Glens Falls Hospital

Community Service Plan

2019 - 2021

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1. Counties Covered:

Warren, Washington and Saratoga Counties

2. Participating Local Health Departments:

Warren County Public Health
Dan Durkee, Senior Health Educator
1340 State Route 9
Lake George, New York 12845

Washington County Public Health
Patty Hunt, Director
415 Lower Main Street #1
Hudson Falls, New York 12839

Saratoga County Public Health
Catherine Duncan, Director
31 Woodlawn Avenue #1
Saratoga Springs, New York 12866

3. Participating Hospitals/Hospital Systems:

Glens Falls Hospital-Lead Agency
Cathleen Traver
100 Park Street
Glens Falls, New York 12801

Saratoga Hospital-collaborative hospital partner within the service area
Dot Jones
211 Church Street
Saratoga Spring, New York 12866

4. Assessment and Planning Coalition:

Adirondack Rural Health Network led by Adirondack Health Institute

Note: Saratoga Hospital and Saratoga County partnered with the Healthy Capital District Initiative for their community needs assessment and planning. Glens Falls Hospital representatives were present during this process.

Executive Summary

Glens Falls Hospital (GFH) conducted the following Community Service Plan (CSP) to identify and prioritize the community health needs of the patients and communities within the GFH service area, and develop a three-year plan of action to address the prioritized needs. The plan was developed in collaboration with Warren, Washington and Saratoga County Public Health Departments, and includes strategies that are evidence-based and aligned with the NYS Prevention Agenda 2019 - 2024. Glens Falls Hospital coordinated the planning through the Adirondack Rural Health Network (ARHN). ARHN provides a forum for local public health leaders, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations to assess regional population health needs and develop collaborative responses to priorities.

Through the ARHN collaborative, GFH coordinated with Warren and Washington counties to conduct a community health assessment in each county. Saratoga County conducted a separate, yet similar process to determine their community's heath needs. The process was mainly coordinated by Saratoga Hospital and Saratoga County Public Health and facilitated by a different regional planning group. GFH representatives were members of the prioritization planning group and actively contributed to the process.

Utilizing the results of the indicator analysis, regional survey and the other county-specific community assessment resources, each county prioritized the most significant health needs for their residents. Each counties' assessment provides the rationale behind the prioritization of significant health needs. In addition to evaluating the priorities and county level data indicators for our local county health departments, GFH considered our expertise and role in the community. To that end, GFH has

identified the following as the most significant health needs for the population served by GFH. These needs will be the major focus of GFH's community health strategies for 2019 – 2021:

Priority Area: 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

Priority Area: Prevent Communicable Diseases

- Focus Area 5 - Antibiotic Resistance and Healthcare-Associated Infections

It is important to note that GFH chose similar chronic disease related priorities during both our 2013-15 and our 2016-18 assessment process. Continuing to focus on these areas will improve, strengthen and sustain the impact of our interventions.

Improving health status in the five priority areas and reducing racial, ethnic, socioeconomic and other health disparities including those among persons with disabilities is an overarching goal of the NYS Prevention Agenda. Warren, Washington and Saratoga counties are predominately White and do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations in upstate New York face a unique combination of factors that create health disparities, which are often rooted in the social determinants of health. Emphasis is placed on interventions that impact these disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community resources.

A variety of data sources were used to inform the county and hospital assessments. For GFH, Warren and Washington County, the two most significant resources used to inform the assessments were developed and provided by the ARHN collaboration: 1) publicly available county health indicator data and 2) data collected from a regional community stakeholder survey. Additional data used by

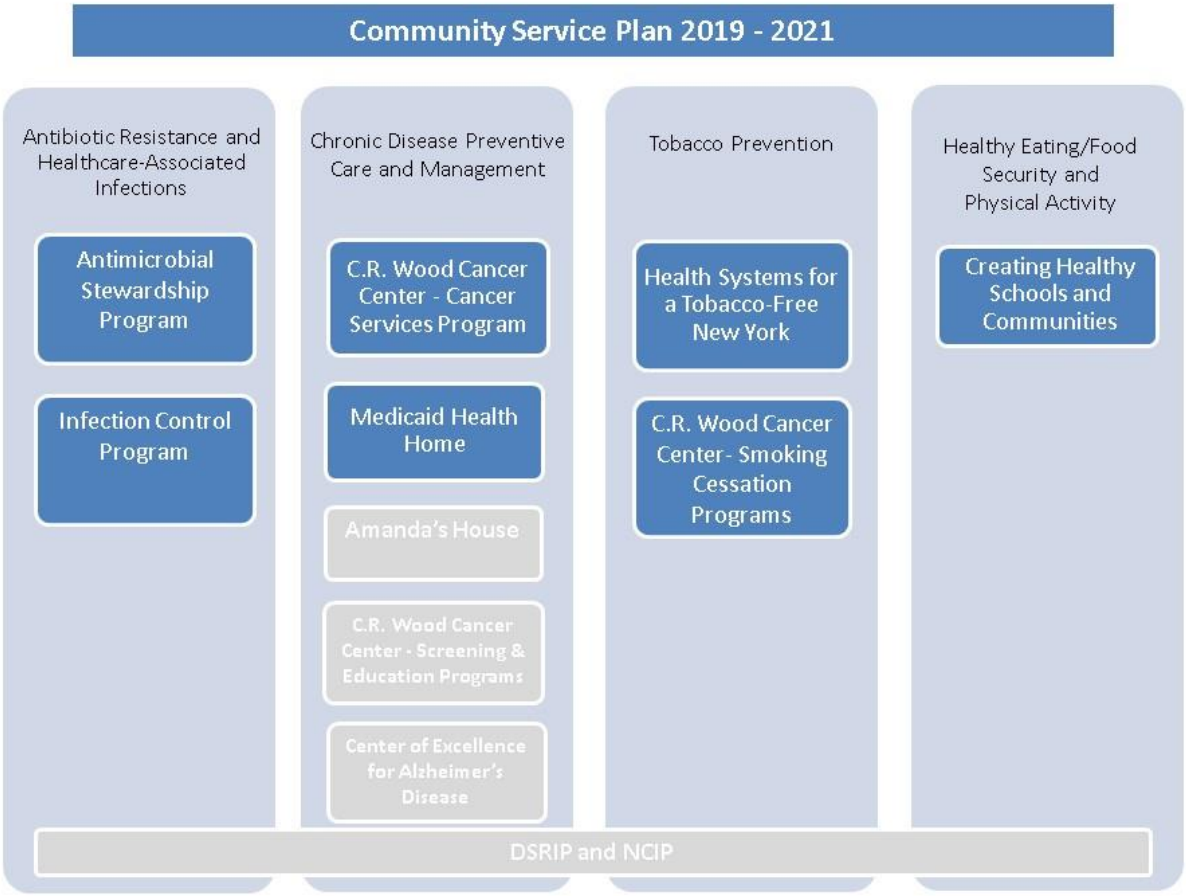
Glens Falls Hospital includes the Prevention Agenda Dashboard, County Health Rankings, the NYS Cancer Registry, Governor's Cancer Research Initiative – Warren County Cancer Incidence Report, and the Warren, Washington, and Saratoga County Tobacco Survey.

GFH will continue to partner with Warren, Washington and Saratoga county Public Health departments to implement the strategies in this action plan. GFH has a long-standing history of partnerships with these and other community-based organizations and agencies to support implementation of community health initiatives. These include a wide array of disciplines, such as schools, workplaces, providers, housing and transportation authorities, Offices for the Aging, county health departments, local economic opportunity councils, Chambers of Commerce and local decision makers. Many of these partners participated in the various county health assessments and planning processes and therefore are well versed in the need for these interventions and are poised to provide the support necessary to ensure the attainment of the proposed goals.

Many of these partnerships will be further enhanced through ongoing participation in the Adirondack Rural Health Network, Population Health Improvement Program, Delivery System Reform Incentive Payment Program, Adirondacks ACO, Health Home and the North Country Innovation Pilot. In addition, community engagement is integral to the success of improving health in our region. GFH will solicit the guidance and expertise of relevant content experts to ensure a coordinated approach and to best meet the needs of the population we serve. In addition, any feedback received from the public at large will also be considered in the planning and implementation. A list of partners and corresponding roles for each intervention is included in the required workplan table.

The visual below outlines the evidence-based interventions led by GFH to address the prioritized community health needs. The interventions were selected by GFH by aligning with the Prevention Agenda goals, building on existing initiatives and community assets, and identifying new initiatives to

complement and further enhance these existing programs. Capacity, funding, and potential impact were also major considerations. The inventions in blue are the selected strategies that are included in the formal DOH required Community Service Plan. The interventions in gray are included here to be comprehensive, as they are part of the IRS-required Implementation Strategy, but are not included in the DOH required Community Service Plan as they do not neatly align with Prevention Agenda goals and/or the required workplan format.

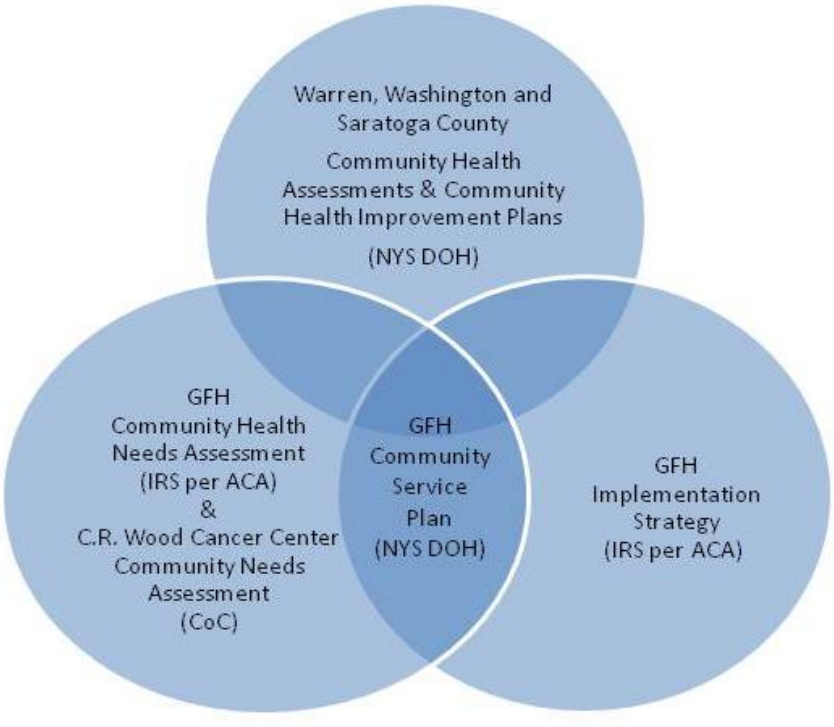


To ensure efficacy of the proposed interventions, GFH will work with Warren, Washington and Saratoga Public Health Departments to monitor and track progress using process and, where applicable, outcome evaluation. Each initiative has clearly defined process and/or outcome measures, as noted in the required workplan table.

Introduction

Glens Falls Hospital (GFH) conducted the following Community Service Plan (CSP) to identify and prioritize the community health needs of the patients and communities within the GFH service area, and develop a three-year plan of action to address the prioritized needs. The plan was developed in collaboration with Warren, Washington and Saratoga County Public Health Departments, and includes strategies that are evidence-based and aligned with the NYS Prevention Agenda 2019 - 2024. This CSP addresses the requirements set forth by the NYS DOH, which require hospitals to work with local health departments to complete a CSP that mirrors the Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) required by the Affordable Care Act (ACA). GFH combined elements from our CHNA and IS documents to create this CSP. The community health needs assessment provision of the ACA (Section 9007) links hospitals' tax-exempt status to the development of a needs assessment and adoption of an implementation strategy to meet the significant health needs of the communities they serve, at least once every three years. The action plan for DOH includes elements from the IRS-required Implementation Strategy, however, the DOH Community Service Plan requirements are more prescriptive. Not all interventions included in the Implementation Strategy are included in the CSP.

The Public Health Accreditation board defines a community health assessment as a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues.[1] The findings in this Community Service Plan are the result of a collaborative process of collecting and analyzing data and consulting with stakeholders throughout the service area and the region. This Community Service Plan can be used to guide service providers, especially public health and healthcare sectors, in their efforts to identify potentially available resources and plan programs and services targeted to improve the overall health and well-being of people and communities in our region.



County health departments in New York State (NYS) have separate yet similar state requirements to conduct a Community Health

[1] Centers for Disease Control and Prevention, Community Health Assessments & Health Improvement Plans, October 2019. Available at https://www.cdc.gov/publichealthgateway/cha/plan.html

Assessment (CHA) and a corresponding Community Health Improvement Plan (CHIP). Beginning in 2012, all American College of Surgeons (ACoS) Commission on Cancer programs are required to complete a community needs assessment to identify needs of the population served, potential to improve cancer health care disparities, and gaps in resources. Consequently, cancer-specific information, data and needs will be highlighted throughout this assessment. Aligning and combining the requirements of these three entities ensures the most efficient use of hospital resources and supports a comprehensive approach to community health and population health management in the region.

Glens Falls Hospital

Founded in 1897, GFH today operates an advanced health care delivery system featuring more than 20 regional facilities. A vast array of specialized medical and surgical services are provided in addition to coronary care, rehabilitation and wellness and others. The main hospital campus is home to the C.R. Wood Cancer Center, the Joyce Stock Snuggery birthing center, the Breast Center and a chronic wound healing center. GFH is a not-for-profit organization and the largest employer in New York's Adirondack region, with over 2,500 employees and a medical staff of over 575 providers (see Appendix A). In September 2019, GFH and Albany Medical Center (AMC) announced that they have taken the next step toward a strategic affiliation, approving the Definitive Agreement for GFH to become an affiliate of AMC. The agreement was approved by both Boards following a nearly year-long due diligence process undertaken by both organizations. Both organizations are working through the necessary regulatory approvals needed to finalize the affiliation, which is expected to be complete in 2020.

The governance of GFH is vested in the Board of Governors (the Board), which is comprised of duly elected community members and physicians. The Board consists of not less than 12 and not more than 18 members, including two ex-officio voting members - the President of the institution and the President of the Medical Staff. The Board is required to meet at least twelve times per year. The officers of the Board include a Chairperson, a Vice Chairperson and a Secretary.

The primary and secondary service areas for GFH include Warren, Washington and northern Saratoga counties, covering over 2,000 square miles. However, patients often travel from as far away as Essex and Hamilton counties to obtain services within the health system. With an extended service area that stretches across five, primarily rural counties and over 6,000 square miles, GFH is responsible for the well-being of an extremely diverse, broad population and region.

As an article 28, not-for-profit, community hospital, GFH has worked to create healthier populations for over 115 years. GFH has established a diverse array of community health and outreach programs, bringing our expertise and services to people in outlying portions of our service area. These programs are especially important for low-income individuals and families who may otherwise fail to seek out health care due to financial or transportation concerns. Our history, experience and proven results demonstrate strong partnerships, regional leadership and active engagement in improving community health outcomes. GFH meets the criteria of an eligible safety net provider under the Delivery System Reform Incentive Payment (DSRIP) Program, as defined by the regional criteria of serving at least 30

percent of all Medicaid, uninsured and dual eligible members in the proposed county or multi-county catchment area.

GFH has worked to create healthier communities and is actively implementing numerous care transformation initiatives to support the Institute for Healthcare Improvement's Triple Aim of better health, better care and lower costs. Additional information on programs and initiatives underway at GFH follow later in this document.

Glens Falls Hospital Mission

The mission of GFH is to improve the health of people in our region by providing access to exceptional, affordable and patient-centered care every day and in every setting. Our fundamental values are: **C**ollaboration, **A**ccountability, **R**espect, **E**xcellence and **S**afety. The GFH Purpose combines our Mission - WHY we exist as an organization, our Pillar Goals -WHAT we need to accomplish in order to fulfill our mission and our Standards of Behavior and Core Values - HOW we interact and provide services as we strive to fulfill our mission.

C.R. Wood Cancer Center at Glens Falls Hospital

The C. R. Wood Cancer Center at GFH (The Center) opened in 1993, and is accredited as a Comprehensive Community Cancer Center by the ACoS CoC. The Center is multi-faceted with an integrated oncology program that provides comprehensive cancer services including: prevention, early detection, screenings, diagnostics, genetic risk evaluation, medical and radiation oncology, pharmacy, clinical research and survivorship care. Education and support services include psychological counseling, patient navigation, nutrition counseling, a children's camp, wellness programs and numerous support groups and weekend retreats.

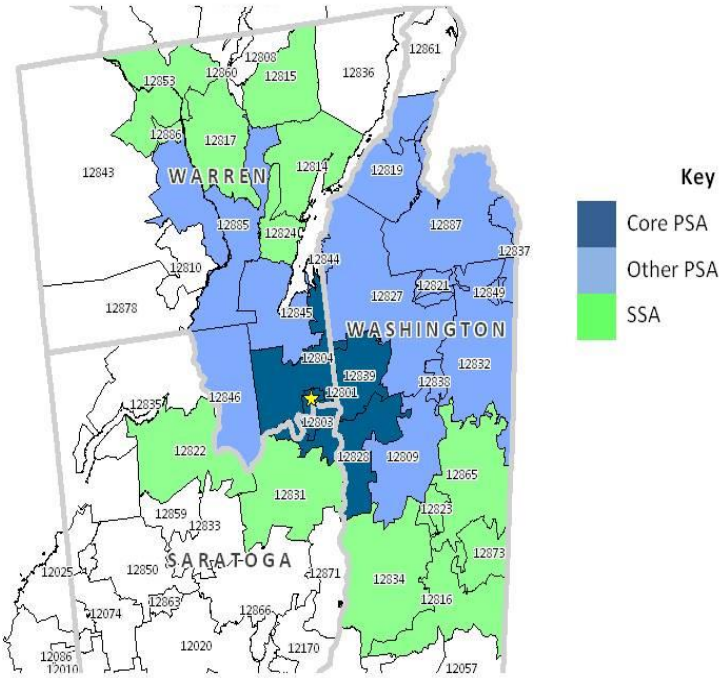
The CoC has recognized the C. R. Wood Cancer Center as an oncology program that offers high-quality cancer care. Only one in four cancer programs at hospitals across the United States receive this special accreditation. The CoC recognizes the quality of our comprehensive patient care and our commitment to provide our community with access to various medical specialists involved in diagnosing and treating cancer.

Patient navigation is facilitated through three nurse navigators and one social worker and a financial navigator that help patients find resources to remove barriers to care. They also provide education and support to patients diagnosed with cancer and their families and care givers. Nurses within the clinics and treatment areas refer to the navigators and/or care managers to help patients on an as needed basis. Patient navigation occurs through contact with newly diagnosed cancer patients. This process begins with an abnormal screening or diagnostic exam and continues through surgery, treatment and

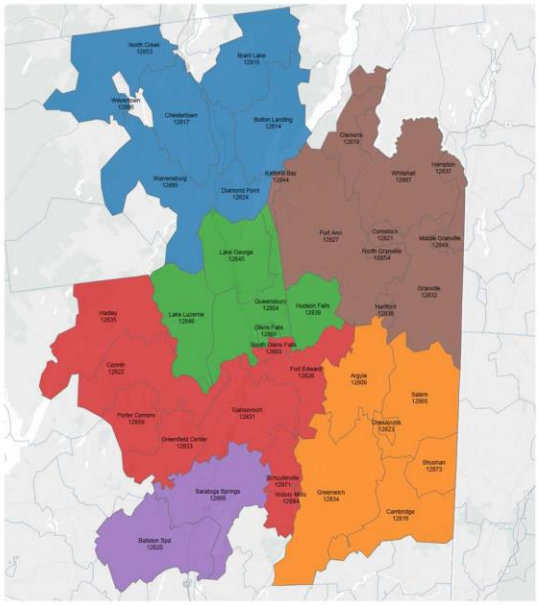
survivorship care. Patients that are identified for navigation are contacted by one of the navigators to provide education and support and identify and reduce any barriers throughout the continuum of care.

Glens Falls Hospital Service Area

Although GFH draws from neighboring communities to the North and West, our primary service area is defined by ZIP codes in Warren, Washington and northern Saratoga counties. This definition results from an analysis of patient origin, market share (which reflects how important GFH is to a particular community), and geographic considerations-



GFH Inpatient Service Area



GFH Ambulatory Service Area

including the need to ensure a contiguous area and takes into consideration both our inpatient and ambulatory services.

The GFH inpatient service area is defined by a Core Primary Service Area (PSA), Other Primary Service Area (Other PSA) and a Secondary Service Area (SSA). The Core PSA represents the ZIP codes immediately contiguous to the hospital. The SSA reflects more outlying areas where GFH has either a strong market share or a critical mass of patients that come to the hospital.

Additional analysis of our service area shows a similar, yet larger service area for our ambulatory population. In addition to those zip codes above, our ambulatory service area extends slightly farther South and West of the inpatient catchment area and captures additional municipalities located in northern Saratoga County that are serviced through our primary care offices and community-based services located throughout the region.

This service area definition also aligns with the counties included in the service area definition for the GFH Medical Staff Development Plan (MSDP).[2] It is important to note that an analysis of 2018 patient origin for the entire GFH health system revealed that approximately 50% of our total patient volume came from suburban areas, including our Primary Service Area and points south. Nearly 47% of total patient volume came from rural areas, mainly to the North, East and West of Glens Falls.

Health Care Transformation

Hospitals and public health departments are key partners in working with providers, agencies and community-based organizations to transform the way that our community members think about and receive health care. There are a number of federal, state, and regional initiatives to restructure the delivery system focusing on the Triple Aim. The Triple Aim is a framework that organizations and communities can use to navigate the transition from a focus on clinical care to optimizing health for individuals and populations. The Triple Aim is improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per capita cost of care for the benefit of communities. GFH plays an integral role in the region on the many health care transformation and delivery initiatives described below.

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

Adirondacks Accountable Care Organization: Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to provide coordinated, high-quality care to their patients. The Adirondacks ACO includes hospitals and participating primary and specialty care providers in Clinton, Essex, Franklin, Hamilton, Warren, Washington and northern Saratoga counties. In January of 2020, the ACO will add 14 behavioral health providers to the network. The Adirondacks ACO has value-based contracts with seven commercial health insurers as well as Medicare. The ACO was able to realize shared savings based on the performance for our commercial contracts in 2018. GFH is an active participant and serves as a member of the Board of Managers for the Adirondacks ACO as well as the Population Health and Quality Committee.

Adirondack Medical Home Initiative: The Adirondack Medical Home Initiative (AMHI) is a collaborative effort by health care providers and public and private insurers to transform health care delivery by emphasizing preventative care, enhanced management of chronic conditions, and assuring a close

[2] The MSDP justifies financial support for physician recruitment into private practices and is also a strategic tool to assess broader physician need including development of new programs and services. Consequently, there is significant overlap between both the content and purpose of the CHNA and MSDP (both federal requirements).

relationship between patients and their primary care providers. The AMHI includes provider partners in Clinton, Essex, Franklin, Hamilton, Warren, Washington and northern Saratoga counties. The Medical Home Initiative introduced the concept of care management in primary care. Through that project, primary care providers received funding to develop and support a care management infrastructure. In 2017, the Medical Home payments were folded into the ACO contracts. As with the Adirondack Medical Home Initiative, each provider is responsible for the care management. The ACO passes the funds along to the providers and does not provide centralized care management.

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

Delivery System Reform Incentive Payment Program: On April 14, 2014 New York finalized terms and conditions with the federal government for a groundbreaking waiver to allow the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team reforms. The waiver amendment dollars have sought to address critical issues throughout the state and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The purpose of DSRIP is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program. Across NYS, there are 25 Performing Provider Systems (PPS) or networks of providers that have agreed to work together. GFH is a partner in the AHI PPS which includes Clinton, Essex, Franklin, Fulton, Hamilton, (western) St. Lawrence, (northern) Saratoga, Warren and Washington counties. The DSRIP program covers a five-year period beginning April 1, 2015 and ending March 31, 2020. On November 27, 2019 the NYS DOH submitted a 1115 Medicaid waiver amendment that establishes a framework for ongoing efforts to drive value. The formal request to the Centers for Medicare and Medicaid Services (CMS) seeks both a one-year extension of the current waiver program and a subsequent three-year renewal to allow the State to build upon the transformation started in the current waiver and continue toward value-based care.

DSRIP is an incentive payment model that rewards providers for performance on delivery system transformation that improve care for low-income patients. Over time measurement of performance has shifted from pay for reporting to pay for performance milestones. The milestones are designed to achieve transformation, leading to the primary goal of reducing avoidable hospital use by 25% over 5 years. In addition, there are a number of quality goals the PPS must achieve including measures of access, preventive care and care coordination, among others.

The AHI PPS coordinates activities in regional entities called Population Health Networks (PHN). Each PHN is led by an Executive Leadership Triad comprised of a regional physician champion, a regional community-based organization administrator and a hospital administrator with support from an AHI administrator. The PHN Management Triad is responsible for the collective quality and cost outcomes for the region as a whole. GFH maintains a leadership role in the Queensbury/Lake George regional triad.

North Country Innovation Pilot: The North Country Innovation Pilot (NCIP) is a unique partnership of providers and community members working together to improve the health of residents of the North Country by assuring access to needed care for those who are sick and promoting health for those who are well. At a very high level, NCIP is a proposed care delivery model supported by payment reform in the North Country, which build upon existing health care transformation initiatives currently underway. A focus will be on novel payment models that incentivize quality and efficiency, care supports and services unique to the needs of individuals in the region, measures to ensure high-value outcomes, and improved communication and integration. NCIP is still in the planning stages with more detailed design required and further partner engagement needed to reach a goal launch date of late 2020.

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

Adirondack Rural Health Network

The Adirondack Rural Health Network (ARHN) is a program of AHI. AHI is a 501c3 not-for-profit organization that is licensed as an Article 28 Central Service Facility. AHI is a joint venture of Adirondack Health, GFH, Hudson Headwaters Health Network (HHHN), St. Lawrence Health System, and The University of Vermont Health Network – Champlain Valley Physicians Hospital. For thirty years the organization has supported hospitals, physician practices, behavioral health providers, community-based organizations, patients and others throughout the region in transforming health care and improving population health.

Established in 1992 through a NYS DOH, Rural Health Development Grant, ARHN provides a forum for local public health leaders, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations to assess regional population health needs and develop collaborative responses to priorities. As a multi-stakeholder regional coalition, ARHN informs regional health planning and assessment, provides education and training to further the NYS DOH Prevention Agenda and Delivery System Reform Incentive Payment (DSRIP) Program, and offers other resources that support the development of the regional health care system. ARHN includes organizations from New York's Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning in the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments working together to utilize a systematic approach to community health planning and assessment. The CHA Committee is made up of members from

Adirondack Health, Clinton County Health Department, UVM Health Network-Alice Hyde Medical Center, UVM Health Network- Elizabethtown Community Hospital, Essex County Public Health, Franklin County Public Health, Fulton County Public Health, GFH, Hamilton County Public Health Services, Nathan Littauer Hospital, UVM Health Network – CVPH, Warren County Health Services, and Washington County Public Health Services. See Appendix B for a full list of ARHN members and meeting dates.

New York State Prevention Agenda 2019 – 2024

The Prevention Agenda 2019-2024 is New York State's health improvement plan, the blueprint for state and local action to improve the health and well-being of all New Yorkers and to promote health equity in all populations who experience disparities. The vision of the Prevention Agenda is that New York is the Healthiest State in the Nation for People of All Ages. The overarching strategy of the Prevention Agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. In addition, the Prevention Agenda serves as a guide for local health departments as they work with their community to develop CHIPs and CHAs and for hospitals as they develop mandated CSPs and CHNAs and an IS as required per the ACA requirements.

The Prevention Agenda 2019-2024 has five priorities with priority-specific action plans developed collaboratively with input from community stakeholders. Each priority-specific action plan includes focus areas, goals, objective and measures for evidence-based intervention to track their impacts- including reduction in health disparities among racial, ethnic, and socioeconomic groups, age groups and persons with disabilities.

These priority areas were used as a foundation for determining the most significant health needs for the GFH service area. The plan features five priority areas and corresponding focus areas that highlight the priority health needs for New Yorkers:

- Prevent Chronic Disease
    - Focus Area 1: Healthy Eating and Food Security
    - Focus Area 2: Physical Activity
    - Focus Area 3: Tobacco Prevention
    - Focus Area 4: 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 - 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

Appendix C is attached for more detail on the 2019-2024 Prevention Agenda. In addition, more information on the Prevention Agenda can be found at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/index.htm.

Community Health Needs Assessment Process

In NYS, hospitals and county health departments are required to work together to assess community health needs and develop a plan that addresses those identified needs. Working within the framework provided by the NYS Prevention Agenda, GFH collaborated with Warren, Washington and Saratoga County Public Health in the development of this Community Service Plan. Additionally, GFH coordinated with Fulton, Essex, Hamilton, Franklin and Clinton County Public Health, in addition to several other hospitals in the region, through the regional health assessment and planning efforts coordinated by ARHN.

The CHA Committee, facilitated by ARHN, is made up of hospitals and county health departments working together utilizing a systematic approach to community health planning. Members include:

- Adirondack Health
- Clinton County Health Department
- Essex County Public Health
- Franklin County Public Health
- Fulton County Public Health
- Glens Falls Hospital
- Hamilton County Public Health Services
- Nathan Littauer Hospital & Nursing Home
- UVM Health Network—Alice Hyde Medical Center
- UVM Health Network—Champlain Valley Physicians Hospital
- UVM Health Network—Elizabethtown Community Hospital
- Warren County Health Services
- Washington County Public Health Services

GFH serves a multi-county area, which fostered the need for a strategic approach to ensure alignment with each county assessment and planning process. Consistent with previous years, GFH determined that the most effective strategy would be twofold: 1) ensure the hospital coordinated with and/or

participated in each of the public health departments' community health assessment processes and 2) utilize the results of each of the county assessments to inform a coordinated and complementary regional Community Service Plan for the GFH service area.

This approach was utilized during the development of our last two Community Service Plans and after evaluating the effectiveness, it was determined that it would be beneficial to use this method again during the current planning cycle. The proceeding sections briefly describes each county's CHA process as well as the subsequent GFH process, followed by the data sources utilized to inform the processes.

Warren, Washington and Saratoga County Community Health Assessments

As a result of the collaborative efforts through ARHN, the information used to conduct a CHA in Warren and Washington County was fairly similar. Saratoga County worked with a different regional planning group to determine the needs of their residents. Representatives from GFH were members of the community-based groups that were assembled to review and assess the available health data and determine priority areas for each county.

Although Saratoga County worked with a different regional planning group, each county's CHA process was similar and involved both data analysis and consultation with key members of the community. Each county convened a group of community partners to review and discuss the data and information, and collectively identify and prioritize the most significant needs for the residents of each county. Because each county's public health department has different needs, capacities and resources, the actual prioritization process for each county varied. The partners included in each county's community health assessment teams (CHATs)[3] were slightly different, and each county also chose to consider slightly different data sources.

Glens Falls Hospital Community Health Needs Assessment

GFH used each county CHA to inform a complementary regional CHNA. GFH did not convene an additional regional team of community partners as this would have duplicated efforts and created confusion among community leaders. In addition, GFH played a slightly different role in each of the county processes. GFH directly participated in the planning of the Warren County CHA. GFH was a participant in the Washington County process. In Saratoga County, the process was mainly coordinated by Saratoga Hospital and Saratoga County Public Health and facilitated by a different regional planning group. However, GFH participated in the workgroup that determined the needs of the county.

Once the assessment process was complete for each county, GFH reviewed the results to coordinate with each county as appropriate, in addition to consideration of resources, expertise and strategic plans.

[3] Each county's group of partners was called something slightly different. However, for ease of reference the term CHAT is utilized in this report to describe the partners that collaborated to conduct the assessment and prioritize needs for each county.

Data Sources

A variety of data sources were used to inform the county and hospital assessments. For GFH, Warren and Washington County, the two most significant resources used to inform the assessments were developed and provided by the ARHN collaboration: 1) publicly available county health indicator data and 2) data collected from a regional community stakeholder survey. Despite the fact that Saratoga County and Saratoga Hospital collaborated with a different facilitator and conducted their own assessment, many of the same publicly available data sets were used to inform their process. Each county, as well as GFH, used additional data sources to supplement this information and inform the process based on their needs. The following is a list of the data sources considered by each county and/or GFH.

New York State Prevention Agenda Dashboard

The New York State Prevention Agenda Dashboard is an interactive visual presentation of the Prevention Agenda tracking indicator data at state and county levels. It serves as a key source for monitoring progress that communities around the state have made with regard to meeting the Prevention Agenda 2018[4] objectives. The state dashboard homepage displays a quick view of the most current data for New York State and the Prevention Agenda 2018 objectives for approximately 100 tracking indicators. The most current data are compared to data from previous time periods to assess the performance for each indicator. Historical (trend) data can be easily accessed and county data (maps and bar charts) are also available for each Prevention Agenda tracking indicator.

The county dashboard homepage includes the most current data available for 68 tracking indicators. Each county in the state has its own dashboard.

County Health Indicator Data

ARHN, a program of AHI, identified and collected data from a variety of sources on the seven counties in the Adirondack region and two adjacent counties to assist in developing individual county community needs assessments. Those counties include: Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren, and Washington.

The initial step in the process was determining which data elements from the 2016 community needs assessment were still publicly available and updated. With the support of the CHA Committee, ARHN staff reviewed and compiled the data and then supplemented that information with data from other sources. Since most of the health behavior, status, and outcome data were only available at the county level, the data is displayed by county and aggregated to the ARHN region.[5]

The overall goal of collecting and providing this data to CHA Committee members was to provide a comprehensive picture of the individual counties within the Adirondack region as well as for two adjacent counties, including providing an overview of population health in addition to an environmental

[4] At the time this report was conducted, the Dashboard tracked indicators for Prevention Agenda 2013-2018. A new dashboard for Prevention Agenda 2019-2024 is scheduled to be available at the end of 2019.
[5] Aggregated data for the ARHN region included Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties but did not include Montgomery and Saratoga counties.

scan. In total, counties and hospitals were provided with about 400 data elements across the following four reports: Demographic Data; Education System Profile; Health Systems Profile; and Health Indicator Data for each County broken out by the Prevention Agenda focus areas. A complete description of the data collection and methodology is attached and labeled Appendix D.

Adirondack Rural Health Network Regional Community Stakeholder Survey

In conducting the CHNA, non-profit hospitals are required to take into account input from persons who represent the broad interests of the community served, including those with special knowledge of or expertise in public health such as local county health departments. In addition, members, leaders or representatives of medically underserved, low-income, minority populations should be consulted.

At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey. The 2019 Community Stakeholder Survey was drafted over the course of seven meetings from mid-July through the end of October 2018. A report on the activities and outcomes of the Ad Hoc Data Sub-Committee was created and shared with the full CHA Committee and is attached as Appendix E. The final version of the survey was approved by the full CHA Committee at December 7, 2018 meeting. ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. See Appendix F for a summary of the ARHN Stakeholder Survey

County Health Rankings

The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The County Health Rankings show the rank of the health of nearly every county in the nation and emphasize the many factors that, if improved, can help make communities healthier places to live, learn, work and play. They help to simplify the complexity of data and provide context and a common language for those working in community health. See http://www.countyhealthrankings.org/ for additional information.

New York State Cancer Registry

Cancer is a reportable disease in every state in the United States. In NYS, Public Health Law Section 2401 requires that all physicians, dentists, laboratories, and other health care providers notify the Department of Health of every case of cancer or other malignant disease. Through the NYS Cancer Registry, the Department collects, processes and reports information about New Yorkers diagnosed with cancer. See http://www.health.ny.gov/statistics/cancer/registry/about.htm for additional information about the NYS Cancer Registry.

Governor's Cancer Research Initiative – Warren County Cancer Incidence Report

The most comprehensive and recent cancer data available was issued in the Fall of 2019, published in the Warren County Cancer Incidence Report. This report summarizes cancer patterns and trends for Warren County, NY and was conducted as part of Governor Cuomo's Cancer Research Initiative. Warren County was identified by the New York State Department of Health because it had the highest rate of all cancers combined in NYS based on 2011-2015 data. Data evaluated included sociodemographic, behavioral, healthcare, occupational, environmental, and cancer registry. With respect to the registry, brain and other nervous system cancer, colorectal cancer, laryngeal cancer, lung cancer, oral cancer and thyroid cancer were selected because their overall or sex-specific incidence rates were statistically significantly higher in Warren County than in New York State excluding New York City (NYS excluding NYC).[6] While a comparable report is not available for Washington and northern Saratoga counties, this information can be used to better understand the burden of cancer in these populations. See https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/ for more information.

Warren, Washington and Saratoga County Tobacco Survey

The GFH Living Tobacco-Free initiative subcontracted with Siena Research Institute to conduct a community survey in the winter of 2015/2016. The purpose of the community survey was to gather information from community members about tobacco use, attitudes towards tobacco use, advertising and tobacco-related policies. Data was collected from 1,177 community members who are 18+ years of age that reside in Saratoga, Warren, and Washington counties. The data was collected, analyzed and compiled into a final report that we are able to share with community members and key stakeholders.

Regional Profile of Warren, Washington and Saratoga Counties[7]

Warren, Washington and Saratoga counties are part of the Capital Region, along with Albany, Columbia, Greene, Rensselaer, and Schenectady counties.[8] The Capital Region is an attractive

[6] Governor's Cancer Research Initiative – Warren County Cancer Incidence Report, Executive Summary, October 2019, available at https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/

[7] Within this report, much of the data presented for Warren, Washington and Saratoga counties represents the entire county, not just the zip codes included in the GFH service area definition. There is very limited data available for an area that is smaller than the county-level. While this does not create a significant issue for Warren and Washington counties, it is important to note that Saratoga County is extremely diverse, and populations in the southern portion of the county have different demographics, health behaviors, health outcomes, and access to care when compared to those living in the northern portion of the county. Typically, the population in northern Saratoga County aligns more closely with Warren County, but Saratoga County data is still included for comparison.

[8] In 2011, Governor Cuomo created 10 Regional Councils to develop long-term strategic plans for economic growth for their regions. Additional information about these councils is available at the NYS Regional Economic Development Councils website, http://regionalcouncils.ny.gov/

place to do business. Among its assets are: a strategic location with proximity to all major markets in the northeast; an extraordinary quality of life with a mix of suburban rural communities and medium sized cities, including the Capital City; a highly skilled workforce and the many world renowned academic and research institutions. These intellectual centers provide unparalleled economic development potential as well as opportunities for companies to grow and expand, especially in high tech and knowledge-based industries. More and more the Capital Region is being nationally recognized as the place to be for cutting-edge research and development, making and moving goods, as well as a rich diversity of arts and cultural experiences. In 2019 the area jumped up 11 slots on U.S. News & World Report's "Best Cities to Live" rankings to 28th. The area ranked 10th on ZipRecruiter's list of the "Hottest Cities for Jobs" and 21st on WalletHub's "Most Educated Cities in America." At the region's core is strategic investment in the emerging new economy which encompasses the area's industry clusters: bio life sciences, nanotechnology, chemical manufacturing, semiconductor development and clean energy production.

County Specific Profiles

The following sections outline key features of Warren, Washington and Saratoga counties and is included in this report to provide an overview of the GFH service area, including geography, infrastructure and services, healthcare facilities, and the educational system. Please see the local economic development corporation for additional details on county attributes.[9] Additional data on the demographics, educational and health systems in each county is attached and labeled Appendix G.

Geography

Warren, Washington and Saratoga counties cover over 2,000 square miles. Warren, Washington and Saratoga counties are bordered by Essex County to the north, Hamilton, Fulton and Montgomery counties to the west, and Schenectady, Albany and Rensselaer counties to the south. Major cities and towns within these three counties include Saratoga Springs, South Glens Falls, Fort Edward, Glens Falls, Lake Luzerne and Queensbury. Many of the towns in the region are located right off of the Adirondack Northway (I-87), which runs from Albany, NY to the Canadian border.

Infrastructure and Services

Warren County[10]

Most of Warren County lies within the boundaries of the Adirondack State Park, which encompasses approximately 6 million acres. The county's population of just under 65,000 people enjoys a lower cost of living than other Capital Region locations with diverse communities, ranging from the small city/suburban environment of Glens Falls and Queensbury in the southern part of the county to the rural towns and villages in the Adirondack Park to the north.

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[9] See Saratoga County Economic Development Corporation at http://saratogaedc.com/
Warren County Economic Development Corporation at http://www.edcwc.org
and Washington County Economic Development Corporation http://washingtoncountyny.gov/470/Economic-Development

[10] Adapted from the Warren County Economic Development Corporation website, http://www.edcwc.org

The county offers many recreational and cultural opportunities with access to world-class golf courses, alpine ski centers, an extensive trail system spanning over 2000 miles for hiking, cross country skiing and snowmobiling and many camping facilities. The county is home to the Hyde Collection and the World Awareness Children's Museum, the Charles R. Wood Theater, and the Cool Insuring Arena - home to the Adirondack Thunder, an NHL affiliate of the New Jersey Devils. Some of Warren County's largest attractions include Lake George, which offers a bustling village as well as year-round recreational activities, the Six Flags Great Escape theme park and Splashwater Kingdom Water Park, and the Fort William Henry Museum, a French & Indian War stronghold.

Warren County's economy largely relies on recreation and tourism, medical device development and manufacturing, insurance, information management, business support services and financial services. Warren County is also an important healthcare provider for the southern Adirondack region. GFH is the area's largest employer with 2500 employees. In 2018, Glens Falls Hospital continued to invest in the community through employee salaries and benefits, community benefit, charity care and capital investments:

- $183 million in employee salaries, wages and benefits
- $29 million in community benefit and charity care to ensure all patients have access to critical healthcare services regardless of their ability to pay.
- More than $20 million in capital improvements to our facilities which helps create local jobs and strengthen our local economy.

GFH, along with many other local and community-based health care providers in the county, contribute to the several hundred ancillary jobs that are dependent on these providers of health care services in the North Country.

Washington County[11]

Washington County is largely rural in nature, with commercial and industrial development in and around nine villages. While over 1/3 of the county's land is agricultural, manufacturing maintains a predominant role in the economy, as does agri-manufacturing, along with tourism becoming a viable industry. Agriculture is a strong economic driver for the county and supports hundreds of local businesses ranging from farms to service providers and retail shops. Washington County is one of New York State's leading dairy counties, with maple syrup and apples being important cash crops. The economic importance of agriculture in the county is over $200 million annually, which includes numerous ancillary businesses. The county is also home to manufacturers of medical instruments, paper making machinery, paper products, furniture and electronic components. Numerous slate quarries are in the northeastern part of the county. Both residents and tourists alike take advantage of numerous recreational opportunities, including downhill and cross country skiing, biking, hiking, fishing, camping, horseback riding, snowmobiling, canoeing, kayaking, rafting, and golfing.

[11] Adapted from the Washington County Economic Development Corporation website, http://www.wcldc.org/906/About-Washington-County-NY

Saratoga County[12]

Saratoga County, made up of 19 towns, 9 villages, and 2 cities, is a thriving business community with fine dining and world-class entertainment. Saratoga Springs is home to the country's oldest thoroughbred race track, which is also the oldest operating sporting venue in the country. In addition to thoroughbred racing, there is harness racing, cross country skiing, downhill skiing, mineral water baths, numerous golf courses, stock car racing, polo, access to tennis, swimming, skating, horseback riding, and sailing, and numerous private country clubs within Saratoga County. There are public parks, trails and many lakes in the County offering public access. The New York City Ballet, The Philadelphia Orchestra, The Chamber Music Society of Lincoln Center, the Freihofer's Saratoga Jazz Festival, Opera Saratoga, and concerts by Live Nation visit the Saratoga Performing Arts Center annually, making it one of America's most prestigious summer festivals. The major companies doing business in Saratoga County include Quad Graphics Inc., State Farm Insurance, Momentive Performance Materials, Target Distribution Center, US Navy-Kesselring Site, Saratoga Hospital, Stewart's Ice Cream, Ace Hardware, Skidmore College and large school districts including Saratoga Springs City School District and Shenendehowa Central School District. GLOBALFOUNDRIES, the largest high-tech economic development project in the country, operates out of the Luther Forest Technology Campus in the Town of Malta and is the largest employer in the county. Amtrak Railways operates a train station in Saratoga Springs, which offers rail service on a daily basis.

Health Care Facilities

There are two hospitals in the three-county area, GFH and Saratoga Hospital. GFH and HHHN are the two largest providers of primary care services in Warren, Washington and northern Saratoga counties. HHHN is a federally-qualified, not-for-profit system of community health centers serving residents and visitors in the upstate New York region.

Warren County

Warren County has one hospital, Glens Falls Hospital, with 391 hospital beds, the majority of which are medical-surgical beds. There are a total of four nursing home facilities, accounting for 399 beds, and four adult care facilities, accounting for 248 beds, with rates per 100,000 of 616.7 and 452.9, respectively. The rate of primary care physicians per 100,000 in Warren County is 153.0 with a total physician rate per 100,000 of 442.5. Warren County consists of 6 health professional shortage areas (HPSAs), three in primary care, one in dental care, and two in mental health.

Washington County

There are total of four nursing home facilities, accounting for 528 beds, and four adult care facilities, accounting for 142 beds, with rates per 100,000 of 849.1 and 403.6, respectively. The rate of primary care physicians per 100,000 in Washington County is 66.4, with a total physician rate per 100,000 of

[12] Adapted from the Saratoga County Economic Development Corporation website, http://saratogaedc.com/saratoga-county, Saratoga Performing Arts Center website, www.spac.org, and Saratoga County website, https://www.saratogacountyny.gov/.

81.4. Washington County consists of 4 HPSAs, one in primary care, one in dental care, and two in mental health.

Saratoga County

Saratoga County has one hospital, Saratoga Hospital, with 171 hospital beds, resulting in a hospital bed rate per 100,000 of 75.5. This rate is significantly lower than the ARHN region (274.2 per 100,000). There are total of three nursing home facilities, accounting for 487 beds, and nine adult care facilities, accounting for 483 beds, with rates per 100,000 of 317.3 and 390.1, respectively. The rate of primary care physicians per 100,000 in Saratoga County is 87.5 with a total physician rate per 100,000 of 179.2.

Educational System

There are 33[13] school districts in Warren, Washington and Saratoga counties, with a total enrollment of approximately 51,200 students. Within Warren County, there are nine school districts, with a total enrollment of 8,880 students. Washington County has 12 school districts, with a total enrollment of 8,655 students and Saratoga County has 12 school districts, with a total enrollment of 33,728 students. In Saratoga County 23% of enrolled students are eligible for free and reduced lunch, with majority eligible for free lunch (87% or 6,646) compared to Warren County where 40% are eligible for free and reduced lunch, with majority eligible for free lunch (91% or 3,158) and Washington County where 48% are eligible for free and reduced lunch, with majority eligible for free lunch (88% or 3,511). The high school dropout rate is 1.0% in Warren County, 4.0% in Washington County and 2.0% in Saratoga County, all higher than the ARHN region (0.8%) and Upstate New York (0.64%). Both Warren and Saratoga Counties are lower than the New York State dropout rate of 3.0%, but Washington County is higher. The student- teacher ratios in both Warren County (11.4 students per teacher) and Washington County (10.8 students per teacher) are comparable to ARHN region but slightly lower than Upstate New York (12.37). There are 13.4 students per teacher in Saratoga County, which is higher than the ARHN region (10.9) and Upstate New York (12.37).

Community Health Needs in Warren, Washington and Saratoga Counties

This section presents a comprehensive overview of the demographics and community health needs for residents of Warren, Washington and Saratoga counties. The information below summarizes the data and information that informed the assessments in each county and for the GFH service area. In general, the information is presented by county because each county conducted independent assessments and thus only looked at the data for their particular geography. However, where applicable, aggregate or average information across the counties is included to demonstrate community health needs for the GFH service area. Each county looked at various aspects of the data to best determine their individual county health issues.

[13] This number includes the Washington-Saratoga-Warren-Hamilton-Essex Board of Cooperative Educational Services (BOCES), which was not included in the 2016-2018 CHNA.

Population and Demographics

The socio-demographic profile for the residents in Warren, Washington and Saratoga counties is shown in the table below.

	County			ARHN	Upstate	NYS
	Saratoga	Warren	Washington	Region*	NYS**	
Square Miles						
Total Square Miles[1]	810.0	867.0	831.2	8,372.2	46,823.75	47,126.4
Population per Square Mile [2]	280.32	74.48	74.35	42.5	239.4	418.9
Population[4]						
Total Population	226,632	64,701	62,183	355,996.0	11,238,156	19,798,228
Percent White, Non-Hispanic	93.2%	96.0%	98.5%	92.8%	79.8%	63.8%
Percent Black, Non-Hispanic	1.7%	1.2%	3.4%	3.3%	9.2%	15.7%
Percent Hispanic/Latino	3.0%	2.4%	2.6%	2.8%	10.9%	18.8%
Percent Asian/Pacific Islander, Non-Hispanic	2.8%	1.1%	0.5%	0.8%	3.9%	8.3%
Percent Alaskan Native/American Indian	0.2%	0.2%	0.2%	1.2%	15.2%	8.7%
Percent Multi-Race/Other	2.0%	1.6%	2.2%	2.3%	16.3%	10.7%
Number Ages 0-4	11,787	2,902	3,051	16,214	616,519	1,176,877
Number Ages 5-14	26,831	6,892	6,845	37,861	1,347,307	2,300,490
Number Ages 15-17	8,830	2,354	2,271	12,630	444,834	725,937
Number Ages 18-64	141,813	39,426	38,982	224,239	6,989,413	12,586,573
Number Ages 65+	37,371	13,127	11,034	64,358	1,840,083	3,008,351
Poverty[3,4]						
Mean Household Income	$96,086	$76,756	$ 65,798	$ 66,618	n/a	$ 93,443
Per Capita Income	$ 39,653	$ 33,127	$ 26,064	$ 27,377	$ 40,926	$ 35,752
Percent of Individuals Under Federal Poverty Level	6.6%	9.9%	12.8%	13.9%	11.7%	15.1%
Percent of Individuals Receiving Medicaid	12.7%	18.8%	25.1%	22.9%	43.1%	24.8%
Education[4]						
Total Population Ages 25 and Older	160,285	47,642	44,765	254,515	7,690,861	13,660,809
Percent with Less than High School Education	6.1%	8.3%	11.6%	11.6%	10.0%	13.9%
Percent High School Graduate/GED	24.8%	32.9%	39.2%	36.0%	28.0%	26.3%
Percent Some College, No Degree	17.1%	18.6%	18.7%	18.9%	17.4%	15.9%
Percent Associate's Degree	11.6%	11.0%	10.7%	11.2%	10.4%	8.7%
Percent Bachelor's Degree	23.3%	15.6%	11.6%	11.9%	18.7%	19.9%
Percent Graduate or Professional Degree	17.0%	13.7%	8.2%	10.4%	15.5%	15.4%
Employment Status[4]						
Percent Unemployed	3.0%	3.0%	3.9%	3.7%	3.8%	4.3%

*ARHN Region excludes Saratoga and Montgomery counties

**Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond)

(n/a) Data Not Available

Sources:

(1) US Department of Agriculture, National Agriculture Statistics Service, 2012

(2) NYS Department of Health, Vital Statistics of New York State 2016

(3) Centers for Medicare and Medicaid Services, CMS Enterprise Portal

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

Over 350,000 people live within Warren, Washington and Saratoga counties. On average, the vast majority of the population is white, non-Hispanic (95.9%) and just over one in four people has obtained a Bachelor's degree or higher level of education (29.8%).

Warren County

Warren County's population is 64,701, making it the second most populated county in the ARHN region. Similar to the rest of Upstate New York, Warren County's population is very limited in its diversity, over 96% are White/non-Hispanics, followed by 1.2% Black/African American, non-Hispanics and 2.4% Hispanic/Latinos. Over 20% of the population is 65 years of age and older, which is slightly higher than the ARHN region (18.0%) and higher than Upstate New York (16.37%).

Household income on average is $76,756, with per capita income at $33,127, which is lower than that of New York State, $93,443 and $35,752 respectively. The percentage of individuals in Warren County living below the Federal Poverty Level is 9.9%, which is lower than the ARHN (13.9%) region and Upstate New York (11.7%). In Warren County, the unemployment rate is 3.0%.

Of the total population in Warren County, approximately 32.9% of individuals 25 years of age and older have a high school diploma or equivalent, and another 40.3% have an Associates or bachelor's degree or higher. Sixty three percent of the population 16 and older is in the workforce, with the highest percentage of individuals in the field of education (26.6%), followed by retail trade (13.3%), arts, entertainment, recreation, hotel & food service (12.7%), and manufacturing (8.4%).

Washington County

Washington County's population is 62,183. Similar to the rest of Upstate New York, Washington County's population is very limited in its diversity, over 93% are White/non-Hispanics, followed by 3.4% Black/African American, non-Hispanics and 2.6% Hispanic/Latinos. Over 17% of the population is 65 years of age and older, which is slightly lower than the ARHN region (18.0%) yet higher than Upstate New York (16.37%).

Household income on average is $65,798, with per capita income at $26,064, which is much lower than that of New York State, $93,443 and $35,752 respectively. The percentage of individuals in Washington County living below the Federal Poverty Level is 12.8%, which is lower than the ARHN (13.9%) region and higher than Upstate New York (11.7%). In Washington County, the unemployment rate is 3.9%.

Of the total population in Washington County, approximately 39.2% of individuals 25 years of age and older have a high school diploma or equivalent, and another 30.5% have an Associates or bachelor's degree or higher. Sixty percent of the population 16 and older is in the workforce, with the highest percentage of individuals in the field of education (23.0%), followed by retail trade (14.3%), manufacturing (14.0%), and arts, entertainment, recreation, hotel & food service (7.8%).

Saratoga County

Saratoga County's population is 226,632. Similar to the rest of Upstate New York, Saratoga County's population is very limited in its diversity, over 93% are White/non-Hispanics, followed by 1.7% Black/African American, non-Hispanics and 3.0% Hispanic/Latinos. Over 16% of the population is 65

years of age and older, which is slightly lower than the ARHN region (18.0%) and Upstate New York (16.37%).

Household income on average is $96,086, with per capita income at $39,653, which is higher than that of New York State, $93,443 and $35,752 respectively. The percentage of individuals in Saratoga County living below the Federal Poverty Level is 6.6%, which is lower than the ARHN (13.9%) region and Upstate New York (11.7%). In Saratoga County, the unemployment rate is 3.0%.

Of the total population in Saratoga County, approximately 24.8% of individuals 25 years of age and older have a high school diploma or equivalent, and another 51.9% have an Associates or bachelor's degree or higher. Sixty seven percent of the population 16 and older is in the workforce, with the highest percentage of individuals in the field of education (25.1%), followed by retail trade (12.1%), other professional occupations (11.9%), and manufacturing (10.5%).

New York State Prevention Agenda Priority Areas

The NYS Prevention Agenda is used as a framework to discuss the community health needs related to each identified priority area. In general, each county reviewed available data to assess each priority area to determine the most significant health needs for the individuals and communities within the counties. For more information on the Priority Areas and corresponding Focus Areas, please see the Action Plans, available at: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/index.htm. See Appendix H for a table of the NYS Prevention Agenda indicators and other indicators for Warren, Washington and Saratoga counties.

Prevent Chronic Diseases

Chronic diseases such as cancer, diabetes, heart disease, stroke, asthma and arthritis are among the leading causes of death, disability and rising health care costs in New York State. However, chronic diseases are also among the most preventable. See Appendix I for the leading cause of premature death by County. The top two for all of Warren, Washington, Saratoga counties as well as New York State as a whole are chronic diseases, cancer and heart disease. Three modifiable risk behaviors - unhealthy eating, lack of physical activity, and tobacco use - are largely responsible for the incidence, severity and adverse outcomes of chronic disease. As such, improving nutrition and food security, increasing physical activity, and preventing tobacco use form the core of the Preventing Chronic Diseases Action Plan. The plan also emphasizes the importance of preventive care and management for chronic diseases, such as screening for cancer, diabetes, and high blood pressure; promoting evidence-based chronic disease management; and improving self-management skills for individuals with chronic diseases.[14] The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Note: In the summaries that follow, all rates are per 100,000 unless otherwise noted.

[14] Adapted from the Preventing Chronic Diseases Action Plan for the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/chr.htm

Warren County

The percentages of adults (29.2%) and children who are obese (19.5%) in Warren County is higher than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. Additionally, the percentage of obesity in elementary school children (18.4%) is higher than Upstate New York (16.0%). In Warren County, the burden of obesity may contribute to higher rates of diabetes death (35.0) than Upstate New York (15.4) and higher rates of hospitalization per 10,000 due to diabetes, any diagnosis, (267.5) than in Upstate New York (237.2).

Smoking and smoking-related diseases seems to pose a significant challenge for Warren County, with seven of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Warren County (23.2%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Benchmark of 12.3%. In Warren County, the rate of chronic lower respiratory deaths (87.5) is higher than in Upstate New York (45.4) and the state as a whole (34.1). Similarly, in Warren County the rate of chronic lower respiratory hospitalizations per 10,000 (36.2) is higher than in Upstate New York (28.0) and the state as a whole (30.6). The percentage of adults with asthma in Warren County (10.4%) is slightly lower, in comparison to the ARHN region (12.0%), but higher than Upstate New York (10.1%), and New York State (9.5%).

The rates of lung and bronchus cancer cases are higher in Warren County (129.5) than in the ARHN region (112.2), Upstate New York (84.3), and New York State (69.7), and lung and bronchus cancer deaths in Warren County (68.9) are higher than the ARHN region (67.4), Upstate New York (53.0) and New York State (43.5). The rate of colon and rectal cancer cases and deaths in Warren County (61.2 and 21.6) is slightly higher than the ARHN region (55.0 and 18.9). The percentage of colorectal screenings for those 50 to 75 years of age in Warren County (75.1%) is higher than the ARHN region (73.6%), Upstate New York (68.5%), and New York State (69.7%).

Washington County

The percentages of adults (40.2%) and children who are obese (21.1%) in Washington County are higher than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. Additionally, the percentage of obesity in elementary school children (18.4%) is higher than Upstate New York (16.0%). In Washington County, the burden of obesity may contribute to higher rates of diabetes death (32.7) than Upstate New York (15.4) and higher rates of hospitalization per 10,000 due to diabetes, any diagnosis, (265.4) than in Upstate New York and (237.2).

Smoking and smoking-related diseases seems to pose a significant challenge for Washington County, with seven of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Washington County (22.3%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Benchmark of 12.3%. In Washington County, chronic lower respiratory deaths are higher (78.3) than in Upstate New York (45.4) and the state as a whole (34.1). Similarly, in Washington County the rates of chronic lower respiratory hospitalizations per 10,000 (40.3) are higher than in Upstate New York (28.0) and the state as a whole (30.6). The

percentage of adults with asthma in Washington County (9.3%) is slightly lower, in comparison to the ARHN region (12.0%), Upstate New York (10.1%), and New York State (9.5%).

The rates of lung and bronchus cancer cases are lower in Washington County (102.4) than in the ARHN region (112.2), but higher than Upstate New York (84.3) and New York State (69.7), and lung and bronchus cancer deaths in Washington County (67.2) are comparable to the ARHN region (67.4), and higher than Upstate New York (53.0) and New York State (43.5). The rate of colon and rectal cancer cases and deaths in Washington County (56.5 and 18.7) is comparable to those of the ARHN region (55.0 and 18.9). The percentage of colorectal screenings for those 50 to 75 years of age in Washington County (69.0%) is lower than the ARHN region (73.6%), and in line with Upstate New York (68.5%), and New York State (69.7%).

Saratoga County

The percentages of adults (27.0%) is higher and children who are obese (14.0%) is lower in Saratoga County than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. Additionally, the percentage of obesity in elementary school children (13.0%) is lower than Upstate New York (16.0%). The burden of obesity may contribute to higher rates of death due to diabetes (any diagnosis) in Saratoga County (17.8) than in Upstate New York (15.4).

Smoking and smoking-related diseases seems to pose a significant challenge for Saratoga County, with seven of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Saratoga County (16.5%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Benchmark of 12.3%. Chronic lower respiratory deaths rates are higher in Saratoga County (47.9) than in Upstate New York (45.4) and the state as a whole (34.1). The percentage of adults with asthma in Saratoga County (14.6%) is higher, in comparison to the ARHN region (12.0%), Upstate New York (10.1%), and New York State (9.5%).

The rates of lung and bronchus cancer cases are lower in Saratoga County (92.4) than in the ARHN region (112.2), but higher than Upstate New York (84.3) and New York State (69.7), and lung and bronchus cancer deaths in Saratoga County (62.8), slightly lower than the ARHN region (67.4), and higher than Upstate New York (53.0) and New York State (43.5). The rate of colon and rectal cancer cases and deaths in Saratoga County (46.7 and 16.4) is slightly lower than the ARHN region (55.0 and 18.9). The percentage of colorectal screenings for those 50 to 75 years of age in Saratoga County (75.6%) is higher than the ARHN region (73.6%), Upstate New York (68.5%), and New York State (69.7%).

Warren, Washington, Saratoga County Tobacco Survey

The results of the Warren, Washington and Saratoga County Tobacco assessment can also inform the community health needs related to chronic disease prevention and the potential for policy and environmental changes related to smoking cessation as a prevention measure. Highlights from the results of the survey are summarized below:

- Most residents think that tobacco should not be sold in stores that are located near schools (Saratoga 67%, Warren 65%, Washington 64%)

- Most residents are in favor of a policy that would prohibit smoking in entrance ways of public buildings and workplaces (Saratoga 74%, Warren 74%, Washington 64%)
- Most residents are in favor of policies that prohibit smoking in apartment buildings and other multi-unit complexes (Saratoga 69%, Warren 62%, Washington 61%)
- Most residents are in favor of a policy that would prohibit the use of e-cigarettes in all work places, including bars and restaurants (Saratoga 63%, Warren 57%, Washington 60%)
- Most residents think that teen smoking is a significant problem in their community (Saratoga 71%, Warren 69%, Washington 70%)

Additionally, New York State conducts annual tobacco surveys targeting both youth and adults. The results of the New York State Youth Tobacco Survey [15]show that emerging products in the tobacco landscape threaten to undo the substantial progress made in youth initiation. Cigarette smoking among high school youth declined by 82% between 2000 and 2018. From 2016 to 2018 the rate increased from 4.3% to 4.8%, the first increase in combustible cigarette use among youth in NYS since 2000. In contrast, use of e-cigarettes among high school youth continues to rise. Between 2014 and 2018, the rate increased fully 160%, from 10.5% to 27.4%. E-cigarettes remain the most commonly used tobacco product among youth surpassing cigarettes, cigars, smokeless tobacco, and hookah.

The results of the New York Adult Tobacco Survey (ATS)[16] show the continued downward trend in the prevalence of adult tobacco use in New York State. However, it highlights populations that continue to smoke at higher rates than the general population. This report also shows where additional resources should be allocated in an effort to further reduce adult smoking prevalence.

Highlights from the results of the ATS are summarized below:

- Percentage of NY Adults with Poor Mental Health Who Currently Smoke: 27.7% (State rate 14.2%)
- Percentage of NY Adults with Less Than a High School Diploma Who Currently Smoke: (21.5%)
- Percentage of NY Adults whose income is less than $25,000 who currently smoke: (20.4%)
- Percentage of Adult Smokers who made a Quit Attempt in the past 12 months: 62.8%

Percentage of Adult Smokers who report that their health care provider assisted them in smoking cessation in the past 12 months: 53.3%

[15] Based on methods developed by CDC, the New York State Youth Tobacco Survey (NYS-YTS) is a school-based survey of a representative sample of high school students in NYS. The average sample size of high school students in the NYS - YTS, for all years excluding 2008, is 4,286. In 2008, a special study was conducted and the sample was increased to 23,133. The NYS-YTS monitors the use of tobacco products available to and used by youth. Cigarettes, cigars, and smokeless tobacco have been monitored since 2000, while products such as hookah (2008) and e-cigarettes (2014) were added to the NYS-YTS as they gained popularity.

[16] The Adult Tobacco Survey (ATS) was developed by the New York Tobacco Control Program (NY TCP) in partnership with RTI International, the independent evaluator for the NY TCP. The survey has been fielded continually since June 2003 to the non-institutionalized adult population of New York State, aged 18 years or older.

Cancer Incidence in Warren County

The Warren County Cancer Incidence Report provides an extremely comprehensive overview of the findings, limitations, conclusions and recommendations for cancer patterns and trends in Warren County.[17]

The following is an excerpt of the key conclusions from the report[18]:

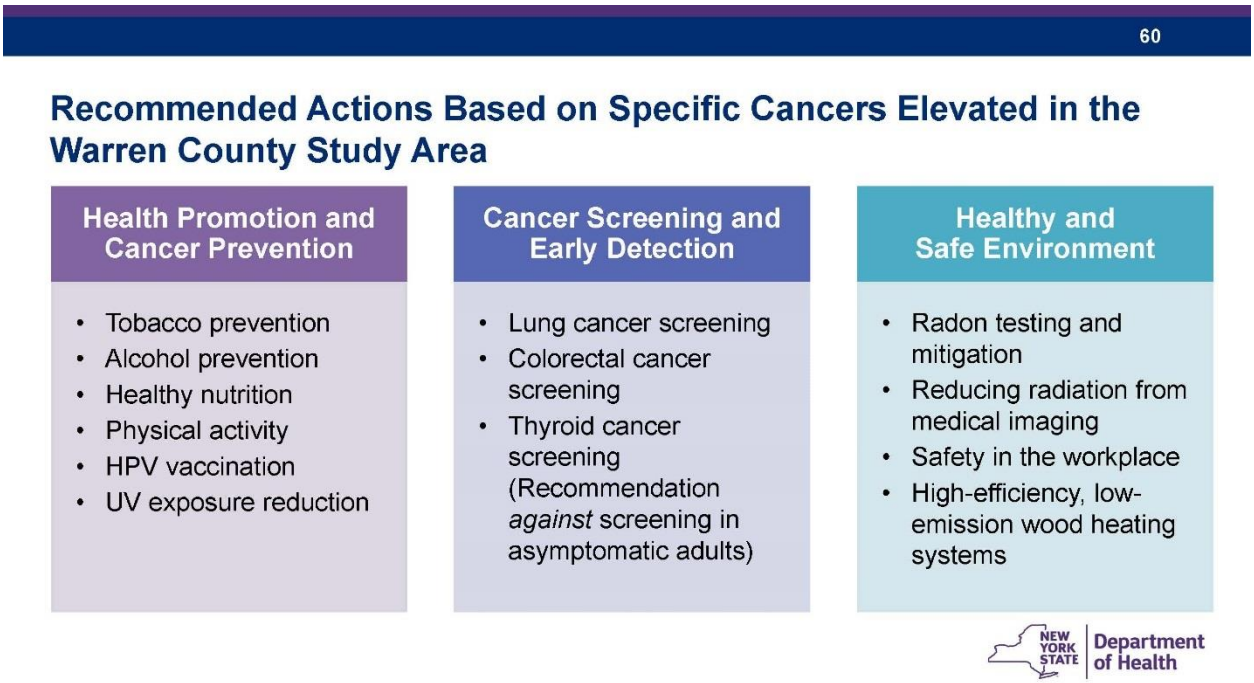
- Environmental factors evaluated in this study, including levels of radon in indoor air, environmental contaminants in outdoor air, contaminants in drinking water, industrial and inactive hazardous waste disposal sites, and proximity to traffic do not stand out from those in other parts of NYS excluding NYC.
- It is likely that a higher proportion of current and former tobacco use contributed to the elevated rates of lung, laryngeal, esophageal, and oral cancers in Warren County. The elevations in the rates for these cancers were more often observed in men.
- Alcohol consumption, independently or through a synergetic effect with tobacco use, might have contributed to the excess of oral, esophageal, and laryngeal cancers in Warren County, particularly among men.
- HPV infection may have contributed to the oral cancer excess.
- Most of the elevation in thyroid cancer incidence among women in Warren County is likely due to increased detection of small papillary tumors by medical imaging and other diagnostic techniques.
- The higher proportion of overweight or obese women in Warren County may have contributed to the excess in female thyroid cancer incidence as well as to the excess in female colorectal cancer incidence.
- The excess in leukemia rates among women in Warren County may represent a time-limited anomaly. DOH will continue to monitor.
- The investigation found no factors that might account for the elevated incidence of cancers of the brain and other nervous system in Warren County. DOH will continue to monitor.

The following recommendations were offered, as a result of the analysis[19]:

[17] Governor's Cancer Research Initiative – Final Report: Cancer Incidence Report for the Warren County Study Area, October 2019, available at https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/

[18] Governor's Cancer Research Initiative – Warren County Cancer Incidence Investigation, October 2019, Presented at SUNY Adirondack Community College on November 7, 2019, Available at https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/

[19] Governor's Cancer Research Initiative – Warren County Cancer Incidence Investigation, October 2019, Presented at SUNY Adirondack Community College on November 7, 2019, Available at https://www.health.ny.gov/diseases/cancer/cancer_research_initiative/



Opportunities exist to reduce the cancer burden within the GFH service area. Cancer risk can be reduced by avoiding tobacco, protecting skin, limiting alcohol use, maintaining a healthy weight, getting screened regularly, and seeking regular medical care. Ensuring guideline concordant vaccines, such as HPV and Hepatitis B, can also reduce the risk of certain cancers. [20]

Promote a Healthy and Safe Environment

The 2019-2024 State Health Improvement Plan to "Promote a Healthy and Safe Environment" in New York State focuses on five core areas that impact health. These are: the quality of the water we drink and enjoy for recreation; the air we breathe; the food and products we ingest and use; the built environments where we live, work, learn and play; as well as injuries, violence and occupational health. "Environment," as used here, incorporates all dimensions of the physical environment that impact health and safety.[21]

In general, water quality and outdoor air quality are not significant issues in Warren, Washington and northern Saratoga counties. While certain indicators for the built environment focus area are below the Prevention Agenda benchmarks, issues such as climate smart communities are beyond the capacity and scope of expertise of the healthcare sector. Efforts to address these focus areas are better lead by policymakers, elected officials and other community stakeholders, through collaboration with and support of the healthcare sector. Consequently, the following outlines the status of injuries and violence in Warren, Washington and Saratoga counties:

[20] Centers for Disease Control and Prevention, Division of Cancer Prevention and Control website, December 2019, https://www.cdc.gov/cancer/dcpc/about/.
[21] Adapted from the Promote a Healthy and Safe Environment Action Plan for the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/env.htm

Note: In the summaries that follow, all rates are per 100,000 unless otherwise noted.

Warren County

Motor vehicle accidents are higher in Warren County while speed-related accidents are lower in Warren County (2,735.1 and 282.0 respectively) than in the ARHN region (2,162.0 and 364.7). Additionally, the rate of motor vehicle accident deaths is higher in Warren County (9.3) than the ARHN region (7.3), Upstate New York (7.1) and the state as a whole (5.0). The rate of violent crimes (165.8) is lower than the ARHN region (171.8) and significantly lower than that of Upstate New York (214.9) and New York State (355.6).

Washington County

Motor vehicle accidents and speed-related accidents are lower in Washington County (1,695.9 and 266.2 respectively) than in the ARHN region (2,162.0 and 364.7). Additionally, the rate of motor vehicle accident deaths is lower in Washington County (4.9) than the ARHN region (7.3), Upstate New York (7.1) and the state as a whole (5.0). The rate of violent crimes (124.8) is significantly lower than the ARHN region (171.8), Upstate New York (214.9) and New York State (355.6).

Saratoga County

Motor vehicle accidents and speed-related accidents are lower in Saratoga County (2,041.6 and 224.9 respectively) than in the ARHN region (2,162.0 and 364.7). Additionally, the rate of motor vehicle accident deaths is higher in Saratoga County (7.8) than the ARHN region (7.3), Upstate New York (7.1) and the state as a whole (5.0). The rate of violent crimes (122.0) is lower than the ARHN region (171.8), Upstate New York (214.9) and New York State (355.6).

Promote Healthy Women, Infants and Children

The health of women, infants, children, and their families is fundamental to population health. This Prevention Agenda priority aligns directly with the Maternal and Child Health Services Block Grant (Title V) Program, the core federal and state public health program for promoting the health and well-being of the nation's mothers, infants, and children, including children and youth with special health care needs, and their families.

The Prevention Agenda goals, objectives, and interventions for Healthy Women, Infants, and Children were drawn from the state's Title V plan, with special consideration for those areas that would benefit from enhanced local action and cross-sector collaboration, and for which local data are available to track progress across the state. Mirroring NY's Title V action plan, the Prevention Agenda Healthy Women, Infants, and Children (HWIC) priority focuses on health outcomes in three focus areas: Maternal and Women's Health, Perinatal and Infant Health, and Child and Adolescent Health, including children with special health care needs. In addition, the HWIC plan includes a fourth cross-cutting focus area on social determinants of health and health equity, intended to address the entire MCH life course.[22]

[22] Adapted from the Promote Healthy Women, Infants, and Children Action Plan for the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/hwic.htm

There are 22 indicators for this particular Priority Area, so only the most significant information is highlighted to demonstrate need. The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Warren County

The percentage of births within 24 months of previous pregnancies in Warren County (22.0%) is higher than the Prevention Agenda Benchmark of 17.0%, as is the percentage of unintended pregnancies in Warren County (33.2%), with the Prevention Agenda Benchmark being 23.8%.

The percentages of women receiving WIC in Warren County with either gestational weight gain greater than ideal is worse than the ARHN region, Upstate New York, and New York State. The percentage of pre-pregnancy obesity (32.9%) is lower than that of the ARHN region (33.3%) and higher than that of Upstate New York (28.0%).

Washington County

The percentage of births within 24 months of previous pregnancies in Washington County (22.5%) is higher than the Prevention Agenda Benchmark of 17.0%, as is the percentage of unintended pregnancies in Washington County (39.1%), with the Prevention Agenda Benchmark being 23.8%.

The percentage of women receiving WIC in Washington County with either gestational weight gain greater than ideal is worse than the ARHN region. The percentage of pre-pregnancy obesity (31.7%) is lower than that of the ARHN region (33.3%) and higher than that of Upstate New York (28.0%).

Saratoga County

The percentage of births within 24 months of previous pregnancies in Saratoga County (21.1%) is higher than the Prevention Agenda Benchmark of 17.0%, while the percentage of unintended pregnancies in Saratoga County (20.1%) is lower than the Prevention Agenda Benchmark (23.8%).

The percentage of women receiving WIC in Saratoga County with either gestational weight gain greater than ideal is worse than the ARHN region. The percentage of pre-pregnancy obesity (34.5%) is higher than that of the ARHN region (33.3%) and Upstate New York (28.0%).

Promote Well-being and Prevent Mental and Substance Abuse Disorders

Mental and emotional well-being is essential to overall health. At any given time, almost one in five young people nationally are affected by mental, emotional and behavioral (MEB) disorders, including conduct disorders, depression and substance abuse. Adverse Childhood Experiences and many MEB disorders, such as substance abuse and depression, have lifelong effects that include high psychosocial and economic costs for people, their families, schools and communities. Mental and physical health problems are interwoven. Improvements in mental health help improve individuals and populations' physical health. The two Focus Areas for this Priority Area are: Promote Well-Being and Mental and

Substance Use Disorder Prevention.[23] The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Note: In the summaries that follow, all rates are per 100,000 unless otherwise noted.

Warren County

The percentage of adults in Warren County who binge drink (20.9%) is higher than the Prevention Agenda Benchmark (18.4%) and the percentage who reported 14 or more poor mental health days within the last month (12.0%) is higher than the Prevention Agenda Benchmarks of 10.1%. The rate of self-inflicted hospitalizations per 10,000 in Warren County (5.9) is higher than in Upstate New York (4.1). The rate of alcohol-related crashes in Warren County (82.1) is significantly higher than New York State (38.0).

Among 15 to 19-year old's, the 2016 Community Health Indicator Reports listed the rate of suicides at 9.3, which is lower than the ARHN region (10.7) and higher than Upstate New York (6.1).

Washington County

The percentage of adults in Washington County who binge drink (21.7%) is higher than the Prevention Agenda Benchmark (18.4%) and the percentage who reported 14 or more poor mental health days within the last month (13.1%) is higher than the Prevention Agenda Benchmarks of 10.1%. The rate of self-inflicted hospitalizations per 10,000 in Washington County (7.6) is higher than in Upstate New York (4.1). The rate of alcohol-related crashes in Washington County (71.4) is significantly higher than New York State (38.0).

Among 15 to 19-year old's, the 2016 Community Health Indicator Reports listed the rate of suicides at 9.2, which is lower than the ARHN region (10.7) and higher than Upstate New York (6.1).

Saratoga County

The percentage of adults in Saratoga County who binge drink (24.0%) is higher than the Prevention Agenda Benchmark (18.4%) and the percentage who reported 14 or more poor mental health days within the last month (9.9%) is lower than the Prevention Agenda Benchmarks of 10.1%. The rate of self-inflicted hospitalizations per 10,000 in Saratoga County (3.7) is lower than in Upstate New York (4.1). The rate of alcohol-related crashes in Saratoga County (77.0) is significantly higher than New York State (38.0).

Among those 15 to 19-year old's, the 2016 Community Health Indicator Reports listed the rate of suicides at 11.7, which is slightly higher than the ARHN region (10.7) and higher than Upstate New York (6.1).

Prevent Communicable Diseases

[23] Adapted from the Promote Well-Being and Prevent Mental and Substance Use Disorders Action Plan for the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/wb.htm

A communicable disease is an illness or infection that can be spread from person to person, animal to person, animal to animal or person to animal. Communicable diseases contribute to sickness and death in New York State and are preventable.

The reduction of vaccine-preventable diseases is an extremely important public health goal achieved through immunization. Although vaccine-preventable disease rates are low in NYS and in the United States, the prevalence of certain diseases is beginning to increase due to pockets of underimmunization and global travel.

HIV/AIDS and sexually transmitted infections continue to be significant public health concerns. NYS remains at the epicenter of the HIV epidemic in the United States, with more people living with HIV/AIDS than in any other state.

Antibiotic resistance, part of a broader threat called antimicrobial resistance, occurs when antibiotics no longer work against bacteria that cause infections. Antibiotics can be lifesaving, but bacteria are becoming more resistant to treatment. Antimicrobial resistance has been found in all regions of the world, and newly discovered strains continue to emerge and spread. Factors such as increased globalization, poor infection control in hospitals and clinics, overprescribing of antibiotics, and unnecessary antibiotic use in agriculture are increasing the global threat. Infections acquired in the healthcare setting, both those with or without resistance, can lead to significant illness and death.

The Prevent Communicable Disease Action plan contains five focus areas: vaccine preventable diseases, Human Immunodeficiency Virus (HIV), Sexually Transmitted Infections (STIs), Hepatitis C Virus (HCV), and Antibiotic Resistance and Healthcare-Associated Infections.[24] The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Note: In the summaries that follow, all rates are per 100,000 unless otherwise noted.

Warren County

The immunization rate for children ages 19 – 35 months with the recommended 4:3:1:3:3:1:4 immunization series (77.9%) is lower than the Prevention Agenda benchmark (80.0%) and the percentage of females 13 to 17 with three dose HPV vaccine (47.2%) is lower than the Prevention Agenda benchmark of 50.0%. The rate of Pertussis cases in Warren County (0.5) is significantly lower than the ARHN region (11.7), Upstate New York (5.9) and New York State (5.1). The rate of pneumonia/flu hospitalizations for those 65 years of age or older per 10,000 is higher in Warren County (99.7) than in ARHN region (93.3), Upstate New York (93.7), and the state as a whole (87.3). The Rate of Community Onset, Healthcare Facility Associated Clostridium difficile infections (CDIs) per 10,000 Patient Days (7.8) is significantly higher than the NYS Prevention Agenda benchmark of 2.05.

[24] Adapted from the Prevent Communicable Diseases Action Plan of the NYS Prevention Agenda, available at https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/comm.htm#FA5.

Washington County

The immunization rate for children ages 19 – 35 months with the recommended 4:3:1:3:3:1:4 immunization series (76.2%) is lower than the Prevention Agenda benchmark (80.0%) and the percentage of females 13 to 17 with three dose HPV vaccine (42.9%) is lower than the Prevention Agenda benchmark of 50.0%. The rate of Pertussis cases in Washington County (1.1) is significantly lower than the ARHN region (11.7), Upstate New York (5.9) and New York State (5.1). The rate of pneumonia/flu hospitalizations for those 65 years of age or older per 10,000 is lower in Washington County (82.9) than in ARHN region (93.3), Upstate New York (93.7), and the state as a whole (87.3).

Saratoga County

The immunization rate for children ages 19 – 35 months with the recommended 4:3:1:3:3:1:4 immunization series (78.4%) is lower than the Prevention Agenda benchmark (80.0%) and the percentage of females 13 to 17 with three dose HPV vaccine (47.2%) is lower than the Prevention Agenda benchmark of 50.0%. The rate of Pertussis cases in Saratoga County (3.1) is significantly lower than the ARHN region (11.7), Upstate New York (5.9) and New York State (5.1). The rate of pneumonia/flu hospitalizations for those 65 years of age or older per 10,000 is similar in Saratoga County (93.7) to that of the ARHN region (93.3) and Upstate New York (93.7), but higher than the state as a whole (87.3). The Rate of Community Onset, Healthcare Facility Associated Clostridium difficile infections (CDIs) per 10,000 Patient Days (2.7) is higher than the NYS Prevention Agenda benchmark of 2.05.

Health Disparities

Improving health status in the five priority areas and reducing racial, ethnic, socioeconomic and other health disparities including those among persons with disabilities is an overarching goal of the NYS Prevention Agenda. The National Institutes of Health defines health disparities as the differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. Populations can be defined by factors such as race or ethnicity, gender, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation. Health disparities are inequitable and are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources. Health disparities result from multiple factors, including poverty, environmental threats, inadequate access to health care, individual and behavioral factors, and educational inequalities. [25]

Warren, Washington and Saratoga counties are predominately White and do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations in upstate New York face a unique combination of factors that create health disparities, which are often rooted in the social determinants of health. The social determinants of health are the circumstances in

[25] Adapted from the Centers for Disease Control and Prevention, Adolescent and School Health, Health Disparities website, https://www.cdc.gov/healthyyouth/disparities/index.htm.

which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness.[26] These factors are often associated with many different types of barriers to care.

Economic factors, cultural and social differences, educational shortcomings, and the isolation of living in a rural area all conspire to repress our population in their struggle to lead a healthy life. Many sections of the GFH service area face significant distance and transportation barriers to accessing community resources, service opportunities, and health care. These communities are traditionally underserved by most assistance programs; thereby creating health disparities among the people living and working in this area.

Limited data publicly exists to demonstrate non-racial or non-ethnic related health disparities in Warren, Washington and northern Saratoga counties. Household income and educational attainment highlight common health disparities within the GFH service area. In Warren and Washington counties, the mean household income is $76,756 and $65,798 respectively, compared to the NYS average of $93,443. Additionally, the percent of individuals living below the Federal Poverty Level is higher in Washington County (12.8%) as compared to Upstate NY (11.7%). Another notable factor is the relatively low level of achievement in higher education in both Warren and Washington Counties, where only 40.3% (Warren) and 30.5% (Washington) of the population age 25 and older has an Associate's, Bachelor's, or Graduate/Professional degree, compared to 44% of the NYS population. The relationship between socioeconomic status and better health outcomes is well established, leaving this geographic region at a disadvantage.

Additional barriers to care that result in health disparities can be attributed to health care provider shortages in the area – Warren County has six HPSA shortage areas, 3 primary care, 1 dental care, 2 mental health, while Washington County has four, 1 primary care, 1 dental care, and 2 mental health. Additional data shows the rate of primary care providers per 100,000 residents in both Washington County (66.4) and Saratoga County (87.5) to be substantially lower than both Upstate NY (102.8) and NYS as a whole (124.1).

Data from the NYS Prevention Agenda utilizes indicators related to premature death, preventable hospitalizations, insurance status and access to care (through % of adults with a regular health care provider) highlights additional items related to health disparities. The following table outlines the status of these indicators for Warren, Washington and Saratoga counties:

[26] Adapted from the Centers for Disease Control and Prevention, Social Determinants of Health website, http://www.cdc.gov/socialdeterminants/

Prevention Agenda Indicators: Disparities

	Warren	Washington	Saratoga	Comparison Regions/Data			
				ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark
1. Percentage of Overall Premature Deaths (before age 65 years), 2016	21.5%	23.7%	22.3%	22.8%	22.4%	24.0%	**21.8%**
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16	2.21+	2.97+	1.80	1.69	2.05	1.95	**1.87**
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16	1.6+	1.36+	1.70	2.12	2.16	1.87	**1.86**
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016	156.6	153.2	115.3	N/A	116.80	124.00	**122.0**
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016	0.84+	0.55+	0.99	N/A	2.04	2.07	**1.85**
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016	0.72+	0.66+	0.44+	N/A	1.27	1.28	**1.38**
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016	94.1%	93.5%	94.9%	N/A	N/A	91.4%	**100.0%**
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016	82.9%	94.2%	88.0%	N/A	84.4%	82.6%	**90.8%**
N/A = insufficient data is available to report on this indicator							

Indicators for Warren, Washington and Saratoga counties reveal limited health disparities as defined by the NYS Prevention Agenda. As demonstrated above, often times there is insufficient data to report on racial and ethnic disparities. With respect to the benchmarks, the areas where there is room for improvement within the GFH service area include overall premature death in Saratoga and Washington counties, the rate of black, non-Hispanic premature deaths to white, non-Hispanic premature deaths in Warren and Washington counties and the rate of age-adjusted preventable hospitalizations per 10,000 population among those 18 years of age and older in Warren and Washington counties. Opportunities to improve these statistics may lie within the number of adults with a regular health care provider, as all both Warren and Saratoga counties fall below the Prevention Agenda benchmark. Lastly, all three counties are below the benchmark for health insurance coverage. These indicators can provide initial information about potential problems in a community that may require further, more in-depth analysis.

Cancer Burden and Disparities in Warren, Washington and Saratoga Counties

Data demonstrating many of the health behaviors that reduce the risk of cancer is described throughout this report. However, certain populations are disproportionately affected by the burden of cancer, and these populations are faced with many of the same challenges described above. These challenges often result in lower screening rates, and higher rates of cancer incidence and mortality.

The sociodemographic makeup of Warren, Washington and Saratoga counties more closely resembles that of NYS excluding NYC, than that of NYS. However, the lack of racial and ethnic diversity, as well as the low prevalence of foreign nativity, distinguishes the counties from NYS excluding NYC. In general, there are very limited racial or ethnic disparities in the region. In Warren, Washington and Saratoga counties, cancer-related disparities exist based on geography, gender, income status and access/transportation.

Geographic disparities are most notable when comparing incidence rates in each of the counties for certain types of cancers. In general, based on data from 2012-2016, Warren County has the highest rates of cancer across the region, and many times, compared to all counties in New York State. In Warren County, the rate for colorectal cancer is 40.2 per 100,000 in for both males and females, compared with 33.0 per 100,000 cases in Washington and 39.4 per 100,000 in Saratoga County. The rates in both Warren and Saratoga counties are higher than the New York State rate for colorectal cancer, which is 38.9 per 100,000. Similarly, the rate for lung and bronchus cancer in Warren County is 81.2 per 100,000 for both males and females, compared with 74.6 per 100,000 for Washington County and 72.2 per 100,000 for Saratoga County. All three counties have a higher rate than New York State, which is 58.9 per 100,000 for males and females. For all invasive malignant tumors, Warren County has the highest incidence rate at 55.4 per 100,00 for males and females, and the highest mortality rate of 179.9 per 100,000 for males and females. This compares to the New York State incidence rate of 482.9 per 100,000 for males and females, and 148.8 per 100,000 for mortality.27 For many of these types of cancer, screening can prevent the disease, or help find cancers at an early stage, when they are more easily cured or treated.

With respect to gender-related disparities, numerous differences between cancer incidence rates among men compared to women have been highlighted above. Income-related disparities are often most visible when understanding access to care. Access to care and transportation in our highly rural service area is also an issue for many residents. In looking at GFH's C.R. Wood Cancer Center data for the period 2007-2016, more than half (51%) of patients diagnosed traveled more than 10 miles for service and 24% of those traveled more than 25 miles. At the same time, the availability of public transportation in the region is limited, coupled with difficult driving conditions in the long winter months in Upstate New York.

[27] New York State Department of Health, New York State Cancer Registry. Cancer Incidence and Mortality by County and Gender, 2012 - 2016

There is a strong link between tobacco use and cancer, and smoking rates are higher in Warren (23.2%), Washington (22.3%) and Saratoga counties (16.5%), as well as most upstate NY counties, than the New York State rate of 14.2%. Current smoking rates in NYS vary by county from 7.0% to 29.0%.[28] While there has been a decline in the rate of tobacco use among both children and adults in NYS (and equally across all ethnic groups), smoking rates have not declined for the poor and less educated, which are significant issues in the GFH service area. This highlights the crucial need for prevention and cessation of tobacco use in these counties, especially for vulnerable populations in this area.

Regional Community Stakeholder Survey Results

As mentioned previously, as a part of the regional work facilitated by the ARHN, the 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at the December 7, 2018 meeting. ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental institutions as well as community members.

The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

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

A total of 409 responses (including 92 from Warren County and 150 from Washington County) were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

The survey results report provides a regional look at the results through a wide-angle lens, focusing on the ARHN service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton,

[28] Bureau of Tobacco Control, StatShot, Prevalence of Current Smoking Among Adults, in New York by County, NYS BRFSS 2016, available at https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume11/n4_current_adult_smoking_by_county.pdf

Warren and Washington counties. Below are highlights from the analyses of Warren and Washington Counties:

- Respondents identified Promote Well-Being and Prevent Mental and Substance Use Disorders and Promote a Healthy and Safe Environment as the top two priority areas. *(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 the priority areas seek to address).*
- Respondents noted mental health conditions, substance abuse, and Alzheimer's disease within their top five health concerns facing the counties. Warren County also identified overweight/obesity and adverse childhood experiences, while Washington County identified opioid use and cancers.
- Top contributors to the health conditions noted above included age of residents, lack of mental health services, changing family structures, and poverty.
- Across the entire region, including Warren and Washington counties, individuals living at or near the federal poverty level is a subpopulation that respondents overwhelming believe experience the poorest health outcomes with individuals with mental health issues being the next subpopulation that experience the poorest health outcomes.
- Respondents were asked to choose three goals within each NYS Prevention Agenda Priority Area that their organization could assist in achieving in their counties. The tables below summarize those responses by county:

	Top Three NYS Prevention Agenda Goals Identified for Warren County		
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Improve self-management skills for individuals with chronic disease	Increase skills and knowledge to support healthy food and beverage choices	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	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	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change

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	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

	Top Three NYS Prevention Agenda Goals Identified for Washington County		
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	Increase skills and knowledge to support healthy food and beverage choices
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	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	Reduce falls among vulnerable populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
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 opioid and other substance misuse and deaths
Prevent Communicable Disease	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

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. For the full analyses of the Survey Results, see Appendix F.

County Health Rankings

To further support the information collected through the county health indicator data and the regional community stakeholder survey, County Health Rankings were used to understand how the health of Warren, Washington and Saratoga counties rank compared to each other and other counties in NYS. In total, there are 62 counties in NYS. Those having high ranks, e.g. 1 or 2, are considered to be the "healthiest."

Health outcomes demonstrate the current health status of the population and are based on two types of measures: how long people live and how healthy people feel while alive. Health factors are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors.

County Health Rankings - 2019

	Warren	Washington	Saratoga
Health Outcomes	**21**	**35**	**4**
Length of Life	**28**	**32**	**6**
Quality of Life	**9**	**29**	**4**
Health Factors	**10**	**42**	**2**
Health Behaviors	**20**	**43**	**11**
Clinical Care	**2**	**42**	**7**
Social & Economic Factors	**15**	**27**	**1**
Physical Environment	**15**	**50**	**49**

Source: County Health Rankings and Roadmaps, Building a Culture of Health, County by County, Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute – 2019, see http://www.countyhealthrankings.org/

For almost all of the ranking categories, Saratoga County ranked the highest (closest to 1), while Washington County ranked the lowest (closest to 62). Warren County was typically in the middle for all eight ranking scores, except for clinical care, where it was higher than most as the #2 county in all of New York State. This is most likely because of the physical presence of GFH in Warren County and the volume of services and providers available to the population. The extreme difference in ranking between Washington and Saratoga counties is striking. It is also important to note that the populations in the southern and northern most points of Saratoga County are extremely diverse. While the County Health Rankings only represent whole counties, typically, the health outcomes and health factors for the population in northern Saratoga County inside the GFH service area align more closely with Warren and Washington counties. The entirety of the data that was used to inform the rankings can be found in Appendix J.

Comments from Public

The Community Service Plan is available on the Glens Falls Hospital website, or by hard copy upon request. To date, Glens Falls Hospital has not received any comments from the public on either document. In 2019, Glens Falls Hospital added information on the website to proactively solicit comments, by advising individuals to use our 'Contact Us' form on the website to provide feedback.

When promoting availability in other reports, Glens Falls Hospital will also proactively solicit comments on the documents.

Gaps in Information

While the information collected through the community health assessment process was extremely comprehensive, there are a variety of gaps in information. First, there is limited data available by zip code, and much of the data is often at least 2 to 3 years old. Second, data sources are extremely limited to quantify the challenges and needs associated with the social determinates of health. Metrics are not available to wholly understand issues such as child care, housing, transportation, food insecurity, and other social barriers facing our populations. Similarly, while racial and ethnic disparities are often easily identified in other parts of New York State, disparities in this region are difficult to measure or quantify.

Prioritized Significant Health Needs

Through the ARHN collaborative, GFH coordinated with Warren and Washington counties to conduct a CHNA in each county. Saratoga County conducted a separate, yet similar process to determine their community's heath needs. The process was mainly coordinated by Saratoga Hospital and Saratoga County Public Health and facilitated by a different regional planning group. GFH representatives were members of the prioritization planning group and actively contributed to the process.

Utilizing the results of the indicator analysis, regional survey and the other county-specific community assessment resources listed previously, each county prioritized the most significant health needs for their residents. Each counties' CHA provides the rationale behind the prioritization of significant health needs. The following table outlines the most significant health needs identified in each county within the GFH service area.

	Warren County	**Washington County**	**Saratoga County / Saratoga Hospital**
Prevention Agenda Priority and/or Focus Area	Prevent Chronic Diseases • Tobacco Prevention • Chronic Disease Preventive Care and Management Promote Well-Being and Prevent Mental and Substance Use Disorders • Promote Well-Being • Mental and Substance Use Disorders Prevention	Prevent Chronic Diseases • Tobacco Prevention Promote Well-Being and Prevent Mental and Substance Use Disorders • Mental and Substance Use Disorders Prevention	Prevent Chronic Diseases • Obesity Prevention (Healthy Eating and Food Security & Physical Activity) Promote Well-Being and Prevent Mental and Substance Use Disorders • Substance Use Disorder Prevention

In addition to evaluating the priorities and county level data indicators for our local county health departments, GFH considered our expertise, capacity, funding, and potential impact. To that end, GFH has identified the following as the most significant health needs for the population served by GFH.

These needs will be the major focus of GFH's community health strategies for 2019 – 2021:

Priority Area: 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**

Priority Area: Prevent Communicable Diseases

- **Focus Area 5 - Antibiotic Resistance and Healthcare-Associated Infections**

It is important to note that GFH chose similar chronic disease related priorities during both our 2013-15 and our 2016-18 Community Service Plan process. Continuing to focus on these areas will improve, strengthen and sustain the impact of our interventions. Emphasis will be placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community resources. Additionally, in this Community Service Plan process, GFH is expanding the scope of work to include the priority area of Prevent Communicable Diseases, with a specific focus on antibiotic resistance and healthcare-associated infections.

Regional Priority

In addition to GFH choosing the four focus areas under the Prevent Chronic Diseases priority area, as part of the community health planning and assessment process, the CHA Committee identified and selected Prevent Chronic Diseases as one of the regional priorities in support of the NYS Prevention Agenda 2019-2024. The CHA Committee also selected a second priority, Promote Well-Being and Prevent Mental and Substance Use Disorders. CHA partners will work in tandem with the ARHN in a variety of ways to both support strategies to address and raise awareness about chronic disease prevention and mental and substance use disorder prevention.

Strategies being explored and formulated on how to best support regional priorities of Prevent Chronic Disease include:

- Identifying professional development/training opportunities for the region.
- Implementing a media campaign.
- Creating Prevention Agenda projects.

- Using social media outlets and websites to raise awareness of initiatives and programs currently in place from partners and others in our region.

Community Health Needs not Addressed in the Action Plan

Additional analysis revealed an increasing demand and need for mental health and substance abuse services throughout the three-county region. GFH recognizes this trend and the need for quality services and program, however, has not historically formalized strategies into the plan due to lack of resources and capacity. Currently, Glens Falls Hospital is the contracted behavioral health provider for Warren and Washington counties. The need will only increase, and we are working to proactively ensure patients have access to the care they need. Most recently, Glens Falls Hospital is working with Warren and Washington Counties to conduct a thoughtful and deliberate partnership exploration process for outpatient behavioral health and substance use services. We are working with the Counties to identify potential partners who can help us better serve patients, with a goal to expand access to much needed specialized behavioral health services in our community. Simultaneously, GFH will continue to work through initiatives such as Health Home and DSRIP to work with all providers on integrated care models and population health strategies.

Additional community health needs, such as housing, transportation, and other social determinants of health, are not addressed in the action plan due to lack of resources, expertise and/or quantitative data to support a proper assessment and plan.

Action Plan Development

After thorough data review and discussions with Senior Leadership, GFH identified evidence-based initiatives to address the prioritized community health needs related to our chosen priority areas. Throughout this process, GFH built on existing initiatives and community assets and identified new initiatives to complement and further enhance these existing programs. As a result, this Community Service Plan is a comprehensive, aligned plan with evidence-based strategies that will have significant impact on the health and well-being of the people and communities in the region.

GFH developed common terminology throughout the various departments within the institution to ensure consistent communication about goals, objectives, performance measures and activities. For each initiative, a Manager or Director participated in the development of a three-year action plan. GFH coordinated with Warren, Washington and Saratoga County Public Health throughout the process, and included other existing and new partners to ensure a collaborative and coordinated approach. Where applicable, GFH provided input into each county plan to ensure coordination and alignment with the hospital plan. Once finalized, the action plan was reviewed by Senior Leadership and presented to the Board of Governors for approval.

Priority Populations

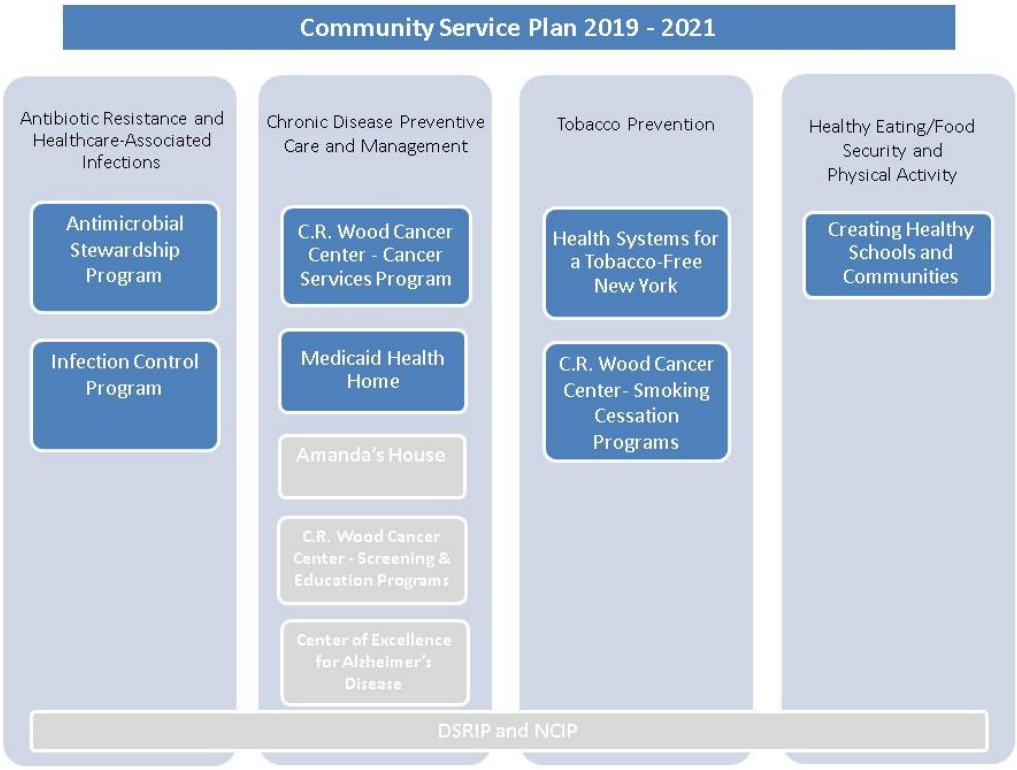
Emphasis throughout the action plan is placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community supports and resources. As described earlier in this plan, Warren, Washington and Saratoga counties do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations falling within our service area in upstate New York face a unique combination of factors that create health disparities, which are often rooted in the social determinants of health. Economic factors, cultural and social differences, educational shortcomings, and the isolation of living in a rural area all combine to create barriers for this population in their effort to lead a healthy life. Many sections of the region face significant distance and transportation barriers to accessing community resources, service opportunities, and health care. These communities are traditionally underserved by most assistance programs; thereby creating health disparities among the people living and working in this area. Throughout the action plan, priority populations for each specific initiative are noted within the section highlighting the health disparities addressed.

Action Plan for 2019-2021

The visual below outlines the evidence-based interventions led by GFH to address the prioritized community health needs. It includes initiatives to address the four focus areas under the Prevent Chronic Disease priority area and the one focus area under the Prevent Communicable Diseases priority area of the NYS Prevention Agenda. Many of the initiatives impact more than one focus area and some influence all focus areas.

The interventions were selected by GFH by aligning with the Prevention Agenda goals, building on existing initiatives and community assets, and identifying new initiatives to complement and further enhance these existing programs. Capacity, funding, and potential impact were also major considerations. The inventions in blue are the selected strategies that are included in the formal DOH required Community Service Plan. The interventions in gray are included here to be comprehensive, as they are part of the IRS-required Implementation Strategy, but are not included in the DOH required Community Service Plan as they do not neatly align with Prevention Agenda goals and/or the required workplan format.

In the corresponding action plan, each initiative includes a brief description, health disparities addressed, goal, SMART objective(s) and corresponding performance measure(s), key activities for the improvement strategy, and a list of partners who collaborate on the initiative and their roles. GFH continues to be actively involved in the counties' and other partner-led initiatives.



Glens Falls Hospital Initiatives

Please see the DOH-required workplan table, which outlines the action plan for each initiative.

Delivery System Reform Incentive Payment Program (DSRIP)

It is important to note that while DSRIP is included as a strategy, there is not a corresponding workplan within this Community Service Plan specific to define the many DSRIP initiatives in which GFH was involved. Most of the workplans have concluded with the pending DSRIP end-date of March 2020. We have, however, chosen to include DSRIP as a strategy with the knowledge that NYS has applied to CMS for a one-year extension of the current waiver program and a subsequent three-year renewal to allow the State to build upon the transformation started in the current waiver and continue on the road to value-based care. Assuming the DSRIP extension and renewal is granted and a workplan is developed, opportunities for alignment will be identified and integrated into the initiatives outlined herein.

North Country Innovation Pilot (NCIP)

It is important to note that while NCIP is included as a strategy, there is not a corresponding workplan within this Community Service Plan. The detailed design of the initiative is still under development, however, we have chosen to include NCIP as a strategy as the overall goals of the initiative align themselves with the population health initiatives identified herein. As the NCIP framework and focus is developed, opportunities for alignment will be identified and integrated into the identified initiatives.

Additional Community Benefit

In addition to the services and programs listed herein, GFH delivers numerous educational programs and screening events on a wide array of topics throughout the service area on an ad hoc basis to best meet the needs of our community members. These programs aim to increase awareness that will strengthen the community's knowledge and skills to improve their ability to better prevent and manage complex health conditions and navigate a complicated health care system. Because these programs are delivered on an as needed basis to meet current trends within the community, they do not lend themselves to fitting into the structure of an on-going action plan with quantifiable, long-term metrics. Rather, GFH tracks these programs as they present themselves as a means to ensure we are meeting the needs of the community through the regular provision of these services. These programs are tracked and noted as community benefit programs and are quantified for inclusion into our Schedule H, as applicable, using staff time, materials, administration and other programmatic supports.

Evaluation Plan

To ensure efficacy of the proposed interventions, GFH will work with Warren, Washington and Saratoga Public Health Departments to monitor and track progress using process and, where applicable, outcome evaluation. GFH will ensure these efforts align with and compliment the evaluation plans developed by each county. Process evaluation will demonstrate if the activities were implemented, if the appropriate populations were reached, and how external factors influenced the implementation. Progress will be tracked through discussion with internal and external partners responsible for each initiative. Through these discussions, mid-course corrections may be made to the plan to ensure goals and objectives are met. Outcome evaluation will demonstrate the impact of the activities, where data is available, and the ability to meet the objectives outlined in the action plan. This information will be used to provide regular updates to the NYS DOH and the IRS, as requested or required. In addition, this information will be used to share successes and challenges, and inform broader communications with the community and key partners.

Glens Falls Hospital Resources to Address Community Health Needs

GFH will dedicate the necessary resources and assets to meet the identified health needs of our community members and in support of the interventions, initiatives, strategies and activities defined within this Community Service Plan. These resources include but are not limited to the provision of traditional resources such as staff time, office space, meeting and community-use space, program supplies, educational and promotional materials, as well as, infrastructure assistance including clinical supports, IT support, financial and administrative support, public relations, media development and marketing expertise. Additional resources will be provided through fostering partnerships and broad-based, multi-sector engagement, and support that will enhance, promote and sustain the work identified herein to maximize impact and increase outcomes.

Partner Engagement

GFH will continue to partner with Warren, Washington and Saratoga county Public Health departments to implement the strategies in this action plan. GFH has a long-standing history of partnerships with these and other community-based organizations and agencies to support implementation of community health initiatives. These include a wide array of disciplines, such as schools, workplaces, providers, housing and transportation authorities, Offices on Aging, county health departments, local economic opportunity councils, Chambers of Commerce and local decision makers. Many of these partners participated in the various county health assessments and planning processes and therefore are well versed in the need for these interventions and are poised to provide the support necessary to ensure the attainment of the proposed goals.

Many of these partnerships will be further enhanced through ongoing participation in the Adirondack Rural Health Network, Population Health Improvement Program, Delivery System Reform Incentive Payment Program, Adirondacks ACO, Health Home and the North Country Innovation Pilot. In addition, community engagement is integral to the success of improving health in our region. GFH will solicit the guidance and expertise of relevant content experts to ensure a coordinated approach and to best meet the needs of the population we serve. In addition, any feedback received from the public at large will also be considered in the planning and implementation. A list of partners and corresponding roles for each intervention is included in the required workplan table.

Community Assets to Meet Needs

Many community assets have been described throughout this Community Service Plan, including those described within the Infrastructure and Services, Health Care Facilities, and Educational System sections.

Countless additional potential partners exist throughout the three-county area, many of which GFH has a long-standing relationship with already[29]. These include, but are not limited to:

- Business sector
- Community-based organizations
- Municipalities, such as those where targeted interventions are planned
- Mental health service providers
- Healthcare providers
- Service providers for individuals with disabilities; and
- Cancer-specific community organizations

Additional community assets that are available to everyone, and will help to address the identified priorities, include the following:

- Glens Falls Hospital services and facilities (see http://glensfallshospital.org/services for a full listing)

[29] The most comprehensive listing of businesses in the region can be found at the GlensFallsRegion.com website, https://www.glensfalls.com/.

- Community gardens
- Farmers markets and community supported agriculture (CSAs)
- Gyms and other wellness facilities
- Parks and Recreation
- Walking trails and bicycle routes
- Grocery stores and convenience stores
- Faith-based organizations

Lastly, there are many community resources and supports that are specific to certain population groups. These include employer-sponsored wellness programs and services, insurer-sponsored wellness and health promotion benefits, other neighborhood or community-specific services or events, school district-specific resources or activities as well as health care provider-specific resources. The Tri-County United Way also offers 2-1-1, which helps people assess their needs and links them directly to the resources that will help.

C.R. Wood Cancer Center Resources

The C.R. Wood Cancer Center has many available resources on site for patients after a diagnosis of cancers. These resources and services include an oncology health psychologist and mental health counselor to assist with psychosocial services; including one on one counseling, retreats, camps and support groups. An oncology social worker to assist with transitions in care, oncology nurse navigators who assess any barriers to care and arrange for interventions included but not limited to: transportation assistance through local community vendors and through paid contracts with local cab companies through donated funds. A financial navigator assesses every patient for out of pocket expenses for all cancer-related medications and helps find foundation funds, co-pay assistance programs and free or replacement drugs for those whom qualify.

Gaps in the Availability of Resources

The most significant gap in the availability of resources is related to housing assistance for patient while undergoing treatment. There has been an increase in the number of patients that are homeless or are in jeopardy of losing their housing while going through treatment. While Glens Falls Hospital is able to offer patients and families temporary housing through Amanda's House, the long-term, permanent needs for families seeking housing options are growing, with limited affordable, permanent housing options in the region. Transportation also continues to be a significant issue in our rural areas.

GFH will continue to use this listing of community assets to determine the most effective group of core partners to address the three prioritized needs identified above. Additional organizations, assets and resources will be identified to respond to emerging issues.

Impact of Previous Community Service Plan

As a result of 2016-2018 Community Service Plan process, GFH chose the following health needs as priorities.

- Increase access to high quality chronic disease preventative care and management in both clinical and community settings
- Reduce obesity in children and adults
- Reduce illness, disability and death related to tobacco use and secondhand smoke exposure

Through many of the health care transformation projects described herein, in addition to strong community partnerships and community-based interventions focused on policy and environmental changes, GFH has made great strides in improving the health of community members. The following is a list of notable accomplishments from 2016 - 2018.

- Provided **Health Home care coordination** services to adults and children enrolled in Medicaid, for a total of 3551 encounters in 2016, 4108 encounters in 2017 and 3455 encounters in 2018. A ´Health Home´ is a group of health care and service providers working together to make sure Medicaid members get the care and services they need to stay healthy.
- Partnered with 5 strategic local human service agencies to refer eligible individuals for **free cancer screenings.** The rates of comprehensive screenings for breast, cervical, colorectal cancer improved to 61%.
- Continued to conduct **smoking cessation program**s for community members that resulted in approximately 20% of individuals successfully reducing consumption of nicotine products. Approximately 5% quit for a short time and are working on reducing their consumption.
- Organized **Cindy's Retreat, a weekend getaway** for women living with and beyond cancer, in partnership with the Silver Bay YMCA Resort and Conference Center. The retreats were held twice a year between 2016 and 2018, for a total of six women's retreats with a total of 56 attendees. A men's retreat was also piloted reaching 10 attendees. All participants evaluated stated that the program helped them with tools for coping after their diagnosis and 100% stated that they felt better connected to services and others with similar diagnosis.
- Provided **wigs and head coverings** free of charge to patients undergoing chemotherapy at the C.R. Wood Cancer Center, through the Uniquely You Boutique and Salon. Nearly 900 patients used the salon between 2016 and 2018, and over 375 wigs were provided free of charge.
- Conducted 5 **Comfort Camps** between 2016 and 2018, a weekend overnight camp for children and teens who have experienced the death of a family member, in partnership with the Double H Hole in the Woods camp. Over 100 individuals participated and evaluation of the program showed that 100% of the families found the education and support helpful in reconnecting their families during the stressful treatment timeframe.
- Conducted **free skin cancer screening** once per year, for a total of three screenings between 2016 and 2018, which are free and open to the community. Nearly 430 individuals participated and each year, 75% of participants stated they had spots that needed to be checked and would not have otherwise seen a provider.

- Provided free accommodations through 1,300 room nights and over 2,000 guest nights, between 2016 and 2018, through **Amanda's House, a home away from home** for Glens Falls Hospital patients and their families who have traveled a distance for health care. The house accommodated guests from as close as an hour away to states as far as Florida and California and countries and territories as far as Canada, Venezuela, Puerto Rico, and Columbia. Family members of patients in the ICU and other units were able to remain close to the hospital to make decisions about their care and in some cases be there when they passed away. Patients who may not otherwise have had access to care were treated at the C.R. Wood Cancer Center, the Wound Center, the Sleep Lab and/or received procedures on almost every unit of the hospital.
- Conducted 12 **support groups** and 6 **diabetes education classes** between 2016 and 2018.
- Achieved NCQA recognition for all 8 primary care practices operated by Glens Falls Hospital under the **2017 Patient-Centered Medical Home (PCMH)** standards. These practices are now enrolled in the annual sustainability model. This model ensures continuous work in meeting quality metrics including patient engagement, access and continuity of care, patient satisfaction, and risk stratification of patients to identify those that would benefit from care management.
- Established all GFH primary care medical centers as **Comprehensive Primary Care Plus** (CPC+) sites.
- Piloted **primary care and behavioral health integration**, developed a solid step up and step down algorithm whereas patients received a warm hand off within the office and then triaged to the appropriate setting and clinician. Due to recruitment and retention challenges, the model is evolving and we are working to explore the use of telehealth.
- Established new services, including a NYS designated **Stroke Center** and a **Center of Excellence for Alzheimer's Disease**.
- Participated in regional care delivery transformation through the **DSRIP program**:
    - Renovated 4 medical centers to create a physical space conducive to integrating behavioral health services into primary care. Through these projects, two of the medical centers also increased their footprint to expand primary care capacity.
    - Established a new Crisis Care Center to expand services of the Emergency Department.
    - Accessed DSRIP workforce and training support to send staff to 30 trainings/conferences for professional development that would not have otherwise been possible. This includes a hospital-wide initiative to address crisis prevention and behavioral safety.
    - Established the Glens Falls Medical Group, a provider engagement and alignment initiative which established a physician-driven governance structure; created a data driven strategic plan that outlined goals around quality improvement, financial stability and patient satisfaction; and improved communication and referrals amongst providers through a newly established meeting framework, newsletters, education and training, data dashboards and a provider directory.
    - Formed new or enhanced existing collaborations with community partners to reach and serve our most vulnerable patients.

- Continued to **advance tobacco prevention and control efforts** across the region:
    - Provided training to over 30 agencies to **increase implementation of evidence-based intervention** and care for tobacco dependence.
    - Established 15 **new tobacco or smoke-free policies** throughout Warren, Washington, and Saratoga Counties by community partners in areas such as parks, worksites, and multi-unit housing complexes. Partners included the Double H Ranch, Skidmore College, and the Saratoga Springs Housing Authority, which resulted in 330 smoke-free homes. Another housing policy resulted in the creation of over 200 new smoke-free homes.
    - Supported 10 **public housing authorities to provide tobacco cessation opportunities** for residents as they develop tobacco free living spaces as per new federal housing law.
    - Sponsored a **Certified Tobacco Treatment Specialist training** resulting in 40 new tobacco treatment professionals throughout the region.
    - Collaborated with the **Medical Society of the State of New York** to train 50 clinicians from Glens Falls Hospital, Hudson Headwaters Health Network, Irongate, Adirondack Health, CVPH, Alice Hyde and others, in contemporary and evidenced-based protocols for Tobacco Dependence Treatment.
    - Partnered with 13 medical and 17 behavioral health system partners to **enhance interventions, policies and workflow protocols** to address tobacco dependence with patients.
- Continued to advance policy and environmental changes to **promote physical activity and nutrition:**
    - Partnered with local agencies to deliver a **Mobile Fresh Produce Pantry** that has provided 2,429 households with 17,557 pounds of fresh produce over two years.
    - Assisted 4 local school districts in improving their **Local Wellness Policies** to provide students with increased opportunities for physical activity and nutrition.
    - Provided local school districts with **hydration stations, healthy food items** for taste testing events, **cafeteria equipment** and equipment to support a **hydroponic vegetable garden** for use in school foods, in addition to **equipment for increased physical activity** during recess, breaks and PE class and after school programs.
    - Hosted **Math and Movement Family Nights** in the Granville Central School District and the Hadley-Luzerne Central School District to bring families together to improve students' math skills while being physically active. The events hosted approximately 120 students and their families.
    - Provided 8 schools in Hudson Falls, Fort Ann, Whitehall, Granville and Lake Luzerne with nearly $15,000 of **equipment and supplies to increase physical activity** during the school day and recess.
    - Created **safer streets for pedestrians and bicyclists** by providing over $35,000 in Complete Streets support (such as speedbumps, signage, and speed feedback detectors) to Hadley, Kingsbury, Hudson Falls and Whitehall.

The complete 2016-2018 IS and corresponding CSP can be found on the GFH website at http://www.glensfallshospital.org/services/community-service/health-promotion-center.

Dissemination

The GFH Community Service Plan and Executive Summary, along with the CHNA and corresponding IS, are available at http://www.glensfallshospital.org/services/community-service/health-promotion-center.

The previous two most recent CSPs, CHNAs, and Implementation Strategies are also available on the site. GFH will use various mailings, newsletters and reports to ensure the availability of the CSP Executive Summary and the full plans are widely publicized. Hard copies will be made available at no-cost to anyone who requests one.

Approval

The Director of Research and Planning worked with Senior Leadership to develop the plans, which were presented to the Board of Governors for approval. The Board was provided with an executive summary of the CHNA and IS in advance and a brief presentation was conducted during a regular monthly meeting to communicate highlights and answer questions. The CHNA and IS were approved on December 19, 2019. Elements from those documents were combined to create this Community Service Plan, for submission to the NYS DOH.

Appendix A: Glens Falls Hospital Regional Health Care System

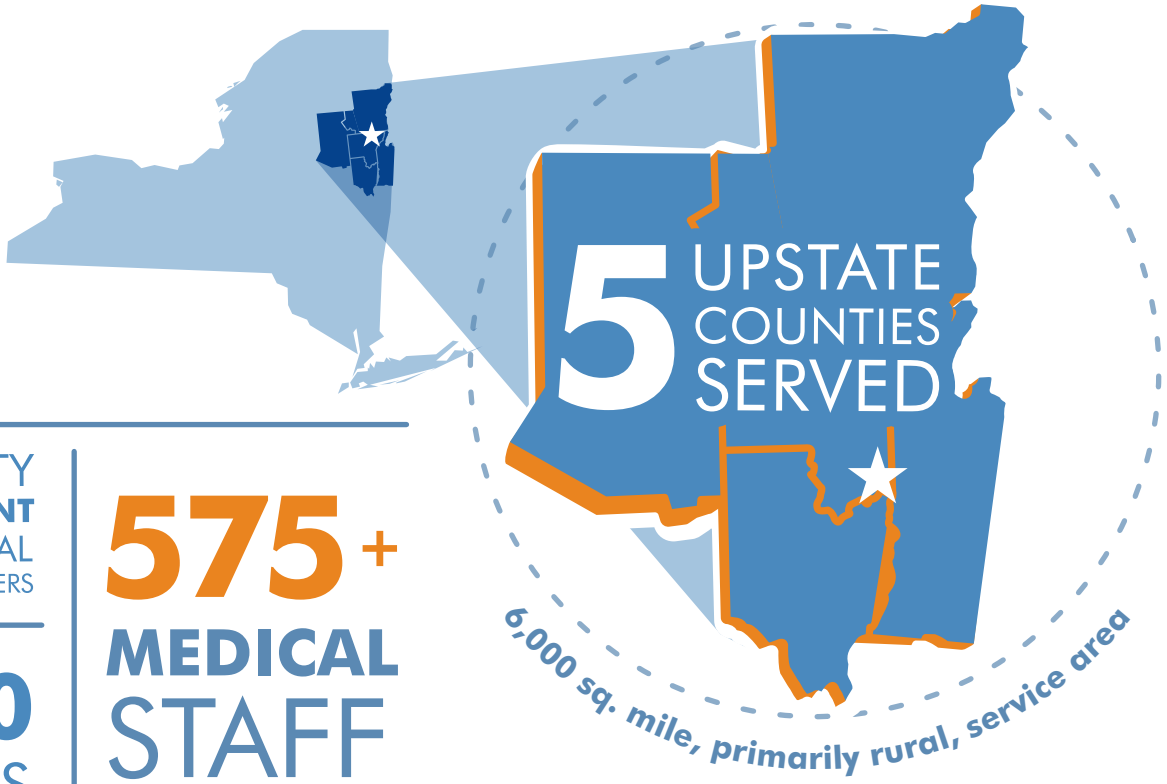
Glens Falls Hospital

A **REGIONAL** HEALTHCARE SYSTEM

20+ **REGIONAL** LOCATIONS

8 *medical* CENTERS

391 BEDS



4 SPECIALTY **OUTPATIENT** BEHAVIORAL HEALTH CENTERS

2,500 EMPLOYEES

575+ **MEDICAL** STAFF

180+ EMPLOYED **PHYSICIANS**, **PHYSICIAN ASSISTANTS** & **NURSE PRACTITIONERS**

SPECIALIZING IN
- General Surgery
- Orthopedics
- ENT
- Urology
- Thoracic
- Neurology
- Oncology
- Cardiology
- Primary Care
- Behavioral Health

C.R. WOOD CANCER CENTER

925+ PATIENTS DIAGNOSED & TREATED ANNUALLY

Annually*

1,200 BABIES BORN IN THE **JOYCE STOCK** SNUGGERY

46,000 E.D. VISITS

13,300 **INPATIENT** DISCHARGES

SURGERIES PERFORMED **10,500**

*NUMBERS BASED ON 2018 CALENDAR YEAR

Updated 8/2019

About Us

Founded in 1897, Glens Falls Hospital today operates an advanced healthcare delivery system recognized by some of the most distinguished accrediting bodies in the country, including DNV GL and the American College of Surgeons. Our mission is to improve the health of people in our region by providing access to exceptional, affordable, and patient-centered care, every day and in every setting.

HOSPITAL PROGRAMS & SERVICES

- Breast Center
- Cardiac Care:
  - Cardiac Rehabilitation
  - Electrophysiology
  - Interventional Cardiology
- Case Management
- Emergency Department
- Gastroenterology (GI) Center
- Interventional Radiology
- Infusion Center
- Inpatient Services:
  - Critical Care
  - Behavioral Health
  - The Joyce Stock Snuggery/Maternity
  - Medical/Surgical
- Laboratory Services
- Medical Imaging
- Neurodiagnostics
- Obstetrics & Gynecology
- Pharmacy
- Respiratory Care Services
- Rehabilitation Services:
  - Occupational Therapy
  - Physical Therapy
  - Speech-Language Therapy
- Stroke Center

OUTPATIENT PROGRAMS & SERVICES

- Behavioral Health Services:
  - Adult Outpatient Center
  - Center for Children & Families
  - Center for Recovery
- Center of Excellence for Alzheimer's Disease
- Community Care Coordination
- Diabetes & Nutrition Center
- Hearing Center
- Medical Imaging
- Rehabilitation & Wellness Center:
  - Audiology
  - Occupational Therapy
  - Physical Therapy
  - Speech-Language Therapy
  - Wellness Services
- Sleep Disorders Center
- Wound Healing Center

C.R. WOOD CANCER CENTER

- Cancer Services Program
- Cancer Center Library
- Clinical Research
- Genetic Counseling
- Medical Oncology & Hematology
- Nutrition Counseling
- Psychosocial Oncology
- Patient Financial Insurance Assistants
- Patient Navigators
- Radiation Oncology
- Spa Services
- Uniquely You Boutique & Salon®
- Support Services:
  - C.G. Men's Retreat
  - Cindy's Comfort Camp
  - Cindy's Retreat
  - Support Groups, Activities & Classes

PHYSICIAN PRACTICES

- Adirondack Cardiology
- Adirondack ENT
- Glens Falls Neurology
- Primary Care:
  - Cambridge Medical Center & Urgent Care
  - Evergreen Medical Center
  - Granville Medical Center
  - Greenwich Medical Center
  - Hudson Falls Medical Center
  - Salem Medical Center
  - Whitehall Medical Center
  - Wilton Medical Center

COMMUNITY SERVICES

- Amanda's House
- Glens Falls Hospital Foundation
- Health Promotion Center:
  - Creating Healthy Schools & Communities
  - Living Tobacco-Free
- Medical Alert Service
- Volunteer Services

SURGICAL SERVICES

- Day Surgery Center
- General Surgery
- Gynecologic Surgery
- Minimally Invasive/ Robotic Surgery
- Neurosurgery
- Plastic Surgery
- Podiatry
- Orthopedic Surgery
- Otolaryngology Surgery (ENT)
- Thoracic Surgery
- Urological Surgery
- Vascular Surgery
- Surgical Specialists of Glens Falls Hospital:
  - General Surgery
  - Orthopedics
  - Thoracic
  - Urology

Appendix B: Adirondack Rural Health Network Community Health Assessment Committee Members and Meeting Schedule

CHA Committee Members

County Health Departments	Phone Number	Representative	Additonal Representatives
Clinton County Health Department	518-565-4840	John Kanoza (john.kanoza@clintoncountygov.com)	Mandy Snay (mandy.snay@clintoncountygov.com) x4928
Essex County Health Department	518-873-3500	Linda Beers (LBeers@co.essex.ny.us) x3515	Jessica Darney-Buehler (jdarney-buehler@co.essex.ny.us) x3514 Susan Allott (sallott@co.essex.ny.us) x3518
Franklin County Public Health	518-481-1709	Katie Strack (kstrack@franklincony.org)	Sarah Granquist (sgranqui@franklincony.org)
Fulton County Public Health	518-736-5721	Laurel Headwell (lheadwell@fultoncountyny.gov) x5720	Angela Stuart Palmer (apalmer@fultoncountyny.gov) Alyssa Craig (acraig@fultoncountyny.gov) x8719
Hamilton County Public Health	518-648-6497	Dr. Erica Mahoney (erica.mahoney.hcphns@frontier.com)	Daryl Parslow (daryl.parslow.hcphns@frontier.com) Carriann Grexa-Allen (carriann.grexa-allen.hcphns@frontier.com)
Warren County Health Services	518-761-6580	Ginelle Jones (jonesg@warrencountyny.gov)	Dan Durkee (durkeed@warrencountyny.gov) x6580 J'nelle Oxford (oxfordj@warrencountyny.gov) x6580
Washington County Public Health	518-746-2400	Patty Hunt *CHA Co-Chair (PHunt@washingtoncountyny.gov) x. 2493	Kathy Jo Mcintyre (kmcintyre@washingtoncountyny.gov) x. 2415
Hospitals			
Adirondack Medical Center	518-897-2735	Heidi Bailey (hbailey@adirondackhealth.org)	Dan Hill (dhill@adirondackhealth.org) x2805
Glens Falls Hospital	518-926-6899	Cathleen Traver *CHA Co-Chair (ctraver@glensfallshosp.org)	
Nathan Littauer Hospital	518-773-5212	Cheryl McGrattan (CMcgrattan@nlh.org)	Tammy Merendo (tmerendo@nlh.org)
UVMHN - Alice Hyde Medical Center	518-481-2425	Annette Marshall (amarshall@alicehyde.com) x2410	
UVMHN - CVPH	518-314-3327	Kaitlyn Tentis (ktentis@cvph.org)	Debra D. Good (DGood@cvph.org) Gregory E. Freeman (GFreeman@cvph.org)
UVMHN - Elizabethtown Community Hospital/Moses Ludington Hospital	518-873-3125	Heather Reynolds (HReynolds@ech.org)	Julie Tromblee (jtromblee@ech.org) Amanda Whisher (awhisher@ech.org)
AHI			
	518-480-0111	Sara Deukmejian (sdeukmejian@ahihealth.org) x317	Courtney Shaler (cshaler@ahihealth.org) x304 Nancy Gildersleeve, (ngildersleeve@ahihealth.org) x313

CHA Committee Meeting Dates

January 12, 2017
March 22, 2017
June 9, 2017
September 8, 2017
December 15, 2017
March 2, 2018 – cancelled due to inclement weather
June 15, 2018
September 11, 2018
December 7, 2018
March 8, 2019
June 11, 2019
September 6, 2019
December 6, 2019

Appendix C: New York State Prevention Agenda Priority Areas, Focus Areas and Goals

Priority Area: Prevent Chronic Diseases	**Focus Area 1: Healthy Eating and Food Security** Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 1.1: Increase access to healthy and affordable foods and beverages
	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
	Goal 1.3: Increase food security
	Focus Area 2: Physical Activity Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
	Goal 2.2: Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
	Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
	Focus Area 3: Tobacco Prevention
	Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults
	Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability
	Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
	Focus Area 4: Preventive Care and Management
	Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer
	Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
	Goal 4.3: Promote the use of evidence-based care to manage chronic diseases
	Goal 4.4: Improve self-management skills for individuals with chronic conditions
Priority Area: Promote a Healthy and Safe Environment	**Focus Area 1: Injuries, Violence and Occupational Health**
	Goal 1.1: Reduce falls among vulnerable populations
	Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations
	Goal 1.3: Reduce occupational injuries and illness
	Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists
	Focus Area 2: Outdoor Air Quality
	Goal 2.1: Reduce exposure to outdoor air pollutants
	Focus Area 3: Built and Indoor Environments
	Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
	Goal 3.2: Promote healthy home and school environments
	Focus Area 4: Water Quality
	Goal 4.1: Protect water sources and ensure quality drinking water
	Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
	Focus Area 5: Food and Consumer Products
	Goal 5.1: Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
	Goal 5.2: Improve food safety management

Priority Area: Promote Healthy Women, Infants and Children	**Focus Area 1: Maternal & Women's Health**
	Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age
	Goal 1.2: Reduce maternal mortality and morbidity
	Focus Area 2: Perinatal & Infant Health
	Goal 2.1: Reduce infant mortality and morbidity
	Goal 2.2: Increase breastfeeding
	Focus Area 3: Child & Adolescent Health
	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships
	Goal 3.2: Increase supports for children and youth with special health care needs
	Goal 3.3: Reduce dental caries among children
	Focus Area 4: Cross Cutting Healthy Women, Infants, & Children
	Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders	**Focus Area 1: Promote Well Being**
	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan
	Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages
	Focus Area 2: Prevent Mental and Substance Use Disorders
	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults
	Goal 2.2: Prevent opioid and other substance misuse and deaths
	Goal 2.3: Prevent and address adverse childhood experiences (ACEs)
	Goal 2.4: Reduce the prevalence of major depressive disorders
	Goal 2.5: Prevent suicides
	Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population
Priority Area: Prevent Communicable Diseases	**Focus Area 1: Vaccine-Preventable Diseases**
	Goal 1.1: Improve vaccination rates
	Goal 1.2: Reduce vaccination coverage disparities
	Focus Area 2: Human Immunodeficiency Virus (HIV)
	Goal 2.1: Decrease HIV morbidity (new HIV diagnoses)
	Goal 2.2: Increase viral suppression
	Focus Area 3: Sexually Transmitted Infections (STIs)
	Goal 3.1: Reduce the annual rate of growth for STIs
	Focus Area 4: Hepatitis C Virus (HCV)
	Goal 4.1: Increase the number of persons treated for HCV
	Goal 4.2: Reduce the number of new HCV cases among people who inject drugs
	Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections
	Goal 5.1: Improve infection control in healthcare facilities
	Goal 5.2: Reduce infections caused by multidrug resistant organisms and C. difficile
	Goal 5.3: Reduce inappropriate antibiotic use

Community Health Assessment Committee
2019 Data Methodology

Background:

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

The overall goal of collecting and providing this data to the CHA Committee was to provide a comprehensive picture of the individual counties and overview of population health within the ARHN region, as well as Montgomery and Saratoga counties.

Demographic Profile:

Demographic data was primarily taken from the 2013-2017 American Consumer Survey 5-year estimates, utilizing the United States Census Bureau American FactFinder website. Other sources include the 2010-2014 American Consumer Survey 5-year estimates, Centers for Medicaid and Medicare Services, through the CMS Enterprise Portal, NYS Department of Health, U.S. Department of Agriculture (USDA), and the National Agriculture Statistics Service.

Information incorporated into the demographic report includes square mileage, population, family structure and status, household information, education and employment status.

Health System Profile:

The vast majority of health systems data comes from the New York State Department of Health, including the NYS Health Profiles, Nursing Home Weekly Bed Census, License Statistics and Adult Care Facility Directory. Other sources include Health Resources and Services Administration (HRSA) and Center for Health Workforce Studies, Health Workforce Planning Data Guide.

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

Education Profile:

The education profile is separated into two parts; education system information and school districts by county. Part one of the education profiles includes data pertaining to education systems in the ARHN region, including student teacher ratios, english proficiency rates, and free lunch eligibility rates as well as available education programs and graduates. Data was pulled from the NYS Education Department, National Center for Education Statistics, and Center for Health Workforce Studies. Part two identifies school districts by county includes county school districts as well as regional school districts.

Data was pulled from the NYS Education Department, National Center for Education Statistics, and Center for Health Workforce Studies.

ALICE Profile:

All data provided in the ALICE profile comes from the 2016 ALICE report, which can be found at www.unitedforalice.org/new-york. Sources utilized in the report include American Consumer Survey, Bureau of Labor Statistics, Consumer Reports, IRS and U.S. Department of Agriculture.

In April 2018, the NYS Department of Health released guidance for 2019-2021 community health assessment and planning. It was suggested that local health departments and hospitals submit one plan per county and hospitals serving more than one county were strongly encouraged to select and prioritize high poverty neighborhoods for action. To address these updates, the Asset Limited, Income Constrained, Employed (ALICE) profile was added. ALICE profile data includes total households, , poverty and ALICE percentages, unemployment rates, percent of residents with health insurance and average annual earnings. Please note that all data on the ALICE profile is reflective of 2016 figures.

Data Sheets:

The data sheets, compiled of 271 data indicators, provide an overview of population health as compared to the ARHN region, Upstate New York and New York State. The reports feature a status field that specifies whether indicators were met, better, or worse than their corresponding benchmarks. When indicators were worse than their corresponding benchmarks, their distances from their respective benchmarks were calculated. On the report, distances from benchmarks were indicated using quartile rankings.

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

The report also showed the percentage of total indicators that were worse than their respective benchmarks by focus area.

- For example, if 20 of the 33 child health focus area indicators were worse than their respective benchmarks, the quartile summary score would be 61% (20/33).
- Additionally, the report identified a severity score, i.e., the percentage of those indicators that were either in quartile 3 or 4. Using the above example, if 9 of the 20 child health focus indicators that were worse than their respective benchmarks were in quartiles 3 or 4, the severity score would be 45% (9/20).

Quartile summary scores and severity scores were calculated for each focus area as well as for Prevention Agenda indicators and “other indicators” within each focus area. Both quartile summary scores and severity scores were used to understand if the specific focus areas were challenges to the counties and hospitals. In certain cases, focus areas would have low severity scores but high quartile summary scores indicating that while not especially severe, the focus area offered significant challenges to the community.

Indicators were broken out by the Prevention Agenda focus areas, across ten tabs. Tabs include *Mortality, Injuries, Violence and Occupational Health, Built Environment and Water, Obesity, Smoke Exposure, Chronic Disease, Maternal and Infant Health, HIV, STD, Immunization and Infections*

Substance Abuse and Mental Health, and *Other.* Data and statistics for all indicators comes from a variety of sources, including:

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

Adirondack Rural Health Network

Community Health Assessment
2019 - 2021

Report on Data Subcommittee Activities and Outcomes

SEVEN COUNTY REGION OF NEW YORK STATE
Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington

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. This report is also available online at www.ahihealth.org/arhn.

Adirondack Health Institute

Lead Empower Innovate

Table of Contents

Overview of Data Subcommittee Activities and Outcomes

CHA Committee Data Subcommittee - Purpose

At the June 15, 2018 CHA Committee meeting it was recommended that the Committee establish a data subcommittee for the purpose of:

- reviewing the tools and processes used by CHA Committee members to develop their Community Health Assessments and Community Health Improvement Plans/Community Service Plans; and
- identifying ways to enhance the CHA/CHIP/CSP processes and outcomes.

Data Subcommittee Outcomes and Activities

Data Subcommittee members concluded that the CHA/CHIP/CSP process would be enhanced by achieving the following outcomes:

- documenting (quantitatively and qualitatively) the impact of social determinants of health on the primary health outcomes and priorities selected by the CHA committee members; and
- strengthening CHA members' ability to foster community stakeholders' understanding of the primary health outcomes in their county/region and to enlist stakeholders' active participation in activities to improve those outcomes.

The subcommittee identified the following six activities that it would focus on to achieve the outcomes noted above:

- analyzing and interpreting community health assessment data;
- engaging stakeholders to solicit feedback on priorities and sharing results of the assessment and planning documents with stakeholders;
- collecting information about the social determinants of health and "changing environment" that impacts the region's health;
- identifying assessments conducted by other community sectors/organizations that may help inform and enhance the CHAs/CHIPs;
- revisiting the tool and process designed to assist in the identification of health priorities; and
- identifying opportunities to strengthen local health departments' ability to meet Public Health Accreditation standards regarding the community health assessment and planning process.

CHA Committee Data Subcommittee Meetings

The initial meeting of the Data Subcommittee (DSC) occurred on July 19, 2018. The DSC met an additional six times on the following dates: July 25; August 15; September 12; October 3; October 16; and, October 30.

Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 DSC members per meeting; meetings were also attended by AHI staff from ARHN, PHIP and Data team.

Summary of Issues Addressed by the Data Subcommittee

The main issues addressed by the DSC were:

- ✓ Developing a 2019 Stakeholder Survey;
- ✓ Incorporating a Social Determinants of Health perspective into the 2019 Community Health Assessment process;
- ✓ Reviewing processes and tools used to identify health priorities;
- ✓ Identifying criteria that could be used to assist in the prioritization process;
- ✓ Reviewing methods for community engagement in the community health assessment and health improvement activities; and
- ✓ Utilizing community asset mapping as a component of the community health assessment and community health improvement/community service plan efforts.

Data Subcommittee Outcomes and Products (See Appendices)

As a result of meetings and activities, the DSC produced the following documents:

- ✓ Draft 2019 Stakeholder Survey (approved by CHA Committee at December 7th meeting);
  - o The Stakeholder Survey includes questions concerning the impact of social determinants of health on the primary health issues affecting the ARHN region;
  - o Promote community engagement in health improvement efforts by providing an opportunity for respondents to identify the Prevention Agenda goals they could contribute toward achieving and to identify the resources they can they can provide to achieve the goals;
- ✓ *Methods for Identification of Local Priorities* - that describes several processes that CHA partners can consider using to assist in the identification and prioritization of local health issues;
- ✓ *Selection of Criteria to Identify Health Priorities* - that provides guidance on the selection of criteria that CHA partners can consider to assist in the prioritization process;
- ✓ *Practices for Community Engagement in Data Collection for CHAs* - that provides guidance on several methods of community engagement to assist in the collection of data for a community health assessment (supplements the 2016 report prepared by the Center for Health Workforce Studies – *Overview of Engagement Strategies Utilized Across NYS)*;
- ✓ A summary of the overall needs assessment by population from the 2019 Local Service Plans for Mental Hygiene Services for the ARHN region; and
- ✓ *Community Asset Mapping Resources* – that provides information and resources on the steps recommended to create an asset map.

***ADK Wellness Connections* Updates**

In addition to the activities listed in the 2019 CHA Timeline and Scope of Services, AHI will:

- ✓ Keep CHA partners informed about the status of *ADK Wellness Connections* and the system's potential for providing more detailed and geographically-sensitive data regarding the social determinants of health and their impact on the priorities selected by the CHA partners.

Data Subcommittee Members

Member	Affiliation
Heidi Bailey	Adirondack Health
Dan Hill	Adirondack Health
Tim Lamay	Adirondack Health
Mandy Snay	Clinton County Health Department
Susan Allot	Essex County Health Department
Jessica Darney-Buehler	Essex County Health Department
Erin Streiff	Franklin County Public Health
Angela Stuart Palmer	Fulton County Public Health
Kelly Pilkey	Glens Falls Hospital
Dr. Erica Mahoney	Hamilton County Public Health
Tammy Merendo	Nathan Littauer Hospital
J'nelle Oxford	Warren County Health Services
Patty Hunt	Washington County Public Health
Kathy Jo McIntyre	Washington County Public Health
Ginger Carriero	UVMHN - Alice Hyde Hospital
Debra Good	UVMHN - CVPH
Kaitlyn Tentis	UVMHN - CVPH
Alyson Arnold	UVMHN - Elizabethtown Hospital
Amanda Whisher	UVMHN- Elizabethtown Hospital
AHI Staff	
Courtney Shaler	ARHN Manager
Sara Deukmejian	ARHN Coordinator
Colleen McVeigh	Data Analyst
Theresa Paeglow	PHIP Manager
Jessica Chanese	Community Engagement Manager (DSRIP)
Tom Tallon	Data Consultant

Adirondack Rural Health Network
Community Health Assessment and Planning
2019 Regional Stakeholder Survey

PURPOSE

The purpose of this survey is to gather information about the factors that impact the health and well-being of residents of the Adirondack region (Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties). The region's health is influenced by a wide-array of factors including but not limited to access to medical services, individual behaviors, socioeconomic conditions, demographic characteristics, and the natural and built environment.

You have been identified as a key informant who can provide insight into the factors that are impacting the health and well-being of the people your organization/agency serves. Your response will help inform the Adirondack Rural Health Network's (ARHN) community health assessment and planning process. More information about ARHN can be found at: www.ahihealth.org/arhn

HOW THE RESULTS WILL BE USED

ARHN and its partners will use the survey results to:

1) guide strategic health planning throughout the Adirondack region;
2) highlight topics for increased public awareness and education;
3) identify areas for training; and
4) inform the NYS Department of Health's Prevention Agenda for 2019-2024.

The Prevention Agenda is a blueprint for state and local action to improve the health of New Yorkers across all ages; it provides guidance for regional health planning activities and resources. More information about the NYS Prevention Agenda can be found at: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/background.htm

YOUR PARTICIPATION

This survey should take 10 to 15 minutes to complete. Please answer the questions in the context of your role within your organization and in representing the population(s) you serve. Due to NYS Department of Health's regulatory reporting requirements, we need to collect your name, title and organization. To thank you for your participation, you may sign up for one of 3 gift cards to be awarded at the conclusion of the survey.

THANK YOU FOR YOUR HELP

For more information, contact Adirondack Rural Health Network Manager, Courtney Shaler, at cshaler@ahihealth.org.

2019 CHA Stakeholder Survey

Introduction

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

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

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

Your Organization/Agency

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

1. Organization/Agency name:

2. Your name:

3. Your job title/role: [to be a dropdown featuring the following titles: Community Members, Direct Service Staff, Program/Project Manager, Administrator/Director, Other]

4. Your email address:

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

- ☐ Business
- ☐ Civic Association
- ☐ College/University
- ☐ Disability Services
- ☐ Early Childhood
- ☐ Economic Development
- ☐ Employment/Job training
- ☐ Faith-Based
- ☐ Food/Nutrition
- ☐ Foundation/Philanthropy

- ☐ Health Based CBO
- ☐ Health Care Provider
- ☐ Health Insurance Plan
- ☐ Housing
- ☐ Law Enforcement/Corrections
- ☐ Local Government (e.g. elected official, zoning/planning board)
- ☐ Media
- ☐ Mental, Emotional, Behavioral Health Provider
- ☐ Public Health
- ☐ Recreation
- ☐ School (K – 12)
- ☐ Seniors/Elderly
- ☐ Social Services
- ☐ Transportation
- ☐ Tribal Government
- ☐ Veterans
- ☐ Other (please specify):

6. Indicate the counties your organization/agency serves. **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. These main priority areas are listed in question #7.

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
- ☐ Drinking water quality
- ☐ Emerging infectious diseases (Ebola, zika virus, tick and mosquito-transmitted, etc.)
- ☐ Exposure to air and water pollutants/hazardous materials
- ☐ Falls
- ☐ Food safety
- ☐ Heart disease
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hunger
- ☐ Infant health
- ☐ Infectious disease
- ☐ LGBT health
- ☐ Maternal health
- ☐ Mental health conditions
- ☐ Motor vehicle safety (impaired/distracted driving)
- ☐ Opioid use
- ☐ Overweight or obesity

- ☐ Pedestrian/bicyclist accidents
- ☐ Prescription drug abuse
- ☐ Respiratory disease (asthma, COPD, etc.)
- ☐ Senior health
- ☐ Sexual assault/rape
- ☐ Sexually transmitted infections
- ☐ Social connectedness
- ☐ Stroke
- ☐ Substance abuse
- ☐ Suicide
- ☐ Tobacco use/nicotine addiction – smoking/vaping/chewing
- ☐ Underage drinking/excessive adult drinking
- ☐ Unintended/Teen pregnancy
- ☐ Violence (assault, firearm related)
- ☐ Other (Please specify):

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

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

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

Social Determinants of Health

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

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

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

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

- **Neighborhood and Built Environment** (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)

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

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

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

Improving Health and Well-Being

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

12. Select the goals your organization/agency can assist in achieving in the counties it serves. There is no limit to the number of goals you may select.

Prevent Chronic Diseases

- Increase access to healthy and affordable food and beverages
- Increase skills and knowledge to support healthy food and beverage choices

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

Promote Healthy Women, Infants, and Children

- ☐ Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age
- ☐ Reduce maternal mortality and morbidity
- ☐ Reduce infant mortality and morbidity
- ☐ Increase breastfeeding
- ☐ Support and enhance children and adolescents' social-emotional development and relationships
- ☐ Increase supports for children with special health care needs
- ☐ Reduce dental caries (cavities) among children
- ☐ Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

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

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

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

13. Based on the goals you selected in Question #12, please identify the resources your organization/agency can contribute toward achieving those goals.

- ☐ Deliver education and counseling relevant to the selected goal(s)

- ☐ Deliver clinical interventions relevant to the selected goal(s)
- ☐ Work to promote changes to policies/laws/community environment to address selected goal(s)
- ☐ Provide subject-matter knowledge and expertise
- ☐ Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)
- ☐ Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals
- ☐ Participate on committees, work groups, coalitions to help achieve the selected goals
- ☐ Share knowledge of community resources (e.g. food, clothing, housing, transportation, etc.)
- ☐ Facilitate access to populations your organization/agency serves (to encourage participation in programs, provide feedback about health improvement efforts, etc.)
- ☐ Promote health improvement activities/events through social media and other communication channels your organization/agency operates
- ☐ Share program-level data to help track progress in achieving goals
- ☐ Provide in-kind space for health improvement meetings/events
- ☐ Offer periodic organizational/program updates to community stakeholders
- ☐ Provide staff time to help conduct goal-related activities
- ☐ Provide letters of support for planned health improvement activities
- ☐ Sign partnership agreements related to community level health improvement efforts
- ☐ Assist with data analysis
- ☐ Offer health related-educational materials
- ☐ Other (please specify):

14. Are you interested in being contacted at a later date to discuss the utilization of the resources you identified in Question #13?

    - ☐ Yes
    - ☐ No

15. 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.

ARHN Community Health Assessment Committee
Data Subcommittee

Methods for the Identification of Local Priorities

The identification of local health priorities is the primary outcome of the community health assessment process. The identification of health priorities requires an analysis of available data and the selection, and description, of the criteria used to identify the priorities. This document quotes relevant guidance concerning the prioritization process and provides three prioritization techniques that could be used by CHA partners to identify their local health priorities.

Relevant Guidance Citations

NYS Department of Health
Letter dated April 4, 2018 about NYSDOH's plans for updating the Prevention Agenda
https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/letter_and_community_health_planning_guidance_and_template_for_2019_2021.pdf

The letter states:

> As in previous years, the NYS Department of Health is asking each local health department (LHD) and all partner hospitals/hospital systems in the county to work together along with other community partners to identify and address local health priorities associated with the NYS Prevention Agenda.

Attached to April 4, 2018 letter is the *Guidance and Template for NYS 2019-2021 Community Health Assessment and Community Health Improvement Plan and Community Service Plan - Required Components*. The guidance states:

> **Community Health Improvement Plan/Community Service Plan**
> Identification of at least two priorities and a description of the process and criteria that were used to identify them in collaboration with community partners including LHDs and hospitals. At least one of these priorities must address a disparity and promote health equity. In this section, provide a description of the community engagement process that was used to select new or confirm existing priorities.

Public Health Accreditation Board (PHAB)
PHAB Standards and Measures – Version 1.5

The Public Health Accreditation Board (PHAB) Standards and Measures document serves as the official standards, measures, required documentation, and guidance blueprint for PHAB national public health department accreditation.

The complete PHAB standards and measures (Version 1.5) can be found at: http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf

The PHAB standards relevant to identification of local priorities are excerpted below:

STANDARD 1.3: Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health.

Measure 1.3.1 A: Data analyzed and public health conclusions drawn (Pages 42 – 43)

The health department must document the analysis of data with conclusions drawn from the data. The provision of data used in the analysis is not required, but evidence of the health department's analysis and conclusions is required. Data to be analyzed can include qualitative and/or quantitative, primary and/or secondary data, or combinations of data.

The type of analytic process used must be stated and/or be evidence based with the citation available. The intent is to have conclusions based on solid analysis, not just collection of data.

The health department must document the review of data analysis selected for Measure 1.3.1. The intent is to document the sharing of data and their analysis with others. The discussions may be internal, with governing entities, with community groups, with other health or social service organizations, or provided to elected bodies. Documentation could be, for example, minutes or documentation of meetings to show the presentation, review, and discussion of data analysis.

STANDARD 1.4: Provide and use the results of health data analysis to develop recommendations regarding public health policies, processes, programs, or interventions.

Measure 1.4.1 A: Data used to recommend and inform public health policy, processes, programs, and/or interventions (Page 51)

The health department must document that public health data have been used to impact the development of policies, processes, programs, or interventions or the revision or expansion of existing policies, processes, programs, or interventions. The data used to inform the policy, process, program, or intervention must also be included.

The data alone will not serve as evidence for this measure. The health department must demonstrate the use of the data. Documentation could be, for example, documented program improvements, or a revised or new policy and procedure. Documentation could also be Tribal Council resolutions and Health Oversight Committee meeting minutes, which demonstrate that data was used to inform policy, processes, programs and/or interventions.

STANDARD 5.2: Conduct a comprehensive planning process resulting in a community health improvement plan.

Measure 5.2.1 L (Pages 132-133)
1. The local health department must document the collaborative community health improvement planning process. The process used may be an accepted national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described.

The local health department must document that the community health improvement planning process included all of the following:

a. Participation by a wide range of community partners representing various sectors of the community.

b. Data and information from the community health assessment provided to participants in the community health improvement planning process for use in their deliberations.

c. Evidence that community and stakeholder discussions were held and that they identified issues and themes.

d. Community assets and resources identified and considered in the community health improvement process.

e. A description of the process used by participants to develop a set of priority health issues

Prioritization Techniques

The *Guide to Prioritization Techniques* published by the National Association of County & City Health Officials (NACCHO) offers information about five widely used prioritization techniques. The complete NACCHO document can be found at: https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/Gudie-to-Prioritization-Techniques.pdf

The information below describes three of those techniques. These techniques appear to be most appropriate for meeting the NYSDOH requirement that local health departments and hospitals work together to identify at least two priorities associated with the Prevention Agenda.

1. Strategy Grids

Strategy grids facilitate agencies in refocusing efforts by shifting emphasis towards addressing problems that will yield the greatest results. This tool is particularly useful when agencies are limited in capacity and want to focus on areas that provide 'the biggest bang for the buck.' Rather than viewing this challenge through a lens of diminished quality in services, strategy grids can provide a mechanism to take a thoughtful approach to achieving maximum results with limited resources. This tool may assist in transitioning from brainstorming with a large number of options to a more focused plan of action.

Step-by-Step Instructions:

1. **Select criteria** – Choose *two* broad criteria that are currently most relevant to the agency (e.g. 'importance/urgency,' 'cost/impact,' 'need/feasibility,' etc.). Competing activities, projects or programs will be evaluated against how well this set of criteria is met. The example strategy described below uses 'Need' and 'Feasibility' as the criteria.

2. **Create a grid** – Set up a grid with four quadrants and assign one broad criteria to each axis. Create arrows on the axes to indicate 'high' or 'low,' as described below.

3. **Label quadrants** – Based on the axes, label each quadrant as either 'High Need/High Feasibility,' 'High Need/Low Impact,' 'Low Need/High Feasibility,' 'Low Need/Low Feasibility.'

4. **Categorize & Prioritize -** Place competing priorities, activities, projects, or programs in the appropriate quadrant based on the quadrant labels. The description below depicts 'Need' and 'Feasibility' as the criteria and items have been prioritized as follows:

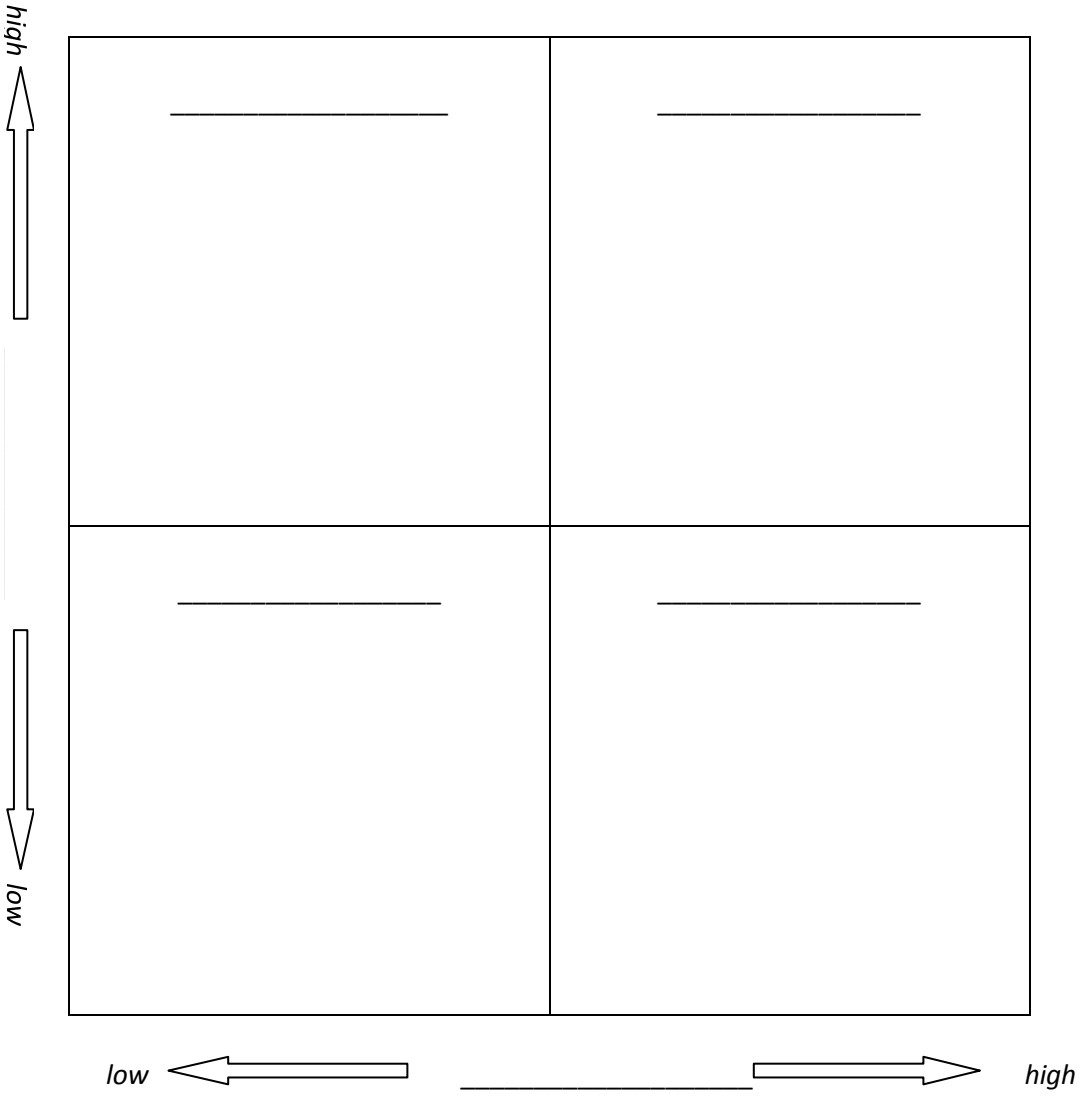
- *High Need/High Feasibility* – With high demand and high return on investment, these are the highest priority items and should be given sufficient resources to maintain and continuously improve.

- *Low Need/High Feasibility* – Often politically important and difficult to eliminate, these items may need to be re-designed to reduce investment while maintaining impact.

- *High Need/Low Feasibility* – These are long term projects which have a great deal of potential but will require significant investment. Focusing on too many of these items can overwhelm an agency.

- *Low Need/Low Feasibility* – With minimal return on investment, these are the lowest priority items and should be phased out allowing for resources to be reallocated to higher priority items.

Strategy Grid



Instructions:

1. Fill in the blank spaces on each axis with the desired criteria
2. Label each quadrant according to the axes
3. Place competing priorities/interventions into the appropriate quadrant

2. Prioritization Matrix

A prioritization matrix is one of the more commonly used tools for prioritization and is ideal when health problems are considered against a large number of criteria or when an agency is restricted to focusing on only one priority health issue. Although decision matrices are more complex than alternative methods, they provide a visual method for prioritizing and account for criteria with varying degrees of importance.

Step-by-Step Instructions:
The following steps outline the procedure for applying a prioritization matrix to prioritize health issues. While working through each step, refer to the table below for a visual representation:

Example Prioritization Matrix

	Criterion 1 (Rating X Weight)	**Criterion 2 (Rating X Weight)**	**Criterion 3 (Rating X Weight)**	**Priority Score**
Health Problem A	2 X 0.5 = 1	1 X .25 = .25	3 X .25 = .75	2
Health Problem B	3 X 0.5 = 1.5	2 X .25 = 0.5	2 X .25 = 0.5	2.5
Health Problem C	1 X 0.5 = 0.5	1 X .25 = .25	1 X .25 = .25	1

1. **Create a matrix –** List all health issues vertically down the y-axis (vertical axis) of the matrix and all the criteria horizontally across the x-axis of the matrix so that each row is represented by a health issue and each column is represented by a criterion. Include an additional column for the priority score.

2. **Rate against specified criteria –** Fill in cells of the matrix by rating each health issue against each criterion which should have been established by the team prior to beginning this process. An example of a rating scale can include the following:

   3 = criterion met well
   2 = criterion met
   1 = criterion not met

3. **Weight the criteria –** If each criterion has a differing level of importance, account for the variations by assigning weights to each criterion. For example, if 'Criterion 1' is twice as important as 'Criterion 2' and 'Criterion 3,' the weight of 'Criterion 1' could be

.5 and the weight of 'Criterion 2' and 'Criterion 3' could be .25. Multiply the rating established in Step 2 with the weight of the criteria in each cell of the matrix. If the chosen criteria all have an equal level of importance, this step can be skipped.

4. **Calculate priority scores –** Once the cells of the matrix have been filled, calculate the final priority score for each health problem by adding the scores across the row. Assign ranks to the health problems with the highest priority score receiving a rank of '1.'

Prioritization Matrix

Health Indicator	_____	_____	_____	Priority Score

Instructions:

1. Fill in items to be prioritized under the 'Health Indicator' column.
2. Fill in the blank spaces in columns 2, 3 and 4 with the chosen criteria.
3. Fill in the ranks for each health indicator under the appropriate criteria.
4. Calculate the priority score by adding the rankings in each row.

3. The Hanlon Method

Developed by J.J. Hanlon, the *Hanlon Method for Prioritizing Health Problems* is a well-respected technique which objectively takes into consideration explicitly defined criteria and feasibility factors. **Though a complex method, the Hanlon Method is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values**.

Step-by-Step Instructions:

1. **Rate against specified criteria** – Once a list of health problems has been identified, on a scale from zero through ten, rate each health problem on the following criteria: *size of health problem, magnitude of health problem, and effectiveness of potential interventions*. It is important to remember that this step requires the collection of baseline data from the community such as from a community health assessment. The table below illustrates an example numerical rating system for rating health problems against the criteria.

The Hanlon Method: Sample Criteria Rating			
Rating	**Size of Health Problem** *(% of population w/health problem)*	**Seriousness of Health Problem**	**Effectiveness of Interventions**
9 or 10	>25% (STDs)	Very serious (e.g. HIV/AIDS)	80% - 100% effective (e.g. vaccination program)
7 or 8	10% - 24.9%	Relatively Serious	60% - 80% effective
5 or 6	1% - 9.9%	Serious	40% - 60% effective
3 or 4	.1% - .9%	Moderately Serious	20% - 40% effective
1 or 2	.01% - .09%	Relatively Not Serious	5% - 20% effective
0	< .01% (Meningococcal Meningitis)	Not Serious (teen acne)	<5% effective (access to care)
Guiding considerations when ranking health problems against the 3 criteria	• Size of health problem should be based on baseline data collected from the individual community.	• Does it require immediate attention? • Is there public demand? • What is the economic impact? • What is the impact on quality of life? • Is there a high hospitalization rate?	• Determine upper and low measures for effectiveness and rate health problems relative to those limits. • For more information on assessing effectiveness of interventions, visit http://www.communityguide.org to view CDC's Guide to *Community Preventive Services*

**Note: The scales in the table are arbitrary models of how numerical scales are established and are not based on real epidemiological data; LHDs should establish scales that are appropriate for the community being served.*

2. Apply the 'PEARL' test - Once health problems have been rated by criteria, use the 'PEARL' Test, to screen out health problems based on the following feasibility factors:

- **P**ropriety – Is a program for the health problem suitable?
- **E**conomics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
- **A**cceptability – Will a community accept the program? Is it wanted?
- **R**esources – Is funding available or potentially available for a program?
- **L**egality – Do current laws allow program activities to be implemented?

Eliminate any health problems which receive an answer of "No" to any of the above factors or proceed with corrective action to ensure that potential health priorities meet all five of the feasibility factors.

3. Calculate priority scores – Based on the three criteria rankings assigned to each health problem in Step 1 of the Hanlon Method, calculate the priority scores using the following formula:

D = [A + (2 x B)] x C

Where: D = Priority Score
A = Size of health problem ranking
B = Seriousness of health problem ranking
C = Effectiveness of intervention ranking

**Note: Seriousness of health problem is multiplied by two because according to the Hanlon technique, it is weighted as being twice as important as size of health problem.*

4. Rank the health problems – Based on the priority scores calculated in Step 3 of the Hanlon Method, assign ranks to the health problems with the highest priority score receiving a rank of '1,' the next high priority score receiving a rank of '2,' and so on.

Hanlon Method Worksheet

Health Indicator	A Size	B Seriousness	C Effectiveness of Intervention	D Priority Score (A + 2B)C	Rank

Instructions:

1. Fill in items to be prioritized under the 'Health Indicator' column.
2. Fill in the 'A,' 'B,' and 'C' columns with the assigned ratings for each health indicator with respect to the three criteria.
3. Calculate the priority score using the formula in column 'D.'
4. Rank the health indicators with the highest priority score receiving a rank of '1.'

ARHN Community Health Assessment Committee
Data Subcommittee

Selection of Criteria to Identify Health Priorities

A critical step in identifying and prioritizing local health issues is to clearly define the criteria that will be used to compare options and guide how final decisions about the selected priorities will be made.

The table below lists some criteria commonly used in prioritization processes:

Criteria to Identify Priority Problem	Criteria to Identify Intervention
• Cost and/or return on investment • Availability of solutions • Impact of problem • Availability of resources (staff, time, money, equipment) to solve problem • Urgency of solving problem (H1N1 or air pollution) • Size of problem (e.g. # of individuals affected)	• Expertise to implement solution • Return on investment • Effectiveness of solution • Ease of implementation/maintenance • Potential negative consequences • Legal considerations • Impact on systems or health • Feasibility of intervention

The questions below may help to identify criteria to be used in the prioritization process. It is recommended that you use no more than four or five criteria to identify priorities.

- Who is affected?
- How many people are affected?
- Are there groups that are affected more than others?
- Where are the greatest opportunities for improvement?
- How severe are the effects? How much does the issue contribute to health outcomes?
- What are the consequences of not intervening?
- Are there strategies that have been shown to effectively address the issue?
- What does the community think? Do they support the issue?
- What do policymakers think? Do they support the issue?
- What assets and resources can partners bring to address the issue?
- How long will it take to reach an outcome?
- What are the potential negative impacts of addressing the problem?
- What has been tried before? What were the barriers and successes of those attempts?

In its April 2018 letter to hospitals and local health departments about the next community health assessment and planning cycle, NYSDOH cited several examples of assessments and plans submitted in 2016.

Below are the criteria to identify priorities used by some of the local health departments and hospitals cited by NYSDOH:

Albany County

Health indicators were considered in the prioritization process if an indicator met the following criteria:

- at least one of the rates was significantly higher than NYS (excluding NYC) data; or
- at least one of the rates is in the highest risk quartile in NYS; or
- rates for the health condition worsened over the past decades; or
- the health condition was a leading cause of death; or
- the disparity between rates was clearly evident in sub-populations; or
- there was a high absolute number of cases of the health condition.

Albany Medical Center

Health issues were considered in the prioritization process if an indicator met the following criteria:

- health conditions where two of the three counties in the region had higher or significantly higher rates than other Upstate counties; or
- a very high number of people in the region were impacted; or
- the disparity between rates for the general population and a sub-population was high.

Indicators that met these criteria were considered during a series of three Prioritization Task Force meetings. Task force participants shared their views for each indicator considering the following criteria:

- the impact of the condition on quality of life and cost of health care;
- community awareness and concern about the condition; and
- the opportunity to prevent or reduce the burden of this health issue on the community.

Chautauqua County

Chautauqua County looked at conditions that were significantly worse than New York State or categorized in the 4th quartile. Issues that affected large numbers of people, but were not necessarily different from state averages, such as obesity, were also flagged as important.

In addition to identifying overall burden of health issues and discrepancies when compared to New York State, needs identified in the community health survey and at community conversations were also considered. Existing infrastructure, support, and funding were also considered in the selection process. The following framework describes how priority areas were selected:

- data indicate great burden to Chautauqua County (high case numbers) or great exceedance over state averages;
- identified as a need in the community health survey and at community conversations;
- relevant actionable steps can be taken by agencies involved with the issue; and
- resources exist to support action items.

Delaware County

Health priorities were selected based on the application of the following criteria:

- the priority was identified by at least two of three of the primary information sources;
- the priority was consistent with the Prevention Agenda;
- the priority area was supported by data;
- the degree of aberration from National Healthy People 2020 goals and/or from Prevention Agenda objectives;
- the priority was identified/recommended during the public input process;
- availability of resources and capacity to address the priority; and
- opportunities exist for development of collaborative interventions by community partners.

ARHN Community Health Assessment Committee
Data Subcommittee

Practices for Engaging Community Members in Data Collection for Community Health Assessments

The information below is from the *Community Health Assessment Toolkit* produced by the Association for Community Health Improvement. The excerpted information provides guidance about four methods that can be used to engage community members and key stakeholders to collect information about the community that cannot be found in existing databases. This information supplements the 2016 report, *Overview of Engagement Strategies Utilized Across NYS,* prepared by the Center for Health Workforce Studies.

The complete *Toolkit* can be found at:
http://www.healthycommunities.org/Resources/Toolkit/files/step4-collect-analyze.shtml#.XAaa_cEm6po

Collect community-engaged primary data

Information not available in existing databases should be collected directly from your community. This is an ideal opportunity to engage your community. There are four main approaches to obtaining primary data:

- **Community surveys:** written surveys distributed widely to the community on paper and/or online
- **Key stakeholder interviews:** one-on-one conversations between trained facilitators and community stakeholders
- **Focus groups:** group-based conversations of 5 to 10 participants led by a trained facilitator
- **Town hall meetings:** community-wide meetings led by a trained facilitator

Guiding principles to consider when soliciting the opinions of community members about their community health needs include:

- Involve community members in developing surveys or interview guides to ensure that questions are culturally appropriate, are understandable and will elicit desired responses. Do not use health care jargon, as most people outside of the field will not understand it.
- When developing questions, make sure the questions accurately and directly address what is being measured.

- Keep the wording of questions simple, with clearly defined terms. Avoid leading questions, two-part questions or questions that make assumptions about the respondent.
- Test the questions on a small sample of potential respondents so they can give feedback and identify any confusing terms or suggest modifications.
- Keep surveys short to reduce the time burden on the respondents and increase the response rate. Include only relevant, necessary questions.
- Collect responses from a large and diverse group of individuals who are representative of the community served. If there is a significant non-English-speaking population, consider approaches that would allow those individuals to participate in their native language.
- Train individuals who will be conducting interviews and focus groups to perform this work consistently and neutrally so as not to influence responses.
- Develop standard processes for analyzing data. This is particularly important when coding qualitative data, as it is a fairly subjective process.

Below are some suggested practices for engaging community members in the data collection process:

Community Surveys

CONTENT AND FORMAT	Assure respondents of confidentiality. Collect race, ethnicity and language data in a culturally appropriate manner. Ensure that survey questions are culturally appropriate and at a literacy level and language that respondents can understand. Review the survey draft with community members to see what needs to be modified. Provide versions of the survey in the languages spoken by community members. Consider using or modifying a validated survey instrument or questions. Assess regularity of health care usage as frequent users may have a unique perspective. Allow space for qualitative answers. Provide the option for respondents to be contacted for further involvement in the CHA process. Distribute the survey online, on paper or both. Consider using both methods if there are major segments of the community's population who do not have internet access.
PARTICIPANTS	Consider oversampling vulnerable populations since interventions would likely need to be focused on the needs of those groups. Distribute the survey where people live, work, learn and play—at churches, local businesses, health fairs, etc. Widely advertise the survey using social media, newspaper advertisements, etc. Engage community leaders to encourage participation in the survey among their constituents. Consider specifically surveying the patient population.

Key Stakeholder Interviews

PARTICIPANTS	Consider whom to interview: • Interview stakeholders from a variety of sectors in the community. • Engage clinicians—including physicians, nurses, community health workers, etc.—for interviews as they likely have insights into the health needs of patients in the hospital. • Interview individuals representative of the community, including subgroups experiencing health disparities. Supplement topic areas with sparse secondary data by interviewing community stakeholders knowledgeable in that area. Find innovative ways to recruit for stakeholder interviews: • Ask community leaders if they know and could provide connections to potential participants with the characteristics being targeted. • Engage clinicians in hospitals or any associated medical groups and practices to identify patients for interviews. • Talk to hospitals' patient and family advisory councils (PFACs).
LOCATION	Make the location easily accessible; consider factors such as proximity to public transportation, time of day, availability of parking, child care, etc. Hold the interviews in a neutral space (i.e., not the hospital). Consider online or phone interviews to reduce barriers to participation.
FACILITATOR	Ensure that the interview facilitator is culturally competent and speaks the language(s) spoken by the interviewees. Use a facilitator who is well trained in moderating interviews, including keeping participants on topic and maintaining a neutral position.
DEVELOPING INTERVIEW QUESTIONS	Develop an interview guide so the same questions are asked across all interviews. Ask short and open-ended questions to encourage dialogue on various topics. Review the list of questions ahead of time with community members to ensure that questions are culturally appropriate and at a level that participants would be able to understand. Be aware that the interview facilitator cannot ask people to identify their health conditions. If possible, provide the questions to attendees ahead of time.
CONDUCTING THE INTERVIEWS	Explain to participants how their input will be used. Establish confidentiality of the participants' responses. Especially in small communities, participants may be worried about their names being attached to their comments. Provide an estimated timeline of when final results will be shared. Ask whether the individual would like to be involved in future stages of the CHA and set the process for continued engagement.

	Establish realistic expectations for what the hospital and partners can do to address community needs.

Focus Groups

PARTICIPANTS	Consider whom to sample: a cross-section of the whole community and/or more targeted groups? Contemplate recruiting from existing groups (e.g., PFACs, church groups). Find innovative ways to recruit for focus groups where people live, learn, work and play (e.g., advertisements on social media, in newspapers, on the radio, at churches, local businesses, etc.). Engage clinicians to identify patients for focus groups. Consider members of the community who may not be easily reached and brainstorm how they can be recruited. Encourage attendance through reminder notices. Limit focus groups to 10 or fewer participants to ensure that everyone's opinions can be heard.
LOCATION	Make the location easily accessible for community members. Consider factors such as proximity to public transportation, time of day, availability of parking, child care, etc. Hold the focus groups in a neutral space (i.e., not the hospital). Consider holding virtual or phone focus groups to reduce barriers to participation. Focus groups should typically last no longer than 90 minutes.
FACILITATOR	Use a facilitator who is well trained in moderating focus groups, including keeping participants on topic, maintaining a neutral position, and making sure that everyone participates and is listened to. Ensure the facilitator is culturally competent and speaks the language(s) spoken by attendees. Consider using a facilitator from a neutral third party, so participants feel more comfortable.
DEVELOPING FOCUS GROUP QUESTIONS	Develop a focus group question guide, so the same questions are asked across multiple focus groups. Ask short and open-ended questions to encourage dialogue on various topics. Review the list of questions ahead of time with community members to ensure that questions are culturally appropriate and at a level that participants would be able to understand. If possible, provide the questions to attendees ahead of time. Refrain from asking very sensitive questions that individuals would not want to share in a group.
CONDUCTING THE FOCUS GROUPS	Establish confidentiality of the participants' responses. Especially in small communities, participants can be concerned about their names being attached to their comments. Explain to participants how their input will be used. Give participants an estimated timeline of when results will be shared.

	Establish realistic expectations for what the hospital and partners can do to address community needs. Ask whether the individual would like to be involved in future stages of the CHA and set the process for continued engagement.

Town Hall Meetings

PARTICIPANTS	Advertise the meetings where people live, work, learn and play using social media, newspapers, radio, announcements and flyers, local organizations, support groups, PFACs, etc. If possible, offer child care for participants. Explain why the CHA is relevant for the whole community.
LOCATION	Make the location easily accessible for community members. Consider factors such as proximity to public transportation, time of day, availability of parking, child care, etc. Hold the meetings in a neutral space (i.e., not the hospital). Consider coordinating the meeting with existing community or town meetings.
FINDING A FACILITATOR	Ensure that the facilitator is culturally competent, speaks the languages spoken by community members and is sensitive to attendees' needs. The facilitator should be well trained in moderating community meetings, including keeping participants on topic, ensuring that louder voices do not drown out others, and maintaining a neutral position.
DEVELOPING AN AGENDA AND QUESTIONS	Develop a draft agenda and questions and, if possible, distribute them to attendees ahead of time. Ask participants open-ended questions to encourage dialogue about various topics. Review the list of questions ahead of time with community members to ensure that questions are culturally appropriate and at a level that participants would be able to understand.
MEETING LOGISTICS	Tell all participants how their feedback will be used and when results will be shared. Consider using voting devices (clickers, cell phone apps, etc.) to gain input from more community members, especially those who may not feel comfortable speaking up in a public setting. Establish realistic expectations for what the hospital and partners can do to address community needs. Provide the option for participants to be contacted for further involvement in the CHA process; this is an easy way to identify individuals who desire increased engagement.

ARHN Community Health Assessment Committee
Data Subcommittee

2019 Local Service Plans for Mental Hygiene Services
Overall Needs Assessment by Population

The following information are excerpts from the 2019 Local Service Plans for Mental Hygiene Services submitted by the Community Service Boards in the ARHN region. The information is from the section of the Local Service Plan entitled *Overall Needs Assessment by Population.*

More detailed descriptions of the mental hygiene service needs are included in each county's service plan. The full 2019 service plan can be accessed through the link listed under each county.

Clinton County

http://www.clmhd.org/img/pdfs/brochure_iomue71kmz.pdf

Level of unmet mental health service needs

Mental Health Services in Clinton County have remained the same from the previous year. There are some areas that have improved, for example, additional psychiatrists and the addition of a mobile crisis team, while others have contributed to the decline of services such as the elimination of paratransit services, and the increase in children with long stays in the mental health unit or in the emergency room.

The University of Vermont Health Network, Champlain Valley Physicians Hospital has successfully recruited psychiatrists which improves psychiatric treatment in our community but there remains a shortage in the outpatient clinics and a deficit in qualified staff in outpatient clinics.

Transportation remains a large contributing factor as unmet transportation needs continues to impact access to services for individuals coming to treatment or for providers going into the communities. The cost of transportation and the time of travel makes services less available to those in need of services. In 2017, the elimination of paratransit services exacerbated the transportation issue. School satellites were expanded and satellites remain in primary care alleviating some of the transportation issues.

This year a mobile crisis team has been established in our community. The response to mental health crisis and reduction of emergency room visits has improved mental health services. The mobile crisis team is currently operating Monday through Friday from 8:00 a.m. to 8:00 p.m. Individuals with night or weekend crisis are left with only the emergency room as an option.

Children's mental health services is a significant issue especially those in crisis. There are very limited options for treatment for children with a crisis that have a mental health diagnosis and /or developmental disability diagnosis. Limited resources for safety plans and stabilization in the community make for long emergency room or mental health unit stays. These children remain on the mental health unit or in the emergency room for extended periods of time with little to no options for appropriate treatment or placement. Some of the barriers include no appropriate placements, long waiting lists at appropriate facilities, lack of trained staff to maintain their behaviors in the community, no local placement option to do meaningful family work and cross-system collaborations.

In the fiscal year 2016/17 there were 529 adults discharged from Behavioral Health Inpatient at the local hospital and 225 children. In the first quarter of 2018 there have been 136 adults discharged with a behavioral health diagnosis and 76 children. If we use the first quarter of 2018 as a quarterly average, there will be more individuals presenting to behavioral health inpatient for both adults and children then the previous year.

Level of unmet substance use disorder needs

The Clinton County Community has seen a significant increase in opioid use and issues and concerns related to its use. The deaths related to opioid use appears to have stayed the same for the current published data.

In 2016 there were 8 deaths related to opioid use, 2 related to heroin and 7 with opioid pain relievers. In 2017 only in the first three quarters, there have been 7 opioid overdoses resulting in death, none related to heroin and 5 related to opioid pain relievers. Given the current information it would appear that 2017 is similar to 2018 in opioid related deaths.

Additionally in 2016 the opioid analgesic prescription rate places Region 5 at a high rate of prescriptions, with Clinton being the second highest in the region.

Patients presenting to the emergency room for Substance Abuse in the fiscal year 2016/17 consisted of 8,995 visits/5,920 adult patients. In the first quarter of 2018 there were 1,981 visits consisting of 1,722 adult patients. Substance Abuse presentation for children and youth visits for 2016/17 674 visits/505 patients and in the first quarter of 2018, 189 visits with 150 patients. Presented with the first quarter numbers of 2018, it would look as though 2018 will have more emergency room visits with a substance abuse presentation then the year before for youth and adults which is very concerning.

The current outpatient treatment facilities are struggling with the lack of CASACs and CASAC-Ts to recruit and retain. The increase in opioids in the community is taxing the system as needs for prevention, education, medication assisted treatment, detox programs, and supports to this population are increasing with the growing epidemic. The community is working on a diversion program with law enforcement but has not committed to any system change at this point.

There are plans to open a detox facility in 2018 providing a needed service for our community and surrounding communities and Alliance for Positive Health is working on prevention initiatives that include overdose treatment training. SPARCC is strengthening the regional collaboration and impact focusing on stigma and glamourizing recovery.

In 2016 there were 24 opioid overdoses more than doubling the year before. Heroin overdoses more than tripled between 2015 (4) and 2016 (14). There were 277 clients admitted for heroin treatment programs and 480 for any opioid. There were 102 Naloxone administrated for 2016 (Emergency Medical Services, Law Enforcement, and Registered Programs).

Level of unmet needs of the developmentally disabled population

The developmental disability community is experiencing growth and uncertainty as the systems transitions to managed care. There remains large gaps in services with a lack available recruitment and retention for trained staff. This has been evident in the developmentally disabled children that have been in crisis in the emergency room or the mental health unit and had to remain there for weeks or months at time because there were no available placement options and no services in the community to provide stabilization and support despite the fact services were approved.

The community is struggling with serving the population in the community as integration continues. There are not enough trained professionals to provide services and not enough housing options for individuals to maintain independence and community involvement in a supportive environment.

Essex County

http://www.clmhd.org/img/pdfs/brochure_25u7242hk7.pdf

Level of unmet mental health service needs

With the implementation of Adult Health Home, HCBS and HARP enrollees, there is an increase in services to the Medicaid Managed Care participants. Additionally, an increase in requests for services made by schools and PCPs has increased the need in our county, which we are preparing ourselves to address. The area that may have "worsened" is the delay in Children's HCBS services.

Level of unmet substance use disorder needs

Like most counties across NYS, we continue to see significant increases in abuse of and addiction to heroin/opiates. While the number of opioid-related deaths in Essex have essentially stayed the same, Addictions, in general, have increased, with an increase in crack and alcohol use. We are hopeful that the number of persons participating in OASAS treatment will increase in the next year given a local provider's grant to open a detox center and residential treatment.

Level of unmet needs of the developmentally disabled population
As OPWDD prepares for NYSTART, the pressures that the rural providers are experiencing in the transformational changes are compounded with workforce issues. Low pay, fear of Justice Center involvement, and a lack of qualified, dedicated workers are the primary concerns of the local provider.

Franklin County

http://www.clmhd.org/img/pdfs/brochure_ub3ac18sqg.pdf

Level of unmet mental health service needs
2018 Updates:
Citizen Advocates Inc. Crisis and Recovery Center is fully operational and serving the North Country. 486 unique individuals were served at the Center from the last week of September through December 2017; with 596 unique individuals served January - April 2018.

Citizen Advocates/ North Star Behavioral Health has been without a permanent psychiatrist since the last quarter of 2017. CCBHC initiatives continue to include the long awaited implementation of the Mobile Crisis Team.

St. Regis Mohawk Tribe will expand the Health Services Building which will allow for mental health, addiction and prevention services to be in one location.

Community Connections continues to create additional programs, to include DSS contracts to provide an adolescent life skills and work experience training program. Community Connections is working with a local ecumenical group to establish a transitional housing program for women in Malone. Along with Lakeside House, the two providers are invested in providing services to our homeless population.

All providers are challenged by workforce issues and acknowledge the significant impact on the delivery of services.

2017 Information:
Several local providers have recently increased capacity to serve Franklin County residents. St. Regis Mohawk Tribe Mental Health Services has received grant funding through SAMHSA and Indian Health Services. Both grants will focus on increasing access for Native Americans, suicide prevention, SUD services, reducing the impact of trauma and promoting wellness and mental health.

Citizen Advocates, Inc. - North Star Behavioral Health is designated to open the Crisis and Recovery Center in summer 2017. The service will provide crisis stabilization, ambulatory detox and respite. The agency is also participating in the Certified Community Behavioral Health Clinic (CCBHC) Pilot and will launch mobile crisis team and related activities.

Adirondack Medical Center, providers and law enforcement have operationalized the MAX Team as of Spring 2017. The DSRIP project supports frequent ED utilizers in an effort to avoid crisis events and decrease the need for hospitalizations in the Saranac Lake region.

Community Connections/Franklin County MHA has taken the lead role in the creation of the Franklin County Connections Coalition, comprised of 18 organizations which share resources and discuss challenges in the county. It is a critical think tank to address areas of unmet needs. Community Connections continues to provide HCBS Waiver Services and has added Family Support services to HARP eligible individuals. The agency received a DSRIP award through Adirondack Health Institute which will add Peer Community Navigators in the Alice Hyde Medical Center ED. PCNs will provide coverage Monday-Sunday 3-11pm; during which they will engage individuals, conduct 24-72 hour follow up and connect individuals to services.

Lakeside House opened Samaritan House in February 2017; an eight bed transitional housing program in Saranac Lake. 81% of referrals have Franklin County residents with varying mental health needs.

Level of unmet substance use disorder needs

2018 Updates:

Citizen Advocates Inc. Crisis and Recovery Center is fully operational and serving the North Country. 486 unique individuals were served at the Center from the last week of September through December 2017; with 596 unique individuals served January - April 2018. 33 individuals presented for detox from the last week of September - December 2017. 44 individuals have accessed detox services January - April 2018. The agency has provided 345 units of MAT services from January - April 2018.

St. Joseph's Addiction Treatment and Recovery Centers have recently been awarded 24/7 Open Access Center and 10 bed Medically Supervised Detoxification Service projects. The two programs will be housed at the same location as the Outpatient Clinic in Saranac Lake; construction is slated to begin in the summer of 2018. The projects will address the increase in the number of individuals in crisis due to SUD; especially opiate/opioid disorders. In the first eight months of 2017, 97% of inpatient admissions had an opiate/opioid diagnosis. 66% of outpatient admissions had an opiate/opioid diagnosis; a 106% increase in eighteen months.

These programs in addition to the CAI Malone Crisis and Recovery Center will increase support to our Franklin County residents in need of crisis SUD services. MH/SUD Treatment Services at the County Correctional Facility are provided by Citizen Advocates - North Star Behavioral Health and St. Joseph's Addiction Treatment and Recovery Centers. Services were provided to 517 individuals between the two providers; with a total of 3770 units of services provided during 2017.

2017 Information:
Citizen Advocates, Inc. - North Star Behavioral Health is designated to open the Crisis and Recovery Center in summer 2017. The service will provide crisis stabilization, ambulatory detox and respite. Although slated to open earlier this year, staffing has been impacted by the lack of licensed clinicians in the North Country.

Franklin County residents continue to have access issues related to detox services as the only detox program in the North Country is Canton Potsdam Hospital in St. Lawrence County.

The Franklin County Substance Use Prevention Task Force has convened a subcommittee to address the increasing number of children in foster care as a result of SUD related issues. 53 cases were identified during the time frame of February 1st - April 30th 2017 involving 102 children. All 53 cases were impacted by SUD: 56.6% marijuana, 43.3% alcohol and 45.28% opiates/opioids and Suboxone. The subcommittee will meet on an ongoing basis to further analyze the data and develop strategies to reduce SUD related foster care cases.

North Star Behavioral Health Prevention Services recently received results from the 2017 Franklin County Prevention Needs Assessment (PNA) distributed to six of the seven school districts. Surveys were distributed to 887 participants in the 8th, 10th and 12th grades. At the time of the survey 46.9% of 12th graders had used alcohol in the past 30 days. 43 of the respondents had attended school while under the influence of either AOD. 46.5% of the respondents had used alcohol while at home with parent permission. At the time of the survey 13 students reported driving after drinking in the past 30 days.

Level of unmet needs of the developmentally disabled population
2018 Updates:
Providers are unable to move forward with the development of onsite respite services due to no change in the approved rates. Very limited progress has occurred with the launch of START services in Franklin County. There have been improvements in accessing supports and services for incarcerated individuals at the Franklin County Correctional Facility who originate from the Sunmount Campus. It is hope this recent collaboration will continue to better support individuals with intellectual and developmental disabilities during incarceration. There continues to be concerns regarding the transition of OPWDD MSC to CCO services related to workforce, delivery of services and interpretation/understanding of the services by individuals and families.

2017 Information:
Reports from providers and key stakeholders indicate an ongoing need for crisis, respite and forensic services for I/DD individuals. Citizen Advocates and the Adirondack Arc are committed to developing on site respite services however approved rates will not fiscally support the services. It is hoped with the launch of START services in September 2017, I/DD individuals will have support at the time of a crisis event and while in local hospital EDs.

Individuals incarcerated at the local jail need behavioral supports and assistance while in the jail environment. Correctional officers need OPWDD supports to ensure safety and overall health and wellness of I/DD individuals.

Fulton County

http://www.clmhd.org/img/pdfs/brochure_4htqs1309s.pdf

Level of unmet mental health service needs

Fulton County is still awaiting the mental health system to change over to managed care system of care.

Level of unmet substance use disorder needs

Fulton County is still awaiting the substance use disorder system to change over to managed care system of care.

Level of unmet needs of the developmentally disabled population

Fulton County is still awaiting the developmental disability system to develop a plan to change over to managed care system of care. Evaluating the change to care coordination organizations and if this will provide adequate services to this population

Hamilton County

http://www.clmhd.org/img/pdfs/brochure_ekppjnxm5b.pdf

Level of unmet mental health service needs

The shortage of mental hygiene professionals, particularly psychiatry and social work, in the region and county continues to significantly challenge the ability of our county's mental health provider to deliver timely and accessible services. Tele-health, as a supplemental resource to address these shortages, was introduced this past year and being successfully used in the County Jail and a local school district. Planning currently is to expand this service to other locations in the county.

Level of unmet substance use disorder needs

Over the past year Hamilton County continues to see a trend upward in individuals with opiate addiction. While the overall numbers are not large the resources available require significant travel time and, with limited transportation available for county residents, this can be challenging. Hamilton County will work with OASAS and regional providers to develop strategies to better meet the treatment needs of individuals with opiate addiction, with particular focus upon accessibility.

Level of unmet needs of the developmentally disabled population
The limited availability of respite and residential opportunities, for individuals residing in the community, has been a challenge...particularly for children and adolescents. The lack of these services has put children at risk and required intervention by local DSS's Child Protective Services to maintain safety. These issues have been brought to the attention of local OPWDD and, while sympathetic, there has been no discernable progress in addressing this issue.

Warren & Washington Counties

http://www.clmhd.org/img/pdfs/brochure_h73xrcad9u.pdf

Level of unmet mental health service needs
Warren and Washington Counties are rural counties located in Northeastern New York State. The two counties have a combined population of approximately 130,000. Both Warren and Washington Counties have a higher percentage of residents who are aged 65 and older as well as a higher percentage of disabled individuals under the age of 65, when compared to statewide averages. In addition, Washington County has a higher than average rate of completed suicide and it appears to be on an upward trend. Warren County's rate of completed suicide, while slightly higher than the statewide rate, appears to be decreasing over the past 3 years.

The most significant issues that are impacting the overall community needs are a limited public transportation system, lack of access to outpatient clinic services and a significant shortage of a qualified behavioral health workforce.

The Adirondack DSRIP Region, which encompasses Warren, Washington, Hamilton, Essex, Franklin and Clinton Counties, has the third lowest rate of licensed Mental Health professionals in any DSRIP region. Namely, Washington County has the lowest county distribution of Mental Health professionals, 13 per 10,000, which is the second lowest rate among all NYS counties. These factors, combined with the rural nature of both counties, contribute to multiple challenges in the delivery of mental health services.

The culture of self-sufficiency, hesitancy on the part of residents to seek behavioral health care in traditional ways and the large number of employment opportunities that are often seasonal and lack health benefits all present unique challenges in the delivery of mental health services in the region.

While there has not been a significant change in unmet mental health services over the past year, we solicited feedback from our local mental health providers and various community stakeholders, most of whom indicated that their perception is that the level of unmet mental health service needs has increased over the past year despite the addition of mobile crisis services and several school based clinics. The mobile crisis services for both adults and children have continued to see a steady increase in referrals and have also been able to expand their hours since the inception of their services. In addition, Parsons Child and Family Center

provides Home Based Crisis Intervention services, which continues to be utilized by families with children that have more acute behavioral and mental health service needs.

We are also working with several of our local outpatient clinics in order to implement an open-access model, which would allow individuals to receive same day appointments for mental health services. This model has been shown to increase client engagement rates by allowing individuals to access services when they are ready to initiate treatment. The feedback received from our local programs as well as individuals attempting to access care is that the long waiting periods necessary to obtain an appointment lead to increased no-show rates for outpatient care. In addition, Parsons/Northern Rivers has received the contract to provide a 48 slot ACT Team. The program is recruiting for a Director/Team Lead as of May 2018. Our counties have seen a significant increase in mental health needs for children.

Over the past year, the number of children and youth SPOA applications grew from 31 applications in the first quarter of 2016 to 53 applications in the first quarter of 2017. Despite the increase in referrals, there are limited community programs and services to meet the needs of these children and families.

Our Children's clinics participated in the open-access project, in attempt to improve access and engagement in outpatient care. Several providers and families have indicated that an increase in mental health prevention programs as well as an increase in support groups for children and families would empower families by building a larger network of support, increasing awareness of community resources and in turn reducing the number of mental health related crises.

Additionally, our counties could benefit from an increase in both adult and child peer programs, as we currently have two mental health programs that utilize peer support services, however these are mainly for adults with behavioral health needs. We recognize that these services are not able to meet the diverse needs of children and adults in our communities and we hope to expand these as they provide positive recovery options, not only for the individuals receiving services but also for the peer employees. The implementation of these programs is critical in engaging our communities in helping to reduce the stigma of behavioral health treatment and diagnoses.

We continue to see an increase in utilization of the 24-hour support line and short term crisis respite services that are provided by the Rose House, a program provided through People, Inc. 2019 will also see the development of a Veteran's Peer Services Program, named after Joseph P. Dwyer, a combat medic who died of a drug overdose after years of struggling with Post-Traumatic Stress Disorder. The program is funded by the state to design, implement and evaluate a county-based veteran peer-to-peer service program for veterans.

One of our most pressing and challenging concerns is the lack of inpatient beds for children within our two counties. Children are being held in the ECC for days at a time while they await appropriate inpatient services, which are often located a significant distance away and create a transportation challenge for families. According to the Adirondack Region DSRIP Needs

Assessment, our larger Adirondack region has 12 child inpatient beds but we have an average daily census of 28.

Glens Falls Hospital is in the process of creating a Crisis Stabilization Center, which will be housed within the hospital's ECC. This area will be patient- and child-centered so that it is much more comfortable for the children and families accessing services. The services provided will be specific to psychiatric crisis and will serve both adults and children, with an area designated specifically for children. The staff will be dedicated to this unit and therefore will have specific training in evidence based practices, including crisis intervention and de-escalation techniques. The Crisis Stabilization Center will incorporate peer and family supports, with goals of increasing community support and engagement, while decreasing inpatient hospitalizations.

On the preventative end of our services, the Council for Prevention has been pioneering numerous community forums and coalitions to address suicide prevention initiatives. The Council has been able to provide free Mental Health First Aid trainings for community and program stakeholders as well as an increase in training programs that are available to licensed behavioral health and substance abuse professionals. These trainings have been available at no cost for our workforce, allowing staff to complete necessary continuing education credits needed to retain their licensure as well as bringing the most up to date evidence based and trauma informed trainings to a smaller, rural region.

The Council has also been spearheading the DSRIP initiative 4.a.iii, improving the mental health and substance abuse infrastructure, further allowing them to use DSRIP funding in creative and engaging ways for program staff and the community at large.

The Suicide Prevention Coalition has also formalized a post-vention team and process that is available to our local communities and school districts to assist the staff and students after a death by suicide or tragic event. Our local schools have embraced these services and have found them to be invaluable as far as education and post-vention support for individuals affected by such events.

The LGU continues to work closely with AHI, our local PPS, around finding a way to fund the SIM (Sequential Intercept Mapping) workshop, which includes a day and a half workshop that assists communities in clarifying how individuals with mental illness may typically intersect with the criminal justice system. This mapping process allows community systems such as law enforcement, criminal justice and mental health to 7 come together to identify diversion opportunities for individuals with mental illness prior to more serious involvement with the legal system. Legal interventions are both costly and ineffective when it comes to addressing the larger issue of mental illness. The goal is to increase service linkages and allow for an increase in quality of life for individuals that are often seen repeatedly in the criminal justice system.

Level of unmet substance use disorder needs

The LGU was able to gather feedback from local programs as well as individuals that are involved in the recovery movement. In reviewing local data sources and community responses it was determined that the level of unmet needs have maintained over the past year. While we continue to work with local programming and OASAS, the development of new programs is not able to keep up with the growing demand for services.

Two other concerns that are paramount in all three disability areas is the difficulty recruiting and retaining qualified professionals as well as a lack of transportation resources due to the rural nature of the area.

Across Warren and Washington Counties there has been a 21% increase in chemical dependency services from years 2014-2016. While the heroin and opiate crisis continues to be the most pressing issue in the arena of substance use disorders, the data shows that there isn't an upward trend in use although the rate continues to maintain. The addition of Fentanyl has proven to be a significant concern and has greatly contributed to an increase in overdoses.

Warren and Washington Counties had the 2nd and 4th highest SUD crisis admits as well as the 2nd and 3rd highest number of residential admits to SUD housing in the North Country RPC.

The two substances that continue to plague our area are opiates and alcohol. Within Warren and Washington Counties we have lost on residential program for women which leaves us with two substance abuse residential programs that serve a total of 36 individuals. Based on the increase in chemical dependency services and the feedback from stakeholders, the increased need for housing programs is a significant issue for those in need of SUD services.

In addition, the lack of detox, inpatient and MAT programs are also a notable gap in service needs for our area. Within our larger Adirondack DSRIP region, which encompasses Clinton, Essex, Franklin, Hamilton, Warren and Washington Counties, we have only two inpatient rehabilitation programs, which are both located in Franklin County. The lack of essential SUD treatment and crisis services make it difficult for individuals with acute needs to access timely services due to increased travel and limited openings across the region. Once the Glens Falls Hospital Crisis Stabilization Center is open they will have some availability to treat SUD individuals however it will likely be on a limited basis.

Locally, our two largest outpatient SUD providers have expanded hours and service availability by implementing specific open access clinic times. Both Glens Falls Hospital Center for Recovery clinics (Glens Falls and Hudson Falls) as well as the Baywood Center clinic offer open access hours.

Hudson Headwaters Health Network received funding last year that has allowed them to increase opioid treatment options. They have partnered with two out of the local outpatient SUD clinics to provide slots for individuals that may need MAT, Medically Assisted Treatment, even after completing outpatient programming.

Our DSRIP region has the highest average daily census of individuals in SUD outpatient programs. Specific to opioid treatment programs the Adirondack DSRIP region has only one treatment program, which is located in Clinton County. The capacity for such programming is the lowest rate of any DSRIP region in the state.

The Council for Prevention continues to lead the local Hometown vs. Heroin and Addiction Coalition, which has been an instrumental part of bringing awareness to our community and reducing the stigma that often comes with addiction and treatment. The Coalition continues to conduct numerous school- and community-based forums with experts in the field of SUD in addition to individuals in recovery and families affected by opiate addiction. The Coalition has several sub-committees to address more targeted needs, such as a neo-natal abstinence group that grew out of the healthcare worker's recognition that there was an increase in infants being born to opiate addicted mothers. The group has successfully garnered the support of local legislators as well as key community and healthcare stakeholders. The Council for Prevention has also continues to oversee the local recovery center, which has a part time staff/peer counselor.

OASAS has strategically planned to enhance treatment and recovery as well as improve the effectiveness of prevention and recovery services. There has been a cultural shift in recent years that has embraced recovery and encouraged a more person-centered, holistic lens around the nature of recovery. Feedback from our two county SUD services and recovery community indicated that there is an increase demand for peer-based services. Peer-based services have great value and there is evidence to indicate that these services can be very effective in supporting individuals throughout the various phases of recovery. There is a focus on a more holistic perspective and our local Warren/Washington Friends of Recovery has done a wonderful job advocating and creating a more public forum to bring attention to how pervasive substance use disorders are in our area.

The Council continues to run the adventure-based diversion program for 18-25 year olds that have been involved with the criminal justice system due to opiate use. This diversion program has the capacity to serve 30 individuals in the course of a year. Referrals will be made from Alternative Sentencing in Washington County and will act as a pre-court diversion from Probation in Warren County.

Level of unmet needs of the developmentally disabled population

One of the most pressing issue in the arena of disability services is workforce recruitment and retention. This concern is one that cuts across all three disability areas but has had a profound impact on developmental/intellectual disability services due to the large number of direct care staff these services employ. Several programs noted that the increasing minimum wage has made recruitment more difficult, particularly for such nuanced work that requires a high level of dedication and empathy. Providers indicate that they are competing with employers in the fast food industry as they are able to provide similar wages for job duties that typically require much less responsibility on the part of the employees when compared to those of a direct care support staff.

The other priority within disability needs is the lack of residential services. From 2014-2016 there has been a twenty percent increase in residential enrollments for Warren County. Within Washington County there has been a slight decrease in the residential enrollments. Also notable is the access to disability services, due in part to the OPWDD transformation, which has a greater emphasis on moving individuals from day support options into employment-based opportunities. The concern is that while employment can be an important piece of supportive services, not all individuals are interested in or able to maintain employment. Those opportunities that are available are limited and highly competitive.

Additionally, the eligibility process for OPWDD services continues to be a long process that often times causes frustration to the families and individuals that are in need of support. The START team is available in our area to provide community-based prevention and crisis intervention to individuals with acute behavioral health needs. The START staff and director continue to engage with our local stakeholders to ensure they are an accessible resource within the community.

ARHN Community Health Assessment Committee
Data Subcommittee

Community Asset Mapping Resources

Asset mapping provides information about the strengths and resources of a community and can help uncover solutions for improving community health. Depicting community strengths and resources on a **map** can assist in generating ideas about how to build on these assets to address community needs and improve health.

There are a number of resources and tools available to assist in constructing a community asset map. Some of those resources can be found at:

Rural Health Information Hub
https://www.ruralhealthinfo.org/toolkits/rural-toolkit/1/asset-identification

UCLA Center for Health Policy Research*
https://healthpolicy.ucla.edu/programs/health-ata/trainings/Documents/tw_cba20.pdf
* The information that follows was excerpted from the UCLA resource.

Advantages and Disadvantages of Asset Maps

Advantages	Disadvantages
• Builds on existing community assets • Mapping the inventory creates a visual depiction of existing and lacking assets • Data can be used to raise awareness about the availability of assets, develop or improve services and programs, or to apply for funding • Can generate a lot of community participation	• Finding the right maps can be difficult, and mapping software can be expensive and difficult to use • Some community assets will be difficult to map if they don't have a physical location • Needs community buy-in and collaboration to adequately inventory up-to-date community resources

Steps for Creating an Asset Map

- ✓ Define community boundaries
- ✓ Identify and involve partners
- ✓ Determine what type of assets to include
- ✓ List the assets of groups
- ✓ List the assets of individuals
- ✓ Organize assets on a map

Examples of Community Assets that Might be Included in an Asset Map

Associations:
Animal care groups
Anti-crime groups
Block clubs
Business organizations
Charitable groups
Civic event groups
Special needs groups
Education groups
Elderly groups
Environmental groups

Physical Space:
Gardens
Parks
Playgrounds
Parking lots
Bike paths
Forest/forest preserves
Picnic areas
Campsites
Fishing spots
Duck ponds

Institutions:
Schools
Universities
Community colleges
Hospitals
Libraries
Social service agencies
Nonprofits
Museums
Fire departments
Media

Individuals:
Gifts, skills, capacities, knowledge and traits of:
Youth
Older adults
Artists
TANF recipients
People with disabilities
Students
Parents
Entrepreneurs

Local Economy:
Business
Consumer expenditures
Merchants
Chamber of commerce
Business associations
Banks
Credit unions
Foundations
Institutional purchasing power

Sources of Information about Assets of Community Groups

Information about groups (organizations, associations, institutions, etc.) in your community can be found through existing resources such as:

- ✓ United Way maintained 2-1-1 systems
- ✓ Local neighborhood/city directories published for your community.
- ✓ Lists of neighborhood businesses from the Chamber of Commerce.
- ✓ Lists of organizations, which are not generally published, such as community resource guides produced by local organizations.
- ✓ Local newspapers and newsletters.

- ✓ Bulletin boards and community calendars located at recreation facilities, churches or other faith-based organizations and on local cable television.
- ✓ Local parks, recreation facilities, and community centers may be the meeting places for many local associations and groups, such as volunteer, social, or special interest groups. Check the activity calendars of these centers to identify formal and informal local groups.
- ✓ Friends and colleagues may know about other lists available or know of groups, organizations, or community assets that are not on any lists.

Sources of Information about Assets of Individuals

Information about the relevant assets of key individuals in the community can be gathered from key stakeholders, people who are familiar and knowledgeable about the community and its residents. Identifying individual assets works best when working within a small community.

The following are some helpful tips for gathering information about assets of individuals in a community:

- ✓ Decide on the community or area you want to map.
- ✓ Identify groups of individuals where asset identification would be relevant to health improvement efforts.
- ✓ Determine the assets you want to identify from individuals and draft your survey questions accordingly. Develop separate questions for knowledge, skills, contacts, and other types of resources of interest to you.
- ✓ If taking an inventory of skills, decide what kind of skills you want: academic, clinical, educational, computer skills, organizing, etc. Be as specific as possible.
- ✓ Design a method to ask questions. Different ways of gathering data include:
    - o Mailing out a survey
    - o Dropping off a survey at various locations
    - o Using a door to door survey
    - o Using a telephone survey

Organize Assets on a Map

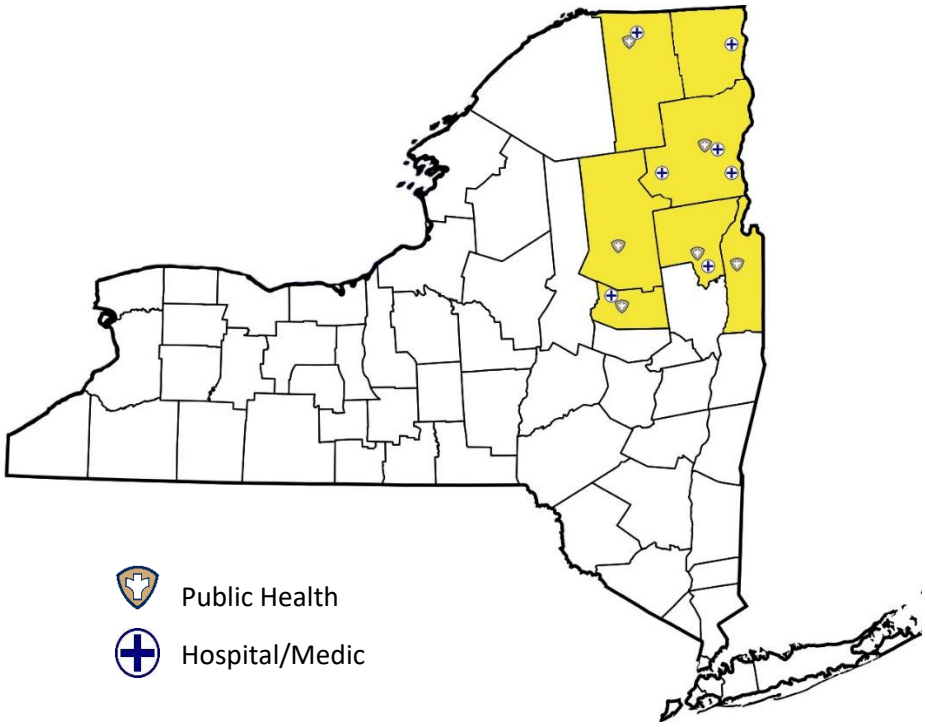
Depicting community assets on maps allows communities to see if there is a concentration of available programs, service overlaps, gaps in services, and unmet community health needs.

General steps for mapping community assets on a street map:

- ✓ Find a map that contains the area you identified.
- ✓ Contact your local government to see if they have a map of the defined community. Maps can also be accessed from MapQuest and Google Maps. Look for a map that provides many details of your community and its boundaries, such as major streets, parks, freeways, lakes, or other landmarks.
- ✓ Use dot stickers to identify the location of the groups and organizations you have found. Use different colors for different types of resources.

- ✓ Decide if you want to map each individual (such as mapping key community contacts at their organization's address) or types of individuals (for example, putting a number on a dot to indicate how many people in an area have nursing degrees).
- ✓ Summarize key points about what the map illustrates (e.g., underused assets, resources that could be included in health improvement activities that are not currently involved, obvious resources gaps, and how gaps might be filled)
- ✓ Use the asset mapping project as an opportunity to identify and develop relationships. The ways residents or interested parties talk and interact with each other—and form relationships—is a major part of community development.

Summary of 2019 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.

April 8, 2019

Background:

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

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

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

CHA Committee, Ad Hoc Data Sub-Committee: At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

The data subcommittee met seven times from mid-July through the end of October 2018. Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 subcommittee members per meeting. Meetings were also attended by AHI staff from ARHN, Population Health Improvement Program (PHIP) and Data teams.

Survey Methodology:

Survey Creation: The 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at December 7, 2018 meeting.

Survey Facilitation: ARHN surveyed stakeholders in the seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental institutions as well as community

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

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

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

Survey Responses and Analysis: A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

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

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

Clinton
Essex
Franklin
Fulton
Hamilton
Warren
Washington

Summary Analysis

1. Indicate county/counties served

Respondents were asked which county their organization/agency serves. Over 68% of respondents were from Essex and Washington counties. Approximately 16% of respondents listed the county they serve as outside of the seven ARHN counties, including Montgomery, Saratoga and St. Lawrence counties. Twelve 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	49	12.04%
Clinton	81	19.90%
Essex	129	31.70%
Franklin	82	20.15%
Fulton	50	12.29%
Hamilton	69	16.95%
Warren	92	22.60%
Washington	150	36.86%
Other	65	15.97%

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

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 160 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including *Education (19.0%)*, *Health Care (13.2%), Social Services (12.5%), Public Health (9.2%), and Health Based Community Based Organizations (CBO) (7.5%),* among many others.

Response Counts by Community Sector	
Community Sector	**Total**
Business	4
Civic Association	3
College/University	7
Disability Services	10
Early Childhood	9
Economic Development	6
Employment/Job Training	2
Faith-Based	3
Food/Nutrition	10
Foundation/Philanthropy	1
Health Based CBO	30
Health Care Provider	53

Health Insurance Plan	1
Housing	7
Law Enforcement/Corrections and Fire Department	10
Local Government (e.g. elected official, zoning/planning board)	29
Media	2
Mental, Emotional, Behavioral Health Provider	22
Public Health	37
Recreation	3
School (K – 12)	69
Seniors/Elderly	28
Social Services	50
Transportation	2
Tribal Government	1
Veterans	2

3. Indicate your job title

Approximately 42.64% of respondents listed themselves as an *Administrator or Director.* There was a significant number of respondents who identified their title as Other (22.69%). Of those responses, the majority included teachers or education professionals and program coordinators.

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	5	1.25%
Direct Service Staff	94	23.44%
Program/Project Manager	40	9.98%
Administrator/Director	171	42.64%
Other	91	22.69%

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* (41.7%) as their top priority, followed by *Promote a Healthy and Safe Environment* (21.9%).

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, Essex, Franklin and Fulton counties identified *Prevent Chronic Disease* as their second choice while Clinton, Essex, Warren and Washington counties identified *Promote a Healthy and Safe Environment* as their second choice. Clinton and Essex counties have an overlap due to ties.

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	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Essex	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote Healthy Women, Infants and Children
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	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Warren	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment
Washington	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

*Overlapping in county choices is due to several ties in response totals.

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 (16.9%), Substance Abuse (12.3%), Opioid Use (9.5%), Overweight/Obesity (8.8%),* and *Child/Adolescent Emotional Health (5.7%).*

Response Counts for ARHN Region Health Concerns					
ARHN Region Health Concerns	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Adverse Childhood Experiences	20	20	19	13	8
Alzheimer's Disease/Dementia	19	17	8	5	9
Arthritis	1	0	2	3	1
Autism	2	2	2	2	4
Cancers	13	14	19	7	8
Child/Adolescent Physical Health	13	12	10	13	8
Child/Adolescent Emotional Health	20	36	20	22	14
Diabetes	10	14	14	6	16
Disability	4	7	5	5	11
Dental Health	1	5	5	10	14
Domestic Abuse/Violence	4	7	16	18	10
Drinking Water Quality	0	1	1	2	5
Emerging Infectious Diseases	2	1	5	1	8
Exposure to Air and Water Pollutants/Hazardous Materials	1	0	1	0	1
Falls	3	7	5	3	4
Food Safety	3	1	2	3	2
Heart Disease	7	11	9	16	12
Hepatitis C	0	0	1	2	1
High Blood Pressure	1	2	8	6	8
HIV/AIDS	0	0	1	0	2
Hunger	4	10	5	6	5
Infant Health	1	0	8	1	4
Infectious Disease	1	0	2	3	4
LGBT Health	0	1	0	1	2
Maternal Health	3	4	3	3	7
Mental Health Conditions	59	48	36	37	23
Motor Vehicle Safety (impaired/distracted driving)	0	0	1	0	7
Opioid Use	33	18	16	14	11
Overweight or Obesity	31	25	26	23	17
Pedestrian/Bicyclist Accidents	0	0	0	0	2
Prescription Drug Abuse	4	7	11	9	7
Respiratory Disease (asthma, COPD, etc.)	5	10	5	9	8

Senior Health	18	9	12	13	11
Sexual Assault/Rape	2	0	0	3	3
Sexually Transmitted Infections	2	0	0	4	4
Social Connectedness	2	4	9	18	16
Stroke	0	2	2	1	2
Substance Abuse	43	33	38	29	10
Suicide	1	5	2	2	7
Tobacco Use/Nicotine Addiction (smoking, vaping, chewing, etc.)	11	7	11	19	27
Underage Drinking/Excessive Adult Drinking	2	8	5	6	5
Unintended/Teen Pregnancy	2	1	1	4	10
Violence (assault, firearm related)	1	0	1	2	5

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 *Adverse Childhood Experiences* as a top health concern in their county.

Warren and Washington county respondents felt that *Alzheimer's Disease* was a concern in their area, while Clinton and Hamilton counties included *Heart Disease* as a concern for their counties. Outliers include Hamilton County listing *Diabetes* and Fulton County listing *Tobacco Use* as a top concern in their county.

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

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 *Poverty (12.7%), Addiction to illicit drugs (10.9%), Changing family structures (10.6%), Lack of mental health services (10.3%), and Age of residents (8.3%).* Forty-four 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					
ARHN Region Contributing Factors	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Addiction to alcohol	14	16	12	7	6
Addiction to illicit drugs	37	36	22	13	5
Addiction to nicotine	7	10	6	7	11
Age of residents	28	11	6	4	7
Changing family structures (increased foster care, grandparents as parents, etc.)	36	22	15	20	8
Crime/violence/community blight	0	1	2	1	4
Deteriorating infrastructure (roads, bridges, water systems, etc.)	1	0	1	0	3
Discrimination/racism	0	0	0	0	1
Domestic violence and abuse	4	6	5	4	7
Environmental quality	0	3	4	5	6
Excessive screen time	2	13	11	4	8
Exposure to tobacco smoke/emissions from electronic vapor products	1	3	5	1	3
Food insecurity	8	13	9	8	7
Health care costs	16	17	21	20	16
Homelessness	1	2	4	4	2
Inadequate physical activity	5	16	15	17	21
Inadequate sleep	0	0	2	3	3
Inadequate/unaffordable housing options	5	9	16	8	13
Lack of chronic disease screening, treatment and self-management services	3	8	7	7	4
Lack of cultural and enrichment programs	1	2	1	1	3
Lack of dental/oral health care services	1	3	0	6	7
Lack of educational opportunities for people of all ages	1	2	3	2	9
Lack of educational, vocational or job-training options for adults	1	1	0	6	1
Lack of employment options	1	3	12	7	7
Lack of health education programs	3	1	4	3	2
Lack of health insurance	3	1	4	3	3
Lack of intergenerational connections within communities	1	0	2	4	8
Lack of mental health services	35	28	27	26	9
Lack of opportunities for health for people with physical limitations or disabilities	2	0	1	4	4

Lack of preventive/primary health care services (screenings, annual check-ups)	6	5	2	3	3
Lack of social supports for community residents	4	3	10	8	9
Lack of specialty care and treatment	1	4	4	3	2
Lack of substance use disorder services	8	8	11	4	6
Late or no prenatal care	0	0	1	2	3
Pedestrian safety (roads, sidewalks, buildings, etc.)	0	0	0	0	1
Poor access to healthy food and beverage options	5	2	6	9	0
Poor access to public places for physical activity and recreation	2	3	1	3	4
Poor educational attainment	2	8	2	8	8
Poor community engagement and connectivity	6	5	4	6	14
Poor eating/dietary practices	12	15	15	17	12
Poor health literacy (ability to comprehend health information)	6	2	4	5	4
Poor referrals to health care, specialty care, & community-based support services	8	5	4	4	7
Poverty	43	18	16	16	23
Problems with Internet access (absent, unreliable, unaffordable)	0	0	0	3	2
Quality of schools	0	0	1	1	3
Religious or spiritual values	0	0	0	1	1
Shortage of child care options	0	1	3	1	3
Stress (work, family, school, etc.)	7	10	15	21	9
Transportation problems (unreliable, unaffordable)	9	13	15	13	14
Unemployment/low wages	3	6	3	8	13

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 Franklin, Hamilton and Warren counties was *Health Care Costs*.

Top Five Contributing Factors by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Poverty	Food Insecurity	Addiction to Illicit Drugs	Lack of Mental Health Services	Inadequate Physical Activity
Essex	Poverty	Lack of Mental Health Services	Changing Family Structures	Addiction to Illicit Drugs	Age of Residents
Franklin	Poverty	Lack of Mental Health Services	Addiction to Illicit Drugs	Changing Family Structures	Health Care Costs
Fulton	Lack of Mental Health Services	Poverty	Poor Eating/ Dietary Practices	Changing Family Structures	Addiction to Illicit Drugs
Hamilton	Age of Residents	Health Care Costs	Lack of Mental Health Services	Poverty	Poor Community Engagement and Connectivity
Warren	Age of Residents	Lack of Mental Health Services	Changing Family Structures	Health Care Costs	Poverty
Washington	Addiction to Illicit Drugs	Age of Residents	Poverty	Lack of Mental Health Services	Changing Family Structures

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) "excellent" to (5) "very poor".

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

Many respondents chose *Health and Health Care (29.0%)* as the social determinant of health that they felt most impacted the residents of the counties that they serve, followed by *Economic Stability (22.4%).* Both of these specific Social Determinants of Health align with the chosen health factors and contributing factors listed previously.

Response Counts per Social Determinants of Health Ranking					
Social Determinants of Health	**1 (Excellent)**	**2**	**3**	**4**	**5 (Very Poor)**
Economic Stability (consider poverty, employment, food security, housing stability)	54	22	33	53	100
Education (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	50	67	66	49	27
Health and Health Care (consider access to primary care, access to specialty care, health literacy)	70	64	79	52	49
Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)	35	67	61	79	43
Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	32	58	73	62	38

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 *Individuals living at or near the federal poverty level (33.3%)* as the population they felt had the poorest health outcomes. For six of the seven ARHN counties, excluding Hamilton, the second population with the highest responses was *Individuals with mental health issues (24.3%).* For Hamilton County, the second population believed to have the poorest health outcomes were *Seniors or Elderly (1.8%).*

Response Counts for Poorest Health Outcomes by County							
Population	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Children/Adolescents	0	5	1	1	2	5	4
Females of reproductive age	0	0	0	0	0	0	0
Individuals living at or near the federal poverty level	35	46	32	14	19	25	39
Individuals living in rural areas	5	6	7	2	8	12	17
Individuals with disability	1	2	0	0	0	1	0

Individuals with mental health issues	19	24	19	11	9	14	29
Individuals with substance abuse issues	2	8	4	1	6	7	16
Migrant workers	1	1	1	0	0	0	0
Seniors/Elderly	5	7	6	6	10	8	17
Specific racial or ethnic groups	0	0	0	0	0	0	0
Other (please specify)	0	1	0	1	1	1	2
Total per county	**68**	**101**	**70**	**37**	**56**	**74**	**126**

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	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
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	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	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change	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 opioid and other substance misuse and deaths
Prevent Communicable Disease	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

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 responses contained two specific goals, *Promote the use of evidence-based care to manage chronic diseases* and *Improve self-management skills for individuals with chronic disease.* Five out of the seven ARHN counties also listed *Promote tobacco use cessation*. Washington County was the only county to include *Improving community environments that support active transportation,* which aligns with the top ARHN goals.

Priority Area: Prevent Chronic Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	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	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Essex	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	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Franklin	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Promote the use of evidence-based care to manage chronic diseases
Fulton	Improve self-management skills for individuals with chronic disease	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use	Increase skills and knowledge to support healthy food and beverage choices
Hamilton	Improve self-management skills for individuals with chronic disease	Promote the use of evidence-based care to manage chronic diseases	Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use
Warren	Improve self-management skills for individuals with chronic disease	Increase skills and knowledge to support healthy food and beverage choices	Promote the use of evidence-based care to manage chronic diseases
Washington	Improve self-management skills for individuals with chronic disease	Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.	Increase skills and knowledge to support healthy food and beverage choices

Promote Healthy Women, Infants and Children

All ARHN counties choose *Support and enhance children and adolescents' social-emotional development and relationships* as their number one goal. Clinton, Fulton, Hamilton, Warren 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	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
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	Increase supports for children with special health care needs
Franklin	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
Fulton	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	Increase supports for children with special health care needs
Hamilton	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
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	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
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 all seven of the ARHN counties, as well as the ARHN region as a whole. *Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change* was also listed in the top three goals for every county.

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

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. Five counties also listed *Prevent opioid and other substance misuse and deaths* 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 opioid and other substance misuse and deaths
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	Prevent opioid and other substance misuse and deaths	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages
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	Prevent and address adverse childhood experiences
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 opioid and other substance misuse and deaths

Prevent Communicable Diseases

All seven ARHN counties listed *Improve vaccination rates, Improve infection control in health care facilities,* and *Reduce inappropriate antibiotic use* in the top three goals that their organization can assist in improving. *Reduce the annual growth rate for Sexually Transmitted Infections (STIs)* was also included in Fulton County's 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 inappropriate antibiotic use
Essex	Improve vaccination rates	Reduce inappropriate antibiotic use	Improve infection control in health care facilities
Franklin	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Fulton	Improve vaccination rates	Reduce inappropriate antibiotic use	Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
Hamilton	Reduce inappropriate antibiotic use	Improve vaccination rates	Improve infection control in health care facilities
Warren	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use
Washington	Improve vaccination rates	Improve infection control in health care facilities	Reduce inappropriate antibiotic use

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 70% of all respondents identified *Participating on committees, workgroups and coalitions* and *Share knowledge of community resources* as the main resources they can contribute to help achieve the NYS Prevention Agenda goals listed above. Respondents also felt strongly that they can deliver education and counseling and provide expertise relevant to achieving the listed goals.

This is the first year that we have asked this question in the stakeholder survey. This would be a helpful resource to explore further once partners begin exacting their approved plans.

Response Counts and Percentages for Resources Organizations Can Contribute		
Resources	**Count**	**Percentage**
Participate on committees, work groups, coalitions to help achieve the selected goals	208	70.99%
Share knowledge of community resources	204	69.62%
Deliver education and counseling relevant to the selected goal(s)	189	64.51%
Provide subject-matter knowledge and expertise	182	62.12%
Promote health improvement activities/events through social media and other communication channels your organization/agency operates	164	55.97%
Facilitate access to populations your organization/agency serves	139	47.44%

Provide letters of support for planned health improvement activities	124	42.32%
Offer health related-educational materials	117	39.93%
Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals	112	38.23%
Work to promote changes to policies/laws/community environment to address selected goal(s)	111	37.88%

Appendix A. 2019 Stakeholder Survey

2019 CHA Stakeholders Survey

Introduction

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

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

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

Your Organization/Agency

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

1. Organization/Agency name:

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

3. Your job title/role:

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

4. Your email address:

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

- ☐ Business
- ☐ Civic Association
- ☐ College/University
- ☐ Disability Services

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

6. Indicate the counties your organization/agency serves. **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. These main priority areas are listed in question #7.

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
- ☐ Drinking water quality
- ☐ Emerging infectious diseases (ebola, zika virus, tick and mosquito-transmitted, etc.)
- ☐ Exposure to air and water pollutants/hazardous materials
- ☐ Falls
- ☐ Food safety
- ☐ Heart disease
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hunger
- ☐ Infant health
- ☐ Infectious disease
- ☐ LGBT health

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

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

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

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

Social Determinants of Health

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

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

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

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

- ☐ **Neighborhood and Built Environment** (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)

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

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

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

Improving Health and Well-Being

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

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

13. Prevent Chronic Diseases

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

14. Promote Healthy Women, Infants, and Children

- ☐ Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age
- ☐ Reduce maternal mortality and morbidity
- ☐ Reduce infant mortality and morbidity
- ☐ Increase breastfeeding
- ☐ Support and enhance children and adolescents' social-emotional development and relationships
- ☐ Increase supports for children with special health care needs
- ☐ Reduce dental caries (cavities) among children
- ☐ Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

15. Promote a Healthy and Safe Environment

- ☐ Reduce falls among vulnerable populations
- ☐ Reduce violence by targeting prevention programs to highest risk populations
- ☐ Reduce occupational injury and illness

- ☐ Reduce traffic-related injuries for pedestrians and bicyclists
- ☐ Reduce exposure to outdoor air pollutants
- ☐ Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
- ☐ Promote healthy home and schools' environments
- ☐ Protect water sources and ensure quality drinking water
- ☐ Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
- ☐ Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
- ☐ Improve food safety management

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

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

17. Prevent Communicable Diseases

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

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

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

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

- ☐ Yes
- ☐ No

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

Appendix G: Demographic, Education, Health System and ALICE Profile for Warren, Washington and Saratoga Counties

Demographic Profile

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS	New York State
Summary of Demographic Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Square Miles[1,2]												
Total Square Miles[1]	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	47,126.4
Total Square Miles for Farms[1]	230.0	85.7	226.6	49.8	3.2	205.3	123.2	14.9	295.9	906.1	11,223.6	11,224.3
Percent of Total Square Miles Farms	22.2%	4.8%	13.9%	10.1%	0.2%	50.9%	15.2%	1.7%	35.6%	10.8%	24.0%	23.8%
Population per Square Mile[2]	78.12	21.24	30.94	108.64	2.64	122.26	280.32	74.48	74.35	42.5	239.4	418.9
Population[5]												
Total Population	81,224	38,233	51,054	53,955	4,646	49,500	226,632	64,701	62,183	355,996.0	11,238,156	19,798,228
Percent White, Non-Hispanic	91.0%	92.8%	82.5%	94.7%	97.9%	88.2%	93.2%	96.0%	98.5%	92.8%	79.8%	63.8%
Percent Black, Non-Hispanic	4.2%	3.2%	5.9%	1.8%	2.6%	1.8%	1.7%	1.2%	3.4%	3.3%	9.2%	15.7%
Percent Hispanic/Latino	2.8%	3.2%	3.4%	2.8%	1.5%	13.2%	3.0%	2.4%	2.6%	2.8%	10.9%	18.8%
Percent Asian/Pacific Islander, Non-Hispanic	1.5%	0.5%	0.6%	0.7%	0.4%	0.8%	2.8%	1.1%	0.5%	0.8%	3.9%	8.3%
Percent Alaskan Native/American Indian	0.2%	0.2%	6.9%	0.3%	1.0%	0.1%	0.2%	0.2%	0.2%	1.2%	15.2%	8.7%
Percent Multi-Race/Other	1.5%	3.3%	3.9%	2.4%	2.5%	9.1%	2.0%	1.6%	2.2%	2.3%	16.3%	10.7%
Number Ages 0-4	3,827	1,538	2,478	2,270	148	3,054	11,787	2,902	3,051	16,214	616,519	1,176,877
Number Ages 5-14	8,388	3,544	5,493	6,322	377	6,273	26,831	6,892	6,845	37,861	1,347,307	2,300,490
Number Ages 15-17	2,411	1,373	2,041	2,049	131	1,999	8,830	2,354	2,271	12,630	444,834	725,937
Number Ages 18-64	53,326	23,602	33,133	33,062	2,708	29,322	141,813	39,426	38,982	224,239	6,989,413	12,586,573
Number Ages 65+	13,028	8,176	7,909	9,802	1,282	8,852	37,371	13,127	11,034	64,358	1,840,083	3,008,351
Number Ages 15-44 Female	14,990	13,125	8,289	9,272	569	8,805	41,090	10,793	10,096	67,134	2,091,141	4,027,930
Family Status[5]												
Number of Households	31,680	15,257	18,956	22,535	19,700	1,095	93,129	27,249	23,988	159,365	4,160,305	7,302,710
Percent Families Single Parent Households	9.9%	7.9%	10.8%	10.7%	11.3%	n/a	6.7%	7.8%	9.3%	9.7%	9.9%	8.9%
Percent Households with Grandparents as Parents	12.5%	24.8%	5.2%	12.1%	5.4%	9.7%	15.2%	9.2%	8.6%	10.7%	27.3%	19.6%
Poverty[5,3]												
Mean Household Income	$ 65,435	$ 69,488	$ 62,870	$ 61,941	$ 64,039	$ 62,118	$ 96,086	$ 76,756	$ 65,798	$ 66,618	n/a	$ 93,443
Per Capita Income	$ 25,833	$ 29,008	$ 24,294	$ 26,298	$ 24,891	$ 25,307	$ 39,653	$ 33,127	$ 26,064	$ 27,377	$ 40,926	$ 35,752
Percent of Individuals Under Federal Poverty Level	15.7%	8.9%	19.4%	16.0%	9.7%	19.6%	6.6%	9.9%	12.8%	13.9%	11.7%	15.1%
Percent of Individuals Receiving Medicaid	23.2%	20.4%	24.6%	25.0%	22.6%	29.7%	12.7%	18.8%	25.1%	22.9%	43.1%	24.8%
Per Capita Medicaid Expenditures[3]	$ 8,574	$ 8,028	$ 7,383	$ 9,148	$ 7,060	$ 9,069	$ 8,397	$ 8,283	$ 8,493	n/a	n/a	$ 9,670
Immigrant Status[5,4]												
Percent Born in American Territories	95.4%	96.9%	95.3%	97.9%	97.1%	96.4%	94.5%	96.3%	97.8%	96.5%	87.7%	76.0%
Percent Born in Other Countries	4.6%	3.1%	4.7%	2.1%	2.9%	3.6%	5.5%	3.7%	2.2%	3.5%	12.3%	24.0%
Percent Speak a Language Other Than English at Home[4]	5.5%	5.9%	7.5%	3.3%	5.6%	14.3%	6.9%	5.2%	3.3%	5.1%	31.2%	30.6%
Housing[5]												
Total Housing Units	36,352	26,114	25,582	29,004	8,885	23,480	103,766	39,559	29,367	194,863	4,164,398	8,255,911
Percent Housing Units Occupied	87.1%	58.4%	74.1%	77.7%	12.3%	83.9%	89.7%	68.9%	81.7%	72.2%	57.0%	88.5%
Percent Housing Units Owner Occupied	68.0%	76.0%	72.9%	71.4%	84.7%	68.9%	71.5%	71.9%	72.7%	71.8%	74.7%	54.0%
Percent Housing Units Renter Occupied	32.0%	24.0%	27.1%	28.6%	15.3%	31.1%	28.5%	28.1%	27.3%	28.2%	38.7%	46.0%
Percent Built Before 1970	45.2%	57.5%	54.2%	64.6%	55.9%	72.8%	34.2%	46.9%	55.8%	53.3%	92.2%	68.0%
Percent Built Between 1970 and 1979	14.6%	10.5%	11.6%	9.7%	11.6%	7.7%	14.1%	11.9%	10.8%	11.7%	70%	10.0%
Percent Built Between 1980 and 1989	14.7%	11.0%	12.1%	8.8%	11.0%	6.8%	16.2%	14.6%	11.6%	12.3%	74.1%	7.6%
Percent Built Between 1990 and 1999	13.5%	8.9%	12.5%	8.9%	11.9%	6.8%	15.2%	11.9%	9.9%	11.1%	75.3%	6.1%
Percent Built 2000 and Later	12.0%	12.2%	9.8%	8.0%	9.6%	5.7%	20.2%	14.7%	11.9%	11.6%	69.9%	8.2%
Availability of Vehicles[5]												
Percent of Households with No Vehicles Available	9.3%	7.5%	9.5%	9.4%	4.8%	12.7%	4.4%	9.0%	6.3%	8.5%	19.2%	29.0%
Percent of Households with One Vehicle Available	33.6%	32.7%	35.0%	36.5%	31.9%	34.4%	31.9%	35.4%	33.7%	34.5%	58.4%	32.8%
Percent of Households with Two Vehicles Available	37.1%	40.7%	40.1%	37.2%	47.5%	34.7%	43.6%	38.0%	39.3%	38.6%	82.1%	26.2%
Percent of Households with Three or More Vehicles Available	19.9%	19.2%	15.4%	16.9%	15.8%	18.2%	20.0%	17.7%	20.7%	18.4%	89.4%	12.0%
Education[5]												
Total Population Ages 25 and Older	55,125	28,866	35,862	38,651	3,604	34,126	160,285	47,642	44,765	254,515	7,690,861	13,660,809
Percent with Less than High School Education	13.3%	9.1%	13.7%	13.0%	12.2%	14.8%	6.1%	8.3%	11.6%	11.6%	10.0%	13.9%
Percent High School Graduate/GED	37.1%	33.3%	37.2%	35.7%	32.0%	35.3%	24.8%	32.9%	39.2%	36.0%	28.0%	26.3%
Percent Some College, No Degree	17.9%	20.2%	18.6%	20.0%	23.5%	19.3%	17.1%	18.6%	18.7%	18.9%	17.4%	15.9%
Percent Associate's Degree	9.9%	10.7%	11.8%	13.6%	12.2%	13.6%	11.6%	11.0%	10.7%	11.2%	10.4%	8.7%
Percent Bachelor's Degree	11.2%	14.5%	9.0%	9.8%	8.7%	10.1%	23.3%	15.6%	11.6%	11.9%	18.7%	19.9%
Percent Graduate or Professional Degree	10.6%	12.2%	9.6%	7.9%	11.3%	6.9%	17.0%	13.7%	8.2%	10.4%	15.5%	15.4%
Employment Status[5]												
Total Population Ages 16 and Older	68,228	32,769	42,189	44,129	4,079	39,440	185,143	54,254	51,620	297,268	9,126,563	16,080,981
Total Population Ages 16 and Older in Armed Forces	26	10	9	7	1	39	1,563	6	50	109	20,938	23,203
Total Population Ages 16 and Older in Civilian Workforce	38,304	18,796	21,744	26,241	2,243	23,696	122,689	34,150	30,756	172,234	5,737,902	10,152,999
Percent Unemployed	3.2%	3.8%	4.2%	4.5%	6.2%	4.4%	3.0%	3.0%	3.9%	3.7%	3.8%	4.3%

Employment Sector[5]												
Total Employed	36,091	17,544	19,960	24,239	1,991	21,956	117,053	32,518	28,741	161,084	5,394,792	9,467,631
Percent in Agriculture, Forestry, Fishing, Hunting, and Mining	2.3%	3.2%	3.1%	0.9%	0.7%	2.2%	0.8%	0.6%	4.0%	2.2%	1.0%	0.6%
Percent in Construction	4.8%	8.2%	6.6%	6.4%	18.5%	6.9%	6.1%	6.8%	8.2%	6.8%	6.1%	5.6%
Percent in Manufacturing	12.3%	8.7%	5.0%	12.3%	6.8%	13.6%	10.5%	8.4%	14.0%	10.5%	8.3%	6.2%
Percent in Wholesale Trade	1.8%	1.2%	1.4%	1.8%	4.7%	2.2%	2.4%	2.6%	1.7%	1.9%	2.6%	2.4%
Percent in Retail Trade	13.3%	11.6%	10.5%	15.3%	9.3%	13.9%	12.1%	13.3%	14.3%	13.2%	11.4%	10.6%
Percent in Transportation, Warehousing, Utilities	4.9%	3.2%	2.8%	5.7%	10.4%	5.3%	3.2%	3.8%	4.6%	4.4%	4.5%	5.2%
Percent in Information Services	1.9%	1.7%	1.2%	1.5%	1.3%	1.1%	1.8%	1.4%	0.9%	1.4%	2.2%	2.9%
Percent in Finance	2.8%	3.9%	3.2%	2.9%	2.0%	4.4%	7.0%	5.2%	4.3%	3.7%	7.0%	8.1%
Percent in Other Professional Occupations	5.2%	5.1%	5.5%	7.1%	5.0%	6.7%	11.9%	8.3%	7.4%	6.5%	10.6%	11.8%
Percent in Education, Health Care and Social Assistance	26.7%	29.1%	33.2%	27.2%	22.9%	26.4%	25.1%	26.6%	23.0%	27.1%	28.2%	27.5%
Percent in Arts, Entertainment, Recreation, Hotel & Food Service	10.8%	13.6%	10.4%	7.8%	7.4%	6.5%	8.7%	12.7%	7.8%	10.4%	8.6%	9.6%
Percent in Other Services	3.8%	4.2%	4.3%	4.7%	2.9%	4.1%	3.7%	4.8%	4.2%	4.3%	4.7%	5.0%
Percent in Public Administration	9.6%	6.3%	12.8%	6.3%	8.2%	6.8%	6.6%	5.5%	5.6%	7.6%	5.1%	4.5%

(n/a) Data Not Available

Sources:

(1) US Department of Agriculture, National Agriculture Statistics Service, 2012

(2) NYS Department of Health, Vital Statistics of New York State 2016

(3) Centers for Medicare and Medicaid Services, CMS Enterprise Portal

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

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

Health Systems Profile

Adirondack Rural Health Network	County									ARHN	Upstate NYS	New York
Summary of Health Systems Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region		State
Population, 2013-2017	81,224	38,233	51,054	53,955	4,646	49,500	226,632	64,701	62,183	355,996	11,238,156	19,798,228
Total Hospital Beds[1]												
Hospital Beds per 100,000 Population	369.3	65.4	334.9	137.2	n/a	262.6	75.5	627.5	n/a	274.2	n/a	n/a
Medical/Surgical Beds	214	0	129	47	n/a	70	115	300	n/a	690.0	n/a	n/a
Intensive Care Beds	14	0	14	8	n/a	5	12	12	n/a	48.0	n/a	n/a
Coronary Care Beds	7	0	0	0	n/a	3	7	12	n/a	19.0	n/a	n/a
Pediatric Beds	10	0	3	12	n/a	0	7	14	n/a	39.0	n/a	n/a
Maternity Beds	21	0	13	7	n/a	8	14	23	n/a	64.0	n/a	n/a
Physical Medicine and Rehabilitation Beds	0	0	0	0	n/a	10	0	15	n/a	15.0	n/a	n/a
Psychiatric Beds	34	0	12	0	n/a	20	16	30	n/a	76.0	n/a	n/a
Other Beds	0	25	0	0	n/a	14	0	0	n/a	25.0	n/a	n/a
Hospital Beds Per Facility[1]												
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	-	-	-	-	-	-	-	406	-	-	-	-
Nathan Littauer Hospital	-	-	-	74	-	-	-	-	-	-	-	-
Saratoga Hospital	-	-	-	-	-	-	171	-	-	-	-	-
St. Mary's Healthcare	-	-	-	-	-	120	-	-	-	-	-	-
St. Mary's Healthcare-Amsterdam Memorial Campus	-	-	-	-	-	10	-	-	-	-	-	-
Total Nursing Home Beds[2]												
Nursing Home Beds per 100,000 Population	603.3	889.3	381.9	667.2	0.0	1191.9	317.3	616.7	849.1	-	-	-
Nursing Home Beds per Facility[2]												
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	-	-	-	-	-	-	-	82	-	-	-	-
Elderwood at Ticonderoga	-	84	-	-	-	-	-	-	-	-	-	-
Elderwood of Uihlein at Lake Placid	-	156	-	-	-	-	-	-	-	-	-	-
Essex Center for Rehabilitation and Healthcare	-	100	-	-	-	-	-	-	-	-	-	-
Fort Hudson Nursing Center, Inc.	-	-	-	-	-	-	-	-	196	-	-	-
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	89	-	-	-	-	-	-	-	-	-	-	-
River Ridge Living Center	-	-	-	-	-	120	-	-	-	-	-	-
Saratoga Center for Rehab and Skilled Nursing Care	-	-	-	-	-	-	257	-	-	-	-	-
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	-	-	-	-
Warren Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	80	-	-	-	-
Washington Center for Rehabilitation and Healthcare	-	-	-	-	-	-	-	-	122	-	-	-
Wells Nursing Home Inc	-	-	-	100	-	-	-	-	-	-	-	-
Wesley Health Care Center Inc	-	-	-	-	-	-	342	-	-	-	-	-
Wilkinson Residential Health Care Facility	-	-	-	-	-	160	-	-	-	-	-	-
Total Adult Care Facility Beds[3]												
Adult Care Facility Beds per 100,000 Population	221.6	928.5	176.3	307.7	0.0	977.8	390.1	452.9	403.6	375.0	550.2	404.7
Total Adult Home Beds	150	194	60	114	n/a	294	483	248	142	908	38,328	49,670
Total Assisted Living Program Beds	30	30	30	52	n/a	160	0	45	69	256	7,072	12,192
Total Assisted Living Residence (ALR) Beds	0	131	0	0	n/a	30	401	0	40	171	16,434	18,255

Adult Home Beds by Total Capacity per Facility[3]												
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	-	-	-	-	-	-	-	-	-	-
Cook Adult Home	-	-	-	-	-	-	13	-	-	-	-	-
Countryside Adult Home	-	-	-	-	-	-	-	48	-	-	-	-
Elderwood Village at Ticonderoga	-	23	-	-	-	-	-	-	-	-	-	-
Emeritus at the Landing of Queensbury	-	-	-	-	-	-	-	88	-	-	-	-
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	-	-	-	-	-	-	-	-	-
The Mansion at South Union	-	-	-	-	-	-	-	-	34	-	-	-
The Sentinel at Amsterdam, LLC	-	-	-	-	-	150	-	-	-	-	-	-
The Terrace at the Glen	-	-	-	-	-	-	-	52	-	-	-	-
Valehaven Home for Adults	40	-	-	-	-	-	-	-	-	-	-	-
Willing Helpers' Home for Women	-	-	-	20	-	-	-	-	-	-	-	-
Woodlawn Commons	-	-	-	-	-	-	42	-	-	-	-	-
Health Professional Shortage Areas (HPSAs)[4,5]												
Number of Primary Care HPSAs[4]	1	8	5	1	2	1	0	3	1	21	111	181
Primary Care HPSA Population[5]	10,339	4,481	5,997	13,950	2,949	11,456	0	2,168	189	40,073	n/a	n/a
Number of Dental Care HPSAs[4]	1	3	5	1	0	1	0	1	1	12	87	139
Dental Care HPSA Population[5]	0	6,368	16,181	0	0	0	0	0	0	22,549	n/a	n/a
Number of Mental Health HPSAs[4]	2	3	2	1	1	1	0	2	2	13	96	159
Mental Care HPSA Population[5]	10,339	39,309	51,698	6,698	4,835	11,456	0	0	0	112,879	n/a	n/a
Population, 2013-2017[5]												
Primary Care Physicians per 100,000 population	119.2	66.2	101.9	99	84.9	83.9	87.5	153	66.4	n/a	102.8	124.1
Subspeciality per 100,000 population												
Obstetrics/Gynecology	14.9	0.0	18.3	7.4	0.0	5.4	8.4	18.6	0.0	n/a	11.0	14.5
IM Subspeciality	34.8	7.0	13.1	9.9	0.0	37.9	21.1	60.0	0.0	n/a	31.8	49.8
General Surgery	6.6	3.5	10.5	9.9	0.0	2.7	3.6	12.4	2.1	n/a	7.9	8.8
Surgical Subspecialties	23.2	10.5	0.0	7.4	0.0	8.1	10.9	37.2	0.0	n/a	17.8	21.6
General Psychiatry	24.8	0.0	15.7	9.9	0.0	8.1	21.1	20.7	8.6	n/a	18.8	36
Other	107.6	20.9	65.3	32.2	56.6	56.9	33.8	159.2	4.3	n/a	87.8	121.1
Total Physician[5]												
Total Physician per 100,000 population	317.9	108.0	206.5	168.3	141.5	200.4	179.2	442.5	81.4	n/a	268.0	362.9

Licensure Data[6]												
Clinical Laboratory Technician	14	6	5	1	0	4	21	9	5	40	1,208	1,649
Clinical Laboratory Technologist	54	19	27	32	1	38	161	50	24	207	7,730	12,064
Dental Assistant	11	2	9	4	0	7	33	10	11	47	1,338	1,435
Dental Hygienist	42	15	16	23	2	26	241	44	38	180	8,035	10,428
Dentist	41	14	17	17	1	25	175	46	15	151	8,771	15,075
Dietition/Nutritionist, Certified	21	9	8	4	1	10	122	22	7	72	3,667	5,492
Licensed Clinical Social Worker (R/P psycotherapy)	42	24	31	21	2	15	266	72	35	227	14,629	25,254
Licensed Master Social Worker (no privileges)	34	22	26	18	2	23	267	53	26	181	14,861	26,884
Licensed Practical Nurse	382	215	321	308	10	362	895	335	438	2,009	48,582	63,082
Physician	211	49	85	59	6	87	528	265	36	711	42,475	75,565
Mental Health Counselor	59	20	32	10	1	13	147	32	13	167	4,647	6,853
Midwife	6	1	3	4	0	2	14	12	5	31	595	1,022
Nurse Practitioner	79	13	36	38	2	27	258	94	29	291	15,282	22,128
Pharmacist	106	29	41	36	2	40	484	64	44	322	13,780	21,306
Physical Therapist	64	40	48	30	3	43	395	67	30	282	13,417	19,277
Physical Therapy Assistant	17	10	18	20	0	26	55	27	16	108	3,988	5,518
Psychologist	11	15	8	10	1	5	109	28	4	77	6,018	11,519
Registered Physician Assistant	43	30	34	21	3	19	199	88	17	236	9,154	13,640
Registered Professional Nurse	1,270	494	744	643	57	714	3,769	1,145	755	5,108	172,978	243,639
Respiratory Therapist	18	3	6	17	0	18	110	21	13	78	4,107	5,763
Respiratory Therapy Technician	6	0	2	2	0	1	12	4	3	17	579	747

(n/a) Data Not Available

Sources:

(1) NYS Department of Health, NYS Health Profiles

(2) NYS Department of Health, Nursing Home Weekly Bed Census, 2018

(3) NYS Department of Health, Adult Care Facility Directory

(4) Health Resources and Services Administration, HPSA Find, 2017-2018

(5) Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014

(6) NYS Office of the Professions, License Statistics, 2019

Education System Profile

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]												
Total Number of Public School Districts	9	11	8	6	5	6	12	9	12	60	725	733
Total Pre-K Enrollment	250	188	335	377	27	432	399	137	344	1,658	51,063	122,681
Total K-12 Enrollment	10,599	3,618	7,158	7,423	401	7,254	33,329	8,743	8,311	46,253	1,604,870	2,629,970
Number of Students Eligible for Free Lunch	4,410	1,533	3,594	3,504	141	3,869	6,646	3,158	3,511	19,851	592,339	1,263,175
Number of Students Eligible for Reduced Lunch	521	290	471	320	32	310	959	321	477	2,432	69,464	131,974
Percent Free and Reduced Lunch	47.0%	50.0%	57.0%	51.0%	43.0%	57.0%	23.0%	40.0%	48.0%	46.5%	40.0%	53.0%
Number Limited English Proficiency[2]	1,259	636	546	965	75	848	6,718	1,684	1,356	6,521	220,797	437,130
Percent with Limited English Proficiency[2]	42.0%	43.0%	25.0%	33.0%	45.0%	30.0%	55.0%	48.0%	42.0%	13.6%	13.3%	45.0%
Total Number of Graduates	774	273	505	514	27	474	2,531	688	561	3,342	116,704	179,863
Number Went to Approved Equivalency Program	1	0	2	0	n/a	3	9	21	5	29	1,097	2,653
Number Dropped Out of High School	78	18	48	89	n/a	112	176	38	94	365	10,670	21,368
Percent Dropped Out of High School	2.0%	2.0%	2.0%	4.0%	n/a	5.0%	2.0%	1.0%	4.0%	0.8%	0.64%	3.0%
Total Number of Public School Teachers[3]	1,008.9	422.0	701.9	602.8	89.5	627.1	2,277.3	784.2	813.8	4,422.9	132,652.7	209,093.4
Student to Teacher Ratio[3]	10.9	9.1	10.7	13.3	4.9	12.6	13.4	11.4	10.8	10.97	12.37	13.05
Education Programs[4]												
Medical Resident Programs	0	0	0	0	0	0	0	0	0	0	203	967
Medical Resident Graduations/Completions	0	0	0	0	0	0	0	0	0	0	920	5,790
Physician Assistant Programs	0	0	0	0	0	0	0	0	0	0	7	27
Physician Assistant Graduations/Completions	0	0	0	0	0	0	0	0	0	0	103	764
Nurse Practitioner Programs	0	0	0	0	0	0	0	0	0	0	24	58
Nurse Practitioner Graduations/Completions	0	0	0	0	0	0	0	0	0	0	249	725
Pharmacist Programs	0	0	0	0	0	0	0	0	0	0	3	6
Pharmacist Graduations/Completions	0	0	0	0	0	0	0	0	0	0	398	913
Dental Hygienist Programs	0	0	0	0	0	0	0	0	0	0	7	13
Dental Hygienist Graduations/Completions	0	0	0	0	0	0	0	0	0	0	197	429
Licensed Practical Nursing Programs	1	1	0	0	0	1	1	0	0	2	36	52
Licensed Practical Nurse Graduations/Completions	23	23	0	0	0	26	70	0	0	46	2,186	3,369
Registered Nursing Programs	2	2	0	0	0	1	1	1	0	5	68	118
Registered Nurse Graduations/Completions	93	93	0	0	0	32	19	86	0	272	4,606	10,192
Social Worker Programs	0	0	0	0	0	0	0	0	0	0	7	22
Social Worker Graduations/Completions	0	0	0	0	0	0	0	0	0	0	645	3624

(n/a) Data Not Available

Sources:

(1) NYS Education Department, School Report Card Data, 2016-2017

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

(3) Institute of Education Sciences, National Center for Education Statistics, District Directory Information 2016-2017 School Year Data

(4) Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014

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

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

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

*Gray highlighting indicates a regional school district

(n/a) Data Not Available

Sources:

(1) Institute of Education Sciences, National Center for Education Statistics, District Directory Information 2016-2017 School Year Data

ALICE Profile

ALICE is a United Way acronym that stands for Asset Limited, Income Constrained, Employed.												
Adirondack Rural Health Network	**County**									**ARHN**	**Upstate NY**	**NYS**
Summary of ALICE Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
ALICE Household Information												
Total Households	30,624	15,298	19,299	22,450	1,239	19,540	93,703	28,841	24,027	141,778	4,101,529	7,216,340
Total Households Over 65 Years of Age	8,150	5,144	4,817	6,339	544	5,484	24,083	8,898	6,738	40,630	705,081	1,839,483
Total ALICE Households	7,350	4,589	5,404	6,511	632	6,448	19,678	6,922	7,208	38,615	1,059,036	2,222,633
ALICE Households Over 65 Years of Age	2,119	1,749	1,590	2,282	261	2,468	6,502	2,936	2,291	13,408	380,182	662,214
Poverty %	15.0%	10.2%	18.2%	15.0%	12.2%	17.6%	6.8%	11.0%	12.1%	13.6%	11.3%	14.4%
ALICE %	24.4%	30.1%	27.8%	29.3%	50.7%	33.2%	21.1%	24.0%	30.4%	27.4%	28.7%	30.8%
Above ALICE %	60.6%	59.7%	54.0%	55.7%	37.1%	49.2%	72.1%	65.1%	57.5%	59.0%	60.0%	54.8%
# of ALICE and Poverty Households	12,062	6,161	8,869	9,945	779	9,928	26,181	10,079	10,204	58,099	1,640,619	3,262,043
Unemployment Rate	5.0%	7.5%	8.5%	8.0%	9.2%	8.4%	2.9%	4.6%	8.1%	n/a	n/a	n/a
Percent of Residents with Health Insurance	95.8%	93.2%	91.3%	91.4%	90.4%	91.2%	96.1%	96.5%	91.9%	n/a	n/a	n/a
Average Annual Earnings	$36,372.00	$37,128.00	$35,148.00	$32,892.00	$32,940.00	$37,704.00	$47,604.00	$40,932.00	$38,028.00	n/a	n/a	n/a
ALICE Households by Race/Ethnicity												
White	8,119	4,449	5,191	6,683	622	6,112	19,596	6,635	7,404	39,103	922,506	1,245,865
Asian	50	n/a	2	28	n/a	28	191	65	27	172	31,141	180,688
Black	122	n/a	13	32	n/a	134	255	100	14	281	125,980	433,433
Hispanic	81	33	41	156	n/a	651	425	126	200	637	134,063	494,216
2+ races	95	49	44	71	n/a	79	278	38	64	361	22,672	54,130

*Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond).

*Data in all categories except *Two or More Races* is for one race alone. Because race and ethnicity are overlapping categories, the totals for each income category do not add to 100 percent exactly.

(n/a) Data Not Available

Sources:

(1) American Community Survey, 2016.

ALICE Demographics:

(2) American Community Survey and the ALICE Threshold, 2016.

Wages:

(3) Bureau of Labor Statistics, 2016

Budget:

(4) Bureau of Labor Statistics, 2016a; Consumer Reports, 2017; Internal Revenue Service, 2016

(5) New York State Office of Children & Family Services, 2016; Tax Foundation, 2016, 2017; U.S. Department of Agriculture; U.S. Department of Housing and Urban Development

Appendix H: Prevention Agenda Indicators and Other Indicators for Warren, Washington and Saratoga Counties

Warren County Revised: April 2019

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
1. Percentage of Overall Premature Deaths (before age 65 years), 2016				21.5%	22.8%	22.4%	24.0%	**21.8%**	Meets/Better						
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				2.21+	1.69	2.05	1.95	**1.87**	Less than 10						
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				1.6+	2.12	2.16	1.87	**1.86**	Less than 10						
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016				156.6	N/A	116.80	124.00	**122.0**	Worse		X				
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016				0.84+	N/A	2.04	2.07	**1.85**	Less than 10						
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016				0.72+	N/A	1.27	1.28	**1.38**	Less than 10						
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016				94.1%	N/A	N/A	91.4%	**100.0%**	Worse	X					
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016				82.9%	N/A	84.4%	82.6%	**90.8%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	1	0	0	37.5%	0.0%
Other Disparity Indicators															
1. Rate of Total Deaths per 100,000 Population, 2014-2016	685	734	692	1,086.9	990.5	**877.4**	769.8	N/A	Worse	X					
2. Rate of Emergency Department Visits per 10,000 Population, 2016				3,714.1	4,866.3	**3,865.6**	4,169.1	N/A	Meets/Better						
3. Rate of Total Hospitalizations per 10,000 Population, 2016				1,206.5	1,039.9	**1,125.3**	1,154.4	N/A	Meets/Better						
4. Percentage of Adults (18 and Older) Who Did Not Receive Medical Care Due to Costs, 2016				9.9%	9.9%	**9.8%**	11.2%	N/A	Worse	X					
5. Percentage of Adults (18 and Older) Who Report 14 Days or More of Poor Physical Health, 2016				11.4%	14.3%	**12.0%**	11.3%	N/A	Meets/Better						
6. Percentage of Adults (18 and Older) Living with a Disability, 2016				23.0%	25.6%	**22.8%**	22.9%	N/A	Worse	X					
Quartile Summary for Other Indicators										3	0	0	0	50.0%	0.0%
Quartile Summary for Focus Area Disparities										5	1	0	0	42.9%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
1. Rate of Hospitalizations due to Falls per 10,000 - Ages 65+, 2016				170.6	155.7	189.9	179.0	**204.6**	Meets/Better						
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children, 2016				410.7	523.8	408.5	397.3	**429.1**	Meets/Better						
3. Rate of Assault-Related Hospitalizations per 10,000 Population, 2016				1.5	1.3	2.2	3.2	**4.3**	Meets/Better						
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	6.4	6.2	**6.7**	Less than 10						
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				0.00+	N/A	2.1	2.8	**2.8**	Less than 10						
6. Ratio of Assault-Related Hospitalizations for Low-Income versus Non-Low Income Zip Codes, 2016				N/A	N/A	2.9	3.0	**2.9**	Less than 10						
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population, 2016				60.4	64.9	29.4	21.3	**33.0**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										0	1	0	1	28.6%	50.0%

Other Indicators																
1. Falls hospitalization rate per 10,000 - Aged <10 years, 2016				16.0	N/A	**6.5**	7.4	N/A	Worse				X		
2. Falls hospitalization rate per 10,000 - Aged 10-14 years, 2016				0.0*	N/A	**3.6**	4.5	N/A	Less than 10						
3. Falls hospitalization rate per 10,000 - Aged 15-24 years, 2016				N/A	N/A	**4.2**	4.8	N/A	Less than 10						
4. Falls hospitalization rate per 10,000 - Aged 25-64 years, 2016				19.6	N/A	**17.4**	17.0	N/A	Worse	X					
5. Rate of Violent Crimes per 100,000 Population, 2017				165.8	171.8	**214.9**	355.6	N/A	Meets/Better						
6. Rate of Property Crimes per 100,000 Population, 2017				1,506.3	1,481.8	**1,479.5**	1,466.1	N/A	Worse	X					
7. Rate of Total Crimes per 100,000 Population, 2017				1,672.1	1,427.1	**1,694.4**	1,821.7	N/A	Meets/Better						
8. Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, '13-15				N/A	N/A	**1.6**	**1.3**	N/A	Less than 10						
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population, 2016				N/A	N/A	**8.8**	6.3	N/A	Less than 10						
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2016				N/A	N/A	**7.7**	5.5	N/A	Less than 10						
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, '14-16	45	44	27	127.0	N/A	**167.3**	133.8	N/A	Meets/Better						
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed, '14-16	8	4	5	18.6	17.9	**18.5**	17.3	N/A	Worse	X					
13. Rate of Total Motor Vehicle Crashes per 100,000, 2017				2,735.1	2,162.0	**2,022.7**	1,558.5	N/A	Worse		X				
14. Rate of Speed-Related Accidents per 100,000 Population, 2017				282.0	364.7	**214.2**	141.6	N/A	Worse		X				
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2017				9.3	7.3	**7.1**	5.0	N/A	Worse		X				
16. Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2016				8.4	N/A	**8.6**	8.3	N/A	Meets/Better						
17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, 2016				73.9	61.8	**68.3**	63.3	N/A	Worse	X					
18. Rate of Unintentional Injury Hospitalizations Ages 10 to 14 per 10,000 Population, 2016				19.9*	N/A	**12.5**	13.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2016				212.7	198.0	**239.3**	227.9	N/A	Meets/Better						
20. Rate of Poisoning Hospitalizations per 10,000 Population, 2016				7.6	N/A	**7.1**	7.2	N/A	Worse	X					
Quartile Summary for Other Indicators										5	3	0	0	40.0%	0.0%
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										5	4	0	1	37.0%	10.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Outdoor Air Quality															
1. Number of Days with Unhealthy Ozone, 2015-2017				N/A	N/A	21.0	N/A	**0.00**	Less than 10						
2. Number of Days with Unhealthy Particulate Matter, 2015-2017				N/A	N/A	0.00	N/A	**0.00**	Less than 10						
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%

Focus Area: Built Environment															
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2017				27.7%	17.2%	61.6%	35.6%	**32.0%**	Worse	X					
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, 2012-2016				18.0%	19.0%	22.9%	45.7%	**49.2%**	Worse			X			
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				3.9%	6.0%	3.9%	2.3%	**2.2%**	Worse			X			
4. Percentage of Adults Experiencing Food Insecurity '13/14				21.8%	23.3%	**22.7%**	29.0%	N/A	Meets/Better						
5. Percentage of Adults Experiencing Housing Insecurity, 2016				29.7%	29.9%	**30.9%**	35.5%	N/A	Meets/Better						
6. Percentage of Homes in Healthy Neighborhoods Program that have Fewer Asthma Triggers During Home Revisits, 2013-2016				N/A	N/A	20.5%	N/A	**25.0%**	Meets/Better						
Quartile Summary for Focus Area Built Environment										1	0	2	0	50.0%	66.7%

Focus Area: Water Quality															
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2017				0.2%	26.9%	46.6%	70.8%	**78.5%**	Worse				X		
Quartile Summary for Focus Area Water Quality										0	0	0	1	100.0%	100.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Reduce Obesity in Children and Adults															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who are Obese, 2016				29.2%	N/A	**27.4%**	25.5%	23.2%	Worse		X				
2. Percentage of Public School Children Who are Obese, '14 - 16				19.5%	N/A	17.3%	N/A	**16.7%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	1	0	0	100.0%	0.0%

Other Indicators															
1. Percentage of Total Students Overweight, '16-18				16.0%	17.5%	**16.5%**	N/A	N/A	Meets/Better						
2. Percentage of Elementary Students Overweight, Not Obese, '16-18				15.0%	17.0%	**15.7%**	N/A	N/A	Meets/Better						
3. Percentage of Elementary Student Obese, '16-18				18.4%	18.3%	**16.0%**	N/A	N/A	Worse	X					
4. Percentage of Middle and High School Students Overweight, Not Obese, '16-18				17.0%	18.1%	**17.4%**	N/A	N/A	Meets/Better						
5. Percentage of Middle and High School Students Obese, '16-18				16.3%	23.6%	**18.8%**	N/A	N/A	Meets/Better						
6. Percentage of WIC Children Ages 2 - 4 Obese, '14-16				15.3%	15.9%	**15.2%**	13.9%	N/A	Worse	X					
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, 2016				65.6%	70.2%	**63.7%**	60.8%	N/A	Worse	X					
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, 2016				79.6%	73.9%	**74.6%**	73.7%	N/A	Meets/Better						
9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014				5.9	5.5	**18.7**	19.2	N/A	Worse			X			
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14				84.7%	79.7%	**84.8%**	84.2%	N/A	Worse	X					
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14				36.5%	36.0%	**33.0%**	31.7%	N/A	Worse	X					
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '14-16	190	212	188	303.8	295.6	**295.7**	272.2	N/A	Worse	X					
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	26	37	32	117.3	111.7	**101.0**	102.4	N/A	Worse	X					
14. Rate of Cardiovascular Pretransport Deaths per 100,000 Population, '14-16	97	114	125	173.0	165.4	**169.6**	153.2	N/A	Worse	X					
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, 2016				157.2	148.7	**1539.0**	149.9	N/A	Meets/Better						
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '14-16	142	166	146	233.7	233.2	**236.5**	220.7	N/A	Meets/Better						
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	22	33	28	102.5	95.9	**82.8**	83.4	N/A	Worse	X					
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '14-16	77	92	101	139.0	134.0	**140.7**	131.0	N/A	Meets/Better						
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2016				103.6	103.1	**104.9**	100.3	N/A	Meets/Better						
20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '14-16	82	97	87	137.0	154.9	**162.7**	168.7	N/A	Meets/Better						
21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	15	22	18	67.9	68.0	**60.5**	66.4	N/A	Worse	X					
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '14-16	39	55	61	79.8	91.1	**101.3**	105.0	N/A	Meets/Better						
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2016				33.0	38.6	**35.4**	35.0	N/A	Meets/Better						
24. Rate of Congestive Heart Failure Deaths per 100,000, '14-16	6	13	10	14.9	17.6	**24.4**	16.5	N/A	Meets/Better						
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	0	2	0	2.5*	4.8	**3.3**	2.5	N/A	Less than 10						
26. Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '14-16	5	7	10	11.3	10.9	**14.5**	9.4	N/A	Meets/Better						
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, 2016				24.9	24.2	**25.6**	24.8	N/A	Meets/Better						
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '14-16	34	32	30	49.4	40.2	**38.1**	31.3	N/A	Worse		X				
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2016				28.0	23.8	**26.9**	25.4	N/A	Worse	X					
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population, 2016				7.0	2.7	**9.4**	9.7	N/A	Meets/Better						
31. Rate of Diabetes Deaths per 100,000 Population, '14-16	22	23	23	35.0	29.5	**19.8**	20.3	N/A	Worse				X		
32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2016				14.4	14.5	**15.4**	17.5	N/A	Meets/Better						
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2016				267.5	246.1	**237.2**	248.1	N/A	Worse	X					
Quartile Summary for Other Indicators										12	1	1	1	45.5%	13.3%
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										13	2	1	1	48.6%	11.8%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who Smoke, 2016				23.2%	N/A	16.2%	14.2%	**12.3%**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										0	0	0	1	100.0%	100.0%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Other Indicators															
1. Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '14-16	56	65	49	87.5	72.8	**45.4**	34.8	N/A	Worse				X		
2. Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2016				36.2	31.2	**28.0**	30.6	N/A	Worse		X				
3. Rate of Asthma Deaths per 100,000 Population, '14-16	0	1	0	0.5*	1.1*	**1.1**	1.5	N/A	Less than 10						
4. Rate of Asthma Hospitalizations per 10,000 Population, 2016				4.2	N/A	**6.3**	10.8	N/A	Meets/Better						
5. Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2016				N/A	N/A	**4.5**	5.6	N/A	Less than 10						
6. Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2016				3.5*	N/A	**5.1**	9.2	N/A	Less than 10						
7. Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2016				N/A	N/A	**4.4**	8.9	N/A	Less than 10						
8. Percentage of Adults with Asthma, '13-14				10.4%	12.0%	**10.1%**	9.5%	N/A	Worse	X					
9. Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '13-15	36	47	51	68.9	67.4	**53.0**	43.5	N/A	Worse		X				
10. Rate of Lung and Bronchus Cancer Cases per 100,000 Population, '13-15	77	86	89	129.5	112.2	**84.3**	69.7	N/A	Worse			X			
11. Number of Registered Tobacco Vendors per 100,000 Population, '15-16				161.8	555.8	**101.3**	107.8	N/A	Worse			X			
12. Percentage of Vendors with Sales to Minors Violations, '15-16				3.80	5.30	**3.90**	4.70	N/A	Meets/Better						
13. Percentage of Vendors with Complaints, '15-16				0.00	0.00	**0.04**	0.90	N/A	Meets/Better						
Quartile Summary for Other Indicators										1	2	2	1	46.2%	50.0%
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										1	2	2	2	50.0%	57.1%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, 2016				75.1%	N/A	69.7%	68.5%	**80.0%**	Worse	X					
2. Rate of Asthma ED Visits per 10,000 Population, 2016				23.5	40.3	42.0	77.0	**75.1**	Meets/Better						
3. Rate of Asthma ED Visits per 10,000 Population, Ages 0 - 4, 2016				51.1	65.5	105.8	186.4	**196.5**	Meets/Better						
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, 2016				N/A	5.0	3.4	3.2	**3.06**	Less than 10						
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, 2016				3.6	5.0	4.1	4.0	**4.86**	Meets/Better						
6. Age-Adjusted Rate of Heart Attack Hospitalizations per 10,000 Population, 2016				12.6	24.9	14.8	13.9	**14.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	16.7%	0.0%
Other Indicators															
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '12-14	188	179	159	43.6	52.4	**47.4**	77.3	N/A	Meets/Better						
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '12-14	24	15	15	14.4	22.7	**19.1**	35.0	N/A	Meets/Better						
3. Rate of All Cancer Cases per 100,000 Population, '13-15	537	545	502	814.1	683.8	**629.8**	564.4	N/A	Worse		X				
4. Rate of all Cancer Deaths per 100,000 Population, '13-15	159	185	191	275.0	227.3	**198.7**	176.2	N/A	Worse		X				
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '13-15	59	73	78	211.6	173.3	**175.9**	158.6	N/A	Worse	X					
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '13-15	14	17	25	56.4	N/A	**53.1**	50.6	N/A	Worse	X					
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '13-15	14	10	10	34.3	N/A	**26.1**	24.6	N/A	Worse		X				
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13-14				87.7%	81.4%	**79.2%**	79.7%	N/A	Meets/Better						
9. Rate of Cervix and Uterine Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	7.1*	N/A	**7.6**	8.5	N/A	Less than 10						
10. Rate of Cervix and Uterine Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**2.3**	2.7	N/A	Less than 10						
11. Percentage of Women Aged 21-65 Years Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14				87.7%	86.0%	**83.5%**	82.2%	N/A	Meets/Better						
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	17.1	N/A	**16.0**	14.8	N/A	Worse	X					
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	7.1*	N/A	**10.4**	9.1	N/A	Less than 10						
14. Rate of Colon and Rectal Cancer Cases per 100,000 Population, '13-15	46	38	35	61.2	55.0	**48.5**	45.7	N/A	Worse		X				
15. Rate of Colon and Rectal Cancer Deaths per 100,000 Population, '13-15	11	14	17	21.6	18.9	**16.7**	15.6	N/A	Worse		X				
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines				75.1%	73.6%	**68.5%**	69.7%	N/A	Meets/Better						
17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '13-15	10	8	11	30.4	N/A	**17.7**	17.3	N/A	Worse			X			
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '13-15	63	48	44	162.6	140.4	**151.7**	141.2	N/A	Worse	X					
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '13-15	9	11	9	30.4	30.0	**26.8**	25.2	N/A	Worse	X					
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '13-15	N/A	N/A	N/A	3.6*	N/A	**3.0**	2.3	N/A	Less than 10						
21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '15-17	4,776	5,133	5,471	30.0%	25.7%	**28.3%**	28.0%	N/A	Meets/Better						
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13-14				69.7%	64.0%	**70.0%**	68.5%	N/A	Worse	X					
23. Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, '13-15				N/A	N/A	**4.2**	4.5	N/A	Less than 10						
24. Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '13-15	17	20	11	24.7	18.9	**14.7**	12.9	N/A	Worse			X			
Quartile Summary for Other Indicators										6	5	2	0	54.2%	15.4%
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										7	5	2	0	46.7%	14.3%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Maternal and Infant Health															
Prevention Agenda Indicators															
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2016				11.1%	9.8%	10.5%	10.3%	**10.2%**	Worse	X					
2. Ratio of Preterm Births (< 37 wks.) Black/NH to White/NH, 2014-2016				N/A	N/A	1.65	1.64	**1.42**	Less than 10						
3. Ratio of Preterm Births (< 37 wks.) Hisp/Latino to White/NH, 2014-2016				1.72+	N/A	1.28	1.29	**1.12**	Less than 10						
4. Ratio of Preterm Births (< 37 wks.) Medicaid to Non-Medicaid, 2014-2016				1.64	N/A	1.10	1.06	**1.00**	Worse			X			
5. Rate of Maternal Mortality per 100,000 Births, 2014-2016				0.0*	N/A	18.9	20.4	**21.0**	Less than 10						
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2016				59.7%	63.0%	50.9%	46.3%	**48.1%**	Meets/Better						
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	0.55	0.59	**0.57**	Less than 10						
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, 2014-2016				0.93	N/A	0.57	0.57	**0.56**	Less than 10						
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, 2014-2016				0.91	N/A	0.68	0.59	**0.66**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										1	0	1	0	22.2%	50.0%
Other Indicators															
1. Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '14-16	7	7	5	1.1%	3.9%	**1.5%**	1.5%	N/A	Meets/Better						
2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '14-16	43	42	51	8.1%	7.5%	**7.4%**	7.3%	N/A	Worse	X					
3. Percentage of Total Births with Weights Less Than 1,500 grams, '14-16	6	7	7	1.2%	1.2%	**1.3%**	1.4%	N/A	Meets/Better						
4. Percentage of Singleton Births with Weights Less Than 1,500 grams, '14-16	4	7	7	1.1%	0.9%	**1.0%**	1.0%	N/A	Worse	X					
5. Percentage of Total Births with Weights Less Than 2,500 grams, '14-16	32	33	41	6.3%	6.7*%	**7.6%**	7.9%	N/A	Meets/Better						
6. Percentage of Singleton Births with Weights Less Than 2,500 grams, '14-16	25	26	30	5.0%	5.1*%	**5.7%**	6.0%	N/A	Meets/Better						
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	**12.9%**	12.2%	N/A	Less than 10						
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '14-16				14.0*%	N/A	**7.5%**	7.7%	N/A	Less than 10						
9. Infant Mortality Rate per 1,000 Live Births, '14-16	0	5	4	5.4*	5.7*	**5.0**	4.5	N/A	Less than 10						
10. Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, '14-16	1	5	1	4.2*	3.5*	**5.3**	5.1	N/A	Less than 10						
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '14-16	394	387	419	72.6%	75.4%	**77.0%**	75.2%	N/A	Worse	X					
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '14-16				N/A	N/A	**68.5%**	64.5%	N/A	Less than 10						
13. Percentage Early Prenatal Care for Hispanic/Latino, '14-16				61.0%	N/A	**71.1%**	76.7%	N/A	Less than 10						
14. Percentage APGAR Scores of Less Than Six at Five Minute Mark of Births Where APGAR Score is Known, '14-16	1	8	7	1.0%	1.1%	**0.9%**	0.7%	N/A	Worse	X					
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '13-15	12	10	9	176.0	110.9	**140.8**	104.8	N/A	Worse		X				
16. Percentage WIC Women Breastfeeding for at least 6 months, '14-16				26.2%	N/A	**30.7%**	40.3%	N/A	Worse	X					
17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '14-16	452	426	447	83.6%	79.5%	**82.9%**	87.3%	N/A	Meets/Better						
Quartile Summary for Other Indicators										5	1	0	0	35.3%	0.0%
Quartile Summary for Focus Area Maternal and Infant Health										6	1	1	0	27.6%	12.5%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Preconception and Reproductive Health															
Prevention Agenda Indicators															
1. Percent of Births within 24 months of Previous Pregnancy, 2016				22.0%	23.2%	22.5%	19.8%	**17.0%**	Worse		X				
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2016				6.4*	11.1	9.9	13.3	**25.6**	Less than 10						
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, 2014-2016				0.0+	N/A	4.30	4.80	**4.40**	Less than 10						
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, 2014-2016				3.5+	N/A	3.50	4.40	**4.10**	Less than 10						
5. Percent of Unintended Pregnancies among Total Births, 2016				33.2%	32.9%	24.9%	22.6%	**23.8%**	Worse		X				
6. Ratio of Unintended Pregnancies Black, non-Hispanic to White, non-Hispanic, 2016				N/A	N/A	2.08	2.12	**1.90**	Less than 10						
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2016				N/A	N/A	1.49	1.68	**1.43**	Less than 10						
8. Ratio of Unintended Births Medicaid to Non-Medicaid, 2016				N/A	N/A	1.96	1.71	**1.54**	Less than 10						
9. Percentage of Women Ages 18- 64 with Health Insurance, 2016				95.3%	N/A	N/A	93.1%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	2	0	0	33.3%	0.0%

Other Indicators															
1. Rate of Total Births per 1,000 Females Ages 15-44, '14-16	567	540	572	51.8	53.2	**57.2**	58.5	N/A	Meets/Better						
2. Percent Multiple Births of Total Births, '14-16	19	14	21	3.8%	3.5%	**4.0%**	3.7%	N/A	Meets/Better						
3. Percent C-Sections to Total Births, '14-16	193	180	205	34.4%	34.1%	**34.2%**	33.5%	N/A	Worse	X					
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '14-16	717	745	745	68.1	64.5	**72.8**	83.8	N/A	Meets/Better						
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	0	0	0	0.0*	0.2*	**0.2**	0.2	N/A	Less than 10						
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	0	0	0	0.0*	0.3*	**0.4**	0.6	N/A	Less than 10						
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '14-16	12	11	7	8.7	12.5	**11.0**	15.1	N/A	Meets/Better						
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	25	30	24	14.9	19.3	**13.2**	14.6	N/A	Worse	X					
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	46	49	43	26.1	28.1	**22.3**	29.8	N/A	Worse	X					
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	21	24	21	35.9	36.3*	**22.9**	25.6	N/A	Worse			X			
11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	34	38	36	58.8	50.4	**37.5**	50.1	N/A	Worse			X			
12. Percent Total Births to Women Ages 35 Plus, '14-16	78	58	81	12.9%	11.7%	**20.2%**	22.1%	N/A	Meets/Better						
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '14-16				658.2	434.5	**652.3**	990.8	N/A	Worse	X					
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '14-16	118	169	133	250.1	181.4	**231.6**	370.9	N/A	Worse	X					
15. Percentage of WIC Women Pre-pregnancy Underweight, '10-12	21	16	17	5.1%	4.9%	**4.1%**	4.7%	N/A	Worse	X					
16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	82	84	68	22.2%	22.3%	**26.3%**	26.6%	N/A	Meets/Better						
17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	116	108	123	32.9%	33.3%	**28.0%**	24.2%	N/A	Worse	X					
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	201	171	161	53.9%	52.4%	**47.1%**	41.7%	N/A	Worse	X					
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	30	35	43	5.8%	7.2%	**5.7%**	5.5%	N/A	Worse	X					
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	59	73	51	13.2%	12.9%	**9.1%**	7.1%	N/A	Worse		X				
Quartile Summary for Other Indicators										9	1	2	0	60.0%	16.7%
Quartile Summary for Focus Area Preconception and Reproductive Health										9	4	3	0	55.2%	18.8%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Child Health															
Prevention Agenda Indicators															
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2016				94.0%	89.8%	82.8%	80.1%	**91.3%**	Meets/Better						
2. Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2016				89.1%	84.9%	82.3%	84.3%	**91.3%**	Worse	X					
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2016				74.6%	69.5%	66.5%	68.1%	**67.1%**	Meets/Better						
4. Percentage of Children Ages 0 -19 with Health Insurance, 2016				97.2%	N/A	N/A	97.4%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	50.0%	0.0%
Other Indicators															
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, '14-16	1	0	0	13.5*	26.8	**19.4**	18.2	N/A	Less than 10						
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children, '14-16	0	0	0	0.0*	9.0	**9.7**	10.0	N/A	Less than 10						
3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children, '14-16	0	0	0	0.0*	15.5	**11.5**	11.4	N/A	Less than 10						
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children, '14-16	0	0	0	0.0*	12.3	**10.6**	10.7	N/A	Less than 10						
5. Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, '14-16	2	0	1	27.8*	36.7	**32.6**	31.1	N/A	Less than 10						
6. Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				30.7*	N/A	**27.4**	43.5	N/A	Less than 10						
7. Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2016				N/A	N/A	**9.5**	18.7	N/A	Less than 10						
8. Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2016				10.0	N/A	**12.9**	23.5	N/A	Meets/Better						
9. Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**8.1**	10.6	N/A	Less than 10						
10. Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**24.4**	2.2	N/A	Less than 10						
11. Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				51.1	N/A	**24.4**	30.9	N/A	Worse				X		
12. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				51.1	65.5	**105.8**	186.4	196.5	Meets/Better						
13. Percentage of Children born in 2013 Screened for Lead by Age 0-8 months, 2013				0.0*%	0.7%	**1.2%**	1.9%	N/A	Less than 10						
14. Percentage of Children Born in 2013 Screened for Lead by Age 9-17 months, 2013				89.8%	77.5%	**71.7%**	74.8%	N/A	Meets/Better						
15. Percentage of Children Born 2013 Screened for Lead by Age 36 months (at least two screenings), 2013				78.8%	63.7%	**55.9%**	62.8%	N/A	Meets/Better						
16. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '14-16	10	4	5	7.0	11.4	**8.3**	4.3	N/A	Meets/Better						
17. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2016				19.2	N/A	**18.1**	18.9	N/A	Worse	X					
18. Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2016				19.9*	N/A	**12.5**	13.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2016				23.9	N/A	**23.1**	23.1	N/A	Worse	X					
20. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				33.3	N/A	**68.1**	137.1	N/A	Meets/Better						
21. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, '15-17	2,872	3,070	3,146	57.9%	48.0%	**48.0%**	47.5%	N/A	Meets/Better						
22. Percentage of 3rd Graders with Dental Caries, '09 - 11				43.3%	N/A	N/A	N/A	N/A	Meets/Better						
23. Percentage of 3rd Graders with Dental Sealants, '09 - 11				29.0%	N/A	N/A	N/A	N/A	Meets/Better						
24. Percentage of 3rd Graders with Dental Insurance, '09 - 11				83.4%	N/A	N/A	N/A	N/A	Meets/Better						
25. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11				87.4%	N/A	N/A	N/A	N/A	Meets/Better						
26. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11				68.8%	N/A	N/A	N/A	N/A	Meets/Better						
27. Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2016				164.7	164.1	**119.7**	90.0	N/A	Worse		X				
28. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '14-16				82.8%	85.7%	**85.0%**	85.3%	N/A	Meets/Better						
Quartile Summary for Other Indicators										2	1	0	1	13.8%	25.0%
Quartile Summary for Focus Area Child Health										4	1	0	1	18.2%	16.7%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Human Immunodeficiency Virus (HIV)															
Prevention Agenda Indicators															
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2014-2016				3.1*	N/A	**6.9**	16.0	16.1	Less than 10						
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, 2014-2016				N/A	N/A	**20.1**	35.2	46.8	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of AIDS Cases per 100,000 Population, '14-16	s	s	s	2.1*	N/A	**3.3**	7.7	N/A	Less than 10						
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '14-16	0	2	0	1.0*	N/A	**1.1**	3.0	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Sexually Transmitted Disease (STDs)															
Prevention Agenda Indicators															
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2016				6.3*	3.3	9.1	24.3	**10.1**	Less than 10						
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2016				3.0*	0.6	0.5	1.3	**0.4**	Less than 10						
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2016					60.6	197.1	206.2	**183.4**	Less than 10						
4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2016					48.2	230.0	452.5	**199.5**	Less than 10						
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2016				1323.9	1170.1	1351.6	1620.7	**1458.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of Early Syphilis Cases per 100,000 Population, '14-16	1	0	3	2.1*	2.52*	**7.9**	25.1	N/A	Less than 10						
2. Rate of Gonorrhea Cases per 100,000 Population, '14-16	15	10	7	16.4	16.1	**64.6**	111.8	N/A	Meets/Better						
3. Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '14-16	2	1	1	37.0*	45.8*	**209.9**	305.8	N/A	Less than 10						
4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '14-16	43	49	48	429.0	352.5	**569.5**	857.7	N/A	Meets/Better						
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '14-16	11	5	7	418.1	403.1	**607.9**	922.5	N/A	Meets/Better						
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '14-16	15	20	15	890.8	779.1	**1,199.7**	1,638.0	N/A	Meets/Better						
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '14-16	137	112	141	1,202.6	1,188.4	**1,300.3**	1,577.4	N/A	Meets/Better						
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '14-16	51	32	37	2,265.4	2,131.7	**2,300.5**	3,147.6	N/A	Meets/Better						
9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '14-16	52	48	66	2,918.9	2,717.9	**2,833.9**	3,424.6	N/A	Worse	X					
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, 2016				N/A	N/A	**1.9**	2.5	N/A	Less than 10						
Quartile Summary for Other Indicators										1	0	0	0	10.0%	0.0%
Quartile Summary for Sexually Transmitted Diseases										1	0	0	0	6.7%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Vaccine Preventable Disease															
Prevention Agenda Indicators															
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2016				77.9%	73.9%	64.0%		**80.0%**	Worse	X					
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2016				47.2%	42.6%	41.7%		**50.0%**	Meets/Better						
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, 2016				61.0%		59.6%	59.5%	**70.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	66.7%	0.0%
Other Indicators															
1. Rate of Pertussis Cases per 100,000 Population, '13-15	1	0	0	0.5*	11.7	**5.9**	5.1	N/A	Less than 10						
2. Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population Age 65 Plus, '12-14				99.7	93.3	**93.7**	87.3	N/A	Worse	X					
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14				78.1%	75.0%	**73.8%**	69.3%	N/A	Meets/Better						
4. Rate of Mumps Cases per 100,000 Population, '13-15	0	0	0	0.0*	0.09	**0.70**	1.08	N/A	Less than 10						
5. Rate of Meningococcal Cases per 100,000 Population, '13-15	0	0	0	0.0*	0.09*	**0.1***	0.1	N/A	Less than 10						
6. Rate of H Influenza Cases per 100,000 Population, '13-15	2	0	2	2.1*	2.0	**1.7**	1.5	N/A	Less than 10						
Quartile Summary for Other Indicators										1	0	0	0	16.7%	0.0%
Quartile Summary for Focus Area Vaccine Preventable Diseases										3	0	0	0	33.3%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Healthcare Associated Infections															
Prevention Agenda Indicators															
1. Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days, 2017				4.9	5.6	N/A	5.2	**5.94**	Meets/Better						
2. Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2017				7.8	53.8	N/A	29.2	**2.05**	Worse				X		
Quartile Summary for Healthcare Associated Infections										0	0	0	1	50.0%	100.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders															
Prevention Agenda Indicators															
1. Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2016				20.9%	N/A	19.1%	18.3%	**18.4%**	Worse	X					
2. Age-adjusted Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, 2016				12.0%	N/A	11.2%	10.7%	**10.1%**	Worse	X					
3. Age Adjusted Rate of Suicides per 100,000 Adjusted Population, '14-16				10.7	N/A	9.6	8.0	**5.9**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										2	0	0	1	100.0%	33.3%
Other Indicators															
1 Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '14-16				9.3*	10.7	**6.1**	5.0	N/A	Less than 10						
2. Rate of Self-inflicted Hospitalizations 10,000 Population, 2016				5.9	N/A	**4.1**	3.5	N/A	Worse		X				
3. Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2016				23.0*	N/A	**8.7**	7.6	N/A	Less than 10						
4. Rate of Cirrhosis Deaths per 100,000 Population, '14-16				16.5	13.8	**7.4**	8.0	N/A	Worse				X		
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, 2016				5.0	1.5	**3.3**	3.0	N/A	Worse			X			
7. Rate of Alcohol-Related Crashes per 100,000, 2017				82.1	69.1	**53.20**	38.0	N/A	Worse				X		
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2017				38.7	28.8	**10.5**	19.4	N/A	Worse				X		
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '12-14	74	101	97	13.9	14.6	**20.3**	24.0	N/A	Meets/Better						
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2015				1,169.6	1,279.4	**642.2**	682.2	N/A	Worse				X		
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				598.2	819.5	**620.5**	689.7	N/A	Meets/Better						
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2015				152.9	141.7	**170.3**	311.4	N/A	Meets/Better						
13. Rate of People Served in Emergency Settings for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2015				69.7	15.6	**20.0**	18.9	N/A	Worse				X		
14. Rate of People Served in Emergency Settings for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				86.5	21.7	**20.0**	25.7	N/A	Worse				X		
15. Rate of People Served in Emergency Settings for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2015				0.0	N/A	**5.7**	7.6	N/A	Meets/Better						
Quartile Summary for Other Indicators										0	1	1	6	53.3%	87.5%
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										2	1	1	7	61.1%	72.7%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Other Non-Prevention Agenda Indicators															
1. Rate of Hepatitis A Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.28*	**0.4**	0.5	N/A	Less than 10						
2. Rate of Acute Hepatitis B Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.0*	**0.3**	0.5	N/A	Less than 10						
3. Rate of TB Cases per 100,000 Population, '14-16	0	0	1	0.5*	0.5*	**1.8**	3.9	N/A	Less than 10						
4. Rate of e. Coli Shiga Toxin Cases per 100,000 Population,'14-16	0	1	0	0.5*	2.0	**2.0**	1.6	N/A	Less than 10						
5. Rate of Salmonella Cases per 100,000 Population, '14-16	7	7	5	9.8	12.0	**12.0**	11.6	N/A	Meets/Better						
6. Rate of Shigella Cases per 100,000 Population, '14-16	1	0	0	0.5*	0.4	**2.5**	3.9	N/A	Less than 10						
7. Rate of Lyme Disease Cases per 100,000 Population,'14-16	46	40	54	72.1	63.9	**N/A**	38.0	N/A	Meets/Better						
8. Rate of Confirmed Rabies Cases per 100,000 Population, 2015				3.1	7.3	**3.3**	1.8	N/A	Meets/Better						
Quartile Summary for Non-Prevention Agenda Issues										0	0	0	0	0.0%	0.0%

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	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
1. Percentage of Overall Premature Deaths (before age 65 years), 2016				23.7%	22.8%	22.4%	24.0%	**21.8%**	Worse	X					
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				2.97+	1.69	2.05	1.95	**1.87**	Less than 10						
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				1.36+	2.12	2.16	1.87	**1.86**	Less than 10						
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016				153.2	N/A	116.80	124.00	**122.0**	Worse		X				
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016				0.55+	N/A	2.04	2.07	**1.85**	Less than 10						
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016				0.66+	N/A	1.27	1.28	**1.38**	Less than 10						
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016				93.5%	N/A	N/A	91.4%	**100.0%**	Worse	X					
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016				94.2%	N/A	84.4%	82.6%	**90.8%**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										2	1	0	0	37.5%	0.0%
Other Disparity Indicators															
1. Rate of Total Deaths per 100,000 Population, 2014-2016	608	592	629	981.2	990.5	**877.4**	769.8	N/A	Worse	X					
2. Rate of Emergency Department Visits per 10,000 Population, 2016				3,541.1	4,866.3	**3,865.6**	4,169.1	N/A	Meets/Better						
3. Rate of Total Hospitalizations per 10,000 Population, 2016				1,146.0	1,039.9	**1,125.3**	1,154.4	N/A	Meets/Better						
4. Percentage of Adults (18 and Older) Who Did Not Receive Medical Care Due to Costs, 2016				10.7%	9.9%	**9.8%**	11.2%	N/A	Worse	X					
5. Percentage of Adults (18 and Older) Who Report 14 Days or More of Poor Physical Health, 2016				15.8%	14.3%	**12.0%**	11.3%	N/A	Worse		X				
6. Percentage of Adults (18 and Older) Living with a Disability, 2016				24.0%	25.6%	**22.8%**	22.9%	N/A	Worse	X					
Quartile Summary for Other Indicators										3	1	0	0	66.7%	0.0%
Quartile Summary for Focus Area Disparities										5	2	0	0	50.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
1. Rate of Hospitalizations due to Falls per 10,000 - Ages 65+, 2016				147.7	155.7	189.9	179.0	**204.6**	Meets/Better						
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children, 2016				488.2	523.8	408.5	397.3	**429.1**	Worse	X					
3. Rate of Assault-Related Hospitalizations per 10,000 Population, 2016				2.0	1.3	2.2	3.2	**4.3**	Less than 10						
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	6.4	6.2	**6.7**	Less than 10						
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	2.1	2.8	**2.8**	Less than 10						
6. Ratio of Assault-Related Hospitalizations for Low-Income versus Non-Low Income Zip Codes, 2016				N/A	N/A	2.9	3.0	**2.9**	Less than 10						
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population, 2016				64.4	64.9	29.4	21.3	**33.0**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										1	1	0	1	42.9%	33.3%

Other Indicators															
1. Falls hospitalization rate per 10,000 - Aged <10 years, 2016				14.4*	N/A	**6.5**	7.4	N/A	Less than 10						
2. Falls hospitalization rate per 10,000 - Aged 10-14 years, 2016				0.0*	N/A	**3.6**	4.5	N/A	Less than 10						
3. Falls hospitalization rate per 10,000 - Aged 15-24 years, 2016				N/A	N/A	**4.2**	4.8	N/A	Less than 10						
4. Falls hospitalization rate per 10,000 - Aged 25-64 years, 2016				17.6	N/A	**17.4**	17.0	N/A	Worse	X					
5. Rate of Violent Crimes per 100,000 Population, 2017				815.4	171.8	**214.9**	355.6	N/A	Worse				X		
6. Rate of Property Crimes per 100,000 Population, 2017				690.5	1,481.8	**1,479.5**	1,466.1	N/A	Meets/Better						
7. Rate of Total Crimes per 100,000 Population, 2017				124.8	1,427.1	**1,694.4**	1,821.7	N/A	Meets/Better						
8. Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, '13-15				N/A	N/A	**1.6**	**1.3**	N/A	Less than 10						
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population, 2016				0.0*	N/A	**8.8**	6.3	N/A	Less than 10						
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2016				0.0*	N/A	**7.7**	5.5	N/A	Less than 10						
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, '14-16	54	45	37	167.1	N/A	**167.3**	133.8	N/A	Meets/Better						
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed, '14-16	9	10	6	30.7	17.9	**18.5**	17.3	N/A	Worse			X			
13. Rate of Total Motor Vehicle Crashes per 100,000, 2017				1,695.9	2,162.0	**2,022.7**	1,558.5	N/A	Meets/Better						
14. Rate of Speed-Related Accidents per 100,000 Population, 2017				266.2	364.7	**214.2**	141.6	N/A	Worse	X					
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2017				4.9	7.3	**7.1**	5.0	N/A	Meets/Better						
16. Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2016				7.3	N/A	**8.6**	8.3	N/A	Meets/Better						
17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, 2016				66.5	61.8	**68.3**	63.3	N/A	Meets/Better						
18. Rate of Unintentional Injury Hospitalizations Ages 10 to 14 per 10,000 Population, 2016				N/A	N/A	**12.5**	13.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2016				177.2	198.0	**239.3**	227.9	N/A	Meets/Better						
20. Rate of Poisoning Hospitalizations per 10,000 Population, 2016				7.3	N/A	**7.1**	7.2	N/A	Worse	X					
Quartile Summary for Other Indicators										3	0	1	1	25.0%	40.0%
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										4	1	1	2	29.6%	37.5%

	Number Per Year (If Available)				Comparison Regions/Data					Quartile Ranking					
	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score
Focus Area: Outdoor Air Quality															
1. Number of Days with Unhealthy Ozone, 2015-2017				N/A	N/A	21.0	N/A	**0.00**	Less than 10						
2. Number of Days with Unhealthy Particulate Matter, 2015-2017				N/A	N/A	0.00	N/A	**0.00**	Less than 10						
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%

Focus Area: Built Environment															
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2017				0.0%	17.2%	61.6%	35.6%	**32.0%**	Less than 10						
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, 2012-2016				19.6%	19.0%	22.9%	45.7%	**49.2%**	Worse			X			
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				4.4%	6.0%	3.9%	2.3%	**2.2%**	Worse				X		
4. Percentage of Adults Experiencing Food Insecurity '13/14				20.1%	23.3%	**22.7%**	29.0%	N/A	Meets/Better						
5. Percentage of Adults Experiencing Housing Insecurity, 2016				32.2%	29.9%	**30.9%**	35.5%	N/A	Worse	X					
6. Percentage of Homes in Healthy Neighborhoods Program that have Fewer Asthma Triggers During Home Revisits, 2013-2016				N/A	N/A	20.5%	N/A	**25.0%**	Meets/Better						
Quartile Summary for Focus Area Built Environment										1	0	1	1	50.0%	66.7%

Focus Area: Water Quality															
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2017				26.4%	26.9%	46.6%	70.8%	**78.5%**	Worse			X			
Quartile Summary for Focus Area Water Quality										0	0	1	0	100.0%	100.0%

	Number Per Year (If Available)				Comparison Regions/Data					Quartile Ranking					
	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score
Focus Area: Reduce Obesity in Children and Adults															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who are Obese, 2016				40.2%	N/A	**27.4%**	25.5%	23.2%	Worse			X			
2. Percentage of Public School Children Who are Obese, '14 - 16				21.1%	N/A	17.3%	N/A	**16.7%**	Worse		X				
Quartile Summary for Prevention Agenda Indicators										1	1	0	0	100.0%	0.0%

Other Indicators															
1. Percentage of Total Students Overweight, '16-18				18.8%	17.5%	**16.5%**	N/A	N/A	Worse	X					
2. Percentage of Elementary Students Overweight, Not Obese, '16-18				18.9%	17.0%	**15.7%**	N/A	N/A	Worse	X					
3. Percentage of Elementary Student Obese, '16-18				18.4%	18.3%	**16.0%**	N/A	N/A	Worse	X					
4. Percentage of Middle and High School Students Overweight, Not Obese, '16-18				19.1%	18.1%	**17.4%**	N/A	N/A	Worse	X					
5. Percentage of Middle and High School Students Obese, '16-18				25.3%	23.6%	**18.8%**	N/A	N/A	Worse		X				
6. Percentage of WIC Children Ages 2 - 4 Obese, '14-16				17.8%	15.9%	**15.2%**	13.9%	N/A	Worse	X					
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, 2016				71.3%	70.2%	**63.7%**	60.8%	N/A	Worse	X					
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, 2016				75.2%	73.9%	**74.6%**	73.7%	N/A	Meets/Better						
9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014				5.9	5.5	**18.7**	19.2	N/A	Worse			X			
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14				78.7%	79.7%	**84.8%**	84.2%	N/A	Worse	X					
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14				35.7%	36.0%	**33.0%**	31.7%	N/A	Worse	X					
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '14-16	195	149	169	275.2	295.6	**295.7**	272.2	N/A	Meets/Better						
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	34	23	36	118.1	111.7	**101.0**	102.4	N/A	Worse	X					
14. Rate of Cardiovascular Pretransport Deaths per 100,000 Population, '14-16	108	91	92	156.1	165.4	**169.6**	153.2	N/A	Meets/Better						
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, 2016				154.9	148.7	**1539.0**	149.9	N/A	Meets/Better						
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '14-16	161	108	130	214.1	233.2	**236.5**	220.7	N/A	Meets/Better						
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	27	19	31	97.8	95.9	**82.8**	83.4	N/A	Worse	X					
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '14-16	91	63	72	121.2	134.0	**140.7**	131.0	N/A	Meets/Better						
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2016				104.5	103.1	**104.9**	100.3	N/A	Meets/Better						
20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '14-16	108	65	78	134.7	154.9	**162.7**	168.7	N/A	Meets/Better						
21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	17	14	19	63.5	68.0	**60.5**	66.4	N/A	Worse	X					
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '14-16	59	41	46	78.3	91.1	**101.3**	105.0	N/A	Meets/Better						
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2016				42.4	38.6	**35.4**	35.0	N/A	Worse	X					
24. Rate of Congestive Heart Failure Deaths per 100,000, '14-16	8	7	10	13.4	17.6	**24.4**	16.5	N/A	Meets/Better						
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	1	0	3	5.1*	4.8	**3.3**	2.5	N/A	Less than 10						
26. Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '14-16	5	5	6	8.6	10.9	**14.5**	9.4	N/A	Meets/Better						
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, 2016				23.9	24.2	**25.6**	24.8	N/A	Meets/Better						
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '14-16	22	24	32	41.8	40.2	**38.1**	31.3	N/A	Worse	X					
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2016				27.2	23.8	**26.9**	25.4	N/A	Worse	X					
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population, 2016				5.8	2.7	**9.4**	9.7	N/A	Meets/Better						
31. Rate of Diabetes Deaths per 100,000 Population, '14-16	22	22	17	32.7	29.5	**19.8**	20.3	N/A	Worse			X			
32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2016				15.4	14.5	**15.4**	17.5	N/A	Meets/Better						
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2016				265.4	246.1	**237.2**	248.1	N/A	Worse	X					
Quartile Summary for Other Indicators										15	1	2	0	54.5%	11.1%
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										16	2	2	0	57.1%	10.0%

	Number Per Year (If Available)				Comparison Regions/Data					Quartile Ranking					
	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who Smoke, 2016				22.3%	N/A	16.2%	14.2%	**12.3%**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										0	0	0	1	100.0%	100.0%

Other Indicators															
1. Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '14-16	39	56	51	78.3	72.8	**45.4**	34.8	N/A	Worse			X			
2. Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2016				40.3	31.2	**28.0**	30.6	N/A	Worse		X				
3. Rate of Asthma Deaths per 100,000 Population, '14-16	1	3	0	2.1*	1.1*	**1.1**	1.5	N/A	Less than 10						
4. Rate of Asthma Hospitalizations per 10,000 Population, 2016				6.6	N/A	**6.3**	10.8	N/A	Worse	X					
5. Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2016				N/A	N/A	**4.5**	5.6	N/A	Less than 10						
6. Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2016				7.5	N/A	**5.1**	9.2	N/A	Less than 10						
7. Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2016				6.2*	N/A	**4.4**	8.9	N/A	Less than 10						
8. Percentage of Adults with Asthma, '13-14				9.3%	12.0%	**10.1%**	9.5%	N/A	Meets/Better						
9. Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '13-15	46	33	47	67.2	67.4	**53.0**	43.5	N/A	Worse		X				
10. Rate of Lung and Bronchus Cancer Cases per 100,000 Population, '13-15	59	63	70	102.4	112.2	**84.3**	69.7	N/A	Worse	X					
11. Number of Registered Tobacco Vendors per 100,000 Population, '15-16				86.4	555.8	**101.3**	107.8	N/A	Meets/Better						
12. Percentage of Vendors with Sales to Minors Violations, '15-16				0.00	5.30	**3.90**	4.70	N/A	Meets/Better						
13. Percentage of Vendors with Complaints, '15-16				0.00	0.00	**0.04**	0.90	N/A	Meets/Better						
Quartile Summary for Other Indicators										2	2	1	0	38.5%	20.0%
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										2	2	1	1	42.9%	33.3%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, 2016				69.0%	N/A	69.7%	68.5%	**80.0%**	Worse	X					
2. Rate of Asthma ED Visits per 10,000 Population, 2016				26.4	40.3	42.0	77.0	**75.1**	Meets/Better						
3. Rate of Asthma ED Visits per 10,000 Population, Ages 0 - 4, 2016				46.7	65.5	105.8	186.4	**196.5**	Meets/Better						
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, 2016				7.3*	5.0	3.4	3.2	**3.06**	Less than 10						
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, 2016				5.2	5.0	4.1	4.0	**4.86**	Worse	X					
6. Age-Adjusted Rate of Heart Attack Hospitalizations per 10,000 Population, 2016				17.5	24.9	14.8	13.9	**14.0**	Worse		X				
Quartile Summary for Prevention Agenda Indicators										2	1	0	0	50.0%	0.0%
Other Indicators															
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '12-14	161	134	106	33.8	52.4	**47.4**	77.3	N/A	Meets/Better						
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '12-14	18	12	10	12.6	22.7	**19.1**	35.0	N/A	Meets/Better						
3. Rate of All Cancer Cases per 100,000 Population, '13-15	379	398	419	638.0	683.8	**629.8**	564.4	N/A	Worse	X					
4. Rate of all Cancer Deaths per 100,000 Population, '13-15	149	130	134	220.3	227.3	**198.7**	176.2	N/A	Worse	X					
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '13-15	36	54	49	153.8	173.3	**175.9**	158.6	N/A	Meets/Better						
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '13-15	13	16	18	52.0	N/A	**53.1**	50.6	N/A	Meets/Better						
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	23.2	N/A	**26.1**	24.6	N/A	Meets/Better						
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13-14				78.6%	81.4%	**79.2%**	79.7%	N/A	Worse	X					
9. Rate of Cervix and Uterine Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	10.0*	N/A	**7.6**	8.5	N/A	Less than 10						
10. Rate of Cervix and Uterine Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**2.3**	2.7	N/A	Less than 10						
11. Percentage of Women Aged 21-65 Years Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14				87.8%	86.0%	**83.5%**	82.2%	N/A	Meets/Better						
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	15.5	N/A	**16.0**	14.8	N/A	Meets/Better						
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	12.2	N/A	**10.4**	9.1	N/A	Less than 10						
14. Rate of Colon and Rectal Cancer Cases per 100,000 Population, '13-15	36	38	32	56.5	55.0	**48.5**	45.7	N/A	Worse	X					
15. Rate of Colon and Rectal Cancer Deaths per 100,000 Population, '13-15	14	8	13	18.7	18.9	**16.7**	15.6	N/A	Worse	X					
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines				69.0%	73.6%	**68.5%**	69.7%	N/A	Meets/Better						
17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '13-15	N/A	N/A	N/A	20.6	N/A	**17.7**	17.3	N/A	Worse	X					
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '13-15	39	43	47	132.8	140.4	**151.7**	141.2	N/A	Meets/Better						
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '13-15	8	9	17	35.0	30.0	**26.8**	25.2	N/A	Worse		X				
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '13-15	N/A	N/A	N/A	N/A	N/A	**3.0**	2.3	N/A	Less than 10						
21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '15-17	5,102	5,281	5,383	28.4%	25.7%	**28.3%**	28.0%	N/A	Meets/Better						
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13-14				66.5%	64.0%	**70.0%**	68.5%	N/A	Worse	X					
23. Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, '13-15				N/A	N/A	**4.2**	4.5	N/A	Less than 10						
24. Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '13-15	N/A	N/A	N/A	17.1	18.9	**14.7**	12.9	N/A	Worse	X					
Quartile Summary for Other Indicators										8	1	0	0	37.5%	0.0%
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										10	2	0	0	40.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Maternal and Infant Health															
Prevention Agenda Indicators															
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2016				13.2%	9.8%	10.5%	10.3%	**10.2%**	Worse		X				
2. Ratio of Preterm Births (< 37 wks.) Black/NH to White/NH, 2014-2016				N/A	N/A	1.65	1.64	**1.42**	Less than 10						
3. Ratio of Preterm Births (< 37 wks.) Hisp/Latino to White/NH, 2014-2016				0.69+	N/A	1.28	1.29	**1.12**	Less than 10						
4. Ratio of Preterm Births (< 37 wks.) Medicaid to Non-Medicaid, 2014-2016				0.90	N/A	1.10	1.06	**1.00**	Meets/Better						
5. Rate of Maternal Mortality per 100,000 Births, 2014-2016				0.0*%	N/A	18.9	20.4	**21.0**	Less than 10						
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2016				49.9%	63.0%	50.9%	46.3%	**48.1%**	Meets/Better						
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	0.55	0.59	**0.57**	Less than 10						
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, 2014-2016				93.0%	N/A	0.57	0.57	**0.56**	Less than 10						
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, 2014-2016				0.82	N/A	0.68	0.59	**0.66**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	11.1%	0.0%
Other Indicators															
1. Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '14-16	7	1	11	1.1%	3.9%	**1.5%**	1.5%	N/A	Meets/Better						
2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '14-16	41	56	53	8.8%	7.5%	**7.4%**	7.3%	N/A	Worse	X					
3. Percentage of Total Births with Weights Less Than 1,500 grams, '14-16	5	2	11	1.1%	1.2%	**1.3%**	1.4%	N/A	Meets/Better						
4. Percentage of Singleton Births with Weights Less Than 1,500 grams, '14-16	2	2	7	0.7%	0.9%	**1.0%**	1.0%	N/A	Meets/Better						
5. Percentage of Total Births with Weights Less Than 2,500 grams, '14-16	36	37	48	7.1%	6.7*%	**7.6%**	7.9%	N/A	Meets/Better						
6. Percentage of Singleton Births with Weights Less Than 2,500 grams, '14-16	29	27	31	5.3%	5.1*%	**5.7%**	6.0%	N/A	Meets/Better						
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '14-16				N/A	N/A	**12.9%**	12.2%	N/A	Less than 10						
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '14-16				2.2*%	N/A	**7.5%**	7.7%	N/A	Less than 10						
9. Infant Mortality Rate per 1,000 Live Births, '14-16	2	1	4	4.1*	5.7*	**5.0**	4.5	N/A	Less than 10						
10. Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, '14-16	2	2	2	3.5*	3.5*	**5.3**	5.1	N/A	Less than 10						
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '14-16	392	403	373	69.8%	75.4%	**77.0%**	75.2%	N/A	Worse	X					
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '14-16				N/A	N/A	**68.5%**	64.5%	N/A	Less than 10						
13. Percentage Early Prenatal Care for Hispanic/Latino, '14-16				48.8%	N/A	**71.1%**	76.7%	N/A	Less than 10						
14. Percentage APGAR Scores of Less Than Six at Five Minute Mark of Births Where APGAR Score is Known, '14-16	7	11	9	1.6%	1.1%	**0.9%**	0.7%	N/A	Worse				X		
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '13-15				136.0	110.9	**140.8**	104.8	N/A	Meets/Better						
16. Percentage WIC Women Breastfeeding for at least 6 months, '14-16				20.7%	N/A	**30.7%**	40.3%	N/A	Worse		X				
17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '14-16	372	390	364	78.6%	79.5%	**82.9%**	87.3%	N/A	Worse	X					
Quartile Summary for Other Indicators										3	1	0	1	29.4%	20.0%
Quartile Summary for Focus Area Maternal and Infant Health										3	2	0	1	20.7%	16.7%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Preconception and Reproductive Health															
Prevention Agenda Indicators															
1. Percent of Births within 24 months of Previous Pregnancy, 2016				22.5%	23.2%	22.5%	19.8%	**17.0%**	Worse		X				
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2016				18.0	11.1	9.9	13.3	**25.6**	Less than 10						
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, 2014-2016				N/A	N/A	4.30	4.80	**4.40**	Less than 10						
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, 2014-2016				N/A	N/A	3.50	4.40	**4.10**	Less than 10						
5. Percent of Unintended Pregnancies among Total Births, 2016				39.1%	32.9%	24.9%	22.6%	**23.8%**	Worse			X			
6. Ratio of Unintended Pregnancies Black, non-Hispanic to White, non-Hispanic, 2016				N/A	N/A	2.08	2.12	**1.90**	Less than 10						
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2016				N/A	N/A	1.49	1.68	**1.43**	Less than 10						
8. Ratio of Unintended Births Medicaid to Non-Medicaid, 2016				1.41	N/A	1.96	1.71	**1.54**	Meets/Better						
9. Percentage of Women Ages 18- 64 with Health Insurance, 2016				95.1%	N/A	N/A	93.1%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	1	1	0	33.3%	33.3%

Other Indicators															
1. Rate of Total Births per 1,000 Females Ages 15-44, '14-16	585	584	542	56.7	53.2	**57.2**	58.5	N/A	Meets/Better						
2. Percent Multiple Births of Total Births, '14-16	22	24	24	4.1%	3.5%	**4.0%**	3.7%	N/A	Worse	X					
3. Percent C-Sections to Total Births, '14-16	174	194	193	32.8%	34.1%	**34.2%**	33.5%	N/A	Meets/Better						
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '14-16	703	744	706	71.3	64.5	**72.8**	83.8	N/A	Meets/Better						
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	1	0	1	0.4*	0.2*	**0.2**	0.2	N/A	Less than 10						
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	1	0	1	0.4*	0.3*	**0.4**	0.6	N/A	Less than 10						
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '14-16	18	20	19	17.7	12.5	**11.0**	15.1	N/A	Worse			X			
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	39	41	33	23.1	19.3	**13.2**	14.6	N/A	Worse				X		
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	58	63	55	36.0	28.1	**22.3**	29.8	N/A	Worse			X			
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	27	31	23	48.6	36.3*	**22.9**	25.6	N/A	Worse				X		
11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	40	43	36	71.3	50.4	**37.5**	50.1	N/A	Worse				X		
12. Percent Total Births to Women Ages 35 Plus, '14-16	53	55	65	10.1%	11.7%	**20.2%**	22.1%	N/A	Meets/Better						
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '14-16	19	22	20	539.8	434.5	**652.3**	990.8	N/A	Meets/Better						
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '14-16	90	144	138	217.4	181.4	**231.6**	370.9	N/A	Meets/Better						
15. Percentage of WIC Women Pre-pregnancy Underweight, '10-12	23	26	17	5.0%	4.9%	**4.1%**	4.7%	N/A	Worse	X					
16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	116	100	87	23.0%	22.3%	**26.3%**	26.6%	N/A	Meets/Better						
17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	142	142	134	31.7%	33.3%	**28.0%**	24.2%	N/A	Worse	X					
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	207	197	20	51.2%	52.4%	**47.1%**	41.7%	N/A	Worse	X					
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	26	30	27	6.9%	7.2%	**5.7%**	5.5%	N/A	Worse	X					
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	69	50	46	13.6%	12.9%	**9.1%**	7.1%	N/A	Worse		X				
Quartile Summary for Other Indicators										5	1	2	3	55.0%	45.5%
Quartile Summary for Focus Area Preconception and Reproductive Health										9	4	3	0	55.2%	18.8%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Child Health															
Prevention Agenda Indicators															
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2016				88.0%	89.8%	82.8%	80.1%	**91.3%**	Worse	X					
2. Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2016				83.4%	84.9%	82.3%	84.3%	**91.3%**	Worse	X					
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2016				69.5%	69.5%	66.5%	68.1%	**67.1%**	Meets/Better						
4. Percentage of Children Ages 0 -19 with Health Insurance, 2016				97.5%	N/A	N/A	97.4%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	75.0%	0.0%

Other Indicators															
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, '14-16	0	0	2	27.2*	26.8	**19.4**	18.2	N/A	Less than 10						
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children, '14-16	1	0	0	10.0*	9.0	**9.7**	10.0	N/A	Worse	#VALUE!	#VALUE!	#VALUE!	#VALUE!		
3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children, '14-16	0	0	12	18.9*	15.5	**11.5**	11.4	N/A	Less than 10						
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children, '14-16	1	0	2	14.5*	12.3	**10.6**	10.7	N/A	Less than 10						
5. Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, '14-16	1	1	3	46.1*	36.7	**32.6**	31.1	N/A	Less than 10						
6. Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				26.7*	N/A	**27.4**	43.5	N/A	Less than 10						
7. Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2016				N/A	N/A	**9.5**	18.7	N/A	Less than 10						
8. Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2016				10.9	N/A	**12.9**	23.5	N/A	Less than 10						
9. Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**8.1**	10.6	N/A	Less than 10						
10. Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**24.4**	2.2	N/A	Less than 10						
11. Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				33.4	N/A	**24.4**	30.9	N/A	Less than 10						
12. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				46.7	65.5	**105.8**	186.4	196.5	Meets/Better						
13. Percentage of Children born in 2013 Screened for Lead by Age 0-8 months, 2013				0.2*%	0.7%	**1.2%**	1.9%	N/A	Less than 10						
14. Percentage of Children Born in 2013 Screened for Lead by Age 9-17 months, 2013				77.9%	77.5%	**71.7%**	74.8%	N/A	Meets/Better						
15. Percentage of Children Born 2013 Screened for Lead by Age 36 months (at least two screenings), 2013				67.2%	63.7%	**55.9%**	62.8%	N/A	Meets/Better						
16. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '14-16	28	14	11	20.6	11.4	**8.3**	4.3	N/A	Worse				X		
17. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2016				28.8	N/A	**18.1**	18.9	N/A	Less than 10						
18. Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2016				N/A	N/A	**12.5**	13.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2016				31.9	N/A	**23.1**	23.1	N/A	Worse		X				
20. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				34.5	N/A	**68.1**	137.1	N/A	Meets/Better						
21. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, '15-17	3,271	3,472	3,441	53.9%	48.0%	**48.0%**	47.5%	N/A	Meets/Better						
22. Percentage of 3rd Graders with Dental Caries, '09 - 11				43.6%	N/A	N/A	N/A	N/A	Meets/Better						
23. Percentage of 3rd Graders with Dental Sealants, '09 - 11				17.2%	N/A	N/A	N/A	N/A	Meets/Better						
24. Percentage of 3rd Graders with Dental Insurance, '09 - 11				81.3%	N/A	N/A	N/A	N/A	Meets/Better						
25. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11				80.4%	N/A	N/A	N/A	N/A	Meets/Better						
26. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11				61.2%	N/A	N/A	N/A	N/A	Meets/Better						
27. Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2016				213.7	164.1	**119.7**	90.0	N/A	Worse				X		
28. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '14-16				96.4%	85.7%	**85.0%**	85.3%	N/A	Worse	X					
Quartile Summary for Other Indicators										1	1	0	2	13.8%	50.0%
Quartile Summary for Focus Area Child Health										4	1	0	2	21.2%	28.6%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Human Immunodeficiency Virus (HIV)															
Prevention Agenda Indicators															
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2014-2016				1.6*	N/A	**6.9**	16.0	16.1	Less than 10						
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, 2014-2016				N/A	N/A	**20.1**	35.2	46.8	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of AIDS Cases per 100,000 Population, '14-16	s	s	s	N/A	N/A	**3.3**	7.7	N/A	Less than 10						
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '14-16	0	1	0	0.5*	N/A	**1.1**	3.0	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)				Comparison Regions/Data					Quartile Ranking					
	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score
Focus Area: Sexually Transmitted Disease (STDs)															
Prevention Agenda Indicators															
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2016				0.0*	3.3	9.1	24.3	**10.1**	Less than 10						
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2016				0.0*	0.6	0.5	1.3	**0.4**	Less than 10						
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2016				##############	60.6	197.1	206.2	**183.4**	Less than 10						
4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2016				##############	48.2	230.0	452.5	**199.5**	Less than 10						
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2016				1151.4	1170.1	1351.6	1620.7	**1458.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of Early Syphilis Cases per 100,000 Population, '14-16	0	2	0	1.1*	2.52*	**7.9**	25.1	N/A	Less than 10						
2. Rate of Gonorrhea Cases per 100,000 Population, '14-16	11	4	11	13.9	16.1	**64.6**	111.8	N/A	Meets/Better						
3. Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '14-16	1	1	4	55.3*	45.8*	**209.9**	305.8	N/A	Less than 10						
4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '14-16	36	31	32	266.2	352.5	**569.5**	857.7	N/A	Meets/Better						
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '14-16	8	6	7	352.3	403.1	**607.9**	922.5	N/A	Meets/Better						
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '14-16	16	12	14	634.4	779.1	**1,199.7**	1,638.0	N/A	Meets/Better						
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '14-16	102	112	114	1,086.2	1,188.4	**1,300.3**	1,577.4	N/A	Meets/Better						
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '14-16	37	34	24	1,944.7	2,131.7	**2,300.5**	3,147.6	N/A	Meets/Better						
9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '14-16	44	47	55	3,032.8	2,717.9	**2,833.9**	3,424.6	N/A	Worse	X					
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, 2016				N/A	N/A	**1.9**	2.5	N/A	Less than 10						
Quartile Summary for Other Indicators										1	0	0	0	10.0%	0.0%
Quartile Summary for Sexually Transmitted Diseases										1	0	0	0	6.7%	0.0%

	Number Per Year (If Available)				Comparison Regions/Data					Quartile Ranking					
	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score
Focus Area: Vaccine Preventable Disease															
Prevention Agenda Indicators															
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2016				76.2%	73.9%	64.0%		**80.0%**	Worse	X					
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2016				42.9%	42.6%	41.7%		**50.0%**	Meets/Better						
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, 2016				55.8%		59.6%	59.5%	**70.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	66.7%	0.0%
Other Indicators															
1. Rate of Pertussis Cases per 100,000 Population, '13-15	2	0	0	1.1*	11.7	**5.9**	5.1	N/A	Less than 10						
2. Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population Age 65 Plus, '12-14				82.9	93.3	**93.7**	87.3	N/A	Meets/Better						
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14				75.6%	75.0%	**73.8%**	69.3%	N/A	Meets/Better						
4. Rate of Mumps Cases per 100,000 Population, '13-15	0	0	0	0.0*	0.09	**0.70**	1.08	N/A	Less than 10						
5. Rate of Meningococcal Cases per 100,000 Population, '13-15	0	1	0	0.5*	0.09*	**0.1***	0.1	N/A	Less than 10						
6. Rate of H Influenza Cases per 100,000 Population, '13-15	0	0	1	0.5*	2.0	**1.7**	1.5	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Focus Area Vaccine Preventable Diseases										2	0	0	0	22.2%	0.0%

	Number Per Year (If Available)				Comparison Regions/Data					Quartile Ranking					
	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score
Focus Area: Healthcare Associated Infections															
Prevention Agenda Indicators															
1. Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days, 2017				N/A	5.6	N/A	5.2	**5.94**	Less than 10						
2. Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2017				N/A	53.8	N/A	29.2	**2.05**	Less than 10						
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)				Comparison Regions/Data					Quartile Ranking					
	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders															
Prevention Agenda Indicators															
1. Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2016				21.7%	N/A	19.1%	18.3%	**18.4%**	Worse	X					
2. Age-adjusted Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, 2016				13.1%	N/A	11.2%	10.7%	**10.1%**	Worse		X				
3. Age Adjusted Rate of Suicides per 100,000 Adjusted Population, '14-16				11.2	N/A	9.6	8.0	**5.9**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										1	1	0	1	100.0%	33.3%
Other Indicators															
1 Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '14-16				9.2*	10.7	**6.1**	5.0	N/A	Less than 10						
2. Rate of Self-inflicted Hospitalizations 10,000 Population, 2016				7.6	N/A	**4.1**	3.5	N/A	Worse				X		
3. Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2016				N/A	N/A	**8.7**	7.6	N/A	Less than 10						
4. Rate of Cirrhosis Deaths per 100,000 Population, '14-16				11.3	13.8	**7.4**	8.0	N/A	Worse			X			
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, 2016				4.0	1.5	**3.3**	3.0	N/A	Worse	X					
7. Rate of Alcohol-Related Crashes per 100,000, 2017				71.4	69.1	**53.20**	38.0	N/A	Worse				X		
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2017				37.3	28.8	**10.5**	19.4	N/A	Worse				X		
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '12-14	62	95	99	13.6	14.6	**20.3**	24.0	N/A	Meets/Better						
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2015				630.4	1,279.4	**642.2**	682.2	N/A	Meets/Better						
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				371.2	819.5	**620.5**	689.7	N/A	Meets/Better						
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2015				45.4	141.7	**170.3**	311.4	N/A	Meets/Better						
13. Rate of People Served in Emergency Settings for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2015				0.0	15.6	**20.0**	18.9	N/A	Less than 10						
14. Rate of People Served in Emergency Settings for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				0.0	21.7	**20.0**	25.7	N/A	Less than 10						
15. Rate of People Served in Emergency Settings for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2015				0.0	N/A	**5.7**	7.6	N/A	Less than 10						
Quartile Summary for Other Indicators										1	0	1	3	33.3%	80.0%
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										2	1	1	4	44.4%	62.5%

	Number Per Year (If Available)				Comparison Regions/Data					Quartile Ranking					
	One	Two	Three	Average Rate, Ratio or Percentage for the Listed Years	ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score
Other Non-Prevention Agenda Indicators															
1. Rate of Hepatitis A Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.28*	**0.4**	0.5	N/A	Less than 10						
2. Rate of Acute Hepatitis B Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.0*	**0.3**	0.5	N/A	Less than 10						
3. Rate of TB Cases per 100,000 Population, '14-16	1	0	0	0.5*	0.5*	**1.8**	3.9	N/A	Less than 10						
4. Rate of e. Coli Shiga Toxin Cases per 100,000 Population,'14-16	0	3	7	5.4	2.0	**2.0**	1.6	N/A	Less than 10						
5. Rate of Salmonella Cases per 100,000 Population, '14-16	5	8	10	12.3	12.0	**12.0**	11.6	N/A	Worse	X					
6. Rate of Shigella Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.4	**2.5**	3.9	N/A	Less than 10						
7. Rate of Lyme Disease Cases per 100,000 Population,'14-16	70	75	85	123.4	63.9	**N/A**	38.0	N/A	Meets/Better						
8. Rate of Confirmed Rabies Cases per 100,000 Population, 2015				6.4	7.3	**3.3**	1.8	N/A	Worse				X		
Quartile Summary for Non-Prevention Agenda Issues										1	0	0	1	25.0%	50.0%

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	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
1. Percentage of Overall Premature Deaths (before age 65 years), 2016				22.3%	22.8%	22.4%	24.0%	**21.8%**	Worse	X					
2. Ratio of Black, Non-Hispanic Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				1.80	1.69	2.05	1.95	**1.87**	Less than 10						
3. Ratio of Hispanic/Latino Premature Deaths (Prior to Age 65) to White, Non-Hispanic Premature Deaths, '14 - 16				1.70	2.12	2.16	1.87	**1.86**	Less than 10						
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 10,000 Population (Ages 18 Plus), 2016				115.3	N/A	116.80	124.00	**122.0**	Meets/Better						
5. Ratio of Black, Non-Hispanic Adult Preventable Age-Adjusted Hospitalizations to White, Non-Hispanic, 2016				0.99	N/A	2.04	2.07	**1.85**	Meets/Better						
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, 2016				0.44+	N/A	1.27	1.28	**1.38**	Less than 10						
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, 2016				94.9%	N/A	N/A	91.4%	**100.0%**	Worse	X					
8. Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2016				88.0%	N/A	84.4%	82.6%	**90.8%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										3	0	0	0	37.5%	0.0%
Other Disparity Indicators															
1. Rate of Total Deaths per 100,000 Population, 2014-2016	1635	1835	1861	786.0	990.5	**877.4**	769.8	N/A	Meets/Better						
2. Rate of Emergency Department Visits per 10,000 Population, 2016				2,355.5	4,866.3	**3,865.6**	4,169.1	N/A	Meets/Better						
3. Rate of Total Hospitalizations per 10,000 Population, 2016				969.7	1,039.9	**1,125.3**	1,154.4	N/A	Worse	X					
4. Percentage of Adults (18 and Older) Who Did Not Receive Medical Care Due to Costs, 2016				7.2%	9.9%	**9.8%**	11.2%	N/A	Meets/Better						
5. Percentage of Adults (18 and Older) Who Report 14 Days or More of Poor Physical Health, 2016				11.2%	14.3%	**12.0%**	11.3%	N/A	Meets/Better						
6. Percentage of Adults (18 and Older) Living with a Disability, 2016				20.3%	25.6%	**22.8%**	22.9%	N/A	Meets/Better						
Quartile Summary for Other Indicators										1	0	0	0	16.7%	0.0%
Quartile Summary for Focus Area Disparities										4	0	0	0	28.6%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
1. Rate of Hospitalizations due to Falls per 10,000 - Ages 65+, 2016				147.5	155.7	189.9	179.0	**204.6**	Meets/Better						
2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children, 2016				191.1	523.8	408.5	397.3	**429.1**	Meets/Better						
3. Rate of Assault-Related Hospitalizations per 10,000 Population, 2016				1.0	1.3	2.2	3.2	**4.3**	Less than 10						
4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				N/A	N/A	6.4	6.2	**6.7**	Less than 10						
5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, 2016				0.00+	N/A	2.1	2.8	**2.8**	Less than 10						
6. Ratio of Assault-Related Hospitalizations for Low-Income versus Non-Low Income Zip Codes, 2016				N/A	N/A	2.9	3.0	**2.9**	Less than 10						
7. Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population, 2016				16.9	64.9	29.4	21.3	**33.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	1	0	1	28.6%	50.0%

Other Indicators																
1. Falls hospitalization rate per 10,000 - Aged <10 years, 2016				7.3	N/A	**6.5**	7.4	N/A	Less than 10							
2. Falls hospitalization rate per 10,000 - Aged 10-14 years, 2016				N/A	N/A	**3.6**	4.5	N/A	Less than 10							
3. Falls hospitalization rate per 10,000 - Aged 15-24 years, 2016				6.1	N/A	**4.2**	4.8	N/A	Less than 10							
4. Falls hospitalization rate per 10,000 - Aged 25-64 years, 2016				13.4	N/A	**17.4**	17.0	N/A	Meets/Better							
5. Rate of Violent Crimes per 100,000 Population, 2017				122.0	171.8	**214.9**	355.6	N/A	Meets/Better							
6. Rate of Property Crimes per 100,000 Population, 2017				1,099.9	1,481.8	**1,479.5**	1,466.1	N/A	Meets/Better							
7. Rate of Total Crimes per 100,000 Population, 2017				1,221.8	1,427.1	**1,694.4**	1,821.7	N/A	Meets/Better							
8. Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, '13-15				2.7	N/A	**1.6**	**1.3**	N/A	Less than 10							
9. Rate of Pneumoconiosis Hospitalizations, Ages 15 Plus, per 100,000 Population, 2016				7.9	N/A	**8.8**	6.3	N/A	Less than 10							
10. Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2016				6.9	N/A	**7.7**	5.5	N/A	Less than 10							
11. Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, '14-16	147	121	139	118.1	N/A	**167.3**	133.8	N/A	Meets/Better							
12. Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 100,000 Individuals Employed, '14-16	17	11	10	11.3	17.9	**18.5**	17.3	N/A	Meets/Better							
13. Rate of Total Motor Vehicle Crashes per 100,000, 2017				2,041.6	2,162.0	**2,022.7**	1,558.5	N/A	Worse	X						
14. Rate of Speed-Related Accidents per 100,000 Population, 2017				224.9	364.7	**214.2**	141.6	N/A	Worse	X						
15. Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2017				7.8	7.3	**7.1**	5.0	N/A	Worse	X						
16. Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2016				7.2	N/A	**8.6**	8.3	N/A	Meets/Better							
17. Rate of Unintentional Injury Hospitalizations per 10,000 Population, 2016				53.5	61.8	**68.3**	63.3	N/A	Meets/Better							
18. Rate of Unintentional Injury Hospitalizations Ages 10 to 14 per 10,000 Population, 2016				10.3	N/A	**12.5**	13.6	N/A	Less than 10							
19. Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2016				181.1	198.0	**239.3**	227.9	N/A	Meets/Better							
20. Rate of Poisoning Hospitalizations per 10,000 Population, 2016				5.2	N/A	**7.1**	7.2	N/A	Meets/Better							
Quartile Summary for Other Indicators										3	0	0	0	15.0%	0.0%	
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										3	1	0	1	18.5%	20.0%	

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Outdoor Air Quality															
1. Number of Days with Unhealthy Ozone, 2015-2017				N/A	N/A	21.0	N/A	**0.00**	Less than 10						
2. Number of Days with Unhealthy Particulate Matter, 2015-2017				N/A	N/A	0.00	N/A	**0.00**	Less than 10						
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%
Focus Area: Built Environment															
1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2017				28.8%	17.2%	61.6%	35.6%	**32.0%**	Less than 10						
2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, 2012-2016				16.4%	19.0%	22.9%	45.7%	**49.2%**	Worse			X			
3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				3.9%	6.0%	3.9%	2.3%	**2.2%**	Worse			X			
4. Percentage of Adults Experiencing Food Insecurity '13/14				18.3%	23.3%	**22.7%**	29.0%	N/A	Meets/Better						
5. Percentage of Adults Experiencing Housing Insecurity, 2016				21.2%	29.9%	**30.9%**	35.5%	N/A	Meets/Better						
6. Percentage of Homes in Healthy Neighborhoods Program that have Fewer Asthma Triggers During Home Revisits, 2013-2016				N/A	N/A	20.5%	N/A	**25.0%**	Meets/Better						
Quartile Summary for Focus Area Built Environment										0	0	2	0	33.3%	100.0%
Focus Area: Water Quality															
1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2017				40.7%	26.9%	46.6%	70.8%	**78.5%**	Worse		X				
Quartile Summary for Focus Area Water Quality										0	1	0	0	100.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Reduce Obesity in Children and Adults															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who are Obese, 2016				27.0%	N/A	**27.4%**	25.5%	23.2%	Meets/Better						
2. Percentage of Public School Children Who are Obese, '14 - 16				14.0%	N/A	17.3%	N/A	**16.7%**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										1	1	0	0	100.0%	0.0%

Other Indicators															
1. Percentage of Total Students Overweight, '16-18				15.4%	17.5%	**16.5%**	N/A	N/A	Meets/Better						
2. Percentage of Elementary Students Overweight, Not Obese, '16-18				14.7%	17.0%	**15.7%**	N/A	N/A	Meets/Better						
3. Percentage of Elementary Student Obese, '16-18				13.0%	18.3%	**16.0%**	N/A	N/A	Meets/Better						
4. Percentage of Middle and High School Students Overweight, Not Obese, '16-18				16.5%	18.1%	**17.4%**	N/A	N/A	Meets/Better						
5. Percentage of Middle and High School Students Obese, '16-18				13.0%	23.6%	**18.8%**	N/A	N/A	Meets/Better						
6. Percentage of WIC Children Ages 2 - 4 Obese, '14-16				14.8%	15.9%	**15.2%**	13.9%	N/A	Meets/Better						
7. Percentage of Age Adjusted Adults (Ages 18 Plus) Overweight or Obese, 2016				64.0%	70.2%	**63.7%**	60.8%	N/A	Worse	X					
8. Percentage of Age Adjusted Adults (Ages 18 Plus) Who Participated in Leisure Activities Last 30 Days, 2016				83.0%	73.9%	**74.6%**	73.7%	N/A	Meets/Better						
9. Number of Recreational and Fitness Facilities per 100,000 Population, 2014				5.9	5.5	**18.7**	19.2	N/A	Worse			X			
10. Percentage of Age Adjusted Adults (Ages 18 Plus) with Cholesterol Check, '13/14				85.7%	79.7%	**84.8%**	84.2%	N/A	Meets/Better						
11. Percentage of Adults (18 Plus) with Physician Diagnosed High Blood Pressure, '13/14				30.8%	36.0%	**33.0%**	31.7%	N/A	Meets/Better						
12. Rate of Cardiovascular Disease Deaths per 100,000 Population, '14-16	497	535	573	236.6	295.6	**295.7**	272.2	N/A	Meets/Better						
13. Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	65	53	80	68.6	111.7	**101.0**	102.4	N/A	Meets/Better						
14. Rate of Cardiovascular Pretransport Deaths per 100,000 Population, '14-16	287	333	340	141.5	165.4	**169.6**	153.2	N/A	Meets/Better						
15. Rate of Cardiovascular Hospitalizations per 10,000 Population, 2016				128.6	148.7	**1539.0**	149.9	N/A	Meets/Better						
16. Rate of Diseases of the Heart Deaths per 100,000 Population, '14-16	401	419	441	185.9	233.2	**236.5**	220.7	N/A	Meets/Better						
17. Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	56	43	67	57.5	95.9	**82.8**	83.4	N/A	Meets/Better						
18. Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, '14-16	241	270	275	115.9	134.0	**140.7**	131.0	N/A	Meets/Better						
19. Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2016				87.8	103.1	**104.9**	100.3	N/A	Meets/Better						
20. Rate of Coronary Heart Diseases Deaths per 100,000 Population, '14-16	253	268	263	115.6	154.9	**162.7**	168.7	N/A	Meets/Better						
21. Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	36	31	42	37.7	68.0	**60.5**	66.4	N/A	Meets/Better						
22. Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, '14-16	160	188	183	78.3	91.1	**101.3**	105.0	N/A	Meets/Better						
23. Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2016				28.5	38.6	**35.4**	35.0	N/A	Meets/Better						
24. Rate of Congestive Heart Failure Deaths per 100,000, '14-16	29	29	41	14.6	17.6	**24.4**	16.5	N/A	Meets/Better						
25. Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, '14-16	0	0	2	0.7*	4.8	**3.3**	2.5	N/A	Less than 10						
26. Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, '14-16	18	18	21	8.4	10.9	**14.5**	9.4	N/A	Meets/Better						
27. Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, 2016				19.2	24.2	**25.6**	24.8	N/A	Meets/Better						
28. Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '14-16	73	73	80	33.3	40.2	**38.1**	31.3	N/A	Meets/Better						
29. Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2016				24.1	23.8	**26.9**	25.4	N/A	Meets/Better						
30. Rate of Hypertension Hospitalizations (Ages 18 Plus) per 10,000 Population, 2016				5.2	2.7	**9.4**	9.7	N/A	Meets/Better						
31. Rate of Diabetes Deaths per 100,000 Population, '14-16	38	42	41	17.8	29.5	**19.8**	20.3	N/A	Meets/Better						
32. Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2016				10.1	14.5	**15.4**	17.5	N/A	Meets/Better						
33. Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2016				183.9	246.1	**237.2**	248.1	N/A	Meets/Better						
Quartile Summary for Other Indicators										1	0	1	0	6.1%	50.0%
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										2	1	1	0	11.4%	25.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 18 Plus Who Smoke, 2016				16.5%	N/A	16.2%	14.2%	**12.3%**	Worse		X				
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	100.0%	0.0%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Other Indicators															
1. Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '14-16	99	110	116	47.9	72.8	**45.4**	34.8	N/A	Worse	X					
2. Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2016				21.9	31.2	**28.0**	30.6	N/A	Meets/Better						
3. Rate of Asthma Deaths per 100,000 Population, '14-16	2	1	2	0.7*	1.1*	**1.1**	1.5	N/A	Less than 10						
4. Rate of Asthma Hospitalizations per 10,000 Population, 2016				3.0	N/A	**6.3**	10.8	N/A	Meets/Better						
5. Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2016				1.8	N/A	**4.5**	5.6	N/A	Less than 10						
6. Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2016				3.1	N/A	**5.1**	9.2	N/A	Less than 10						
7. Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2016				N/A	N/A	**4.4**	8.9	N/A	Less than 10						
8. Percentage of Adults with Asthma, '13-14				14.6%	12.0%	**10.1%**	9.5%	N/A	Worse		X				
9. Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, '13-15	148	144	132	62.8	67.4	**53.0**	43.5	N/A	Worse	X					
10. Rate of Lung and Bronchus Cancer Cases per 100,000 Population, '13-15	196	197	231	92.4	112.2	**84.3**	69.7	N/A	Worse	X					
11. Number of Registered Tobacco Vendors per 100,000 Population, '15-16				84.0	555.8	**101.3**	107.8	N/A	Meets/Better						
12. Percentage of Vendors with Sales to Minors Violations, '15-16				1.60	5.30	**3.90**	4.70	N/A	Meets/Better						
13. Percentage of Vendors with Complaints, '15-16				0.00	0.00	**0.04**	0.90	N/A	Meets/Better						
Quartile Summary for Other Indicators										3	1	0	0	30.8%	0.0%
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										3	2	0	0	35.7%	0.0%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, 2016				75.6%	N/A	69.7%	68.5%	**80.0%**	Worse	X					
2. Rate of Asthma ED Visits per 10,000 Population, 2016				14.1	40.3	42.0	77.0	**75.1**	Meets/Better						
3. Rate of Asthma ED Visits per 10,000 Population, Ages 0 - 4, 2016				41.4	65.5	105.8	186.4	**196.5**	Meets/Better						
4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, 2016				2.1*	5.0	3.4	3.2	**3.06**	Less than 10						
5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, 2016				3.1	5.0	4.1	4.0	**4.86**	Meets/Better						
6. Age-Adjusted Rate of Heart Attack Hospitalizations per 10,000 Population, 2016				13.2	24.9	14.8	13.9	**14.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	16.7%	0.0%
Other Indicators															
1. Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '12-14				23.7	52.4	**47.4**	77.3	N/A	Meets/Better						
2. Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '12-14				13.1	22.7	**19.1**	35.0	N/A	Meets/Better						
3. Rate of All Cancer Cases per 100,000 Population, '13-15	1413	1443	1587	658.2	683.8	**629.8**	564.4	N/A	Worse	X					
4. Rate of all Cancer Deaths per 100,000 Population, '13-15	469	430	472	203.1	227.3	**198.7**	176.2	N/A	Worse	X					
5. Rate of Female Breast Cancer Cases per 100,000 Female Population, '13-15	194	197	210	176.0	173.3	**175.9**	158.6	N/A	Worse	X					
6. Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '13-15	66	69	71	60.3	N/A	**53.1**	50.6	N/A	Worse	X					
7. Rate of Female Breast Cancer Deaths per 100,000 Female Population, '13-15	28	25	29	24.0	N/A	**26.1**	24.6	N/A	Meets/Better						
8. Percentage of Women Aged 50-74 years Receiving Breast Cancer Screening Based on Recent Guidelines '13-14				77.9%	81.4%	**79.2%**	79.7%	N/A	Worse	X					
9. Rate of Cervix and Uterine Cancer Cases per 100,000 Female Population, '13-15	N/A	N/A	N/A	4.4	N/A	**7.6**	8.5	N/A	Less than 10						
10. Rate of Cervix and Uterine Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	N/A	N/A	**2.3**	2.7	N/A	Less than 10						
11. Percentage of Women Aged 21-65 Years Receiving Cervical Cancer Screening Based on Recent Guidelines, 13/14				85.0%	86.0%	**83.5%**	82.2%	N/A	Meets/Better						
12. Rate of Ovarian Cancer Cases per 100,000 Female Population, '13-15	19	12	22	15.5	N/A	**16.0**	14.8	N/A	Meets/Better						
13. Rate of Ovarian Cancer Deaths per 100,000 Female Population, '13-15	N/A	N/A	N/A	7.6	N/A	**10.4**	9.1	N/A	Less than 10						
14. Rate of Colon and Rectal Cancer Cases per 100,000 Population, '13-15	104	108	103	46.7	55.0	**48.5**	45.7	N/A	Meets/Better						
15. Rate of Colon and Rectal Cancer Deaths per 100,000 Population, '13-15	43	31	17	16.4	18.9	**16.7**	15.6	N/A	Meets/Better						
16. Percentage of Adults Aged 50-75 years receiving colorectal cancer screening based on recent guidelines				75.6%	73.6%	**68.5%**	69.7%	N/A	Meets/Better						
17. Rate of Prostate Cancer Deaths per 100,000 Male Population, '13-15	11	23	14	14.4	N/A	**17.7**	17.3	N/A	Meets/Better						
18. Rate of Prostate Cancer Cases per 100,000 Male Population, '13-15	170	166	176	153.5	140.4	**151.7**	141.2	N/A	Worse	X					
19. Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '13-15	38	33	28	29.7	30.0	**26.8**	25.2	N/A	Worse	X					
20. Rate of Melanoma Cancer Deaths per 100,000 Population, '13-15	18	7	9	5.0	N/A	**3.0**	2.3	N/A	Less than 10						
21. Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '15-17	9,725	10,509	10,678	27.4%	25.7%	**28.3%**	28.0%	N/A	Worse	X					
22. Percentage of Age Adjusted Adults with a Dental Visit Within the Last 12 Months, '13-14				75.0%	64.0%	**70.0%**	68.5%	N/A	Meets/Better						
23. Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, '13-15	s	s	s	3.8	N/A	**4.2**	4.5	N/A	Less than 10						
24. Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, '13-15	22	35	40	14.4	18.9	**14.7**	12.9	N/A	Meets/Better						
Quartile Summary for Other Indicators										8	0	0	0	33.3%	0.0%
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										9	0	0	0	30.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Maternal and Infant Health															
Prevention Agenda Indicators															
1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, 2016				8.1%	9.8%	10.5%	10.3%	**10.2%**	Meets/Better						
2. Ratio of Preterm Births (< 37 wks.) Black/NH to White/NH, 2014-2016				1.45	N/A	1.65	1.64	**1.42**	Less than 10						
3. Ratio of Preterm Births (< 37 wks.) Hisp/Latino to White/NH, 2014-2016				1.36	N/A	1.28	1.29	**1.12**	Less than 10						
4. Ratio of Preterm Births (< 37 wks.) Medicaid to Non-Medicaid, 2014-2016				0.93	N/A	1.10	1.06	**1.00**	Meets/Better						
5. Rate of Maternal Mortality per 100,000 Births, 2014-2016				0.0*	N/A	18.9	20.4	**21.0**	Less than 10						
6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, 2016				68.1%	63.0%	50.9%	46.3%	**48.1%**	Meets/Better						
7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, 2014-2016				93.0%	N/A	0.55	0.59	**0.57**	Less than 10						
8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, 2014-2016				1.1%	N/A	0.57	0.57	**0.56**	Less than 10						
9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, 2014-2016				0.84	N/A	0.68	0.59	**0.66**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Percentage Preterm Births < 32 weeks of Total Births Where Gestation Period is Known, '14-16	36	26	30	1.4%	3.9%	**1.5%**	1.5%	N/A	Meets/Better						
2. Percentage Preterm Births 32 to < 37 Weeks of Total Births Where Gestation Period is Known, '14-16	146	160	149	6.9%	7.5%	**7.4%**	7.3%	N/A	Meets/Better						
3. Percentage of Total Births with Weights Less Than 1,500 grams, '14-16	30	24	30	1.3%	1.2%	**1.3%**	1.4%	N/A	Meets/Better						
4. Percentage of Singleton Births with Weights Less Than 1,500 grams, '14-16	14	18	17	0.8%	0.9%	**1.0%**	1.0%	N/A	Meets/Better						
5. Percentage of Total Births with Weights Less Than 2,500 grams, '14-16	142	144	139	6.4%	6.7*%	**7.6%**	7.9%	N/A	Meets/Better						
6. Percentage of Singleton Births with Weights Less Than 2,500 grams, '14-16	89	100	96	4.5%	5.1*%	**5.7%**	6.0%	N/A	Meets/Better						
7. Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '14-16				6.6*%	N/A	**12.9%**	12.2%	N/A	Less than 10						
8. Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '14-16				9.2*%	N/A	**7.5%**	7.7%	N/A	Less than 10						
9. Infant Mortality Rate per 1,000 Live Births, '14-16	6	7	9	3.3	5.7*	**5.0**	4.5	N/A	Less than 10						
10. Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, '14-16	8	9	5	3.3	3.5*	**5.3**	5.1	N/A	Less than 10						
11. Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '14-16	1751	1701	1776	79.7%	75.4%	**77.0%**	75.2%	N/A	Meets/Better						
12. Percentage Early Prenatal Care for Black, Non-Hispanic, '14-16				71.1%	N/A	**68.5%**	64.5%	N/A	Less than 10						
13. Percentage Early Prenatal Care for Hispanic/Latino, '14-16				70.5%	N/A	**71.1%**	76.7%	N/A	Less than 10						
14. Percentage APGAR Scores of Less Than Six at Five Minute Mark of Births Where APGAR Score is Known, '14-16	24	24	23	1.1%	1.1%	**0.9%**	0.7%	N/A	Worse	X					
15. Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '13-15				71.4	110.9	**140.8**	104.8	N/A	Meets/Better						
16. Percentage WIC Women Breastfeeding for at least 6 months, '14-16				25.6%	N/A	**30.7%**	40.3%	N/A	Worse	X					
17. Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '14-16	1786	1742	1774	86.7%	79.5%	**82.9%**	87.3%	N/A	Meets/Better						
Quartile Summary for Other Indicators										2	0	0	0	11.8%	0.0%
Quartile Summary for Focus Area Maternal and Infant Health										2	0	0	0	6.9%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Preconception and Reproductive Health															
Prevention Agenda Indicators															
1. Percent of Births within 24 months of Previous Pregnancy, 2016				21.1%	23.2%	22.5%	19.8%	**17.0%**	Worse	X					
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, 2016				4.4	11.1	9.9	13.3	**25.6**	Less than 10						
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, 2014-2016				1.44+	N/A	4.30	4.80	**4.40**	Less than 10						
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, 2014-2016				2.01+	N/A	3.50	4.40	**4.10**	Less than 10						
5. Percent of Unintended Pregnancies among Total Births, 2016				20.1%	32.9%	24.9%	22.6%	**23.8%**	Meets/Better						
6. Ratio of Unintended Pregnancies Black, non-Hispanic to White, non-Hispanic, 2016				N/A	N/A	2.08	2.12	**1.90**	Less than 10						
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, 2016				1.5	N/A	1.49	1.68	**1.43**	Less than 10						
8. Ratio of Unintended Births Medicaid to Non-Medicaid, 2016				2.19	N/A	1.96	1.71	**1.54**	Worse		X				
9. Percentage of Women Ages 18- 64 with Health Insurance, 2016				95.8%	N/A	N/A	93.1%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	1	0	0	33.3%	0.0%

Other Indicators															
1. Rate of Total Births per 1,000 Females Ages 15-44, '14-16	2,235	2,174	2,211	53.9	53.2	**57.2**	58.5	N/A	Meets/Better						
2. Percent Multiple Births of Total Births, '14-16	107	98	91	4.5%	3.5%	**4.0%**	3.7%	N/A	Worse	X					
3. Percent C-Sections to Total Births, '14-16	720	715	760	33.2%	34.1%	**34.2%**	33.5%	N/A	Meets/Better						
4. Rate of Total Pregnancies per 1,000 Females Ages 15-44, '14-16	2,659	2,604	2,592	63.9	64.5	**72.8**	83.8	N/A	Meets/Better						
5. Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	0	0	1	0.0*	0.2*	**0.2**	0.2	N/A	Less than 10						
6. Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '14-16	0	2	1	0.1*	0.3*	**0.4**	0.6	N/A	Less than 10						
7. Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '14-16	26	20	19	5.0	12.5	**11.0**	15.1	N/A	Meets/Better						
8. Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	61	55	55	8.1	19.3	**13.2**	14.6	N/A	Meets/Better						
9. Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 15-19, '14-16	107	96	90	13.9	28.1	**22.3**	29.8	N/A	Meets/Better						
10. Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	47	48	46	17.6	36.3*	**22.9**	25.6	N/A	Meets/Better						
11. Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '14-16	81	76	71	28.4	50.4	**37.5**	50.1	N/A	Meets/Better						
12. Percent Total Births to Women Ages 35 Plus, '14-16	466	467	494	21.6%	11.7%	**20.2%**	22.1%	N/A	Worse	X					
13. Rate of Abortions Ages 15 - 19 per 1000 Live Births, Mothers Ages 15-19, '14-16	43	40	34	684.2	434.5	**652.3**	990.8	N/A	Worse	X					
14. Rate of Abortions All Ages per 1000 Live Births to All Mothers, '14-16	345	372	308	154.8	181.4	**231.6**	370.9	N/A	Meets/Better						
15. Percentage of WIC Women Pre-pregnancy Underweight, '10-12	13	16	10	3.2%	4.9%	**4.1%**	4.7%	N/A	Meets/Better						
16. Percentage of WIC Women Pre-pregnancy Overweight but not Obese, '10 - 12	124	98	76	24.7%	22.3%	**26.3%**	26.6%	N/A	Meets/Better						
17. Percentage of WIC Women Pre-pregnancy Obese, '10 - 12	136	152	128	34.5%	33.3%	**28.0%**	24.2%	N/A	Worse	X					
18. Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '09 - 11	296	327	284	54.8%	52.4%	**47.1%**	41.7%	N/A	Worse	X					
19. Percentage of WIC Women with Gestational Diabetes, '09 - 11	38	34	34	6.3%	7.2%	**5.7%**	5.5%	N/A	Worse	X					
20. Percentage of WIC Women with Gestational Hypertension, '09 - 11	77	83	51	12.5%	12.9%	**9.1%**	7.1%	N/A	Worse		X				
Quartile Summary for Other Indicators										6	1	0	0	35.0%	0.0%
Quartile Summary for Focus Area Preconception and Reproductive Health										9	4	3	0	55.2%	18.8%

	Number Per Year (If Available)			Rate, Ratio or Percentage for the Listed	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Child Health															
Prevention Agenda Indicators															
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2016				91.4%	89.8%	82.8%	80.1%	**91.3%**	Meets/Better						
2. Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2016				85.8%	84.9%	82.3%	84.3%	**91.3%**	Worse	X					
3. Percentage of Children Age 12 -21 Years with Government Insurance with Recommended Well Visits, 2016				69.6%	69.5%	66.5%	68.1%	**67.1%**	Meets/Better						
4. Percentage of Children Ages 0 -19 with Health Insurance, 2016				97.9%	N/A	N/A	97.4%	**100.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	50.0%	0.0%

Other Indicators																
1. Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, '14-16	1	2	0	10.6*	26.8	**19.4**	18.2	N/A	Less than 10						
2. Rate of Children Deaths Ages 5 - 9 per 100,000 Population Children, '14-16	0	1	0	2.6*	9.0	**9.7**	10.0	N/A	Less than 10						
3. Rate of Children Deaths Ages 10 - 14 per 100,000 Population Children, '14-16	1	3	4	19.1*	15.5	**11.5**	11.4	N/A	Less than 10						
4. Rate of Children Deaths Ages 5 - 14 per 100,000 Population Children, '14-16	1	4	4	11.2*	12.3	**10.6**	10.7	N/A	Less than 10						
5. Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, '14-16	5	9	6	46.9	36.7	**32.6**	31.1	N/A	Less than 10						
6. Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				16.1	N/A	**27.4**	43.5	N/A	Less than 10						
7. Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2016				3.4*	N/A	**9.5**	18.7	N/A	Less than 10						
8. Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2016				5.9	N/A	**12.9**	23.5	N/A	Less than 10						
9. Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				N/A	N/A	**8.1**	10.6	N/A	Less than 10						
10. Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				5.9*	N/A	**24.4**	2.2	N/A	Less than 10						
11. Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2016				12.7	N/A	**24.4**	30.9	N/A	Less than 10						
12. Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				41.4	65.5	**105.8**	186.4	196.5	Meets/Better						
13. Percentage of Children born in 2013 Screened for Lead by Age 0-8 months, 2013				1.5%	0.7%	**1.2%**	1.9%	N/A	Less than 10						
14. Percentage of Children Born in 2013 Screened for Lead by Age 9-17 months, 2013				82.9%	77.5%	**71.7%**	74.8%	N/A	Meets/Better						
15. Percentage of Children Born 2013 Screened for Lead by Age 36 months (at least two screenings), 2013				69.4%	63.7%	**55.9%**	62.8%	N/A	Meets/Better						
16. Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '14-16	28	8	18	5.6	11.4	**8.3**	4.3	N/A	Meets/Better						
17. Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2016				15.9	N/A	**18.1**	18.9	N/A	Less than 10						
18. Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2016				10.3	N/A	**12.5**	13.6	N/A	Less than 10						
19. Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2016				23.3	N/A	**23.1**	23.1	N/A	Worse	X					
20. Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				21.9	N/A	**68.1**	137.1	N/A	Meets/Better						
21. Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, '15-17	5,399	5,929	6,147	49.5%	48.0%	**48.0%**	47.5%	N/A	Meets/Better						
22. Percentage of 3rd Graders with Dental Caries, '09 - 11				27.6%	N/A	N/A	N/A	N/A	Meets/Better						
23. Percentage of 3rd Graders with Dental Sealants, '09 - 11				34.8%	N/A	N/A	N/A	N/A	Meets/Better						
24. Percentage of 3rd Graders with Dental Insurance, '09 - 11				92.4%	N/A	N/A	N/A	N/A	Meets/Better						
25. Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11				83.6%	N/A	N/A	N/A	N/A	Meets/Better						
26. Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11				47.9%	N/A	N/A	N/A	N/A	Meets/Better						
27. Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2016				76.3	164.1	**119.7**	90.0	N/A	Meets/Better						
28. Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '14-16				96.0%	85.7%	**85.0%**	85.3%	N/A	Worse	X					
Quartile Summary for Other Indicators										2	0	0	0	6.9%	0.0%
Quartile Summary for Focus Area Child Health										4	0	0	0	12.1%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Human Immunodeficiency Virus (HIV)															
Prevention Agenda Indicators															
1. Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2014-2016				2.9	N/A	**6.9**	16.0	16.1	Less than 10						
2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, 2014-2016				20.0+	N/A	**20.1**	35.2	46.8	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of AIDS Cases per 100,000 Population, '14-16	4	4	3	1.6	N/A	**3.3**	7.7	N/A	Less than 10						
2. Rate of AIDS Deaths per 100,000 Adjusted Population, '14-16	1	2	0	0.4*	N/A	**1.1**	3.0	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Sexually Transmitted Disease (STDs)															
Prevention Agenda Indicators															
1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2016				6.2*	3.3	9.1	24.3	**10.1**	Less than 10						
2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2016				0.0*	0.6	0.5	1.3	**0.4**	Less than 10						
3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2016				###########	60.6	197.1	206.2	**183.4**	Less than 10						
4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2016				###########	48.2	230.0	452.5	**199.5**	Less than 10						
5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Female Population Ages 15 - 44, 2016				935.8	1170.1	1351.6	1620.7	**1458.0**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
1. Rate of Early Syphilis Cases per 100,000 Population, '14-16	9	7	13	4.3	2.52*	**7.9**	25.1	N/A	Meets/Better						
2. Rate of Gonorrhea Cases per 100,000 Population, '14-16	19	38	51	16.0	16.1	**64.6**	111.8	N/A	Meets/Better						
3. Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '14-16	3	4	6	30.5	45.8*	**209.9**	305.8	N/A	Less than 10						
4. Rate of Chlamydia Cases All Males per 100,000 Male Population, '14-16	143	144	148	341.5	352.5	**569.5**	857.7	N/A	Meets/Better						
5. Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '14-16	12	19	20	235.3	403.1	**607.9**	922.5	N/A	Meets/Better						
6. Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '14-16	58	54	55	768.6	779.1	**1,199.7**	1,638.0	N/A	Meets/Better						
7. Rate of Chlamydia Cases All Females per 100,000 Female Population, '14-16	326	361	382	869.6	1,188.4	**1,300.3**	1,577.4	N/A	Meets/Better						
8. Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '14-16	100	114	99	1,489.9	2,131.7	**2,300.5**	3,147.6	N/A	Meets/Better						
9. Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '14-16	135	163	176	2,452.7	2,717.9	**2,833.9**	3,424.6	N/A	Meets/Better						
10. Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, 2016				N/A	N/A	**1.9**	2.5	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Sexually Transmitted Diseases										0	0	0	0	0.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Vaccine Preventable Disease															
Prevention Agenda Indicators															
1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2016				78.4%	73.9%	64.0%		**80.0%**	Worse	X					
2. Percent females 13 - 17 with 3 dose HPV vaccine, 2016				47.2%	42.6%	41.7%		**50.0%**	Meets/Better						
3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, 2016				62.2%		59.6%	59.5%	**70.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	66.7%	0.0%
Other Indicators															
1. Rate of Pertussis Cases per 100,000 Population, '13-15	4	4	13	3.1	11.7	**5.9**	5.1	N/A	Meets/Better						
2. Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population Age 65 Plus, '12-14				93.7	93.3	**93.7**	87.3	N/A	Meets/Better						
3. Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '13/14				76.1%	75.0%	**73.8%**	69.3%	N/A	Meets/Better						
4. Rate of Mumps Cases per 100,000 Population, '13-15	0	2	1	0.44*	0.09	**0.70**	1.08	N/A	Less than 10						
5. Rate of Meningococcal Cases per 100,000 Population, '13-15	0	0	1	0.1*	0.09*	**0.1***	0.1	N/A	Less than 10						
6. Rate of H Influenza Cases per 100,000 Population, '13-15	0	2	4	0.9	2.0	**1.7**	1.5	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Focus Area Vaccine Preventable Diseases										2	0	0	0	22.2%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Healthcare Associated Infections															
Prevention Agenda Indicators															
1. Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days, 2017				0.9	5.6	N/A	5.2	**5.94**	Meets/Better						
2. Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2017				2.7	53.8	N/A	29.2	**2.05**	Worse		X				
Quartile Summary for Healthcare Associated Infections										0	1	0	0	50.0%	0.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders															
Prevention Agenda Indicators															
1. Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2016				2.4%	N/A	19.1%	18.3%	**18.4%**	Meets/Better						
2. Age-adjusted Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, 2016				9.9%	N/A	11.2%	10.7%	**10.1%**	Meets/Better						
3. Age Adjusted Rate of Suicides per 100,000 Adjusted Population, '14-16				11.3	N/A	9.6	8.0	**5.9**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										0	0	0	1	33.3%	100.0%
Other Indicators															
1 Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, '14-16				11.7*	10.7	**6.1**	5.0	N/A	Less than 10						
2. Rate of Self-inflicted Hospitalizations 10,000 Population, 2016				3.7	N/A	**4.1**	3.5	N/A	Meets/Better						
3. Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population Ages 15 - 19, 2016				8.7	N/A	**8.7**	7.6	N/A	Less than 10						
4. Rate of Cirrhosis Deaths per 100,000 Population, '14-16				10.8	13.8	**7.4**	8.0	N/A	Worse		X				
5. Rate of Cirrhosis Hospitalizations per 10,000 Population, 2016				3.3	1.5	**3.3**	3.0	N/A	Meets/Better						
7. Rate of Alcohol-Related Crashes per 100,000, 2017				77.0	69.1	**53.20**	38.0	N/A	Worse				X		
8. Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2017				29.1	28.8	**10.5**	19.4	N/A	Worse				X		
9. Rate of Drug-Related Hospitalizations per 10,000 Population, '12-14	242	296	340	13.1	14.6	**20.3**	24.0	N/A	Meets/Better						
10. Rate of People Served in Mental Health Outpatient Settings Ages 17 and under per 100,000 Population Ages 17 and under, 2015				268.0	1,279.4	**642.2**	682.2	N/A	Meets/Better						
11. Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				205.9	819.5	**620.5**	689.7	N/A	Meets/Better						
12. Rate of People Served in Mental Health Outpatient Settings Ages 65+ per 100,000 Population Ages 65+, 2015				24.4	141.7	**170.3**	311.4	N/A	Meets/Better						
13. Rate of People Served in Emergency Settings for Mental Health Ages17 and under per 100,000 Population Ages under 17 and under, 2015				7.9	15.6	**20.0**	18.9	N/A	Less than 10						
14. Rate of People Served in Emergency Settings for Mental Health Ages 18 - 64 per 100,000 Population Ages 18 - 64, 2015				0.0	21.7	**20.0**	25.7	N/A	Less than 10						
15. Rate of People Served in Emergency Settings for Mental Health Ages 65+ per 100,000 Population Ages 65+, 2015				0.0	N/A	**5.7**	7.6	N/A	Less than 10						
Quartile Summary for Other Indicators										0	1	0	2	20.0%	66.7%
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										0	1	0	3	22.2%	75.0%

	Number Per Year (If Available)			Average Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN	Upstate NY	New York State	2018 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Other Non-Prevention Agenda Indicators															
1. Rate of Hepatitis A Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.28*	**0.4**	0.5	N/A	Less than 10						
2. Rate of Acute Hepatitis B Cases per 100,000 Population, '14-16	0	0	0	0.0*	0.0*	**0.3**	0.5	N/A	Less than 10						
3. Rate of TB Cases per 100,000 Population, '14-16	1	1	1	0.4*	0.5*	**1.8**	3.9	N/A	Less than 10						
4. Rate of e. Coli Shiga Toxin Cases per 100,000 Population,'14-16	4	2	3	1.3*	2.0	**2.0**	1.6	N/A	Less than 10						
5. Rate of Salmonella Cases per 100,000 Population, '14-16	21	12	23	8.3	12.0	**12.0**	11.6	N/A	Meets/Better						
6. Rate of Shigella Cases per 100,000 Population, '14-16	6	2	2	1.5	0.4	**2.5**	3.9	N/A	Less than 10						
7. Rate of Lyme Disease Cases per 100,000 Population,'14-16	170	253	245	98.5	63.9	**N/A**	38.0	N/A	Meets/Better						
8. Rate of Confirmed Rabies Cases per 100,000 Population, 2015				6.2	7.3	**3.3**	1.8	N/A	Worse				X		
Quartile Summary for Non-Prevention Agenda Issues										0	0	0	1	12.5%	100.0%

Appendix I: Leading Causes of Death in Warren, Washington, and Saratoga Counties

The table below outlines the leading causes of premature death by county:

Leading Cause of Premature Death by County:

County	1st	2nd	3rd	4th	5th
Warren	Cancer	Heart Disease	Chronic Lower Respiratory Disease	Unintentional Injury	Liver Disease
Washington	Cancer	Heart Disease	Chronic Lower Respiratory Disease	Unintentional Injury	Stroke
Saratoga	Cancer	Heart Disease	Chronic Lower Respiratory Disease	Unintentional Injury	Suicide
NYS	Cancer	Heart Disease	Unintentional Injury	Chronic Lower Respiratory Disease	Diabetes

Source: New York State Department of Health, Reports: Leading Causes of All Deaths and Leading Causes of Premature Deaths (death before age 75), 2016 Available at https://apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/

Appendix J: County Health Rankings for Warren, Washington and Saratoga Counties

	NYS	Warren	Washington	Saratoga
Health Outcomes		**21**	**35**	**4**
Mortality		**28**	**32**	**6**
Premature death	5400	6400	6600	4900
Morbidity		**9**	**29**	**4**
Poor or fair health	16%	11%	14%	11%
Poor physical health days	3.6	3.6	3.9	3.3
Poor mental health days	3.6	3.5	4.0	3.6
Low birthrate	8%	7%	7%	7%
Health Factors		**10**	**42**	**2**
Health Behaviors		**20**	**43**	**11**
Adult smoking	14%	18%	19%	16%
Adult obesity	26%	30%	35%	26%
Physical Inactivity	25%	20%	24%	20%
Excessive drinking	19%	22%	20%	22%
Alcohol-impaired driving deaths	21%	12%	24%	29%
Sexually transmitted infections	552.8	295.3	239.4	242.7
Teen births	16	19	25	9
Clinical Care		**2**	**42**	**7**
Uninsured	7%	5%	6%	4%
Primary care physicians	1200:1	820:1	3250:1	1440:1
Dentists	1230:1	1060:1	4400:1	1570:1
Preventable hospital stays	4141	4022	3817	4069
Flu vaccinations	46%	52%	44%	51%
Mammography screening	41%	54%	44%	49%
Social & Economic Factors		**15**	**27**	**1**
High school graduation	82%	88%	80%	91%
Some college	68%	65%	55%	78%
Unemployment	4.7%	5.3%	4.7%	4.0%
Children in poverty	20%	15%	18%	8%
Income inequality	5.7	4.1	4.1	3.9
Children in single-parent households	34%	34%	38%	24%
Violent Crime rate	379	138	141	103
Physical Environment		**15**	**50**	**49**
Air pollution–particulate matter	8.5	8.5	8.9	9.4
Drinking water violations		No	Yes	Yes
Access to exercise opportunities	93%	98%	66%	92%
Food environment index	9.1	8.5	8.4	8.9

Source: Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute County Health Rankings 2019. Available at http://www.countyhealthrankings.org/