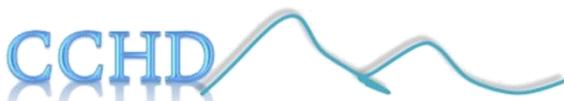




# Community Service Plan

Working Together to Strengthen Our Community



Clinton County **HEALTH** Department



THE  
**University of Vermont**  
HEALTH NETWORK

**Champlain Valley Physicians Hospital**

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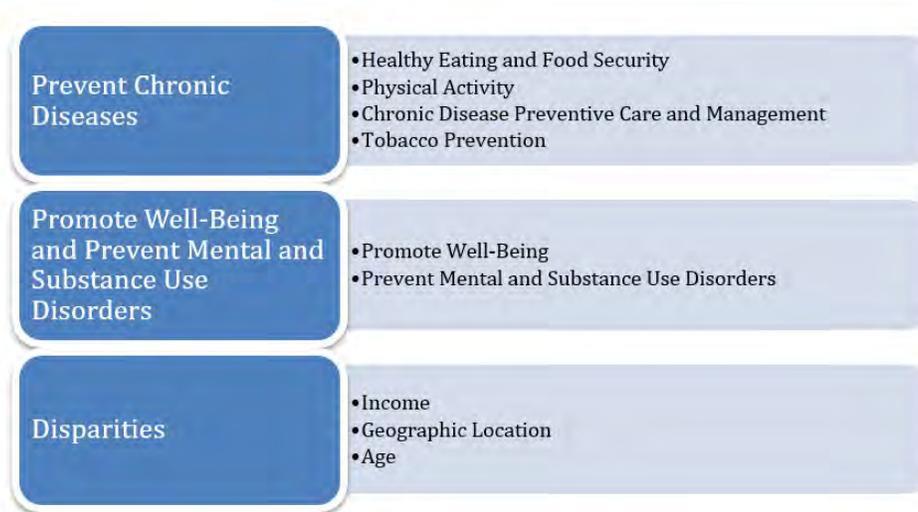
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## Executive Summary

After a year-long process, Clinton County health partners have selected the two following priority areas and disparities as most imperative for Clinton County to address as a community over the next three years.



To reach this conclusion, The University of Vermont Health Network- Champlain Valley Physicians Hospital (UVMHN-CVPH) and Clinton County Health Department (CCHD), lead entities in the process, facilitated/completed the following activities with the Clinton County community:

- Two community based, health focused surveys;
- A review of over 300 health indicators and a secondary data analysis;
- A Community Health Priority Setting Session;
- A Priority and Focus Area Finalization Process; and
- Creation of shared Action Plans.

Health indicators from scores of resources were considered in the process, including data from the NYS Prevention Agenda Dashboard, Community Health Indicator Reports,

NYS Office of Mental Health, Division of Criminal Justice Services, NYS Expanded Behavioral Risk Factor Survey, USDA Economic Research Service, American Community Survey, Health Resources and Services Administration, Center for Health Workforce Studies and others. Locally generated and/or collected data were also considered, when available. Primary data included feedback from resident surveys related to health, social and environmental concerns as well as qualitative program data from various community based organizations and CCHD.

The selected priority areas reflect continued commitment to the priorities selected in the 2016 and 2019 community health assessment processes. While the local process that has been instituted by the lead partners over many years of collaboration was maintained this cycle, several intentional adjustments were made to increase inclusivity and participation over the year as well as to better understand residents' experiences and existing health inequities. Demonstrative changes of process quality improvement include: modifying survey tools to better identify subpopulations while maintaining anonymity of respondents, extending invitations to participate in the Community Health Priority Setting Session to 25% more stakeholders, creating virtual participation options for all prioritization activities to accommodate the process and stakeholder preferences despite pandemic restrictions, and expanding the discussion around inequities and disparities throughout the assessment and planning process. Participation in health priority selection represented at least 18 distinct community sectors including healthcare (clinical, population and public health), business, community based organization/service, housing, human services, and mental/behavioral health. These very partners contribute activities and resources to create local action plans and are noted throughout the document as "resources and assets" and "responsible parties". The resulting action plans feature in-progress and planned work related to the selected health priorities and intend to alter health outcomes for the better of all residents. Featured interventions reflect a range of activities and approaches that fall across the Health Impact Pyramid and include service

infrastructure, program development and education; many will require high level, cross-sector collaborations.

Ongoing oversight of health improvement progress will continue to be managed by the Action for Health Consortium, which organizes bi-monthly meetings utilizing the NYS Prevention Agenda as its framework. A formal progress update is captured annually and this progress is shared with health stakeholders and the community by CCHD and UVMHN-CVPH. These updates serve as an opportunity to celebrate success just as much as a means to adjust course based on emerging needs and new resources in Clinton County.

CCHD and UVMHN-CVPH have and will continue to evaluate the local collaborative approach to community health assessment and improvement planning. At present, direct stakeholder feedback and participation trends along with emerging best-practices greatly inform and influence the local process. The lead entities monitor awareness and use of the resulting assessment documents among partners, striving to continually increase both process measures.

## Introduction

The University of Vermont Health Network - Champlain Valley Physicians Hospital (CVPH) and the Clinton County Health Department (CCHD) conducted this Community Health Needs Assessment (CHNA) or Community Health Assessment (CHA) (these terms are used interchangeably) to identify and prioritize the community health needs of the patients and communities within Clinton County (CVPH's primary service area). A CHA is a systematic process to collect data and information that provides a sound basis for decision making and action. Done collaboratively with the community, partners strive to better understand the factors and root causes that contribute to higher health risks and poorer health outcomes. This understanding is then used to inform strategies and plans to enable all community members to attain their optimal health. Those plans, identified as the *Implementation Strategy* (IS) for CVPH and CCHD's *Community Health Improvement Plan* (CHIP), are also included in this document and detail goals, objectives, strategies for health improvement and their measurable and time-framed targets. Interventions align with the NYS Prevention Agenda 2019-2024 and are rooted in sound research and evidence base.

The findings in this CHA result from a year-long process of collecting and analyzing data and consulting with stakeholders throughout the community and the region. This document can be used as a roadmap to guide service providers, especially public health and healthcare, in their efforts to plan programs and services targeted to improve the overall health and well-being of people and communities in our region.

This CHA will address the requirements set forth by the NYS Department of Health (NYSDOH), the Internal Revenue Service through the Affordable Care Act (ACA), and the Commission on Cancer. The NYS Department of Health requires hospitals and local health departments to work together to create a Community Service Plan (CSP) that addresses the findings of the CHA. The CHA and IS are combined to create the CSP. County health departments in NYS have separate yet similar state requirements to conduct a CHA and create a corresponding and actionable CHIP. Health departments must also demonstrate engagement in a collaborative process to draw conclusions about the health status, challenges and assets of the population served to meet standards for national accreditation. CCHD is an accredited health department by the Public Health Accreditation Board.

The CHA and IS will fulfill the requirements set forth by the Internal Revenue Service through the ACA. The community health needs assessment provision of the ACA 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. Beginning in 2012, all American College of Surgeons (ACOS) Commission on Cancer (CoC) cancer programs are required to complete a community needs assessment to identify needs of the population served, potential to improve cancer health care disparities, and gaps in resources. Consequently, cancer-specific information and data were considered throughout the assessment process. Aligning and combining the requirements of these three entities ensures the most efficient

use of resources and supports a comprehensive approach to community and population health management and improvement in the region.

## Lead Organizations in the Community Health Assessment Process

### **The University of Vermont Health Network – Champlain Valley Physicians Hospital (CVPH)**

The mission of CVPH is “United heads, hands and hearts for patients and each other.” The vision of CVPH is “Working together, we improve people’s lives.” The values of CVPH are “By embracing our strengths and honoring our differences, we learn and grow together through honesty, respect, and teamwork.” The mission, vision, and values guide the organization’s commitment to community needs. Additionally, CVPH has five core beliefs: Patients First, Embrace Change, Build Bridges, Speak Up! and Own It.

CVPH is a voluntary, not-for-profit, Article 28 organization that is governed by a voluntary Board of Directors and is licensed for 300 beds. CVPH is located at 75 Beekman Street in Plattsburgh, New York with satellite services at a number of other authorized locations within the Plattsburgh area. CVPH is part of The University of Vermont Health Network, which is comprised of six hospitals, a home health and hospice agency, and an employed medical group. It is affiliated with an academic medical center in Burlington, Vermont. CVPH offers a variety of services including cardiovascular, orthopedics, obstetrics, psychiatry, long term care, and primary care. It has a Family Medicine Residency program to help address primary care shortages in the community. CVPH provides cancer services through the Fitzpatrick Cancer Center. In addition, CVPH has a robust Patient-Centered Medical Home Initiative as well as the Adirondacks Accountable Care Organization, which are key partners in addressing community health needs.

### **Clinton County Health Department (CCHD)**

The Clinton County Health Department strives “To improve and protect the health, well-being, and environment of the people of Clinton County.” CCHD realizes its mission and vision of “Healthy People in a Healthy Community” through its core values of advocacy, collaboration, excellence, innovation, integrity, and service. Its Director of Public Health oversees five distinct divisions of multi-disciplinary teams. The Department reports to the Clinton County Board of Health and County Legislature.

CCHD plays a critical role in the identification of local health needs, determination of strategies to address issues, and the coordination of local partners to make shared health improvement agendas reality. CCHD also provides essential health services in the community including immunizations, maternal child health programs, infectious disease surveillance, monitoring of local health data and trends of public health significance, and environmental health and safety services. CCHD provides guidance and leadership during emergencies and disasters, ensuring preparedness in the county’s people and supporting

community resilience. It has also led the community in the implementation of policy, systems and environmental strategy work aimed at improving the health of all residents by changing the context in which many health related decisions are made. Through long established community partnerships, the health improvement and prevention programs developed and implemented by CCHD are sound and impactful. CCHD is the only local health department in the Adirondack region to be nationally accredited by the Public Health Accreditation Board (PHAB), demonstrating the Department meets the highest of standards for local health departments.

## Community Health Needs Assessment Leading Partners

### **Clinton County Action for Health Consortium**

The Clinton County Action for Health (AFH) Consortium is a multi-sector, multi-disciplinary collection of local health system partners working towards community health improvement. The group is facilitated by CCHD. The primary work of the Consortium has been built around data driven identified needs (NYS Prevention Agenda) and available community resources. Partners in the effort include: municipalities, businesses, grassroots community groups, health care providers, the local hospital, human service agencies, schools and local not-for-profits. The group has existed for nearly two decades and presently has over forty members that have formally committed to its purpose by signing Partnership Letters. Recruitment of new members is ongoing.

The AFH Consortium meets periodically for updates, issue discussion, and information sharing, including review of new data, resources, and emerging opportunities and potential threats to health. It is the means by which stakeholders update each other on progress in CHIP/IS related activities and other health improvement efforts. A minimum of six meetings are scheduled each year, with additional gatherings scheduled as needed. As lead facilitator, CCHD tracks health improvement progress continually and prepares a year-end summary which includes updates on work related to the two featured Priority Areas and a summary of accomplishments by local partners related to each of the NYSDOH Prevention Plan Priority Areas. Captured activities demonstrate work on all tiers of the Health Impact Pyramid.

### **Adirondack Rural Health Network**

The Adirondack Rural Health Network (ARHN) is a strategic partner-driven, seven-county region rural health network that supports the NYS Prevention Agenda through advocacy, education, collaboration, training, funding, and data sharing to improve the health and well-being of its rural residents. Since 2002, ARHN has been coordinating regional collaborative community health assessment and planning efforts of public health departments and hospitals in the seven county Adirondack region.

The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of 13 hospitals and county health departments, from seven counties, which have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. CHA Committee representatives are from: Adirondack Health, The University of Vermont Health Network - Alice Hyde Medical Center, Clinton County Health Department, The University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital, The University of Vermont Health Network - Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health. This multi-county, regional committee has been meeting, in person and virtually, throughout the last assessment and planning cycle and will continue to do so during the 2022-2024 cycle. This collaboration assists partners in tracking plan progress and in making mid-course corrections if needed.

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

*Please see Appendix A for: Committee Members and Meeting Schedules.*

### [New York State's Prevention Agenda 2019-2024](#)

The Prevention Agenda 2019-2024 is New York State's health improvement plan, the blueprint for state and local action to improve the health and well-being of all New Yorkers and to promote equity in all populations who experience disparities. In partnership with more than 100 organizations across the state, the Prevention Agenda is updated by the New York State Public Health and Health Planning Council at the request of the Department of Health. This is the third cycle for this statewide initiative that started in 2008. New to this 2019-2024 cycle is the incorporation of a Health Across All Policies approach, initiated in 2017, which calls on all State agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. It embraces Healthy Aging to support New York's commitment as the first age-friendly state. The Prevention Agenda serves as a guide for local health departments and hospitals as they work with their communities to complete a CHA, IS and CHIP.

The Prevention Agenda 2019-2024 has five priorities with priority-specific action plans developed collaboratively with input from state-wide community stakeholders. Each

priority-specific action plan includes focus areas, goals, objectives, and measures for evidence-based interventions to track their impacts – including reductions in health disparities among racial, ethnic, and socioeconomic groups, age groups, and persons with disabilities.

CCHD and UVMHN-CVPH use the Prevention Agenda as a framework for assessing health, identifying local health priorities and planning collaborative health improvement efforts within Clinton County.

To review the full NYS Prevention Agenda, visit:

[https://www.health.ny.gov/prevention/prevention\\_agenda/2019-2024/](https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/).

## Health Care System Transformation

The COVID-19 pandemic has impacted health systems and economies across the country and throughout the world. It has affected every facet of the local health care system and this system is still very much in a state of strain as it recovers from the pressures of the pandemic response. Strategies enacted to control the spread of COVID-19 infection influenced health care utilization and further exacerbated infrastructure weaknesses in both clinical care systems and public health systems. While much has been invested in advancing medical care and in the treatment of illnesses, injuries and diseases, research confirms the practice of healthy behaviors, social and economic factors, the physical environment and other factors account for 80% of health outcomes.

Elected officials, clinical providers and public health experts from federal, state and local levels all agree the COVID-19 pandemic has created a long needed opportunity to modernize public health infrastructure, advance health equity and better support timely, affordable, effective clinical care for all. This sentiment was echoed in Clinton County and was evident during the engagement activities of the community health assessment process. NYS has already demonstrated commitment to this transformation with a \$20 billion multi-year healthcare investment aimed at infrastructure: changes to improve care and wait times, pay reform for front line health care workers, and expansion of Medicaid eligibility are just some planned approaches. Improved investment in core public health is also being seen from federal and state entities and many plans are detailed in the American Rescue Plan Act. Programs like the NYS Public Health Corps Fellowship Program are already underway and supporting local efforts to better recruit, retain and train the public health workforce. While the Delivery System Reform Incentive Payment Program was in full swing during the last assessment cycle, the program expired in 2020. The next 1115 Medicaid Redesign Team waiver will focus on enhancing social services and connecting clinical and community health partners. All of these efforts will improve conditions, including those beyond clinical care, that influence health outcomes.

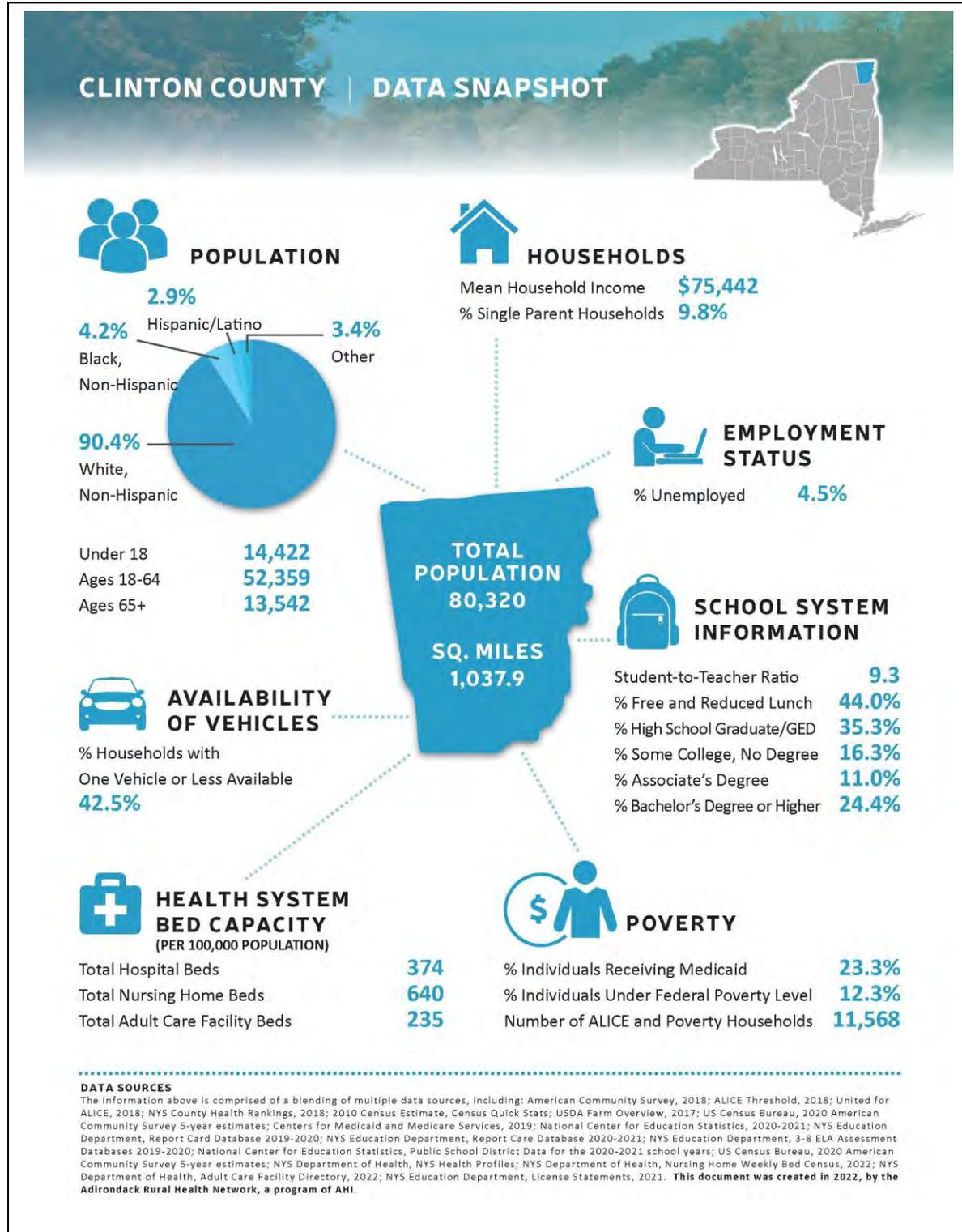
## Complementary Community Assessments

Efforts to build healthier communities have the potential for being more successful when agencies, programs and individuals from multiple community sectors work together. Collaboration between the health sector and other community sectors can generate new opportunities to improve health. Recognizing this dynamic, community needs assessments, service plans and strategic plans from other community sectors in the region were reviewed and considered as part as the health assessment process and to identify opportunities for collaboration between local health department/hospitals and other community entities. Documents from such community sectors as behavioral health service providers, community action/economic opportunity agencies, regional economic development councils, business associations and others reveal many opportunities for collaboration and include but are not limited to:

- Local Services Plan for Mental Hygiene Services
- Community Action/Economic Development
- Regional Economic Development Councils.

# Community Profile: Description & Discussion of Relevant Supporting and Opposing Factors

## Demographics & Disparities



A comprehensive community health assessment and improvement plan will evaluate problems and service gaps that exist, identify root causes of both and plan effective, feasible solutions. Identifying resources and assets available to address recognized challenges and to contribute to the work is part of that process. Clinton County is fortunate to have a strong developed network of partners representing many different community sectors and offering a variety of resources and capacities for achieving its shared vision for community health. While not exhaustive, following discussion of available, significant health metrics and related context, assets and resources have been identified. Additional detail on partners assuming responsibility for featured work is included specifically in the community services plan/community health improvement plan.

Clinton County's population is 80,320, making it the most populated county in the ARHN region. The county spans 1,038 square miles and is made up of a number of small, distinct townships and one large rural core, where approximately one quarter of the population lives and a majority of services, jobs and other resources are accessed. Similar to the rest of Upstate New York, Clinton County's population is limited in its ethnic and racial diversity; 90.4 % of residents identify as White/non-Hispanic, followed by 4.2% Black/African American, non-Hispanic and 2.9% Hispanic/Latino. Despite limited ethnic and racial diversity, many special populations exist within the community. It is often through these special populations that health and health care experiences are considered and interventions are designed with an equity focus, meaning they are designed intently to help all residents attain their full health potential.

There is little to no data to allow health disparities to be explored based on race and ethnicity in Clinton County. However, health disparities are also evident when there are social, economic and other differences among individuals or groups of individuals that create disadvantages. There are many factors in Clinton County that create disparate experiences as residents access healthcare, health related services and strive to be healthy. Health stakeholders have identified and routinely consider a number of disparities including: income, geographic location, age, ability, level of education, sexual identity/orientation, and race/ethnicity. From this list, income, geographic location and age were most recently identified as the most common disparities impacting Clinton County residents. In most cases, health and social challenges reported by residents in a recent survey can be connected to one or more of these disparities. It should be noted, data sets available at the time of this assessment almost exclusively represent pre-pandemic conditions. Assessment partners anticipate changes in many metrics when serial data sets become available. Whenever possible, CCHD and CVPH have included reference to local primary data, whether qualitative or quantitative, as it is often more timely and, in many

**2 in 3**  
residents faced at least 1  
**barrier to receiving  
medical care in the  
past year.**



*Source: 2022 CHA Community Survey*

instances, a better indicator of current experiences even with acknowledged limitations of this local data.

Seeking a comprehensive understanding, residents themselves are asked to participate in our community health assessment process. Through a resident survey, assessment partners gain valuable perspectives on challenges faced by residents across the county in their pursuit of health. In the most recent resident survey, over 60% of the respondents reported experiencing at least one barrier to medical care for themselves or their family in the past year. The most commonly reported barriers included: no appointments available with a specialist (32.8%), no specialist was available locally (32.8%), insurance was not accepted (27.8%), co-pays or deductibles were too high (25.7%), and no appointment was available for primary care (23.2%). Measures from other sources, which report 9.7% of adults did not receive medical care due to costs, may underestimate true hardship. It is important to note, the top issues related to accessing care reflect a combination of inadequate services and financially associated hardships.

The percentage of adults with health insurance in Clinton County is at 94.1%, with 78.3% of adults having a regular health care provider. This is a drop from last assessment at which time 88.5% of adults had a regular health care provider. The rate of age-adjusted preventable hospitalizations per 10,000 population among those 18 years of age and older (121.0) is higher than the rate for Upstate New York (120.4), and the Prevention Agenda benchmark (115.0) rate. The rate of ED visits per 10,000 population in Clinton County (4,970.3) is higher than the ARHN region (4,694.3) and significantly higher than Upstate New York (3843.0). No change in these patterns are evident from the time of the last assessment. From CCHD's resident survey, residents living in areas further from the county's population center were more likely to be without a primary care provider. Likewise, respondents with lower annual household incomes and lower levels of education both reported not having a primary care provider more frequently than respondents with higher annual reported incomes or higher levels of education. Not surprisingly, residents with no primary care provider rated both their physical and mental health less favorably overall than residents with a primary care provider. More context will be added to these disparities later in this section. While residents may have a primary care provider, they may not be consistently seeking preventive services, such as annual wellness visits or seeing through primary care recommendations that call for care from a specialist. Based on these findings and resident experience data, the regional health care system falls short of meeting a number of preventive care performance goals.

Over 16.8% of the population is 65 years of age and older; this demographic has been increasing over multiple assessments. In the resident survey, 35% of respondents reported issues related to aging. It should be noted, this age demographic was slightly overrepresented in resident survey with approximately 25% of all respondents reporting their age as 65 years or older. However, a number of



**35%**

of residents reported experiencing **issues related to aging.**

*Source: 2022 CHA Community Survey*

health metrics demonstrate the need to address system shortcomings in serving this population. The rate of hospitalizations due to falls among adults aged 65 and over (173.0) is far worse than the ARHN region (158.6). While chronic disease diagnoses are not limited to individuals over 65 years of age, only 7.5% of Clinton County adults with a chronic condition have taken a course or class to learn how to manage their condition. Self-management education is key to achieving control, long-term positive health outcomes and quality of life for patients with these diagnoses. On a positive note, the rate of unintentional injury hospitalizations for residents age 65 and older (199.7) is better than the state average.

**20.6%** of residents reported having at least **1 disability**.



**The most reported disabilities included difficulties:**

- Walking or climbing stairs.
- Completing errands alone.
- Concentrating, remembering or making decisions.

*Source: 2022 CHA Community Survey*

The percentage of adults 18 years of age and older in Clinton County with a disability (25.7%) is lower than the ARHN region (29.2%) but higher when compared to the Upstate New York (24.6%) rate. In the resident survey, 20.6% of respondents reported at least one disability, which may indicate underrepresentation of this demographic in the survey. However, much was gleaned regarding the types of challenges faced. The most reported

disability among respondents was related to mobility, or serious difficulty walking or climbing stairs (52.1%), followed by difficulty completing errands alone because of a physical, mental or emotional condition (37.0%). The next most reported disability was related to cognition, where respondents indicated having difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition (36.53%). Over 15% of all respondents selected issues related to intellectual/developmental disabilities or physical disabilities as a top health concern and nearly a quarter of all respondents identified access to opportunities for these residents as a top social challenge.

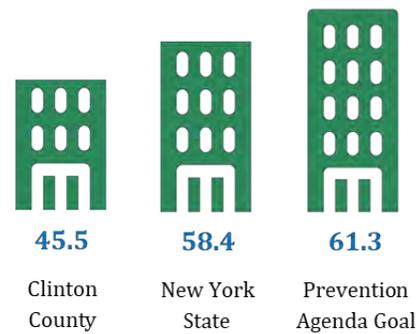
In total, there are 31,392 households in Clinton County, a 2.5% increase since the time of the last assessment. Mean annual household income is \$75,442, with per capita income at \$29,960, which is much lower than that of Upstate New York State, \$97,962 and \$33,208, respectively. The percentage of individuals in Clinton County living below the Federal Poverty Level (FPL) is 12.3%, which is higher than the ARHN (11.9%) region but slightly lower than the Upstate New York average (12.5). This metric does indicate an improvement since last assessment at which time 15.2% of residents were living below the FPL. Beyond the 12.3% poverty rate, 24.6% of households qualify as Asset Limited, Income Constrained, Employed (ALICE). Together this equates to 11,568 households designated as either poverty or ALICE. Specific to ALICE households, the majority are white (7,753), which far exceeds the second largest group of ALICE households comprised of Asian residents (102). Low income and economic status was again identified by stakeholders as the most impactful disparity for residents in achieving ideal health.

The percentage of individuals enrolled in Medicaid is 23.3%. This is below the NYS percentage and has not changed significantly since the last assessment, where a large jump in enrollment was noted and likely associated with ACA requirements rather than a major shift in economic conditions at the time.

Of the total population in Clinton County, approximately 35.3% of individuals 25 years of age and older have a high school diploma or equivalent. Another 35.3% have an Associate or Bachelor degree or higher. The percent of the population possessing a high school education has decreased slightly since the last assessment but the percent of the population pursuing higher level degrees has increased. Clinton County’s unemployment rate is 4.5% with 38,029 residents aged 16 and older employed in the civilian workforce, representing a 10 percentage point increase since last assessment. The highest employment sector with 26.6% of the workforce is the field of Education, Health Care and Social Assistance. This is followed by retail trade (13.4%) and manufacturing (12.5%).

New composite measures are helping community stakeholders track improvements in meeting a range of needs related to the social determinants of health and known to influence well-being. The Opportunity Index is made up of 17 indicators across the four dimensions (Economy, Education, Health and Community) that are averaged to create dimension-level Opportunity Scores ranging from 0 to 100. Clinton County’s Opportunity Index Score is 54.3, just below the state’s score of 57.4 and Prevention Agenda benchmark set at 59.2. The Community Score, another composite measure, is compiled from seven data sources:

Clinton County’s **Community Score** is **lower** than the Prevention Agenda Benchmark and NYS scores.



Source: Prevention Agenda Dashboard

volunteering, voter registration, youth disconnection, violent crime, access to primary health care, access to healthy food and incarceration. Clinton County’s Community Score is 45.4, well below the NYS score of 58.4 and the Prevention Agenda benchmark of 61.3.

| <b>Resources &amp; Assets: Demographics &amp; Disparities</b> |   |
|---|---|
| <b><i>Older Adults &amp; Aging:</i></b>                       |   |
| Clinton County Office for the Aging                           | Compassionate Companion Volunteer Program |
| Nutrition Program for the Elderly                             | Retired & Senior Volunteer Program        |
| Senior Citizens Council of Clinton County                     |   |
| <b><i>Veteran’s Services:</i></b>                             |   |
| Clinton County Veterans Service Agency                        | North Country Veteran’s Association       |

|  |   |
|--|---|
| <b><i>Inclusivity Services:</i></b>          |   |
| Advocacy & Resource Center of Clinton County | North Country Association for the Visually Impaired, Inc. |
| North Country Center for Independence        | Office for People with Developmental Disabilities         |
| List is not all inclusive.                   |   |

Health System Profile

Clinton County has one hospital, Champlain Valley Physicians Hospital (CVPH), with 300 hospital beds, the majority of which are medical/surgical beds. This results in a total hospital bed rate of 374 when considering the regional population. This rate is higher than the ARHN region’s total hospital bed rate of 274. There are a total of four nursing home facilities, accounting for 514 beds, resulting in a total nursing home bed rate of 235. The Clinton County Nursing Home, an 80 bed facility, is currently for sale, lending some uncertainty to these statistics. There are three adult care facilities, accounting for 150 beds resulting in an adult care facility bed rate of 235. Both nursing home and adult care facility bed rates are lower than the ARHN region, 685 and 443, respectfully. It should be noted that not all of the adult care facility beds are currently open for patients on a regular basis.

The rate of total physicians in Clinton County is 273, which is higher than the ARHN region’s rate of 198. This is likely due to the presence of the county’s population center, Plattsburgh, being one of the larger cities within the region. There are a number of private practices for primary care and some specialists; many residents travel to Burlington, VT or south to Glens Falls and Albany, if not entirely out of the area, for specialty care. Multiple federally qualified health care centers have been established since the last assessment. Clinton County is officially designated as a health professional shortage areas (HPSAs) by the U.S. Department of Health and Human Services for primary care and mental health. A majority of physical and mental health services and associated programs are located within the county’s rural core, namely the City and Town of Plattsburgh. Residents living outside of the rural core, namely the City and Town of Plattsburgh, must travel to receive health care services and/or take advantage of health related opportunities. No access to needed transportation was noted by 11% of respondents in a resident survey as a barrier to receiving medical care.

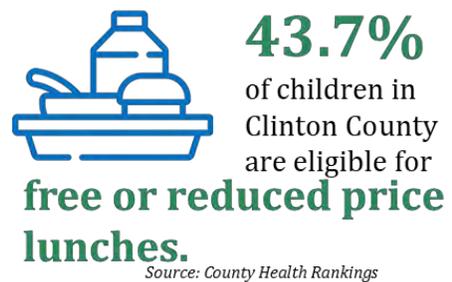
In an effort to address the Primary Care HPSA, CVPH began building its Family Medicine Residency program in 2015. The program became accredited by the Accreditation Council for Graduate Medical Education (ACGME) in July of the same year. The program welcomed its first class of 4 residents in July 2016 and quickly applied for a compliment increase to increase the number of residents per year from 4 to 6 residents. To date the program has successfully graduated 4 classes and a total of 19 Family Medicine Doctors. The program’s mission to address the primary care shortage has exceeded expectations in the number of residents who have chosen to stay in the area. Of the 19 graduates, 14 have chosen to practice in the Northeast. Nine have stayed in the immediate area (CVPH, Elizabethtown, Alice Hyde and Hudson Headwaters Health Network), five are practicing in the surrounding

areas (3 in Vermont, 1 in Glens Falls, 1 returned home to Ogdensburg), 1 is practicing in California and 4 others have returned home to Maine and Canada. Currently, 18 Residents are enrolled in the program with anticipated completion dates between 2022 and 2024.

| <b>Resources &amp; Assets: Health System Profile</b> |  |
|--|--|
| <i>Access to Health Care Services:</i>               |  |
| Adirondack Medical Home Initiative/CVHN              | ADK Wellness Connection                        |
| Clinton County Health Department                     | Health Care of Rochester (HCR)                 |
| Hudson Headwaters Health Network                     | Plattsburgh VA Clinic                          |
| Private Practice Primary Care Providers              | The University of Vermont Health Network, CVPH |
| Federally Qualified Health Care Centers              |  |
| List is not all inclusive.                           |  |

### Education Profile

Within Clinton County, there are ten school districts (eight public and two private), with a total enrollment of 10,314 students. Of the enrolled students, 43.7% are eligible for free or reduced lunch, with a majority eligible for free lunch (91% or 4,113). Three school districts began providing universal free breakfast and lunch prior to the last assessment. For students in districts not providing universally free meals, State of Emergency declarations and pandemic related programs have provided a safety net to students who may have otherwise experienced food and nutrition insecurity through the pandemic. State and federal supports for universal breakfast and lunch in all schools expired in the Fall of 2022. A number of state and federal organizations are lobbying for reinstatement and permanent status of universal benefit meal programs.



The total annual number of high school graduates is 724 with a high school dropout rate of 7.0%. This is higher than the ARHN (5.3%) region and New York (4.0%) dropout rates, but slightly lower than the Upstate New York dropout rate of 7.3%. There are 963.5 public school teachers making the student to teacher ratio 9.3 in Clinton County. While this represents a slight improvement since last assessment and is better than the ARHN region ratio of 9.8, it is worse than Upstate New York ratio of 8.9. The county is home to two college campuses, a two year and a four year institution. Both schools are associated with

the state’s university system and are a resource for residents interested in pursuing higher level degrees close to home.

| <b>Resources &amp; Assets: Education Profile</b>      |                                      |
|---|--------------------------------------|
| <b><i>Education:</i></b>                              |                                      |
| <b><i>Clinton County Public School Districts:</i></b> |                                      |
| AuSable Valley School District                        | Beekmantown School District          |
| Chazy School District                                 | Northeastern Clinton School District |
| Northern Adirondack School District                   | Peru School District                 |
| Plattsburgh City School District                      | Saranac School District              |
| <b><i>Private School Districts:</i></b>               |                                      |
| Seton Catholic  | Lakeshore Christian School           |
| <b><i>Vocational School:</i></b>                      |                                      |
| Champlain Valley Educational Services<br>(CV-TECH)    |                                      |
| <b><i>Higher Education:</i></b>                       |                                      |
| Clinton Community College                             | SUNY Plattsburgh                     |
| <b><i>Early Education:</i></b>                        |                                      |
| Adirondack Helping Hands, Inc.                        | JCEO Head Start                      |
| North Country Kids, Inc.                              | YMCA – Y Wee Care Program            |
| <b><i>Libraries:</i></b>                              |                                      |
| <b><i>Clinton-Essex-Franklin Library System</i></b>   |                                      |
| <b><i>Clinton County Libraries:</i></b>               |                                      |
| Altona Reading Center                                 | Champlain Memorial Library           |
| Chazy Public Library                                  | Dannemora Free Library               |
| Dodge Library (West Chazy)                            | Ellenburg Center Reading Center      |
| Ellenburg Sara A. Munsil Free Library                 | Mooers Free Library                  |
| Peru Free Library                                     | Plattsburgh Public Library           |
| Rouses Point Dodge Memorial Library                   |                                      |
| List is not all inclusive.                            |                                      |

## NYS Prevention Agenda Priority Areas Related Analysis

### Prevent Chronic Diseases

Overweight and obesity continue to be of concern in Clinton County. Of all students in Clinton County, 34.1% are overweight (16.2% of elementary students and 17.9% of middle/high school students) and 48% are obese (19.9% of elementary students and 28.1% of middle/high school students). It is important to note these statistics align with pre-pandemic data collections and, while changes are relatively minimal from previous percentages, improvement is not evident nor anticipated with post-pandemic collections. The percentage of adults who are either overweight or obese is 70.8%; this is higher than the ARHN region (69.1%), Upstate New York (64.2%) and New York State (62.7%).

**48%**  
of middle and high school  
students in Clinton County are  
**overweight or obese.**



Source: NYS Department of Health

The burden of obesity may contribute to Clinton County's challenges related to diabetes. The county's statistics surpass benchmark averages for several common metrics including: rate of diabetes deaths and rate of diabetes hospitalizations (primary diagnosis). While definitive data is not available yet, in considering referral and enrollment data to regional chronic disease self-management education opportunities, participation of Clinton County residents appears to lag behind residents of neighboring counties.

There is room for improvement with dental health. Only 61.5% of adults have had a dentist visit within the past year; that number drops to 24.2% for Medicaid enrollees. Chronic conditions, like diabetes, increase one's risk for periodontal disease and vice versa. Clinton County no longer has an official designation as a provider shortage area for dental health and new pediatric focused practices have allowed children to establish dental medical homes more easily and earlier in life but access issues likely persist for many residents regardless of age.

More than  
**1 in 4**  
Clinton County residents  
experience low access to a  
**grocery store.**

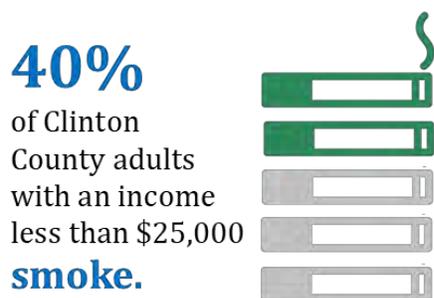


Source: US Dept. of Agriculture—Food Environment Atlas

The percent of adults self-reporting no leisure time physical activity is 29.1%. This metric has had a slow increase over the past decade, increasing nearly three percentage points since the last assessment alone. Less than one quarter of all residents consume adequate servings of fruits and vegetables daily. Clinton County has seen a decrease in total number of full grocery stores since its last full health assessment with 16.28 stores/100,000 population, less than half the state average. Despite this decrease in opportunity, only one census tract in the county qualifies as an official food desert, but the area is home to nearly one tenth of the

county's population. Overall, one quarter of the county's population is considered to have low access to a grocery store and 10% of the county's total population is considered low

income with low access to a supermarket or large grocery store. This is worse than the ARHN region (6.0%), Upstate New York (3.9%) and New York State (2.2%). The county's food retailers exceed the state rate of 8.58 SNAP Authorized Retailers/10,000 population with a rate of 10.91. This is a positive as rural residents often rely on non-traditional food outlets, such as convenience stores, drug stores and dollar stores for grocery shopping. This pattern often increases access to less healthy food options, closer to home but SNAP designations assure the availability of healthier options in these locations. Clinton County partners have worked collaboratively to increase township food pantry ability to accept, store and redistribute healthier food options safely, among other interventions. Local food retailers have also voluntarily worked to increase access to healthier options by carrying new items, partnering with local farmers to feature locally grown produce, and labeling healthier options.



Source: County Health Rankings

Smoking and smoking-related diseases seem to pose a significant challenge for Clinton County, with six of the indicators having worse performance than the comparison benchmark. The percentage of adults who smoke in Clinton County is 19.9%; this percentage jumps to 39% when looking at the adult population with income less than \$25,000/year. While this indicates approximately a five percentage point decrease since last assessment, the change is not statistically significant and the metric remains higher

than Upstate New York (13.9%) and the Prevention Agenda Benchmark of 11%. Changes to data collection protocols may complicate ability to compare new data to older metrics; the changing landscape of tobacco products (i.e. smokeless tobacco, legalization of marijuana) has also complicated usage tracking. Of note, the number of registered tobacco vendors in the county (134) is also higher than the ARHN region (132.7), Upstate New York (102), and New York State (110), increasing the accessibility of tobacco products to residents. Chronic lower respiratory deaths in Clinton County (58.7) are higher than Upstate New York (48.3) and New York State (36.7). Hospitalizations for chronic lower respiratory disease also surpass regional and state rates. Targeted efforts between outpatient and inpatient health system partners since the last assessment appear successful; the rate of asthma hospitalizations due to asthma for all ages are lower in Clinton County than in the upstate region or across the state.

The rates of lung and bronchus cancer cases have increased since last assessment and are now higher in Clinton County (138.2) than in the ARHN region (119), Upstate New York (87.6) and New York State (72.6). Lung and bronchus cancer deaths (57.5) have also increased in Clinton County.

The rate of colon and rectal cancer cases and deaths is lower in Clinton County than the other geographies. This could be partially contributed to high screening rates; the percentage of colorectal screenings for those 50 to 75 years of age in Clinton County is 65.3% and nearly meets the Prevention Agenda benchmark of 66.3%. While rates of

female breast cancer deaths in Clinton County are lower than the ARHN region, Upstate New York and New York State, only about 75% of women ages 50-74 are receiving breast cancer screening according to latest guidelines. Clinton County has sustained funding for many years to support cancer screening, namely for breast and colon cancers, for those who have low or no insurance coverage. UVMHN-CVPH is in the process of reapplying for this funding from the NYS Department of Health for the next five years. Overall, the rate of cancer cases (654.1) is better than the ARHN region (710.8) and Upstate New York (656.9).

The local rates of overweight and obesity across the age continuum continue to climb and incidence/prevalence rates of common chronic disease benchmarks, like diabetes, hypertension and heart disease, remain high despite emphasis on upstream, population level change work over the past two community health assessment cycles. This delay in evident impact is not entirely unanticipated and many shorter term measures are demonstrating progress. For example,

primary data on local breastfeeding rates indicates there has been at least a 15% increase in Clinton County infants receiving human milk in their first year of life. All Clinton County communities have passed Complete Streets resolutions, demonstrating commitment to health in new construction projects on the municipality level and many play spaces have been revitalized with accessibility for

all ages and abilities in mind over the past few years. Local pediatric providers and school districts have been proactive in their efforts to address overweight and obesity. Grant funding from the NYS Department of Health has allowed CCHD to engage with school districts and their Wellness Committees in change work. The most recent iteration of this funding represents the most comprehensive funding ever received to do such work in the county and has allowed CCHD to work with nearly 100% of county school districts and townships; CCHD has dedicated core resources to assure uncovered districts are also supported. Through this project, CCHD and school leaders improve policies, practices, and environments for physical activity and nutrition through establishing a strong Wellness Committee, a meaningful Wellness Policy, and yearly Action Plan. Annual goals are developed around the central elements of inclusion, equity, and impact. Work has led to integration of nutrition education throughout the core curriculum, a focus on physical activities that can be learned and maintained throughout life, and the establishment of joint-use agreements for community use of school grounds and resources for healthy opportunities. A number of recreation and physical activity stakeholders are also engaged in providing inclusive opportunities for movement and exercise to residents across the lifespan and of all abilities. In light the data trends and the need to further the impact of environmental change work, more needs to be done.



of adults in Clinton County are **overweight or obese.**

*Source: NYS Expanded Behavioral Risk Factor Survey*

| <b>Resources &amp; Assets: Prevent Chronic Diseases</b>        |   |
|--|---|
| <b><i>Food Relief Services:</i></b>                            |   |
| Clinton County WIC Program                                     | JCEO Food Shelf & Township Food Pantries  |
| Plattsburgh Interfaith Food Shelf                              | St. Alexander's/St. Joseph's Soup Kitchen |
| St. Augustine's Soup Kitchen                                   | St. Peter's Church                        |
| The Salvation Army Community and Worship Center                | Trinity Episcopal Church                  |
| United Methodist Church Food Shelf                             | USDA Summer Feeding Sites                 |
| Nutrition Incentive Programs: SNAP, FMNP, Double Up Food Bucks |   |
| <b><i>Other:</i></b>   |   |
| Cancer Services Program  | Tobacco Free Clinton Franklin Essex       |
| <b><i>Also see Recreation Parks &amp; Trails</i></b>           |   |
| List is not all inclusive.                                     |   |

Promote Well-Being and Prevent Mental and Substance Use Disorders

According to the NYS Behavioral Risk Factor Surveillance Survey, 16% of the population reports frequent mental distress. This is the highest level in the ARHN region and higher than the New York State average of 11.2%. It also surpasses the Prevention Agenda benchmark of 10.7%. From CCHD's resident survey, approximately 11% of respondents self-reported their mental health as poor or extremely poor and more than 33% reported mental health was a challenge for themselves or a family member. These respondents more frequently identified social determinants of health like the ability to secure affordable housing and a clean environment as important features of a healthy community. The ratio of population to mental health providers has slowly improved since 2010 and is currently 302.5:1. This ratio is under the New York State ratio of 310.2:1. Despite slow improvement, nearly 37% of respondents to the resident survey identified access to mental health services as a challenge in the community and 21% of respondents reported experiencing this challenge personally. Additionally, recruitment and retention of psychiatrists and other mental health professionals remains a challenge.

More than **1 in 3** Clinton County adults self-reported that **mental health was a challenge.**



Source: 2022 CHA Community Survey

Like most regions, Clinton County has seen a significant increase in all drug use and issues related to drug use. Age-adjusted mortality rates for population aged 15-64 related to drug overdose mortality is 20.7 (for years 2016-2020); this has increased from the last rate of 13.4 (2011-2015). The same pattern is evident specifically for opioid overdoses with a current mortality rate of 15.2 (for years 2016-2020) compared to 10.4 (2011-2015). Not surprising in light of the county's rural geography, average distance to common treatment and recovery services, such as medication assisted treatment or recovery residences, exceed state and national averages, when they are available.

The ratio of population to mental health providers is

**302.5:1**

in Clinton County and

**310:1**

in New York State.



Source: County Health Ranking

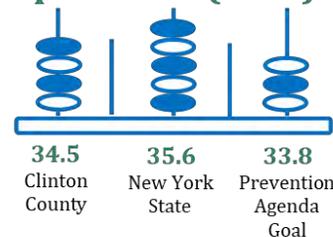
Collaborative health improvement activities have focused on building infrastructure to support continuity of care between inpatient and outpatient mental and behavioral health settings. A mobile crisis team was established in 2017 and continues to serve the community. A local stabilization

and rehabilitation center opened in late 2018 and integrated primary care with behavioral health services debuted in the county in early 2019. Most recently a suboxone bridge clinic was established in the community in 2019 and has served over 100 residents since its opening. With these services established, partners are focused on building capacity into existing organizations and programs.

The rate of self-inflicted hospitalizations in Clinton County (4.4) is higher compared to last assessment and the New York State rate (3.7) but is lower than the ARHN rate of 6.1. The percentage of adults in Clinton County who binge drink (19.9%) is higher than the Prevention Agenda Benchmarks of 16.4%. The rate of alcohol-related crashes in Clinton County (55.2) is higher than New York State (40.1). This has not changed significantly since the last assessment. Among 15 to 19-year olds, the 2016 Community Health Indicator Report listed the rate of suicides at 12.1, which is slightly higher than the ARHN region (8.1) and Upstate New York (7.3).

Adverse childhood experiences (ACEs) can have a tremendous impact on future violence, victimization and perpetration, and lifelong health and opportunity. In Clinton County, 34.5% of adults have experienced two or more adverse childhood experiences. This is above the Prevention Agenda benchmark of 33.8%. Significant work was done in the community to raise awareness of ACEs and their impact prior to the pandemic; school districts were a key partner with local mental and behavioral health providers. Some gains may have been lost and re-engaging in this work emerged as a need from these partners throughout the assessment process.

Percentage of adults who have experienced **two or more adverse childhood experiences (ACEs).**



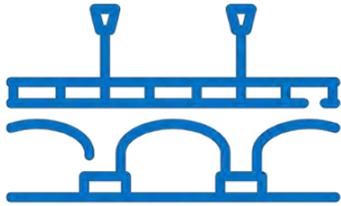
Source: NYS Prevention Agenda

| <b>Resources &amp; Assets:<br/>           Promote Well-Being and Prevent Mental and Substance Use Disorders</b> |   |
|---|---|
| <b><i>Mental Health, Addiction, Substance Abuse:</i></b>  |   |
| Alliance for Positive Health  | Behavioral Health Services North, Inc.              |
| Champlain Valley Family Center  | Clinton County Mental Health and Addiction Services |
| Conifer Park  | Mobile Crisis Team (BHSN)                           |
| NAMI  | Recovery Campus (CVFC)                              |
| Stop Domestic Violence  | SPARCC  |
| University of Vermont Health Network CVPH   |   |
| <b><i>Housing:</i></b>  |   |
| Clinton County Department of Social Services  | ETC Housing Corporation                             |
| Friends of the North Country  | HAPEC – Clinton County Office                       |
| MHAB  | Plattsburgh Housing Authority                       |
| Victory Place   | Clinton County Housing Assistance Program           |
| List is not all inclusive.  |   |

Promote a Healthy and Safe Environment

Rates of motor vehicle accidents and speed-related accidents are lower in Clinton County (2144.7 and 204.3, respectively) than in the ARHN region (2,298.7 and 260.2) and lower than state rates. Additionally, the rate of motor vehicle accident deaths has decreased since last assessment and is lower in Clinton County (3.8) than the ARHN region (7.2), Upstate New York (7.6) and the state as a whole (5.3). The rate of violent crimes (160.4) is higher than the ARHN region (157.0) but lower than that of Upstate New York (204.7) and New York State (364.9).

Over 60% of responding residents identified aging infrastructure as a top environmental concern for Clinton County. Air quality and climate data remain limited for the area but water quality, for both recreational and drinking water sources, also remains a top environmental concern for residents. Nearly 40% of respondents identified concerns related to stream, river, and lake quality, and 35% identified drinking water quality as a top concern. While only a few districts enact fluoridated water programs, these districts serve more than half of



More than **60%** of Clinton County residents surveyed identified **aging infrastructure** as a top environmental concern in our community.

*Source: 2022 CHA Community Survey*

the county's total population. The percentage of residents served by community water systems that have optimally fluoridated water (63.4%) is higher than the ARHN region (25.2%) and Upstate New York (46.9%) but lower than New York State (71.1%) and the 2024 Prevention Agenda benchmark of 77.5%. Nearly three quarters of the population are served by monitored public water systems and just over a quarter of all residents rely on unregulated, private water systems.

The built environment poses several challenges in Clinton County. The percentage of the population with low-income and low access to supermarkets or large grocery stores is significantly higher in Clinton County (10.1%) than in the ARHN region (6.0%), Upstate New York (3.9%), the state as a whole (2.3%), and the Prevention Agenda Benchmark of 2.2%. The loss of full grocery stores, often in favor of non-traditional food outlets like dollar and convenience stores, has negatively impacted the overall food environment. However, farmers market and farm stand participation in local, state and national nutrition incentive programs has been maximized with a 50% increase in sites accepting SNAP from 2015-2018 and an increase of more than two times the number of sites participating in the state's Farmers Market Nutrition Program during the same time frame. In 2018, Clinton County was also selected as a North Country pilot site for the Double Up Food Bucks program run out of the Field and Fork Network of Buffalo, NY, providing additional financial support and buying power to low-income households. This program has received additional funding support in the NYS Annual Budget for the past several years. From 2021-2022, Clinton County created and launched its first Food Action Plan, intended to identify activities that could strengthen all facets of the local food system through collective impact.

As of 2022, all major Clinton County municipal districts (19) have passed complete streets resolutions. Since 2020, 18 of those districts have worked with CCHD in developing concept plans that will ensure health, wellness, and safety are considered in all improvement projects. Past projects have included the creation of new walking paths, installation of safety features to support active transportation and revision/upgrades to more traditional play spaces. Since last assessment, CCHD was able to secure the most comprehensive funding to date to support complete streets/active transportation projects and has been able to extend technical assistance and other supports through gap funding and core staff. Work with this new funding got underway in 2021.

Challenges related to rising housing costs persist and may have been exacerbated by the COVID-19 pandemic. Resident survey responses reflected this with 43% of all respondents identifying affordable housing as a concern in the community; 25% of respondents identified it as a challenge for themselves or their family. Data indicates 14% of residents experience severe housing problems, including overcrowding,

10% of households experience severe housing burden, spending more than **50%** of their total income on **housing**.



Source: County Health Rankings & Roadmaps

high housing costs, and lack of kitchen or plumbing facilities. In addition, 10% of residents experience severe housing burden, spending half or more of their household income on housing. Both situations increase risk of housing insecurity. There are a number of initiatives addressing this need, especially among high needs sub-populations. Multiple new low income residences have been established in recent years but many conditions have elevated the need (pandemic, inflation, aging population, etc.).

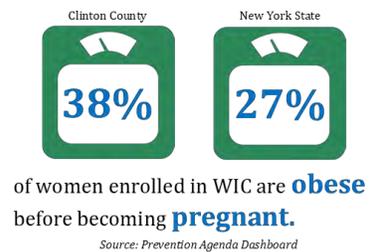
| <b>Resources &amp; Assets: Promote a Healthy and Safe Environment</b> |  |
|---|--|
| <b><i>Exercise, Nutrition &amp; Food Safety:</i></b>                  |  |
| CVPH Diabetes Education Center  | City of Plattsburgh Recreation Department                          |
| Clinton County Health Department                                      | Clinton County Youth Bureau  |
| Cornell Cooperative Extension   | Healthy Steps Network Providers                                    |
| Mountain View Pediatrics  | Nutrition Incentive Programs: SNAP, FMNP, WIC, Double Up Food Buck |
| Plattsburgh Farmer’s Market & Others                                  | Plattsburgh Primary Care Pediatrics                                |
| Private Practice Nutrition Counseling Services                        | Senior Meal Sites & Home Delivered Meal Program                    |
| Town of Plattsburgh Recreation Department                             | YMCA   |
| <b><i>Built Environment/Natural Environment:</i></b>                  |  |
| <b><i>State Parks:</i></b>  |  |
| Cumberland Bay State Park   | Macomb State Park  |
| Point Au Roche State Park   |  |
| <b><i>Recreation Parks &amp; Trails:</i></b>                          |  |
| <b><i>City of Plattsburgh:</i></b>                                    |  |
| Belmont Park  | Broadway Park  |
| Centennial Park   | Champlain Park   |
| Fort Brown Park   | Hamilton Park  |
| Jay Park and Terry Gordon Bike Path                                   | Karen Fleury Memorial Bike Path                                    |
| Lakeview Park and Soldier Point                                       | MacDonough Park  |
| Melissa Penfield Park   | Peace Point  |
| Peter Blumette Park   | South Acres Park   |
| South Platt Street Park   | Tremblay Park  |
| Trinity Park  | U.S. Oval  |

|   |  |
|---|--|
| Wilcox Dock and Healthy Lung Trail          | YMCA of the Oval   |
| <b><i>Town of Plattsburgh:</i></b>          |  |
| Cadyville Recreation Park                   | Cadyville Riverfront Park                                  |
| Cliff Haven Park                            | Cumberland Head Park                                       |
| East Morrisonville Park                     | Guy Cedar Park   |
| May Currier Park                            | South Plattsburgh Park                                     |
| Treadwells Mills Park                       | Wallace Hill Park  |
| West Plattsburgh Park                       |  |
| <b><i>Town of Schuyler Falls:</i></b>       |  |
| Broadwell-Raposa Park                       | Christon-Campbell Park                                     |
| Jefferson-Duquette Memorial Field           | River Street Park  |
| Turner Memorial Park                        |  |
| <b><i>Other Parks/Trails/Resources:</i></b> |  |
| Beekmantown Town Park and Pavilion          | Champlain Area Trails Northern Champlain Valley Trails Map |
| Chazy Recreation Park                       | Clinton County Recreational Trails Map (CCHD)              |
| Ellenburg Recreation Park                   | Feinberg Park, Altona                                      |
| Gazebo Park, Peru                           | Heritage Trail, Plattsburgh                                |
| Heyworth/Mason Park, Peru                   | Lafountain Park, Dannemora                                 |
| Laphams Mills Park, Peru                    | Little Ausable River Trail, Peru                           |
| Lyon Mountain Firetower Trail               | Mooers Recreation Park                                     |
| Mooers Forks Recreation Park                | Northern Tier Recreation Trail                             |
| Perry Mills Park, Champlain                 | Picketts Corners Park, Saranac                             |
| Rouses Point Civic Center                   | Saranac River Trail Greenway                               |
| Sullivan Park, Peru                         | West Chazy Recreation Park                                 |
| <b><i>Transportation:</i></b>               |  |
| Clinton County Public Transit               | First Transit  |
| Private Services (taxis, ambulettes)        | Rural Transportation Program (JCEO)                        |
| List is not all inclusive.                  |  |

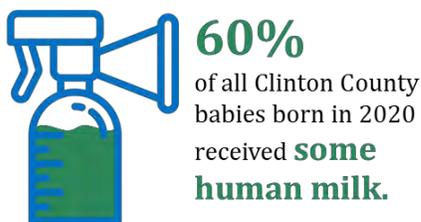
## Promote Healthy Women, Infants and Children

The percentage of births within 18 months of a previous pregnancy in Clinton County is 34.2%. This has increased since last assessment and is higher than the New York State average of 30.4%. Of all births, 81.1% had adequate prenatal care; 7.9% received late or no prenatal care. Both of these metrics have worsened since last assessment and surpass state averages of 75.5% and 5.4%, respectively. The infant mortality rate per 1,000 live births is 7.4. This is higher than the ARHN region (5.1), Upstate New York (4.8) and New York State (4.4).

The percentages of women receiving WIC in Clinton County with gestational weight gain greater than ideal (51.0%), gestational diabetes (11.3%) or gestational hypertension (13.2%) are all higher than the New York State averages. The percentage of pre-pregnancy obesity (38.0%) is also higher than the New York State average (26.6%). However, Clinton County WIC childhood obesity rates (14.3%) are below the Upstate New York average (15.5%).



A trend favoring increased breastfeeding initiation, duration and exclusivity for all infants has been maintained in the community. From data collected by CCHD in collaboration with local pediatric practices since 2013, it has been possible to closely monitor the impact of collective work. Compared to 2013 data, there has been at least a 15% increase in infants receiving human milk during their first year of life. In 2020, 60% of babies received some human milk and, compared to 2013, there has been at least a 78% increase in the number of infants exclusively chest/breastfeeding.



Source: Clinton County 2020 Breastfeeding Data Summary, 2022

The overall increase in breastfeeding in our community may be attributed to community-wide efforts to remove barriers and change the social context of breastfeeding, as well as an increased capacity to provide individualized clinical support through primary care. In the past 10 years, CCHD has assisted 175 entities across a five county region in pursuing the “breastfeeding friendly” designation from the NYS Department of Health. These entities

include health care providers, childcare sites and worksites. In addition, over 50 health and wellness professionals have taken advantage of lactation support trainings. While significant improvement has been seen in chest/breastfeeding, Clinton County continues to fall short of meeting several Healthy People 2030 targets related to breastfeeding and many families still struggle to meet their chest/breastfeeding goals because of stressors like returning to work and school. Opportunities still exist to further improve local breastfeeding rates and are rooted in strengthening the continuity of care associated with chest/breastfeeding support throughout the community.

Referrals into services to address childhood developmental delays are increasing. On average the Early Intervention Program received 219 referrals per year from 2018-2021. The number of referrals received by the program in just the first three quarters of 2022 exceeds that multi-year average. Staffing shortages of key professionals, like occupational, physical therapists and speech language pathologists have additionally created a significant waitlist for services among Clinton County families. While this is consistent with what other counties are experiencing, Clinton County has organized an Early Intervention Ethics Council to navigate through these challenges and help assure services/resources are distributed as ethically and equitably as possible.

| <b>Resources &amp; Assets: Promote Healthy Women, Infants and Children</b> |  |
|--|--|
| Child Care Coordinating Council of the North Country, Inc.                 | Clinton County Breastfeeding Coalition |
| CCHD Improved Pregnancy Outcome Program                                    | Clinton County WIC Program             |
| Healthy Families of the North Country                                      | Planned Parenthood                     |
| Private Practice Women’s Health Care Providers                             | Birthright of Plattsburgh              |
| List is not all inclusive.   |  |

### Prevent Communicable Diseases

CCHD completed over 9,000 communicable disease case investigations in 2021. Over 90% of the investigations were for COVID-19. Of the eligible population within the county, 60.7% have completed the COVID-19 vaccine series, including booster. The pattern of COVID-19 infection in Clinton County followed state and national patterns, with cases spiking during colder months and tapering off during warmer months. In total, CCHD provided 17,475 COVID-19 vaccinations in 2021 (this includes first dose, second dose, third dose and booster vaccinations).



**60.7%**  
of the eligible population has completed the **COVID-19 vaccine series** including booster.

Source: NYS COVID-19 Vaccine Tracker

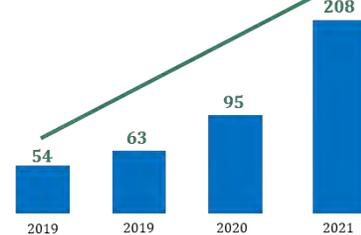
The immunization rate for children ages 24-35 months with 4:3:1:3:3:1:4 (82.7%) shows a small improvement since last assessment and is now higher than the Prevention Agenda benchmark (70.5%). The percentage of 13-year-old adolescents with a complete HPV vaccine series is 35.2%; this is lower than the Prevention Agenda benchmark of 37.4%. With the return of in-person learning this past fall, a greater number of school-aged children were in need of “catch-up” vaccinations. This suggests as newer, post-pandemic data becomes available, it is very likely there will be a consistent trend towards a greater number of children not meeting vaccination benchmarks. Changes within the local pediatric healthcare system are also making it more challenging for families to stay current

with vaccinations and other preventive care. Collaborative solutions may be necessary to prevent negative health impacts.

While chlamydia remains one the most frequently diagnosed communicable diseases in Clinton County, incidence has been on the decline since 2018. However, following similar trends seen in recent years across New York State (NYS), diagnosed gonorrhea in Clinton County increased significantly from 2020 (16 cases) to 2021 (57 cases). Syphilis cases have also been increasing statewide, and congenital syphilis cases are on the rise nationwide, though this trend has not been seen in local surveillance and year-to-date numbers for all STIs have moderated in 2022. In NYS, Expedited Partner Therapy (EPT) is an option for infection management in sex partner(s) for chlamydia, gonorrhea, and/or trichomoniasis STIs. The use of EPT by local medical providers when appropriate may be helping to moderate infection rates.

Incidence of tickborne disease continues to rise in the North Country. There were 208 reported cases of Lyme disease in 2021, this is four times the number of cases reported in 2018. While Lyme disease remains the most commonly diagnosed tickborne disease in this region, rates of other tickborne diseases are also increasing. Anaplasmosis cases have seen a six fold increase from 2018 to 2021.

Cases of **Lyme disease** in Clinton County have increased **285%** since 2018.



*(Increased case numbers being attributed to increased awareness and changes in environment).*

Source: HCS Annual Report 2021

In 2021, CCHD completed 301 animal bite investigations, a 17% increase from 2020. A total of 18 individuals received post- exposure prophylaxis. Only one specimen tested positive for rabies, consistent with previous years. The rate of confirmed rabies cases is lower in Clinton County (1.2) than in Upstate New York (3.1). Increased rabies activity was noted in surrounding areas in 2022 and future trends will need to be monitored. Participation in local rabies clinics for pets continues to be high, with nearly 1,400 cats and dogs receiving vaccines at 2021 clinics. Ongoing education regarding the importance of pet rabies vaccination, approaches for safely capturing bats for testing and the need for timely reporting of potential exposures remain key components of CCHD rabies related health messaging.

| <b>Resources &amp; Assets: Prevent Communicable Diseases</b> |  |
|--|--|
| Clinton County Health Department-<br>Communication Disease   | Clinton County Health Department-<br>Environmental Health & Safety |
| UVMHN-CVPH Infectious Disease                                | Planned Parenthood of Plattsburgh                                  |
| STI Partner Coalition  | Ryan White Program (Hudson Headwaters HN)                          |
| NYSDOH Uninsured Care Programs                               |  |
| List is not all inclusive.                                   |  |

## Community Health Assessment Process and Methods

### Overview

Described below is the process through which CCHD and CVPH solicited and took into account input from community residents and those who represent the broad interests of the community served, including the medically underserved, low income, and other disparate populations. Such community input was sought to:

- Understand the community's perceived significant health needs, concerns, disparities;
- Expand knowledge and gain insights on data findings;
- Identify barriers to accessing and receiving care; and
- Identify assets and resources within the community.

The process of identifying the priority health care needs of the residents of Clinton County (e.g., the service area) involved health data analysis, review of common population profiles, consultation with key members of the community and direct resident input. UVMHN-CVPH and CCHD, the lead entities in the process, facilitated/completed the following activities with the Clinton County community:

- Two community based, health focused surveys;
- Review of over 300 health indicators and a secondary data analysis;
- A Community Health Priority Setting Session;
- A Priority and Focus Area Finalization Process; and
- Creation of shared Action Plans.

In early 2022, the ARHN conducted a survey of selected stakeholders representing social service, education, government, and health service-providing agencies within a seven-county region. The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight into what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns. During a similar timeframe, CCHD conducted a health survey directly targeting residents of Clinton County. The results of both surveys were intended to provide an overview of regional needs and priorities, to inform planning and the development of a shared health improvement agenda.

Since 2002, the ARHN has compiled and analyzed a health indicator dataset, producing and sharing the reports with regional CHA committee members to inform healthcare and improvement planning. ARHN also provides members population profiles for consideration in the CHA process. The health indicators and provided profile are used as a starting point

for the preceding Community Profile. Lead organizations have further developed this baseline profile by contributing additional health metrics, discussion and reference to supporting and opposing factors influencing health, health equity and health improvement progress in our community.

A group of stakeholders was convened for a Health Priority Setting Session in July 2022. Attendees were tasked with identifying the health priority areas most important for the Clinton County community to focus on collectively. The event was facilitated and hosted by CCHD and UVMHN-CVPH and consisted of a wide range of attendees representing various community sectors. Smaller groups of stakeholders were convened following this event to finalize priority selections, identify focus areas and begin identifying interventions. A detailed description of this process is outlined in this section. Using the results of an indicator analysis, regional and local survey findings, other community assessments, and stakeholder input, shared action plans were created to address the identified health concerns.

## Stakeholder Surveys

### **Community Resident Survey Process – Clinton County 2022 Community Health Assessment Survey**

The CCHD surveyed Clinton County residents to provide the CHA stakeholders with resident perspective about community health. Residents were asked to identify features of a strong, vibrant, healthy community; for their opinions on health, social and environmental challenges in the community; to identify health and social challenges and any barriers to medical care experienced by themselves or a family member within the past year; and for demographic information about individual respondents and their households.

The survey tool was adapted from the Clinton County 2019 Community Health Assessment Community Survey, developed by CCHD. Updates and revisions to the tool were completed in November 2021. The addition of several new demographic questions intended to assist lead organizations in understanding subpopulation experiences through deaggregation. New questions also sought to collect self-reported physical and mental health. The fielded survey included 20 questions, 12 of which assessed demographics and potential disparities; it was anonymous and no names, addresses or phone numbers were collected. CCHD utilized existing community partners to distribute the survey. It was made available as a web-based link which was shared via email. Paper copies of the survey were also distributed, as well as a small card with the web-based link URL and a poster with the web-based link and QR code. Survey development, fielding and analysis were completed over a 10 month period.

### **Results of Clinton County Resident Survey**

A total of 1,253 responses were received, of which, 1,081 were complete surveys from Clinton County residents. Periodic reviews of demographic information provided by

respondents during survey fielding allowed the CCHD to target specific pockets of the population not already reached, ensuring that responses received mirrored census data to the greatest extent possible. Final demographic analysis suggest a reasonable representative sample of the Clinton County population was reached.

Noteworthy findings from the analysis have been integrated into the *Community Profile's Description & Discussion* section of this report. The full survey summary report has been included as an appendix to this report.

While the survey was not framed around the *Prevention Agenda 2019-2024: NYS's Health Improvement Plan*, careful consideration was given to the responses in relation to the Prevention Agenda upon analysis so collected perspective could be successfully incorporated into health priority setting activities. When considered against this framework, there is considerable connection to locally selected priorities. One third of respondents reported living with a chronic disease. One third of respondents also indicated mental health was a challenge for them or their family. In fact, the top five reported health challenges of greatest concern and the top five self-reported health or social challenges easily align with the selected health priorities.

Further analysis of resident responses will continue into 2023 to better understand the experiences of special populations within the county. This information will be valuable as health improvement activities are developed and implemented over the next three years.

*Please see Appendix B for: Clinton County 2019 Community Health Assessment Resident Survey Summary*

### **ARHN 2019 Community Stakeholder Survey**

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

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

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

CCHD and UVMHN-CVPH opted to personally reach out to all identified non-respondents to maximize participation. The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns.

## Results of the ARHN Community Stakeholder Survey

A total of 263 responses were received through March 1, 2022, for a total response rate of 32.63%; 51 Clinton County stakeholders responded to the survey, comprising 19.62% of the total response percentage. It took respondents an average of 20 minutes to complete the survey, with a median response time of approximately 16 minutes. To analyze the chosen priority areas, responses were totaled per county and the priority area that received the most responses is listed as the First Choice, followed by the second most responses listed as Second Choice. All seven of the ARHN counties identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* as their top priority. Additionally, Clinton, Franklin, Fulton, Hamilton, and Warren counties identified *Prevent Chronic Disease* as their second choice while Essex and Washington counties identified *Promote a Healthy and Safe Environment* as their second choice.

Community stakeholders were asked to choose what they believed to be the top five health concerns affecting the residents in the counties their organization/agency served. The choices were ranked from one, being the highest health concern, to five, indicating the lowest health concern. Survey respondents felt that the top five health concerns affecting the residents within the ARHN region were Mental Health (20.96%), Substance Use/Alcoholism/Opioid Use (13.1%), Child/Adolescent emotional health (9.61%), Overweight/Obesity (7.42%), and Adverse childhood experiences (6.99%).

*Please see Appendix C for: Summary of 2022 Community Stakeholder Survey*

## Secondary Data Analysis

An analysis of [largely] secondary community health data was also used to help identify the significant community needs for Clinton County. Included in this data are multiple population profiles (demographic, health system, education system, etc.) used to better understand the community under assessment. Provided health indicator data was grouped within the five NYS Prevention Agenda Priority Areas for ease of interpretation. Data from each Prevention Agenda Priority Area was considered for selection.

The health data sheets, featuring nearly 300 indicators, provide an overview of population health as compared to the ARHN region, Upstate New York and New York State. The reports feature a status field that specifies whether indicators were met, better, or worse than the corresponding benchmarks. When indicators were worse than the applicable

benchmark, their distance from each was calculated. On the report, distances from benchmarks were indicated using quartile rankings. All compiled metrics are featured in Appendix D.

Indicators were broken out by the Prevention Agenda Focus Areas, across ten categories. These include *Mortality, Injuries, Violence and Occupational Health, Built Environment and Water, Obesity, Smoke Exposure, Chronic Disease, Maternal and Infant Health, HIV, STD, Immunization and Infections, Substance Abuse and Mental Health, and Other*. Data and statistics for all indicators come from a variety of sources, including:

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

A full description of the Data Methodology utilized by ARHN and the CHA Committee is available for reference in Appendix E. All metrics were reviewed and a core group of metrics that were most relevant to the population of Clinton County were identified. Relevancy was based on metric performance (county placement compared to regional/state/national performance and benchmarks) and relation to current or anticipated health improvement activities. These specific metrics were featured in a series of infographics displayed at the Health Priority Setting Session. When appropriate or needed to enhance understanding, primary data, collected by local partners, and other data sources, were also accessed. An infographic was created for each Priority Area (see Appendix F) to assist community partners in reviewing available metrics. Metrics, as needed, were revisited during the Priority and Focus Area Finalization process.

There is an ever increasing number of data sources available for consideration, both primary and secondary. The following resources were also accessed and reviewed to inform Clinton County's community health assessment process:

- Clinton County 2022 Infant Feeding Summary
- County Health Rankings & Roadmaps- Clinton County
- Community Commons Spark Map Report 2022
- NORC Recovery Ecosystem Index Score

- Vital Statistics of NYS

## Community Health Priority Setting Session

Clinton County has a successful history of convening community stakeholders to assist in the identification of priority health issues. On July 14<sup>th</sup>, 2022 this approach was once again utilized. Approximately 150 Clinton County stakeholders, a 25% increase in invitees over 2019 activities, were invited to the Community Health Priority Setting Session facilitated by CCHD and CVPH. Clinton Community College in Plattsburgh, NY served as the location for the event and was chosen specifically for its capacity to accommodate more guests and familiarity of the space among community partners.

The event was three hours in length and did not have a structured agenda. Rather, attendees were free to come and go at any point throughout the morning. Attendees filtered through stations dedicated to the Prevention Agenda Priority Areas. Each station featured a colorful infographic depicting up-to-date data related to the area. This year, an additional station was added specifically to address disparities and highlight findings from the resident survey. Stations were manned by subject matter experts whose line of work aligned with the assigned priority area. Attendees had the opportunity to visit each station, read educational materials, review related health metrics and discuss current activities, progress and challenges with the subject matter experts. Once attendees had visited each station, they were asked to complete a short survey that captured their vote for which areas they believed were most important for Clinton County to address as a community over the next several of years. The survey also captured their insights related to Focus Area selection.

The event was intentionally designed to encourage interaction between stakeholders from different community sectors. To assure invitees' comfort and observe COVID-19 state of emergency restrictions that were still in place, a virtual option was offered to invitees following the in-person event. In total, 74 stakeholders (44 in person and 30 virtually), representing a minimum of 18 community sectors, participated and shared their views. Sectors represented included community health care, public health, clinical healthcare, government, recreation, human services, planning, business, mental/behavioral health, media and transportation. Special populations that were represented from within the attendee pool included seniors, low literacy, low income, individuals with disabilities, and youth. Participants' experience with the Prevention Agenda and involvement in community health planning varied. Excitingly, 46% of attendees reported this as their first time contributing to priority setting activities; 54% reported participating in past activities.

Responses from health system and community partners participating in the Prioritization Session overwhelmingly selected *Promote Well-Being and Prevent Mental and Substance Use Disorders* as the top Priority Areas for collaborative work. *Prevent Chronic Diseases* was selected as the second priority area, just edging out *Promote a Healthy and Safe Community*. Focus Area voting was far less definitive. To help clarify partner contributions relating to

the focus areas, smaller subcommittees were convened. The process applied is explained in detail in the *Priority and Focus Area Finalization* section.

Participant characteristics, voting results, finalization findings and additional methodology applied in the processes described above can be found in Appendix G.

### Priority and Focus Area Finalization

To finalize Priority and Focus Area selections and to begin developing local strategies and related activities, a subcommittee consisting of members from the Action for Health Consortium and UVMHN-CVPH was convened. Selection finalization was based primarily on the following:

1. Results of stakeholder surveys outlined above;
2. Data analysis outlined above;
3. Health priority setting session outlined above;
4. Application of the Hanlon Method.

### **Participants**

The subcommittee members represented stakeholders with community and clinical knowledge, as well as familiarity with the priority areas, existing services/activities landscape and willingness to inform the needs assessment process.

### **Process**

Subcommittee members were convened in October 2022 to finalize Priority Area and Focus Area selection. Members of the subcommittee noted the consistency in findings from the stakeholder survey, community survey, secondary data analysis and community priority setting session voting. Therefore, *Prevent Chronic Diseases* and *Promote Well-Being and Prevent Mental and Substance Use Disorders* were accepted as selected Priority Areas for Clinton County.

To clarify the selection of Focus Areas, members applied the Hanlon Method to each Focus Area. The Hanlon Method is a quantitative process and a NACCHO supported prioritization tool that can be applied to rank specific health problems based on the criteria of: size of the health problem, seriousness of the health problem and effectiveness of interventions. From these ratings, a priority score is calculated using a method related formula. Individual scores were averaged to obtain final Hanlon Method scores.

Lastly, the subcommittee was asked to consider common disparities that influence health. Each were presented a list of eight disparities, which they ranked from 1-8, with one representing the disparity most apparent in our community and across priority areas.

### **Outcomes**

Hanlon Method scores did not significantly differentiate between focus areas under *Prevent Chronic Diseases - Healthy Eating and Food Security*, *Chronic Disease Preventive Care*, and

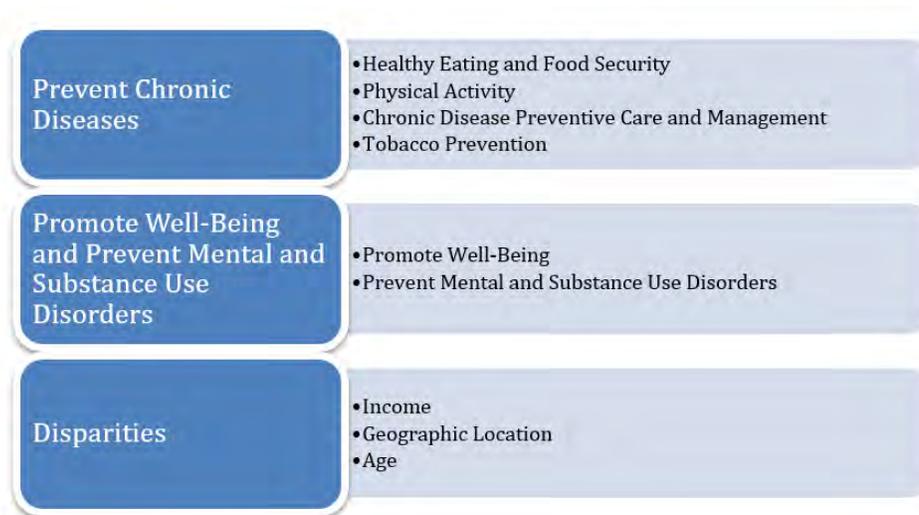
*Management, Physical Activity and Tobacco Prevention.* It was decided goals and objectives could be developed for all. Both focus areas from *Promote Well-Being and Prevent Mental and Substance Use Disorders* were selected. It was determined by the subcommittee that each of the selected focus areas would be addressed with its own action plan.

Of the eight disparities presented to the subcommittee for consideration, income, geographic location and age were identified as the top conditions most significant in the Clinton County community as residents seek to be healthy.

A summary of participant characteristics, event voting results, and finalization methodology and results has been included in Appendix G.

### **Significant Community Needs (Aligning Secondary Data and Community Input)**

To identify the significant community needs, the results of the data analysis were combined with the results of the community input and grouped by priority area. The priority areas, focus areas and disparities that emerged were as follows:



### **Leveraging Community Assets and Resources**

UVMHN-CVPH and CCHD understand the key to successfully impacting the health of Clinton County is partnering with the community and its organizations and combining resources. It is the intent of the lead partners that action plans capture the partnership, contributions and support of many community organizations to strengthen the impact of the planned interventions and assure the responsible use of limited resources. Throughout the community health needs assessment process, CCHD, UVMHN-CVPH and their partners have considered existing assets and resources that can be leveraged to help the community to

continue to make progress in meeting its long range health goals. Assets and resources were identified through the assessment process as supporting and opposing factors were taken into consideration. All assets/resources listed are potential resources for the implementation of Clinton County's Community Health Improvement Plan and particular attention is always given to identifying resources that could assist in engaging residents, disseminating messages, and maximizing reach into disparate/high needs subpopulations.

## **Action Plans**

Lead staff from CCHD and UVMHN-CVPH have worked with partners to collect and organize activities and interventions that will address the identified health priorities. This was done utilizing a variety of methods: review of current CHIP/IS activities and progress as well as those of other shared work plans (ie. Community Services Plan), individual meetings with key partners, emails soliciting suggestions and contributions of related activities from Action for Health participants, and review of information collected from the priority setting event and directly from residents through the survey process. Information was then organized by goals/objectives within each focus area, resulting in six action plans and formatted following NYSDOH guidance and provided tools. These action plans become CCHD's CHIP and UVMHN-CVPH's IS for the next three years.

It is impossible to feature all the health improvement work that will occur in Clinton County over the next three years in the Action Plans. Much thought is given to the featured interventions; often it is the items that best demonstrate the local commitment to collective impact work, innovation, and cross-system collaboration. There is also an intentional blend of activities that will vary in duration. As such, there will be progress to acknowledge and celebrate perpetually. This also allows new interventions to be considered and added regularly based on emerging local needs and resources. Target programs and locations for the featured interventions are determined by a number of factors including review of health indicator data, especially to identify high needs populations and areas within the county, and feasibility of activities meeting success (existence of potential sites, accessibility, receptiveness, etc.). Featured interventions and projected outcomes are influenced by partner resources including staff, funding and expertise.

As the CHA process is a recurring cycle and the identified health priorities for this cycle maintain the current course, the new action plans feature a combination of interventions that are carrying over into the new action cycle along with new activities that build off successes and progress realized to date.

## **Maintaining Engagement & Tracking Progress**

Active engagement with others in the community to implement change is challenging given diminishing resources and competing priorities. The process of setting shared goals and

creating collective action plans has helped define partner roles and has improved the use of available resources. Efficient and effective use of existing assets requires unprecedented collaboration and cooperation by everyone, not just by the agencies or organizations whose primary missions directly relate to health issues. Higher level decision makers from agencies and organizations in the community now participate in the process demonstrating an actionable level of commitment to the health of the community. Increased capacity for community assessment work has allowed more partners, including residents, to be included in the process and through a number of channels.

Clinton County's collaborative strategy can be traced back to the mid 2000's when the Mobilizing for Action through Planning and Partnerships (MAPP) process was first used locally. Clinton County MAPP partners have evolved into the Action for Health Consortium (AFH). This group has representatives from a wide variety of community sectors that have implemented effective policy, systems and environmental strategies for nearly two decades, for the purpose of improving community health. A full description of this group is available earlier in this document.

It has become standard practice for AFH to assemble subcommittees of partners possessing technical and professional expertise to implement and update priority area action plans. For example, in 2019, a diverse group of food environment stakeholders was convened for a discussion intended to identify next steps for improving the local food system which has led to the creation of the county's first Food Action Plan in 2022. Members of identified subcommittees and participants of brainstorming work sessions bring subject matter expertise to the AFH Consortium. It is the intent of UVMHN-CVPH and CCHD to continue to use the developed model of partner engagement described while also always seeking new ways to improve processes for all involved.

Formal progress updates on the CSP/CHA/CHIP/IS are captured throughout the year and summarized in an annual document. During the last quarter of each year, responsible parties for each featured "activity" submit a progress update to the AFH Consortium. Activities are then categorized as "completed" or "in progress". When applicable, new activities are integrated into the plan each year and often reflect progress and rely on emerging resources. Annual updates serve as a means of celebrating successes and motivating partners. Progress is reported out to the community at large through social media messaging, press-releases and other means as appropriate.

## **Dissemination of Plan to the Public**

UVMHN-CVPH and CCHD will actively disseminate the CSP/CHA/CHIP/IS to the public. The plan will reside conspicuously in PDF format in the "About- Partnerships" section of [www.cvph.org](http://www.cvph.org). CCHD will post the CHA and CHIP in the *Statistical Data and Annual Reports* section of its webpage found at [www.clintonhealth.org](http://www.clintonhealth.org). Links to all documents and updates, when available, will be shared via social media and other media channels. Promotional efforts will then drive the community to these locations to view and download the assessment and related plans. Promotional efforts will include a press release sent to all

local media outlining the plan; interviews with the media (as appropriate); regular posts on social media sites such as Facebook and Twitter; and mentions in a variety of print and online communications produced by UVMHN-CVPH and CCHD.

CCHD will, as it has in the past, dedicate an edition of its *Profiles in Public Health* to the new CHA/CHIP. The short overview document will highlight priority areas, planned work, and partners. It will also provide specific calls to action for residents, health professionals, and community leaders. The profile will be posted on CCHD's website and promoted through the standard mechanisms referenced above. Other communication efforts and channels will be considered throughout the year to help increase awareness of shared, community level health improvement plans among partners and residents alike.

Notification will be sent to key stakeholders through a cover letter document announcing community members can access community health assessment related documents. In addition, community presentations will include:

- AFH members (and to their Directors or oversight Boards as requested);
- Targeted local elected officials;
- Clinton County Board of Health;
- Foundation of CVPH;
- All other appropriate and identified community stakeholders.

Active and ongoing distribution and promotion throughout the community will maximize reach and awareness of these documents and shared plans for health improvement. Community presentations will highlight how residents and stakeholders informed the process and can contribute to collective efforts going forward. All dissemination activities will help build the grassroots need to address health improvement efforts across the county by engaging both traditional and nontraditional partners in sustainable and permanent community-based interventions.

## **Evaluation Plan**

CCHD and UVMHN-CVPH use a number of process and outcome measures to evaluate the community health assessment process and health improvement progress. For example, prior to the assessment, goals are set for the number and demographics of residents reached through survey activities and stakeholder participation in priority setting events. Dates for completing each stage of the process keep all partners on track.

Progress on collaborative health improvement plans are tracked through regular discussions at AFH meetings. These on-going discussions allow new data, resources and emerging conditions to be considered; at times, mid-course corrections are made to assure activity goals and objectives are met. Each AFH meeting agenda is framed around the NYS Prevention Agenda to assure work related to all five priority areas is periodically captured.

CCHD and UVMHN-CVPH use feedback from stakeholders to determine use and reach of all the formal documents (CHA/CHNA/CSP/CHIP/IS). For past iterations of the assessment, approximately 60% of surveyed partners use these documents for strategic planning, 64% for staff education/development, and 55% as a data resource. Partners also share these collaborative documents. One third share the documents annually with their advisory boards and link directly to them on their website (connecting directly to the documents on the CCHD or UVMHN-CVPH website); 16% embed the documents within their own websites. A quarter of partners retain hard copy documents in accessible spaces for staff reference/use; a few partners (6%) display the documents in public spaces. Use and reach will be assessed again following the release of this assessment.

CCHD and UVMHN-CVPH will continue to monitor trends in use to best meet partner needs and maximize participation in the plans. Lead partners will also continue to look for new opportunities to learn about the effectiveness and efficiency in the current process, modifying the approach as appropriate.

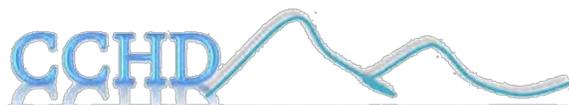
## **Hospital Approval**

Business Operations worked with Senior Leadership to share the CHNA and IS, which were combined to create the Community Service Plan, to the Board of Directors of CVPH. The Board was provided with the Executive Summary of the document as well as the document in its entirety, to include the action plan that is associated. All documents were approved prior to December 31, 2022.



# Community Service Plan

Working Together to Strengthen Our Community



Clinton County **HEALTH** Department



THE  
**University of Vermont**  
HEALTH NETWORK

**Champlain Valley Physicians Hospital**

## 2022-2024 Community Services/ Health Improvement Plan

### NYS Department of Health Prevention Agenda Priority Area: Promote Wellbeing and Prevent Mental and Substance Use Disorders

**Focus Area: Promote Wellbeing**

|  |
|--|
| <b>Goal:</b> Strengthen opportunities to build well-being and resilience across the lifespan.  |
| <b>Goal:</b> Facilitate supportive environments that promote respect and dignity for people of all ages.   |
| <b>Objective:</b> Reduce the percentage of adult Clinton County residents with self-perceived poor or extremely poor mental health. (Baseline: 11.19%, <i>Clinton County 2022 Community Health Assessment Community Survey</i> ) |
| <b>Objective:</b> Increase Clinton County’s Opportunity Index Score by 5%. (Baseline: 54.3, 2019; <i>Opportunity Nation/Index</i> )  |

| Interventions/Activities   | Partner (Role)  | Measures  | Disparity                  |
|--|---|---|----------------------------|
| Integrate social and emotional approaches across the lifespan.   | Office for the Aging, JCEO, St. Joseph’s Community Outreach Center<br><br>Foundation of CVPH  | Establish and grow the Compassionate Companion Volunteer Program in Clinton County.<br>-# of program volunteers trained; # of residents served<br>Offer Sweethearts & Heroes (coping skills program) to local schools.<br>-# of participating schools (Goal: 12 schools in 2023)  | Age<br>Geographic location |
| Create and sustain inclusive, healthy public spaces.   | Town of Plattsburgh Recreation Dept.<br><br>Clinton County Health Department<br><br>UVHN-CVPH | -TOP Recreation Master Plan integrating promotion of physical and mental well-being in all supported spaces.<br>-# of community spaces identified as breastfeeding friendly (Goal: 6 spaces in 2023)<br>-Creation of dedicated wellness space for employees<br>Expansion of EAP, DEI initiatives for employees (w/ focus on counseling services, life skills, etc_. | Ability                    |
| Offer Mental Health First Aid to teach people how to respond to individuals who are experiencing one or more acute mental health | CCMH&AS   | -# of Law enforcement officers trained  |                            |

|  |  |  |  |  |
|--|--|--|--|--|
| crises or are in the early stages of one or more chronic mental health problems. |  | Expansion of offer to other direct service staff (probation, emergency response, emergency services, etc.) |  |  |
|--|--|--|--|--|

### Focus Area: Prevent Mental and Substance Use Disorders

|   |
|---|
| <b>Goal:</b> Prevent opioid and other substance misuse and deaths.  |
| <b>Objective:</b> Reduce Drug Overdose Mortality by three points. (Baseline: 20.7, 2016-2020; rei.norc.org)   |
| <b>Objective:</b> Reduce Opioid Overdose Mortality by three points. (Baseline: 15.2, 2016-2020; rei.norc.org)   |
| <b>Goal:</b> Prevent and address adverse childhood experiences.   |
| <b>Objective:</b> Decrease the percentage of Clinton County adults who have experienced two or more adverse childhood experiences (ACEs). (Baseline 34.5%, NYS BRFSS) |

| Interventions/Activities   | Partner (Role)                 | Measures  | Disparity                     |  |
|--|--------------------------------|---|-------------------------------|--|
| Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine. | Alliance for Positive Health   | -Increase of physician coverage to 1 FTE at Bridge Clinic<br>-Expansion of clinical services (wound care, etc.)   | Income<br>Geographic location |  |
| Build support systems to care for opioid users or at risk of an overdose.                                    | CVFC<br>CVPH                   | -Establishment of a 24-hr crisis center<br>-Secure OMH certification for CVFC to provide mental health counseling services<br>-Create a peer support program in the in-patient setting                              | Income<br>Geographic location |  |
| Integrate trauma informed approaches in training staff and implementing program and policy.                  | CCMH&AS                        | -# clinical staff trained in polyvagal theory and other trauma informed approaches<br>-# of human service, social service and health professionals trained in polyvagal theory and other trauma informed approaches |                               |  |
| Integrate principles of trauma-informed approaches in governance and leadership.                             | CCMH&AS, school administrators | Re-engage schools in addressing adverse childhood experiences and in trauma informed activities.<br>-# of schools participating in planned activities   |                               |  |

## NYS Department of Health Prevention Agenda Priority Area: Prevent Chronic Disease

### Focus Area: Healthy Eating and Food Security

|   |
|---|
| <b>Goal:</b> Reduce obesity and the risk of chronic disease.  |
| <b>Objective:</b> Decrease the percentage of adults ages 18 years and older with obesity. (Baseline 36.7%, <i>Prevention Agenda Dashboard, BRFSS</i> )<br>Decrease the percentage of children and adolescents with obesity. (Baseline 21.50, <i>Prevention Agenda Dashboard, SWSCRS</i> ) |
| <b>Objective:</b> Decrease the percentage of adults with an annual household income less than \$25,000 with perceived food security. (Baseline 66.3%, <i>NYS BRFSS</i> )  |

| Interventions/Activities   | Partner (Role)           | Measures   | Disparity                     |  |
|--|--------------------------|--|-------------------------------|--|
| Facilitate worksite nutrition and physical activity programs designed to improve health behaviors and results. | CCHD, local worksites    | -Increase the number of worksites and community settings that implement healthy food guidelines by 8 sites in 2023   | Geographic location<br>Income |  |
| Screen for food insecurity, facilitate and actively support referral.  | CCHD, community partners | -# of health, human service, social service professionals educated on food/nutrition security, local resources<br>-Local system to collect FI data to help track root causes of FI is developed and implemented; data shared back to partners & community<br>-Move forward at least 2 identified activities in the Clinton County Food Action Plan to strengthen the local food system | Income                        |  |
|  |                          |  |                               |  |

## Focus Area: Physical Activity

|  |
|--|
| <b>Goal:</b> Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities.  |
| <b>Objective:</b> Decrease the percentage of adults ages 18 years and older with obesity. (Baseline 36.7%, <i>Prevention Agenda Dashboard, BRFSS</i> )<br>Decrease the percentage of children and adolescents with obesity. (Baseline 21.50, <i>Prevention Agenda Dashboard, SWSCRS 2020</i> ) |
| <b>Goal:</b> Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity.   |
| <b>Objective:</b> Increase the percentage of adults age 18 years and older who participate in leisure-time physical activity. (Baseline 70.9%, <i>BRFSS</i> )  |
| <b>Objective:</b> Decrease the percentage of Clinton County residents reporting a lack of access to opportunities for health for those with physical limitations or disabilities. (Baseline: 12.67%, <i>Clinton County 2022 Community Health Assessment Community Survey</i> )                 |

| Interventions/Activities  | Partner (Role)                             | Measures  | Disparity                                       |  |
|---|--|---|---|--|
| Adopt and implement policies, programs, and best practices through multi-component programs across community settings that allow residents of all ages to explore indoor and outdoor environments and meet national guidelines for physical activity. | TOP Recreation, other partners<br><br>CCHD | -Offer at least 2 activities each season for each target age population (youth, adults, seniors).<br>-Increase the number of worksites that implement physical activity interventions by 3 in 2023.<br>-Increase the number of child care providers that improve policies, practices and environment for physical activity and nutrition by 8 in 2023.<br>-Increase the number of schools that improve school wellness policies for physical activity and nutrition by 3 in 2023.<br>-Increase the number of municipalities that adopt and implement community planning and active transportation interventions to increase safe and accessible physical activity for all residents by 3 in 2023. | Age<br>Ability<br>Geographic location<br>Income |  |

## Focus Area: Chronic Disease Preventive Care and Management

|   |
|---|
| <b>Goal:</b> Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.  |
| <b>Objective:</b> Increase the percentage of adults who had a test for high blood sugar or diabetes within the past three years, aged 45+ years. (Baseline 58%, <i>NYS Prevention Agenda</i> )                                    |
| <b>Objective:</b> Reduce rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 population. (Baseline 19.4, <i>Community Health Indicator Reports, 2017-2019</i> )  |
| <b>Goal:</b> In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.                           |
| <b>Objective:</b> Increase the percentage of adults with chronic conditions who have taken a course or class to learn how to manage their condition. (Baseline variable by intervention or NA)                                    |
| <b>Objective:</b> Reduce the percentage of adult Clinton County resident with self-perceived poor or extremely poor physical health. (Baseline: 10.64%, <i>Clinton County 2022 Community Health Assessment Community Survey</i> ) |

| Interventions/Activities   | Partners (Role)  | Measures   | Disparity                                  |  |
|--|--|--|--|--|
| Promote a team-based approach (which may include pharmacist, community health worker, registered dietitian, podiatrist, and other health workers) to chronic disease care to improve health outcomes.  | Adks ACO, UVHN-CVPH, CCHD, other partners  | Develop an Adirondacks ACO provider network supported cross-sector diabetes initiative (providing evidence-based prevention and treatment).<br>-meeting dates, # of participating sectors/partners<br>-process & outcomes measures established, monitored  | Income                                     |  |
| Expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone. | North Country Healthy Heart Network, CCHD, others<br><br>UVHN-CVPH Occupational Health, Clinton County OFA, CCHD, others | -Support the organization and coordination of a regional Chronic Disease Prevention Coalition (imbed at least 1 NYSPHC Fellow)<br>-Promotion of CDSM learning opportunities to at least 4 different target groups in 2023 (ie. pharmacies, community based orgs, physicians, residents, staff)<br>-Offer at least one in person CDSM opportunity in Clinton County/ quarter in 2023.<br>-Participation in CDSM education opportunities (in-person and virtual) increased by 25% (Baseline- | Income<br>Geographic location<br>Education |  |

## Focus Area: Tobacco Prevention

**Goal:** Promote tobacco use cessation.

**Objective:** Decrease the prevalence of smoking by adults age 18 years and older. (Baseline 19.9%, *Prevention Agenda Dashboard*)

**Goal:** Prevent initiation of tobacco use.

**Objective:** Decrease the percentage of high schools students reporting use of any tobacco product. (Baseline 16.5%- national statistic from CDC)

|   | Partner (Role)  | Measures   | Disparity                |  |
|---|---|--|--------------------------|--|
| Educate organizational decision makers, conduct community education, and use paid and earned media to increase community knowledge of the dangers of secondhand smoke exposure and secondhand aerosol/emission exposure from electronic vapor products. | Tobacco Free Clinton Franklin Essex/<br>Reality Check | -# of retail observations of licensed tobacco retailers in Clinton County, including vape shops (1 visit/ yr)<br>-Present retails observation findings to Clinton County Legislature’s Health Committee (meeting date)<br>-# of municipalities undertaking policy action to reduce impact of tobacco marketing & flavored tobacco products with support from TFCFE |                          |  |
| Use media and health communications to highlight the dangers of tobacco, promote effective tobacco control policies and reshape social norms.   | Tobacco Free Clinton Franklin Essex/<br>Reality Check | -Implementation of the “Its Not Just” campaign to increase awareness of the impact of methanol products on youth, LGBTQ+, BIPOC communities (# media activities, reach of activities)  | Identity/<br>orientation |  |

## **Appendices**

## Appendix A:

### Community Health Needs Assessment Stakeholder Groups Committee Members and Meeting Schedules

#### Action for Health Consortium Members

|                  |   |
|------------------|---|
| Diana Aguglia    | Alliance For Positive Health  |
| Maria Alexander  | Senior Citizens Council   |
| Maryann Barto    | Clinton County Health Department, Environmental Health Division           |
| Rachel Brown     | Senior Citizens Council   |
| Dana Bushey      | Champlain Valley Family Center  |
| Trevor Cole      | Town of Plattsburgh Planning Department                                   |
| Darleen Collins  | Clinton County Office for the Aging                                       |
| Carrie Coryer    | Alliance For Positive Health  |
| Rheannon Croy    | Alliance for Positive Health  |
| Lisa Cyphers     | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Bob Dickie       | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Adele Douglas    | Town of Peru Community Development Coordinator                            |
| Valarie Drown    | Center for Neurobehavioral Health – SUNY Plattsburgh                      |
| Brenton Dumas    | Behavioral Health Services North  |
| Linda Gilliland  | Cornell Cooperative Extension   |
| Lisa Goodrow     | Joint Council for Economic Opportunity                                    |
| Richelle Gregory | Clinton County Mental Health and Addictions                               |
| Kerry Haley      | The Foundation of CVPH  |
| Mark Hamilton    | City of Plattsburgh Housing Authority                                     |
| Karen Kalman     | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| John Kanoza      | Clinton County Health Department, Administration                          |
| Jessica Kogut    | Town of Plattsburgh   |
| Paula Lacombe    | Citizen   |
| Shelby LaRock    | Behavioral Health Services North  |
| Dorothy Latta    | Plattsburgh Interfaith Food Council                                       |
| Crystal Mang     | Adirondack Health Institute   |
| Megan Murphy     | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Erin Pangborn    | Town of Plattsburgh Recreation Department                                 |
| Joyce Porter     | Adirondack Health Institute   |
| Robert Poulin    | North Country Center for Independence                                     |
| Sara Rowden      | Citizen   |
| Shawn Sabella    | Behavioral Health Services North  |
| Shey Schnell     | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Margaret Searing | Citizen   |
| Terra Sisco      | Clinton County Youth Bureau   |
| Mandy Snay       | Clinton County Health Department, Health Planning and Promotion           |
| Julie Stalker    | Joint Council For Economic Opportunity                                    |

|                  |   |
|------------------|---|
| Susan Sullivan   | Village of Rouses Point   |
| Kaitlyn Tentis   | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Shannon Thayer   | Clinton County Planning Department  |
| Jennifer Trudeau | Clinton County Health Department  |
| Philip Vonbargen | Citizen   |

**Action for Health Consortium 2022 Meeting Schedule**

January 12, 2022  
 March 9, 2022  
 May 11, 2022  
 July 13, 2022  
 September 14, 2022  
 November 16, 2022

**Tentative 2023 Meeting Dates**

January 11, 2023  
 March 8, 2023  
 May 10, 2023  
 July 12, 2023  
 September 13, 2023  
 November 15, 2023

# Adirondack Rural Health Network Community Health Assessment

## Committee Members

| <b>Name</b>   | <b>Organization</b>   |
|---|---|
| Dan Hill<br>Rachelle Waters                                   | Adirondack Medical Center   |
| Cathleen Traver   | Glens Falls Hospital  |
| Geoff Peck  | Nathan Littauer Hospital  |
| Annette Marshall  | University of Vermont Health Network – Alice Hyde Medical Center            |
| Kaitlyn Tentis<br>Gregory Freeman                             | University of Vermont Health Network - Champlain Valley Physicians Hospital |
| Heather Reynolds<br>Julie Tromblee<br>Amanda Whisher          | University of Vermont Health Network - Elizabethtown Community Hospital     |
| Sara Deukmejian<br>Andrea Bonacci                             | Adirondack Health Institute   |
| Mandy Snay  | Clinton County Health Department  |
| Linda Beers<br>Jessica Darney Buehler<br>Andrea Whitmarsh     | Essex County Public Health  |
| Katie Strack<br>Sarah Granquist                               | Franklin County Public Health   |
| Laurel Headwell<br>Angela Stuart Palmer                       | Fulton County Public Health   |
| Dr. Erica Mahoney<br>Victoria Fish                            | Hamilton County Public Health   |
| Ginelle Jones<br>Dan Durkee<br>Olivia Cohens<br>Drew Crawford | Warren County Health Services   |
| Tina McDougall<br>Elizabeth St. John                          | Washington County Public Health   |

## Meeting Dates

### 2020

December 6

### 2021

June 4

August 25

September 10

October 12

November 10

December 17

### 2022

March 4

June 17

September 9

December 9

**Appendix B:**  
**Clinton County 2022 Community Health Assessment**  
**Community Survey Summary**

## Introduction

The Clinton County Health Department (CCHD) surveyed Clinton County residents to provide the Community Health Assessment (CHA) stakeholders with resident perspective about community health. Residents were asked to identify features of a strong, vibrant, healthy community; for their opinions on health, social and environmental challenges in the community; to identify health and social challenges and any barriers to medical care experienced by themselves or a family member within the past year; and, for demographic information about individual respondents and their households.

## Methods

The Clinton County 2022 Community Health Assessment Community Survey was adapted from the Clinton County 2019 Community Health Assessment Community Survey, developed by CCHD. The survey team consisted of a Principal Public Health Educator, and the Director of the Division of Health Planning & Promotion; other CCHD staff and students [students represented the disciplines of Public Health and Nursing] were used throughout the process to field the survey and to assist in interpretation of findings.

Notable changes from Clinton County's 2019 Community Survey to the 2022 version include: the addition of five new questions, the removal of a question specifically addressing cancer care within the community, and additional response choices based on common 'write-in' responses from the 2019 survey respondents. One of the new questions sought to provide further context to respondents' selections for features of a healthy community. The remaining four new questions were included in the Demographics section to assist in identifying differences in experiences between those active in the health care system versus not, differences in experiences based on employment status and differences in experience for self-perceived physical and mental health. In total, the survey included twenty questions, ten of which assessed demographics of the respondents. However, the survey was anonymous; no names, addresses or phone numbers were collected from respondents. Survey development, fielding and analysis were completed over a six-month period. A pdf of the survey tool is included at the end this report.

The CCHD utilized existing community partners to distribute the survey. It was made available as a web-based link which was shared via email. Paper copies of the survey were also distributed, as well as a small card with the web-based link URL and a poster with the web-based link and QR code. An email with the web-based link URL was sent to many partners throughout the county, including: Clinton County employees, Action for Health Consortium members, Town Supervisors and Mayors, and local school Superintendents. The North Country Chamber of Commerce also included the survey link in an issue of their "Daily Dose" newsletter. Survey fielding was also completed in-person at numerous agencies and events within the community. Sites included: University of Vermont Healthcare Network Champlain Valley Physicians Hospital, Clinton County Nutrition Program for the Elderly Congregate lunch sites, Plattsburgh Housing Authority senior living facilities and administrative offices, Rock's Grocery in Schuyler Falls and the 2022 Child Advocacy Center event.



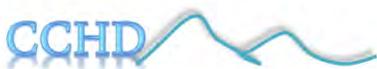
## Clinton County 2022 Community Health Assessment Community Survey Summary

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The CCHD utilized SUNY Plattsburgh nursing interns to expand capacity and assist with survey fielding throughout the county. Some agencies also facilitated completion of surveys by their clients, including Cornell Cooperative Extension and Clinton County Office for the Aging. A news release was distributed to local media outlets to further increase survey awareness and participation among the target population. CCHD used its Facebook, Twitter and Instagram pages to promote the survey, providing the web-based link URL. Local municipalities and school districts were called upon to share posts on their own social media platforms to best reach their own followers.

Survey respondents were first asked if they felt they lived in a healthy community. They were given a Likert scale identifying responses of *strongly disagree*, *disagree*, *neutral*, *agree*, or *strongly agree*. They were then asked for their definition of a healthy community; specifically, “*When you imagine a strong, vibrant, healthy community, what are the most important features you think of?*” and asked to choose up to three of eighteen identified features. The survey then assessed health, social and environmental challenges within the community. Residents were asked to choose up to five health challenges (from twenty-three identified challenges) that they feel are of greatest concern in the community. They were then asked to choose up to five social challenges (from twenty-four identified challenges) and up to five environmental challenges (from sixteen identified challenges) that they feel are of greatest concern in the community. The survey then asked respondents what individual health and social challenges they or a family member experienced in the past year, and instructed them to check all that apply (from a list of twenty-three possible health challenges and twenty-four possible social challenges). Respondents were also asked about barriers to medical care; specifically, “*If there was a time in the past year that you or a family member needed medical care but could not get it, why did you not get care?*” and instructed to select all that apply from a list of sixteen identified possible barriers. The survey then requested that respondents complete ten demographic questions, which collected information on their gender, age, city/ town of primary residence, primary language spoken in the household, race/ethnicity, highest level of education, the household’s annual income, primary employment status, if they had a primary care provider, and disabilities. Lastly, respondents were asked to rate their physical health and their mental health using the same Likert scale as described previously; specifically, “*My physical health is...*” and “*My mental health is...*”. CCHD made a concerted effort to reach a representative sample of all Clinton County residents. A periodic review of demographic information provided by respondents during survey fielding allowed the CCHD to target specific pockets of the population not already reached, ensuring that responses received mirrored census data to the greatest extent possible.

Analysis for this report was conducted by CCHD Health Planning & Promotion (HPP) staff and a Master in Public Health student candidate from Brown University School of Public Health. During analysis, open-ended responses in which the respondent mentioned an offered response but did not mark the corresponding response were manually categorized by staff. The 2020 US Census Statistics for Clinton County, NY were used to evaluate demographic representation/ participation in this survey (*see Table 1*). When appropriate and noteworthy, responses in the current iteration were compared to findings from previous iterations of this survey. STATA Version 17.0 was used to analyze data collected in the Clinton County Health Department 2022 Resident Survey (StataCorp. 2021. Stata Statistical Software: Release 17. College Station, TX: StataCorp LLC.). Unweighted frequencies and percentages of responses and demographics were reported in Table(s) x. Descriptive statistics to determine percentages for each category by question



were completed by creating contingency tables for each potential response. Respondents were able to write in responses which were indicated as “Other” in the data. However, to avoid potential misclassification bias, written-in responses were not reorganized into the category in which their response was fitting or related to. Instead, each written-in response was read and evaluated by members of the Health Planning and Promotion Division of the Clinton County Health Department and will be used to improve the survey tool in future iterations.

Survey findings were formally shared with stakeholders during the 2022 Clinton County Community Health Assessment Priority Setting Session to assist event attendees in selecting priority health areas for the 2022-2024 Community Health Improvement Plan and Community Services Plan.

### Findings

A total of 1,253 responses were received, of which, 1,081 were complete surveys from Clinton County residents. Incomplete surveys and those completed by non-residents were not included in result findings.

#### *Demographics of Survey Respondents*

Clinton County is comprised of approximately 48.6% female and 51.4% male. Approximately 3.61% (39) of respondents to the Clinton County 2022 Community Health Assessment Resident Survey preferred not to identify their gender. Of the 1,042 individuals who shared information regarding their gender identity, 78.79% (821) of respondents identified as female, 19.87% male (207), 0.38% non-binary (4), and 0.96% selected “other” (10) (*see Table 2 and Figure 1*). Those who selected “other” and filled in a response often indicated that there were only two genders, indicating a potential misunderstanding within the community between sex and gender. These observed differences in gender of respondents suggest that female residents were oversampled in the survey relative to their composition within the population.

Regarding age, survey respondents more closely represented the composition of Clinton County residents; however, individuals aged 18-24 years were slightly underrepresented compared to other age groups. While there were no restrictions prohibiting survey completion by any age group, the survey did not specifically target residents 17 years and younger. Individuals aged 17 and under represent nearly 18% of the County’s population, therefore, a higher percentage of each of the other age groups were targeted accordingly. 0.37% of respondents were 17 years and under (4); 4.07% were 18-24 years old (44); 35.43% were 25-44 years old (383); 35.25% were 45-64 years old (381); 17.95% were 65-79 years old (194); and 6.94% were 80 years and over (75) (*see Table 2 and Figure 2*).

According to the 2020 U.S. Census, almost 40% of Clinton County’s population reside in two of the fifteen municipalities, those being the City and Town of Plattsburgh. Due to the rural geographic nature of the county, a concerted effort was made to reach a representative sample of residents from each of the townships within the county. See *Table 2 and Figure 3* for a comparison of survey respondents and Census population by township. Of the 1081 respondents, 27 live in Altona (2.50%); 37 in AuSable (3.42%); 81 in Beekmantown (7.49%); 15 in Black Brook (1.39%); 69 in Champlain, including Rouses Point (6.38%); 52 in Chazy (4.81%); 26 in Clinton (2.41%); 22 in Dannemora (2.04%); 27 in Ellenburg (2.50%); 23 in

## Clinton County 2022 Community Health Assessment Community Survey Summary

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Mooers (2.13%); 96 in Peru (8.88%); 341 in the City of Plattsburgh (31.54%); 173 in the Town of Plattsburgh (16%); 30 in Saranac (2.78%); and 62 in Schuyler Falls (5.74%).

Of the 1,081 survey respondents, over 99% (1,076) of respondents identified English as the primary language spoken in their home. Other primary languages spoken in the households of the respondents included: American Sign Language (1), Italian (1), and Polish (1) (*see Table 2*).

Respondents were asked to identify their race/ethnicity and instructed to select all that apply; therefore, responses for this demographic will not total 100%. Of the 1,081 survey respondents, 5.27% (57) preferred not to identify their race/ethnicity. Of the 1,024 individuals who shared information regarding their race/ethnicity, 96.67% (993) were White. 1.46% of individuals were American Indian or Alaskan Native (15), 0.78% were Asian or Pacific Islander (8), 1.25% were Black or African American (13), 1.76% were Hispanic, Latino, or Spanish origin (18), and 0.59% selected “other” (6). See *Table 2* and *Figure 4* for a comparison of survey respondents and Census population by race/ethnicity.

The highest level of education completed by survey respondents was diverse. Of the 1,081 respondents, the highest level of education obtained was some high school but did not finish in 42 respondents (3.89%); high school diploma or GED in 165 respondents (15.26%); completed some college but did not finish in 149 respondents (13.78%); technical or trade school certificate in 35 respondents (3.24%); an Associate degree in 117 individuals (10.82%); a Bachelor degree in 285 individuals (26.36%); a Master degree or higher in 273 respondents (25.25%); and 15 individuals selected “other” when asked about their highest level of education (1.39%) (*see Table 2* and *Figure 5*). According to the U.S. Census data, of the Clinton County population 25 years and older, 88% were a high school graduate or higher, while 24.4% had a Bachelor degree or higher. Comparatively, of respondents 25 years and older, 96.37% were a high school graduate or higher, while 53.48% had a bachelor’s degree or higher (respondents who answered “other” for this question were excluded from this analysis).

The household annual income reported by respondents varied; of the 1,081 respondents, 13.41% (141) respondents preferred to not report their household’s annual income. Of the 940 respondents who reported their household’s annual income, 4.16% (45) reported a household annual income of less than \$10,000; 10.36% (112) reported \$10,000-24,999; 16.10% (174) reported \$25,000-49,999; 29.51% (319) reported \$50,000-99,999; 16.93% (183) reported \$100,000-149,999; and 9.90% (107) reported \$150,000 or more (*see Table 2* and *Figure 6*). According to the 2020 U.S. Census data for Clinton County, the median household income was \$59,510, with a per capita income in the past 12 months of \$29,960; meanwhile, 11.1% of Clinton County residents live in poverty.

Of the 1,081 respondents, a majority were full-time employees (54.12%) or retired (22.76%). 85 individuals were part-time employees (7.86%); 51 reported being disabled (4.72%); 1 reported being in the armed forces (0.09%); 38 reported being a homemaker (3.52%); 21 reported being a student (1.94%); and 24 reported being unemployed (2.22%). 30 individuals selected “other” for their primary employment status (2.78%) (*see Table 2* and *Figure 7*).

While 79.74% (862) of respondents reported having no disability, 20.26% of individuals reported at least one disability (219). Of note, as respondents were asked to select all that apply, responses for self-reported

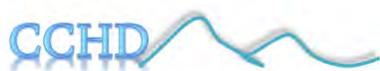


disabilities will not total 100%. According to the Centers for Disease Control (CDC), 21% of adults in New York have some type of disability. The most reported disability among respondents was related to mobility, or serious difficulty walking or climbing stairs (52.51%), followed by difficulty completing errands alone because of a physical, mental, or emotional condition (36.99%). The next most reported disability was related to cognition, where respondents indicated having difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition (36.53%) (*see Table 2 and Figure 8*).

Nearly 10% of respondents reported that they did not have a primary care provider (*Figure 9*). When asked if they had a primary care provider, townships with the greatest number of respondents without a primary care provider were Altona (25.93%), Black Brook (20.00%), Clinton (15.38%), Dannemora (13.64%), and AuSable (10.81%). It should be noted that these towns are further away from centralization of care in Plattsburgh. Additionally, a greater number of male respondents do not have a primary care provider compared to female respondents, 12.56% and 8.77%, respectively. Likewise, respondents with lower annual household incomes reported having not having a primary care provider more frequently than respondents with higher annual household incomes. It was found that 15.56% of respondents with an annual household income less than \$10,000 reported having no primary care provider while 4.67% of those with an annual household income greater than \$150,000 reported having no primary care provider. Education also seems to be a factor in our community in determining whether a resident has a primary care provider. It was found that 14.29% of those with less than a high school diploma reported having no primary care provider while those at every education level higher than some high school reported having no primary care provider less often. Those with no primary care provider self-reported their physical health as *average* more frequently than *good* or *excellent*, 52.43% and a combined 40.78%, respectively. Comparatively, those with a primary care provider reported having good or excellent physical health more than those who reported having average physical health, a combined 51.84% and 37.12%, respectively. Those with no primary care provider reported having poor, extremely poor, or average mental health more than those with a primary care provider, a combined 47.57% and 45.4%, respectively. The breakdown for all respondents' reported physical and mental health can be found in *Table 11 and Figure 18 and Table 12 and Figure 19*, respectively.

### *Definition of a Healthy Community*

Approximately one-third of respondents identified a clean environment, health care services, and affordable housing as the most important features of a strong, vibrant, healthy community. These features have changed entirely from the 2019 resident survey, where good schools, livable wages, and a safe environment were the most important features. Those aged 25-64 years old identified a clean environment as a top feature the most (66.76%). Those aged 45-64 years old identified health care services as a top feature the most (37.5%). Those aged 25-64 years old identified affordable housing as a top feature the most (63.6%). Females identified all three of these as top features in a strong, vibrant, healthy community the most. Females identified every listed feature as important more than males, likely due to the overrepresentation of females by the survey.



When asked whether they believed they lived in a healthy community, 41.54% of respondents agreed or strongly agreed that they live in a healthy community. Likewise, 22.38% disagreed or strongly disagreed with this statement; 36.08% of respondents felt neutral toward this statement. Respondents were then asked to identify the top three features of a strong, vibrant, healthy community; therefore, responses for this demographic will not total 100%. Of those who agreed or strongly agreed with this statement, the top features of a strong, vibrant, healthy community are a clean environment (42.76%); healthcare services (35.86%); affordable housing (34.97%); a safe environment (33.63%); good schools (32.29%); livable wages (26.06%); and economic opportunities (17.37%). Of those who disagreed or strongly disagreed with this statement, the top features of a strong, vibrant, healthy community are healthcare services (33.06%); affordable housing (30.17%); livable wages (29.75%); mental health services (26.03%); a clean environment (24.79%); being drug-free (24.79%); and a safe environment (21.90%). See *Table 3* and *Figure 10* for perceptions of living in a healthy community by residents and *Table 4* and *Figure 11* for the top features of a strong, vibrant, healthy community. It is notable that both groups of respondents that either agreed or strongly agreed with the statement compared to those that disagreed or strongly disagreed identified several of the same top features for a strong, vibrant, healthy community, yet have different perceptions of whether they live in a healthy community.

### *Health Challenges of Concern and Experienced*

Nearly 91% of respondents reported experiencing one or more health challenge in the past year by themselves or a family member. Almost half of respondents identified substance abuse as a health challenge in the community, while just over 11% of respondents reported it as a health challenge experienced by themselves or a family member within the past year. Meanwhile, nearly 40% of respondents identified mental health as a challenge in the community and nearly 35% of respondents reported experiencing mental health challenges by themselves or a family member within the past year. However, an overwhelming majority of respondents reported that their mental health was average, good, or excellent, when asked, leaving just over 11% of respondents reporting that their mental health was poor or extremely poor. Likewise, nearly 37% of respondents identified access to mental health services as a health challenge in the community, while just over 21% of respondents reported having trouble in accessing mental health services. Additionally, 36% of respondents identified overweight/obesity as a health challenge in the community and over 1 in 3 (34.52%) respondents reported it as a health challenge experienced by themselves or a family member in the past year. Furthermore, nearly 36% of respondents identified access to healthcare services as a top health challenge in the community, while nearly 19% reported having trouble in accessing healthcare services. Over 62% of respondents reported experiencing at least one barrier to receiving medical care in the past year for themselves or for a family member. The most reported barriers included: no appointment available for a specialist (32.84%), no specialist locally (32.84%), insurance was not accepted (27.79%), co-pays or deductibles were too high (25.71%), and no appointment available for primary care (23.18%). See *Table 5* and *Figure 12* for health challenges identified in our community, *Table 6* and *Figure 13* for health challenges experienced by residents, and *Table 7* and *Figure 14* for barriers to receiving medical care.

## *Social Challenges of Concern and Experienced*

Nearly 3 in 4 (74.56%) respondents reported experiencing at least one social challenge in the past year by themselves or a family member. Nearly 2 in 5 (43.20%) respondents identified affordable housing as a top social concern in the community, while 1 in 4 (24.94%) respondents experienced affordable housing issues by themselves or a family member within the past year. Just over 39% of respondents identified lack of a livable wage being a top social challenge in the community, while just under 33% reported experiencing this challenge in the past year. Likewise, over 26% of respondents identified access to healthy foods as a social challenge in the community while just under 13% of respondents reported having trouble in accessing healthy foods in the past year. Nearly 25% of respondents identified child abuse/neglect as a top social concern in our community, while under 3% of respondents reported experiencing child abuse/neglect. The percentage of those experiencing child abuse/neglect in our community is likely underreported due to social desirability bias and concerns associated with reporting child abuse/neglect. Issues related to childcare were reported by nearly 23% of respondents as being a top social challenge in our community, while over 11% of respondents reported experiencing issues related to childcare by themselves or a family member within the past year. See *Table 8* and *Figure 15* for social challenges of concern in our community and *Table 9* and *Figure 16* for social challenges experienced by residents.

## *Environmental Concerns*

Over 60% of respondents identified aging infrastructure as a top environmental concern in our community. Nearly 40% of respondents also identified concern related to stream, river, and lake quality, while over 35% of respondents identified drinking water quality as a top environmental concern. Additionally, 1 in 3 (33.33%) respondents identified school safety as a top environmental concern in our community. Nearly 33% of respondents identified climate change as an environmental concern within our community as well. See *Table 10* and *Figure 17* for environmental concerns in our community.

## *Self- Perceived Physical and Mental Health*

Over three quarters of respondents self-reported their physical health as average (38.58%) or good (38.76%). Just over 10% reported their physical health as poor or extremely poor; 12.03% reported their physical health as excellent. A similar pattern in responses was seen for self-reported mental health with 74.84% of respondents reporting their mental health as average, good or excellent; 10.08% and 1.11% of respondents reported their mental as poor or extremely poor, respectfully. See *Table 11* and *Figure 18* and *Table 12* and *Figure 19* for a breakdown of self-reported physical and mental health responses, respectively.

Respondents reporting extremely poor or poor physical health more frequently selected “affordable housing” as the top feature of a healthy community. Those reporting good or excellent physical health more frequently selected “clean environment” as the top feature of a health community. The same pattern was seen for self-reported mental health (See *Table 13* and *Table 14*). Both features were in the top three features when considering all responses. Interestingly, those self-reporting their mental health as “excellent” were the only category of respondents to not identify “affordable housing” as one of the top three features of a healthy community. In addition, nearly half of the respondents who self- reported their physical health as “poor” or “extremely poor” felt they live in a healthy community, selecting either

“agree” or “strongly agree” for that question; only 15% of those respondents “disagreed” or “strongly disagreed” with the question (See *Table 15*). No respondents who self-reported their mental health as “extremely poor” selected “strongly agree” when asked if they lived in a healthy community but 25% of those same respondents “agreed” with that statement (See *Table 16*).

### *Township Level Results*

Saranac (96.67%), Altona (96.30%), Chazy (94.23%), Champlain (94.20%), and Black Brook (93.33%) residents reported experiencing a health challenge the most. Interestingly, these towns are some of the furthest located towns from Champlain Valley Physicians Hospital and the centralization of most of Clinton County’s healthcare resources. Additionally, Black Brook (86.67%), Saranac (83.33%), the City of Plattsburgh (80.94%), and Altona (77.78%) residents reported experiencing a social challenge the most. As it can be seen, respondents to the survey reported experiencing health challenges more than social challenges.

The top health, social, and environmental concerns for each township varied. While it should be noted some townships have very few responses, it is generally accepted that the data may provide valuable, more granular insight into health experiences and attitudes among residents for township leaders and constituents. For that reason, township level reports are being developed separately from this summary report and will be available for the public.

### Considerations/Limitations

Having completed a survey of similar magnitude in both 2016 and 2019, the CCHD was able to leverage survey fielding experience and existing partners within the community to efficiently reach over 1,000 residents. There were 172 surveys submitted that were completed by residents of a neighboring county or not completely filled out. Those surveys were eliminated, resulting in 1,081 surveys fully completed by Clinton County residents. This equates to only approximately 1.4% of the county’s population and represents a decrease in reach from the survey’s previous iteration. Survey fielding was completed over the winter months from December 2021 to March 2022, when many pandemic restrictions were still in place. Few large scale events were happening and many residents were appropriately following state and national guidance to limit interactions. A majority of fielding efforts focused on soliciting participation through virtual means. Efforts to field the survey 1:1 targeted known hard-to-reach populations. Responses from these groups were monitored closely throughout the process and locations were often selected to reduce disparities in responses when they were identified.

Similar challenges in fielding as noted in the past also persisted. The CCHD continues to find that reaching certain subpopulations and communities, especially the most rural, is difficult. Females were more likely to complete the survey than males and male respondents proved to be one of the most difficult subpopulations to engage.

The ongoing COVID-19 pandemic did not only make it challenging to reach residents but may have also influenced their attitudes and willingness to participate when they were reached. A notable shift in willingness to participate was evident when face-to-face efforts were undertaken but no data on number of

refusals or rationale was collected in this iteration or in previous iterations. However, open-ended responses collected did capture a level of frustration among respondents not noted in the past. Comments collected highlighted distrust of local health agencies and/or a feeling of being tired of hearing from them. Others used the survey to voice their disagreement with COVID-19 related mandates or requirements, despite that not being a focus of this survey.

This survey required that residents self-report their opinions on key challenges prevalent in the community and experienced by themselves and their families. It also, for multiple demographic questions, required respondents to self-select categories without any parameters. This method has its own limitations in regards to the accuracy of resident's recall and discretion as well as what information they choose to disclose.

This survey was available both in-person and as an electronic survey. In-person respondents had the advantage of having available a staff member to explain directions or questions if necessary, but may have not felt as anonymous as those filling out the survey online. For example, it was noted, especially among the senior population, a need to distinguish between mental health and cognitive health. Online respondents, therefore, had the advantage of being completely anonymous, but the disadvantage of not having a person that could provide explanations as necessary.

The second question asked respondents to choose "up to 3" features and the third, fourth, and fifth questions asked respondents to choose "up to 5" challenges; some respondents chose less than three or five, respectively, and some respondents completing the paper survey chose more than three or five, respectively. All responses were counted in the final numbers. The online version of the survey did not allow respondents to choose more than three responses for the second question or more than five responses for the third, fourth, and fifth questions.

## Conclusions

This survey provided valuable feedback from the community for the CCHD and UVM Health Network-CVPH. It represents the largest reaching approach to community inclusion in the local community health assessment process. This is Clinton County's third large scale effort to collect direct resident insight for consideration in selecting local health priorities. Demographic findings suggest a reasonable representative sample of the Clinton County population was reached.

An overview of the survey process and collected data will be readily shared with community health stakeholders and residents. The full report will be featured in the 2022-2024 Community Health Assessment; a summary infographic has been created to make survey findings more accessible (included). The infographic is featured on the CCHD website and has already been shared through a number of channels.

While the survey was not framed around the *Prevention Agenda 2019-2024: NYS's Health Improvement Plan*, careful consideration is given to the responses in relation to the Prevention Agenda upon analysis so collected perspective could be successfully incorporated into health priority setting activities. Not



surprisingly, community health stakeholders, taking resident input into consideration along with nearly 300 other health indicators, have opted to “hold the course” in collaborative health improvement efforts. Clinton County will maintain its current priority health areas of *Prevent Chronic Disease* and *Promote Well-being and Prevent Mental and Substance Use Disorders* in its next Community Health Improvement Plan. When responses are considered against the Prevention Agenda framework, there is considerable connection to locally selected priorities. One third of respondents reported living with a chronic disease and one third of respondents indicated mental health was a challenge for them or their family. In fact, the top five reported *Health Challenges of Greatest Concern in Our Community* and the top five self-reported health or social challenges easily align with the recently selected health priorities. Top responses also highlight shortcomings in our local health care system, namely in accessing care, which should also be considered as improvement plans are made.

This survey was able to capture, perhaps more clearly than past efforts, the extent of concern many residents experience with a range of factors that influence overall health and well-being. Nearly three quarters of all respondents reported experiencing a social challenge with lack of a livable wage, opportunities for physical activity, affordable housing and street safety being the top challenges selected in this category. More than half of respondents selected aging infrastructure as the top environmental concern; stream, river or lake quality was the second top environmental concern among respondents, demonstrating a shift from last iteration. Such findings reinforces the importance of the social determinants of health and the need to continue to favor strategies and interventions that address upstream factors that play a fundamental role in health outcomes. Despite the challenges identified by residents, over 40% of survey respondents feel they live in a healthy community. This finding will serve as a benchmark to measure progress in subsequent iterations.

While survey findings have served their primary purpose (inform the local health priority selection process), there is still much to be gained from more in-depth analysis of the information collected. Adjustments to the survey in this iteration were intended to allow more granular analysis of special populations within the county. Such review and analysis will continue in the years ahead and additional findings will be used to inform ongoing collaborative planning intended to improve the health of all residents.

Tables & Figures

**Table 1. 2022 U.S. Census. Population Statistics for Clinton County**

| Municipality   | 2010          | 2020          |
|--|---------------|---------------|
| Altona   | 2,887         | 2,666         |
| AuSable (including Village of Keeseville)                    | 3,146         | 3,183         |
| Beekmantown  | 5,545         | 5,508         |
| Black Brook  | 1,497         | 1,453         |
| Champlain (including Villages of Champlain and Rouses Point) | 5,754         | 5,745         |
| Chazy  | 4,284         | 4,096         |
| Clinton  | 737           | 652           |
| Dannemora (including Village of Dannemora)                   | 4,898         | 4,037         |
| Ellenburg  | 1,743         | 1,842         |
| Mooers   | 3,592         | 3,467         |
| Peru   | 6,998         | 6,772         |
| Plattsburgh (city)   | 19,989        | 19,841        |
| Plattsburgh (town)   | 11,870        | 11,886        |
| Saranac  | 4,007         | 3,852         |
| Schuyler Falls   | 5,181         | 4,843         |
| <b>Clinton County</b>  | <b>82,128</b> | <b>79,843</b> |

**Table 2. 2022 Clinton County Community Health Assessment Community Survey, Demographics of Respondents**

| Demographic  |                      | % (#)        |
|--|----------------------|--------------|
| Gender<br>(n = 1,042)*   | Female               | 78.79% (821) |
|  | Male                 | 19.87% (207) |
|  | Non-Binary           | 0.38% (4)    |
|  | Other                | 0.96% (10)   |
| <i>*Note: Of all 1,081 respondents, 3.61% (39) declined to answer.</i> |                      |              |
| Age<br>(n = 1,081)   | 17 years and younger | 0.37% (4)    |
|  | 18-24 years          | 4.07% (44)   |
|  | 25-44 years          | 35.43% (383) |
|  | 45-64 years          | 35.25% (381) |
|  | 65-79 years          | 17.95% (194) |
|  | 80 years and older   | 6.94% (75)   |



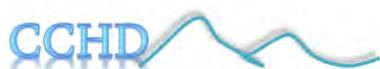
**Table 2 Continued. 2022 Clinton County Community Health Assessment Community Survey, Demographics of Respondents**

| Demographic   |  | % (#)          |
|---|--|----------------|
| Township of primary residence<br>(n = 1,081)        | Altona   | 2.50% (27)     |
|   | AuSable  | 3.42% (37)     |
|   | Beekmantown  | 7.49% (81)     |
|   | Black Brook  | 1.39% (15)     |
|   | Champlain (including Rouses Point)   | 6.38% (69)     |
|   | Chazy  | 4.81% (52)     |
|   | Clinton  | 2.41% (26)     |
|   | Dannemora  | 2.04% (22)     |
|   | Ellenburg  | 2.50% (27)     |
|   | Mooers   | 2.13% (23)     |
|   | Peru   | 8.88% (96)     |
|   | Plattsburgh (City of)  | 31.54% (341)   |
|   | Plattsburgh (Town of)  | 16.00% (173)   |
|   | Saranac  | 2.78% (30)     |
| Schuyler Falls                                      | 5.74% (62)   |                |
| Primary language spoken in household<br>(n = 1,081) | English  | 99.54% (1,076) |
|   | American Sign Language   | 0.09% (1)      |
|   | Chinese  | 0.00% (0)      |
|   | French   | 0.00% (0)      |
|   | Haitian-Creole   | 0.00% (0)      |
|   | Italian  | 0.09% (1)      |
|   | Korean   | 0.00% (0)      |
|   | Polish   | 0.09% (1)      |
|   | Russian  | 0.00% (0)      |
|   | Spanish  | 0.00% (0)      |
|   | Other  | 0.19% (2)      |
| Race/ethnicity<br>(n = 1,024)*                      | American Indian  | 1.46% (15)     |
|   | Asian or Pacific Islander  | 0.78% (8)      |
|   | Black or African American  | 1.25% (13)     |
|   | Hispanic, Latino or Spanish origin   | 1.76% (18)     |
|   | White  | 96.97% (993)   |
|   | Other  | 0.59% (6)      |
|   | *Note: Of all 1,081 respondents, 5.27% (57) declined to answer. For this question respondents were asked to select all that apply; therefore, responses will not total 100%. |                |
| Highest level of education<br>(n = 1,081)           | Some high school (did not finish)  | 3.89% (42)     |
|   | High school diploma or GED   | 15.26% (165)   |
|   | Technical or trade school certificate  | 3.24% (35)     |
|   | Some college   | 13.78% (149)   |
|   | Associate's degree   | 10.82% (117)   |
|   | Bachelor's degree  | 26.36% (285)   |
|   | Master's degree or higher  | 25.25% (273)   |
|   | Other  | 1.39% (15)     |

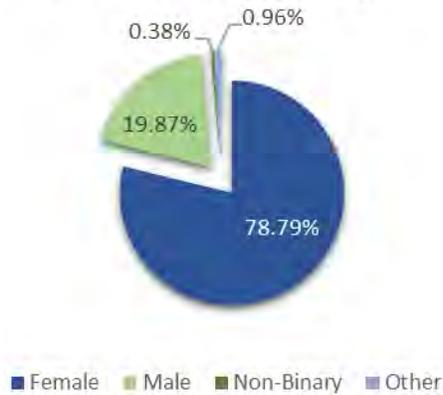


**Table 2 Continued. 2022 Clinton County Community Health Assessment Community Survey, Demographics of Respondents**

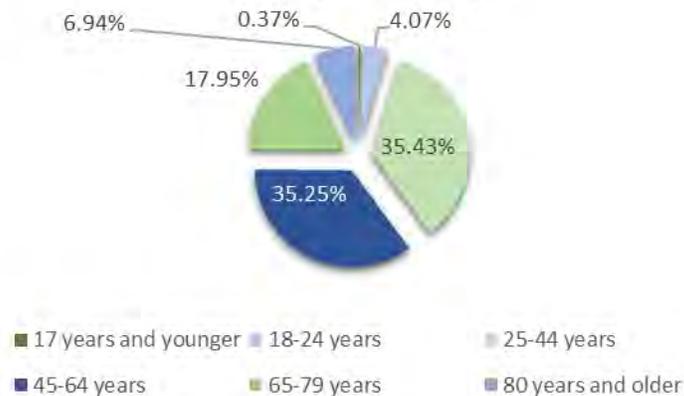
| Demographic                           |  | % (#)        |
|---------------------------------------|--|--------------|
| Household annual income (n = 940)*    | Less than \$10,000   | 4.79% (45)   |
|                                       | \$10,000 - \$24,999  | 11.91% (112) |
|                                       | \$25,000 - \$49,999  | 18.51% (174) |
|                                       | \$50,000 - \$99,999  | 33.94% (319) |
|                                       | \$100,000 - \$149,999  | 19.47% (183) |
|                                       | \$150,000 or more  | 11.38% (107) |
|                                       | <i>*Note: Of all 1,081 respondents, 13.04% (141) declined to answer.</i>   |              |
| Employment Status (n = 1,081)         | Full-time  | 54.12% (585) |
|                                       | Part-time  | 7.86% (85)   |
|                                       | Armed forces   | 0.09% (1)    |
|                                       | Disabled   | 4.72% (51)   |
|                                       | Homemaker  | 3.52% (38)   |
|                                       | Retired  | 22.76% (246) |
|                                       | Student  | 1.94% (21)   |
|                                       | Unemployed   | 2.22% (24)   |
|                                       | Other (please specify)   | 2.78% (30)   |
| Self-reported disabilities (n = 219)* | I am deaf or have serious difficulty hearing.  | 21.92% (48)  |
|                                       | I am blind or have serious difficulty seeing, even when wearing glasses.   | 7.31% (16)   |
|                                       | Because of a physical, mental, or emotional condition, I have serious difficulty concentrating, remembering, or making decisions.  | 36.53% (80)  |
|                                       | I have serious difficulty walking or climbing stairs.  | 52.51% (115) |
|                                       | I have difficulty dressing or bathing.   | 7.76% (17)   |
|                                       | Because of a physical, mental, or emotional condition, I have difficulty doing errands alone, such as visiting a doctor's office or shopping.  | 36.99% (81)  |
|                                       | <i>*Note: Of all 1,081 respondents, 79.74% (862) reported no difficulties; alternatively, 20.26% (219) respondents reported at least one disability. For this question respondents were instructed to select all that apply; therefore, responses will not total 100%.</i> |              |
| Primary Care Provider (n = 1,081)     | Yes  | 90.47% (978) |
|                                       | No   | 9.53% (103)  |



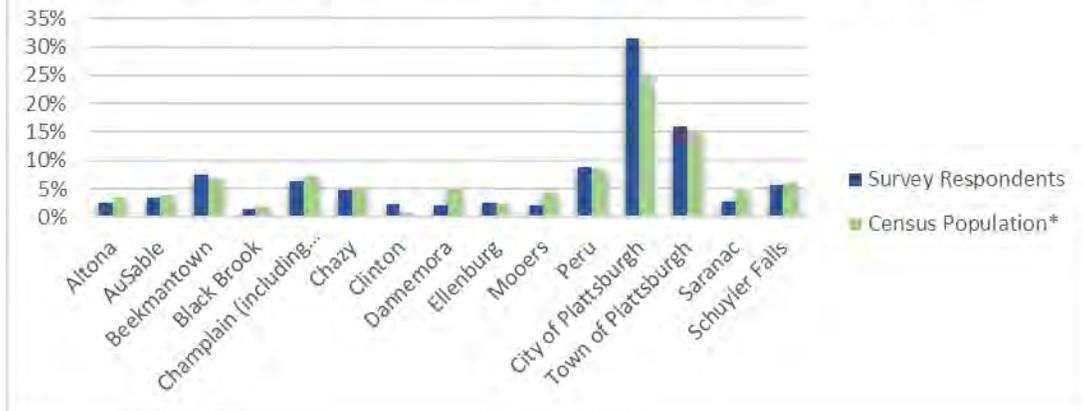
**Figure 1: 2022 Clinton County Community Health Assessment Community Survey: Gender (n=1,042)\***



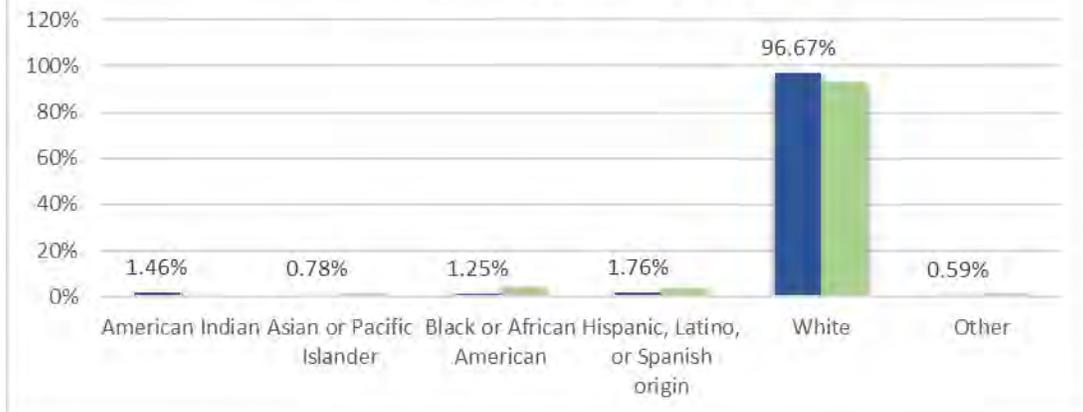
**Figure 2: 2022 Clinton County Community Health Assessment Community Survey: Age (n=1,081)**

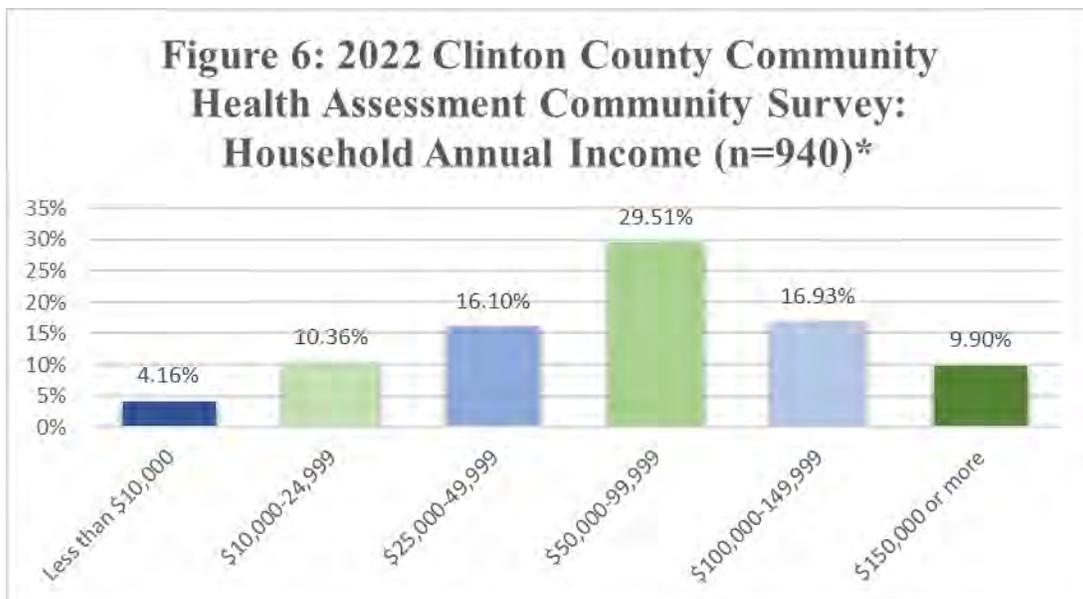
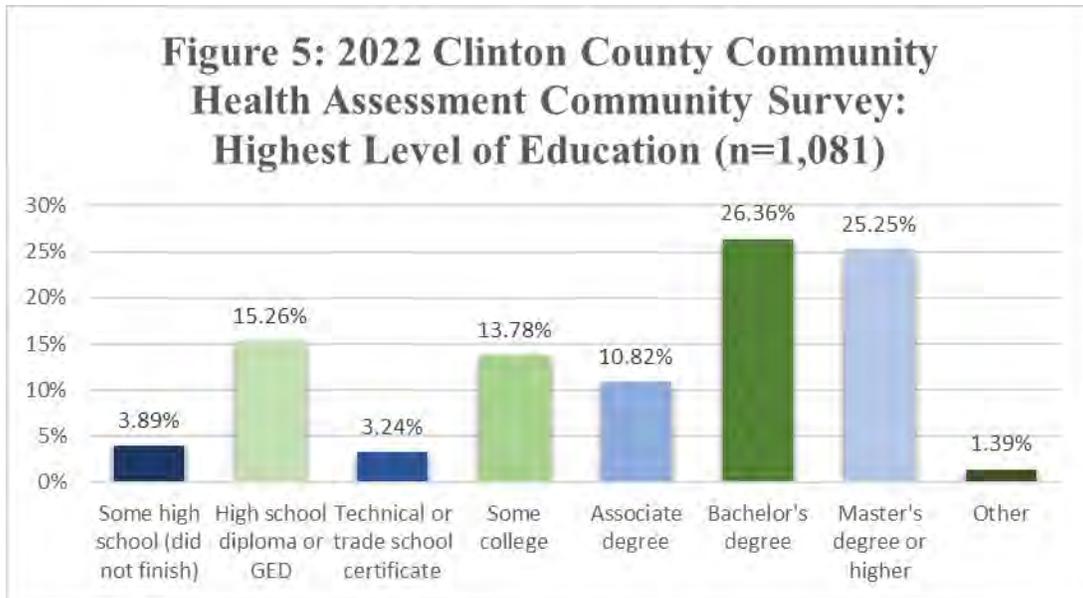


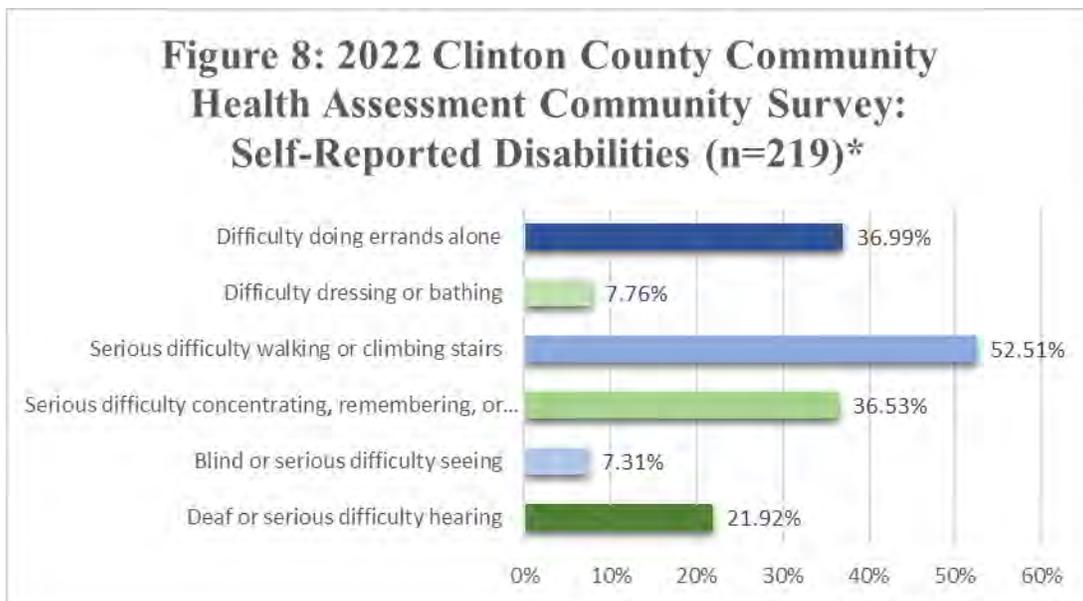
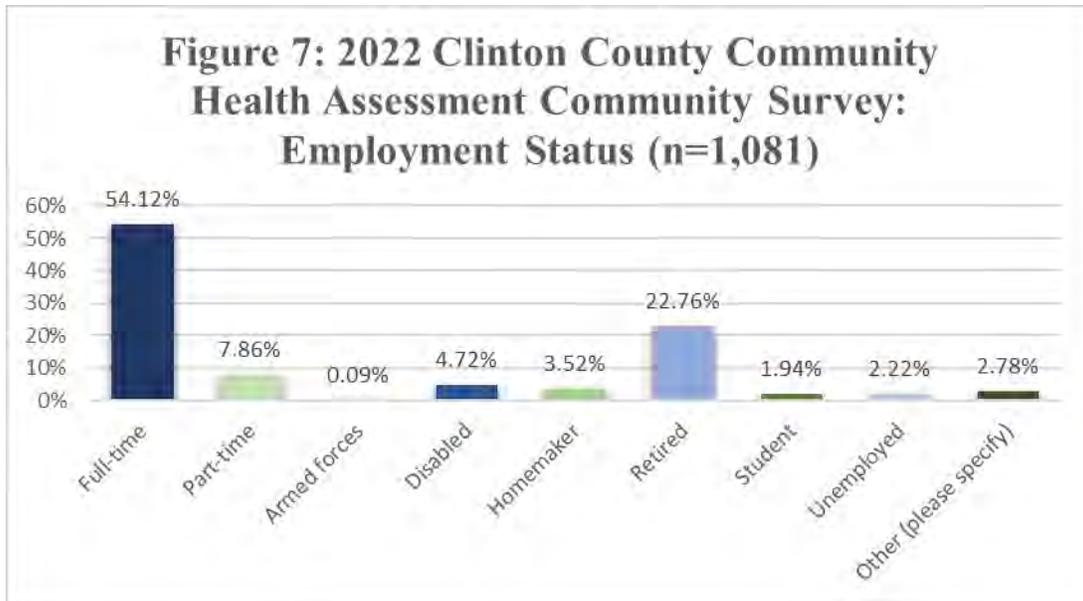
**Figure 3: 2022 Clinton County Community Health Assessment Community Survey: Township of Primary Residence (n=1,081)**



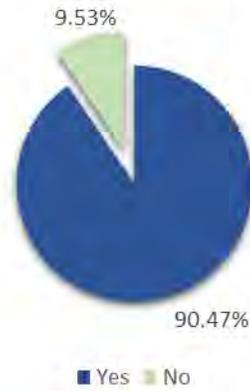
**Figure 4: 2022 Clinton County Community Health Assessment Community Survey: Race/Ethnicity (n=1,024)\***







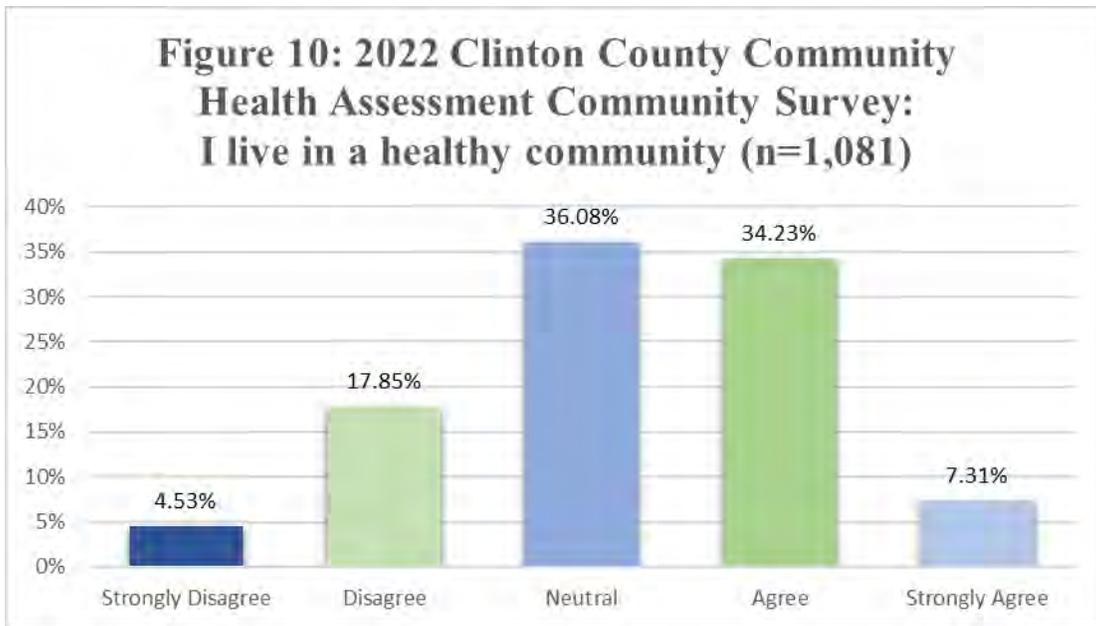
**Figure 9: 2022 Clinton County Community Health Assessment Community Survey: Primary Care Provider (n=1,081)**



**Table 3. 2022 Clinton County Community Health Assessment Community Survey, Living in a Healthy Community**

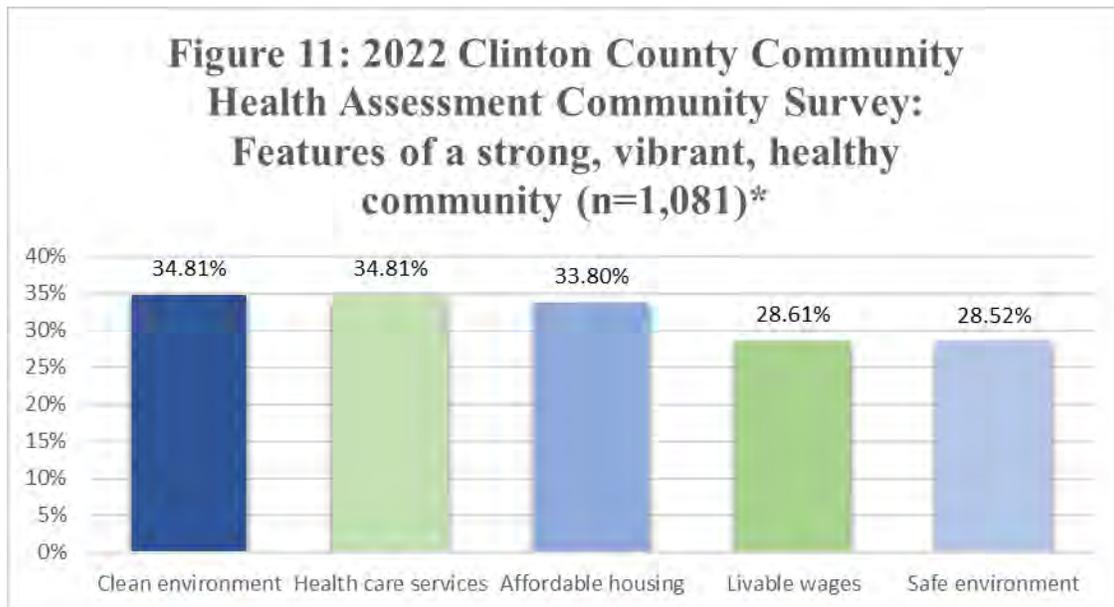
| I live in a healthy community             |                   | % (#)        |
|---|-------------------|--------------|
| I live in a healthy community (n = 1,081) | Strongly Disagree | 4.53% (49)   |
|   | Disagree          | 17.85% (193) |
|   | Neutral           | 36.08% (390) |
|   | Agree             | 34.23% (370) |
|   | Strongly Agree    | 7.31% (79)   |

**Figure 10: 2022 Clinton County Community Health Assessment Community Survey: I live in a healthy community (n=1,081)**



**Table 4. 2022 Clinton County Community Health Assessment Community Survey, Definition of a Healthy Community**

| Features   |                                      | % (#)        |
|--|--------------------------------------|--------------|
| Features of a strong, vibrant, healthy community<br>(n = 1,081*)   | Affordable housing                   | 33.80% (365) |
|  | Clean environment                    | 34.81% (376) |
|  | Diverse populations                  | 6.48% (70)   |
|  | Drug & alcohol free communities      | 19.44% (210) |
|  | Economic opportunities               | 18.52% (200) |
|  | Equality                             | 6.67% (72)   |
|  | Good childcare                       | 8.43% (91)   |
|  | Good schools                         | 24.72% (267) |
|  | Health care services                 | 34.81% (376) |
|  | Healthy food choices                 | 15.65% (169) |
|  | Livable wages                        | 28.61% (309) |
|  | Mental health services               | 15.93% (172) |
|  | Parks & recreation resources         | 16.48% (178) |
|  | Safe environment                     | 28.52% (308) |
|  | Senior housing                       | 6.48% (70)   |
|  | Senior services                      | 9.44% (102)  |
|  | Transportation                       | 6.20% (67)   |
|  | Walkable & bike friendly communities | 12.41% (134) |
| Other  | 3.98% (43)                           |              |
| *Note: For this question respondents were instructed to select up to 3 features; therefore, responses will not total 100%. |                                      |              |



**Table 5. 2022 Clinton County Community Health Assessment Community Survey, Health Challenges of Greatest Concern in Our Community**

| Health Challenges   |  | % (#)        |
|---|--|--------------|
| Health challenges of greatest concern<br>(n = 1,081*)   | Access to dental care  | 23.24% (251) |
|   | Access to health care services   | 35.74% (386) |
|   | Access to health care specialist   | 30.74% (332) |
|   | Access to mental health services   | 36.94% (399) |
|   | Autoimmune disease (ALS, Crohn's, MS, RA, etc)   | 6.11% (66)   |
|   | Cancer   | 20.56% (222) |
|   | Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.) | 31.20% (337) |
|   | Falls  | 6.57% (71)   |
|   | Immunization rates   | 7.41% (80)   |
|   | Infectious disease (hepatitis A, B or C, flu, COVID-19, etc.)                                  | 14.91% (161) |
|   | Health concerns of intellectual or developmental disabilities                                  | 7.78% (84)   |
|   | Health concerns of physical disabilities   | 5.93% (64)   |
|   | Issues related to aging (arthritis, hearing/vision loss, etc.)                                 | 20.93% (226) |
|   | Lung disease (asthma, COPD, etc.)  | 4.91% (53)   |
|   | Mental Health  | 39.07% (422) |
|   | Overweight/obesity   | 36.02% (389) |
|   | Physical activity  | 22.13% (239) |
|   | Prenatal care/maternal & infant health   | 5.37% (58)   |
|   | Sexually transmitted infections (including HIV)  | 1.57% (17)   |
|   | Smoking or tobacco use (including e-cigarettes or vaping)                                      | 14.26% (154) |
| Substance abuse (drugs, alcohol, etc.)  | 44.26% (478)   |              |
| Suicide (completed or attempted)  | 10.56% (114)   |              |
| Vector-Borne disease (Lyme Disease, West Nile Virus, etc.)  | 6.94% (75)   |              |
| Other   | 5.74% (62)   |              |
| *Note: For this question respondents were instructed to select up to 5 health challenges; therefore, responses will not total 100%. |  |              |

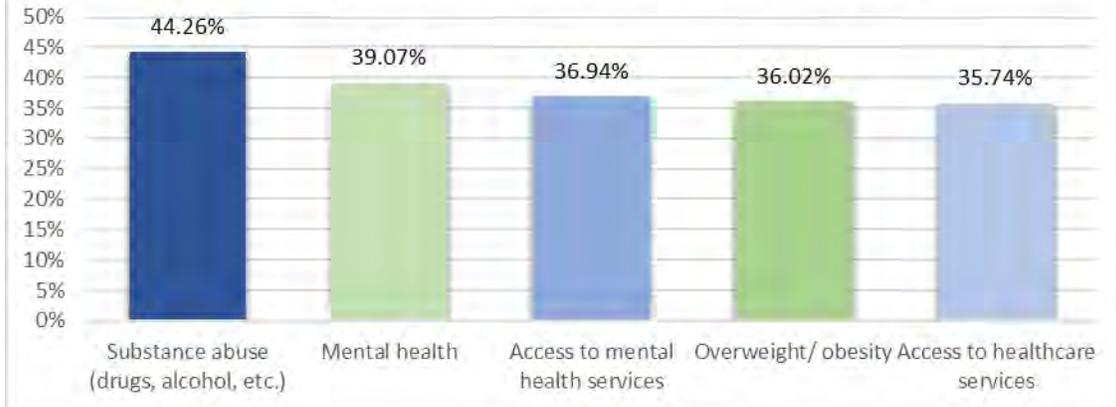


**Table 6. 2022 Clinton County Community Health Assessment Community Survey, Self-reported Health Challenges Experienced by Residents Within the Past Year**

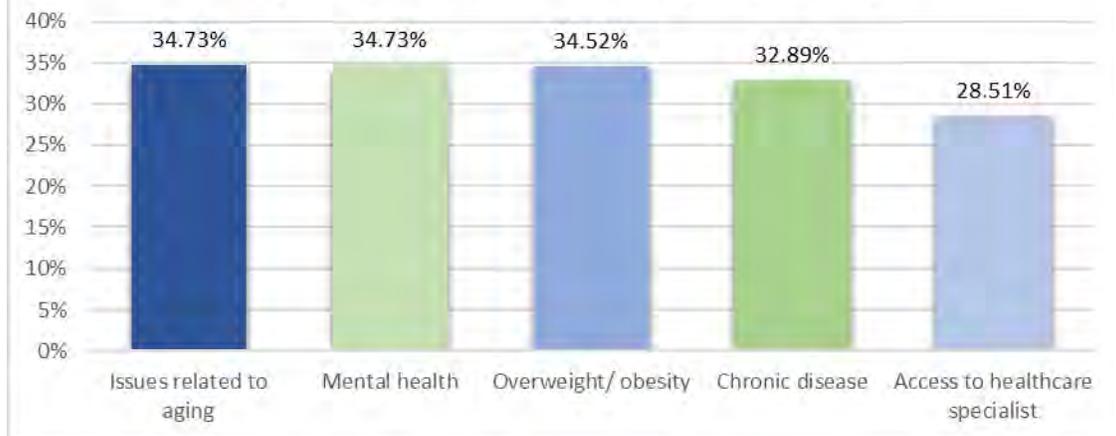
| Health Challenges  |  | % (#)        |
|--|--|--------------|
| Self-reported health challenges<br>(n = 982*)  | Access to dental care  | 23.63% (232) |
|  | Access to health care services   | 18.84% (185) |
|  | Access to health care specialist   | 28.51% (280) |
|  | Access to mental health services   | 21.28% (209) |
|  | Autoimmune disease (ALS, Crohn's, MS, RA, etc)   | 12.22% (120) |
|  | Cancer   | 15.38% (151) |
|  | Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.) | 32.89% (323) |
|  | Falls  | 11.71% (115) |
|  | Immunization rates   | 9.98% (98)   |
|  | Infectious disease (hepatitis A, B or C, flu, COVID-19, etc.)                                  | 20.01% (197) |
|  | Health concerns of intellectual or developmental disabilities                                  | 6.42% (63)   |
|  | Health concerns of physical disabilities   | 9.88% (97)   |
|  | Issues related to aging (arthritis, hearing/vision loss, etc.)                                 | 34.73% (341) |
|  | Lung disease (asthma, COPD, etc.)  | 13.54% (133) |
|  | Mental Health  | 34.73% (341) |
|  | Overweight/obesity   | 34.52% (339) |
|  | Physical activity  | 25.25% (248) |
|  | Prenatal care/maternal & infant health   | 3.77% (37)   |
|  | Sexually transmitted infections (including HIV)  | 0.92% (9)    |
|  | Smoking or tobacco use (including e-cigarettes or vaping)                                      | 10.69% (105) |
| Substance abuse (drugs, alcohol, etc.)   | 11.61% (114)   |              |
| Suicide (completed or attempted)   | 4.07% (40)   |              |
| Vector-Borne disease (Lyme Disease, West Nile Virus, etc.)   | 5.60% (55)   |              |
| Other  | 8.15% (80)   |              |
| <p><i>*Note:</i> For this question, respondents were asked, "What health challenges have you or a family member had in the past year?" and instructed to select all that apply; therefore, responses will not total 100%. Of all 1,081 respondents, 9.16% (99) reported no health challenges in the past year. Alternatively, 90.84% (982) respondents reported experiencing at least one health challenge in the past year.</p> |  |              |



**Figure 12: 2022 Clinton County Community Health Assessment Community Survey: Health Challenges of Greatest Concern (n=1,081)\***

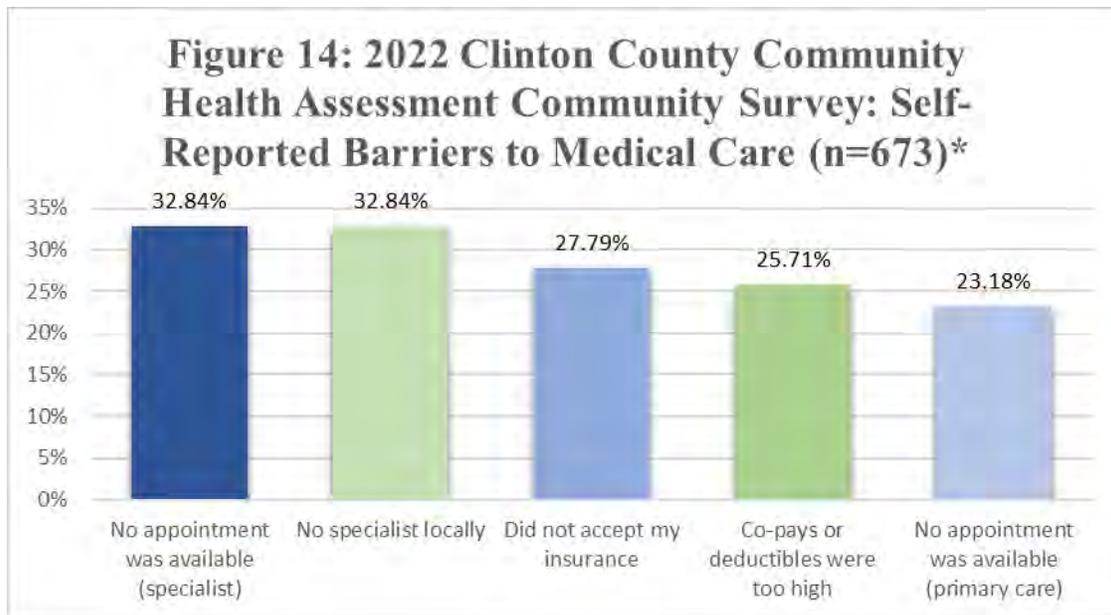


**Figure 13: 2022 Clinton County Community Health Assessment Community Survey: Self-Reported Health Challenges (n=982)\***



**Table 7. 2022 Clinton County Community Health Assessment Community Survey, Self-reported Barriers to Medical Care Experienced by Residents Within the Past Year**

| Barriers to medical care  |  | % (#)        |
|---|--|--------------|
| Self-reported barriers to medical care<br>(n = 673*)  | Co-pays or deductibles were too high   | 25.71% (173) |
|   | Could not afford (including co-pays or deductibles that were too high)       | 23.03% (155) |
|   | Could not leave work/school  | 21.55% (145) |
|   | Did not accept my insurance  | 27.79% (187) |
|   | Did not have a health care provider  | 12.93% (87)  |
|   | Did not have childcare   | 9.36% (63)   |
|   | Did not have dental or vision insurance                                      | 22.29% (150) |
|   | Did not have medical insurance   | 5.65% (38)   |
|   | Did not have transportation  | 11.00% (74)  |
|   | No access for people with physical disabilities                              | 1.93% (13)   |
|   | No accommodations for people with intellectual or developmental disabilities | 1.78% (12)   |
|   | No appointment was available (primary care)                                  | 23.18% (156) |
|   | No appointment was available (specialist)                                    | 32.84% (221) |
|   | No specialist locally  | 32.84% (221) |
|   | No veteran services locally  | 3.12% (21)   |
|   | Provider did not speak my language   | 0.30% (2)    |
|   | Other  | 11.89% (80)  |
| <p><i>*Note:</i> For this question respondents were asked, “If there was a time in the past year that you or a family member needed medical care but could not get it, why did you not get care?” and instructed to select all that apply; therefore, responses will not total 100%. Of all 1,081 respondents, 37.74% (408) reported no barriers to medical care in the past year; alternatively, 62.26% (673) respondents reported experiencing at least one barrier to medical care in the past year.</p> |  |              |



**Table 8. 2022 Clinton County Community Health Assessment Community Survey, Social Challenges of Greatest Concern in Our Community**

| Social Challenges   |  | % (#)        |
|---|--|--------------|
| Social challenges of greatest concern<br>(n = 1,081*)   | Access to healthy foods  | 26.27% (284) |
|   | Access to opportunities for health for those with intellectual or developmental disabilities | 9.81% (106)  |
|   | Access to opportunities for health for those with physical limitations or disabilities       | 12.67% (137) |
|   | Affordable housing   | 43.20% (467) |
|   | Bullying   | 19.52% (211) |
|   | Child abuse/neglect  | 24.33% (263) |
|   | Childcare  | 22.94% (248) |
|   | Crime/vandalism  | 18.96% (205) |
|   | Domestic violence  | 18.22% (197) |
|   | Elder abuse/neglect  | 10.64% (115) |
|   | Homelessness   | 13.88% (150) |
|   | Hunger   | 13.23% (143) |
|   | Incarceration rates (number of people in jail)   | 2.96% (32)   |
|   | Lack of employment opportunities   | 20.81% (225) |
|   | Lack of a livable wage   | 39.13% (423) |
|   | Lack of support/resources for LGBTQ+   | 6.11% (66)   |
|   | Lack of support/resources for seniors  | 16.37% (177) |
|   | Lack of support/resources for veterans   | 10.82% (117) |
|   | Lack of support/resources for youth  | 14.52% (157) |
|   | Opportunities for physical activity  | 17.39% (188) |
|   | Racial or cultural discrimination  | 9.99% (108)  |
| Safe recreational areas   | 17.67% (191)   |              |
| Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)  | 17.02% (184)   |              |
| Transportation  | 17.58% (190)   |              |
| Other   | 5.46% (59)   |              |
| *Note: For this question respondents were instructed to select up to 5 social challenges; therefore, responses will not total 100%. |  |              |

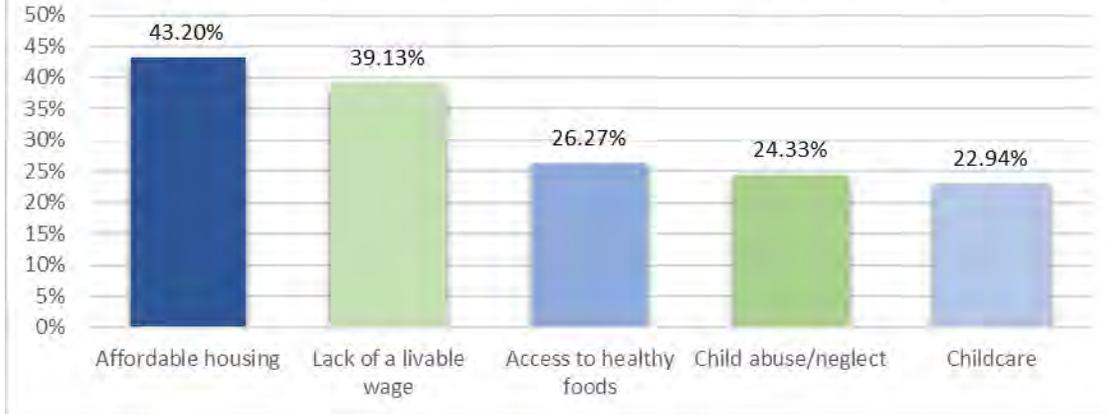


**Table 9. 2022 Clinton County Community Health Assessment Community Survey, Self-reported Social Challenges Experienced by Residents Within the Past Year**

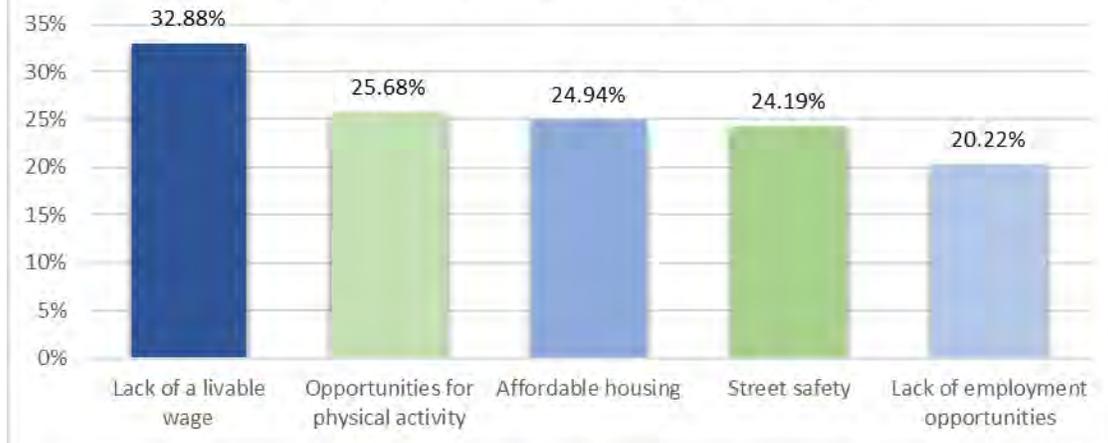
| Social Challenges  |  | % (#)        |
|--|--|--------------|
| Self-reported social challenges<br>(n = 806*)  | Access to healthy foods  | 17.37% (140) |
|  | Access to opportunities for health for those with intellectual or developmental disabilities | 5.71% (46)   |
|  | Access to opportunities for health for those with physical limitations or disabilities       | 9.93% (80)   |
|  | Affordable housing   | 24.94% (201) |
|  | Bullying   | 13.28% (107) |
|  | Child abuse/neglect  | 3.72% (30)   |
|  | Childcare  | 15.38% (124) |
|  | Crime/vandalism  | 6.82% (55)   |
|  | Domestic violence  | 5.21% (42)   |
|  | Elder abuse/neglect  | 5.21% (42)   |
|  | Homelessness   | 3.85% (31)   |
|  | Hunger   | 4.09% (33)   |
|  | Incarceration rates (number of people in jail)   | 0.74% (6)    |
|  | Lack of employment opportunities   | 20.22% (163) |
|  | Lack of a livable wage   | 32.88% (265) |
|  | Lack of support/resources for LGBTQ+   | 5.83% (47)   |
|  | Lack of support/resources for seniors  | 17.00% (137) |
|  | Lack of support/resources for veterans   | 7.94% (64)   |
|  | Lack of support/resources for youth  | 12.66% (102) |
|  | Opportunities for physical activity  | 25.68% (207) |
|  | Racial or cultural discrimination  | 5.96% (48)   |
| Safe recreational areas  | 15.76% (127)   |              |
| Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)   | 24.19% (195)   |              |
| Transportation   | 16.13% (130)   |              |
| Other  | 7.82% (63)   |              |
| <p><i>*Note:</i> For this question, respondents were asked, "What social challenges have you or a family member had in the past year?" and instructed to select all that apply; therefore, responses will not total 100%. Of all 1,081 respondents, 25.44% (275) reported no social challenges in the past year. Alternatively, 74.56% (806) respondents reported experiencing at least one social challenge in the past year.</p> |  |              |



**Figure 15: 2022 Clinton County Community Health Assessment Community Survey: Social Challenges of Greatest Concern (n=1,081)\***



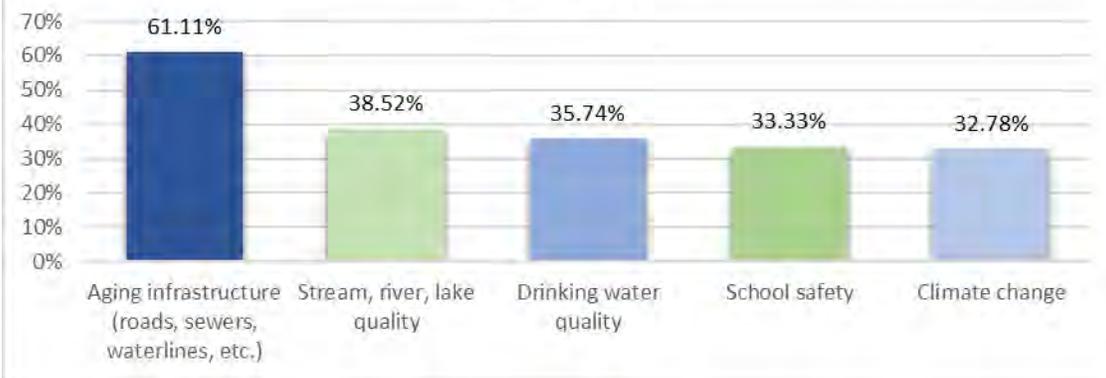
**Figure 16: 2022 Clinton County Community Health Assessment Community Survey: Self-Reported Social Challenges (n=806)\***



**Table 10. 2022 Clinton County Community Health Assessment Community Survey, Environmental Challenges of Greatest Concern in Our Community**

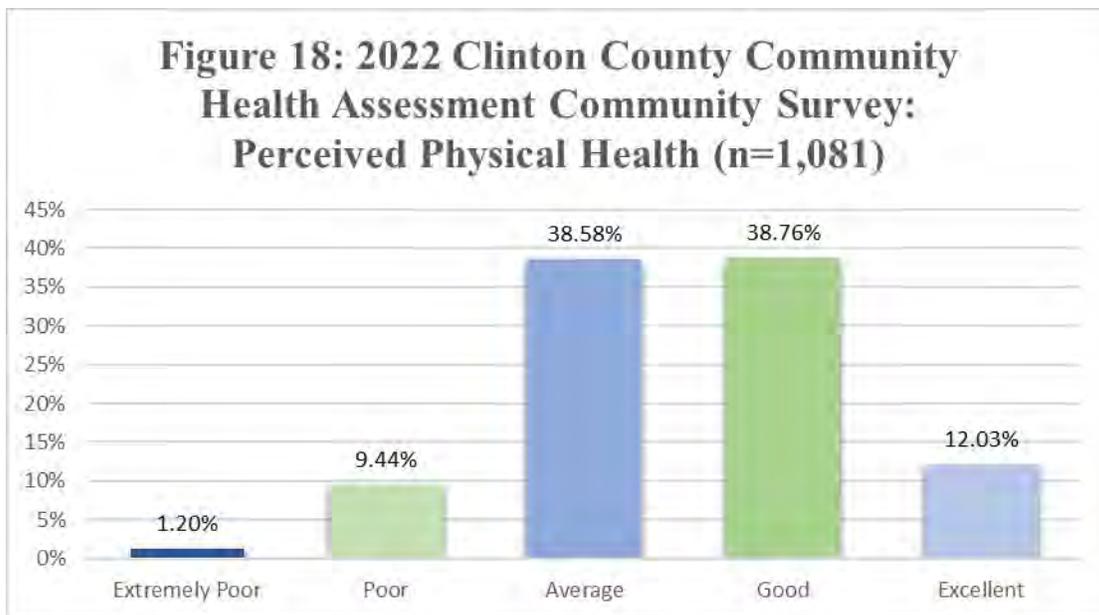
| Environmental Challenges   |  | % (#)        |
|--|--|--------------|
| Environmental challenges of greatest concern<br>(n = 1,081*)   | Aging infrastructure (roads, sewers, waterlines, etc.) | 61.11% (660) |
|  | Agricultural runoff (manure, pesticides, etc.)         | 24.44% (264) |
|  | Air pollution  | 14.44% (156) |
|  | Climate change   | 32.78% (354) |
|  | Drinking water quality                                 | 35.74% (386) |
|  | Exposure to tobacco smoke                              | 12.22% (132) |
|  | Failing septic systems                                 | 10.74% (116) |
|  | Flooding/soil drainage                                 | 8.43% (91)   |
|  | Home safety  | 20.19% (218) |
|  | Lead-based paint hazards                               | 4.44% (48)   |
|  | Nuisance wildlife/stray animals                        | 11.57% (125) |
|  | Safe food  | 18.24% (197) |
|  | School safety  | 33.33% (360) |
|  | Stream, river, lake quality                            | 38.52% (416) |
|  | Vector-borne diseases (mosquitos, ticks, etc.)         | 25.65% (277) |
|  | Waste disposal/recycling                               | 30.19% (326) |
| Other  | 3.89% (42)   |              |
| *Note: For this question respondents were instructed to select up to 5 environmental challenges; therefore, responses will not total 100%. |  |              |

**Figure 17: 2022 Clinton County Community Health Assessment Community Survey: Environmental Challenges of Greatest Concern (n=1,081)**



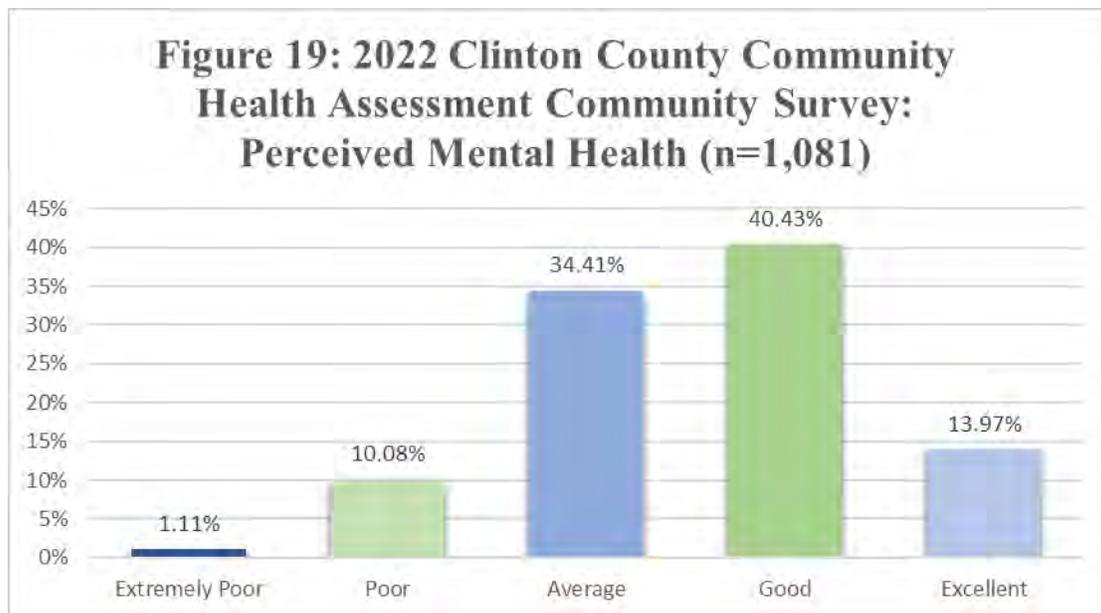
**Table 11. 2022 Clinton County Community Health Assessment Community Survey, Self-Perceived Physical Health**

| My physical health is...                |                | % (#)        |
|---|----------------|--------------|
| My physical health is...<br>(n = 1,081) | Extremely Poor | 1.20% (13)   |
|   | Poor           | 9.44% (102)  |
|   | Average        | 38.58% (417) |
|   | Good           | 38.76% (419) |
|   | Excellent      | 12.03% (130) |



**Table 12. 2022 Clinton County Community Health Assessment Community Survey, Self-Perceived Mental Health**

| My mental health is...                |                | % (#)        |
|---------------------------------------|----------------|--------------|
| My mental health is...<br>(n = 1,081) | Extremely Poor | 1.11% (12)   |
|                                       | Poor           | 10.08% (109) |
|                                       | Average        | 34.41% (372) |
|                                       | Good           | 40.43% (437) |
|                                       | Excellent      | 13.97% (151) |



**Table 13. 2022 Clinton County Community Health Assessment Community Survey, Top Features of a Healthy Community and Self-Reported Physical Health (n=1,081\*)**

| Physical Health Status | Feature 1            | %      | Feature 2            | %      | Feature 3              | %      |
|------------------------|----------------------|--------|----------------------|--------|------------------------|--------|
| Extremely Poor         | Affordable housing   | 69.23% | Livable wages        | 46.15% | Health care services   | 38.46% |
| Poor                   | Affordable housing   | 45.10% | Safe environment     | 34.31% | Health care services   | 33.33% |
| Average                | Health care services | 35.25% | Affordable housing   | 34.53% | Livable wages          | 32.37% |
| Good                   | Clean environment    | 37.23% | Health care services | 36.28% | Affordable housing     | 31.98% |
| Excellent              | Clean environment    | 43.85% | Health care services | 29.23% | Economic opportunities | 26.15% |

\*Note: For this question, respondents were asked, "When you imagine a strong, vibrant, healthy community, what are the most important features you think of?" and instructed to select 3 choices; therefore, responses will not total 100%.

**Table 14. 2022 Clinton County Community Health Assessment Community Survey, Top Features of a Healthy Community and Self-Reported Mental Health (n=1,081\*)**

| Physical Health Status | Feature 1          | %      | Feature 2            | %      | Feature 3            | %      |
|------------------------|--------------------|--------|----------------------|--------|----------------------|--------|
| Extremely Poor         | Affordable housing | 50.00% | Livable wages        | 50.00% | Safe environment     | 41.67% |
| Poor                   | Affordable housing | 39.45% | Livable wages        | 38.53% | Health care services | 35.78% |
| Average                | Livable wages      | 34.14% | Affordable housing   | 33.06% | Health care services | 32.53% |
| Good                   | Clean environment  | 39.82% | Health care services | 38.44% | Affordable housing   | 32.27% |
| Excellent              | Clean environment  | 41.72% | Affordable housing   | 34.44% | Safe environment     | 30.46% |

\*Note: For this question, respondents were asked, "When you imagine a strong, vibrant, healthy community, what are the most important features you think of?" and instructed to select 3 choices; therefore, responses will not total 100%.

**Table 15. 2022 Clinton County Community Health Assessment Community Survey, Self-Reported Physical Health and Healthy Communities (n=1,081\*)**

| Physical Health | I live in a healthy community... |          |         |        |                |
|-----------------|----------------------------------|----------|---------|--------|----------------|
|                 | Strongly Disagree                | Disagree | Neutral | Agree  | Strongly Agree |
| Extremely Poor  | 7.69%                            | 7.69%    | 38.46%  | 38.46% | 7.69%          |
| Poor            | 7.84%                            | 25.49%   | 42.16%  | 19.61% | 4.90%          |
| Average         | 3.36%                            | 18.71%   | 41.49%  | 29.02% | 7.43%          |
| Good            | 5.25%                            | 16.23%   | 31.03%  | 41.29% | 6.21%          |
| Excellent       | 3.08%                            | 15.38%   | 30.00%  | 39.23% | 12.31%         |

**Table 16. 2022 Clinton County Community Health Assessment Community Survey, Self-Reported Mental Health and Healthy Communities (n=1,081\*)**

| Mental Health  | I live in a healthy community... |          |         |        |                |
|----------------|----------------------------------|----------|---------|--------|----------------|
|                | Strongly Disagree                | Disagree | Neutral | Agree  | Strongly Agree |
| Extremely Poor | 7.69%                            | 7.69%    | 38.46%  | 38.46% | 7.69%          |
| Poor           | 7.84%                            | 25.49%   | 42.16%  | 19.61% | 4.90%          |
| Average        | 3.36%                            | 18.71%   | 41.49%  | 29.02% | 7.43%          |
| Good           | 5.25%                            | 16.23%   | 31.03%  | 41.29% | 6.21%          |
| Excellent      | 3.08%                            | 15.38%   | 30.00%  | 39.23% | 12.31%         |



# 2022

## Community Health Assessment Clinton County, New York

### Community Survey

#### Introduction

The Clinton County Health Department (CCHD) and the UVM Health Network-CVPH are completing a community health assessment. As part of this process we are conducting a survey to assess the top health needs of our community. Your input will help shape our goals for future community health initiatives. We want to hear from you!

The survey will take about 5-10 minutes to complete. Your participation is voluntary.

Thank you for your time.

To take this survey online visit:

<https://www.surveymonkey.com/r/CHA2022>



November 2021

## Healthy Community

Please tell us your definition of a healthy community.

### 1. I live in a healthy community.

- Strongly Disagree
         
  Disagree
         
  Neutral
         
  Agree
         
  Strongly Agree

### 2. When you imagine a strong, vibrant, healthy community, what are the most important features you think of?

(Choose up to 3.)

- |   |  |
|---|--|
| <input type="radio"/> Affordable housing              | <input type="radio"/> Livable wages                        |
| <input type="radio"/> Clean environment               | <input type="radio"/> Mental health services               |
| <input type="radio"/> Diverse populations             | <input type="radio"/> Parks & recreation resources         |
| <input type="radio"/> Drug & alcohol free communities | <input type="radio"/> Safe environment                     |
| <input type="radio"/> Economic opportunities          | <input type="radio"/> Senior housing                       |
| <input type="radio"/> Equality                        | <input type="radio"/> Senior services                      |
| <input type="radio"/> Good childcare                  | <input type="radio"/> Transportation                       |
| <input type="radio"/> Good schools                    | <input type="radio"/> Walkable & bike friendly communities |
| <input type="radio"/> Health care services            | <input type="radio"/> Other (please specify) _____         |
| <input type="radio"/> Healthy food choices            | _____  |

## Challenges in Our Community

Please tell us what health, social and environmental challenges you feel are of greatest concern in our community.

### 3. When you think about health challenges in the community where you live, what are you most concerned about?

(Choose up to 5.)

- Access to dental care
- Access to healthcare services
- Access to healthcare specialist
- Access to mental health services
- Autoimmune disease  
(ALS, Crohn's, MS, RA, etc.)
- Cancer
- Chronic disease  
(diabetes, heart disease, high blood pressure,  
high cholesterol, stroke, etc.)
- Falls
- Immunization rates
- Infectious disease  
(hepatitis A, B or C, flu, COVID-19, etc.)
- Health concerns of intellectual or  
developmental disabilities
- Health concerns of physical disabilities
- Issues related to aging  
(arthritis, hearing/vision loss, etc.)
- Lung disease (asthma, COPD, etc.)
- Mental health
- Overweight/obesity
- Physical activity
- Prenatal care/maternal & infant health
- Sexually transmitted infections (including HIV)
- Smoking or tobacco use  
(including e-cigarettes or vaping)
- Substance abuse (drugs, alcohol, etc.)
- Suicide (completed or attempted)
- Vector-borne Disease  
(Lyme Disease, West Nile Virus, etc.)
- Other (please specify) \_\_\_\_\_  
\_\_\_\_\_

## Community Health Assessment

Clinton County, New York

4. When you think about social challenges in the community where you live, what are you most concerned about?

(Choose up to 5.)

- |  |   |
|--|---|
| <input type="radio"/> Access to healthy foods  | <input type="radio"/> Lack of employment opportunities                                    |
| <input type="radio"/> Access to opportunities for health for those with intellectual or developmental disabilities | <input type="radio"/> Lack of a livable wage  |
| <input type="radio"/> Access to opportunities for health for those with physical limitations or disabilities       | <input type="radio"/> Lack of support/resources for LGBTQ+                                |
| <input type="radio"/> Affordable housing   | <input type="radio"/> Lack of support/resources for seniors                               |
| <input type="radio"/> Bullying   | <input type="radio"/> Lack of support/resources for veterans                              |
| <input type="radio"/> Child abuse/neglect  | <input type="radio"/> Lack of support/resources for youth                                 |
| <input type="radio"/> Childcare  | <input type="radio"/> Opportunities for physical activity                                 |
| <input type="radio"/> Crime/vandalism  | <input type="radio"/> Racial or cultural discrimination                                   |
| <input type="radio"/> Domestic violence  | <input type="radio"/> Safe recreational areas   |
| <input type="radio"/> Elder abuse/neglect  | <input type="radio"/> Street safety<br>(crosswalks, shoulders, bike lanes, traffic, etc.) |
| <input type="radio"/> Homelessness   | <input type="radio"/> Transportation  |
| <input type="radio"/> Hunger   | <input type="radio"/> Other (please specify) _____  |
| <input type="radio"/> Incarceration rates (number of people in jail)   | _____   |

5. When you think about environmental challenges in the community where you live, what are you most concerned about?

(Choose up to 5.)

- |   |  |
|---|--|
| <input type="radio"/> Aging infrastructure<br>(roads, sewers, waterlines, etc.) | <input type="radio"/> Lead-based paint hazards                       |
| <input type="radio"/> Agricultural runoff (manure, pesticides, etc.)            | <input type="radio"/> Nuisance wildlife/stray animals                |
| <input type="radio"/> Air pollution   | <input type="radio"/> Safe food                                      |
| <input type="radio"/> Climate change  | <input type="radio"/> School safety                                  |
| <input type="radio"/> Drinking water quality                                    | <input type="radio"/> Stream, river, lake quality                    |
| <input type="radio"/> Exposure to tobacco smoke                                 | <input type="radio"/> Vector-borne diseases (mosquitos, ticks, etc.) |
| <input type="radio"/> Failing septic systems                                    | <input type="radio"/> Waste disposal/recycling                       |
| <input type="radio"/> Flooding/soil drainage                                    | <input type="radio"/> Other (please specify) _____                   |
| <input type="radio"/> Home safety   | _____  |

## Individual Challenges

Please tell us what health and social challenges have been of greatest concern for you or your family members.

### 6. What health challenges have you or a family member had in the past year?

(Select all that apply.)

- Access to dental care
- Access to healthcare services
- Access to healthcare specialist
- Access to mental health services
- Autoimmune disease  
(ALS, Crohn's, MS, RA, etc.)
- Cancer
- Chronic disease  
(diabetes, heart disease, high blood pressure,  
high cholesterol, stroke, etc.)
- Falls
- Immunization
- Infectious disease  
(hepatitis A, B or C, flu, COVID-19, etc.)
- Health concerns of intellectual or  
developmental disabilities
- Health concerns of physical disabilities
- Issues related to aging  
(arthritis, hearing/vision loss, etc.)
- Lung disease (asthma, COPD, etc.)
- Mental health
- Overweight/obesity
- Physical activity
- Prenatal care/maternal & infant health
- Sexually transmitted infections (including HIV)
- Smoking or tobacco use  
(including e-cigarettes or vaping)
- Substance abuse (drugs, alcohol, etc.)
- Suicide (completed or attempted)
- Vector-borne Disease  
(Lyme Disease, West Nile Virus, etc.)
- Other (please specify) \_\_\_\_\_  
\_\_\_\_\_

**7. What social challenges have you or a family member had in the past year?****(Select all that apply.)**

- Access to healthy foods
- Access to opportunities for health for those with intellectual or developmental disabilities
- Access to opportunities for health for those with physical limitations or disabilities
- Affordable housing
- Bullying
- Child abuse/neglect
- Childcare
- Crime/vandalism
- Domestic violence
- Elder abuse/neglect
- Homelessness
- Hunger
- Incarceration rates (number of people in jail)
- Lack of employment opportunities
- Lack of a livable wage
- Lack of support/resources for LGBTQ+
- Lack of support/resources for seniors
- Lack of support/resources for veterans
- Lack of support/resources for youth
- Opportunities for physical activity
- Racial or cultural discrimination
- Safe recreational areas
- Street safety  
(crosswalks, shoulders, bike lanes, traffic, etc.)
- Transportation
- Other (please specify) \_\_\_\_\_  
\_\_\_\_\_

8. If there was a time in the past year that you or a family member needed medical care but could not get it, why did you not get care?

(Select all that apply.)

- Co-pays or deductibles were too high
- Could not afford (including co-pays or deductibles that were too high)
- Could not leave work/school
- Did not accept my insurance
- Did not have a healthcare provider
- Did not have childcare
- Did not have dental or vision insurance
- Did not have medical insurance
- Did not have transportation
- No access for people with physical disabilities
- No accommodations for people with intellectual or developmental disabilities
- No appointment was available (primary care)
- No appointment was available (specialist)
- No specialist locally
- No veteran services locally
- Provider did not speak my language
- Other (please specify) \_\_\_\_\_  
\_\_\_\_\_
- N/A

## Demographics

Please tell us more about yourself and your household. This information lets us know we have collected responses from many different residents.

### 9. What gender do you identify with?

- Female
  Prefer not to answer  
 Male
  Other \_\_\_\_\_  
 Non-binary
 \_\_\_\_\_

### 10. What is your age?

- 17 years and under
  45-64 years  
 18-24 years
  65-79 years  
 25-44 years
  80 years and over

### 11. What city/town do you live in?

(Select only one based on your primary residence.)

- Altona
  Ellenburg  
 AuSable
  Mooers  
 Beekmantown
  Peru  
 Black Brook
  Plattsburgh (City of)  
 Champlain (including Rouses Point)
  Plattsburgh (Town of)  
 Chazy
  Saranac  
 Clinton
  Schuyler Falls  
 Dannemora
  Other (please specify) \_\_\_\_\_  
 \_\_\_\_\_

**12. What is the primary language spoken in your household?**

- |   |  |
|---|--|
| <input type="radio"/> English                 | <input type="radio"/> 한국의 (Korean)                 |
| <input type="radio"/> American Sign Language  | <input type="radio"/> Polski (Polish)              |
| <input type="radio"/> 中文 (Chinese)            | <input type="radio"/> Русский (Russian)            |
| <input type="radio"/> Français (French)       | <input type="radio"/> Español (Spanish)            |
| <input type="radio"/> Kreyòl (Haitian-Creole) | <input type="radio"/> Other (please specify) _____ |
| <input type="radio"/> Italiano (Italian)      | _____  |

**13. What is your race?****(Select all that apply.)**

- |  |  |
|--|--|
| <input type="radio"/> American Indian or Alaskan Native  | <input type="radio"/> White                        |
| <input type="radio"/> Asian or Pacific Islander          | <input type="radio"/> Prefer not to answer         |
| <input type="radio"/> Black or African American          | <input type="radio"/> Other (please specify) _____ |
| <input type="radio"/> Hispanic, Latino or Spanish origin | _____  |

**14. What is your highest level of education?**

- |   |  |
|---|--|
| <input type="radio"/> Some high school (did not finish)     | <input type="radio"/> Associate's degree           |
| <input type="radio"/> High school diploma or GED            | <input type="radio"/> Bachelor's degree            |
| <input type="radio"/> Technical or trade school certificate | <input type="radio"/> Master's degree or higher    |
| <input type="radio"/> Some college                          | <input type="radio"/> Other (please specify) _____ |
|   | _____  |

**15. What is your household's annual income?**

- |  |  |
|--|--|
| <input type="radio"/> Less than \$10,000 | <input type="radio"/> \$100,000—\$149,999  |
| <input type="radio"/> \$10,000—\$24,999  | <input type="radio"/> \$150,000 or more    |
| <input type="radio"/> \$25,000—\$49,999  | <input type="radio"/> Prefer not to answer |
| <input type="radio"/> \$50,000—\$99,999  |  |

**16. What is your primary employment status?**

- Full-time
  Retired  
 Part-time
  Student  
 Armed forces
  Unemployed  
 Disabled
  Other (please specify) \_\_\_\_\_  
 Homemaker
 \_\_\_\_\_

**17. Do you have a primary care provider?**

- Yes  
 No

**18. Do any of the following apply to you?****(Select all that apply.)**

- I am deaf or have serious difficulty hearing.  
 I am blind or have serious difficulty seeing, even when wearing glasses.  
 Because of a physical, mental, or emotional condition, I have serious difficulty concentrating, remembering, or making decisions.  
 I have serious difficulty walking or climbing stairs.  
 I have difficulty dressing or bathing.  
 Because of a physical, mental, or emotional condition, I have difficulty doing errands alone, such as visiting a doctor's office or shopping.  
 N/A

**19. My physical health is...**

- Extremely Poor
  Poor
  Average
  Good
  Excellent

**20. My mental health is...**

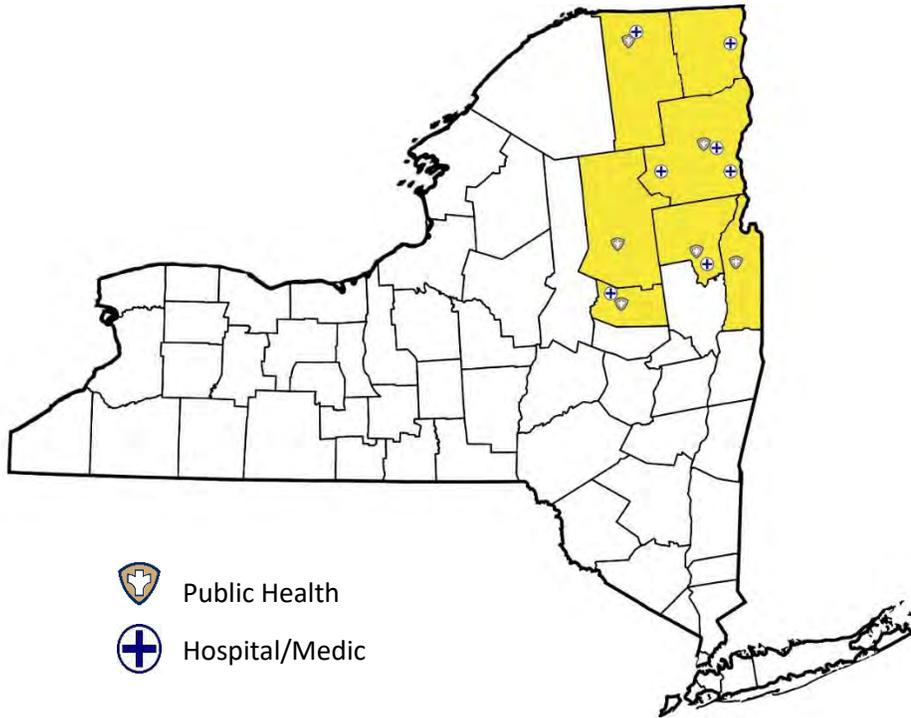
- Extremely Poor
  Poor
  Average
  Good
  Excellent

**Thank you for completing our survey!**

**Appendix C:**

**Summary of 2022 ARHN Community Stakeholder Survey**

# Summary of 2022 Community Stakeholder Survey



## Adirondack Rural Health Network Service Area Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington Counties



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

## **Background:**

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

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

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

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

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

## **Survey Methodology:**

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

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

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

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

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

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

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

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

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

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

## Summary Analysis

### 1. Indicate your job title

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

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

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

### 2. Indicate the community sector that best describes your organization

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

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

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

### 3. Indicate County/Counties served

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

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

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

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

#### 4. NYS Prevention Agenda Priority Areas

##### **Top Priority Area for the ARHN Region:**

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

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

##### **Top Priority Area by County:**

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

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

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

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

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

***Health Concerns for the ARHN Region:***

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

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

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

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

**Health Concerns by County:**

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

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

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

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

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

***Contributing Factors for the ARHN Region:***

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

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

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

**Contributing Factors by County:**

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

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

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

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

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

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

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

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

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

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

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

## 10. New York State Prevention Agenda Goals

### *Top Three Goals for the ARHN Region:*

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

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

**Top Three Goals by County:**

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

*Prevent Chronic Disease*

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

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

*Promote Healthy Women, Infants and Children*

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

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

*Promote a Healthy and Safe Environment*

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

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

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

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

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

*Prevent Communicable Diseases*

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

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

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

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

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

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

## 2022 CHA Stakeholders Survey

### Introduction

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

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

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

### Your Organization/Agency

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

1. Organization/Agency name: \_\_\_\_\_

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

3. Your job title/role: \_\_\_\_\_

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

4. Your email address: \_\_\_\_\_

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

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

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

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

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

## Health Priorities, Concerns and Factors

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

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

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

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

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

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

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

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

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

## **Social Determinants of Health**

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

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

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

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

## Improving Health and Well-Being

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

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

### **12. Prevent Chronic Diseases**

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

### **13. Promote Healthy Women, Infants, and Children**

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

#### **14. Promote a Healthy and Safe Environment**

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

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

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

#### **16. Prevent Communicable Diseases**

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

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

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

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

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

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

Additional Details:

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

- Yes
- No

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

**Appendix D:**

**Population Data Profiles & Health Indicator Data Tables**

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

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

N/A - Data not available

(1) 2010 Census Estimate; Census Quick Stats

(2) USDA Farm Overview; 2017

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

(4) Centers for Medicaid and Medicare Services; 2019

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

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

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

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

N/A - Data not available

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

(2) NYS Department of Health; NYS Health Profiles

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

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

(5) NYS Education Department; License Statistics, 2021

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

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

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

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

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

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

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

| Adirondack Rural Health Network   |   |  |  |  |
|---|---|--|--|--|
| Summary of Education System Information   |   |  |  |  |
| School Districts by County <sup>1</sup>   |   |  |  |  |
| Clinton   | Essex   | Franklin   | Fulton   | Hamilton   |
| AUSABLE VALLEY CENTRAL SCHOOL DISTRICT<br>BEEKMANTOWN CENTRAL SCHOOL DISTRICT<br>CHAZY UNION FREE SCHOOL DISTRICT<br>NORTHEASTERN CLINTON CENTRAL SCHOOL DISTRICT<br>NORTHERN ADIRONDACK CENTRAL SCHOOL DISTRICT<br>PERU CENTRAL SCHOOL DISTRICT<br>PLATTSBURGH CITY SCHOOL DISTRICT<br>SARANAC CENTRAL SCHOOL DISTRICT | BOQUET VALLEY CSD*<br>CROWN POINT CENTRAL SCHOOL DISTRICT<br>KEENE CENTRAL SCHOOL DISTRICT<br>LAKE PLACID CENTRAL SCHOOL DISTRICT<br>MINERVA CENTRAL SCHOOL DISTRICT<br>MORIAH CENTRAL SCHOOL DISTRICT<br>NEWCOMB CENTRAL SCHOOL DISTRICT<br>SCHROON LAKE CENTRAL SCHOOL DISTRICT<br>TICONDEROGA CENTRAL SCHOOL DISTRICT<br>WILLSBORO CENTRAL SCHOOL DISTRICT | BRUSHTON-MOIRA CENTRAL SCHOOL DISTRICT<br>CHATEAUGAY CENTRAL SCHOOL DISTRICT<br>MALONE CENTRAL SCHOOL DISTRICT<br>SAINT REGIS FALLS CENTRAL SCHOOL DISTRICT<br>SALMON RIVER CENTRAL SCHOOL DISTRICT<br>SARANAC LAKE CENTRAL SCHOOL DISTRICT<br>TUPPER LAKE CENTRAL SCHOOL DISTRICT | BROADALBIN-PERTH CENTRAL SCHOOL DISTRICT<br>GLOVERSVILLE CITY SCHOOL DISTRICT<br>JOHNSTOWN CITY SCHOOL DISTRICT<br>MAYFIELD CENTRAL SCHOOL DISTRICT<br>NORTHVILLE CENTRAL SCHOOL DISTRICT<br>WHEELERVILLE UNION FREE SCHOOL DISTRICT | INDIAN LAKE CENTRAL SCHOOL DISTRICT<br>LAKE PLEASANT CENTRAL SCHOOL DISTRICT<br>LONG LAKE CENTRAL SCHOOL DISTRICT<br>WELLS CENTRAL SCHOOL DISTRICT |

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

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

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

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

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

(1) American Community Survey, 2018

(2) ALICE Threshold, 2018

(3) United for Alice, 2018

(4) NYS County Health Rankings, 2018

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

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

|  | Number Per Year (If Available) |        |        | Clinton County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data |            |                |                                  | Comparison to Benchmark | Quartile Ranking |    |    |    | Quartile Score | Severity Score | Source | Updated   | Notes   |
|--|--------------------------------|--------|--------|--|-------------------------|------------|----------------|----------------------------------|-------------------------|------------------|----|----|----|----------------|----------------|--------|---|---|
|  | One                            | Two    | Three  |  | ARHN <sup>1</sup>       | Upstate NY | New York State | 2024 Prevention Agenda Benchmark |                         | Q1               | Q2 | Q3 | Q4 |                |                |        |   |   |
|  |                                |        |        |  |                         |            |                |                                  |                         |                  |    |    |    |                |                |        |   |   |
| <b>Focus Area: Disparities</b>   |                                |        |        |  |                         |            |                |                                  |                         |                  |    |    |    |                |                |        |   |   |
| <b>Prevention Agenda Indicators</b>  |                                |        |        |  |                         |            |                |                                  |                         |                  |    |    |    |                |                |        |   |   |
| Percentage of Overall Premature Deaths (before age 65 years), 2019   |                                |        |        | 25.2%  | 22.1%                   | 21.0%      | 22.7%          | 22.8%                            | Worse                   | X                |    |    |    |                |                | 0.11   | <a href="#">Prevention Agenda Dashboard</a>                             | Feb-22  |
| Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2019                                  |                                |        |        | 50.0+  | N/A                     | 20.2       | 17.7           | 17.3                             | Less than 10            |                  |    |    |    |                |                | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                             | Feb-22  |
| Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2019   |                                |        |        | -8.3+  | N/A                     | 21.1       | 16.4           | 16.2                             | Less than 10            |                  |    |    |    |                |                | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                             | Feb-22  |
| Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2019  |                                |        |        | 121.0  | 142.52                  | 120.4      | 125.9          | 115.0                            | Worse                   | X                |    |    |    |                |                | 0.05   | <a href="#">Prevention Agenda Dashboard</a>                             | Feb-22  |
| Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2019 |                                |        |        | 23.3   | N/A                     | 128.4      | 115.8          | 94.0                             | Meets/Better            |                  |    |    |    |                |                | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                             | Feb-22  |
| Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2019            |                                |        |        | -55.7+   | N/A                     | 1.0        | 34.6           | 23.9                             | Less than 10            |                  |    |    |    |                |                | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                             | Feb-22  |
| Percentage of Adults (Ages 18 - 64) with Health Insurance, 2019  |                                |        |        | 94.1%  | 93.6%                   | 94.00      | 92.5%          | 97.0%                            | Worse                   | X                |    |    |    |                |                | 0.03   | <a href="#">Prevention Agenda Dashboard</a>                             | Feb-22 Upstate NY calculated using county data. |
| Age-Adjusted Percentage of Adults with Regular Health Care Provider Over 18 Years, 2018  |                                |        |        | 78.3%  | 82.3%                   | 82.0%      | 79.1%          | 86.7%                            | Worse                   | X                |    |    |    |                |                | 0.11   | <a href="#">Prevention Agenda Dashboard</a>                             | Feb-22  |
| <b>Quartile Summary for Prevention Agenda Indicators</b>   |                                |        |        |  |                         |            |                |                                  |                         | 4                | 0  | 0  | 0  | 50.0%          | 0.0%           |        |   |   |
| <b>Other Disparity Indicators</b>  |                                |        |        |  |                         |            |                |                                  |                         |                  |    |    |    |                |                |        |   |   |
| Rate of Total Deaths per 100,000 Population, 2017-2019   | 681                            | 776    | 781    | 925.0  | 1,069.7                 | 916.2      | 798.8          | N/A                              | Worse                   | X                |    |    |    |                |                | 0.01   | <a href="#">Community Health Indicator Reports</a>                      | Feb-22  |
| Rate of Emergency Department Visits per 10,000 Population, 2017-2019   | 46,775                         | 37,047 | 36,431 | 4,970.3  | 4,694.3                 | 3,843.0    | 4,134.7        | N/A                              | Worse                   |                  | X  |    |    |                |                | 0.29   | <a href="#">Community Health Indicator Reports</a>                      | Feb-22  |
| Rate of Total Hospitalizations per 10,000 Population, 2017-2019  | 7,606                          | 5,233  | 6,407  | 795.5  | 981.2                   | 1,144.2    | 1,154.8        | N/A                              | Meets/Better            |                  |    |    |    |                |                | 0.00   | <a href="#">Community Health Indicator Reports</a>                      | Feb-22  |
| Percentage of Adults Who Did Not Receive Medical Care Due to Costs, 2018   |                                |        |        | 9.7%   | 9.6%                    | 9.2%       | 11.0%          | N/A                              | Worse                   | X                |    |    |    |                |                | 0.06   | <a href="#">NYS Expanded Behavioral Risk Factor Surveillance System</a> | Mar-22  |
| Percentage of adults reporting 14 or more days of poor physical health, 2018   |                                |        |        | 11.6%  | 13.0%                   | 11.1%      | 11.2%          | N/A                              | Worse                   | X                |    |    |    |                |                | 0.05   | <a href="#">NYS Expanded Behavioral Risk Factor Surveillance System</a> | Mar-22  |
| Percentage of adults living with a disability (based on 6 ACA disability questions), 2018  |                                |        |        | 29.5%  | 29.2%                   | 24.6%      | 26.2%          | N/A                              | Worse                   | X                |    |    |    |                |                | 0.20   | <a href="#">NYS Expanded Behavioral Risk Factor Surveillance System</a> | Mar-22  |
| <b>Quartile Summary for Other Indicators</b>   |                                |        |        |  |                         |            |                |                                  |                         | 4                | 1  | 0  | 0  | 83.3%          | 0.0%           |        |   |   |
| <b>Quartile Summary for Mortality</b>  |                                |        |        |  |                         |            |                |                                  |                         | 8                | 1  | 0  | 0  | 64.3%          | 0.0%           |        |   |   |

N/A: Data does not meet reporting criteria

\*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

|  | Number Per Year<br>(If Available) |     |       | Clinton County<br>Average, Rate,<br>Ratio or<br>Percentage for the<br>Listed Years | Comparison Regions/Data |            |                   |  | Comparison to<br>Benchmark | Quartile Ranking |    |    |    | Quartile<br>Score | Severity<br>Score |
|--|-----------------------------------|-----|-------|--|-------------------------|------------|-------------------|--|----------------------------|------------------|----|----|----|-------------------|-------------------|
|  | One                               | Two | Three |  | ARHN <sup>1</sup>       | Upstate NY | New York<br>State | 2024 Prevention<br>Agenda<br>Benchmark |                            | Q1               | Q2 | Q3 | Q4 |                   |                   |
| <b>Focus Area: Injuries, Violence, and Occupational Health</b>   |                                   |     |       |  |                         |            |                   |  |                            |                  |    |    |    |                   |                   |
| <b>Prevention Agenda Indicators</b>  |                                   |     |       |  |                         |            |                   |  |                            |                  |    |    |    |                   |                   |
| Rate of Hospitalizations due to falls among adults per 10,000 population, aged 65+, 2019                       |                                   |     |       | 173.0  | 165.2                   | 210.4      | 193.9             | 173.7                                  | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Assault-Related Hospitalizations per 10,000 Population, 2019   |                                   |     |       | N/A  | 1.00                    | 2.2        | 3.1               | 3.0                                    | Less than 10               |                  |    |    |    |                   |                   |
| Ratio of Rates of Assault-related hospitalizations between Black non-Hispanics and White non-Hispanics, 2019   |                                   |     |       | N/A  | N/A                     | 5.6        | 5.1               | 5.5                                    | Less than 10               |                  |    |    |    |                   |                   |
| Ratio of Rates of Assault-related hospitalizations, between Hispanics and White non-Hispanics, 2019            |                                   |     |       | N/A  | N/A                     | 1.8        | 2.4               | 2.5                                    | Less than 10               |                  |    |    |    |                   |                   |
| Ratio of Rates of Assault-Related Hospitalizations for Low-Income ZIP codes and Non-Low Income Zip Codes, 2019 |                                   |     |       | N/A  | N/A                     | 3.0        | 2.8               | 2.7                                    | Less than 10               |                  |    |    |    |                   |                   |
| <b>Quartile Summary for Prevention Agenda Indicators</b>   |                                   |     |       |  |                         |            |                   |  |                            | 0                | 0  | 0  | 0  | 0.0%              | 0.0%              |
| <b>Other Indicators</b>  |                                   |     |       |  |                         |            |                   |  |                            |                  |    |    |    |                   |                   |
| Falls hospitalization rate per 10,000 - Aged <10 years, 2017-2019  |                                   |     |       | N/A  | 5.5                     | 6.2        | 6.8               | N/A                                    | Less than 10               |                  |    |    |    |                   |                   |
| Falls hospitalization rate per 10,000 - Aged 10-14 years, 2017-2019  |                                   |     |       | 0.0*   | 2.6*                    | 3.4        | 4.0               | N/A                                    | Less than 10               |                  |    |    |    |                   |                   |
| Falls hospitalization rate per 10,000 - Aged 15-24 years, 2017-2019  |                                   |     |       | 2.3*   | 2.9                     | 4.0        | 4.4               | N/A                                    | Less than 10               |                  |    |    |    |                   |                   |
| Falls hospitalization rate per 10,000 - Aged 25-64 years, 2017-2019  | 67                                | 45  | 70    | 14.5   | 18.5                    | 19.7       | 18.8              | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Violent Crimes per 100,000 Population, 2020  |                                   |     |       | 160.4  | 157.0                   | 204.7      | 364.9             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Property Crimes per 100,000 Population, 2020   |                                   |     |       | 1,266.9  | 1,056.8                 | 1,292.1    | 1,406.5           | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Total Crimes per 100,000 Population, 2020  |                                   |     |       | 1,427.4  | 1,213.9                 | 1,496.8    | 1,771.4           | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, 2016-2018                |                                   |     |       | N/A  | 1.2*                    | 1.4        | 1.1               | N/A                                    | Less than 20               |                  |    |    |    |                   |                   |
| Rate of Pneumococcal Hospitalizations, Ages 15 and older, per 100,000 Population, 2017-2019                    |                                   |     |       | 7.3  | 9.4                     | 9.0        | 6.6               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2017-2019                            |                                   |     |       | 7.3  | 0.8                     | 0.8        | 5.7               | N/A                                    | Worse                      |                  |    |    | X  |                   |                   |
| Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, 2017-2019       | 36                                | 23  | 27    | 83.2   | 138.1                   | 175.8      | 145.9             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Total Motor Vehicle Crashes per 100,000, 2020  |                                   |     |       | 2,144.7  | 2,298.7                 | 2,157.0    | 1,693.1           | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Speed-Related Accidents per 100,000 Population, 2020   |                                   |     |       | 204.3  | 260.2                   | 205.7      | 146.0             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2020   |                                   |     |       | 3.8  | 7.2                     | 6.6        | 5.3               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2017-2019                               | 21                                | 19  | 7     | 1.9  | 6.4                     | 9.0        | 8.5               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019                    | 284                               | 215 | 319   | 199.7  | 210.3                   | 275.1      | 249.9             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Poisoning Hospitalizations per 10,000 Population, 2017-2019  | 36                                | 39  | 58    | 5.5  | 6.7                     | 7.6        | 8.0               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| <b>Quartile Summary for Other Indicators</b>   |                                   |     |       |  |                         |            |                   |  |                            | 0                | 0  | 0  | 1  | 5.9%              | 100.0%            |
| <b>Quartile Summary for Focus Area Injuries, Violence, and Occupational Health</b>                             |                                   |     |       |  |                         |            |                   |  |                            | 0                | 0  | 0  | 1  | 4.5%              | 100.0%            |

| Source | Updated | Notes |
|--------|---------|-------|
|--------|---------|-------|

|   |        |  |
|---|--------|--|
| 0.00 <a href="#">Prevention Agenda Dashboard</a>  | Feb-22 |  |
| 0.00 <a href="#">Prevention Agenda Dashboard</a>  | Feb-22 |  |
| 0.00 <a href="#">Prevention Agenda Dashboard</a>  | Feb-22 |  |
| 0.00 <a href="#">Prevention Agenda Dashboard</a>  | Feb-22 |  |
| 0.00 <a href="#">Prevention Agenda Dashboard</a>  | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not included due to unstable rate. |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 |  |
| 0.00 <a href="#">Division of Criminal Justice Services Index, Property, and Firearm</a> | Oct-21 |  |
| 0.00 <a href="#">Division of Criminal Justice Services Index, Property, and Firearm</a> | Oct-21 |  |
| 0.00 <a href="#">Division of Criminal Justice Services Index, Property, and Firearm</a> | Oct-21 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 | ARHN calculation not included due to unstable rate   |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 |  |
| 8.03 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 |  |
| 0.00 <a href="#">NYS Traffic Safety Statistical Repository</a>                          | Feb-22 |  |
| 0.00 <a href="#">NYS Traffic Safety Statistical Repository</a>                          | Feb-22 |  |
| 0.00 <a href="#">NYS Traffic Safety Statistical Repository</a>                          | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>                                 | Feb-22 |  |

N/A: Data does not meet reporting criteria

\*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

! : ARHN data not available when two or more counties do not have reported data

|  | Number Per Year<br>(If Available) |     |       | Clinton County<br>Average, Rate,<br>Ratio or Percentage<br>for the Listed Years | Comparison Regions/Data |            |                   |  | Comparison to<br>Benchmark | Quartile Ranking |    |    |    | Quartile<br>Score | Severity<br>Score | Source                                      | Updated | Notes |
|--|-----------------------------------|-----|-------|---|-------------------------|------------|-------------------|--|----------------------------|------------------|----|----|----|-------------------|-------------------|---|---------|-------|
|  | One                               | Two | Three |   | ARHN <sup>1</sup>       | Upstate NY | New York<br>State | 2024 Prevention<br>Agenda<br>Benchmark |                            | Q1               | Q2 | Q3 | Q4 |                   |                   |   |         |       |
| <b>Focus Area: Outdoor Air Quality</b>   |                                   |     |       |   |                         |            |                   |  |                            |                  |    |    |    |                   |                   |   |         |       |
| <b>Prevention Agenda Indicators</b>  |                                   |     |       |   |                         |            |                   |  |                            |                  |    |    |    |                   |                   |   |         |       |
| Annual number of days with air quality index >100 (unhealthy levels of ozone or particulate matter), 2021      |                                   |     |       | N/A   | N/A                     | N/A        | 20                | 3                                      | Less than 10               |                  |    |    |    |                   | 0.00              | <a href="#">Prevention Agenda Dashboard</a> | Feb-22  |       |
| <b>Quartile Summary for Focus Area Outdoor Air Quality</b>   |                                   |     |       |   |                         |            |                   |  |                            | 0                | 0  | 0  | 0  | 0.0%              | 0.0%              |   |         |       |
| <b>Focus Area: Built Environment</b>   |                                   |     |       |   |                         |            |                   |  |                            |                  |    |    |    |                   |                   |   |         |       |
| <b>Prevention Agenda Indicators</b>  |                                   |     |       |   |                         |            |                   |  |                            |                  |    |    |    |                   |                   |   |         |       |
| Percentage of population living in a certified Climate Smart Community, 2021                                   |                                   |     |       | 0.0%*   | 20                      | 54.2%      | 31.3%             | 8.6%                                   | Less than 10               |                  |    |    |    |                   | 0.00              | <a href="#">Prevention Agenda Dashboard</a> | Feb-22  |       |
| Percentage of people who commute to work using alternate modes of transportation or who telecommute, 2015-2019 |                                   |     |       | 17.2%   | 17.4%                   | 22.9%      | 45.6%             | 47.9%                                  | Worse                      |                  |    | X  |    |                   | 0.64              | <a href="#">Prevention Agenda Dashboard</a> | Feb-22  |       |
| Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015          |                                   |     |       | 9.9%  | 6.0%                    | 3.9%       | 2.2%              | N/A                                    | Worse                      |                  |    |    | X  |                   | 1.53              | <a href="#">USDA Food Environment Atlas</a> | Dec-20  |       |
| <b>Quartile Summary for Focus Area Built Environment</b>   |                                   |     |       |   |                         |            |                   |  |                            | 0                | 0  | 1  | 1  | 66.7%             | 100.0%            |   |         |       |
| <b>Focus Area: Water Quality</b>   |                                   |     |       |   |                         |            |                   |  |                            |                  |    |    |    |                   |                   |   |         |       |
| <b>Prevention Agenda Indicators</b>  |                                   |     |       |   |                         |            |                   |  |                            |                  |    |    |    |                   |                   |   |         |       |
| Percentage of residents served by community water systems that have optimally fluoridated water, 2019          |                                   |     |       | 63.4%   | 26.8%                   | 46.9%      | 71.1%             | 77.5%                                  | Worse                      | X                |    |    |    |                   | 0.18              | <a href="#">Prevention Agenda Dashboard</a> | Aug-21  |       |
| <b>Quartile Summary for Focus Area Water Quality</b>   |                                   |     |       |   |                         |            |                   |  |                            | 1                | 0  | 0  | 0  | 100.0%            | 0.0%              |   |         |       |
| <b>Quartile Summary for Focus Area Air Quality, Built Environment, Water Quality</b>                           |                                   |     |       |   |                         |            |                   |  |                            | 1                | 0  | 1  | 1  | 60.0%             | 66.7%             |   |         |       |

|  | Number Per Year<br>(If Available) |     |       | Clinton County<br>Average, Rate,<br>Ratio or<br>Percentage for<br>the Listed Years | Comparison Regions/Data |            |                   |  | Comparison to<br>Benchmark | Quartile Ranking |    |    |    | Quartile<br>Score | Severity<br>Score |
|--|-----------------------------------|-----|-------|--|-------------------------|------------|-------------------|--|----------------------------|------------------|----|----|----|-------------------|-------------------|
|  | One                               | Two | Three |  | ARHN <sup>1</sup>       | Upstate NY | New York<br>State | 2024 Prevention<br>Agenda<br>Benchmark |                            | Q1               | Q2 | Q3 | Q4 |                   |                   |
| <b>Focus Area: Reduce Obesity in Children and Adults</b>   |                                   |     |       |  |                         |            |                   |  |                            |                  |    |    |    |                   |                   |
| <b>Prevention Agenda Indicators</b>  |                                   |     |       |  |                         |            |                   |  |                            |                  |    |    |    |                   |                   |
| Percentage of Adults Ages 18 Plus Who are Obese, 2018  |                                   |     |       | 36.7%  | 34%                     | 29.1%      | 27.6%             | 24.2%                                  | Worse                      |                  |    | X  |    |                   |                   |
| <b>Quartile Summary for Prevention Agenda Indicators</b>   |                                   |     |       |  |                         |            |                   |  |                            | 0                | 0  | 1  | 0  | 100.0%            | 100.0%            |
| <b>Other Indicators</b>  |                                   |     |       |  |                         |            |                   |  |                            |                  |    |    |    |                   |                   |
| Percentage of Total Students Overweight, 2018-2019   |                                   |     |       | 16.9%  | 17.5%                   | 16.9%      | N/A               | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Percentage of Elementary Students Overweight, Not Obese, 2018-2019                                     |                                   |     |       | 16.2%  | 17.2%                   | 16.1%      | N/A               | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Percentage of Elementary Student Obese, 2018-2019  |                                   |     |       | 19.9%  | 19.4%                   | 16.6%      | N/A               | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Percentage of Middle and High School Students Overweight, Not Obese, 2018-2019                         |                                   |     |       | 17.9%  | 17.4%                   | 17.8%      | N/A               | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Percentage of Middle and High School Students Obese, 2018-2019   |                                   |     |       | 28.1%  | 25.3%                   | 19.5%      | N/A               | N/A                                    | Worse                      |                  | X  |    |    |                   |                   |
| Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC, 2015-2017               |                                   |     |       | 14.3%  | 16.1%                   | 15.5%      | 13.8%             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Percentage of adults overweight or obese, 2018   |                                   |     |       | 70.8%  | 69.1%                   | 64.2%      | 62.7%             | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Percentage of adults who participated in leisure time physical activity in the past 30 days, 2018      |                                   |     |       | 70.9%  | 73.3%                   | 77.6%      | 76.2%             | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Number of Recreational and Fitness Facilities per 100,000 Population, 2016                             |                                   |     |       | 6.17   | 8.8                     | 13.2       | 12.3              | N/A                                    | Worse                      |                  |    | X  |    |                   |                   |
| Percentage of adults who had a test for high blood sugar or diabetes within the past three years, 2018 |                                   |     |       | 44.0%  | 49.1%                   | 48.6%      | 51.1%             | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Rate of Cardiovascular Disease Deaths per 100,000 Population, 2017-2019                                | 197                               | 230 | 207   | 262.0  | 309.6                   | 295.9      | 278.3             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019               | 37                                | 48  | 43    | 134.0  | 123.3                   | 102.4      | 104.2             | N/A                                    | Worse                      |                  | X  |    |    |                   |                   |
| Rate of Cardiovascular Disease Pretransport Deaths per 100,000 Population, 2017-2019                   | 96                                | 129 | 109   | 138.0  | 184.7                   | 179.5      | 163.6             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Cardiovascular Hospitalizations per 10,000 Population, 2017-2019                               | 1,037                             | 916 | 870   | 111.3  | 141.4                   | 161.7      | 155.2             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Diseases of the Heart Deaths per 100,000 Population, 2017-2019                                 | 154                               | 176 | 160   | 202.5  | 240.1                   | 234.0      | 169.4             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019        | 32                                | 41  | 34    | 112.1  | 100.9                   | 82.4       | 83.9              | N/A                                    | Worse                      |                  | X  |    |    |                   |                   |
| Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, 2017-2019                     | 78                                | 104 | 89    | 112.0  | 149.1                   | 147.2      | 138.7             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2017-2019                         | 778                               | 528 | 637   | 80.3   | 97.5                    | 111.2      | 84.2              | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Coronary Heart Diseases Deaths per 100,000 Population, 2017-2019                               | 98                                | 116 | 101   | 130.2  | 155.2                   | 162.4      | 173.4             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019      | 23                                | 31  | 26    | 83.8   | 69.6                    | 59.7       | 66.4              | N/A                                    | Worse                      |                  | X  |    |    |                   |                   |
| Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, 2017-2019                   | 56                                | 74  | 58    | 77.7   | 100.8                   | 106.6      | 112.4             | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |

| Source | Updated | Notes |
|--------|---------|-------|
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|  |        |   |
|--|--------|---|
| 0.52 <a href="#">Prevention Agenda Dashboard</a>         | Feb-22 |   |
| 0.00 <a href="#">Student Weight Status Category Rept</a> | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| 0.00 <a href="#">Student Weight Status Category Rept</a> | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| 0.20 <a href="#">Student Weight Status Category Rept</a> | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| 0.00 <a href="#">Student Weight Status Category Rept</a> | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| 0.44 <a href="#">Student Weight Status Category Rept</a> | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.10 <a href="#">NYS Expanded Behavioral Risk Fact</a>   | Mar-22 |   |
| 0.09 <a href="#">NYS Expanded Behavioral Risk Fact</a>   | Mar-22 |   |
| 0.53 <a href="#">USDA Food Environment Atlas</a>         | Dec-20 |   |
| 0.10 <a href="#">NYS Expanded Behavioral Risk Fact</a>   | Mar-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.31 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.36 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.40 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |   |

|  |      |      |      |       |       |              |       |     |              |    |   |   |   |       |       |  |
|--|------|------|------|-------|-------|--------------|-------|-----|--------------|----|---|---|---|-------|-------|--|
| Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2017-2019                                   | 233  | 141  | 140  | 21.2  | 29.1  | <b>32.9</b>  | 31.5  | N/A | Meets/Better |    |   |   |   |       |       |  |
| Rate of Congestive Heart Failure Deaths per 100,000, 2017-2019   | 16   | 18   | 15   | 20.3  | 19.1  | <b>22.3</b>  | 15.1  | N/A | Meets/Better |    |   |   |   |       |       |  |
| Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019                 | 2    | 2    | 2    | 6.3*  | 4.2*  | <b>3.2</b>   | 2.4   | N/A | Less than 10 |    |   |   |   |       |       |  |
| Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, 2017-2019                             | 8    | 9    | 9    | 10.7  | 12.2  | <b>13.7</b>  | 8.7   | N/A | Meets/Better |    |   |   |   |       |       |  |
| Rate of Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019 | 270  | 157  | 229  | 34.4  | 38.8  | <b>69.4</b>  | 41.3  | N/A | Meets/Better |    |   |   |   |       |       |  |
| Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, 2017-2019  | 32   | 44   | 29   | 43.4  | 41.5  | <b>38.2</b>  | 31.5  | N/A | Worse        | X  |   |   |   |       |       |  |
| Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2017-2019                                 | 135  | 104  | 96   | 13.8  | 23.7  | <b>28.2</b>  | 26.6  | N/A | Meets/Better |    |   |   |   |       |       |  |
| Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019          | 36   | 8    | 31   | 3.8   | 2.7   | <b>5.9</b>   | 7.3   | N/A | Meets/Better |    |   |   |   |       |       |  |
| Rate of Diabetes Deaths per 100,000 Population, 2017-2019  | 22   | 22   | 23   | 27.7  | 33.0  | <b>22.5</b>  | 22.5  | N/A | Worse        | X  |   |   |   |       |       |  |
| Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2017-2019                             | 197  | 117  | 115  | 19.4  | 18.9  | <b>18.9</b>  | 21.4  | N/A | Worse        | X  |   |   |   |       |       |  |
| Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2017-2019                                 | 2030 | 1357 | 1718 | 211.0 | 238.0 | <b>252.0</b> | 262.7 | N/A | Meets/Better |    |   |   |   |       |       |  |
| <b>Quartile Summary for Other Indicators</b>   |      |      |      |       |       |              |       |     |              | 10 | 4 | 1 | 0 | 46.9% | 6.7%  |  |
| <b>Quartile Summary for Focus Area Reduce Obesity in Children and Adults</b>                                       |      |      |      |       |       |              |       |     |              | 10 | 4 | 2 | 0 | 48.5% | 12.5% |  |

0.00 [Community Health Indicator Reports](#) Feb-22

0.00 [Community Health Indicator Reports](#) Feb-22

0.00 [Community Health Indicator Reports](#) Feb-22 ARHN calculation not included due to unstable rate

0.00 [Community Health Indicator Reports](#) Feb-22

0.00 [Community Health Indicator Reports](#) Feb-22

0.14 [Community Health Indicator Reports](#) Feb-22

0.00 [Community Health Indicator Reports](#) Feb-22

0.00 [Community Health Indicator Reports](#) Feb-22

0.23 [Community Health Indicator Reports](#) Feb-22

0.03 [Community Health Indicator Reports](#) Feb-22

0.00 [Community Health Indicator Reports](#) Feb-22

N/A: Data does not meet reporting criteria

\*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

|   | Number Per Year<br>(If Available) |     |       | Clinton County<br>Average, Rate,<br>Ratio or<br>Percentage for<br>the Listed Years | Comparison Regions/Data |              |                   |  | Comparison to<br>Benchmark | Quartile Ranking |    |    |    | Quartile<br>Score | Severity<br>Score |
|---|-----------------------------------|-----|-------|--|-------------------------|--------------|-------------------|--|----------------------------|------------------|----|----|----|-------------------|-------------------|
|   | One                               | Two | Three |  | ARHN <sup>1</sup>       | Upstate NY   | New York<br>State | 2024 Prevention<br>Agenda<br>Benchmark |                            | Q1               | Q2 | Q3 | Q4 |                   |                   |
|   |                                   |     |       |  |                         |              |                   |  |                            |                  |    |    |    |                   |                   |
| <b>Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure</b>                       |                                   |     |       |  |                         |              |                   |  |                            |                  |    |    |    |                   |                   |
| <b>Prevention Agenda Indicators</b>   |                                   |     |       |  |                         |              |                   |  |                            |                  |    |    |    |                   |                   |
| Percentage of Adults Ages 18 Plus Who Smoke, 2018   |                                   |     |       | 19.9%  | 19.5%                   | 13.9%        | 12.8%             | <b>11.0%</b>                           | Worse                      |                  |    |    | X  |                   |                   |
| <b>Quartile Summary for Prevention Agenda Indicators</b>  |                                   |     |       |  |                         |              |                   |  |                            | 0                | 0  | 0  | 1  | 100.0%            | 100.0%            |
| <b>Other Indicators</b>   |                                   |     |       |  |                         |              |                   |  |                            |                  |    |    |    |                   |                   |
| Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, 2017-2019  | 51                                | 53  | 38    | 58.7   | 76.6                    | <b>48.3</b>  | 36.7              | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2017-2019  | 335                               | 175 | 258   | 31.7   | 32.5                    | <b>28.7</b>  | 29.7              | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Rate of Asthma Deaths per 100,000 Population, 2017-2019   | 0                                 | 1   | 0     | 0.4*   | 0.7*                    | <b>0.9</b>   | 1.4               | N/A                                    | Less than 10               |                  |    |    |    |                   |                   |
| Rate of Asthma Hospitalizations per 10,000 Population, 2017-2019  | 27                                | 10  | 15    | 2.1  | 3.1                     | <b>6.2</b>   | 9.8               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2017-2019   |                                   |     |       | 2.4  | 2.4                     | <b>4.2</b>   | 5.0               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2017-2019   |                                   |     |       | 2.1  | 2.9                     | <b>5.2</b>   | 8.8               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2017-2019   | 8                                 | 0   | 7     | 3.7  | 3.9                     | <b>4.9</b>   | 9.3               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Percentage of adults with current asthma, 2018  |                                   |     |       | 14.9%  | 13.5%                   | <b>10.6%</b> | 10.1%             | N/A                                    | Worse                      |                  | X  |    |    |                   |                   |
| Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, 2016-2018   | 42                                | 49  | 48    | 57.5   | 65.0                    | <b>48.1</b>  | 39.6              | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Rate of Lung and Bronchus Cancer Cases per 100,000 Population, 2016-2018  | 95                                | 115 | 124   | 138.2  | 119.0                   | <b>87.6</b>  | 72.6              | N/A                                    | Worse                      |                  |    | X  |    |                   |                   |
| Number of Registered Tobacco Vendors per 100,000 Population, 2016-2017  |                                   |     |       | 134  | 132.7                   | <b>104.4</b> | 110               | N/A                                    | Worse                      |                  | X  |    |    |                   |                   |
| Tobacco Sales to Minors Violations per 100,000 Population, 2016-2017  |                                   |     |       | 2.5  | 4.0*                    | <b>4.0</b>   | 6.6               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Percentage of Vendors with Complaints per 100,000 Population, 2016-2017   |                                   |     |       | 0.00   | 0.0*                    | <b>0.0*</b>  | 1.1               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| <b>Quartile Summary for Other Indicators</b>  |                                   |     |       |  |                         |              |                   |  |                            | 3                | 2  | 1  | 0  | 46.2%             | 16.7%             |
| <b>Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use &amp; Secondhand Smoke Exposure</b> |                                   |     |       |  |                         |              |                   |  |                            | 3                | 2  | 1  | 1  | 50.0%             | 28.6%             |

| Source | Updated | Notes |
|--------|---------|-------|
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|   |        |   |
|---|--------|---|
| 0.81 <a href="#">Prevention Agenda Dashboard</a>                          | Feb-22 |   |
| 0.22 <a href="#">Community Health Indicator Reports</a>                   | Feb-22 |   |
| 0.11 <a href="#">Community Health Indicator Reports</a>                   | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>                   | Feb-22 | ARHN calculation not included due to unstable rate  |
| 0.00 <a href="#">Community Health Indicator Reports</a>                   | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>                   | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>                   | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicator Reports</a>                   | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available.                        |
| 0.41 <a href="#">NYS Expanded Behavioral Risk Factor Surveillance Sys</a> | Mar-22 |   |
| 0.20 <a href="#">Community Health Indicator Reports</a>                   | Feb-22 |   |
| 0.58 <a href="#">Community Health Indicator Reports</a>                   | Feb-22 |   |
| 0.29 <a href="#">NYS Department of Health Tobacco Enforcement Cor</a>     | Oct-19 | Population is 5-year Census data 2015-2020  |
| 0.00 <a href="#">NYS Department of Health Tobacco Enforcement Cor</a>     | Oct-19 | Population is 5-year Census data 2015-2020<br>ARHN calculation not included due to unstable rate. |
| 0.00 <a href="#">NYS Department of Health Tobacco Enforcement Cor</a>     | Oct-19 | Population is 5-year Census data 2015-2020<br>ARHN calculation not included due to unstable rate. |

N/A: Data does not meet reporting criteria

\*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

|   | Number Per Year<br>(If Available) |       |       | Clinton County<br>Average, Rate,<br>Ratio or<br>Percentage for<br>the Listed Years | Comparison Regions/Data |            |                   |                                     | Comparison to<br>Benchmark | Quartile Ranking |    |    |    | Quartile<br>Score | Severity<br>Score | Source | Updated                                     | Notes   |        |
|---|-----------------------------------|-------|-------|--|-------------------------|------------|-------------------|-------------------------------------|----------------------------|------------------|----|----|----|-------------------|-------------------|--------|---|---|--------|
|   | One                               | Two   | Three |  | ARHN <sup>1</sup>       | Upstate NY | New York<br>State | 2024 Prevention<br>Agenda Benchmark |                            | Q1               | Q2 | Q3 | Q4 |                   |                   |        |   |   |        |
| <b>Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings</b> |                                   |       |       |  |                         |            |                   |                                     |                            |                  |    |    |    |                   |                   |        |   |   |        |
| <b>Prevention Agenda Indicators</b>   |                                   |       |       |  |                         |            |                   |                                     |                            |                  |    |    |    |                   |                   |        |   |   |        |
| Asthma emergency department visits, rate per 10,000, aged 0-17 years, 2019  |                                   |       |       | 25.6   | 42.3                    | 57.5       | 99.9              | 131.1                               | Meets/Better               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Prevention Agenda Dashboard</a> | Feb-22  |        |
| <b>Quartile Summary for Prevention Agenda Indicators</b>  |                                   |       |       |  |                         |            |                   |                                     |                            | 0                | 0  | 0  | 0  | 0.0%              | 0.0%              |        |   |   |        |
| <b>Other Indicators</b>   |                                   |       |       |  |                         |            |                   |                                     |                            |                  |    |    |    |                   |                   |        |   |   |        |
| Asthma emergency department visit rate per 10,000 - aged 18-64 years, 2017-2019   |                                   |       |       | 49.4   | 41.4                    | 39.0       | 63.3              | N/A                                 | Worse                      |                  | X  |    |    |                   |                   |        | 0.27  | <a href="#">Asthma Summary Report</a>               | Feb-22 |
| Asthma emergency department visit rate per 10,000 - aged 65+ years, 2017-2019   |                                   |       |       | 20.7   | 16.0                    | 14.8       | 28.2              | N/A                                 | Worse                      |                  | X  |    |    |                   |                   |        | 0.40  | <a href="#">Asthma Dashboard-County Level</a>       | Feb-22 |
| Rate of All Cancer Cases per 100,000 Population, 2016-2018  | 488                               | 532   | 561   | 654.1  | 710.8                   | 657.0      | 587.7             | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of all Cancer Deaths per 100,000 Population, 2016-2018   | 161                               | 154   | 163   | 197.8  | 232.6                   | 194.7      | 175.5             | N/A                                 | Worse                      | X                |    |    |    |                   |                   |        | 0.02  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Female Breast Cancer Cases per 100,000 Female Population, 2016-2018   | 43                                | 73    | 53    | 144.0  | 176.3                   | 180.1      | 164.6             | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, 2016-2018  | 8                                 | 24    | 17    | 41.7   | 48.6                    | 50.9       | 49.3              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Female Breast Cancer Deaths per 100,000 Female Population, 2016-2018  |                                   |       |       | 22.2   | 24.9                    | 26.3       | 25.1              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines, 2018                                   |                                   |       |       | 74.6%  | 80.4%                   | 80.9%      | 82.1%             | N/A                                 | Worse                      | X                |    |    |    |                   |                   |        | 0.08  | <a href="#">NYS Expanded Behavioral Risk Factor</a> | Mar-22 |
| Rate of Cervix Uteri Cancer Incidence per 100,000, 2016-2018  |                                   |       |       | 6.0*   | 8.9                     | 7.1        | 8.3               | N/A                                 | Less than 20               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Cervix and Uteri Cancer Deaths per 100,000 Female Population, 2016-2018   |                                   |       |       | N/A  | 6.2*                    | 2.2        | 2.5               | N/A                                 | Less than 20               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Percentage of women aged 21-65 years receiving cervical cancer screening based on recent guidelines, 2018                                 |                                   |       |       | 82.5%  | 87.2%                   | 86.1%      | 84.7%             | N/A                                 | Worse                      | X                |    |    |    |                   |                   |        | 0.04  | <a href="#">NYS Expanded Behavioral Risk Factor</a> | Mar-22 |
| Rate of Ovarian Cancer Cases per 100,000 Female Population, 2016-2018   |                                   |       |       | 11.9*  | 14.8                    | 15.2       | 14.2              | N/A                                 | Less than 20               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Ovarian Cancer Deaths per 100,000 Female Population, 2016-2018  |                                   |       |       | 7.7*   | 8.8                     | 9.3        | 8.7               | N/A                                 | Less than 20               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Colon and Rectal Cancer incidence per 100,000 Population, 2016-2018   | 45                                | 34    | 35    | 47.2   | 54.2                    | 48.8       | 45.7              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Colon and Rectal Cancer Deaths per 100,000 Population, 2016-2018  | 14                                | 12    | 9     | 14.5   | 19.8                    | 15.7       | 15.1              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Prostate Cancer Deaths per 100,000 Male Population, 2016-2018   |                                   |       |       | 20.9   | 22.1                    | 18.9       | 18.5              | N/A                                 | Worse                      | X                |    |    |    |                   |                   |        | 0.11  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Prostate Cancer Incidence per 100,000 Male Population, 2016-2018  | 55                                | 54    | 61    | 136.7  | 166.2                   | 174.9      | 158.7             | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, 2016-2018  | 15                                | 12    | 13    | 32.2   | 38.3                    | 33.3       | 30.5              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Rate of Melanoma Cancer Deaths per 100,000 Population, 2016-2018  |                                   |       |       | N/A  | 3.6                     | 2.7        | 2.1               | N/A                                 | Less than 20               |                  |    |    |    |                   |                   |        | 0.00  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, 2018-2020                                     | 5,401                             | 5,398 | 4,191 | 24.2%  | 26.0%                   | 27.7%      | 26.9%             | N/A                                 | Worse                      | X                |    |    |    |                   |                   |        | 0.13  | <a href="#">Community Health Indicator Reports</a>  | Feb-22 |
| Percentage of adults who had a dentist visit within the past year, 2018   |                                   |       |       | 61.5%  | 63.8%                   | 71.6%      | 69.8%             | N/A                                 | Worse                      | X                |    |    |    |                   |                   |        | 0.14  | <a href="#">NYS Expanded Behavioral Risk Factor</a> | Mar-22 |

ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not included due to unstable rate.

ARHN rate is not inclusive of Fulton County as there is no data available.

|   |    |   |    |      |      |             |      |     |              |   |   |   |   |       |      |
|---|----|---|----|------|------|-------------|------|-----|--------------|---|---|---|---|-------|------|
| Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, 2016-2018  |    |   |    | N/A  | 5.0* | <b>4.7</b>  | 4.6  | N/A | Less than 20 |   |   |   |   |       |      |
| Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, 2016-2018   | 14 | 9 | 12 | 14.5 | 17.4 | <b>16.3</b> | 14.1 | N/A | Meets/Better |   |   |   |   |       |      |
| <b>Quartile Summary for Other Indicators</b>  |    |   |    |      |      |             |      |     |              | 6 | 2 | 0 | 0 | 34.8% | 0.0% |
| <b>Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care &amp; Management</b> |    |   |    |      |      |             |      |     |              | 6 | 2 | 0 | 0 | 33.3% | 0.0% |

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Feb-22

ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not included due to unstable rate.

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N/A: Data does not meet reporting criteria

\*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

|   | Number Per Year<br>(If Available) |     |       | Clinton County<br>Average, Rate, Ratio<br>or Percentage for the<br>Listed Years | Comparison Regions/Data |            |                   |                                     | Comparison to<br>Benchmark | Quartile Ranking |    |    |    | Quartile<br>Score | Severity<br>Score | Source | Updated  | Notes  |  |
|---|-----------------------------------|-----|-------|---|-------------------------|------------|-------------------|-------------------------------------|----------------------------|------------------|----|----|----|-------------------|-------------------|--------|--|--------|--|
|   | One                               | Two | Three |   | ARHN <sup>1</sup>       | Upstate NY | New York<br>State | 2024 Prevention<br>Agenda Benchmark |                            | Q1               | Q2 | Q3 | Q4 |                   |                   |        |  |        |  |
|   |                                   |     |       |   |                         |            |                   |                                     |                            |                  |    |    |    |                   |                   |        |  |        |  |
| <b>Focus Area: Maternal and Infant Health</b>   |                                   |     |       |   |                         |            |                   |                                     |                            |                  |    |    |    |                   |                   |        |  |        |  |
| <b>Prevention Agenda Indicators</b>   |                                   |     |       |   |                         |            |                   |                                     |                            |                  |    |    |    |                   |                   |        |  |        |  |
| Percentage of births that are preterm, 2019   |                                   |     |       | 9.1%  | 9.4%                    | 9.3%       | 9.2%              | 8.3%                                | Worse                      | X                |    |    |    |                   |                   | 0.10   | <a href="#">Prevention Agenda Dashboard</a>                | Feb-22 |  |
| Percentage of Black, non-hispanic births that are pre-term, 2019  |                                   |     |       | N/A   | N/A                     | N/A        | 13.2%             | 8.3%                                | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                | Feb-22 |  |
| Percentage of Hispanic births that are pre-term, 2019   |                                   |     |       | N/A   | N/A                     | N/A        | 10.1%             | 8.3%                                | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                | Feb-22 |  |
| Percentage of births that are pre-term on Medicaid, 2019  |                                   |     |       | N/A   | N/A                     | N/A        | 9.6%              | 8.3%                                | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                | Feb-22 |  |
| Rate of Maternal Mortality per 100,000 Births, 2017-2019  |                                   |     |       | 0.0*  | 0.0**                   | 18.8       | 19.3              | 16.0                                | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                | Feb-22 | ARHN calculation not included due to unstable rate |
| Percentage of infants who are exclusively breastfed in the hospital among all infants, 2019               |                                   |     |       | 82.1%   | 65.8%                   | 49.6%      | 47.1%             | 51.7%                               | Meets/Better               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                | Feb-22 |  |
| Percentage of Black, non-hispanic infants who are exclusively breastfed in delivery hospital, 2019        |                                   |     |       | N/A   | N/A                     | N/A        | 34.9%             | 51.7%                               | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                | Feb-22 |  |
| Percentage of Hispanic infants who are exclusively breastfed in delivery hospital, 2019                   |                                   |     |       | N/A   | N/A                     | N/A        | 35.7%             | 51.7%                               | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                | Feb-22 |  |
| Percentage of Infants Exclusively Breastfed in Delivery Hospital on Medicaid Insurance, 2019              |                                   |     |       | N/A   | N/A                     | N/A        | 34.9%             | 51.7%                               | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Prevention Agenda Dashboard</a>                | Feb-22 |  |
| <b>Quartile Summary for Prevention Agenda Indicators</b>  |                                   |     |       |   |                         |            |                   |                                     |                            | 1                | 0  | 0  | 0  | 11.1%             | 0.0%              |        |  |        |  |
| <b>Other Indicators</b>   |                                   |     |       |   |                         |            |                   |                                     |                            |                  |    |    |    |                   |                   |        |  |        |  |
| Percentage Preterm Births < 32 weeks of Total Births, 2017-2019   | 4                                 | 12  | 8     | 1.1%  | 1.3%                    | 1.5%       | 1.5%              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Community Health Indicator Reports</a>         | Oct-21 |  |
| Percentage Preterm Births 32 to < 37 Weeks of Total Births, 2017-2019                                     | 34                                | 57  | 57    | 6.9%  | 7.8%                    | 7.6%       | 7.6%              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Community Health Indicator Reports</a>         | Oct-21 |  |
| Percentage of very low birthweight Less Than 1,500 grams, 2017-2019                                       | 2                                 | 9   | 8     | 0.9%  | 1.1%                    | 1.3%       | 1.4%              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Community Health Indicator Reports</a>         | Oct-21 |  |
| Percentage of Singleton Births with Weights Less Than 1,500 grams, 2017-2019                              | 2                                 | 9   | 6     | 0.8%  | 0.9%                    | 1.0%       | 1.0%              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Community Health Indicator Reports</a>         | Oct-21 |  |
| Percentage of Total Births with Weights Less Than 2,500 grams, 2017-2019                                  | 35                                | 70  | 53    | 7.3%  | 7.7%                    | 7.7%       | 8.1%              | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Community Health Indicator Reports</a>         | Oct-21 |  |
| Percentage of Singleton Births with weight less than 2,500 grams, 2017-2019                               | 31                                | 51  | 44    | 6.1%  | 6.0%                    | 5.9%       | 6.3%              | N/A                                 | Worse                      | X                |    |    |    |                   |                   | 0.03   | <a href="#">Community Health Indicator Reports</a>         | Oct-21 |  |
| Percentage of low birthweight births (< 2.5 kg) for Black, Non-Hispanic, 2016-2018                        |                                   |     |       | N/A   | N/A                     | 13.2%      | 12.6%             | N/A                                 | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">State and County Indicators for Tracking P</a> | Jul-21 |  |
| Percentage of low birthweight births (< 2.5 kg) for Hispanic/Latino, 2016-2018                            |                                   |     |       | 3%*   | N/A                     | 7.9%       | 8.1%              | N/A                                 | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">State and County Indicators for Tracking P</a> | Jul-21 |  |
| Infant Mortality Rate per 1,000 Live Births- Infant (<1 year), 2017-2019                                  | 5                                 | 6   | 5     | 7.4   | 5.1                     | 4.8        | 4.4               | N/A                                 | Worse                      |                  |    | X  |    |                   |                   | 0.55   | <a href="#">Community Health Indicator Reports</a>         | Feb-22 |  |
| Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, 2017-2019 | 5                                 | 5   | 2     | 5.6   | 4.9                     | 5.1        | 5.1               | N/A                                 | Worse                      | X                |    |    |    |                   |                   | 0.11   | <a href="#">Community Health Indicator Reports</a>         | Feb-22 |  |
| Percentage of births with early (1st trimester) prenatal care, 2017-2019                                  | 557                               | 590 | 561   | 79.5%   | 77.8%                   | 78.4%      | 76.3%             | N/A                                 | Meets/Better               |                  |    |    |    |                   |                   | 0.00   | <a href="#">Community Health Indicator Reports</a>         | Oct-21 |  |
| Percentage of births with adequate prenatal care (APNCU) for Black, Non-Hispanic, 2016-2018               |                                   |     |       | N/A   | N/A                     | 68.4%      | 66.1%             | N/A                                 | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">State and County Indicators for Tracking P</a> | Jul-21 |  |
| Percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino, 2016-2018                   |                                   |     |       | N/A   | N/A                     | 70.9%      | 71.1%             | N/A                                 | Less than 10               |                  |    |    |    |                   |                   | 0.00   | <a href="#">State and County Indicators for Tracking P</a> | Jul-21 |  |

|  |     |     |     |       |       |              |       |     |              |   |   |   |   |       |       |
|--|-----|-----|-----|-------|-------|--------------|-------|-----|--------------|---|---|---|---|-------|-------|
| Percentage of births with a 5 minute APGAR <6, 2017-2019               | 7   | 11  | 6   | 1.1%  | 1.4%  | <b>0.8%</b>  | 0.7%  | N/A | Worse        |   | X |   |   |       |       |
| Percentage WIC Women Breastfeeding for at least 6 months, 2015-2017    |     |     |     | 28.8% | 24.6% | <b>30.6%</b> | 41.0% | N/A | Worse        | X |   |   |   |       |       |
| Percentage Infants Fed Any Breast Milk in Delivery Hospital, 2017-2019 | 577 | 531 | 563 | 86.5% | 79.8% | <b>84.2%</b> | 88.5% | N/A | Meets/Better |   |   |   |   |       |       |
| <b>Quartile Summary for Other Indicators</b>                           |     |     |     |       |       |              |       |     |              | 3 | 1 | 1 | 0 | 31.3% | 20.0% |
| <b>Quartile Summary for Focus Area Maternal and Infant Health</b>      |     |     |     |       |       |              |       |     |              | 4 | 1 | 1 | 0 | 24.0% | 16.7% |

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0.00 [Community Health Indicator Reports](#) Oct-21

**Focus Area: Preconception and Reproductive Health**

|   |  |  |  |     |     |     |       |              |              |   |   |   |   |      |      |
|---|--|--|--|-----|-----|-----|-------|--------------|--------------|---|---|---|---|------|------|
| <b>Prevention Agenda Indicators</b>                         |  |  |  |     |     |     |       |              |              |   |   |   |   |      |      |
| Percentage of Women Ages 18- 64 with Health Insurance, 2019 |  |  |  | N/A | N/A | N/A | 94.0% | <b>97.0%</b> | Less than 10 |   |   |   |   |      |      |
| <b>Quartile Summary for Prevention Agenda Indicators</b>    |  |  |  |     |     |     |       |              |              | 0 | 0 | 0 | 0 | 0.0% | 0.0% |

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|  |     |     |     |       |       |              |              |     |              |   |   |   |   |       |       |
|--|-----|-----|-----|-------|-------|--------------|--------------|-----|--------------|---|---|---|---|-------|-------|
| <b>Other Indicators</b>  |     |     |     |       |       |              |              |     |              |   |   |   |   |       |       |
| Rate of Total Births per 1,000 Females Ages 15-44, 2017-2019                           | 711 | 719 | 722 | 47.5  | 53.1  | <b>57.1</b>  | 57.5         | N/A | Meets/Better |   |   |   |   |       |       |
| Percent Multiple Births of Total Births, 2017-2019                                     | 20  | 35  | 16  | 3.3%  | 3.4%  | <b>3.7%</b>  | 3.5%         | N/A | Meets/Better |   |   |   |   |       |       |
| Percent C-Sections to Total Births, 2017-2019  | 213 | 257 | 195 | 30.9% | 32.2% | <b>34.2%</b> | 33.6%        | N/A | Meets/Better |   |   |   |   |       |       |
| Rate of Total Pregnancies per 1,000 Females Ages 15-44, 2017-2019                      | 846 | 835 | 827 | 55.4  | 64.0  | <b>72.3</b>  | 79.7         | N/A | Meets/Better |   |   |   |   |       |       |
| Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, 2017-2019                    | 0   | 0   | 0   | 0.0*  | 0.1*  | <b>0.1</b>   | 0.1          | N/A | Less than 10 |   |   |   |   |       |       |
| Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, 2017-2019                    | 7   | 6   | 7   | 5.6   | 5.7   | <b>4.7</b>   | 4.9          | N/A | Worse        | X |   |   |   |       |       |
| Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019                    | 21  | 20  | 20  | 13.2  | 30.2  | <b>20.1</b>  | 21.5         | N/A | Meets/Better |   |   |   |   |       |       |
| Rate of Teen pregnancy per 1,000 females aged <18 years, 2017-2019                     | 10  | 9   | 9   | 2.9   | 3.7   | <b>3.7</b>   | 4.7          | N/A | Meets/Better |   |   |   |   |       |       |
| Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019               | 29  | 29  | 29  | 18.9  | 42.4  | <b>32.8</b>  | 41.1         | N/A | Meets/Better |   |   |   |   |       |       |
| Percent Total Births to Women Ages 35 Plus, 2017-2019                                  | 88  | 107 | 97  | 13.6% | 13.9% | <b>22.3%</b> | 24.5%        | N/A | Meets/Better |   |   |   |   |       |       |
| Ratio+ of Abortions All Ages per 1000 Live Births to All Mothers, 2017-2019            | 85  | 69  | 70  | 104.1 | N/A   | N/A          | <b>333.1</b> | N/A | Meets/Better |   |   |   |   |       |       |
| Percentage of WIC Women Pre-pregnancy Underweight (BMI less than 18.5), 2015-2017      | 21  | 25  | 20  | 5.3%  | 4.7%  | <b>3.9%</b>  | 4.6%         | N/A | Worse        |   | X |   |   |       |       |
| Percentage of WIC Women Pre-pregnancy Overweight but not Obese (BMI 25 >30), 2015-2017 | 96  | 91  | 88  | 22.2% | 23.1% | <b>27.1%</b> | 27.6%        | N/A | Meets/Better |   |   |   |   |       |       |
| Percentage of WIC Women Pre-pregnancy Obese (BMI > 30), 2015-2017                      | 157 | 151 | 163 | 38.0% | 35.8% | <b>31.1%</b> | 26.6%        | N/A | Worse        | X |   |   |   |       |       |
| Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, 2015-2019     | 203 | 195 | 176 | 51.0% | 51.9% | <b>45.7%</b> | 41.0%        | N/A | Worse        | X |   |   |   |       |       |
| Percentage of WIC Women with Gestational Diabetes, 2015-2017                           | 50  | 41  | 39  | 11.3% | 8.2%  | <b>6.6%</b>  | 6.6%         | N/A | Worse        |   |   | X |   |       |       |
| Percentage of WIC Women with Gestational Hypertension, 2015-2017                       | 45  | 52  | 55  | 13.2% | 13.1% | <b>9.0%</b>  | 7.5%         | N/A | Worse        |   | X |   |   |       |       |
| <b>Quartile Summary for Other Indicators</b>   |     |     |     |       |       |              |              |     |              | 3 | 2 | 1 | 0 | 35.3% | 16.7% |

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|   |   |   |   |   |       |       |
|---|---|---|---|---|-------|-------|
| Quartile Summary for Focus Area Preconception and Reproductive Health | 3 | 2 | 1 | 0 | 33.3% | 16.7% |
|---|---|---|---|---|-------|-------|

**Focus Area: Child Health**

| Other Indicators  |       |       |       |       |              |              |       |     |                              |   |  |  |  |  |  |  |  |
|---|-------|-------|-------|-------|--------------|--------------|-------|-----|------------------------------|---|--|--|--|--|--|--|--|
| Percentage of children with recommended number of well child visits in government sponsored insurance programs, 2019                              |       |       |       | 75.7% | 74.1%        | <b>73.3%</b> | 75.2% | N/A | Meets/Better                 |   |  |  |  |  |  |  |  |
| Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, 2017-2019   | 0     | 1     | 0     | 10.7* | 25.1*        | <b>18.9</b>  | 17.7  | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, 2017-2019   | 0     | 2     | 1     | 18.2* | 32.5         | <b>31.3</b>  | 30.1  | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019   |       |       |       | N/A   | 10.8         | <b>24.9</b>  | 35.6  | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2017-2019  |       |       |       | N/A   | 3.4          | <b>9.4</b>   | 16.6  | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2017-2019  |       |       |       | 1.4*  | 4.9          | <b>12.4</b>  | 20.3  | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019  |       |       |       | N/A   | 4.3          | <b>7.5</b>   | 10.4  | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019   |       |       |       | 0.0*  | 1.6*         | <b>1.5</b>   | 1.8   | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019  |       |       |       | N/A   | 18.3         | <b>20.3</b>  | 25.2  | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016   |       |       |       | 54.7  | 65.5         | <b>105.9</b> | 186.4 | N/A | Meets/Better                 |   |  |  |  |  |  |  |  |
| Percentage of Children born in 2016 Screened for Lead by Age 0-8 months, 2016   |       |       |       | 2.4%  | 2.4%         | <b>1.2%</b>  | 1.7%  | N/A | Meets/Better                 |   |  |  |  |  |  |  |  |
| Percentage of Children Born in 2016 Screened for Lead by Age 9-17 months, 2016  |       |       |       | 82.4% | 81.7%        | <b>73.0%</b> | 75.6% | N/A | Meets/Better                 |   |  |  |  |  |  |  |  |
| Percentage of Children Born 2016 Screened for Lead by Age 36 months (at least two screenings), 2016   |       |       |       | 61.2% | 63.7%        | <b>57.8%</b> | 63.3% | N/A | Meets/Better                 |   |  |  |  |  |  |  |  |
| Rate of Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) Per 1,000 tested children aged <72 months, 2017-2019 | 2     | 5     | 3     | 2.7   | 8.5          | <b>6.6</b>   | 3.8   | N/A | Meets/Better                 |   |  |  |  |  |  |  |  |
| Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2017-2019                                 |       |       |       | 2.5*  | 12.9         | <b>17.7</b>  | 18.4  | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2017-2019                                 |       |       |       | N/A   | 8.9          | <b>12.7</b>  | 13.2  | N/A | Less than 10                 |   |  |  |  |  |  |  |  |
| Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2017-2019                             | 16    | 12    | 8     | 9.2   | 17.7         | <b>23.1</b>  | 22.6  | N/A | Meets/Better                 |   |  |  |  |  |  |  |  |
| Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016  |       |       |       | 55.7  | 51.3         | <b>68.1</b>  | 137.1 | N/A | Meets/Better                 |   |  |  |  |  |  |  |  |
| Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, 2018-2020                                       | 3,298 | 3,326 | 2,853 | 48.1% | 49.3%        | <b>47.9%</b> | 46.9% | N/A | Meets/Better                 |   |  |  |  |  |  |  |  |
| Percentage of 3rd Graders with Dental Caries Experience, 2009-2011  |       |       |       | 59.6% | N/A          | N/A          | N/A   | N/A | No comparison data available |   |  |  |  |  |  |  |  |
| Percentage of 3rd Graders with Dental Sealants, 2009-2011   |       |       |       | 31.3% | N/A          | N/A          | N/A   | N/A | No comparison data available |   |  |  |  |  |  |  |  |
| Percentage of 3rd Graders with Dental Insurance, 2009-2011  |       |       |       | 81.1% | 85.2%        | N/A          | N/A   | N/A | Worse                        | X |  |  |  |  |  |  |  |
| Percentage of 3rd Graders with at Least One Dental Visit, 2009-2011   |       |       |       | 76.0% | <b>81.0%</b> | N/A          | N/A   | N/A | Worse                        | X |  |  |  |  |  |  |  |

|      |  |        |  |
|------|--|--------|--|
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Nov-21 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 | ARHN calculation not included due to unstable rate |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 | ARHN calculation not included due to unstable rate |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 |  |
| 0.00 | <a href="#">Asthma Dashboard-County Level</a>      | Feb-22 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Sep-21 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Sep-21 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Sep-21 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Feb-22 |  |
| 0.00 | <a href="#">Asthma Summary Report</a>              | Feb-22 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Sep-21 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Aug-12 |  |
| 0.00 | <a href="#">Community Health Indicator Reports</a> | Aug-12 |  |
| 0.05 | <a href="#">Community Health Indicator Reports</a> | Aug-12 |  |
| 0.07 | <a href="#">Community Health Indicator Reports</a> | Aug-12 |  |

|   |    |    |    |       |       |              |       |     |                              |   |   |   |   |       |      |
|---|----|----|----|-------|-------|--------------|-------|-----|------------------------------|---|---|---|---|-------|------|
| Percentage of 3rd Graders Taking Fluoride Tablets Regularly, 2009-2011                    |    |    |    | 61.0% | N/A   | N/A          | N/A   | N/A | No comparison data available |   |   |   |   |       |      |
| Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2017-2019 | 28 | 56 | 31 | 159.9 | 228.2 | <b>146.7</b> | 146.4 | N/A | Worse                        | X |   |   |   |       |      |
| Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, 2015-2017     |    |    |    | 86.9% | 85.4% | <b>84.9%</b> | 86.6% | N/A | Meets/Better                 |   |   |   |   |       |      |
| <b>Quartile Summary for Other Indicators</b>  |    |    |    |       |       |              |       |     |                              | 3 | 0 | 0 | 0 | 11.5% | 0.0% |
| <b>Quartile Summary for Focus Area Child Health</b>                                       |    |    |    |       |       |              |       |     |                              | 3 | 0 | 0 | 0 | 11.5% | 0.0% |

0.00 [Community Health Indicator Reports](#) Aug-12

0.09 [Community Health Indicator Reports](#) Nov-21

0.00 [Community Health Indicator Reports](#) Jun-18

N/A: Data does not meet reporting criteria

\*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

|   | Number Per Year<br>(If Available) |     |       | Clinton County<br>Average, Rate,<br>Ratio or<br>Percentage for<br>the Listed Years | Comparison Regions/Data |            |                |                                     | Comparison to<br>Benchmark | Quartile Ranking |    |    |    | Quartile<br>Score | Severity<br>Score |
|---|-----------------------------------|-----|-------|--|-------------------------|------------|----------------|-------------------------------------|----------------------------|------------------|----|----|----|-------------------|-------------------|
|   | One                               | Two | Three |  | ARHN <sup>1</sup>       | Upstate NY | New York State | 2024 Prevention<br>Agenda Benchmark |                            | Q1               | Q2 | Q3 | Q4 |                   |                   |
| <b>Focus Area: Human Immunodeficiency Virus (HIV)</b>                     |                                   |     |       |  |                         |            |                |                                     |                            |                  |    |    |    |                   |                   |
| <b>Prevention Agenda Indicators</b>                                       |                                   |     |       |  |                         |            |                |                                     |                            |                  |    |    |    |                   |                   |
| Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2017-2019       |                                   |     |       | 2.1*   | 4.3*                    | 5.7        | 13.1           | 5.2                                 | Less than 10               |                  |    |    |    |                   |                   |
| <b>Quartile Summary for Prevention Agenda Indicators</b>                  |                                   |     |       |  |                         |            |                |                                     |                            | 0                | 0  | 0  | 0  | 0.0%              | 0.0%              |
| <b>Other Indicators</b>   |                                   |     |       |  |                         |            |                |                                     |                            |                  |    |    |    |                   |                   |
| AIDS Deaths per 100,000, 2017-2019  | 0                                 | 0   | 0     | 0.0*   | 0.4*                    | 0.9        | 2.2            | N/A                                 | Less than 10               |                  |    |    |    |                   |                   |
| <b>Quartile Summary for Other Indicators</b>                              |                                   |     |       |  |                         |            |                |                                     |                            | 0                | 0  | 0  | 0  | 0.0%              | 0.0%              |
| <b>Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)</b> |                                   |     |       |  |                         |            |                |                                     |                            | 0                | 0  | 0  | 0  | 0.0%              | 0.0%              |

| Source | Updated | Notes |
|--------|---------|-------|
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|---|--------|--|
| 0.00 <a href="#">Prevention Agenda Dashboard</a>        | Feb-22 | ARHN calculation not included due to unstable rate |
| 0.00 <a href="#">Community Health Indicator Reports</a> | Feb-22 | ARHN calculation not included due to unstable rate |

|  |     |     |     |         |          |         |         |       |              |   |   |   |   |       |        |
|--|-----|-----|-----|---------|----------|---------|---------|-------|--------------|---|---|---|---|-------|--------|
| <b>Focus Area: Sexually Transmitted Disease (STDs)</b>   |     |     |     |         |          |         |         |       |              |   |   |   |   |       |        |
| <b>Prevention Agenda Indicators</b>  |     |     |     |         |          |         |         |       |              |   |   |   |   |       |        |
| Early syphilis diagnoses, age-adjusted rate per 100,000 population, 2019                           |     |     |     | 3.6*    | 3.71*    | 15.3    | 38.6    | 79.6  | Less than 10 |   |   |   |   |       |        |
| Gonorrhea diagnoses, age-adjusted rate per 100,000 population, 2019                                |     |     |     | 34.9    | 33.40    | 114.9   | 217     | 242.6 | Meets/Better |   |   |   |   |       |        |
| Chlamydia diagnoses, age-adjusted rate per 100,000 population, 2019                                |     |     |     | 312.8   | 244.33   | 457.5   | 667.9   | 676.9 | Meets/Better |   |   |   |   |       |        |
| <b>Quartile Summary for Prevention Agenda Indicators</b>   |     |     |     |         |          |         |         |       |              | 0 | 0 | 0 | 0 | 0.0%  | 0.0%   |
| <b>Other Indicators</b>  |     |     |     |         |          |         |         |       |              |   |   |   |   |       |        |
| Rate of Gonorrhea case rate per 100,000 males - Aged 15-44 years, 2017-2019                        | 4   | 13  | 8   | 51.1    | 54.45    | 267.8   | 614.9   | N/A   | Meets/Better |   |   |   |   |       |        |
| Gonorrhea case rate per 100,000 females - Aged 15-44 years, 2017-2019                              | 1   | 17  | 18  | 79.5    | 88.72    | 218.3   | 252.5   | N/A   | Meets/Better |   |   |   |   |       |        |
| Rate of Gonorrhea case rate per 100,000 - Aged 15-19 years, 2017-2019                              | 1   | 4   | 6   | 66.7    | 73.15    | 246.4   | 401.5   | N/A   | Meets/Better |   |   |   |   |       |        |
| Rate of Chlamydia Cases All Males Aged 15-44 years per 100,000 Male Population, 2017-2019          | 88  | 98  | 85  | 513.3   | 406.45   | 41.2    | 1,175.1 | N/A   | Worse        |   |   |   | X |       |        |
| Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, 2017-2019 | 18  | 12  | 13  | 520.0   | 466.03   | 766.4   | 1,142.6 | N/A   | Meets/Better |   |   |   |   |       |        |
| Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, 2017-2019       | 47  | 48  | 40  | 1,177.8 | 945.09   | 1,513.3 | 2,107.1 | N/A   | Meets/Better |   |   |   |   |       |        |
| Rate of Chlamydia Cases All Females Aged 15-44 years per 100,000 Female Population, 2017-2019      | 179 | 199 | 178 | 1,128.5 | 1,118.40 | 1,455.2 | 1,741.1 | N/A   | Meets/Better |   |   |   |   |       |        |
| Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population, 2017-2019               | 53  | 59  | 49  | 1,960.3 | 2,006.20 | 2,623.6 | 3,535.7 | N/A   | Meets/Better |   |   |   |   |       |        |
| Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population, 2017-2019              | 87  | 93  | 81  | 2,316.9 | 2,740.07 | 3,203.9 | 3,912.5 | N/A   | Meets/Better |   |   |   |   |       |        |
| Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population, 2017-2019          |     |     |     | N/A     | 0.95*    | 1.9     | 2.5     | N/A   | Less than 10 |   |   |   |   |       |        |
| <b>Quartile Summary for Other Indicators</b>   |     |     |     |         |          |         |         |       |              | 0 | 0 | 0 | 1 | 10.0% | 100.0% |
| <b>Quartile Summary for Sexually Transmitted Diseases</b>  |     |     |     |         |          |         |         |       |              | 0 | 0 | 0 | 1 | 7.7%  | 100.0% |

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| 0.00 <a href="#">Prevention Agenda Dashboard</a>         | Feb-22 | ARHN calculation not included due to unstable rate |
| 0.00 <a href="#">Prevention Agenda Dashboard</a>         | Feb-22 |  |
| 0.00 <a href="#">Prevention Agenda Dashboard</a>         | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |  |
| 11.46 <a href="#">Community Health Indicator Reports</a> | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 |  |
| 0.00 <a href="#">Community Health Indicator Reports</a>  | Feb-22 | ARHN calculation not included due to unstable rate |

|   |     |     |    |       |       |       |       |       |              |   |   |   |   |       |      |
|---|-----|-----|----|-------|-------|-------|-------|-------|--------------|---|---|---|---|-------|------|
| <b>Focus Area: Vaccine Preventable Disease</b>  |     |     |    |       |       |       |       |       |              |   |   |   |   |       |      |
| <b>Prevention Agenda Indicators</b>   |     |     |    |       |       |       |       |       |              |   |   |   |   |       |      |
| Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series, 2020 |     |     |    | 82.7% | 68.2% | 66.3% | 66.1% | 70.5% | Meets/Better |   |   |   |   |       |      |
| Percentage of 13-year-old adolescents with a complete HPV vaccine series, 2020          |     |     |    | 35.2% | 25.8% | 32.8% | 39.8% | 37.4% | Worse        | X |   |   |   |       |      |
| <b>Quartile Summary for Prevention Agenda Indicators</b>                                |     |     |    |       |       |       |       |       |              | 1 | 0 | 0 | 0 | 50.0% | 0.0% |
| <b>Other Indicators</b>   |     |     |    |       |       |       |       |       |              |   |   |   |   |       |      |
| Rate of Pertussis Cases per 100,000 Population, 2017-2019                               | 31  | 8   | 27 | 27.3  | 12.3  | 5.0   | 3.8   | N/A   | Worse        |   |   |   | X |       |      |
| Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019    | 138 | 103 | 94 | 81.8  | 87.7  | 95.2  | 85.5  | N/A   | Meets/Better |   |   |   |   |       |      |
| Percentage of adults aged 65+ years with pneumococcal immunization, 2018                |     |     |    | 70.4% | 70.0% | 69.4% | 64.0% | N/A   | Meets/Better |   |   |   |   |       |      |

|   |        |                                    |
|---|--------|------------------------------------|
| 0.00 <a href="#">Prevention Agenda Dashboard</a>            | Oct-21 | Age range adjusted to 24-35 months |
| 0.06 <a href="#">Prevention Agenda Dashboard</a>            | Oct-21 |                                    |
| 4.46 <a href="#">Community Health Indicator Reports</a>     | Feb-22 |                                    |
| 0.00 <a href="#">Community Health Indicator Reports</a>     | Feb-22 |                                    |
| 0.00 <a href="#">NYS Expanded Behavioral Risk Factor Su</a> | Mar-22 |                                    |

|   |   |   |   |      |      |     |     |     |              |   |   |   |   |       |        |
|---|---|---|---|------|------|-----|-----|-----|--------------|---|---|---|---|-------|--------|
| Rate of Mumps Cases per 100,000 Population, 2017-2019         | 1 | 0 | 0 | 0.4* | 1.4* | 1.3 | 1.7 | N/A | Less than 10 |   |   |   |   |       |        |
| Rate of Meningococcal Cases per 100,000 Population, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.0* | 0.1 | 0.1 | N/A | Less than 10 |   |   |   |   |       |        |
| Rate of H Influenza Cases per 100,000 Population, 2017-2019   | 4 | 4 | 4 | 5.0  | 2.1  | 2.3 | 2.0 | N/A | Worse        |   |   |   | X |       |        |
| Quartile Summary for Other Indicators                         |   |   |   |      |      |     |     |     |              | 0 | 0 | 0 | 2 | 33.3% | 100.0% |
| Quartile Summary for Focus Area Vaccine Preventable Diseases  |   |   |   |      |      |     |     |     |              | 1 | 0 | 0 | 2 | 37.5% | 66.7%  |

|  |  |  |  |     |     |     |     |     |       |   |   |   |   |        |        |
|--|--|--|--|-----|-----|-----|-----|-----|-------|---|---|---|---|--------|--------|
| <b>Focus Area: Healthcare Associated Infections</b>  |  |  |  |     |     |     |     |     |       |   |   |   |   |        |        |
| <b>Prevention Agenda Indicators</b>  |  |  |  |     |     |     |     |     |       |   |   |   |   |        |        |
| Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days (Risk-adjusted), 2019 |  |  |  | 6.3 | N/A | N/A | 4.0 | N/A | Worse |   |   | X |   |        |        |
| Rate of Community Onset, Healthcare Facility Associated CDIs per 100 Admissions, not risk-adjusted, 2019     |  |  |  | 0.4 | N/A | N/A | 0.2 | N/A | Worse |   |   |   | X |        |        |
| Quartile Summary for Healthcare Associated Infections  |  |  |  |     |     |     |     |     |       | 0 | 0 | 1 | 1 | 100.0% | 100.0% |

N/A: Data does not meet reporting criteria

\*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

±: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

0.00 [Community Health Indicator Reports](#) Feb-22 ARHN calculation not included due to unstable rate

0.00 [Community Health Indicator Reports](#) Feb-22 ARHN calculation not included due to unstable rate

1.50 [Community Health Indicator Reports](#) Feb-22

0.60 [NYS Department of Health Hospital Report](#) May-21 CDI Hospital Onset; No data for Essex County; Elizabethtown Hospital

0.85 [NYS Department of Health Hospital Report](#) May-21 CDI Community Onset Not-My-Hospita; No data for Essex County; Elizabethtown Hospital

|   | Number Per Year<br>(If Available) |     |       | Clinton County<br>Average, Rate,<br>Ratio or<br>Percentage for<br>the Listed Years | Comparison Regions/Data |             |                   |  | Comparison to<br>Benchmark | Quartile Ranking |    |    |    | Quartile<br>Score | Severity<br>Score |
|---|-----------------------------------|-----|-------|--|-------------------------|-------------|-------------------|--|----------------------------|------------------|----|----|----|-------------------|-------------------|
|   | One                               | Two | Three |  | ARHN <sup>1</sup>       | Upstate NY  | New York<br>State | 2024 Prevention<br>Agenda<br>Benchmark |                            | Q1               | Q2 | Q3 | Q4 |                   |                   |
| <b>Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavioral Disorders</b>                      |                                   |     |       |  |                         |             |                   |  |                            |                  |    |    |    |                   |                   |
| <b>Prevention Agenda Indicators</b>   |                                   |     |       |  |                         |             |                   |  |                            |                  |    |    |    |                   |                   |
| Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2018   |                                   |     |       | 19.9%  | 16.6%                   | 18.4%       | 17.5%             | <b>16.4%</b>                           | Worse                      | X                |    |    |    |                   |                   |
| Age Adjusted Rate of Suicides per 100,000 Adjusted Population, 2017-2019  |                                   |     |       | 10.6   | N/A                     | 9.9         | 8.2               | <b>7.0</b>                             | Worse                      |                  |    | X  |    |                   |                   |
| <b>Quartile Summary for Prevention Agenda Indicators</b>  |                                   |     |       |  |                         |             |                   |  |                            | 1                | 0  | 1  | 0  | 100.0%            | 50.0%             |
| <b>Other Indicators</b>   |                                   |     |       |  |                         |             |                   |  |                            |                  |    |    |    |                   |                   |
| Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, 2017-2019                                      | 0                                 | 2   | 0     | 12.1*  | 8.1*                    | <b>7.3</b>  | 6.0               | N/A                                    | Less than 10               |                  |    |    |    |                   |                   |
| Rate of Self-inflicted injury Hospitalizations 10,000 Population, 2017-2019   | 32                                | 26  | 48    | 4.4  | 6.1                     | <b>4.4</b>  | 3.7               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Self-inflicted injury Hospitalizations for Ages 15 - 19 per 10,000 Population, 2017-2019                      |                                   |     |       | 7.3  | 17.0                    | <b>10.3</b> | 9.0               | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| Rate of Cirrhosis Deaths per 100,000 Population, 2017-2019  | 14                                | 15  | 8     | 15.3   | 15.3                    | <b>10.1</b> | 8.4               | N/A                                    | Worse                      |                  |    | X  |    |                   |                   |
| Rate of Alcohol-Related Crashes per 100,000, 2020   |                                   |     |       | 55.2   | 66.4                    | <b>52.0</b> | 40.1              | N/A                                    | Worse                      | X                |    |    |    |                   |                   |
| Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2020  |                                   |     |       | 15.0   | 28.7                    | <b>28.8</b> | 23.3              | N/A                                    | Meets/Better               |                  |    |    |    |                   |                   |
| <b>Quartile Summary for Other Indicators</b>  |                                   |     |       |  |                         |             |                   |  |                            | 1                | 0  | 1  | 0  | 33.3%             | 50.0%             |
| <b>Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavioral Disorders</b> |                                   |     |       |  |                         |             |                   |  |                            | 2                | 0  | 2  | 0  | 50.0%             | 50.0%             |

| Source | Updated | Notes |
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|--|--------|---|
| 0.21 <a href="#">Prevention Agenda Dashb</a>     | Feb-22 |   |
| 0.51 <a href="#">Prevention Agenda Dashb</a>     | Feb-22 | Not enough information to calculate ARHN region rate. |
| 0.00 <a href="#">Community Health Indicat</a>    | Feb-22 | ARHN calculation not included due to unstable rate    |
| 0.00 <a href="#">Community Health Indicat</a>    | Feb-22 |   |
| 0.00 <a href="#">Community Health Indicat</a>    | Feb-22 |   |
| 0.51 <a href="#">Community Health Indicat</a>    | Feb-22 |   |
| 0.06 <a href="#">NYS Traffic Safety Statisti</a> | Jan-22 |   |
| 0.00 <a href="#">NYS Traffic Safety Statisti</a> | Jan-22 |   |

N/A: Data does not meet reporting criteria

\*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

|   | Number Per Year<br>(If Available) |     |       | Clinton County,<br>Average Rate,<br>Ratio or<br>Percentage for<br>the Listed Years | Comparison Regions/Data |            |                   |  | Comparison to<br>Benchmark | Quartile Ranking |    |    |    | Quartile<br>Score | Severity<br>Score | Source   | Updated | Notes  |
|---|-----------------------------------|-----|-------|--|-------------------------|------------|-------------------|--|----------------------------|------------------|----|----|----|-------------------|-------------------|--|---------|--|
|   | One                               | Two | Three |  | ARHN <sup>1</sup>       | Upstate NY | New York<br>State | 2024 Prevention<br>Agenda<br>Benchmark |                            | Q1               | Q2 | Q3 | Q4 |                   |                   |  |         |  |
| <b>Other Non-Prevention Agenda Indicators</b>                       |                                   |     |       |  |                         |            |                   |  |                            |                  |    |    |    |                   |                   |  |         |  |
| Rate of Hepatitis A Cases per 100,000 Population, 2017-2019         | 1                                 | 0   | 0     | 0.8*   | 0.4*                    | 1.4        | 1.3               | N/A                                    | Less than 10               |                  |    |    |    |                   | 0.00              | <a href="#">Community Health Indicator Reports</a>     | Feb-22  | ARHN calculation not included due to unstable rate   |
| Rate of Acute Hepatitis B Cases per 100,000 Population, 2017-2019   | 0                                 | 1   | 1     | 0.8*   | 0.3*                    | 0.4        | 0.4               | N/A                                    | Less than 10               |                  |    |    |    |                   | 0.00              | <a href="#">Community Health Indicator Reports</a>     | Feb-22  | ARHN calculation not included due to unstable rate   |
| Rate of TB Cases per 100,000 Population, 2017-2019                  | 0                                 | 1   | 1     | 0.8*   | 0.6*                    | 1.7        | 3.9               | N/A                                    | Less than 10               |                  |    |    |    |                   | 0.00              | <a href="#">Community Health Indicator Reports</a>     | Feb-22  | ARHN calculation not included due to unstable rate   |
| Rate of E. Coli Shiga Toxin Cases per 100,000 Population, 2017-2019 | 1                                 | 1   | 1     | 1.2*   | 3.0                     | 3.1        | 4.1               | N/A                                    | Less than 10               |                  |    |    |    |                   | 0.00              | <a href="#">Community Health Indicator Reports</a>     | Feb-22  |  |
| Rate of Salmonella Cases per 100,000 Population, 2017-2019          | 5                                 | 5   | 8     | 7.4  | 11.1                    | 12.9       | 14.0              | N/A                                    | Meets/Better               |                  |    |    |    |                   | 0.00              | <a href="#">Community Health Indicator Reports</a>     | Feb-22  |  |
| Rate of Shigella Cases per 100,000 Population, 2017-2019            | 0                                 | 0   | 3     | 1.2*   | 0.5*                    | 3.4        | 6.3               | N/A                                    | Less than 10               |                  |    |    |    |                   | 0.00              | <a href="#">Community Health Indicator Reports</a>     | Feb-22  | ARHN calculation not included due to unstable rate   |
| Rate of Lyme Disease Cases per 100,000 Population, 2017-2019        | 55                                | 42  | 61    | 65.3   | 118.1                   | 70.7       | 44.7              | N/A                                    | Meets/Better               |                  |    |    |    |                   | 0.00              | <a href="#">Community Health Indicator Reports</a>     | Feb-22  | Upstate NY rate calculated using county data.  |
| Rate of Confirmed Rabies Cases per 100,000 Population, 2020         |                                   |     |       | 1.2  | 3.4*                    | 3.1        | 1.8               | N/A                                    | Meets/Better               |                  |    |    |    |                   | 0.00              | <a href="#">Department of Health, Wadsworth Center</a> | Dec-20  | Used 2020 Profile Population data (U.S. Census Bureau)<br>ARHN calculation not included due to unstable rate |
| <b>Quartile Summary for Non-Prevention Agenda Issues</b>            |                                   |     |       |  |                         |            |                   |  |                            | 0                | 0  | 0  | 0  | 0.0%              | 0.0%              |  |         |  |

N/A: Data does not meet reporting criteria

\*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

**Appendix E:**

**AHI Community Health Assessment Committee  
2022 Data Methodology**



## Community Health Assessment Committee 2022 Data Methodology

### **Background:**

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

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

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

### **Demographic Profile:**

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

### **Health System Profile:**

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

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

### **Education Profile:**

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

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

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

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

**Data Sheets:**

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

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

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

$$\begin{array}{cc} \text{Clinton County rate: } 20.7 & \text{Upstate NY: } 14.8 \\ \boxed{20.7/14.8 = 1.39} & \end{array}$$

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

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

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

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

ARHN region and Upstate NY calculations:

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

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

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

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

$$\left[ \frac{\text{Total for New York State} - \text{Total for New York City region}}{(\text{Average Population for New York State} - \text{Average for New York City region}) \times 3} \right] \times 100,000$$

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

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

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

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



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### **Source Information for 2022 CHA Data Analysis**

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

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

#### **2022 CHA Data Sheets and Written Analysis Data Sources:**

- Community Health Indicator Reports (CHIRs)
- Department of Health, Wadsworth Center
- Division of Criminal Justice Services Index, Property, and Firearm Rates
- NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators
- NYS Department of Health Hospital Report on Hospital Acquired Infections
- NYS Department of Health Tobacco Enforcement Compliance Results
- NYS Department of Health, Asthma Dashboard
- NYS Traffic Safety Statistical Repository
- Prevention Agenda Dashboard



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- State and County Indicators for Tracking Public Health Priority Areas
- Student Weight Status Category Reporting System (SWSCRS) Data
- USDA Economic Research Service Fitness Facilities Data
- USDA Food Environment Atlas

**Appendix F:**

**Priority Setting Session Prevention Agenda Infographics**

# Prevention Agenda 2019-2024: New York State's Health Improvement Plan

## Prevent Chronic Disease (Select Clinton County indicators)

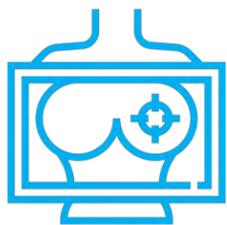
### Priority Area:

Prevent Chronic Disease

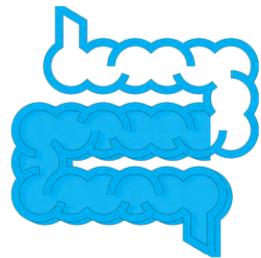
### Focus Areas:

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

**74.6%**  
of Clinton County women ages 50-74 have had a **mammogram** in the past 2 years.



Source: NYS Expanded Behavioral Risk Factor Survey



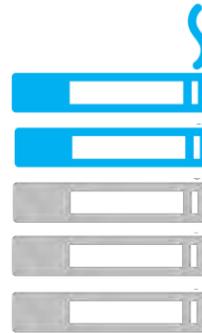
**65.3%**  
of Clinton County adults ages 50-64 have been screened for **colon cancer**.

**65%**  
of Clinton County residents qualify for **SNAP** or other **nutrition programs** based on income.



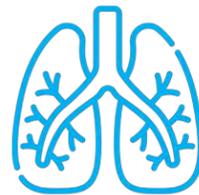
Source: Feeding America

**40%**  
of Clinton County adults with an income less than \$25,000 **smoke**.



Source: County Health Rankings

Almost **15%**  
of Clinton County adults have **asthma**.



Source: NYS Expanded Behavioral Risk Factor Survey



Only **61.5%**  
of Clinton County adults have at least 1 **preventive dental visit** each year.

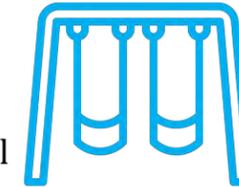
Source: NYS Prevention Agenda

More than

**36%**

Clinton County elementary school students are

**overweight or obese.**



Source: NYS Department of Health

**46%**

middle and high school students in Clinton County are **overweight or obese.**



Source: NYS Department of Health



of adults in Clinton County are **overweight or obese.**

Source: NYS Expanded Behavioral Risk Factor Survey



**10,490**

Clinton County adults experience **food insecurity.**

Source: NYS Expanded Behavioral Risk Factor Survey



**29.1%**

of Clinton County adults are **sedentary.**

Source: NYS Expanded Behavioral Risk Factor Survey

Only **7.5%** of Clinton County adults with **chronic conditions** have taken a course to learn how to manage their condition.



Source: NYS Prevention Agenda

# Prevention Agenda 2019-2024: New York State's Health Improvement Plan

## Promote Mental Health and Prevent Substance Abuse (Select Clinton County indicators)

### Priority Area:

Promote Mental Health and Prevent Substance Abuse.

### Focus Areas:

- Promote Well Being
- Mental and Substance Use Disorders Prevention

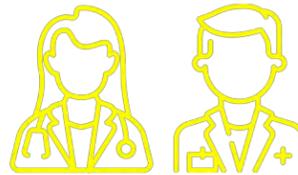
The ratio of population to mental health providers is

**330:1**

in Clinton County and

**310:1**

in New York State.



Source: County Health Ranking



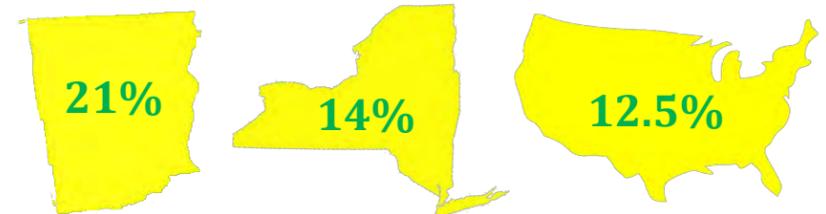
The **Mental Health Provider** rate in Clinton County has shown **consistent improvement** since 2010.

Source: County Health Rankings

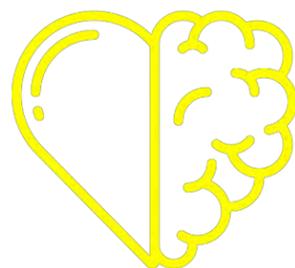
From 2016-2020 the 5-year average rate of death from **suicide** per 100,000 was **11.6**. This is **3.4 points higher** than the state average.



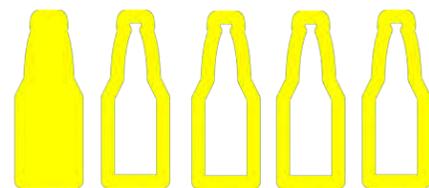
Source: CDC National Vital Statistics System



More than **1 in 3** Clinton County adults self-reported that **mental health was a challenge**.



Source: 2022 CHA Community Survey

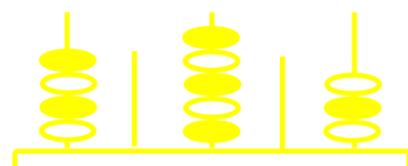


**1 in 5**

Clinton County adults self-report **excessive drinking** within the last month.

Source: Prevention Agenda Dashboard

Percentage of adults who have experienced **two or more adverse childhood experiences (ACEs)**.



34.5 Clinton County, 35.6 New York State, 33.8 Prevention Agenda Goal

Source: NYS Prevention Agenda



The Alliance for Positive Health's **Suboxone Bridge Clinic** has served **over 100** residents since opening in 2019.

Source: 2021 Local Services Plan

The age-adjusted rate of **adults who smoke** in Clinton County is **higher** than both state and national averages.

Source: 2019 County Health Rankings, CDC Data & Statistics



**15.7%** of adults in Clinton County reported **experiencing frequent mental distress** in the past month. This is **4.5 points higher** than the state average.

Source: NYS Expanded Behavioral Risk Factor Surveillance System

# Prevention Agenda 2019-2024: New York State's Health Improvement Plan

## Promote a Healthy and Safe Environment (Select Clinton County indicators)

### Priority Area:

Promote a Healthy and Safe Environment

### Focus Areas:

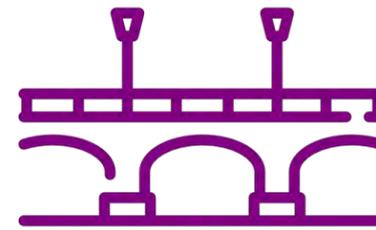
- Injuries, Violence and Occupational Health
- Outdoor Air Quality
- Built and Indoor Environment
- Water Quality
- Food and Consumer Products

More than  
**1 in 4**

Clinton County residents experience low access to a **grocery store.**



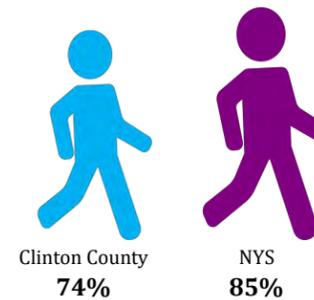
Source: US Dept. of Agriculture—Food Environment Atlas



More than **60%** of Clinton County residents surveyed identified **aging infrastructure** as a top environmental concern in our community.

Source: 2022 CHA Community Survey

Clinton County residents are **11%** less likely than the NYS average to have adequate access to locations for **physical activity.**



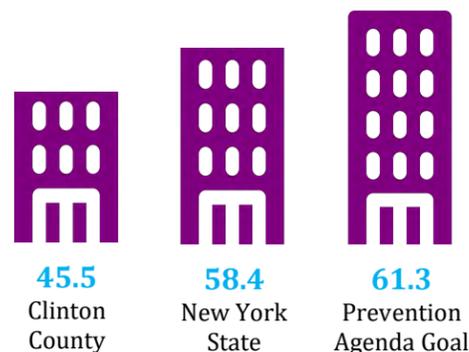
Source: 2021 County Health Rankings



of Clinton County residents are **not** served by community water systems with **fluoridated water.**

Source: Prevention Agenda Dashboard

Clinton County's **Community Score** is **lower** than the Prevention Agenda Benchmark and NYS scores.



Source: Prevention Agenda Dashboard



**1 in 3**

Clinton County residents surveyed identify **school safety** as a top concern.

Source: 2022 CHA Community Survey

10% of households spend more than **50%** of their total income on **housing.**



Source: County Health Rankings & Roadmaps



The rate of **hospitalizations due to falls** for those ages 65+ in Clinton County is worse than the **NYS average.**

Source: Prevention Agenda Dashboard

Clinton County's **Food Environment Index** is **8 out of 10** compared to 9.0 for NYS.



Source: County Health Rankings

# Prevention Agenda 2019-2024: New York State's Health Improvement Plan

## Prevent Communicable Disease (Select Clinton County indicators)

### Priority Area:

Prevent Communicable Disease

### Focus Areas:

- Vaccine Preventable Disease
- Human Immunodeficiency Virus (HIV)
- Sexually Transmitted Infections (STI's)
- Hepatitis C Virus (HCV)
- Antibiotic Resistance and Healthcare-Associated Infections

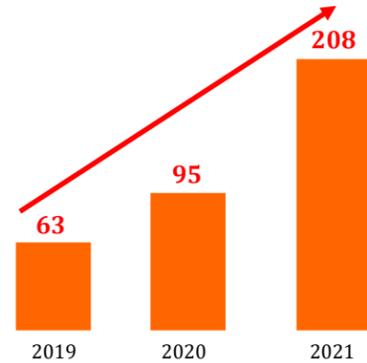
The incidence rate of **chlamydia** in Clinton County is **312.8** per 100,000.



This is a decrease of **32 points** since 2018.

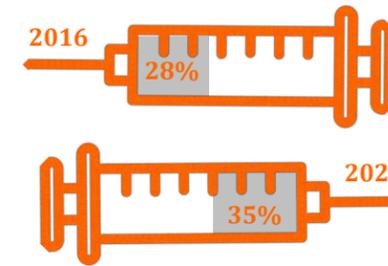
Source: NYS Department of Health

Cases of **Lyme disease** in Clinton County have increased **230%** since 2019.



(Increased case numbers being attributed to increased awareness and changes in environment).

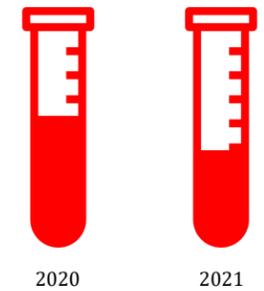
Source: HCS Annual Report 2021



The percent of 13-year old adolescents with a complete **HPV vaccine series** has increased **26%** since 2016.

Source: NYS Prevention Agenda

In 2021, **STI's** made up just over **35%** of reportable communicable disease in Clinton County (excluding COVID-19) compared to **50%** in 2020.



Source: HCS Annual Report, 2021



**60.7%**

of the eligible population has completed the **COVID-19 vaccine series** including booster.

Source: NYS COVID-19 Vaccine Tracker

The incidence rate of **gonorrhea** in Clinton County is **34.9** per 100,000.

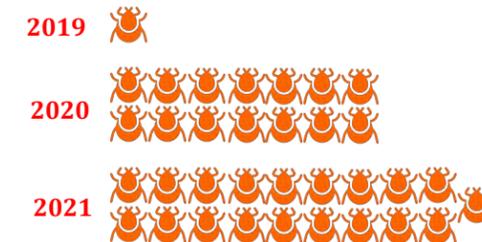


Source: NYS Department of Health

The **HIV** diagnosis rate in Clinton County is **2.1 per 100,000**. That is **11 points lower** than the New York State rate.



Source: Prevention Agenda Dashboard



Much like Lyme disease, cases of **anaplasmosis**, another tick-borne disease, have **increased significantly** since 2019.

Source: HCS Annual Report 2021

CCHD completed **9,123 communicable disease case investigations** in 2021, **8,467** of which were for **COVID-19**.



Source: HCS Annual Report, 2021

# Prevention Agenda 2019-2024: New York State's Health Improvement Plan

## Promote Healthy Women, Infants and Children

(Select Clinton County indicators)

### Priority Area:

Promote Healthy Women, Infants and Children.

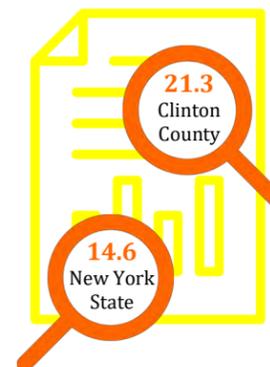
### Focus Areas:

- Maternal and Women's Health
- Prenatal and Infant Health
- Child and Adolescent Health
- Cross-Cutting Healthy Women, Infants and Children



In 2020, **43.7%** of Clinton County babies were **exclusively breastfed** through **6 months of age**.

Source: Clinton County 2020 Breastfeeding Data Summary, 2022



Indicated reports of **child abuse or maltreatment** in Clinton County is **21.3** per 100,000.

Source: NYS Prevention Agenda



**87%** of Clinton County ninth-grade students **graduate high school in 4 years**.

Source: 2022 County Health Rankings & Roadmaps



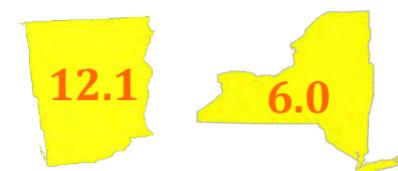
The ratio of **women's median earnings** to men's median earnings in Clinton County is **.92**. In **NYS** it is **.87**.

Source: 2022 County Health Rankings & Roadmaps



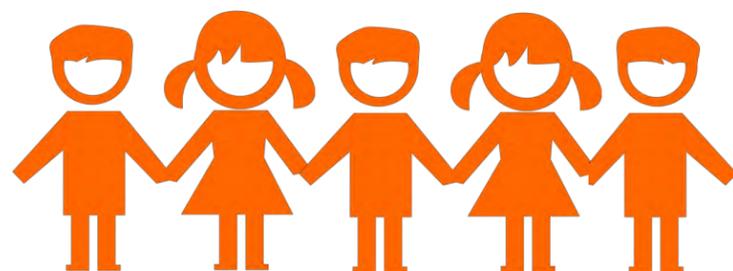
**47%** of children in Clinton County are eligible for **free or reduced price lunches**.

Source: County Health Rankings



The **suicide mortality rate** among Clinton County youth aged 15-19 years is **2x** the NYS rate.

Source: NYS Prevention Agenda



**13%** of Clinton County children live **below the poverty line**.

Source: County Health Rankings

**48.9%** of women aged 18-44 report talking with a health care provider about ways to **prepare for a healthy pregnancy**.



Source: NYS Prevention Agenda



**81.6%** of all Clinton County babies born in 2020 received **some breastmilk** before their 2 day well visit.

Source: Clinton County 2020 Breastfeeding Data Summary, 2022

**7%** of Clinton County babies are born with **low birth weight**.

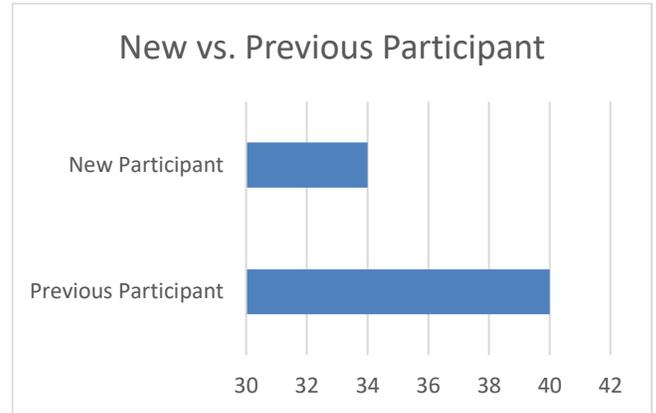
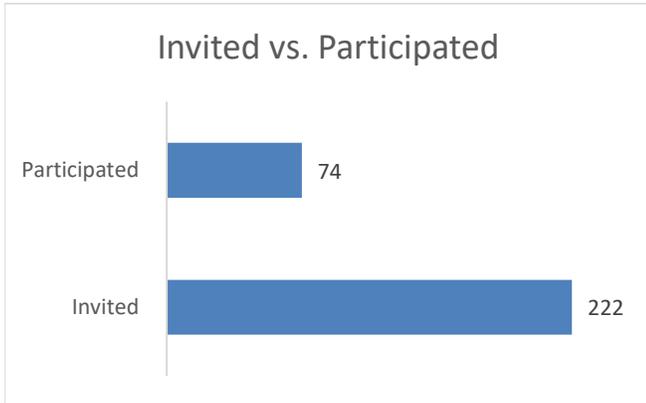


Source: County Health Rankings

## Appendix G:

### **Participant Characteristics, Event Voting Results, and Finalization Methodology & Results**

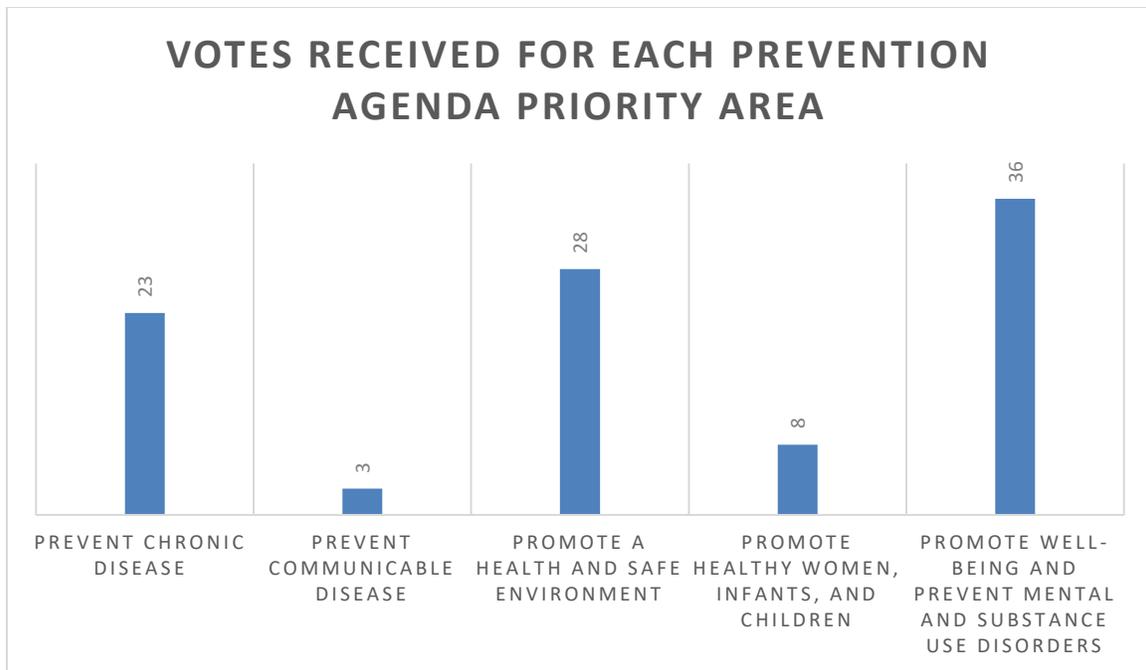
#### Participant Characteristics



| Sectors Represented*   |                                   |
|--|-----------------------------------|
| Business (1)   | High Risk Population Services (4) |
| Community Based Organization (14)  | Housing (1)                       |
| Community Development (2)  | Human Services (4)                |
| Economic Development (2)   | Law Enforcement (1)               |
| Education/ Schools (6)   | Mental/ Behavioral Health (6)     |
| Elected Official/Local Government (7)  | Not-for-Profit (8)                |
| Faith Based Organization (1)   | Parks & Recreation (2)            |
| Food System/Agriculture (2)  | Public Health (15)                |
| Healthcare (15)  | Resident (7)                      |
| *Invitees who participated virtually were allowed to select all sectors they identified with. 18 out of 20 distinct sectors were represented (no participants identified as from “Media” or “Zoning”). |                                   |

#### Priority and Focus Area Selection Results

Responses from health system and community partners participating in the July 14th Community Health Priority Selection session selected Promote Wellbeing and Prevent Mental Health & Substance Abuse and Prevent Chronic Disease as the top two Priority Areas for the next Community Health Improvement Plan.



In addition to voting on Priority Areas, participants were also asked to vote on focus area preference for each Priority Area. However, during Focus Area Selection activities, stakeholders determined all Focus Areas for each health priority area would be included.

Focus Area subcommittees were engaged through surveys and virtual meetings throughout the Fall of 2022. These activities aimed to finalize focus area selections by considering available data and stakeholder input received at the community event.

Participants included:

- Lisa Turner, Clinton County Health Department
- Erin Pangborn, Town of Plattsburgh
- Kerry Haley, The Foundation of CVPH
- Karen Ashline, Adirondacks ACO
- Mandy Snay, Clinton County Health Department
- Diana Aguglia, Alliance for Positive Health
- Bethany Sousis, UVMHN/CVPH
- Richelle Gregory, Clinton County Mental Health & Addiction Services
- Connie Willie, Champlain Valley Family Center
- Rheta Recore, UVMHN/CVPH
- Gail Bjelko, UVMHN/CVPH
- Amanda Bulris- Allen, NAMI
- Kaitlyn Tentsis, UVMHN/ CVPH

To score each health problem (or Focus Area) for the two selected Priority Areas, the Hanlon Method was applied. The following table illustrates a numerical system for rating health problems against the selected criteria and was used by subcommittee members to determine the scores assigned.

| <b>D</b>   | <b>A</b>   | <b>B</b>  | <b>C</b>   |
|--|--|---|--|
| <b>Rating</b>  | <b>Size of Health Problem<br/>(% of population w/ problem)</b>   | <b>Seriousness of Health Problem</b>  | <b>Effectiveness of Interventions</b>  |
| 9 or 10  | > 25%<br>(STDs)  | Very serious<br>(e.g. HIV/AIDS)   | 80% - 100% effective<br>(e.g. vaccination program)   |
| 7 or 8   | 10% - 24.9%  | Relatively serious  | 61% - 80% effective  |
| 5 or 6   | 1% - 9.9%  | Serious   | 41% - 60% effective  |
| 3 or 4   | 0.1% - 0.9%  | Moderately serious  | 21% - 40% effective  |
| 1 or 2   | 0.01% - 0.09%  | Relatively not serious  | 5% - 20% effective   |
| 0  | < 0.01%<br>(Meningococcal Meningitis)  | Not serious<br>(teen acne)  | < 5% effective<br>(access to care)   |
| <i>Guiding considerations when ranking health problems against the three criteria:</i> | <i>Size of health problem should be based on baseline data collective from the individual community.</i> | <i>Does it require immediate attention?<br/>Is there public demand?<br/>What is the economic impact?<br/>What is the impact on quality of life?<br/>Is there a high hospitalization rate?</i> | <i>Determine upper and low measures for effectiveness and rate health problems relative to those limits.</i> |

$$D = [A + (2 \times B)] \times C$$

Focus Area Rating Results (Average scores)

### Prevent Chronic Disease

| <b>Health Problem 1: Healthy Eating and Food Security</b> |                        |                               |                                |
|---|------------------------|-------------------------------|--------------------------------|
|   | Size of Health Problem | Seriousness of Health Problem | Effectiveness of Interventions |
| Rating<br><b>135.6</b>                                    | <b>7.8</b>             | <b>7.4</b>                    | <b>6.0</b>                     |

| <b>Health Problem 2: Chronic Disease Preventive Care and Management</b> |                        |                               |                                |
|---|------------------------|-------------------------------|--------------------------------|
|   | Size of Health Problem | Seriousness of Health Problem | Effectiveness of Interventions |
| Rating<br><b>146.5</b>  | <b>7.4</b>             | <b>7.4</b>                    | <b>6.6</b>                     |

| <b>Health Problem 3: Physical Activity</b> |                        |                               |                                |
|--|------------------------|-------------------------------|--------------------------------|
|  | Size of Health Problem | Seriousness of Health Problem | Effectiveness of Interventions |
| Rating<br><b>134.6</b>                     | <b>6.8</b>             | <b>6.8</b>                    | <b>6.6</b>                     |

| <b>Health Problem 4: Tobacco Prevention</b> |                        |                               |                                |
|---|------------------------|-------------------------------|--------------------------------|
|   | Size of Health Problem | Seriousness of Health Problem | Effectiveness of Interventions |
| Rating<br><b>132.7</b>                      | <b>6.6</b>             | <b>7.4</b>                    | <b>6.2</b>                     |

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

| <b>Health Problem 1: Mental and Substance Use Disorders</b> |                        |                               |                                |
|---|------------------------|-------------------------------|--------------------------------|
|   | Size of Health Problem | Seriousness of Health Problem | Effectiveness of Interventions |
| Rating<br><b>158.0</b>                                      | <b>8.8</b>             | <b>8.8</b>                    | <b>6.0</b>                     |

| <b>Health Problem 2: Well-Being</b> |                        |                               |                                |
|-------------------------------------|------------------------|-------------------------------|--------------------------------|
|                                     | Size of Health Problem | Seriousness of Health Problem | Effectiveness of Interventions |
| Rating<br><b>139.88</b>             | <b>7.6</b>             | <b>7.7</b>                    | <b>6.1</b>                     |

### Disparity Ranking Results

The Priority Area subcommittees were also asked to consider common disparities that influence health. Each were presented a list of eight disparities, which they ranked from 1-7, with one representing the disparity most influential in our community and across priority areas and 7 representing the disparity least apparent in our community and across priority areas.

| <b>Disparity</b>            | <b>Total Score</b> | <b>Average Score</b> | <b>Ranking</b> |
|-----------------------------|--------------------|----------------------|----------------|
| Age                         | 54                 | 4.2                  | <b>3</b>       |
| Disability                  | 56                 | 4.3                  | <b>4</b>       |
| Gender/Sex                  | 83                 | 6.4                  | <b>8</b>       |
| Geographic location         | 45                 | 3.5                  | <b>2</b>       |
| Income                      | 37                 | 2.8                  | <b>1</b>       |
| Level of education          | 59                 | 4.5                  | <b>5</b>       |
| Race/ethnicity              | 68                 | 5.2                  | <b>7</b>       |
| Sexual identity/orientation | 66                 | 5.0                  | <b>6</b>       |