



ALBANY MED Health System

GLENS FALLS HOSPITAL

Community Service Plan

2025 - 2027

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Cover Page

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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Washington County Public Health

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Hudson Falls, NY 12839

Saratoga County Department of Health

Dr. Daniel Kuhles, Commissioner of Health
Rachel Maxwell, Director of Community Health Services
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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 2025 - 2030. 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. Glens Falls Hospital has been working with each hospital within the Albany Medical Health System. Each hospital in the system conducted separate, yet similar processes to determine their community's health 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 organization's 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 2025-2027:

Domain: Social and Community Context

- Priority: Mental Wellbeing and Substance Use
 - Tobacco/E-Cigarettes Use

Domain: Education Access and Quality

- Priority: PreK-12 Student Success and Educational Attainment
 - Health and Wellness Promoting Schools

Domain: Health Care Access and Quality

- Priority: Health Insurance Coverage and Access to Care
 - Preventative Services for Chronic Disease Prevention and Control
- Healthy Children
 - Preventative Services
 - Hearing Screening and Follow-up

It is important to note that GFH chose similar domain and priority areas as in the previous 2022-2024 CSP process. Continuing to focus on these areas will improve, strengthen and sustain the impact of our interventions.

Improving health status in the three 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 Albany Medical Health System, 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, Health Home, and the Adirondack ACO. 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 interventions below have checkmarks that are the selected priorities that are included in the formal DOH required Community Service Plan.

Community Service Plan 2025-2027



To ensure efficacy of the proposed interventions, GFH will work with Warren, Washington and Saratoga Public Health Departments, as well as Albany Medical Health System, 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.

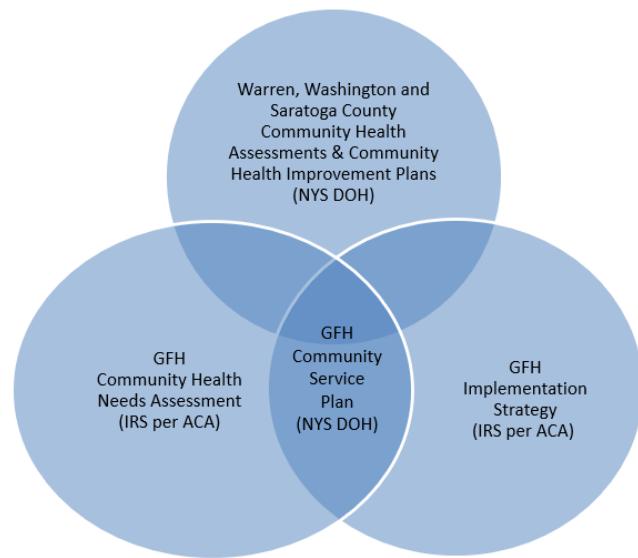
Introduction

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 Albany Medical Health System, and includes strategies that are evidence-based and aligned with the NYS Prevention Agenda 2025 - 2030. 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 and benefit of a community health assessment is to

develop strategies to address the community's health needs and identified issues¹. 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.



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 2,380 employees and a medical staff of over 563 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

¹ Centers for Disease Control and Prevention, Community Planning for Health Assessment: CHA & CHIP May 2024. Available at [Community Planning for Health Assessment: CHA & CHIP | Public Health Gateway | CDC](https://www.cdc.gov/healthpromotionandcommunity/technicalassistance/CommunityPlanningforHealthAssessment-CHA-CHIP.html)

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 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: **Collaboration, Accountability, Respect, Excellence and Safety**. 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.



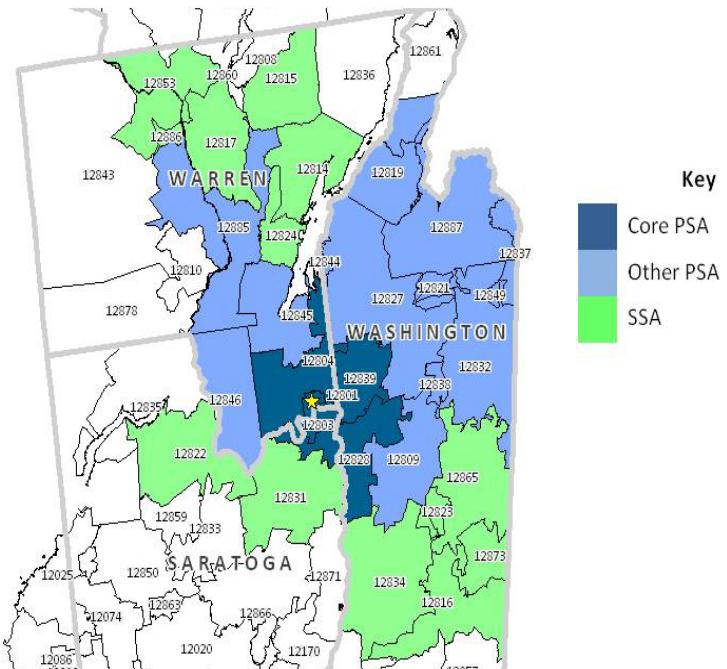
Glens Falls Hospital Service Area

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.

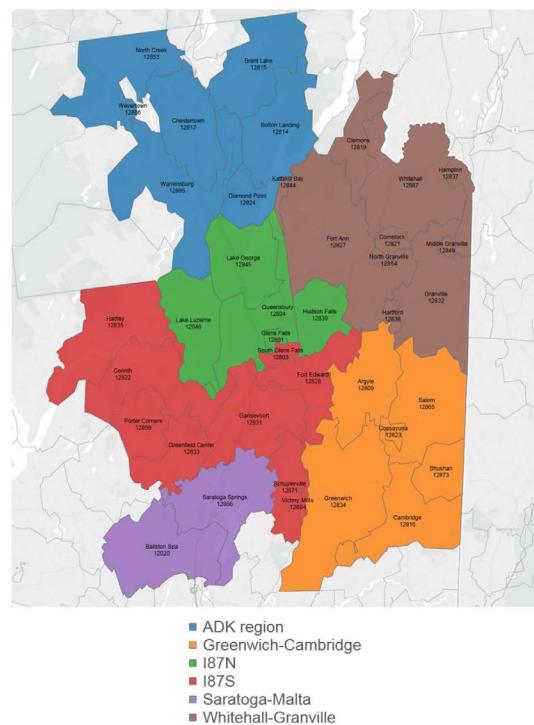
The GFH inpatient service area is defined by a Core Primary Service Area (PSA), Other Primary Service Area (Other PSA) and a Secondary Service Area (SSA). The Core PSA represents the ZIP codes immediately contiguous to the hospital. The SSA reflects more outlying areas where GFH has either a strong market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

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 recent analysis of 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.



GFH Inpatient Service Area



GFH Ambulatory Service Area

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).

Nearly 47% of total patient volume came from rural areas, mainly to the North, East and West of Glens Falls.

Health Care Transformation

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

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 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.

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.

Adirondack ACO: GFH continues its participation with the Adirondack ACO, serving a number of patients who are not covered by Medicare or Medicaid. Adirondack ACO is a coalition of North Country providers that brings together representatives from acute, primary, and behavioral health care, along with a regional health planning entity, a regional ACO, and community-based organizations. This collaborative partnership builds on ongoing health care transformation efforts and seeks to engage in future opportunities that promote quality and efficiency, expand supports and services tailored to the unique needs of individuals in the region, and strengthen communication and integration across systems. At the

core of these initiatives is the Triple Aim: improving care quality and patient experience while ensuring cost-effective delivery.

GFH is involved in two new projects for 2026:

Healthy Alliance: Healthy Alliance connects community members to a robust Social Care Network (SCN) composed of organizations of every size, all dedicated to delivering essential services that support healthier lives. Recognizing that health begins within our communities, Healthy Alliance collaborates across the entire health care ecosystem—from regional health systems and federally qualified health centers to grassroots providers of clothing, household goods, and more. Together, they address vital social needs such as food security, housing assistance, transportation, benefits navigation, and other supports before these challenges escalate into costly medical issues. As the official SCN lead entity for the Capital Region, Central New York, and the North Country under New York's 1115 Waiver Demonstration Amendment, known as New York Health Equity Reform (NYHER), Healthy Alliance coordinates 1,300 partner sites across 24 counties. Their mission is to ensure consistent access to resources so that every New Yorker has the same opportunity to achieve health. Beginning January 1, 2026, GFH will screen all patients for social determinants of health and coordinate services for those in need. This initiative will allow GFH to provide targeted screening and navigation for patients with the greatest needs.

Honest Health: Honest Health is the new REACH ACO that GFH will join to serve all Medicare Fee-for-Service patients. The program is designed to close gaps in care by emphasizing proactive screening and early detection through testing, helping to reduce the risk of future adverse clinical outcomes. In addition, it provides education and training for clinicians to code claims with the highest level of specificity, ensuring accurate patient risk scoring and better alignment of 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 2025-2030

The Prevention Agenda is New York State’s Health Improvement Plan (SHIP), a six-year initiative focused on advancing health and reducing disparities through a strong emphasis on prevention. It serves as a roadmap for coordinated action at both the state and local levels to improve the well-being of all New Yorkers.

The vision for the 2025–2030 Prevention Agenda is that every individual in New York, regardless of background or circumstance, has the opportunity to achieve their highest level of health throughout their life. The objectives outlined in the plan act as aspirational benchmarks for public health progress, guiding strategic planning and implementation by health departments, hospitals, and community organizations.

To support these goals, the Prevention Agenda offers hundreds of evidence-based interventions that organizations may choose to adopt. These strategies are optional, providing flexibility so communities can tailor approaches to their specific needs, resources, and priorities.

Together, the objectives and interventions are illustrative rather than exhaustive, representing examples of measures that can be leveraged to reduce health disparities and promote equity across New York State.

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:

- Domain: Economic Stability
 - Priority Area: Economic Wellbeing
 - Poverty
 - Unemployment
 - Nutrition Security
 - Housing Stability and Affordability
- Domain: Social and Community Context
 - Priority Area: Mental Wellbeing and Substance Use

- Anxiety and Stress
 - Suicide
 - Depression
 - Primary Prevention, Substance Misuse, and Overdose Prevention
 - Tobacco/E-Cigarette Use
 - Alcohol Use
 - Adverse Childhood Experiences
 - Healthy Eating
- Domain: Neighborhood and Built Environment
 - Priority Area: Safe and Healthy Communities
 - Opportunities for Active Transportation and Physical Activity
 - Access to Community Services and Support
 - Injuries and Violence
- Domain: Health Care Access and Quality
 - Priority Area: Health Insurance Coverage and Access to Care
 - Access to and Use of Prenatal Care
 - Prevention of Infant and Maternal Mortality
 - Preventive Services for Chronic Disease Prevention and Control
 - Oral Health Care
 - Priority Area: Healthy Children
 - Preventive Services
 - Immunization
 - Hearing Screening and Follow Up
 - Lead screening
 - Early Intervention
 - Childhood Behavioral Health
- Domain: Education Access and Quality
 - Priority Area: PreK-12 Student Success and Educational Attainment
 - Health and Wellness Promoting Schools
 - Opportunities for Continued Education

Appendix C is attached for more detail on the 2025-2030 Prevention Agenda. In addition, more information on the Prevention Agenda can be found at

[Prevention Agenda 2025-2030: New York State's Health Improvement Plan](#)

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. 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. Saratoga Hospital and Glens Falls Hospital are also part of the Albany Medical Health System.

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.

Once the assessment process was complete for Warren and Washington county, 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.

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 tool that presents tracking indicator data at both the state and county levels. It serves as a central resource for monitoring community progress toward achieving the Prevention Agenda 2025–2030 objectives. The state dashboard homepage provides a snapshot of the most current data for New York State, covering approximately 100 tracking indicators. Each indicator's performance is assessed by comparing current data with previous time periods, while historical trends are easily accessible. County-level data, including maps and bar charts, are also available for every tracking indicator.

The county dashboard homepage highlights the latest data for 70 tracking indicators, with each county in New York maintaining its own dashboard. As new information becomes available, the Prevention Agenda Dashboard will be updated to reflect the 2025–2030 priorities and indicators.

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 2022-2024 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 region³.

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 priority 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 nine times from January 2024 through January 2025. Meetings were held via Webex/Zoom. Attendance ranged from 6 to 11 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 February 7, 2025, 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

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.

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 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 Counties⁵

Warren, Washington, and Saratoga counties are part of the Capital Region, along with Albany, Columbia, Greene, Rensselaer, and Schenectady counties⁶. 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 attributes⁷. 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 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 County⁸

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 Harding Mazzotti 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 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 2024, Glens Falls Hospital continued to invest in the community through employee salaries and benefits, community benefit, and charity care:

- \$238 million in employee salaries, wages and benefits
- \$45 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 County⁹

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

Saratoga County¹⁰

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 racetrack, 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 for 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, Glens Falls Hospital 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 399 beds, and five adult care facilities, accounting for 278 beds, with rates per 100,000 of 610 and 648, respectively. The total physician rate is 347.2 per 100,000, higher than the ARHN region at 190 per 100,000.

Washington County

There are total of four nursing home facilities, accounting for 528 beds, and four adult care facilities, accounting for 152 beds, with rates per 100,000 of 867.7 and 221.7, respectively. The total physician rate is 47.6 per 100,000, significantly lower than the ARHN region at 190.2 per 100,000.

Saratoga County

Saratoga County has one hospital, Saratoga Hospital, with 171 hospital beds, resulting in a hospital bed rate per 100,000 of 71.6. There are two nursing home facilities, accounting for 462 beds, and nine adult care facilities, accounting for 495 beds, with rates per 100,000 of 193.5 and 293.2, respectively. The total physician rate is 270.6 per 100,000, which is lower than New York State.

Educational System

There are 33 school districts in Warren, Washington and Saratoga counties, with a total enrollment of approximately 47,279 students. Within Warren County, there are nine school districts, with a total enrollment of 7,919 students. Washington County has 12 school districts, with a total enrollment of 7,641 students and Saratoga County has 12 school districts, with a total enrollment of 31,719 students.

In Saratoga County 29% of enrolled students are eligible for free and reduced lunch, with majority eligible for free lunch (8,443 students) compared to Warren County where 42% are eligible for free and reduced lunch, with majority eligible for free lunch (3,147 students) and Washington County where 46% are eligible for free and reduced lunch, with majority eligible for free lunch (3,269 students) . The high school dropout rate is 9.0% in Warren County, 7.0% in Washington County and 4.0% in Saratoga County. The New York State dropout rate is 5.0%.

The student- teacher ratios in both Warren County (9.8 students per teacher) and Washington County (10.2 students per teacher) are comparable to ARHN region (9.6) and slightly lower than New York State (11.2). There are 11.7 students per teacher in Saratoga County, which is higher than the ARHN region (9.6) and New York State (11.2).

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.

| Demographic Profile | | | | | | |
|--|-----------|----------|------------|----------|----------|----------------|
| Adirondack Rural Health Network | | | | ARHN | Upstate | New York State |
| Summary of Demographic Information | Saratoga | Warren | Washington | | | |
| Square Miles | | | | | | |
| Total Square Miles | 810 | 867.2 | 831.2 | 8372.4 | 300.5 | 47123.6 |
| Total Square Miles for Farms | 39.5 | 0.79 | 121.7 | N/A | N/A | 4947.9 |
| Percent of Total Square Miles Farms | 4.90% | 0.10% | 14.60% | N/A | N/A | 10.50% |
| Population per Square Mile | 290.8 | 75.8 | 73.8 | 387.1 | N/A | 428.7 |
| Population | | | | | | |
| Total Population | 237075 | 65560 | 60883 | 347436 | 11313181 | 19571216 |
| Percent White, Non-Hispanic | 89.30% | 93.30% | 90.60% | 90.30% | 70.70% | 55.10% |
| Percent Black, Non-Hispanic | 1.60% | 1.30% | 2.50% | 2.40% | 8.70% | 14.30% |
| Percent Hispanic/Latino | 3.80% | 2.80% | 2.90% | 3.10% | 13.50% | 19.80% |
| Percent Asian, Native Hawaiian, Pacific Islander | 3.00% | 0.80% | 0.60% | 0.90% | 4.60% | 9.10% |
| Percent Alaskan Native/American Indian | 0.20% | 0.00% | 0.10% | 1.00% | 0.50% | 0.70% |
| Percent Two or more races | 4.80% | 4.10% | 4.20% | 4.10% | 9.00% | 10.50% |
| Poverty | | | | | | |
| Mean Household Income | \$123,673 | \$94,235 | \$86,922 | \$87,810 | N/A | \$122,227 |
| Per Capita Income | \$53,782 | \$43,718 | \$35,496 | N/A | N/A | \$48,847 |
| Percent of Individuals Under Federal Poverty Level | 6.70% | 9.10% | 10.80% | 12.60% | 11.10% | 13.70% |
| Percent of Individuals Receiving Medicaid | 15.00% | 22.50% | 27.60% | 25.90% | 21.9 | 27.4 |
| Education | | | | | | |
| Total Population Ages 25 and Older | 172398 | 49426 | 45248 | 254274 | 8040086 | 13996138 |
| Percent with Less than High School Education | 5.80% | 8.20% | 9.70% | 10.40% | 45.00% | 12.20% |
| Percent High School Graduate/GED | 24.40% | 28.00% | 39.90% | 33.70% | 61.70% | 24.60% |
| Percent Some College, no degree | 14.90% | 16.80% | 17.60% | 16.60% | 62.60% | 14.90% |
| | | | | | | |
| Percent Associates Degree | 11.20% | 12.50% | 11.60% | 12.70% | 69.10% | 8.90% |
| Percent Bachelor's Degree | 24.40% | 18.70% | 12.50% | 15.00% | 52.70% | 22.00% |
| Percent Graduate or Professional Degree | 19.40% | 15.90% | 8.70% | 11.50% | 56.00% | 17.50% |
| Employment Status | | | | | | |
| Total Population Ages 16 and Older | 199085 | 55611 | 51012 | 291048 | 9284447 | 16,085,030 |
| Total Population Ages 16 and Older in Armed Forces | 615 | 0 | 30 | 261 | 19215 | 23559 |
| Total Population Ages 16 and Older in Civilian labor force | 127,599 | 35,223 | 29998 | 168320 | 5736756 | 10083719 |
| Percent Unemployed | 1.60% | 1.60% | 3.20% | 2.10% | 4.40% | 5.20% |

*ARHN Region excludes Saratoga County

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

Sources:

U.S. Census Bureau, U.S. Department of Commerce. "Selected Economic Characteristics." American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP03, 2023

U.S. Census Bureau, U.S. Department of Commerce. "Selected Social Characteristics in the United States." American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP02, 2023

U.S. Census Bureau, U.S. Department of Commerce. "Medicaid/Means-Tested Public Coverage by Sex by Age." American Community Survey, ACS 5-Year Estimates Detailed Tables, Table C27007, 2023

U.S. Census Bureau, U.S. Department of Commerce. "Poverty Status in the Past 12 Months." American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1701, 2023

Over 360,000 people live within Warren, Washington and Saratoga counties. On average, the vast majority of the population is white, non-Hispanic (91%) and nearly one in three people has obtained a Bachelor's degree or higher level of education (33.2%).

Warren County

Spanning 867 square miles, the population of Warren County is 65,560, 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 93.3% of the population White, Non-Hispanic, followed by 2.8% Hispanic/Latino and 4.1% 2+ races. 23.5% of the population is aged 65 years and older, which is higher than both the ARHN region (21.1%) and Upstate New York (18.5%).

Mean household income is \$94,235, which is less than New York State (\$122,227). The per capita income is \$43,718. The percentage of individuals in Warren County living below the Federal Poverty Level is 9.1%, which is lower than both the ARHN region (12.6%) and Upstate New York* (11.1%).

When considering the total population of Warren County, approximately 75.5% of individuals are aged 25 years of age or older. Of that population, 28.0% are a High School Graduate or have their General Education Diploma (GED). An additional 47.1% have an Associates, Bachelor's, or higher education degree.

Warren County's unemployment rate is 1.6% with 35,223 employed aged 16 and older in the Civilian Workforce. The highest employment sector with 25.3% is the field of Education, Health Care and Social Assistance. This is followed by Other Professional Occupations (12.0%) and Arts, Entertainment, Recreation, Hotel & Food Service (11.2%).

Washington County

Spanning 831 square miles, the population of Washington County is 60,883. Like Upstate New York, Washington County's population is limited in its diversity. 90.6% of the population is White, Non-Hispanic, followed by 2.5% Hispanic/Latino and 4.2% 2+ races. 20.8% of the population is aged 65 years and older, which is higher than the ARHN region (21.1%) and Upstate New York region (18.5%).

Mean household income is \$86,922 and per capita income is \$35,496. These averages are less than New York State which are \$48,847. The percentage of individuals in Washington County living below the Federal Poverty Level is 10.8%, which is lower than the ARHN region (12.6%) and Upstate New York (11.1%).

When considering the total population of Washington County, approximately 74.3% of individuals are aged 25 years of age or older. Of that population, 39.9% are a High School Graduate or have their General Education Diploma (GED). An additional 32.8% have an Associates, Bachelor's, or higher education degree.

Washington County's unemployment rate is 3.2% with 29,998 employed aged 16 and older in the Civilian Workforce. The highest employment sector with 22.6% is the field of Education, Health Care and Social Assistance. This is followed by Retail Trade (13.4%) and Manufacturing (13.1%).

Saratoga County

Spanning 810 square miles, the population of Saratoga County is 237,075. Like Upstate New York*, Saratoga County's population is limited in its diversity. 89.3% of the population is White, Non-Hispanic, followed by 3.8% Hispanic/Latino and 4.8% 2+ races. 19.3% of the population is aged 65 years and older, which is lower than Upstate New York* (19.4%).

Mean household income is \$108,479 and per capita income is \$123,673. These averages are higher than AHRN which are \$87,810 and New York State \$122,227 respectively. The percentage of individuals in Saratoga County living below the Federal Poverty Level is 6.7%, which is lower than Upstate New York* (11.1%).

When considering the total population of Saratoga County, approximately 72.7% of individuals are aged 25 years of age or older. Of that population, 24.4% are a High School Graduate or have their General Education Diploma (GED). An additional 55% have an Associates, Bachelor's, or higher education degree.

Saratoga County's unemployment rate is 1.6% with 127,599 employed aged 16 and older in the Civilian Workforce. The highest employment sector with 24.6% is the field of Education, Health Care and Social Assistance. This is followed by Other professional Occupations (12.6%) and Manufacturing (11.0%).

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: [Prevention Agenda 2025-2030: New York State's Health Improvement Plan](#)
See Appendix H for a table of the NYS Prevention Agenda indicators and other indicators for Warren, Washington and Saratoga counties.

Economic Stability

Socioeconomic disparity is directly linked to adverse health outcomes, negatively affecting physical and socioemotional health as well as educational development. Unemployment and underemployment are significant public health challenges in NYS, contributing to critical issues within our communities.

Social and Community Context

Unrelenting anxiety and stress can increase the chances of poor mental health and lead to premature death. New York State has seen an increasing trend of frequent mental distress since 2016, though the rate declined to 14.2% in 2023 after peaking at 15.9% in 2022. Depression and anxiety remain significant mental health issues, but reported symptoms dropped by 40% between July 2023 and July 2024. These conditions continue to affect a substantial portion of the population, leading to considerable personal and economic challenges. Suicide, defined as death caused by self-injury with the intent to die, remains a major public health concern, though New York State has one of the lowest suicide rates in the nation, at about 6 deaths per 100,000 residents in 2024.

Cigarette smoking remains the leading preventable cause of morbidity and mortality in New York State (NYS) and in the United States. Smoking combustible cigarettes results in an estimated 480,000 deaths each year in the United States, and approximately 30,000 deaths in NYS. The list of illnesses caused by tobacco use includes 16 forms of cancer, heart disease, stroke, chronic obstructive pulmonary disease, other lung diseases and causes complications during pregnancy. Secondhand smoke exposure contributes to a long list of preventable illnesses and deaths also. Tobacco use in NYS causes unbelievable economic costs. Smoking-attributable health care costs are \$9.7 billion annually, including about \$4.7 billion on Medicaid and Medicare expenditures. Reducing tobacco use has the potential to save NYS taxpayers billions of dollars every year.

Approximately 1.4 million New Yorkers are current cigarette smokers. The prevalence of cigarette smoking among New York State adults in 2023 was 9.3%, marking the first time this rate has dropped below 10%. Smoking rates are highest among adults with less than a high school education (19.1%); those with an annual household income of less than \$25,000 (16.6%); those without health insurance (15.3%); adults with Medicaid (15.2%); disabled adults (14.2); and those reporting frequent mental distress (14.2%). For the first time since surveillance on cigarette smoking began, smoking rates are higher among women (10.9%) compared to men (7.8%). Smoking rates are highest among adults in the all-other race groups combined, non-Hispanic category (17.1%). Communities that are disproportionately targeted by the tobacco industry include African American and other racial and ethnic minorities; people who identify as lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ+); people living with mental illness and substance abuse disorders, and those who live in lower income communities.

(Cigarette Smoking; New York State Adults 2023-NYS BRFSS Number 2025-18)

Although combustible cigarette use remains low at 2.4%, one in six youth still use tobacco. Tobacco and nicotine use carries significant health risks for youth and young adults. Nicotine use during adolescence causes addiction and negatively affects brain development. Youth and young adult use of tobacco products consists primarily of e-cigarette use. While use of e-cigarettes/vaping among NYS youth has decreased since 2018, youth tobacco use in any form is a concern, and currently using any tobacco products including cigarettes, e-cigarettes, cigar products, nicotine pouches, and other tobacco products (including chewing tobacco, snuff, snus, dip, dissolvable, waterpipe/hookah, pipe tobacco, and heated tobacco products). In 2024, the New York Youth Tobacco Survey (NY-YTS) released data showing the lowest level of tobacco use since 2000 at 17%. E-cigarette use, otherwise known as vaping, is 13% and remains the most used tobacco product among youth. Nicotine pouch use has doubled from 1.5%-3.0%.

(StatShot | New York State Tobacco Control Program Vol. 17, #2025-1 | Release Date: October 2025
High School Youth Tobacco Use Continues to Decline, One in Six Youth Still Use Tobacco)

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

Warren County, NY:

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 (21.3%) is higher than Upstate New York (9.3%), ARHN Region (20.8%) New York State (12%) and the Prevention Agenda Benchmark (7.9%).

There are currently 93 locations where a person can purchase tobacco or vaping products. The top locations are convenience stores and gas stations, discount stores and tobacco retailers, grocery stores and pharmacies.

Chronic lower respiratory deaths rates per 100,000 population are higher in Warren County (63.4) than Upstate New York (40.9) and New York State (31.3). The percentage of adults with asthma in Warren County (15.7%) is higher, in comparison to Upstate New York (10.8%), and New York State (10.1%).

Washington County, NY:

Smoking and smoking-related diseases seem to pose a significant challenge for Washington County, with seven of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Washington County (22.7%) is higher than Upstate New York (9.3%), New York State (12%), the ARHN region (19.5%) and the Prevention Agenda Benchmark (7.9%).

In 2020, Washington County had the highest adult smoking rate in NYS at 25.3%, compared to the statewide average of 12.8%.² Although rates have decreased, Washington County remains in the 10%, and smoking continues to cause disproportionately high rates of death and disease among people with low socioeconomic status (low SES), who are more likely to smoke than those with higher socioeconomic status. According to the American Lung Association, individuals living in poverty smoke cigarettes more heavily and smoke for nearly twice as many years as people of three times the poverty rate.

Tobacco use is statistically prevalent, yet an underrepresented issue in Washington County. A potential contributor to this disparity is the existing retail environment in Washington County. Although there are less (49) licensed tobacco retailers in Washington County compared to Warren and Saratoga counties, 65.3% of the tobacco retail environment in Washington County is comprised of retailers that sell basic grocery items.

Chronic lower respiratory deaths rates per 100,000 population are higher in Washington County (74.9) than Upstate New York (40.9) and New York State (31.3). The percentage of adults with asthma in Washington County (13.2%) is higher, in comparison to Upstate New York (10.8%), and New York State (10.1%). [New York State Community Health Indicator Reports Dashboard.](#)

Saratoga County, NY:

Smoking rates have dropped in Saratoga County with the current percentage of adults who smoke at 15.1%, which is lower than Upstate New York (19.5%) but still higher than the NYS average of 9.3% and the Prevention Agenda Benchmark (7.9%).

There are currently 167 locations where a person can purchase tobacco or vaping products. The top locations are convenience stores and gas stations, discount stores and tobacco retailers, grocery stores and pharmacies.

Chronic lower respiratory deaths rates per 100,000 population are higher in Saratoga County (47.3) than Upstate New York (40.9) and New York State (31.3). The percentage of adults with asthma in Saratoga County (9.8%) is on par, in comparison to Upstate New York (10.8%), and New York State (10.1%). [New York State Community Health Indicator Reports Dashboard.](#)

Neighborhood and Built Environment

The environment one lives in has a direct impact of one's physical and mental health. Factors like access to transportation, as well as access to healthy affordable food, is the first step to helping reduce health disparities.

Regular physical activity has significant benefits across the lifespan, including reduced risk of chronic diseases such as heart disease, stroke, type 2 diabetes, and several types of cancers, and can lead to stronger muscles and bones, improved mental health and sleep function, and increased life expectancy. Injuries are a leading cause of death and disability among all age groups in NYS and are the leading cause of death for individuals 1-44 years of age.

Efforts to address these focus areas are better led 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:

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 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).

Healthcare Access and Quality

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. 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. Because of this there is an increased 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 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.

Prenatal care is one of the most common preventive care services in the US and aims to improve the health of 4 million birthing persons and their children each year. The 3 main components of prenatal care are: risk assessment, health promotion and education, and therapeutic intervention. Infant mortality is an important marker of the overall health of a society and gives us key information about the health of pregnant people and infants.

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. 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.

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

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%.

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).

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

¹¹ Adapted from the Preventing Chronic Diseases Action Plan for the NYS Prevention Agenda, available at [Community Health Planning Resources - Prevention Agenda 2025-2030: New York State's Health Improvement Plan](https://www.health.ny.gov/prevention/2025-2030/chronic_diseases.htm)

gestational weight gain greater than ideal, gestational diabetes or gestational hypertension are all higher than the Upstate New York benchmark.

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 (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).

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%.

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.

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).

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 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 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%.

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.

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 immunization rate for children aged 24-35 months with the recommended 4:3:1:3:1:4 (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).

Education Access and Quality

Chronic absenteeism within New York State and Saratoga, Warren and Washington Counties remain high and have increased significantly post the COVID-19 pandemic with the latest data from 2022-23 school year in NYS rising from 15% to 26%. showing 34.1% of high schoolers being chronically absent. Chronic absenteeism is termed as a student missing 10 percent or more of school days for reasons that are excused, non-excused, and disciplinary actions. Absences can also be tied to health problems, such as asthma, diabetes, and oral and mental health issues. Barriers to students attending school include the lack of close access to a nearby school bus, a safe route to school, and food insecurity. We can link chronic absenteeism to reduced student achievement, an increase of a student dropping out of high school leading to poverty in adulthood and continued adverse health outcomes including chronic disease. In economically disadvantaged areas the percentage for chronic absenteeism increases. It is shown in the present 2022-2023 data that 34% of economically disadvantaged students are chronically absent compared to 26.4% for all students. The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Warren County

The absentee rates on average for Warren County at the elementary levels is 20% and the secondary school average is 25%. The high school graduation rate for Warren County overall for 2022-2023 is 88%

but for students that are economically disadvantaged the rate is 78%. Per census data the poverty level is 10.5% for the county and 15% under the age of 18.

Washington County

The absentee rates on average for Washington County at the elementary levels is 20% and the secondary school average is 27%. The high school graduation rate for Washington County overall for 2023-2024 is 83% but for students that are economically disadvantaged the rate is 74.1%. Per census data the poverty level is 11.5 for the county and 15.5% under the age of 18.

Saratoga County

The absentee rates on average for Saratoga County at the elementary levels is 12% and the secondary school average is 22%. The high school graduation rate for Saratoga County overall for 2022-2023 is 92% but for students that are economically disadvantaged the rate is 79%. Per census data the poverty level is 7.2% for the county and 8.3% under the age of 18.

Health Disparities

Improving health status in the five Domain 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.¹²

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 outcomes¹³. 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

¹² Adapted from the Centers for Disease Control and Prevention, Adolescent and School Health, Health Disparities website, <https://www.cdc.gov/healthyyouth/disparities/index.htm>.

¹³ Adapted from the Centers for Disease Control and Prevention, Social Determinants of Health website, <http://www.cdc.gov/socialdeterminants/>

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 median household income is \$78,239 and \$72,342 respectively, compared to the Upstate New York average of \$86,072. 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:

| Prevention Agenda Indicators: Disparities | | | | | | | |
|--|----------|--------|------------|-------------------|---------------------------|----------------|----------------------------------|
| | | | | | Comparison Regions / Data | | |
| | Saratoga | Warren | Washington | ARHN ¹ | Upstate NY | New York State | 2030 Prevention Agenda Benchmark |
| Percentage of Overall Premature Deaths (before age 65 years), 2022 | 20.50% | 21.90% | 24% | 23.20% | 22% | 23.6 | 22.40% |
| Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2022 | 16.2 | 56.9 | 1.8 | N/A | N/A | 19.4 | 18.4 |
| Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2022 | 61.5 | 29.1 | 51.8 | N/A | N/A | 17.9 | 17 |
| Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2024 | 60.6 | 122.1 | 51.8 | 129 | 90.8 | 93.7 | 89.2 |
| Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2024 | 44.1 | 157.2 | N/A | N/A | N/A | 103.5 | 96.7 |
| Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2024 | -41.6 | -67.1 | N/A | N/A | N/A | 34.6 | 31 |
| Percentage of Adults (Ages 18 - 64) with Health Insurance, 2022 | 95.70% | 94.40% | 93.90% | 93% | N/A | 93.2 | 95% |
| Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2021 | 90.60% | 88.10% | 89.30% | 88% | 87.10% | 85.8 | 87.50% |

N/A: Data does not meet reporting criteria

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 health insurance, as both Warren and Washington counties fall below the

Prevention Agenda benchmark. 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 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:

| | | | | | | Comparison Regions / Data | |
|--|----------|--------|------------|-------------------|------------|---------------------------|----------------------------------|
| | Saratoga | Warren | Washington | ARHN ¹ | Upstate NY | New York State | 2030 Prevention Agenda Benchmark |
| Total Mortality rate per 100,000, 2022 | 946.7 | 1252.1 | 1283.6 | N/A | 1038.2 | 888.4 | N/A |
| Total Emergency Department Visits per 10,000 Population, 2022 | 2000 | 3200 | 3000 | N/A | 3300 | 3813 | N/A |
| Rate of Total Hospitalizations per 10,000 Population, 2022 | 832.7 | 1035.3 | 975.8 | N/A | 1013.4 | 1037.6 | N/A |
| Age-adjusted percentage of adults who did not receive medical care because of cost, 2022 | N/A | 3.60% | 6.40% | 7.10% | 6.50% | 8.50% | N/A |
| Percentage of adults reporting 14 or more days of poor mental health, 2021 | 9.30% | 15.50% | 13.80% | 13.30% | 12.60% | 13.4 | N/A |
| Percentage of adults living with a disability (based on 6 ACA disability questions), 2018-2022 | 23.20% | 33.10% | 31.20% | 30.10% | 25.80% | 11.9 | N/A |

N/A: Data does not meet reporting criteria

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 county lagged in 4 out of the 6 measures, while Washington County lagged behind in 3 out of the 6 measures compared to Upstate New York counties while Saratoga County meets or exceeds 5 of the 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 in the future if populations continue to delay health

care. Lastly, the percentage of adults reporting 14 or more days of poor mental 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 demonstrates many 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 cancer. 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.¹⁴ 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

¹⁴ New York State Department of Health, New York State Cancer Registry. Cancer Incidence and Mortality by County and Gender, 2012 - 2016

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 (22.7%) and Warren (21.3%) Counties, as well as most upstate NY counties (9.3), than the New York State rate of 12.0%. Current smoking rates in NYS vary by county from a low in Westchester at 5.6% to a high in Washington at 22.7%.¹⁵ While there has been a decline in the rate of tobacco use among both children and adults in NYS (and equally across all ethnic groups), smoking rates have not declined for the poor and less educated, which are significant issues in the GFH service area. This highlights the crucial need for prevention and cessation of tobacco use in these counties, especially for vulnerable populations in this area.

Regional Community Stakeholder Survey Results

As mentioned previously, as a part of the regional work facilitated by the ARHN, the 2025 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 889 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 February 2025 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 after the initial reach out. CHA Committee members were provided with the names of all non-respondents for additional follow-up, at partner discretion. The survey requested that community stakeholders rank the five domains of SDOH based on their impact within their communities and identify key priority areas addressed by their organizations. Respondents also provided insight into what they viewed as the top health concerns in their communities and the most influential contributing factors.

A total of 307 responses were received through March 14, 2025, for a total response rate of 34.5%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate.

¹⁵ Bureau of Tobacco Control, StatShot, Prevalence of Current Smoking Among Adults, in New York by County, NYS BRFSS 2021, available at https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume15/n2_smoking_among_adults.pdf

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 Mental Health Conditions as the top priority area in all counties. Warren and Washington County respondents selected Substance Abuse/Alcoholism/Opioid Use as the second top priority area.
- Respondents noted mental health conditions, substance use/alcoholism/opioid use, child/adolescent emotional health, adverse childhood experiences and cancers within their top five health concerns facing Warren and Washington counties.
- Top contributors to the health conditions noted above included lack of mental health services, poverty, and addiction to alcohol/illicit drugs. Warren County respondents also identified transportation problems, healthcare costs and homelessness. Washington County identified age of residents and changing family structures.
- 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 subpopulations that respondents overwhelmingly believe experience the poorest health outcomes.
- Respondents were asked to choose three goals (priorities) within each NYS Prevention Agenda Domain 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 Domain Areas | Priority #1 | Priority #2 | Priority #3 |
| Economic Stability | Nutrition Security | Housing Stability and Affordability | Poverty |
| Social and Community Context | Anxiety and Stress | Healthy Eating | Tied: Primary Prevention, Substance Misuse, and Overdose Prevention & Adverse Childhood Experiences |
| Neighborhood and Built Environment | Access to Community Services and Support | Opportunities for Active Transportation and Physical Activity | Injuries and Violence |
| Health Care Access and Quality | Childhood Behavioral Health | Prevention Services for Chronic Disease | Preventive Services |
| Education Access and Quality | Health and Wellness Promoting Schools | Opportunities for Continued Education | N/A |
| Top Three NYS Prevention Agenda Goals Identified for Washington County | | | |
| NYS Prevention Agenda Domain Areas | Priority #1 | Priority #2 | Priority #3 |
| Economic Stability | Nutrition Security | Tied: Poverty and Housing Stability and Affordability | Unemployment |
| Social and Community Context | Anxiety and Stress | Tied: Adverse Childhood Experiences & Healthy Eating | Primary Prevention, Substance Misuse, and Overdose Prevention |
| Neighborhood and Built Environment | Access to Community Services and Support | Opportunities for Active Transportation and Physical Activity | Injuries and Violence |
| Health Care Access and Quality | Childhood Behavioral Health | Early Intervention | Preventive Services |
| Education Access and Quality | Health and Wellness Promoting Schools | Opportunities for Continued Education | N/A |

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 analysis of the Survey Results, see Appendix E.

Warren, Washington and Saratoga County Health Comparison

To further support the information collected through the county health indicator data and the regional community stakeholder survey, County Health Comparisons were made to understand how the health of Warren, Washington and Saratoga counties compared to each other.

Health outcomes demonstrate the current health status of the population and are based on two types of measures: Length of life (Deaths of individuals under age 75) and Quality of Life. There were 4 categories measured to account for quality of life: Average number of physically unhealthy days reported in the past 30 days, Percentage of live births with low birth weight, Average number of mentally unhealthy days reported in the past 30 days and Percentage of adults reporting fair or poor health.

County Health Comparison– 2025

| County Health Rankings Population Health and Well-being Profile | | | | |
|---|----------|--------|------------|------|
| Indicator | Saratoga | Warren | Washington | NYS |
| Length of Life | | | | |
| Deaths of individuals under age 75, per 100,000 people | 5500 | 7400 | 8500 | 6600 |
| Quality of Life | | | | |
| Average number of physically unhealthy days reported in the past 30 days | 3.4 | 3.8 | 4 | 3.9 |
| Percentage of live births with low birth weight (<2500 grams) | 7% | 8% | 8% | 8% |
| Average number of mentally unhealthy days reported in the past 30 days (age-adjusted) | 5 | 5.1 | 5.4 | 4.9 |
| Percentage of adults reporting fair or poor health (age-adjusted) | 10% | 16% | 15% | 16% |

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 – 2025, see <http://www.countyhealthrankings.org/>

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 first 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.

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 organization's 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 Domain and/or Focus Area | <ul style="list-style-type: none"> • Domain: Social and Community Context: <ul style="list-style-type: none"> • Primary prevention, Substance misuse and overdose prevention • Anxiety & Stress • Domain: Healthcare Access and Quality: <ul style="list-style-type: none"> • Childhood Behavioral Health • Domain: Economic Stability: <ul style="list-style-type: none"> • Housing Stability & Affordability | <ul style="list-style-type: none"> • Domain: Economic Stability: <ul style="list-style-type: none"> • Poverty • Domain: Social and Community Context: <ul style="list-style-type: none"> • Tobacco/E-Cigarette Use • Domain: Health Care Access and Quality: <ul style="list-style-type: none"> • Prevention Service for Chronic Disease Prevention and Control | <ul style="list-style-type: none"> • Domain: Economic Stability: <ul style="list-style-type: none"> • Food security • Domain: Social and Community Context: <ul style="list-style-type: none"> • Reduced major depressive episodes • Domain: Healthcare Access and Quality: <ul style="list-style-type: none"> • Increased A1C testing and cancer screening |

At the time of this assessments publishing, the chart above reflects Saratoga Hospital as Saratoga County has not yet finalized their prevention agenda indicators.

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 2025-2027:

Domain: Social and Community Context

- Priority: Mental Wellbeing and Substance Use
 - Tobacco/E-Cigarettes Use

Domain: Education Access and Quality

- Priority: PreK-12 Student Success and Educational Attainment
 - Health and Wellness Promoting Schools

Domain: Health Care Access and Quality

- Priority: Health Insurance Coverage and Access to Care
 - Preventative Services for Chronic Disease Prevention and Control
- Healthy Children
 - Preventative Services
 - Hearing Screening and Follow-up

It is important to note that GFH chose similar chronic disease and communicable disease related priorities in the previous 2022-2024 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.

Regional Priority

In addition to GFH choosing Domain areas, as part of the community health planning and assessment process, the CHA Committee identified and selected Social and Community Context, Healthcare Access and Quality and Economic Stability as regional priorities in support of the NYS Prevention Agenda 2025-2030. 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 Social and Community Context, Healthcare Access and Quality and Economic Stability 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. 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 support 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, it 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.

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 domain 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 Hospital Affairs Committee 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 support 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 2025-2027

The following three-year action plan includes initiatives led by GFH to address the prioritized community health needs. It includes initiatives to address one priority area under the **Social and Community Context** domain, one priority area under **Education Access and Quality domain**, and two priority areas under the **Health Care Access and Quality** domain 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 with a checkmark are the selected strategies that are included in the formal DOH required Community Service Plan.

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.

Community Service Plan 2025-2027

| | | | | | |
|---|---|---|--|---|--|
|  | Social and Community Context <ul style="list-style-type: none">• Mental Wellbeing and Substance Use<ul style="list-style-type: none">• Tobacco/E-Cigarettes Use✓ Health Systems for Tobacco Free New York✓ CR Wood Cancer Center – Smoking Cessation Programs |  | Healthcare Access and Quality <ul style="list-style-type: none">• Health Insurance Coverage and Access to Care<ul style="list-style-type: none">• Preventive Services for Chronic Disease Prevention and Control✓ Cancer Services Program• Healthy Children<ul style="list-style-type: none">• Preventative Services• Hearing Screening and Follow Up✓ Audiology screenings |  | Education Access and Quality <ul style="list-style-type: none">• PreK Student Success and Educational Attainment<ul style="list-style-type: none">• Health and Wellness Promoting Schools✓ Creating Healthy Schools and Communities |
|---|---|---|--|---|--|

Glens Falls Hospital Initiatives

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

Health Alliance and Honest Health

GFH is preparing to strengthen both the social and clinical sides of health care through two complementary initiatives. With Healthy Alliance, the focus is on Medicaid and Managed Medicaid. Recognizing that health is shaped by more than medical visits, Healthy Alliance has built a vast Social Care Network across 24 counties in New York, linking hospitals, health centers, and grassroots organizations that provide essentials like food, housing, transportation, and household goods. Beginning in 2026, GFH will screen all patients for social determinants of health and connect those with the greatest needs to this network, ensuring that challenges such as food insecurity or lack of transportation are addressed before they become medical crises. The mission is clear: every New Yorker should have equal access to the resources that make healthier lives possible.

At the same time, GFH is joining Honest Health, a REACH ACO designed to serve Medicare Fee-for-Service patients. This program emphasizes proactive care—screening and testing to catch issues early, reducing the risk of serious outcomes later. Honest Health also equips clinicians with training to document patient conditions with precision, improving risk scoring and aligning care more closely with each patient's needs. By combining early detection with accurate coding, the program aims to close gaps in care and elevate the quality of service for Medicare patients.

Together, these two efforts reflect GFH's commitment to a holistic vision of health: Healthy Alliance addresses the social foundations of well-being, while Honest Health strengthens the clinical side through prevention and precision. The result is a more complete system of support, where patients are cared for not only in the exam room but also in the communities where they live.

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.¹⁶ These include, but are not limited to:

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

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

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

¹⁶ The most comprehensive listing of businesses in the region can be found at the GlensFallsRegion.com website, <https://www.glenfalls.com/>.

cancer-related medications and helps find foundation funds, co-pay assistance programs and free or replacement drugs for those who qualify.

Gaps in the Availability of Resources

One significant gap in the availability of resources is related to housing assistance for patients 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 area.

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 2022-2024 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: 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

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 2022 - 2024.

Communicable Disease Prevention:

Clostridioides difficile (CDI) Performance Update

- Standardized Infection Ratio (SIR) Performance
 - 2022 SIR: 0.435
 - 2023 SIR: 0.142
 - 2024 SIR: 0.537

Summary of Performance (2018–2024)

Glens Falls Hospital has demonstrated sustained progress in reducing hospital-onset Clostridioides difficile infections (CDI) over the past several years. From the baseline period (2018–2019), the organization achieved a 50 percent reduction, decreasing the SIR from 0.88 to 0.44 in 2022.

The onset of the COVID-19 pandemic temporarily shifted organizational priorities, contributing to a slight increase in the SIR from 0.44 in 2019 to 0.53 in 2020. However, improvement efforts resumed with notable success, resulting in a 31 percent decline from 0.53 to 0.36 in 2021. Overall, despite pandemic-related operational challenges and ongoing staffing pressures, Glens Falls Hospital achieved a 59 percent reduction in CDI between 2018 and 2021.

Post-pandemic recovery trends are reflected in subsequent years, with SIR results of 0.435 (2022), 0.142 (2023), and 0.537 (2024). These data continue to inform targeted quality-improvement strategies, including antimicrobial stewardship, environmental hygiene optimization, diagnostic stewardship, and adherence to evidence-based infection-prevention practices.

Healthcare-Associated Infections:

Surgical Site Infection (SSI) Performance Update

- Standardized Infection Ratio (SIR) Performance
 - 2022 SIR: 1.162
 - 2023 SIR: 1.134
 - 2024 SIR: 0.488

Summary of Performance (2018-2024)

Glens Falls Hospital has continued to implement and sustain evidence-based strategies to reduce surgical site infections (SSIs) across surgical service lines. These initiatives—including preoperative optimization, standardized skin antisepsis, enhanced intraoperative sterile technique, and postoperative wound surveillance—enabled the organization to achieve and maintain a 57 percent reduction in all SSIs in 2019, significantly outperforming the original 30 percent reduction target.

Performance over the 2022–2024 period reflects ongoing recovery and stabilization following the operational disruptions of the COVID-19 pandemic. SIRs of 1.162 (2022) and 1.134 (2023) improved markedly to 0.488 in 2024, demonstrating renewed progress in aligning surgical infection outcomes with state and national benchmarks.

These results continue to guide focused QI efforts, including perioperative workflow standardization, antimicrobial stewardship, surgical safety bundle reinforcement, and cross-disciplinary performance monitoring to sustain long-term reductions in SSIs.

Chronic Disease Prevention:

- Provided **Health Home** care coordination services to adults and children enrolled in Medicaid. A 'Health Home' is a group of health care and service providers working together to make sure Medicaid members get the care and services they need to stay healthy.

- Partnered with 5 strategic local human service agencies to refer eligible individuals for **free cancer screenings**. The rates of comprehensive screenings for breast, cervical, colorectal cancer stayed steady compared to prior years at 60%.
- 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 2022 - 2024 there were 6 retreats held with 10 participants at each retreat. Each spring the retreat is held for women who have metastatic or stage 4 cancer and every fall are for women whose cancer are treated for cure. All participants evaluated stated that the program helped them with tools for coping after their diagnosis and 100% stated that they felt better.
- 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 850 patients used the salon between 2022 and 2024, and over 350 wigs were provided free of charge.
- Conducted 1 Comfort Camp each year in 2022-2024, 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. Each camp had 35 children and evaluation of the program showed that 100% of the campers found the education and support helpful in reconnecting with their families during the stressful treatment timeframe.
- Conducted **free skin cancer screening** once per year, for a total of three screenings between 2022 and 2024, which are free and open to the community. Total number of individuals screened over the three years was 368. There were 5 early-stage melanomas found during this time frame. 80% of the attendees did not do annual screening and do not have a dermatologist and were thankful for this free event.
- Provided free accommodation through 755 room nights between 2022 and 2024, 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. 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
- Continue to build dementia capacity across the 17-county region that is served by the two AMHS "CEADs" (**Centers of Excellence for Alzheimer's Disease and Related Dementias**) and fulfill the objectives of the NYS Department of Health (NYS DoH) grant (June 1, 2022-May 31, 2027).
 - Facilitate continuing education for Health Professionals to enhance the quality of care rendered to constituents, with an emphasis on diagnostic/management skills and research opportunities.
 - Maintain the MOU with the region's Federally Qualified Health Center (FQHC) to collaborate on initiatives that help identify neurocognitive diseases earlier in their progression. Continue to provide case review education sessions to the providers of Hudson Headwaters Health Network.
 - Execute on the work that is outlined in the BOLD grant which was awarded to the Glens Falls Hospital's CEAD by NYS DoH and The Centers for Disease Control to support public health initiatives for earlier diagnoses.

- Leverage the CEAD program to obtain additional funding and research opportunities in the Aging and Alzheimer's/Other Dementia space.
- Embed health professional education into the local nursing education programs to elevate nursing students' knowledge of dementia.
- Extend the impact of the GFH's original designation as an Age-Friendly Health System which was achieved in 2022 with the CEAD and an interdisciplinary group of professionals. Contribute to continuous improvement priorities, as established by the institution that help with aging and brain health; build on the foundation by serving Quality workgroups such as *Age-Friendly Health* and *Geriatric Emergency Care*.
- Continue to administer the grant that helps to underwrite, in-part, the salaries of the Neurologists, Advanced Practice Providers, and Social Worker who comprise the Neurology team. Fulfill the organization's grant obligation of operationalizing a successful interdisciplinary medical-social model.
- Implemented and sustained telehealth services post Covid era through 2022-2024. GFH leadership received the Telehealth Innovator of the Year for the entire north country.

Completed efforts to advance tobacco within the GFH Region:

- Outreached, engaged and/or re-engaged 15 medical and behavioral health systems and their key administrators to ascertain the current state of each systems tobacco use and dependence interventions and to assist and support the integration of evidence-based, tobacco dependence treatment services and policies across the healthcare system
- Educated 5 health systems on the benefits of integrating evidence-based, tobacco dependence treatment services and policies across the healthcare system
- Met with and enlisted influential local and regional organizations and members in activities to support and advance advocacy with decision makers of the targeted medical health systems.
- Obtained 1 system wide policy to the integration of evidence-based, tobacco dependence treatment services and policies across the healthcare system
- Obtained 5 MOU agreements to increase the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention.
- Collaborated on 2 HHHN Pilot Projects to identify gaps to increase the integrated of evidenced based tobacco treatment services via the Community Needs Assessment and the CD

Glens Falls Hospital: CR Wood Cancer Ctr

- Obtained MOU to utilize 5 A's and implement evidence based tobacco treatment programming to newly diagnosed patients identified as tobacco dependent
- Identified gaps, successes within current tobacco screening practices
- Established a system to offer/provide NYS Quit line resources
- Identified a RN Onc Navigator as a Tobacco Treatment Lead (TTD) and completed Certified Tobacco Treatment Specialist Training with Rutgers University
- Established a referral system to new onsite Certified Tobacco Treatment Specialist

HHHN:

- **Community Needs Assessment Pilot Project:** Obtained an MOU with HHHN to address tobacco use and health disparities within communities, and for HHHN to become the first Federally Qualified Health Center (FQHC) to complete a The Tobacco Use Treatment Capacity Needs Assessment Tool. This tool is designed to be utilized by HSTFNY grantees to engage healthcare organizations and their staff in reviewing their current clinical practices related to the delivery of

tobacco use treatment services to the patients they serve. The HHHN CNA team identified three of nineteen focus areas available to improve clinical practices related to the delivery of tobacco use treatment services to the patients they serve. The three focus areas were:

- Focus Area 10: Prescribing and Providing NRT
- Focus Area 12: Maximize Billing and Reimbursement
- Focus Area 13: Competent and Trained Staff
- **Heart Network CDCCN Pilot Project:** collaborated to do an internal Train the Trainer training of 5 A's and the process of referral for Nurse Leaders, Care Coord and others to improve implementation of comprehensive tobacco treatment

ASCEND:

- Improved implementation of a comprehensive tobacco dependence treatment with the adoption of a standard of care with North Country Nicotine Consultants and the Health Systems for a Tobacco Free NY grant at GFH.
- Re-ignited this partnership, obtained an MOU and to facilitated partnership and collaboration with Washington County Public Health TTS via the Commit to Quit Program to support the integration of comprehensive, evidence-based tobacco treatment program for nicotine within 2 locations
- Formed and maintained a committee meet to work toward the goals of increasing the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention.
- Offered/provided NYS Quitline resources within Quit Kits

SUNY ADK:

- Signed an MOU to increase the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention.
- Identified tobacco champion lead for CTTs training
- Coordinated with Washington County Public Health TTS to support the integration of comprehensive, evidence-based programs for nicotine addiction on campus
- Conducted E-Check Up to Go Assessment
- Establishing a referral system to tobacco treatment specialists and the NYS Quitline

Washington County Public Health and Disparity Project:

- Obtained an MOU to increase the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention via Washington County Public Health's Commit to Quit Program at ASCEND Mental Wellness, Washington County Jail, and at SUNY Adirondack.
- Supported the development and implementation of a system to document referrals and services to assist and support the integration of evidence-based, tobacco dependence treatment services and policies across the healthcare system
- Formed and maintained a committee to increase the delivery of comprehensive, evidence-based treatment for nicotine addiction and tobacco-use prevention.
- Facilitated partnership with the NYS Quitline to promote, refer and offer NYS Quitline resources
- Supported the development of the Tobacco Treatment Tablet Project with public libraries located within Washington County to implement and sustain online cessation. 2 tablets were provided and are maintained by Glens Falls Hospital. 3 individuals were supported virtually.
- Coordinated with community-based organizations within Washington County to promote the Washington County Commit to Quit Program and expand outreach.
- Funded the designing and creation of the Commit to Quit, Quit Kits

- Continued to advance policy and environmental changes to **promote physical activity and nutrition:**
 - Number of 3 worksites and 7 community settings recruited, assessed, and applying behavioral design strategies
 - 14 childcare providers that improve policies, practices, and environments for physical activity and nutrition
 - 9 of municipalities identified, assessed, and received training, technical assistance, and resources
 - 8 school districts with established wellness committees and implemented Wellness Policies and Comprehensive School Physical Activity Programs

The complete 2022-2024 Community Service Plan can be found on the GFH website at <https://www.albanymed.org/glensfalls/glens-falls-hospital-health-promotion-center/>.

Dissemination

The GFH Community Service Plan with action plan, along with the CHNA and corresponding Implementation Strategy, are available at <https://www.albanymed.org/glensfalls/glens-falls-hospital-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 CHNA Committee worked with Senior Leadership to develop the plans, which were presented to the Glens Falls Hospital Affairs Committee for approval. The Affairs Committee was provided with an overview 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 20, 2025. Elements from those documents were combined to create this Community Service Plan, for submission to the NYS DOH.

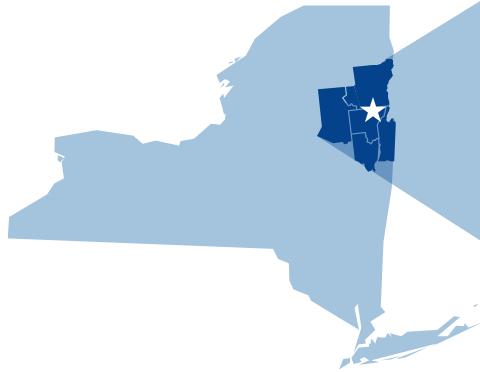


ALBANY MED Health System

GLENS FALLS HOSPITAL

A REGIONAL HEALTHCARE SYSTEM


20+ REGIONAL LOCATIONS


391
BEDS


5 UPSTATE COUNTIES SERVED
6,000 sq. mile, primarily rural, service area


2,380
EMPLOYEES

563
MEDICAL STAFF

PROUD TO ACHIEVE
MAGNET®
RECOGNITION
FOR NURSING EXCELLENCE

153

EMPLOYED PHYSICIANS,
PHYSICIAN ASSISTANTS
& NURSE PRACTITIONERS

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

C.R. WOOD
CANCER
CENTER

1,000+
PATIENTS DIAGNOSED
& TREATED ANNUALLY

Annually *

882

BABIES BORN

IN THE

JOYCE STOCK
SNUGGERY

42,540

E.D. VISITS

12,473
INPATIENT
DISCHARGES

SURGERIES

PERFORMED

9,086

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

| County Health Departments | Phone Number | Primary Representative | Additional 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 | Hannah Busman (hannah.busman@franklincountyny.gov) | Sarah Granquist (sarah.granquist@franklincountyny.gov) |
| Fulton County Public Health | 518-736-5721 | Laurel Headwell (lheadwell@fultoncountyny.gov) x5720 | Angela Stuart Palmer (apalmer@fultoncountyny.gov) Jacob Stewart (jstewart@fultoncountyny.gov) |
| Hamilton County Public Health | 518-648-6497 | Junie Delizo (jdelizo@hamiltoncountyny.gov) | Maria Luz McKay (mmckay@hamiltoncountyny.gov) |
| Warren County Health Services | 518-761-6580 | Ginelle Jones (jonesg@warrencountyny.gov) | Dan Durkee (durkeed@warrencountyny.gov) x6580 Olivia Cohen (coheno@warrencountyny.gov) Jignasha Shah (shahj@warrencountyny.gov) Katie Boyle (boylek@warrencountyny.gov) |
| Washington County Public Health | 518-746-2400 | Tina McDougall (tmcdougall@washingtoncountyny.gov) x2429 | Elizabeth St. John (estjohn@washingtoncountyny.gov) Alyssa Arlen (aarlen@washingtoncountyny.gov) |
| Hospitals | | | |
| Adirondack Medical Center | 518-897-2735 | Matt Scollin (mgscollin@adirondackhealth.org) 518-897-2341 | Lisa Tuggle (ltoggle@adirondackhealth.org) 518-897-4774 |
| Glens Falls Hospital | 518-926-6899 | Shannon Gaczol (sgaczol@glensfallshosp.org) | |
| Nathan Littauer Hospital | 518-773-5212 | Geoff Peck (gpeck@nlh.org) | Dakota Pike (dpike@nlh.org) |
| UVMHN - Alice Hyde Medical Center | 518-481-2410 | Annette Marshall (amarshall@alicehyde.com) x2410 | |
| UVMHN - CVPH | 518-314-3327 | Ken Thayer (kthayer@cvph.org) | Gregory E. Freeman (GFreeman@cvph.org) |
| UVMHN - Elizabethtown Community Hospital | 518-873-3125 | Amanda Whisher (awhisher@ech.org) 518-873-3125 | Julie Tromblee (jtromblee@ech.org) Jodi Gibbs (jgibbs@ech.org) |
| AHI | | | |
| | 518-480-0111 | Sara Deukmejian (sdeukmejian@ahihealth.org) x317 | Jennifer Muthig (jmuthig@ahihealth.org) Laura Morris (lmorris@ahihealth.org) |

Committee Meeting Dates

| | |
|---|--|
| 2023 CHA Quarterly Meeting Dates: | |
| 10-Mar-23 | |
| 9-Jun-23 | |
| 8-Sep-23 | |
| 8-Dec-23 | |
| 2025 Data Sub-Committee Meeting Dates: | |
| 17-Jan-25 | |
| 19-Feb-25 | |
| 12-Mar-25 | |
| 2025 CHA Quarterly Meeting Dates: | |
| 7-Mar-25 | |
| 16-May-25 | |
| 5-Sep-25 | |
| 5-Dec-25 | |

Domains and Priorities

| Domain | Priorities |
|--|---|
|  Economic Stability | Economic Wellbeing <ul style="list-style-type: none"> • Poverty • Unemployment • Nutrition Security • Housing Stability and Affordability |
|  Social and Community Context | Mental Wellbeing and Substance Use <ul style="list-style-type: none"> • Anxiety and Stress • Suicide • Depression • Primary Prevention, Substance Misuse, and Overdose Prevention • Tobacco/ E-cigarette Use • Alcohol Use • Adverse Childhood Experiences • Healthy Eating |
|  Neighborhood and Built Environment | Safe and Healthy Communities <ul style="list-style-type: none"> • Opportunities For Active Transportation and Physical Activity • Access to Community Services and Support • Injuries and Violence |
|  Health Care Access and Quality | Health Insurance Coverage and Access to Care <ul style="list-style-type: none"> • Access to and Use of Prenatal Care • Prevention of Infant and Maternal Mortality • Preventive Services for Chronic Disease Prevention and Control • Oral Health Care Healthy Children <ul style="list-style-type: none"> • Preventive Services <ul style="list-style-type: none"> ◦ Immunization ◦ Hearing screening and follow up ◦ Lead screening • Early Intervention • Childhood Behavioral Health |
|  Education Access and Quality | PreK-12 Student Success And Educational Attainment <ul style="list-style-type: none"> • Health and Wellness Promoting Schools • Opportunities for Continued Education |



2025 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 provided as a benchmark statistic. Upstate NY is calculated as the NYS total minus New York City (NYC), which includes New York, Kings, Bronx, Richmond, and Queens counties.

Demographic Profile:

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

Health System Profile:

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

Education Profile:

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

- 1) The Education System Profile includes student enrollment, student to teacher ratios, English proficiency rates, free lunch eligibility rates, as well as high school graduate

statistics. Data was sourced from the NYSED and the National Center for Education Statistics (NCES).

- 2) The Education System Profiles by School District identifies all the school districts in each county, sourced from the National Center for Education Statistics (NCES).

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

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

County Health Rankings (CHR) Profile:

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

The County Health Rankings identifies the two focus areas as:

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

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

Data Dashboard:

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

Each source file has visualization aspects to better depict data, as well as a deep dive tab that provides a table with a benchmark comparison, color-coded to identify where the county rate falls in comparison.

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

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

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

ARHN Region Calculations:

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

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

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

UPSTATE Calculations:

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

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

- For rates per 1000, formula is $[(A) * 1000]$

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

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

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

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

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

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

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

Unstable Estimates:

Due to limitations in the PowerBI software, all unstable estimates are identified in a column of each data sources deep dive or data compilation table. For further information on what

quantifies the indicator as unstable, please see below for explanations (provided by each data source) or visit the data source website for more information.

Prevention Agenda Dashboard

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

Data Suppression for Confidentiality

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

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

| Data Sources | Suppression Criteria | Statistical Significance Techniques |
|---|---------------------------------|--|
| Sample Surveys | | |
| Pregnancy Risk Assessment Monitoring System | Denominator <30 | 95% CI comparison |
| BRFSS and Expanded BRFSS | Numerator <6 or Denominator <50 | 95% CI comparison |
| US Census | | 90% CI comparison |
| National Survey on Drug Use and Health | | 95% CI comparison |
| Youth Risk Behavior Surveillance System | Denominator <100 | 95% CI comparison |
| Youth Tobacco Survey | | 95% CI comparison |
| Population Count Data | | |

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

CI: Confidence Interval

BRFSS: Behavioral Risk Factor Surveillance System

SPARCS: Statewide Planning and Research Cooperative System

Community Health Indicator Reports (CHIRs)

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

- For notation purposes, an asterisk (*) symbol is used to indicate that a percentage, rate, or ratio is unreliable/unstable. This usually occurs when there are less than 10 events in the numerator (RSE is greater than 30%).

Data Suppression Rules for Confidentiality

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

Table 1. Summary of Data Suppression Rules

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

NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators

Limitations of Use:

- Data are sample based and therefore subject to sampling variability. The sampling variability for each indicator is highlighted by including the 95% confidence interval.
- Data are based on respondents' answers to a telephone survey, so data are self-reported and therefore potentially subject to response bias, recall bias, social desirability bias, and other limitations associated with self-report. Great effort is undertaken when administering the BRFSS to mitigate or minimize the risk of such biases, but they cannot be eliminated altogether.
- Indicator estimates are sometimes based on small samples, resulting in low precision of the estimates. If the eBRFSS or BRFSS sample has less than 10 respondents with the condition measured by the health indicator or less than 50 respondents at risk for the health condition, the crude and age-adjusted rates are suppressed. The suppression is noted in the "Notes" field.
- Some crude/age-adjusted rates that meet this requirement may still be estimated but with high variability. Highly variable rates are defined as having confidence limits greater than $\pm 10\%$.
- These highly variable rates are flagged as being unreliable in the "Notes" section. In addition, the age-adjustment process may generate rates that are suspect, due to small (three or fewer observations) age-adjustment cells. The age-adjusted rates with which there are concerns are identified in the "Notes" field. Age-adjusted rates are not calculated for indicators that apply to a specific age-group (e.g., adults 50 to 75 years of age). The indicators with an age-restriction are identified in the "Notes" field.

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

Limitations of Data Use:

- Although crime reports are collected from more than 500 NYS police and sheriffs' departments, this data set is limited to the crimes reported to the police agencies but not the total crimes that occurred.

- Requests for additional information, missing data or actual copies of the crime reports should be directed to DCJS or the local submitting police agency.
- Public access to this crime data is intended solely to allow the public convenient and immediate access to public information. While all attempts are made to provide accurate, current and reliable information, the Division of Criminal Justice Services recognizes the possibility of human and/or mechanical error and that information captured at a point in time may change over time

NYS Traffic Safety Statistical Repository (TSSR)

- ITSMR provides data on police-reported fatal and personal injury crashes and select tickets issued by law enforcement agency via our PTS Data Form. These data include numbers of crashes submitted to the DMV that were “reportable,” meaning a motor vehicle crash reported by a police officer or a motorist, in which there was a fatality, a person injured, and/or property damage of more than \$1,000 to the vehicle of one person. Crashes that occurred in parking lots or on private property are excluded. The ticket counts include only those tickets issued by the police agency and submitted to the DMV.
- In the TSSR ITSMR also provides Crash Data by County and Municipality and Ticket Data by County and Municipality. The crash data here include reportable crashes that occurred within the municipality, regardless of the agency that submitted the crash reports. The ticket data here include the municipality where the tickets were issued, regardless of the agency that submitted the tickets. In the TSSR report County Traffic Tickets — Select Violations by Enforcement Agency, tables show TSLED tickets issued by enforcement agency and submitted to the DMV.
- Tickets submitted to the DMV after DMV has given ITSMR the okay to finalize the ticket data for a calendar year will not appear in that year’s totals.

Student Weight Status Category Reporting System (SWSCRS) Data

Limitations of Data:

- Because of restrictions in reporting due to the FERPA there was variation in how much of the student population was represented in the data school districts submitted, especially among smaller school districts. Therefore, the percentage of the student population represented in the county and regional level estimates may vary. This limits researchers’ ability to draw absolute conclusions about observed differences in student weight status among counties and regions.
- Because school district boundaries do not align with county or regional boundaries, the county and regional-level estimates reflect data from students attending school within districts assigned a particular county or regional-code. County/regional assignment is not based on county or region of residence. The Page 3 of 3 county and regional-level

estimates represent the percentage of students within a weight status category reported to the Student Weight Status Category Reporting System.

- These data should not be considered to represent all school aged-children attending school in that county or region because of: restrictions in reporting due to FERPA, parents/guardians' ability to request that their child's weight status data be excluded from reporting, and other sources of missing data.

US Department of Agriculture (USDA) Food Atlas

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

In the downloadable Excel spreadsheets:

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

NYS Department of Health Tobacco Enforcement Compliance Results

Limitations of Use:

- County health departments and the New York City Department of Consumer Affairs may provide this information on their own websites. These websites and the data on them may be updated more frequently. More detailed information may be obtained directly from these partner agencies or DOH through the Freedom of Information Law (FOIL) process. The FOIL process for DOH can be found on its website, for other agencies' FOIL process please contact them directly.
- Enforcement data reflects information that was gathered during an inspection, and confirmed through official enforcement action. There may be a significant delay between the date of an inspection and the date that a violation is confirmed through

enforcement action. Accordingly, enforcement data included in a certain measurement period may actually reflect violations that occurred in a previous measurement period.

- As previously stated, the data in Health Data NY maps, data lists, and data tables is updated annually. Requests for data pertaining to more recent inspections, or requests for more detailed information or copies of individual inspection reports should be directed to the individual county health department, New York City Department of Consumer Affairs, or State District Office which conducted the inspection or inspections in question.

NYS Department of Health Maternal and Child Health

Unstable Estimates:

- Multiple years of data were combined to generate more stable estimates when the number of events for an indicator was small (i.e., rare conditions). The relative standard error (RSE) is a tool for assessing reliability of an estimate. A large RSE is produced when estimates are calculated based on a small number of cases.¹ Estimates with large RSEs are considered less reliable than estimates with small RSEs. The [National Center for Health Statistics](#) recommends that estimates with RSEs greater than 30% should be considered unreliable/unstable.²
- The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying that result by 100. The RSE is expressed as a percent of the estimate.
- For the Maternal and Child Health dashboard, an asterisk (*) symbol is used to indicate that a percentage or rate is unreliable/unstable. This usually occurs when there are fewer than 10 events in the numerator (RSE is greater than 30%).

Data Suppression for Confidentiality

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

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

| Data Sources | Suppression Criteria | Statistical Significance Techniques |
|-----------------------|---|-------------------------------------|
| Sample Surveys | | |
| BRFSS (NYS) | Unweighted numerator <6 or Unweighted denominator <50 | 95% CI comparison |
| BRFSS (CDC) | Unweighted denominator <30 | 95% CI comparison |

| | | |
|--|-------------------------------------|---|
| NSCH | Unweighted denominator <30 | 95% CI comparison |
| YRBSS | Unweighted denominator <100 | 95% CI comparison |
| NYS PRAMS | Unweighted denominator <30 | 95% CI comparison |
| Population Count Data | | |
| NYS VS | Denominator population or event <30 | Rate/percentage: one sided chi-square test with p-value <0.05 |
| NYS SPARCS | Numerator between 1 - 5 cases | Rate/percentage: one sided chi-square test with p-value <0.05 |
| HCUP-SID | Numerator <=10 | Rate/percentage: one sided chi-square test with p-value <0.05 |
| NVSS | Numerator <10 | Rate/percentage: one sided chi-square test with p-value <0.05 |
| Special Supplemental Nutrition Program for WIC | Indicator has a denominator <50 | Rate/percentage: one sided chi-square test with p-value <0.05 |

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

Department of Health, Wadsworth Center

Limitations of Use:

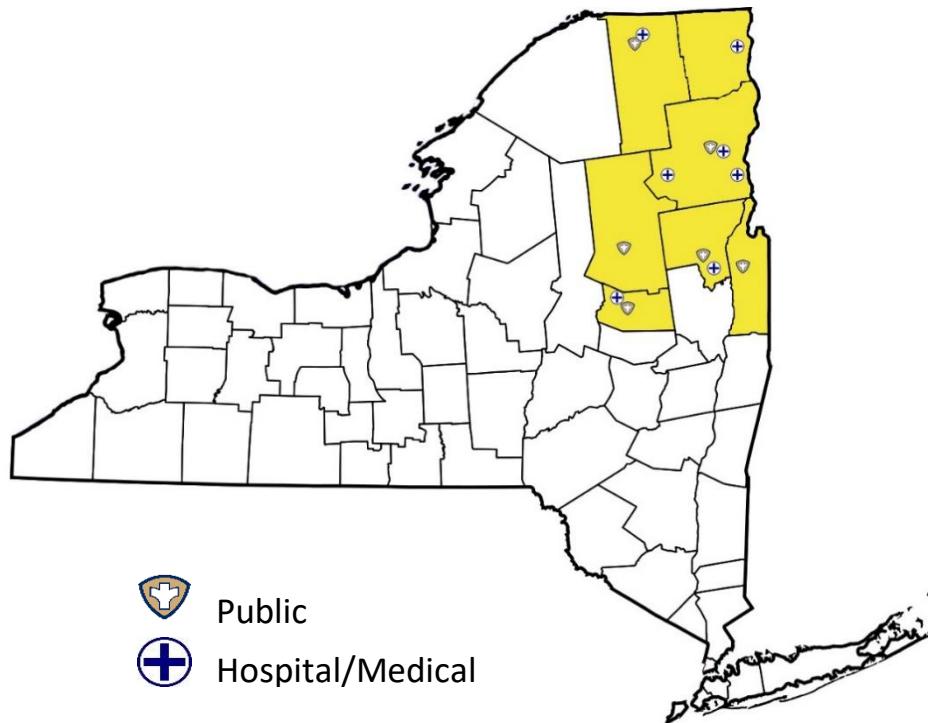
- Address accuracy is dependent on the information provided by the individual submitting the rabies specimen. Additionally, not all submissions are included in the monthly

reports; samples received from out of state and samples that are unsatisfactory for testing are not listed. However, all samples, regardless of the testing outcome, are included in the annual report

(<https://www.wadsworth.org/programs/id/rabies/reports>).

- The data does not describe why the animal was tested. The most common reason to request rabies testing is due to human exposure. However, because rabies has a 99.9% fatality rate, the laboratory often receives samples from animals with neurological illness to rule out rabies before additional tests are performed. For example, the laboratory receives exotic animals with neurological illnesses from zoological settings for rabies testing. If these animals test negative for rabies, additional post- mortem tests can be completed to determine the cause of illness without the risk of exposing multiple people or testing facilities to rabies. The data is not necessarily representative of rabies in wild populations. The data may be biased, since a greater number of sick animals are submitted for testing, as opposed to healthy animals randomly chosen from the wild population.

2025 STAKEHOLDER SURVEY REPORT



Adirondack Rural Health Network Area

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



Adirondack
Rural Health
N E T W O R K

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

2025

BACKGROUND INFORMATION:

Adirondack Rural Health Network:

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

Description of the Community Health Assessment Committee:

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

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

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

CHA Data Sub-Committee:

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

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

SURVEY METHODOLOGY:

Survey Creation:

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

Survey Facilitation:

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

Survey Logistics:

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

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

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

Survey Responses and Analysis:

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

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

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

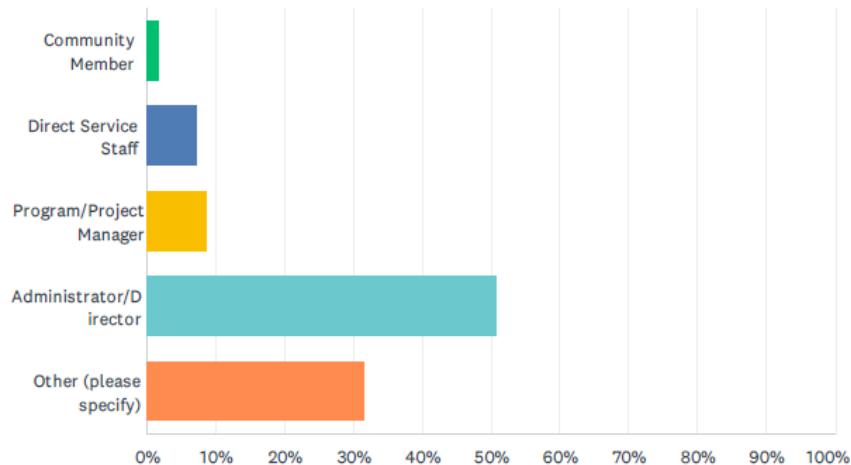
| |
|------------|
| Clinton |
| Essex |
| Franklin |
| Fulton |
| Hamilton |
| Warren |
| Washington |

ANALYSIS:

Q3. Job Title/Role

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

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



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

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

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

Among those who selected “Other,” most listed roles could have fit into one of the defined sectors. To improve clarity in future surveys, it is recommended to refine sector definitions or offer clarifying examples to help respondents accurately categorize their roles.

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

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

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

| Respondents by County | | |
|---------------------------------|-------|------------|
| County | Count | Percentage |
| Adirondack/North Country Region | 68 | 22.30% |
| Clinton | 78 | 25.57% |
| Essex | 118 | 38.68% |
| Franklin | 70 | 22.95% |
| Fulton | 52 | 17.05% |
| Hamilton | 46 | 15.08% |
| Montgomery | 30 | 9.84% |
| Saratoga | 39 | 12.79% |
| Warren | 65 | 21.31% |
| Washington | 89 | 29.18% |
| Other (please specify) | 18 | 5.90% |

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

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

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

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

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

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

| | | | | | |
|---|----|----|----|----|----|
| Maternal Health | 10 | 3 | 4 | 2 | 4 |
| Diabetes | 9 | 15 | 14 | 8 | 7 |
| Hunger | 7 | 3 | 5 | 16 | 8 |
| Dental Health | 5 | 4 | 6 | 4 | 10 |
| Child/Adolescent Physical Health | 4 | 13 | 6 | 8 | 14 |
| Alzheimer's Disease/Dementia | 4 | 9 | 7 | 5 | 5 |
| Respiratory Disease (Asthma, COPD, etc.) | 4 | 3 | 3 | 10 | 13 |
| Disability | 4 | 2 | 5 | 12 | 11 |
| Tobacco Use/Nicotine Addiction- Smoking/Vaping/Chewing | 3 | 12 | 18 | 9 | 15 |
| Domestic Abuse/Violence | 3 | 6 | 9 | 8 | 7 |
| Social Connectedness | 2 | 5 | 17 | 21 | 24 |
| Infant Health | 2 | 5 | 0 | 1 | 3 |
| Prescription Drug Abuse | 2 | 0 | 6 | 2 | 8 |
| Falls | 1 | 3 | 3 | 2 | 3 |
| High Blood Pressure | 1 | 2 | 3 | 4 | 10 |
| Food Safety | 1 | 1 | 1 | 2 | 3 |
| Motor Vehicle Safety (Impaired/Distracted Driving) | 1 | 0 | 1 | 5 | 0 |
| Unintended/Teen Pregnancy | 1 | 0 | 0 | 1 | 5 |
| Autism | 0 | 5 | 5 | 3 | 7 |
| Exposure to Air and Water Pollutants/Hazardous Materials | 0 | 2 | 1 | 1 | 3 |
| Infectious Disease | 0 | 2 | 0 | 3 | 1 |
| Pedestrian/Bicyclist Accidents | 0 | 2 | 0 | 0 | 0 |
| Underage Drinking | 0 | 1 | 3 | 1 | 1 |
| Sexually Transmitted Infections | 0 | 1 | 2 | 1 | 2 |
| Violence (Assault, Firearm Related) | 0 | 1 | 1 | 3 | 3 |
| LGBT Health | 0 | 1 | 1 | 2 | 4 |
| Sexual Assault/Rape | 0 | 1 | 0 | 1 | 0 |
| Suicide | 0 | 0 | 7 | 7 | 5 |
| Stroke | 0 | 0 | 0 | 3 | 3 |
| HIV/AIDS | 0 | 0 | 0 | 2 | 1 |
| Hepatitis C | 0 | 0 | 0 | 1 | 0 |
| Arthritis | 0 | 0 | 0 | 0 | 1 |

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

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

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

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

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

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

| Contributing Factors | Highest (1) | 2 | 3 | 4 | Lowest (5) |
|--|-------------|----|----|----|------------|
| Addiction to Alcohol/Illlicit Drugs | 36 | 17 | 18 | 9 | 10 |
| Addiction to Nicotine | 6 | 9 | 7 | 7 | 6 |
| Age of Residents | 23 | 9 | 3 | 6 | 8 |
| Changing Family Structures (Increased Foster Care, Grandparents as Parents, etc.) | 16 | 24 | 9 | 10 | 9 |
| Crime/Violence | 1 | 2 | 2 | 3 | 4 |
| Community Blight/Deteriorating Infrastructure (Roads, Bridges, Water Systems, etc.) | 0 | 1 | 1 | 1 | 0 |
| Discrimination/Racism | 0 | 2 | 1 | 3 | 0 |
| Domestic Violence and Abuse | 3 | 8 | 4 | 6 | 7 |
| Environmental Quality | 4 | 3 | 4 | 6 | 1 |
| Excessive Screen Time | 9 | 8 | 14 | 13 | 3 |
| Exposure to Tobacco Smoke/Emissions from Electronic Vapor Products | 1 | 2 | 4 | 2 | 3 |
| Food Insecurity | 8 | 10 | 15 | 11 | 8 |
| Health Care Costs | 10 | 15 | 17 | 7 | 10 |
| Homelessness | 5 | 10 | 7 | 6 | 6 |
| Inadequate Physical Activity | 6 | 15 | 10 | 15 | 7 |
| Inadequate Sleep | 0 | 4 | 3 | 1 | 4 |
| Inadequate/Unaffordable Housing Options | 4 | 13 | 12 | 12 | 7 |
| Lack of Chronic Disease Screening Treatment and Self-Management Services | 6 | 5 | 8 | 7 | 4 |
| Lack of Cultural and Enrichment Programs | 1 | 2 | 2 | 1 | 1 |
| Lack of Dental/Oral Health Care Services | 3 | 2 | 8 | 5 | 4 |
| Lack of Quality Educational Opportunities for People of All Ages | 2 | 1 | 0 | 1 | 2 |
| Lack of Educational, Vocational, or Job-Training Options for Adults | 0 | 0 | 1 | 0 | 3 |
| Lack of Employment Options | 3 | 1 | 2 | 1 | 4 |
| Lack of Health Education Programs | 2 | 0 | 2 | 2 | 2 |
| Lack of Health Insurance | 1 | 3 | 2 | 9 | 2 |
| Lack of Intergenerational Connections within Communities | 2 | 2 | 1 | 6 | 7 |
| Lack of Mental Health Services | 36 | 22 | 23 | 16 | 8 |
| Lack of Opportunities for Health for People with Physical Limitations or Disabilities | 2 | 1 | 1 | 2 | 1 |
| Lack of Preventive/Primary Health Care Services (Screenings, Annual Check-Ups) | 6 | 5 | 4 | 5 | 1 |
| Lack of Social Supports for Community Residents | 1 | 6 | 3 | 8 | 10 |
| Lack of Specialty Care and Treatment | 3 | 4 | 3 | 3 | 6 |
| Lack of Substance Use Disorder Services | 1 | 6 | 7 | 5 | 4 |
| Late or No Prenatal Care | 0 | 2 | 0 | 2 | 0 |

| | | | | | |
|--|----|----|----|----|----|
| Pedestrian Safety (Roads, Sidewalks, Buildings, etc.) | 0 | 0 | 0 | 0 | 1 |
| Poor Access to Healthy Food and Beverage Options | 3 | 5 | 7 | 4 | 7 |
| Poor Access to Public Places for Physical Activity and Recreation | 0 | 0 | 1 | 5 | 4 |
| Poor Community Engagement and Connectivity | 4 | 2 | 4 | 5 | 10 |
| Poor Eating/Dietary Practices | 11 | 9 | 12 | 5 | 7 |
| Poor Referrals to Health Care, Specialty Care, and Community-Based Support Services | 4 | 3 | 4 | 5 | 4 |
| Poverty | 30 | 12 | 14 | 19 | 20 |
| Problems with Internet Access (Absent, Unreliable, Unaffordable) | 0 | 0 | 0 | 0 | 1 |
| Religious or Spiritual Values | 0 | 0 | 1 | 1 | 1 |
| Shortage of Child Care Options | 2 | 2 | 2 | 4 | 8 |
| Stress (Work, Family, School, etc.) | 6 | 16 | 12 | 15 | 15 |
| Transportation Problems (Unreliable, Unaffordable) | 4 | 8 | 9 | 13 | 15 |
| Unemployment/Low Wages | 6 | 0 | 5 | 2 | 19 |

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

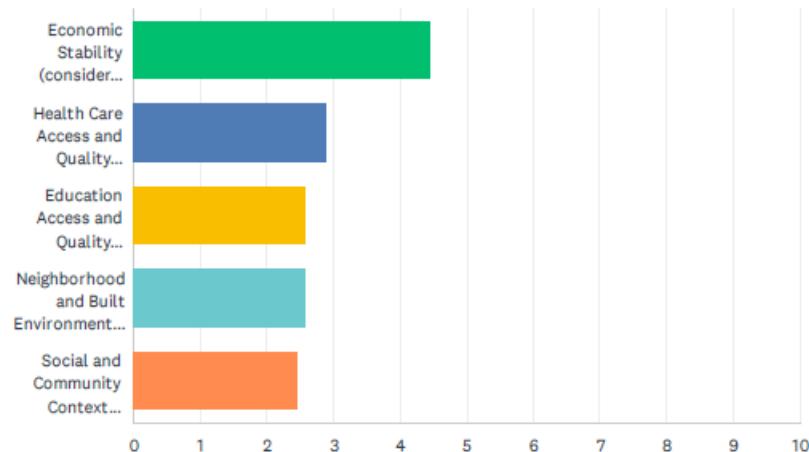
| Top Five Contributing Factors by County | | | | | |
|---|------------------------------------|------------------------------------|------------------------------------|------------------------------------|-------------------|
| County | 1 st | 2 nd | 3 rd | 4 th | 5 th |
| Clinton | Poverty | Addiction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

| | | | | | |
|------------|---------|--------------------------------|------------------------------------|----------------------------|----------------------------------|
| Warren | Poverty | Lack of Mental Health Services | Addiction to alcohol/illicit drugs | Transportation problems | Health Care Costs & Homelessness |
| Washington | Poverty | Lack of Mental Health Services | Addiction to alcohol/illicit drugs | Changing Family Structures | Age of Residents |

Q9. Social Determinants of Health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

Please rate the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "most impact" to (5) "least impact".

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



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

| SDOH Domain | 1 Most Impact | 2 | 3 | 4 | 5 Least Impact | Score |
|---------------------------------------|-----------------|----------------|----------------|----------------|----------------|-------|
| Economic Stability | 170 (66.15%) | 56 (21.79%) | 16 (6.23%) | 10 (3.89%) | 5 (1.95%) | 4.46 |
| Health Care Access and Quality | 38 (14.79%) | 64 (24.90%) | 51 (19.84%) | 41 (15.95%) | 63 (24.51%) | 2.89 |
| Education Access and Quality | 25 (9.73%) | 46 (17.90%) | 50 (19.46%) | 71 (27.63%) | 65 (25.29%) | 2.59 |

| | | | | | | |
|---|---------------|----------------|----------------|----------------|----------------|------|
| Neighborhood and Built Environment | 15 (5.84%) | 50 (19.46%) | 65 (25.29%) | 66 (25.68%) | 61 (23.74%) | 2.58 |
| Social and Community Context | 9 (3.50%) | 41 (15.95%) | 75 (29.18%) | 69 (26.85%) | 63 (24.51%) | 2.47 |

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

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

| Population | Count | Percentage |
|--|--------------|-------------------|
| Children/Adolescents | 17 | 6.32% |
| Females of Reproductive Age | 2 | 0.74% |
| Individuals living at or near the federal poverty level | 88 | 32.71% |
| Individuals living in rural areas | 26 | 9.67% |
| Individuals with Disability | 11 | 4.09% |
| Individuals with Mental Health issues | 58 | 21.56% |
| Individuals with Substance Abuse Issues | 26 | 9.67% |
| Migrant Workers | 1 | 0.37% |
| Other (please specify) | 2 | 0.74% |
| Seniors/Elderly | 37 | 13.75% |
| Specific racial and ethnic groups | 1 | 0.37% |

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

| Response Counts for Poorest Health Outcomes by County | | | | | | | |
|--|----------------|--------------|-----------------|---------------|-----------------|---------------|-------------------|
| Population | Clinton | Essex | Franklin | Fulton | Hamilton | Warren | Washington |
| Children/Adolescents | 2 | 7 | 3 | 1 | 1 | 2 | 5 |
| Females of reproductive age | 1 | 0 | 0 | 1 | 0 | 0 | 0 |
| Individuals living at or near the federal poverty level | 20 | 32 | 22 | 15 | 12 | 17 | 27 |
| Individuals living in rural areas | 10 | 10 | 7 | 3 | 4 | 8 | 10 |
| Individuals with disability | 5 | 6 | 3 | 0 | 3 | 6 | 4 |
| Individuals with mental health issues | 12 | 19 | 7 | 13 | 9 | 14 | 13 |

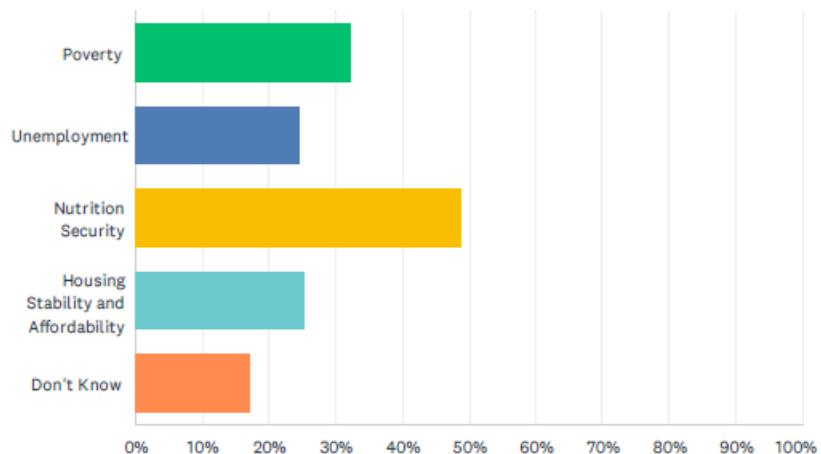
| | | | | | | | |
|---|----|-----|----|----|----|----|----|
| Individuals with substance abuse issues | 9 | 10 | 9 | 5 | 6 | 4 | 6 |
| Migrant workers | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Seniors/Elderly | 10 | 14 | 9 | 7 | 5 | 3 | 7 |
| Specific racial or ethnic groups | 0 | 1 | 0 | 0 | 1 | 1 | 1 |
| Other (please specify) | 1 | 1 | 1 | 2 | 1 | 2 | 1 |
| Total per county | 76 | 116 | 69 | 52 | 46 | 64 | 89 |

2025 New York State Prevention Agenda:

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

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

Q11. Economic Stability (Economic Well-Being)



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

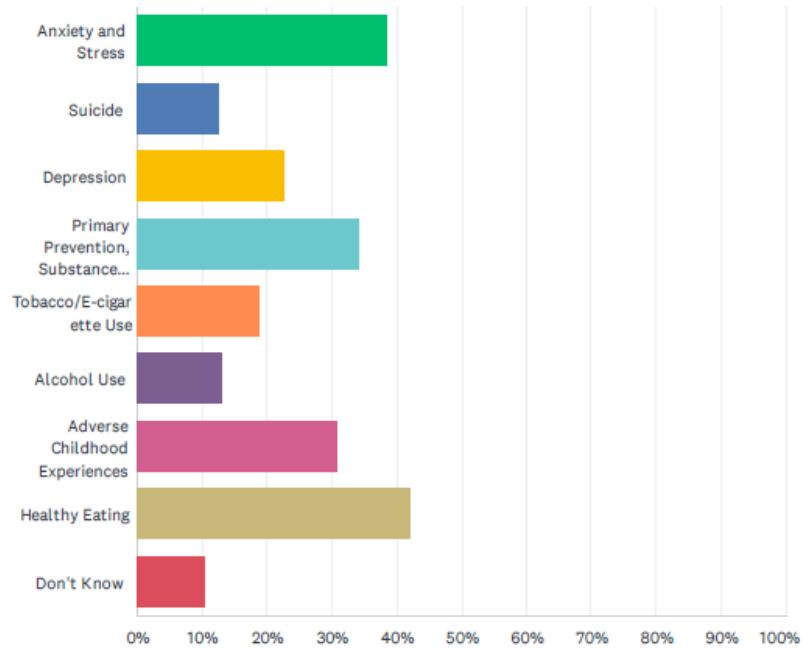
Respondents identified *Nutrition Security* (48.91%), *Poverty* (32.31%), and *Housing Stability and Affordability* (25.33%) as the top three priority areas that their organization are best positioned to support achieving in the region. Six out of seven ARHN counties identified

Nutrition Security as the top priority, with the exception of Franklin County which identified *Poverty*.

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

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

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



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

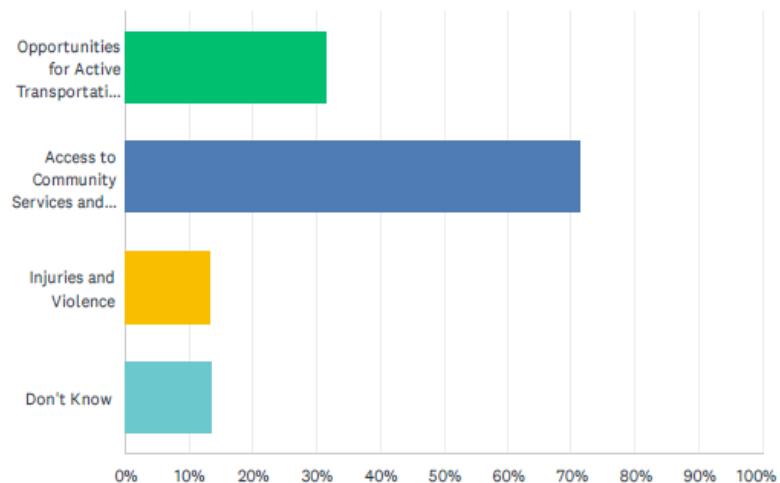
| Domain: Social and Community Context | | | |
|--|-------|------------|--|
| Priority Area | Count | Percentage | |
| Adverse Childhood Experiences | 74 | 30.96% | |
| Alcohol Use | 31 | 12.97% | |
| Anxiety and Stress | 92 | 38.49% | |
| Depression | 54 | 22.59% | |
| Healthy Eating | 101 | 42.26% | |
| Primary Prevention, Substance Misuse, and Overdose Prevention | 82 | 34.31% | |
| Suicide | 30 | 12.55% | |
| Tobacco/E-cigarette Use | 45 | 18.83% | |
| Don't Know | 25 | 10.46% | |

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

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

| Domain: Social and Community Context | | | | | | | |
|---|---------|-------|----------|--------|----------|--------|------------|
| Priority Area | Clinton | Essex | Franklin | Fulton | Hamilton | Warren | Washington |
| Adverse Childhood Experiences | 16 | 29 | 12 | 12 | 8 | 16 | 23 |
| Alcohol Use | 8 | 16 | 11 | 6 | 6 | 6 | 7 |
| Anxiety and Stress | 26 | 32 | 19 | 17 | 12 | 20 | 26 |
| Depression | 17 | 22 | 18 | 8 | 9 | 10 | 12 |
| Healthy Eating | 29 | 34 | 17 | 15 | 10 | 18 | 23 |
| Primary Prevention, Substance Misuse, and Overdose Prevention | 22 | 34 | 22 | 15 | 12 | 16 | 22 |
| Suicide | 10 | 16 | 12 | 4 | 6 | 4 | 5 |
| Tobacco/E-cigarette Use | 15 | 17 | 15 | 6 | 8 | 9 | 13 |
| Don't Know | 4 | 10 | 3 | 5 | 4 | 5 | 6 |

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

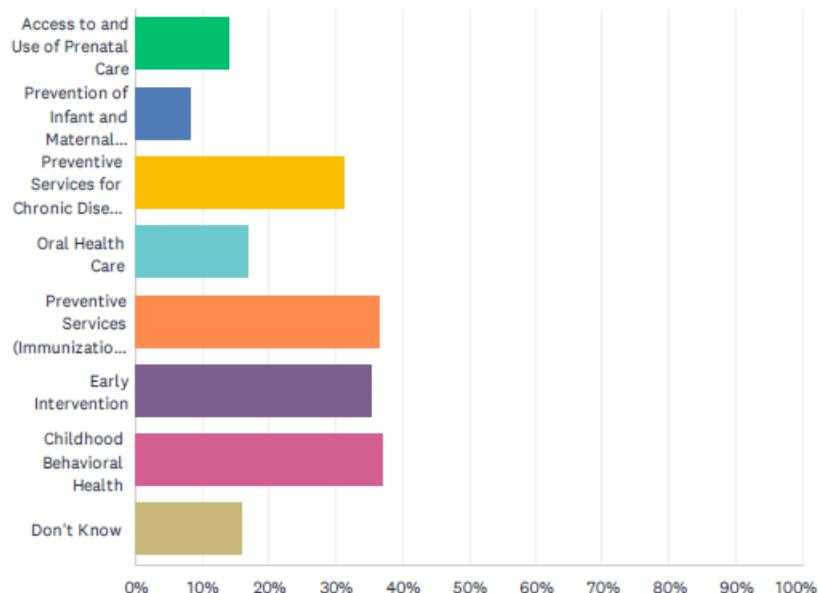


| Domain: Neighborhood and Built Environment | | |
|---|-------|------------|
| Priority Area | Count | Percentage |
| Access to Community Services and Support | 167 | 71.37% |
| Injuries and Violence | 31 | 13.25% |
| Opportunities for Active Transportation and Physical Activity | 74 | 31.62% |
| Don't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

| Domain: Neighborhood and Built Environment | | | |
|--|--|---|-----------------------|
| County/Region | Priority #1 | Priority #2 | Priority #3 |
| Clinton | Access to Community Services and Support | Opportunities for Active Transportation and Physical Activity | Injuries and Violence |
| Essex | Access to Community Services and Support | Opportunities for Active Transportation and Physical Activity | Injuries and Violence |
| Franklin | Access to Community Services and Support | Opportunities for Active Transportation and Physical Activity | Injuries and Violence |
| Fulton | Access to Community Services and Support | Opportunities for Active Transportation and Physical Activity | Injuries and Violence |
| Hamilton | Access to Community Services and Support | Tied: Opportunities for Active Transportation and Physical Activity & Injuries and Violence | |
| Warren | Access to Community Services and Support | Opportunities for Active Transportation and Physical Activity | Injuries and Violence |
| Washington | Access to Community Services and Support | Opportunities for Active Transportation and Physical Activity | Injuries and Violence |

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

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

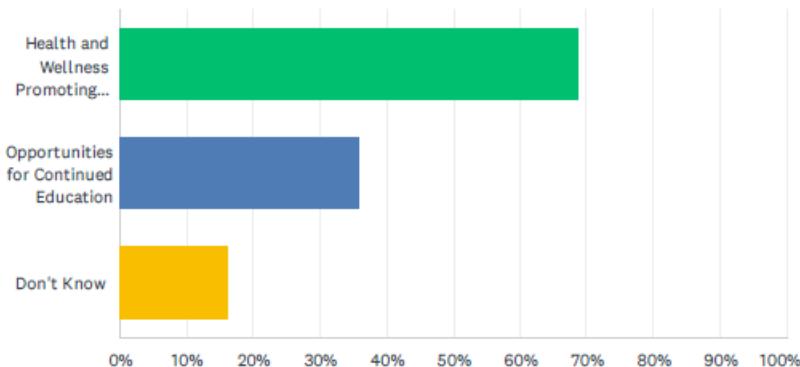


| Domain: Health Care Access and Quality | | | |
|--|-------|------------|--|
| Priority Area | Count | Percentage | |
| Access to and Use of Prenatal Care | 32 | 14.16% | |
| Childhood Behavioral Health | 84 | 37.17% | |
| Early Intervention | 80 | 35.40% | |
| Oral Health Care | 38 | 16.81% | |
| Prevention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

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

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

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



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

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

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

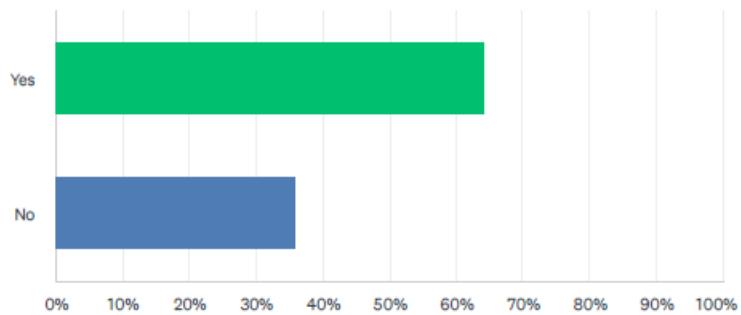
Q16. Please identify the primary assets/resources your organization/agency can contribute toward achieving the goals you have selected.

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

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

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

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



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

Appendix: The 2025 Stakeholder Survey

2025 CHA Stakeholders Survey

Introduction

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

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

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

Your Organization/Agency

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

1. Organization/Agency name: _____

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

3. Your job title/role: _____

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

4. Your email address: _____

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

- Business
- Civic Association
- College/University

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

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

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

Health Priorities, Concerns and Factors

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

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

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

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

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

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

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

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

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

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

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

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

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

Social Determinants of Health

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

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

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

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

Improving Health and Well-Being

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

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

11. Economic Stability (Economic Well-being)

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

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

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

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

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

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

- Access to and Use of Prenatal Care
- Prevention of Infant and Maternal Mortality

- Preventive Services for Chronic Disease Prevention and Control
- Oral Health Care
- Preventive Services (Immunization, Hearing Screening and follow up, Lead screening)
- Early Intervention
- Childhood Behavioral Health

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

- Health and Wellness Promoting Schools
- Opportunities for Continued Education

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

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

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

- Yes
- No

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

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

| Category | Agency |
|------------------------------------|---|
| STI, HIV, Infectious Diseases | Alliance for Positive Health |
| Aging/Seniors | Office for the Aging Nutrition Services |
| Aging/Seniors | Senior Citizens Council |
| | AHI/Adirondacks ACO |
| DSS/Child Welfare | STOP Domestic Violence |
| Young Children (EI, Special Needs) | Child Care Coordinating Council |
| | Community Pediatrician |
| Education | Champlain Valley Educational Services |
| Other Agencies | United Way |
| | Clinton County Legislature |
| | Clinton County Nursing Home |
| Hospitals | UVMHN-CVPH Medical Center |
| Other Agencies | NAMI |
| | St. Joseph's Community Outreach Center |
| | Clinton County Health Department |
| Employment and Training | Literacy Volunteers |
| Healthy Environment | Town of Plattsburgh |
| Public Health | Strand Center for the Arts |
| | Community Primary Care MD/CCHD Medical Consultant |
| | Town of Plattsburgh, Planning |
| STI, HIV, Infectious Diseases | Planned Parenthood of NCNY |
| Aging/Seniors | Office for the Aging |
| Behavioral Health (MH and SA) | BHSN |
| Employment and Training | ETS |
| DSS/Child Welfare | Catholic Charities |
| Other Agencies | Office of Emergency Services |
| Behavioral Health (MH and SA) | Clinton County Addiction Services |
| | Clinton County Board of Health |
| Other Agencies | American Red Cross |
| Other Agencies | Chamber of Commerce |
| | Former Legislator, Farmer |
| | SUNY Plattsburgh |
| Other Agencies | Sheriff |
| Employment and Training | One Work Source |
| MR, DD, People with Disabilities | ARC of Clinton County |
| Aging/Seniors | Clinton County RSVP |
| Employment and Training | Cornell Cooperative Extension |
| Education | SUNY Plattsburgh |
| | JCEO |
| Other Agencies | NYS Police |
| Housing/Homelessness | ETC Housing Corporation |
| Other Agencies | Mountain Lake PBS |
| Housing/Homelessness | Plattsburgh Housing Authority |
| | City of Plattsburgh, Mayor |
| Other agencies | YMCA |
| Education | Tobacco Free CFE |
| Other Agencies | Office of NYS Assemblyman |
| Employment and Training | The Development Corporation |
| | Clinton County Board of Health |
| | Plattsburgh Interfaith Food Shelf |
| Housing/Homelessness | JCEO |
| Employment and Training | Veteran's Department |
| Education | Superintendent Pburgh School |
| Public Health | Director of Health Care Services |
| | Chazy CSD |
| DSS/Child Welfare | Victim's Advocate |
| | Village of Champlain |
| | Friends of the North Country |
| | Town of Plattsburgh, Recreation |
| Education | Superintendent Saranac CSD |
| DSS/Child Welfare | Department of Social Services |
| Other Agencies | Healthy Families NY, BHSN |
| MR, DD, People with Disabilities | North Country Center for Independence |
| Other Agencies | Meadowbrook Admin |
| Other Agencies | Salvation Army |
| Public Health | Director of Environmental Health and Safety |
| | BHSN |
| MR, DD, People with Disabilities | Office for People with Devleopmental Disabilities |

| | |
|------------------------------------|---|
| Education | Planned Parenthood of NCNY |
| Young Children (EI, Special Needs) | Youth Bureau |
| Public Health | Clinton County Health Department |
| Business | Small Business Development Center |
| Other Agencies | US Representative |
| | Adirondack Food System Network |
| Other Agencies | Department of Planning |
| | Town of Champlain |
| Public Health | Hospice of the North Country |
| Education | Headstart |
| Behavioral Health (MH and SA) | Champlain Valley Family Center |
| Other Agencies | Clinton County District Attorney |
| | Clinton Community College |
| Public Health | Community Link Mobile Health |
| Other Agencies | County Administrator |
| Behavioral Health (MH and SA) | Mental Health Association |
| Health | Essex County Health Department-PHAC |
| DDS/Child Welfare | Essex County Social Services |
| | |
| Local Government | Town of Chesterfield |
| Hospitals | Adirondack Health-Lake Placid Health Center |
| Aging/Seniors | Mercy Care for the Adirondacks |
| Public Health | Essex County Health Department |
| Health | Essex County Health Department-WIC Program |
| Other Agency | United Way of Clinton, Essex, Franklin Counties |
| Education | Ticonderoga CS, High School |
| Education | Northwood School |
| Pharmacy | Keeseeville Pharmacy |
| Education | Minerva Central School |
| Local Government | Town of Moriah |
| Foundation | Adirondack Foundation |
| Education | Ticonderoga CS, Elem. |
| Other Agency | Industrial Development Agency of Essex County |
| Healthcare | Planned Parenthood of North Country NY |
| Education | Mountainside Christian Academy |
| Behavioral Health (MH and SA) | Families First in Essex County |
| MR, DD, People with Disabilities | Tri-Lakes Center for Independent Living |
| Education | Crown Point Central School |
| Health | Essex County Health Department-Children's Services |
| Healthcare | UVHN-Elizabethtown Community Hospital |
| Local Government | Town of North Hudson |
| Behavioral Health (MH and SA) | Essex County Mental Health |
| Other Agency | Literacy Volunteers of Essex-Franklin Counties |
| Public Health | Essex County Health Department-Public Health |
| Law Enforcement | NYS Police |
| Pantry | Minerva Food Pantry |
| Local Government | Town of Newcomb |
| Local Government | Lake Placid Village |
| Law Enforcement | Lake Placid Police Department |
| Local Government | Town of North Elba |
| Other Agency | North Country Chamber of Commerce |
| Pharmacy | Schroon Lake Pharmacy |
| Education | Saranac Lake Central School |
| Other Agency | Craigardan |
| Healthcare clinic | Hudson Headwaters Health Network |
| Local Government | Essex County |
| Hospitals | UVHN-Elizabethtown Community Hospital - AuSable Forks |
| Other Agency | Essex County Office of Emergency Services |
| Education | Adirondack Community Action Program |
| Education | Newcomb Central School |
| Education | Ausable Valley Central School |
| Education | Willsboro Central School |
| Aging/Seniors | UVMHN Elizabethtown Community Hospital - Community Volunteer Friendship Program |
| Local Government | Town of Willsboro |
| Employment and Training | Elizabethtown One Work Source Center |
| Education | Boquet Valley Central School - Lake View Campus |
| Local Government | Town of Crown Point |
| Media | North Country Public Radio |
| Education | North Country School |
| Healthcare clinic | Hudson Headwaters Health Network-Ticonderoga |
| Local Government | Town of Essex |

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| Law Enforcement | Ticonderoga Police Department |
| Hospitals | Adirondack Health-Keene Health Center |
| Other Agency | Tobacco Free CFE & Reality Check |
| Education | Adirondack Community Action Program/Elizabethtown One Work Source Center |
| Education | North County Community College |
| Hospitals | Adirondack Health |
| Hospitals | Inter-Lakes Health |
| Law Enforcement | Essex County Government |
| Education | Moriah Central School |
| Other Agency | Cornell Cooperative Extension |
| Aging/Seniors | Essex County Office for the Aging |
| MR, DD, People with Disabilities | Mountain Lake Services |
| Pharmacy | Willsboro Pharmacy |
| Education | Lake Placid Central School |
| Education | Mountain Lake Academy |
| Media | Adirondack Daily Enterprise |
| Education | Keene Central School |
| Local Government | Town of Minerva |
| Education | Boquet Valley Central School |
| Aging/Seniors | Retired Senior Volunteer Program |
| Local Government | Town of Lewis |
| Media | Press Republican |
| Health | Healthy Heart Network |
| Pantry | St. Patrick's Church Hall |
| Pantry | Jay/Wilmington Food Shelf |
| Housing/Homelessness | Adirondack Roots |
| Education | Ticonderoga Central School |
| Healthcare | Essex County Health Department-Home Health |
| Education | Boquet Valley Central School - Mountain View Campus |
| Hospitals | UVHIN-Elizabethtown Community Hospital and Ticonderoga Campus |
| Education | Schroon Lake Central School |
| Behavioral Health (MH and SA) | Substance Abuse Prevention Team of Essex County |
| Behavioral Health (MH and SA) | St. Josephs Outpatient Clinic |
| Local Government | Town of Elizabethtown |
| Law Enforcement | Essex County Sheriff |
| Other Agency | Essex County Community Resources Department |
| Aging/Seniors | Keene Valley Neighborhood House |
| Media | Adk Explorer |
| Health | NYSDOH District Office for Environmental Health |
| Healthcare | Planned Parenthood of Greater NY |
| Aging/Seniors | Champlain Valley Senior Center |
| Hospitals | UVHIN-Elizabethtown Community Hospital - Smith House |
| Local Government | Town of Wilmington |
| Education | Ausable Valley CS, Ausable Forks Elem. |
| Local Government | Town of Jay |
| Healthcare clinic | Hudson Headwaters Health Network-Schroon Lake |
| Local Government | Town of St. Armand |
| Hospitals | UVHIN-Elizabethtown Community Hospital |
| Behavioral Health (MH and SA) | Behavioral Health Services North |
| Aging/Seniors | Elderwood Village |
| Education | St. Agnes Parochial School |
| Local Government | Town of Westport |
| Pharmacy | Port Henry Pharmacy |
| Aging/Seniors | Saranac Village at Will Rogers |
| Healthcare clinic | UVMHN- Elizabethtown Community Hospital - Crown Point Health Center |
| Local Government | Village of Saranac Lake |
| Housing/Homelessness | PRIDE of Ticonderoga |
| Local Government | Town of Keene |
| Healthcare clinic | Hudson Headwaters Health Network- Moriah |
| Education | Saranac Lake Central School - Bloomingdale Elementary |
| Local Government | Town of Schroon |
| Local Government | Town of Ticonderoga |
| Pantry | Ecumenical Charity Program of Lake Placid |
| Aging/Seniors | Montcalm Manor |
| Behavioral Health (MH and SA) | Birth to Three |
| Education | Adirondack Christian School |
| Education | FEH BOCES |
| Media | Sun Community News |
| Media | Lake Placid News |
| Media | Local 22 WVNY Local 44 WFFF |
| Media | NBC News Channel 5 |

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| Media | WCAX |
| Other Agency | Essex County Veteran's Services |
| Pantry | Ausable Forks Food Pantry |
| Pantry | Ticonderoga First United Methodist Church |
| Substance Use/Harm Reduction | Alliance for Positive Health |
| Veteran Support | Homeward Bound Adirondacks |
| Housing/Homelessness | Tupper Lake Housing Authority |
| Other Agencies | Community Health Center of the North Country |
| Hospitals | Alice Hyde Medical Center |
| Other Agencies | United Way of the ADK Region |
| Aging/Seniors | Franklin County Office for the Aging/CARES |
| Public Health | Franklin County Public Health |
| MR, DD, People with Disabilities | North Star/Citizen Advocates |
| Behavioral Health (MH and SA) | Adirondack ARC |
| Other Agencies | Tupper Lake Fire Department |
| Law Enforcement | Franklin County Sheriff |
| Behavioral Health (MH and SA) | St. Regis Mohawk Health Services |
| Law Enforcement | Franklin County District Attorney |
| Emergency Services | Franklin County Emergency Services |
| County Leadership | Franklin County Legislature |
| County Leadership | Legislator |
| Economic Development | Adirondack Frontier |
| County Leadership | Tupper Lake Mayor |
| Education | Chateaugay Central School |
| Housing/Homelessness | Franklin County Community Housing |
| Other Agencies | Cornell Coop |
| Education | Literacy Volunteers of Essex & Franklin Counties |
| Other Agencies | North Country Healthy Heart Network |
| Education | Salmon River Central School |
| Economic Development | Franklin County Economic Development |
| Other Agencies | Saranac Lake Volunteer Rescue Squad |
| Hospitals | Adirondack Medical Center |
| Other Agencies | Greater Malone YMCA |
| Other Agencies | Tobacco Free CEF |
| Other Agencies | North Country Community College |
| Other Agencies | Cornell Cooperative Extension |
| Other Agencies | St. Regis Mohawk Health Services |
| Other Agencies | Saranac Lake Fire Department |
| County Leadership | County Manager |
| Behavioral Health (MH and SA) | Community Connections of Franklin County |
| Substance Use Treatment | St. Joseph's Addiction, Treatment, and Recovery |
| Public Health | Franklin County Community Services |
| Home Health Care | North Country Home Services |
| Education | Brushton-Moira Central School |
| Housing/Homelessness | Malone Housing Authority |
| Transportation | Franklin County Transportation |
| Transportation | Franklin County Highway Department |
| DSS/Child Welfare | Franklin County Social Services |
| Education | Malone CS, Davis Elem. |
| Housing/Homelessness | Harrietstown Housing Authority |
| Other Agencies | Malone Callfiremen |
| Education | Malone Central School District |
| Education | Malone CS, Flanders |
| Behavioral Health (MH and SA) | Citizen Advocates |
| Education | Malone CS, St. Joseph's Elem. |
| Healthy Environment | NYSDOH Regional Office |
| Education | Malone CS, Franklin Academy |
| Education | Tupper Lake Central School |
| Aging/Seniors | Hospice of the North Country |
| County Leadership | Saranac Lake Mayor |
| Other Agencies | Families R Us |
| Education | Gloversville Enlarged School District |
| Education | Wheelerville Union Free School |
| Other Agencies | ACCES V-R |
| Education | HFM BOCES |
| Education | Greater Johnstown School District |
| Education | Oppenheim-Ephrathah-St Johnsville School District |
| Healthcare | Nathan Littauer Hospital |
| Healthcare | Planned Parenthood of Greater New York |
| Healthcare | Cancer Prevention In Action of Fulton, Montgomery & Schenectady Counties |
| Education | Northville Central School |

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| Education | Mayfield Central School |
| Other Agencies | HFM Prevention/ASAP's Promise |
| Other Agencies | Centro Civico of Amsterdam Inc. |
| Aging/Seniors | Gloversville Senior Center |
| Behavioral Health (MH and SA) | Family Counseling Center |
| Behavioral Health (MH and SA) | Mental Health Association of Fulton & Montgomery Counties |
| Healthcare | St. Mary's Healthcare |
| Aging/Seniors | Mountain Valley Hospice |
| Aging/Seniors | Fulton County Office for the Aging |
| Other Agencies | Community Services Board |
| Other Agencies | Cornell Cooperative Extension (Washington County) |
| healthcare | Cancer Services Program of Fulton, Montgomery & Schenectady Counties |
| healthcare | Fulton County Public Health |
| education | Oppenheim-Ephratah-St. Johnsville School District |
| Other Agencies | Gloversville Workforce Solutions (FMS Workforce Solutions) |
| Other Agencies | Capital District Childcare Coordinating Council changed to Brightside Up |
| Other Agencies | Lexington Center |
| Other Agencies | Brightside Up |
| education | Gloversville Enlarged School District |
| Aging/Seniors | Resource Center for Independent Living |
| Other Agencies | Traffic Safety Board & Lifeline |
| Other Agencies | Mountain Valley Hospice |
| Other Agencies | NYSDOH Herkimer District Office |
| Education | Broadalbin-Perth Central School District |
| Other Agencies | Catholic Charities |
| Other Agencies | YMCA |
| Healthcare | Veteran's Affairs |
| Other Agencies | Gloversville Housing Authority |
| healthcare | Nathan Littauer Hospital |
| Aging/Seniors | Johnstown Senior Center |
| Behavioral Health (MH and SA) | Fulton County Department of Social Services |
| Education | Fulton Montgomery Community College |
| Other Agencies | Fulmont Development- WIC Program |
| Other Agencies | Fulmont Development |
| Other Agencies | Warren/Hamilton Community Action |
| Other Agencies | Parsons Family and Child Center |
| Other Agencies | Adirondack Speculator Region of Commerce |
| Other Agencies | SAIL |
| Other Agencies | Department of Social Services |
| Other Agencies | OPWDD |
| Other Agencies | HFM Prevention Council |
| Healthcare | Nathan Littauer Primary Care - Speculator |
| Healthcare | Fidelis/Insurance |
| Hospitals/Health Centers | Hudson Headwaters Health Network |
| Health Centers & Physician Practices | Emergency Care Center at GFH |
| Education | Johnsburg Central School |
| Hospital | Emergency Care Center at GFH |
| Education | North Warren Central School |
| Housing/Homelessness | Town of Queensbury Housing |
| | North Country Ministries |
| Education | Lake George School District |
| | Queensbury Central School |
| Hospitals/Health Center | Glens Falls Hospital |
| Employment and Training | Adirondack Chamber of Commerce |
| Education | Bolton Landing Central School |
| MR, DD, People with Disabilities | Community Workshops Inc. |
| Health Centers & Physician Practices | Adirondack Cardiology |
| DSS/Child Welfare | Warren County DSS |
| STI, HIV, Infectious Disease | Hudson Headwaters Health Network |
| Education | Warrensburg Central School |
| Other Agencies | Adirondack Health Institute |
| Other Agencies | Glens Falls Family YMCA |
| Other Agencies | Tri County United Way |
| Education | Glens Falls City Schools |
| | Adirondack Health Institute |
| Other Agency | Lake George Caldwell Presbyterian Church |
| MR, DD, People with Disabilities | Warren Washington County Chapter NYSARC |
| Education | WSWHE BOCES |
| | Glens Falls Pediatrics |
| Health Centers & Physician Practices | Adirondack ENT |
| Young Children | Prospect Child & Family Center |

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| Other Agencies | Warren County Veteran's Services |
| | St. Mary's Regional Academy |
| Public Health | Warren County Health Services |
| Hospitals/Health Centers | Adirondack Pediatrics |
| Hospitals | Glens Falls Hospital Cancer Services |
| Education | SUNY Adirondack |
| Young Children | Big Brothers/Big Sisters of Warren/Washington Counties |
| | Johnsburg Central School |
| Other Agencies | Hague Community Center |
| | SUNY Adirondack |
| Education | Queensbury Central School |
| Education | Abraham Wing Common School |
| Other Agencies | Parks and Trails New York |
| Other Agencies | Church of the Messiah |
| Behavioral Health | Warren-Washington Assoc. for Mental Health |
| Education | Saint Mary's Academy |
| Health Centers & Physician Practices | Saratoga Endocrinology |
| Education | Hadley-Luzerne School |
| Other Agencies | Mountain Lakes Regional EMS Council |
| Other Agencies | Community Maternity Services of Warren/Washington Counties |
| Other Agency | Adirondack Health Institute |
| | Warrensburg Central School |
| Young Children | Warren County Headstart |
| Other Agencies | Office of Senator Betty Little |
| | Warren County Headstart |
| Other Agencies | North Country Ministries |
| Housing/Homelessness | Homeless Youth Coalition-Wait House |
| Health Centers & Physician Practices | Nutrition Center at GFH |
| | Adirondack Pediatrics |
| Hospitals/Health Centers | Glens Falls Pediatrics |
| Employment & Training | One Stop Career Center of Warren County |
| Health Centers & Physician Practices | Evergreen Health Center |
| | Warren County Office for the Aging |
| Other Agencies | Conkling Center |
| Other Agencies | Cornell Cooperative Extension of Warren County |
| Health Centers & Physician Practices | Cambridge Family Health Center & Urgent Care |
| Hospitals/Health Centers | Irongate Family Practice Associates |
| Public Health | Catholic Charities-Saratoga/Warren/Washington Counties |
| Health Centers & Physician Practices | Center for Lung & Chest Surgery |
| Other Agencies | Glens Falls Foundation |
| Other Agencies | Adirondack Community Outreach Center |
| Health Centers & Physician Practices | CR Wood Cancer Center |
| Other Agencies | Planned Parenthood Mohawk Hudson Inc. |
| Behavioral Health | Mental Health Office of Community Service |
| Behavioral Health | ASCEND Mental Wellness |
| Other Agencies | Cancer Services Program GFH |
| Education | Salem Central School |
| Public Health | Washington County Public Health |
| Other Agencies | Office of Senator Jacob Ashby |
| Public Health | Greenwich Central School |
| Local Government | Board of Supervisors |
| Public Health | Fort Edward UFSD |
| People with Disabilities | Battenkill Community Services |
| Law Enforcement | Granville Village PD |
| DSS/ Child Welfare | Hudson Falls Recreation Program |
| Other Agencies | Office of NYS Assembly Member Scott Bendett |
| Education | Argyle Central School |
| Public Health | WSWHE BOCES |
| DSS/ Child Welfare | Washington County Department of Social Services |
| Other Agencies | AHI |
| Community | Community Member/ Hebron First Response/ Salem EMS |
| Local Government | Probation |
| Public Health | Hudson Falls CSD |
| Education | Putnam Central School |
| Community | Comfort Food Community |
| Public Health | Salem Central School |
| DSS/ Child Welfare | Warren/ Washington Youth Bureau/Alternative Sentencing |
| Local | Washington County Public Safety |
| Community | Easton Greenwich Rescue/ EMS Advisory Board |
| Hospitals/Health Centers | Fort Hudson Health Services |
| Healthy Environment | NYSDOH Glens Falls District Office |

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| Hospitals/Health Center | Glens Falls Hospital |
| Community | Washington County Public Safety/ Salem EMS |
| Aging/Seniors | Washington County Aging & Disabilities Resource Center |
| Tri County United Way | Community Member |
| Education | Hartford Central School |
| Other Agencies | Hudson Mohawk AHEC |
| Aging/Seniors | Fort Hudson Health Services |
| Public Health | Public Health Nursing Supervisor |
| Public Health | Cambridge Central School |
| Employment & Training | One Stop of Washington County |
| Law Enforcement | Cambridge/Greenwich PD |
| Education | Whitehall Central School |
| DSS/ Child Welfare | Department of Social Services |
| Employment & Training | Local Development Corporation |
| People with Disabilities | Community Workshops Inc. |
| DSS/ Child Welfare | Healthy Families of Fulton & Washington Counties |
| Other Agencies | SUNY Adirondack |
| Hospitals/Health Centers | Greenwich Family Health Center - GFH |
| Other Agencies | Healthy Alliance |
| People with Disabilities | Liberty House |
| Education | Cambridge Central School |
| Local Government | Washington County |
| Other Agencies | Adk/GF Transportation Council |
| Community | Cornell Cooperative Extension |
| Public Health | Washington County Public Safety |
| Healthy Environment | Washington County Code Enforcement |
| STI, HIV, Infectious Disease | Alliance for Positive Health |
| Education | Fort Edward School |
| Local Government | Washington County Public Safety |
| Law Enforcement | Washington County Sheriff |
| Local Government | Washington County Board of Supervisors Chairman |
| Other Agencies | BHSN |
| Hospitals/Health Centers | Glens Falls Hospital |
| Other Agencies | AHI Community Access Team |
| Education | Fort Ann Central School |
| Education | Granville Jr./Sr. High School |
| Local Government | Washington County District Attorney's Office |
| Other Agencies | Fidelis Care |
| Public Health | Argyle Central School |
| Law Enforcement | Hudson Falls Village PD |
| Local Government | Washington County Economic Development |
| Local Government | Washington County Personnel/HR/Employee Wellness |
| People with Disabilities | Warren Washington County Chapter NYSARC |
| Community | Community Member/ Senior Citizens Clubs of Washington County |
| DSS/ Child Welfare | Warren & Washington County CARE Center |
| Education | Granville Central School |
| DSS/ Child Welfare | Wait House |
| Other Agencies | AHI EASE Program |
| Hospitals/Health Centers | Cambridge Family Health Center & Urgent Care |
| Public Health | Whitehall Central School |
| Other Agencies | Catholic Charities DV Victim Advocate |
| Community | Open Door |
| Other Agencies | Washington County Sheriff |
| Housing/Homelessness | Catholic Charities |
| Public Health | Fort Ann Central School |
| Community | Community Member/ Argyle EMS |
| Aging/Seniors | Holbrooks Adult Home |
| Other Agencies | Granville Ecumenical Food Pantry |
| Local Government | Washington County Aging & Disabilities Resource Center |
| Behavioral Health | Council for Prevention |
| Public Health | Washington County WIC |
| Hospitals/Health Centers | Granville Family Health Center (also staffs Whitehall) |
| Other Agencies | Argyle United Presbyterian Church |
| DSS/ Child Welfare | Southern Adirondack Child Care Network |
| Other Agencies | Office of NYS Assembly Member Matthew Simpson |
| Public Health | Hartford Central School |
| Employment & Training | Washington County Economic Opportunity Council |
| Community | Family Services Association of Glens Falls, Inc. |
| Other Agencies | Washington County Public Safety/ Cambridge Valley Rescue Squad |
| Community | Alzheimer's Association |
| STI, HIV, Infectious Disease | Planned Parenthood of Greater New York |

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| Other Agencies | Office of Senator Daniel Stec |
| Education | Greenwich Central School |
| Community | Adirondack Food System Network |
| Education | LEAP/Headstart |
| Hospitals/Health Center | Hudson Headwaters Health Network |
| DSS/ Child Welfare | Cornell Cooperative Extension |
| Other Agencies | Bread of Life Food Pantry, Zion Episcopal Church |
| Hospitals/Health Center | Glens Falls Hospital Rehabilitation Services |
| Public Health | Washington County Early Intervention |
| Hospice | Haynes House of Hope |
| Housing/Homelessness | Wait House |
| Education | Hudson Falls Central School |
| Behavioral Health | Adirondack Samaritan Counseling Center |
| People with Disabilities | Southern Adirondack Independent Living Center |
| Community | Community Member/ Fort Edward |
| Behavioral Health | Washington County Veterans Services Department |
| Other Agencies | Office of NYS Assembly Member Carrie Woerner |
| Hospitals/Health Centers | Glens Falls Hospital Cancer Services Program |
| Behavioral Health | Office of Community Services for Warren & Washington Counties |
| Other Agencies | Washington County Public Safety/ Granville Rescue Squad |
| Other Agencies | Cornerstone Bible Church |

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

| Demographic Profile | | | | | | | | | | | | | |
|---|--|----------|----------|----------|----------|----------|------------|-----------|----------|------------|----------|------------|----------------|
| Adirondack Rural Health Network | | County | | | | | | | | | ARHN | Upstate | New York State |
| Summary of Demographic Information | | Clinton | Essex | Franklin | Fulton | Hamilton | Montgomery | Saratoga | Warren | Washington | | | |
| Square Miles | | | | | | | | | | | | | |
| Total Square Miles | | 1,038 | 1,794 | 1,629 | 496 | 1,717 | 403 | 810 | 867 | 831 | 8,372 | 301 | 47,124 |
| Total Square Miles for Farms | | 269 | 13 | 79 | 53 | N/A | 131 | 40 | 1 | 122 | N/A | N/A | 4,948 |
| Percent of Total Square Miles Farms | | 25.9% | 0.7% | 4.9% | 10.7% | N/A | 32.5% | 4.9% | 0.1% | 14.6% | N/A | N/A | 10.5% |
| Population per Square Mile | | 77 | 21 | 29 | 108 | 3 | 123 | 291 | 76 | 74 | 387 | N/A | 429 |
| Population | | | | | | | | | | | | | |
| Total Population | | 78,961 | 37,077 | 47,066 | 52,787 | 5,102 | 49,461 | 237,075 | 65,560 | 60,883 | 347,436 | 11,313,181 | 19,571,216 |
| Percent White, Non-Hispanic | | 90.0% | 92.9% | 84.3% | 89.9% | 92.0% | 83.0% | 89.3% | 93.3% | 90.6% | 90.3% | 70.7% | 55.1% |
| Percent Black, Non-Hispanic | | 3.1% | 2.5% | 3.4% | 1.5% | 1.0% | 3.1% | 1.6% | 1.3% | 2.5% | 2.4% | 8.7% | 14.3% |
| Percent Hispanic/Latino | | 3.4% | 2.8% | 2.8% | 4.1% | 2.0% | 15.2% | 3.8% | 2.8% | 2.9% | 3.1% | 13.5% | 19.8% |
| Percent Asian, Native Hawaiian, Pacific Islander | | 1.5% | 0.3% | 0.7% | 1.0% | 0.4% | 0.7% | 3.0% | 0.8% | 0.6% | 0.9% | 4.6% | 9.1% |
| Percent Alaskan Native/American Indian | | 0.3% | 0.2% | 6.9% | 0.0% | 0.0% | 0.3% | 0.2% | 0.0% | 0.1% | 1.0% | 0.5% | 0.7% |
| Percent Two or more races | | 3.7% | 3.0% | 2.7% | 6.2% | 5.6% | 6.9% | 4.8% | 4.1% | 4.2% | 4.1% | 9.0% | 10.5% |
| Population by Age | | | | | | | | | | | | | |
| Under 5 years | | 3,545 | 1,399 | 2,291 | 2,460 | 159 | 3,049 | 11,066 | 2,769 | 2,771 | 15,394 | 590,144 | 1,035,708 |
| 5 to 14 years | | 8,341 | 3,278 | 5,409 | 6,233 | 366 | 6,301 | 26,398 | 6,774 | 6,464 | 36,865 | 1,417,466 | 2,214,151 |
| 15 to 17 years | | 2,494 | 1,200 | 1,856 | 1,942 | 141 | 2,073 | 8,443 | 2,063 | 2,068 | 11,764 | 427,466 | 700,890 |
| Under 18 years | | 14,380 | 5,877 | 9,556 | 10,635 | 666 | 11,423 | 45,907 | 11,606 | 11,303 | 64,023 | 2,316,783 | 3,950,749 |
| 18 years and over | | 64,581 | 31,200 | 37,510 | 42,152 | 4,436 | 38,038 | 191,168 | 53,954 | 49,580 | 283,413 | 8,996,398 | 15,620,467 |
| 65 years plus | | 14,447 | 9,525 | 8,902 | 10,746 | 1,671 | 9,376 | 45,947 | 15,454 | 12,718 | 73,463 | 2,205,779 | 3,635,501 |
| Family Status | | | | | | | | | | | | | |
| Number of Households | | 33,276 | 16,039 | 19,234 | 22,607 | 2,111 | 19,234 | 99,835 | 30,041 | 24,254 | 147,562 | 4,355,640 | 7,668,956 |
| Percent Families Single Parent Households | | 4.8% | 4.8% | 4.4% | 4.6% | 3.6% | 6.6% | 4.4% | 3.6% | 4.6% | 4.4% | 5.3% | 6.0% |
| Percent Households with Grandparents as Parents | | 1.7% | 1.1% | 2.3% | 1.9% | 1.5% | 1.6% | 1.1% | 1.5% | 2.7% | 1.9% | 1.3% | 1.3% |
| Poverty | | | | | | | | | | | | | |
| Mean Household Income | | \$91,067 | \$92,245 | \$78,937 | \$80,448 | \$90,814 | \$79,106 | \$123,673 | \$94,235 | \$86,922 | \$87,810 | N/A | \$122,227 |
| Per Capita Income | | \$39,384 | \$40,807 | \$31,801 | \$34,843 | \$41,820 | \$31,975 | \$53,782 | \$43,718 | \$35,496 | N/A | N/A | \$48,847 |
| Percent of Individuals Under Federal Poverty Level | | 13.8% | 11.8% | 16.5% | 14.5% | 10.0% | 14.7% | 6.7% | 9.1% | 10.8% | 12.6% | 11.1% | 13.7% |
| Percent of Individuals Receiving Medicaid | | 23.8% | 23.3% | 28.1% | 31.3% | 23.7% | 30.6% | 15.0% | 22.5% | 27.6% | 25.9% | 21.9% | 27.4% |
| Immigrant Status | | | | | | | | | | | | | |
| Percent Born in American Territories | | 90.8% | 92.1% | 91.9% | 93.2% | 95.6% | 90.7% | 89.7% | 92.5% | 92.4% | 92.1% | 82.8% | 73.0% |
| Percent Born in Other Countries | | 4.7% | 4.1% | 3.2% | 2.1% | 1.2% | 3.1% | 5.7% | 3.3% | 3.1% | 3.4% | 12.2% | 22.9% |
| Percent Speak a Language Other Than English at Home | | 2.5% | 3.0% | 4.3% | 1.8% | 1.3% | 9.1% | 2.8% | 1.7% | 2.4% | 2.5% | 16.9% | 17.3% |
| Housing | | | | | | | | | | | | | |
| Total Housing Units | | 37,461 | 25,318 | 25,442 | 28,169 | 7,893 | 22,944 | 111,127 | 40,177 | 29,111 | 193,571 | 4,924,670 | 8,631,232 |
| Percent Housing Units Occupied | | 88.8% | 0.3% | 0.3% | 0.3% | 0.3% | 0.4% | 0.1% | 0.2% | 0.3% | 17.4% | 78.5% | 84.1% |
| Percent Housing Units Owner Occupied | | 0.2% | 0.3% | 0.3% | 0.2% | 1.0% | 0.3% | 0.1% | 0.2% | 0.3% | 0.3% | 54.7% | 45.1% |
| Percent Housing Units Renter Occupied | | 0.1% | 0.1% | 0.1% | 0.1% | 0.2% | 0.1% | 0.0% | 0.1% | 0.1% | 0.1% | 17.5% | 39.0% |
| | | | | | | | | | | | | | |
| Percent Built Before 1970 | | 45.4% | 50.3% | 52.7% | 65.1% | 52.7% | 70.7% | 32.6% | 46.8% | 55.6% | 52.0% | 58.2% | 63.5% |
| Percent Built Between 1970 and 1979 | | 12.3% | 11.7% | 12.0% | 9.5% | 11.9% | 8.1% | 12.2% | 12.3% | 9.9% | 11.4% | 11.9% | 10.1% |
| Percent Built Between 1980 and 1989 | | 13.1% | 11.7% | 12.1% | 9.6% | 10.3% | 7.2% | 13.9% | 14.1% | 11.4% | 12.1% | 9.5% | 7.6% |
| Percent Built Between 1990 and 1999 | | 12.7% | 9.7% | 10.4% | 7.5% | 10.0% | 6.9% | 13.8% | 10.7% | 9.2% | 10.2% | 7.5% | 5.8% |

| Adirondack Rural Health Network | | County | | | | | | | | | ARHN | Upstate | New York State |
|--|--|---------|--------|----------|--------|----------|------------|----------|--------|------------|---------|-----------|----------------|
| Summary of Demographic Information | | Clinton | Essex | Franklin | Fulton | Hamilton | Montgomery | Saratoga | Warren | Washington | | | |
| Percent Built 2000 and Later | | 16.5% | 16.7% | 12.7% | 8.5% | 15.1% | 7.2% | 27.3% | 15.9% | 13.9% | 14.3% | 13.0% | 13.1% |
| Availability of Vehicles | | | | | | | | | | | | | |
| Percent of Households with No Vehicles Available | | 10.2% | 8.4% | 11.3% | 9.7% | 3.3% | 12.5% | 4.8% | 8.0% | 8.4% | 9.0% | 8.8% | 29.4% |
| Percent of Households with One Vehicle Available | | 32.3% | 34.8% | 32.9% | 35.5% | 36.3% | 35.6% | 33.6% | 35.1% | 32.8% | 34.0% | 34.1% | 32.8% |
| Percent of Households with Two Vehicles Available | | 40.2% | 38.4% | 37.3% | 36.6% | 43.2% | 34.0% | 42.4% | 40.4% | 38.2% | 38.9% | 39.1% | 26.3% |
| Percent of Households with Three or More Vehicles Available | | 17.3% | 18.3% | 18.5% | 18.2% | 17.2% | 17.9% | 19.2% | 16.5% | 20.6% | 18.0% | 17.9% | 11.5% |
| Education | | | | | | | | | | | | | |
| Total Population Ages 25 and Older | | 54,905 | 28,918 | 33,482 | 38,160 | 4,135 | 34,228 | 172,398 | 49,426 | 45,248 | 254,274 | 8,040,086 | 13,996,138 |
| Percent with Less than High School Education | | 11.8% | 8.5% | 12.7% | 11.5% | 10.7% | 11.5% | 5.8% | 8.2% | 9.7% | 10.4% | 45.0% | 12.2% |
| Percent High School Graduate/GED | | 32.5% | 33.1% | 33.9% | 35.9% | 31.0% | 35.4% | 24.4% | 28.0% | 39.9% | 33.7% | 61.7% | 24.6% |
| Percent Some College, no degree | | 17.0% | 15.7% | 15.7% | 16.3% | 15.9% | 18.7% | 14.9% | 16.8% | 17.6% | 16.6% | 62.6% | 14.9% |
| Percent Associates Degree | | 11.9% | 11.4% | 14.0% | 15.2% | 15.6% | 13.9% | 11.2% | 12.5% | 11.6% | 12.7% | 69.1% | 8.9% |
| Percent Bachelor's Degree | | 15.3% | 16.9% | 13.1% | 13.2% | 14.2% | 11.4% | 24.4% | 18.7% | 12.5% | 15.0% | 52.7% | 22.0% |
| Percent Graduate or Professional Degree | | 11.5% | 14.4% | 10.7% | 7.8% | 12.7% | 9.2% | 19.4% | 15.9% | 8.7% | 11.5% | 56.0% | 17.5% |
| Employment Status | | | | | | | | | | | | | |
| Total Population Ages 16 and Older | | 65,792 | 32,078 | 38,628 | 43,403 | 4,524 | 39,216 | 199,085 | 55,611 | 51,012 | 291,048 | 9,284,447 | 16,085,030 |
| Total Population Ages 16 and Older in Armed Forces | | 185 | 2 | 0 | 44 | 0 | 52 | 615 | 0 | 30 | 261 | 19,215 | 23,559 |
| Total Population Ages 16 and Older in Civilian labor force | | 37,356 | 17,679 | 20,256 | 25,451 | 2,357 | 23,929 | 127,599 | 35,223 | 29,998 | 168,320 | 5,736,756 | 10,083,719 |
| Percent Unemployed | | 1.0% | 2.8% | 2.5% | 2.2% | 2.8% | 2.9% | 1.6% | 1.6% | 3.2% | 2.1% | 4.4% | 5.2% |
| Employment Sector | | | | | | | | | | | | | |
| Total Employed (Civilian Employed Pop) | | 36,687 | 16,792 | 19,302 | 24,495 | 2,230 | 22,798 | 124,500 | 34,333 | 28,381 | 162,220 | 5,181,251 | 9,254,578 |
| Percent in Agriculture, Forestry, Fishing, Hunting, and Mining | | 1.4% | 2.2% | 3.4% | 1.2% | 4.3% | 2.5% | 0.3% | 1.3% | 3.4% | 2.0% | 0.1% | 0.6% |
| Percent in Construction | | 6.6% | 9.1% | 6.7% | 7.5% | 16.5% | 7.8% | 6.0% | 6.5% | 8.3% | 7.4% | 2.1% | 5.6% |
| Percent in Manufacturing | | 11.6% | 8.9% | 3.9% | 10.7% | 2.6% | 12.2% | 11.0% | 7.6% | 13.1% | 9.5% | 1.3% | 6.5% |
| Percent in Wholesale Trade | | 0.5% | 0.9% | 1.1% | 2.3% | 1.3% | 1.6% | 2.3% | 1.3% | 1.6% | 1.3% | 0.6% | 2.5% |
| Percent in Retail Trade | | 9.2% | 8.3% | 13.9% | 14.9% | 8.7% | 13.0% | 9.5% | 10.9% | 13.4% | 11.6% | 3.6% | 10.8% |
| Percent in Transportation, Warehousing, Utilities | | 5.2% | 3.3% | 3.9% | 5.7% | 4.9% | 7.2% | 3.6% | 4.9% | 3.9% | 4.6% | 2.9% | 5.1% |
| Percent in Information Services | | 1.0% | 1.9% | 1.7% | 1.2% | 2.1% | 1.1% | 2.8% | 1.7% | 1.2% | 1.4% | 1.6% | 2.9% |
| Percent in Finance/Insurance/Real Estate | | 1.9% | 5.2% | 2.6% | 3.3% | 4.8% | 4.4% | 9.7% | 5.5% | 4.1% | 3.7% | 4.1% | 8.0% |
| Percent in Other Professional Occupations | | 5.7% | 8.1% | 5.6% | 6.3% | 6.0% | 5.6% | 12.6% | 12.0% | 9.1% | 7.9% | 7.1% | 11.4% |
| Percent in Education, Health Care and Social Assistance | | 32.7% | 28.1% | 33.0% | 27.2% | 22.2% | 27.0% | 24.6% | 25.3% | 22.6% | 28.0% | 12.5% | 27.5% |
| Percent in Arts, Entertainment, Recreation, Hotel & Food Service | | 10.1% | 12.3% | 7.8% | 7.5% | 10.6% | 5.7% | 7.2% | 11.2% | 8.0% | 9.6% | 4.1% | 9.5% |
| Percent in Other Services | | 5.6% | 5.5% | 4.2% | 6.0% | 3.5% | 6.1% | 4.0% | 5.4% | 4.6% | 5.3% | 2.3% | 5.0% |
| Percent in Public Administration | | 8.4% | 6.2% | 12.3% | 6.1% | 12.3% | 5.8% | 6.2% | 6.5% | 6.6% | 7.6% | 1.7% | 4.6% |

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

U.S. Census Bureau, U.S. Department of Commerce. "Selected Economic Characteristics." American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP03, 2023

U.S. Census Bureau, U.S. Department of Commerce. "Selected Social Characteristics in the United States." American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP02, 2023

U.S. Census Bureau, U.S. Department of Commerce. "Medicaid/Means-Tested Public Coverage by Sex by Age." American Community Survey, ACS 5-Year Estimates Detailed Tables, Table C27007, 2023

U.S. Census Bureau, U.S. Department of Commerce. "Poverty Status in the Past 12 Months." American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1701, 2023

| Education System Profile | | | | | | | | | | | | | |
|---|--|---------|-------|----------|--------|----------|------------|----------|--------|------------|-------------|--------------|----------------|
| 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 | | | |
| Total Number of Public School Districts | | 9 | 10 | 8 | 6 | 4 | 6 | 12 | 9 | 12 | 58 | 796 | 1,104 |
| Total Pre-K Enrollment | | 450 | 135 | 344 | 291 | 0 | 419 | 670 | 180 | 203 | 1,603.00 | 56,808 | 157,128 |
| Total K-12 Enrollment | | 10,418 | 3,352 | 6,592 | 6,638 | 352 | 6,866 | 31,049 | 7,739 | 7,438 | 42,529 | 1,504,729 | 2,418,513 |
| Number of Students Eligible for Free Lunch | | 4,678 | 1,453 | 3,427 | 3,602 | 133 | 4,094 | 8,443 | 3,147 | 3,269 | 19,709 | 638,721 | 1,329,551 |
| Number of Students Eligible for Reduced Lunch | | 199 | 126 | 264 | 154 | 8 | 92 | 581 | 105 | 141 | 997 | 35,463 | 60,287 |
| Percent Free and Reduced Lunch | | 47.0% | 47.0% | 56.0% | 56.0% | 40.0% | 61.0% | 29.0% | 42.0% | 46.0% | 48.0% | N/A | 57.0% |
| Number of English as a New Language | | 87 | 14 | N/A | 42 | N/A | 273 | 435 | 52 | 27 | 222 | 147,210 | 259,829 |
| Percent Students with Disabilities | | 12.0% | 22.0% | 19.0% | 14.0% | 14.0% | 15.0% | 14.0% | 17.0% | 20.0% | 16.5% | 17.8% | 19.0% |
| Total Number of Graduates | | 664 | 245 | 462 | 494 | 34 | 617 | 2,539 | 667 | 638 | 3,204 | 123,135 | 199,694 |
| Number Went to GED Transfer Program | | 0 | 0 | 0 | 1 | 0 | 0 | 9 | 4 | 11 | 16 | 527 | 1,130 |
| Number Dropped Out of High School | | 57 | 15 | 31 | 48 | 1 | 56 | 113 | 60 | 45 | 257 | 5,834 | 9,751 |
| Percent Dropped Out of High School | | 7.0% | 6.0% | 6.0% | 8.0% | 3.0% | 9.0% | 4.0% | 9.0% | 7.0% | 6.6% | N/A | 5.0% |
| Percent Economically Disadvantaged | | 50.0% | 52.0% | 58.0% | 58.0% | 42.0% | 66.0% | 31.0% | 44.0% | 49.0% | 51.3% | N/A | 59.0% |
| Turnover Rate of Teachers | | 99 | 123 | 129 | 77 | 28 | 55 | 126 | 122 | 132 | 101.4 | N/A | N/A |
| Total Number of Teachers | | 1029 | 398 | 753 | 642 | 79 | 711 | 2645 | 790 | 726 | 4,417 | N/A | 215,701 |
| Student to Teacher Ratio | | 10.1 | 8.4 | 8.8 | 10.3 | 4.5 | 9.7 | 11.7 | 9.8 | 10.2 | 9.6 | N/A | 11.2 |

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

1: CCD Public School District Data for the 2023-2024 school year

| Health Systems Profile | | | | | | | | | | | | | |
|---|--------|---------|--------|----------|--------|----------|------------|----------|--------|------------|-------------|--------------|----------------|
| 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, 2023 ACS 1-Year Estimates | 78,115 | 37,077 | 47,066 | 52,787 | 5,102 | 49,461 | 238,711 | 65,380 | 60,883 | 346,410 | 8,258,035 | 19,571,216 | |
| Total Hospital Beds | | | | | | | | | | | | | |
| Hospital Beds per 100,000 Population | 366.1 | 67.4 | 255 | 140.2 | N/A | 262.8 | 71.6 | 598 | N/A | 258.7 | - | - | |
| Medical/Surgical Beds | 204 | 0 | 90 | 47 | N/A | 70 | 115 | 300 | N/A | 641 | - | - | |
| Intensive Care Beds | 14 | 0 | 8 | 8 | N/A | 5 | 12 | 12 | N/A | 42 | - | - | |
| Coronary Care Beds | 7 | 0 | 0 | 0 | N/A | 3 | 7 | 12 | N/A | 19 | - | - | |
| Pediatric Beds | 10 | 0 | 3 | 12 | N/A | 0 | 7 | 14 | N/A | 39 | - | - | |
| Maternity Beds | 21 | 0 | 7 | 7 | N/A | 8 | 14 | 23 | N/A | 58 | - | - | |
| Physical Medicine and Rehabilitation Beds | 0 | 0 | 0 | 0 | N/A | 10 | 0 | 0 | N/A | 0 | - | - | |
| Psychiatric Beds | 30 | 0 | 12 | 0 | N/A | 20 | 16 | 30 | N/A | 72 | - | - | |
| Other Beds | 0 | 25 | 0 | 0 | N/A | 14 | 0 | 0 | N/A | 25 | - | - | |
| Hospital Beds Per Facility | | | | | | | | | | | | | |
| Adirondack Medical Center-Lake Placid Site | - | - | - | - | - | - | - | - | - | - | - | - | |
| Adirondack Medical Center-Saranac Lake Site | - | - | 95 | - | - | - | - | - | - | 95 | - | - | |
| UVMHN - Alice Hyde Medical Center | - | - | 25 | - | - | - | - | - | - | 25 | - | - | |
| Champlain Valley Physicians Hospital Medical Center | 286 | - | - | - | - | - | - | - | - | 286 | - | - | |
| Elizabethtown Community Hospital | - | 25 | - | - | - | - | - | - | - | 25 | - | - | |
| Glens Falls Hospital | - | - | - | - | - | - | - | 391 | - | 391 | - | - | |
| Nathan Littauer Hospital | - | - | - | 74 | - | - | - | - | - | 74 | - | - | |
| Saratoga Hospital | - | - | - | - | - | - | 171 | - | - | - | - | - | |
| St. Mary's Healthcare | - | - | - | - | - | 106 | - | - | - | - | - | - | |
| St. Mary's Healthcare-Amsterdam Memorial Campus | - | - | - | - | - | 24 | - | - | - | - | - | - | |
| Total Nursing Home Beds | | | | | | | | | | | | | |
| Nursing Home Beds per 100,000 Population | 627.3 | 917 | 414.3 | 682 | 0 | 1192.9 | 193.5 | 610.3 | 867.2 | 667.4 | N/A | N/A | |
| Nursing Home Beds per Facility | | | | | | | | | | | | | |
| Alice Hyde Medical Center | - | - | 135 | - | - | - | - | - | - | 135 | - | - | |
| Capstone Center for Rehabilitation and Nursing | - | - | - | - | - | 120 | - | - | - | - | - | - | |
| Champlain Valley Physicians Hospital Medical Center SNF | 34 | - | - | - | - | - | - | - | - | 34 | - | - | |
| Clinton County Nursing Home | 80 | - | - | - | - | - | - | - | - | 80 | - | - | |
| Elderwood at North Creek | - | - | - | - | - | - | 82 | - | - | 82 | - | - | |
| Elderwood at Ticonderoga | - | 84 | - | - | - | - | - | - | - | 84 | - | - | |
| Elderwood of Uihlein at Lake Placid | - | 156 | - | - | - | - | - | - | - | 156 | - | - | |
| Essex Center for Rehabilitation and Healthcare | - | 100 | - | - | - | - | - | - | - | 100 | - | - | |
| Fort Hudson Nursing Center, Inc. | - | - | - | - | - | - | - | - | 196 | 196 | - | - | |
| Fulton Center for Rehabilitation and Healthcare | - | - | - | 176 | - | - | - | - | - | 176 | - | - | |
| Glens Falls Center for Rehabilitation and Nursing | - | - | - | - | - | - | - | 117 | - | 117 | - | - | |
| Granville Center for Rehabilitation and Nursing | - | - | - | - | - | - | - | - | 122 | 122 | - | - | |
| Meadowbrook Healthcare | 287 | - | - | - | - | - | - | - | - | 287 | - | - | |
| Mercy Living Center | - | - | - | - | - | - | - | - | - | - | - | - | |
| Nathan Littauer Hospital Nursing Home | - | - | - | 84 | - | - | - | - | - | 84 | - | - | |
| Palatine Nursing Home | - | - | - | - | - | 70 | - | - | - | - | - | - | |
| Plattsburgh Rehabilitation and Nursing Center | 89 | - | - | - | - | - | - | - | - | 89 | - | - | |
| River Ridge Living Center | - | - | - | - | - | 120 | - | - | - | - | - | - | |
| Seton Health at Schuyler Ridge Residential Healthcare | - | - | - | - | - | - | 120 | - | - | - | - | - | |
| Slate Valley Center for Rehabilitation and Nursing | - | - | - | - | - | - | - | - | 88 | 88 | - | - | |

| 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 | | | |
| St Johnsville Rehabilitation and Nursing Center | - | - | - | - | - | - | 120 | - | - | - | - | - | - |
| The Pines at Glens Falls Center for Nursing & Rehabilitation | - | - | - | - | - | - | - | - | 120 | - | 120 | - | - |
| Tupper Lake Center for Nursing and Rehabilitation | | | | 60 | | | | | | | 60 | | |
| Warren Center for Rehabilitation and Nursing | - | - | - | - | - | - | - | - | 80 | - | 80 | - | - |
| Washington Center for Rehabilitation and Healthcare | - | - | - | - | - | - | - | - | - | 122 | 122 | - | - |
| Wells Nursing Home Inc | - | - | - | 100 | - | - | - | - | - | - | 100 | - | - |
| Wesley Health Care Center Inc | - | - | - | - | - | - | - | 342 | - | - | - | - | - |
| Wilkinson Residential Health Care Facility | - | - | - | - | - | - | 160 | - | - | - | - | - | - |
| Total Adult Care Facility Beds | | | | | | | | | | | - | - | - |
| Adult Care Facility Beds per 100,000 Population | 294.4 | 728.2 | 127.5 | 98.5 | 0 | 628.8 | 293.2 | 648.5 | 221.7 | 338 | 483.4 | 265.1 | |
| Total Adult Home Beds | 230 | 270 | 60 | 52 | 0 | 311 | 700 | 424 | 135 | 1,171 | 39,921 | 51,893 | |
| Total Assisted Living Program Beds | 185 | 39 | 30 | 52 | 0 | 209 | 0 | 54 | 75 | 435 | 8,882 | 14,123 | |
| Total Assisted Living Residence (ALR) Beds | 0 | 181 | 0 | 0 | 0 | 61 | 315 | 170 | 50 | 401 | 19,237 | 21,885 | |
| Total Enhanced ALR Beds | 25 | 29 | 0 | 0 | 0 | 41 | 279 | 149 | 0 | 203 | 8,787 | 10,520 | |
| Special Needs ALR Beds | 20 | 21 | 0 | 0 | 0 | 0 | 106 | 51 | 10 | 102 | 5,063 | 5,767 | |
| Adult Home Beds by Total Capacity per Facility | | | | | | | | | | | - | - | - |
| Adirondack Manor HFA D.B.A Adirondack Manor HFA ALP | - | - | - | - | - | - | - | - | 60 | - | 60 | - | - |
| Adirondack Manor HFA D.B.A Montcalm Manor HFA | - | 40 | - | - | - | - | - | - | - | - | 40 | - | - |
| Ahana House | - | - | - | - | - | - | - | 17 | - | - | - | - | - |
| Alice Hyde Assisted Living Program | - | - | 30 | - | - | - | - | - | - | - | 30 | - | - |
| Argyle Center for Independent Living | - | - | - | - | - | - | - | - | - | 35 | 35 | - | - |
| Arkell Hall | - | - | - | - | - | 24 | - | - | - | - | - | - | - |
| Champlain Valley Senior Community | - | 81 | - | - | - | - | - | - | - | - | 81 | - | - |
| Countryside Adult Home | - | - | - | - | - | - | - | 48 | - | - | 48 | - | - |
| Elderwood Village at Ticonderoga | - | 23 | - | - | - | - | - | - | - | - | 23 | - | - |
| Hillcrest Spring Residential | - | - | - | - | - | 80 | - | - | - | - | - | - | - |
| Holbrook Adult Home | - | - | - | - | - | - | - | - | 33 | - | 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 | - | - | - | - | - | - | - | - | 50 | - | - |
| Peregrine Senior Living at Clifton Park | | | | | | | 64 | | | | | | |
| Pine Harbour | 66 | - | - | - | - | - | - | - | - | - | 66 | - | - |
| Pineview Commons H.F.A. | - | - | - | 94 | - | - | - | - | - | - | 94 | - | - |
| Samuel F. Vilas Home | 80 | - | - | - | - | - | - | - | - | - | 80 | - | - |
| Sarah Jane Sanford Home | - | - | - | - | - | 40 | - | - | - | - | - | - | - |
| The Cambridge | - | - | - | - | - | - | - | - | 40 | - | 40 | - | - |
| The Farrar Home | - | - | 30 | - | - | - | - | - | - | - | 30 | - | - |
| The Landing at Queensbury | - | - | - | - | - | - | - | 88 | - | - | 88 | - | - |
| The Mansion at South Union | - | - | - | - | - | - | - | - | 44 | - | 44 | - | - |
| The Sentinel at Amsterdam, LLC | - | - | - | - | - | 150 | - | - | - | - | - | - | - |
| The Terrace at the Glen at Hiland Meadows | - | - | - | - | - | - | - | 52 | - | - | 52 | - | - |
| Memory Care at The Glen at Hiland Meadows | | | | | | | | 30 | - | - | 30 | - | - |
| Valehaven Home for Adults | 40 | - | - | - | - | - | - | - | - | - | 40 | - | - |

| 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 | | | |
| Willow Ridge Pointe | - | - | - | - | - | - | - | 13 | - | - | - | - | - |
| Woodlawn Commons | - | - | - | - | - | - | - | 42 | - | - | - | - | - |
| Total Physician | | | | | | | | | | | | | |
| Total Physician per 100,000 population | 272.7 | 153.7 | 167.8 | 89.0 | 137.2 | 127.4 | 270.6 | 347.2 | 47.6 | 190.2 | N/A | 410.0 | |
| Licensure Data | | | | | | | | | | | | | |
| Clinical Laboratory Technician | 11 | 5 | 6 | 1 | 0 | 3 | 12 | 6 | 5 | 34 | 1,223 | 1,623 | |
| Clinical Laboratory Technologist | 49 | 21 | 26 | 34 | 0 | 27 | 154 | 40 | 22 | 192 | 7,181 | 11,084 | |
| Dental Hygienist | 42 | 15 | 13 | 20 | 2 | 24 | 280 | 46 | 32 | 170 | 7,938 | 10,594 | |
| Dentist | 45 | 11 | 14 | 14 | 0 | 19 | 182 | 46 | 12 | 142 | 8,504 | 14,677 | |
| Dietition/Nutritionist, Certified | 17 | 10 | 9 | 6 | 3 | 10 | 133 | 22 | 6 | 73 | 3,926 | 5,923 | |
| Licensed Clinical Social Worker (LCSW) | 48 | 25 | 33 | 24 | 5 | 22 | 342 | 85 | 41 | 261 | 17,670 | 29,479 | |
| Licensed Master Social Worker (LMSW) | 59 | 27 | 29 | 25 | 4 | 41 | 318 | 50 | 37 | 231 | 17,990 | 31,810 | |
| Licensed Practical Nurse | 362 | 162 | 287 | 266 | 11 | 330 | 841 | 308 | 399 | 1,795 | 45,788 | 58,010 | |
| Physicians | 213 | 57 | 79 | 47 | 7 | 63 | 646 | 227 | 29 | 659 | 45,066 | 80,239 | |
| Mental Health Counselor | 86 | 23 | 29 | 15 | 1 | 23 | 230 | 56 | 24 | 234 | 7,276 | 10,865 | |
| Midwife | 4 | 2 | 3 | 4 | 0 | 2 | 15 | 15 | 5 | 33 | 674 | 1,125 | |
| Nurse Practitioner | 113 | 30 | 60 | 57 | 3 | 53 | 239 | 128 | 43 | 434 | 22,543 | 32,589 | |
| Pharmacists | 113 | 26 | 33 | 32 | 1 | 31 | 522 | 71 | 47 | 323 | 14,795 | 23,018 | |
| Physical Therapist | 69 | 43 | 51 | 33 | 4 | 43 | 480 | 83 | 32 | 315 | 15,677 | 22,343 | |
| Physical Therapy Assistant | 16 | 8 | 24 | 17 | 0 | 17 | 55 | 24 | 9 | 98 | 1,086 | 2,697 | |
| Psychologist | 8 | 13 | 5 | 7 | 1 | 3 | 121 | 26 | 5 | 65 | 6,073 | 11,394 | |
| Physician Assistant | 59 | 30 | 31 | 23 | 2 | 25 | 313 | 84 | 22 | 251 | 12,537 | 18,146 | |
| Registered Professional Nurse | 1,316 | 552 | 769 | 656 | 55 | 753 | 4,318 | 1,237 | 805 | 5,390 | 192,584 | 272,352 | |
| Respiratory Therapist | 20 | 2 | 5 | 15 | 0 | 17 | 101 | 30 | 13 | 85 | 4,263 | 5,886 | |
| Respiratory Therapy Technician | 1 | 0 | 2 | 1 | 0 | 2 | 12 | 3 | 5 | 12 | 481 | 652 | |

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

New York State Licensed Professions, NYS Education Department, Office of the Professions, January 2025

U.S. Census Data 2023 American Community Survey 1-Year Estimates

NYS Department of Health, NYS Health Profiles, May 2025

| Asset Limited, Income Constrained, Employed (ALICE) Profile | | | | | | | | | | | | | |
|--|----------|----------|----------|----------|----------|------------|----------|----------|------------|----------|-------------|-----------|--|
| ALICE is a United Way acronym that stands for Asset Limited, Income Constrained, Employed. | | | | | | | | | | | | | |
| County | Clinton | Essex | Franklin | Fulton | Hamilton | Montgomery | Saratoga | Warren | Washington | ARHN | Upstate NY* | NYS | |
| Total Households | 33,231 | 15,750 | 18,933 | 22,103 | 1,725 | 18,918 | 101,315 | 29,782 | 24,235 | 145,759 | 4,385,605 | 7,758,644 | |
| Total Alice Households | 7,695 | 4,657 | 5,028 | 6,514 | 603 | 6,443 | 27,077 | 7,985 | 7,721 | 40,203 | 1,191,265 | 2,416,106 | |
| Total Poverty Households | 5,763 | 1,701 | 2,999 | 3,099 | 149 | 2,836 | 7,426 | 2,579 | 2,859 | 19,149 | 510,829 | 1,131,514 | |
| Total Above Alice Households | 19,773 | 9,392 | 10,906 | 12,490 | 973 | 9,639 | 66,812 | 19,218 | 13,655 | 86,407 | 2,662,155 | 4,189,668 | |
| ALICE Households over 65 years of age | 3,848 | 2,282 | 2,564 | 3,648 | 259 | 3,866 | 12,997 | 3,833 | 3,938 | 20,371 | 1,378,457 | 2,204,582 | |
| ALICE Households by Race/Ethnicity | | | | | | | | | | | | | |
| Asian | 365 | 28 | 58 | 147 | N/A | 178 | 2,533 | 217 | 108 | 776 | 159,350 | 606,443 | |
| Black | 430 | 18 | 72 | 208 | 3 | 495 | 1,257 | 277 | 39 | 1,047 | 346,078 | 1,071,085 | |
| Hawaiian | N/A | N/A | N/A | N/A | N/A | 6 | N/A | N/A | 2 | N/A | 1,366 | 2,944 | |
| Hispanic | 296 | 148 | 166 | 645 | 5 | 2,183 | 2,412 | 486 | 422 | 2,168 | 379,928 | 1,258,451 | |
| American Indian/ Alaska Native | 29 | 34 | 1,143 | N/A | N/A | 88 | 89 | 3 | 32 | 1,241 | 13,089 | 30,225 | |
| White | 30,763 | 15,146 | 17,069 | 20,499 | 1652 | 15,666 | 91,265 | 28,593 | 23,163 | 136,885 | 3,345,930 | 4,544,209 | |
| 2+ races | 721 | 293 | 416 | 752 | 69 | 836 | 2,438 | 880 | 467 | 3,598 | 195,798 | 580,422 | |
| | | | | | | | | | | | | | |
| Households in Poverty % | 17.0% | 11.0% | 16.0% | 14.0% | 9.0% | 15.0% | 7.0% | 9.0% | 12.0% | 13.1% | 11.6% | 15.0% | |
| Households in ALICE % | 23.0% | 30.0% | 27.0% | 29.0% | 35.0% | 34.0% | 27.0% | 27.0% | 32.0% | 27.6% | 27.2% | 31.0% | |
| Above ALICE % | 60.0% | 60.0% | 58.0% | 57.0% | 56.0% | 51.0% | 66.0% | 65.0% | 56.0% | 59.3% | 60.7% | 54.0% | |
| # of ALICE and Poverty Households | 13,458 | 6,358 | 8,027 | 9,613 | 752 | 9,279 | 34,503 | 10,564 | 10,580 | 59,352 | 1,702,094 | 3,547,620 | |
| Unemployment Rate | 2.6% | 2.9% | 2.7% | 2.5% | 2.5% | 3.5% | 2.3% | 2.5% | 3.0% | 2.7% | N/A | 3.4% | |
| Median Household Income | \$66,152 | \$68,090 | \$60,270 | \$60,557 | \$66,891 | \$58,033 | \$93,301 | \$69,865 | \$68,703 | \$65,790 | N/A | N/A | |

[Home](#) | [UnitedForALICE](#)

Data included in the ALICE profile is reflective of the most recent update provided by [UnitedforAlice.org](#) in May 2025. Sourcing information below:

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

ARHN region reflects an average of ARHN counties

ALICE Threshold, 2010-2022; American Community Survey, 2010-2022

ALICE Threshold, 2022; American Community Survey, 2022

American Community Survey, 2022; ALICE Threshold, 2022

American Community Survey, 2022; Federal Reserve Bank of St. Lewis, 2022

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

CHRONIC DISEASE INDICATORS

| County | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
|--------|---|--------|-------|---------|-----------|-----------|---------------------|-----------|----------------------|
| Warren | Asthma hospitalization rate per 10,000 | | 3.3 | 3.8 | 6.3 N/A | | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Asthma hospitalization rate per 10,000 - Aged 0-17 years | | 4.9 | 8.5 | 13.4 N/A | | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Asthma hospitalization rate per 10,000 - Aged 0-4 years | | 9.5 | 17.2 | 24.9 N/A | | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Asthma hospitalization rate per 10,000 - Aged 25-44 years | | 3.3 | 2.7 | 3.6 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Asthma hospitalization rate per 10,000 - Aged 45-64 years | | 2.5 | 2.8 | 5.2 N/A | | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Asthma hospitalization rate per 10,000 - Aged 5-14 years | | 4 | 6.5 | 10.6 N/A | | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Asthma hospitalization rate per 10,000 - Aged 5-64 years | | 2.9 | 3.2 | 5.2 N/A | | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Asthma hospitalization rate per 10,000 - Aged 65 years or older | | 3.3 | 2.7 | 5.4 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Asthma mortality rate per 100,000 | | 1.5 | 1 | 1.4 N/A | | Higher than Upstate | 2022 | Unstable Estimate |
| Warren | Cardiovascular disease hospitalization rate per 10,000 | | 158.9 | 141.2 | 137.3 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Cardiovascular disease mortality rate per 100,000 | | 341.8 | 293.9 | 282.8 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Cardiovascular disease premature death (aged 35-64 years) rate per 100,000 | | 151.2 | 110 | 113.6 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Cardiovascular disease pretransport mortality rate per 100,000 | | 231.3 | 190.3 | 181.8 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Cerebrovascular disease (stroke) hospitalization rate per 10,000 | | 30.3 | 26.2 | 25.3 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Cerebrovascular disease (stroke) mortality rate per 100,000 | | 53.7 | 38.2 | 33.2 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Cerebrovascular disease (stroke) premature death (aged 35-64 years) rate per 100,000 | | 16.7 | 11.9 | 11.9 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Cerebrovascular disease (stroke) pretransport mortality rate per 100,000 | | 28.7 | 19.2 | 15.3 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis) | | 211.8 | 179.4 | 181.5 N/A | | Higher than Upstate | 2019-2022 | Stable Estimate |
| Warren | Chronic kidney disease hospitalization rate per 10,000 (any diagnosis) | | 183.6 | 149.4 | 151 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Chronic lower respiratory disease hospitalization rate per 10,000 | | 19.3 | 14.7 | 16.5 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Chronic lower respiratory disease mortality rate per 100,000 | | 63.4 | 40.9 | 31.3 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Colon and rectum cancer incidence rate per 100,000 | | 48.7 | | 43.4 N/A | | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Colon and rectum cancer mortality rate per 100,000 | | 14.2 | | 13.9 N/A | | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Congestive heart failure mortality rate per 100,000 | | 16.4 | 19.2 | 14.5 N/A | | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Congestive heart failure premature death (aged 35-64 years) rate per 100,000 | | 3.8 | 3.1 | 2.9 N/A | | Higher than Upstate | 2022 | Unstable Estimate |
| Warren | Congestive heart failure pretransport mortality rate per 100,000 | | 10.7 | 11.2 | 7.6 N/A | | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Coronary heart disease hospitalization rate per 10,000 | | 30.9 | 26.4 | 25.4 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Coronary heart disease mortality rate per 100,000 | | 173 | 164.3 | 174.9 N/A | | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Coronary heart disease premature death (aged 35-64 years) rate per 100,000 | | 79.4 | 65.9 | 72.8 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Coronary heart disease pretransport mortality rate per 100,000 | | 127.4 | 118 | 127.2 N/A | | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Diabetes hospitalization rate per 10,000 (any diagnosis) | | 251.1 | 230.9 | 247.3 N/A | | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Diabetes hospitalization rate per 10,000 (primary diagnosis) | | 23.1 | 18.2 | 20.3 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Diabetes mortality rate per 100,000 | | 49.1 | 27.1 | 25.3 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Diabetes short-term complications hospitalization rate per 10,000 - Aged 6-17 Years | | 0 | 2.5 | 2.5 N/A | | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Diseases of the heart hospitalization rate per 10,000 | | 108.2 | 96 | 91.3 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Diseases of the heart mortality rate per 100,000 | | 257.4 | 231.9 | 226.1 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Diseases of the heart premature death (aged 35-64 years) mortality rate per 100,000 | | 119.2 | 88.7 | 91.7 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Diseases of the heart pretransport mortality rate per 100,000 | | 181.6 | 156.1 | 153.2 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Female breast cancer incidence rate per 100,000 | | 229.6 | | 167.6 N/A | | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Female breast cancer late stage incidence rate per 100,000 | | 64.5 | | 48.7 N/A | | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Female breast cancer mortality rate per 100,000 | | 36.3 | | 23.1 N/A | | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Heart attack hospitalization rate per 10,000 | | 20.6 | 15.9 | 13.9 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Heart attack mortality rate per 100,000 | | 33.8 | 33.4 | 27.3 N/A | | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Hypertension without heart failure emergency department visit rate per 10,000 - Aged 18 years and older | | 16.4 | 22.4 | 25.9 N/A | | Lower than Upstate | 2019-2022 | Stable Estimate |
| Warren | Hypertension without heart failure emergency department visit rate per 10,000 (any diagnosis) - Aged 18 years and older | | 636.3 | 930.2 | 988.7 N/A | | Lower than Upstate | 2019-2022 | Stable Estimate |
| Warren | Hypertension without heart failure hospitalization rate per 10,000 (any diagnosis) - Aged 18 years and older | | 462.5 | 432.4 | 429.6 N/A | | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Lung and bronchus cancer incidence rate per 100,000 | | 111.1 | | 67.6 N/A | | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Lung and bronchus cancer mortality rate per 100,000 | | 57.8 | | 34.4 N/A | | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Percentage of women (aged 50-74 years) who had a mammogram between October 1, 2019 and December 31, 2021 | | 64.1 | 58.51 | 65.5 N/A | | No Upstate Rate | 2022 | Stable Estimate |

| | | | | | | | |
|--------|---|-------|-------|----------|---------------------|------|---------------------|
| Warren | Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines | 77.1 | 79.65 | 78.2 N/A | No Upstate Rate | 2021 | Unstable Estimate |
| Warren | Potentially preventable diabetes short-term complications hospitalization rate per 10,000 - Aged 18 years and older | 9.8 | 6.7 | 7 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older | 40.9 | 35.8 | 36.1 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older | 3 | 5.3 | 6.6 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Prostate cancer incidence rate per 100,000 | 230.8 | | 169 N/A | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Prostate cancer late stage incidence rate per 100,000 | 49 | | 34.1 N/A | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Prostate cancer mortality rate per 100,000 | 19.4 | | 16.3 N/A | No Upstate Rate | 2021 | Unstable Estimate |
| Warren | Percentage of adults ever had their blood cholesterol checked | 93.5 | 91.9 | 91.8 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults living with a disability who are obese | 42.1 | 43.8 | 39.1 | Approx = ARHN | 2021 | Unreliable estimate |
| Warren | Percentage of adults living with a disability who smoke | 31.5 | 29.3 | 19.4 | Approx = ARHN | 2021 | Unreliable estimate |
| Warren | Percentage of adults living with a disability with cardiovascular disease (heart attack, coronary heart disease, or stroke) | 15.2 | 17.2 | 17.7 | Lower than ARHN | 2021 | Reliable |
| Warren | Percentage of adults overweight or obese | 71.4 | 71 | 66.6 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults who are current smokers | 21.3 | 19.7 | 13.2 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults who are obese | 32.4 | 33 | 31.6 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults who consume one or more sugary drinks daily | 27.3 | 21.6 | 18.9 | Higher than ARHN | 2021 | Reliable |
| Warren | Percentage of adults who had a test for high blood sugar or diabetes within the past three years | 58.8 | 50.1 | 51.1 | Higher than ARHN | 2021 | Reliable |
| Warren | Percentage of adults who have ever had physician-diagnosed asthma | 21.7 | 18.3 | 14.7 | Higher than ARHN | 2021 | Reliable |
| Warren | Percentage of adults who have taken a course or class to learn how to manage their chronic disease or condition | 9.8 | 11.4 | 9.9 | Lower than ARHN | 2021 | Reliable |
| Warren | Percentage of adults who participated in leisure time physical activity in the past 30 days | 76.3 | 74.1 | 75.7 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults who report consuming less than one fruit and less than one vegetable daily (no fruits or vegetables) | 30 | 32.7 | 32.2 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults who use e-cigarettes | 6 | 7.4 | 6 | Lower than ARHN | 2021 | Reliable |
| Warren | Percentage of adults with an annual household income less than \$25,000 who are obese | 41.8 | | 36.6 | No ARHN Rate | 2021 | Unreliable estimate |
| Warren | Percentage of adults with annual household income less than \$25,000 who are current smokers | 24.1 | 29.4 | 26.5 | Lower than ARHN | 2021 | Unreliable estimate |
| Warren | Percentage of adults with cardiovascular disease (heart attack, coronary heart disease, or stroke) | 9 | 9.1 | 8.1 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults with COPD | 8.6 | 9.4 | 6.5 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults with current asthma | 15 | 12.5 | 10.4 | Higher than ARHN | 2021 | Reliable |
| Warren | Percentage of adults with diagnosed high blood pressure taking high blood pressure medication | 72.4 | 78.2 | 81.2 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults with health care provider diagnosed diabetes | 14 | 13.2 | 11 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults with health care provider diagnosed high blood pressure | 34.1 | 37.2 | 31.7 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults with health care provider diagnosed prediabetes | 8.7 | 9.4 | 10.8 | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines | 77.1 | 79.7 | 78.8 | Approx = ARHN | 2021 | Unreliable estimate |

| Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year | Estimate Reliability |
|--|--------|------|---------|----------|-----------|-----------------------|------|----------------------|
| | | | | | | | | |
| Percentage of adults who had a test for high blood sugar or diabetes within the past three years, aged 45+ years | 69.9 | 62.6 | 63.8 | 64.3 | 71.7 | Approx = Benchmark | 2021 | Stable Estimate |
| Percentage of adults who participate in leisure-time physical activity | 76.3 | 74.1 | 75.7 | 74.2 | 77.4 | Approx = Benchmark | 2021 | Stable Estimate |
| Percentage of adults who participate in leisure-time physical activity, aged 65+ years | 68.4 | 70.5 | 68.5 | 68.4 | 75.9 | Approx = Benchmark | 2021 | Stable Estimate |
| Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines, aged 50-64 years | 74.2 | 68.3 | 66.5 | 65.4 | 66.3 | Higher than Benchmark | 2018 | Stable Estimate |
| Percentage of adults who smoke cigarettes among adults with income less than \$25,000 | 24.1 | 21 | 26.5 | 20.4 | 15.3 | Higher than Benchmark | 2021 | Unstable Estimate |
| Percentage of adults with an annual household income less than \$25,000 with obesity | 41.8 | | 36.6 | 34.4 | 29 | Higher than Benchmark | 2021 | Unstable Estimate |
| Percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition | 9.8 | 11.4 | 9.9 | 9.8 | 10.6 | Approx = Benchmark | 2021 | Stable Estimate |
| Percentage of adults with disabilities who participate in leisure-time physical activity | 58.7 | 61.3 | 58.7 | 58.3 | 61.8 | Approx = Benchmark | 2021 | Unstable Estimate |
| Percentage of adults with hypertension who are currently taking medicine to manage their high blood pressure | 72.4 | 78.2 | 81.2 | 80.2 | 80.7 | Lower than Benchmark | 2021 | Stable Estimate |
| Percentage of adults with obesity | 32.4 | 33 | 31.6 | 29.1 | 24.2 | Higher than Benchmark | 2021 | Stable Estimate |

HEALTHY WOMEN, INFANTS, CHILDREN INDICATORS

| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
|-------------|---|--------|------|---------|----------|-----------|---------------------|------|----------------------|
| Warren | Asthma hospitalization rate per 10,000 - Aged 0-17 years | 4.9 | | 8.5 | 13.4 N/A | | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Asthma hospitalization rate per 10,000 - Aged 0-4 years | 9.5 | | 17.2 | 24.9 N/A | | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Asthma hospitalization rate per 10,000 - Aged 5-14 years | 4 | | 6.5 | 10.6 N/A | | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Birth rate per 1,000 population | 8 | | 10.2 | 10.6 N/A | | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Maternal mortality rate per 100,000 live births | 0 | | 22 | 21.3 N/A | | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Mortality rate per 1,000 live births - Fetal death (20 weeks gestation or more) | 5.7 | | 4.8 | 6 N/A | | Higher than Upstate | 2022 | Unstable Estimate |

| | | | | | | | |
|--------|---|------|-------|----------|---------------------|-----------|-------------------|
| Warren | Mortality rate per 1,000 live births - Infant (<1 year) | 5.1 | 4.6 | 4.2 N/A | Higher than Upstate | 2022 | Unstable Estimate |
| Warren | Mortality rate per 1,000 live births - Neonatal (<28 days) | 4.5 | 2.9 | 2.6 N/A | Higher than Upstate | 2022 | Unstable Estimate |
| Warren | Mortality rate per 1,000 live births - Perinatal (20 weeks gestation - <28 days of life) | 10.2 | 7.7 | 8.7 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Mortality rate per 1,000 live births - Perinatal (28 weeks gestation - <7 days of life) | 7 | 4.6 | 4.7 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Mortality rate per 1,000 live births - Post-neonatal (1 month to 1 year) | 0.6 | 1.7 | 1.5 N/A | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Mortality rate per 100,000 - Aged 10-14 years | 9.7 | 12.4 | 12.2 N/A | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Mortality rate per 100,000 - Aged 1-4 years | 14.7 | 19.1 | 16.8 N/A | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Mortality rate per 100,000 - Aged 15-19 years | 48.2 | 34.6 | 34.3 N/A | Higher than Upstate | 2022 | Unstable Estimate |
| Warren | Mortality rate per 100,000 - Aged 5-14 years | 10.1 | 11.3 | 11.3 N/A | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Mortality rate per 100,000 - Aged 5-9 years | 10.5 | 10.2 | 10.4 N/A | Approx = Upstate | 2022 | Unstable Estimate |
| Warren | Percentage low birthweight (<2.5 kg) births | 6.9 | 6.77 | 8 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Percentage low birthweight (<2.5kg) singleton births | 5.7 | 5.47 | 6.3 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births delivered by cesarean section | 34.9 | 27.72 | 34.8 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births that were first births | 42.2 | 34.14 | 38.5 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births that were multiple births | 3 | | 3.5 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births to teens - Aged 15-17 years | 0.6 | 0.34 | 0.6 N/A | Approx = Upstate | 2022 | Unstable Estimate |
| Warren | Percentage of births to teens - Aged 15-19 years | 3.2 | 3.61 | 2.9 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births to women aged 25 years and older without a high school education | 6 | 6.55 | 9.1 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births to women aged 35 years and older | 17.6 | 13.95 | 24.3 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births with a 5 minute APGAR <6 | 1.6 | 1.27 | 0.9 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births with adequate prenatal care | 85 | 69.51 | 77.3 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births with early (1st trimester) prenatal care | 83.9 | 67.84 | 77.5 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage of births with late (3rd trimester) or no prenatal care | 3.1 | 4.84 | 4.6 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Percentage of children who had 2+ well-child visit during 15-30 months of life in government sponsored insurance programs | 88.6 | 72.52 | 42.5 N/A | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of children who had 6+ well-child visits in the first 15 months of life in government sponsored insurance programs | 82.6 | 63.21 | 67.4 N/A | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of infants fed any breast milk in delivery hospital | 84.2 | 70 | 84.8 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage of infants fed exclusively breast milk in delivery hospital | 66.7 | 55.14 | 47.8 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Percentage of live births conceived within 18 months of a previous live birth | 34.9 | 30.02 | 34.1 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher) | 31.8 | 30.64 | 26.6 N/A | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25 to less than 30) | 24.1 | 19.8 | 27.6 N/A | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of pregnant women in WIC who were pre-pregnancy underweight (BMI less than 18.5) | 4.8 | 4.02 | 4.6 N/A | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of pregnant women in WIC with early (1st trimester) prenatal care | 91.1 | 77.78 | 90.7 N/A | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of pregnant women in WIC with gestational diabetes | 7.7 | 6.98 | 6.6 N/A | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of premature births with <32 weeks gestation | 1.3 | 1.22 | 1.4 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage of premature births with <37 weeks gestation | 8.9 | 8.34 | 9.5 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage of premature births with 32 - <37 weeks gestation | 7.6 | 7.1 | 8 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage very low birthweight (<1.5 kg) births | 1.2 | 1.11 | 1.3 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Percentage very low birthweight (<1.5kg) singleton births | 0.9 | 0.91 | 1 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Pregnancy rate per 1,000 (all pregnancies/female population aged 15-44 years) | 63.5 | 68.2 | 71.7 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Teen fertility rate per 1,000 (births to mothers aged 10-14 years/female population aged 10-14 years) | 0.2 | 0.12 | 0.12 N/A | Higher than Upstate | 2022 | Unstable Estimate |
| Warren | Teen fertility rate per 1,000 (births to mothers aged 15-17 years/female population aged 15-17 years) | 2.9 | 3.6 | 3.6 N/A | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Teen fertility rate per 1,000 (births to mothers aged 15-19 years/female population aged 15-19 years) | 10.2 | 9 | 9 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Teen fertility rate per 1,000 (births to mothers aged 18-19 years/female population aged 18-19 years) | 23.1 | 15.9 | 16.5 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Teen pregnancy rate per 1,000 females aged <18 years | 2 | 2.9 | 3.4 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Teen pregnancy rate per 1,000 females aged 15-19 years | 16.6 | 15.4 | 18.3 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Teen pregnancy rate per 1,000 females aged 18-19 years | 37.1 | 26.1 | 31.9 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Child and adolescent mortality, rate per 100,000 population aged 10-19 years | 29 | 24.1 | 23.6 N/A | No ARHN Rate | 2020-2022 | Unstable Estimate |
| Warren | Child mortality rate per 100,000 children aged 1-9 years | 12 | 14 | 13.3 N/A | No ARHN Rate | 2020-2022 | Unstable Estimate |
| Warren | Infant mortality rate per 1,000 live births | 6 | 4.7 | 4.3 N/A | No ARHN Rate | 2022 | Unstable Estimate |
| Warren | Maternal mortality rate per 100,000 live births | 0 | 22 | 21.3 N/A | No ARHN Rate | 2020-2022 | Unstable Estimate |
| Warren | Neonatal mortality rate per 1,000 live births | 6 | 2.9 | 2.7 N/A | No ARHN Rate | 2022 | Unstable Estimate |

| | | | | | | | |
|--------|---|----|----------|-----------|-----------------|-----------------|-----------|
| Warren | Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (any diagnosis), crude rate per 1,000 newborn discharges | 27 | 9.6 | 6 N/A | No ARHN Rate | 2022 | |
| Warren | Percent of families participating in the Early Intervention Program, Part C, who report that early intervention services have helped the family effectively communicate the needs of their children | 80 | 88.46154 | 94.56 N/A | Approx = ARHN | 2021-2022 | |
| Warren | Percent of families participating in the Early Intervention Program, Part C, who report that early intervention services have helped the family help their children develop and learn | 80 | 91.66667 | 94.4 N/A | Lower than ARHN | 2021-2022 | |
| Warren | Percent of families participating in the Early Intervention Program, Part C, who report that early intervention services have helped the family know their rights | 80 | 92.30769 | 92.7 N/A | Lower than ARHN | 2021-2022 | |
| Warren | Percentage of births with early (1st trimester) prenatal care | 84 | 78.60944 | 76.6 | 73.8 N/A | Approx = ARHN | 2022 |
| Warren | Percentage of NYS residents served by community water systems that have optimally fluoridated water | 0 | 26.93099 | 48 | 71.6 N/A | Lower than ARHN | 2023 |
| Warren | Percentage of preterm births (less than 37 weeks gestation) | 9 | 9.702277 | 9.5 | 9.4 N/A | Approx = ARHN | 2022 |
| Warren | Perinatal mortality rate per 1,000 live births plus fetal deaths | 4 | | 4.4 | 4.6 N/A | No ARHN Rate | 2022 |
| Warren | Post-neonatal mortality rate per 1,000 live births | 1 | | 1.7 | 1.5 N/A | No ARHN Rate | 2020-2022 |
| Warren | Suicide mortality among youth, rate per 100,000 population aged 15-19 years | 10 | | 5.6 | 4.8 N/A | No ARHN Rate | 2020-2022 |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year | Estimate Reliability |
|-------------|--|--------|------|---------|----------|-----------------------|-----------------------|-----------------|----------------------|
| Warren | Indicated reports of abuse/maltreatment, rate per 1,000 children, aged 0-17 years | 13.7 | | 13.7 | 12.4 | 15.6 | Lower than Benchmark | 2022 | Stable Estimate |
| Warren | Percentage of 13-year-old adolescents with a complete HPV vaccine series | 33.7 | 25 | 31.3 | 37.2 | 37.4 | Approx = Benchmark | 2023 | Stable Estimate |
| Warren | Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series | 85.2 | 78.9 | 69.1 | 70.5 | 70.5 | Higher than Benchmark | 2023 | Stable Estimate |
| Warren | Percentage of children and adolescents with obesity | 22.4 | 25.1 | 20.6 | 16.4 | Higher than Benchmark | 2021-2023 | Stable Estimate | |
| Warren | Percentage of infants who are exclusively breastfed in the hospital among all infants | 67.8 | 57.1 | 46.7 | 44 | 51.7 | Higher than Benchmark | 2022 | Stable Estimate |
| Warren | Percentage of WIC enrolled infants who are breastfed at 6 months | 25 | | 38 | 45.5 | Lower than Benchmark | 2022 | Stable Estimate | |
| Warren | Percentage of women with a preventive medical visit in the past year, aged 18-44 years | 70.3 | 56.3 | 77.2 | 75.9 | 80.6 | Lower than Benchmark | 2021 | Unstable Estimate |
| Warren | Percentage of women with a preventive medical visit in the past year, aged 45+ years | 89.7 | 88 | 87.7 | 87.9 | 85 | Approx = Benchmark | 2021 | Stable Estimate |

| STI'S/HIV INDICATORS | | | | | | | | | |
|----------------------|---|--------|-------|---------|----------|--------------------|-------------------|-------------------|----------------------|
| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
| Warren | AIDS mortality rate per 100,000 | 0 | | 0.8 | 2 N/A | Lower than Upstate | 2022 | Unstable Estimate | |
| Warren | Chlamydia case rate per 100,000 females - Aged 15-19 years | 1147.8 | | 2626.2 | N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Warren | Chlamydia case rate per 100,000 females - Aged 15-44 years | 753.5 | | 1450.7 | N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Warren | Chlamydia case rate per 100,000 females - Aged 20-24 years | 2359.3 | | 3389.8 | N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Warren | Chlamydia case rate per 100,000 males - Aged 15-19 years | 309.5 | | 847 | N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Warren | Chlamydia case rate per 100,000 males - Aged 15-44 years | 325.7 | | 991.8 | N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Warren | Gonorrhea case rate per 100,000 - Aged 15-19 years | 125.3 | | 416.9 | N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Warren | Gonorrhea case rate per 100,000 females - Aged 15-44 years | 100.1 | | 326.4 | N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Warren | Gonorrhea case rate per 100,000 males - Aged 15-44 years | 122.5 | | 667.9 | N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Warren | Percentage of sexually active young women (aged 16-24) with at least one chlamydia test in Medicaid program | 66.9 | 55.78 | | 72.6 N/A | No Upstate Rate | 2022 | Stable Estimate | |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year | Estimate Reliability |
|-------------|--|--------|--------|---------|----------|-----------|----------------------|-----------|----------------------|
| Warren | Chlamydia diagnoses, age-adjusted rate per 100,000 population | 261.4 | 190.03 | 372.5 | 553.4 | 676.9 | Lower than Benchmark | 2022 | Stable Estimate |
| Warren | Early syphilis diagnoses, age-adjusted rate per 100,000 population | 3.5 | 5.5 | 23.6 | 49.5 | 79.6 | Lower than Benchmark | 2022 | Unstable Estimate |
| Warren | Gonorrhea diagnoses, age-adjusted rate per 100,000 population | 38 | 47.1 | 134.3 | 230.9 | 242.6 | Lower than Benchmark | 2022 | Stable Estimate |
| Warren | Newly diagnosed HIV cases, rate per 100,000 population | 2 | 6.9 | 5 | 11.3 | 5.2 | Lower than Benchmark | 2020-2022 | Unstable Estimate |

| HEALTHY & SAFE ENVIRONMENT INDICATORS | | | | | | | | | |
|---------------------------------------|---|--------|------|---------|----------|---------------------|-------------------|-------------------|----------------------|
| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
| Warren | Alcohol related motor vehicle injuries and deaths per 100,000 | 43.5 | | 25 | N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Warren | Falls hospitalization rate per 10,000 | 59.6 | | 49.1 | 45.1 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Warren | Falls hospitalization rate per 10,000 - Aged <10 years | 7.8 | | 5.7 | 6.1 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Warren | Falls hospitalization rate per 10,000 - Aged 15-24 years | 3.9 | | 3.8 | 4.4 N/A | Approx = Upstate | 2022 | Unstable Estimate | |
| Warren | Falls hospitalization rate per 10,000 - Aged 25-64 years | 27.4 | | 20.5 | 20.6 N/A | Higher than Upstate | 2022 | Stable Estimate | |

| | | | | | | | |
|--------|---|-------|-------|-----------|---------------------|------|-------------------|
| Warren | Falls hospitalization rate per 10,000 - Aged 65-74 years | 94.4 | 88.6 | 86.9 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Falls hospitalization rate per 10,000 - Aged 75-84 years | 218.2 | 238.1 | 221.6 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Falls hospitalization rate per 10,000 - Aged 85 years and older | 647.7 | 647.5 | 572.2 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Fatal work-related injuries per 100,000 employed persons aged 16 years and older | 5.7 | | 2.8 N/A | No Upstate Rate | 2022 | Unstable Estimate |
| Warren | Motor vehicle injury mortality rate per 100,000 | 9.2 | 8.4 | 6.5 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Non-motor vehicle injury mortality rate per 100,000 | 19.4 | 46.3 | 43.5 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Traumatic brain injury hospitalization rate per 10,000 | 9.5 | 8.6 | 8.4 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Unintentional injury hospitalization rate per 10,000 | 92.3 | 86.6 | 81.2 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Unintentional injury hospitalization rate per 10,000 - Aged <10 years | 15.6 | 18.6 | 18.3 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Unintentional injury hospitalization rate per 10,000 - Aged 10-14 years | 6.8 | 14.1 | 13.5 N/A | Lower than Upstate | 2022 | Unstable Estimate |
| Warren | Unintentional injury hospitalization rate per 10,000 - Aged 15-24 years | 24.8 | 24 | 25.3 N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Unintentional injury hospitalization rate per 10,000 - Aged 25-64 years | 63 | 56.8 | 56.6 N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Unintentional injury hospitalization rate per 10,000 - Aged 65 years and older | 237.6 | 280.7 | 260.5 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Unintentional injury mortality rate per 100,000 | 28.7 | 54.7 | 50 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Warren | Violent crime rate per 100,000 | 139.1 | | 430.6 N/A | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Work-related hospitalizations per 100,000 employed persons aged 16 years and older | 84.7 | | 99.9 N/A | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of adults using active transportation (walking or biking) in a typical month | 61.5 | 59.4 | 59.3 N/A | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults who participated in leisure time physical activity in the past 30 days | 76.3 | 74.1 | 75.7 N/A | Approx = ARHN | 2021 | Reliable |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year | Estimate Reliability |
|-------------|--|--------|------|---------|----------|-----------|----------------------------|------|----------------------|
| Warren | Assault-related hospitalizations, rate per 10,000 population | | 1.1 | 1.03 | 2.5 | 3.6 | 3 Lower than Benchmark | 2020 | Unstable Estimate |
| Warren | Assault-related hospitalizations, ratio of rates between Black non-Hispanics and White non-Hispanics | | 0 | | | 6.51 | 5.54 Lower than Benchmark | 2020 | Unstable Estimate |
| Warren | Assault-related hospitalizations, ratio of rates between Hispanics and White non-Hispanics | | 0 | | | 2.85 | 2.5 Lower than Benchmark | 2020 | Unstable Estimate |
| Warren | Crash-related pedestrian fatalities, rate per 100,000 population | | 3.13 | 1.1 | 1.71 | 1.72 | 1.43 Higher than Benchmark | 2019 | Unstable Estimate |
| Warren | Firearm assault-related hospitalizations, rate per 10,000 population | | 0 | 0 | 0.39 | 0.48 | 0.38 Lower than Benchmark | 2020 | Unstable Estimate |
| Warren | Hospitalizations due to falls among adults, rate per 10,000 population, aged 65+ years | | 153 | 158.5 | 189.7 | 177.2 | 173.7 Lower than Benchmark | 2020 | Stable Estimate |
| Warren | Percentage of population living in a certified Climate Smart Community | | 100 | 20.2 | 61.6 | 35.6 | 8.6 Higher than Benchmark | 2024 | Stable Estimate |

| HEALTH ACCESS & EQUITY INDICATORS | | | | | | | | | |
|-----------------------------------|---|--------|-------|---------|-----------|-----------|-------------------|-----------|----------------------|
| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
| Warren | Annual median household income in US dollars | 69849 | | | 79463 N/A | | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Number of dentists per 100,000 population | 88 | | | 83 N/A | | No Upstate Rate | 2021 | Stable Estimate |
| Warren | Number of mental health providers per 100,000 population | 459 | | | 356 N/A | | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Number of primary care physicians per 100,000 population | 111 | | | 80 N/A | | No Upstate Rate | 2020 | Stable Estimate |
| Warren | Percentage of children (aged 2-20 years) with at least one dental visit in government sponsored insurance programs | 72.2 | 61.44 | | 52.7 N/A | | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of children aged <18 years below poverty | 14.3 | 16.34 | | 18.6 N/A | | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of children who had 2+ well-child visit during 15-30 months of life in government sponsored insurance programs | 88.6 | 72.52 | | 42.5 N/A | | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of children who had 6+ well-child visits in the first 15 months of life in government sponsored insurance programs | 82.6 | 63.21 | | 67.4 N/A | | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of enrolled students eligible for free/reduced priced lunch | 38.9 | 44.47 | | 54.1 N/A | | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of high school students who dropped out | 9 | 6.57 | | 4.9 N/A | | No Upstate Rate | 2022-2023 | Stable Estimate |
| Warren | Percentage of high school students who graduated | 85.5 | 87.82 | | 86.4 N/A | | No Upstate Rate | 2022-2023 | Stable Estimate |
| Warren | Percentage of Medicaid enrollees (aged 2-20 years) who had at least one dental visit within the last year | 62.1 | 53.05 | | 46.5 N/A | | No Upstate Rate | 2023 | Stable Estimate |
| Warren | Percentage of Medicaid enrollees (aged 2-20 years) with at least one preventive dental visit within the last year | 58.7 | 49.27 | | 42.5 N/A | | No Upstate Rate | 2023 | Stable Estimate |
| Warren | Percentage of Medicaid enrollees with at least one dental visit within the last year | 30.8 | 28.64 | | 29.7 N/A | | No Upstate Rate | 2023 | Stable Estimate |
| Warren | Percentage of Medicaid enrollees with at least one preventive dental visit within the last year | 26.8 | 23.61 | | 25.7 N/A | | No Upstate Rate | 2023 | Stable Estimate |
| Warren | Percentage of population in poverty | 10.1 | 12.3 | | 14.2 N/A | | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of population who did not have access to a reliable source of food during the past year (Food insecurity) | 11.7 | 12.88 | | 13.4 N/A | | No Upstate Rate | 2022 | Stable Estimate |
| Warren | Percentage of adults aged 18-64 years who saw a health care provider for a routine checkup within the last year | 78.9 | 75.9 | 75.1 | 75.1 N/A | | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults aged 18-64 years with healthcare coverage | 95.7 | | | N/A | | No ARHN Rate | 2021 | Reliable |
| Warren | Percentage of adults who did not receive medical care because of cost | 3.6 | 7.1 | 6.5 | 8 N/A | | Lower than ARHN | 2021 | Reliable |
| Warren | Percentage of adults with food security over the last 12 months | 77 | 77.7 | 79.3 | 75.1 N/A | | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of women aged 18-64 years with health care coverage | 96.8 | 95.6 | 95.2 | 94 N/A | | Approx = ARHN | 2021 | Reliable |
| Warren | Women aged 18-44 years who saw a health care provider for a routine checkup within the last year | 70.3 | 78.8 | 77.2 | 75.9 N/A | | Lower than ARHN | 2021 | Unreliable estimate |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year | Estimate Reliability | |
|-------------|--|--------|-------|---------|----------|-----------|----------------------|-----------------------|----------------------|-------------------|
| Warren | Adults who have a regular health care provider, age-adjusted percentage | | 88.1 | 88.3 | 87.1 | 85 | 86.7 | Approx = Benchmark | 2021 | Stable Estimate |
| Warren | Percentage of adults with health insurance, aged 18-64 years | | 94.4 | 93.3 | | 93.2 | 97 | Approx = Benchmark | 2022 | Stable Estimate |
| Warren | Percentage of women with a preventive medical visit in the past year, aged 18-44 years | | 70.3 | 56.3 | 77.2 | 75.9 | 80.6 | Lower than Benchmark | 2021 | Unstable Estimate |
| Warren | Percentage of women with a preventive medical visit in the past year, aged 45+ years | | 89.7 | 88 | 87.7 | 87.9 | 85 | Approx = Benchmark | 2021 | Stable Estimate |
| Warren | Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000 | 101.4 | 129.4 | 90.8 | 96.8 | | 115 | Lower than Benchmark | 2022 | Stable Estimate |
| Warren | Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black non-Hispanics and White non-Hispanics | | 45.8 | | | 101.5 | 94 | Lower than Benchmark | 2022 | Unstable Estimate |
| Warren | Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White non-Hispanics | | -12.5 | | | 29.5 | 23.9 | Lower than Benchmark | 2022 | Stable Estimate |
| Warren | Premature deaths (before age 65 years), difference in percentages between Black non-Hispanics and White non-Hispanics | | 56.9 | | | 19.4 | 17.3 | Higher than Benchmark | 2022 | Unstable Estimate |
| Warren | Premature deaths (before age 65 years), difference in percentages between Hispanics and White non-Hispanics | | 29.1 | | | 17.9 | 16.2 | Higher than Benchmark | 2022 | Unstable Estimate |
| Warren | Percentage of people who commute to work using alternate modes of transportation (e.g., public transportation, carpool, bike/walk) or who telecommute | | 20.2 | 21.6 | 27.2 | 47.7 | 47.9 | Lower than Benchmark | 2018-2022 | Stable Estimate |

MENTAL HEALTH, SUBSTANCE MISUSE INDICATORS

| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
|-------------|---|--------|------|---------|------|-----------|---------------------|-----------|----------------------|
| Warren | Percentage of adult binge drinking during the past month | 20 | 18.9 | 14.5 | 14.9 | N/A | Approx = ARHN | 2021 | Reliable |
| Warren | Percentage of adults reporting a depressive disorder | 25.7 | 23.2 | 18.1 | 17 | N/A | Higher than ARHN | 2021 | Reliable |
| Warren | Percentage of adults who used cannabis in the past 30 days | 14.6 | 16.3 | 12.4 | 12.6 | N/A | Lower than ARHN | 2021 | Unreliable estimate |
| Warren | Percentage of adults with poor mental health for 14 or more days in the last month | 15.5 | 13.3 | 12.6 | 13 | N/A | Higher than ARHN | 2021 | Reliable |
| Warren | Percentage of adults with 2 or more adverse childhood experiences (ACEs) | 44.4 | 42.6 | 40.5 | 41.9 | N/A | Approx = ARHN | 2021 | Unreliable estimate |
| Warren | Cirrhosis hospitalization rate per 10,000 | 4.7 | | 4.3 | 4.4 | N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Cirrhosis mortality rate per 100,000 | 22 | | 12 | 9.7 | N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Self-inflicted injury hospitalization rate per 10,000 | 10.3 | | 5.3 | 4.5 | N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Self-inflicted injury hospitalization rate per 10,000 - Aged 15-19 years | 20.2 | | 13 | 11.5 | N/A | Higher than Upstate | 2022 | Stable Estimate |
| Warren | Suicide mortality rate per 100,000 | 10.2 | | 10.1 | 8.5 | N/A | Approx = Upstate | 2022 | Stable Estimate |
| Warren | Suicide mortality rate per 100,000 - Aged 15-19 years | 9.6 | | 5.6 | 4.8 | N/A | Higher than Upstate | 2022 | Unstable Estimate |
| Warren | Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (any diagnosis), crude rate per 1,000 newborn discharges | 27 | | 9.6 | 6 | N/A | No ARHN Rate | 2022 | |
| Warren | Suicide mortality among youth, rate per 100,000 population aged 15-19 years | 10 | | 5.6 | 4.8 | N/A | No ARHN Rate | 2020-2022 | Unstable Estimate |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year | Estimate Reliability | |
|-------------|--|--------|--------|---------|----------|-----------|----------------------|-----------------------|----------------------|-------------------|
| Warren | Emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate per 100,000 population | 72.9 | 44.7 | 64.8 | 67.1 | | 53.3 | Higher than Benchmark | 2022 | Stable Estimate |
| Warren | Frequent mental distress during the past month among adults, age-adjusted percentage | 19.2 | 16.4 | 13.2 | 13.4 | | 10.7 | Higher than Benchmark | 2021 | Stable Estimate |
| Warren | Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioid or other substance (any diagnosis), crude rate per 1,000 newborn discharges | 27 | | 9.6 | 6 | | 9.1 | Higher than Benchmark | 2022 | Stable Estimate |
| Warren | Opioid analgesic prescription, age-adjusted rate per 1,000 population | 389.2 | 533.4 | 283.8 | 225.6 | | 350 | Higher than Benchmark | 2023 | Stable Estimate |
| Warren | Overdose deaths involving any opioids, age-adjusted rate per 100,000 population | 15.9 | 25.8 | 27.5 | 26.7 | | 14.3 | Higher than Benchmark | 2022 | Stable Estimate |
| Warren | Patients who received at least one buprenorphine prescription for opioid use disorder, age-adjusted rate per 100,000 population | 1322.4 | 1561.3 | 705.4 | 464 | | 415.6 | Higher than Benchmark | 2023 | Stable Estimate |
| Warren | Suicide mortality among youth, rate per 100,000, aged 15-19 years | 9.6 | 14.8 | 5.6 | 4.8 | | 4.7 | Higher than Benchmark | 2020-2022 | Unstable Estimate |
| Warren | Suicide mortality, age-adjusted rate per 100,000 population | 10.5 | | 9.7 | 8 | | 7 | Higher than Benchmark | 2020-2022 | Stable Estimate |
| Warren | Binge drinking during the past month among adults, age-adjusted percentage | 24 | 22.2 | 16.1 | 16 | | 16.4 | Higher than Benchmark | 2021 | Stable Estimate |

Chronic Disease Indicators

| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
|-------------|---|--------|------|---------|------|-----------|---------------------|------|----------------------|
| Washington | Asthma hospitalization rate per 10,000 | | 2.5 | | 3.8 | 6.3 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Washington | Asthma hospitalization rate per 10,000 - Aged 0-17 years | | 3.80 | | 8.5 | 13.4 N/A | Lower than Upstate | 2022 | Stable Estimate |
| Washington | Asthma hospitalization rate per 10,000 - Aged 0-4 years | | 9.60 | | 17.2 | 24.9 N/A | Lower than Upstate | 2022 | Unstable Estimate |
| Washington | Asthma hospitalization rate per 10,000 - Aged 25-44 years | | 3.1 | | 2.7 | 3.6 N/A | Higher than Upstate | 2022 | Stable Estimate |

| | | | | | | | | |
|------------|---|--------|-------|-----------|---------------------|---------------|-------------------|----------|
| Washington | Asthma hospitalization rate per 10,000 - Aged 45-64 years | 2.3 | 2.8 | 5.2 N/A | Lower than Upstate | 2022 | Stable Estimate | |
| Washington | Asthma hospitalization rate per 10,000 - Aged 5-14 years | | 6.50 | 10.60 N/A | No County Data | 2022 | Stable Estimate | |
| Washington | Asthma hospitalization rate per 10,000 - Aged 5-64 years | 2.30 | 3.2 | 5.2 N/A | Lower than Upstate | 2022 | Stable Estimate | |
| Washington | Asthma hospitalization rate per 10,000 - Aged 65 years or older | 1.60 | 2.7 | 5.4 N/A | Lower than Upstate | 2022 | Stable Estimate | |
| Washington | Asthma mortality rate per 100,000 | 0.00 | 1 | 1.4 N/A | Lower than Upstate | 2022 | Unstable Estimate | |
| Washington | Cardiovascular disease hospitalization rate per 10,000 | 149.30 | 141.2 | 137.3 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Cardiovascular disease mortality rate per 100,000 | 345.90 | 293.9 | 282.8 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Cardiovascular disease premature death (aged 35-64 years) rate per 100,000 | 117.00 | 110 | 113.6 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Cardiovascular disease pretransport mortality rate per 100,000 | 237.70 | 190.3 | 181.8 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Cerebrovascular disease (stroke) hospitalization rate per 10,000 | 31.60 | 26.2 | 25.3 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Cerebrovascular disease (stroke) mortality rate per 100,000 | 48.60 | 38.2 | 33.2 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Cerebrovascular disease (stroke) premature death (aged 35-64 years) rate per 100,000 | 14.60 | 11.9 | 11.9 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Cerebrovascular disease (stroke) pretransport mortality rate per 100,000 | 21.90 | 19.2 | 15.3 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Chronic kidney disease emergency department visit rate per 10,000 (any diagnosis) | 196.40 | 179.4 | 181.5 N/A | Higher than Upstate | 2019-2022 | Stable Estimate | |
| Washington | Chronic kidney disease hospitalization rate per 10,000 (any diagnosis) | 166.30 | 149.4 | 151 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Chronic lower respiratory disease hospitalization rate per 10,000 | 25.10 | 14.7 | 16.5 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Chronic lower respiratory disease mortality rate per 100,000 | 74.90 | 40.9 | 31.3 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Colon and rectum cancer incidence rate per 100,000 | 50.60 | | 43.4 N/A | No Upstate Rate | 2021 | Stable Estimate | |
| Washington | Colon and rectum cancer mortality rate per 100,000 | 23.40 | | 13.9 N/A | No Upstate Rate | 2021 | Stable Estimate | |
| Washington | Congestive heart failure mortality rate per 100,000 | 17.50 | 19.2 | 14.5 N/A | Lower than Upstate | 2022 | Stable Estimate | |
| Washington | Congestive heart failure premature death (aged 35-64 years) rate per 100,000 | 4.00 | 3.1 | 2.9 N/A | Higher than Upstate | 2022 | Unstable Estimate | |
| Washington | Congestive heart failure pretransport mortality rate per 100,000 | 11.50 | 11.2 | 7.6 N/A | Approx = Upstate | 2022 | Stable Estimate | |
| Washington | Coronary heart disease hospitalization rate per 10,000 | 29.00 | 26.4 | 25.4 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Coronary heart disease mortality rate per 100,000 | 186.90 | 164.3 | 174.9 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Coronary heart disease premature death (aged 35-64 years) rate per 100,000 | 65.10 | 65.9 | 72.8 N/A | Approx = Upstate | 2022 | Stable Estimate | |
| Washington | Coronary heart disease pretransport mortality rate per 100,000 | 140.40 | 118 | 127.2 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Diabetes hospitalization rate per 10,000 (any diagnosis) | 244.40 | 230.9 | 247.3 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Diabetes hospitalization rate per 10,000 (primary diagnosis) | 19.60 | 18.2 | 20.3 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Diabetes mortality rate per 100,000 | 45.40 | 27.1 | 25.3 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Diabetes short-term complications hospitalization rate per 10,000 - Aged 6-17 Years | | 2.5 | 2.5 N/A | No County Data | 2022 | Stable Estimate | |
| Washington | Diseases of the heart hospitalization rate per 10,000 | 98.20 | 96 | 91.3 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Diseases of the heart mortality rate per 100,000 | 267.80 | 231.9 | 226.1 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Diseases of the heart premature death (aged 35-64 years) mortality rate per 100,000 | 98.40 | 88.7 | 91.7 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Diseases of the heart pretransport mortality rate per 100,000 | 192.90 | 156.1 | 153.2 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Female breast cancer incidence rate per 100,000 | 183.10 | | 167.6 N/A | No Upstate Rate | 2021 | Stable Estimate | |
| Washington | Female breast cancer late stage incidence rate per 100,000 | 37.30 | | 48.7 N/A | No Upstate Rate | 2021 | Stable Estimate | |
| Washington | Female breast cancer mortality rate per 100,000 | 24.90 | | 23.1 N/A | No Upstate Rate | 2021 | Stable Estimate | |
| Washington | Heart attack hospitalization rate per 10,000 | 19.10 | 15.9 | 13.9 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Heart attack mortality rate per 100,000 | 51.40 | 33.4 | 27.3 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Hypertension without heart failure emergency department visit rate per 10,000 - Aged 18 years and older | 13.00 | 22.4 | 25.9 N/A | Lower than Upstate | 2019-2022 | Stable Estimate | |
| Washington | Hypertension without heart failure emergency department visit rate per 10,000 (any diagnosis) - Aged 18 years and older | 626.50 | 930.2 | 988.7 N/A | Lower than Upstate | 2019-2022 | Stable Estimate | |
| Washington | Hypertension without heart failure hospitalization rate per 10,000 (any diagnosis) - Aged 18 years and older | 441.40 | 432.4 | 429.6 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Lung and bronchus cancer incidence rate per 100,000 | 120.70 | | 67.6 N/A | Higher than NYS | 2021 | Stable Estimate | |
| Washington | Lung and bronchus cancer mortality rate per 100,000 | 62.00 | | 34.4 N/A | Higher than NYS | 2021 | Stable Estimate | |
| Washington | Percentage of women (aged 50-74 years) who had a mammogram between October 1, 2019 and December 31, 2021 | 54.90 | 58.51 | 65.5 N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Washington | Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines | 76.00 | 79.65 | 78.2 N/A | No Upstate Rate | 2021 | Unstable Estimate | |
| Washington | Potentially preventable diabetes short-term complications hospitalization rate per 10,000 - Aged 18 years and older | 6.70 | 6.7 | 7 N/A | Approx = Upstate | 2022 | Stable Estimate | |
| Washington | Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older | 40.70 | 35.8 | 36.1 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older | 2.50 | 5.3 | 6.6 N/A | Lower than Upstate | 2022 | Stable Estimate | |
| Washington | Prostate cancer incidence rate per 100,000 | 156.20 | | 169 N/A | No Upstate Rate | 2021 | Stable Estimate | |
| Washington | Prostate cancer late stage incidence rate per 100,000 | 30.40 | | 34.1 N/A | No Upstate Rate | 2021 | Stable Estimate | |
| Washington | Prostate cancer mortality rate per 100,000 | | | 16.3 N/A | No County Data | 2021 | Unstable Estimate | |
| Washington | Percentage of adults ever had their blood cholesterol checked | 88.40 | 91.9 | 91.8 | 92.2 N/A | Approx = ARHN | 2021 | Reliable |

| | | | | | | | | |
|------------|---|-------|------|------|----------|------------------|------|---------------------|
| Washington | Percentage of adults living with a disability who are obese | 41.20 | 43.8 | 39.1 | 38.1 N/A | Approx = ARHN | 2021 | Unreliable estimate |
| Washington | Percentage of adults living with a disability who smoke | 33.10 | 29.3 | 19.4 | 17.4 N/A | Higher than ARHN | 2021 | Unreliable estimate |
| Washington | Percentage of adults living with a disability with cardiovascular disease (heart attack, coronary heart disease, or stroke) | 14.10 | 17.2 | 17.7 | 16.3 N/A | Lower than ARHN | 2021 | Reliable |
| Washington | Percentage of adults overweight or obese | 66.20 | 71 | 66.6 | 63.6 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults who are current smokers | 22.70 | 19.7 | 13.2 | 12 N/A | Higher than ARHN | 2021 | Reliable |
| Washington | Percentage of adults who are obese | 32.60 | 33 | 31.6 | 29.1 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults who consume one or more sugary drinks daily | 24.00 | 21.6 | 18.9 | 19 N/A | Higher than ARHN | 2021 | Reliable |
| Washington | Percentage of adults who had a test for high blood sugar or diabetes within the past three years | 42.20 | 50.1 | 51.1 | 50.5 N/A | Lower than ARHN | 2021 | Reliable |
| Washington | Percentage of adults who have ever had physician-diagnosed asthma | 17.60 | 18.3 | 14.7 | 14.2 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults who have taken a course or class to learn how to manage their chronic disease or condition | 13.40 | 11.4 | 9.9 | 9.8 N/A | Higher than ARHN | 2021 | Reliable |
| Washington | Percentage of adults who participated in leisure time physical activity in the past 30 days | 78.30 | 74.1 | 75.7 | 74.2 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults who report consuming less than one fruit and less than one vegetable daily (no fruits or vegetables) | 37.80 | 32.7 | 32.2 | 33.8 N/A | Higher than ARHN | 2021 | Reliable |
| Washington | Percentage of adults who use e-cigarettes | 8.70 | 7.4 | 6 | 5.3 N/A | Higher than ARHN | 2021 | Reliable |
| Washington | Percentage of adults with an annual household income less than \$25,000 who are obese | 21.10 | | 36.6 | 34.4 N/A | No ARHN Rate | 2021 | Unreliable estimate |
| Washington | Percentage of adults with annual household income less than \$25,000 who are current smokers | 38.10 | 29.4 | 26.5 | 20.4 N/A | Higher than ARHN | 2021 | Unreliable estimate |
| Washington | Percentage of adults with cardiovascular disease (heart attack, coronary heart disease, or stroke) | 8.40 | 9.1 | 8.1 | 7.4 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults with COPD | 8.10 | 9.4 | 6.5 | 5.5 N/A | Lower than ARHN | 2021 | Reliable |
| Washington | Percentage of adults with current asthma | 12.40 | 12.5 | 10.4 | 9.8 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults with diagnosed high blood pressure taking high blood pressure medication | 81.60 | 78.2 | 81.2 | 80.2 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults with health care provider diagnosed diabetes | 12.30 | 13.2 | 11 | 11.4 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults with health care provider diagnosed high blood pressure | 33.70 | 37.2 | 31.7 | 30.5 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults with health care provider diagnosed prediabetes | 7.40 | 9.4 | 10.8 | 11.6 N/A | Lower than ARHN | 2021 | Reliable |
| Washington | Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines | 76.00 | 79.7 | 78.8 | 78.2 N/A | Approx = ARHN | 2021 | Unreliable estimate |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year |
|-------------|--|--------|------|---------|----------|-----------|----------------------------|------|
| Washington | Percentage of adults who had a test for high blood sugar or diabetes within the past three years, aged 45+ years | 56.70 | 62.6 | 63.8 | 64.3 | | 71.7 Lower than Benchmark | 2021 |
| Washington | Percentage of adults who participate in leisure-time physical activity | 78.30 | 74.1 | 75.7 | 74.2 | | 77.4 Approx = Benchmark | 2021 |
| Washington | Percentage of adults who participate in leisure-time physical activity, aged 65+ years | 68.70 | 70.5 | 68.5 | 68.4 | | 75.9 Approx = Benchmark | 2021 |
| Washington | Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines, aged 50-64 years | 67.20 | 68.3 | 66.5 | 65.4 | | 66.3 Approx = Benchmark | 2018 |
| Washington | Percentage of adults who smoke cigarettes among adults with income less than \$25,000 | 38.10 | 21 | 26.5 | 20.4 | | 15.3 Higher than Benchmark | 2021 |
| Washington | Percentage of adults with an annual household income less than \$25,000 with obesity | 21.10 | | 36.6 | 34.4 | | 29 Lower than Benchmark | 2021 |
| Washington | Percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition | 13.40 | 11.4 | 9.9 | 9.8 | | 10.6 Higher than Benchmark | 2021 |
| Washington | Percentage of adults with disabilities who participate in leisure-time physical activity | 64.70 | 61.3 | 58.7 | 58.3 | | 61.8 Approx = Benchmark | 2021 |
| Washington | Percentage of adults with hypertension who are currently taking medicine to manage their high blood pressure | 81.60 | 78.2 | 81.2 | 80.2 | | 80.7 Approx = Benchmark | 2021 |
| Washington | Percentage of adults with obesity | 32.60 | 33 | 31.6 | 29.1 | | 24.2 Higher than Benchmark | 2021 |

Healthy Women, Infants, and Children Indicators

| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year |
|-------------|--|--------|------|---------|----------|-----------|---------------------|------|
| Washington | Asthma hospitalization rate per 10,000 - Aged 0-17 years | 3.8 | | 8.5 | 13.4 N/A | | Lower than Upstate | 2022 |
| Washington | Asthma hospitalization rate per 10,000 - Aged 0-4 years | 9.6 | | 17.2 | 24.9 N/A | | Lower than Upstate | 2022 |
| Washington | Asthma hospitalization rate per 10,000 - Aged 5-14 years | | | 6.5 | 10.6 N/A | | No County Data | 2022 |
| Washington | Birth rate per 1,000 population | 8.9 | | 10.2 | 10.6 N/A | | Lower than Upstate | 2022 |
| Washington | Maternal mortality rate per 100,000 live births | 0 | | 22 | 21.3 N/A | | Lower than Upstate | 2022 |
| Washington | Mortality rate per 1,000 live births - Fetal death (20 weeks gestation or more) | 3.7 | | 4.8 | 6 N/A | | Lower than Upstate | 2022 |
| Washington | Mortality rate per 1,000 live births - Infant (<1 year) | 6.2 | | 4.6 | 4.2 N/A | | Higher than Upstate | 2022 |
| Washington | Mortality rate per 1,000 live births - Neonatal (<28 days) | 3.1 | | 2.9 | 2.6 N/A | | Higher than Upstate | 2022 |
| Washington | Mortality rate per 1,000 live births - Perinatal (20 weeks gestation - <28 days of life) | 6.8 | | 7.7 | 8.7 N/A | | Lower than Upstate | 2022 |
| Washington | Mortality rate per 1,000 live births - Perinatal (28 weeks gestation - <7 days of life) | 3.1 | | 4.6 | 4.7 N/A | | Lower than Upstate | 2022 |
| Washington | Mortality rate per 1,000 live births - Post-neonatal (1 month to 1 year) | 3.1 | | 1.7 | 1.5 N/A | | Higher than Upstate | 2022 |
| Washington | Mortality rate per 100,000 - Aged 10-14 years | 20.1 | | 12.4 | 12.2 N/A | | Higher than Upstate | 2022 |
| Washington | Mortality rate per 100,000 - Aged 1-4 years | 29.7 | | 19.1 | 16.8 N/A | | Higher than Upstate | 2022 |
| Washington | Mortality rate per 100,000 - Aged 15-19 years | 20 | | 34.6 | 34.3 N/A | | Lower than Upstate | 2022 |

| | | | | | | |
|------------|---|------|----------|-----------|---------------------|-----------|
| Washington | Mortality rate per 100,000 - Aged 5-14 years | 20.8 | 11.3 | 11.3 N/A | Higher than Upstate | 2022 |
| Washington | Mortality rate per 100,000 - Aged 5-9 years | 21.5 | 10.2 | 10.4 N/A | Higher than Upstate | 2022 |
| Washington | Percentage low birthweight (<2.5 kg) births | 7.9 | 6.77 | 8 N/A | Approx = Upstate | 2022 |
| Washington | Percentage low birthweight (<2.5kg) singleton births | 6.4 | 5.47 | 6.3 N/A | Approx = Upstate | 2022 |
| Washington | Percentage of births delivered by cesarean section | 32.8 | 27.72 | 34.8 N/A | Lower than Upstate | 2022 |
| Washington | Percentage of births that were first births | 39.4 | 34.14 | 38.5 N/A | Higher than Upstate | 2022 |
| Washington | Percentage of births that were multiple births | 3.8 | 3.5 | 3.3 N/A | Approx = Upstate | 2022 |
| Washington | Percentage of births to teens - Aged 15-17 years | 0.8 | 0.34 | 0.6 N/A | Higher than Upstate | 2022 |
| Washington | Percentage of births to teens - Aged 15-19 years | 4.3 | 3.61 | 2.9 N/A | Higher than Upstate | 2022 |
| Washington | Percentage of births to women aged 25 years and older without a high school education | 7.1 | 6.55 | 9.1 N/A | Lower than Upstate | 2022 |
| Washington | Percentage of births to women aged 35 years and older | 13.4 | 13.95 | 24.3 N/A | Lower than Upstate | 2022 |
| Washington | Percentage of births with a 5 minute APGAR <6 | 1.7 | 1.27 | 0.9 N/A | Higher than Upstate | 2022 |
| Washington | Percentage of births with adequate prenatal care | 86.3 | 69.51 | 77.3 N/A | Higher than Upstate | 2022 |
| Washington | Percentage of births with early (1st trimester) prenatal care | 81.5 | 67.84 | 77.5 N/A | Higher than Upstate | 2022 |
| Washington | Percentage of births with late (3rd trimester) or no prenatal care | 4.5 | 4.84 | 4.6 N/A | Approx = Upstate | 2022 |
| Washington | Percentage of children who had 2+ well-child visit during 15-30 months of life in government sponsored insurance programs | 86.4 | 72.52 | 42.5 N/A | Higher than ARHN | 2022 |
| Washington | Percentage of children who had 6+ well-child visits in the first 15 months of life in government sponsored insurance programs | 76.4 | 63.21 | 67.4 N/A | Higher than ARHN | 2022 |
| Washington | Percentage of infants fed any breast milk in delivery hospital | 80.3 | 70 | 84.8 N/A | Lower than Upstate | 2022 |
| Washington | Percentage of infants fed exclusively breast milk in delivery hospital | 58.9 | 55.14 | 47.8 N/A | Higher than Upstate | 2022 |
| Washington | Percentage of live births conceived within 18 months of a previous live birth | 33.8 | 30.02 | 34.1 N/A | Approx = Upstate | 2022 |
| Washington | Percentage of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher) | 37.4 | 30.64 | 26.6 N/A | Higher than ARHN | 2022 |
| Washington | Percentage of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25 to less than 30) | 22 | 19.8 | 27.6 N/A | Higher than ARHN | 2022 |
| Washington | Percentage of pregnant women in WIC who were pre-pregnancy underweight (BMI less than 18.5) | 4.6 | 4.02 | 4.6 N/A | Higher than ARHN | 2022 |
| Washington | Percentage of pregnant women in WIC with early (1st trimester) prenatal care | 88.7 | 77.78 | 90.7 N/A | Higher than ARHN | 2022 |
| Washington | Percentage of pregnant women in WIC with gestational diabetes | 7.4 | 6.98 | 6.6 N/A | Higher than ARHN | 2022 |
| Washington | Percentage of premature births with <32 weeks gestation | 1.4 | 1.22 | 1.4 N/A | Approx = Upstate | 2022 |
| Washington | Percentage of premature births with <37 weeks gestation | 11.4 | 8.34 | 9.5 N/A | Higher than Upstate | 2022 |
| Washington | Percentage of premature births with 32 - <37 weeks gestation | 10 | 7.1 | 8 N/A | Higher than Upstate | 2022 |
| Washington | Percentage very low birthweight (<1.5 kg) births | 1.4 | 1.11 | 1.3 N/A | Approx = Upstate | 2022 |
| Washington | Percentage very low birthweight (<1.5kg) singleton births | 1.3 | 0.91 | 1 N/A | Approx = Upstate | 2022 |
| Washington | Pregnancy rate per 1,000 (all pregnancies/female population aged 15-44 years) | 70 | 68.2 | 71.7 N/A | Higher than Upstate | 2022 |
| Washington | Teen fertility rate per 1,000 (births to mothers aged 10-14 years/female population aged 10-14 years) | 0.21 | 0.12 | 0.12 N/A | Higher than Upstate | 2022 |
| Washington | Teen fertility rate per 1,000 (births to mothers aged 15-17 years/female population aged 15-17 years) | 4.4 | 3.6 | 3.6 N/A | Higher than Upstate | 2022 |
| Washington | Teen fertility rate per 1,000 (births to mothers aged 15-19 years/female population aged 15-19 years) | 15.9 | 9 | 9 N/A | Higher than Upstate | 2022 |
| Washington | Teen fertility rate per 1,000 (births to mothers aged 18-19 years/female population aged 18-19 years) | 40.3 | 15.9 | 16.5 N/A | Higher than Upstate | 2022 |
| Washington | Teen pregnancy rate per 1,000 females aged <18 years | 3.3 | 2.9 | 3.4 N/A | Approx = Upstate | 2022 |
| Washington | Teen pregnancy rate per 1,000 females aged 15-19 years | 22.7 | 15.4 | 18.3 N/A | Higher than Upstate | 2022 |
| Washington | Teen pregnancy rate per 1,000 females aged 18-19 years | 54.4 | 26.1 | 31.9 N/A | Higher than Upstate | 2022 |
| Washington | Child and adolescent mortality, rate per 100,000 population aged 10-19 years | 20 | 24.1 | 23.6 N/A | No ARHN Rate | 2020-2022 |
| Washington | Child mortality rate per 100,000 children aged 1-9 years | 25 | 14 | 13.3 N/A | Higher than Upstate | 2020-2022 |
| Washington | Infant mortality rate per 1,000 live births | 6 | 4.7 | 4.3 N/A | Higher than Upstate | 2022 |
| Washington | Maternal mortality rate per 100,000 live births | 0 | 22 | 21.3 N/A | No ARHN Rate | 2020-2022 |
| Washington | Neonatal mortality rate per 1,000 live births | 2 | 2.9 | 2.7 N/A | No ARHN Rate | 2022 |
| Washington | Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (any diagnosis), crude rate per 1,000 newborn discharges | | 9.6 | 6 N/A | No County Data | 2022 |
| Washington | Percent of families participating in the Early Intervention Program, Part C, who report that early intervention services have helped the family effectively communicate the needs of their children | 100 | 88.46154 | 94.56 N/A | Higher than ARHN | 2021-2022 |
| Washington | Percent of families participating in the Early Intervention Program, Part C, who report that early intervention services have helped the family help their children develop and learn | 100 | 91.66667 | 94.4 N/A | Higher than ARHN | 2021-2022 |
| Washington | Percent of families participating in the Early Intervention Program, Part C, who report that early intervention services have helped the family know their rights | 100 | 92.30769 | 92.7 N/A | Higher than ARHN | 2021-2022 |
| Washington | Percentage of births with early (1st trimester) prenatal care | 82 | 78.60944 | 76.6 N/A | Approx = ARHN | 2022 |
| Washington | Percentage of NYS residents served by community water systems that have optimally fluoridated water | 25 | 26.93099 | 48 N/A | Approx = ARHN | 2023 |

| | | | | | | | |
|------------|---|----|----------|-----|---------|------------------|-----------|
| Washington | Percentage of preterm births (less than 37 weeks gestation) | 12 | 9.702277 | 9.5 | 9.4 N/A | Higher than ARHN | 2022 |
| Washington | Perinatal mortality rate per 1,000 live births plus fetal deaths | 2 | | 4.4 | 4.6 N/A | No ARHN Rate | 2022 |
| Washington | Post-neonatal mortality rate per 1,000 live births | 3 | | 1.7 | 1.5 N/A | No ARHN Rate | 2020-2022 |
| Washington | Suicide mortality among youth, rate per 100,000 population aged 15-19 years | 10 | | 5.6 | 4.8 N/A | No ARHN Rate | 2020-2022 |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark |
|-------------|--|--------|------|---------|----------|-----------|-----------------------|
| Washington | Indicated reports of abuse/maltreatment, rate per 1,000 children, aged 0-17 years | 37.6 | | 13.7 | 12.4 | 15.6 | Higher than Benchmark |
| Washington | Percentage of 13-year-old adolescents with a complete HPV vaccine series | 27.8 | 25 | 31.3 | 37.2 | 37.4 | Lower than Benchmark |
| Washington | Percentage of 24-35-month old children with the 4:3:1:3:1:4 immunization series | 81.4 | 78.9 | 69.1 | 70.5 | 70.5 | Higher than Benchmark |
| Washington | Percentage of children and adolescents with obesity | 27.2 | 25.1 | 20.6 | | 16.4 | Higher than Benchmark |
| Washington | Percentage of infants who are exclusively breastfed in the hospital among all infants | 65 | 57.1 | 46.7 | 44 | 51.7 | Higher than Benchmark |
| Washington | Percentage of WIC enrolled infants who are breastfed at 6 months | 19.4 | | | 38 | 45.5 | Lower than Benchmark |
| Washington | Percentage of women with a preventive medical visit in the past year, aged 18-44 years | 78.7 | 56.3 | 77.2 | 75.9 | 80.6 | Approx = Benchmark |
| Washington | Percentage of women with a preventive medical visit in the past year, aged 45+ years | 88.7 | 88 | 87.7 | 87.9 | 85 | Approx = Benchmark |

| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year |
|-------------|---|--------|-------|---------|------------|-----------|--------------------|------|
| Washington | AIDS mortality rate per 100,000 | 0 | | 0.8 | 2 N/A | | Lower than Upstate | 2022 |
| Washington | Chlamydia case rate per 100,000 females - Aged 15-19 years | 1295.2 | | | 2626.2 N/A | | No Upstate Rate | 2022 |
| Washington | Chlamydia case rate per 100,000 females - Aged 15-44 years | 807.6 | | | 1450.7 N/A | | No Upstate Rate | 2022 |
| Washington | Chlamydia case rate per 100,000 females - Aged 20-24 years | 2281.9 | | | 3389.8 N/A | | No Upstate Rate | 2022 |
| Washington | Chlamydia case rate per 100,000 males - Aged 15-19 years | 214.1 | | | 847 N/A | | No Upstate Rate | 2022 |
| Washington | Chlamydia case rate per 100,000 males - Aged 15-44 years | 194.9 | | | 991.8 N/A | | No Upstate Rate | 2022 |
| Washington | Gonorrhea case rate per 100,000 - Aged 15-19 years | 70 | | | 416.9 N/A | | No Upstate Rate | 2022 |
| Washington | Gonorrhea case rate per 100,000 females - Aged 15-44 years | 72.2 | | | 326.4 N/A | | No Upstate Rate | 2022 |
| Washington | Gonorrhea case rate per 100,000 males - Aged 15-44 years | 79.1 | | | 667.9 N/A | | No Upstate Rate | 2022 |
| Washington | Percentage of sexually active young women (aged 16-24) with at least one chlamydia test in Medicaid program | 58.1 | 55.78 | | 72.6 N/A | | No Upstate Rate | 2022 |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year |
|-------------|--|--------|--------|---------|----------|-----------|----------------------|-----------|
| Washington | Chlamydia diagnoses, age-adjusted rate per 100,000 population | 194.1 | 190.03 | 372.5 | 553.4 | 676.9 | Lower than Benchmark | 2022 |
| Washington | Early syphilis diagnoses, age-adjusted rate per 100,000 population | 0 | 5.5 | 23.6 | 49.5 | 79.6 | Lower than Benchmark | 2022 |
| Washington | Gonorrhea diagnoses, age-adjusted rate per 100,000 population | 34.9 | 47.1 | 134.3 | 230.9 | 242.6 | Lower than Benchmark | 2022 |
| Washington | Newly diagnosed HIV cases, rate per 100,000 population | | 6.9 | 5 | 11.3 | 5.2 | No County Data | 2020-2022 |

| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
|-------------|--|--------|------|---------|-----------|-----------|---------------------|------|----------------------|
| Washington | Alcohol related motor vehicle injuries and deaths per 100,000 | 38.8 | | | 25 N/A | | Higher than NYS | 2022 | Stable Estimate |
| Washington | Falls hospitalization rate per 10,000 | 53 | | 49.1 | 45.1 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Washington | Falls hospitalization rate per 10,000 - Aged <10 years | 5.7 | | 5.7 | 6.1 N/A | | Approx = Upstate | 2022 | Stable Estimate |
| Washington | Falls hospitalization rate per 10,000 - Aged 15-24 years | 4 | | 3.8 | 4.4 N/A | | Approx = Upstate | 2022 | Unstable Estimate |
| Washington | Falls hospitalization rate per 10,000 - Aged 25-64 years | 21.4 | | 20.5 | 20.6 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Washington | Falls hospitalization rate per 10,000 - Aged 65-74 years | 93.7 | | 88.6 | 86.9 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Washington | Falls hospitalization rate per 10,000 - Aged 75-84 years | 240.5 | | 238.1 | 221.6 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Washington | Falls hospitalization rate per 10,000 - Aged 85 years and older | 593.4 | | 647.5 | 572.2 N/A | | Lower than Upstate | 2022 | Stable Estimate |
| Washington | Fatal work-related injuries per 100,000 employed persons aged 16 years and older | 6.4 | | | 2.8 N/A | | No Upstate Rate | 2022 | Unstable Estimate |
| Washington | Motor vehicle injury mortality rate per 100,000 | 16.4 | | 8.4 | 6.5 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Washington | Non-motor vehicle injury mortality rate per 100,000 | 21.9 | | 46.3 | 43.5 N/A | | Lower than Upstate | 2022 | Stable Estimate |
| Washington | Traumatic brain injury hospitalization rate per 10,000 | 9.8 | | 8.6 | 8.4 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Washington | Unintentional injury hospitalization rate per 10,000 | 88.5 | | 86.6 | 81.2 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Washington | Unintentional injury hospitalization rate per 10,000 - Aged <10 years | 20.9 | | 18.6 | 18.3 N/A | | Higher than Upstate | 2022 | Stable Estimate |
| Washington | Unintentional injury hospitalization rate per 10,000 - Aged 10-14 years | 17.1 | | 14.1 | 13.5 N/A | | Higher than Upstate | 2022 | Unstable Estimate |
| Washington | Unintentional injury hospitalization rate per 10,000 - Aged 15-24 years | 28 | | 24 | 25.3 N/A | | Higher than Upstate | 2022 | Stable Estimate |

| | | | | | | | | |
|------------|---|-------|-------|-----------|---------------------|---------------|-----------------|----------|
| Washington | Unintentional injury hospitalization rate per 10,000 - Aged 25-64 years | 59.8 | 56.8 | 56.6 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Unintentional injury hospitalization rate per 10,000 - Aged 65 years and older | 244.9 | 280.7 | 260.5 N/A | Lower than Upstate | 2022 | Stable Estimate | |
| Washington | Unintentional injury mortality rate per 100,000 | 38.3 | 54.7 | 50 N/A | Lower than Upstate | 2022 | Stable Estimate | |
| Washington | Violent crime rate per 100,000 | 146.4 | | 430.6 N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Washington | Work-related hospitalizations per 100,000 employed persons aged 16 years and older | 87.9 | | 99.9 N/A | No Upstate Rate | 2022 | Stable Estimate | |
| Washington | Percentage of adults using active transportation (walking or biking) in a typical month | 61.2 | 59.4 | 59.3 | 67.6 N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults who participated in leisure time physical activity in the past 30 days | 75 | 74.1 | 75.7 | 74.2 N/A | Approx = ARHN | 2021 | Reliable |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year | Estimate Reliability |
|-------------|--|--------|-------|---------|----------|-----------|----------------------|------|----------------------|
| Washington | Assault-related hospitalizations, rate per 10,000 population | 2.3 | 1.03 | 2.5 | 3.6 | 3 | Lower than Benchmark | 2020 | Unstable Estimate |
| Washington | Assault-related hospitalizations, ratio of rates between Black non-Hispanics and White non-Hispanics | | | | 6.51 | 5.54 | No County Data | 2020 | Unstable Estimate |
| Washington | Assault-related hospitalizations, ratio of rates between Hispanics and White non-Hispanics | | | | 2.85 | 2.5 | No County Data | 2020 | Unstable Estimate |
| Washington | Crash-related pedestrian fatalities, rate per 100,000 population | 0 | 1.1 | 1.71 | 1.72 | 1.43 | Lower than Benchmark | 2019 | Unstable Estimate |
| Washington | Firearm assault-related hospitalizations, rate per 10,000 population | 0 | 0 | 0.39 | 0.48 | 0.38 | Lower than Benchmark | 2020 | Unstable Estimate |
| Washington | Hospitalizations due to falls among adults, rate per 10,000 population, aged 65+ years | 181.1 | 158.5 | 189.7 | 177.2 | 173.7 | Approx = Benchmark | 2020 | Stable Estimate |
| Washington | Percentage of population living in a certified Climate Smart Community | 0 | 20.2 | 61.6 | 35.6 | 8.6 | Lower than Benchmark | 2024 | Stable Estimate |

| Health Access and Equity Indicators | | | | | | | | | |
|-------------------------------------|---|--------|-------|---------|-------|-----------|-------------------|-----------|----------------------|
| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
| Washington | Annual median household income in US dollars | 67013 | | | 79463 | N/A | Lower than NYS | 2022 | Stable Estimate |
| Washington | Number of dentists per 100,000 population | 21 | | | 83 | N/A | Lower than NYS | 2021 | Stable Estimate |
| Washington | Number of mental health providers per 100,000 population | 176 | | | 356 | N/A | Lower than NYS | 2022 | Stable Estimate |
| Washington | Number of primary care physicians per 100,000 population | 36 | | | 80 | N/A | Lower than NYS | 2020 | Stable Estimate |
| Washington | Percentage of children (aged 2-20 years) with at least one dental visit in government sponsored insurance programs | 67.7 | 61.44 | | 52.7 | N/A | Higher than ARHN | 2022 | Stable Estimate |
| Washington | Percentage of children aged <18 years below poverty | 14.6 | 16.34 | | 18.6 | N/A | Lower than ARHN | 2022 | Stable Estimate |
| Washington | Percentage of children who had 2+ well-child visit during 15-30 months of life in government sponsored insurance programs | 86.4 | 72.52 | | 42.5 | N/A | Higher than ARHN | 2022 | Stable Estimate |
| Washington | Percentage of children who had 6+ well-child visits in the first 15 months of life in government sponsored insurance programs | 76.4 | 63.21 | | 67.4 | N/A | Higher than ARHN | 2022 | Stable Estimate |
| Washington | Percentage of enrolled students eligible for free/reduced priced lunch | 42.3 | 44.47 | | 54.1 | N/A | Lower than ARHN | 2022 | Stable Estimate |
| Washington | Percentage of high school students who dropped out | 7.1 | 6.57 | | 4.9 | N/A | Higher than ARHN | 2022-2023 | Stable Estimate |
| Washington | Percentage of high school students who graduated | 85.1 | 87.82 | | 86.4 | N/A | Lower than ARHN | 2022-2023 | Stable Estimate |
| Washington | Percentage of Medicaid enrollees (aged 2-20 years) who had at least one dental visit within the last year | 59.9 | 53.05 | | 46.5 | N/A | Higher than ARHN | 2023 | Stable Estimate |
| Washington | Percentage of Medicaid enrollees (aged 2-20 years) with at least one preventive dental visit within the last year | 56.5 | 49.27 | | 42.5 | N/A | Higher than ARHN | 2023 | Stable Estimate |
| Washington | Percentage of Medicaid enrollees with at least one dental visit within the last year | 30.1 | 28.64 | | 29.7 | N/A | Higher than ARHN | 2023 | Stable Estimate |
| Washington | Percentage of Medicaid enrollees with at least one preventive dental visit within the last year | 26.2 | 23.61 | | 25.7 | N/A | Higher than ARHN | 2023 | Stable Estimate |
| Washington | Percentage of population in poverty | 10.6 | 12.3 | | 14.2 | N/A | Lower than ARHN | 2022 | Stable Estimate |
| Washington | Percentage of population who did not have access to a reliable source of food during the past year (Food insecurity) | 12.1 | 12.88 | | 13.4 | N/A | Approx = ARHN | 2022 | Stable Estimate |
| Washington | Percentage of adults aged 18-64 years who saw a health care provider for a routine checkup within the last year | 71.8 | 75.9 | 75.1 | 75.1 | N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults aged 18-64 years with healthcare coverage | 98.8 | 95 | 93.4 | 92.4 | N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of adults who did not receive medical care because of cost | 5.3 | 7.1 | 6.5 | 8 | N/A | Lower than ARHN | 2021 | Reliable |
| Washington | Percentage of adults with food security over the last 12 months | 80.1 | 77.7 | 79.3 | 75.1 | N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Percentage of women aged 18-64 years with health care coverage | 96.4 | 95.6 | 95.2 | 94 | N/A | Approx = ARHN | 2021 | Reliable |
| Washington | Women aged 18-44 years who saw a health care provider for a routine checkup within the last year | | 78.8 | 77.2 | 75.9 | N/A | No County Data | 2021 | Unreliable estimate |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year | Estimate Reliability |
|-------------|--|--------|-------|---------|----------|-----------|----------------------|------|----------------------|
| Washington | Adults who have a regular health care provider, age-adjusted percentage | 89.3 | 88.3 | 87.1 | 85 | 86.7 | Approx = ARHN | 2021 | Stable Estimate |
| Washington | Percentage of adults with health insurance, aged 18-64 years | 93.9 | 93.3 | | 93.2 | 97 | Approx = Benchmark | 2022 | Stable Estimate |
| Washington | Percentage of women with a preventive medical visit in the past year, aged 18-44 years | 78.7 | 56.3 | 77.2 | 75.9 | 80.6 | Approx = Benchmark | 2021 | Unstable Estimate |
| Washington | Percentage of women with a preventive medical visit in the past year, aged 45+ years | 88.7 | 88 | 87.7 | 87.9 | 85 | Approx = Benchmark | 2021 | Stable Estimate |
| Washington | Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000 | 109.2 | 129.4 | 90.8 | 96.8 | 115 | Approx = Benchmark | 2022 | Stable Estimate |
| Washington | Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black non-Hispanics and White non-Hispanics | -58.2 | | | 101.5 | 94 | Lower than Benchmark | 2022 | Unstable Estimate |
| Washington | Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White non-Hispanics | | | | 29.5 | 23.9 | No County Data | 2022 | Stable Estimate |

| | | | | | | | | |
|------------|---|------|------|------|------|---------------------------|-----------|-------------------|
| Washington | Premature deaths (before age 65 years), difference in percentages between Black non-Hispanics and White non-Hispanics | 1.8 | | 19.4 | 17.3 | Lower than Benchmark | 2022 | Unstable Estimate |
| Washington | Premature deaths (before age 65 years), difference in percentages between Hispanics and White non-Hispanics | 51.8 | | 17.9 | 16.2 | Higher than Benchmark | 2022 | Unstable Estimate |
| Washington | Percentage of people who commute to work using alternate modes of transportation (e.g., public transportation, carpool, bike/walk) or who telecommute | 17.7 | 21.6 | 27.2 | 47.7 | 47.9 Lower than Benchmark | 2018-2022 | Stable Estimate |

| Mental Health, Substance Misuse Indicators | | | | | | | | | |
|--|---|--------|------|---------|----------|---------------------|-------------------|---------------------|----------------------|
| County Name | Indicator | County | ARHN | Upstate | NYS | Benchmark | County vs Upstate | Year | Estimate Reliability |
| Washington | Percentage of adult binge drinking during the past month | 17 | 18.9 | 14.5 | 14.9 N/A | Approx = ARHN | 2021 | Reliable | |
| Washington | Percentage of adults reporting a depressive disorder | 25.6 | 23.2 | 18.1 | 17 N/A | Higher than ARHN | 2021 | Reliable | |
| Washington | Percentage of adults who used cannabis in the past 30 days | 16.8 | 16.3 | 12.4 | 12.6 N/A | Higher than ARHN | 2021 | Unreliable estimate | |
| Washington | Percentage of adults with poor mental health for 14 or more days in the last month | 13.8 | 13.3 | 12.6 | 13 N/A | Higher than ARHN | 2021 | Reliable | |
| Washington | Percentage of adults with 2 or more adverse childhood experiences (ACEs) | 51.3 | 42.6 | 40.5 | 41.9 N/A | Higher than ARHN | 2021 | Unreliable estimate | |
| Washington | Cirrhosis hospitalization rate per 10,000 | 4.5 | | 4.3 | 4.4 N/A | Approx = Upstate | 2022 | Stable Estimate | |
| Washington | Cirrhosis mortality rate per 100,000 | 15.3 | | 12 | 9.7 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Self-inflicted injury hospitalization rate per 10,000 | 9 | | 5.3 | 4.5 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Self-inflicted injury hospitalization rate per 10,000 - Aged 15-19 years | 27 | | 13 | 11.5 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Suicide mortality rate per 100,000 | 16.9 | | 10.1 | 8.5 N/A | Higher than Upstate | 2022 | Stable Estimate | |
| Washington | Suicide mortality rate per 100,000 - Aged 15-19 years | 10 | | 5.6 | 4.8 N/A | Higher than Upstate | 2022 | Unstable Estimate | |
| Washington | Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (any diagnosis), crude rate per 1,000 newborn discharges | | | 9.6 | 6 N/A | No County Rate | 2022 | | |
| Washington | Suicide mortality among youth, rate per 100,000 population aged 15-19 years | 10 | | 5.6 | 4.8 N/A | No ARHN Rate | 2020-2022 | Unstable Estimate | |

| County Name | Indicator | County | ARHN | Upstate | Full NYS | Benchmark | County vs. Benchmark | Year | Estimate Reliability |
|-------------|--|--------|--------|---------|----------|-----------|-----------------------|-----------|----------------------|
| Washington | Emergency department visits (including outpatients and admitted patients) involving any opioid overdose, age-adjusted rate per 100,000 population | 51.1 | 44.7 | 64.8 | 67.1 | 53.3 | Approx = Benchmark | 2022 | Stable Estimate |
| Washington | Frequent mental distress during the past month among adults, age-adjusted percentage | 17.8 | 16.4 | 13.2 | 13.4 | 10.7 | Higher than Benchmark | 2021 | Stable Estimate |
| Washington | Newborns with neonatal withdrawal syndrome and/or affected by maternal use of opioid or other substance (any diagnosis), crude rate per 1,000 newborn discharges | | | 9.6 | 6 | 9.1 | No County Data | 2022 | Stable Estimate |
| Washington | Opioid analgesic prescription, age-adjusted rate per 1,000 population | 429.1 | 533.4 | 283.8 | 225.6 | 350 | Higher than Benchmark | 2023 | Stable Estimate |
| Washington | Overdose deaths involving any opioids, age-adjusted rate per 100,000 population | 49 | 25.8 | 27.5 | 26.7 | 14.3 | Higher than Benchmark | 2022 | Stable Estimate |
| Washington | Patients who received at least one buprenorphine prescription for opioid use disorder, age-adjusted rate per 100,000 population | 1662.7 | 1561.3 | 705.4 | 464 | 415.6 | Higher than Benchmark | 2023 | Stable Estimate |
| Washington | Suicide mortality among youth, rate per 100,000, aged 15-19 years | 10 | 14.8 | 5.6 | 4.8 | 4.7 | Higher than Benchmark | 2020-2022 | Unstable Estimate |
| Washington | Suicide mortality, age-adjusted rate per 100,000 population | 15.5 | | 9.7 | 8 | 7 | Higher than Benchmark | 2020-2022 | Stable Estimate |
| Washington | Binge drinking during the past month among adults, age-adjusted percentage | 19.5 | 22.2 | 16.1 | 16 | 16.4 | Higher than Benchmark | 2021 | Stable Estimate |

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

| County | 1st | 2nd | 3rd | 4th | 5th |
|------------|--------|---------------|---|---|----------------------|
| Warren | Cancer | Heart Disease | Chronic Lower Respiratory Diseases (CLRD) | Unintentional Injury | COVID-19 |
| Washington | Cancer | Heart Disease | Chronic Lower Respiratory Diseases (CLRD) | COVID-19 | Unintentional Injury |
| Saratoga | Cancer | Heart Disease | Unintentional Injury | Chronic Lower Respiratory Diseases (CLRD) | COVID-19 |
| NYS | Cancer | Heart Disease | Unintentional Injury | COVID-19 | Diabetes |

Source: New York State Department of Health, Reports: Leading Causes of All Deaths and Leading Causes of Premature Deaths (death before age 75), 2022 Available at
https://apps.health.ny.gov/public/tabcis/PHIG_Public/lcd/

| County Health Rankings Community Conditions Profile | | | | | | | | | | |
|---|---------|--------|----------|--------|----------|------------|----------|--------|------------|--------|
| Indicator | County | | | | | | | | | NYS |
| | Clinton | Essex | Franklin | Fulton | Hamilton | Montgomery | Saratoga | Warren | Washington | |
| Health Infrastructure | | | | | | | | | | |
| Percentage of fee-for-service (FFS) Medicare enrollees who had an annual flu vaccination | 49% | 51% | 46% | 48% | 50% | 47% | 57% | 51% | 47% | 51% |
| Percentage of population with adequate access to locations for physical activity. | 72% | 100% | 57% | 90% | 100% | 54% | 86% | 99% | 71% | 93% |
| Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best). | 8.3 | 8.8 | 7.5 | 8 | 7.5 | 6.4 | 9.1 | 8.4 | 8.6 | 8.7 |
| Ratio of population to primary care physicians. | 1240:1 | 1960:1 | 1900:1 | 3120:1 | 2560:1 | 1910:1 | 1440:1 | 900:1 | 2770:1 | 1240:1 |
| Ratio of population to mental health providers. | 280:1 | 490:1 | 280:1 | 380:1 | 1690:1 | 970:1 | 420:1 | 210:1 | 550:1 | 260:1 |
| Ratio of population to dentists | 1540:1 | 3690:1 | 1780:1 | 4050:1 | N/A | 1650:1 | 1470:1 | 1130:1 | 4680:1 | 1200:1 |
| Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. | 2,808 | 2,018 | 2,991 | 3,231 | 1,600 | 2,689 | 2,389 | 2,631 | 2,487 | 2,595 |
| Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening | 54% | 43% | 49% | 44% | 45% | 44% | 52% | 52% | 43% | 44% |
| Percentage of population under age 65 without health insurance | 5% | 5% | 6% | 6% | 9% | 5% | 4% | 5% | 5% | 6% |
| Physical Environment | | | | | | | | | | |
| Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. | 12% | 11% | 14% | 12% | 9% | 15% | 11% | 11% | 13% | 23% |
| Percentage of the workforce that drives alone to work. | 77% | 73% | 76% | 81% | 74% | 77% | 75% | 79% | 81% | 50% |
| Among workers who commute in their car alone, the percentage that commute more than 30 minutes. | 22% | 31% | 21% | 32% | 38% | 37% | 37% | 28% | 40% | 39% |
| Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) | 6.2 | 3.2 | 6.5 | 7 | 5.7 | 7.3 | 8.2 | 7.3 | 7.6 | 6.9 |
| Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation. | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | N/A |
| Percentage of households with broadband internet connection | 87% | 89% | 85% | 87% | 88% | 82% | 92% | 89% | 86% | 90% |
| Library visits per person living within the library service area per year. | <1 | 2 | 2 | 4 | 13 | 2 | 3 | 2 | 1 | 3 |
| Social and Economic Factors | | | | | | | | | | |
| Percentage of adults ages 25-44 with some post-secondary education. | 63% | 58% | 52% | 62% | 63% | 58% | 78% | 68% | 53% | 71% |
| Percentage of adults ages 25 and over with a high school diploma or equivalent. | 88% | 92% | 87% | 88% | 89% | 89% | 94% | 92% | 90% | 88% |
| Percentage of population ages 16 and older unemployed but seeking work. | 3.5% | 3.8% | 3.8% | 4.4% | 5.0% | 4.6% | 2.9% | 3.7% | 3.4% | 4.2% |
| Ratio of household income at the 80th percentile to income at the 20th percentile. | 4.9 | 4.4 | 4.5 | 4.3 | 3.9 | 4.8 | 4.2 | 4.6 | 3.9 | 5.8 |
| Percentage of people under age 18 in poverty. | 16% | 17% | 19% | 20% | 14% | 23% | 8% | 15% | 16% | 19% |
| Number of deaths due to injury per 100,000 population. | 64 | 71 | 61 | 71 | 81 | 67 | 47 | 55 | 71 | 60 |
| Number of membership associations per 10,000 population. | 6.1 | 14.9 | 10.1 | 9.1 | 13.7 | 6.2 | 7.3 | 12 | 870% | 7.9 |
| Child care costs for a household with two children as a percent of median household income. | 38% | 35% | 39% | 39% | 36% | 40% | 32% | 41% | 34% | 38% |

Key (according to County Health Rankings)

*Purple highlight indicates areas of strength

*Orange highlight indicates areas to explore

| County Health Rankings Population Health and Well-being Profile | | | | | | | | | | |
|---|---------|-------|----------|--------|----------|------------|----------|--------|------------|-------|
| Indicator | County | | | | | | | | | NYS |
| | Clinton | Essex | Franklin | Fulton | Hamilton | Montgomery | Saratoga | Warren | Washington | |
| Length of Life | | | | | | | | | | |
| Deaths of individuals under age 75, per 100,000 people | 7,300 | 7,200 | 8,000 | 9,900 | N/A | 9,200 | 5,500 | 7,400 | 8,500 | 6,600 |
| Quality of Life | | | | | | | | | | |
| Average number of physically unhealthy days reported in the past 30 days | 4 | 4.1 | 4.6 | 4.2 | 4.2 | 4.6 | 3.4 | 3.8 | 4 | 3.9 |
| Percentage of live births with low birth weight (<2500 grams) | 8% | 8% | 7% | 8% | 6% | 8% | 7% | 8% | 8% | 8% |
| Average number of mentally unhealthy days reported in the past 30 days (age-adjusted) | 5.9 | 5.6 | 6.1 | 5.5 | 5.8 | 5.6 | 5 | 5.1 | 5.4 | 4.9 |
| Percentage of adults reporting fair or poor health (age-adjusted) | 17% | 15% | 18% | 19% | 17% | 19% | 10% | 16% | 15% | 16% |

2025 Annual Data Release, County Health Rankings and Roadmaps

For a full list of data sources, visit: <https://www.countyhealthrankings.org/health-data/county-health-rankings-measures>