Franklin County 2022-2024 Community Health Assessment and Community Health Improvement Plan and Community Service Plan

THE University of Vermont HEALTH NETWORK
Alice Hyde Medical Center

FRANKLIN COUNTY SEAL

Public Health
Prevent. Promote. Protect.

ADIRONDACK HEALTH
Better Health, Better Lives

New York State 2022-2024 Community Health Needs Assessment, Community Health Improvement Plan and Community Service Plan

1. County Covered:
   Franklin County

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

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

   Adirondack Health
   2233 State Route 86
   Saranac Lake NY 12983
   518-891-4141

Contents

A. Executive Summary

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

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

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

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

1. Promote Well-Being & Prevent Mental and Substance Use Disorders

2. Prevent Chronic Disease

Both priorities reflect disparities of Poverty and Access to Care.

Franklin County Public Health, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital work group obtained and examined data from a variety of sources; the details of which are explained in their entirety throughout the CHA. Additionally, Community Stakeholder assessments contributed to our choosing of priorities.

The Community Health Assessment (CHA) Committee, facilitated by ARHN, has developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. CHA Committee members from Franklin County are Adirondack Health Medical Center, The University of Vermont Health Network - Alice Hyde Medical Center, and Franklin County Public Health Services (FCPHS). The committee has been meeting in person every three months throughout the last assessment and planning cycle and will continue to do so during the 2022-2024 cycle. This collaboration assists partners in tracking plan progress and in making mid-course corrections if needed.

To engage the broad community, the CHA Committee created a stakeholder survey to garner constructive feedback. The stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The survey summary provided a regional look at the results through a wide-

angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area and provided individual analyses of Franklin County.

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

The completion of the 2022-2024 Franklin County Community Health Assessment and Community Service Plan/Community Health Improvement Plan was a collaborative effort between Franklin County Public Health Services, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital and a number of community-based organizations. These include Cornell Cooperative Extension, St. Joseph's Rehabilitation Services, Franklin County Community Housing, Adirondack ARC, Harrietstown Housing Authority, Catholic Charities, Franklin County Community Services, North Country Healthy Heart Network, Franklin County Office of the Aging/NY Connects, the Department of Social Services, the Joint Council for Economic Opportunity (JCEO), Community Health Center of the North Country Federally Qualified Health Care Center (FQHC), Hospice of the North Country, Tri-Lakes Center for Independent Living, and the Youth Advocate Program. Ongoing engagement with the Adirondack Rural Health Network will continue.

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

All implementation strategies, interventions, activities and measures are outlined in great detail within the 2022 – 2024 Implementation Plan. Evidence-based interventions were selected directly from those offered in the Prevention Agenda. Data findings suggest that the leading causes of death and illness in Franklin County can be directly linked to obesity, poor

nutrition, physical inactivity, and tobacco use, as well as a lack of supports related to mental, emotional, and behavioral (MEB) well-being. Franklin County Public Health Services, The University of Vermont Health Network – Alice Hyde Medical Center, and Adirondack Health Medical Center Hospital are committed to enhancing opportunities for all residents to live more healthful lives by promoting safe, healthful behaviors and creating supportive environments.

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

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

New York State's Prevention Agenda 2019 – 2024

The Prevention Agenda 2019-2024 is a blueprint for local, regional, and state action to improve the health of New Yorkers in five priority areas, and to reduce health disparities for racial, ethnic, disability, and low socioeconomic groups, as well as other populations who experience them. 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-Healthy Eating and Food Security
    - Focus Area 2-Physical Activity
    - Focus Area 3-Tobacco Prevention
    - Focus Area 4 - Chronic Disease Preventive Care and Management

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

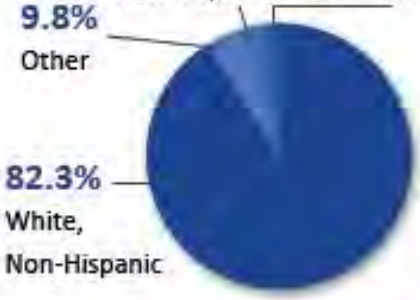
- Promote Healthy Women, Infants and Children
    - Focus Area 1-Maternal and Women's Health
    - Focus Area 2-Perinatal and Infant Health
    - Focus Area 3-Child and Adolescent Health
    - Focus Area 4-Cross Cutting Healthy Women, Infants, and Children

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

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

FRANKLIN COUNTY | DATA SNAPSHOT

POPULATION



Under 18	9,748
Ages 18-64	25,071
Ages 65+	8,610

HOUSEHOLDS

Mean Household Income	$69,689
% Single Parent Households	10.0%

EMPLOYMENT STATUS

% Unemployed	7.0%

TOTAL POPULATION 50,389

SQ. MILES 1,629.1

SCHOOL SYSTEM INFORMATION

Student-to-Teacher Ratio	10.2
% Free and Reduced Lunch	58.0%
% High School Graduate/GED	37.4%
% Some College, No Degree	16.6%
% Associate's Degree	12.9%
% Bachelor's Degree or Higher	20.7%

AVAILABILITY OF VEHICLES

% Households with One Vehicle or Less Available

42.6%

HEALTH SYSTEM BED CAPACITY

(PER 100,000 POPULATION)

Total Hospital Beds	339
Total Nursing Home Beds	387
Total Adult Care Facility Beds	179

POVERTY

% Individuals Receiving Medicaid	25.9%
% Individuals Under Federal Poverty Level	17.8%
Number of ALICE and Poverty Households	8,214

DATA SOURCES

The information above is comprised of a blending of multiple data sources, including: American Community Survey, 2018; ALICE Threshold, 2018; United for ALICE, 2018; NYS County Health Rankings, 2018; 2010 Census Estimate, Census Quick Stats; USDA Farm Overview, 2017; US Census Bureau, 2020 American Community Survey 5-year estimates; Centers for Medicaid and Medicare Services, 2019; National Center for Education Statistics, 2020-2021; NYS Education Department, Report Card Database 2019-2020; NYS Education Department, Report Care Database 2020-2021; NYS Education Department, 3-8 ELA Assessment Databases 2019-2020; National Center for Education Statistics, Public School District Data for the 2020-2021 school years; US Census Bureau, 2020 American Community Survey 5-year estimates; NYS Department of Health, NYS Health Profiles; NYS Department of Health, Nursing Home Weekly Bed Census, 2022; NYS Department of Health, Adult Care Facility Directory, 2022; NYS Education Department, License Statements, 2021. This document was created in 2022, by the Adirondack Rural Health Network, a program of AHI.

B. Franklin County Community Health Assessment

B1a. GEOGRAPHY/SERVICE AREA PROFILE

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

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

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

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

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

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

Demographic Characteristics

Spanning 1,629 square miles, the population of Franklin County is 50,389. Like Upstate New York*, Franklin County's population is limited in its diversity. 82.3% of the population is White, Non-Hispanic, followed by 6.2% Alaskan Native/American Indian and 5.6% Black, Non-Hispanic. 17.1% of the population is aged 65 years and older, which is lower than both the ARHN region (19.6%) and Upstate New York* (17.7%).

Mean household income is $69,689 and per capita income is $26,886. These averages are less than Upstate New York* which are $97,962 and $33,208 respectively. The percentage of individuals in Franklin County living below the Federal Poverty Level is 17.8%, which is higher than both the ARHN Region (11.9%) and Upstate New York* (12.5%).

When considering the total population of Franklin County, approximately 70.6% of individuals are aged 25 years of age or older. Of that population, 37.4% are a High School Graduate or have their General Education Diploma (GED). An additional 33.6% have an Associates, Bachelor's, or higher education degree.

Franklin County's unemployment rate is 7.0% with 21,195 employed aged 16 and older in the Civilian Workforce. The highest employment sector with 31.3% is the field of Education, Health Care and Social Assistance. This is followed by Public Administration (13.7%) and Retail Trade (13.5%).

Health System Profile
Franklin County has two hospitals, Adirondack Medical Center - Saranac Lake Site and Alice Hyde Medical Center. Adirondack Medical Center-Saranac Lake Site has 95 beds and Alice Hyde Medical Center has 76 beds. Majority of the beds within the region have a designation of medical/surgical beds, resulting in a total hospital beds rate of 339 when considering the total regional population. This rate is higher than the ARHN region (274).

There are two nursing home facilities within the county, totaling 195 nursing home beds resulting in a total nursing home beds rate of 387. There are two adult care facilities totaling 60 beds resulting in an adult care facility rate of 179.

Both nursing home and adult care facilities rates are lower than the ARHN region (685, 443). The rate of total physicians in Franklin County is 159 which is lower than the ARHN region (198).

Educational Profile
Franklin County has seven school districts, with a total enrollment of 6,717 students. When considering total enrolled students, 58.1% are eligible for free and reduced lunch, with majority of those being eligible for free lunch (89.8%, 3,506 students). The total number of high school graduates is 435 with a percent dropped out of high school rate of 4.0%. This is lower than both the ARHN Region (5.3%) and Upstate New York* (7.3%) and the same as New York State (4.0%).

There are 687.1 public school teachers making the student to teacher ratio 10.2. This is higher than the ARHN region (9.8) and Upstate New York* (8.9).

Asset-Limited, Income Constrained, Employed (ALICE) Profile
There are 19,088 households in Franklin County with 2,055 of those as ALICE householders over 65 years of age. There is a 17.7% poverty rate and 25.4% ALICE rate totaling 8,214 households designated as either

poverty or ALICE.

Specific to ALICE households, the majority are White (4,768), which far exceeds the second largest group of ALICE households comprised American Indian/ Alaska Native residents (298).

B1b. HEALTH INDICATORS

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

Health Disparities/ Mortality:

While there are no significant health disparities or mortality statistics based on race and ethnicity in Franklin County, there continues to be limited access to care. The percentage of adults with health insurance in Franklin County is 91.7%, with 75.5% of adults having a regular health care provider. Both indicators are worse performing than the 2024 Prevention Agenda benchmarks (97.0%, 86.7%).

The percentage of adults who did not receive medical care due to costs in Franklin County is 8.3% which is better than both the ARHN region (9.6%) and Upstate New York* (9.2%).

The rate of total hospitalizations per 10,000 population is 864.4 which is lower than the rate for both ARHN region (981.2) and Upstate New York* (1,144.2). The rate of ED visits per 10,000 population is 4,691.9 which is just slightly lower than the ARHN region (4,694.3) but higher than Upstate New York* (3,843.0).

The percentage of adults 18 years of age and older living with disability based on the six ACA disability questions (29.1%) is lower than the ARHN region (29.2%) but higher than Upstate New York* (24.6%).

Injuries, Violence, and Occupational Health:

Rate of hospitalizations due to falls among adults, aged 65+ (136.4) is better than both the ARHN region (165.2) and the 2024 Prevention Agenda Benchmark (173.7). The rate of unintentional injury hospitalizations ages 65 plus (157.3) is better than the ARHN region (210.3), Upstate New York* (275.1) and New York State (249.9).

The rate of violent crimes in Franklin County (157.5) is higher than the ARHN region (157.0) but lower than Upstate New York* (204.7) and New York State (364.9).

Motor vehicle accidents and speed-related accidents are higher in Franklin County (2,463.7, 280.2) than in the ARHN region (2,298.7, 260.2). The rate of motor vehicle accident deaths is lower in Franklin County (4.0) than the ARHN region (7.2), Upstate New York* (6.6) and New York State (5.3).

Chronic Disease:

When considering preventative care for women, the percentage of women aged 50-74 years receiving breast cancer screenings and the percentage of women aged 21-65 years receiving cervical cancer screenings both performed worse than benchmark. Overall, the rate of cancer cases (636.3) is better than the ARHN region (710.8) and Upstate New York State* (657.0).

The rate for Asthma emergency department visits for those aged 65+ years (22.2) performed worse than the ARHN region (16.0) and Upstate New York* (14.8).

Franklin County has room for improvement for increasing dental health awareness with 22.4% of Medicaid enrollees having at least one preventive dental visit within the year. Additionally, 63.2% of adults had a dentist visit within the past year. Both indicators performed worse than then Upstate New York* benchmark.

Women, Infants and Children:

Both the WIC women breastfeeding for at least six months and the percentage of infants fed any breast milk in delivery hospital performed worse than the Upstate New York* benchmark. The percentages of women receiving WIC in Franklin County who are either obese, have gestational weight gain greater than ideal, gestational diabetes or gestational hypertension are all higher than the Upstate New York* benchmark.

Franklin County could have additional focus on child health. The percentage of children screened for lead by ages 9-17 months (69.7%) is worse performing than the respective Upstate New York* benchmark (73.0%). The percentage of children with recommended number of well child visits in government sponsored insurance programs (69.8%) is also worse than the ARHN region (74.1%), Upstate New York* (73.3%) and New York State (75.2%).

Awareness can also be focused on children's dental hygiene as 78.7% of third graders have dental insurance compared to the ARHN region benchmark of 85.2%. Only 69.3% of the county's third graders had at least one dental visit compared to the ARHN region benchmark of 81.0%.

Substance Abuse and Behavioral Health:
The percentage of adults in Franklin County who have reported binge drinking within the past month (17.1%) is higher than the Prevention Agenda Benchmark (16.4%). The age adjusted rate of suicides (11.7) is also higher than the Prevention Agenda Benchmark (7.0).

Outdoor Air and Water Quality and Built Environment:
Due to the rural location of Franklin County, the built environment poses several challenges. The percentage of the population with low-income and low access to supermarkets or large grocery stores is higher (9.1%) than the ARHN region (6.0%), Upstate New York* (3.9%), and New York State (2.2%).

Additionally, the percentage of residents served by community water systems that have optimally fluoridated water (3.3%) is lower than the ARHN region (26.8%), Upstate New York* (46.9%), New York State (71.1%) and the 2024 Prevention Agenda Benchmark (77.5%).

Obesity in Children and Adults:
The percentages of children in elementary, middle, and high school who are either overweight or obese are higher than that of Upstate New York* over five indicators. The percentage of adults who are either overweight or

obese (75.5%) is higher than the ARHN region (69.1%), Upstate New York* (64.2%) and New York State (62.7%).

With the challenge of obesity in adults in Franklin County, both the percentage of adults who participated in leisure time physical activity in the past 30 days as well as the number of recreational and fitness facilities per 100,000 Population were worse than the Upstate New York* benchmark.

The burden of obesity and access to recreational facilities may contribute to Franklin County's Diabetes and Heart Disease challenges which include higher than benchmark average for the following three indicators 1) Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64), 2) Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64), and 3) Rate of Diabetes Death.

Smoke Exposure:

Smoking and smoking-related diseases seem to present a challenge for Franklin County, with four indicators having worse performance than the comparison benchmark.

The percentage of adults who smoke in Franklin County (20.6%) is higher than Upstate New York* (19.5%) and the Prevention Agenda Benchmark (11.0%). This may stem from the number of registered tobacco vendors being higher (123) than Upstate New York* (104.4) and New York State (110) making the availability of tobacco products more accessible to residents. The rate of lung and bronchus cancer deaths and rate of chronic lower respiratory disease deaths are worse than their respective benchmarks.

HIV/STD's, Vaccines-Preventable Disease, and Health Care-Associated Infections:

Newly reported on during this CHA cycle, the rate of males with Gonorrhea aged 15-44 (13.7) is better than the Upstate New York* benchmark (267.8). Franklin County can focus on preventable disease vaccine education as the immunization rate for children aged 24-35 months with 4:3:1:3:3:1:4

(68.4%) is lower than the Prevention Agenda benchmark (70.5%) and the percentage of 13-year-old adolescents with a complete HPV vaccine series (15.5%) is lower than the Prevention Agenda benchmark of 37.4%.

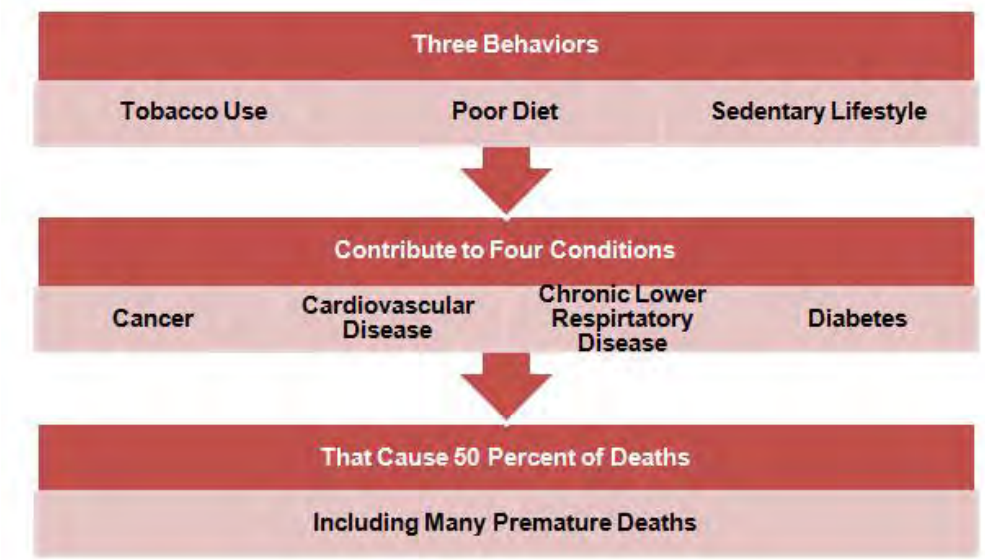
The rate of Pertussis cases in Franklin County (12.6) is higher than the ARHN region (12.3) and Upstate New York* (5.0). The rate of pneumonia/flu hospitalizations for those 65 years of age or older is higher in Franklin County (107.4) than in ARHN region (87.7), Upstate New York* (95.2) and New York State (85.5).

Other Findings:
The rate of salmonella cases (17.2) is higher in Franklin County than in the ARHN region (11.1), Upstate New York* (12.9), and New York State (14.0). The rate of confirmed rabies cases is lower in Franklin County (0.0) than in Upstate New York* (3.1).

The 3-4-50 Framework

We know from research that health status is influenced by multiple factors including genetics, social circumstances, environmental exposures, health care, and behavioral patterns. What we might not fully realize is that behavioral patterns have the single greatest influence on personal and population health. This means that achieving better health at lower cost will require improvements in health promotion and prevention at the community level. The 3-4-50 framework can be a helpful tool for focusing these strategies.

3-4-50: A Focusing Framework for Community Health Improvement



The 3-4-50 Framework

3-4-50 is a community health improvement strategy based on evidence that three health behaviors elevate risk for four chronic conditions that together cause more than fifty percent of deaths.

- The three health risk behaviors are unhealthy diet, sedentary lifestyle, and tobacco use.
- The four chronic conditions are cardiovascular disease, cancer, chronic lower respiratory disease, and diabetes.

- These four conditions cause more than 50 percent of all deaths in that vast majority of communities.

We know from research and experience that our health behaviors can be influenced by the environments where we live, learn, work, and socialize. Accordingly, community health interventions work best when we are able to create collective impact by providing consistent supports for healthy behaviors across settings. 3-4-50 is designed to support collaborative community strategies that potentially engage:

- Individuals and families;
- Businesses and employers;
- Health care systems, insurers, and clinicians;
- Community, non-profit and faith-based organizations;
- Early learning centers, schools, colleges, and universities; and
- State and local government.

The Evidence for 3-4-50

The 3-4-50 concept was originally developed by the Oxford Health Alliance in response to global concerns about chronic disease. The evidence indicates that the core elements of 3-4-50 are strikingly relevant in the US at the national, state, and community level. For example:

- There is strong evidence the 3-4-50 risk factors (individually or in combination) elevate risk for cardiovascular disease, cancer, chronic lower respiratory disease, and diabetes in the U.S. (HealthyPeople.gov).
- The 3-4-50 diseases do in fact account for 50 percent of total deaths in the vast majority of communities.
- There are many evidence-based interventions consistent with 3-4-50 that can be implemented in the community, the clinic, the school, and the workplace.(Community Preventive Services Task Force, US Preventive Services Task Force).
- Assuming evidence-based interventions are effectively implemented, the near-term (1-2 year) impact of a 3-4-50 approach should include better health behaviors, better screening rates, and improvements in

clinical indicators related to each disease. There may also be improvements in health service utilization and reductions in preventable hospital utilization for some higher risk populations. (Community Preventive Services Task Force, US Preventive Services Task Force).

- The longer-term impacts on disease rates, death rates, and health spending can only be predicted based on evidence that populations with healthier lifestyles tend to live longer and spend less on preventable conditions. Even marginal reductions in disease development can have a substantial impact on health and economic indicators over time.

3-4-50 Interventions

3-4-50 interventions are aimed at supporting healthy living choices by individuals and families. Ideally these interventions are consistently implemented in health care settings, school settings, workplace settings, and additional community settings. Using evidence-based recommendations from the US National Prevention Strategy as a guide, a 3-4-50 project might include the following interventions for Healthy Eating, Active Living, and Tobacco-Free Living:

- Helping people recognize and make healthy food and beverage choices
- Increasing access to healthy and affordable foods in communities
- Implementing organizational and programmatic nutrition standards and policies
- Assuring food safety and improving nutritional quality of food supply
- Supporting policies and programs that promote breastfeeding
- Assessing physical activity levels and providing education, counseling, and referrals
- Supporting workplace policies and programs that increase physical activity
- Facilitating access to safe and affordable places for physical activity
- Encouraging community design and development that supports physical activity

- Promoting and strengthening school and early learning policies and programs that increase physical activity
- Supporting comprehensive tobacco free and other evidence-based tobacco control policies
- Expanding use of tobacco cessation services
- Using media to educate and encourage people to live tobacco free

Initiatives like these can be implemented community-wide or within particular settings (e.g. health care, schools, or workplace). They can also be focused on the general population or on special populations with particular needs (e.g. children, seniors, medically underserved, persons with disabilities).

B2. Franklin County's Main Health Challenges

B2a. 3-4-50 Behavioral Risk Factors

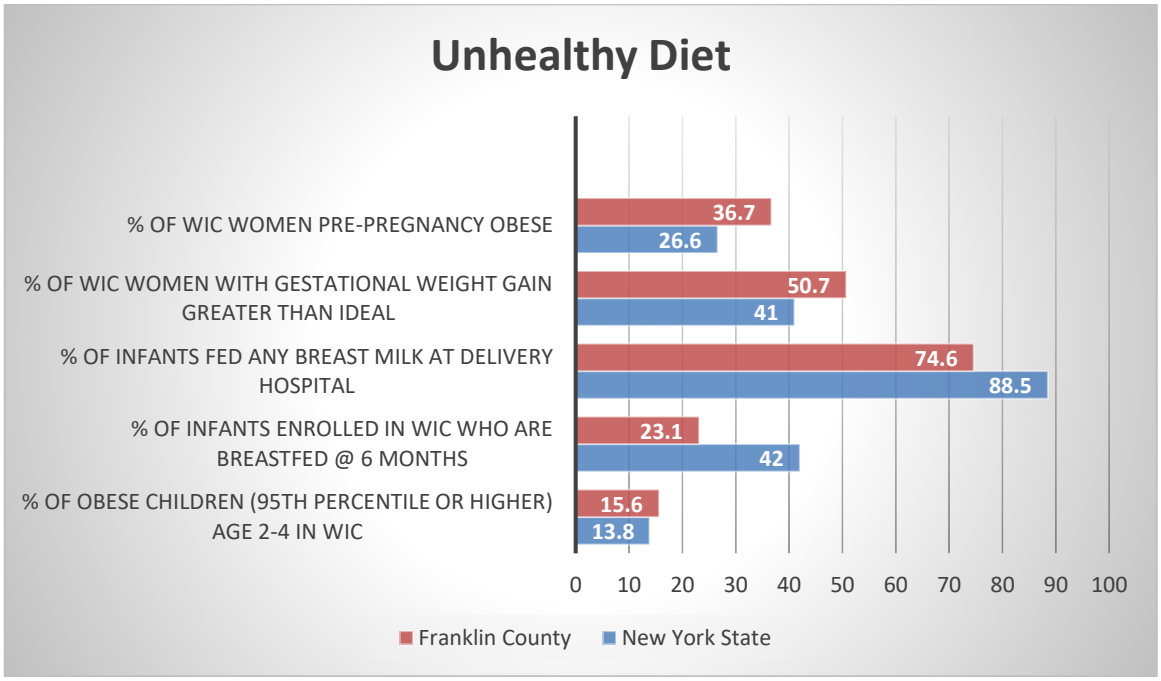
3 Health Risk Behaviors lead to 4 Chronic Conditions which result in 50% of Deaths in Franklin County

3 Health Risk Behaviors

Unhealthy Diet

An unhealthy diet can lead to health issues such as malnutrition, poor digestion, inflammation, unwanted weight gain and obesity. It can also increase the risk of chronic diseases, such as diabetes and heart disease, and impact mental health.

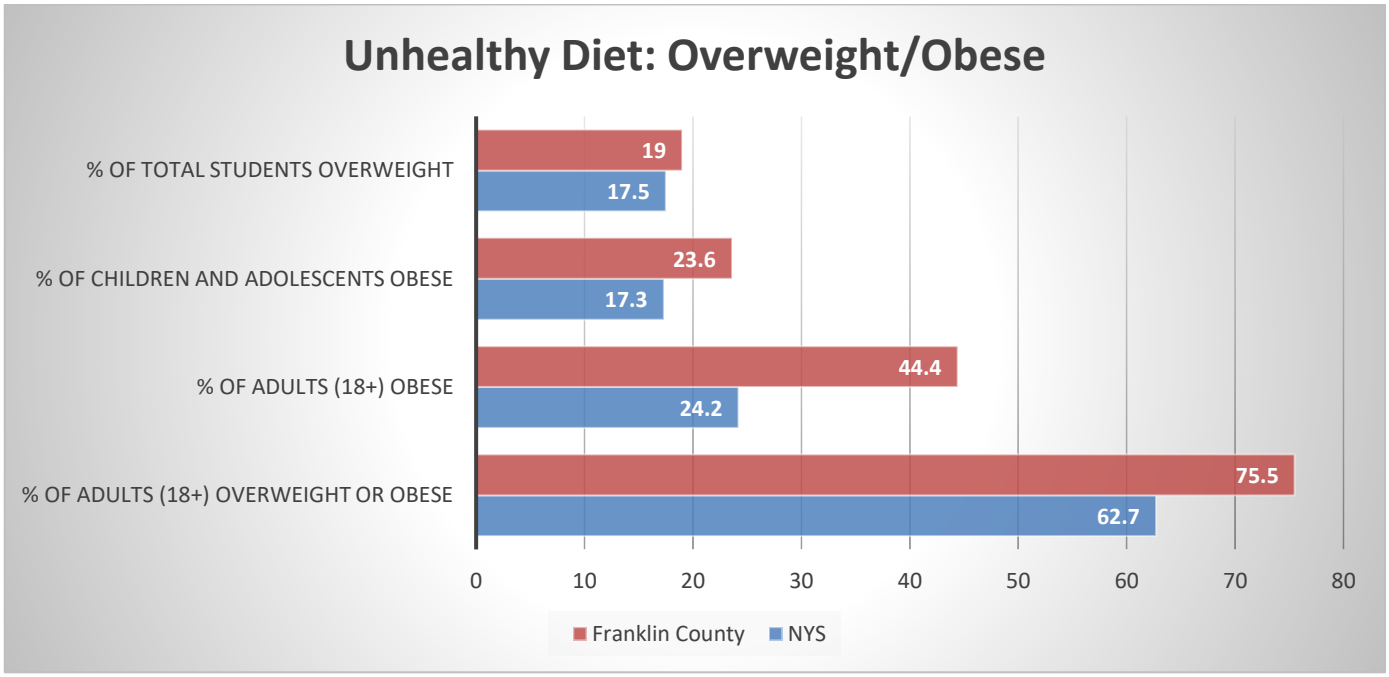
Breastfeeding has many benefits for mothers as well as infants. Infants benefit from a reduced risk of obesity, asthma, and type 1 diabetes. Mothers reduce their risk of high blood pressure, type 2 diabetes, ovarian and breast cancer.



Unhealthy Diet - Obesity

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.

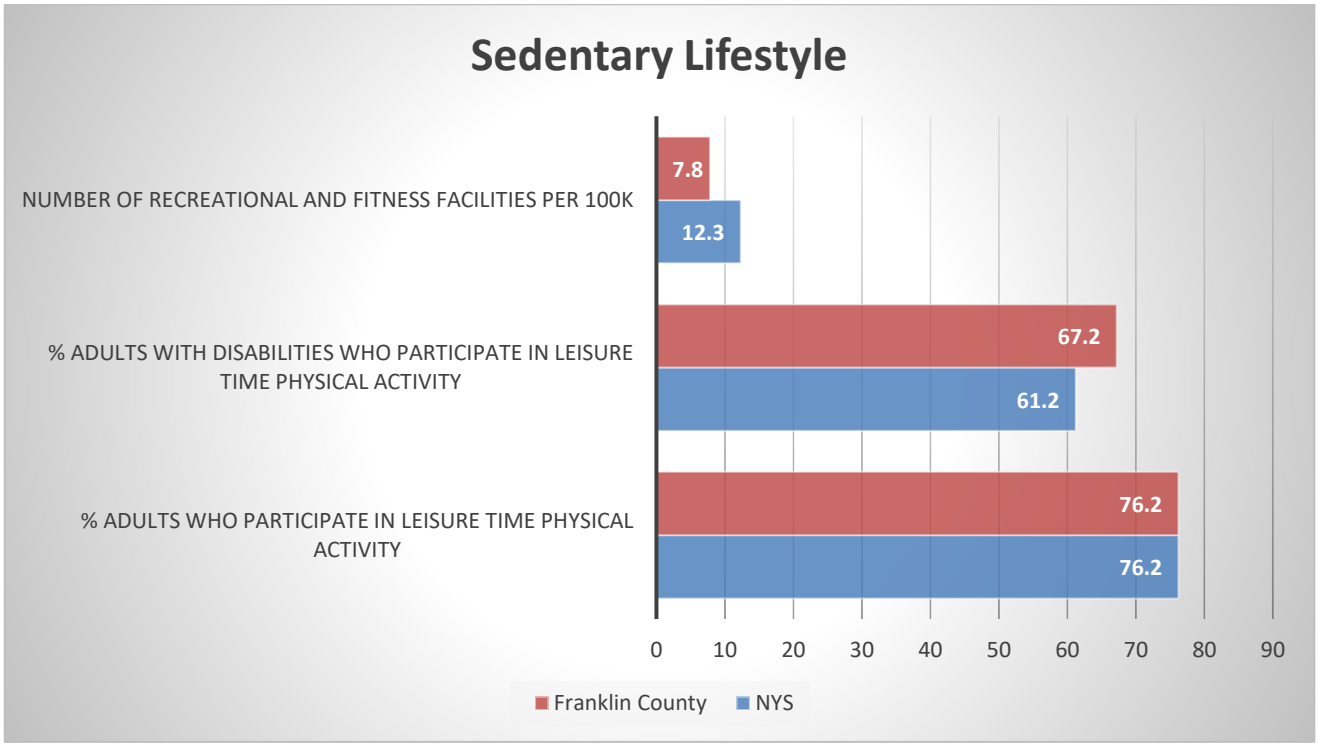
Obesity is a serious health concern for children and adolescents. According to the Centers for Disease Control and Prevention, obese children and adolescents are more likely to become obese as adults. Contributing factors to childhood obesity include dietary patterns, physical inactivity, genetics, medication 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.



Sedentary Lifestyle

During our leisure time, we are often sitting: while using a computer or other device, watching TV, or playing video games. Many of our jobs have become more sedentary, with long days sitting at a desk. And the way most of us get around involves sitting - in cars or on buses.

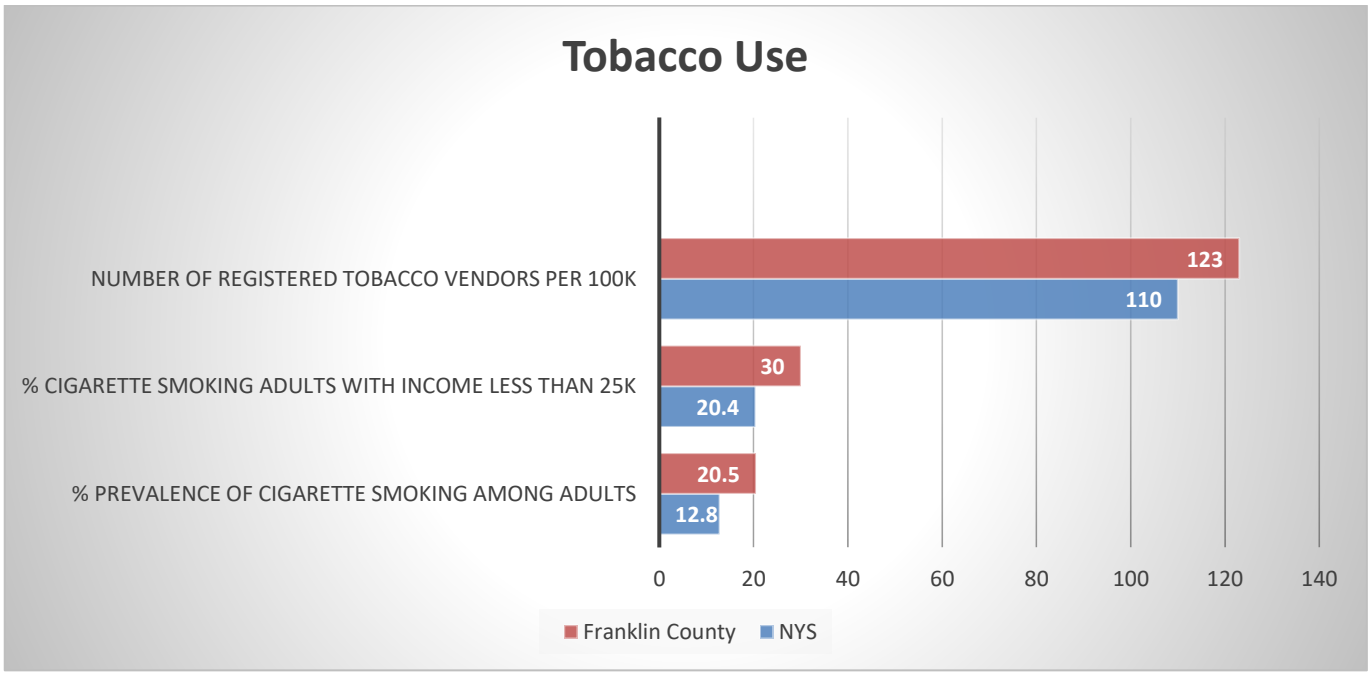
Having an inactive lifestyle can be one of the causes of many chronic diseases. By not getting regular exercise, you raise your risk of obesity, heart diseases, including coronary artery disease and heart attack, high blood pressure, high cholesterol, stroke, metabolic syndrome, type 2 diabetes, certain cancers, including colon, breast, and uterine cancers, osteoporosis and falls, and increased feelings of depression and anxiety. Having a sedentary lifestyle can also raise your risk of premature death. And the more sedentary you are, the higher your health risks are.



Tobacco Use

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.

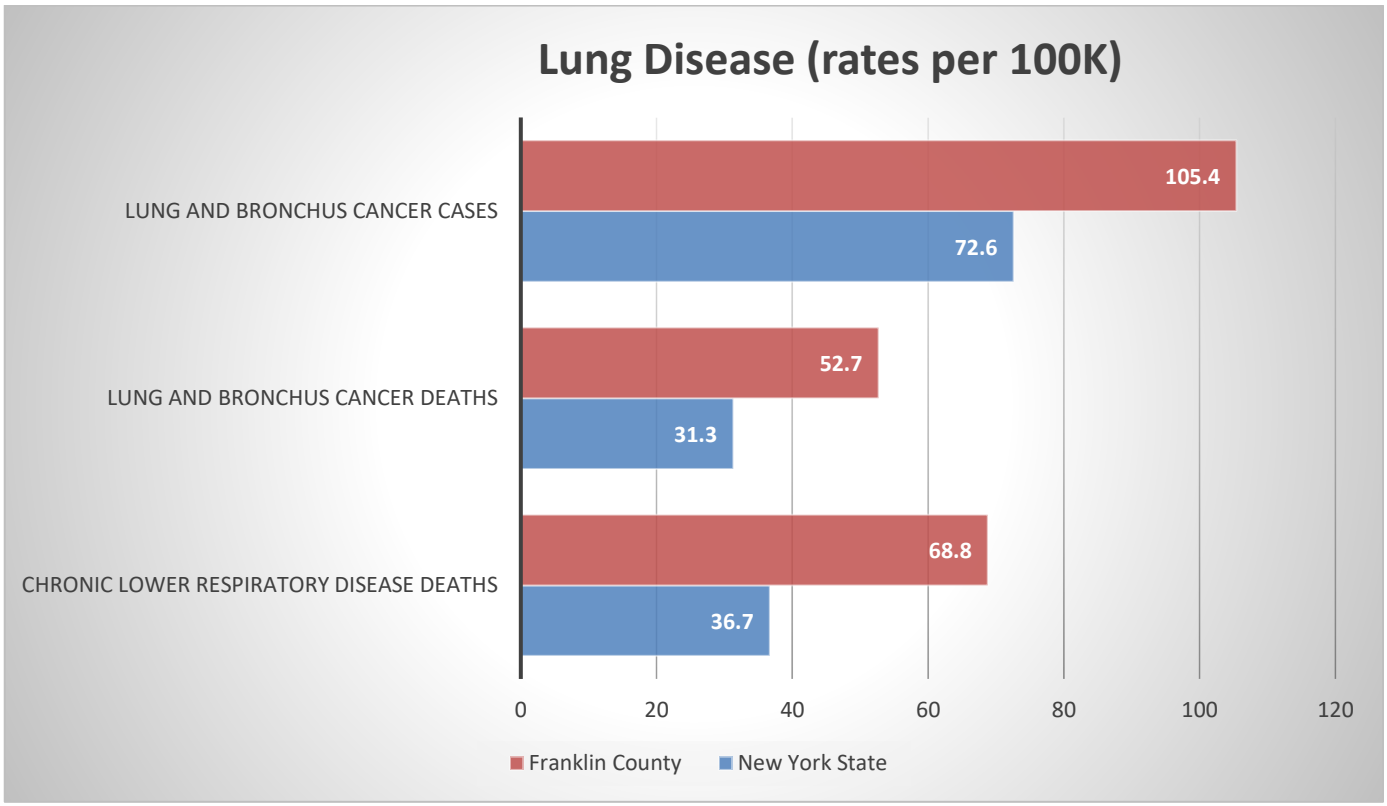


4 Chronic Conditions

Lung Disease

Lung diseases are some of the most common medical conditions in the world. Tens of millions of people have lung disease in the U.S. alone. Smoking, infections, and genes cause most lung diseases.

Lungs are part of a complex system, expanding and relaxing thousands of times each day to bring in oxygen and send out carbon dioxide. Lung disease can happen when there are problems in any part of this system.

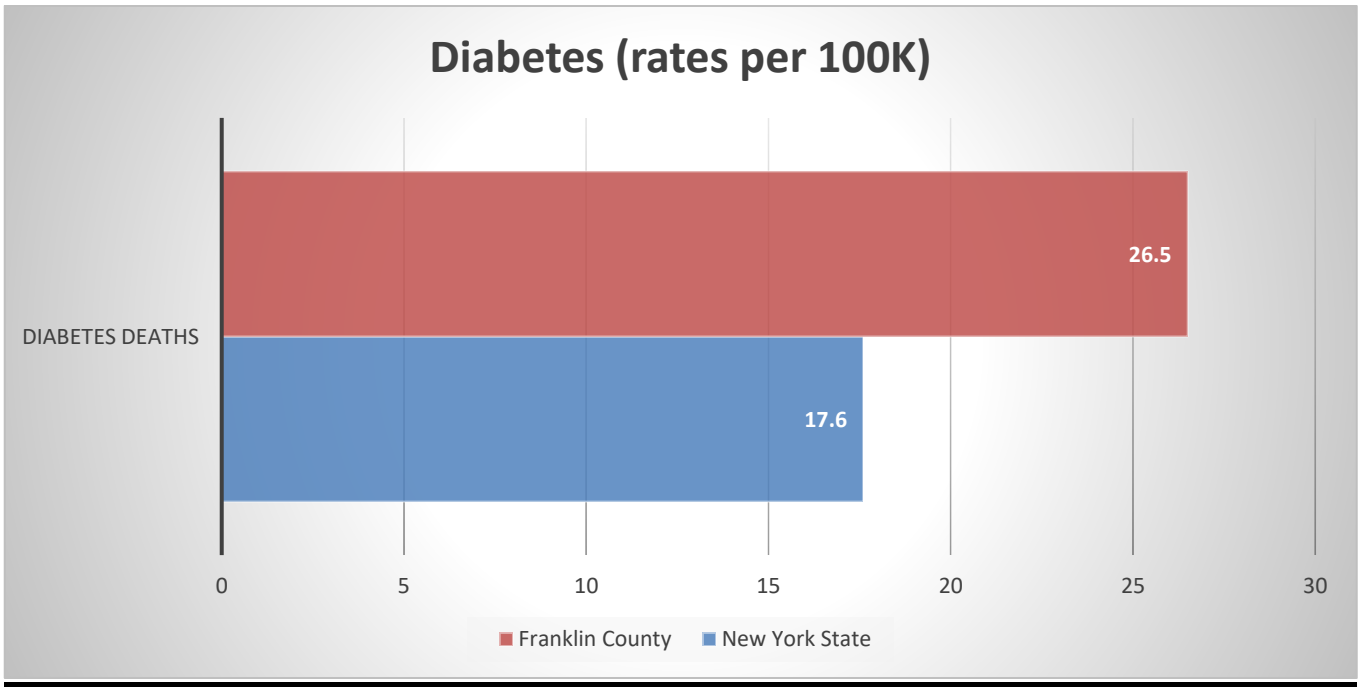


Diabetes

Risk factors for diabetes depend on the type of diabetes. Family history may play a part in all types. Environmental factors and geography can add to the risk of type 1 diabetes.

Race or ethnicity also may raise the risk of developing type 2 diabetes. Although it's unclear why, certain people — including Black, Hispanic, American Indian and Asian American people — are at higher risk. Prediabetes, type 2 diabetes and gestational diabetes are more common in people who are overweight or obese.

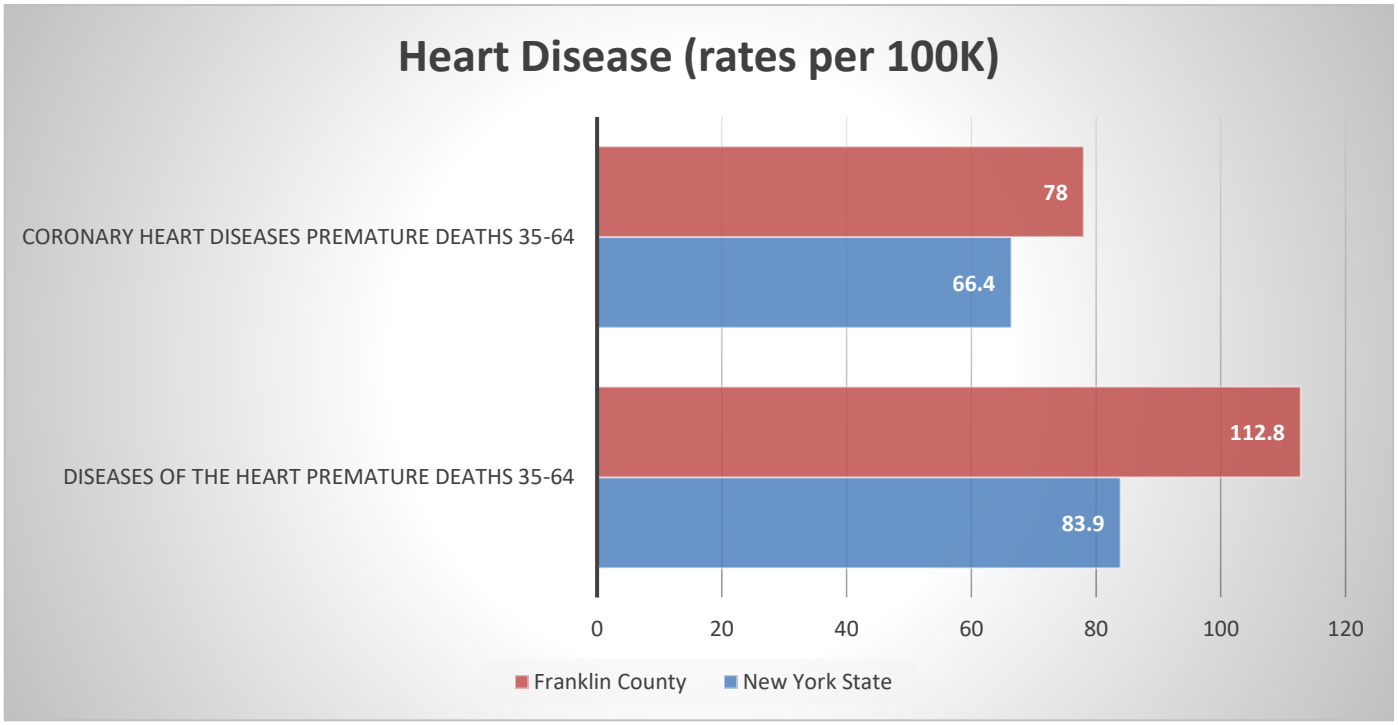
Long-term complications of diabetes develop gradually. The longer you have diabetes — and the less controlled your blood sugar — the higher the risk of complications. Eventually, diabetes complications may be disabling or even life-threatening. In fact, prediabetes can lead to type 2 diabetes. Type 1 diabetes can't be prevented. But the healthy lifestyle choices that help treat prediabetes, type 2 diabetes and gestational diabetes can also help prevent them. Diabetes risk can be reduced by eating healthy foods, being physically active, and losing excess weight.



Heart Disease

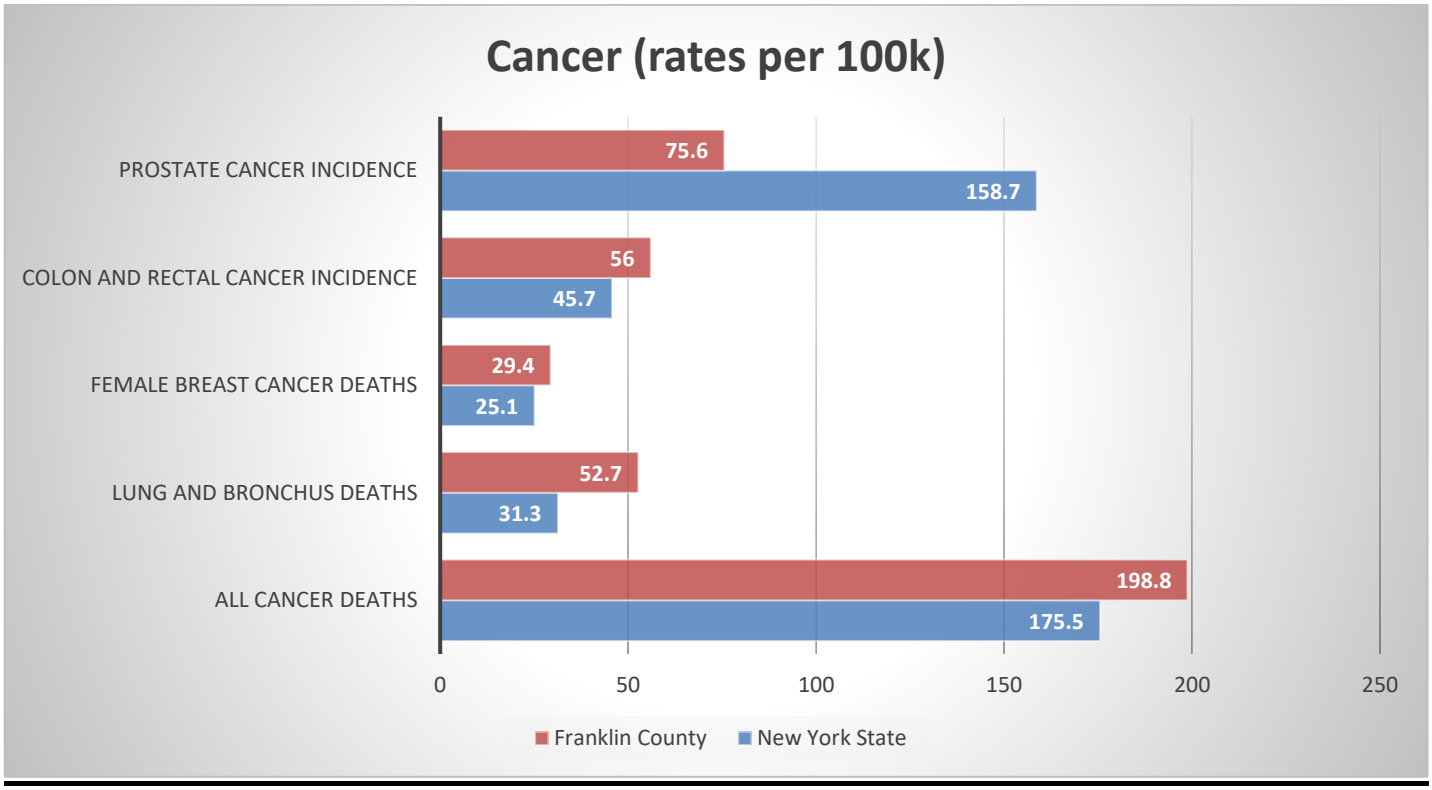
High blood pressure, high blood cholesterol, and smoking are key risk factors for heart disease.

Several other medical conditions and lifestyle choices can also put people at a higher risk for heart disease, including: diabetes, overweight and obesity, unhealthy diet, physical inactivity, and excessive alcohol use.

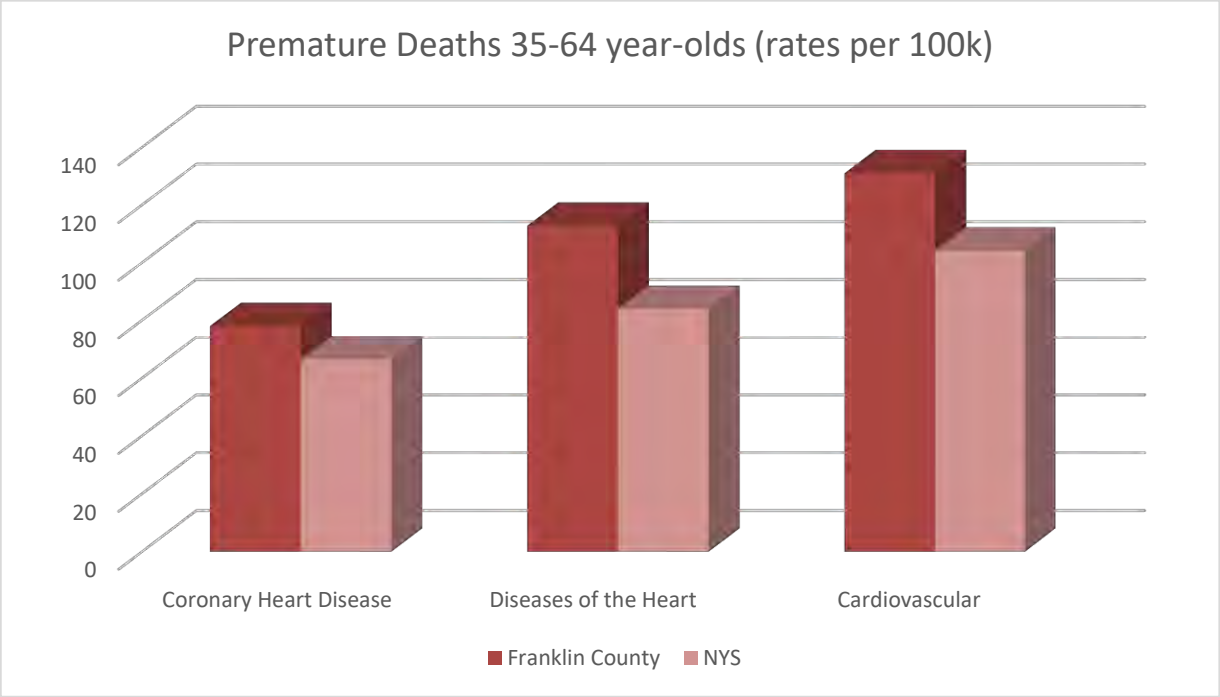


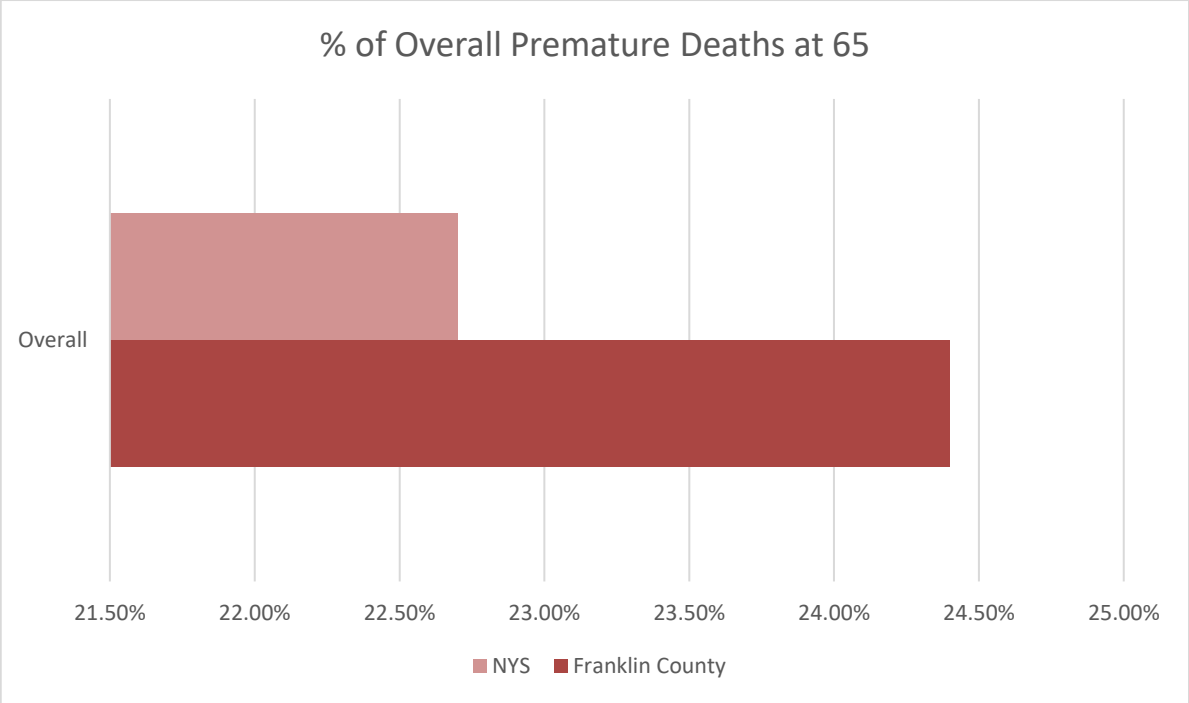
Cancer

Cancer is a complex group of diseases with many possible causes but certain lifestyle choices are known to increase your risk of cancer. Older age, a personal or family history of cancer, using tobacco, obesity, alcohol use, some types of viral infections, such as human papillomavirus (HPV), specific chemicals, and exposure to radiation, including ultraviolet radiation from the sun can contribute to cancer.



50% of Deaths in Franklin County





B2b. Environmental Risk Factors

Every community must prepare for and respond to hazardous events, whether a natural disaster like a tornado or disease outbreak, or a human-made event such as a harmful chemical spill. A number of factors, including poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prevent human suffering and financial loss in a disaster. These factors are known as social vulnerability.

ATSDR's Geospatial Research, Analysis & Services Program (GRASP) created databases to help emergency response planners and public health officials identify and map communities that will most likely need support before, during, and after a hazardous event. The CDC/ATSDR SVI uses U.S. Census data to determine the social vulnerability of every census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. The SVI ranks each tract on 16 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes. Maps of the four themes are shown in the figure below. Each tract receives a separate ranking for each of the four themes, as well as an overall ranking.

The SVI can help public health officials and local planners better prepare for and respond to emergency events like hurricanes, disease outbreaks, or exposure to dangerous chemicals.

CDC/ATSDR SVI databases and maps can be used to:

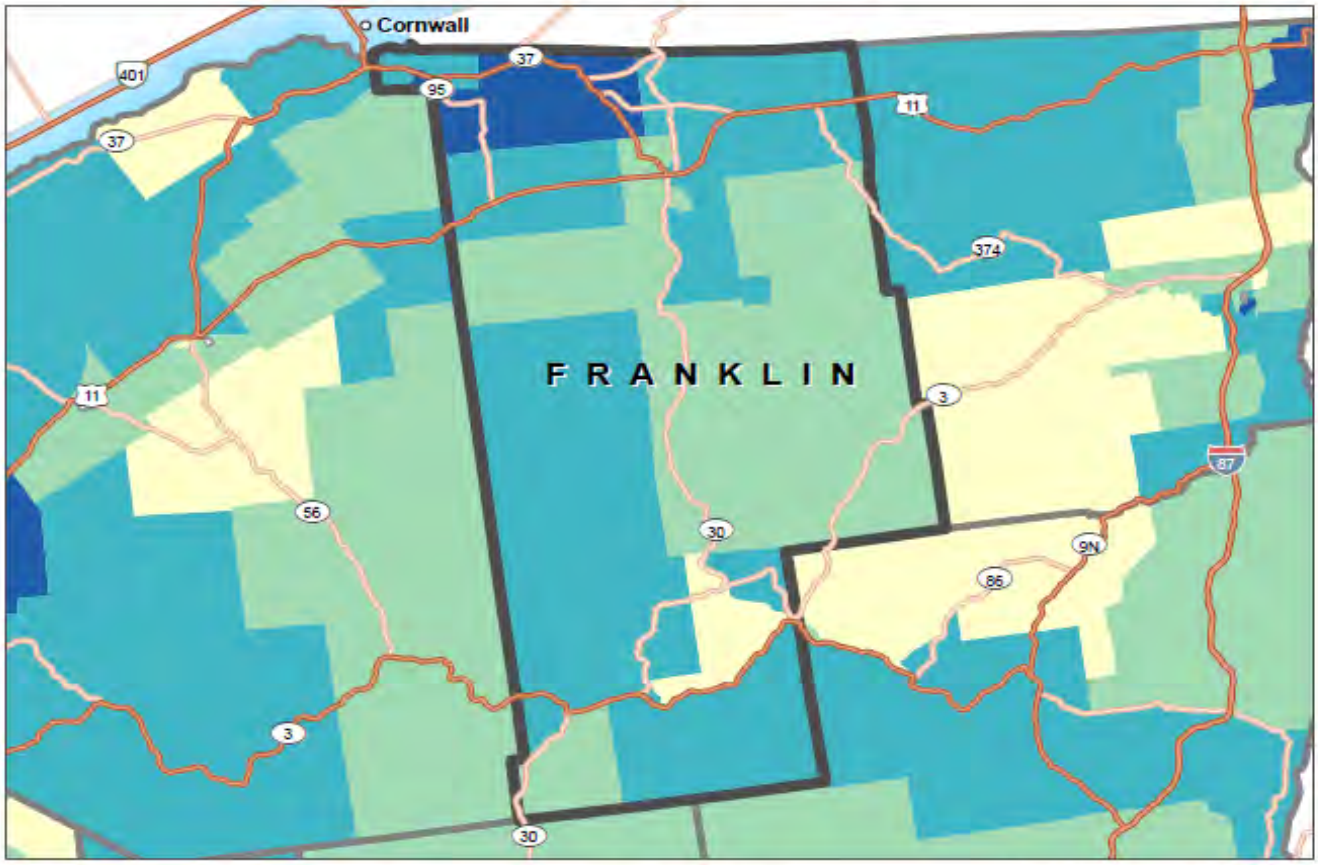
- Estimate the amount of needed supplies like food, water, medicine, and bedding.
- Help decide how many emergency personnel are required to assist people.
- Identify areas in need of emergency shelters.
- Plan the best way to evacuate people, accounting for those who have special needs, such as people without vehicles, the elderly, or people who do not understand English well.
- Identify communities that will need extra funding and support before, during, and after a disaster.

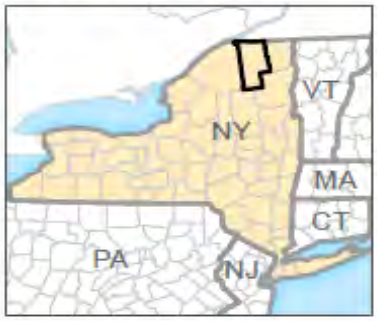
Franklin County's overall ranking by the CDC/ATSDR Social Vulnerability Index 2020 is Medium/High.

CDC/ATSDR Social Vulnerability Index 2020

FRANKLIN COUNTY, NEW YORK

Overall Social Vulnerability[1]





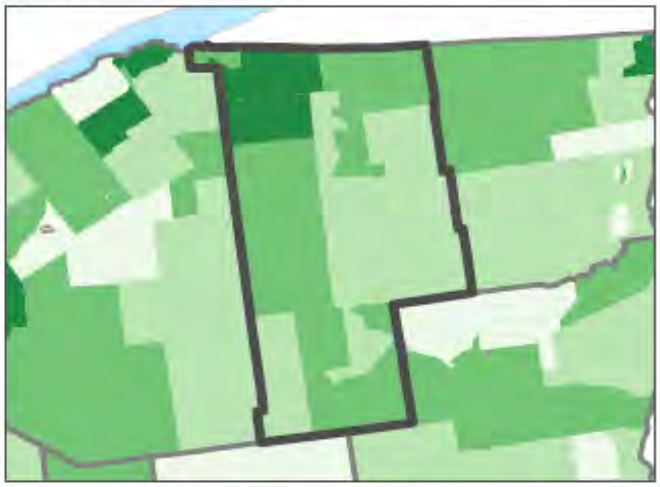
Social vulnerability refers to a community's capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters, such as tornadoes or disease outbreaks, to human-caused threats, such as toxic chemical spills. The **CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI 2020)[4] County Map** depicts the social vulnerability of communities, at census tract level, within a specified county. CDC/ATSDR SVI 2020 groups **sixteen census-derived factors** into **four themes** that summarize the extent to which the area is socially vulnerable to disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and vehicle access. Overall Social Vulnerability combines all the variables to provide a comprehensive assessment.

ATSDR Agency for Toxic Substances and Disease Registry

GRASP Geospatial Research, Analysis, and Services Program

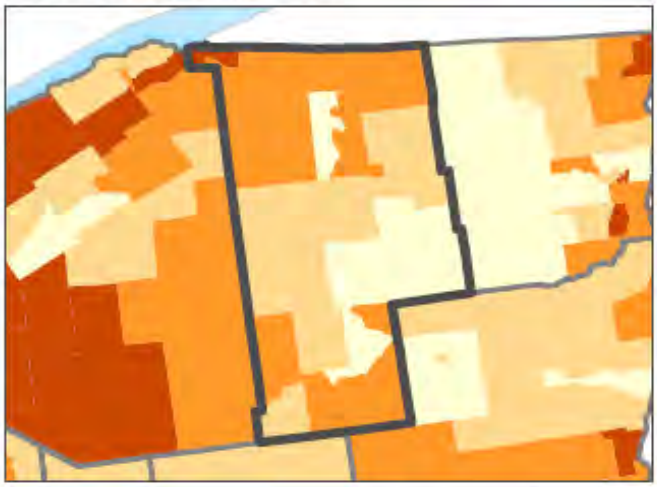
CDC/ATSDR SVI Themes

Socioeconomic Status[5]



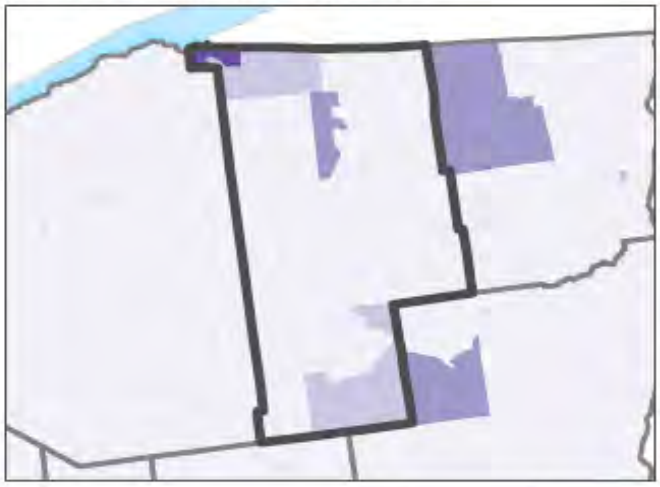
Highest (Top 4th) | Vulnerability (SVI 2020)[2] | Lowest (Bottom 4th)

Household Characteristics[6]



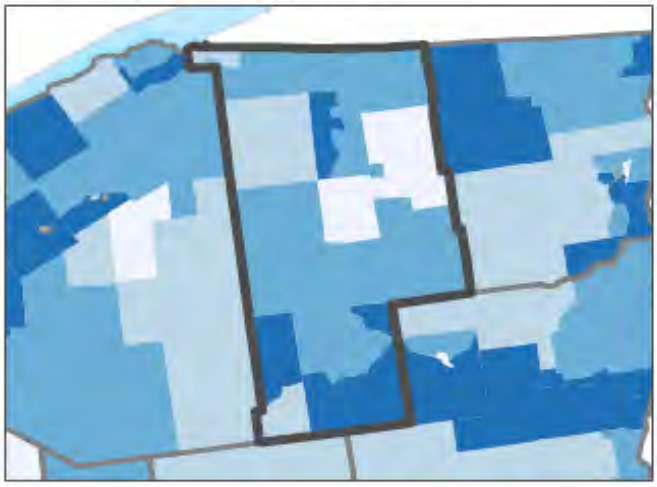
Highest (Top 4th) | Vulnerability (SVI 2020)[2] | Lowest (Bottom 4th)

Racial and Ethnic Minority Status[7]



Highest (Top 4th) | Vulnerability (SVI 2020)[2] | Lowest (Bottom 4th)

Housing Type/Transportation[8]



Highest (Top 4th) | Vulnerability (SVI 2020)[2] | Lowest (Bottom 4th)

Data Sources: [2]CDC/ATSDR/GRASP, U.S. Census Bureau, Esri® StreetMapTM Premium.

Notes: [1]Overall Social Vulnerability: All 16 variables. [3]Census tracts with 0 population. [4]The CDC/ATSDR SVI combines percentile rankings of US Census American Community Survey (ACS) 2016-2020 variables, for the state, at the census tract level. [5]Socioeconomic Status: Below 150% Poverty, Unemployed, Housing Costs Burden, No High School Diploma, No Health Insurance. [6]Household Characteristics: Aged 65 and Older, Aged 17 and Younger, Civilian with a Disability, Single-Parent Household, English Language Proficiency. [7]Race/Ethnicity: Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino. [8]Housing Type/Transportation: Multi-Unit Structures, Mobile Homes, Crowding, No Vehicle, Group Quarters.

Projection: New York NAD 1983 UTM Zone 18N, CM shifted to -76.

References: Flanagan, B.E., et al., A Social Vulnerability Index for Disaster Management. *Journal of Homeland Security and Emergency Management*, 2011. 8(1).
CDC/ATSDR SVI web page: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

Four (4) themes and 15 social factors of the SVI for Franklin County:

Overall Vulnerability

Socioeconomic Status	Below Poverty[6]	17.8%
	Unemployed[6]	7.0%
	Income[6]	52,905
	No High School Diploma[6]	13.3%
Household Composition & Disability	Aged 65 or Older[6]	8610
	Aged 18 or Younger[6]	11,130
	People with a Disability[5]	16.4%
	Single-Parent Households[6]	25%
Minority Status & Language	Minority[6]	18.6%
	Speak English "Less than Well" [3]	2%
Housing & Transportation	Multi-Unit Structures[3]	3,179
	Mobile Homes[3]	1928
	Crowding[1]	29.2 per sq mile
	No Vehicle[2]	4.69%
	Group Quarters[3]	3947

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

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

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

Medical Frailty Indicators

NYS Health Commerce System Empower Map Tool 2022

Electricity Dependent	798
Cardiac Device	77
Ventilator	122
BiPap	99
O2 Concentrator	675
Internal Feeding	102
IV Infusion Pump	143
Suction Pump	22
At Home ESRD	22
Motorized Mobility device	77
Electric Bed	143

Franklin County Data

Receive Medicaid[6]	25.9%
Per Capita Medicaid Expenses[6]	N/A

NYSDOH Behavior Risk Surveillance System - BRFSS 2020[3]

Cognitive Disability	7.1%
Hearing Difficulty	4.7%
Self-Care Difficulty	2.5%
Vision Difficulty	2.4%
Mobility Disability	11%
Independent Living Difficulty	7.2%

Emotional Health Frailty Indicators

- Frequent mental distress 8.16%
- Frequent physical distress 8.14%
- Poor Mental Health (14 days or more) 14%
- Percentage of disconnected youth[7] 13.7%

VULNERABILITY PROFILE
FRANKLIN COUNTY
What makes some people especially Vulnerable in Disasters?

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

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

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

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

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

1. Some Senior Citizens[1] 17.7%
2. People with Disabilities[5] 16.4%
   Seniors with Disabilities 33.3%
3. People who are Non-English Speakers[3] N/A
4. People who are Culturally or Geographically Isolated[1]
   30.9 per Square Mile
   4.69% No Vehicle
5. People with Substance Abuse Issues (Residential treatment) N/A
6. People who are Homeless[3] Marginally Housed or Shelter Dependent 24
7. Children (<18) with Disability[7] 7.1%
8. People Living in Poverty[6] 17.8%
   Alice & Poverty Households[6] 8,214
9. Illegal Residents N/A
10. Single-Parent Households[6] 25%
    Grandparents as Parents 1.3%

Data Sources for Vulnerability Profile

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

Abbreviations:

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

Franklin County residents have indicators for what makes people vulnerable.

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

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

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

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

Among the greatest needs zip codes, Hogansburg belongs to the St. Regis Mohawk Tribe. Tribal members receive health care services from St. Regis Mohawk Tribe Health Services. FCPHS provides Early Intervention services, Healthy Family's home visiting and collaborates with Emergency Preparedness activities on the Reservation. FCPHS works with USDA to provide a rabies clinic in Hogansburg.

Alice Hyde Medical Center has health center sites serving the other three greatest need zip codes providing Family Medicine. Adirondack Medical Center maintains a health center in St. Regis Falls.

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

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

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

The geographic size of the county and poor weather in winter with only 29.2 persons per square mile compounded by 4.69% of the Franklin County population having no vehicle illustrates the need for safe reliable transportation in order to access health care services.

Department of Social Services provides transportation to medical appointments. Behavioral Health facilities offer vouchers for transportation or arrange for travel to/from appointments themselves. The county provides door-to-door pick up/ drop off. Transportation needs will continue and contribute to the overall vulnerability of Franklin County residents.

B2b. Policy Environment

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

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

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

The Certified Home Health Care Agency (CHHA) provides skilled nursing and other therapeutic health services to individuals in the

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

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

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

Family Health staff at Franklin County Public Health Services (FCPHS) operationalize Children and Youth with Special Health Care Needs (CYSHCN), Early Intervention, Child Find, and the Maternal Child Health program. The CYSHCN program is a referral/case management program and serves children between the ages of 0 and 21. The Early Intervention Program serves children under the

age of three with identified disabilities or delays. Early Intervention's counterpart program, Child Find, services children under the age of the three who are at risk for developmental delay. Under the Maternal Child Health program, FCPHS is able to offer expecting mothers and new mothers breastfeeding guidance and troubleshooting with our two Certified Lactation Councilors on staff. FCPHS also provides postpartum support by reaching out to all new mothers by telephone offering guidance and education. A postpartum home visit is offered to all mothers and babies born in Franklin County.

The Lead Poisoning Prevention Program provides case management to those children identified with a blood lead level of 5 and above. Lead screening and testing is offered at many community based organizations, such as WIC and JCEO Early/Head Start, along with being offered at FCPHS Weekly Immunization Clinics, currently held every Monday and Wednesday from 10am to 2pm.

Franklin County Early Intervention Program has been unable to provide sufficient therapy services to children in program due to lack of provider capacity. It is anticipated that the municipality will expand current Early Intervention Services to include therapy: Physical Therapy, Occupational Therapy and Speech-Language Pathologists. The long term hope is that the expansion of municipal Early Intervention service provision will decrease the burden on school Special Education programs.

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

- Adopting a Complete Streets policy for all projects.
- Working on Health in All Policies (HiAP) initiative
- Supporting an Employee Wellness Program initiative for Franklin County employees.
- Supporting initiatives to achieve smoke free Franklin County worksites
- Committing funding in county budget to expand transportation projects
- Supporting town/village housing grant applications
- Consolidating county offices in the south end of the county to one site addressing concern for the county north/south differences
- Promoting programming to increase presence and services in the south end of the county

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

B2c. Unique Characteristics

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

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

B3. Summary of Franklin County Health Assets to Address Public Health Issues and Challenges

Franklin County identified its own assets that are available to address the five health priorities described in the 2019-2024 Prevention Agenda. The list summarizes the programs and initiatives within Franklin County that have contributed to addressing each health issue at the local level.

Assets to Prevent Chronic Disease

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

Health Issue	• Franklin County Assets
Cancer	• Merrill Oncology Center • Reddy Cancer Treatment Center • Breast Health Navigator • Various Cancer Screenings • Cancer Services Program of Northeastern NY • Genetic Testing • The Julie Fund & Merrill Oncology Center Travel Fund
Nutrition	• Certified Dieticians Inpatient/Outpatient Consultations • Hunger prevention and Nutrition Assistance Program • Comprehensive School Policies for Physical Activity and Nutrition • Healthy Vending Machine options • Employee Wellness Programs • “Farm to Patient” nutritional services philosophy

Obesity	• Medical and Surgical Bariatric Programs • Breastfeeding Education • Chronic disease prevention and self-management program • Registered diabetes educators • Diabetes self-management educational classes • Decker Learning Center for Health Education • Pediatric Healthy Eating Initiative • Chronic Disease Prevention Coalition • Creating Healthy Schools and Communities
Physical Activity	• Medical Fitness Center • Employee Wellness Events and Challenges • Fit For Life (medically supervised activity) • Cardiac Rehabilitation Program
Tobacco Use Prevention and Control	• Decker Learning Center for Health Education • Registered Tobacco Cessation Specialist • Tobacco cessation tools, programs, and interventions • Tobacco Free Clinton, Essex, Franklin • Health Systems for a Tobacco Free NY • NYS Smokers' Quitline

Assets to Promote a Healthy and Safe Environment

Health Issue	Franklin County Assets
Foodborne Disease	• Bureau of Community Environmental Health and Food Protection (NYSDOH) • NYSDOH Saranac Lake District Office • County Communicable Disease Division • County Immunization Program
Public Water Supply	• NYSDOH Saranac Lake District Office • Franklin County Soil and Water Department • County Communicable Disease Unit
Injuries, Violence and Occupational Health	• Environment of Care Committee • SECURE conflict de-escalation training for staff • Smart Screening forms – pediatric and women's health • Emergency Preparedness Coordinator/Committee • Physical therapy/rehabilitation services • Occupational therapy services • Occupational Health and Wellness • Speech Therapy services • Traffic Safety Board • Stop DWI • Domestic Violence CMTE • Sharps Disposal towns/villages/public • Crisis Intervention
Built Environment	• Franklin County Complete Streets • Lead Poisoning Prevention Programs • Franklin County Highway Department • Franklin County Community Housing Council

Assets to Prevent Communicable Diseases

Health Issue	Franklin County Assets
HIV/AIDS and Sexually Transmitted infections	• Harm Reduction/Syringe Exchange – planned 2023 • HIV/STD/HCV Prevention Services • Regional Prevention and Support Programs • STD Testing and Awareness
Vaccine-preventable disease	• COVID-19 vaccine and boosters • Influenza vaccine clinics • Standard immunizations from birth+ • Pediatric infant vaccine tracking program • Primary Care vaccinations and immunizations
Antimicrobial resistance and healthcare-associated infections	• Antibiotic Stewardship Committee • Infection prevention and education • Infection Control Committee • Quality Assurance/Performance Improvement Committee • Sepsis Committee • Communicable Disease Surveillance in Healthcare & Community • CDC/NYS Roadmap Antibiotic/Antimicrobial Resistance • CDC “One Health”

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

Health Issue	Franklin County Assets
Substance Use	• Overdose Reversal • Medication reconciliation • Secure medication disposal drop-box • Crisis clinicians (staffed in emergency department) • Pain management program • Pain management specialists • Ambulatory pharmacist-led medication review • Case management program • NYS PSYCKES System reporting • Colby Unit-geriatric psychiatric services • St. Joseph's Addiction Treatment and Recovery • Community Services - local services plan • Opioid Stewardship program • Emergency Department Peer Navigator Program • Opioid Overdose Prevention Program • Prevention Task Force & Subcommittees • Crisis Stabilization Unit • Telephone support; "Warm Line" • Addiction Support Services

Assets to Promote Healthy Women, Infants and Children

Health Issue	Franklin County Assets
Maternal and Women's Health	• Pre- and Post-Natal Women's Health Program • Healthy Families Home Visiting Program • Maternal-Child Nurse Home Visiting • Women's Health/OB/GYN Services • Childbirth Classes
Perinatal and Infant Health	• Pediatric Practices • Medicaid Program • Perinatal Program • Child Find • Car seat checks • Childcare safety classes
Child and Adolescent Health	• Child Lead Poisoning Prevention Program • Children with Special Health Care Needs Program • Early Intervention Program/Pre School Program • Birth to 3 Collaborative • Community Intervention Partnership • Child Care Coordinating Council • System of Care

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

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

COMPLEMENTARY HEALTH INITIATIVES IN OUR REGION

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

Below is a summary of county, regional and statewide planning documents, policy agendas, and mission statements from a variety of community sectors that address health-related issues. Links are included to facilitate access to the documents and web sites. The contents are organized by the relevant Prevention Agenda Focus Areas; *Promote Well-Being and Prevent Mental and Substance Use Disorders* and *Prevent Chronic Disease.* The summary does not provide an exhaustive analysis of multi-sector health priorities, but is provided to illustrate the potential for collaborative health improvement efforts in the county and region.

Promote Well-Being and Reduce Mental and Substance Use Disorders

Franklin County Community Services

Welcome to Franklin County, NY (franklincountyny.gov)

Franklin County Community Services manages a system of agencies that provide mental health programs throughout the county.
As a local government unit, or LGU, the department is authorized to receive and distribute mental hygiene funds. The department is governed by New York State Mental Hygiene Law.

Community Services oversees the following services and activities:

- Development of a comprehensive county plan for mental health, developmental disability and chemical dependency services.
- Allocation of funding to local mental hygiene contract agencies based on community priorities, treatment outcomes and program performance.
- Provide fiscal oversight and technical assistance to contract agencies.
- Coordinate services across levels of care and among community providers and other county departments.

Community Connections of Franklin County
https://www.communityconnectionsfc.com/

Mission
Our mission at Community Connections of Franklin County is ensuring overall wellness for those we serve and support with thoughtfulness, empathy and care.

Vision
We, at Community Connections of Franklin County, believe in a society where all individuals have the power to create their own opportunities and successes. Together we will build a healthier, stigma free, trauma aware community.

Programs and Services
Community Oriented Recovery Empowerment
Peer Recovery and Support Services
Barnabas House Male Transitional Shelter
Health Home Care Management
Day By Day Mentoring Program
Ruth House Shelter for Women and Children
Mutual Support Warm Line
Training Programs
School Based Family Support Advocate
Rescued Treasures Thrift Store and Adolescent Work Training Program
First Step to New Beginnings Non-Residential Domestic Violence Services
Clinton County Transitional Dormitory Housing Program

Alliance for Positive Health
https://www.allianceforpositivehealth.org

Program Services
The Alliance for Positive Health provides a continuum of direct services to people living with or impacted by HIV/AIDS or other chronic illnesses.

Care/Case Management
The Alliance for Positive Health offers care/case management for those living with HIV/AIDS or other chronic illnesses and need assistance to regularly access medical and support services. Care/case managers assess an individual's needs to assist with obtaining and engaging in medical care, and provide referrals to services. Care managers are trained to address the unique challenges of those we serve including LGBT individuals, rural communities, families, women, and people living in poverty.

Criminal Justice Services (CJS)
The Alliance for Positive Health's Criminal Justice Services (CJS) focus on providing resources and services to incarcerated individuals in designated New York State Correctional Facilities. With the goal of preventing new HIV and Hepatitis C infections, CJS staff members educate incarcerated individuals on how to maintain a healthy lifestyle and offer referrals to reentry services throughout New York State. CJS Linkage Specialists provide linkage and navigation services to incarcerated individuals living with HIV and/or Hepatitis C to ensure and support linkage to medical care and other needed services with the goals of viral suppression, access to treatment and increased health literacy.

Education & Support Groups

The Alliance for Positive Health offers a diverse selection of education and support groups. Enrollment is free and group discussions remain confidential.

Food4Life*

Food4Life is a nutrition education program for HIV+ individuals that enables them to practice maintaining a healthy diet, learn to cook meals appropriate for their health needs, shop for food on a budget and link to community food resources. Participants receive a nutritional assessment, set dietary goals and receive food pantry bags, food vouchers and incentives based on their level of need.
For HIV+ individuals only.

Harm Reduction Services

Opioid abuse is on the rise throughout New York State, bringing with it HIV and HCV transmission, and death by overdose. To curve these trends, the Alliance for Positive Health started a Syringe Exchange Program, Project Exchange. Established in June 2015, Project Exchange provides new sterile syringes and other injection supplies, safe disposal of used syringes, and opioid overdose prevention.

Health Insurance Access Program (HIAP)

The Health Insurance Access Program (HIAP) assists individuals with enrollment into comprehensive health insurance plans, including Medicare, Medicaid, and the New York State of Health Marketplace. We also have specialists who assist HIV+ individuals to access specific insurance programs to assist with costly medical care and prescriptions, and our PrEP specialist is trained to assist with the various insurance options to pay for PrEP. Our Outreach Specialists or Health Navigators help individuals to assess their insurance needs and enroll in appropriate networks.

HIV, STI, & Hep C Testing

The Alliance for Positive Health provides a robust continuum of community-based free, confidential HIV, STI and HCV testing for those who are at high risk and do not access testing from their medical provider. We utilize rapid HIV, HCV and syphilis screens with preliminary results during the test counseling session. We confirm reactive results with testing through blood draws with results in a few days. We also provide urine screening as well as throat and rectal swabs for chlamydia and gonorrhea with results in a few days. During test counseling sessions, staff assist clients to assess their risk, decide which testing is needed, and develop risk reduction plans to reduce becoming infected or transmitting infections to others if results are positive. Individuals also have the opportunity to learn about or get immediately linked to other Alliance for Positive Health services if other needs are identified through this discussion.

Housing Retention Services*

Having housing is crucial to getting and staying healthy. We provide a variety of services to help people with HIV who are homeless, at risk of being homeless, or unstably housed maintain safe and affordable housing, while also preventing eviction and utility shut off. Housing Retention Specialists assist individuals establish and maintain housing stability and develop the skills necessary to remain in stable housing and live independently, thus increasing positive health outcomes.

For HIV+ individuals only.

LGBTQ+ Health

Alliance for Positive Health is a comprehensive health resource for our region's LGBT+ community. Our LGBT+ Health programs address multiple factors that impact an individual's well-being including stigma, access to LGBT+ friendly resources, communication with partners and providers, and sexual health.

Link2Care

Link2Care helps individuals with or at risk for HIV and Hepatitis C get and stay in medical care, access PrEP, address barriers, and navigate complex systems in order to access health and support services. Link2Care uses a team approach with Peer Navigators who are reflective of the target population and staff to increase access to services.

Peer Navigation

The Alliance for Positive Health's Peer Workforce program provides services designed to help address clients' internal and external barriers to achieving positive health outcomes by offering guidance, encouragement and hope from team members whose role it is to share their own lived experience with clients.

PrEP

PrEP (pre-exposure prophylaxis) is a way that HIV negative individuals can greatly reduce the risk of HIV infection by taking daily anti-retroviral medications. The Alliance for Positive Health's Project HOPE has a PrEP Assistance Program for those seeking more information and access to PrEP.

Ryan White Medical Transportation*

White Medical Transportation is for people living with HIV/AIDS who need help with transportation to get to medical and other services that help them maintain their health. Transportation assistance may be in the form of taxi.

For HIV+ individuals only.

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

Prevent Chronic Disease

NYS Office for the Aging State Plan 2019-2023

https://aging.ny.gov/system/files/documents/2019/10/state_plan_2019-2023_070119_final2com.pdf#:~:text=The%202019%2D2023%20New%20York,to%20measure%20effectiveness%20and%20efficacy.

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

North Country Healthy Heart Network
https://heartnetwork.org/projects/

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

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

The current projects include Creating Healthy Schools and Communities, the North Country Chronic Disease Prevention Coalition, and Healthy Systems for a Tobacco Free New York.

Joint Council for Economic Opportunity of Clinton and Franklin Counties, Inc. (JCEO)
https://www.jceo.org/home

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

Complete Streets
Complete Streets (ny.gov)

The Complete Streets Act was signed into law on August 15, 2011 and requires state, county and local agencies to consider the convenience and mobility of all users when developing transportation projects that receive state and federal funding. The New York State Department of Transportation (NYSDOT) is working to ensure that its policies and procedures meet the new standards. The initiative presents an opportunity to expand upon existing programs and collaborate with bicyclists, pedestrians, people with disabilities and others to identify best practices and designs for transportation facilities.

Strengthening NYSDOT's Complete Streets efforts requires both internal evaluation and ideas from everyone who uses and relies upon the transportation system - individuals, organizations and even entire communities. We encourage you to provide your comments about Complete Streets in New York State at completestreets@dot.ny.gov

Cornell Cooperative Extension Franklin County
https://franklin.cce.cornell.edu/about-us

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

of individuals, families, businesses, and communities throughout Franklin County.

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

Mission
Educate. Engage. Empower. We work with communities to create healthier places to live, work, and play. We are dedicated to reducing youth tobacco use rates.

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

Promote Healthy Women, Infants and Children

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

The Adirondack Birth to Three Alliance's core activities include:

- Building awareness of the five building blocks of successful development: universal nurse home visiting; family resource centers; comprehensive home visiting services for vulnerable families; high-quality early childhood education; and high-quality comprehensive health care.
- Advocating for policies and programs that enhance the education, care, and nutrition children receive by working directly with officials elected and decision makers.
- Offering information training and professional development opportunities to early childhood educators and providers.

Catholic Charities of Franklin County
http://www.cathcharities.org

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

New York State Early Childhood Advisory Council
www.nysecac.org

The NYS Early Childhood Advisory Council (ECAC) identifies six levers for change as critical for strengthening the early childhood system and providing an infrastructure to support the grounding of this work in social justice, removing barriers to access services, and facilitating equitable child outcomes.

The levers are:
1) Family Engagement
2) Data
3) Quality Improvement and Assurance
4) Workforce Development
5) Finances
6) Research and Evaluation

With the young child and family as the focus these levers guide the work of the ECAC across four essential elements 1) Providers and Practitioners; 2) Comprehensive Health, Community, and Education Services; 3) Standards, Regulations and Statutes; and, 4) Policy and Governance. These levers and elements are intertwined and their alignment is necessary in order to support families' access to the

equitable, comprehensive, and culturally relevant services, thereby ensuring healthy development.

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

Promote a Healthy and Safe Environment

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

COMMUNITY HEALTH ASSESSMENT PROCESS AND METHODS

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

In January of 2022, the Adirondack Rural Health Network (ARHN) conducted a survey of selected stakeholders representing health care and service-providing agencies within a seven-county region. The results of the survey are intended to provide an overview of regional needs and priorities, to inform future planning and the development of a regional health care agenda. The survey results were presented at both the county and regional levels.

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

C. Community Health Improvement Plan/ Community Service Plan

C1. Community Engagement Stakeholder Survey

Background

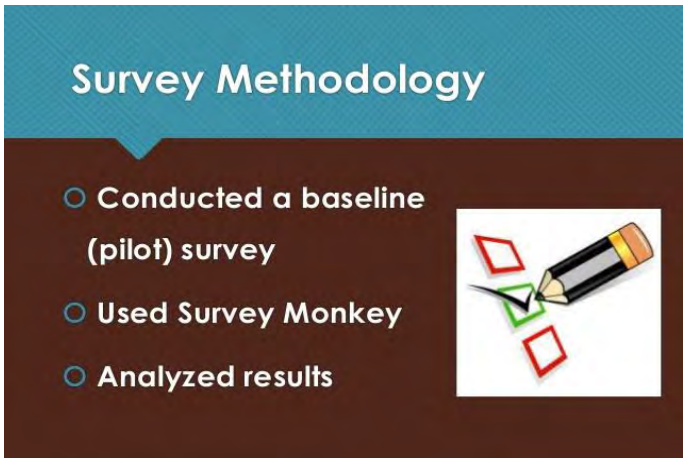
Adirondack Rural Health Network: The Adirondack Rural Health Network (ARHN) is a program of AHI - Adirondack Health Institute, Inc. Established in 1992 through a New York State Department of Health Rural Health Development Grant, ARHN is a multi-stakeholder, regional coalition that informs planning,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

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

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

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

CHA Committee, Ad Hoc Data Sub-Committee: At the June 4, 2021, CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.
The data subcommittee met four times from mid-July through mid-November 2021. Meetings were held via Webex/Zoom. Attendance ranged from 6 to 10 subcommittee members per meeting. Meetings were also attended by AHI staff from the Adirondack Rural Health Network.



Survey Methodology

Survey Creation: The 2022 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at the November 10, 2021, meeting.

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

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 806 community stakeholders.

An initial email was sent to the community stakeholders in early January 2022 by the CHA Committee partners, introducing and providing a web-based link to the survey. CHA Committee partners released a follow-up email approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

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

Survey Responses and Analysis: A total of 263 responses were received through March 1, 2022, for a total response rate of 32.63%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. It took respondents an average of 20 minutes to complete the survey, with a median response time of approximately 16 minutes. Community stakeholder survey respondents were asked which county their organization/agency serves. 62 of the respondents were from Franklin County.

Top priority areas for Franklin County

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

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

Top five health concerns affecting the residents of Franklin County

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

Franklin County survey respondents recognized **mental health conditions, substance use/alcoholism/opioid use, diabetes, child/adolescent emotional health, and disability** as their top 5 health concerns.

Contributing Factors for Franklin County:

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

Franklin County survey respondents identified **addiction to alcohol/illicit drugs, poverty, lack of mental health services, changing family structures, and poor eating/dietary practices** as the contributing factors to the health concerns they chose.

Priority Selection

SELECTION BASIS AND METHOD

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

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

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

- Kathleen Farrell Strack, FCPHS
- Sarah Granquist, FCPHS
- Matt Scollin, AH
- Lisa Tuggle, AH
- Annette Marshall, UVMHN-AHMC

Process

The subcommittee listed above representing the public health department and hospitals convened on 11/15/2022 to finalize Priority Area and Focus Area selection. Members of the subcommittee noted the consistency in findings from the stakeholder survey and data analysis. Therefore, ***Promote Well-Being & Prevent Mental and Substance Use Disorders*** and ***Prevent Chronic Disease*** were accepted as selected Priority Areas for Franklin County.

Action Plans:

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

2022-2024 PRIORITIES AND GOALS

County/Service Area Priorities and Disparities

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

Focus Areas

- Promote Well-Being
- Mental and Substance Use Disorders Prevention

Priority 2— Prevent Chronic Disease

Focus Areas

- Healthy Eating and Food Security
- Physical Activity
- Tobacco Prevention
- Prevention and Care Management

Disparities Addressed

Access; Care Coordination; Poverty/Income level; Education; Disability; Health Equity; Built Environment

ADIRONDACK HEALTH

Better Health, Better Lives

Priority Area 1: Promote Well-Being and Prevent Mental and Substance Use Disorders
Focus Area 2: Mental and Substance Use Disorders Prevention
Goal Prevent opioid and other substance misuse and deaths.
Objective 1. Safe disposal receptacles located in Adirondack Health's primary care health centers in St. Regis Falls, Lake Placid, Tupper Lake, and Keene. There is already a safe disposal receptacle located in the main lobby of Adirondack Medical Center.
Interventions 2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days
By December 2023, we will have completed… Installation of safe disposal receptacles in at least two of four Adirondack Health primary care health centers.
Partner Role(s) and Resources Health system grantee will provide support on policy implementation as the lead for this intervention. Franklin and Essex county health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the counties, and connect to healthcare resources.
Disparities Addressed All

Priority Area 2: Prevent Chronic Disease
Focus Area: Tobacco Prevention
Goal Promote tobacco use cessation
Objective Increase the percentage of smokers who received assistance from their healthcare providers to quit smoking by 5%.
Intervention Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline.
By December 2023, we will have completed… 1. Provide guidance and education to health center-based primary care providers. 2. Participate in marketing outreach. 3. Monitor patients via quality dashboard.
Partner Role(s) and Resources Health system grantee will provide support on policy implementation and the development of standards of care as the lead for this intervention. Franklin and Essex county health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the counties, and connect to healthcare resources.
Disparities addressed Income, Access, Disability

Priority Area 2: **Prevent Chronic Disease**
Focus Area: Prevention and Care Management
Goal Increase cancer screening rates
Objective Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50-75 years old) by 5%.
Interventions Systems change for cancer screening reminders
By December 2023, we will have completed… 1. Review current practice for reliability and timeliness to ensure reminders are being sent by all providers. 2. Continue to track patient reminders. 3. Monitor patients via quality dashboard.
Partner Role(s) and Resources Health system grantee will partner and support this intervention. Franklin and Essex county health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital staff attuned to health disparities in the county, and connect to healthcare resources.
Disparities addressed Income, Access, Disability

THE

University of Vermont

HEALTH NETWORK

Alice Hyde Medical Center

PRIORITY AREA 1: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS
Focus Area 1: Promote Well-Being
Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan. 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages.
Objective 1.1.2 Reduce the age-adjusted percentage of adult New Yorkers reporting frequent mental distress during the past month by 10% to no more than 10.7%. Baseline 11.9%
Intervention 1.1.3 Create and sustain inclusive, healthy public spaces: Ensure space for physical activity, food access, sleep; civic and community engagement across the lifespan 1.1.5 Enable resilience for people living with chronic illness: Strengthening protective factors include independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety. 1.2.3 Policy and Program interventions that promote inclusion, integration and competence.
Activities • The Alice Center Walkway and Beatification Project: Develop accessible and multi-purpose use outdoor facility space for residents and families enjoyment, including a paved wheelchair accessible walkway, Generations' Park, areas for dining, gardens and activities to promote health and mental well-being for residents of our Long-term care facility and their families. • Chronic Disease Self-Management Program focusing on CHF, COPD, and Diabetes, to increase patient chronic disease knowledge, self-management skills, and reduce readmissions. • Investigate and implement community partnerships for expanded Primary Care offerings in the Malone community to improve access to care. • In partnership with Community Connections of Franklin County, continue the ED Peer Navigator Program implemented in the Alice Hyde Emergency Department to provide access to and coordination of community based resources for patients frequenting the ED, who need additional community based services to manage their health and well-being. • Achieve Geriatric Emergency Department (GEDA) accreditation in 2022 to support the needs of our aging population. • Implement the Northern NY Regional Transportation Hub located in Malone, NY, to ensure appropriate care coordination and transportation avenues for patients to the appropriate level of care within the UVM Health Network and North Country Region. (Care Coordination System/NY Region). • Develop and plan for an enhanced/modernized/reimagined hospital campus through NYS Transformation IV Grant funding. • Develop a Community Health Liaison Committee comprised of various constituents in the community to investigate, discuss and educate on community health needs, community health offerings, and opportunities for improved care delivery. • Acquisition of a Simulator Mannequin (to support Adult Care and OB-GYN Care training), and development of a Sim-Lab open to North Country regional partners, to promote education/training, and high level competency in patient emergency care for providers and staff at Alice Hyde Medical Center and various levels of health care providers in the greater North Country region.
Resources AHMC primary care; Citizen Advocates, Inc.; Hudson Headwaters Health Network; Community Health Center of the North Country, UVMHN; Community Connections of Franklin County.
Disparity Addressed Access; Care Coordination; Poverty/Income level; Health Equity

PRIORITY AREA 1: PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS
Focus Area 2: Mental and Substance Use Disorder Prevention
Goal 2.2 Prevent opioid and other substance misuse and deaths 2.4 Reduce the prevalence of major depressive disorders. 2.6 Reduce the mortality gap between those living with serious mental illness and the general population.
Objectives 2.2.1 Reduce the age-adjusted overdose deaths involving any opioid by 7% to 14.3 per 100,000 population 2.2.3 Reduce the opioid analgesics prescription for pain, age-adjusted rate by 5% to 347 per 1,000 population 2.2.4 Reduce all emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate by 5% to 53.3 per 100,000 population
Interventions 2.2.4 Build support systems to care for opioid users or at risk of an overdose 2.2.6 Integrate trauma informed approaches in training staff and implementing program and policy 2.4.2 Strengthening resources for families and caregivers
Activities • Continued coordination/collaboration between AHMC ED and the Citizen Advocates' Crisis Intervention Center to ensure patients presenting to the AHMC ED receive the appropriate level of care. • Creation of fully trained AHMC CISM Team (Critical Incident Stress Management Team) in 2022 to support staff, patients and families experiencing crisis events. • Utilize the expertise of the UVMHN Communications and Engagement Strategies Team to educate providers, staff and the broader community on Mental and Substance Use Disorders and Prevention/early intervention strategies.
Resources AHMC Primary Care; Citizen Advocates, Inc.; UVMHN Communications and Engagement Strategies Team (Marketing and Communications); AHMC Clinical Education.
Disparity Addressed Access; Care Coordination; Poverty/Income level; Education

PRIORITY AREA 2: PREVENT CHRONIC DISEASE
Focus Area 1: Healthy Eating and Food Security *Overarching Goal: Reduce Obesity and the risk of chronic diseases*
Goals 1.1 Increase Access to healthy and affordable foods and beverages 1.2 Increase skills and knowledge to support healthy food and beverage choices
Objectives 1.4 Decrease the percentage of adults ages 18 years and older with obesity (among all adults) 1.9 Decrease the percentage of adults who consume less than one fruit and less than one vegetable per day (among all adults)
Intervention 1.0.3 Worksite nutrition and physical activity programs designed to improve health behaviors and results. Local health departments, hospitals, health centers, businesses, CBOs and other stakeholders can implement wellness programs at their own worksite and work with local worksites to implement nutrition and physical activity interventions as part of a comprehensive worksite wellness program.
Activities • Establishment and Continued Enhancement of Employee Wellness Committee (EWC) to Promote Health and Well-Being for all employees. • Collaborate with JCEO for onsite Mobile Food Market providing access to healthy fruits and vegetables weekly during the growing season. • Partner with local orchard for onsite access to local apples, honey, and other naturally grown products for ease of access • Utilize the expertise of the UMVHN Communication and Engagement Strategies to create and promote media pieces spotlighting and educating staff, patients and the community about the health benefits associated with healthy eating.
Resources AHMC Wellness Committee; local community organizations; UVMHN Community and Engagement Strategies
Disparity Addressed Access; Education

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

PRIORITY AREA: PREVENT CHRONIC DISEASE
Focus Area 3: Tobacco Prevention
Goal 3.2 Promote tobacco use cessation
Objectives 3.2.1 Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%. 3.2.2 Decrease the prevalence of cigarette smoking by adults ages 18 years and older (among all adults) 3.2.8 Increase the utilization of smoking cessation benefits (counseling and/or medications) among smokers who are enrolled in any Medicaid* program
Interventions 3.2.1 Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers, Community Health Centers and behavioral health providers. 3.2.2 Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline 3.2.3 Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment.
Activities • Implement workflow to ensure all primary care patients are screened and tracked for tobacco use (all forms) and referred for intervention services. • Utilize the expertise of AHMC Communications and Engagement Strategies Division to create content to promote and educate smokers about the benefits of evidence-based quitting approaches, including annual promotion of the national Great American Smokeout Initiative. • Work with primary care leadership and providers to promote the delivery of evidence-based cessation services by health care providers to patients, including access to certified tobacco cessation specialists as needed and also collaborate with North Country Healthy Heart Network to create and provide education opportunities and tobacco cessation intervention materials for health care providers and patients.
Resources: AHMC Primary Care Practice; AHMC Wellness Committee; UVMHN Communications and Engagement Strategies (Marketing and Communications); Adirondacks ACO; North Country Healthy Heart Network.
Disparity Addressed : Access; Education

PRIORITY AREA: PREVENT CHRONIC DISEASE
Focus Area 4: Chronic Disease Preventive Care and Management
Goals 4.1 Increase Cancer Screening Rates 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.
Objectives 4.1.3 Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50 to 75 years) 4.2.1 Increase the percentage of adults 45+ who had a test for high blood sugar or diabetes within the past three years by 5% 4.3.4 Increase the percentage of adult members who had hypertension whose blood pressure was adequately controlled during the measurement year
Interventions 4.1.1 Work with health care providers/clinics to put systems in place for patient and provider screening reminders (e.g., letter, postcards, emails, recorded phone messages, electronic health records [EHR] alerts). 4.3.3 Promote the use of Health Information Technology for: Measurement, Registry Development, Patient Alerts, Bi-Directional Referrals, Reporting 4.4.2 Expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone.
Activities • Continue to optimize the Epic EMR system to enhance patient care delivery, measurement and reporting. • Utilize the EPIC EMR Reminder System in primary care to ensure completion of annual patient screenings, including management of patient alerts and reminders. • Implement cancer screening partnership opportunities including education for providers. • Continue to deliver the Chronic Disease Self-Management program to existing patients (inpatients as identified) to educate patients on best practice strategies for managing their chronic condition specifically with the focus on CHF, COPD and diabetes, with the goal of reducing avoidable readmissions and improving the health of our patient population living with chronic disease.
Resources: AHMC Primary Care Practice; Reddy Cancer Treatment Center; Marketing and Communications; North Country Healthy Heart Network/Chronic Disease Prevention Coalition
Disparity Addressed Access; Income, Education

Franklin County
Community Health Improvement Plan

Priority: Promote Well Being and Prevent Mental and Substance Use Disorders	
Focus Area 1 – Promote Well Being	
Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan	
Objective 1.1.2: By December 31, 2024, reduce the age-adjusted percentage of adult New Yorkers reporting frequent mental distress during the past month by 10% from 14% to 12.6%.	
Key Actions: • Promote staff training opportunities on early detection of Behavioral Health needs across the lifespan • Promote participation in County EAP Wellness Program activities • Conduct food security screenings for home care patients in the greatest need zip codes. • Provide Public Health Messaging on physical, emotional health services offered in the county • Increase overdose reversal capacity opportunities • Promote overdose reversal training by partners • Seek opportunities for Maternal Child Health program enhancements	**Anticipated Impact** • Improved staff early detection of behavioral health needs • Improved county employee well being • Increased utilization of behavioral and health prevention services • Increase number of people able to reverse opioid overdose. • Increased access to number of people without provider or health insurance accessing primary health services and substance use care • Increased knowledge and awareness of behavioral health services, maternal depression, Adverse Childhood Experiences (ACEs).
Disparity: Access, Education	

Priority AREA: Prevent Chronic Disease	
Focus Area 1 – Healthy Eating and Food Security	
Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices.	
Objective 1.4 By December 31, 2024, decrease the % of adults ages 18 years and older with obesity (among all adults) by 5% from 44.4% to 42.2%?	
Key Actions: • Increase the availability of healthy food through collaboration with community-based organizations • Develop and provide public health messaging to educate residents on nutritional value of food • Institute a Franklin County Employee Wellness Program • Strengthen systems within the county that support community capacity building	**Anticipated Impact** • Increased number of people with knowledge of nutritional value of food • Increased agency staff knowledge of food security community wealth building and well being • Increased agency staff ability to advocate for the needs of the community
Disparity: Access, Education	

Priority AREA: Prevent Chronic Disease	
Focus Area 2 – Physical Activity	
Goal 2.2: Promote school, child care and worksite environments that increase physical activity.	
Objective 1.7: By December 31, 2024, increase the % of adults age 18 and older who participate in leisure-time physical activity by 5% from 76.2% to 80%.	
Key Actions: • Develop and implement county employee Wellness Committee wellness activities • Support implementation of county Complete Streets Policy • Promote safe and more connected communities that prevent injury (designing safer environments fostering economic growth) and provide safe shared spaces for county residents to interact.	**Anticipated Impact** • Increased number of programs that promote physical activity and healthy eating • Increased ability of multisector body to leverage existing resources across systems • Increase number of individuals trained on assessing health impact in community planning and development • Increased access to safe public spaces and environments
Disparity: Built Environment, Education	

C3. Maintaining Engagement and Tracking Progress

The multi-county, regional CHA Committee, coordinated by ARHN, will meet every three months throughout the 2022-2024 cycle. The committee convenes to support regional ongoing health planning and assessment, working collaboratively on interventions and sharing promising evidence-based programing.

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

C4. Dissemination of Plan to Public

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

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APPENDIX

A: CHA Committee 2022 Data Methodology

B: Source Information for 2022 CHA Data Analysis

C: NYS Data Resources

D: 2022 CHA Data Profiles

E. 2022 Stakeholder Survey Summary Report

F. 3-4-50 Data

G. ALICE National COVID Report

H. Franklin County SOC Needs Assessment 2021

I. Community Services Goals and Plans Document

J. 2021-2022 Meeting Dates for CHA and Public Health/Hospitals

Community Health Assessment Committee
2022 Data Methodology

Background:

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

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

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

Demographic Profile:

Demographic data was primarily taken from the United States Census Bureau 2020 American Consumer Survey 5-year estimates. Additional sources include 1) 2010 Census Estimate: Census Quick Stats 2) USDA Farm Overview, 2017 and 3) Centers for Medicaid and Medicare Services, 2019. Information included in the demographic profile includes square mileage, population, family status, poverty, immigrant status, housing,

vehicle accessibility education, and employment status/sector.

Health System Profile:

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

Most health systems data is sourced from New York State. Data used from NYS DOH includes health profiles, weekly nursing home bed census counts, and the adult care facility directory. NYS Education Department (NYSED) sourced licensure data.

Education Profile:

The Education Profile is separated into two parts: 1) Education System Information and 2) School Districts by County. Part One of the Education Profile includes data related to the education system in the ARHN, NYS, and upstate NY region. Metric data includes student enrollment, student to teacher ratios, English proficiency rates, free lunch eligibility rates, as well as high school graduate statistics. Data was sourced from the NYSED and the National Center for Education Statistics (NCES). Part two of the Education Profile provides detail on the school district count by county. School district data was sourced from the NCES.

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

ALICE profile data includes total households, ALICE households over 65 years, ALICE households by race/ethnicity, poverty/ALICE percentages within each county, unemployment rates, percent of residents with health insurance, and median household income. All ALICE data is reflective of 2018 figures.

Data presented in the ALICE profile originated from the 2018 ALICE report (www.unitedforalice.org/new-york). Within the ALICE report, data was pulled from the 2018 American Community Survey, 2018 ALICE Threshold and ALICE county demographics.

Data Sheets:

The data sheets, compiled of 222 data indicators, provides an overview of population health as compared to the ARHN region, Upstate New York region, Prevention Agenda Benchmark and/or NYS. Within each data report, there is a benchmark comparison that indicates whether a data

indicator's performance met, was better, or worse than the corresponding benchmark. If a data indicator was worse than the corresponding benchmark, the distance from the respective benchmark was calculated using quartile rankings:

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

Quartile Score example: *Asthma Emergency Department Visit Rate per 10,000 – aged 65+ years, 2017-2019 for Clinton County*

Clinton County rate: 20.7 Upstate NY: 14.8
20.7/14.8 = 1.39

The Clinton County rate is higher than Upstate NY, making it worse than the benchmark. As .39 falls between .25 and .5, this falls under Quartile 2.

The data report also shows the percentage of total indicators that have worse performance than the respective benchmark by focus area:

- If 20 of 33 child health focus area indicators were worse than the respective benchmark, the quartile summary score would be 61% (20/33).
- Additionally, the report identifies a severity score (the percentage of "worse" performance indicators that are in either quartile three or four). Following the above example, if nine of the twenty child health focus indicators, which are worse than the respective benchmark, land in quartile three or four, the severity score would be 45% (9/20).

Quartile summary scores and severity scores are calculated for each focus area within the data sheets. Both quartile summary scores and severity

scores are used to gauge if a specific focus area offers challenges to a county and/or regional hospital(s). In certain instances, a focus area could have a low severity score but high quartile summary score which would indicate that while not especially severe, the focus area offered significant challenges to the community.

ARHN region and Upstate NY calculations:

ARHN rate calculation example: *All cancer incidence rate per 100,000, 2016-2018*

$$\frac{\text{Total for North Country region + Total for Fulton County}}{\text{(Average Population for North Country region + Average Population for Fulton County) x 3}} \times 100{,}000$$

**For all Prevention Agenda, Community Health Indicator Reports, Asthma Dashboard, and any other NYS dashboard indicators, the North Country region includes Clinton, Essex, Franklin, Hamilton, Warren, and Washington counties.*

Upstate NY rate calculation example: *All cancer incidence rate per 100,000, 2016-2018*

$$\frac{\text{Total for New York State - Total for New York City region}}{\text{(Average Population for New York State – Average for New York City region) x 3}} \times 100{,}000$$

**For all Prevention Agenda, Community Health Indicator Reports, Asthma Dashboard, and any other NYS dashboard indicators, the New York City region includes the five boroughs of NYC.*

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

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

- Prevention Agenda Dashboard
- Community Health Indicator Reports (CHIRs)
- NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators
- Division of Criminal Justice Services Index, Property, and Firearm Rates
- NYS Traffic Safety Statistical Repository
- USDA Food Environment Atlas
- Student Weight Status Category Reporting System (SWSCRS) Data
- USDA Economic Research Service Fitness Facilities Data
- NYS Department of Health Tobacco Enforcement Compliance Results
- State and County Indicators for Tracking Public Health Priority Areas
- NYS Department of Health, Asthma Dashboard
- NYS Department of Health Hospital Report on Hospital Acquired Infections
- Department of Health, Wadsworth Center

AHI Source Information for 2022 CHA Data Analysis

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

- ALICE Threshold, 2018
- American Community Survey, 2018
- Centers for Medicaid and Medicare Services, Medicaid Per Capita Expenditures Overview, 2019
- National Center for Education Statistics, 2020-2021
- National Center for Education Statistics, public school district data for the 2019-2020, 2020-2021 school years
- NYS County Health Rankings, 2018
- NYS Department of Health, Adult Care Facility Directory, 2022
- NYS Department of Health, Nursing Home Weekly Bed Census, 2022
- NYS Department of Health, NYS Health Profiles
- NYS Education Department, License Statistics, 2021
- NYS Education Department; 3-8 ELA Assessment Database 2019-2020
- NYS Education Department; Report Card Database, 2019-2020, 2020-2021
- United for ALICE, 2018
- US Census Bureau, 2020 American Community Survey 5-year Estimates
- US Census Bureau, Quick Facts, 2010
- US Department of Agriculture, Farm Overview, 2017

2022 CHA Data Sheets and Written Analysis Data Sources:

- Community Health Indicator Reports (CHIRs)
- Department of Health, Wadsworth Center
- Division of Criminal Justice Services Index, Property, and Firearm Rates

- NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators
- NYS Department of Health Hospital Report on Hospital Acquired Infections
- NYS Department of Health Tobacco Enforcement Compliance Results
- NYS Department of Health, Asthma Dashboard
- NYS Traffic Safety Statistical Repository
- Prevention Agenda Dashboard
- State and County Indicators for Tracking Public Health Priority Areas
- Student Weight Status Category Reporting System (SWSCRS) Data
- USDA Economic Research Service Fitness Facilities Data
- USDA Food Environment Atlas

Appendix C – NYS Data Resources

Sources for Evidence Based Interventions

The Prevention Agenda
Prevention Agenda 2019-2024: New York State's Health Improvement Plan (ny.gov)

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

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

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

Substance Abuse and Mental Health Services Administration

National Registry of Evidence-based Programs and Practices
https://www.samhsa.gov/nrepp?_sm_au_=iHVVZpZ0Q8L1rspF

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

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

The Health Across All Policies/Age-Friendly NY (AAAP/AFNY/Roadmaps)
roadmap_report.pdf (ny.gov)

Data resources:

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

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

Community Health Indicator Reports
This site links the previous Community Health Data Set (CHDS) and Community Health Assessment Indicators (CHAI), with nearly 300 health-related indicators available. State and county trend data are available for most indicators. The top part of this site allows the user

to access indicator data for all counties in the state by health topic areas. The bottom part of this site provides access to individual county profiles of these health topic areas with direct links to county historical (trend) data.

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

New York State 2021 Health Equity Reports (ny.gov)
The New York State 2017 Health Equity Reports present data on health outcomes, demographics, and other community characteristics for select cities and towns with a 40% or greater non-White population throughout New York State. Each town or city specific report contains data associated with the priority areas of the Prevention Agenda, as well as social determinant indicators such as housing, educational attainment and insurance coverage.

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

Additional resources can be found at:
Data Sources for Prevention Agenda 2019-2024
Community Assessment, Planning and Implementation
(ny.gov)

https://ahihealth.org/healthyadk/

Franklin, New York | County Health Rankings & Roadmaps

Appendix

Appendix D: 2022 CHA Data Profiles

Appendix E: 2022 Stakeholder Survey Summary Report

Appendix F: 3-4-50 Data
ALICE National COVID Report

Appendix G: Franklin County SOC Needs Assessment 2021
2023 Goals and Plans Document

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS*	New York City	New York State
Summary of Demographic Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington				
Square Miles [1,2]													
Total Square Miles	1,037.9	1,794.2	1,629.1	495.5	1,717.4	403.0	810.0	867.0	831.2	8,372.2	46,823.75	302.65	47,126.4
Total Square Miles for Farms	252.5	90.0	219.9	34.7	1.5	179.7	111.9	15.8	289.5	903.8	10,727.98	0.42	10,728.40
Percent of Total Square Miles Farms	24.3%	5.0%	13.5%	7.0%	0.1%	44.6%	13.8%	1.8%	34.8%	10.8%	0.23	0.1%	22.8%
Population per Square Mile	77.4	20.8	30.9	107.9	2.6	122.3	283.1	74.0	73.4	41.9	237.8	27687.3	414.1
Population [3]													
Total Population	80,320	37,281	50,389	53,452	4,454	49,294	229,313	64,187	61,034	351,117	11,135,297	8,379,552	19,514,849
Percent White, Non-Hispanic	90.4%	93.0%	82.3%	93.0%	94.9%	86.5%	92.1%	95.5%	92.6%	87.9%	79.8%	41.4%	62.3%
Percent Black, Non-Hispanic	4.2%	3.2%	5.6%	1.9%	0.5%	2.8%	1.7%	1.1%	3.0%	3.0%	10.1%	23.8%	15.4%
Percent Hispanic/Latino	2.9%	3.1%	3.6%	3.4%	1.7%	14.7%	3.3%	2.7%	2.8%	2.9%	13.0%	28.8%	19.1%
Percent Asian/Pacific Islander, Non-Hispanic	1.2%	0.4%	1.2%	0.8%	0.0%	0.7%	2.9%	0.9%	0.6%	0.8%	4.9%	14.3%	8.6%
Percent Alaskan Native/American Indian	0.2%	0.2%	6.2%	0.4%	0.0%	0.2%	0.2%	0.2%	0.3%	1.1%	0.4%	0.4%	0.4%
Percent Multi-Race/Other	2.2%	1.9%	2.4%	3.3%	3.9%	3.8%	2.6%	2.0%	2.6%	2.3%	4.3%	5.6%	4.7%
Number Ages 0-4	3,775	1,506	2,405	2,750	135	3,114	11,481	2,829	2,868	16,268	605,910	534,759	1,140,669
Number Ages 5-14	8,142	3,260	5,622	6,104	342	6,147	25,765	6,635	6,625	36,730	1,302,649	934,646	2,237,295
Number Ages 15-17	2,502	1,229	1,721	1,943	123	2,048	8,525	2,176	2,042	11,736	425,114	268,064	693,178
Number Ages 18-64	52,359	22,537	25,071	32,223	2,481	28,798	141,996	38,228	37,864	210,763	6,832,435	5,389,570	12,222,005
Number Ages 65+	13,542	8,749	8,610	10,432	1,373	9,187	41,546	14,319	11,905	68,930	1,969,189	1,252,513	3,221,702
Number Ages 15-44 Female	15,026	5,401	7,825	9,016	526	8,702	40,725	10,485	9,787	58,066	579,669	3,317,146	3,896,815
Family Status [3]													
Number of Households	31,557	16,182	18,880	22,406	1,416	19,621	95,898	29,034	24,054	143,529	4,222,533	3,191,691	7,414,224
Percent Families Single Parent Households	9.8%	10.5%	10.0%	11.9%	N/A	11.4%	8.6%	11.8%	11.8%	11.0%	N/A	6.2%	7.3%
Percent Households with Grandparents as Parents	9.1%	24.8%	9.0%	12.8%	3.6%	8.6%	19.8%	14.1%	7.2%	11.5%	7.2%	18.9%	18.2%
Poverty [3,4]													
Mean Household Income	$ 75,442	$ 77,483	$ 69,689	$ 69,513	$ 71,980	$ 67,109	$ 108,479	$ 85,859	$ 71,922	$ 74,555	$ 97,962	$ 104,788	$ 105,304
Per Capita Income	$ 29,960	$ 33,906	$ 26,886	$ 29,984	$ 28,758	$ 27,346	$ 45,624	$ 38,740	$ 29,014	$ 31,035	$ 33,208	$ 41,907	$ 40,898
Percent of Individuals Under Federal Poverty Level	12.3%	10.1%	17.8%	14.8%	8.6%	17.8%	5.9%	8.5%	10.9%	11.9%	12.5%	16.8%	13.6%
Percent of Individuals Receiving Medicaid	23.3%	27.1%	25.9%	28.5%	24.9%	30.4%	12.9%	19.7%	26.5%	24.2%	20.2%	32.9%	25.7%
Per Capita Medicaid Expenditures	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9,762
Immigrant Status [3]													
Percent Born in American Territories	95.4%	95.8%	96.8%	98.1%	98.2%	96.5%	94.0%	96.1%	97.5%	96.6%	87.5%	61.3%	76.3%
Percent Born in Other Countries	4.6%	4.2%	3.2%	1.9%	1.8%	3.5%	6.0%	3.9%	2.5%	3.4%	12.5%	38.7%	23.7%
Percent Speak a Language Other Than English at Home	5.9%	6.2%	8.0%	2.5%	3.0%	13.8%	6.8%	4.1%	5.0%	5.2%	17.2%	48.0%	30.3%
Housing [3]													
Total Housing Units	36,723	26,390	25,835	29,148	8,964	23,529	107,192	40,119	29,562	196,741	4,843,376	3,519,595	8,362,971
Percent Housing Units Occupied	85.9%	61.3%	73.1%	76.9%	15.8%	83.4%	89.5%	72.4%	81.4%	73.0%	87.2%	90.7%	88.7%
Percent Housing Units Owner Occupied	67.9%	76.4%	72.1%	69.7%	85.3%	67.5%	72.1%	70.7%	72.7%	71.9%	61.2%	29.8%	54.1%
Percent Housing Units Renter Occupied	32.1%	23.6%	27.9%	30.3%	14.7%	32.5%	27.9%	29.3%	27.3%	28.1%	26.0%	60.9%	45.9%
Percent Built Before 1970	46.2%	53.3%	56.2%	65.0%	52.4%	70.6%	34.1%	45.5%	58.0%	53.2%	60.6%	75.4%	66.8%
Percent Built Between 1970 and 1979	13.5%	12.6%	10.9%	10.8%	13.4%	7.6%	13.5%	11.7%	9.4%	11.7%	12%	7.0%	9.9%
Percent Built Between 1980 and 1989	14.0%	10.5%	12.5%	9.7%	10.2%	8.6%	14.4%	13.9%	10.6%	12.0%	9.6%	4.8%	7.6%
Percent Built Between 1990 and 1999	13.8%	9.2%	11.0%	6.7%	12.7%	7.2%	14.4%	11.1%	9.6%	10.5%	8.1%	3.9%	6.3%
Percent Built 2000 and Later	12.5%	14.4%	9.5%	7.9%	11.2%	6.0%	23.7%	17.9%	12.4%	12.7%	9.7%	8.9%	9.4%
Availability of Vehicles [3]													
Percent of Households with No Vehicles Available	9.4%	8.4%	10.3%	10.2%	3.0%	13.4%	4.4%	8.8%	9.3%	9.3%	9.5%	54.8%	29.0%
Percent of Households with One Vehicle Available	33.1%	34.8%	32.3%	33.0%	32.1%	34.9%	31.7%	33.8%	30.9%	32.9%	33.2%	31.6%	32.5%
Percent of Households with Two Vehicles Available	38.6%	40.2%	41.1%	38.0%	48.0%	33.7%	44.0%	39.7%	38.5%	39.3%	37.9%	10.3%	26.0%
Percent of Households with Three or More Vehicles Available	19.0%	16.5%	16.2%	18.7%	16.9%	18.0%	19.9%	17.8%	21.4%	18.5%	19.4%	3.2%	12.5%
Education [3]													
Total Population Ages 25 and Older	55,208	28,740	35,561	38,599	3,485	34,193	164,817	48,041	44,788	254,422	7,715,731	5,933,426	13,649,157
Percent with Less than High School Education	11.4%	10.3%	12.9%	12.1%	19.8%	13.3%	6.6%	8.4%	12.8%	11.4%	9.4%	16.7%	12.5%
Percent High School Graduate/GED	35.3%	32.0%	37.4%	36.5%	28.7%	34.8%	24.3%	29.1%	39.5%	34.9%	27.1%	23.7%	25.6%
Percent Some College, no degree	16.3%	17.3%	16.6%	18.6%	17.6%	21.1%	15.9%	18.9%	17.5%	17.5%	16.9%	13.6%	15.5%
Percent Associates Degree	11.0%	11.4%	12.9%	15.4%	13.9%	13.0%	11.6%	11.4%	10.8%	12.1%	10.7%	6.4%	8.9%
Percent Bachelor's Degree	13.5%	16.6%	10.6%	9.8%	10.0%	10.6%	23.2%	17.2%	11.6%	13.2%	19.6%	22.6%	20.9%
Percent Graduate or Professional Degree	10.9%	13.3%	10.1%	8.4%	9.9%	8.0%	18.8%	15.1%	8.6%	11.1%	16.5%	16.5%	16.5%

	County									ARHN Region	Upstate NYS*	New York City	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington				
Employment Status [3]													
Total Population Ages 16 and Older	67,495	32,128	41,941	43,871	3,922	39,368	189,434	54,190	51,155	294,702	9,087,149	6,821,791	15,908,940
Total Population Ages 16 and Older in Armed Forces	80	7	5	27	3	42	1,342	112	46	280	20,858	2,654	23,512
Total Population Ages 16 and Older in Civilian Workforce	38,029	17,794	21,195	25,913	2,088	23,651	125,915	33,622	29,810	168,451	5,681,725	4,327,484	10,009,209
Percent Unemployed	4.5%	4.7%	7.0%	4.0%	2.1%	6.0%	3.2%	4.1%	5.6%	4.8%	3.0%	4.2%	5.7%
Employment Sector [3]													
Total Employed (Civilian Employed Pop)	36,323	16,952	19,721	24,881	2,044	22,235	121,132	32,257	28,146	160,324	5,398,633	4,040,006	9,438,639
Percent in Agriculture, Forestry, Fishing, Hunting, and Mining	2.0%	2.7%	3.6%	1.5%	5.6%	2.2%	0.8%	0.6%	3.8%	2.3%	0.9%	0.1%	0.6%
Percent in Construction	5.4%	8.4%	6.0%	6.5%	13.7%	6.6%	5.8%	7.2%	7.7%	6.8%	5.9%	5.1%	5.7%
Percent in Manufacturing	12.5%	9.6%	3.8%	11.2%	3.2%	15.1%	10.8%	7.8%	13.7%	10.1%	7.7%	3.1%	6.0%
Percent in Wholesale Trade	1.8%	0.5%	0.9%	1.9%	1.8%	2.2%	2.5%	1.8%	1.4%	1.5%	2.3%	1.9%	2.2%
Percent in Retail Trade	13.4%	9.1%	13.5%	13.3%	6.2%	10.7%	10.2%	12.0%	15.0%	12.8%	10.2%	8.9%	9.9%
Percent in Transportation, Warehousing, Utilities	5.8%	3.2%	4.2%	5.7%	10.0%	7.1%	3.9%	3.7%	4.3%	4.7%	4.6%	6.6%	5.5%
Percent in Information Services	1.4%	2.1%	1.2%	1.5%	1.3%	1.6%	1.5%	0.8%	1.1%	1.3%	2.0%	3.8%	2.8%
Percent in Finance/Insurance/Real Estate	2.4%	4.3%	2.3%	3.9%	6.4%	4.2%	6.8%	5.3%	3.9%	3.7%	6.8%	9.5%	8.1%
Percent in Other Professional Occupations	5.5%	6.7%	6.2%	7.4%	7.3%	6.4%	11.7%	8.4%	8.0%	7.0%	10.4%	14.2%	12.2%
Percent in Education, Health Care and Social Assistance	26.6%	28.2%	31.3%	28.5%	21.4%	25.8%	25.5%	28.3%	23.2%	27.3%	27.6%	27.5%	28.3%
Percent in Arts, Entertainment, Recreation, Hotel & Food Service	9.5%	13.9%	9.3%	6.9%	10.6%	5.8%	9.0%	11.7%	8.1%	9.7%	7.8%	10.2%	9.0%
Percent in Other Services	4.9%	6.0%	4.2%	5.6%	3.7%	6.0%	4.5%	4.9%	3.7%	4.8%	4.3%	5.2%	4.8%
Percent in Public Administration	8.8%	5.3%	13.7%	6.2%	8.8%	6.4%	7.1%	7.6%	6.2%	7.9%	5.2%	3.9%	4.8%

N/A - Data not available

(1) 2010 Census Estimate; Census Quick Stats

(2) USDA Farm Overview; 2017

(3) US Census Bureau, 2020 American Community Survey 5-year Estimates

(4) Centers for Medicaid and Medicare Services; 2019

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS*	New York State
Summary of Health Systems Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Population, 2020 ACS 5-Year Estimates [1]	80,320	37,281	50,389	53,452	4,454	49,294	229,313	64,187	61,034	351,117	11,135,297	19,514,849
Total Hospital Beds [2]												
Hospital Beds per 100,000 Population	374	67	339	138	0	264	75	609	0	274	N/A	N/A
Medical/Surgical Beds	214	0	129	47	0	70	115	300	0	690	N/A	N/A
Intensive Care Beds	14	0	14	8	0	5	12	12	0	48	N/A	N/A
Coronary Care Beds	7	0	0	0	0	3	7	12	0	19	N/A	N/A
Pediatric Beds	10	0	3	12	0	0	7	14	0	39	N/A	N/A
Maternity Beds	21	0	13	7	0	8	14	23	0	64	N/A	N/A
Physical Medicine and Rehabilitation Beds	0	0	0	0	0	24	0	0	0	0	N/A	N/A
Psychiatric Beds	34	0	12	0	0	20	16	30	0	76	N/A	N/A
Other Beds	0	25	0	0	0	0	0	0	0	25	N/A	N/A
Hospital Beds Per Facility [2]												
Adirondack Medical Center-Lake Placid Site	-	-	-	-	-	-	-	-	-	-	-	-
Adirondack Medical Center-Saranac Lake Site	-	-	95	-	-	-	-	-	-	-	-	-
Alice Hyde Medical Center	-	-	76	-	-	-	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center	300	-	-	-	-	-	-	-	-	-	-	-
Elizabethtown Community Hospital	-	25	-	-	-	-	-	-	-	-	-	-
Glens Falls Hospital	-	-	-	-	-	-	-	391	-	-	-	-
Nathan Littauer Hospital	-	-	-	74	-	-	-	-	-	-	-	-
Saratoga Hospital	-	-	-	-	-	-	171	-	-	-	-	-
St. Mary's Healthcare	-	-	-	-	-	120	-	-	-	-	-	-
St. Mary's Healthcare-Amsterdam Memorial Campus	-	-	-	-	-	10	-	-	-	-	-	-
Total Nursing Home Beds [3]												
Nursing Home Beds per 100,000 Population	640	909	387	715	0	1274	201	637	929	685	672	614
Nursing Home Beds per Facility [3]												
Alice Hyde Medical Center	-	-	135	-	-	-	-	-	-	-	-	-
Capstone Center for Rehabilitation and Nursing	-	-	-	-	-	120	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center SNF	34	-	-	-	-	-	-	-	-	-	-	-
Clinton County Nursing Home	80	-	-	-	-	-	-	-	-	-	-	-
Elderwood at North Creek	-	-	-	-	-	-	-	92	-	-	-	-
Elderwood at Ticonderoga	-	83	-	-	-	-	-	-	-	-	-	-
Elderwood of Uihlein at Lake Placid	-	156	-	-	-	-	-	-	-	-	-	-
Essex Center for Rehabilitation and Healthcare	-	100	-	-	-	-	-	-	-	-	-	-
Fort Hudson Nursing Center, Inc.	-	-	-	-	-	-	-	-	211	-	-	-
Fulton Center for Rehabilitation and Healthcare	-	-	-	176	-	-	-	-	-	-	-	-
Glens Falls Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	117	-	-	-	-
Granville Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	122	-	-	-
Meadowbrook Healthcare	287	-	-	-	-	-	-	-	-	-	-	-
Mercy Living Center	-	-	60	-	-	-	-	-	-	-	-	-
Nathan Littauer Hospital Nursing Home	-	-	-	84	-	-	-	-	-	-	-	-
Palatine Nursing Home	-	-	-	-	-	70	-	-	-	-	-	-
Plattsburgh Rehabilitation and Nursing Center	113	-	-	-	-	-	-	-	-	-	-	-
River Ridge Living Center	-	-	-	-	-	120	-	-	-	-	-	-
Seton Health at Schuyler Ridge Residential Healthcare	-	-	-	-	-	-	120	-	-	-	-	-
Slate Valley Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	88	-	-	-
St Johnsville Rehabilitation and Nursing Center	-	-	-	-	-	120	-	-	-	-	-	-
The Pines at Glens Falls Center for Nursing & Rehabilitation	-	-	-	-	-	-	-	120	-	-	-	-

	County									ARHN Region	Upstate NYS*	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Warren Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	80	-	-	-	-
Washington Center for Rehabilitation and Healthcare	-	-	-	-	-	-	-	-	146	-	-	-
Wells Nursing Home Inc	-	-	-	122	-	-	-	-	-	-	-	-
Wesley Health Care Center Inc	-	-	-	-	-	-	342	-	-	-	-	-
Wilkinson Residential Health Care Facility	-	-	-	-	-	198	-	-	-	-	-	-
Total Adult Care Facility Beds [4]												
Adult Care Facility Beds per 100,000 Population	235	1086	179	311	0	1024	521	633	493	443	735	534
Total Adult Home Beds	150	194	60	114	0	294	483	248	152	918	39921	51893
Total Assisted Living Program Beds	39	30	30	52	0	169	0	54	75	280	8882	14123
Total Assisted Living Residence (ALR) Beds	0	131	0	0	0	21	401	52	50	233	19237	21885
Total Enhanced ALR Beds	0	29	0	0	0	21	252	52	14	95	8787	10520
Special Needs ALR Beds	0	21	0	0	0	0	58	0	10	31	5063	5767
Adult Home Beds by Total Capacity per Facility [4]												
Adirondack Manor HFA D.B.A Adirondack Manor HFA ALP	-	-	-	-	-	-	-	60	-	-	-	-
Adirondack Manor HFA D.B.A Montcalm Manor HFA	-	40	-	-	-	-	-	-	-	-	-	-
Ahana House	-	-	-	-	-	-	17	-	-	-	-	-
Alice Hyde Assisted Living Program	-	-	30	-	-	-	-	-	-	-	-	-
Argyle Center for Independent Living	-	-	-	-	-	-	-	-	35	-	-	-
Arkell Hall	-	-	-	-	-	24	-	-	-	-	-	-
Beacon Pointe Memory Care Community	-	-	-	-	-	-	52	-	-	-	-	-
Champlain Valley Senior Community	-	81	-	-	-	-	-	-	-	-	-	-
Countryside Adult Home	-	-	-	-	-	-	-	48	-	-	-	-
Elderwood Village at Ticonderoga	-	23	-	-	-	-	-	-	-	-	-	-
Hillcrest Spring Residential	-	-	-	-	-	80	-	-	-	-	-	-
Holbrook Adult Home	-	-	-	-	-	-	-	-	33	-	-	-
Home of the Good Shepherd at Highpointe	-	-	-	-	-	-	86	-	-	-	-	-
Home of the Good Shepherd	-	-	-	-	-	-	42	-	-	-	-	-
Home of the Good Shepherd Moreau	-	-	-	-	-	-	72	-	-	-	-	-
Home of the Good Shepherd Saratoga	-	-	-	-	-	-	105	-	-	-	-	-
Home of the Good Shepherd Wilton	-	-	-	-	-	-	54	-	-	-	-	-
Keene Valley Neighborhood House	-	50	-	-	-	-	-	-	-	-	-	-
Pine Harbour	66	-	-	-	-	-	-	-	-	-	-	-
Pineview Commons H.F.A.	-	-	-	94	-	-	-	-	-	-	-	-
Samuel F. Vilas Home	44	-	-	-	-	-	-	-	-	-	-	-
Sarah Jane Sanford Home	-	-	-	-	-	40	-	-	-	-	-	-
The Cambridge	-	-	-	-	-	-	-	-	40	-	-	-
The Farrar Home	-	-	30	-	-	-	-	-	-	-	-	-
(3) US Census Bureau, 2020 American Community Survey 5-year Estimates	-	-	-	-	-	-	-	88	-	-	-	-
(4) Centers for Medicaid and Medicare Services; 2019	-	-	-	-	-	-	-	-	44	-	-	-
The Sentinel at Amsterdam, LLC	-	-	-	-	-	150	-	-	-	-	-	-
The Terrace at the Glen at Hiland Meadows	-	-	-	-	-	-	-	52	-	-	-	-
Valehaven Home for Adults	40	-	-	-	-	-	-	-	-	-	-	-
Willing Helpers' Home for Women	-	-	-	20	-	-	-	-	-	-	-	-
Willow Ridge Pointe	-	-	-	-	-	-	13	-	-	-	-	-
Woodlawn Commons	-	-	-	-	-	-	42	-	-	-	-	-
Total Physician [5]												
Total Physician per 100,000 population	273	134	159	112	157	156	259	391	48	198	393	399

	County									ARHN Region	Upstate NYS*	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Licensure Data [5]												
Clinical Laboratory Technician	14	6	6	1	0	3	19	8	4	39	1,211	1,631
Clinical Laboratory Technologist	49	20	30	29	0	34	148	49	26	203	7,421	11,418
Dental Assistant	12	3	10	3	0	7	40	11	14	53	1,372	1,521
Dental Hygienist	45	17	13	23	2	23	260	46	40	186	7,969	10,459
Dentist	44	12	20	16	0	24	180	44	17	153	8,695	14,893
Dietitian/Nutritionist, Certified	23	9	10	4	1	11	127	22	6	75	3,767	5,678
Licensed Clinical Social Worker (LCSW)	43	27	28	21	2	18	292	81	34	236	15,553	26,630
Licensed Master Social Worker (LMSW)	44	20	28	22	3	30	294	49	36	202	16,001	28,452
Licensed Practical Nurse	376	195	397	291	7	340	885	321	418	2005	47,600	61,550
Physician	219	50	80	60	7	77	595	251	29	696	43,720	77,825
Mental Health Counselor	63	21	33	10	1	15	184	41	16	185	5,573	8,306
Midwife	5	1	2	4	0	4	17	15	4	31	640	1,080
Nurse Practitioner	85	20	43	46	3	39	346	99	30	326	18,074	26,172
Pharmacist	102	27	36	40	2	36	505	78	42	327	14,089	21,930
Physical Therapist	73	45	48	31	4	43	414	71	30	302	14,245	20,265
Physical Therapy Assistant	19	5	21	20	0	23	62	26	15	106	4,080	5,619
Psychologist	12	12	5	10	1	5	115	26	5	71	6,227	11,730
Registered Physician Assistant	46	30	35	11	3	27	248	82	19	226	10,459	15,282
Registered Professional Nurse	1320	512	742	644	57	751	4029	1166	778	5219	181,132	255,088
Respiratory Therapist	21	2	6	19	0	17	113	20	14	82	4,161	5,806
Respiratory Therapy Technician	6	0	3	2	0	1	14	4	1	16	524	678

N/A - Data not available

(1) US Census Bureau, 2020 American Community Survey 5-year Estimates

(2) NYS Department of Health; NYS Health Profiles

(3) NYS Department of Health; Nursing Home Weekly Bed Census, 2022

(4) NYS Department of Health; Adult Care Facility Directory,2022

(5) NYS Education Department; License Statistics, 2021

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

Adirondack Rural Health Network	County									ARHN	Upstate	New York
Summary of Education System Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region	NYS*	State
School System Information [1,2,3,4]												
Total Number of Public School Districts	8	10	7	6	4	5	12	9	11	55	439	731
Total Pre-K Enrollment	367	164	269	220	18	145	319	44	217	1,299	41,126	112,797
Total K-12 Enrollment	10,314	3,423	6,717	6,802	379	6,985	31,780	8,058	7,708	43,401	1,531,010	2,512,973
Number of Students Eligible for Free Lunch	4,113	1,433	3,506	3,398	137	4,055	7,313	3,092	3,177	18,856	625,885	1,343,837
Number of Students Eligible for Reduced Lunch	393	216	397	273	24	191	724	223	188	1,714	53,943	87,949
Percent Free and Reduced Lunch	44%	48%	58%	54%	42%	61%	25%	41%	44%	47%	44%	57%
Number English Proficiency	1,317	608	596	1,041	76	900	7,063	1,616	1,284	6,538	228,804	447,858
Percent with English Proficiency	37.0%	41.0%	25.0%	34.0%	44.0%	30.0%	56.0%	47.0%	39.0%	37.5%	42.6%	45.0%
Total Number of Graduates	724	263	435	490	30	533	2,510	603	540	3,085	114,153	179,195
Number Went to GED Transfer Program	0	0	0	0	0	0	7	17	6	23	584	1,187
Number Dropped Out of High School	60	12	21	57	0	34	101	38	44	232	4,969	8,699
Percent Dropped Out of High School	7.0%	4.0%	4.0%	10.0%	0.0%	6.0%	4.0%	5.0%	7.0%	5.3%	7.3%	4.0%
Total Number of Public School Teachers	963.5	393.8	687.1	593.9	78.0	553.4	2,631.7	781.9	736.9	4,235.1	136,911	212,296
Student to Teacher Ratio	9.3	11.5	10.2	8.7	20.6	7.9	8.3	9.7	9.6	9.8	8.9	8.4

(1) National Center for Education Statistics, 2020-2021

(2) NYS Education Department; Report Card Database 2019-2020

(3) NYS Education Department; Report Card Database 2020-2021

(4) NYS Education Department; 3-8 ELA Assessment Database 2019-2020

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

Adirondack Rural Health Network
Summary of Education System Information
School Districts by County [1]

Clinton	Essex	Franklin	Fulton	Hamilton
AUSABLE VALLEY CENTRAL SCHOOL DISTRICT	BOQUET VALLEY CSD*	BRUSHTON-MOIRA CENTRAL SCHOOL DISTRICT	BROADALBIN-PERTH CENTRAL SCHOOL DISTRICT	INDIAN LAKE CENTRAL SCHOOL DISTRICT
BEEKMANTOWN CENTRAL SCHOOL DISTRICT	CROWN POINT CENTRAL SCHOOL DISTRICT	CHATEAUGAY CENTRAL SCHOOL DISTRICT	GLOVERSVILLE CITY SCHOOL DISTRICT	LAKE PLEASANT CENTRAL SCHOOL DISTRICT
CHAZY UNION FREE SCHOOL DISTRICT	KEENE CENTRAL SCHOOL DISTRICT	MALONE CENTRAL SCHOOL DISTRICT	JOHNSTOWN CITY SCHOOL DISTRICT	LONG LAKE CENTRAL SCHOOL DISTRICT
NORTHEASTERN CLINTON CENTRAL SCHOOL DISTRICT	LAKE PLACID CENTRAL SCHOOL DISTRICT	SAINT REGIS FALLS CENTRAL SCHOOL DISTRICT	MAYFIELD CENTRAL SCHOOL DISTRICT	WELLS CENTRAL SCHOOL DISTRICT
NORTHERN ADIRONDACK CENTRAL SCHOOL DISTRICT	MINERVA CENTRAL SCHOOL DISTRICT	SALMON RIVER CENTRAL SCHOOL DISTRICT	NORTHVILLE CENTRAL SCHOOL DISTRICT	
PERU CENTRAL SCHOOL DISTRICT	MORIAH CENTRAL SCHOOL DISTRICT	SARANAC LAKE CENTRAL SCHOOL DISTRICT	WHEELERVILLE UNION FREE SCHOOL DISTRICT	
PLATTSBURGH CITY SCHOOL DISTRICT	NEWCOMB CENTRAL SCHOOL DISTRICT	TUPPER LAKE CENTRAL SCHOOL DISTRICT		
SARANAC CENTRAL SCHOOL DISTRICT	SCHROON LAKE CENTRAL SCHOOL DISTRICT			
	TICONDEROGA CENTRAL SCHOOL DISTRICT			
	WILLSBORO CENTRAL SCHOOL DISTRICT			

Montgomery	Saratoga	Warren	Washington
AMSTERDAM CITY SCHOOL DISTRICT	BALLSTON SPA CENTRAL SCHOOL DISTRICT	BOLTON CENTRAL SCHOOL DISTRICT	ARGYLE CENTRAL SCHOOL DISTRICT
CANAJOHARIE CENTRAL SCHOOL DISTRICT	BURNT HILLS-BALLSTON LAKE CENTRAL SCHOOL DISTRICT	GLENS FALLS CITY SCHOOL DISTRICT	CAMBRIDGE CENTRAL SCHOOL DISTRICT
FONDA-FULTONVILLE CENTRAL SCHOOL DISTRICT	CORINTH CENTRAL SCHOOL DISTRICT	GLENS FALLS COMMON SCHOOL DISTRICT	FORT ANN CENTRAL SCHOOL DISTRICT
FORT PLAIN CENTRAL SCHOOL DISTRICT	EDINBURG COMMON SCHOOL DISTRICT	HADLEY-LUZERNE CENTRAL SCHOOL DISTRICT	FORT EDWARD UNION FREE SCHOOL DISTRICT
OPPENHEIM-EPHRATAH-ST. JOHNSVILLE CSD	GALWAY CENTRAL SCHOOL DISTRICT	JOHNSBURG CENTRAL SCHOOL DISTRICT	GRANVILLE CENTRAL SCHOOL DISTRICT
	MECHANICVILLE CITY SCHOOL DISTRICT	LAKE GEORGE CENTRAL SCHOOL DISTRICT	GREENWICH CENTRAL SCHOOL DISTRICT
	SARATOGA SPRINGS CITY SCHOOL DISTRICT	NORTH WARREN CENTRAL SCHOOL DISTRICT	HARTFORD CENTRAL SCHOOL DISTRICT
	SCHUYLERVILLE CENTRAL SCHOOL DISTRICT	QUEENSBURY UNION FREE SCHOOL DISTRICT	HUDSON FALLS CENTRAL SCHOOL DISTRICT
	SHENENDEHOWA CENTRAL SCHOOL DISTRICT	WARRENSBURG CENTRAL SCHOOL DISTRICT	PUTNAM CENTRAL SCHOOL DISTRICT
	SOUTH GLENS FALLS CENTRAL SCHOOL DISTRICT		SALEM CENTRAL SCHOOL DISTRICT
	STILLWATER CENTRAL SCHOOL DISTRICT		WHITEHALL CENTRAL SCHOOL DISTRICT
	WATERFORD-HALFMOON UNION FREE SCHOOL DISTRICT		

(1) National Center for Education Statistics, public school district data for the 2020-2021 school years

* BOQUET VALLEY CSD was formed when Elizabethtown-Lewis CSD and Westport CSD merged in December 2018

Hamilton County Inlet School- no longer a public school, tuition only

ALICE is a United Way acronym that stands for Asset Limited, Income Constrained, Employed.

Adirondack Rural Health Network	County									ARHN**	Upstate NYS*	New York State
Summary of ALICE Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Total Households	31,392	15,425	19,088	22,439	1,124	19,665	94,156	28,007	24,009	141,484	4,185,726	7,370,222
ALICE Households over 65 years of age	3,209	2,109	2,055	2,911	158	2,792	10,254	3,613	2,871	16,926	476,148	816,702
ALICE Households by Race/Ethnicity												
Asian	102	0	0	5	0	59	326	76	0	183	29,940	192,069
Black	63	0	19	41	0	166	397	119	37	279	125,803	456,100
Hispanic	67	33	42	185	0	711	454	196	89	612	130,972	513,372
American Indian/ Alaska Native	29	0	298	0	0	0	17	0	0	327	5,051	11,770
White	7,753	4,187	4,768	6,047	520	5,647	24,511	8,312	7,738	39,325	886,364	1,251,617
2+ races	61	43	43	52	0	65	256	70	57	326	21,622	62,524
Poverty %	12.3%	9.7%	17.7%	14.0%	9.9%	17.2%	6.4%	9.5%	12.0%	12.4%	11.0%	13.7%
ALICE %	24.6%	27.8%	25.4%	26.0%	46.2%	30.4%	26.8%	29.7%	31.6%	27.6%	27.1%	31.0%
Above ALICE %	63.1%	62.5%	57.0%	59.9%	44.0%	52.4%	66.9%	60.8%	56.4%	60.0%	61.9%	55.3%
# of ALICE and Poverty Households	11,568	5,782	8,214	8,988	630	9,357	31,199	10,984	10,469	56,635	1,593,472	3,291,828
Unemployment Rate	3.8%	5.8%	7.1%	6.1%	8.0%	7.7%	3.6%	4.7%	5.7%	5.9%	N/A	5%
Percent of Residents with Health Insurance	95%	96%	93%	95%	94%	95%	96%	95%	95%	94.7%	N/A	6%
Median Household Income	$56,704	$56,196	$51,696	$50,248	$57,552	$45,837	$83,765	$56,482	$54,114	$54,713	N/A	$67,844

(1) American Community Survey, 2018

(2) ALICE Threshold, 2018

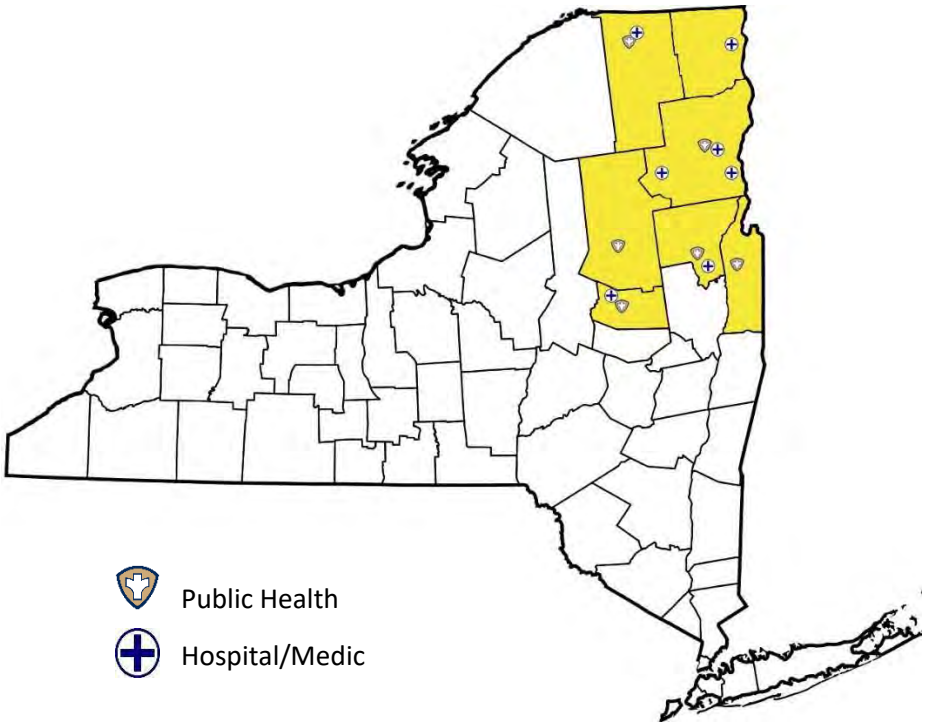
(3) United for Alice, 2018

(4) NYS County Health Rankings, 2018

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

***ARHN region reflects an average of ARHN counties*

Summary of 2022 Community Stakeholder Survey



Adirondack Rural Health Network Service Area

Clinton, Essex, Franklin, Fulton, Hamilton,
Warren and Washington Counties

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

2022

Background:

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

Description of the Community Health Assessment Committee: Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from Adirondack Health, Clinton County Health Department, University of Vermont Health Network - Alice Hyde Medical Center, University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health and Nursing Services, Nathan Littauer Hospital, University of Vermont Health Network – Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health.

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

CHA Committee, Ad Hoc Data Sub-Committee: At the June 4, 2021, CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

The data subcommittee met four times from mid-July through mid-November 2021. Meetings were held via Webex/Zoom. Attendance ranged from 6 to 10 subcommittee members per meeting. Meetings were also attended by AHI staff from the Adirondack Rural Health Network.

Survey Methodology:

Survey Creation: The 2022 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at the November 10, 2021, meeting.

Survey Facilitation: ARHN facilitated the release of the stakeholder survey in its seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental

institutions, as well as community members. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington Counties.

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 806 community stakeholders.

An initial email was sent to the community stakeholders in early January 2022 by the CHA Committee partners, introducing and providing a web-based link to the survey. CHA Committee partners released a follow-up email approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

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

Survey Responses and Analysis: A total of 263 responses were received through March 1, 2022, for a total response rate of 32.63%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 20 minutes to complete the survey, with a median response time of approximately 16 minutes.

Analysis is sorted alphabetically and in order of how the questions were listed in the survey to make the analysis easier to comprehend. Each table is labeled to identify whether the information is by response count or percentage. For tables containing counties, the table below indicates table is color coded to identify counties. All written analysis for each section is provided, with table below, and all written results are done in percentages.

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

Clinton
Essex
Franklin
Fulton
Hamilton
Warren
Washington

Summary Analysis

1. Indicate your job title

Approximately 48.22% of respondents listed themselves as an *Administrator or Director.* There was a significant number of respondents who identified their title as Other (39.13%). Of those responses, the majority included police and fire chiefs, health educators, school nurses, and town supervisors.

It's important to note that based off responses, there did not seem to be enough answer choices. Moving forward, a recommendation would be to broaden answer choices to incorporate more community stakeholders.

Respondent Job Titles		
Job Title	**Responses**	
	Count	**Percentage**
Community Member	9	3.56%
Direct Service Staff	7	2.77%
Program/Project Manager	16	6.32%
Administrator/Director	122	48.22%
Other	99	39.13%

2. Indicate the community sector that best describes your organization

Community stakeholders were asked to indicate one community sector that best described their organization or agency. Over 198 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including *Education (22.75%)*, *Health Care (19.22%), Public Health (10.2%), and Local Government (8.63%),* among many others.

Response Counts by Community Sector	
Community Sector	**Total**
Business	1
Civic Association	2
College/University	1
Disability Services	6
Early Childhood	6
Economic Development	2
Employment/Job training	0
Faith-Based	0
Food/Nutrition	4
Foundation/Philanthropy	0
Health Based CBO	1
Health Care Provider	49
Health Insurance Plan	0
Housing	2
Law Enforcement/Corrections	7
Local Government (e.g. elected official, zoning/planning board)	22

Media	1
Mental, Emotional, Behavioral Health Provider	13
Public Health	26
Recreation	3
School (K – 12)	58
Seniors/Aging Services	12
Social Services	12
Transportation	0
Tribal Government	0
Veterans	1
Other (please specify)	26

3. Indicate County/Counties served

Respondents were asked which county their organization/agency serves. Over 64% of respondents were from Essex and Washington counties. Approximately 20% of respondents listed the county they serve as outside of the seven ARHN counties, including Montgomery, Saratoga, and St. Lawrence counties. Twenty-five percent of respondents identified themselves as serving the Adirondack/North Country region as a whole.

It should be noted that the figures below may not add up to 100%, due to organizations with multiple county coverage areas.

Respondents by County		
County/Region	**Total Response Count**	**Total Response Percentage**
Adirondack/North Country Region	67	25.77%
Clinton	51	19.62%
Essex	90	34.62%
Franklin	62	23.85%
Fulton	44	16.92%
Hamilton	44	16.92%
Warren	67	25.77%
Washington	79	30.38%
Other (please specify)	52	20.0%

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

4. NYS Prevention Agenda Priority Areas

Top Priority Area for the ARHN Region:

Survey participants were asked to rank the NYS Prevention Agenda Priority Areas in order of most to least impact. Overall, respondents in the ARHN region identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* (38.05%) as their top priority, followed by *Promote a Healthy and Safe Environment* (29.33%).

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

Top Priority Area by County:

To analyze the chosen priority areas, responses were totaled per county and the priority area that received the most responses is listed as the *First Choice*, followed by the second most responses listed as *Second Choice.*

All seven of the ARHN counties identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* as their top priority. Additionally, Clinton, Franklin, Fulton, Hamilton, and Warren counties identified *Prevent Chronic Disease* as their second choice while Essex and Washington counties identified *Promote a Healthy and Safe Environment* as their second choice.

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

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

5. In your opinion, what are the top five health concerns affecting the residents of the counties your organization/agency serves?

Health Concerns for the ARHN Region:

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

Survey respondents felt that the top five health concerns affecting the residents within the ARHN region were *Mental Health (20.96%), Substance Use/Alcoholism/Opioid Use (13.1%), Child/Adolescent emotional health (9.61%), Overweight/Obesity (7.42%),* and *Adverse childhood experiences (6.99%).*

Response Counts for ARHN Region Health Concerns					
ARHN Region Health Concerns	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Adverse childhood experiences	16	15	9	11	8
Alzheimer's disease/Dementia	2	9	3	10	5
Arthritis	0	1	0	1	1
Autism	0	3	1	2	2
Cancers	14	12	8	5	5
Child/Adolescent physical health	6	10	7	4	7
Child/Adolescent emotional health	22	23	17	15	9
Diabetes	10	12	10	12	4
Disability	7	4	1	2	7
Dental health	0	5	4	5	12
Domestic abuse/violence	5	3	9	7	11
Exposure to air and water pollutants/hazardous materials	1	1	0	1	4
Falls	0	1	6	3	3
Food safety	3	0	1	1	4
Heart disease	5	6	15	7	5
Hepatitis C	0	1	2	1	0
High blood pressure	0	3	0	5	3
HIV/AIDS	0	0	1	0	2
Hunger	3	3	8	5	10
Infant health	1	1	2	0	1
Infectious disease	7	2	3	3	7
LGBT health	1	1	1	0	1
Maternal health	2	4	1	1	6
Mental health conditions	48	28	32	26	11
Motor vehicle safety (impaired/distracted driving)	0	2	1	2	1
Overweight or obesity	17	8	15	23	17
Pedestrian/bicyclist accidents	0	0	0	0	1
Prescription drug abuse	0	4	4	10	2
Respiratory disease (asthma, COPD, etc.)	1	5	5	2	5
Senior health	16	5	9	8	13
Sexual assault/rape	0	1	0	1	0
Sexually transmitted infections	1	2	0	2	3

Social connectedness	5	8	8	9	9
Stroke	0	0	0	3	2
Substance abuse/Alcoholism/Opioid Use	30	29	30	14	16
Suicide	0	3	2	5	4
Tobacco use/nicotine addiction – smoking/vaping/chewing	6	8	9	17	17
Underage drinking	0	2	1	3	6
Unintended/Teen pregnancy	0	1	2	0	0
Violence (assault, firearm related)	0	1	0	0	2

Health Concerns by County:

Overall, most of the health concerns identified per county aligned with the top five health concerns identified for the ARHN region. Several counties recognized health concerns outside the top five for the ARHN region. Three out of the seven ARHN counties listed *Diabetes* as a top health concern in their county.

Warren and Washington county respondents felt that *Senior Health* was a concern in their area, while Franklin and Hamilton counties included *Disability* as a concern for their counties. Outliers include Fulton County listing *Cancers* as a top concern in their county.

Top Five Health Concerns by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Diabetes	Adverse Childhood Experiences	Overweight or Obesity
Essex	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Child/Adolescent Emotional Health	Adverse Childhood Experiences	Diabetes
Franklin	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Diabetes	Child/Adolescent Emotional Health	Disability
Fulton	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Child/Adolescent Emotional Health	Cancers	Diabetes
Hamilton	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Senior Health	Overweight or Obesity	Disability
Warren	Mental Health Conditions	Child/Adolescent Emotional Health	Substance Use/Alcoholism/Opioid Use	Adverse Childhood Experiences	Senior Health
Washington	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Adverse Childhood Experiences	Senior Health	Child/Adolescent Emotional Health

6. In your opinion, what are the top five contributing factors to the health concerns you chose in the previous question, affecting the residents of the counties your organization/agency serves?

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

Contributing Factors for the ARHN Region:

The top five contributing factors identified by survey respondents are *Lack of mental health services (14.2%), Poverty (12.9%), Addiction to alcohol/illicit drugs (12.0%), Age of residents (10.2%), and Changing family structures (9.8%).* Forty-six percent of respondents chose these factors as either the highest or second highest contributing factors for the health concerns that they had previously identified.

Response Counts for Top Contributing Factors in the ARHN Region					
Contributing Factors	**Highest (1)**	**2**	**3**	**4**	**Lowest (5)**
Addiction to alcohol/illicit drugs	27	26	20	12	7
Addiction to nicotine	6	5	7	4	5
Age of residents	23	5	4	9	8
Changing family structures (increased foster care, grandparents as parents, etc.)	22	16	9	9	5
Community blight/Deteriorating infrastructure (roads, bridges, water systems, etc.)	1	1	2	1	1
Crime/violence	0	2	2	1	2
Discrimination/racism	0	1	0	1	1
Domestic violence and abuse	0	4	6	4	8
Environmental quality	4	1	6	1	4
Excessive screen time	2	8	4	5	8
Exposure to tobacco smoke/emissions from electronic vapor products	2	2	2	2	4
Food insecurity	5	8	4	6	4
Health care costs	7	11	7	5	5
Homelessness	0	2	3	3	4
Inadequate physical activity	4	14	11	10	10
Inadequate sleep	0	0	2	2	3
Inadequate/unaffordable housing options	2	3	12	10	1
Lack of chronic disease screening, treatment and self-management services	4	2	7	5	1
Lack of cultural and enrichment programs	2	1	1	0	1
Lack of dental/oral health care services	1	3	5	2	3
Lack of educational, vocational or job-training options for adults	1	4	1	0	3
Lack of employment options	0	3	3	5	4
Lack of health education programs	3	2	3	2	1
Lack of health insurance	1	0	4	1	2
Lack of intergenerational connections within communities	4	2	0	3	2
Lack of mental health services	32	16	17	12	12
Lack of opportunities for health for people with physical limitations or disabilities	1	2	2	1	4

Lack of preventive/primary health care services (screenings, annual check-ups)	1	3	2	3	3
Lack of quality educational opportunities for people of all ages	1	1	1	2	2
Lack of social supports for community residents	1	8	6	12	5
Lack of specialty care and treatment	2	1	5	3	3
Lack of substance use disorder services	1	5	2	2	2
Late or no prenatal care	0	1	0	1	0
Pedestrian safety (roads, sidewalks, buildings, etc.)	0	0	0	1	0
Poor access to healthy food and beverage options	0	4	8	5	6
Poor access to public places for physical activity and recreation	1	2	2	4	4
Poor community engagement and connectivity	2	4	2	6	9
Poor eating/dietary practices	10	9	5	14	13
Poor referrals to health care, specialty care, and community-based support services	6	5	3	4	6
Poverty	29	9	14	12	11
Problems with Internet access (absent, unreliable, unaffordable)	0	1	1	0	3
Religious or spiritual values	0	0	0	0	1
Shortage of childcare options	0	0	2	6	3
Stress (work, family, school, etc.)	14	11	12	12	13
Transportation problems (unreliable, unaffordable)	1	9	12	15	12
Unemployment/low wages	2	7	3	3	7

Contributing Factors by County:

The majority of the ARHN counties identified contributing factors that fell in line with the overall ARHN region's top five. Another contributing factor indicated by Clinton and Franklin counties was *Poor eating/dietary practices.*

Top Five Contributing Factors by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Addiction to alcohol/illicit drugs	Poverty	Poor eating/dietary practices	Age of residents	Poor referrals to health care, specialty care, and community-based support services
Essex	Changing family structures	Poverty	Addiction to alcohol/illicit drugs	Lack of mental health services	Age of residents
Franklin	Addiction to alcohol/illicit drugs	Poverty	Lack of mental health services	Changing family structures	Poor eating/dietary practices
Fulton	Poverty	Addiction to alcohol/illicit drugs	Lack of mental health services	Changing Family Structures	Age of residents
Hamilton	Addiction to alcohol/illicit drugs	Age of residents	Lack of mental health services	Poverty	Addiction to nicotine
Warren	Lack of mental health services	Changing Family Structures	Poverty	Addiction to alcohol/illicit drugs	Lack of chronic disease screening, treatment and self-management services
Washington	Lack of mental health services	Changing Family Structures	Poverty	Age of residents	Addiction to alcohol/illicit drugs

8. Please rank the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "very poor" to (5) "excellent".

This survey question asked respondents to rank the Social Determinants of Health, listed below, in order from one, very poor, to five, excellent. The table below encompasses response counts for the entire survey.

Many respondents chose *Economic Stability (55.7%)* as the social determinant of health that they felt most impacted the residents of the counties that they serve, followed by *Social and Community Context (14.2%).*

Response Counts per Social Determinants of Health Ranking					
Social Determinants of Health	**1 (Very Poor)**	**2**	**3**	**4**	**5 (Excellent)**
Economic Stability (consider poverty, employment, food security, housing stability)	106	37	25	10	9
Education (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	14	31	48	48	47
Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	27	39	53	45	35
Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)	19	59	42	47	34
Health and Health Care (consider access to primary care, access to specialty care, health literacy)	24	40	45	51	53

9. In your opinion, what population in the counties your organization/agency serves experiences the poorest health outcomes?

To help determine who the target audience that has the greatest need is, we asked, in their opinion, what population, in the counties they serve, experiences the poorest health outcomes.

Every county in the ARHN region chose either *Individuals living at or near the federal poverty level* or *Individuals with mental health issues* as the population they felt had the poorest health outcomes. Clinton, Essex, Fulton, and Hamilton counties identified *Individuals living at or near the federal poverty level* or *Individuals with mental health issues*, while Warren and Washington counties identified *Individuals with mental health issues*. Franklin county had a split tie between the two.

Response Counts for Poorest Health Outcomes by County							
Population	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Children/adolescents	1	3	2	4	1	4	4
Females of reproductive age	1	1	1	0	0	0	0
Individuals living at or near the federal poverty level	13	28	16	12	11	14	15
Individuals living in rural areas	4	8	5	1	6	8	12
Individuals with disability	0	3	2	1	2	0	0
Individuals with mental health issues	11	17	16	10	10	21	17
Individuals with substance abuse issues	8	11	6	4	7	8	8
Migrant workers	0	0	0	0	0	0	0
Seniors/elderly	9	9	9	4	5	4	7
Specific racial and ethnic groups	0	0	0	0	0	0	0
Other (please specify)	0	0	0	1	0	0	1
Total per county	47	80	57	37	42	59	64

10. New York State Prevention Agenda Goals

Top Three Goals for the ARHN Region:

Respondents were asked to choose three goals that their organization could assist in achieving in their counties. The top three goals for each NYS Prevention Agenda priority area aligned with most of the individual county goals.

Top Three Prevention Agenda Goals for the ARHN Region			
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Increase skills and knowledge to support healthy food and beverage choices	Promote school, child-care, and worksite environments that support physical activity for people of all ages and abilities	Promote the use of evidence-based care to manage chronic diseases
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Promote a Healthy and Safe Environment	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Reduce violence by targeting prevention programs to highest risk populations
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Prevent Communicable Disease	Improve vaccination rates	Reduce inappropriate antibiotic use	Improve infection control in health care facilities

Top Three Goals by County:

To align with the structure of the survey, county analysis is provided per NYS Prevention Agenda priority area.

Prevent Chronic Disease

Most of the counties contained three specific goals, *Promote the use of evidence-based care to manage chronic diseases, improve self-management skills for individuals with chronic disease, and Increase skills and knowledge to support health food and beverage choices.* Essex County also identified *Promote school, childcare, and worksite environments that support physical activity for people of all ages and disabilities,* while Hamilton County identified *Increase screening rates for breast, cervical, and colorectal cancer.* Lastly, Washington County identified *Increase food security* and *Promote the use of evidence-based care to manage chronic diseases.*

Priority Area: Prevent Chronic Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve self-management skills for individuals with chronic disease	Promote the use of evidence-based care to manage chronic diseases	Increase skills and knowledge to support healthy food and beverage choices
Essex	Increase skills and knowledge to support healthy food and beverage choices	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
Franklin	Promote the use of evidence-based care to manage chronic diseases	Improve self-management skills for individuals with chronic disease	Increase skills and knowledge to support healthy food and beverage choices
Fulton	Promote the use of evidence-based care to manage chronic diseases	Increase skills and knowledge to support healthy food and beverage choices	Improve self-management skills for individuals with chronic disease
Hamilton	Promote the use of evidence-based care to manage chronic diseases	Improve self-management skills for individuals with chronic disease	Increase screening rates for breast, cervical, and colorectal cancer
Warren	Increase skills and knowledge to support healthy food and beverage choices	Promote the use of evidence-based care to manage chronic diseases	Improve self-management skills for individuals with chronic disease
Washington	Increase skills and knowledge to support healthy food and beverage choices	Increase food security	Promote the use of evidence-based care to manage chronic diseases

Promote Healthy Women, Infants and Children

All ARHN counties choose *Support and enhance children and adolescents' social-emotional development and relationships* or *Increase use of primary and preventive care services by women of all ages* as their number one goal. Clinton, Essex, Franklin, and Washington counties also listed *Reduce racial, ethnic, economic and geographic disparities in maternal and child health outcomes* as one of their top three goals.

Priority Area: Promote Healthy Women, Infants and Children			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Support and enhance children and adolescents' social-emotional development and relationships	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Essex	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Franklin	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Support and enhance children and adolescents' social-emotional development and relationships	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Fulton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Hamilton	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Support and enhance children and adolescents' social-emotional development and relationships	Increase supports for children with special health care needs
Warren	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Washington	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

Promote a Healthy and Safe Environment

Promote healthy home and schools' environments was chosen as the top goal for six out of seven of the ARHN counties, with *Reduce falls among vulnerable populations* chosen by Hamilton County. *Reduce violence by targeting prevention programs to highest risk populations* was also listed as one of the top three goals for Clinton, Essex, Franklin, Warren, and Washington counties.

Priority Area: Promote a Healthy and Safe Environment			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Reduce violence by targeting prevention programs to highest risk populations
Essex	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Reduce falls among vulnerable populations
Franklin	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Reduce violence by targeting prevention programs to highest risk populations
Fulton	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Reduce occupational injury and illness
Hamilton	Reduce falls among vulnerable populations	Promote healthy home and schools' environments	Reduce occupational injury and illness
Warren	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Washington	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Reduce falls among vulnerable populations

Promote Well-Being and Prevent Mental and Substance Use Disorders

Strengthen opportunities to promote well-being and resilience across the lifespan and *facilitate supportive environments that promote respect and dignity for all ages* were both within the top three goals for every county. Clinton, Franklin, and Fulton counties listed *Prevent opioid and other substance misuse and deaths* in their top three goals, while Essex, Warren, and Washington counties listed *Prevent and address adverse childhood experiences* in their top three goals.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Essex	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Franklin	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Fulton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Hamilton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Reduce the mortality gap between those living with serious mental illness and the general population
Warren	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Washington	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences

Prevent Communicable Diseases

All seven ARHN counties listed *Improve vaccination rates* as their number one goal. *Improve infection control in health care facilities* was identified at the number two goal by Clinton, Essex, Franklin, and Washington counties. Fulton and Hamilton counties listed *Reduce inappropriate antibiotic use* as their number two goal. Five out of seven counties also listed *Reduce vaccination coverage disparities* in their top three goals.

Priority Area: Prevent Communicable Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve vaccination rates	Improve infection control in health care facilities	Reduce vaccination coverage disparities
Essex	Improve vaccination rates	Improve infection control in health care facilities	Reduce vaccination coverage disparities
Franklin	Improve vaccination rates	Improve infection control in health care facilities	Reduce vaccination coverage disparities
Fulton	Improve vaccination rates	Reduce inappropriate antibiotic use	Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
Hamilton	Improve vaccination rates	Reduce inappropriate antibiotic use	Reduce vaccination coverage disparities
Warren	Improve vaccination rates	Reduce vaccination coverage disparities	Improve infection control in health care facilities
Washington	Improve vaccination rates	Improve infection control in health care facilities	Reduce vaccination coverage disparities

12. **Based on the goals you selected, please identify the resources your organization/agency can contribute toward achieving these goals.**

Respondents were asked to indicate the resources that their organization/agency would be able to contribute toward achieving the goals they listed. The table below encompasses the top ten resources listed.

Approximately 59% of all respondents identified *Participating on committees, workgroups, and coalitions* and *Provide subject-matter knowledge and expertise* as the main resources they can contribute to help achieve the NYS Prevention Agenda goals listed above. Respondents also felt strongly that they can *Share knowledge of community resources* and *Promote health improvement activities through social media* to help achieve the listed goals.

Response Counts and Percentages for Resources Organizations Can Contribute		
Resources	**Count**	**Percentage**
Participate on committees, work groups, coalitions to help achieve the selected goals	59.33%	124
Provide subject-matter knowledge and expertise	57.89%	121
Share knowledge of community resources (e.g. food, clothing, housing, transportation, etc.)	49.76%	104
Promote health improvement activities/events through social media and other communication channels your organization/agency operates	47.37%	99
Offer health-related educational materials	33.97%	71
Facilitate access to populations your organization/agency serves (to encourage participation in programs, provide feedback about health improvement efforts, etc.)	31.58%	66
Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals	29.19%	61
Provide letters of support for planned health improvement activities	29.19%	61
Sign partnership agreements related to community level health improvement efforts	22.97%	48
Offer periodic organizational/program updates to community stakeholders	22.01%	46
Provide in-kind space for health improvement meetings/events	21.53%	45
Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)	17.7%	37
Share program-level data to help track progress in achieving goals	17.22%	36
Assist with data analysis	11.48%	24

Appendix A. 2022 Stakeholder Survey

2022 CHA Stakeholders Survey

Introduction

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

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

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

Your Organization/Agency

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

1. Organization/Agency name: _____

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

3. Your job title/role: _____

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

4. Your email address:_____

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

- ⌋ Business
- ⌋ Civic Association
- ⌋ College/University
- ⌋ Disability Services
- ⌋ Early Childhood
- ⌋ Economic Development

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

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

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

Health Priorities, Concerns and Factors

The NYS Prevention Agenda for 2019-2024 identifies five main priority areas that are key to improving the health of residents that you serve.

7. Please rank, **by indicating 1 through 5**, the priority areas that, if addressed locally, would have the greatest to the smallest impact on improving the health and well-being of the residents of the counties your organization/agency serves. (#1 ranked priority area would have the most impact; #5 ranked priority area would have the least impact.)

- ⎦ Prevent Chronic Diseases
- ⎦ Promote Healthy Women, Infants, and Children
- ⎦ Prevent Communicable Diseases
- ⎦ Promote a Healthy and Safe Environment
- ⎦ Promote Well-Being and Prevent Mental and Substance Use Disorders

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

- ⎦ Adverse childhood experiences
- ⎦ Alzheimer's disease/Dementia
- ⎦ Arthritis
- ⎦ Autism
- ⎦ Cancers
- ⎦ Child/Adolescent physical health
- ⎦ Child/Adolescent emotional health
- ⎦ Diabetes
- ⎦ Disability
- ⎦ Dental health
- ⎦ Domestic abuse/violence
- ⎦ Exposure to air and water pollutants/hazardous materials
- ⎦ Falls
- ⎦ Food safety
- ⎦ Heart disease
- ⎦ Hepatitis C
- ⎦ High blood pressure
- ⎦ HIV/AIDS
- ⎦ Hunger
- ⎦ Infant health
- ⎦ Infectious disease
- ⎦ LGBT health
- ⎦ Maternal health

- ⎫ Mental health conditions
- ⎫ Motor vehicle safety (impaired/distracted driving)
- ⎫ Overweight or obesity
- ⎫ Pedestrian/bicyclist accidents
- ⎫ Prescription drug abuse
- ⎫ Respiratory disease (asthma, COPD, etc.)
- ⎫ Senior health
- ⎫ Sexual assault/rape
- ⎫ Sexually transmitted infections
- ⎫ Social connectedness
- ⎫ Stroke
- ⎫ Substance abuse/Alcoholism/Opioid Use
- ⎫ Suicide
- ⎫ Tobacco use/nicotine addiction – smoking/vaping/chewing
- ⎫ Underage drinking
- ⎫ Unintended/Teen pregnancy
- ⎫ Violence (assault, firearm related)
- ⎫ Other (Please specify):

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

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

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

Social Determinants of Health

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

Economic Stability (consider poverty, employment, food security, housing stability)

- ⎦ **Education** (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)

- ⎦ **Social and Community Context** (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)

- ⎦ **Neighborhood and Built Environment** (consider access to healthy foods and beverages,

quality of housing, crime and violence, environmental conditions, transportation)

- ⎦ **Health and Health Care** (consider access to primary care, access to specialty care, health literacy)

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

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

Improving Health and Well-Being

The NYS Prevention Agenda 2019-2024 identifies specific goals for improving the health of New Yorkers of all ages. New York State envisions that improving the health of all New Yorkers requires strategies that can be implemented by a diverse set of health and non-health organizations and agencies.

Over the next 5 questions, select the top 3 goals your organization/agency can assist in achieving in the counties it serves.

11. Prevent Chronic Diseases

- ⎦ Increase access to healthy and affordable food and beverages
- ⎦ Increase skills and knowledge to support healthy food and beverage choices
- ⎦ Increase food security
- ⎦ Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
- ⎦ Promote school, childcare, and worksite environments that support physical

activity for people of all ages and abilities

- Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
- Prevent initiation of tobacco use, including combustible tobacco and vaping products by youth and young adults
- Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including low income; frequent mental distress/substance use disorder; LGBT; and disability
- Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
- Increase screening rates for breast, cervical, and colorectal cancer
- Increase early detection of cardiovascular disease, diabetes, prediabetes, and obesity
- Promote the use of evidence-based care to manage chronic diseases
- Improve self-management skills for individuals with chronic disease

12. Promote Healthy Women, Infants, and Children

- Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age
- Reduce maternal mortality and morbidity
- Reduce infant mortality and morbidity
- Increase breastfeeding
- Support and enhance children and adolescents' social-emotional development and relationships
- Increase supports for children with special health care needs
- Reduce dental caries (cavities) among children

13. Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

14. Promote a Healthy and Safe Environment

- Reduce falls among vulnerable populations
- Reduce violence by targeting prevention programs to highest risk populations
- Reduce occupational injury and illness
- Reduce traffic-related injuries for pedestrians and bicyclists
- Reduce exposure to outdoor air pollutants
- Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
- Promote healthy home and schools' environments
- Protect water sources and ensure quality drinking water
- Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
- Raise awareness of the potential presence of chemical contaminants and

promote strategies to reduce exposure
- ⎦ Improve food safety management

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

- ⎦ Strengthen opportunities to promote well-being and resilience across the lifespan
- ⎦ Facilitate supportive environments that promote respect and dignity for people of all ages
- ⎦ Prevent underage drinking and excessive alcohol consumption by adults
- ⎦ Prevent opioid and other substance misuse and deaths
- ⎦ Prevent and address adverse childhood experiences
- ⎦ Reduce the prevalence of major depressive episodes
- ⎦ Prevent suicides
- ⎦ Reduce the mortality gap between those living with serious mental illness and the general population

16. Prevent Communicable Diseases

- ⎦ Improve vaccination rates
- ⎦ Reduce vaccination coverage disparities
- ⎦ Decrease HIV morbidity (new HIV diagnoses)
- ⎦ Increase HIV viral suppression
- ⎦ Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
- ⎦ Increase the number of persons treated for Hepatitis C
- ⎦ Reduce the number of new Hepatitis C cases among people who inject drugs
- ⎦ Improve infection control in health care facilities
- ⎦ Reduce infections caused by multidrug resistant organisms and C. difficile
- ⎦ Reduce inappropriate antibiotic use

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

- ⎦ Provide subject-matter knowledge and expertise
- ⎦ Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)
- ⎦ Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals
- ⎦ Participate on committees, work groups, coalitions to help achieve the selected goals

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

18. With the overwhelming impact of COVID-19, were operations with your organization put on hold or modified, and if so, for how long? Via the scale below, please measure the impact of COVID-19 on your organization's operations.

- ☐ 1 – Operations were not changed
- ☐ 2 - Minimal operational changes
- ☐ 3 - Moderate operational changes
- ☐ 4 - Significant operational changes
- ☐ 5 - Operations cannot be completed (Limited or no resources available)

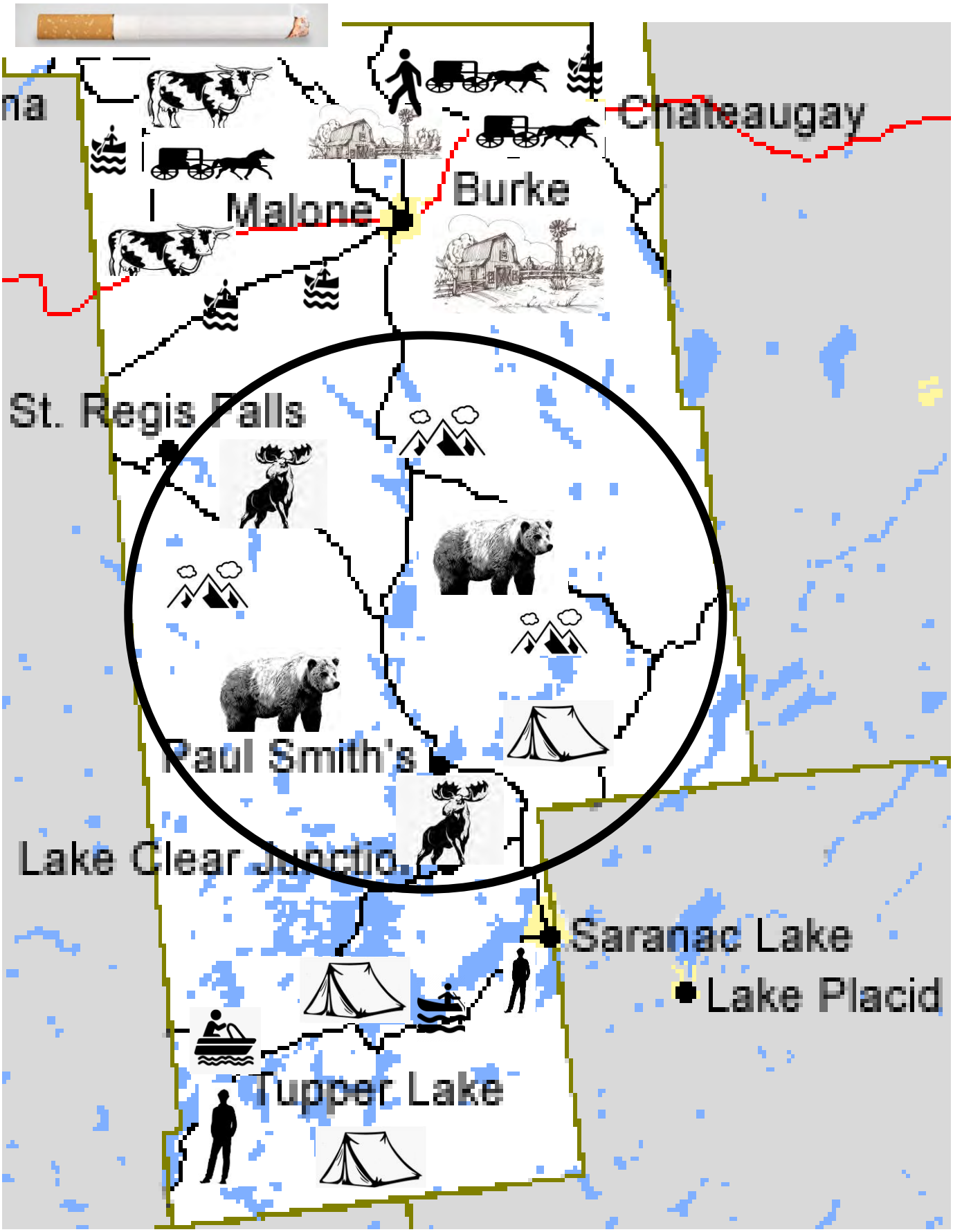
Additional Details:

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

- ⎦ Yes
- ⎦ No

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

Appendix 3



X:Katie/County Map

Franklin County New York

Northern border of the U.S. state of NY; St. Regis Mohawk Reservation within county border; 4 border crossings, 2 unmanned; **Area** 1697 sq mi., 4% water, 4th largest county in NY by land area; 29.2 people per sq. mi. **Population** declining - 65 + increased from 16.2% to 17.7%; **Hospitals-2** UVM AHMC & AMC; 1 **FQHC;** 7 **School Districts,** 2 **Colleges** NCCC & Paul Smiths

FRANKLIN COUNTY PUBLIC HEALTH SERVICES Prevention Agenda

Current Public Health Staff – 4 Vacant - 3, Admin-3

PRIORITIES

*Promote Well-Being and Prevent Mental and Substance Use Disorders Focus Area Promote Well-being and Resilience >Frequent mental distress during past month among adults F 14% PA 10.7%; >% of adults who have experienced 2 or more ACE's F 40.1% PA 33%; >Indicated # of abuse/maltreatment rate per 1k children age 0-17 F 26.9% NYS 14.6; >Suicide mortality age adjusted rate per 100k F 11.7 PA 7; >Newborns with neonatal withdrawal symptoms affected by maternal use of drugs F 16.3% PA 9.1%; >Percentage of people under age 18 in poverty. FC 25%, NVS 17%

FCPHS will Re-register as an Opioid Overdose Prevention Program + MCH Program Enhancements

*Prevent Chronic Disease. Focus Areas Healthy Eating; Food Security; Physical Activity >% of adults with annual income less than $25k with: obesity F 43% PA29%, consume 1 or more sugary drinks per day F 31.3% PA 28.5%, perceived food insecurity F 59.5% NYS 55.8%, smoke cigarettes F 30% PA 15.9; >% of population with low income low access to supermarket or grocery store F 9.1% NVS 2.2%; # of registered tobacco vendors F 123 NYS 110; >Prevalence of cigarette smoking F 20.5% (from (28.8%) PA 11% Participate in Leisure time physical activity F 76.2% PA 77.4%, > participate in leisure activity age 65+ F68.9% PA 75.9%, > Number of Recreational and Fitness Facilities per 100K 7.8 NYS 12; Premature Deaths – Age 35-64 > Diseases of the Heart F112.8 NYS 83.9 > Overall premature deaths F24.4% PA 22.8%

FCPHS will implement 3-4-50 Prevent Chronic Disease Framework, Age Friendly literacy initiatives, Support Complete Streets initiatives, and institute a county employee wellness program

Partners: UVM, AHMC, AMC, County CHHA, OFA, DSS, Community Services, FQHC, Highway, Community Connections, Heart Network, Catholic Charities, to name a few

3 Health Risk Behaviors Cause

1. Unhealthy Diet

Pre-pregnancy *: % of WIC pre-pregnant obese [3]
Pregnancy *: Rate of pregnancy's and births age 18-19 [1,2&11]
Pregnancy consequences of obesity *: [4-6] Gestational weight gain, diabetes, hypertension, preterm [9] NAS drugs of addiction [10]
Birth – Breastfeeding * % of infants fed breast milk at delivery hospital [7] * % exclusively BF in hospital [12]
WIC – Breastfeeding * * Enrolled in WIC who are BF @ 6 mos [8] Improving
WIC – Breastfeeding * % of infants supplemented with formula in hospital
Age 2-4 * % of obese receiving WIC [13] ; *TV viewing 2 hours or less [14]
Children * Overweight/Obese [15,16] *Elementary [19] *Middle School [18] *High School [17]
*Adolescents [2] * Total Students [15]
18+ * [20]
Adults * [21] *Percentage of adults with annual income less than $25k consuming sugary drinks [23]

2. Sedentary Lifestyle

Leisure Time Physical Activity * [26,29]
Number of recreational and Fitness Facilities * [30]

3. Tobacco Use

Rate 20.5%* - 28.8% previously*
Number of Tobacco Vendors: Franklin-123 NYS-110*
Adults with incomes less $25K*

Concurrent Factors affecting health risk behaviors:

*Food Insecurity [25,27] * Lack of Supermarket access [28]
*Wellbeing [31,32,33,34] : *Indicated child abuse reports [35] Improving *Suicide age adjusted [36] Improving
*Overdoses [37] *Alcohol consumption *MVA's [38]
*Access [59] : *Rate of pneumonia/flu hospitalizations 65+ [56] ** Rate of asthma hospitalizations in age groups [57,43,44] 25-44 45-64 65+ *Screenings: breast cancer [53] cervical cancers [54] prostrate [51] colon 49 and rectal [50] cancer *Rate of preventable hospitalizations [55] *Government sponsored insurance well child visits and vaccination compliance [51,52] * % of adults over age 18 with regular medical provider 75.5% [53] - % of adults with health insurance 91.7% [54]

4 Chronic Conditions

1. **Lung Disease** [43, 44, 45, 49]

2. **Diabetes** [46]

3. **Heart Disease** [41, 42]

4. **Cancer** [44, 47] Colon Rectal [49] Prostate [51]
Breast [48]

Claiming the lives of 50% FC Residents

Premature Deaths

*Age 35-64 rate of diseases of the heart [41]
*Age 35-64 rate of coronary heart disease [42]
*Age 35-64 rate of cardiovascular diseases [42]
*% of overall premature deaths at 65 [52]

Rate of Total Deaths *[51]

Cancer
Lung [44]
Bronchus [44]
Colon/Rectal [50]
All [47]

Diabetes [46]

Chronic Lower Respiratory Disease [43]

Key: Red means worse
Green means improved

SUMMARY OF 2022 COMMUNITY HEALTH DATA

1. Rate of pregnancies ages 18-19 per 1K females 2017-2019
   F 51.1% NYS 41.1%
2. Rate of births ages 18-19 per 1K females' ages 18-19, 2017-2019
   F 43.4% NYS 21.1%
3. % of WIC women pre-pregnancy obese (BMI >30) 2015-2017
   F 36.7% NYS 26.6%
4. % of WIC Women with gestational weight gain greater than ideal 2015-2019
   F 50.7% NYS 41%
5. % of WIC Women with gestational diabetes 2015-2017
   F 10.1% NYS 6.6%
6. % of WIC Women with gestational HTN 2015-2017
   F 11.2% NYS 7.5%
7. % of infants fed any breast milk in delivery hospitals 2017-2019
   F 74.6% NYS 88.5%
8. (#35) % of infants enrolled in WIC who are Breast Fed at 6 months among all WIC infants
   F 23.1% NYS 42% PA 2024 45.5%
9. (#31) % of births that are preterm
   F 8.7% NYS 9.2% PA 2024 8.3% No Significant Change
10. (#32) Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addictions
    F 16.3% NYS 7.9% PA 2024 9.1% No Significant Change
11. % of births with early (1st trimester) prenatal care 2017-2019
    F 73% NYS 76.3%
12. (#33) % of infants who are exclusively breastfed in the hospital among all infants
    F 60.3% NYS 47.1% PA 2024 41.9% No Significant Change
13. (#34) % of infants supplemented with formula in the hospitals among breastfed infants
    F 20% NYS 46.9% PA2024 41.9% No Significant Change

    % of obese (95th percentile or higher) children age 2-4 in WIC 2015-2017
    F 15.6% NYS 13.8% CHRIS RPT

    (#5) % of obesity WIC home among children ages 2-4 participating in WIC
    F 18.1% NYS 13.9% PA 2024 13% Worse
14. % of WIC children ages 2-4 viewing two hours TV or less per day 2015-2017
    F 83.1% NYS 86.6% Worse
15. % of total students overweight 2018-2019
    F 19% AHRN 17.8% No change for NYS
16. % of elementary students overweight, not obese 2018-2019
    F 19.3% AHRN 17.2% No change for NYS
17. % of middle and high school overweight, not obese 2018-2019
    F 18.4% AHRN 17.4% No change for NYS
18. % of middle school and high school obese 2018-2019
    F 33% AHRN 25.3% No change for NYS
19. % of elementary students obsess 2018-2019
    F 29.4% AHRN 19.4% No changes for NYS

20. (#7) % of adults 18+ who are obese 2018
    F 44.4% PA 24.2% No changes for NYS
21. % of adults overweight or obese 2018
    F 75.5% NYS 62.7%
22. (#7.1) % of adults with annual household income less than $25K with obesity
    F 43.6% NYS 31.8% PA 2024 29% No Significant Change
23. (#8) % of adults with annual income less than $25K who consume 1 or more sugary drinks per day
    F 31.3% NYS 31% PA2024 28.5% No Significant Change
24. (#6) % of children and adolescents with obesity
    F 23.6% NYS 17.3% PA2024 16.4% No Significant Change
25. (#9) % of adults with annual income less than 25K with perceived food insecurity
    F 59.5% NYS 55.8% PA 61.4% **Baseline**
26. (#10) % of adults who participate in leisure time physical activity
    F 76.2% NYS 76.2% PA 77.4% No Significant Change
    (#10.2) % of adults who participate in leisure time physical activity age 65+
    F 68.9% NYS 68.9% PA 2024 75.9% No Significant Change
27. (#9) % of population with low-income and low access to a supermarket or grocery store 2015
    F 9.1% NYS 2.2% AHRN 6% **Worse**
28. % of adults with an annual income less than $25K with perceived food security
    F 59.5% NYS 55.8% PA 2024 61.4 **Baseline**

PA Opportunity Index #40, #41, #42, #48

29. (#10.1) % of adults living with a disability 2018
    F 29.1% NYS 26.2% AHRN 29.2% **Worse**
    (#10.2) % of adults with disabilities who participate in leisure time physical activity.
    F 67.2% NYS 61.2% PA 61.8% No Significant Change
30. Number of Recreational and Fitness Facilities per 100K 2016
    F 7.8 NYS 12.3
31. (#40) Frequent mental distress during past month among adults, age adjusted percentage
    F 14% NYS 11.2% PA 10.7% No Significant Change
32. (#48) Percentage of adults who have experienced 2 or more adverse childhood experiences (ACE's)
    F 40.1% NYS 35.6% PA 33% **BASELINE**
33. (#41) Economy Score
    F 51.3% NYS 51.9% PA 51.9% **IMPROVED**
34. (#42) Community Score
    F 33.1% NYS 58.4% PA 16.4% **WORSE**
35. (#49) Indicated reports of abuse/maltreatment rate per 1,000 children age 0-17
    F 26.9% NYS 14.6% PA 15.6% **IMPROVED**
36. (#50) Suicide mortality age-adjusted rate per 100K
    F 11.7 NYS 8.2 PA 2024 7 **IMPROVED**

37. (#44) OD deaths involving any opioids, age adjusted rate per 100K

F 7.2 NYS 14.9 PA 2024 14.9 **WORSE**

Opioid analysis prescription age adjusted rate per 100K

F 462.2 NYS 270.7 PA 350 **Significantly Improved**

38. Rate of total motor vehicle crashes per 100K 2020

F 2463.7 NYS 1693.1 Upstate 2157.0 **WORSE**

AHRN 2298.7

Rate of speed related accidents per 100K 2020

F 280.2 NYS 292.08 Upstate 205.7 **WORSE**

AHRN 260.2

(PA) Opportunity Index Score

F 48.7% NYS 57.4% PA 59.2% 2024 **IMPROVED**

Suicide rate for 15-19 per 100K

F 0% NYS 6% AHRN 6.2%

39. (#11) Prevalence of cigarette smoking among adults

F 20.5% NYS 12.8% PA 2024 11% No Significant Change

40. (#11.1) % of cigarette smoking among adults with income less than $25K

F 30% NYS 20.4% PA 15.9% No Significant Change

41. Number of registered tobacco vendors per 100K 2016-2018

F 123 NYS 110 **WORSE**

Rate of diseases of the heart premature deaths 35-64 yrs per 100K 2017-2019

F 112.8 NYS 83.9

42. Rate of Coronary Heart diseases premature death 35-64 yrs per 100K 2017-2019

F 78 NYS 66.4

Rate of cardiovascular premature deaths 35-64 yrs per 100k 2017-2019

F 131 NYS 104.2

43. Rate of chronic lower respiratory disease deaths per 100K 2017-2019

F 68.8 NYS 36.7 **WORSE**

44. Rate of lung and bronchus cancer deaths per 100K 2016-2018

F 52.7 NYS 31.3 **WORSE**

Rate of lung/bronchus cases per 100k 2016-2018

F 105.4 NYS 72.6

45. Number of registered tobacco vendors per 100k 2016-2018

F 123 NYS 110 WORSE

46. Rate of diabetes deaths per 100K 2017-2019

F 26.5 NYS 17.6

47. Rate of all cancer deaths per 100K 2016-2018

F 198.8 NYS 175.5

48. Rate o female Breast Cancer deaths per 100K Female population 2016-2018

F 29.4 NYS 25.1

49. Rate of colon and rectal cancer incidence per 100K

F 56 NYS 45.7

50. Rate of colon and rectal cancer deaths per 100K 2016-2018

F 20.4 NYS 15.1

51. Rate of prostate cancer incidence per 100K

F 75.6 NYS 158.7

Rate of prostate cancer late stage cancer cases per 100K

F 39.9 NYS 30.5

Rate of total deaths per 100K 2017-2019

F 937.6 NYS 798.8 **WORSE**

% of children with recommended number of well child visits in government sponsored insurance programs 2019

F 69.8% NYS 75.2%

52. Percentage of overall premature deaths at 65

F 24.4% NYS 22.7% PA2024 22.8% No Significant Change

Percentage of 24-35 month old children with the 4:3:1:3:3:1:4 Immunizations series 2022

F 48.9% NYS 62.7% PA 70.5% Medium

Largest % increase 2% - IAP action plan No Significant Change

Percentage of 13yrs with complete HPV series 2020

F 15.5 PA 37.4%

Increase HPV vaccination coverage among county girls and boys aged 13yrs

F2022 19% NYS 26.08% LOW

Target increase 4-5% - IAP action Plan No Significant Change

53. Age adjusted percentage of adults with regular health care provider over age 18

F 75.5% NYS 79.1% PA 86.7% No Significant Change

% of women ages 50-74 years receiving breast cancer screening based on recent guidelines 2018

F 80.7% NYS 82.1%

54. % of adults age 18-64 with health insurance

F 91.7% NYS 92.5% PA2024 97% No Significant Change

% of women 21-65 years receiving cervical cancer screenings based on recent guidelines 2018

F 80.3% NYS 84.7% AHRN 87.2%

55. Rate of potentially preventable hospitalizations among adults per 10K 2019

F 125.1 NYS 125.9 PA 115 No Significant Change

56. Rate of pneumonia/flu hospitalizations ages 65{+ per 10K population 2017-2019

F 107.4 NYS 85.5 AHRN 83.9 **WORSE**

57. *All asthma rates in yellow Hospitalizations

25-44 45-64 65+

58. **DENTAL**

% of MKD enrollers ages 2-20 with at least one dental visits with in the last year 2018-2020

F 43.1% NYS 46.9 AHRN 49.3%

% off 3rd graders with dental insurance 2009-2011

F 78.7% AHRN 85.2%

% of 3rd graders with at least one dental visit 2009-2011

F 69.3% AHRN 81%

Rate of caries outpatient visits for children ages 3-5 yrs per 10K 2017-2019

F 229.6 NYS 146.4 AHRN 243.2

% of adults who had a dental visit within the last year 2018

F 63.2% NYS 69.8%

% of MKD enrollees with at least one preventive dental visit within the year 2018-2020

F 22.4% NYS 26.9%

59. **Access**

Increase medical doctor visits needed:

- Well child government sponsored insurance (51)
- Vaccinations and HPV vaccine (52)
- Screenings: breast cancer (53), cervical cancers (54), prostrate (51), colon (49) and rectal(50) cancer

% of adults 18-64 with health insurance 91.7% (54)

% of adults with regular HCP over 18 75.5% (53)

Rate of preventable hospitalizations (55)

Rat of pneumonia/flu hospitalizations 65+ (56)

Increase Dental Disaster (58)

60. Claiming the lives of 50% FC residents

Premature Deaths:

Age 35-64 rate of diseases of the heart (41)

Age 35-64 rate of coronary heart disease (42)

% of overall premature deaths at 65 (52)

Other Deaths:

Cancer (Lung (44), Bronchi's (44), Colon/Rectal (50), all)

Diabetes (46)

Chronic LR Disease (43)

61. Rate of hospital onset C. diff infections (CDI's) per 10K patient days (risk adjusted), 2019

F 11.8 NYS 4.0

62. Rate of community onset healthcare facility Associated CDI's per 100 admissions, not risk adjusted, 2019

F.2 NYS .2

SUMMARY OF 2022 COMMUNITY HEALTH DATA

Key: Red means worse
Green means improved
Yellow means caution

WIC

- % of WIC women pre-pregnancy obese (BMI >30) 2015-2017

  F 36.7% NYS 26.6%
- % of WIC Women with gestational weight gain greater than ideal 2015-2019

  F 50.7% NYS 41%
- % of WIC Women with gestational diabetes 2015-2017

  F 10.1% NYS 6.6%
- % of WIC Women with gestational HTN 2015-2017

  F 11.2% NYS 7.5%
- (#35) % of infants enrolled in WIC who are Breast Fed at 6 months among all WIC infants

  F 23.1% NYS 42% PA 2024 45.5% Improved
- % of obese (95th percentile or higher) children age 2-4 in WIC 2015-2017

  F 15.6% NYS 13.8% CHRIS RPT
- (#5) % of obesity WIC home among children ages 2-4 participating in WIC

  F 18.1% NYS 13.9% PA 2024 13% **Worse**
- % of WIC children ages 2-4 viewing two hours TV or less per day 2015-2017

  F 83.1% NYS 86.6% Worse

MCH/Breast Feeding

- Rate of pregnancies ages 18-19 per 1K females 2017-2019

  F 51.1% NYS 41.1%
- Rate of births ages 18-19 per 1K females' ages 18-19, 2017-2019

  F 43.4% NYS 21.1%
- % of infants fed any breast milk in delivery hospitals 2017-2019

  F 74.6% NYS 88.5%
- (#31) % of births that are preterm

  F 8.7% NYS 9.2% PA 2024 8.3% No significant change
- (#32) Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addictions

F 16.3% NYS 7.9% PA 2024 9.1% No significant change

- % of births with early (1st trimester) prenatal care 2017-2019

F 73% NYS 76.3%

- (#33) % of infants who are exclusively breastfed in the hospital among all infants

F 60.3% NYS 47.1% PA 2024 51.7% No significant change

- (#34) % of infants supplemented with formula in the hospitals among breastfed infants

F 20% NYS 46.9% PA 2024 41.9% No significant change

Prevent Chronic Disease/Obesity

- % of total students overweight 2018-2019

F 19% AHRN 17.8% No data for NYS

- % of elementary students overweight, not obese 2018-2019

F 19.3% AHRN 17.2% No data for NYS

- % of middle and high school overweight, not obese 2018-2019

F 18.4% AHRN 17.4% No data for NYS

- % of middle school and high school obese 2018-2019

F 33% AHRN 25.3% No data for NYS

- % of elementary students obese 2018-2019

F 29.4% AHRN 19.4% No data for NYS

- (#7) % of adults 18+ who are obese 2018

F 44.4% PA 24.2% No significant change

- % of adults overweight or obese 2018

F 75.5% NYS 62.7%

- (#7.1) % of adults with annual household income less than $25K with obesity

F 43.6% NYS 31.8% PA 2024 29% No significant change

- (#8) % of adults with annual income less than $25K who consume 1 or more sugary drinks per day

F 31.3% NYS 31% PA2024 28.5% No significant change

- (#6) % of children and adolescents with obesity

F 23.6% NYS 17.3% PA2024 16.4% No significant change

- (#9) % of adults with annual income less than 25K with perceived food insecurity

F 59.5% NYS 55.8% PA 61.4% **Baseline**

- (#10) % of adults who participate in leisure time physical activity

F 76.2% NYS 76.2% PA 77.4% No significant change

- (#10.2) % of adults who participate in leisure time physical activity age 65+

F 68.9% NYS 68.9% PA 2024 75.9% No significant change

Disparity CHIP

- (#9) % of population with low-income and low access to a supermarket or grocery store

2015
F 9.1% NYS 2.2% AHRN 6% **Worse**

- % of adults with an annual income less than $25K with perceived food security

F 59.5% NYS 55.8% PA 2024 61.4 **Baseline**

- PA Opportunity Index Score

F 48.7 NYS 57.4 PA 59.2 **IMPROVED**

- (#10.1) % of adults living with a disability 2018

F 29.1% NYS 26.2% AHRN 29.2% **Worse**

- (#10.2) % of adults with disabilities who participate in leisure time physical activity.

F 67.2% NYS 61.2% PA 61.8% No significant change

- Number of Recreational and Fitness Facilities per 100K 2016

F 7.8 NYS 12.3

- Rate of diseases of the heart premature deaths 35-64 yrs per 100K 2017-2019

F 112.8 NYS 83.9

- Rate of Coronary Heart diseases premature death 35-64 yrs per 100K 2017-2019

F 78 NYS 66.4

- Age adjusted percentage of adults with regular health care provider over age 18

F 75.5% NYS 79.1% PA 86.7% No significant change

- % of adults age 18-64 with health insurance

F 91.7% NYS 92.5% PA 2024 97% No significant change

- Rate of potentially preventable hospitalizations among adults per 10K 2019

F 125.1 NYS 125.9 PA 115 No significant change

Injuries, Violence, Occ Health

- (#40) Frequent mental distress during past month among adults, age adjusted percentage

  F 14 NYS 11.2 PA 10.7 No significant change
- (#48) Percentage of adults who have experienced 2 or more adverse childhood experiences (ACE's)

  F 40.1% NYS 35.6% PA 33% **BASELINE**
- (#41) Economy Score

  F 51.3% NYS 51.9% PA 51.9% **IMPROVED**
- (#42) Community Score

  F 33.1% NYS 58.4% PA 16.4% **WORSE**
- (#49) Indicated reports of abuse/maltreatment rate per 1,000 children age 0-17

  F 26.9% NYS 14.6% PA 15.6% **IMPROVED**
- (#50) Suicide mortality age-adjusted rate per 100K

  F 11.7 NYS 8.2 PA 2024 7 **IMPROVED**
- (#44) Overdose deaths involving any opioids, age adjusted rate per 100K

  F 7.2 NYS 14.9 PA 2024 14.9 **WORSE**
- (#46) Opioid analysis prescription age adjusted rate per 100K

  F 462.2 NYS 270.7 PA 350 **Significantly Improved**
- Rate of total motor vehicle crashes per 100K 2020

  F 2463.7 NYS 1693.1 Upstate 2157.0 **WORSE**
  AHRN 2298.7
- Rate of speed related accidents per 100K 2020

  F 280.2 NYS 292.08 Upstate 205.7 **WORSE**
  AHRN 260.2
- (PA) Opportunity Index Score

  F 48.7 NYS 57.4 PA 2024 59.2 **IMPROVED**
- Suicide rate for 15-19 per 100K

  F 0% NYS 6% AHRN 6.2%

Reduce Illness, Disability & Death Related to Smoking

- (#11) Prevalence of cigarette smoking among adults

  F 20.5% NYS 12.8% PA 2024 11% No significant change
  (Past prevalence 28.8%)

- (#11.1) % of cigarette smoking among adults with income less than $25K

F 30 NYS 20.4 PA 15.9 No significant change

- Rate of chronic lower respiratory disease deaths per 100K 2017-2019

F 68.8 NYS 36.7 **WORSE**

- Rate of lung and bronchus cancer deaths per 100K 2016-2018

F 52.7 NYS 31.3 **WORSE**

- Number of registered tobacco vendors per 100K 2016-2018

F 123 NYS 110 **WORSE**

- Rate of diabetes deaths per 100K 2017-2019

F 26.5 NYS 17.6

- Rate of all cancer deaths per 100K 2016-2018

F 198.8 NYS 175.5

- Rate of female Breast Cancer deaths per 100K Female population 2016-2018

F 29.4 NYS 25.1

- Rate of colon and rectal cancer incidence per 100K 2016-2018

F 56 NYS 45.7

- Rate of colon and rectal cancer deaths per 100K 2016-2018

F 20.4 NYS 15.1

- Rate of prostate cancer incidence per 100K

F 75.6 NYS 158.7

- Rate of prostate cancer late stage cancer cases per 100K

F 39.9 NYS 30.5

- Rate of total deaths per 100K 2017-2019

F 937.6 NYS 798.8 **WORSE**

- Percentage of overall premature deaths before 65

F 24.4% NYS 22.7% PA 2024 22.8% No significant change

- % of women ages 50-74 years receiving breast cancer screening based on recent guidelines 2018

F 80.7% NYS 82.1%

- % of women 21-65 years receiving cervical cancer screenings based on recent guidelines 2018

F 80.3% NYS 84.7% AHRN 87.2%

- Rate of pneumonia/flu hospitalizations ages 65+ per 10K population 2017-2019

F 107.4 NYS 85.5 AHRN 83.9 **WORSE**

- All asthma rates and asthma hospitalizations at 25-65+ age group CAUTION

Vaccination/Kids

- Percentage of 24-35 month old children with the 4:3:1:3:3:1:4 Immunizations series 2022

  F 48.9% NYS 62.7% PA 70.5% No significant change

- Percentage of 13yrs with complete HPV series 2020

  F 15.5 PA 37.4%

- HPV vaccination coverage among county girls and boys aged 13yrs

  F 19% NYS 26.08% No significant change

- % of children with recommended number of well child visits in government sponsored
  insurance programs 2019
  F 69.8% NYS 75.2%

Antibiotic Resistance

- Rate of hospital onset C. diff infections (CDI's) per 10K patient days (risk adjusted),
  2019
  F 11.8 NYS 4.0
- Rate of community onset healthcare facility associated CDI's per 100 admissions,
  not risk adjusted, 2019
  F 0.2 NYS 0.2

DENTAL

- % of MKD enrollers ages 2-20 with at least one dental visits with in the last year 2018-
  2020
  F 43.1% NYS 46.9% AHRN 49.3%
- % of 3rd graders with dental insurance 2009-2011

  F 78.7% AHRN 85.2%
- % of 3rd graders with at least one dental visit 2009-2011

  F 69.3% AHRN 81%
- Rate of caries outpatient visits for children ages 3-5 yrs per 10K 2017-2019

F 229.6 NYS 146.4 AHRN 243.2

- % of adults who had a dental visit within the last year 2018

F 63.2% NYS 69.8%

- % of MKD enrollees with at least one preventive dental visit within the year 2018-2020

F 22.4% NYS 26.9%

Access

Increase medical doctor and dental visits needed:

- Well child government sponsored insurance (51)
- Vaccinations and HPV vaccine (52)
- Screenings: breast cancer (53), cervical cancers (54), prostrate (51), colon (49) and rectal(50) cancer

% of adults 18-64 with health insurance 91.7% (54)
% of adults with regular HCP over 18 75.5% (53)
Rate of preventable hospitalizations (55)
Rate of pneumonia/flu hospitalizations 65+ (56)
Increase Dentist visits needed (58)

Claiming the lives of 50% FC residents

Premature Deaths:

Age 35-64 rate of diseases of the heart (41)
Age 35-64 rate of coronary heart disease (42)
Age 35-64 rate of cardiovascular disease (42)
% of overall premature deaths before 65 (52)

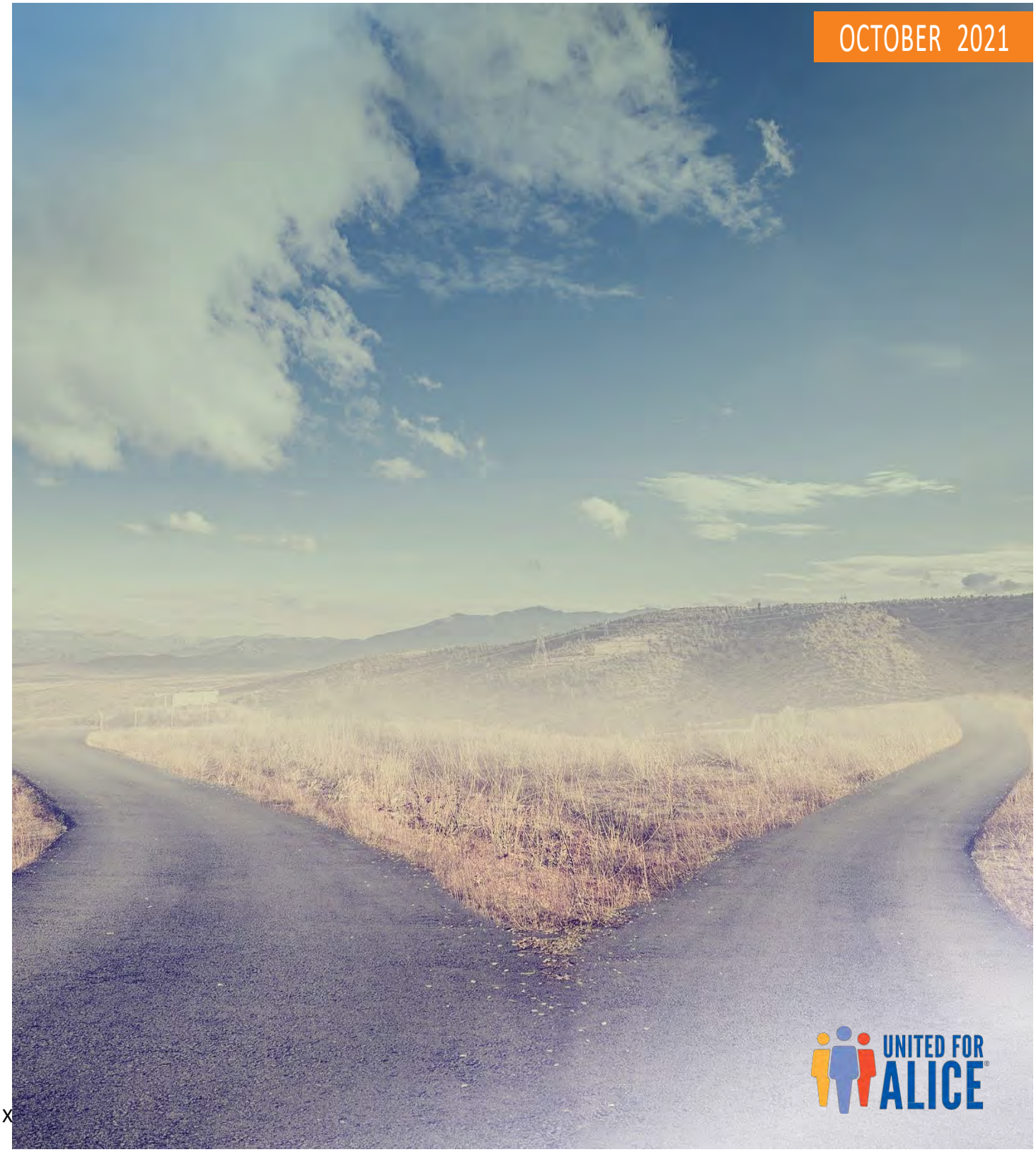
Other Deaths:

Cancer (Lung (44), Bronchus (44), Colon/Rectal (50), all (47)
Diabetes (46)
Chronic Lower Respiratory Disease (43)
Rate of total deaths (51)

Appendix 3

THE PANDEMIC DIVIDE:

An ALICE Analysis of National COVID Surveys



WHAT IS UNITED FOR ALICE?

United For ALICE is a driver of innovation, research, and action around financial hardship. At its core is ALICE: Asset Limited, Income Constrained, Employed — a measure of households that earn above the Federal Poverty Level but below the cost of household basics. The ALICE research drills down to the local level for both household incomes and costs, showing the mismatch between low-paying jobs and what it takes to survive financially, county by county and state by state.

This research is bolstered by external advisory committees of experts in fields ranging from health care and child care to labor and technology. The ALICE research team collaborates with a state-level committee in each partner state, and it draws on those experts nationwide for a biennial Methodology Review. This collaborative model ensures that all ALICE products and tools are based on unbiased data that is transparent, replicable, current, and incorporates local context.

With this data and research, ALICE partners convene, advocate, and innovate in their communities to highlight the issues faced by ALICE households, and to build solutions that promote financial stability.

KEY TERMS

ALICE: Asset Limited, Income Constrained, Employed — households with income above the Federal Poverty Level but below the basic cost of living.

Household Survival Budget: The lowest-cost options for household basics (housing, child care, food, transportation, health care, and a smartphone plan, plus taxes and a small contingency). Calculated at the county level for various household types.

ALICE Threshold of Financial Survival (the ALICE Threshold): The average income that a household needs to afford the household basics defined by the Household Survival Budget for each county.

Below ALICE Threshold: Includes both poverty-level and ALICE households — all households unable to afford the basics.

ALICE Essentials Index: A national standardized measure of the change over time in the costs of household basics included in the Household Survival Budget.

ALICE ONLINE

Visit UnitedForALICE.org for more details about ALICE, including:

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ALICE Essentials Index

See change over time in the cost of household essentials, **compared to other rates of inflation**

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Explore how wage levels impact ALICE and what wages different **occupations pay by location**

COVID Tracker

See **COVID-19 cases mapped** with ALICE data, and learn **more about the impacts of** COVID on ALICE

Methodology

Read an overview of the sources and calculations used in the ALICE research

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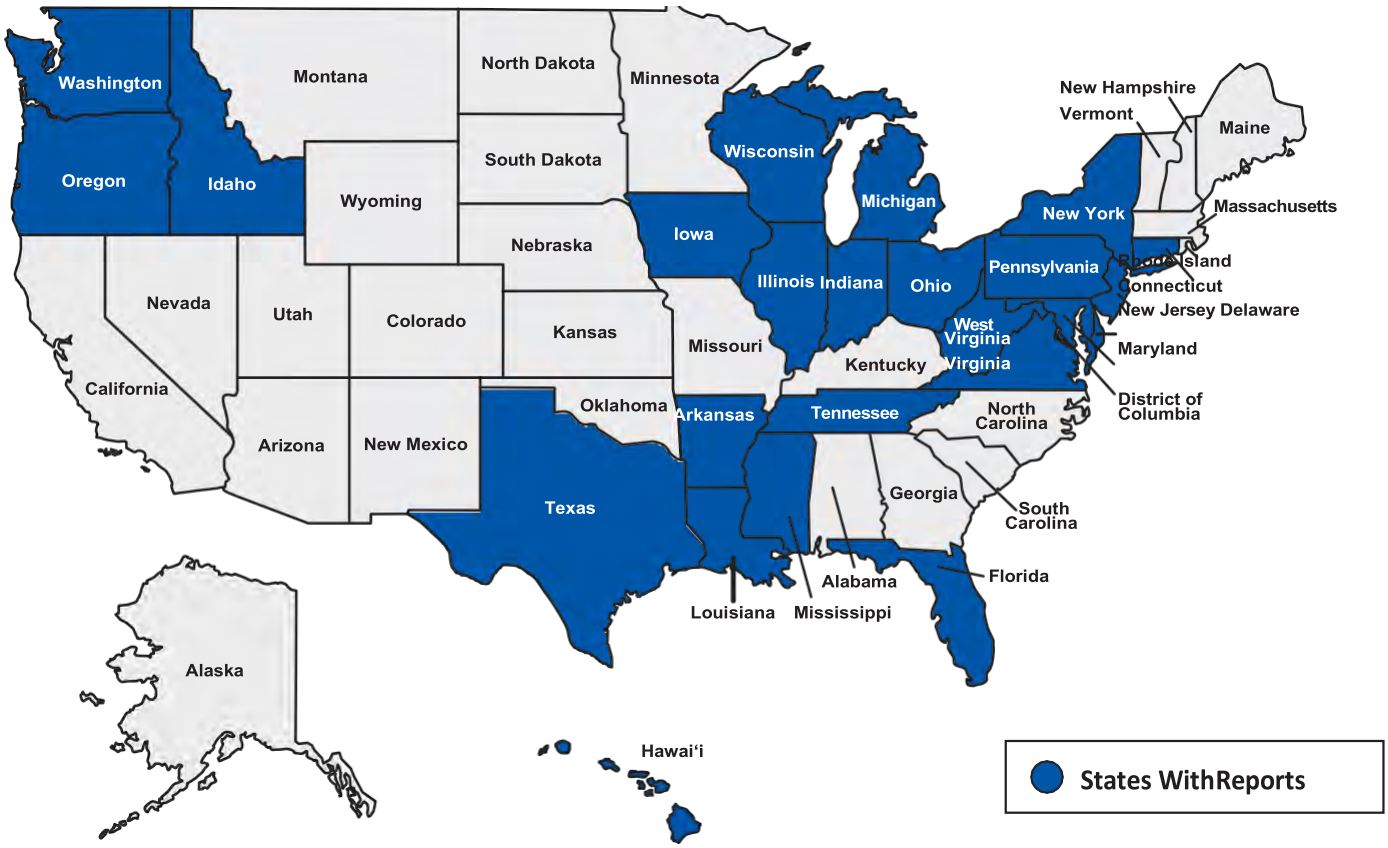
UNITED FOR ALICE STATES AND PARTNERS

Over the last decade, United For ALICE has grown from a study of financial hardship in Morris County, NJ, to a grassroots movement that includes United Ways, corporations, foundations, and nonprofits in 24 states. Learn more about our partners at UnitedForALICE.org/Governance.



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INTRODUCTION: A TALE OF TWO PANDEMICS

There are many emerging stories about the impact of the COVID-19 pandemic in the U.S. over the past 18 months. Some are stories of job loss, rising food insecurity, housing instability, and health concerns.[1] Others point to an economy in full recovery — new businesses opening at a record rate, household debt at a near low, savings rates and home prices rising, and the stock market at an all-time high.[2] All of these stories are true. The highs and lows of the pandemic have been experienced very differently across the U.S. population — and initial reports indicate that a key differentiator is income.[3]

United For ALICE, a driver of research, innovation, and action on financial hardship in the U.S., shines a light on the challenges of ALICE: Asset Limited, Income Constrained, Employed — households that struggle to make ends meet and have little or no savings, but often make too much to qualify for public assistance. The ALICE Threshold of Financial Survival draws a line between survival (the bare minimum needed to live and work in the modern economy) and stability; it is based on the ALICE Household Survival Budget (the lowest-cost options for housing, child care, food, transportation, health care, and a smartphone plan for all household types in each U.S. county).

Many of the economic indicators that are used to guide policy are averages of households at all income levels. These averages conceal the harsh realities millions of families faced during the pandemic. By contrast, the ALICE Threshold delineates two categories of households that experienced the pandemic in very different ways:

- Below the ALICE Threshold: households with income that is too low to cover the Household Survival Budget for their household type in the counties where they live. This group includes ALICE households and households with income below the Federal Poverty Level (FPL).
- Above the ALICE Threshold: households with income greater than the cost of the Survival Budget for their household type in the counties where they live.

Using the ALICE Threshold as its framework, this Report analyzes three nationally representative surveys about household experiences during COVID-19, as well as findings from a series of non-representative local ALICE COVID-19 Impact Surveys:

- Federal Reserve Board's Survey of Household Economics and Decision making (SHED)
- University of Southern California's Understanding America Study's Understanding Coronavirus in America survey (UAS COVID survey)
- U.S. Census Bureau's COVID-19 Household Pulse Survey (Household Pulse Survey)
- United For ALICE's COVID-19 Impact Surveys conducted with state and local partners (United For ALICE Surveys)

Together, the survey results show that households below the ALICE Threshold fared significantly worse than households above the Threshold — financially, physically, and emotionally — during the pandemic.

Together, the survey results show that households below the ALICE Threshold fared significantly worse than households above the Threshold — financially, physically, and emotionally — during the pandemic. Even with the added protective measures of eviction moratoria and housing and food assistance programs, conditions worsened for households below the ALICE Threshold from March 2020 to May 2021.



Overall, the survey data included in this Report reveals that during the pandemic, experiences and realities diverged for households above and below the ALICE Threshold. Compared to households above the ALICE Threshold, those below the ALICE Threshold were more likely to have:

- **Struggled financially:**
  - Reported that they were "just getting by" or "finding it difficult to get by"
  - Were less likely to have reported "living comfortably"
- Had few savings or assets:
  - Had no rainy day funds, even before the pandemic started
  - Had no assets or retirement savings, or had a much lower amount
  - Saw a decrease in the funds usually in their checking/savings accounts
  - Were renters rather than homeowners
- **Faced disruptions in employment:**
  - Lost a job, experienced a temporary layoff, or worked fewer hours
  - Were not employed in full-time, salaried jobs
  - Worked in hourly paid jobs, had employment gaps, or were underemployed
  - Wanted to work, or if they were already working, wanted to work more hours
- Faced barriers to work:
  - Had caregiving demands
  - Faced health issues
  - Had few paid sick days available
- **Faced additional concerns as parents:**
  - Worked reduced hours or quit a job because their children's classes were not completely in-person or access to child care was disrupted
  - Faced food insecurity
  - Had concerns about paying housing expenses, paying off debts, and facing non-COVID-19-related medical issues
  - Didn't always have a computer or other digital device available to children for educational purposes

- **Experienced more mental and physical health challenges:**
  - Had a household member with a health issue
  - Faced elevated symptoms of anxiety and depression
  - Had health issues that increased concerns about paying housing expenses, providing food, paying off debt, and losing a job
- Needed alternative sources of income to make ends meet:
  - Didn't have the same income sources as before the pandemic
  - Used stimulus payments and unemployment benefits to cover basic needs
  - Relied on public and private assistance
  - Borrowed from friends and family

These surveys also provide an alarming look at the breakdown of pandemic experiences by race/ethnicity. The differences here are even starker than when looking at income alone, giving credence to concerns that the pandemic is exacerbating racial inequities across all facets of life. The analysis reveals that, in particular, Black and Hispanic households have been negatively impacted by the pandemic.

The combined analysis of these surveys represents a new and fruitful frontier for understanding ALICE households. With questions on a variety of topics not previously covered by ALICE research, these surveys offer new insights into the challenges ALICE households face and the strategies they employ to get by. The surveys also provide additional validation for the ALICE Threshold as a meaningful measure, as most survey questions revealed significant differences between households above and below the Threshold.

ALICE BEFORE THE PANDEMIC

It is precisely the challenges that ALICE families were facing before the pandemic that made them so vulnerable to the health and economic crises of COVID-19. Before the pandemic, ALICE households already faced persistent challenges related to income, basic expenses, employment, and savings and credit, and for many households these issues were compounded by systemic racism and discrimination. These challenges are detailed in the national 2020 ALICE Report *On Uneven Ground: ALICE and Financial Hardship in the U.S.* and outlined below:

- ALICE never recovered from the Great Recession.
- ALICE was already struggling to afford essential household items — and the costs of these basics continue to rise.
- Employment growth over the last decade has been concentrated in low-wage jobs.
- ALICE earns too little to save, yet too much to qualify for many public and private assistance programs.
- Many households face systemic barriers to financial stability.
- Households face additional expenses not captured by the Household Survival Budget.
- ALICE households are more vulnerable in times of crisis, as they feel the economic impact almost immediately.

SURVEY DATA & METHODOLOGY

This Report presents the results from three nationally representative surveys using an ALICE lens, as well as findings from a series of local surveys conducted by United For ALICE and our partners:

- The October 2019 and November 2020 Full Surveys and July 2020 Supplementary Survey of Household Economics and Decision making from the Board of Governors of the Federal Reserve (SHED) (see Appendix A)
- The ongoing biweekly Understanding America Study's Understanding Coronavirus in America ("Covid") survey conducted by the University of Southern California's Center for Economic and Social Research (UAS COVID survey) (see Appendix B)
- The ongoing weekly/biweekly COVID-19 Household Pulse Survey conducted by the U.S. Census Bureau (Household Pulse Survey) (see Appendix C)
- September 2020 to June 2021 United For ALICE COVID-19 Impact Surveys conducted in 18 locations with state and local United Ways and their community partners, with more than 45,000 respondents (United For ALICE Surveys) (see Appendix D)

There are differences between the surveys that are noted in the text and fully detailed in the appendices. Notably, the surveys varied in survey dates, sample size, and the time point used for income determination. In addition, the SHED, the UAS COVID survey, and the Household Pulse Survey are representative samples, so the weighted results are reported for population or households (according to the question). The United For ALICE Surveys are non-representative convenience samples, so results are reported for respondents only.

Survey Dates: For ongoing surveys, the weeks and/or waves chosen for analysis were based on 1) when the question being analyzed was asked (not all questions are repeated in each iteration of the ongoing surveys), and 2) if the question was asked multiple times, whether the data is presented over time or a specific week is selected based on relevance to the topic (e.g., weeks when school was in session for questions about parents' work impacts), or to match the time period for which a related question was asked in one of the other surveys.

ALICE Threshold of Financial Survival (the ALICE Threshold): With the raw data from these surveys, we were able to determine whether the survey participants were above or below the ALICE Threshold using three key criteria: 1) household income, 2) location, and 3) household composition. Location and family composition were used to identify the appropriate Household Survival Budget (based on 2018 United For ALICE data), which was then compared to the respondent's household income to determine whether they were above or below the ALICE Threshold.

Significance Testing: The differences reported between the responses of respondents above and below the ALICE Threshold were statistically significant (not attributed to chance) at a 95% confidence level. Depending on the type of question, chi-squared tests, Welch's t-tests (two-tailed), and ranked t-tests (in cases where Welch's t-tests assumptions were not met) were used.

Analysis by Race/Ethnicity: Where possible, we share data by race/ethnicity, with the following groups included in this Report:

- AIAN/Hawaiian/Pacific Islander — American Indian or Alaska Native, Native Hawaiian, or Pacific Islander
- Asian — further breakdown of this broad group was not possible due to lack of data on country of origin
- Black — reported here as non-Hispanic, though in many areas of the country there is substantial overlap between race and Hispanic ethnicity
- Hispanic — includes respondents identifying as Spanish, Hispanic, or Latinx
- White — reported here as non-Hispanic, though in many areas of the country there is substantial overlap between race and Hispanic ethnicity

The groupings and the ability to break down respondents by race/ethnicity differed across surveys. See the appendices and the notes shown below figures for more details.

To access the data used in this Report, download the Report Crosstabs at UnitedForALICE.org/National-Reports

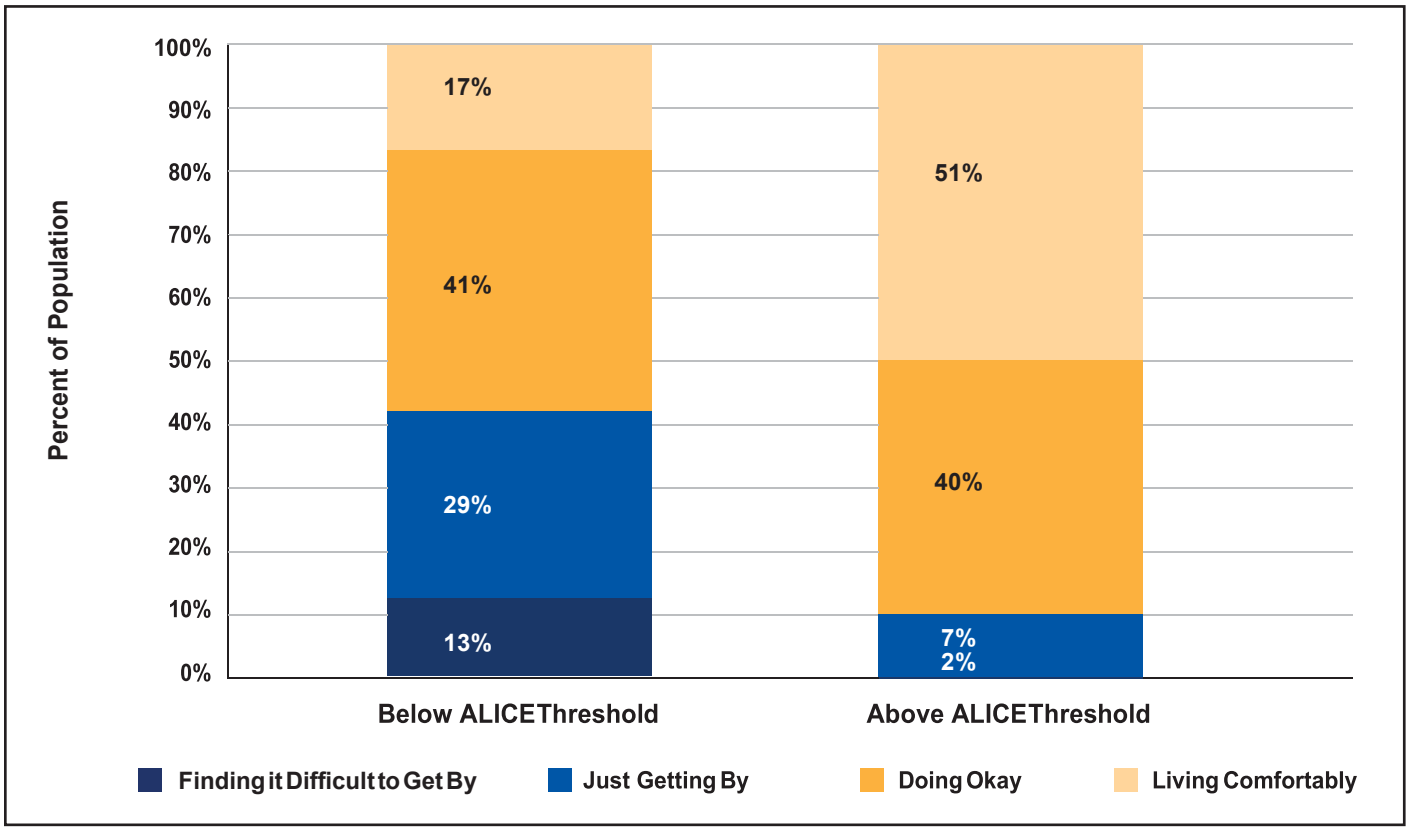
THE FINANCIAL IMPACT OF COVID-19

For many households, overall household finances were constricted during the pandemic, and it became more difficult to meet basic needs. There were a variety of reasons for this: reduced income or other employment impacts, school closures, gaps in access to health care, new or worsening health problems, decreased social support during quarantine, and other issues.[4] While all households were undoubtedly affected in some way, it is not surprising that those who were already struggling to make ends meet before the pandemic fared worse.

The serious financial impact of the pandemic has been concealed by summary statistics. For example, according to the Federal Reserve SHED, there was a slight increase in the percentage of households struggling to get by financially at the beginning of the pandemic (from 25% in October 2019 to 27% in April 2020), but rates improved, falling to below pre-pandemic levels by July 2020 (23%).[5] Similarly, the percentage of households reporting that they were "living comfortably" decreased slightly at the beginning of the pandemic (from 36% in October 2019 to 29% in April 2020) but improved by July 2020 (ending at 37%).

But behind the averages of all respondents, two very different trajectories emerged for people with household income above and below the ALICE Threshold. In July 2020, when total responses suggested full recovery, the reality was quite different: When asked in the SHED how they were managing financially overall, 42% of respondents below the ALICE Threshold were struggling, compared to less than 10% of those above the Threshold (29% vs. 7% were "just getting by" and 13% vs. 2% were "finding it difficult to get by"). Conversely, respondents above the ALICE Threshold were significantly more likely than those below the Threshold to say that they were "living comfortably" (51% vs. 17%) (Figure 1).

Figure 1.
Managing Financially by the ALICE Threshold

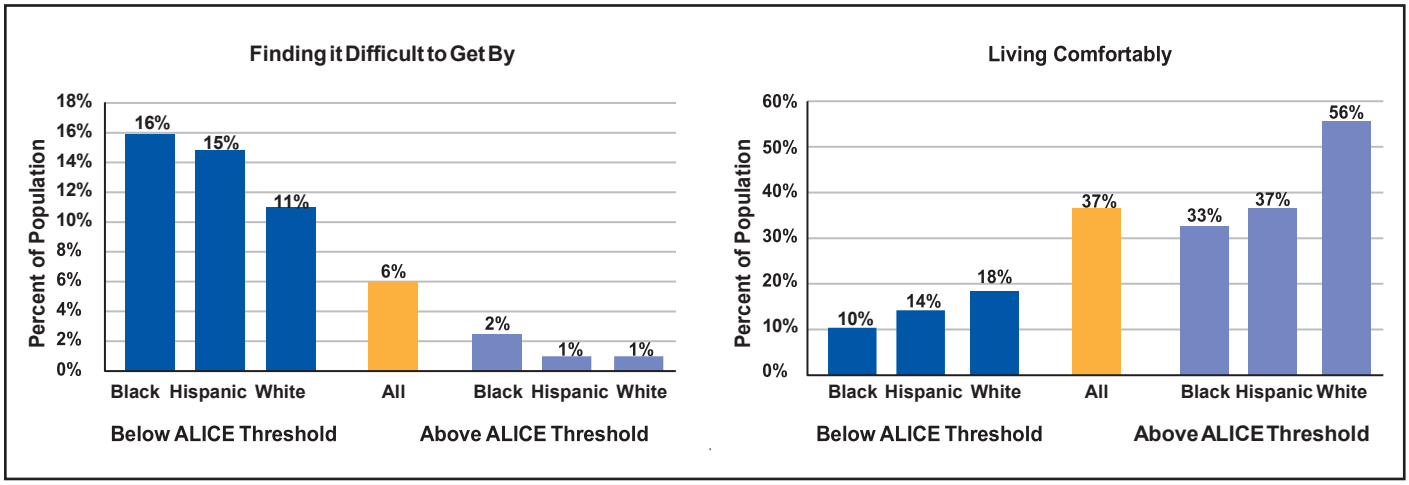


Question: Overall, which of the following best describes how you are managing financially these days?

Source: ALICE Threshold, 2018; Federal Reserve Board, Survey of Household Economics and Decisionmaking (SHED), July 2020

The gap between those struggling financially during the pandemic and those living comfortably was even wider by race/ethnicity. According to the July 2020 SHED, Black and Hispanic respondents below the ALICE Threshold were significantly more likely to report that they were "finding it difficult to get by" (16% and 15%, respectively) compared to White respondents (11%) and especially to respondents of all race/ethnicities above the ALICE Threshold (less than 3%). On the other end of the spectrum, above the ALICE Threshold, White respondents were significantly more likely to report that they were "living comfortably" (56%) compared to Black and Hispanic respondents (33% and 37%) (Figure 2).

Figure 2.
Managing Financially by the ALICE Threshold and Race/Ethnicity



Question: Overall, which of the following best describes how you are managing financially these days? Note: Groupings include Black non-Hispanic, Hispanic, and White non-Hispanic respondents.

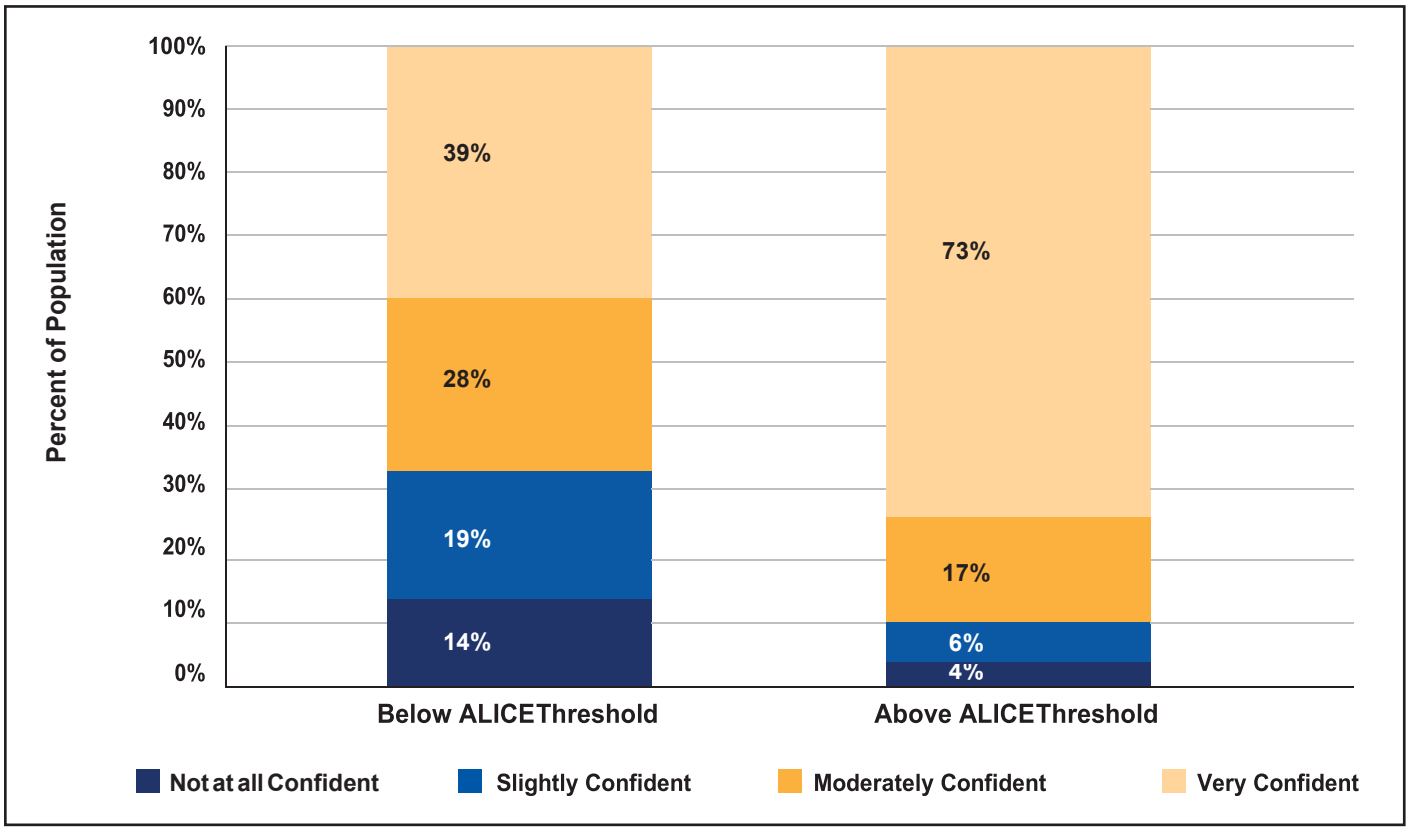
Source: ALICE Threshold, 2018; Federal Reserve Board, Survey of Household Economics and Decisionmaking (SHED), July 2020

Ability to Afford Basic Expenses: The subjective experiences of how households are managing financially during the pandemic were reflected in their ability to cover the cost of household basics:

- Respondents below the ALICE Threshold were almost three times more likely to report difficulty paying for household expenses. Over half (52%) of respondents below the ALICE Threshold said that it was "somewhat difficult" or "very difficult" to pay for usual household expenses (including but not limited to food, rent or mortgage, car payments, medical expenses, and student loans), a significantly higher percentage than respondents above the ALICE Threshold, at 19% (Household Pulse Survey, August 19–August 31, 2020).
- The majority of households below the ALICE Threshold had difficulty meeting at least one basic need in the Household Survival Budget. Only 23% reported that their household had no trouble meeting basic needs, compared to more than two-thirds (69%) of those above the Threshold who reported no trouble meeting basic needs (United For ALICE Surveys, February–June 2021).
- By race, Black respondents were significantly more likely to report that it was "somewhat difficult" or "very difficult" to pay for usual household expenses (47%), compared to White or Asian respondents (29% and 31%, respectively), and the difference was even greater when considering ALICE Threshold status. Sixty-one percent of Black respondents below the ALICE Threshold had difficulty paying usual household expenses, a significantly higher percentage than White or Asian respondents (Household Pulse Survey, August 19–August 31, 2020)
- Only 39% of respondents below the ALICE Threshold said in July 2020 that they were very confident they would be able to pay all their bills in full in August, compared to 73% of respondents above the ALICE Threshold (SHED, July 2020) (Figure 3).

Figure 3.

Ability to Pay Bills in Full by the ALICE Threshold



Question: How confident are you that you will be able to pay all of your bills in full in August?

Source: ALICE Threshold, 2018; Federal Reserve Board, Survey of Household Economics and Decisionmaking (SHED), July 2020

Breaking down expenses further exposes the depth and breadth of the financial challenges households faced during the pandemic and provides context for the differences in pandemic impacts between households above and below the ALICE Threshold, as discussed in subsequent sections.

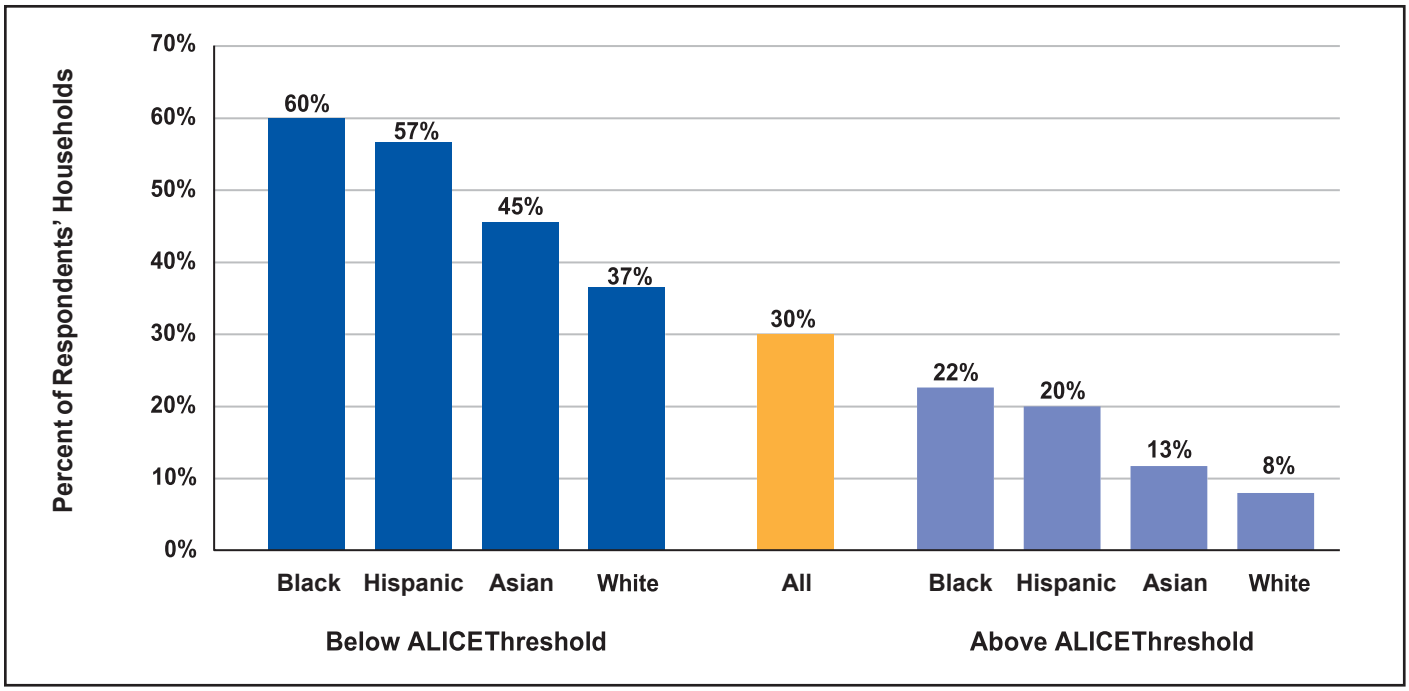
Ability to Afford Housing: Because housing provides underlying stability for all other facets of daily life, difficulties paying housing expenses were a substantial concern for many during the pandemic:

- Among UAS COVID survey respondents below the ALICE Threshold, 17% reported in August 2020 that they thought there was more than a 25% chance that they would be evicted, go into foreclosure, or be forced by a landlord to move in the next 30 days, compared to only 4% of those above the Threshold.
- Among renters, households below the ALICE Threshold were significantly more likely to have asked their landlords for permission to delay or reduce payment of rent than those above the Threshold (18% vs. 13%) (UAS COVID survey, May 2020).
- Among renter households below the ALICE Threshold, those headed by someone of color were more likely to report being behind on rent (29% of Black respondents, 23% of Asian respondents, and 22% of Hispanic respondents, compared to 17% of White respondents) (Household Pulse Survey, August 19–31, 2020).
- These differences between groups also played out over time: From August 2020 to May 2021, renter households below the ALICE Threshold were significantly more likely to report that they were not caught up on rent payments than those above the ALICE Threshold (fluctuating between 19% and 28% of renters below the ALICE Threshold vs. between 7% and 11% of renters above the Threshold) (Household Pulse Survey, August 19–August 31, 2020 and May 12–24, 2021).

Given these difficulties, it is not surprising that meeting housing needs was the concern most often selected by respondents below the ALICE Threshold in the United For ALICE Surveys (conducted February to June 2021): 68% of respondents below the ALICE Threshold said that they were concerned about paying for housing expenses during the pandemic and 36% said it was their biggest concern. In contrast, the concern most often selected by respondents above the ALICE Threshold was contracting COVID-19 (78%) — only 21% said that paying housing expenses was a concern, and even fewer (9%) said that it was their biggest concern.

Respondents below the ALICE Threshold were significantly more likely than those above the Threshold to say that they had difficulty meeting housing needs during the pandemic (51% vs. 12%). Additionally, the percentage of households struggling to meet their housing expenses was significantly higher among Black (60%) and Hispanic (57%) households below the ALICE Threshold, compared to 37% of White households below the Threshold (Figure 4).

Figure 4.
Difficulty Meeting Housing Needs by the ALICE Threshold and Race/Ethnicity



Question: Since March 1, 2020, has your household had trouble meeting any of the following needs? ["Difficulty meeting housing needs" selected]

Note: All racial groups include respondents who selected that race alone. The Hispanic ethnic group includes respondents who selected "Spanish, Hispanic, or Latinx" alone or in combination with one or more racial groups.

Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

Ability to Afford Non-Housing Expenses: Housing was not the only budget category that posed a challenge to struggling households during the pandemic. Respondents below the ALICE Threshold were significantly more likely than those above the Threshold to say that they had difficulty meeting non-housing expenses, including food needs (39% vs. 8%), health care needs (22% vs. 12%), technology needs (16% vs. 8%), and transportation needs (15% vs. 3%). (See the "Challenges for Families With Children" section for more details on child care needs.)

SAVINGS AND ASSETS

A defining feature of ALICE households is in the phrase "asset limited." As the previous section highlights, ALICE families struggle to meet their households' immediate, basic needs, which makes saving for an emergency — let alone for the future — a difficult task. As a result, ALICE families can neither build assets nor catch up to those who already have assets (especially those who have been building them for generations). But until now, there has not been definitive data on savings and assets specifically for households below the ALICE Threshold. Analysis of the SHED helps fill this gap.

Savings for a Rainy Day: It has been widely reported that savings increased during the pandemic.[6] One indicator of this was in the SHED's question about whether respondents had set aside emergency or "rainy day funds" that would cover their expenses for three months in case of sickness, job loss, economic downturn, or other emergencies. In October 2019, just over half of all respondents (53%) reported having these funds; by November 2020, that share had increased to 55% (Figure 5).

Yet this average conceals a huge gulf between those above and below the ALICE Threshold. Only one-third of respondents below the ALICE Threshold reported having rainy day funds, with the percentage dropping from 33% in October 2019 to 32% by November 2020. In contrast, more than two-thirds of those above the Threshold had rainy day funds, and that share increased from 68% to 71% during the pandemic.

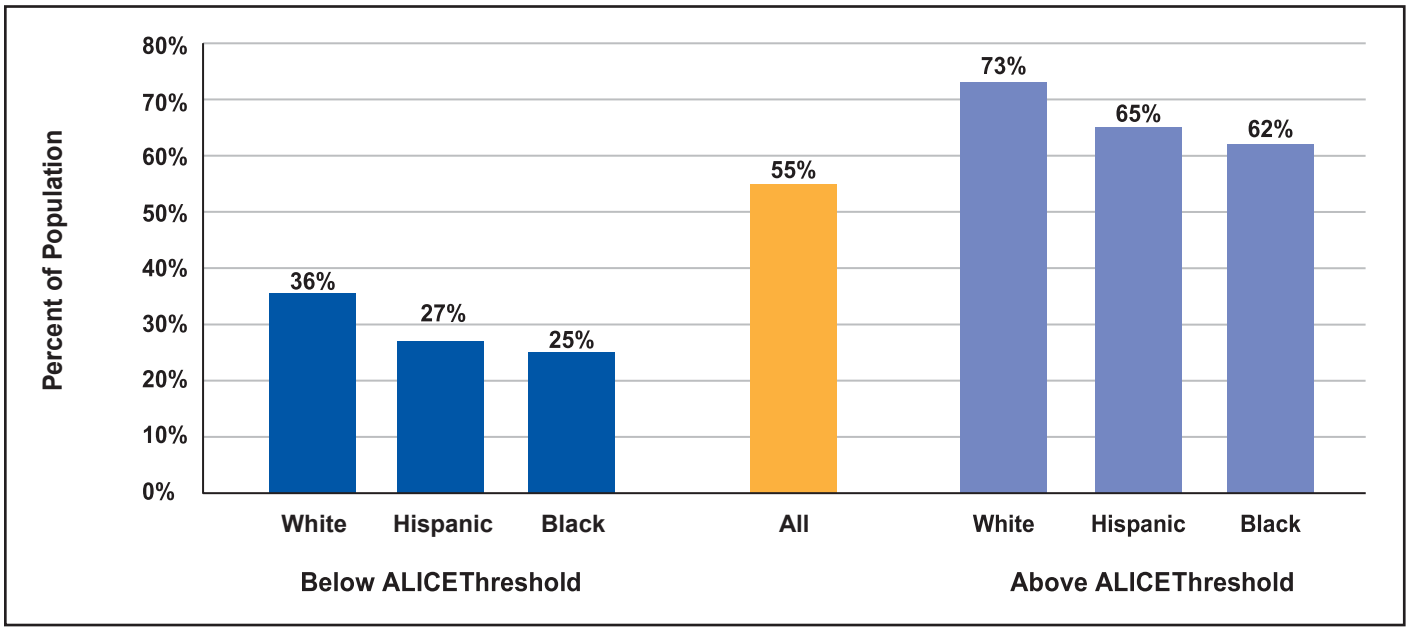
The gap by race/ethnicity was even greater, with White respondents significantly more likely to report that they had savings for an emergency than Black and Hispanic respondents — both above and below the ALICE Threshold (Figure 5). From October 2019 to November 2020, the percentage of respondents below the ALICE Threshold with savings decreased for Hispanic respondents (from 28% to 27%) and Black respondents (from 27% to 25%) while remaining flat at 36% for White respondents. In contrast, the percentage of respondents with savings increased for all groups above the ALICE Threshold, narrowing the racial/ethnic gap slightly: 73% for White respondents (up from 70% in October 2019) vs. 65% for Hispanic respondents (up from 57%) and 62% for Black respondents (up from 55%) (SHED, October 2019; SHED, November 2020).

Because of the loss of work of two of the three people in my household...we cannot pay our bills, car loans, etc. Our three credit cards have been cancelled due to nonpayment, damaging our credit score. There are things happening that I never thought could so quickly destroy your life.

— United For ALICE Survey respondent, Tennessee

Figure 5.

Rainy Day Funds to Cover Three Months' Expenses by the ALICE Threshold and Race/Ethnicity



Question: Have you set aside emergency or rainy day funds that would cover your expenses for 3 months in the case of sickness, job loss, economic downturn, or other emergencies?

Note: Groupings include Black, non-Hispanic, Hispanic, and White non-Hispanic respondents.

Source: ALICE Threshold, 2018; Federal Reserve Board, Survey of Household Economics and Decisionmaking (SHED), November 2020

Covering New and/or Unexpected Expenses: Not having a financial cushion makes ALICE households more vulnerable to the effects of disasters from floods, hurricanes, and wildfires to pandemics, and crises ranging from illness to car accidents. ALICE families feel the economic impact almost immediately — if they can't work, they lose pay, and if they get sick, there are unbudgeted medical bills to pay.

The overall picture of the pandemic reported in the 2020 SHED, however, was one of financial stability. On average, most households found that their monthly income increased or stayed the same and their monthly spending decreased or stayed the same; as a result, their checking account balance increased or stayed the same compared to one year prior (pre-pandemic, November 2019).

Breaking down the responses by income levels, however, reveals a different experience for those below the ALICE Threshold than for those above it:

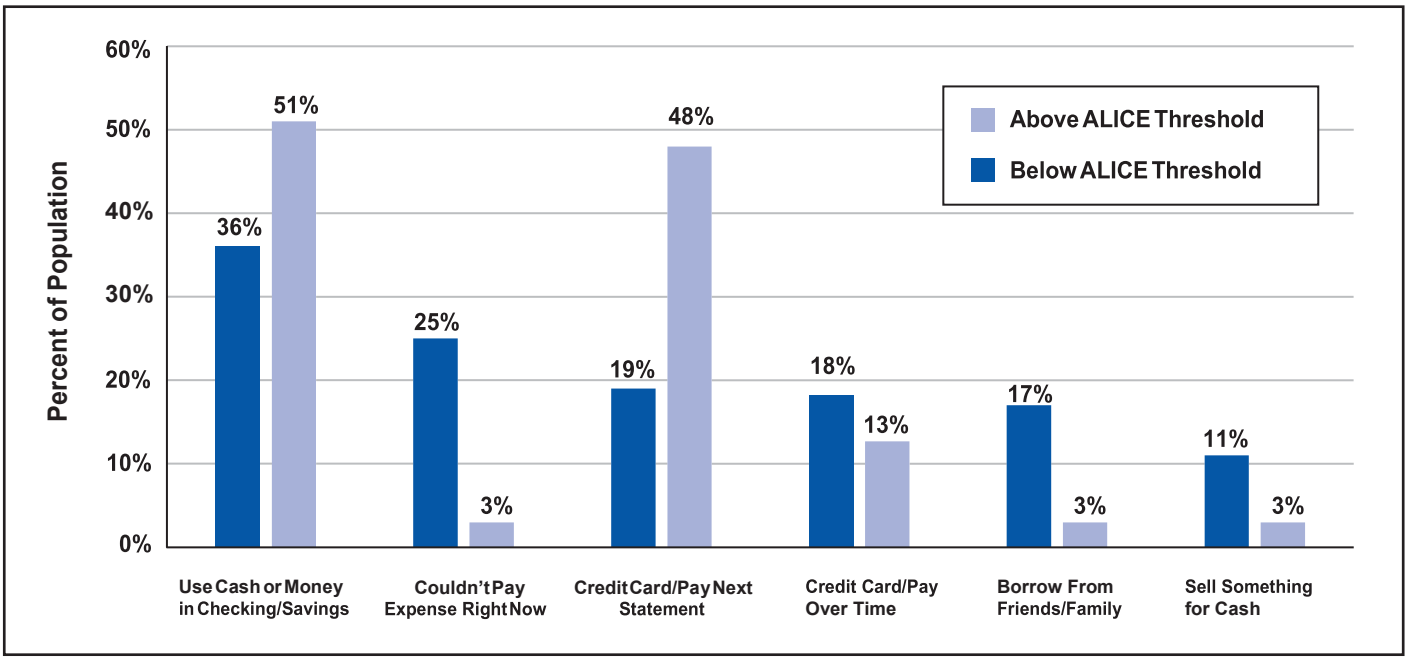
- Monthly income decreased for 26% of households below the ALICE Threshold vs. 14% above the Threshold
- **Monthly spending increased** for 24% of households below the ALICE Threshold vs. 16% above the Threshold
- **The amount of money usually in checking/savings accounts (after paying monthly bills) decreased** for 33% of households below the ALICE Threshold vs. 15% above the Threshold

The November 2020 SHED provides insight into how households cover unexpected expenses. Respondents were asked, "If you had an unexpected emergency expense that costs $400, how would you pay for this expense?" (Figure 6). Responses differed for households above and below the ALICE Threshold:

- Respondents above the ALICE Threshold were significantly more likely than those below to say that they would pay the expense with the money currently in their checking/savings account or with cash (51% vs. 36%) or put it on their credit card and pay it off in full at the next statement (48% vs. 19%).

- Respondents below the ALICE Threshold were significantly more likely than those above to say that they would put the expense on credit and pay over time (18% vs. 13%), borrow from friends or family (17% vs. 3%), sell something (11% vs. 3%), use a bank loan or line of credit (3% vs. 2%), or use a payday loan, deposit advance, or overdraft (2% vs. 1%).
- Among respondents below the ALICE Threshold, 25% said that they wouldn't be able to pay for the expense right now, while only 3% of those above the Threshold said that they wouldn't be able to pay.

Figure 6.
How Respondents Would Cover a $400 Emergency Expense by the ALICE Threshold



Question: Suppose that you have an emergency expense that costs $400. Based on your current financial situation, how would you pay for this expense? Note: Respondents could select all that apply

Source: ALICE Threshold, 2018; Federal Reserve Board, Survey of Household Economics and Decisionmaking (SHED), November 2020

Responses also differed by race/ethnicity. Among respondents below the ALICE Threshold:

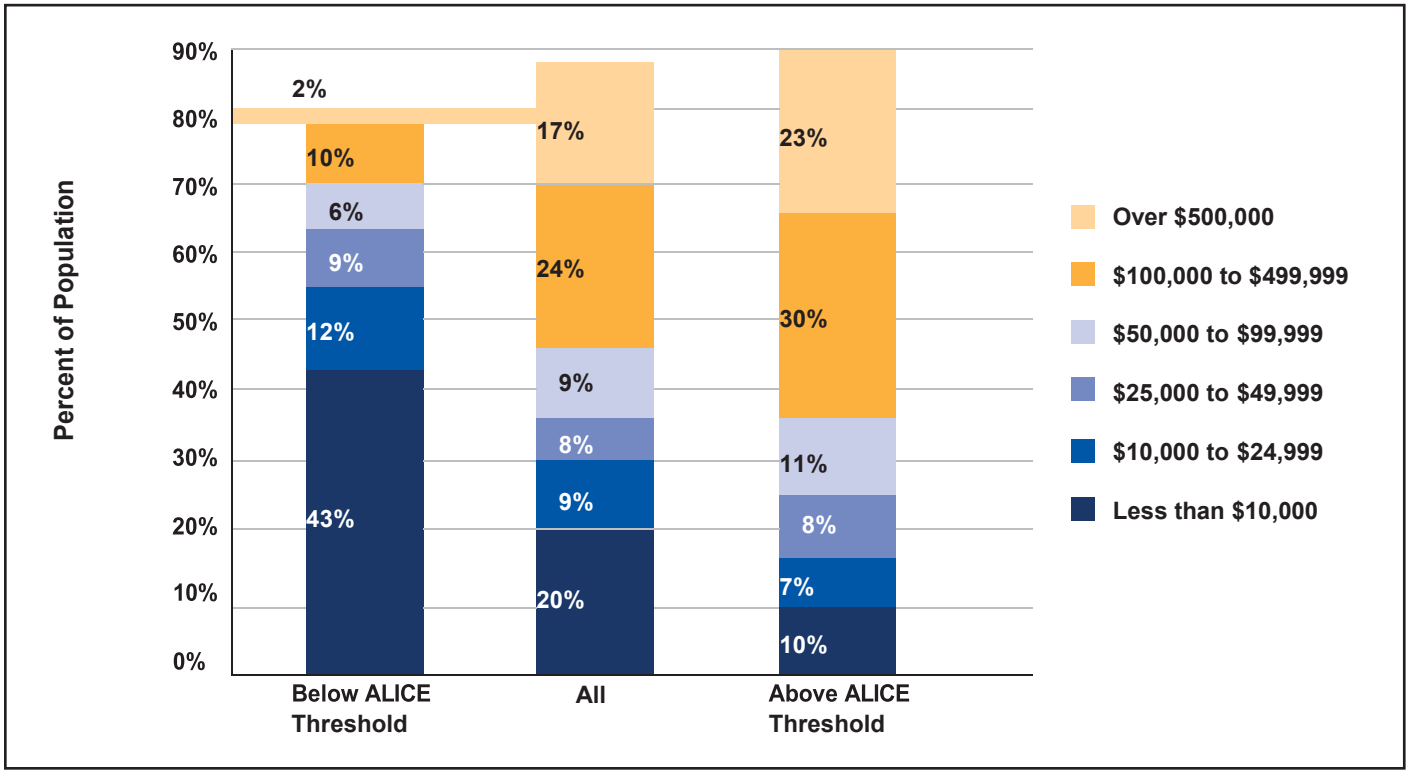
- White respondents were significantly more likely to say that they would pay the expense with the money currently in their checking/savings account or with cash than Black or Hispanic respondents (39% vs. 32% and 34%, respectively) or put it on their credit card and pay it off in full at the next statement (23% vs. 11% or 14%, respectively).
- Hispanic respondents were significantly more likely to say that they would put the expense on credit and pay over time than White or Black respondents (22% vs. 17% each), borrow from friends or family (23% vs. 15% and 17% respectively), or sell something (17% vs. 8% and 12%, respectively).
- Black respondents were significantly more likely to say that they wouldn't be able to pay for the expense right now (37%) compared to 27% of Hispanic respondents and 22% of White respondents.

Bank Accounts: The way that households save (or don't) varied across households above and below the ALICE Threshold and by race/ethnicity. According to the October 2019 SHED, across all households, most had a checking, savings, or money market account (94%); however, those above the ALICE Threshold were significantly more likely to have one (99% versus 90%). The percentage of households with a bank account (savings or checking) varied further by race/ethnicity:

- **Gaps between racial/ethnic groups:** Almost all White households (97%) had a bank account, compared to 87% of Black households.
- **Gaps within races/ethnicities:** For White households, 100% above the ALICE Threshold had a bank account vs. 94% below the Threshold. For Hispanic households, the rates were 99% for those above the Threshold vs. 87% for those below, and for Black households, 99% for those above the Threshold vs. 82% for those below.

Retirement Savings: A lack of savings also limits future possibilities. Sending a child to college, putting a down payment on a house, or building a nest egg for retirement become unattainable dreams. The 2020 SHED provides more concrete data on retirement savings, yet the gap by income status is concealed by the totals. For example, of the total population, 20% of respondents reported having less than $10,000 in savings for retirement in November 2020. However, most respondents below the ALICE Threshold (43%) had less than $10,000 in savings and only 12% had more than $100,000. At the other end of the spectrum, nearly one-third (30%) of those above the ALICE Threshold had $100,000 to $500,000, and almost another quarter (23%) had more than $500,000 saved (Figure 7).

Figure 7.
Amount Saved for Retirement by the ALICE Threshold

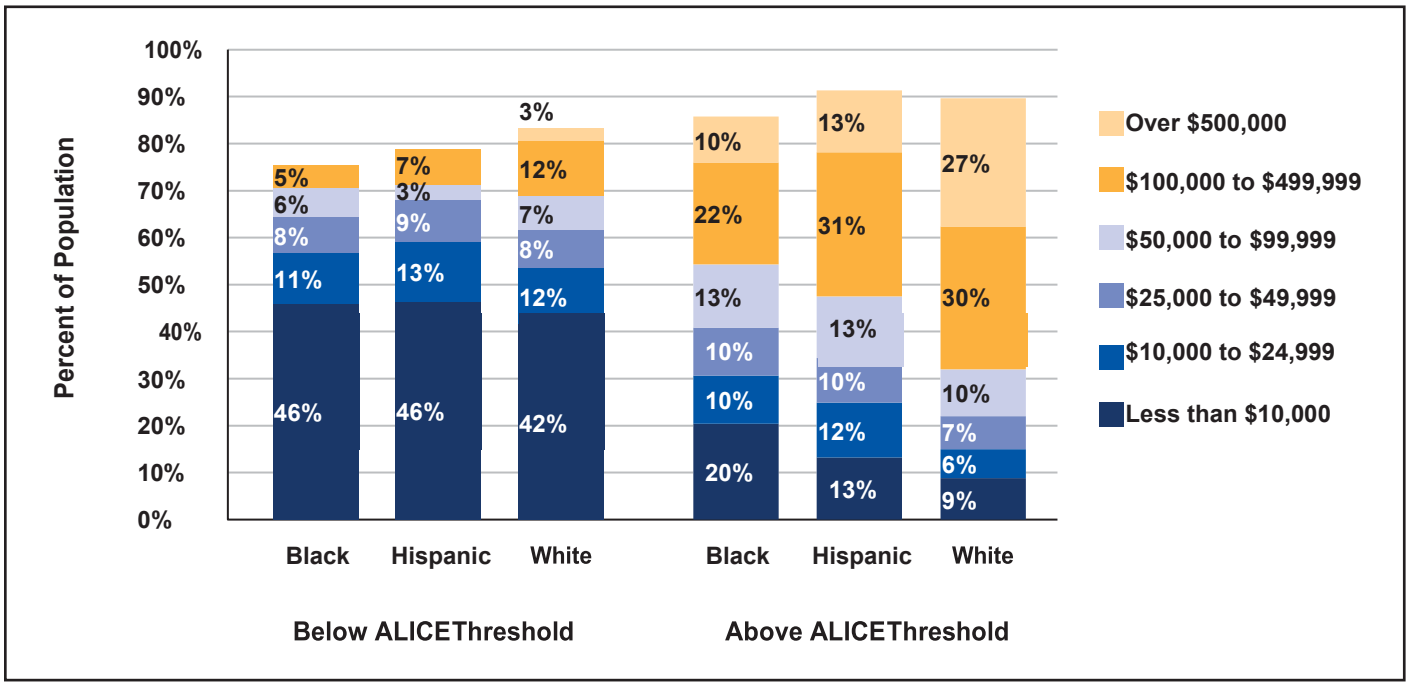


Question: Approximately how much money do you currently have saved for retirement? Note: Respondents who selected "Don't Know" are not shown.

Source: ALICE Threshold, 2018; Federal Reserve Board, Survey of Household Economics and Decisionmaking (SHED), November 2020

The gaps in retirement savings were even greater by race/ethnicity. Among those below the ALICE Threshold, Black and Hispanic respondents were significantly more likely to report having less than $10,000 in savings compared to White respondents (46% each vs. 42%). And at the other end of the spectrum, White respondents above the ALICE Threshold were significantly more likely to have savings of $100,000 or more compared to Hispanic or Black respondents above the Threshold (57% vs. 44% and 32%, respectively) (Figure 8).

Figure 8.
Amount Saved for Retirement by the ALICE Threshold and Race/Ethnicity



Question: Approximately how much money do you currently have saved for retirement?

Note: Groupings include Black, non-Hispanic, Hispanic, and White non-Hispanic respondents. Respondents who selected "Don't Know" are not shown.

Source: ALICE Threshold, 2018; Federal Reserve Board, Survey of Household Economics and Decisionmaking (SHED), November 2020

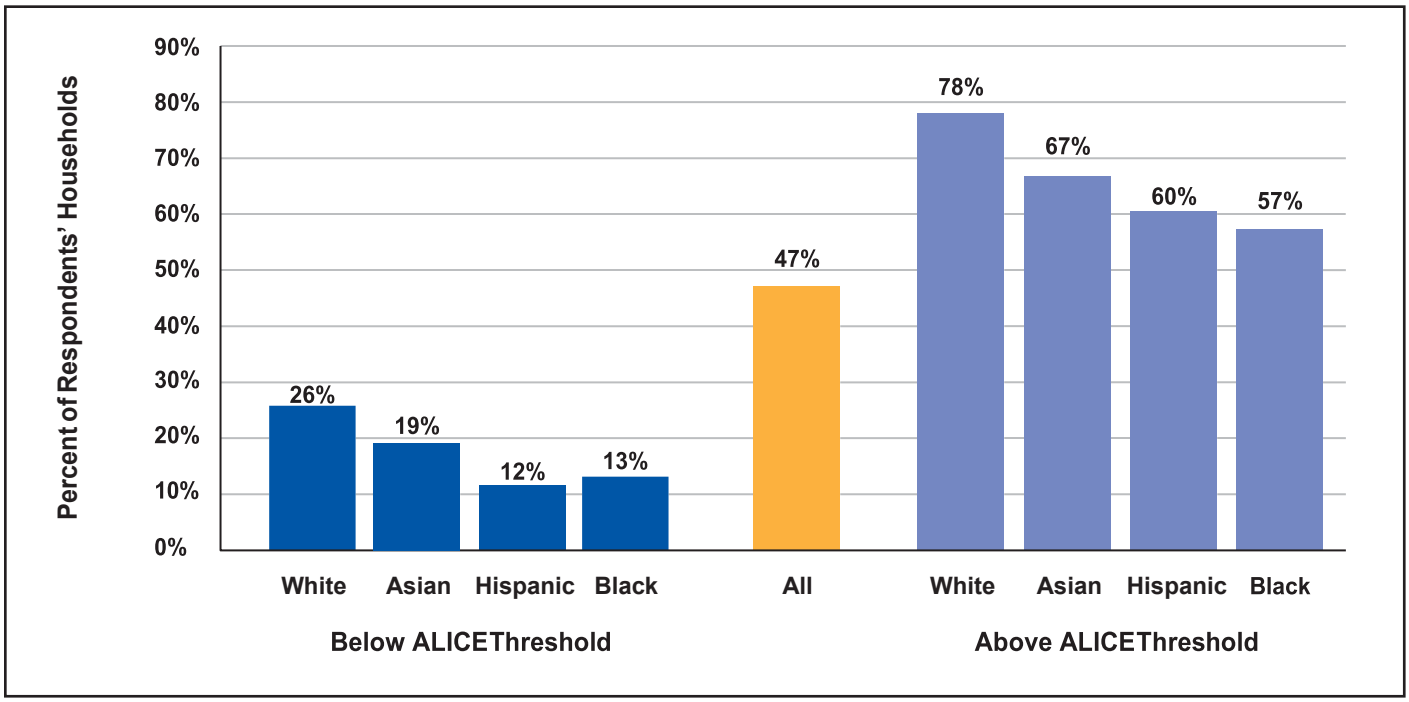
Investments: Given these differences in the amount of retirement savings between households above and below the ALICE Threshold and by race/ethnicity, it is not surprising that gaps exist in whether households have and use related financial tools — assets such as 401(k)s, IRAs, or other investments that produce income (like stocks or rental properties).

According to the November 2020 SHED, respondents above the ALICE Threshold were significantly more likely to have the following retirement assets compared to those below the Threshold:

- 401(k): 74% vs. 29%
- IRA: 48% vs. 14%
- Pension: 31% vs. 9%
- **Business or real estate that will provide income in retirement: 14% vs. 3%**
- Additional retirement savings: 68% vs. 28%[7]

United For ALICE Surveys show substantial racial/ethnic disparities in investment asset ownership. Overall, almost half of respondents reported having a 401(k), IRA, or other investment, concealing huge gulfs between those above and below the ALICE Threshold and by race/ethnicity. White respondents were significantly more likely to have investments than Asian, Hispanic, or Black respondents; and for each race/ethnicity, those above the ALICE Threshold were at least three times as likely to have investments as those below (Figure 9).

Figure 9.
Investments by the ALICE Threshold and Race/Ethnicity



Question: Which of the following assets does your household have? ["Have a 401(k), IRA, or other investment" selected]

Note: All racial groups include respondents who selected that race alone. The Hispanic ethnic group includes respondents who selected "Spanish, Hispanic, or Latinx" alone or in combination with one or more racial groups.

Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

Vehicles: ALICE households depend on reliable transportation to reach jobs, schools and child care, health care, stores, and more. Yet vehicles are not an effective means of accumulating wealth because the value of a car normally decreases over time. Results from the United For ALICE Surveys suggest substantial disparities in vehicle ownership between households above and below the ALICE Threshold and by race/ethnicity.

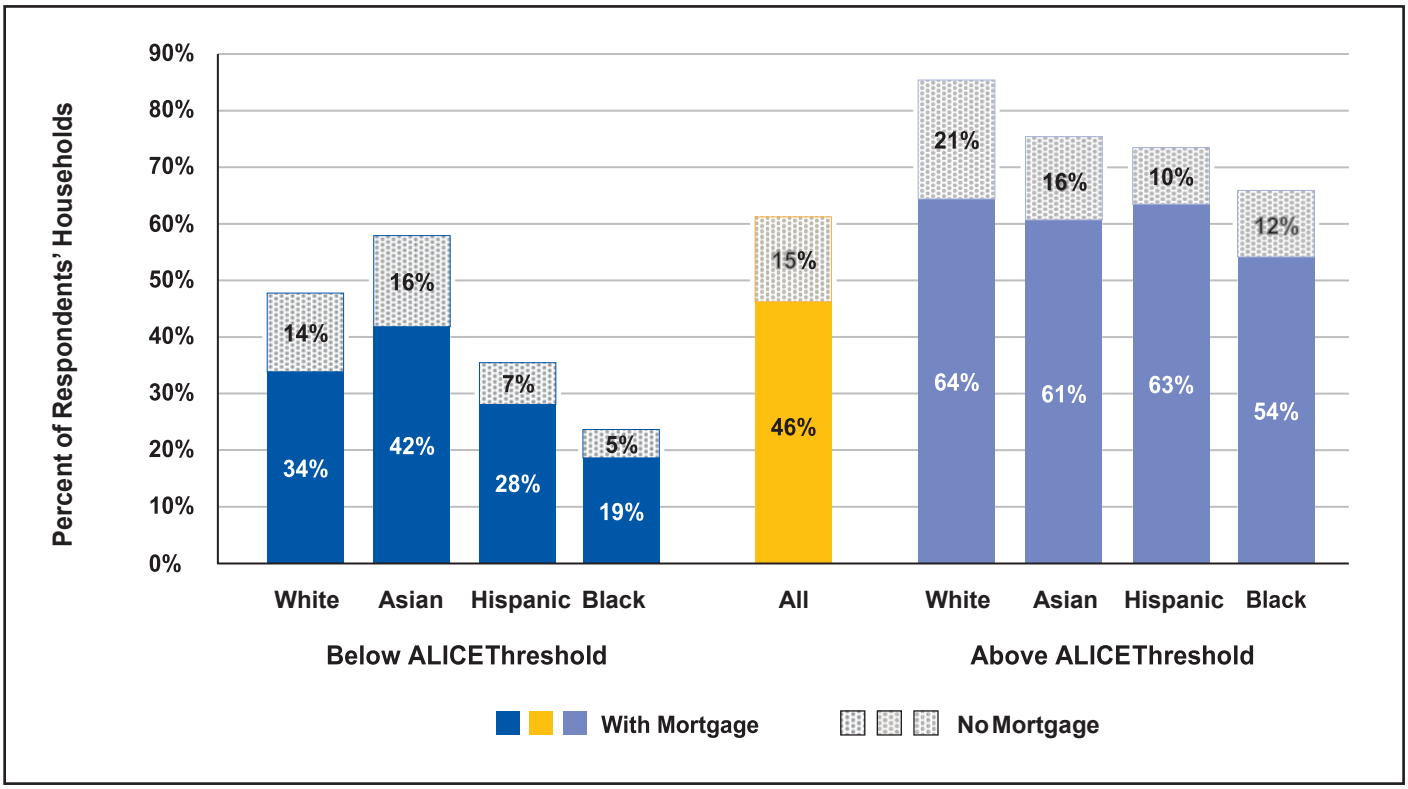
Almost all respondents above the ALICE Threshold, of all races and ethnicities, reported that their household owns a vehicle (91%). Vehicle ownership was less universal for respondents below the ALICE Threshold (75%), with substantial gaps by race/ethnicity: White (81%), Asian (67%), Hispanic (68%), and Black (63%). There were also gaps in ownership with or without an auto loan within every race/ethnicity.

Homeownership: The next most common asset is a home — perhaps the most important asset in providing financial stability and a means for low-income families to accumulate wealth. Homeownership can increase both financial and social stability for families. But with less income to save for a down payment, build credit, and qualify for a mortgage, it's not surprising that households below the ALICE Threshold had significantly lower homeownership rates than those above (41% vs 82%) (United For ALICE Surveys).

The results of the United For ALICE Surveys also revealed stark differences in homeownership by race/ethnicity at all income levels for those both with and without a mortgage (Figure 10):

- Homeownership for Black and Hispanic respondents' households was significantly lower than for other groups:
  - Below ALICE Threshold: 24% of Black and 35% of Hispanic households vs. 48% of White and 58% of Asian households
  - Above ALICE Threshold: 65% of Black and 73% of Hispanic vs. 77% of Asian and 85% of White households
- Black and Hispanic respondents' households were significantly less likely to own their homes without a mortgage:
  - Below ALICE Threshold: 5% of Black and 7% of Hispanic households vs. 14% of White and 16% of Asian households
  - Above ALICE Threshold: 10% of Hispanic and 12% of Black households vs. 16% of Asian and 21% of White households

Figure 10.
Homeownership by the ALICE Threshold and Race/Ethnicity



Question: Which of the following assets does your household have? ["Own your home with a mortgage" or "own your home with NO mortgage" selected]

Note: All racial groups include respondents who selected that race alone. The Hispanic ethnic group includes respondents who selected "Spanish, Hispanic, or Latinx" alone or in combination with one or more racial groups.

Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

EMPLOYMENT CHANGES AND CHALLENGES

With shutdowns, business restrictions, and mask mandates in place to curb the spread of COVID-19, many workers and businesses struggled throughout the pandemic. Along with case counts and deaths, the unemployment rate has been one of the most closely watched metrics of the pandemic as a barometer for the state of the economy. In April 2020, the unemployment rate reached 14.8% — the highest rate observed since this measure was established in 1948.[8] By February 2021, almost half (48%) of respondents to the Household Pulse Survey reported that someone in their household had experienced a loss of employment income during the pandemic. Yet even these alarming statistics capture only part of the enormous shift in employment experienced during the pandemic, and in so doing, they conceal the disproportionate hardship experienced by most families with income below the ALICE Threshold.

In addition to greater job loss, workers with income below the ALICE Threshold were more likely to have trouble finding a new job. For those who were able to continue working, they were more likely to have their hours and wages reduced or to be required to work on-site, and less likely to receive paid sick days.

Job Loss and Unemployment: By the beginning of 2021, 60% of households with income below the ALICE Threshold had experienced a loss of employment income, compared to 40% of households above the Threshold (Household Pulse Survey, January 20–February 1, 2021).

As the pandemic unfolded, employment and labor-force status fluctuated, with trends differing by household income (Figure 11). According to the UAS COVID survey, while workers of all incomes faced a steep decline in work from March to April 2020, respondents with household income below the ALICE Threshold were both less likely to have had a job before the pandemic and less likely to return to work as the economy rebounded in late 2020. Respondents from households below the ALICE Threshold also:

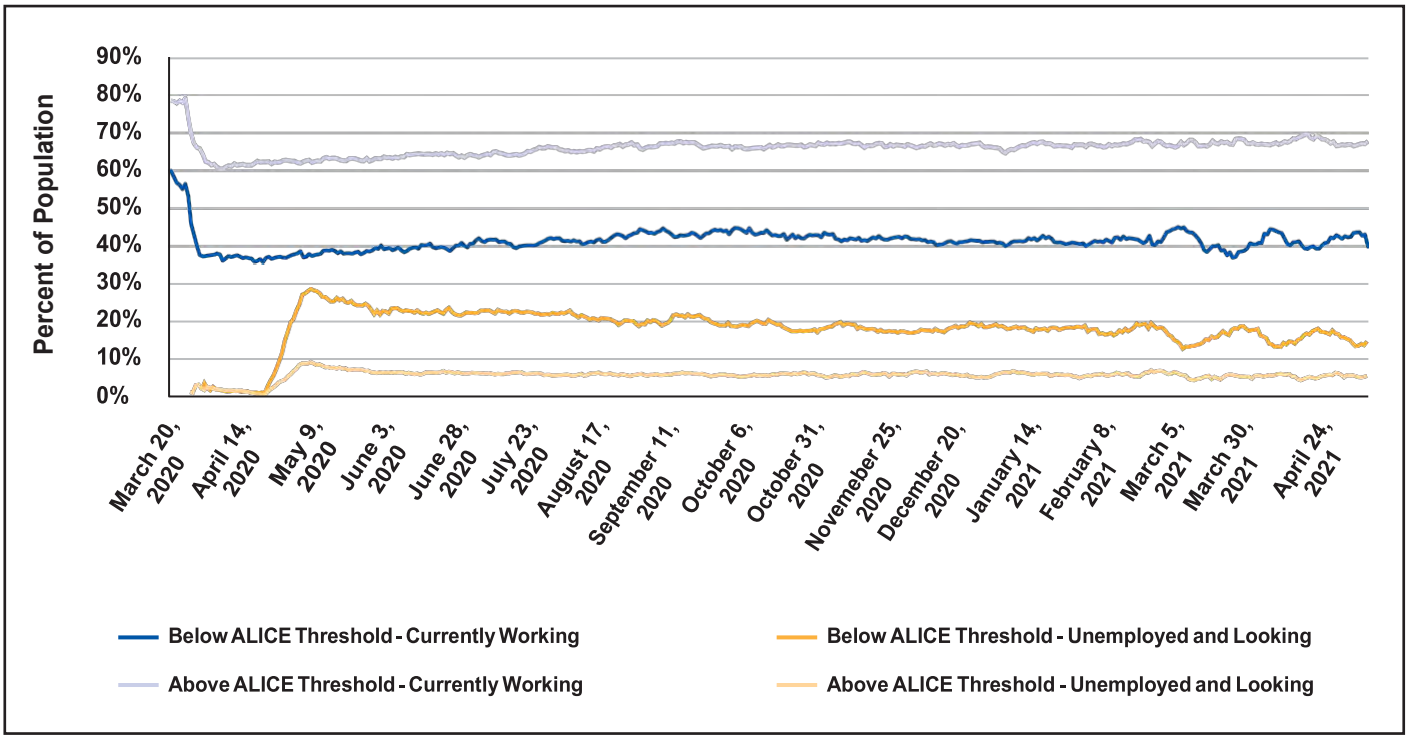
- **Faced a bumpy ride:** Pre-pandemic, 56% of respondents reported that they were working. That rate dropped to 37% in April 2020, before rebounding slightly to 42% by May 2021.
- Were more likely to be looking for work: 28% of respondents reported that they were looking for work in May 2020, a rate that steadily declined to 14% by April 2021.
- **Were more likely to report being out of the labor force:** This rate rose from 10% in April 2020 to 14% in April 2021.
- **Were more likely to report being retired:** Retirement increased from 18% in April 2020 to 25% in April 2021.

In contrast, respondents with household income above the ALICE Threshold were more likely to have had a job before the pandemic and to return to work more quickly. These respondents:

- **Had more job stability:** More than three in four respondents above the ALICE Threshold were working in March 2020. That percentage fell to 61% in April 2020 and then rebounded by September 2020 to 67%, where it remained through May 2021.
- Were less likely to be looking for work: The share of respondents looking for work was 2% in April 2020. It rose to 9% in May 2020 but fell quickly to below 6% and remained there through May 2021.
- **Were less likely to report being out of the labor force:** This rate remained flat at less than 5% throughout this period.
- **Were less likely to report being retired:** Retirement remained flat at approximately 20% throughout this period.

Figure 11.

Labor Status Over Time by the ALICE Threshold, March 20, 2020–April 24, 2021



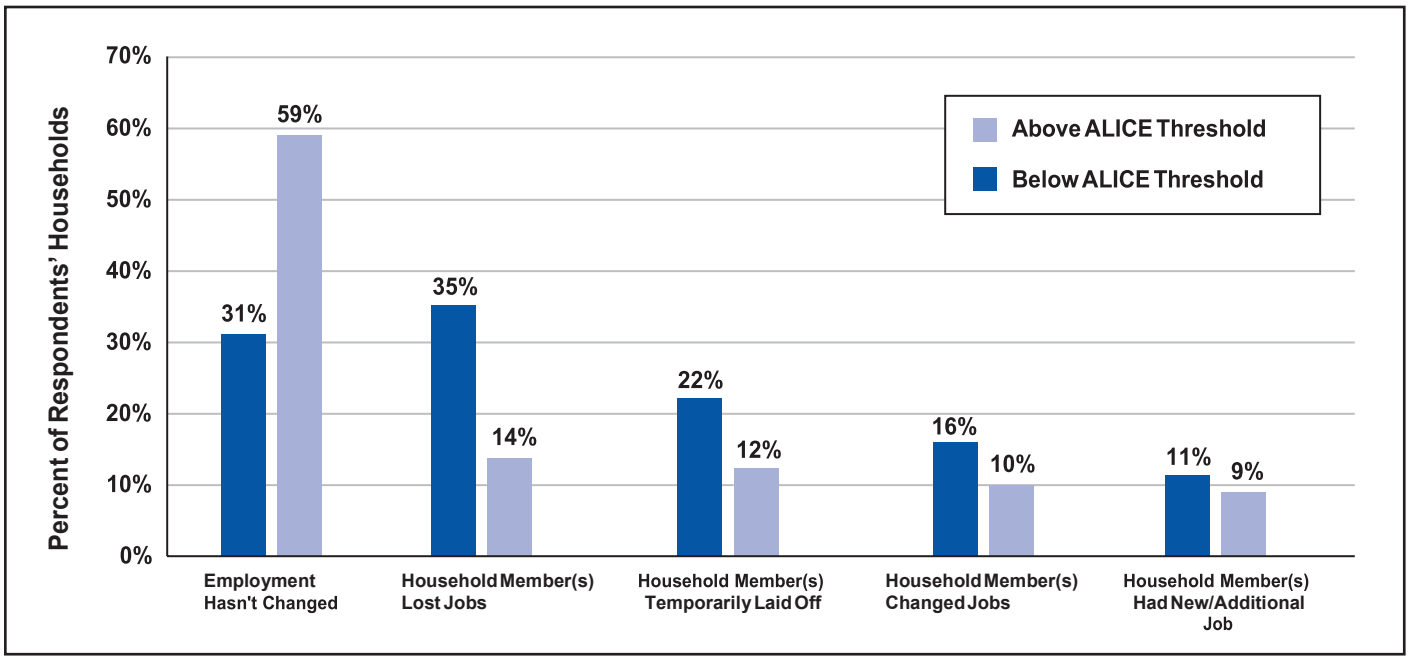
Question: Labor Status ["Currently working" or "Unemployed, looking" selected]

Source: ALICE Threshold, 2018; University of Southern California, Understanding America Study's Understanding Coronavirus in America Survey, March 20, 2020–April 24, 2021

Results from the United For ALICE Surveys also highlight similar and substantial differences in employment among household members based on ALICE Threshold status. **Households below the ALICE Threshold were significantly more likely to experience a disruption in their employment.** Only 31% of respondents below the ALICE Threshold reported no employment change, while households above the Threshold had twice as much employment stability, with almost 60% reporting no change (Figure 12). In addition, respondents below the ALICE Threshold were significantly more likely to report that they or a household member:

- **Lost a job:** 35% of respondents below the ALICE Threshold said that someone in their household lost a job (vs. 14% of respondents above the Threshold).
- **Experienced a temporary layoff:** 22% of respondents below the ALICE Threshold reported that someone in their household was temporarily laid off (vs. 12% of respondents above the Threshold).
- **Started a new job:** 11% of respondents below the ALICE Threshold reported that someone in their household started a new or additional job (vs. 9% of respondents above the Threshold).
- **Changed jobs:** 16% of respondents below the ALICE Threshold reported that someone in their household changed jobs (vs. 10% of respondents above the Threshold).

Figure 12.
Changes in Employment Status by the ALICE Threshold



Note: Respondents could select all that apply and were asked to report employment impacts for themselves or for other household members. Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020 - June 2021

There were also significant gaps in employment stability by race/ethnicity. White and Asian respondents were less likely to report that someone in their household had a change in employment status during the pandemic:

- **No change in employment:** Approximately half of White and Asian respondents reported that no one in their household had a change in employment (49% and 45%, respectively), compared to approximately one-third of Black (37%), Hispanic (34%), and AIAN/Hawaiian/Pacific Islander (34%) respondents.

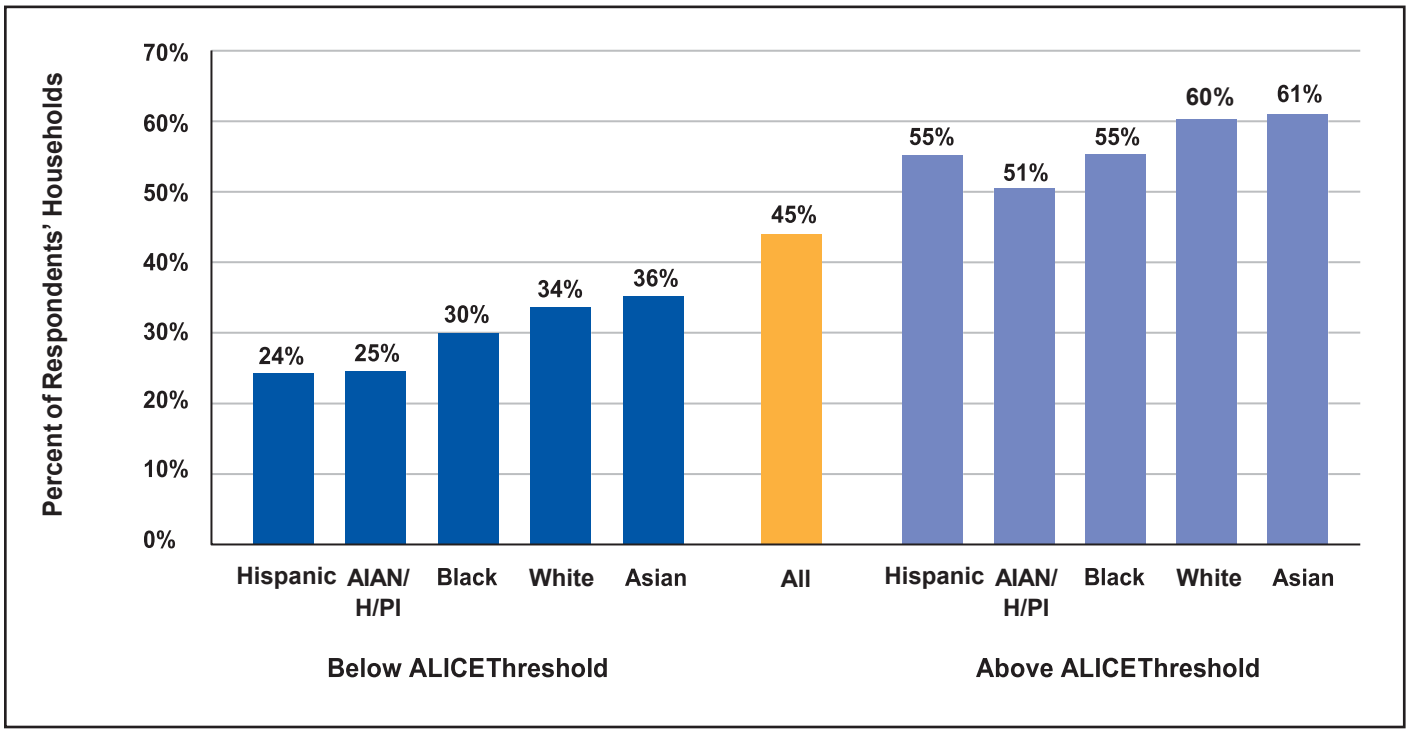
- Job loss: Less than one-quarter of Asian and White respondents reported that no one in their household lost a job during the pandemic (24% and 21%, respectively), compared to approximately one-third of Hispanic (35%), AIAN/Hawaiian/Pacific Islander (34%), and Black (32%) respondents.

This pandemic has completely impacted my family. One [household member] completely lost a job, no unemployment [insurance], and can't find another job. One is working less hours and cannot afford anything. I go hungry so my kids can eat.
Food stamps got taken away because of what I make...

— United For ALICE Survey respondent, Shenandoah Valley, Virginia

The largest gaps in employment change during the pandemic, however, emerge when looking at employment differences by race/ethnicity and income together. Across all five racial/ethnic groups in Figures 13 and 14, the most significant differences were found when comparing households above and below the ALICE Threshold. There were also gaps by race and ethnicity both above and below the Threshold. For example, Hispanic, AIAN/Hawaiian/Pacific Islander, and Black respondents were significantly less likely to report no change to their employment than White and Asian respondents, and though there was less change overall for respondents above the ALICE Threshold, the gaps by race/ethnicity persisted (Figure 13).

Figure 13.
No Changes in Employment Status by the ALICE Threshold and Race/Ethnicity



Question: Since March 1, 2020, has employment changed for any household members? ["Employment hasn't changed for any household members" selected]

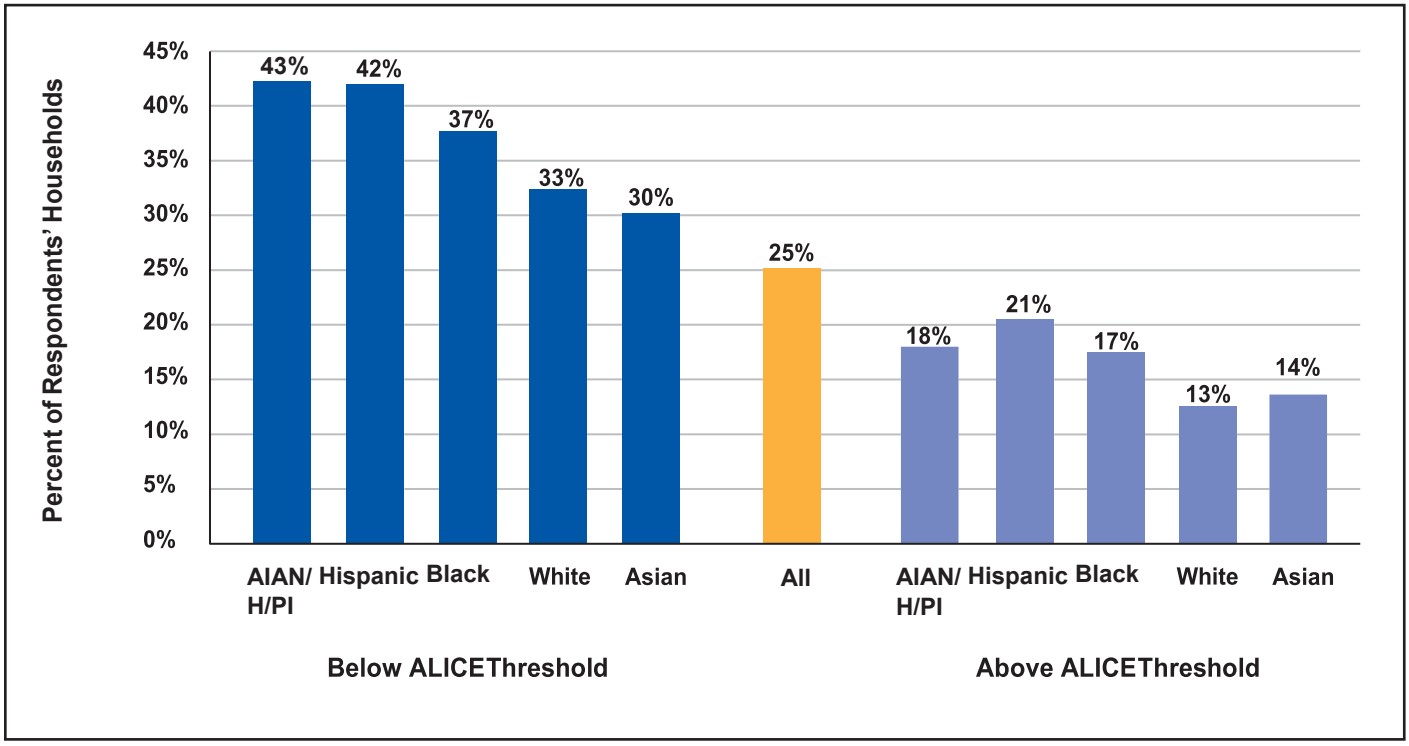
Note: Respondents could select all that apply (except "employment hasn't changed," which was exclusive) and were asked to report employment impacts for themselves or for other household members. All racial groups include respondents who selected that race alone, except for "AIAN/H/PI," which includes respondents who selected "American Indian or Alaska Native" or "Native Hawaiian or Pacific Islander" alone or in combination with other races (non-Hispanic). The Hispanic ethnic group includes respondents who selected "Spanish, Hispanic, or Latinx" alone or in combination with one or more racial groups.

Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

Similarly, Hispanic, AIAN/Hawaiian/Pacific Islander, and Black respondents below the ALICE Threshold were significantly more likely to report that one or more household members lost a job than White and Asian respondents, and though there was less job loss overall among respondents above the ALICE Threshold, those disparities persisted (Figure 14).

Figure 14.

Job Loss by Race/Ethnicity and ALICE Threshold Status



Question: Since March 1, 2020, has employment changed for any household members? ["One or more household members lost a job" selected]

Note: Respondents could select all that apply and were asked to report employment impacts for themselves or for other household members. All racial groups include respondents who selected that race alone, except for "AIAN/H/PI," which includes respondents who selected "American Indian or Alaska Native" or "Native Hawaiian or Pacific Islander" alone or in combination with other races (non-Hispanic). The Hispanic ethnic group includes respondents who selected "Spanish, Hispanic, or Latinx" alone or in combination with one or more racial groups.

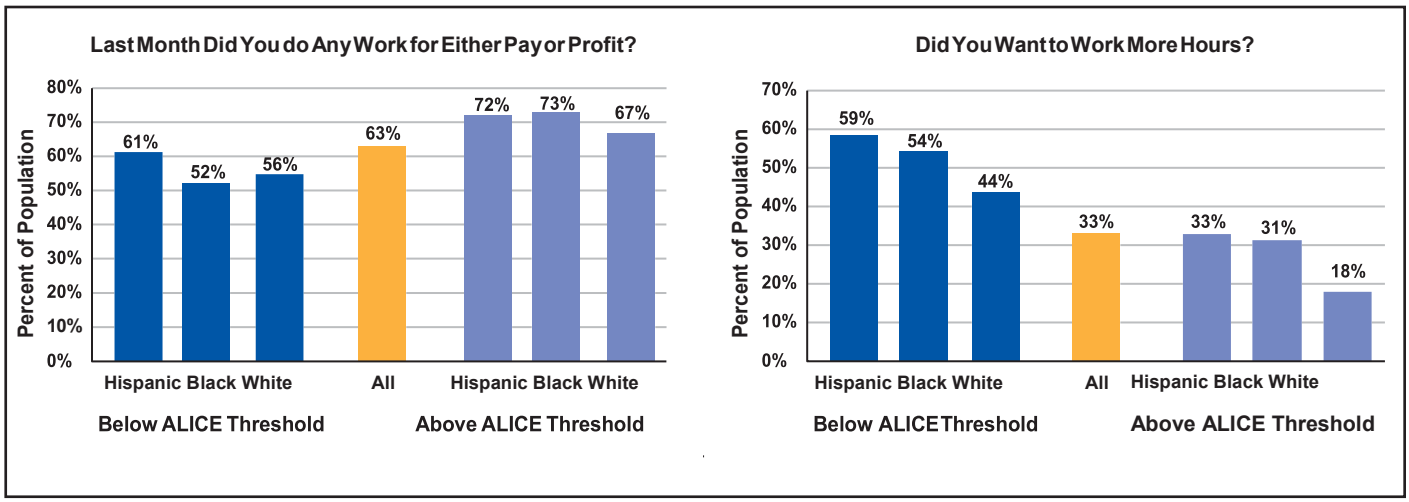
Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

My household member would still have a business (co-owned a tour bus company) if everything wasn't shut down due to this pandemic. He had to shut it down, liquidate everything, and lost a lot of money. He still has buses he is making payments on and no business.

— United For ALICE Survey respondent, Arkansas

Employment and opportunities to work were at the heart of the differences by income as well as by race/ethnicity. Responses from the SHED reveal that across all races/ethnicities, households below the ALICE Threshold were significantly less likely to report that they did any work for pay or profit in the previous month than those above the Threshold. The follow-up question reveals a significant difference by race/ethnicity: Black and Hispanic respondents below the ALICE Threshold were significantly more likely to say that they wanted to work, or if they were already working, wanted to work more hours (54% and 59%, respectively), compared with White respondents (44%) (Figure 15).

Figure 15.
Current Work and Desire to Work More by the ALICE Threshold and Race/Ethnicity



Questions: Last month, did you do any work for either pay or profit? And: At any time during the past month, did you want to work/work more hours? Note: Groupings include Black non-Hispanic, Hispanic, and White non-Hispanic respondents.

Source: ALICE Threshold, 2018; Federal Reserve Board, Survey of Household Economics and Decisionmaking (SHED), October 2019

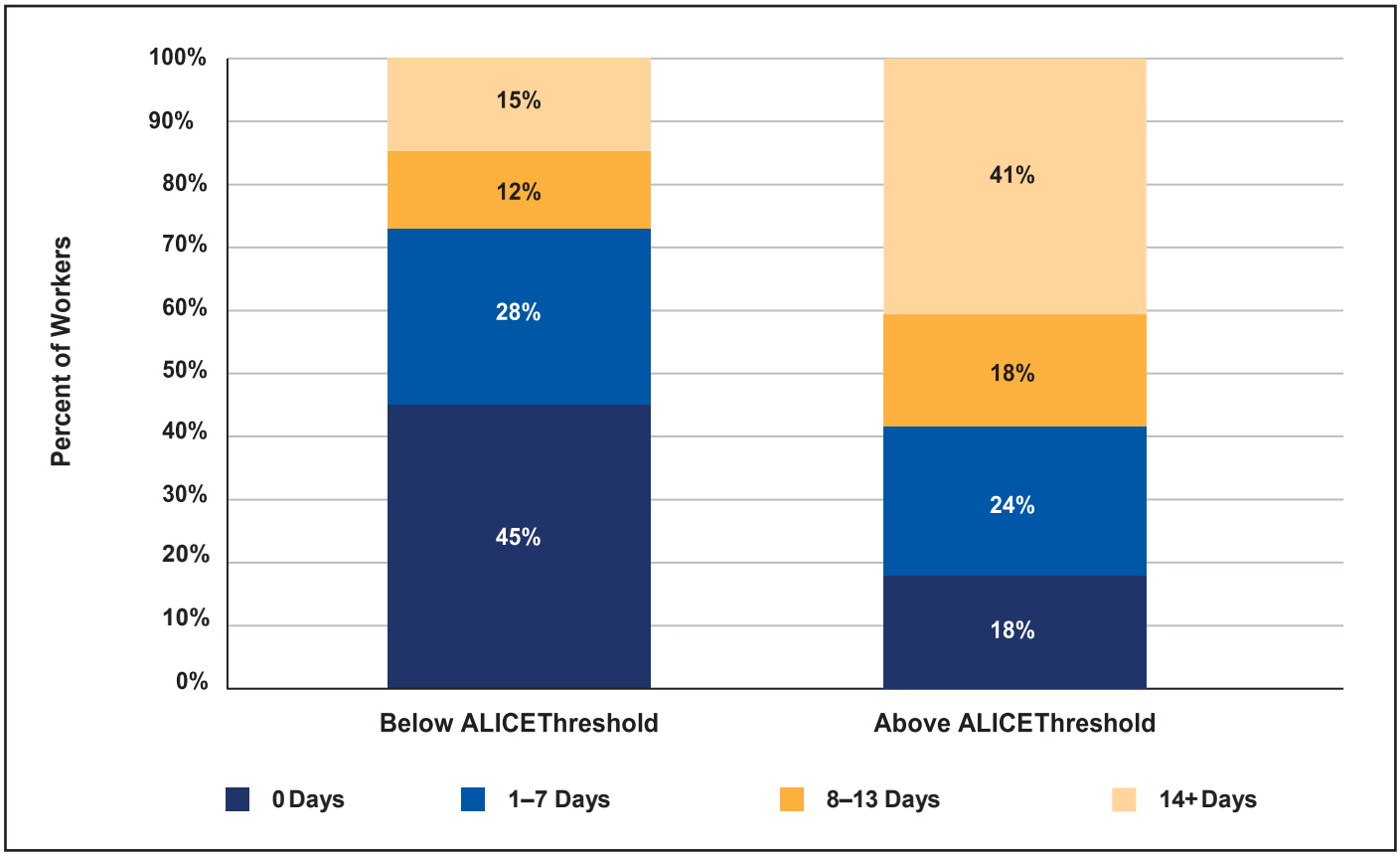
Barriers to work: For more insight into the situations of people looking for work, the United For ALICE Surveys asked jobseekers about the barriers they had been facing during the pandemic. For respondents both above and below the ALICE Threshold, "trouble finding a job" was the most reported barrier (53% of all respondents), and both groups reported difficulties finding a job that pays enough (46% of all respondents). Beyond the top two barriers, however, there were differences between households above and below the ALICE Threshold. Jobseekers below the ALICE Threshold were significantly more likely than jobseekers above the Threshold to report that the following five factors were barriers to securing employment:

- Caregiving for a child, older adult, or person with special needs (48% vs. 20%)
- Concerns about contracting COVID-19 (38% vs. 30%)
- Existing health issues (19% vs. 14%)
- Transportation issues (17% vs. 6%)
- Internet/computer issues (9% vs. 5%)

Similarly, the Household Pulse Survey found that among non-retired respondents who had not worked in the previous seven days (surveyed between January 20 and February 1, 2021, when case counts were increasing rapidly across the country), health issues were a major reason why respondents reported not working. Of these respondents, 20% with household incomes below the ALICE Threshold and 13% above the Threshold said that they were not working because they were sick or disabled (8% and 6%, respectively, reported that they were sick with COVID-19).

Lack of Paid Sick Days: The UAS COVID survey sheds light on why these differences in employment status might exist, especially during a public health crisis. Workers with household income below the ALICE Threshold were significantly less likely to report that they had any paid sick days (45% said that they had no paid sick time), while workers with household income above the Threshold were significantly more likely to report having more than 14 sick days (41%) (Figure 16). See the "Mental and Physical Health" section of this Report for more detailed information on this topic.

Figure 16.
Allowable Sick Days by the ALICE Threshold



Question: If you get sick, how many days can you stay home from your job and still get paid?

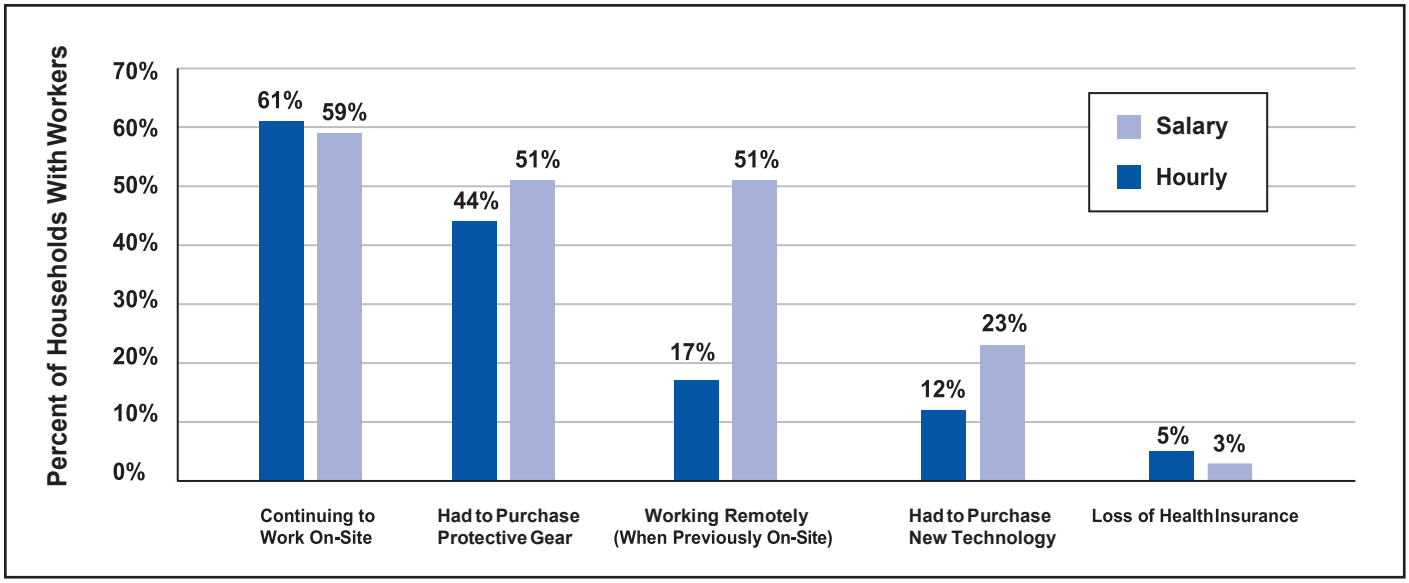
Source: ALICE Threshold, 2018; University of Southern California, Understanding America Study's Understanding Coronavirus in America Survey, Wave 24 Fielded February 2, 2021–March 3, 2021

The lack of paid sick days is an especially critical issue for workers with household income below the ALICE Threshold, as they were less likely to report being able to work from home. Throughout the pandemic, less than 15% of workers below the ALICE Threshold reported that their employer instructed them to work from home. For workers above the ALICE Threshold, the rate declined over time, falling from 55% in April 2020 to 30% in May 2021, but it was always significantly higher than the rate for workers below the Threshold (UAS COVID survey).

Hourly vs. Salaried Work: ALICE workers are more likely to work in hourly paid jobs than in salaried jobs. According to the United For ALICE COVID Surveys, among those working during the pandemic, employment impacts differed for workers in hourly paid jobs compared to salaried positions (Figure 17), which may also help explain differences in benefits, like paid sick days, and in caregiving issues. Respondents with household income below the ALICE Threshold were significantly more likely than those above the Threshold to rely on income from hourly paid work (70% vs. 45%), and significantly less likely to have household members who work for a salary (25% vs. 69%).

This dichotomy led to differences in the ability to work remotely: Only 17% of those below the ALICE Threshold were able to shift to remote work when the pandemic started, compared to over half (51%) of salaried workers. That, in turn, led to significant differences in the need to purchase protective gear and new technology (Figure 17).

Figure 17.
Pandemic Employment Impacts, Hourly vs. Salary Work



Questions: For adults in your household who work for a salary, which of the following have occurred as a result of the COVID-19 pandemic? And For adults in your household who work in jobs that are paid by the hour, which of the following have occurred as a result of the COVID-19 pandemic?

Note: Respondents could select all that apply and were asked to report employment impacts for themselves and other household members. Source:

United For ALICE COVID Impact Surveys, September 2020–June 2021

Hourly vs. Salaried Work Above and Below the ALICE Threshold: Within these two employment groups (hourly vs. salary), there were significant differences by income. Notably, among households with hourly paid workers, **respondents below the ALICE Threshold were significantly more likely to be working fewer hours than before the pandemic (34%** vs. 24%) and significantly less likely to be working remotely (11% vs. 20%). Among households with salaried workers, respondents below the ALICE Threshold were significantly less likely to be working remotely (28% vs. 50%).

Households with hourly paid workers who worked fewer hours overwhelmingly reported that it was because their employer had less business or needed fewer workers (73% below the ALICE Threshold and 79% above the Threshold). Respondents below the ALICE Threshold also faced additional challenges: They were significantly more likely to say that they were working fewer hours due to caregiving needs (28% vs. 14%), fear of catching or spreading COVID-19 (23% vs. 14%), health issues (11% vs. 5%), and limited computer or internet access (2% vs. 1%).

CHALLENGES FOR FAMILIES WITH CHILDREN

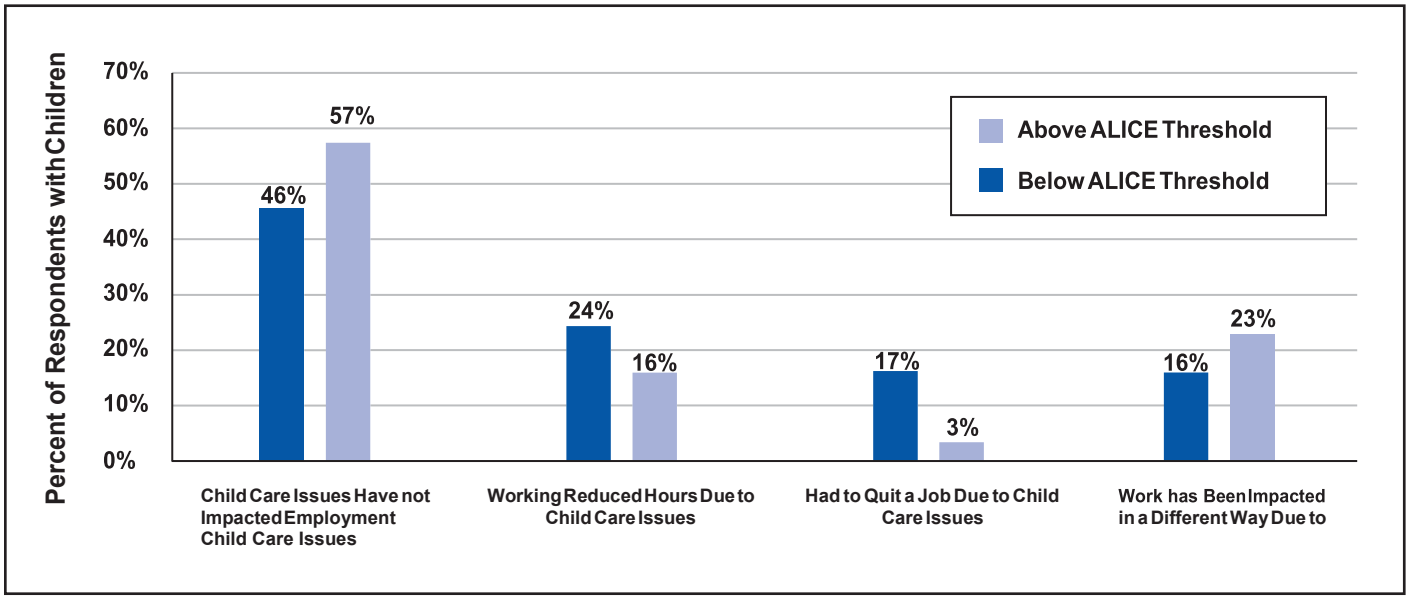
Families with children were among the hardest hit by the pandemic. With the closure of child care centers and schools, there was significant disruption to learning, working, and family activity. Children have had to adjust to new child care and education structures and settings, parents have had to juggle work (remote and in-person), and child care providers have had to adapt to smaller groups and new protocols. The November 2020 SHED revealed that three out of five parents (60%) reported that their access to child care had been disrupted since the onset of the pandemic.

Impacts on Parent Work: Results from the UAS COVID survey confirm that the pandemic created challenges for parents with school-aged children at all income levels. At the beginning of the pandemic, almost 40% of parents reported that school closures made it difficult to both work and do other household tasks. Additionally, 40% said that they were not satisfied with how much their children were learning (in April and May 2020).

By November 2020, households below the ALICE Threshold with children faced more employment challenges than those above the Threshold because their children's classes were not completely in-person, or because access to child care was disrupted. These households were more likely than those above the ALICE Threshold to report that these child care issues led to their working less (23% vs. 16%) or not working (21% vs. 6%) (SHED, November 2020).

The United For ALICE Surveys found similar gaps (Figure 18). Respondents above the ALICE Threshold with children were significantly less likely to report that child care issues had an impact on employment than respondents below the Threshold (57% vs. 46%). Respondents below the ALICE Threshold were significantly more likely to say that they were working reduced hours (24% vs. 16%) or that they had to quit a job (17% vs. 3%) due to child care issues.

Figure 18.
Child Care Impacts on Household Employment by the ALICE Threshold



Question: Since March 1, 2020, how have child care issues impacted household members' ability to work?

Note: Respondents could select all that apply and were asked to report employment impacts for themselves or for other household members. Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

Food Insecurity: Families with children also faced unique challenges in meeting basic needs, most notably with the most fundamental need — food. Access to and affordability of food was a challenge for many throughout the pandemic, especially for households below the ALICE Threshold with children, and reported across all surveys:

- Among respondents below the ALICE Threshold with children, 41% reported that "sometimes" or "often" their children were not eating enough because the household couldn't afford enough food. While this was less common in higher-income households, a substantial 17% of respondents above the ALICE Threshold also struggled to afford food for their children (Household Pulse Survey, January 20– February 1, 2021).
- Among respondents below the ALICE Threshold with children, 56% reported that they were concerned about having enough food for the household compared to 15% of respondents above the Threshold (United For ALICE Surveys).
- Black and Hispanic respondents below the ALICE threshold were more likely to report difficulty affording food for their children during the pandemic (49% of both Black and Hispanic respondents, compared to 35% of White respondents) (Household Pulse Survey, January 20– February 1, 2021).
- Results from the UAS COVID survey confirm that among families with children, households below the ALICE Threshold were significantly more likely to report facing food insecurity due to lack of meals provided at school (21% vs. 7%).

> *I am a single mom of three kids. I work a full-time, 12-hour night shift job at a long-term nursing home. It's a struggle to sleep for work, help with school work, and maintain a normal life for my kids.*
>
> *— United For ALICE Survey respondent, Shenandoah Valley, Virginia*

Other Concerns for Families With Children: Beyond food needs, United For ALICE Survey respondents below the ALICE Threshold with children were also significantly more likely than respondents above the Threshold to say that they were concerned about:

- Paying housing expenses (71% vs. 22%)
- Paying off debts (50% vs. 27%)
- A reduction in hours/wages for household members who were working (42% vs. 23%)
- Loss of jobs (41% vs. 20%)
- Non-COVID-19-related medical issues (28% vs. 21%)

Technology for Families With Children: As internet and device access became increasingly important for work and learning during the pandemic, households below the ALICE Threshold with children reported concerns about access to technology.

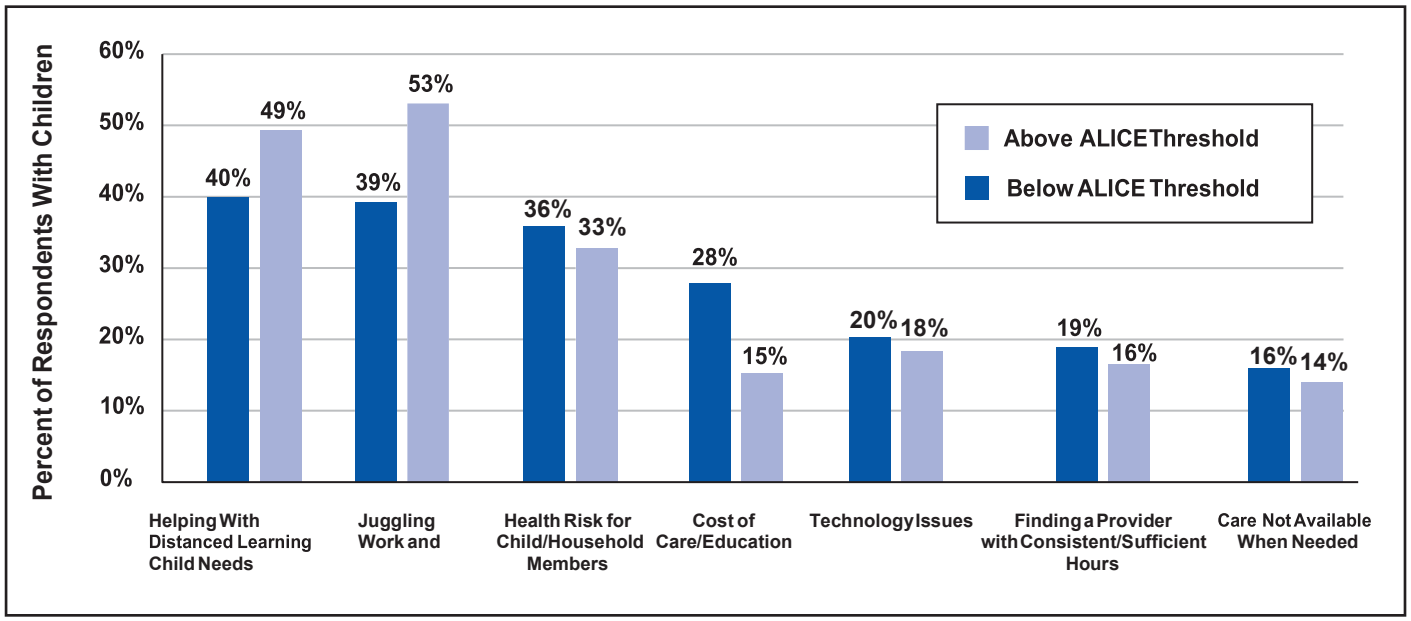
- For families with children in school, those below the ALICE Threshold were less likely to always have a computer or other digital device available for educational purposes. At the beginning of the pandemic (Spring 2020), the percentage of respondents below the ALICE Threshold who said they "usually or always" had technology available for educational purposes hovered around 80%; by the following school year, that percentage rose to 90%. For those above the ALICE Threshold, the percentage was 96% throughout (Household Pulse Survey, April 23, 2020–March 29, 2021, excluding June and August 2020).
- Respondents below the ALICE Threshold with children were significantly more likely to have concerns about internet and device access (20% vs. 18%) (United For ALICE Surveys) (Figure 19).

Child Care and Learning Issues: The pandemic brought about substantial changes in child care and education, which created new challenges for families with children (Figure 19):

- Respondents below the ALICE Threshold with children were significantly more likely to be concerned about health risks for children/household members (36% vs. 33%), the cost of child care/education (28% vs. 15%), finding a provider with consistent/sufficient hours (19% vs. 16%) and that care would not be available when needed (16% vs. 14%).

- While helping with distanced learning and juggling work and child needs were the top concerns for both groups, respondents above the ALICE Threshold with children were significantly more likely to have these concerns (53% vs. 39% for juggling work and child needs and 49% vs. 40% for helping with distanced learning).

Figure 19.
Household Child Care and Education Issues or Concerns by the ALICE Threshold



Question: Since March 1, 2020, as a result of the COVID-19 pandemic, what child care issues or concerns or issues have members of your household had?

Note: Respondents could select all that apply.

Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

Our biggest concern is the limited number of child care facilities in our rural area and that has prevented my husband from being able to return to work. The few childcare facilities in our area have been struggling with COVID-19 outbreaks, where they have had sporadic available hours. I am an essential worker for the state, working remotely, and carry the health insurance for our family, therefore I have been the one that has remained employed.

— United For ALICE Survey respondent, Indiana

PHYSICAL AND MENTAL HEALTH

The health impacts of COVID-19 are the most obvious outcomes of the pandemic, with the virus both directly and indirectly affecting physical and mental wellness. The virus had taken the lives of at least 710,000 people in the U.S. and infected over 44 million as of October 2021, and in the process it both uncovered and worsened disparities in health care quality, access, and affordability — most notably by income and race/ethnicity.[9] Simultaneously, the uncertainty, grief, and isolation of the pandemic have contributed to new or worsening mental health issues for many.[10]

Respondents below the ALICE threshold were significantly more likely than those above the Threshold to report that they or a household member had ever had a documented health issue. Gaps in reported health issues also existed by race/ethnicity:

- Mental health: According to the UAS COVID survey, almost one-third (30%) of respondents had been told by a doctor, nurse, or other health professional that they had a mental health issue like depression or Post Traumatic Stress Disorder (PTSD). This rate was significantly higher for respondents below the ALICE Threshold at 35%, compared to 25% for those above the Threshold (Wave 24 Fielded February 2, 2021–March 3, 2021).

- Physical health: Over half of UAS COVID survey respondents (53%) said they had a doctor-diagnosed physical health condition like high blood pressure or diabetes. This rate was high for both groups, and significantly higher for households below the ALICE Threshold (55%) than for respondents above the Threshold (51%).

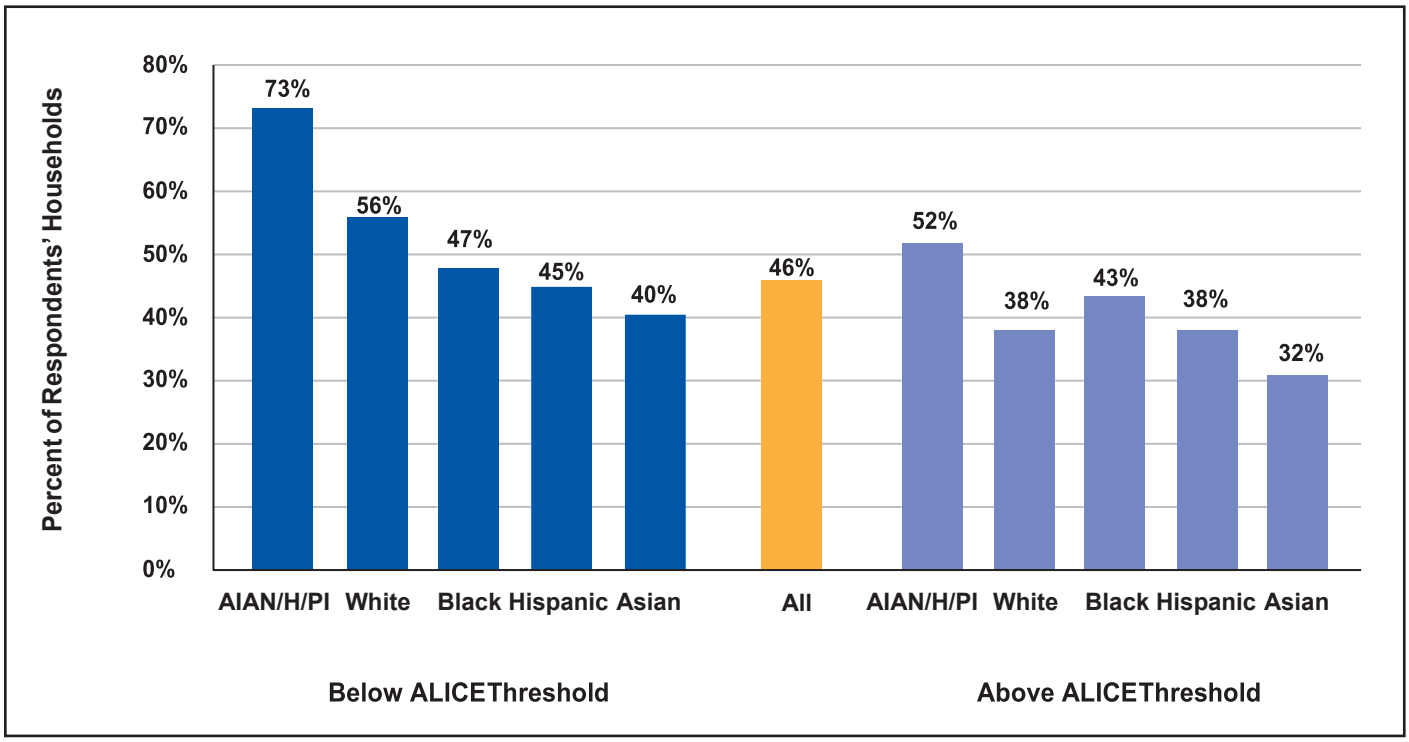
- Differences by race/ethnicity: AIAN/Hawaiian/Pacific Islander respondents below the ALICE Threshold were the most likely to report a significant health issue at almost three in four households (73%). In addition, just over half (52%) of respondents in this group above the ALICE Threshold reported a significant health issue. These extraordinarily high percentages warrant additional research. Among households below the ALICE Threshold, there were significant health issues for more than half (56%) of White respondents, compared to 47% of Black respondents, 45% of Hispanic respondents, and 40% of Asian respondents (Figure 20).

We have kept our small children home instead of daycare and had to balance one parent now working full time remotely and the other still needing to report to an office several times a week — the mental toll of the pandemic has been incredible. The anxiety, stress, sadness, and depression...is like nothing I ever could have predicted.

— United For ALICE Survey respondent, Greater Fredericksburg Region, Virginia

Figure 20.

Presence of a Significant Health Issue by the ALICE Threshold and Race/Ethnicity



Question: Do you or anyone in your household have a serious health issue or disability? ["Chronic health condition, such as diabetes or a heart condition," "mental disability," "physical disability," or "other serious health issue or disability" selected]

Note: All racial groups include respondents who selected that race alone, except for "AIAN/H/PI," which includes respondents who selected "American Indian or Alaska Native" or "Native Hawaiian or Pacific Islander" alone or in combination with other races (non-Hispanic). The Hispanic ethnic group includes respondents who selected "Spanish, Hispanic, or Latinx" alone or in combination with one or more racial groups.

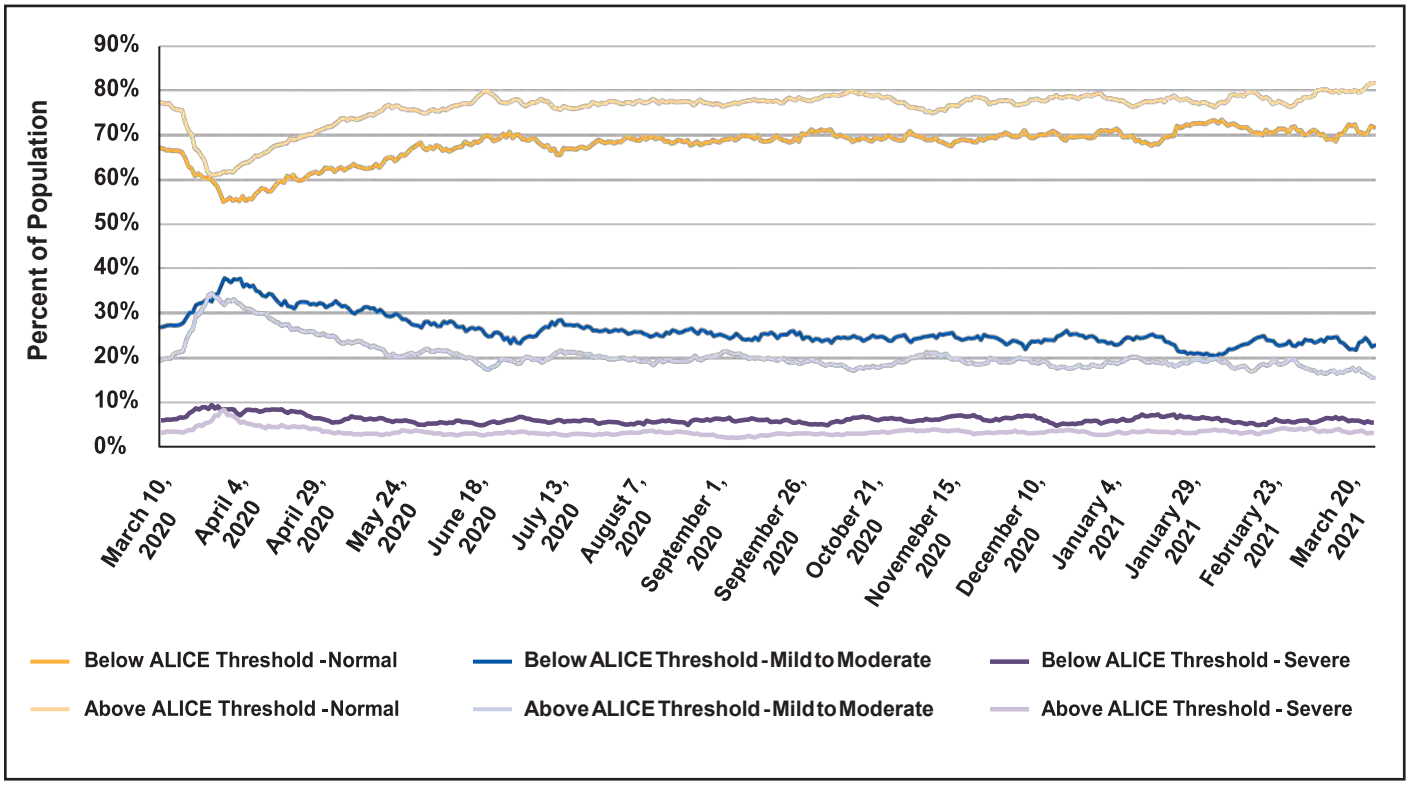
Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

Results from the UAS COVID survey also illuminated how mental health has been impacted over time during the pandemic. As shown in Figure 21, the percentage of respondents with mild to moderate symptoms of anxiety and depression peaked in April 2020, while the percentage of respondents with no or few symptoms ("normal" symptomology) dropped. The percentage with mild to moderate symptoms gradually decreased through mid-June 2020 and then remained relatively flat through March 2021.

At almost every point, however, there were significant differences between households above and below the ALICE Threshold. Respondents below the ALICE Threshold were more likely to have mild to moderate or severe symptoms, while respondents above the Threshold were more likely to have few or no symptoms. For example, in April 2020, 44% of respondents below the ALICE Threshold had symptoms above the normal range, significantly higher than the 35% of respondents above the Threshold. By March 2021, rates were lower for both groups, but the gap persisted (29% vs. 19%).

Figure 21.

Symptoms of Anxiety and Depression by the ALICE Threshold, March 10, 2020–March 20, 2021



Note: Mental health groupings shown in this figure are based on responses to the Patient Health Questionnaire-4, a four-question diagnostic survey that measures the core symptoms and signs of depression and anxiety.[11]

Source: ALICE Threshold, 2018; University of Southern California, Understanding America Study's Understanding Coronavirus in America Survey, March 10, 2020–March 20, 2021

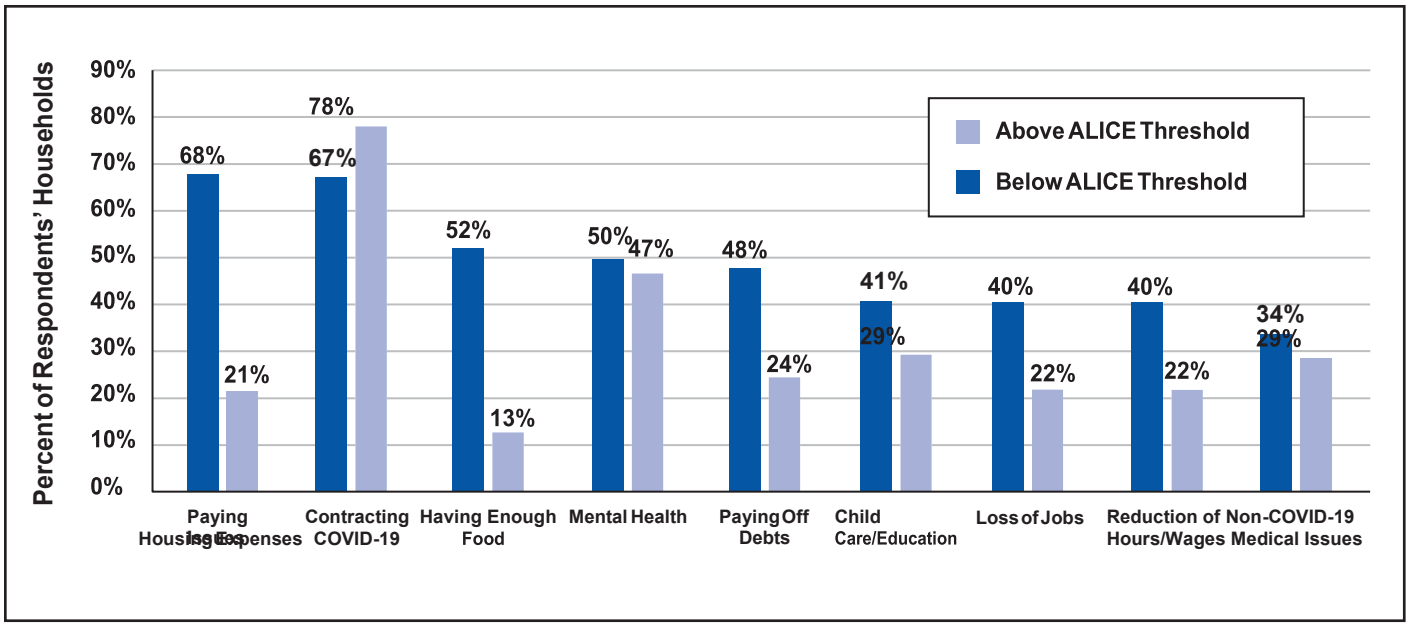
Concerns During the Pandemic: The United For ALICE Surveys provide important insight into the specific worries and concerns that households dealt with during the pandemic and how they differed by income (Figure 22). Across all respondents, the most frequently selected concern was contracting COVID-19 (73%). However, this was significantly more likely to be a concern for respondents above the ALICE Threshold than for those below the Threshold (78% vs. 67%). On the other hand, households below the ALICE Threshold were significantly more likely to be concerned about paying housing expenses (68% vs. 21%), having enough food for the household (52% vs. 13%), paying off debts (48% vs. 24%), child care/education (41% vs. 29%), losing one or more jobs (40% vs. 22%), reduction of hours/wages (40% vs. 22%), and non-COVID-19-related medical issues (34% vs. 29%).

Mental health for me personally is poor due to the changes associated from shifting to at-home work, juggling distance learning, adapting to 'new normal', learning new technology, and losing the sanctuary of my home (every room is now work/office).

— United For ALICE Survey respondent, Florida

Figure 22.

Household Concerns During the Pandemic by the ALICE Threshold



Question: What are your household's concerns during the COVID-19 pandemic?

Note: Respondents could select all that apply. Child care impacts are out of all households, not just households with children. Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

When respondents to the United For ALICE Surveys were asked a follow-up question about their biggest concern, the top three responses included worries about contracting COVID-19 (37% of all respondents), paying housing expenses (23% of all respondents), and mental health issues (9% of all respondents). However, the choice and ranking of the biggest household concerns differed by income. The top three concerns for respondents below the ALICE Threshold were paying housing expenses (36%), contracting COVID-19 (25%), and mental health issues (7%). For respondents above the Threshold, the top three concerns were contracting COVID-19 (50%), mental health issues (11%), and child care/education (10%).

Drilling down further, responses by health status provided great insight into who was struggling simply to meet basic needs. Households below the ALICE Threshold with health issues were significantly more likely to be concerned about paying housing expenses (69%), providing food for the household (56%), and paying off debts during the pandemic (48%) than either households below the Threshold without health issues or households above the Threshold with health issues (Figure 23) (United For ALICE Surveys).

Figure 23.

Household Concerns During the Pandemic by ALICE Threshold and Health Status

Households	Paying Housing Expenses	Providing Enough Food for the Household	Paying Off Debts
WITH HEALTH ISSUES			
Below ALICE Threshold	69%	56%	48%
Above ALICE Threshold	26%	17%	29%
WITHOUT HEALTH ISSUES			
Below ALICE Threshold	66%	48%	47%
Above ALICE Threshold	18%	10%	22%

Question: What are your household's concerns during the COVID-19 pandemic?

Source: ALICE Threshold, 2018; United For ALICE COVID Impact Surveys, September 2020–June 2021

In addition, over half (51%) of households below the ALICE Threshold with a health issue said that someone in their household was looking for work during the pandemic (compared to 27% of households above the Threshold with a health issue and 37% of all respondents). These households also faced additional barriers to securing employment. Job-seeking households below the ALICE Threshold with health issues were significantly more likely than job-seeking households above the Threshold with health issues to say that caregiving needs (for a child, older adult, or person with special needs) were a barrier to securing employment (54% vs. 24%). They were also significantly more likely to report other barriers to securing a job including concerns about contracting COVID-19 (44% vs. 36%), existing health issues (31% vs. 26%), transportation issues (20% vs. 9%), and internet access/computer issues (11% vs. 6%).

I had a credit card maxed out and lost my health insurance because I couldn't pay for it. All jobs require either reliable transportation or Internet speeds of 10/5 and I have neither, and have no way to obtain either. I literally don't have enough money to work.

This is not how I thought my life would be at 55. I barely have enough food. I can't even worry about retiring in 20 years.

— United For ALICE Survey respondent, Florida

HOW HOUSEHOLDS MET EXPENSES

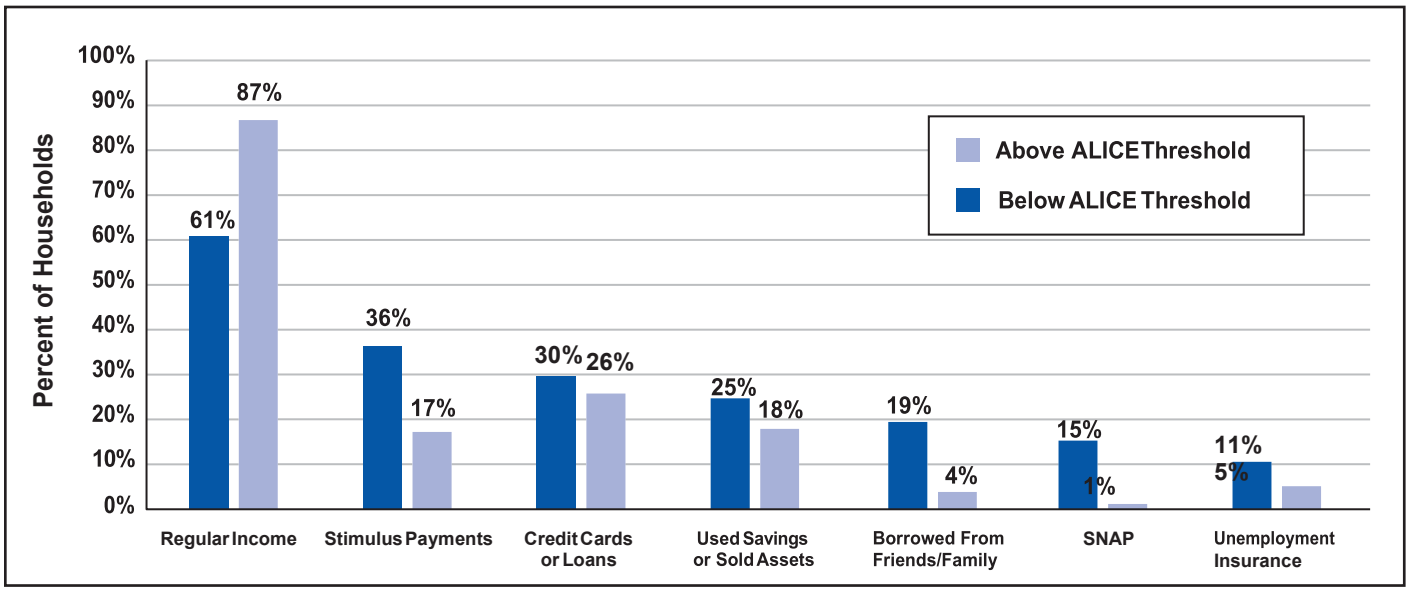
With insufficient income and little or no savings, households below the ALICE Threshold struggled before the pandemic, often pushed into difficult, no-win choices to make ends meet. The pandemic added to this stress by further destabilizing ALICE worker income, as well as adding new and unexpected expenses. This section provides the first detailed analysis of the different resources that households above and below the ALICE Threshold had access to and used to get by during the pandemic.

Well into the pandemic (May 2021), the Household Pulse Survey asked respondents to select which of the following actions they or their household members took to meet spending needs over the previous seven days (Figure 24). Most households used regular income sources like those received before the pandemic to cover spending needs, but those above the ALICE Threshold were significantly more likely to use regular income than those below the Threshold (87% vs. 61%).

To cover spending needs, 74% of households below the ALICE Threshold reported using additional income sources (other than regular income sources, like those used before the pandemic) compared to 46% of households above the Threshold. Households below the ALICE Threshold were significantly more likely to have used:

- Stimulus payments (36% vs. 17%)
- Credit cards or loans (30% vs. 26%)
- Money from savings or selling assets (25% vs. 18%)
- Supplemental Nutrition Assistance Program (SNAP) benefits (15% vs. 1%)
- Unemployment insurance (UI) benefit payments (11% vs. 5%)
- Money borrowed from friends and family (19% vs. 4%)

Figure 24.
Ways Households Met Spending Needs by the ALICE Threshold, May 2021



Question: Thinking about your experience in the last 7 days, which of the following did you or your household members use to meet your spending needs? Note: Respondents could select all that apply.

Source: ALICE Threshold, 2018; U.S. Census Bureau, Household Pulse Survey, Week 30: May 12–May 24, 2021

Significant gaps also existed by race/ethnicity. Most notably, White households below the ALICE Threshold were more likely to have used regular income sources, like those received before the pandemic, to cover spending needs (63%, vs. 57% of Asian and 54% of Black and 51% of Hispanic households). In addition, Black households below the ALICE Threshold were more likely to have borrowed from friends or family (27%, vs. 22% of Hispanic, 18% of White, and 16% of Asian households) and used SNAP benefits (23%, vs. 13% of Hispanic, 14% of White, and 5% of Asian households).

Responses over time to the Household Pulse Survey (April 2020 to May 2021) show that households below the ALICE Threshold experienced more disruptions for a longer period than those above the Threshold. This was especially pronounced for use of regular income sources to cover spending needs, borrowing from friends and family, and UI benefit payments:

- Regular income sources: Respondents below the ALICE Threshold were significantly less likely to have used regular income to cover spending needs, with the percentage ranging from 52% to 61%, while the percentage of households above the Threshold using regular income sources remained above 80% throughout this period.

- Borrowing from friends and family: Respondents below the ALICE Threshold were significantly more likely to have borrowed from friends or family to cover spending needs, with the percentage ranging from 17% to 29%, while the percentage of households above the Threshold who borrowed from family or friends stayed at or below 6% throughout the period.

> *The unemployment [insurance] we received for my husband put us over the limit for qualifying for the EITC for 2020...Without the new stimulus payment coming this week we would not have been able to cover our household bills and expenses.*
>
> *— United For ALICE Survey respondent, Maryland*

- **Unemployment Insurance (UI) benefits:** The percentage of respondents below the ALICE Threshold who used UI benefit payments increased to 20% in August, October, and November 2020, then slowly declined to 11%, while the percentage of households above the Threshold who used UI benefit payments reached 12% in July and August 2020, then declined to 5%.

The November 2020 SHED also asked about community-based support that households received during the pandemic. Respondents below the ALICE Threshold were significantly more likely to report that they received:

- Free groceries or meals through a food pantry, religious, or community organization (22% vs. 4%)
- Financial assistance from friends or family members not living with them (15% vs. 3%)
- Financial assistance from a religious or community organization (4% vs. 1%)

Similar gaps in income were found in the actions participants reported in the United For ALICE Surveys (although at higher rates in this non-representative sample). For respondents below the ALICE Threshold, the top five most selected actions were applying for government assistance programs like SNAP, Temporary Assistance for Needy Families (TANF), and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) (43%); receiving food from a food pantry/bank (40%); applying for unemployment (40%); borrowing from family or friends (36%); or taking money out of a savings account (33%). For respondents above the ALICE Threshold, fewer actions were taken and the top actions differed — taking money out of a savings account (28%) was most selected, followed by applying for unemployment (19%), increasing a balance on a credit card (19%), and finding a new way to make money (11%). Among respondents above the ALICE Threshold, 39% said that they did not take any of these actions to get by (compared to only 9% of respondents below the ALICE Threshold).

Finally, the Household Pulse Survey provides additional insights into how households used their government-issued Economic Stimulus Payments ($1,200 for an individual in April 2020, $600 in December 2020/January 2021, and $1,400 in March 2021). Based on income limits, 78% of all households and 100% of households below the ALICE Threshold were eligible to receive these payments.[12] The ways in which households used these payments spotlights the differing needs and priorities of households above and below the ALICE Threshold:

- **First stimulus payment** (Household Pulse Survey, July 16–July 21, 2020):
  - Of those who reported receiving a stimulus payment at the time of the survey, households below the ALICE Threshold were significantly more likely than households above the ALICE Threshold to "mostly spend" their stimulus payment (84% vs. 66%) and significantly less likely to add it to savings (4% vs. 17%) or use it to pay off debts (12% vs. 16%).
  - Households below the ALICE Threshold were more likely to use the first stimulus payment to cover basic needs: They were significantly more likely than households above the ALICE Threshold to report using it to pay for food (78% vs. 63%); telecommunications and utilities, including natural gas, electricity, cable, internet, or a cellphone (63% vs. 45%); rent (45% vs. 17%); or vehicle payments (29% vs. 22%).
  - Households above the ALICE Threshold were more likely to put the stimulus funds into savings or investments (19% vs. 8%) or to make a charitable donation (7% vs. 3%). Both groups were similarly likely to report using it to pay down credit card debt, student loans, or other debts (24% vs. 23%).
- **Subsequent stimulus payments:** (Household Pulse Survey, January 20–February 1, 2021):
  - By late January/early February 2021, when most households had received a second stimulus payment, households below the ALICE Threshold had largely shifted from spending the payment (down sharply to 25%) to using it to pay down debt (up sharply to 59%). This percentage was significantly higher than that of households above the ALICE Threshold who used it to pay off debt (44%).
  - Black and Hispanic households below the ALICE Threshold were more likely to use their stimulus payments to pay off debt than White or Asian households below the Threshold (69% and 65%, respectively, vs. 58% and 42%, respectively) and less likely to add to savings (10% and 13%, respectively, vs. 17% and 19%, respectively).

Direct financial support for families facing crisis is needed right now. There just isn't enough support out there to help folks who haven't ever faced this kind of need before. Cash in hand would change my family's life, but we haven't found any we qualify for yet.

— United For ALICE Survey respondent, Arkansas

CONCLUSION: ALICE AT A CROSSROADS

The ALICE analysis of the four surveys presented in this Report shows that those who went into the pandemic struggling —starting out with low incomes, low-wage jobs, and little or no savings — were the most vulnerable to the dual impact of the health crisis and the ensuing economic disruption. The differences between how households above and below the ALICE Threshold experienced the pandemic are striking.

Who did better and worse? The November 2020 SHED asked respondents to consider their current financial standing in comparison to 12 months earlier. Respondents below the ALICE Threshold were significantly more likely to report being somewhat or much worse off than those above the ALICE Threshold (34% vs. 17%).

But 19% of respondents below the ALICE Threshold reported being much better off or somewhat better off. Characteristics of this group provide some insight into what helps families to be more financially stable (Figure 25):

- Respondents below the ALICE Threshold who reported being somewhat or much better off were more likely to have worked full time, received a raise or promotion, started a new job, had insurance through an employer or union, maintained a savings or checking account, kept rainy day funds, had a retirement plan on track, and been very confident in approval for credit.
- Those below the Threshold who reported being somewhat or much worse off were more likely to have worked part time, been laid off or lost a job, had household income that varied quite often from month to month, rented rather than owned a home, had to pay an unexpected medical bill out of pocket, owed outstanding credit card debt, had medical debt, set aside no rainy day funds, and not been confident in approval for credit.

Figure 25.
Characteristics of Those Better and Worse Off

Household Characteristics	Respondents Below the ALICE Threshold: Household Financial Status Compared to 12 Months Prior (November 2020–November 2021)	
	MUCH BETTER OFF OR SOMEWHAT BETTER OFF	MUCH WORSE OFF OR SOMEWHAT WORSE OFF
Employment	• Full-time job • Received a raise or promotion • Started a new job	• Part-time job • Laid off or lost a job • Household income that varied quite often from month to month
Housing Tenure		• Rent
Health Insurance	• Insurance through employer or union	• Paid unexpected medical bill out of pocket
Savings, Assets and Debt	• Savings or checking account • Rainy day funds • Retirement plan on track	• Unpaid balance on credit card • Medical debt • No rainy day funds
Access to Credit	• Very confident in approval chances	• Not confident in approval chances

Note: Differences between groups were significant.

Source: ALICE Threshold, 2018; Federal Reserve Board, Survey of Household Economics and Decisionmaking (SHED), November 2020

Directions for future research: The four surveys analyzed in this Report provide additional insight into the numerous and varied barriers to financial stability that households below the ALICE Threshold face, and they highlight areas for future research. Six barriers that stand out are:

1. Factors that lead to stability: The correlations between characteristics of those who did better or worse during the pandemic suggest important areas for additional research to understand the cause and effect for each factor as well as the impact of a combination of factors. There also needs to be greater understanding of the impact of these factors over time and of long-term sustainability.

2. **The role of public assistance:** Respondents below the ALICE Threshold who reported being much worse off or somewhat worse off financially were also more likely to report that their household received TANF, SNAP, Supplemental Security Income (SSI), free or reduced-price lunch, stimulus payments, unemployment insurance, Medicare/Medicaid, or free groceries or meals — an indicator that public assistance was reaching those most in need. These households also reported that they were more likely to receive financial assistance from friends or family.

With the release of 2020 decennial census data, news headlines have touted that increased public assistance during the pandemic has reduced poverty.[13] But if pandemic relief measures are only temporary, many households will fall back into poverty. The ALICE measures demonstrate that insufficient income extends well beyond the official poverty measures, and survey results confirm that even households that were eligible for public assistance continued to struggle during the pandemic. Additional research is needed to understand whether public assistance can serve only as a stopgap measure during a crisis, or whether it can be structured so that it helps households reach long-term financial stability.

3. Race/ethnicity: The consistent discrepancies by race/ethnicity for households above and below the ALICE Threshold strongly suggest that barriers by race/ethnicity are in fact barriers to financial stability in the U.S. today. Additional research is needed to understand how these barriers are perpetuated.

To do so, additional data is needed, especially for smaller racial/ethnic groups including Two or More Races, American Indian or Alaska Native, and Native Hawaiian and Pacific Islander.

> *In addition to the financial impact that this pandemic has had in our community, we have started and will continue to see the emotional scars that the community at large will have once things start to be a little normal again.*
>
> *— United For ALICE Survey respondent, Miami-Dade County, Florida*

4. Health: Households below the ALICE Threshold were more likely to have a member with a serious health issue. These households were also more likely to experience job loss and to have someone in the household looking for work during the pandemic. They also faced additional barriers to securing employment such as caregiving needs (for a child, older adult, or person with special needs), having trouble finding a job, and not being able to find a job that pays enough.

There were significant health issues among more than half (56%) of White respondents below the ALICE Threshold, compared to 47% of Black respondents, 45% of Hispanic respondents, and 40% of Asian respondents.

Additional research is needed to understand how and where else health and race/ethnicity overlap. In particular, the extraordinarily high prevalence of AIAN/Hawaiian/Pacific Islander respondents below the ALICE Threshold with a significant health issue (73%) needs more attention.

5. **Additional discrepancies:** In addition to racial/ethnic groups, there are other demographic groups that have long faced barriers to financial security. Additional work is needed in both data collection and analysis to understand the impact of COVID-19 and economic disruption on groups including women; veterans; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people; recent immigrants by country of origin; undocumented workers; formerly incarcerated people; and people with disabilities.

6. Long term tracking: Given what we have learned from previous disasters, it is clear that it can take years for ALICE families to recover financially. Tracking families over time is essential to understanding which supports and policies make a difference. In addition, the long-term health impacts for those who contracted COVID-19 will need to be followed closely since the effects of the virus over time are not yet fully understood, though early research suggests potential for ongoing multi-organ impacts or autoimmune conditions.[14] Chronic health issues will also create additional expenses and employment impacts for individuals and their family caregivers.

DIG DEEPER: UNITED FOR ALICE TOOLS AND RESOURCES

- Meet ALICE in your community on our website, with topline ALICE data on every U.S. county and more detailed data for our 24 United For ALICE partner states.
- Read about the trends over the last decade that contributed to a growing number of ALICE households nationwide in our 2020 report, *On Uneven Ground: ALICE and Financial Hardship in the U.S*.
- Learn about change over time in the cost of household essentials through a United For ALICE signature measure, the ALICE Essentials Index.
- **See COVID-19 cases and deaths mapped with ALICE data** using our ALICE & COVID-19 Tracker.
- **Explore how wage levels impact ALICE households** and what wages different occupations pay by location using the ALICE Wage Tool.
- **Learn more about the difficult decisions that households face when they can't afford the basics** in our Report, *The Consequences of Insufficient Household Income*.
- **Gain deeper understanding of the United For ALICE methodology** in our Methodology Overview.
- Connect to your local United Way for support and volunteer opportunities.

APPENDIX A

FEDERAL RESERVE BOARD'S SURVEY OF HOUSEHOLD ECONOMICS AND DECISIONMAKING (SHED)

Overview

Since 2013, the Federal Reserve Board has conducted the Survey of Household Economics and Decisionmaking (SHED), which evaluates the economic well-being of U.S. households and identifies potential risks to their financial stability. The survey includes modules on a range of topics of current relevance to financial well-being, including credit access and behaviors, savings, retirement, economic fragility, and education and student loans.

For more information: https://www.federalreserve.gov/publications/report-economic-well-being-us-households.htm

Who Conducted the Survey?

The Board of Governors of the Federal Reserve System

Data Collection Method

Online survey using a nationally representative panel (Ipsos Knowledge Panel)

Frequency/Timing

Surveys included in this analysis were:

- Survey of Household Economics and Decisionmaking conducted in October 2019
- COVID-19 supplemental survey conducted in July 2020 (focused on pandemic impacts)
- Survey of Household Economics and Decisionmaking conducted in November 2020

Sample Size

N-November 2020= 11,648; N-July 2020= 4,174; N-October 2019= 12,173

ALICE Calculations and Considerations

The ALICE Threshold status of survey participants' households were determined using three key components: 1) household income, 2) location, and 3) household composition. Location and family composition were used to identify the appropriate Household Survival Budget (based on 2018 United For ALICE data), which was then compared to the respondent's household income to determine their ALICE Threshold status.

HOW AND WHEN INCOME DATA WAS COLLECTED

Each panelist's income bracket was collected upon their joining the Ipsos Knowledge Panel and published under the variable "I40". For the October 2019 survey, all income information was prior to the pandemic, and the July 2020 supplemental SHED surveyed the same respondents so did not ask for income data again. Since panelists rotate through, roughly one-third of the panel is new each year, for the November 2020 roughly one-third of respondents' income information was collected during the pandemic.

Which of the following categories best describes the total income that you (and your spouse / and your partner) received from all sources, before taxes and deductions, in the past 12 months?

1) $0 to $4,999
2) $5,000 to $14,999
3) $15,000 to $24,999
4) $25,000 to $39,999
5) $40,000 to $49,999
6) $50,000 to $74,999
7) $75,000 to $99,999
8) $100,000 to $149,999
9) $150,000 to $199,999
10) $200,000 or higher

LOCATION

Each panelist's state of residence was collected upon their joining the Ipsos Knowledge Panel and published under the variable "ppstaten". Smaller geographies (like county or ZIP code) were either not collected or not published. Therefore, the state average Household Survival Budget for each household type was matched to each respondent to determine if their income was above or below the ALICE Threshold.

HOUSEHOLD COMPOSITION

Each panelist's household composition (presence of household members by age) was collected upon their joining the Ipsos Knowledge Panel and published in the following five variables by age:

Presence of Household Members Children 0–1 (ppt01) Presence of

Household Members Children 2–5 (ppt25) Presence of Household

Members Children 6–12 (ppt612) Presence of Household Members

Children 13–17 (ppt1317) Presence of Household Members Adults 18+

(ppt18ov)

Households were assigned Household Survival Budgets based on their composition. Children aged 0–1 years were assigned infant costs, children 2–5 were assigned preschooler costs, children 6–12 and children 13–17 were assigned school-aged costs. Adults were broken down into non-seniors and seniors.

Race/Ethnicity

The racial/ethnic groupings included in this dataset are as follows:

2+ Races, Non-Hispanic (N-November 2020= 371; N-July 2020= 60; N-October 2019= 400)

Black, Non-Hispanic (N-November 2020= 1,158; N-July 2020= 468; N-October 2019= 1,228)

Hispanic (N-November 2020= 1,423; N-July 2020= 567; N-October 2019= 1,456)

Other, Non-Hispanic (N-November 2020= 571; N-July 2020= 255; N-October 2019= 564)

White, Non-Hispanic (N-November 2020= 8,125; N-July 2020= 2,824; N-October 2019= 8,525)

APPENDIX B

UNIVERSITY OF SOUTHERN CALIFORNIA CENTER FOR ECONOMIC AND SOCIAL RESEARCH'S UNDERSTANDING AMERICA STUDY'S UNDERSTANDING CORONAVIRUS IN AMERICA (COVID) SURVEY (UAS COVID SURVEY)

Acknowledgement

The project described in this paper relies on data from survey(s) administered by the Understanding America Study, which is maintained by the Center for Economic and Social Research (CESR) at the University of Southern California. The content of this paper is solely the responsibility of the authors and does not necessarily represent the official views of USC or UAS. The collection of the UAS COVID-19 tracking data is supported in part by the Bill & Melinda Gates Foundation and by grant U01AG054580 from the National Institute on Aging, and many others.

Overview

The Understanding America Survey, conducted by the University of Southern California, is a nationally representative, probability-based online panel of adults who were drawn from the more than 9,000 members of the UAS. The margin of sampling error is plus or minus 1 percentage point.

Link for more information: https://uasdata.usc.edu/index.php

Who Conducted the Survey?

The University of Southern California Dornsife Center for Economic and Social Research

Data Collection Method

The study relies on an "Internet Panel," which means that respondents answer surveys on a computer, tablet, or smartphone, wherever they are and whenever they wish to participate.

Frequency/Timing

Per UAS: "The first survey was fielded on March 10, 2020. The survey was in the field until April 1. In contrast to later waves, all respondents were invited on March 10. The distribution of responses over the survey period is therefore not random and concentrated in the first part of the survey period (see the Survey Methods tab on the COVID-19 Pulse site). As of April 1, a new survey is fielded every two weeks. Each day one-fourteenth of the respondents are invited to take the survey. Since respondents have two weeks to answer the survey, the total field period is four weeks, so that responses during the last two weeks of a field period of one survey overlap with responses in the first two weeks of the subsequent survey. For more information about survey waves, see https://uasdata.usc.edu/index.php"

Sample Size

Surveys are ongoing with approximately 7,000 people participating in each wave.

ALICE Calculations and Considerations

The ALICE Threshold status of each survey participant's household was determined using three key components: 1) household income, 2) location, and 3) household composition. Location and family composition were used to identify the appropriate Household Survival Budget (based on 2018 United For ALICE data), which was then compared to the respondent's household income to determine their ALICE Threshold status.

HOW AND WHEN INCOME DATA WAS COLLECTED

Income was collected when respondents joined the panel (updated quarterly) using the following income brackets:

1) Less than $5,000 2) 5,000 to 7,499
3) 7,500 to 9,999
4) 10,000 to 12,499
5) 12,500 to 14,999
6) 15,000 to 19,999
7) 20,000 to 24,999
8) 25,000 to 29,999
9) 30,000 to 34,999
10) 35,000 to 39,999
11) 40,000 to 49,999
12) 50,000 to 59,999
13) 60,000 to 74,999
14) 75,000 to 99,999
15) 100,000 to 149,999
16) 150,000 or more

LOCATION

Each respondent's state of residence was collected and published under the variable "STATERESIDE". Smaller geographies (like county or ZIP code) were either not collected or not published. Therefore, the state average Household Survival Budget for each household type was matched to each respondent to determine if their income was above or below the ALICE Threshold.

HOUSEHOLD COMPOSITION

Household composition (presence of household members by age) was collected and reported using the following variable:

HHMEMBERAGE _1-18 up to 18 individuals in a household by age

Race/Ethnicity

The racial/ethnic groupings included in this dataset include Hispanic, non-Hispanic, American Indian/Alaska Native, Asian, Black, Native Hawaiian/Pacific Islander, and White. Race/ethnicity data for this dataset is not used in this Report.

APPENDIX C

U.S. CENSUS BUREAU COVID-19 HOUSEHOLD PULSE SURVEY (HOUSEHOLD PULSE SURVEY)

Overview

To help understand the social and economic impacts of COVID-19 on American households in near real-time, the U.S. Census Bureau developed the Household Pulse Survey in partnership with five federal statistical partner agencies: the Bureau of Labor Statistics, the National Center for Health Statistics, the United States Department of Agriculture's Economic Research Service, the National Center for Education Statistics, and the Department of Housing and Urban Development. The survey was designed to meet the goal of accurate and timely weekly estimates.

Link for more information:
https://www.census.gov/programs-surveys/household-pulse-survey/technical-documentation.html

Who Conducted the Survey?

U.S. Census Bureau

Data Collection Method

The Household Pulse Survey is a 20-minute online survey. Respondents are selected from housing units in the Census Bureau's Master Address File (MAF) where at least one email address or cell phone number is known. Sampled households are sent the survey link by email and text if both are available, by email if no cellphone number is available, and by text if no email is available. Because personal visits are not possible during COVID19, follow-up is pursued with the emails and/or cell phones associated with the address until a response is received. Once a complete interview is obtained from a household, that household remains in the sample for up to two additional weekly interviewing periods.

Sample Size

N-Week 12 (July 16–July 21, 2020)= 86,792; N-Week 13 (August 19–August 31, 2020)= 109,051; N-Week 23 (January 20–February 1, 2021)= 80,567; N-Week 30 (May 12–24, 2021)= 72,897

Frequency/Timing

Phase 1 began April 23, 2020, and ended on July 21, 2020, and was collected weekly. Phase 2 began August 19, 2020, and was collected biweekly, as with all subsequent phases. Phase 3.2 is currently underway and is scheduled to continue until October2021.

ALICE Calculations and Considerations

The ALICE Threshold status of each survey participant's household was determined using three key components: 1) household income, 2) location, and 3) household composition. Location and family composition were used to identify the appropriate Household Survival Budget (based on 2018 United For ALICE data), which was then compared to the respondent's household income to determine their ALICE Threshold status.

HOW AND WHEN INCOME DATA WAS COLLECTED

Participants answered the following question (respondents' 2019 household income before taxes was used to capture pre-COVID-19 income):

In 2019, what was your total household income before taxes?

1) Less than $25,000	*5) $75,000 - $99,999*
2) $25,000 - $34,999	*6) $100,000 - $149,999*
3) $35,000 - $49,999	*7) $150,000 - $199,999*
4) $50,000 - $74,999	*8) $200,000 and above*

LOCATION

Each respondent's state of residence was collected and published under the variable "EST_ST". Metropolitan Statistical Area was also collected but was not a reliable variable for calculating ALICE Threshold status, as data was missing for non-metropolitan areas. Smaller geographies (like county or ZIP code) were either not collected or not published. Thus, the state average Household Survival Budget for each household type was matched to each respondent to determine if their income was above or below the ALICE Threshold.

HOUSEHOLD COMPOSITION

Each panelist's household composition (presence of household members by age) was collected in the surveys and reported using the following two variables:

Total number of people under 18-years-old in household (THHLD_NUMKID) Recode for the

number of Adults in the household (THHLD_NUMADLT)

Respondents were assigned Household Survival Budgets based on their responses. The specific ages of children were not reported; therefore, all children were assigned the budget costs for a school-age child. Adults were assigned adult costs as indicated by the respondent.

Race/Ethnicity

The racial/ethnic groupings included in this dataset are as follows:

Hispanic (N-Week 13 (August 19–August 31, 2020)= 10,208; N-Week 23 (January 20–February 1, 2021)= 7,943)

Non-Hispanic (N-Week 13 (August 19–August 31, 2020)= 98,843; N-Week 23 (January 20–February 1, 2021)= 72,624)

Asian, Alone (N-Week 13 (August 19–August 31, 2020)= 5,722; N-Week 23 (January 20–February 1, 2021)= 3,968)

Black, Alone (N-Week 13 (August 19–August 31, 2020)= 9,366; N-Week 23 (January 20–February 1, 2021)= 6,153)

White, Alone (N-Week 13 (August 19–August 31, 2020)= 88,545; N-Week 23 (January 20–February 1, 2021)= 66,522)

Any other race alone, or race in combination (N-Week 13 (August 19–August 31, 2020)= 5,418; N-Week 23 (January 20–February 1, 2021)= 3,924)

APPENDIX D

UNITED FOR ALICE COVID-19 IMPACT SURVEYS (UNITED FOR ALICE SURVEYS)

Overview

From September 2020 to June 2021, over 45,000 people responded to state surveys in Arkansas, Florida, Indiana, Maryland, New York, and Tennessee, and regional surveys in Franklin County, Ohio (Columbus), Roanoke Valley, Virginia, Shenandoah Valley, Virginia, and the Greater Fredericksburg Region, Virginia, about how their households have been impacted by the COVID-19 pandemic since March 1, 2020. The surveys were conducted by United Ways and local collaborators in partnership with United For ALICE. These surveys relied on convenience sampling and are not a representative sample of the national population. However, the respondents match national demographics in terms of race/ethnicity, age, and urban/rural location. With this caveat, the combined results of these surveys provide important insights into the issues ALICE households faced during the pandemic.

For more information: contact Info@UnitedForALICE.org

Who Conducted the Survey?

United For ALICE, in partnership with state and local United Ways

Data Collection Method

Online surveys

Frequency/Timing

Surveys were conducted between September 2020 and June 2021

Sample Size

N = 45,057

ALICE Calculations and Considerations

The ALICE Threshold status of each participant's household was determined using three key components: 1) household income, 2) location, and 3) household composition. Location and family composition were used to identify the appropriate Household Survival Budget (based on 2018 United For ALICE data), which was then compared to the respondent's household income to determine their ALICE Threshold status.

HOW AND WHEN INCOME DATA WAS COLLECTED

Participants answered the following question (2019 or 2020 was used as the reference year, depending on when the survey was in the field):

What was your household income last year before taxes?

1) Less than $25,000
2) $25,000 to $34,999
3) $35,000 to $49,999
4) $50,000 to $74,999
5) $75,000 to $99,999
6) $100,000 to $149,999
7) $150,000 or more

LOCATION

Respondents were asked to provide their zip code and county of residence. The county-level Household Survival Budget for each household type was matched to each respondent to determine if their income was above or below the ALICE Threshold.

HOUSEHOLD COMPOSITION

Each respondent's household composition (presence of household members by age) was collected using the following question:

How many children, adults, and seniors are in your household — including yourself? Adults (18

to 64 years old)

Seniors (65 years or older) Children

(0 to 5 years old)

Children (6 to 17 years old)

Race/Ethnicity

The racial/ethnic groupings included in this dataset are as follows:

American Indian or Alaska Native, Native Hawaiian or Pacific Islander, alone or in combination with other races; non-Hispanic (N=576)

Asian, alone (N= 536)

Black or African American, alone (N= 6,073)

Spanish, Hispanic, or Latinx, alone or in combination (N= 5,022) White,

alone (N= 30,216)

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c. IRA or Roth IRA
d. Savings outside a retirement account
e. Own a business or real estate that will provide income in retirement
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A Comprehensive Needs Assessment of the Franklin County System of Care

AUGUST 2021

Prepared By: Lauren Polvere, Ph.D.

POLICY STRATEGY CONSULTANTS, LLC

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Executive Summary

Characterized by its rural terrain, Franklin County is located in the Adirondack Park. Its three largest population centers are separated by large tracts of publicly protected land resulting in access barriers to services and supports, as well as geographic isolation. Franklin County has a whole-county mental health shortage designation, an issue compounded by transportation barriers. Many Franklin County families experience intergenerational risk factors, including poverty. Additionally, child abuse and neglect are pervasive issues in the county.

Franklin County maintains an active System of Care committee that has been meeting for over a decade. Trauma-informed care training and implementation are county priorities, with strong stakeholder support. To date, over five hundred providers and school personnel have been trained in trauma-informed care. In addition, Franklin County has participated actively in several New York State-wide System of Care initiatives and trainings.

The needs assessment findings indicate notable strengths in the Franklin County System of Care, including cross-sector collaboration and strong relationships with the school districts. Priority populations in need of enhanced services include youth in foster care or kinship care; transition-aged youth; youth with acute mental health needs or co-occurring disorders, including those at risk of out-of-home placement; and young children in need of early intervention. Gaps and needs identified include those related to infrastructure; the lack of day treatment programs for school-aged youth with acute mental health needs; limited crisis respite services for youth; few early intervention services, particularly for children younger than age three; and limited opportunities for parent training and educational programming, given the level of need.

Franklin County stakeholders suggested the need to broaden eligibility for care coordination services; improve communication, coordination, and accountability across agencies and providers; expand outreach to youth and families; create greater awareness of available services; and ease the burden of service navigation. Gaps related to youth and family participation were identified at the system level, as there was limited evidence of regular youth and family voice within the Franklin County System of Care.

Given the needs assessment findings, recommendations include: 1- expanding schools as "hubs" for comprehensive services; 2- considering approaches for expanding service access (i.e., per diem clinician roles and telehealth); 3- renewing efforts to engage youth and families; 4- creating and expanding services identified as current gaps; 5- developing a web-based repository, listing programs, services, and up-to-date contact information; 6- bringing promising practices in care coordination to scale; and 7- developing evaluation capacity.

Key Messages

Service Needs and Gaps in Franklin County, New York, Based on Published Data

Geographic characteristics contribute to barriers. Characterized by its rural terrain, Franklin County is located in the Adirondack Park. Its three largest population centers are separated by large tracts of publicly protected land, resulting in access barriers to services and supports, and geographic isolation.

A provider shortage and transportation barriers challenge service provision. Franklin County has a whole-county mental health shortage designation, as well as a shortage designation in primary care and dental health. As a result, youth and families in Franklin County experience unmet mental health and physical health needs. Transportation barriers further limit service access for youth and families in the county.

Many Franklin County families experience intergenerational risk factors, including poverty. Over a quarter of county children are living below the poverty line, a level that has increased steadily and is significantly higher than the New York State average. Access to safe, affordable housing is a challenge to many families. Additionally, child abuse and neglect are pervasive issues in Franklin County. The rate of indicated child abuse and neglect reports is the highest of any county in New York State. Educational attainment is lower in the county compared to the New York State average. In addition, a significant number of households lack high speed internet or a computer, creating additional barriers to education and employment.

Overview of the Franklin County System of Care

Franklin County maintains an active System of Care committee. In Franklin County, a diverse cross-sector System of Care committee has been meeting and collaborating for over a decade. As described by numerous stakeholders involved in the Franklin County System of Care, Franklin County is a small community where relationships matter.

Trauma-informed care training and implementation are county priorities, with strong stakeholder support. The Franklin County System of Care has made a commitment to the implementation of trauma-informed care since 2013. Franklin County has trained over five hundred providers and school personnel in trauma-informed care. Franklin County will soon implement a train-the-trainer, non-violent Therapeutic Crisis Intervention (TCI) program, with basic TCI training to begin in the fall of 2021.

The Franklin County System of Care participates actively in New York State initiatives. Franklin County participated actively in SAMHSA-funded New York State projects, including *New York State Success*, through which providers were trained in System of Care principles; *New York State Achieve*, in which Franklin County Community Services staff became trained in System of Care facilitation; the *New York State System of Care Pilot*, through which provider agencies were trained in high-fidelity Wraparound; and, recently, a New York State Office of Mental Health-led series of facilitated sessions on of Systems of Care.

Interview and Focus Group Findings

Interviews and focus groups (n=44) with a diverse array of System of Care stakeholders, including Franklin County departments (Probation, Department of Social Services, Public Health), mental health provider agencies, family members, school-based clinicians and CPSE chairs, superintendents, prevention and substance abuse provider agencies, developmental disability provider agencies, and providers serving families within the St. Regis Mohawk Tribe revealed the following emergent themes regarding strengths and needs in the Franklin County System of Care:

System of Care strengths include cross-sector collaboration; strong relationships with the school districts; provision of in-home clinical services for youth in foster care and families at risk of out-of-home care; current revitalization of the highly regarded Family Intervention Team (FIT) model; impactful single point of access (SPOA) meetings that promote accountability and service coordination; and school-based services, including clinical support and prevention activities offered within the districts.

Priority populations in need of enhanced services include youth in foster care or kinship care; transition-aged youth; youth with acute mental health needs or co-occurring disorders, including those at risk of out-of-home placement; and young children in need of early intervention. These priority populations were often described as trauma-impacted, which exacerbates mental health issues and presenting concerns. The populations were further described as disproportionately likely to be from low-income backgrounds and to experience intergenerational risk factors, such as poverty, familial mental illness, and/or substance use disorders.

Gaps and needs include those related to infrastructure, service offerings, service delivery, and youth and family participation:

Infrastructure gaps include the mental health provider shortage in Franklin County, transportation barriers, housing needs, and insufficient access to high-speed internet.

Gaps related to service offerings include the lack of day treatment programs for school-aged youth with acute mental health needs; limited crisis respite services for youth; few early intervention services, particularly for children younger than age three; and limited opportunities for parent training and educational programming, given the level of need.

Needs related to strengthening service delivery included broadening eligibility for care coordination services; improving communication, coordination, and accountability across agencies and providers; expanding outreach to youth and families; and creating greater awareness of available services, both for families and for providers, including developing approaches to ease the burden of service navigation.

Gaps related to youth and family participation were identified at the system level, as there was limited evidence of regular youth and family voice within the Franklin County System of Care. Barriers to youth and family participation include the need for childcare and transportation, as well as limited time and energy for family involvement, due to demands of working and child rearing.

Training needs were identified, including overwhelming support for additional trauma-informed care training, particularly given high turnover in some agencies since the county's trauma-informed training programs were initiated. Other training needs described included suicide prevention training, mental health awareness and stigma reduction training that is inclusive of families and community members, mental health first aid and basic skills training for paraprofessionals, and training related to early childhood development and signs of developmental delays.

Evidence-based practices currently in place in Franklin County, per the respondents, include Motivational Interviewing, the Strengthening Families model, Triple P, Nurturing Parenting, Cognitive Behavioral Therapy, and Trauma-Focused Cognitive Behavioral Therapy. Providers expressed interest in learning about and potentially implementing evidence-based practices including Multi-Systemic Therapy, Functional Family Therapy, and evidence-based trauma-informed modalities.

Conclusions and Recommendations

The following recommendations are offered based on the synthesis of interview and focus group data and publicly available Franklin County data:

1. ***Expand schools as "hubs" for comprehensive services***, including clinical services for students, telemedicine, and embedding in the schools family advocates who can assist families in navigating services and supports;
2. ***Consider approaches for expanding service access***, such as introducing per diem roles for clinicians and bringing telemedicine to scale, with technical support from providers;
3. ***Renew efforts to engage youth and families***, drawing on the Parent Council model that has shown promise within the Saranac Lake School District;
4. ***Create and expand services identified as current gaps***, including, as fiscally viable, school-based day treatment, crisis respite services, and early intervention services.
5. ***Develop a web-based repository*** with a list of programs, services, and contacts to increase awareness of services and streamline service navigation;
6. ***Bring promising practices in care coordination to scale*** by distilling strategies that make the SPOA process and other care coordination practices impactful for families, and by making all families eligible for care coordination;
7. ***Develop evaluation capacity***, particularly to assess the impact of potential pilot projects for high-need subgroups of children and youth, and use evaluation findings to advocate for additional funding;
8. ***Expand advocacy with New York State entities*** to bring awareness to the service barriers experienced by Franklin County and other rural counties, including the implications of state-level initiatives and decisions experienced by rural counties and communities;
9. ***Facilitate learning communities*** through which providers can share best practices and lessons learned regarding innovative programs or practices that are showing promise in terms of improving the outcomes and quality of life of Franklin County youth and families.

Introduction

Located in the North Country region of New York State, Franklin County is a rural county covering 1,628.8 square miles, the fourth-largest county in the state by area (ACS, 2019). It borders Quebec, Ontario, and four other upstate New York counties and includes a portion of the St. Regis Mohawk Tribe. Characterized by its rural terrain, Franklin County is located in the Adirondack Park. Its three largest population centers are separated by large tracts of publicly protected land, resulting in access barriers to services and supports, as well as geographic isolation – particularly during the harsh winter months (CHA, 2019).

The total Franklin County population is 50,477, with 9,886 children and youth under the age of 18 (ACS, 2019). Calculated based on U.S. prevalence rates, approximately 1,000 to 1,200 youth in the county have a serious emotional disturbance (SED) with impairment in at least one domain.[1] Like many rural counties, Franklin County has a whole-county mental health shortage designation (HRSA, 2019), with just 17 providers per 10,000 people (DSRIP, 2016). The county is also a designated Health Professional Shortage Area in primary care and dental health (HRSA, 2019). As a result, unmet mental health and physical health needs of youth and families are significant. Transportation barriers further limit service access for youth and families in the county. Specifically, 9.5% of adults have no vehicle, and substantially more lack access to safe, reliable transportation (CHA, 2019).

Poverty is significant in Franklin County. Over a quarter (26.9%) of county children are living below the poverty line, a level that has increased steadily and is significantly higher than the New York State rate of 18.2%. (ACS, 2019). In 2018, 43% of Franklin County households were impoverished or Asset Limited Income Employment Constrained (ALICE) households (ALICE New York Report, 2020). While the majority of Franklin County residents are white, residents who are Black, Hispanic, and of two or more races are disproportionately likely to have lived below the poverty level in the past year (56.3%, 18%, and 19.7%, respectively) (ACS, 2019). Fifty-seven percent (57%) of students in grades K through 12 are eligible for free or reduced lunch (NYS KWIC, 2019) and 22.6% are chronically food insecure, a figure which is projected to increase due to the COVID-19 pandemic (Feeding America, 2019, 2020). Further, 9.1% of Franklin County residents reported limited access to grocery stores, and 13.9% were without a reliable food source during the past year (CHIRS, 2016).

Access to safe, affordable housing is a challenge to many families in Franklin County. Among renter households, 40.2% are housing cost burdened, and 20.2% are severely housing cost burdened (ACS, 2019).[2] Among homeowners, 19.6% of Franklin County residents experience housing costs that are above the affordability threshold, and 8.7% experience housing costs that are above the severe cost burden threshold (Housing Affordability in New York State, 2019).

In Franklin County, 12.6% of adults have less than a high school diploma and just 9.9% hold a bachelor's degree (ACS, 2019). Estimates suggest that 23% of Franklin County residents are at or below a level 1 literacy level, indicating poor literacy skills that may hinder the ability of some parents to assist their children with academics.[3] Further, over a quarter of households (26.1%) lack high-speed internet and 16.4% lack a computer, creating barriers to education and employment (ACS, 2019).

Child abuse and neglect are pervasive issues in Franklin County. The rate of indicated child abuse/neglect reports is 49.5 per 1,000 children, the highest rate of any county in New York State (NYS KWIC, 2019). Based on recent data, there were 344 indicated reports of child abuse and neglect in 2020 (Franklin County DSS, 2021). Foster care admission rates are also among the state's highest, (NYS KWIC, 2019), with 128 youth in foster care and 51 new admissions in 2020 (Franklin County, 2021). See Table 1 below for a summary of pertinent Franklin County statistics.

1 A recent meta-analysis estimated SED prevalence at 10.06% among youth age 2 through 18 (Williams 2018). Applying this rate to 11,383 Franklin County children age 0 to 19 (ACS, 2019) yields a figure of 1,145 children. Census data reports number of Franklin County children under 18 or between 0-19; this extrapolation is based on the number of children, 0-19.

2 HUD housing cost burden and severe cost burden are defined as spending 30% and 50% of income or more on housing costs, respectively.

3 National Center for Education Statistics. https://nces.ed.gov/surveys/piaac/skillmap/

TABLE 1. Franklin County Demographics, ACS 2019 5-Year Estimates

Population	
Total Population	50,477
Population Under 18	9,886
Under Age 6	30.8%
Age 6-11	36.1%
Age 12-17	33%
Demographics	
Male	54.4%
Female	45.6%
White	82.7%
American Indian/Alaska Native	7.1%
Two or More Races	2.1%
Hispanic/Latino Origin	3.5%
Black	5.7%
Native Hawaiian/Pacific Islander/Asian/Other	Each <1%
Limited English-speaking Households	.4%
Employment & Education	
Employment rate	46.5%
Less Than High School Diploma	12.6%
High School Diploma/GED (age 25+)	37.7%
Bachelor's Degree	9.9%
Poverty/Insurance Status	
Below Poverty Level (Residents Overall)	17.8%
Children Below Poverty Level	26.9%
Black Residents Below Poverty Level	53.6%
Hispanic Residents Below Poverty Level	18%
Residents of 2+ Races Below Poverty Level	19.7%
Uninsured	5.1%
On Medicaid	27.1%
Housing	
Rent Burdened	40.2%
Severely Rent Burdened	20.2%
Median Household Income	$50,407

Overview of the Franklin County System of Care[4]

As described by numerous stakeholders involved in the Franklin County System of Care, Franklin County is a small community where relationships matter. In Franklin County, a cross-sector System of Care committee has been meeting and collaborating for over a decade. The System of Care committee has participation from county agencies (e.g., Department of Social Services, Probation), primary care providers, agencies serving youth with mental health issues, agencies serving youth and adults with substance use disorders, agencies serving youth and adults with developmental disabilities, school stakeholders and staff, mental health professionals serving the St. Regis Mohawk Tribe, and faith leaders.

The Franklin County System of Care has made a commitment to the implementation of trauma-informed care since 2013, due to awareness of the devastating impact of intergenerational poverty, abuse, neglect, loss, and chronic hardship experienced by many families in the county. Franklin County has trained over five hundred providers and school personnel in trauma-informed care. In addition to this county-wide effort, local agencies, including Citizen Advocates, Community Connections, and agencies within the St. Regis Mohawk Tribe, initiated additional trauma-informed staff training. The county implemented a learning circle, where school district staff met regularly with a trauma-informed care expert to ensure the transfer of knowledge to practice. Franklin County is currently implementing a train-the-trainer, non-violent Therapeutic Crisis Intervention (TCI) program, with basic TCI training to begin in the fall of 2021, thus continuing its commitment to trauma-informed care.

Franklin County participated actively in SAMHSA-funded New York State projects, including *New York State Success*, through which providers were trained in System of Care principles; *New York State Achieve*, in which Franklin County Community Services staff became trained in System of Care facilitation; and the *New York State System of Care* pilot, through which provider agencies were trained in high-fidelity Wraparound. In June, 2021, the Franklin County System of Care participated in a New York State Office of Mental Health-led series of facilitated sessions about Systems of Care, which culminated in an action plan.

Brief Methodology

Interviews and focus groups were conducted with Franklin County System of Care stakeholders between December 2020 and June 2021. In total, 44 individuals participated in interviews or focus groups (see Table 2).

Interview and focus group participants were recruited in collaboration with Franklin County Community Services. A contact list was provided, and outreach was conducted by phone and email. Participants sometimes suggested additional colleagues to interview for more specific information, and these individuals were then contacted and invited to participate.

Interviews and focus groups were conducted virtually, using GoToMeeting. The interviews and focus groups were guided by semi-structured protocols (see Appendix A and Appendix B). Interviews and focus groups typically lasted between 30 and 60 minutes. The interviews were recorded with the permission of the participants and were later transcribed for analysis.

TABLE 2. Interview and Focus Group Participation

Stakeholder Group	# of Participants
County Departments (DSS, Public Health, Probation)	8
Mental Health Provider Agencies (Staff & Supervisors)	7
Family Members	5
School-Based Clinicians & CPSE Chairs	9
Superintendents	3
Prevention/Substance Abuse Provider Agencies (Staff & Supervisors)	5
Developmental Disability Provider Agencies (Staff & Supervisors)	4
St. Regis Mohawk Providers: Mental Health, Prevention, and Developmental Disabilities (Staff & Supervisors)	3
Total	**44**

4 This summary of the Franklin County System of Care was informed by personal communications with Franklin County Community Services staff, as well as a review of local documentation.

At the start of the process, an advisory committee of Franklin County System of Care stakeholders was assembled to provide feedback and project oversight. Committee members had expertise in mental health and school-based services throughout Franklin County. They offered feedback on the interview/focus group protocols, and also provided contextual information about the development and progression of the Franklin County System of Care.

Data Analysis

Detailed notes were taken during and immediately after all key informant interviews and focus groups. Analytic matrices and cross-case displays were developed to analyze the qualitative data into data summaries and emergent themes (Charmaz, 2006; Miles & Huberman, 2013).

Focus Group Findings

System of Care Strengths

The respondents highlighted several strengths regarding the Franklin County System of Care. Collaboration between System of Care stakeholders, strong relationships with school districts, in-home service provision for youth and families, and the revitalization of the FIT model were noted most frequently across stakeholder groups as key assets.

System of Care Collaboration. The respondents underscored that Franklin County is a small county where relationships between providers are essential. Many identified collaboration between System of Care providers as a principal strength, noting that providers work together to support families to the best of their ability, and advance solutions to address unmet needs. As the stakeholders described:

> *"We are trying to collaborate together and work together – that is a strength."*

> *"I do think that we are pretty close knit here in Franklin County."*

> *"Franklin County doesn't just identify needs. They identify needs and put solutions in place."*

School Relationships. The respondents identified several Franklin County school districts as key resources for supporting children and families. Many described collaborative relationships with the schools, noting that school leaders are interested in working with provider agencies to support children and families. As the respondents reported:

> *"I know that we have a good working relationship with the schools. I think just having the open communication with them is a big plus that we have."*

> *"The schools that we work with are very good with getting their kids with SED connected. They have a true concern; they have the follow up. It's great to see the urgency that they want to help their students. They are also really looking at, how do we help the family as a whole? So that is working very well."*

In-Home Service Provision. Several stakeholders perceived in-home service provision as a strength of the current System of Care that can be built upon. Specifically, Franklin County DSS employs a clinician who provides clinical services and supports to children and families in foster care, as well as those using preventative services within a family's home. The respondents indicated that this model is impactful, as youth in foster care and those using preventative services were described as a high-need population due to trauma exposure and the presence of multiple risk factors. The respondents further indicated that in-home service provision allows clinicians to work with families in developing skills within the actual family environment in which conflicts occur, rather than at a clinic. Several respondents also indicated that in-home service provision eliminates transportation barriers that limit service access. As one respondent reported:

> *"Having someone that can go inside the homes outside of the sterile environment of a clinic is incredibly important."*

Family Intervention Team (FIT) Revitalization. The Franklin County System of Care is in the process of restarting a previous initiative known as Family Intervention Teams (FIT), in which all providers supporting the family meet together to formulate goals and track progress. The respondents frequently described FITs as an area of strength within the Franklin County System of Care, as the model is designed to promote collaboration

among service providers. In addition, FITs were viewed by many as an opportunity to ensure consistent and clear service delivery when more than one provider is working with a family. As one respondent reported:

> *"And now we are in the process of working on bringing the "FIT" back. The FIT Program was working very well when it was active."*

Impactful SPOA Meetings. The respondents universally viewed SPOA meetings as an area of strength within the Franklin County System of Care. All who discussed involvement in SPOA meetings noted that the meetings are impactful, as they ensure coordination and accountability among service providers. SPOA meetings enable providers to ensure that they are on the same page with one another and with the family in terms of formulating goals and addressing needs. As the respondents described:

> *"I know one thing I can say is that our SPOA is going very great....that program was going very well to make sure that people were coming in [for services], how they were coming in, and the level of services that they needed when they were coming in."*

> *"Everyone is on the same page and is able to communicate. That was super helpful because you could actually see [the other providers] and get their phone number."*

School-Based Services. The respondents highlighted initiatives including embedding clinicians in the schools as particularly impactful. Several discussed the positive impact of introducing family advocates into some districts to address needs related to social determinants of health, such as food insecurity, housing needs, and transportation to health and mental health appointments. As one respondent reported, school spaces are less stigmatizing for families than are traditional mental health settings:

> *"The plus is that the school is the hub for every community, it really is. It is either the church or the school. Those are the hubs in the community. The community and the families are more willing to work with somebody that either is part of the church or the school."*

Others discussed school-based mental health services as a mechanism for providing services to youth more rapidly by reducing wait lists at local clinics:

> *"Having a counselor in the schools every day of the week would relieve the service delivery at the clinics."*

Priority Populations in Need of Enhanced Services

When asked to identify subgroups of children and youth who are experiencing unmet needs in Franklin County, the respondents most frequently mentioned youth in foster care or kinship care; transition-aged youth; youth with acute mental health needs or co-occurring disorders, including those at risk of out-of-home placement; and young children in need of early intervention. The respondents commonly noted that these subgroups of children and youth are often trauma-impacted, exacerbating mental health issues and presenting concerns. They also indicated that many of these subgroups are disproportionately likely to be from low-income backgrounds and to experience intergenerational family risk factors, such as poverty and familial mental illness and/or substance use conditions.

A few subgroups of children and youth were mentioned less frequently, but were described as experiencing unmet need by some respondents. These groups included youth with lower-acuity mental health issues, justice-involved youth, and medically fragile children and youth, such as those with disabilities who require oxygen and other medical interventions.

Youth in Foster Care. Youth in foster care were identified as a high-need population with significant unmet needs. The respondents indicated that youth in foster care in Franklin County are trauma-impacted, thus requiring trauma-informed and strength-based services. Many underscored the need to provide more comprehensive supports to foster parents as well. As the respondents indicated:

> *"[There is a need for] more strengths-based work with foster care kids, getting more support for foster parents because no matter what anyone says, if they are in foster care, they are traumatized and those foster parents, if it is grandparents, aunts, uncles, or strangers, they need way more support to deal with that trauma. Nobody is superhuman."*

> *"What's the toughest is our foster care kids have it the hardest because there's not a lot of foster care placements in general in the county and if they are placed with family, I think there is a lot of needed support there and there is not a lot of support available."*

Many described how youth in foster care experience multiple placements and continued disruptions to their lives and relationships, which causes additional trauma:

> *"Their foster parents are constantly '10-day noticing' to get [foster children] out of their home, because they don't have the skills to provide the higher level of need that the children have. So then they flop around and when they do that, they may start having therapy in Plattsburgh at a therapeutic foster home, and then they have to move to [another town] because that foster home gave a 10-day notice and they can't be there anymore, so then they leave and move an hour away. So, they lose a therapist and have to start over again, constantly. There is just no continuum of services for these kids."*

Some respondents described struggles to keep siblings together while prioritizing permanency for youth in foster care:

> *"We just find that these children struggle to find permanency especially if they are part of a sibling group. You have one child in a sibling group that has exaggerated behaviors and the foster parent wants to get rid of that one child, but keep the rest. So now you are looking at taking siblings away from each other, which we try desperately not to do, but it holds up the other children's permanency. So we struggle on a regular basis on how to best serve all of the children's needs and also keep the kids together. I think we are struggling more with this right now than I think we ever have."*

Several respondents acknowledged how child welfare system involvement causes additional trauma to youth and families:

> *"[DSS is] the trigger to the trauma because we have been with them from the beginning and we may have had to make some really difficult decisions. Sometimes the youth, some of them are really close to their staff but some of them are really upset and may blame them, and that's okay."*

In regard to youth in kinship care, several respondents indicated a need for greater support, both for youth and for kinship caregivers:

> *"The kids are often in family care, which then puts additional strain on other family members to care for them. Oftentimes, grandparents aren't really equipped to manage some of these kids with some of the behavioral issues."*

Transition-aged Youth. The respondents identified transition-aged youth as an underserved population in Franklin County.[5] Specifically, the respondents indicated that transition-aged youth would benefit from programming that addresses employment support, life skills, and housing needs, with services tailored to the specific needs experienced by young people at this stage of life. The respondents further indicated that transition-aged youth are often disconnected from services and thus unaware of services currently available. As one respondent indicated:

> *"Transition-age youth and that population is something that we have been talking about for a couple years. And we do need to do something for this group, because before they are transitioning, we have to get them educated, and we have to let them know for the future. It goes back to; Let's educate for the future and educate them on the services that are available to them should they hit a bump in the road. Because we must remember that in 2019 there were approximately 180 kids in our foster care system. I could not tell you how many of them were probably 16- to 18-year-old age and getting ready to transition. But they had lots of services wrapped around them so they wouldn't fall. And, then, all of a sudden, 18, it's 'stand on your own.'"*

Respondents serving transition-aged youth with substance use disorders noted that this age group is typically included in adult services. However, they noted how transition-aged youth are developmentally distinctive, also underscoring the impact of substance abuse on the developing brains of young adults:

> *"Especially today, 18 to 22 is very different from a 40- to 60-year-old.... [transition-aged youth present with] substance abuse, and honestly, there's so much more mental health and trauma now than I ever [saw before].... I was just having a conversation with one of the peers here, the amount of methamphetamine that's going around in the North Country right now.... So the substances that individuals are using are very different, too. It's just so much damage to the young brain."*

5 Franklin County SPOA data show an increase in SPOA referrals for transition-aged youth in 2020, including referrals related to housing.

Some respondents expressed concerns about transition-aged youth during the pandemic:

> *"I think it's been even more exacerbated during COVID, there's not much healthy activities, or not much social activities. They get pulled into some of those more negative lifestyle choices. Then that's their transition into adulthood – it is through that kind of lifestyle."*

Others described housing challenges experienced by transition-aged youth in Franklin County:

> *"I feel like some of the individuals that we serve, our populations, end up going into really unhealthy housing, because they don't have the resources or the family members that are going to be welcoming them in."*

Children in Need of Early Intervention. Respondents identified children in need of early intervention as a priority population. The respondents indicated that children in need of early intervention services are often not screened and identified, and are thus missed during an age where early intervention could be most impactful. Additionally, those who are indeed identified as eligible for early intervention services often do not receive intervention until they reach preschool, resulting in these children falling further behind. As the respondents indicated:

> *"There's a few [agencies], but the few that are providing services, they only provide them once a week for the children that they are providing them to, which sometimes isn't even enough. And then we have an extensive waitlist of children."*

> *"These children are identified at an early age as needing services, but until they get to school, sometimes they're unable to receive services, which is I mean, I have no words for that."*

> *"The OT, PT, and speech, of course, is a huge need, especially for that early intervention population, not just in Franklin County, but in several county regions. So you've got kids, even if they can get early intervention services, can't get any of those specialty services that they need."*

School stakeholders indicated observing children with significant delays and behavioral health needs at kindergarten screenings, further describing the impact of the gap in early intervention services for this population. As one respondent indicated:

> *"It just snowballs because these children could be just simply late talkers, and then by the time they get to school age, they're behind exponentially more than if we were able to have them receive services through early intervention."*

One respondent noted that a substantial proportion of children in need of early intervention are those in foster care or kinship care; thus, this population overlaps with another priority population identified by the respondents.

When considering the needs of the early intervention population, both parents and providers mentioned the lack of child care providers, and high-quality child care providers particularly, as an additional gap in the county.

Youth with Acute Mental Health Needs and/or Co-Occurring Disorders. The respondents frequently identified youth with serious mental health needs, many of whom experience co-occurring disorders, as a group with significant unmet mental health needs. Many noted that youth with co-occurring disorders often fall between systems (e.g., mental health and substance abuse, mental health and developmental disability services, etc.). As the respondents described:

> *"I feel like our dual-diagnosed kids, people fight over who doesn't have to take them and they're your forgotten children, and they cost the county the most money and are probably the neediest service recipients. We spend more time fighting with people to get them services. We should not have to fight this hard for children to get services anywhere in New York State."*

> *"We're meeting in the same room, telling each other what we're not able to do."*

Youth with Lower-Acuity Mental Health Needs. Some respondents, including both providers and school stakeholders, noted that youth with lower-acuity mental health needs have unmet needs. They typically attributed this to resource constraints, as high-acuity youth require significant time and attention from providers. For instance, several school-based clinicians described a waitlist of students who need to be seen. The clinicians have not yet met with these students, as their days are spent responding to youth with significant behavioral issues who may require de-escalation. Others noted that youth with high-acuity needs are often easier to identify, while youth with depression or anxiety may be suffering quietly.

In addition, several providers described how youth and families sometimes do not meet criteria for intensive services, and thus are less supported:

> *"There are kids and families that don't quite meet the criteria for [intensive services]. And so then it's kind of finding ways to support them as the grandparents or other family members are trying to care for these kids with higher emotional needs, difficulties with behavioral problems, and then oftentimes, trying to manage their own mental health as the caregivers. So, I think that group is the one that I find the most often falls through the cracks."*

Youth with Justice Involvement. A couple of respondents identified service gaps for youth with justice involvement. Particularly, they identified youth who committed sexual offenses as a population that is difficult to serve, as these youth require evaluations to determine their likelihood of reoffending. There are limited services, including evidence-based services, for addressing the needs of this population. As one provider reported:

> *"[There is a need] to have evaluations to determine if [a sexual offense] is just a one-time incident or if it is something that is going to be showing up in the future. There really is nowhere to send them to other than a mental health unit."*

Medically Fragile Children and Youth. Some respondents, particularly those who work with children and youth with developmental disabilities, described medically fragile youth as an underserved population. Specifically, they described a lack of qualified nurses or other medical providers who can treat children who require oxygen or g-tubes, including medically fragile infants in need of pediatric home care. As one respondent described:

> *"I think pediatric home care in Franklin County is lacking, especially for a really, really sick babies…the babies coming home on ventilators. It is because we don't have that experience either [to provide needed services]."*

Some respondents further described a lack of foster parents who can provide the needed level of care when medically fragile children experience child welfare involvement. As one respondent described:

> *"So having had a lot of youth come into foster care who are being placed with foster parents who really aren't prepared to provide care with, for example, kids with a g-tube, you know, some really specialized services. And [there is] a real nursing crisis in our area…getting a Health Home RN to come and oversee and train a family to make sure they are comfortable with oxygen or a g-tube is really challenging. I think we have some youth with developmental disabilities who are needing foster care, and we have folks who just don't have the skill set to provide that care."*

Gaps and Needs

The respondents described gaps and needs related to (1) infrastructure, (2) service offerings, (3) service delivery, and (4) youth and family participation in the Franklin County System of Care, as detailed below.

1. Infrastructure

According to the respondents, many of the most significant gaps in the Franklin County System of Care revolve around issues related to infrastructure. Specifically, the mental health provider shortage, transportation difficulties, housing needs, and the lack of high-speed internet create barriers to effective and comprehensive service provision to youth and families.

Mental Health Provider Shortage. The respondents indicated that Franklin County struggles to recruit and retain trained mental health providers. Particularly, there is a shortage of skilled, licensed clinicians and professionals who are able to prescribe psychotropic medication (e.g., psychiatrists and psychiatric nurse practitioners). It was often noted that this shortage is particularly acute in the south end of the county, including Tupper Lake and Saranac Lake. As the respondents reported:

> *"The bigger issue is finding licensed, trained, and experienced professionals to serve the population."*

> *"There are risk factors [making kids more likely] to be affected by mental health or substance abuse issues, but also, [there is] the inability to access services so they can improve or lower that risk.*

> *"The county is split into the northern and southern end, and the northern end is the most populated, so the southern end, which is Tupper and Saranac Lake, kind of gets shafted when it comes to services and supports. We have definitely done some things to help*

with that, but it still is historically the ugly stepsister of the county, basically."

Many respondents attributed the provider shortage to the inability of a rural county to provide the salaries that professionals can make in different regions of the state, and in an urban area particularly:

"I think a lot of it comes down to money. We're not able to offer the salaries that cities are able to offer, unfortunately."

As a result of the provider shortage, clinics often maintain long waitlists for services, and families struggle to secure weekly appointments for their children. Family members reported the perception that there is a lack of services for children and youth. As two family members described:

"The big problem around here is there is no one."

"Where we are, there is nothing."

Family members often noted that even when they can make counseling appointments, clinics often lack availability to meet with their child weekly. Several parents indicated that when their child is experiencing serious mental health symptoms, the lack of availability is extremely problematic. Many described feeling alone and at a loss for how to manage the situation.

Providers also described how long waitlists can adversely impact Franklin County families, noting that a child or youth's presenting problems can escalate to a crisis level due to the lack of immediate services. As the respondents reported:

"Even pre-pandemic, everything had to move to a crisis level to get immediate access. We did harm to that individual, whether they were an adult or adolescent... we did harm because they had to get to a crisis level for service delivery."

"You can have a teenager at a certain level in their mental health, but because it took 30 to 60 days to get them in, their mental health has escalated now."

Transportation. Transportation is a significant barrier to services in Franklin County. The respondents indicated that given the size of rural Franklin County, families are often forced to drive significant distances to receive services. Many providers noted that specific services are also extremely limited for families, particularly those who need to see a child psychiatrist, pediatric dentist, or developmental pediatrician.

For working families and those who struggle economically, this barrier often results in children receiving limited services or no services at all when they are in need. Transportation further reduces the ability of youth and families to access additional programing that could be helpful, as one respondent described:

"We have had people who are ready, willing, and able to go through the Probation Employment program, but there's transportation issues that impacts their ability to get to the job site. So we have had kids that we weren't able to serve for that reason. Even though there is a public transportation system, it doesn't hit all of the different townships or the times of the day when they would be needed."

In response to transportation barriers, several stakeholders advocated for increased in-home service provision, school-based services, and telemedicine.

Housing. The respondents indicated that many families in the county struggle to secure and pay for quality housing that is affordable. Many indicated that housing is a critical social determinant of health, noting that families require more support to find and maintain healthy and appropriate housing. As one respondent noted:

"Housing is a huge concern. We have to stop and think that we are working with some families that do not have the educational level to fill out applications for housing or a HUD voucher."

Lack of High-Speed Internet. The respondents commonly reported how many families living in the county do not have access to reliable internet services, which worsens inequities; respondents noted this was particularly important during the COVID-19 pandemic when children were attending school remotely. As one respondent described, many families experience barriers to all of the aforementioned infrastructure issues:

"I've noticed the biggest concern in this area for need recently is housing, internet, and transportation."

2. Service Offerings

Across the stakeholder groups, key service gaps were identified in the Franklin County System of Care. These included day treatment; crisis services for children and youth; early intervention services; and prevention services for youth and families.

Day Treatment. At present, Franklin County does not offer a day treatment program for youth with serious emotional dis-

turbances. School stakeholders and providers agreed that this presents a significant challenge, as schools struggle to meet the needs of youth with acute mental health conditions. As the respondents reported:

> *"We don't have [day treatment] so right now, they struggle at home, at school, and in the community, and they do the revolving door of crisis, ER, hospital....crisis, ER, hospital, and then they do intermittent individual therapy in the meantime."*

> *"Often, the children's needs in terms of education are being met, but I don't know if we can meet the mental health needs."*

Some respondents perceived that the lack of day treatment options creates trauma for youth in need of this service, as well as for others in the school community. As one respondent explained:

> *"It is also traumatic for everyone involved, the kid [in need of day treatment] can't live up to the expectation; the teacher doesn't understand why they can't live up to it. The kids are scared of the student; the student gets hateful and resentful. You know, it is never going to foster positivity or growth because it is an unrealistic expectation and unrealistic environment."*

The school stakeholders further described struggling to meet the needs of students with less acute mental health conditions, because significant time and resources are spent responding to the mental health needs of students with higher-acuity mental health conditions, as mentioned earlier. This issue is compounded by long wait lists at mental health clinics in the community. According to the respondents:

> *"Moderate outside supports are very difficult to come by....we missed that middle ground of kids."*

> *"The ones who have the behavioral problems get noticed, referred, and followed through on more than those who are anxiety-ridden or really quiet."*

Crisis Respite. Several stakeholders discussed a current gap in crisis services for youth in Franklin County. The Children's Crisis Respite Program requires parents to stay with the child, as there is a lack of sufficient separation between adult and child clients due to the floorplan of the building. Many stakeholders described this as problematic. The respondents indicated a need for crisis services throughout all parts of the county. Many noted that both youth and families need a safe option for deescalating, highlighting that for some, time and space apart is what is most needed:

> *"Children's crisis respite needs to be a focus, not on one end of our county, but there needs to be a focus for all hubs [of the county]. So, Children's Crisis Respite program, I like to say it's not a true program, because we do have one, but the parents have to stay with the child to be a part of it, and sometimes it's also the parent that needs space."*

The respondents further indicated that crisis respite is critical to preventing out-of-home placement and hospitalization, which can be retraumatizing to children and youth. As one respondent described, crisis services currently utilized are far from a youth's home and community.

> *"For a lot of our kids right now, so say, you're in crisis and you either go to Northstar Behavioral Health and have a crisis evaluation or call the crisis line, or go to the local emergency room, besides that, the next level of care is going to put you, the closest would be CVPH in Plattsburgh, which rarely happens, so it is going to be St. Lawrence, Four Winds, Ogdensburg, it is going to be far."*

Another respondent indicated that options are limited regarding crisis respite for youth in foster care:

> *"If we had a way to access more crisis response beds, short-term crisis, that doesn't put the burden back on DSS to provide supervision for the child....we need a place because a lot of times, kids will de-escalate on their own, they just need a safe space."*

Providers serving youth with substance use disorders also indicated a need for crisis respite services, including when youth are stepping down from a more restrictive setting, and to prevent the need for restrictive settings. As one respondent indicated:

> *"One of the other things that I'm always hearing about is, if there's things going on at home, or there's a situation that comes up where the child's is under the influence or experiencing mental health issues, there's not even a temporary respite place....like what we have in the adult world, where we have a crisis center."*

Early Intervention. The respondents, particularly those working in the field of developmental disabilities, highlighted early intervention as a significant gap in the county. At present, respondents indicated a gap in early intervention services for children between the ages of 0 and 3. As a result, families need to travel to surrounding counties (Clinton County or Essex County) in order to receive services. Where early intervention services are provided in Franklin County, waitlists are long. According to one respondent:

> *"The early intervention program closed and no one replaced it....kids from 0 to 3 are receiving no services....in the north end, if you want services you have to travel to Plattsburgh....in the south end, you have to go to Essex, Lake Placid...."*

Several stakeholders described how changes at the state level reduced the ability of local providers to offer fiscally viable early intervention programming. They reported that in 2013, the state took over early intervention services; prior to that, counties held contracts with agencies that provided early intervention programming. The county would contract with local agencies and bill insurance on their behalf, thus making it easier for the programs to provide the services. When the state took over, the county no longer held the contracts and thus could not assist agencies with billing. As one respondent explained:

> *"Agencies were now having to bill, which they've never done before, because since the beginning of time [the county] billed for them. So now you have agencies that don't have the capacity or knowledge to bill for services, billing for services, And it's not easy. Agencies that are now thrown into not knowing how to [manage billing] are now trying to do it, and just not making ends meet because they weren't well-versed in how to basically recoup all these monies. Reimbursement rates don't help at all, because there are very, very low reimbursement rates for these services....so a lot of these agencies stopped providing [early intervention] services."*

The respondents indicated that prior to the pandemic, county stakeholders were looking into logistics regarding how the county might establish itself as a provider of early intervention services to overcome these challenges, a process they hope to reinitiate.

Providers serving children with developmental disabilities and the early intervention population further expressed frustration about what they viewed as state-level decisions that limited service provision in Franklin County. As the respondents indicated, funding cuts have put increasing pressure on providers by creating an unrealistic workload for employees, limiting the ability to hire new people, and providing low salaries that create barriers to recruiting and retaining quality staff. As one respondent indicated:

> *"We've been consistently, repeatedly, year after year after year, been asked to do more with less. I only have so much time in my day, and we don't have the money to hire other people. To continue to reduce funding, cut funding, and then put more responsibility on the providers, it's just, there's no time in the day."*

The respondents further highlighted complications with Medicaid billing that require significant time and resources, particularly when claims are denied due to paperwork errors. This places additional stress on the workforce. They also described how reimbursement rates make it difficult for programs to remain viable:

> *"When you're limited with your area and population, providers can't just bill Medicaid and survive, and the requirements are too high for any provider to even be able to make a living."*

Several providers did not feel that providers from rural counties are given a voice at the state level, noting that well-intended initiatives miss the mark due to a lack of participation from rural providers at the grassroots level, including care managers, as well as family members:

> *"Let people who are doing the job and families that are dealing with services [meaningfully contribute]. You can sit there and say that we have public comment. By the time that public comment is coming out, it's already been decided what's going to happen, for the most part. There should be families. There should be parents helping to develop these programs. And that's what I mean by collaborative effort. Right now, it's not collaborative."*

The respondents indicate a pressing need to identify and address developmental delays and mental health issues earlier to improve child outcomes. At present, many noted that children with delays and/or behavioral health issues are not identified until they enter kindergarten, at which time their needs are significant and readily apparent. As one respondent described:

"Children come in for kindergarten screening…we know almost immediately who is going to be the highest need."

Affordability was cited as a barrier experienced by families, as evaluations by a licensed psychologists or psychiatrists are often cost prohibitive, in addition to being limited due to the provider shortage:

"Seeing a psychiatrist or a psychologist, a lot of times, families want to do the assessments, and they can't afford the upfront costs…there seems to be a gap with providers, qualified providers, especially psychologists, psychiatrists – accessing them and being affordable."

"I just think that if we really want early intervention services, they need to stop with the income requirements…. [parents say] it's this much money, so I'm not going to [pursue services], and who suffers? The child…. it's just really frustrating to see that a lot of the families that I see falling between the cracks aren't necessarily in poverty."

In addition, some described the importance of approaching families with sensitivity when there is a concern that their child may have a developmental delay or disability. According to some providers, families resist early intervention after negative or insensitive interactions with educators:

"The teachers would approach the family and then make it seem like that there was something wrong with their child, which is the last thing that a parent really wants to hear. Then they immediately shut down: 'My child doesn't have a disability'…. and then we'd lose them until it was crisis time."

Of note, several providers noted that in response to the pandemic, the state allowed some early intervention services to be provided through telehealth. In the context of early intervention, this opened some opportunities to expand service provision, as providers outside of the county were able to provide services. As one respondent explained:

"I know a lot of programs have suffered because of the pandemic…. but early intervention could use telehealth [as a result of the pandemic]. We actually had an agency out of the Poughkeepsie area reach out to us and say, 'We have speech providers that are willing to provide services [via] telehealth.'… [This] is still just a band-aid, but it's better than what we were able to offer before."

Prevention Services. The respondents described a significant need for additional prevention services to meet the needs of children and families. Specifically, many described the need for comprehensive parenting education programs and parent support services. The respondents expressed awareness of the obstacles and hardships faced by many parents in Franklin County. As one respondent explained:

"The parents are exhausted, [and they] don't have a solid support circle…. they are working off hours or multiple jobs to provide for their family."

Many noted that parent training is often provided only after children are removed from a household, underscoring the need to intervene sooner to prevent trauma and out-of-home placement. The respondents described the need for training to support positive and responsive parenting strategies, as well as education about child development and what is developmentally appropriate and expected at various ages. As the respondents indicated:

"Parent training is a big piece that is lacking. It's not until there is very little chance of the parent making a positive impact that we force parents into any kind of required parenting group."[6]

"One of the things that I talk about with the families a lot is, 'What is appropriate childhood development?' I am amazed at how many families I work with, whether it is the biological family or even foster families, of what is developmentally appropriate, what is normative behavior, and how to parent appropriately. Even the prudent parenting standards that they should know, it is a discussion that we have quite a bit. What does a typical kid look like? And what does a kid that experienced trauma or disruptions in their family placement look like? So I would say, really understanding child development across the board [is a need]."

The parents interviewed indicated that they would like opportunities to attend trainings or meetings with providers to learn more about their child's mental health condition. They were

6 Currently, Triple P and Nurturing Parenting programs are offered in Franklin County. However, many providers were unaware that families can access these programs without DSS involvement.

particularly interested in learning about strategies to manage their child's behavior at home and to improve communication with their child.

Similarly, school stakeholders indicated the need for parent support while children are young, noting that delayed support results in more serious issues for the family to navigate:

> *"Many of our students who end up with an emotional disturbance classification, I think the parents need the most support at a younger age.... [When the child grows older,] the parents have lost control."*

Some described a need to expand family-based clinical service offerings, as opposed to individual counseling only:

> *"Sometimes it's that you have the youth involved and they are getting the services, and then there are other times that the youth aren't getting the services but the parents are getting the services. There isn't the whole-family approach."*

3. Strengthening Service Delivery

The respondents indicated a need to strengthen service delivery as it pertains to care coordination, communication, and outreach.

Care coordination. Several respondents indicated that the service system can be difficult for families to navigate, noting particularly that multiple referrals can be confusing to families. They described how families can feel overwhelmed by interactions with multiple providers and may be unclear about who is offering which service, and which agency the providers are affiliated with. As one respondent explained:

> *"[Family members'] biggest thing is not really knowing what agencies that their kids are actually working with. They said that they know that they speak with this person and this person, but don't actually know what agency that that individual works for."*

Several respondents described how Wraparound was previously offered within Franklin County. Some indicated that the notion of service coordination through Wraparound is sound in theory but had encountered challenges in implementation due to a lack of clarity, particularly through interactions with families:

> *"I know with Wraparound services, the goal is to "wrap around services." However, it's very difficult for a family, because there's no explanation. It's like, one provider comes in, five other providers come in, they could all be from the same agency, but the coordination aspect of Wraparound services is what is missing."*

Some indicated that collaboration and coordination between providers may be strong at the leadership level, but may encounter problems during implementation at the provider level. As one respondent described:

> *"There's a lot of different sectors coming to the table for a similar focus, and that is really good. I think sometimes it breaks down though. The people at the head of those agencies get together and say, we could really work together to create this kind of system. But then the pieces kind of fall apart. Not by anybody's fault. We might contact [an agency] after both directors were at a meeting and want something to happen, but then they lose sight of us, and we forget about them... the intention is there, and I think, on the top level, [collaboration is] starting to happen. But it's just really hard."*

Additionally, a few respondents noted that service coordination is available for children who are eligible for Health Homes, but wished to see this service expanded to all children and youth receiving services through the Franklin County System of Care. As one respondent suggested:

> *"Could we do a care coordination that makes everyone eligible.... with a care coordinator whose only goal is to coordinate all service delivery for that family? I think the families can sometimes get lost in all the people that they deal with. To have one or two people that they can deal with to get their services would be great."*

Communication. School and agency staff reported difficulties reaching other providers involved in a child or family's care, particularly regarding youth in foster care, and wished for greater accountability and follow-through. In regard to particularly vulnerable youth, such as those in foster care, school-based stakeholders desired improved communication with DSS:

> *"We need a streamlined point person.... Is this the person that will be handling where the child is, what they are doing, and is this person going to be calling us back in a timely manner?"*

Other respondents indicated a need for greater accountability from large agencies in the county. They desired more responsive communication from other service providers to ensure

that families are receiving services in a timely manner. As the respondents explained:

> *"Personally, I would like to see other agencies that we work with holding up their end of what services that they are supposed to be offering. If they don't have the service available that they are supposed to be offering, then it falls back on me to refer them to another source."*

> *"There was a time when we could have any kind of collaboration [with a large agency]. We could pick up the phone, reach a counselor and talk about what's going on with whoever it is, the problem areas, strengths and all that, and it is just not like that anymore. It seems that if we want to have those conversations, we actually have to request records monthly. It got to the point where we weren't able to talk to somebody that much."*

Similarly, parents indicated the need for improved communication, indicating that they would like for providers to initiate more dialogues with them about their child's progress. Several parents indicated that they did not feel meaningfully included in the planning of their child's clinical services in the community. Parents also perceived a need for improved communication between providers when more than one provider is involved in their child's services. In particular, they indicated the need for better communication between school-based and community-based providers.

Outreach. When asked about outreach to youth and families, most respondents indicated a belief that families are very often unaware of the services available to families and how to go about accessing them. As the respondent indicated:

> *"Some of the parents that I spoke to, said that they're not aware of all of the services that are out there. I told them that I could set up a meeting with them and we could go over all of the services that are available and I can refer them…"*

> *"The high-needs group that is missed is the family that has not been a part of a service delivery, and all of a sudden, something has happened where they need to become part of a service delivery. And I can honestly say in Franklin County, that we all need to improve on that. We've been [offering a program] for almost a year, and I can bet you that at least 80 percent of the families in [the community served] don't even know we are there."*

The respondents often reported that as providers, they are sometimes unaware of current services and programs available in the county. As new programs are initiated or changed, they indicated that it is difficult to keep track. In particular, pediatricians were often mentioned as a stakeholder group who may be unaware of where to refer children and families for mental health services. As one respondent indicated:

> *"It's a confusion and huge frustration for local pediatricians that I've spoken to. They have these kids that they know need services and they don't know how to get them services."*

In response, some respondents suggested the need to develop and continuously update a resource list, with up-to-date contact information for local programs, to disseminate to both providers and community members. Some felt that a website would be optimal, as providers could easily access a website and disseminate it through social media. They also noted that paper copies could be made available at local community centers and town halls, in collaboration with local leaders. As one respondent suggested:

> *"If we could create a web-based hub with resources under Franklin County Community Services…. with clear numbers and ways to connect…"*

The respondents indicated that despite their best efforts, they are concerned about missing hard-to-reach families in particular. These families may be unaware of services or may be hesitant to reach out due to concerns about potential child welfare involvement, as well as stigma. Others indicated that families with addiction and other issues are difficult to reach or more hesitant to reach out for help:

> *"… The children and youth that are in need of most services [are those] who are struggling with parents that have addiction issues, but are actively absent for one reason or another, incarcerated, or just out there using and not in the kids' lives."*

> *"When there is drug addiction or trauma in the family, different kinds of abuses happening, it is a very hush-hush thing. I think with that, oftentimes, it comes to this need to show everybody that everything's fine."*

4. Fostering Youth/Family Participation

When asked to describe the state of youth and family participation within the Franklin County System of Care, the respondents universally indicated that this is an area for continued emphasis

and growth. Although most respondents indicated that youth and families have a voice in their own services, they discussed a number of barriers to youth and family participation at the system level. They noted that when they organize outreach events or invite families to meetings, the families rarely attend. Most respondents believe that the lack of involvement is due to families having busy and often difficult lives to navigate, including the need to balance work and childrearing. Others indicated that transportation and childcare are known barriers to family engagement. As one respondent reported:

> *"We have zero involvement [from parents]. It is very hard in this community to get people to come to a meeting. And/or we're finding it's even hard to get them to join a Zoom meeting."*

In contrast, staff from one school district described making positive inroads regarding parent participation. The Saranac Lake School District initiated a Parent Council prior to the pandemic. Parents would convene at the school, with transportation, childcare, and food provided. These meetings served as a forum for parents to articulate their needs and feedback, allowing the school stakeholders to initiate actionable strategies in response. As a stakeholder from the Saranac Lake School District described:

> *"We chose families who have a lot to say, but not necessarily a platform to say it on. And the superintendent attended all of our meetings… we met once a month and this was all pre-COVID. We had a hot meal at no cost; we invited their children and provided childcare. We would sit and eat together and the natural conversations that came from those meetings drove so much of our programming later."*

For instance, after learning that families were struggling to assist children with math homework, they brought a math tutor to provide workshops to the parents:

> *"Parents would say that I can't help my second grader with their math homework… Well, we were at the table. We were listening so intently that we knew that we needed to provide math coaching to our parents. So, we invited a math coach to come in, and everybody loves her."*

The stakeholders involved in developing the Parent Council noted that critical ingredients include providing transportation and childcare and incentivizing participation where possible (such as by offering a meal to families). They further noted that families are sent home with additional meals from the meeting, which are appreciated.

The parent respondents indicated that parents are often interested in opportunities to be involved, but have competing needs that make attendance difficult. They indicated interest in parent groups and parent peer support opportunities that would allow them to connect with other parents who are raising children with mental health or other disabilities. The parents also indicated interest in opportunities to learn about child mental health and how to parent children with special needs. Of note, a few parents indicated a degree of concern with support groups, due to the issue of confidentiality in a small community. The parents were unanimous in indicating that family participation would increase if providers could organize daycare and transportation for families to encourage attendance at meetings and events. Further, they expressed interest in fun and positive youth and family activities as a way for the Franklin County System of Care to engage families.

Training. When asked about training needs within the county, the respondents overwhelmingly supported additional trauma-informed training and viewed it as important to enhancing the System of Care. As the respondents reported:

> *"I feel that the trauma-informed trainings have been very helpful for our county and a lot of people have taken advantage of them. However, with the workforce constantly changing, people coming and going, I think it is a good idea to keep those trainings going so that the newer people coming onboard could take them."*

> *"I think because we've had so much turnover in the last couple of years, that it would be nice to kind of reengage in [trauma-informed training]. Because I think that most people that were involved with the trauma-informed care have since left [our agency]."*

In addition, several respondents indicated that crisis intervention training would advance the System of Care in Franklin County. Others advocated for additional suicide prevention training, as well as mental health and anti-stigma training that is inclusive of families and community members. A few respondents also indicated a need for a training similar to mental health first aid, designed for caseworkers and paraprofessionals who need to build a skill set in working with families. Respondents working with individuals with substance use disorders advocated for additional NARCAN trainings.

Respondents working with individuals with developmental disabilities indicated a need for training in child development and signs of developmental delays to promote awareness and early intervention. Some noted the need for training on the topic of autism specifically, for both providers and parents. As the respondents indicated:

> *"I had a parent one time say to me that they wished they could have learned about signs to watch out for... if your child is not making eye contact, that may be a red flag. That parent education piece, so they know what they are looking out for – they felt that was missing."*

> *"One of the biggest issues is just training and education of service providers. Knowing what to look for [regarding developmental delays] would be a huge improvement in the early childhood area or for early intervention...."*

Some further indicated that providers require training in how to talk to parents about their child's potential developmental delays and disabilities, noting that insensitive interactions often cause families to refuse services that could help their child.

Evidence-Based Practices. The respondents described a number of evidence-based practices for youth and families that are currently in place within Franklin County. Specifically, the respondents indicated using evidence-based practices such as Motivational Interviewing, the Strengthening Families model, Triple P, Nurturing Parenting, Cognitive Behavioral Therapy, and Trauma-Focused Cognitive Behavioral Therapy. Providers expressed interest in learning about and implementing evidence-based practices that included Multi-systemic Therapy (MST), Functional Family Therapy (FFT), and evidence-based trauma-informed modalities (see Appendix C for a review and description of these evidence-based practices).

Of note, some providers described hesitations in regard to evidence-based practices given the limitations of implementing complex interventions in a rural setting. They stressed that any evidence-based practices selected must be appropriate for rural Franklin County and responsive to the needs of the children and families who live there:

> *"I will be honest with you that I am sometimes apprehensive about evidence-based... when we're looking at evidence-based, this is a very rural county of [about] 50,000 people that it has more cows than it does people. And you have a program that was written in California and when they consider a rural county is 300,000 people with an average median income of a million dollars, that program is not going to work here. It is not written to where we need to be, and a lot of times, what we discuss is that our materials need to be at a sixth-grade [reading] level. And if you have an evidence-based practice that is not presented at that level [it won't work].... How do you utilize an evidence-based practice that is not going to reach the people that you are working with?"*

Others highlighted the shortage of licensed providers as a barrier to the implementation of evidence-based practices:

> *"I think the bigger issue is finding licensed, trained, and experienced professionals to serve the population. You can spend money and get a grant to do things, but then you are going to have people who don't have that foundation, who aren't fully trained and trying to implement an approach that is meant for trained professionals."*

Conclusions/Recommendations

The findings of this needs assessment indicate that the Franklin County System of Care has significant strengths, including a long history of commitment and collaboration characterized by personal relationships and trust, creativity in developing solutions and strategies in spite of funding limitations, and leadership in the area of trauma-informed care. These strengths can be leveraged to address the gaps and challenges within the Franklin County System of Care.

The following recommendations are offered based on the synthesis of interview and focus group findings and publicly available Franklin County data.

1. **Expand Schools as "hubs" for comprehensive services.** Given the infrastructure challenges faced by the Franklin County System of Care, including the mental health provider shortage, service gaps, and transportation barriers, expanding mental health services within the schools may be a practical and cost-effective approach to develop a more comprehensive service array, and to ensure the delivery of regular services to youth at appropriate intensity. The focus group findings indicate that, at present, many view the schools as critical System of Care partners, noting strong collaboration and openness to addressing student mental health. Current initiatives include integrating family advocates into some districts.[7] Family advocates may work with families to address social determinants of health, completing housing applications, ensuring access to food, and assisting with transportation to mental health and other medical appointments. This approach directly addresses known needs and gaps in Franklin County, given the high poverty level and hardships experienced by families. In addition, school stakeholders reported success incorporating clinicians into their buildings, with the Saranac Lake School District also initiating a Parent Council to facilitate family involvement. The Franklin County System of Care can investigate building upon these strategies to further the goal of reaching and effectively serving youth and families. The approach of partnering with rural schools to create hubs for services is consistent with emerging research, which indicates that in rural areas, schools can serve a critical function in the delivery of mental health services to youth and families (Clark & Jerrott, 2011; Robinson, 2000 & 2002; Vanderploeg, 2010). Recent models include offering primary care services through the schools as well, through supervised telemedicine appointments to address another gap in the rural health care system.

2. **Consider approaches for expanding service access despite the provider shortage.** Perhaps the most challenging barrier within the Franklin County System of Care is the mental health provider shortage. The providers consistently described challenges in recruiting and retaining licensed mental health professionals. Given the reality that this shortage is likely to be a continued challenge in the future, the Franklin County System of Care may wish to consider developing per diem clinician roles, a suggestion offered by one of the respondents. Such roles may be of interest to providers who currently hold full-time jobs and are interested in supplementing their salaries with evening or weekend work, and/or to retired providers who are open to working shorter and more flexible hours. Additionally, telemedicine has become more prevalent, particularly during the pandemic. While this approach is not always ideal or a fit for all youth and families, the county may wish to consider bringing this approach to scale in areas that are particularly underserved. Telehealth may be a way to expand opportunities to see providers that are especially difficult for families to access, such as child psychiatrists. It is important to note, however, that many families struggle with technology and lack access to high-speed internet. Thus, it might be impactful to offer telemedicine options on site at local clinics and schools, with staff available to support families in using the technology.

3. **Renew efforts to engage youth and families.** The focus group findings suggest that while Franklin County System of Care members see the importance of youth and family involvement and have made efforts to bring youth and families to the table, regular engagement has not yet been achieved. Citing barriers such as the need for childcare and transportation to meetings, and the reality that families are often busy and focused on their day-to-day lives, both providers and parents noted that youth and family

7 The family advocate program in Franklin County school districts is provided through Community Connections.

participation is challenging to achieve. To initiate regular youth and family engagement, agencies may wish to devote resources to assisting families with transportation, offering childcare at meetings and events, providing meals, and offering small incentives to show respect for families' time. Parents indicated the importance of offering meetings or workshops that parents find relevant, such as education sessions to learn more about children's mental health conditions and parent groups that allow parents to connect with others who have shared experiences. The Franklin County System of Care may also consider leveraging relationships with schools to initiate youth and family involvement, as with the Parent Council model described above that has been initiated in the Saranac Lake district. Schools may be critical partners in engaging youth as well, as school stakeholders can promote engagement from existing relationships with district students.

4. **Create and expand services identified as current gaps.** The focus group findings highlighted service gaps that were consistently recognized across provider groups as areas of need. Particularly, providers see a need for day treatment in Franklin County. As suggested above, embedding day treatment services within local school districts may be a promising and research-supported model for this rural county to pursue (Blackstock, 2018; Probst, 2018; Wilger, 2015). Early intervention was widely seen as a significant gap in the county, particularly for children between birth and age three. While the county had been in communication with New York State to explore options for creating a fiscally viable early intervention program, there is a recognized need to reinvigorate and prioritize this effort. Capital funding, though difficult to obtain, could be used to prioritize the development of crisis respite settings specific for youth, with trained staff available to supervise youth without a parent or guardian present. While this small, rural county encounters continued struggles with insufficient funding for mental health services given the level of need, the Franklin County System of Care may wish to consider, where fiscally viable, initiating pilot projects to address some of these gaps, and evaluating their efforts, which may assist with obtaining additional funding to bring promising programs and approaches to scale.

5. **Create a web-based repository of services and engage local leaders in outreach.** Both providers and parents described their lack of awareness regarding available programs and services for youth and families in the community. In some cases, providers themselves are unaware of programs and offerings that may be helpful to the parents they serve. For instance, many of those interviewed wished for parent education and support programming and were unaware of current options, such as Triple P and Nurturing Parenting, available in the county. As one provider suggested, the Franklin County System of Care may wish to develop a website listing the programs offered by each county agency, along with clear and updated contact information to ease the burden encountered by families who are unaware of how to navigate services. While this would be a significant undertaking that would require ongoing maintenance and updating, it may prove valuable in addressing the need to simplify the process of navigating services and increasing awareness of what is available. In addition, some providers described a need to engage local leaders who are in frequent communication with their constituents, as these leaders could assist with continued outreach, including making materials about services available at town halls and community meetings.

6. **Bring care coordination to scale.** Franklin County System of Care stakeholders frequently described the need to better coordinate services for families, particularly when more than one provider or agency is involved. It was noted that children who meet specified criteria can receive Health Home care coordination, but many families are not eligible. As some suggested, the Franklin County System of Care might also consider developing a care coordination program under a centralized body, such as Franklin County Community Services, to ensure greater accountability and coordination of services for youth and families. The Franklin County System of Care might consider distilling the strategies that make SPOA impactful as a first step in developing a broader care coordination approach. Evaluating the FIT model may be another approach to identify characteristics that are working well regarding service coordination. Some providers noted characteristics of Wraparound that were impactful in the past, but also described the need to address implementation issues if this care coordination approach is to be reengaged in the future. If the county reengages Wraparound as an evidence-based intervention, careful study of the implementation process is warranted to understand barriers and to ensure appropriateness for Franklin County's rural culture and context.

7. **Develop evaluation capacity through pilot projects for high-need subgroups.** Franklin County System of Care

stakeholders articulated a number of subpopulations of children and youth with unmet mental health needs. Given the challenging fiscal environment, the county may wish to consider funding pilot projects to assess impactful services for these high-need groups, including youth in foster care, the early intervention population, and transition-aged youth. The county may wish to build internal evaluation capacity to allow for data-driven decision making, and evaluation findings from pilots may serve as a mechanism for securing additional funding.

8. **Expand advocacy with New York State entities.** Providers within the Franklin County System of Care often articulated a perception that New York State initiatives are implemented without careful consideration of the needs and constraints experienced within a rural county. For instance, providers indicated that the state takeover of early intervention services resulted in agencies closing their programs due to inability to manage the complexities of insurance billing, coupled with low reimbursement rates. The steep learning curve in managing billing is one example of a significant hurdle within a resource-limited rural county. Such examples highlight the need for continued advocacy to bring the perspectives of rural providers and parents to the state level, in order to ensure that state initiatives are cognizant of implications to rural counties.

9. **Develop a protocol for assessing inter-agency coordination and communication.** Some providers articulated communication hurdles when attempting to communicate with other agencies about a family's services. It was noted that at the leadership level, there is a strong commitment to coordination and collaboration; however, this sometimes does not trickle down to the provider level. As leaders are meeting to foster stronger communication and collaboration, they might consider developing a structure for accountability, with a clearly articulated plan to collect feedback from agency staff about their experiences communicating with other providers/agencies. This feedback can be brought back to leadership meetings to foster continuous quality improvement. Agency leaders can continuously assess provider experiences with inter-agency coordination through low-cost methods that can be carried out internally, such as informal provider focus groups or electronic surveys.

10. **Facilitate learning communities to share impactful practices.** Several organizations throughout the Franklin County System of Care reported practices, programs, or initiatives that they identified as impactful for youth and families. The Franklin County System of Care may wish to consider developing and facilitating learning communities in areas of priority throughout the system to share lessons learned and to improve practice. For instance, organizations and/or providers implementing parent training and education programs may convene to share best practices regarding outreach, and lessons learned through implementing these programs. Similarly, schools or organizations that are making progress with youth and family engagement may convene to share what is working well, with the goal of bringing effective strategies that are contextually relevant in Franklin County to scale.

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Appendix A

Franklin County Needs Assessment

System of Care Stakeholder Protocol

Target Populations

1. In your opinion, which children (and families) in Franklin County are most in need of strengthened or additional SOC services/supports? What are their presenting problems/needs?

2. The Franklin County System of Care has been considering a priority focus on youth in care/at risk of out-of-home placement and transition-aged youth. In your view, should these groups be a priority focus, in addition to the groups you just mentioned? Why/why not?

Perspectives on Strengths and Gaps

3. When you consider Franklin County's System of Care, what do you see as the strengths as it relates to supporting children with serious emotional disturbance (SED) and/or other presenting problems?

4. What are the current gaps within Franklin's System of Care for supporting children with SED and/or other presenting problems?

   4a. How can Franklin County best address these gaps, in your opinion?

5. What is the current outreach capacity within the county? Are youth/families most in need being reached?

6. When youth are identified as needing services, how quickly are they connected with appropriate services? Is there a need for improvement in this area?

Cross-Agency Collaboration

7. What, if anything, is going well with cross-agency collaboration in Franklin County?

8. In which areas/with which stakeholder groups is there a need for greater collaboration, if applicable?

Youth/Family Involvement

9. What is the current state of youth/family voice and involvement in your agency/organization?

10. Have you experienced any barriers to ongoing youth/family involvement? What are these barriers?

    10a. What has been tried in the past to promote family/youth involvement?

    10b. Do you have any suggestions for engaging youth/families within the Franklin County SOC?

Workforce Training

11. What training/technical assistance is needed to strengthen work with youth with SEDs and their families?

    11a. Which stakeholder groups/staff require training/technical assistance, in your opinion?

    11b. Are there any training initiatives currently underway in your organization? If so, what are they?

Evidence-Based/Evidence-Informed Services and Supports

12. Are there any evidence-based/evidence-informed services in place within your agency/organization? If so, what are they?

13. Do you have any thoughts regarding evidence-based services for youth with SED and/or other presenting issues that Franklin County should consider implementing?

Other/Closing

14. Do you have any other thoughts or feedback to share?

Appendix B

Franklin County Needs Assessment

Family Member Protocol

Perspectives on Strengths/Gaps

1. Which behavioral health services and supports are you familiar with in Franklin County? (These can be services that your child has received, or services you have considered for your child.)
2. When your child was in need of services, did you know how to go about finding the assistance you needed?
   a. What was easy or difficult about finding the services you needed?
   b. What was the referral/intake process like?
   c. About how long did it take to get these services in place?
3. How well did these services meet your child's needs?
   a. What, if anything, was helpful about these services?
   b. What, if anything, was unhelpful about these services?
   c. What, if anything, can improve these services?
4. Were there any services that your child/family needed that were unavailable to you in Franklin County? If so, which services?

Cross-Agency Collaboration

5. Does your child or family use services that are provided by more than one agency or organization?
   a. If so, what is communication like between service providers from different agencies?
   b. Can anything be improved regarding communication between providers or organizations?

Youth/Family Involvement

6. In your opinion, are family members given opportunities to be actively involved in the child's services?
   a. Are you invited to all meetings about your child's services?
   b. Are your schedule/transportation needs taken into consideration when planning meetings to discuss your child's services?
   c. Is your feedback encouraged and taken into consideration by the service providers/organizations serving your child?
7. What can service providers/organizations do to encourage the voices and participation of family members?
8. The Franklin County System of Care stakeholders are interested in strengthening family voice and involvement in service planning. Can you share ideas about how the county might improve engagement with family members and bring more family members into the planning process?
   a. What would help in terms of outreach (e.g., how to advertise opportunities; social media, etc.)?
   b. What would make family members/youth want to attend planning meetings and other activities?
   c. What would make it easier for family members/youth to attend planning meetings and other activities?
   d. What types of activities do you think family members/youth would find most beneficial (e.g., education events, involvement on planning meetings, connecting with other youth/families, etc.)?

Appendix C

Overview of Evidence-Based Practices

The respondents indicated that they are implementing particular evidence-based practices in their organizations, such as Motivational Interviewing, the Nurturing Parenting model, Triple P, and Trauma-Focused Cognitive Behavioral Therapy. Franklin County will soon embark on a train-the-trainer program regarding non-violent Therapeutic Crisis Intervention.

In addition to these evidence-based or promising practices, the respondents indicated interest in learning about and implementing additional evidence-based practices that they believe will be a strong fit for youth and families in Franklin County. These practices included Functional Family Therapy, high-fidelity Wraparound, and Multi-Systemic Therapy.

The table below provides a summary of the evidence-based practices currently being implemented in Franklin County, as well as those that are under consideration.

Evidence-Based or Promising Practice	Description	Populations Served	Status of Implementation in Franklin County
Functional Family Therapy (FFT) *Evidence-based*	Intensive clinical intervention program that provides in-home family counseling for youth at risk of out-of-home placement (Alexander et al., 2013).	Youth at risk of out-of-home placement	Under consideration
High-Fidelity Wraparound *Evidence-based*	Team-based care coordination process that brings together key people in the family's life to support the family in reaching goals (Miles et al., 2019).	Families and children who experience serious emotional disturbances	Not currently implemented, though providers are trained in the model
Motivational Interviewing *Evidence-based*	Collaborative conversation to enhance one's own motivation and commitment to change (Dean et al., 2016).	Youth with dual diagnoses (mental health and substance use); youth with mental health diagnosis; youth with juvenile justice involvement	Currently implemented
Multi-Systemic Therapy *Evidence-based*	Ecologically based model that addresses multiple determinants of serious antisocial behavior in youths. This type of integrated and home-based treatment primarily occurs within the youth's natural setting (Borduin & Schaeffer, 2002; Conroy et al., 2021).	Youth engaged in juvenile justice system for chronic and violent behaviors	Under consideration
Nurturing Parenting Model *Evidence-based*	Trauma-informed curriculum that teaches positive parenting behaviors to reduce abuse and neglect (Maher, 2011).	Families at risk for abuse and neglect with children from the prenatal period to age 18	Currently implemented
Non-violent Therapeutic Crisis Intervention *Promising practice*	Trauma-informed, verbal strategies for preventing and de-escalating a crisis (Nunno et al., 2003).	Youth with serious emotional disturbances	Train-the-trainer program to begin in summer 2021
Trauma-Focused Cognitive Behavioral Treatment (TF-CBT) *Evidence-based*	Approach that uses cognitive behavioral principles and exposure techniques to address symptoms of post-traumatic stress following trauma exposure, as well as symptoms of depression, behavioral problems, and caregiver difficulties (de Arellano et al., 2014).	Youth who have experienced physical abuse, sexual abuse, interpersonal violence, or natural disasters	Currently implemented
Triple P *Evidence-based*	Multilevel parenting education program that prevents abuse and neglect and offers five levels of intervention on a tiered continuum of increasing intensity. Functions on the basis that children and parents may have different needs and desires regarding the type, intensity, and mode of assistance (De Graaf et al., 2008).	Youth with severe behavioral, emotional, and developmental problems	Currently implemented

A Comprehensive Needs Assessment of the Franklin County System of Care

AUGUST 2021

Appendix 5

2023 Goals and Plans Form

Franklin County Community Services

Goal 1: Housing: Create housing opportunities for community members with mental health and co-occurring disorders in need of safe and affordable housing.
Goal 2: Crisis Services: Ensure that crisis intervention and stabilization services are available and accessible to support Franklin County youth and adults who are experiencing mental health / co-occurring crises.
Goal 3: Transportation: Develop or expand mobile services and Medicaid-reimbursable transportation options to make services more accessible.
Goal 4 (Optional): High-Need Individuals: Enhance collaboration between agencies to provide comprehensive supports to the highest-need community members with mental health, substance abuse, and IDD, and particularly those with co-occurring disorders.
Goal 5 (Optional): Prevention: Strengthen existing prevention and engagement strategies to reduce substance use and improve mental health through education and support for youth, adults, and families.
Goal 6 (Optional): Workforce: Develop and implement strategies to recruit and retain a highly skilled rural mental hygiene workforce.
Goal 7 (Optional): Strengthening Relationships with Law Enforcement: Provide education and support to officers during and after calls involving individuals with mental health needs and co-occurring disorders to promote trauma-informed responses.
Goal 8 (Optional): Adverse Childhood Experiences: Expand trauma-informed, school-based, and community-based services to youth to reduce the need for out-of-home placement and to improve long-term outcomes for youth and families.

Annual and intermediate plans for <u>addiction</u> services:
Prevention

- Expand partnerships between the Tri-Lakes Community Alliance for Addiction Prevention in the south end and the Franklin County Prevention Taskforce in the north end to develop and enhance substance abuse prevention activities for Franklin County community members across the county by quarter 2 of 2023 (Citizen Advocates, St. Joe's, Franklin County Community Services).

- Explore funding opportunities to hire a coordinator for the Tri-Lakes Community Alliance by quarter 2 of 2023 (Franklin County Community Services, St. Joe's).

- Explore a pilot project within Akwesasne that would provide mental health first aid training to community members, allowing them to intervene when family or community

members are struggling with addiction or mental health needs, in partnership with supporting clinicians, by quarter 3 of 2023 (Akwesasne).

Transportation

- Continue to develop a collaboration with the Department of Transportation (DOT) to provide Medicaid reimbursement for transporting individuals who are accessing addiction services (St. Joe's).

- Continue to increase outreach, engagement, and clinical services through the use of mobile treatment vehicles (St. Joe's).

High-Need Individuals

- Expand substance use disorder treatment and support services for incarcerated individuals in Franklin County through the introduction of peer support workers by quarter 1 of 2023 (St. Joe's, Citizen Advocates).

- Develop a cross-agency task force to coordinate services for high-need individuals with addiction needs and mental health conditions who engage frequently with law enforcement in Akwesasne (St. Regis Mohawk Tribe Police, DSS, mental health and substance use disorder services, Franklin County Community Services).

Collaboration with Law Enforcement

- Note that plans for law enforcement collaboration described above under plans for mental health services apply to addiction services as well.

Housing

- Note that plans for Harison Place and the Ruth House conversion described under plans for mental health services apply to addiction services also:

o Specifically, 8 beds at Harrison Place will be for individuals with addiction.
o Ruth House, which is being converted to housing for transition-aged youth, will offer substance use prevention and treatment services to youth with addictions or co-occurring disorders.

Workforce

- Note that plans for addressing workforce issues described above under plans for mental health services apply to addiction services as well.

Annual and intermediate plans for <u>developmental disability</u> services:

Crisis Services

- Raise awareness of CSIDD opportunities to support individuals in co-occurring crisis

through presentations to the Community Services Board and agencies (OPWDD, CSIDD, Franklin County Community Services).

- Create strategies to better support individuals with IDD / co-occurring disorders when they present at hospital emergency departments in crisis situations (Alice Hyde, Adirondack Medical Center, Adirondack ARC, Franklin County Community Services).

- Develop a plan to proactively identify individuals with IDD / co-occurring disorders to prevent the escalation of crisis (Adirondack ARC, Citizen Advocates, Franklin County Community Services).

- Educate staff about the needs of people with developmental disabilities who may require crisis services through a training presentation, including the supports and services available during a crisis (Citizen Advocates, OPWDD).

Collaboration with Law Enforcement

- Note that plans for law enforcement collaboration described above under plans for mental health services apply to developmental disability services as well.

Workforce

- Note that plans for addressing workforce issues described above under plans for mental health services apply to developmental disability services as well.

Annual and intermediate plans for <u>mental health</u> services:

Housing

- By December 2023, complete construction on Harison Place. Develop plans for a SPOA process to accept referrals for individuals with serious mental illness and substance use disorders (12 beds will be available for SMI and 8 beds will be available for SUD) (Franklin County Community Services, Citizen Advocates).

- Convert Ruth House, a transitional housing facility in the county, to a residence that supports women and children, with the potential to support transition-aged youth, ages 16-28 (Department of Social Services). Develop a preliminary plan and begin implementation of individualized, recovery-oriented on-site mental health and addiction services for individuals residing at Ruth House (Community Connections, Franklin County Department of Social Services, Franklin County Community Services).

Crisis Services

- By the first quarter of 2023, renovate the crisis center to create separate suites for adults and children in need of crisis services, allowing children/youth to utilize the crisis center without a parent or guardian present on site (Citizen Advocates).

- Submit an application to OMH for a 589 / Children's Crisis Residence to expand crisis services for children, youth, and adults in Franklin County by the end of 2022 (Citizen Advocates).

- Implement Therapeutic Crisis Intervention (TCI) as a trauma-informed community model across Franklin County to reduce crisis incidents and improve client outcomes. In 2022, Franklin County engaged Cornell University to train 16 providers as certified TCI trainers. In 2023, these trainers will provide TCI training within their organizations to approximately 50 to 75 additional providers (Franklin County Community Services).

Adverse Childhood Experiences

- Through Franklin County's SAMHSA System of Care grant, implement the school-as-a-hub model within the Tupper Lake, Saranac Lake, and Chateaugay school districts. This model provides youth with serious emotional disturbances (SED) with intensive in-school mental health support services, including clinical services, care coordination, family support, youth peer support, and crisis support. The model supports youth with mental health needs in their homes, schools, and communities, with the goals of reducing the need for out-of-home/out-of-school placements and improving long-term outcomes (Franklin County Community Services, school districts, partner organizations).

- Through Franklin County's SAMHSA System of Care grant, expand the provision of in-home clinical and support services for youth in foster care and preventative care in Franklin County. Funding will be used to hire additional clinical and support staff who can serve more families through an intensive service model, with the goals of accelerating permanency for youth and preventing the need for multiple foster placements and/or residential placement (Franklin County Community Services, school districts, partner organizations).

- By the first quarter of 2023, the Franklin County System of Care Council will collaborate to develop a shared mission, vision, and values statement, in addition to a logo. These efforts will be used to increase collaboration and buy-in from county partners and to enhance awareness of the Council and its activities (Franklin County Community Services).

- To increase awareness of available services and improve the ease of navigating services, Franklin County is partnering with Flyer Connect to deploy the ReachWell app. This interactive app streamlines how families are informed about services and updates in the community through a user-friendly interface. Messages can be sent to families in several formats, and the app allows for language translation (System of Care Council, Franklin County Community Services).

- Expand the Family Support Advocate program to additional school districts, including Brushton, St. Regis, and Malone, by quarter 1 of 2023. Family Support Advocates will

work with families on social determinants of health, including housing needs, referrals, and transportation to service appointments (Community Connections).

Strengthening Collaboration with Law Enforcement

- Conduct Mental Health First Aid for Public Safety trainings throughout the county for law enforcement, EMS, and fire/rescue agencies, including one training in the south end of the county and one training in Akwesasne (Franklin County Community Services).

- Conduct outreach efforts within the Saranac Lake and Tupper Lake police departments to expand participation in Crisis Intervention Team (CIT) training (Community Connections).

- Provide additional training and technical support to officers on data collection to evaluate the impact of current law enforcement and provider collaborations (Community Connections).

- Increase officer awareness about clinical support offered through Clinician and Law Enforcement Partnership (CALEP) through outreach and training, and explore expanding the CALEP programs to new communities, including Tupper Lake and Malone, by quarter 1 of 2023 (Citizen Advocates).

- Reconvene an advisory council of law enforcement and provider agencies to implement sequential intercept mapping for Franklin County by quarter 3 of 2023 (Law Enforcement, Franklin County Community Services).

Workforce

- The Community Services Board and participating agencies will collaborate with the Northern Area Health Education Center / Institute for Career Advancement in Medicine to develop workforce recruitment and retention strategies (Community Services Board, Franklin County Community Services, participating agencies).

- Provide opportunities for participating agencies of the Community Services Board to share ideas and strategies to improve recruitment and retention of the workforce (Community Services Board, participating agencies).

- Explore opportunities to partner with the BOCES New Vision for Teachers program to develop a workforce pathway for the human services field (Franklin County Community Services).

LGU Representative Name: Suzanne Lavigne
LGU Representative Title: Director of Community Services
Submitted for: Franklin County Community Services

J. 2021-2022 CHA and Public Health/Hospitals Meetings

2021-2022 CHA Committee Meeting Dates:

2021

June 4, 2021
Data Subcommittee Meeting – July 13, 2021
Data Subcommittee Meeting – August 25, 2021
September 10, 2021
Data Subcommittee Meeting – October 12, 2021
Data Subcommittee Meeting – November 10, 2021
December 17, 2021

2022

March 4, 2022
June 17, 2022
September 9, 2022
December 9, 2022

Franklin County – Public Health/Hospitals 2022 Meetings

July 22, 2022
October 5, 2022
November 15, 2022