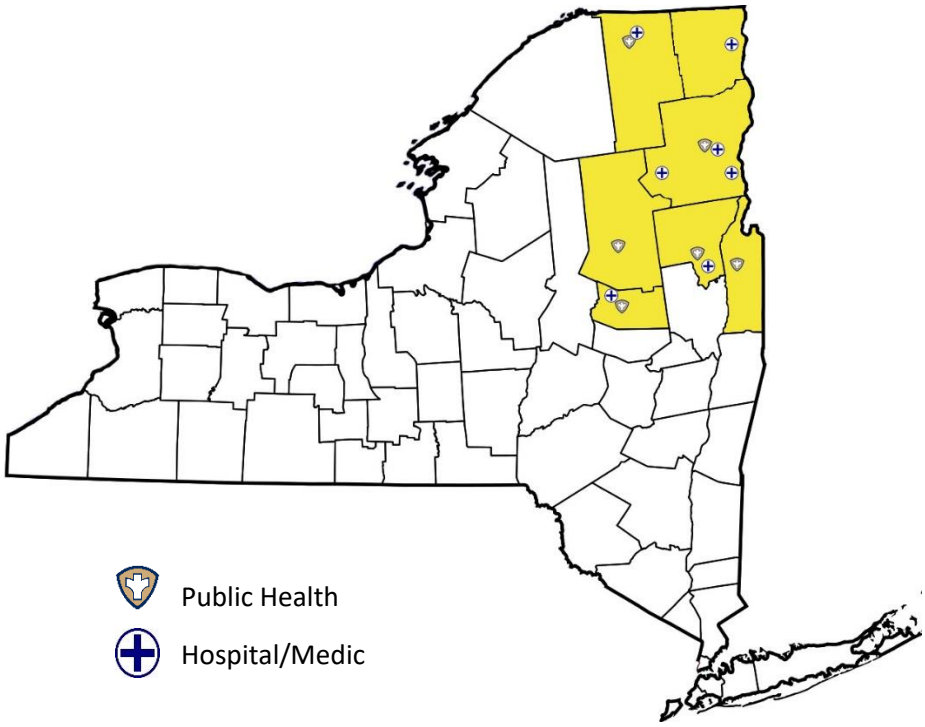
APPENDIX 1

# Summary of 2022 Community Stakeholder Survey




## Adirondack Rural Health Network Service Area

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

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

2022

**Background:**

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

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

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

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

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

**Survey Methodology:**

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

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

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

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

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

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

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

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

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

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

**Summary Analysis**

**1. Indicate your job title**

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

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

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

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

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

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

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

**3. Indicate County/Counties served**

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

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

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

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

**4. NYS Prevention Agenda Priority Areas**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***Health Concerns by County:***

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

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

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

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

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

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

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

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

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

***Contributing Factors by County:***

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

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

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

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

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

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

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

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

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

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

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

**10. New York State Prevention Agenda Goals**

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

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

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

***Top Three Goals by County:***

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

*Prevent Chronic Disease*

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

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

*Promote Healthy Women, Infants and Children*

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

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

*Promote a Healthy and Safe Environment*

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

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

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

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

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

*Prevent Communicable Diseases*

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

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

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

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

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

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

**Appendix A. 2022 Stakeholder Survey**

## *2022 CHA Stakeholders Survey*

### Introduction

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

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

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

### Your Organization/Agency

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

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

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

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

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

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

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

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

## Health Priorities, Concerns and Factors

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

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

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

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

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

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

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

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

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

## Social Determinants of Health

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

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

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

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

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

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

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

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

## Improving Health and Well-Being

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

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

**12. Prevent Chronic Diseases**

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

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

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

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

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

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

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

**16. Prevent Communicable Diseases**

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

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

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

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

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

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

Additional Details:

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

- ☐ Yes
- ☐ No

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

APPENDIX 2

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

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

N/A - Data not available

(1) 2010 Census Estimate; Census Quick Stats

(2) USDA Farm Overview; 2017

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

(4) Centers for Medicaid and Medicare Services; 2019

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

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

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

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

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

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

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

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

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

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

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

**Adirondack Rural Health Network**

**Summary of Education System Information**

**School Districts by County** [1]

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

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

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

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

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

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

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

# APPENDIX 3

**Essex County Revised: August 2022**

| | Number Per Year (If Available) | | | Essex County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | | Source | Updated | Notes |
| **Focus Area: Disparities** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of Overall Premature Deaths (before age 65 years), 2019 | | | | 19.3% | 22.1% | 21.0% | 22.7% | **22.8%** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2019 | | | | -19.2+ | N/A | 20.2 | 17.7 | **17.3** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2019 | | | | 30.8+ | N/A | 21.1 | 16.4 | **16.2** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2019 | | | | 67.0 | 142.52 | 120.4 | 125.9 | **115.0** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2019 | | | | -66.8+ | N/A | 128.4 | 115.8 | **94** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2019 | | | | -66.8+ | N/A | 1.0 | 34.6 | **23.9** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Adults (Ages 18 - 64) with Health Insurance, 2019 | | | | 94.4% | 93.6% | 94.00 | 92.5% | **97.0%** | Worse | X | | | | | | 0.03 | Prevention Agenda Dashboard | Feb-22 | Upstate NY calculated using county data. |
| Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2018 | | | | 82.2% | 82.3% | 82.0% | 79.1% | **86.7%** | Worse | X | | | | | | 0.05 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 2 | 0 | 0 | 0 | 25.0% | 0.0% | | | | |
| **Other Disparity Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Total Deaths per 100,000 Population, 2017-2019 | 429 | 407 | 487 | 1,179.8 | 1,069.7 | **916.2** | 798.8 | N/A | Worse | | X | | | | | 0.29 | Community Health Indicator Reports | Feb-22 | |
| Rate of Emergency Department Visits per 10,000 Population, 2017-2019 | 19,386 | 18,291 | 18,291 | 4,990.9 | 4,694.3 | **3,843.0** | 4,134.7 | N/A | Worse | | X | | | | | 0.30 | Community Health Indicator Reports | Feb-22 | |
| Rate of Total Hospitalizations per 10,000 Population, 2017-2019 | 2,897 | 2,359 | 2,499 | 691.5 | 981.2 | **1,144.2** | 1,154.8 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of Adults Who Did Not Receive Medical Care Due to Costs, 2018 | | | | 9.7% | 9.6% | **9.2%** | 11.0% | N/A | Worse | X | | | | | | 0.06 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Percentage of adults reporting 14 or more days of poor physical health, 2018 | | | | 16.8% | 13.0% | **11.1%** | 11.2% | N/A | Worse | | | X | | | | 0.51 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Percentage of adults living with a disability (based on 6 ACA disability questions), 2018 | | | | 33.0% | 29.2% | **24.6%** | 26.2% | N/A | Worse | | X | | | | | 0.34 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 1 | 3 | 1 | 0 | 83.3% | 20.0% | | | | |
| **Quartile Summary for Mortality** | | | | | | | | | | 3 | 3 | 1 | 0 | 50.0% | 14.3% | | | | |

N/A: Data does not meet reporting criteria

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

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

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

| | Number Per Year (If Available) | | | Comparison Regions/Data | | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | Essex County Average, Rate, Ratio or Percentage for the Listed Years | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | Source | Updated | Notes |
| **Focus Area: Injuries, Violence, and Occupational Health** | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | |
| Rate of Hospitalizations due to falls among adults per 10,000 population, aged 65+, 2019 | | | | 140.8 | 165.2 | 210.4 | 193.9 | **173.7** | Meets/Better | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Rate of Assault-Related Hospitalizations per 10,000 Population, 2019 | | | | 0* | 1.00 | 2.2 | 3.1 | **3.0** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Ratio of Rates of Assault-related hospitalizations between Black non-Hispanics and White non-Hispanics, 2019 | | | | N/A | N/A | 5.6 | 5.1 | **5.5** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Ratio of Rates of Assault-related hospitalizations, between Hispanics and White non-Hispanics, 2019 | | | | 0.00+ | N/A | 1.8 | 2.4 | **2.5** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Ratio of Rates of Assault-Related Hospitalizations for Low-Income ZIP codes and Non-Low Income Zip Codes, 2019 | | | | N/A | N/A | 3.0 | 2.8 | **2.7** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | |
| Falls hospitalization rate per 10,000 - Aged <10 years, 2017-2019 | | | | N/A | 5.5 | **6.2** | 6.8 | N/A | Less than 10 | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| Falls hospitalization rate per 10,000 - Aged 10-14 years, 2017-2019 | | | | N/A | 2.6* | **3.4** | 4.0 | N/A | Less than 10 | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not included due to unstable rate. |
| Falls hospitalization rate per 10,000 - Aged 15-24 years, 2017-2019 | | | | N/A | 2.9 | **4.0** | 4.4 | N/A | Less than 10 | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| Falls hospitalization rate per 10,000 - Aged 25-64 years, 2017-2019 | 33 | 21 | 26 | 13.4 | 18.5 | **19.7** | 18.8 | N/A | Meets/Better | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| Rate of Violent Crimes per 100,000 Population, 2020 | | | | 172.0 | 157.0 | **204.7** | 364.9 | N/A | Meets/Better | | | | | | | 0.00 Division of Criminal Justice Services Index, Property, and Firearm Rates | Oct-21 | |
| Rate of Property Crimes per 100,000 Population, 2020 | | | | 722.5 | 1,056.8 | **1,292.1** | 1,406.5 | N/A | Meets/Better | | | | | | | 0.00 Division of Criminal Justice Services Index, Property, and Firearm Rates | Oct-21 | |
| Rate of Total Crimes per 100,000 Population, 2020 | | | | 894.5 | 1,213.9 | **1,496.8** | 1,771.4 | N/A | Meets/Better | | | | | | | 0.00 Division of Criminal Justice Services Index, Property, and Firearm Rates | Oct-21 | |
| Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, 2016-2018 | | | | N/A | 1.2* | **1.4** | 1.1 | N/A | Less than 20 | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Pneumoconiosis Hospitalizations, Ages 15 and older, per 100,000 Population, 2017-2019 | | | | N/A | 9.4 | **9.0** | 6.6 | N/A | Less than 10 | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2017-2019 | | | | 0.0* | 0.8 | **0.8** | 5.7 | N/A | Less than 10 | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, 2017-2019 | 13 | 13 | 15 | 84.4 | 138.1 | **175.8** | 145.9 | N/A | Meets/Better | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| Rate of Total Motor Vehicle Crashes per 100,000, 2020 | | | | 2,382.7 | 2,298.7 | **2,157.0** | 1,693.1 | N/A | Worse | X | | | | | | 0.10 NYS Traffic Safety Statistical Repository | Feb-22 | |
| Rate of Speed-Related Accidents per 100,000 Population, 2020 | | | | 482.5 | 260.2 | **205.7** | 146.0 | N/A | Worse | | | | X | | | 1.35 NYS Traffic Safety Statistical Repository | Feb-22 | |
| Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2020 | | | | 13.6 | 7.2 | **6.6** | 5.3 | N/A | Worse | | | | X | | | 1.05 NYS Traffic Safety Statistical Repository | Feb-22 | |
| Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2017-2019 | 9 | 10 | 11 | 2.7 | 6.4 | **9.0** | 8.5 | N/A | Meets/Better | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019 | 127 | 123 | 152 | 154.6 | 210.3 | **275.1** | 249.9 | N/A | Meets/Better | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| Rate of Poisoning Hospitalizations per 10,000 Population, 2017-2019 | 10 | 10 | 11 | 2.8 | 6.7 | **7.6** | 8.0 | N/A | Meets/Better | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 1 | 0 | 0 | 2 | 17.6% | 66.7% | | | |
| **Quartile Summary for Focus Area Injuries, Violence, and Occupational Health** | | | | | | | | | | 1 | 0 | 0 | 2 | 13.6% | 66.7% | | | |

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

| | Number Per Year (If Available) | | | Essex County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | | Source | Updated | Notes |
| **Focus Area: Outdoor Air Quality** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Annual number of days with air quality index >100 (unhealthy levels of ozone or particulate matter), 2021 | | | | N/A | N/A | N/A | 20 | **3** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Focus Area Outdoor Air Quality** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Focus Area: Built Environment** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of population living in a certified Climate Smart Community, 2021 | | | | 0.0%* | 20 | 54.2% | 31.3% | **8.6%** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of people who commute to work using alternate modes of transportation or who telecommute, 2015-2019 | | | | 21.2% | 17.4% | 22.9% | 45.6% | **47.9%** | Worse | | | X | | | | 0.56 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015 | | | | 2.1% | 6.0% | **3.9%** | 2.2% | N/A | Meets/Better | | | | | | | 0.00 | USDA Food Environment Atlas | Dec-20 | |
| **Quartile Summary for Focus Area Built Environment** | | | | | | | | | | 0 | 0 | 1 | 0 | 33.3% | 100.0% | | | | |
| **Focus Area: Water Quality** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of residents served by community water systems that have optimally fluoridated water, 2019 | | | | 0.0%* | 26.8% | 46.9% | 71.1% | **77.5%** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Aug-21 | |
| **Quartile Summary for Focus Area Water Quality** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Quartile Summary for Focus Area Air Quality, Built Enviroment, Water Qaulity** | | | | | | | | | | 0 | 0 | 1 | 0 | 20.0% | 100.0% | | | | |

N/A: Data does not meet reporting criteria

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

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

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

| | Number Per Year (If Available) | | | Essex County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | | Source | Updated | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | | | | |
| **Focus Area: Reduce Obesity in Children and Adults** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of Adults Ages 18 Plus Who are Obese, 2018 | | | | 30.6% | 34% | 29.1% | 27.6% | **24.2%** | Worse | | X | | | | | 0.26 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 1 | 0 | 0 | 100.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of Total Students Overweight, 2018-2019 | | | | 15.3% | 17.5% | **16.9%** | N/A | N/A | Meets/Better | | | | | | | 0.00 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| Percentage of Elementary Students Overweight, Not Obese, 2018-2019 | | | | 15.3% | 17.2% | **16.1%** | N/A | N/A | Meets/Better | | | | | | | 0.00 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| Percentage of Elementary Student Obese, 2018-2019 | | | | 14.9% | 19.4% | **16.6%** | N/A | N/A | Meets/Better | | | | | | | 0.00 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| Percentage of Middle and High School Students Overweight, Not Obese, 2018-2019 | | | | 0.0% | 17.4% | **17.8%** | N/A | N/A | Meets/Better | | | | | | | 0.00 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| Percentage of Middle and High School Students Obese, 2018-2019 | | | | 32.9% | 25.3% | **19.5%** | N/A | N/A | Worse | | | X | | | | 0.69 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight |
| Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC, 2015-2017 | | | | 16.5% | 16.1% | **15.5%** | 13.8% | N/A | Worse | X | | | | | | 0.06 | Community Health Indicator Reports | Feb-22 | |
| Percentage of adults overweight or obese, 2018 | | | | 67.2% | 69.1% | **64.2%** | 62.7% | N/A | Worse | X | | | | | | 0.05 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Percentage of adults who participated in leisure time physical activity in the past 30 days, 2018 | | | | 73.7% | 73.3% | **77.6%** | 76.2% | N/A | Worse | X | | | | | | 0.05 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Number of Recreational and Fitness Facilities per 100,000 Population, 2016 | | | | 10.5 | 8.8 | **13.2** | 12.3 | N/A | Worse | X | | | | | | 0.20 | USDA Food Environment Atlas | Dec-20 | |
| Percentage of adults who had a test for high blood sugar or diabetes within the past three years, 2018 | | | | 47.7% | 49.1% | **48.6%** | 51.1% | N/A | Worse | X | | | | | | 0.02 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Rate of Cardiovascular Disease Deaths per 100,000 Population, 2017-2019 | 141 | 100 | 120 | 321.9 | 309.6 | **295.9** | 278.3 | N/A | Worse | X | | | | | | 0.09 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cardiovascular Premature Deaths ( Ages 35 - 64) per 100,000 Population, 2017-2019 | 20 | 15 | 18 | 114.0 | 123.3 | **102.4** | 104.2 | N/A | Worse | X | | | | | | 0.11 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cardiovascular Disease Pretransport Deaths per 100,000 Population, 2017-2019 | 92 | 58 | 66 | 192.6 | 184.7 | **179.5** | 163.6 | N/A | Worse | X | | | | | | 0.07 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cardiovascular Hospitalizations per 10,000 Population, 2017-2019 | 439 | 310 | 352 | 98.2 | 141.4 | **161.7** | 155.2 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Diseases of the Heart Deaths per 100,000 Population, 2017-2019 | 115 | 83 | 86 | 253.3 | 240.1 | **234.0** | 169.4 | N/A | Worse | X | | | | | | 0.08 | Community Health Indicator Reports | Feb-22 | |
| Rate of Diseases of the Heart Premature Deaths ( Ages 35 - 64) per 100,000 Population, 2017-2019 | 16 | 13 | 12 | 88.2 | 100.9 | **82.4** | 83.9 | N/A | Worse | X | | | | | | 0.07 | Community Health Indicator Reports | Feb-22 | |
| Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, 2017-2019 | 77 | 49 | 51 | 157.8 | 149.1 | **147.2** | 138.7 | N/A | Worse | X | | | | | | 0.07 | Community Health Indicator Reports | Feb-22 | |
| Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2017-2019 | 290 | 216 | 258 | 68.1 | 97.5 | **111.2** | 84.2 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Coronary Heart Diseases Deaths per 100,000 Population, 2017-2019 | 71 | 56 | 62 | 168.5 | 155.2 | **162.4** | 173.4 | N/A | Worse | X | | | | | | 0.04 | Community Health Indicator Reports | Feb-22 | |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019 | 12 | 10 | 9 | 66.7 | 69.6 | **59.7** | 66.4 | N/A | Worse | X | | | | | | 0.12 | Community Health Indicator Reports | Feb-22 | |
| Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, 2017-2019 | 46 | 39 | 37 | 108.8 | 100.8 | **106.6** | 112.4 | N/A | Worse | X | | | | | | 0.02 | Community Health Indicator Reports | Feb-22 | |
| Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2017-2019 | 83 | 52 | 59 | 17.3 | 29.1 | **32.9** | 31.5 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Congestive Heart Failure Deaths per 100,000, 2017-2019 | 12 | 3 | 4 | 16.9 | 19.1 | **22.3** | 15.1 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019 | 2 | 0 | 1 | 6.5* | 4.2* | **3.2** | 2.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, 2017-2019 | 9 | 2 | 3 | 12.5 | 12.2 | **13.7** | 8.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019 | 72 | 68 | 85 | 24.0 | 38.8 | **69.4** | 41.3 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, 2017-2019 | 10 | 10 | 24 | 39.2 | 41.5 | **38.2** | 31.5 | N/A | Worse | X | | | | | | 0.03 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2017-2019 | 78 | 44 | 59 | 16.1 | 23.7 | **28.2** | 26.6 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019 | | | | 1.4 | 2.7 | **5.9** | 7.3 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Diabetes Deaths per 100,000 Population, 2017-2019 | 10 | 15 | 22 | 41.9 | 33.0 | **22.5** | 22.5 | N/A | Worse | | | | X | | | 0.86 | Community Health Indicator Reports | Feb-22 | |
| Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2017-2019 | 34 | 47 | 38 | 10.6 | 18.9 | **18.9** | 21.4 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2017-2019 | 613 | 486 | 591 | 150.7 | 238.0 | **252.0** | 262.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 15 | 0 | 1 | 1 | 53.1% | 11.8% | | | | |
| **Quartile Summary for Focus Area Reduce Obesity in Children and Adults** | | | | | | | | | | 15 | 1 | 1 | 1 | 54.5% | 11.1% | | | | |

N/A: Data does not meet reporting criteria

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

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

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

| | Number Per Year (If Available) | | | Essex County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | | Source | Updated | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | | | | |
| **Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of Adults Ages 18 Plus Who Smoke, 2018 | | | | 16.4% | 19.5% | 13.9% | 12.8% | **11.0%** | Worse | | X | | | | | 0.49 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 1 | 0 | 0 | 100.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, 2017-2019 | 36 | 29 | 24 | 79.4 | 76.6 | **48.3** | 36.7 | N/A | Worse | | | X | | | | 0.64 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2017-2019 | 143 | 59 | 60 | 23.4 | 32.5 | **28.7** | 29.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Deaths per 100,000 Population, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.7* | **0.9** | 1.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Asthma Hospitalizations per 10,000 Population, 2017-2019 | | | | 0.9 | 3.1 | **6.2** | 9.8 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2017-2019 | | | | 0.0* | 2.4 | **4.2** | 5.0 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2017-2019 | | | | N/A | 2.9 | **5.2** | 8.8 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2017-2019 | | | | N/A | 3.9 | **4.9** | 9.3 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. |
| Percentage of adults with current asthma, 2018 | | | | 15.4% | 13.5% | **10.6%** | 10.1% | N/A | Worse | | X | | | | | 0.45 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, 2016-2018 | 32 | 19 | 24 | 66.7 | 65.0 | **48.1** | 39.6 | N/A | Worse | | X | | | | | 0.39 | Community Health Indicator Reports | Feb-22 | |
| Rate of Lung and Bronchus Cancer Cases per 100,000 Population, 2016-2018 | 41 | 40 | 33 | 101.4 | 119.0 | **87.6** | 72.6 | N/A | Worse | X | | | | | | 0.16 | Community Health Indicator Reports | Feb-22 | |
| Number of Registered Tobacco Vendors per 100,000 Population, 2016-2017 | | | | 166.3 | 132.7 | **104.4** | 110 | N/A | Worse | | | X | | | | 0.59 | NYS Department of Health Tobacco Enforcement Compliance Results | Oct-19 | Population is 5-year Census data 2015-2020 |
| Tobacco Sales to Minors Violations per 100,000 Population, 2016-2017 | | | | 10.7 | 4.0* | **4.0** | 6.6 | N/A | Worse | | | | X | | | 1.68 | NYS Department of Health Tobacco Enforcement Compliance Results | Oct-19 | Population is 5-year Census data 2015-2020<br>ARHN calculation not included due to unstable rate. |
| Percentage of Vendors with Complaints per 100,000 Population, 2016-2017 | | | | 0.0 | 0.0* | **0.0*** | 1.1 | N/A | Meets/Better | | | | | | | 0.00 | NYS Department of Health Tobacco Enforcement Compliance Results | Oct-19 | Population is 5-year Census data 2015-2020<br>ARHN calculation not included due to unstable rate. |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 1 | 2 | 2 | 1 | 46.2% | 50.0% | | | | |
| **Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure** | | | | | | | | | | 1 | 3 | 2 | 1 | 50.0% | 42.9% | | | | |

N/A: Data does not meet reporting criteria

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

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

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

| | Number Per Year (If Available) | | | Essex County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | | Source | Updated | Notes |
| **Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Asthma emergency department visits, rate per 10,000, aged 0-17 years, 2019 | | | | 55.7 | 42.3 | 57.5 | 99.9 | **131.1** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Asthma emergency department visit rate per 10,000 - aged 18-64 years, 2017-2019 | | | | 32.7 | 41.4 | **39.0** | 63.3 | N/A | Meets/Better | | | | | | | 0.00 | Asthma Summary Report | Feb-22 | |
| Asthma emergency department visit rate per 10,000 - aged 65+ years, 2017-2019 | | | | 20.0 | 16.0 | **14.8** | 28.2 | N/A | Worse | | X | | | | | 0.35 | Asthma Dashboard-County Level | Feb-22 | |
| Rate of All Cancer Cases per 100,000 Population, 2016-2018 | 260 | 275 | 235 | 684.8 | 710.8 | **657.0** | 587.7 | N/A | Worse | X | | | | | | 0.04 | Community Health Indicator Reports | Feb-22 | |
| Rate of all Cancer Deaths per 100,000 Population, 2016-2018 | 115 | 92 | 86 | 260.6 | 232.6 | **194.7** | 175.5 | N/A | Worse | | X | | | | | 0.34 | Community Health Indicator Reports | Feb-22 | |
| Rate of Female Breast Cancer Cases per 100,000 Female Population, 2016-2018 | 38 | 33 | 21 | 169.3 | 176.3 | **180.1** | 164.6 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, 2016-2018 | 13 | 9 | 9 | 57.1 | 48.6 | **50.9** | 49.3 | N/A | Worse | X | | | | | | 0.12 | Community Health Indicator Reports | Feb-22 | |
| Rate of Female Breast Cancer Deaths per 100,000 Female Population, 2016-2018 | | | | 29.4* | 24.9 | **26.3** | 25.1 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines, 2018 | | | | 76.7% | 80.4% | **80.9%** | 82.1% | N/A | Worse | X | | | | | | 0.05 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Rate of Cervix Uteri Cancer Incidence per 100,000, 2016-2018 | | | | 11.0* | 8.9 | **7.1** | 8.3 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cervix and Uteri Cancer Deaths per 100,000 Female Population, 2016-2018 | | | | N/A | 6.2* | **2.2** | 2.5 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not included due to unstable rate. |
| Percentage of women aged 21-65 years receiving cervical cancer screening based on recent guidelines, 2018 | | | | 83.2% | 87.2% | **86.1%** | 84.7% | N/A | Worse | X | | | | | | 0.03 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Rate of Ovarian Cancer Cases per 100,000 Female Population, 2016-2018 | | | | 12.9* | 14.8 | **15.2** | 14.2 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Ovarian Cancer Deaths per 100,000 Female Population, 2016-2018 | | | | 11.0* | 8.8 | **9.3** | 8.7 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. |
| Rate of Colon and Rectal Cancer incidence per 100,000 Population, 2016-2018 | 20 | 23 | 23 | 58.7 | 54.2 | **48.8** | 45.7 | N/A | Worse | X | | | | | | 0.20 | Community Health Indicator Reports | Feb-22 | |
| Rate of Colon and Rectal Cancer Deaths per 100,000 Population, 2016-2018 | 13 | 8 | 7 | 24.9 | 19.8 | **15.7** | 15.1 | N/A | Worse | | | X | | | | 0.58 | Community Health Indicator Reports | Feb-22 | |
| Rate of Prostate Cancer Deaths per 100,000 Male Population, 2016-2018 | | | | 25.8* | 22.1 | **18.9** | 18.5 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Prostate Cancer Incidence per 100,000 Male Population, 2016-2018 | 26 | 35 | 33 | 161.8 | 166.2 | **174.9** | 158.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, 2016-2018 | | | | 31.0* | 38.3 | **33.3** | 30.5 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Melanoma Cancer Deaths per 100,000 Population, 2016-2018 | | | | 5.3* | 3.6 | **2.7** | 2.1 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, 2018-2020 | 2,499 | 2,398 | 1,816 | 25.5% | 26.0% | **27.7%** | 26.9% | N/A | Worse | X | | | | | | 0.08 | Community Health Indicator Reports | Feb-22 | |
| Percentage of adults who had a dentist visit within the past year, 2018 | | | | 69.3% | 63.8% | **71.6%** | 69.8% | N/A | Worse | X | | | | | | 0.03 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, 2016-2018 | | | | 0.0* | 5.0* | **4.7** | 4.6 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available.<br>ARHN calculation not included due to unstable rate. |
| Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, 2016-2018 | 6 | 6 | 6 | 16.0* | 17.4 | **16.3** | 14.1 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 7 | 2 | 1 | 0 | 43.5% | 10.0% | | | | |
| **Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management** | | | | | | | | | | 7 | 2 | 1 | 0 | 41.7% | 10.0% | | | | |

N/A: Data does not meet reporting criteria

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

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

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

| | Number Per Year (If Available) | | | Essex County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | | Source | Updated | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | | | | |
| **Focus Area: Maternal and Infant Health** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of births that are preterm, 2019 | | | | 9.6% | 9.4% | 9.3% | 9.2% | **8.3%** | Worse | X | | | | | | 0.16 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Black, non-hispanic births that are pre-term, 2019 | | | | N/A | N/A | N/A | 13.2% | **8.30** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Hispanic births that are pre-term, 2019 | | | | N/A | N/A | N/A | 10.1% | **8.30** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of births that are pre-term on Medicaid, 2019 | | | | N/A | N/A | N/A | 9.6% | **8.30** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Rate of Maternal Mortality per 100,000 Births, 2017-2019 | | | | 0.0* | 0.0*% | 18.8 | 19.3 | **16.0** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | ARHN calculation not included due to unstable rate |
| Percentage of infants who are exclusively breastfed in the hospital among all infants, 2019 | | | | 76.5% | 65.8% | 49.6% | 47.1% | **51.7%** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Black, non-hispanic infants who are exclusively breastfed in delivery hospital, 2019 | | | | N/A | N/A | N/A | 34.9% | **51.7** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Hispanic infants who are exclusively breastfed in delivery hospital, 2019 | | | | N/A | N/A | N/A | 35.7% | **51.7** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Infants Exclusively Breastfed in Delivery Hospital on Medicaid Insurance, 2019 | | | | N/A | N/A | N/A | 34.9% | **51.7** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 1 | 0 | 0 | 0 | 11.1% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage Preterm Births < 32 weeks of Total Births, 2017-2019 | 4 | 7 | 4 | 1.7% | 1.3% | **1.5%** | 1.5% | N/A | Worse | X | | | | | | 0.16 | Community Health Indicator Reports | Oct-21 | |
| Percentage Preterm Births 32 to < 37 Weeks of Total Births, 2017-2019 | 17 | 21 | 26 | 7.1% | 7.8% | **7.6%** | 7.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| Percentage of very low birthweight Less Than 1,500 grams, 2017-2019 | 3 | 5 | 2 | 1.1% | 1.1% | **1.3%** | 1.4% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| Percentage of Singleton Births with Weights Less Than 1,500 grams, 2017-2019 | 2 | 5 | 2 | 1%* | 0.9% | **1.0%** | 1.0% | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| Percentage of Total Births with Weights Less Than 2,500 grams, 2017-2019 | 26 | 26 | 25 | 8.5% | 7.7% | **7.7%** | 8.1% | N/A | Worse | X | | | | | | 0.10 | Community Health Indicator Reports | Oct-21 | |
| Percentage of Singleton Births with weight less than 2,500 grams, 2017-2019 | 21 | 21 | 19 | 7.0% | 6.0% | **5.9%** | 6.3% | N/A | Worse | X | | | | | | 0.18 | Community Health Indicator Reports | Oct-21 | |
| Percentage of low birthweight births (< 2.5 kg) for Black, Non-Hispanic, 2016-2018 | | | | N/A | N/A | **13.2%** | 12.6% | N/A | Less than 10 | | | | | | | 0.00 | State and County Indicators for Tracking Public Health Priority Areas | Jul-21 | |
| Percentage of low birthweight births (< 2.5 kg) for Hispanic/Latino, 2016-2018 | | | | N/A | N/A | **7.9%** | 8.1% | N/A | Less than 10 | | | | | | | 0.00 | State and County Indicators for Tracking Public Health Priority Areas | Jul-21 | |
| Infant Mortality Rate per 1,000 Live Births- Infant (<1 year), 2017-2019 | 0 | 1 | 0 | 1.1* | 5.1 | **4.8** | 4.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, 2017-2019 | 0 | 1 | 0 | 1.0* | 4.9 | **5.1** | 5.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of births with early (1st trimester) prenatal care, 2017-2019 | 194 | 244 | 231 | 74.5% | 77.8% | **78.4%** | 76.3% | N/A | Worse | X | | | | | | 0.05 | Community Health Indicator Reports | Oct-21 | |
| Percentage of births with adequate prenatal care (APNCU) for Black, Non-Hispanic, 2016-2018 | | | | N/A | N/A | **68.4%** | 66.1% | N/A | Less than 10 | | | | | | | 0.00 | State and County Indicators for Tracking Public Health Priority Areas | Jul-21 | |
| Percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino, 2016-2018 | | | | N/A | N/A | **70.9%** | 71.1% | N/A | Less than 10 | | | | | | | 0.00 | State and County Indicators for Tracking Public Health Priority Areas | Jul-21 | |
| Percentage of births with a 5 minute APGAR <6, 2017-2019 | 1 | 4 | 5 | 1.1% | 1.4% | **0.8%** | 0.7% | N/A | Worse | | X | | | | | 0.32 | Community Health Indicator Reports | Oct-21 | |
| Percentage WIC Women Breastfeeding for at least 6 months, 2015-2017 | | | | 27.9% | 24.6% | **30.6%** | 41.0% | N/A | Worse | X | | | | | | 0.09 | Community Health Indicator Reports | Jun-18 | |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage Infants Fed Any Breast Milk in Delivery Hospital, 2017-2019 | 186 | 168 | 175 | 84.6% | 79.8% | **84.2%** | 88.5% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 5 | 1 | 0 | 0 | 37.5% | 0.0% | | | | |
| **Quartile Summary for Focus Area Maternal and Infant Health** | | | | | | | | | | 6 | 1 | 0 | 0 | 28.0% | 0.0% | | | | |
| **Focus Area: Preconception and Reproductive Health** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of Women Ages 18- 64 with Health Insurance, 2019 | | | | N/A | N/A | N/A | 94.0% | **97.0%** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Jul-21 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Total Births per 1,000 Females Ages 15-44, 2017-2019 | 283 | 308 | 314 | 54.6 | 53.1 | **57.1** | 57.5 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percent Multiple Births of Total Births, 2017-2019 | 10 | 10 | 10 | 3.3% | 3.4% | **3.7%** | 3.5% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| Percent C-Sections to Total Births, 2017-2019 | 83 | 97 | 104 | 31.4% | 32.2% | **34.2%** | 33.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| Rate of Total Pregnancies per 1,000 Females Ages 15-44, 2017-2019 | 362 | 364 | 371 | 60.3 | 64.0 | **72.3** | 79.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.1* | **0.1** | 0.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, 2017-2019 | 3 | 2 | 0 | 3.0* | 5.7 | **4.7** | 4.9 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019 | 13 | 12 | 5 | 29.1 | 30.2 | **20.1** | 21.5 | N/A | Worse | | X | | | | | 0.45 | Community Health Indicator Reports | Feb-22 | |
| Rate of Teen pregnancy per 1,000 females aged <18 years, 2017-2019 | 3 | 2 | 0 | 1.1* | 3.7 | **3.7** | 4.7 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019 | 21 | 14 | 8 | 38.4 | 42.4 | **32.8** | 41.1 | N/A | Worse | X | | | | | | 0.17 | Community Health Indicator Reports | Feb-22 | |
| Percent Total Births to Women Ages 35 Plus, 2017-2019 | 45 | 53 | 56 | 17.0% | 13.9% | **22.3%** | 24.5% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Ratio+ of Abortions All Ages per 1000 Live Births to All Mothers, 2017-2019 | 38 | 27 | 19 | 85.5 | N/A | N/A | **333.1** | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of WIC Women Pre-pregnancy Underweight (BMI less than 18.5), 2015-2017 | 6 | 10 | 6 | 4.3% | 4.7% | **3.9%** | 4.6% | N/A | Worse | X | | | | | | 0.10 | Community Health Indicator Reports | Feb-22 | |
| Percentage of WIC Women Pre-pregnancy Overweight but not Obese (BMI 25 >30), 2015-2017 | 37 | 37 | 33 | 20.9% | 23.1% | **27.1%** | 27.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of WIC Women Pre-pregnancy Obese (BMI > 30),2015-2017 | 65 | 47 | 76 | 36.6% | 35.8% | **31.1%** | 26.6% | N/A | Worse | X | | | | | | 0.18 | Community Health Indicator Reports | Feb-22 | |
| Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, 2015-2019 | 86 | 71 | 88 | 52.1% | 51.9% | **45.7%** | 41.0% | N/A | Worse | X | | | | | | 0.14 | Community Health Indicator Reports | Feb-22 | |
| Percentage of WIC Women with Gestational Diabetes, 2015-2017 | 15 | 8 | 16 | 8.1% | 8.2% | **6.6%** | 6.6% | N/A | Worse | X | | | | | | 0.22 | Community Health Indicator Reports | Feb-22 | |
| Percentage of WIC Women with Gestational Hypertension, 2015-2017 | 29 | 23 | 22 | 15.4% | 13.1% | **9.0%** | 7.5% | N/A | Worse | | | X | | | | 0.72 | Community Health Indicator Reports | Feb-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 5 | 1 | 1 | 0 | 41.2% | 14.3% | | | | |
| **Quartile Summary for Focus Area Preconception and Reproductive Health** | | | | | | | | | | 5 | 1 | 1 | 0 | 38.9% | 14.3% | | | | |
| **Focus Area: Child Health** | | | | | | | | | | | | | | | | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of children with recommended number of well child visits in government sponsored insurance programs, 2019 | | | | 69.1% | 74.1% | **73.3%** | 75.2% | N/A | Worse | X | | | | | | 0.00 | Community Health Indicator Reports | Nov-21 | |
| Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, 2017-2019 | 1 | 0 | 0 | 28.3* | 25.1* | **18.9** | 17.7 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, 2017-2019 | 0 | 1 | 0 | 17.3* | 32.5 | **31.3** | 30.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019 | | | | N/A | 10.8 | **24.9** | 35.6 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2017-2019 | | | | 0.0* | 3.4 | **9.4** | 16.6 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2017-2019 | | | | N/A | 4.9 | **12.4** | 20.3 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019 | | | | 0.0* | 4.3 | **7.5** | 10.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019 | | | | 0.0* | 1.6* | **1.5** | 1.8 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019 | | | | N/A | 18.3 | **20.3** | 25.2 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016 | | | | 60.4* | 65.5 | **105.9** | 186.4 | N/A | Less than 10 | | | | | | | 0.00 | Asthma Dashboard-County Level | Feb-22 | |
| Percentage of Children born in 2016 Screened for Lead by Age 0-8 months, 2016 | | | | .8%* | 2.4% | **1.2%** | 1.7% | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Sep-21 | |
| Percentage of Children Born in 2016 Screened for Lead by Age 9-17 months, 2016 | | | | 83.0% | 81.7% | **73.0%** | 75.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Sep-21 | |
| Percentage of Children Born 2016 Screened for Lead by Age 36 months (at least two screenings), 2016 | | | | 61.9% | 63.7% | **57.8%** | 63.3% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Sep-21 | |
| Rate of Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) Per 1,000 tested children aged <72 months, 2017-2019 | 3 | 3 | 0 | 4.4* | 8.5 | **6.6** | 3.8 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2017-2019 | | | | 8.5* | 12.9 | **17.7** | 18.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2017-2019 | | | | N/A | 8.9 | **12.7** | 13.2 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2017-2019 | | | | 8.6 | 17.7 | **23.1** | 22.6 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016 | | | | 55.7 | 51.3 | **68.1** | 137.1 | N/A | Meets/Better | | | | | | | 0.00 | Asthma Summary Report | Feb-22 | |
| Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, 2018-2020 | 1,437 | 1,409 | 1,212 | 48.3% | 49.3% | **47.9%** | 46.9% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Sep-21 | |
| Percentage of 3rd Graders with Dental Caries Experience, 2009-2011 | | | | 50.4% | N/A | N/A | N/A | N/A | No comparison data available | | | | | | | 0.00 | Community Health Indicator Reports | Aug-12 | |
| Percentage of 3rd Graders with Dental Sealants, 2009-2011 | | | | 34.5% | N/A | N/A | N/A | N/A | No comparison data available | | | | | | | 0.00 | Community Health Indicator Reports | Aug-12 | |
| Percentage of 3rd Graders with Dental Insurance, 2009-2011 | | | | 86.6% | 85.2% | N/A | N/A | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Aug-12 | |
| Percentage of 3rd Graders with at Least One Dental Visit, 2009-2011 | | | | 76.8% | **81.0%** | N/A | N/A | N/A | Worse | X | | | | | | 0.05 | Community Health Indicator Reports | Aug-12 | |
| Percentage of 3rd Graders Taking Fluoride Tablets Regularly, 2009-2011 | | | | 85.4% | N/A | N/A | N/A | N/A | No comparison data available | | | | | | | 0.00 | Community Health Indicator Reports | Aug-12 | |
| Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2017-2019 | 10 | 31 | 20 | 221.3 | 228.2 | **146.7** | 146.4 | N/A | Worse | | | X | | | | 0.51 | Community Health Indicator Reports | Nov-21 | |
| Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, 2015-2017 | | | | 88.4% | 85.4% | **84.9%** | 86.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Jun-18 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 2 | 0 | 1 | 0 | 11.5% | 33.3% | | | | |
| **Quartile Summary for Focus Area Child Health** | | | | | | | | | | 2 | 0 | 1 | 0 | 11.5% | 33.3% | | | | |

N/A: Data does not meet reporting criteria

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

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

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

| | Number Per Year (If Available) | | | Comparison Regions/Data | | | | | Quartile Ranking | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | Essex County Average, Rate, Ratio or Percentage for the Listed Years | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | Comparison to Benchmark | Q1 | Q2 | Q3 | Q4 | Quartile Score | Severity Score | | Source | Updated | Notes |
| **Focus Area: Human Immunodeficiency Virus (HIV)** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2017-2019 | | | | N/A | 4.3* | 5.7 | 13.1 | **5.2** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | ARHN calculation not included due to unstable rate |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| AIDS Deaths per 100,000, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.4* | **0.9** | 2.2 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Focus Area: Sexually Transmitted Disease (STDs)** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Early syphilis diagnoses, age-adjusted rate per 100,000 population, 2019 | | | | 0.0* | 3.71* | 15.3 | 38.6 | **79.6** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | ARHN calculation not included due to unstable rate |
| Gonorrhea diagnoses, age-adjusted rate per 100,000 population, 2019 | | | | 39.5 | 33.40 | 114.9 | 217 | **242.6** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Chlamydia diagnoses, age-adjusted rate per 100,000 population, 2019 | | | | 219.1 | 244.33 | 457.5 | 667.9 | **676.9** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Gonorrhea case rate per 100,000 males - Aged 15-44 years, 2017-2019 | 2 | 6 | 4 | 57.7 | 54.45 | **267.8** | 614.9 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Gonorrhea case rate per 100,000 females - Aged 15-44 years, 2017-2019 | | | | N/A | 88.72 | **218.3** | 252.5 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Gonorrhea case rate per 100,000 - Aged 15-19 years, 2017-2019 | 1 | 0 | 0 | 17.3* | 73.15 | **246.4** | 401.5 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | 10 |
| Rate of Chlamydia Cases All Males Aged 15-44 years per 100,000 Male Population, 2017-2019 | | | | N/A | 406.45 | **41.2** | 1,175.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, 2017-2019 | 2 | 8 | 5 | 485.4 | 466.03 | **766.4** | 1,142.6 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, 2017-2019 | | | | N/A | 945.09 | **1,513.3** | 2,107.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases All Females Aged 15-44 years per 100,000 Female Population, 2017-2019 | | | | N/A | 1118.40 | **1,455.2** | 1,741.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population, 2017-2019 | | | | N/A | 2006.20 | **2,623.6** | 3,535.7 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population, 2017-2019 | | | | N/A | 2740.07 | **3,203.9** | 3,912.5 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population, 2017-2019 | | | | 0.0* | 0.95* | **1.9** | 2.5 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Quartile Summary for Sexually Transmitted Diseases** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Focus Area: Vaccine Preventable Disease** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series, 2020 | | | | 62.4% | 68.2% | 66.3% | 66.1% | **70.5%** | Worse | X | | | | | | 0.13 | Prevention Agenda Dashboard | Oct-21 | Age range adjusted to 24-35 months |

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of 13-year-old adolescents with a complete HPV vaccine series, 2020 | | | | 17.7% | 25.8% | 32.8% | 39.8% | **37.4%** | Worse | | | | X | | | 1.11 | Prevention Agenda Dashboard | Oct-21 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 1 | 0 | 0 | 1 | 100.0% | 50.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Pertussis Cases per 100,000 Population, 2017-2019 | 3 | 17 | 1 | 18.7 | 12.3 | **5.0** | 3.8 | N/A | Worse | | | | X | | | 2.74 | Community Health Indicator Reports | Feb-22 | |
| Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019 | 82 | 77 | 64 | 85.7 | 87.7 | **95.2** | 85.5 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of adults aged 65+ years with pneumococcal immunization, 2018 | | | | 70.8% | 70.0% | **69.4%** | 64.0% | N/A | Meets/Better | | | | | | | 0.00 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Rate of Mumps Cases per 100,000 Population, 2017-2019 | 3 | 0 | 1 | 3.6* | 1.4* | **1.3** | 1.7 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Meningococcal Cases per 100,000 Population, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.0* | **0.1** | 0.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of H Influenza Cases per 100,000 Population, 2017-2019 | 0 | 0 | 1 | 0.9* | 2.1 | **2.3** | 2.0 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 0 | 0 | 0 | 1 | 16.7% | 100.0% | | | | |
| **Quartile Summary for Focus Area Vaccine Preventable Diseases** | | | | | | | | | | 1 | 0 | 0 | 2 | 37.5% | 66.7% | | | | |
| **Focus Area: Healthcare Associated Infections** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days (Risk-adjusted), 2019 | | | | N/A | N/A | N/A | **4.0** | N/A | Worse | #VALUE! | #VALUE! | #VALUE! | #VALUE! | | | #VALUE! | NYS Department of Health Hospital Report on Hospital Acquired Infections | May-21 | CDI Hospital Onset; No data for Essex County; Elizabethtown Hospital |
| Rate of Community Onset, Healthcare Facility Associated CDIs per 100 Admissions, not risk-adjusted, 2019 | | | | N/A | N/A | N/A | **0.2** | N/A | Worse | #VALUE! | #VALUE! | #VALUE! | #VALUE! | | | #VALUE! | NYS Department of Health Hospital Report on Hospital Acquired Infections | May-21 | CDI Community Onset Not-My-Hospita; No data for Essex County; Elizabethtown Hospital |
| **Quartile Summary for Healthcare Associated Infections** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |

N/A: Data does not meet reporting criteria

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

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

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

| | Number Per Year (If Available) | | | Essex County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | | Source | Updated | Notes |
| **Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2018 | | | | 13.2% | 16.6% | 18.4% | 17.5% | **16.4%** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Age Adjusted Rate of Suicides per 100,000 Adjusted Population, 2017-2019 | | | | 8.1 | N/A | 9.9 | 8.2 | **7.0** | Worse | X | | | | | | 0.16 | Prevention Agenda Dashboard | Feb-22 | Not enough information to calculate ARHN region rate. |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 1 | 0 | 0 | 0 | 50.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, 2017-2019 | 0 | 0 | 0 | 0.0* | 8.1* | **7.3** | 6.0 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Self-inflicted injury Hospitalizations 10,000 Population, 2017-2019 | 11 | 13 | 7 | 2.8 | 6.1 | **4.4** | 3.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Self-inflicted injury Hospitalizations for Ages 15 - 19 per 10,000 Population, 2017-2019 | | | | 15.6* | 17.0 | **10.3** | 9.0 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cirrhosis Deaths per 100,000 Population, 2017-2019 | 9 | 2 | 10 | 18.7 | 15.3 | **10.1** | 8.4 | N/A | Worse | | | | X | | | 0.84 | Community Health Indicator Reports | Feb-22 | |
| Rate of Alcohol-Related Crashes per 100,000, 2020 | | | | 100.3 | 66.4 | **52.0** | 40.1 | N/A | Worse | | | | X | | | 0.93 | NYS Traffic Safety Statistical Repository | Jan-22 | |
| Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2020 | | | | 46.1 | 28.7 | **28.8** | 23.3 | N/A | Worse | | | X | | | | 0.60 | NYS Traffic Safety Statistical Repository | Jan-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 0 | 0 | 1 | 2 | 50.0% | 100.0% | | | | |
| **Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders** | | | | | | | | | | 1 | 0 | 1 | 2 | 50.0% | 75.0% | | | | |

N/A: Data does not meet reporting criteria

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

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

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

| | Number Per Year (If Available) | | | Essex County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | | Source | Updated | Notes |
| **Other Non-Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Hepatitis A Cases per 100,000 Population, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.4* | **1.4** | 1.3 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Acute Hepatitis B Cases per 100,000 Population, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.3* | **0.4** | 0.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of TB Cases per 100,000 Population, 2017-2019 | 0 | 0 | 1 | 0.9* | 0.6* | **1.7** | 3.9 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of E. Coli Shiga Toxin Cases per 100,000 Population, 2017-2019 | 1 | 2 | 0 | 2.7* | 3.0 | **3.1** | 4.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Salmonella Cases per 100,000 Population, 2017-2019 | 6 | 4 | 2 | 10.7 | 11.1 | **12.9** | 14.0 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Shigella Cases per 100,000 Population, 2017-2019 | 1 | 0 | 1 | 1.8* | 0.5* | **3.4** | 6.3 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Lyme Disease Cases per 100,000 Population, 2017-2019 | 121 | 37 | 107 | 236.3 | 118.1 | **70.7** | 44.7 | N/A | Worse | | | | X | | | 1.00 | Community Health Indicator Reports | Feb-22 | Upstate NY rate calculated using county data. |
| Rate of Confirmed Rabies Cases per 100,000 Population, 2020 | | | | 5.4 | 3.4* | **3.1** | 1.8 | N/A | Worse | | | X | | | | 0.73 | Department of Health, Wadsworth Center | Dec-20 | Used 2020 Profile Population data (U.S. Census Bureau) ARHN calculation not included due to unstable rate |
| **Quartile Summary for Non-Prevention Agenda Issues** | | | | | | | | | | 0 | 0 | 1 | 1 | 25.0% | 100.0% | | | | |

N/A: Data does not meet reporting criteria

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

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

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

**Essex County Revised: August 2022**

| | Number Per Year (If Available) | | | Essex County Average, Rate, Ratio or Percentage for the Listed Years | Comparison Regions/Data | | | | Comparison to Benchmark | Quartile Ranking | | | | Quartile Score | Severity Score | Source | Updated | Notes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | One | Two | Three | | ARHN[1] | Upstate NY | New York State | 2024 Prevention Agenda Benchmark | | Q1 | Q2 | Q3 | Q4 | | | | | |
| **Focus Area: Disparities** | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | |
| Percentage of Overall Premature Deaths (before age 65 years), 2019 | | | | 19.3% | 22.1% | 21.0% | 22.7% | **22.8%** | Meets/Better | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2019 | | | | -19.2+ | N/A | 20.2 | 17.7 | **17.3** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2019 | | | | 30.8+ | N/A | 21.1 | 16.4 | **16.2** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2019 | | | | 67.0 | 142.52 | 120.4 | 125.9 | **115.0** | Meets/Better | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2019 | | | | -66.8+ | N/A | 128.4 | 115.8 | **94** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2019 | | | | -66.8+ | N/A | 1.0 | 34.6 | **23.9** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Adults (Ages 18 - 64) with Health Insurance, 2019 | | | | 94.4% | 93.6% | 94.00 | 92.5% | **97.0%** | Worse | X | | | | | | 0.03 Prevention Agenda Dashboard | Feb-22 | Upstate NY calculated using county data. |
| Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2018 | | | | 82.2% | 82.3% | 82.0% | 79.1% | **86.7%** | Worse | X | | | | | | 0.05 Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 2 | 0 | 0 | 0 | 25.0% | 0.0% | | | |
| **Other Disparity Indicators** | | | | | | | | | | | | | | | | | | |
| Rate of Total Deaths per 100,000 Population, 2017-2019 | 429 | 407 | 487 | 1,179.8 | 1,069.7 | **916.2** | 798.8 | N/A | Worse | | X | | | | | 0.29 Community Health Indicator Reports | Feb-22 | |
| Rate of Emergency Department Visits per 10,000 Population, 2017-2019 | 19,386 | 18,291 | 18,291 | 4,990.9 | 4,694.3 | **3,843.0** | 4,134.7 | N/A | Worse | | X | | | | | 0.30 Community Health Indicator Reports | Feb-22 | |
| Rate of Total Hospitalizations per 10,000 Population, 2017-2019 | 2,897 | 2,359 | 2,499 | 691.5 | 981.2 | **1,144.2** | 1,154.8 | N/A | Meets/Better | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |
| Percentage of Adults Who Did Not Receive Medical Care Due to Costs, 2018 | | | | 9.7% | 9.6% | **9.2%** | 11.0% | N/A | Worse | X | | | | | | 0.06 NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Percentage of adults reporting 14 or more days of poor physical health, 2018 | | | | 16.8% | 13.0% | **11.1%** | 11.2% | N/A | Worse | | | X | | | | 0.51 NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Percentage of adults living with a disability (based on 6 ACA disability questions), 2018 | | | | 33.0% | 29.2% | **24.6%** | 26.2% | N/A | Worse | | X | | | | | 0.34 NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 1 | 3 | 1 | 0 | 83.3% | 20.0% | | | |
| **Quartile Summary for Mortality** | | | | | | | | | | 3 | 3 | 1 | 0 | 50.0% | 14.3% | | | |
| **Focus Area: Injuries, Violence, and Occupational Health** | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | |
| Rate of Hospitalizations due to falls among adults per 10,000 population, aged 65+, 2019 | | | | 140.8 | 165.2 | 210.4 | 193.9 | **173.7** | Meets/Better | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Rate of Assault-Related Hospitalizations per 10,000 Population, 2019 | | | | 0* | 1.00 | 2.2 | 3.1 | **3.0** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Ratio of Rates of Assault-related hospitalizations between Black non-Hispanics and White non-Hispanics, 2019 | | | | N/A | N/A | 5.6 | 5.1 | **5.5** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Ratio of Rates of Assault-related hospitalizations, between Hispanics and White non-Hispanics, 2019 | | | | 0.00+ | N/A | 1.8 | 2.4 | **2.5** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| Ratio of Rates of Assault-Related Hospitalizations for Low-Income ZIP codes and Non-Low Income Zip Codes, 2019 | | | | N/A | N/A | 3.0 | 2.8 | **2.7** | Less than 10 | | | | | | | 0.00 Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | |
| Falls hospitalization rate per 10,000 - Aged <10 years, 2017-2019 | | | | N/A | 5.5 | **6.2** | 6.8 | N/A | Less than 10 | | | | | | | 0.00 Community Health Indicator Reports | Feb-22 | |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Falls hospitalization rate per 10,000 - Aged 10-14 years, 2017-2019 | | | | N/A | 2.6* | **3.4** | 4.0 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not |
| Falls hospitalization rate per 10,000 - Aged 15-24 years, 2017-2019 | | | | N/A | 2.9 | **4.0** | 4.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Falls hospitalization rate per 10,000 - Aged 25-64 years, 2017-2019 | 33 | 21 | 26 | 13.4 | 18.5 | **19.7** | 18.8 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Violent Crimes per 100,000 Population, 2020 | | | | 172.0 | 157.0 | **204.7** | 364.9 | N/A | Meets/Better | | | | | | | 0.00 | Division of Criminal Justice Services Index, Property, and Firearm Rates | Oct-21 | |
| Rate of Property Crimes per 100,000 Population, 2020 | | | | 722.5 | 1,056.8 | **1,292.1** | 1,406.5 | N/A | Meets/Better | | | | | | | 0.00 | Division of Criminal Justice Services Index, Property, and Firearm Rates | Oct-21 | |
| Rate of Total Crimes per 100,000 Population, 2020 | | | | 894.5 | 1,213.9 | **1,496.8** | 1,771.4 | N/A | Meets/Better | | | | | | | 0.00 | Division of Criminal Justice Services Index, Property, and Firearm Rates | Oct-21 | |
| Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, 2016-2018 | | | | N/A | 1.2* | **1.4** | 1.1 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Pneumoconiosis Hospitalizations, Ages 15 and older, per 100,000 Population, 2017-2019 | | | | N/A | 9.4 | **9.0** | 6.6 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2017-2019 | | | | 0.0* | 0.8 | **0.8** | 5.7 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, 2017-2019 | 13 | 13 | 15 | 84.4 | 138.1 | **175.8** | 145.9 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Total Motor Vehicle Crashes per 100,000, 2020 | | | | 2,382.7 | 2,298.7 | **2,157.0** | 1,693.1 | N/A | Worse | X | | | | | | 0.10 | NYS Traffic Safety Statistical Repository | Feb-22 | |
| Rate of Speed-Related Accidents per 100,000 Population, 2020 | | | | 482.5 | 260.2 | **205.7** | 146.0 | N/A | Worse | | | | X | | | 1.35 | NYS Traffic Safety Statistical Repository | Feb-22 | |
| Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2020 | | | | 13.6 | 7.2 | **6.6** | 5.3 | N/A | Worse | | | | X | | | 1.05 | NYS Traffic Safety Statistical Repository | Feb-22 | |
| Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2017-2019 | 9 | 10 | 11 | 2.7 | 6.4 | **9.0** | 8.5 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019 | 127 | 123 | 152 | 154.6 | 210.3 | **275.1** | 249.9 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Poisoning Hospitalizations per 10,000 Population, 2017-2019 | 10 | 10 | 11 | 2.8 | 6.7 | **7.6** | 8.0 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 1 | 0 | 0 | 2 | 17.6% | 66.7% | | | | |
| **Quartile Summary for Focus Area Injuries, Violence, and Occupational Health** | | | | | | | | | | 1 | 0 | 0 | 2 | 13.6% | 66.7% | | | | |
| **Focus Area: Outdoor Air Quality** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Annual number of days with air quality index >100 (unhealthy levels of ozone or particulate matter), 2021 | | | | N/A | N/A | N/A | 20 | **3** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Focus Area Outdoor Air Quality** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Focus Area: Built Environment** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of population living in a certified Climate Smart Community, 2021 | | | | 0.0%* | 20 | 54.2% | 31.3% | **8.6%** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of people who commute to work using alternate modes of transportation or who telecommute, 2015-2019 | | | | 21.2% | 17.4% | 22.9% | 45.6% | **47.9%** | Worse | | | X | | | | 0.56 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015 | | | | 2.1% | 6.0% | **3.9%** | 2.2% | N/A | Meets/Better | | | | | | | 0.00 | USDA Food Environment Atlas | Dec-20 | |
| **Quartile Summary for Focus Area Built Environment** | | | | | | | | | | 0 | 0 | 1 | 0 | 33.3% | 100.0% | | | | |
| **Focus Area: Water Quality** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of residents served by community water systems that have optimally fluoridated water, 2019 | | | | 0.0%* | 26.8% | 46.9% | 71.1% | **77.5%** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Aug-21 | |
| **Quartile Summary for Focus Area Water Quality** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Quartile Summary for Focus Area Air Quality, Built Enviroment, Water Qaulity** | | | | | | | | | | 0 | 0 | 1 | 0 | 20.0% | 100.0% | | | | | |
| **Focus Area: Reduce Obesity in Children and Adults** | | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | | |
| Percentage of Adults Ages 18 Plus Who are Obese, 2018 | | | | 30.6% | 34% | 29.1% | 27.6% | **24.2%** | Worse | | X | | | | | 0.26 | Prevention Agenda Dashboard | Feb-22 | | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 1 | 0 | 0 | 100.0% | 0.0% | | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | | |
| Percentage of Total Students Overweight, 2018-2019 | | | | 15.3% | 17.5% | **16.9%** | N/A | N/A | Meets/Better | | | | | | | 0.00 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight | |
| Percentage of Elementary Students Overweight, Not Obese, 2018-2019 | | | | 15.3% | 17.2% | **16.1%** | N/A | N/A | Meets/Better | | | | | | | 0.00 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight | |
| Percentage of Elementary Student Obese, 2018-2019 | | | | 14.9% | 19.4% | **16.6%** | N/A | N/A | Meets/Better | | | | | | | 0.00 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight | |
| Percentage of Middle and High School Students Overweight, Not Obese, 2018-2019 | | | | 0.0% | 17.4% | **17.8%** | N/A | N/A | Meets/Better | | | | | | | 0.00 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight | |
| Percentage of Middle and High School Students Obese, 2018-2019 | | | | 32.9% | 25.3% | **19.5%** | N/A | N/A | Worse | | | X | | | | 0.69 | Student Weight Status Category Reporting System (SWSCRS) Data | Jul-20 | Total Population is the number of overweight/obese and total healthy weight | |
| Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC, 2015-2017 | | | | 16.5% | 16.1% | **15.5%** | 13.8% | N/A | Worse | X | | | | | | 0.06 | Community Health Indicator Reports | Feb-22 | | |
| Percentage of adults overweight or obese, 2018 | | | | 67.2% | 69.1% | **64.2%** | 62.7% | N/A | Worse | X | | | | | | 0.05 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | | |
| Percentage of adults who participated in leisure time physical activity in the past 30 days, 2018 | | | | 73.7% | 73.3% | **77.6%** | 76.2% | N/A | Worse | X | | | | | | 0.05 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | | |
| Number of Recreational and Fitness Facilities per 100,000 Population, 2016 | | | | 10.5 | 8.8 | **13.2** | 12.3 | N/A | Worse | X | | | | | | 0.20 | USDA Food Environment Atlas | Dec-20 | | |
| Percentage of adults who had a test for high blood sugar or diabetes within the past three years, 2018 | | | | 47.7% | 49.1% | **48.6%** | 51.1% | N/A | Worse | X | | | | | | 0.02 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | | |
| Rate of Cardiovascular Disease Deaths per 100,000 Population, 2017-2019 | 141 | 100 | 120 | 321.9 | 309.6 | **295.9** | 278.3 | N/A | Worse | X | | | | | | 0.09 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Cardiovascular Premature Deaths ( Ages 35 - 64) per 100,000 Population, 2017-2019 | 20 | 15 | 18 | 114.0 | 123.3 | **102.4** | 104.2 | N/A | Worse | X | | | | | | 0.11 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Cardiovascular Disease Pretransport Deaths per 100,000 Population, 2017-2019 | 92 | 58 | 66 | 192.6 | 184.7 | **179.5** | 163.6 | N/A | Worse | X | | | | | | 0.07 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Cardiovascular Hospitalizations per 10,000 Population, 2017-2019 | 439 | 310 | 352 | 98.2 | 141.4 | **161.7** | 155.2 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Diseases of the Heart Deaths per 100,000 Population, 2017-2019 | 115 | 83 | 86 | 253.3 | 240.1 | **234.0** | 169.4 | N/A | Worse | X | | | | | | 0.08 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Diseases of the Heart Premature Deaths ( Ages 35 - 64) per 100,000 Population, 2017-2019 | 16 | 13 | 12 | 88.2 | 100.9 | **82.4** | 83.9 | N/A | Worse | X | | | | | | 0.07 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, 2017-2019 | 77 | 49 | 51 | 157.8 | 149.1 | **147.2** | 138.7 | N/A | Worse | X | | | | | | 0.07 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2017-2019 | 290 | 216 | 258 | 68.1 | 97.5 | **111.2** | 84.2 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Coronary Heart Diseases Deaths per 100,000 Population, 2017-2019 | 71 | 56 | 62 | 168.5 | 155.2 | **162.4** | 173.4 | N/A | Worse | X | | | | | | 0.04 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019 | 12 | 10 | 9 | 66.7 | 69.6 | **59.7** | 66.4 | N/A | Worse | X | | | | | | 0.12 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, 2017-2019 | 46 | 39 | 37 | 108.8 | 100.8 | **106.6** | 112.4 | N/A | Worse | X | | | | | | 0.02 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2017-2019 | 83 | 52 | 59 | 17.3 | 29.1 | **32.9** | 31.5 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Congestive Heart Failure Deaths per 100,000, 2017-2019 | 12 | 3 | 4 | 16.9 | 19.1 | **22.3** | 15.1 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | | |
| Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019 | 2 | 0 | 1 | 6.5* | 4.2* | **3.2** | 2.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, 2017-2019 | 9 | 2 | 3 | 12.5 | 12.2 | **13.7** | 8.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019 | 72 | 68 | 85 | 24.0 | 38.8 | **69.4** | 41.3 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, 2017-2019 | 10 | 10 | 24 | 39.2 | 41.5 | **38.2** | 31.5 | N/A | Worse | X | | | | | | 0.03 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2017-2019 | 78 | 44 | 59 | 16.1 | 23.7 | **28.2** | 26.6 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019 | | | | 1.4 | 2.7 | **5.9** | 7.3 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Diabetes Deaths per 100,000 Population, 2017-2019 | 10 | 15 | 22 | 41.9 | 33.0 | **22.5** | 22.5 | N/A | Worse | | | | X | | | 0.86 | Community Health Indicator Reports | Feb-22 | |
| Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2017-2019 | 34 | 47 | 38 | 10.6 | 18.9 | **18.9** | 21.4 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2017-2019 | 613 | 486 | 591 | 150.7 | 238.0 | **252.0** | 262.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 15 | 0 | 1 | 1 | 53.1% | 11.8% | | | | |
| **Quartile Summary for Focus Area Reduce Obesity in Children and Adults** | | | | | | | | | | 15 | 1 | 1 | 1 | 54.5% | 11.1% | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of Adults Ages 18 Plus Who Smoke, 2018 | | | | 16.4% | 19.5% | 13.9% | 12.8% | **11.0%** | Worse | | X | | | | | 0.49 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 1 | 0 | 0 | 100.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, 2017-2019 | 36 | 29 | 24 | 79.4 | 76.6 | **48.3** | 36.7 | N/A | Worse | | | X | | | | 0.64 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2017-2019 | 143 | 59 | 60 | 23.4 | 32.5 | **28.7** | 29.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Deaths per 100,000 Population, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.7* | **0.9** | 1.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Asthma Hospitalizations per 10,000 Population, 2017-2019 | | | | 0.9 | 3.1 | **6.2** | 9.8 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2017-2019 | | | | 0.0* | 2.4 | **4.2** | 5.0 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2017-2019 | | | | N/A | 2.9 | **5.2** | 8.8 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2017-2019 | | | | N/A | 3.9 | **4.9** | 9.3 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. |
| Percentage of adults with current asthma, 2018 | | | | 15.4% | 13.5% | **10.6%** | 10.1% | N/A | Worse | | X | | | | | 0.45 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, 2016-2018 | 32 | 19 | 24 | 66.7 | 65.0 | **48.1** | 39.6 | N/A | Worse | | X | | | | | 0.39 | Community Health Indicator Reports | Feb-22 | |
| Rate of Lung and Bronchus Cancer Cases per 100,000 Population, 2016-2018 | 41 | 40 | 33 | 101.4 | 119.0 | **87.6** | 72.6 | N/A | Worse | X | | | | | | 0.16 | Community Health Indicator Reports | Feb-22 | |
| Number of Registered Tobacco Vendors per 100,000 Population, 2016-2017 | | | | 166.3 | 132.7 | **104.4** | 110 | N/A | Worse | | | X | | | | 0.59 | NYS Department of Health Tobacco Enforcement Compliance Results | Oct-19 | Population is 5-year Census data 2015-2020 |
| Tobacco Sales to Minors Violations per 100,000 Population, 2016-2017 | | | | 10.7 | 4.0* | **4.0** | 6.6 | N/A | Worse | | | | X | | | 1.68 | NYS Department of Health Tobacco Enforcement Compliance Results | Oct-19 | Population is 5-year Census data 2015-2020 ARHN calculation not included due to unstable |
| Percentage of Vendors with Complaints per 100,000 Population, 2016-2017 | | | | 0.0 | 0.0* | **0.0*** | 1.1 | N/A | Meets/Better | | | | | | | 0.00 | NYS Department of Health Tobacco Enforcement Compliance Results | Oct-19 | Population is 5-year Census data 2015-2020 ARHN calculation not included due to unstable |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 1 | 2 | 2 | 1 | 46.2% | 50.0% | | | | |
| **Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure** | | | | | | | | | | 1 | 3 | 2 | 1 | 50.0% | 42.9% | | | | |
| **Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Asthma emergency department visits, rate per 10,000, aged 0-17 years, 2019 | | | | 55.7 | 42.3 | 57.5 | 99.9 | **131.1** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Asthma emergency department visit rate per 10,000 - aged 18-64 years, 2017-2019 | | | | 32.7 | 41.4 | **39.0** | 63.3 | N/A | Meets/Better | | | | | | | 0.00 | Asthma Summary Report | Feb-22 | |
| Asthma emergency department visit rate per 10,000 - aged 65+ years, 2017-2019 | | | | 20.0 | 16.0 | **14.8** | 28.2 | N/A | Worse | | X | | | | | 0.35 | Asthma Dashboard-County Level | Feb-22 | |
| Rate of All Cancer Cases per 100,000 Population, 2016-2018 | 260 | 275 | 235 | 684.8 | 710.8 | **657.0** | 587.7 | N/A | Worse | X | | | | | | 0.04 | Community Health Indicator Reports | Feb-22 | |
| Rate of all Cancer Deaths per 100,000 Population, 2016-2018 | 115 | 92 | 86 | 260.6 | 232.6 | **194.7** | 175.5 | N/A | Worse | | X | | | | | 0.34 | Community Health Indicator Reports | Feb-22 | |
| Rate of Female Breast Cancer Cases per 100,000 Female Population, 2016-2018 | 38 | 33 | 21 | 169.3 | 176.3 | **180.1** | 164.6 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, 2016-2018 | 13 | 9 | 9 | 57.1 | 48.6 | **50.9** | 49.3 | N/A | Worse | X | | | | | | 0.12 | Community Health Indicator Reports | Feb-22 | |
| Rate of Female Breast Cancer Deaths per 100,000 Female Population, 2016-2018 | | | | 29.4* | 24.9 | **26.3** | 25.1 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines, 2018 | | | | 76.7% | 80.4% | **80.9%** | 82.1% | N/A | Worse | X | | | | | | 0.05 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Rate of Cervix Uteri Cancer Incidence per 100,000, 2016-2018 | | | | 11.0* | 8.9 | **7.1** | 8.3 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cervix and Uteri Cancer Deaths per 100,000 Female Population, 2016-2018 | | | | N/A | 6.2* | **2.2** | 2.5 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not |
| Percentage of women aged 21-65 years receiving cervical cancer screening based on recent guidelines, 2018 | | | | 83.2% | 87.2% | **86.1%** | 84.7% | N/A | Worse | X | | | | | | 0.03 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Rate of Ovarian Cancer Cases per 100,000 Female Population, 2016-2018 | | | | 12.9* | 14.8 | **15.2** | 14.2 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Ovarian Cancer Deaths per 100,000 Female Population, 2016-2018 | | | | 11.0* | 8.8 | **9.3** | 8.7 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. |
| Rate of Colon and Rectal Cancer incidence per 100,000 Population, 2016-2018 | 20 | 23 | 23 | 58.7 | 54.2 | **48.8** | 45.7 | N/A | Worse | X | | | | | | 0.20 | Community Health Indicator Reports | Feb-22 | |
| Rate of Colon and Rectal Cancer Deaths per 100,000 Population, 2016-2018 | 13 | 8 | 7 | 24.9 | 19.8 | **15.7** | 15.1 | N/A | Worse | | | X | | | | 0.58 | Community Health Indicator Reports | Feb-22 | |
| Rate of Prostate Cancer Deaths per 100,000 Male Population, 2016-2018 | | | | 25.8* | 22.1 | **18.9** | 18.5 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Prostate Cancer Incidence per 100,000 Male Population, 2016-2018 | 26 | 35 | 33 | 161.8 | 166.2 | **174.9** | 158.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, 2016-2018 | | | | 31.0* | 38.3 | **33.3** | 30.5 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Melanoma Cancer Deaths per 100,000 Population, 2016-2018 | | | | 5.3* | 3.6 | **2.7** | 2.1 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, 2018-2020 | 2,499 | 2,398 | 1,816 | 25.5% | 26.0% | **27.7%** | 26.9% | N/A | Worse | X | | | | | | 0.08 | Community Health Indicator Reports | Feb-22 | |
| Percentage of adults who had a dentist visit within the past year, 2018 | | | | 69.3% | 63.8% | **71.6%** | 69.8% | N/A | Worse | X | | | | | | 0.03 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, 2016-2018 | | | | 0.0* | 5.0* | **4.7** | 4.6 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not |
| Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, 2016-2018 | 6 | 6 | 6 | 16.0* | 17.4 | **16.3** | 14.1 | N/A | Less than 20 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 7 | 2 | 1 | 0 | 43.5% | 10.0% | | | | |
| **Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management** | | | | | | | | | | 7 | 2 | 1 | 0 | 41.7% | 10.0% | | | | |
| **Focus Area: Maternal and Infant Health** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of births that are preterm, 2019 | | | | 9.6% | 9.4% | 9.3% | 9.2% | **8.3%** | Worse | X | | | | | | 0.16 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Black, non-hispanic births that are pre-term, 2019 | | | | N/A | N/A | N/A | 13.2% | **8.30** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of Hispanic births that are pre-term, 2019 | | | | N/A | N/A | N/A | 10.1% | **8.30** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of births that are pre-term on Medicaid, 2019 | | | | N/A | N/A | N/A | 9.6% | **8.30** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Rate of Maternal Mortality per 100,000 Births, 2017-2019 | | | | 0.0* | 0.0** | 18.8 | 19.3 | **16.0** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | ARHN calculation not included due to unstable rate |
| Percentage of infants who are exclusively breastfed in the hospital among all infants, 2019 | | | | 76.5% | 65.8% | 49.6% | 47.1% | **51.7%** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Black, non-hispanic infants who are exclusively breastfed in delivery hospital, 2019 | | | | N/A | N/A | N/A | 34.9% | **51.7** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Hispanic infants who are exclusively breastfed in delivery hospital, 2019 | | | | N/A | N/A | N/A | 35.7% | **51.7** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Percentage of Infants Exclusively Breastfed in Delivery Hospital on Medicaid Insurance, 2019 | | | | N/A | N/A | N/A | 34.9% | **51.7** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 1 | 0 | 0 | 0 | 11.1% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage Preterm Births < 32 weeks of Total Births, 2017-2019 | 4 | 7 | 4 | 1.7% | 1.3% | **1.5%** | 1.5% | N/A | Worse | X | | | | | | 0.16 | Community Health Indicator Reports | Oct-21 | |
| Percentage Preterm Births 32 to < 37 Weeks of Total Births, 2017-2019 | 17 | 21 | 26 | 7.1% | 7.8% | **7.6%** | 7.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| Percentage of very low birthweight Less Than 1,500 grams, 2017-2019 | 3 | 5 | 2 | 1.1% | 1.1% | **1.3%** | 1.4% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| Percentage of Singleton Births with Weights Less Than 1,500 grams, 2017-2019 | 2 | 5 | 2 | 1%* | 0.9% | **1.0%** | 1.0% | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| Percentage of Total Births with Weights Less Than 2,500 grams, 2017-2019 | 26 | 26 | 25 | 8.5% | 7.7% | **7.7%** | 8.1% | N/A | Worse | X | | | | | | 0.10 | Community Health Indicator Reports | Oct-21 | |
| Percentage of Singleton Births with weight less than 2,500 grams, 2017-2019 | 21 | 21 | 19 | 7.0% | 6.0% | **5.9%** | 6.3% | N/A | Worse | X | | | | | | 0.18 | Community Health Indicator Reports | Oct-21 | |
| Percentage of low birthweight births (< 2.5 kg) for Black, Non-Hispanic, 2016-2018 | | | | N/A | N/A | **13.2%** | 12.6% | N/A | Less than 10 | | | | | | | 0.00 | State and County Indicators for Tracking Public Health Priority Areas | Jul-21 | |
| Percentage of low birthweight births (< 2.5 kg) for Hispanic/Latino, 2016-2018 | | | | N/A | N/A | **7.9%** | 8.1% | N/A | Less than 10 | | | | | | | 0.00 | State and County Indicators for Tracking Public Health Priority Areas | Jul-21 | |
| Infant Mortality Rate per 1,000 Live Births- Infant (<1 year), 2017-2019 | 0 | 1 | 0 | 1.1* | 5.1 | **4.8** | 4.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, 2017-2019 | 0 | 1 | 0 | 1.0* | 4.9 | **5.1** | 5.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of births with early (1st trimester) prenatal care, 2017-2019 | 194 | 244 | 231 | 74.5% | 77.8% | **78.4%** | 76.3% | N/A | Worse | X | | | | | | 0.05 | Community Health Indicator Reports | Oct-21 | |
| Percentage of births with adequate prenatal care (APNCU) for Black, Non-Hispanic, 2016-2018 | | | | N/A | N/A | **68.4%** | 66.1% | N/A | Less than 10 | | | | | | | 0.00 | State and County Indicators for Tracking Public Health Priority Areas | Jul-21 | |
| Percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino, 2016-2018 | | | | N/A | N/A | **70.9%** | 71.1% | N/A | Less than 10 | | | | | | | 0.00 | State and County Indicators for Tracking Public Health Priority Areas | Jul-21 | |
| Percentage of births with a 5 minute APGAR <6, 2017-2019 | 1 | 4 | 5 | 1.1% | 1.4% | **0.8%** | 0.7% | N/A | Worse | | X | | | | | 0.32 | Community Health Indicator Reports | Oct-21 | |
| Percentage WIC Women Breastfeeding for at least 6 months, 2015-2017 | | | | 27.9% | 24.6% | **30.6%** | 41.0% | N/A | Worse | X | | | | | | 0.09 | Community Health Indicator Reports | Jun-18 | |
| Percentage Infants Fed Any Breast Milk in Delivery Hospital, 2017-2019 | 186 | 168 | 175 | 84.6% | 79.8% | **84.2%** | 88.5% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 5 | 1 | 0 | 0 | 37.5% | 0.0% | | | | |
| **Quartile Summary for Focus Area Maternal and Infant Health** | | | | | | | | | | 6 | 1 | 0 | 0 | 28.0% | 0.0% | | | | |
| **Focus Area: Preconception and Reproductive Health** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of Women Ages 18- 64 with Health Insurance, 2019 | | | | N/A | N/A | N/A | 94.0% | **97.0%** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Jul-21 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |

| Other Indicators | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of Total Births per 1,000 Females Ages 15-44, 2017-2019 | 283 | 308 | 314 | 54.6 | 53.1 | **57.1** | 57.5 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Percent Multiple Births of Total Births, 2017-2019 | 10 | 10 | 10 | 3.3% | 3.4% | **3.7%** | 3.5% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 |
| Percent C-Sections to Total Births, 2017-2019 | 83 | 97 | 104 | 31.4% | 32.2% | **34.2%** | 33.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Oct-21 |
| Rate of Total Pregnancies per 1,000 Females Ages 15-44, 2017-2019 | 362 | 364 | 371 | 60.3 | 64.0 | **72.3** | 79.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.1* | **0.1** | 0.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 ARHN calculation not included due to unstable rate |
| Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, 2017-2019 | 3 | 2 | 0 | 3.0* | 5.7 | **4.7** | 4.9 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019 | 13 | 12 | 5 | 29.1 | 30.2 | **20.1** | 21.5 | N/A | Worse | | X | | | | | 0.45 | Community Health Indicator Reports | Feb-22 |
| Rate of Teen pregnancy per 1,000 females aged <18 years, 2017-2019 | 3 | 2 | 0 | 1.1* | 3.7 | **3.7** | 4.7 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019 | 21 | 14 | 8 | 38.4 | 42.4 | **32.8** | 41.1 | N/A | Worse | X | | | | | | 0.17 | Community Health Indicator Reports | Feb-22 |
| Percent Total Births to Women Ages 35 Plus, 2017-2019 | 45 | 53 | 56 | 17.0% | 13.9% | **22.3%** | 24.5% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Ratio+ of Abortions All Ages per 1000 Live Births to All Mothers, 2017-2019 | 38 | 27 | 19 | 85.5 | N/A | N/A | **333.1** | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Percentage of WIC Women Pre-pregnancy Underweight (BMI less than 18.5), 2015-2017 | 6 | 10 | 6 | 4.3% | 4.7% | **3.9%** | 4.6% | N/A | Worse | X | | | | | | 0.10 | Community Health Indicator Reports | Feb-22 |
| Percentage of WIC Women Pre-pregnancy Overweight but not Obese (BMI 25 >30), 2015-2017 | 37 | 37 | 33 | 20.9% | 23.1% | **27.1%** | 27.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Percentage of WIC Women Pre-pregnancy Obese (BMI > 30),2015-2017 | 65 | 47 | 76 | 36.6% | 35.8% | **31.1%** | 26.6% | N/A | Worse | X | | | | | | 0.18 | Community Health Indicator Reports | Feb-22 |
| Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, 2015-2019 | 86 | 71 | 88 | 52.1% | 51.9% | **45.7%** | 41.0% | N/A | Worse | X | | | | | | 0.14 | Community Health Indicator Reports | Feb-22 |
| Percentage of WIC Women with Gestational Diabetes, 2015-2017 | 15 | 8 | 16 | 8.1% | 8.2% | **6.6%** | 6.6% | N/A | Worse | X | | | | | | 0.22 | Community Health Indicator Reports | Feb-22 |
| Percentage of WIC Women with Gestational Hypertension, 2015-2017 | 29 | 23 | 22 | 15.4% | 13.1% | **9.0%** | 7.5% | N/A | Worse | | | X | | | | 0.72 | Community Health Indicator Reports | Feb-22 |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 5 | 1 | 1 | 0 | 41.2% | 14.3% | | | |
| **Quartile Summary for Focus Area Preconception and Reproductive Health** | | | | | | | | | | 5 | 1 | 1 | 0 | 38.9% | 14.3% | | | |

| Focus Area: Child Health | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Other Indicators** | | | | | | | | | | | | | | | | | | |
| Percentage of children with recommended number of well child visits in government sponsored insurance programs, 2019 | | | | 69.1% | 74.1% | **73.3%** | 75.2% | N/A | Worse | X | | | | | | 0.00 | Community Health Indicator Reports | Nov-21 |
| Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, 2017-2019 | 1 | 0 | 0 | 28.3* | 25.1* | **18.9** | 17.7 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 ARHN calculation not included due to unstable rate |
| Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, 2017-2019 | 0 | 1 | 0 | 17.3* | 32.5 | **31.3** | 30.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019 | | | | N/A | 10.8 | **24.9** | 35.6 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2017-2019 | | | | 0.0* | 3.4 | **9.4** | 16.6 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2017-2019 | | | | N/A | 4.9 | **12.4** | 20.3 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019 | | | | 0.0* | 4.3 | **7.5** | 10.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 |
| Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019 | | | | 0.0* | 1.6* | **1.5** | 1.8 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 ARHN calculation not included due to unstable rate |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019 | | | | N/A | 18.3 | **20.3** | 25.2 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016 | | | | 60.4* | 65.5 | **105.9** | 186.4 | N/A | Less than 10 | | | | | | | 0.00 | Asthma Dashboard-County Level | Feb-22 | |
| Percentage of Children born in 2016 Screened for Lead by Age 0-8 months, 2016 | | | | .8%* | 2.4% | **1.2%** | 1.7% | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Sep-21 | |
| Percentage of Children Born in 2016 Screened for Lead by Age 9-17 months, 2016 | | | | 83.0% | 81.7% | **73.0%** | 75.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Sep-21 | |
| Percentage of Children Born 2016 Screened for Lead by Age 36 months (at least two screenings), 2016 | | | | 61.9% | 63.7% | **57.8%** | 63.3% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Sep-21 | |
| Rate of Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) Per 1,000 tested children aged <72 months, 2017-2019 | 3 | 3 | 0 | 4.4* | 8.5 | **6.6** | 3.8 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2017-2019 | | | | 8.5* | 12.9 | **17.7** | 18.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2017-2019 | | | | N/A | 8.9 | **12.7** | 13.2 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2017-2019 | | | | 8.6 | 17.7 | **23.1** | 22.6 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016 | | | | 55.7 | 51.3 | **68.1** | 137.1 | N/A | Meets/Better | | | | | | | 0.00 | Asthma Summary Report | Feb-22 | |
| Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, 2018-2020 | 1,437 | 1,409 | 1,212 | 48.3% | 49.3% | **47.9%** | 46.9% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Sep-21 | |
| Percentage of 3rd Graders with Dental Caries Experience, 2009-2011 | | | | 50.4% | N/A | N/A | N/A | N/A | No comparison data available | | | | | | | 0.00 | Community Health Indicator Reports | Aug-12 | |
| Percentage of 3rd Graders with Dental Sealants, 2009-2011 | | | | 34.5% | N/A | N/A | N/A | N/A | No comparison data available | | | | | | | 0.00 | Community Health Indicator Reports | Aug-12 | |
| Percentage of 3rd Graders with Dental Insurance, 2009-2011 | | | | 86.6% | 85.2% | N/A | N/A | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Aug-12 | |
| Percentage of 3rd Graders with at Least One Dental Visit, 2009-2011 | | | | 76.8% | **81.0%** | N/A | N/A | N/A | Worse | X | | | | | | 0.05 | Community Health Indicator Reports | Aug-12 | |
| Percentage of 3rd Graders Taking Fluoride Tablets Regularly, 2009-2011 | | | | 85.4% | N/A | N/A | N/A | N/A | No comparison data available | | | | | | | 0.00 | Community Health Indicator Reports | Aug-12 | |
| Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2017-2019 | 10 | 31 | 20 | 221.3 | 228.2 | **146.7** | 146.4 | N/A | Worse | | | X | | | | 0.51 | Community Health Indicator Reports | Nov-21 | |
| Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, 2015-2017 | | | | 88.4% | 85.4% | **84.9%** | 86.6% | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Jun-18 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 2 | 0 | 1 | 0 | 11.5% | 33.3% | | | | |
| **Quartile Summary for Focus Area Child Health** | | | | | | | | | | 2 | 0 | 1 | 0 | 11.5% | 33.3% | | | | |
| **Focus Area: Human Immunodeficiency Virus (HIV)** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2017-2019 | | | | N/A | 4.3* | 5.7 | 13.1 | **5.2** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | ARHN calculation not included due to unstable rate |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| AIDS Deaths per 100,000, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.4* | **0.9** | 2.2 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Focus Area: Sexually Transmitted Disease (STDs)** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Early syphilis diagnoses, age-adjusted rate per 100,000 population, 2019 | | | | 0.0* | 3.71* | 15.3 | 38.6 | **79.6** | Less than 10 | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | ARHN calculation not included due to unstable rate |
| Gonorrhea diagnoses, age-adjusted rate per 100,000 population, 2019 | | | | 39.5 | 33.40 | 114.9 | 217 | **242.6** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Chlamydia diagnoses, age-adjusted rate per 100,000 population, 2019 | | | | 219.1 | 244.33 | 457.5 | 667.9 | **676.9** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Gonorrhea case rate per 100,000 males - Aged 15-44 years, 2017-2019 | 2 | 6 | 4 | 57.7 | 54.45 | **267.8** | 614.9 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Gonorrhea case rate per 100,000 females - Aged 15-44 years, 2017-2019 | | | | N/A | 88.72 | **218.3** | 252.5 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Gonorrhea case rate per 100,000 - Aged 15-19 years, 2017-2019 | 1 | 0 | 0 | 17.3* | 73.15 | **246.4** | 401.5 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | 10 |
| Rate of Chlamydia Cases All Males Aged 15-44 years per 100,000 Male Population, 2017-2019 | | | | N/A | 406.45 | **41.2** | 1,175.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, 2017-2019 | 2 | 8 | 5 | 485.4 | 466.03 | **766.4** | 1,142.6 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, 2017-2019 | | | | N/A | 945.09 | **1,513.3** | 2,107.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases All Females Aged 15-44 years per 100,000 Female Population, 2017-2019 | | | | N/A | 1118.40 | **1,455.2** | 1,741.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population, 2017-2019 | | | | N/A | 2006.20 | **2,623.6** | 3,535.7 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population, 2017-2019 | | | | N/A | 2740.07 | **3,203.9** | 3,912.5 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population, 2017-2019 | | | | 0.0* | 0.95* | **1.9** | 2.5 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Quartile Summary for Sexually Transmitted Diseases** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Focus Area: Vaccine Preventable Disease** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series, 2020 | | | | 62.4% | 68.2% | 66.3% | 66.1% | **70.5%** | Worse | X | | | | | | 0.13 | Prevention Agenda Dashboard | Oct-21 | Age range adjusted to 24-35 months |
| Percentage of 13-year-old adolescents with a complete HPV vaccine series, 2020 | | | | 17.7% | 25.8% | 32.8% | 39.8% | **37.4%** | Worse | | | | X | | | 1.11 | Prevention Agenda Dashboard | Oct-21 | |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 1 | 0 | 0 | 1 | 100.0% | 50.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Pertussis Cases per 100,000 Population, 2017-2019 | 3 | 17 | 1 | 18.7 | 12.3 | **5.0** | 3.8 | N/A | Worse | | | | X | | | 2.74 | Community Health Indicator Reports | Feb-22 | |
| Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019 | 82 | 77 | 64 | 85.7 | 87.7 | **95.2** | 85.5 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Percentage of adults aged 65+ years with pneumococcal immunization, 2018 | | | | 70.8% | 70.0% | **69.4%** | 64.0% | N/A | Meets/Better | | | | | | | 0.00 | NYS Expanded Behavioral Risk Factor Surveillance System | Mar-22 | |
| Rate of Mumps Cases per 100,000 Population, 2017-2019 | 3 | 0 | 1 | 3.6* | 1.4* | **1.3** | 1.7 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Meningococcal Cases per 100,000 Population, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.0* | **0.1** | 0.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of H Influenza Cases per 100,000 Population, 2017-2019 | 0 | 0 | 1 | 0.9* | 2.1 | **2.3** | 2.0 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 0 | 0 | 0 | 1 | 16.7% | 100.0% | | | | |
| **Quartile Summary for Focus Area Vaccine Preventable Diseases** | | | | | | | | | | 1 | 0 | 0 | 2 | 37.5% | 66.7% | | | | |
| **Focus Area: Healthcare Associated Infections** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days (Risk-adjusted), 2019 | | | | N/A | N/A | N/A | **4.0** | N/A | Worse | #VALUE! | #VALUE! | #VALUE! | #VALUE! | | | ##### | NYS Department of Health Hospital Report on Hospital Acquired Infections | May-21 | CDI Hospital Onset; No data for Essex County; Elizabethtown Hospital |
| Rate of Community Onset, Healthcare Facility Associated CDIs per 100 Admissions, not risk-adjusted, 2019 | | | | N/A | N/A | N/A | **0.2** | N/A | Worse | #VALUE! | #VALUE! | #VALUE! | #VALUE! | | | ##### | NYS Department of Health Hospital Report on Hospital Acquired Infections | May-21 | CDI Community Onset Not-My-Hospita; No data for Essex County; Elizabethtown Hospital |

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Quartile Summary for Healthcare Associated Infections** | | | | | | | | | | 0 | 0 | 0 | 0 | 0.0% | 0.0% | | | | |
| **Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders** | | | | | | | | | | | | | | | | | | | |
| **Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2018 | | | | 13.2% | 16.6% | 18.4% | 17.5% | **16.4%** | Meets/Better | | | | | | | 0.00 | Prevention Agenda Dashboard | Feb-22 | |
| Age Adjusted Rate of Suicides per 100,000 Adjusted Population, 2017-2019 | | | | 8.1 | N/A | 9.9 | 8.2 | **7.0** | Worse | X | | | | | | 0.16 | Prevention Agenda Dashboard | Feb-22 | Not enough information to calculate ARHN region rate. |
| **Quartile Summary for Prevention Agenda Indicators** | | | | | | | | | | 1 | 0 | 0 | 0 | 50.0% | 0.0% | | | | |
| **Other Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, 2017-2019 | 0 | 0 | 0 | 0.0* | 8.1* | **7.3** | 6.0 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Self-inflicted injury Hospitalizations 10,000 Population, 2017-2019 | 11 | 13 | 7 | 2.8 | 6.1 | **4.4** | 3.7 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Self-inflicted injury Hospitalizations for Ages 15 - 19 per 10,000 Population, 2017-2019 | | | | 15.6* | 17.0 | **10.3** | 9.0 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Cirrhosis Deaths per 100,000 Population, 2017-2019 | 9 | 2 | 10 | 18.7 | 15.3 | **10.1** | 8.4 | N/A | Worse | | | | X | | | 0.84 | Community Health Indicator Reports | Feb-22 | |
| Rate of Alcohol-Related Crashes per 100,000, 2020 | | | | 100.3 | 66.4 | **52.0** | 40.1 | N/A | Worse | | | | X | | | 0.93 | NYS Traffic Safety Statistical Repository | Jan-22 | |
| Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2020 | | | | 46.1 | 28.7 | **28.8** | 23.3 | N/A | Worse | | | X | | | | 0.60 | NYS Traffic Safety Statistical Repository | Jan-22 | |
| **Quartile Summary for Other Indicators** | | | | | | | | | | 0 | 0 | 1 | 2 | 50.0% | 100.0% | | | | |
| **Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders** | | | | | | | | | | 1 | 0 | 1 | 2 | 50.0% | 75.0% | | | | |
| **Other Non-Prevention Agenda Indicators** | | | | | | | | | | | | | | | | | | | |
| Rate of Hepatitis A Cases per 100,000 Population, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.4* | **1.4** | 1.3 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Acute Hepatitis B Cases per 100,000 Population, 2017-2019 | 0 | 0 | 0 | 0.0* | 0.3* | **0.4** | 0.4 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of TB Cases per 100,000 Population, 2017-2019 | 0 | 0 | 1 | 0.9* | 0.6* | **1.7** | 3.9 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of E. Coli Shiga Toxin Cases per 100,000 Population, 2017-2019 | 1 | 2 | 0 | 2.7* | 3.0 | **3.1** | 4.1 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Salmonella Cases per 100,000 Population, 2017-2019 | 6 | 4 | 2 | 10.7 | 11.1 | **12.9** | 14.0 | N/A | Meets/Better | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | |
| Rate of Shigella Cases per 100,000 Population, 2017-2019 | 1 | 0 | 1 | 1.8* | 0.5* | **3.4** | 6.3 | N/A | Less than 10 | | | | | | | 0.00 | Community Health Indicator Reports | Feb-22 | ARHN calculation not included due to unstable rate |
| Rate of Lyme Disease Cases per 100,000 Population, 2017-2019 | 121 | 37 | 107 | 236.3 | 118.1 | **70.7** | 44.7 | N/A | Worse | | | | X | | | 1.00 | Community Health Indicator Reports | Feb-22 | Upstate NY rate calculated using county data. |
| Rate of Confirmed Rabies Cases per 100,000 Population, 2020 | | | | 5.4 | 3.4* | **3.1** | 1.8 | N/A | Worse | | | X | | | | 0.73 | Department of Health, Wadsworth Center | Dec-20 | Used 2020 Profile Population data (U.S. Census Bureau) ARHN calculation not |
| **Quartile Summary for Non-Prevention Agenda Issues** | | | | | | | | | | 0 | 0 | 1 | 1 | 25.0% | 100.0% | | | | |

N/A: Data does not meet reporting criteria

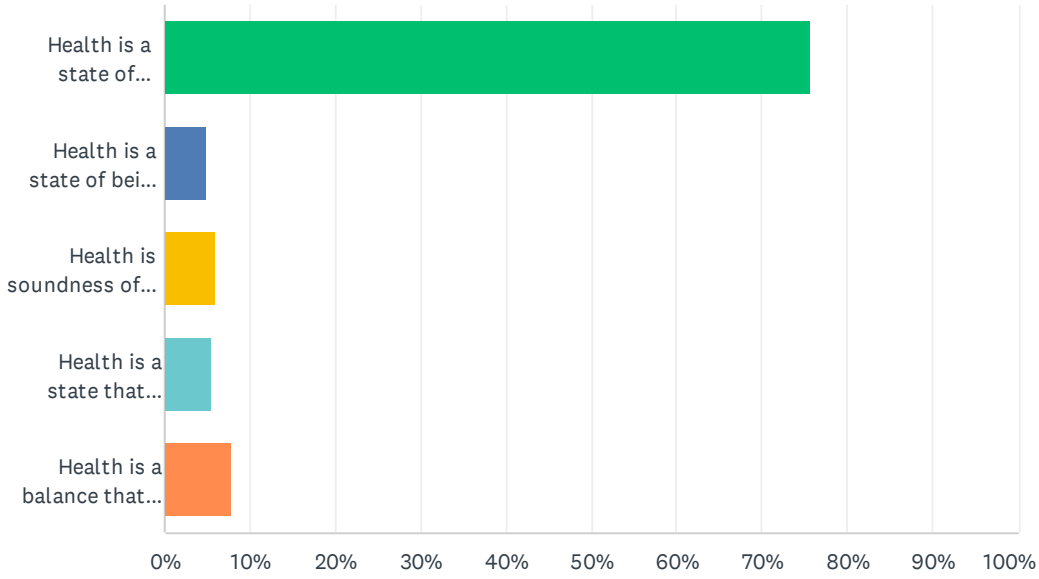
*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

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

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

# Q1 Which one definition below best describes what you think of as "health"? Select one.

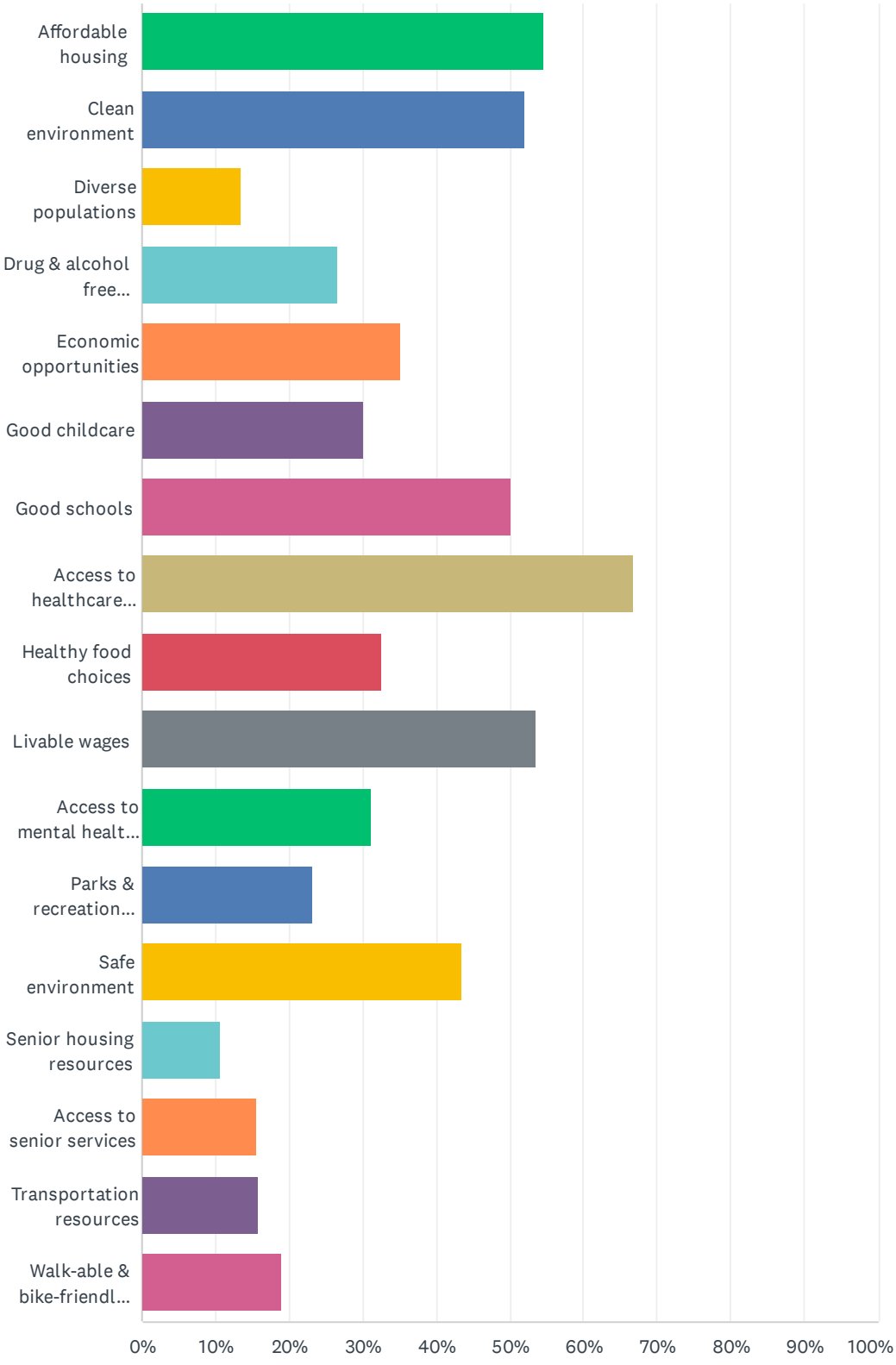
Answered: 485 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. | 75.67% | 367 |
| Health is a state of being free from illness or injury. | 4.95% | 24 |
| Health is soundness of mind and body | 5.98% | 29 |
| Health is a state that allows an individual to cope with all demands of daily life. | 5.57% | 27 |
| Health is a balance that an individual has between him/herself and his/her social and physical environment. | 7.84% | 38 |
| TOTAL | | 485 |

# Q2 When you imagine a strong, vibrant, healthy community, what are the most important features you think of? Choose up to 5.

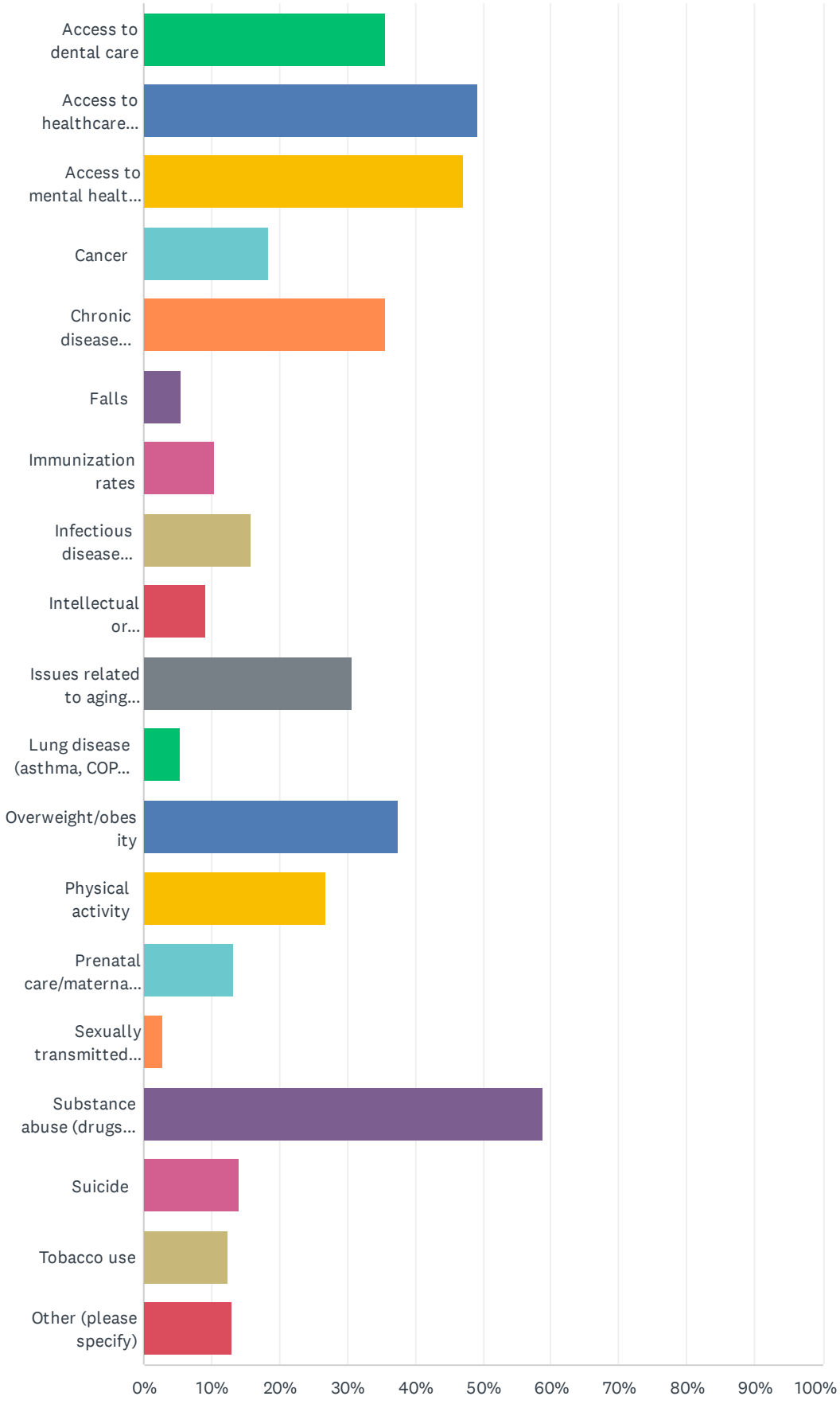
Answered: 485 Skipped: 0


Affordable housing
Clean environment
Diverse populations
Drug & alcohol free...
Economic opportunities
Good childcare
Good schools
Access to healthcare...
Healthy food choices
Livable wages
Access to mental healt...
Parks & recreation...
Safe environment
Senior housing resources
Access to senior services
Transportation resources
Walk-able & bike-friendl...
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Affordable housing | 54.64% | 265 |
| Clean environment | 51.96% | 252 |
| Diverse populations | 13.40% | 65 |
| Drug & alcohol free communities | 26.60% | 129 |
| Economic opportunities | 35.26% | 171 |
| Good childcare | 30.10% | 146 |
| Good schools | 50.10% | 243 |
| Access to healthcare services | 66.80% | 324 |
| Healthy food choices | 32.58% | 158 |
| Livable wages | 53.61% | 260 |
| Access to mental health services | 31.13% | 151 |
| Parks & recreation resources | 23.30% | 113 |
| Safe environment | 43.51% | 211 |
| Senior housing resources | 10.72% | 52 |
| Access to senior services | 15.67% | 76 |
| Transportation resources | 15.88% | 77 |
| Walk-able & bike-friendly communities | 18.97% | 92 |
| Total Respondents: 485 | | |

# Q3 When you think about health challenges in the community where you live, what are you most concerned about? Choose up to 5.

Answered: 440 Skipped: 45


Access to dental care
Access to healthcare...
Access to mental healt...
Cancer
Chronic disease...
Falls
Immunization rates
Infectious disease...
Intellectual or...
Issues related to aging...
Lung disease (asthma, COP...
Overweight/obesity
Physical activity
Prenatal care/materna...
Sexually transmitted...
Substance abuse (drugs...
Suicide
Tobacco use
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Access to dental care | 35.68% | 157 |
| Access to healthcare services | 49.32% | 217 |
| Access to mental health services | 47.05% | 207 |
| Cancer | 18.41% | 81 |
| Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.) | 35.68% | 157 |
| Falls | 5.45% | 24 |
| Immunization rates | 10.45% | 46 |
| Infectious disease (COVID-19, Hepatitis A, B or C, flu, etc.) | 15.68% | 69 |
| Intellectual or developmental disabilities | 9.09% | 40 |
| Issues related to aging (arthritis, hearing/vision loss, etc.) | 30.68% | 135 |
| Lung disease (asthma, COPD, etc.) | 5.23% | 23 |
| Overweight/obesity | 37.50% | 165 |
| Physical activity | 26.82% | 118 |
| Prenatal care/maternal & infant health | 13.18% | 58 |
| Sexually transmitted infections (including HIV) | 2.73% | 12 |
| Substance abuse (drugs, alcohol, etc.) | 58.86% | 259 |
| Suicide | 14.09% | 62 |
| Tobacco use | 12.27% | 54 |
| Other (please specify) | 12.95% | 57 |
| Total Respondents: 440 | | |

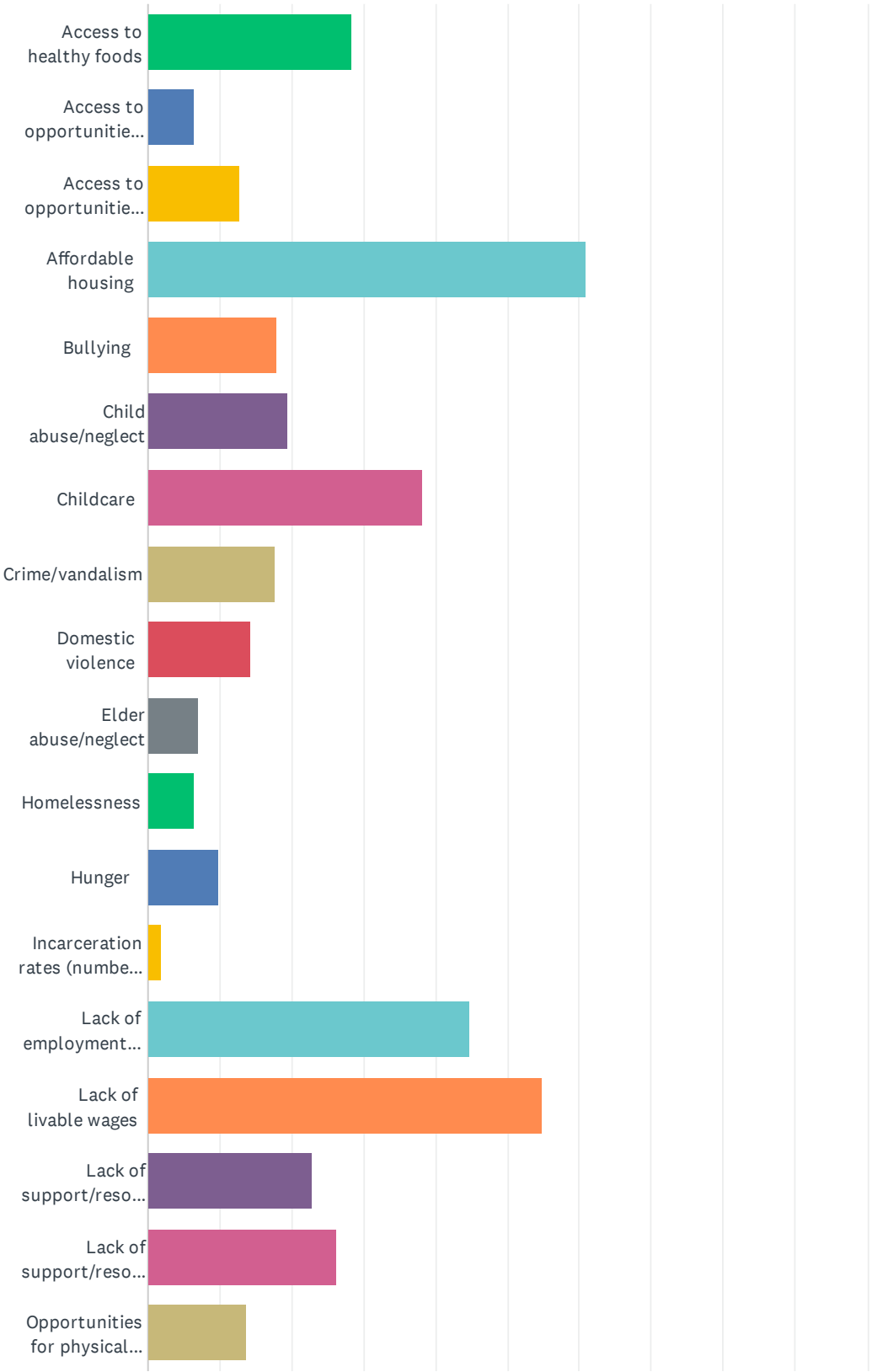
| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | Transportation, owning a car, low & middle income housing | 6/21/2022 2:56 PM |
| 2 | distance to healthcare providers | 6/21/2022 2:46 PM |
| 3 | Have access to healthcare, dental, and mental health services, but can't afford to pay health insurance and dr. bills | 6/21/2022 2:43 PM |
| 4 | Isolation - especially in winter months | 6/21/2022 2:24 PM |
| 5 | Chronic pain | 5/19/2022 1:49 PM |
| 6 | High # of people relying on public assistance to live. | 5/19/2022 4:14 AM |
| 7 | Air and noise pollution. Traffic. | 5/19/2022 3:29 AM |
| 8 | rodent, nuisance animal and stray cat infestation | 5/16/2022 2:51 PM |
| 9 | A community (especially health care services) that can better communicate with those who are hearing impaired or deaf. | 5/16/2022 10:57 AM |
| 10 | political disinformation and polarization | 5/11/2022 1:35 AM |
| 11 | Tickborne disease | 5/10/2022 8:51 PM |
| 12 | Government intrusion | 5/10/2022 3:35 PM |

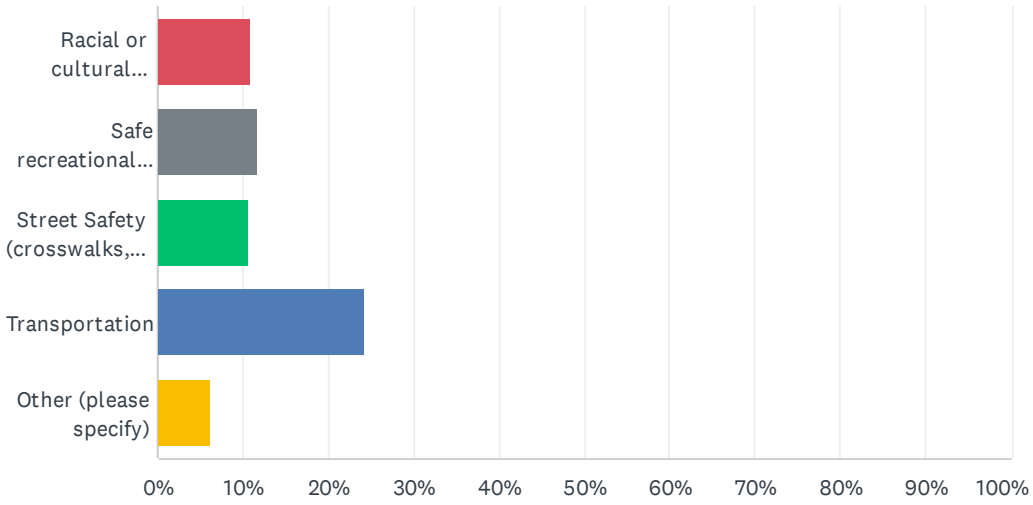
| | | |
|---|---|---|
| 13 | The idea that health is found in prescriptions and vaccines is false and yet widely propagated | 4/26/2022 12:23 PM |
| 14 | Opportunities for relationship building especially in winter | 4/26/2022 8:39 AM |
| 15 | Tick born Illnesses | 4/26/2022 8:23 AM |
| 16 | Faulty education | 4/19/2022 8:52 PM |
| 17 | going to a doc for ANYTHING and having it NOT be covered by Medicare OR my supplemental so called insurance | 4/9/2022 7:26 AM |
| 18 | I don't think my community has a lack of any of these listed as access, and have no idea about the other conditions listed. | 4/8/2022 11:19 AM |
| 19 | Health literacy | 4/8/2022 8:07 AM |
| 20 | Access to healthy food | 4/8/2022 8:00 AM |
| 21 | Distance to diagnostic services | 4/8/2022 6:30 AM |
| 22 | There is no hospital in the community. | 4/7/2022 11:25 PM |
| 23 | Not being able to afford it and/or meds….I am on the market place and had an asthma attack. I had to pay almost $400 for two inhalers because my deductible is so high. | 4/7/2022 9:08 PM |
| 24 | Access to home health care; access to transportation | 4/7/2022 6:47 PM |
| 25 | Safe family life. | 4/7/2022 12:05 PM |
| 26 | access to health care specialists | 4/1/2022 2:57 PM |
| 27 | Sex Education for Youths | 3/29/2022 2:40 PM |
| 28 | lack of accessing help due to lack of affordable insurance | 3/28/2022 1:19 PM |
| 29 | Mental Health Challenges | 3/27/2022 1:34 PM |
| 30 | Challenging getting therapy appointments OT PT ST Pysch | 3/27/2022 8:32 AM |
| 31 | Access to home care for elderly | 3/26/2022 11:55 AM |
| 32 | Bullying and suicidal ideation in teens | 3/25/2022 7:52 PM |
| 33 | Healthcare is poor here, lack of interest in patient services. | 3/25/2022 12:31 PM |
| 34 | Access to child care | 3/25/2022 11:01 AM |
| 35 | Knowledge of specific health issues within the community. | 3/25/2022 10:26 AM |
| 36 | Woke, progressive, neo-marxist communistic authoritarianism and bullying are eroding healthy political and social discourse and driving people insane | 3/25/2022 10:10 AM |
| 37 | i moved out of the Town i lived in because it was not a safe place to be a pedestrian. | 3/25/2022 9:19 AM |
| 38 | a local government that cares about the people not the dollar | 3/25/2022 9:04 AM |
| 39 | maintaining the excellent level of available resources we currently have. | 3/25/2022 8:53 AM |
| 40 | Access to resources such as groceries, recreation, transportation | 3/25/2022 8:29 AM |
| 41 | affordable and adequate housing for all age groups | 3/25/2022 8:25 AM |
| 42 | Lack of gluten free food options | 3/24/2022 9:32 PM |
| 43 | elderly people who live alone and refuse services, fear of change | 3/24/2022 8:26 PM |
| 44 | Access to QUALITY healthcare | 3/24/2022 7:37 PM |
| 45 | Understanding that food is medicine and that stress causes disease. These are 2 most important factors to create health. Need more education and public policy based on this vs. Medication and vaccines. | 3/24/2022 6:37 PM |
| 46 | Home health care for elderly | 3/24/2022 6:34 PM |

| | | |
|---|---|---|
| 47 | Childcare | 3/24/2022 4:44 PM |
| 48 | Drug use | 3/24/2022 1:33 PM |
| 49 | Accessibility and resources for individuals with physical impairments | 3/24/2022 1:16 PM |
| 50 | Senior housing | 3/24/2022 12:24 PM |
| 51 | The very poor communication, accountability & analytical ability of the county health dept. | 3/24/2022 8:42 AM |
| 52 | Access to a good Doctor | 3/24/2022 6:45 AM |
| 53 | Housing also affects health as does fixed and low income | 3/24/2022 6:06 AM |
| 54 | Access to quality doctors | 3/23/2022 8:49 PM |
| 55 | Understanding what services are available where and access to specialists, notably in endocrinology, dermatology and neurology. | 3/23/2022 8:04 PM |
| 56 | Difficulty getting medical appointments with specialists | 3/23/2022 6:28 PM |
| 57 | Socialization and diversity. Good supply of organic fruit and veggies | 3/21/2022 3:48 PM |

# Q4 When you think about social challenges in the community where you live, what are you most concerned about? Choose up to 5.

Answered: 440 Skipped: 45




Racial or cultural...
Safe recreational...
Street Safety (crosswalks,...
Transportation
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

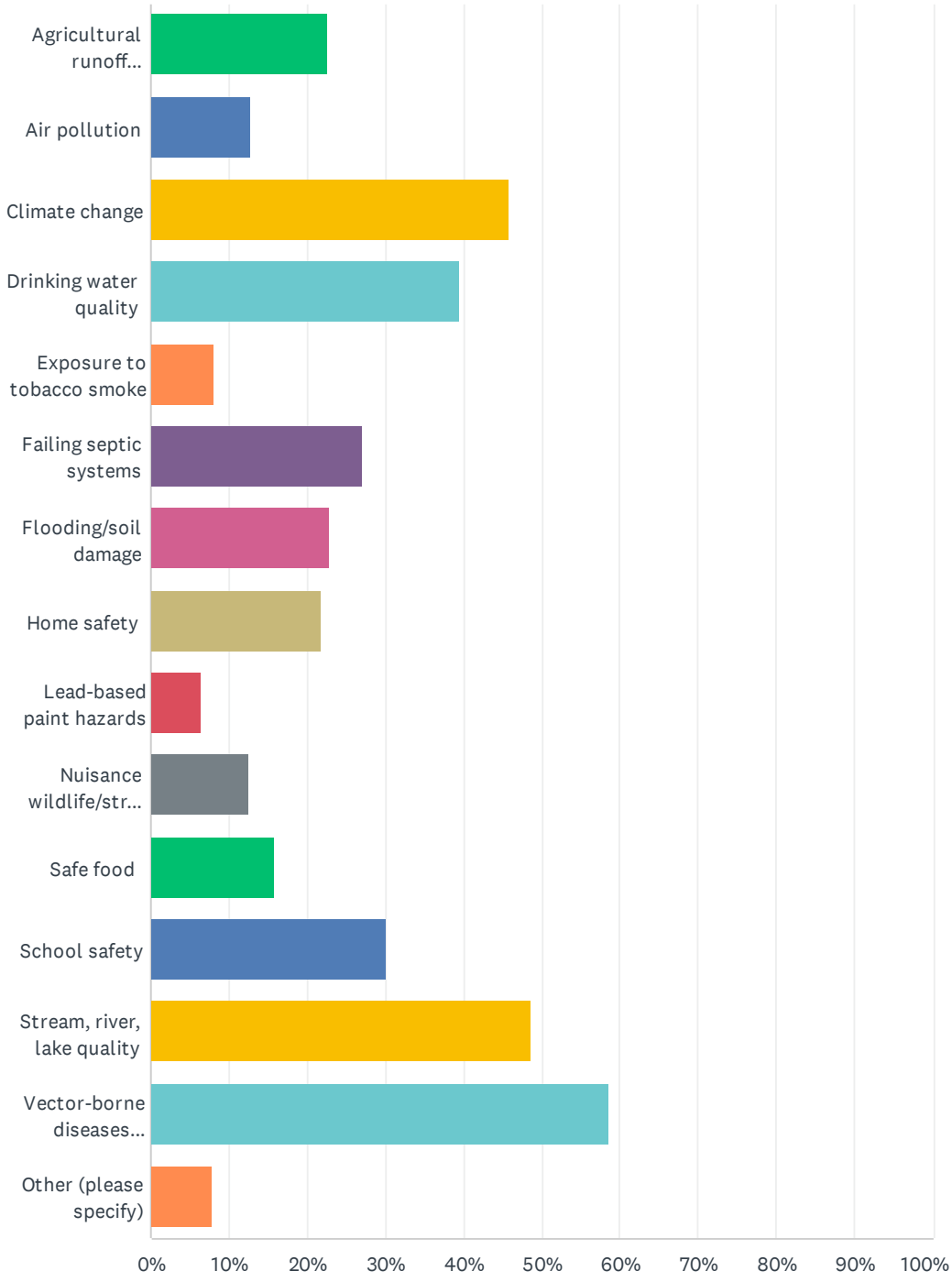
| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Access to healthy foods | 28.41% | 125 |
| Access to opportunities for health for people with intellectual or developmental disabilities | 6.36% | 28 |
| Access to opportunities for people with physical limitations or disabilities | 12.73% | 56 |
| Affordable housing | 60.91% | 268 |
| Bullying | 17.95% | 79 |
| Child abuse/neglect | 19.32% | 85 |
| Childcare | 38.18% | 168 |
| Crime/vandalism | 17.73% | 78 |
| Domestic violence | 14.32% | 63 |
| Elder abuse/neglect | 7.05% | 31 |
| Homelessness | 6.36% | 28 |
| Hunger | 9.77% | 43 |
| Incarceration rates (number of people in jail) | 1.82% | 8 |
| Lack of employment opportunities | 44.77% | 197 |
| Lack of livable wages | 54.77% | 241 |
| Lack of support/resources for seniors | 22.73% | 100 |
| Lack of support/resources for youth | 26.14% | 115 |
| Opportunities for physical activity | 13.64% | 60 |
| Racial or cultural discrimination | 10.91% | 48 |
| Safe recreational areas | 11.82% | 52 |
| Street Safety (crosswalks, shoulders, bike lanes, traffic) | 10.68% | 47 |
| Transportation | 24.32% | 107 |
| Other (please specify) | 6.14% | 27 |
| Total Respondents: 440 | | |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | Affordable health insurance | 6/21/2022 3:14 PM |
| 2 | Speed limit on Water St. is too high. | 5/21/2022 10:54 PM |
| 3 | Elise Stefanic | 5/21/2022 10:45 PM |
| 4 | politics, right-wing agenda, MAGA-followers | 5/11/2022 1:35 AM |
| 5 | Censorship, inflation, democrats | 5/10/2022 3:35 PM |
| 6 | Substance and alcohol abuse/addiction, lack of sober supports | 4/28/2022 3:34 AM |
| 7 | that many people are choosing welfare instead of working | 4/26/2022 12:23 PM |
| 8 | Faulty education | 4/19/2022 8:52 PM |

| | | |
|---|---|---|
| 9 | Lack of enough services locally | 4/6/2022 7:03 PM |
| 10 | Animal abuse | 4/5/2022 8:09 PM |
| 11 | Lack of affordable houses comparable the salaries | 4/2/2022 9:46 PM |
| 12 | Lack of anything for deaf children | 3/31/2022 10:54 AM |
| 13 | clean/affordable water source | 3/30/2022 11:05 AM |
| 14 | Addiction | 3/29/2022 8:58 PM |
| 15 | Drugs related | 3/28/2022 11:47 AM |
| 16 | How is substance abuse not a listed option here? Years of progressive enabling, victimhood ideology, open borders, and soft-on-crime policies are driving substance abuse through the roof. It is here and will only get worse without a move away from progressivism | 3/25/2022 10:10 AM |
| 17 | a local government that cares | 3/25/2022 9:04 AM |
| 18 | Maintaining the excellent level we currently enjoy. | 3/25/2022 8:53 AM |
| 19 | Lack of laundry facilities in towns and rural areas where people can not clean their clothes | 3/24/2022 8:26 PM |
| 20 | The municipalities continually put the comfort of visitors over the needs of locals | 3/24/2022 6:36 PM |
| 21 | The Changing demographic: all the new people to the area bring their failed systems from which they came and pushing them here. | 3/24/2022 1:48 PM |
| 22 | No leadership or sense of direction and improvement. No priorities, no accountability, no communication and no value for money. The County is more of a non-accountable employment mechanism than a value-adding service mechanism. Although, the snow management is quite good. | 3/24/2022 8:42 AM |
| 23 | Their are jobs, but a lack of pay scale to meet housing costs | 3/24/2022 6:06 AM |
| 24 | Understanding of quality food preparation | 3/23/2022 8:49 PM |
| 25 | Availability of simple supportive services for the elderly and disabled, such as snow shoveling, changing batteries in smoke/CO detectors, installing grab bars, etc. | 3/23/2022 8:04 PM |
| 26 | Political divisiveness | 3/23/2022 6:56 PM |
| 27 | Willsboro CS often times does not have enough bus drivers and cancels route for the day | 3/23/2022 3:02 PM |

# Q5 When you think about environmental challenges in the community where you live, what are you most concerned about?  Choose up to 5.

Answered: 440 Skipped: 45



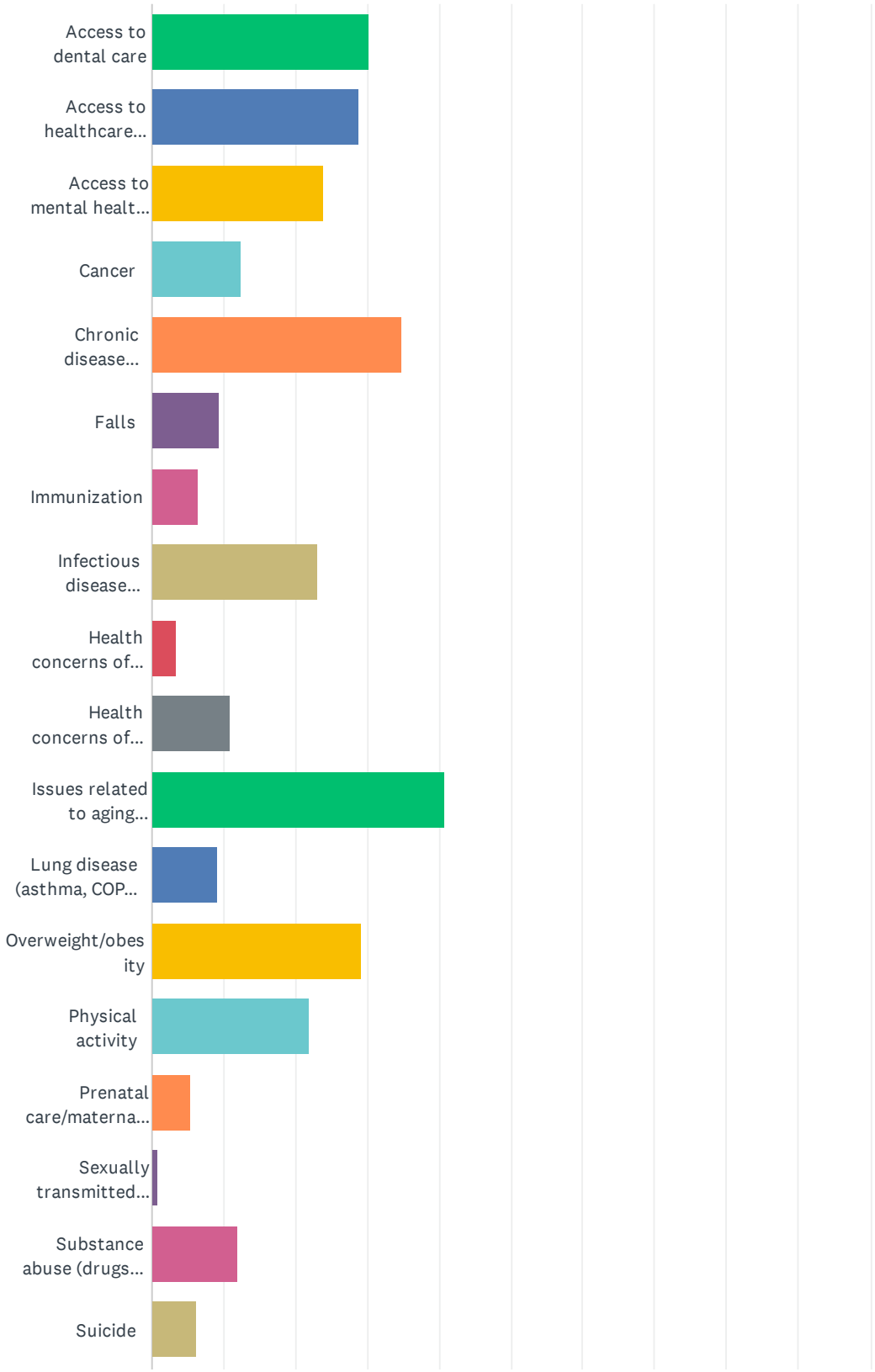
| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Agricultural runoff (manure, pesticides, etc.) | 22.50% | 99 |
| Air pollution | 12.73% | 56 |
| Climate change | 45.91% | 202 |
| Drinking water quality | 39.55% | 174 |
| Exposure to tobacco smoke | 8.18% | 36 |
| Failing septic systems | 27.05% | 119 |
| Flooding/soil damage | 22.73% | 100 |
| Home safety | 21.82% | 96 |
| Lead-based paint hazards | 6.36% | 28 |
| Nuisance wildlife/stray animals | 12.50% | 55 |
| Safe food | 15.68% | 69 |
| School safety | 30.00% | 132 |
| Stream, river, lake quality | 48.64% | 214 |
| Vector-borne diseases (mosquitoes, ticks, etc.) | 58.64% | 258 |
| Other (please specify) | 7.95% | 35 |
| Total Respondents: 440 | | |

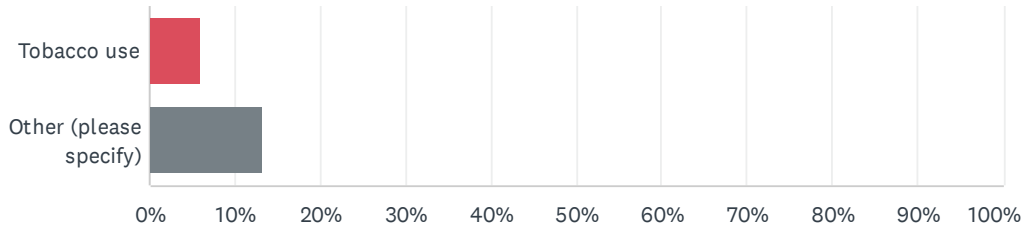
| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | Illegal disposal of toxic waste such as chemicals, oil, paint, etc. | 6/21/2022 2:24 PM |
| 2 | People burning garbage is a concern. I'm also concerned with how our drinking water source is being protected, managed and tested. | 5/21/2022 10:54 PM |
| 3 | Programs for very low income | 5/19/2022 1:49 PM |
| 4 | when i worked at Uihlein 10 years ago they flushed medication down the toilets to “properly” dispose of them | 5/18/2022 9:33 PM |
| 5 | unkempt properties; trash, discarded appliances, vehicles | 5/16/2022 2:51 PM |
| 6 | Government propaganda | 5/10/2022 3:35 PM |
| 7 | Pesticides where children play, and salt runoff from the roads, chlorine and other supposedly safe chemicals added to our town water. | 4/26/2022 8:39 AM |
| 8 | Energy rates for heating and cooling homes affordabley | 4/26/2022 8:23 AM |
| 9 | limited education | 4/19/2022 8:52 PM |
| 10 | Poor infrastructure, aging sewers and municipal water systems, lack of affordable waste removal options | 4/6/2022 7:03 PM |
| 11 | Negative Impact of so many junk cars/appliances on properties | 4/2/2022 9:46 PM |
| 12 | Asbestos | 3/31/2022 10:55 AM |
| 13 | recycling not being processed | 3/30/2022 5:58 PM |
| 14 | The amount of salt put down on the roads seems excessive and worrisome for water quality. If drivers could slow down and the DOT put more dirt we could potentially reduce salt on | 3/28/2022 2:58 PM |

| | | |
|---|---|---|
| | roadways. I'm concerned about the effect in our streams, lakes and drinking water. The environmental impact on vehicles, home appliances and water quality seems unnecessary. | |
| 15 | Smoke from outdoor boilers, trash burning | 3/27/2022 9:15 PM |
| 16 | Road salt | 3/27/2022 1:35 PM |
| 17 | Road salt contamination and ecological damage. | 3/26/2022 8:54 AM |
| 18 | Local Public transportation at any level for other than seniors | 3/25/2022 7:52 PM |
| 19 | Law enforcement at all levels have neglected to enforce vehicle emissions laws. Obnoxious, illegally modified exhaust systems on trucks and motorcycles have become a public menace. | 3/25/2022 10:10 AM |
| 20 | light pollution | 3/25/2022 9:53 AM |
| 21 | Roadway Runoff / Salt/Sand / | 3/25/2022 9:19 AM |
| 22 | a local government that cares | 3/25/2022 9:04 AM |
| 23 | maintaining the excellent level of these we currently have. | 3/25/2022 8:53 AM |
| 24 | challenges related to living in an adverse climate such as heating costs in the winter, un safe road conditions | 3/25/2022 8:29 AM |
| 25 | Dogs which are unleashed | 3/25/2022 12:03 AM |
| 26 | Excess cows | 3/24/2022 10:30 PM |
| 27 | Noise | 3/24/2022 9:32 PM |
| 28 | Homes that are unfit to live in, leaking roof, failed septic, lack of heat and clean water | 3/24/2022 8:26 PM |
| 29 | finding ways that include multiple methods of creating power for our homes cars and equipment | 3/24/2022 6:45 PM |
| 30 | Mold in environment exploding because of pesticides | 3/24/2022 6:37 PM |
| 31 | out of control motorcycle noise pollution | 3/23/2022 8:49 PM |
| 32 | Fires from chimneys not being inspected annually. | 3/23/2022 6:45 PM |
| 33 | Road salt | 3/21/2022 9:41 PM |
| 34 | None | 3/21/2022 7:23 PM |
| 35 | mold- we are in an area with water | 3/21/2022 3:48 PM |

# Q6 What health challenges have you or a family member had in the past year? Select all that apply.

Answered: 417 Skipped: 68






| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Access to dental care | 30.22% | 126 |
| Access to healthcare services | 28.78% | 120 |
| Access to mental health services | 23.98% | 100 |
| Cancer | 12.47% | 52 |
| Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.) | 34.77% | 145 |
| Falls | 9.35% | 39 |
| Immunization | 6.47% | 27 |
| Infectious disease (hepatitis A, B, C, flu, COVID-19 etc.) | 23.02% | 96 |
| Health concerns of intellectual or developmental disability | 3.36% | 14 |
| Health concerns of physical disability | 10.79% | 45 |
| Issues related to aging (arthritis, hearing/vision loss, etc.) | 40.77% | 170 |
| Lung disease (asthma, COPD, etc.) | 9.11% | 38 |
| Overweight/obesity | 29.26% | 122 |
| Physical activity | 22.06% | 92 |
| Prenatal care/maternal & infant health | 5.28% | 22 |
| Sexually transmitted infections (including HIV) | 0.96% | 4 |
| Substance abuse (drugs, alcohol, etc.) | 11.99% | 50 |
| Suicide | 6.24% | 26 |
| Tobacco use | 6.00% | 25 |
| Other (please specify) | 13.19% | 55 |
| Total Respondents: 417 | | |

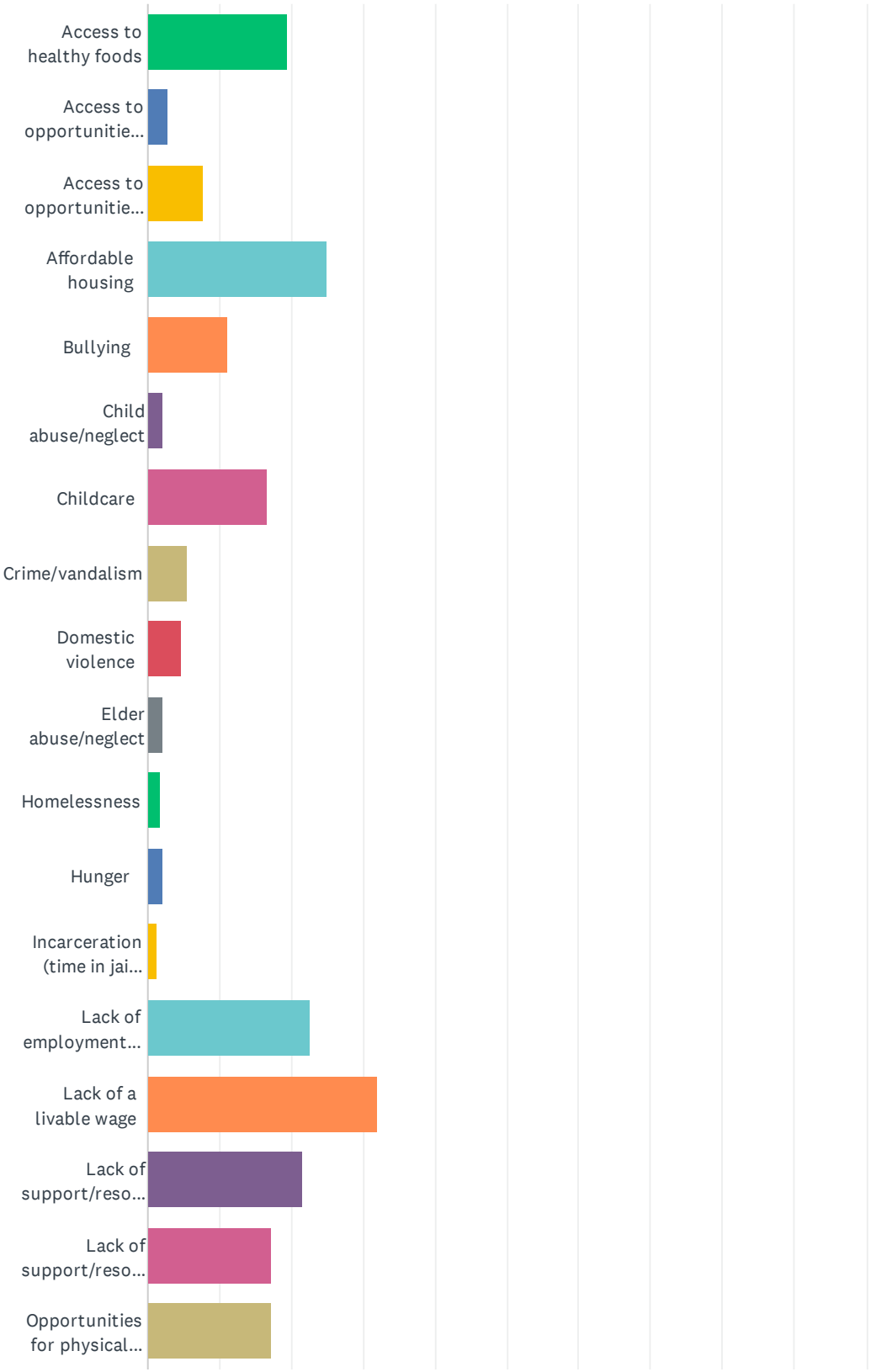
| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | Access to affordable health insurance | 6/21/2022 3:15 PM |
| 2 | Urinary problem - I had to go to Syracuse for adequate treatment | 6/21/2022 3:02 PM |
| 3 | All health concerns are important | 6/21/2022 2:57 PM |
| 4 | N/A | 6/21/2022 2:44 PM |
| 5 | No answer | 6/21/2022 2:39 PM |

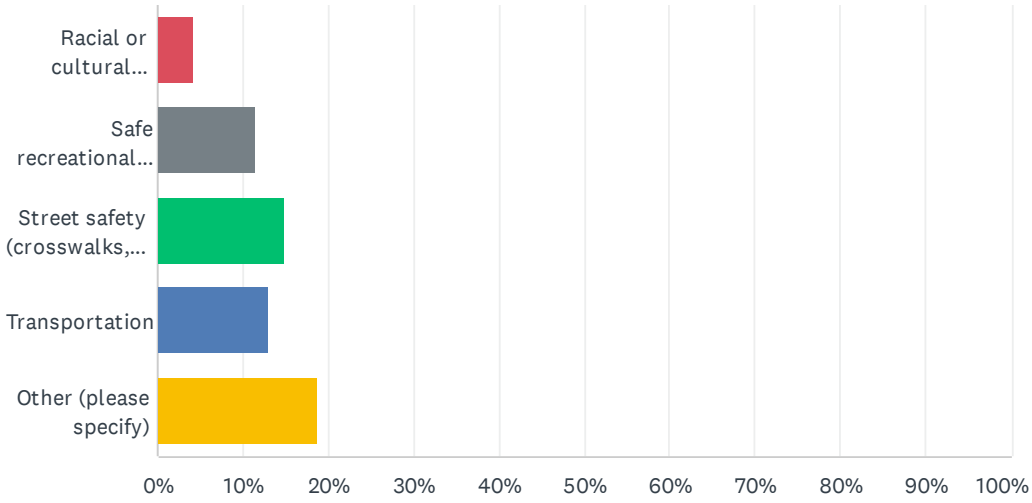
| | | |
|---|---|---|
| 6 | I have been lucky that I have relatively good health and economically can afford good health and dental care. I am concerned that there is such inequality in my town...and state...that too many people are in need. | 6/21/2022 2:34 PM |
| 7 | Chronic pain | 5/19/2022 1:51 PM |
| 8 | None | 5/19/2022 4:17 AM |
| 9 | Lyme disease | 5/19/2022 3:33 AM |
| 10 | Lack of understanding how to communicate with a person with hearing impairment. | 5/16/2022 11:01 AM |
| 11 | Lyme's disease 2x | 5/11/2022 1:39 AM |
| 12 | No Dental provider in the area that accepts state medicaid and or fidelis | 5/10/2022 7:05 PM |
| 13 | Bullying due to vaxx rules | 5/10/2022 3:38 PM |
| 14 | Help with aging parents | 5/10/2022 11:46 AM |
| 15 | none | 4/26/2022 12:25 PM |
| 16 | health concerns / undiagnosed | 4/19/2022 8:59 AM |
| 17 | regular Preventive Anything(s) that are NOT covered if YOU pay for your insurance. | 4/9/2022 7:29 AM |
| 18 | Respite services for caregivers | 4/8/2022 8:10 AM |
| 19 | tic bites | 4/7/2022 11:27 PM |
| 20 | Stress | 4/7/2022 8:02 PM |
| 21 | Lack of school awareness about mental health | 4/7/2022 6:25 PM |
| 22 | VA Medical Support | 4/7/2022 8:52 AM |
| 23 | Shortage of physicians, inability to schedule an appointment with a medical professional in a timely manor | 4/6/2022 7:08 PM |
| 24 | access to primary care physicians....I've been on a waitlist...dr's not taking new patients | 3/30/2022 4:31 PM |
| 25 | none | 3/29/2022 3:22 PM |
| 26 | When we moved to the area it took almost a year to get a new patient appointment to establish care with a primary provider. | 3/28/2022 3:05 PM |
| 27 | Lyme disease | 3/28/2022 1:21 PM |
| 28 | None | 3/27/2022 1:45 PM |
| 29 | None | 3/27/2022 1:37 PM |
| 30 | Na | 3/27/2022 1:13 PM |
| 31 | A lack of even online mental health services. Very challenging to find, maintain and afford | 3/25/2022 8:01 PM |
| 32 | affordable health insurance | 3/25/2022 1:09 PM |
| 33 | Stress and anxiety due to constant socio-political issues constantly pushed into every aspect of daily life, including sports, work, and entertainment. The mainstreaming of anti-American neo-marxist/communist ideology in the Democrat Party is of huge concern to the stability of my family's future and for the Country. | 3/25/2022 10:20 AM |
| 34 | Autoimmune issues | 3/25/2022 9:53 AM |
| 35 | a local government that cares | 3/25/2022 9:06 AM |
| 36 | cost of healthcare and insurance | 3/25/2022 8:33 AM |
| 37 | Lack of gluten free food options | 3/24/2022 9:37 PM |
| 38 | I go to Vermont for medical services | 3/24/2022 8:29 PM |
| 39 | coping with constantly changing Covid rules and the oppressive Federal response especially which continues via mandates to this day. | 3/24/2022 6:52 PM |

| | | |
|---|---|---|
| 40 | Lyme/mold | 3/24/2022 6:40 PM |
| 41 | Nutritious food for youth | 3/24/2022 6:26 PM |
| 42 | None | 3/24/2022 4:46 PM |
| 43 | NA | 3/24/2022 3:04 PM |
| 44 | Livable Wage | 3/24/2022 1:58 PM |
| 45 | The forcing of vaccines. And quarantining | 3/24/2022 12:55 PM |
| 46 | none | 3/24/2022 12:39 PM |
| 47 | bullying | 3/24/2022 12:16 PM |
| 48 | Being on the NY marketplace insurance has severely limited health issues I should have checked by a specialist because I cannot afford the medical care/doctor, etc. - that does not mean the health problem dissapated. | 3/24/2022 6:15 AM |
| 49 | Quality doctors- having to travel to UVM | 3/23/2022 8:52 PM |
| 50 | none | 3/23/2022 8:06 PM |
| 51 | late stage dementia | 3/23/2022 6:50 PM |
| 52 | Tick born disease | 3/22/2022 7:12 AM |
| 53 | immunocompromised | 3/21/2022 7:16 PM |
| 54 | Grief—lost a parent | 3/21/2022 7:10 PM |
| 55 | Availability of diverse organic veggies and fruit | 3/21/2022 3:53 PM |

# Q7 What social challenges have you or a family member had in the past year? Select all that apply.

Answered: 417 Skipped: 68




Racial or cultural...
Safe recreational...
Street safety (crosswalks,...
Transportation
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Access to healthy foods | 19.42% | 81 |
| Access to opportunities for health for those with intellectual or developmental disabilities | 2.88% | 12 |
| Access to opportunities for health for those with physical limitations or disabilities | 7.67% | 32 |
| Affordable housing | 24.94% | 104 |
| Bullying | 11.03% | 46 |
| Child abuse/neglect | 2.16% | 9 |
| Childcare | 16.55% | 69 |
| Crime/vandalism | 5.52% | 23 |
| Domestic violence | 4.80% | 20 |
| Elder abuse/neglect | 2.16% | 9 |
| Homelessness | 1.68% | 7 |
| Hunger | 2.16% | 9 |
| Incarceration (time in jail or prison) | 1.20% | 5 |
| Lack of employment opportunities | 22.54% | 94 |
| Lack of a livable wage | 31.89% | 133 |
| Lack of support/resources for seniors | 21.58% | 90 |
| Lack of support/resources for youth | 17.27% | 72 |
| Opportunities for physical activity | 17.27% | 72 |
| Racial or cultural discrimination | 4.32% | 18 |
| Safe recreational areas | 11.51% | 48 |
| Street safety (crosswalks, shoulders, bike lanes, traffic, etc.) | 14.87% | 62 |
| Transportation | 12.95% | 54 |
| Other (please specify) | 18.71% | 78 |
| Total Respondents: 417 | | |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | Access to affordable health insurance | 6/21/2022 3:15 PM |
| 2 | None | 6/21/2022 3:02 PM |
| 3 | Many people are finding cost of food and utilities a challenge | 6/21/2022 2:57 PM |
| 4 | Isolation due to COVID | 6/21/2022 2:53 PM |
| 5 | N/A | 6/21/2022 2:50 PM |
| 6 | N/A | 6/21/2022 2:47 PM |
| 7 | N/A | 6/21/2022 2:44 PM |
| 8 | N/A | 6/21/2022 2:39 PM |

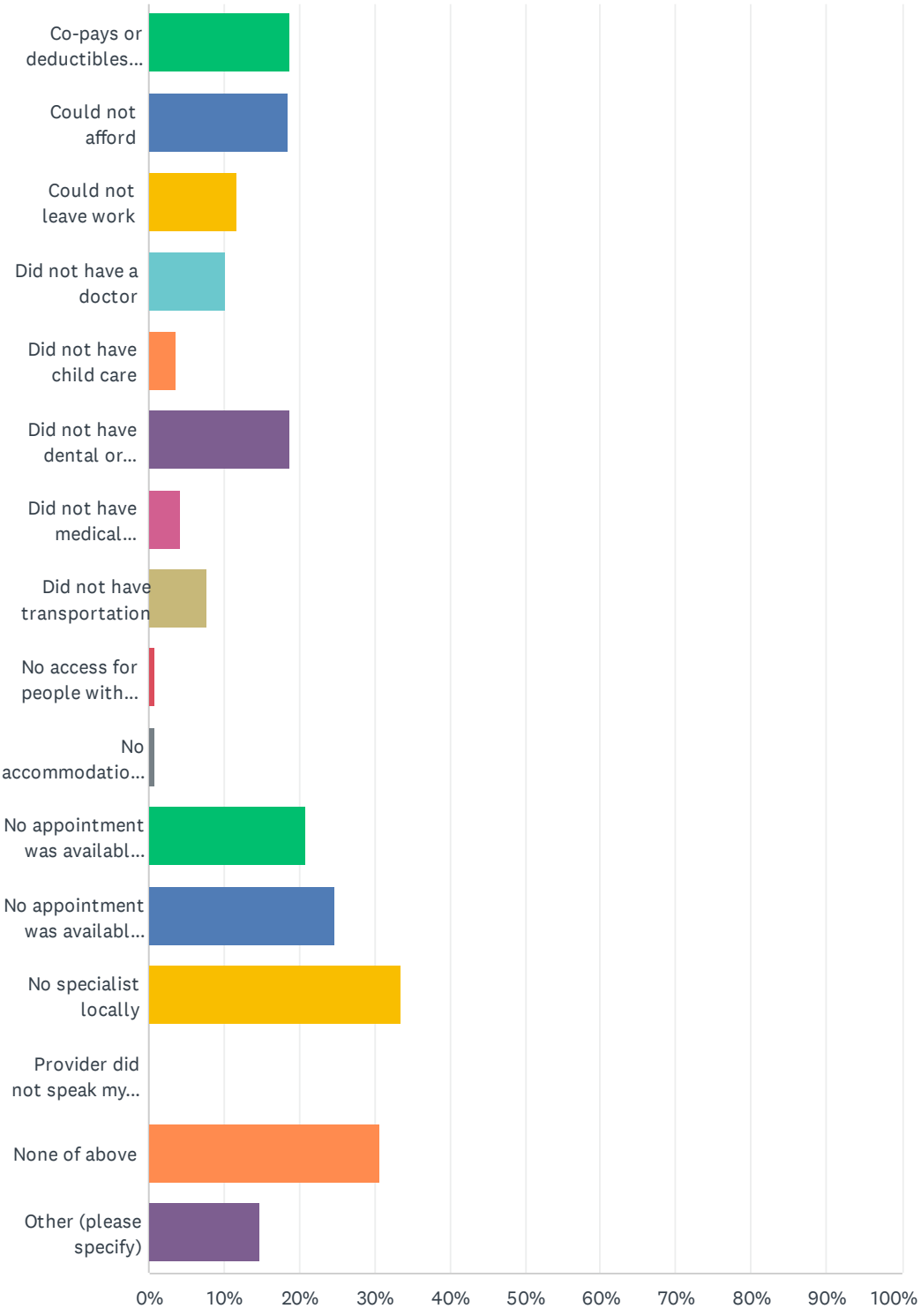
| | | |
|---|---|---|
| 9 | Again, I worry for my fellows in my county. | 6/21/2022 2:34 PM |
| 10 | Excessive speed limits in residential area. | 5/21/2022 10:54 PM |
| 11 | Phone scams | 5/19/2022 7:01 PM |
| 12 | Programs for chronic pain | 5/19/2022 1:51 PM |
| 13 | None personally | 5/19/2022 5:47 AM |
| 14 | Having to drive 45+ minutes for quality, healthy foods is inconvenient | 5/19/2022 4:17 AM |
| 15 | Noise and air pollution | 5/19/2022 3:33 AM |
| 16 | Lack of help for mental illness | 5/18/2022 9:08 PM |
| 17 | None of the above | 5/18/2022 9:07 PM |
| 18 | unease because of pressure from outspoken political MAGA supporters | 5/11/2022 1:39 AM |
| 19 | Conmection with people during Covid and non-compliance by others with Covid precautions and preventive measures | 5/11/2022 12:39 AM |
| 20 | None of these apply to ME | 5/10/2022 5:49 PM |
| 21 | Covid shutdown fallout!!!! Constant fear mongering | 5/10/2022 3:38 PM |
| 22 | Lack of opportunities for sober supports for family member with addiction | 4/28/2022 3:39 AM |
| 23 | none | 4/27/2022 3:03 AM |
| 24 | 2nd home owners taking over town | 4/26/2022 5:29 PM |
| 25 | Access to doctor, rather than PA, in local ER on a Sunday am | 4/26/2022 3:28 PM |
| 26 | inflation | 4/26/2022 12:25 PM |
| 27 | Nowhere to exercise indoors when weather is bad | 4/26/2022 8:30 AM |
| 28 | Opportunities for social activity | 4/19/2022 8:55 PM |
| 29 | Had to go to VT for a basic food allergy test | 4/9/2022 1:38 PM |
| 30 | none i guess... | 4/9/2022 7:29 AM |
| 31 | None of the above | 4/8/2022 4:45 PM |
| 32 | None of these | 4/8/2022 9:53 AM |
| 33 | Respite care for caregivers | 4/8/2022 8:10 AM |
| 34 | N/A | 4/8/2022 6:32 AM |
| 35 | No social challenges. | 4/7/2022 11:27 PM |
| 36 | None | 4/7/2022 10:16 PM |
| 37 | None | 4/7/2022 9:05 PM |
| 38 | Lack of in person social activities | 4/7/2022 8:02 PM |
| 39 | Non we | 4/5/2022 6:46 PM |
| 40 | None | 4/1/2022 2:11 PM |
| 41 | Airbnb | 3/31/2022 4:30 PM |
| 42 | None | 3/31/2022 10:40 AM |
| 43 | Access to affordable counseling for seniors | 3/31/2022 7:59 AM |
| 44 | none | 3/29/2022 3:22 PM |
| 45 | none | 3/28/2022 10:25 PM |
| 46 | Our previous community had many bike lanes and we, as a family, rode bicycles to parks, out | 3/28/2022 3:05 PM |

| | | |
|---|---|---|
| | for dinner or errands. In Lake Placid, with the traffic it isn't safe for us to bike as a family. We only live 1.5 mile from Main Street and rarely go there to shop because we can't bike nor find free parking. Bike lanes and bike racks would be amazing! | |
| 47 | N/A | 3/28/2022 11:48 AM |
| 48 | rising costs for everything making it difficult to live on one income | 3/28/2022 8:33 AM |
| 49 | none | 3/27/2022 1:45 PM |
| 50 | None | 3/27/2022 1:37 PM |
| 51 | None | 3/27/2022 1:35 PM |
| 52 | none | 3/27/2022 12:57 PM |
| 53 | Isolation due. To covid | 3/26/2022 2:11 PM |
| 54 | Need indoor recreation during the long winter months for all ages | 3/25/2022 8:01 PM |
| 55 | Coping with tyrannical lockdowns and being forced to wear masks against my will- mostly driven by Democrats and unelected officials. Recent studies by major Universities have proven these tactics to have done more harm than good, and were ineffective. No main stream attention on physical fitness and weight loss to combat COVID though... curious. We know obesity and diabetes are at the top of the list for many health problems, especially COVID complications and mortality. | 3/25/2022 10:20 AM |
| 56 | a local government that cares | 3/25/2022 9:06 AM |
| 57 | none - we live in a great community. | 3/25/2022 8:56 AM |
| 58 | lack of recreational opportunities, lack of access to affordable groceries, lack of employers that care about employees, not the bottom line | 3/25/2022 8:33 AM |
| 59 | No where to run safely | 3/25/2022 8:09 AM |
| 60 | None of these, I am very fortunate but I know others who are not | 3/24/2022 8:29 PM |
| 61 | none | 3/24/2022 6:52 PM |
| 62 | NA | 3/24/2022 3:04 PM |
| 63 | NO HELP FOR DRUG ADDICTS | 3/24/2022 2:35 PM |
| 64 | none | 3/24/2022 2:17 PM |
| 65 | None of the above | 3/24/2022 2:15 PM |
| 66 | none, though we have watched many people in the community suffer from the challenges above. | 3/24/2022 1:35 PM |
| 67 | none | 3/24/2022 12:11 PM |
| 68 | Political hatred | 3/24/2022 8:47 AM |
| 69 | none | 3/24/2022 8:27 AM |
| 70 | Living on a lower fixed income automatically limits you to joining a gym, etc. - as it is preventable medicine in the bank! Frustrating when your income is not low enough for assistance of any kind, not high enough to break the glass ceiling of opportunity- | 3/24/2022 6:15 AM |
| 71 | Quality food | 3/23/2022 8:52 PM |
| 72 | social isolation of COVID | 3/23/2022 8:06 PM |
| 73 | None personally | 3/23/2022 7:14 PM |
| 74 | Participating in a community during a pandemic | 3/23/2022 7:00 PM |
| 75 | Retired with reasonable income, and currently not challenged | 3/23/2022 6:29 PM |
| 76 | Tick born disease not understood | 3/22/2022 7:12 AM |
| 77 | Overwork | 3/21/2022 7:10 PM |

| | | |
|---|---|---|
| 78 | Furthering education for seniors at the college would be nice, subjects including mentally stimulating opportunities, employment, how to do this, that... | 3/21/2022 3:53 PM |

# Q8 If there was a time in the past year that you or a family member needed medical care but could not get it, why did you not get care? Select all that apply.

Answered: 417 Skipped: 68



| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Co-pays or deductibles were too high | 18.71% | 78 |
| Could not afford | 18.47% | 77 |
| Could not leave work | 11.75% | 49 |
| Did not have a doctor | 10.31% | 43 |
| Did not have child care | 3.60% | 15 |
| Did not have dental or vision insurance | 18.71% | 78 |
| Did not have medical insurance | 4.32% | 18 |
| Did not have transportation | 7.67% | 32 |
| No access for people with physical disabilities | 0.96% | 4 |
| No accommodations for people with intellectual or developmental disabilities | 0.96% | 4 |
| No appointment was available (primary care) | 20.86% | 87 |
| No appointment was available (specialist) | 24.70% | 103 |
| No specialist locally | 33.57% | 140 |
| Provider did not speak my language | 0.00% | 0 |
| None of above | 30.70% | 128 |
| Other (please specify) | 14.63% | 61 |
| Total Respondents: 417 | | |

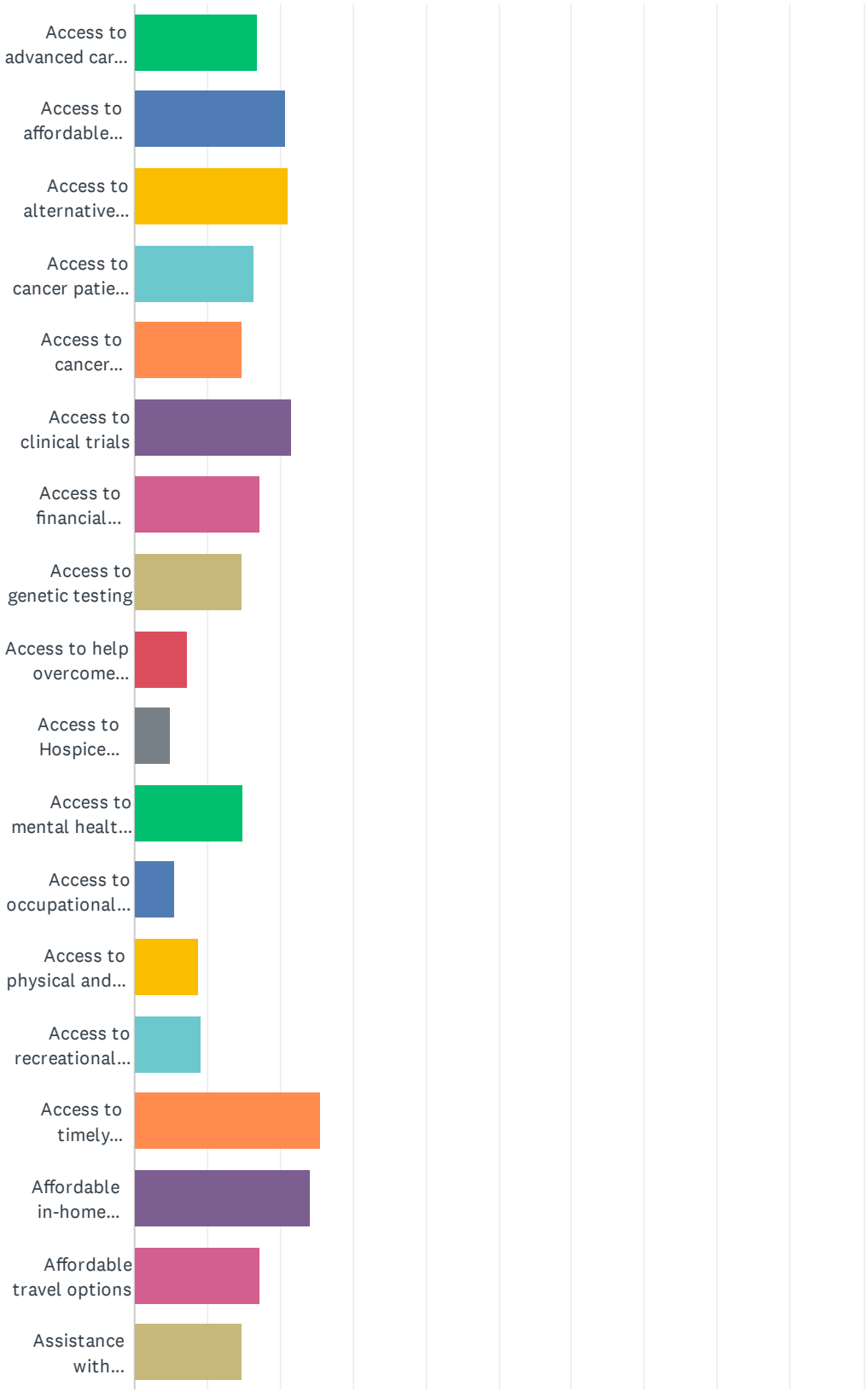
| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | wait for COVID vaccines to arrive | 6/21/2022 2:53 PM |
| 2 | N/A | 6/21/2022 2:50 PM |
| 3 | N/A | 6/21/2022 2:47 PM |
| 4 | The cost of insurance is so high. Doesn't leave much leftover to pay cost of co-pays or deductibles. | 6/21/2022 2:44 PM |
| 5 | Dental - stopped taking people | 6/21/2022 2:29 PM |
| 6 | Covid | 5/21/2022 10:54 PM |
| 7 | No dental care nearby for medicaid folks | 5/20/2022 11:43 AM |
| 8 | Health center refusal to see patients in an exam room. Granddaughter was having issues with her belly and was refused exam room visit because of Covid. Apparently weeks of belly pain could result in a positive Covid diagnosis. Had to take her to the emergency room to be evaluated properly | 5/19/2022 2:41 PM |
| 9 | Transportation and insurance won’t pay fir tests | 5/19/2022 1:51 PM |
| 10 | Covid Fears | 5/19/2022 10:42 AM |
| 11 | Covid-19 protocols limited ability to see a doctor without having to quarantine every visit | 5/18/2022 9:41 PM |
| 12 | There was NO time in the past year we did not get the medical help we needed | 5/10/2022 5:49 PM |
| 13 | Covid and masking restrictions | 5/10/2022 3:38 PM |
| 14 | Needed someone to come into our home to assist elderly parent and no one who could accept | 5/10/2022 11:46 AM |

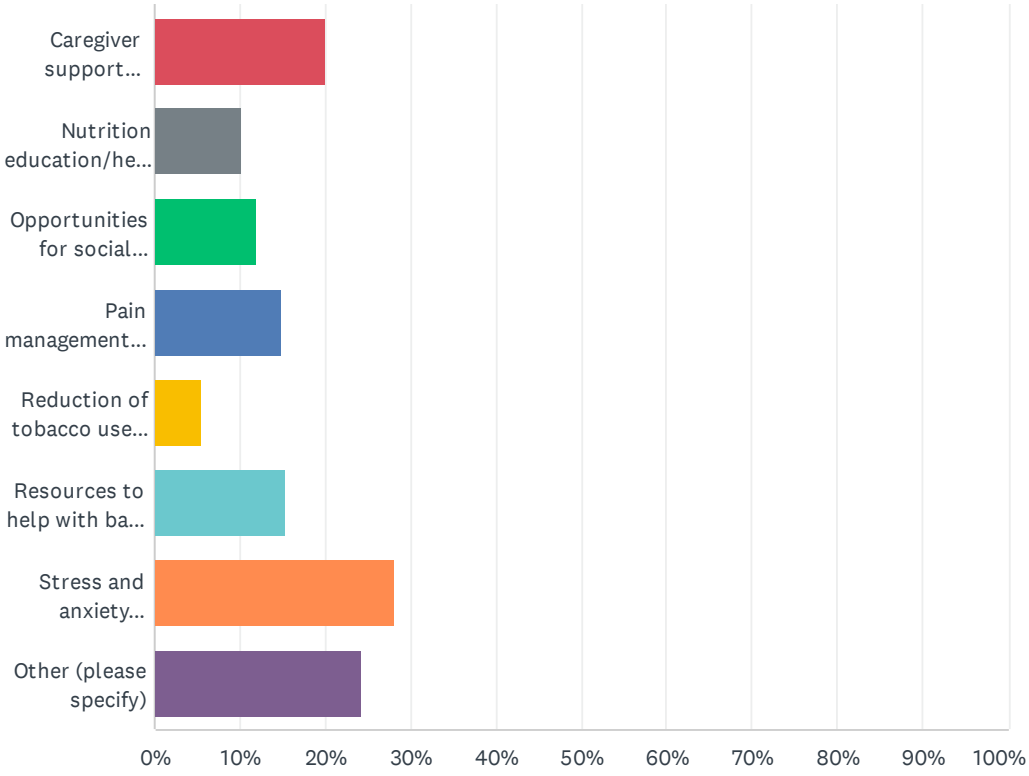
| | | |
|---|---|---|
| | mom's insurance was available | |
| 15 | Distance required to travel for appointments conflicted with work. Medical care delayed due to Covid restrictions in senior living community for a family member. | 4/28/2022 3:39 AM |
| 16 | Lack of physical therapists. Doctor would not treat for tick bite | 4/26/2022 8:30 AM |
| 17 | braces for my son in local area with work its hard to travel 2 hours away and add on gas prices now | 4/8/2022 11:54 AM |
| 18 | No provider would see new patients or there was at least a six month wait for an appointment. Some instances a provider would not even return our calls. We have lived here for three years and have had to drive back to NYC for healthcare services because we have zero access to care here. We are moving out of the area because this is unsustainable for our life | 4/8/2022 8:03 AM |
| 19 | prescription med not dispensed in timely manner | 4/8/2022 7:37 AM |
| 20 | Does not apply | 4/7/2022 8:19 PM |
| 21 | Not applicable | 4/7/2022 6:50 PM |
| 22 | Lack of mental health providers | 4/7/2022 6:25 PM |
| 23 | no medicaid doctors in our area | 4/7/2022 8:52 AM |
| 24 | pandemic | 4/4/2022 7:42 PM |
| 25 | N/A | 4/1/2022 2:11 PM |
| 26 | This question does not apply to me | 4/1/2022 1:11 PM |
| 27 | Providers did not take insurance | 3/31/2022 9:17 AM |
| 28 | Lack of mental health options/counseling | 3/30/2022 6:00 PM |
| 29 | Providers didn’t accept the kind of insurance we have | 3/29/2022 7:21 AM |
| 30 | None | 3/28/2022 7:13 PM |
| 31 | Particularly hard to find dentist that accepts medicaid | 3/27/2022 9:17 PM |
| 32 | Concern about exposure to COVID-19 | 3/27/2022 1:23 PM |
| 33 | Covid prevented access to Dr office | 3/26/2022 12:35 AM |
| 34 | More that I had the care then months and months later get slammed with a large bill | 3/25/2022 8:56 PM |
| 35 | The county did not even have the capability to provide enough mental health appointments. They knew my child needed services 3x a week and knowing that they couldn’t offer that they insisted I get and pay for an evaluation. Waste of time and money for us but the county pushed paper and made money off if my family. So sad so wrong | 3/25/2022 8:01 PM |
| 36 | Specialist in my area did not take insurance | 3/25/2022 4:57 PM |
| 37 | NO dental | 3/25/2022 1:20 PM |
| 38 | Our medical insurance wasn't accepted by our previous providers. | 3/25/2022 11:06 AM |
| 39 | No local dentist or vision provider would take the insurance when we had it. | 3/25/2022 11:06 AM |
| 40 | Insurance doesn't cover certain preventable health measures | 3/25/2022 9:21 AM |
| 41 | a local government that cares | 3/25/2022 9:06 AM |
| 42 | Needed bandages changed after surgery, could not get local help with that. | 3/25/2022 12:06 AM |
| 43 | Concerns relating to Covid-19 | 3/24/2022 9:37 PM |
| 44 | I have what I need | 3/24/2022 8:29 PM |
| 45 | Covid 19 rextrictions | 3/24/2022 7:30 PM |
| 46 | none, we managed as a family | 3/24/2022 6:52 PM |
| 47 | Dna | 3/24/2022 6:32 PM |

| | | |
|---|---|---|
| 48 | Covid restrictions limited care | 3/24/2022 4:47 PM |
| 49 | NO HELP FOR DRUG ADDICTS | 3/24/2022 2:35 PM |
| 50 | Having to wait several months for an appointment. | 3/24/2022 12:43 PM |
| 51 | Medical insurance will not cover a lot of things. | 3/24/2022 12:21 PM |
| 52 | Go ahead… get the flu or have a sudden issue try and see a doctor in this community. | 3/24/2022 8:47 AM |
| 53 | I have sold x-c skis to see a dr to have a cyst drained several times so it would not become sepsis- what is not right about that picture?! | 3/24/2022 6:15 AM |
| 54 | Maintain doctors 2, and 5 hours away from home | 3/23/2022 8:52 PM |
| 55 | NA | 3/23/2022 8:06 PM |
| 56 | Had no issues. | 3/23/2022 7:58 PM |
| 57 | Did not have a dentist | 3/23/2022 7:00 PM |
| 58 | No home health care nurse available for evaluating a patient. | 3/23/2022 6:50 PM |
| 59 | excessively long wait times for appointments | 3/23/2022 2:16 PM |
| 60 | gender affirming healthcare | 3/21/2022 7:16 PM |
| 61 | PT isn't covered at the hospital because it is called a post op care out patient facility, blue cross won't cover unless I have surgery. CRAZY | 3/21/2022 3:53 PM |

# Q9 Select the cancer services you feel are missing or lacking in the community based on your experience. Select all that apply.

Answered: 403 Skipped: 82




Caregiver support...
Nutrition education/he...
Opportunities for social...
Pain management...
Reduction of tobacco use...
Resources to help with ba...
Stress and anxiety...
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Access to advanced care planning | 16.87% | 68 |
| Access to affordable prescription/medication coverage | 20.60% | 83 |
| Access to alternative healthcare providers (acupuncture, chiropractors, etc.) | 21.09% | 85 |
| Access to cancer patient support groups | 16.38% | 66 |
| Access to cancer screenings/resources/information | 14.64% | 59 |
| Access to clinical trials | 21.59% | 87 |
| Access to financial assistance programs for co-pays and bills | 17.37% | 70 |
| Access to genetic testing | 14.64% | 59 |
| Access to help overcome drug/alcohol dependence | 7.20% | 29 |
| Access to Hospice services | 4.96% | 20 |
| Access to mental health services | 14.89% | 60 |
| Access to occupational therapy | 5.46% | 22 |
| Access to physical and exercise therapy | 8.68% | 35 |
| Access to recreational/exercise facilities and services for individuals with physical impairments and disabilities | 9.18% | 37 |
| Access to timely specialty care | 25.56% | 103 |
| Affordable in-home services | 24.07% | 97 |
| Affordable travel options | 17.37% | 70 |
| Assistance with understanding health insurance benefits and coverage | 14.64% | 59 |
| Caregiver support (respite) | 20.10% | 81 |
| Nutrition education/healthy meal planning | 10.17% | 41 |
| Opportunities for social connections | 11.91% | 48 |
| Pain management services | 14.89% | 60 |
| Reduction of tobacco use including e-cigarettes | 5.46% | 22 |
| Resources to help with basic needs (food, housing, paying bills, etc.) | 15.38% | 62 |
| Stress and anxiety resources and treatment | 28.04% | 113 |
| Other (please specify) | 24.32% | 98 |
| Total Respondents: 403 | | |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | N/A | 6/21/2022 3:15 PM |
| 2 | N/A | 6/21/2022 3:02 PM |
| 3 | Cost of medications, access to timely care and support groups would all be essential | 6/21/2022 2:58 PM |
| 4 | N/A | 6/21/2022 2:50 PM |
| 5 | N/A | 6/21/2022 2:47 PM |

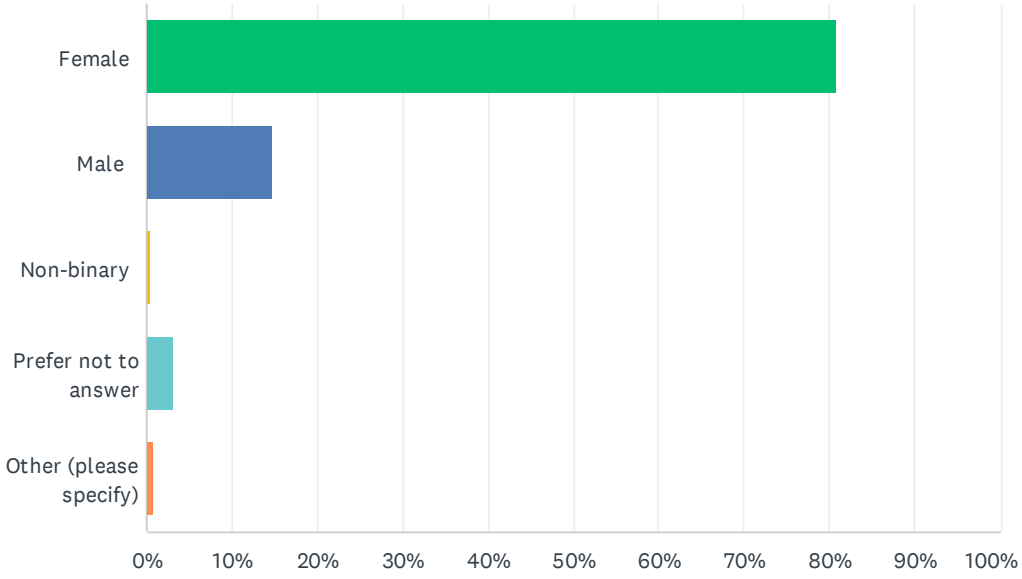
| | | |
|---|---|---|
| 6 | N/A | 6/21/2022 2:44 PM |
| 7 | N/A | 6/21/2022 2:39 PM |
| 8 | I was living in a very different community when I was diagnosed with breast cancer and had access to excellent care (within an hour's drive) | 6/21/2022 2:35 PM |
| 9 | N/A | 6/21/2022 2:29 PM |
| 10 | Not applicable | 5/20/2022 5:00 AM |
| 11 | Whoever designed this survey needed to add a “n/a”option | 5/19/2022 7:02 PM |
| 12 | Transportation | 5/19/2022 1:52 PM |
| 13 | none | 5/19/2022 10:42 AM |
| 14 | No | 5/19/2022 5:48 AM |
| 15 | No personal experience with this. Obviously the fact that people have to travel at least an hour for quality treatment for any medical appointments could be hard for some people. | 5/19/2022 4:18 AM |
| 16 | it’s always a concern but not had to deal with it yet | 5/18/2022 9:36 PM |
| 17 | Does not apply. | 5/16/2022 11:02 AM |
| 18 | Unknown | 5/11/2022 12:40 AM |
| 19 | Transportation to treatments | 5/10/2022 8:53 PM |
| 20 | When I had cancer 15 years ago I had all the services needed. Many of the above services did not apply to me at that time. | 5/10/2022 5:51 PM |
| 21 | N/A | 5/10/2022 4:23 PM |
| 22 | Have not experienced cancer | 5/10/2022 2:50 PM |
| 23 | n/a | 4/27/2022 3:03 AM |
| 24 | N/A | 4/26/2022 11:13 AM |
| 25 | NA-No experience with cancer treatments | 4/25/2022 5:42 PM |
| 26 | I have no experience in this area. | 4/19/2022 8:57 PM |
| 27 | My daughter was living outside the US. | 4/8/2022 4:46 PM |
| 28 | NA | 4/8/2022 11:22 AM |
| 29 | no experience in this community | 4/8/2022 9:54 AM |
| 30 | Transportation costs to Vermont | 4/8/2022 9:42 AM |
| 31 | While I have not been diagnosed with cancer based on my experience in being able to get access to primary care and specialty care for other health concerns there is zero access to cancer care in Essex county. | 4/8/2022 8:05 AM |
| 32 | Not applicable | 4/8/2022 7:24 AM |
| 33 | N/A | 4/7/2022 10:17 PM |
| 34 | D/n apply | 4/7/2022 9:11 PM |
| 35 | N/A | 4/7/2022 9:05 PM |
| 36 | Does not apply | 4/7/2022 8:20 PM |
| 37 | Not applicable | 4/7/2022 6:34 PM |
| 38 | NA | 4/7/2022 6:26 PM |
| 39 | Not pertinent | 4/7/2022 9:32 AM |
| 40 | N/A | 4/6/2022 7:09 PM |

| | | |
|---|---|---|
| 41 | None | 4/5/2022 8:12 PM |
| 42 | Social services and mental health in hospital setting | 4/4/2022 7:29 PM |
| 43 | N/A | 4/1/2022 2:59 PM |
| 44 | #9 above does not apply to me | 4/1/2022 1:13 PM |
| 45 | n/a | 4/1/2022 10:13 AM |
| 46 | None. Community too small and access is within 2 hrs | 4/1/2022 9:56 AM |
| 47 | No dermatologist within 2 hour drive | 3/31/2022 4:33 PM |
| 48 | Does not apply to me | 3/31/2022 10:45 AM |
| 49 | None | 3/31/2022 10:42 AM |
| 50 | Na | 3/31/2022 9:17 AM |
| 51 | n/a | 3/30/2022 9:22 AM |
| 52 | NA | 3/29/2022 9:05 PM |
| 53 | none | 3/29/2022 3:22 PM |
| 54 | None | 3/28/2022 7:14 PM |
| 55 | Access to higher levels of care than Albany or Burlington can provide for complicated cases. | 3/28/2022 3:50 PM |
| 56 | N/A | 3/28/2022 3:06 PM |
| 57 | N/A (no experience here) | 3/27/2022 1:37 PM |
| 58 | Support for patient whose services were on the other side of the lake | 3/27/2022 1:25 PM |
| 59 | Ccx | 3/26/2022 10:12 PM |
| 60 | NA | 3/25/2022 12:27 PM |
| 61 | Multiple cancer dx in family, but don't live in this community. | 3/25/2022 11:08 AM |
| 62 | n/a | 3/25/2022 9:53 AM |
| 63 | unknown | 3/25/2022 9:22 AM |
| 64 | no local specialists | 3/25/2022 9:07 AM |
| 65 | we've received excellent care / support as caregiver and patient. | 3/25/2022 8:57 AM |
| 66 | Essex county healthcare is severely lacking. I go to VT for better services that I feel confident in | 3/25/2022 8:35 AM |
| 67 | Na | 3/25/2022 8:09 AM |
| 68 | Complacent medical staff | 3/24/2022 10:34 PM |
| 69 | I have not had cancer | 3/24/2022 8:29 PM |
| 70 | NA | 3/24/2022 8:03 PM |
| 71 | None | 3/24/2022 7:31 PM |
| 72 | none, but this is confusing as to your goal in collecting information | 3/24/2022 6:53 PM |
| 73 | N/A | 3/24/2022 6:47 PM |
| 74 | No cancer | 3/24/2022 6:37 PM |
| 75 | Na | 3/24/2022 6:16 PM |
| 76 | NA | 3/24/2022 4:46 PM |
| 77 | OUR COMMUNITY HAS NONE OF THIS | 3/24/2022 2:36 PM |
| 78 | none | 3/24/2022 2:18 PM |

| | | |
|---|---|---|
| 79 | Not applicable | 3/24/2022 2:16 PM |
| 80 | NA | 3/24/2022 1:52 PM |
| 81 | N/A | 3/24/2022 1:07 PM |
| 82 | n/a | 3/24/2022 12:17 PM |
| 83 | ALL OPTIONS AVAILABLE | 3/24/2022 12:17 PM |
| 84 | Assistance to family members going through this | 3/24/2022 12:11 PM |
| 85 | n/a | 3/24/2022 10:27 AM |
| 86 | The crackdown on narcotic abuse has made prescriber too frightened or overburdened with paperwork to consider the whole patient | 3/24/2022 8:54 AM |
| 87 | Timely cancer services and expertise is a complete void. If you think access to a general oncologist once a month is a sufficient care plan for an acute case, you simply do not understand some types of cancer. | 3/24/2022 8:51 AM |
| 88 | N/A | 3/24/2022 8:28 AM |
| 89 | While this has not been a disease I / we have dealt with (their are other issues though), we have an exceedingly number of fund raisers for folks in the area for treatment costs, etc.-the health insurance is inadequate for the majority of the people. | 3/24/2022 6:19 AM |
| 90 | Access to quality surgeon, oncologist and radiologist | 3/23/2022 8:54 PM |
| 91 | Not applicable | 3/23/2022 8:41 PM |
| 92 | NA | 3/23/2022 8:06 PM |
| 93 | N/A | 3/23/2022 2:24 PM |
| 94 | N/A | 3/23/2022 2:17 PM |
| 95 | Don’t know | 3/22/2022 7:13 AM |
| 96 | Doesn't apply | 3/21/2022 7:25 PM |
| 97 | My family members with cancer lived in other states | 3/21/2022 7:11 PM |
| 98 | I don't have this issue | 3/21/2022 3:54 PM |

# Q10 What gender do you identify with?

Answered: 396 Skipped: 89

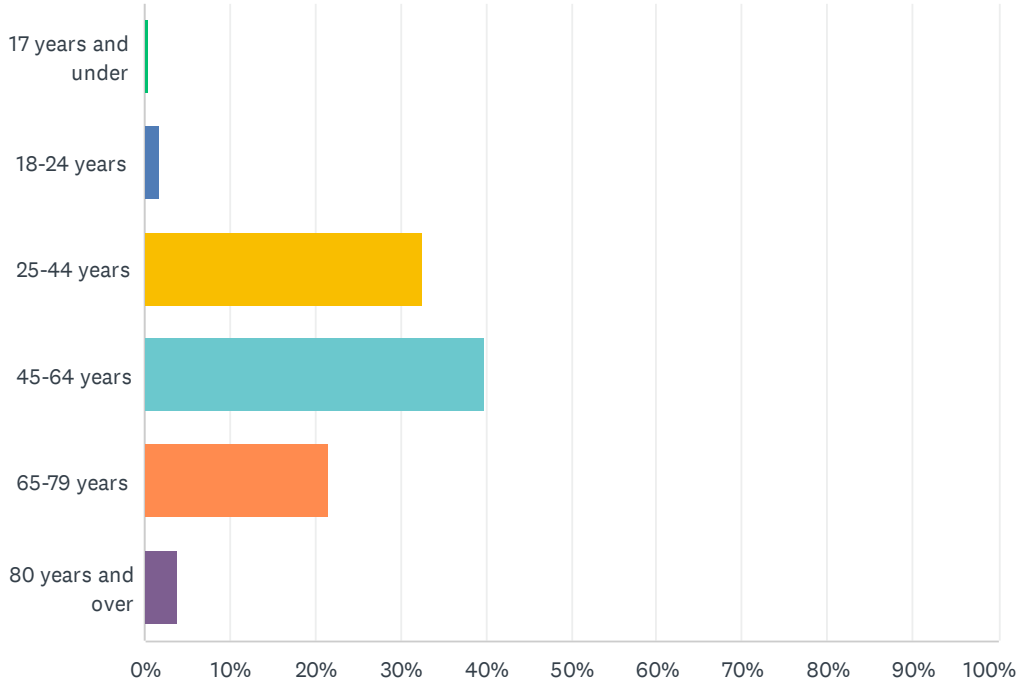



| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Female | 80.81% | 320 |
| Male | 14.65% | 58 |
| Non-binary | 0.51% | 2 |
| Prefer not to answer | 3.28% | 13 |
| Other (please specify) | 0.76% | 3 |
| TOTAL | | 396 |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | Agender | 4/8/2022 4:08 PM |
| 2 | The three of us are two males and a female | 3/24/2022 6:56 PM |
| 3 | I no more trust your data collection process than I trust your communication skills. | 3/24/2022 8:55 AM |

# Q11 What is your age?

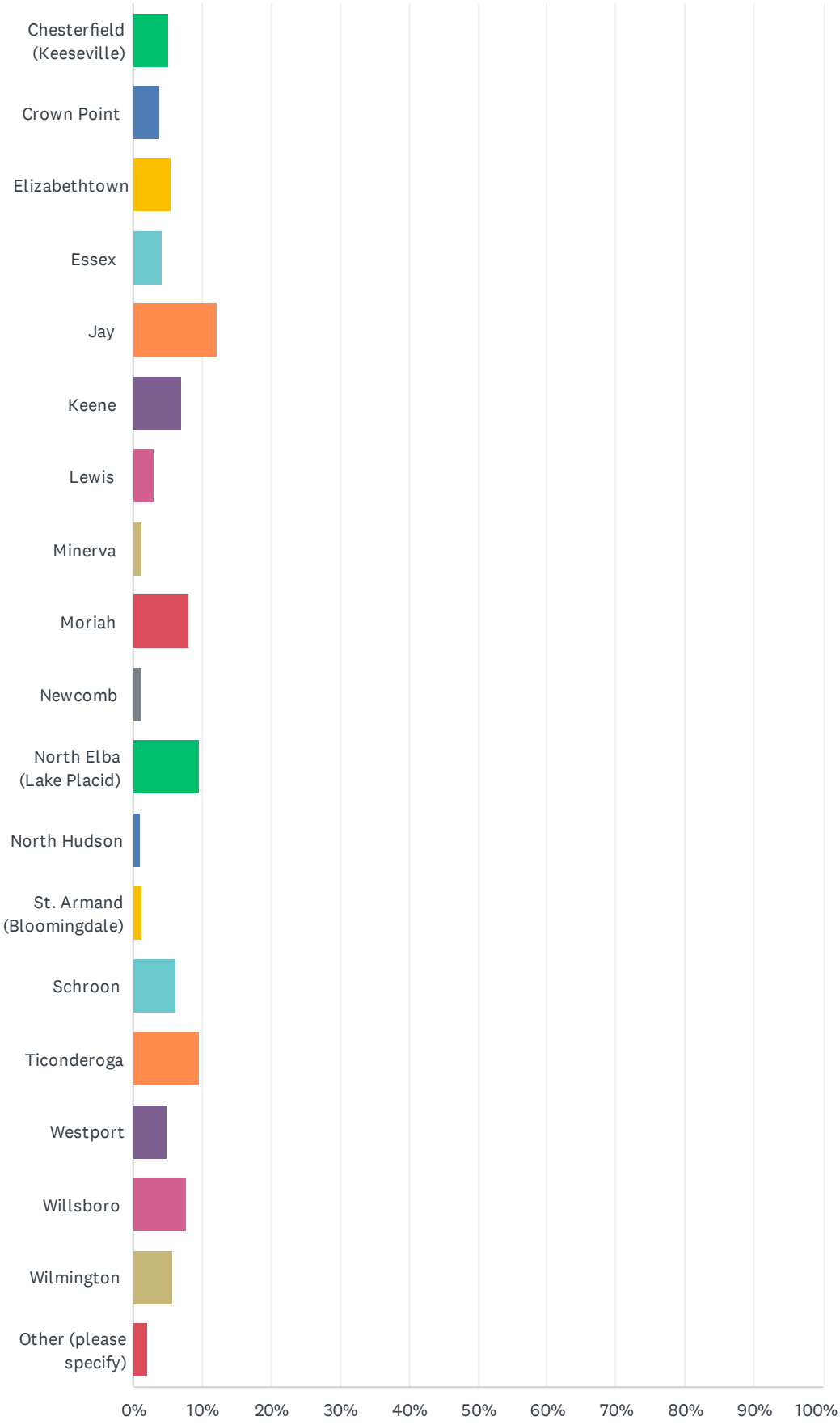
Answered: 396 Skipped: 89




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| 17 years and under | 0.51% | 2 |
| 18-24 years | 1.77% | 7 |
| 25-44 years | 32.58% | 129 |
| 45-64 years | 39.90% | 158 |
| 65-79 years | 21.46% | 85 |
| 80 years and over | 3.79% | 15 |
| TOTAL | | 396 |

# Q12 What city/town do you live in? Select only one based on your primary residence.

Answered: 393 Skipped: 92

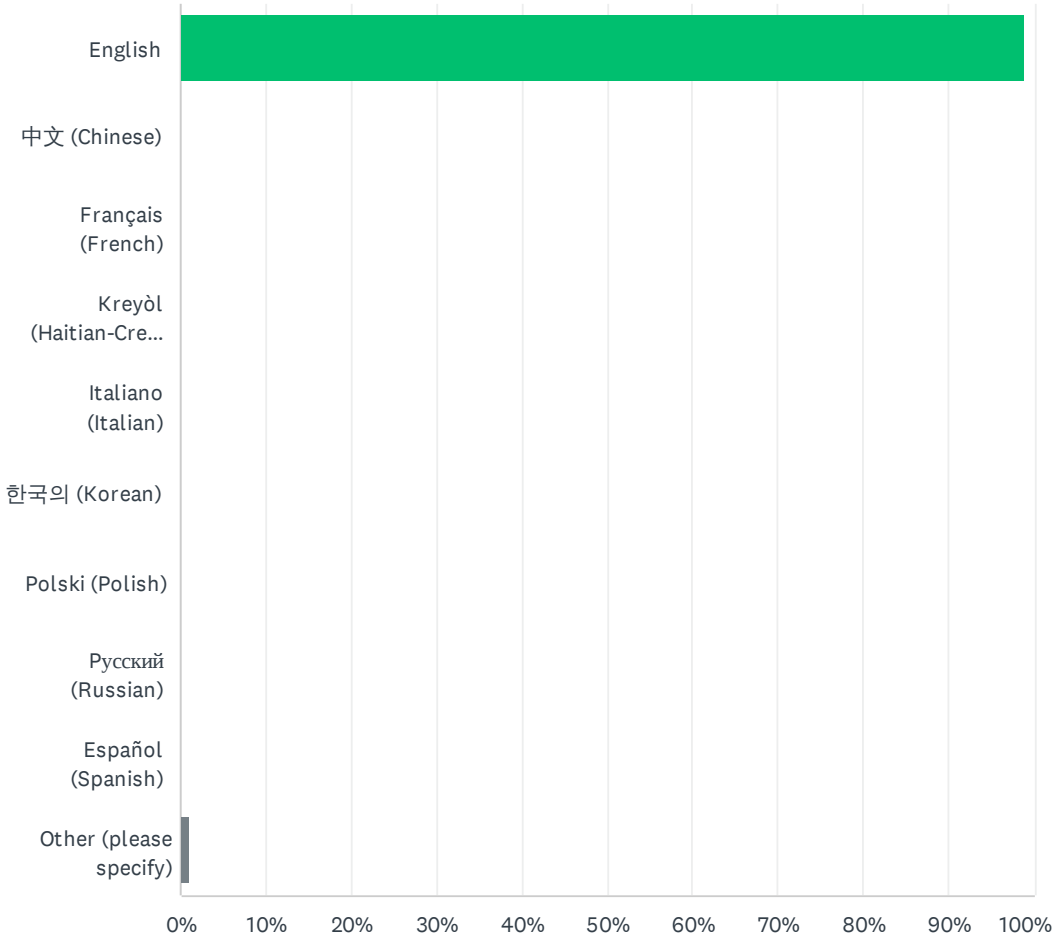

Chesterfield (Keeseville)
Crown Point
Elizabethtown
Essex
Jay
Keene
Lewis
Minerva
Moriah
Newcomb
North Elba (Lake Placid)
North Hudson
St. Armand (Bloomingdale)
Schroon
Ticonderoga
Westport
Willsboro
Wilmington
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Chesterfield (Keeseville) | 5.09% | 20 |
| Crown Point | 3.82% | 15 |
| Elizabethtown | 5.60% | 22 |
| Essex | 4.33% | 17 |
| Jay | 12.21% | 48 |
| Keene | 7.12% | 28 |
| Lewis | 3.05% | 12 |
| Minerva | 1.27% | 5 |
| Moriah | 8.14% | 32 |
| Newcomb | 1.27% | 5 |
| North Elba (Lake Placid) | 9.67% | 38 |
| North Hudson | 1.02% | 4 |
| St. Armand (Bloomingdale) | 1.27% | 5 |
| Schroon | 6.11% | 24 |
| Ticonderoga | 9.67% | 38 |
| Westport | 4.83% | 19 |
| Willsboro | 7.63% | 30 |
| Wilmington | 5.85% | 23 |
| Other (please specify) | 2.04% | 8 |
| TOTAL | | 393 |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | New Russia | 4/4/2022 7:45 PM |
| 2 | Olmstedville | 3/31/2022 8:01 AM |
| 3 | saranac lake | 3/30/2022 4:34 PM |
| 4 | Putnam Station NY | 3/25/2022 1:27 PM |
| 5 | Cadyville | 3/25/2022 8:55 AM |
| 6 | Port Henry | 3/24/2022 7:59 PM |
| 7 | CITY OF ELIZABETHTOWN/TOWN OF LEWIS | 3/24/2022 12:18 PM |
| 8 | Essex County | 3/24/2022 8:55 AM |

# Q13 What is the primary language spoken in your household?

Answered: 396 Skipped: 89

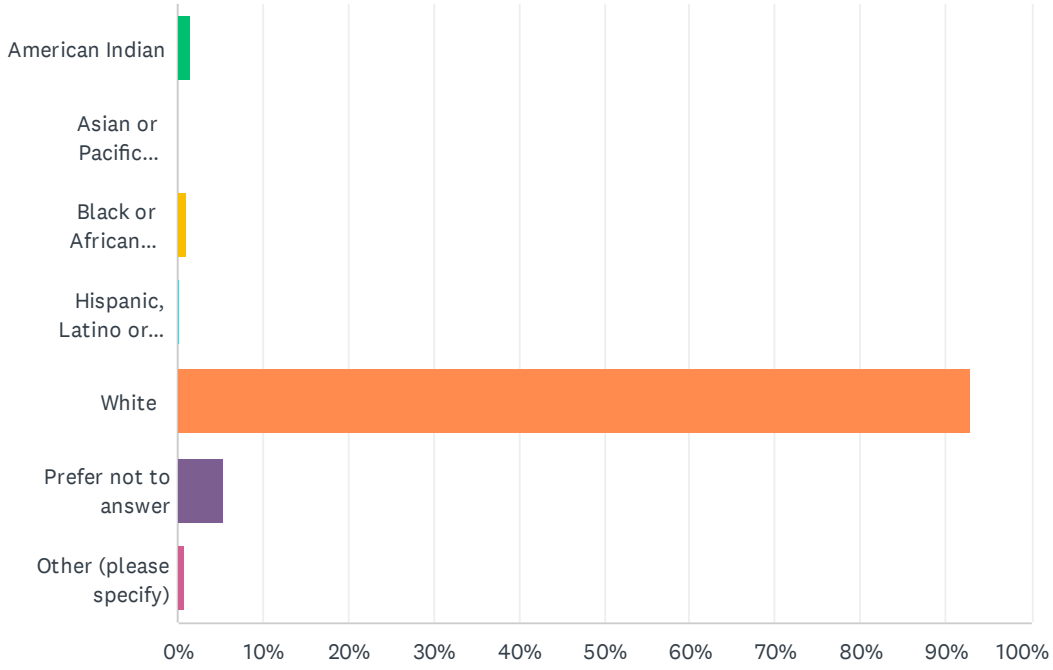


| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| English | 98.99% | 392 |
| 中文 (Chinese) | 0.00% | 0 |
| Français (French) | 0.00% | 0 |
| Kreyòl (Haitian-Creole) | 0.00% | 0 |
| Italiano (Italian) | 0.00% | 0 |
| 한국의 (Korean) | 0.00% | 0 |
| Polski (Polish) | 0.00% | 0 |
| Русский (Russian) | 0.00% | 0 |
| Español (Spanish) | 0.00% | 0 |
| Other (please specify) | 1.01% | 4 |
| TOTAL | | 396 |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | no answer provided | 6/21/2022 3:13 PM |
| 2 | Macedonian | 5/18/2022 7:42 PM |
| 3 | cat | 4/9/2022 7:33 AM |
| 4 | American Sign Language | 4/8/2022 4:08 PM |

# Q14 What is your race/ethnicity? Select all that apply.

Answered: 396 Skipped: 89

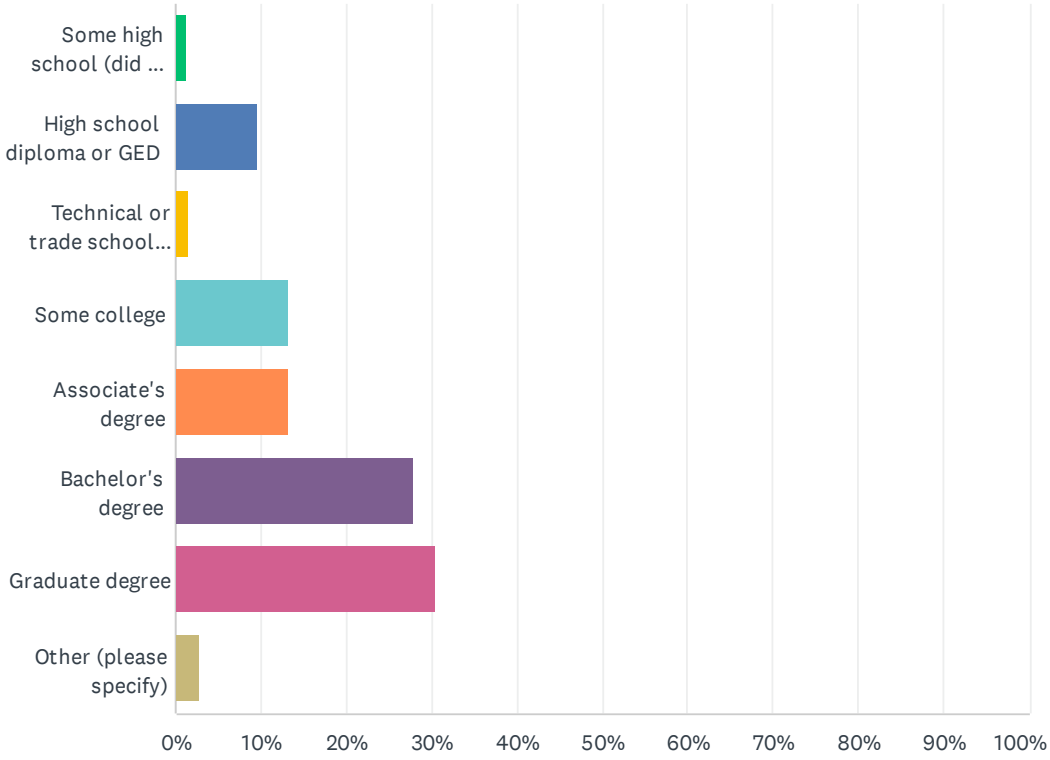



| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| American Indian | 1.52% | 6 |
| Asian or Pacific Islander | 0.00% | 0 |
| Black or African American | 1.01% | 4 |
| Hispanic, Latino or Spanish origin | 0.25% | 1 |
| White | 92.93% | 368 |
| Prefer not to answer | 5.30% | 21 |
| Other (please specify) | 0.76% | 3 |
| Total Respondents: 396 | | |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | local / Adirondack | 4/9/2022 7:33 AM |
| 2 | MENA | 3/31/2022 9:19 AM |
| 3 | XYZ | 3/24/2022 8:55 AM |

# Q15 What is your highest level of education?

Answered: 396 Skipped: 89



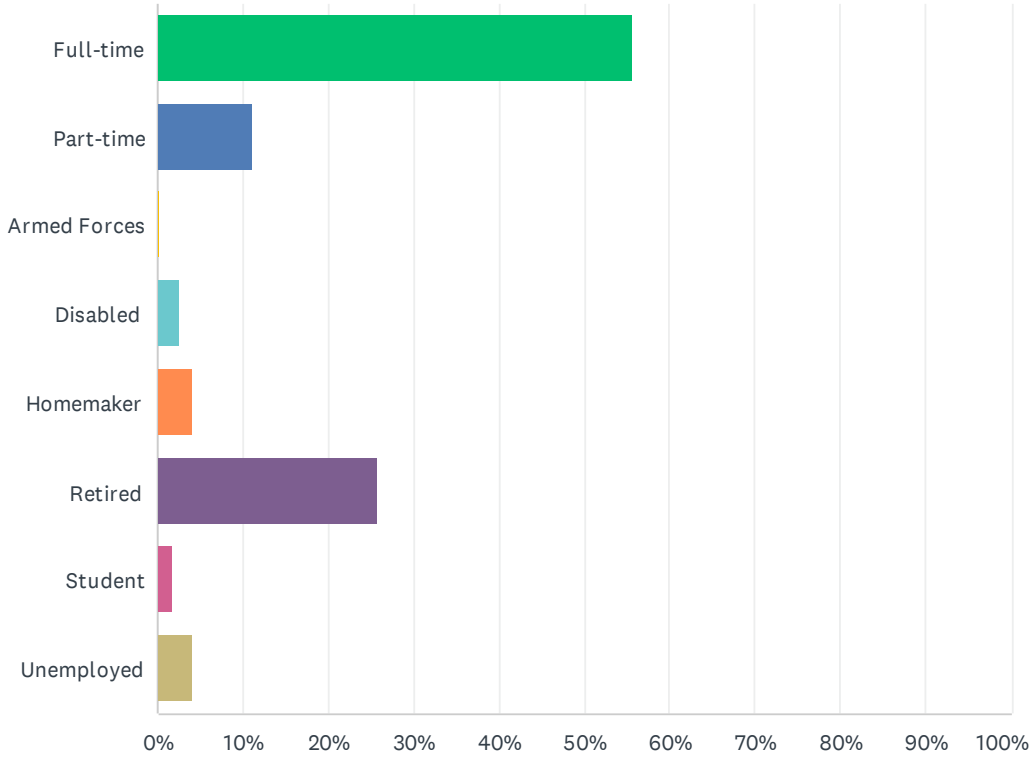

| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Some high school (did not finish) | 1.26% | 5 |
| High school diploma or GED | 9.60% | 38 |
| Technical or trade school certificate | 1.52% | 6 |
| Some college | 13.13% | 52 |
| Associate's degree | 13.13% | 52 |
| Bachelor's degree | 28.03% | 111 |
| Graduate degree | 30.56% | 121 |
| Other (please specify) | 2.78% | 11 |
| TOTAL | | 396 |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | Post graduate studies | 5/23/2022 5:04 PM |
| 2 | Masters | 4/7/2022 9:12 PM |
| 3 | Currently in high school | 3/31/2022 6:27 PM |
| 4 | Graduate degree + EDD | 3/27/2022 8:41 AM |

| | | |
|---|---|---|
| 5 | Masters | 3/25/2022 12:28 PM |
| 6 | Doctorate | 3/25/2022 8:11 AM |
| 7 | Doctorate | 3/24/2022 10:36 PM |
| 8 | Doctorate | 3/24/2022 9:42 PM |
| 9 | BA in history AAS in nursing | 3/24/2022 8:56 AM |
| 10 | XYZ | 3/24/2022 8:55 AM |
| 11 | Masters | 3/24/2022 6:21 AM |

# Q16 What is your current employment status?

Answered: 396 Skipped: 89



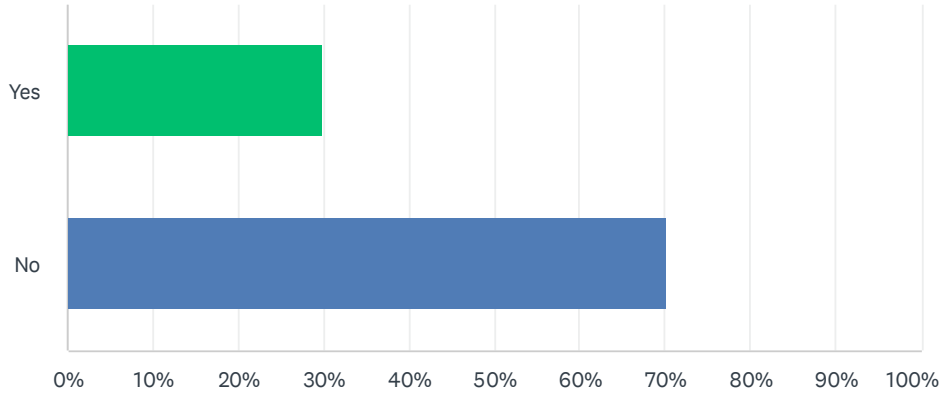

| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Full-time | 55.56% | 220 |
| Part-time | 11.11% | 44 |
| Armed Forces | 0.25% | 1 |
| Disabled | 2.53% | 10 |
| Homemaker | 4.04% | 16 |
| Retired | 25.76% | 102 |
| Student | 1.77% | 7 |
| Unemployed | 4.04% | 16 |
| Total Respondents: 396 | | |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | Medical Leave | 5/18/2022 7:37 PM |
| 2 | just laid off | 4/9/2022 7:33 AM |
| 3 | Self Employed | 4/7/2022 9:42 PM |
| 4 | Semi-retired | 4/4/2022 6:20 PM |

| | | |
|---|---|---|
| 5 | I have both a full time and part time job- cost of living doesn't equal wages | 3/30/2022 6:03 PM |
| 6 | N/A | 3/28/2022 7:13 PM |
| 7 | Full time as well as another part time job | 3/27/2022 8:41 AM |
| 8 | seasonal employee / semi-retired | 3/26/2022 8:54 AM |
| 9 | Haven't been able to work because of a high needs mentally ill child | 3/25/2022 8:06 PM |
| 10 | self employed | 3/25/2022 10:00 AM |
| 11 | RETIRED, STILL WORK FULL TIME | 3/24/2022 1:09 PM |
| 12 | and 2 part time jobs | 3/24/2022 12:18 PM |
| 13 | Per diem | 3/24/2022 8:56 AM |
| 14 | XYZ | 3/24/2022 8:55 AM |
| 15 | Volunteer | 3/21/2022 3:59 PM |

# Q17 Did the COVID-19 pandemic negatively impact your employment status (i.e. lay-off, reduction is hours/wages, left job due to childcare issues, etc.)?

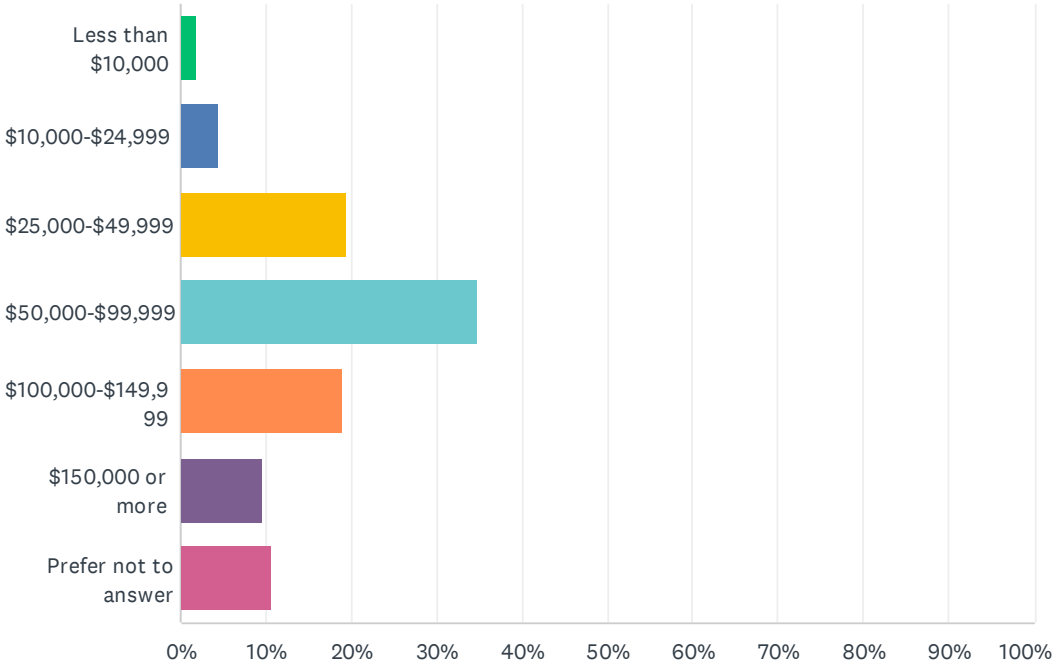
Answered: 396 Skipped: 89




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 29.80% | 118 |
| No | 70.20% | 278 |
| TOTAL | | 396 |

# Q18 What is your household's annual income?

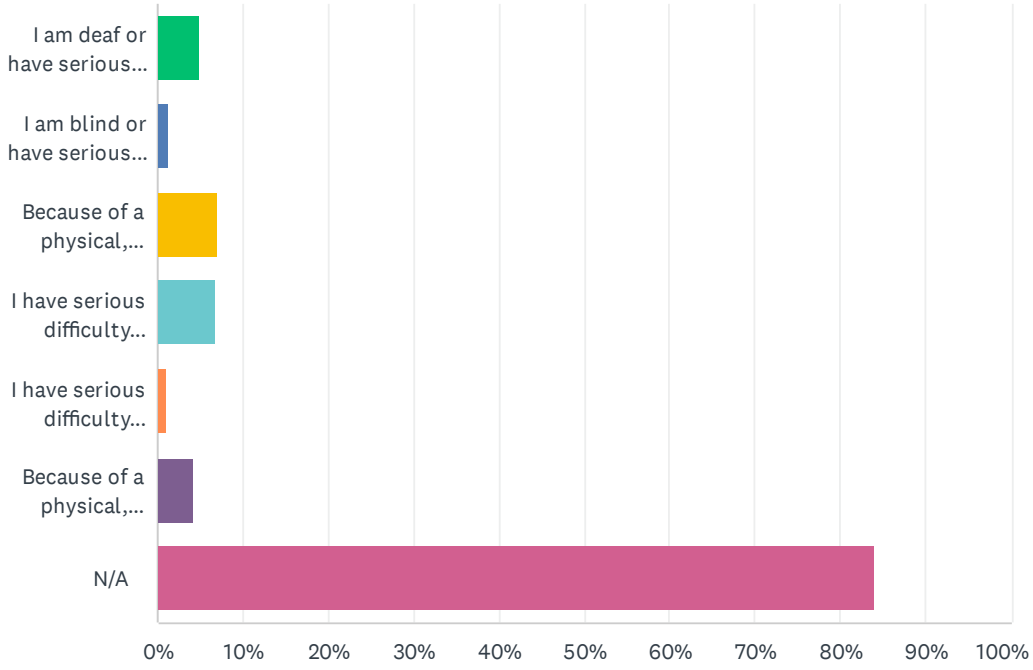
Answered: 396 Skipped: 89




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Less than $10,000 | 2.02% | 8 |
| $10,000-$24,999 | 4.55% | 18 |
| $25,000-$49,999 | 19.44% | 77 |
| $50,000-$99,999 | 34.85% | 138 |
| $100,000-$149,999 | 18.94% | 75 |
| $150,000 or more | 9.60% | 38 |
| Prefer not to answer | 10.61% | 42 |
| TOTAL | | 396 |

# Q19 Do any of the following apply to you? Select all that apply.

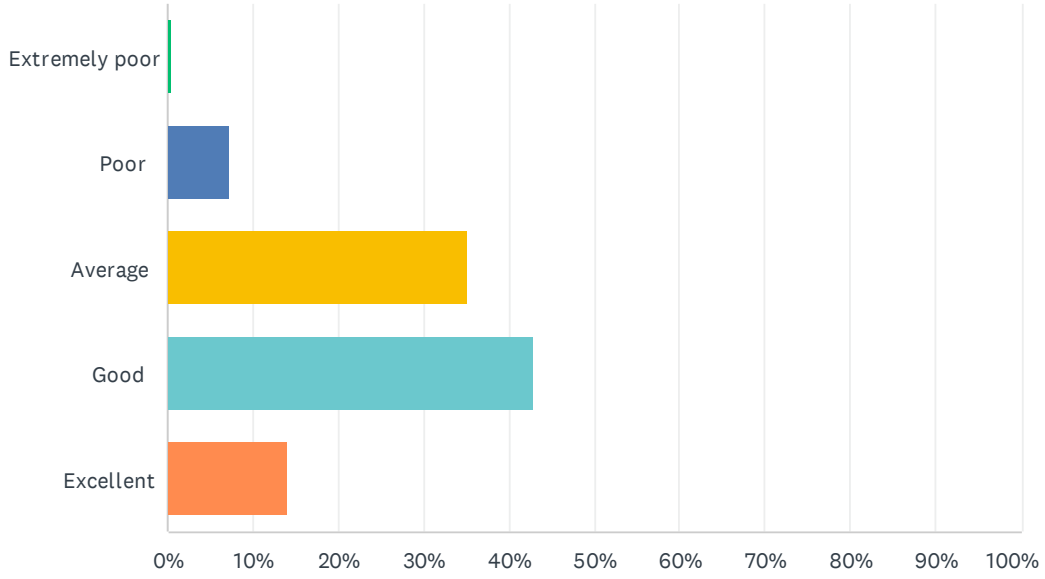
Answered: 396 Skipped: 89




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| I am deaf or have serious difficulty hearing | 4.80% | 19 |
| I am blind or have serious difficulty seeing, even when wearing glasses | 1.26% | 5 |
| Because of a physical, mental, or emotional condition, I have serious difficulty concentrating, remembering, or making decisions. | 7.07% | 28 |
| I have serious difficulty walking or climbing stairs | 6.82% | 27 |
| I have serious difficulty dressing or bathing | 1.01% | 4 |
| Because of a physical, mental, or emotional condition, I have difficulty doing errands alone, such as visiting a doctor's office or shopping. | 4.29% | 17 |
| N/A | 84.09% | 333 |
| Total Respondents: 396 | | |

# Q20 My physical health is:

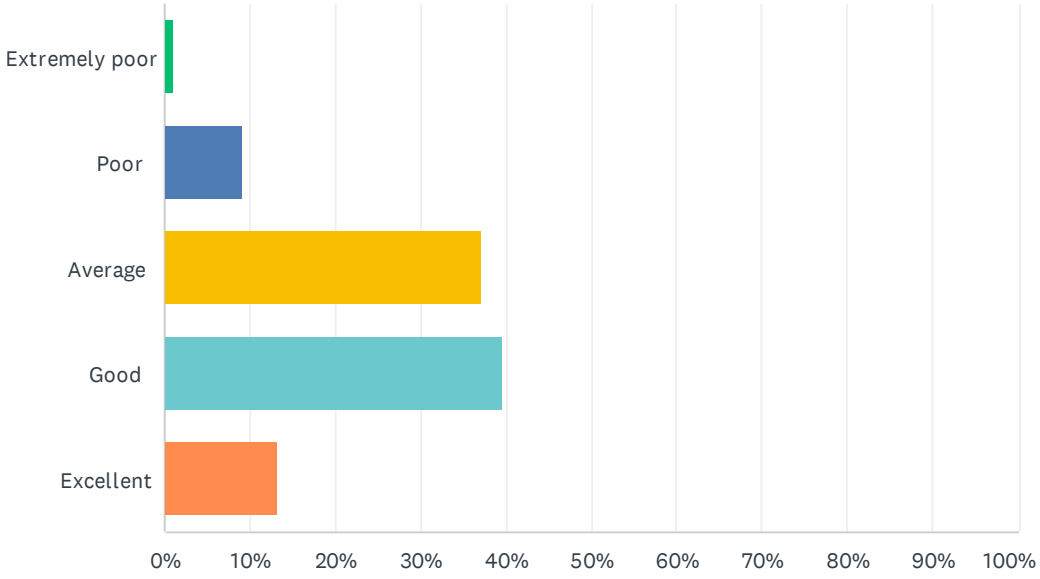
Answered: 395 Skipped: 90




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Extremely poor | 0.51% | 2 |
| Poor | 7.34% | 29 |
| Average | 35.19% | 139 |
| Good | 42.78% | 169 |
| Excellent | 14.18% | 56 |
| TOTAL | | 395 |

# Q21 My mental health is:

Answered: 396 Skipped: 89




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Extremely poor | 1.01% | 4 |
| Poor | 9.09% | 36 |
| Average | 37.12% | 147 |
| Good | 39.65% | 157 |
| Excellent | 13.13% | 52 |
| TOTAL | | 396 |

**APPENDIX 5**

# Collaborative Committee Lists

## REGIONAL COLLABORATIVE COMMITTEE

Adirondack Health Institute; Adirondack Rural Health Network

**Communinty Health Assessment Committee**

| County Health Departments | Primary Representative | Additonal Representatives |
|---|---|---|
| Clinton County Health Department | Mandy Snay | |
| | | Jessica Darney Buehler |
| Essex County Health Department | Linda Beers | Andrea Whitmarsh |
| Franklin County Public Health | Katie Strack | Sarah Granquist |
| Fulton County Public Health | Laurel Headwell | Angela Stuart Palmer |
| Hamilton County Public Health | Dr. Erica Mahoney | Victoria Fish |
| | | Dan Durkee |
| | | Olivia Cohens |
| Warren County Health Services | Ginelle Jones | Drew Crawford |
| Washington County Public Health | Tina McDougall | Elizabeth St. John |
| **Hospitals** | | |
| Adirondack Medical Center | Dan Hill | Rachelle Waters |
| Glens Falls Hospital | Cathleen Traver *CHA Co-Chair | |
| Nathan Littauer Hospital | Geoff Peck | |
| UVMHN - Alice Hyde Medical Center | Annette Marshall | |
| UVMHN - CVPH | Kaitlyn Tentis | Gregory E. Freeman |
| UVMHN - Elizabethtown Community Hospital | Amanda Whisher | Julie Tromblee |
| **AHI** | | |
| | Sara Deukmejian | Andrea Bonacci |

**Data Subcommittee Members**

| Member | Affiliation |
|---|---|
| Dan Hill | Adirondack Health |
| Mandy Snay | Clinton County Health Department |
| Angela Stuart Palmer | Fulton County Public Health |
| Amanda Whisher | UVMHN- Elizabethtown Hospital |
| Sarah Granquist | Franklin County Public Health |
| Andrea Whitmarsh | Essex County Health Department |
| Cathleen Traver | Glens Falls Hospital |
| Dan Durkee | Warren County Health Services |
| | |
| AHI Staff | |
| Sara Deukmejian | ARHN Manager |
| Andrea Bonacci | Director of Population Health Programs |

# LOCAL COLLABORATIVE COMMITTEES

## 2022 Essex County Board of Supervisors/Board of Health

| Member | Town/Role |
|---|---|
| Clayton J. Barber | Chesterfield |
| Charles Harrington | Crown Point |
| Noel Merrihew | Elizabethtown |
| Ken Hughes | Essex |
| Matthew Stanley | Jay |
| Joe Pete Wilson | Keene |
| James W. Monty | Lewis, Vice-Chairman |
| Stephen McNally | Minerva |
| Thomas Scozzafava | Moriah |
| Robin DeLoria | Newcomb |
| Derek Doty | North Elba |
| Stephanie DeZalia | North Hudson |
| Davina Winemiller | St. Armand |
| Margaret Wood | Schroon |
| Mark Wright | Ticonderoga |
| Michael K. Tyler | Westport |
| Shaun Gillilland | Willsboro, Chairman |
| Roy Holzer | Wilmington |
| Daniel T. Manning, III | County Attorney |
| Daniel L. Palmer | County Manager |

## 2022 Human Services Subcommittee

| Member | Role |
|---|---|
| Joe Pete Wilson | Chairman |
| Charles Harrington | |
| Stephen McNally | |
| Thomas R. Scozzafava | |
| Ken Hughes | |
| Matthew Stanley | |
| Derek Doty | |
| Margaret Wood | |
| Mark Wright | |

**County Agency Representation**

Social Services
Mental Health
Public Health Aging

## Essex County Health Department

### Professional Advisory Committee/Public Health Advisory Committee

| Member | Organization |
|---|---|
| Kristen Sayers | NYSDOH - Saranac Lake District Office of Environmental Health |
| Jennifer Newberry, RN, BSN | Essex County Health Department - Home Health Unit |
| Jessica Darney Buehler | Essex County Health Department - Public Health Unit |
| Diana Dodd, DVM | Community Member |
| Michael Celotti, MD | Hudson Headwaters Health Network |
| Julie Tromblee | UVMHN-ECH |
| Hannah Smith, PT | Essex County Health Department - Home Health Unit |
| Linda Beers | Essex County Health Department |
| Mary Halloran, MD | UVMHN-ECH |
| Kathy Dagget | Community Member |
| Krissy Leerkes | Essex County Office of the Aging |
| Terri Morse | Essex County Mental Health |
| Derek Doty | Town Supervisor |
| Katie Alexander, DVM | Ticonderoga Animal Hospital |
| Matthew Watts | Essex County Emergency Services |
| Danielle Van Ness | Keene Central School |
| Morgan Conley | ACAP Headstart |
| Megan Murphy | Housing Assistance Program of Essex County |
| Jessica Duhaime | Adirondack Health |

## Essex County Breastfeeding Coalition

| Member | Organization |
|---|---|
| Elizabeth Terry | ECHD - Public Health Unit |
| Krista Berger | ECHD - WIC Unit |
| Morgan Conley | ACAP - Head Start |
| Ginger Phinney | ACAP - Daycare |
| Lindsay Marcotte-Hamel | ACAP - Health Programs |
| KayLeigh Raville | Clinton County Health Department |
| Alexandra Mesick | Clinton County Health Department |
| Lucianna Celotti | ECHD - Children's Services |
| Amanda Whisher | UVMHN-ECH |
| Esther Piper | Behavioral Health Services North - Healthy Families |
| Meghan Lovering | Hudson Headwaters Health Network |
| Cassandra Jones | Hudson Headwaters Health Network |

## Building Resilience in Essex Families - Member Organizations

Adirondack Birth to Three Alliance
Adirondack Community Action Program, Inc
Adirondack Foundation
Adirondack North Country Gender Alliance
Bridges to Empowerment Mentorship Program
Champlain Valley Educational Services
Champlain Valley Physicians Hospital
Child Advocacy Center
Child Care Coordinating Council of the North Country
Cloudsplitter Foundation
Community, Family, and Youth Member Representatives
Cornell Cooperative Extension of Clinton County
Cornell Cooperative Extension of Essex County
Elizabethtown Community Hospital and Health Center
Essex County Community Services Board
Essex County Department of Social Services
Essex County Health Department, Childrens Services Unit
Essex County Health Department, Public Health Unit
Essex County Health Department, WIC Unit
Essex County Jail
Essex County Mental Health Services
Essex County Office for the Aging
Essex County Probation Department
Essex County School Districts
Essex County Youth Advocate Program
Essex County Youth Bureau
Families First of Essex County
Family Forever
Housing Assistance Program of Essex County
Hudson Headwaters Health Network
Mental Health Association in Essex County
Mountain Lake Services
New York State Office of Mental Health
North Country Early Childhood Family & Community Engagement Center
North Country School-Age Family & Community Engagement Center
Plattsburgh Primary Care Pediatrics
Sameritan House
St. Johns Episcopal Church, Essex NY
St. Joseph's Addiction Treatment & Recovery Centers
Steppingstone Psychological Services
Stop DV
Substance Abuse Prevention Team of Essex County, Inc
United Way - ADK 211

## Essex County Heroin & Other (Drug) Prevention Coalition - Member Organizations

ACAP
Adirondack Health
Adirondack Health Institute
Alliance for Positive Health
Americorps Vista - United Way
NYS Assembly
Board of Superviors - Town Supervisor
Champlain Valley Family Center
Conifer Park
UVMHN-Champlain Valley Physician's Hospital
DEA - HIDTA
Deputy County Manager - Essex County
Essex County Health Department
Essex County Community Services/Mental Health
Essex County Department of Social Services
Essex County District Attorney
Essex County Emergency Services
Essex County Probation Department/Governmental Agency
Essex County Sheriff's Department
Families First
Hudson Mohawk AHEC
Husdon Headwaters Health Network
Lake Placid Central School
Lake Placid Police Department
Liberty Behavioral Management
Mental Health Association in Essex County
New York State Assembly
Northwinds Integrated Health Network
NY Courts
NYS Troopers
OASAS
Prevention team
St. Joseph's Addiction Treatment & Recovery
The Northeast Group
The Prevention Team
UVMHN-Elizabethtown Community Hospital

# APPENDIX 6

Note: Enlarged copies available upon request

| | | | | | |
|---|---|---|---|---|---|
| **Name of County - Organization(s) 2023 Workplan** | Essex County Health Department (ECHD) | North Country Healthy Heart Network | Champlain Valley Family Center | Cancer Services Program of Northeastern NY | UVMHN Elizabethtown Community Hospital |
| **Planning Report Liaison** | Molly Lawrence | Ann Morgan | Dana Bushy Isabella | Didi Remchuk | Amanda Whisher |
| **E-mail:** | Mary.lawrence@essexcounty.gov | amorgan@heartnetwork.org | tobaccofree@cvfamilycenter.org | dremchuk@cvph.org | awhisher@ech.org |

| Priority | Focus Area (select one from drop down list) | Goal Focus Area (select one from drop down list) | Objectives through 2024 | Disparities | Interventions | Family of Measures | By December 2023, we will have completed . . . | Implementation Partner *(Please select one partner from the dropdown list per row)* | Partner Role(s) and Resources | Lead Agency |
|---|---|---|---|---|---|---|---|---|---|---|
| Prevent Chronic Diseases | Focus Area 1: Healthy eating and food security | Goal 1.0 Reduce obesity and the risk of chronic disease | Increase the number of schools offering preschool programs that reinvigorate and improve nutrition policies and practices in at least 3 of 11 school districts in Essex County in an effort to reduce the percentage of early childhood obesity (among children ages 2 - 4 years participating in SNAP for WIC) rates from 16.5% to the NYS Prevention Agenda benchmark of 13.0% by December 2024. | Socioeconomic, Neighborhood and Built Environment (Limited access to healthy foods and physical activity. Examples: sidewalks and grocery stores). | 1.0.2 - Quality nutrition (and physical activity) in early learning and child care settings. | *Input measures: provide assessment, targeted technical assistance to school wellness committees to support their efforts to improve, communicate and implement their school wellness policies.<br>*Output measures: Three school districts will demonstrate improved implementation of policies and practices in three areas: 1) Nutrition Standards for Competitive Foods and Other Foods and Beverages; 2) Physical Education and Physical Activity; 3) School Wellness Promotion and Marketing<br>*Short-term Outcome: Number of school districts with Wellness Committees meeting 2 x per year with goals related to implementation and having complete pre-assessments.<br>*Intermediate Outcome: Number of school districts with improved implementation of policies and practices related to PA&N<br>*Long-term Outcome: reduction in overweight and obese school-aged children in the three targeted school districts. | ECHD will collaborate with local school districts to reinvigorate existing/implement multi-component school-based obesity prevention interventions to include policy and environmental changes that target physical activity and nutrition (PA&N) for pre-school before, during and/or after school. ECHD will provide pre/post assessment and targeted technical assistance to three of the highest risk Essex County School Districts, to support their implementation of implement policies and practices to increase PA&N. | K-12 School | School districts with onsite preschool programs, Wellness Committees, and administrative leaders meet regularly with ECPH specialists to review and enact recommendations (provided through assessment) to improve implementation of school wellness policies. | Essex County Health Department |
| Prevent Chronic Diseases | Focus Area 1: Healthy eating and food security | Goal 1.0 Reduce obesity and the risk of chronic disease | Increase the number of schools that reinvigorate and improve nutrition policies and practices in at least 3 of 11 school districts in Essex County in an effort to reduce the percentage of school children obesity rates from 21.7% to the NYS Prevention Agenda benchmark of 16.4% by December 2024. | Socioeconomic, Neighborhood and Built Environment (Limited access to healthy foods and physical activity. Examples: sidewalks and grocery stores). | 1.0.4 - Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders can collaborate to work with local school districts and parent-teacher organizations (PTOs) to support policy, and environmental changes that target physical activity and nutrition before, during or after school. | *Input measures: provide assessment, targeted technical assistance to school wellness committees to support their efforts to improve, communicate and implement their school wellness policies.<br>*Output measures: Three school districts will demonstrate improved implementation of policies and practices in three areas: 1) Nutrition Standards for Competitive Foods and Other Foods and Beverages; 2) Physical Education and Physical Activity; 3) School Wellness Promotion and Marketing<br>*Short-term Outcome: Number of school districts with Wellness Committees meeting 2 x per year with goals related to implementation and having complete pre-assessments.<br>*Intermediate Outcome: Number of school districts with improved implementation of policies and practices related to PA&N<br>*Long-term Outcome: reduction in overweight and obese school-aged children in the three targeted school districts. | ECHD will provide pre/post assessment and targeted technical assistance to three of the highest risk Essex County School Districts, to support their implementation of implement policies and practices to increase PA&N. | K-12 School | School district Wellness Committees and administrative leaders meet regularly with ECPH specialists to review and enact recommendations (provided through assessment) to improve implementation of school wellness policies. | Essex County Health Department |
| Prevent Chronic Diseases | Focus Area 1: Healthy eating and food security | Goal 1.1 Increase access to healthy and affordable foods and beverages | 1.12 Increase the percentage of adults who buy fresh fruit and vegetables in their neighborhood | Socioeconomic, Neighborhood and Built Environment (Limited access to healthy foods and physical activity. Examples: sidewalks and grocery stores). | 1.0.5 Increase the availability fruit and vegetable incentive programs Systematic evidence reviews find that financial incentive programs can increase affordability, access, purchases, and consumption of fruits and vegetables. Incentive programs for the purchase of fruits and vegetables have also been shown to increase sales and use of food assistance benefits (e.g., SNAP or WIC) at farmers' markets. Financial incentives can be a dollar-for-dollar match or a set amount per dollar spent (i.e., $2 for every $5 spent). Local health departments, hospitals, health centers, insurers, businesses, CBOs, hunger prevention advocates and other stakeholders can collaborate | Input Measures: Total number of participants in the program WIlness RX.<br>Output Measures: Output measures will included looking at increased consumption of fruits and vegetables, reduction in A1c and/or weight. Long-term Outcome: Increased access to fruits and vegetable aiding in improved health outcomes. | UVMHN ECH will continue to support the Wellness RX program looking at opportunities for improvement such as additional locations, redemption sites, and expansion of program objectives. The hospital will continue to build upon relationships with community partners and remain active in the Well Fed Collabortive sponsored by Essex County Health Department. By the end of 2023 Wellness Rx will increase redemption sites from 11 to 13 and increase consumption of fruits and vegetables by 5% of participants. | Hospital | Well Fed Collaborative (Essex County Health Depart | UVMHN Elizabethtown Community Hospital |
| Prevent Chronic Diseases | Focus Area 2: Physical activity | Goal 2.3 Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity. | Increase access and awareness for outdoor and indoor activity through collaboration with libraries and media promotion to encourage adult exercise, and exercise as a family, to reduce adult obesity rates from 29.2% to the NYS Prevention Agenda Benchmark of 24.2% by December 2024. | Natural and Buld Environment | 2.3.1 Implement and/or promote a combination of community walking, wheeling, or biking programs, Open Streets programs, joint use agreements with schools and community facilities, Safe Routes to School programs, increased park and recreation facility safety and decreased incivilities, new or upgraded park or facility amenities or universal design features; supervised activities or programs combined with onsite marketing, community outreach, and safety education. | Input Measures: # of participating libraries, # of times snowshoes are checked out of each library<br>Output Measures: # of indoor fitness and outdoor recreational activity ideas (snowshoe trails, hiking trails, playgounds, etc..) media posts, ads, and campaigns posted/printed/promoted<br>Short-term Outcome: increased exercise and health communications via social media. Increased publications, distribution and promotion of no cost outdoor recreation opportunities.<br>Intermediate Outcome: Increase in access to physical activities for adults.<br>Long-term Outcome: Increase the number of adults participating in regular exercise. | ECHD will collaborate with at least four local libraries to promote outside winter recreation opportunities, and promote local trails, outdoor recreation opportunities year round, and home exercises for all fitness levels through media posts and community outreach.<br>ECHD will distribute snowshoes to four libraries and have checkout data for one winter season to review.<br>ECHD will review and update existing ECHD created information regarding local trails and outdoor recreational activities. ECHD will create a guide for family friendly outside hikes and recreational activities, if the review of existing materials warrants. ECHD will post at least one in-home fitness activity per month for all fitness levels. | Media | Media - publish content and disseminate information to Essex County residents. Libaries - lend out snowshoes and track use data. ECHD - develop and review recreational informaiton, review data. | Essex County Health Department |
| Prevent Chronic Diseases | Focus Area 3: Tobacco prevention | Goal 3.2 Promote tobacco use cessation | Increase (or maintain) % of medical and behavioral health provider systems serving Essex County residents that have adopted Public Health Service (PHS) guideline concordant policies for treatment of tobacco addiction to at least 75% (Medical Baseline: 100%; Behavioral Baseline: 33%) by December 2024. | Health Care Access | 3.2.1 - Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers, Community Health Centers and behavioral health providers. Evidenced Based Intervention - Treating Tobacco Use and Dependence - Public Health Services Guideline (2008 edition)https://www.ahrq.gov/prevention/guidelines/tobacco/index.html | Input Measures: Administrative presentations offered; Improvement process trainings offered; Planning meetings held; Model policies shared<br>Output Measures: # presentations/trainings offered; # Memorandum of understanding (MOU); # planning meetings held<br>Short-term Outcome: # policy development, implementation or improvement plans created; # new policies/standards of care adopted<br>Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation benefits (counseling and/or medication)<br>Long-term Outcome: Decrease in prevalence of adult tobacco use | The North Country Healthy Heart Network will provide technical assistance for adoption of PHS guideline concordant policy to remaining medical and behavioral health systems where policies have not yet been adopted.<br><br>Provide ongoing support to medical and behavioral health systems with PHS guideline concordant policies to ensure ongoing improvement of tobacco treatment policy implementation. | Providers | Providers adopt and implement PHS guideline concordant policies.<br><br>Health Systems for a Tobacco Free NY contractor (North Country Healthy Heart Network) provides technical assistance and patient and/or provider education materials to all health system providers in the county. | North Country Healthy Heart Network |
| Prevent Chronic Diseases | Focus Area 3: Tobacco prevention | Goal 3.2 Promote tobacco use cessation | 3.2.1 Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%. | Health Care Access | 3.2.1 Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers, Community Health Centers and behavioral health | Number of patients who quit and sustained smoking cessation. Input Measures: Administrative presentations offered; Improvement process trainings offered; Planning meetings held; Model policies shared<br>Output Measures: # presentations/trainings offered; # Memorandum of understanding (MOU); # planning meetings held<br>Short-term Outcome: # policy development, implementation or improvement plans created; # new policies/standards of care adopted<br>Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation | Provide technical assistance for adoption of PHS guideline concordant policy to at least one behavioral health system.<br><br>Provide ongoing support to medical and behavioral health systems with PHS guideline concordant policies to ensure ongoing improvement of tobacco treatment policy implementation. Standing orders followed and administered by health center clinical staff. | Hospital | Providers adopt and implement PHS guideline concordant policies.<br><br>Health Systems for a Tobacco Free NY contractor (North Country Healthy Heart Network) provides technical assistance and patient and/or provider education materials to all health system providers in the county. | UVMHN Elizabethtown Community Hospital |
| Prevent Chronic Diseases | Focus Area 3: Tobacco prevention | Goal 3.2 Promote tobacco use cessation | Increase/maintain the use of health communications and social media opportunities to promote tobacco dependence treatment by at least 12 messages (once monthly) by December 2024. | Health Care Access | 3.2.2 - Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline.<br>Evidenced Based Intervention - https://talktoyourpatients.health.ny.gov/ https://www.nysmokefree.com/ | Input Measures: # of tobacco cessation social media posts, ads, and campaigns created<br>Output Measures: # of tobacco cessation social media posts, ads, and campaigns posted/printed/promoted<br>Short-term Outcome: increased tobacco cessation health communications<br>Intermediate Outcome: increased # of residents who engage in tobacco cessation campaign/communications<br>Long-term Outcome: increase in tobacco cessation referrals and quit attempts | Post monthly tobacco dependence treatment health messaging on the Essex County Health Department Facebook page promoting local evidence-based tobacco cessation services and the NY Quits line.<br>Create and print newspaper ads promoting cessation services available during targeted tobacco public health observances (E.g. November - Great American Smoke Out, December - New Years Eve, March - Kick Butts Day). | Media | ECHD - Will create educational materials using evidence-based interventions and will distribute though various media outlets.<br>Media - Will publish ads and disseminate information to Essex County residents. | Essex County Health Department |

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| **Name of County - Organization(s) 2023 Workplan** | Essex County Health Department (ECHD) | North Country Healthy Heart Network | Champlain Valley Family Center | Cancer Services Program of Northeastern NY | UVMHN Elizabethtown Community Hospital |
| **Planning Report Liaison** | Molly Lawrence | Ann Morgan | Dana Bushy Isabella | Didi Remchuk | Amanda Whisher |
| **E-mail:** | Mary.lawrence@essexcounty.gov | amorgan@heartnetwork.org | tobaccofree@cvfamilycenter.org | dremchuk@cvph.org | awhisher@ech.org |

| Priority | Focus Area (select one from drop down list) | Goal Focus Area (select one from drop down list) | Objectives through 2024 | Disparities | Interventions | Family of Measures | By December 2023, we will have completed . . . | Implementation Partner *(Please select one partner from the dropdown list per row)* | Partner Role(s) and Resources | Lead Agency |
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| Prevent Chronic Diseases | Focus Area 3: Tobacco prevention | Goal 3.2 Promote tobacco use cessation | Increase the percentage of smokers who received assistance from their healthcare providers to quit smoking by 5%. | Income, Access, Disability | 3.2.2 Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline. | Number of media and marketing outreach encounters. Number of providers participating in smoking cessation campaigns. | **1.** Provide guidance and education to health center-based primary care providers. **2.** Participate in marketing outreach. **3.** Monitor patients via quality dashboard. | Community-based organizations | Health system grantee will provide support on policy implementation and the development of standards of care as the lead for this intervention. Franklin and Essex county health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the counties, and connect to healthcare resources. | Adirondack Health |
| Prevent Chronic Diseases | Focus Area 3: Tobacco prevention | Goal 3.2 Promote tobacco use cessation | Engage at least 3 health providers (medical and behavioral health) in Essex County in a communications campaign. | Economic Stability, Health & Health Care | 3.2.3 - Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment. | Input Measures: Planning meeting structure<br>Output Measures: # Meetings held; Implementation Plans created; campaign materials distributed<br>Short-term Outcome: % tobacco using patients "advised" to quit tobacco increases<br>Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation benefits (counseling and/or medication)<br>Long-term Outcome: Decrease in prevalence of adult tobacco use | Provide technical assistance for implementation of the campaign.<br>Provide ongoing support for continued implementation of the campaign. | Providers | Providers participate in campaign implementation planning process; then monitor implementation.<br><br>Health Systems for a Tobacco Free NY contractor (Year 1 - North Country Healthy Heart Network) provides technical assistance and campaign materials to participating provider systems. | North Country Healthy Heart Network |
| Prevent Chronic Diseases | Focus Area 3: Tobacco prevention | Goal 3.3 Eliminate exposure to secondhand smoke | Utilize the It's Not Just campaign to raise awareness of the impact of mentol products on youth, LGBTQ+ and BIPOC communities. | Economic Stability, Neighborhood & Built Environment, Education | 3.1.3 - Pursue policy action to reduce the impact of tobacco marketing in lower-income and racial/ethnic minority communities, disadvantaged urban neighborhoods and rural areas. | Input Measures: target communities, schools, areas identified for campaign launch<br>Output Measures: Develop communications/campaign materials.<br>Short-term Outcome: # of materials distributed/ads placed/articles and letters to the editor written.<br>Intermediate Outcome: # of communities, schools, areas that have received campaign materials/information.<br>Long-term Outcome: decrease in youth/target community smoking rates. | Conduct a community education campaign (presentations, print materials, newsletter articles, letters to the editor) to raise awareness of tobacco marketing and the impact of flavored products on tobacco use. | Students | CVFC ATFC - will work with youth and student groups to advance educational campaigns. | Champlain Valley Family Center |
| Prevent Chronic Diseases | Focus Area 3: Tobacco prevention | Goal 3.3 Eliminate exposure to secondhand smoke | Present findings from all retail observations to the Essex County Health Committee and Essex County Board of Supervisors.<br>Provide community support for any policy action developed by any interested local municipality to reduce the impact of tobacco marketing and flavored tobacco products. | Neighborhood & Built Environment | 3.1.5 - Decrease the availability of flavored tobacco products including menthol flavors used in combustible and non-combustible tobacco products and flavored liquids including menthol used in electronic vapor products.<br>Evidence-based intervention: Public Health Law Center - http://www.publichealthlawcenter.org/sites/default/files/resources/Regulating-Flavored-Tobacco-Products-2017.PDF | Input Measures: # of retail observations conducted.<br>Output Measures: summary of retail observations<br>Short-term Outcome: increase the # of municipal leaders/organizational decision makers engaged in conversations about the availability of flavored tobacco products.<br>Intermediate Outcome: Increase the # of municipal/organizational decision makers that are in support of policies that limit the amount of flavored tobacco products available for purchase at retail locations.<br>Long-term Outcome: decrease the % of youth and minority groups that have access to flavored tobacco products. | Conduct retail observation of all licensed tobacco retailers (including vape shops) in Essex County. | Business | CVFC ATFC - Facilitate and conduct retail observation and presentations to Essex County leaders and policy makers. | Champlain Valley Family Center |
| Prevent Chronic Diseases | Focus Area 4: Preventative care and management | Goal 4.1 Increase cancer screening rates | Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50-75 years old) by 5%. | Income, Access, Disability | 4.1.1 Systems change for cancer screening reminders | Number of patients reached through patient reminder system and compliance with cancer screening guidelines. | **1.** Review current practice for reliability and timeliness to ensure reminders are being sent by all providers. **2.** Continue to track patient reminders. **3.** Monitor patients via quality dashboard. | Community-based organizations | Health system grantee will partner and support this intervention. Franklin and Essex county health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital staff attuned to health disparities in the county, and connect to healthcare resources. | Adirondack Health |
| Prevent Chronic Diseases | Focus Area 4: Preventive care and management | Goal 4.1 Increase cancer screening rates | 4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines. 4.1.2 Increase the percentage of women with an annual household income less than $25,000 who receive a cervical cancer screening based on the most recent guidelines | Health Access, Economic Stability | 4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings. | ECH will offer an increased number and locations of screening events throughout the year. Continued collaboration with the Cancer Screening Program and joint patient engagement will allow for positive patient outcomes. At least four events per year will hightlight cancer screening education. The hospital will continue to build screening events that are open and free to the public to address economic and access barriers. | Cancer screening events will be expanded to include additional services to aid with transportation barriers. The hospital will coordinate | Hospital | Cancer Services Program of Northeastern NY | UVMHN Elizabethtown Community Hospital |
| Prevent Chronic Diseases | Focus Area 4: Preventive care and management | Goal 4.1 Increase cancer screening rates | Increase colorectal cancer screening rates in Essex County from 66.9% to at least 68.5% to meet upstate NY colorectal cancer screening rate by December 2024. | Health Access, Education, Economic Stability | 4.1.3 - Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand of the importance of colorectal cancer screening.<br>Evidence Based Intervention - The Community Guide - https://www.thecommunityguide.org/topic/cancer | Input Measures: # of cancer screening social media posts, ads, and campaigns created<br>Output Measures: # of cancer screening social media posts, ads, and campaigns posted/printed/promoted<br>Short-term Outcome: increased cancer screening health communications<br>Intermediate Outcome: increased # of residents who engage in cancer screening campaign/communications and # of locations materials were distributed.<br>Long-term Outcome: increase in cancer screening referrals and screening events | Post cancer screening health messaging on the Essex County Health Department Facebook page to remind people of the importance of prevention and early detection.<br>Create and print newspaper ads promoting the importance of cancer screening including targeted cancer screening public health observances (E.g. March - Colorectal Cancer Awareness).<br>Collaborate with the CSP of Northeastern NY on awareness campaigns and assist in promoting scheduled screening events. | Media | ECHD - collaborate with CSP Northeastern NY on creating educational materials using evidence-based interventions assist in distributing though various media outlets.<br>CSP Northeastern NY - collaborate with ECHD on creating educational materials using evidence-based interventions and assist in distribution, collaborate with health networks to schedule and offer screening events<br>Media - publish ads and disseminate information to Essex County residents. | Cancer Services Program of Northeastern NY |

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| **Name of County - Organization(s) 2023 Workplan** | Essex County Health Department (ECHD) | Essex County Mental Health | The Prevention Team | Alliance for Positive Health | UVMHN Elizabethtown Community Hospital | Adirondack Health |
| Planning Report Liaison | Andrea Whitmarsh | Stefanie Miller | Traci Ploufe | Meagan Strack | Amanda Whisher | Matthew Scollin |
| **E-mail:** | andrea.whitmarsh@essexcountyny.gov | stefanie.v.miller@essexcountyny.gov | traci@preventionteam.org | mstrack@alliancefph.org | awhisher@ech.org | mgscollin@adirondackhealth.org |

| Priority | Focus Area | Goal | Objectives through 2024 | Disparities | Interventions | Family of Measures | By December 2023, we will have completed . . . | Implementation Partner *(Please select one partner from the dropdown list per row)* | Partner Role(s) and Resources | Lead Agency |
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| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 1: Promote Well-Being | Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages | Home-visiting program staff will make a connection with 75% of the Essex County families with newborns in 2024 to offer home visits or a newborn welcome packet. | Income<br>Access to healthcare<br>Transportation | 1.2.1 Implement evidence-based home visiting programs | Input measures: engage in technical assistance sessions with home visiting program models to determine which is the best fit for Essex County.<br>Output Measures: Launch a universal home visiting program in Essex County.<br>Short-Term Outcome: train at least 2 ECHD staff members in program delivery components.<br>Intermediate Outcomes: Conduct targeted outreach with area OB providers, pediatricians and hospitals to raise awareness of the program.<br>Long-Term Measures: Home-visiting program staff will make a connection with 90% of Essex County families with newborns to either receive home visits or a newborn welcome packet. | Launch a universal newborn home-visiting program in Essex County, partnering with ECHD WIC and Children's Services Units, as well as community-based partners and healthcare providers to ensure early supports and wrap-around care. | Local governmental unit | ECHD Public Health Unit will collaborate with the WIC, Home Health, and Children's Services Units to develop, launch, and maintain a universal newborn home visiting program in Essex County. | Essex County Health Department |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 1: Promote Well-Being | Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages | 1. Develop and administer Equity Assessment for Essex County Health & Human Services organizations that can be used to inform the future development of DEI strategic plans.<br>2. Increase from 0 to 2 the number of Essex County Health & Human Services agencies that have a DEI Strategic Plan (or an existing stategic plan updated to include DEI concepts) in place at the organizational level. | All | 1.2.3 Implement policy and program interventions that promote inclusion, integration, and competence | Input measures: DEI survey development, dissemination and analysis<br>Output measures: presentation of survey results and additional training for participating organizations<br>Short term outcomes: increase in the number of organizations in Essex County that have a shared understanding of DEI (including language, standards, etc.)<br>Intermediate Outcomes: increase in the the number of organizations in Essex County that have adopted DEI plans.<br>Long-term Outcomes: increase in employee recruitment and retention rates for Essex County Health & Human Services organizations, translating to an increase in the ability to provide critical and timely services to residents. | 1. DEI Survey development<br>2. DEI Survey dissemination<br>3. DEI Survey analysis<br>4. Presentation of survey results<br>5. DEI Strategic Planning walk through training | Other (please describe partner and role(s) in column D) | Essex County Community Services Board; BRIEF Program Coordinator; CCSI will work with Essex County Health & Human Services agencies to increase DEI practices and policies within their organizations. | Essex County Community Services |

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| **Name of County - Organization(s) 2023 Workplan** | Essex County Health Department (ECHD) | Essex County Mental Health | The Prevention Team | Alliance for Positive Health | UVMHN Elizabethtown Community Hospital | Adirondack Health | |
| Planning Report Liaison | Andrea Whitmarsh | Stefanie Miller | Traci Ploufe | Meagan Strack | Amanda Whisher | Matthew Scollin | |
| **E-mail:** | andrea.whitmarsh@essexcountyny.gov | stefanie.v.miller@essexcountyny.gov | traci@preventionteam.org | mstrack@alliancefph.org | awhisher@ech.org | mgscollin@adirondackhealth.org | |

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| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 1: Promote Well-Being | Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages | 1. Implement evidence-based communications practices for messaging around mental illness and substance use.<br>2. Share best practices and resources with CBOs, human service agencies, mental, emotional and behavioral health agencies in Essex County through existing networks and coalitions (e.g. ECHO, BRIEF). | Mental health<br>Substance Use Disorder | 1.2.4 Use thoughtful messaging on mental illness and substance use | Input measures: Train Communications staff on materials related to cultural competance around communications that address mental health and substance use disorder.<br>Output measures: Update the ECHD Communications Plan to include references to the National Academy of Sciences *Ending Discrimination Against People with Mental and Substance Use Disorders.*<br>Short Term Outcomes: update the ECHD Communications Plan<br>Intermediate Outcomes: create a social media messaging and content plan utilizing the concepts outlined in the National Academy of Sciences article.<br>Long Term Outcomes: share information and best practices with other MH/SUD organizations in order to increase use of shared communication concepts | 1. Develop a Mental Health and Substance Use Disorder communications plan using the National Academcy of Sciences *Ending Discrimination Against People with Mental and Substance Use Disorders* as a guide.<br>2. Create messages and content for ECHD social media pages utilizing the communications plan developed. | Community-based organizations | ECHD will work with Community Based Organizations to share best practices in communication strategies for outreach to populations living with mental health and substance use disorders. | Essex County Health Department |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults | 1. Increase by 50% the number of school districts participating in the evidence-based program Mind-Up.<br>2. Increase by 20% the number of evidence-based prevention programs conducted in Essex County schools. | Mental health<br>Access (to Mental Health Care) | 2.1.2 Implement School based prevention | Input measures: outreach to schools in Essex County to increase awareness of programs and services offered by The Prevention Team.<br>Output measures: program dissemination plan for Essex County. Short Term Outcomes: increase in the number of school districts participating in evidence-based programs<br>Intermediate Outcomes: increase in the number of programs conducted and students reached by programs. Long Term Outcomes: Decrease in the number of behavioral issues/referrals in schools participating. | 1. Mind-Up implmentation in 3 additional Essex County school districts<br>2. Administration of the Prevention Needs Assessment which will be utilized to determine | K-12 School | The Prevention Team;<br>Essex County Youth Bureau will collaborate with schools to deliver evidence-based prevention education in Essex County schools. | The Prevention Team |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults | 1. Increase the number of individual screened for alcohol use in patient 18 years and older by 20% by December 31, 2024. | Substance Use Disorders<br>Access to care | 2.1.4 Implement routine screening and brief behavioral counseling in primary care settings to reduce unhealthy alcohol use for adults 18 years or older, including pregnant women | Input measure: number of patients 18 years and older who have had a visit within the measurement year.<br>Output Measure: number of patients 18 years and older who have had a visit within the measurment year and who have been screened for alcohol use. Intermediate outcome: Increase screening for alcohol use.<br>Longterm Outcomes: See intervention 2.1.5. | By December 2023 staff education will be completed regarding alcohol and substance use screenigs. A list of referral resources will be maintained and quarterly care team meeting will address any barriers or concerns related to social determinants within the population served. | Hospital | | UVMHN Elizabethtown Community Hospital |

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| Planning Report Liaison | Andrea Whitmarsh | Stefanie Miller | Traci Ploufe | Meagan Strack | Amanda Whisher | Matthew Scollin | |
| **E-mail:** | andrea.whitmarsh@essexcountyny.gov | stefanie.v.miller@essexcountyny.gov | traci@preventionteam.org | mstrack@alliancefph.org | awhisher@ech.org | mgscollin@adirondackhealth.org | |

| Priority | Focus Area | Goal | Objectives through 2024 | Disparities | Interventions | Family of Measures | By December 2023, we will have completed . . . | Implementation Partner *(Please select one partner from the dropdown list per row)* | Partner Role(s) and Resources | Lead Agency |
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| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults | 1. Increase the Trauma Responsive Understanding Self-Assessment Tool (TRUST) Survey scores of participating Essex County Health & Human Services organizations by 25%<br>2. Offer a TRUST feedback session for Essex County Health & Human Services organizational Leaders | Mental Health<br>Substance Use Disorders | 2.1.6 Integrate trauma-informed approaches and responses into prevention programs by training staff, developing protocols and engaging in cross-system collaboration | Input Measures: Conduct learning sessions, offer consultation hours and re-administer the TRUST survey. Output Measures: Analyze & disseminate results and offer a feedback session for participants. Short-term Outcomes: increase in number of Essex County Health & Human Services agencies that have trauma-informed leadership.<br>Intermediate Outcomes: increase in number of Essex County Health & Human Service agencies that have trauma-informed staff.<br>Long-term Outcomes: Increase in number of Essex County Health & Human Service agencies that have implemented plans/policies/procedures that include trauma-informed approaches and strategies. | **1.** Conduct (3) Trauma Responsive Practice Learning Community training sessions with Essex County Health & Human Services organizations: (1) Equity Focused, Trauma Responsive Practice to support staff resilience (2) Trauma Responsive Supervision (3) Trauma Responsive Policies and Practices **2.** Conduct (4) quarterly calls for the Learning Community teams to support implmentation of trauma responsive work plans **3.** Offer consultation hours for Learning Community teams **4.** Re-administer the TRUST survey to measure level of implementation of SAMSHA's 10 Implementation Domains for implementation of Trauma-Informed Approach | Other (please describe partner and role(s) in column D) | Essex County Community Services Board; BRIEF Program Coordinator; CCSI will work with Essex County Health & Human Services agencies to increase trauma-informed training and practices and policies within their organizations. | Essex County Community Services |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.2 Prevent opioid overdose deaths | 1. Increase the number of MAT prescribers | Substance Use Disorders<br>Access to care | 2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine | Number of MAT prescribers | ECH will increase the number of providers who are x-waivered to be able to prescribe MAT. | Hospital | | UVMHN Elizabethtown Community Hospital |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.2 Prevent opioid overdose deaths | 1. Continue to increase overdose prevention and response training opportunities for pharmacists, prescribers, and consumers. 2. Increase distribution of narcan kits to healthcare establishments, community members, and participants. | Substance Use Disorders<br>Access to care | 2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists, and consumers | Input Measures: Offer and execute trainings. Output Measures: Distribute Narcan kits to community members and locations.<br>Short-Term Outcomes: Increased community access and awareness to opioid overdose reversal materials. Intermediate Outcomes: Increased availability and use of opioid overdose reversal medication.<br>Long-Term Outcomes: decreased stigma around and increased utilization of harm reduction strategies for substance use disorders. | 1. Offer and execute 30+ trainings. 2. Distribute 250 kits to community members and healthcare facilities such as outpatient and or inpatient locations. 3. Conduct quarterly reporting of data measurements. | Pharmacies | Alliance for Positive Health will work with pharmacists, prescribers, and consumers to increase overdose prevention strategies. | Alliance for Positive Health |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.2 Prevent opioid overdose deaths | 1. Increase awareness to prescribing practices and education on best practices will be provided. | Substance Use Disorders | 2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations | Input Measure: Quarterly meetings Output Measures: The number of controlled prescriptions provided (provider specific)<br>Long-Term Outcomes: decreased prescribing of opioids. | The pharmacy team at the hospital will host Opioid stewardship meetings on a quarterly basis. The Stewardship will focus on prescribing paterns and education for providers on best practices associated with prescribing of controlled medications. | Hospital | The hospital pharmacy team will provide education and host quarterly Opioid Stewardship meetings | UVMHN Elizabethtown Community Hospital |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Mental and Substance Use Disorders Prevention | Goal 2.2 Prevent opioid and other substance misuse and deaths | **1.** Safe disposal receptacles located in Adirondack Health's primary care health centers in St. Regis Falls, Lake Placid, Tupper Lake, and Keene. There is already a safe disposal receptacle located in the main lobby of Adirondack Medical Center. | All | 2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days | Number of prescription drugs deposited in safe disposal receptacles | **1.** Installation of safe disposal receptacles in at least two of four Adirondack Health primary care health centers | Community-based organizations | Health system grantee will provide support on policy implementation as the lead for this intervention. Franklin and Essex county health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the counties, and connect to healthcare resources. | Adirondack Health |

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| **Name of County - Organization(s) 2023 Workplan** | Essex County Health Department (ECHD) | Essex County Mental Health | The Prevention Team | Alliance for Positive Health | UVMHN Elizabethtown Community Hospital | Adirondack Health |
| Planning Report Liaison | Andrea Whitmarsh | Stefanie Miller | Traci Ploufe | Meagan Strack | Amanda Whisher | Matthew Scollin |
| **E-mail:** | andrea.whitmarsh@essexcountyny.gov | stefanie.v.miller@essexcountyny.gov | traci@preventionteam.org | mstrack@alliancefph.org | awhisher@ech.org | mgscollin@adirondackhealth.org |

| Priority | Focus Area | Goal | Objectives through 2024 | Disparities | Interventions | Family of Measures | By December 2023, we will have completed . . . | Implementation Partner *(Please select one partner from the dropdown list per row)* | Partner Role(s) and Resources | Lead Agency |
|---|---|---|---|---|---|---|---|---|---|---|
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.2 Prevent opioid overdose deaths | 1. By the end of 2024, 75% of ECHD leaders and staff will have completed at least 2 instructor-led/evidence-based training on trauma-informed approaches.<br>2. By the end of 2024, ECHD will have adopted a department-wide plan/policy that requires trauma-informed approaches be embedded in program and service delivery. | All | 2.2.6 Integrate trauma informed approaches in training staff and implementing program and policy. | Input Measures: Train ECHD leaders and staff in trauma-informed concepts and approaches.<br>Output Measures: Adopt a department-wide plan/policy that incorporates trauma-informed care concepts.<br>Short-Term Outcomes: Increase in the number of ECHD leaders who are familiar with trauma-informed approaches, concepts, and language.<br>Intermediate Outcomes: Increase in the number of ECHD staff who are familiar with trauma-informed approaches, concepts, and language.<br>Long-Term Outcomes: Increase in the number of ECHD programs that are developed/delivered considering trauma informed care approaches. | ECHD will pursue trauma-informed training opportunities that are geared appropriately toward service sector target populations (e.g. children, young adults, older adults, etc.). By the end of 2023, 75% of ECHD Unit leaders and staff will have completed at least 1 instructor-led/evidence-based training on trauma-informed approaches. | Local governmental unit | ECHD will work with Essex County Community Services Board/BRIEF Coordinator/CCSI to coordinate and implement trauma-informed training for organizational leaders and staff. | Essex County Health Department |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.3 Prevent and address adverse childhood experiences | 2.3.3 Increase communities reached by opportunities to build resilience by at least 10 percent. | All | 2.3.2 Address Adverse Childhood Experiences and other types of trauma in the primary care setting | Input Measure: Health Center staff training of ACEs. Output Measure: Children who screen positive will be referred to additional resources/services.<br>Long-Term Measure: The affects of childhood trauma will be addressed once identified to reduce the impact on the child's long term healthcare needs. | The hospital's pediatrician will implement an ACEs screen within the primary care setting. | Hospital | The hospital's pediatrician will work with staff on the importance of screening. Referrals to social work/community resources will occur when appropriate. | UVMHN Elizabethtown Community Hospital |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.3 Prevent and address adverse childhood experiences | Home-visiting program staff will make a connection with 75% of the Essex County families with newborns in 2024 to offer home visits or a newborn welcome packet. | Income<br>Access | 2.3.4 Implement evidence-based home visiting programs | Input measures: engage in technical assistance sessions with home visiting program models to determine which is the best fit for Essex County.<br>Output Measures: Launch a universal home visiting program in Essex County.<br>Short-Term Outcome: train at least 2 ECHD staff members in program delivery components.<br>Intermediate Outcomes: Conduct targeted outreach with area OB providers, pediatricians and hospitals to raise awareness of the program.<br>Long-Term Measures: Home-visiting program staff will make a connection with 90% of Essex County families with newborns to either receive home visits or a newborn welcome packet. | Launch a universal newborn home-visiting program in Essex County, partnering with ECHD WIC and Children's Services Units, as well as community-based partners and healthcare providers to ensure early supports and wrap-around care. | Local governmental unit | ECHD Public Health Unit will collaborate with the WIC, Home Health, and Children's Services Units to develop, launch, and maintain a universal newborn home visiting program in Essex County. | Essex County Health Department |

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| **Name of County - Organization(s) 2023 Workplan** | Essex County Health Department (ECHD) | Essex County Mental Health | The Prevention Team | Alliance for Positive Health | UVMHN Elizabethtown Community Hospital | Adirondack Health |
| Planning Report Liaison | Andrea Whitmarsh | Stefanie Miller | Traci Ploufe | Meagan Strack | Amanda Whisher | Matthew Scollin |
| **E-mail:** | andrea.whitmarsh@essexcountyny.gov | stefanie.v.miller@essexcountyny.gov | traci@preventionteam.org | mstrack@alliancefph.org | awhisher@ech.org | mgscollin@adirondackhealth.org |

| Priority | Focus Area | Goal | Objectives through 2024 | Disparities | Interventions | Family of Measures | By December 2023, we will have completed . . . | Implementation Partner *(Please select one partner from the dropdown list per row)* | Partner Role(s) and Resources | Lead Agency |
|---|---|---|---|---|---|---|---|---|---|---|
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population | Increase by 2 clients per quarter with documented NYS Quitline active referrals; Decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4% | An identified barrier/disparity is obtaining client consent for NYS Quitline referral. | 2.6.1 Implement a multilevel intervention model that focused at the individual, health systems, community and policy-levels | Input measures: number of quarterly meetings held, number of data reports reviewed<br>Output measures: Number of staff receiving feedback and support with delivering quit assistance to clients<br>Outcome measures: Number of clients receiving active referrals to NYS Quitline; prevalence of cigarette smoking in individuals diagnosed with serious mental illness | The ECMH Tobacco Dependance Treatment Team (TDTT) will continue to meet quarterly in collaboration with the NC Heart Network. Quarterly Utilization Review (UR) meetings with ECMH administration and clinical staff highlight documentation consistency, which includes presence of a Tobacco diagnosis and 5 As assessments. RN will run quarterly data reports in the Electronic Clinical Record (ECR) on clients with Tobacco diagnosis and cross references these clients with presence of ECR documented 5 As assessment. The RN will meet quarterly with Champlain Valley Family Center (CVFC) for Drug Treatment & Youth Services Tobacco-Free CFE & Reality Check staff and the Essex County Prevention Team. Agenda items include CVFC environment and policy strategies, school initiatives and vaping strategies. RN will meet quarterly with the NCHHN Tobacco Treatment Network to discuss and problem solve area wide strategies. The ECMH D/DCS will provide outreach to customers and stakeholders via the Community Service Board and Essex County Board of Supervisors meetings and reports of ECMH Tobacco Dependence Treatment progress. | | | |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Focus Area 2: Prevent Mental and Substance User Disorders | Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population | Maintain an average of 80% ECMH clients with tobacco diagnosis that have documented 5As. Maintain 100% of clinician offices displaying tobacco and nicotine cessation messages | Access to care, income | 2.6.2 Integrated treatment: Concurrent therapy for mental illness and nicotine addiction have the best outcomes. Smokers who receive mental health treatment have higher quit rates than those who do not. For example, people with schizophrenia showed better quit rates with the medication bupropion, compared with placebo, and showed no worsening of psychiatric symptoms. A combination of the medication varenicline and behavioral support has shown promise for helping people with bipolar and major depressive disorders quit, with no worsening of psychiatric symptoms. A clinical trial found that a combination of varenicline and cognitive behavioral therapy (CBT) was more effective than CBT alone for helping people with serious mental illness stop smoking for a prolonged period—after 1 year of treatment and at 6 months after treatment ended. | Input measures: number of therapists receiving feedback and support with offering quit assistance<br>Output measures: number of clients reached with information and/or prescriptions for quit support Outcome measures: % of clients with tobacco diagnosis that have quit support documents in EMR; % of clinician offices with cessation messaging displayed | ECR will document oral consent for the NYS Quit Line and provide electronic Quitline referral. Many mental health clients remain reluctant to connect with the NYS Quitline, so ECMH clinicians will provide behavioral counseling and refer clients to the RN and NPP for NRT and resources such as Quit Kits and other tobacco dependance treatment incentives. The RN will offer clients Smokerlyzer CO2 Monitor breath test (on hold during the pandemic) and advocate for applying a trauma-informed framework across multiple levels to address tobacco-related disparities among individuals with mental health/substance use challenges with trauma histories. The RN will provide quarterly emails to therapists with a list of their tobacco clients missing 5 As assessments and add these to their schedules as indicated. The ECR will alert clinicians when their client 5 As assessments are due. ECMH clients will be prescribed bupropion and/or varenicline as indicated. Communication will be bi-directional with ECMH clinicians, prescribers and client health care providers.The ECMH Wait Room video loop will contain tobacco dependance messages, including NYS Quitline access. A Nicotine Dependance resource page will be updated quarterly on the ECMH website with a variety of evidence-based links, apps and resources | | | |

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| **Name of County - Organization(s)**<br>**2023 Workplan** | Essex County Health Dept. | Essex County Health Dept. (WIC) | Essex County Health Dept. (Early Intervention) | Healthy Families North Country | UVMHN Elizabethtown Community Hospital |
| **Planning Report Liaison**<br>**E-mail:** | Elizabeth Terry<br>elizabeth.terry@essexcountyny.gov | Krista Berger<br>krista.berger@essexcountyny.gov | Lucianna Celotti<br>lucianna.celotti@essexcountyny.gov | Esther Piper<br>epiper@bhsn.org | Amanda Whisher<br>awhisher@ech.org |

| Priority | Focus Area | Goal | Objectives through 2024 | Disparities | Interventions | Family of Measures | By December 2023, we will have completed . . . | Implementation Partner (Please select one partner from the dropdown list per row) | Partner Role(s) and Resources | Lead Agency |
|---|---|---|---|---|---|---|---|---|---|---|
| Promote Healthy Women, Infants and Children | Focus Area 1: Maternal & Women's Health | Goal 1.1: Increase use of primary and preventive health care services by women, with a focus on women of reproductive age | By December 31, 2024, UVMHN ECH will increase the percentage of women who have had an annual exam by at least 2%. | Access to healthcare | Intervention 1.1.2: Increase the percentage of women ages 45 years and older with a past year preventive medical visit by 2%. | Input Measures: # of women aged 45 years and older who are established with Primary Care (UVMHN ECH PCP)<br>Output Measures: # of established women aged 45 years and older who have had an annual preventive exam<br>Short-term Outcome: Additional GYN providers offering services at both the Elizabethtown and Ticonderoga Campus.<br>Long-term Outcome: An increase in women who have preventive exams. | 1. GYN clinics began at the Ticonderoga campus in 2022. By December of 2023 UVMHN ECH will have increased the number of days per month GYN services will be available at the Ticonderoga campus. | Hospital | The hospital will continue to work on recruitment and retention strategies and identify innovative, evidence-based practices to providing preventive care in a rural setting. | UVMHN - Elizabethtown Community Hospital |
| Promote Healthy Women, Infants and Children | Focus Area 1: Maternal and Women's Health | Goal 1.2: Reduce maternal mortality & morbidity | By December 31, 2024, ECHD will screen 90% of postpartum women that accepts a home visit through the Baby Steps to Bright Futures Home Visiting Program. | Access to healthcare | Intervention 1.2.4: Screen all pregnant and postpartum women for depression, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. | Input Measures: Screening tool identified<br>Output Measures: # of screening tools completed. women/families engaged.<br>Short-term Outcome: Referral created to mental health supports. | 1. Implement maternal depression screening into Baby Steps to Bright Futures Home Visiting Program. | Local governmental unit | Essex County Community Service Board will provide the mental health and substance use services. | Essex County Health Department |
| Promote Healthy Women, Infants and Children | Focus Area 2: Perinatal and Infant Health | Goal 2.2: Increase breastfeeding | By December 31, 2024, ECHD WIC Unit will increase the Breastfeeding Initiation Rate of Infants and Children from 75% to 77%. | Access to healthcare | Intervention 2.2.1: Increase access to professional support, peer support, and formal education to change behavior and outcomes. | Input Measures: Update information on local breastfeeding support services.<br>Output Measures: Breastfeeding Resource Guide is shared publicly and with providers/CBO's.<br>Short-term Outcome: # of social media engagements, # of providers reached | 1. WIC staff will visit local Health Care Provider offices 2 times per month to provide education on how ECHD staff can support breastfeeding women.<br>2. Staff will conduct visits to birthing hospitals 1 x per year to provide information on ECHD programs and local Essex County breastfeeding supports. 3. WIC Staff will contact every prenatal woman based on NYS PC Program Frequency of Contacts Guidance and will be trained on the BAPT tool and start implementation. | Providers | Health care providers will make breastfeeding support referrals to local programs and services or provide information to families on how to refer. | Essex County Health Department |
| Promote Healthy Women, Infants and Children | Focus Area 2: Perinatal and Infant Health | Goal: 2.2 Increase breastfeeding | By December 31, 2024, ECHD Public Health Unit will work with local health care provider offices to offer lactation support groups once a month at two Essex County health care provider locations. | Access to healthcare Transportation | Intervention 2.2.8: Increase access to peer and professional breastfeeding support by creating drop-in centers (e.g., Baby Cafés) in faith-based, community-based or health care organizations in communities. | Input Measures: # of lactation support groups offered.<br>Output Measures: # of breastfeeding women/families engaged.<br>Short-term Outcome: # lactation support groups offered.<br>Intermediate Outcome: # of mothers/families that receive | 1. Meet monthly with Elizabethtown Community Hospital and the Creating Breastfeeding Friendly Communities grant to discuss collaboration and logestics to starting a lactation support group.<br>2. Launch a lactation support group by March 2023 at the Elizabethtown Community Hospital with meetings to be held once a month.<br>3. Launch a second lactation support group by June 2023 at the UVM Ticonderoga Campus with meetings to be held once a month to serve those in the southern region of Essex County. | Hospital | Elizabethtown Community Hospital<br>and Creating Breastfeeding Friendly Communities grant will collaborate to provide support and TA for lactation support group. | UVMHN - Elizabethtown Community Hospital |
| Promote Healthy Women, Infants and Children | Focus Area 2. Perinatal & Infant Health | Goal 2.1 Reduce infant mortality & morbidity | ECHD will launch a Universal Home Visiting Program and program staff will make a connection with 75% of the Essex County families with newborns in 2024 to offer home visits or a newborn welcome packet. | Transportation | Intervention 2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs | Input measures: engage in technical assistance sessions with home visiting program models to determine which is the best fit for Essex County. Output Measures: Launch a universal home visiting program in Essex County.<br>Short-Term Outcome: train at least 2 ECHD staff members in program delivery components.<br>Intermediate Outcomes: Conduct targeted outreach with area OB providers, pediatricians and hospitals to raise awareness of the program.<br>Long-Term Measures: Home-visiting program staff will make a connection with 90% of Essex County families with newborns to either receive home visits or a newborn welcome packet. | Launch a universal newborn home-visiting program in Essex County, partnering with ECHD WIC and Children's Services Units, as well as community-based partners and healthcare providers to ensure early supports and wrap-around care. | Local governmental unit | ECHD Public Health Unit will collaborate with the WIC, Home Health, and Children's Services Units to develop, launch, and maintain a universal newborn home visiting program in Essex County. | Essex County Health Department |
| Promote Healthy Women, Infants and Children | Focus Area 2. Perinatal & Infant Health | Goal 2.1 Reduce infant mortality & morbidity | Healthy Families North County will launch a new program in Essex County and will serve at least 12 families by December 31, 2024. | Income, Educational Attainment, Mental Health | Intervention 2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs | Input Measures: # of families referred to Healthy Families Essex Program.<br>Output Measures: # of Essex Families that accept the program.<br>Short-term Outcome: Number of families that accept the referral.<br>Intermediate Outcome: # of people that complete the entire program.<br>Long-term Outcome: Increased number of children receive EIP s families are served by the Healthy Families Essex Program. | Healthy Families North County will launch a new program in Essex County and will serve at least 12 families by December 31, 2024. | Community-based organizations | Community based organizations, health care providers and local government will provide referrals to the Healthy Families Program. | Healthy Families North Country |
| Promote Healthy Women, Infants and Children | Focus Area 3. Child & Adolescent Health | Goal 3.2: Increase supports for children and youth with special health care needs | Increase the number of children enrolled in the EIP by 20% by December 31, 2024. | Educational attainment | Intervention 3.2.1: Engage families in planning and systems work to improve family centered services and effective practices for supporting CSHCN and their families. | Input Measures: # Create system to improve referral follow-up with primary referral sources.<br>Output Measures: New referral follow up process implemented on January 1, 2023.<br>Short-term Outcome: Increased number of referrals accepted.<br>Intermediate Outcome: Increased number of children enrolled in EIP after successfully completing evaluation.<br>Long-term Outcome: Increased number of children receive EIP services based of their individualized service plan. | 1. Increase outreach to primary referral sources (health care providers and community based organizations) and follow up with those referral sources when the program is declined for re-referral and family education/support. 2. Include a follow up call to referred family approximately one month after initial EI referral or services are declined to provide support and education on program benefits for child suspected of delay.<br>3. Provide outreach, educational and marketing materials to the Baby Steps to Bright Futures Universal Home Visiting program to increase referrals and resources to families to support their child's development.<br>4. Survey families with children participating in the Children with Special Healthcare Needs Program to identify strengths and barriers of local resources. | Providers | Health care providers will reach out to parents to re-refer to EIP. | Essex County Health Department |
| Promote Healthy Women, Infants and Children | Cross Cutting Healthy Women, Infants, & Children | Goal 4.1 : Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations | 4.1 - Increase and enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families through bi-monthly coalition meetings through December 2024. | Access to healthcare | Intervention 4.1: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course. | Input Measures: # of community based partners invited<br>Output Measures: # of community based partners engaged<br>Short-term Outcome: # of coalition meetings scheduled<br>Intermediate Outcome: # of collaborations with partners that address social determinants of health impacting women, infants, children, and families.<br>Long-term Outcome: Identify racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations | 1. ECHD will schedule and facilitate coalition meetings bi-monthly starting in November 2022 to address strengths, challenges, and collaboration opportunities for all agencies and providers serving children, youth, and families. | Other (please describe partner and role(s) in column D) | Community based Organizations and Health Care Providers will participate and collaborate with the Bright Futures Coalition. | Essex County Health Department |

## APPENDIX 7

| Master Source List | |
|---|---|
| 1 | New York State Department of Health Prevention Agenda |
| 2 | IRS - Requirements for 501(c)(3) Hospitals Under the Affordable Care Act - Section 501 (r) |
| 3 | Public Health Accreditation Board Standards & Measures |
| 4 | Association for Community Health Improvement (2017) Community Health Assessment Toolkit |
| 5 | Essex County Real Property Tax Services Department |
| 6 | Adirodack Land Trust |
| 7 | Adirondack Park Agency |
| 8 | United States Census Bureau |
| 9 | Asterhill Research Company - Essex County Housing and Population Study, 2022 |
| 10 | Data USA; Essex County, NY |
| 11 | NYS Board of Elections, Enrollment by County |
| 12 | NYS Legislature - Laws of NY |
| 13 | Pew Research Center |
| 14 | County Health Rankings |
| 15 | NYS Leading Causes of Death Reports |
| 16 | NYS Physical Activity Dashboard - Essex County |
| 17 | Well Fed Essex County Collaborative - An Evaluation of 5 Food Projects Report |
| 18 | CDC - Preventing Chronic Disease |
| 19 | NYS BRFSS Brief - Cigarette Smoking 2022; 2022-12 |
| 20 | NYS Youth Tobacco Data Sheet |
| 21 | NY Prevention Needs Assessment Survey - Essex County, 2021 |
| 22 | 2019 Essex County Community Health Assessment; 2019-2022 Community Health Improvement Plan |
| 23 | National Institute on Drug Abuse |
| 24 | Adirondacks ACO - North Country COVID-19 Vaccine Dashboard |
| 25 | Neighborhood Atlas |
| 26 | CDC - Excessive Alcohol Use |
| 27 | NYS Comptroller Report: Continuing Crisis - Drug Overdose Deaths in New York, November 2022 |
| 28 | Essex County Heroin & Other (Drug) Coalition - HIDTA ODMAP |
| 29 | 2021 Monitoring and Analysis Profiles with Selected Trend Data: 2017-2021; Child Protective Services, Foster Care, Adoption. Essex County |
| 30 | New York State Opioid Dashboard |
| 31 | NYSDOH: NYS Opioid Annual Data Report 2021 |
| 32 | Prescription Opioids and Heroin Research Report, 2018 |
| 33 | Mayo Clinic - Preterm Birth |
| 34 | NYS Community Health Indicator Reports |
| 35 | CDC Well Child Visits and Recommended Vaccinations |
| 36 | USDA WIC Eligibility and Coverage Rates 2018 |
| 37 | Center for American Progress - The Basic Facts About Women in Poverty |
| 38 | NYS Health Assessment - Contributing Causes of Health Challenges |
| 39 | NACCHO - Guide to Prioritization Techniques |
| 40 | Digital Prosperity: How broadband can deliver health and equity to all communities, Brookings Institute. February 27, 2020 |
| 41 | for Community Living, November 16, 2021 |

| Master Source List (cont'd) | |
|---|---|
| 42 | ARHN Community Profile Data Sheets |
| 43 | Healthy People 2030 - Poverty |
| 44 | United for ALICE - NY, 2018 County Profiles |
| 45 | Poverty USA |
| 46 | Rural Health Information Hub - Federal Office of Rural Health Policy |
| 47 | The Wellbeing of Infants and Toddlers in the Adirondacks, second edition, 2021. Adirondack Birth to Three Alliance |
| 48 | NYS Education Department |
| 49 | Center for Neighborhood Technology |
| 50 | United States Department of Commerce - Broadband USA |
| 51 | Office of Addiction Services and Supports - Find Addiction Treatment |