CLINTON COUNTY

2025-2027



COMMUNITY HEALTH ASSESSMENT

Working Together to Strengthen Our Community

Facilitated jointly by:

CCHD
Clinton County HEALTH Department

THE University of Vermont HEALTH NETWORK
Champlain Valley Physicians Hospital

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Executive Summary:

2025 Clinton County Community Health Assessment

The purpose of this community health assessment is to provide a comprehensive analysis of the health status in Clinton County, NY, serving as a foundation for informed decision-making and the development of shared action plans aimed at improving the health of all county's residents.

University of Vermont Health Network-Champlain Valley Physicians Hospital (UVHN-CVPH) and the Clinton County Health Department (CCHD) served as lead entities in this process. Their responsibilities included facilitating the assessment, conducting the data analysis, organizing opportunities to gather resident and stakeholder input, ensuring compliance with IRS and Public Health Accreditation Board standards, and capturing the overall process.

Together they facilitated a 15-month process including the following activities:

- A community based, health and wellness focused resident survey
- A review and analysis of health and wellness indicators
- A review of complementary and relevant needs assessments
- A Community Health Priority Setting Session
- A Domain and Priorities Finalization Process
- The development of shared Action Plans

The partners that comprise the Action for Health Consortium provided additional reach into the community, among other benefits to this process. The Adirondack Rural Health Network coordinated community health assessment partners across the region, providing a broader perspective to community health planning.

The assessment and health needs prioritization processes were guided by the 2025-2030 New York State Prevention Agenda Framework. Partners reviewed and analyzed hundreds of objective, measurable indicators of health status and outcomes from over 25 different sources, including but limited to the NYS Prevention Agenda Dashboard, NYS Community Health Indicator Reports, NYS Behavioral Health Risk Factor Surveillance System, USDA Food Environment Atlas. Partners also utilized several sources of local primary data, such as those related to breastfeeding, STI surveillance, and nutrition security. Partners then sought connections to resident and stakeholder identified issues, needs and concerns.

Clinton County stakeholders overwhelming selected *Housing Stability and Affordability* as the top priority for collaborative work by health system and community partners during the prioritization process. However, process activities also identified significant challenges with mental health, chronic disease and substance use. Socioeconomic status (poverty) was

identified as a cross-cutting social determinant of health affecting many of the identified issues and outcomes. Access to services and opportunities for health also remain top concerns. Clinton County's leading community health needs, when aligned with the NYS Prevention Agenda, are:

Leading Community Health Needs
Domain: Economic Stability
Priority Areas
Housing Stability and Affordability Poverty Nutrition Security
Domain: Social and Community Context
Priority Area
Primary Prevention, Substance Misuse and Overdose Prevention
Domain: Health Care Access and Quality
Priority Area
Preventive Services
Domain: Neighborhood and Built Environment
Priority Area
Access to Community Services and Support

Lead staff from CCHD and UVHN-CVPH worked closely with partners to gather and organize the activities and interventions that will address the identified health priorities. This information was collected through multiple methods: reviewing current Community Health Improvement Plan (CHIP)/ Implementation Strategy (IS) activities and progress, examining other shared work plans (such as the Local Services Plan), conducting individual meetings with key partners, soliciting input from Action for Health members, and analyzing findings from the priority-setting event and community surveys. The resulting information was organized by goals and objectives within each domain area, producing five action plans formatted according to NYSDOH guidance.

Progress in the shared plans will be tracked through the existing infrastructure of the lead partners and an annual year-end summary will capture advancement. Ongoing conversations will allow partners to consider new data, emerging conditions, and available resources. The lead partners will also seek new opportunities to assess and enhance the efficiency and effectiveness of the overall process during the implementation phase.

Introduction

The purpose of this community health assessment is to provide a comprehensive analysis of the health status in Clinton County, NY, serving as a foundation for informed decision-making and collective action. The findings presented here are the result of a 15-month process of gathering and analyzing both quantitative and qualitative data. Lead partners are focused on identifying the factors and root causes that contribute to higher health risks and poorer outcomes. Additionally, they seek to understand the priorities and action plans outlined by community partners through their own needs assessments, aiming to coordinate efforts and minimize duplication. These findings are shared with all stakeholders, who are then invited to collaborate in shaping a collective path forward. The strategies and plans that emerge from this process aim to ensure that all community members can achieve their highest level of health and well-being.

The assessment process was designed to meet the requirements of its lead partners: The University of Vermont Health Network – Champlain Valley Physicians Hospital (UVHN-CVPH) and the Internal Revenue Service (IRS) mandate to conduct a community health needs assessment, as well as the Clinton County Health Department (CCHD) and the Public Health Accreditation Board standards for community health assessment. While these requirements guided the work, the process itself is rooted in the *Mobilizing for Action through Planning & Partnership* (MAPP) framework and has evolved over time to reflect what is most effective for our community.

CCHD and UVHN-CVPH also used the New York State Prevention Agenda to guide the identification of local health priorities and to support coordinated health improvement planning within the county. The structure and organization of this document follow the guidance provided by the Office of Public Health Practice within the New York State Department of Health.

Lead Organizations in the Community Health Assessment Process

The University of Vermont Health Network – Champlain Valley Physicians Hospital (UVHN-CVPH)

The mission of UVHN-CVPH is "United heads, hands and hearts for patients and each other." The vision of UVHN-CVPH is "Working together, we improve people's lives." The values of UVHN-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, UVHN-CVPH has five core beliefs: Patients First, Embrace Change, Build Bridges, Speak Up! and Own It.

UVHN-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. UVHN-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. UVHN-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. UVHN-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. UVHN-CVPH provides cancer services through the Fitzpatrick Cancer Center. UVHN-CVPH also addresses community health needs through its partnership with the Adirondack ACO and by operating the Population Health Service Organization.

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 Supporting Entities

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 as defined by the community's own health needs assessment and the NYS Prevention Agenda. AFH members are considered community resources for collaborative health improvement work and 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 perpetual.

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 health improvement related activities. 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 identified 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.

The 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 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 6 hospitals and 7 county health departments, which have developed and implemented a coordinated process for community health assessment and planning for the defined area to address identified regional priorities. CHA Committee representatives are from: Adirondack Medical Center, Glens Falls Hospital, Nathan Littauer Hospital, 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, Hamilton County Public Health, 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 2025-2027 cycle. This collaboration assists partners in tracking plan progress and in making mid-course corrections if needed. It also helps partners identify opportunities for collaboration and a space to discuss successes and challenges.

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

2025 CLINTON COUNTY COMMUNITY HEALTH PROFILE

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. To do this, lead partners in this local effort have collated a community profile of objective, measurable indicators of health status and outcomes, including many secondary data sources and primary data, where available. We compare our status to that of our region* and to state and national measures to offer perspective. Clinton County residents were also asked to share their perspectives on community health and experiences with the local and regional health care systems. Findings from this endeavor have been weaved into this profile and provide context and depth to the more quantitative health indicators noted. For this assessment, an updated review of assets and resources was undertaken and will assist partners in improvement planning. Where possible, reference to history of success and persisting challenges in addressing individual and community level health needs are also noted. Beyond this, 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. Many of these partners have taken on their own focused needs assessments in recent years; their findings and plans have also informed this assessment.

The next sections present key findings from the 2025 community health needs assessment. Findings have been organized utilizing the 2025-2030 New York State Prevention Agenda Framework and its five domains as defined by the *Healthy People 2030's Social Determinants of Health.* This intentional organization allows us to adopt the same broad perspective the State applied in their assessment, emphasizing factors that influence health beyond traditional health outcomes, prevention strategies, medical care, and public health systems. Doing so allows us to acknowledge all the distinctive populations within our community and to see how interconnected community health needs are with each other.

**__The Adirondack Rural Health Network (ARHN) region__, which is frequently referenced, encompasses Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties. __The Upstate NY region__ is also referenced throughout this profile and is defined as NYS excluding the five NY City counties of New York, Kings, Bronx, Richmond and Queens. All rates are per 100,000 unless otherwise specified.*

2025-2030 New York State Prevention Agenda Framework



COMMUNITY DEMOGRAPHICS

Clinton County's total population is 78,961, slightly less than upon last assessment but the county continues to be 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 jobs and other resources are accessed. In relation to health, the rural core of Plattsburgh offers most of the region's healthcare infrastructure, including a hospital, many primary care providers, two federally qualified health centers, mental and behavioral health services, and social services. The remaining 75% of the population, a substantial portion, resides in rural areas, where access to transportation, specialty care, and preventive services is even more limited.

Over 81% of the population is aged 18 or older with a median age of 41.5 years. While the county has a relatively balanced age structure, like many rural counties in the state, it is experiencing an aging population. Presently, 20.5% of the total population is 65 years or older. This demographic trend often signals the need for age-friendly services, chronic disease management, and long-term care resources. Resident survey findings align with this assumption with nearly one in three respondents to our survey noting experiencing

issues related to aging. In addition, 16% of respondents selected a “lack of support/resources for seniors” as a top social challenge.

Historically, Clinton County has had a predominantly White population. However, the county has experienced a gradual increase in racial and ethnic diversity over time. Presently, 90.0% of residents identify as White/non-Hispanic, followed by 4.2% Black/African American, non-Hispanic and 2.9% Hispanic/Latino. Nearly all residents identify English as their primary language. The resident survey captured a small number of families identifying Spanish, American Sign Language, Chinese and French as the primary language spoken in their household. The shifting demographic trends signal the need for culturally responsive services. In fact, 75 respondents to our resident survey noted securing access to a culturally competent health care provider as a personal health challenge.

Clinton County includes a mix of family households, single-person households, and group quarters populations (including SUNY Plattsburgh with 2,700 residential students and multiple state correctional facilities). According to 2023 statistics, there were 33,860 households in the county; this is a noted increase since last assessment. Of them, 7,500 report a female head-of-household. Socioeconomic indicators show that a significant portion of the population within our borders face economic challenges. The connection between economic and housing challenges among residents and how this connects to health will be explored in more depth within the respective social determinants of health.

35%

of respondents **agree** or **strongly agree** they **live in a healthy community.**

The top features of a healthy community were identified as:

- Affordable housing
- Health care services
- Livable wages
- Safe environment
- Clean environment
- Drug & alcohol free communities
- Good schools

ECONOMIC STABILITY

Domain:

- Economic Stability

Priorities:

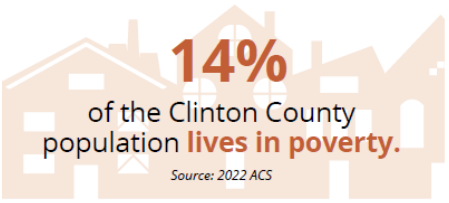
- Poverty
- Unemployment
- Nutrition Security
- Housing Stability & Affordability

In 2023, the average household income in Clinton County was $91,067 and the median household income was $69,208. The per capita income was $39,384. These all represent increases from the last assessment but, by all measures, household income lags behind state and national measures.

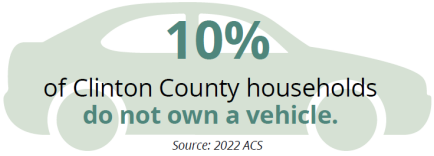
The poverty rate in Clinton County stands at 13.8%, which is higher than the ARHN region's rate of 12.6% and the Upstate New York rate of 11.1%. This also represents a slight

increase from the last assessment which noted 12.3% of individuals living below the federal poverty level.

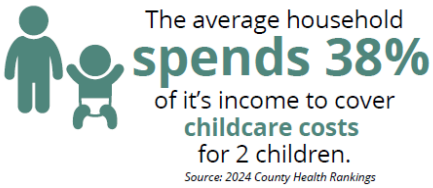
The ALICE framework captures the number of households that are earning above the federal poverty level but still do not have sufficient income to afford basic living costs in their local area (i.e. the "Household Survival Budget"). Together with those in poverty, these households are considered to be below the ALICE threshold—meaning they cannot fully meet essentials such as housing, child care, food, transportation, health care, and technology. Of all Clinton County households, 28% met the ALICE (asset limited, income constrained, employed) threshold, marking a five percentage point increase from 2022-2023. This translates to approximately 13,460 households within the county classified as either living in poverty or as ALICE. Among ALICE households, the majority are White (30,763), significantly outnumbering the second largest group by race, which consists of residents who identify under two or more races (721). Of households with children, 11% of married households fall below ALICE thresholds, whereas 59% of single-male head of household and 70% of single-female head of household do. Out of all households, 12% (3,848) of them are ALICE households headed by individuals aged 65 or older. Overall, more households are falling under the ALICE threshold since the COVID-19 pandemic for myriad reasons to be discussed throughout this profile. In addition, community partners are preparing for more families to find themselves living below the ALICE threshold due to the anticipated changes to SNAP, Medicaid and state sponsored health plans.



An increase in ALICE households is significant to health planning. These households are disproportionately impacted by the gap between wages and the true cost of living. They are more likely to need to consider trade-offs in areas critical to maintaining health—such as deferring medical care, cutting back on nutritious food, foregoing preventive health services, or delaying needed maintenance (home, vehicle) that impact access to care. In a rural area like the Adirondacks, where distances between towns are significant, a lack of reliable transportation can be as great a barrier to care as the cost of the care itself. The increase in households falling under the ALICE threshold also means a substantial number of families are highly vulnerable to economic stressors they sometimes have little control over such as job stability, illness, and inflation.

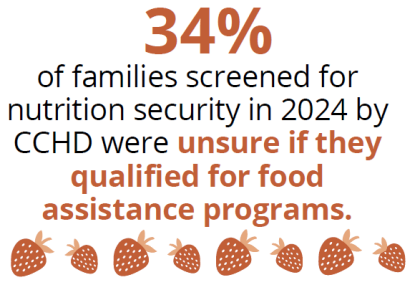


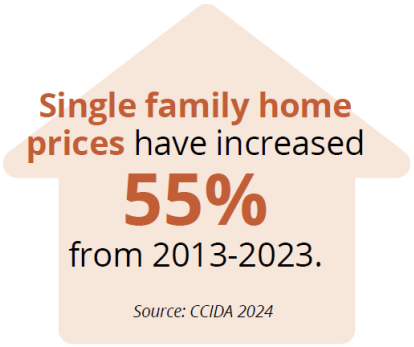
Clinton County's employment levels have rebounded post-pandemic with modest signs of continued job growth. The largest employment sectors are Education, Health Care, and Social Assistance, accounting for 32.7% of jobs, followed by Manufacturing (11.6%), and Arts, Entertainment, Recreation, Hotel & Food Service (10.1%). Clinton County's unemployment rate was 4.2% in July 2025. There is a 56.9% civilian labor force participation rate; this represents residents aged 16 and older who are either working or actively seeking employment. While low unemployment suggests that most residents seeking work are able to find it, it does not necessarily indicate widespread economic security. Many regional individuals are employed in low-wage or part-time positions. Many other employment opportunities are seasonal and do not provide adequate income or benefits. Multiple needs assessments completed by partners within the community identify the state of childcare as a contributing factor to the full employment and economic picture. The Adirondack Birth to Three Alliance estimated a 33.6% loss in childcare capacity in Clinton County from 2019-2024. Though this is far better than the loss experienced by neighboring counties, a majority of Adirondack region remains a child care desert. A lack of available and affordable childcare can force parents to choose between working and caring for their children, perpetuating a cycle of poverty and stress that negatively impacts the entire family's health.



The short supply of well-paying, stable, year-round employment opportunities is certainly echoed in resident survey data. The "lack of a livable wage" was the second highest social challenge of greatest concern and nearly one quarter of respondents noted a lack of employment opportunities also as a top social challenge.

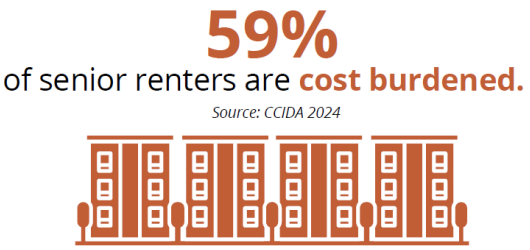
Nutrition security, defined as consistent and equitable access to affordable, nutritious food necessary for health and well-being, remains a key concern in Clinton County. A 2023 data release from NYS noted 19.9% of adults in Clinton County self-reported food insecurity. While limited in scope, data collected directly by CCHD aimed at better understanding nutrition security among residents also found around 20% of those screened experience nutrition insecurity. All cases do not stem from a lack of financial resources. Findings indicate geographic, educational and skilled based barriers also have an impact on residents' nutrition security; many of those screened were unsure if they qualified for food assistance programs. Approximately 9.3% of Clinton County residents live without close access to a large

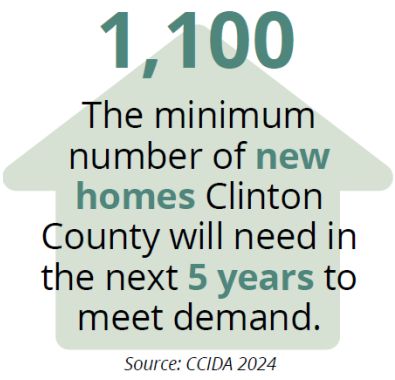




grocery store, which limits the ability to regularly purchase affordable, healthy food; 6.3% of residents have limited access to a large grocery store and are low income. Approximately 12,000 Clinton County residents receive SNAP benefits; 21% of all children within the county are beneficiaries of the program.

The top social challenge noted in the resident survey was a lack of affordable housing. The *2024 Clinton County, NY Housing Needs Assessment* completed by Camion Associates assessed affordability and cost burden, highlighting that many households in Clinton County are committing a disproportionately large share of their income toward housing. The report finds that 25% of all households in Clinton County are "cost-burdened," with this number rising to 45% for renters and, a striking, 59% for senior renters. Single-family home prices increased 55% from 2013-2023. Increasing home prices and elevated mortgage rates have made homeownership unaffordable for many residents. In addition, the report finds that rental units are in short supply, driving up rates. The report concludes approximately 1,100 or more new housing units will need to be constructed over the next five years to adequately meet demand—either by replacing aging stock or developing new housing. Many residents are being priced out of housing. In addition, the NYS 2024 Point-in-Time Count Report indicates the number of individuals experiencing homelessness has doubled in just one year from 133 individuals in 2023 to 266 in 2024. This pattern of increase has been repeated each year since 2021. Multiple local organizations identify the growing number of unhoused residents as an immediate concern, further underscoring housing as a critical issue in current times and a potential driver of poor health outcomes in the months and years to come.





SOCIAL & COMMUNITY CONTEXT

Domain:
- Social & Community Context

Priorities:
- Anxiety & Stress
- Suicide
- Depression
- Primary Prevention, Substance Misuse & Overdose Prevention
- Tobacco/E-Cigarette Use
- Alcohol Use
- Adverse Childhood Experiences
- Healthy Eating

Mental health is a critical component of overall community well-being and has been a local priority in health improvement efforts for many years. Local data suggest both significant challenges and areas of progress and resilience. Many partners, within their own assessments, identify a critical need for mental health services. Resident feedback echoes this need, along with challenges in accessing these services. One quarter of all resident survey respondents reporting a health challenge selected "access to mental health & behavioral services" as an issue for themselves or a household member. Health metrics further reveal the burden of mental illness in our community.

Frequent mental distress is notably elevated in Clinton County (18.6%) compared to the Prevention Agenda benchmark (10.7%). For this measure, Clinton County is the second highest in the ARHN region. Depressive disorder affects a larger percentage of adults in Clinton County (27.5%) compared to ARHN region (23.2%). County residents report an average of 5.9 unhealthy days over the course of a month; this is higher than the NYS average of 4.9. One in every ten resident survey respondents identified their mental health as poor or extremely poor. The 2020–2022 suicide mortality rate in Clinton County (11.0) exceeds both the Prevention Agenda benchmark (7.0) and the Upstate New York rate (9.7). While still higher, this represents a continued gradual decline compared with the 2018–2020 and 2019-2021 data sets. The Clinton County 2026 Local Services Plan (LSP) notes a marked increase in 911 emergency calls in the second half of 2024 and first quarter of 2025 related to mental health crises, suicide and domestic violence compared to previous years. Mental health related ER visits in Clinton County are 113.7 per 10,000, compared to the NYS average of 108.9. Despite all the progress that has been made, this elevated rate likely highlights the continued need to develop and evolve community services and coordinated care models.



2 in 5

Clinton County adults self-reported that mental health was a challenge.

Source: 2025 Clinton County Resident Survey

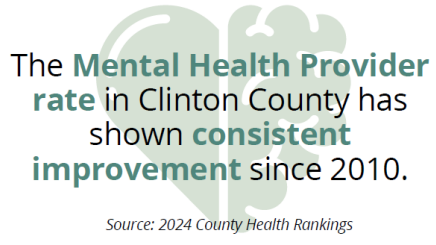
Adverse Childhood Experiences (ACEs) include emotional, physical, or sexual abuse; neglect;

exposure to domestic violence; parental substance use or mental illness; or separation/divorce. ACEs are strongly associated with poorer health and social outcomes throughout life. In Clinton County, adults commonly reported experiencing multiple adverse childhood experiences (36.4%) more frequently than the state benchmark (33.8%), indicating ongoing social and health challenges. Much work over the last decade has been invested in increasing awareness of and approaches to managing ACES in adults, as well as primary prevention and resilience building in younger residents. Despite this work, youth mental health crisis is escalating. There were 113 admissions to UVHN-CVPH's child mental health unit in 2024 and early admissions data suggest that number will be exceeded in 2025. Through collective work, mental and behavioral health partners successfully brought home-based crisis stabilization for children to the community in 2024 and an Intensive Crisis Stabilization Center will open in 2025.



When assessing the number of individuals engaging in substance abuse related behaviors, the rate of binge drinking in Clinton County (17%) slightly exceeds both the benchmark (16.4%) and Upstate New York average (16.1%). Newborns affected by neonatal withdrawal syndrome in Clinton County (17.70) occur at nearly twice the rate of Upstate New York (9.60) and the Prevention Agenda benchmark (9.10). According to the Prevention Agenda Dashboard, the age adjusted rate for overdose deaths involving any opioid in Clinton County was 25.2 in 2022, almost double the state's benchmark of 14.3. Clinton County has been above this critical benchmark since 2021.

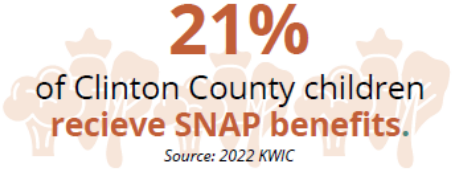
Clinton County has a variety of mental health and substance use treatment services in place. Through a variety of partners established services include psychology, group therapy, crisis intervention, peer support services, family education, and prevention services. Many of the services are funded through a mix of state, federal and local resources, meaning it is often possible to utilize sliding-scale fees, expanding access. There are in-patient and out-patient options for services. Collaborative system improvement activities over the past several years have focused on building the infrastructure needed to support continuity of care between service settings and addressing identified gaps altogether. Evidence of success is already apparent. For example, Clinton County leads the ARHN region with higher rates of buprenorphine prescriptions



(Clinton: 2,172.7, ARHN: 1,561.3, and Benchmark: 415.6). This suggests improved access to treatment, likely due in part to the recent establishment of a buprenorphine bridge clinic in the community during the last assessment cycle. This clinic provides a short-term, low-barrier option, quickly connecting people with opioid use disorder to treatment.



In terms of other substance use, Clinton County reports lower rates than the ARHN region across several behaviors: e-cigarette use (4.6% vs. 7.4%), binge drinking (16.0% vs. 18.9%), and cannabis use over the course of 30 days (12.0% vs. 16.3%). The percentage of adults who smoke in Clinton County is 19.5%, which is higher than both Upstate New York (16.5%) and the Prevention Agenda Benchmark of 15.3%. According to Tobacco Enforcement Compliance results, Clinton County has the highest number of registered tobacco vendors in the ARHN region (108), which may contribute to it also having the highest number of sales to minors (3) and vendors fined or penalized (3). This correlation indicates that increased vendor presence not only increases access to these products, it may also elevate the risk of violations and necessitate the need for stronger enforcement and compliance education, which is challenging to implement with limited resources. The higher availability of tobacco products could also be a contributing factor to increased smoking rates in the region. There are multiple regional efforts supporting population and clinical level interventions to reduce tobacco use. Clinton County is fortunate to have two state funded tobacco control programs working with its residents, providers and decision makers in addressing point-of sale marketing, tobacco-free outdoor spaces, smoke-free housing and offering treatment policy support to providers. There are a limited number of smoking cessation specialists available within the community beyond the healthcare setting.



Data related to diet and eating behavior for Clinton County residents specifically is limited. A greater number of adults in Clinton County (42.2%) consume less than one serving each of fruit and vegetables daily. Obesity rates, addressed elsewhere in this profile, are high, perhaps suggesting unhealthy dietary patterns. There are only about half a dozen full-sized grocery stores in the county, with smaller, independently and locally owned/ operated convenience stores filling the gap. All of the full size and a select number of the smaller stores accept SNAP and WIC benefits. CCHD works directly with a number of the smaller retailers and many have voluntarily increased healthy options and integrated nudges and other point-of-

purchase visuals making it easier to identify better options. Opportunities for free nutrition education within the community are limited and target high needs groups. WIC families benefit from regular access to nutrition professionals, and for many years Clinton County Cooperative Extension has provided SNAP-Ed programming to eligible groups. However, the anticipated loss of SNAP-Ed funding will significantly reduce free nutrition education opportunities and create a service gap that should not be overlooked.

NEIGHBORHOOD & BUILT ENVIRONMENT

Domain:

- Neighborhood & Built Environment

Priorities:

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

Emergency department usage is notably higher in Clinton County, with a total visit rate of 3,800.3 per 10,000 residents, compared to 3,302.1 in Upstate New York. This is not an uncommon pattern for rural communities but one in which resources for many years have been allocated to alter in Clinton County. Partners like the Adirondack Medical Home Initiative, the Adirondack Rural Health Network, and private practice providers have all participated in these efforts. As already noted, mental health admissions from the ER are higher than ideal and efforts are underway to address this but, for now, this usage contributes to these numbers. In addition, the unintentional injury hospitalization rate among adults aged 65 and older stands at 308.3 per 10,000—exceeding both the ARHN average (280.7) and the statewide rate (260.5).

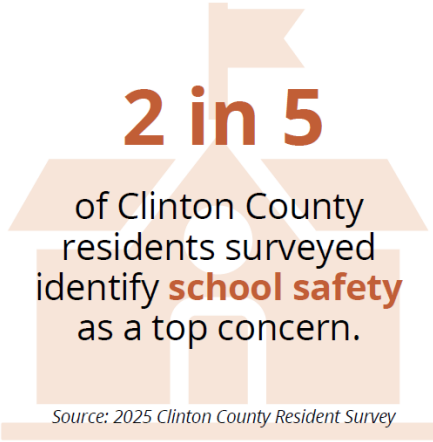
According to the Institute for Traffic Safety Report, Clinton County has a lower alcohol-related crash rate (5.89 per 10,000) compared to the ARHN region (9.33), indicating fewer such incidents. However, the alcohol-related fatality rate in Clinton (0.26) is higher than ARHN's (0.07), indicating more severe outcomes when crashes do occur. For speed-related crashes, Clinton also reports a lower overall crash rate (29.57) versus ARHN (36.26) and a lower fatality rate (0.13 vs. 0.29 respectively), reflecting fewer and less deadly speed-related incidents than in the broader region. Clinton County also experiences more adult hospitalizations due to falls (215.4) than the Prevention Agenda benchmark (173.7), perhaps a reflection of our aging

The county rate of **hospitalizations due to falls** for those 65+ is worse than the **NYS average.**

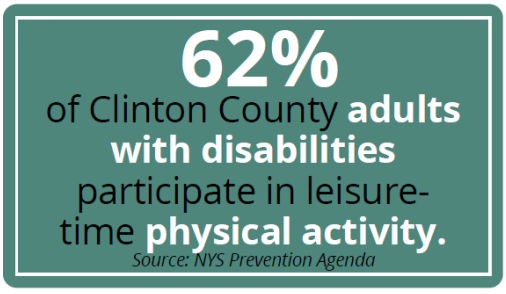
Source: NYS Prevention Agenda

population demographics but also indicating greater injury risks.

Per the Department of Criminal Justice Services Index, Property and Violent Crime Report, Clinton County's property crime rate of 1,491.2, with a violent crime rate of 188.1, are both higher than the ARHN region rates of 1,138.9 and 176.29, respectively. Firearm-related crimes in Clinton County are slightly higher then ARHN average, with rates of 14.0 and 11.02 per 100,000, respectively. The homicide rate in the county is very low but has increased over recent years. A notable share of these incidences are domestically related; drug use and persisting mental health issues are likely also contributing to this pattern. Beyond the efforts of mental and behavioral partners in strengthening service offerings, in 2023 CCHD began an education initiative to highlight safe firearm storage practices and has established a small network of partners to distribute resources to families to practice safe storage. Notably, respondents identified school safety as the second highest environmental concern in the resident survey.



The USDA Food Environment Atlas reveals Clinton County has fewer recreation and fitness facilities per 10,000 people (6.17) compared to the ARHN region (8.8) and the Upstate New York average (13.2), indicating more limited access to opportunities for physical activity. Despite this, 75% of adults participate in leisure time physical activity; 62% of adults with disabilities report the same. CCHD has worked for many years to make roads, byways and shared spaces accessible and safer to modes of active transportation by partnering with communities. All towns and villages within the county have executed Complete Streets resolutions to ensure these needs are considered as renovations and normal upkeep projects are addressed. Since 2020, CCHD alone has been able to "activate" over 100 distinct spaces across the county, making public and private spaces safer, more accessible and health supportive. Often these changes result from collaborative walk-audits of the communities themselves, where experts and residents identify needed changes together. Other long-term partners have joined in this effort. For example, the Town of Plattsburgh's Recreation Master Plan executed in 2023 accounted for park and space upgrades across their facilities. They have since completed at least 15 different upgrade projects and have met their annual commitment to providing accessible



programming to residents of all ages. They are also often able to open their opportunities to residents living beyond the Town's borders. A "safe environment", a "clean environment", "parks and recreation services", "walkable and bike friendly" were all common choices among residents for characteristics of a healthy community. Residents also made it known that access to opportunities for health for those with physical, intellectual or developmental disabilities were a concern and need.

The Towns of Dannemora and Black Brook, the Village of Champlain and the City of Plattsburgh are all registered Climate Smart Communities with NYS indicating a commitment among their residents to mitigate and adapt to climate change. CCHD has worked with a number of communities to create small-scale community level food waste recycling programs. In addition, in 2024, Casella established an organics compost facility at the Clinton County Landfill. Climate change was included for the first time as a selection for an environmental challenge on the resident survey and 36% of respondents selected it as a top concern.

HEALTH CARE ACCESS & QUALITY

Domain:

- Health Care Access & Quality

Priorities:

- Access to & use of Prenatal Care
- Prevention of Infant & Maternal Mortality
- Preventive Services for Chronic Disease Prevention & Control
- Oral Health Care
- Preventive Services
- Early Intervention
- Childhood Behavioral Health

Clinton County ranks in the middle among counties in the Adirondack Rural Health Network (ARHN) region when it comes to overall quality of life. Clinton County residents report an average of 4.0 physically unhealthy days per month—relatively consistent with the New York State average of 3.9 days. Additionally, 17% of adults report being in fair or poor health, which slightly exceeds both the state average (16%) and that of other counties in the region such as Essex (15%) and Washington (15%). Over 17% of adults experience 14+ physically unhealthy days per month; this is significantly higher than the Upstate New York average of 10.0%.

The county has one major hospital, Champlain Valley Physicians Hospital (UVHN-CVPH), which is part of the University of Vermont Health Network. The hospital offers 286 inpatient beds, primarily focused on medical and surgical care. This provides a hospital bed rate of 366.1 per 100,000, notably higher than the ARHN average (258.7) and only second

to Warren County. This does represent a slight loss since last assessment (374 beds per 100,000) but, notably, there was a small shift to increase favoring the total number of inpatient psychiatric beds.

There are four nursing home facilities, namely UVHN-CVPH's Skilled Nursing Facility, Clinton County Nursing Home, Meadowbrook Healthcare and Plattsburgh Rehabilitation and Nursing Center. Together they provide 627.3 beds/ 100,000. This also represents a slight decrease from last assessment when the rate was noted as 640 beds per 100,000. The greatest capacity loss is noted to be at Plattsburgh Rehabilitation and Nursing Center. It is noteworthy to mention a process is underway to privatize the Clinton County Nursing Home; completion of the sale process to a private entity is expected in the next year and is likely to affect this resource. Three adult care facilities provide a total of 230 beds for residents able to live more independently. Bed availability in these categories falls below the regional average.

The physician availability rate in the county (273 per 100,000) is significantly higher than the ARHN regional rate (190.2), and its primary care physician ratio (1240:1) is on par with the state average. This correlates to approximately 65 primary care providers available through private and group practices. There has been little change to the ratio of physicians per 100,000 population since the last assessment. There are three federally qualified health centers in the county. One specializes in pediatric and adolescent health which opened in 2024 and has helped cover the loss of a large pediatric practice in 2023. In assessing licensed health professionals across myriad specialties, there have been minor changes with the most noteworthy being a gain of Licensed Master Social Workers and Nurse Practitioners and a slight loss of Psychologists. Other specialties, such as Nurses, Dietitians, and Physical Therapists, remain relatively stable. This does not necessarily translate into adequate numbers of specialists to meet needs, however. Recruitment and retention of health specialists remain issues for most health facilities in the region.

In 2022,

95%

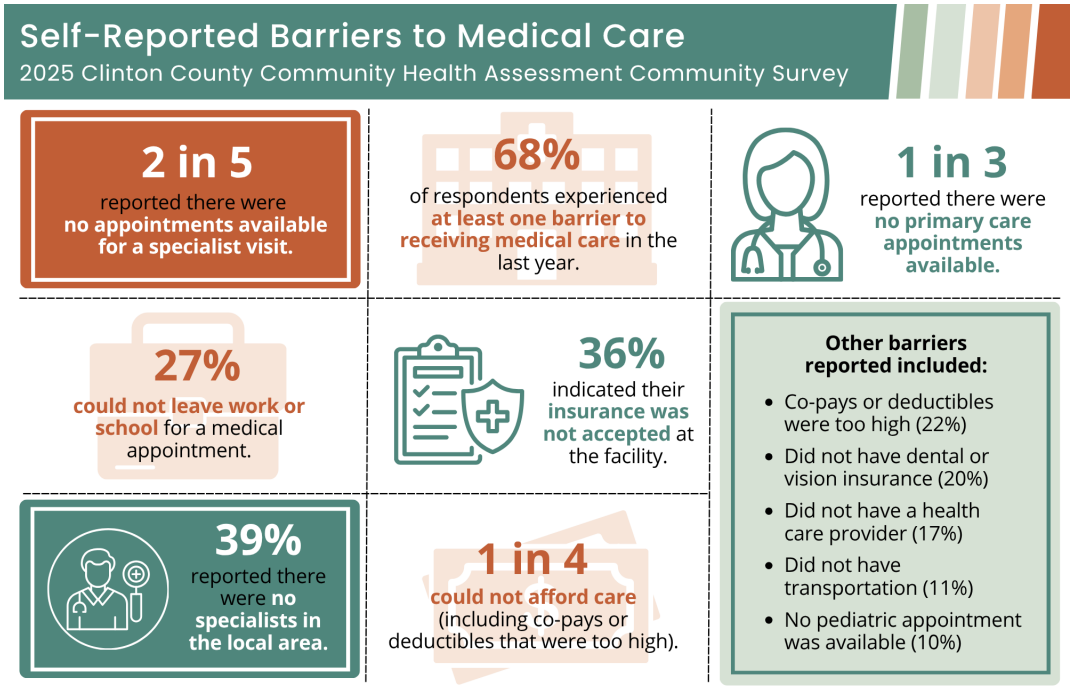
of adults under 65 in Clinton County had **health insurance.**

Source: County Health Rankings

By most measures, Clinton County has adequate primary care provider availability. In fact, only about 8% of county residents do not have a usual source of primary care, compared to 14% in NYS. However, health care services and private practices are mostly concentrated within the Plattsburgh area. The NY Health Foundation's *Care Across Communities Dashboard,* highlights the uneven distribution of primary care resources throughout the county. This metric ranges from a low of 7% to a high of 15% and 17% in the Town of Plattsburgh and Village of Dannemora, respectfully. The dashboard also shows 13% of adult

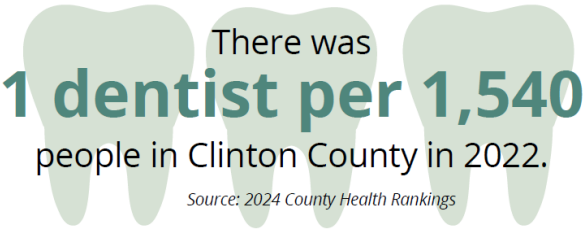
ER visits were potentially avoidable, suggesting residents may rely on emergency services at times for issues that could be addressed in primary care. Considered collectively, findings may indicate the rural geography and variable provider density across the county still pose challenges for many residents and create inequities in access to essential services that affect overall health and well-being.

While measures of availability for specialists are harder to find, nearly 40% of our resident survey respondents reported access to specialists as a health challenge experienced by themselves or a household member. While common specialists like cardiology, dermatology, ophthalmology, and oncology practice in the area, they are serving residents across the region, creating waiting periods and challenges with appointment availability. Notably, the county has experienced the closure of two obstetrics and gynecology practices since 2023. While preventive care utilization is high, with 84.7% of adults aged 18–64 reporting a routine checkup in the past year, the previously referenced dashboard estimates 5% of residents delay care due to costs. Residents provided further insight into barriers when seeking medical care in our community, which are wide-ranging and include financial barriers, concerns with health insurance, and inflexibility with schedules.



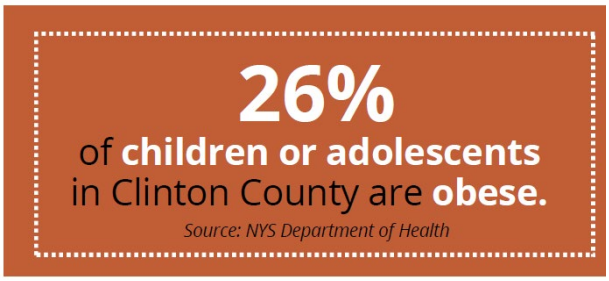
Despite these challenges, residents are seeking preventive care. For instance, 41% of adults aged 65 and over are up-to-date on core preventive services. In addition, 93.6% of women aged 45 and older in Clinton County report receiving preventive medical visits, surpassing both regional and state benchmarks. The county leads the ARHN region in annual

mammography screening among Medicare-enrolled women aged 65–74, with a rate of 54%, significantly exceeding the state average (44%). Among women aged 18–44, preventive care engagement (81.1%) meets the state benchmark (80.6%) and is significantly higher than the ARHN average (56.3%). In 2023, 83% of children completed the standard childhood immunization series, which exceeds the Prevention Agenda objective of 70.5%. Also in 2023, HPV vaccine completion among 13-year-olds was low (31.3%), falling short of the state benchmark (37.4%) rate. Newer, preliminary data suggests a downward trend for both of these metrics, likely a reflection of multiple factors including family choice and changes in the pediatric care system locally. CCHD works closely with local pediatric providers and NYSDOH to reach an annual target increase for these preventive interventions. The county benefits from lower-than-average pediatric asthma emergency visits (35.0 per 10,000), suggesting effective asthma management or favorable environmental conditions.



Outpatient visits for dental caries among children aged 3–5 are more frequent in Clinton County (181.2 per 10,000) than in the ARHN region (130.2), indicating potential gaps in early childhood oral health prevention. However, since 2019, the area has seen the establishment of two new pediatric dental practices. While the area no longer meets the HRSA Health Professional Shortage Area for dental health, residents continue to experience barriers with dental services related to costs, insurance, and extended wait times for appointments.

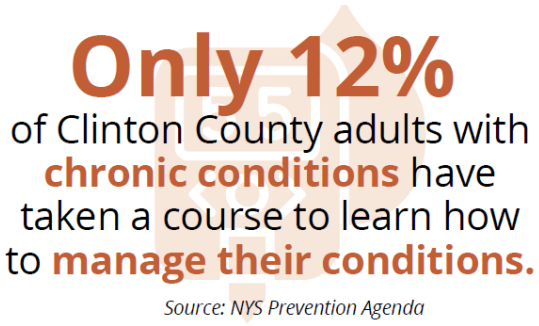
Despite favorable measures for many common screenings, chronic disease remains a pressing concern in Clinton County. Youth weight trends in Clinton County closely mirror or slightly exceed those in the broader ARHN region. Among elementary school children, overweight and obesity rates are comparable across genders. Among middle and high school students, obesity is notably lower for females in Clinton County (23.77%) than in ARHN (35.15%), while male rates are nearly identical.



In turning to adult measures, adult obesity (36.4%), diabetes prevalence (12%) and adults with high blood pressure (35%) are all higher than regional and state averages, contributing to an elevated burden of related health conditions. Diabetes-related hospitalizations (26.1 per 10,000) and mortality (43.3 per 100,000) are also significantly higher than both the ARHN region and state averages. Cardiovascular health outcomes are

similarly poor. The county's overall cardiovascular disease mortality rate (312.6 per 100,000), cardiovascular death rate among individuals younger than 65 years (148.0), and pre-transport mortality (196.0) all exceed state and regional figures, suggesting barriers to timely care or underlying health risks. On average, only 35% of residents report having a cholesterol screening in the past 5 years. These findings indicate persisting challenges to improving outcomes and, perhaps, engagement in preventive activities beyond clinical services.

Regionally coordinated efforts have brought the evidence-based Stanford Chronic Disease Self-Management Programs (CDSM) to the county. Presently, two organizations (UVHN-CVPH and the Clinton County Office for the Aging) have active facilitators providing courses. Over the years, several organizations have had staff and volunteers trained as facilitators. High staff turnover, inconsistent course participation, and persistent recruitment challenges have slowed the establishment of CDSM, limiting its capacity to serve the community effectively. As of the third quarter of 2025, there were 16 participants in Clinton County workshops and19 Clinton County residents have participated in a workshop regionally (taking advantage of virtual formats) this year. This is consistent with state data indicating only approximately 12% of Clinton County adults with a chronic condition have taken a course to learn how to manage their health. This clearly falls drastically short of ideal and presents opportunity for improvement in the next planning cycle.



For Clinton County, the all-cancer age-adjusted incidence rate for 2019–2021 was 627.3 per 100,000 and the age-adjusted all cancer mortality rate was 161.3, compared to the NYS rates of 577.8 and 124.8, respectively, indicating a higher burden of overall incidence and death from cancer in Clinton County. Age adjusted incidence rates for colon/rectal, lung and ovarian cancers are all higher than state incidence rates, contributing to this burden. The age-adjusted female breast cancer rate of 121.0 is better than the NYS average rate of 134.2. The age-adjusted incidence rate for prostate cancer of 91.5 is also better than the NYS average of 131.6. The age-adjusted mortality rates for both of these cancers are also better than the state average. Just under 20% of resident survey respondents reported that they or someone they live with had been diagnosed with cancer within the last three years. They identified access to information about cancer screening services and other resources as a strength of our local cancer services system, along with access to cancer health care providers. The same respondents identified the need for more financial assistance programs and community support opportunities for individuals receiving cancer care.

Clinton County shows several positive maternal and child health indicators. A high percentage of expectant mothers (84%) receive early prenatal care, and preterm births are lower (7.0%) than both the ARHN (9.7%) and Upstate New York (9.5%) averages. Cesarean rates among low-risk births are lower (25.1%) than the regional average (30.2%) and exclusive hospital breastfeeding rates are strong (71%). Given the well-established link between breastfeeding and reduced risk of chronic disease, CCHD has diligently monitored infant feeding practices in Clinton County for more than a decade. Since 2013, collaborative efforts across the community have led to increases in breastfeeding at every infant milestone, including a remarkable 40% increase in chest/breastfeeding at one year. CCHD has also worked throughout the North Country to normalize chest/breastfeeding and create supportive spaces. As of 2024, CCHD had partnered with 30 health care practices, 79 childcare sites and 120 worksites in creating chest/breastfeeding friendly environments.

From 2013-2023,
CCHD helped
30 healthcare practices
achieve **Breastfeeding Friendly Designation**
from NYSDOH.

The Prevention Agenda captured an infant mortality rate of 9.8 per 1,000 live births in 2022, which is alarmingly high compared to Upstate New York (4.7). The maternal mortality rate for 2020-2022 also appears high. However, it should be noted both of these metrics are unstable estimates and should be interpreted with caution. Local data does not necessarily support a discernable departure from standard incidence for either of these metrics. The same source captures a neonatal withdrawal syndrome rate (18.0 per 1,000 births) that is nearly twice the regional average and significantly above the Prevention Agenda benchmark (9.1). While this rate is also noted as unstable, trend data consistently indicates a high rate for this metric, likely underscoring the ongoing substance use concerns within the community, including during pregnancy.

Teen birth rates (4.2%) also surpass the ARHN average (2.9%), while births among women aged 35 and older (16.8%) are lower than in the broader Upstate region (24.3%). Noted earlier, the community has lost two obstetrics and gynecology practices since 2023. While the system has slowly adjusted to meet need, measures of longer-term impact will reveal how successful the adjustments have been.

CCHD STI surveillance captured a total of 190 STI cases in 2024. According to the Prevention agenda,

Overall rates of **Chlamydia** cases in Clinton County have decreased but over
60%
of cases occur in 15-29 year olds.
Source: HCS Annual Report

the county's chlamydia diagnosis rate (209.3 per 100,000) is slightly higher than the ARHN average (190.0) but remains substantially lower than the Upstate New York average (372.5). In fact, the age-adjusted diagnosis rates for chlamydia, gonorrhea and early syphilis all meet Prevention Agenda benchmarks. STI testing is generally available through private practice but also through a number of mental/behavioral health providers and Planned Parenthood of the North Country. CCHD tracking finds expedited partner therapy (EPT) is issued in less than one-third of appropriate cases. Due to its individual and population level benefits, CCHD continues to work with local providers to address barriers to prescribing EPT.

Nearly 30% of Clinton County adults live with a disability—a figure slightly lower than the ARHN average (30.1%) but higher than the state average (25.8%). Notably, resident survey responses did capture access concerns for some with physical, intellectual and developmental disabilities, which warrants further study.

EDUCATION ACCESS & QUALITY

Domain:
- Education Access & Quality

Priorities:
- Health & Wellness Promoting Schools
- Opportunities for Continuing Education

Regarding educational attainment, 69.5% of Clinton County residents are 25 years of age or older. Of these, 32.5% are high school graduates or hold a General Education Diploma (GED), while another 38.7% have earned an associate's degree, bachelor's degree, or higher. Sixty-three percent of adults aged 25-44 in Clinton County have some form of post-secondary education, placing the county in the second highest rank across the ARHN region.

Since first executed, Clinton County **School Wellness Policies** demonstrate a

46.5

average point **increase in strength.**

Clinton County is served by nine school districts, with a total enrollment of 10,868 students. Of these, prior to state level initiatives to cover costs of all student meals in the Fall of 2025, 44.9% qualified for free or reduced school meals, with the majority (95.9%, or 4,678 students) eligible for free meals. The county graduates 664 high school students on average annually, with a dropout rate of 7.0%. This rate is higher than the ARHN region's rate of 6.6% and New York State's rate of 5.0%. The county employs 1,029 teachers, resulting in a student-to-teacher ratio of 10.1, which is higher than the ARHN region's ratio of 9.6, but lower than the NYS

ratio of 11.2. All local school districts have active Wellness Committees and fully executed Wellness Policies.

Clinton County is home to two higher education institutions that play a vital role in the region's education, workforce development, and community health infrastructure: SUNY Plattsburgh and Clinton Community College (CCC). SUNY Plattsburgh is a four-year public liberal arts college and part of the State University of New York (SUNY) system. With an enrollment of approximately 4,800 students, it offers a wide range of undergraduate and graduate programs, including majors in nursing, nutrition, social work, public health, and psychology—fields that directly contribute to the region's health workforce. SUNY Plattsburgh also partners with local agencies for community-based learning, research of public health significance, and health promotion initiatives. Clinton Community College, a member of the SUNY system, serves about 1,500 students, offering associate degrees and certificate programs with a focus on career readiness and workforce development. CCC plays an essential role in providing accessible education and vocational training, including programs in nursing, allied health, and human services. The college also supports nontraditional students and rural learners through flexible course formats and workforce retraining opportunities, helping to address health disparities linked to education and employment. The colleges integrated campuses in 2025. Both institutions contribute significantly to community wellbeing by increasing educational attainment, preparing health professionals, and supporting research and service in health-related fields. Their presence helps mitigate healthcare provider shortages and strengthens the county's capacity to meet public health needs.

The **graduation rate** for **economically disadvantaged students** is

81%.

Source: NYS Department of Education

ASSETS & RESOURCES

Assessing a community's assets and resources is a vital component of a comprehensive community health assessment. It highlights the strengths and supports that already exist within the community. By identifying key organizations, services and physical spaces, this process helps create a clearer picture of the community's capacity to promote health and well-being. It also ensures that any new initiatives build on what is already working and take advantage of existing infrastructure, experience and resources, rather than duplicating efforts or overlooking valuable community contributions. The following tables represent such for the Clinton County community. These assets and resources will be used to guide collaborative planning and implementation of those plans over the next three years.

Resources & Assets: Demographics & Special Populations	
Older Adults & Aging	
Clinton County Office for the Aging	Compassionate Companion Volunteer Program
JCEO – Senior Outreach Program	Nutrition Program for the Elderly
Retired & Senior Volunteer Program	Senior Citizens Council of Clinton County
Veteran's Services	
American Legion	Clinton County Veteran's Service Agency
Homeward Bound Adirondacks	North County Veteran's Association (NCVA)
Plattsburgh VA Clinic	
Inclusivity Services	
Advocacy and Resource Center – Champlain Valley	Autism Alliance of Northeastern NY
North Country Association for the Visually Impaired, Inc.	North Country Center for Independence
North Country Family and Community Engagement (FACE) Center	Office for People with Developmental Disabilities
Residential Resources, Inc.	
Immigrants/ New Americans	
Legal Aid Society of Northeastern NY	ONA North Country Immigrant Resource Coordinator – St. Josephs
Plattsburgh Cares	
	List is not inclusive.

Resources & Assets: Economic Stability	
Essential Services & Assistance	
Clinton County Department of Social Services	Joint Economic for Economic Opportunity - JCEO
Unemployment	
Clinton County Department of Social Services	Clinton County Employment and Training Administration (CCETA)
Coryer Staffing	ETS, Inc.
Manpower	OneWorkSource
Westaff	
Nutrition Security	
Clinton County WIC Program	Clinton County Health Department
Cornell Cooperative Extension	JCEO Food Shelf & Township Food Pantries
Nutrition Incentive Programs: SNAP, FMNP, Double Up Food Bucks	Plattsburgh Farmer's Market & Others
Plattsburgh Interfaith Food Shelf	Private Practice Nutrition Counseling Services
Senior Meal Sites & Home Delivered Meal Program	St. Alexander's/St. Joseph's Soup Kitchen

St. Augustine's Soup Kitchen	The Salvation Army Community and Worship Center
United Methodist Church Food Shelf	USDA Summer Feeding Sites
Housing Stability and Affordability	
Clinton County Department of Social Services	Clinton County Housing Assistance Program
ETC Housing Corporation	Friends of the North Country
HAPEC – Clinton County Office	Joint Council for Economic Opportunity - JCEO
MHAB	Plattsburgh Housing Authority
Early Education:	
Adirondack Helping Hands	JCEO Head Start
North Country Kids, Inc.	YMCA – Y Wee Care Program
	List is not inclusive.

Resources & Assets: Social and Community Context	
Mental, Emotional Wellbeing	
Behavioral Health Services North, Inc. (BHSN)	Champlain Valley Family Center (CVFC)
Clinton County Coalition to Prevent Suicide	Clinton County Mental Health and Addiction Services
Champlain Valley Family Center	Mobile Crisis Team (BHSN)
NAMI	University of Vermont Medical Center - CVPH
Primary Prevention, Substance Misuse, and Overdose Prevention	
Alliance for Positive Health	Behavioral Health Services North, Inc.
Champlain Valley Family Center	Conifer Park
MHAB	NAMI
Recovery Campus (CVFC)	University of Vermont Health Network - CVPH
Tobacco/E-Cigarette Use	
Advancing Tobacco Free Communities	CCHD – ATUPA Program
North Country Nicotine Consultants	Reality Check Team
Alcohol Use	
Behavioral Health Services North, Inc	Champlain Valley Family Center
Clinton County Mental Health and Addiction Services	Conifer Park
NAMI	University of Vermont Health Network - CVPH
Adverse Childhood Experiences & Childhood Behavioral Health	
Behavioral Health Services North, Inc	Champlain Valley Family Center
Clinton County Mental Health and Addiction Services (SPOA)	CVPH Adult & Child Psychiatry
NAMI	SPARC of Clinton County
Stop Domestic Violence	
Healthy Eating	

Clinton County WIC Program	Cornell Cooperative Extension
Get Healthy North Country	Nutrition Incentive Programs: SNAP, FMNP, Double Up Food Bucks
Private Practice Nutrition Counseling Services	Senior Meal Sites & Home Delivered Meal Program
USDA Summer Feeding Sites	
	List is not inclusive.

Resources & Assets: Neighborhood and Built Environment	
Opportunities for Active Transportation and Physical Activity	
Transportation	
Clinton County Public Transit	First Transit
Private Services (taxis, ambulettes)	Rural Transportation Program (JCEO)
Built Environment/Natural Environment	
State Parks	
Cumberland Bay State Park	Macomb State Park
Point Au Roche State Park	
Recreation Parks and Trails	
14 City of Plattsburgh Parks	14 Town of Plattsburgh Parks
Jay Park and Terry Gordon Bike Path	Karen Fleury Memorial Bike Path
U.S. Oval Park	Wilcox Dock and Healthy Lung Trail
YMCA of the Oval	
Other Parks/Trail Resources	
AC North Sports Center	Beekmantown Town Park and Pavilion
Champlain Area Trails Northern Champlain Trails Map	Chazy Recreation Park
Ellenburg Recreation Park	Feinberg Park, Altona
Gazebo Park, Peru	Heritage Trail, Plattsburgh
Heyworth/Mason Park, Peru	Lafontain Park, Dannemora
Lapham Mills Park, Peru	LaPierre Lane Riverway Park, Schuyler Falls
Little Ausable River Trail, Peru	Lyon Mountain Firetower Trail
Mooers Forks Recreation Park	Mooers Recreation Park
New Land Trust, Saranac	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
Access to Community Services & Support	
Behavioral Health Services North	Child Care Coordinating Council of the North Country
Clinton County Office for the Aging	Clinton County Department of Social Services
Clinton County Health Department	Joint Council of Economic Opportunity - JCEO
NAMI	Senior Citizens Council of Clinton County
	List is not inclusive.

Resources & Assets: Health System Profile	
Access to/Provision of Health Care Services	
Adirondack Medical Home Initiative/CVHN	ADK Wellness Connection
Clinton County Health Department	Federally Qualified Health Care Centers
Health Care of Rochester (HCR)	Plattsburgh VA Clinic
Private Practice Primary Care Providers	The University of Vermont Health Network, CVPH
Adirondack Health Institute/Adirondack Rural Health Network	Private practice specialists
	List is not inclusive.

Resources & Assets: Health Care Access and Quality	
Infant and Maternal Health	
Birthright of Plattsburgh	CCHD Improved Pregnancy Outcome Program
Child Advocacy Center	Child Care Coordinating Council of the North Country, Inc.
Clinton County Breastfeeding Coalition	Clinton County WIC Program
Healing Grace: Center for Hope and Healing	Healthy Families of the North Country
Heart Well Homestead	Hudson Headwaters Health Network – Plattsburgh Pediatric and Adolescent Health
Planned Parenthood	Private Practice Pediatric Providers
University of Vermont Health Network - CVPH	
Prevention Services	
Get Healthy North Country	Planned Parenthood of Plattsburgh
Health Related Coalitions/ Groups/Advocates	
Action for Health Consortium	Clinton County Board of Health
Board of CVPH	STI Partner Coalition
Community Services Board	Adirondack Food System Network
Adirondack Community Foundation	New York Health Foundation
New York State Department of Health	
Oral Health Care	
Private Practice Dental Providers (14)	Private Practice Pediatric Dental Providers (3)
	List is not inclusive.

Resources & Assets: Education Access & Quality	
Education	
Clinton County Public School Districts:	
Ausable Valley Central School District	Beekmantown Central School District
Chazy Rural Central School District	Northern Adirondack Central School District
Northeastern Clinton Central School District	Peru Central School District
Plattsburgh City School District	Saranac Central School District

Private School Districts:	
Lakeshore Christian School	Seton Catholic
Vocational School & Other Work Readiness Programs:	
Champlain Valley Educational Services (CV-TECH)	ETS Ready4Real
Institute for Advance Manufacturing, at CCC	Ramp Program (Coryer Staffing)
Higher Education:	
Clinton Community College	SUNY Plattsburgh
Early Education:	
Adirondack Helping Hands	JCEO Head Start
North Country Kids, Inc.	YMCA – Y Wee Care Program
Clinton-Essex-Franklin Library System	
Clinton County Libraries:	
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	
Other:	
Clinton County Youth Bureau	Creating Health Schools & Communities
	List is not inclusive.

Community Health Assessment Process and Methods

Overview

Described below is the process through which CCHD and UVHN-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 health needs, concerns, inequities;
- 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 gathering direct resident input. UVHN-CVPH and CCHD, the lead entities in the process, facilitated/completed the following activities with the Clinton County community as part of the assessment process:

- A community based, health and wellness focused survey
- An analysis of over 300 health and wellness indicators
- A Review of complementary and relevant needs assessments
- A Community Health Priority Setting Session
- A Domain and Priorities Finalization Process
- The development of shared Action Plans.

In addition, in early 2025, the ARHN conducted a survey of selected stakeholders to provide the CHA Committee with insight into regional health care needs and priorities. Survey respondents represented social service, education, government, and health service-providing agencies within its defined seven-county region. Findings from this regional survey endeavor were considered in the Domain and Priorities Finalization Process.

Since 2002, the ARHN has compiled and analyzed health indicator data, producing and sharing reports with regional CHA committee members to inform health improvement planning. This dataset is now maintained within a data portal. The health indicators were used as a starting point for the preceding Community Profile. Lead organizations have expanded this baseline profile through a detailed data analysis, adding additional health metrics and highlighting the factors—both supportive and challenging—that shape health, equity, and overall community well-being.

Community/ Stakeholder Surveys

Community Resident Survey Process – Clinton County 2025 Community Health Assessment Resident Survey

The CCHD surveyed Clinton County residents to give CHA stakeholders a community perspective on local health. Residents were asked to describe the characteristics of a strong, vibrant, and healthy community; share their views on health, social, and environmental challenges; identify any health or social issues they or a family member experienced in the recent year; report barriers to medical care; and provide demographic information about themselves and their households.

The survey tool was adapted from CCHD's 2022 Community Health Assessment Community Survey. Updates were completed in November 2024 and included new demographic questions to help the lead organizations better understand subpopulation experiences. Additional response options were added based on open-ended feedback from the 2022 survey and partner requests. The final survey included 22 questions, 14 of which focused on demographics and potential disparities. It was anonymous; no names, addresses, or phone numbers were collected. Respondents could also share their experiences with local cancer services, if they or a family member had received care locally within the past three years.

CCHD distributed the survey through existing community partners. It was offered online via a web link shared through email, and also as paper copies. A card with the survey link and a poster featuring the link and QR code were provided to support distribution. Survey development, fielding, and analysis took place over a 10-month period.

Results of Clinton County Resident Survey

A total of 1,888 responses were received, including 1,523 complete surveys from Clinton County residents. This reflects more than a 40% increase in participation compared to the previous assessment cycle. However, partners acknowledge that the survey still reached only about 2% of the county's total population. Throughout the fielding period, the CCHD reviewed respondent demographics and targeted outreach to underrepresented groups, helping ensure that the final response pool aligned as closely as possible with census data. The final demographic analysis suggests that the survey achieved a reasonably representative sample of the county population. Key survey findings were used to further develop the Community Profile, providing important human-experience context for the health status and outcome measures presented in this important piece of the assessment process.

Although the survey was not designed around the *Prevention Agenda 2025–2030: New York State's Health Improvement Plan*, responses were carefully analyzed for their connection to the updated domains and priority areas. This allowed community perspectives to inform health priority-setting activities.

CCHD and its partners recognize that the dataset offers additional opportunities for deeper analysis. Revisions made for this survey cycle were intended to support more detailed exploration of specific population groups. As a result, extended analysis of resident responses will continue into 2026, and the findings will guide health improvement efforts over the next three years.

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

ARHN 2025 Stakeholder Survey

ARHN surveyed stakeholders across its seven-county service area to provide the CHA Committee with insight into regional health care needs and priorities. Stakeholders included professionals from health care, social services, education, and government. The ARHN region includes Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

The survey, created in SurveyMonkey, included 14 community health questions and several demographic items. The CHA Committee compiled a county-level list of health care, social service, education, government, and other service providers (hereafter referred to as *stakeholders*) to receive the survey. In total, 889 stakeholders were identified for distribution. In early February 2025, CHA Committee partners emailed stakeholders an introduction to the survey and a link to the online questionnaire. ARHN sent several reminder emails to those who had not responded. CHA Committee members also received the names of non-respondents so they could follow up at their discretion.

CCHD and UVHN–CVPH chose to personally contact all non-respondents identified as Clinton County stakeholders to maximize participation. The survey asked stakeholders to rank the five domains of the social determinants of health (SDOH) based on their impact in the community and to identify key priority areas their organizations address. Respondents also shared what they viewed as the most significant health concerns in their communities and the factors contributing to those issues.

Results of the ARHN Community Stakeholder Survey

A total of 307 responses were received through March 14, 2025, yielding a response rate of 34.5%. Respondents were asked to indicate all counties in which they provide services. Clinton County had 78 respondents, representing 26% of all responses.

Community stakeholders were then asked to identify the top five health concerns affecting residents in the counties their organizations serve. They ranked these concerns from 1 (highest concern) to 5 (lowest concern).

Survey results show that the top five health concerns across the ARHN region were:

1. Mental Health
2. Substance Use/Alcoholism/Opioid Use
3. Child/Adolescent Emotional Health
4. Adverse Childhood Experiences (ACEs)
5. A tie between Overweight/Obesity and Cancers

For Clinton County, specifically, the top five concerns were:

1. Mental Health
2. Substance Use/Alcoholism/Opioid Use
3. Cancers
4. Adverse Childhood Experiences
5. Overweight/Obesity

Please see Appendix C for: Summary of 2025 Stakeholder Survey Report

Analysis of Health and Wellness Indicators

An analysis of community health data was also conducted to help identify and best understand significant health needs in Clinton County. To support this effort, ARHN developed a CHA Committee Data Dashboard. The dashboard was designed to give CHA Committee partners access to population health information for the region, offering a comprehensive view of overall community health and enabling them to monitor and respond to county-specific needs. It provides county-level data for all counties within the ARHN region, allowing partners to compare their county's status with others.

When available and relevant, the dashboard included three benchmark metrics: the ARHN regional total, the Upstate New York total (NYS excluding the five New York City counties), and the Prevention Agenda goal.

Findings from the dashboard, along with additional health and outcome measures, were used to develop infographics for the Priority Setting Event. These infographics helped participants quickly review and understand key health metrics before selecting priorities (see Appendix C). The data was also incorporated into the Community Profile to support local context and storytelling.

CHA Data Dashboard Sources included and can be accessed at the following:

Prevention Agenda Dashboard
Community Health Indicator Reports
NYS Behavioral Health Risk Factor Surveillance System
NYS Maternal and Child Health
NYS Student Weight Status
NYS Tobacco Enforcement Compliance Results
USDA Food Environment Atlas
Institute for Traffic Safety Report
NYS Index, Property, and Violent Crime Report
NYS Department of Health Wadsworth Center Rabies Data

Demographic, Health Systems, Education and ALICE Profile Data Sources included reports and profiles from the following sources:

U.S. Census Bureau, U.S. Department of Commerce, American Community Survey
United State Department of Agriculture (USDA) FSA Crop Acreage Data

NYS Department of Health, NYS Health Profiles
NYS Education Department (NYSED)
National Center for Education Statistics
United for ALICE

These reports and profiles are included in Appendix D. A full description of the 2025 Data Methodology utilized by ARHN and the CHA Committee is available for reference in Appendix E.

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

Clinton County Health Department Nutrition Security Data (public release pending)
County Health Rankings & Roadmaps- Clinton County
Infant Feeding in Clinton County, 2013-2024
NY Health Foundation Care Across Communities Dashboard
NYS Balance of State Continuum of Care 2024 Point-in-Time Count Report

Finally, an increasing number of community partners across various sectors are conducting their own needs assessments. Aligning and collaborating with these partners enhances opportunities to improve community health and strengthens our understanding of the diverse needs and experiences of local residents. In recognition of this, needs assessments, service plans, and strategic plans from regional partners were reviewed and incorporated into our analysis. These perspectives were frequently used to inform both this assessment and prioritization processes.

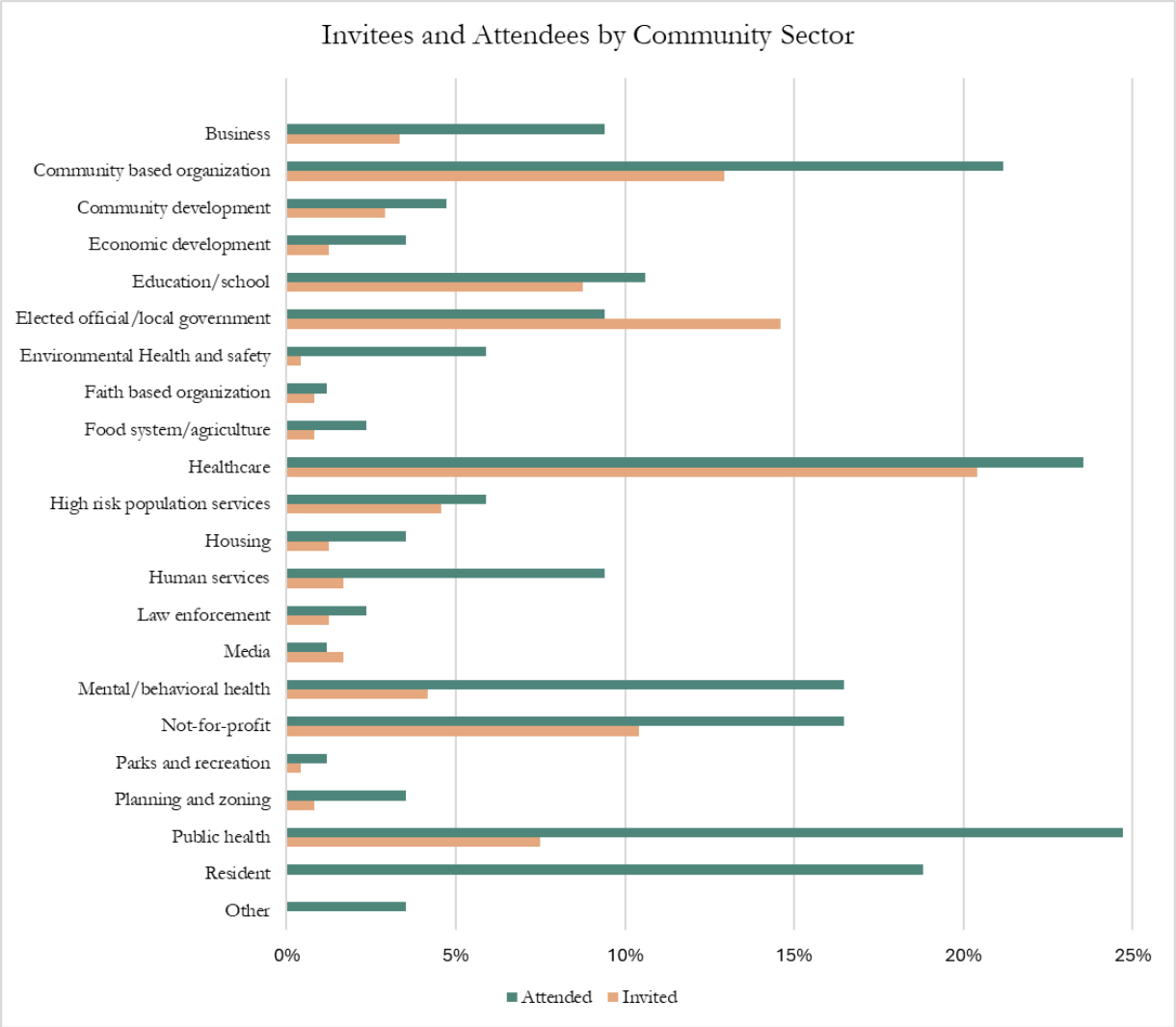
Documents consulted included those developed by behavioral health providers, community action and economic opportunity agencies, regional economic development councils, business associations, and others:

Clinton County, NY Housing Needs Assessment (Camoin Associates)
Clinton County 2024-2027 Local Services Plan
Adirondack Regional Social Safety Network 2024 Report (Adirondack Foundation)
Clinton County, NY Needs Assessment-Youth February 2025 (Apter & O'Connor)
JCEO 2024 Community Needs Assessment

All identified data sources and associated metrics were thoroughly reviewed. Those determined to be most relevant to the population of Clinton County were incorporated into the assessment process. Relevance was primarily evaluated based on metric performance (i.e., county standing relative to regional, state, and national benchmarks), alignment with current or anticipated health improvement initiatives, and the presence of any notable trends, whether positive or negative. The most relevant findings were further used in the Community Profile and throughout the prioritization activities.

Community Health Priority Setting Session

Clinton County has a successful history of convening community stakeholders to assist in the identification of priority health issues. Approximately 220 Clinton County stakeholders were invited to the Community Health Priority Setting Session facilitated by CCHD and UVHN-CVPH on July 17th, 2025. This represented a 25% increase in invitations extended for this event compared to 2022. An open invitation was also made to the community at-large for the first time. The opportunity was promoted through social media and word-of-mouth by the sponsoring partners. The session was held at the MHAB Life Skills Campus, a location chosen specifically for its capacity to accommodate guests and familiarity of the space among community partners. The event space was intentionally set up to encourage interaction between attendees, with refreshments and several spaces for networking and visiting.



The event was four hours in length, running purposely through the lunch hour to offer flexibility. There was not a structured agenda. Instead, attendees filtered through stations

dedicated to either one of the five Prevention Agenda Domains (and their related priority areas) or to resident survey findings. Each station featured a colorful infographic depicting a collection of relevant data measures identified in the secondary data analysis and related to the domain (included in *Appendix F*). Local subject matter experts attended to participants at each station, reviewing the featured data, sharing their firsthand experiences and discussing current activities, progress and challenges with the attendees. They were also asked to record noteworthy insights from their interactions. Attendees were allowed to work their way through all stations at their own pace and, when ready, asked to complete a short survey that captured their vote for which priorities they believed were most important for Clinton County to address as a community over the next several of years.

The short survey included five questions. The first asked whether the respondent had previously participated in a county-level health priority-setting session, with response options of Yes, No, or Other. The second question asked respondents to identify the sector they represented in the priority-setting process. They could select from 22 predefined sectors or choose "Other" and provide an open-ended response. Because stakeholders in small communities often serve in multiple roles, respondents were permitted to select more than one sector. The remaining questions asked respondents to identify the Prevention Agenda Priority Areas they believed were the most important, second most important, and third most important for the community to assess. Each question listed all 24 new Prevention Agenda Priority Areas as options.

A virtual option to weigh in on priorities was offered to invitees following the in-person event to maximize inclusion and participation. In total, 85 stakeholders (61 in-person and 24 virtually), representing over 20 different community sectors, participated in this assessment activity.

Participants who attended in-person and virtually	
Virtual attendee	28% (61)
In-person attendee	72% (24)
Total:	85

Participants' experience with the Prevention Agenda and involvement in community health planning varied. Excitingly, 51% of attendees reported this as their first time contributing to priority setting activities; 49% reported participating in past activities.

Participants who have participated in a county level health priority setting event before.	
Previous participant	49% (41)
First time participant	51% (44)
Total:	85

Responses from health system and community partners participating in the Prioritization Session overwhelmingly selected *Housing Stability and Affordability* as the top priority for collaborative work.

Domain and Priorities Finalization

All participants' votes were considered equally, regardless of mode of attendance (in-person versus virtually). Voting results were, however, weighted by choice position with their first selection assigned the strongest preference, second choice assigned a less strong preference and third selection assigned the least strong preference. After assigning the corresponding weight value, values were totaled across all respondents.

Weighted Scores of All Priorities

Priority	Weighted Score
Housing Stability and Affordability	105
Poverty	59
Access to Community Services & Support	48
Primary Prevention, Substance Misuse and Overdose Prevention	39
Nutrition Security	24
Preventive Services	23
Early Intervention	23
Services for Chronic Disease and Prevention and Control	21
Anxiety and Stress	20
Opportunities for Active Transportation and Physical Activity	20
Alcohol Use	16
Depression	14
Suicide	13
Oral Healthcare	13
Tobacco and E-Cigarette Use	12
Health and Wellness Promoting Schools	10
Unemployment	8
Healthy Eating	8
Adverse Childhood Experiences	7
Prevention of Infant and Maternal Mortality	5
Access to and Use of Prenatal Care	3
Childhood Behavioral Health	3
Injuries and Violence	2
Opportunities for Continued Education	2

Apart from the top priority, a high number of priority areas across multiple domains received similar scores. Due to this outcome, the revised NYS Prevention Agenda's emphasis on social determinants of health, and partners' commitment to addressing cross-cutting issues, the team chose a different approach than in previous years and did not

reconvene partners for further prioritization. Instead, lead assessment partners connected with stakeholders to gather insight into related local strategies and ongoing or planned activities connected to the identified priorities in the top four highest domains.

Leading Community Health Needs *(Aligning Data Analysis and Community Input)*

As a result of the preceding process, Clinton County's leading community health needs, when aligned with the NYS Prevention Agenda, are:

Leading Community Health Needs	
Domain: Economic Stability	
Priority Areas	
Priority	Weighted Score
Housing Stability and Affordability	105
Poverty	59
Nutrition Security	24
Domain: Social and Community Context	
Priority Area	
Priority	Weighted Score
Primary Prevention, Substance Misuse and Overdose Prevention	39
Domain: Health Care Access and Quality	
Priority Area	
Priority	Weighted Score
Preventive Service	23
Domain: Neighborhood and Built Environment	
Priority Area	
Priority	Weighted Score
Access to Community Services and Support	48

Leveraging Community Assets and Resources

UVHN-CVPH and CCHD recognize that improving the health of Clinton County depends on strong partnerships with community organizations and the strategic coordination of resources. The lead partners aim for all action plans to reflect these collaborations, highlighting the contributions and support of many organizations to strengthen intervention impact and ensure responsible use of limited resources.

Throughout the community health needs assessment, CCHD, UVHN-CVPH, and their partners identified existing assets and resources that can help the community advance its

long-term health goals. These assets were documented as part of the assessment, with both supporting and opposing factors considered. All resources listed in the Community Profile are potential supports for implementing Clinton County's Community Health Improvement Plan. Those that can enhance resident engagement, expand message dissemination, and increase reach among disparate or high-need populations will be of significant importance during implementation phases.

Action Plans

Lead staff from CCHD and UVHN-CVPH worked closely with partners to gather and organize the activities and interventions that will address the identified health priorities. This information was collected through multiple methods: reviewing current Community Health Improvement Plan (CHIP)/ Implementation Strategy (IS) activities and progress, examining other shared work plans (such as the Local Services Plan), conducting individual meetings with key partners, soliciting input from Action for Health members, and analyzing findings from the priority-setting event and community surveys. The resulting information was organized by goals and objectives within each domain area, producing five action plans formatted according to NYSDOH guidance. These plans serve as CCHD's CHIP and UVHN-CVPH's IS for the next three years.

Because so much health improvement work occurs across Clinton County, it is not possible for the action plans to capture every initiative or address every identified issue. Local processes ensure ongoing discussion and collaboration across all Prevention Agenda domains. For example, while Action for Health formally tracks CHIP interventions, its meetings are structured around the Prevention Agenda, creating space to recognize all community needs and ongoing efforts. Featured interventions are selected carefully—sometimes because they exemplify local commitment to collective impact, innovation, or cross-system collaboration; other times because they represent complex, community-level efforts carried over from the previous cycle. The plans intentionally include a mix of short- and long-term activities, allowing for continuous progress, regular celebration of achievements, and the flexibility to add new interventions as emerging needs and resources arise.

Maintaining Engagement & Tracking Progress

Active engagement in community health improvement is challenging, especially amid limited resources, competing priorities, and anticipated changes within the healthcare system. Addressing these challenges requires unprecedented collaboration across all sectors—not only among health-focused organizations, but among any agency or group that influences community well-being. Encouragingly, more non-traditional partners are participating in the process, demonstrating a deeper, action-oriented commitment to improving community health. Expanded assessment capacity has also enabled more partners, including residents, to engage meaningfully through multiple avenues.

Clinton County's collaborative approach has deep roots. In the mid-2000s, the county began using the Mobilizing for Action through Planning and Partnerships (MAPP) framework. Over time, MAPP partners evolved into the Action for Health (AFH) Consortium—a diverse group of representatives from multiple community sectors that has implemented policy, systems, and environmental strategies for nearly two decades. A detailed description of this group appears earlier in the document.

Today, AFH serves as a sounding board, a hub for calls to action, and an accountability mechanism for community health improvement. Formal progress updates on the CSP/CHA/CHIP/IS are collected throughout the year by the AFH facilitator and compiled into an annual summary. Each fall, responsible parties submit updates on their featured activities, which are then categorized as "completed" or "in progress." When appropriate, new activities—reflecting emerging needs, resources, or momentum—are added to the plan. UVHN-CVPH also develops an annual summary of accomplishments as a means of tracking progress and evaluating impact (see Appendix F). The annual updates help celebrate successes, sustain partner motivation, and inform the broader community when shared through social media, press releases, and other communication channels.

UVHN–CVPH and CCHD intend to continue using this proven model of partner engagement to support mid-course adjustments and continuously strengthen local processes. With increasing emphasis on the social determinants of health as the foundation for community improvement, lead partners also plan to leverage insights from existing groups, such as the Clinton County Community Services Board and Lake Champlain-Lake George Regional Planning Board, to ensure coordinated, data-driven action.

Dissemination of Plan to the Public

UVMHN–CVPH and CCHD will actively promote and share the CSP/CHA/CHIP/IS with the community. The full assessment and plan will be posted prominently on the UVHN-CVPH website under "Community Impact" and the system "Community Benefit" website. CCHD will post the same documents on its website in the "Statistical Data and Annual Reports" section. Links to these documents, and any updates, will be shared through social media, press releases, and other communication channels. Media interviews, routine social media posts, and mentions in organizational newsletters and publications will help drive residents to the documents.

CCHD will also feature the new CHA/CHIP in a special edition of its *Profiles in Public Health*, summarizing priority areas, planned initiatives, key partners, and calls to action for residents, professionals, and community leaders. This overview will be posted online and promoted through standard outreach efforts. Additional communication strategies will be explored throughout the year to further increase awareness and engagement.

Key stakeholders will receive a formal notice announcing the release of the assessment and related plans. Presentations will be offered to AFH members, local elected officials, the County Board of Health, the Foundation of CVPH, and other interested groups.

Ongoing dissemination and promotion will maximize community awareness and involvement. Presentations and outreach efforts will highlight how residents and partners informed the process and how they can continue contributing to collective health improvement. These activities aim to strengthen grassroots engagement and mobilize both traditional and nontraditional partners in advancing sustainable, community-wide health initiatives.

Evaluation Plan

CCHD and UVHN–CVPH use a range of process and outcome measures to evaluate both the community health assessment and the county's progress on health improvement. Before the assessment begins, process measures are established—for example, targets for the number and demographics of residents reached through surveys and for stakeholder participation in priority-setting activities are set. Timelines for each stage of the process help keep all partners aligned and on track.

Progress on collaborative health improvement plans is monitored through regular discussions at Action for Health (AFH) meetings. These ongoing conversations allow partners to consider new data, emerging conditions, and available resources. When necessary, mid-course adjustments are made to ensure goals and objectives are met. AFH meeting agendas are structured around the NYS Prevention Agenda to ensure that work across all five priority areas is routinely reviewed.

CCHD and UVHN–CVPH also gather stakeholder feedback to understand how the CHA/CHNA/CSP/CHIP/IS documents are used and shared. In previous assessment cycles, approximately 60% of surveyed partners reported using these documents for strategic planning, 64% for staff education and development, and 55% as a data resource. One-third share the documents annually with advisory boards and provide direct website links, while 16% embed the documents within their own sites. Social media and website analytics offer additional insight into community reach, interest, and engagement.

CCHD and UVHN–CVPH will continue to monitor these trends to better meet partner needs and strengthen participation in the plans. The lead partners will also seek new opportunities to assess and enhance the efficiency and effectiveness of the overall process, adjusting their approach as needed.

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 UVHN-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, 2025.

2025-2027 Clinton County
Community Health Improvement Plan

2025-2027 Clinton County Community Health Improvement Plan

NYS Department of Health Prevention Agenda Domain: Economic Stability

Priority Areas: Housing Stability and Affordability, Nutrition Security

Goal: Identify, promote and implement programs that address socioeconomic disparities.
Objective: Reduce the housing cost burden to below 20% in Clinton County. (Baseline: 22.0%, *2017-2022 American Community Survey*)
Objective: Reduce the number of individuals experiencing homelessness within the community. (Baseline: 266; *2024 Point-in-Time Count Report*)

Interventions/Activities	Partners	Measures	Population of Focus/Disparity
Establish a 72 multi-unit complex with 24 supportive housing units for those experiencing long-term homelessness.	ETC Housing Corp (lead partner)	Date of ground-breaking; date of complex opening 90% of tenants will remain housed in the program for at least 12 consecutive months; 85% of tenants exiting the program will move into permanent housing without a subsidy or other supportive housing	Unhoused individuals; adults in rural, low-income communities
Establish a 120-unit complex, with 20 units for OPWDD individuals and 100 for residents meeting ALICE guidelines.	Clinton County ARC (lead partner)	Date of ground-breaking; date of complex opening % of OPWDD units filled % of low-income units filled	Individuals living with developmental disabilities, individuals with housing needs and limited income
Creation of a Community Warming Shelter (for temporary cold weather relief).	Department of Social Services, MHAB, NAMI	Date of opening, number of individuals served during season, number of individuals connected to more stable housing	Unhoused individuals, residents with unstable housing
Continue periodic community-based nutrition security screenings to better understand barriers and to prioritize the development of nutrition related programming in high-risk areas.	Clinton County Health Department	# of events attended highlighting screening # of nutrition security assessments collected (2026 goal= 200)	Individuals who experience barriers accessing healthy foods; all residents
Implement nutrition standards and food service guidelines for meals and snacks served in facilities, worksites and institutions.	Clinton County Health Department Community sites (TBD)	# of sites recruited # of sites with implemented nutrition standards/guidelines (2026 goal= 8)	People who live or work in rural, disadvantaged communities
Complete a Community & Agriculture Resilience Audit to help create a more equitable, accountable and transparent food system.	Adirondack Food System Network Clinton County Health Department Community partners	Dates of planning meetings, # of partners participating in audit, completed audit, date of released findings/action plan	People who live in rural, disadvantaged communities, all residents

NYS Department of Health Prevention Agenda Domain: Social & Community Context

Priority Area: Primary Prevention, Substance Misuse and Overdose Prevention

Goal: Reduce substance use, misuse, overdose and/ or associated harms.
Objective: Reduce the age-adjusted rate for overdose deaths involving any opioid in Clinton County from 25.2 to 22. (2022, *NYS Prevention Agenda Dashboard*)
Objective: Decrease the percentage of Clinton County adults who experience frequent mental distress from 18.6% to 15.0%. (2021, *NYS Prevention Agenda Dashboard*)
Objective: Reduce the percentage of NYS high school students who use tobacco products from 17.0% to 14.5% (*NYS Prevention Agenda*)
Objective: Reduce the prevalence of cigarette smoking among Clinton County adults from 19.9% to 15%. (2021, *NYS Prevention Agenda*)

Interventions/Activities	Partners	Measures	Population of Focus/Disparity
Create and implement an Opioid Fatality Review Team (to identify system gaps and community-specific overdose prevention and intervention strategies).	Clinton County Mental Health & Addiction Services (Lead), CVPH Law Enforcement, Coroner, Emergency Services, Crisis agencies	Meeting dates, number of case reviews, # of new strategies identified/ implemented, # of education opportunities provided	People with substance use disorder
Integrate a Peer Support Specialist (at CVPH).	CVPH	Hire date, # of individuals engaged in the hospital setting, # of individuals linked to a support service	Individuals with identified social needs and substance/mental health community needs
Contract with NYS Unified Court System to enhance access to treatment services and create new programming locally for justice-involved individuals.	Clinton County Mental Health & Addiction Services (Lead)	Interview dates with partner agencies, resource guide of service system	Individuals with identified social needs and substance/mental health community needs/ court system involvement
Street level engagement of unhoused residents offering connection, overdose resources, test strips, and linkage to services.	Champlain Valley Family Center, NAMI	# of days on streets, # of engagements	Unhoused individuals, individuals with unstable housing, Individuals with identified social needs and substance/mental health community needs
Co-locate tobacco treatment specialists in community settings where youth and young adults gather.	Champlain Valley Family Center (Advancing Tobacco Free Communities, Clinton County Health Department	# of new specialists trained, training dates # of locations with embedded specialists	All youth, youth and young adults in communities disproportionately impacted by tobacco marketing practices
Investigate ability of and resources for the enhancement of local regulatory and enforcement tools related to tobacco sales (ie. establishing a local ATUPA reporting line).	Clinton County Health Department	Meeting dates, action plan	Communities disproportionately impacted by tobacco marketing practices; all residents

NYS Department of Health Prevention Agenda Domain: Health Care Access & Quality

Priority Area: Preventive Services for Chronic Disease Prevention and Control

Goal: Increase utilization of evidence-based preventive services.
Objective: Reduce the percentage of Clinton County residents with self-perceived poor or extremely poor physical health to 8.0%. (Baseline: 9.52%, *2025 Clinton County CHA Survey*)
Objective: Reduce the percentage of Clinton County residents reporting access to health care services as a challenge for themselves or a family member to 25%. (Baseline: 27.42%, *2025 Clinton County CHA Survey)*
Objective: Reduce the percentage of Clinton County residents reporting access to mental health and behavioral services as a health challenge for themselves or a family member to 22%. (Baseline: 24.51%, *2025 Clinton County CHA Survey)*
Objective: Reduce the percentage of premature death among Clinton County residents from 22.5% to 20%. (2022, *NYS Prevention Agenda Dashboard*)

Interventions/Activities	Partners	Measures	Population of Focus/Disparity
Provide at least 5 in-person CDSME courses in Clinton County in 2026.	CVPH, Office for the Aging, new partners	Course dates, course completion rates, # of Clinton County residents enrolled, # of CDSME provider partners (baseline= 2, target= 4)	Individuals living with chronic illness, adults in underserved communities
Complete 25 CDSME-related public health detailing visits with local providers and pharmacies.	Clinton County Health Department	Visit dates, pre/post visit referrals	Healthcare providers serving rural communities
Expand access to tobacco treatment specialists within the community.	Advancing Tobacco Free Communities, Clinton County Health Department	# of individuals recruited/trained, training dates, # of sites with treatment specialists (2026 goal= TBD)	Adults who use tobacco products, communities disproportionately impacted by tobacco industry marketing practices
UVHN-CVPH Family Medicine residents will host healthy cooking sessions.	CVPH	Dates of sessions, # of sessions (2026 goal=5), # of attendees at sessions	Adults in underserved communities, people living with chronic illness
Implement Integrated Primary Care model in an outpatient substance abuse treatment facility.	Champlain Valley Family Center, CVPH Family Medicine	Process developed, provider coverage determined, launch date, # of individuals utilizing service	Adults in substance use treatment with primary care needs
Establish a dedicated Heart Failure RN Educator	CVPH	# of heart failure readmissions, % reduction in readmissions, # of consults provided	Residents with a diagnosis of heart failure, Individuals living with chronic illness

NYS Department of Health Prevention Agenda Domain: Neighborhood & Built Environment

Priority Area: Access to Community Services and Support

Goal: Improve awareness, affordability, accessibility and acceptability of community services and supports.
Objective: Increase Clinton County's Community Score to 52.0. (Baseline: 49.6, 2023; *Opportunity Nation/Index*)
Objective: Decrease the percent of Clinton County residents reporting opportunities for physical activity as a social challenge for themselves or a family member to < 20%. (Baseline: 22.3%; *2025 Clinton County CHA Survey*)
Objective: Decrease the percent of Clinton County residents reporting a lack of safe/supportive areas as a social challenge for themselves or a family member to <19%. (Baseline: 21.13%, *2025 Clinton County CHA Survey)*

Interventions/Activities	Partners	Measures	Population of Focus/Disparity
Increase the number of municipalities that adopt and implement community planning and active transportation to increase access to safe and accessible spaces for physical activity. (2026 goal=3)	Clinton County Health Department Clinton County Municipalities	# of communities recruited # of resolutions executed Intervention reach	People who live in disadvantaged communities; residents of low-income households
Seek continued funding to support implementation of evidence-based nutrition and physical activity strategies in priority communities.	Clinton County Health Department	Proposal submission date Award date	People who live in disadvantaged communities; residents of low-income households
Increase the number of community and public spaces that adopt policies and implement practices that are supportive of breast/chestfeeding and lactation. (2026 goal= 6)	Clinton County Health Department Recruited communities	# of community sites recruited # of policies executed Intervention reach	Pregnant/post-partum people, breast/chestfeeding families; Families living under the burden of socioeconomic disparities
Integrate physical and/or well-being supports in Town of Plattsburgh parks and playgrounds. (2026 goal= 10 sites total; 4 sites w/ accessibility upgrades)	Town of Plattsburgh Recreation	Project start/end dates # of parks/playgrounds with completed projects Project reach	People who live in disadvantaged communities; residents of low-income households; individuals living with physical, mental or intellectual disabilities

Community Service Plan

As part of the joint plan, Champlain Valley Physicians Hospital (CVPH) has completed and included their Community Health Improvement Plan (CHIP)- Community Service Plan. The Community Service Plan outlines evidence-informed strategies and available resources to address the selected priorities. To carry out a feasible and meaningful CHIP and inform the corresponding lead partner action plans, six total priorities across four domains were selected. Due to capacity, resource availability, and sphere of influence, CVPH will focus on addressing the following priority areas of the joint CHIP: *Primary Prevention, Substance Misuse and Overdose Prevention* and *Preventive Services for Chronic Disease Prevention and Control*.

2025-2027 Champlain Valley Physicians Hospital Community Service Plan

NYS Department of Health Prevention Agenda Domain: Social & Community Context
Priority Area: Primary Prevention, Substance Misuse and Overdose Prevention
Goal: Reduce substance use, misuse, overdose and/or associated harms.
Objective: Decrease the percentage of Clinton County adults who experience frequent mental distress from 18.6% to 15.0%. (2021, NYS Prevention Agenda Dashboard)
Interventions/Activities
Integrate of Peer Support Specialist (at CVPH).
Geographic Focus
Clinton County
Resource Commitment
Onboarding a Peer Support Specialist at CVPH to contract at facility.
Participant Roles
– Champlain Valley Family Center (CVFC) hires and supervises Peer Support Specialist. – CVPH and CVFC work together to better coordinate social determinants of health (SDOH) resource needs and patients needing substance services. MOU is in place.
Population of Focus/ Disparities Addressed
Individuals with identified social needs and substance/mental health community supports
Family of Measures
– Hire peer support specialist – Establish clear interagency referral pathway and cross-team education focused on peer engagement at the bedside and connection to services

– # of individuals engaged in the hospital setting and linked to a support service
Timeframe
2/1/2026- 12/31/2027

NYS Department of Health Prevention Agenda Domain: Healthy Care Access and Quality
Priority Area: Preventive Services for Chronic Disease Prevention and Control
Goal: Provide opportunity for the establishment of primary care via the substance use clinic.
Objective: Reduce the percentage of premature deaths among Clinton County residents from 22.5% to 20%. (2022, NYS Prevention Agenda Dashboard)
Interventions/Activities
Implement an Integrated Primary Care model in an outpatient substance use disorder (SUD) treatment facility.
Geographic Focus
Clinton County
Resource Commitment
UVMH-CVPH Family Medicine: provider resources and operational support
Participant Roles
– Once state funds are released, CVPH will support a provider from Family Medicine to cover Champlain Valley Family Center (CVFC) for initial intake for Primary Care.
Population of Focus/ Disparities Addressed
– Adults in substance use treatment – Adults needing primary care
Family of Measures
– Implement a process for primary care in SUD clinic – Identify primary care provider coverage – Track number of individuals seen utilizing this model
Timeframe
3/31/2026-12/31/2026
Interventions/Activities
– Establish a dedicated Heart Failure RN Educator.

– Engage patients with heart failure admissions/readmissions and provide initial and reoccurring education for admitted patients. – Connect patients with heart failure admissions/readmissions to Heart Failure Clinic at the time of discharge. – Focus on healthy eating, chronic disease management, and connection to specialty providers in the community.
Geographic Focus
Clinton County
Resource Commitment
An inpatient Heart Failure Educator consulting on Heart Failure admissions/readmissions.
Participant Roles
CVPH Heart Failure Educator will provide consultation to inpatient identified patients with heart failure readmissions and to newly diagnosed patients. CVPH Heart Failure Educator will recommend referrals to appropriate partner agency resources supporting those with heart failure. This includes the Heart Failure Clinic, Hudson Headwaters, CVPH Family Medicine, and Home Healthcare Agencies.
Population of Focus/ Disparities Addressed
– Residents with a diagnosis of heart failure – Individuals living with chronic illness
Family of Measures
– # of heart failure readmissions – % reduction in heart failure readmissions – # of consults provided
Timeframe
10/1/2025- 21/31/2027

Appendices

Appendix A:

Committee Members and Meeting Schedules

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 & Safety
Lydia Brown	Behavioral Health Services North
Starr Burke	St. Joseph's Community Outreach Center
Dana Isabella	Champlain Valley Family Center
Trevor Cole	Town of Plattsburgh Planning Department
Darleen Collins	Clinton County Office for the Aging
Sara Deukmejian	Adirondack Health Institute
Adele Douglas	Town of Peru
Valarie Drown	Center for Neurobehavioral Health – SUNY Plattsburgh
Donna Gallup	Adirondack Health Institute
Linda Gillilland	Cornell Cooperative Extension
Lisa Goodrow	Joint Council for Economic Opportunity
Morgan Greenwood	North Country Healthy Heart Network
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
Jessica Kogut	Town of Plattsburgh
Amy Kohanski	North Country Healthy Heart Network
Paula Lacombe	Citizen
Shelby LaRock	Behavioral Health Services North
Dorothy Latta	Plattsburgh Interfaith Food Council
Molly Lawrence	University of Vermont Health Network
Nichole Louis	Clinton County Health Department – Health Care Services
Crystal Mang	Adirondack Health Institute
Nikita Marshall	Alliance for Positive Health
Jennifer Meschinelli	Senior Citizens Council of Clinton County
Warren Middlemiss	North Country Center for Independence
Akanksha Misra	State University of NY - Plattsburgh
Ann Morgan	North Country Healthy Heart Network
Crystal Narducci	Friends of the North Country
Michelle Ouelette	State University of NY - Plattsburgh
Erin Pangborn	Town of Plattsburgh Recreation Department
Robert Poulin	North Country Center for Independence
Lan Pratt	University of Vermont Health Network – Champlain Valley Physicians Hospital – Fitzpatrick Cancer Center
Alisa Preston	Adirondack Health Institute
Gabi Quintana	Alliance for Positive Health
Hanna Schneider	North Country Healthy Heart Network
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
Josh Stephani	Adirondack Food System Network
Dan Sweet	North Country Healthy Heart Network
Ken Thayer	University of Vermont Health Network – Champlain Valley Physicians Hospital
Shannon Thayer	Clinton County Planning Department
Kim Trombly	Adirondack Community Foundation
Jennifer Trudeau	Clinton County Health Department
Philip Vonbargen	Citizen

Action for Health Consortium 2025 Meeting Schedule

January 8, 2025
March 12, 2025
May 14, 2025
July 9, 2025
September 10, 2025
November 12, 2025

Tentative 2026 Meeting Dates

January 14, 2026
March 11, 2026
May 13, 2026
July 8, 2026
September 9, 2026
November 18, 2026

Adirondack Rural Health Network Community Health Assessment

Committee Members

Name	Organization
Matt Scollin Lisa Tuggle	Adirondack Medical Center
Shannon Gaczol	Glens Falls Hospital
Geoff Peck Dakota Pike	Nathan Littauer Hospital
Annette Marshall	University of Vermont Health Network – Alice Hyde Medical Center
Ken Thayer	University of Vermont Health Network - Champlain Valley Physicians Hospital
Amanda Whisher Julie Tromblee Jodi Gibbs	University of Vermont Health Network - Elizabethtown Community Hospital
Sara Deukmejian Laura Morris	Adirondack Health Institute
Mandy Snay	Clinton County Health Department
Linda Beers Jessica Darney Buehler Andrea Whitmarsh	Essex County Public Health
Hanna Busman Sarah Granquist	Franklin County Public Health
Laurel Headwell Jacob Stewart	Fulton County Public Health
Junie Delizo Maria Luz McKay	Hamilton County Public Health
Ginelle Jones Dan Durkee Olivia Cohen Jigmasha Shah Katie Boyle	Warren County Health Services
Tina McDougall Elizabeth St. John Alyssa Arlen	Washington County Public Health

Meeting Dates

2025

March 7
May 16
September 5
December 5

2026 & 2027

Dates TBD

Appendix B:

Clinton County 2025
Community Health Assessment Survey

June 2025

Introduction

The Clinton County Health Department (CCHD) surveyed Clinton County residents to provide Community Health Assessment (CHA) stakeholders with resident perspective on community health and added context to experiences within community. 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. Basic demographic information about individual respondents and their households was also collected.

Methods

The Clinton County 2025 Community Health Assessment Community Survey was adapted from the Clinton County 2022 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 were used throughout the process to field and maximize reach of the survey.

Notable changes from Clinton County's 2022 Community Survey to the 2025 version include: the addition of two new questions, the reintegration of a question specifically addressing cancer care within the community, and additional response choices based on common 'write-in' responses from the 2022 iteration. The new questions sought to provide further context to respondents' selections and how they differed if their household included children under the age of 18. In total, the survey included twenty-three questions, twelve 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, and a series of posters 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, Community Services Board members, Town Supervisors and Mayors, local school Superintendents, and local healthcare providers. 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, Plattsburgh Interfaith Food Shelf, Champlain Valley Athletic Association Sectional Finals, and the Adirondack Coast Craft Fair.

The CCHD utilized New York State Public Health Fellowship Corps staff 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, Clinton County Office for the Aging, Clinton County Mental Health & Addiction Services, and Champlain Valley Educational Services. 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. Several local employers did this as well.

Survey respondents were first asked if they felt they lived in a heathy 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-seven 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-seven 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 nineteen identified possible barriers. The survey then requested that respondents complete twelve demographic questions, which collected information on their gender, age, city/ town of primary residence, makeup of their household, 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. 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 U.S. Census Statistics for Clinton County, NY were used to evaluate demographic representation/ participation in this survey (*see Table 1*). Responses in the current iteration were compared to findings from previous iterations of this survey. Survey findings were formally shared with stakeholders during the 2025 Clinton County Community Health Assessment Priority Setting Session to assist event attendees in selecting priority health areas for the 2025-2028 Community Health Improvement Plan and Community Services Plan.

Findings

A total of 1,888 responses were received, of which, 1,523 were complete surveys from Clinton County residents. This is the highest response rate since the survey's inception. Incomplete surveys and those completed by non-residents were not included in result findings.

Demographics of Survey Respondents

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 based on population density. Residents from Altona, Black Brook, Champlain (including Rouses Point), Dannemora, and Schuyler Falls were slightly underrepresented, while residents from Beekmantown, Chazy, Clinton, and the Town of Plattsburgh were slightly overrepresented. See *Table 1* and *Figure 1* for a comparison of survey respondents and Census population by township. Of the 1,523 respondents, 21 live in Altona (1.38%); 61 in AuSable (4.01%); 126 in Beekmantown (8.27%); 11 in Black Brook (0.72%); 94 in Champlain, including Rouses Point (6.17%); 114 in Chazy (7.49%); 35 in Clinton (2.30%); 27 in Dannemora (1.77%); 27 in Ellenburg (1.77%); 62 in Mooers (4.07%); 123 in Peru (8.08%); 389 in the City of Plattsburgh (25.54%); 301 in the Town of Plattsburgh (19.76%); 65 in Saranac (4.27%); and 67 in Schuyler Falls (4.04%).

Clinton County is comprised of approximately 48.6% female and 51.4% male. Approximately 3.22% (49) of respondents to the Clinton County 2025 Community Health Assessment Resident Survey preferred not to identify their gender. Of the 1,474 individuals who shared information regarding their gender identity, 78.36% (1,155) of respondents identified as female, 20.15% male (297), 0.75% non-binary (11), and 0.75% selected "other" (11) (*see Table 2*). 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. 0.26% of respondents were 17 years and under (4); 2.89% were 18-24 years old (44); 37.89% were 25-44 years old (577); 38.94% were 45-64 years old (593); 14.45% were 65-79 years old (220); and 5.58% were 80 years and over (85) (*see Table 2 and Figure 2*).

Of the 1,523 survey respondents, over 99% (1,508) of respondents identified English as the primary language spoken in their home. Other primary languages spoken in the households of the respondents included: Spanish (3), American Sign Language (2), Chinese (1), and French (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 1,523 survey respondents, 4.40% (67) preferred not to identify their race/ethnicity. Of the 1,456 individuals who shared information regarding their race/ethnicity, 96.43% (1,404) identified as White. 2.06% identified as Hispanic, Latino, or Spanish origin (30), 1.79% as Black or African American (26), 1.24% as American Indian or Alaskan Native (18), 1.17% as Asian or Pacific Islander (17), and 0.96% as something other than what was listed (14) (see *Table 2).*

The highest level of education completed by survey respondents was diverse. Of the 1,523 respondents, the highest level of education obtained was *some high school but did not finish* in 47 respondents (3.09%); *high school diploma or GED* in 225 respondents (14.77%); *completed some college but did not finish* in 178 respondents (11.69%); *technical or trade school certificate* in 58 respondents (3.81%); an *Associate degree* in 196 individuals (12.87%); a Bachelor degree in 354 individuals (23.24%); a *Master degree* or higher in 434 respondents (28.50%); and 31 individuals selected "other" when asked about their highest level of education (2.04%) (*see Table 2* and *Figure 3*). 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.

The household annual income reported by respondents varied; of the 1,523 respondents, 11.62% (177) respondents opted not to report their household's annual income. Of the 1,346 respondents who reported their household's annual income, 3.71% (50) reported a household annual income of less than $10,000; 10.55% (142) reported $10,000-24,999; 14.64% (197) reported $25,000-49,999; 28.38% (382) reported $50,000-99,999; 25.26% (340) reported $100,000-149,999; and 17.46% (235) reported $150,000 or more (*see Table 2* and *Figure 4*). 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 1,523 respondents, a majority were full-time employees (62.57%) or retired (19.30%). 119 individuals were part-time employees (7.81%); 80 reported being disabled (5.25%); 1 reported being in the armed forces (0.07%); 39 reported being a homemaker (2.56%); 23 reported being a student (1.51%); and 55 reported being unemployed (3.61%). 25 individuals selected "other" for their primary employment status (1.64%) (*see Table 2*).

Nearly 10% of respondents reported that they did not have a primary care provider (151)(*Table 2*).

While 79.97% (1,218) of respondents reported having no disability, 20.03% of individuals reported at least one disability (305). 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 (47.87%); followed by difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition (45.25%). (36.99%). The next most reported disability was difficulty completing errands alone because of a physical, mental, or emotional condition, where respondents indicated (31.48%) (see *Table 3* and *Figure 5*).

Almost half (47.34%) of respondents indicated there was one or more child living in their household (721). 52.66% reported zero children living in their household (802), 20.68% reported one child living in their household (315), 19.04% reported 2 children living in the household (290), and 7.62% reported three or more children living in the household (116). 53.58% reported two adults living in their household (816), while 19.11% reported three or more adults (291) (see *Table 4* and *Figure 6*). Data from this question indicates that while only 1,523 surveys were collected, the responses contained in those surveys reflected the experiences of more than 4,000 county residents.

Definition of a Healthy Community

When asked whether they believed they lived in a healthy community, 35.26% of respondents agreed or strongly agreed that they live in a healthy community. Alternatively, 28.82% disagreed or strongly disagreed with this statement; 35.92% 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%. The top features reported were affordable housing (36.31%), health care services (35.33%), livable wages (31.32%), safe environment (31.32%), and clean environment (30.01%). See *Table 5* and *Figure 7* for perceptions of living in a healthy community by residents and *Table 6* and *Figure 8* for the top features of a strong, vibrant, healthy community.

Health Challenges of Concern and Experienced

More than 90% of respondents reported experiencing one or more health challenge in the past year by themselves or a family member. Mental health was identified as the top health challenge in the community (46.75%) and was the most reported health related challenge experienced by respondents (41.53%). However, an overwhelming majority of respondents reported that their mental health was average, good, or excellent, when asked, leaving just about 10% of respondents reporting that their mental health was poor or extremely poor. Likewise, nearly 36% of respondents identified access to mental health services as a health challenge in the community, while just under 25% of respondents reported having trouble accessing mental health services. Conversely, 44.32 % of respondents identified substance abuse as a health challenge in the community, while only 12.73% of respondents reported it as a health challenge experienced by themselves or a family member within the past year. Additionally, 31.06% of respondents identified overweight/obesity as a health challenge in the community and more than 1 in 3 (36.36%) respondents reported it as a health challenge experienced by themselves or a family member in the past year. Furthermore, nearly 30% of respondents or a family member experienced a chronic disease, yet less than a quarter (24.75%) identified it as a top health challenge in the community. Over 68% 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 (39.96%), no specialist locally (37.84%), insurance was not accepted (35.91%), no appointment available for primary care (30.21%), and could not leave work or school (26.74%). See *Table 7* and *Figure 9* for health challenges identified in our community, *Table 8* and *Figure 10* for health challenges experienced by residents, and *Table 9* and *Figure 11* for barriers to receiving medical care.

Social Challenges of Concern and Experienced

Nearly 3 in 4 (73.01%) respondents reported that they or a family member experienced at least one social challenge in the past year. Nearly half of (46.62%) respondents identified affordable housing as a top social concern in the community, while more than 1 in 4 (28.96%) 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 about 37% reported experiencing this challenge in the past year. Likewise, nearly a quarter (23.02%) respondents reported that they or a family member has experienced bullying in the last year, 23.70% identified it as a social challenge in the community. Just over 12% of respondents identified street safety as a social concern in the community, yet more than 1 in 5 (21.85%) identified it as a challenge for themselves or a family member. Access to healthy foods continues to be a commonly reported social challenge of concern in our community (28.10%) and experienced by respondents or their families (21.49%). See *Table 10* and *Figure 12* for social challenges of concern in our community and *Table 11* and *Figure 13* for social challenges experienced by residents.

Environmental Concerns

More than half (56.20%) of respondents identified aging infrastructure as a top environmental concern in our community. Over 45% of respondents also identified concern related school safety, while almost 40% of respondents identified drinking water quality as a top environmental concern. Additionally, about 1 in 3 (36.24%) respondents identified climate change as a top environmental concern in our community. Nearly 35% of respondents identified stream, river, lake quality as an environmental concern within our community. See *Table 12* and *Figure 14* for environmental concerns in our community.

Self- Perceived Physical and Mental Health

More than 4 in 5 respondents self-reported their physical health as average (40.84%) or good (39.33%). Less than 10% reported their physical health as poor or extremely poor; 10.31% reported their physical health as excellent. A similar pattern in responses was seen for self-reported mental health with 89.69% of respondents reporting their mental health as average, good or excellent; 8.67% and 1.64% of respondents reported their mental as poor or extremely poor, respectively. See *Table 13* and *Figure 15* and *Table 14* and *Figure 16* for a breakdown of self-reported physical and mental health responses, respectively.

Changes over time

The 2025 survey marks the third time CCHD has used the same survey tool for this process. Though the most recent iteration contains additional questions and answer options, its consistent use allows for changes over time to be evident. Relative risk was used to relate respondents' answers from 2019 to 2025, as well as (in some cases) 2022 to 2025. Relative risk is the ratio of the probability of an event happening in one group compared to the probability of the same event happening in another group. In other words, how much more or less likely a selection was made in one year compared to another.

Though this is only the second time respondents were asked whether they believed they lived in a healthy community, over all, more residents disagreed or strongly disagreed with this statement. In 2022, 22.39% of respondents disagreed or strongly disagreed with this statement, while 41.54% agreed or strongly agreed. Respondents who disagreed or strongly disagreed increased to 28.82% and respondents who agreed or strongly agreed decreased to 35.26% in 2025 (see *figure 7*). There were also differences in respondents' definition of a healthy community over time *(see figure 8)*. Though affordable housing has appeared in the top five each iteration, the number of respondents who selected it as a top feature has increased 5.29 percentage points since 2019. Respondents were less also likely to identify economic opportunities and good schools in 2025, when compared to 2019.

When asked to identify health challenges in the community, 2025 respondents were almost three times less likely to identify suicide (death by suicide or completed). Residents two times less likely to select cancer as a health challenge in the community than they were in 2019. An interesting change in respondents experiencing an infectious disease was revealed when comparing 2019, 2022, and 2025 data. In 2019 4.99% of respondents reported experiencing an infectious disease. This rose to 20.01% in 2022, during the COVID-19 pandemic, then dropped down to 12.29% in 2025. Since 2019 respondents who needed medical care but could not access it due to co-pays or deductibles being too high or not having dental or vision insurance decreased. Conversely, respondents who could not get care because they could not leave work or school or could not find a primary care appointment increased. The number of respondents who identified lack or medical care due to not having a specialist locally increased two-fold. See *figure 9*, *figure 10*, and *figure 11* for health challenges in the community, health challenges experienced, and barriers to medical care.

Though lack of a livable wage continues to be a top social challenge in the community, respondents identifying lack of employment opportunities in the community decreased from 2019 to 2025. Residents reporting crime or vandalism as a social concern in the community increased over the last six years. Respondents also reported experiencing issues related to access to healthy foods (1.4), bullying (13.3), lack of a livable wage (1.2), and safe recreational areas (1.58) as social challenges they experienced at a greater rate in 2025 than 2019. See *figure 12* for social challenges in the community and *figure 13* for social challenges experienced.

Perhaps the most significant pattern seen from year to year is the increase in residents experiencing one or more health challenge, social challenge, and barrier to medical care. In 2019, about 86% of respondents reported experiencing one or more health challenge over the last year, this rose to 90% in 2025. In terms of social challenges, in 2019 62% of respondents reported experiencing one or more social challenge, this increased to 73% in 2025. Another significant increase from 2019 to 2025 was in respondents who identified one or more barrier to receiving medical care. This rose from 50% to 68% over six years. Also of note, the number of health challenges, social challenges, and barriers to medical care experienced per person also increased from 2019 to 2025. Health challenges increased from 3.43 to 4.34 per person; social challenges from 2.94 to 3.43 per person; and barriers to medical care increased from 2.37 to 3.08 per person. See *figure 17* for health challenges, social challenges, and barriers to medical care over time and *figure 18* for challenges and barriers experienced per respondent over time.

Considerations/Limitations

Having completed a survey of similar magnitude in 2016, 2019, and 2022, the CCHD was able to leverage survey fielding experience and existing partners within the community to efficiently reach it's highest number of residents ever. There were 365 surveys submitted that were completed by residents of a neighboring county or not completely filled out. Those surveys were not included in this analysis, resulting in 1,523 surveys fully completed by Clinton County residents. This equates to only approximately 2% of the county's population but represents an increase in reach from the survey's previous iterations.

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. Survey fielding was completed over the winter months from December 2024 to April 2025, potentially limiting reach due to weather. Females were more likely to complete the survey than males and male respondents proved to be one of the most difficult subpopulations to engage.

Though trust in public health seems still to be fractured, that was not reflected in residents' willingness to participate. In the last iteration of the survey, open-ended responses collected captured a level of frustration among respondents. 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 the survey. This type of comment was not reflected during this iteration.

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. The majority of responses were received electronically. 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. 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.

Three response selections were inadvertently left off the online version of the survey. The option to select *access to immunizations* on questions three and six (regarding health challenges) and the option to select *no*

developmental services provider was available (speech, OT, PT, etc.) on question eight (barriers to medical care) were not available for online respondents. Therefore, these responses may be underreported.

Conclusions

This survey provided valuable feedback from the community for the CCHD and UVM Health Network-CVPH. It represents the widest reaching approach to community inclusion in the local community health assessment process. This is Clinton County's fourth 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.

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, affordable housing, opportunities for physical activity, and street safety being top challenges selected in this category for the third straight iteration. More than half of respondents selected aging infrastructure as the top environmental concern; school safety was the second top environmental concern among respondents, demonstrating a shift from last iteration. Such findings reinforce the importance of the social determinants of health and the need to continue to favor strategies and interventions that address up-stream factors that play a fundamental role in health outcomes. Despite the challenges identified by residents, over 35% of survey respondents feel they live in a healthy community.

While the survey was not framed around the *Prevention Agenda 2025-2030: 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. Survey findings will certainly fulfil their primary purpose of informing the local health priority selection process. Yet, CCHD and many of its partners recognize there is more to be gained from deeper 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 continuous collaborative planning intended to improve the health of all residents.

An overview of the survey process, collected data and full analysis will be readily shared with community health stakeholders and residents. This full report will be featured in the 2025-2028 Community Health Assessment, which is posted prominently on CCHD's and CVPH's websites. 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. Additional reports and visuals will be created as further data analysis is completed and shared through similar means.

Tables & Figures

Table 1. **2025 Clinton County Community Health Assessment Community Survey, Residency of Respondents and 2020 U.S. Census. Population Statistics for Clinton County**

Demographic		2025 Survey % (#)	2020 Census % (#)
Township of primary residence (n = 1,523)	Altona	1.38% (21)	3.34% (2,666)
	AuSable	4.01% (61)	3.99% (3,183)
	Beekmantown	8.27% (126)	6.90% (5,508)
	Black Brook	0.72% (11)	1.82% (1,453)
	Champlain (including Rouses Point)	6.17% (94)	7.20% (5,745)
	Chazy	7.49% (114)	5.13% (4,096)
	Clinton	2.30% (35)	0.82% (652)
	Dannemora	1.77% (27)	5.06% (4,037)
	Ellenburg	1.77% (27)	2.31% (1,842)
	Mooers	4.07% (62)	4.34% (3,467)
	Peru	8.08% (123)	8.48% (6,772)
	Plattsburgh (City of)	25.54% (389)	24.85% (19,841)
	Plattsburgh (Town of)	19.76% (301)	14.89% (11,886)
	Saranac	4.27% (65)	4.82% (3,852)
	Schuyler Falls	4.40% (67)	6.07% (4,843)

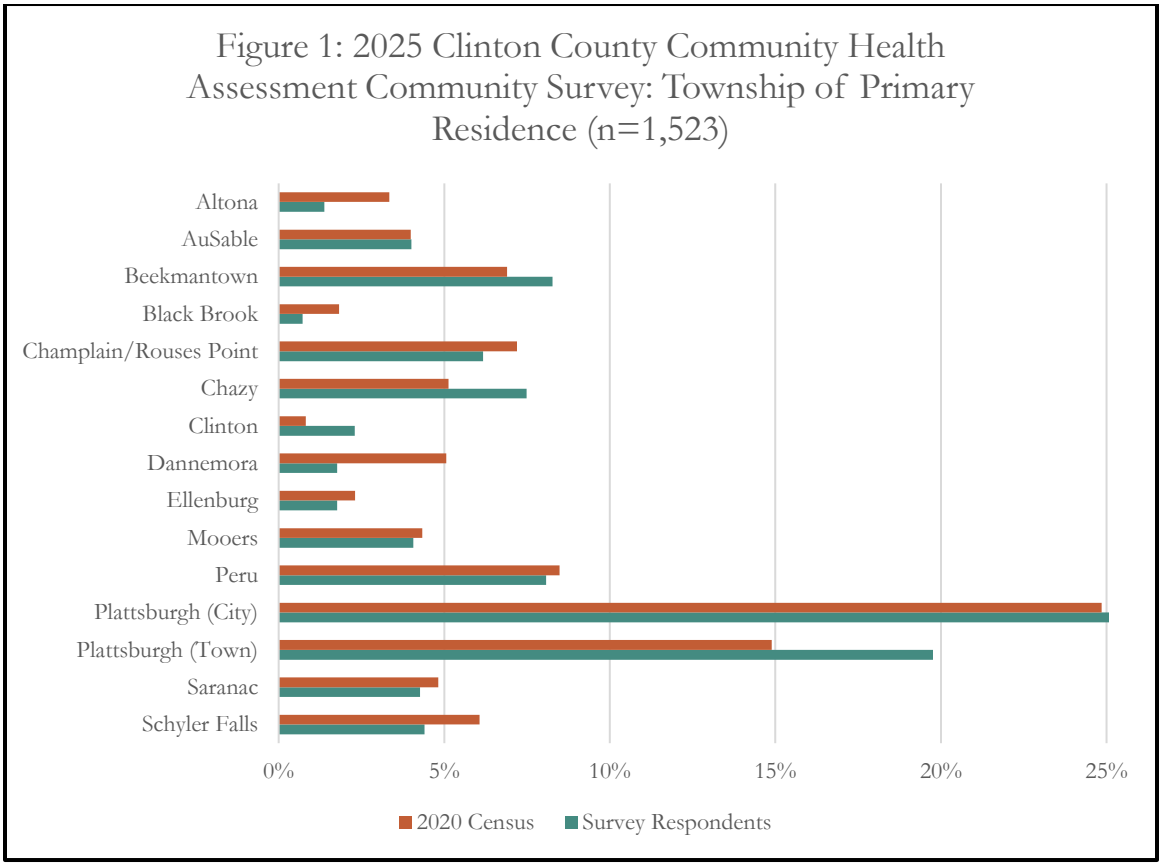


Table 2. **2025 Clinton County Community Health Assessment Community Survey, Demographics of Respondents**		
Demographic		% (#)
Gender (n = 1,474)*	Female	78.36% (1155)
	Male	20.15% (297)
	Non-Binary	0.75% (11)
	Other	0.75% (11)
	**Note:* Of all 1,523 respondents, 3.22% (49) declined to answer.	
Age (n = 1,523)	45-64 years	38.94% (593)
	25-44 years	37.89% (577)
	65-79 years	14.45% (220)
	80 years and older	5.58% (85)
	18-24 years	2.89% (44)
	17 years and younger	0.26% (4)
Primary language spoken in household (n = 1,523)	English	99.02% (1,508)
	Other	0.53% (8)
	Spanish	0.20% (3)
	American Sign Language	0.13% (2)
	Chinese	0.07% (1)
	French	0.07% (1)
	Haitian-Creole	0.00% (0)
	Italian	0.00% (0)
	Korean	0.00% (0)
	Polish	0.00% (0)
	Russian	0.00% (0)
Race/ethnicity (n = 1,456)*	White	96.43% (1,404)
	Hispanic, Latino or Spanish origin	2.06% (30)
	Black or African American	1.79% (26)
	American Indian	1.24% (18)
	Asian or Pacific Islander	1.17% (17)
	Other	0.96% (14)
	**Note:* Of all 1,523 respondents, 4.40% (67) declined to answer. For this question respondents were asked to select all that apply; therefore, responses will not total 100%.	
Highest level of education (n = 1,523)	Master's degree or higher	28.50% (434)
	Bachelor's degree	23.24% (354)
	High school diploma or GED	14.77% (225)
	Associate's degree	12.87% (196)
	Some college	11.69% (178)
	Technical or trade school certificate	3.81% (58)
	Some high school (did not finish)	3.09% (47)
	Other	2.04% (31)

Table 2 Continued. **2025 Clinton County Community Health Assessment Community Survey, Demographics of Respondents**		
Demographic		% (#)
Household annual income (n = 1,346)*	$50,000 - $99,999	28.38% (382)
	$100,000 - $149,999	25.26% (340)
	$150,000 or more	17.46% (235)
	$25,000 - $49,999	14.64% (197)
	$10,000 - $24,999	10.55% (142)
	Less than $10,000	3.71% (50)
	**Note:* Of all 1,523 respondents, 11.62% (177) declined to answer.	
Employment Status (n = 1,523)	Full-time	62.57% (953)
	Retired	19.30% (294)
	Part-time	7.81% (119)
	Disabled	5.25% (80)
	Unemployed	3.61% (55)
	Homemaker	2.56% (39)
	Other (please specify)	1.64% (25)
	Student	1.51% (23)
	Armed forces	0.07% (1)
Primary Care Provider (n = 1,523)	Yes	90.09% (1,372)
	No	9.91% (151)

Figure 2: 2025 Clinton County Community Health Assessment Community Survey: Age (n=1,523)

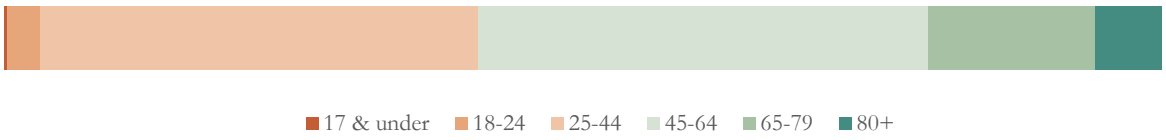


Figure 3: 2025 Clinton County Community Health Assessment Community Survey: Highest Level of Education (n=1,346*)

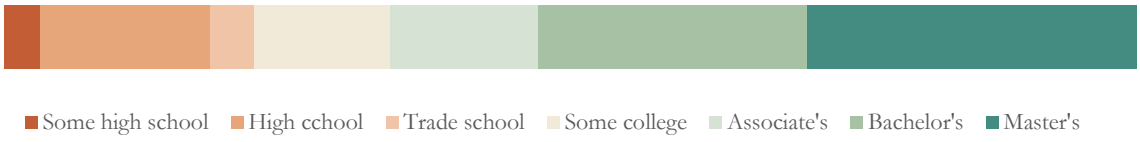


Figure 4: 2025 Clinton County Community Health Assessment Community Survey: Household Annual Income (n=1,346*)

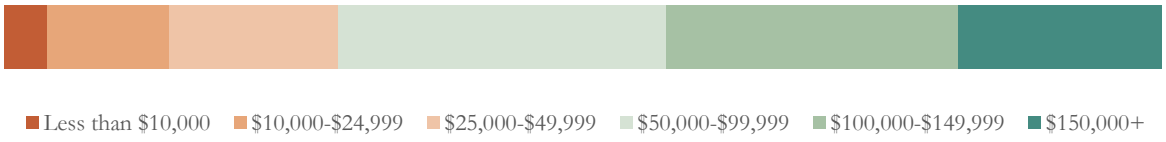


Table 3. **2025 Clinton County Community Health Assessment Community Survey, Self-Reported Disabilities**		
Demographic		% (#)
Self-reported disabilities (n = 305)*	I have serious difficulty walking or climbing stairs.	47.87% (146)
	Because of a physical, mental, or emotional condition, I have serious difficulty concentrating, remembering, or making decisions.	45.25% (138)
	Because of a physical, mental, or emotional condition, I have difficulty doing errands alone, such as visiting a doctor's office or shopping.	31.48% (96)
	I am deaf or have serious difficulty hearing.	22.62% (69)
	I have difficulty dressing or bathing.	10.82% (33)
	I am blind or have serious difficulty seeing, even when wearing glasses.	8.20% (25)
	**Note:* Of all 1,523 respondents, 79.97% (1,218) reported no difficulties; alternatively, 20.03% (305) respondents reported at least one disability. For this question respondents were instructed to select all that apply; therefore, responses will not total 100%.	

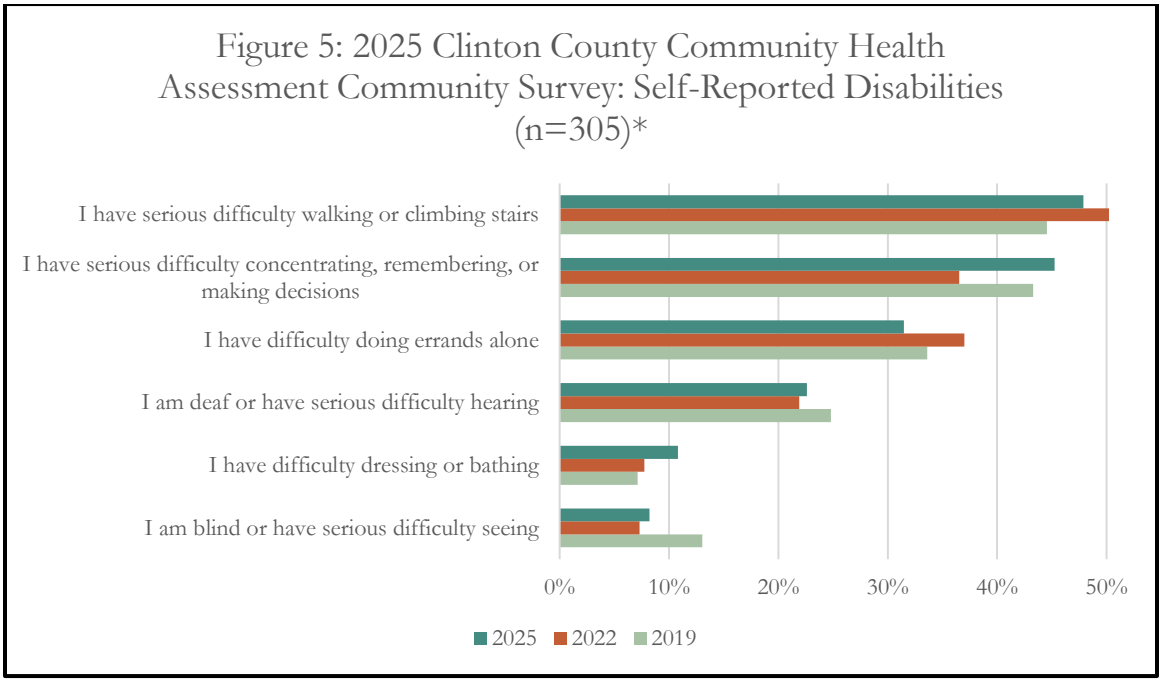


Table 4. **2025 Clinton County Community Health Assessment Community Survey, Household Size**		
Demographic		% (#)
Adults Living in the Home (n = 1,523)	0	4.53% (69)
	1	22.78% (347)
	2	53.58% (816)
	3 or more	19.11% (291)
Children Living in the Home (n = 1,523)	0	52.66% (802)
	1	20.68% (315)
	2	19.04% (290)
	3 or more	7.62% (116)
	Any children	47.34% (721)

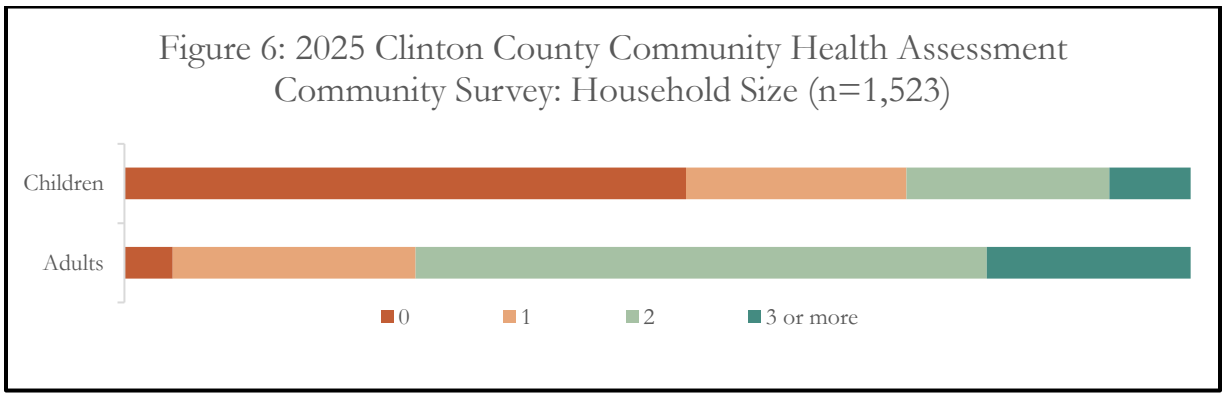


Table 5. **2025 Clinton County Community Health Assessment Community Survey, Living in a Healthy Community**		
I live in a healthy community		% (#)
I live in a healthy community (n = 1,523)	Strongly Disagree	5.25% (80)
	Disagree	23.57% (359)
	Neutral	35.92% (547)
	Agree	30.01% (457)
	Strongly Agree	5.25% (80)

Figure 7: 2025 Clinton County Community Health Assessment Community Survey: I Live in a Healthy Community (n=1,523)

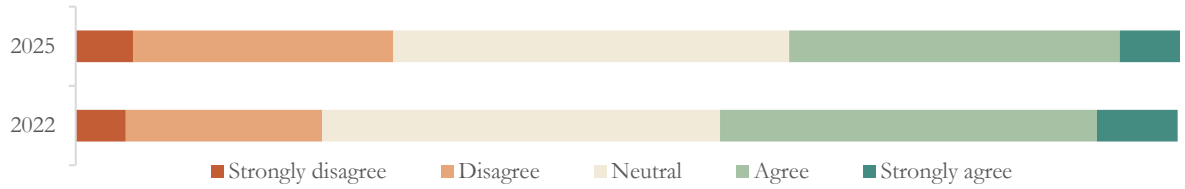


Table 6. **2025 Clinton County Community Health Assessment Community Survey, Definition of a Healthy Community**		
Features		% (#)
Features of a strong, vibrant, healthy community (n = 1,523*)	Affordable housing	36.31% (553)
	Health care services	35.33% (538)
	Livable wages	31.32% (477)
	Safe environment	31.32% (477)
	Clean environment	30.01% (457)
	Drug & alcohol free communities	24.82% (378)
	Good schools	24.10% (367)
	Healthy food choices	16.68% (254)
	Mental health services	15.52% (282)
	Economic opportunities	14.84% (226)
	Parks & recreation resources	14.64% (223)
	Walkable & bike friendly communities	11.42% (174)
	Senior services	8.21% (125)
	Equality	7.88% (120)
	Good childcare	7.62% (116)
	Transportation	7.42% (113)
	Senior housing	5.84% (89)
	Diverse populations	5.12% (78)
	Other	3.48% (53)
	**Note:* For this question respondents were instructed to select up to 3 features; therefore, responses will not total 100%.	

Figure 8: 2025 Clinton County Community Health Assessment Community Survey: Features of a Strong, Vibrant, Healthy Community (n=1,523)*

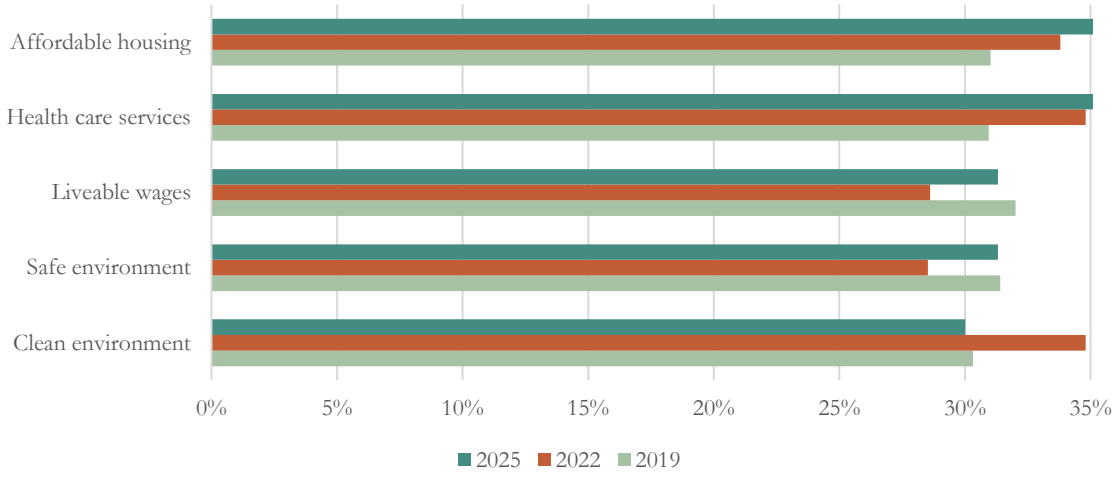


Table 7. **2025 Clinton County Community Health Assessment Community Survey, Health Challenges of Greatest Concern in Our Community**		
Health Challenges		% (#)
Health challenges of greatest concern (n = 1,523*)	Mental Health (anxiety, depression, social wellbeing, etc.)	46.75% (712)
	Substance misuse (drugs, alcohol, etc.)	44.32% (675)
	Access to health care services	40.45% (616)
	Access to mental health & behavioral services	35.46% (540)
	Access to health care specialist	31.19% (475)
	Overweight/obesity	31.06% (473)
	Access to dental care/dentist	25.67% (391)
	Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)	24.75% (377)
	Physical activity	19.30% (294)
	Issues related to aging (arthritis, hearing/vision loss, etc.)	16.19% (245)
	Access to developmental services for children	15.23% (232)
	Cancer	14.77% (225)
	Smoking or tobacco use (including e-cigarettes or vaping)	14.12% (215)
	Suicide (death by suicide or attempts)	11.36% (173)
	Access to pediatric care	9.85% (150)
	Infectious disease (hepatitis A, B or C, flu, COVID-19, etc.)	9.52% (145)
	Health concerns of intellectual or developmental disabilities	8.80% (134)
	Health concerns of physical disabilities	8.21% (125)
	Access to a culturally competent provider	7.55% (115)
	Autoimmune disease (ALS, Crohn's, MS, RA, etc.)	7.03% (107)
	Prenatal care/maternal & infant health	6.83% (104)
	Other	6.24% (95)
	Access to cancer screenings	6.17% (94)
	Falls	6.11% (93)
	Vector-Borne disease (EEE, Lyme disease, West Nile virus, etc.)	5.84% (89)
	Lung disease (asthma, COPD, etc.)	4.66% (71)
	Sexually transmitted infections (including HIV)	1.71% (26)
	Immunization rates**	1.38% (21)
	**Note:* For this question respondents were instructed to select up to 5 health challenges; therefore, responses will not total 100%. ***Note:* This response was inadvertently left off online survey. Data only reflects paper surveys.	

Figure 9: 2025 Clinton County Community Health Assessment Community Survey: Health Challenges of Greatest Concern (n=1,523)*

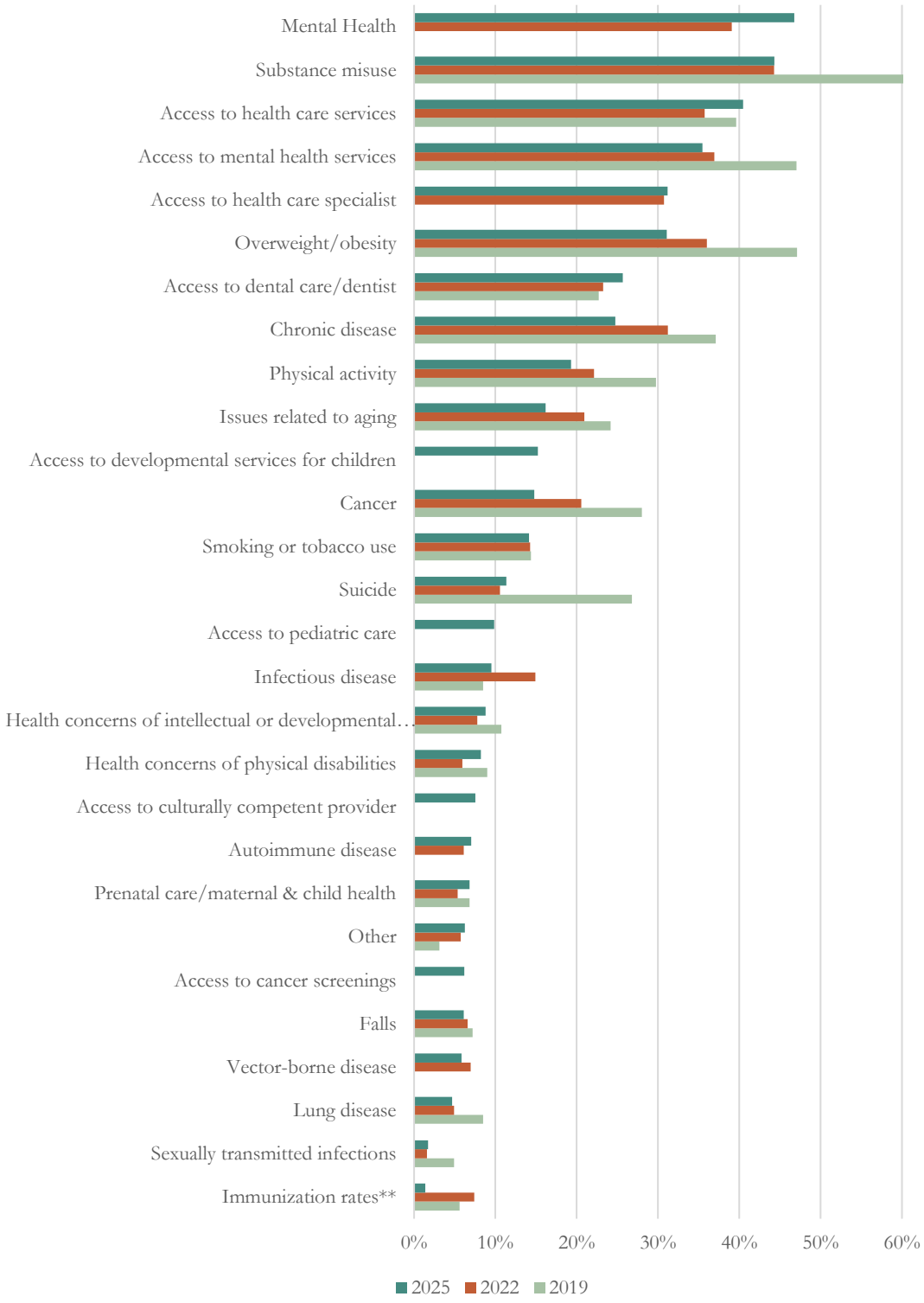


Table 8. **2025 Clinton County Community Health Assessment Community Survey, Self-reported Health Challenges Experienced by Residents Within the Past Year**		
Health Challenges		% (#)
Self-reported health challenges (n = 1,375*)	Mental Health (anxiety, depression, social wellbeing, etc.)	41.53% (571)
	Access to health care specialist	37.02% (509)
	Overweight/obesity	36.36% (500)
	Access to dental care/dentist	30.18% (415)
	Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)	29.38% (404)
	Issues related to aging (arthritis, hearing/vision loss, etc.)	28.73% (395)
	Access to health care services	27.42% (377)
	Access to mental health & behavioral services	24.51% (337)
	Physical activity	22.98% (316)
	Cancer	13.02% (179)
	Lung disease (asthma, COPD, etc.)	12.87% (177)
	Substance misuse (drugs, alcohol, etc.)	12.73% (175)
	Infectious disease (hepatitis A, B or C, flu, COVID-19, etc.)	12.29% (169)
	Falls	11.93% (164)
	Health concerns of physical disabilities	11.78% (162)
	Smoking or tobacco use (including e-cigarettes or vaping)	11.71% (161)
	Autoimmune disease (ALS, Crohn's, MS, RA, etc.)	11.42% (157)
	Access to developmental services for children	9.60% (132)
	Health concerns of intellectual or developmental disabilities	8.15% (112)
	Access to pediatric care	8.07% (111)
	Access to cancer screenings	5.75% (79)
	Access to a culturally competent provider	5.45% (75)
	Other	5.31% (73)
	Suicide (death by suicide or attempts)	4.36% (60)
	Vector-Borne disease (EEE, Lyme disease, West Nile virus, etc.)	4.00% (55)
	Access to immunizations	3.20% (44)
	Access to prenatal care/maternal & infant health	2.62% (36)
	Sexually transmitted infections (including HIV)	1.16% (16)
	**Note:* 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 1,523 respondents, 9.72% (148) reported no health challenges in the past year. Alternatively, 90.28% (1,375) respondents reported experiencing at least one health challenge in the past year. ***Note:* This response was inadvertently left off online survey. Data only reflects paper surveys.	

Figure 10: 2025 Clinton County Community Health Assessment Community Survey: Self-Reported Health Challenges (n=1,375)*

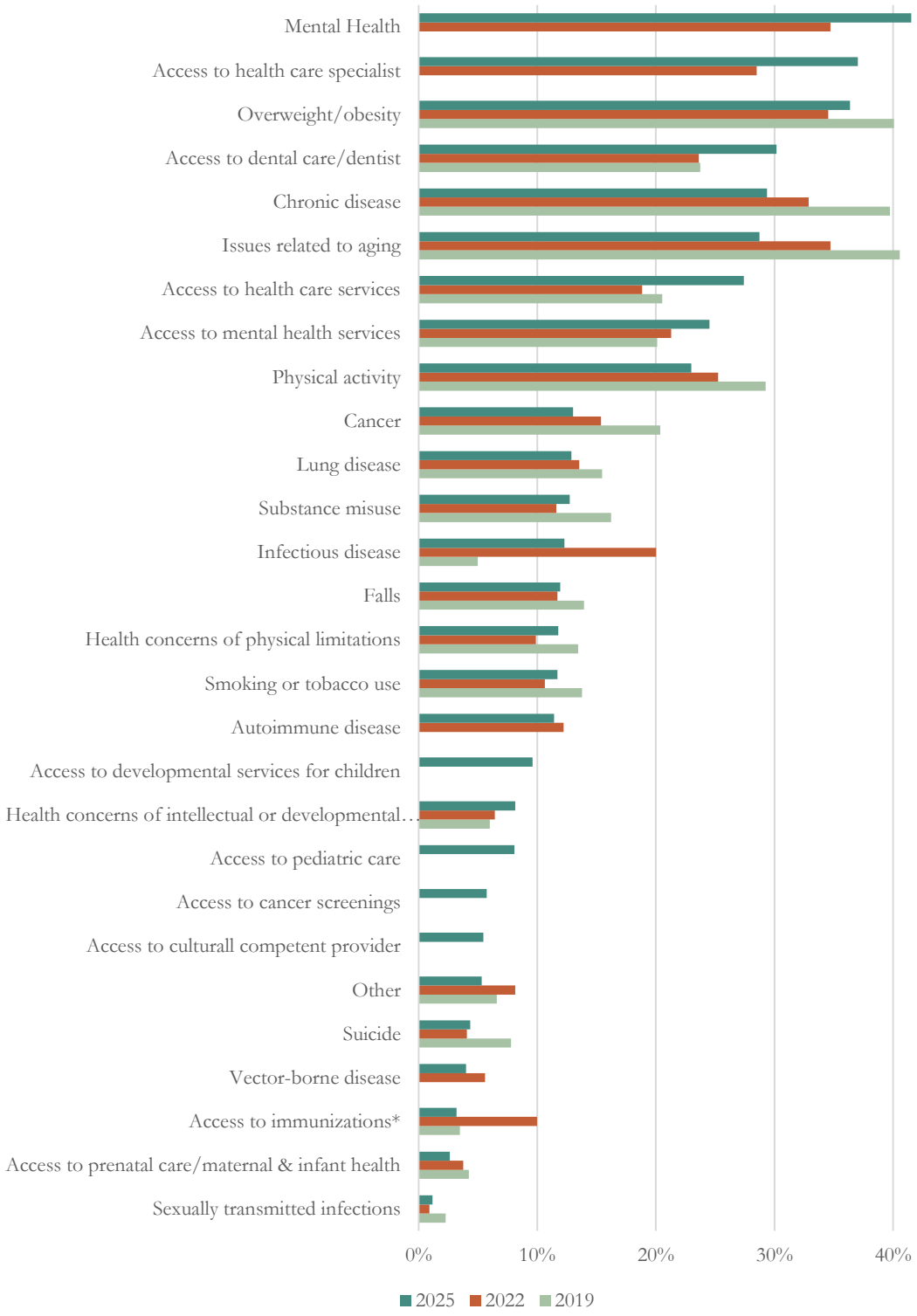


Table 9. **2025 Clinton County Community Health Assessment Community Survey, Self-reported Barriers to Medical Care Experienced by Residents Within the Past Year**		
Barriers to medical care		% (#)
Self-reported barriers to medical care (n = 1,036*)	No appointment was available (specialist)	39.96% (414)
	No specialist locally	38.84% (392)
	Did not accept my insurance	35.91% (372)
	No appointment was available (primary care)	30.21% (313)
	Could not leave work/school	26.74% (277)
	Could not afford (including co-pays or deductibles that were too high)	24.42% (253)
	Co-pays or deductibles were too high	21.81% (226)
	Did not have dental or vision insurance	20.27% (210)
	Did not have a health care provider	16.99% (176)
	Did not have transportation	11.00% (114)
	No appointment was available (pediatric)	10.23% (106)
	Other	8.98% (93)
	Did not have medical insurance	6.95% (72)
	Did not have childcare	5.79% (60)
	No veteran services locally	2.80% (29)
	No culturally competent providers	2.70% (28)
	No accommodations for people with intellectual or developmental disabilities	2.32% (24)
	No access for people with physical disabilities	2.22% (23)
	Provider did not speak my language	0.77% (8)
	No developmental services provider was available (speech, OT, PT, etc.)**	0.48% (5)
	**Note:* 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 1,523 respondents, 31.98% (487) reported no barriers to medical care in the past year; alternatively, 68.02% (1,036) respondents reported experiencing at least one barrier to medical care in the past year. ***Note:* This response was inadvertently left off online survey. Data only reflects paper surveys	

Figure 11: 2025 Clinton County Community Health Assessment Community Survey: Self-Reported Barriers to Medical Care (n=1,036)*

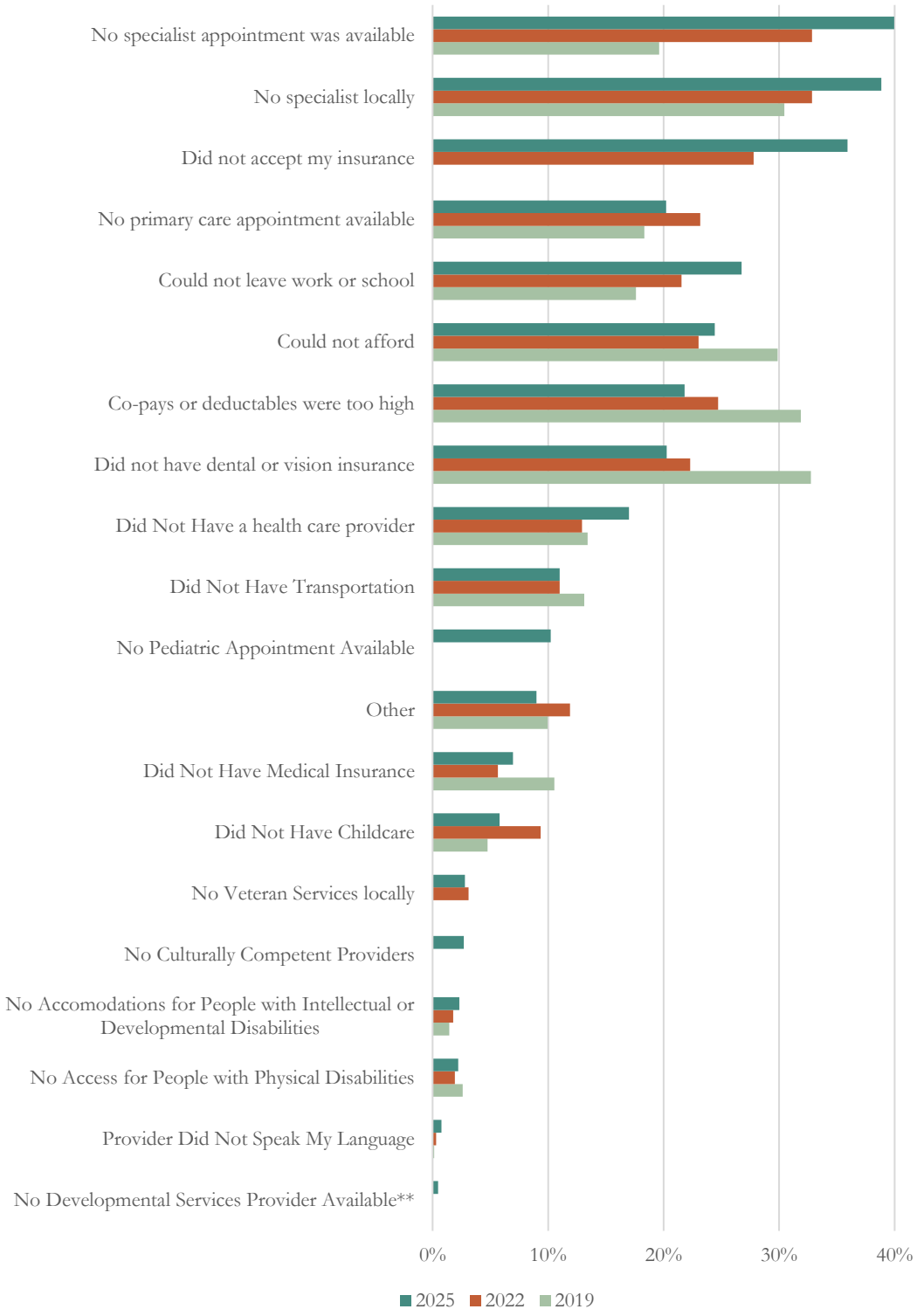


Table 10. **2025 Clinton County Community Health Assessment Community Survey, Social Challenges of Greatest Concern in Our Community**		
Social Challenges		% (#)
Social challenges of greatest concern (n = 1,523*)	Lack of affordable housing	46.62% (710)
	Lack of a livable wage	39.53% (602)
	Access to healthy foods	28.10% (428)
	Child abuse/neglect	26.13% (398)
	Crime/vandalism	25.08% (382)
	Bullying	23.70% (361)
	Lack of employment opportunities	23.11% (352)
	Domestic violence	21.21% (323)
	Childcare	20.16% (307)
	Number of unhoused residents	19.70% (300)
	Transportation	18.19% (277)
	Safe recreational areas	17.73% (270)
	Lack of support/resources for seniors	16.41% (250)
	Opportunities for physical activity	15.95% (243)
	Lack of support/resources for youth	15.82% (241)
	Hunger	15.10% (230)
	Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)	12.80% (195)
	Access to opportunities for health for those with physical limitations or disabilities	11.95% (182)
	Lack of support/resources for veterans	11.56% (176)
	Access to opportunities for health for those with intellectual or developmental disabilities	10.90% (166)
	Racial or cultural discrimination	10.51% (160)
	Elder abuse/neglect	9.19% (140)
	Lack of support/resources for LGBTQ+	6.30% (96)
	Other	4.46% (68)
	Incarceration rates (number of people in jail)	3.28% (50)
	**Note:* For this question respondents were instructed to select up to 5 social challenges; therefore, responses will not total 100%.	

Figure 12: 2025 Clinton County Community Health Assessment Community Survey: Social Challenges of Greatest Concern (n=1,523)*

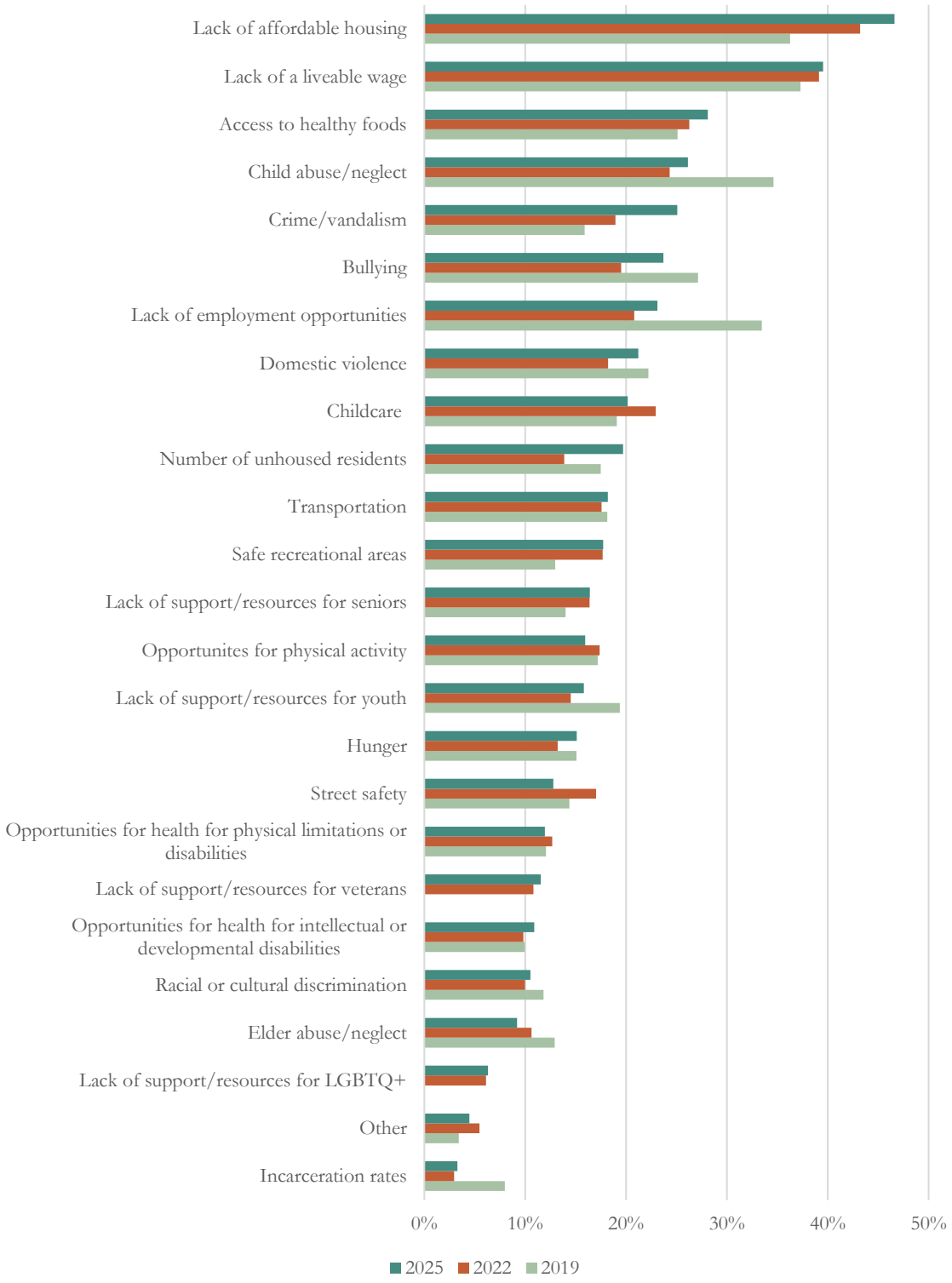


Table 11. **2025 Clinton County Community Health Assessment Community Survey, Self-reported Social Challenges Experienced by Residents Within the Past Year**		
Social Challenges		% (#)
Self-reported social challenges (n = 1,112*)	Lack of a livable wage	36.96% (411)
	Lack of affordable housing	28.96% (322)
	Bullying	23.02% (256)
	Opportunities for physical activity	22.30% (248)
	Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)	21.85% (243)
	Access to healthy foods	21.49% (239)
	Safe recreational areas	21.13% (235)
	Lack of employment opportunities	20.14% (224)
	Lack of support/resources for seniors	18.62% (207)
	Transportation	16.55% (184)
	Childcare	15.83% (176)
	Lack of support/resources for youth	15.74% (175)
	Crime/vandalism	9.71% (108)
	Access to opportunities for health for those with physical limitations or disabilities	9.17% (102)
	Lack of support/resources for veterans	7.91% (88)
	Access to opportunities for health for those with intellectual or developmental disabilities	7.46% (83)
	Racial or cultural discrimination	7.28% (81)
	Domestic violence	7.10% (79)
	Lack of support/resources for LGBTQ+	7.10% (79)
	Number of unhoused residents	6.83% (76)
	Hunger	5.49% (61)
	Other	4.23% (47)
	Elder abuse/neglect	3.60% (40)
	Child abuse/neglect	3.24% (36)
	Incarceration rates (number of people in jail)	1.71% (19)
	**Note:* 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 1,523 respondents, 26.99% (411) reported no social challenges in the past year. Alternatively, 73.01% (1,112) respondents reported experiencing at least one social challenge in the past year.	

Figure 13: 2025 Clinton County Community Health Assessment Community Survey: Self-Reported Social Challenges (n=1,112)*

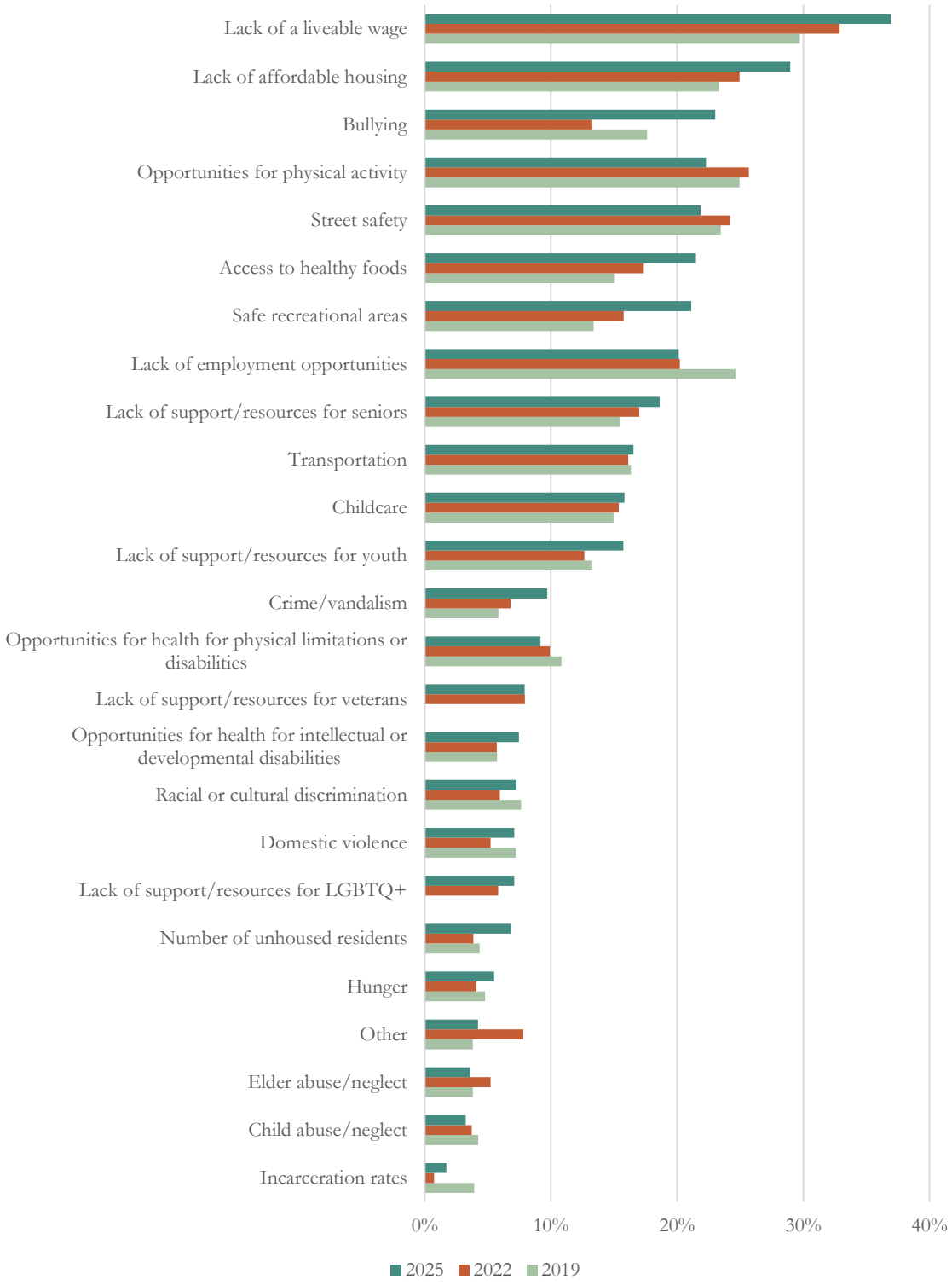


Table 12. **2025 Clinton County Community Health Assessment Community Survey, Environmental Challenges of Greatest Concern in Our Community**		
Environmental Challenges		% (#)
Environmental challenges of greatest concern (n = 1,523*)	Aging infrastructure (roads, sewers, waterlines, etc.)	56.20% (856)
	School safety	45.37% (691)
	Drinking water quality	39.46% (601)
	Climate change	36.24% (552)
	Stream, river, lake quality	34.21% (521)
	Waste disposal/recycling	27.31% (416)
	Agricultural runoff (manure, pesticides, etc.)	25.54% (389)
	Home safety	23.77% (362)
	Safe food	23.77% (362)
	Vector-borne diseases (EEE, Lyme disease, West Nile virus, etc.)	22.51% (343)
	Air pollution	16.68% (254)
	Flooding/soil drainage	11.82% (180)
	Exposure to tobacco smoke	11.69% (178)
	Failing septic systems	9.52% (145)
	Nuisance wildlife/stray animals	8.67% (132)
	Lead hazards (water, paint, etc.)	7.75% (118)
	Other	3.41% (52)
	**Note:* For this question respondents were instructed to select up to 5 environmental challenges; therefore, responses will not total 100%.	

Figure 14: 2025 Clinton County Community Health Assessment Community Survey: Environmental Challenges of Greatest Concern (n=1,523)*

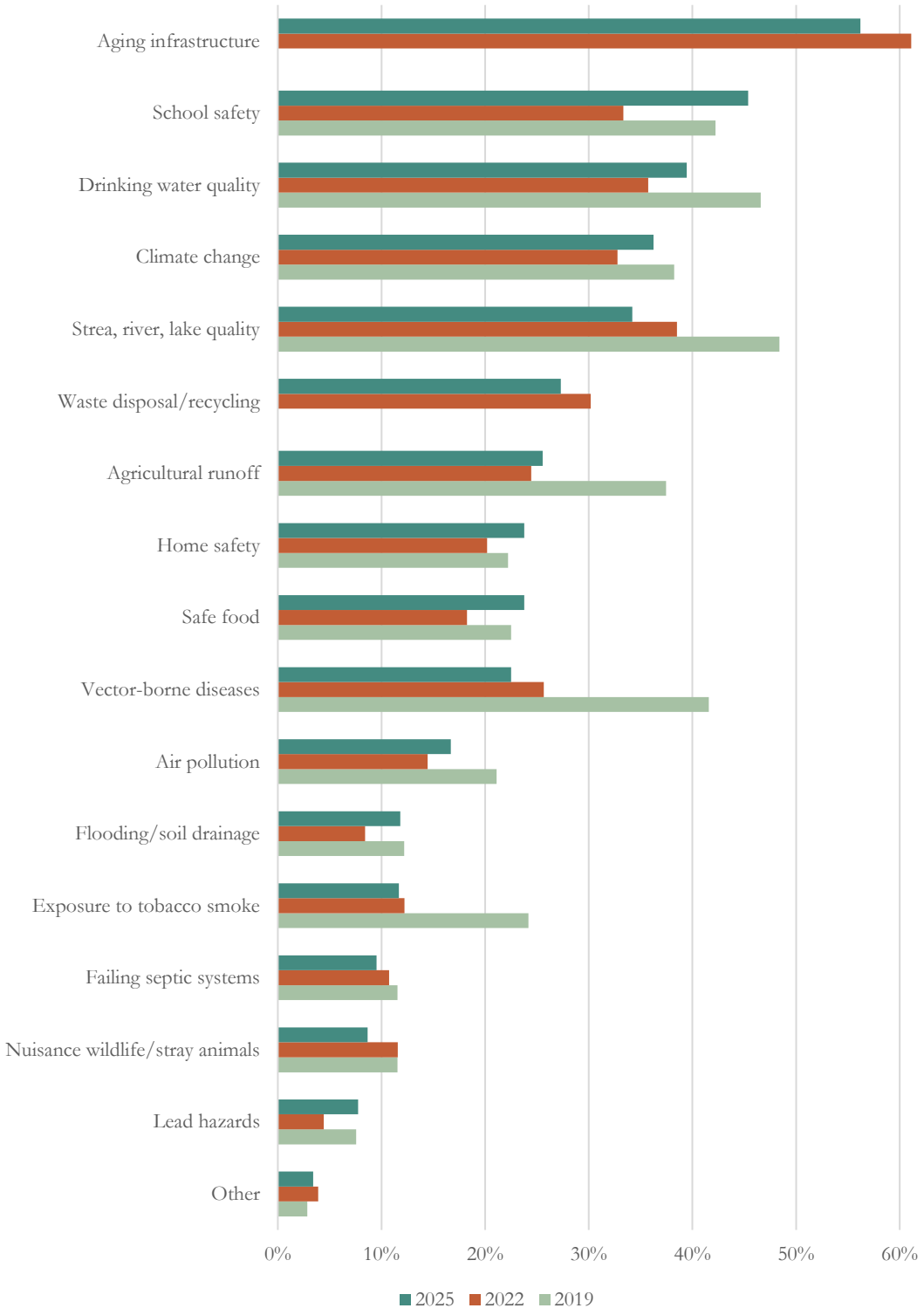


Table 13. **2025 Clinton County Community Health Assessment Community Survey, Self-Perceived Physical Health**		
My physical health is…		% (#)
My physical health is… (n = 1,523)	Extremely Poor	0.66% (10)
	Poor	8.86% (135)
	Average	40.84% (622)
	Good	39.33% (599)
	Excellent	10.31% (157)

Figure 15: 2025 Clinton County Community Health Assessment Community Survey: Percieved Physical Health (n=1,523)

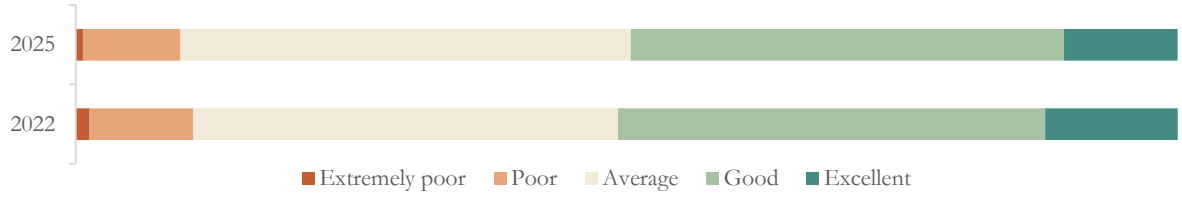


Table 14. **2025 Clinton County Community Health Assessment Community Survey, Self-Perceived Mental Health**		
My mental health is…		% (#)
My mental health is… (n = 1,523)	Extremely Poor	1.64% (25)
	Poor	8.67% (132)
	Average	37.95% (578)
	Good	40.58% (618)
	Excellent	11.61% (170)

Figure 16: 2025 Clinton County Community Health Assessment Community Survey: Percieved Mental Health (n=1,523)

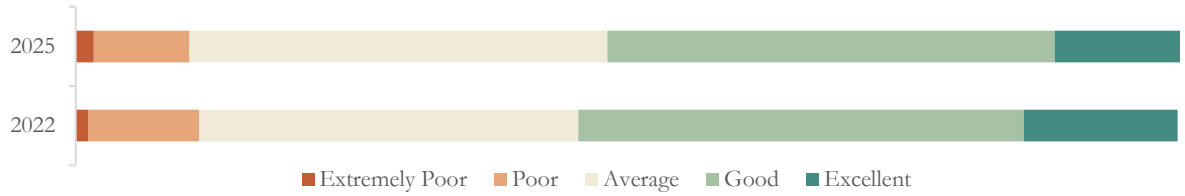


Figure 17: Clinton County Community Health Assessment Community Survey: Percentage of Respondents Self-Reported Challenges or Barriers

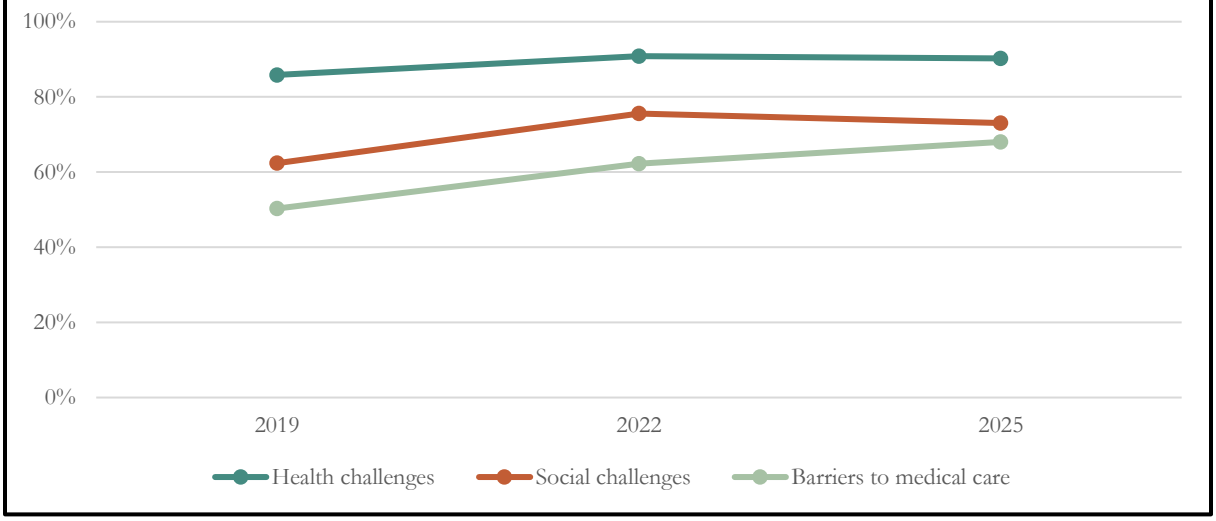
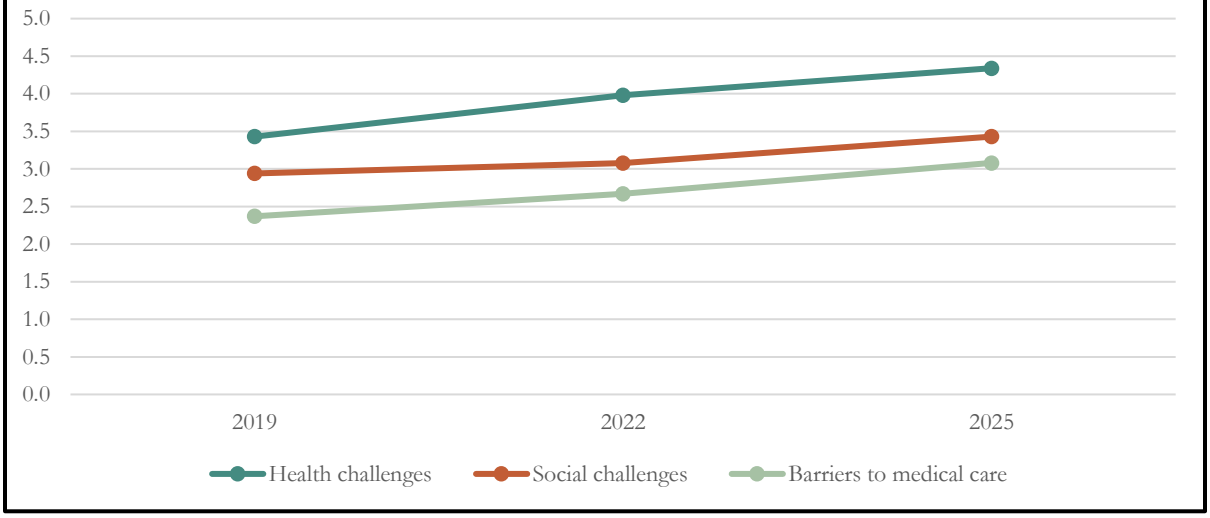


Figure 18: Clinton County Community Health Assessment Community Survey: Number of Self-Reported Challenges or Barriers per Respondent



2025 Community Health Assessment Resident Survey Key Findings

The Clinton County Health Department asked county residents for their opinions on health, social and environmental issues in the community. They were also asked to identify any barriers to medical care experienced by themselves or their family in the past year. Surveys were collected from 1,523 residents. For a full report of all findings visit https://health.clintoncountyny.gov/pdf%20files/ResidentSurvey.pdf.

35%

of respondents **agree** or **strongly agree** they **live in a healthy community.**

The top features of a healthy community were identified as:

- Affordable housing
- Health care services
- Livable wages
- Safe environment
- Clean environment
- Drug & alcohol free communities
- Good schools

90%

faced **at least 1 health challenge** in the past year.

- **42%** experienced a **mental health challenge.**
- **37%** lacked access to a **health care specialist.**
- **36%** were **overweight or obese.**
- **30%** lacked access to **dental care.**
- **29%** had a **chronic disease.**

Aging infrastructure was the top environmental concern with more than **half of residents** surveyed selecting it.

More than **45%** of respondents indicated **stream, river, or lake quality** was an environmental concern.

1 in 5

respondents reported they or a family member experienced a lack of **opportunities for physical activity** in the last year.

68%

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

Most common barriers:

- No specialist appointment
- No local specialist
- Did not accept my insurance
- No primary appointment
- Could not leave work or school

46%

of respondents feel **affordable housing** is a **social challenge** in our community.

1 in 5

respondents had difficulty **accessing healthy food** in the past year.

73%

reported **at least 1 social challenge** in the past year.

Top ranked challenges:

- Lack of a livable wage
- Lack of affordable housing
- Bullying
- Opportunities for physical activity
- Street Safety
- Access to healthy foods

Note: Statistics on issues for individuals and their family are based on those respondents who indicated that they had any issues. 32% of respondents reported no health issues; 27% reported no social issues. Survey responses represented residents from 100% of Clinton County townships, ages 17—80+, and all census income and education categories.

Clinton County Health Department

6/2025

COMMUNITY SURVEY

Introduction

The Clinton County Health Department (CCHD) and Champlain Valley Physicians Hospital (UVMHN-CVPH) are conducting a survey to measure the health needs of our community. Your answers will help shape future community health activities. 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/CHA2025
or scan the QR code.

SCAN ME!

CCHD Clinton County HEALTH Department

THE University of Vermont HEALTH NETWORK
Champlain Valley Physicians Hospital

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.)

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

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 a culturally competent provider
- ◯ Access to cancer screenings
- ◯ Access to dental care/dentist
- ◯ Access to developmental services for children
- ◯ Access to health care services
- ◯ Access to health care specialist
- ◯ Access to mental health & behavioral services
- ◯ Access to pediatric care
- ◯ Autoimmune disease (ALS, Crohn's, MS, RA, etc.)
- ◯ Cancer
- ◯ Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)
- ◯ Falls
- ◯ Health concerns of intellectual or developmental disabilities
- ◯ Health concerns of physical disabilities
- ◯ Immunization rates
- ◯ Infectious disease (hepatitis A, B or C, flu, COVID-19, etc.)
- ◯ Issues related to aging (arthritis, hearing/vision loss, etc.)
- ◯ Lung disease (asthma, COPD, etc.)
- ◯ Mental health (anxiety, depression, social wellbeing, etc.)
- ◯ Overweight/obesity
- ◯ Physical activity
- ◯ Prenatal care/maternal & infant health
- ◯ Sexually transmitted infections (including HIV)
- ◯ Smoking or tobacco use (including e-cigarettes or vaping)
- ◯ Substance misuse (drugs, alcohol, etc.)
- ◯ Suicide (death by suicide or attempts)
- ◯ Vector-borne disease (EEE, Lyme disease, West Nile virus, etc.)
- ◯ Other (please specify) _____
  _____

4. When you think about social challenges in the community where you live, what are you most concerned about? (Choose up to 5.)

- ◯ 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
- ◯ Bullying
- ◯ Child abuse/neglect
- ◯ Childcare
- ◯ Crime/vandalism
- ◯ Domestic violence
- ◯ Elder abuse/neglect
- ◯ Hunger
- ◯ Incarceration rates (number of people in jail)
- ◯ Lack of affordable housing
- ◯ 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
- ◯ Number of unhoused residents
- ◯ Opportunities for physical activity
- ◯ Racial or cultural discrimination
- ◯ Safe recreational areas
- ◯ Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)
- ◯ Transportation
- ◯ Other (please specify) _____
  _____

5. When you think about environmental challenges in the community where you live, what are you most concerned about? (Choose up to 5.)

- ◯ Aging infrastructure (roads, sewers, waterlines, etc.)
- ◯ Agricultural runoff (manure, pesticides, etc.)
- ◯ Air pollution
- ◯ Climate change
- ◯ Drinking water quality
- ◯ Exposure to tobacco smoke
- ◯ Failing septic systems
- ◯ Flooding/soil drainage
- ◯ Home safety
- ◯ Lead hazards (water, paint, etc.)
- ◯ Nuisance wildlife/stray animals
- ◯ Safe food
- ◯ School safety
- ◯ Stream, river, lake quality
- ◯ Vector-borne diseases (EEE, Lyme disease, West Nile virus, etc.)
- ◯ Waste disposal/recycling
- ◯ Other (please specify) _____
  _____

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 a culturally competent provider
- ◯ Access to cancer screenings
- ◯ Access to dental care/dentist
- ◯ Access to developmental services for children
- ◯ Access to health care services
- ◯ Access to health care specialist
- ◯ Access to immunizations
- ◯ Access to mental health & behavioral services
- ◯ Access to pediatric care
- ◯ Access to prenatal care/maternal & infant health
- ◯ Autoimmune disease (ALS, Crohn's, MS, RA, etc.)
- ◯ Cancer
- ◯ Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)
- ◯ Falls
- ◯ Health concerns of intellectual or developmental disabilities
- ◯ Health concerns of physical disabilities
- ◯ Infectious disease (hepatitis A, B or C, flu, COVID-19, etc.)
- ◯ Issues related to aging (arthritis, hearing/vision loss, etc.)
- ◯ Lung disease (asthma, COPD, etc.)
- ◯ Mental health (anxiety, depression, social wellbeing, etc.)
- ◯ Overweight/obesity
- ◯ Physical activity
- ◯ Sexually transmitted infections (including HIV)
- ◯ Smoking or tobacco use (including e-cigarettes or vaping)
- ◯ Substance misuse (drugs, alcohol, etc.)
- ◯ Suicide (death by suicide or attempts)
- ◯ Vector-borne disease (EEE, Lyme disease, West Nile virus, etc.)
- ◯ Other (please specify) _____ _____
- ◯ None

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
- ◯ Bullying
- ◯ Child abuse/neglect
- ◯ Childcare
- ◯ Crime/vandalism
- ◯ Domestic violence
- ◯ Elder abuse/neglect
- ◯ Hunger
- ◯ Incarceration rates (number of people in jail)
- ◯ Lack of affordable housing
- ◯ 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
- ◯ Number of unhoused residents
- ◯ Opportunities for physical activity
- ◯ Racial or cultural discrimination
- ◯ Safe recreational areas
- ◯ Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)
- ◯ Transportation
- ◯ Other (please specify) _____
  _____
- ◯ None

8. If there was a time in the past year that you or a family member needed health 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 (pediatric)
- ◯ No appointment was available (primary care)
- ◯ No appointment was available (specialist)
- ◯ No culturally competent providers
- ◯ No developmental services provider was available (speech, OT, PT, etc.)
- ◯ No providers spoke my language
- ◯ No specialist locally
- ◯ No veteran services locally
- ◯ Provider did not speak my language
- ◯ Other (please specify) _____ _____
- ◯ None

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
- ◯ Male
- ◯ Non-binary
- ◯ Prefer not to answer
- ◯ Other (please specify) _____
  _____

10. What is your age?

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

11. What city/town do you live in?
(Select only one based on your primary residence.)

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

12. How many people 18 years of age and OLDER live in your home?

◯ 0 ◯ 1 ◯ 2 ◯ 3 or more

13. How many people UNDER 18 years of age live in your home?

◯ 0 ◯ 1 ◯ 2 ◯ 3 or more

102

14. What is the primary language spoken in your household?

- ◯ English
- ◯ American Sign Language
- ◯ 中文 (Chinese)
- ◯ Français (French)
- ◯ Kreyòl (Haitian-Creole)
- ◯ Italiano (Italian)
- ◯ 한국의 (Korean)
- ◯ Polski (Polish)
- ◯ Русский (Russian)
- ◯ Español (Spanish)
- ◯ Other (please specify) _____
  _____

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

- ◯ American Indian or Alaskan Native
- ◯ Asian or Pacific Islander
- ◯ Black or African American
- ◯ Hispanic, Latino or Spanish origin
- ◯ White
- ◯ Prefer not to answer
- ◯ Other (please specify) _____
  _____

16. What is your highest level of education?

- ◯ Some high school (did not finish)
- ◯ High school diploma or GED
- ◯ Technical or trade school certificate
- ◯ Some college
- ◯ Associate's degree
- ◯ Bachelor's degree
- ◯ Master's degree or higher
- ◯ Other (please specify) _____
  _____

17. What is your household's annual income?

- ◯ Less than $10,000
- ◯ $10,000—$24,999
- ◯ $25,000—$49,999
- ◯ $50,000—$99,999
- ◯ $100,000—$149,999
- ◯ $150,000 or more
- ◯ Prefer not to answer

18. What is your primary employment status?

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

19. Do you have a primary care provider?

- ◯ Yes
- ◯ No

20. 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.
- ◯ None

21. My physical health is...

◯	◯	◯	◯	◯
Extremely Poor	Poor	Average	Good	Excellent

22. My mental/emotional health is...

◯	◯	◯	◯	◯
Extremely Poor	Poor	Average	Good	Excellent[104]

Cancer Services

CCHD and UVMHN-CVPH are working with the UVM Cancer Center to assess the cancer-related services of our community.

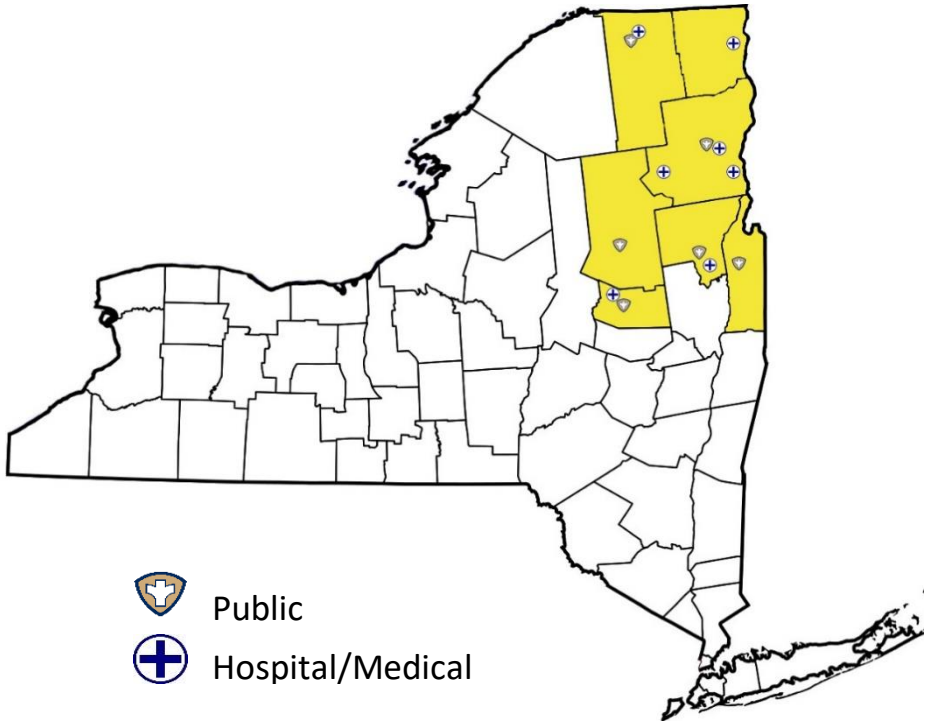
If you or someone you live with been diagnosed with cancer within the past three years (while living in this community) please select the option that best represents your experience with the following cancer care services.
(skip this question if it does not apply to you)

	Missing or lacking	Working well	I don't know
Access to cancer health care providers (timely appointments, appointments with specialists).	○	○	○
Access to cancer support health care providers (nutritionists, stress relief, mental health counseling, alternative providers).	○	○	○
Access to information about cancer (screening services & resources).	○	○	○
In home services (caregiver respite, nursing care).	○	○	○
Opportunities for health promotion (tobacco cessation, exercise, substance abuse counseling) .	○	○	○
Financial assistance programs, affordable medications, housing costs, travel costs associated with diagnosis, understanding of insurance coverage.	○	○	○
Opportunities to participate in community support groups, exercise, recreation programs.	○	○	○
Access to symptom relief (pain, nausea, etc. with medications, prescriptions or alternative therapies).	○	○	○
Information about genetic testing or clinical trials.	○	○	○
Information about advanced care planning and hospice services.	○	○	○

Appendix C:

Summary of the 2025 Stakeholder Survey Report (ARHN)

2025 STAKEHOLDER SURVEY REPORT



Adirondack Rural Health Network Area

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

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

2025

BACKGROUND INFORMATION:

Adirondack Rural Health Network:

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

Description of the Community Health Assessment Committee:

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

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

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

CHA Data Sub-Committee:

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

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

SURVEY METHODOLOGY:

Survey Creation:

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

Survey Facilitation:

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

Survey Logistics:

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

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

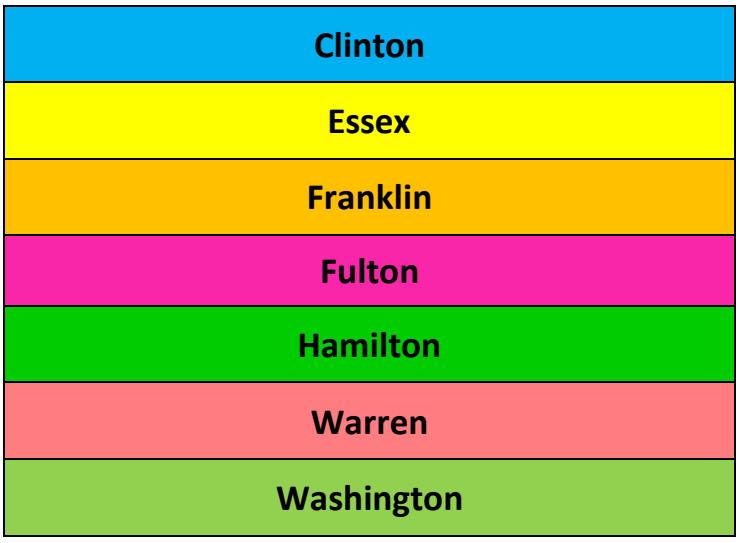
The survey requested that community stakeholders rank the five domains of SDOH based on their impact within their communities and identify key priority areas addressed by their organizations. Respondents also provided insight into what they viewed as the top health concerns in their communities and the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

Survey Responses and Analysis:

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

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

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

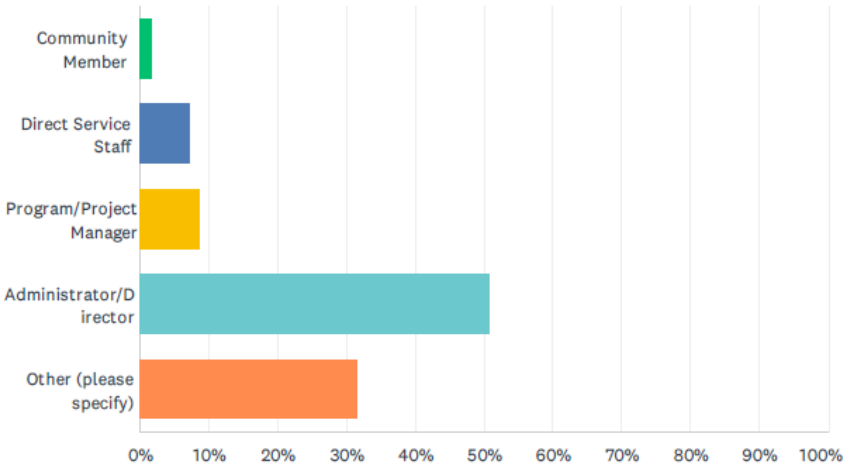


ANALYSIS:

Q3. Job Title/Role

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

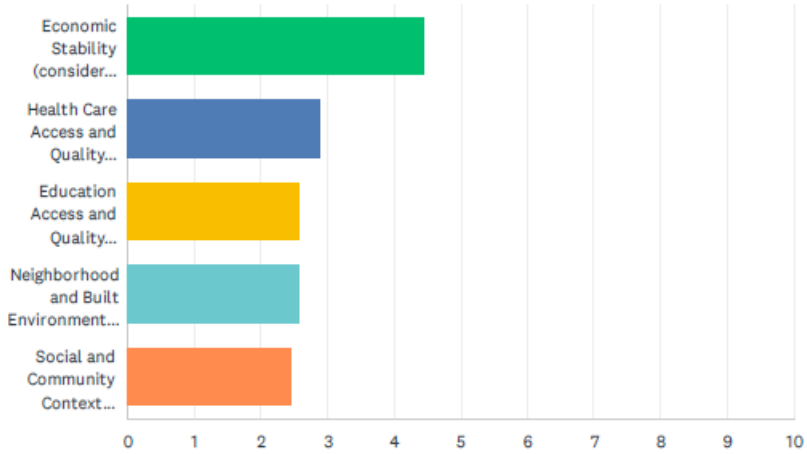
The majority of ARHN counties identified contributing factors that closely aligned with the overall top five for the region. However, several counties also highlighted unique concerns specific to their populations. Clinton County identified food insecurity as a significant contributing factor, while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

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

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

Q9. Social Determinants of Health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Please rate the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "most impact" to (5) "least impact".

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



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

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

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

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

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

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

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

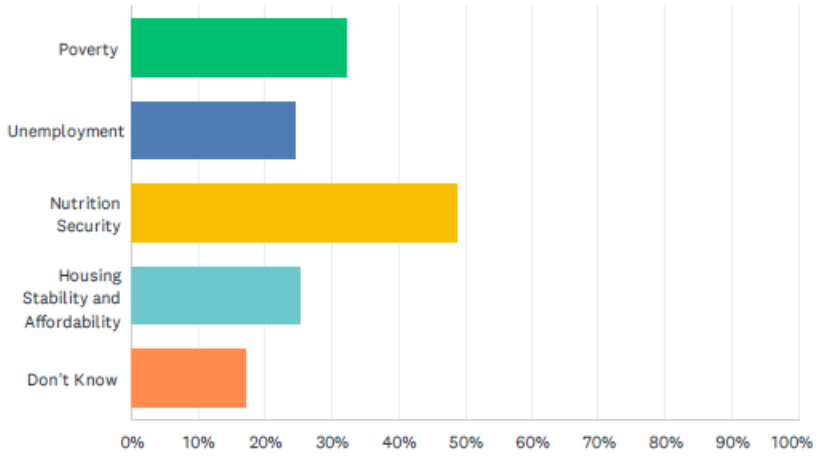
Response Counts for Poorest Health Outcomes by County							
Population	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Children/Adolescents	2	7	3	1	1	2	5
Females of reproductive age	1	0	0	1	0	0	0
Individuals living at or near the federal poverty level	20	32	22	15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

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

2025 New York State Prevention Agenda:

The NYS Prevention Agenda is an initiative focused on improving the health and well-being of all New Yorkers. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare. Addressing these issues is crucial for reducing health disparities.
The next five questions of the survey asked respondents to select the top three goals their organization or agency can assist in achieving in the counties it serves.

Q11. Economic Stability (Economic Well-Being)



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

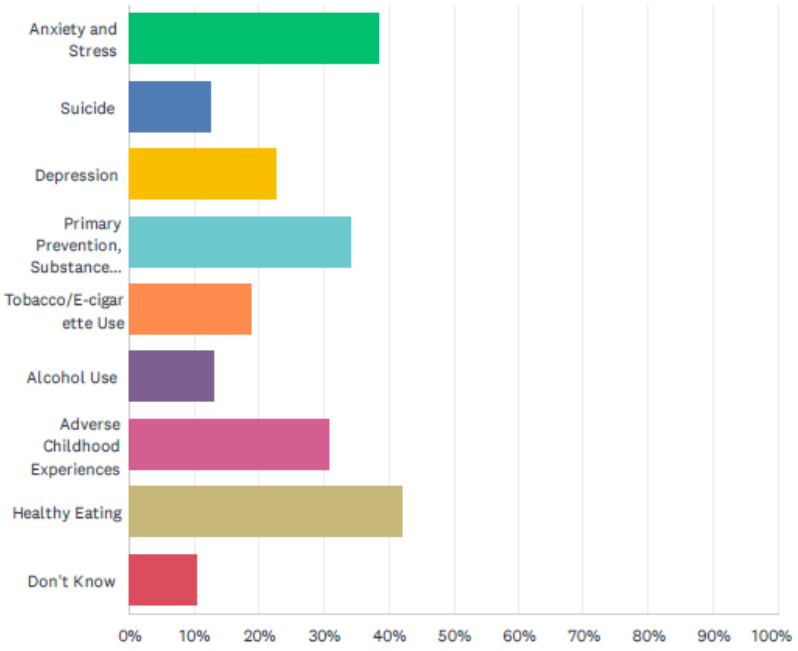
Respondents identified *Nutrition Security* (48.91%), *Poverty* (32.31%), and *Housing Stability and Affordability* (25.33%) as the top three priority areas that their organization are best positioned to support achieving in the region. Six out of seven ARHN counties identified

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

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

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

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



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

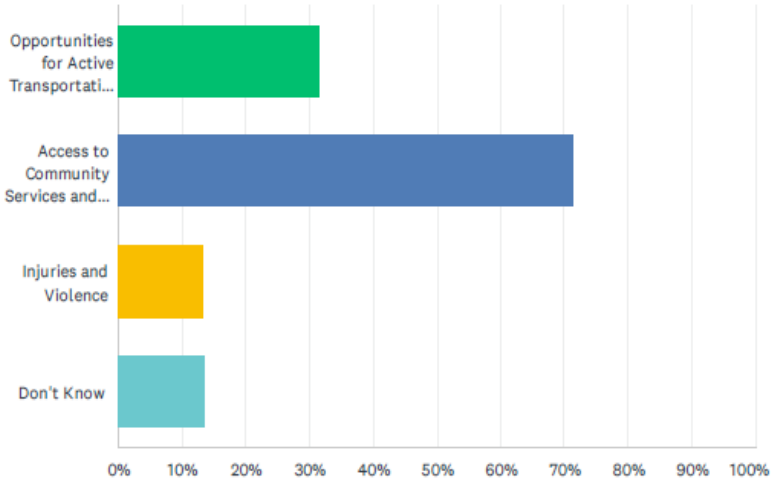
Domain: Social and Community Context		
Priority Area	**Count**	**Percentage**
Adverse Childhood Experiences	74	30.96%
Alcohol Use	31	12.97%
Anxiety and Stress	92	38.49%
Depression	54	22.59%
Healthy Eating	101	42.26%
Primary Prevention, Substance Misuse, and Overdose Prevention	82	34.31%
Suicide	30	12.55%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

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

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

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

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

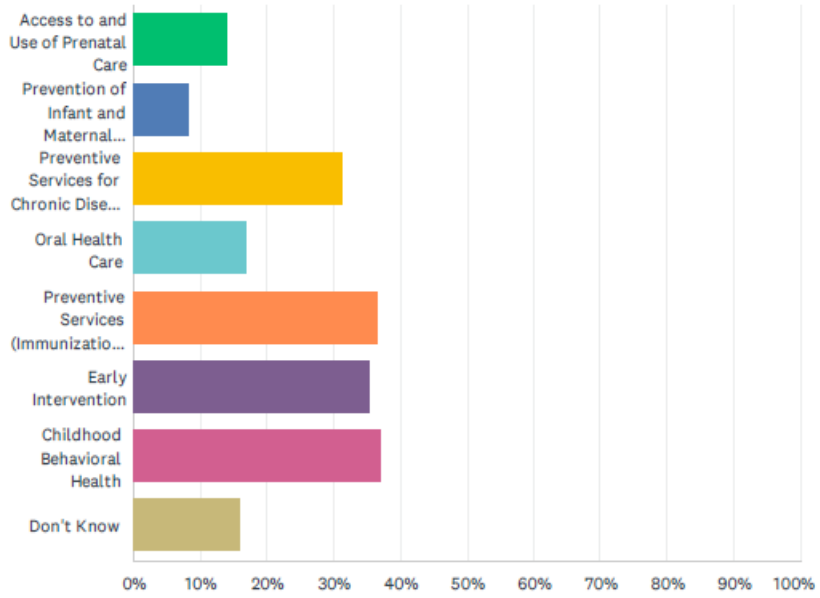


Domain: Neighborhood and Built Environment		
Priority Area	**Count**	**Percentage**
Access to Community Services and Support	167	71.37%
Injuries and Violence	31	13.25%
Opportunities for Active Transportation and Physical Activity	74	31.62%
Don't Know	32	13.68%

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

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

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

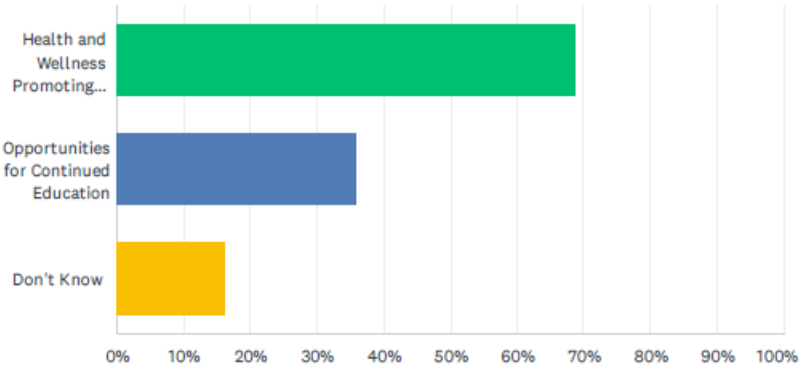


Domain: Health Care Access and Quality		
Priority Area	**Count**	**Percentage**
Access to and Use of Prenatal Care	32	14.16%
Childhood Behavioral Health	84	37.17%
Early Intervention	80	35.40%
Oral Health Care	38	16.81%
Prevention of Infant and Maternal Mortality	19	8.41%
Prevention Services for Chronic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

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

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

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



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

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

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

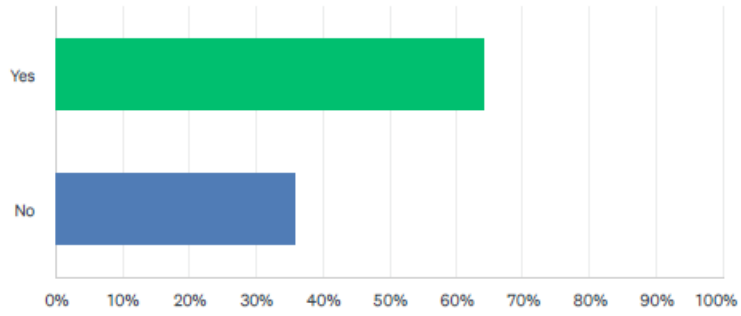
Q16. Please identify the primary assets/resources your organization/agency can contribute toward achieving the goals you have selected.

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

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

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

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



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

Appendix: The 2025 Stakeholder Survey

2025 CHA Stakeholders Survey

Introduction

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

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

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

Your Organization/Agency

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

1. Organization/Agency name: _____

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

3. Your job title/role: _____

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

4. Your email address: _____

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

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

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

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

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

Health Priorities, Concerns and Factors

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

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

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

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

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

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

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

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

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

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

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

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

For more information on Healthy People's 2030 Social Determinants of Health, please visit: Social Determinants of Health - Healthy People 2030 | odphp.health.gov.

Social Determinants of Health

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

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

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

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

Improving Health and Well-Being

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

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

11. Economic Stability (Economic Well-being)

□ Poverty

□ Unemployment

□ Nutrition Security

□ Housing Stability and Affordability

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

□ Anxiety and Stress

□ Suicide

□ Depression

□ Primary Prevention, Substance Misuse, and Overdose Prevention

□ Tobacco/E-cigarette Use

□ Alcohol Use

□ Adverse Childhood Experiences

□ Healthy Eating

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

□ Opportunities for Active Transportation and Physical Activity

□ Access to Community Services and Support

□ Injuries and Violence

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

□ Access to and Use of Prenatal Care

□ Prevention of Infant and Maternal Mortality

□ Preventive Services for Chronic Disease Prevention and Control

□ Oral Health Care

□ Preventive Services (Immunization, Hearing Screening and follow up, Lead screening)

□ Early Intervention

□ Childhood Behavioral Health

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

□ Health and Wellness Promoting Schools

□ Opportunities for Continued Education

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

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

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

- ☐ Yes
- ☐ No

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

Appendix D:

Demographic, Health Systems, Education and ALICE Profiles

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

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

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

ARHN region reflects an average of ARHN counties

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

ALICE Threshold, 2022; American Community Survey, 2022

American Community Survey, 2022; ALICE Threshold, 2022

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

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

Key (according to County Health Rankings)

**Purple highlight indicates areas of strength*

**Orange highlight indicates areas to explore*

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

2025 Annual Data Release, County Health Rankings and Roadmaps

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

Demographic Profile

Adirondack Rural Health Network	County									ARHN	Upstate	New York State
Summary of Demographic Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Square Miles												
Total Square Miles	1037.8	1794.1	1629.3	495.5	1717.4	403.11	810	867.2	831.2	8372.4	300.5	47123.6
Total Square Miles for Farms	268.79	12.5	79.3	52.9	N/A	130.9	39.5	0.79	121.7	N/A	N/A	4947.9
Percent of Total Square Miles Farms	25.90%	0.70%	4.90%	10.70%	N/A	32.50%	4.90%	0.10%	14.60%	N/A	N/A	10.50%
Population per Square Mile	76.9	20.8	29.2	107.6	3	122.9	290.8	75.8	73.8	387.1	N/A	428.7
Population												
Total Population	78961	37077	47066	52787	5102	49461	237075	65560	60883	347436	11313181	19571216
Percent White, Non-Hispanic	90.00%	92.90%	84.30%	89.90%	92.00%	83.00%	89.30%	93.30%	90.60%	90.30%	70.70%	55.10%
Percent Black, Non-Hispanic	3.10%	2.50%	3.40%	1.50%	1.00%	3.10%	1.60%	1.30%	2.50%	2.40%	8.70%	14.30%
Percent Hispanic/Latino	3.40%	2.80%	2.80%	4.10%	2.00%	15.20%	3.80%	2.80%	2.90%	3.10%	13.50%	19.80%
Percent Asian, Native Hawaiian,Pacific Islander	1.50%	0.30%	0.70%	1.00%	0.40%	0.70%	3.00%	0.80%	0.60%	0.90%	4.60%	9.10%
Percent Alaskan Native/American Indian	0.30%	0.20%	6.90%	0.00%	0.00%	0.30%	0.20%	0.00%	0.10%	1.00%	0.50%	0.70%
Percent Two or more races	3.70%	3.00%	2.70%	6.20%	5.60%	6.90%	4.80%	4.10%	4.20%	4.10%	9.00%	10.50%
Population by Age												
Under 5 years	3545	1399	2291	2460	159	3049	11066	2769	2771	15394	590144	1035708
5 to 14 years	8341	3278	5409	6233	366	6301	26398	6774	6464	36865	1417466	2214151
15 to 17 years	2494	1200	1856	1942	141	2073	8443	2063	2068	11764	427466	700890
Under 18 years	14380	5877	9556	10635	666	11423	45907	11606	11303	64023	2316783	3950749
18 years and over	64581	31200	37510	42152	4436	38038	191168	53954	49580	283413	8996398	15620467
65 years plus	14447	9525	8902	10746	1671	9376	45947	15454	12718	73463	2205779	3635501
Family Status												
Number of Households	33276	16039	19234	22607	2111	19234	99835	30041	24254	147562	4355640	7668956
Percent Families Single Parent Households	4.80%	4.80%	4.40%	4.60%	3.60%	6.60%	4.40%	3.60%	4.60%	4.40%	229769	462170
Percent Households with Grandparents as Parents	1.70%	1.10%	2.30%	1.90%	1.50%	1.60%	1.10%	1.50%	2.70%	1.90%	55271	101510
Poverty												
Mean Household Income	$91,067	$92,245	$78,937	$80,448	$90,814	$79,106	$123,673	$94,235	$86,922	$87,810	N/A	$122,227
Per Capita Income	$39,384	$40,807	$31,801	$34,843	$41,820	$31,975	$53,782	$43,718	$35,496	N/A	N/A	$48,847
Percent of Individuals Under Federal Poverty Level	13.80%	11.80%	16.50%	14.50%	10.00%	14.70%	6.70%	9.10%	10.80%	12.60%	11.10%	13.70%
Percent of Individuals Receiving Medicaid	23.80%	23.30%	28.10%	31.30%	23.70%	30.60%	15.00%	22.50%	27.60%	25.90%	21.9	27.4
Immigrant Status												
Percent Born in American Territories	90.80%	92.10%	91.90%	93.20%	95.60%	90.70%	89.70%	92.50%	92.40%	92.10%	82.80%	73.00%
Percent Born in Other Countries	4.70%	4.10%	3.20%	2.10%	1.20%	3.10%	5.70%	3.30%	3.10%	3.40%	12.20%	22.90%
Percent Speak a Language Other Than English at Home	2.50%	3.00%	4.30%	1.80%	1.30%	9.10%	2.80%	1.70%	2.40%	2.50%	16.90%	17.30%
Housing												
Total Housing Units	37461	25318	25442	28169	7893	22944	111127	40177	29111	193571	4924670	8631232
Percent Housing Units Occupied	88.83%	63.35%	75.60%	80.25%	26.75%	83.83%	89.84%	74.77%	83.32%	76.23%	78.50%	84.10%
Percent Housing Units Owner Occupied	68.90%	78.10%	71.20%	69.20%	82.50%	69.30%	72.20%	71.50%	76.60%	72.20%	54.70%	45.10%

Demographic Profile

Adirondack Rural Health Network	County									ARHN	Upstate	New York State
Summary of Demographic Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Percent Housing Units Renter Occupied	31.10%	21.90%	28.80%	30.80%	17.50%	30.70%	27.80%	28.50%	23.40%	27.80%	17.50%	39.00%
Percent Built Before 1970	45.40%	50.30%	52.70%	65.10%	52.70%	70.70%	32.60%	46.80%	55.60%	52.00%	58.20%	63.5
Percent Built Between 1970 and 1979	12.30%	11.70%	12.00%	9.50%	11.90%	8.10%	12.20%	12.30%	9.90%	11.40%	11.90%	10.1
Percent Built Between 1980 and 1989	13.10%	11.70%	12.10%	9.60%	10.30%	7.20%	13.90%	14.10%	11.40%	12.10%	9.50%	7.6
Percent Built Between 1990 and 1999	12.70%	9.70%	10.40%	7.50%	10.00%	6.90%	13.80%	10.70%	9.20%	10.20%	7.50%	5.8
Percent Built 2000 and Later	16.50%	16.70%	12.70%	8.50%	15.10%	7.20%	27.30%	15.90%	13.90%	14.30%	13.00%	13.1
Availability of Vehicles												
Percent of Households with No Vehicles Available	10.20%	8.40%	11.30%	9.70%	3.30%	12.50%	4.80%	8.00%	8.40%	9.00%	8.80%	29.40%
Percent of Households with One Vehicle Available	32.30%	34.80%	32.90%	35.50%	36.30%	35.60%	33.60%	35.10%	32.80%	34.00%	34.10%	32.80%
Percent of Households with Two Vehicles Available	40.20%	38.40%	37.30%	36.60%	43.20%	34.00%	42.40%	40.40%	38.20%	38.90%	39.10%	26.30%
Percent of Households with Three or More Vehicles Available	17.30%	18.30%	18.50%	18.20%	17.20%	17.90%	19.20%	16.50%	20.60%	18.00%	17.90%	11.50%
Education												
Total Population Ages 25 and Older	54905	28918	33482	38160	4135	34228	172398	49426	45248	254274	8040086	13996138
Percent with Less than High School Education	11.80%	8.50%	12.70%	11.50%	10.70%	11.50%	5.80%	8.20%	9.70%	10.40%	45.00%	12.20%
Percent High School Graduate/GED	32.50%	33.10%	33.90%	35.90%	31.00%	35.40%	24.40%	28.00%	39.90%	33.70%	61.70%	24.60%
Percent Some College, no degree	17.00%	15.70%	15.70%	16.30%	15.90%	18.70%	14.90%	16.80%	17.60%	16.60%	62.60%	14.90%
Percent Associates Degree	11.90%	11.40%	14.00%	15.20%	15.60%	13.90%	11.20%	12.50%	11.60%	12.70%	69.10%	8.90%
Percent Bachelor's Degree	15.30%	16.90%	13.10%	13.20%	14.20%	11.40%	24.40%	18.70%	12.50%	15.00%	52.70%	22.00%
Percent Graduate or Professional Degree	11.50%	14.40%	10.70%	7.80%	12.70%	9.20%	19.40%	15.90%	8.70%	11.50%	56.00%	17.50%
Employment Status												
Total Population Ages 16 and Older	65,792	32078	38628	43403	4524	39216	199085	55611	51012	291048	9284447	16,085,030
Total Population Ages 16 and Older in Armed Forces	185	2	0	44	0	52	615	0	30	261	19215	23559
Total Population Ages 16 and Older in Civilian labor force	37,356	17679	20,256	25451	2357	23929	127,599	35,223	29998	168320	5736756	10083719
Percent Unemployed	1.00%	2.80%	2.50%	2.20%	2.80%	2.90%	1.60%	1.60%	3.20%	2.10%	4.40%	5.20%
Employment Sector												
Total Employed (Civillian Employed Pop)	36687	16,792	19,302	24,495	2,230	22,798	124,500	34,333	28,381	162220	5181251	9254578
Percent in Agriculture, Forestry, Fishing, Hunting, and Mining	1.40%	2.20%	3.40%	1.20%	4.30%	2.50%	0.30%	1.30%	3.40%	2.00%	0.10%	0.60%
Percent in Construction	6.60%	9.10%	6.70%	7.50%	16.50%	7.80%	6.00%	6.50%	8.30%	7.40%	2.10%	5.60%
Percent in Manufacturing	11.60%	8.90%	3.90%	10.70%	2.60%	12.20%	11.00%	7.60%	13.10%	9.50%	1.30%	6.50%
Percent in Wholesale Trade	0.50%	0.90%	1.10%	2.30%	1.30%	1.60%	2.30%	1.30%	1.60%	1.30%	0.60%	2.50%
Percent in Retail Trade	9.20%	8.30%	13.90%	14.90%	8.70%	13.00%	9.50%	10.90%	13.40%	11.60%	3.60%	10.80%
Percent in Transportation, Warehousing, Utilities	5.20%	3.30%	3.90%	5.70%	4.90%	7.20%	3.60%	4.90%	3.90%	4.60%	2.90%	5.10%
Percent in Information Services	1.00%	1.90%	1.70%	1.20%	2.10%	1.10%	2.80%	1.70%	1.20%	1.40%	1.60%	2.90%

Demographic Profile												
Adirondack Rural Health Network	County									ARHN	Upstate	New York State
Summary of Demographic Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Percent in Finance/Insurance/Real Estate	1.90%	5.20%	2.60%	3.30%	4.80%	4.40%	9.70%	5.50%	4.10%	3.70%	4.10%	8.00%
Percent in Other Professional Occupations	5.70%	8.10%	5.60%	6.30%	6.00%	5.60%	12.60%	12.00%	9.10%	7.90%	7.10%	11.40%
Percent in Education, Health Care and Social Assistance	32.70%	28.10%	33.00%	27.20%	22.20%	27.00%	24.60%	25.30%	22.60%	28.00%	12.50%	27.50%
Percent in Arts, Entertainment, Recreation, Hotel & Food Service	10.10%	12.30%	7.80%	7.50%	10.60%	5.70%	7.20%	11.20%	8.00%	9.60%	4.10%	9.50%
Percent in Other Services	5.60%	5.50%	4.20%	6.00%	3.50%	6.10%	4.00%	5.40%	4.60%	5.30%	2.30%	5.00%
Percent in Public Administration	8.40%	6.20%	12.30%	6.10%	12.30%	5.80%	6.20%	6.50%	6.60%	7.60%	1.70%	4.60%

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

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

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

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

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

Education System Profile - School Districts by County

Clinton	Number of Schools
AUSABLE VALLEY CENTRAL SCHOOL DISTRICT	4
BEEKMANTOWN CENTRAL SCHOOL DISTRICT	4
CHAZY UNION FREE SCHOOL DISTRICT	2
CLINTON-ESSEX-WARREN-WASHINGTON BOCES	1
NORTHEASTERN CLINTON CENTRAL SCHOOL DISTRICT	4
NORTHERN ADIRONDACK CENTRAL SCHOOL DISTRICT	2
PERU CENTRAL SCHOOL DISTRICT	3
PLATTSBURGH CITY SCHOOL DISTRICT	5
SARANAC CENTRAL SCHOOL DISTRICT	4
Total Number of Schools in the County	29

Essex	Number of Schools
BOQUET VALLEY CSD	2
CROWN POINT CENTRAL SCHOOL DISTRICT	1
KEENE CENTRAL SCHOOL DISTRICT	1
LAKE PLACID CENTRAL SCHOOL DISTRICT	2
MINERVA CENTRAL SCHOOL DISTRICT	1
MORIAH CENTRAL SCHOOL DISTRICT	2
NEWCOMB CENTRAL SCHOOL DISTRICT	1
SCHROON LAKE CENTRAL SCHOOL DISTRICT	1
TICONDEROGA CENTRAL SCHOOL DISTRICT	2
WILLSBORO CENTRAL SCHOOL DISTRICT	1
Total Number of Schools in the County	14

Franklin	Number of Schools
BRUSHTON-MOIRA CENTRAL SCHOOL DISTRICT	2
CHATEAUGAY CENTRAL SCHOOL DISTRICT	2
FRANKLIN-ESSEX-HAMILTON BOCES	1
MALONE CENTRAL SCHOOL DISTRICT	5
SAINT REGIS FALLS CENTRAL SCHOOL DISTRICT	1
SALMON RIVER CENTRAL SCHOOL DISTRICT	4
SARANAC LAKE CENTRAL SCHOOL DISTRICT	4
TUPPER LAKE CENTRAL SCHOOL DISTRICT	2
Total Number of Schools in the County	21

Fulton	Number of Schools
BROADALBIN-PERTH CENTRAL SCHOOL DISTRICT	2
GLOVERSVILLE CITY SCHOOL DISTRICT	5
JOHNSTOWN CITY SCHOOL DISTRICT	4
MAYFIELD CENTRAL SCHOOL DISTRICT	2
NORTHVILLE CENTRAL SCHOOL DISTRICT	2
WHEELERVILLE UNION FREE SCHOOL DISTRICT	1
Total Number of Schools in the County	16

Hamilton	Number of Schools
INDIAN LAKE CENTRAL SCHOOL DISTRICT	1
LAKE PLEASANT CENTRAL SCHOOL DISTRICT	1
LONG LAKE CENTRAL SCHOOL DISTRICT	1
WELLS CENTRAL SCHOOL DISTRICT	1
Total Number of Schools in the County	4

Montgomery	Number of Schools
AMSTERDAM CITY SCHOOL DISTRICT	6
CANAJOHARIE CENTRAL SCHOOL DISTRICT	3
FONDA-FULTONVILLE CENTRAL SCHOOL DISTRICT	3
FORT PLAIN CENTRAL SCHOOL DISTRICT	2
HAMILTON-FULTON-MONTGOMERY BOCES	1
OPPENHEIM-EPHRATAH-ST. JOHNSVILLE CSD	2
Total Number of Schools in the County	17

Saratoga	Number of Schools
BALLSTON SPA CENTRAL SCHOOL DISTRICT	6
BURNT HILLS-BALLSTON LAKE CENTRAL SCHOOL DISTRICT	5
CORINTH CENTRAL SCHOOL DISTRICT	3
EDINBURG COMMON SCHOOL DISTRICT	1
GALWAY CENTRAL SCHOOL DISTRICT	2
MECHANICVILLE CITY SCHOOL DISTRICT	2
SARATOGA SPRINGS CITY SCHOOL DISTRICT	8
SCHUYLERVILLE CENTRAL SCHOOL DISTRICT	3
SHENENDEHOWA CENTRAL SCHOOL DISTRICT	12
SOUTH GLENS FALLS CENTRAL SCHOOL DISTRICT	6
STILLWATER CENTRAL SCHOOL DISTRICT	2
WATERFORD-HALFMOON UNION FREE SCHOOL DISTRICT	2
Total Number of Schools in the County	52

Warren	Number of Schools
BOLTON CENTRAL SCHOOL DISTRICT	1
GLENS FALLS CITY SCHOOL DISTRICT	5
GLENS FALLS COMMON SCHOOL DISTRICT	1
HADLEY-LUZERNE CENTRAL SCHOOL DISTRICT	2
JOHNSBURG CENTRAL SCHOOL DISTRICT	1
LAKE GEORGE CENTRAL SCHOOL DISTRICT	2
NORTH WARREN CENTRAL SCHOOL DISTRICT	1
QUEENSBURY UNION FREE SCHOOL DISTRICT	4
WARRENSBURG CENTRAL SCHOOL DISTRICT	2
Total Number of Schools in the County	19

Washington	Number of Schools
ARGYLE CENTRAL SCHOOL DISTRICT	2
CAMBRIDGE CENTRAL SCHOOL DISTRICT	2
FORT ANN CENTRAL SCHOOL DISTRICT	2
FORT EDWARD UNION FREE SCHOOL DISTRICT	1
GRANVILLE CENTRAL SCHOOL DISTRICT	3
GREENWICH CENTRAL SCHOOL DISTRICT	2
HARTFORD CENTRAL SCHOOL DISTRICT	2
HUDSON FALLS CENTRAL SCHOOL DISTRICT	5
PUTNAM CENTRAL SCHOOL DISTRICT	1
SALEM CENTRAL SCHOOL DISTRICT	2
WASHINGTON-SARATOGA-WARREN-HAMILTON-ESSEX BOCES	1
WHITEHALL CENTRAL SCHOOL DISTRICT	2
Total Number of Schools in the County	25

https://nces.ed.gov/ccd/districtsearch/index.asp
Source: CCD public school district data for the 2023-2024 school year

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

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

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

Health Systems Profile

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

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS*	New York State
Summary of Health Systems Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
St Johnsville Rehabilitation and Nursing Center	-	-	-	-	-	120	-	-	-		-	-
The Pines at Glens Falls Center for Nursing & Rehabilitation	-	-	-	-	-	-	-	120	-	120	-	-
Tupper Lake Center for Nursing and Rehabilitation			60							60		
Warren Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	80	-	80	-	-
Washington Center for Rehabilitation and Healthcare	-	-	-	-	-	-	-	-	122	122	-	-
Wells Nursing Home Inc	-	-	-	100	-	-	-	-	-	100	-	-
Wesley Health Care Center Inc	-	-	-	-	-	-	342	-	-	-	-	-
Wilkinson Residential Health Care Facility	-	-	-	-	-	160	-	-	-	-	-	-
Total Adult Care Facility Beds												
Adult Care Facility Beds per 100,000 Population	294.4	728.2	127.5	98.5	0	628.8	293.2	648.5	221.7	338	483.4	265.1
Total Adult Home Beds	230	270	60	52	0	311	700	424	135	1,171	39,921	51,893
Total Assisted Living Program Beds	185	39	30	52	0	209	0	54	75	435	8,882	14,123
Total Assisted Living Residence (ALR) Beds	0	181	0	0	0	61	315	170	50	401	19,237	21,885
Total Enhanced ALR Beds	25	29	0	0	0	41	279	149	0	203	8,787	10,520
Special Needs ALR Beds	20	21	0	0	0	0	106	51	10	102	5,063	5,767
Adult Home Beds by Total Capacity per Facility												
Adirondack Manor HFA D.B.A Adirondack Manor HFA ALP	-	-	-	-	-	-	-	60	-	60	-	-
Adirondack Manor HFA D.B.A Montcalm Manor HFA	-	40	-	-	-	-	-	-	-	40	-	-
Ahana House	-	-	-	-	-	-	17	-	-	-	-	-
Alice Hyde Assisted Living Program	-	-	30	-	-	-	-	-	-	30	-	-
Argyle Center for Independent Living	-	-	-	-	-	-	-	-	35	35	-	-
Arkell Hall	-	-	-	-	-	24	-	-	-	-	-	-
Champlain Valley Senior Community	-	81	-	-	-	-	-	-	-	81	-	-
Countryside Adult Home	-	-	-	-	-	-	-	48	-	48	-	-
Elderwood Village at Ticonderoga	-	23	-	-	-	-	-	-	-	23	-	-
Hillcrest Spring Residential	-	-	-	-	-	80	-	-	-	-	-	-
Holbrook Adult Home	-	-	-	-	-	-	-	-	33	33	-	-
Home of the Good Shepherd at Highpointe	-	-	-	-	-	-	86	-	-	-	-	-
Home of the Good Shepherd	-	-	-	-	-	-	42	-	-	-	-	-
Home of the Good Shepherd Moreau	-	-	-	-	-	-	72	-	-	-	-	-
Home of the Good Shepherd Saratoga	-	-	-	-	-	-	105	-	-	-	-	-
Home of the Good Shepherd Wilton	-	-	-	-	-	-	54	-	-	-	-	-
Keene Valley Neighborhood House	-	50	-	-	-	-	-	-	-	50	-	-
Peregrine Senior Living at Clifton Park							64					
Pine Harbour	66	-	-	-	-	-	-	-	-	66	-	-
Pineview Commons H.F.A.	-	-	-	94	-	-	-	-	-	94	-	-
Samuel F. Vilas Home	80	-	-	-	-	-	-	-	-	80	-	-
Sarah Jane Sanford Home	-	-	-	-	-	40	-	-	-	-	-	-
The Cambridge	-	-	-	-	-	-	-	-	40	40	-	-
The Farrar Home	-	-	30	-	-	-	-	-	-	30	-	-
The Landing at Queensbury	-	-	-	-	-	-	-	88	-	88	-	-
The Mansion at South Union	-	-	-	-	-	-	-	-	44	44	-	-
The Sentinel at Amsterdam, LLC	-	-	-	-	-	150	-	-	-	-	-	-
The Terrace at the Glen at Hiland Meadows	-	-	-	-	-	-	-	52	-	52	-	-
Memory Care at The Glen at Hiland Meadows								30		30		
Valehaven Home for Adults	40	-	-	-	-	-	-	-	-	40	-	-

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

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

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

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

NYS Department of Health, NYS Health Profiles, May 2025

Appendix E:

2025 Data Methodology

2025 Data Methodology

Background:

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

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

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

Demographic Profile:

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

Health System Profile:

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

Education Profile:

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

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

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

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

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

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

County Health Rankings (CHR) Profile:

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

The County Health Rankings identifies the two focus areas as:

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

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

Data Dashboard:

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

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

The Data Dashboard is composed of 10 sources, each with their own overview and deep dive tab.
Data and statistics for all indicators come from a variety of sources, including:

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

<u>ARHN Region Calculations:</u>
The ARHN region includes Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington Counties.

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

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

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

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

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

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

1. PA
    a. The NYS Prevention Agenda Dashboard provides a New York State (excluding NYC) region.
2. CHIRs
    a. A NYS (excluding NYC) region is provided for some indicators. For indicators without a NYS (excluding NYC) measure, calculations were provided (using the methodology above) when data was available.

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

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

**NYS totals are either provided by the source or computer incorporating all the counties within NYS.*
**NYC totals include the five NYC boroughs: Bronx, Kings, New York, Queens, and Richmond counties.*
**Specific rate multiplier depends on the indicator (i.e. rate per 100,000, rate per 10,000, or rate per 1,000).*

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

Unstable Estimates:

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

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

Prevention Agenda Dashboard

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

Data Suppression for Confidentiality

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

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

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

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

CI: Confidence Interval
BRFSS: Behavioral Risk Factor Surveillance System
SPARCS: Statewide Planning and Research Cooperative System

Community Health Indicator Reports (CHIRs)

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

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

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

Table 1. Summary of Data Suppression Rules

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

NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators

Limitations of Use:

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

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

Limitations of Data Use:

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

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

NYS Traffic Safety Statistical Repository (TSSR)

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

Student Weight Status Category Reporting System (SWSCRS) Data

Limitations of Data:

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

estimates represent the percentage of students within a weight status category reported to the Student Weight Status Category Reporting System.
- These data should not be considered to represent all school aged-children attending school in that county or region because of: restrictions in reporting due to FERPA, parents/guardians' ability to request that their child's weight status data be excluded from reporting, and other sources of missing data.

US Department of Agriculture (USDA) Food Atlas

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

In the downloadable Excel spreadsheets:

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

NYS Department of Health Tobacco Enforcement Compliance Results

Limitations of Use:

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

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

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

NYS Department of Health Maternal and Child Health

Unstable Estimates:

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

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

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

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

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

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

Department of Health, Wadsworth Center

Limitations of Use:

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

reports; samples received from out of state and samples that are unsatisfactory for testing are not listed. However, all samples, regardless of the testing outcome, are included in the annual report (https://www.wadsworth.org/programs/id/rabies/reports).

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

Appendix F:

Infographics of Select Clinton County Indicators

ECONOMIC STABILITY

2025-2028 Community Health Assessment *(Select Clinton County Indicators)*

Domain:

- Economic Stability

Priorities:

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

14%

of the Clinton County population **lives in poverty.**

Source: 2022 ACS

Total unemployment still remains **5% below** pre-pandemic levels.

Source: CCIDA 2024

59%

of senior renters are **cost burdened.**

Source: CCIDA 2024

The average household **spends 38%** of it's income to cover **childcare costs** for 2 children.

Source: 2024 County Health Rankings

Over 1 in 5

families screened for nutrition security by CCHD in 2024 reported it was **"hard"** or **"very hard"** for their household to regularly **get and eat healthy food.**

Single family home prices have increased **55%** from 2013-2023.

Source: CCIDA 2024

10,840

Clinton County adults experience **food insecurity.**

Source: Feeding America 2023

Average **rental rates** have **increased 23%** since 2023.

Source: CCIDA 2024

46%

of Clinton County children receive **free or reduced school lunch.**

Source: 2022 KWIC

34%

of families screened for nutrition security in 2024 by CCHD were **unsure if they qualified for food assistance programs.**

10%

of Clinton County households **do not own a vehicle.**

Source: 2022 ACS

1 in 5

children (under 18) live in a household with a **single parent of guardian.**

Source: 2022 5 Year American Community Survey

21%

of Clinton County children **recieve SNAP benefits.**

Source: 2022 KWIC

2,249

Clinton County children live **below the poverty line.**

Source: 2024 County Health Rankings

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SOCIAL & COMMUNITY CONTEXT

2025-2028 Community Health Assessment *(Select Clinton County Indicators)*

Domain:

- Social & Community Context

Priorities:

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

The prevalence of **cigarette smoking** is

20%

among adults in Clinton County.

Source: NYS Prevention Agenda

Clinton County's **suicide mortality rate** per 100,000 is

11.0.

New York State's is 8.0.

Source: NYS Prevention Agenda

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

Source: 2024 County Health Rankings

The percentage of **adults** who have experienced two or more **adverse childhood experiences** (ACEs) is

36%

in Clinton County and

42%

in New York State.

Source: NYS Prevention Agenda

Clinton County reports

higher

rates of **children** experiencing **abuse, entering foster care,** and **living in foster care** than NYS.

Source: NYS Council on Children & Families, 2022

Indicated reports of **child abuse/maltreatment** is

17.5 per 100,000

in Clinton County and

12.4 per 100,000

in New York State.

Source: NYS Prevention Agenda

The ratio of population to mental health providers is

344:1

in **Clinton County** and

356:1

in **New York State**.

Source: 2024 County Health Rankings

The rate of **adolescents hospitalized for self harm** has been **increasing** in Clinton County since 2017.

Source: SPARCs

2 in 5

Clinton County adults self-reported that mental health was a challenge.

Source: 2025 Clinton County Resident Survey

The age-adjusted rate of **adults who smoke** in Clinton County is **higher** than the upstate average.

Source: BRFSS 2021

1 in 5

adults self-report **excessive drinking** within the last month. **5% higher** than the **NYS average.**

Source: NYS Prevention Agenda

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NEIGHBORHOOD & BUILT ENVIRONMENT

2025-2028 Community Health Assessment *(Select Clinton County Indicators)*

Domain:

- Neighborhood & Built Environment

Priorities:

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

Clinton County's **Food Environment Index is**

8.3

compared to

8.7

for New York State.

Source: 2024 County Health Rankings

1,100

The minimum number of **new homes** Clinton County will need in the next **5 years** to meet demand.

Source: CCIDA 2024

35%

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

Source: NYS Prevention Agenda

2 in 5

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

Source: 2025 Clinton County Resident Survey

14% of Clinton County households **do not have broadband access.**

Source: 2022 ACS

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

Source: NYS Prevention Agenda

36%

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

Source: NYS BRFFS

10%

of Clinton County households **do not own a vehicle.**

Source: 2022 ACS

55%

of Clinton County residents identified **aging infrastructure** as a top environmental concern in our community.

Source: 2025 Clinton County Resident Survey

Clinton County residents are

21 percentage points

less likely than the NYS average to have **adequate access** to locations for **physical activity.**

Source: 2024 County Health Rankings

1 in 3

Clinton County adults has a **disability.**

Source: NYS BRFFS

25%

of Clinton County adults are **sedentary.**

Source: NYS Prevention Agenda

Less than 25%

of Clinton County residents live in a **Climate Friendly Community.**

Source: County Health Rankings

65%

of Clinton County residents are served by community water systems that have **optimally fluoridated water.**

Source: NYS Prevention Agenda

62%

of Clinton County **adults with disabilities** participate in leisure-time **physical activity.**

Source: NYS Prevention Agenda

26%

of **children or adolescents** in Clinton County are **obese.**

Source: NYS Department of Health

The county rate of **hospitalizations due to falls** for those 65+ is worse than the **NYS average.**

Source: NYS Prevention Agenda

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HEALTH CARE ACCESS & QUALITY

2025-2028 Community Health Assessment *(Select Clinton County Indicators)*

Domain:

- Health Care Access & Quality

Priorities:

- Access to & use of Prenatal Care
- Prevention of Infant & Maternal Mortality
- Preventive Services for Chronic Disease Prevention & Control
- Oral Health Care
- Preventive Services
- Early Intervention
- Childhood Behavioral Health

65%
of Clinton County adults ages 50-64 have been screened for **colon cancer.**
Source: NYS BRFFS

In 2022,
95%
of adults under 65 in Clinton County had **health insurance.**
Source: County Health Rankings

7%
of Clinton County **births are preterm.**
Source: NYS Prevention Agenda

There was a
40%
increase in chest/ breastfeeding a 1 year old from 2013 to 2021.
Source: 2024 Breastfeeding Data Summary

The **HIV** diagnosis rate in Clinton County is
1.7 per 100,000
That is **9.6 points lower** than the New York State rate.
Source: NYS Prevention Agenda

2 in 5
Clinton County women ages 50-74 have had a **mammogram in the past 2 years.**
Source: NYS BRFFS

From 2013-2023, CCHD helped
30 healthcare practices
achieve **Breastfeeding Friendly Designation** from NYSDOH.

75%
of all Clinton County babies born in 2021 received some **human milk** by their 1st birthday.
Source: 2024 Breastfeeding Data Summary

Overall rates of **Chlamydia** cases in Clinton County have decreased but over
60%
of cases occur in 1 5-29 year olds.
Source: HCS Annual Report

26%
of **children or adolescents** in Clinton County are **obese.**
Source: NYS Department of Health

Cases of **Lyme disease** and other **tick-borne diseases** continue to **increase** and remain significantly under-reported.
Source: HCS Annual Report

There was
1 dentist per 1,540
people in Clinton County in 2022.
Source: 2024 County Health Rankings

36%
of adults in Clinton County are **obese.**
Source: NYS BRFFS

Only 12%
of Clinton County adults with **chronic conditions** have taken a course to learn how to **manage their conditions.**
Source: NYS Prevention Agenda

According to CCHD tracking,
50%
of 13 year old adolescents seen by their pediatrician in the 1st quarter of 2025 have a complete **HPV vaccine series.**

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EDUCATION ACCESS & QUALITY

2025-2028 Community Health Assessment *(Select Clinton County Indicators)*

Domain:

- Education Access & Quality

Priorities:

- Health & Wellness Promoting Schools
- Opportunities for Continuing Education

100%

of the public school districts in Clinton County have fully executed **School Wellness Policies.**

The **graduation rate** for students with **disabilities** is

62%

compared to 87% overall.

Source: NYS Department of Education

Only 40%

of Clinton County children ages 3-4 are **enrolled in preschool.**

Source: 2023 ACS

From 2021-2025, CCHD's **Creating Healthy Schools & Communities** has invested over

$330,000

in Clinton County schools.

In Clinton County,

63% of adults

(age 25-44) have **completed some post-secondary** education, including vocational/technical school, junior colleges, or four year colleges. **This is less than state (71%) and national (68%) averages.**

Source: 2024 County Health Rankings

In the 2022-2023 school year, **chronic absenteeism** ranged from

21% - 37%

for **high school students** in Clinton County school districts

Source: NYS Department of Education

In the 2023-2024 school year there were

226

homeless students in Clinton County.

Source: NYS Department of Education

In the 2022-2023 school year, **chronic absenteeism** among Clinton County **elementary students** ranged from

12% - 25%

Source: NYS Department of Education

26%

of **children or adolescents** in Clinton County are **obese.**

Source: NYS Department of Health

Since first executed, Clinton County **School Wellness Policies** demonstrate a

46.5

average point **increase in strength.**

The **graduation rate** for **economically disadvantaged students** is

81%.

Source: NYS Department of Education

Third grade **reading proficiency** levels are **below** the NYS average in

7 out of 8

Clinton County school districts.

Source: NYS Department of Education

Since first executed, Clinton County **School Wellness Policies** demonstrate a

39.4

average point **increase in comprehensiveness.**

2 in 5

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

Source: 2025 Clinton County Resident Survey

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2025 Community Health Assessment
Resident Survey Key Findings

The Clinton County Health Department asked county residents for their opinions on health, social and environmental issues in the community. They were also asked to identify any barriers to medical care experienced by themselves or their family in the past year. Surveys were collected from 1,523 residents. For a full report of all findings visit www.clintonhealth.org/pdf%20files/CHA_CHIP.pdf.

35%

of respondents **agree** or **strongly agree** they **live in a healthy community.**

The top features of a healthy community were identified as:

- Affordable housing
- Health care services
- Livable wages
- Safe environment
- Clean environment
- Drug & alcohol free communities
- Good schools

90% faced **at least 1 health challenge** in the past year.

42% experienced a **mental health challenge**.

37% lacked access to a **health care specialist.**

36% were **overweight or obese.**

30% lacked access to **dental care.**

29% had a **chronic disease.**

Aging infrastructure was the top environmental concern with more than **half of residents** surveyed selecting it.

More than **45%** of respondents indicated **stream, river, or lake quality** was an environmental concern.

1 in 5

respondents reported they or a family member experienced a lack of **opportunities for physical activity** in the last year.

68%

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

Most common barriers:

- No specialist appointment
- No local specialist
- Did not accept my insurance
- No primary appointment
- Could not leave work or school

46%

of respondents feel **affordable housing** is a **social challenge** in our community.

1 in 5

respondents had difficulty **accessing healthy food** in the past year.

73%

reported **at least 1 social challenge** in the past year.

Top ranked challenges:

- Lack of a livable wage
- Lack of affordable housing
- Bullying
- Opportunities for physical activity
- Street Safety
- Access to healthy foods

Note: Statistics on issues for individuals and their family are based on those respondents who indicated that they had any issues. 32% of respondents reported no health issues; 27% reported no social issues. Survey responses represented residents from 100% of Clinton County townships, ages 17—80+, and all census income and education categories.

CCHD
Clinton County HEALTH Department

Appendix G:

UVHN-CVPH Community Health Improvement Plan 2024 Annual Report

Community Health Improvement Plan 2024 Annual Report



THE University of Vermont HEALTH NETWORK

Champlain Valley Physicians Hospital

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A Message From Leadership



Michelle LeBeau, RN, BS, MHRM

President & Chief Operating Officer
Champlain Valley Physicians Hospital

The University of Vermont Health Network - Champlain Valley Physicians Hospital (CVPH) is committed to improving the health and well-being of the people of our North Country communities. Every three years, UVM Health Network's six health care partners conduct a Community Health Needs Assessment (CHNA). The CHNA is built upon the foundation of New York State's Prevention Agenda — its health improvement plan and blueprint for state and local action to improve the overall health and well-being of all of our citizens. CHNAs help us reflect on our work to date as a critical healthcare partner in this region and consider the challenges and opportunities involved in creating healthier communities. This process informs how we respond to the changing needs of patients across our region and how we work in collaboration with our diverse community partners. This will be the last annual report for this Community Health Improvement Plan cycle focused on addressing the priority areas of Promote Well-Being and Prevent Mental and Substance Use Disorders and Prevent Chronic Diseases.

CVPH's Calendar Year 2024 Community Health Improvement Plan (CHIP) annual report serves as a year-over-year demonstration of our upstanding commitment, accountability and effectiveness strengthening the health of our region. This report highlights successes with our key partners as well as opportunities for carrying the work forward in the year ahead. We will continue to center the needs of those in our community most impacted by the social, economic and environmental factors influencing health outcomes. Work is ongoing to ensure that all individuals have fair access to the care and services that meet their needs.

I hope this report offers you a snapshot of how our dedicated, skilled, and compassionate team members are taking action each day to improve the health and well-being of our community served. We look forward to building on this work and identifying new opportunities for collaborating with our patients, friends, families, and neighbors on responsive local solutions. Thank you for taking time to learn about our investment in community health.

In partnership,

Introduction

Annual Report Overview

Adopting an 'Implementation Strategy' and evaluating the impact of our Community Benefit programs is a requirement of our health system's tax-exempt status. This demonstrates our commitment, accountability and effectiveness in addressing our communities' identified health priorities. An annual progress report is best practice for Community Benefit. This report spotlights programmatic highlights, investments made, and collaboration with our key partners to improve the health of our community in 2024.

ABOUT US

The University of Vermont Health Network - Champlain Valley Physicians Hospital (CVPH) is part of a six-hospital network serving patients and their families in northern New York and Vermont. We're not just caregivers and staff - we're your friends and neighbors, offering expertise and compassionate care as close to home as possible. That's what we call the heart and science of medicine.

Prioritization

The Clinton County 2022-2024 Community Health Assessment priorities were informed by rigorous, year-long assessment activities carried out and facilitated by CVPH and Clinton County Health Department (CCHD). This included the Community Health Priority Setting Session, which improved outreach to 25% more stakeholders this cycle. The Community Health Priority Session included partners representing 18 sectors. Priorities selected reflect a commitment from partners to continue addressing the priorities from the previous two health assessment cycles. The two priority areas and goals being addressed collaboratively for the next three years are:

Promote Well-Being and Prevent Mental Health and Substance Use Disorders
Focus Areas:

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

Prevent Chronic Diseases
Focus Areas:

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

Summary of Accomplishments

This annual report for calendar year 2024 details key actions taken to advance population health initiatives and community health priorities.

Highlights of 2024

- Our organization is proud of the strides University of Vermont Health Network - Champlain Valley Physicians Hospital (CVPH) has made in improving the health and well-being of our community. The year was marked by significant milestones, impactful partnerships, and a steadfast commitment to addressing critical social and health needs
- In 2024, we also saw the release of the New York State Department of Health's Prevention Agenda for 2025–2030, emphasizing social needs. This aligns with our writing year for the next Community Health Needs Assessment (CHNA). As a partner with the Clinton County Health Department, CVPH is actively collaborating to create a comprehensive CHNA, which will guide future initiatives.
- Our foundation's funding initiatives continued to focus on resilience and community health across the lifespan. Some of these efforts included:
    - Supporting walking groups and distributing bicycle helmets to promote physical activity.
    - Providing funding to Sweethearts and Heroes, which offers training and education to educators and school-aged children, emphasizing social-emotional learning.
- Internally, CVPH prioritized employee wellness and engagement through the work of the Wellness Committee. Efforts included:
    - Introducing the Cart of Connection and Well-Being , a mobile resource providing support and care to employees at their workstations. Leaders have utilized the cart on approximately 15 occasions this year.
    - Organizing activities such as walking challenges and movie nights to promote team building and well-being.
    - Expanding access to mental health resources through Lyra Health, enhancing support for our staff.
- In the area of mental health and substance use prevention, CVPH supported a care coordinator in the Emergency Department (ED) through Champlain Valley Family Centers.
    - This addition has helped streamline transitions for patients with substance use needs back into the community.
    - Efforts also included implementing social determinants of health screenings in the ED to better address patients' social challenges .
    - Anti-Stigma training was provided to approximately 100 CVPH staff in 2024.

Highlights of 2024 CONT.

- Our focus on chronic disease prevention and management has expanded through partnerships with the Heart Network and inclusion in the Chronic Disease Care Coordination Network. Highlights included:
    - Introducing programs related to SNAP benefits and vegetable prescription programs.
    - Redesigning the Chronic Disease Self-Management Program in collaboration with Get Healthy North Country providers.

Key Community Partnerships

- Behavioral Health Services North
- Champlain Valley Family Center
- United Way of Northeastern New York
- National Alliance on Mental Illness
- NYS Office of New Americans

Investments

United Way of Northeastern New York

$20,000

Funds supported ALICE families (Asset Limited, Income Constrained, Employed), those facing severe poverty, homelessness and other essential services. These funds will assist North Country residents in times of need and are distributed across multiple agencies in Clinton County through United Way. Most often, they are focused on homelessness prevention, food insecurity, transportation, access to medical care, mental health, youth development and general wellness.

Town of Plattsburgh Parks

$5,000

This marks the second year of this funding. These funds are being used to upgrade town parks, ensuring they are accessible to all, including individuals with developmental disabilities.

TOTAL: $25,000

Work Underway/Anticipated for 2025

- We are excited about the development of our new Community Health Needs Assessment and the opportunity to further strengthen relationships with community partners. Together, we aim to create a healthier, safer, and more supportive environment for our CVPH family and the communities we serve.
- The Initiation of the Population Health Service Organization (PHSO) Diabetic Care Mgt Pathway will aim to coordinate and improve the care of individuals with diabetes. This will be established by the care manager assessing the need for resources and linking individuals with resources. This could include any or all of the following: Pharmacist, Resource Coordinator, Health and Wellness Coach and/or Clinical Diabetes Care and Education Specialist.
- In the pilot we are also partnering with NY Quits for smoking cessation and will be educating patients about CDSMP (chronic disease self-management program).
- CVPH will host a virtual chronic disease self-management program in January of 2025.
- Establish workflows to facilitate timely admission to Champlain Valley Family Center (CVFC) Intensive Crisis Stabilization Center (ICSC), (Opening July 2025). This site will establish a separate location for those in the community facing a crisis, not requiring ED or hospital level care.
- Our Wellness team is continuing work on establishing Wellness ambassadors.

Thank you to our team, partners and stakeholders for making 2024 such a great year. We look forward to continued collaboration and success in the year ahead.





Calendar Year 2024: Work to Date



Chronic Disease Preventive Care and Management



IN ALIGNMENT WITH NYS PREVENTION AGENDA GOALS: Prevent Chronic Diseases

1. **Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.**
   Measures:
   - **Increase the percentage of adults who had a test for high blood sugar or diabetes within the past three years, aged 45+ years.**
   - **Reduce rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 population.**
2. **In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity.**
   Measures:
   - **Increase the percentage of adults with chronic conditions who have taken a course or class to learn how to manage their condition**
   - **Reduce the percentage of adult Clinton County resident with self-perceived poor or extremely poor physical health.**

Objective: 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.

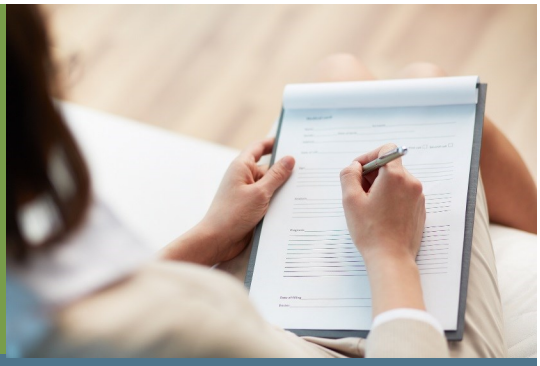
Calendar Year 2024: Work to Date

- A1C control QI project: included calling patients overdue for their A1C testing to get them scheduled to see their provider. Ended the year about the same as we started - 19.5% of our diabetic patients have an A1C over nine (slightly down from 19.7% at the start of the year. Our target is <10%.
- Launched partnerships with the Heart Network and Adirondack Health Institute (AHI) to be part of the Chronic Disease Care Coordination Network. Providers are referring patients to:
  - SNAP-Ed Fruit and Vegetable Prescription program: Any patient at risk of or diagnosed with a diet-related chronic disease and has food insecurity qualifies. Partnered with Cornell Cooperative for this program in mid-2024. As part of the program, patients attend classes that teach them about eating healthy and how to cook healthy. For each class they attend, they receive a $25 voucher for fruits and vegetables.

- SNAP-Ed Fruit and Vegetable Prescription program cont.
    - There are a total of six classes for each session. These classes are free of charge.
- Chronic Disease Self-Management program through Get Healthy North Country: Providers refer patients via gethealthynoco.org. Participants attend classes on a variety of topics related to chronic disease: diabetes management, pain management and chronic disease. These classes are free of charge. Chronic disease courses are scheduled for 2025.
- CVPH is a pilot site for the Chronic Disease Care Coordination Network.
- The PHSO has initiated the Diabetic Care Management Pathway:
    - Any patient with a A1C <9% qualifies for the DM Care Management Pathway.

Progress on measures: No outcome measurement data reported at time of report.

Prevent Mental and Substance Use Disorders



IN ALIGNMENT WITH NYS PREVENTION AGENDA GOALS: Promote Well-Being and Prevent Mental and Substance Use Disorders

1. **Prevent opioid and other substance misuse and deaths.**

Measures:

- **Reduce Drug Overdose Mortality by three points.**
- **Reduce Opioid Overdose Mortality by three points.**

2. **Prevent and address adverse childhood experiences.**

Measures:

- **Decrease the percentage of Clinton County adults who have experienced two or more adverse childhood experiences (ACEs).**

Objective: Build support systems to care for opioid users or at risk of an overdose.

Calendar Year 2024: Work to Date

- As of 2024, CVFC provides a targeted case manager primarily in the Emergency Department (ED) focused on:
  - Screen individuals for health-related social needs.
  - Engage in SUD services for those in need among any of the service providers.
  - Provide Narcan to patients and families upon request.
  - Follow-up with individuals until connected with intake agency.
- CVPH Emergency Department is part of a research project with UVM Start treatment and Recovery (STAR). Buprenorphine Emergency Department Quick Start Algorithm created and in use in ED.
  - Anti-Stigma training was provided to approximately 100 CVPH staff in 2024.
- In 2024, Behavioral Health Services North (BHSN) opened an Adult and Child residential respite facility.
  - BHSN and CVPH have collaborated in facilitating individuals from ED or Inpatient to these less restrictive beds and continue their treatment.

Populations of focus: Adults across the lifespan

Key community partnerships:

- CVFC
- NAMI

Progress on measures:

- By end of the year, case manager engaged with 17 patients to provide or connect them to services addressing an identified social need, including enrollment in a substance use disorder program. Additionally, two individuals were helped to get to an inpatient rehab from the ED.



Promote Well-Being



IN ALIGNMENT WITH NYS PREVENTION AGENDA GOALS[1]: Promote Well-Being and Prevent Mental and Substance Use Disorders

1. **Strengthen opportunities to build well-being and resilience across the lifespan.**
2. **Facilitate supportive environments that promote respect and dignity for people of all ages.**

Measures:

- **Reduce the percentage of adult Clinton County residents with self-perceived poor or extremely poor mental health.**
- **Increase Clinton County's Opportunity Index Score by 5%.**

Objectives:

1. **Create and sustain inclusive, healthy public spaces.**
2. **Increase access to health and wellness programs for North Country residents .**
3. **Establish a working committee focusing on wellness and well-being.**
4. **Engage employees in wellness and well-being activities.**
5. **Provide education on resources available to CVPH employee's that would support/ enhance their own wellness and well-being.**

Strategies:

1. **Support programming within local townships and schools.**
2. **Create a cart of Connection and Well-being .**
3. **Identify minimum of three activities for engaging wellness and well-being for employees.**
4. **Consistent attendance and participation in committee events.**
5. **Build an ambassador program for engagement in wellness and well-being activities.**

Calendar Year 2024: Work to Date

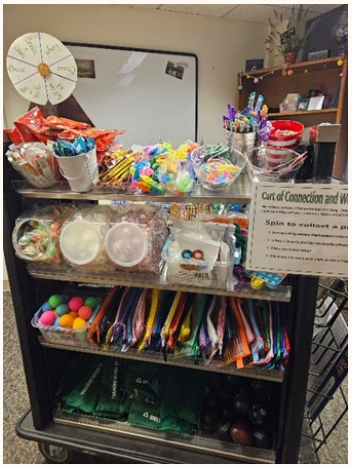
- The Foundation of CVPH sponsored several wellness programs and increased access to fitness activities through its community grant program and strategic partnerships.
    - Sponsored a walking group in Champlain, NY.
    - Supported improvements to the community hockey rink in Champlain, NY.
    - Purchased an adaptive wheelchair for local pickleball courts.

    - Sponsored an adaptive cycling clinic.
    - Purchased 400 bicycle helmets for children in Essex County.
    - Partnered with four townships in Clinton County to sponsor free summer activities.
    - Partnered with Shine On! and Sweethearts & Heroes programming to encourage social and emotional wellness for students throughout the region.
- Plan to invest in current partnerships in 2025 to ensure access to programming remains.
- The mission of CVPH's standing Wellness and Well-Being committee is to work together to foster well-being by encouraging balance, awareness of personal strengths and resources by creating a workplace where wellness is a priority.
- **Goal:** to increase and maintain involvement and engagement for all CVPH employees including hospital-based employee's as well as offsite clinical and support locations.
    - The wellness and well-being committee is responsible for identifying goals, providing resources/information/activities related to the betterment of CVPH employee's wellness and wellbeing using the standard focus of the NIH's eight dimensions of wellness.
    - Committee members will focus on best practice, education as well as performance improvement. Key indicators selected based on OKR's of the UVM Health Network and CVPH hospital and offering forums for feedback from employees. Quality data will be obtained from results of surveys and feedback given during educational sessions and activities.
    - Committee highlights in 2024:
        - Presentation at Explore Conference " Wellness and Well-Being."
        - Implemented "Cart of Connection and Well-Being."
        - Organizational Wellness/Gratitude Board and Wellness Cards
        - Promoted Organizational "Healthy Recipes" over holidays and Walking Challenge over the summer.
        - Partner with OCC Health and Wellness for community engagement (Movie Night, YMCA night).
        - Wellness Wednesday (one time monthly) for education and engagement.
        - Dedicated Staff wellness spaces added to the Emergency Department and Adult Psychiatry.

- CISM team continues to be activated more frequently to support staff post traumatic internal events, in addition to providing ongoing support to staff for evolving complex cases presenting challenges to staff.

- CVPH launched Lyra Health in 2024: Increased access to an array of counseling services, both in-person and virtual options.





Populations of focus:

- School-aged children
- Seniors
- Differently-abled individuals
- All CVPH Employees



Key community partnerships:

- Local townships and schools
- Town of Plattsburgh
- YMCA
- Lyra Health
- CVPH Occupational Health and Wellness

Progress on measures:

- Cart of Connection and Well-Being has been utilized: on 15 different occasions supporting APP/NPP's, Nursing Students, Clinical floor staff on R3, R4, R5, inpatient and outpatient rehab, Nutrition Services, EVS and Leadership (clinical and non-clinical) for a total over 200 individuals impacted.
- Wellness Challenge (walking): 17 unique individuals participated.

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