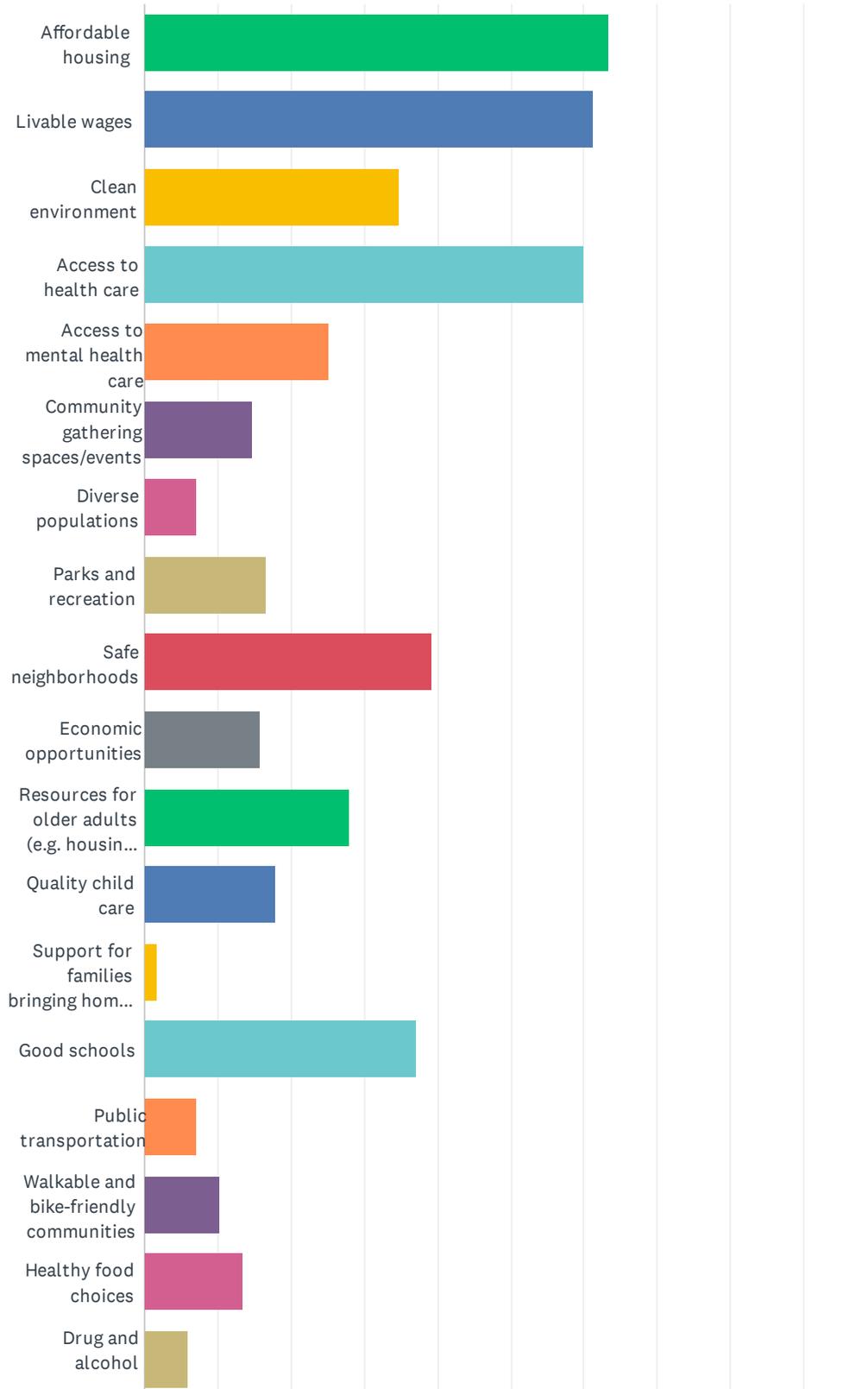
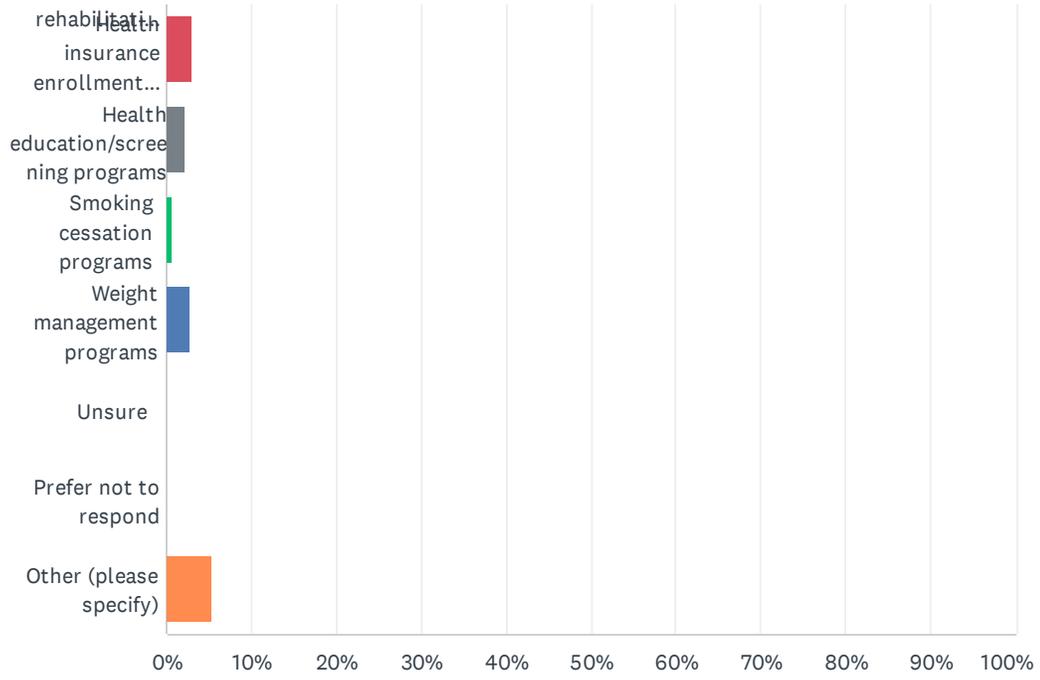


# Q1 When you imagine a strong, vibrant, healthy community, what are the most important features that come to mind? Choose up to 5.

Answered: 562 Skipped: 0



# 2025 Community Survey

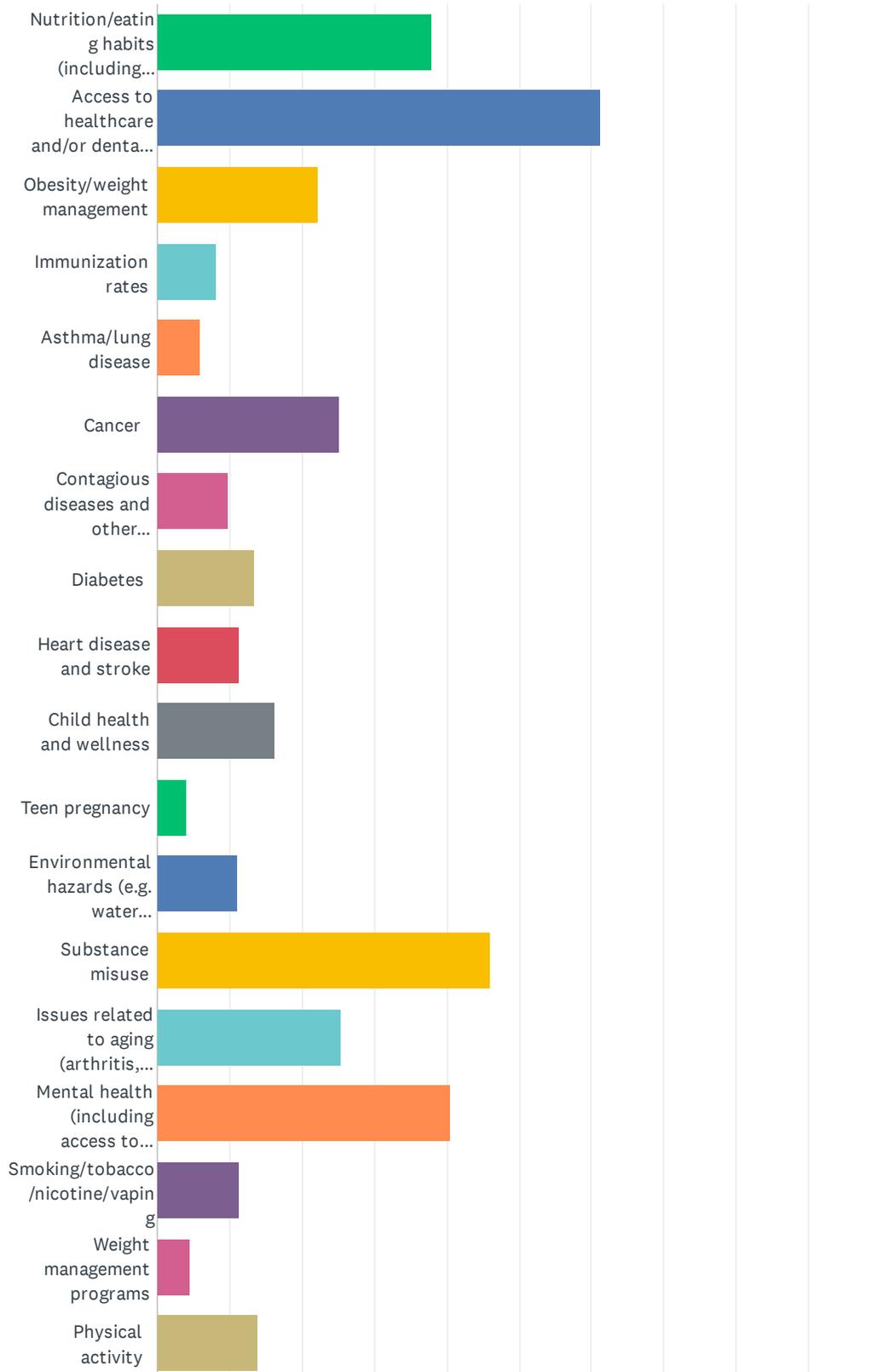


## 2025 Community Survey

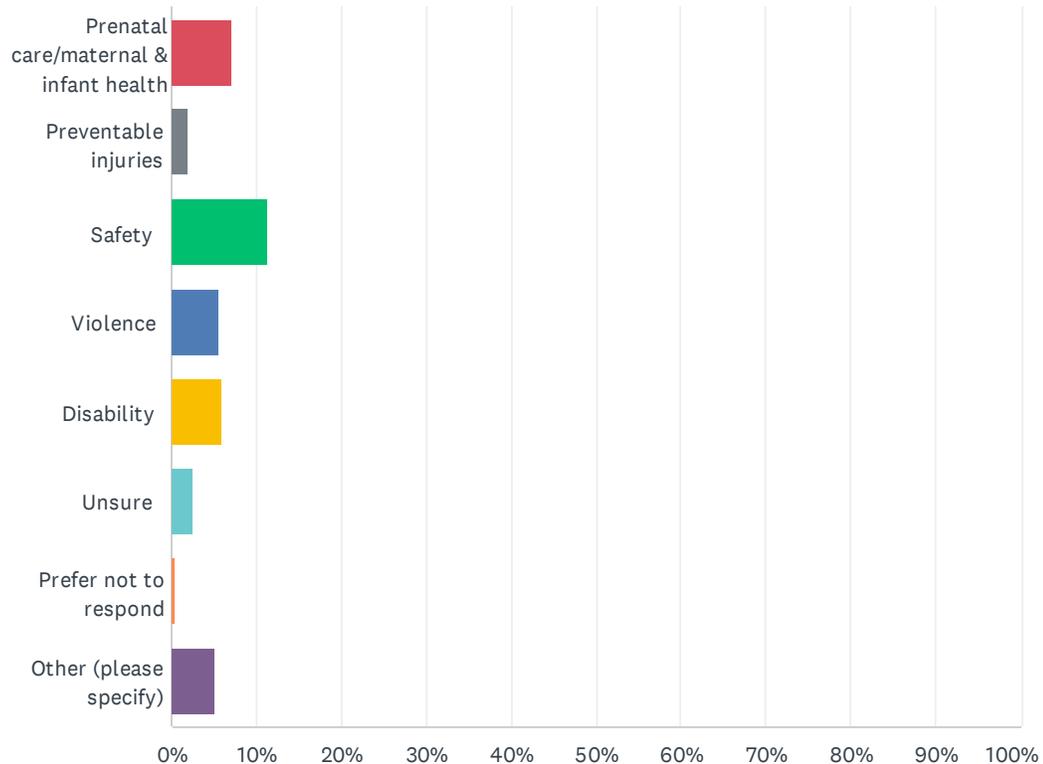
| ANSWER CHOICES   | RESPONSES |     |
|--|-----------|-----|
| Affordable housing   | 63.35%    | 356 |
| Livable wages  | 61.21%    | 344 |
| Clean environment  | 34.70%    | 195 |
| Access to health care  | 59.96%    | 337 |
| Access to mental health care   | 25.09%    | 141 |
| Community gathering spaces/events  | 14.77%    | 83  |
| Diverse populations  | 7.12%     | 40  |
| Parks and recreation   | 16.55%    | 93  |
| Safe neighborhoods   | 39.32%    | 221 |
| Economic opportunities   | 15.84%    | 89  |
| Resources for older adults (e.g. housing, home health, Meals on Wheels, community centers) | 27.94%    | 157 |
| Quality child care   | 17.97%    | 101 |
| Support for families bringing home new babies  | 1.78%     | 10  |
| Good schools   | 37.19%    | 209 |
| Public transportation  | 7.12%     | 40  |
| Walkable and bike-friendly communities   | 10.32%    | 58  |
| Healthy food choices   | 13.52%    | 76  |
| Drug and alcohol rehabilitation services   | 5.87%     | 33  |
| Health insurance enrollment programs   | 3.02%     | 17  |
| Health education/screening programs  | 2.14%     | 12  |
| Smoking cessation programs   | 0.71%     | 4   |
| Weight management programs   | 2.85%     | 16  |
| Unsure   | 0.00%     | 0   |
| Prefer not to respond  | 0.00%     | 0   |
| Other (please specify)   | 5.34%     | 30  |
| Total Respondents: 562   |           |     |

## Q2 What are the main health concerns in the community where you live? Choose up to 5.

Answered: 562 Skipped: 0



# 2025 Community Survey

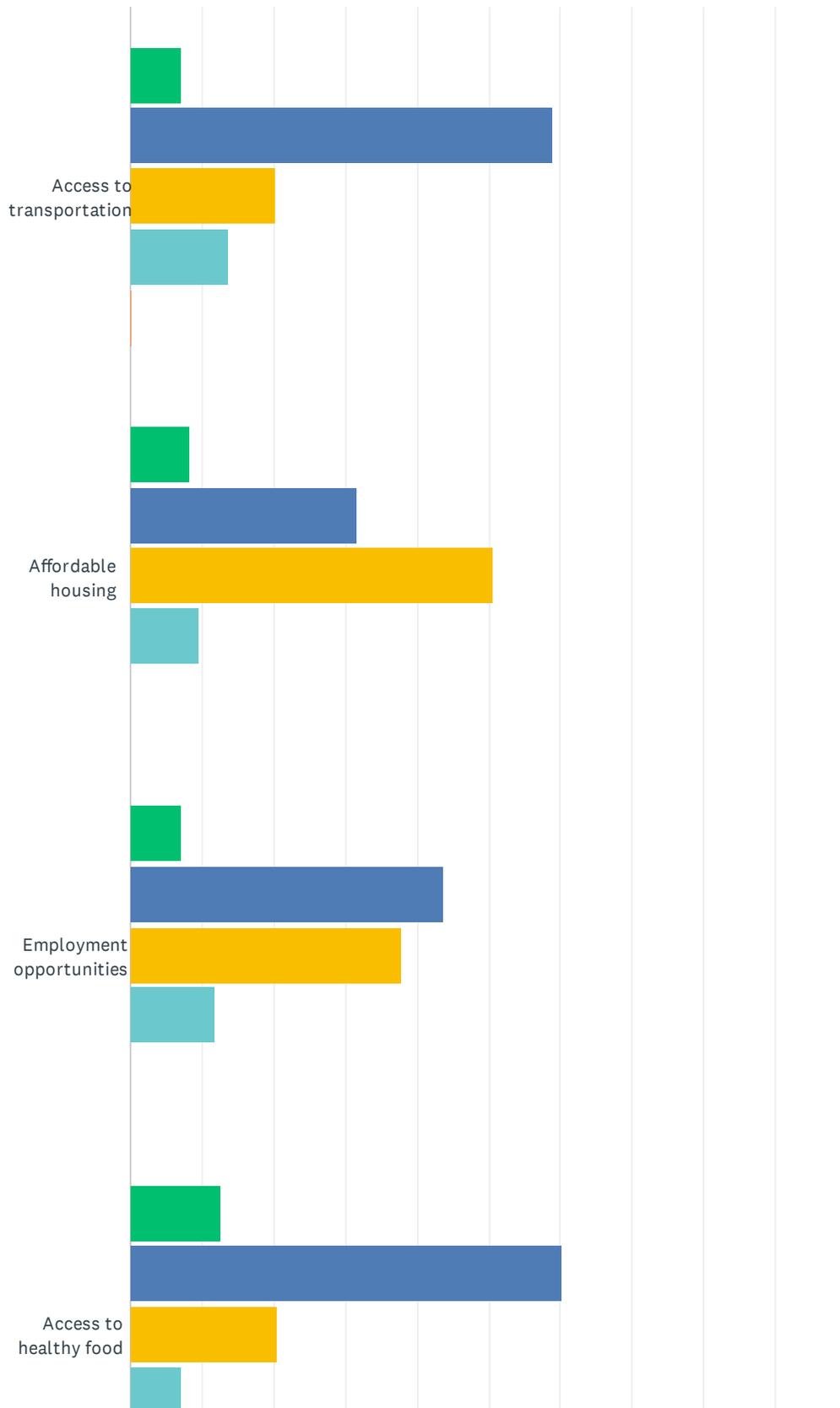


## 2025 Community Survey

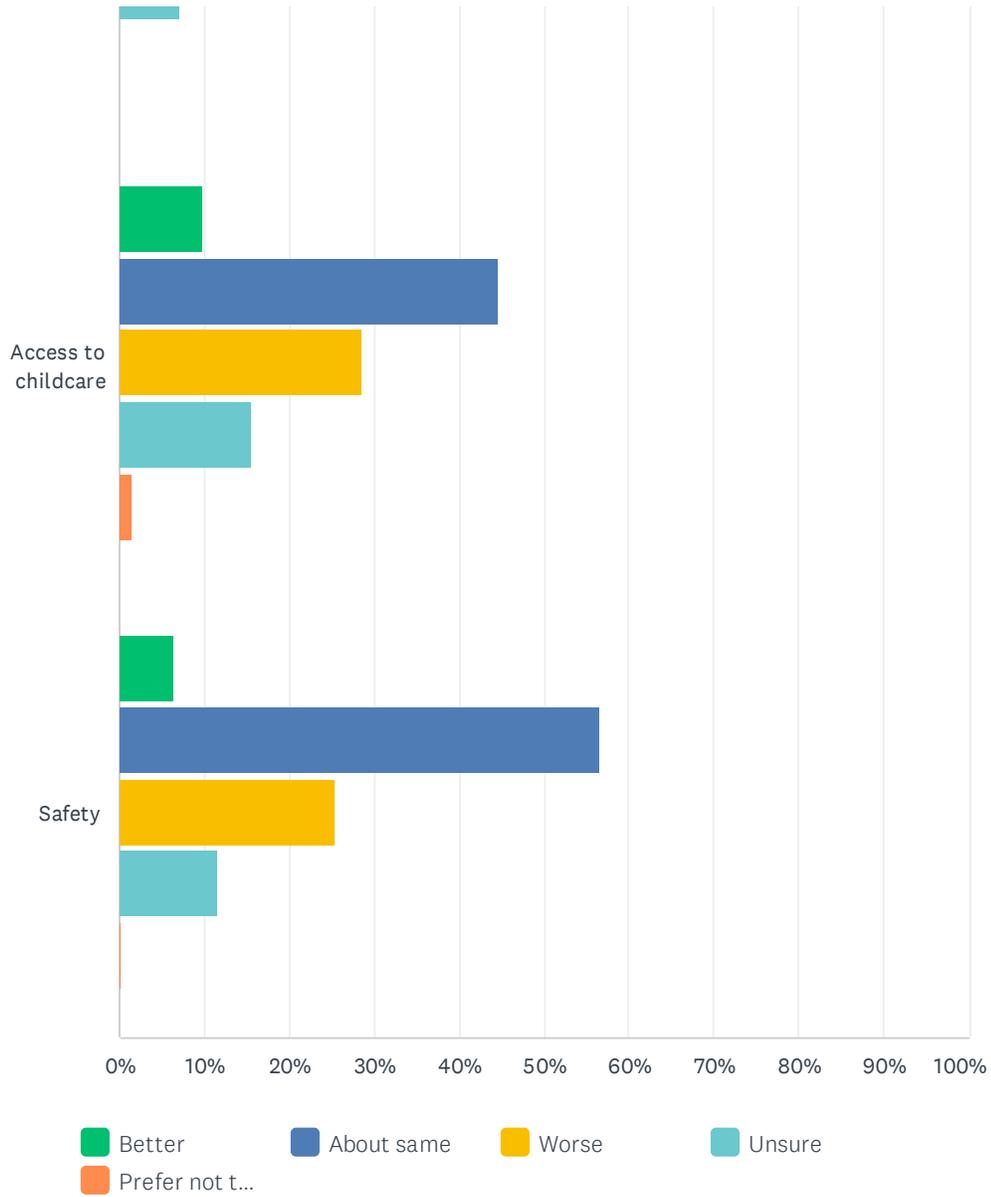
| ANSWER CHOICES  | RESPONSES |     |
|---|-----------|-----|
| Nutrition/eating habits (including access to healthy food)                            | 37.90%    | 213 |
| Access to healthcare and/or dental providers  | 61.21%    | 344 |
| Obesity/weight management   | 22.24%    | 125 |
| Immunization rates  | 8.01%     | 45  |
| Asthma/lung disease   | 5.87%     | 33  |
| Cancer  | 25.09%    | 141 |
| Contagious diseases and other infections  | 9.79%     | 55  |
| Diabetes  | 13.52%    | 76  |
| Heart disease and stroke  | 11.39%    | 64  |
| Child health and wellness   | 16.19%    | 91  |
| Teen pregnancy  | 4.09%     | 23  |
| Environmental hazards (e.g. water pollution, air quality, etc.)                       | 11.03%    | 62  |
| Substance misuse  | 46.09%    | 259 |
| Issues related to aging (arthritis, falls, hearing/vision loss, cognitive impairment) | 25.44%    | 143 |
| Mental health (including access to mental health services)                            | 40.57%    | 228 |
| Smoking/tobacco/nicotine/vaping   | 11.21%    | 63  |
| Weight management programs  | 4.45%     | 25  |
| Physical activity   | 13.88%    | 78  |
| Prenatal care/maternal & infant health  | 7.12%     | 40  |
| Preventable injuries  | 1.96%     | 11  |
| Safety  | 11.21%    | 63  |
| Violence  | 5.52%     | 31  |
| Disability  | 5.87%     | 33  |
| Unsure  | 2.49%     | 14  |
| Prefer not to respond   | 0.36%     | 2   |
| Other (please specify)  | 5.16%     | 29  |
| Total Respondents: 562  |           |     |

### Q3 How do you think your community will be doing in 5 years?

Answered: 561 Skipped: 1



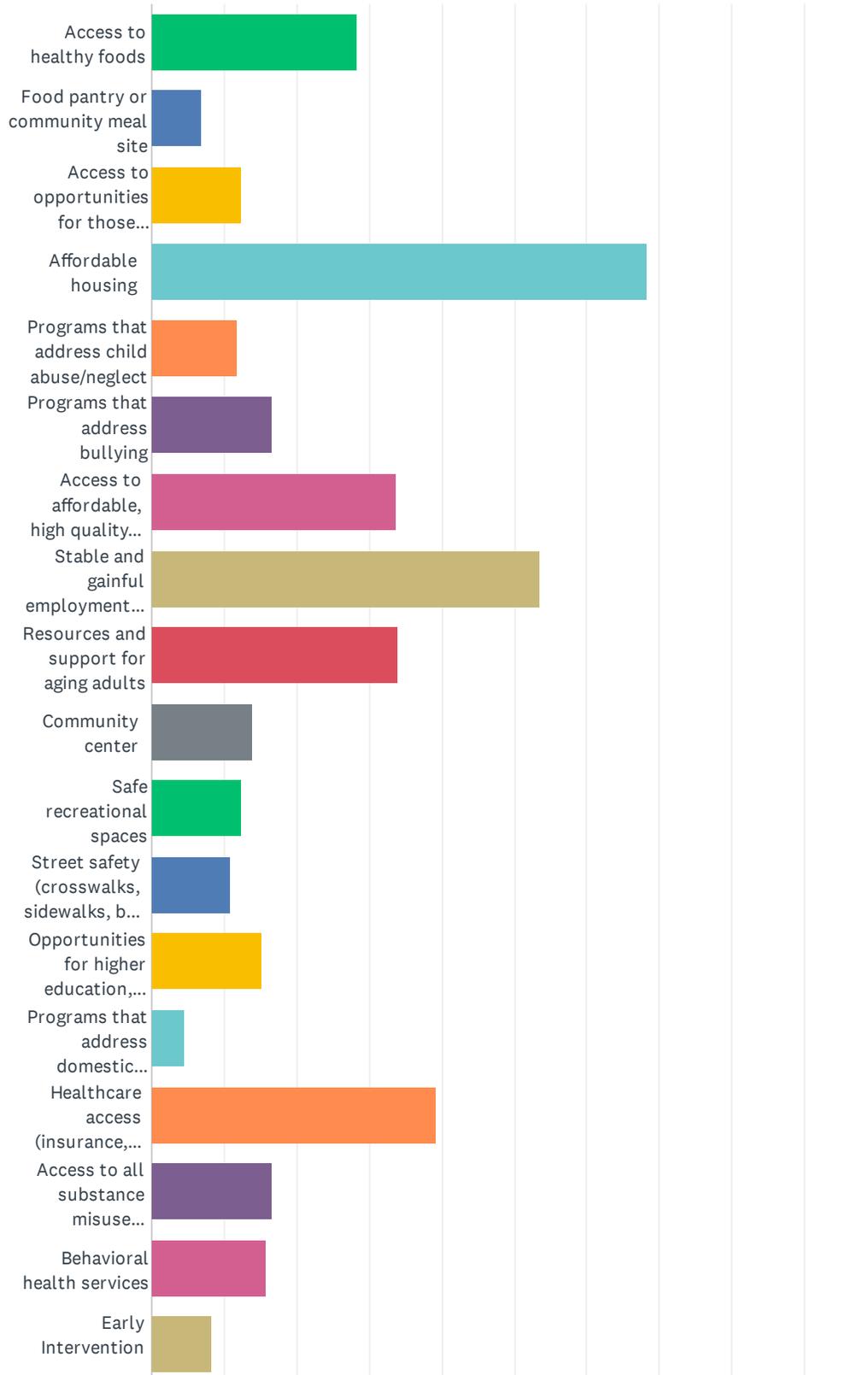
## 2025 Community Survey



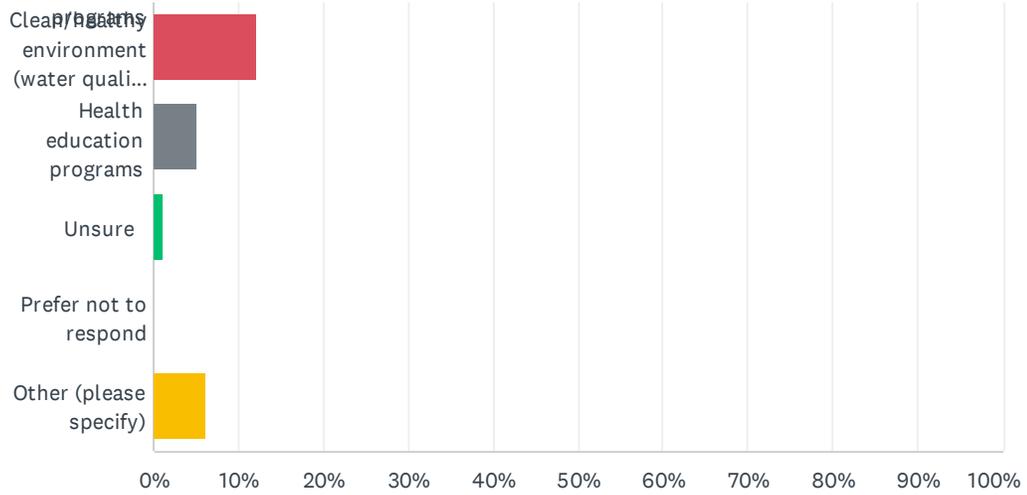
|                          | BETTER       | ABOUT SAME    | WORSE         | UNSURE       | PREFER NOT TO RESPOND | TOTAL |
|--------------------------|--------------|---------------|---------------|--------------|-----------------------|-------|
| Access to transportation | 6.95%<br>39  | 58.82%<br>330 | 20.32%<br>114 | 13.73%<br>77 | 0.18%<br>1            | 561   |
| Affordable housing       | 8.30%<br>46  | 31.59%<br>175 | 50.54%<br>280 | 9.57%<br>53  | 0.00%<br>0            | 554   |
| Employment opportunities | 7.00%<br>39  | 43.63%<br>243 | 37.70%<br>210 | 11.67%<br>65 | 0.00%<br>0            | 557   |
| Access to healthy food   | 12.52%<br>70 | 60.11%<br>336 | 20.39%<br>114 | 6.98%<br>39  | 0.00%<br>0            | 559   |
| Access to childcare      | 9.91%<br>55  | 44.50%<br>247 | 28.65%<br>159 | 15.50%<br>86 | 1.44%<br>8            | 555   |
| Safety                   | 6.47%<br>36  | 56.47%<br>314 | 25.36%<br>141 | 11.51%<br>64 | 0.18%<br>1            | 556   |

# Q4 What would help most in the community where you live? Choose up to 5.

Answered: 562 Skipped: 0



# 2025 Community Survey

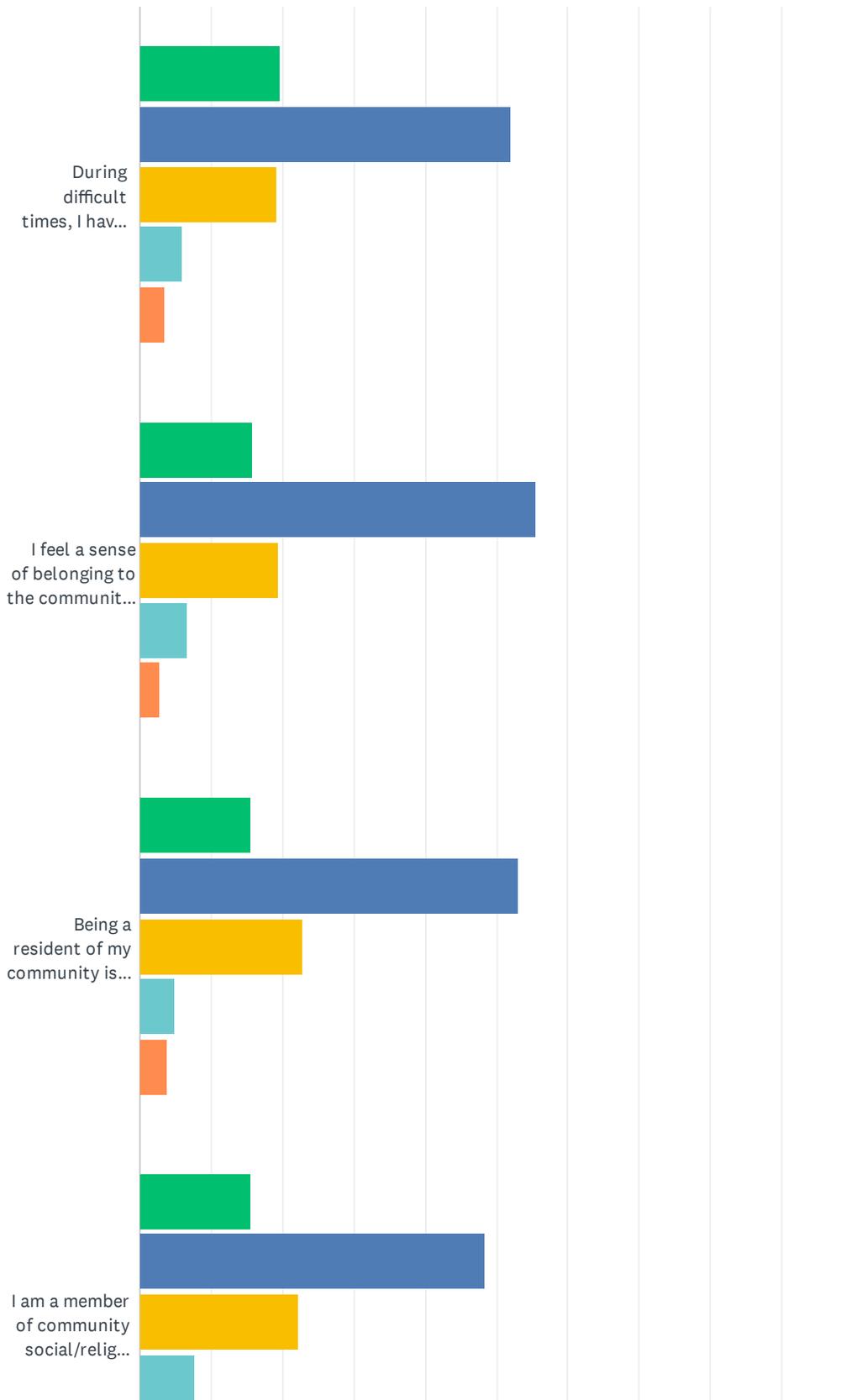


## 2025 Community Survey

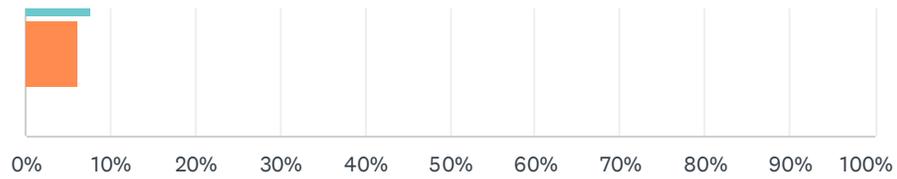
| ANSWER CHOICES   | RESPONSES |     |
|--|-----------|-----|
| Access to healthy foods  | 28.29%    | 159 |
| Food pantry or community meal site   | 6.76%     | 38  |
| Access to opportunities for those living with a disability   | 12.46%    | 70  |
| Affordable housing   | 68.33%    | 384 |
| Programs that address child abuse/neglect  | 11.74%    | 66  |
| Programs that address bullying   | 16.55%    | 93  |
| Access to affordable, high quality child care  | 33.63%    | 189 |
| Stable and gainful employment opportunities  | 53.56%    | 301 |
| Resources and support for aging adults   | 33.81%    | 190 |
| Community center   | 13.88%    | 78  |
| Safe recreational spaces   | 12.28%    | 69  |
| Street safety (crosswalks, sidewalks, bike lanes)  | 10.85%    | 61  |
| Opportunities for higher education, continuing education, and trades   | 15.12%    | 85  |
| Programs that address domestic violence  | 4.45%     | 25  |
| Healthcare access (insurance, affordability, proximity, availability of appointments, specialty care, screening, etc.) | 39.32%    | 221 |
| Access to all substance misuse treatments available  | 16.55%    | 93  |
| Behavioral health services   | 15.84%    | 89  |
| Early Intervention programs  | 8.36%     | 47  |
| Clean/healthy environment (water quality, air pollution, climate change, etc.)   | 12.10%    | 68  |
| Health education programs  | 5.16%     | 29  |
| Unsure   | 1.07%     | 6   |
| Prefer not to respond  | 0.00%     | 0   |
| Other (please specify)   | 6.23%     | 35  |
| Total Respondents: 562   |           |     |

## Q5 How would you rate the following statements?

Answered: 562 Skipped: 0



## 2025 Community Survey



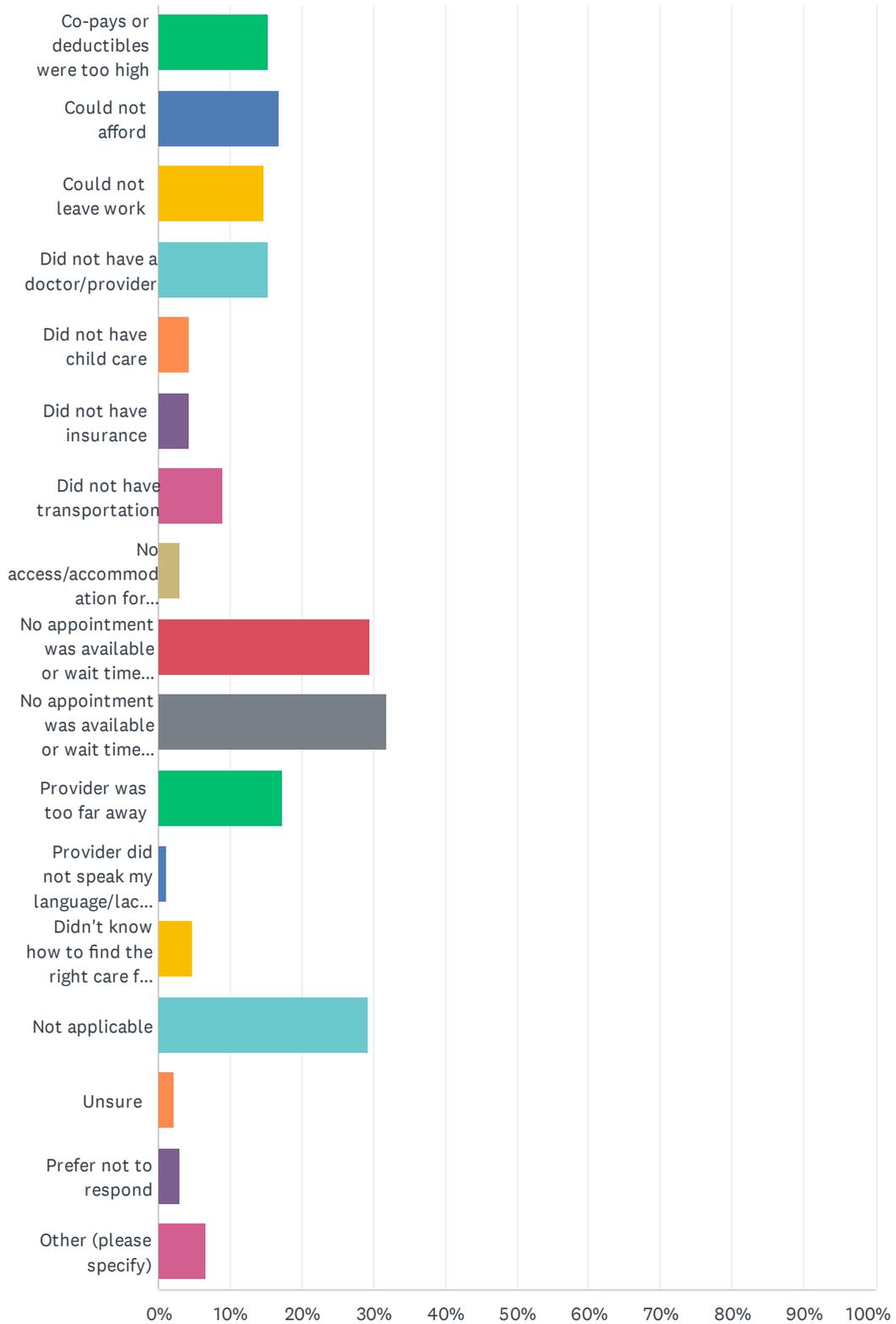
■ Strongly ag...   
 ■ Agree   
 ■ Disagree   
 ■ Strongly dis...  
■ Prefer not t...

|  | STRONGLY AGREE | AGREE         | DISAGREE      | STRONGLY DISAGREE | PREFER NOT TO RESPOND | TOTAL |
|--|----------------|---------------|---------------|-------------------|-----------------------|-------|
| During difficult times, I have "a village" I can call on for support.                              | 19.57%<br>110  | 51.96%<br>292 | 19.22%<br>108 | 5.87%<br>33       | 3.38%<br>19           | 562   |
| I feel a sense of belonging to the community where I live.   | 15.74%<br>88   | 55.46%<br>310 | 19.32%<br>108 | 6.62%<br>37       | 2.86%<br>16           | 559   |
| Being a resident of my community is an important part of how I see myself.                         | 15.51%<br>87   | 53.12%<br>298 | 22.82%<br>128 | 4.81%<br>27       | 3.74%<br>21           | 561   |
| I am a member of community social/religious/other groups and/or I participate in community events. | 15.56%<br>87   | 48.30%<br>270 | 22.18%<br>124 | 7.69%<br>43       | 6.26%<br>35           | 559   |

**Q6 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: 553 Skipped: 9

# 2025 Community Survey

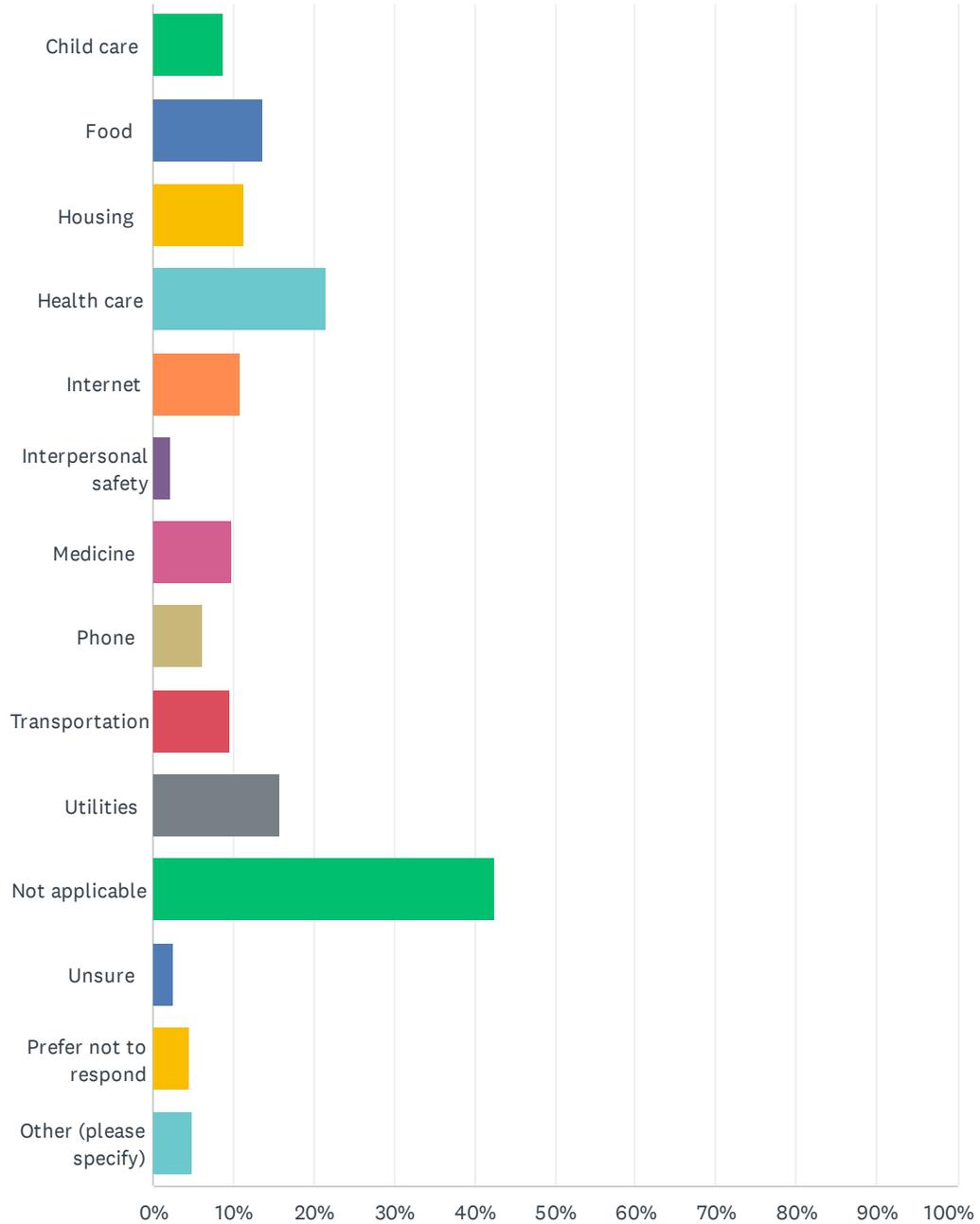


## 2025 Community Survey

| ANSWER CHOICES   | RESPONSES |     |
|--|-----------|-----|
| Co-pays or deductibles were too high                                   | 15.37%    | 85  |
| Could not afford   | 16.82%    | 93  |
| Could not leave work   | 14.65%    | 81  |
| Did not have a doctor/provider   | 15.37%    | 85  |
| Did not have child care  | 4.34%     | 24  |
| Did not have insurance   | 4.34%     | 24  |
| Did not have transportation  | 8.86%     | 49  |
| No access/accommodation for people with disabilities                   | 2.89%     | 16  |
| No appointment was available or wait time too long (primary care)      | 29.48%    | 163 |
| No appointment was available or wait time too long (specialist)        | 31.83%    | 176 |
| Provider was too far away  | 17.18%    | 95  |
| Provider did not speak my language/lack of culturally appropriate care | 1.08%     | 6   |
| Didn't know how to find the right care for my medical need             | 4.70%     | 26  |
| Not applicable   | 29.11%    | 161 |
| Unsure   | 2.17%     | 12  |
| Prefer not to respond  | 3.07%     | 17  |
| Other (please specify)   | 6.69%     | 37  |
| Total Respondents: 553   |           |     |

Q7 In the last year, have you had trouble meeting your needs or the needs of those in your household in any of the following areas? Check all that apply.

Answered: 526 Skipped: 36

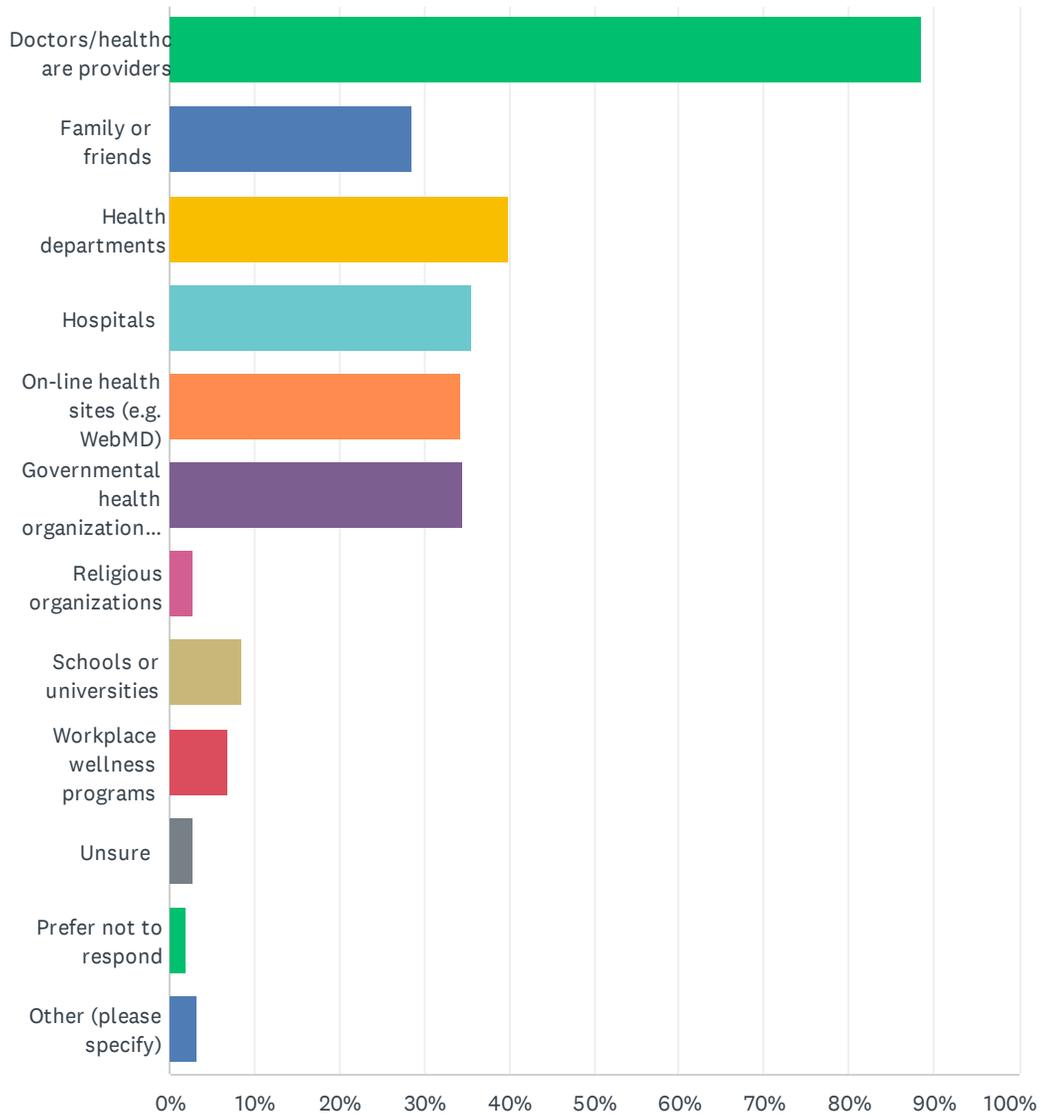


## 2025 Community Survey

| ANSWER CHOICES         | RESPONSES |     |
|------------------------|-----------|-----|
| Child care             | 8.75%     | 46  |
| Food                   | 13.69%    | 72  |
| Housing                | 11.41%    | 60  |
| Health care            | 21.48%    | 113 |
| Internet               | 10.84%    | 57  |
| Interpersonal safety   | 2.09%     | 11  |
| Medicine               | 9.89%     | 52  |
| Phone                  | 6.27%     | 33  |
| Transportation         | 9.70%     | 51  |
| Utilities              | 15.78%    | 83  |
| Not applicable         | 42.40%    | 223 |
| Unsure                 | 2.47%     | 13  |
| Prefer not to respond  | 4.56%     | 24  |
| Other (please specify) | 4.94%     | 26  |
| Total Respondents: 526 |           |     |

### Q8 What are the trusted sources of health information for you and your family? Please check all that apply.

Answered: 559 Skipped: 3

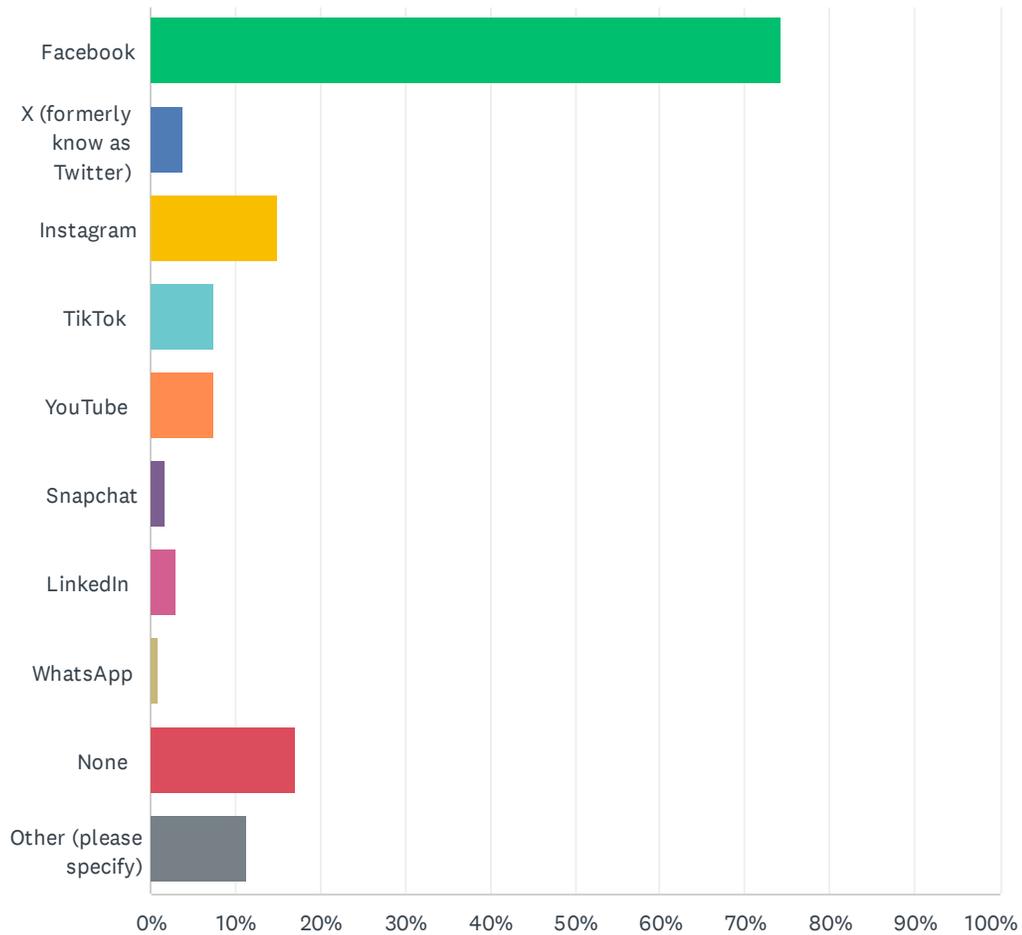


## 2025 Community Survey

| ANSWER CHOICES  | RESPONSES |     |
|---|-----------|-----|
| Doctors/healthcare providers  | 88.55%    | 495 |
| Family or friends   | 28.62%    | 160 |
| Health departments  | 39.89%    | 223 |
| Hospitals   | 35.60%    | 199 |
| On-line health sites (e.g. WebMD)   | 34.35%    | 192 |
| Governmental health organizations (CDC, Department of Health & Human Services, World Health Organization, etc.) | 34.53%    | 193 |
| Religious organizations   | 2.86%     | 16  |
| Schools or universities   | 8.59%     | 48  |
| Workplace wellness programs   | 6.80%     | 38  |
| Unsure  | 2.68%     | 15  |
| Prefer not to respond   | 1.97%     | 11  |
| Other (please specify)  | 3.22%     | 18  |
| Total Respondents: 559  |           |     |

### Q9 Which of the following social media platforms/pages do you use to learn about local health or community-related events and programs? Check all that apply.

Answered: 560 Skipped: 2

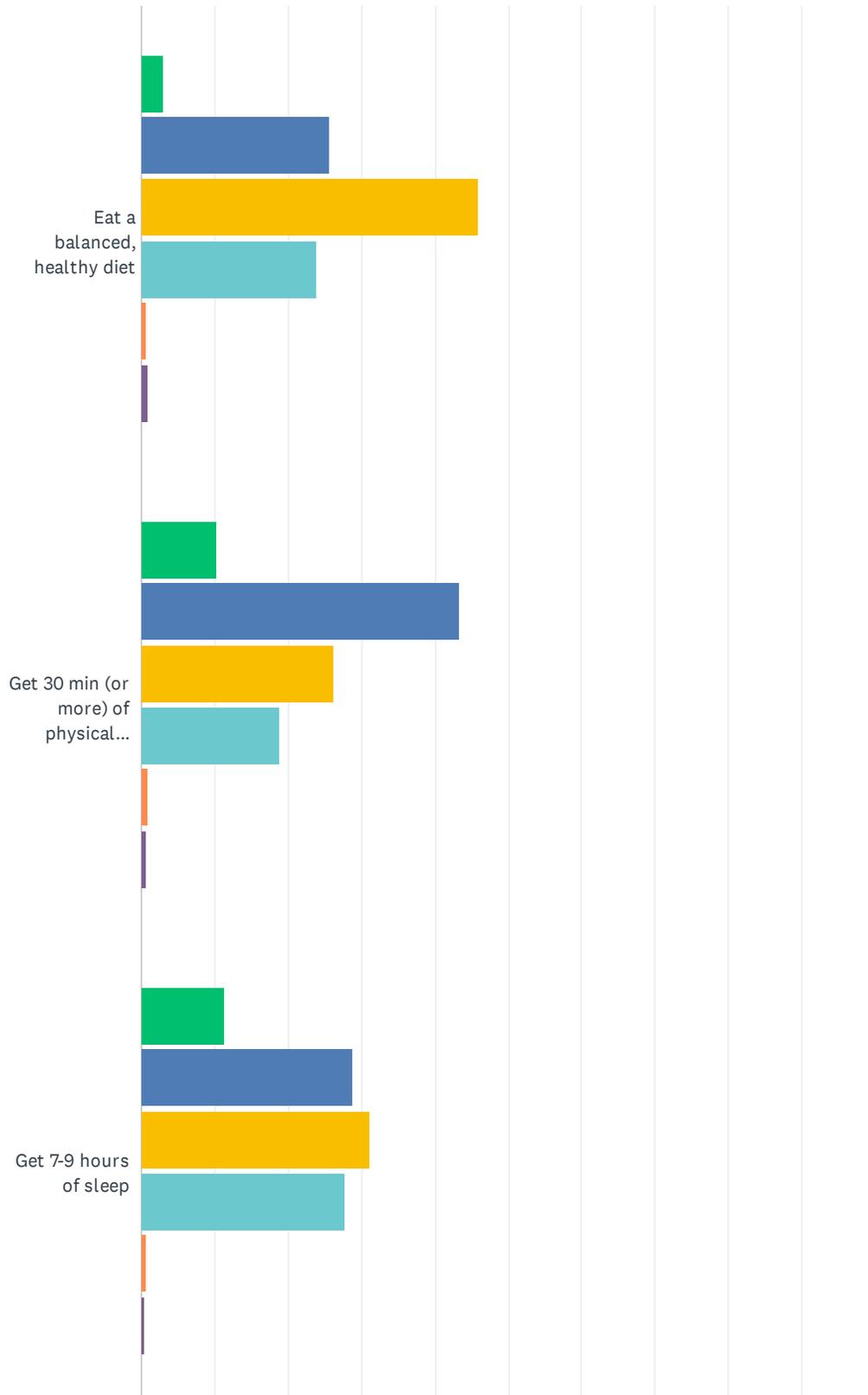


## 2025 Community Survey

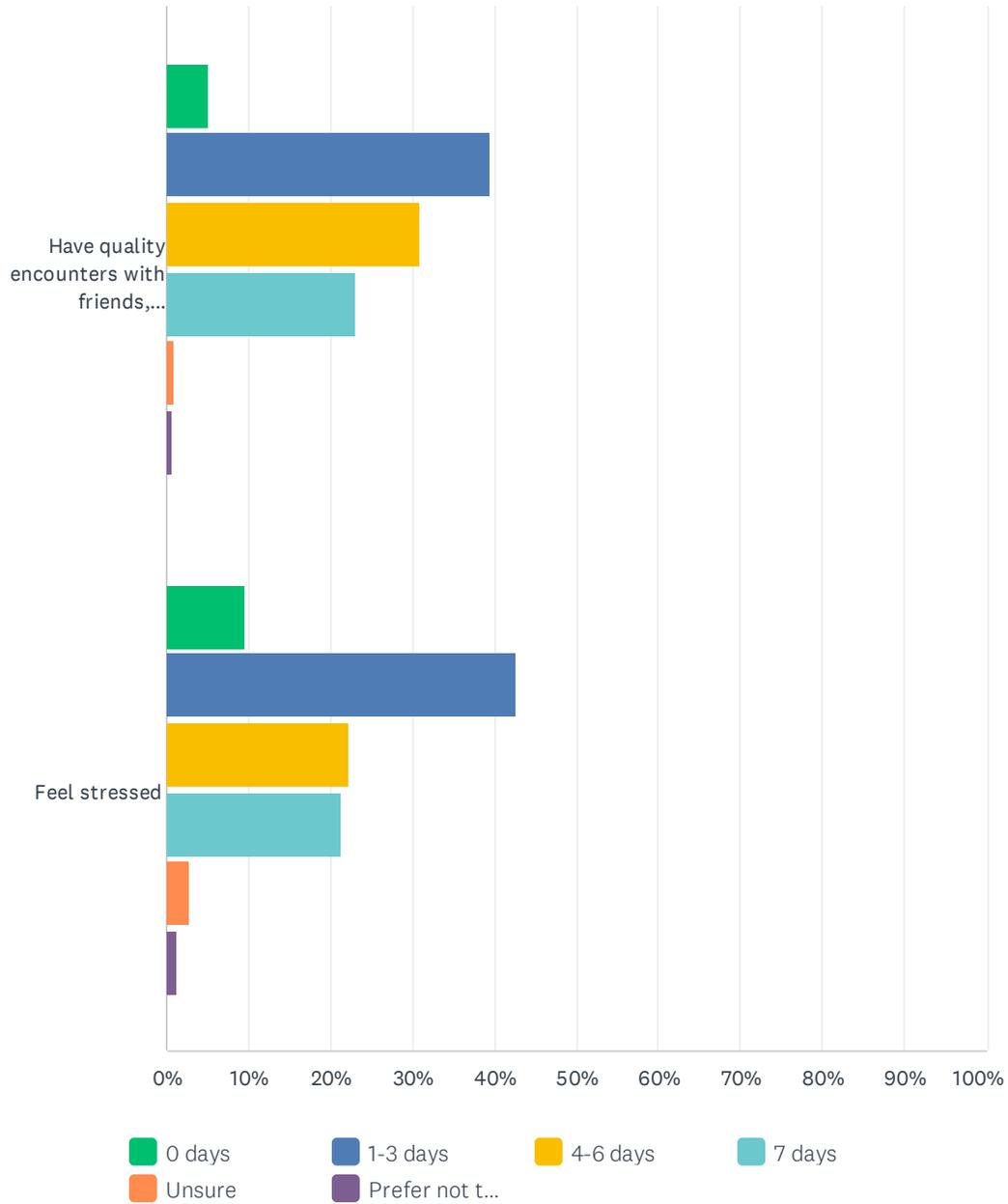
| ANSWER CHOICES               | RESPONSES |     |
|------------------------------|-----------|-----|
| Facebook                     | 74.29%    | 416 |
| X (formerly know as Twitter) | 3.75%     | 21  |
| Instagram                    | 15.00%    | 84  |
| TikTok                       | 7.50%     | 42  |
| YouTube                      | 7.50%     | 42  |
| Snapchat                     | 1.61%     | 9   |
| LinkedIn                     | 3.04%     | 17  |
| WhatsApp                     | 0.89%     | 5   |
| None                         | 16.96%    | 95  |
| Other (please specify)       | 11.25%    | 63  |
| Total Respondents: 560       |           |     |

### Q10 In the last year, in an average week, how often did you (please check one response per row):

Answered: 561 Skipped: 1



## 2025 Community Survey

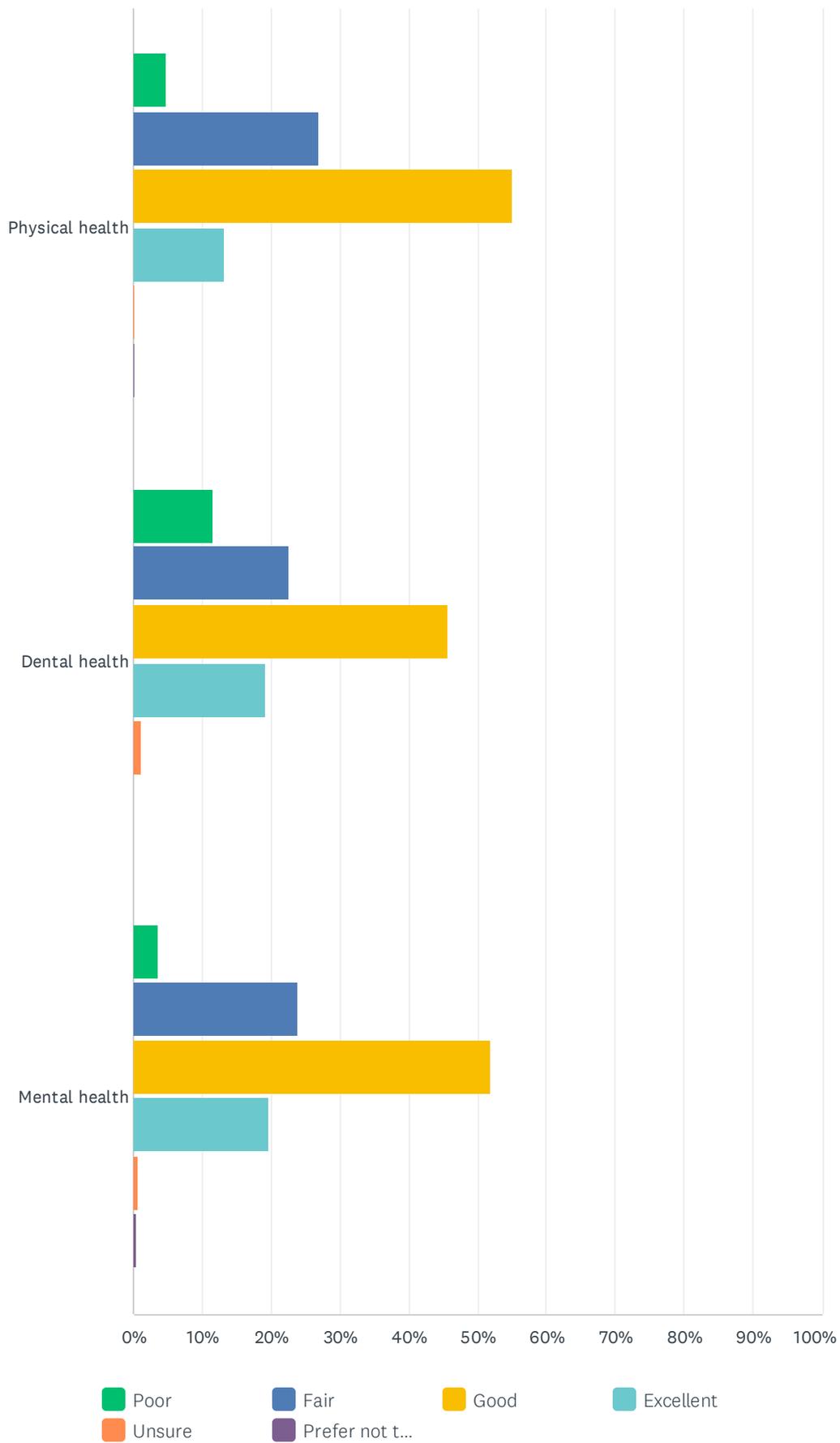


|  | 0 DAYS       | 1-3 DAYS      | 4-6 DAYS      | 7 DAYS        | UNSURE      | PREFER NOT TO RESPOND | TOTAL |
|--|--------------|---------------|---------------|---------------|-------------|-----------------------|-------|
| Eat a balanced, healthy diet                                       | 3.03%<br>17  | 25.67%<br>144 | 45.81%<br>257 | 23.89%<br>134 | 0.71%<br>4  | 0.89%<br>5            | 561   |
| Get 30 min (or more) of physical activity                          | 10.20%<br>57 | 43.29%<br>242 | 26.30%<br>147 | 18.78%<br>105 | 0.89%<br>5  | 0.54%<br>3            | 559   |
| Get 7-9 hours of sleep   | 11.23%<br>63 | 28.88%<br>162 | 31.19%<br>175 | 27.81%<br>156 | 0.53%<br>3  | 0.36%<br>2            | 561   |
| Have quality encounters with friends, family, or community members | 5.20%<br>29  | 39.43%<br>220 | 30.82%<br>172 | 23.12%<br>129 | 0.90%<br>5  | 0.54%<br>3            | 558   |
| Feel stressed  | 9.69%<br>54  | 42.73%<br>238 | 22.08%<br>123 | 21.36%<br>119 | 2.87%<br>16 | 1.26%<br>7            | 557   |

**Q11 How would you rate your health in each area below? Please check one response per row.**

Answered: 562 Skipped: 0

# 2025 Community Survey

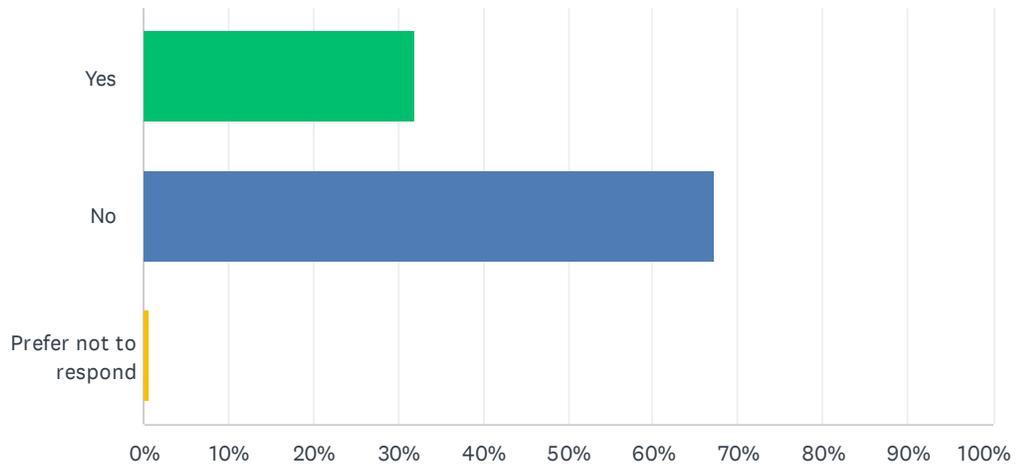


## 2025 Community Survey

|                 | POOR         | FAIR          | GOOD          | EXCELLENT     | UNSURE     | PREFER NOT TO RESPOND | TOTAL |
|-----------------|--------------|---------------|---------------|---------------|------------|-----------------------|-------|
| Physical health | 4.63%<br>26  | 26.87%<br>151 | 54.98%<br>309 | 13.17%<br>74  | 0.18%<br>1 | 0.18%<br>1            | 562   |
| Dental health   | 11.43%<br>64 | 22.68%<br>127 | 45.54%<br>255 | 19.29%<br>108 | 1.07%<br>6 | 0.00%<br>0            | 560   |
| Mental health   | 3.58%<br>20  | 23.97%<br>134 | 51.88%<br>290 | 19.68%<br>110 | 0.54%<br>3 | 0.36%<br>2            | 559   |

## Q12 Are there children under the age of 18 living in your household?

Answered: 562 Skipped: 0

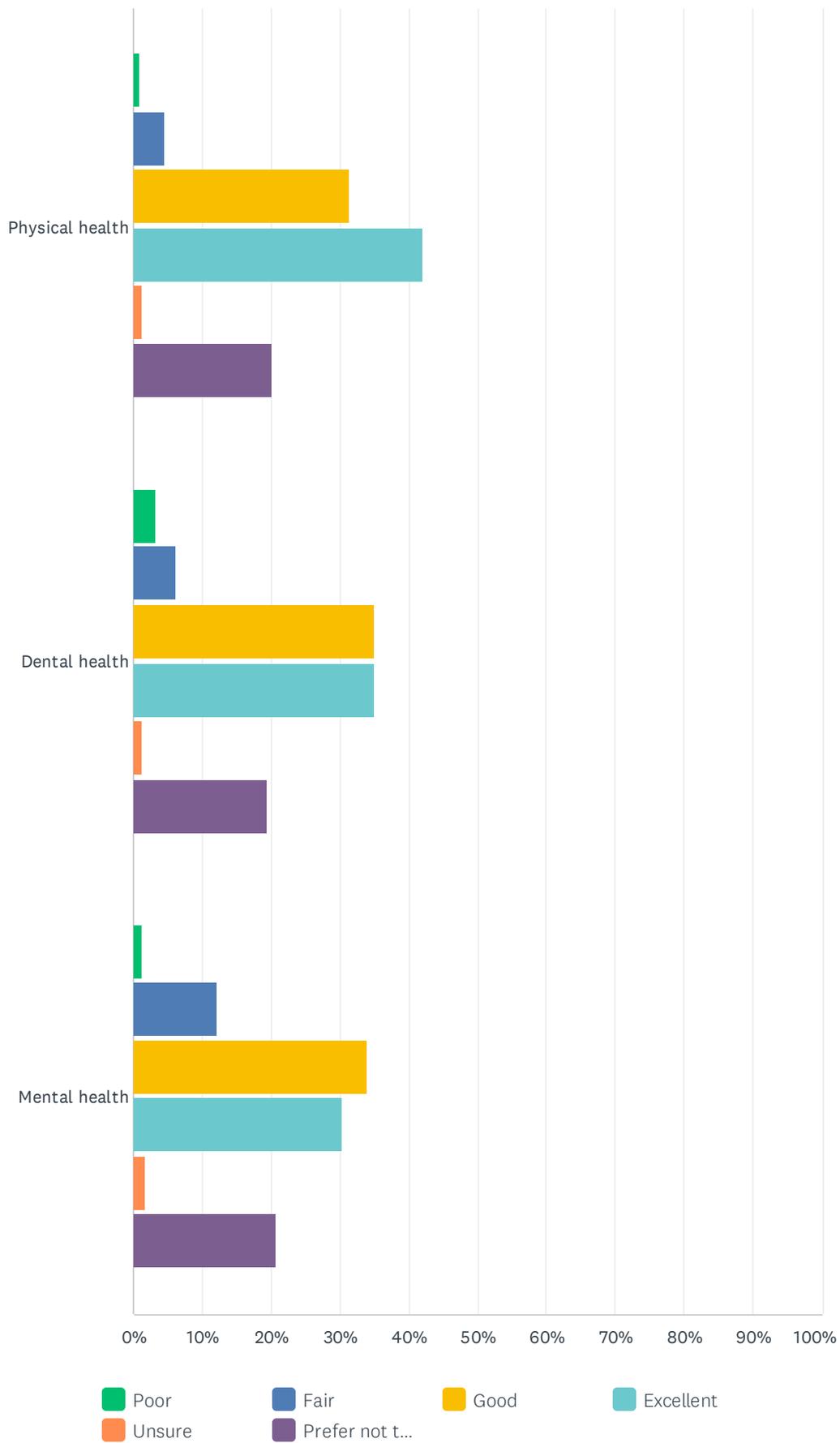


| ANSWER CHOICES        | RESPONSES |            |
|-----------------------|-----------|------------|
| Yes                   | 32.03%    | 180        |
| No                    | 67.26%    | 378        |
| Prefer not to respond | 0.71%     | 4          |
| <b>TOTAL</b>          |           | <b>562</b> |

Q13 If you answered yes to question #12, how would you rate the health of the children in your household (please check one response per row):

Answered: 248 Skipped: 314

# 2025 Community Survey



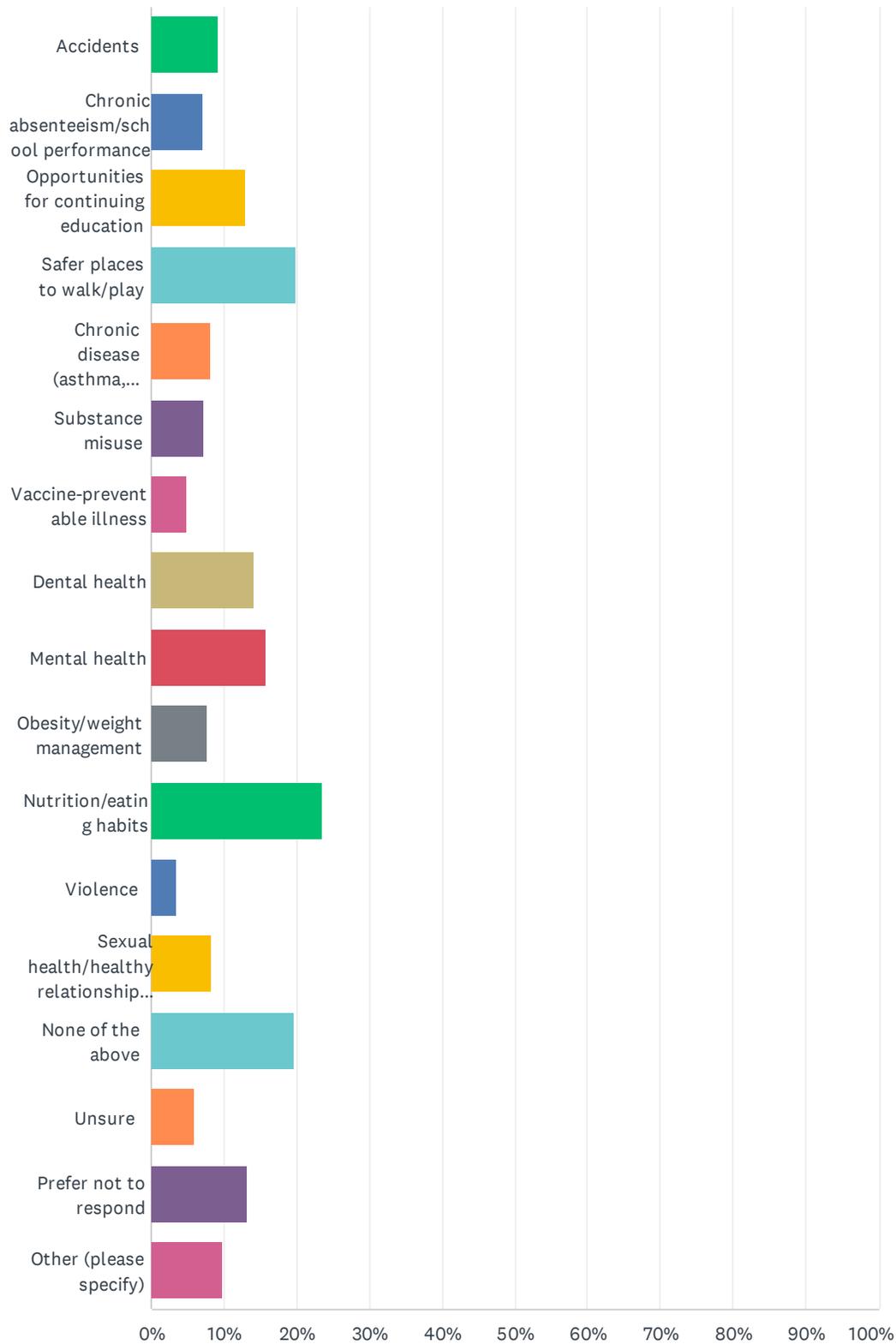
## 2025 Community Survey

|                 | POOR       | FAIR         | GOOD         | EXCELLENT     | UNSURE     | PREFER NOT TO RESPOND | TOTAL |
|-----------------|------------|--------------|--------------|---------------|------------|-----------------------|-------|
| Physical health | 0.83%<br>2 | 4.58%<br>11  | 31.25%<br>75 | 42.08%<br>101 | 1.25%<br>3 | 20.00%<br>48          | 240   |
| Dental health   | 3.29%<br>8 | 6.17%<br>15  | 34.98%<br>85 | 34.98%<br>85  | 1.23%<br>3 | 19.34%<br>47          | 243   |
| Mental health   | 1.21%<br>3 | 12.15%<br>30 | 34.01%<br>84 | 30.36%<br>75  | 1.62%<br>4 | 20.65%<br>51          | 247   |

**Q14 If you answered yes to question #12, what are the biggest concerns for the children in your household? Please check up to 3 major categories.**

Answered: 286 Skipped: 276

# 2025 Community Survey

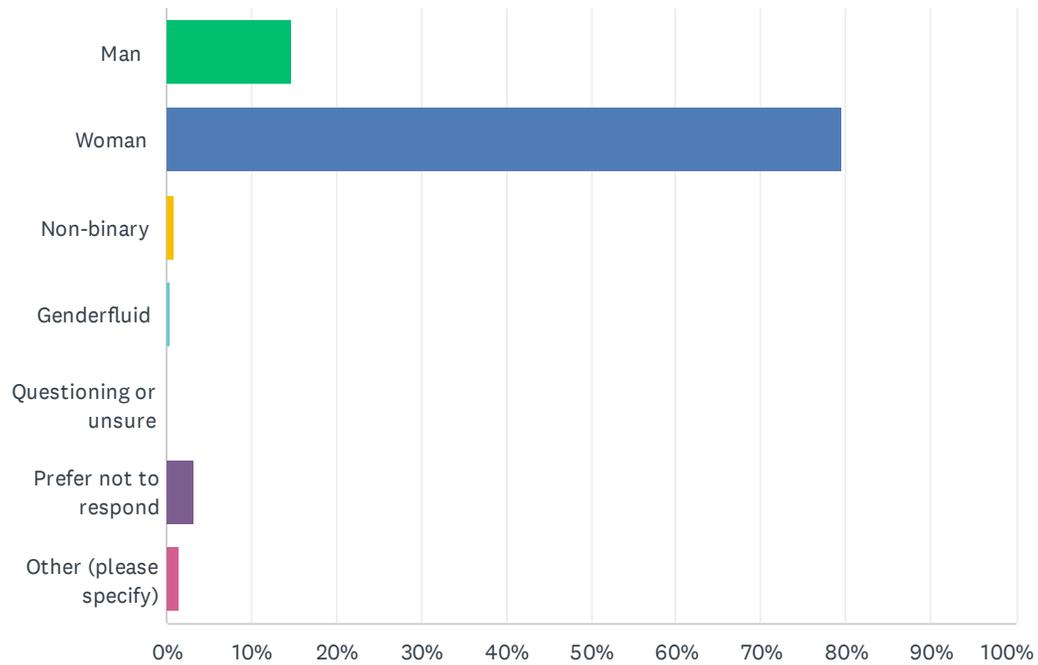


## 2025 Community Survey

| ANSWER CHOICES   | RESPONSES |    |
|--|-----------|----|
| Accidents  | 9.09%     | 26 |
| Chronic absenteeism/school performance                   | 6.99%     | 20 |
| Opportunities for continuing education                   | 12.94%    | 37 |
| Safer places to walk/play                                | 19.93%    | 57 |
| Chronic disease (asthma, diabetes, etc.)                 | 8.04%     | 23 |
| Substance misuse   | 7.34%     | 21 |
| Vaccine-preventable illness                              | 4.90%     | 14 |
| Dental health  | 13.99%    | 40 |
| Mental health  | 15.73%    | 45 |
| Obesity/weight management                                | 7.69%     | 22 |
| Nutrition/eating habits                                  | 23.43%    | 67 |
| Violence   | 3.50%     | 10 |
| Sexual health/healthy relationships/pregnancy prevention | 8.39%     | 24 |
| None of the above  | 19.58%    | 56 |
| Unsure   | 5.94%     | 17 |
| Prefer not to respond                                    | 13.29%    | 38 |
| Other (please specify)                                   | 9.79%     | 28 |
| Total Respondents: 286                                   |           |    |

## Q15 What gender do you identify with?

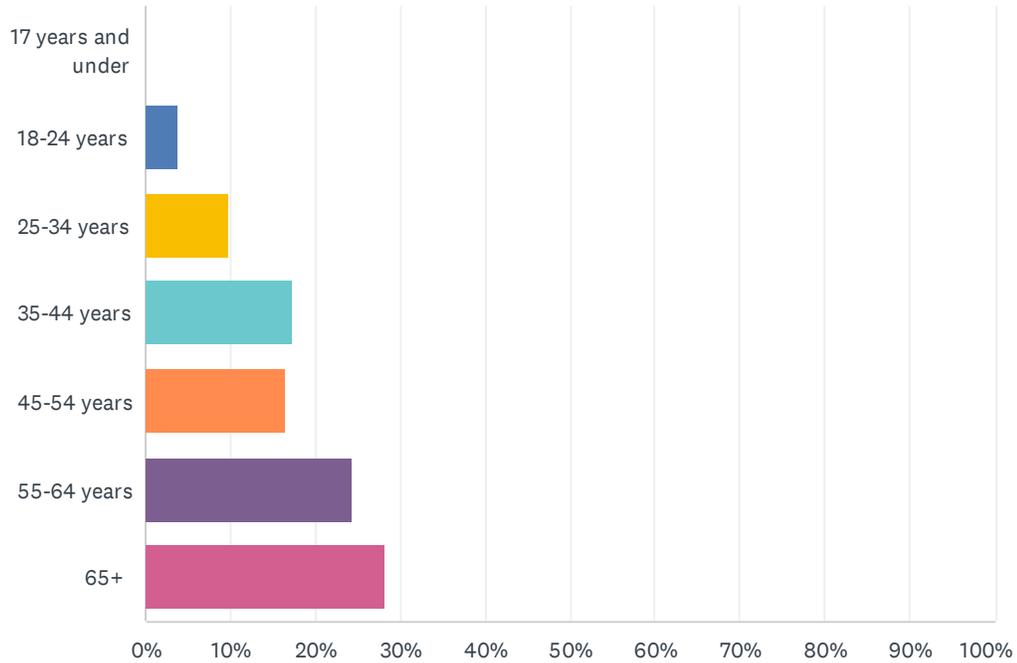
Answered: 561 Skipped: 1



| ANSWER CHOICES         | RESPONSES |            |
|------------------------|-----------|------------|
| Man                    | 14.62%    | 82         |
| Woman                  | 79.50%    | 446        |
| Non-binary             | 0.89%     | 5          |
| Genderfluid            | 0.36%     | 2          |
| Questioning or unsure  | 0.00%     | 0          |
| Prefer not to respond  | 3.21%     | 18         |
| Other (please specify) | 1.43%     | 8          |
| <b>TOTAL</b>           |           | <b>561</b> |

## Q16 What is your age?

Answered: 560 Skipped: 2

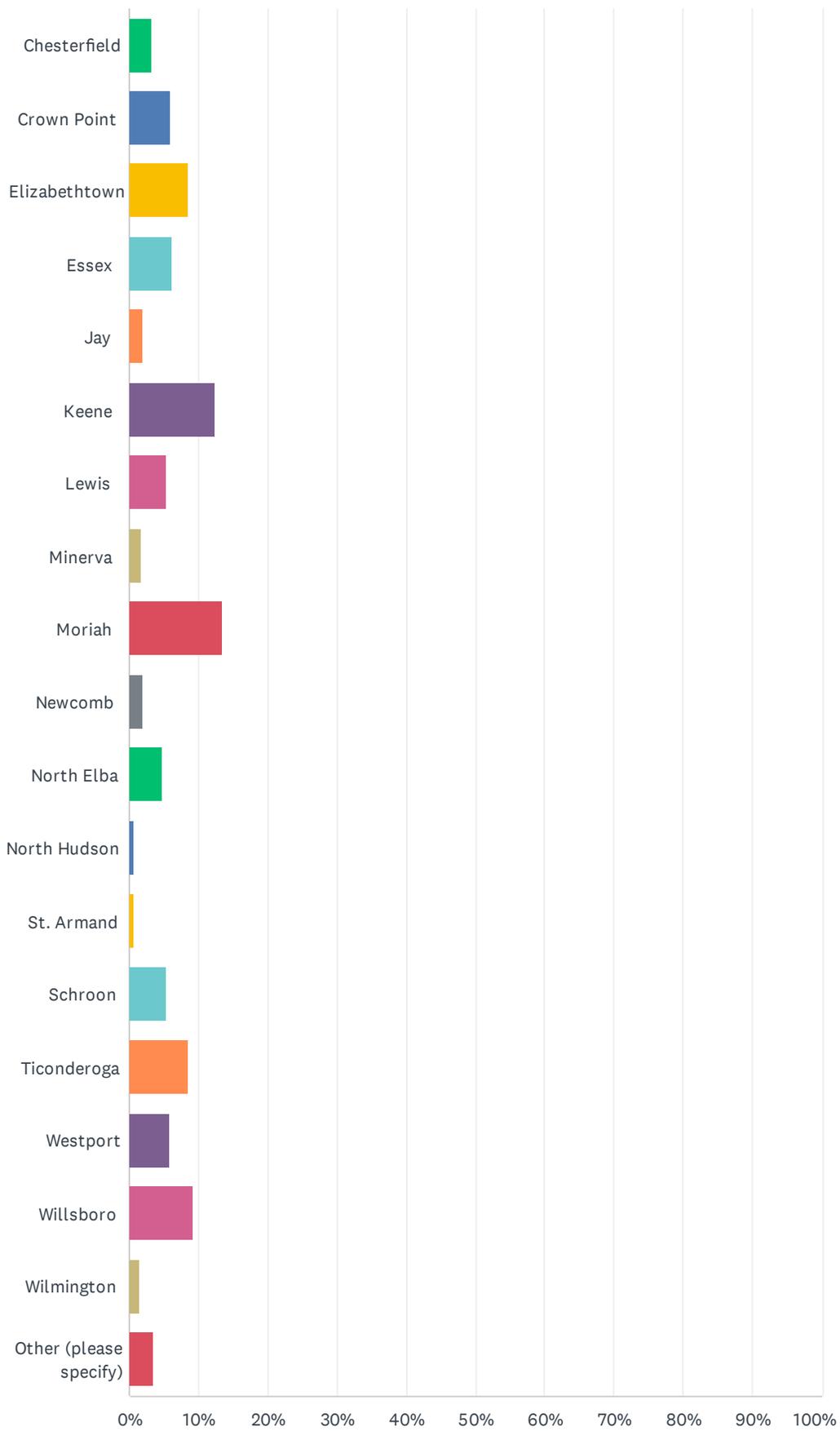


| ANSWER CHOICES     | RESPONSES |            |
|--------------------|-----------|------------|
| 17 years and under | 0.00%     | 0          |
| 18-24 years        | 3.93%     | 22         |
| 25-34 years        | 9.82%     | 55         |
| 35-44 years        | 17.32%    | 97         |
| 45-54 years        | 16.43%    | 92         |
| 55-64 years        | 24.29%    | 136        |
| 65+                | 28.21%    | 158        |
| <b>TOTAL</b>       |           | <b>560</b> |

**Q17 In which town of Essex County do you reside? Select only one based on your primary residence**

Answered: 562 Skipped: 0

# 2025 Community Survey



## 2025 Community Survey

| ANSWER CHOICES         | RESPONSES |    |
|------------------------|-----------|----|
| Chesterfield           | 3.20%     | 18 |
| Crown Point            | 6.05%     | 34 |
| Elizabethtown          | 8.54%     | 48 |
| Essex                  | 6.23%     | 35 |
| Jay                    | 1.96%     | 11 |
| Keene                  | 12.46%    | 70 |
| Lewis                  | 5.34%     | 30 |
| Minerva                | 1.60%     | 9  |
| Moriah                 | 13.52%    | 76 |
| Newcomb                | 1.96%     | 11 |
| North Elba             | 4.63%     | 26 |
| North Hudson           | 0.53%     | 3  |
| St. Armand             | 0.53%     | 3  |
| Schroon                | 5.34%     | 30 |
| Ticonderoga            | 8.54%     | 48 |
| Westport               | 5.69%     | 32 |
| Willsboro              | 9.07%     | 51 |
| Wilmington             | 1.42%     | 8  |
| Other (please specify) | 3.38%     | 19 |
| Total Respondents: 562 |           |    |

## Q18 What is the primary language spoken in your household?

Answered: 560 Skipped: 2

# 2025 Community Survey

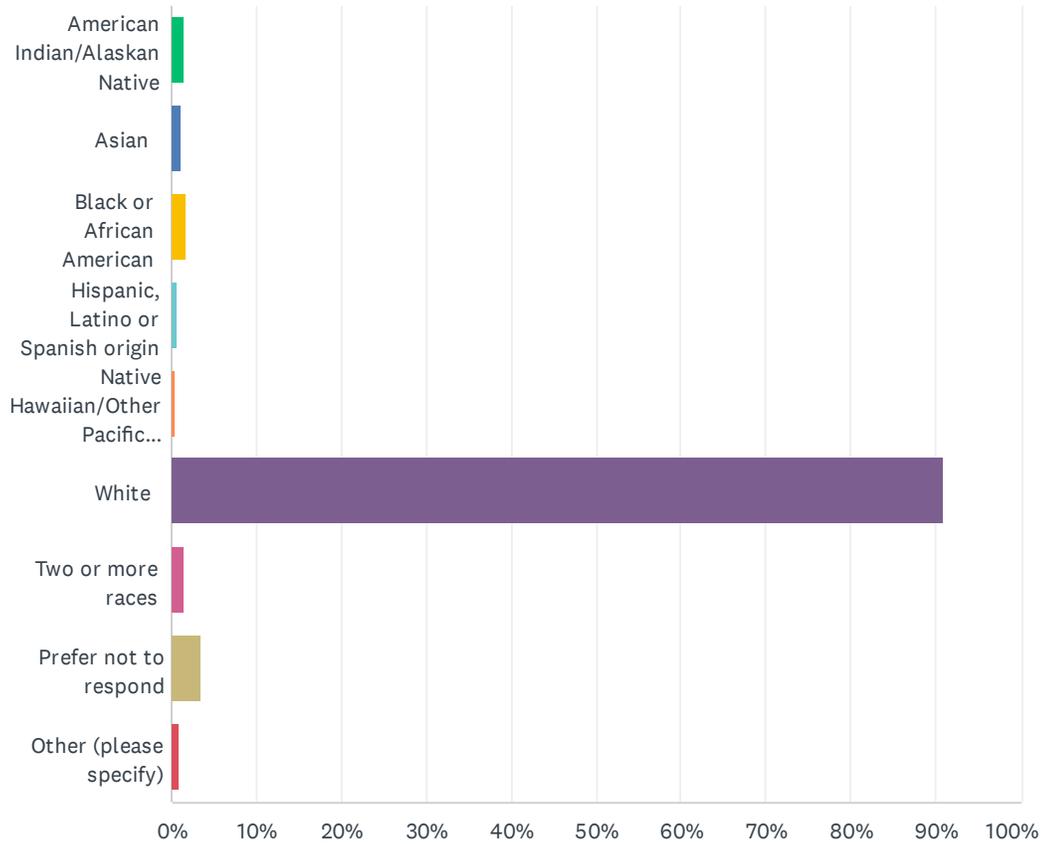


## 2025 Community Survey

| ANSWER CHOICES         | RESPONSES |            |
|------------------------|-----------|------------|
| English                | 98.93%    | 554        |
| French                 | 0.00%     | 0          |
| Spanish                | 0.36%     | 2          |
| French-Creole          | 0.00%     | 0          |
| Haitian-Creole         | 0.00%     | 0          |
| Polish                 | 0.36%     | 2          |
| Portuguese             | 0.00%     | 0          |
| Chinese                | 0.00%     | 0          |
| Korean                 | 0.00%     | 0          |
| Russian                | 0.00%     | 0          |
| Italian                | 0.00%     | 0          |
| Arabic                 | 0.00%     | 0          |
| Albanian               | 0.00%     | 0          |
| Farsi                  | 0.00%     | 0          |
| Samoan                 | 0.00%     | 0          |
| Yiddish                | 0.00%     | 0          |
| Hindi                  | 0.00%     | 0          |
| Other (please specify) | 0.36%     | 2          |
| <b>TOTAL</b>           |           | <b>560</b> |

## Q19 What is your race/ethnicity?

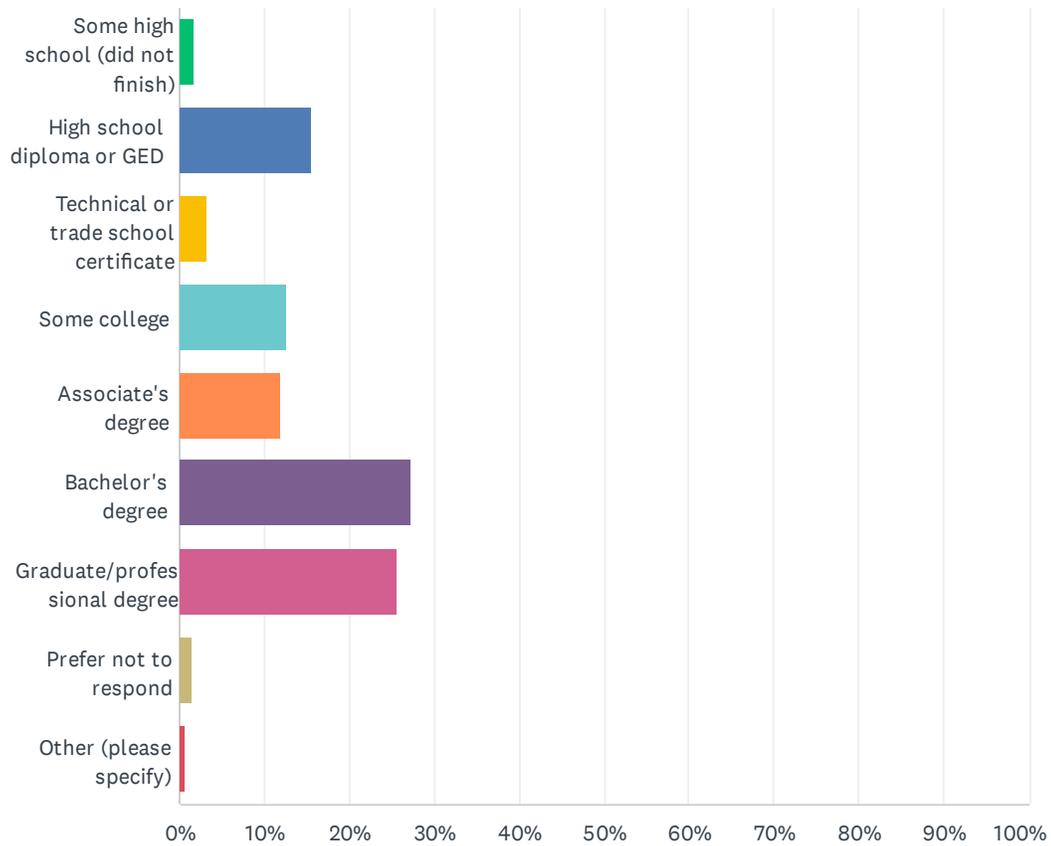
Answered: 556 Skipped: 6



| ANSWER CHOICES                         | RESPONSES |     |
|--|-----------|-----|
| American Indian/Alaskan Native         | 1.44%     | 8   |
| Asian                                  | 1.08%     | 6   |
| Black or African American              | 1.80%     | 10  |
| Hispanic, Latino or Spanish origin     | 0.54%     | 3   |
| Native Hawaiian/Other Pacific Islander | 0.36%     | 2   |
| White                                  | 90.83%    | 505 |
| Two or more races                      | 1.44%     | 8   |
| Prefer not to respond                  | 3.42%     | 19  |
| Other (please specify)                 | 0.90%     | 5   |
| Total Respondents: 556                 |           |     |

## Q20 What is your highest level of education?

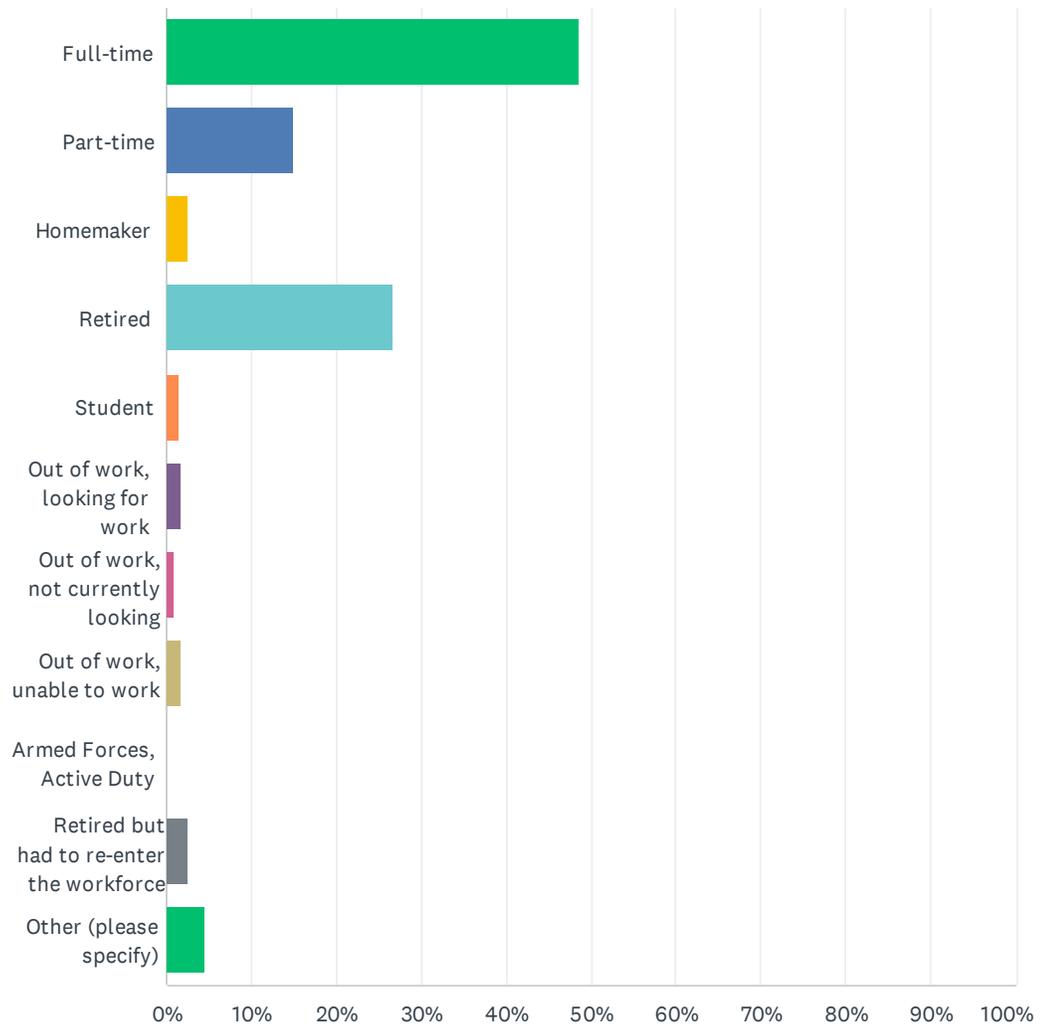
Answered: 559 Skipped: 3



| ANSWER CHOICES                        | RESPONSES |            |
|---------------------------------------|-----------|------------|
| Some high school (did not finish)     | 1.79%     | 10         |
| High school diploma or GED            | 15.56%    | 87         |
| Technical or trade school certificate | 3.22%     | 18         |
| Some college                          | 12.52%    | 70         |
| Associate's degree                    | 11.99%    | 67         |
| Bachelor's degree                     | 27.37%    | 153        |
| Graduate/professional degree          | 25.58%    | 143        |
| Prefer not to respond                 | 1.43%     | 8          |
| Other (please specify)                | 0.54%     | 3          |
| <b>TOTAL</b>                          |           | <b>559</b> |

## Q21 What is your current employment status?

Answered: 561 Skipped: 1

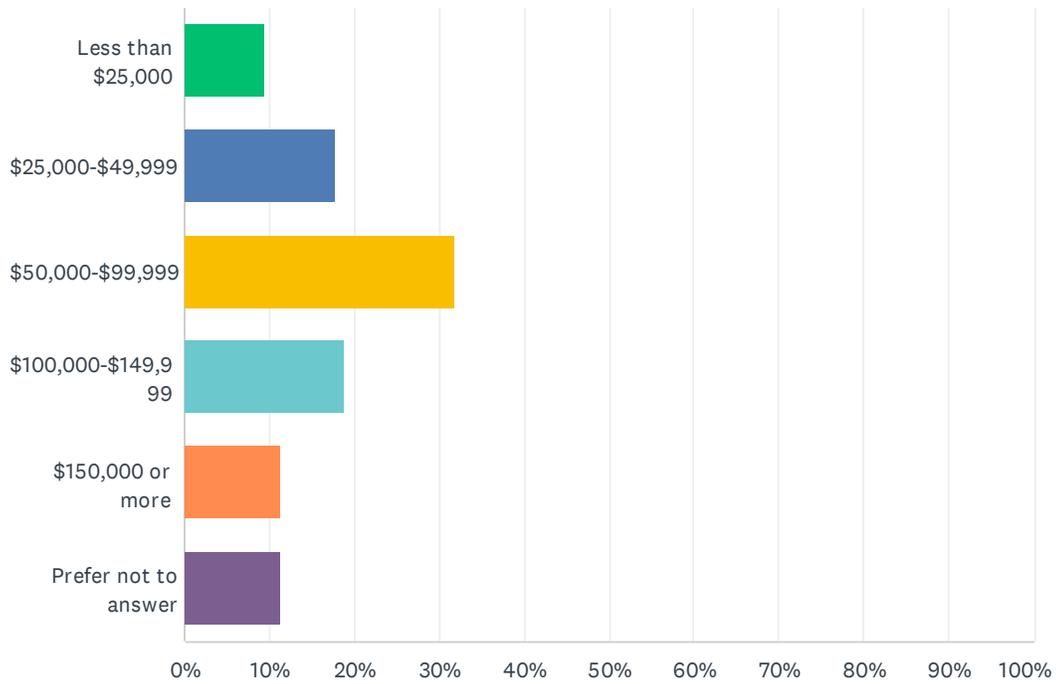


## 2025 Community Survey

| ANSWER CHOICES                            | RESPONSES |     |
|---|-----------|-----|
| Full-time                                 | 48.66%    | 273 |
| Part-time                                 | 14.97%    | 84  |
| Homemaker                                 | 2.50%     | 14  |
| Retired                                   | 26.74%    | 150 |
| Student                                   | 1.43%     | 8   |
| Out of work, looking for work             | 1.60%     | 9   |
| Out of work, not currently looking        | 0.89%     | 5   |
| Out of work, unable to work               | 1.78%     | 10  |
| Armed Forces, Active Duty                 | 0.00%     | 0   |
| Retired but had to re-enter the workforce | 2.50%     | 14  |
| Other (please specify)                    | 4.46%     | 25  |
| Total Respondents: 561                    |           |     |

## Q22 What is your annual household income?

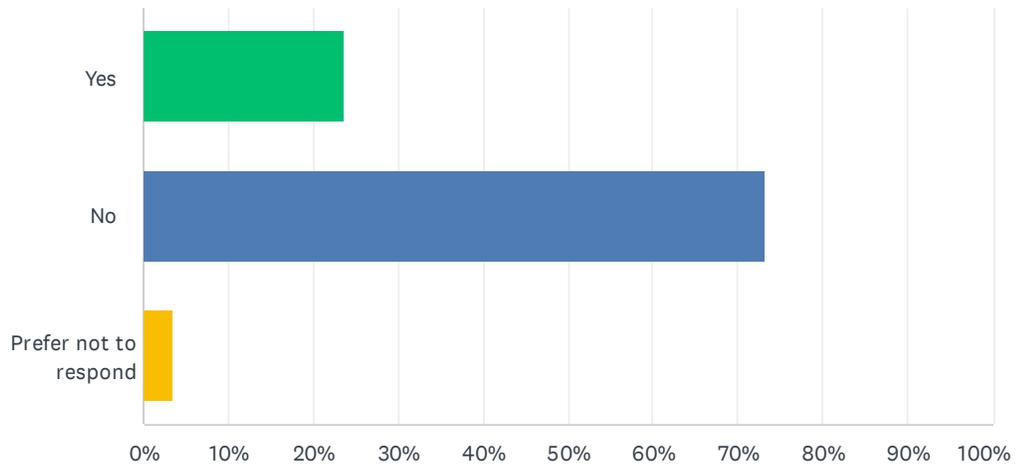
Answered: 560 Skipped: 2



| ANSWER CHOICES       | RESPONSES |            |
|----------------------|-----------|------------|
| Less than \$25,000   | 9.29%     | 52         |
| \$25,000-\$49,999    | 17.68%    | 99         |
| \$50,000-\$99,999    | 31.79%    | 178        |
| \$100,000-\$149,999  | 18.75%    | 105        |
| \$150,000 or more    | 11.25%    | 63         |
| Prefer not to answer | 11.25%    | 63         |
| <b>TOTAL</b>         |           | <b>560</b> |

## Q23 Do you or does anyone in your household have a disability?

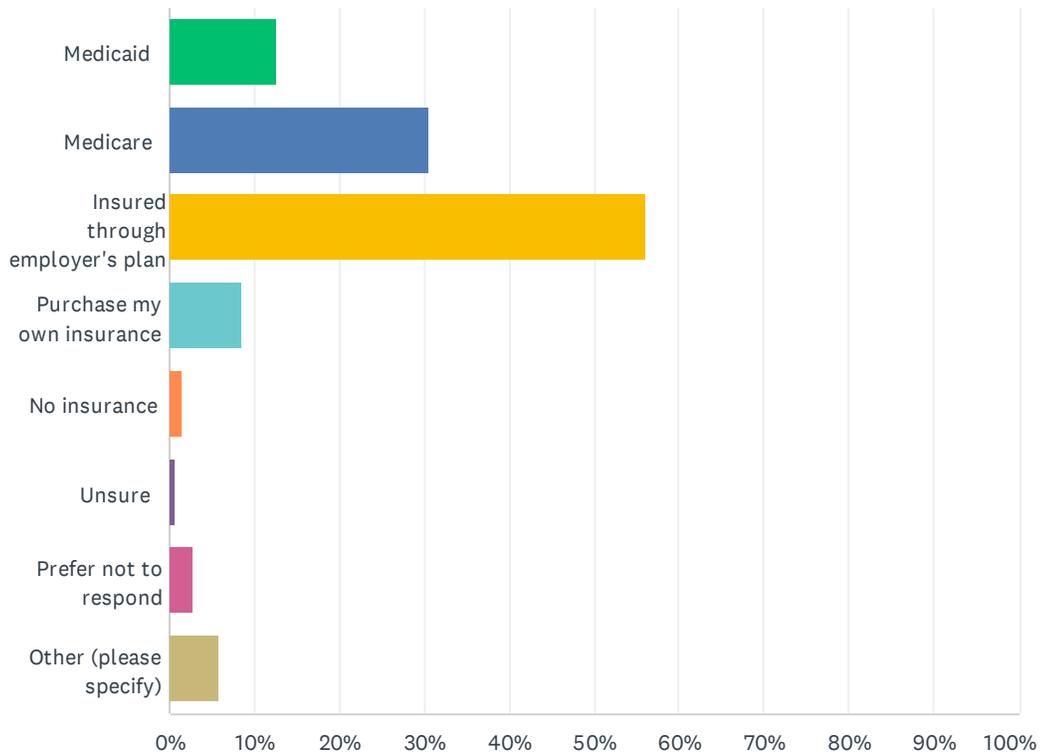
Answered: 560 Skipped: 2



| ANSWER CHOICES        | RESPONSES |            |
|-----------------------|-----------|------------|
| Yes                   | 23.57%    | 132        |
| No                    | 73.04%    | 409        |
| Prefer not to respond | 3.39%     | 19         |
| <b>TOTAL</b>          |           | <b>560</b> |

## Q24 What type of health insurance do you currently have?

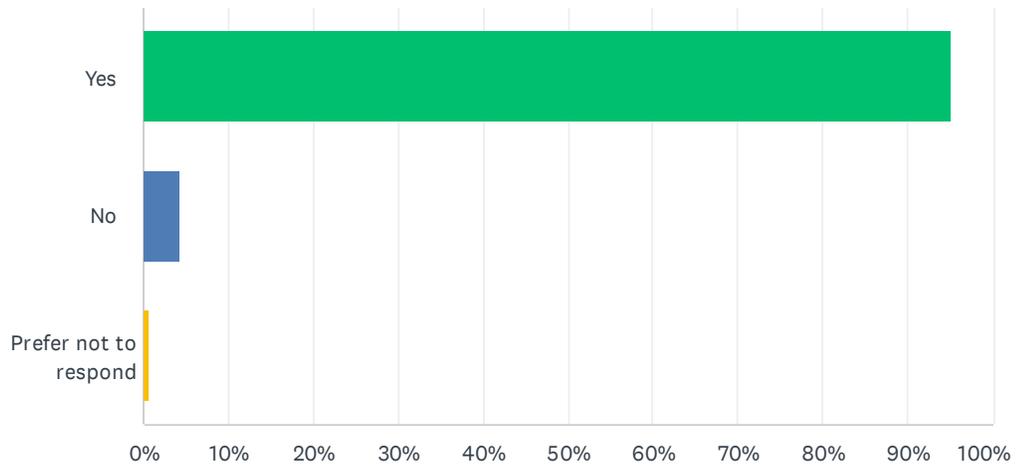
Answered: 560 Skipped: 2



| ANSWER CHOICES                  | RESPONSES |     |
|---------------------------------|-----------|-----|
| Medicaid                        | 12.68%    | 71  |
| Medicare                        | 30.54%    | 171 |
| Insured through employer's plan | 56.07%    | 314 |
| Purchase my own insurance       | 8.57%     | 48  |
| No insurance                    | 1.43%     | 8   |
| Unsure                          | 0.71%     | 4   |
| Prefer not to respond           | 2.68%     | 15  |
| Other (please specify)          | 5.71%     | 32  |
| Total Respondents: 560          |           |     |

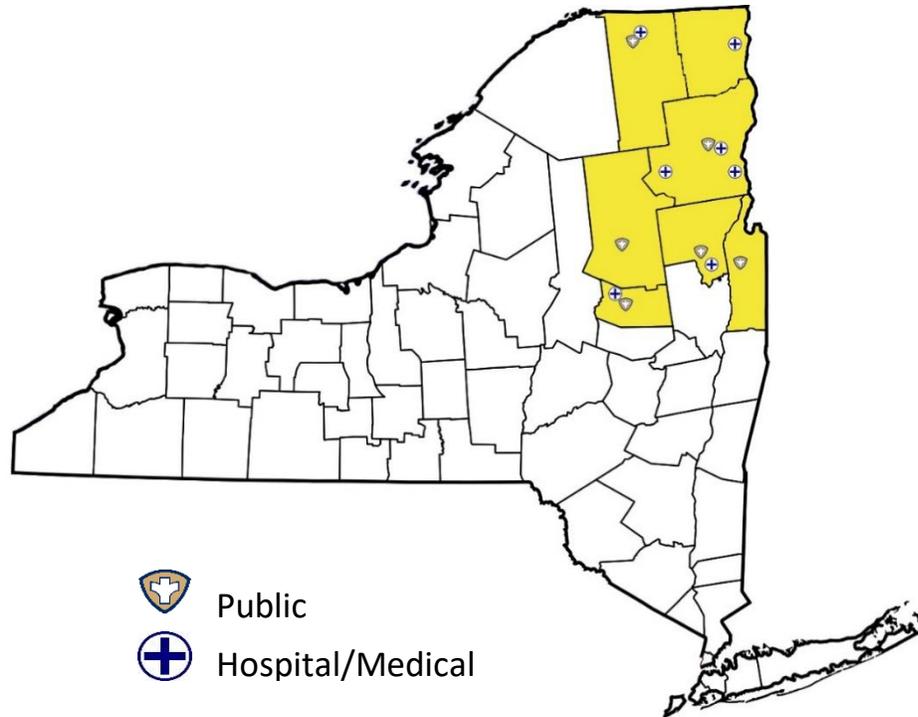
## Q25 Do you have reliable access to the internet in your home?

Answered: 560 Skipped: 2



| ANSWER CHOICES        | RESPONSES |            |
|-----------------------|-----------|------------|
| Yes                   | 95.18%    | 533        |
| No                    | 4.29%     | 24         |
| Prefer not to respond | 0.54%     | 3          |
| <b>TOTAL</b>          |           | <b>560</b> |

# 2025 STAKEHOLDER SURVEY REPORT



## Adirondack Rural Health Network Area

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



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

2025

## **BACKGROUND INFORMATION:**

### **Adirondack Rural Health Network:**

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

### **Description of the Community Health Assessment Committee:**

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

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

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

### CHA Data Sub-Committee:

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

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

## **SURVEY METHODOLOGY:**

### Survey Creation:

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

### Survey Facilitation:

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

### Survey Logistics:

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

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

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

### Survey Responses and Analysis:

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

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

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

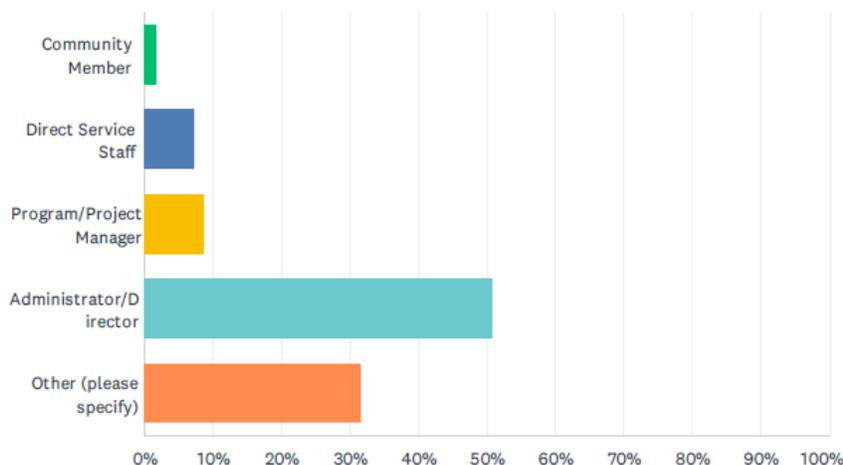
|                   |
|-------------------|
| <b>Clinton</b>    |
| <b>Essex</b>      |
| <b>Franklin</b>   |
| <b>Fulton</b>     |
| <b>Hamilton</b>   |
| <b>Warren</b>     |
| <b>Washington</b> |

## **ANALYSIS:**

### Q3. Job Title/Role

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

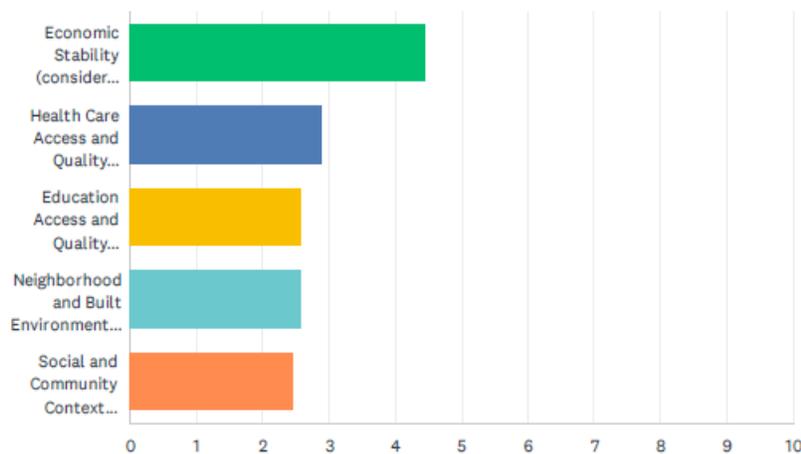
The majority of ARHN counties identified contributing factors that closely aligned with the overall top five for the region. However, several counties also highlighted unique concerns specific to their populations. Clinton County identified food insecurity as a significant contributing factor, while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

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

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

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

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



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

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

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

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

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

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

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

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

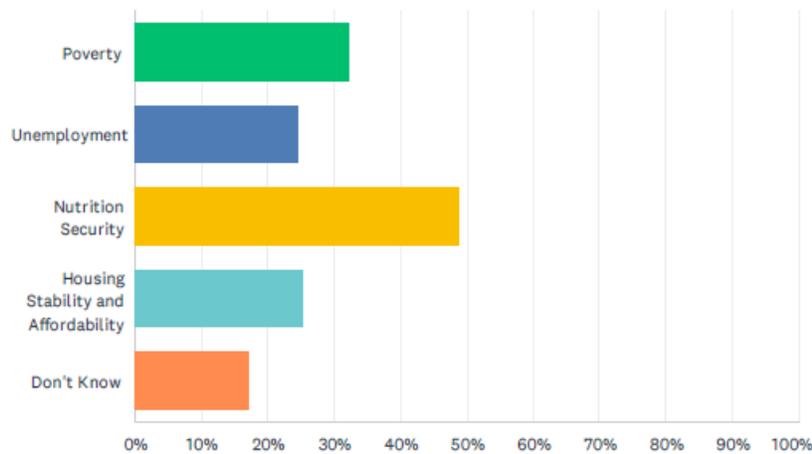
|   |    |     |    |    |    |    |    |
|---|----|-----|----|----|----|----|----|
| Individuals with substance abuse issues | 9  | 10  | 9  | 5  | 6  | 4  | 6  |
| Migrant workers                         | 0  | 0   | 0  | 0  | 0  | 0  | 1  |
| Seniors/Elderly                         | 10 | 14  | 9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

### 2025 New York State Prevention Agenda:

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

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

### Q11. Economic Stability (Economic Well-Being)



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

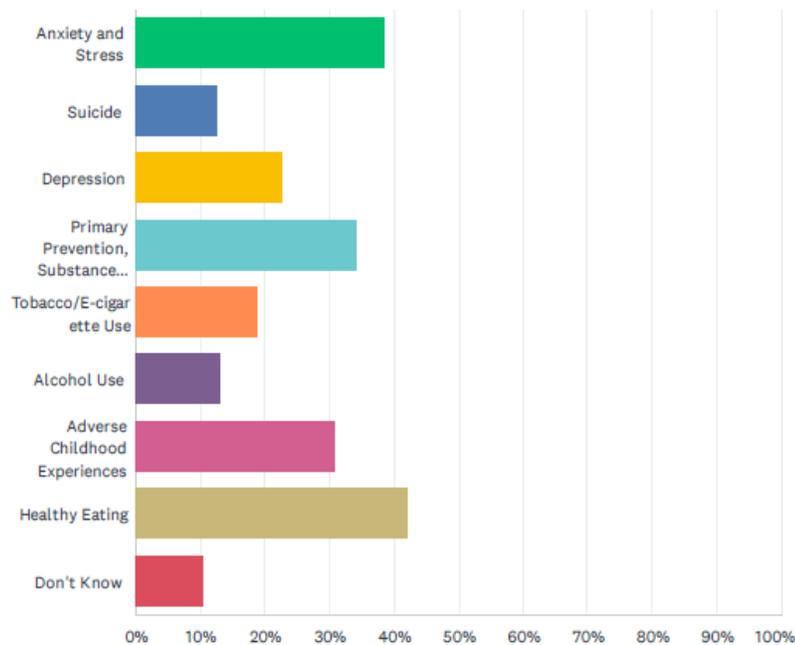
Respondents identified *Nutrition Security* (48.91%), *Poverty* (32.31%), and *Housing Stability and Affordability* (25.33%) as the top three priority areas that their organization are best positioned to support achieving in the region. Six out of seven ARHN counties identified

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

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

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

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



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

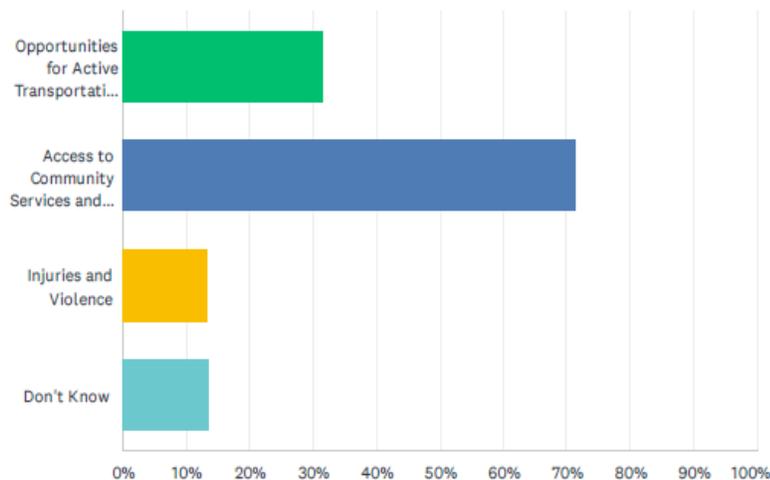
| Domain: Social and Community Context                                 |       |            |
|--|-------|------------|
| Priority Area  | Count | Percentage |
| <b>Adverse Childhood Experiences</b>                                 | 74    | 30.96%     |
| <b>Alcohol Use</b>   | 31    | 12.97%     |
|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

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

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

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

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

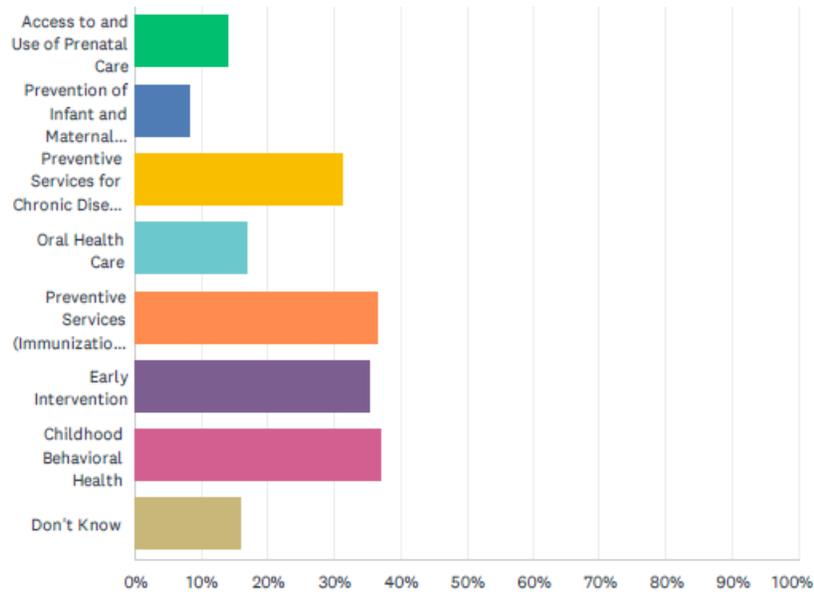


| Domain: Neighborhood and Built Environment                    |       |            |
|---|-------|------------|
| Priority Area   | Count | Percentage |
| Access to Community Services and Support                      | 167   | 71.37%     |
| Injuries and Violence   | 31    | 13.25%     |
| Opportunities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

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

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

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

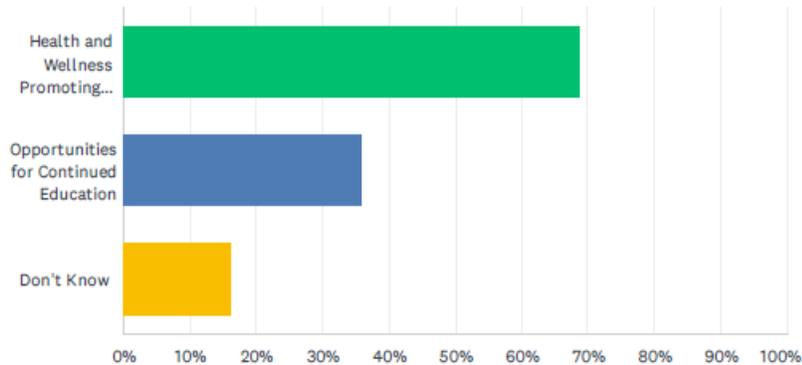


| Domain: Health Care Access and Quality   |       |            |
|--|-------|------------|
| Priority Area  | Count | Percentage |
| Access to and Use of Prenatal Care   | 32    | 14.16%     |
| Childhood Behavioral Health  | 84    | 37.17%     |
| Early Intervention   | 80    | 35.40%     |
| Oral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

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

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

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



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

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

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

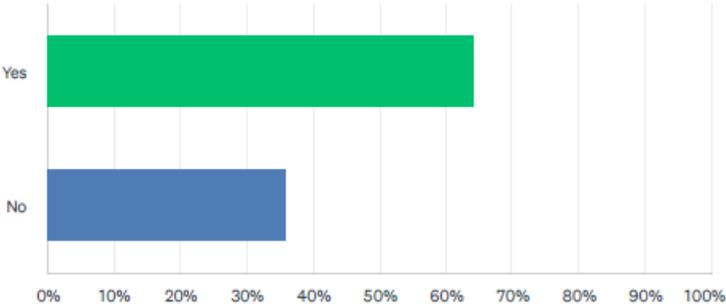
**Q16. Please identify the primary assets/resources your organization/agency can contribute toward achieving the goals you have selected.**

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

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

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

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



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

## Appendix: The 2025 Stakeholder Survey

### 2025 CHA Stakeholders Survey

#### Introduction

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

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

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

#### Your Organization/Agency

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

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

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

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

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

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

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

- Business
- Civic Association
- College/University

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

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

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

## Health Priorities, Concerns and Factors

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

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

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

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

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

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

### **Prevention Agenda 2025 -2030: New York State’s Health Improvement Plan**

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

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

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

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

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

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

## Social Determinants of Health

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

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

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

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

## **Improving Health and Well-Being**

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

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

### **11. Economic Stability (Economic Well-being)**

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

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

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

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

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

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

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

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

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

- Health and Wellness Promoting Schools
- Opportunities for Continued Education

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

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

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

Yes

No

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

# Appendix 3

# ARHN Community Profile Data Sheets

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

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

## Demographic Profile

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

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

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

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

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

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

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

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

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

\*Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties  
New York State Licensed Professions, NYS Education Department, Office of the Professions, January 2025  
U.S. Census Data 2023 American Community Survey 1-Year Estimates  
NYS Department of Health, NYS Health Profiles, May 2025

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

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

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

**Education System Profile - School Districts by County**

| <b>Clinton</b>                               | <b>Number of Schools</b> | <b>Essex</b>                                 | <b>Number of Schools</b> | <b>Franklin</b>                              | <b>Number of Schools</b> |
|--|--------------------------|--|--------------------------|--|--------------------------|
| AUSABLE VALLEY CENTRAL SCHOOL DISTRICT       | 4                        | BOQUET VALLEY CSD                            | 2                        | BRUSHTON-MOIRA CENTRAL SCHOOL DISTRICT       | 2                        |
| BEEKMANTOWN CENTRAL SCHOOL DISTRICT          | 4                        | CROWN POINT CENTRAL SCHOOL DISTRICT          | 1                        | CHATEAUGAY CENTRAL SCHOOL DISTRICT           | 2                        |
| CHAZY UNION FREE SCHOOL DISTRICT             | 2                        | KEENE CENTRAL SCHOOL DISTRICT                | 1                        | FRANKLIN-ESSEX-HAMILTON BOCES                | 1                        |
| CLINTON-ESSEX-WARREN-WASHINGTON BOCES        | 1                        | LAKE PLACID CENTRAL SCHOOL DISTRICT          | 2                        | MALONE CENTRAL SCHOOL DISTRICT               | 5                        |
| NORTHEASTERN CLINTON CENTRAL SCHOOL DISTRICT | 4                        | MINERVA CENTRAL SCHOOL DISTRICT              | 1                        | SAINT REGIS FALLS CENTRAL SCHOOL DISTRICT    | 1                        |
| NORTHERN ADIRONDACK CENTRAL SCHOOL DISTRICT  | 2                        | MORIAH CENTRAL SCHOOL DISTRICT               | 2                        | SALMON RIVER CENTRAL SCHOOL DISTRICT         | 4                        |
| PERU CENTRAL SCHOOL DISTRICT                 | 3                        | NEWCOMB CENTRAL SCHOOL DISTRICT              | 1                        | SARANAC LAKE CENTRAL SCHOOL DISTRICT         | 4                        |
| PLATTSBURGH CITY SCHOOL DISTRICT             | 5                        | SCHROON LAKE CENTRAL SCHOOL DISTRICT         | 1                        | TUPPER LAKE CENTRAL SCHOOL DISTRICT          | 2                        |
| SARANAC CENTRAL SCHOOL DISTRICT              | 4                        | TICONDEROGA CENTRAL SCHOOL DISTRICT          | 2                        | <b>Total Number of Schools in the County</b> | <b>21</b>                |
| <b>Total Number of Schools in the County</b> | <b>29</b>                | WILLSBORO CENTRAL SCHOOL DISTRICT            | 1                        |  |                          |
|  |                          | <b>Total Number of Schools in the County</b> | <b>14</b>                |  |                          |

| <b>Fulton</b>                                | <b>Number of Schools</b> | <b>Hamilton</b>                              | <b>Number of Schools</b> | <b>Montgomery</b>                            | <b>Number of Schools</b> |
|--|--------------------------|--|--------------------------|--|--------------------------|
| BROADALBIN-PERTH CENTRAL SCHOOL DISTRICT     | 2                        | INDIAN LAKE CENTRAL SCHOOL DISTRICT          | 1                        | AMSTERDAM CITY SCHOOL DISTRICT               | 6                        |
| GLOVERSVILLE CITY SCHOOL DISTRICT            | 5                        | LAKE PLEASANT CENTRAL SCHOOL DISTRICT        | 1                        | CANAJOHARIE CENTRAL SCHOOL DISTRICT          | 3                        |
| JOHNSTOWN CITY SCHOOL DISTRICT               | 4                        | LONG LAKE CENTRAL SCHOOL DISTRICT            | 1                        | FONDA-FULTONVILLE CENTRAL SCHOOL DISTRICT    | 3                        |
| MAYFIELD CENTRAL SCHOOL DISTRICT             | 2                        | WELLS CENTRAL SCHOOL DISTRICT                | 1                        | FORT PLAIN CENTRAL SCHOOL DISTRICT           | 2                        |
| NORTHVILLE CENTRAL SCHOOL DISTRICT           | 2                        | <b>Total Number of Schools in the County</b> | <b>4</b>                 | HAMILTON-FULTON-MONTGOMERY BOCES             | 1                        |
| WHEELERVILLE UNION FREE SCHOOL DISTRICT      | 1                        |  |                          | OPPENHEIM-EPHRATAH-ST. JOHNSVILLE CSD        | 2                        |
| <b>Total Number of Schools in the County</b> | <b>16</b>                |  |                          | <b>Total Number of Schools in the County</b> | <b>17</b>                |

| <b>Saratoga</b>                                   | <b>Number of Schools</b> | <b>Warren</b>                                | <b>Number of Schools</b> | <b>Washington</b>                               | <b>Number of Schools</b> |
|---|--------------------------|--|--------------------------|---|--------------------------|
| BALLSTON SPA CENTRAL SCHOOL DISTRICT              | 6                        | BOLTON CENTRAL SCHOOL DISTRICT               | 1                        | ARGYLE CENTRAL SCHOOL DISTRICT                  | 2                        |
| BURNT HILLS-BALLSTON LAKE CENTRAL SCHOOL DISTRICT | 5                        | GLENS FALLS CITY SCHOOL DISTRICT             | 5                        | CAMBRIDGE CENTRAL SCHOOL DISTRICT               | 2                        |
| CORINTH CENTRAL SCHOOL DISTRICT                   | 3                        | GLENS FALLS COMMON SCHOOL DISTRICT           | 1                        | FORT ANN CENTRAL SCHOOL DISTRICT                | 2                        |
| EDINBURG COMMON SCHOOL DISTRICT                   | 1                        | HADLEY-LUZERNE CENTRAL SCHOOL DISTRICT       | 2                        | FORT EDWARD UNION FREE SCHOOL DISTRICT          | 1                        |
| GALWAY CENTRAL SCHOOL DISTRICT                    | 2                        | JOHNSBURG CENTRAL SCHOOL DISTRICT            | 1                        | GRANVILLE CENTRAL SCHOOL DISTRICT               | 3                        |
| MECHANICVILLE CITY SCHOOL DISTRICT                | 2                        | LAKE GEORGE CENTRAL SCHOOL DISTRICT          | 2                        | GREENWICH CENTRAL SCHOOL DISTRICT               | 2                        |
| SARATOGA SPRINGS CITY SCHOOL DISTRICT             | 8                        | NORTH WARREN CENTRAL SCHOOL DISTRICT         | 1                        | HARTFORD CENTRAL SCHOOL DISTRICT                | 2                        |
| SCHUYLerville CENTRAL SCHOOL DISTRICT             | 3                        | QUEENSBURY UNION FREE SCHOOL DISTRICT        | 4                        | HUDSON FALLS CENTRAL SCHOOL DISTRICT            | 5                        |
| SHENENDEHOWA CENTRAL SCHOOL DISTRICT              | 12                       | WARRENSBURG CENTRAL SCHOOL DISTRICT          | 2                        | PUTNAM CENTRAL SCHOOL DISTRICT                  | 1                        |
| SOUTH GLENS FALLS CENTRAL SCHOOL DISTRICT         | 6                        | <b>Total Number of Schools in the County</b> | <b>19</b>                | SALEM CENTRAL SCHOOL DISTRICT                   | 2                        |
| STILLWATER CENTRAL SCHOOL DISTRICT                | 2                        |  |                          | WASHINGTON-SARATOGA-WARREN-HAMILTON-ESSEX BOCES | 1                        |
| WATERFORD-HALFMOON UNION FREE SCHOOL DISTRICT     | 2                        |  |                          | WHITEHALL CENTRAL SCHOOL DISTRICT               | 2                        |
| <b>Total Number of Schools in the County</b>      | <b>52</b>                |  |                          | <b>Total Number of Schools in the County</b>    | <b>25</b>                |

<https://nces.ed.gov/ccd/districtsearch/index.asp>

Source: CCD public school district data for the 2023-2024 school year

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

Key (according to County Health Rankings)

\*Purple highlight indicates areas of strength

\*Orange highlight indicates areas to explore

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

2025 Annual Data Release, County Health Rankings and Roadmaps  
For a full list of data sources, visit: <https://www.countyhealthrankings.org/health-data/county-health-rankings-measures>

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

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

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

ARHN region reflects an average of ARHN counties

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

ALICE Threshold, 2022; American Community Survey, 2022

American Community Survey, 2022; ALICE Threshold, 2022

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

## Appendix 4

# 2025 Data Methodology

### Background:

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

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

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

### Demographic Profile:

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

### Health System Profile:

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

### Education Profile:

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

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

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

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

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

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

### County Health Rankings (CHR) Profile:

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

The County Health Rankings identifies the two focus areas as:

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

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

### Data Dashboard:

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

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

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

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

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

#### ARHN Region Calculations:

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

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

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

#### UPSTATE Calculations:

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

- For percentages, formula is  $[(\mathbf{A}) * 100]$
- For rates per 100,000, formula is  $[(\mathbf{A}) * 100000]$
- For rates per 10,000, formula is  $[(\mathbf{A}) * 10000]$

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

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

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

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

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

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

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

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

### Unstable Estimates:

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

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

### **Prevention Agenda Dashboard**

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

#### *Data Suppression for Confidentiality*

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

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

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

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

**CI:** Confidence Interval

**BRFSS:** Behavioral Risk Factor Surveillance System

**SPARCS:** Statewide Planning and Research Cooperative System

### **Community Health Indicator Reports (CHIRs)**

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

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

*Data Suppression Rules for Confidentiality*

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

*Table 1. Summary of Data Suppression Rules*

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

**NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators**

*Limitations of Use:*

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

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

#### *Limitations of Data Use:*

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

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

### **NYS Traffic Safety Statistical Repository (TSSR)**

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

### **Student Weight Status Category Reporting System (SWSCRS) Data**

#### *Limitations of Data:*

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

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

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

### **US Department of Agriculture (USDA) Food Atlas**

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

In the downloadable Excel spreadsheets:

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

### **NYS Department of Health Tobacco Enforcement Compliance Results**

*Limitations of Use:*

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

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

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

**NYS Department of Health Maternal and Child Health**

*Unstable Estimates:*

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

*Data Suppression for Confidentiality*

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

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

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

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

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

### **Department of Health, Wadsworth Center**

#### *Limitations of Use:*

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

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

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

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

Appendix 5

Community Health Improvement Plan 2026-2030  
Work Plan

| Submitting Organization   |                        |                  |  |
|---|------------------------|------------------|--|
| Organization Name   | County(ies) of Service | Liaison Name     | Liaison Email  |
| Essex County Health Department  | Essex                  | Andrea Whitmarsh | <a href="mailto:andrea.whitmarsh@essexcountyny.gov">andrea.whitmarsh@essexcountyny.gov</a> |
| Is this a joint plan? Yes/No  | Yes                    |                  |  |
| <p><i>Note: a joint plan is defined as submitting one Community Health Assessment and Community Health Improvement Plan for both the LHD(s) and hospital(s) within the same county.</i></p> |                        |                  |  |

| Participating Organization(s)                                      |                        |                    |  |
|--|------------------------|--------------------|--|
| Organization Name  | County(ies) of Service | Liaison Name       | Liaison Email  |
| University of Vermont Health -<br>Elizabethtown Community Hospital | Essex                  | Amanda Bola        | <a href="mailto:abola@ech.org">abola@ech.org</a>                                 |
| Adirondack Health  | Essex and Franklin     | Matthew G. Scollin | <a href="mailto:mgsollin@adirondackhealth.org">mgsollin@adirondackhealth.org</a> |
| Org D:   |                        |                    |  |

| Domain  | Priority<br>(select one from drop down list)    | Objective<br>(select one from drop down list)  | Intervention   | Disparities Being Addressed  | Family of Measures  | Timeframe                  |                                 | Implementation Partner<br>(Please select one partner from the dropdown list per row) | Partner Role(s) and Resources   |
|---|---|--|--|--|---|----------------------------|---------------------------------|--|---|
|   |   |  |  |  |   | Start Date<br>(mm/dd/yyyy) | Completion Date<br>(mm/dd/yyyy) |  |   |
| <b>Economic Stability</b><br><b>Instructions:</b><br>Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP):<br><a href="https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidance.pdf">https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidance.pdf</a> .<br>- Columns B & C: Priorities and Objectives can be selected from the dropdown menus.<br>- Please note: These objectives include statewide baseline and target measures and those selected should align with your local plan.<br>- Column D: Enter and cite the intervention your organization plans to implement to address the selected objective. Each intervention must be listed in a separate row. Use evidence-based interventions; if not available, best or promising practices.<br>- Column E: List any disparities the intervention addresses.<br>- Column F: Identify the specific metric or measure used to evaluate the intervention's implementation progress. |   |  |  |  |   |                            |                                 |  |   |
| Economic Stability  | Priority 1: Poverty                             | 1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.   | Partner with, promote, and refer to supplemental nutrition programs including Women, Infants, and Children (WIC) and Supplemental Nutrition Assistance (SNAP) and the NYS Agency Nutrition programs.   | Low-income individuals and families<br>Other populations experiencing barriers to accessing programs:<br>*lower educational attainment levels;<br>*working multiple jobs;<br>*language barriers;<br>*involvement with multiple agencies;<br>*expressed barrier of any sort with enrollment | 1. Essex County Department of Social Services will participate in 6 community meetings to educate agency partners about SNAP program by 12/31/2026.<br>2. Mental Health Association will host 1 SNAP education class in 2026 and 1 class in 2027.<br>3. Essex County Mental Health will facilitate 100% of Medicaid and Managed Care clients to 1115 Waiver Screening by 12/31/2026.<br>3. Essex County Health Department will embed nutritional program informational prompts into 100% of direct outreach services by 12/31/2027.<br>4. Get Healthy North Country (GHNC) Network will coordinate with Essex County Health Department to provide education about GHNC programs to WIC and SNAP staff annually beginning in 2026. | 1/1/2026                   | 12/31/2027                      | Social Services  | Full partner roles and resources are listed under the Family of Measures column.  |
| Economic Stability  | Priority 1: Poverty                             | 1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.   | Conduct regular screening of patients at the hospital or community members accessing programs for SDOH factors like income and unemployment  | Low income individuals and families<br>Justice-involved individuals  | 1. UVMH-Elizabethtown Community Hospital will conduct standardized screening for SDOH.<br>2. Mental Health Association will aim to screen 80% of referrals for health care needs and refer 60% for 2026.  | 1/1/2026                   | 12/31/2026                      | Hospital   |   |
| Economic Stability  | Priority 2: Unemployment                        | 2.0 Reduce unemployment among individuals aged 16 and older from 6.2% to 5.5%.   | Engage in multi-sector collaborations that highlight the health burden of unemployment and underemployment and leverage these collaborations to create local pathways to meaningful employment. Strategies include identifying the partners and resources to develop job training programs and job opportunities that align with local labor market demands. | Low income individuals and families<br>Education   | 1. By 06/30/2026, work with ECHD- Home Health create/promote paid Home Health Summer internship program for college bound or high school students interested in health careers<br>2. By 12/31/2026, ECHD will develop a list of agencies/coalitions/networks that address employment/unemployment for Essex County Residents.<br>3. By 13/31/2027, ECHD will share timely health data relevant to employment with 75% of these agencies/coalitions/networks.  | 1/1/2026                   | 12/31/2027                      | Local health department  | Partners will invite/include ECHD in collaborations and allow data sharing and engagement.  |
| Economic Stability  | Priority 2: Unemployment                        | 2.0 Reduce unemployment among individuals aged 16 and older from 6.2% to 5.5%.   | Strengthen partnerships among health care employers, Boards of Cooperational Services (BOCES) programs, high schools, and community colleges to expand training, apprenticeships, and employment opportunities for entry-level careers.  | Education  | 1. Participation rates among number of graduates from high school and community college that complete hospital-based learning programs<br>2. Percentage of new hires that completed programs  | 1/1/2026                   | 12/31/2028                      | Educational institution  | Full partner roles and resources are listed under the Family of Measures column.  |
| Economic Stability  | Priority 3: Nutrition Security                  | 3.1 Increase food security in households with an annual total income of less than \$25,000 from 46.6% to 56.7%.  | Promote and expand the availability of fruit and vegetable incentive programs  | Low income individuals and families  | 1. By 12/31/2027, the Well Fed Collaborative will identify and secure funding from at least one (1) source for the enhancement and expansion of fruit and vegetable incentive programs.<br>2. By 12/31/2030, ECHD will share updated (timely) health data relevant to nutritional security with Well Fed Collaborative, at least annually (for a total of 5 updates if new data available).   | 1/1/2026                   | 12/31/2030                      | Community-based organizations  | Well Fed Collaborative partners:<br>Essex County Health Department<br>-Public Health<br>-MHC<br>UVMH-Elizabethtown Community Hospital<br>Cornell Cooperative Extension - Essex County<br>ADK Action<br>North Country Ministries<br>Essex County Office for the Aging<br>Essex County Food Hub |
| Economic Stability  | Priority 4: Housing Stability and Affordability | 4.1 Increase the percentage of adults, with an annual income of less than \$25,000, who were able to pay their mortgage, rent, or utility bills in the past 12 months from 65.1% to 75.1%. | Provide Supported Housing Program to individuals with serious or persistent mental illness.  | Mental health/frequent mental distress   | 1. By 12/31/2026, the Mental Health Association will provide 30 rental stipends to individuals in Essex County who have serious or persistent mental illness.<br>2. By 12/31/2026, MHA will devise a process to formally track the number of people monthly on the waitlist for these stipends/services in order to show need for increased funding.  | 1/1/2026                   | 12/31/2026                      | Community-based organizations  |   |
| Economic Stability  | Priority 4: Housing Stability and Affordability | 4.0 Increase the number of people living in HUD-subsidized housing from 987,957 to 1,092,000.  | Collaborate with new and current partners to increase access to safe and affordable housing.   | Low income individuals and families  | 1. Essex County Director of Community Services will participate in 100% of Essex County Housing Task Force meetings in 2026 to promote multi-agency collaboration<br>2. MHA will complete training to screen individuals for 1115 waiver services by 03/01/2026.<br>3. By 12/31/2030, ECHD will share updated (timely) health data relevant to housing with the Essex County Housing Task Force, at least annually (for a total of 5 updates if new data available).  | 1/1/2026                   | 12/31/2026                      | Local government   |   |

| Domain   | Priority<br>(select one from drop down list)                              | Objective<br>(select one from drop down list)   | Intervention  | Disparities Being Addressed   | Family of Measures   | Timeframe                  |                                 | Implementation Partner<br>(Please select one partner from the dropdown list per row) | Partner Role(s) and Resources  |
|--|---|---|---|---|--|----------------------------|---------------------------------|--|--|
|  |   |   |   |   |  | Start Date<br>(mm/dd/yyyy) | Completion Date<br>(mm/dd/yyyy) |  |  |
|  |   |   |   |   |  |                            |                                 |  |  |
| <b>Social &amp; Community Context</b><br><b>Instructions:</b><br>Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): <a href="https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidance.pdf">https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidance.pdf</a> .<br><b>Columns B &amp; C:</b> Priorities and Objectives can be selected from the dropdown menus.<br><b>Please note:</b> These objectives include statewide baseline and target measures and those selected should align with your local plan.<br><b>Column D:</b> Enter and cite the intervention you organization plans to implement to address the selected objective. Each intervention must be listed in a separate row. Use evidence-based interventions; if not available, best or promising practices.<br><b>Column E:</b> List any disparities the intervention addresses.<br><b>Column F:</b> Identify the specific metric or measure used to evaluate the intervention's implementation progress. |   |   |   |   |  |                            |                                 |  |  |
| Social & Community Context   | Priority 3: Depression  | 3.0 Reduce the percentage of adults with a major depressive episode during the past year from 6.7% to 5.7%.   | Implement and promote Mental Health First Aid (MHFA) and Teen Mental Health First Aid training in communities and health care settings.   | Mental health/frequent mental distress  | 1. UVMH-Elizabethtown Community Hospital will increase the number of MHFA trainers and the number of organizations participating in training.<br>2. Essex County Mental Health will implement and promote Teen Mental Health First Aid to all 9th grade classes of local schools who agree to this initiative, with the target being 60% of 9th grade classes in Essex County (or 6 out of 10 public school districts) in 2026.        | 1/1/2026                   |                                 | Hospital   |  |
| Social & Community Context   | Priority 4: Primary Prevention, Substance Misuse, and Overdose Prevention | 4.8 Reduce the rate of overdose deaths involving drugs per 100,000 people from 32.3 to 22.6.  | Provide or expand access to naloxone to reduce overdose fatalities.   | Substance misuse<br>Rural communities<br>Access to care<br>Low income individuals   | 1. Adirondack Health will implement a program to distribute take-home doses of naloxone to patients in the emergency care setting by the end of 2026.<br>2. UVMH-Elizabethtown Community Hospital will increase the availability of naloxone.<br>3. ECHD will expand Community Care Kiosk program (which includes naloxone kit distribution) to offer online requests for resources by 12/31/2028.                                     | 1/1/2026                   | 12/31/2028                      | Hospital   | Full partner roles and resources are listed under the Family of Measures column.   |
| Social & Community Context   | Priority 5: Tobacco/E-Cigarette Use                                       | 5.0 Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%.   | Provide access to tobacco cessation treatments, including individual, group, telephone counseling, and FDA approved cessation medications.  | Access to care  | Percentage of patients screened and number of referrals for positive screenings.   | 1/1/2026                   | 12/21/2030                      | Hospital   | UVMH-Elizabethtown Community Hospital  |
| Social & Community Context   | Priority 5: Tobacco/E-Cigarette Use                                       | 5.0 Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%.   | Implement screening for tobacco use and navigate to appropriate services in all health care practice settings.  | Access to care  | 1. The Heart Network will increase the percent of Essex County healthcare provider systems that have adopted evidence-based nicotine treatment protocols in clinical settings to at least 80% by 12/31/2030.<br>2. Adirondack Health will increase tobacco use assessments for all health-center-based primary care patients 18+ by five percent.  | 1/1/2026                   | 12/31/2030                      | Community-based organizations  | Heart Network - facilitate nicotine treatment protocols<br>UVMH-Elizabethtown Community Hospital, Adirondack Health, Mental Health Association and FQHCs will adopt protocols  |
| Social & Community Context   | Priority 5: Tobacco/E-Cigarette Use                                       | 5.1 Reduce the percentage of high school students who use tobacco products from 14.8% to 12.6%.   | Advance community-wide support for restricting minors' access to tobacco products. Examples include:<br>• Promotion of community-wide education on tobacco issues<br>• Education to retailers about restricting the sale of tobacco to minors   | Access to care  | # of School engaged in evidenced-based prevention programming &<br># Sessions provided by year   | 1/1/2026                   | 12/31/2026                      | Educational institution  | Prevention Team is contract with by the Essex County Health Department to offer evidenced-based programs: Stanford Medicine's "You and Me Vape Free" Curriculum.   |
| Social & Community Context   | Priority 7: Adverse Childhood Experiences                                 | 7.5 Reduce the rate of indicated reports of abuse/maltreatment among children and youth aged 0-17 years from 11.5 to 10.0.                              | Strengthen community partnerships to support education, case coordination, and referrals of at-risk families to local health departments, hospitals, and other community-based organizations to increase participation in home visiting programs (e.g., Healthy Families, Community Health Worker (CHW), Nurse Family Partnership (NFP)). | Families referred through perinatal database system as high risk or received as a referral from healthcare provider to accept services.<br>Mental health/frequent mental distress | 1. # of families that accept Baby Steps to Bright Futures Program;<br># Referrals to Healthy Families, NY;<br># Referrals to Early Head Start/Head Start<br># Families Baby Steps DSS Preventive Services collaborative families<br>3. Essex County Mental Health clinical staff will utilize the 10 ACEs questionnaires with at least 50% of all new clients and will refer positive screens to home visiting programs as applicable. | 1/1/2026                   | 12/31/2030                      | Community-based organizations  | Healthy Families NY provides ongoing in-homes supports.<br>Early Head Start/Head Start provides ongoing parenting education & support.<br>DSS Prevent Collaborative Families are high risk families access additional supports from the Health Dept & DSS. |
| Social & Community Context   | Priority 8: Healthy Eating  | 8.1 Decrease the percentage of adults with an annual household income less than \$50,000 who consume no fruits or vegetables daily from 31.7% to 30.1%. | Establish, enhance, or expand Food as Medicine programs and connect these programs with disease prevention and management programs.   | Income  | 1. Increase the number of participants in the Wellness Rx Program.<br>2. Increase the redemption rate of Wellness Rx coupons<br>3. Expand the number of vendor sites accepting Wellness Rx coupons<br>4. Increase community education sessions for the Wellness Rx Program   | 1/1/2026                   | 12/31/2030                      | Hospital   | UVMH-Elizabethtown Community Hospital is administering the Wellness Rx Program   |

**Neighborhood & Built Environment**

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| Domain                           | Priority<br>(select one from drop down list)         | Objective<br>(select one from drop down list)  | Intervention   | Disparities Being Addressed | Family of Measures   | Timeframe                  |                                 | Implementation Partner<br>(Please select one partner from the dropdown list per row) | Partner Role(s) and Resources  |
|----------------------------------|--|--|--|-----------------------------|--|----------------------------|---------------------------------|--|--|
|                                  |  |  |  |                             |  | Start Date<br>(mm/dd/yyyy) | Completion Date<br>(mm/dd/yyyy) |  |  |
| Neighborhood & Built Environment | Priority 2: Access to Community Services and Support | 2.1 Increase the number of cooling centers on the Cooling Center Finder, accessible to individuals living in high heat-vulnerable areas and disadvantaged communities from 698 to 768. | Educate policymakers and healthcare leaders on promoting age-friendly practices in health care and community infrastructures, focusing on integrating aging into core health care practices. | Aging                       | 1. Essex County Health Department - Home Health will provide one educational offering with health care leaders regarding access to community services by 12/31/2026.<br>2. Essex County Mental Health/Community Service Board will participate in 100% of bi-monthly meetings with the Aging Working Group in 2026 to promote collaboration with other human services partners on the high-needs/high-risk adult populations.<br>3. Mercy Care for the Adirondacks will develop a Health Care Companion Volunteer Advocate Program in 2026, training 10 new volunteers by end of year.<br>4. Mercy Care of the Adirondacks will host quarterly Caregiving Work Group of the North Country meetings throughout 2026.<br>5. Heart Network will provide annual education sessions to healthcare leaders and policy makers that emphasize the importance of access to prevention/chronic disease self-management services as part of healthy aging strategies. | 1/1/2026                   | 12/31/2030                      | Community-based organizations  | Full partner roles and resources listed in Family of Measures column |
| Neighborhood & Built Environment | Priority 2: Access to Community Services and Support | 2.1 Increase the number of cooling centers on the Cooling Center Finder, accessible to individuals living in high heat-vulnerable areas and disadvantaged communities from 698 to 768. | Promote and prioritize age-friendly initiatives by educating primary care providers during annual wellness visits, ensuring they are equipped to discuss and implement these practices.      | Aging                       | 1. Number of older adults who participate in screenings<br>2. Assess knowledge/awareness in preventive care options<br>3. Assess engagement with health resources  | 1/1/2026                   | 12/31/2025                      | Hospital   |  |

**Healthcare Access & Quality**

**Instructions:**  
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|-----------------------------|--|---|--|---|--|----------------------------|---------------------------------|--|---------------------------------------|
|                             |  |   |  |   |  | Start Date<br>(mm/dd/yyyy) | Completion Date<br>(mm/dd/yyyy) |  |                                       |
| Healthcare Access & Quality | Priority 3: Preventative Services for Chronic Disease Prevention and Control | 3.6 Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80.0%.    | Encourage the use of client reminders by providers to increase cancer screening per the Community Guide national guidelines.   | Access to health care<br>Income<br>Disability | 1. Adirondack Health will send annual e-mail reminders to the full medical staff, highlighting the most recent colorectal cancer screening guidelines.<br>2. Adirondack Health will continuously review current practices for reliability and timeliness to ensure reminders are being sent by all providers.<br>3. Adirondack Health will continue to track patient reminders and monitor patients via quality dashboard and HEDIS dashboard. | 1/1/2026                   | 12/31/2027                      | Hospital   | Adirondack Health                     |
| Healthcare Access & Quality | Priority 3: Preventative Services for Chronic Disease Prevention and Control | 3.0 Increase the percentage of adults aged 35+ who had a test for high blood sugar in the past year from 78.1% to 82.4%.  | Implement community screenings to detect and address diabetes  | Access to health care<br>Income<br>Disability | Number of events within the community setting where hospital provides screening and education for diabetes.  | 1/1/2026                   | 12/31/2030                      | Hospital   | UVMH-Elizabethtown Community Hospital |
| Healthcare Access & Quality | Priority 3: Preventative Services for Chronic Disease Prevention and Control | 3.5 Increase the percentage of adult Medicaid members aged 18+ with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%. | Implement community screenings to detect and address hypertension.   | Access to health care<br>Income<br>Disability | Number of events within the community setting where hospital provides screening and education for hypertension.  | 1/1/2026                   | 12/31/2030                      | Hospital   | UVMH-Elizabethtown Community Hospital |
| Healthcare Access & Quality | Priority 3: Preventative Services for Chronic Disease Prevention and Control | 3.6 Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80.0%.    | Work with local cancer screening programs such as the NYS Cancer Services Program to improve access to cancer screening and diagnostic testing for individuals without health insurance. | Access to health care<br>Income<br>Disability | 1. Increase percentage of individuals meeting current cancer screening guidelines  | 1/1/2026                   | 12/31/2030                      | Hospital   | UVMH-Elizabethtown Community Hospital |