FRANKLIN COUNTY 2016 - 2018

Community Health Needs Assessment

Community Service Plan/Community Health Improvement Plan

Franklin County Seal

Public Health
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THE University of Vermont HEALTH NETWORK

Alice Hyde Medical Center

Adirondack Health
Leading care for a healthy community.

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Executive Summary

As part of an ongoing partnership, facilitated by the Adirondack Health Institute, Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital collaborate to improve the health of the residents of Franklin County. We have worked together on our assessment and intervention plans, resulting in this joint Community Health Assessment (CHA) and Community Service Plan(CSP)/Community Health Improvement Plan (CHIP). The partnership between our organizations assures meaningful strategic efforts towards the common goal of improving the population's health.

Prevention Agenda Priorities: Working collaboratively, and informed by community stakeholders and residents, our organizations selected *Prevent Chronic Disease* and *Promote Mental Health and Prevent Substance Abuse* as our priority areas. Under *Prevent Chronic Disease* we have chosen two focus areas, *Reduce Obesity in Children and Adults* and *Increase Access to High Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings.* Under the first focus area, we have chosen two goals: to create community environments that promote and support healthy food and beverage choices and promote physical activity, and to expand the role of health care and health service providers in obesity prevention. Under the second focus area, our goal is to promote culturally relevant chronic disease self management education. We have chosen one focus area under *Promote Mental Health and Prevent Substance Abuse*, which is to *Strengthen Infrastructure Across Systems.* Our goal is to support collaboration among leaders, professionals, and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention treatment and recovery. Major disparities identified in Franklin

County include *Poverty* and *Access to Care*. We have chosen interventions throughout our implementation strategy that work to address these disparities.

Emerging Issues and Continuing Priorities: *Preventing Chronic Disesase* remains a significant priority identified by community stakeholders and validated by the data analysis. Our planned interventions and activities in this area expand upon work accomplished since 2013. However, the addition of the second priority area, *Promote Mental Health and Prevent Substance Abuse*, is a major change since the 2013 plan. Due in large part to overwhelming indication by stakeholders, we felt it necessary to add this priority area to our planned interventions. This is also supported by the data analyzed in this assessment. Because this is a new priority area, we have chosen to strengthen infrastructure as a focus area in hopes to build the collaborative environment necessary to address this subject.

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

Partnerships: The completion of the 2016 – 2018 Franklin County Community Health Assessment and Community Service Plan/Community Health Improvement Plan was a collaborative effort between Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital. Franklin County, thanks to the visionary leadership of Community Connections and under DSRIP Project 2.d.i., has an additional network of collaboration with a number of community-based

organizations. These include Cornell Cooperative Extension, St. Joseph's Rehabilitation services, Franklin County Community Housing, Harrietstown Housing, Catholic Charities, Franklin County Community Services, North Country Healthy Heart Network, Franklin County Office of the Aging/NY Connects, the Department of Social Services, the Joint Council for Economic Opportunity, Community Health Center of the North Country, and the Youth Advocate Program. Ongoing engagement with the Adirondack Rural Health Network will be sustained, as well as Adirondack Health Institute, our regional PPS.

Community Engagement: The community engagement process involved a survey of key community stakeholders, conducted by the Adirondack Rural Health Network in conjunction with the Center for Workforce Studies. A smaller workgroup met several times to assess the results of this survey and align it with the data. We will continue to engage the community throughout the implementation of this plan to assure that our interventions and efforts are addressing their needs.

Planned Interventions and Strategies: All implementation strategies, interventions, activities and measures are outlined in great detail within the 2016 – 2018 Implementation Plan. Interventions were selected to align with current DSRIP projects, to continue ongoing interventions related to our most recent Community Service Plan/Community Health Improvement Plan, and also based off the NYS DOH 'Refresh" chart of evidence based interventions. Data findings suggest that the leading causes of death and illness in Franklin County can be directly linked to obesity, nutrition, physical activity, and tobacco use, as well as supports related to mental, emotional, and behavioral (MEB) well-being. Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital are committed to enhancing opportunities for all residents to live more healthful lives by promoting safe, healthful behaviors and creating

supportive environments. These actions include working with other community based organization partners to provide outdoor spaces that are appropriate and available for physical activity and play; promoting accessibility and affordability of healthful foods; and promoting wellness policies that include breastfeeding friendly and tobacco free environments. We are also committed to strengthening regional infrastructure to promote mental health and prevent substance abuse by participating in Public Health Networks and implementing DSRIP projects that support both physical and MEB health. Our interventions described in this Community Service Plan/Community Health Improvement Plan will decrease the incidence and burden of obesity and other chronic diseases, and contribute to the overall health – physical, social, and emotional – of our county residents.

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

Introduction

MESSAGE TO THE COMMUNITY

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

Working within the framework provided by New York State's Prevention Agenda 2013-2018, Adirondack Health Medical Center Hospital, the University of Vermont Health Network Alice Hyde Medical Center and Franklin County Public Health collaborated in the development of this CHA/CHNA. Additionally, Adirondack Health Medical Center Hospital, the University of Vermont Health Network Alice Hyde Medical Center and Franklin County Public Health County Public Health participated in regional health assessment and planning efforts conducted by the Adirondack Rural Health Network.

THE ADIRONDACK RURAL HEALTH NETWORK

The Adirondack Rural Health Network (ARHN) is a program of the Adirondack Health Institute, Inc. (AHI). AHI is a 501c3 not-for-profit organization that is licensed as an Article 28 Central Service Facility. AHI is a joint venture of Adirondack Health (Adirondack Medical Center), University of Vermont Health Network – Champlain Valley Physicians Hospital, Glens Falls Hospital and Hudson Headwaters Health Network. The mission of AHI is to promote, sponsor, and coordinate initiatives and programs that improve health care quality, access, and service delivery in the Adirondack region.

Established in 1992 through a New York State Department of Health, Rural Health Development Grant, the Adirondack Rural Health Network (ARHN) provides a forum for local public health services, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations to address rural health care delivery barriers, identify regional health needs and support the NYS Prevention Agenda to improve health care in the region. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning in the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments working together utilizing a systematic approach to community health planning. The CHA Committee is made up of members from Adirondack Health, UVM Health Network - Alice Hyde Medical Center, UVM Health Network - Elizabethtown Community Hospital, Essex County Public Health, Franklin

County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health Services, Moses Ludington Hospital & Inter-Lakes Health, Nathan Littauer Hospital, UVM Health Network – CVPH, Warren County Health Services, and Washington County Public Health Services.

NEW YORK STATE'S PREVENTION AGENDA 2013 - 2018

The Prevention Agenda 2013-2018 is a blueprint for local, regional, and state action to improve the health of New Yorkers in five priority areas, and to reduce health disparities for racial, ethnic, disability, and low socioeconomic groups, as well as other populations who experience them. In addition, the Prevention Agenda serves as a guide to local health departments as they work with their community to develop mandated Community Health Improvement Plans and Community Health Assessments and to hospitals as they develop mandated Community Service Plans and Community Health Needs Assessments required by the Affordable Care Act.

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

- Prevent Chronic Disease
    - Focus Area 1-Reduce Obesity in Children and Adults
    - Focus Area 2-Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
    - Focus Area 3-Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings

- Promote Healthy and Safe Environments
    - Focus Area 1-Outdoor Air Quality
    - Focus Area 2-Water Quality
    - Focus Area 3-Built Environment
    - Focus Area 4-Injuries, Violence and Occupational Health

- Promote Healthy Women, Infants and Children
    - Focus Area 1-Maternal and Infant Health
    - Focus Area 2-Child Health
    - Focus Area 3-Reproductive, Preconception and Inter-Conception Health

- Promote Mental Health and Prevent Substance Abuse
    - Focus Area 1-Promote Mental, Emotional and Behavioral Well-Being in Communities
    - Focus Area 2 - Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
    - Focus Area 3 - Strengthen Infrastructure across Systems

- Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Health Care-Associated Infections
    - Focus Area 1-Prevent HIV and STDs
    - Focus Area 2-Prevent Vaccine-Preventable Diseases
    - Focus Area 3-Prevent Health Care-Associated Infections

*The Prevention Agenda was originally a five year plan (2013-2017), it was extended to 2018 to align its timeline with other state and federal health care reform initiatives.

HEALTH CARE TRANSFORMATION: POPULATION HEALTH INITIATIVES IN OUR REGION

Public Health Departments and Hospitals are key partners working with providers, agencies and community based organizations to transform the way that our community members think about and receive health care. There are a number of federal, state, and regional initiatives to restructure the delivery system focusing on the Triple Aim. The Triple Aim is a framework that organizations and communities can use to navigate the transition from a focus on clinical care to optimizing health for individuals and populations. The Triple Aim is: improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities.

Some Population Health Initiatives include all community members

Adirondack Medical Home Initiative: The Adirondack Medical Home Initiative (AMHI) is a collaborative effort by health care providers and public and private insurers to transform health care delivery by emphasizing preventative care, enhanced management of chronic conditions, and assuring a close relationship between patients and their primary care providers.
The Initiative serves six Adirondack counties in New York State – Clinton, Essex, Franklin, Hamilton, Warren, and Washington. More than 100 primary care providers, five hospitals, and seven health insurance organizations are working together to develop an innovative, patient-centered model of health care that strengthens the role of primary care.

Population Health Improvement Program: The North Country (PHIP) is bringing together a variety of stakeholders in the North Country that impact, or are impacted by, health and health care issues. PHIP assists providers, agencies and organizations with identifying data and using data driven, collaborative decision making to address the social determinants of health that contribute to health disparities in the region. The PHIP is engaged with stakeholders in Franklin, Clinton, Essex, Hamilton, Warren, and Washington counties.

NYS Health Innovation Plan and State Innovation Model: New York's State Innovation Model (SIM) testing grant seeks to transform primary care delivery and payment models across the State, eventually reaching 80 percent of New York's primary care providers, payers, and patients. The SIM is a part of New York's larger State Health Innovation Plan (SHIP), which is driving evolution of health delivery and payment systems through numerous initiatives. The

intent and goal is to identify and stimulate the spread of promising innovations in health care delivery and payment that result in optimal health outcomes for all New Yorkers.

Some Population Health Initiatives focus on Medicare members

Accountable Care Organizations: Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. Adirondacks ACO includes hospitals and participating primary and specialty care providers in Clinton, Essex, Franklin, Hamilton, Warren, Washington and northern Saratoga counties.

Some Population Health Initiatives focus on Medicaid members

Delivery System Reform Incentive Payment Program: Delivery System Reform Incentive Payments (DSRIP) purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program. Across NYS, there are 25 Performing Provider Systems (PPSs) or networks of providers that have agreed to work together. DSRIP is an incentive payment model that rewards providers for performance on delivery system transformation projects that improve care for low-income patients.

Each DSRIP project has specific milestones and metrics associated. The projects and milestones are state-specific and tend to have an increasing focus on outcomes over time. The milestones are designed to achieve transformation leading to the primary goal of reducing avoidable hospital use by 25% over 5 years. In addition, there are a number of quality goals the PPS must achieve including measures of access, preventive care and care coordination, among others. The DSRIP program covers a five-year period commencing April 1, 2015 and ending March 31, 2020. See Appendix J for a list of AHI PPS Projects.

Health Home: A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that a patient's needs are addressed in a complete and comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all of the services an individual's needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations. When all the services are considered collectively they become a virtual "Health Home." Health Home focuses on people who have complex medical, behavioral, and long term care needs thus need help navigating multiple systems of care.

At this time there are some new initiatives developing. One is the NYS Office for Mental Health Regional Planning Consortiums (RPCs). The RPCs will be a vehicle to promote the effective implementation of managed Medicaid behavioral health services and cross system/community collaboration. On the federal level CMS is implementing the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA initiates changes to the way that Medicare pays physicians.

The common thread throughout these initiatives is the underlying objectives in the Triple Aim, to improve quality and experience while providing cost effective care.

COMPLEMENTARY HEALTH INITIATIVES IN OUR REGION

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

Below is a summary of county, regional and statewide planning documents and policy agendas from a variety of community sectors that address health-related issues. Links are included to facilitate access to the documents. The contents are organized by the relevant Prevention Agenda Focus Area. The summary does not provide an exhaustive analysis of multi-sector health priorities, but is provided to illustrate the potential for collaborative health improvement efforts in the county and region.

Prevent Chronic Diseases
NYS Office for the Aging State Plan 2015-2019
http://www.aging.ny.gov/NYSOFA/Final_State_Plan_2015_2019.pdf

- Strengthen partnerships with health care providers and develop models that reach new populations.
- Work with other state agencies and local partners to prevent readmission to hospitals.
- Teach older adults how to manage complex chronic conditions.
- Promote and expand access to health and wellness/disease management and prevention programs.
- Expand opportunities for integration of non-clinical support services within physical and behavioral health care systems.
- Provide one-on-one assistance to understand the complexities of and navigating Medicare and other health insurance.
- Utilize the experience, expertise and skills of older New Yorkers to help address workforce shortages in areas such as health care.

Promote a Safe and Healthy Environment
New York State Affordable Housing Solutions: 5 Year Plan (2017-2021)
http://www.nysafah.org/cmsBuilder/uploads/nys-5-yr-housing-plan-recommendations-final-12-07-2015.pdf

- Create a new Senior Housing Plus Services program to support aging in place of New York's rapidly growing low-income elder population. The program should emphasize wellness and healthy aging, and avoidance of premature entry into Medicaid funded institutional settings.

- Incentivize Affordable Housing Development in High-Opportunity Neighborhoods to increase fair housing options while also complementing existing efforts to revitalize low-income neighborhoods.
- Work with municipalities to develop incentives in the area of zoning and local siting of affordable housing projects.
- Facilitate the development of a diversity of affordable housing types, particularly family and supportive housing serving low- and extremely low-income households.

Complete Streets Policies
https://www.dot.ny.gov/programs/completestreets
The Town of Malone has a Complete Streets policy.

Promote Healthy Women, Infants and Children
Adirondack Birth to Three Alliance
http://www.adirondackbt3.org/about-us
The Adirondack Birth to Three (BT3) Alliance has identified the following five building blocks of services to improve outcomes for children:

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

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

- All pregnancies are wanted, healthy, and safe, and include prenatal screening.
- Children's environments are free from preventable injury and illness.
- Children achieve optimal physical, social, emotional and cognitive development.
- Children receive early recognition and intervention services for their special needs.
- Children are enrolled in public or private health insurance programs.
- Children's health, mental health, and oral health services are accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally respectful.

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

Promote Mental Health and Reduce Substance Abuse
Franklin County Community Services - 2016 Local Services Plan for Mental Hygiene Services
http://www.clmhd.org/img/pdfs/brochure_f25an8gc9m.pdf

- Organize and strengthen collaborative partnerships between service systems.
- Complete NYS Success System of Care Innovative Fund Project: Creating Trauma Sensitive Schools.
- Strengthen the continuum of care, increase opportunities for individuals to access care and achieve greater outcomes.
- Develop a county wide cross systems approach to suicide prevention, intervention and postvention.
- Insure vocational training opportunities are available to those seeking competitive and supported employment.
- Individuals with developmental and/or psychiatric disabilities will learn how to effectively advocate for themselves in their day to day lives.
- Create opportunities in the local communities for those in need of safe and affordable housing to include efficient transitional services upon discharge from regional hospitals.
- Promote timely and clinically appropriate access to care for County residents.
- Create and strengthen existing prevention and engagement strategies to promote overall wellness, recovery and healthy communities.
- Strategize and respond to system transformation as a result of Health Care Reform and Medicaid Redesign.
- Collaborate and pool resources to insure ongoing education, training and professional development of staff.
- Insure transportation is available to Franklin County residents to insure access to services and competitive employment.

The Alcoholism and Substance Abuse Providers of New York State (ASAP)
Legislative Recommendations
http://www.asapnys.org/wp-content/uploads/2015/07/Policy-Recommendations-2016.pdf

- Lift roadblocks to employment and housing for people in recovery who developed a criminal justice history while actively suffering from their addiction disease.
- Strengthen access to emergency/crisis services for persons with substance use disorders, especially those with co-occurring health and mental health issues.
- Create wraparound services for adolescents and adults while in treatment and to support recovery post-treatment. Such services would include case management, peer supports; employment support; transportation assistance, and other recovery supports.
- Make treatment more accessible, eliminate waiting lists, make a comprehensive continuum of SUD services accessible in every region of the state.
- Reduce under-age drinking using such measures as making labeling and marketing practices that are specifically targeting persons under age 21 illegal, educating stores and persons that sell alcohol products about under-age drinking risks and consequences, and environmental strategies that reduce the likelihood of problems related to under-age alcohol and other drug use.
- Make Naloxone more readily available; provide naloxone training to first responders, teachers, family members, and concerned persons; and facilitate access to Naloxone.
- Mandate continuing education for physicians and other practitioners that prescribe opiates with a focus on addiction and appropriate assessment, brief intervention, and referral to treatment.
- Promote harm reduction to reduce the chances for persons becoming positive for HIV/AIDS, hepatitis, and other health conditions associated with IV and other drug use.

Improve Health Status and Reduce Health Disparities
New York Association on Independent Living – 2016 Priority Agenda
http://www.ilny.org/advocacy/advocacy-priorities

- Allow non-licensed professionals, under the supervision of a registered nurse and who are trained and certified as “advanced” aides, to perform assistance with and maintenance of skills necessary for the individual with a disability to accomplish health-related tasks. This would help provide a support system for all people to access as an alternative to nursing facility/institutional placement, regardless of age, diagnosis or severity of disability.
- Incorporate inclusive home design features in new residential housing that receives financial assistance for construction from federal, state, county or local governments. Housing built with basic accessibility features, known as “inclusive home design”, would meet the needs of people throughout the lifespan and allow homes to be accessible to friends and family members with disabilities.
- Establish a small business tax credit for the employment of people with disabilities to provide an incentive for small businesses to hire individuals with disabilities, increasing the opportunities for New Yorkers with disabilities to achieve gainful employment and self-sufficiency.
- Require transportation service providers, such as taxis and limousines, to purchase accessible vehicles. Cap fares for paratransit at levels no higher than the base fares for transportation of non-disabled adults using the public transit system.

New York State Community Action Association – 2016 Policy Agenda
http://nyscommunityaction.org/wp-content/uploads/2015/01/Revised-2-24-Draft-2016-Policy-Agenda-2.pdf

- Support the implementation of federally-mandated health and safety requirements and new federal requirements to help avoid a reduction in child care subsidies for low-income parents.
- Support funding for the Hunger Prevention and Nutrition Assistance Program (HPNAP) to address the increased demand and rising food costs.
- Support increased access and participation in the Supplemental Nutrition Assistance Program (SNAP).
- Support incentive programs that increase buying power for fruits and vegetables at farmers markets.
- Support increased homeless shelter allowances and creation of a Community Restoration Fund to prevent foreclosures, improve neighborhood stabilization and provide funding for the Mortgage Assistance Program.
- Support increased public transportation offerings in rural areas of the state to promote better access to employment opportunities, health care, and safe housing.

Economic Development

There are a number of entities that are playing active roles in promoting economic development in the North Country and the state. Regional Economic Development Councils, County Economic Development Corporations, and Regional/Local Chambers of Commerce help guide local, community-based approaches to economic growth. Economic development priorities such as job creation, work force training, affordable housing, technology access, broadband Internet access, educational opportunities, transportation expansion, energy and weatherization improvement, and employee wellness programs all have an impact on the region's health and quality of life. Active participation of the public health and health care sectors in local and regional economic development planning bodies can help ensure that health-related concerns are considered when economic growth projects and priorities are developed.

Information about economic development priorities and activities in the region and county can be found at:

- North Country Regional Economic Development Council
  http://regionalcouncils.ny.gov/content/north-country
- North Country Chamber of Commerce
  http://www.northcountrychamber.com/
- Franklin County Industrial Development Agency
  http://www.franklinida.org/
- AdkAction.org
  http://adkaction.org/broadband

For the Delivery System Reform Incentive Payment (DSRIP) program the AHI PPS conducted a Community Needs Assessment (CNA) in late 2014. The DSRIP CNA used much of the same publicly available data that is used in this Assessment. It also used some Medicaid utilization data that the NYS DOH made available as DSRIP focuses on Medicaid members. The AHI PPS partners have focused on Care Coordination projects to address chronic disease and behavioral health projects based on the data. This focus closely mirrors the Public Health and Hospital partners' choices for priorities under the Prevention Agenda.

COMMUNITY HEALTH ASSESSMENT PROCESS AND METHODS

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

The health indicator data is collected and published by New York State and contains nearly 300 different health indicators. Since 2002, The Adirondack Rural Health Network has been compiling this data for the region and producing reports to inform healthcare planning on a regional basis.

In March and April of 2016, the Adirondack Rural Health Network (ARHN) conducted a survey of selected stakeholders representing health care and service-providing agencies within an eight-county region. The results of the survey are intended to provide an overview of regional needs and priorities, to inform future planning and the development of a regional health care agenda. The survey results were presented at both the county and regional levels.

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

Community Profile

GEOGRAPHY/SERVICE AREA PROFILE

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

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

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

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

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

DEMOGRAPHIC CHARACTERISTICS

Franklin County is the most racially/ethnic county in the ARHN region, with 18% of its population racial/ethnic minorities. Franklin County also has the smallest percentage of elderly in the ARHN region. Franklin County has a number of issues, including health disparities, injuries, obesity and obesity-related illnesses, smoking and smoking-related issues, alcohol-related accidents, and vaccinations.

Franklin County has a population of just over 51,500, including 14.1% elderly. Franklin County's racial/ethnic diversity includes 7.0% Native American, 5.6% Black/African American, and 3.2% Hispanic/Latino.

ECONOMIC PROFILE

The mean household income is $58,932 and the per capita income is $22,322, the lowest in the ARHN region. Nearly 20% of the population in Franklin County is living below the Federal Poverty Level, the highest in the ARHN region, and almost 18% of the population receive Medicaid. More than half of public school children in Franklin County receive free or reduced lunch, higher than any other county in the ARHN region.

Fifty-two percent of the population 16 and older is in the workforce, and Franklin County has an unemployment rate of 7.3%, which is higher than the ARHN region (6.8%) and Upstate New York (5.6%). The largest employment sector in Franklin County is education, health care and social assistance (31.7% of those employed), followed by public administration (13.7%) and retail trade (11.3).

EDUCATIONAL PROFILE

There are 7 school districts in Franklin County, with an enrollment for primary and secondary schools of over 7,200. Franklin County has a high school dropout rate of 8.6%, which is lower than the dropout rates of the ARHN region and of Upstate New York, 12.7% and 8.8% respectively. There are 10.5 students per one teacher in Franklin County public school system, comparable to that of the ARHN regional but lower than the Upstate New York rate. Fifty-six percent of the population 25 and older in Franklin County has a high school diploma or equivalent, and another 28% have an Associate, Bachelor's, or higher degree.

HEALTH SYSTEM PROFILE

Franklin County has two hospitals with a total of 171 beds for a rate of 297 beds per 100,000 population. There are also 195 nursing home beds (339 beds per 100,000 population) and 94 adult home beds (165 beds per 100,000) in Franklin County. There are 4 primary care health professional shortage areas (HPSA) in Franklin County, 1 dental health HPSA, and 1 mental health HPSA. Franklin County has 94.1 primary care physicians per 100,000 population, higher than the rates for the ARHN region (81.5) and Upstate New York (89.3) but comparable to New York State (94.2).

North West Franklin County is also a designated Medically Underserved area, including the towns of Brandon, Dickinson, Fort Covington, Moira, Bangor, and Bombay. This means that there is a deficiency of health care resources, and it is determined by ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over, by the United States Health Resources and Service Administration. This is part of the catchment for Malone's Federally Qualified Health Center (FQHC), which offers primary and preventive care services to

everyone, regardless of income or insurance status. The FQHC also houses Franklin County Women Infants and Children (WIC) federally funded supplemental food program. WIC provide supplemental foods, health care referrals, and nutrition education for low - income pregnant, breastfeeding, and non - breastfeeding postpartum women, and infants/children up to age five; WIC also has a peer counselor on call 24/7 available to help assist anyone who is or plans on breastfeeding.

Health Indicators

IMPROVE HEALTH STATUS AND REDUCE DISPARITIES

While there are not significant health disparities based on race and ethnicity in Franklin County, there are, however, access to care issues. Nearly 77% of the Franklin County population have a regular source of care, lower than Upstate New York (84.6%), the state as a whole (84.4%), and the Prevention Agenda Benchmark of 90.8%. Franklin County also has higher percentages of adults who did not receive health care due to costs (17.6%), higher than the ARHN region (11.4%), Upstate New York (11.2%), and New York State (13.1%). Additionally, Franklin County has a high percentage of adults who report 14 days or more in a month of poor physical health and a higher percentage of adults with disabilities compared to their respective Upstate New York Benchmarks.

The rate of ED visits per 10,000 population is higher in Franklin County (4,658.3) than in the ARHN region (4,418.4), Upstate New York (3,752.5), and the state as a whole (4,086.4). The rate of avoidable hospitalizations in Franklin County (118.8) is higher than in Upstate New York (107.3) but lower than the Prevention Agenda Benchmark of 122.0.

PROMOTE HEALTHY AND SAFE ENVIRONMENT

Food and housing insecurity are also issues in Franklin County. The percentage of adults with food insecurity is higher in Franklin County (35.0%) than in the ARHN region (23.3%), Upstate New York (22.7%), and New York State (29.0%), and the percentage of low-income individuals with low access to a supermarket is three times as high in Franklin County (6.7%) compared to the Prevention Agenda Benchmark of 2.2%. Additionally, housing insecurity for adults is higher in Franklin County (47.2%) than the ARHN region (36.1%), Upstate New York (36.6%), and the state as a whole (43.4%).

Injuries, Violence, and Occupational Health pose a problem for Franklin County. The rate of ED visits due to falls for children ages 1 – 4 is higher in Franklin County (608.0) than the ARHN region (486.6), Upstate New York (442.7), New York State (440.1), and the Prevention Agenda Benchmark of 429.1. The rate of ED occupational injuries among working adolescents ages 15 – 19 is also higher in Franklin County (34.2) than in the ARHN region (21.5), Upstate New York (28.2), the state was a whole (20.6), and the Prevention Agenda Benchmark of 33.

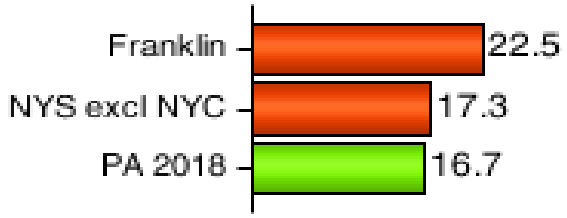
Additionally, the rates of total motor vehicle crashes, speed-related motor vehicle crashes, and deaths due to motor vehicle crashes are all higher in Franklin County when compared to their respective benchmarks.

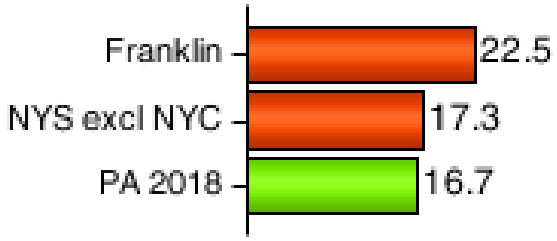
PREVENT CHRONIC DISEASES

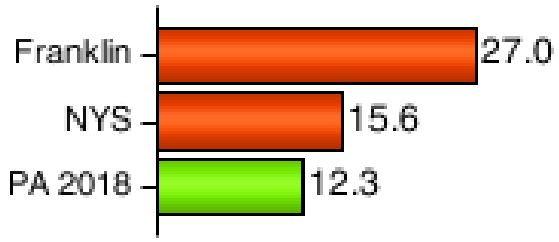
Asthma and smoking-related diseases are significant issues in Franklin County. Twenty-seven percent of adults 18 years of age or older smoke in Franklin County, significantly worse than the ARHN (22.5%), Upstate New York (17.3%), New York State (15.6%) and the Prevention

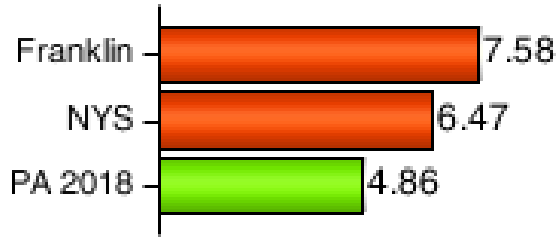
Agenda Benchmark of 12.3%. The rates of chronic lower respiratory disease hospitalizations and deaths are higher in Franklin County (51.7 and 54.2, respectively) than in Upstate New York (33.0 and 46.2) and New York State (36.5 and 35.6). Additionally, the rates of lung and bronchus cancer cases and deaths are also higher in Franklin County (91.0 and 63.3, respectively) than in Upstate New York (83.0 and 55.9) and the state as a whole (69.6 and 46.4).

Obesity is a significant challenge for Franklin County. Both adults over 18 (33.7%) and public school children (22.5%) have obesity rates higher than Upstate New York (27.0% and 17.3%) and their respective prevention agenda benchmarks of 23.2% and 16.7%. The percentage of adults 18 and older with physician diagnosed high blood pressure is higher in Franklin County (36.8%) than in the ARHN region (32.9%), Upstate New York (30.2%), and the state as a whole (28.3%).

PERCENTAGE OF ADULTS WHO ARE OBESE	
The percentage of obese adults is an indicator of the overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions, including heart disease, type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and osteoarthritis. Losing weight and maintaining a healthy weight help to prevent and control these diseases. Being obese also carries significant economic costs due to increased healthcare spending and lost earnings.	 *PA is the Prevention Agenda Goal for 2018

PERCENTAGE OF CHILDREN WHO ARE OBESE	
Obesity is a serious health concern for children and adolescents. According to the Centers for Disease Control and Prevention, obese children and adolescents are more likely to become obese as adults. Contributing factors to childhood obesity include dietary patterns, physical inactivity, genetics, medication use, and the physical and social environment. Obese and overweight youth are more likely to have risk factors associated with cardiovascular diseases, such as high blood pressure, high cholesterol, and type 2 diabetes. Losing weight, in addition to a healthy diet, helps to prevent and control multiple chronic diseases and improves quality of life.	

PERCENTAGE OF ADULTS WHO USE TOBACCO	
Tobacco is the agent most responsible for avoidable illness and death in America today. According to the Centers for Disease Control and Prevention, tobacco use brings premature death to almost half a million Americans each year, and it contributes to profound disability and pain in many others. The World Health Organization states that approximately one-third of all tobacco users in this country will die prematurely because of their dependence on tobacco. Areas with a high smoking prevalence will also have greater exposure to secondhand smoke for non-smokers, which can cause or exacerbate a wide range of adverse health effects such as cancer, respiratory infections, and asthma.	

HOSPITALIZATIONS FOR SHORT-TERM COMPLICATIONS OF DIABETES Rate per 10,000 - Aged 18+	
Diabetes is a leading cause of death in the United States. According to the Centers for Disease Control and Prevention (CDC), more than 25 million people have diabetes, including both diagnosed and undiagnosed cases. This disease can have a harmful effect on most of the organ systems in the human body; it is a frequent cause of end-stage renal disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working age adults. Persons with diabetes are also at increased risk for ischemic heart disease, neuropathy, and stroke. According to the CDC, the direct medical expenditures attributable to diabetes are over $116 billion. Diabetes disproportionately affects minority populations and the elderly, and its incidence is likely to increase as minority populations grow and the U.S. population ages.	

PROMOTE HEALTHY WOMAN, INFANTS AND CHILDREN

Pregnancy and birth rates for female teenagers aged 15 – 17 and 18 - 19 years of age in Franklin County (10.8 and 26.0, respectively) are worse than their respective rates in the ARHN region (8.9 and 23.4), Upstate New York (7.9 and 17.3), and the state as a whole (9.3 and

19.5). The percentage of births in Franklin County within 24 months of a previous pregnancy or were unintended (24.7% and 37.7%, respectively) were higher than in the ARHN region (23.0% and 30.3%), Upstate New York (21.1% and 26.5%), New York State (18.9% and 24.5%), and the Prevention Agenda Benchmarks of 17.0% and 23.8%. Gestational weight gain, gestational diabetes, and gestational hypertension are also issues for women on WIC in Franklin County.

PREVENT HIV/STD'S, VACCINE PREVENTABLE DISEASES AND HEALTH CARE-ASSOCIATED INFECTIONS

The percentage of children ages 19 – 35 months with 4:3:1:3:3:1:4 and percentage of females ages 13 – 17 with 3 dose HPV vaccines are worse in Franklin County (62.9% and 24.0%, respectively) than their respective Prevention Agenda Benchmarks of 80.0% and 50.0%. While the percentage of adults 65 and above with flu shots within the last year is better than its corresponding Prevention Agenda Benchmark, the rate of hospitalizations for pneumonia/flu for adults ages 65 and above in Franklin County (133.1) is higher than in Upstate New York (121.9) and New York State (112.6).

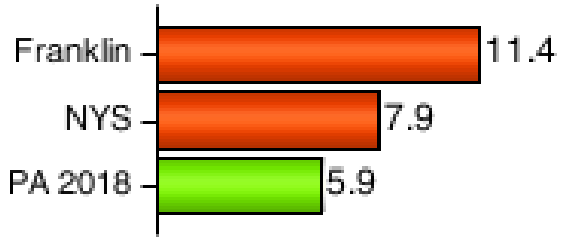
PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

Substance abuse and behavioral health are major issues in Franklin County. The rate of suicides and suicides for those 15 – 19 in Franklin County (11.4 and 29.0) are higher than in Upstate New York (9.5 and 6.3) and the state as a whole (7.9 and 5.4). Self-inflicted hospitalizations and self-inflicted hospitalizations for those ages 15 to 19 are comparable or higher in Franklin County (6.8 and 15.4, respectively) than in Upstate New York (6.8 and 12.5) and New York State (5.8 and 11.3). The rate of alcohol-related crashes is higher in Franklin County (89.7) than New York State (43.4) though comparable to the ARHN region (90.8). The rate of alcohol related injuries and deaths is higher in Franklin County (63.2) than in the ARHN region (60.1), Upstate New York (44.4), or the state as a whole (33.3).

SUICIDE DEATH RATE

Age Adjusted per 100,000

Suicide is a leading cause of death in the United States, presenting a major, preventable public health problem. More than 33,000 people kill themselves each year according to the Centers for Disease Control and Prevention, but suicide deaths only account for part of the problem. An estimated 25 attempted suicides occur per every suicide death, and those who survive suicide may have serious injuries, in addition to having depression and other mental problems. Other repercussions of suicide include the combined medical and lost work costs on the community, totaling to over $30 billion for all suicides in a year, and the emotional toll on family and friends. Men are about four times more likely



than women to die of suicide, but three times more women than men report attempting suicide.	

Community Input

STAKEHOLDER SURVEY PROCESS

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

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

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

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

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

Once respondents identified their top two priorities, they were also asked to rank the focus areas within each priority area and identify potential barriers addressing that focus area. Analysis for this report was conducted by county. Many health care, social service, and educational providers deliver services in multiple counties. Their opinions are reflected in each county they provide services.

RESULTS OF FRANKLIN COUNTY STAKEHOLDER SURVEY

Overwhelming, providers in Franklin County identified “promoting mental health and preventing substance abuse” (33) as their top priority followed by “preventing chronic disease” (13) as a distant second. “Preventing chronic disease” and “providing a healthy and safe environment” were tied at 18 as their second priority.

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

Priority Area	Count	
	Top Priority	Second Priority
Prevent Chronic Disease	13	18
Provide a Healthy and Safe Environment	2	18
Promote Healthy Women, Infants, and Children	8	10
Promote Mental Health and Prevent Substance Abuse	33	7
Prevent HIV, Sexually Transmitted Diseases, Vaccine Preventable Diseases, and Health Care Associated Infections	0	2

Priority Selection

SELECTION BASIS AND METHOD

Selection was based primarily on the following:

1. Results of stakeholder surveys outlined above
2. Data analysis outlined above
3. Community health planning session

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

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

- Kathleen Farrell Strack, FCPH
- Bonnie Ohmann, AMC
- Megan Bryden, UVMHN-AHMC
- Ginger Carriero, UVMHN-AHMC
- Josy Delaney, UVMHN-AHMC
- Erin Streiff, FCPH
- Deborah Beach, UVMHN-AHMC (July 29th only)
- Jeanette Messenger, UVMHN-AHMC (July 29th only)
- Patricia McGillicuddy, FCPH (November 8th only)
- Amy O'Connor, UVMHN-AHMC (November 8th only)

Process:
The subcommittee listed above representing different community sectors was convened on July 29th, 2016 and again on November 8th, 2016 to finalize Priority Area and Focus Area selection. Members of the subcommittee noted the consistency in findings from the stakeholder survey and data analysis. Therefore, *Prevent Chronic Disease* and *Promote Mental Health and Prevent Substance Abuse* were accepted as selected Priority Areas for Franklin County.

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

Franklin County Public Health's ongoing partnerships with the Franklin County Community Services Board, and the North Country Healthy Heart Network.

2016-2018 PRIORITIES AND GOALS

County/Service Area Priorities and Disparities 2016-2018

Priority 1—Prevent Chronic Diseases
Goal – Reduce Obesity in Children and Adults
Goal- Chronic Disease Preventive Care and Management

Priority 2—Promote Mental Health and Prevent Substance Abuse
Goal – Strengthen Infrastructure across Systems

Disparities—Poverty and Access to Care

Implementation Plan

PRIORITY AREA:	PREVENT CHRONIC DISEASE			
FOCUS AREA 1:	Reduce Obesity in Children and Adults			
GOAL 1.1:	Create community environments that promote and support healthy food and beverage choices and physical activity.			
OBJECTIVE 1.1.2:	Increase the percentage of adults ages 18 years and older who participate in leisure time physical activity.			
INTERVENTIONS	**ACTIVITIES**	**PERFORMANCE MEASURE**	**LEAD AND PARTNERS**	**WILL ACTION ADDRESS DISPARITY**
Implementation of programs to increase access to leisure time activities for members of the community.	Host 5K Run/Walk for local community	• Number of Participants	• Alice Hyde (Lead)	
	Support implementation of Explore Malone Walk/Bike Challenge by making trail maps available.	• Number of maps distributed.	• Malone Complete Streets Advisory Board (Lead) • Alice Hyde (Partner) • Malone Chamber of Commerce (Partner) • FCHD (Partner) • Healthy Heart Network (Partner)	Low Income
Implement hospital employee wellness committee to promote wellbeing for health professionals.	Implement walking trails on Medical Center campus.	• Establishment of walking trails in two locations.	• Alice Hyde (Lead)	
	Explore feasibility of implementing employee fitness center.	• Completion of feasibility study to determine if fitness center can be implemented. If yes, implementation in subsequent years	• Alice Hyde (Lead)	
	Conduct general education for health professionals on diet and exercise.	• Number of employee wellness events conducted.	• Alice Hyde (Lead)	
Increase awareness of obesity as a risk factor for chronic disease.	Use social media to promote awareness of key obesity prevention strategies/practices	• Number of pertinent posts to Franklin County Public Health Facebook page per quarter	• FCHD (Lead)	

OBJECTIVE 1.1.3:	Increase the number of municipalities that have passed Complete Streets policies.			
INTERVENTIONS	**ACTIVITIES**	**PERFORMANCE MEASURE**	**LEAD AND PARTNERS**	**WILL ACTION ADDRESS DISPARITY**
Adopt, improve, or implement Complete Streets principles.	Support and strengthen local complete streets policies and guidelines and implement Complete Streets projects.	• Number of projects implemented	• Malone Complete Streets Advisory Board (Lead) • Alice Hyde (Partner) • FCHD (Partner) • Village of Malone Board (Partner) • Town of Malone Board (Partner) • North Country Healthy Heart Network (Partner)	Low Income
GOAL 1.3:	**Expand the role of health care and health service providers and insurers in obesity prevention.**			
OBJECTIVE 1.3.1:	**Increase the percentage of children and adults with an outpatient visit with a primary care provider or obstetrics/gynecology practitioner during the measurement year who received appropriate assessment for weight status.**			
INTERVENTIONS	**ACTIVITIES**	**PERFORMANCE MEASURE**	**LEAD AND PARTNERS**	**WILL ACTION ADDRESS DISPARITY**
Increase the capacity of primary care providers to implement screening, prevention and treatment measures for obesity in children and adults.	Providers at primary care practices will document patient BMI, develop a plan with the patient and document in the patient EMR.	• Number of patients with BMI ≥26 with documented discussion with provider regarding plan for overweight/obesity.	• Alice Hyde (Lead)	Access to Care
	Develop a Childhood Obesity Initiative to be implemented in Pediatric Primary Care practice	• Program developed and implemented in Pediatric Primary Care practice	• Alice Hyde (Lead)	Access to Care Low Income
	Contact Clinton County Public Health Department to initiate Adirondack Health pediatrician into project	• Adirondack Health Pediatrician enrolled in program – concluded	• Adirondack Health • County Public Health	Access to Care
	Pediatrician works with Obesity Prevention in Pediatric Health Care Settings to implement best practices	• Practices implemented in Pediatrician practice	• Adirondack Health	Access to Care

OBJECTIVE 1.3.2	Increase the percentage of infants born in NYS hospitals who are exclusively breastfed during the birth hospitalization.			
INTERVENTIONS	**ACTIVITIES**	**PERFORMANCE MEASURE**	**LEAD AND PARTNERS**	**WILL ACTION ADDRESS DISPARITY**
Link health care based efforts with community based programs and services for breastfeeding counseling and support.	Continued participation in Great Beginnings, NY.	• Breastfeeding rates at discharge.	• Alice Hyde (Lead)	
	Encourage adoption of breastfeeding friendly policies in hospital owned practices.	• Number of practices certified as NYS Breastfeeding Friendly Practices.	• Alice Hyde (Lead)	
	Continued participation in Breastfeeding Council of Malone	• Attend Meetings	• Breastfeeding Council of Malone (Lead) • Alice Hyde (Support) • FCHD (Partner) • North Country Children's Clinic/WIC (Partner) • Catholic Charities (Partner) • Cornell Cooperative Extension (Partner)	Low Income
Ensure access to breastfeeding education, lactation counseling and support.	Implement lactation support program, including availability of Certified Lactation Counselors, and pre-natal breastfeeding education in OB/GYN practice.	• Number of Certified Lactation Counselors Trained • Number of women who receive lactation support or education.	• Alice Hyde (Lead)	Access to Care
	Participate in NY Academy of Medicine Breastfeeding Community of Practice Advancing Prevention Project	• Number of Learning Sessions Attended • Strategic plan resulting from program specific consultation	• FCHD (Lead) • Alice Hyde (Partner) • WIC (Partner	
	Provide support to Breastfeeding mothers through Franklin County Public Health Nurse Home Visiting Program; Healthy Families NY Program, and JCEO Early Head Start	• Number of phone calls made to breastfeeding mothers • Number of home visits made to breastfeeding mothers	• FCHD (Lead) • Alice Hyde (Partner) • Adirondack Medical Center (Partner) • Healthy Families (Partner) • JCEO (Partner)	Access to Care
	Establish Childbirth Classes to provide education to new mothers.	• Number of classes held. • Number of participants in classes.	• Alice Hyde (Lead)	
	Determine the feasibility of the implementation of a pre-natal Centering program.	• Completion of feasibility study to determine if it makes sense to move forward with implementation. If yes, implementation in subsequent years.	• Alice Hyde (Lead)	Access to Care
	Maternity Practices in Infant Nutrition and Care	• Increase breastfeeding rates	• Adirondack Health • mPINC/CDC/Albany Medical Center	Access to Care Low Income

FOCUS AREA 3:	Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings			
GOAL 3.3:	**Promote culturally relevant chronic disease self management education.**			
OBJECTIVE 3.3.1:	**Increase the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition.**			
INTERVENTIONS	**ACTIVITIES**	**PERFORMANCE MEASURE**	**LEAD AND PARTNERS**	**WILL ACTION ADDRESS DISPARITY**
Develop a sustainable infrastructure for widely accessible, readily available self-management interventions.	Assure instructors for chronic disease self management (CDSM) classes are trained.	• Number of instructors trained.	• Eastern Adirondack Health Care Network (Lead) • Alice Hyde (Partner)	
	Provide evidence based interventions (EBIs) for Chronic Disease Self Management at least twice per year in Franklin County. IE: CDSMP – Living Healthy with Chronic Conditions, CDC National Diabetes Prevention Program, Diabetes Self Management Program, Tai Chi for Health, Arthritis, and Fall Prevention.	• Number and type of EBIs offered. • Number of participants in EBIs offered.	• Alice Hyde (Lead) • Eastern Adirondack Health Care Network (Partner) • St. Regis Mohawk Office for the Aging (Partner) • Community Connections of Franklin County (Partner)	
	Assure trained lifestyle intervention professionals are available in clinical and community settings.	• List of CDSM professionals is developed and given to case managers and care managers.	• Eastern Adirondack Health Care Network (Lead) • Alice Hyde (Partner) • FCHD (Partner)	
Foster collaboration among traditional and non-traditional community partners to improve access to clinical and community preventive services.	Participate in area coalitions, partnerships, and task forces related to chronic disease management.	• List of participating agencies and community based organizations. • List of programs/services offered by partner organizations.	• FCHD (Lead) • Alice Hyde (Partner) • North Country Healthy Heart Network (Partner) • Eastern Adirondack Health Care Network (Partner) • Adirondack Health Institute (Partner)	Access to Care
Support a “health in all policies” approach to legislation	Present to County Legislators, County Manager, and Tribal Leadership on County Health Rankings and the impact of policymaking on health outcomes	• Number of individual meetings held with county policymakers.	• FCHD (Lead) • Adirondack Foundation Bt3 Alliance and members (partner)	
Establish clinical-community linkages that connect patients to self-management education and community resources.	Maintain a community resource list of Chronic Disease Self Management Opportunities	• Create and make available to clinicians and the public a list of community-based CDSM opportunities.	• Eastern Adirondack Health Care Network (Lead) • Alice Hyde (Partner) • FCHD (Partner)	
	Adopt policies and a system for identifying and	• System developed and adopted.	• Alice Hyde (Lead)	

	referring patients to CDSM opportunities in the community setting.	• Number of referrals to EBIs from health care professionals.	• Adirondack Medical Home (Partner)	
Implementation of the CDC National Diabetes Prevention Program	Partners work with Adirondack Health Institute to submit a region wide grant to support funding training and implementation of the CDC National Diabetes Prevention Program.	• Grant Application Funded	• Adirondack Health • Tupper Lake Health Center • Healthy Heart Network	Access to Care Aging Low Income
	Staff attends training and creates implementation plan for program in Adirondack Health service area	• Implementation Plan complete	• Adirondack Health • Franklin County Public Health	Access to Care Aging Low Income
	Regional partners work with New York State Health Foundation and CDC to establish reimbursement for this prevention program.	• Two of seven regional health insurance companies agree to cover prevention classes.	• Regional Partners • Adirondack Health Institute • New York State Health Foundation	Low Income
	Work with local primary care providers to introduce them to the program and make referrals.	• Contact with 80% of primary care providers. Referrals from 50% of primary care providers in the service area.	• Adirondack Health • Primary Care Providers • Franklin County Public Health	Access to Care
	CDC National Diabetes Prevention Program classes implemented.	• 30-40 participants signed up in the first year.	• Adirondack Health • Franklin County Public Health	Access to Care
	Track and collect the data and information required by CDC and submit the information at the end of the year.	• 100% of data submitted to CDC	• Adirondack Health • Franklin County Public Health • Eastern Adirondack Health Care Network	Access to Care Aging Low Income
	Make improvements to program based on data collected including CDC data, provider referrals, and participant feedback.	• Increase referrals by 10%, increase number of participants by 20%.	• Adirondack Health • Franklin County Public Health	Access to Care Aging Low Income

PRIORITY AREA:	PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE			
FOCUS AREA 3:	**Strengthen infrastructure across systems.**			
GOAL 3.1:	**Support collaboration among leaders, professionals, and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention treatment and recovery.**			
OBJECTIVE 3.1.1:	**Identify and strengthen opportunities for sharing data on access to care, identifying service gaps, studying cost effectiveness strategies for integration and coordination, and the impact of interventions.**			
INTERVENTIONS	**ACTIVITIES**	**PERFORMANCE MEASURE**	**LEAD AND PARTNERS**	**WILL ACTION ADDRESS DISPARITY**
Identify key representatives from governmental agencies, health care and community based organizations, schools, etc. to serve on an interdisciplinary team to address the specific MEB issues in the community that includes an approach that balances promotion, prevention, treatment and maintenance.	Partner with Citizen Advocates in the creation of a Crisis Stabilization Unit on Medical Center campus. Develop policies and procedures to identify patients that need referrals to the unit.	• Program established. • Policy in Place for referrals. • Number of patients referred to program.	• Alice Hyde (Lead) • Citizen Advocates (Lead)	Access to Care
	Participate in area coalitions, partnerships, and task forces related to MEB health promotion and substance abuse prevention.	• Number of meetings. • Development of Behavioral Health Strategic plan.	• Alice Hyde (Partner) • FCHD (Partner) • Community Connections (Partner) • Citizen Advocates (Partner) • Law Enforcement (Partner) • School System (Partner) • County Agencies (Partner)	
		• Increase in Community Education forums	• Adirondack Health	Access to Care
	Develop taskforce to address and prevent opioid addiction using Project Lazarus model.	• Taskforce development and number of organizations or agencies who commit to participate.	• FCHD (Partner) • Franklin County Sheriff's Department (Partner)	

OBJECTIVE 3.1.4:	Support efforts to integrate MEB disorder screening and treatment into Primary Care.			
INTERVENTIONS	**ACTIVITIES**	**PERFORMANCE MEASURE**	**LEAD AND PARTNERS**	**WILL ACTION ADDRESS DISPARITY**
Support a collaborative care model in primary care settings.	Integrate behavioral health into primary care practice.	• Number of patients receiving behavioral health services.	• Alice Hyde (Lead) • Citizen Advocates (Partner)	Access to Care
		• NCQA Certification	• Adirondack Health	Access to Care
	Integrate mental health screening into primary care	• Number of patients screened	• Alice Hyde (Lead)	Access to Care
	Expand AHMC Primary Care building, developing a coordinated, multi-disciplinary approach that includes behavioral health.	• Business Plan Approval. • CON Submission. • CON Approval. • Construction completed in 2018.	• Alice Hyde (Lead)	Access to Care
	Work with local and regional Health Home providers to ensure comprehensive care for patients.	• DSRIP Deliverables	• Adirondack Health	Access to Care
	Work with local primary care providers to introduce them to the program and encourage evidence-based practices and environmental strategies that promote mental, emotional, and behavioral health.	• DSRIP 3.a.i project – increase in engaged patients	• Adirondack Health	Access to Care
	Monthly outreach events in 4 communities	• Increase in attendance	• Adirondack Health	Access to Care
	Adirondack **Healthy** Programs – Chair Yoga, Meditation	• Continued increase in participation	• Adirondack Health	Access to Care Low Income Aging

Maintaining Engagement and Tracking Progress

Active engagement with others in the community to implement change has historically been challenging in Franklin County. Diminishing resources and competing priorities have led to a lack of coordination. While our organizations have each worked to address community health needs, our efforts have been siloed and disparate. In the creation of the 2016 – 2018 Community Health Assessment and Community Service Plan/Community Health Improvement Plan, we have made an unprecedented effort to collaborate and align our efforts. Higher level decision makers from our organizations are actively engaged in this process, demonstrating an actionable commitment to improving the health of the community.

As part of this renewed effort toward improving population health, our organizations will continue to participate in area health coalitions and meetings throughout the year. Additionally, Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital have committed to meet bi-annually to discuss progress and evaluate results. We will assess measurable outcomes identified in our interventions chart, discuss strategy updates or changes, and collaborate on additional plans. Progress towards the identified health goals will be continually tracked with formal progress captured in annual reports.

Dissemination of Plan to Public

The Community Health Needs Assessment and Community Service Plan/Community Health Improvement Plan will be disseminated to the public through the websites of Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health. The plan will also be available through the website of the Adirondack Health Institute.

Approval

The respective Boards of each organization have approved these documents.

Appendix A: (ARHN) Community Health Assessment (CHA) Committee Members and Meeting Schedule

ARHN COMMUNITY HEALTH ASSESSMENT COMMITTEE

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

COMMUNITY HEALTH ASSESSMENT (CHA) COMMITTEE MEETING DATES

September 10, 2014
December 5, 2014
March 11, 2015
June 10, 2015
October 15, 2015
January 8, 2016
March 30, 2016
June 24, 2016
September 15, 2016
*January 12, 2017 *Scheduled*

Appendix B: Prevention Agenda

Prevention Agenda Priority Area	Focus Areas	Goals
Improve Health Status and Reduce Health Disparities	Improve Health Status and Reduce Health Disparities	Improve the health status of all New Yorkers
Promote a Healthy and Safe Environment	Injuries, Violence, and Occupational Health	Reduce fall risks among the most vulnerable populations
	Outdoor Air Quality	Reduce exposure to outdoor air pollutants, with a focus on burdened communities
	Built Environment	Improve the design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
		Improve the design and maintenance of home environments to promote health and reduce related illness
	Water Quality	Increase the percentage of State residents that receive optimally fluoridated drinking water
		Reduce potential public health risks related to drinking water and recreational water
Prevent Chronic Disease	Reduce Obesity in Children and Adults	Create community environments that promote and support healthy food and beverage choices and physical activity
		Prevent childhood obesity through early child care and schools
		Expand the role of health care and health service providers and insurers in obesity prevention
		Expand the role of public and

		private employers in obesity prevention
	Reduce illness, disability and death related to tobacco use and secondhand smoke exposure	Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations
		Promote tobacco use cessation, especially among low SES populations and those with poor mental health
		Eliminate exposure to secondhand smoke
	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Promote use of evidence-based care to manage chronic diseases
		Promote culturally relevant chronic disease self-management education
Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections	Vaccine-Preventable Diseases	Improve childhood and adolescent immunization rates
		Educate all parents about importance of immunizations
		Decrease the burden of pertussis disease
		Decrease the burden of influenza disease
		Decrease the burden of disease caused by humanpapillomavirus
	Human Immunodeficiency Virus (HIV)	Decrease HIV morbidity
		Increase early access to and retention in HIV care
	Sexually Transmitted Diseases (STDs)	Decrease STD morbidity
	Hepatitis C Virus (HCV)	Increase and coordinate HCV prevention and treatment capacity
	Healthcare-Associated Infections	Reduce Clostridium difficile (C. difficile) infections
		Reduce infections caused by

		multidrug resistant organisms
		Reduce device-associated infections
Promote Healthy Women, Infants, and Children	Maternal and Infant Health	Reduce premature births in New York State
		Increase the proportion of NYS babies who are breastfed
		Reduce the rate of maternal deaths in New York State
	Child Health	Increase the proportion of NYS children who receive comprehensive well child care in accordance with AAP guidelines
		Reduce the prevalence of dental caries among NYS children
	Preconception and Reproductive Health	Reduce the rate of adolescent and unplanned pregnancies in NYS
		Increase utilization of preventive health services among women of reproductive age to improve wellness, pregnancy outcomes and reduce recurrence of adverse birth outcomes
Promote Mental Health and Prevention Substance Abuse	Promote Mental, Emotional and Behavioral Health (MEB)	Promote mental, emotional and behavioral well-being in communities
	Prevent Substance Abuse and Other MEB Disorders	Prevent underage drinking, nonmedical use of prescription drugs by youth, and excessive use of alcohol consumption by adults
		Prevent and reduce occurrences of mental, emotional and behavioral disorders among youth and

		adults
		Prevent suicides among youth and adults
		Reduce tobacco use among adults who report poor mental health
	Strengthen Infrastructure Across Systems	Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery
		Strengthen infrastructure for mental, emotional behavioral health promotion, and mental, emotional behavioral disorder prevention

Appendix C: Demographic Profile

Adirondack Rural Health Network Summary of Demographic Information, Page 1 of 2	County Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washing	ARHN Region (1)	Upstate NYS	New York State
Square Miles												
Total Square Miles	1,038	1,794	1,629	495	1,717	403	810	867	831	8,372	46,824	47,126
Total Square Miles for Farms	230	86	227	50	3	205	123	15	296	906	11,224	11,224
Percent of Total Square Miles Farms	22.2%	4.8%	13.9%	10.1%	0.2%	50.9%	15.2%	1.7%	35.6%	10.8%	24.0%	23.8%
Population per Square Mile	78.8	21.8	31.6	110.7	2.8	123.9	274.7	75.4	75.7	43.0	240.0	415.8
Population												
Total Population	81,829	39,072	51,508	54,870	4,783	49,951	222,512	65,388	62,910	360,360	11,239,441	19,594,330
Percent White, Non-Hispanic	90.6%	92.5%	82.0%	93.5%	96.1%	84.1%	92.1%	94.7%	93.0%	91.3%	75.5%	57.3%
Percent Black, Non-Hispanic	4.0%	2.8%	5.6%	1.5%	0.4%	1.5%	1.5%	1.1%	2.7%	2.9%	8.3%	14.4%
Percent Hispanic/Latino	2.6%	2.8%	3.2%	2.6%	1.2%	12.0%	2.7%	2.0%	2.4%	2.6%	10.2%	18.2%
Percent Asian/Pacific Islander, Non-Hispanic	1.3%	0.5%	0.4%	0.7%	0.1%	0.6%	2.0%	1.0%	0.6%	0.8%	3.7%	7.7%
Percent Alaskan Native/American Indian	0.3%	0.3%	7.0%	0.2%	0.0%	0.1%	0.1%	0.2%	0.1%	1.2%	0.3%	0.2%
Percent Multi-race/Other	1.2%	1.1%	1.8%	1.5%	2.2%	1.7%	1.6%	1.0%	1.1%	1.3%	1.9%	2.2%
Number Ages 0 - 4	3,969	1,654	2,681	2,859	156	2,980	11,756	3,142	3,195	17,656	623,966	1,170,258
Number Ages 5 - 17	11,366	5,370	7,639	8,827	655	8,487	36,857	9,673	9,629	53,159	1,862,922	3,101,974
Number Ages 18 - 64	54,858	24,397	33,902	33,918	2,790	29,997	141,249	40,490	39,876	230,231	7,044,052	12,566,926
Number Ages 65 Plus	11,636	7,651	7,286	9,266	1,182	8,487	32,650	12,083	10,210	59,314	1,708,501	2,755,172
Number Ages 15 - 44 Female	15,816	5,981	8,268	9,622	590	9,000	41,490	11,171	10,596	62,044	2,120,373	4,049,852
Family Status												
Number of Households	31,976	15,571	19,131	22,440	1,639	19,655	89,876	27,699	24,165	142,621	4,159,597	7,255,528
Percent Families Single Parent Households	15.6%	13.2%	17.8%	18.6%	9.2%	17.9%	12.7%	15.7%	17.4%	16.4%	16.6%	19.8%
Percent Households with Grandparents as Parents	1.3%	1.3%	1.6%	2.4%	1.4%	1.8%	1.1%	1.8%	2.1%	1.7%	1.5%	1.8%
Poverty												
Mean Household Income	$64,485	$64,341	$58,932	$58,147	$63,710	$58,106	$87,334	$71,229	$61,153	N/A	N/A	$85,736
Per Capita Income	$25,279	$26,755	$22,322	$24,265	$29,974	$23,809	$35,860	$30,662	$23,877	N/A	N/A	$32,829
Percent of Individuals Under Federal Poverty Level	15.2%	11.4%	19.7%	16.2%	9.5%	19.1%	6.8%	11.9%	13.0%	14.5%	11.8%	15.6%
Percent of Individuals Receiving Medicaid	18.1%	15.2%	17.8%	21.9%	13.0%	23.8%	9.7%	15.6%	17.0%	17.6%	16.9%	24.7%
Per Capita Medicaid Expenditures	$1,636.24	#######	$1,850.6	#######	$1,450.42	$2,413.03	$1,061.8	#######	$1,612.67	$1,793.51	$1,713.78	$2,500.22
Immigrant Status												
Percent Born in American Territories	0.3%	0.3%	0.7%	0.5%	0.1%	3.7%	0.3%	0.2%	0.3%	0.3%	0.8%	1.6%
Percent Born in Other Countries	4.8%	4.0%	4.6%	2.4%	2.0%	3.5%	4.7%	3.4%	2.2%	3.6%	11.3%	22.3%
Percent Speak a Language Other Than English at Home	6.4%	6.3%	7.1%	4.7%	3.4%	14.0%	6.6%	4.5%	3.1%	5.3%	16.3%	30.2%
Housing												
Total Housing Units	35,909	25,675	25,292	28,616	8,742	23,159	100,185	38,873	28,956	192,063	4,745,377	8,153,309
Percent Housing Units Occupied	89.0%	60.6%	75.6%	78.4%	18.7%	84.9%	89.7%	71.3%	83.5%	74.3%	87.7%	89.0%
Percent Housing Units Owner Occupied	68.3%	73.5%	71.7%	69.3%	81.8%	67.3%	71.3%	70.0%	73.5%	70.8%	70.2%	53.8%
Percent Housing Units Renter Occupied	31.7%	26.5%	28.3%	30.7%	18.2%	32.7%	28.7%	30.0%	26.5%	29.2%	29.8%	46.2%
Percent Build Before 1970	49.5%	57.1%	56.7%	65.8%	56.4%	72.6%	36.2%	50.3%	56.1%	55.4%	62.7%	69.1%
Percent Built Between 1970 and 1979	12.1%	11.7%	11.2%	10.1%	12.9%	8.3%	15.3%	13.0%	10.9%	11.7%	12.1%	10.1%
Percent Built Between 1980 and 1989	14.0%	12.1%	10.9%	9.6%	10.5%	6.6%	16.7%	14.3%	12.0%	12.3%	9.7%	7.5%
Percent Built Between 1990 and 1999	12.1%	9.7%	12.3%	8.0%	11.4%	7.0%	15.4%	10.6%	10.6%	10.6%	8.0%	6.1%
Percent Build 2000 and Later	12.3%	9.4%	8.9%	6.6%	8.8%	5.5%	16.4%	11.8%	10.4%	10.1%	7.5%	7.2%
Availability of Vehicles												
Percent Households with No Vehicles Available	9.5%	8.5%	10.7%	9.1%	4.8%	12.9%	5.0%	8.1%	6.4%	8.6%	9.9%	29.3%
Percent Households with One Vehicle Available	33.3%	34.4%	35.8%	39.5%	36.2%	37.3%	33.0%	35.2%	34.4%	35.3%	33.8%	32.7%
Percent Households with Two Vehicles Available	39.4%	39.3%	38.5%	36.4%	45.0%	35.1%	43.7%	40.3%	37.9%	38.8%	38.3%	26.5%
Percent Households with Three or More Vehicles Available	17.8%	17.8%	15.0%	15.0%	14.0%	14.7%	18.4%	16.3%	21.3%	17.3%	18.0%	11.5%

Adirondack Rural Health Network Summary of Demographic Information, Page 2 of 2	County Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washingt	ARHN Region (1)	Upstate NYS	New York State

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

(1) Excludes Montgomery County and Saratoga County
(D) Withheld to avoid disclosing data for individual farms.
Sources:
Square Miles: United States Department of Agriculture, 2012
Employment Sector: American Community Survey, 2010 - 2014
Unemployment Rate: Bureau of Labor Statistics, Local Area Unemployment Statistics, 2014
Medicaid Data: New York State Department of Health, 2014
All Other Data: American Community Survey, 2010 - 2014

Appendix D: Educational Profile

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

Registered Nursing Programs, 2014-2015	County Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington
Clinton County Community College New	37	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0
	41	0	0	0	0	0	0	0	0
		0	0	0	0	0	0	0	0
	0	58	0	0	0	0	0	0	0
	0		0	0	0	0	0	0	0
	0	0	0	40	0	0	0	0	0
	0	0	0		0	0	0	0	0
	0	0	0	0	0	0	0	78	0
	0	0	0	0	0	0	0		0

Licensed Practical Nursing Programs, 2014-	County Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington
Clinton, Essex, Warren, Washington BOCES (29 total)	*	*						*	*
Hamilton, Fulton, Montgomery BOCES (20 total)				*	*	*			
North Country Community College		83							
Washington, Saratoga, Warren, Hamilton, Essex BOCES (61		*			*		*	*	*

(1) Excludes Montgomery and Saratoga County

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

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

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

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

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

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

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

Appendix E: Health System Profile

Adirondack Rural Health Network	County									ARHN	Upstate	New York
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Population2010-2014	**81,829**	**39,072**	**57,508**	**54,870**	**4,783**	**49,951**	**222,512**	**65,388**	**62,910**	**366,360**	**11,239,44**	**19,594,330**
Total Hospital Beds	**300**	**40**	**171**	**74**	**0**	**130**	**171**	**410**	**0**	**995**	30,148	54,516
Hospital Beds per 100,000 Population	367	102	297	135	0	260	77	627	0	272	268	278
Medical/Surgical Beds	214	0	129	47	0	70	115	300	0	690	18,574	32,659
Intensive Care Beds	14	0	14	8	0	5	12	12	0	48	1,655	2,939
Coronary Care Beds	7	0	0	0	0	3	7	12	0	19	742	1,133
Pediatric Beds	10	0	3	12	0	0	7	16	0	41	1,086	2,210
Maternity Beds	21	0	13	7	0	8	14	23	0	64	1,846	3,251
Physical Therapy and Rehabilitation Beds	0	0	0	0	0	0	0	7	0	7	1,130	1,928
Psychiatric Beds	34	0	12	0	0	20	16	32	0	78	2,390	5,279
Other Beds	0	40	0	0	0	24	0	8	0	48	2,725	5,117
Hospital Beds Per Facility												
Adirondack Medical Center-Lake Placid Site	0	0	0	0	0	0	0	0	0			
Adirondack Medical Center-Saranac Lake Site	0	0	95	0	0	0	0	0	0			
Alice Hyde Medical Center	0	0	76	0	0	0	0	0	0			
Champlain Valley Physicians Hospital Medical Center	300	0	0	0	0	0	0	0	0			
Elizabethtown Community Hospital	0	25	0	0	0	0	0	0	0			
Glens Falls Hospital	0	0	0	0	0	0	0	410	0			
Moses-Ludington Hospital	0	15	0	0	0	0	0	0	0			
Nathan Littauer Hospital	0	0	0	74	0	0	0	0	0			
Saratoga Hospital	0	0	0	0	0	0	171	0	0			
St. Mary's Healthcare	0	0	0	0	0	120	0	0	0			
St. Mary's Healthcare-Amsterdam Memorial Campus	0	0	0	0	0	10	0	0	0			
Total Nursing Home Beds	**423**	**340**	**195**	**360**	**0**	**590**	**755**	**402**	**528**	**2,838**	**69,633**	**113,592**
Nursing Home Beds per 100,000 Population	517	870	339	656	0	1181	339	615	839	775	620	580
Nursing Home Beds per Facility												
Adirondack Tri-County Nursing and Rehabilitation Center, Inc	0	0	0	0	0	0	0	82	0			
Alice Hyde Medical Center	0	0	135	0	0	0	0	0	0			
Capstone Center for Rehabilitation and Nursing	0	0	0	0	0	120	0	0	0			
Champlain Valley Physicians Hospital Medical Center SNF	54	0	0	0	0	0	0	0	0			
Clinton County Nursing Home	80	0	0	0	0	0	0	0	0			
Essex Center for Rehabilitation and Healthcare	0	100	0	0	0	0	0	0	0			
Evergreen Valley Nursing Home	89	0	0	0	0	0	0	0	0			
Fort Hudson Nursing Center, Inc.	0	0	0	0	0	0	0	0	196			
Fulton Center for Rehabilitation and Nursing Center	0	0	0	176	0	0	0	0	0			
Heritage Commons Residential Health Care	0	84	0	0	0	0	0	0	0			
Indian River Rehabilitation and Nursing Center	0	0	0	0	0	0	0	0	122			
Meadowbrook Healthcare	200	0	0	0	0	0	0	0	0			
Mercy Living Center	0	0	60	0	0	0	0	0	0			
Nathan Littauer Hospital Nursing Home	0	0	0	84	0	0	0	0	0			
Palatine Nursing Home	0	0	0	0	0	70	0	0	0			
River Ridge Living Center, LLC	0	0	0	0	0	120	0	0	0			
Saratoga Center for Rehab and Skilled Nursing Care	0	0	0	0	0	0	257	0	0			
Saratoga Hospital Nursing Home	0	0	0	0	0	0	36	0	0			
Schuyler Ridge A Residential Health Care Facility	0	0	0	0	0	0	120	0	0			
St Johnsville Rehabilitation Nursing Center	0	0	0	0	0	120	0	0	0			
The Orchard Nursing and Rehabilitation Centre	0	0	0	0	0	0	0	0	88			
The Pines at Glens Falls Center for Nursing & Rehabilitation	0	0	0	0	0	0	0	120	0			
The Stanton Nursing and Rehabilitation Centre	0	0	0	0	0	0	0	120	0			
Uihlein Living Center	0	156	0	0	0	0	0	0	0			
Washington Center for Rehabilitation and Healthcare	0	0	0	0	0	0	0	0	122			
Wells Nursing Homes Inc	0	0	0	100	0	0	0	0	0			
Wesley Health Care Center Inc	0	0	0	0	0	0	342	0	0			
Westmount Health Facility	0	0	0	0	0	0	0	80	0			
Wilkinson Residential Health Care Facility	0	0	0	0	0	160	0	0	0			

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

	County											
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomer	Saratoga	Warren	Washingt			
	3,689	10,709	1,862	306	1,289	323	13,410	34,708	29,166	81,729	926,227	1,901,994
	4.18%	19.0%	3.06%	0.30%	15.02%	0.40%	4.56%	49.90%	28.89%	16.84%	6.96%	8.69%

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

Adirondack Rural Health Network	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington		Upstate	
Population, 2015												
Primary Care per 100,000 population	89.9	54.5	94.1	90.2	37.2	79.7	74.1	107.0	53.8	81.5	89.3	94.2
Other Subspecialty												
Obstetrics/Gynecology	18.7	0.0	19.6	5.0	0.0	12.3	7.9	23.5	0.0	12.1	15.0	16.4
IM Subspecialty	34.3	5.2	6.8	10.1	0.0	44.4	19.8	54.5	0.0	20.9	39.9	43.3
General Surgery	3.4	4.9	11.3	9.9	0.0	0.0	5.0	13.7	0.0	6.9	8.0	7.8
Surgical Specialties	44.0	14.3	15.5	18.4	0.0	22.3	20.2	55.9	2.3	27.3	34.3	35.2
Facility Based	38.3	4.7	41.3	9.4	0.0	16.5	7.0	62.0	0.0	27.9	40.6	41.4
Psychiatry	24.1	0.0	14.5	8.6	0.0	9.1	16.4	21.1	4.8	13.6	21.4	28.3
Other	43.7	9.9	14.8	3.7	0.0	13.7	12.6	55.4	0.0	23.9	36.3	40.4
Total Physician												
Total Physican per 100,000 population	296.4	93.5	217.8	155.4	37.2	197.9	162.9	393.1	60.9	214.2	284.8	307.0

	County											
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region	Upstate NY	New York State
Licensure Data												
Clinical Laboratory Technician	17	9	1	2	0	5	22	9	5	70	1,293	1,807
Clinical Laboratory Technologist	51	20	36	35	1	44	187	50	30	454	8,243	12,782
Dental Assistant	13	2	6	4	0	4	29	5	12	75	1,292	1,359
Dental Hygienist	42	16	18	24	4	31	233	48	30	446	7,939	10,074
Dentist	50	18	28	23	2	26	194	62	19	422	10,084	17,003
Dietition/Nutritionist, Certified	22	6	13	6	1	7	106	20	6	187	3,410	5,135
Licensed Clinical Social Worker (R/P psycotherap48		28	31	29	5	19	291	73	37	561	14,963	25,568
Licensed Master Social Worker (no privileges)	31	23	23	28	4	22	234	49	26	440	14,770	26,673
Licensed Practical Nurse	403	227	373	317	11	346	1,013	371	460	3,521	51,818	67,700
Physician	261	83	127	92	7	111	699	309	55	1,744	49,087	85,592
Mental Health Counseling	51	22	22	5	1	11	102	25	9	248	3,741	5,454
Midwife	5	1	3	4	0	1	7	16	3	40	588	996
NPs, All	73	13	33	30	3	25	205	69	19	470	12,949	18,104
Nurse Practitioner, Adult Health	22	1	7	6	0	3	43	15	3	100	3,791	5,199
Nurse Practitioner, Community Health	1	0	0	0	0	0	0	0	0	1	64	69
Nurse Practitioner, Family Health	30	6	20	15	1	18	94	34	10	228	5,255	7,251
Nurse Practitioner, Gerentology	0	0	0	1	0	0	3	0	0	4	297	605
Nurse Practitioner, Obstetrics & Gynecology	6	1	0	1	0	1	5	5	1	20	229	301
Nurse Practitioner, Pediatrics	2	2	1	0	1	0	13	1	0	20	1,177	1,633
Nurse Practitioner, Psychiatry	7	2	2	3	1	2	23	11	2	53	1,057	1,383
Pharmacist	96	28	41	43	2	45	469	73	52	849	14,024	21,345
Physical Therapist	61	38	41	22	0	38	363	65	28	656	12,375	17,947
Physical Therapy Assistant	18	14	21	21	1	28	59	29	16	207	3,693	5,145
Psychologist	14	12	15	10	3	7	108	34	6	209	6,408	11,965
Registered Physician Assistant	35	45	31	19	5	18	184	96	17	450	8,118	12,005
Registered Professional Nurse	1,258	477	706	638	57	741	3,527	1,080	719	9,203	164,768	230,657
Respiratory Therapist	16	5	3	16	0	22	109	23	10	204	3,983	5,575
Respiratory Therapy Technician	5	0	2	9	0	2	11	4	1	34	812	1,042

Sources: Hospital, Nursing Home, and Adult Care Beds: New York State Department of Health Physician Data: Center for Health Workforce Study Licensure Data: New York State Education Department

Appendix F: Data Consultants and Data Sources

COMMUNITY HEALTH ASSESSMENT PROCESS – DATA CONSULTANTS

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

Rochel Rubin, PhD, Graduate Research Assistant

Robert Martiniano, MPA, MPH, Senior Program Manager

DATABASES USED FOR THE COMMUNITY HEALTH ASSESSMENT

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

Appendix G: Indicators with Links

	Data Element	Data Source	
	Focus Area: Disparities		
	Prevention Agenda Indicators		
1	Percentage of Overall Premature Deaths (Age 35-64) , 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5	Ratio of Black, Non-Hispanic Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '12 -	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Preventaion Agenda Dashboard
6	Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
7	Percentage of Adults (Ages 18 - 64) with Health Insurance, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
8	Age Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2013-2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
	Other Disparity Indicators		
1	Rate of Total Deaths per 100,000 Population, '11 - 13	New York State Deparmtne of Health; Vital Statistics of New York State	Prevention Agenda Dashboard
2	Rate of Emergency Department Visits per 10,000 Population, '11 - 13	New York State Deparmtne of Health; Vital Statistics of New York State	Prevention Agenda Dashboard
3	Rate of Total Hospital Discharges per 10,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Prevention Agenda Dashboard
4	Percentage of Adults (18 and Older) Who Did Not Receive Care Due to Costs, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	Prevention Agenda Dashboard
5	% of Adults (18 and Older) with 14 Days or More of Poor Physical Health, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	Prevention Agenda Dashboard
6	Percentage of Adults (18 and Older) with Disabilities, '13/14	New York State Expanded Behavioral Risk Factor Surveillance System	Prevention Agenda Dashboard
	Focus Area: Injuries, Violence, and Occupational Health		
	Prevention Agenda Indicators		
1	Rate of Hospitalizations due to Falls for Ages 65 Plus per 10,000 Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children Ages 1 - 4, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Rate of Assault-Related Hospitalizations per 10,000 Population, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5	Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
6	Ratio of Assault-Related Hospitalizations for Low-Income versus non-Low Income Zip Codes, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
7	Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
	Other Indicators		
1	Rate of Hospitalizations for Falls for Children Ages Under 10 per 10,000 Population Children Ages Under 10 , '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Hospitalizations for Falls for Children Ages 10 - 14 per 10,000 Population Children Ages 10 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of Hospitalizations for Falls for Individuals Ages 15 - 24 per 10,000 Population Individuals Ages 15 - 24, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Hospitalizations for Falls for Adults Ages 25 - 64 per 10,000 Population Adults Ages 25 - 64, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
			Department of Criminal Justice County Index
			Crime Counts and Rates
			Department of Criminal Justice County Index
			Crime Counts and Rates
			Department of Criminal Justice County Index
			Crime Counts and Rates
8	Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population Ages 15 Plus, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
9	Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population Ages 15 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population Ages 15 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
11	Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed Ages 16 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
12	Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed Ages 16 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
			NYS Department of Motor Vehicles Traffic Safety Data

			NYS Department of Motor Vehicles Traffic Safety Data
			NYS Department of Motor Vehicles Traffic Safety Data
16	Rate of TBI Hospitalizations per 10,000 Population, '11 - 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17	Rate of Unintentional Injury Hospitalizations per 10,000 Population, '11 - 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Rate of Unintentional Injury Hospitalizations Ages 14 and Under per 10,000 Population Ages 10 - 14, '11 - 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population Ages 65 Plus, '11 - 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
20	Rate of Poisoning Hospitalizations per 10,000 Population, '11- 13	NSYDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Focus Area: Outdoor Air Quality		
1	1. Number of Days with Unhealthy Ozone, 2011/2013	County Health Rankings and Roadmaps	County Health Rankings
2	2. Numbert of Days with Unhealthy Particulated Matter, 2011/2013	County Health Rankings and Roadmaps	County Health Rankings
	Focus Area: Built Environment		
1	Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2015	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Percentage of Commuters Who Use Alternative Modes of Transportation to Work, '10-14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2010	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
		New York State Expanded Behavior Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
		New York State Expanded Behavior Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
6	Percentage of Homes in Vulnerable Neighborhoods that have Fewer Asthma Triggers During Home Revisits, '11-14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
	Focus Area: Water Quality		
1	Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2015	New York State Department of Health; Indicators for Trracking Public Health Priority Areas	Prevention Agenda Dashboard
	Focus Area: Reduce Obesity in Children and Adults		
	Prevention Agenda Indicators		
1	Percentage of Adults Ages 18 Plus Who are Obese, '13/14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
		New York State Department of Health; Indicators for Tracking	Student Weight Status Category Reporting System (SWSCRS) Data
	Other Indicators		
			Student Weight Status Category Reporting System (SWSCRS) Data
			Student Weight Status Category Reporting System (SWSCRS) Data
			Student Weight Status Category Reporting System (SWSCRS) Data
	Percentage of Middle and High School Students Overweight, Not Obese,		Student Weight Status Category Reporting System (SWSCRS) Data
			Student Weight Status Category Reporting System (SWSCRS) Data
6	Percentage of WIC Children Ages 2 - 4 Obese, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese,	New York State Expanded Behavioral Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
	Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in	New York State Expanded Behavioral Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
	Number of Recreational and Fitness Facilities per 100,000 Population,	United States Department of Agriculture, Food, Environment	USDA Economic Research Service Fitness Facilities Data
	Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check,	New York State Expanded Behavioral Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
	Percentage of Adults (18 Plus) with Physician Diagnosed High Blood	New York State Expanded Behavioral Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
12	Rate of Cardiovascular Disease Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
13	Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
14	Rate of Pretransport Deaths per 100,000 Population, '12-14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

15	Rate of Cardiovascular Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
16	Rate of Diseases of the Heart Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17	Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Rate of Disease of the Heart Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
20	Rate of Coronary Heart Diseases Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
21	Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
22	Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
23	Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
24	Rate of Congestive Heart Failure Deaths per 100,000, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
25	Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population Ages 35 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
26	Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
27	Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
28	Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
29	Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
30	Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population Ages 18 Plus, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
31	Rate of Diabetes Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
32	Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
33	Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure			
	Prevention Agenda Indicators		
1	1. Percentage of Adults Ages 18 Plus Who Smoke '13/14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Other Indicators		
1	Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of Asthma Deaths per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Asthma Hospitalizations per 10,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population Ages 25 - 44, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population Ages 45 - 64, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population Ages 65 Plus, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
		New York State Expanded Behavioral Risk Factor Surveillance	2013 - 2014 NYS Expanded Behavioral Risk Factor Surveillance System
9	Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '1012	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Lung and Bronchus Cases per 100,000 Population, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
			NYS Department of Health Tobacco Enforcement Program Annual Report
			NYS Department of Health Tobacco Enforcement Program Annual Report
			NYS Department of Health Tobacco Enforcement Program Annual Report
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings			
	Prevention Agenda Indicators		
1	Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, '2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard

2	Rate of Asthma ED Visits per 10,000 Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Rate of Asthma ED Visits Ages 0 - 4, per 10,000 Population Ages, 0 - 4, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, Ages 6 - 17, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5	Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, Ages 18 Plus, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
6	Rate of Heart Attack Hospitalizations per 10,000 Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
	Other Indicators		
1	Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '11 - 13	New York State Department of Health; Information on Asthma in New York State	Asthma Summary Report
2	Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '11-13	New York State Department of Health; Information on Asthma in New York State	Asthma Summary Report
3	Rate of All Cancer Cases per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of all Cancer Deaths per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Female Breast Cancer Cases per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Female Breast Cancer Deaths per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
8	Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13/14	NYSDOH; New York State Community Health Indicator Reports	Prevention Agenda Dashboard
9	Rate of Cervix and Uteric Cancer Cases per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Cervix and Uteric Cancer Deaths per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	of Less than $25,000 Receiving Cervical Cancer Screening Based on	New York State Expanded Behavioral Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
12	Rate of Ovarian Cancer Cases per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
13	Rate of Ovarian Cancer Deaths per 100,000 Female Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
14	14. Rate of Colon and Rectum Cancer Cases per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
15	Rate of Colon and Rectum Cancer Deaths per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Percentage of Adults Aged 50-75 years receiving colorectal cancer	New York State Expanded Behavioral Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
17	Rate of Prostate Cancer Deaths per 100,000 Male Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Rate of Prostate Cancer Cases per 100,000 Male Population, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
20	Rate of Melanoma Cancer Deaths per 100,000 Population, '10 - '12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
21	Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12	New York State Expanded Behavioral Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
23	Oral Cavity and Pharnyx Cancer Deaths per 100,000 Population, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
24	Oral Cavity and Pharnyx Cancer Cases per 100,000 Population, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Focus Area: Maternal and Infant Health		
	Prevention Agenda Indicators		
1	Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Ratio of Preterm Births (< 37 wks) Black/NH to White/NH, '12- 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Ratio of Preterm Births (< 37 wks) Hisp/Latino to White/NH, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Ratio of Preterm Births (< 37 wks) Medicaid to Non-Medicaid, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5	Rate of Maternal Mortality per 100,000 Births, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
6	Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
7	Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard

8	Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
9	Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
	Other Indicators		
1	Percentage Perterm Births < 32 weeks of Total Births Where Gestation Period is Known, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Percentage of Total Births with Weights Less Than 1,500 grams, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Percentage of Singleton Births with Weights Less Than 1,500 grams, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Percentage of Total Births with Weights Less Than 2,500 grams, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Percentage of Singleton Births with Weights Less Than 2,500 grams, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Percentage of Total Births for Black, Non-Hispanic, with Weights Less	NYSDOH; State and County Indicators for Tracking Public Health	State and County Indicators for Tracking Public Health Priority Areas
	Percentage of Total Births for Hispanic/Latino, with Weights Less than	NYSDOH; State and County Indicators for Tracking Public Health	State and County Indicators for Tracking Public Health Priority Areas
9	Infant Mortality Rate per 1,000 Live Births, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Deaths (28 Weeks Gestation to Seven Days) per 1,000 Live Births and Perinatal Deaths, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
11	Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
		NYSDOH; State and County Indicators for Tracking Public Health	State and County Indicators for Tracking Public Health Priority Areas
		NYSDOH; State and County Indicators for Tracking Public Health	State and County Indicators for Tracking Public Health Priority Areas
14	Percentage APGAR Scores of Less Than Five at Five Minute Mark of Births Where APGAR Score is Known, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
15	Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
16	Percentage WIC Women Breastfed at Six months, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17	Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Focus Area: Preconception and Reproductive Health		
	Prevention Agenda Indicators		
1	Percent of Births within 24 months of Previous Pregnancy, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5	Percent of Unintended Births to Total Births, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
6	Ratio of Unintended Births Black, non-Hispanic to White, non-Hispanic, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
7	Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
8	Ratio of Unintended Births Medicaid to Non-Medicaid, '2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
9	Percentage of Women Ages 18- 64 with Health Insurance, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
	Other Indicators		
1	Rate of Total Births per 1,000 Females Ages 15-44, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Percent Multiple Births of Total Births, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Percent C-Sections to Total Births, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Total Pregnancies per 1,000 Females Ages 15-44, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

8	Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
9	Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 5-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
11	Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
12	Percent Total Births to Women Ages 35 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
13	Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
14	Rate of Abortions All Ages per 1000 Live Births to All Mothers, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
15	Percentage of WIC Women Pre-pregnancy Underweight, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
16	Percentage of WIC Women Pre-pregnancy Overweight but not Obese, 10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17	Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Percentage of WIC Women with Gestational Diabetes, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
20	Percentage of WIC Women with Gestational Hypertension, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Focus Area: Child Health		
	Prevention Agenda Indicators		
1	Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Percentage of Children Ages 0 -19 with Health Insurance, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
	Other Indicators		
1	Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children Ages 1 - 4, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children Ages 1 - 4, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children ages 10 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children Ages 5 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Children Deaths Ages 15 - 19 per 100,000 Population Children Ages 15 - 19 , '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Children Deaths Ages 1 - 19 per 100,000 Population Children Ages 1 - 19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
8	Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children Ages 5 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
9	Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children Ages 0 - 17, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of Gastroenteristis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
11	Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
12	Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children Ages 0 - 4, '10-12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
13	Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Populaiton Children Ages 0 - 4, '2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
14	Percentage of Children Screened for Lead by Age 9 months	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
15	Percentage of Children Screened for Lead by Age 18 months	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
16	Percentage of Children Screened for Lead by Age 36 months (at least two screenings)	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
17	Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
18	Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children Under Age 10, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
19	Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children Ages 10 - 14, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

20	Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population Ages 15 - 24, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
21	Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children Ages 0 - 17, '11 - 13	New York State Department of Health; Information on Asthma in New York State	Asthma Summary Report
22	Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit, 12 - 14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
23	Percentage of 3rd Graders with Dental Caries, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
24	Percentage of 3rd Graders with Dental Sealants, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
25	Percentage of 3rd Graders with Dental Insurance, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
26	Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
27	Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
28	Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population Children Ages 3 - 5, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
29	Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '10 - 12	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
Focus Area: Human Immunodeficiency Virus (HIV)			
Prevention Agenda Indicators			
1	Rate of Newly Diagnosed HIV Cases per 100,000 Population, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators			
1	Rate of AIDS Cases per 100,000 Population, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of AIDS Deaths per 100,000 Adjusted Population, '12 - 14	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
Focus Area: Sexually Transmitted Disease (STDs)			
Prevention Agenda Indicators			
1	Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
4	Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
5	Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators			
1	Rate of Early Syphilis Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Gonorrhea Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Chlamydia Cases All Males per 100,000 Male Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
7	Rate of Chlamydia Cases All Females per 100,000 Female Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
8	Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
9	Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
10	Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
Focus Area: Vaccine Preventable Disease			
Prevention Agenda Indicators			
1	Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Percent females 13 - 17 with 3 dose HPV vaccine, 2014	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
		New York State Expanded Behavioral Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System

Other Indicators			
1	Rate of Pertussis Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Pneumonia/flu Hospitalizations Ages 65 Plus per 100,000 Population Age 65 Plus, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
		New York State Expanded Behavioral Risk Factor Surveillance	2013-2014 NYS Expanded Behavioral Risk Factor Surveillance System
4	Rate of Mumps Cases per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Meningococcal Cases per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of H Influenza Cases per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
Focus Area: Healthcare Associated Infections			
Prevention Agenda Indicators			
			NYS Department of Health Hospital Report on Hospital Acquired Infections
	Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000		NYS Department of Health Hospital Report on Hospital Acquired Infections
Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavioral Disorders			
Prevention Agenda Indicators			
1	Percent of Adults Binge Drinking within the Last Month, '13/14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
2	Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, '13-14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
3	Rate of Age Adjusted Suicides per 100,000 Adjusted Population, '12 - 14	New York State Department of Health; Indicators for Tracking Public Health Priority Areas	Prevention Agenda Dashboard
Other Indicators			
1	Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Self-inflicted Hospitalizations 10,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of Cirrhosis Deaths per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Cirrhosis Hospitalizations per 10,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
			NYS Department of Motor Vehicles Traffic Safety Data
7	Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, '11 - 13	Safe New York: Governor's Traffic Safety Committee Report	NYS Department of Motor Vehicles Data
8	Rate of Drug-Related Hospitalizations per 10,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
	Rate of People Served in Mental Health Outpatient Settings Ages 17 and		NYS Office of Mental Health, PCS Summary Report
	Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64		NYS Office of Mental Health, PCS Summary Report
	Rate of People Served in Mental Health Outpatient Settings Ages 65* per		NYS Office of Mental Health, PCS Summary Report
	Rate of People Served in ED for Mental Health Ages17 and under per		NYS Office of Mental Health, PCS Summary Report
	Rate of People Served in ED for Mental Health Ages 18 - 64 per 100,000		NYS Office of Mental Health, PCS Summary Report
	Rate of People Served in ED for Mental Health Ages 65* per 100,000		NYS Office of Mental Health, PCS Summary Report
Other Non-Preventive Agenda Indicators			
1	Rate of Hepatitis A Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
2	Rate of Acute Hepatitis B Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
3	Rate of TB Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
4	Rate of e. Coli 157 Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
5	Rate of Salmonella Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
6	Rate of Shigella Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

7	Rate of Lyme Disease Cases per 100,000 Population, '11 - 13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports
8	Rate of Confirmed Rabies Cases per 100,000 Population, '11-13	NYSDOH; New York State Community Health Indicator Reports	Community Health Indicator Reports

Appendix H: ARHN Regional Stakeholder Report

Prepared for AHI by

June 10, 2016

Executive Summary

A. Background

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

B. Methods

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

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

C. Survey Responses

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

Exhibit 1: Respondents by County

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

D. Findings

Over 200 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including education (122), prevention and wellness (115), health care (96), healthy environment (65), and social services among others. Survey respondents also served a wide range of individuals, including school-aged children (163), individuals

living at or near the federal poverty level (149), adults (146), individuals with behavioral health issues (123), individuals who are senior citizens (122), and individuals with disabilities (121).

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

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

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

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

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

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

Overview

A. Background

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

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

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

B. Methods

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

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

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

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

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

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

C. Survey Responses

1. By County

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

Exhibit 2: Respondents by County

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

2. By Services Provided

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

Exhibit 3: Respondents by Services Delivered

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

2.1.1 Health Care Services

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

2.1.2. Prevention and Wellness

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

Exhibit 4: Type of Prevention/Wellness Services Provider

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

3. By Populations Served

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

Exhibit 5: Respondents by Population Serviced

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

4. By Population Served and by Services Provided

Exhibit 6: Respondents by Population Serviced and by Services Provided

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

I. ARHN Region

A. ARHN's Priorities

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

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

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

B. Identifying the Top Priority

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Identifying the Second Priority

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Franklin County

A. Franklin County's Priorities

Overwhelming, providers in Franklin County identified "promoting mental health and preventing substance abuse" (33) as their top priority followed by "preventing chronic disease" (13) as a distant second. "Preventing chronic disease" and "providing a healthy and safe environment" were tied at 18 as their second priority.

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

Priority Area	Count	
	Top Priority	Second Priority
Prevent Chronic Disease	13	18
Provide a healthy and safe environment	2	18
Promote Healthy Women, Infants, and Children	8	10
Promote Mental Health and Prevent Substance Abuse	33	7
Prevent HIV, Sexually Transmitted Diseases, Vaccine Preventable Diseases, and Health Care Associated Infections	0	2

B. Identifying the Top Priority

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

For service providers in Franklin County that identified "preventing chronic disease" as their top priority, they ranked "reducing obesity in children and adults" (5) as their top focus area, followed by "reducing illness, disability, and death related to tobacco use and second hand" (4).

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

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

B.2. Barriers to Addressing Chronic Diseases Prevention as the Top Priority for Franklin County

Service providers in Franklin County that identified "preventing chronic disease" as their top priority indicated that major barriers to addressing this priority was "a shortage of professionals and staff" (7), followed by "travel distance and the geography of the Adirondacks" (6). One respondent noted that "prevention is still not a priority."

Exhibit II.3. Barriers to Addressing Chronic Diseases Prevention as the Top Priority for Franklin County

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	0
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	0
Existing Strategies Have Not Been Effective	4
Lack of Financial Resources/Reimbursement in the Short-Term	5
Lack of Financial Resources/Reimbursement in the Long-Term	3
Lack of Evidenced-Based Strategies	1
There is a Shortage of Professionals/Staff	7
The Existing Population Does Not Believe that My Top Priority is an Issue	4
There are Other Priorities More Important to Address	1
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	6
Other	3

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

Only two service providers in Franklin County indicated that "providing a healthy and safe environment" was their top priority, and they ranked "built environment" and "injuries, violence, and occupational" health as the main focus areas, both with one.

Exhibit II.4: Ranking the Focus Areas for Providing a Healthy and Safe Environment when Providing a Healthy and Safe Environment is the Top Priority for Franklin County

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

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

The only barrier listed for service providers in Franklin County that identified "a healthy and safe environment" as their top priority was "lack of financial resources/reimbursement in the long-term."

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

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

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

For service providers in Franklin County that indicated that "promoting healthy women, infants, and children" were their top priority, they ranked "child health" (4) as their top focus area, followed by "maternal and infant health" (3).

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

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

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

Service providers in Franklin County that identified "healthy women, infant, and children" as their top priority, indicated a number of barriers to addressing this priority, including "lack of financial resources/reimbursement in the long-term" (5), followed by five other barriers all with four.

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

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

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

Franklin County service providers that identified "promoting mental health and preventing substance abuse" as their top priority ranked "strengthening (the mental health) infrastructure across systems" (18) as their main focus area to address.

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

	Rank		
	1st	**2nd**	**3rd**
Promote Mental, Emotional, and Well-Being in Communities	7	15	10
Prevent Substance Abuse and other Mental and Emotional Disorders	7	11	14
Strengthen Infrastructure Across Systems	18	6	8

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

Service providers in Franklin County that indicated that "promoting mental health and preventing substance abuse" was their top priority identified a number of barriers to addressing this focus area, including "a shortage of professionals and staff" (22), "lack of financial resources/reimbursement in the long-term" (20) and "in the short-term" (17), and "travel distance and the geography of the Adirondacks" 16. One respondent noted, "what happens with drugs and alcohol outside of school is directly impacting on the success of our students and I am not sure how to tackle that problem."

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

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	1
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	3
Existing Strategies Have Not Been Effective	9
Lack of Financial Resources/Reimbursement in the Short-Term	17
Lack of Financial Resources/Reimbursement in the Long-Term	20
Lack of Evidenced-Based Strategies	3
There is a Shortage of Professionals/Staff	22
The Existing Population Does Not Believe that My Top Priority is an Issue	2
There are Other Priorities More Important to Address	5
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	16
Other	6

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

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

C. Identifying the Second Priority

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

For service providers in Franklin County that identified "preventing chronic diseases" as their second priority, they ranked "increase access to high quality chronic disease preventive care and management" (12) as the top focus area.

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

	Rank		
	1st	2nd	3rd
Reduce Obesity in Children and Adults	5	8	5
Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure	1	4	12
Increase Access to High Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings	12	6	0

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

Respondents from Franklin County that identified "preventing chronic diseases" as their second priority indicated that "travel distance and geography of the Adirondacks" (10) was the biggest barrier for address this priority, followed by "lack of financial resources/reimbursement in the long-term" and "a shortage of professionals and staff," both with six. One respondent noted that the "high prevalence rates of tobacco use and obesity requires a 'full court press' to address successfully."

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

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	2
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	1
Existing Strategies Have Not Been Effective	4
Lack of Financial Resources/Reimbursement in the Short-Term	5
Lack of Financial Resources/Reimbursement in the Long-Term	6
Lack of Evidenced-Based Strategies	0
There is a Shortage of Professionals/Staff	6
The Existing Population Does Not Believe that My Top Priority is an Issue	4
There are Other Priorities More Important to Address	2
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	10
Other	7

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

Service providers in Franklin County that indicated that "providing a healthy and safe environment" was their second priority ranked "injuries, violence, and occupational health" (10) as their main focus area, followed by "build environment" (7).

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

	Rank			
	1st	2nd	3rd	4th
Outdoor Air Quality	0	4	4	7
Water Quality	1	2	8	4
Built Environment	7	5	1	2
Injuries, Violence, and Occupational Health	10	4	2	2

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

Franklin County providers that identified "providing a healthy and safe environment" as their second priority indicated that "lack of financial resources in the short-term" (8) and "in the long-term" (7) were the biggest barriers to addressing this priority.

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

Barrier	Count
I am not Aware of any Current Work Addressing My Top Priority	2
Cost of Providing Services and/or the per Client/Patient Cost is Too High/Outweigh the Benefits	1
Existing Strategies Have Not Been Effective	0
Lack of Financial Resources/Reimbursement in the Short-Term	8
Lack of Financial Resources/Reimbursement in the Long-Term	7
Lack of Evidenced-Based Strategies	2
There is a Shortage of Professionals/Staff	3
The Existing Population Does Not Believe that My Top Priority is an Issue	3
There are Other Priorities More Important to Address	4
Travel Distance/Geography of the Adirondacks Makes it Difficult to Address Patient/Client Needs	1
Other	2

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

For service providers in Franklin County that identified "promoting healthy women, infants, and children" as their second priority ranked "maternal and infant health" and "child health" as their main focus areas, both with 4.

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

	Rank		
	1st	2nd	3rd
Maternal and Infant Health	4	6	0
Child Health	4	3	3
Reproductive, Preconception, and Inter-conception Health	2	1	7

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

Franklin County service providers who indicated that "promoting women, infants, and children" as their second priority identified "travel distance and geography of the Adirondacks" (4) as the biggest barrier for addressing this priority, followed by "a shortage of professionals and staff" (3).

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

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

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

Service providers in Franklin County that indicated that "promoting mental health and preventing substance abuse" was their second priority ranked "preventing substance abuse and other mental and emotional disorders" (4) as their main focus areas, followed by "promoting mental, emotional, and well-being in communities" (2).

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

	Rank		
	1st	2nd	3rd
Promote Mental, Emotional, and Well-Being in Communities	2	4	1
Prevent Substance Abuse and other Mental and Emotional Disorders	4	3	0
Strengthen Infrastructure Across Systems	1	0	6

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

Franklin County service providers that identified "promoting mental health and preventing substance abuse" as their second priority indicated that "a shortage of professionals and staff" (6) was their biggest barrier, followed by "lack of financial resources/reimbursement in the short-term" (5), in "the long-term" (4), and "travel distance and geography of the Adirondacks" (4).

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

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

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

Two respondents from Franklin County indicated that "preventing HIV, sexually transmitted diseases, vaccine-preventable diseases, and health care associated infections" was their second priority, and they both ranked "preventing HIV and sexually transmitted diseases" as the main focus area to address. They indicated the only barrier to addressing this priority was "travel distance and the geography of the Adirondacks."

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

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

Appendix I: AHI PPS DSRIP Projects

AHI PPS – Delivery System Reform Incentive Payment Program (DSRIP)
The AHI PPS has elected to participate in eleven projects, covering three domains:

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

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

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

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

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

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

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

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

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

Appendix J: 2016 Project Updates

Franklin County
2016 Community Health Improvement Plan Summary Report

Priority Area 1: **Reduce Obesity in Children and Adults**

Goal: 1.1 Create a community environment that promotes nutritional standards for healthy food and beverage procurement and supports physical activity (NYS Prevention Agenda)

Objective 1: Increase the number of locations where fruits and vegetables and healthy food options are available in low income communities and work sites in Franklin County.
The North Country Healthy Heart Network partnered with Franklin County (employer) to identify opportunities for increasing employee access to nutritious snacks and beverages during the work day. Activities were focused on development and approval of healthy meeting and healthy vending policies. The Heart Network also supported increased access to nutritious food and beverages in the community by adding four new "Fit Pix" convenience stores to the current list of stores committed to offering healthy "grab-n-go" items for sale.

Objective 2: Increase by one the number of municipalities in Franklin County that are working towards adoption or implementation of a Complete Streets policy, plan or project.
Healthy Heart Network worked with residents in Fort Covington to conduct sidewalk assessments/walking audits and used that data to create a map of existing conditions. Next a map of potential improvements will be drafted for use to draft a sidewalk improvement plan that will be presented to the board for adoption. A walk audit was also conducted with the St. Regis Mohawk Tribe to assess the route from the Mohawk School to the Walking Trail/Park area; information will be used to create a corridor improvement plan.

Objective 3: Increase the number of students who walk or bike to school using the Safe Routes to School grant and curriculum.
Franklin County Public Health, Highway Department, and Traffic Safety as well as the Healthy Heart Network continue to collaborate to offer Safe Routes to School Education and Encouragement to the Malone and Saranac Lake School Districts. Activities and incentive items were expanded to three additional school districts: St. Regis Falls CSD, Brushton-Moira CSD, and Salmon River CSD.

Objective 4: Increase the number of infants born at Alice Hyde Medical Center who are exclusively breastfed during the birth hospitalization and for the first 6 month of life.
The Breastfeeding Council of Malone continued to support Alice Hyde Maternity Staff to increase breastfeeding rates. At this time two additional maternity staff as well as one ObGyn staff person have been trained as CLCs thanks to grants from Adirondack Health Institute co-written by Franklin County Public Health and Alice Hyde staff. Maternity staff continue to send referrals to Public Health for post partum Nurse Home Visits that include breastfeeding education.

Priority Area 2: Increase Access to high-quality Chronic Disease Prevention Care and Management in both Clinical and Community Settings

Goal: 3.3 Promote culturally relevant chronic disease self-management education.

Objective 1: Increase by at least 5% the number of adults with a chronic condition that have taken the Stanford University class *Healthy Living with a Chronic Condition.*
Eastern Adirondack Health Care Network Sponsored a Health Coaches Class that included participants from Franklin County Community Based Organizations to increase the availability of chronic disease self-management educational opportunities in the region.

Objective 2: Conduct at least two National Diabetes Prevention Program classes per year in at least one community in Franklin County.
No classes were held in 2016 due to difficulty recruiting and retaining participants to enroll in and complete the entire curriculum.

The overarching goal of the CHIP was to decrease the percentage of adults and children who are overweight or obese by 5%. According to the New York State Prevention Agenda Dashboard, this goal was achieved for adults (obesity in adults declined from 35.7% to 33.7%), but was not met for children (obesity in children increased slightly from 22.3% to 22.5%). This indicates that interventions targeting adults should continue, and interventions for children should be adjusted and/or intensified.

Appendix K: Crosswalk of Other Initiatives of Essex and Franklin County Partners with Priorities, Emerging Issues & Disparities

This section serves to identify how other initiatives of Essex and Franklin Counties align with Priorities & Disparities identified in the CHNA. These initiatives support, not supplant, efforts to achieve shared community health improvement goals.

Initiatives

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

*A priority for Franklin County and Emerging for Essex County

Appendix L

Prioritization Tool/Final Prioritization Franklin County

			NEED				**FEASIBILITY/IMPACT**		
			Demonstrated Need	**Variance**	**Trend**	**Perceived Need**	**Confidence**	**Resources**	**Capacity**
	SCORING DEFINED		Size (% or rate) of population affected 0=none/very small 1 = small 3=considerable 5=significant	compared to Upstate NY 0=better 1=same 3=worse 5=sig worse	compared to previous assessment 0=better 1=same 3=worse 5=sig worse	Stakeholder survey 0=4th or 5th priority 1= 3rd priority 3=2nd priority 5=1st priority	Perceived confidence in ability to address the issue - control level, stakeholder engagement/influence 0=none/NA -small need 1=low 3 = fair 5=high	Evidenced based interventions, funding & staffing 0=none/NA -small need 1=low 3 = fair 5=high	capacity to continue or do more to influence 0=none/NA -small need 1=low 3 = fair 5=high
	RELATIVE WEIGHT	**WEIGHTED SCORE**	**2**	**1**	**2**	**0.5**	**2**	**2**	**1**
Environmental Health	Injuries, Violence, and Occupational Health	**26**	5	3	3	0	1	3	1
	Outdoor Air Quality	**4**	1	0	1	0	0	0	0
	Built Environment	**2**	1	0	0	0	0	0	0
	Water Quality	**3**	1	1	0	0	0	0	0
Chronic Diseases	Obesity in Children and Adults	**35.5**	5	3	3	3	1	5	3
	Tobacco Use and Secondhand Smoke Exposure	**16**	3	1	0	0	1	3	1
	Chronic Disease Preventive Care and Management	**47.5**	5	5	5	3	3	5	5
Women, Infants, Children	Maternal and Infant Health	**20**	1	3	0	0	3	3	3
	Preconception and Reproductive Health	**18**	1	3	1	0	3	1	3
	Child Health	**25**	1	0	0	0	5	5	3
Communicable Diseases	HIV	**0**	0	0	0	0	0	0	0
	Sexually Transmitted Diseases	**0**	0	0	0	0	0	0	0
	Immunizations/Vaccine-Preventable Diseases	**36**	5	3	3	0	3	3	5
	Healthcare Associated Infections	**26**	1	1	1	0	3	5	5
MEB Health.Substance Abus	Substance Abuse and Mental, Emotional, and Behavioral Health	**46.5**	5	5	5	5	5	3	3