A historical map of Franklin County, New York, and its surrounding areas. The map is color-coded by county: Franklin County is pink, DeWitt County is yellow, Hamilton County is green, and Schoharie County is grey. The map shows a grid of latitude and longitude lines, with labels for various towns and geographical features. At the top, it says 'PROVINCE OF QUEBEC' and 'NEW YORK'. At the bottom right, it says 'FRANKLIN COUNTY NEW YORK' and 'SCALE OF MILES'.

FRANKLIN COUNTY

Community Health Assessment, 2025
Community Health Improvement Plan, 2025-2030

Franklin County Health Partners
Franklin County Public Health Services
Alice Hyde Medical Center
Adirondack Health

Community Health Assessment, 2025
Community Health Improvement Plan, 2025-2030

County Covered: Franklin County

A joint plan created by the following health partners:

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Malone NY 12953

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Adirondack Health

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Contents

- Executive Summary..... 4
 - Prevention Agenda Priorities 4
 - Data Review 4
 - Partners and Roles 5
 - Interventions and Strategies..... 5
 - Progress and Evaluation..... 5
- Community Health Assessment 6
 - Community Description 6
 - Service Area 6
 - Demographics and Complementary Profiles 7
 - Health Status Description 8
 - Data Sources 8
 - Data Collection Methods 9
 - Community Engagement 20
 - Relevant Health Indicators..... 24
 - Health Challenges and Associated Risk Factors 30
 - Community Assets and Resources 34
- Community Health Improvement Plan/Community Service Plan (CHIP/CSP)..... 37
 - Major Community Health Needs 37
 - Prioritization Methods 37
 - Description of the Prioritization Process 37
 - Community Engagement 38
 - Justification of Unaddressed Health Needs 39
- Objectives, Interventions, and Action Plans 39
 - Adirondack Health Action Plan** 39
 - Alice Hyde Medical Center Action Plan** 41
 - Franklin County Public Health Action Plan** (to be included in June 2026 update)..... 46
- Partner Engagement 46
- Sharing Findings with the Community 46
- Appendix - 2025 Stakeholder Survey Report 47

Executive Summary

Franklin County Public Health Services, along with Adirondack Health in Saranac Lake and Alice Hyde Medical Center in Malone, worked together to review community health data and identify the most important health issues facing residents. This process supports the New York State Prevention Agenda, which focuses on improving health and reducing disparities across all communities.

Prevention Agenda Priorities

The [New York State Prevention Agenda 2025–2030](#) serves as the state’s blueprint for improving the health and well-being of all New Yorkers and reducing health disparities across communities. It outlines priority areas and measurable objectives that guide local health departments and hospitals in developing their Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs).

In alignment with the Prevention Agenda, Franklin County Public Health Services, Adirondack Health, and Alice Hyde Medical Center used the framework to identify local priorities, select evidence-based strategies, and coordinate efforts to address the most pressing health challenges facing Franklin County residents. After reviewing data and community input, the work group selected Mental Health & Substance Use and Chronic Disease as Franklin County’s top health priorities. These priorities fall under the Social & Community Context and Health Care Access & Quality domains of the Social Determinants of Health (SDOH). Data revealed persistent disparities in mental health outcomes, substance use, and chronic disease rates across the county—particularly among low-income residents, rural populations, and individuals with limited access to care.

Data Review

The 2025 Community Health Assessment draws on a wide range of reliable state and national data to provide a clear picture of the region’s health status and community conditions. Demographic, health system, education, and economic data were compiled from sources such as the U.S. Census Bureau, New York State Department of Health, New York State Education Department, and United for ALICE. Health indicators were drawn from the Prevention Agenda Dashboard, Behavioral Risk Factor Surveillance System (BRFSS), Community Health Indicator Reports, and other New York State data systems.

Additional information on community conditions—including crime, transportation safety, and food access—was provided through state and federal data sets, including the Division of Criminal Justice Services, Institute for Traffic Safety Management and Research, and the U.S. Department of Agriculture. Data were analyzed regionally through the Adirondack Rural Health Network (ARHN) and compiled in an interactive dashboard that includes more than 350 indicators. This comprehensive data foundation supports regional collaboration and guides priorities for the 2025–2030 New York State Prevention Agenda.

Partners and Roles

The Adirondack Rural Health Network (ARHN) leads a regional partnership of seven counties to support the New York State Prevention Agenda through data sharing, collaboration, and coordinated planning. The Community Health Assessment (CHA) Committee, led by ARHN, includes 13 hospitals and county health departments from Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties. Together, members review data, identify priorities, and track progress toward improving regional health outcomes.

To ensure broad input, a stakeholder survey was distributed to nearly 900 professionals and community members representing health care, social services, education, and government sectors. The survey results guided the identification of key health needs and priorities across the region.

In Franklin County, the county health department and local hospitals met with Franklin County stakeholders to review survey results and finalize the selection of priorities for the Community Health Assessment and community health improvement efforts.

Interventions and Strategies

The partner hospitals have completed and included their Community Health Improvement Plans (CHIPs) as part of their 2025 Community Service Plans. Franklin County Public Health Services will continue this work by developing its Community Health Improvement Plan in the first half of 2026.

The plans outline evidence-based strategies to improve mental health and increase preventive care. Key actions include expanding access to services; conducting comprehensive suicide prevention and Mental Health First Aid training for staff; integrating behavioral health and tobacco use assessments into primary care practices; increasing access to tobacco/e-cigarette cessation and education services; expanding naloxone distribution; and sending reminders for age-appropriate cancer screenings.

Progress and Evaluation

Progress towards the identified health goals will be tracked, with formal progress captured in annual community health improvement plan documents. Interventions identified in our improvement plan have measurable outcomes, which will be reported. Franklin County Public Health, Alice Hyde Medical Center, Adirondack Health, and participating community-based organizations will continue to meet bi-annually to assess progress and report on the measurable outcomes identified in our interventions chart.

Community Health Assessment

Community Description

Service Area

This section describes Franklin County's service area to provide important context for understanding the county's health status and priorities. Geographic, demographic, and historical characteristics influence access to care, community resources, and overall health outcomes. By outlining the county's size, location, population centers, and unique features—such as its rural setting and significant area within the Adirondack Park—this section helps illustrate the environmental and logistical factors that shape public health in Franklin County.

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

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

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

The Adirondacks, which were once a barrier to settlement, began to serve as a draw for tourists in the late 19th century, and now serve as one of Franklin County's defining features. The Adirondack Park is 6 million acres of both public and private land, making it the largest publicly protected area in the lower forty-eight states. About fifty percent of the land belongs to the residents of New York State and is protected as "forever wild". The remaining fifty percent is made up of small towns and villages, farms, timberland and homes both summer and year-round.

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

*Upstate New York is defined as all counties other than that which make up New York City (Bronx, New York, Kings, Richmond, and Queens Counties). -All rates are per 100,000 unless otherwise specified.

Demographics and Complementary Profiles

This section describes key characteristics of the county and the conditions that shape residents' daily lives. It includes demographic information, such as age, race, and household makeup, as well as details about the local health and education systems and an ALICE profile, which shows the share of households struggling to meet basic needs. Together, these data help us understand who lives in the community, the resources available to them, and the challenges they may face.

Demographics

23.7% are 65 years or older, which is higher than both the ARHN region (21.1%) and Upstate New York* (19.5%).

The average household income in Franklin County is \$78,937, and the per capita income is \$31,801. The poverty rate in Franklin County stands at 16.5%, which is higher than the ARHN region's rate of 12.6% and Upstate New York* rate of 11.1%.

Regarding educational attainment, 82.1% of Franklin County residents are 25 years of age or older. Of these, 33.9% are high school graduates or hold a General Education Diploma (GED), while another 37.8% have earned an associate's degree, bachelor's degree, or higher.

Franklin County's unemployment rate is 2.5%, with 20,256 individuals aged 16 and older in the civilian workforce. The largest employment sectors are Education, Health Care, and Social Assistance, accounting for 33.0% of jobs, followed by Retail Trade (13.9%), and Public Administration (12.3%).

Health System Profile

Franklin County is home to two hospitals, Adirondack Medical Center-Saranac Lake Site and Alice Hyde Medical Center in Malone, with a total of 120 hospital beds, primarily designated for medical and surgical care. When factoring in the county's overall population, this results in a hospital bed rate of 255.0, falling closely to the ARHN region's rate of 258.7.

The county has two nursing home facilities, providing a total of 195 nursing home beds, leading to a nursing home bed rate of 414.3. Additionally, there are two adult care facilities with a combined total of 60 beds, giving an adult care facility rate of 127.5. Both the nursing home and adult care facility rates are lower than those in the ARHN region, which are 667.4 and 338.0, respectively. Franklin County's physician rate is 168, which is lower than the ARHN region's rate of 190.2.

Education System Profile

Franklin County is served by eight school districts, with a total enrollment of 6,936 students. Of

these, 56.0% qualify for free or reduced lunch, with the majority (92.8%, or 3,427 students) eligible for free lunch. The county graduates 462 high school students annually, with a dropout rate of 6.0%. This rate is lower than the ARHN region's rate of 6.6% but above the New York State's rate of 5.0%.

The county employs 753 teachers, resulting in a student-to-teacher ratio of 8.8, which is lower than both the ARHN region's ratio of 9.6 and the NYS ratio of 11.2.

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

Franklin County has a total of 18,933 households, including 2,564 households headed by individuals aged 65 or older who fall under the ALICE category. The county has a poverty rate of 16.0% and an ALICE rate of 27.0%, resulting in a total of 8,027 households classified as either living in poverty or as ALICE households.

Among ALICE households, the majority are White (17,069), significantly outnumbering the second largest group, American Indian/Alaska Native (1,143).

Health Status Description

Data Sources

Demographic, Health Systems, Education, and ALICE Profile Data Sources:

- U.S. Census Bureau, U.S. Department of Commerce, American Community Survey
 - Selected Economic Characteristics
 - Selected Social Characteristics in the United States
 - Medicaid/Means-Tested Public Coverage by Sex by Age
 - Poverty Status in the Past 12 Months
- United State Department of Agriculture (USDA) FSA Crop Acreage Data
- NYS Department of Health, NYS Health Profiles
 - Hospital Profile
 - Nursing Homes Profile
 - Adult Care Facilities Profile
- NYS Education Department (NYSED)
 - Licensed Professions
 - Enrollment Database Report
 - Student and Educator Database Report
 - Enrollment Data by County Report
 - High School Graduation Rate Report
- National Center for Education Statistics
- United for ALICE

2025 CHA Data Sheets and Written Analysis Data Sources:

- Community Health Indicator Reports (CHIRs)
- NYS Department of Health, Wadsworth Center
- Division of Criminal Justice Services Index, Property, and Violent Crime Report
- NYS Behavioral Risk Factor Surveillance System (BRFSS)
- Institute for Traffic Safety Report (ITSMR), Traffic Safety Statistical Repository
- Prevention Agenda Dashboard
- Student Weight Status Category Reporting System (SWSCRS)
- USDA Food Environment Atlas

Data Collection Methods

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

The overarching goal of collecting and providing this data to the CHA Committee is to provide a comprehensive picture of individual counties as well as an overview of population health within the ARHN region, as well as Montgomery and Saratoga counties. The ARHN region is comprised of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

When available, Upstate New York (NY) data is provided as a benchmark statistic. Upstate NY is calculated as the NYS total minus New York City (NYC), which includes New York, Kings, Bronx, Richmond, and Queens counties.

Demographic Profile:

Demographic data was primarily taken from the United States Census Bureau 2023 American Consumer Survey 5-year estimates. Additional sources include: 2020 Census Estimate: Census Quick Stats, and United States Department of Agriculture (USDA) Farm Service Agency (FSA) Crop Acreage Data Reported to FSA. Information included in the demographic profile includes square mileage, population, family status, poverty, immigrant status, housing, vehicle accessibility education, and employment status/sector.

Health System Profile:

The Health System Profile data includes hospital, nursing home, and adult care facilities, bed counts, physician data, and licensure data. Data on facilities is sourced from the NYS Department of Health, NYS Health Profiles, covering profiles for hospitals, nursing homes, and adult care facilities. Licensure data is pulled from the NYS Education Department (NYSED).

Education Profile:

The Education Profile is separated into two parts: 1) Education System Information and 2) School Districts by County.

- 1) The Education System Profile includes student enrollment, student to teacher ratios, English proficiency rates, free lunch eligibility rates, as well as high school graduate statistics. Data was sourced from the NYSED and the National Center for Education Statistics (NCES).
- 2) The Education System Profiles by School District identifies all the school districts in each county, sourced from the National Center for Education Statistics (NCES).

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

ALICE profile data includes total households, ALICE households over 65 years, ALICE households by race/ethnicity, poverty/ALICE percentages within each county, unemployment rates, percent of residents with health insurance, and median household income. All ALICE data is reflective of data presented in the ALICE profile originated from the 2024 ALICE report (www.unitedforalice.org/new-york). Within the ALICE report, data was pulled from the 2022 American Community Survey, 2022 ALICE Threshold and ALICE county demographics.

County Health Rankings (CHR) Profile:

The County Health Rankings profile includes indicators from the 2025 CHR release, with focuses on Population Health and Well-Being and Community Conditions. The population health and well-being section focuses on length of life and quality of life indicators. The community conditions section focuses on health infrastructure, physical environment, and social and economic factors.

The County Health Rankings identifies the two focus areas as:

- **Population health and well-being** is something we create as a society, not something an individual can attain in a clinic or be responsible for alone. Health is more than being free from disease and pain; health is the ability to thrive. Well-being covers both quality of life and the ability of people and communities to contribute to the world. Population health involves optimal physical, mental, spiritual and social well-being.
- **Community conditions** include the social and economic factors, physical environment and health infrastructure in which people are born, live, learn, work, play, worship and age. Community conditions are also referred to as the social determinants of health.

**All data included in the written analysis relating to the County Health Rankings section is pulled from the website directly and does not reflect analysis completed by ARHN. Strengths and areas for improvement are identified by County Health Rankings.*

Data Dashboard:

The Data Dashboard, compiled of 355 data indicators, provides an overview of population health as compared to the ARHN region, Upstate New York region, Prevention Agenda Benchmark and/or NYS.

Each source file has visualization aspects to better depict data, as well as a deep dive tab that

provides a table with a benchmark comparison, color-coded to identify where the county rate falls in comparison.

The Data Dashboard is composed of 10 sources, each with their own overview and deep dive tab.

Data and statistics for all indicators come from a variety of sources, including:

- Prevention Agenda Dashboard (PA) – 65 indicators
- Community Health Indicator Reports (CHIRs) – 204 indicators
- NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators – 45 indicators
- Division of Criminal Justice Services Index, Property, and Firearm Rates (DCJS) – 3 indicators
- NYS Traffic Safety Statistical Repository (ITSMR) – 6 indicators
- Student Weight Status Category Reporting System (SWSCRS) Data – 8 indicators
- US Department of Agriculture (USDA) Food Atlas – 2 indicators
- NYS Department of Health Tobacco Enforcement Compliance Results (Tobacco) – 4 indicators
- NYS Department of Health Maternal and Child Health (MCH) – 15 indicators
- Department of Health, Wadsworth Center (Wadsworth) – 3 indicators

ARHN Region Calculations:

The ARHN region includes Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington Counties.

- For percentages, formula is $[\text{sum all numerators}/\text{sum of all denominators}] * 100$.
- For rates per 100,000, formula is $[(\text{sum all numerators}/\text{sum of all denominators}) * 100000]$
- For rates per 10,000, formula is $[(\text{sum all numerators}/\text{sum of all denominators}) * 10000]$
- For rates per 1000, formula is $[\text{sum all numerators}/\text{sum of all denominators}] * 1000]$

** For ratio of rates, differences in rates, and indicators that include 3 or more ARHN counties as unstable/unavailable/suppressed, ARHN rates/percentages are unable to be calculated.*

UPSTATE Calculations:

Upstate NY includes all counties in NYS counties except for the five boroughs of NYC: Kings, Queens, New York, Richmond, and Bronx counties.

- For percentages, formula is $[(A) * 100]$
- For rates per 100,000, formula is $[(A) * 100000]$
- For rates per 10,000, formula is $[(A) * 10000]$
- For rates per 1000, formula is $[(A) * 1000]$

For all data sources, the information under a. identifies **A.**

1. PA
 - a. The NYS Prevention Agenda Dashboard provides a New York State (excluding NYC) region.
2. CHIRs
 - a. A NYS (excluding NYC) region is provided for some indicators. For indicators without a NYS (excluding NYC) measure, calculations were provided (using the methodology above) when data was available.
3. BRFSS
 - a. A NYS exclusive of NYC region is available for some indicators. For indicators without a NYS Exclusive of NYC region, calculations were provided (using the methodology above) when data was available.
4. MCH
 - a. The NYS Maternal-Child Health Dashboard provides a New York State (excluding NYC) measure.
5. SWSCRS
 - a. The Student Weight Status Category Reporting System features a Statewide (Excluding NYC) region.
6. For Wadsworth, DCJS, ITSMR, USDA, and Tobacco data sources, upstate rates were calculated using the calculation below:

$$\left[\frac{\text{Total numerator for NYS} - \text{Total numerator for NYC}}{\text{Total denominator for NYS} - \text{Total denominator for NYC}} \right] \times \text{Specific Rate}$$

**NYS totals are either provided by the source or computer incorporating all the counties within NYS.*

**NYC totals include the five NYC boroughs: Bronx, Kings, New York, Queens, and Richmond counties.*

**Specific rate multiplier depends on the indicator (i.e. rate per 100,000, rate per 10,000, or rate per 1,000).*

All rates in the ARHN region and Upstate NY (where not provided by the data source) are calculated (unless data is not available for calculations).

Unstable Estimates:

Due to limitations in the PowerBI software, all unstable estimates are identified in a column of each data sources deep dive or data compilation table. For further information on what quantifies the indicator as unstable, please see below for explanations (provided by each data source) or visit the data source website for more information.

Prevention Agenda Dashboard

- Multiple years of data were combined to generate more stable estimates when the number of events for an indicator was small (i.e., rare conditions).
The relative standard error (RSE) is a tool for assessing reliability of an estimate. A large RSE is produced when estimates are calculated based on a small number of cases.² Estimates with large RSEs are considered less reliable than estimates with small RSEs. The [National Center for Health Statistics](#) recommends that estimates with RSEs greater than 30% should be considered unreliable/unstable.³
- The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying that result by 100. The RSE is expressed as a percentage of the estimate.
- For the Prevention Agenda dashboard, an asterisk (*) or plus (+) symbol is used to indicate that a percentage, rate, or ratio is unreliable/unstable. This usually occurs when there are less than 10 events in the numerator (RSE is greater than 30%).

Data Suppression for Confidentiality

Results are not shown (i.e., suppressed) when issues of confidentiality exist. Suppression rules vary depending on the data source and the indicator.

Table 1. Summary of data suppression and statistical evaluation significance for the Prevention Agenda Indicators by data source

Data Sources	Suppression Criteria	Statistical Significance Techniques
Sample Surveys		
Pregnancy Risk Assessment Monitoring System	Denominator <30	95% CI comparison
BRFSS and Expanded BRFSS	Numerator <6 or Denominator <50	95% CI comparison
US Census		90% CI comparison
National Survey on Drug Use and Health		95% CI comparison
Youth Risk Behavior Surveillance System	Denominator <100	95% CI comparison
Youth Tobacco Survey		95% CI comparison
Population Count Data		
Death	Single Year: Denominator population <50; Three-Year Combined:	Rate/percentage: one sided chi-square test with p-value <0.05 Rate difference: one sided 95% CI

	Denominator population <30	comparison
Birth	Single Year: Denominator total Births <50	One sided chi-square test with p-value <0.05
Sexually Transmitted Infection (STI) Surveillance		One sided chi-square test with p-value <0.05
HIV Surveillance	Numerator 1-2 cases	County level (rate): one sided 95% CI comparison; State level (rate): one sided chi-square test with p-value <0.05
SPARCS	Numerator between 1 - 5 cases	Rate/percentage: one sided chi-square test with p-value <0.05; Ratio/Rate difference: one sided 95% CI comparison
Prescription Monitoring Program (PMP) Registry	Numerator between 1 - 5 cases	One sided chi-square test with p-value <0.05

CI: Confidence Interval

BRFSS: Behavioral Risk Factor Surveillance System

SPARCS: Statewide Planning and Research Cooperative System

Community Health Indicator Reports (CHIRs)

- Multiple years of data were combined to generate more stable estimates when the number of events for an indicator was small (i.e., rare conditions).
The relative standard error (RSE) is a tool for assessing reliability of an estimate. A large RSE is produced when estimates are calculated based on a small number of cases.² Estimates with large RSEs are considered less reliable than estimates with small RSEs. The [National Center for Health Statistics](#) recommends that estimates with RSEs greater than 30% should be considered unreliable/unstable.³
- The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying that result by 100. The RSE is expressed as a percent of the estimate.
- For notation purposes, an asterisk (*) symbol is used to indicate that a percentage, rate, or ratio is unreliable/unstable. This usually occurs when there are less than 10 events in the numerator (RSE is greater than 30%).

Data Suppression Rules for Confidentiality

Results are not shown (i.e., suppressed) when issues of confidentiality exist. Suppression rules vary depending on the data source and the indicator. An 's' notation indicates that the data did

not meet reporting criteria.

Table 1. Summary of Data Suppression Rules

Data Sources	Suppression Criteria
Bureau of Dental Health (BDH)	Margin of error >20% or Denominator <50
Behavioral Risk Factor Surveillance System (BRFSS) and Expanded BRFSS	Denominator <50 or Numerator < 10
Vital Statistics - Death Records	Denominator population <30
Statewide Perinatal Data System (SPDS) - birth records	Denominator population/births <30
AIDS/HIV	Numerator 1-2 cases
Statewide Planning and Research Cooperative System (SPARCS) - ED and hospital records	Numerator 1-5 cases
Office of Quality and Patient Safety (QARR and eQARR)	Denominator <30 and Numerator >0 cases
Cancer Registry	Numerator 1 - 15 cases
Sexually Transmitted Disease Surveillance System	Annual population less than 1,000 and secondary suppression
NYS Pregnancy Nutrition Surveillance System (PNSS) - WIC Program	Denominator <100

NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators

Limitations of Use:

- Data are sample based and therefore subject to sampling variability. The sampling variability for each indicator is highlighted by including the 95% confidence interval.
- Data are based on respondents’ answers to a telephone survey, so data are self-reported and therefore potentially subject to response bias, recall bias, social desirability bias, and other limitations associated with self-report. Great effort is undertaken when administering the BRFSS to mitigate or minimize the risk of such biases, but they cannot be eliminated altogether.
- Indicator estimates are sometimes based on small samples, resulting in low precision of the

estimates. If the eBRFSS or BRFSS sample has less than 10 respondents with the condition measured by the health indicator or less than 50 respondents at risk for the health condition, the crude and age-adjusted rates are suppressed. The suppression is noted in the “Notes” field.

- Some crude/age-adjusted rates that meet this requirement may still be estimated but with high variability. Highly variable rates are defined as having confidence limits greater than $\pm 10\%$.
- These highly variable rates are flagged as being unreliable in the “Notes” section. In addition, the age-adjustment process may generate rates that are suspect, due to small (three or fewer observations) age-adjustment cells. The age-adjusted rates with which there are concerns are identified in the “Notes” field. Age-adjusted rates are not calculated for indicators that apply to a specific age-group (e.g., adults 50 to 75 years of age). The indicators with an age-restriction are identified in the “Notes” field.

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

Limitations of Data Use:

- Although crime reports are collected from more than 500 NYS police and sheriffs’ departments, this data set is limited to the crimes reported to the police agencies but not the total crimes that occurred.
- Requests for additional information, missing data or actual copies of the crime reports should be directed to DCJS or the local submitting police agency.
- Public access to this crime data is intended solely to allow the public convenient and immediate access to public information. While all attempts are made to provide accurate, current and reliable information, the Division of Criminal Justice Services recognizes the possibility of human and/or mechanical error and that information captured at a point in time may change over time.

NYS Traffic Safety Statistical Repository (TSSR)

- ITSMR provides data on police-reported fatal and personal injury crashes and select tickets issued by law enforcement agency via our PTS Data Form. These data include numbers of crashes submitted to the DMV that were “reportable,” meaning a motor vehicle crash reported by a police officer or a motorist, in which there was a fatality, a person injured, and/or property damage of more than \$1,000 to the vehicle of one person. Crashes that occurred in parking lots or on private property are excluded. The

ticket counts include only those tickets issued by the police agency and submitted to the DMV.

- In the TSSR ITSMR also provides Crash Data by County and Municipality and Ticket Data by County and Municipality. The crash data here include reportable crashes that occurred within the municipality, regardless of the agency that submitted the crash reports. The ticket data here include the municipality where the tickets were issued, regardless of the agency that submitted the tickets. In the TSSR report County Traffic Tickets — Select Violations by Enforcement Agency, tables show TSLED tickets issued by enforcement agency and submitted to the DMV.
- Tickets submitted to the DMV after DMV has given ITSMR the okay to finalize the ticket data for a calendar year will not appear in that year's totals.

Student Weight Status Category Reporting System (SWSCRS) Data

Limitations of Data:

- Because of restrictions in reporting due to the FERPA there was variation in how much of the student population was represented in the data school districts submitted, especially among smaller school districts. Therefore, the percentage of the student population represented in the county and regional level estimates may vary. This limits researchers' ability to draw absolute conclusions about observed differences in student weight status among counties and regions.
- Because school district boundaries do not align with county or regional boundaries, the county and regional-level estimates reflect data from students attending school within districts assigned a particular county or regional-code. County/regional assignment is not based on county or region of residence. The Page 3 of 3 county and regional-level estimates represent the percentage of students within a weight status category reported to the Student Weight Status Category Reporting System.
- These data should not be considered to represent all school aged-children attending school in that county or region because of: restrictions in reporting due to FERPA, parents/guardians' ability to request that their child's weight status data be excluded from reporting, and other sources of missing data.

US Department of Agriculture (USDA) Food Atlas

The current version of the Food Environment Atlas has more than 280 variables, including new indicators on food banks and nutrition assistance program participation rates. All of the data included in the Atlas are aggregated into an Excel spreadsheet for easy download. These data come from a variety of sources and cover varying years and geographic levels. The documentation for each version of the data provides complete information on definitions and data sources.

In the downloadable Excel spreadsheets:

- State and county Federal information processing standards (FIPS) codes are provided.

- The variable lookup file links the short field descriptions (indicator names) used in the data file with the longer indicator names used in the Atlas.
- Unless otherwise noted with asterisks on the longer indicator names (in the variable lookup file), indicators are county-level measures. A single asterisk * denotes a State-level indicator, while a double asterisk ** denotes a regional-level indicator.
- "No data" fields are empty or referenced with "-9999".
- Supplemental data are provided in additional tabs (State- and county-level data are provided separately).

NYS Department of Health Tobacco Enforcement Compliance Results

Limitations of Use:

- County health departments and the New York City Department of Consumer Affairs may provide this information on their own websites. These websites and the data on them may be updated more frequently. More detailed information may be obtained directly from these partner agencies or DOH through the Freedom of Information Law (FOIL) process. The FOIL process for DOH can be found on its website, for other agencies' FOIL process please contact them directly.
- Enforcement data reflects information that was gathered during an inspection, and confirmed through official enforcement action. There may be a significant delay between the date of an inspection and the date that a violation is confirmed through enforcement action. Accordingly, enforcement data included in a certain measurement period may actually reflect violations that occurred in a previous measurement period.
- As previously stated, the data in Health Data NY maps, data lists, and data tables is updated annually. Requests for data pertaining to more recent inspections, or requests for more detailed information or copies of individual inspection reports should be directed to the individual county health department, New York City Department of Consumer Affairs, or State District Office which conducted the inspection or inspections in question.

NYS Department of Health Maternal and Child Health

Unstable Estimates:

- Multiple years of data were combined to generate more stable estimates when the number of events for an indicator was small (i.e., rare conditions). The relative standard error (RSE) is a tool for assessing reliability of an estimate. A large RSE is produced when estimates are calculated based on a small number of cases.¹ Estimates with large RSEs are considered less reliable than estimates with small RSEs. The [National Center for Health Statistics](#) recommends that estimates with RSEs greater than 30% should be considered unreliable/unstable.²

- The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying that result by 100. The RSE is expressed as a percent of the estimate.
- For the Maternal and Child Health dashboard, an asterisk (*) symbol is used to indicate that a percentage or rate is unreliable/unstable. This usually occurs when there are fewer than 10 events in the numerator (RSE is greater than 30%).

Data Suppression for Confidentiality

Results are not shown (i.e., suppressed) when issues of confidentiality exist. Suppression rules vary depending on the data source and the indicator.

Table 1. Summary of data suppression and statistical evaluation significance for the Maternal and Child Health Indicators by data source

Data Sources	Suppression Criteria	Statistical Significance Techniques
Sample Surveys		
BRFSS (NYS)	Unweighted numerator <6 or Unweighted denominator <50	95% CI comparison
BRFSS (CDC)	Unweighted denominator <30	95% CI comparison
NSCH	Unweighted denominator <30	95% CI comparison
YRBSS	Unweighted denominator < 100	95% CI comparison
NYS PRAMS	Unweighted denominator < 30	95% CI comparison
Population Count Data		
NYS VS	Denominator population or event <30	Rate/percentage: one sided chi-square test with p-value <0.05
NYS SPARCS	Numerator between 1 - 5 cases	Rate/percentage: one sided chi-square test with p-value <0.05
HCUP-SID	Numerator <=10	Rate/percentage: one sided chi-square test with p-value <0.05
NVSS	Numerator <10	Rate/percentage: one sided chi-square test with p-value <0.05
Special Supplemental Nutrition Program for WIC	Indicator has a denominator <50	Rate/percentage: one sided chi-square test with p-value <0.05

- **CI:** Confidence Interval

- **BRFSS**: Behavioral Risk Factor Surveillance System
SPARCS: Statewide Planning and Research Cooperative System
Vital Statistics: New York State Vital Statistics (NYS VS Event Registry)
YRBSS: Youth Risk Behavioral Surveillance System
PRAMS: Pregnancy Risk Assessment Monitoring System
- **HRSA provided data**⁶ are from the following sources:
 - **BRFSS (CDC)**: Behavioral Risk Factor Surveillance System
HCUP-SID: Healthcare Cost and Utilization Project-State Inpatient Database
NSCH: National Survey of Children's Health
NVSS: National Vital Statistics System (**Natality and Death**)
WIC: Women, Infants, and Children (Special Supplemental Nutrition Program)
CMS: Centers for Medicare and Medicaid Services

Department of Health, Wadsworth Center

Limitations of Use:

- Address accuracy is dependent on the information provided by the individual submitting the rabies specimen. Additionally, not all submissions are included in the monthly reports; samples received from out of state and samples that are unsatisfactory for testing are not listed. However, all samples, regardless of the testing outcome, are included in the annual report (<https://www.wadsworth.org/programs/id/rabies/reports>).
- The data does not describe why the animal was tested. The most common reason to request rabies testing is due to human exposure. However, because rabies has a 99.9% fatality rate, the laboratory often receives samples from animals with neurological illness to rule out rabies before additional tests are performed. For example, the laboratory receives exotic animals with neurological illnesses from zoological settings for rabies testing. If these animals test negative for rabies, additional post-mortem tests can be completed to determine the cause of illness without the risk of exposing multiple people or testing facilities to rabies. The data is not necessarily representative of rabies in wild populations. The data may be biased, since a greater number of sick animals are submitted for testing, as opposed to healthy animals randomly chosen from the wild population.

Community Engagement

2025 Stakeholder Survey

BACKGROUND INFORMATION:

Adirondack Rural Health Network: The Adirondack Rural Health Network (ARHN) is a program of Adirondack Health Institute, Inc. (AHI), a 501c3 not-for-profit organization. ARHN is the longest-running program of AHI, established in 1987 through a New York State Department of

Health (NYS DOH) Rural Health Network Development Grant. ARHN is a multi-stakeholder, regional coalition that informs planning and assessment, provides education and training to further the implementation of the NYS DOH Health Prevention Agenda, and offers other resources that support the development of the regional health care system. Since its inception, ARHN has provided a forum to assess regional population health needs and develop collaborative responses to priorities. ARHN includes organizations from Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Description of the Community Health Assessment Committee:

Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is a multi-county, regional stakeholder group consisting of hospitals and local county health departments that convenes to develop and support a sophisticated process for ongoing community health planning and assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from the following organizations:

- Adirondack Health
- Clinton County Health Department
- University of Vermont Health Network - Alice Hyde Medical Center
- University of Vermont Health Network - Elizabethtown Community Hospital
- Essex County Health Department
- Franklin County Public Health
- Fulton County Public Health
- Glens Falls Hospital
- Hamilton County Public Health and Nursing Services
- Nathan Littauer Hospital
- University of Vermont Health Network – Champlain Valley Physicians Hospital
- Warren County Health Services
- Washington County Public Health.

The purpose of the CHA Committee is to address regional priorities, identify interventions, and develop the planning documents required by NYS DOH and the Internal Revenue Service (IRS) in an effort to advance the New York State Prevention Agenda.

CHA Data Sub-Committee:

The Data Sub-Committee (DSC) is a subset of CHA partners that meets regularly to review the tools and processes used by CHA Committee members to develop their Community Health Assessments (CHAs) and Community Health Needs Assessments (CHNAs), as well as their Community Health Improvement Plans (CHIPs) and Community Service Plans (CSPs). The DSC also works to identify opportunities to strengthen the CHA/CHNA/CHIP/CSP process. One of the primary activities of the DSC was to collaboratively develop a stakeholder survey.

The DSC met nine times from January 2024 through January 2025. Meetings were held via Webex. Attendance ranged from 6 to 11 subcommittee members per meeting. Meetings were facilitated by AHI staff from ARHN and attended by members of the AHI Data and Analytics team.

SURVEY METHODOLOGY:

Survey Creation:

The 2025 CHA Stakeholder Survey was updated by the DSC, with the definitive version incorporating additional questions and information related to Social Determinants of Health (SDOH), aligning with the priorities of the 2025-2030 NYS Prevention Agenda.

Survey Facilitation:

ARHN facilitated the release of the stakeholder survey across its seven-county service area to gather input on regional health care needs and priorities for the CHA Committee. Survey participants included professionals from health care, social services, education, and government, as well as community members. The ARHN region comprises Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington Counties.

Survey Logistics:

The survey was developed through SurveyMonkey and included 14 community health questions along with several demographic questions. The CHA Committee compiled a county level list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) to receive the survey. In total, 889 community stakeholders were identified for distribution.

In early February 2025, CHA Committee partners sent an initial email to community stakeholders introducing the survey and providing a web-based link. ARHN followed up with several reminder emails to stakeholders who had not completed the survey. Additionally, CHA Committee members were provided with the names of all non-respondents for additional follow-up, at partner discretion.

The survey requested that community stakeholders rank the five domains of SDOH based on their impact within their communities and identify key priority areas addressed by their organizations. Respondents also provided insight into what they viewed as the top health concerns in their communities and the most influential contributing factors. A full list of survey questions can be found under Appendix A.

Survey Responses and Analysis:

A total of 307 responses were received through March 14, 2025, resulting in a response rate of 34.5%. Respondents were asked to indicate the counties in which they provide services and were able to select multiple counties, as appropriate. County specific response totals are outlined in the "By County" section.

Analysis is organized both alphabetically and in the order of which questions appeared on the survey to support easier comprehension. Each table is clearly labeled to indicate whether the data is presented as response counts or percentages. For tables involving county data, color coding is used to differentiate counties. Written analysis accompanies each section and present findings are in percentages.

The report provides a regional overview of the results, focusing on the ARHN service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties. The stakeholder survey aimed to collect insights from diverse sectors and perspectives to inform our understanding of community needs. These findings will guide strategic planning across the Adirondack region, benefiting partners who serve individual counties, and those whose footprint covers multiple counties.

See the Appendix for the complete 2025 Regional Stakeholder Survey. Franklin County results from the survey are summarized below:

Of the 100 invited Franklin County stakeholders, 70 shared their perspectives on pressing health issues, contributing factors, and opportunities for collaboration in Franklin County. Respondents represented health care, education, government, social services, and other community sectors.

Health Concerns and Contributing Factors

Mental health conditions emerged as the leading health concern among Franklin County stakeholders, followed closely by substance use—including alcoholism and opioid use. Chronic diseases such as diabetes and heart disease were highlighted as particular priorities for Franklin County, with diabetes being a shared concern only with Hamilton County and heart disease identified as unique to Franklin. Overweight and obesity also ranked among the top health issues facing the community.

When asked about the underlying causes contributing to these health challenges, stakeholders identified addiction to alcohol and illicit drugs and a lack of mental health services as the most significant factors. Poor dietary practices—a concern identified uniquely in Franklin County—were also cited, along with the aging population and widespread poverty, both of which continue to shape the county’s overall health landscape.

Social Determinants of Health and Population Impacts

Stakeholders overwhelmingly ranked economic stability as the most influential social determinant of health, followed by health care access and quality. Those most likely to experience poor health outcomes include individuals living at or near the federal poverty level and, distinctively for Franklin County, older adults and seniors.

Priority Areas Within the NYS Prevention Agenda

Survey responses also helped identify priority domains aligned with the New York State Prevention Agenda.

- **Economic Stability:** Poverty was identified as Franklin County’s top priority—differing from most other counties, which prioritized nutrition security—followed by nutrition security and unemployment.
- **Social and Community Context:** Primary prevention efforts, substance misuse, and overdose prevention were considered most urgent, along with addressing anxiety and stress. Depression was highlighted as a unique priority for Franklin County.
- **Neighborhood and Built Environment:** Improving access to community services and supports topped the list, followed by expanding opportunities for physical activity and addressing injuries and violence.
- **Health Care Access and Quality:** Priorities included strengthening prevention services for chronic disease management, improving early intervention, and enhancing childhood behavioral health services.
- **Education Access and Quality:** Stakeholders emphasized the importance of creating health- and wellness-promoting school environments and expanding opportunities for continued education.

Community Capacity and Collaboration

Franklin County stakeholders expressed a strong willingness to support collaborative health improvement efforts. They reported the capacity to contribute in several ways, including providing subject-matter expertise, participating in committees and workgroups, sharing knowledge of local community resources, and promoting health improvement activities and events.

Relevant Health Indicators

County Health Rankings & Roadmaps:

Community Conditions:

The 2025 County Health Rankings highlights three strengths in Franklin County. The fine particulate matter average density in Franklin County (6.5) is the second lowest in the ARHN region, and slightly lower than the NYS average density of 6.9. The household income (80th vs. 20th) percentile for Franklin County (4.5) is lower than the New York State ratio of 5.8. Additionally, Franklin County has the lowest rate of deaths due to injury (61) in the ARHN region and is in line with New York State (61).

There are four areas of focus for improvement in Franklin County: the percentage of population with adequate access to locations for physical activity (57%), percentage of adults aged 25-44 with some post-secondary education (52%), percentage of adults ages 25 and over with a high

school diploma or equivalent (87%), and the child care costs for a household with two children as a percent of median household income (39%).



Franklin County Community Conditions - 2025

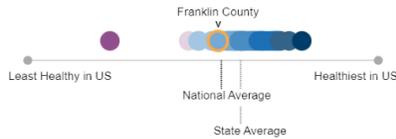


Diagram summarizes data released on 03/19/2025

Franklin County is faring slightly worse than the average county in New York for Community Conditions, and about the same as the average county in the nation.

Population Health and Well-being:

Franklin County has the third lowest rate of deaths among individuals under 75 in the ARHN region (8,000), which is higher than the New York State average (6,600).

When it comes to quality of life, Franklin County ranks on the higher end of the ARHN region. The average number of physically unhealthy days reported over the course of 30 days is 4.6, which is the highest in the ARHN region and higher than New York State (3.9). The percentage of live births with low birth weight in Franklin County (7%) is the second lowest in the ARHN region and lower than New York State (8%). However, Franklin County has room for improvement in reducing the average number of mentally unhealthy days reported over the course of 30 days, which is 6.1 as this is the highest in the ARHN region and higher than the New York State average (4.9). Additionally, the percentage of adults reporting fair or poor health in Franklin County is relatively high at 18%, which exceeds the New York State average of 16% and is the second highest in the ARHN region.



Franklin County Population Health and Well-being - 2025

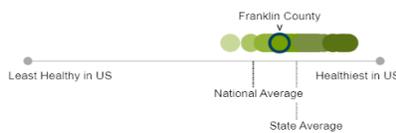


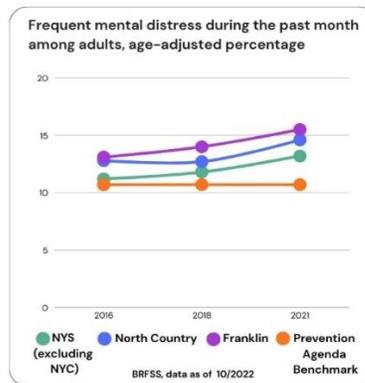
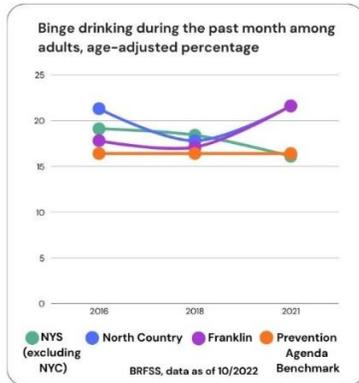
Diagram summarizes data released on 03/19/2025

Franklin County is faring about the same as the average county in New York for Population Health and Well-being, and better than the average county in the nation.

NYS Prevention Agenda Dashboard:

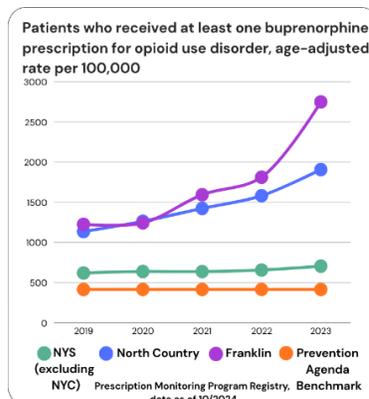
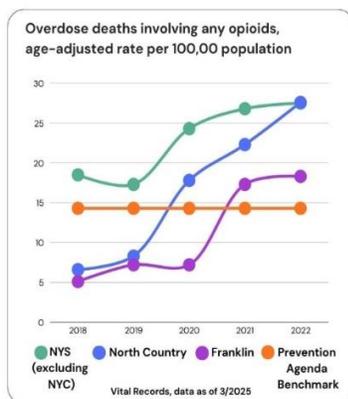
All references to “benchmark” refer to the Prevention Agenda.

Binge drinking in Franklin County (21.6%) exceeds both the benchmark (16.4%) and Upstate average (16.1%) but falls in line with the ARHN rate of 22.2%, indicating higher levels of risky alcohol consumption across the region. Frequent mental distress is notably elevated in both Franklin County and ARHN (15.5% and 16.4% respectively) compared to the benchmark (10.7%).



The suicide mortality rate for Franklin County is 18.9, which exceeds the benchmark of 7.0 and Upstate New York* (9.7). Franklin County experiences fewer adult hospitalizations due to falls than ARHN (107.9 and 158.5 respectively) and the benchmark (173.7), indicating lesser injury risks. Infant and maternal mortality rates in both Franklin County (2.3 and 74.8) and ARHN (6.5 and 68.5) are well above the benchmark (4.0 and 16.0), emphasizing urgent public health concerns.

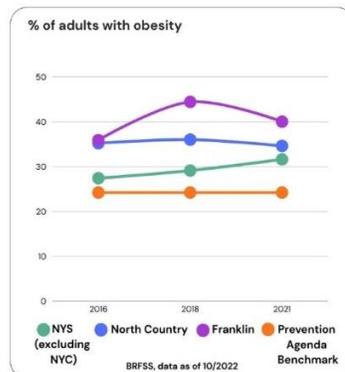
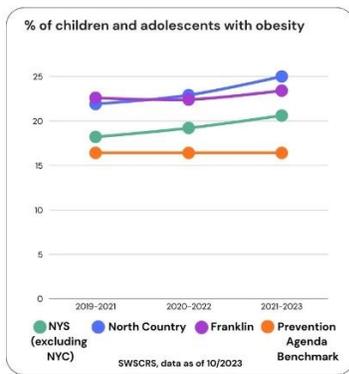
Opioid overdose deaths in Franklin County (18.3) and ARHN (25.8) are higher than the benchmark (14.3), however, higher rates of buprenorphine prescriptions (Franklin: 2,749.6, ARHN: 1,561.3, and Benchmark: 415.6) indicate increased access to treatment amid this crisis.



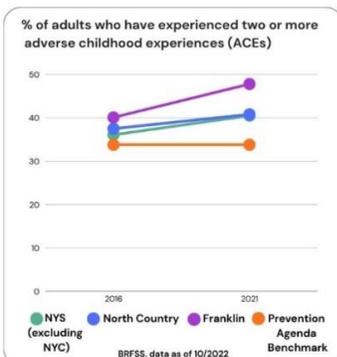
Positive public health efforts are reflected in higher childhood immunization rates, with Franklin County’s rate of 77.4% for children receiving the 4:3:1:1:3:3:1:4 and the ARHN region (78.9%) being higher than the Upstate New York* rate of 69.1%. Additionally, asthma-related emergency department visits for children aged 0–17 are significantly lower in Franklin County (33.9 per 10,000) and the ARHN region (38.92 per 10,000) compared to Upstate New York* (57.4 per 10,000), which may reflect better asthma management or environmental conditions.

Conversely, HPV vaccine completion rate among 13-year-olds is lower in Franklin County (18.0%) and the ARHN region (25.0%) than the benchmark (37.4%), indicating potential areas for improvement in vaccination efforts.

Adult obesity rates in Franklin County and ARHN (40.0% and 33.0% respectively) exceed the benchmark of 24.2%, although childhood obesity is higher in Franklin County (18.1%) compared to ARHN (15.8%) and the benchmark (13.0%). The percentage of low-income adults who smoke in Franklin County is 41.0%, which is higher than both Upstate New York* (26.5%) and the benchmark of 15.3%. Women aged 45 and older in Franklin County report more preventive medical visits (89.1%) than both ARHN (88.0%) and the benchmark (85.0%).



Adults also reported more adverse childhood experiences (47.8%) in comparison to ARHN (42.6%) and the benchmark (33.8), indicating ongoing social and health challenges.



Community Health Indicator Reports (CHIRs):

Franklin County exhibits slightly higher rates than the Upstate New York* average regarding premature cardiovascular death (121.8 vs. 110.0), while showing lower or equal to rates for cardiovascular disease mortality (293.4 vs. 293.9 per 100,000) and pre-transport cardiovascular mortality (185.6 vs. 190.3).

The county also reports elevated rates of diabetes-related hospitalizations and mortality—211.6 per 10,000 and 42.4 per 100,000, respectively—compared to both the ARHN region (18.2 and 27.1) and New York State overall (20.3 and 25.3).

Emergency department usage is notably higher in Franklin County, with a total visit rate of 3,886.9 per 10,000 residents, compared to 3,302.1 in Upstate New York*. Additionally, the unintentional injury hospitalization rate among adults aged 65 and older stands at 182.6 per 10,000—significantly lower than both the ARHN average (280.7) and the statewide rate (260.5).

Among children aged 3–5, outpatient visits for dental caries are also more common in Franklin County (132.4 per 10,000) than in the ARHN region (130.2). Furthermore, the percentage of births to teens aged 15–19 is higher in the county (5.2%) compared to the ARHN region (2.9%), while births to women aged 35 years or older is less common, with Franklin County at 15.8% compared to Upstate New York* at 24.3%.

On the positive side, a greater proportion of infants are exclusively breastfed in-hospital in the county (64.7%) as compared to Upstate New York* (47.8%), and cesarean rates among low-risk births for Franklin County (30.4%) are in line with the ARHN region (30.2%).

Behavioral Risk Factor Surveillance Survey (BRFSS):

Franklin County shows higher rates of poor mental health (14.2%) compared to the broader ARHN region (13.3%) and lower rates of current asthma (8.8% vs. 12.5%, respectively). Additionally, a lesser number of adults in Franklin County (30.8%) consume less than one serving each fruit and vegetables daily, indicating poorer dietary habits than ARHN (32.7%).

Franklin County does show a higher rate of daily sugary drink consumption (30.5%) in comparison to the ARHN region (21.6%). In addition, obesity is also more prevalent in Franklin County (40%) versus ARHN (33.0%), underscoring ongoing challenges related to nutrition and increased risks for chronic conditions associated with unhealthy weight.

Franklin County (8.7%) reports lower rates of poor physical health (defined as 14 or more days of poor health per month) than the Upstate New York* average (10.0%), while ARHN reports higher rates (12.4%), highlighting a greater burden of physical health issues in the overall region. In addition, 28.9% of adults live with a disability, which is slightly lower than the ARHN region (30.1%), but higher than Upstate New York* (25.80%).

Depressive disorder affects a larger percentage of adults in Franklin County (26.5%) compared to ARHN (23.2%). Despite this, access to healthcare appears relatively strong, as adults aged 18-64 in Franklin County are likely to have had a routine checkup in the past year (76.1%), and in line with the overall ARHN region (75.9%), indicating access to preventive healthcare in the county. The majority of adults in Franklin County (90.6%) and the ARHN region (90.5%) report having a regular healthcare provider, slightly higher than Upstate New York*(88.7%).

In terms of substance use, Franklin County reports higher rates than ARHN across several behaviors: e-cigarette use (10.2% vs. 7.4%), binge drinking (20.0% vs. 18.9%), and cannabis use over the course of 30 days (22.4% vs. 16.3%). This indicates comparatively higher substance use in Franklin County relative to the broader ARHN region.

NYS Maternal-Child Health:

Infant mortality is lower in Franklin County (2.0 per 1,000 live births) than the Upstate New York* average (4.7 per 1,000 live births), while maternal mortality is significantly higher in Franklin County (75.0) in comparison to Upstate New York* (22.0).

On a positive note, preterm birth rates are lower in Franklin County (6.0%) compared to both ARHN (9.7%) and Upstate (9.5%), indicating better birth outcomes in this metric. However, 61% of expectant mothers in Franklin County sought out and utilized early prenatal care, significantly less than the ARHN rate of 78.61%, which indicates a need for prenatal education in the region.

Community programs also demonstrate areas of need, with 3% of Franklin County residents served by optimally fluoridated systems, significantly lower than both the ARHN region (26.93%) and Upstate New York* (48%). In addition, early intervention services in Franklin County are reported to be helpful by participating families, consistent with feedback across the ARHN region.

NYS Student Weight Status Category Reporting:

In Franklin County, overweight rates among middle and high school males (16.61%) and elementary school males (15.07%) are slightly higher than those in the ARHN region (14.93% and 14.98%, respectively). Among females, Franklin County reports a marginally higher overweight rate for middle/high school students (19.38%) compared to ARHN (18.17%), while elementary school females in Franklin County (15.72%) have a slightly lower rate than ARHN (18.87%). Overall, Franklin County's youth show comparable or slightly higher rates of being overweight than the broader ARHN region, with the exception of elementary school females.

Obesity rates among youths in Franklin County vary compared to the ARHN region. Among elementary students, obesity rates are slightly higher for females (23.17%) compared to the ARHN region (22.23%), while Franklin County males have a slightly lower rate (23.17%) than the ARHN region (24.88%). In middle/high school, Franklin County females have a significantly

lower obesity rate (23.81%) compared to ARHN (35.15%), whereas male obesity rates are nearly the same (Franklin, 31.21%, and ARHN, 32.22%).

NYS Tobacco Enforcement Compliance Results:

Franklin County has 62 registered tobacco vendors and 2 sales to minors, in line with Essex County, tied for the third lowest number of registered vendors in the ARHN region.

USDA Food Environment Atlas:

Franklin County has fewer recreation and fitness facilities per 10,000 people (7.82) compared to the ARHN region (8.8) and the Upstate New York* average (13.2), indicating more limited access to opportunities for physical activity. Additionally, food access challenges persist, with a higher percentage of residents in Franklin County (9.05%) and the ARHN region (6.00%) living with both low income and limited access to grocery stores compared to Upstate New York* (3.9%).

Institute for Traffic Safety Report (ITSMR):

Franklin County has a lower alcohol-related crash rate (8.82 per 10,000) compared to the ARHN region (9.33), indicating fewer such incidents, with a 0.0 rate of fatalities.

For speed-related crashes, Franklin reports a higher overall crash rate (41.93) versus ARHN (36.26) and a lower fatality rate (0.00 vs. 0.29 respectively), reflecting a higher number of crashes but less deadly speed-related incidents than in the broader region.

Department of Criminal Justice Services Index, Property, and Violent Crime Report:

Franklin County's property crime rate stands at 1,349.3 incidents, with a violent crime rate of 210.8, which are higher than the ARHN rates of 1,138.9 and 176.29. Firearm-related crimes in Franklin County are lower than ARHN, with rates of 8.7 and 11.02, respectively.

Department of Health, Wadsworth Center:

Franklin County reported 4 positive rabies tests, all from bat samples, resulting in a positivity rate of 17.32 per 1,000 samples. This highlights bats as the primary source of rabies detection in the area.

Health Challenges and Associated Risk Factors

Behavioral Risk Factors

Many of the health challenges in Franklin County are linked to behaviors that increase the risk of disease and poor health outcomes. Tobacco use is one of the most significant issues — about 41% of low-income adults smoke, much higher than the state rate of 15.3%. High smoking and vaping rates raise the risk of lung disease, heart disease, cancer, and other chronic conditions.

Poor nutrition is another major concern. About 30.8% of adults eat fewer than one serving of fruits or vegetables each day, and 30.5% drink sugary beverages daily, both of which are worse

than regional averages. These behaviors increase the risk of obesity, diabetes, and heart disease.

Lack of physical activity also contributes to poor health outcomes. Limited access to recreational facilities and safe places to exercise — only 57% of residents have access to physical activity opportunities — makes it harder for people to stay active. As a result, obesity rates are high (40%), increasing the risk for chronic diseases like diabetes and cardiovascular disease.

Substance use and mental health behaviors further impact community health. Franklin County faces high rates of alcohol and drug use, which contribute to higher rates of overdose, accidents, and mental health conditions. Many adults have also experienced adverse childhood experiences (ACEs), which can lead to unhealthy coping behaviors and long-term health problems.

Environmental Risk Factors

Franklin County's physical, built, and social environments contribute significantly to many of the health challenges facing its residents. One of the most prominent environmental concerns is limited access to spaces and infrastructure that support healthy behaviors. Only 57% of residents have adequate access to locations for physical activity, and the county has fewer recreation and fitness facilities (7.82 per 10,000 residents) than both the regional (8.8) and Upstate New York averages (13.2). These limitations make it more difficult for residents to engage in regular exercise, contributing to high obesity rates and elevated risk for chronic disease.

Access to nutritious food is another significant environmental risk factor. A higher percentage of residents (9.05%) live with both low income and limited access to grocery stores, compared with 3.9% statewide. These food access barriers increase the risk of poor nutrition, obesity, diabetes, and other diet-related conditions. Additionally, only 3% of the population is served by optimally fluoridated water systems, far below state levels (48%), which may contribute to higher rates of dental problems, especially among children.

The social and community environment also shapes health risks. Higher rates of property crime (1,349.3 per 100,000) and violent crime (210.8 per 100,000) compared with regional averages reflect safety concerns that may deter outdoor activity and increase stress. Speed-related traffic crashes are more frequent in Franklin County (41.93 per 10,000) than in the region overall, signaling potential transportation safety risks. Environmental exposures are also present, with rabies-positive bat samples indicating ongoing zoonotic disease risks in the area.

Finally, access to healthcare and preventive infrastructure represents an environmental determinant of health. Higher emergency department utilization (3,886.9 visits per 10,000) suggests that some residents may lack reliable access to primary care. Barriers such as

geographic isolation, rural infrastructure, and socioeconomic disparities further compound these environmental risks, limiting access to services and healthy living conditions.

Socioeconomic Factors

Socioeconomic conditions play a major role in shaping health outcomes in Franklin County, contributing to many of the disparities seen across the community. Income and poverty remain key challenges. A significant portion of residents have low incomes, and 9.05% live with both low income and limited access to grocery stores, far higher than the statewide rate (3.9%). High childcare costs and limited availability further strain household budgets, reducing disposable income for healthy food, housing, and healthcare.

Education and employment indicators also reveal disparities. Lower educational attainment contributes to limited job opportunities and reduced health literacy, which can make it more difficult for residents to navigate the healthcare system or adopt healthy behaviors. Adverse childhood experiences (ACEs)—reported by more than half of adults—reflect underlying social stressors that often perpetuate cycles of poverty, mental health challenges, and chronic disease risk into adulthood.

Access to essential services is another socioeconomic concern. Higher emergency department utilization (3,886.9 visits per 10,000) suggests that many residents may not have consistent access to primary care or preventive services, often a reflection of financial or transportation barriers. Food insecurity and poor access to fresh, affordable food options further compound the effects of low income and rural isolation, increasing the risk for diet-related conditions like obesity and diabetes.

Finally, safety and community stability indicators highlight additional socioeconomic risks. Property and violent crime rates in Franklin County exceed regional averages, which can deter investment, limit economic growth, and contribute to chronic stress among residents. Together, these factors—poverty, limited educational and employment opportunities, high childcare costs, food insecurity, and community safety concerns—intersect to create social and economic conditions that make it more difficult for residents to achieve and maintain good health.

Policy Environment

Franklin County has a strong public health foundation that helps protect and support its residents. The county health department follows state public health laws, which provide a strong safety net for disease prevention and emergency response. The health department, as well as local agencies, are also acting on substance use by making overdose-reversing medications like Narcan more available and expanding access to treatment. Housing is another area of progress, as new affordable housing projects and lead-safety programs are improving living conditions. For children, vaccination rates are high and early intervention programs are effective. The county also works closely with regional partners to prepare for health emergencies, and state data helps guide decision-making.

At the same time, there are clear policy gaps that make health challenges harder to solve. Franklin County struggles with a shortage of doctors, dentists, and mental health providers, which limits access to care. Policies that support healthy living, such as improving access to healthy food, safe places to exercise, and reliable transportation, are limited. Many renters still live in poor-quality housing with few protections, and environmental health policies, like adding fluoride to water supplies, are weak. Finally, many programs rely on short-term grants, which makes it difficult to sustain progress over time.

In short, Franklin County has a solid foundation in public health policy and some important successes, but more work is needed to expand access to care, strengthen prevention efforts, improve housing and transportation, and ensure long-term funding to support community health.

Health Disparities

Franklin County experiences significant health disparities across multiple domains, many of which are closely linked to underlying social and economic conditions. Mental and behavioral health represent some of the most pressing concerns. Rates of frequent mental distress (15.5%) and depressive disorders (26.5%) exceed both state and regional averages, and adults report more mentally unhealthy days than any other county in the region. The county's suicide mortality rate (18.9 per 100,000) is more than double the state benchmark, while high rates of adverse childhood experiences (47.8%) underscore the long-term impacts of trauma. Substance use is also more common, with higher levels of binge drinking, e-cigarette use, cannabis use, and opioid overdose deaths than state benchmarks.

Chronic disease burden is another critical disparity. Adult obesity (40%) and childhood obesity (18.1%) far exceed state targets, and diabetes-related hospitalizations and mortality are dramatically higher than both regional and state averages. Smoking rates among low-income adults (41%) are among the highest in the state, and premature death rates remain elevated. These patterns are influenced by broader health behaviors—such as poor nutrition, high sugary drink consumption, and low fruit and vegetable intake—that contribute to cardiovascular disease, diabetes, and other chronic conditions.

Maternal and child health disparities are equally concerning. While infant mortality and preterm birth rates are favorable, maternal mortality is more than three times the state average, and early prenatal care utilization remains significantly lower than in the region overall. Teen birth rates are higher, HPV vaccination rates lag far behind benchmarks, and access to optimally fluoridated water is extremely limited. These indicators point to gaps in preventive care, prenatal education, and community health infrastructure.

Underlying many of these health challenges are inequities in the social and physical environment. Educational attainment is lower than state benchmarks, access to physical activity resources is limited, and a higher percentage of residents face barriers to healthy food access. Emergency department utilization is higher, suggesting potential gaps in primary care or

preventive services. Additionally, property and violent crime rates exceed regional averages, and higher rates of speed-related crashes highlight ongoing safety concerns. Together, these conditions illustrate the complex, interconnected factors driving health disparities in Franklin County and underscore the need for comprehensive, equity-focused strategies that address behavioral health, chronic disease prevention, maternal and child health, and the social determinants that shape health outcomes.

Community Assets and Resources

Franklin County has a range of community assets and resources that support efforts to improve health and address priority challenges. Key assets include strong partnerships among the Franklin County Public Health Department, Alice Hyde Medical Center, Adirondack Health, and other regional providers, as well as active coalitions and local prevention councils. The county also benefits from committed community leaders, engaged schools, and collaboration across sectors including public safety, education, and social services.

Available resources include local hospitals and primary care clinics, behavioral health and substance use treatment providers, county public health programs, human service agencies, food access programs, and local transportation services that improve access to care.

Assets and resources were identified in Franklin County to address the five Social Determinants of Health (SDOH) domains outlined in the 2025–2030 New York State Prevention Agenda. This list highlights key community organizations, programs, and partnerships that contribute to improving health and well-being, though it is not exhaustive.

SDOH Domain I: Economic Stability

- [Alice Hyde Medical Center](#)
- [Adirondack Health](#)
- [Franklin County Public Health Services](#)
- [Franklin County Department of Social Services](#)
- [Regional Food Bank](#)
- [New York State Department of Labor: Franklin County OneWorkSource Center](#)
- [Citizen Advocates](#)
- [Cornell Cooperative Extension Franklin County](#)
- [Adirondack Community Foundation](#)
- [Cloudsplitter Foundation](#)
- [Franklin County Community Housing Council Inc.](#)
- [Franklin County Economic Development and Tourism](#)
- [Harriestown Housing Authority](#)
- [Malone Housing Authority](#)
- [Tupper Lake Housing Authority](#)
- [New York State Department of Labor](#)

- [Hunger Prevention and Nutrition Assistance Program \(HPNAP\)](#)
- [New York State Council on Children and Families](#)
- [Regional Food Bank: Franklin County Food Pantries](#)

SDOH Domain II: Social and Community Context

- [Alice Hyde Medical Center](#)
- [Adirondack Health](#)
- [Franklin County Public Health Services](#)
- [The Heart Network](#)
- [Franklin County Public Health Harm Reduction Services](#)
- [Franklin County Community Services](#)
- [Community Connections of Franklin County](#)
- [Alliance for Positive Health](#)
- [InUnity Alliance](#)
- [Adirondack Arc](#)
- [988 Lifeline](#)
- [Catholic Charities of Franklin County](#)
- [Franklin County Veterans Services Agency](#)
- [New York State Early Childhood Advisory Council](#)
- [Franklin County Community and Housing Council](#)
- [Family Matters](#)
- [Families R US Resource Center](#)
- [Franklin County SPOA – Single Point of Access](#)
- [NYS Breast/Chestfeeding Promotion, Protection, and Support](#)
- [Mercy Care for the Adirondacks](#)
- [North Country Home Services](#)
- [Franklin County Office for the Aging/ NY Connects](#)
- [Child Care Coordinating Council of the North Country](#)
- [Homeward Bound Adirondacks](#)
- [Hospice of the North Country](#)
- [Tri-Lakes Center for Independent Living](#)
- [United Way of the Adirondack Region, Inc.](#)
- [Warm Lines For New York State](#)
- [New York State Department of Health's Bureau of Community Environmental Health and Food Protection](#)
- [Adirondack Birth to Three Alliance](#)
- **Franklin County Suicide Prevention Coalition**
- [Franklin County Prevention Task Force](#)

SDOH Domain III: Neighborhood and Build Environment

- [Alice Hyde Medical Center](#)
- [Adirondack Health](#)
- [Franklin County Public Health Services](#)
- [Governor's Traffic Safety Committee](#)
- [Franklin County Traffic Safety Board](#)
- [Franklin County Stop DWI](#)
- [The Heart Network](#)
- [Complete Streets](#)
- [NYS Office for the Aging State Plan 2023-2027](#)
- [Explore Adirondack Frontier- Always Franklin](#)
- [Adirondack Frontier Franklin County, New York](#)
- [Malone Rec Park](#)
- [Franklin County Transportation](#)
- [Malone YMCA](#)

SDOH Domain IV: Health Care Access and Quality

- [Alice Hyde Medical Center](#)
- [Adirondack Health](#)
- [Franklin County Public Health Services](#)
- [The Heart Network](#)
- [Joint Council for Economic Opportunity of Clinton and Franklin Counties, Inc. \(JCEO\)](#)
- [C-TURN CFE](#)
- [Citizen Advocates](#)
- [St. Regis Mohawk Community & Family Services](#)
- [Saranac Lake Health Association](#)
- [Cancer Services Program of Northeastern NY](#)
- [Hudson Headwaters Health Network](#)
- [Planned Parenthood of the North Country, New York](#)
- [Saint Regis Mohawk Health Services](#)
- [Franklin County Emergency Services](#)
- [St. Joseph Addiction Treatment & Recovery Centers](#)
- [CDC One Health](#)

SDOH Domain V: Education Access and Quality

- [Alice Hyde Medical Center](#)
- [Adirondack Health](#)
- [Franklin County Public Health Services](#)

- [School Wellness Policies](#)
- [The Heart Network](#)
- [North Country Community College](#)
- [Adirondack Educational Center – FEH BOCES](#)
- [Malone Central School District](#)
- [Brushton-Moira Central School District](#)
- [Salmon River Central School District](#)
- [St Regis Falls Central School District](#)
- [Saranac Lake Central School District](#)
- [Chateaugay Central School District](#)
- [Tupper Lake Central School District](#)

Community Health Improvement Plan/Community Service Plan (CHIP/CSP)

Major Community Health Needs

As shown in the data and supported by community input, Franklin County faces several important health challenges. Mental health is a top concern, with many adults experiencing frequent stress, depression, and high rates of suicide. Substance use is also a problem, including alcohol, tobacco, vaping, cannabis, and opioid overdoses.

Chronic diseases and obesity are major issues. Many adults and children are overweight or obese, and diabetes and heart-related problems are common. Preventive health is another area of need — HPV vaccination rates are low, some expectant mothers do not get early prenatal care, dental problems are higher than average, and many residents rely on the emergency room instead of regular primary care.

Access to healthy foods and physical activity is limited. Many residents live far from grocery stores, and there are few safe places or facilities for exercise. Socioeconomic and environmental factors make things harder, including high childcare costs, lower education levels, higher crime rates, rural isolation, and limited transportation.

In short, Franklin County’s health needs are shaped by mental health and substance use challenges, chronic diseases and obesity, gaps in preventive care, limited opportunities for healthy living, and social and economic barriers that make it harder for people to stay healthy.

Prioritization Methods

Description of the Prioritization Process

Franklin County’s health priorities were chosen using several sources of information. The

process included reviewing the results from the stakeholder survey, looking closely at the community health data, and discussing local needs during a community health planning session held on September 4, 2025. Together, this information helped identify the most important health issues on which the county will focus.

Community Engagement

A work group was convened to help identify and prioritize key areas of focus for Franklin County's Community Health Improvement Plan (CHIP).

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

- Hannah Busman, Franklin County Public Health Services
- Sarah Granquist, Franklin County Public Health Services
- Matt Scollin, Adirondack Health
- Annette Marshall, Alice Hyde Medical Center
- Kristin Ellis-Wood – Alice Hyde Medical Center
- Angela Bashaw – Alice Hyde Medical Center
- Brenda Murphy – Alice Hyde Medical Center
- Arriana Patraw – The Heart Network
- Dana Isabella – C-TURN CFE
- Donna Beal – Mercy Care for the Adirondacks
- Hannah Pelletieri- Mercy Care for the Adirondacks
- Tonya Allen – Franklin County Transportation
- Jodie Poirier – Citizen Advocates
- Maggie Garneau – Citizen Advocates
- Becky Leahy – North Country Home Services
- Didi Remchuk – Cancer Services Program of NENY
- Pam Fisher – Hudson Headwaters Health Network
- Melissa Gooley – Hudson Headwaters Health Network
- Michelle Breen – Franklin County Office for the Aging
- Lee Rivers – Community Connections of Franklin County
- Nicole Hills – Planned Parenthood of the North Country New York
- Scott Gordon – Cornell Cooperative Extension
- Brandon Pelkey – Malone Central School District
- Dan Kiefer-Bach – Cloudsplitter Foundation
- Jeremy Evans – Franklin County Economic Development Corporation

Social Determinants of Health (SDOH) Domains and Priorities

After careful review, the work group identified *Social and Community Context* and *Health Care*

Access and Quality as the two Social Determinants of Health domains that will guide planning efforts. Under the *Social and Community Context* domain, Adirondack Health and Alice Hyde Medical Center selected the following priority areas: Primary Prevention, Substance Misuse & Overdose Prevention; Tobacco/E-Cigarette Use; and Mental Well-Being/Substance Use, including anxiety and stress, suicide, and depression. Within the *Health Care Access and Quality* domain, the priority of Preventive Services for Chronic Disease Prevention and Control was chosen to support long-term community health improvement.

Justification of Unaddressed Health Needs

During the Community Health Assessment process, several important health issues were identified in Franklin County, including social and economic conditions, housing quality, maternal and infant health, and injury and violence prevention. While these needs remain important, our local public health system must focus its limited resources where they can have the greatest impact. After reviewing data, listening to community feedback, and considering available resources, we chose to focus on mental health and substance use and chronic disease prevention as our top priorities for this planning cycle. These issues have the highest burden on community health, are strongly supported as priorities by local stakeholders, and offer opportunities for meaningful, measurable improvement.

Although we are not directly addressing all identified needs at this time, many will still benefit indirectly from our efforts. For example, improving mental health services can also help reduce injuries, violence, and improve maternal health outcomes. Likewise, chronic disease prevention strategies can support healthier families and communities overall. We will continue to monitor all identified needs, support partner organizations working in these areas, and re-evaluate priorities in future assessments as community conditions and resources change.

Objectives, Interventions, and Action Plans

Adirondack Health and Alice Hyde Medical Center have completed and included their Community Health Improvement Plans (CHIPs) as part of their 2025 Community Service Plans. Franklin County Public Health Services will continue this work by developing its Community Health Improvement Plan in the first half of 2026. The plans outline evidence-based strategies to address the selected priorities.

Adirondack Health Action Plan

SDOH Domain - Social and Community Context

PRIORITY 1

Primary Prevention, Substance Misuse, and Overdose Prevention

Actions and Impact

Adirondack Health will provide or expand access to naloxone to reduce overdose fatalities.

Geographic Focus

Franklin County, Essex County

Resource Commitment

Franklin County Public Health (LHD) will provide take-home doses of naloxone to Adirondack Medical Center. Adirondack Medical Center will provide the emergency care setting in which the naloxone is available for patients/families to take home and keep on hand for emergency overdose prevention (2026, 2027).

Participant Roles

Adirondack Health will coordinate naloxone ordering/resupply with Franklin County Public Health and track distribution quantities, based on resupply quantities, for future reporting (2026, 2027). Franklin County Public Health Department will provide the naloxone to Adirondack Health (2026, 2027).

Health Equity

These actions will address health disparities by reducing economic barriers to emergency naloxone access and deployment in community-based settings.

PRIORITY 2

Tobacco/E-Cigarette Use

Actions and Impact

Adirondack Health will increase tobacco use assessments for all health-center-based primary care patients 18+ by five percent.

Geographic Focus

Franklin County, Essex County

Resource Commitment

Adirondack Health will maintain prompts in EMR workflows to screen patients 18+ for tobacco use, maintain the EMR system's overall functionality and security, and employ the clinicians conducting the assessments (2025, 2026, 2027).

Participant Roles

Adirondack Health will provide guidance and education to health center-based primary care providers via electronic communication promoting tobacco cessation programming through Adirondack Health's Decker Community Learning Center (2026, 2027). Adirondack Health will execute a print media campaign, placing multiple advertisements in publications based in both Franklin and Essex counties (2026). A digital version of an informational flyer will also be distributed to local health departments for printing and posting in both public and staff-facing office areas (2026). Adirondack Health will monitor progress via quality dashboard and HEDIS dashboard (2026, 2027).

Health Equity

These actions will address health disparities including income, access, and disability. By striving for 100% assessment compliance in primary care settings, Adirondack Health is maximizing the patient population that would benefit from such assessment.

SDOH Domain - Health Care Access and Quality

PRIORITY 3

Preventative Services

Actions and Impact

Adirondack Health will increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (45-75 years old) by five percent.

Geographic Focus

Franklin County, Essex County

Resource Commitment

Adirondack Health will send annual email reminders to the full medical staff, highlighting the most recent colorectal cancer screening guidelines. Adirondack Health also employs the physicians conducting colorectal cancer screenings (2026, 2027).

Participant Roles

Adirondack Health will continuously review current practices for reliability and timeliness to ensure reminders are being sent by all providers (2026, 2027). Adirondack Health will continue to track patient reminders and monitor patients via quality dashboard and HEDIS dashboard (2025, 2026, 2027). Adirondack Health will provide guidance and education to all providers via electronic communication promoting colorectal cancer screening guidelines and best practices from the American Cancer Society (2026, 2027).

Health Equity

These actions will address health disparities including income, access, and disability. By striving for 100% assessment compliance in primary care settings, Adirondack Health is maximizing the patient population that would benefit from such assessment.

Alice Hyde Medical Center Action Plan

SDOH Domain - Social and Community Context

PRIORITY 1

Mental Well-Being and Substance Use: Anxiety and Stress

Actions and Impact

Alice Hyde will implement and promote Mental Health First Aid Course Training.

Geographic Focus

Franklin County

Resource Commitment

In conjunction with System level resources, Alice Hyde will work to decrease the percentage of adults and youth who experience frequent mental distress by offering training resources and certification coursework for staff to effectively support patients presenting for services experiencing mental health crises due to anxiety, stress, and other mental health related factors.

Participant Roles

Alice Hyde will train one (1) individual in a community health lead position in Youth Mental Health First Aid (including certification) in 2025 through the support of system level resources. Alice Hyde will expand training and certification opportunities to at least six (6) additional employees in 2026, and 2027, who serve in patient facing roles, and frequently encounter patients experiencing mental health issues or crises.

Health Equity

These actions will address health disparities including income, access, education, and disability.

PRIORITY 2

Mental Well-Being and Substance Use: Anxiety & Stress

Actions and Impact

ED High Utilizer Reduction Program: Alice Hyde will implement a program to reduce high utilization of the ED by patients who need non-emergent or social/community services rather than emergent medical care.

Geographic Focus

Franklin County/Primary & Secondary Service Area

Resource Commitment

Alice Hyde Medical Center will develop a multi-disciplinary team to track and trend data relative to high utilization/inappropriate Emergency department care visits, and develop processes to formulate plans to ensure patients receive the appropriate level of care in the community.

Participant Roles

Alice Hyde Medical Center will use a multidisciplinary approach to review data on patients visiting the AHMC Emergency Department with high-utilization trends—specifically individuals with more than four visits or more per quarter. The team will assess whether these patients are using services appropriately (screen for stress, anxiety, and social needs), identify any gaps in care, and determine if additional services or supports are needed. Personalized care plans will be developed to promote patient well-being and ensure the safety of our patients, staff, and community by certified crisis clinicians in the Emergency department setting. Committee will be developed (2025). Data Assessment to identify opportunities for improvement in correct level of patient care (2025). Implement processes and procedures to refer patients to the appropriate level of care or social service needs (2026). Reduce high utilization rates by 25% from 2025-2026. Hardwire processes to see further reductions in high utilizer rates by 2027 and beyond. AHMC will utilize/partner with existing community mental health and social service agencies to support patients in the Franklin County service area.

Health Equity

These efforts by Alice Hyde Medical Center will address health equity concerns in the areas of poverty, education/health literacy, access to care, quality of care, support systems, and disability.

PRIORITY 3

Mental Well-Being and Substance Use: Suicide

Actions and Impact

Implementation of System Suicide Pathway in the AHMC ED.

Geographic Focus

Franklin County

Resource Commitment

UVMH System will provide guidance, resources and training in order to implement the Suicide Pathway for the AHMC ED in 2025. AHMC will train staff, implement and monitor progress throughout 2026-2027.

Participant Roles

AHMC will implement program processes, policies and procedures in order to impact/reduce the suicide mortality rate, and adolescent suicide attempts in the Franklin County Region. Pathway implementation will occur in the AHMC ED in mid 2025. AHMC will track number of trainings delivered to health care staff, and track the rate of implementation of policies and practices in the pathway in order to begin offering services and care in this model by late 2026.

Health Equity

Access to care, poverty, disability, support systems.

PRIORITY 4

Mental Well-Being and Substance Use: Depression

Actions and Impact

Integrate Behavioral Health into AHMC Primary Care Practices

Geographic Focus

Franklin County

Resource Commitment

AHMC will increase behavioral and mental health resources in the AHMC Primary Care Practices beginning in 2026. The goal will be to reduce the percentage of adults with major depressive episodes and improve mental health offerings and counseling. AHMC will also offer telehealth visits with a system level psychiatrist/psychologist for additional access to care. AHMC will utilize the EMR for tracking referrals for additional services and services provided. PC Practices will continue to conduct a SDOH screening upon annual wellness visits.

Participant Roles

AHMC will recruit for specialized behavioral health providers to embed in the AHMC Primary Care Practices beginning in 2026. The goal will be to reduce the percentage of adults with major depressive episodes and improve mental health offerings and counseling for the AHMC patient population in an easy to access, stigma-free environment. It is further noted that addressing mental health and wellbeing can impact a patient's physical well-being in a positive manner. By creating a cohesive treatment pathway, better outcomes for the patient population are anticipated.

Health Equity

Integrating behavioral health services into the primary care practices at AHMC, will increase access to critical mental health services in rural Franklin County. These services will address access, poverty, disability, and discrimination/stigma.

PRIORITY 5

Primary Prevention, Substance Misuse, & Overdose Prevention

Actions and Impact

ED Naloxone Distribution Program: Alice Hyde will provide or expand access to naloxone to reduce overdose fatalities.

Geographic Focus

Franklin County

Resource Commitment

Franklin County Public Health (LHD) will provide take-home doses of naloxone to Alice Hyde Medical Center. Alice Hyde Medical Center will provide the kits in the emergency department setting in which the naloxone is available for patients and families to take home and keep on hand for emergency overdose prevention (2025, 2026, 2027).

Participant Roles

Alice Hyde Medical Center ED leadership will coordinate naloxone ordering/resupply with Franklin County Public Health (LHD) and track distribution quantities, based on resupply quantities, for future reporting (2026, 2027). Franklin County Public Health Department will provide the naloxone to Alice Hyde Medical Center (2025, 2026, 2027).

Health Equity

These actions will address health disparities by reducing economic barriers to emergency naloxone access and deployment in community-based settings. This will also reduce stigma associated with accessing resources for substance use.

PRIORITY 6

Tobacco/E-Cigarette Use

Actions and Impact

Alice Hyde will increase access to tobacco/e-cigarette cessation and education services for the patients of the AHMC primary care practices, with the overall goal of reducing the percentage of adults (18+) who use tobacco products. AHMC will measure success through collecting data on the number of individuals referred/connected for cessation resources and services. AHMC will further conduct outreach to the local secondary school systems to reduce prevalence of youth tobacco/e-cigarette use, and provide education on cessation services, and health related benefits of quitting, particularly to communities disproportionately impacted by tobacco industry marketing practices.

Geographic Focus

Franklin County

Resource Commitment

Alice Hyde Medical Center will utilize EMR workflows to screen patients 18+ for tobacco use, maintain the EMR system's overall functionality and security, and educate clinicians on conducting assessments and referrals for cessation services (2025, 2026, 2027). AHMC will provide training and education to secondary school age children in local school districts in Franklin County on dangers of tobacco use and cessation options. (2026, 2027)

Participant Roles

Alice Hyde Medical Center will provide guidance and education to health center-based primary care providers promoting tobacco cessation screening, assessment and referral for treatment services through inhouse, locally available or regional resources. Alice Hyde Medical Center will monitor progress in tobacco/e-cigarette cessation interventions through tracking of data in the outpatient primary care practices at Alice Hyde Medical Center (2026, 2027). AHMC will track number of patients screened, and referred for cessation services. AHMC will conduct education for local school districts.

Health Equity

These actions will address health disparities including income, access, education, and disability.

SDOH Domain - Health Care Access and Quality

PRIORITY 7

Preventive Services for Chronic Disease Prevention and Control

Actions and Impact

Colorectal Screening Program in the Alice Hyde Primary Care Practices

Geographic Focus

Franklin County

Resource Commitment

AHMC will work to increase the percentage of adults aged 45-75 years who are up to date on their colorectal cancer screening based upon the most recent guidelines. AHMC will ensure providers identify patients with care gaps, and track and trend colorectal screening rates as a clinical quality improvement activity in 2025 and 2026. Work will include pre-visit planning, treatment planning, and outreach reminders for cancer screenings.

Participant Roles

AHMC will implement strategies to increase the percentage of adults aged 45-75 years who are up to date on their colorectal cancer screening based upon the most recent guidelines. AHMC will increase colorectal screening rates of appropriately identified patients in 2026, from 65.1% to 75.0% for the period October 1, 2025-September 30, 2026. AHMC will review data to determine number of Medicaid patients receiving colorectal screening in FY2026.

Health Equity

This initiative addresses health equity issues related to access to care, education, and poverty.

Franklin County Public Health Action Plan (to be included in June 2026 update)

Partner Engagement

The multi-county regional CHA committee, coordinated by ARHN, will meet every three months throughout the 2025-2030 cycle. The committee convenes to support ongoing regional health planning and assessment, working collaboratively on interventions and sharing promising evidence-based programming.

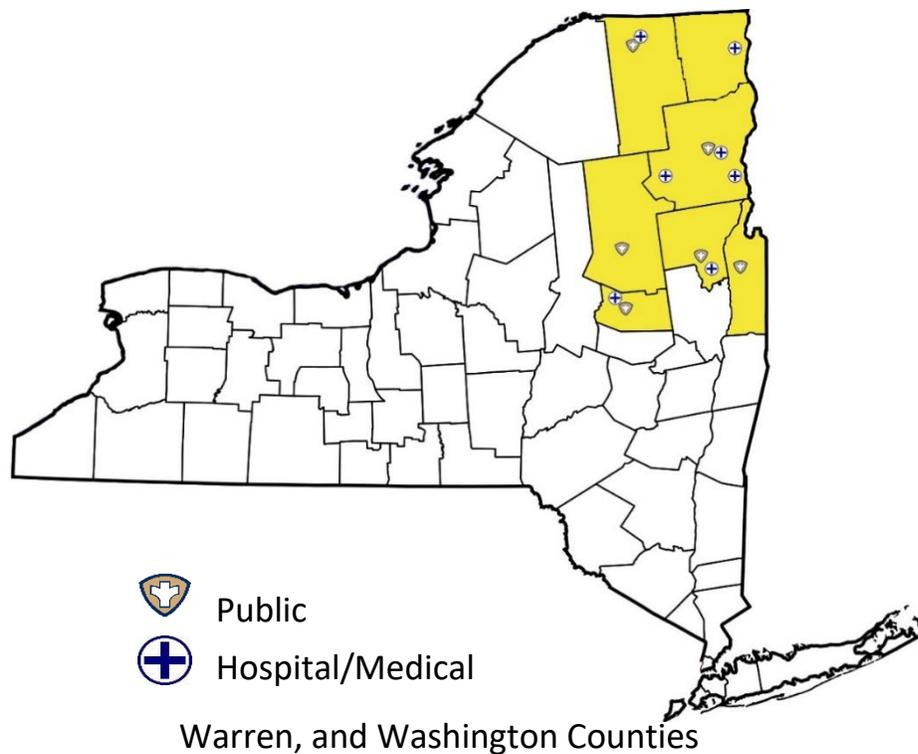
Additionally, Franklin County Public Health, Alice Hyde Medical Center, Adirondack Health, and all community-based organizations involved in the Community Health Improvement Plan have committed to meeting bi-annually to discuss progress and evaluate results. We will assess measurable outcomes identified in our interventions workplan, discuss strategy updates or changes, and collaborate on additional plans. Progress towards the identified health goals will be continually tracked, with formal progress captured in annual reports.

Sharing Findings with the Community

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

Appendix - 2025 Stakeholder Survey Report

2025 Stakeholder Survey Report



The Adirondack Rural Health Network (ARHN) is a program of AHI-Adirondack Health Institute, supported by the New York State Department of Health, Office of Health Systems Management, Division of Health Facility Planning, Charles D. Cook Office of Rural Health.

BACKGROUND INFORMATION:

Adirondack Rural Health Network:

The Adirondack Rural Health Network (ARHN) is a program of Adirondack Health Institute, Inc. (AHI), a 501c3 not-for-profit organization. ARHN is the longest-running program of AHI, established in 1987 through a New York State Department of Health (NYS DOH) Rural Health Network Development Grant. ARHN is a multi-stakeholder, regional coalition that informs planning and assessment, provides education and training to further the implementation of the NYS DOH Health Prevention Agenda, and offers other resources that support the development of the regional health care system. Since its inception, ARHN has provided a forum to assess regional population health needs and develop collaborative responses to priorities. ARHN includes organizations from Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Description of the Community Health Assessment Committee:

Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is a multi-county, regional stakeholder group consisting of hospitals and local county health departments that convenes to develop and support sophisticated process for ongoing community health planning and assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from the following organizations:

- Adirondack Health
- Clinton County Health Department
- University of Vermont Health Network - Alice Hyde Medical Center
- University of Vermont Health Network - Elizabethtown Community Hospital
- Essex County Health Department
- Franklin County Public Health
- Fulton County Public Health
- Glens Falls Hospital
- Hamilton County Public Health and Nursing Services
- Nathan Littauer Hospital
- University of Vermont Health Network – Champlain Valley Physicians Hospital
- Warren County Health Services

- Washington County Public Health.

The purpose of the CHA Committee is to address regional priorities, identify interventions, and develop the planning documents required by NYS DOH and the Internal Revenue Service (IRS) in an effort to advance the New York State Prevention Agenda.

CHA Data Sub-Committee:

The Data Sub-Committee (DSC) is a subset of CHA partners that meet regularly to review the tools and processes used by CHA Committee members to develop their Community Health Assessments (CHAs) and Community Health Needs Assessments (CHNAs), as well as their Community Health Improvement Plans (CHIPs) and Community Service Plans (CSPs). The DSC also works to identify opportunities to strengthen the CHA/CHNA/CHIP/CSP process. One of the primary activities of the DSC was to collaboratively develop a stakeholder survey.

The DSC met nine times from January 2024 through January 2025. Meetings were held via Webex. Attendance ranged from 6 to 11 subcommittee members per meeting. Meetings were facilitated by AHI staff from ARHN and attended by members of the AHI Data and Analytics team.

SURVEY METHODOLOGY:

Survey Creation:

The 2025 CHA Stakeholder Survey was updated by the DSC, with the definitive version incorporating additional questions and information related to Social Determinants of Health (SDOH), aligning with the priorities of the 2025-2030 NYS Prevention Agenda.

Survey Facilitation:

ARHN facilitated the release of the stakeholder survey across its seven-county service area to gather input on regional health care needs and priorities for the CHA Committee. Survey participants included professionals from health care, social services, education, and government, as well as community members. The ARHN region comprises Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington Counties.

Survey Logistics:

The survey was developed through SurveyMonkey and included 14 community health questions along with several demographic questions. The CHA Committee compiled a county level list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) to receive the survey. In total, 889 community stakeholders were identified for distribution.

In early February 2025, CHA Committee partners sent an initial email to community

stakeholders introducing the survey and providing a web-based link. ARHN followed up with several reminder emails to stakeholders who had not completed the survey. Additionally, CHA Committee members were provided with the names of all non-respondents for additional follow-up, at partner discretion.

The survey requested that community stakeholders rank the five domains of SDOH based on their impact within their communities and identify key priority areas addressed by their organizations. Respondents also provided insight into what they viewed as the top health concerns in their communities and the most influential contributing factors. A full list of survey questions can be found under Appendix A.

Survey Responses and Analysis:

A total of 307 responses were received through March 14, 2025, resulting in a response rate of 34.5%. Respondents were asked to indicate the counties in which they provide services and were able to select multiple counties, as appropriate. County specific response totals are outlined in the “By County” section.

Analysis is organized both alphabetically and in the order of which questions appeared on the survey to support easier comprehension. Each table is clearly labeled to indicate whether the data is presented as response counts or percentages. For tables involving county data, color coding is used to differentiate counties. Written analysis accompanies each section and present findings are in percentages.

This report provides a regional overview of the results, focusing on the ARHN service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties. The stakeholder survey aimed to collect insights from diverse sectors and perspectives to inform our understanding of community needs. These findings will guide strategic planning across the Adirondack region, benefiting partners who serve individual counties, and those whose footprint covers multiple counties.

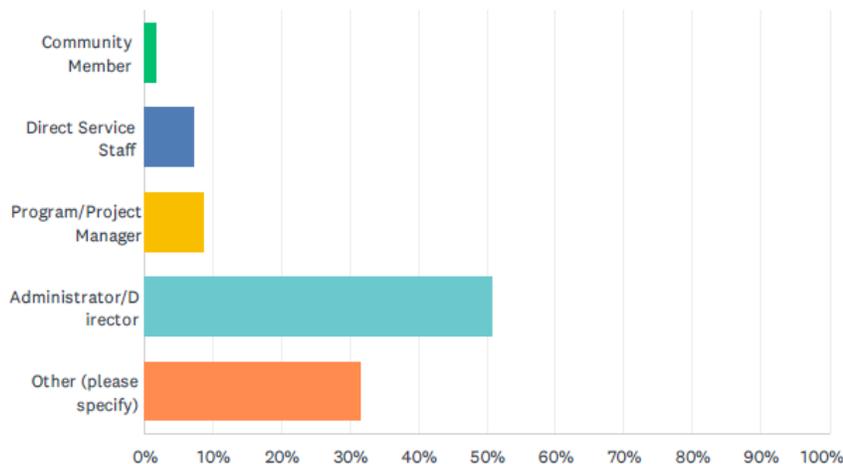
Clinton
Essex
Franklin
Fulton
Hamilton
Warren
Washington

ANALYSIS:

Q3. Job Title/Role

Approximately 50.83% of respondents identified themselves as *Administrator or Director*, making it the most common selection. The second most frequent response was the “*Other*” category, accounting for 31.56% of responses. Among those who selected “*Other*,” common roles included *President, Nurse and Purse Practitioner, School Nurse, Town Supervisors, or other county-level roles*.

It is important to note that based on responses indicated their roles did not fit the available options. To improve future surveys, it is recommended to expand the list of job titles to better capture the range of positions held by stakeholders



Respondent Job Titles		
Job Title	Responses	
	Count	Percentage
Community Member	5	1.66%
Direct Service Staff	22	7.31%
Program/Project Manager	26	8.64%
Administrator/Director	153	50.83%
Other	95	31.56%

Q5. Indicate the one community sector that best describes your organization/agency:

Community stakeholders were asked to identify one community sector that best described their organization or agency. Respondents represented a diverse range of services, with the most frequently selected sectors being *Education (27.09%)*, which includes both K-12 and College/Universities, followed by *Health Care Provider (12.04%)*, *Local Government (11.04%)*, and *Other (10.70%)*.

Among those who selected “*Other*,” most listed roles could have fit into one of the defined sectors. To improve clarity in future surveys, it is recommended to refine sector definitions or

offer clarifying examples to help respondents accurately categorize their roles.

Community Sector	1-25	25-50	50-75	75-100
College/University	2 (0.67%)			
Disability Services	5 (1.67%)			
Early Childhood	7 (2.34%)			
Economic Development	2 (0.67%)			
Employment/Job Training	3 (1.00%)			
Food/Nutrition	8 (2.68%)			
Foundation/Philanthropy	1 (0.33%)			
Health Based CBO	7 (2.34%)			
Health Care Provider		36 (12.04%)		
Housing	3 (1.00%)			
Law Enforcement/Corrections	11 (3.68%)			
Local Government (e.g., elected official, zoning/planning board)		33 (11.04%)		
Media	1 (0.33%)			
Mental, Emotional, Behavioral Health Provider	15 (5.02%)			
Other		32 (10.70%)		
Public Health	23 (7.69%)			
Recreation	3 (1.00%)			
School (K-12)				79 (26.42%)
Seniors/Aging Services	10 (3.34%)			
Social Services	15 (5.02%)			
Transportation	3 (1.00%)			

Q6. Indicate the region/counties your organization/agency serves:

Respondents were asked to indicate which county or counties their organization or agency serves. Over 93% of responses (285 total) were from Clinton, Essex, and Washington counties. Approximately 28.5% of respondents reported serving counties outside the seven ARHN counties, including Montgomery and Saratoga counties. In addition, 22% of respondents identified themselves as serving the entirety of the Adirondack/North Country region. It should be noted that the figures below exceed 100%, as many organizations serve multiple counties.

Respondents by County		
County	Count	Percentage
Adirondack/North Country Region	68	22.30%

Clinton	78	25.57%
Essex	118	38.68%
Franklin	70	22.95%
Fulton	52	17.05%
Hamilton	46	15.08%
Montgomery	30	9.84%
Saratoga	39	12.79%
Warren	65	21.31%
Washington	89	29.18%
Other (please specify)	18	5.90%

**Figures do not add up to 100% due to multiple counties per organization*

Respondents in the *Other* column identified a variety of counties outside the region, including St. Lawrence (6), Schenectady (4), Albany (3), Rensselaer (3), Jefferson (3), Schoharie (3), Herkimer (2), Vermont (2), and Herkimer (2).

Q7. What are the top five health concerns affecting the residents of the counties your organization/agency serves?

Community stakeholders were asked to identify what they believed to be the top five health concerns affecting residents in the counties their organization or agency serves. Respondents ranked their selections from one, the highest health concern, to five, indicating the lowest health concern.

According to the survey results, the top five health concerns affecting the residents within the ARHN region were *Mental Health (22.83%), Substance Use/Alcoholism/Opioid Use (11.59%), Child/Adolescent emotional health (10.14%), Adverse Childhood Experiences (8.33%), with a tie for fifth between Overweight/Obesity (6.88%) and Cancers (6.88%).*

Health Concern	Highest (1)	2	3	4	Lowest (5)
Mental Health Conditions	63	43	37	15	12
Substance Abuse/Alcoholism/Opioid Use	32	37	28	33	13
Child/Adolescent Emotional Health	28	28	18	20	17
Adverse Childhood Experiences	23	16	13	15	14
Overweight or Obesity	19	19	19	19	10
Cancers	19	12	8	8	6
Senior Health	16	7	16	7	9
Heart Disease	12	11	9	7	7
Maternal Health	10	3	4	2	4
Diabetes	9	15	14	8	7
Hunger	7	3	5	16	8
Dental Health	5	4	6	4	10
Child/Adolescent Physical Health	4	13	6	8	14
Alzheimer's Disease/Dementia	4	9	7	5	5

Respiratory Disease (Asthma, COPD, etc.)	4	3	3	10	13
Disability	4	2	5	12	11
Tobacco Use/Nicotine Addiction- Smoking/Vaping/Chewing	3	12	18	9	15
Domestic Abuse/Violence	3	6	9	8	7
Social Connectedness	2	5	17	21	24
Infant Health	2	5	0	1	3
Prescription Drug Abuse	2	0	6	2	8
Falls	1	3	3	2	3
High Blood Pressure	1	2	3	4	10
Food Safety	1	1	1	2	3
Motor Vehicle Safety (Impaired/Distracted Driving)	1	0	1	5	0
Unintended/Teen Pregnancy	1	0	0	1	5
Autism	0	5	5	3	7
Exposure to Air and Water Pollutants/Hazardous Materials	0	2	1	1	3
Infectious Disease	0	2	0	3	1
Pedestrian/Bicyclist Accidents	0	2	0	0	0
Underage Drinking	0	1	3	1	1
Sexually Transmitted Infections	0	1	2	1	2
Violence (Assault, Firearm Related)	0	1	1	3	3
LGBT Health	0	1	1	2	4
Sexual Assault/Rape	0	1	0	1	0
Suicide	0	0	7	7	5
Stroke	0	0	0	3	3
HIV/AIDS	0	0	0	2	1
Hepatitis C	0	0	0	1	0
Arthritis	0	0	0	0	1

Overall, the majority of health concerns identified at the individual county level aligned with the top five health concerns identified for the ARHN region. Several counties recognized health concerns outside the top five for the ARHN region. Five out of the seven ARHN counties listed *Cancers* as a top health concern in their county.

Franklin and Hamilton County respondents identified *Diabetes* as a concern in their area, while Fulton County identified Maternal Health, and Hamilton County identified Senior Health. Outliers include Franklin County listing *Heart Disease* as a top concern in their county.

Top Five Health Concerns Identified by County					
County	1 st	2 nd	3 rd	4 th	5 th
Clinton	Mental Health	Substance Use/Alcoholism/Opioid	Cancers	Adverse Childhood	Overweight or Obesity

	Conditions	Use		Experiences	
Essex	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Child/Adolescent Emotional Health	Adverse Childhood Experiences	Overweight or Obesity
Franklin	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Diabetes	Heart Disease	Overweight or Obesity
Fulton	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Cancers	Child/Adolescent Emotional Health	Maternal Health
Hamilton	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Cancers	Diabetes	Senior Health
Warren	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Child/Adolescent Emotional Health	Adverse Childhood Experiences	Cancers
Washington	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Child/Adolescent Emotional Health	Adverse Childhood Experiences	Cancers

Q8. What are the top five contributing factors to the health concerns you identified in Question 7?

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

The top five contributing factors identified by survey respondents were *Lack of Mental Health Services (13.28%), Addiction to Alcohol/Illicit Drugs (13.28%), Poverty (11.07%), Age of Residents (8.49%), and Changing Family Structures (5.90%).*

Contributing Factors	Highest (1)	2	3	4	Lowest (5)
Addiction to Alcohol/Illicit Drugs	36	17	18	9	10
Addiction to Nicotine	6	9	7	7	6
Age of Residents	23	9	3	6	8
Changing Family Structures (Increased Foster Care, Grandparents as Parents, etc.)	16	24	9	10	9
Crime/Violence	1	2	2	3	4
Community Blight/Deteriorating Infrastructure (Roads, Bridges, Water Systems, etc.)	0	1	1	1	0
Discrimination/Racism	0	2	1	3	0
Domestic Violence and Abuse	3	8	4	6	7

Environmental Quality	4	3	4	6	1
Excessive Screen Time	9	8	14	13	3
Exposure to Tobacco Smoke/Emissions from Electronic Vapor Products	1	2	4	2	3
Food Insecurity	8	10	15	11	8
Health Care Costs	10	15	17	7	10
Homelessness	5	10	7	6	6
Inadequate Physical Activity	6	15	10	15	7
Inadequate Sleep	0	4	3	1	4
Inadequate/Unaffordable Housing Options	4	13	12	12	7
Lack of Chronic Disease Screening Treatment and Self-Management Services	6	5	8	7	4
Lack of Cultural and Enrichment Programs	1	2	2	1	1
Lack of Dental/Oral Health Care Services	3	2	8	5	4
Lack of Quality Educational Opportunities for People of All Ages	2	1	0	1	2
Lack of Educational, Vocational, or Job-Training Options for Adults	0	0	1	0	3
Lack of Employment Options	3	1	2	1	4
Lack of Health Education Programs	2	0	2	2	2
Lack of Health Insurance	1	3	2	9	2
Lack of Intergenerational Connections within Communities	2	2	1	6	7
Lack of Mental Health Services	36	22	23	16	8
Lack of Opportunities for Health for People with Physical Limitations or Disabilities	2	1	1	2	1
Lack of Preventive/Primary Health Care Services (Screenings, Annual Check-Ups)	6	5	4	5	1
Lack of Social Supports for Community Residents	1	6	3	8	10
Lack of Specialty Care and Treatment	3	4	3	3	6
Lack of Substance Use Disorder Services	1	6	7	5	4
Late or No Prenatal Care	0	2	0	2	0
Pedestrian Safety (Roads, Sidewalks, Buildings, etc.)	0	0	0	0	1
Poor Access to Healthy Food and Beverage Options	3	5	7	4	7
Poor Access to Public Places for Physical Activity and Recreation	0	0	1	5	4
Poor Community Engagement and Connectivity	4	2	4	5	10
Poor Eating/Dietary Practices	11	9	12	5	7
Poor Referrals to Health Care, Specialty Care, and Community-Based Support Services	4	3	4	5	4
Poverty	30	12	14	19	20
Problems with Internet Access (Absent, Unreliable,	0	0	0	0	1

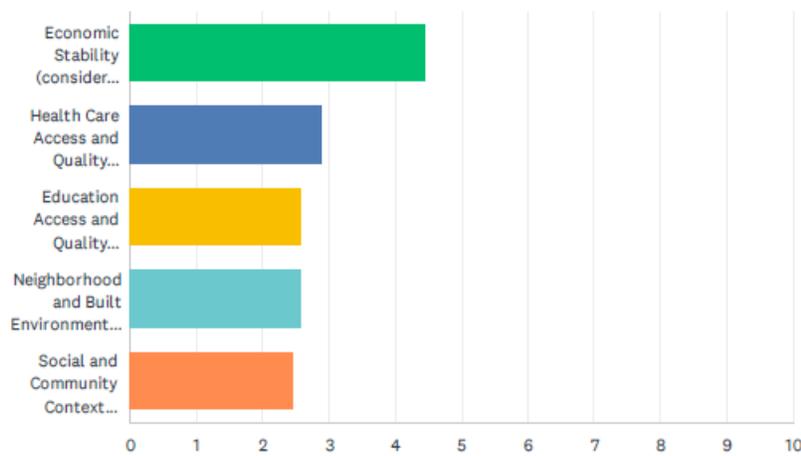
Unaffordable)					
Religious or Spiritual Values	0	0	1	1	1
Shortage of Child Care Options	2	2	2	4	8
Stress (Work, Family, School, etc.)	6	16	12	15	15
Transportation Problems (Unreliable, Unaffordable)	4	8	9	13	15
Unemployment/Low Wages	6	0	5	2	19

The majority of ARHN counties identified contributing factors that closely aligned with the overall top five for the region. However, several counties also highlighted unique concerns specific to their populations. Clinton County identified food insecurity as a significant contributing factor, while Franklin County emphasized poor eating and dietary practices. Warren County respondents pointed to both transportation and health care costs as key issues. Additionally, Fulton, Hamilton, and Warren counties all included health care costs among their top five contributing factors. Notably, in Warren County, health care costs and homelessness were tied as the fifth most significant contributing factor. These variations underscore the importance of addressing both regional and county-level priorities when planning public health strategies.

Top Five Contributing Factors by County					
County	1st	2nd	3rd	4th	5th
Clinton	Poverty	Addiction to alcohol/illicit drugs	Lack of Mental Health Services	Age of Residents	Food Insecurity
Essex	Poverty	Lack of Mental Health Services	Addiction to alcohol/illicit drugs	Changing Family Structures	Age of Residents
Franklin	Addiction to alcohol/illicit drugs	Lack of Mental Health Services	Poor eating/dietary practices	Age of Residents	Poverty
Fulton	Lack of Mental Health Services	Poverty	Addiction to alcohol/illicit drugs	Changing Family Structures	Health Care Costs
Hamilton	Age of Residents	Lack of Mental Health Services	Poverty	Addiction to alcohol/illicit drugs	Health Care Costs
Warren	Poverty	Lack of Mental Health Services	Addiction to alcohol/illicit drugs	Transportation problems	Health Care Costs & Homelessness
Washington	Poverty	Lack of Mental Health Services	Addiction to alcohol/illicit drugs	Changing Family Structures	Age of Residents

Q9. Social Determinants of Health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Please rate the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "most impact" to (5) "least impact".

Respondents were asked to rank SDOH, listed below, on a scale from one (excellent) to five (very poor). The table below presents the response counts for each determinant across all survey participants.



Sixty-six percent of respondents identified *Economic Stability* as the SDOH that most impacts residents of the counties they serve, followed by *Health Care Access and Quality* (14.79%).

SDOH Domain	1 Most Impact	2	3	4	5 Least Impact	Score
Economic Stability	170 (66.15%)	56 (21.79%)	16 (6.23%)	10 (3.89%)	5 (1.95%)	4.46
Health Care Access and Quality	38 (14.79%)	64 (24.90%)	51 (19.84%)	41 (15.95%)	63 (24.51%)	2.89
Education Access and Quality	25 (9.73%)	46 (17.90%)	50 (19.46%)	71 (27.63%)	65 (25.29%)	2.59
Neighborhood and Built Environment	15 (5.84%)	50 (19.46%)	65 (25.29%)	66 (25.68%)	61 (23.74%)	2.58
Social and Community Context	9 (3.50%)	41 (15.95%)	75 (29.18%)	69 (26.85%)	63 (24.51%)	2.47

Q10. What population in the counties your organization/agency serves experiences the poorest health outcomes?

To help identify the population with the greatest need, respondents were asked to indicate which group, in their opinion, experiences the poorest health outcomes in the counties they serve.

Population	Count	Percentage
Children/Adolescents	17	6.32%
Females of Reproductive Age	2	0.74%
Individuals living at or near the federal poverty level	88	32.71%

Individuals living in rural areas	26	9.67%
Individuals with Disability	11	4.09%
Individuals with Mental Health issues	58	21.56%
Individuals with Substance Abuse Issues	26	9.67%
Migrant Workers	1	0.37%
Other (please specify)	2	0.74%
Seniors/Elderly	37	13.75%
Specific racial and ethnic groups	1	0.37%

Across all counties in the ARHN, *Individuals living at or near the federal poverty level (66.21%)* were identified as the population experiencing the poorest health outcomes. In six of the seven ARHN counties, excluding Franklin County, the second most commonly identified population was *Individuals with mental health issues (39.72%)*. In contrast, Franklin County respondents identified *Seniors or Elderly (4.11%)* as the population with the second poorest health outcomes.

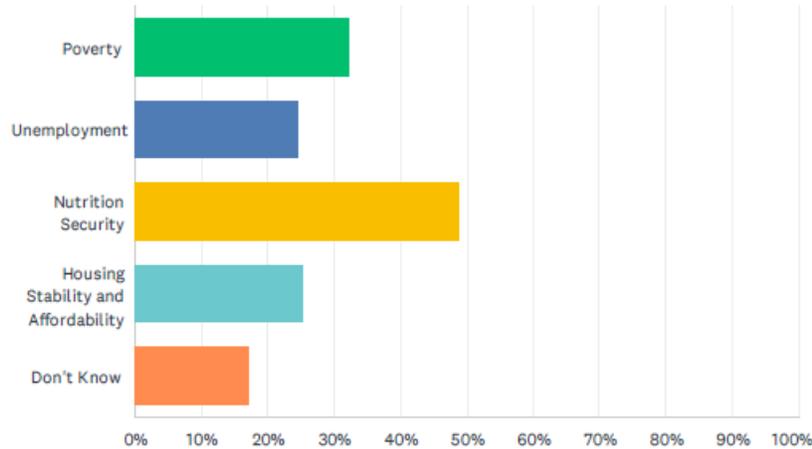
Response Counts for Poorest Health Outcomes by County							
Population	Clinton	Essex	Franklin	Fulton	Hamilton	Warren	Washington
Children/Adolescents	2	7	3	1	1	2	5
Females of reproductive age	1	0	0	1	0	0	0
Individuals living at or near the federal poverty level	20	32	22	15	12	17	27
Individuals living in rural areas	10	10	7	3	4	8	10
Individuals with disability	5	6	3	0	3	6	4
Individuals with mental health issues	12	19	7	13	9	14	13
Individuals with substance abuse issues	9	10	9	5	6	4	6
Migrant workers	0	0	0	0	0	0	1
Seniors/Elderly	10	14	9	7	5	3	7
Specific racial or ethnic groups	0	1	0	0	1	1	1
Other (please specify)	1	1	1	2	1	2	1
Total per county	76	116	69	52	46	64	89

2025 New York State Prevention Agenda:

The NYS Prevention Agenda is an initiative focused on improving the health and well-being of all New Yorkers. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare. Addressing these issues is crucial for reducing health disparities.

The next five questions of the survey asked respondents to select the top three goals their organization or agency can assist in achieving in the counties it serves.

Q11. Economic Stability (Economic Well-Being)



Domain: Economic Stability		
Priority Area	Count	Percentage
Poverty	74	32.31%
Unemployment	56	24.45%
Nutrition Security	112	48.91%
Housing Stability and Affordability	58	25.33%
Don't Know	39	17.03%

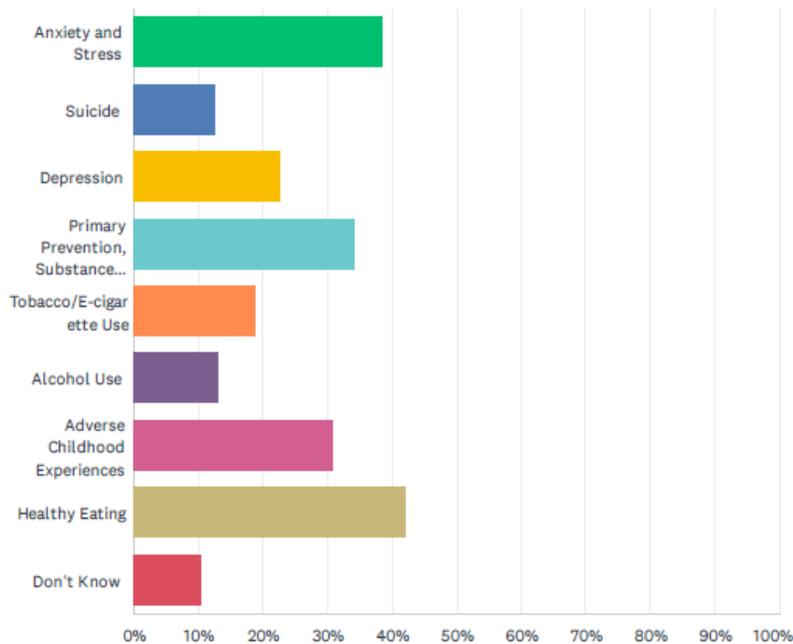
Respondents identified *Nutrition Security* (48.91%), *Poverty* (32.31%), and *Housing Stability and Affordability* (25.33%) as the top three priority areas that their organization are best positioned to support achieving in the region. Six out of seven ARHN counties identified *Nutrition Security* as the top priority, with the exception of Franklin County which identified *Poverty*.

Domain: Economic Stability			
County/Region	Priority #1	Priority #2	Priority #3
Clinton	Nutrition Security	Poverty	Tied: Unemployment & Housing Stability and Affordability
Essex	Nutrition Security	Poverty	Tied: Unemployment & Housing Stability and Affordability
Franklin	Poverty	Nutrition Security	Unemployment
Fulton	Nutrition Security	Poverty	Tied: Unemployment & Housing Stability and Affordability
Hamilton	Nutrition Security	Poverty	Tied: Unemployment & Housing Stability and Affordability
Warren	Nutrition Security	Housing Stability and Affordability	Poverty

Washington	Nutrition Security	Tied: Poverty and Housing Stability and Affordability	Unemployment
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Domain: Economic Stability							
Priority Area	Clinton	Essex	Franklin	Fulton	Hamilton	Warren	Washington
Poverty	23	26	24	13	9	14	18
Housing Stability and Affordability	17	21	14	9	7	15	18
Nutrition Security	31	38	20	20	13	21	31
Unemployment	16	21	17	8	7	12	14
Don't Know	8	12	5	10	8	9	10

Q12. Social and Community Context (Mental Well-Being and Substance Use)



Respondents identified *Healthy Eating* (42.26%) as the top priority area that their organization could assist with achieving, followed by *Anxiety and Stress* (38.49%) and *Primary Prevention, Substance Misuse, and Overdose prevention* (34.31%) as the third highest priority areas.

Domain: Social and Community Context		
Priority Area	Count	Percentage
Adverse Childhood Experiences	74	30.96%
Alcohol Use	31	12.97%
Anxiety and Stress	92	38.49%
Depression	54	22.59%

Healthy Eating	101	42.26%
Primary Prevention, Substance Misuse, and Overdose Prevention	82	34.31%
Suicide	30	12.55%
Tobacco/E-cigarette Use	45	18.83%
Don't Know	25	10.46%

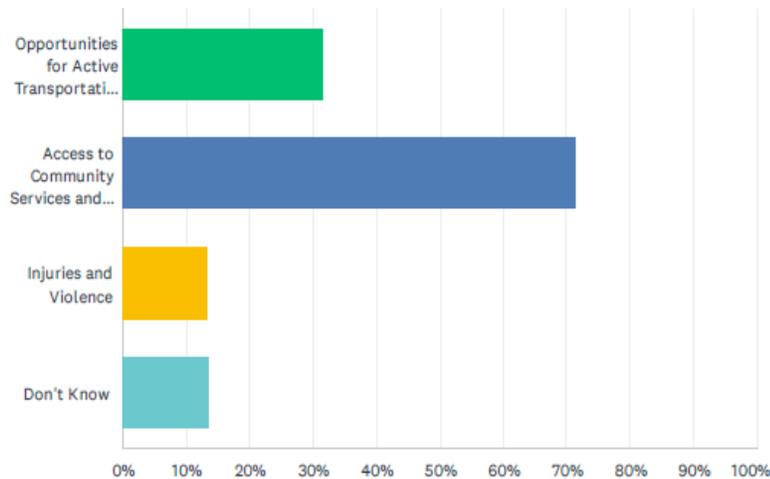
All seven counties identified the same top three regional priorities, apart from Franklin County, which included Depression among its top three. Additionally, four of the seven counties identified *Adverse Childhood Experiences* in their top three priority areas.

Domain: Social and Community Context			
County/Region	Priority #1	Priority #2	Priority #3
Clinton	Healthy Eating	Anxiety and Stress	Primary Prevention, Substance Misuse, and Overdose Prevention
Essex	Tied: Primary Prevention, Substance Misuse, and Overdose Prevention & Healthy Eating	Anxiety and Stress	Adverse Childhood Experiences
Franklin	Primary Prevention, Substance Misuse, and Overdose Prevention	Anxiety and Stress	Depression
Fulton	Anxiety and Stress	Tied: Primary Prevention, Substance Misuse, and Overdose Prevention & Healthy Eating	Adverse Childhood Experiences
Hamilton	Primary Prevention, Substance Misuse, and Overdose Prevention	Anxiety and Stress	Tied: Depression & Healthy Eating
Warren	Anxiety and Stress	Healthy Eating	Tied: Primary Prevention, Substance Misuse, and Overdose Prevention & Adverse Childhood Experiences
Washington	Anxiety and Stress	Tied: Adverse Childhood Experiences & Healthy Eating	Primary Prevention, Substance Misuse, and Overdose Prevention

Domain: Social and Community Context							
Priority Area	Clinton	Essex	Franklin	Fulton	Hamilton	Warren	Washington

Adverse Childhood Experiences	16	29	12	12	8	16	23
Alcohol Use	8	16	11	6	6	6	7
Anxiety and Stress	26	32	19	17	12	20	26
Depression	17	22	18	8	9	10	12
Healthy Eating	29	34	17	15	10	18	23
Primary Prevention, Substance Misuse, and Overdose Prevention	22	34	22	15	12	16	22
Suicide	10	16	12	4	6	4	5
Tobacco/E-cigarette Use	15	17	15	6	8	9	13
Don't Know	4	10	3	5	4	5	6

Q13. Neighborhood and Built Environment (Safe and Healthy Communities)



Domain: Neighborhood and Built Environment		
Priority Area	Count	Percentage
Access to Community Services and Support	167	71.37%
Injuries and Violence	31	13.25%
Opportunities for Active Transportation and Physical Activity	74	31.62%
Don't Know	32	13.68%

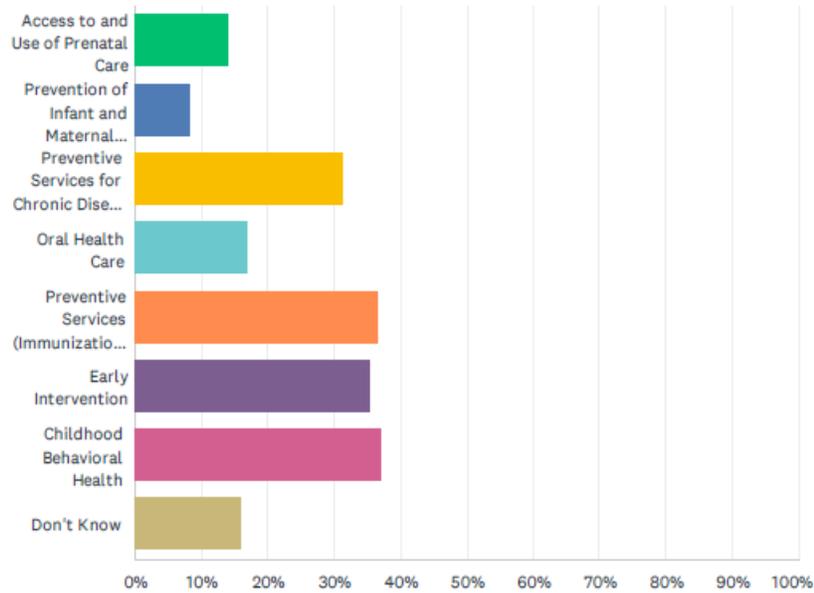
Domain: Neighborhood and Built Environment			
County/Region	Priority #1	Priority #2	Priority #3
Clinton	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence
Essex	Access to Community Services	Opportunities for Active	Injuries and Violence

	and Support	Transportation and Physical Activity	
Franklin	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence
Fulton	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence
Hamilton	Access to Community Services and Support	Tied: Opportunities for Active Transportation and Physical Activity & Injuries and Violence	
Warren	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence
Washington	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence

Domain: Neighborhood and Built Environment

Priority Area	Clinton	Essex	Franklin	Fulton	Hamilton	Warren	Washington
Access to Community Services and Support	44	62	36	28	21	21	42
Injuries and Violence	11	10	12	4	6	6	10
Opportunities for Active Transportation and Physical Activity	22	25	18	8	6	14	23
Don't Know	7	13	5	5	8	7	7

Q14. Health Care Access and Quality (Health Insurance Coverage and Access to Care and Healthy Children)



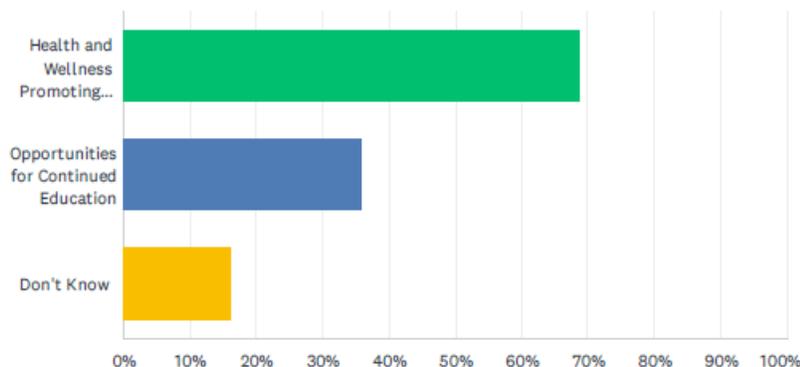
Domain: Health Care Access and Quality		
Priority Area	Count	Percentage
Access to and Use of Prenatal Care	32	14.16%
Childhood Behavioral Health	84	37.17%
Early Intervention	80	35.40%
Oral Health Care	38	16.81%
Prevention of Infant and Maternal Mortality	19	8.41%
Prevention Services for Chronic Disease Prevention and Control	71	31.42%
Preventive Services (Immunization, Hearing Screening, and follow up, Lead Screening)	83	36.73%
Don't Know	36	15.93%

Domain: Health Care Access and Quality			
County/Region	Priority #1	Priority #2	Priority #3
Clinton	Prevention Services for Chronic Disease Prevention and Control	Preventive Services	Early Intervention
Essex	Childhood Behavioral Health	Tied: Prevention Services for Chronic Disease Prevention and Control & Preventive Services	Early Intervention
Franklin	Prevention Services for Chronic Disease Prevention and Control	Early Intervention	Childhood Behavioral Health
Fulton	Preventive Services	Childhood Behavioral Health	Prevention Services for

			Chronic Disease Prevention and Control
Hamilton	Prevention Services for Chronic Disease Prevention and Control	Preventive Services	Childhood Behavioral Health
Warren	Childhood Behavioral Health	Prevention Services for Chronic Disease Prevention and Control	Preventive Services
Washington	Childhood Behavioral Health	Early Intervention	Preventive Services

Domain: Health Care Access and Quality							
Priority Area	Clinton	Essex	Franklin	Fulton	Hamilton	Warren	Washington
Access to and Use of Prenatal Care	13	15	8	8	10	5	7
Childhood Behavioral Health	18	38	16	16	12	20	27
Early Intervention	20	26	17	13	8	11	24
Oral Health Care	6	15	9	9	4	5	12
Prevention of Infant and Maternal Mortality	6	10	6	7	8	7	8
Prevention Services for Chronic Disease Prevention and Control	27	27	23	15	19	16	20
Preventive Services (Immunization, Hearing Screening, and follow up, Lead Screening)	25	27	15	21	13	12	23
Don't Know	5	13	7	7	5	5	6

Q15. Education Access and Quality (PreK-12 Student Success and Educational Attainment)



Domain: Education Access and Quality		
Priority Area	Count	Percentage
Health and Wellness Promoting Schools	152	68.78%
Opportunities for Continued Education	79	35.74%
Don't Know	36	16.29%

Domain: Education Access and Quality		
County/Region	Priority #1	Priority #2
Clinton	Health and Wellness Promoting Schools	Opportunities for Continued Education
Essex	Health and Wellness Promoting Schools	Opportunities for Continued Education
Franklin	Health and Wellness Promoting Schools	Opportunities for Continued Education
Fulton	Health and Wellness Promoting Schools	Opportunities for Continued Education
Hamilton	Health and Wellness Promoting Schools	Opportunities for Continued Education
Warren	Health and Wellness Promoting Schools	Opportunities for Continued Education
Washington	Health and Wellness Promoting Schools	Opportunities for Continued Education

Domain: Education Access and Quality							
Priority Area	Clinton	Essex	Franklin	Fulton	Hamilton	Warren	Washington
Health and Wellness Promoting Schools	39	21	36	26	22	32	41
Opportunities for Continued Education	18	10	15	15	11	9	13
Don't Know	7	3	6	9	8	6	10

Q16. Please identify the primary assets/resources your organization/agency can contribute toward achieving the goals you have selected.

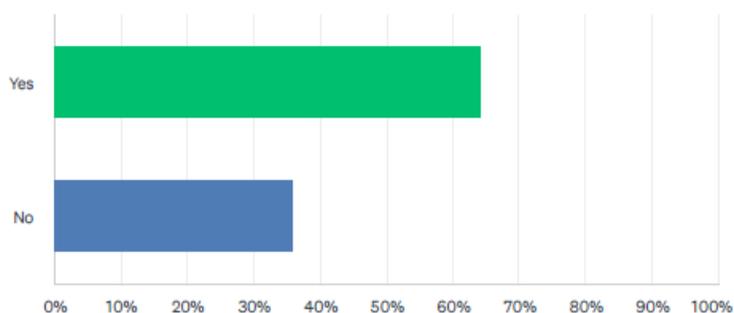
Respondents were asked to indicate the resources that their organization or agency could contribute toward achieving the goals they identified.

Approximately 59% of all respondents indicated that providing expertise and knowledge, as well as participating in committees, workgroups, and coalitions were key ways they could support progress towards the NYS Prevention Agenda goals listed above. Additionally, respondents noted that they could contribute sharing resources and promoting initiatives via social media to help advance the listed goals.

Response Counts and Percentages for Resources Organizations Can Contribute		
Resources	Count	Percentage
Participate on committees, work groups, and coalitions to help achieve the selected goals	124	59.33%
Provide subject-matter knowledge and expertise	121	57.89%
Share knowledge of community resources (e.g. food, clothing, housing,	104	49.76%

transportation, etc.)		
Promote health improvement activities/events through social media and other communication channels your organization/agency operates	99	47.37%
Offer health-related educational materials	71	33.97%
Facilitate access to populations your organization/agency serves (to encourage participation in programs, provide feedback about health improvement efforts, etc.)	66	31.58%
Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals	61	29.19%
Provide letters of support for planned health improvement activities	61	29.19%
Sign partnership agreements related to community level health improvement efforts	48	22.97%
Offer periodic organizational/program updates to community stakeholders	46	22.01%
Provide in-kind space for health improvement meetings/events	45	21.53%
Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)	37	17.7%
Share program-level data to help track progress in achieving goals	36	17.22%
Assist with data analysis	24	11.48%

Q17. Are you interested in being contacted at a later date?



Over 64% of respondents indicated they would be open to being contacted at a later date. Depending on the content and priorities outlined in the official 2025-2030 NYS Prevention Agenda official release, it may be beneficial to follow-up with partners to gather more targeted input or ask specific questions aligned with the finalized goals.

Appendix: The 2025 Stakeholder Survey

2025 CHA Stakeholders Survey

Introduction

To help inform a collaborative approach to improving community health, the Adirondack Rural Health Network (ARHN) and Community Health Assessment (CHA) Committee seeks to identify priorities, factors and resources that influence the health of residents of the Adirondack region (Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties).

You have been identified as a key informant who can provide insight into the health and well-being of the people your organization/agency serves. Please answer the survey questions in the context of your role within your organization/agency and in representing the population(s) your organization/agency serves.

All survey information will be held confidential, and no responses will be attributed to anyone individual or agency.

Your Organization/Agency

Please provide the following information about your organization/agency and yourself:

1. Organization/Agency name: _____

2. Your name (Please provide first and last name): _____

3. Your job title/role: _____

- Community Member
- Direct Service Staff
- Program/Project Manager
- Administrator/Director
- Other (please specify)

4. Your email address: _____

5. Indicate the **one** community sector that best describes your organization/agency:

- Business
- Civic Association
- College/University
- Disability Services
- Early Childhood

- Economic Development
- Employment/Job training
- Faith-Based
- Food/Nutrition
- Foundation/Philanthropy
- Health Based CBO
- Health Care Provider
- Health Insurance Plan
- Housing
- Law Enforcement/Corrections
- Local Government (e.g., elected official, zoning/planning board)
- Media
- Mental, Emotional, Behavioral Health Provider
- Public Health
- Recreation
- School (K – 12)
- Seniors/Aging Services
- Social Services
- Transportation
- Tribal Government
- Veterans
- Other (please specify):

6. Indicate the counties your organization/agency serves. **Check all that apply.**

- Adirondack/North Country Region
- Clinton
- Essex
- Franklin
- Fulton
- Hamilton
- Warren
- Washington
- Other: _____

Health Priorities, Concerns and Factors

7. In your opinion, what are the **top five (5) health concerns** affecting the residents of the counties your organization/agency serves? Please rank the health concerns from 1 (highest) to 5 (lowest).

- Adverse childhood experiences
- Alzheimer's disease/Dementia
- Arthritis
- Autism
- Cancers
- Child/Adolescent physical health
- Child/Adolescent emotional health
- Diabetes
- Disability
- Dental health
- Domestic abuse/violence
- Exposure to air and water pollutants/hazardous materials
- Falls
- Food safety
- Heart disease
- Hepatitis C
- High blood pressure
- HIV/AIDS
- Hunger
- Infant health
- Infectious disease
- LGBT health
- Maternal health
- Mental health conditions
- Motor vehicle safety (impaired/distracted driving)
- Overweight or obesity
- Pedestrian/bicyclist accidents
- Prescription drug abuse
- Respiratory disease (asthma, COPD, etc.)
- Senior health
- Sexual assault/rape
- Sexually transmitted infections
- Social connectedness
- Stroke
- Substance abuse/Alcoholism/Opioid Use

- Suicide
- Tobacco use/nicotine addiction – smoking/vaping/chewing
- Underage drinking
- Unintended/Teen pregnancy
- Violence (assault, firearm related)
- Other (Please specify):

8. In your opinion, what are the **top five (5) contributing factors** to the health concerns you chose in question #7? Please rank the contributing factors from 1 (highest) to 5 (lowest).

- Addiction to alcohol/illicit drugs
- Addiction to nicotine
- Age of residents
- Changing family structures (increased foster care, grandparents as parents, etc.)
- Crime/violence
- Community blight/Deteriorating infrastructure (roads, bridges, water systems, etc.)
- Discrimination/racism
- Domestic violence and abuse
- Environmental quality
- Excessive screen time
- Exposure to tobacco smoke/emissions from electronic vapor products
- Food insecurity
- Health care costs
- Homelessness
- Inadequate physical activity
- Inadequate sleep
- Inadequate/unaffordable housing options
- Lack of chronic disease screening, treatment, and self-management services
- Lack of cultural and enrichment programs
- Lack of dental/oral health care services
- Lack of quality educational opportunities for people of all ages
- Lack of educational, vocational, or job-training options for adults
- Lack of employment options
- Lack of health education programs
- Lack of health insurance
- Lack of intergenerational connections within communities
- Lack of mental health services
- Lack of opportunities for health for people with physical limitations or disabilities

- Lack of preventive/primary health care services (screenings, annual check-ups)
- Lack of social support for community residents
- Lack of specialty care and treatment
- Lack of substance use disorder services.
- Late or no prenatal care
- Pedestrian safety (roads, sidewalks, buildings, etc.)
- Poor access to healthy food and beverage options
- Poor access to public places for physical activity and recreation
- Poor community engagement and connectivity
- Poor eating/dietary practices
- Poor referrals to health care, specialty care, and community-based support services
- Poverty
- Problems with Internet access (absent, unreliable, unaffordable)
- Religious or spiritual values
- Shortage of childcare options
- Stress (work, family, school, etc.)
- Transportation problems (unreliable, unaffordable)
- Unemployment/low wages
- Other (please specify)

Prevention Agenda 2025 -2030: New York State’s Health Improvement Plan

The NYS Prevention Agenda is a six-year initiative aimed at improving the health and well-being of all New Yorkers. By outlining the key health priority areas, the prevention agenda is a tool for agencies to collaborate and prioritize strategies that advance health.

Although not officially released, NYS DOH recognizes that the 2025-2030 Prevention Agenda will “adopt a broader perspective, emphasizing factors that influence health beyond traditional health outcomes, prevention strategies, medical care, and public health systems”.

Twenty-four priorities have been identified based on Healthy People’s 2030 Social Determinants of Health domains, listed below:

1. Economic Stability
2. Social and Community Context
3. Neighborhood and Built Environment
4. Health Care Access and Quality
5. Education Access and Quality

For more information on the upcoming 2025-2030 NYS Prevention Agenda, please visit: [Prevention Agenda 2025-2030: New York State's Health Improvement Plan](#).

For more information on Healthy People’s 2030 Social Determinants of Health, please visit: [Social Determinants of Health - Healthy People 2030 | odphp.health.gov](#).

Social Determinants of Health

9. Social Determinants of Health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Please rate the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "most impact" to (5) "least impact".

- Economic Stability (consider poverty, employment, food security, housing stability)
- Education Access and Quality (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)
- Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)
- Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)
- Health Care Access and Quality (consider access to primary care, access to specialty care, health literacy)

10. In your opinion, what **population** in the counties your organization/agency serves experiences the poorest health outcomes? Please select **one** population.

- Specific racial or ethnic groups
- Children/adolescents
- Females of reproductive age
- Seniors/elderly
- Individuals with disability
- Individuals living at or near the federal poverty level
- Individuals with mental health issues
- Individuals living in rural areas
- Individuals with substance abuse issues
- Migrant workers
- Others (please specify):

Improving Health and Well-Being

The NYS Prevention Agenda is an initiative focused on improving the health and well-being of all New Yorkers. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare. Addressing these issues is crucial for reducing health disparities.

Over the next 5 questions, please check all the priority areas that your organization serves.

11. Economic Stability (Economic Well-being)

- Poverty
- Unemployment
- Nutrition Security
- Housing Stability and Affordability

12. Social and Community Context (Mental Well-being and Substance Use)

- Anxiety and Stress
- Suicide
- Depression
- Primary Prevention, Substance Misuse, and Overdose Prevention
- Tobacco/E-cigarette Use
- Alcohol Use
- Adverse Childhood Experiences
- Healthy Eating

13. Neighborhood and Built Environment (Safe and Healthy Communities)

- Opportunities for Active Transportation and Physical Activity
- Access to Community Services and Support
- Injuries and Violence

14. Health Care Access and Quality (Health Insurance Coverage and Access to Care and Healthy Children)

- Access to and Use of Prenatal Care
- Prevention of Infant and Maternal Mortality
- Preventive Services for Chronic Disease Prevention and Control
- Oral Health Care
- Preventive Services (Immunization, Hearing Screening and follow up, Lead screening)
- Early Intervention
- Childhood Behavioral Health

15. Education Access and Quality (PreK-12 Student Success and Educational Attainment)

- Health and Wellness Promoting Schools
- Opportunities for Continued Education

16. Based on the priorities you selected in Questions 12-16, please identify the primary assets/resources your organization/agency can contribute toward achieving the goals you have selected.

- Provide subject-matter knowledge and expertise
- Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)

- Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals
- Participate on committees, work groups, coalitions to help achieve the selected goals
- Share knowledge of community resources (e.g. food, clothing, housing, transportation, etc.)
- Facilitate access to populations your organization/agency serves (to encourage participation in programs, provide feedback about health improvement efforts, etc.)
- Promote health improvement activities/events through social media and other communication channels your organization/agency operates
- Share program-level data to help track progress in achieving goals
- Provide in-kind space for health improvement meetings/events
- Offer periodic organizational/program updates to community stakeholders
- Provide letters of support for planned health improvement activities
- Sign partnership agreements related to community level health improvement efforts
- Assist with data analysis
- Offer health-related educational materials
- Other (please specify):

17. Are you interested in being contacted at a later date to discuss the utilization of the resources you identified in Question #16?

- Yes
- No

18. Please add any other comments/recommendations you have about improving the health and well-being of the residents of the counties your organization/agency serves.