ALBANY MED Health System

GLENS FALLS HOSPITAL

Community Service Plan

2022 - 2024

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1. Counties Covered:

Warren, Washington and Saratoga Counties

2. Participating Local Health Departments:

Warren County Public Health
Dan Durkee, Public Health Program Coordinator &
Emergency Preparedness Coordinator
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3. Participating Hospitals/Hospital Systems:

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4. Assessment and Planning Coalition:

Adirondack Rural Health Network led by Adirondack Health Institute

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, as well as Saratoga Hospital, 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 and Saratoga Hospital conducted separate, yet similar processes to determine their community's heath needs. While their processes were separate, all organizations remain coordinated in their planning efforts.

Utilizing the results of the indicator analysis, regional survey and the other county-specific community assessment resources, each organization prioritized the most significant health needs for their residents. Each organizations' 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 partners, 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 2022-2024:

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: Promote Well-Being and Prevent Mental and Substance Use Disorders

- **Focus Area 2 – Mental and Substance Use Disorder Prevention**

Priority Area: Prevent Communicable Diseases

- **Focus Area 1 – Vaccine Preventable Diseases**
- **Focus Area 5 - Antibiotic Resistance and Healthcare-Associated Infections**

It is important to note that GFH chose similar chronic disease and communicable disease related priorities in the previous 2019-2021 CSP 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

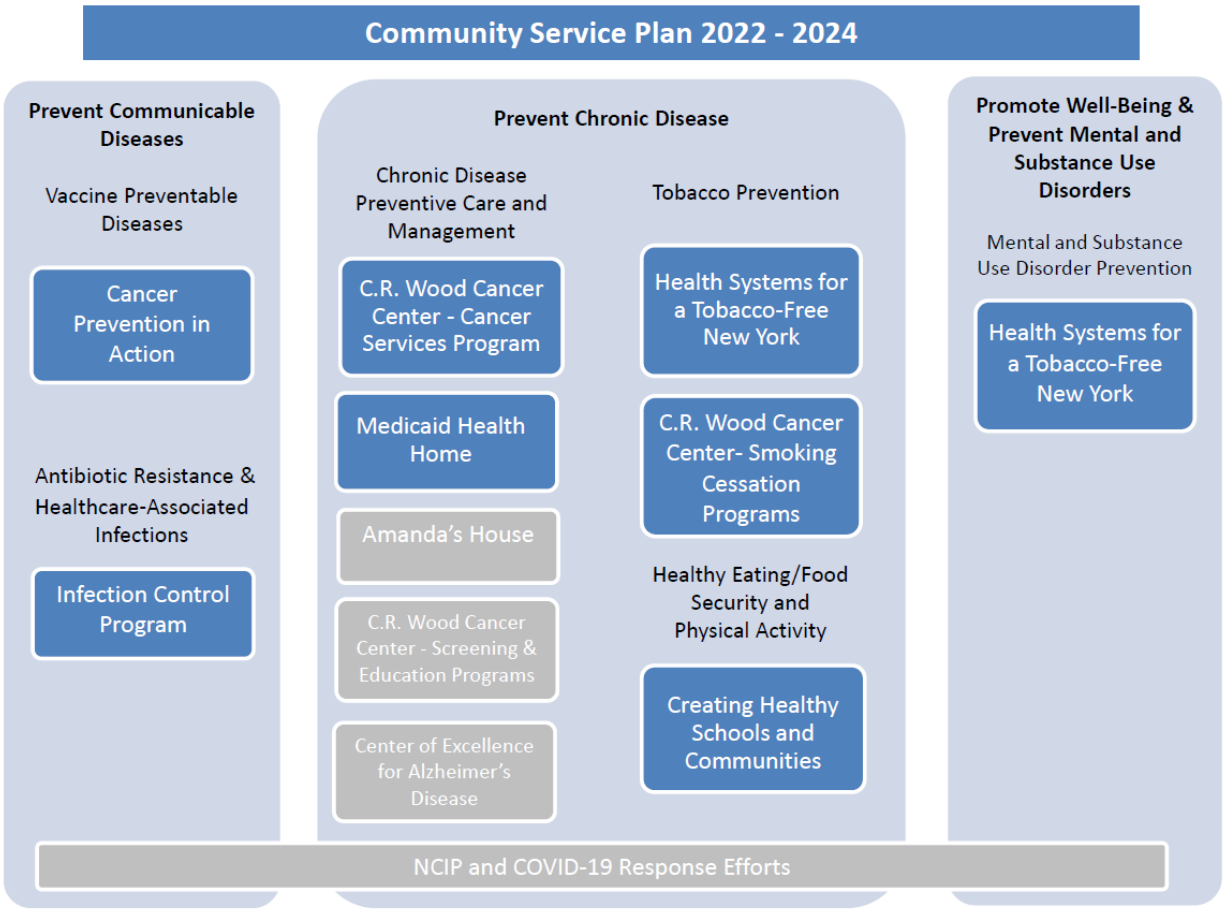
Prevention Agenda. Warren, Washington and Saratoga counties are predominately White and do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations in upstate New York face a unique combination of factors that create health disparities, 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 sources used by GFH include the NYS Prevention Agenda Dashboard, County Health Rankings, the NYS Cancer Registry, the Governor's Cancer Research Initiative – Warren County Cancer Incidence Report, and tobacco reports from the New York State Tobacco Control Program.

GFH will continue to partner with Warren, Washington and Saratoga County Public Health departments, as well as Saratoga Hospital, 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, Adirondacks ACO, Health Home, and the North Country Innovation Project. 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.



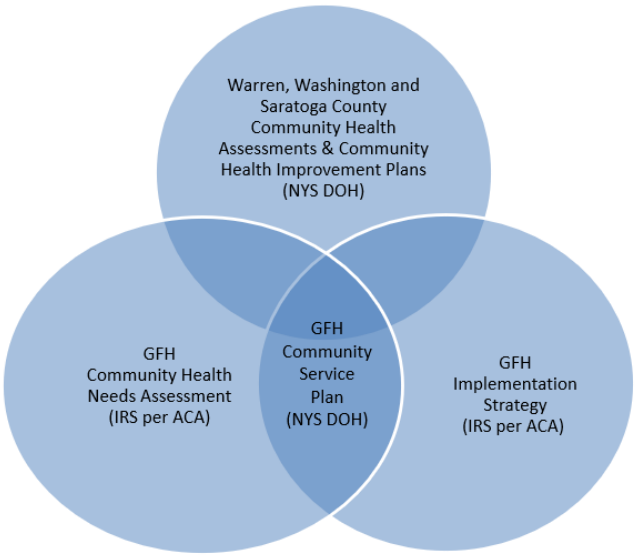
To ensure efficacy of the proposed interventions, GFH will work with Warren, Washington and Saratoga Public Health Departments, as well as Saratoga Hospital, to monitor and track progress using process and, where applicable, outcome evaluation. Each initiative has clearly defined process and/or outcome 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, as well as Saratoga Hospital, 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 CSP are the result of a collaborative process of collecting and analyzing data and consulting with stakeholders throughout the service area and the region. This CSP 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 Assessment (CHA) and a corresponding Community Health Improvement Plan (CHIP). 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.



[1] Centers for Disease Control and Prevention, Community Health Assessments & Health Improvement Plans, October 2022. Available at https://www.cdc.gov/publichealthgateway/cha/plan.html

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 the largest employer in New York's Adirondack region, with over 2,300 employees and a medical staff of over 550 providers (see Appendix A).

On July 1, 2020, Glens Falls Hospital became an affiliate of the Albany Med Health System which includes Albany Medical Center, Columbia Memorial Hospital, Glens Falls Hospital, and Saratoga Hospital. Together, our four-hospital system is enhancing the quality of care for more than three million people in our region. A region is a collection of its communities, and each community has its own characteristics. The hospitals, physician practice offices and urgent care centers of the Albany Med Health System retain their own unique identities for the communities they serve. Each hospital maintains its own name, leadership, employees, board and fundraising team.

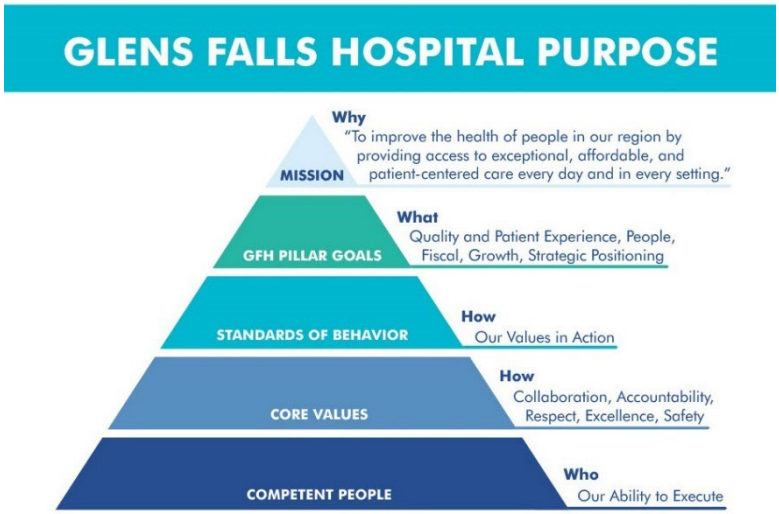
The primary and secondary service areas for GFH include Warren, Washington, and northern Saratoga counties, covering over 2,000 square miles. However, patients often travel from as far away as Essex and Hamilton counties to obtain services within the GFH system. With an extended service area that stretches 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 120 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 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

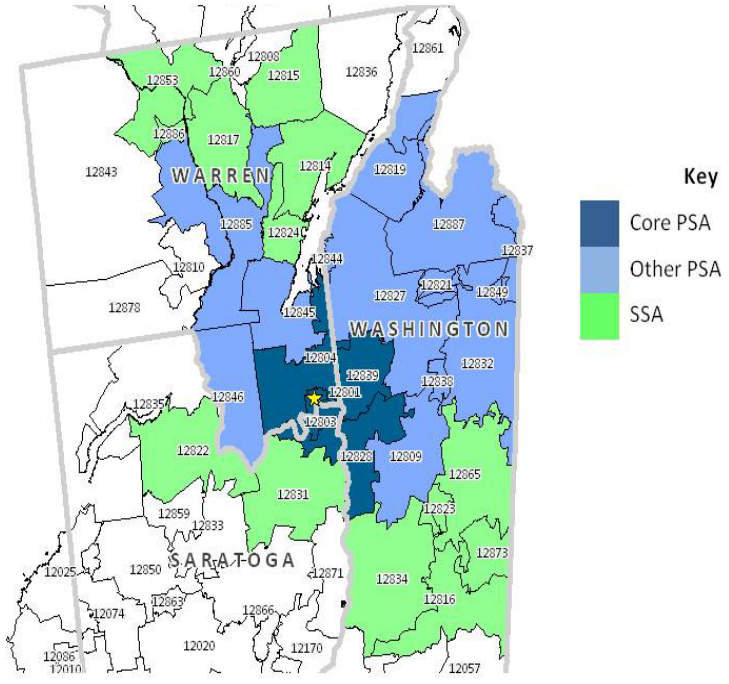
The mission of GFH is to improve the health of people in our region by providing access to exceptional, affordable and patient-centered care every day and in every setting. Our fundamental values are: **C**ollaboration, **A**ccountability, **R**espect, **E**xcellence and **S**afety. The GFH Purpose combines 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.



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

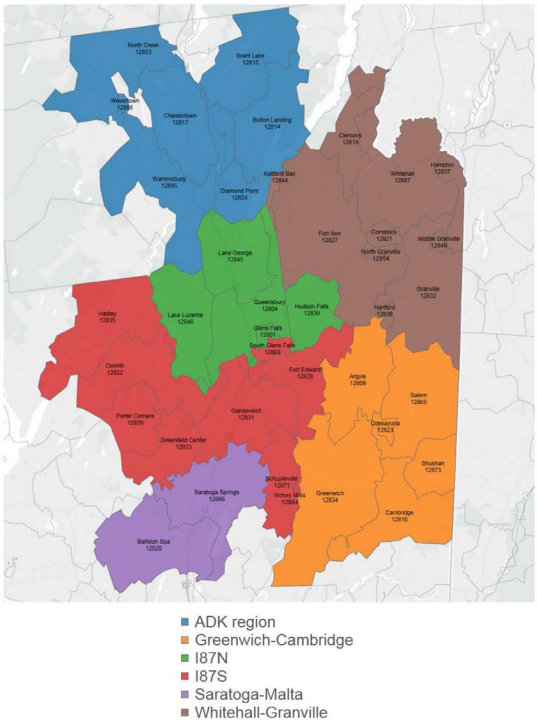
The GFH inpatient service area is defined by a Core Primary Service Area (PSA), Other Primary Service Area (Other PSA) and a Secondary Service Area (SSA). The Core PSA represents the ZIP codes immediately contiguous to the hospital. The SSA reflects more outlying areas where GFH has either a strong market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



GFH Inpatient Service Area

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.



GFH Ambulatory Service Area

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.

Adirondack Medical Home Initiative: The Adirondack Medical Home Initiative (AMHI) began in 2010 as a collaborative effort by health care providers and public and private insurers to transform health care delivery by emphasizing preventative care, enhanced management of chronic conditions, and assuring a close relationship between patients and their primary care providers. The AMHI included 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. The Adirondacks ACO carries on the work of the Medical Home by continuing to work with primary care

[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).

providers and hospitals, and expand into working with mental health providers, substance use treatment centers, and other sectors in health care. The network providers are committed to whole-person care and to improving health care for all who live and work in the region.

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 more than 1,000 participating doctors, clinicians, and other health care professionals throughout Clinton, Essex, Franklin, Hamilton, Warren, Washington, and northern Saratoga counties. In January of 2020, the ACO added behavioral health providers to the network to further enhance coordination and delivery of whole-person health for the approximately 140,900 update New Yorker's who are covered by payers in the Adirondacks ACO program. 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 Medicare Shared Savings Program (MSPP) in 2020, the first time in the ACO's history earning shared savings with MSSP. The ACO also experienced a 6.5% increase in the overall commercial performance over 2019, with increases seen in colorectal cancer screening, childhood immunizations, and adolescent immunizations. GFH is an active participant and holds two seats on the Board of Managers for the Adirondacks ACO.

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 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 was to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program. Across NYS, there were 25 Performing Provider Systems (PPS) or networks of providers that agreed to work together. GFH was a partner in the Adirondack Health Institute (AHI) PPS which included Clinton, Essex, Franklin, Fulton, Hamilton, (western) St. Lawrence, (northern) Saratoga, Warren and Washington counties. The DSRIP program covered a five-year period beginning April 1, 2015 and ending March 31, 2020.

Glens Falls Hospital was heavily engaged from the initial planning year through the end of the DSRIP program serving in a leadership role first on the Regional Health Innovation Team and later as a Population Health Network (PHN) Triad Lead. GFH had representation on the AHI PPS Steering Committee, Finance Committee, Workforce Committee, Compliance Committee, Quality Committee,

Community and Beneficiary Engagement Committee and Information Technology Committee. GFH operational leaders also served on project specific committees and workgroups. Throughout the duration of DSRIP, 25+ management-level staff served on 20+ DSRIP committees or workgroups having varying meeting schedules, ranging from every two weeks to monthly and included varying levels of commitment and responsibility. GFH was the largest provider in AHI PPS, and as such directly supported the success experienced by the AHIPPS including being 1 of 3 PPSs to earn 4 High Performance targets in year 5 as well as having earned the highest percentage of claims-based metrics in year 4 and 5 of all PPSs.

COVID-19 hit the United States as the DSRIP program concluded in March 2020. Even with significant time and resources devoted to the COVID-19 response efforts, members of the AHI PPS Steering Committee remained connected. As a result, a leadership group referred to as the North Country Innovation Project, continues to collaborate and plan for future opportunities in regional care transformation.

North Country Innovation Project: The North Country Innovation Project (NCIP) is a coalition of North Country providers and includes representatives of acute, primary and behavioral health care, a regional health planning entity, a regional ACO and community-based organizations. This unique partnership aims to build upon existing health care transformation initiatives currently underway and collaborate under any future opportunities that incentivize quality and efficiency, enhance care supports and services unique to the needs of individuals in the region, and improve communication and integration. This group is monitoring the outcome of New York State's waiver amendment proposal to the Centers for Medicare and Medicaid Services (CMS) to fund a new Medicaid 1115 Waiver that incorporates lessons learned from its DSRIP Program experience to address the inextricably linked health disparities and systemic health care delivery issues that have been both highlighted and intensified by the COVID-19 pandemic. If approved, this 1115 waiver amendment would utilize an array of multi-faceted and interconnected initiatives in order to fundamentally change the way the Medicaid program integrates and pays for social, physical health, and behavioral health care in New York State. It would also lay the groundwork for reducing long standing racial, disability-related, and socioeconomic health disparities, increase health equity though measurable improvement of clinical quality and outcomes. Should a new Medicaid 1115 waiver be approved for implementation in New York State, the NCIP will likely integrate as an essential participant in the process for the North Country.

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. 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. 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. Together, we advance patient, provider and community connections while working with a large network of stakeholders to improve access to care and improve 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 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, including capacity development, provision of decision-making resources/tools, and leveraging collaborative partnerships/resources to address identified regional priorities. The CHA Committee is made up of members from 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, Nathan Littauer Hospital & Nursing Home, University of Vermont Health Network – Alice Hyde Medical Center, University of Vermont Health Network – Champlain Valley Physicians Hospital, University of Vermont Health Network – Elizabethtown Community Hospital, Warren County Health Services, and Washington County 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, objectives, 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 Counties as well as Saratoga Hospital in the development of this CSP. 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 available results of each of the county assessments to inform a coordinated and complementary regional CSP for the GFH service area.

This approach was utilized during our last three 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. Multiple 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 Warren and Washington Counties. At the time of the writing of this assessment, Saratoga County was still in process of conducting an independent analysis to determine the needs of their residents and will subsequently choose priorities based on the specific needs of the county. GFH and Saratoga County have agreed to continue to coordinate and collaborate where priorities align. Saratoga Hospital, primarily serving Saratoga County residents, conducted a similar analysis to determine priority areas for their CSP. Due to overlapping service areas, Saratoga Hospital and Glens Falls Hospital also coordinate where appropriate.

Although Saratoga County conducted an independent analysis, each county's CHA process involved both data analysis and consultation with key members of the community. Warren and Washington county each 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 varies. The partners included in each county's community health assessment teams were slightly different, and each county also chose to consider slightly different data sources.

Glens Falls Hospital Community Health Needs Assessment

GFH used completed county CHAs 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

assessment processes. GFH directly participated in the planning of the Warren County CHA. GFH was an active participant in the Washington County process. In Saratoga County, GFH representatives participated in Saratoga Hospital's assessment and planning process and while Saratoga County Public Health's process has yet to be completed at the time of the writing of this plan, GFH remains in contact with Saratoga County leadership to ensure coordination and alignment where applicable.

Once the assessment process was complete for Warren and Washington county and Saratoga Hospital, GFH reviewed the results to coordinate with each entity as appropriate in addition to consideration of resources, expertise and strategic plans. GFH remains in contact with Saratoga County Public Health to coordinate as appropriate and review opportunities for collaboration on an ongoing basis. Preliminary data gathered by Saratoga County Public Health suggests alignment in at least one priority area across the region.

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. Each county and hospital, 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 2024 objectives. The state dashboard homepage displays a quick view of the most current data for New York State and the Prevention Agenda 2024 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 70 tracking indicators. Each county in the state has its own dashboard.

County Health Indicator Data

ARHN 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 2019 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[3].

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 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 4, 2021, CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey. The data subcommittee met four times from mid-July through mid-November 2021. Meetings were held via Webex/Zoom. Attendance ranged from 6 to 10 subcommittee members per meeting. Meetings were also attended by AHI staff from the Adirondack Rural Health Network. The final version of the survey was approved by the full CHA Committee at the November 10, 2021, 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 E for a summary of the ARHN Stakeholder Survey which includes details on how and over what time period the survey was conducted, the extent of input by various community sectors, and perceived areas of need by county. See Appendix F for a list of names of organizations who were solicited for feedback in Warren and Washington Counties.

County Health Rankings & Roadmaps

The County Health Rankings & Roadmaps (CHR&R) program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The CHR&R program provides data, evidence, guidance, and examples to build awareness of the multiple factors that influence health and support leaders in growing community power to improve health equity. The Rankings are unique in their ability to measure the health of nearly every county in all 50 states, and are complemented by guidance, tools, and resources designed to accelerate community learning and action. CHR&R is known for effectively translating and communicating complex data and evidence-informed policy into accessible models, reports, and products that deepen the understanding of what makes communities healthy and inspires and supports improvement efforts. County Health Rankings & Roadmaps' work is rooted in a sincere belief in health equity, the idea that everyone deserves a fair and

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

just opportunity to be as healthy as possible. 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)[4]. 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.

New York State Tobacco Control Program - Tobacco Reports

The New York State Tobacco Control Program (NYS TCP) works to reduce illness, disability and death related to tobacco use and secondhand smoke exposure, and to alleviate the social and economic burdens caused by tobacco use. TCP uses an evidence-based, policy-driven and cost-effective approach to decrease tobacco initiation by youth, motivate adult smokers to quit and eliminate exposure to secondhand smoke. TCP uses the most current research findings to drive program activities and provides StatShots, briefs, and reports related to NYS specific data and statistics. More information can be found at https://www.health.ny.gov/prevention/tobacco_control/reports.htm.

[4] 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/

Regional Profile of Warren, Washington and Saratoga Counties[5]

Warren, Washington, and Saratoga counties are part of the Capital Region, along with Albany, Columbia, Greene, Rensselaer, and Schenectady counties[6]. The Capital Region is an attractive 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. The Capital Region vision is to foster an ecosystem in which the private sector, academia, and government work in harmony to stimulate economic growth. Locally collaborative. Globally competitive. Economically vibrant.

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[7]. 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,

[5] 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.

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

[7] 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

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[8]

Most of Warren County lies within the boundaries of the Adirondack State Park, which encompasses approximately 6 million acres. The county's population of 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.

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, the ECHL professional minor league hockey team. 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 2300 employees. In 2020, Glens Falls Hospital continued to invest in the community through employee salaries and benefits, community benefit, and charity care:

- $182 million in employee salaries, wages and benefits
- $38 million in community benefit and charity care to ensure all patients have access to critical healthcare services regardless of their ability to pay.

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

Washington County[9]

Nestled in the foothills of the Adirondacks Washington County is known for its astounding beauty and abundant natural resources sprinkled with historic villages and captivating Main Streets. Thriving arts and cultural resources, safe and secure communities, a wealth of outdoor recreation opportunities as well as significant historic legacy contribute to the quality of life of residents and attract visitors year-round. Washington County is largely rural in nature, with agriculture serving as a strong economic driver for the county supporting hundreds of local businesses ranging from farms to service providers and retail shops. The local agriculture industry generates near $140 million in direct sales annually. Direct economic contribution from agricultural production is estimated at over $224 million annually.

[8] Adapted from the Warren County Economic Development Corporation website, http://www.edcwc.org
[9] Adapted from the Washington County Local Development Corporation website, http://www.wcldc.org/906/About-Washington-County-NY

Dairy forms the backbone of Washington County's agricultural economy. Beef, other livestock, field crops, maple syrup, and apples are amongst the important commodities produced here in Washington County. Many of these commodities drive numerous ancillary business such as hard cider and cheese production. The Equine industry, with its established ties to nearby Saratoga, is growing. Washington County's agriculture is also strongly connected to tourism as many area farms are open to the public throughout the year and offer tours such as Maple Weekend, Fiber Tour, Cheese Tour, as well as the Craft Beverage Trail which entices thousands to the area each year. 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.

Farmers markets are found throughout the County, offering a plentiful supply of healthy local foods, Longstanding farm stands as well as more informal roadside stands dot the landscape enticing people with their displays of produce, bedding plants and locally produced value-added products. Several Community Supported Agriculture programs offer shares of locally grown, freshly delivered foods.

Washington County is home to diverse array of businesses with 16 large employers contributing over 3,000 jobs equating to 20% of all private sector jobs in the County. Industries include manufacturing of paper products, machinery, furniture, polymer products, as well as filtration and energy solutions. Healthcare providers and supermarkets also contribute to private sector jobs.

Saratoga County[10]

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.

Saratoga County boasts a well-educated, skilled and productive workforce largely attributed to the region's variety of skilled training programs that are custom tailored to the growing industries in and around the Capital Region through programming offered at community colleges, vocational technical schools and training programs. These programs have built a pipeline of a qualified, skilled workforce to enter into employment locally. The major companies doing business in Saratoga County include Quad Graphics Inc., 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.

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

Health Care Facilities

There are two hospitals in the three-county area, GFH and Saratoga Hospital, both affiliates of the Albany Med Health System. 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 409 beds, and four adult care facilities, accounting for 248 beds, with rates per 100,000 of 637 and 633, respectively. The total physician rate is 391 per 100,000, higher than the ARHN region at 198 per 100,000. However, 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 567 beds, and four adult care facilities, accounting for 152 beds, with rates per 100,000 of 929 and 493, respectively. The total physician rate is 48 per 100,000, significantly lower than the ARHN region at 198 per 100,000. 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. There are two nursing home facilities, accounting for 462 beds, and nine adult care facilities, accounting for 483 beds, with rates per 100,000 of 201 and 521, respectively. The total physician rate is 259 per 100,000, which is lower than Upstate New York.

Educational System

There are 32 school districts in Warren, Washington and Saratoga counties, with a total enrollment of approximately 47,500 students. Within Warren County, there are nine school districts, with a total enrollment of 8,058 students. Washington County has 11 school districts, with a total enrollment of 7,708 students and Saratoga County has 12 school districts, with a total enrollment of 31,780 students.

In Saratoga County 25.3% of enrolled students are eligible for free and reduced lunch, with majority eligible for free lunch (91.0% or 7,313 students) compared to Warren County where 41% are eligible for free and reduced lunch, with majority eligible for free lunch (93.3% or 3,315 students) and Washington County where 43.7% are eligible for free and reduced lunch, with majority eligible for free lunch (94.4% or 3,365 students) . The high school dropout rate is 5.0% in Warren County, 7.0% in Washington County and 4.0% in Saratoga County, all higher than or equal to the New York State dropout rate of 4.0% but lower than compared to Upstate New York (7.3%).

The student- teacher ratios in both Warren County (9.7 students per teacher) and Washington County (9.6 students per teacher) are comparable to ARHN region (9.8) but slightly higher than Upstate New York (8.9). There are 8.3 students per teacher in Saratoga County, which is lower than the ARHN region (9.8) and Upstate New York (8.9).

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 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.

Population and Demographics

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

	County			ARHN Region*	Upstate NYS**	NYS
	Saratoga	Warren	Washington			
Square Miles[1,2]						
Total Square Miles	810.0	867.0	831.2	8,372.2	46,823.75	47,126.4
Population per Square Mile	283.1	74.0	73.4	41.9	237.8	414.1
Population[3]						
Total Population	229,313	64,187	61,034	351,117	11,135,297	19,514,849
Percent White, Non-Hispanic	92.1%	95.5%	92.6%	87.9%	79.8%	62.3%
Percent Black, Non-Hispanic	1.7%	1.1%	3.0%	3.0%	10.1%	15.4%
Percent Hispanic/Latino	3.3%	2.7%	2.8%	2.9%	13.0%	19.1%
Percent Asian/Pacific Islander, Non-Hispanic	2.9%	0.9%	0.6%	0.8%	4.9%	8.6%
Percent Alaskan Native/American Indian	0.2%	0.2%	0.3%	1.1%	0.4%	0.4%
Percent Multi-Race/Other	2.6%	2.0%	2.6%	2.3%	4.3%	4.7%
Number Ages 0-4	11,481	2,829	2,868	16,268	605,910	1,140,669
Number Ages 5-14	25,765	6,635	6,625	36,730	1,302,649	2,237,295
Number Ages 15-17	8,525	2,176	2,042	11,736	425,114	693,178
Number Ages 18-64	141,996	38,228	37,864	210,763	6,832,435	12,222,005
Number Ages 65+	41,546	14,319	11,905	68,930	1,969,189	3,221,702
Poverty[3,4]						
Mean Household Income	$ 108,479	$ 85,859	$ 71,922	$ 74,555	$ 97,962	$ 105,304
Per Capita Income	$ 45,624	$ 38,740	$ 29,014	$ 31,035	$ 33,208	$ 40,898
Percent of Individuals Under Federal Poverty Level	5.9%	8.5%	10.9%	11.9%	12.5%	13.6%
Percent of Individuals Receiving Medicaid	12.9%	19.7%	26.5%	24.2%	20.2%	25.7%
Education[4]						
Total Population Ages 25 and Older	164,817	48,041	44,788	254,422	7,715,731	13,649,157
Percent with Less than High School Education	6.6%	8.4%	12.8%	11.4%	9.4%	12.5%
Percent High School Graduate/GED	24.3%	29.1%	39.5%	34.9%	27.1%	25.6%
Percent Some College, no degree	15.9%	18.9%	17.5%	17.5%	16.9%	15.5%
Percent Associates Degree	11.6%	11.4%	10.8%	12.1%	10.7%	8.9%
Percent Bachelor's Degree	23.2%	17.2%	11.6%	13.2%	19.6%	20.9%
Percent Graduate or Professional Degree	18.8%	15.1%	8.6%	11.1%	16.5%	16.5%
Employment Status[4]						
Percent Unemployed	3.2%	4.1%	5.6%	4.8%	3.0%	5.7%

*ARHN Region excludes Saratoga County

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

Sources:

(1) 2010 Census Estimate; Census Quick Stats (2) USDA Farm Overview; 2017 (3) US Census Bureau, 2020 American Community Survey 5-year Estimates (4) Centers for Medicaid and Medicare Services; 2019

Over 350,000 people live within Warren, Washington and Saratoga counties. On average, the vast majority of the population is white, non-Hispanic (93.4%) and nearly one in three people has obtained a Bachelor's degree or higher level of education (31.5%).

Warren County

Spanning 867 square miles, the population of Warren County is 64,187 making it the second most populated county in the ARHN region. Like Upstate New York, Warren County's population is limited in its diversity with 95.5% of the population White, Non-Hispanic, followed by 2.7% Hispanic/Latino and 2.0% 2+ races. 22.3% of the population is aged 65 years and older, which is higher than both the ARHN region (19.6%) and Upstate New York (17.7%).

Mean household income is $85,859, which is less than Upstate New York ($97,962), however the per capita income is $38,740 which is higher than Upstate New York ($33,208). The percentage of individuals in Warren County living below the Federal Poverty Level is 8.5%, which is lower than both the ARHN region (11.9%) and Upstate New York* (12.5%).

When considering the total population of Warren County, approximately 74.8% of individuals are aged 25 years of age or older. Of that population, 29.1% are a High School Graduate or have their General Education Diploma (GED). An additional 43.7% have an Associates, Bachelor's, or higher education degree.

Warren County's unemployment rate is 4.1% with 32,257 employed aged 16 and older in the Civilian Workforce. The highest employment sector with 28.3% is the field of Education, Health Care and Social Assistance. This is followed by Retail Trade (12.0%) and Arts, Entertainment, Recreation, Hotel & Food Service (11.7%).

Washington County

Spanning 831 square miles, the population of Washington County is 61,034. Like Upstate New York, Washington County's population is limited in its diversity. 92.6% of the population is White, Non-Hispanic, followed by 2.8% Hispanic/Latino and 2.6% 2+ races. 19.5% of the population is aged 65 years and older, which is lower than the ARHN region (19.6%) but higher than Upstate New York (17.7%).

Mean household income is $71,922 and per capita income is $29,014. These averages are less than Upstate New York which are $97,962 and $33,208 respectively. The percentage of individuals in Washington County living below the Federal Poverty Level is 10.9%, which is lower than the ARHN region (11.9%) and Upstate New York (12.5%).

When considering the total population of Washington County, approximately 73.4% of individuals are aged 25 years of age or older. Of that population, 39.5% are a High School Graduate or have their General Education Diploma (GED). An additional 31.0% have an Associates, Bachelor's, or higher education degree.

Washington County's unemployment rate is 5.6% with 28,146 employed aged 16 and older in the Civilian Workforce. The highest employment sector with 23.2% is the field of Education, Health Care and Social Assistance. This is followed by Retail Trade (15.0%) and Manufacturing (13.7%).

Saratoga County

Spanning 810 square miles, the population of Saratoga County is 229,313. Like Upstate New York*, Saratoga County's population is limited in its diversity. 92.1% of the population is White, Non-Hispanic, followed by 3.3% Hispanic/Latino and 2.6% 2+ races. 18.1% of the population is aged 65 years and older, which is higher than Upstate New York* (17.7%).

Mean household income is $108,479 and per capita income is $45,624. These averages are higher than Upstate New York* which are $97,962 and $33,208 respectively. The percentage of individuals in Saratoga County living below the Federal Poverty Level is 5.9%, which is lower than Upstate New York* (12.5%).

When considering the total population of Saratoga County, approximately 71.9% of individuals are aged 25 years of age or older. Of that population, 24.3% are a High School Graduate or have their General Education Diploma (GED). An additional 53.6% have an Associates, Bachelor's, or higher education degree.

Saratoga County's unemployment rate is 3.2% with 125,915 employed aged 16 and older in the Civilian Workforce. The highest employment sector with 25.5% is the field of Education, Health Care and Social Assistance. This is followed by Manufacturing (10.8%) and Retail Trade (10.2%).

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.[11] The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

[11] 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

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

Warren County

The percentage of adults who are either overweight or obese (60.6%) is lower than the ARHN region (69.1%), Upstate New York (64.2%) and New York State (62.7%). However, the 2024 Prevention Agenda Benchmark goal for percentage of adults who are obese is set at 24.2% and Warren County fairs worse at 25.2%. Interestingly, while there are reportedly more accessible recreational and fitness facilities in Warren County (17.1) compared to the ARHN Region (8.8) and Upstate New York (13.2), the percentage of adults who participated in leisure time physical activity in Warren County (77.5%) is still slightly behind Upstate New York (77.6%). The percentage of children in elementary school who are either overweight (16.7%) or obese (17.5%) are higher than their respective Upstate New York measures of 16.1% and 16.6% respectively. Conversely, students in middle and high school are experiencing lower percentages of overweight and obesity compared to the ARHN Region and Upstate New York. In Warren County, the burden of obesity may contribute to higher than benchmark performance on 12 of 23 indicators related to Diabetes, Cardiovascular Disease, Heart Disease and Stroke.

Smoking and smoking-related diseases seem to present a challenge for Warren County, with seven indicators having worse performance than the comparison benchmark. The percentage of adults who smoke in Warren County (19.1%) is higher than Upstate New York (13.9%), New York State (12.8%) and the Prevention Agenda Benchmark (11.0%). This may stem from the number of registered tobacco vendors per 100,000 population being higher (166.7) then the ARHN region (132.7), Upstate New York (104.4) and New York State (110) making the availability of tobacco products more accessible to residents.

In Warren County, the rate of chronic lower respiratory deaths (88.1) is higher than in Upstate New York (48.3) and New York State (36.7). Similarly, in Warren County the rate of chronic lower respiratory hospitalizations per 10,000 (37.4) is higher than in Upstate New York (28.7) and New York State (29.7). The percentage of adults with asthma in Warren County (10.6%) is slightly lower, in comparison to the ARHN region (13.5%), the same as Upstate New York State (10.6%), and higher than New York State (10.1%).

The rate of all cancer cases (797.9) and rate of all cancer deaths (271.5) in Warren County is much higher than Upstate New York, at 657 and 194.7 respectively. The rate of female breast cancer cases (226.6) and late stage breast cancer cases (53.8) are also higher than Upstate New York at 180.1 and 50.9 respectively. The rates of lung and bronchus cancer cases are higher in Warren County (122.3) than in the ARHN region (119), Upstate New York (87.6), and New York State (72.6), and lung and bronchus cancer deaths in Warren County (77.2) are higher than the ARHN region (65), Upstate New York (48.1) and New York State (39.6). The rate of colon and rectal cancer incidence and deaths in Warren County (55.4 and 20.7) is slightly higher than the ARHN region (54.2 and 19.8). The rate of lip, oral cavity, and pharynx cancer cases (20.2) is higher than the ARHN Region (17.4), Upstate New York (16.3), and New York State (14.1).

Washington County

The percentages of children in elementary, middle, and high school who are either overweight or obese are higher than that of Upstate New York over five indicators suggesting an obesity challenge within Washington County. The percentage of adults who are either overweight or obese (71.6%) is higher than the ARHN region (69.1%), Upstate New York (64.2%) and New York State (62.7%). The 2024 Prevention

Agenda Benchmark goal for percentage of adults who are obese is set at 24.2% and Washington County fairs worse at 38.7%.

A possible contributing factor to the higher than benchmark performance in both children and adult obesity indicators could be the lower access to recreational and fitness facilities compared to the ARHN region and Upstate New York. The percentage of adults who participated in leisure time physical activity in the past 30 days (72.7%) is lower compared to the Upstate New York (77.6%).

The burden of obesity may contribute to Washington County's Diabetes challenges which include higher than benchmark average 14 of 23 indicators related to Diabetes, Cardiovascular Disease, Heart Disease and Stroke.

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 (25.3%) is higher than Upstate New York (13.9%), the ARHN region (19.5%) and the Prevention Agenda Benchmark (11.0%).

In Washington County, chronic lower respiratory deaths are higher (87.4) than in Upstate New York (48.3) and New York State (36.7). Similarly, in Washington County the rates of chronic lower respiratory hospitalizations per 10,000 (41) are higher than in Upstate New York (28.7) and New York State (29.7). The percentage of adults with asthma in Washington County (16.5%) in higher in comparison to the ARHN region (13.5%), Upstate New York (10.6%), and New York State (10.1%).

The rate of all cancer cases (726.3) and rate of all cancer deaths (241) in Washington County is much higher than Upstate New York, at 657 and 194.7 respectively. The rate of female breast cancer cases (199.7) is also higher than the ARHN Region (176.3), Upstate New York (180.1) and New York State (164.6). The rates of lung and bronchus cancer cases are lower in Washington County (110.5) than in the ARHN region (119), but higher than Upstate New York (87.6) and New York State (72.6), and lung and bronchus cancer deaths in Washington County (63.4) are lower than the ARHN region (65.0), and higher than Upstate New York (48.1) and New York State (39.6). The rate of colon and rectal cancer incidence and deaths in Washington County (54.2 and 21.1) is comparable to those of the ARHN region (54.2 and 19.8) but higher than Upstate New York (48.8 and 15.7). The rate of lip, oral cavity, and pharynx cancer cases (21.7) is higher than the ARHN Region (17.4), Upstate New York (16.3), and New York State (14.1).

Saratoga County

The percentage of adults who are overweight or obese is 68.8% which is higher than the Upstate New York benchmark of 64.2%. Additionally, 30.1% of adults are obese compared to the 2024 Prevention Agenda benchmark of 24.2%. Interestingly, the percentage of overweight and obesity persist despite more accessible recreational and fitness facilities in Saratoga County (14.9) compared to the ARHN Region (8.8) and Upstate New York (13.2), and higher percentage of adults who participated in leisure time physical activity in Saratoga County (86.0%) compared to Upstate New York (77.6%).

The percentages of total students overweight (17.0%) in Saratoga County is comparable to Upstate New York (16.9%) and better than the ARHN Region (17.5%). However, there is a noticeable difference in percentage of overweight in elementary students (15.8%) which is lower than Upstate New York (16.1%) verses middle and high school students' percentage of overweight (18.5%) which is higher than Upstate New York (17.8%).

Smoking rates have dropped in Saratoga County with the current percentage of adults who smoke in at 12.8%, which is lower than Upstate New York (19.5%) but still higher than the Prevention Agenda Benchmark (11.0%). Chronic lower respiratory deaths rates are higher in Saratoga County (55.4) than in Upstate New York (48.3) and New York State (36.7). The percentage of adults with asthma in Saratoga County (13.7%) is higher, in comparison to the ARHN region (13.5%), Upstate New York (10.6%), and New York State (10.1%).

The rates of lung and bronchus cancer incidence are lower in Saratoga County (95.1) than in the ARHN region (119.0), but higher than Upstate New York (87.6) and New York State (72.6), and lung and bronchus cancer deaths in Saratoga County (56.8), are lower than the ARHN region (65.0), and higher than Upstate New York (48.1) and New York State (39.6). The rate of colon and rectal cancer cases and deaths in Saratoga County (49.4 and 18.2) is higher than Upstate New York (48.8 and 15.7).

Saratoga County has worse performance on the rate of all cancer cases (679.0) and the rate of all cancer deaths (204.5) than the Upstate New York benchmarks (657.0, 194.7). The rate of female breast cancer cases (189.8) and the rate of female late-stage breast cancer cases (53.9) also performed worse than their respective Upstate New York benchmark (180.0, 50.9). The rate of lip, oral cavity, and pharynx cancer cases (19.8) is higher than the ARHN Region (17.4), Upstate New York (16.3), and New York State (14.1).

New York State Tobacco Control Program - Tobacco Reports

New York State conducts annual tobacco surveys targeting both youth and adults that 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. The results of the New York State Youth Tobacco Survey[12] show after staggering increases in youth tobacco use between 2014 and 2018, primarily driven by electronic cigarettes (also referred to as e-cigarettes, Electronic Nicotine Delivery Systems or ENDS), new data from the NY Youth Tobacco Survey (NY-YTS) indicate that tobacco use among high school age youth has declined across all product categories from 30.6% to 25.6% between 2018 and 2020. According to the data:

- Cigarette smoking among high school youth is at an all-time low: only 2.4% of high school youth are current smokers, representing a 91% decline in the youth smoking rate since 2000 when 27.1% of high school age youth were current smokers.
- E-cigarette use among high school youth decreased in 2020, a first since NY has monitored use of these products, from 27.5% in 2018 to 22.5% in 2020. However, ENDS are still the most commonly used tobacco products among youth.
- Other tobacco product use, including cigars, smokeless tobacco, pipe tobacco, and hookah, also decreased among high school youth, from 9.2% in 2018 to 6.1% in 2020.

[12] Based on methods developed by CDC, the 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 YTS, for all years excluding 2008 and 2020, is 8,000. In 2008, a special study was conducted, and the sample was increased to 23,133. In 2020, due to school closures during the COVID-19 pandemic, approximately half the sample was collected (n=3895); non-response bias analyses were performed which concluded data quality and representativeness were not impacted by reduced sample size.

The results of the New York Adult Tobacco Survey (ATS)[13] 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%

The Clinical Practice Guidelines for Treating Tobacco Use and Dependence recommend that health care providers ASK if their patients smoke, ADVISE smokers to quit, and ASSIST patients with quit attempts through counseling and medications. According to 2019 data from ATS, an estimated 75.5% of current smokers have seen a health care provider in the past 12 months; among them:

- ASK: 89.4% of current smokers who saw a health care provider in the past 12 months were asked if they smoke cigarettes.
- ADVISE: More than three-quarters (78.1%) reported their health care provider advised them to quit smoking. This represents a 12.5% increase between 2014 and 2019.
- ASSIST: 55.5% reported their health care provider offered assistance to quit. This represents a 23.3% increase between 2014 and 2019.2

In 2019, 59% of adult smokers stopped smoking for one day or more because they were trying to quit smoking. Receiving health care provider assistance doubles the odds of quitting.

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.[14]

The following is an excerpt of the key conclusions from the report[15]:

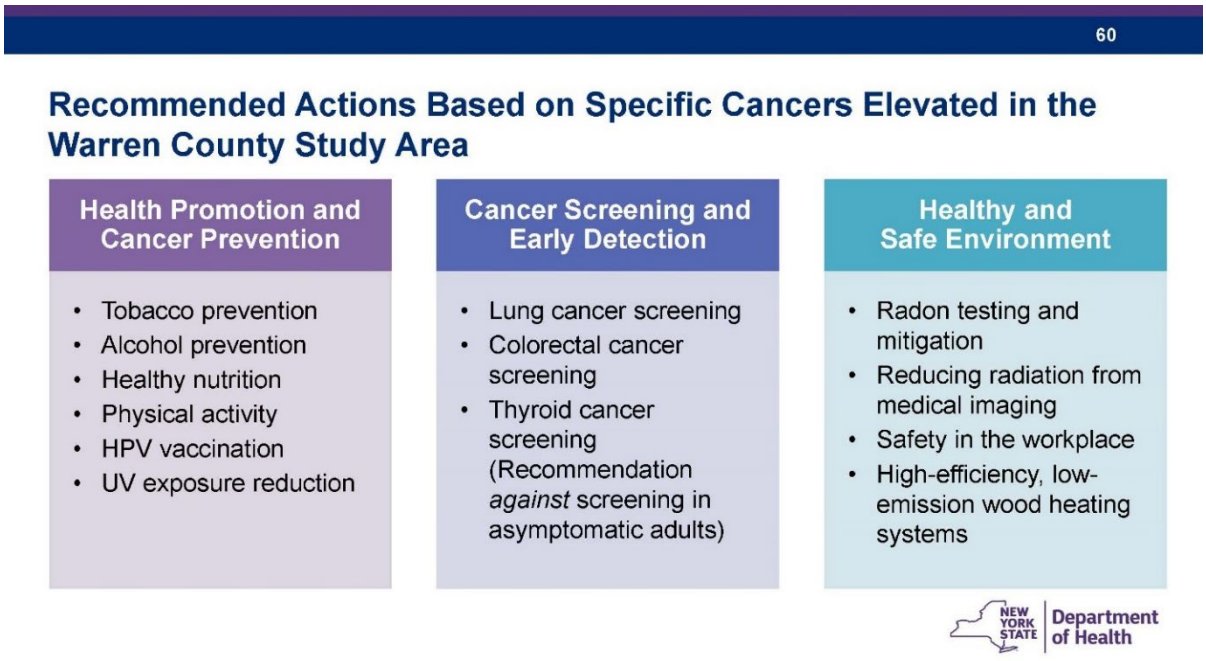
- Environmental factors evaluated in this study, including levels of radon in indoor air, environmental contaminants in outdoor air, contaminants in drinking water, industrial and

[13] 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.
[14] 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/
[15] 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/

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[16]:



[16] 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.

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.[17]

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:

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

Warren County

Motor vehicle accidents and speed-related accidents are higher in Warren County (2,856.2, 269.8) than Upstate New York (2,157.0, 205.7), however the rate of motor vehicle accident deaths is lower in Warren County (3.1) than the ARHN region (7.2), Upstate New York (6.6) and New York State (5.3). The rate of both violent and property crimes in Warren County (121.5, 1,045.0) is lower than both the ARHN Region (157.0, 1,056.8) and Upstate New York (204.7, 1,292.1).

The rate of hospitalizations due to falls among adults per 10,000 population, aged 65+ (196.3), those aged less than 10 years (9.8) and those aged between 25-64 (22.5) all performed worse than the respective benchmark (173.7, 6.2, 19.7).

Washington County

Motor vehicle accidents and speed-related accidents are lower in Washington County (1,904.1, 174.9) than in the ARHN region (2,298.7, 260.2), however the rate of motor vehicle accident deaths is higher in Washington County (8.3) than the ARHN region (7.2), Upstate New York (6.6) and New York State (5.3). The rate of both violent and property crimes in Washington County (130.4, 447.3) is lower than both the ARHN Region (157.0, 1,056.8) and Upstate New York (204.7, 1,292.1).

Rate of hospitalizations due to falls among adults per 10,000 population, aged 65+ (184.7), those less than 10 years of age (7.7) and those aged 25-64 (21.9) all performed worse than their respective

[17] 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

benchmark. Work related hospitalizations for those employees over 16 years of age (181.9) is higher than the ARHN Region (138.1), Upstate New York (175.8) and New York State (145.9).

Saratoga County

Motor vehicle accidents and speed-related accidents are lower in Saratoga County (2,013.0, 191.1) than in Upstate New York (2,157.0, 205.7), however the rate of motor vehicle accident deaths is higher in Saratoga County (7.8) than Upstate New York (6.6) and New York State (5.3). The rate of violent and property crimes in Saratoga County (95.4, 868.8) are lower than Upstate New York (204.7, 1,292.1) and New York State (364.9, 1,406.5).

Rate of hospitalizations due to falls among adults per 10,000 population, aged 65+ (200.3) is worse than the 2024 Prevention Agenda Benchmark of 173.7. Additionally, the rate of falls hospitalizations for those aged less than 10 (6.3), those aged 10-14 (5.0) and those aged 15-24 (5.0) performed worse than the respective Upstate New York benchmark (6.2, 3.4, 4.0).

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.[18]

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 preterm births in Warren County (10.3%) is higher than the prevention agenda benchmark of 8.3%. The percentage of total births with weights less than 2,500 grams in Warren County (8.8%) is higher than the ARHN Region and Upstate New York, both sharing the same rate of 7.7%. The percentages of women receiving WIC in Warren County who are either underweight, obese, have gestational weight gain greater than ideal, gestational diabetes or gestational hypertension are all higher than the Upstate New York benchmark.

[18] 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

The percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino was 62.5% compared to the Upstate New York benchmark of 70.9%. Additionally, the percentage of births with a 5-minute APGAR <6 for all races was 2.1% compared to the Upstate New York benchmark of .8%.

Interestingly, access to care in Warren County is high with the percentage of births with early (1st trimester) prenatal care of 81.2% compared to the ARHN Region (77.8%) Upstate New York (78.4) and New York State (76.3%).

Washington County

The percentage of preterm births in Washington County (10.1%) is higher than the prevention agenda benchmark of 8.3%. The percentage of total births with weights less than 2,500 grams in Washington County (8.0%) is higher than the ARHN Region and Upstate New York, both sharing the same rate of 7.7%. The percentage of WIC women breastfeeding for at least six months (20.6%) performed worse than the Upstate New York benchmark of 30.6%. The percentages of women receiving WIC in Washington County who are either underweight, obese, have gestational weight gain greater than ideal, gestational diabetes or gestational hypertension are all higher than the Upstate New York benchmark.

The percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino was 63.4% compared to the Upstate New York benchmark of 70.9%. Additionally, the percentage of births with a 5-minute APGAR <6 for all races was 1.7% compared to the Upstate New York benchmark of .8%.

Interestingly, access to care in Washington County is high with the percentage of births with early (1st trimester) prenatal care of 80.1% compared to the ARHN Region (77.8%) Upstate New York (78.4) and New York State (76.3%).

Saratoga County

The percentage of preterm births in Saratoga County (8.2%) is slightly lower than the prevention agenda benchmark of 8.3%. The percentage of total births with weights less than 2,500 grams in Saratoga County (6.4%) is lower than the ARHN Region and Upstate New York, both sharing the same rate of 7.7%. However, WIC women breastfeeding for at least six months (26.6%) performed worse than the Upstate New York benchmark (30.6%). The percentages of women receiving WIC in Saratoga County who are either underweight, obese, have gestational weight gain greater than ideal, gestational diabetes or gestational hypertension are all higher than the Upstate New York benchmark.

The percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino was 74.8% compared to the Upstate New York benchmark of 70.9%. Additionally, the percentage of births with a 5-minute APGAR <6 for all races was 1.2% compared to the Upstate New York benchmark of .8%.

Interestingly, access to care in Saratoga County is high with the percentage of births with early (1st trimester) prenatal care of 78.7% compared to the ARHN Region (77.8%) Upstate New York (78.4) and New York State (76.3%).

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.[19] 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 have reported binge drinking within the past month (24.6%) is higher than the Prevention Agenda Benchmark (16.4%). With this high rate of binge drinking, both the rate of alcohol related crashes (86.3) as well as the rate of alcohol related injuries and deaths (29.8) are higher than the ARHN Region (66.4, 28.7) and Upstate New York (52.0, 28.8). Additionally, the rage of cirrhosis deaths at 16.1 is higher than the ARHN Region (15.3), Upstate New York (10.1) and New York State (8.4).

The age adjusted rate of suicides (11.4) in Warren County is also higher than the Prevention Agenda Benchmark (7.0). Related data points show the overall rate of self-inflicted injury hospitalizations is 9.2 per 10,000 in Warren County compared to 4.4/10,000 in New York State and 6.1/10,000 in the ARHN region. When drilling down to the adolescent ages 15-19, the rate of self-inflicted injury hospitalizations is a staggering 33.3 per 10,000 in Warren County verses 10.3/10,000 in Upstate New York and 17.0/10,000 in the ARHN Region.

Washington County

The percentage of adults in Washington County who have reported binge drinking within the past month (16%) is lower than the Prevention Agenda Benchmark (16.4%) however, both the rate of alcohol related crashes (75.9) as well as the rate of alcohol related injuries and deaths (34.7) are higher than Upstate New York (52.0, 28.8). Additionally, the rate of cirrhosis deaths at 13.0 is higher than Upstate New York (10.1) and New York State (8.4) but lower than the ARHN Region (15.3).

The age adjusted rate of suicides (10.4) is higher than the Prevention Agenda Benchmark (7.0). Related data points show the overall rate of self-inflicted injury hospitalizations is 8.1 per 10,000 in Washington County compared to 4.4/10,000 in New York State and 6.1/10,000 in the ARHN region. When drilling down to the adolescent ages 15-19, the rate of self-inflicted injury hospitalizations is 24.4 per 10,000 in Washington County verses 10.3/10,000 in Upstate New York and 17.0/10,000 in the ARHN Region.

Saratoga County

The age-adjusted percent of adults who have reported binge drinking within the past month (19.5%) is higher than the Prevention Agenda benchmark of 16.4%. With this high rate of binge drinking, both the rate of alcohol related crashes (58.2) and the rate cirrhosis deaths (10.7) is worse than the Upstate New York benchmarks of 52.0 and 8.4 respectively.

[19] 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

The age adjusted rate of suicides (11.1) is higher in Saratoga County than the Prevention Agenda Benchmark (7.0). While the rate of the overall rate of self-inflicted injury hospitalizations is 4.4 per 10,000 is the same as Upstate New York (also 4.4/10,000) and better than the ARHN Region (6.1/10,00) the rate of self-inflicted hospitalizations for ages 15-19 per 10,000 population is 12.1 which is higher than the Upstate New York benchmark of 10.3/10,000.

Prevent Communicable Diseases

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 under-immunization and global travel. In addition, lagging human papillomavirus (HPV) and influenza vaccine coverage in NYS puts New Yorkers at risk of these serious vaccine-preventable diseases.

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.[20] 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 24 – 35 months with the recommended 4:3:1:3:3:1:4 immunization series (79.8%) is higher than the Prevention Agenda benchmark (70.5%) and the percentage of 13-year-old adolescents with a complete HPV vaccine series (36.9%) is lower than the Prevention Agenda benchmark of 37.4%. While both aged- adjusted gonorrhea and chlamydia diagnoses rates (56.5 and 266.0) are better than Prevention Agenda Benchmarks (242.6 and 676.9), there is a higher rate of chlamydia cases amongst all males aged 15-44 (510.3) compared to the ARHN Region

[20] 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.

(406.45) and Upstate New York (41.2). The rates of gonorrhea for both males and females aged 15-44 (89.1, 101.9) are better than Upstate New York benchmarks (267.8, 218.3).

The Rate of Community Onset, Healthcare Facility Associated Clostridium difficile infections (CDIs) per 10,000 Patient Days risk-adjusted (3.7) is lower than New York State (4.0). The rate of community onset healthcare facility associated CDIs per 100 admissions, not risk-adjusted (0.1) is also better than New York State (0.2).

Washington County

The immunization rate for children aged 24-35 months with the recommended 4:3:1:3:3:1:4 (73.2%) is higher than the Prevention Agenda benchmark (70.5%) and the percentage of 13-year-old adolescents with a complete HPV vaccine series (27.1%) is lower than the Prevention Agenda benchmark of 37.4%. While both aged- adjusted gonorrhea and chlamydia diagnoses rates (23.8 and 221.7) are better than Prevention Agenda Benchmarks (242.6 and 676.9), there is a higher rate of chlamydia cases amongst all males aged 15-44 (288.4) compared to Upstate New York (41.2).

Saratoga County

The immunization rate for children aged 24-35 months with the recommended 4:3:1:3:3:1:4 (81.4%) is higher than the Prevention Agenda benchmark (70.5%) and the percentage of 13-year-old adolescents with a complete HPV vaccine series (29.4%) is lower than the Prevention Agenda benchmark of 37.4%. While both aged- adjusted gonorrhea and chlamydia diagnoses rates (43.1 and 248.4) are better than Prevention Agenda Benchmarks (242.6 and 676.9), there is a higher rate of chlamydia cases amongst all males aged 15-44 (343.7) compared to Upstate New York (41.2).

The Rate of Community Onset, Healthcare Facility Associated Clostridium difficile infections (CDIs) per 10,000 Patient Days risk-adjusted (3.4) is lower than New York State (4.0). The rate of community onset healthcare facility associated CDIs per 100 admissions, not risk-adjusted (0.1) is also better than New York State (0.2).

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. [21]

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

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 conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes[22]. 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 $85,859 and $71,922 respectively, compared to the Upstate New York average of $97,962. Another notable factor is the relatively low level of achievement in higher education in both Warren and Washington Counties, where only 43.7% (Warren) and 31% (Washington) of the population age 25 and older has an Associate's, Bachelor's, or Graduate/Professional degree, compared to 46.8% of Upstate New York and 46.3% of New York State. 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.

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:

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

Prevention Agenda Indicators: Disparities							
				Comparison Regions / Data			
	Saratoga	Warren	Washington	ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark
Percentage of Overall Premature Deaths (before age 65 years), 2019	18.6%	18.1%	20.0%	22.1%	21.0%	22.7%	**22.8%**
Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2019	6.5+	22.2+	13.6+	N/A	20.2	17.7	**17.3**
Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2019	8.2+	82.2+	5.3+	N/A	21.1	16.4	**16.2**
Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2019	94.8	113.1	128.0	142.52	120.4	125.9	**115.0**
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2019	54.30	23.4+	-59.9	N/A	128.4	115.8	**94**
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2019	-74.0	N/A	N/A	N/A	1.0	34.6	**23.9**
Percentage of Adults (Ages 18 - 64) with Health Insurance, 2019	95.8%	95.0%	94.0%	93.6%	94.00	92.5%	**97.0%**
Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2018	89.2%	82.8%	85.0%	82.3%	82.0%	79.1%	**86.7%**

N/A: Data does not meet reporting criteria
+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.
1- ARHN data not available when two or more counties do not have reported data

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 or unstable data to report on racial and ethnic disparities. Opportunities to improve these statistics may lie within the number of adults with a regular health care provider, as all both Warren and Washington 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.

Given the limitations within the data from the NYS Prevention Agenda as compared to the GFH region, further insights can be drawn from the community health indicator reports and NYS Expanded Behavioral Risk Factor Surveillance System tracking data points across New York State which can also be

compared at the county level. The following table outlines the status of these indicators for Warren, Washington and Saratoga counties:

Other Disparity Indicators							
				Comparison Regions / Data			
	Saratoga	Warren	Washington	ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark
Rate of Total Deaths per 100,000 Population, 2017-2019	848.1	1,157.3	1,101.6	1,069.7	**916.2**	798.8	N/A
Rate of Emergency Department Visits per 10,000 Population, 2017-2019	2,275.8	3,544.8	3,412.7	4,694.3	**3,843.0**	4,134.7	N/A
Rate of Total Hospitalizations per 10,000 Population, 2017-2019	954.2	1,152.8	1,116.8	981.2	**1,144.2**	1,154.8	N/A
Percentage of Adults Who Did Not Receive Medical Care Due to Costs, 2018	6.1%	10.1%	10.0%	9.6%	**9.2%**	11.0%	N/A
Percentage of adults reporting 14 or more days of poor physical health, 2018	10.5%	12.2%	15.1%	13.0%	**11.1%**	11.2%	N/A
Percentage of adults living with a disability (based on 6 ACA disability questions), 2018	21.2%	22.6%	29.8%	29.2%	**24.6%**	26.2%	N/A

N/A: Data does not meet reporting criteria
+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.
1- ARHN data not available when two or more counties do not have reported data

The indicators above may support some of the health outcomes previously discussed as well as help in identifying areas of opportunity for the GFH region. Warren and Washington Counties each lag behind in 4 out of the 6 measures compared to Upstate New York counties while Saratoga County meets or exceeds all 6 measures compared to Upstate New York indicating a potentially higher disparity in those counties. Notably, the percentage of adults in both Warren and Washington County who did not receive medical care due to costs suggests there could potentially be an increase in poor health outcomes into the future if populations continue to delay health care. Lastly, the percentage of adults reporting 14 or more days of poor physical health in Warren and Washington Counties exceeds Upstate New York, the ARHN Region and New York State as a whole.

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 2015-2019, 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 of all invasive malignant tumors is 525.3 per 100,000 for both males and females, Washington County has a rate of 514.1 per 100,000, and Saratoga County has a rate of 523.8 per 100,000. All three counties in the GFH service area have a higher incidence rate compared to all counties in New York State at 484.8 per 100,000. In Washington County, the rate for colorectal cancer is 40.8 per 100,000 for both males and females, compared with 35.5 per 100,000 cases in Warren and 38.7 per 100,000 in Saratoga County. The rates in both Washington and Saratoga counties are higher than the New York State rate for colorectal cancer, which is 37.7 per 100,000. Similarly, the rate for lung and bronchus cancer in Washington County is 77.7 per 100,000 for both males and females, compared with 74.8 per 100,000 for Warren County and 70.2 per 100,000 for Saratoga County. All three counties have a higher rate than New York State, which is 57.6 per 100,000 for males and females. Lastly, the rate of melanoma of the skin is 34.0 per 100,000 for both males and females in Warren County, compared with 23.7 per 100,000 in Washington County and 27.5 per 100,000 in Saratoga County. Again, all three counties have higher incidence than all New York State Counties at a rate of 18.1 per 100,000. Overall, the incidence and mortality of colorectal cancer, lung and bronchus cancer, and melanoma of the skin is higher amongst men compared to women throughout the three counties in the GFH service area, consistent with all counties in New York State.[23] 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.

There is a strong link between tobacco use and cancer, and smoking rates are higher in Washington (25.3%) and Warren (19.1%) Counties, as well as most upstate NY counties, than the New York State rate of 12.8%. Current smoking rates in NYS vary by county from a low in Westchester at 7.0% to a high in Washington at 25.3%.[24] 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

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

[24] Bureau of Tobacco Control, StatShot, Prevalence of Current Smoking Among Adults, in New York by County, NYS BRFSS 2018, available at https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume14/n2_prevalence_of_current_smoking.pdf

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 2022 Community Stakeholder Survey was implemented throughout the seven-county service area to provide the CHA Committee with input on regional health care needs and priorities.

Drafted by the Ad Hoc Data Sub-Committee, the final version of the survey was approved by the full CHA Committee at the November 10, 2021 meeting. 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 professionals from a variety of sectors including health care, social services, education, government, and community service providers as well as community members (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 806 community stakeholders representing a full spectrum of perspectives including those serving low-income and medically underserved and vulnerable populations.

An initial email was sent to the community stakeholders in early January 2022 by the CHA Committee partners, introducing and providing a web-based link to the survey. CHA Committee partners released a follow-up email approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion. The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns.

A total of 263 responses (including 67 from Warren County and 79 from Washington County) were received through March 1, 2022, for a total response rate of 32.63%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. It took respondents an average of 20 minutes to complete the survey, with a median response time of approximately 16 minutes.

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, 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 as the top priority area in both counties. Warren County respondents selected Prevent Chronic Disease as the second top priority area and Washington County respondents selected Promote a Healthy and Safe Environment. *(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 use/alcoholism/opioid use, child/adolescent emotional health, adverse childhood experiences and senior health within their top five health concerns facing the counties.

- Top contributors to the health conditions noted above included lack of mental health services, changing family structures, poverty, and addiction to alcohol/illicit drugs. Warren County respondents also identified lack of chronic disease screening, treatment and self-management services and Washington County identified age of residents.
- Across the entire region, including Warren and Washington counties, individuals living at or near the federal poverty level and individuals with mental health issues are two subpopulation that respondents overwhelming believe 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	Increase skills and knowledge to support healthy food and beverage choices	Promote the use of evidence-based care to manage chronic diseases	Improve self-management skills for individuals with chronic disease
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Promote a Healthy and Safe Environment	Promote healthy home and schools' environments	Reduce 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
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Prevent Communicable Disease	Improve vaccination rates	Reduce vaccination coverage disparities	Improve infection control in health care facilities
	Top Three NYS Prevention Agenda Goals Identified for Washington County		
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	Increase food security	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 violence by targeting prevention programs to highest risk populations	Reduce falls among vulnerable populations
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	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 vaccination coverage disparities

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 E.

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 – 2022

	Warren	Washington	Saratoga
Health Outcomes	**27**	**34**	**3**
Length of Life	**35**	**30**	**6**
Quality of Life	**16**	**43**	**1**
Health Factors	**9**	**32**	**2**
Health Behaviors	**18**	**32**	**11**
Clinical Care	**3**	**35**	**4**
Social & Economic Factors	**16**	**28**	**1**
Physical Environment	**24**	**33**	**27**

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 – 2022, 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 #3 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. 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 has also proactively solicited comments and feedback. To date, Glens Falls Hospital has not received any comments from the public.

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 childcare, 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.

Lastly, the direct and indirect impacts of the COVID-19 pandemic on health outcomes are not yet reflected in the data we have available today. Community health concerns and trends that were supported by data prior to the COVID-19 pandemic are likely to be amplified following the pandemic and/or may reveal potentially new or emerging health concerns. It is widely believed that the long-term collective trauma of the pandemic will be a global issue impacting the public's health. Demand for mental health and well-being services and supports is at an all-time high, exasperating an already limited supply of services, yet robust mental health data is not readily available even pre-pandemic. As data and trends are shared and better understood over the next three years, health systems and community/public health planners should take those findings into consideration and adapt to the changing and emerging needs of communities served.

Prioritized Significant Health Needs

Through the ARHN collaborative, GFH coordinated with Warren and Washington counties to conduct a CHA in each county. Saratoga Hospital, primarily serving Saratoga County residents, conducted a separate, yet similar process to determine their community's needs and GFH representatives were members of the prioritization planning group and contributed to the process. While Saratoga County Public Health's CHA is not yet finalized, GFH remains in contact with county leadership to coordinate as

appropriate and review opportunities for collaboration on an ongoing basis. Preliminary data gathered by Saratoga County Public Health suggests alignment in at least one priority area across the region.

Utilizing the results of the indicator analysis, regional survey and the other county-specific community assessment resources listed previously, each organization prioritized the most significant health needs for their residents. Each organizations' 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 • Increasing Physical Activity • Tobacco Prevention • Chronic Disease Preventive Care and Self-Management Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Diseases • Tobacco Prevention • Chronic Disease Preventive Care and Self-Management Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Diseases • Heart Disease Promote Well-Being and Prevent Mental and Substance Use Disorders • Pediatric Mental Health • Adult Mental Health Opioid and other substance misuse

In addition to evaluating the priorities and county level data indicators for our local county partners, 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 2022-2024:

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: Promote Well-Being and Prevent Mental and Substance Use Disorders

- **Focus Area 2 – Mental and Substance Use Disorder Prevention**

Priority Area: Prevent Communicable Diseases

- **Focus Area 1 – Vaccine Preventable Diseases**
- **Focus Area 5 - Antibiotic Resistance and Healthcare-Associated Infections**

It is important to note that GFH chose similar chronic disease and communicable disease related priorities in the previous 2019-2021 CSP 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 CSP process, GFH is expanding the scope of work to include the priority area of Promote Well-Being and Prevent Mental and Substance Use Disorders as well as focusing on vaccine preventable diseases.

Regional Priority

In addition to GFH choosing priority areas, as part of the community health planning and assessment process, the CHA Committee identified and selected Prevent Chronic Diseases and Promote Well-Being and Prevent Mental and Substance Use Disorders as regional priorities in support of the NYS Prevention Agenda 2019-2024. 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 and Promote Well-Being and Prevent Mental and Substance Use Disorders 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

GFH acknowledges the wide range of community health issues that emerged from the Community Health Needs Assessment process. GFH determined that it would place the most significant focus on those health needs which were deemed most pressing, within our ability to influence and would have long term benefit and impact on our community. Due to a lack of current available data reflecting the direct and indirect impacts of the COVID-19 pandemic on health outcomes, GFH understands that new or changing health concerns may emerge within the timeframe of the action plan. As our resources, capacity and expertise allow, GFH remains positioned to pivot to address the unpredicted needs of the community.

Additional analysis revealed an increasing demand and need for mental health and substance abuse services throughout the three-county region. It is widely believed that the long-term collective trauma of the pandemic will be a global issue impacting the public's health. Demand for mental health and well-being services and supports is at an all-time high, exasperating an already limited supply of services. Currently, Glens Falls Hospital is including mental and substance use disorder prevention in the action plan through our Health Systems for a Tobacco Free New York program, which includes work to impact individuals with behavioral health diagnoses. GFH recognizes the trend and the need for quality services and programs is far reaching and complex, however, has not historically formalized strategies into the plan due to lack of resources and capacity. While not included in the action plan, Glens Falls Hospital is actively pursuing opportunities for collaboration regionally to address the community-wide capacity issues our region is facing together. The work is in its infancy and therefore GFH is not yet ready to formalize an action plan for this IS. In addition, GFH will continue to work through initiatives such as Health Home and NCIP 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. GFH recognizes a growing need to work collaboratively across the region to address social drivers of health and remains actively engaged with community partners working to address these issues.

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 as well as Saratoga Hospital 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 below, priority populations for each specific initiative are noted within the section highlighting the health disparities addressed.

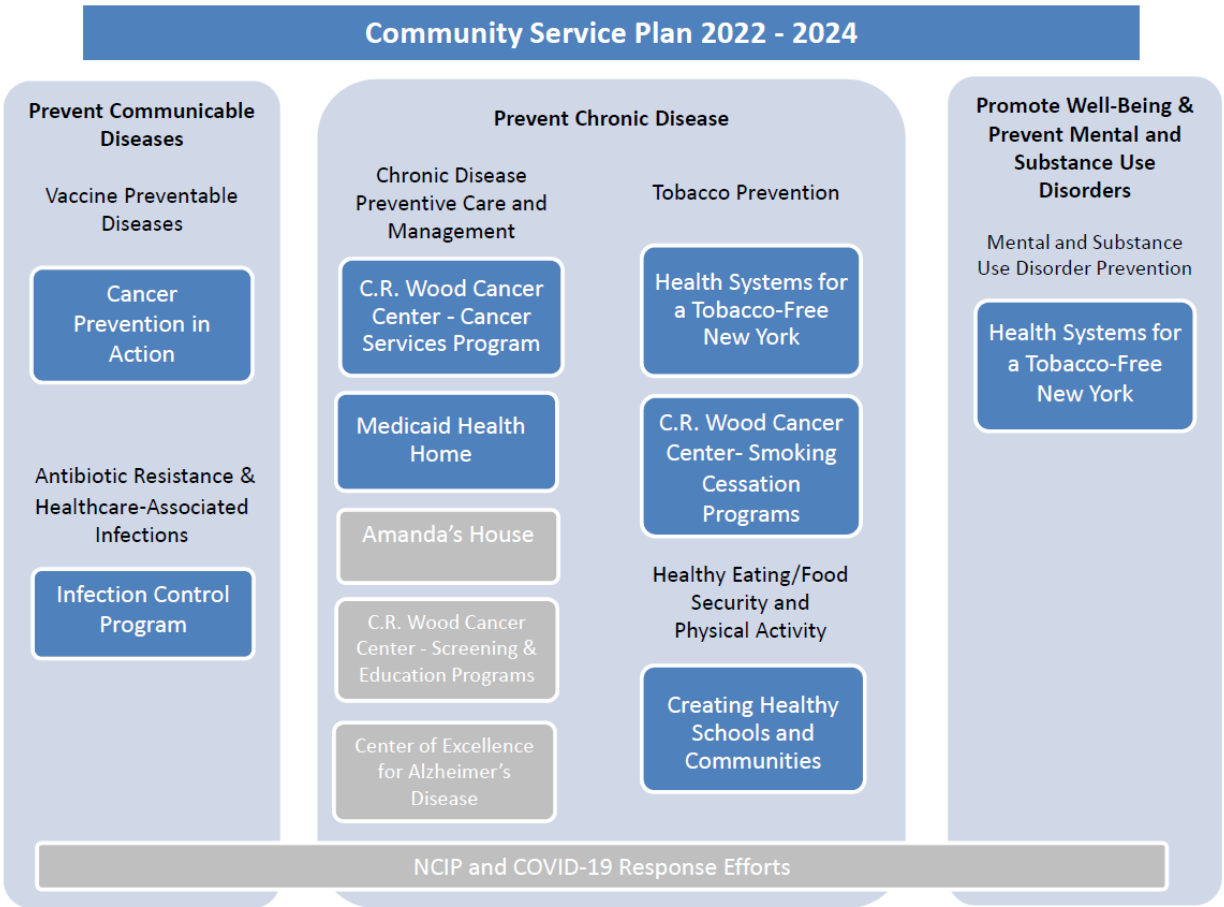
Action Plan for 2022-2024

The following three-year action plan includes initiatives 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, the one focus area under Promote Well-Being and Prevent Mental and Substance Use

Disorders, and the two focus areas 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.

North Country Innovation Project

It is important to note that while North Country Innovation Project (NCIP), a coalition of North Country providers, is included as a strategy, there is not a corresponding workplan within this IS. We have, however, chosen to include NCIP as a strategy with the knowledge that NYS has applied to the Centers for Medicare and Medicaid Services (CMS) to fund a new Medicaid 1115 Waiver that incorporates lessons learned from its DSRIP Program experience to address the inextricably linked health disparities and systemic health care delivery issues that have been both highlighted and intensified by the COVID-19 pandemic. Because the approval of the initiative is still under review and not yet finalized, we have chosen to include NCIP as a strategy as the overall goals of the coalition align themselves with the population health initiatives identified herein. Should a new Medicaid 1115 waiver be approved for implementation in New York State, opportunities for alignment will be identified and integrated into the identified initiatives.

COVID-19 Response Efforts

It is important to note that while COVID-19 response efforts is included as a strategy, there is not a corresponding activities within the workplan. With the unpredictability of COVID-19 surges and variants and subsequent impact on hospital operations and the surrounding community, developing a structured workplan with detailed strategies and desired outcomes would be futile. COVID-19 response has evolved over time and will likely continue to change as we settle into our new normal. GFH continues to take all necessary precautions per State and Federal guidelines to safeguard our patients and community throughout the implementation of all programs outlined herein. In addition, GFH will continue to be a leader in promoting science-based precautions to keep our communities safe, including COVID-19 vaccination. GFH will continue to offer COVID-19 vaccine to employees of the hospital and to inpatients as appropriate. As COVID-19 related needs evolve overtime, GFH will continue to be a responsive and engaged partner of our State and Local Health Departments as we together keep our communities safe.

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 County 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, as well as Saratoga Hospital, 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. 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.

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.[25] These include, but are not limited to:

- Business sector

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

- 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)
- Community gardens
- Farmers markets and community supported agriculture (CSAs)
- Gyms and other wellness facilities
- Parks and Recreation
- Walking trails and bicycle routes
- Grocery stores, convenience stores and food pantries
- Libraries
- 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

One 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.

Additionally, the ongoing global COVID-19 pandemic, first declared a national state of emergency in March 2020, continues to impact the hospital and community providers. The socio-economic impact of the pandemic touches all aspects of our community including but not limited to the cost and availability of goods and services. The pandemic has also exasperated the ongoing shortage of health care and public health workers.

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 2019-2021 Community Service Plan process, GFH chose the following health needs as priorities.

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

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 2019 - 2021.

Communicable Disease Prevention and COVID-19 Response:

- Developed and implemented weekly **institutional COVID-19 educational videos** covering guidance changes, proper disinfection, personal protective equipment, patient placement, testing protocols, vaccination information, and local, state, national and international trends. Infection Control Team also completed numerous news station interviews to disseminate information as it became available and **recorded community education videos** available on the GFH website.
- Hosted, staffed, and maintained regular **outpatient COVID-19 vaccination clinics** from December 2020 - September 2021 and eligible inpatient vaccination continues. We administered our first **monoclonal antibody therapy treatment** on 12/15/2020, administering a total of 1,217 treatments for outpatients during 2021, this number does not capture the inpatient population served with the same therapies.
- Reduced hospital onset Clostridioides difficile infections (CDI's) by 50% from 2018-2019 with a Standardized Infection Ratio (SIR) dropping from 0.88 to 0.44. The beginning of the pandemic altered the focus slightly with a marginal increase of CDI from 0.44 in 2019 to 0.53 in 2020. Once again, in 2021 another significant reduction of 31% from 0.53 to 0.36. Despite a pandemic and

continued staffing shortages, Glens Falls Hospital demonstrated **a total reduction of 59% from the baseline data in 2018 through 2021**.

- Implemented evidence-based interventions to address surgical site infections (SSIs) resulting in our ability to **maintain a 57% reduction in all SSIs in 2019 far exceeding the 30% goal** originally set forth.

Chronic Disease Prevention:

- Provided **Health Home care coordination** services to adults and children enrolled in Medicaid, for a total of 3433 encounters in 2019, 3776 encounters in 2020 and 3282 encounters in 2021. 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.** During Covid-19 many screening services were placed on hold, however the rates of comprehensive screenings for breast, cervical, colorectal cancer stayed steady compared to prior years at 60%.
- In 2019 4 **smoking cessation classes** for community members were held with a total of 14 attendees that resulted in 50% of individuals reducing consumption by 20% or more, 25% quit completely and 25% were not ready to quit. Classes were suspended during the COVID-19 pandemic from 2020 – 2021 due to COVID-19 precautions within the hospital.
- 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. In 2019 there were 2 retreats held with a total of 16 participants. 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. Due to COVID-19 precautions there were no retreats in 2020 or 2021.
- 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 800 patients used the salon between 2019 and 2021, and over 325 wigs were provided free of charge.
- Conducted 2 **Comfort Camps** in 2019, 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. Family camp had 35 individuals and children's camp had 29 campers and evaluation of the program showed that 100% of the families and campers found the education and support helpful in reconnecting their families during the stressful treatment timeframe. Due to COVID-19 precautions camps were not held in 2020 and 2021.
- Conducted **free skin cancer screening** once per year, for a total of three screenings between 2019 and 2021, which are free and open to the community. Due to COVID-19 precautions smaller scale screening events were held in 2020 and 2021. Approximately 280 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 949 room nights between 2019 and 2021, 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. Due to COVID-19 precautions occupancy was limited to serving one family at a time throughout 2020 and 2021. 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.

- Maintained NCQA recognition and enrollment in the annual sustainability model for all 7 primary care practices operated by Glens Falls Hospital under the **2017 Patient-Centered Medical Home (PCMH)** standards. 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.
- Transitioned all GFH primary care medical centers from Comprehensive Primary Care Plus (CPC+) sites to the **CMS Primary Care First (PCF) model**. This newly established 5-year program builds upon concepts of CPC+ by prioritizing the clinician-patient relationship, enhancing care for patients with complex chronic needs, and focusing on improved health outcomes.
- Established a partnership with aptihealth, the leader in intelligent integrated behavioral healthcare, to deliver **innovative teletherapy program to patients in our primary care practices**, addressing a critical community need that has been exacerbated by the COVID-19 pandemic. Patients can now access **integrated physical and behavioral care** through the aptihealth platform. This supportive care team model and patient-driven 90-day care program has been shown to decrease symptom severity by over 50%, resulting in improved health outcomes and reduced care costs. This implementation awarded GFH the North Country Telehealth Partnership's 2021 Telehealth Innovator of the Year in recognition of outstanding achievements.
- Pivoted to the use of **telehealth in GFH practice sites** due to COVID-19, allowing patients to receive the services they needed in a virtual setting. In parallel, a strategy was approved and implemented for those patients that required in-person care. In addition, **a pathway to provide COVID-19 testing was initiated** whereas patients could receive testing locally all while providing the necessary precautions for staff.
- Continued to improve the standard of quality and access to care for the community through the Stroke Center:
    - Achieved **Primary Stroke Certification** through DNV in 2019.
    - Received the 2021 American Heart Association's **Gold Plus Get With The Guidelines®-Stroke Quality Achievement Award** for our commitment to ensuring stroke patients receive the most appropriate treatment according to nationally recognized, research-based guidelines.
    - Offered robust **community outreach and education** through multiple modalities including virtual events, Farmer's Markets, educational lectures, and social media posts contributing to a progressive decline of approximately 25% of ambulatory arrivals and increase of about 15% in EMS arrivals, a favorable trend as EMS activation is recommended for suspected stroke victims to expedite care.
    - Experienced a total stroke reoccurrence rate of 10.5% from 2019 through April 2022 for patients that presented to our organization compared to world-wide statistics indicating nearly 26% of patients have a second stroke within 5 years.
- Continue to offer an interdisciplinary approach to diagnosing and managing Alzheimer's Disease and related dementias through the **Center of Excellence for Alzheimer's Disease**:
    - Formalized an agreement with a regional Federally Qualified Health Center (FQHC) to collaborate on opportunities to improve the FQHC's diagnostic approach for **earlier detection**, **enhance data sharing** for greater understanding of process improvement opportunities with cognitive assessment, and **promote public health education** efforts.

- Assessed the incidence of dementia and other neurocognitive affective diagnoses among GFH patients who present with aggression during a hospitalization and found 60% of patients who have a dementia diagnosis will develop aggressive symptoms. Strategies implemented to improve patient care and keep staff safe include two new algorithms for process improvement related to pharmacologic therapies, a new order set for non-pharmacologic interventions that can help with the sensory overload a dementia patient experiences in a hospital environment, and a training deployed to frontline staff to teach optimal verbal and non-verbal communication strategies when interacting with people with dementia.
- Formalized a team to participate in the HANYS Age-Friendly Action Community which focused on the tenets of the Institute for Health Improvement's Age-Friendly 4Ms initiative. The team started its work in 2021, and by August 2022, Glens Falls Hospital had been recognized with **Level-1 Designation as an "Age-Friendly Health System**".

- Participated in regional care delivery transformation through the **DSRIP program in 2019 – Q1 2020**:
  - Sustained the **Opioid Diversion Program**, a collaborative effort between Glens Falls Hospital's Center for Recovery and the Council for Prevention, to provide individuals arrested for crimes related to their opioid addiction an alternative to incarceration allowing them to receive treatment and recovery services via Adventure Based Counseling. In 2019, 19 individuals participated in programming, 4 graduated the program in its entirety, many became employed full-time, 2 resumed college coursework, and 1 started their own business. 95% of participants were kept out of the inpatient behavioral health unit, crisis care center, and were not rearrested. 76% of participants reported improved mental health and improved access to health care. 100% of participants would recommend the program to others seeking treatment and reported that the program helped them achieve their goals in the areas of substance use, general physical health and social life/leisure.
  - Piloted a Vertical Integration model of care in partnership with Fort Hudson Health System to **enhance coordination of patients across service lines** through expanded Care Management function and purpose; purposeful sharing of data and clinical processes/outcomes; creation of preferred network of services; and expansion of best practice clinical pathways.
  - Contributed to the Adirondack Health Institute Performing Provider System's (AHI PPS) performance in earning the **highest percentage of claims-based metrics** in measurement years 4 and 5 in New York State. The outcomes-based performance was based on 32 distinct population health metrics in the areas of potentially preventable readmissions, potentially preventable visits, primary care visits, and behavioral health services.
  - 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:
  - Formed **a regional task force** with a goal of passing local level Tobacco 21 legislation. Continued to facilitate the group and developed a presentation that was used for schools, rotaries, businesses, and local level governments to increase awareness of, and

garner support for the legislation. **Regional support was a key factor in the statewide passing of Tobacco 21 legislation in November 2019**.

- Supported the Gloversville Housing Authority to go Tobacco Free, impacting the residents of the **85 apartments.** Cessation materials and nicotine replacement therapies were distributed to residents to assist with implementation.
- Partnered with Skidmore College to **plan, implement and sustain a 100% tobacco-free campus policy and adopt a comprehensive tobacco dependence treatment policy** within their campus health center **impacting more than 2,500 students, 1,000 staff and an additional 500 first-year students who join the campus community annually**. Training and cessation resources were provided to staff, while students were provided with education and access to quitting aids.
- Educated **5 school districts on the Vaping Epidemic** via community panel discussions to increase community awareness of the issue as well as educate the community on local level resources that are available.
- Educated **4 Behavioral Health Care, 4 Medical Health Care and 2 dental practices** on the burden of tobacco on their patients, the steps they can take as a system to fortify their response, and the impact they have as providers on their patients' outcomes.
- Formed the **North Country Tobacco Treatment Specialists group** which continues to meet monthly to idea share, receive training, and discuss implementing best practices at their respective health systems. The model for this group is now being replicated across New York State.
- Staff attended, sponsored, and presented at numerous regional, statewide, and national conferences. Staff was able to educate providers of both medical and behavioral health systems, as well as providers at FQHCs on **the burden of tobacco use** and engage them in ways they can partner with the HSTFNY initiative **to fortify their institution's response to tobacco dependence**.
- Developed a **new comprehensive assessment tool** for use at medical and behavioral health systems across the region which determines their baseline state for tobacco dependence treatment and sets goals towards the implementation of gold standard tobacco dependence treatment. This assessment tool is now being replicated and used as a template across New York State.

- Continued to advance policy and environmental changes to **promote physical activity and nutrition:**
  - Assisted 8 local school districts in improving their **Local Wellness Policies** to provide students with increased opportunities for physical activity and nutrition including sponsoring one school district administration's attendance to a **Leadership Conference** to increase child wellness in schools.
  - Provided 9 local schools with **materials for school cafeterias to promote healthy eating. Cafeteria equipment** was provided such as breakfast carts to **increase breakfast participation**, salad bars to **increase consumption of fruits and vegetables,** and equipment to support a **hydroponic vegetable garden** for use in school foods.
  - Provided local schools with equipment to **increase physical activity.** Physical Education teachers from 2 school districts received **Professional Development.** To increase physical activity during elementary recess and breaks 12 schools received specially crafted **Obstacle course bins** and **Hallway Sensory Paths, Gaga Ball pits**. Middle and

high school students benefited from **flexible seating options** to stand and move in class and **outdoor recreations supplies** to use during lunch period.

- Hosted **Math and Movement** training for 5 school districts and provided materials to implement the curriculum in 7 elementary and primary schools.
- Provided 5 districts in Hudson Falls, Fort Ann, Whitehall, Granville, Hadley, and Lake Luzerne with nearly $68,0000 of **equipment, supplies, and training to increase physical activity and nutrition** throughout the school day.
- Increased access to **healthy food and drinks options in 9 locations** in Washington county, which included employees of the Washington County Municipal center and local food pantries.
- Increased physical activity at worksites and in the community providing **Washington County Municipal Center employees** with **stand-up workstations**, hosting a **Get out & Go Granville event,** providing materials for a **Story Board Walk,** and **treadmills and yoga mats** for teachers**.**

The complete 2019-2021 Community Service Plan can be found on the GFH website at http://www.glensfallshospital.org/services/community-service/health-promotion-center.

Dissemination

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

The previous three 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 and the action plans are widely publicized with opportunity to provide comments and feedback. Hard copies will be made available at no-cost to anyone who requests one.

Approval

The Assistant Vice President of 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 November 17, 2022. 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

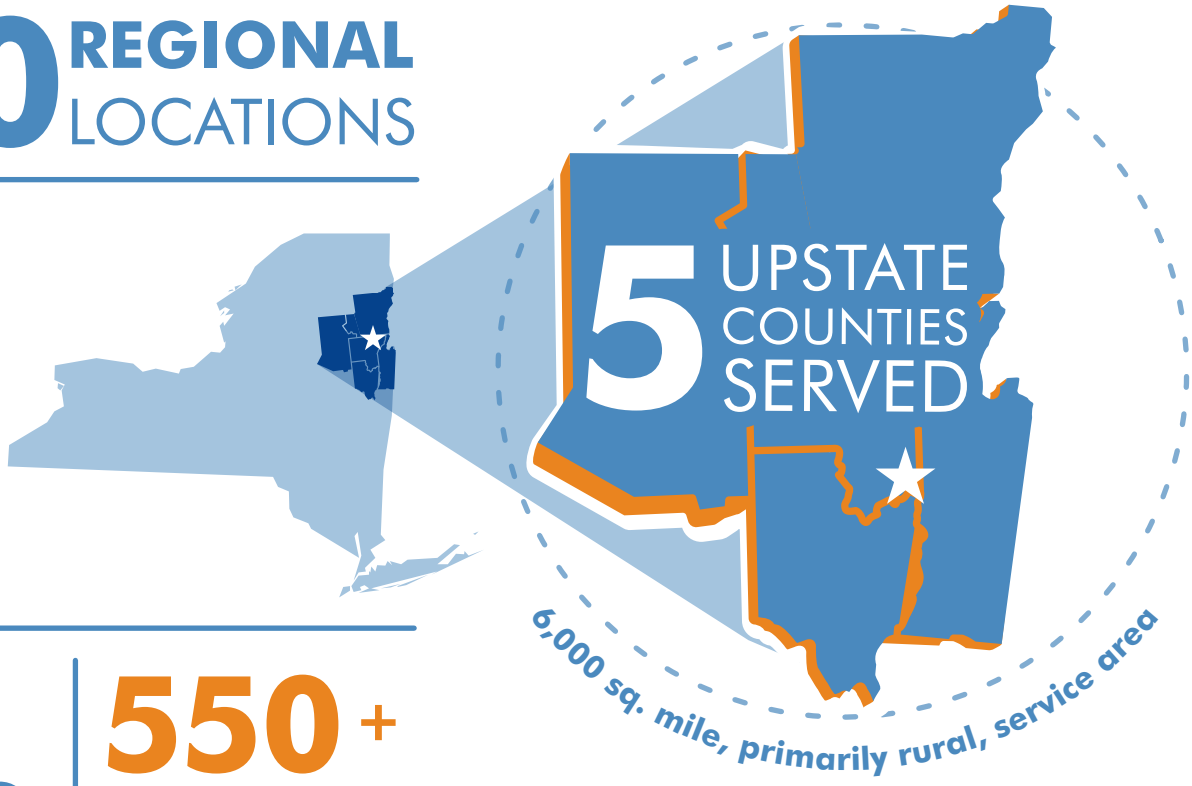
ALBANY MED Health System

GLENS FALLS HOSPITAL

A **REGIONAL** HEALTHCARE SYSTEM

20 REGIONAL LOCATIONS

391 BEDS



2,300 EMPLOYEES

550+ MEDICAL STAFF

PROUD TO ACHIEVE **MAGNET® RECOGNITION** FOR NURSING EXCELLENCE

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Forbes 2021 AMERICA'S BEST-IN-STATE EMPLOYERS
POWERED BY STATISTA

170+ 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

1,000+ PATIENTS DIAGNOSED & TREATED ANNUALLY

Annually*

1,110 BABIES BORN IN THE **JOYCE STOCK SNUGGERY**

11,641 INPATIENT DISCHARGES

41,391 E.D. VISITS

SURGERIES PERFORMED 8,946

*NUMBERS BASED ON 2021 CALENDAR YEAR

Updated 5/2022

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. In July 2020, Glens Falls Hospital became an affiliate of the Albany Med Health System, which also includes Albany Medical Center, Columbia Memorial Health and Saratoga Hospital.

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
  - Joyce Stock Snuggery/Maternity
  - Medical/Surgical
  - Palliative Care
- 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

- 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
- 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:
  - CG Men's Retreat
  - Cindy's Comfort Camp
  - Cindy's Retreat
  - Support Groups, Activities & Classes

PHYSICIAN PRACTICES

- Adirondack Cardiology
- Adirondack ENT
- Glens Falls Neurology
- Orthopedic Specialists of Glens Falls Hospital
- 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
- Surgical Specialists of Glens Falls Hospital:
  - General Surgery
  - Thoracic
  - Urology

COMMUNITY SERVICES

- Amanda's House
- Glens Falls Hospital Foundation
- Health Promotion Center
- 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

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

CHA Committee Members

County Health Departments	Phone Number	Primary Representative	Additonal Representatives
Clinton County Health Department	518-565-4840	Mandy Snay (mandy.snay@clintoncountygov.com) x4928	
Essex County Health Department	518-873-3500	Linda Beers (Linda.Beers@essexcountyny.gov) x3515	Jessica Darney Buehler (jessica.darneybuehler@essexcountyny.gov) x3514 Andrea Whitmarsh (andrea.whitmarsh@essexcountyny.gov)
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)
Hamilton County Public Health	518-648-6497	Dr. Erica Mahoney (erica.mahoney.hcphns@frontier.com)	Victoria Fish (vfish@hamiltoncountyny.gov)
Warren County Health Services	518-761-6580	Ginelle Jones (jonesg@warrencountyny.gov)	Dan Durkee (durkeed@warrencountyny.gov) x6580 Olivia Cohens (coheno@wrrencountyny.gov) Drew Crawford (crawfordd@warrencountyny.gov)
Washington County Public Health	518-746-2400	Tina McDougall (tmcdougall@washingtoncountyny.gov) x2429	Elizabeth St. John (estjohn@washingtoncountyny.gov)
Hospitals			
Adirondack Medical Center	518-897-2735	Dan Hill (dhill@adirondackhealth.org) x2805	Rachelle Waters (rwaters@adirondackhealth.org) 518-354-9673
Glens Falls Hospital	518-926-6899	Cathleen Traver *CHA Co-Chair (ctraver@glensfallshosp.org)	
Nathan Littauer Hospital	518-773-5212	Geoff Peck (gpeck@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)	Gregory E. Freeman (GFreeman@cvph.org)
UVMHN - Elizabethtown Community Hospital	518-873-3125	Heather Reynolds (HReynolds@ech.org)	Julie Tromblee (jtromblee@ech.org) Amanda Whisher (awhisher@ech.org) 518-873-3125
AHI			
	518-480-0111	Sara Deukmejian (sdeukmejian@ahihealth.org) x317	Andrea Bonacci (abonacci@ahihealth.org) x338

CHA Committee Meeting Dates

2020

**Regularly scheduled meetings cancelled due to prioritizing COVID-19 Response efforts by partners*

Friday, December 11, 2020

2021

Friday, June 4, 2021

Data Subcommittee Meeting – July 13, 2021

Data Subcommittee Meeting – August 25, 2021

Friday, September 10, 2021

Data Subcommittee Meeting – October 12, 2021

Data Subcommittee Meeting – November 10, 2021

Friday, December 17, 2021

2022

Friday, March 4, 2022

Friday, June 17, 2022

Friday, September 9, 2022

Scheduled for Friday, December 9, 2022

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

NYS Prevention Agenda 2019-2024
Priorities, 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
	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
2022 Data Methodology

Background:

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

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

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

Demographic Profile:

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

Health System Profile:

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

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

Education Profile:

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

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

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

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

Data Sheets:

The data sheets, compiled of 222 data indicators, provides an overview of population health as compared to the ARHN region, Upstate New York region, Prevention Agenda Benchmark and/or NYS. Within each data report, there is a benchmark comparison that indicates whether a data indicator's performance met, was better, or worse than the corresponding benchmark. If a data indicator was worse than the corresponding benchmark, the distance from the respective benchmark was calculated using quartile rankings:

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

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

Clinton County rate: 20.7 Upstate NY: 14.8

20.7/14.8 = 1.39

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

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

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

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

ARHN region and Upstate NY calculations:

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

$$\left[\frac{\text{Total for North Country region + Total for Fulton County}}{\text{(Average Population for North Country region + Average Population for Fulton County) x 3}}\right] \text{x100,000}$$

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

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

$$\left[\frac{\text{Total for New York State - Total for New York City region}}{\text{(Average Population for New York State – Average for New York City region) x 3}}\right] \text{x100,000}$$

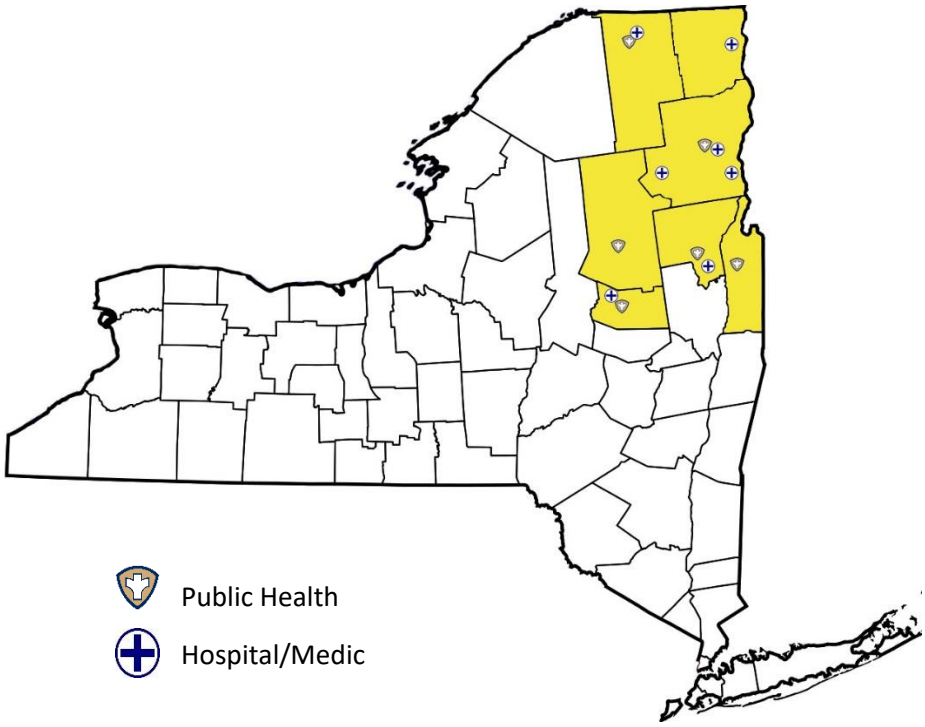
**For all Prevention Agenda, Community Health Indicator Reports, Asthma Dashboard, and any other NYS dashboard indicators, the New York City region includes the five boroughs of NYC.*

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

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

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

Summary of 2022 Community Stakeholder Survey



Adirondack Rural Health Network Service Area

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

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

2022

Background:

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

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

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

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

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

Survey Methodology:

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

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

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

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

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

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

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

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

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

Clinton
Essex
Franklin
Fulton
Hamilton
Warren
Washington

Summary Analysis

1. Indicate your job title

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

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

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

2. Indicate the community sector that best describes your organization

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

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

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

3. Indicate County/Counties served

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

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

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

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

4. NYS Prevention Agenda Priority Areas

Top Priority Area for the ARHN Region:

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

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

Top Priority Area by County:

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

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

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

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

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

Health Concerns for the ARHN Region:

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

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

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

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

Health Concerns by County:

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

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

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

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

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

Contributing Factors for the ARHN Region:

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

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

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

Contributing Factors by County:

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

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

Washington	Lack of mental health services	Changing Family Structures	Poverty	Age of residents	Addiction to alcohol/illicit drugs

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

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

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

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

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

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

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

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

10. New York State Prevention Agenda Goals

Top Three Goals for the ARHN Region:

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

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

Top Three Goals by County:

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

Prevent Chronic Disease

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

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

Promote Healthy Women, Infants and Children

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

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

Promote a Healthy and Safe Environment

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

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

Promote Well-Being and Prevent Mental and Substance Use Disorders

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

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

Prevent Communicable Diseases

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

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

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

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

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

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

Appendix A. 2022 Stakeholder Survey

2022 CHA Stakeholders Survey

Introduction

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

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

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

Your Organization/Agency

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

1. Organization/Agency name: _____
2. Your name (Please provide first and last name): _____
3. Your job title/role: _____

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

4. Your email address:_____
5. Indicate the **<u>one</u>** community sector that best describes your organization/agency:

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

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

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

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

Health Priorities, Concerns and Factors

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

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

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

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

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

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

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

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

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

Social Determinants of Health

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.

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

12. Prevent Chronic Diseases

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

13. 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

14. Promote a Healthy and Safe Environment

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

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

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

16. Prevent Communicable Diseases

- ☐ Improve vaccination rates
- ☐ Reduce vaccination coverage disparities
- ☐ Decrease HIV morbidity (new HIV diagnoses)
- ☐ Increase HIV viral suppression
- ☐ Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
- ☐ Increase the number of persons treated for Hepatitis C
- ☐ Reduce the number of new Hepatitis C cases among people who inject drugs
- ☐ Improve infection control in health care facilities

- ☐ Reduce infections caused by multidrug resistant organisms and C. difficile
- ☐ Reduce inappropriate antibiotic use

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

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

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

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

Additional Details:

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

- ☐ Yes
- ☐ No

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

Appendix F: Adirondack Rural Health Network Stakeholder Survey - Distribution List

Category	Agency
Other Agencies	NYConnects
Other Agencies	Office of Senator Betty Little
DSS/ Child Welfare	Hudson Falls Recreation Program
MR, DD, People with Disabilities	Liberty House
Health Centers & Physician Practices	Planned Parenthood
Other Agencies	Easton Greenwich Capt.
Other Agencies	Comfort Food Community
Healthy Environment	Wash. Co. Code Enforcement
EMS	Salem EMS Capt.
Aging/Seniors	Washington County Aging & Disabilities Resource Center
STI/HIV/Infectious Disease	Infection Control Wash. Co. Public Health
Local Government	Board of Supervisors
Employment & Training	One Stop of Washington County
Other Agencies	Open Door
Other Agencies	Hudson Mohawk AHEC
Aging/Seniors	Fort Hudson Health Services
Employment Local Government	Washington County - All Departments and Unit Heads
Behavioral Health	Warren-Washington Assoc. for Mental Health
DSS/ Child Welfare	Department of Social Services
Employment & Training	Local Development Corporation
Education	WSWHE BOCES
MR, DD, People with Disabilities	Community Workshops Inc.
DV Support Services	DV victim advocate catholic charities
Local Government Wellness	Personnel/HR/Employee Wellness
Transportation	Adk/Gf Transprotation Council
Healthy Environment	DOH Glens Falls District Office
Education	Hudson Falls Central School
Public Health	Public Safety Wash. Co. Public Health
Other Agencies	Cornerstone Bible Church
DSS/ Child Welfare	Youth Bureau/Alternative Sentencing
Housing/Homelessness	Homeless Youth Coalition
Other Agencies	Washington County Board of Supervisors
Education	Granville Jr./Sr. High School
Other Agencies	Community Maternity Services of Warren/Washington Counties
Employment & Training	One Stop Career Center of Warren County
Public Health	Washington County Public Health
Healthcare	Alliance for Positive health
MR, DD, People with Disabilities	Warren Washington County Chapter NYSARC
EMS	EMS Coordinator
Other Agencies	Cornell Cooperative Extension
Other Agency	Alternative Sentencing/Youth Bureau
Housing/Homelessness	Catholic Charities
Aging/Seniors	Holbrooks Adult Home
Other Agencies	Granville Ecumenical Food Pantry
community education	Council for Prevention
Behavioral Health	Behavioral Health Services North
Education	Headstart
Public Health	WIC
Other Agencies	Argyle United Presbyterian Church
DSS/ Child Welfare	Southern Adirondack Child Care Network
Non profit	American Cancer Society
Other Agencies	Whitehall Capt.
Other Agencies	Office of NYS Assemblyman

Victim Advocate DA office	District Attorneys office
Other Agencies	Bread of Life Food Pantry, Zion Episcopal Church
Other Agencies	Girl Scouts of NENY
Other Agencies	Warren & Washington County CARE Center
Behavioral Health	Adirondack Samaritan Center
Behavioral Health	Council for Prevention
Local Government	Probation
Behavioral Health	Washington County Veterans Services Department
EMS	EMS Coord. Granville Squad Capt.
Other Agencies	Washington County Fire chiefs
Non profit	Alzheimer's Assocation
Hospitals/Health Centers	Hudson Headwaters Health Network - Multipe Leadership Contacts
Health Centers & Physician Practices	Glens Falls Hospital - Multiple Leadership contacts
Education	Johnsburg Central School
Education	Warrensburg Central School
Education	Hadley-Luzerne School
Housing/Homelessness	Town of Queensbury Housing
Education	St. Mary's Regional Academy
Education	Lake George School District
Employment and Training	Adirondack Chamber of Commerce
Education	North Warren Central School
Education	Bolton Landing Central School
DSS/Child Welfare	Warren County DSS
Other Agencies	SAIL
MR, DD, People with Disabilities	Southern Adirondack Independent Living Center
Other Agencies	Adirondack Health Institute
Education	Glens Falls City Schools
Other Agencies	Glens Falls Family YMCA
MR, DD, People with Disabilities	Warren Washington County Chapter NYSARC
Education	WSWHE BOCES
Young Children	Prospect Child & Family Center
Other Agencies	Warren County Veteran's Services
MR, DD, People with Disabilities	Community Workshops Inc.
Public Health	Warren County Health Services
Hospitals/Health Centers	Adirondack Pediatrics
Education	SUNY Adirondack
Young Children	Big Brothers/Big Sisters of Warren/Washington Counties
Other Agencies	Hague Community Center
Education	Queensbury Central School
Education	Abraham Wing Common School
Other Agencies	Parks and Trails New York
Other Agencies	Church of the Messiah
Other Agencies	Mountain Lakes Regional EMS Council
Other Agencies	Community Maternity Services of Warren/Washington Counties
Other Agency	Adirondack Health Institute
Young Children	Warren County Headstart
Other Agencies	North Country Ministries
Housing/Homelessness	Homeless Youth Coalition-Wait House
Hospitals/Health Centers	Glens Falls Pediatrics
Other Agencies	Glens Falls Foundation
Employment & Training	One Stop Career Center of Warren County
Managed Care/3rd Party Health Insurance/Ssi/Disability	DSS/Adult Services
Other Agencies	Conkling Center
Other Agencies	Cornell Cooperative Extension of Warren County
Other Agencies	Tri County United Way
Hospitals/Health Centers	Irongate Family Practice Associates
Public Health	Catholic Charities-Saratoga/Warren/Washington Counties
Other Agencies	Adirondack Community Outreach Center

Health Centers & Physician Practices	CR Wood Cancer Center Of Glens Falls Hospital
Other Agencies	Planned Parenthood Mohawk Hudson Inc.
Other Agency	Lake George Caldwell Presbyterian Church
Behavioral Health	Mental Health Office of Community Service

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

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

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

N/A - Data not available

(1) 2010 Census Estimate; Census Quick Stats

(2) USDA Farm Overview; 2017

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

(4) Centers for Medicaid and Medicare Services; 2019

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

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

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

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

N/A - Data not available
(1) US Census Bureau, 2020 American Community Survey 5-year Estimates
(2) NYS Department of Health; NYS Health Profiles
(3) NYS Department of Health; Nursing Home Weekly Bed Census, 2022
(4) NYS Department of Health; Adult Care Facility Directory,2022
(5) NYS Education Department; License Statistics, 2021
**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

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

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

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

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

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

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

Adirondack Rural Health Network

Summary of Education System Information

School Districts by County [1]

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

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

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

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

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

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

(1) American Community Survey, 2018
(2) ALICE Threshold, 2018
(3) United for Alice, 2018
(4) NYS County Health Rankings, 2018
**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*
***ARHN region reflects an average of ARHN counties*

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

Warren County Revised: August 2022

	Number Per Year (If Available)			Average, Rate, Ratio or & for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score
	One	Two	Three		ARHN[1]	Upstate NY	New York State	Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
Percentage of Overall Premature Deaths (before age 65 years), 2019				18.1%	22.1%	21.0%	22.7%	**22.8%**	Meets/Better						
Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2019				22.2+	N/A	20.2	17.7	**17.3**	Less than 10						
Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2019				82.2+	N/A	21.1	16.4	**16.2**	Less than 10						
Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2019				113.1	142.52	120.4	125.9	**115.0**	Meets/Better						
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2019				23.4+	N/A	128.4	115.8	**94**	Less than 10						
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2019				N/A	N/A	1.0	34.6	**23.9**	Less than 10						
Percentage of Adults (Ages 18 - 64) with Health Insurance, 2019				95.0%	93.6%	94.00	92.5%	**97.0%**	Worse	X					
Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2018				82.8%	82.3%	82.0%	79.1%	**86.7%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	25.0%	0.0%
Other Disparity Indicators															
Rate of Total Deaths per 100,000 Population, 2017-2019	733	750	750	1,157.3	1,069.7	**916.2**	798.8	N/A	Worse		X				
Rate of Emergency Department Visits per 10,000 Population, 2017-2019	23,278	22,498	22,618	3,544.8	4,694.3	**3,843.0**	4,134.7	N/A	Meets/Better						
Rate of Total Hospitalizations per 10,000 Population, 2017-2019	7,612	7,497	7,137	1,152.8	981.2	**1,144.2**	1,154.8	N/A	Worse	X					
Percentage of Adults Who Did Not Receive Medical Care Due to Costs, 2018				10.1%	9.6%	**9.2%**	11.0%	N/A	Worse	X					
Percentage of adults reporting 14 or more days of poor physical health, 2018				12.2%	13.0%	**11.1%**	11.2%	N/A	Worse	X					
Percentage of adults living with a disability (based on 6 ACA disability questions), 2018				22.6%	29.2%	**24.6%**	26.2%	N/A	Meets/Better						
Quartile Summary for Other Indicators										3	1	0	0	66.7%	0.0%
Quartile Summary for Mortality										5	1	0	0	42.9%	0.0%

Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
Rate of Hospitalizations due to falls among adults per 10,000 population, aged 65+, 2019				196.3	165.2	210.4	193.9	**173.7**	Worse	X					
Rate of Assault-Related Hospitalizations per 10,000 Population, 2019				2.0	1.00	2.2	3.1	**3.0**	Meets/Better						
Ratio of Rates of Assault-related hospitalizations between Black non-Hispanics and White non-Hispanics, 2019				0.00+	N/A	5.6	5.1	**5.5**	Less than 10						
Ratio of Rates of Assault-related hospitalizations, between Hispanics and White non-Hispanics, 2019				0.00+	N/A	1.8	2.4	**2.5**	Less than 10						
Ratio of Rates of Assault-Related Hospitalizations for Low-Income ZIP codes and Non-Low Income Zip Codes, 2019				N/A	N/A	3.0	2.8	**2.7**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	20.0%	0.0%
Other Indicators															
Falls hospitalization rate per 10,000 - Aged <10 years, 2017-2019				9.8	5.5	**6.2**	6.8	N/A	Worse			X			
Falls hospitalization rate per 10,000 - Aged 10-14 years, 2017-2019				N/A	2.6*	**3.4**	4.0	N/A	Less than 10						
Falls hospitalization rate per 10,000 - Aged 15-24 years, 2017-2019				3.9*	2.9	**4.0**	4.4	N/A	Less than 10						
Falls hospitalization rate per 10,000 - Aged 25-64 years, 2017-2019	65	93	70	22.5	18.5	**19.7**	18.8	N/A	Worse	X					
Rate of Violent Crimes per 100,000 Population, 2020				121.5	157.0	**204.7**	364.9	N/A	Meets/Better						
Rate of Property Crimes per 100,000 Population, 2020				1,045.0	1,056.8	**1,292.1**	1,406.5	N/A	Meets/Better						
Rate of Total Crimes per 100,000 Population, 2020				1,166.5	1,213.9	**1,496.8**	1,771.4	N/A	Meets/Better						
Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, 2016-2018				N/A	1.2*	**1.4**	1.1	N/A	Less than 20						
Rate of Pneumoconiosis Hospitalizations, Ages 15 and older, per 100,000 Population, 2017-2019				N/A	9.4	**9.0**	6.6	N/A	Less than 10						
Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2017-2019				N/A	0.8	**0.8**	5.7	N/A	Less than 10						
Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, 2017-2019	37	39	33	121.3	138.1	**175.8**	145.9	N/A	Meets/Better						
Rate of Total Motor Vehicle Crashes per 100,000, 2020				2,856.2	2,298.7	**2,157.0**	1,693.1	N/A	Worse		X				
Rate of Speed-Related Accidents per 100,000 Population, 2020				269.8	260.2	**205.7**	146.0	N/A	Worse		X				
Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2020				3.1	7.2	**6.6**	5.3	N/A	Meets/Better						
Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2017-2019	66	66	58	9.8	6.4	**9.0**	8.5	N/A	Worse	X					
Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	302	353	363	239.1	210.3	**275.1**	249.9	N/A	Meets/Better						
Rate of Poisoning Hospitalizations per 10,000 Population, 2017-2019	61	59	48	8.7	6.7	**7.6**	8.0	N/A	Worse	X					
Quartile Summary for Other Indicators										3	2	1	0	35.3%	16.7%
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										4	2	1	0	31.8%	14.3%

Focus Area: Outdoor Air Quality																
Prevention Agenda Indicators																
Annual number of days with air quality index >100 (unhealthy levels of ozone or particulate matter), 2021				N/A	N/A	N/A	20	**3**	Less than 10							
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%	
Focus Area: Built Environment																
Prevention Agenda Indicators																
Percentage of population living in a certified Climate Smart Community, 2021				100.0%	17.5%*	54.2%	31.3%	**8.6%**	Meets/Better							
Percentage of people who commute to work using alternate modes of transportation or who telecommute, 2015-2019				17.0%	17.4%	22.9%	45.6%	**47.9%**	Worse			X				
Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				3.9%	6.0%	**3.9%**	2.2%	N/A	Meets/Better							
Quartile Summary for Focus Area Built Environment										0	0	1	0	33.3%	100.0%	
Focus Area: Water Quality																
Prevention Agenda Indicators																
Percentage of residents served by community water systems that have optimally fluoridated water, 2019				0.2%	25.2%	46.9%	71.1%	**77.5%**	Worse				X			
Quartile Summary for Focus Area Water Quality										0	0	0	1	100.0%	100.0%	
Quartile Summary for Focus Area Air Quality, Built Enviroment, Water Qaulity										0	0	1	1	40.0%	100.0%	
Focus Area: Reduce Obesity in Children and Adults																
Prevention Agenda Indicators																
Percentage of Adults Ages 18 Plus Who are Obese, 2018				25.2%	34%	29.1%	27.6%	**24.2%**	Worse	X						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	100.0%	0.0%	
Other Indicators																
Percentage of Total Students Overweight, 2018-2019				16.8%	17.5%	**16.9%**	N/A	N/A	Meets/Better							
Percentage of Elementary Students Overweight, Not Obese, 2018-2019				16.7%	17.2%	**16.1%**	N/A	N/A	Worse	X						
Percentage of Elementary Student Obese, 2018-2019				17.5%	19.4%	**16.6%**	N/A	N/A	Worse	X						
Percentage of Middle and High School Students Overweight, Not Obese, 2018-2019				16.9%	17.4%	**17.8%**	N/A	N/A	Meets/Better							
Percentage of Middle and High School Students Obese, 2018-2019				18.5%	25.3%	**19.5%**	N/A	N/A	Meets/Better							
Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC, 2015-2017				15.4%	16.1%	**15.5%**	13.8%	N/A	Meets/Better							
Percentage of adults overweight or obese, 2018				60.6%	69.1%	**64.2%**	62.7%	N/A	Meets/Better							
Percentage of adults who participated in leisure time physical activity in the past 30 days, 2018				77.5%	73.3%	**77.6%**	76.2%	N/A	Worse	X						
Number of Recreational and Fitness Facilities per 100,000 Population, 2016				17.1	8.8	**13.2**	12.3	N/A	Meets/Better							
Percentage of adults who had a test for high blood sugar or diabetes within the past three years, 2018				45.3%	49.1%	**48.6%**	51.1%	N/A	Worse	X						
Rate of Cardiovascular Disease Deaths per 100,000 Population, 2017-2019	217	211	220	335.8	309.6	**295.9**	278.3	N/A	Worse	X						
Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	25	25	30	102.3	123.3	**102.4**	104.2	N/A	Meets/Better							
Rate of Cardiovascular Disease Pretransport Deaths per 100,000 Population, 2017-2019	138	132	136	210.4	184.7	**179.5**	163.6	N/A	Worse	X						
Rate of Cardiovascular Hospitalizations per 10,000 Population, 2017-2019	1,075	1,176	1,129	175.2	141.4	**161.7**	155.2	N/A	Worse	X						

Rate of Diseases of the Heart Deaths per 100,000 Population, 2017-2019	159	151	171	249.3	240.1	**234.0**	169.4	N/A	Worse	X					
Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	21	21	22	81.8	100.9	**82.4**	83.9	N/A	Meets/Better						
Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, 2017-2019	108	95	108	161.2	149.1	**147.2**	138.7	N/A	Worse	X					
Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2017-2019	702	763	774	116.0	97.5	**111.2**	84.2	N/A	Worse	X					
Rate of Coronary Heart Diseases Deaths per 100,000 Population, 2017-2019	97	88	104	149.8	155.2	**162.4**	173.4	N/A	Meets/Better						
Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	12	15	13	51.1	69.6	**59.7**	66.4	N/A	Meets/Better						
Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, 2017-2019	66	56	69	99.0	100.8	**106.6**	112.4	N/A	Meets/Better						
Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2017-2019	211	233	214	34.1	29.1	**32.9**	31.5	N/A	Worse	X					
Rate of Congestive Heart Failure Deaths per 100,000, 2017-2019	6	14	16	18.7	19.1	**22.3**	15.1	N/A	Meets/Better						
Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	0	0	1	1.3*	4.2*	**3.2**	2.4	N/A	Less than 10						
Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, 2017-2019	6	11	9	13.5	12.2	**13.7**	8.7	N/A	Meets/Better						
Rate of Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019	223	249	260	46.4	38.8	**69.4**	41.3	N/A	Meets/Better						
Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, 2017-2019	33	32	29	48.7	41.5	**38.2**	31.5	N/A	Worse		X				
Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2017-2019	203	251	225	35.2	23.7	**28.2**	26.6	N/A	Worse	X					
Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019	18	18	8	2.8	2.7	**5.9**	7.3	N/A	Meets/Better						
Rate of Diabetes Deaths per 100,000 Population, 2017-2019	19	21	22	32.1	33.0	**22.5**	22.5	N/A	Worse		X				
Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2017-2019	109	134	131	19.4	18.9	**18.9**	21.4	N/A	Worse	X					
Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2017-2019	1,719	1,762	1,631	264.9	238.0	**252.0**	262.7	N/A	Worse	X					
Quartile Summary for Other Indicators										14	2	0	0	50.0%	0.0%
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										15	2	0	0	51.5%	0.0%

Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure															
Prevention Agenda Indicators															
Percentage of Adults Ages 18 Plus Who Smoke, 2018				19.1%	19.5%	13.9%	12.8%	**11.0%**	Worse			X			

Quartile Summary for Prevention Agenda Indicators										0	0	1	0	100.0%	100.0%
Other Indicators															
Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, 2017-2019	55	68	47	88.1	76.6	**48.3**	36.7	N/A	Worse				X		
Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2017-2019	293	239	189	37.4	32.5	**28.7**	29.7	N/A	Worse		X				
Rate of Asthma Deaths per 100,000 Population, 2017-2019	2	1	0	1.6*	0.7*	**0.9**	1.4	N/A	Less than 10						
Rate of Asthma Hospitalizations per 10,000 Population, 2017-2019	25	37	33	4.9	3.1	**6.2**	9.8	N/A	Meets/Better						
Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2017-2019				4.4	2.4	**4.2**	5.0	N/A	Worse	X					
Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2017-2019				3.8	2.9	**5.2**	8.8	N/A	Meets/Better						
Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2017-2019				4.9	3.9	**4.9**	9.3	N/A	Meets/Better						
Percentage of adults with current asthma, 2018				10.6%	13.5%	**10.6%**	10.1%	N/A	Meets/Better						
Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, 2016-2018	52	65	32	77.2	65.0	**48.1**	39.6	N/A	Worse			X			
Rate of Lung and Bronchus Cancer Cases per 100,000 Population, 2016-2018	82	85	69	122.3	119.0	**87.6**	72.6	N/A	Worse		X				
Number of Registered Tobacco Vendors per 100,000 Population, 2016-2017				166.7	132.7	**104.4**	110	N/A	Worse			X			
Tobacco Sales to Minors Violations per 100,000 Population, 2016-2017				7.8	4.0*	**4.0**	6.6	N/A	Worse				X		
Percentage of Vendors with Complaints per 100,000 Population, 2016-2017				0.0	0.0*	**0.0***	1.1	N/A	Meets/Better						
Quartile Summary for Other Indicators										1	2	2	2	53.8%	57.1%
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										1	2	3	2	57.1%	62.5%

Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
Asthma emergency department visits, rate per 10,000, aged 0-17 years, 2019				39.1	42.3	57.5	99.9	**131.1**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
Asthma emergency department visit rate per 10,000 - aged 18-64 years, 2017-2019				24.1	41.4	**39.0**	63.3	N/A	Meets/Better						
Asthma emergency department visit rate per 10,000 - aged 65+ years, 2017-2019				9.3	16.0	**14.8**	28.2	N/A	Meets/Better						
Rate of All Cancer Cases per 100,000 Population, 2016-2018	512	541	487	797.9	710.8	**657.0**	587.7	N/A	Worse	X					
Rate of all Cancer Deaths per 100,000 Population, 2016-2018	176	197	151	271.5	232.6	**194.7**	175.5	N/A	Worse		X				
Rate of Female Breast Cancer Cases per 100,000 Female Population, 2016-2018	63	90	70	226.6	176.3	**180.1**	164.6	N/A	Worse		X				
Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, 2016-2018	12	21	20	53.8	48.6	**50.9**	49.3	N/A	Worse	X					
Rate of Female Breast Cancer Deaths per 100,000 Female Population, 2016-2018	8	9	7	24.4	24.9	**26.3**	25.1	N/A	Meets/Better						
Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines, 2018				83.8%	80.4%	**80.9%**	82.1%	N/A	Meets/Better						
Rate of Cervix Uteri Cancer Incidence per 100,000, 2016-2018				N/A	8.9	**7.1**	8.3	N/A	Less than 20						
Rate of Cervix and Uteri Cancer Deaths per 100,000 Female Population, 2016-2018				0.0*	6.2*	**2.2**	2.5	N/A	Less than 20						
Percentage of women aged 21-65 years receiving cervical cancer screening based on recent guidelines, 2018				90.4%	87.2%	**86.1%**	84.7%	N/A	Meets/Better						

Rate of Ovarian Cancer Cases per 100,000 Female Population, 2016-2018				15.2*	14.8	**15.2**	14.2	N/A	Less than 20						
Rate of Ovarian Cancer Deaths per 100,000 Female Population, 2016-2018				8.1*	8.8	**9.3**	8.7	N/A	Less than 20						
Rate of Colon and Rectal Cancer incidence per 100,000 Population, 2016-2018	45	30	32	55.4	54.2	**48.8**	45.7	N/A	Worse	X					
Rate of Colon and Rectal Cancer Deaths per 100,000 Population, 2016-2018	17	13	10	20.7	19.8	**15.7**	15.1	N/A	Worse		X				
Rate of Prostate Cancer Deaths per 100,000 Male Population, 2016-2018	6	9	13	29.6	22.1	**18.9**	18.5	N/A	Worse			X			
Rate of Prostate Cancer Incidence per 100,000 Male Population, 2016-2018	53	75	73	212.5	166.2	**174.9**	158.7	N/A	Worse	X					
Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, 2016-2018	12	23	8	45.5	38.3	**33.3**	30.5	N/A	Worse		X				
Rate of Melanoma Cancer Deaths per 100,000 Population, 2016-2018				5.2*	3.6	**2.7**	2.1	N/A	Less than 20						
Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, 2018-2020	5,490	5,528	4,144	30.2%	26.0%	**27.7%**	26.9%	N/A	Meets/Better						
Percentage of adults who had a dentist visit within the past year, 2018				68.5%	63.8%	**71.6%**	69.8%	N/A	Worse	X					
Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, 2016-2018				7.3*	5.0*	**4.7**	4.6	N/A	Less than 20						
Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, 2016-2018	12	15	12	20.2	17.4	**16.3**	14.1	N/A	Worse	X					
Quartile Summary for Other Indicators										6	4	1	0	47.8%	9.1%
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										6	4	1	0	45.8%	9.1%
Focus Area: Maternal and Infant Health															
Prevention Agenda Indicators															
Percentage of births that are preterm, 2019				10.3%	9.4%	9.3%	9.2%	**8.3%**	Worse	X					
Percentage of Black, non-hispanic births that are pre-term, 2019				N/A	N/A	N/A	13.2%	**8.30**	Less than 10						
Percentage of Hispanic births that are pre-term, 2019				N/A	N/A	N/A	10.1%	**8.30**	Less than 10						
Percentage of births that are pre-term on Medicaid, 2019				N/A	N/A	N/A	9.6%	**8.30**	Less than 10						
Rate of Maternal Mortality per 100,000 Births, 2017-2019				0.0*	0.0*%	18.8	19.3	**16.0**	Less than 10						
Percentage of infants who are exclusively breastfed in the hospital among all infants, 2019				68.0%	65.8%	49.6%	47.1%	**51.7%**	Meets/Better						
Percentage of Black, non-hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10						
Percentage of Hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	35.7%	**51.7**	Less than 10						
Percentage of Infants Exclusively Breastfed in Delivery Hospital on Medicaid Insurance, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	11.1%	0.0%

Other Indicators															
Percentage Preterm Births < 32 weeks of Total Births, 2017-2019	10	9	10	1.8%	1.3%	**1.5%**	1.5%	N/A	Worse	X					
Percentage Preterm Births 32 to < 37 Weeks of Total Births, 2017-2019	50	54	45	9.2%	7.8%	**7.6%**	7.6%	N/A	Worse	X					
Percentage of very low birthweight Less Than 1,500 grams, 2017-2019	11	11	9	1.9%	1.1%	**1.3%**	1.4%	N/A	Worse		X				
Percentage of Singleton Births with Weights Less Than 1,500 grams, 2017-2019	4	5	8	1.1%	0.9%	**1.0%**	1.0%	N/A	Worse	X					
Percentage of Total Births with Weights Less Than 2,500 grams, 2017-2019	60	45	37	8.8%	7.7%	**7.7%**	8.1%	N/A	Worse	X					
Percentage of Singleton Births with weight less than 2,500 grams, 2017-2019	41	30	33	6.7%	6.0%	**5.9%**	6.3%	N/A	Worse	X					
Percentage of low birthweight births (< 2.5 kg) for Black, Non-Hispanic, 2016-2018				N/A	N/A	**13.2%**	12.6%	N/A	Less than 10						
Percentage of low birthweight births (< 2.5 kg) for Hispanic/Latino, 2016-2018				10.2%*	N/A	**7.9%**	8.1%	N/A	Less than 10						
Infant Mortality Rate per 1,000 Live Births- Infant (<1 year), 2017-2019	2	7	2	6.8	5.1	**4.8**	4.4	N/A	Worse		X				
Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, 2017-2019	6	2	6	8.6	4.9	**5.1**	5.1	N/A	Worse			X			
Percentage of births with early (1st trimester) prenatal care, 2017-2019	429	434	429	81.2%	77.8%	**78.4%**	76.3%	N/A	Meets/Better						
Percentage of births with adequate prenatal care (APNCU) for Black, Non-Hispanic, 2016-2018				N/A	N/A	**68.4%**	66.1%	N/A	Less than 10						
Percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino, 2016-2018				62.5%	N/A	**70.9%**	71.1%	N/A	Worse	X					
Percentage of births with a 5 minute APGAR <6, 2017-2019	6	15	13	2.1%	1.4%	**0.8%**	0.7%	N/A	Worse				X		
Percentage WIC Women Breastfeeding for at least 6 months, 2015-2017				23.2%	24.6%	**30.6%**	41.0%	N/A	Worse	X					
Percentage Infants Fed Any Breast Milk in Delivery Hospital, 2017-2019	412	397	408	82.4%	79.8%	**84.2%**	88.5%	N/A	Worse	X					
Quartile Summary for Other Indicators										8	2	1	1	75.0%	16.7%
Quartile Summary for Focus Area Maternal and Infant Health										9	2	1	1	52.0%	15.4%
Focus Area: Preconception and Reproductive Health															
Prevention Agenda Indicators															
Percentage of Women Ages 18- 64 with Health Insurance, 2019				N/A	N/A	N/A	94.0%	**97.0%**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
Rate of Total Births per 1,000 Females Ages 15-44, 2017-2019	542	544	533	51.6	53.1	**57.1**	57.5	N/A	Meets/Better						
Percent Multiple Births of Total Births, 2017-2019	22	25	10	3.5%	3.4%	**3.7%**	3.5%	N/A	Meets/Better						
Percent C-Sections to Total Births, 2017-2019	178	196	179	34.2%	32.2%	**34.2%**	33.6%	N/A	Meets/Better						
Rate of Total Pregnancies per 1,000 Females Ages 15-44, 2017-2019	705	706	695	67.1	64.0	**72.3**	79.7	N/A	Meets/Better						
Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, 2017-2019	0	0	1	.2*	0.1*	**0.1**	0.1	N/A	Less than 10						
Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, 2017-2019	6	5	2	4.2	5.7	**4.7**	4.9	N/A	Meets/Better						
Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	21	16	13	29.4	30.2	**20.1**	21.5	N/A	Worse		X				
Rate of Teen pregnancy per 1,000 females aged <18 years, 2017-2019	10	12	6	3.5	3.7	**3.7**	4.7	N/A	Meets/Better						
Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	32	28	25	50.0	42.4	**32.8**	41.1	N/A	Worse			X			
Percent Total Births to Women Ages 35 Plus, 2017-2019	82	95	84	16.1%	13.9%	**22.3%**	24.5%	N/A	Meets/Better						

Ratio+ of Abortions All Ages per 1000 Live Births to All Mothers, 2017-2019	129	125	124	233.5	N/A	N/A	**333.1**	N/A	Meets/Better						
Percentage of WIC Women Pre-pregnancy Underweight (BMI less than 18.5), 2015-2017	11	15	15	4.8%	4.7%	**3.9%**	4.6%	N/A	Worse	X					
Percentage of WIC Women Pre-pregnancy Overweight but not Obese (BMI 25 >30), 2015-2017	80	67	59	24.1%	23.1%	**27.1%**	27.6%	N/A	Meets/Better						
Percentage of WIC Women Pre-pregnancy Obese (BMI > 30),2015-2017	91	100	81	31.8%	35.8%	**31.1%**	26.6%	N/A	Worse	X					
Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, 2015-2019	160	134	109	52.5%	51.9%	**45.7%**	41.0%	N/A	Worse	X					
Percentage of WIC Women with Gestational Diabetes, 2015-2017	18	23	19	7.7%	8.2%	**6.6%**	6.6%	N/A	Worse	X					
Percentage of WIC Women with Gestational Hypertension, 2015-2017	38	35	34	13.9%	13.1%	**9.0%**	7.5%	N/A	Worse			X			
Quartile Summary for Other Indicators										4	1	2	0	41.2%	28.6%
Quartile Summary for Focus Area Preconception and Reproductive Health										4	1	2	0	38.9%	28.6%
Focus Area: Child Health															
Other Indicators															
Percentage of children with recommended number of well child visits in government sponsored insurance programs, 2019				81.9%	74.1%	**73.3%**	75.2%	N/A	Meets/Better						
Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, 2017-2019	2	0	0	28.9*	25.1*	**18.9**	17.7	N/A	Less than 10						
Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, 2017-2019	2	1	2	48.9*	32.5	**31.3**	30.1	N/A	Less than 10						
Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				17.4	10.8	**24.9**	35.6	N/A	Meets/Better						
Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2017-2019				6.0	3.4	**9.4**	16.6	N/A	Meets/Better						
Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2017-2019	9	13	7	8.2	4.9	**12.4**	20.3	N/A	Meets/Better						
Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				N/A	4.3	**7.5**	10.4	N/A	Less than 10						
Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				N/A	1.6*	**1.5**	1.8	N/A	Less than 10						
Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				22.1	18.3	**20.3**	25.2	N/A	Worse	X					
Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				51.1	65.5	**105.9**	186.4	N/A	Meets/Better						
Percentage of Children born in 2016 Screened for Lead by Age 0-8 months, 2016				1.4%*	2.4%	**1.2%**	1.7%	N/A	Less than 10						
Percentage of Children Born in 2016 Screened for Lead by Age 9-17 months, 2016				96.2%	81.7%	**73.0%**	75.6%	N/A	Meets/Better						
Percentage of Children Born 2016 Screened for Lead by Age 36 months (at least two screenings), 2016				84.4%	63.7%	**57.8%**	63.3%	N/A	Meets/Better						
Rate of Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) Per 1,000 tested children aged <72 months, 2017-2019	4	2	5	3.3	8.5	**6.6**	3.8	N/A	Meets/Better						
Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2017-2019	20	9	12	22.3	12.9	**17.7**	18.4	N/A	Worse		X				

Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2017-2019				14.5	8.9	**12.7**	13.2	N/A	Worse	X					
Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2017-2019	18	26	11	26.8	17.7	**23.1**	22.6	N/A	Worse	X					
Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				33.3	51.3	**68.1**	137.1	N/A	Meets/Better						
Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, 2018-2020	3,248	3,268	2,806	60.1%	49.3%	**47.9%**	46.9%	N/A	Meets/Better						
Percentage of 3rd Graders with Dental Caries Experience, 2009-2011				43.3%	N/A	N/A	N/A	N/A	Less than 10						
Percentage of 3rd Graders with Dental Sealants, 2009-2011				29.0%	N/A	N/A	N/A	N/A	Less than 10						
Percentage of 3rd Graders with Dental Insurance, 2009-2011				83.4%	85.2%	N/A	N/A	N/A	Worse	X					
Percentage of 3rd Graders with at Least One Dental Visit, 2009-2011				87.4%	**81.0%**	N/A	N/A	N/A	Meets/Better						
Percentage of 3rd Graders Taking Fluoride Tablets Regularly, 2009-2011				68.8%	N/A	N/A	N/A	N/A	Less than 10						
Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2017-2019	32	47	78	289.9	228.2	**146.7**	146.4	N/A	Worse				X		
Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, 2015-2017				81.7%	85.4%	**84.9%**	86.6%	N/A	Worse	X					
Quartile Summary for Other Indicators										5	1	0	1	26.9%	14.3%
Quartile Summary for Focus Area Child Health										5	1	0	1	26.9%	14.3%
Focus Area: Human Immunodeficiency Virus (HIV)															
Prevention Agenda Indicators															
Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2017-2019				2.1*	4.3*	5.7	13.1	**5.2**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
AIDS Deaths per 100,000, 2017-2019	0	0	1	0.5*	0.4*	**0.9**	2.2	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%
Focus Area: Sexually Transmitted Disease (STDs)															
Prevention Agenda Indicators															
Early syphilis diagnoses, age-adjusted rate per 100,000 population, 2019				10.4*	3.71*	15.3	38.6	**79.6**	Less than 10						
Gonorrhea diagnoses, age-adjusted rate per 100,000 population, 2019				56.5	33.40	114.9	217	**242.6**	Meets/Better						
Chlamydia diagnoses, age-adjusted rate per 100,000 population, 2019				266.0	244.33	457.5	667.9	**676.9**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
Rate of Gonorrhea case rate per 100,000 males - Aged 15-44 years, 2017-2019	6	8	15	89.1	54.45	**267.8**	614.9	N/A	Meets/Better						
Gonorrhea case rate per 100,000 females - Aged 15-44 years, 2017-2019	9	10	13	101.9	88.72	**218.3**	252.5	N/A	Meets/Better						
Rate of Gonorrhea case rate per 100,000 - Aged 15-19 years, 2017-2019	2	0	3	48.9*	73.15	**246.4**	401.5	N/A	Less than 10						
Rate of Chlamydia Cases All Males Aged 15-44 years per 100,000 Male Population, 2017-2019	69	59	38	510.3	406.45	**41.2**	1,175.1	N/A	Worse				X		
Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, 2017-2019	6	13	9	517.8	466.03	**766.4**	1,142.6	N/A	Meets/Better						

Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, 2017-2019	32	13	14	1,133.1	945.09	**1,513.3**	2,107.1	N/A	Meets/Better						

Rate of Chlamydia Cases All Females Aged 15-44 years per 100,000 Female Population, 2017-2019	126	141	91	1,140.2	1118.40	**1,455.2**	1,741.1	N/A	Meets/Better						
Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population, 2017-2019	29	39	23	1,890.7	2006.20	**2,623.6**	3,535.7	N/A	Meets/Better						
Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population, 2017-2019	65	58	37	3,155.8	2740.07	**3,203.9**	3,912.5	N/A	Meets/Better						
Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population, 2017-2019				1.9*	0.95*	**1.9**	2.5	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	1	10.0%	100.0%
Quartile Summary for Sexually Transmitted Diseases										0	0	0	1	7.7%	100.0%
Focus Area: Vaccine Preventable Disease															
Prevention Agenda Indicators															
Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series, 2020				79.8%	68.2%	66.3%	66.1%	**70.5%**	Meets/Better						
Percentage of 13-year-old adolescents with a complete HPV vaccine series, 2020				36.9%	25.8%	32.8%	39.8%	**37.4%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	50.0%	0.0%
Other Indicators															
Rate of Pertussis Cases per 100,000 Population, 2017-2019	1	0	1	1.0*	12.3	**5.0**	3.8	N/A	Less than 10						
Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	109	114	121	80.8	87.7	**95.2**	85.5	N/A	Meets/Better						
Percentage of adults aged 65+ years with pneumococcal immunization, 2018				70.9%	70.0%	**69.4%**	64.0%	N/A	Meets/Better						
Rate of Mumps Cases per 100,000 Population, 2017-2019	2	0	2	2.1*	1.4*	**1.3**	1.7	N/A	Less than 10						
Rate of Meningococcal Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.0*	**0.1**	0.1	N/A	Less than 10						
Rate of H Influenza Cases per 100,000 Population, 2017-2019	1	1	2	2.1*	2.1	**2.3**	2.0	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										1	0	0	0	12.5%	0.0%
Focus Area: Healthcare Associated Infections															
Prevention Agenda Indicators															
Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days (Risk-adjusted), 2019				3.7	N/A	N/A	**4.0**	N/A	Meets/Better						
Rate of Community Onset, Healthcare Facility Associated CDIs per 100 Admissions, not risk-adjusted, 2019				0.1	N/A	N/A	**0.2**	N/A	Meets/Better						
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders															
Prevention Agenda Indicators															
Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2018				24.6%	16.6%	18.4%	17.5%	**16.4%**	Worse			X			
Age Adjusted Rate of Suicides per 100,000 Adjusted Population, 2017-2019				11.4	N/A	9.9	8.2	**7.0**	Worse			X			
Quartile Summary for Prevention Agenda Indicators										0	0	2	0	100.0%	100.0%
Other Indicators															
Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, 2017-2019	0	1	0	9.8*	8.1*	**7.3**	6.0	N/A	Less than 10						
Rate of Self-inflicted injury Hospitalizations 10,000 Population, 2017-2019	66	67	45	9.2	6.1	**4.4**	3.7	N/A	Worse				X		
Rate of Self-inflicted injury Hospitalizations for Ages 15 - 19 per 10,000 Population, 2017-2019	19	9	6	33.3	17.0	**10.3**	9.0	N/A	Worse				X		

Rate of Cirrhosis Deaths per 100,000 Population, 2017-2019	11	12	8	16.1	15.3	**10.1**	8.4	N/A	Worse			X			
Rate of Alcohol-Related Crashes per 100,000, 2020				86.3	66.4	**52.0**	40.1	N/A	Worse			X			
Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2020				29.8	28.7	**28.8**	23.3	N/A	Worse	X					
Quartile Summary for Other Indicators										1	0	2	2	83.3%	80.0%
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										1	0	4	2	87.5%	85.7%
Other Non-Prevention Agenda Indicators															
Rate of Hepatitis A Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.4*	**1.4**	1.3	N/A	Less than 10						
Rate of Acute Hepatitis B Cases per 100,000 Population, 2017-2019	0	0	1	0.5*	0.3*	**0.4**	0.4	N/A	Less than 10						
Rate of TB Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.6*	**1.7**	3.9	N/A	Less than 10						
Rate of E. Coli Shiga Toxin Cases per 100,000 Population, 2017-2019	5	1	3	4.7*	3.0	**3.1**	4.1	N/A	Less than 10						
Rate of Salmonella Cases per 100,000 Population, 2017-2019	8	6	5	9.8	11.1	**12.9**	14.0	N/A	Meets/Better						
Rate of Shigella Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.5*	**3.4**	6.3	N/A	Less than 10						
Rate of Lyme Disease Cases per 100,000 Population, 2017-2019	24	39	195	133.7	118.1	**70.7**	44.7	N/A	Worse	X					
Rate of Confirmed Rabies Cases per 100,000 Population, 2020				4.7	3.4*	**3.1**	1.8	N/A	Worse			X			
Quartile Summary for Non-Prevention Agenda Issues										1	0	1	0	25.0%	50.0%

N/A: Data does not meet reporting criteria
*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable
+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.
1: ARHN data not available when two or more counties do not have reported data

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	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[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
Percentage of Overall Premature Deaths (before age 65 years), 2019				20.0%	22.1%	21.0%	22.7%	**22.8%**	Meets/Better						
Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2019				13.6+	N/A	20.2	17.7	**17.3**	Less than 10						
Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2019				5.3+	N/A	21.1	16.4	**16.2**	Less than 10						
Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2019				128.0	142.52	120.4	125.9	**115.0**	Worse	X					
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2019				-59.9	N/A	128.4	115.8	**94**	Worse	X					
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2019				N/A	N/A	1.0	34.6	**23.9**	Less than 10						
Percentage of Adults (Ages 18 - 64) with Health Insurance, 2019				94.0%	93.6%	94.00	92.5%	**97.0%**	Worse	X					
Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2018				85.0%	82.3%	82.0%	79.1%	**86.7%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										4	0	0	0	50.0%	0.0%
Other Disparity Indicators															
Rate of Total Deaths per 100,000 Population, 2017-2019	648	681	701	1,101.6	1,069.7	**916.2**	798.8	N/A	Worse	X					
Rate of Emergency Department Visits per 10,000 Population, 2017-2019	21,340	20,683	20,863	3,412.7	4,694.3	**3,843.0**	4,134.7	N/A	Meets/Better						
Rate of Total Hospitalizations per 10,000 Population, 2017-2019	7,171	6,948	6,461	1,116.8	981.2	**1,144.2**	1,154.8	N/A	Meets/Better						
Percentage of Adults Who Did Not Receive Medical Care Due to Costs, 2018				10.0%	9.6%	**9.2%**	11.0%	N/A	Worse	X					
Percentage of adults reporting 14 or more days of poor physical health, 2018				15.1%	13.0%	**11.1%**	11.2%	N/A	Worse		X				
Percentage of adults living with a disability (based on 6 ACA disability questions), 2018				29.8%	29.2%	**24.6%**	26.2%	N/A	Worse	X					
Quartile Summary for Other Indicators										3	1	0	0	66.7%	0.0%
Quartile Summary for Mortality										7	1	0	0	57.1%	0.0%

Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
Rate of Hospitalizations due to falls among adults per 10,000 population, aged 65+, 2019				184.7	165.2	210.4	193.9	**173.7**	Worse	X					
Rate of Assault-Related Hospitalizations per 10,000 Population, 2019				1.5*	1.00	2.2	3.1	**3.0**	Less than 10						
Ratio of Rates of Assault-related hospitalizations between Black non-Hispanics and White non-Hispanics, 2019				0.00+	N/A	5.6	5.1	**5.5**	Less than 10						
Ratio of Rates of Assault-related hospitalizations, between Hispanics and White non-Hispanics, 2019				N/A	N/A	1.8	2.4	**2.5**	Less than 10						
Ratio of Rates of Assault-Related Hospitalizations for Low-Income ZIP codes and Non-Low Income Zip Codes, 2019				N/A	N/A	3.0	2.8	**2.7**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	20.0%	0.0%
Other Indicators															
Falls hospitalization rate per 10,000 - Aged <10 years, 2017-2019				7.7	5.5	**6.2**	6.8	N/A	Worse	X					
Falls hospitalization rate per 10,000 - Aged 10-14 years, 2017-2019				N/A	2.6*	**3.4**	4.0	N/A	Less than 10						
Falls hospitalization rate per 10,000 - Aged 15-24 years, 2017-2019				4.3*	2.9	**4.0**	4.4	N/A	Less than 10						
Falls hospitalization rate per 10,000 - Aged 25-64 years, 2017-2019	60	73	84	21.9	18.5	**19.7**	18.8	N/A	Worse	X					
Rate of Violent Crimes per 100,000 Population, 2020				130.4	157.0	**204.7**	364.9	N/A	Meets/Better						
Rate of Property Crimes per 100,000 Population, 2020				447.3	1,056.8	**1,292.1**	1,406.5	N/A	Meets/Better						
Rate of Total Crimes per 100,000 Population, 2020				577.7	1,213.9	**1,496.8**	1,771.4	N/A	Meets/Better						
Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, 2016-2018				N/A	1.2*	**1.4**	1.1	N/A	Less than 20						
Rate of Pneumoconiosis Hospitalizations, Ages 15 and older, per 100,000 Population, 2017-2019				9.0	9.4	**9.0**	6.6	N/A	Meets/Better						
Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2017-2019				3.9*	0.8	**0.8**	5.7	N/A	Less than 10						
Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, 2017-2019	60	38	48	181.9	138.1	**175.8**	145.9	N/A	Worse	X					
Rate of Total Motor Vehicle Crashes per 100,000, 2020				1,904.1	2,298.7	**2,157.0**	1,693.1	N/A	Meets/Better						
Rate of Speed-Related Accidents per 100,000 Population, 2020				174.9	260.2	**205.7**	146.0	N/A	Meets/Better						
Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2020				8.3	7.2	**6.6**	5.3	N/A	Worse	X					
Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2017-2019	55	71	60	10.1	6.4	**9.0**	8.5	N/A	Worse	X					
Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	278	318	291	248.6	210.3	**275.1**	249.9	N/A	Meets/Better						
Rate of Poisoning Hospitalizations per 10,000 Population, 2017-2019	32	61	43	7.4	6.7	**7.6**	8.0	N/A	Meets/Better						
Quartile Summary for Other Indicators										5	0	0	0	29.4%	0.0%
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										6	0	0	0	27.3%	0.0%

Focus Area: Outdoor Air Quality															
Prevention Agenda Indicators															
Annual number of days with air quality index >100 (unhealthy levels of ozone or particulate matter), 2021				N/A	N/A	N/A	20	**3**	Less than 10						
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%
Focus Area: Built Environment															
Prevention Agenda Indicators															
Percentage of population living in a certified Climate Smart Community, 2021				0.0%*	17.5%*	54.2%	31.3%	**8.6%**	Less than 10						
Percentage of people who commute to work using alternate modes of transportation or who telecommute, 2015-2019				17.4%	17.4%	22.9%	45.6%	**47.9%**	Worse			X			
Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				4.3%	6.0%	**3.9%**	2.2%	N/A	Worse	X					
Quartile Summary for Focus Area Built Environment										1	0	1	0	66.7%	50.0%
Focus Area: Water Quality															
Prevention Agenda Indicators															
Percentage of residents served by community water systems that have optimally fluoridated water, 2019				26.3%	25.2%	46.9%	71.1%	**77.5%**	Worse			X			
Quartile Summary for Focus Area Water Quality										0	0	1	0	100.0%	100.0%
Quartile Summary for Focus Area Air Quality, Built Enviroment, Water Qaulity										1	0	2	0	60.0%	66.7%
Focus Area: Reduce Obesity in Children and Adults															
Prevention Agenda Indicators															
Percentage of Adults Ages 18 Plus Who are Obese, 2018				38.7%	34%	29.1%	27.6%	**24.2%**	Worse			X			
Quartile Summary for Prevention Agenda Indicators										0	0	1	0	100.0%	100.0%
Other Indicators															
Percentage of Total Students Overweight, 2018-2019				32.1%	17.5%	**16.9%**	N/A	N/A	Worse				X		
Percentage of Elementary Students Overweight, Not Obese, 2018-2019				18.8%	17.2%	**16.1%**	N/A	N/A	Worse	X					
Percentage of Elementary Student Obese, 2018-2019				21.2%	19.4%	**16.6%**	N/A	N/A	Worse		X				
Percentage of Middle and High School Students Overweight, Not Obese, 2018-2019				18.3%	17.4%	**17.8%**	N/A	N/A	Worse	X					
Percentage of Middle and High School Students Obese, 2018-2019				26.0%	25.3%	**19.5%**	N/A	N/A	Worse		X				
Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC, 2015-2017				17.9%	16.1%	**15.5%**	13.8%	N/A	Worse	X					
Percentage of adults overweight or obese, 2018				71.6%	69.1%	**64.2%**	62.7%	N/A	Worse	X					
Percentage of adults who participated in leisure time physical activity in the past 30 days, 2018				72.7%	73.3%	**77.6%**	76.2%	N/A	Worse	X					
Number of Recreational and Fitness Facilities per 100,000 Population, 2016				4.9	8.8	**13.2**	12.3	N/A	Worse			X			
Percentage of adults who had a test for high blood sugar or diabetes within the past three years, 2018				51.5%	49.1%	**48.6%**	51.1%	N/A	Meets/Better						
Rate of Cardiovascular Disease Deaths per 100,000 Population, 2017-2019	154	226	193	311.0	309.6	**295.9**	278.3	N/A	Worse	X					
Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	27	33	24	109.9	123.3	**102.4**	104.2	N/A	Worse	X					
Rate of Cardiovascular Disease Pretransport Deaths per 100,000 Population, 2017-2019	92	142	121	192.7	184.7	**179.5**	163.6	N/A	Worse	X					
Rate of Cardiovascular Hospitalizations per 10,000 Population, 2017-2019	969	1,042	1,007	163.8	141.4	**161.7**	155.2	N/A	Worse	X					

Rate of Diseases of the Heart Deaths per 100,000 Population, 2017-2019	119	182	156	248.0	240.1	**234.0**	169.4	N/A	Worse	X					
Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	21	30	19	91.6	100.9	**82.4**	83.9	N/A	Worse	X					
Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, 2017-2019	76	117	101	159.5	149.1	**147.2**	138.7	N/A	Worse	X					
Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2017-2019	647	699	681	110.0	97.5	**111.2**	84.2	N/A	Meets/Better						
Rate of Coronary Heart Diseases Deaths per 100,000 Population, 2017-2019	68	127	105	162.8	155.2	**162.4**	173.4	N/A	Worse	X					
Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	17	21	13	66.7	69.6	**59.7**	66.4	N/A	Worse	X					
Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, 2017-2019	42	86	77	111.2	100.8	**106.6**	112.4	N/A	Worse	X					
Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2017-2019	192	217	223	34.3	29.1	**32.9**	31.5	N/A	Worse	X					
Rate of Congestive Heart Failure Deaths per 100,000, 2017-2019	10	8	9	14.7	19.1	**22.3**	15.1	N/A	Meets/Better						
Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	0	0	0	0.0*	4.2*	**3.2**	2.4	N/A	Less than 10						
Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, 2017-2019	6	6	6	9.8	12.2	**13.7**	8.7	N/A	Meets/Better						
Rate of Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019	210	236	206	43.6	38.8	**69.4**	41.3	N/A	Meets/Better						
Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, 2017-2019	20	31	18	37.4	41.5	**38.2**	31.5	N/A	Meets/Better						
Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2017-2019	194	174	184	30.0	23.7	**28.2**	26.6	N/A	Worse	X					
Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019	9	13	14	2.4	2.7	**5.9**	7.3	N/A	Meets/Better						
Rate of Diabetes Deaths per 100,000 Population, 2017-2019	15	31	28	40.2	33.0	**22.5**	22.5	N/A	Worse				X		
Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2017-2019	124	120	141	20.9	18.9	**18.9**	21.4	N/A	Worse	X					
Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2017-2019	1,682	1,676	1,633	270.9	238.0	**252.0**	262.7	N/A	Worse	X					
Quartile Summary for Other Indicators										19	2	1	2	75.0%	12.5%
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										19	2	2	2	75.8%	16.0%
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure															
Prevention Agenda Indicators															
Percentage of Adults Ages 18 Plus Who Smoke, 2018				25.3%	19.5%	13.9%	12.8%	**11.0%**	Worse				X		
Quartile Summary for Prevention Agenda Indicators										0	0	0	1	100.0%	100.0%
Other Indicators															
Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, 2017-2019	57	49	55	87.4	76.6	**48.3**	36.7	N/A	Worse				X		
Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2017-2019	308	226	221	41.0	32.5	**28.7**	29.7	N/A	Worse		X				
Rate of Asthma Deaths per 100,000 Population, 2017-2019	0	0	1	0.5*	0.7*	**0.9**	1.4	N/A	Less than 10						
Rate of Asthma Hospitalizations per 10,000 Population, 2017-2019	28	43	19	4.9	3.1	**6.2**	9.8	N/A	Meets/Better						

Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2017-2019				2.0*	2.4	**4.2**	5.0	N/A	Less than 10						
Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2017-2019	11	13	6	5.5	2.9	**5.2**	8.8	N/A	Worse	X					
Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2017-2019				5.6	3.9	**4.9**	9.3	N/A	Worse	X					
Percentage of adults with current asthma, 2018				16.5%	13.5%	**10.6%**	10.1%	N/A	Worse			X			
Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, 2016-2018	38	40	39	63.4	65.0	**48.1**	39.6	N/A	Worse		X				
Rate of Lung and Bronchus Cancer Cases per 100,000 Population, 2016-2018	58	74	72	110.5	119.0	**87.6**	72.6	N/A	Worse		X				
Number of Registered Tobacco Vendors per 100,000 Population, 2016-2017				88.5	132.7	**104.4**	110	N/A	Meets/Better						
Tobacco Sales to Minors Violations per 100,000 Population, 2016-2017				0.0	4.0*	**4.0**	6.6	N/A	Meets/Better						
Percentage of Vendors with Complaints per 100,000 Population, 2016-2017				0.0	0.0*	**0.0***	1.1	N/A	Meets/Better						
Quartile Summary for Other Indicators										2	3	1	1	53.8%	28.6%
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										2	3	1	2	57.1%	37.5%
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
Asthma emergency department visits, rate per 10,000, aged 0-17 years, 2019				39.1	42.3	57.5	99.9	**131.1**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
Asthma emergency department visit rate per 10,000 - aged 18-64 years, 2017-2019				26.1	41.4	**39.0**	63.3	N/A	Meets/Better						
Asthma emergency department visit rate per 10,000 - aged 65+ years, 2017-2019				9.4	16.0	**14.8**	28.2	N/A	Meets/Better						
Rate of All Cancer Cases per 100,000 Population, 2016-2018	427	449	465	726.3	710.8	**657.0**	587.7	N/A	Worse	X					
Rate of all Cancer Deaths per 100,000 Population, 2016-2018	145	153	147	241.0	232.6	**194.7**	175.5	N/A	Worse	X					
Rate of Female Breast Cancer Cases per 100,000 Female Population, 2016-2018	59	50	69	199.7	176.3	**180.1**	164.6	N/A	Worse	X					
Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, 2016-2018	12	14	18	49.4	48.6	**50.9**	49.3	N/A	Meets/Better						
Rate of Female Breast Cancer Deaths per 100,000 Female Population, 2016-2018	10	10	7	30.3	24.9	**26.3**	25.1	N/A	Worse	X					
Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines, 2018				78.1%	80.4%	**80.9%**	82.1%	N/A	Worse	X					
Rate of Cervix Uteri Cancer Incidence per 100,000, 2016-2018				12.3*	8.9	**7.1**	8.3	N/A	Less than 20						
Rate of Cervix and Uteri Cancer Deaths per 100,000 Female Population, 2016-2018				N/A	6.2*	**2.2**	2.5	N/A	Less than 20						
Percentage of women aged 21-65 years receiving cervical cancer screening based on recent guidelines, 2018				94.1%	87.2%	**86.1%**	84.7%	N/A	Meets/Better						
Rate of Ovarian Cancer Cases per 100,000 Female Population, 2016-2018				13.5*	14.8	**15.2**	14.2	N/A	Less than 20						
Rate of Ovarian Cancer Deaths per 100,000 Female Population, 2016-2018				11.2*	8.8	**9.3**	8.7	N/A	Less than 20						
Rate of Colon and Rectal Cancer incidence per 100,000 Population, 2016-2018	33	38	29	54.2	54.2	**48.8**	45.7	N/A	Worse	X					
Rate of Colon and Rectal Cancer Deaths per 100,000 Population, 2016-2018	16	8	15	21.1	19.8	**15.7**	15.1	N/A	Worse		X				
Rate of Prostate Cancer Deaths per 100,000 Male Population, 2016-2018				19.9*	22.1	**18.9**	18.5	N/A	Less than 20						
Rate of Prostate Cancer Incidence per 100,000 Male Population, 2016-2018	40	45	54	145.5	166.2	**174.9**	158.7	N/A	Meets/Better						

Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, 2016-2018	11	14	8	34.5	38.3	**33.3**	30.5	N/A	Worse	X					
Rate of Melanoma Cancer Deaths per 100,000 Population, 2016-2018				6.0*	3.6	**2.7**	2.1	N/A	Less than 20						
Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, 2018-2020	5,383	5,307	4,054	28.5%	26.0%	**27.7%**	26.9%	N/A	Meets/Better						
Percentage of adults who had a dentist visit within the past year, 2018				59.0%	63.8%	**71.6%**	69.8%	N/A	Worse	X					
Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, 2016-2018				7.9*	5.0*	**4.7**	4.6	N/A	Less than 20						
Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, 2016-2018	17	14	9	21.7	17.4	**16.3**	14.1	N/A	Worse		X				
Quartile Summary for Other Indicators										8	2	0	0	43.5%	0.0%
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										8	2	0	0	41.7%	0.0%
Focus Area: Maternal and Infant Health															
Prevention Agenda Indicators															
Percentage of births that are preterm, 2019				10.1%	9.4%	9.3%	9.2%	**8.3%**	Worse	X					
Percentage of Black, non-hispanic births that are pre-term, 2019				N/A	N/A	N/A	13.2%	**8.30**	Less than 10						
Percentage of Hispanic births that are pre-term, 2019				N/A	N/A	N/A	10.1%	**8.30**	Less than 10						
Percentage of births that are pre-term on Medicaid, 2019				N/A	N/A	N/A	9.6%	**8.30**	Less than 10						
Rate of Maternal Mortality per 100,000 Births, 2017-2019				0.0*	0.0*%	18.8	19.3	**16.0**	Less than 10						
Percentage of infants who are exclusively breastfed in the hospital among all infants, 2019				57.8%	65.8%	49.6%	47.1%	**51.7%**	Meets/Better						
Percentage of Black, non-hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10						
Percentage of Hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	35.7%	**51.7**	Less than 10						
Percentage of Infants Exclusively Breastfed in Delivery Hospital on Medicaid Insurance, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	11.1%	0.0%
Other Indicators															
Percentage Preterm Births < 32 weeks of Total Births, 2017-2019	6	14	4	1.5%	1.3%	**1.5%**	1.5%	N/A	Meets/Better						
Percentage Preterm Births 32 to < 37 Weeks of Total Births, 2017-2019	32	59	52	8.8%	7.8%	**7.6%**	7.6%	N/A	Worse	X					
Percentage of very low birthweight Less Than 1,500 grams, 2017-2019	8	12	4	1.5%	1.1%	**1.3%**	1.4%	N/A	Worse	X					
Percentage of Singleton Births with Weights Less Than 1,500 grams, 2017-2019	6	6	2	0.9%	0.9%	**1.0%**	1.0%	N/A	Meets/Better						
Percentage of Total Births with Weights Less Than 2,500 grams, 2017-2019	31	54	45	8.0%	7.7%	**7.7%**	8.1%	N/A	Worse	X					
Percentage of Singleton Births with weight less than 2,500 grams, 2017-2019	23	41	32	6.1%	6.0%	**5.9%**	6.3%	N/A	Worse	X					
Percentage of low birthweight births (< 2.5 kg) for Black, Non-Hispanic, 2016-2018				N/A	N/A	**13.2%**	12.6%	N/A	Less than 10						
Percentage of low birthweight births (< 2.5 kg) for Hispanic/Latino, 2016-2018				7.3%*	N/A	**7.9%**	8.1%	N/A	Less than 10						
Infant Mortality Rate per 1,000 Live Births- Infant (<1 year), 2017-2019	4	1	4	5.5*	5.1	**4.8**	4.4	N/A	Less than 10						
Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, 2017-2019	4	1	3	4.9*	4.9	**5.1**	5.1	N/A	Less than 10						

Percentage of births with early (1st trimester) prenatal care, 2017-2019	404	438	441	80.1%	77.8%	**78.4%**	76.3%	N/A	Meets/Better							
Percentage of births with adequate prenatal care (APNCU) for Black, Non-Hispanic, 2016-2018				N/A	N/A	**68.4%**	66.1%	N/A	Less than 10							
Percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino, 2016-2018				63.4%	N/A	**70.9%**	71.1%	N/A	Worse	X						
Percentage of births with a 5 minute APGAR <6, 2017-2019	14	9	5	1.7%	1.4%	**0.8%**	0.7%	N/A	Worse				X			
Percentage WIC Women Breastfeeding for at least 6 months, 2015-2017				20.6%	24.6%	**30.6%**	41.0%	N/A	Worse		X					
Percentage Infants Fed Any Breast Milk in Delivery Hospital, 2017-2019	373	352	369	77.8%	79.8%	**84.2%**	88.5%	N/A	Worse	X						
Quartile Summary for Other Indicators										6	1	0	1	50.0%	12.5%	
Quartile Summary for Focus Area Maternal and Infant Health										7	1	0	1	36.0%	11.1%	
Focus Area: Preconception and Reproductive Health																
Prevention Agenda Indicators																
Percentage of Women Ages 18- 64 with Health Insurance, 2019				N/A	N/A	N/A	94.0%	**97.0%**	Less than 10							
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%	
Other Indicators																
Rate of Total Births per 1,000 Females Ages 15-44, 2017-2019	526	551	558	55.9	53.1	**57.1**	57.5	N/A	Meets/Better							
Percent Multiple Births of Total Births, 2017-2019	14	27	23	3.9%	3.4%	**3.7%**	3.5%	N/A	Worse	X						
Percent C-Sections to Total Births, 2017-2019	179	180	177	32.8%	32.2%	**34.2%**	33.6%	N/A	Meets/Better							
Rate of Total Pregnancies per 1,000 Females Ages 15-44, 2017-2019	656	701	680	69.7	64.0	**72.3**	79.7	N/A	Meets/Better							
Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, 2017-2019	0	1	0	.2*	0.1*	**0.1**	0.1	N/A	Less than 10							
Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, 2017-2019	2	11	6	6.3	5.7	**4.7**	4.9	N/A	Worse		X					
Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	25	22	22	46.1	30.2	**20.1**	21.5	N/A	Worse				X			
Rate of Teen pregnancy per 1,000 females aged <18 years, 2017-2019	8	17	11	4.5	3.7	**3.7**	4.7	N/A	Worse	X						
Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	40	35	27	68.1	42.4	**32.8**	41.1	N/A	Worse				X			
Percent Total Births to Women Ages 35 Plus, 2017-2019	66	55	69	11.6%	13.9%	**22.3%**	24.5%	N/A	Meets/Better							
Ratio+ of Abortions All Ages per 1000 Live Births to All Mothers, 2017-2019	110	129	99	206.7	N/A	N/A	**333.1**	N/A	Meets/Better							
Percentage of WIC Women Pre-pregnancy Underweight (BMI less than 18.5), 2015-2017	17	17	11	4.6%	4.7%	**3.9%**	4.6%	N/A	Worse	X						
Percentage of WIC Women Pre-pregnancy Overweight but not Obese (BMI 25 >30), 2015-2017	73	67	75	22.0%	23.1%	**27.1%**	27.6%	N/A	Meets/Better							
Percentage of WIC Women Pre-pregnancy Obese (BMI > 30),2015-2017	139	109	117	37.3%	35.8%	**31.1%**	26.6%	N/A	Worse	X						
Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, 2015-2019	175	161	138	53.5%	51.9%	**45.7%**	41.0%	N/A	Worse	X						
Percentage of WIC Women with Gestational Diabetes, 2015-2017	22	20	24	7.4%	8.2%	**6.6%**	6.6%	N/A	Worse	X						
Percentage of WIC Women with Gestational Hypertension, 2015-2017	30	54	41	13.8%	13.1%	**9.0%**	7.5%	N/A	Worse			X				
Quartile Summary for Other Indicators										6	1	1	2	58.8%	30.0%	
Quartile Summary for Focus Area Preconception and Reproductive Health										6	1	1	2	55.6%	30.0%	

Focus Area: Child Health															
Other Indicators															
Percentage of children with recommended number of well child visits in government sponsored insurance programs, 2019				75.1%	74.1%	**73.3%**	75.2%	N/A	Meets/Better						
Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, 2017-2019	0	0	1	14.1*	25.1*	**18.9**	17.7	N/A	Less than 10						
Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, 2017-2019	2	2	1	48.8*	32.5	**31.3**	30.1	N/A	Less than 10						
Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				14.8	10.8	**24.9**	35.6	N/A	Meets/Better						
Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2017-2019				6.1	3.4	**9.4**	16.6	N/A	Meets/Better						
Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2017-2019				7.5	4.9	**12.4**	20.3	N/A	Meets/Better						
Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				9.1*	4.3	**7.5**	10.4	N/A	Less than 10						
Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				N/A	1.6*	**1.5**	1.8	N/A	Less than 10						
Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				32.0	18.3	**20.3**	25.2	N/A	Worse			X			
Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				46.7	65.5	**105.9**	186.4	N/A	Meets/Better						
Percentage of Children born in 2016 Screened for Lead by Age 0-8 months, 2016				.9%*	2.4%	**1.2%**	1.7%	N/A	Less than 10						
Percentage of Children Born in 2016 Screened for Lead by Age 9-17 months, 2016				87.6%	81.7%	**73.0%**	75.6%	N/A	Meets/Better						
Percentage of Children Born 2016 Screened for Lead by Age 36 months (at least two screenings), 2016				73.2%	63.7%	**57.8%**	63.3%	N/A	Meets/Better						
Rate of Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) Per 1,000 tested children aged <72 months, 2017-2019	13	8	25	15.6	8.5	**6.6**	3.8	N/A	Worse				X		
Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2017-2019	10	13	12	19.2	12.9	**17.7**	18.4	N/A	Worse	X					
Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2017-2019				16.8	8.9	**12.7**	13.2	N/A	Worse		X				
Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2017-2019	29	14	22	30.9	17.7	**23.1**	22.6	N/A	Worse		X				
Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				34.5	51.3	**68.1**	137.1	N/A	Meets/Better						
Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, 2018-2020	3,479	3,549	3,078	56.9%	49.3%	**47.9%**	46.9%	N/A	Meets/Better						
Percentage of 3rd Graders with Dental Caries Experience, 2009-2011				43.6%	N/A	N/A	N/A	N/A	No comparison data available						
Percentage of 3rd Graders with Dental Sealants, 2009-2011				17.2%	N/A	N/A	N/A	N/A	No comparison data available						

Percentage of 3rd Graders with Dental Insurance, 2009-2011				81.3%	85.2%	N/A	N/A	N/A	Worse	X					
Percentage of 3rd Graders with at Least One Dental Visit, 2009-2011				80.4%	**81.0%**	N/A	N/A	N/A	Worse	X					
Percentage of 3rd Graders Taking Fluoride Tablets Regularly, 2009-2011				61.2%	N/A	N/A	N/A	N/A	No comparison data available						
Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2017-2019	22	51	90	294.2	228.2	**146.7**	146.4	N/A	Worse				X		
Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, 2015-2017				95.9%	85.4%	**84.9%**	86.6%	N/A	Meets/Better						
Quartile Summary for Other Indicators										3	2	1	2	30.8%	37.5%
Quartile Summary for Focus Area Child Health										3	2	1	2	30.8%	37.5%
Focus Area: Human Immunodeficiency Virus (HIV)															
Prevention Agenda Indicators															
Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2017-2019				N/A	4.3*	5.7	13.1	**5.2**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
AIDS Deaths per 100,000, 2017-2019	1	0	0	.5*	0.4*	**0.9**	2.2	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%
Focus Area: Sexually Transmitted Disease (STDs)															
Prevention Agenda Indicators															
Early syphilis diagnoses, age-adjusted rate per 100,000 population, 2019				3.6*	3.71*	15.3	38.6	**79.6**	Less than 10						
Gonorrhea diagnoses, age-adjusted rate per 100,000 population, 2019				23.8	33.40	114.9	217	**242.6**	Meets/Better						
Chlamydia diagnoses, age-adjusted rate per 100,000 population, 2019				221.7	244.33	457.5	667.9	**676.9**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
Rate of Gonorrhea case rate per 100,000 males - Aged 15-44 years, 2017-2019	5	3	6	38.8	54.45	**267.8**	614.9	N/A	Meets/Better						
Gonorrhea case rate per 100,000 females - Aged 15-44 years, 2017-2019	12	5	5	75.3	88.72	**218.3**	252.5	N/A	Meets/Better						
Rate of Gonorrhea case rate per 100,000 - Aged 15-19 years, 2017-2019	1	0	1	19.5*	73.15	**246.4**	401.5	N/A	Less than 10						
Rate of Chlamydia Cases All Males Aged 15-44 years per 100,000 Male Population, 2017-2019	38	31	35	288.4	406.45	**41.2**	1,175.1	N/A	Worse				X		
Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, 2017-2019	7	8	3	313.7	466.03	**766.4**	1,142.6	N/A	Meets/Better						
Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, 2017-2019	23	9	11	688.6	945.09	**1,513.3**	2,107.1	N/A	Meets/Better						
Rate of Chlamydia Cases All Females Aged 15-44 years per 100,000 Female Population, 2017-2019	119	102	78	1,022.8	1118.40	**1,455.2**	1,741.1	N/A	Meets/Better						
Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population, 2017-2019	38	40	22	2,214.8	2006.20	**2,623.6**	3,535.7	N/A	Meets/Better						
Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population, 2017-2019	51	37	41	2,851.5	2740.07	**3,203.9**	3,912.5	N/A	Meets/Better						
Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population, 2017-2019				N/A	0.95*	**1.9**	2.5	N/A	Less than 10						
Quartile Summary for Other Indicators										0	0	0	1	10.0%	100.0%
Quartile Summary for Sexually Transmitted Diseases										0	0	0	1	7.7%	100.0%

Focus Area: Vaccine Preventable Disease																
Prevention Agenda Indicators																
Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series, 2020				73.2%	68.2%	66.3%	66.1%	**70.5%**	Meets/Better							
Percentage of 13-year-old adolescents with a complete HPV vaccine series, 2020				27.1%	25.8%	32.8%	39.8%	**37.4%**	Worse		X					
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	50.0%	0.0%	
Other Indicators																
Rate of Pertussis Cases per 100,000 Population, 2017-2019	3	0	3	3.3*	12.3	**5.0**	3.8	N/A	Less than 10							
Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	84	118	108	86.9	87.7	**95.2**	85.5	N/A	Meets/Better							
Percentage of adults aged 65+ years with pneumococcal immunization, 2018				71.3%	70.0%	**69.4%**	64.0%	N/A	Meets/Better							
Rate of Mumps Cases per 100,000 Population, 2017-2019	2	0	0	1.1*	1.4*	**1.3**	1.7	N/A	Less than 10							
Rate of Meningococcal Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.0*	**0.1**	0.1	N/A	Less than 10							
Rate of H Influenza Cases per 100,000 Population, 2017-2019	1	1	0	1.1*	2.1	**2.3**	2.0	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										0	1	0	0	12.5%	0.0%	
Focus Area: Healthcare Associated Infections																
Prevention Agenda Indicators																
Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days (Risk-adjusted), 2019				N/A	N/A	N/A	**4.0**	N/A	Less than 10							
Rate of Community Onset, Healthcare Facility Associated CDIs per 100 Admissions, not risk-adjusted, 2019				N/A	N/A	N/A	**0.2**	N/A	Less than 10							
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%	
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders																
Prevention Agenda Indicators																
Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2018				16.0%	16.6%	18.4%	17.5%	**16.4%**	Meets/Better							
Age Adjusted Rate of Suicides per 100,000 Adjusted Population, 2017-2019				10.4	N/A	9.9	8.2	**7.0**	Worse		X					
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	50.0%	0.0%	
Other Indicators																
Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, 2017-2019	0	0	0	0.0*	8.1*	**7.3**	6.0	N/A	Less than 10							
Rate of Self-inflicted injury Hospitalizations 10,000 Population, 2017-2019	41	59	49	8.1	6.1	**4.4**	3.7	N/A	Worse				X			
Rate of Self-inflicted injury Hospitalizations for Ages 15 - 19 per 10,000 Population, 2017-2019	7	10	8	24.4	17.0	**10.3**	9.0	N/A	Worse				X			
Rate of Cirrhosis Deaths per 100,000 Population, 2017-2019	6	9	9	13.0	15.3	**10.1**	8.4	N/A	Worse		X					
Rate of Alcohol-Related Crashes per 100,000, 2020				75.9	66.4	**52.0**	40.1	N/A	Worse		X					
Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2020				34.7	28.7	**28.8**	23.3	N/A	Worse	X						
Quartile Summary for Other Indicators										1	2	0	2	83.3%	40.0%	
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										1	3	0	2	75.0%	33.3%	
Other Non-Prevention Agenda Indicators																
Rate of Hepatitis A Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.4*	**1.4**	1.3	N/A	Less than 10							

Rate of Acute Hepatitis B Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.3*	**0.4**	0.4	N/A	Less than 10						
Rate of TB Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.6*	**1.7**	3.9	N/A	Less than 10						
Rate of E. Coli Shiga Toxin Cases per 100,000 Population, 2017-2019	0	5	2	3.8*	3.0	**3.1**	4.1	N/A	Less than 10						
Rate of Salmonella Cases per 100,000 Population, 2017-2019	4	9	5	9.8	11.1	**12.9**	14.0	N/A	Meets/Better						
Rate of Shigella Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.5*	**3.4**	6.3	N/A	Less than 10						
Rate of Lyme Disease Cases per 100,000 Population, 2017-2019	86	55	143	154.1	118.1	**70.7**	44.7	N/A	Worse		X				
Rate of Confirmed Rabies Cases per 100,000 Population, 2020				9.8	3.4*	**3.1**	1.8	N/A	Worse				X		
Quartile Summary for Non-Prevention Agenda Issues										0	1	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[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4		
Focus Area: Disparities															
Prevention Agenda Indicators															
Percentage of Overall Premature Deaths (before age 65 years), 2019				18.6%	22.1%	21.0%	22.7%	**22.8%**	Meets/Better						
Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2019				6.5+	N/A	20.2	17.7	**17.3**	Less than 10						
Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2019				8.2+	N/A	21.1	16.4	**16.2**	Less than 10						
Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2019				94.8	142.52	120.4	125.9	**115.0**	Meets/Better						
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2019				54.3	N/A	128.4	115.8	**94**	Meets/Better						
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2019				-74.0	N/A	1.0	34.6	**23.9**	Worse	X					
Percentage of Adults (Ages 18 - 64) with Health Insurance, 2019				95.8%	93.6%	94.00	92.5%	**97.0%**	Worse	X					
Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2018				89.2%	82.3%	82.0%	79.1%	**86.7%**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	25.0%	0.0%
Other Disparity Indicators															
Rate of Total Deaths per 100,000 Population, 2017-2019	1957	1966	1925	848.1	1,069.7	**916.2**	798.8	N/A	Meets/Better						
Rate of Emergency Department Visits per 10,000 Population, 2017-2019	51,398	52,719	52,815	2,275.8	4,694.3	**3,843.0**	4,134.7	N/A	Meets/Better						
Rate of Total Hospitalizations per 10,000 Population, 2017-2019	22,089	21,912	21,799	954.2	981.2	**1,144.2**	1,154.8	N/A	Meets/Better						
Percentage of Adults Who Did Not Receive Medical Care Due to Costs, 2018				6.1%	9.6%	**9.2%**	11.0%	N/A	Meets/Better						
Percentage of adults reporting 14 or more days of poor physical health, 2018				10.5%	13.0%	**11.1%**	11.2%	N/A	Meets/Better						
Percentage of adults living with a disability (based on 6 ACA disability questions), 2018				21.2%	29.2%	**24.6%**	26.2%	N/A	Meets/Better						
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%
Quartile Summary for Mortality										2	0	0	0	14.3%	0.0%
Focus Area: Injuries, Violence, and Occupational Health															
Prevention Agenda Indicators															
Rate of Hospitalizations due to falls among adults per 10,000 population, aged 65+, 2019				200.3	165.2	210.4	193.9	**173.7**	Worse	X					
Rate of Assault-Related Hospitalizations per 10,000 Population, 2019				1.10	1.00	2.2	3.1	**3.0**	Meets/Better						
Ratio of Rates of Assault-related hospitalizations between Black non-Hispanics and White non-Hispanics, 2019				N/A	N/A	5.6	5.1	**5.5**	Less than 10						
Ratio of Rates of Assault-related hospitalizations, between Hispanics and White non-Hispanics, 2019				N/A	N/A	1.8	2.4	**2.5**	Less than 10						
Ratio of Rates of Assault-Related Hospitalizations for Low-Income ZIP codes and Non-Low Income Zip Codes, 2019				N/A	N/A	3.0	2.8	**2.7**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	20.0%	0.0%

Other Indicators															
Falls hospitalization rate per 10,000 - Aged <10 years, 2017-2019	17	13	16	6.3	5.5	**6.2**	6.8	N/A	Worse	X					
Falls hospitalization rate per 10,000 - Aged 10-14 years, 2017-2019				5.0	2.6*	**3.4**	4.0	N/A	Worse		X				
Falls hospitalization rate per 10,000 - Aged 15-24 years, 2017-2019	12	18	11	5.0	2.9	**4.0**	4.4	N/A	Worse	X					
Falls hospitalization rate per 10,000 - Aged 25-64 years, 2017-2019	201	241	256	18.9	18.5	**19.7**	18.8	N/A	Meets/Better						
Rate of Violent Crimes per 100,000 Population, 2020				95.4	157.0	**204.7**	364.9	N/A	Meets/Better						
Rate of Property Crimes per 100,000 Population, 2020				868.8	1,056.8	**1,292.1**	1,406.5	N/A	Meets/Better						
Rate of Total Crimes per 100,000 Population, 2020				964.2	1,213.9	**1,496.8**	1,771.4	N/A	Meets/Better						
Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, 2016-2018				1.2*	1.2*	**1.4**	1.1	N/A	Less than 20						
Rate of Pneumoconiosis Hospitalizations, Ages 15 and older, per 100,000 Population, 2017-2019	12	14	16	7.3	9.4	**9.0**	6.6	N/A	Meets/Better						
Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2017-2019				6.4	0.8	**0.8**	5.7	N/A	Less than 10						
Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, 2017-2019	141	117	116	108.9	138.1	**175.8**	145.9	N/A	Meets/Better						
Rate of Total Motor Vehicle Crashes per 100,000, 2020				2,013.0	2,298.7	**2,157.0**	1,693.1	N/A	Meets/Better						
Rate of Speed-Related Accidents per 100,000 Population, 2020				191.1	260.2	**205.7**	146.0	N/A	Meets/Better						
Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2020				7.8	7.2	**6.6**	5.3	N/A	Worse	X					
Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2017-2019	222	184	190	8.6	6.4	**9.0**	8.5	N/A	Meets/Better						
Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	822	972	1075	231.7	210.3	**275.1**	249.9	N/A	Meets/Better						
Rate of Poisoning Hospitalizations per 10,000 Population, 2017-2019	121	143	139	5.8	6.7	**7.6**	8.0	N/A	Meets/Better						
Quartile Summary for Other Indicators										3	1	0	0	23.5%	0.0%
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										4	1	0	0	22.7%	0.0%
Focus Area: Outdoor Air Quality															
Prevention Agenda Indicators															
Annual number of days with air quality index >100 (unhealthy levels of ozone or particulate matter), 2021				N/A	N/A	N/A	20	**3**	Less than 10						
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%
Focus Area: Built Environment															
Prevention Agenda Indicators															
Percentage of population living in a certified Climate Smart Community, 2021				12.1%	17.5%*	54.2%	31.3%	**8.6%**	Meets/Better						
Percentage of people who commute to work using alternate modes of transportation or who telecommute, 2015-2019				16.2%	17.4%	22.9%	45.6%	**47.9%**	Worse			X			
Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				4.0%	6.0%	**3.9%**	2.2%	N/A	Worse	X					
Quartile Summary for Focus Area Built Environment										1	0	1	0	66.7%	50.0%
Focus Area: Water Quality															
Prevention Agenda Indicators															
Percentage of residents served by community water systems that have optimally fluoridated water, 2019				40.6%	25.2%	46.9%	71.1%	**77.5%**	Worse		X				
Quartile Summary for Focus Area Water Quality										0	1	0	0	100.0%	0.0%
Quartile Summary for Focus Area Air Quality, Built Enviroment, Water Qaulity										1	1	1	0	60.0%	33.3%
Focus Area: Reduce Obesity in Children and Adults															
Prevention Agenda Indicators															
Percentage of Adults Ages 18 Plus Who are Obese, 2018				30.1%	34%	29.1%	27.6%	**24.2%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	100.0%	0.0%

Other Indicators															
Percentage of Total Students Overweight, 2018-2019				17.0%	17.5%	**16.9%**	N/A	N/A	Worse	X					
Percentage of Elementary Students Overweight, Not Obese, 2018-2019				15.8%	17.2%	**16.1%**	N/A	N/A	Meets/Better						
Percentage of Elementary Student Obese, 2018-2019				11.7%	19.4%	**16.6%**	N/A	N/A	Meets/Better						
Percentage of Middle and High School Students Overweight, Not Obese, 2018-2019				18.5%	17.4%	**17.8%**	N/A	N/A	Worse	X					
Percentage of Middle and High School Students Obese, 2018-2019				16.3%	25.3%	**19.5%**	N/A	N/A	Meets/Better						
Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC, 2015-2017				15.7%	16.1%	**15.5%**	13.8%	N/A	Worse	X					
Percentage of adults overweight or obese, 2018				68.8%	69.1%	**64.2%**	62.7%	N/A	Worse	X					
Percentage of adults who participated in leisure time physical activity in the past 30 days, 2018				86.0%	73.3%	**77.6%**	76.2%	N/A	Meets/Better						
Number of Recreational and Fitness Facilities per 100,000 Population, 2016				14.9	8.8	**13.2**	12.3	N/A	Meets/Better						
Percentage of adults who had a test for high blood sugar or diabetes within the past three years, 2018				48.8%	49.1%	**48.6%**	51.1%	N/A	Meets/Better						
Rate of Cardiovascular Disease Deaths per 100,000 Population, 2017-2019	600	586	583	256.5	309.6	**295.9**	278.3	N/A	Meets/Better						
Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	69	79	68	75.4	123.3	**102.4**	104.2	N/A	Meets/Better						
Rate of Cardiovascular Disease Pretransport Deaths per 100,000 Population, 2017-2019	355	368	375	159.2	184.7	**179.5**	163.6	N/A	Meets/Better						
Rate of Cardiovascular Hospitalizations per 10,000 Population, 2017-2019	3,037	3,073	3,208	135.1	141.4	**161.7**	155.2	N/A	Meets/Better						
Rate of Diseases of the Heart Deaths per 100,000 Population, 2017-2019	448	448	441	193.9	240.1	**234.0**	169.4	N/A	Meets/Better						
Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	52	60	52	57.3	100.9	**82.4**	83.9	N/A	Meets/Better						
Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, 2017-2019	272	303	296	126.3	149.1	**147.2**	138.7	N/A	Meets/Better						
Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2017-2019	2007	2062	2213	91.1	97.5	**111.2**	84.2	N/A	Meets/Better						
Rate of Coronary Heart Diseases Deaths per 100,000 Population, 2017-2019	265	260	279	116.6	155.2	**162.4**	173.4	N/A	Meets/Better						
Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	32	29	30	31.8	69.6	**59.7**	66.4	N/A	Meets/Better						
Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, 2017-2019	158	184	188	76.9	100.8	**106.6**	112.4	N/A	Meets/Better						
Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2017-2019	639	604	645	27.4	29.1	**32.9**	31.5	N/A	Meets/Better						
Rate of Congestive Heart Failure Deaths per 100,000, 2017-2019	29	37	42	15.7	19.1	**22.3**	15.1	N/A	Meets/Better						
Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	2	5	0	2.4*	4.2*	**3.2**	2.4	N/A	Less than 10						
Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, 2017-2019	20	20	32	10.4	12.2	**13.7**	8.7	N/A	Meets/Better						
Rate of Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019	554	573	615	31.6	38.8	**69.4**	41.3	N/A	Meets/Better						
Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, 2017-2019	102	92	82	40.0	41.5	**38.2**	31.5	N/A	Worse	X					
Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2017-2019	583	620	598	26.1	23.7	**28.2**	26.6	N/A	Meets/Better						
Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019	44	42	52	2.5	2.7	**5.9**	7.3	N/A	Meets/Better						
Rate of Diabetes Deaths per 100,000 Population, 2017-2019	39	43	56	20.0	33.0	**22.5**	22.5	N/A	Meets/Better						
Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2017-2019	276	293	311	12.8	18.9	**18.9**	21.4	N/A	Meets/Better						
Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2017-2019	4418	4620	4580	197.5	238.0	**252.0**	262.7	N/A	Meets/Better						

Quartile Summary for Other Indicators	5	0	0	0	15.6%	0.0%
Quartile Summary for Focus Area Reduce Obesity in Children and Adults	6	0	0	0	18.2%	0.0%

Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure															
Prevention Agenda Indicators															
Percentage of Adults Ages 18 Plus Who Smoke, 2018				12.8%	19.5%	13.9%	12.8%	**11.0%**	Worse	X					
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	100.0%	0.0%
Other Indicators															
Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, 2017-2019	127	127	128	55.4	76.6	**48.3**	36.7	N/A	Worse	X					
Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2017-2019	671	495	505	24.2	32.5	**28.7**	29.7	N/A	Meets/Better						
Rate of Asthma Deaths per 100,000 Population, 2017-2019	1	2	2	0.7*	0.7*	**0.9**	1.4	N/A	Less than 10						
Rate of Asthma Hospitalizations per 10,000 Population, 2017-2019	70	62	70	2.9	3.1	**6.2**	9.8	N/A	Meets/Better						
Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2017-2019	8	11	17	2.1	2.4	**4.2**	5.0	N/A	Meets/Better						
Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2017-2019	29	18	12	2.9	2.9	**5.2**	8.8	N/A	Meets/Better						
Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2017-2019	15	12	13	3.2	3.9	**4.9**	9.3	N/A	Meets/Better						
Percentage of adults with current asthma, 2018				13.7%	13.5%	**10.6%**	10.1%	N/A	Worse		X				
Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, 2016-2018	142	108	140	56.8	65.0	**48.1**	39.6	N/A	Worse	X					
Rate of Lung and Bronchus Cancer Cases per 100,000 Population, 2016-2018	215	207	231	95.1	119.0	**87.6**	72.6	N/A	Worse	X					
Number of Registered Tobacco Vendors per 100,000 Population, 2016-2017				89.0	132.7	**104.4**	110	N/A	Meets/Better						
Tobacco Sales to Minors Violations per 100,000 Population, 2016-2017				2.2	4.0*	**4.0**	6.6	N/A	Meets/Better						
Percentage of Vendors with Complaints per 100,000 Population, 2016-2017				0.0	0.0*	**0.0***	1.1	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										4	1	0	0	35.7%	0.0%

Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings															
Prevention Agenda Indicators															
Asthma emergency department visits, rate per 10,000, aged 0-17 years, 2019				21.3	42.3	57.5	99.9	**131.1**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%
Other Indicators															
Asthma emergency department visit rate per 10,000 - aged 18-64 years, 2017-2019				12.9	41.4	**39.0**	63.3	N/A	Meets/Better						
Asthma emergency department visit rate per 10,000 - aged 65+ years, 2017-2019				5.6	16.0	**14.8**	28.2	N/A	Meets/Better						
Rate of All Cancer Cases per 100,000 Population, 2016-2018	1553	1565	1544	679.0	710.8	**657.0**	587.7	N/A	Worse	X					
Rate of all Cancer Deaths per 100,000 Population, 2016-2018	473	469	462	204.5	232.6	**194.7**	175.5	N/A	Worse	X					
Rate of Female Breast Cancer Cases per 100,000 Female Population, 2016-2018	220	215	223	189.8	176.3	**180.1**	164.6	N/A	Worse	X					
Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, 2016-2018	62	67	58	53.9	48.6	**50.9**	49.3	N/A	Worse	X					
Rate of Female Breast Cancer Deaths per 100,000 Female Population, 2016-2018	31	24	34	25.7	24.9	**26.3**	25.1	N/A	Meets/Better						
Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines, 2018				88.3%	80.4%	**80.9%**	82.1%	N/A	Meets/Better						
Rate of Cervix Uteri Cancer Incidence per 100,000, 2016-2018				5.8	8.9	**7.1**	8.3	N/A	Meets/Better						
Rate of Cervix and Uteri Cancer Deaths per 100,000 Female Population, 2016-2018				N/A	6.2*	**2.2**	2.5	N/A	Less than 20						
Percentage of women aged 21-65 years receiving cervical cancer screening based on recent guidelines, 2018				96.4%	87.2%	**86.1%**	84.7%	N/A	Meets/Better						

Rate of Ovarian Cancer Cases per 100,000 Female Population, 2016-2018	14	18	6	11.0	14.8	**15.2**	14.2	N/A	Meets/Better							
Rate of Ovarian Cancer Deaths per 100,000 Female Population, 2016-2018	12	11	6	8.4	8.8	**9.3**	8.7	N/A	Meets/Better							
Rate of Colon and Rectal Cancer incidence per 100,000 Population, 2016-2018	108	117	114	49.4	54.2	**48.8**	45.7	N/A	Worse	X						
Rate of Colon and Rectal Cancer Deaths per 100,000 Population, 2016-2018	41	42	42	18.2	19.8	**15.7**	15.1	N/A	Worse	X						
Rate of Prostate Cancer Deaths per 100,000 Male Population, 2016-2018	18	26	22	19.4	22.1	**18.9**	18.5	N/A	Worse	X						
Rate of Prostate Cancer Incidence per 100,000 Male Population, 2016-2018	185	181	239	178.0	166.2	**174.9**	158.7	N/A	Worse	X						
Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, 2016-2018	43	35	56	39.4	38.3	**33.3**	30.5	N/A	Worse	X						
Rate of Melanoma Cancer Deaths per 100,000 Population, 2016-2018	9	8	12	4.2	3.6	**2.7**	2.1	N/A	Worse			X				
Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, 2018-2020	11,181	11,026	8,936	27.8%	26.0%	**27.7%**	26.9%	N/A	Meets/Better							
Percentage of adults who had a dentist visit within the past year, 2018				77.2%	63.8%	**71.6%**	69.8%	N/A	Meets/Better							
Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, 2016-2018				5.8*	5.0*	**4.7**	4.6	N/A	Less than 20							
Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, 2016-2018	48	41	47	19.8	17.4	**16.3**	14.1	N/A	Worse	X						
Quartile Summary for Other Indicators										10	0	1	0	47.8%	9.1%	
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										10	0	1	0	45.8%	9.1%	
Focus Area: Maternal and Infant Health																
Prevention Agenda Indicators																
Percentage of births that are preterm, 2019				8.2%	9.4%	9.3%	9.2%	**8.3%**	Meets/Better							
Percentage of Black, non-hispanic births that are pre-term, 2019				N/A	N/A	N/A	13.2%	**8.30**	Less than 10							
Percentage of Hispanic births that are pre-term, 2019				N/A	N/A	N/A	10.1%	**8.30**	Less than 10							
Percentage of births that are pre-term on Medicaid, 2019				N/A	N/A	N/A	9.6%	**8.30**	Less than 10							
Rate of Maternal Mortality per 100,000 Births, 2017-2019				16.1*	0.0*%	18.8	19.3	**16.0**	Less than 10							
Percentage of infants who are exclusively breastfed in the hospital among all infants, 2019				70.8%	65.8%	49.6%	47.1%	**51.7%**	Meets/Better							
Percentage of Black, non-hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10							
Percentage of Hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	35.7%	**51.7**	Less than 10							
Percentage of Infants Exclusively Breastfed in Delivery Hospital on Medicaid Insurance, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10							
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%	
Other Indicators																
Percentage Preterm Births < 32 weeks of Total Births, 2017-2019	22	25	28	1.2%	1.3%	**1.5%**	1.5%	N/A	Meets/Better							
Percentage Preterm Births 32 to < 37 Weeks of Total Births, 2017-2019	159	113	139	6.6%	7.8%	**7.6%**	7.6%	N/A	Meets/Better							
Percentage of very low birthweight Less Than 1,500 grams, 2017-2019	24	16	23	1.0%	1.1%	**1.3%**	1.4%	N/A	Meets/Better							
Percentage of Singleton Births with Weights Less Than 1,500 grams, 2017-2019	14	16	11	0.7%*	0.9%	**1.0%**	1.0%	N/A	Worse	#VALUE!	#VALUE!	#VALUE!	#VALUE!			
Percentage of Total Births with Weights Less Than 2,500 grams, 2017-2019	150	120	128	6.4%	7.7%	**7.7%**	8.1%	N/A	Meets/Better							
Percentage of Singleton Births with weight less than 2,500 grams, 2017-2019	101	94	84	4.7%	6.0%	**5.9%**	6.3%	N/A	Meets/Better							
Percentage of low birthweight births (< 2.5 kg) for Black, Non-Hispanic, 2016-2018				5.4%*	N/A	**13.2%**	12.6%	N/A	Less than 10							
Percentage of low birthweight births (< 2.5 kg) for Hispanic/Latino, 2016-2018				8.6%	N/A	**7.9%**	8.1%	N/A	Worse	X						

Infant Mortality Rate per 1,000 Live Births- Infant (<1 year), 2017-2019	8	9	5	3.5	5.1	**4.8**	4.4	N/A	Meets/Better							
Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, 2017-2019	8	9	5	3.5	4.9	**5.1**	5.1	N/A	Meets/Better							
Percentage of births with early (1st trimester) prenatal care, 2017-2019	1676	1584	1579	78.7%	77.8%	**78.4%**	76.3%	N/A	Meets/Better							
Percentage of births with adequate prenatal care (APNCU) for Black, Non-Hispanic, 2016-2018				78.3%	N/A	**68.4%**	66.1%	N/A	Meets/Better							
Percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino, 2016-2018				74.8%	N/A	**70.9%**	71.1%	N/A	Meets/Better							
Percentage of births with a 5 minute APGAR <6, 2017-2019	29	24	23	1.2%	1.4%	**0.8%**	0.7%	N/A	Worse		X					
Percentage WIC Women Breastfeeding for at least 6 months, 2015-2017				26.6%	24.6%	**30.6%**	41.0%	N/A	Worse	X						
Percentage Infants Fed Any Breast Milk in Delivery Hospital, 2017-2019	1745	1676	1689	88.3%	79.8%	**84.2%**	88.5%	N/A	Meets/Better							
Quartile Summary for Other Indicators										2	1	0	0	18.8%	0.0%	
Quartile Summary for Focus Area Maternal and Infant Health										2	1	0	0	12.0%	0.0%	
Focus Area: Preconception and Reproductive Health																
Prevention Agenda Indicators																
Percentage of Women Ages 18- 64 with Health Insurance, 2019				N/A	N/A	N/A	94.0%	**97.0%**	Less than 10							
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%	
Other Indicators																
Rate of Total Births per 1,000 Females Ages 15-44, 2017-2019	2,145	2,025	2,052	50.6	53.1	**57.1**	57.5	N/A	Meets/Better							
Percent Multiple Births of Total Births, 2017-2019	97	56	92	3.9%	3.4%	**3.7%**	3.5%	N/A	Worse	X						
Percent C-Sections to Total Births, 2017-2019	707	655	677	32.8%	32.2%	**34.2%**	33.6%	N/A	Meets/Better							
Rate of Total Pregnancies per 1,000 Females Ages 15-44, 2017-2019	2,513	2,395	2,494	60.2	64.0	**72.3**	79.7	N/A	Meets/Better							
Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, 2017-2019	0	0	0	0.0*	0.1*	**0.1**	0.1	N/A	Less than 10							
Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, 2017-2019	13	2	6	1.7	5.7	**4.7**	4.9	N/A	Meets/Better							
Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	39	24	34	12.0	30.2	**20.1**	21.5	N/A	Meets/Better							
Rate of Teen pregnancy per 1,000 females aged <18 years, 2017-2019	21	10	14	1.4	3.7	**3.7**	4.7	N/A	Meets/Better							
Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	52	49	58	19.6	42.4	**32.8**	41.1	N/A	Meets/Better							
Percent Total Births to Women Ages 35 Plus, 2017-2019	483	476	541	24.1%	13.9%	**22.3%**	24.5%	N/A	Worse	X						
Ratio+ of Abortions All Ages per 1000 Live Births to All Mothers, 2017-2019	291	286	340	147.4	N/A	N/A	**333.1**	N/A	Meets/Better							
Percentage of WIC Women Pre-pregnancy Underweight (BMI less than 18.5), 2015-2017	28	28	23	4.9%	4.7%	**3.9%**	4.6%	N/A	Worse		X					
Percentage of WIC Women Pre-pregnancy Overweight but not Obese (BMI 25 >30), 2015-2017	169	127	118	25.4%	23.1%	**27.1%**	27.6%	N/A	Meets/Better							
Percentage of WIC Women Pre-pregnancy Obese (BMI > 30),2015-2017	171	178	177	32.3%	35.8%	**31.1%**	26.6%	N/A	Worse	X						
Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, 2015-2019	295	252	227	51.7%	51.9%	**45.7%**	41.0%	N/A	Worse	X						
Percentage of WIC Women with Gestational Diabetes, 2015-2017	36	33	36	6.9%	8.2%	**6.6%**	6.6%	N/A	Worse	X						
Percentage of WIC Women with Gestational Hypertension, 2015-2017	62	68	56	12.3%	13.1%	**9.0%**	7.5%	N/A	Worse		X					
Quartile Summary for Other Indicators										5	2	0	0	41.2%	0.0%	
Quartile Summary for Focus Area Preconception and Reproductive Health										5	2	0	0	38.9%	0.0%	
Focus Area: Child Health																
Other Indicators																

Percentage of children with recommended number of well child visits in government sponsored insurance programs, 2019				79.0%	74.1%	**73.3%**	75.2%	N/A	Meets/Better						
Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, 2017-2019	1	0	0	3.5*	25.1*	**18.9**	17.7	N/A	Less than 10						
Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, 2017-2019	9	5	0	33.2*	32.5	**31.3**	30.1	N/A	Worse	#VALUE!	#VALUE!	#VALUE!	#VALUE!		
Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019	7	8	18	9.4	10.8	**24.9**	35.6	N/A	Meets/Better						
Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2017-2019				2.6	3.4	**9.4**	16.6	N/A	Meets/Better						
Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2017-2019	11	18	26	4.0	4.9	**12.4**	20.3	N/A	Meets/Better						
Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				2.3*	4.3	**7.5**	10.4	N/A	Less than 10						
Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				N/A	1.6*	**1.5**	1.8	N/A	Less than 10						
Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019	17	15	6	10.8	18.3	**20.3**	25.2	N/A	Meets/Better						
Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				41.4	65.5	**105.9**	186.4	N/A	Meets/Better						
Percentage of Children born in 2016 Screened for Lead by Age 0-8 months, 2016				1.3%	2.4%	**1.2%**	1.7%	N/A	Meets/Better						
Percentage of Children Born in 2016 Screened for Lead by Age 9-17 months, 2016				84.4%	81.7%	**73.0%**	75.6%	N/A	Meets/Better						
Percentage of Children Born 2016 Screened for Lead by Age 36 months (at least two screenings), 2016				73.1%	63.7%	**57.8%**	63.3%	N/A	Meets/Better						
Rate of Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) Per 1,000 tested children aged <72 months, 2017-2019	8	7	13	2.4	8.5	**6.6**	3.8	N/A	Meets/Better						
Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2017-2019	38	30	32	13.6	12.9	**17.7**	18.4	N/A	Meets/Better						
Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2017-2019	15	17	20	13.1	8.9	**12.7**	13.2	N/A	Worse	X					
Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2017-2019	70	53	47	20.6	17.7	**23.1**	22.6	N/A	Meets/Better						
Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				21.9	51.3	**68.1**	137.1	N/A	Meets/Better						
Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, 2018-2020	6,448	6,443	5,800	52.5%	49.3%	**47.9%**	46.9%	N/A	Meets/Better						
Percentage of 3rd Graders with Dental Caries Experience, 2009-2011				27.6%	N/A	N/A	N/A	N/A	No comparison data available						
Percentage of 3rd Graders with Dental Sealants, 2009-2011				34.8%	N/A	N/A	N/A	N/A	No comparison data available						
Percentage of 3rd Graders with Dental Insurance, 2009-2011				92.4%	85.2%	N/A	N/A	N/A	Meets/Better						
Percentage of 3rd Graders with at Least One Dental Visit, 2009-2011				83.6%	**81.0%**	N/A	N/A	N/A	Meets/Better						
Percentage of 3rd Graders Taking Fluoride Tablets Regularly, 2009-2011				47.9%	N/A	N/A	N/A	N/A	No comparison data available						
Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2017-2019	40	54	56	66.8	228.2	**146.7**	146.4	N/A	Meets/Better						
Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, 2015-2017				95.8%	85.4%	**84.9%**	86.6%	N/A	Meets/Better						
Quartile Summary for Other Indicators										1	0	0	0	3.8%	0.0%
Quartile Summary for Focus Area Child Health										1	0	0	0	3.8%	0.0%
Focus Area: Human Immunodeficiency Virus (HIV)															
Prevention Agenda Indicators															
Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2017-2019				1.7*	4.3*	5.7	13.1	**5.2**	Less than 10						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%

Other Indicators															
AIDS Deaths per 100,000, 2017-2019	0	1	1	.3*	0.4*	**0.9**	2.2	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%

Focus Area: Sexually Transmitted Disease (STDs)															
Prevention Agenda Indicators															
Early syphilis diagnoses, age-adjusted rate per 100,000 population, 2019				4.2*	3.71*	15.3	38.6	**79.6**	Less than 10						
Gonorrhea diagnoses, age-adjusted rate per 100,000 population, 2019				43.1	33.40	114.9	217	**242.6**	Meets/Better						
Chlamydia diagnoses, age-adjusted rate per 100,000 population, 2019				248.4	244.33	457.5	667.9	**676.9**	Meets/Better						
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%

Other Indicators																
Rate of Gonorrhea case rate per 100,000 males - Aged 15-44 years, 2017-2019	37	36	42	89.6	54.45	**267.8**	614.9	N/A	Meets/Better							
Gonorrhea case rate per 100,000 females - Aged 15-44 years, 2017-2019	27	25	36	71.6	88.72	**218.3**	252.5	N/A	Meets/Better							
Rate of Gonorrhea case rate per 100,000 - Aged 15-19 years, 2017-2019	5	12	9	61.7	73.15	**246.4**	401.5	N/A	Meets/Better							
Rate of Chlamydia Cases All Males Aged 15-44 years per 100,000 Male Population, 2017-2019	162	150	129	343.7	406.45	**41.2**	1,175.1	N/A	Worse				X			
Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, 2017-2019	38	36	12	400.9	466.03	**766.4**	1,142.6	N/A	Meets/Better							
Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, 2017-2019	62	53	63	844.8	945.09	**1,513.3**	2,107.1	N/A	Meets/Better							
Rate of Chlamydia Cases All Females Aged 15-44 years per 100,000 Female Population, 2017-2019	419	382	341	929.3	1118.40	**1,455.2**	1,741.1	N/A	Meets/Better							
Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population, 2017-2019	138	113	98	1,684.7	2006.20	**2,623.6**	3,535.7	N/A	Meets/Better							
Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population, 2017-2019	191	179	158	2,717.2	2740.07	**3,203.9**	3,912.5	N/A	Meets/Better							
Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population, 2017-2019				1.0	0.95*	**1.9**	2.5	N/A	Meets/Better							
Quartile Summary for Other Indicators										0	0	0	1	10.0%	100.0%	
Quartile Summary for Sexually Transmitted Diseases										0	0	0	1	7.7%	100.0%	
Focus Area: Vaccine Preventable Disease																
Prevention Agenda Indicators																
Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series, 2020				81.4%	68.2%	66.3%	66.1%	**70.5%**	Meets/Better							
Percentage of 13-year-old adolescents with a complete HPV vaccine series, 2020				29.4%	25.8%	32.8%	39.8%	**37.4%**	Worse		X					
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	50.0%	0.0%	
Other Indicators																
Rate of Pertussis Cases per 100,000 Population, 2017-2019	4	13	12	4.2	12.3	**5.0**	3.8	N/A	Meets/Better							
Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	273	375	321	78.3	87.7	**95.2**	85.5	N/A	Meets/Better							
Percentage of adults aged 65+ years with pneumococcal immunization, 2018				77.4%	70.0%	**69.4%**	64.0%	N/A	Meets/Better							
Rate of Mumps Cases per 100,000 Population, 2017-2019	33	4	1	5.5	1.4*	**1.3**	1.7	N/A	Worse				X			
Rate of Meningococcal Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.0*	**0.1**	0.1	N/A	Less than 10							
Rate of H Influenza Cases per 100,000 Population, 2017-2019	4	6	5	2.2	2.1	**2.3**	2.0	N/A	Meets/Better							
Quartile Summary for Other Indicators										0	0	0	1	16.7%	100.0%	
Quartile Summary for Focus Area Vaccine Preventable Diseases										0	1	0	1	25.0%	50.0%	
Focus Area: Healthcare Associated Infections																
Prevention Agenda Indicators																
Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days (Risk-adjusted), 2019				3.4	N/A	N/A	**4.0**	N/A	Meets/Better							
Rate of Community Onset, Healthcare Facility Associated CDIs per 100 Admissions, not risk-adjusted, 2019				0.1	N/A	N/A	**0.2**	N/A	Meets/Better							
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%	
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders																
Prevention Agenda Indicators																
Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2018				19.5%	16.6%	18.4%	17.5%	**16.4%**	Worse	X						
Age Adjusted Rate of Suicides per 100,000 Adjusted Population, 2017-2019				11.1	N/A	9.9	8.2	**7.0**	Worse			X				
Quartile Summary for Prevention Agenda Indicators										1	0	1	0	100.0%	50.0%	
Other Indicators																

Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, 2017-2019	2	1	0	7.1*	8.1*	**7.3**	6.0	N/A	Less than 10						
Rate of Self-inflicted injury Hospitalizations 10,000 Population, 2017-2019	84	115	102	4.4	6.1	**4.4**	3.7	N/A	Meets/Better						
Rate of Self-inflicted injury Hospitalizations for Ages 15 - 19 per 10,000 Population, 2017-2019	17	18	16	12.1	17.0	**10.3**	9.0	N/A	Worse	X					
Rate of Cirrhosis Deaths per 100,000 Population, 2017-2019	22	30	22	10.7	15.3	**10.1**	8.4	N/A	Worse	X					
Rate of Alcohol-Related Crashes per 100,000, 2020				58.2	66.4	**52.0**	40.1	N/A	Worse	X					
Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2020				23.9	28.7	**28.8**	23.3	N/A	Meets/Better						
Quartile Summary for Other Indicators										3	0	0	0	50.0%	0.0%
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										4	0	1	0	62.5%	20.0%
Other Non-Prevention Agenda Indicators															
Rate of Hepatitis A Cases per 100,000 Population, 2017-2019	2	0	1	0.4*	0.4*	**1.4**	1.3	N/A	Less than 10						
Rate of Acute Hepatitis B Cases per 100,000 Population, 2017-2019	0	0	1	0.1*	0.3*	**0.4**	0.4	N/A	Less than 10						
Rate of TB Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.6*	**1.7**	3.9	N/A	Less than 10						
Rate of E. Coli Shiga Toxin Cases per 100,000 Population, 2017-2019	4	2	3	1.3*	3.0	**3.1**	4.1	N/A	Less than 10						
Rate of Salmonella Cases per 100,000 Population, 2017-2019	9	19	22	7.3	11.1	**12.9**	14.0	N/A	Meets/Better						
Rate of Shigella Cases per 100,000 Population, 2017-2019	0	2	5	1.0*	0.5*	**3.4**	6.3	N/A	Less than 10						
Rate of Lyme Disease Cases per 100,000 Population, 2017-2019	316	192	208	103.8	118.1	**70.7**	44.7	N/A	Meets/Better						
Rate of Confirmed Rabies Cases per 100,000 Population, 2020				4.8	3.4*	**3.1**	1.8	N/A	Worse			X			
Quartile Summary for Non-Prevention Agenda Issues										0	0	1	0	12.5%	100.0%

N/A: Data does not meet reporting criteria
*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable
+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.
1: ARHN data not available when two or more counties do not have reported data

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	Diabetes	Unintentional Injury
Washington	Cancer	Heart Disease	Chronic Lower Respiratory Disease	Diabetes	Unintentional Injury
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), 2019 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		**27**	**34**	**3**
Mortality		**35**	**30**	**6**
Premature death	6000	6800	6700	4900
Morbidity		**16**	**43**	**1**
Poor or fair health	16%	15%	18%	13%
Poor physical health days	3.6	3.7	4.1	3.3
Poor mental health days	3.9	4.6	4.9	4.3
Low birthrate	8%	7%	7%	7%
Health Factors		**9**	**32**	**2**
Health Behaviors		**18**	**32**	**11**
Adult smoking	13%	17%	20%	15%
Adult obesity	27%	33%	32%	30%
Physical Inactivity	27%	26%	28%	23%
Excessive drinking	19%	23%	22%	24%
Alcohol-impaired driving deaths	20%	22%	17%	19%
Sexually transmitted infections	640.6	225.2	192.8	218.0
Teen births	13	14	22	6
Clinical Care		**3**	**35**	**4**
Uninsured	6%	4%	5%	4%
Primary care physicians	1180:1	850:1	2780:1	1430:1
Dentists	1190:1	1060:1	4660:1	1440:1
Mental Health Providers	310:1	250:1	670:1	500:1
Preventable hospital stays	3717	3365	3440	3323
Flu vaccinations	49%	50%	49%	56%
Mammography screening	43%	53%	46%	52%
Social & Economic Factors		**16**	**28**	**1**
High school graduation	87%	92%	88%	94%
Some college	70%	68%	55%	78%
Unemployment	10.0%	8.4%	7.2%	6.7%
Children in poverty	17%	14%	16%	6%
Income inequality	5.7	4.2	4.2	4.0
Children in single-parent households	26%	24%	22%	15%
Violent Crime rate	379	138	141	103
Physical Environment		**24**	**33**	**27**
Air pollution–particulate matter	6.9	7.2	7.2	7.7
Drinking water violations		No	No	No
Access to exercise opportunities	93%	98%	66%	92%
Severe Housing Problems	23%	14%	14%	11%

Source: Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute County Health Rankings 2022. Available at http://www.countyhealthrankings.org/