
	1st	2nd	3rd
Promote Mental, Emotional, and Well-Being in Communities	25	26	20
Prevent Substance Abuse and other Mental and Emotional Disorders	27	25	19
Strengthen Infrastructure Across Systems	19	20	32

C.8. **Barriers to Promoting Mental Health and Preventing Substance Abuse as the Second Priority**

Service providers in the ARHN region that identified "promoting mental health and preventing substance abuse" as their second priority indicated that the biggest barriers to addressing this priority included "a shortage of professionals and staff" (44), "lack of financial resources/reimbursement in the short-term" (37), "lack of financial resources/reimbursement in the long-term" (33), and "travel distance and geography of the Adirondacks" (32).

Exhibit I.19. Barriers to Promoting Mental Health and Preventing Substance Abuse as the Second Priority for the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Second Priority	6
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	15
Existing Strategies Have Not Been Effective	21
Lack of Financial Resources/Reimbursement in the Short-Term	37
Lack of Financial Resources/Reimbursement in the Long-Term	33
Lack of Evidenced-Based Strategies	3
There is a Shortage of Professionals/Staff	44
The Existing Population in My Service Area Does Not Believe that My Second Priority is an Issues	6
There are Other Priorities More Important to Address	7
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	32
Other	10

C.9. **Ranking the Focus Areas for Preventing HIV, Sexually Transmitted Diseases, Vaccine- Preventable Diseases, and Health Care Associated Infections when Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections is the Second Priority**

Service providers in the ARHN region that identified "preventing HIV, sexually transmitted diseases, vaccine-preventable diseases", and "health care associated infections" as their second priority ranked "preventing HIV and sexually preventable diseases" and "preventing vaccine-preventable diseases" as their top focus area, both at six.

Exhibit I.20. Ranking the Focus Areas for Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections when Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections is the Second Priority for the ARHN Region

	Rank		
	1st	**2nd**	**3rd**
Prevent HIV and Sexually Transmitted Diseases	6	1	5
Prevent Vaccine-Preventable Diseases	6	6	0
Prevent Health Care Associated Infections	0	5	6

C.10. Barriers to Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections as the Second Priority

Service providers who identified "preventing HIV, sexually transmitted diseases, vaccine-preventable diseases", and "health care associated infections" as their second priority indicated that "the existing population does not believe that (preventing HIV, sexually transmitted diseases, vaccine-preventable diseases, and health care associated infections) is an issue" (7) as the biggest barrier to addressing it.

Exhibit I.21. Barriers Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections the Second Priority for the ARHN Region

Barrier	Count
I am not Aware of any Current Work Addressing My Second Priority	0
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	0
Existing Strategies Have Not Been Effective	2
Lack of Financial Resources/Reimbursement in the Short-Term	2
Lack of Financial Resources/Reimbursement in the Long-Term	3
Lack of Evidenced-Based Strategies	1
There is a Shortage of Professionals/Staff	4
The Existing Population in My Service Area Does Not Believe that My Second Priority is an Issue	7
There are Other Priorities More Important to Address	2
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	2
Other	1

II.   Essex County

A.   Essex County's Priorities

Service providers whose service area included Essex County identified "promoting mental health and preventing substance abuse" (37) as the top priority followed by "preventing chronic disease" (29). "Promoting mental health and preventing substance abuse" was identified as the second priority by Essex County service providers.

Exhibit II.1: Identification of Priority Areas for Essex County

PriorityArea	Count	
	Top Priority	Second Priority
Prevent Chronic Disease	29	17
Provide a healthy and safe environment	6	23
Promote Healthy Women, Infants, and Children	7	8
Promote Mental Health and Prevent Substance Abuse	37	26
Prevent HIV, Sexually Transmitted Diseases, Vaccine Preventable Diseases, and Health Care Associated Infections	0	3

B.   Identifying the Top Priority

B.1.   Ranking the Focus Areas for Chronic Diseases Prevention when Chronic Disease Prevention is the Top Priority

For service providers in Essex County that identified "preventing chronic disease" as their top priority, the focus areas they believed should be addressed include "increase access to high quality chronic disease preventive care and management" (15), followed by "reducing obesity in children and adults" (11).

Exhibit II.2: Ranking the Focus Areas for Chronic Diseases Prevention when Chronic Disease Prevention is the Top Priority for Essex County

	Rank		
	1st	2nd	3rd
Reduce Obesity in Children and Adults	11	8	8
Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure	2	9	15
Increase Access to High Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings	15	11	2

B.2.   BarrierstoAddressingChronicDiseasesPreventionastheTopPriorityforEssex County

For service providers in Essex County that chose "preventing chronic disease" as their top priority indicated that "travel distance and the geography of the Adirondacks" (16) was the biggest barrier for achieving this priority, followed by "lack of financial resources/reimbursement to in the short-term," (13), "a shortage of professionals/staff" (12), and "lack of financial resources/reimbursement in the   long-term" (11). One provider noted that the population lacked the self-efficacy to achieve this change.

ExhibitII.3.BarrierstoAddressingChronicDiseasesPreventionastheTopPriorityforEssex County

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	2
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	6
Existing Strategies Have Not Been Effective	6
Lack of Financial Resources/Reimbursement in the Short-Term	13
Lack of Financial Resources/Reimbursement in the Long-Term	11
Lack of Evidenced-Based Strategies	1
There is a Shortage of Professionals/Staff	12
The Existing Population Does Not Believe that My Top Priority is an Issue	4
There are Other Priorities More Important to Address	2
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	16
Other	6

B.3.   Ranking the Focus Areas for Providing a Healthy and Safe Environment when Providing a Healthy

and Safe Environment is the Top Priority

For those respondents whose service area includes Essex County and that indicated "a healthy and safe environment" was their top priority, "injuries, violence, and occupational health" was ranked as the most import focus area followed by "water quality."

Exhibit II.4: Ranking the Focus Areas for Providing a Healthy and Safe Environment when Providing a Healthy and Safe

environment is the Top Priority for Essex County

	Rank			
	1st	2nd	3rd	4th
Outdoor Air Quality	0	0	3	3
Water Quality	2	0	2	2
Built Environment	1	5	0	0
Injuries, Violence, and Occupational Health	3	1	1	1

B.4. Barriers to Providing a Healthy and Safe Environment as the Top Priority for Essex County

The two biggest barriers identified by Essex County service providers who indicated that a "healthy and safe environment" was their top priority were both financial, the "lack of financial support and reimbursement to address the issue in the long-term" (4) and "in the short-term" (3).

Exhibit II.5. Barriers to Providing a Healthy and Safe environment as the Top Priority for Essex County

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	0
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	0
Existing Strategies Have Not Been Effective	1
Lack of Financial Resources/Reimbursement in the Short-Term	3
Lack of Financial Resources/Reimbursement in the Long-Term	4
Lack of Evidenced-Based Strategies	0
There is a Shortage of Professionals/Staff	1
The Existing Population Does Not Believe that My Top Priority is an Issue	0
There are Other Priorities More Important to Address	0
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	0
Other	2

B.5. Ranking the Focus Areas for Promoting Healthy Women, Infants, and Children when Promoting Healthy Women, Infant, and Children is the Top Priority

Service providers in Essex County that identified "promoting healthy women, infant, and children" as their top priority ranked "child health" (3) as the top focus area, followed by "maternal and infant health" (2) and "reproductive, preconception, and inter-conception health" (2).

Exhibit II.6: Ranking the Focus Areas for Promoting Healthy Women, Infants, and Children when Promoting Healthy Women, Infant, and Children is the Top Priority for Essex County

	Rank		
	1st	2nd	3rd
Maternal and Infant Health	2	4	0
Child Health	3	2	1
Reproductive, Preconception, and Inter-conception Health	2	0	5

B.6. Barriers to Promoting Healthy Women, Infants, and Children as the Top Priority for Essex County

Essex County service providers that identified "promoting healthy women, infants, and children" as their top priority indicated that lack of the "existing population believing this is an issue" (4) is the top barrier, followed by "a shortage of professionals and staff" (3) and "travel distance and geography of the Adirondacks" (3).

Exhibit II.7. Barriers to Promoting Healthy Women, Infants, and Children as the Top Priority for Essex County

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	0
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	1
Existing Strategies Have Not Been Effective	1
Lack of Financial Resources/Reimbursement in the Short-Term	2
Lack of Financial Resources/Reimbursement in the Long-Term	2
Lack of Evidenced-Based Strategies	0
There is a Shortage of Professionals/Staff	3
The Existing Population Does Not Believe that My Top Priority is an Issue	4
There are Other Priorities More Important to Address	0
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	3
Other	1

B.7. Ranking the Focus Areas for Promoting Mental Health and Preventing Substance Abuse when Promoting Mental Health and Preventing Substance Abuse is the Top Priority

Essex County service providers that identified "promoting mental health and preventing substance abuse" as their top priority ranked "strengthening the (mental health) infrastructure across systems"
(18) as their top focus area followed by "promoting mental, emotional, and well-being in communities" (12).

Exhibit II.8. Ranking the Focus Areas for Promoting Mental Health and Preventing Substance Abuse when Promoting Mental Health and Preventing Substance Abuse is the Top Priority for Essex County

	Rank		
	1st	2nd	3rd
Promote Mental, Emotional, and Well-Being in Communities	12	13	11
Prevent Substance Abuse and other Mental and Emotional Disorders	6	14	16
Strengthen Infrastructure Across Systems	18	9	9

B.8. Barriers to Promoting Mental Health and Preventing Substance Abuse as the Top Priority for Essex County

For Essex County service providers who indicated that "promoting mental health and preventing substance abuse" was their top priority, the biggest barriers to addressing this priority were a "shortage of professionals and staff" (27) and "travel distance and the geography of the Adirondacks" (21).

Exhibit II.9. Barriers to Promoting Mental Health and Preventing Substance Abuse as the Top Priority for Essex County

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	2
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	8
Existing Strategies Have Not Been Effective	10
Lack of Financial Resources/Reimbursement in the Short-Term	16
Lack of Financial Resources/Reimbursement in the Long-Term	17
Lack of Evidenced-Based Strategies	2
There is a Shortage of Professionals/Staff	27
The Existing Population Does Not Believe that My Top Priority is an Issue	0
There are Other Priorities More Important to Address	6
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	21
Other	6

B.9. Ranking the Focus Areas for Preventing HIII, Sexually Transmitted Diseases, Vaccine- Preventable Diseases, and Health Care Associated Infections when Preventing HIII, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections is the Top Priority

No service provider in Essex County identified "preventing HIV, sexually transmitted diseases, vaccine-preventable diseases, and health care associated infections" as their top priority.

C. Identifying the Second Priority

C.1. Ranking the Focus Areas for Chronic Diseases Prevention when Chronic Disease Prevention is the Second Priority

Service providers in Essex County that identified "preventing chronic disease" as their second priority ranked "reducing obesity in children and adults" and "increasing access to high quality chronic disease preventive care and management" as their top focus areas, both with eight.

Exhibit II.10: Ranking the Focus Areas for Chronic Diseases Prevention when Chronic Disease Prevention is the Second Priority for Essex County

	Rank		
	1st	2nd	3rd
Reduce Obesity in Children and Adults	8	4	5
Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure	1	7	8
Increase Access to High Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings	8	6	3

C.2. Barriers to Addressing Chronic Diseases Prevention as the Second Priority

Respondents in Essex County who identified "preventing chronic disease" as their second priority indicated that "travel distance and geography of the Adirondacks" (8) was the biggest barrier to addressing this priority followed by "existing strategies have not been effective" (5). One respondent noted that the "high prevalence rates of tobacco use and obesity requires a 'full court press' to address successfully."

Exhibit II.11. Barriers to Addressing Chronic Diseases Prevention as the Second Priority for Essex County

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	1
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	0
Existing Strategies Have Not Been Effective	5
Lack of Financial Resources/Reimbursement in the Short-Term	3
Lack of Financial Resources/Reimbursement in the Long-Term	4
Lack of Evidenced-Based Strategies	1
There is a Shortage of Professionals/Staff	4
The Existing Population Does Not Believe that My Top Priority is an Issue	3
There are Other Priorities More Important to Address	2
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	8
Other	6

C.3. Ranking the Focus Areas for Providing a Healthy and Safe Environment when Providing a Healthy and Safe environment is the Second Priority

For service providers that indicated "providing a healthy and safe environment" was their second priority, they ranked the "built environment" (9) and "injuries, violence, and occupational health" (8) as their top two focus areas.

Exhibit II.12: Ranking the Focus Areas for Providing a Healthy and Safe Environment when Providing a Healthy and Safe Environment is the Second Priority for Essex County

	Rank			
	1st	2nd	3rd	4th
Outdoor Air Quality	1	4	4	9
Water Quality	2	3	9	4
Built Environment	9	4	4	1
Injuries, Violence, and Occupational Health	8	7	1	4

C.4. Barriers to Providing a Healthy and Safe Environment as the Second Priority

Essex County service providers that identified a "healthy and safe environment" as their second priority indicated that financial resources and reimbursement were the biggest barriers to addressing the priority, both in the short-term (8) and the long-term (7).

Exhibit II.13. Barriers to Providing a Healthy and Safe Environment as the Second Priority for Essex County

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	7
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	2
Existing Strategies Have Not Been Effective	2
Lack of Financial Resources/Reimbursement in the Short-Term	8
Lack of Financial Resources/Reimbursement in the Long-Term	7
Lack of Evidenced-Based Strategies	3
There is a Shortage of Professionals/Staff	2
The Existing Population Does Not Believe that My Top Priority is an Issue	3
There are Other Priorities More Important to Address	6
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	4
Other	4

C.5. Ranking the Focus Areas for Promoting Healthy Women, Infants, and Children when Promoting Healthy Women, Infant, and Children is the Second Priority

Essex County service providers that identified "promoting healthy women, infant, and children" as their second priority ranked "maternal and infant health" and "child health" as their top two focus areas, both with three.

Exhibit II.14: Ranking the Focus Areas for Promoting Healthy Women, Infants, and Children when Promoting Healthy Women, Infant, and Children is the Second Priority for Essex County

	Rank		
	1st	2nd	3rd
Maternal and Infant Health	3	3	2
Child Health	3	3	2
Reproductive, Preconception, and Inter-conception Health	2	2	3

C.6. Barriers to Promoting Healthy Women, Infants, and Children as the Second Priority

Essex County service providers who indicated that "healthy women, infants, and children" were their second priority identified the "lack of financial resources and reimbursement in the short-term and in the long-term" and "travel distance and geography of the Adirondacks" as biggest barriers for achieving this priority, all with five.

Exhibit II.15. Barriers to Promoting Healthy Women, Infants, and Children as the Second Priority for Essex County

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	0
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	1
Existing Strategies Have Not Been Effective	0
Lack of Financial Resources/Reimbursement in the Short-Term	5
Lack of Financial Resources/Reimbursement in the Long-Term	5
Lack of Evidenced-Based Strategies	0
There is a Shortage of Professionals/Staff	4
The Existing Population Does Not Believe that My Top Priority is an Issue	1
There are Other Priorities More Important to Address	1
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	5
Other	1

C.7. Ranking the Focus Areas for Promoting Mental Health and Preventing Substance Abuse when Promoting Mental Health and Preventing Substance Abuse is the Second Priority

Essex County service providers that identified "promoting mental health and preventing substance abuse" as their second priority ranked "preventing substance abuse and other mental and emotional disorders" (16) as their top focus area.

Exhibit II.16. Ranking the Focus Areas for Promoting Mental Health and Preventing Substance Abuse when Promoting Mental Health and Preventing Substance Abuse is the Second Priority for Essex County

	Rank		
	1st	2nd	3rd
Promote Mental, Emotional, and Well-Being in Communities	5	9	12
Prevent Substance Abuse and other Mental and Emotional Disorders	16	7	3
Strengthen Infrastructure Across Systems	5	10	11

C.8. Barriers to Promoting Mental Health and Preventing Substance Abuse as the Second Priority

For Essex County service providers who identified "promoting mental health and preventing substance abuse" as their second priority, they indicated the biggest barriers to addressing this priority included "a shortage of professionals and staff" (18), "lack of financial resources/reimbursement in the short-term" (15), "travel distance and geography of the Adirondacks" (15), and "lack of financial resources/reimbursement in the long-term" (14).

Exhibit II.17. Barriers to Promoting Mental Health and Preventing Substance Abuse as the Second Priority for Essex County

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	2
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	6
Existing Strategies Have Not Been Effective	10
Lack of Financial Resources/Reimbursement in the Short-Term	15
Lack of Financial Resources/Reimbursement in the Long-Term	14
Lack of Evidenced-Based Strategies	0
There is a Shortage of Professionals/Staff	18
The Existing Population Does Not Believe that My Top Priority is an Issue	2
There are Other Priorities More Important to Address	2
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	15
Other	3

C.9. **Ranking the Focus Areas for Preventing HIV, Sexually Transmitted Diseases, Vaccine- Preventable Diseases, and Health Care Associated Infections when Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections is the Second Priority**

Three Essex County service providers indicated that "preventing HIV, sexually transmitted diseases, vaccine preventable diseases, and health care associated infections" was their second priority, and all of them ranked "preventing HIV and sexually transmitted diseases" as their main focus area to address.

Exhibit II.18. Ranking the Focus Areas for Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections when Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated InfectionsistheSecondPriorityforEssexCounty

	Rank		
	1st	2nd	3rd
Prevent HIV and Sexually Transmitted Diseases	3	0	0
Prevent Vaccine-Preventable Diseases	0	3	0
Prevent Health Care Associated Infections	0	0	3

C.10. **Barriers to Preventing HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases, and Health Care Associated Infections as the Second Priority**

Essex County service providers that identified "preventing HIV, sexually transmitted diseases, vaccine-preventable diseases, and health care associated infections" indicated that barriers included a "shortage of professionals and staff" (2) and the "existing population does not believe that this is an issue" (2).

Adirondack Rural Health Network –Community Health Assessment (CHA) Committee

Organization	Committee Member
Adirondack Health	Bonnie Ohmann
Alice Hyde Medical Center	Ginger Carriero
Alice Hyde Medical Center	Josy Delaney
The University of Vermont Health Network Champlain Valley Physicians Hospital	Kati Jock
The University of Vermont Health Network Elizabethtown Community Hospital	Healther Reynolds
The University of Vermont Health Network Elizabethtown Community Hospital	Julie Tromblee
The University of Vermont Health Network Elizabethtown Community Hospital	Kristin Dooley
Essex County Public Health	Linda Beers
Essex County Public Health	Jessica Darney Buehler
Franklin County Public Health	Kathleen Strack
Franklin County Public Health	Erin Streiff
Fulton County Public Health	Irina Gelman
Glens Falls Hospital	Tracy Mills
Glens Falls Hospital	Kelly Pilkey
Hamilton County Public Health	Susan Franko
Inter-Lakes Health	Tammy Smith
Nathan Littauer Hospital	Cheryl McGrattan
Warren County Health Services	Pat Auer
Warren County Health Services	Dan Durkee
Warren County Health Services	Ginelle Jones
Washington County Public Health	Patty Hunt
Washington County Public Health	Kathy Jo Mcintyre

Community Health Assessment (CHA) Committee Meeting Dates

September 10, 2014
December 5, 2014
March 11, 2015
June 10, 2015
October 15, 2015
January 8, 2016
March 30, 2016
June 24, 2016
August 17, 2016
September 15, 2016

Essex County Health Partners Meeting Dates for Prioritization and CHIP/CSP Development*

August 4, 2016
October 14, 2016
October 26, 2016
November 4, 2016

* These meeting dates denote only meeting to which all partners were invited. Numerous informal communications between partners was ongoing throughout the CHA/CHIP/CSP process.

Appendix D

NYSDOH Prevention Agenda

Prevention Agenda Priority Area	Focus Areas	Goals
Improve Health Status and Reduce Health Disparities	Improve Health Status and Reduce Health Disparities	Improve the health status of all New Yorkers
Promote a Healthy and Safe Environment	Injuries, Violence, and Occupational Health	Reduce fall risks among the most vulnerable populations
	Outdoor Air Quality	Reduce exposure to outdoor air pollutants, with a focus on burdened communities
	Built Environment	Improve the design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
		Improve the design and maintenance of home environments to promote health and reduce related illness
	Water Quality	Increase the percentage of State residents that receive optimally fluoridated drinking water
		Reduce potential public health risks related to drinking water and recreational water
Prevent Chronic Disease	Reduce Obesity in Children and Adults	Create community environments that promote and support healthy food and beverage choices and physical activity Prevent childhood obesity through early child care and schools
		Expand the role of health care and health service providers and insurers in obesity prevention
		Expand the role of public and private employers in obesity prevention
	Reduce illness, disability and death related to tobacco use and secondhand smoke exposure	Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations
		Promote tobacco use cessation, especially among low SES populations and those with poor mental health
		Eliminate exposure to secondhand smoke
	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote use of evidence-based care to manage chronic diseases
		Promote culturally relevant chronic disease self-management education

Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections	Vaccine-Preventable Diseases	Improve childhood and adolescent immunization rates
		Educate all parents about importance of immunizations
		Decrease the burden of pertussis disease
		Decrease the burden of influenza disease
		Decrease the burden of disease caused by human papillomavirus
	Human Immunodeficiency Virus (HIV)	Decrease HIV morbidity
		Increase early access to and retention in HIV care
	Sexually Transmitted Diseases (STDs)	Decrease STD morbidity
	Hepatitis C Virus (HCV)	Increase and coordinate HCV prevention and treatment capacity
	Healthcare-Associated Infections	Reduce Clostridium difficile (C. difficile) infections
		Reduce infections caused by multidrug resistant organisms
		Reduce device-associated infections
Promote Healthy Women, Infants, and Children	Maternal and Infant Health	Reduce premature births in New York State
		Increase the proportion of NYS babies who are breastfed
		Reduce the rate of maternal deaths in New York State
	Child Health	Increase the proportion of NYS children who receive comprehensive well child care in accordance with AAP guidelines
		Reduce the prevalence of dental caries among NYS children
	Preconception and Reproductive Health	Reduce the rate of adolescent and unplanned pregnancies in NYS
		Increase utilization of preventive health services among women of reproductive age to improve wellness, pregnancy outcomes and reduce recurrence of adverse birth outcomes

Promote Mental Health and Prevention Substance Abuse	Promote Mental, Emotional and Behavioral Health (MEB)	Promote mental, emotional and behavioral well-being in communities
	Prevent Substance Abuse and Other MEB Disorders	Prevent underage drinking, nonmedical use of prescription drugs by youth, and excessive use of alcohol consumption by adults
		Prevent and reduce occurrences of mental, emotional and behavioral disorders among youth and adults
		Prevent suicides among youth and adults
		Reduce tobacco use among adults who report poor mental health
	Strengthen Infrastructure Across Systems	Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery
		Strengthen infrastructure for mental, emotional behavioral health promotion, and mental, emotional behavioral disorder prevention

Source:

https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/tracking_indicators.pdf

Appendix E

Prioritization Tool/Final Prioritization Essex County

			NEED				FEASIBILITY/IMPACT		
			Demonstrated Need	Variance	Trend	Perceived Need	Confidence	Resources	Capacity
			Size (% or rate) of population affected	compared to Upstate NY	compared to previous assessment	Stakeholder survey	Perceived confidence in ability to address the issue - control level, stakeholder engagement/influence	Evidenced based interventions, funding & staffing	capacity to continue or do more to influence
	SCORING DEFINED		0=none/very small 1 = small 3=considerable 5=significant	0=better 1=same 3=worse 5=sig worse	0=better 1=same 3=worse 5=sig worse	0=4th or 5th priority 1= 3rd priority 3=2nd priority 5=1st priority	0=none/NA -small need 1=low 3 = fair 5=high	0=none/NA -small need 1=low 3 = fair 5=high	0=none/NA -small need 1=low 3 = fair 5=high
	RELATIVE WEIGHT	EIGHTED SCORE	2	1	2	0.5	2	2	1
Environmental Health	Injuries, Violence, and Occupational Health	26	5	3	3	0	1	3	1
	Outdoor Air Quality	4	1	0	1	0	0	0	0
	Built Environment	2	1	0	0	0	0	0	0
	Water Quality	3	1	1	0	0	0	0	0
Chronic Diseases	Obesity in Children and Adults	41.5	5	3	3	3	3	5	5
	Tobacco Use and Secondhand Smoke Exposure	16	3	1	0	0	1	3	1
	Chronic Disease Preventive Care and Management	47.5	5	5	5	3	3	5	5
Women, Infants, Children	Maternal and Infant Health	20	1	3	0	0	3	3	3
	Preconception and Reproductive Health	18	1	3	1	0	3	1	3
	Child Health	25	1	0	0	0	5	5	3
Communicable Diseases	HIV	0	0	0	0	0	0	0	0
	Sexually Transmitted Diseases	0	0	0	0	0	0	0	0
	Immunizations/Vaccine-Preventable Diseases	36	5	3	3	0	3	3	5
	Healthcare Associated Infections	26	1	1	1	0	3	5	5
MEB Health.SubstanceAbuse	Substance Abuse and Mental, Emotional, and Behavioral Health	36.5	3	3	3	5	5	3	3

Appendix F.1

**Essex County [Public] Health Department Community Health Improvement Plan 2014-2017
Summary Report 2014-2016**

Priority & Focus Areas 2013
Chronic Disease Prevention was the priority selected.

Focus areas were 1) reducing obesity in children and adults, and
　　　　　　2) increasing access to chronic disease preventive care management in clinical & community settings.

Outcome Summary (Overarching Objectives)

The color of the 2016 Assessment indicator numeric value indicates an improvement (green) or deterioration (red) for the indicator from the 2013 to 2016 assessment; it does not indicate whether the 2017 benchmark target was met.

Priority 1: Reducing Obesity in Children & Adults Overarching Objectives	2013 Assessment	2017 Benchmark Target	2016 Assessment
Reduce the percentage of children who are obese • WIC children (ages 2-4 years); and • among public school children	15.5%* 18.8%	NA* 16.7%	**17.1%** **16.6%**
Reduce the percentage of adults ages 18 years and older who are overweight or obese.	64.3%	59.3%	**68.6%**
Reduce the percent of adults ages 18 years + who are obese.	24.9%	23.0%	**32.2%**

* Data reported in the Community Health Assessment Essex County, NY 2103 for this indicator was reported as 46.5% with a benchmark of 45.7%. Between the 2013 and 2016 assessments the criteria used to meet the definition of obesity changed. Therefore the data as currently reported for that previous time period is currently reported as 15.5%. Source: http://www.health.ny.gov/statistics/chac/general/g72_15.htm

Priority 2: Increasing Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings Overarching Objectives	2013 Assessment	2017 Benchmark Target	2016 Assessment
Reduce the rate of All Cancer deaths (/100K)	263.9	204.1	**244.0**
Reduce the rate of Diseases of the Heart deaths (/100K) from 263	262.9	243.6	**258.3**
Reduce the rate of Diseases of the Heart premature deaths ages 35-64) (/100K) from 263	110.4**	NA	**115.3**
Reduce the rate of Diabetes deaths (/100K)	28.7	17.7	**31.6**

** Data reported in the Community Health Assessment Essex County, NY 2103 for this indicator was reported as 45.3 with a benchmark of 32.2. The rate as currently reported for that previous time period uses a different comparison population (crude rather than age adjusted) therefore reflecting a different rate. Current data still demonstrates an increase in premature deaths due to diseases of the heart when comparing 2013 to 2016 points in time. Source: http://www.health.ny.gov/statistics/chac/mortality/d5_15.htm

Obesity Prevention Goal Specific Objectives

1. Create **community environments** that promote and support healthy food and beverage choices and physical activity. *Communities of lower income will be targeted as a means of addressing the income disparity for food and activity access.*		
Objective	Target	Performance/Status as of December 2016 *Resource/Partner*
Increase visibility and access to affordable, nutritious foods and/or beverages through store layout and displays.	2	4 Store layout/display improvements plus 10 buy local racks with recipe cards. *Creating Healthy Places Grant*
Increase the number of municipalities that have passed local complete streets resolutions or policies.	10	14 Policy Adoption: Essex County; Chesterfield; Elizabethtown; Essex; Lewis; Minerva; Moriah; Village of Port Henry; Newcomb; North Hudson; Schroon; Westport; Willsboro; Wilmington. 2 Language in Comp Plans: North Elba; Ticonderoga. *Creating Healthy Places Grant*

2. Create **school environments** that promote and support healthy food and beverage choices and physical activity. *Schools with high percentages of free and reduced lunches will be targeted as a means of addressing the income disparity.*		
Objective	Target	Performance/Status as of December 2016 *Resource/Partner*
Increase the number of school districts with adopted competitive food policies and practices that meet or exceed the Institute of Medicine recommendations for competitive foods or sugar sweetened beverages.	2	2 Wellness Policy Updates to meet the Healthy Hunger Free Kids Act (HHFKA) standards: Elizabethtown-Lewis Central School; Crown Point Central School. 1 District with policy revisions under way: Moriah Central *NYS Health Foundation CHIP Grant*
Increase the number of school districts that meet or exceed NYS regulations for physical activity.	2	1 District exceeds the Required Instruction frequency for pupils in grades K-3 (participate in PE on a daily basis) by achieving K-5 daily PE: Elizabethtown-Lewis Central School. *District PE Instructor*

3. Expand the role of **health care and health service providers and insurers** in obesity prevention.
* As there are no birthing hospitals in Essex County, ECPH will strive to partner with hospitals outside of Essex County where babies are born.
**This objective and data is found under the Healthy Mother, Infants and Children though included here for its role in obesity prevention. Because WIC is an income dependent program and provides access to a lactation consultant, this objective addresses income and access disparities.

Objective	Target	Performance/Status as of December 2016 _Resource/Partner_
Increase the percentage of infants born in hospitals who receive any breast milk in delivery hospital.*	71.0%	80.1% '11-'13 ECHD staff assessed breastfeeding friendly policies for 3 local birthing hospitals (Champlain Valley Physician's Hospital, Glens Falls Hospital and Adirondack Medical Center) and Elizabethtown Community Hospital (non-birthing hospital) and their affiliate health centers. The Breast Feeding Friendly (BFF) Hospital designation is reported by the birthing hospitals as difficult to achieve due to expense and documentation. However they all 3 describe practices that follow the 10 steps to meet criteria for being Breastfeeding Friendly. All 3 hospitals also have designated breast pumping areas for staff and provide support ranging from available pumps to break time allowed. Elizabethtown Community Hospital adopted a BFF policy that includes the hospital & affiliate health centers as being breast feeding friendly & installed provided wall-art and table stands with images of women breastfeeding & stating, "Breast feeding welcome here.". _Adirondack Rural Health Network, Prevention Agenda Project_
Increase the percent of WIC women who breastfeed at 6 months. **	39.7%	19.9% WIC has 1 Certified Lactation Counselor. 1 ECHD RN became a Certified Lactation Counselor (CLC®) and sat for the International Board Certified Lactation Consultant® (IBCLC®) exam in October 2016. _Adirondack Rural Health Network, Prevention Agenda Project_
Increase the number of provider practices that use electronic health records to cue for counseling for overweight and obesity.	1	3 1 Hudson Headwater practices – Ticonderoga Health Ctr. 2 Adirondack Health practices – Keene & Lake Placid Health Centers _Obesity Prevention in Pediatric Health Care Setting Grant_

4. Expand the role of **public and private employers** in obesity prevention.
Patients, residents & others impacted by organizational nutrition are identified as having limited access to nutritionally valuable foods & beverages.

Objective	Target	Performance/Status as of December 2016 _Resource/Partner_
Establish a Learning Collaborative around organizational nutrition to build knowledge and practices of evidenced based strategies that create healthy foods and beverage policies, systems & environments.	NA	ECHD did not pursue the Learning Collaborative because Designing a Strong & Healthy New York (DASH NY) initiated a Learning Collaborative that served the same purpose. _NYSDOH_

Chronic Disease Prevention and Management Goal Specific Objectives

1. Increase **screening rates** for breast, cervical and colorectal cancers, especially among disparate populations. *Men and women without health insurance are the target for this goal thereby addressing the income disparity.*		
		Performance/Status as of December 2016
Objective	Target	*Resource/Partner*
Increase percent of breast cancer (mammography) screening within the last 2 years	79.7%	83.0% An outreach plan to reach those without health insurance was developed & implemented. Screening rates for low-income women is still unavailable. *Cancer Screening Program Grant*
Increase the screening percentages for colorectal cancers (through sigmoidoscopy or colonoscopy) within the last 10 years	62.9%	68.3% An outreach plan to reach those without health insurance was developed & implemented. Screening rates for low-income women & men is still unavailable. *Cancer Screening Program Grant*

2. Improve availability, accessibility and use of chronic disease **self-management education**. *Self-Management opportunity locations will be targeted to those communities with income and access disparities.*		
		Performance/Status as of December 2016
Objective	Target	*Resources/Partner*
Develop a promotion plan for existing chronic disease self-management (CDSM) opportunities (diabetes self-management, living with a chronic condition, others) and ensure on-going opportunities.	3	>=3 Diabetes Self-Management Series & Diabetes Support Group Cardiac Rehabilitation Programs Living Healthy with Chronic Conditions series Pulmonary Rehabilitation Program Alzheimer's Disease Third Age Adult Day Center & Care-giver Support Group Assessment of existing opportunities completed 2015. It included topic-specific programs (diabetes, arthritis, etc.) and different types of programs (lectures, community based, clinically based, independent learning/self-help, etc.). Completion of promotion plan anticipated by end of 2016. *SUNY Plattsburgh Nursing Internship Program*
Develop a promotion pan for existing internet (web or phone) application self-management support systems and promote systems.	1	1 Web and phone-app based opportunities assessment started. Completion of promotion plan anticipated by end of 2016. *SUNY Plattsburgh Nursing Internship Program*

Appendix F.2

Adirondack Health Community Health Needs Assessment & Community Service Plan

2016 CSP Summary Report
December 2016

2015-2016 Activities

Throughout 2015, Adirondack Health has continued nurturing partnerships at the core of our strategic plan to provide the foundation for improving the health of all our residents in our Adirondack communities.

In addition to providing the highest quality care for patients at our primary locations, we at Adirondack Health aim to apply our clinical strengths to support the health needs of the broader community throughout the Adirondack Region.

Through the Community Health Needs Assessment and the partnerships outlined in our Community Service Plan, we seek to create a platform for evidence-based health promotion and disease prevention at the community level, fostering healthy behavior change and reducing risk factors for disease.

Aligning with New York State, our three-year Community Service Plan (2013-2015) takes a child- and family-centered approach to our first focus of reducing risk factors for obesity in children and adults; and the second focus area of increasing access to high quality chronic disease preventive care and management in both clinical and community settings.

Progress

Adirondack Health continues with increased participation and progress with the following:

- Participating in DSRIP (Delivery System Reform Incentive Payment) with seven projects all of which are part of a comprehensive program to reduce hospital admissions and Emergency Department admissions by 5% per year over the next five years,   In our service area alone, over 800 homes will benefit from initiatives to provide healthcare in the home via either telemedicine by the patient themselves or with the assistance of home healthcare workers; and education and lifestyle changes for disease prevention. Project teams have been established and initial data analysis have been submitted to meet milestones. Projects have moved into the performance phase in 2016 and tools have been developed and implemented to determine benchmarks of patient healthcare status. To date all deliverables have been met. DSRIP funds are continuing to flow into these projects which are an investment in Population Health as the system ramps up to value based payment. Our projects align with the prevention agenda and Chronic Disease continues to be a focus area, with an emphasis on palliative care; as well as integration of behavioral health into primary care, among others.

- Our partnership with Adirondack Health Institute (AHI) helps us to expand regional collaboration among healthcare and social service providers serving the Adirondacks. AHI's goal is to help members and their communities navigate the ever changing health care industry through partnerships and collaboration. We are active in Medical Home through the ACO and considering Health Home as our next initiative.

- Using the National Diabetes Prevention Program as a model, Adirondack provided a pre-diabetes program for all Adirondack Health employees which has been proven to be successful and is just about completing Phase II of the program. To date there is low participation rate and efforts are being taken to increase awareness of the program and move it out into the community on a larger scale.

- Adirondack Health's obstetrical department is currently participating in the NYS Breastfeeding Quality Improvement in Hospitals Collaborative through February of 2016. In 2014 the Stafford New Life Center submitted a Peak of Excellence project on "Exclusive Breastfeeding Practices Quality Improvement Initiatives". The department was recognized for its ongoing efforts in promoting breastfeeding. Adirondack Medical Center's Stafford New Life Center continues to excel in promoting breastfeeding in the Adirondack park of NYS. A recent comparison study of all NYS hospitals rated our hospital 9th in the state in meeting Healthy People 2020 goals of Exclusive breastfeeding rates of at least 70% and any breastfeeding goal of 82%. As of October 2015 Adirondack Health's exclusive breastfeeding rate is@ 75.5% and any breastfeeding rate is @ 84.9%.

- Participating in a NYS grant from DOH with Clinton County Obesity Prevention in Pediatric Health Care Settings (OPPHCS), which provides for education materials and supplies for physical activity for pediatric providers. Educational materials are available in all four clinics for primary care providers to use when providing information on prevention of obesity in children. A Healthy Lifestyle Quiz has been incorporated into the EMR which allows for good data collection which is submitted to the County. Data analysis are sent to us monthly by County showing marked improvement and progress by each of our providers which provides nutrition, physical activity and screen time measures.

- Four community forums were held in late 2015 conducted by our CEO to convene community stakeholders to engage in robust discussions on emerging healthcare trends. Adirondack Health is committed to listen and learn to gain a shared understanding of the impact that health and healthcare has on the community.   Further dialogue was encouraged by both Adirondack Health and the community. For 2016, four informational lectures to inform everyone about how changes and trends might impact hospitals; and are being held as part of the endeavor to prompt community engagement and provide information as to how stakeholders can influence the hospital programs and processes.

- In late 2014, Adirondack Health began meeting with transgender advocates in the community as a result of them not feeling welcome at our facility. At that time, representatives of administration began meeting with the LGBTQ community members to put a plan together for education of staff and physicians, in order to respectfully treat LGBTQ patients in our system. During 2015, several educational programs were held with employees and physicians to educate them on the issues that LGBTQ patients face, their specific healthcare needs, and how AH had made changes to policies/protocols to assure that members of the LGBTQ community were treated respectfully and appropriately at AH. This was a huge success, and in 2016, more educational programs will be conducted in the community to continue educational efforts.

- The creation of a Women's Health Center is underway which will utilize our Women's Health Navigator, along with our published guidebook established in 2015-16 to help women navigate the intricate healthcare system and provide the necessary information for access to all women need throughout their lives and the lives of their family.

Appendix F.3

THE
University *of* Vermont
H E A L T H   N E T W O R K

Elizabethtown Community Hospital

Community Service Plan 2015 Update

To address needs identified in the community health needs assessment, Elizabethtown Community Hospital worked toward developing strategies and tactics independently through healthcare-based initiatives and also by engaging key community partners in implementing particular strategies. Acknowledging that many organizations and resources are already in place to address certain health needs within the community, Elizabethtown Community Hospital has strategically reviewed both internal and external resources to best meet the goals of the community service plan (CSP).

Many of the strategies and activities address risk factors associated with multiple health problems. For example, strategies to reduce obesity will affect heart disease and diabetes. These strategies also might have a positive impact on mental health, as will strategies to reduce substance abuse. Some strategies and activities outlined below have been in coordination with Essex County Public Health, or other health-oriented organizations in the area. Many of these strategies aligned with those of other community-based organizations, and other stakeholders have been engaged.

1. New York State Prevention Agenda Priority: Prevent / Manage Chronic Disease

Community Health Need: **The rate of diabetes in Essex County is increasing.** Many residents are at risk for developing diabetes or have poorly controlled diabetes. **Heart disease is the leading cause of death in Essex County.** Both of these issues contribute to emergent visits and hospitalizations. This is expected to increase as the population ages.

Priority	Goal	Intervention	ECH	Partner	Measurement
Prevent & manage chronic disease *By promoting evidence-based care.*	Improve access to primary care through PCP recruitment / establishment of community-based health centers.	Active recruitment of PCP and addition of hospital-owned, community-based health centers.	Human Resources Department, ECH medical staff & planning staff	Essex County Public Health - to help inform Essex County residents.	Addition of one primary care provider and one additional health center by 2015. Completed – Added community-based health center in Au Sable Forks, NY
	Increase the number of patients at the ECH network of community-based health centers.	Advertising strategies, and information provided to community organizations.	ECH Marketing department	Essex County Public Health.	Increase number of newly established adult patients at all ECH health centers by 10% by 2015. Completed- As of EOY 2014, this had been increased by 26%.
	Reduce the long-term effects of diabetes on patients of the hospital's community-based health centers.	Encourage patients with diabetes to take part in training by the hospital's CDE.	Medical & other clinical staff at ECH-owned health centers.	Cornell Cooperative Extension Adirondack Medical Home Project	Increase the number of patients taking part in the program by 15% by 2015. 2015- 138 Completed
	Ensure that patients from the hospital's service area receive cardiac rehabilitation after experiencing a cardiac issue.	Encourage patients to attend cardiac rehabilitation by increasing physician referrals.	ECH medical staff ECH Manager of Outpatient Services	CVPH Fletcher Allen Health Care	Increase the number of patients that take part in the program by 15% by 2015 62 took part in 2012 2013 = 32 2014= 62 2015=60
	Ensure that qualified patients from the hospital's service area receive pulmonary rehabilitation as required.	Encourage patients to attend pulmonary rehabilitation by increasing physician referrals.	ECH medical staff ECH Manager of Outpatient Services	CVPH Fletcher Allen Health Care	Plan and develop program. Aim for 15 patients each year by 2015. Program in place 2013 = 5 participants 2014= 7 2015= 6

2. New York State Prevention Agenda indicator:
Obesity

Community Health Need: **Obesity contributes to chronic disease prevalence** in Essex County.
Almost 25% of adults are obese (2008-09); **as are 12.5% of children** (2008-10).

Priority	Goal	Intervention	ECH	Partner	Measurement
Reduce Obesity in Children & Adults *By expanding the role of health care and providers in obesity prevention.*	Increase the number of new pediatric patients at the ECH community-based health center in Elizabethtown so that they can be under a physician's care; especially with regard to achieving / maintaining a healthy BMI.	Pediatrician assesses BMI at each well child visit; offers information regarding healthy eating, portion control and snack options.	ECH Marketing department. Elizabethtown Community Health Center ECH pediatrician	Essex County Public Health. Hudson Headwaters Health Network Local schools	Newly established pediatric patients at ECHC in 2012 = 79 Increase that by 10% to 87 by 2015. New ped pts: 2013 = 115 2014= 49 2015= 72 Completed
	Improve food options served at ECH for patients. Review and alter vending options for staff and visitors, as appropriate.	Assess food choices at ECH, in terms of vending options. Also assess and alter patient meals as appropriate to ensure healthy options.	ECH planning, nursing, food service, medical director.	Local vendor. Adirondack Community Action Program	Rise in patient satisfaction scores, in terms of quality of meals. Patient satisfaction score (quality of meals) in 2012 = 72.6% 2013 = 87.6% 2014= 80% 2015= 80% Completed
	Endeavor to become a Weight Watchers site for the local communities.	Search for group leader. Enlist physician support	ECH Clinical Services & Marketing Department. Funding organization (TBD)	Weight Watchers organization. Program leader (TBD). Organization to provide funding (TBD). Various organizations to solicit participants	Track number of participants and total weight loss of participants. Have not implemented this initiative. Could not get a representative to come to this area. Many attempts and meetings were had but it was not sustainable.
	Develop an employee wellness incentive program tied to the hospital's health insurance.	Take advantage of the Blue4U program through Excellus.	ECH Human Resources	Excellus	50% staff (who receive insurance from ECH) participation in the program by 2015. Started this program as of January 2014 and still in effect. 58% of staff that take health insurance participates in the wellness incentive.

Health Disparity: Access to care

Disparity	Goal	Intervention	ECH	Partner	Measurement
Access to care *Increase access to care for those in surrounding communities in terms of both opportunity and cost.*	Increase access to primary care in communities throughout Essex County	Increase number of primary care providers. Increase number of hospital-owned health centers	Planning. Medical Director. ECH marketing	Essex County Public Health News organizations	Increase number of newly established adult patients at all ECH health centers by 10% by 2015. Completed 2014= As of EOY 2014, this had been increased by 26%.
	Host 4 health fairs each year. Offer basic health assessment at each Involve ECH staff in the health fair organized by the certified diabetes educator to offer BMI, EKG, A1C	Make referrals to physicians within (close to) the participants' home communities.	ECH medical & clinical staff. ECH Marketing department	Essex County Public Health; Essex County Office for the Aging; Fidelis; Cornell Cooperative Extension; Cancer Screening Services Program of Essex and Franklin Counties; news organizations	Increase the number of total participants by 15% by 2015. There were 100 participants in 2012 Total participants: 2013 = 95 2014= 117 2015= 110
	Increase number of patients at ECH's community-based health centers that have access to a CDE	Hire a diabetes educator; ensure that health centers are accredited.	ECH nursing & planning departments.		Establish DSME program at health centers by 2015 Hired CDE to work for ECH and take referrals from community physicians and providers as well as health centers.

Appendix F.4

Moses Ludington Hospital
Community Service Plan Update
Summary of 2015

The Moses Ludington Hospital community service plan identifies the community health needs. Moses Ludington Hospital worked toward developing strategies and tactics independently through healthcare-based initiatives and also by engaging key community partners in implementing particular strategies. Acknowledging that many organizations and resources are already in place to address certain health needs within the community, Elizabethtown Community Hospital has strategically reviewed both internal and external resources to best meet the goals of the community service plan (CSP).

Many of the strategies and activities address risk factors associated with multiple health problems. For example, strategies to reduce obesity will affect heart disease and diabetes. These strategies also might have a positive impact on mental health, as will strategies to reduce substance abuse. Some strategies and activities outlined below have been in coordination with Essex County Public Health, or other health-oriented organizations in the area. Many of these strategies aligned with those of other community-based organizations, and other stakeholders.

Moses Ludington Hospital has attempted many tactics to reduce obesity in children and adults with minimal success in 2014, and 2015. Moses Ludington Hospital also has attempted to achieve tactics related to increasing access to high quality chronic disease preventative care and management in both the clinical and community setting. It should be noted Moses Ludington Hospital has been experiencing frequent leadership position changes relate to the financial future of the organization. The organization has experienced difficult financial distress in the last three years without improvement. In addition several programs were eliminated as a cost saving measure related to the financial distress of the organization.

New York Prevention Agenda
Results for 2014-2015

Priority: Reduce Obesity in Children and Adults

Goal	Intervention	MLH	Partner	Measurement	Intervention Status	Results
Expand the role of health care and health service providers and insurers in obesity prevention.	Dietary vendor, Unidine, will develop a plan for our café whereby the nutritional values of the main meals have been calculated and are on display for customers. A healthy option entitled OHSO Good™ will be available at each meal.	Director of Support Services	Unidine Corporation	Track how many meals purchased in our café are OHSO Good™. Aim for **15%** of purchased meals are OHSO Good™ Tracked monthly through specific cash register designation.	Program started **2015 UPDATE: OHSO Good meals are offered in the Café daily. Sales are not being tracked.**	OHSO Good Tracking Log.xlsx On average for 2014, 5.2% of the meals served in our café were OHSO Good™ option.
Expand the role of health care and health service providers and insurers in obesity prevention.	Promote internally and externally the free "MyFitnessPal" application for personal electronic devices.	Director of Clinical Services	Resource: www.myfitnesspal.com	Information provided in **100%** of employee benefits packages. Information provided in **100%** of health fair carry-bags provided to guests.	MLH had a health fair on October 21, 2014 with 25 exhibitors and 60 participants. This information was not included in the carry bags. MLH held its Annual Benefits Fair on November 14, 2014. This information was not provided at that event.	**2015 UPDATE: No information provided to staff/public.**
Expand the role of health care and health service providers and insurers in	Host educational programs for parents on limiting computer and TV time and use it as a reward for family exercise time. Function as "host site" for	Public Relations Committee	Hudson Headwaters Health Network Essex	Host two healthy lifestyles lectures.	MLH did not host any healthy lifestyles lectures in 2014. **2015 UPDATE: No lectures held in**	

obesity prevention.	healthy lifestyles lectures.		County Public Health		**2015.**	
Expand the role of health care and health service providers and insurers in obesity prevention.	Offer onsite aerobics or Zumba classes for a minimal fee.	Director of Support Services	TiNY Wellness Center	Offer aerobics or Zumba classes **1 night/week**. Track attendance.	Our partner for this initiative no longer has available instructors to offer classes on our campus. We have, however, asked if our employees could purchase reduced priced monthly memberships to the Wellness Center through our HR department. We are still working through that arrangement. **2015 UPDATE: No Classes being offered @ ILH. Discount not currently available.**	
Expand the role of health care and health service providers and insurers in obesity prevention.	Continue to offer use of our Therapy Department's gym equipment in the off-hours to employees for $5.00/month. Promote this benefit.	Therapy Department Human Resources	Moses Ludington Hospital	Provide information in **100%** of employee benefits packages. Track monthly membership. Membership tracked by Therapy Department	This benefit continues to employees. Additionally, we offer wellness gym membership to patients who have completed their outpatient rehab sessions for $5/month for three months, after which they can renew for	Employee Gym Memberships 2014: Jan 11 Feb 5 Mar 6 Apr 4 May 0 June 1 July 0 Aug 5 Sept 0 Oct 3

					another 3 months with physician approval.	Nov 2 Dec 1
					This benefit was included in the Employee Health Benefits Fair on November 14, 2014. **2015 UPDATE: This information continues to be offered to employees and rehab patients for $5/month. 2015 #'s – Employees: Jan. 3 Feb. 6 Mar. 3 Apr. 2 May 2 June 2 July 4 Aug. 2 Sept. 6 Oct. 7 Nov. 8** **Wellness: Jan. 21 Feb. 20 Mar. 20 Apr. 23 May 25**	Wellness Gym Memberships 2014 Jan 11 Feb 11 Mar 12 Apr 15 May 15 June 17 July 22 Aug 20 Sept 21 Oct 18 Nov 13 Dec 15

					June 23 **July 35** **Aug. 39** **Sept. 28** **Oct. 27** **Nov. 27**	
Expand the role of health care and health service providers and insurers in obesity prevention.	Provide Eat Smart NY information to Emergency Department patients and others.	Director of Clinical Services	Cornell Cooperative Extension	Distribute brochures in **100%** of the carry-bags provided to health fair guests.	This information was not distributed in the Health Fair carry bags. Our partner, Cornell Cooperative Extension advised their grant had expired leaving them unable to conduct community outreach. They were unable, therefore, to attend our Health Fair. **2015 UPDATE: Eat Smart New York/SNAP-Ed program representatives were at the ILH Health Fair on October 28th.**	

Priority: Increase Access to High Quality Chronic Disease Preventive Care and Management in both Clinical and Community Settings

Goal	Intervention	MLH	Partner	Measurement	Intervention Status	Results
Increase screenings rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.	Undertake educational campaign promoting mammograms and other cancer screenings.	Director of Clinical Services	Cancer Services Program Essex County Public Health	Provide educational materials at annual health fair. Publish ad in local newspaper during Breast Cancer Awareness Month.	Information was provided to the public at our Health Fair. Cancer Services of Essex/Franklin Counties had a booth along with Essex County Public Health. Free mammograms were offered by the Cancer Services Program and five exams were performed that day. During October an ad was placed in the local paper, "Times of Ti" for breast cancer awareness month. **2015 UPDATE: Cancer Services and Essex County Public Health at 2015 ILH Health Fair. Free mammograms offered in partnership w/Essex County Cancer Services during October**	

					2015 Health Fair. Ad placed in Times of Ti for Breast Cancer Awareness Month.	
Promote evidence-based care	Make referrals to the NY State Smokers' Quitline.	Director of Clinical Services	NY State Smokers' Quitline North Country Healthy Heart Network	Track number of referrals to NY State Smokers' Quitline. Query our HIS regarding cessation.	All ED patients are asked their smoking status and it is documented in our HIS. Patients identifying themselves as smokers are referred to the NY State Smokers' Quitline but we are not currently tracking those referrals. Data gleaned from our HIS for ED patients reporting changes in smoking status throughout the course of 2014:-Current Every Day Smoker →Former Smoker = 39 patients	
Promote culturally relevant chronic disease self-management education.	Invite a Pulmonologist to do a community presentation hosted by the hospital.	Administration	Fletcher Allen Healthcare Glens Falls Hospital	A Pulmonologist does a community presentation hosted by the hospital.	MLH is in talks currently with a Pulmonologist to provide services in our outpatient clinic. We have not yet arranged for a community presentation.	

					2015 UPDATE: To date, unable to secure a Pulmonologist s for our Outpatient Clinic.	

2017
Local Services Plan
For Mental Hygiene Services

Essex County Community Services
August 5, 2016

NEW YORK
STATE OF
OPPORTUNITY.

Office of
Mental Health | Office of Alcoholism and
Substance Abuse Services | Office for People With
Developmental Disabilities

Table of Contents

Planning Form	LGU/Provider/PRU	Status
Essex County Community Services	**70060**	**(LGU)**
Executive Summary	Optional	**Not Completed**
Needs Assessment Report	Required	**Certified**
Multiple Disabilities Considerations Form	Required	**Certified**
Priority Outcomes Form	Required	**Certified**
Community Services Board Roster	Required	**Certified**
OMH Transformation Plan Survey	Required	**Certified**
LGU Emergency Manager Contact Information	Required	**Certified**
Mental Hygiene Local Planning Assurance	Required	**Certified**

2017 Needs Assessment Report
Essex County Community Services (70060) Certified: Stephen Valley (5/31/16)

Consult the LSP Guidelines for additional guidance on completing this exercise.
PART A: Local Needs Assessment

1. **Assessment of Mental Hygiene and Associated Issues** - In this section, describe the nature and extent of mental hygiene disabilities and related issues. Use this section to identify any unique conditions or circumstances in the county that impact these issues. You have the option to attach documentation, as appropriate.

The prevalence and severity of mental hygiene disabilities in Essex County are consistent with the norm for the rest of NYS. The impact of these issues is compounded by the rural nature of the county, its' lack of job opportunities and resultant poverty, and social isolation.

2. **Analysis of Service Needs and Gaps** - In this section, describe and quantify (where possible) the prevention, treatment and recovery support service needs of each disability population, including other individualized person-centered supports and services. Describe the capacity of existing resources available to meet the identified needs, including those services that are accessed outside of the county and outside the funded and certified service system. Describe the gaps between services needed and services provided. Describe existing barriers to accessing needed services. Identify specific underserved populations or populations that require specialized services. You have the option to attach documentation, as appropriate.

Essex County has a limited number of providers for services. There is one county operated outpatient mental health clinic with one psychiatrist. Private MH practitioners are few and far between. MHA provides Health Home Care Management, supported housing, employment & vocational services, community outreach and mobile crisis outreach. They plan to provide HCBS services when HARPs are implemented in 2016. Families First provides community-based services to youth and families including; HCBS Waiver, ICM, family support and crisis respite. Mountain Lakes Services provides an array of basic services for the DD population. St Joseph's Addiction Treatment & Recovery Centers operates outpatient clinics in four locations. The Substance Abuse Prevention Team provides school and community based prevention curricula, counseling and consultation. These agencies have limited capacity to provide the depth and breadth of services relative to the needs presented by the population. The primary barrier to accessing services is lack of affordable, reliable transportation. There are no inpatient services for mental health or alcohol & substance abuse treatment in the county. Residents of Essex must travel to neighboring counties to the north or south for those services. The child & adolescent MH unit in Clinton county recently stopped admission of children under the age of 12, forcing local families to decide between placing their young children in facilities hundreds of miles away, or waiting for a closer bed to open. There are no residential treatment facilities in Essex County for mental health or substance abuse. There is a great lack of resources that will be necessary to intervene successfully with the forensic system to address mental health and substance abuse issues, especially related to the heroin/opiate epidemic. We cold benefit greatly from funding to support initiatives such Sequential Intercept Mapping and Crisis Intervention Teams.

3. **Assessment of Local Needs** - For each category listed in this section, indicate the extent to which it is an area of need by checking the appropriate check box under "High", "Moderate", or "Low" for each population: Youth (Under 21) and Adults (21 and Over). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation. For each issue that you identify as a "High" need, answer the follow-up question to provide additional detail.

Issue Category	Youth (< 21)			Adult (21+)		
	High	Moderate	Low	High	Moderate	Low
Substance Use Disorder Services:						
a) Prevention Services	●	○	○	○	●	○
b) Crisis Services	○	●	○	●	○	○
c) Inpatient Treatment Services	●	○	○	●	○	○
d) Opioid Treatment Services	●	○	○	●	○	○
e) Outpatient Treatment Services	○	●	○	○	●	○
f) Residential Treatment Services	○	○	●	○	●	○
g) Housing.	○	●	○	●	○	○
h) Transportation.	○	●	○	○	●	○
i) Other Recovery Support Services	○	●	○	○	●	○
j) Workforce Recruitment and Retention	●	○	○	●	○	○
k) Coordination/Integration with Other Systems	○	●	○	○	●	○
l) Other (specify):	○	○	○	○	○	○
Mental Health Services:						
m) Prevention	●	○	○	●	○	○
	●	○	○	●	○	○
	○	●	○	○	●	○
	○	●	○	●	○	○
	○	●	○	○	●	○
	●	○	○	○	●	○
				●	○	○
	●	○	○			
	○	●	○	○	●	○

v) Housing	○	●	○	●	○	○
w) Transportation	○	●	○	○	●	○
x) Workforce Recruitment and Retention	●	○	○	●	○	○
y) Coordination/Integration with Other Systems	●	○	○	●	○	○
z) Other (specify):	○	○	○	○	○	○
Developmental Disability Services:						
aa) Crisis Services	●	○	○	●	○	○
bb) Clinical Services	○	●	○	○	●	○
cc) Children Services	○	●	○			
dd) Adult Services				○	○	●
ee) Student/Transition Services	○	○	●	○	○	●
ff) Respite Services	●	○	○	●	○	○
gg) Family Supports	○	●	○	○	●	○
hh) Self-Directed Services	○	●	○	○	●	○
ii) Autism Services	●	○	○	●	○	○
jj) Person Centered Planning	○	●	○	○	●	○
	○	●	○	○	●	○
	○	●	○	○	●	○
	○	●	○	●	○	○
	○	●	○	○	●	○
	○	●	○	●	○	○
	●	○	○	●	○	○
	○	●	○	○	●	○
	○	○	○	○	○	○

Follow-up Questions to "Prevention Services" (Question 3a)

3a1. Briefly describe the issue and why it is a high need for the populations selected.
With age of use becoming younger and younger, prevention is at it's highest need. Expansion of prevention services to all schools in the county is critical, to combat the trend of gateway drug use leading to heroin, and heroin and Rx opiate use is increasing among teens

Follow-up Questions to "Crisis Services" (Question 3b)

3b1. Briefly describe the issue and why it is a high need for the populations selected.
Need for accessible detox services and response to opiate-related ODs.

Follow-up Questions to "Inpatient Treatment Services" (Question 3c)

3c1. Briefly describe the issue and why it is a high need for the populations selected.
Insurance authorization / approval is a major obstacle.

Follow-up Questions to "Opioid Treatment Services" (Question 3d)

3d1. Briefly describe the issue and why it is a high need for the populations selected.
Opiate addiction has surpassed all other substances in prevalence and scope.

Follow-up Questions to "Housing" (Question 3g)

3g1. Briefly describe the issue and why it is a high need for the populations selected.
Affordable, stable housing is a primary social determinant of health and recovery for people with SUDs.

Follow-up Questions to "Workforce Recruitment and Retention" (Question 3j) 3j1.

Briefly describe the issue and why it is a high need for the populations selected.
If systems transformation and implementation of MMC are to succeed, there will need to be a significant increase in the number of trained professionals in the Substance Abuse field.

Follow-up Questions to "Prevention" (Question 3m)

3m1. Briefly describe the issue and why it is a high need for the populations selected.
For both youth and adults, preventative services can help lessen the number of high needs services (and the associated costs) necessary at a later date. There is also a critical need for more substantial, sustainable state aid to support suicide prevention coalitions across the state.

Follow-up Questions to "Crisis Services" (Question 3n)

3n1. Briefly describe the issue and why it is a high need for the populations selected.
Crisis intervention services will be critical in order for us to meet NYS's goal to reduce hospital/ER admissions.

Follow-up Questions to "Clinic Treatment Services" (Question 3p)

3p1. Briefly describe the issue and why it is a high need for the populations selected.
Integration of outpatient MH services in primary care will increase access for rural citizens, who must often travel long distances for clinic tx. NYS could help facilitate this by relaxing regulatory restrictions and reimbursement limits.

Follow-up Questions to "Care Coordination" (Question 3r)

3r1. Briefly describe the issue and why it is a high need for the populations selected.
Implementation of Health Homes for children is expected on 9.1.2016.

Follow-up Questions to "HARP HCBS Services (Adult)" (Question 3s)

3s1. Briefly describe the issue and why it is a high need for the populations selected.
Implementation is pending in upstate NY.

Follow-up Questions to "HCBS Waiver Services (Children)" (Question 3t)

3t1. Briefly describe the issue and why it is a high need for the populations selected.
These are the essential services that kids and families need to maintain stability and to remain at home with their families.

Follow-up Questions to "Housing" (Question 3v)

3v1. Briefly describe the issue and why it is a high need for the populations selected.
Affordable, stable housing is a primary social determinant of health and recovery for people with mental illnesses.

Follow-up Questions to "Workforce Recruitment and Retention" (Question 3x) 3x1.

Briefly describe the issue and why it is a high need for the populations selected.
If systems transformation, integration of care and implementation of MMC are to succeed, there will need to be a significant increase in the number of trained mental health professionals including: psychiatrists, LCSWs and peers.

Follow-up Questions to "Coordination/Integration with Other Systems" (Question 3y) 3y1.

Briefly describe the issue and why it is a high need for the populations selected.
We are seeing a consistent trend of individuals who suffer from a number of co-occurring disorders and conditions that require services from a spectrum of systems.

Follow-up Questions to "Crisis Services" (Question 3aa)

3aa1. Briefly describe the issue and why it is a high need for the populations selected.
Our DD provider is seeing increasing numbers of consumers who are diagnosed with co-occurring mental health disorders. When these individuals experience a acute Mh or behavioral symptoms, the traditional MH crisis services are not appropriate to meet their needs, so they often end up being transported to the ER to be evaluated for admission to the MHU.

Follow-up Questions to "Respite Services" (Question 3ff)

3ff1. Briefly describe the issue and why it is a high need for the populations selected.
As a follow-up to the above description for 3aa1., there is a need for respite services as a stand-alone apart from the community residences. This would provide an option to the hospital/ER when consumer is in crisis.

Follow-up Questions to "Autism Services" (Question 3ii)

3ii1. Briefly describe the issue and why it is a high need for the populations selected.
We are experiencing increased numbers of youths and adults who are diagnosed with autism spectrum disorders. It is often a long and difficult task to get through the

"Front Door" and establish that these individuals qualify for DD services, if they do at all. In the meantime, they end up using resources from other sources, usually the mental health system. This happens too frequently with youth who are given OMH HCBS waiver slots with the goal of establishing OPWDD eligibility.

Follow-up Questions to "Transportation" (Question 3mm)

3mm1. Briefly describe the issue and why it is a high need for the populations selected.
Essex County is a large, sparsely populated county without a main population center. Public transportation is minimal at best. Families are forced to travel long distances for goods and services.

Follow-up Questions to "Employment" (Question 3oo)

3oo1. Briefly describe the issue and why it is a high need for the populations selected.
This is in relation to the impact of the state plan to transition from sheltered workshops to more integrated work settings. This is a rural county with limited job opportunities, which creates an additional challenges in finding community based work sites for this disabled population.

Follow-up Questions to "Workforce Recruitment and Retention" (Question 3pp) 3pp1.

Briefly describe the issue and why it is a high need for the populations selected.
This is a chronic issue that will likely become more of a challenge as the NYS minimum wage initiative is implemented in the upcoming years.

Local needs generally do not change significantly from one year to the next. It often takes years of planning, policy change, and action to see real change. In an effort to assess what changes may be happening more rapidly across the state, indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year.

4. How have the overall needs of the **mental health** population changed in the past year?
○ a) Overall needs have stayed about the same.
○ b) Overall needs have improved.
◉ c) Overall needs have worsened.
○ d) Overall needs have been a mix of improvement and worsening.
○ e) Not sure.

4c. If you would like to elaborate on why you believe the overall needs of the mental health population have worsened over the past year, briefly describe here

5. How have the overall needs of the **substance use disorder** population changed in the past year?
○ a) Overall needs have stayed about the same.
○ b) Overall needs have improved.
◉ c) Overall needs have worsened.
○ d) Overall needs have been a mix of improvement and worsening.
○ e) Not sure.

5c. If you would like to elaborate on why you believe the overall needs of the substance use disorder population have worsened over the past year, briefly describe here

6. How have the overall needs of the **developmentally disabled** population changed in the past year?
○ a) Overall needs have stayed about the same.
○ b) Overall needs have improved.
○ c) Overall needs have worsened.
◉ d) Overall needs have been a mix of improvement and worsening.
○ e) Not sure.

6d. If you would like to elaborate on why you believe the overall needs of the developmentally disabled population have been a mix of improvement and worsening over the past year, briefly describe here

In addition to working with local mental hygiene agencies, LGUs frequently work with other government and non-government agencies within the county and with other LGUs in their region to identify and address the major issues that have a cross-system or regional impact. The following questions ask about the nature and extent of those collaborative planning activities.

7. In the past year, has your agency been included in collaborative planning activities related to the Prevention Agenda 2013-2018 with your Local Health Department?
◉ a. Yes
○ b. No

7a. Briefly describe those planning activities with your Local Health Department.

We have worked together on the Essex County Suicide Prevention Coalition and the Essex County Heroin and Opiate (ECHO) Prevention Coalition.

8. In the past year, has your agency participated in collaborative planning activities with other local government agencies and non-government organizations?

⦿ a. Yes
◯ b. No

8a. Briefly describe those planning activities with other local government agencies and non-government organizations.

DSRIP PPS (Adirondack Health Institute), PHIP (Adirondack Health Institute), the Essex County Child and Family Serving System, and the Franklin Essex Housing Coalition (HUD Continuum of Care.

9. In the past year, has your agency participated in collaborative planning activities with other other LGUs in your region?

⦿ a. Yes
◯ b. No

9a. List each activity and the LGU(s) involved in that collaboration and provide a brief (one or two sentence) description of the activity.

The North Country Regional Directors of the CLMHD meets regularly, 5-6 times per year including a 2-day retreat, to discuss common needs & challenges and to share resources & ideas. While there is no formal process of needs assessment, common themes are regularly identified.

9b. Did your collaborative planning activities with other LGUs in your region include identifying common needs that should be addressed at a regional level?

⦿ a. Yes
◯ b. No

9c. Did the counties in your region reach a consensus on what the regional needs are?

⦿ a. Yes
◯ b. No

9d. Briefly describe the consensus needs identified by the counties in your region

The top priorities are: integration of services, suicide prevention/intervention, availability of safe, affordable housing, access to services and opiate abuse prevention/intervention.

2017 Multiple Disabilities Considerations Form Essex County Community Services (70060) Certified:
Stephen Valley (3/28/16)

Consult the LSP Guidelines for additional guidance on completing this form.
LGU: Essex County Community Services (70060)

The term "multiple disabilities" means, in this context, persons who have at least two of the following disabling conditions: a developmental disability, a mental illness, or an addiction. In order to effectively meet the needs of these individuals, several aspects should be addressed in a comprehensive plan for services. Accordingly:

1. Is there a component of the local governmental unit which is responsible for identifying persons with multiple disabilities?

Y◯ No
◉

If yes, briefly describe the mechanism used to identify such persons:

2. Is there a component of the local governmental unit which is responsible for planning of services for persons with multiple disabilities?

Y◉ No
◯

If yes, briefly describe the mechanism used in the planning process:

The Community Services Board has a meeting format which is designed to encourage a more integrated approach to planning and service delivery.

Members of all three Subcommittees (Mental Health, Substance Abuse and Developmental Disabilities) attend a combined Subcommittee meeting each month. Agency reports during Subcommittee meetings will be limited to a brief verbal review of a previously-submitted written report. This allows more time for the Subcommittee members from each disability area to learn more about the other disabilities outside their primary area of focus, with respect to the needs and challenges facing both individuals in our county and the providing agencies. This also provides opportunities for provider representatives to discuss improved collaboration to better serve individuals with multiple disabilities. From this perspective, the Subcommittees are better able to report information and recommendations to the CSB as it carries out the local planning process throughout the year.

3. Are there mechanisms at the local or county level, either formal or informal in nature, for resolving disputes concerning provider responsibility for serving persons with multiple disabilities?

Y◉ No
◯

If yes, describe the process(es), either formal or informal, for resolving disputes at the local or county level and/or at other levels of organization for those persons affected by multiple disabilities:

We have found that the best method for resolving such disputes is prevention. We have very active SPOA committees for both children and adults, with robust participation from a broad spectrum of providers representing multiple disabilities. Adhering ot a client-centered approach tends to resolve most issues before they reach the level of a dispute. In cases where consensus cannot be reached, agency executives or managers are encouraged to meet to resolve the issue. The Director of Community Services is available as a mediator whenever necessary to facilitate an agreement.

Mental Hygiene Priority Outcomes Form Essex County Community Services (70060) Plan Year: 2017
Certified: Stephen Valley (5/20/16)

Consult the LSP Guidelines for additional guidance on completing this form.

2017 Priority Outcomes - Please note that to enter information into the new items under each priority, you must click on the "Edit" link next to the appropriate Priority Outcome number.

Priority Outcome 1:

Enhance integration of care within the Essex County service system.

Progress Report: (optional) *new*
All of Essex County's CSB agencies have joined the DSRIP PPS and have participated in planning of clinical integration projects. Clinicians at the County MH clinic and St Joseph's Rehab Ctr have received Integrated Mental Health / Addictions Treatment training. The County MH clinic has received a VAP award to establish satellite clinics in two community health centers and to add an RN to the MH clinic staff.

Priority Rank: 1

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new*

- ☑ The State Health Innovation Plan (SHIP)/State Innovation Models (SIM)
- ☑ Population Health Improvement Plan (PHIP)
- ☑ Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
- ☑ Adult Medicaid Behavioral Health Managed Care Implementation
- ☑ Child Medicaid Behavioral Health Managed Care Implementation

Is this priority also a Regional Priority? *new* Yes

Strategy 1.1

Integrate mental health and substance abuse with primary care services to promote coordination of care for both services.
Applicable State Agencies: OASAS OMH

Strategy 1.2

Promote expanded use of brief mental health and wellness screenings in primary care, other healthcare settings and schools.
Applicable State Agency: OMH

Strategy 1.3

Expand awareness and use of brief substance abuse screenings and interventions in healthcare, social service, forensic and school settings.
Applicable State Agency: OASAS

Strategy 1.4

Increase the number of substance abuse & mental health clinicians who have been trained in integrated treatment for co-occurring disorders.
Applicable State Agencies: OASAS OMH

Strategy 1.5

Increase representation of medical health care and prevention on CSB and Subcommittees.
Applicable State Agencies: OASAS OMH OPWDD

Strategy 1.6

Identify and inventory barriers to providing services to dually diagnosed individuals.
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 2:

Provide readily accessible behavioral health services that will allow access to appropriate level of service and providers.

Progress Report: (optional) *new*
Strategies 2.3 through 2.6 are all new for 2017. All contract agencies have joined the DSRIP PPS and are poised to participate for implementation of the Community Crisis Stabilization project.

Priority Rank: 2

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new*

- ☑ The Prevention Agenda 2013-2018
- ☑ The State Health Innovation Plan (SHIP)/State Innovation Models
- ☑ (SIM) Population Health Improvement Plan (PHIP)
- ☑ Medicaid Delivery System Reform Incentive Payment Program
- ☑ (DSRIP) Adult Medicaid Behavioral Health Managed Care
- ☑ Implementation
- ☑ Child Medicaid Behavioral Health Managed Care Implementation
- ☑ Combat Heroin and Prescription Drug Abuse
  OPWDD People First Transformation

Is this priority also a Regional Priority? *new* Yes

Strategy 2.1

Establish a plan to provide Behavioral Health Community Crisis Stabilization Services to include mobile crisis teams, ER diversion protocols and observation/stabilization units.
Applicable State Agencies: OASAS OMH OPWDD

Strategy 2.2

Increase availability of respite services for children and families.
Applicable State Agencies: OASAS OMH OPWDD

Strategy 2.3

Participate in the implementation process for the regional detox programs, and advocate for development of a plan to ensure that Essex County residents have access.
Applicable State Agencies: OASAS OMH

Strategy 2.4

Explore expanded hours of operation for clinics and community programs, to include evenings and weekends.
Applicable State Agencies: OASAS OMH OPWDD

Strategy 2.5

Determine the availability of Medically Assisted Treatment (MAT) in all regions of the county.
Applicable State Agency: OASAS

Priority Outcome 3:

Increase availability of supportive/therapeutic housing for County residents with serious mental illness or diseases of addiction.

Progress Report: (optional) *new*
Strategy 3.3 is new for the 2017 plan. MHA has applied for funding opportunities through OMH and the Franklin Essex Housing Coalition / HUD, but did not receive any awards.

Priority Rank: 3

Applicable State Agencies: OASAS OMH

Aligned State Initiative: *new*

☑ The Prevention Agenda 2013-2018 Population
☑ Health Improvement Plan (PHIP) OMH
☑ Transformation Plan

Is this priority also a Regional Priority? *new* Yes

Strategy 3.1

Secure sustainable funding to reestablish MHA's Intensive Supported Housing Pilot Project.
Applicable State Agencies: OASAS OMH

Strategy 3.2

Monitor initiatives from OMH, OASAS, HUD and DSRIP and identify opportunities for development of sustainable housing programs for county residents.
Applicable State Agencies: OASAS OMH

Strategy 3.3

Pursue OASAS Residential Redesign opportunities to increase availability of local residential treatment options and short-term crisis/respite services for individuals with substance use disorders.
Applicable State Agency: OASAS

Priority Outcome 4:

Increase the understanding among clients/consumers of the risks of regular marijuana use, countering the trend in increasing approval of marijuana use nationally.

Progress Report: (optional)*new* **Priority**

Rank: *Unranked*

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative:*new*

The Prevention Agenda 2013-2018

Is this priority also a Regional Priority?*new* No

Strategy 4.1

CSB providers will incorporate accurate information regarding current scientific research about marijuana effects and potential for addiction/harm into messaging with their clients/consumers, as appropriate in their settings.
Applicable State Agencies: OASAS OMH OPWDD

Strategy 4.2

Provide training/dialogue sessions with provider staff about the research basis for concern of the harmful effects of regularly marijuana use and its addictive potential.
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 5:

Monitor efforts in Essex County to reduce the impact of heroin/opiate use among county residents.

Progress Report: (optional)*new*
Several CSB contract agencies have participated in the formation of the Essex County Heroin & Opiate (ECHO) Coaltion.

Priority Rank: 4

Applicable State Agencies: OASAS OMH

Aligned State Initiative:*new*

- ☑ The Prevention Agenda 2013-2018
- ☑ Medicaid Delivery System Reform Incentive Payment Program
- ☑ (DSRIP) Adult Medicaid Behavioral Health Managed Care
- ☑ Implementation Combat Heroin and Prescription Drug Abuse
- ☑ Talk2Prevent

Is this priority also a Regional Priority?*new* Yes

Strategy 5.1

Participate in the Essex County Heroin/Opiate Coalition.
Applicable State Agencies: OASAS OMH

Priority Outcome 6:

Decrease the suicide rate for children and adults in Essex County.

Progress Report: (optional)*new*
The suicide rate for Essex County continues to be well above the statewide rate. The Essex County Suicide prevention Coalition has been active in providing school based programming and training, as well as community awareness events and gatekeeper training.

Priority Rank: 5

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative:*new*

☑ The Prevention Agenda 2013-2018

Is this priority also a Regional Priority? *new* Yes

Strategy 6.1

Collaborate with the NYS Suicide Prevention Initiative to provide training and technical support for local school districts to effectively address youth suicide, discuss and plan prevention strategies and keep at-risk students safe.
Applicable State Agencies: OASAS OMH

Strategy 6.2

Collaborate with the NYSSPI to provide Gatekeeper and Community Training/Education to raise suicide awareness, knowledge and skills for stakeholders, service providers and community members, including veterans.
Applicable State Agencies: OASAS OMH

Priority Outcome 7:

Increase consumer involvement in the local service system.

Progress Report: (optional) *new*
4 out of 6 CSB contract agencies have implemented plans to recruit and train consumers. There is representation od consumers on all boards, including the CSB and it's subcommittees. Most agencies have consumers on staff, some in leadership positions.

Priority Rank: *Unranked*

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative:*new*

☑ OPWDD People First Transformation

Is this priority also a Regional Priority? *new* No

Strategy 7.1

Increase outreach and engagement of consumers and family members to participate in the system.
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 8:

Ensure adequate vocational opportunities for the supported populations.

Progress Report: (optional) *new*
This is a new Priority for 2017. Mountain Lakes Services has already begun preparations for the transition from the Sheltered Workshop model to more integrated work settings.

Priority Rank: *Unranked*

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative:*new*

☑ The Prevention Agenda 2013-2018
☑ Population Health Improvement Plan (PHIP)
☑ OPWDD People First Transformation

Is this priority also a Regional Priority? *new* Not Sure

Strategy 8.1

Implement a plan to transition from the Sheltered Workshop model to more integrated work settings while maintaining prevocational funding.
Applicable State Agency: OPWDD

Strategy 8.2

CSB agencies will monitor, then apply for new funding opportunities to increase supported employment services.
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 9:Reduce the incidence of tobacco use and dependence among behavioral health consumers in Essex County

Progress Report: (optional)*new*
This is a new Priority for 2017. Several CSB agencies have already begun work with the North Country Health Heart Network.

Priority Rank: *Unranked*

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative:*new*

- ☑ The Prevention Agenda 2013-2018
- ☑ Population Health Improvement Plan (PHIP)
- ☑ Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
- ☑ Adult Medicaid Behavioral Health Managed Care Implementation

Is this priority also a Regional Priority? *new* Not Sure

Strategy 9.1

CSB agencies will partner with the North Country Health Heart Network to develop and begin implementation of policies that ensure all tobacco using consumers have the opportunity to receive evidence-based tobacco cessation treatment.
Applicable State Agencies: OASAS OMH OPWDD**2017 Community Service Board Roster** Essex County Community Services (70060) Certified: Stephen Valley (3/28/16)

Consult the LSP Guidelines for additional guidance on completing this form.

Note: There must be 15 board members (counties under 100,000 population may opt for a 9-member board). Indicate if member is a licensed physician or certified psychologist. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the particular community interest being represented. Members shall serve four-year staggered terms.

Chairperson		Member Name	
Name	Geoff Neu No	Physician Psychologist	George King No
Physician	No	Represents Term	No
Psychologist	Community Member	Expires eMail	Provider Agency
Represents	12/31/2016		12/31/2018
Term Expires	geobasics@hotmail.com		kinggeo@westelcom.com
eMail			

Member		Member Name	
Name	George Anderson		John O'Neill
Physician	No No	Physician Psychologist	No No
Psychologist	Community Member	Represents Term	DSS Commissioner
Represents	12/31/2018	Expires eMail	12/31/2018
Term Expires	ganderson004@nycap.rr.com		johno@co.essex.ny.us
eMail			

Member		Member Name	
Name	Carolyn Sicher		Mary Bell
Physician	No Yes	Physician Psychologist	No No
Psychologist	Provider Agency	Represents Term	Community Member
Represents	12/31/2019	Expires eMail	12/31/2019
Term Expires	csicher@gmail.com		bellme996@gmail.com
eMail			

Member		Member Name	
Name	Charles Harrington		Lynne Macco
Physician	No No	Physician Psychologist	Yes No
Psychologist	Board of Supervisors	Represents Term	Physician
Represents	12/31/2019	Expires eMail	12/31/2016
Term Expires	cwharrington@cptelco.net		lemacco@gmail.com
eMail			

Member		Member Name	
Name	John Tibbits		Cliff Johnson
Physician	No No	Physician Psychologist	No No
Psychologist	State Police	Represents Term	Consumer
Represents	12/31/2016	Expires eMail	12/31/2017
Term Expires	John.Tibbitts@troopers.ny.gov		t7x70.clif@aol.com
eMail			

Member		Member Name	
Name	JoAnn Morris		Clay Reaser
Physician	No No	Physician Psychologist	No No
Psychologist	Public Health	Represents Term	Community Member
Represents	12/31/2017	Expires eMail	12/31/2017
Term Expires	jmorris@co.essex.ny.us		claytonreaser@mac.com
eMail			

OMH Transformation Plan Survey
Essex County Community Services (70060) Certified: Stephen Valley (3/28/16)

Consult the LSP Guidelines for additional guidance on completing this exercise.

The OMH Transformation Plan aims to rebalance the agency's institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so the Plan will strengthen and broaden the public mental health system to enhance the community safety net; allowing more individuals with mental illness to be supported with high quality, cost-effective services within home and community-based settings and avoid costly inpatient psychiatric stays.

Beginning with the State fiscal year (SFY) 2014-15 State Budget and continuing through SFY 2015-16, the OMH Transformation Plan "pre-invested" $59 million annualized into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay. In addition, $15 million has been reinvested from Article 28 and 31 inpatient facilities to further support the OMH Transformation Plan goals.

1. Did your LGU/County receive OMH Transformation Plan Reinvestment Resources (State and Locally funded) over the last year?

◉ a) Yes

◯ b) No

◯ c) Don't know

If "Yes":
Please briefly describe any impacts the reinvestment resources have had since implementation, particularly as it relates to impacts in State or community inpatient utilization. If known, identify which types of services/programs have made such impacts.
We have received additional System Transformation Plan funds in the amount of $46,832 that has been allocated evenly between two community agencies. MHA in Essex County has expanded their mobile crisis services in preparation for implementation of HCBS services under Medicaid Managed Care and the DSRIP Crisis Stabilization Project. Families First in Essex County has hired a Coordinator of Direct Services who has begun to develop and implement a plan to expand community based services for children and families. This has enabled FF to improve it's readiness for the expansion of services under the proposed HCBS waiver. Essex County has also received funding for three additional RPC Supported Housing slots. To this date we have only been able to fill one of those slots.
This has been due to a lack of viable referrals from the OMH Psych centers and Article 28 hospitals.

2. Please provide any other comments regarding Transformation Plan investments and planning.
Please direct any future "reinvestment" directly to the LGU, and away from state services for programs like MIT, etc.

LGU Emergency Manager Contact Information Essex County Community Services (70060)
Certified: Stephen Valley (3/28/16)

Emergency Manager contact information is necessary in order for OASAS to communicate directly with each LGU and OASAS-certified treatment program to ensure proper planning and preparedness during emergency situations. A rapid and coordinated response to an emergency is necessary to ensure the safety of staff and patients and continuity of care. The information entered here will be maintained in CPS until it can be incorporated into the OASAS Provider Directory System (PDS) where other program contact information is maintained

All questions regarding this survey should be directed to Kevin Doherty, OASAS Emergency Manager, at (518) 485-1983, or at KevinDoherty@oasas.ny.gov.

First Name: Annie
Last Name: McKinley
Job Title: Assistant Director
Email Address: amckinley@co.essex.ny.us
Main Work Phone: 518-873-3670 **Desk Work Phone:** 518-873-3670 **Home Phone:**   518-962-8346
Mobile Phone: 518-572-2300

NOTE: To ensure privacy, home and mobile phone numbers will not be displayed in CPS output reports.

2017 Mental Hygiene Local Planning Assurance Essex County Community Services (70060) Certified:
Stephen Valley (3/28/16)

Consult the LSP Guidelines for additional guidance on completing this form.

Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies; persons and families who receive services and advocates; other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities have provided advice to the Director of Community Services and have participated in the development of the Local Services Plan. The full Board and the Subcommittees have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c);

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities meet regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and other ethnic characteristics of the area served. The Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.

OASAS, OMH and OPWDD accept the certified 2017 Local Services Planning Assurance form in the Online County Planning System as the official LGU assurance that the above conditions have been met for the 2017 Local Services planning process.

Appendix H

Demographics Data

Adirondack Rural Health Network			County							ARHN		New York
Summary of Demographic Information, Page 1 of 2	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region (1)	Upstate NYS	State
Square Miles												
Total Square Miles	1,038	1,794	1,629	495	1,717	403	810	867	831	8,372	46,824	47,126
Total Square Miles for Farms	230	86	227	50	3	205	123	15	296	906	11,224	11,224
Percent of Total Square Miles Farms	22.2%	4.8%	13.9%	10.1%	0.2%	50.9%	15.2%	1.7%	35.6%	10.8%	24.0%	23.8%
Population per Square Mile	78.8	21.8	31.6	110.7	2.8	123.9	274.7	75.4	75.7	43.0	240.0	415.8
Population												
Total Population	81,829	39,072	51,508	54,870	4,783	49,951	222,512	65,388	62,910	360,360	11,239,441	19,594,330
Percent White, Non-Hispanic	90.6%	92.5%	82.0%	93.5%	96.1%	84.1%	92.1%	94.7%	93.0%	91.3%	75.5%	57.3%
Percent Black, Non-Hispanic	4.0%	2.8%	5.6%	1.5%	0.4%	1.5%	1.5%	1.1%	2.7%	2.9%	8.3%	14.4%
Percent Hispanic/Latino	2.6%	2.8%	3.2%	2.6%	1.2%	12.0%	2.7%	2.0%	2.4%	2.6%	10.2%	18.2%
Percent Asian/Pacific Islander, Non-Hispanic	1.3%	0.5%	0.4%	0.7%	0.1%	0.6%	2.0%	1.0%	0.6%	0.8%	3.7%	7.7%
Percent Alaskan Native/American Indian	0.3%	0.3%	7.0%	0.2%	0.0%	0.1%	0.1%	0.2%	0.1%	1.2%	0.3%	0.2%
Percent Multi-race/Other	1.2%	1.1%	1.8%	1.5%	2.2%	1.7%	1.6%	1.0%	1.1%	1.3%	1.9%	2.2%
Number Ages 0 - 4	3,969	1,654	2,681	2,859	156	2,980	11,756	3,142	3,195	17,656	623,966	1,170,258
Number Ages 5 - 17	11,366	5,370	7,639	8,827	655	8,487	36,857	9,673	9,629	53,159	1,862,922	3,101,974
Number Ages 18 - 64	54,858	24,397	33,902	33,918	2,790	29,997	141,249	40,490	39,876	230,231	7,044,052	12,566,926
Number Ages 65 Plus	11,636	7,651	7,286	9,266	1,182	8,487	32,650	12,083	10,210	59,314	1,708,501	2,755,172
Number Ages 15 - 44 Female	15,816	5,981	8,268	9,622	590	9,000	41,490	11,171	10,596	62,044	2,120,373	4,049,852
Family Status												
Number of Households	31,976	15,571	19,131	22,440	1,639	19,655	89,876	27,699	24,165	142,621	4,159,597	7,255,528
Percent Families Single Parent Households	15.6%	13.2%	17.8%	18.6%	9.2%	17.9%	12.7%	15.7%	17.4%	16.4%	16.6%	19.8%
Percent Households with Grandparents as Parents	1.3%	1.3%	1.6%	2.4%	1.4%	1.8%	1.1%	1.8%	2.1%	1.7%	1.5%	1.8%
Poverty												
Mean Household Income	$64,485	$64,341	$58,932	$58,147	$63,710	$58,106	$87,334	$71,229	$61,153	N/A	N/A	$85,736
Per Capita Income	$25,279	$26,755	$22,322	$24,265	$29,974	$23,809	$35,860	$30,662	$23,877	N/A	N/A	$32,829
Percent of Individuals Under Federal Poverty Level	15.2%	11.4%	19.7%	16.2%	9.5%	19.1%	6.8%	11.9%	13.0%	14.5%	11.8%	15.6%
Percent of Individuals Receiving Medicaid	18.1%	15.2%	17.8%	21.9%	13.0%	23.8%	9.7%	15.6%	17.0%	17.6%	16.9%	24.7%
Per Capita Medicaid Expenditures	$1,636.24	######	$1,850.64	######	$1,450.42	$2,413.03	$1,061.87	######	$1,612.67	$1,793.51	$1,713.78	$2,500.22
Immigrant Status												
Percent Born in American Territories	0.3%	0.3%	0.7%	0.5%	0.1%	3.7%	0.3%	0.2%	0.3%	0.3%	0.8%	1.6%
Percent Born in Other Countries	4.8%	4.0%	4.6%	2.4%	2.0%	3.5%	4.7%	3.4%	2.2%	3.6%	11.3%	22.3%
Percent Speak a Language Other Than English at Home	6.4%	6.3%	7.1%	4.7%	3.4%	14.0%	6.6%	4.5%	3.1%	5.3%	16.3%	30.2%
Housing												
Total Housing Units	35,909	25,675	25,292	28,616	8,742	23,159	100,185	38,873	28,956	192,063	4,745,377	8,153,309
Percent Housing Units Occupied	89.0%	60.6%	75.6%	78.4%	18.7%	84.9%	89.7%	71.3%	83.5%	74.3%	87.7%	89.0%
Percent Housing Units Owner Occupied	68.3%	73.5%	71.7%	69.3%	81.8%	67.3%	71.3%	70.0%	73.5%	70.8%	70.2%	53.8%
Percent Housing Units Renter Occupied	31.7%	26.5%	28.3%	30.7%	18.2%	32.7%	28.7%	30.0%	26.5%	29.2%	29.8%	46.2%
Percent Build Before 1970	49.5%	57.1%	56.7%	65.8%	56.4%	72.6%	36.2%	50.3%	56.1%	55.4%	62.7%	69.1%
Percent Built Between 1970 and 1979	12.1%	11.7%	11.2%	10.1%	12.9%	8.3%	15.3%	13.0%	10.9%	11.7%	12.1%	10.1%
Percent Built Between 1980 and 1989	14.0%	12.1%	10.9%	9.6%	10.5%	6.6%	16.7%	14.3%	12.0%	12.3%	9.7%	7.5%
Percent Built Between 1990 and 1999	12.1%	9.7%	12.3%	8.0%	11.4%	7.0%	15.4%	10.6%	10.6%	10.6%	8.0%	6.1%
Percent Build 2000 and Later	12.3%	9.4%	8.9%	6.6%	8.8%	5.5%	16.4%	11.8%	10.4%	10.1%	7.5%	7.2%

Availability of Vehicles												
Percent Households with No Vehicles Available	9.5%	8.5%	10.7%	9.1%	4.8%	12.9%	5.0%	8.1%	6.4%	8.6%	9.9%	29.3%
Percent Households with One Vehicle Available	33.3%	34.4%	35.8%	39.5%	36.2%	37.3%	33.0%	35.2%	34.4%	35.3%	33.8%	32.7%
Percent Households with Two Vehicles Available	39.4%	39.3%	38.5%	36.4%	45.0%	35.1%	43.7%	40.3%	37.9%	38.8%	38.3%	26.5%
Percent Households with Three or More Vehicles Available	17.8%	17.8%	15.0%	15.0%	14.0%	14.7%	18.4%	16.3%	21.3%	17.3%	18.0%	11.5%
Education												
Total Population Ages 25 and Older	55,509	29,010	36,039	38,758	3,674	34,299	155,438	47,327	44,657	254,974	7,606,459	13,329,734
Percent with Less than High School Education/GED	14.7%	12.0%	15.2%	14.3%	10.1%	17.1%	6.1%	9.3%	12.1%	12.9%	10.6%	14.6%
Percent High School Graduate/GED	35.5%	33.6%	36.6%	38.4%	32.4%	35.9%	25.7%	33.3%	42.3%	36.6%	28.8%	26.9%
Percent Some College, No Degree	18.2%	20.7%	19.7%	19.6%	17.7%	17.9%	18.2%	17.6%	17.8%	18.7%	17.7%	16.3%
Percent Associate Degree	9.2%	9.9%	10.7%	12.0%	16.0%	12.8%	11.8%	11.6%	9.4%	10.5%	10.1%	8.5%
Percent Bachelor's Degree	12.1%	13.4%	9.1%	8.6%	12.4%	9.9%	22.2%	15.6%	10.8%	11.7%	17.9%	19.1%
Percent Graduate or Professional Degree	10.4%	10.4%	8.6%	7.1%	11.3%	6.5%	15.9%	12.7%	7.7%	9.6%	14.8%	14.6%
Employment Status												
Total Population Ages 16 and Older	68,580	33,176	42,300	44,744	4,101	39,789	179,700	54,331	51,736	298,968	9,064,295	15,832,743
Total Population Ages 16 and Older in Armed Forces	36	5	21	5	0	67	1,399	42	27	136	21,098	23,816
Total Population Ages 16 and Older in Civilian Workforce	38,692	19,250	22,027	26,819	2,153	24,151	120,730	34,104	31,536	174,581	5,743,319	10,030,632
Percent Unemployed	6.7%	6.9%	7.3%	7.6%	7.3%	7.5%	4.6%	6.5%	6.0%	6.8%	5.6%	6.3%
Employment Sector												
Total Employed	35,880	17,586	20,090	24,133	1,993	21,629	113,075	31,794	28,439	159,915	5,290,295	9,137,540
Percent in Agriculture, Forestry, Fishing, Hunting, and Mining	2.4%	3.4%	2.9%	1.2%	1.4%	2.9%	0.9%	0.9%	3.8%	2.3%	1.0%	0.6%
Percent in Construction	5.8%	7.8%	5.8%	6.9%	14.3%	7.5%	6.1%	6.9%	9.6%	7.2%	6.0%	5.6%
Percent in Manufacturing	11.8%	7.7%	4.9%	12.4%	4.3%	12.7%	9.4%	8.7%	15.3%	10.5%	8.6%	6.6%
Percent in Wholesale Trade	1.7%	1.4%	1.6%	1.9%	0.2%	2.3%	2.8%	1.9%	2.0%	1.8%	2.7%	2.5%
Percent in Retail Trade	11.8%	12.0%	11.3%	15.9%	10.4%	14.1%	11.7%	13.5%	13.3%	13.0%	11.5%	10.8%
Percent in Transportation, Warehousing, Utilities	4.8%	2.9%	2.9%	4.8%	2.2%	4.5%	3.2%	3.6%	3.9%	3.9%	4.5%	5.1%
Percent in Information Services	1.7%	1.4%	1.4%	1.8%	0.7%	1.3%	2.0%	2.0%	1.1%	1.6%	2.3%	2.9%
Percent in Finance	3.0%	3.4%	4.0%	2.8%	4.3%	4.6%	7.6%	5.9%	4.1%	3.9%	6.9%	8.1%
Percent in Other Professional Occupations	5.0%	6.0%	4.6%	5.6%	4.5%	5.9%	10.7%	7.9%	6.3%	5.9%	10.2%	11.3%
Percent in Education, Health Care and Social Assistance	27.8%	30.3%	31.7%	29.5%	25.8%	25.3%	25.8%	26.1%	23.4%	27.7%	28.3%	27.5%
Percent in Arts, Entertainment, Recreation, Hotel, & Food Service	9.5%	12.7%	10.7%	7.0%	15.7%	7.6%	8.7%	13.1%	7.5%	10.1%	8.2%	9.2%
Percent in Other Services	4.5%	4.5%	4.6%	4.9%	4.6%	4.1%	4.1%	4.7%	4.1%	4.5%	4.7%	5.1%
Percent in Public Administration	10.0%	6.6%	13.7%	5.4%	11.7%	7.2%	7.1%	4.8%	5.7%	7.6%	5.3%	4.7%

(1) Excludes Montgomery County and Saratoga County

(D) Withheld to avoid disclosing data for individual farms. Sources:

Square Miles: United States Department of Agriculture, 2012 Employment Sector:

American Community Survey, 2010 - 2014

Unemployment Rate: Bureau of Labor Statistics, Local Area Unemployment Statistics, 2014 Medicaid Data: New

York State Department of Health, 2014

All Other Data: American Community Survey, 2010 - 2014

Education System

Adirondack Rural Health Network 4/29/2016

Adirondack Rural Health Network Page 1 of 2	Clinton	County Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	ARHN Region (1)	Upstate NYS (2)	New York State
Summary Primary-Secondary Education, 2014- 2015												
Total Number Public School Districts (3)	8	11	7	6	7	5	12	9	11	59	694	726
Total Pre-K Enrollment	193	196	329	300	28	342	381	141	315	1,502	47,034	112,264
Total K-12 Enrollment	10,590	3,643	7,201	7,571	418	7,298	33,499	8,866	8,381	46,670	1,593,319	2,608,247
Number Free Lunch	3,572	1,261	3,097	3,051	106	3,202	5,290	2,557	2,385	16,029	483,903	1,170,671
Number Reduced Lunch	964	446	780	692	61	493	1,406	588	673	4,204	101,239	161,792
Percent Free and Reduced Lunch	42.1%	44.5%	51.5%	47.6%	37.4%	48.4%	19.8%	34.9%	35.2%	42.0%	35.7%	49.0%
Number Limited English Proficiency	17	4	5	14	0	153	291	36	20	96	73,984	213,378
Percent with Limited English Proficiency	0.2%	0.1%	0.1%	0.2%	0.0%	2.0%	0.9%	0.4%	0.2%	0.2%	4.5%	7.8%
Total Number of Graduates	796	313	536	551	29	476	2,463	700	578	3,503	120,110	184,251
Number Went to Approved Equivalency Program	2	1	8	1	s	6	22	27	11	50	1,492	2,904
Number Dropped Out of High School	115	27	46	106	s	90	200	71	80	445	10,518	23,526
Percent Dropped Out of High School	14.4%	8.6%	8.6%	19.2%	NA	18.9%	8.1%	10.1%	13.8%	12.7%	8.8%	12.8%
Total Number of Teachers(3)	1,045	427	715	643	120	628	2,632	806	879	4,635	130,463	196,799
Student to Teacher Ratio	10.3	9.0	10.5	12.2	3.7	12.2	12.9	11.2	9.9	10.4	12.6	13.8

Registered Nursing Programs, 2014-2015	Clinton	Essex	County Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren
Clinton County Community College	37	0	0	0	0	0	0	0	0
New Graduates Clinton County	0	0	0	0	0	0	0	0	0
Community College BSN Completers	41	0	0	0	0	0	0	0	0
SUNY Plattsburgh New Graduates	23	0	0	0	0	0	0	0	0
	0	58	0	0	0	0	0	0	0
SUNY Plattsburgh BSN Completers	0	0	0	0	0	0	0	0	0
North Country Community College New	0	0	0	40	0	0	0	0	0
Graduates North Country Community	0	0	0	0	0	0	0	0	0
College BSN Completers Fulton-	0	0	0	0	0	0	0	78	0
	0	0	0	0	0	0	0	0	0

Licensed Practical Nursing Programs, 2014-2015	Clinton	County Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington
Clinton, Essex, Warren, Washington BOCES (29 Hamilton, Fulton, Montgomery BOCES (20 total)	*	*		*	*	*		*	*
North Country Community College		83							
Washington, Saratoga, Warren, Hamilton, Essex		*			*			*	*

(1) Excludes Montgomery and Saratoga County

(2) Excludes the following counties: Bronx, Kings, New York, Queens, Richmond

(3) No Charter Schools in the ARHN region, Montgomery County, or Saratoga County. Private School data was not available

(4) BOCES LPN programs span multiple counties within the ARHN region, Montgomery County, and Saratoga County.

Sources: Primary and Secondary Education Data: New York State Education Department, School Report Card 2014
LPN Graduation Data: National Center for Education Statistics, Integrated Postsecondary Education Data System (IPEDS) RN Graduation Data: Center
for Health Workforce Studies, University at Albany School of Public Health

Clinton	Essex	Franklin	Fulton*	Hamilton
Ausable Valley	Crown Point	Brushton- Moira	Broadalbin- Perth	Indian Lake
Beekmantown	Elizabethtown-Lewis	Chateaugay	Gloversville	Inlet Common
Chazy Union Free	Keene	Malone	Johnstown	Lake Pleasant
Northeastern Clinton	Lake Placid	Salmon River	Mayfield	Long Lake
Northern Adirondack	Minerva	Saranac Lake	Northville	Piseco Common
Peru	Moriah	St. Regis Falls	Wheelerville Union Free	Raquetter Lake Union Free**
Plattsburgh	Newcomb	Tupper Lake		Wells
Saranac	Schroon Lake			
	Ticonderoga			
	Westport			
	Willsboro			

Montgomery	Saratoga	Warren	Washington	
Amsterdam City	Ballston Spa	Bolton	Argyle	
Canajoharie	Burnt Hills-Ballston Lake	Glens Falls City	Cambridge	
Fonda-Fultonville	Corinth	Glens Falls Common	Fort Ann	
Fort Plain	Edinburg Common	Hadley-Luzerne	Fort Edward Union Free	
Oppenheim-Ephratah-St.	Galway	Johnsburg	Granville	
	Mechanicville	Lake George	Greenwich	
	Saratoga Springs	North Warren	Hartford	
	Schuylerville	Queensbury Union Free	Hudson Falls	
	Shenendehowa	Warrensburg	Putnam	
	South Glens Falls		Salem	
	Stillwater		Whitehall	
	Waterford-Halfmoon Union Free			

* Oppenheim-Ephratah SD is merged with St. Johnsville SD
** New School District
*** St. Johnsville SD is merged with Oppenheim-Ephratah SD

Essex County Community Health Assessment 2016. Community Health Improvement & Service Plan 2016-2018.

Appendix J

Adirondack Rural Health Network Health System Profile 4/29/2016	County									ARHN	Upstate	New York
Page 1 of 3	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region (1)	NYS	State
Population, 2010-2014	81,829	39,072	57,508	54,870	4,783	49,951	222,512	65,388	62,910	366,360	11,239,441	19,594,330
Total Hospital Beds	300	40	171	74	0	130	171	410	0	995	30,148	54,516
Hospital Beds per 100,000 Population	367	102	297	135		260	77	627		272	268	278
Medical/Surgical Beds	214	0	129	47	0	70	115	300	0	690	18,574	32,659
Intensive Care Beds	14	0	14	8	0	5	12	12	0	48	1,655	2,939
Coronary Care Beds Pediatric	7	0	0	0	0	3	7	12	0	19	742	1,133
Beds Maternity Beds	10	0	3	12	0	0	7	16	0	41	1,086	2,210
Physical Therapy and Rehabilitation Beds Psychiatric	21	0	13	7	0	8	14	23	0	64	1,846	3,251
Beds	0	0	0	0	0	0	0	7	0	7	1,130	1,928
Other Beds	34	0	12	0	0	20	16	32	0	78	2,390	5,279
	0	40	0	0	0	24	0	8	0	48	2,725	5,117
Hospital Beds Per Facility												
Adirondack Medical Center-Lake Placid Site	0	0	0	0	0	0	0	0	0			
Adirondack Medical Center-Saranac Lake Site	0	0	95	0	0	0	0	0	0			
Alice Hyde Medical Center	0	0	76	0	0	0	0	0	0			
Champlain Valley Physicians Hospital Medical Center	300	0	0	0	0	0	0	0	0			
Elizabethtown Community Hospital	0	25	0	0	0	0	0	0	0			
Glens Falls Hospital	0	0	0	0	0	0	0	410	0			
Moses-Ludington Hospital	0	15	0	0	0	0	0	0	0			
Nathan Littauer Hospital	0	0	0	74	0	0	0	0	0			
Saratoga Hospital	0	0	0	0	0	0	171	0	0			
St. Mary's Healthcare	0	0	0	0	0	120	0	0	0			
St. Mary's Healthcare-Amsterdam Memorial Campus	0	0	0	0	0	10	0	0	0			
Total Nursing Home Beds	423	340	195	360	0	590	755	402	528	2,838	69,633	113,592
Nursing Home Beds per 100,000 Population	517	870	339	656	0	1181	339	615	839	775	620	580
Nursing Home Beds per Facility												
Adirondack Tri-County Nursing and Rehabilitation Center, Inc	0	0	0	0	0	0	0	82	0			
Alice Hyde Medical Center	0	0	135	0	0	0	0	0	0			
Capstone Center for Rehabilitation and Nursing	0	0	0	0	0	120	0	0	0			
Champlain Valley Physicians Hospital Medical Center SNF	54	0	0	0	0	0	0	0	0			
Clinton County Nursing Home	80	0	0	0	0	0	0	0	0			
Essex Center for Rehabilitation and Healthcare	0	100	0	0	0	0	0	0	0			
Evergreen Valley Nursing Home	89	0	0	0	0	0	0	0	0			
Fort Hudson Nursing Center, Inc.	0	0	0	0	0	0	0	0	196			
Fulton Center for Rehabilitation and Nursing Center	0	0	0	176	0	0	0	0	0			
Heritage Commons Residential Health Care	0	84	0	0	0	0	0	0	0			
Indian River Rehabilitation and Nursing Center	0	0	0	0	0	0	0	0	122			
Meadowbrook Healthcare	200	0	0	0	0	0	0	0	0			
Mercy Living Center	0	0	60	0	0	0	0	0	0			
Nathan Littauer Hospital Nursing Home	0	0	0	84	0	0	0	0	0			
Palatine Nursing Home	0	0	0	0	0	70	0	0	0			
River Ridge Living Center, LLC	0	0	0	0	0	120	0	0	0			
Saratoga Center for Rehab and Skilled Nursing Care	0	0	0	0	0	0	257	0	0			
Saratoga Hospital Nursing Home	0	0	0	0	0	0	36	0	0			
Schuyler Ridge A Residential Health Care Facility	0	0	0	0	0	0	120	0	0			
St Johnsville Rehabilitation Nursing Center	0	0	0	0	0	120	0	0	0			
The Orchard Nursing and Rehabilitation Centre	0	0	0	0	0	0	0	0	88			
The Pines at Glens Falls Center for Nursing & Rehabilitation	0	0	0	0	0	0	0	120	0			
The Stanton Nursing and Rehabilitation Centre	0	0	0	0	0	0	0	120	0			
Uihlein Living Center	0	156	0	0	0	0	0	0	0			
Washington Center for Rehabilitation and Healthcare	0	0	0	0	0	0	0	0	122			
Wells Nursing Homes Inc	0	0	0	100	0	0	0	0	0			
Wesley Health Care Center Inc	0	0	0	0	0	0	342	0	0			
Westmount Health Facility	0	0	0	0	0	0	0	80	0			
Wilkinson Residential Health Care Facility	0	0	0	0	0	160	0	0	0			

Essex County Community Health Assessment 2016. Community Health Improvement & Service Plan 2016-2018.

Adirondack Rural Health Network	County									ARHN Region (1)	Upstate NYS	New York State
Page 2 of 3	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Population, 2010-2015												
Total Adult Care Facility Beds	**150**	**194**	**94**	**134**	**0**	**144**	**378**	**248**	**102**	**922**	**35,734**	**46,810**
Adult Care Facility Beds per 100,000 Population	183	497	163	244	0	288	170	379	162	252	318	239
Total Adult Home Beds	130	43	64	82	0	104	124	218	102	639	19,023	25,040
Total Assisted Living Program Beds	20	20	30	52	0	40	0	30	0	152	5,229	8,735
Total Assisted Living Residence (ALR) Beds	0	131	0	0	0	0	254	0	0	131	11,482	13,035
Adult Home Beds by Total Capacity per Facility												
Adirondack Manor HFA D.B.A Montcalm Manor HFA (Essex)	0	40	0	0	0	0	0	0	0			
Adirondack Manor HFA D.B.A Adirondack Manor HFA (Warren)	0	0	0	0	0	0	0	60	0			
Adirondack Manor Home for Adults (Clinton)	40	0	0	0	0	0	0	0	0			
Adirondack Manor Home for Adults (Franklin)	0	0	34	0	0	0	0	0	0			
Ahana House	0	0	0	0	0	0	17	0	0			
Arkell Hall	0	0	0	0	0	24	0	0	0			
Beacon Pointe Memory Care Community	0	0	0	0	0	0	52	0	0			
Cambridge Guest Home	0	0	0	0	0	0	0	0	34			
Cook Adult Home	0	0	0	0	0	0	13	0	0			
Countryside Adult Home	0	0	0	0	0	0	0	48	0			
David & Helen Getman Memorial Home	0	0	0	20	0	0	0	0	0			
Emeritus at the Landing of Queensbury	0	0	0	0	0	0	0	88	0			
Hillcrest Spring Residential	0	0	0	0	0	80	0	0	0			
Holbrook's Adult Home, Inc.	0	0	0	0	0	0	0	0	33			
Home of the Good Shepherd	0	0	0	0	0	0	42	0	0			
Home of the Good Shepherd at Highpointe	0	0	0	0	0	0	86	0	0			
Home of the Good Shepherd Wilton	0	0	0	0	0	0	54	0	0			
Keene Valley Neighborhood House	0	50	0	0	0	0	0	0	0			
Moses Ludington Adult Care Facility	0	23	0	0	0	0	0	0	0			
Pine Harbour	66	0	0	0	0	0	0	0	0			
Pineview Commons H.F.A	0	0	0	94	0	0	0	0	0			
Washington Co. Public Home	0	0	0	0	0	0	0	0	35			
Samuel F. Vilas Home	44	0	0	0	0	0	0	0	0			
Sarah Jane Sanford Home	0	0	0	0	0	40	0	0	0			
The Farrar Home	0	0	30	0	0	0	0	0	0			
The Terrace at the Glen	0	0	0	0	0	0	0	52	0			
Willing Helpers' Home for Women	0	0	0	20	0	0	0	0	0			
Woodlawn Commons	0	0	0	0	0	0	0	0	0			

	County									ARHN Region	Upstate NYS	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Community Health Center												
(CHC) Usage,	3,689	10,709	1,862	306	1,289	323	13,410	34,	29,166	81,729	926,227	1,901,994
2014 Estimated	4.18%	19.0%	3.06%	0.30%	15.02%	0.40%	4.56%	49.9	28.89%	16.84%	6.96%	8.69%

	County									ARHN Region	Upstate NYS	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Health Professional Shortage Areas (HPSAs)	1	5	4	1	2	1	0	2	1	16	87	113
Number of Primary Care HPSAs	10,376	8,080	14,106	13,986	3,447	11,435	0	3,631	1,445	55,071	1,653,497	3,619,561
Primary Care HPSA Population Total	0	1	1	0	0	1	0	0	0	3	27	41
Number of Dental Care HPSAs	0	6,395	16,203	39,113	0	39,113	0	0	0	61,711	1,140,979	2,391,517
Dental Care HPSA Population	1	1	1	1	1	1	0	0	0	6	41	58
Total Number of Mental Health HPSAs	10,376	35,299	44,612	6,684	4,881	11,435	0	0	0	113,287	1,304,118	2,926,329
Mental health APSA Population Total												

Adirondack Rural Health Network Page 3 of 3 Population, 2015	County									ARHN Region (1)	Upstate NYS	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Primary Care per 100,000 population	89.9	54.5	94.1	90.2	37.2	79.7	74.1	107.0	53.8	81.5	89.3	94.2
Other Subspecialty												
Obstetrics/Gynecology IM	18.7	0.0	19.6	5.0	0.0	12.3	7.9	23.5	0.0	12.1	15.0	16.4
Subspecialty General Surgery	34.3	5.2	6.8	10.1	0.0	44.4	19.8	54.5	0.0	20.9	39.9	43.3
Surgical Specialties Facility Based	3.4	4.9	11.3	9.9	0.0	0.0	5.0	13.7	0.0	6.9	8.0	7.8
Psychiatry	44.0	14.3	15.5	18.4	0.0	22.3	20.2	55.9	2.3	27.3	34.3	35.2
Other Total	38.3	4.7	41.3	9.4	0.0	16.5	7.0	62.0	0.0	27.9	40.6	41.4
Physician	24.1	0.0	14.5	8.6	0.0	9.1	16.4	21.1	4.8	13.6	21.4	28.3
Total Physician per 100,000 population	43.7	9.9	14.8	3.7	0.0	13.7	12.6	55.4	0.0	23.9	36.3	40.4
	296.4	93.5	217.8	155.4	37.2	197.9	162.9	393.1	60.9	214.2	284.8	307.0
Licensure Data												
Clinical Laboratory Technician	17	9	1	2	0	5	22	9	5	70	1,293	1,807
Clinical Laboratory Technologist	51	20	36	35	1	44	187	50	30	454	8,243	12,782
Dental Assistant	13	2	6	4	0	4	29	5	12	75	1,292	1,359
Dental Hygienist	42	16	18	24	4	31	233	48	30	446	7,939	10,074
Dentist	50	18	28	23	2	26	194	62	19	422	10,084	17,003
Dietitian/Nutritionist, Certified	22	6	13	6	1	7	106	20	6	187	3,410	5,135
Licensed Clinical Social Worker (R/Psychotherapy	48	28	31	29	5	19	291	73	37	561	14,963	25,568
Licensed Master Social Worker (no privileges)	31	23	23	28	4	22	234	49	26	440	14,770	26,673
Licensed Practical Nurse	403	227	373	317	11	346	1,013	371	460	3,521	51,818	67,700
Physician	261	83	127	92	7	111	699	309	55	1,744	49,087	85,592
Mental Health Counseling	51	22	22	5	1	11	102	25	9	248	3,741	5,454
Midwife	5	1	3	4	0	1	7	16	3	40	588	996
NPs, All	73	13	33	30	3	25	205	69	19	470	12,949	18,104
Nurse Practitioner, Adult Health	22	1	7	6	0	3	43	15	3	100	3,791	5,199
Nurse Practitioner, Community Health	1	0	0	0	0	0	0	0	0	1	64	69
Nurse Practitioner, Family Health	30	6	20	15	1	18	94	34	10	228	5,255	7,251
Nurse Practitioner, Gerontology	0	0	0	1	0	0	3	0	0	4	297	605
Nurse Practitioner, Obstetrics & Gynecology	6	1	0	1	0	1	5	5	1	20	229	301
Nurse Practitioner, Pediatrics	2	2	1	0	1	0	13	1	0	20	1,177	1,633
Nurse Practitioner, Psychiatry	7	2	2	3	1	2	23	11	2	53	1,057	1,383
Pharmacist	96	28	41	43	2	45	469	73	52	849	14,024	21,345
Physical Therapist	61	38	41	22	0	38	363	65	28	656	12,375	17,947
Physical Therapy Assistant	18	14	21	21	1	28	59	29	16	207	3,693	5,145
Psychologist	14	12	15	10	3	7	108	34	6	209	6,408	11,965
Registered Physician Assistant	35	45	31	19	5	18	184	96	17	450	8,118	12,005
Registered Professional Nurse	1,258	477	706	638	57	741	3,527	1,080	719	9,203	164,768	230,657
Respiratory Therapist	16	5	3	16	0	22	109	23	10	204	3,983	5,575
Respiratory Therapy Technician	5	0	2	9	0	2	11	4	1	34	812	1,042

Sources: Hospital, Nursing Home, and Adult Care Beds: New York State Department of Health

Physician Data: Center for Health Workforce Study

Licensure Data: New York State Education Department

Appendix K

Health Indicators

Essex County: Revised 7/27/2016																
	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
1. Percentage of Overall Premature Deaths (Age 35-64) , 2013				23.7%	21.2%	22.0%	23.7%	**21.8%**	Worse	X					
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '11 - 13				0.00	2.50	2.10	1.98	**1.87**	Meets/Better						
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '11 - 13				0.78	2.51	2.24	1.92	**1.86**	Less than 10						
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2013				88.9	N/A	107.3	119.0	**122**	Meets/Better						
5. Ratio of Black, Non-Hispanic Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '11 - 13				N/A	N/A	1.94	2.11	**1.85**	Less than 10						
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '11 - 13				N/A	N/A	1.51	1.52	**1.38**	Less than 10						
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2013				89.8%	N/A	N/A	87.6%		Worse	X					
8. Age Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2013-2014				77.8%	N/A	84.6%	84.4%	**90.8%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	37.5%	0.0%
Other Disparity Indicators															
1. Rate of Total Deaths per 100,000 Population, '11 - 13				1,012.8	952.5	**854.1**	753.1	N/A	Worse	X					
2. Rate of Emergency Department Visits per 10,000 Population, '11 - 13	16,852	17,997	17,580	4,484.8	4,418.4	**3,752.5**	4,086.4	N/A	Worse	X					
3. Rate of Total Hospital Discharges per 10,000 Population, '11 - 13	3,361	3,395	2,963	831.4	1,121.4	**1,168.1**	1,226.2	N/A	Meets/Better						
4. Percentage of Adults (18 and Older) Who Did Not Receive Care Due to Costs, '13/14				10.0%	11.4%	**11.2%**	13.1%	N/A	Meets/Better						
5. % of Adults (18 and Older) with 14 Days or More of Poor Physical Health, '13/14				12.0%	13.4%	**12.3%**	11.8%	N/A	Meets/Better						
6. Percentage of Adults (18 and Older) with Disabilities, '13/14				21.1%	25.2%	**22.4%**	20.8%	N/A	Meets/Better						
Quartile Summary for Other Indicators										2	0	0	0	33.3%	0.0%
Quartile Summary for Focus Area Disparities										5	0	0	0	35.7%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention		Q1	Q2	Q3	Q4		
Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
1. Rate of Hospitalizations due to Falls for Ages 65 Plus per 10,000 Population, 2013				110.9	161.7	188.7	183.6	204.6	Meets/Better						
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children Ages 1 - 4, 2014			51	392.6	486.6	442.7	440.1	429.1	Meets/Better						
3. Rate of Assault-Related Hospitalizations per 10,000 Population, '11 - 13			10	0.9	1.6	2.4	3.9	4.3	Meets/Better						
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '11 - 13				N/A	N/A	7.68	7.28	6.69	Less than 10						
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '11 - 13				N/A	N/A	2.55	3.45	2.75	Less than 10						
6. Ratio of Assault-Related Hospitalizations for Low-Income versus non-Low Income Zip Codes, '11 - 13				N/A	N/A	3.24	3.29	2.92	Less than 10						
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2013			23	101.7	21.5	28.2	20.6	33.0	Worse				X		
Quartile Summary for Prevention Agenda Indicators										0	1	0	1	28.6%	50.0%
Other Indicators															
1. Rate of Hospitalizations for Falls for Children Ages Under 10 per 10,000 Population Children Ages Under 10 , '11 - 13				0.0	5.4	7.5	8.9	N/A	Less than 10						
2. Rate of Hospitalizations for Falls for Children Ages 10 - 14 per 10,000 Population Children Ages 10 - 14, '11 - 13				N/A	2.6	5.0	6.1	N/A	Less than 10						
3. Rate of Hospitalizations for Falls for Individuals Ages 15 - 24 per 10,000 Population Individuals Ages 15 - 24, '08 - 10				N/A	3.2	5.2	5.7	N/A	Less than 10						
4. Rate of Hospitalizations for Falls for Adults Ages 25 - 64 per 10,000 Population Adults Ages 25 - 64, '11 - 13	25	35	22	12.9	17.1	18.4	18.4	N/A	Meets/Better						
5. Rate of Violent Crimes per 100,000 Population, 2014				118.2	91.8	203.2	366.4	N/A	Meets/Better						
6. Rate of Property Crimes per 100,000 Population, 2014				797.9	1,559.7	1,786.5	1,707.3	N/A	Meets/Better						
7. Rate of Total Crimes per 100,000 Population, 2014				916.1	1,651.6	1,989.7	2,073.7	N/A	Meets/Better						
8. Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population Ages 15 Plus, '10 - 12					1.9	1.7	1.3	N/A	Less than 10						
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population Ages 15 Plus, '11 - 13				6.0	16.7	14.0	10.3	N/A	Meets/Better						
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population Ages 15 Plus, '11 - 13				6.0	13.7	12.7	9.3	N/A	Meets/Better						
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 10,000 Individuals Employed Ages 16 Plus, '11 - 13	21	18	13	32.2	138.9	191.1	156.5	N/A	Meets/Better						
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 10,000 Individuals Employed Ages 16 Plus, '11 - 13	1	0	1	6.8	19.3	22.7	22.3	N/A	Less than 10						
13. Rate of Total Motor Vehicle Crashes per 100,000, 09 - 11	1,023	1,047	1,041	2,661.2	2,180.5	2,061.9	1,545.7	N/A	Worse		X				
14. Rate of Speed-Related Accidents per 100,000 Population, '11 - 13	260	257	226	635.6	357.3	217.1	143.1	N/A	Worse				X		
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, '11 - 13	6	8	1	12.8	10.1	7.4	5.6	N/A	Worse			X			
16. Rate of TBI Hospitalizations per 10,000 Population, '11 - 13	15	19	13	4.0	6.3	10.2	10.0	N/A	Meets/Better						
17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, '11 - 13	243	236	202	58.3	68.2	71.6	68.3	N/A	Meets/Better						
18. Rate of Unintentional Injury Hospitalizations Ages 14 and Under per 10,000 Population Ages 10 - 14, '11 - 13				11.5	12.1	16.0	18.0	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population Ages 65 Plus, '11 - 13	162	161	133	198.6	241.6	262.9	252.3	N/A	Meets/Better						
20. Rate of Poisoning Hospitalizations per 10,000 Population, '11 - 13	34	35	33	8.7	13.2	11.0	11.1	N/A	Worse	X					
Quartile Summary for Other Indicators										1	1	1	1	20.0%	50.0%
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										1	2	1	2	22.2%	50.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention		Q1	Q2	Q3	Q4		
Focus Area: Outdoor Air Quality															
1. Number of Days with Unhealthy Ozone, 2011/2013				N/A	N/A	14	N/A	0	Less than 10						
2. Numbert of Days with Unhealthy Particulated Matter, 2011/2013				0	0	0	0	0	Less than 10						
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%
Focus Area: Built Environment															
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2015				100.0%	17.2%	56.8%	32.8%	32.0%	Meets/Better						
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, '10-14				20.7%	19.7%	22.6%	45.1%	49.2%	Worse			X			
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2010				2.0%	4.9%	4.2%	2.5%	2.2%	Meets/Better						
4. Percentage of Adults Experiencing Food Insecurity				21.0%	23.3%	22.7%	29.0%	N/A	Meets/Better						
5. Percentage of Adults Experiencing Housing Insecurity				37.5%	36.1%	36.6%	43.4%	N/A	Meets/Better						
6. Percentage of Homes in Vulnerable Neighborhoods that have Fewer Asthma Triggers During Home Revisits, '11-14				N/A	N/A	18.0%	N/A	25.0%	Less than 10						
Quartile Summary for Focus Area Built Environment										0	0	1	0	16.7%	100.0%
Focus Area: Water Quality															
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2014				0.0%	19.1%	52.6%	72.1%	78.5%	Worse				X		
Quartile Summary for Focus Area Water Quality										0	0	0	1	100.0%	100.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Reduce Obesity in Children and Adults															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who are Obese, '13/14				32.2%	29.8%	27.0%	24.9%	**23.2%**	Worse		X				
2. Percentage of Public School Children Who are Obese, '12 - 14				19.2%	N/A	17.3%	N/A	**16.7%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	1	0	0	100.0%	0.0%
Other Indicators															
1. Percentage of Total Students Overweight, '12 - 14				17.1%	17.5%	**16.7%**	N/A	N/A	Worse	X					
2. Percentage of Elementary Students Overweight, Not Obese, '12 - 14				12.8%	16.8%	**16.4%**	N/A	N/A	Meets/Better						
3. Percentage of Elementary Student Obese, '12 - 14				17.7%	18.6%	**16.8%**	N/A	N/A	Worse	X					
4. Percentage of Middle and High School Students Overweight, Not Obese, '12 - 14				19.5%	N/A	**17.1%**	N/A	N/A	Worse	X					
5. Percentage of Middle and High School Students Obese, '12 - 14				18.9%	21.6%	**18.1%**	N/A	N/A	Worse	X					
6. Percentage of WIC Children Ages 2 - 4 Obese, '10-12				16.6%	15.1%	**15.1%**	14.3%	N/A	Worse	X					
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, '13/14				68.6%	64.4%	**62.2%**	60.9%	N/A	Worse	X					
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, '13/14				76.2%	73.8%	**73.7%**	72.8%	N/A	Meets/Better						
9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014				6.0	5.5	**18.7**	19.2	N/A	Worse			X			
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14				78.2%	79.7%	**84.2%**		N/A	Meets/Better						
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14				30.8%	33.4%	**30.2%**	28.3%	N/A	Worse	X					
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '11-13	97	136	142	320.8	292.4	**297.4**	272.5	N/A	Worse	X					
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	21	21	22	127.2	110.5	**96.8**	99.0	N/A	Worse		X				
14. Rate of Pretransport Deaths per 100,000 Population, '12-14	53	70	85	177.9	155.7	**162.3**	146.7	N/A	Worse	X					
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, '11-13	517	554	473	132.1	160.4	**165.9**	163.6	N/A	Meets/Better						
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '11-13	82	108	112	258.3	228.4	**238.7**	222.1	N/A	Worse	X					
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	19	18	21	115.3	92.7	**79.9**	80.6	N/A	Worse		X				
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '11-13	44	62	65	146.3	123.7	**134.7**	126.3	N/A	Worse	X					
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, '11-13	353	390	339	92.6	109.2	**111.9**	108.5	N/A	Meets/Better						
20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '11-13	59	64	80	173.6	153.5	**171.8**	175.1	N/A	Worse	X					
21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	13	9	16	75.5	65.8	**60.7**	65.5	N/A	Worse	X					
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '11-13	32	37	48	100.1	83.6	**100.0**	103.6	N/A	Worse	X					
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, '11-13	116	128	95	29.0	36.1	**39.9**	40.0	N/A	Meets/Better						
24. Rate of Congestive Heart Failure Deaths per 100,000, '11-13	4	4	11	16.3	17.7	**21.6**	14.7	N/A	Meets/Better						
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	1	0	2	6.0	2.2	**2.3**	1.9	N/A	Less than 10						
26. Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '11-13	0	3	4	6.0	10.2	**12.4**	8.0	N/A	Less than 10						
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, '11-13	110	114	121	29.5	32.0	**29.3**	28.8	N/A	Worse	X					
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '11-13	7	20	16	36.8	40.6	**38.5**	30.9	N/A	Meets/Better						
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, '11-13	77	80	64	18.9	25.6	**28.9**	26.9	N/A	Meets/Better						
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 100,000 Population Ages 18 Plus, '11-13				2.1	3.2	**5.0**	7.4	N/A	Meets/Better						
31. Rate of Diabetes Deaths per 100,000 Population, '11-13	16	7	14	31.6	29.8	**19.6**	20.3	N/A	Worse		X				
32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, '11-13	40	41	48	11.0	15.3	**15.6**	19.3	N/A	Meets/Better						
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, '11-13	714	750	677	183.1	248.2	**225.8**	244.1	N/A	Meets/Better						
Quartile Summary for Other Indicators										15	2	2	0	57.6%	10.5%
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										16	3	2	0	60.0%	9.5%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who Smoke '13/14				16.6%	22.5%	17.3%	15.6%	**12.3%**	Worse		X				
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	100.0%	0.0%
Other Indicators															
1. Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '11-13	17	34	15	56.5	69.2	**46.2**	35.6	N/A	Worse	X					
2. Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population '11-13	113	114	94	27.5	46.1	**33.0**	36.5	N/A	Meets/Better						
3. Rate of Asthma Deaths per 100,000 Population, '11-13	0	1	0	0.9	1.2	**0.9**	1.4	N/A	Less than 10						
4. Rate of Asthma Hospitalizations per 10,000 Population, '11-13	24	20	12	4.8	10.1	**11.1**	18.2	N/A	Meets/Better						
5. Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population Ages 25 - 44, '11-13				2.2	6.6	**6.6**	8.6	N/A	Meets/Better						
6. Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population Ages 45 - 64, '11-13				6.0	11.9	**11.6**	19.7	N/A	Meets/Better						
7. Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population Ages 65 Plus, '11-13				7.8	15.9	**17.7**	29.4	N/A	Meets/Better						
8. Percentage of Adults with Asthma, '13/14				9.6%	13.4%	**10.2%**	10.1%	N/A	Meets/Better						
9. Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '10-12	28	28	33	75.7	67.9	**55.9**	46.4	N/A	Worse		X				
10. Rate of Lung and Bronchus Cases per 100,000 Population, '10-12	45	34	53	112.2	108.5	**83.0**	69.6	N/A	Worse		X				
11. Number of Registered Tobacco Vendors per 100,000 Population, '10 - 12				54.4	47.8	**22.7**	41.4	N/A	Worse				X		
12. Percentage of Vendors with Sales to Minors Violations, '10 - 12				3.8%	3.2%	**5.5%**	8.9%	N/A	Meets/Better						
13. Percentage of Vendors with Complaints, '10 - 12				0.0%	0.0%	**0.0%**	0.9%	N/A	Less than 10						
Quartile Summary for Other Indicators										1	2	0	1	30.8%	25.0%
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										1	3	0	1	35.7%	20.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, '13/14				68.3%	68.3%	70.0%	69.3%	**80.0%**	Worse	X					
2. Rate of Asthma ED Visits per 10,000 Population, 2013				43.7	44.5	48.8	85.4	**75.1**	Meets/Better						
3. Rate of Asthma ED Visits Ages 0 - 4, per 10,000 Population Ages, 0 - 4, 2013				91.8	70.2	117.0	205.6	**196.5**	Meets/Better						
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, Ages 6 - 17, '08 - 10				N/A	2.5	2.9	3.0	**3.06**	Less than 10						
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, Ages 18 Plus, 2013				4.1	6.7	6.0	6.5	**4.86**	Meets/Better						
6. Rate of Heart Attack Hospitalizations per 10,000 Population, 2013				14.8	23.2	14.7	13.8	**14.0**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	33.3%	0.0%
Other Indicators															
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '11 - 13				48.2	49.2	**46.8**	77.6	N/A	Worse	X					
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '11-13				15.9	14.0	**15.1**	31.9	N/A	Worse	X					
3. Rate of All Cancer Cases per 100,000 Population, '10 - 12	254	245	283	664.8	650.6	**610.5**	550.9	N/A	Worse	X					
4. Rate of all Cancer Deaths per 100,000 Population, '10 - 12	93	82	112	244.0	235.2	**202.4**	180.7	N/A	Worse	X					
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '10 -12	25	29	32	151.7	158.1	**164.5**	149.1	N/A	Meets/Better						
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '10 - 12				49.4	47.8	**51.4**	49.2	N/A	Meets/Better						
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '10 - 12	6	6	6	31.8	27.6	**28.1**	26.3	N/A	Worse	X					
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13/14				83.0%	79.7%	**80.5%**	80.9%	N/A	Meets/Better						
9. Rate of Cervix and Uteric Cancer Cases per 100,000 Female Population, '10 - 12				N/A	8.1	**7.2**	8.3	N/A	Less than 10						
10. Rate of Cervix and Uteric Cancer Deaths per 100,000 Female Population, '10 - 12				N/A	2.6	**2.4**	2.7	N/A	Less than 10						
11. Percentage of Women Aged 21-65 Years with Annual Household Income of Less than $25,000 Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14				N/A	82.8%	**79.5%**	80.6%	N/A	Less than 10						
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '10 - 12				15.9	15.3	**16.2**	14.9	N/A	Meets/Better						
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '10 - 12				12.3	10.8	**10.4**	9.5	N/A	Worse	X					
14. Rate of Colon and Rectum Cancer Cases per 100,000 Population, '10 - 12	25	24	24	62.1	51.6	**49.6**	46.7	N/A	Worse		X				
15. Rate of Colon and Rectum Cancer Deaths per 100,000 Population, '10 - 12	8	7	9	20.4	20.6	**17.2**	16.6	N/A	Worse	X					
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines				68.3%	69.9%	**70.0%**	69.3%	N/A	Worse	X					
17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '10 - 12				14.8	21.2	**18.6**	18.3	N/A	Meets/Better						
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '10-12	26	37	32	155.9	147.8	**167.6**	156.7	N/A	Meets/Better						
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '10 - 12	6	9	7	36.1	27.0	**25.1**	23.3	N/A	Worse		X				
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '10 -'12				6.0	3.2	**3.3**	2.5	N/A	Less than 10						
21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '12 - 14	1,822	1,902	2,102	21.8%	20.2%	**25.1%**	26.6%	N/A	Worse	X					
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '12/14				65.8%	66.2%	**71.3%**	69.8%	N/A	Worse	X					
23. Oral Cavity and Pharnyx Cancer Deaths per 100,000 Population, '10-12				N/A	5.7	**4.6**	4.8	N/A	Less than 10						
24. Oral Cavity and Pharnyx Cancer Cases per 100,000 Population, '10 - 12	7	6	8	17.9	15.7	**13.5**	12.1	N/A	Worse		X				
Quartile Summary for Other Indicators										10	3	0	0	54.2%	0.0%
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										12	3	0	0	50.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Maternal and Infant Health															
Prevention Agenda Indicators															
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, '11 - 13				8.2%	9.5%	10.8%	10.8%	**10.2%**	Meets/Better						
2. Ratio of Preterm Births (< 37 wks) Black/NH to White/NH, '11 - 13				N/A	N/A	1.59	1.60	**1.42**	Less than 10						
3. Ratio of Preterm Births (< 37 wks) Hisp/Latino to White/NH, '11 - 13				N/A	N/A	1.21	1.25	**1.12**	Less than 10						
4. Ratio of Preterm Births (< 37 wks) Medicaid to Non-Medicaid, '11 - 13				1.23	N/A	1.12	1.07	**1.00**	Worse	X					
5. Rate of Maternal Mortality per 100,000 Births, 2013				0.0	N/A	18.0	18.7	**21.0**	Less than 10						
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, '11 - 13				75.0%	70.4%	51.1%	43.1%	**48.1%**	Meets/Better						
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, '11 - 13				N/A	N/A	0.5	0.56	**0.57**	Less than 10						
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, '11 - 13				N/A	N/A	0.58	0.54	**0.64**	Less than 10						
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, '11 - 13				0.86	N/A	0.69	0.58	**0.66**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	11.1%	0.0%
Other Indicators															
1. Percentage Perterm Births < 32 weeks of Total Births Where Gestation Period is Known, '11 - 13	4	10	6	2.1%	2.0%	**1.8%**	1.8%	N/A	Worse	X					
2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '11 - 13	27	20	31	8.2%	8.7%	**9.1%**	9.1%	N/A	Meets/Better						
3. Percentage of Total Births with Weights Less Than 1,500 grams, '11 - 13	2	5	5	1.3%	1.5%	**1.4%**	1.4%	N/A	Meets/Better						
4. Percentage of Singleton Births with Weights Less Than 1,500 grams, '11 - 13	1	2	4	0.8%	1.0%	**1.0%**	1.1%	N/A	Less than 10						
5. Percentage of Total Births with Weights Less Than 2,500 grams, '11 - 13	19	22	29	7.3%	7.7%	**7.6%**	8.0%	N/A	Meets/Better						
6. Percentage of Singleton Births with Weights Less Than 2,500 grams, '11 - 13	11	14	23	5.2%	5.6%	**5.6%**	6.0%	N/A	Meets/Better						
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '11 - 13				N/A	N/A	**12.9%**	12.5%	N/A	Less than 10						
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '11 - 13				N/A	N/A	**7.2%**	7.6%	N/A	Less than 10						
9. Infant Mortality Rate per 1,000 Live Births, '11 - 13				3.1	5.4	**5.5**	5.0	N/A	Meets/Better						
10. Rate of Deaths (28 Weeks Gestation to Seven Days) per 1,000 Live Births and Perinatal Deaths, '11 - 13	8	1	2	10.3	6.4	**5.4**	5.4	N/A	Worse	X					
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '11 - 13	227	232	240	73.3%	73.1%	**75.4%**	73.1%	N/A	Worse	X					
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '11 - 13				N/A	N/A	**64.7%**	63.3%	N/A	Less than 10						
13. Percentage Early Prenatal Care for Hispanic/Latino, 2014				N/A	N/A	**68.2%**	67.2%	N/A	Less than 10						
14. Percentage APGAR Scores of Less Than Five at Five Minute Mark of Births Where APGAR Score is Known, '11 - 13	3	3	4	1.0%	1.1%	**0.7%**	0.6%	N/A	Worse		X				
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '11 - 13	0	0	0	101.9	119.4	**123.2**	95.0	N/A	Less than 10						
16. Percentage WIC Women Breastfed at Six months, '10 - 12				19.9%	17.1%	**27.8%**	38.2%	N/A	Worse		X				
17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '11 - 13	244	253	229	80.1%	74.3%	**78.0%**	83.1%	N/A	Meets/Better						
Quartile Summary for Other Indicators										3	2	0	0	29.4%	0.0%
Quartile Summary for Focus Area Maternal and Infant Health										4	2	0	0	20.7%	0.0%

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	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Preconception and Reproductive Health															
Prevention Agenda Indicators															
1. Percent of Births within 24 months of Previous Pregnancy, 2014				19.5%	23.0%	21.1%	18.9%	**17.0%**	Worse	X					
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, '11 - 13				10.3	14.4	11.7	17.0	**25.6**	Meets/Better						
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, '11 - 13				N/A	N/A	4.13	5.16	**4.90**	Less than 10						
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, '11 - 13				N/A	N/A	3.14	4.41	**4.10**	Less than 10						
5. Percent of Unintended Births to Total Births, 2013				31.7%	30.3%	26.5%	24.5%	**23.8%**	Worse		X				
6. Ratio of Unintended Births Black, non-Hispanic to White, non-Hispanic, '11 - 13				N/A	N/A	2.14%	2.21	**1.90**	Less than 10						
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, '11 - 13				N/A	N/A	1.48%	1.73	**1.43**	Less than 10						
8. Ratio of Unintended Births Medicaid to Non-Medicaid, '11 - 13				1.82	N/A	1.97	1.76	**1.54**	Worse	X					
9. Percentage of Women Ages 18- 64 with Health Insurance, 2014				91.7%	N/A	N/A	89.7%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	1	0	0	44.4%	0.0%
Other Indicators															
1. Rate of Total Births per 1,000 Females Ages 15-44, '11 - 13	314	337	307	53.8	54.6	**56.8**	59.0	N/A	Meets/Better						
2. Percent Multiple Births of Total Births, '11 - 13	19	17	7	4.5%	4.2%	**4.1%**	3.9%	N/A	Worse	X					
3. Percent C-Sections to Total Births, '11 - 13	101	117	116	34.9%	36.5%	**35.6%**	34.1%	N/A	Meets/Better						
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '11 - 13	420	427	402	63.6	67.3	**72.6**	87.9	N/A	Meets/Better						
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '11 - 13	0	1	0	0.3	0.3	**0.2**	0.3	N/A	Less than 10						
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '11 - 13	0	1	0	0.3	0.6	**0.6**	0.9	N/A	Less than 10						
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '11 - 13	6	5	1	5.7	8.9	**7.9**	9.3	N/A	Meets/Better						
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '11 - 13	29	22	12	19.4	23.4	**17.3**	19.5	N/A	Worse	X					
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 5-19, '11 - 13	42	31	24	27.0	34.2	**28.7**	41.3	N/A	Meets/Better						
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '11 - 13	23	17	11	45.2	44.3	**29.9**	33.5	N/A	Worse			X			
11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '11 - 13	32	23	18	58.2	62.8	**47.6**	67.2	N/A	Worse	X					
12. Percent Total Births to Women Ages 35 Plus, '11 - 13	39	45	54	14.4%	11.2%	**18.9%**	20.5%	N/A	Meets/Better						
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '11 - 13				420.3	433.8	**624.6**	1,050.3	N/A	Meets/Better						
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '11 - 13	64	50	59	162.9	206.6	**233.2**	412.3	N/A	Meets/Better						
15. Percentage of WIC Women Pre-pregnancy Underweight, '10 - 12	12	11	11	5.4%	4.9%	**4.1%**	4.7%	N/A	Worse		X				
16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	45	38	54	21.6%	22.3%	**26.3%**	26.6%	N/A	Meets/Better						
17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	66	63	55	29.1%	33.3%	**28.0%**	24.2%	N/A	Worse	X					
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	103	105	87	52.9%	52.4%	**47.1%**	41.7%	N/A	Worse	X					
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	14	23	20	9.6%	7.2%	**5.7%**	5.5%	N/A	Worse			X			
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	31	32	23	14.5%	12.9%	**9.1%**	7.1%	N/A	Worse			X			
Quartile Summary for Other Indicators										5	1	3	0	45.0%	33.3%
Quartile Summary for Focus Area Preconception and Reproductive Health										9	4	3	0	55.2%	18.8%

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	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Child Health															
Prevention Agenda Indicators															
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2014				92.2%	91.1%	84.3%	80.8%	**91.3%**	Meets/Better						
2. Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2014				86.2%	84.6%	81.4%	84.2%	**91.3%**	Worse	X					
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2014				53.1%	64.7%	62.0%	64.9%	**67.1%**	Worse	X					
4. Percentage of Children Ages 0 -19 with Health Insurance, 2014				95.8%	N/A	N/A	96.6%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	75.0%	0.0%
Other Indicators															
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children Ages 1 - 4, '11 - 13	0	0	0	0.0	23.1	**21.1**	20.0	N/A	Less than 10						
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children Ages 1 - 4, '11 - 13	1	0	0	18.1	7.0	**9.7**	10.1	N/A	Less than 10						
3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children ages 10 - 14, '11 - 13	1	1	0	32.7	11.4	**11.8**	11.9	N/A	Less than 10						
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children Ages 5 - 14, '11 - 13	2	1	0	25.8	9.3	**10.8**	11.0	N/A	Less than 10						
5. Rate of Children Deaths Ages 15 - 19 per 100,000 Population Children Ages 15 - 19 , '11 - 13	4	1	0	70.8	56.8	**35.2**	33.4	N/A	Less than 10						
6. Rate of Children Deaths Ages 1 - 19 per 100,000 Population Children Ages 0 - 19, '11 - 13	6	2	0	35.0	26.3	**25.0**	19.2	N/A	Less than 10						
7. Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '11 - 13				11.7	20.0	**30.2**	50.5	N/A	Less than 10						
8. Rate of Asthma Hospitalizations Children Ages 5 - 14, '11 - 13				N/A	9.0	**10.4**	20.5	N/A	Less than 10						
9. Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children Ages 0 - 17, '10-12				4.2	10.4	**14.2**	26.6	N/A	Meets/Better						
10. Rate of Gastroenteristis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '10-12				0.0	5.6	**8.6**	11.3	N/A	Less than 10						
11. Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '10-12				N/A	2.6	**1.9**	2.5	N/A	Less than 10						
12. Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '10-12				0.0	28.8	**31.3**	39.4	N/A	Less than 10						
13. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Populaiton Children Ages 0 - 4, 2014				91.8	70.2	**117.0**	205.6	196.5	Meets/Better						
14. Percentage of Children Screened for Lead by Age 9 months				1.8%	1.2%	**4.2%**	3.5%	N/A	Less than 10						
15. Percentage of Children Screened for Lead by Age 18 months				35.9%	25.0%	**53.5%**	65.0%	N/A	Worse		X				
16. Percentage of Children Screened for Lead by Age 36 months (at least two screenings)				11.3%	15.7%	**42.1%**	55.1%	N/A	Worse			X			
17. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '08 - 10	5	2	2	8.3	12.7	**8.8**	4.9	N/A	Less than 10						
18. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children Under Age 10, '11-13	0	0	0	N/A	15.5	**20.4**	23.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children Ages 10 - 14, '11 - 13				11.5	12.1	**16.0**	18.0	N/A	Meets/Better						
20. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population Ages 15 - 24, '11 - 13	10	7	11	20.9	24.7	**29.7**	28.7	N/A	Meets/Better						
21. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children Ages 0 - 17, '11 - 13	46	48	31	58.7	46.8	**75.7**	151.4	N/A	Meets/Better						
22. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit, 12 - 14				44.2%	41.6%	N/A	**45.0%**	N/A	Worse	X					
23 Percentage of 3rd Graders with Dental Caries, '09 - 11				59.6%	N/A	N/A	N/A	N/A	N/A						
24. Percentage of 3rd Graders with Dental Sealants, '09 - 11				34.5%	N/A	N/A	N/A	N/A	N/A						
25. Percentage of 3rd Graders with Dental Insurance, '09 - 11				86.6%	N/A	N/A	N/A	N/A	N/A						
26. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11				76.8%	N/A	N/A	N/A	N/A	N/A						
27. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11				85.4%	N/A	N/A	N/A	N/A	N/A						
28. Rate of Caries ED Visits for Children Ages 3 - 5 per 10,000 Population Children Ages 3 - 5, '11 - 13	7	8	12	85.5	66.9	**93.5**	79.2	N/A	Meets/Better						
29. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '10 -12				95.2%	84.3%	**81.1%**	79.9%	N/A	Worse	X					
Quartile Summary for Other Indicators										2	1	1	0	13.8%	25.0%
Quartile Summary for Focus Area Child Health										5	1	1	0	21.2%	14.3%

Essex County: Revised 7/27/2016	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Human Immunodeficiency Virus (HIV)															
Prevention Agenda Indicators															
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, '12-14				N/A	3.0	7.1	17.9	**16.1**	Less than 10						
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, '12-14				N/A	N/A	22.0	40.4	**46.8**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of AIDS Cases per 100,000 Population, '11 - 13				N/A	N/A	**4.8**	12.2	N/A	Less than 10						
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '11 - 13	1	0	0	0.9	0.7	**1.4**	4.0	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Sexually Transmitted Disease (STDs)															
Prevention Agenda Indicators															
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2014				0.0	2.2	7.0	17.3	**10.1**	Less than 10						
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2014				0.0	0.6	0.3	0.5	**0.4**	Less than 10						
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2014				34.5*	49.2	140.1	165.4	**183.4**	Meets/Better						
4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2014				13.2	36.1	145.3	303.1	**199.5**	Meets/Better						
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2014				691.0	1184.5	1249.6	1536.4	**1458.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of Early Syphilis Cases per 100,000 Population, '11 - 13	2	3	0	4.3	2.8	**3.6**	14.4	N/A	Less than 10						
2. Rate of Gonorrhea Cases per 100,000 Population, '11 - 13	15	33	17	6.0	16.5	**61.1**	107.7	N/A	Meets/Better						
3. Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '11 - 13	0	0	0	0.0	32.7	**203.6**	368.1	N/A	Less than 10						
4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '11 - 13	11	12	14	61.0	121.0	**203.0**	336.0	N/A	Meets/Better						
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '11 - 13				52.4	360.8	**608.6**	1,029.1	N/A	Meets/Better						
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '11 - 13	35	48	38	451.2	752.4	**1,089.0**	1,492.7	N/A	Meets/Better						
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '11 - 13	40	50	55	257.7	378.4	**466.8**	672.3	N/A	Meets/Better						
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '11 - 13	15	9	16	1,234.6	1,989.6	**2,387.5**	3,595.5	N/A	Worse	X					
9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '11 - 13	18	24	27	2,457.3	2,563.4	**2,743.8**	3,432.2	N/A	Meets/Better						
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, '08 - 10				N/A	2.3	**2.1**	3.0	N/A	Less than 10						
Quartile Summary for Other Indicators										1	0	0	0	10.0%	0.0%
Quartile Summary for Sexually Transmitted Diseases										1	0	0	0	6.7%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Vaccine Preventable Disease															
Prevention Agenda Indicators															
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2014				61.5%	70.0%	59.4%	70.7%	**80.0%**	Worse	X					
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2014				24.7%	34.0%	30.3%	40.1%	**50.0%**	Worse			X			
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, '13/14				68.3%	74.4%	77.1%	72.1%	**70.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	1	0	100.0%	33.3%
Other Indicators															
1. Rate of Pertussis Cases per 100,000 Population, '11 - 13	2	14	3	16.3	13.0	**12.9**	8.8	N/A	Worse		X				
2. Rate of Pneumonia/flu Hospitalizations Ages 65 Plus per 100,000 Population Age 65 Plus, '11 - 13	93	94	120	133.7	145.5	**121.9**	112.6	N/A	Worse	X					
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14				59.3%	73.7%	**70.7%**	65.1%	N/A	Worse	X					
4. Rate of Mumps Cases per 100,000 Population, '11-13	0	0	0	0.0	0.09	**0.08**	0.17	N/A	Less than 10						
5. Rate of Meningococcal Cases per 100,000 Population, '11-13	0	0	0	0.0	0.4	**0.2**	0.2	N/A	Less than 10						
6. Rate of H Influenza Cases per 100,000 Population, '11-13	1	0	0	0.9	1.9	**1.7**	1.7	N/A	Less than 10						
Quartile Summary for Other Indicators										2	1	0	0	50.0%	0.0%
Quartile Summary for Focus Area Vaccine Preventable Diseases										4	1	1	0	66.7%	16.7%

Essex County: Revised 7/27/2016	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda		Q1	Q2	Q3	Q4		
Focus Area: Healthcare Associated Infections															
Prevention Agenda Indicators															
1. Rate of Hospital Onset CDIs per 10,000 Patient Days, 2011				N/A	5.1	8.3	11.2	**5.94**	Less than 10						
2. Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2011				N/A	6.3	2.7	10.0	**2.05**	Less than 10						
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders															
Prevention Agenda Indicators															
1. Percent of Adults Binge Drinking within the Last Month, '13/14				21.9%	N/A	17.4%	17.8%	**18.4%**	Worse	X					
2. Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, '13-14				11.3%	N/A	11.8%	11.2%	**10.1%**	Worse	X					
3. Rate of Age Adjusted Suicides per 100,000 Adjusted Population, '11 - 13				14.8	N/A	9.5	7.9	**5.9**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										2	0	0	1	100.0%	33.3%
Other Indicators															
1 Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '11 - 13	1	0	0	14.2	14.2	**6.3**	5.4	N/A	Less than 10						
2. Rate of Self-inflicted Hospitalizations 10,000 Population, '11 - 13	23	30	26	6.8	10.4	**6.8**	5.8	N/A	Meets/Better						
3. Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, '11 - 13	0	0	0	22.7	22.0	**12.5**	11.3	N/A	Less than 10						
4. Rate of Cirrhosis Deaths per 100,000 Population, '11 - 13	3	5	6	12.0	12.8	**8.7**	7.7	N/A	Worse		X				
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, '11 - 13				1.8	2.9	**2.5**	2.8	N/A	Meets/Better						
7. Alcohol-Related Crashes, 11 - 13				102.6	90.8	N/A	**43.4**	N/A	Worse				X		
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, '11 - 13	28	14	22	54.7	60.1	**44.4**	33.3	N/A	Worse	X					
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '11 - 13	39	42	42	10.5	15.9	**20.4**	23.9	N/A	Meets/Better						
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2013			36	521.9	1,041.8	**607.3**	681.7	N/A	Meets/Better						
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2013			84	356.3	682.0	**603.6**	705.4	N/A	Meets/Better						
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2014			7	88.0	147.7	**171.8**	318.5	N/A	Meets/Better						
13. Rate of People Served in ED for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2013			N/A	N/A	59.0	**50.5**	52.3	N/A	Less than 10						
14. Rate of People Served in ED for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2013			N/A	N/A	13.2	**22.5**	26.9	N/A	Less than 10						
15. Rate of People Served in ED for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2014			N/A	N/A	3.2	**4.3**	6.1	N/A	Less than 10						
Quartile Summary for Other Indicators										1	1	0	1	20.0%	33.3%
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders										3	1	0	2	33.3%	33.3%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2017 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Other Non-Prevention Agenda Indicators															
1. Rate of Hepatitis A Cases per 100,000 Population, '11 - 13	0	0	0	0.0	0.2	**0.5**	0.7	N/A	Less than 10						
2. Rate of Acute Hepatitis B Cases per 100,000 Population, '11 - 13	0	0	0	0.0	0.5	**0.5**	0.6	N/A	Less than 10						
3. Rate of TB Cases per 100,000 Population, '11 - 13	0	0	0	0.0	0.5	**1.9**	4.5	N/A	Less than 10						
4. Rate of e. Coli 157 Cases per 100,000 Population, '11 - 13	1	0	0	0.9	1.1	**0.8**	0.6	N/A	Less than 10						
5. Rate of Salmonella Cases per 100,000 Population, '11 - 13	8	4	2	12.0	14.0	**12.2**	12.9	N/A	Meets/Better						
6. Rate of Shigella Cases per 100,000 Population, '11 - 13	1	0	1	1.7	0.7	**4.4**	4.8	N/A	Less than 10						
7. Rate of Lyme Disease Cases per 100,000 Population, '11 - 13	16	22	83	103.5	84.2	**57.8**	36.6	N/A	Worse				X		
8. Rate of Confirmed Rabies Cases per 100,000 Population, '11-13	9	19	5	28.2	7.0	**3.4**	1.9	N/A	Worse				X		
Quartile Summary for Non-Prevention Agenda Issues															

Appendix L

Adirondack Health Institute (AHI)
Performing Provider System(PPS)
Delivery System Reform Incentive Payment Program (DSRIP) **Projects**

The AHI PPS has elected to participate in eleven projects, covering three domains:

- *System Transformation* projects are designed to accomplish New York's State Innovation Plan, a roadmap to achieve the "Triple Aim" for all New Yorkers: improved health, better health care quality and consumer experience, and lower costs. This multi-faceted approach has at its core an advanced primary care model that integrates care with all parts of the health care system, including behavioral health and community-based providers and aligns payment with this care model.

  - o 2ai "Integrated Delivery System"
  - o 2aii "Advancing Primary Care"
  - o 2aiv "Medical Village"
  - o 2bviii "Hospital-Home Collaboration Solutions"
  - o 2di "Patient Activation"

- *Clinical Improvement* projects focus on a specific disease or service category (ex, behavioral health, substance abuse, palliative care) that have been identified as a significant cause of avoidable hospital use by Medicaid beneficiaries in our region.

  - o 3ai "Integrating Behavioral Health with Primary care"
  - o 3aii "Crisis Stabilization"
  - o 3aiv "Withdrawal Management"
  - o 3gi "Integration of Palliative Care into the PCMH Model"

- *Population-Wide Strategy Implementation* projects focus on progress on measures from the New York State Prevention Agenda.

  The Prevention Agenda is a blueprint for state and local action to improve the health of New Yorkers in five priority areas (prevent chronic disease; promote a healthy & safe environment; promote healthy women, infants & children; promote mental health and prevent substance abuse; prevent HIV, sexually transmitted diseases, vaccine preventable disease and healthcare associated infections) and to reduce health disparities for racial, ethnic, disability and low socio-economic groups, as well as other populations who experience them.

  - o 4aiii "Strengthening the Mental Health & Substance Abuse Infrastructure"
  - o 4bii "Chronic Care: COPD"

Nearly 100 Regional Partners are part of the AHI PPS. Partners are organized by Regional Health Innovation Teams (RHIT). RHITs provide a forum for collaborative planning, monitoring, and development of innovative health system programs/projects.

AHI has convened stakeholders in the nine-county service area (Warren, Washington, Essex, Franklin, Clinton, Hamilton and parts of St. Lawrence, Fulton and Saratoga counties) to discuss the unmet needs of the communities and the barriers to accessing care.