Glens Falls Hospital

Community Service Plan

2013 - 2015

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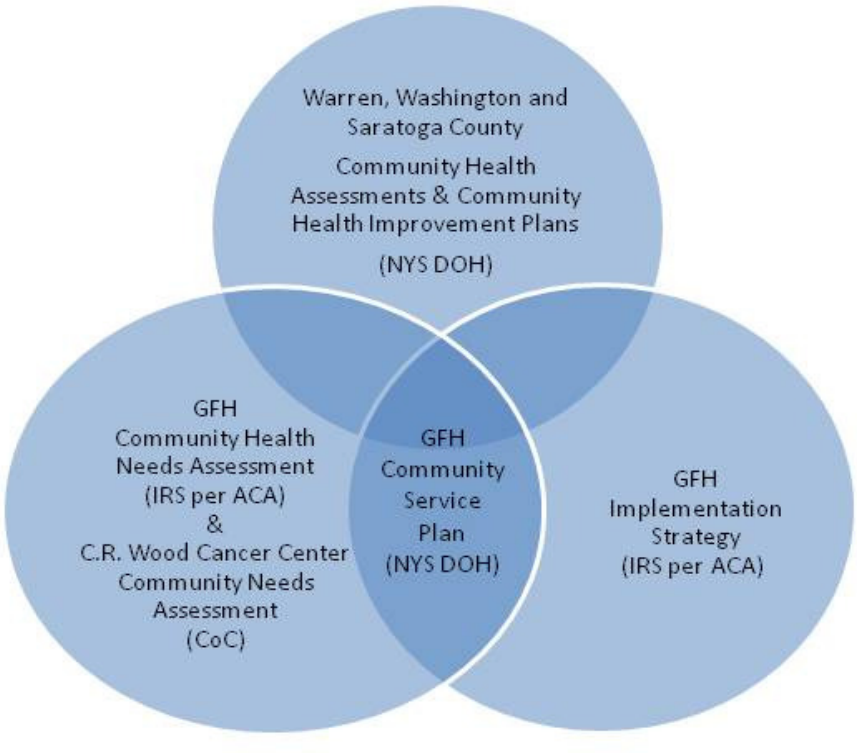
Introduction

Glens Falls Hospital (GFH) developed this Community Service Plan (CSP) to identify and prioritize the community health needs of the patients and communities within the GFH service area, and develop a three-year plan of action to address the prioritized needs. The plan was developed in collaboration with Warren, Washington and Saratoga County Public Health Departments, and includes strategies that are evidence-based and aligned with the NYS Prevention Agenda 2013 – 2017. This CSP addresses the requirements set forth by the NYS Department of Health, which asks hospitals to work with local health departments to complete a CSP that mirrors the Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) required by the Affordable Care Act (ACA). GFH combined the CHNA and IS documents to create this CSP.

The community health needs assessment provision of the ACA (Section 9007) links hospitals' tax exempt status to the development of a needs assessment and adoption of an implementation strategy to meet the significant health needs of the communities they serve, at least once every three years.
A CHNA is a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon unmet community health needs.[1] The findings in the GFH CHNA result from a year-long process of collecting and analyzing data and consulting with stakeholders throughout the community and the region. The GFH CHNA also addresses the American College of Surgeons (ACS) Commission on Cancer (CoC) requirements to complete a community needs assessment to identify needs of the population served, potential to improve cancer health care disparities, and gaps in resources. Consequently, cancer-specific information, data and needs are highlighted throughout the assessment. The Implementation Strategy is a three-year plan of action including goals, objectives, improvement strategies and performance measures with measurable and time-framed targets.

County health departments in NYS have separate yet similar state requirements to conduct a Community Health Assessment (CHA) and a corresponding Community Health Improvement Plan (CHIP). Aligning and combining the requirements of NYS DOH, the ACA and the CoC, in addition to coordinating with each county health department, ensures the most efficient and effective use of hospital resources and supports a comprehensive approach to community health and population health management in the region.



[1] Catholic Health Association, *Assessing and Addressing Community Health Needs,* February 2012. Available at http://www.chausa.org/communitybenefit/printed-resources/assessing-and-addressing-community-health-needs

Glens Falls Hospital

GFH is the largest and most diverse healthcare provider in the area, and provides a comprehensive safety net of health care services to a rural, economically-challenged region in upstate New York. The not-for-profit health system includes the sole acute care hospital located in this region – a 410-bed comprehensive community hospital in Warren County, approximately 50 miles north of Albany. GFH is the largest hospital between Albany and Montreal, the largest employer in the region, and the tenth largest private sector employer in Northeastern New York. The Healthcare Association of New York State (HANYS) estimates GFH's total annual economic impact on the region to be more than $516 million.[2] More than 300 affiliated physicians and more than 100 physician extenders provide services that combine advanced medical technology with compassionate, patient-centered care.

GFH serves as the hub of a regional network of healthcare providers and offers a vast array of health care services including general medical/surgical and acute care, emergency care, intensive care, coronary care, obstetrics, gynecology, a comprehensive cancer center, renal center, occupational health, inpatient and outpatient rehabilitation, behavioral health care, primary care, and chronic disease management, including a chronic wound healing center. In addition to the hospital's main campus, these services are provided through 11 neighborhood primary care health centers and physician practices, several outpatient rehabilitation sites, seven specialty practices (including three staff endocrinologists), three occupational health clinics, and two rural school-based health centers. These community-based care sites afford GFH unique opportunities to link hospital-based services to primary care and community health services in historically underserved rural communities. See Appendix A for a map of the GFH regional health care system.

GFH has worked to create healthier communities since its founding in 1897, and is actively implementing numerous care transformation initiatives to support the Institute for Healthcare Improvement's Triple Aim of better health, better care and lower costs:

- **Patient-Centered Medical Homes:** Within the health centers, GFH is working to transform the model of primary care delivery through implementation of patient-centered medical homes. This transformation will strengthen the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship between the patient and provider.

- **NYS Medicaid Health Home:** In addition, GFH is designated as a lead Medicaid Health Home under the New York State Medicaid Health Home Program. A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. The target population is individuals with complex chronic conditions including medical and behavioral care needs that drive a high volume of high cost services such as inpatient and long-term institutional care.

- **Community-based Care Transitions Program:** Through the Community-based Care Transitions Program, GFH is working with a consortium consisting of six community-based organizations and ten hospitals serving ten counties to reduce the risk of readmission when a patient is transitioned from hospital to home.

[2] Healthcare Association of New York State, *The Impact of Glens Falls Hospital on the Economy and the Community*, January 2013.

- **Community Health and Wellness:** Additional community health initiatives include an extensive set of outreach programs and population-based initiatives to improve the health status of those living in the region. These include, but are not limited to, NYS DOH-funded initiatives such as Creating Healthy Places to Live Work and Play, the Tobacco Cessation Center, Healthy Schools New York, and the Cancer Services Program.

Enhancing the quality of life and access to health care services for the geographically scattered population of this region, many of whom struggle economically, is a priority for GFH.

C.R. Wood Cancer Center at Glens Falls Hospital

The C. R. Wood Cancer Center at Glens Falls Hospital opened in 1993. As a Center of Excellence that is hospital-based, it is multi-faceted with an integrated oncology program that provides comprehensive cancer services including: prevention, early detection, screenings, diagnostics, genetic risk evaluation, medical and radiation oncology, pharmacy, clinical research, education and support services that include psychological counseling, patient navigation, nutrition counseling, a children's camp, wellness programs and numerous support groups and weekend retreats.

The American College of Surgeons Commission on Cancer has recognized the C. R. Wood Cancer Center as an oncology program that offers high-quality cancer care. Only one in four cancer programs at hospitals across the United States receives this special accreditation. The CoC recognizes the quality of our comprehensive patient care and our commitment to provide our community with access to various medical specialists involved in diagnosing and treating cancer.

Patient Navigation

Currently there are two Nurse Navigators that help patients find resources to remove barriers to care. They also provide education and support to patients and their families diagnosed with cancer. Nurses within the clinics and treatment areas refer to the navigators and/or care managers to help patients on an as needed basis. Breast cancer patient navigation occurs through nurse contact with newly diagnosed breast cancer patients that are referred either from the Glens Falls Hospital Breast Center or through the Baywood Surgical Associates. This process begins with an abnormal screening or diagnostic exam and continues through surgery, treatment and survivorship care. Prostate Cancer patients are identified for navigation through referrals from Urologists and Radiation Oncologists. Newly diagnosed lung cancer patients referred to the Nurse Navigators from the thoracic surgeon and/or Medical Oncologist of the C. R. Wood Cancer Center are contacted by one of the Nurse Navigators to provide education and support, and identify and reduce any barriers throughout the continuum of care.

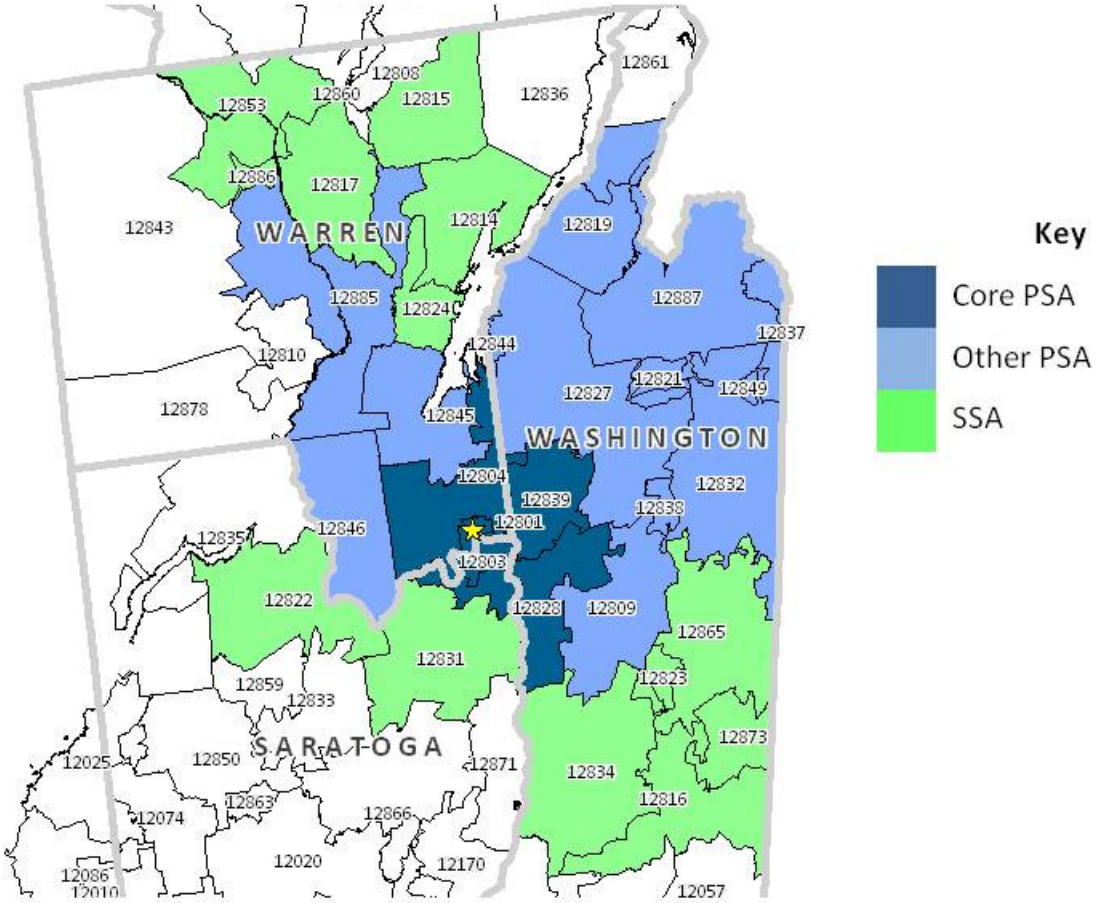
Glens Falls Hospital Mission

The mission of GFH is to improve the health of people in our region by providing access to exceptional, affordable and patient-centered care every day and in every setting. Our fundamental values are (1) Respect, by treating each individual with courtesy and compassion, (2) Responsiveness, through innovation and continuous improvement, and (3) Responsibility, to assure a wide range of high quality healthcare services to all.

Glens Falls Hospital Service Area

The service area for GFH is composed of ZIP codes in Warren, Washington and northern Saratoga counties. This definition results from a recent analysis of patient origin, market share (which reflects how important GFH is to a particular community), and geographic considerations, including the need to ensure a contiguous area.

The GFH service area is defined by a Core Primary Service Area (PSA), Other Primary Service Area and a Secondary Service Area (SSA). The Core PSA represents the ZIP codes immediately contiguous to the hospital. These five ZIP codes have a combined patient origin of 51% and a GF H market share of 85%. The Other Primary Service Area rings the Core PSA and includes 14 ZIP codes with a combined patient origin of 20% and GFH market share of 79%. Combined, the Core PSA and Other PSA have a patient origin of 71% and GFH market share of 83%. The Secondary Service Area (SSA) reflects more outlying areas where GFH has either a strong market share or a critical mass of patients that come to the hospital. These 13 ZIP codes have a combined patient origin of 13% and GFH market share of 49%. The Core PSA, Other PSA and SSA combined represent the residence of 84% of patients that are served by GFH. This service area definition also aligns with the counties included in the service area definition for the GFH Medical Staff Development Plan (MSDP).[3]



[3] The MSDP justifies financial support for physician recruitment into private practices, and is also a strategic tool to assess broader physician need including development of new programs and services. Consequently, there is significant overlap between both the content and purpose of the CHNA and MSDP (both federal requirements).

Core Primary Service Area			
Zip	Primary City	Combined Patient Origin	GFH Market Share
12801	Glens Falls	51%	85%
12804	Queensbury		
12803	South Glens Falls		
12828	Fort Edward		
12839	Hudson Falls		
Other Primary Service Area			
12819	Clemons	20%	79%
12887	Whitehall		
12837	Hampton		
12827	Fort Ann		
12844	Kattskill Bay		
12821	Comstock		
12849	Middle Granville		
12832	Granville		
12838	Hartford		
12809	Argyle		
12846	Lake Luzerne		
12845	Lake George		
12885	Warrensburg		
12854	North Granville		
Secondary Service Area			
12853	North Creek	13%	49%
12817	Chestertown		
12815	Brant Lake		
12824	Diamond Point		
12814	Bolton Landing		
12865	Salem		
12823	Cossayuna		
12873	Shushan		
12834	Greenwich		
12816	Cambridge		
12822	Corinth		
12831	Gansevoort		
12886	Wevertown		

The Adirondack Rural Health Network

Glens Falls Hospital is an active member of the Adirondack Rural Health Network (ARHN), a regional multi-stakeholder coalition that conducts community health assessment and planning activities. ARHN provides the forum for local public health services, community health centers, hospitals, community mental health programs, emergency medical services, and other community-based organizations to assess regional needs and the effectiveness of the rural health care delivery system. See Appendix B for a full list of ARHN members and roles.

ARHN is a program of the Adirondack Health Institute, Inc. (AHI), a 501c3 not-for-profit organization that is licensed as an Article 28 Central Service Facility and a joint venture of Adirondack Health (Adirondack Medical Center), Community Providers, Inc. (Champlain Valley Physicians Hospital Medical Center) and Hudson Headwaters Health Network. Established in 1992 through a New York State Department of Health Rural Health Development Grant, ARHN plans, facilitates and coordinates many different activities required for successful transformation of the health care system including: conducting community health assessments, provider education and training, patient and family engagement, identifying and implementing best practices to optimize health care quality, and publishing regional and county-specific data and reports at www.arhn.org.

Since 2002, ARHN has supported the coordination of efforts for Essex, Fulton, Hamilton, Saratoga, Warren and Washington Counties. During 2011- 2012, ARHN expanded its regional community health planning efforts to include Clinton and Franklin counties, and currently includes critical stakeholders from all eight counties in the regional planning process. ARHN provides guidance and technical assistance to the Community Health Planning Committee (CHPC), a regional forum for hospitals, county health departments and community partners, who provide oversight of planning and assessment activities. The group is further comprised of subcommittees developed to address areas specific to hospital, public health and data-specific requirements. Regular meetings of each subcommittee and the full CHPC have resulted in a systematic approach to community health planning and the development of regional and local strategies to address health care priorities.

New York State's Prevention Agenda 2013 - 2017[4]

In collaboration with ARHN, Glens Falls Hospital utilized the NYS Prevention Agenda framework to plan, inform and guide the community health needs assessment process. *The Prevention Agenda 2013-17* is New York State's Health Improvement Plan for 2013 through 2017, developed by the New York State Public Health and Health Planning Council (PHHPC) at the request of the Department of Health, in partnership with more than 140 organizations across the state. This plan involves a unique mix of organizations including local health departments, health care providers, health plans, community based organizations, advocacy groups, academia, employers as well as state agencies, schools, and businesses whose activities can influence the health of individuals and communities and address health disparities.

The *Prevention Agenda* serves as a guide to local health departments and hospitals as they work with their community to assess community health needs and develop a plan for action. *The Prevention Agenda* vision is "New York as the Healthiest State in the Nation." The plan features five areas that highlight the priority health needs for New Yorkers:

- Prevent chronic disease
- Promote healthy and safe environments
- Promote healthy women, infants and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare-associated Infections

[4] Adapted from the New York State Department of Health, Prevention Agenda website, http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/summary.htm

The Prevention Agenda establishes focus areas and goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities. Throughout this assessment, these priority areas were used as a foundation for determining the most significant health needs for the GFH service area. See Appendix C for a matrix of the Prevention Agenda priority areas, focus areas and goals. More information about the Prevention Agenda can be found at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017.

Community Health Needs Assessment (CHNA) Process

In NYS, hospitals and county health departments are encouraged to work together to assess the community health needs and develop a plan that addresses the needs identified. Working within the framework provided by New York State's Prevention Agenda, Glens Falls Hospital and Warren, Washington and Saratoga County Public Health collaborated in the development of a CHNA. Additionally, GFH coordinated with Fulton, Montgomery, Essex, Hamilton, Franklin and Clinton County Public Health, in addition to seven other hospitals in the eight-county region, through the regional health assessment and planning efforts coordinated by ARHN. Collaboration is an essential element for improving population health, and working together reduced duplication and facilitated an effective and efficient approach.[5] See Appendix D for the ARHN CHPC meeting schedule and attendance list.

GFH serves a multi-county area, which encouraged a strategic approach to ensure alignment with each county assessment and planning process. After careful consideration and extensive internal and external discussions, GFH determined that the most effective strategy would be twofold: 1) ensure the hospital coordinated with and/or participated in each of the public health departments' CHA processes and 2) utilize the results of each of the county assessments to inform a coordinated and complementary regional CHNA for the GFH service area. Consequently, this section briefly describes each county's Community Health Assessment (CHA) process as well as the subsequent GFH process, followed by the data sources utilized to inform the processes.

Warren, Washington and Saratoga County CHAs

As a result of the collaborative efforts through ARHN, the information used to conduct a CHA in Warren, Washington and Saratoga counties was fairly similar. Each county's CHA process involved both data analysis and consultation with key members of the community. Each county convened a group of community partners to review and discuss the data and information, and collectively identify and prioritize the most significant needs for the residents of each county. However, each county public health department has different needs, capacities and resources and the actual prioritization process for each county varied. The partners included in each county community health assessment teams (CHATs)[6] were slightly different, and each county also choose to consider slightly different data sources. The table below outlines the key county differences:

[5] More information about the guidance provided to counties and hospitals can be found at NYS Department of Health, Prevention Agenda 2013-2017, Community Health Planning Guidance and Data website, http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf

[6] Each county's group of partners was called something slightly different. However, for ease of reference the term CHAT is utilized in this report to describe the partners that collaborated to conduct the assessment and prioritize needs for each county.

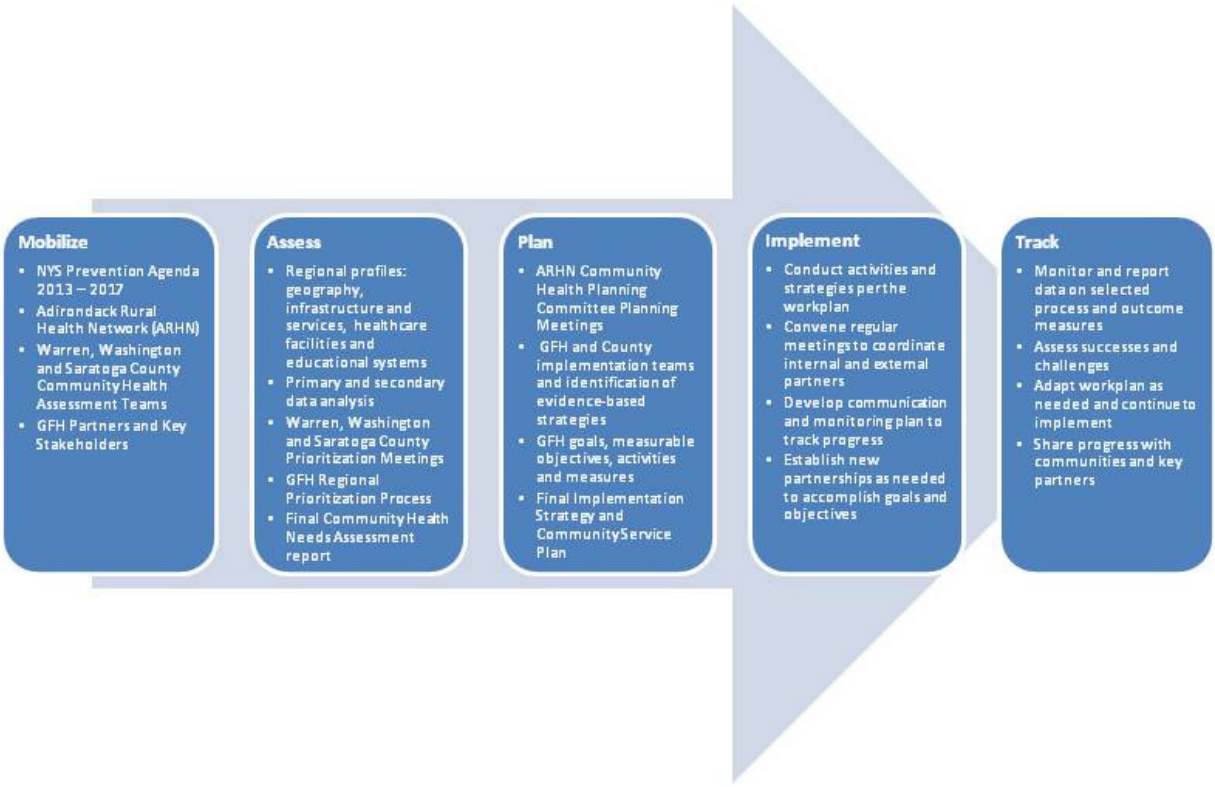
	Warren County	Washington County	Saratoga County
Data Sources	County Health Indicator Data Regional Community Provider Survey County Health Rankings	County Health Indicator Data Regional Community Provider Survey	County Health Indicator Data Regional Community Provider Survey Saratoga Hospital Community Survey
Partners	Warren County Public Health Warren County Office for the Aging Cornell Cooperative Extension of Warren County Office of Community Services for Warren and Washington Counties (mental health) Resident of Warren County Glens Falls Hospital, including: • Creating Healthy Places to Live, Work and Play • Healthy Schools NY • Tobacco Cessation Center • Cancer Services Program	Washington County Public Health Washington County WIC Council for Prevention Washington County Office for the Aging Washington County Dept of Social Services Washington County Sexual Trauma & Recovery Services (STARS) Adirondack Rural Health Network Southern Adirondack Tobacco Free Coalition Glens Falls Hospital, including: • Creating Healthy Places to Live, Work and Play • Healthy Schools NY • Cancer Services Program	Saratoga County Public Health Saratoga Hospital Saratoga County Mental Health Services

Glens Falls Hospital CHNA

GFH used each county CHA to inform a complementary regional CHNA. GFH did not convene an additional regional team of community partners as this would have duplicated efforts and created confusion among community leaders. In addition, GFH played a slightly different role in each of the county processes. GFH directly participated in the planning and implementation of the Warren County CHA process. GFH was a participant in the Washington County process. In Saratoga County, the process was mainly coordinated by Saratoga Hospital and Saratoga County Public Health. However, GFH consulted with Saratoga County Public Health before and after the needs assessment was conducted, and worked to ensure alignment and coordination.

Once the assessment process was complete for each county, GFH reviewed the results and also considered additional clinical information. This data was used to better understand the specific health care needs of the residents in the GFH service area. Consequently, given the collaborative and comprehensive CHNA process, there were no known information gaps that impacted the hospital's ability to assess the health needs of the people and communities in the region.

Glens Falls Hospital Community Health Assessment and Improvement Process



Adapted from the Healthy People 2020 Map-It Framework for Implementation, available at http://healthypeople.gov/2020/implement/MapIt.aspx

Data Sources

A variety of data sources were used to inform the county and hospital assessments. The two most significant resources used to inform the assessments were developed and provided by the ARHN collaboration: 1) publically available county health indicator data and 2) data collected from a regional community provider survey. Each county, as well as GFH, used additional data sources to supplement this information and inform the process based on their needs. The following is a list of all the data sources considered by each county and/or GFH.

County Health Indicator Data

The health indicator data contains over 450 distinct data elements across the following four areas: 1) demographic data, 2) educational profile, 3) health delivery system profile and 4) health behaviors, health outcomes, and health status. Since 2003, the Adirondack Rural Health Network has been compiling this data for the region and producing reports to inform healthcare planning on a regional basis. Last year, ARHN undertook a project to systemize this data into a relational database to provide improved access and analysis. The results of this analysis provide a statistical assessment of the health status for the region and each county therein. See Appendix E for a more detailed description of the county health indicator data methodology and a complete list of sources.

ARHN Regional Community Provider Survey
In conducting the CHNA, non-profit hospitals are required to take into account input from persons who represent the broad interests of the community served, including those with special knowledge of or expertise in public health. In addition, members, leaders or representatives of medically underserved, low-income, minority populations should be consulted. In the winter of 2012-2013, GFH worked with ARHN to conduct a survey of these and other selected stakeholders representing health care and service-providing agencies within the eight-county region. The results of the survey provide an overview of regional needs and priorities, and inform future planning and the development of a regional health care agenda. The survey results were presented at both the county and regional levels. See Appendix F for a comprehensive description of the survey methodology and results and Appendix G for the list of individuals who responded to the survey.

County Health Rankings
The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The County Health Rankings show the rank of the health of nearly every county in the nation and emphasize the many factors that, if improved, can help make communities healthier places to live, learn, work and play. They help to simplify the complexity of data and provide context and a common language for those working in community health. See http://www.countyhealthrankings.org/ for additional information.

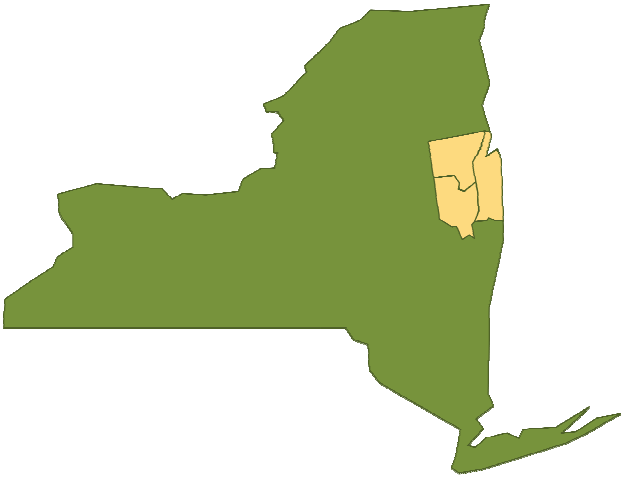
NYS Cancer Registry
Cancer is a reportable disease in every state in the United States. In New York State, Public Health Law Section 2401 requires that all physicians, dentists, laboratories, and other health care providers notify the Department of Health of every case of cancer or other malignant disease. Through the New York State Cancer Registry, the Department collects, processes and reports information about New Yorkers diagnosed with cancer. See http://www.health.ny.gov/statistics/cancer/registry/about.htm for additional information

GFH Electronic Medical Record Data
Data on select screenings was also analyzed from the electronic medical record system, Epic, for the 11 GFH primary care health centers. This data was used primarily to understand preventive care screening needs and potential disparities between different patient populations.

Warren and Washington County Nutrition Assessment
The GFH Creating Healthy Places to Live, Work and Play initiative conducted a community nutrition assessment in the Spring-Summer of 2013. The purpose of the assessment was to gain an understanding of factors that would encourage healthful food choices by low-income residents of Washington and Warren Counties who are not currently utilizing government assistance programs. Focus groups and a survey were used to gather data about residents' decision-making processes to identify areas that might feasibly be changed. Thirty individuals participated in focus groups conducted in Glens Falls, Chestertown and Salem. The survey is being administered verbally by trained research associates from the Center for Human Services Research at the University at Albany. A minimum of 500 residents of Warren and Washington Counties will participate in the survey. Participants are recruited through public events and venues, such as the YMCA, County Fair, Civic Center, Mall and Community College. Over 320 individuals responded to the survey as of October 2013.This assessment was conducted later in the year, after the county assessment and prioritization meetings occurred. Therefore, this data was not available for review by the CHATs in each county, but results to date are included in this report to further support the regional GFH CHNA process.

See Appendix H for a list of Data Consultants that supported the CHNA process.

Regional Profile of Warren, Washington and Saratoga Counties[7]



Warren, Washington and Saratoga counties are part of the Capital Region, along with Albany, Columbia, Greene, Rensselaer, and Schenectady counties.[8] The region's assets include a strategic location with proximity to all major markets in the northeast; an extraordinary quality of life with a mix of suburban rural communities and medium sized cities, including the Capital City; a highly skilled workforce and the many world renowned academic and research institutions. These intellectual centers provide unparalleled economic development potential as well as opportunities for companies to grow and expand, especially in high tech and knowledge-based industries. The Albany Airport provides direct air service to major US cities and connections to international cities. The Port of Albany is located on the Hudson River only 30 miles from central Saratoga County.[9]

The following sections outline key features of Warren, Washington and Saratoga Counties. This information was not specifically presented to the CHATs during the prioritization process, as the partners invited were regional experts with extensive knowledge of each county they served. However, it is included in this report to provide an overview of the GFH service area, including geography, infrastructure and services, healthcare facilities, and the educational system. Please see the local economic development corporation for additional details on county attributes.[10] The Cornell Program on Applied Demographics also has a detailed analysis of county-specific demographic, social, economic and agricultural data available at http://pad.human.cornell.edu/profiles/index.cfm.

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[7] Within this report, much of the data presented for Warren, Washington and Saratoga counties represents the entire county, not just the zip codes included in the GFH service area definition. There is very limited data available for an area that is smaller than the county-level. While this does not create a significant issue for Warren and Washington counties, it is important to note that Saratoga County is extremely diverse, and populations in the southern portion of the county have different demographics, health behaviors, health outcomes, and access to care when compared to those living in the northern portion of the county. Typically, the population in northern Saratoga County aligns more closely with Warren county, but Saratoga County data is still included for comparison.

[8] In 2011, Governor Cuomo created 10 Regional Councils to develop long-term strategic plans for economic growth for their regions. Additional information about these councils is available at the NYS Regional Economic Development Councils website, http://regionalcouncils.ny.gov/

[9] Adapted from the Capital Region Economic Development Council website, http://regionalcouncils.ny.gov/content/capital-region

[10] See Saratoga County Economic Development Corporation at, http://www.saratogaedc.com/executivesummary.php;Warren County Economic Development Corporation at http://www.edcwc.org/regional.htm and Washington County Economic Development Corporation at http://www.wcldc.org/aboutwc.html

Geography

Warren, Washington and Saratoga counties cover over 2,500 square miles. The northern portion of Saratoga County that is included in the GFH services area includes the towns of South Glens Falls (12803), Gansevoort (12831) and Corinth (12822). In Saratoga County, these towns make up 139 (17%) square miles of the total 810 total square miles of Saratoga County. Warren, Washington and Saratoga Counties are bordered by Essex County to the north, Hamilton, Fulton and Montgomery Counties to the west, and Schenectady, Albany and Rensselaer Counties to the south. Major cities and towns within these three counties include Saratoga Springs, South Glens Falls, Fort Edward, Glens Falls, Lake Luzerne, and Queensbury. Many of the towns in the region are located right off of the Adirondack Northway (I-87), which runs from Albany, NY to the Canadian border.

Infrastructure and Services

Warren County[11]

Most of Warren County lies within the boundaries of the Adirondack State Park, which encompasses approximately 6 million acres. Warren County is home to more four-star resort destinations than anywhere in New York State, which are supported by countless entertainment venues offering music, theater, dance, visual arts, museums, and fine pubs and restaurants. Some of Warren County's largest attractions include Lake George, which offers a bustling village as well as year-round recreational activities, the Six Flags Great Escape theme park and Splashwater Kingdom water park, and the Fort William Henry Museum, a French & Indian War stronghold. Camping is another robust market with 36 different facilities in the county and nearly 5,000 campsites. Every year, the Adirondack Balloon Festival occurs in September, which is the oldest and largest balloon event on the East Coast. Glens Falls Hospital is the county's single largest employer with close to 3,000 employees, and hundreds of ancillary jobs that depend on the hospital for their existence. Finch Paper, also located in Glens Falls, employees an estimated 750 individuals, making it among the largest manufacturers in the 11-county Capital Region. Glens Falls is the headquarters of two major financial institutions: TD Banknorth New York and Glens Falls National Bank & Trust Company. Both full-service financial institutions have branches located throughout the county; and both rank in the top-ten of Capital Region banks, based on market share. Today, the Glens Falls MSA, which includes Warren County, is home to one of the state's largest clusters of medical/surgical instrument firms, including industry leaders CR Bard, and AngioDynamics.

Washington County[12]

Washington County is rural and agricultural in nature, with commercial and industrial development in and around the nine villages. While over one-third of the county's land is agricultural, manufacturing maintains a predominant role in the economy, as does agri-manufacturing, along with tourism becoming a viable industry. Washington County is one of New York State's leading dairy counties, with maple syrup and apples being important cash crops. The economic importance of agriculture in the county is over $200 million annually, which includes numerous ancillary businesses. The county is also home to manufacturers of medical instruments, paper making machinery, paper products, furniture and electronic components. Numerous slate quarries are in the northeastern part of the county (known as the Slate Capital of the World), yielding the world's only source of red slate. Today, residents and

[11] Adapted from the Warren County Economic Development Corporation website, http://www.edcwc.org/regional.htm

[12] Adapted from the Washington County Economic Development Corporation website, http://www.wcldc.org/aboutwc.html

tourists alike take advantage of numerous recreational opportunities, including downhill and cross country skiing, biking, boating, fishing, hiking and golfing.

Saratoga County[13]

Saratoga County is a thriving business community with fine dining and world-class entertainment. Saratoga Springs is home to the country's oldest and most beautiful thoroughbred race track, which is often considered to be the oldest sporting venue of any kind in the country. Within Saratoga County there is thoroughbred racing, harness racing, cross country skiing, downhill skiing, mineral water baths, numerous golf courses, stock car racing, polo, access to tennis, swimming, skating, horseback riding, and sailing, in addition to numerous private country clubs. There are three major public parks, and many lakes in the County with public access. There are 28 public libraries, in addition to the Skidmore College Library, which is also a Federal Depository. The New York City Ballet and the Philadelphia Orchestra visit the Saratoga Performing Arts Center annually. The major companies who are doing business in Saratoga County include Quad/Graphics, State Farm Insurance, Momentive Materials, Target; Cascades Paper Company; SCA Tissue, Stewart's Ice Cream; Ace Hardware; Sysco Food Services; and the Ball Corporation. GLOBALFOUNDRIES, a partnership between AMD and ATIC, broke ground on a $4.2 billion chip fab at the Luther Forest Technology Campus in the Town of Malta. Amtrak Railways operates a train station in Saratoga Springs, which offers rail service on a daily basis.

Health Care Facilities

There are two hospitals in the three county area, Glens Falls Hospital and Saratoga Hospital. Glens Falls Hospital and Hudson Headwaters Health Network (HHHN) are the two largest providers of primary care services in Warren, Washington and northern Saratoga counties. HHHN is a federally-qualified, not-for-profit system of community health centers serving residents and visitors in the upstate New York region. An estimated 317 full time equivalent primary care physicians are practicing in the three-county area.

Warren County

Warren County has one hospital, Glens Falls Hospital, located in Glens Falls. The hospital has 410 beds for a rate of 622.8 per 100,000 population, more than three times the rate of the ARHN region (204.5) and more than twice the Upstate New York rate (276.3). The county has 4 nursing homes and 4 adult care facilities with a total of 402 and 240 beds respectively.

There are almost 90 full time equivalent (FTE) primary care physicians practicing in Warren County, or 134.5 per 100,000 population, which is substantially higher than both the ARHN region (99.9) and Upstate New York (108.5) rates. There are 995 registered nurses, 370 licensed practical nurses, and 257 licensed physicians in the county. Slightly more than 35% of county residents were seen at a local community health center in 2011. Warren County has two primary care health professional shortage area designations.

[13] Adapted from the Saratoga County Economic Development Corporation website. http://www.saratogaedc.com/executivesummary.php,

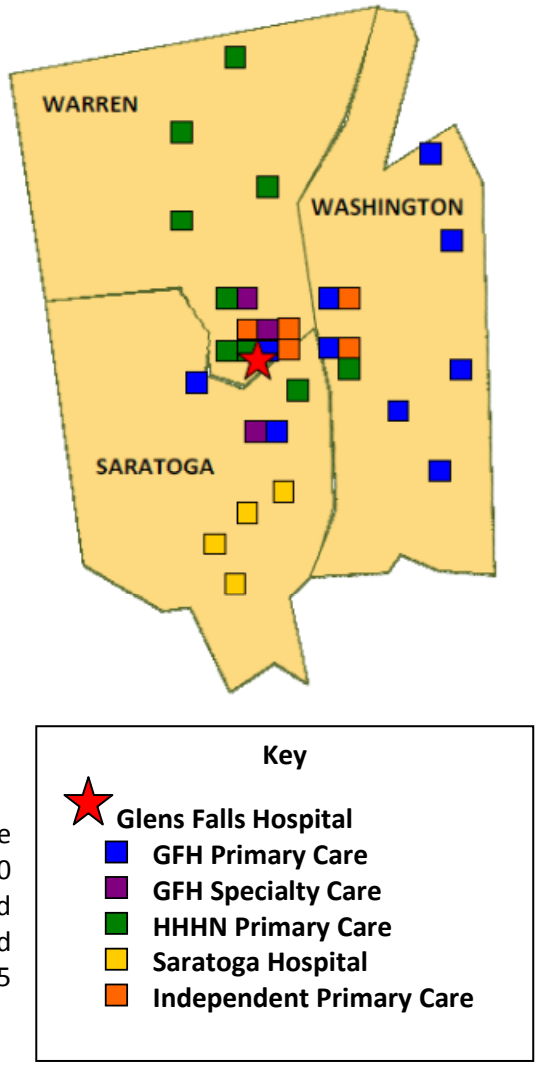
Washington County

Washington County does not have a hospital; it does have 4 nursing homes and 3 adult care facilities with a total of 528 and 102 beds respectively. There are nearly 37 full time equivalent (FTE) primary care physicians practicing in Washington County, or 57.7 per 100,000 population, which is substantially lower than the rates in both the ARHN region (99.9) and Upstate New York (108.5). There are 664 registered nurses, 459 licensed practical nurses, and 35 physicians licensed in the County. Washington County includes one primary care health professional shortage area designation.

Saratoga County

Saratoga County has one hospital, Saratoga Hospital, located in Saratoga Springs. The hospital has 171 beds for a rate of 77.4 per 100,000 population, substantially lower than the rates in the ARHN region (204.5) and Upstate New York (276.3). There are 4 nursing homes and 7 adult care facilities in the county with 789 beds and 306 beds respectively.

There are nearly 190 full time equivalent (FTE) primary care physicians practicing in Saratoga County, or 85.5 per 100,000 population, lower than both the ARHN region (99.9) and Upstate New York (108.5) rates. There are 3,280 registered nurses, 999 licensed practical nurses, 456 physicians, and 425 pharmacists licensed in Saratoga County.



Educational System

There are 32 public school districts in Warren, Washington and Saratoga Counties, with a total enrollment of approximately 54,700 students. Warren County has 9 school districts with a total enrollment of nearly 10,000. Washington County has 11 school districts with a total enrollment of nearly 9,300. Saratoga County has 12 school districts with a total enrollment of more than 35,400. In Saratoga County, 16% of enrolled students receive free or reduced lunches, compared to 30% in Warren County and 29% in Washington County. The high school dropout rate is 1.6% in Warren and Washington Counties and 1.1% in Saratoga County. These numbers are comparable to their respective rates in the ARHN region (29.3% free and reduced lunch and 1.7% dropout rate). There are 11.2 students per teacher in Warren County, 10.9 students per teacher in Washington County and 12.9 students per teacher in Saratoga County. The ARHN regional rate of students per teacher is 11.6 and the Upstate New York rate is 12.2.

Community Health Needs in Warren, Washington and Saratoga Counties

This section presents a comprehensive overview of the demographics and community health needs for residents of Warren, Washington and Saratoga Counties. The information below summarizes the data and information that informed the assessment in each county and for the GFH service area. In general, the information is presented by county because each county conducted independent assessments and

thus only looked at the data for their particular geography. However, where applicable, aggregate or average information across the counties is included to demonstrate community health needs for the GFH service area. In order to simplify the prioritization process, only select data was presented to the various partner groups in each county to provide context for the community health issues of each population.

Population and Demographics

The socio-demographic profile for the residents in Warren, Washington and Saratoga counties is shown in the table below.

	County			ARHN Region*	Upstate NYS	New York State
	Saratoga	Warren	Wash			
Square Miles						
Total Square Miles	810	867	831	9,182	46,824	47,126
Population per Square Mile	269.8	75.9	76.0	63.3	238.6	409.6
Population						
Total Population	218,520	65,767	63,174	581,120	11,173,468	19,302,448
% White, Non-Hispanic	92.9%	95.4%	93.3%	92.0%	77.0%	58.7%
% Black, Non-Hispanic	1.4%	0.9%	2.8%	2.4%	8.2%	14.5%
% Hispanic/Latino	2.4%	1.8%	2.3%	2.4%	9.4%	17.4%
% Asian/Pacific Islander, Non-Hispanic	1.6%	0.8%	0.5%	1.1%	3.4%	7.3%
% Alaskan Native/American Indian	0.2%	0.4%	0.1%	0.7%	0.3%	0.2%
% Multi-race/Other	1.7%	0.7%	0.9%	1.5%	1.7%	1.9%
Number Ages 0 - 4	12,113	3,303	3,268	30,359	636,529	1,158,007
Number Ages 5 - 17	37,897	10,361	10,045	94,311	1,935,757	3,189,602
Number Ages 18 - 64	139,108	41,071	40,219	371,862	6,994,924	12,363,940
Number Ages 65 Plus	29,402	11,032	9,642	84,588	1,606,258	2,590,899
Poverty						
Mean Household Income	$82,308	$67,353	$59,259	N/A	N/A	$82,699
Per Capita Income	$33,490	$28,939	$23,252	N/A	N/A	$31,796
% of Indiv. Under Fed Poverty Level	6.5%	10.7%	11.9%	10.9%	10.9%	14.5%
% of Indiv. Receiving Medicaid	10.7%	15.7%	18.1%	15.9%	16.3%	25.4%
Education						
% with Less than High School Education/GED	7.4%	9.4%	13.7%	11.6%	11.4%	15.4%
% High School Graduate/GED	28.2%	32.8%	42.1%	33.9%	29.7%	27.8%
% Some College, No Degree	17.4%	18.3%	17.5%	17.5%	17.4%	16.1%
% Associate Degree	11.6%	11.7%	9.8%	10.8%	9.8%	8.2%
% Bachelor's Degree	20.3%	16.2%	9.5%	14.9%	17.5%	18.5%
% Graduate/Professional Degree	15.1%	11.7%	7.4%	11.2%	14.2%	14.0%
Employment Status						
% Unemployed	6.7%	8.3%	7.6%	8.1%	7.7%	8.3%

Sources: American Community Survey, 2007 – 2011 and Bureau of Labor Statistics, Local Area Unemployment Statistics, 2011; *ARHN Region excludes Montgomery county

Over 347,000 people live within Warren, Washington and Saratoga counties. Within the GFH service area, there are approximately 71,737 people in the Core PSA, 38,259 in the Other PSA, and 46,134 in the SSA, for a total of 156,130 individuals. On average, the vast majority of the population is white, non-Hispanic (93.9%) and just over one in four people has obtained a Bachelor's degree or higher level of education (26.7%). Based on both inpatient and outpatient discharges from GFH for the first six months of 2013 (January – June), almost 60% of the GFH patient population is covered by Medicare (47%) or Medicaid (12%), 28% are covered by Blue Cross, Blue Shield, CDPHP or MVP, 8% have other commercial insurance, almost 3% are self-pay, just over 1% are workers compensation claims and less than 1% are through no-fault coverage.

Warren County

Warren County's population is nearly 66,000, making it the third most populous county in the ARHN region and the 38th most populous in the state. The population is neither racially nor ethnically diverse; over 95% of the population is White, Non-Hispanic, 1.4% is Black/African American, Non-Hispanic, and 2.4% is Hispanic/Latino. Nearly 17% of the population is 65 years of age and older, a higher percentage than in either the ARHN region (14.6%) or Upstate New York (14.3%) as a whole.

Mean household income in the county is $67,353 and per capita income is $28,939, both lower than the state-wide figures of $82,699 and $31,796 respectively.[14] The percentage of individuals in Warren County living below the Federal Poverty Level is 10.7%, comparable to the percentages in the ARHN region and Upstate New York (both 10.9%). The percentage of individuals receiving Medicaid in the county (15.7%) is also comparable to that of the ARHN region (15.9%) but slightly lower than Upstate New York (16.3%).

The highest level of education completed by 51% of the population ages 25 and older is a high school diploma or GED, and an additional 40% have an Associate's, Bachelor's, or Graduate/Professional degree. More than 63% of the population aged 16 and older is in the workforce. In 2011, Warren County's unemployment rate was 8.3%, higher than the rates in both the ARHN region (8.1%) and Upstate New York (7.7%). The largest employment sector in Warren County is health care and social assistance (17.2% of those employed), followed by arts, entertainment, recreation, hotel, and food service (13.2%) and retail trade (13.1%).

Washington County

Washington County's population is just over 63,000, making it the fourth most populous county in the ARHN region and the 41st most populous in the state. The population is neither racially nor ethnically diverse; over 93% of the population is White, Non-Hispanic, 2.8% is Black/African American, Non-Hispanic, and 2.3% is Hispanic/Latino. More than 15% of the population in Washington County is 65 years of age and older, slightly higher than in the ARHN region (14.6%) and Upstate New York (14.3%).

Mean household income in the county is $59,259 and per capita income is $23,252, both lower than the state-wide figures of $82,699 and $31,796 respectively. A higher percentage of individuals in Washington County live below the Federal Poverty Level (11.9%) than in the ARHN region or Upstate New York as a whole (both 10.9%). The percentage of individuals receiving Medicaid in Washington County (18.1%) is also higher than the ARHN region (15.9%) and Upstate New York (16.3%).

[14] Mean household income was determined by averaging the yearly income as reported by the American Community Survey, 2007-2011.

The highest level of education completed by 56% of the population ages 25 and older is a high school diploma or GED, and an additional 27% have an Associate's, Bachelor's, or Graduate/Professional degree. More than 62% of the population ages 16 and older is in the workforce. In 2011, Washington County had an unemployment rate of 7.6%, lower than the rates in both the ARHN region (8.1%) and Upstate New York (7.7%).The largest employment sector in Washington County is manufacturing (15.8%), followed by health care and social assistance (14.7%), retail trade (13.8%), and construction (10.0%).

Saratoga County

Saratoga County's population is nearly 220,000, making it the most populous county in the ARHN region and the 17th most populous in the state. Saratoga County is neither racially nor ethnically diverse; nearly 93% of the population is White, Non-Hispanic, 1.4% is Black/African American, Non-Hispanic, and 2.4% is Hispanic/Latino. Slightly more than 13% of the population is 65 years of age and older, a lower percentage than in either the ARHN region (14.6%) or Upstate New York (14.3%) as a whole.

Mean household income in the county is $82,308 and per capita income is $33,490, comparable to the state-wide figures of $82,699 and $31,796 respectively. A substantially lower percentage of individuals in Saratoga County live below the Federal Poverty Level (6.5%) than in the ARHN region or Upstate New York as a whole (both 10.9%).

The highest level of education completed by 46% of the population ages 25 and older is a high school diploma or GED, and an additional 47% have an Associate's, Bachelor's, or Graduate/Professional degree. Nearly 68% of the population 16 and older is in the workforce. In 2011, Saratoga County's unemployment rate was 6.7%, significantly lower than the rates in both the ARHN region (8.1%) and Upstate New York (7.7%). The largest employment sector in Saratoga County is health care and social assistance (13.5%), followed by education (12.6%), retail trade (11.1%), and other professional occupations (10.2%).

NYS Prevention Agenda Priority Areas

The NYS Prevention Agenda is used as a framework to discuss the community health needs related to each identified priority area. In general, each county CHAT reviewed available data to assess each priority area and to determine and the most significant health needs for the individuals and communities within the counties. For more information on the Priority Areas and corresponding Focus Areas, please see the Action Plans, available at: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017. See Appendix I for a table of the NYS Prevention Agenda indicators, Warren, Washington and Saratoga county rates and NYS benchmarks.

Promote a Healthy and Safe Environment

The NYS Prevention Agenda Priority Area of Promote a Healthy and Safe Environments includes four core Focus Areas that impact health. These are 1) water quality, 2) outdoor air quality, 3) built environment, and 4) injuries, violence and occupational health. 'Environment,' as used here, incorporates all dimensions of the physical environment that impact health and safety.[15] In general,

[15] Adapted from the Promote a Healthy and Safe Environment Action Plan for the NYS Prevention Agenda. Available at: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

water quality and outdoor air quality are not significant issues in Warren, Washington and northern Saratoga counties. While certain indicators for the built environment focus area are below the Prevention Agenda benchmarks, issues such as public transportation, climate smart communities and grocery store access are beyond the capacity and scope of expertise of the healthcare sector. Efforts to address these focus areas are better lead by policymakers, elected officials and other community stakeholders, through collaboration with and support of the healthcare sector. Consequently, the following outlines the status of injuries, violence and occupational health in Warren, Washington and Saratoga Counties:

Warren County

Falls and occupational injuries are a significant challenge for Warren County residents. The rate of emergency department (ED) visits due to falls for children ages 1 to 4 per 10,000 population (660.6) was higher than the ARHN region (515.5) and Upstate New York (511.9) rates and significantly worse than the Prevention Agenda benchmark of 429.1 per 10,000 population. The rate of hospitalizations due to falls for adults ages 65 and above (257.0 per 10,000 population) was higher than the rates for both the ARHN region (208.4) and Upstate New York (215.8) as well as the Prevention Agenda benchmark of 204.6. The rates of hospitalizations for falls for all other age groups were higher than their respective ARHN rates and all but one were higher than their respective Upstate New York rates.

The rate of ED occupational injury visits for working adolescents ages 15 to 19 per 10,000 population (56.5) was slightly higher than the ARHN region (56.1) and Upstate New York (51.8) rates but substantially higher than the Prevention Agenda benchmark of 33.0 per 10,000. The rate of malignant mesothelioma cases per 100,000 population ages 15 and older (1.8) and the rates of pneumoconiosis and asbestosis hospitalizations per 10,000 population ages 15 and older (2.8 and 59.9, respectively) were all higher than their respective ARHN (1.5, 1.8 and 4.8) and Upstate New York rates (1.7, 1.9 and 2.1). The rate of work-related hospitalizations for those employed, ages 16 and older, per 10,000 population (23.7) was also higher than that of the ARHN region (19.1) and Upstate New York (21.1).

Washington County

Falls and occupational injuries are also a challenge for Washington County. The rate of emergency department (ED) visits due to falls for children ages 1 to 4 per 10,000 population (505.0) is lower than the ARHN region (515.5) and Upstate New York (511.9) rates but worse than the Prevention Agenda benchmark of 429.1 per 10,000 population. The rate of hospitalizations due to falls for adults ages 65 and above (218.9 per 10,000 population) was higher than the rates for both the ARHN region (208.4) and Upstate New York (215.8) as well as the Prevention Agenda benchmark of 204.6.

The following rates were all above their respective Upstate New York rates:

- malignant mesothelioma cases per 100,000, ages 15 and above (1.9 per 100,000 compared to 1.7 for Upstate NY);
- pneumoconiosis hospitalizations per 10,000, ages 15 above (2.1 compared to 1.4 for Upstate NY);
- asbestosis hospitalizations per 10,000, ages 15 and above (2.3 compared to 2.1 for Upstate NY) ; and
- work-related hospitalizations per 10,000, ages 16 and above (22.4 compared to 21.1 for Upstate NY).

The rate of ED visits for occupational injuries for working adolescents ages 15 to 19 per 10,000 population was lower (51.1) than both the ARHN region (56.1) and Upstate New York (51.8) rates but higher than the Prevention Agenda benchmark of 33.0 per 10,000. Additionally, the rate of elevated

blood lead levels for those employed per 10,000 population ages 16 and above was higher (3.0) than both the ARHN (2.6) and Upstate New York rates (2.4).

Saratoga County

In general, falls are not a significant issue in Saratoga County as the rates of hospitalizations due to falls for age 65 plus and ED visits due to falls for children ages 1 to 4 are lower (better) than the Prevention Agenda benchmark. Occupational injuries and hospitalizations are a challenge for Saratoga County. The rate of ED occupational injury visits among working adolescents ages 15 to 19 per 10,000 population (57.9) was substantially higher than the Prevention Agenda benchmark of 33.0. Additionally, the rate of asbestosis hospitalizations ages 15 and older (8.4) and the rate of work-related hospitalizations ages 16 and older (21.8) per 10,000 population were higher than the respective rates for both the ARHN region (4.8 and 19.1) and Upstate New York (2.1 and 21.1). Finally, the rate of speed-related accidents in Saratoga County per 100,000 population was higher (266.1) than the Upstate New York rate of 225.1, though lower than the ARHN rate of 310.9.

Prevent Chronic Disease

Chronic diseases such as cancer, diabetes, heart disease, stroke and asthma are conditions of long duration and generally slow progression. Chronic diseases are among the leading causes of death, disability and rising health care costs in New York State (NYS). In Warren, Washington and Saratoga counties, cancer is the leading cause of premature death, followed by heart disease. See Appendix J for the leading causes of premature death in each county. However, chronic diseases are also among the most preventable. Three modifiable risk behaviors – lack of physical activity, unhealthy nutrition, and tobacco use – are largely responsible for the incidence, severity and adverse outcomes of chronic disease. The three Focus Areas identified by the NYS Prevention Agenda are 1) Reduce obesity in children and adults, 2) Reduce Illness, disability and death related to tobacco use and secondhand smoke exposure and 3) Increase access to high quality chronic disease preventive care management in both clinical and community settings.[16] The following outlines the status of this Priority Area in Warren, Washington and Saratoga counties:

Warren County

Obesity and smoking rates are high in Warren County. Nearly 28% of adults in Warren County are obese, higher than the Prevention Agenda benchmark of 23.2%. Additionally, nearly one in five public school children are obese, also higher than the Prevention Agenda benchmark of 16.7%. More than 30% of age-adjusted adults have ever been diagnosed with high blood pressure, higher than the New York State rate of nearly 26%. Likewise, 9.3% of age-adjusted adults in the county were diagnosed with angina, heart attack, or stroke compared to 7.6% statewide. Nearly 21% of adults smoke, slightly more than in the ARHN region (21.1%) or Upstate New York (18.5%) and higher than the Prevention Agenda benchmark of 15.0%. Overall asthma hospitalizations per 10,000 population and for individual age groups in Warren County were all higher than their respective ARHN and Upstate New York rates.

With respect to diabetes, the most recent data from 2009 indicates that 9.8% of Warren County residents have been diagnosed with diabetes, compared to 9.0% for NYS and 8.5% for NYS excluding

[16] Adapted from the Preventing Chronic Diseases Action Plan for the NYS Prevention Agenda. Available at: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

NYC.[17] The rate of short-term diabetes hospitalizations for ages 18 and older (3.5 per 10,000) is better than the Prevention Agenda benchmark of 4.86, but the rate for the 6-17 year old population (7.8 per 10,000) is significantly worse than the Prevention Agenda benchmark (3.06 per 10,000). In addition, the rates of diabetes hospitalizations (16.3 per 10,000 – primary diagnosis; 270.4 per 10,000 – any diagnosis) are worse than the Upstate NY averages (15.5 per 10,000 and 228.9 per 10,000 respectively).

In Warren County, it is estimated that 9 individuals are diagnosed with cancer each week, and 3 individuals will die from cancer each week.[18] The annual incidence rate has increased 11.2% since 1995-1999, while the annual mortality rate has decreased 11.6%. For 2005-2009, there were an average of 547.0 cases per 100,000 people per year, and an average of 192.7 deaths per 100,000 people per year for this same time period.[19] The rates of lung and bronchus deaths and cases, as well as the rates of lower chronic respiratory disease deaths and cases, were higher than their respective ARHN and Upstate New York rates per 100,000 population. Four cancer sites (lung & bronchus, prostate, female breast, and colorectal) represent 51.8% of all new cancer cases and 47.0% of all new cancer deaths in Warren County.

Washington County

Obesity and smoking rates are also high in Washington County. Nearly 29% of adults are obese, substantially higher than the Prevention Agenda benchmark of 23.2%. Additionally, slightly more than one in five public school children are obese, also higher than the Prevention Agenda benchmark of 16.7%. Nearly 30% of age-adjusted adults have ever been diagnosed with high blood pressure, higher than the New York State rate of approximately 26%. Slightly more than 23% of adults smoke, higher than the percentages in the ARHN region (21.1%) or Upstate New York (18.5%), and significantly higher than the Prevention Agenda benchmark of 15.0%. Overall asthma hospitalizations per 10,000 population and for individual age groups in Washington County were all higher than their respective ARHN and Upstate New York rates.

The most recent data for Washington County indicates that 8.1% of the population has been diagnosed with diabetes, compared to 9.0% for NYS and 8.5% for NYS excluding NYC.[20] Rates of diabetes deaths per 100,000 population were significantly higher in the county (27.5) compared to rates in the ARHN region (17.8) and Upstate New York (17.7). The rate of diabetes hospitalizations (any diagnosis) per 10,000 was also higher in Washington County (254.7) compared to the ARHN region (228.1), Upstate NY (228.9) or NYS (248.7). Short-term diabetes hospitalization rates for the 6-17 year old population (7.0 per 10,000) is significantly worse than the Prevention Agenda benchmark of 4.86 per 10,000, but the county rate for ages 18 and older (3.0) was better than the benchmark of 4.86 per 10,000.

In Washington County, it is estimated that 8 individuals are diagnosed with cancer each week, and 3 individuals will die from cancer each week[21]. The annual incidence rate has increased 7.2% since 1995-1999, while the annual mortality rate has decreased 10.9%. For 2005-2009, there were an average of

[17] NYS Expanded Behavioral Risk Factor Surveillance System, July 2008 – June 2009, Prevention Agenda Report – Warren County. Available at http://www.health.ny.gov/statistics/brfss/expanded/2009/prevention_agenda/county/docs/warren.pdf

[18] NYS Cancer Burden Profiles for Saratoga County, 2012.

[19] NYS Cancer Burden Profiles for Saratoga County, 2012.

[20] NYS Expanded Behavioral Risk Factor Surveillance System, July 2008 – June 2009, Prevention Agenda Report – Washington County. Available at http://www.health.ny.gov/statistics/brfss/expanded/2009/prevention_agenda/county/docs/washington.pdf

[21] NYS Cancer Burden Profiles for Washington County, 2012.

544.6 cases per 100,000 people per year, and an average of 193.7 deaths per 100,000 people per year for this same time period.[22] The rates of lung and bronchus deaths and cases, as well as the rates of lower chronic respiratory disease deaths and cases, were higher than their respective ARHN region and Upstate New York rates per 100,000 population. Four cancer sites (lung & bronchus, prostate, female breast, and colorectal) represent 53.9% of all new cancer cases and 52.2% of all new cancer deaths in Washington County.

Saratoga County

Nearly 29% of adults in Saratoga County are obese, higher than the Prevention Agenda benchmark of 23.2%. Additionally, both the percentage of age-adjusted adults ever diagnosed with high blood pressure and the percentage of age-adjusted adults with a physician diagnosis of angina, heart attack, or stroke were higher than their respective Upstate New York percentages. An estimated 17% of county adults smoke, slightly higher than the Prevention Agenda benchmark of 15.0%.

The prevalence of diabetes in Saratoga County falls between Warren and Washington County at 8.4%.[23] With respect to diabetes hospitalizations, Saratoga County is similar to Warren and Washington counties, with a rate of short-term diabetes hospitalizations for ages 6-17 (3.8 per 10,000) that is worse than the Prevention Agenda benchmark of 3.06 per 10,000. The rate of short-term diabetes hospitalizations for ages 18 and older is better than the benchmark, as well as the rates of diabetes deaths and diabetes hospitalizations (primary and any diagnosis).

In Saratoga County, it is estimated that 24 individuals are diagnosed with cancer each week, and 8 individuals will die from cancer each week[24]. The annual incidence rate has increased 8.2% since 1995-1999, while the annual mortality rate has decreased 9.0%. For 2005-2009, there were an average of 527.5 cases per 100,000 people per year, and an average of 184.5 deaths per 100,000 people per year for this same time period.[25] The rates of lung and bronchus cases and deaths per 100,000 population was slightly higher than their respective Upstate New York rates but lower than the rates for the ARHN as a whole. Both the rates of death for female breast cancer and ovarian cancer per 100,000 female population were higher than their respective rates in the ARHN region and in Upstate New York. Four cancer sites (lung & bronchus, prostate, female breast, and colorectal) represent 52.6% of all new cancer cases and 48.7% of all new cancer deaths in Saratoga County.

Warren and Washington County Nutrition Assessment

Lastly, the results of the nutrition assessment can also inform the community health needs related chronic disease prevention. The focus groups were primarily used to inform the development of the survey questions. A full report will be available later in the year; highlights from the results of the assessment to date are summarized below:

- Seventy-nine percent (79%) of respondents do some grocery shopping for themselves or their households. Two-thirds of these respondents shop at least once a week.

[22] NYS Cancer Burden Profiles for Washington County, 2012.

[23] NYS Expanded Behavioral Risk Factor Surveillance System, July 2008 – June 2009, Prevention Agenda Report – Saratoga County. Available at http://www.health.ny.gov/statistics/brfss/expanded/2009/prevention_agenda/county/docs/saratoga.pdf

[24] NYS Cancer Burden Profiles for Saratoga County, 2012.

[25] NYS Cancer Burden Profiles for Saratoga County, 2012.

- The majority of respondents ate food prepared at home five or more days per week, and almost three-quarters ate dinner at home five or more nights per week
- Smaller percentages included a fruit or vegetable in each meal five or more days per week.

Percent of meals frequently prepared at home and meals that frequently include vegetables (N=322)

Meal	Meal prepared at home at least 5 days last week	Meal included a vegetable at least 5 days last week	Meal included a fruit at least 5 days last week
Breakfast	52%	7%	23%
Lunch	59%	24%	19%
Dinner	74%	60%	14%

- Perishability was the most frequently cited barrier to eating produce, with cost a close second.

Barriers to eating vegetables and fruits (N=322)

Barrier	Barrier to eating vegetables	Barrier to eating fruits
Perishability	29%	35%
Cost	22%	26%
Other household members will not eat	11%	5%
Taste	9%	5%
Preferred produce not available locally	5%	3%
Difficult to prepare	5%	.3%
Don't know how to prepare	3%	.3%
No barriers	40%	40%

(Participants could provide multiple responses so totals equal more than 100%.)

- When asked what might help participants eat more produce, lower prices were by far the most common response (59%), and other cost-saving measures such as farmer's market coupons (17%), veggie mobiles that sell discounted produce in areas without good access to fresh fruits and vegetables (12%), and discounted produce boxes (10%) were fairly popular options.

Promote Healthy Women, Infants and Children

The health and well-being of mothers and children are fundamental to overall population health. Improving health outcomes for women, infants and children is a priority for NYS, aligning with goals of the State's Medicaid program and Title V/Maternal Child Health Services Block Grant. Of great concern, New York's key population indicators of maternal and child health have been stagnant or worsened during the last decade. The three Focus Areas for this Priority Area are 1) Maternal & Infant Health, 2) Preconception & Reproductive Health, and 3) Child Health.[26] There are 24 indicators for this particular Priority Area, so only the most significant information is highlighted to demonstrate need. The following outlines the status of this Priority Area in Warren, Washington and Saratoga Counties:

[26] Adapted from the Promote Healthy Women, Infants and Children Action Plan for the NYS Prevention Agenda. Available at: http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Warren County
With respect to maternal and infant health, the percentage of infants exclusively breastfed in the hospital is better than the ARHN rate, NYS rate and Prevention Agenda benchmark. When comparing the Warren County rates of infants exclusively breastfed in the hospital for Medicaid and Non-Medicaid populations, the Warren County rate of .8 is worse than the Prevention Agenda benchmark of 0.66. This highlights the need to focus on low-income populations. Other indicators that are worse than the Prevention Agenda benchmark include the percentage of preterm births less than 37 weeks and the ratio of preterm births Medicaid to Non-Medicaid. Most of the indicators related to racial and ethnic disparities for maternal and infant health have very small or even unreportable rates due to the demographics in this region.

With respect to preconception and reproductive health, the percent of births within 24 months of a previous pregnancy, the percent of unintended births to total births, and the percentage of women ages 18-64 with health insurance are all worse in Warren County than the Prevention Agenda benchmark. Those indicators that are better than the benchmark include rate of pregnancies ages 15-17, including the ratio of Black to White and Hispanic to White, as well as the ratio of unintended births for the Medicaid versus non-Medicaid populations.

In the area of child health, Warren County is doing better than the Prevention Agenda benchmark for the percentage of children ages 0-15 months and 3-6 years with government insurance with recommended well visits. The percentage of children ages 12-21 years with government insurance with recommended well visits is worse than the benchmark, in addition to the percentage of children ages 0-19 with health insurance. Warren County is also doing better than the benchmark for indicators related to untreated tooth decay. The rate of unintentional injury hospitalizations for children under age 10 per 10,000 population and for individuals ages 15 to 24 per 10,000 population were higher than their respective ARHN region and Upstate New York rates. Additionally, the percentages of children screened for lead by age 9 months, by age 18 months, and with two screenings by age 36 months were lower in Warren County than in Upstate New York.

Washington County
Similar to Warren County, the percentage of infants exclusively breastfed in the hospital for Washington County residents is also better than the ARHN rate, NYS rate and Prevention Agenda benchmark. When comparing the Washington County rate of infants exclusively breastfed in the hospital for Medicaid and Non-Medicaid populations, the Washington County rate of 0.9 is worse than the Prevention Agenda benchmark of 0.66. Again, the need to focus on low-income populations is evident given these disparities. The ratio of preterm births for the Medicaid population compared to the non-Medicaid population (1.21) is also worse than the Prevention Agenda benchmark of 1.00. As in Warren County, most of the indicators related to racial and ethnic disparities for maternal and infant health in Washington County have very small sample sizes, or even unreportable rates, due to the demographics in this region.

With respect to preconception and reproductive health, the status of the Prevention Agenda indicators for Washington County align with the status in Warren County, except that the ratio of unintended births in the Medicaid population compared to the non-Medicaid population is worse than the benchmark. In addition, the rates of birth per 1,000 females to teenagers ages 15 to 17 and 18 to 19 in Washington County were higher than those in the ARHN region or Upstate New York, particularly births to women ages 18 and 19 (67.8 per 1,000 females in the County compared to 35.4 in Upstate New York). Pregnant women receiving WIC had higher rates of pre-pregnancy obesity, gestational weight gain

greater than the ideal, gestational diabetes, and gestational hypertension than comparable populations in New York.

In the area of child health, Washington County also mirrors Warren County with respect to the Prevention Agenda benchmarks, except for the percentage of 3rd graders with untreated tooth decay, which is worse than the Prevention Agenda benchmark. The percentages of children screened for lead by age 9 months, by age 18 months, and with two screenings by age 36 months were lower in Washington County than their respective Upstate New York percentages. Additionally, the rate of children younger than 6 with confirmed blood lead levels greater than or equal to 10 mg/dl per 1,000 children tested was higher than both the ARHN and Upstate New York rates.

Saratoga County

Saratoga County is somewhat different than Warren and Washington Counties when reviewing health status related to the three focus area. With respect to maternal and infant health, Saratoga County is worse on almost all the indicators when compared to the benchmark, except for the ratio of preterm births for the Hispanic/Latino population as compared to White, and the percentage of infants exclusively breastfed in the hospital. With respect to preconception and reproductive health, Saratoga County is doing better than the Prevention Agenda benchmark for the indicators related to rate of pregnancies for females ages 15-17 as well as the ratio of pregnancy rates for Black to White populations and Hispanic/Latino to White populations. In addition, the percent of unintended births to total births, including the ratio of Hispanic/Latino to White, in Saratoga County is better than the benchmarks. The percent for births within 24 months of previous pregnancy, ratio of unintended births for Black populations compared to White populations and Medicaid to non-Medicaid population, as well as the percentage of women ages 18-64 with health insurance are all worse than the benchmark in Saratoga County. Pregnant women receiving WIC had higher rates of pre-pregnancy obesity, gestational weight gain greater than the ideal, gestational diabetes, and gestational hypertension than comparable populations in New York.

Children's health issues are also a concern. Saratoga County is doing better than the Prevention Agenda benchmark for the percentage of children ages 0-15 months and 3-6 years with government insurance with recommended well visits. The percentage of children ages 12-21 years with government insurance with recommended well visits is worse than the benchmark, as well as the percentage of children ages 0-19 with health insurance and the indicators related to untreated tooth decay. Overall, the mortality rate for children ages 1 to 19 per 100,000 population in Saratoga County (25.1) was higher than the rate for Upstate New York (21.8) as was the mortality rate for the specific age ranges of 1 to 4 and 5 to 14. Additionally, the percentages of children screened for lead by age 9 months, by age 18 months, and with two screenings by age 36 months were lower in Saratoga County than in Upstate New York but higher than in the ARHN region.

Prevent HIV/STDs, Vaccine Preventable Diseases & Healthcare-Associated Infections

HIV/AIDS, sexually transmitted diseases (STDs) and hepatitis C (HCV) are significant public health concerns. New York State (NYS) remains at the epicenter of the HIV epidemic in the country, ranking first in the number of persons living with HIV/AIDS.

Immunization is one of the most successful and safest public health strategies for preventing communicable diseases. High immunization rates have reduced vaccine-preventable disease (VPD) to

extremely low levels in the United States. In New York State (NYS), high immunization levels are achieved by the time children reach school age and are supported by school entry laws. However, the immunization rates of very young children, 19-35 months of age, are still below the Healthy People 2020 goal of 80 percent.

According to the federal Centers for Disease Control and Prevention (CDC), in 2002 there were an estimated 1.7 million health care-associated infections and 99,000 deaths from those infections. Many health care-associated infections are preventable. The focus in NYS is on CDIs, MDROs, and device-associated infections (CLABSIs and CAUTIs). The four Focus Areas for this Priority Area are 1) Human Immunodeficiency Virus, 2) Sexually Transmitted Diseases, 3) Vaccine Preventable Disease and 4) Healthcare Associated Infections.[27] The following outlines the status of this Priority Area in Warren, Washington and Saratoga Counties:

Warren County
Overall, Warren County rates for indicators in the areas of HIV, STDs, and healthcare associated infections are better than the Prevention Agenda benchmarks. However, it is important to note that the rate of Chlamydia cases continues to rise, especially in young females 15-24 years of age. The biggest challenge is in the area of vaccine-preventable disease. The percentage of children ages 19 to 35 months with the appropriate immunization series[28] in the County (58.2%) was lower than the Prevention Agenda benchmark of 80%. Additionally, the percentage of females ages 13 to 17 with the 3 dose HPV vaccine (38.6%) is significantly lower than the Prevention Agenda benchmark of 50%.

Washington County
Overall, Washington County rates for indicators in the areas of HIV, STDs, and healthcare associated infections are also better than the Prevention Agenda benchmarks and the biggest challenge is also in the area of vaccine-preventable disease. The percentage of children ages 19 to 35 months with the appropriate immunization series in the county (58.3%) was lower than the Prevention Agenda benchmark of 80%. Additionally, the percentage of females ages 13 to 17 with the 3 dose HPV vaccine (34.2%) was also lower than the Prevention Agenda benchmark of 50%, as well as the percent of adults ages 65 and older with a flu shot in the past year (74%), compared to the benchmark of 75.1%.

Saratoga County
Saratoga County is also the same as Warren and Washington Counties with respect to HIV, STDs and healthcare associated infections. Rates of vaccine preventable diseases are also the biggest challenge in Saratoga County. The percentage of children ages 19 to 35 months with the appropriate immunization series was lower (62.3%) than the Prevention Agenda benchmark of 80%. Additionally, the percentage of females ages 13 to 17 with the 3 dose HPV vaccine (33.4%) was lower than the Prevention Agenda benchmark of 50%. The rate of pertussis cases per 100,000 population in Saratoga County (7.3) was higher than the rates for both the ARHN region and Upstate New York. Finally, the percentage of adults in Saratoga County ages 65 and older with flu shots within the last year (70.1%) was lower than the Prevention Agenda benchmark (75.1%).

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[27] Adapted from the Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infection Action Plan for the NYS Prevention Agenda, available at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017

[28] The number of children (ages 19-35 months) per 100 population who received their 4:3:1:3:3:1:4 immunization series (4 DTaP, 3 polio, 1 MMR, 3 hep B, 3 Hib, 1 varicella, 4 PCV13).

Substance Abuse and Other Mental, Emotional and Behavioral Disorders

Mental and emotional well being is essential to overall health. At any given time, almost one in five young people nationally are affected by mental, emotional and behavioral (MEB) disorders, including conduct disorders, depression and substance abuse. The best opportunities to improve the public's mental health are interventions delivered before a disorder manifests itself, to prevent its development. Many MEB disorders, such as substance abuse and depression, have lifelong effects that include high psychosocial and economic costs for people, their families, schools and communities. The three Focus Areas for this Priority Area are: 1) Promote Mental, Emotional and Behavioral Health, 2) Prevent Substance Abuse and Other Mental, Emotional, and Behavioral Disorders, and 3) Strengthen Infrastructure Across Systems. The following outlines the status of this Priority Area in Warren, Washington and Saratoga Counties:

Warren County

Warren County rates for the Prevention Agenda indicators are all worse than the benchmark, including the percent of adults binge drinking in the last month and the percent of adults with poor mental health. The rate of age-adjusted suicides per 100,000 population (12.0) as well as the overall rate of self-inflicted hospitalizations per 10,000 population (12.6) in Warren County were significantly higher than their respective rates in the ARHN region (10.0, 9.1 respectively) or in Upstate New York (8.0, 6.1 respectively), with the overall number of suicides trending upward. Additionally, the rate of self-inflicted hospitalizations per 10,000 population for ages 15 to 19 (27.5) was more than double the Upstate New York rate (11.0) and nearly 40% higher than the ARHN rate (20.3).

Washington County

Washington County rates for the percent of adults with poor mental health in the last month (10%) is better than the benchmark of 10.1%. The rates of age-adjusted suicides per 100,000 population (13.0) and of self-inflicted hospitalizations per 10,000 population (11.8) in Washington County were significantly higher than their respective rates in the ARHN region (10.0, 9.1 respectively) or in Upstate New York (8.0, 6.1 respectively). Additionally, the rate of self-inflicted hospitalizations for ages 15 to 19 per 10,000 population (30.2) was more than double the Upstate New York rate (11.0) and nearly 50% higher than the ARHN rate (20.3).

The percentage of adults binge drinking in the past month is 21.1%, compared to the benchmark of 17.6%. The rates of alcohol-related accidents (88.5) and injuries and deaths (57.7) per 100,000 population were worse than their respective Upstate New York rates. The rate of children served in mental health outpatient settings per 100,000 population for ages 8 and under and for ages 9 to 17 were substantially higher than their respective ARHN region and Upstate New York rates.

Saratoga County

Saratoga County rates for the percent of adults with poor mental health in the last month (9.9%) is also better than the benchmark of 10.1%. The rate of age-adjusted suicides per 100,000 population(8.5), the overall rate of self-inflicted hospitalizations per 10,000 population (6.3), and the rate of self-inflicted hospitalizations for ages 15 to 19 (12.8) in Saratoga County were higher than their respective rates in Upstate New York. The rate of alcohol-related accidents (89.1) and the rate of alcohol-related injuries and deaths (55.1) per 100,000 were worse than their respective Upstate New York rates, and the percent of adults binge drinking within the last month (20.1%) was worse than the benchmark of 17.6%.

Health Disparities and Barriers to Care

Improving health status in the five priority areas and reducing racial, ethnic, socioeconomic and other health disparities including those among persons with disabilities is an overarching goal of the NYS Prevention Agenda. The National Institutes of Health defines health disparities as the differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. Warren, Washington and Saratoga counties are predominately White and do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations in upstate New York face a unique combination of factors that create health disparities, which are often rooted in the social determinants of health. The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness.[29] These factors are often associated with many different types of barriers to care.

Economic factors, cultural and social differences, educational shortcomings, and the isolation of living in a rural area all conspire to repress this population in their struggle to lead a healthy life. Many sections of the region face significant distance and transportation barriers to accessing community resources, service opportunities, and health care. These communities are traditionally underserved by most assistance programs; thereby creating health disparities among the people living and working in this area.

Limited data publically exists to demonstrate non-racial or non-ethnic related health disparities in Warren, Washington and northern Saratoga counties. Mean household income can shed light on economic disparities in the GFH service area. In Warren and Washington counties, the mean household income is $67,353 and $59,259 respectively, compared to the NYS average of $82,699. Another notable factor is the relatively low level of achievement in higher education in Washington County, where only 27% of the population age 25 and older has an Associate's, Bachelor's, or Graduate/Professional degree, compared to almost 41% of the NYS population. The relationship between socioeconomic status and better health outcomes is well established, leaving this geographic region at a disadvantage.

Additional insight into barriers to care and resulting health disparities was collected through the nutrition assessment conducted in Warren and Washington counties. In addition to asking about barriers to healthy eating, the survey also collected information on general barriers to good health and health care. Cost and lack of insurance (which is highly relevant to cost) were most frequently perceived as the biggest barriers to health care.

What are the biggest barriers to health care in your community?

Barrier	Percent (N=322)
Cost	51%
Lack of insurance	27%
Transportation/ distance	9%
Other	8%
Difficulty accessing primary care	7%
Individual lack of knowledge or responsibility	6%
Time	4%

(Participants could provide multiple responses so total equals more than 100%.)

[29] Adapted from the Centers for Disease Control and Prevention, Social Determinants of Health website, http://www.cdc.gov/socialdeterminants/

Lastly, the NYS Prevention Agenda utilizes indicators related to premature death, preventable hospitalizations, insurance status and access to care (through % of adults with a regular health care provider) to track progress related to health disparities. The following table outlines the status of these indicators for Warren, Washington and Saratoga Counties:

NYS Prevention Agenda Indicators: Disparities							
				Comparison Regions/Data			
	Warren	Washington	Saratoga	ARHN	Upstate NY	New York State	2017 Prevention Agenda Benchmark
1. Percentage of Overall Premature Deaths (Ages 35 - 64), '08 - 10	20.3%	22.0%	22.1%	22.3%	22.0%	24.3%	**21.8%**
2. Ratio of Black, Non-Hispanic Premature Deaths (Ages 35 - 64) to White, Non-Hispanic Premature Deaths, '08 - 10	N/A	2.92	2.61	N/A	N/A	2.13	**1.87**
3. Ratio of Hispanic/Latino Premature Deaths (Ages 35 - 64) to White, Non-Hispanic Premature Deaths, '08 - 10	N/A	N/A	N/A	N/A	N/A	2.14	**1.86**
4. Rate of Adult Age-Adjusted Preventable Hospitalizations per 100,000 Population (Ages 18 Plus), '08 - 10	144.7	139.1	113.3	147.3	138.9	155.0	**133.3**
5. Ratio of Black, Non-Hispanic Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '08 - 10	1.00	0.32	1.23	N/A	N/A	2.09	**1.85**
6. Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '08 - 10	0.43	0.26	0.29	N/A	N/A	1.46	**1.38**
7. Percentage of Adults (Ages 18 - 64) with Health Insurance, '08/09	85.6%	83.6%	81.2%	83.2%	85.7%	83.1%	**100.0%**
8. Percentage of Adults with Regular Health Care Provider, '08/09	89.4%	81.8%	92.4%	86.6%	N/A	83.0%	**90.8%**

N/A = insufficient data is available to report on this indicator

Overall, the indicators for Warren, Washington and Saratoga Counties reveal limited health disparities as defined by the NYS Prevention Agenda. As demonstrated above, often times there is insufficient data to report on racial and ethnic disparities. With respect to the benchmarks, the areas where there is room for improvement within the GFH service area include overall premature death (Washington and Saratoga counties), rate of black, non-Hispanic premature deaths to white, non-Hispanic premature deaths (Washington and Saratoga counties), and preventable hospitalizations (Warren and Washington counties). Preventable hospitalizations are defined by admission to the hospital for conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. Lastly, all three counties are below the benchmark for health insurance coverage, and Warren and Washington counties are below the benchmark for adults with a regular health care provider. These indicators can provide initial

information about potential problems in a community that may require further, more in-depth analysis.[30]

Cancer Burden Disparities in Warren, Washington and Saratoga Counties

Opportunities exist to reduce cancer risk and prevent some cancers for all population groups. Cancer risk can be reduced by avoiding tobacco, limiting alcohol use, limiting exposure to ultraviolet rays from the sun and tanning beds, eating a diet rich in fruits and vegetables, maintaining a healthy weight, being physically active, and seeking regular medical care.[31] Data demonstrating many of these health behaviors is described throughout this report. However, certain populations are disproportionately affected by the burden of cancer, and these populations are faced with many of the same challenges described above. These challenges often result in lower screening rates, and higher rates of cancer incidence and mortality.

In Warren, Washington and Saratoga counties, cancer-related disparities exist based on geography, gender and income status. Geographic disparities are most notable when comparing screening rates in each of the counties for certain types of cancers. On average, four cancer sites (lung & bronchus, prostate, breast and colorectal) represent 52.8% of all new cancer cases and 49.3% of all new cancer deaths in Warren, Washington and Saratoga Counties.[32] For these types of cancer, screening can prevent the disease, or help find cancers at an early stage, when they are more easily cured or treated.

Understanding the state at which these types of cancers are detected is critically important for the purposes of understanding community health needs. The table below outlines the percent of colorectal, breast and prostate cancer cases detected at early stage in each county:

Cancer Site	Warren County	Washington County	Saratoga County	NYS excluding NYC
Colorectal – Male	33.7%	43.9%	47.7%	46.0%
Colorectal – Female	31.6%	34.3%	40.5%	44.2%
Female Breast	71.0%	65.4%	66.8%	65.3%
Prostate	91.8%	92.4%	86.3%	86.7%

Source: NYS DOH, State Cancer Registry, 2012

When comparing the three counties, the greatest opportunity to improve screening for colorectal cancer is in Warren County, where the lowest percentage of colorectal cancer cases (33.7% colorectal - male and 31.6% colorectal -female) were detected at an early stage, which is also below the NYS average. The greatest opportunity to improve breast cancer screening is in Washington County, although the percentage of breast cancer cases detected at an early stage (65.4%) is just above the NYS average of 65.3%. Saratoga County had the lowest percentage of prostate cancer cases detected at an early stage, which was just below the NYS average of 86.7%.

[30] Excerpt from the NYS Department of Health Prevention Quality Indicators. Available at https://apps.health.ny.gov/statistics/prevention/quality_indicators/start.map;jsessionid=E8099B7DE3ABA2B446B8D586723C2A3D

[31] Centers for Disease Control and Prevention, Chronic Disease Prevention and Health Promotion, Cancer website, http://www.cdc.gov/chronicdisease/resources/publications/AAG/dcpc.htm

[32] NYS Cancer Burden Profiles for Warren, Washington and Saratoga Counties, 2012.

Additional geographic disparities exist specific to lung and bronchus cancer and the disproportionately high mortality rates in this area. On average, lung and bronchus cancers account for 15.8% of all cancer cases in Warren, Washington and Saratoga counties, but an alarming 29.6% of all cancer deaths in this same area. Of the three counties, Washington County has the highest rate of cancer deaths attributable to lung and bronchus cancers at 31.2%.

Gender-related disparities also exist for lung cancer. Men living in Washington County experience some of the highest rates of lung cancer (112.9 per 100,000 people) compared to other counties in NYS, exceeding the state average (excluding NYC) of 84.3 per 100,0000 people.[33] Women in both Warren and Washington counties also experience higher rates of lung cancer (76.6 and 80.6 per 100,000 respectively) compared to 64.5 per 100,0000 people for NYS (excluding NYC).

There is a strong link between tobacco use and lung cancer, and smoking rates are higher in Warren, Washington and Saratoga counties (as well as most upstate NY counties) than the NYS average. While there has been a decline in the rate of tobacco use among both children and adults in NYS (and equally across all ethnic groups), smoking rates have not declined for the poor and less educated. This highlights the crucial need for prevention and cessation of tobacco use in these counties, especially for vulnerable populations in this area. [34]

Lastly, income related disparities can be best understood by comparing screening data to insurance status. GFH patients on Medicaid generally have lower rates of important preventive care screenings as compared to the Medicare or commercially insured populations. For example, approximately 44% of all GFH patients (female age 21-64) with an office visit in the past 3 months had record of a pap smear during the past 3 years, compared to an estimated 37% of GFH patients on Medicaid. Similarly, 49% of all GFH patients (age 50-80) with an office visit in the past three months had a colonoscopy in accordance with their physician's recommendations, compared to an estimated 37% of GFH patients on Medicaid. The same also holds true for breast cancer screening. An estimated 45% of all GFH patients (female age 40-69) with an office visit in the past three months had a mammogram in the past year, compared to an estimated 39% of the GFH patients on Medicaid.

However, it is important to understand limitations related to this data. These figures only include those patients that have seen their provider recently, which means those individuals who are not seeking regular healthcare are not included. In addition, it is extremely difficult to ensure medical records remain updated with services that occur external to the GFH system. Consequently, the rates for breast, colonoscopy and pap smear screenings are most likely much higher than what is currently reported. Nevertheless, it is expected that the disparities between populations would remain the same.

Regional Community Provider Survey Results

The ARHN Regional Community Provider Survey was distributed electronically to 624 participants. In total, 285 surveys were completed, a response rate of 45.7 percent.

- Among the five NYS Prevention Agenda priority areas, chronic disease was ranked as the area of highest community need and agency interest.

[33] American Cancer Society, New York and New Jersey, *The Cancer Burden in New York State*, July 2012. Available at http://www.acscan.org/ovc_images/file/action/states/ny/NY_Cancer_Burden_Report_2012.pdf.
[34] American Cancer Society, New York and New Jersey, *The Cancer Burden in New York State*, July 2012. Available at http://www.acscan.org/ovc_images/file/action/states/ny/NY_Cancer_Burden_Report_2012.pdf. NYS Cancer Burden Profiles for Warren, Washington and Saratoga Counties, 2012.

- The agenda area of HIV, STIs, and vaccine preventable diseases was ranked lowest in terms of overall interest and concern.
- The top emerging issues in the region include increases in obesity and related health issues, increases in substance abuse, and mental illness.
- The population groups identified most in need of targeted interventions are: the poor, children, individuals with mental health issues, the elderly, and substance abusers.
- Only about half of survey respondents reported being familiar with the NYS Department of Health Prevention Agenda priority areas.
- The individual issues of greatest importance to survey respondents were the general health and safety of the physical environment, diabetes prevention, substance abuse, mental health screening and treatment, and the prevention of heart disease.
- When asked to rate the effectiveness of current local efforts to address major health issues, a large portion of respondents indicated that they did not know, which suggests that additional information and publicity may be needed for health activities in the region.
- Education is the dominant strategy currently used to address major health issues in the region. Direct, hands-on strategies such as screening or clinical services are less prevalent.
- Technology is not highly utilized by health service providers and their clients in the region. A slight majority of respondents agreed that technology enhancement should be a top priority for the region.
- The top future concern for stakeholders was funding. Regional health care organizations expressed concerns about reimbursement rates and expectations of reduced funding through government payments and other grants.

See Appendix F for a comprehensive description of the survey methodology and results.

County Health Rankings

To further support the information collected through the county health indicator data, clinical data, community nutrition assessment and the regional community provider survey, County Health Rankings were used to understand how the health of Warren, Washington and Saratoga counties rank compared to each other and other counties in NYS. In total, there are 62 counties in NYS. Those having high ranks, e.g. 1 or 2, are considered to be the "healthiest."

County Health Rankings - 2013

	Warren	Washington	Saratoga
Health Outcomes	**12**	**42**	**5**
Mortality	**16**	**33**	**8**
Morbidity	**7**	**45**	**6**
Health Factors	**17**	**40**	**5**
Health Behaviors	**44**	**56**	**12**
Clinical Care	**2**	**26**	**5**
Social & Economic Factors	**23**	**28**	**2**
Physical Environment	**3**	**28**	**9**

Source: County Health Rankings and Roadmaps, A Healthier Nation, County by County, Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute – 2013, See http://www.countyhealthrankings.org/

Health outcomes demonstrate the current health status of the population through morbidity (quality of life) and mortality (length of life). Health factors are what drives how long and how well populations will live and where we can target our actions, emphasizing what is modifiable and can be improved.

For almost all of the ranking categories, Saratoga County ranked the highest (closest to 1) and Washington County ranked the lowest (closest to 62). Warren County was typically in the middle for all eight ranking scores, except for clinical care. This is most likely because of the physical presence of Glens Falls Hospital in Warren County. It is also important to note that the populations in the southern and northern most points of Saratoga County are extremely diverse. While the County Health Rankings only represent whole counties, typically, the health outcomes and health factors for the population in northern Saratoga County align more closely with Warren County. The entirety of the data that was used to inform the rankings can be found in Appendix K.

Prioritized Significant Health Needs

As described above, GFH coordinated with Warren, Washington and Saratoga counties to conduct a community health assessment (CHA) in each county. Using the results of the indicator analysis, regional survey and the other county-specific community assessment resources listed previously, each county prioritized the most significant health needs for their residents. Each counties' CHA provides the rationale behind the prioritization of significant health needs. The following table outlines the method for prioritization and the most significant health needs identified in each county.

	Warren County	**Washington County**	**Saratoga County/Saratoga Hospital**
Prioritization Method[35]	Dot Method	Dot Method	Weighted Method
Prioritized Health Needs	Increase access to high quality chronic disease preventive care and management in both clinical and community settings Promote mental, emotional and behavioral health (MEB)	Reduce obesity in children and adults Reduce illness, disability and death related to tobacco use and secondhand smoke exposure Prevent substance abuse and other mental, emotional and behavioral health disorders	Increase access to high quality chronic disease preventive care and management in both clinical and community settings Improve child health Prevent substance abuse and other mental, emotional and behavioral disorders Prevent vaccine-preventable diseases Prevent healthcare associated infections STDs

[35] For a complete description of the Dot and Weighted prioritization methods, see Appendix L.

GFH compared the priorities identified by each county to determine similarities and differences. Warren, Washington and Saratoga Counties all selected focus area within Chronic Disease and Mental Health/Substance Abuse. Saratoga County is also planning to address focus areas related to Healthy Women, Infants and Children and Vaccines/Healthcare-Associated Infections.

In addition, GFH considered criteria similar to those described in Appendix L regarding the Dot and Weighted prioritization methods, including expertise, capacity, funding, and potential impact. The following have been identified as the most significant health needs for the population served by Glens Falls Hospital. These needs will be the major focus of GFH's community health strategies for 2013 – 2015, and inform the development of the Implementation Strategy:

1. Increase access to high quality chronic disease preventive care and management in both clinical and community settings
2. Reduce obesity in children and adults
3. Reduce illness, disability and death related to tobacco use and secondhand smoke exposure

By selecting all the focus areas related to the Chronic Disease priority area, GFH will be able to ensure consistency and alignment across the counties, and ensure resources are used most effectively and efficiently. While Mental Health and Substance Abuse was also a common need across the three counties, focusing on all of the areas under Chronic Disease will also ensure a comprehensive approach to this significant issue, as opposed to solely focusing on certain risk factors, or only addressing prevention or management. GFH will work to implement strategies that address all three focus areas in all three counties and will ensure collaboration with each of the Public Health departments and their respective partners. Emphasis will be placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community resources.

Community Assets to Meet Needs

Many community assets have been described throughout the assessment, including those described within the Infrastructure and Services, Health Care Facilities, and Educational System sections. In addition, the partners that participated in the county prioritization processes will be key resources within the community that can help to address the prioritized needs. See page 11 for a listing of these partners.

Countless additional potential partners exist throughout the three county area, many of which GFH has a long-standing relationship with already[36]. These include, but are not limited to:

- business sector
- community-based organizations
- municipalities, such as those where targeted interventions are planned
- mental health service providers
- healthcare providers
- service providers for individuals with disabilities; and
- cancer-specific community organizations

Existing coalitions can also be an invaluable resource for planning and outreach, including:

[36] The most comprehensive listing of businesses in the region can be found at the GlensFallsRegion.com website, http://www.glensfallsregion.com/guide.cfm.

- Southern Adirondack Tobacco Free Coalition
- Warren, Washington and Hamilton Counties Cancer Services Program Partnership
- Warren County Safe & Quality Bicycling Group
- Washington County Healthy Communities Coalition

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

- Glens Falls Hospital services and facilities (see http://www.glensfallshospital.org/services.cfm for a full listing)
- Community gardens
- Farmers markets and community supported agriculture (CSAs)
- Gyms and other wellness facilities
- Parks and Recreation
- Walking trails and bicycle routes
- Grocery stores and convenience stores
- Faith-based organizations

Lastly, there are many community resources and supports that are specific to certain population groups. These include employer-sponsored wellness programs and services, insurer-sponsored wellness and health promotion benefits, other neighborhood or community-specific services or events, school district-specific resources or activities as well as health care provider-specific resources.

GFH will use this listing of community assets to determine the most effective group of core partners to address the three prioritized needs identified above. Additional organizations, assets and resources will be identified to respond to emerging issues.

Community Health Needs not Addressed in the Action Plan

GFH will not be directly addressing the focus areas under Substance Abuse and Other Mental, Emotional and Behavioral Disorders in the IS due to a variety of factors. It would not be prudent to spread hospital and community resources across too many initiatives. While behavioral health is a significant need for individuals and communities in the GFH service area, GFH is currently working to reassess the behavioral health services line to ensure long-term sustainability and maximum capacity. GFH is exploring partnerships to meet these needs, and will need adequate time to develop a solid infrastructure. Nevertheless, GFH will be addressing the behavioral health needs of select priority populations through the Medicaid Health Home initiative, and the Integrated Behavioral Health in Primary Care initiative. Through both of these initiatives, patients will have increased access to chronic disease prevention and management, including behavioral health services, through integrated primary care and care coordination approaches.

With respect to the other focus areas being addressed in Saratoga County, GFH will serve as a collaborative partner as the need arises but does not intend to implement specific regional strategies. In general, HIV, STDs and healthcare associated infections are not a significant need across all three counties. GFH is not explicitly addressing the priority area Promote Healthy Women, Infants and Children in this plan, but is continuously working to support the needs of these patients. Through the creation of the Medical Staff Development Plan, GFH will ensure adequate resources for obstetrics and pediatrics through an emphasis on the utilization of mid-level providers and advanced practice nurses. These providers will be critical resources in the development of educational strategies for women,

teens, and children. In addition, GFH will support the counties as the Public Health departments continue to serve these populations. GFH also continues to identify ways to expand education through both GFH school-based health centers at Stuart M. Townsend Middle School and Whitehall Elementary School.

With respect to the priority area of Promote a Healthy and Safe Environment, the majority of these focus areas are beyond the capacity and scope of expertise of GFH and the healthcare sector. Efforts to address these focus areas are better lead by policy makers, elected officials and other community stakeholders through collaboration and support of the healthcare sector. The one area of particular relevance within this priority area is injuries, violence and occupational health. Falls and occupational injuries tend to be a significant challenge for residents in Warren and Washington counties. GFH will continue to support the counties as the Public Health departments develop and maintain relevant programs for these populations. GFH is currently recruiting a new leader for the Occupational Health department and is also working to identify appropriate staff to conduct a falls prevention program. Consequently, these two factors will require significant time to build capacity and therefore the initiatives that will be managed by these two positions have not been included in this plan.

Implementation Strategy Development

GFH utilized the results of the CHNA to develop an Implementation Strategy. The Director of Research and Planning worked with Senior Leadership to identify evidence-based initiatives to address the prioritized community health needs related to chronic disease. Throughout this process, GFH built on existing initiatives and community assets and also identified new initiatives to complement and further enhance these existing programs. As a result, the Implementation Strategy is a comprehensive, aligned plan with evidence-based strategies that will have significant impact on the health and well-being of the people and communities in the region.

GFH developed common terminology throughout the various departments within the institution to ensure consistent communication about goals, objectives, performance measures and activities. For each initiative, a Manager or Director participated in the development of a three-year action plan. GFH coordinated with Warren, Washington and Saratoga County Public Health throughout the process, and included other existing and new partners to ensure a collaborative and coordinated approach. Where applicable, GFH provided input into each county plan to ensure coordination and alignment with the hospital plan. Once finalized, the Implementation Strategy was reviewed by Senior Leadership and presented to the Board of Governors for approval.

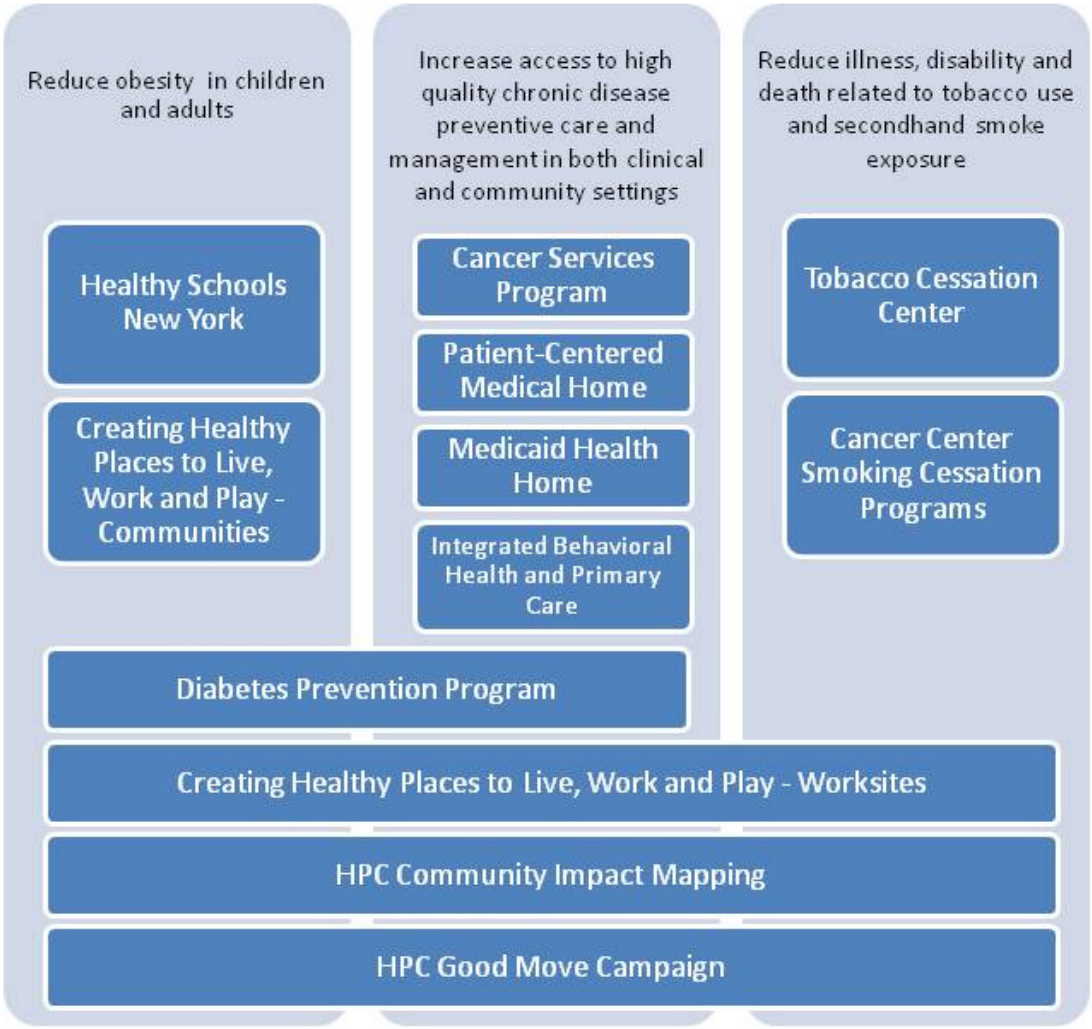
Priority Populations

Emphasis throughout the IS is placed on interventions that impact disparate and underserved populations in the service area, especially low-income populations and those with limited access to healthcare and other community resources. As described in the CHNA, Warren, Washington and Saratoga counties do not face the traditional racial or ethnic disparities typically found in more urban or populated areas. Instead, populations in upstate New York face a unique combination of factors that create health disparities, which are often rooted in the social determinants of health. Economic factors, cultural and social differences, educational shortcomings, and the isolation of living in a rural area all conspire to repress this population in their struggle to lead a healthy life. Many sections of the region face significant distance and transportation barriers to accessing community resources, service opportunities, and health care. These communities are traditionally underserved by most assistance

programs; thereby creating health disparities among the people living and working in this area. Throughout the action plan below, priority populations for each specific initiative are noted within the section highlighting the health disparities addressed.

Action Plan

The following three-year action plan includes initiatives led by GFH to address the prioritized community health needs. It includes 12 initiatives to address the three focus areas under the Prevent Chronic Disease priority area of the NYS Prevention Agenda. Many of the initiatives will impact more than one focus area and three of the initiatives address all three focus areas. Each initiative is presented below and includes a brief description, health disparities addressed, goal, SMART objective(s) and corresponding performance measure(s), and key activities for the improvement strategy. GFH continues to be actively involved in the counties' and other partner-led initiatives.



GFH Initiative/Improvement Strategy: Healthy Schools New York	
Initiative – Brief Description/Background: The Healthy Schools New York initiative works with school districts to implement policy, systems and environmental changes to promote consumption of healthy foods and beverages, and expanded opportunities to be physically active, including compliance with state physical education requirements. Healthy Schools NY is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health. This initiative is implemented in Warren, Washington and Saratoga counties, in addition to Fulton and Montgomery counties.	
Health Disparities Addressed: Low socio-economic status populations as demonstrated by schools with the highest levels of students qualifying for free/reduced lunch	
GFH Goal: Improve the health of people in the GFH region through prevention of childhood obesity in early child care and schools**.**	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, increase opportunities for physical activity, before, during and after the school day for all students in grades K-12 by developing or revising the physical activity policy in 12 school districts.	# of school districts initiating the process of assessing and developing or revising the policy as either a separate school board approved policy or integrated into the school district's local school wellness policies
By December 2015, improve school environments to support and promote healthful eating for all students in grades K-12 by developing or revising the nutrition policy in 12 school districts.	# of school districts initiating the process of assessing and developing or revising the policy as either a separate school board approved policy or integrated into the school district's local school wellness policies
Activities	
Obtain administrative commitment from school, finalize MOU and identify a primary school liaison.	
Establish or enhance a wellness committee and assist the committee in establishing a physical activity/nutrition policy assessment, development, implementation and evaluation timeline.	
Review the current policies and/or develop new policies and identify strengths, weaknesses and opportunities for improvement.	
Engage key PA and nutrition staff to support implementation of the policies and provide support to ensure approval.	
Provide assistance and guidance to ensure effective implementation of policies and communication throughout the school community.	

GFH Initiative/Improvement Strategy Creating Healthy Places to Live, Work and Play - Communities	
Initiative – Brief Description/Background: The Creating Healthy Places to Live, Work and Play initiative works with community leaders and local governments to design and implement the types of policy, systems and environmental changes that create more opportunities for physical activity and healthful eating. Creating Healthy Places to Live, Work and Play is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health. Due to funding restrictions, this initiative is only implemented in Warren and Washington counties.	
Health Disparities Addressed: Low socio-economic status populations with limited access to physical activity and healthful foods	
GFH Goal: Improve the health of people in the GFH region through the creation of community environments that promote and support healthy food and beverage choices and physical activity.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, enhance opportunities for physical activity by implementing 12 policy or environmental changes such as park revitalizations, Complete Streets policies, and other community improvements.	# of joint use agreements, Complete Streets policies and other environmental changes established
Activities	
Engage communities in a GIS mapping exercise to identify community supports for recreation and physical activity. Systematically rate each asset using the Physical Activity Resource Assessment (PARA) tool and collect baseline data to evaluate current usage.	
Identify gaps or deficiencies in community environment and work with partners to create a revitalization plan.	
Conduct evaluation using PARA tool to rate assets after improvements have been made and gather follow-up usage data .	
Develop and implement strategies to increase awareness about the enhancements and promote the improvements and community support.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, improve the food retail environment by implementing 4 policy or environmental changes in the community to support increased availability and visibility of healthful foods.	# of policy/environmental changes that promote healthy foods and increase availability or visibility in grocery stores, convenience stores and other retail outlets
Activities	
Develop and conduct a community nutrition assessment to collect information regarding consumer's food-related behaviors and perceived community assets and barriers to accessing healthy foods.	
Analyze data and generate report of findings, including a plan for action to improve the food retail environment.	
Engage partners to support implementation of the plan of action.	
Assess successes and challenges and communicate regularly with the community on progress and lessons learned.	

GFH Initiative/Improvement Strategy Good Move Campaign	
Initiative – Brief Description/Background: *Good Move* is a campaign to encourage individuals and families to take steps toward good health in the community, in the workplace, and in the school. The campaign promotes being active, eating healthy foods, tobacco cessation, breastfeeding and making use of preventative care. Good Move is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health through Healthy Schools NY and Creating Healthy Places to Live, Work and Play.	
Health Disparities Addressed: Low socio-economic status populations with limited access to community resources with increased risk for chronic disease	
GFH Goal: Improve the health of people in the GFH region by enhancing access to clinical and community preventive services through coordinated health-related messaging.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, coordinate chronic disease messaging by establishing 60 distribution sites for a campaign to promote awareness of and demand for community, school, and worksite resources as well as preventive care services.	# of community organizations, partners and/or sites distributing and promoting the Good Move campaign
Activities	
Develop a campaign highlighting physical activity, nutrition, breastfeeding, smoking cessation and preventive care messages to encourage individuals and families to take steps toward good health in the community, in the workplace, and in the school.	
Develop a communications plan to support a coordinated and integrated network of partners such as healthcare providers, schools, worksites and community-based organizations or municipalities.	
Work with partners to determine setting-specific messaging and placement of materials.	
Conduct an evaluation of the campaign to understand successes and challenges and inform future plans including development of materials and distribution strategies.	

GFH Initiative/Improvement Strategy Creating Healthy Places to Live Work and Play - Worksites	
Initiative – Brief Description/Background: The Creating Healthy Places to Live, Work and Play initiative for Worksites supports businesses to design and implement the types of policy, systems and environmental changes that create more opportunities for physical activity, healthful eating, preventive screenings and tobacco cessation. Creating Healthy Places to Live, Work and Play is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health. Due to funding restrictions, this initiative is only implemented in Warren County.	
Health Disparities Addressed: Low socio-economic status populations at high risk for developing chronic disease with limited access to community resources	
GFH Goal: Improve the health of people in the GFH region by expanding the role of public and private employers in obesity prevention, tobacco use cessation, and the use of evidence-based care to manage chronic disease.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, 10 worksites will improve comprehensive worksite wellness programs as measured by an increase in their wellness score by a minimum of 15%.	# of worksites completing a pre and post assessment whose score increases by at least 15%
Activities	
Recruit small- to medium-sized businesses to commit to working on evidence-based wellness strategies.	
Work with each business to conduct a baseline assessment of worksite wellness.	
Provide training and technical assistance to worksites to support implementation of strategies and comprehensive worksite wellness plans.	
Work with each business to conduct a post assessment of worksite wellness.	
Provide general information on worksite wellness to partners and key stakeholders and develop a promotional campaign to increase awareness of wellness goals and strategies for the business community.	
Engage worksites in transition planning to enhance sustainability.	

GFH Initiative/Improvement Strategy	Diabetes Prevention Program
Initiative – Brief Description/Background: The Diabetes Prevention Program (DPP) is an evidence-based 16-week lifestyle modification program for people at high-risk for diabetes, or with pre-diabetes. GFH is working to build capacity to deliver the intervention for patients and community members.	
Health Disparities Addressed: Low socio-economic status populations at high risk for developing diabetes with limited access to community resources	
GFH Goal: Improve the health of people in the GFH region by linking health care-based efforts with community prevention activities.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, average weight loss achieved by participants attending at least four core sessions of the DPP is a minimum of 5% of body weight.	% average weight loss for participants attending at least 4 core sessions
Activities	
Establish capacity to deliver the program by training staff to become Lifestyle Coaches	
Determine target population and develop materials, information and a communication plan to promote the DPP and recruit eligible participants.	
Identify a system to manage participant inquiries and interest.	
Establish a schedule for the programs and identify appropriate locations and times for each program.	
Recruit and enroll participants in the program(s) and implement at least 2 16-week lifestyle intervention programs.	
Collect all necessary data and submit to the CDC for recognition.	
Work with internal and external stakeholders to identify sustainability plan including additional funding streams and/or third party reimbursement.	

GFH Initiative/Improvement Strategy	Tobacco Cessation Center
Initiative – Brief Description/Background: The Tobacco Cessation Center works with healthcare provider organizations to implement policies and practices for screening & treating tobacco dependence in accordance with the Clinical Practice Guidelines for Tobacco Use Dependence. The TCC is a program of the Health Promotion Center of Glens Falls Hospital and is partially funded by the New York State Department of Health. This initiative is implemented in Warren, Washington and Saratoga counties, in addition to Fulton and Montgomery counties.	
GFH Goal: Improve the health of people in the GFH region through the promotion of tobacco use cessation.	
Health Disparities Addressed: Low socio-economic status populations at high-risk for chronic disease	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, work with 1 FQHC and 50 other healthcare provider organizations (HCPOs) to adopt systems-level change to screen all patients for tobacco use, provide brief advice to quit at every patient visit and provide assistance to quit successfully.	# of providers signing MOU that complete systems level change
Activities	
Conduct outreach and obtain administrative commitment from new HCPOs.	
Conduct staff training needs assessments with targeted HCPOs.	
Identify site champion and provide on-site training and technical assistance to clinicians and staff.	

GFH Initiative/Improvement Strategy	Cancer Center Smoking Cessation Programs
Initiative – Brief Description/Background: The C.R. Wood Cancer Center offers smoking cessation programs for patients and community members. The 4-week program is currently offered twice a year, lead by a health psychologist and held at the Cancer Center. The Cancer Center is currently working to build capacity to offer two additional programs per year, for a total of four programs annually.	
Health Disparities Addressed: Individuals at high-risk for poor health outcomes	
GFH Goal(s): Improve the health of people in the GFH region through the promotion of tobacco use cessation and the elimination of exposure to secondhand smoke.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, individuals attending the smoking cessation programs will demonstrate a 20% decrease in the amount of cigarettes smoked.	% average decrease of cigarettes smoked by program participants
Activities	
Partner with the Tobacco Cessation Center to certify two additional staff members to provide smoking cessation counseling.	
Provide semi-annual (2013) and quarterly (2014 and 2015) smoking cessation classes.	
Offer individual smoking cessation counseling to high risk individuals who have been screened through the high risk lung screening clinic.	
Provide pre- and post-evaluations to qualify the cessation program effectiveness.	
Provide timely follow-up to ensure and reinforce knowledge base.	

GFH Initiative/Improvement Strategy	Cancer Services Program
Initiative – Brief Description/Background: The Integrated Breast, Cervical and Colorectal Cancer Screening Program provides comprehensive screening for uninsured residents. Cancer Services Program (CSP) partners with close to 50 local health care providers for screening services. Outreach and education practices are in place with strong relationships cultivated with community partners. The CSP partners are key community leaders, public health departments, elected officials, the Chamber of Commerce and the local libraries. The CSP is a program of C.R. Wood Cancer Center of Glens Falls Hospital and is partially funded by the New York State Department of Health.	
Health Disparities Addressed: Low socio-economic status populations and uninsured individuals with limited access to screening services	
GFH Goal: Improve the health of the people in the GFH region by increasing screening rates for breast/cervical/colorectal cancer.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, conduct cancer screenings in priority populations to ensure: • 20% of clients screened are women who are rarely or never screened • 20% of clients screened are male clients, and • 20% of clients screened are those needing comprehensive screenings (breast, cervical and colorectal)	NYSDOH Cancer Services Program Monthly Performance Measures; PM#2 PM#4 PM#7
Activities	
Develop and implement advertising campaigns during breast, cervical and colorectal cancer awareness months. (October, January & March)	
Broaden inreach efforts within GFH to include ER and Behavioral Health to identify uninsured and age-eligible people for cancer screenings.	
Utilize the CSP centralized intake system to ensure comprehensive screenings have been completed.	
Establish and maintain relationships with community-based organizations and providers who are referral sources for clients.	
Collaborate and actively engage organizations and individuals throughout the service area to assist in implementing required activities to meet or exceed program performance measures.	

GFH Initiative/Improvement Strategy	GFH Patient-Centered Medical Home Initiative
Initiative – Brief Description/Background: Within the 11 health centers, GFH is working to transform the model of primary care delivery through implementation of patient-centered medical homes. This transformation will strengthen the physician-patient relationship by replacing episodic care with comprehensive primary care focused on providing high quality, evidence based care and coordinating care across all settings. Whole-person and patient-centered care is facilitated by a team based approach to self-care support, care management/ coordination, and enhanced access.	
Health Disparities Addressed: Individuals living in rural areas with limited access to comprehensive**,** coordinated care	
GFH Goal: Improve the health of people in the GFH region by increasing access to high quality, evidence based preventive care and chronic disease management.	
GFH SMART Objective(s):	**Performance Measure(s)**
By December 2015, expand the use of the patient-centered medical home model in 11 GFH health centers.	# of health centers receiving level 3 PCMH recognition from NCQA
Activities	
Adapt and use certified electronic health records to support clinical decision making, population management, improvement in clinical quality measures, and coordination of care.	
Upgrade to the 2012 functionality of Epic, the electronic medical record system for GFH.	
Attest to Meaningful Use	
Engage GFH health centers in the completion of the Enhanced Primary Care training program through CDPHP.	
Create linkages with and connect patients to community resources for physical activity, nutrition and social support.	
Develop a referral tracking process that ensures follow up and coordination of care.	
Support and inform care delivery, coordination, and patient engagement through the utilization of a longitudinal plan of care.	
Develop and implement patient advisory councils for all primary care health centers to involve patients in quality improvement process.	

GFH Initiative/Improvement Strategy: Integrate Behavioral Health and Primary Care	
Initiative – Brief Description/Background: GFH is working to advance health care for older adults through the integration of behavioral health care into the primary care health centers. Physical and mental health treatment and services will be internally integrated and coordinated with the wider health care network in order to promote and support health, wellness and recovery.	
Health Disparities Addressed: Individuals with limited access to behavioral health services	
GFH Goal(s): Improve the health of people in the GFH region by promoting the use of evidence-based, integrated care to prevent and manage chronic disease.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, advance health care for adult patients through the integration of primary and behavioral health care at three health centers.	# of GFH health centers with a psychiatric provider and/or social worker available to provide onsite assessment and treatment services
Activities	
Identify health centers with the capacity and need for integrated primary and behavioral health care.	
Recruit and hire psychiatric nurse practitioners and/or licensed clinical social workers.	
Provide staff education and training relative to rolls for existing office staff and providers.	
Finalize and implement communications plan, including the development of relevant educational materials.	
Ensure appropriate orientation and training for newly hired NPPs and LCSWs.	

GFH Initiative/Improvement Strategy	Medicaid Health Home Program
Initiative – Brief Description/Background: GFH is designated as a health home provider under the New York State Medicaid Health Home Program. A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. The target population is individuals with complex chronic conditions including medical and behavioral care needs that drive a high volume of high cost services such as inpatient and long term institutional care.	
Health Disparities Addressed: Low socio-economic status populations on Medicaid disproportionately affected by complex chronic conditions	
GFH Goal: Improve the health of people in the GFH region by promoting coordinated care to prevent and manage chronic disease.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, 50% of enrolled members will be affiliated with a GFH primary care practice.	% of enrolled members that have a GFH provider listed as their PCP
Activities	
Convene an internal care coordination workgroup to begin to identify current capacity, gaps and needs.	
Utilize Epic EMR system, including the disease registries, to identify potential Health Home members.	
Partner with local behavioral health organizations to ensure access to comprehensive services.	
Expand utilization of the patient portal, My Chart, to increase patient engagement.	
Expand care coordination capacity through the identification of new downstream providers.	
Conduct outreach to existing PCPs to assess capacity for additional patients.	

GFH Initiative/Improvement Strategy	Community Impact Mapping
Initiative – Brief Description/Background: The Health Promotion Center is planning to develop a series of maps to serve as a communication tool with current and future partners, as well as key stakeholders and decision makers. These maps will demonstrate collective impact of DOH funding/initiatives for this area, encourage additional partnerships and engagement in areas that show gaps, and develop a cohesive and integrated strategy to evaluate progress over time.	
Health Disparities Addressed: Low socio-economic status populations with limited access to health care and community resources	
GFH Goal: Improve the health of people in the GFH service area by increasing support for local community initiatives that increase access to high-quality chronic disease preventive care and management services.	
GFH SMART Objective(s)	**Performance Measure(s)**
By December 2015, increase awareness of local chronic disease initiatives by sharing the maps with 10 key partners, stakeholders and decision makers.	# of partners, stakeholder and decision makers receiving the maps through formal discussion with HPC staff
Activities	
Select a consultant with expertise and capacity to develop the appropriate maps.	
Develop 5-7 maps to show the entirety of the GFH and grant-specific service areas, disparate populations, initiative-specific engagement, and overall impact of collective DOH-funding/HPC efforts.	
Identify most effective methods to share maps including websites, meetings, mailings, presentations and other formal and informal interactions.	
Present information to key partners, stakeholders and decision makers and offer information on appropriate next steps.	

Partner Engagement

GFH will continue to partner with Warren, Washington and Saratoga county Public Health departments to implement the strategies in this action plan. GFH has a long-standing history of partnerships with these and other community-based organizations and agencies to support implementation of community health initiatives. Many of these partners participated in the various county health assessments and planning processes through the Community Health Assessment Teams (CHATs)[37] . The partners included in each county's CHAT are listed on page 11 of this plan. As previously discussed, GFH serves a multi-county area, which encouraged a strategic approach to ensure alignment with each county. GFH did not convene an additional regional team of community partners as this would have duplicated efforts and created confusion among community leaders. GFH will continue to partner with each county to convene the CHATs and be actively involved in the implementation of each county's CHIP to ensure partner engagement on the county and regional level.

[37] Each county's group of partners was called something slightly different. However, for ease of reference the term CHAT is utilized in this report to describe the partners that collaborated to conduct the assessment and prioritize needs for each county.

Evaluation Plan

GFH will work with Warren, Washington and Saratoga Public Health Departments to develop a comprehensive evaluation plan that includes both process and outcome evaluation. GFH will ensure this plan aligns with and compliments the evaluation plans developed by each county. Process evaluation will demonstrate if the activities were implemented, if the appropriate populations were reached, and how external factors influenced the implementation. Progress will be tracked through discussion at quarterly meetings with internal and external partners responsible for each initiative. Through these discussions, mid-course corrections may be made to the plan to ensure goals and objectives are met. Outcome evaluation will demonstrate the impact of the activities and the ability to meet the objectives outlined in the action plan. This information will be used to provide regular updates to the NYS Department of Health and the Internal Revenue Service, as requested or required. In addition, this information will be used to share successes and challenges, and inform broader communications with the community and key partners.

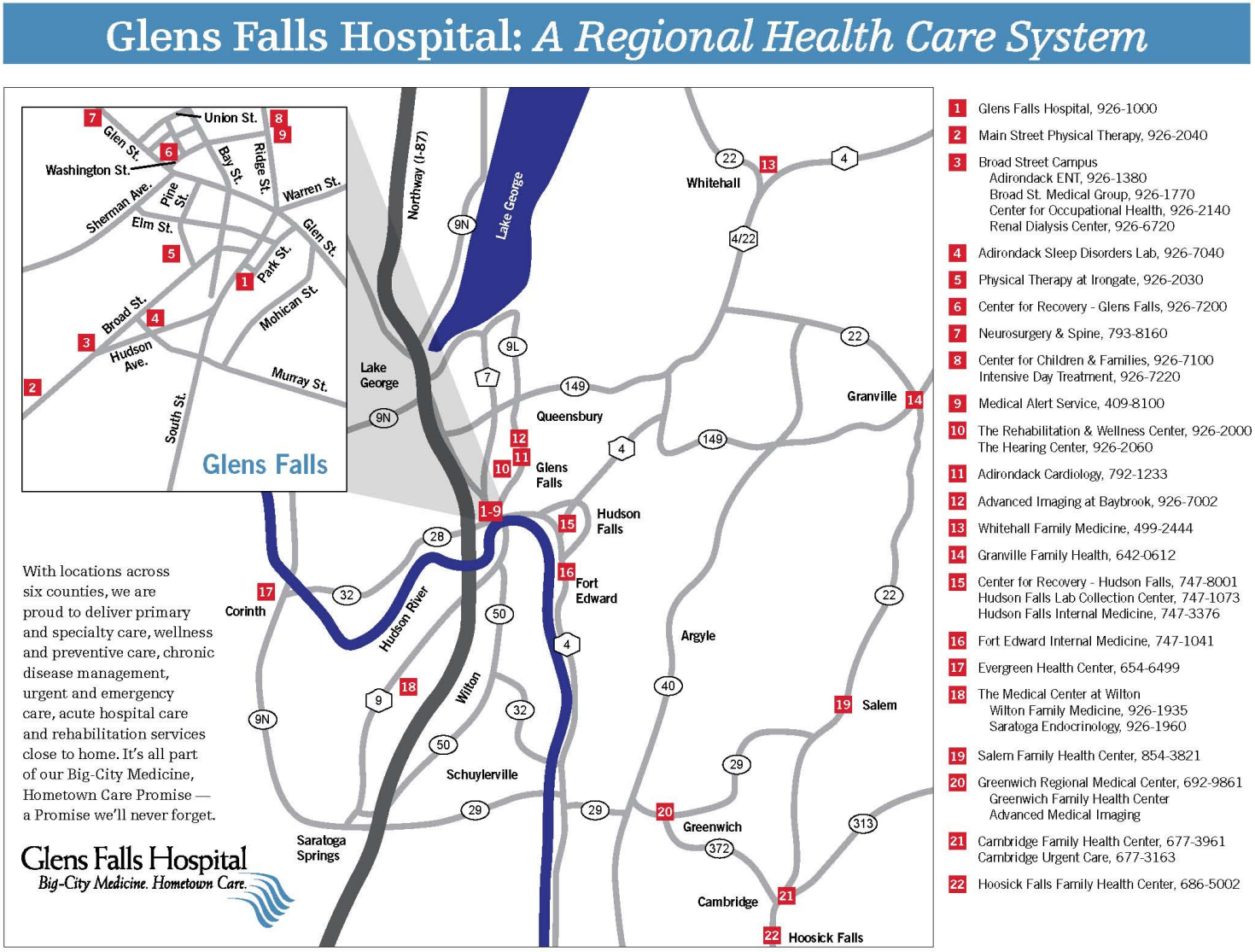
Dissemination

The Glens Falls Hospital Community Service Plan, along with the Community Health Needs Assessment and Implementation Strategy, is available at http://www.glensfallshospital.org/services/health-promotion-center.cfm. GFH will also use various mailings, newsletters and reports to ensure the availability of the CSP, CHNA and IS is widely publicized. Hard copies will be made available at no-cost to anyone who requests one.

Approval

The Director of Research and Planning worked with Senior Leadership to present the CHNA and IS, which were combined to create this Community Service Plan, to the Board of Governors. The Board was provided with an executive summary of the documents in advance of the meeting. A brief presentation was conducted at the meeting to communicate highlights and answer questions. The CHNA and IS were approved on October 22, 2013.

Appendix A: Glens Falls Hospital Regional Health Care System



Appendix B: Adirondack Rural Health Network – Membership Affiliation, Steering Committee & Community Health Planning Committee (CHPC)

Name and Organization	Steering Committee	CHPC
Christina Akey, Health Educator, Fulton County Public Health		X
Pat Auer, RN, Director, Warren County Health Services	X	X
Linda Beers, Director, Essex County Public Health	X	X
Sue Cridland, RN, BSN, Director of Community Education, HealthLink Littauer		X
Jessica Darney-Buehler, CGS Public Health, Essex County Public Health		X
Josy Delaney, MS, CHES, Community Wellness Specialist, Alice Hyde Medical Center		X
Dan Durkee, Health Educator Warren County Health Services		X
Denise Frederick, Director, Fulton County Public Health	X	X
Peter Groff, Executive Director, Warren-Washington Association for Mental Health	X	
Katie Jock, Champlain Valley Physicians Hospital Medical Center		X
Chip Holmes, Chief Executive Officer, Inter-Lakes Health	X	X
Jane Hooper, Director of Community Relations, Elizabethtown Community Hospital		X
Travis Howe, Director, Mountain Lakes Regional EMS Council	X	
Patty Hunt, Director, Washington County Health Services	X	X
Lottie Jameson, Executive Director, Hudson Mohawk AHEC	X	X
Dot Jones, Director of Planning, Saratoga Hospital	X	X
Robert Kleppang, Director, Hamilton County Community Services	X	
Karen Levison, Director, Saratoga County Public Health	X	X
Ginger Carriero, VP of Medical Practices, Alice Hyde Medical Center		X
Cheryl McGratten, VP of Development, Nathan Littauer Hospital		X
Tracy Mills, Director, Research & Planning, Glens Falls Hospital		X
Megan Murphy, Grants & Strategic Projects Director, Adirondack Health		X
Sue Patterson, Public Health Educator, Franklin County Public Health		X
Jeri Reid, Director, Clinton County Health Department		X
John Rugge, MD, Chief Executive Officer, Hudson Headwaters Health Network	X	
Beth Ryan, Director, Hamilton County Public Health	X	X
Paul Scimeca, Vice President, Physician Practices and Community Health, Glens Falls Hospital		X
Trip Shannon, Chief Development Officer, Hudson Headwaters Health Network	X	

Appendix C: NYS Prevention Agenda Priority Areas, Focus Areas and Goals

Priority Areas	Focus Areas	Goals – See Priority Area Action Plans for full list of objectives and recommended interventions by Health Impact Pyramid and Sector
Prevent chronic diseases	Reduce Obesity in Children and Adults	Create community environments that promote and support healthy food and beverage choices and physical activity
		Prevent childhood obesity through early child care and schools
		Expand the role of health care and health service providers and insurers in obesity prevention
		Expand the role of public and private employers in obesity prevention
	Reduce illness, disability and death related to tobacco use and secondhand smoke exposure	Prevent initiation of tobacco use by NY youth and young adults, especially among low socioeconomic status (SES) populations
		Promote tobacco use cessation, especially among low SES populations and those with poor mental health
		Eliminate exposure to secondhand smoke
	Increase access to high quality chronic disease preventive care and management in both clinical and community settings	Increase screening rates for cardiovascular disease, diabetes and breast/cervical/colorectal cancer, especially among disparate populations
		Promote use of evidence-based care to manage chronic diseases
		Promote culturally relevant chronic disease self-management education
Promote healthy and safe environments	Injuries, Violence and Occupational Health	Reduce fall risks among the most vulnerable populations
		Reduce violence by targeting violence prevention programs particularly to highest-risk populations
		Reduce occupational injury and illness focusing on adolescents
	Outdoor Air Quality	Reduce exposure to outdoor air pollutants, with a focus on burdened communities
	Built Environment	Improve the design and maintenance of the built environment to promote healthy lifestyles, sustainability and adaptation to climate change
		Improve the design and maintenance of home environments to promote health and reduce related illness
	Water Quality	Increase the percentage of State residents that receive optimally fluoridated drinking water
		Reduce potential public health risks associated with drinking water and recreational water
Promote healthy women, infants and children	Maternal and Infant Health	Reduce premature births in NYS
		Increase the proportion of NYS babies who are breastfed
		Reduce the rate of maternal deaths in NYS
	Child Health	Increase the proportion of NYS children who receive comprehensive well child care in accordance with AAP guidelines
		Reduce the prevalence of dental caries among NYS children
	Preconception and Reproductive Health	Reduce the rate of adolescent and unplanned pregnancies in NYS
		Increase utilization of preventive health services among women of reproductive age to improve wellness, pregnancy outcomes and reduce recurrence of adverse birth outcomes
Promote mental health and prevent substance abuse	Promote Mental, Emotional and Behavioral Health (MEB)	Promote mental, emotional and behavioral well-being in communities
	Prevent Substance Abuse and Other MEB Disorders	Prevent underage drinking, non-medical use of prescription drugs by youth, and excessive use of alcohol consumption by adults
		Prevent and reduce occurrences of mental emotional and behavioral disorders among youth and adults
		Prevent suicides among youth and adults
		Reduce tobacco use among adults who report poor mental health
	Strengthen Infrastructure Across Systems	Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery
		Strengthen infrastructure for mental, emotional behavioral health promotion, and mental emotional behavioral disorder prevention
Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare-associated Infections	Vaccine-Preventable Diseases	Improve childhood and adolescent immunization rates Educate all parents about importance of immunizations
		Decrease burden of pertussis
		Decrease burden of influenza disease
		Decrease the burden of disease caused by human papillomavirus
	Human Immunodeficiency Virus (HIV)	Decrease HIV morbidity
		Increase early access to and retention in HIV care
	Sexually Transmitted Diseases (STDs)	Decrease STD morbidity
	Hepatitis C Virus (HCV)	Increase and coordinate HCV prevention and treatment capacity
	Healthcare Associated Infections	Reduce C. difficile infections
		Reduce infection caused by multidrug resistant organisms
		Reduce device-associated infections

Appendix D: Adirondack Rural Health Network, Community Health Planning Committee – Meeting Schedule and Attendance List

Participating Organization	ARHN Meeting Dates 2012 - 2013						
	2/28/12	4/17/12	6/28/12	10/11/12	12/13/12	3/28/13	4/26/13
Adirondack Health	✓	✓	✓	✓	✓	✓	✓
Alice Hyde Medical Center		✓	✓	✓	✓	✓	✓
CVPH Medical Center				✓			✓
Clinton County Health Department		✓	✓	✓		✓	✓
Elizabethtown Community Hospital			✓	✓	✓	✓	✓
Essex County Public Health	✓	✓	✓	✓	✓	✓	✓
Franklin County Public Health	✓	✓	✓		✓		✓
Fulton County Public Health	✓	✓		✓	✓	✓	✓
Glens Falls Hospital	✓	✓	✓	✓	✓	✓	✓
Hamilton County Public Health		✓				✓	
Hudson Headwaters Health Network				✓	✓	✓	
Hudson Mohawk AHEC	✓		✓		✓	✓	
Inter-Lakes Health	✓		✓	✓	✓	✓	✓
Nathan Littauer Hospital	✓	✓	✓	✓	✓	✓	✓
Saratoga County Public Health	✓	✓		✓	✓	✓	✓
Saratoga Hospital	✓	✓	✓	✓	✓	✓	✓
Tri-County United Way	✓	✓	✓				
Warren County Health Services	✓	✓	✓	✓	✓	✓	✓
Washington County Health Services	✓	✓	✓	✓	✓	✓	✓

Appendix E: County Health Indicator Data Methodology and Sources

The Center for Health Workforce Studies at the University at Albany School of Public Health (the Center) under contract with the Adirondack Rural Health Network, a program of the Adirondack Health Institute, identified and collected data from a variety of sources on the nine counties in the Adirondack region. Those counties include: Clinton, Essex, Franklin, Fulton, Hamilton, Montgomery, Saratoga, Warren, and Washington.

The initial step in the process was identifying which data elements to collect. Center staff received an initial list of potential data elements from the ARHN Data Subcommittee and then supplemented that information with data from other sources. Since most of the health behavior, status, and outcome data were only available at the county level, the Center in conjunction with the ARHN Data Subcommittee concluded that all data used for the project would be displayed by county and aggregated to the ARHN region.[1] Additionally, other data were collected to further enhance already identified data. For example, one Prevention Agenda indicator was assault-related hospitalizations. That indicator was augmented by other crime statistics from the New York State Division of Criminal Justice.

The overall goal of collecting and providing these data to ARHN members was to provide a comprehensive picture of the individual counties within the Adirondack region, including providing an overview of population health as well as an environmental scan. In total, counties and hospitals were provided with nearly 450 distinct data elements across the following four reports:

- Demographic Data;
- Educational Profile;
- Health Behaviors, Health Outcomes, and Health Status; and
- Health Delivery System Profile.

Data was provided to all counties and hospitals as PDFs as well as in Excel files. All sources for the data were listed and made available to the counties and hospitals. The sources for the data elements in the Health Behaviors, Health Outcomes, and Health Status report were listed in a separate file and included their respective internet URL links. The data in each of the four reports were aggregated, when feasible, into the ARHN region, Upstate New York (all counties but the five in New York City), and statewide.

<u>Demographic Data</u>

Demographic data was primarily taken from the 2007 - 2011 American Community Survey, supplemented with data from the Bureau of Labor Statistics, Local Area Unemployment Statistics for 2011; the New York State Department of Health (NYSDOH) Medicaid Data for 2011; and employment sector data from the 2009 – 2011 American Community Survey. Among the information incorporated into the demographic report included:

- Race/Ethnicity;
- Age by groups (0 – 4, 5 – 17, 18 – 64, and 65 plus);
- Income and poverty, including the percent who received Medicaid;
- Housing stock;
- Availability of vehicles;
- Education status for those 25 and older;

[1] Aggregated data for the ARHN region included Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, Warren, and Washington counties but did not include Montgomery County.

- Employment status; and
- Employment sector.

Educational Profile

The education profile was taken mainly from the New York State Education Department (NYSED), School Report Card for 2010 – 2011, supplemented with data from the National Center for Education Statistics, Integrated Post-Secondary Data System on Post-Secondary graduations for 2010 – 2011 and registered nurse graduations from the Center. Among the data displayed in the educational profile included:

- Number of school districts;
- Total school district enrollment;
- Number of students on free and reduced lunch;
- Dropout rate;
- Total number of teachers;
- Number of and graduations from licensed practical nurse programs; and
- Number of and graduations from registered nurse programs.

Health Behaviors, Health Outcomes, and Health Status

The vast majority of health behaviors, outcomes, and status data come from NYSDOH. Data sources included the:

- Community Health Indicators Report (http://www.health.ny.gov/statistics/chac/indicators/);
- County Health Indicators by Race/Ethnicity (http://www.health.ny.gov/statistics/community/minority/county/);
- County Dashboards of Indicators for Tracking Public Health Priority Areas, 2013 - 2013 (http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/indicator_map.htm); and
- 2008 – 2009 Behavioral Risk Factor Surveillance System (BRFSS) (http://www.health.ny.gov/statistics/brfss/).

Information on NYSDOH's methodologies used to collect and display data from the above sources can be found on their respective data pages.

NYSDOH data used in this report are updated annually, with the exception of BRFSS data, and most of the data were for the years 2008 – 2010. Cancer data were for the years 2007 – 2009, and BRFSS data were from the 2008 and 2009 survey. Data displayed in this report included an average annual rate or percentage and, when available, counts for the individual three years. The years the data covered were listed both in the report as well as in the sources document.

NYSDOH data also was supplemented from other sources such as the County Health rankings, the New York State Division of Criminal Justice Services, the New York State Institute for Traffic Safety Management and Research, and the New York State Office of Mental Health Patient Characteristics Survey, among others. To the extent possible, Center staff used similar years for the additional data that were collected. Nearly 300 data elements are displayed in this report broken out by the Prevention Agenda focus areas.

Data were downloaded from their various sources and stored in separate Excel files, based on their respective focus area. The Health Behaviors, Health Outcomes, and Health Status report was created in

Excel and linked to the raw data, and population rates were recalculated based on the number of cases as well as the population listed in the data source.

Data in the report were organized by the six priority areas as outlined by NYSDOH at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/. The data were also separated into two subsections, those that were identified as Prevention Agenda indicators and those that were "other indicators." The data elements were organized by 17 focus areas as outlined in the table below.

Focus Area	Number of Indicators	
	Prevention Agenda	Other
Health Disparities	8	11
Injuries, Violence, and Occupational Health	7	21
Outdoor Air Quality	2	0
Built Environment	4	0
Water Quality	1	0
Obesity in Children and Adults	2	35
Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure	1	13
Increase Access to High Quality Chronic Disease Preventive Care and Management	6	28
Maternal and Infant Health	9	19
Preconception and Reproductive Health	9	20
Child Health	6	29
HIV	2	2
STDs	5	10
Vaccine Preventable Diseases	3	6
Healthcare Associated Infections	2	0
Substance Abuse and other Mental, Emotional, and Behavioral Disorders	3	20
Other Illnesses	0	9

Those data elements that were Prevention Agenda indicators were compared against their respective Prevention Agenda benchmarks. "Other indicators" were compared against either Upstate New York benchmarks, when available or then New York State benchmarks when Upstate New York benchmarks were not available. The report also included a status field that indicated whether indicators were met, were better, or were worse than their corresponding benchmarks. When indicators were worse than their corresponding benchmarks, their distances from their respective benchmarks were calculated. On the report, distances from benchmarks were indicated using quartiles rankings, i.e., if distances from their corresponding benchmarks were less than 25%, indicators were in quartile 1, if distances were between 25% and 49.9% from their respective benchmarks, indicators were in quartile 2, etc.

The Health Behaviors, Health Outcomes, and Health Status Report also indicated the percentage of total indicators that were worse than their respective benchmarks by focus area. For example, if 21 of the 35 child health focus area indicators were worse than their respective benchmarks, the quartile summary score would be 60% (21/35). Additionally, the report identified a severity score, i.e., the percentage of those indicators that were either in quartile 3 or 4 compared to all indicators which were worse than

their corresponding benchmarks. Using the above example, if 9 of the 21 child health focus indicators that were worse than their respective benchmarks were in quartiles 3 or 4, the severity score would be 43% (9/21). Quartile summary scores and severity scores were calculated for each focus area as well as for Prevention Agenda indicators and for "other indicators" within each focus area. Both quartile summary scores and severity scores were used to understand if the specific focus areas were challenges to the counties and hospitals. In certain cases, focus areas would have low severity scores but high quartile summary scores indicating that while not especially severe, the focus area offered significant challenges to the community.

Health Delivery System Profile

The data on the health system came from NYSDOH list of facilities, NYSED licensure file for 2011, the UDS Mapper for 2011 Community Health Center Patients, the Health Resources and Services Administration Data Warehouse for health professional shortage (HPSAs) areas for 2012, and Center data on 2011 physicians. Among the data incorporated into this report included:

- Hospital, nursing home, and adult care facility beds;
- Number of community health center patients;
- Number of and population within primary care, mental health, or dental care HPSAs;
- Total physicians and physicians by certain specialties and sub-specialties; and
- Count of individuals licensed.[2]

[2] County is determined by the main address listed on the licensure file. The address listed may be a private residence or may represent those with active licenses but not actively practicing patient care. Therefore, the information provided may not truly reflect who is practicing in a profession in the county.

HEALTH BEHAVIOR, HEALTH OUTCOMES. AND HEALTH STATUS DATA ELEMENTS SOURCE DOCUMENTATION

	Data Element	Data Source	Hyperlink
Focus Area: Disparities			
Prevention Agenda Indicators			
1	Percentage of Overall Premature Deaths (Ages 35 - 64) , '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p1.htm
2	Ratio of Black, Non-Hispanic Premature Deaths (Ages 35 - 64) to White, Non-Hispanic Premature Deaths, '08 - 1(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p2.htm
3	Ratio of Hispanic/Latino Premature Deaths (Ages 35 - 64) to White, Non-Hispanic Premature Deaths, '08 - 1(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p3.htm
4	Rate of Adult Age-Adjusted Preventable Hospitalizations per 100,000 Population (Ages 18 Plus), '08 - 1(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p4.htm
5	Ratio of Black, Non-Hispanic Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '08 - 1(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p5.htm
6	Ratio of Hispanic/Latino Adult Age-Adjusted Preventable Hospitalizations to White, Non-Hispanic, '08 - 1(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p6.htm
7	Percentage of Adults (Ages 18 - 64) with Health Insurance, '08/09	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p7.htm
8	Percentage of Adults with Regular Health Care Provider, '08/09	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p8.htm
Other Disparity Indicators			
1	Rate of Total Deaths per 100,000 Population, '08 - 10	New York State Department of Health; Vital Statistics of New York State	http://www.health.ny.gov/statistics/chac/mortality/d32.htm
2	Rate of Total Deaths per 100,000 Adjusted Population, '08 - 1(	New York State Department of Health; Vital Statistics of New York State	http://www.health.ny.gov/statistics/chac/mortality/d32.htm
3	Rate of Emergency Department Visits per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/ed/e2.htm
4	Rate of Emergency Department Visits per 10,000 Adjusted Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/ed/e2.htm
5	Rate of Total Hospital Discharges per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h44.htm
6	Rate of Total Hospital Discharges per 10,000 Adjusted Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h44.htm
7	Percentage of Adults (18 and Older) Who Did Not Receive Care Due to Costs, '08/0(	New York State Expanded Behavioral Risk Factor Surveillance System	http://www.health.ny.gov/statistics/brfss/expanded/2009/county
8	% of Adults (18 and Older) with Poor Physical Health, '08/09	New York State Expanded Behavioral Risk Factor Surveillance System	http://www.health.ny.gov/statistics/brfss/expanded/2009/county
9	% of Adults (18 and Older) with Physical Limitations, '08/09	New York State Expanded Behavioral Risk Factor Surveillance System	http://www.health.ny.gov/statistics/brfss/expanded/2009/county
10	% of Adults (18 and Older) with Health Problems that Need Special Equipment, '08/0(	New York State Expanded Behavioral Risk Factor Surveillance System	http://www.health.ny.gov/statistics/brfss/expanded/2009/county
11	Percentage of Adults (18 and Older) with Disabilities, '08/0(	New York State Expanded Behavioral Risk Factor Surveillance System	http://www.health.ny.gov/statistics/brfss/expanded/2009/county
Focus Area: Injuries, Violence, and Occupational Health			
Prevention Agenda Indicators			
1	Rate of Hospitalizations due to Falls for Ages 65 Plus per 10,000 Population, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p9.htm
2	Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population, Children Ages 1 - 4, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p10.htm
3	Rate of Assault-Related Hospitalizations per 10,000 Population, '08 - 1(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p11.htm
4	Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '08 - 1(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p12.htm
5	Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '08 - 1(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p13.htm
6	Ratio of Assault-Related Hospitalizations for Low-Income versus non-Low income Zip Codes, '08 - 1(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p14.htm
7	Rate of ED Occupational Injuries Among Working Adolescents Ages 15 - 19 per 10,000 Population Ages 15 - 19, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p15.htm
Other Indicators			
1	Rate of Hospitalizations for Falls for Children Ages Under 10 per 10,000 Population, Children Ages Under 10 , '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h25.htm
2	Rate of Hospitalizations for Falls for Children Ages 10 - 14 per 10,000 Population, Children Ages 10 - 14, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h26.htm
3	Rate of Hospitalizations for Falls for Individuals Ages 15 - 24 per 10,000 Individuals Ages 15 - 24, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h27.htm
4	Rate of Hospitalizations for Falls for Adults Ages 25 - 64 per 10,000 Adults Ages 25 - 64, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h28.htm
5	Rate of Violent Crimes per 100,000 Population, '07 - 11	NY State Division of Criminal Justice, 2011 Crime Statistics	http://www.criminaljustice.ny.gov/crimnet/ojsa/countycrimestats.htm
6	Rate of Property Crimes per 100,000 Population, '07 - 11	NY State Division of Criminal Justice, 2011 Crime Statistics	http://www.criminaljustice.ny.gov/crimnet/ojsa/countycrimestats.htm
7	Rate of Total Crimes per 100,000 Population, '07 - 11	NY State Division of Criminal Justice, 2011 Crime Statistics	http://www.criminaljustice.ny.gov/crimnet/ojsa/countycrimestats.htm
8	Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population Ages 15 Plus, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g78.htm
9	Rate of Pneumonconisis Hospitalizations, Ages 15 Plus, per 10,000 Population Ages 15 Plus, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g79.htm
10	Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population Ages 15 Plus, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g80.htm
11	Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 10,000 Individuals Employed Ages 16 Plus, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g81.htm
12	Rate of Elevated Blood Lead Levels Ages 16 Plus Employed per 10,000 Individuals Employed Ages 16 Plus, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g82.htm
13	Rate of Total Motor Vehicle Crashes per 100,000 Population, '09 - 11	Safe New York: Governor's Traffic Safety Committee	http://www.safeny.ny.gov/11data/NYS09-11byCo_5Crash.pdf
14	Rate of Pedestrian-Related Accidents per 100,000 Population, '09 - 11	Safe New York: Governor's Traffic Safety Committee	http://www.safeny.ny.gov/11data/NYS09-11byCo_5Crash.pdf
15	Rate of Speed-Related Accidents per 100,000 Population, '09 - 11	Safe New York: Governor's Traffic Safety Committee	http://www.safeny.ny.gov/11data/NYS09-11byCo_5Crash.pdf
16	Rate of Motor Vehicle Accident Deaths per 100,000 Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d28.htm
17	Rate of TBI Hospitalizations per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h33.htm
18	Rate of Unintentional Injury Hospitalizations per 10,000 Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h18.htm
19	Rate of Unintentional Injury Hospitalizations Ages 14 and Under per 10,000 Population Ages 14 and Under , '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h20.htm
20	Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population Ages 65 Plus, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h23.htm
21	Rate of Poisoning Hospitalizations per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h32.htm
Focus Area: Outdoor Air Quality			
1	Number of Days with Unhealthy Ozone, 2007	County Health Rankings and Roadmaps	http://www.countyhealthrankings.org/rankings/data
2	Numbert of Days with Unhealthy Particulated Matter, 2007	County Health Rankings and Roadmaps	http://www.countyhealthrankings.org/rankings/data
Focus Area: Built Environment			
1	Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 201:	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p16.htm
2	Percentage of Commuters Who Use Alternative Modes of Transportation to Work, '07 - 11	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p17.htm
3	Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 201(	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p18.htm
4	Percentage of Homes in Vulnerable Neighborhoods that have Fewer Asthma Triggers During Home Revisits, '08 - 1:	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p19.htm
Focus Area: Water Quality			
1	Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 201:	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p20.htm
Focus Area: Reduce Obesity in Children and Adults			
Prevention Agenda Indicators			
1	Percentage of Adults 18 and Older Who are Obese, '08/09	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p21.htm
2	Percentage of Public School Children Who are Obese, '10 - 12	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201:	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p22.htm
Other Indicators			
1	Percentage of Total Students Overweight, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g63.htm
2	Percentage of Elementary Students Overweight, Not Obese, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g66.htm
3	Percentage of Elementary Students Obese, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g67.htm
4	Percentage of Middle and High School Students Overweight, Not Obese, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g69.htm
5	Percentage of Middle and High School Students Obese	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g70.htm
6	Percentage of WIC Children Ages 2 - 4 Obese, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g72.htm
7	Percentageof Age Adjusted Adults Overweight or Obese, '08/0(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g74.htm
8	Percentage of Age Adjusted Adults Who Did Not Participate in Leisure Activities Last 30 Days, '08/0(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g76.htm
9	Number of Recreational and Fitness Facilities per 100,000 Population, 200(	United States Department of Agriculture, Food Environment Atlas Data File	http://www.ers.usda.gov/data-products/food-environment-atlas/data-access-and-documentation-downloads.asp
10	Percentage of Age Adjusted Adults Eating Five or More Vegetables per Day, '08/0(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g77.htm
11	Percentage of Age Adjusted Adults with Cholesterol Check within the Last Five Years, '08/0!	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g23.htm
12	Percentage of Age Adjusted Adults Ever Diagnosed with High Blood Pressure, '08/0(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g24.htm
13	Percentage of Age Adjusted Adults with Physician Diagnoses Angina, Heart Attack, or Stroke, '08/0(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g22.htm
14	Rate of Cardiovascular Disease Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d1.htm
15	Rate of Cardiovascular Premature Deaths (35 - 64) per 100,000 Population 35 - 64, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d2.htm
16	Rate of Pretransport Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d3.htm
17	Rate of Cardiovascular Hospitalizastions per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h1.htm
18	Rate of Diseases of the Heart Deaths per 100,000 Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d4.htm
19	Rate of Diseases of the Heart Premature Deaths (35 - 64) per 100,000 Population Ages 35 - 64, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d5.htm
20	Rate of Disease of the Heart Transport Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d6.htm
21	Rate of Disease of the Heart Hospitalizations per 10,000 Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h2.htm
22	Rate of Coronary Heart Diseases Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d7.htm
23	Rate of Coronary Heart Diseases Premature Deaths (35 - 64) per 100,000 Population Ages 35 - 64, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d8.htm
24	Rate of Coronary Heart Disease Transport Deaths per 100,000 Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d9.htm
25	Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h3.htm
26	Rate of Congestive Heart Failure Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d10.htm
27	Rate of Congestive Heart Failure Premature Deaths (35 - 64) per 100,000 Population Ages 35 - 64, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d11.htm
28	Rate of Congestive Heart Failure Transport Deaths per 100,000 Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d12.htm
29	Rate of Congestive Heart Failure Hospitalizations per 10,000 Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h4.htm
30	Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d13.htm
31	Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h5.htm
32	Rate of Hypertension Hospitalizations (18 Plus) per 100,000 Population 18 Plus, '08 - 1(	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h6.htm

33	Rate of Diabetes Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d22.htm
34	Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h11.htm
35	Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h12.htm
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure			
Prevention Agenda Indicators			
1	Percentage of Adults 18 and Older Who Smoke '08/09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g108.htm
Other Indicators			
1	Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d30.htm
2	Rate of Chronic Lower Respiratory Disease Hospitalzations per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h34.htm
3	Rate of Asthma Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d31.htm
4	Rate of Asthma Hospitalizations per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h35.htm
5	Rate of Asthma Hospitalizations, 25 - 44, per 10,000 Population Ages 25 - 44, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h41.htm
6	Rate of Asthma Hospitalizations, 45 - 64, per 10,000 Population Ages 45 - 64, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h42.htm
7	Rate of Asthma Hospitalizations,65 Plus, per 10,000 Population Ages 65 Plus, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h43.htm
8	Percentage of Adults with Asthma, '08/09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g95.htm
9	Rate of Lung and Bronchus Deaths per 100,000 Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g8.htm
10	Rate of Lung and Bronchus Cases per 100,000 Population, '07- 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g7.htm
11	Number of Registered Tobacco Vendors per 100,000 Population, '09 - 10	NYSDOH; Tobacco Enforcement Program Annual Report	http://www.health.ny.gov/prevention/tobacco_control/docs/tobacco_enforcement_annual_report_2009-2010.pd
12	Percentage of Vendors with Sales to Minors Violations, '09 - 10	NYSDOH; Tobacco Enforcement Program Annual Report	http://www.health.ny.gov/prevention/tobacco_control/docs/tobacco_enforcement_annual_report_2009-2010.pd
13	Percentage of Vendors with Complaints, '09 - 10	NYSDOH; Tobacco Enforcement Program Annual Report	http://www.health.ny.gov/prevention/tobacco_control/docs/tobacco_enforcement_annual_report_2009-2010.pd
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care ad Management in Both Clinical and Community Settings			
Prevention Agenda Indicators			
1	Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, '08/0	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p24.htm
2	Rate of Asthma ED Visits per 10,000 Population, '08 - '10	New York State Department of Health; Information on Asthma in New York Stat	http://www.health.ny.gov/statistics/ny_asthma/ed/asthmaed6.htm
3	Rate of Asthma ED Visits Ages 0 - 4, per 10,000 Population Ages, 0 - 4, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p26.htm
4	Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, Ages 6 - 17, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p28.htm
5	Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, Ages 18 Plus, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p29.htm
6	Rate of Age Adjusted Heart Attack Hospitalizations per 10,000 Population, 201	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p27.htm
Other Indicators			
1	Rate of Asthma ED Visits for Ages 18 - 64 per 10,000 Population Ages 18 - 64, '08 - '10	New York State Department of Health; Information on Asthma in New York Stat	http://www.health.ny.gov/statistics/ny_asthma/ed/asthmaed5a.htm
2	Rate of Asthma ED Visits for Ages 65 Plus per 10,000 Population Ages 65 Plus, '08 - '10	New York State Department of Health; Information on Asthma in New York Stat	http://www.health.ny.gov/statistics/ny_asthma/ed/asthmaed5.htm
3	Rate of All Cancer Cases per 100,000 Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g1.htm
4	Rate of all Cancer Deaths per 100,000 Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g2.htm
5	Rate of Female Breast Cancer Cases per 100,000 Female Population, '07 -09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g9.htm
6	Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g11.htm
7	Rate of Female Breast Cancer Deaths per 100,000 Female Population, '07	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g10.htm
8	Percentageof Women 40 Plus With Mammogram within Last Two Years, '08/ 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g21.htm
9	Rate of Cervix and Uteric Cancer Cases per 100,000 Female Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g12.htm
10	Rate of Cervix and Uteric Cancer Deaths per 100,000 Female Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g13.htm
11	Percentageof Women 18 and Older with a Pap Smear within the Last Three Yearrs, '08/ 0	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g20.htm
12	Rate of Ovarian Cancer Cases per 100,000 Female Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g14.htm
13	Rate of Ovarian Cancer Deaths per 100,000 Female Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g15.htm
14	Rate of Colon and Rectum Cancer Cases per 100,000 Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g5.htm
15	Rate of Colon and Rectum Cancer Deaths per 100,000 Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g6.htm
16	Percentage of Adults 50 Plus with Home Blood Stool Test within the Last Two Years, '08/0	New York State Expanded Behavioral Risk Factor Surveillance System	http://www.health.ny.gov/statistics/brfss/expanded/2009/county
17	Percentageof Adults 50 Plus with Sigmoidoscopy or Colonoscopy within Last Ten Years, '08/0	New York State Expanded Behavioral Risk Factor Surveillance System	http://www.health.ny.gov/statistics/brfss/expanded/2009/county
18	Rate of Prostate Cancer Deaths per 100,000 Male Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g17.htm
19	Rate of Prostate Cancer Cases per 100,000 Male Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g16.htm
20	Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g18.htm
21	Percentage of Males, 40 and Older with a Digital Rectal Exam within Last Two Years, '08/09	New York State Expanded Behavioral Risk Factor Surveillance System	http://www.health.ny.gov/statistics/brfss/expanded/2009/county
22	Percentage of Males, 40 and Older with a Prostate Antigen Test within Last Two Years, '08/0	New York State Expanded Behavioral Risk Factor Surveillance System	http://www.health.ny.gov/statistics/brfss/expanded/2009/county
23	Rate of Melanoma Cancer Deaths per 100,000 Population, '07 - '09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g19.htm
24	Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, '08 - 1	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g92.htm
25	Percentage of Age Adjusted Adults with a Dental Visit Within the Last Twelve Months, '08/0	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g90.htm
26	Oral Cavity and Pharnyx Cancer Deaths per 100,000 Population, '07-09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g4.htm
27	Oral Cavity and Pharnyx Cancer Deaths, Adults 45 - 74, per 100,000 Population, 45 - 74, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g94.htm
28	Oral Cavity and Pharnyx Cancer Cases per 100,000 Population, '07 - 09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g3.htm
Focus Area: Maternal and Infant Health			
Prevention Agenda Indicators			
1	Percentage Preterm Births < 37 Weeks of total births known gestation period, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b40.htm
2	Ratio of Preterm Births (< 37 wks) Black/NH to White/NH, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p42.htm
3	Ratio of Preterm Births (< 37 wks) Hisp/Latino to White/NH, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p43.htm
4	Ratio of Preterm Births (< 37 wks) Medicaid to Non-Medicaid. '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p44.htm
5	Rate of Maternal Mortality per 100,000 Births, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b33.htm
6	Percentage of Live birth Infants Exclusively Breastfed in Delivery Hospital, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b25.htm
7	Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, '08 - 1	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p46.htm
8	Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, '08 - 1	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p47.htm
9	Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p48.htm
Other Indicators			
1	Percentage Perterm Births < 32 weeks of total births known gestation period, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b38.htm
2	Percentage Preterm Births 32 to < 37 Weeks of total births known gestation period, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b39.htm
3	Percentage of Total Births with Weights Less Than 1,500 grams, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b34.htm
4	Percentageof Singleton Births with Weights Less Than 1,500 grams, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b35.htm
5	Percentage of Total Births with Weights Less Than 2,500 grams, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b36.htm
6	Percentage of Singleton Births with Weights Less Than 2,500 grams, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b37.htm
7	Percentage of Total Births for Black, Non-Hispanic, with Weights Less than 2,500 Grams, '08 - 10	NYSDOH; State and County Indicators for Tracking Public Health Priority Area	http://www.health.ny.gov/statistics/community/minority/county/
8	Percentage of Total Births for Hispanic/Latino, with Weights Less than 2,500 Grams, '08 - 10	NYSDOH; State and County Indicators for Tracking Public Health Priority Area	http://www.health.ny.gov/statistics/community/minority/county/
9	Infant Mortality Rate per 1,000 Live Births, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b27.htm
10	Infant Mortality Rate for Black, Non-Hispanic per 1,000 Births, '08 - 10	NYSDOH; State and County Indicators for Tracking Public Health Priority Area	http://www.health.ny.gov/statistics/community/minority/county/
11	Infant Mortality Rate for Hispanic/Latino per 1,000 Births, '08 - 10	NYSDOH; State and County Indicators for Tracking Public Health Priority Area	http://www.health.ny.gov/statistics/community/minority/county/
12	Rate of Deaths (28 Weeks Gestation to Sevem Days) per 1,000 Live Births and Perinatal Deaths, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b32.htm
13	Percentage Early Prenatal Care of Total Births Where Prenatal Care Status is Known, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b21.htm
14	Percentage Early Prenatal Care for Black, Non-Hispanic, '08 - 10	NYSDOH; State and County Indicators for Tracking Public Health Priority Area	http://www.health.ny.gov/statistics/community/minority/county/
15	Percentge Early Prenatal Care for Hispanic/Latino, '08 - 10	NYSDOH; State and County Indicators for Tracking Public Health Priority Area	http://www.health.ny.gov/statistics/community/minority/county/
16	Percentage APGAR Scores of Less Than Five at Five Minute Mark of Births Where APGAR Score is Known, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b41.htm
17	Rate of Newborn Drug Related Hospitalizations per 10,000 Births, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h46.htm
18	Percentage WIC Women Breastfed at Six months, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g62.htm
19	Percentage Infants Receiving Any Breast Milk in Delivery Hospital, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b24.htm
Focus Area: Preconception and Reproductive Health			
Prevention Agenda Indicators			
1	Percent of Births within 24 months of Previous Pregnancy, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b1.htm
2	Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b12.htm
3	Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p55.htm
4	Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p56.htm
5	Percent of Unintended Births to Total Births, 2011	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p57.htm
6	Ratio of Unintended Births Black, non-Hispanic to White, non-Hispanic, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p58.htm
7	Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p59.htm
8	Ratio of Unintended Births Medicaid to Non-Medicaid, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p60.htm
9	Percentage of Women Ages 18- 64 with Health Insurance, '08/09	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-201	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p61.htm
Other Indicators			
1	Rate of Total Births per 1,000 Females Ages 15-44, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b5.htm
2	Percent Multiple Births of Total Births, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b20.htm
3	Percent C-Sections to Total Births. '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b26.htm
4	Rate of Total Pregnancies per 1,000 Females Ages 15-44, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b10.htm

5	Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b6.htm
6	Rate of Pregnancies Ages 10 - 14 per 1,000 Females Ages 10-14, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b11.htm
7	Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b7.htm
8	Rate of Births Ages 15 - 19 per 1,000 Females Ages 15-19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b8.htm
9	Rate of Pregnancies Ages 15 - 19 per 1,000 Females Ages 5-19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b13.htm
10	Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b9.htm
11	Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b14.htm
12	Percent Total Births to Women Ages 35 Plus, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b4.htm
13	Rate of Abortions Ages 15 - 19 per 100 Live Births, Mothers Ages 15-19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b15.htm
14	Rate of Abortions All Ages per 100 Live Births to All Mothers, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/birth/b16.htm
15	Percentage of WIC Women Pre-pregnancy Underweight, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g55.htm
16	Percentage of WIC Women Pre-pregnancy Overweight but not Obese, ' 08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g56.htm
17	Percentage of WIC Women Pre-pregnancy Obese, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g57.htm
18	Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g59.htm
19	Percentage of WIC Women with Gestational Diabetes, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g60.htm
20	Percentage of WIC Women with Gestational Hypertension, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g61.htm
Focus Area: Child Health			
Prevention Agenda Indicators			
1	Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2011	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p66.htm
2	Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2011	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p67.htm
3	Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits, 2011	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p68.htm
4	Percentage of Children Ages 0 -19 with Health Insurance, 2010	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p51.htm
5	Percentage of 3rd Graders with Untreated Tooth Decay, '09 - 11	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p52.htm
6	Ratio of 3rd Graders with Untreated Tooth Decay, Low Income Children to Non-Low income Children, '09 - 11	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p53.htm
Other Indicators			
1	Rate of Children Deaths Ages 1 - 4 per 100,000 Children Ages 1 - 4, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d16.htm
2	Rate of Children Deaths Ages 5 - 9 per 100,000 Children Ages 5 - 9, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d17.htm
3	Rate of Children Deaths Ages 10 - 14 per 100,000 Children ages 10 - 14, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d18.htm
4	Rate of Children Deaths Ages 5 - 14 per 100,000 Children Ages 5 - 14, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d19.htm
5	Rate of Children Deaths Ages 5 - 19 per 100,000 Children Ages 15 - 19 , '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d20.htm
6	Rate of Children Deaths Ages 1 - 19 per 100,000 Children Ages 1 - 19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/indicators/cah.htm
7	Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population, Children Ages 0 - 4, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h36.htm
8	Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population, Children Ages 5 - 14, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h37.htm
9	Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Ages Children 0 - 17,	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h38.htm
10	Rate of Gastroenteristis Hospitalizations Children Ages 0 - 4 per 10,000 Population, Children Ages 0 - 4	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h7.htm
11	Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population, Children Ages 0 - 4	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h8.htm
12	Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population, Children Ages 0 - 4	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h9.htm
13	Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population, Children Ages 0 - 4 '08-'10	NYSDOH; Information on Asthma in New York State	http://www.health.ny.gov/statistics/ny_asthma/ed/asthmaed0.htm
14	Percentage of Children Screened for Lead by Age 9 months	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g25.htm
15	Percentage of Children Screened for Lead by Age 18 months	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g26.htm
16	Percentage of Children Screened for Lead by Age 36 months (at least two screenings	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g27.htm
17	Rate of Children Ages < 6 with Confirmed Blood Lead Levels >= 10 mg/dl Cases Per 1,000 Children Tested, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g28.htm
18	Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population, Children Under Age 10, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h19.htm
19	Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population, Children Ages 10 - 14, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h20.htm
20	Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Ages 15 - 24, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h21.htm
21	Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population, Children Ages 0 - 17, '07 - 09	New York State Department of Health; Information on Asthma in New York State	http://www.health.ny.gov/statistics/ny_asthma/ed/asthmaed2b.htm
22	Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit, 08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g93.htm
23	Percentage of 3rd Graders with Dental Caries, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g84.htm
24	Percentage of 3rd Graders with Dental Sealants, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g86.htm
25	Percentage of 3rd Graders with Dental Insurance, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g87.htm
26	Percentage of 3rd Graders with at Least One Dental Visit, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g88.htm
27	Percentage of 3rd Graders Taking Fluoride Tablets Regularly, '09 - 11	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g89.htm
28	Rate of Caries ED Visits for Children Ages 3 - 5 per 10,000 Population, Children Ages 3 - 5, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/ed/e1.htm
29	Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g73.htm
Focus Area: Human Immunodeficiency Virus (HIV)			
Prevention Agenda Indicators			
1	Rate of Newly Diagnosed HIV Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g43.htm
2	Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p34.htm
Other Indicators			
1	Rate of AIDS Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g44.htm
2	Rate of AIDS Deaths per 100,000 Adjusted Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d23.htm
Focus Area: Sexually Transmitted Disease (STDs)			
Prevention Agenda Indicators			
1	Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2010	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p39.htm
2	Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2010	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p40.htm
3	Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2010	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p36.htm
4	Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2010	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p37.htm
5	Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Females Ages 15 - 44, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p38.htm
Other Indicators			
1	Rate of Early Syphilis Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g45.htm
2	Rate of Gonorrhea Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g46.htm
3	Rate of Gonorrhea Ages 15 - 19 Cases per 100,000 Population Ages 15-19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g47.htm
4	Rate of Chlamydia Cases All Males per 100,000 Male Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g48.htm
5	Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g49.htm
6	Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g50.htm
7	Rate of Chlamydia Cases All Females per 100,000 Female Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g51.htm
8	Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population Ages 15 - 19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g52.htm
9	Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population Ages 20-24, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g53.htm
10	Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population Ages 15 - 44, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h14.htm
Focus Area: Vaccine Preventable Disease			
Prevention Agenda Indicators			
1	Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2011	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p30.htm
2	Percent females 13 - 17 with 3 dose HPV vaccine, 2011	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p31.htm
3	Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, '08/09	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p32.htm
Other Indicators			
1	Rate of Pertussis Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g30.htm
2	Rate of Pneumonia/flu Hospitalizations Ages 65 Plus per 100,000 Population Age 65 Plus, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h13.htm
3	Percent of Adults Ages 65 Plus Ever Received a Pneumonia Shot, '08/09	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g42.htm
4	Rate of Mumps Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g31.htm
5	Rate of Meningococcal Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g32.htm
6	Rate of H influenza Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g33.htm
Focus Area: Healthcare Associated Infections			
Prevention Agenda Indicators			
1	Rate of Hospital Onset CDIs per 10,000 Patient Days, 2011*	NYSDOH Hospital Report on Hospital Acquired Infections	https://health.data.ny.gov/Health/Hospital-Acquired-Infections/utrt-zdsj
2	Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2011*	NYSDOH Hospital Report on Hospital Acquired Infections	https://health.data.ny.gov/Health/Hospital-Acquired-Infections/utrt-zdsj

(*) Caution should be taken when comparing Clostridium difficile rates due to differences in laboratory testing methods and patient risk factors between hospitals

Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders			
Prevention Agenda Indicators			
1	Percent of Adults Binge Drinking within the Last Month, '08/09	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p64.htm
2	Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, '08/09	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p63.htm
3	Rate of Age Adjusted Suicides per 100,000 Adjusted Population, '08 - 10	New York State Department of Health; Indicators for Tracking Public Health Priority Areas 2013-2017	http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p65.htm

Other Indicators			
1	Rate of Suicides for Ages 15 - 19 per 100,000 Population, Ages 15 - 19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d25.htm
2	Rate of Self-inflicted Hospitalizations 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h15.htm
3	Rate of Self-inflicted Hospitalizations for Ages 15 - 19 per 10,000 Population, Ages 15 - 19, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h16.htm
4	Rate of Cirrhosis Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/mortality/d21.htm
5	Rate of Cirrhosis Hospitalizations per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h10.htm
6	Rate of Alcohol-Related Accidents per 100,000 Population, '09 - 11	Safe New York: Governor's Traffic Safety Committee	http://www.safeny.ny.gov/11data/NYS09-11byCo_5Crash.pdf
7	Percentage of Alcohol-Related Crashes to Total Accidents, 09 - 11	Safe New York: Governor's Traffic Safety Committee	http://www.safeny.ny.gov/11data/NYS09-11byCo_5Crash.pdf
8	Rate of Alcohol-Related Injuries ad Deaths per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g107.htm
9	Rate of Drug-Related Hospitalizations per 10,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/hospital/h45.htm
10	Rate of People Served in Mental Health Outpatient Settings Ages 8 and Below per 100,000 Population, Ages 8 and Below, 201	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=gen-pop&yearval=2011
11	Rate of People Served in Mental Health Outpatient Settings Ages 9 - 17 per 100,000 Population, Ages 9 - 17, 2011	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=gen-pop&yearval=2011
12	Rate of People Served in Mental Health Outpatient Settings Ages 18 - 64 per 100,000 Population, Ages 18 - 64, 2011	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=gen-pop&yearval=2011
13	Rate of People Served in Mental Health Outpatient Settings Ages 65 Plus per 100,000 Population, Ages 65 Plus, 2011	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=gen-pop&yearval=2011
14	Rate of People Served in ED for Mental Health Ages 8 and Below per 100,000 Population, Ages 8 and Below, 2011	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=gen-pop&yearval=2011
15	Rate of People Served in ED for Mental Health Ages 9 - 17 per 100,000 Population, Ages 9 - 17, 2011	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=gen-pop&yearval=2011
16	Rate of People Served in ED for Mental Health Ages 18 - 64 per 100,000 Population, Ages 18 - 64, 2011	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=gen-pop&yearval=2011
17	Rate of People Served in ED for Mental Health Ages 65 Plus per 100,000 Population, Ages 65 Plus, 2011	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=gen-pop&yearval=2011
18	Percentage of Children Ages 9 - 17 with Serious Emotional Disturbances (SED) Served to Total SED Children Ages 9 - 17, 201	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=pop-smi&yearval=2011
19	Percentage of Adults Ages 18 - 64 with Serious Mental Illness (SMI) Served, 2011	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=pop-smi&yearval=2011
20	Percentage of Adults Ages 65 Plus with Serious Mental Illness (SMI) Served, 2011	Office of Mental Health, PCS Planning Reports	http://bi.omh.ny.gov/pcs/Planning%20Report?pageval=pop-smi&yearval=2011
Other Non Preventive Agenda Indicators			
1	Rate of Hepatitis A Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g34.htm
2	Rate of Acute Hepatitis B Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g35.htm
3	Rate of TB Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g36.htm
4	Rate of e. Coli 157 Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g37.htm
5	Rate of Salmonella Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g38.htm
6	Rate of Shigella Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g39.htm
7	Rate of Lyme Disease Cases per 100,000 Population, '08 - 10	NYSDOH; New York State Community Health Indicator Reports	http://www.health.ny.gov/statistics/chac/general/g40.htm
8	Rate of Confirmed Rabies Cases per 100,000 Population, ' 08 - 10	NYSDOH, Rabies Laboratory at Wadsworth	http://www.wadsworth.org/rabies/annualsum.htm
9	Rate of Confirmed West Nile Virus Cases (Humans, Horses, Other Animals, Mosquito Pools) per 100,000 Population, '08 - 10	NYSDOH, West Nile Virus	http://www.health.ny.gov/diseases/west_nile_virus/update/

Appendix F: Regional Community Provider Survey Methodology and Results

Results of the Adirondack Regional Health Network Survey

Regional Results Summary

March 28, 2013

Report to the Adirondack Rural Health Network

Brad R. Watts
Center for Human Services Research
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Executive Summary

In December 2012 and January 2013, the Adirondack Regional Health Network (ARHN) conducted a survey of selected stakeholders representing health care and service-providing agencies within the eight-county region. The results of the survey are intended to provide an overview of regional needs and priorities, to inform future planning and the development of a regional health care agenda.

- The 81-question survey was distributed electronically to 624 participants. In total, 285 surveys were completed, a response rate of 45.7 percent.
- Among the five NYS Prevention Agenda priority areas, chronic disease was ranked as the area of highest community need and agency interest.
- The agenda area of HIV, STIs, and vaccine preventable diseases was ranked lowest in terms of overall interest and concern.
- The top emerging issues in the region include increases in obesity and related health issues, increases in substance abuse, and mental illness.
- The population groups identified most in need of targeted interventions are: the poor, children, individuals with mental health issues, the elderly, and substance abusers.
- Only about half of survey respondents reported being familiar with the NYS Department of Health Prevention Agenda priority areas.
- The individual issues of greatest importance to survey respondents were the general health and safety of the physical environment, diabetes prevention, substance abuse, mental health screening and treatment, and the prevention of heart disease.
- When asked to rate the effectiveness of current local efforts to address major health issues, a large portion of respondents indicated that they did not know, which suggests that additional information and publicity may be needed for health activities in the region.
- Education is the dominant strategy currently used to address major health issues in the region. Direct, hands-on strategies such as screening or clinical services are less prevalent.
- Technology is not highly utilized by health service providers and their clients in the region. A slight majority of respondents agreed that technology enhancement should be a top priority for the region.
- The top future concern for stakeholders was funding. Regional health care organizations expressed concerns about reimbursement rates and expectations of reduced funding through government payments and other grants.

Overview

This report details the findings of a survey conducted by the Center for Human Services Research (CHSR) and the Adirondack Rural Health Network (ARHN) between December 5, 2012 and January 21, 2013. The purpose of the study was to obtain feedback from community service providers in order to: 1) guide strategic planning, 2) highlight topics for increased public awareness, 3) identify areas for training, and 4) inform the statewide prevention agenda. Results presented in this report are for the entire region served by the Adirondack Rural Health Network, which includes eight counties located in upstate New York. In this report, these counties will be referred to as "the region":

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

Methodology

The 81 question survey was developed through a collaborative effort by a seven-member ARHN subcommittee during the Fall of 2012. The seven volunteer members are representatives of county public health departments and hospitals in the region that are involved in the ARHN. Subcommittee members were responsible for identifying the broad research questions to be addressed by the survey, as well as for drafting the individual survey questions.

Subcommittee members were also charged with identifying potential respondents to participate in the survey. Because each county in the region is unique in its health care and service-provision structure, ARHN members from each of the counties were asked to generate a list of relevant stakeholders from their own communities who would represent the full range of programs and service providers. As such, the survey population does not necessarily represent a random sampling of health care and service providers, but an attempt at a complete list of the agencies deemed by the ARHN to be the most important and representative within the region.

The survey was administered electronically using the web-based Survey Monkey program and distributed to an email contact list of 624 individuals identified in the stakeholder list created by the subcommittee. Two weeks before the survey was launched on December 5, 2012, an announcement was sent to all participants to encourage participation. After the initial survey email, two reminder notices were also sent to those who had not yet completed the survey. Additionally, participation was also incentivized through an opt-in gift card drawing, with 20 entrants randomly selected to receive a $25 Stewarts gift card at the conclusion of the survey. Ultimately, 285 surveys were completed during the six-week survey period, a response rate of 45.7 percent.

Profile of Survey Respondents

The tables in this section do not provide survey results, but instead provide a summary overview of the composition of survey participants. The representativeness of the survey participants as a true sample of health organizations in the region is dependent upon the mailing list compiled by ARHN and the willing and unbiased participation of the stakeholders that received the survey invitations.

Survey participants represent a diverse array of different agencies, population groups, and service-areas within the overall eight-county ARHN region. Below, Table A.1 shows the primary functions selected by respondents and Table 2 shows the populations that their agencies serve. Health care and educational agencies are well represented, and the majority provides services to children and adolescents, as well as people living at or near the poverty level.

Table A.1. Primary functions indicated by survey respondents

Organization Primary Function	Percent of all applicants
Health care	36.8
Education	36.5
Behavioral health	17.5
Healthy environment	14.7
Early childhood svcs.	14.4
Social services	11.9
Senior services	11.2
Other services	9.1
Developmental disability svcs.	8.4
Employ & training	8.4
Housing services	8.1
STI/HIV prevention	6.0
Physical disability svcs.	4.9
Government agency	2.1
Testing and prevention	2.1

Note: Respondents could select more than one primary function.

Table A.2. Populations served by survey respondent agencies

Population Served	Percent of all respondents
Children/adolescents	59.6
People living at or near poverty level	50.9
Seniors/elderly	44.9
People with disabilities	38.9
People with mental health issues	32.3
Women of reproductive age	31.9
People with substance abuse issues	25.6
Specific health condition or disease	24.6
Farmers	14.0
Migrant workers	11.2
Other	10.5
Specific racial or ethnic groups	8.4
Specific geographic area	5.3
Everyone	5.3
Specific age group	3.5

Note: respondents could select multiple populations.

Table A.3 shows the percent of respondents that provide services in each of the eight counties in the region. Most respondents represent health care service providers that work in multiple counties within the region. As the table illustrates, between roughly 18 and 30 percent of all respondents work in each county, which provides a significant level of overlap in services.

Table A.3. Percent of respondent agencies providing service in each county in the region

County	Percent
Essex	30.2
Franklin	29.1
Fulton	22.8
Warren	20.4
Hamilton	19.6
Washington	19.6
Clinton	18.6
Saratoga	18.2

Results

The findings are presented by thematic area: health trends, prevention agenda priorities, and technology trends and regional challenges. Additionally, within the Health Prevention Priorities section the results are detailed by the five areas of the NYS Department of Health Prevention Agenda, which are as follows:

- **Prevent chronic disease**. Focus on heart disease, cancer, respiratory disease, and diabetes and the shared risk factors of diet, exercise, tobacco, alcohol, and associated obesity.
- **Promote a healthy and safe environment**. Focus on environmental quality and the physical environment where people live, work, play, and learn.
- **Promote healthy women, infants, and children**. Focus on improving the health of women and mothers, birth outcomes, and child health including oral health.
- **Promote mental health and prevent substance abuse.** Focus on primary and secondary prevention and strategies for increasing screening to diagnose and connect people to needed services.
- **Prevent HIV, STIs, and vaccinate for preventable diseases**. Focus on preventing HIV, sexually transmitted infections, and preventable diseases via immunization.

Both quantitative and qualitative responses are summarized to present an overview of the respondents' perceptions of health care trends, the relevance of the priorities, the magnitude of difficulty faced by the region, areas of need, and the effectiveness of current efforts.

Emerging Health Trends

Survey respondents were asked two major questions about emerging community health trends: the first was an open-ended query about the most significant trend emerging over the next three years, while the second asked respondents to identify populations that need targeted efforts to address emerging health trends. Responses to the open-ended question were examined and coded into thematic categories in order to identify general areas of growing concern in the region. Table 1 shows the percentage of those who provided a response to the question who identified a trend within each thematic area. Because many respondents identified more than one emerging trend, the percentages do not add to 100.

By a large margin, the dominant trend emerging in the region is obesity, followed by growing substance abuse, mental health issues, and a declining availability of services and insurance coverage for community residents. The theme of chronic disease, which was cited by 5.4 percent of respondents, included trends of increasing cases of cancer, COPD (chronic obstructive pulmonary disease), heart disease, and other conditions that require ongoing or intensive care that is not always available in rural communities. Mentions of sexually transmitted infections (STIs) or diseases (STDs) were not dominant, despite the fact that the theme is similar to the identified NYS priority area.

Table 1.Percent selecting general emerging health trend

Theme	Percent
Growing obesity, childhood obesity, and related ailments	25.5
Substance abuse (alcohol, drugs, prescriptions)	16.2
Mental health issues	15.8
Lack of service availability, lack of insurance	13.1
Aging population / need for senior care	10.8
Increase in chronic diseases	5.4
Increasing STI/STD cases in community	5.4
Other	34.7

Total percentage is greater than 100 because more than one category could be identified

As shown in Table 2, many of the population groups identified as being in need of targeted efforts are reflected in the previous emerging themes. *Three of the top five population groups selected by respondents for targeting are: people with mental health issues, seniors/elderly, and people with substance abuse issues.* The two groups mentioned by a majority of respondents–people living in poverty and children/adolescents–are general groups of individuals who were frequently associated with emerging health issues in the open-ended question. For example, themes were sometimes listed as growing amongst children (e.g. childhood obesity, teen drug use) or related to an increase in regional poverty. Again, because survey respondents were allowed to select more than one group of individuals to target, the cumulative percentages exceed 100.

Table 2. Populations in need of targeted service efforts

Population group	Percent selecting
People living at or near poverty level	56.5
Children/adolescents	53.7
People with mental health issues	42.8
Seniors/elderly	39.6
People with substance abuse issues	37.5
People with disabilities	27.4
Women of reproductive age	26.3
Specific health condition or disease	22.5
Specific racial or ethnic groups	10.5
Migrant workers	5.3
Farmers	3.9
Everyone *	3.9
Other	3.9
Don't know	1.8

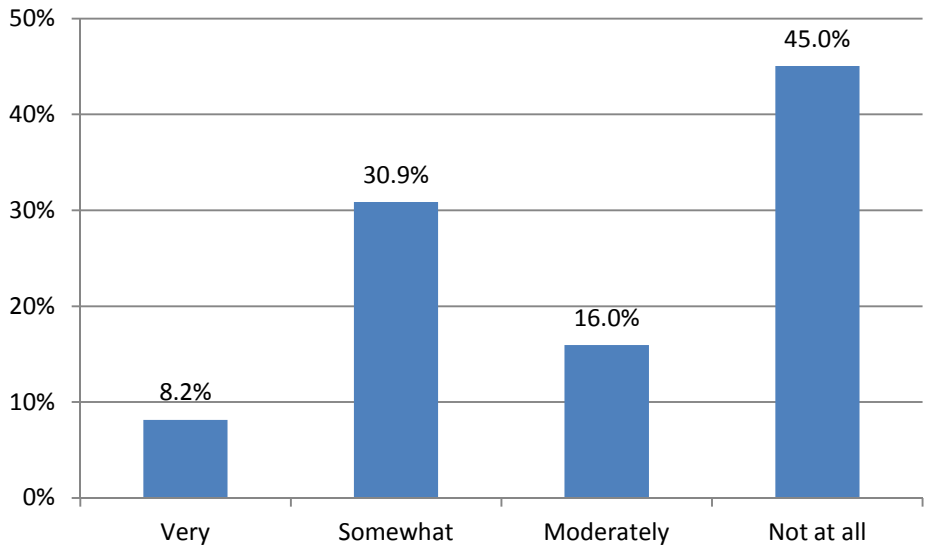
* Dominant write-in selection under other.

Health Prevention Agenda Priorities

Most of the survey items focus on identifying perceptions and needs within the region related to the five priorities selected by the NYS Department of Health Prevention Agenda. This section begins with a summary of service provider perceptions on how relevant these priorities are to the needs of their community, as well as the effectiveness of current efforts to address the issue. The latter part of this section presents data specific to each priority area: the strategies being employed, the local populations in need of targeted efforts, and a summary of any unique perspectives from the field.

Respondents were queried about their awareness of the NYS Department of Health (NYSDH) Prevention Agenda. *Slightly over half (50.9 percent) indicated that their organization was already aware that the Department of Health has a prevention agenda; 30.2 percent indicated that their organization was not aware and 18.9 percent indicated that they were not sure.* Those who selected "don't know" would seem to be indicating that while the respondent was not aware of the agenda, they felt it was possible that other leaders within the organization were aware. When survey respondents were asked about their own personal knowledge of the agenda, they indicated limited overall familiarity. As shown in Chart 1, 45 percent indicated that they were not at all familiar with the agenda, while only 8.2 percent were very familiar with the agenda. Obviously, for many of the survey respondents, their first exposure to the priority agenda focus areas occurred through participation in the ARHN survey.

Chart 1. Respondent ratings of own familiarity with the NYSDH Prevention Agenda



The ratings of priority area relevance should reflect both the unique needs of the respondent's region (which may vary from NYS as a whole) and the mix of service providers who completed the survey. Respondents were asked to rank order the five priorities from most to least important. Interestingly, the results shown in Table 3 indicate a slightly different perspective in priorities than was revealed by the earlier write-in question about emerging health trends. *The "prevent chronic disease" priority area was identified as the most important for the region, with nearly 40 percent selecting the priority as most important and approximately 19 percent selecting it as the second most important*. The health priority

area involving the "promotion of mental health" and the "prevention of substance abuse" was ranked most important by the second largest portion of respondents, 22.5 percent, and also was selected as the least important priority area by the smallest share of survey-takers, only 3.5 percent. At the other end of the spectrum, the priority area of "preventing STIs and promoting vaccines" was selected as most important by only 4.2 percent of respondents and selected as least important to the region by a majority of respondents, 62.3 percent.

Table 3.Priority areas by percent of respondents selecting ranking of importance to the region

	Importance ranking				
	Most	2nd	3rd	4th	5th
Prevent chronic disease	39.7	19.2	13.2	16.7	10.9
Promote mental health; prevent substance abuse	22.5	23.1	24.5	26.4	3.5
Promote healthy, safe environment	22.1	22.7	21.4	17.1	16.7
Promote healthy women & children	11.5	31.5	34.2	16.7	6.6
Prevent HIV/STIs; promote vaccines	4.2	3.5	6.6	23.3	62.3

In addition to ranking the importance of the five major NYS priority categories, respondents were also asked to select up to five specific issues most important to their service area. Although the option to select up to five areas of importance, along with the opportunity to write-in another option, allowed for a liberal interpretation of the "most important" issues, there was a clear division between the issues. The issues most frequently selected by respondents are shown in Table 4.

The issues that were identified as most important or most relevant as selected by around half of all survey respondents were: promoting a healthy and safe environment, preventing diabetes, prevention of substance abuse, and mental health screening. Once again, although the ordering was not entirely consistent with the findings from previous survey questions regarding regional priority areas, there were commonalities in the presence of the issues of "preventing diabetes" (a chronic condition), "prevention of substance abuse," "mental health screening," and the "promotion of a safe and healthy environment." Additionally, "preventing HIV and STIs" was once again ranked relatively low, with only 4.9 percent selecting the issue as among the most important.

Table 4. Percent selecting specific issues as most important or relevant to their service area

Issue	Percent selecting issue
Promoting a healthy & safe physical environment	50.9
Preventing diabetes	48.4
Prevention of substance abuse	44.9
Mental health screening & connection services	44.9
Preventing heart disease	39.3
Improving child health	37.9
Improving the health of women & mothers	33.0
Preventing cancer	31.9
Preventing respiratory disease	28.1
Immunizing against preventable diseases	23.2
Promoting environmental quality	21.4
Improving birth outcomes	12.6
Preventing HIV & STIs	12.3
Other	4.9

Another way of gauging the relevance of the five priority areas to the region is whether or not health agencies and service providers are already involved in efforts to improve related conditions within their own service areas. Survey respondents were asked about agency involvement in issues relating to the priority areas. Additionally, for each priority area, survey respondents were also asked whether or not their agency would be interested in collaborating on efforts to address the issue if it was selected as a priority community health issue for the Adirondack region. A summary of the results is presented in Chart 2 and Chart 3.

Agency involvement was highest for efforts to address the health of women and children, followed by efforts to prevent chronic disease, and efforts to promote a healthy and safe environment in the community (Chart 2). Involvement was least prevalent in efforts to prevent HIV, STIs and vaccine-preventable diseases, which only 37.1 percent of survey respondents indicated was an area of activity for their agency. For the priority area of promoting mental health and preventing substance abuse, the level of involvement was in the middle; 56.2 percent of respondents worked for agencies involved in mental health promotion efforts and a somewhat smaller portion were involved in substance abuse prevention efforts.

A majority of survey respondents indicated that their agency would be interested in collaborating to address most priority area issues if it was selected as a priority within the region (Chart 3). The exception was the prevention of HIV, STIs, and vaccine preventable diseases, which only 43.2 percent of respondents indicated would be an issue their agency would be willing to collaborate on. This suggests that HIV, STI, and vaccine preventable disease efforts are either an area of low interest for the region's

health care and service providers or that many feel they do not have the capacity or expertise to be involved in the issue. The lack of interest neatly corresponds with the limited current involvement with the issue that was illustrated in Chart 2.

Chart 2.Percentindicating agency currently involved with issue

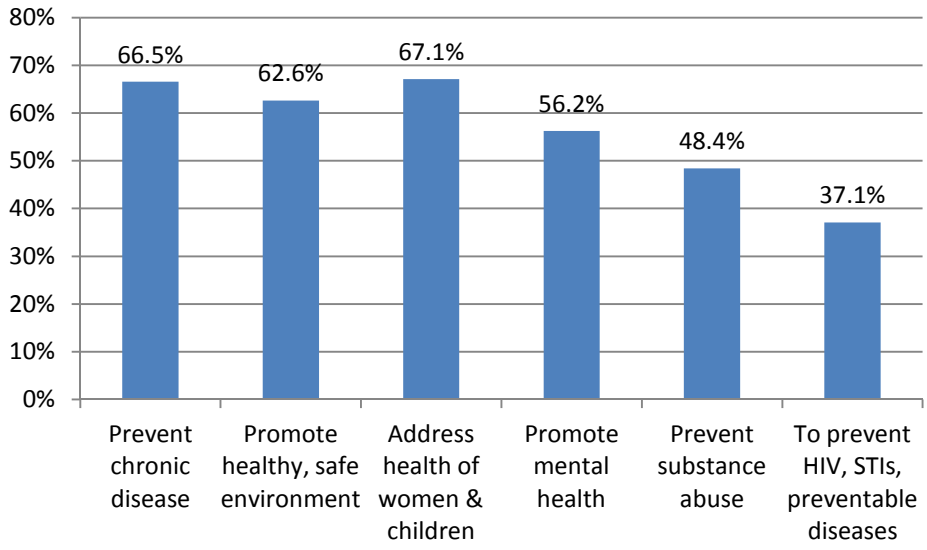
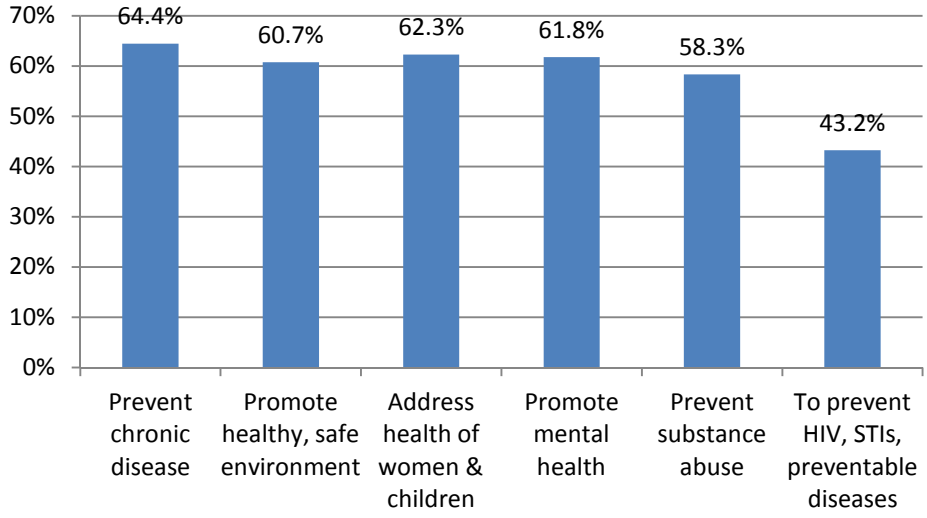


Chart 3. Percent interested in collaborating if issue is selected as a priority for the region



Priority Area Strategies and Effectiveness

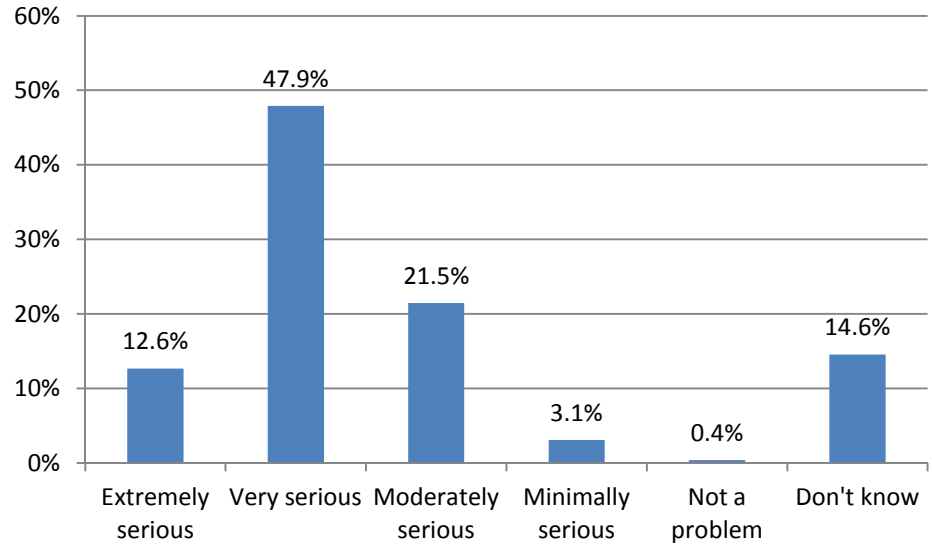
This section of the report details survey responses that are specific to each of the five different priority areas. While the previous section summarizes relative importance, involvement, and level of community need across the priority areas, this section focuses on how health agencies and other service providers have been addressing issues related to the priority areas, the perceived effectiveness of existing efforts

at their own and other agencies, and the level of interest in becoming involved with collaborating on future efforts.

Area 1: Prevent chronic disease

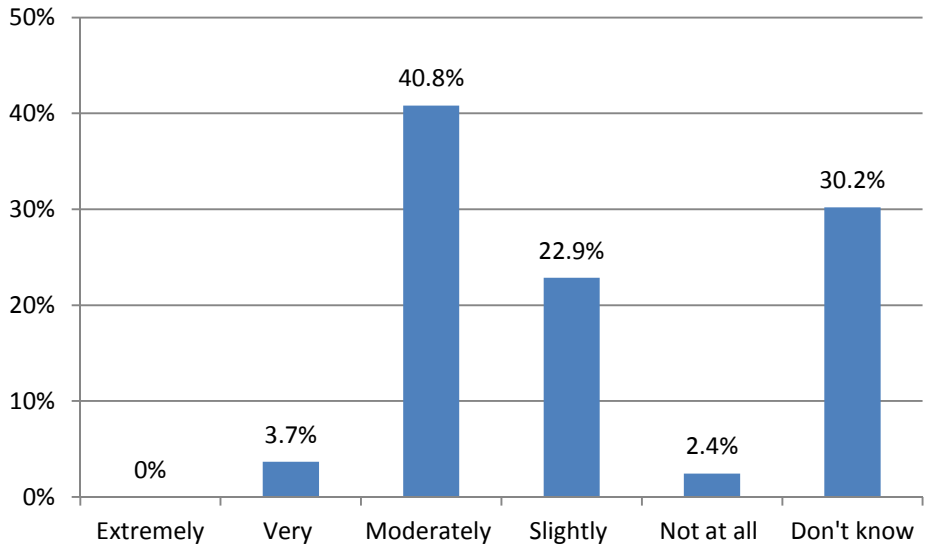
As shown earlier, a large portion of survey respondents believe that prevention of chronic disease is the most important and relevant priority area for the region (Table 3). This high prioritization may be related to the severity of chronic disease as a problem in the region. Chart 4 illustrates how respondents view the severity of the problem of chronic disease. *More than half indicated that the problem of chronic disease is either "very serious" or "extremely serious" while only 0.4 percent indicated that chronic disease is not a problem*. These ratings suggest that chronic disease is a more severe problem than the issues associated with the four other priority areas.

Chart 4. Rating of severity of chronic disease as a problem by share of respondents



One concern may be that effective programs to target chronic disease are limited in the region. None of the survey respondents indicated that existing efforts were extremely effective and only 3.7 percent rated them as very effective (Chart 5). Additionally, approximately 30 percent indicated that they did not know about the effectiveness of any area programs, which suggests that they may be limited in visibility or even absent from some parts of the region. Among those that provided statements on how these efforts might be improved, education and awareness were the most common themes, though many also noted that reducing chronic disease would require lifestyle changes, which would neither be easy nor quick to accomplish. It was also mentioned that growing poverty and shrinking budgets for programs targeting prevention were already hampering efforts to address problems like diabetes and obesity. When asked who should be targeted by efforts to address chronic disease, the majority identified persons living at or near poverty level, followed by senior citizens.

Chart 5. Rating of chronic disease effort effectiveness by share of respondents



Survey respondents were also asked to provide one or two top strategies being employed in the region by their agency to address chronic disease. *An analysis of open-ended responses revealed that educational efforts were the most common strategy to address chronic disease, followed by service coordination and cooperation efforts, and awareness promotion and service marketing* (Table 5). Note that because many respondents reported agency engagement in more than one strategy, the cumulative values shown in Table 5 exceed 100 percent.

Table 5. Percent reported as engaged in strategy to address issue of chronic disease

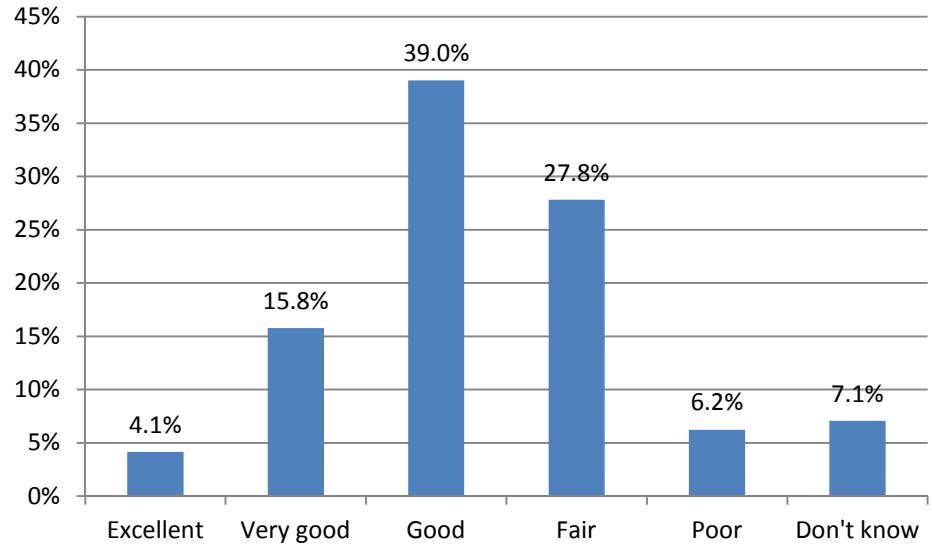
Strategy	Percent
Education (treatment options, prevention, risk factors)	41.8%
Service coordination, cooperation between agencies	14.4%
Promotion & marketing, community awareness campaigns	12.4%
Screening or testing (e.g. cancer, diabetes)	11.1%
Clinics operation, provision of basic medical services, home services	11.1%
Policy advocacy	11.1%
Drug abuse treatment programs, smoking cessation programs	3.9%
Other	23.5%

Area 2: Promote a healthy and safe environment

As stated previously, the priority area of promoting a healthy and safe environment was ranked by survey respondents as being very important in terms of its relative importance for the region; however, respondents provided a generally moderate assessment of current conditions. A plurality of respondents, 39 percent, rated the overall health and safety of the region "good," followed by 27.8 percent who selected the rating of "fair" (Chart 6). Few respondents selected ratings at either end of the ratings

scale: 6.2 percent rated the region's overall health and safety as poor and less than one percent described conditions as excellent.

Chart 6. Rating of overall regional health and safety by share of responses



Most respondents also provided only moderate rankings on the effectiveness of existing efforts to promote a healthy and safe environment. As shown in Chart 7, more than one-in-three respondents indicated that existing efforts are moderately effective, followed by approximately one-in-five who indicated that existing efforts are only "slightly" effective. A high portion of respondents, 31.6 percent, indicated that they don't know about the effectiveness of any current efforts to promote a healthy safe environment, which suggests that in some service areas such efforts are either poorly publicized or absent. Overall, the ratings seem to suggest that room exists for improvement in the programs that currently exist. When asked how current efforts could be improved, many respondents stated that they didn't know and several also suggested that there were not many efforts or that there was not enough follow through. Other respondents also suggested that increased coordination and more broad, community-level efforts were necessary.

As was the case with the chronic disease priority area, *the most prevalent strategy employed by respondent agencies to promote a healthy and safe environment was education*. When asked to provide one or two top strategies used by their own agency, 30.9 percent of respondents identified an activity associated with education of area residents on issues related to health and safety (Table 6). Other popular strategies included providing physical improvements in the community, coordinating with other agencies, and policy advocacy. The most commonly identified population groups for targeted efforts to improve general health and safety were people living at or near poverty, children and adolescents, and senior citizens.

Chart 7. Rating of effectiveness of existing efforts to promote health and safety by share of responses

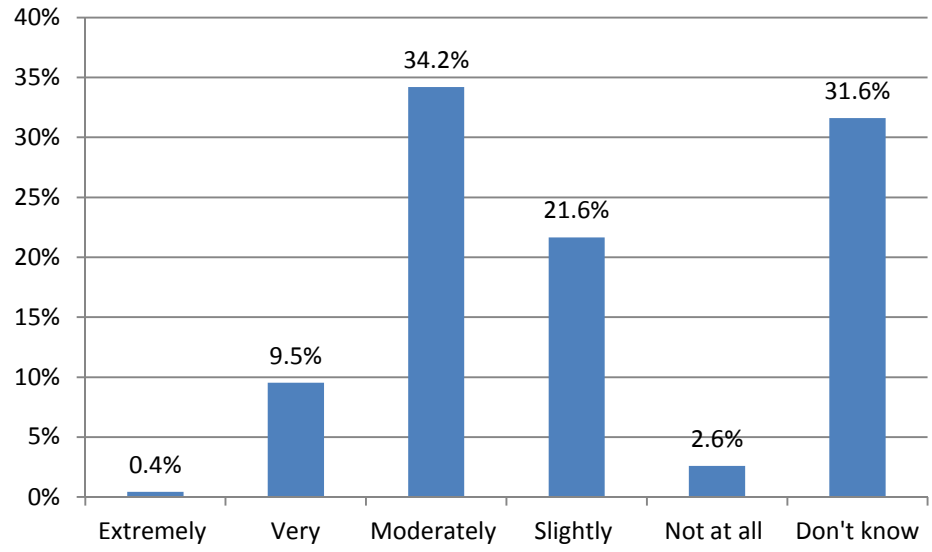


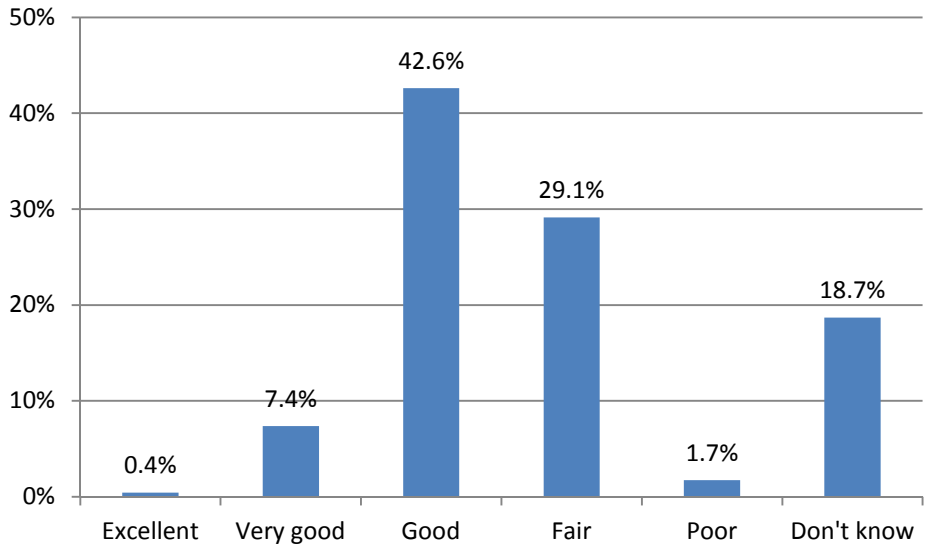
Table 6. Percent reported as engaged in strategy to promote health and safety

Strategy	Percent
Education (prevention and health ed., worker training)	30.9
Provide physical improvements (equipment, housing improvements, sidewalks and trails, community assets)	18.7
Service coordination, cooperation between agencies	15.4
Policy advocacy, create and implement safety rules	10.6
Exercise, food, and cooking programs	9.8
Inspection (safety), regulatory enforcement	8.1
Services for children, WIC, child care	8.1
Promotion & marketing, community awareness campaigns	6.5
Other	21.1

Area 3: Promote healthy women, infants, and children

The overall health of women, infants, and children was rated similar to that of the overall health and safety of the region: *most gave a rating of "good" or "fair" with few selecting the highest or lowest ratings* (Chart 8). Once again, a somewhat high portion of respondents, 18.7 percent, indicated that they did not know about the health of women, infants, and children in the region. The prevalence of "don't know" responses throughout the survey suggests that many stakeholders have not been informed about other health care efforts going on in the region. Also, very few described conditions as either excellent or poor.

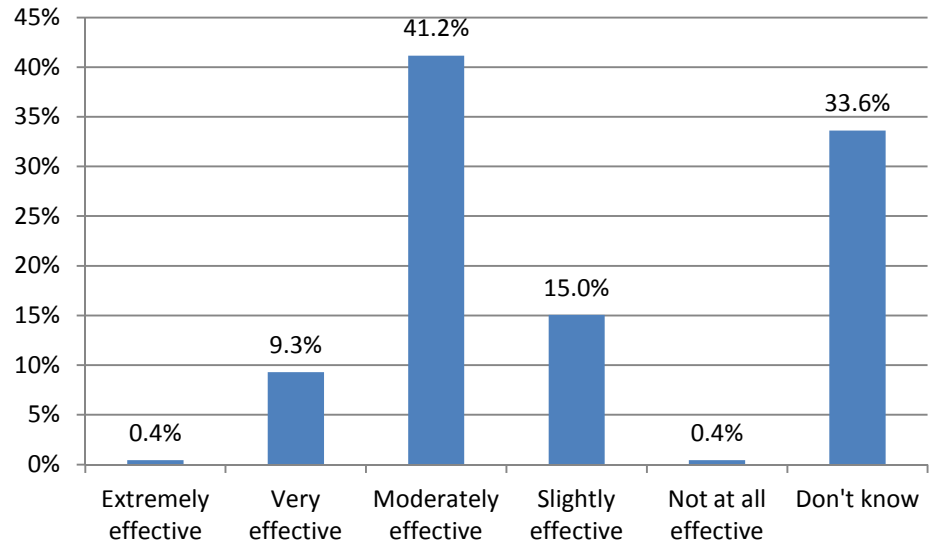
Chart 8.Rating of overall regional health of women, infants, and children



The largest portion of respondents, 41.2 percent, rated the effectiveness of current efforts to promote the health of mothers, infants, and children were rated by the as moderately effective, followed by 33.6 that indicated that they don't know about the effectiveness of current efforts (Chart 9). The large portion of respondents that indicated a lack of knowledge about the effectiveness of current efforts was surprising given that 67.1 percent previously indicated that their own agency was already involved with the issue (Chart 2). Effectiveness ratings at either extreme of the scale were almost non-existent, though 15 percent indicated that existing efforts are slightly effective and 9.3 percent described current efforts as very effective. Overall, the survey suggests that current efforts are middling and unknown to many.

When asked how current efforts to address the health of mothers, infants, and children could be improved, respondents provided a wide range of responses. Comments in favor of increasing education and outreach efforts were common, particularly around sex education and pregnancy prevention. Many respondents also noted specific health services that needed to be made more accessible, especially dental services for children. Not surprisingly, the population groups identified as being in need of targeting for this Health Agenda area were women of reproductive age, people in poverty, and children and adolescents.

Chart 9.Rating of effectiveness of existing efforts to promote health of women, infants, and children



As shown in Table 7, the most common agency strategy used to address the health of women, infants, and children was education programs—particularly those aimed at mothers, such as breastfeeding classes, nutritional classes, and courses on child care skills or health. Other popular strategies included home visiting and assessment programs, the direct provision of medical care services, and food assistance programs such as WIC. Policy advocacy and awareness or publicity campaigns were mentioned, but less prevalent than for other priority areas.

Table 7.Percent reported as engaged in strategy to promote health of women, infants, and children

Strategy	Percent
Education (breastfeeding, nutrition, child care skills)	49.2
Home visiting programs, assessment and referral services	18.9
Medical care services	16.4
Food assistance, formula, WIC program	10.7
Awareness campaigns	6.6
Daycare and preschool programs	2.5
Policy advocacy	2.5
Other	23.8

Area 4: Promote mental health and prevent substance abuse

The “promote mental health and prevent substance abuse” priority area differs slightly from the other priority areas in that it includes two relatively distinct types of ailments: mental illness and drug and alcohol abuse. As a result, the survey separates the major issues of the priority area in many of the

questions. An example of the division into separate mental health issues and substance abuse issues was previously reported earlier in the section (see Chart 2 & 3).

In general, most survey respondents indicated that both mental health and substance abuse are problematic for the region. Chart 10 summarizes the respondent's ratings on the severity of untreated mental illness and Chart 11 summarizes ratings of the severity of substance abuse problems. The largest portion, 34.5 percent, indicated that untreated mental illness is a very severe problem, followed by 31 percent who view the problem as moderately severe, and 10.2 percent who see the problem as extremely severe. Substance abuse was rated as an even more serious problem for the region, as nearly half of all respondents described the problem as very severe. Of course, it should be noted that there were also signs that the extent of both problems is not universally understood by health and service providers. A lack of knowledge about the severity of the issue was cited by respondents roughly 20 percent of the time on the issue of untreated mental illness and by 13.4 percent of respondents in regards to the issue of substance abuse.

The extent to which untreated mental illness and substance abuse are seen as regional problems exhibits a pattern similar to the importance rankings of other issues previously reported in Table 3. Untreated mental illness and substance abuse are both problematic, but are rated at a level of severity that is behind that of chronic disease.

Chart 10. Rating of severity of problem of untreated mental illness by share of respondents

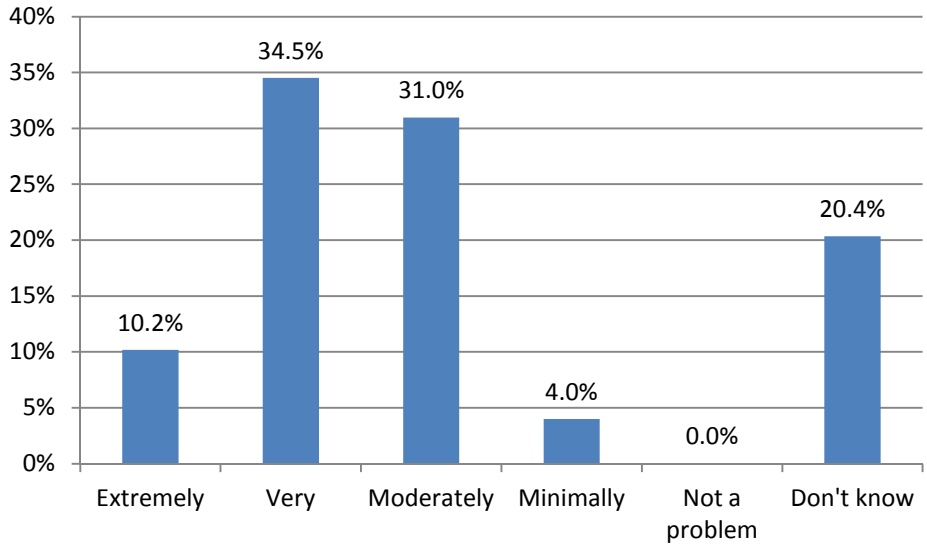
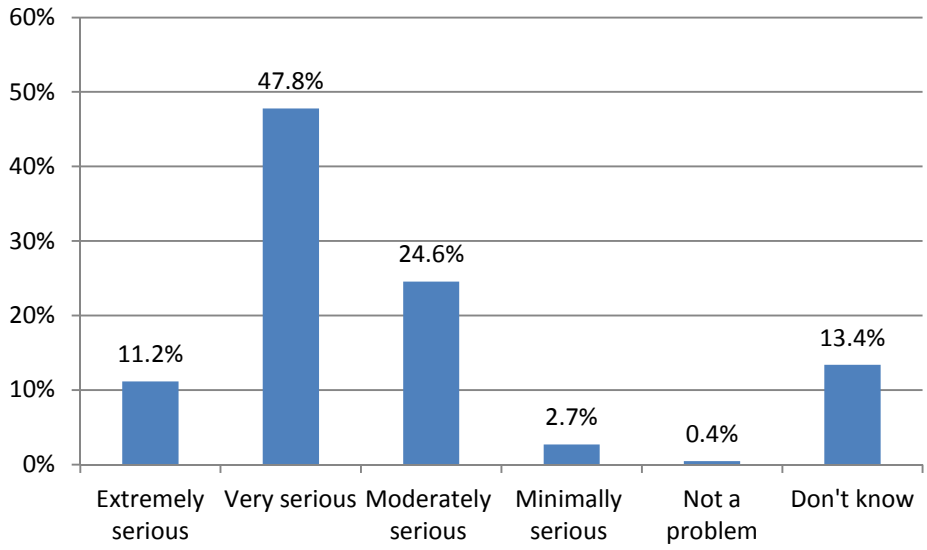


Chart 11. Rating of severity of substance abuse as a problem by share of respondents



Survey respondents frequently indicated that they don't know about the effectiveness of current efforts to promote mental health and current efforts to prevent substance abuse. As shown in Chart 12 and 13, ratings of "extremely" or "very" effective were rare; most survey respondents selected ratings of "moderately" effective or lower, and roughly one-third simply indicated that they didn't know. The results suggest both a poor perception of mental health and substance abuse programs in the region, as well as a possible lack of programs, given the limited knowledge of effective efforts demonstrated by a survey group primarily comprised of health care and service professionals.

Chart 12.Rating of effectiveness of existing efforts to promote mental health

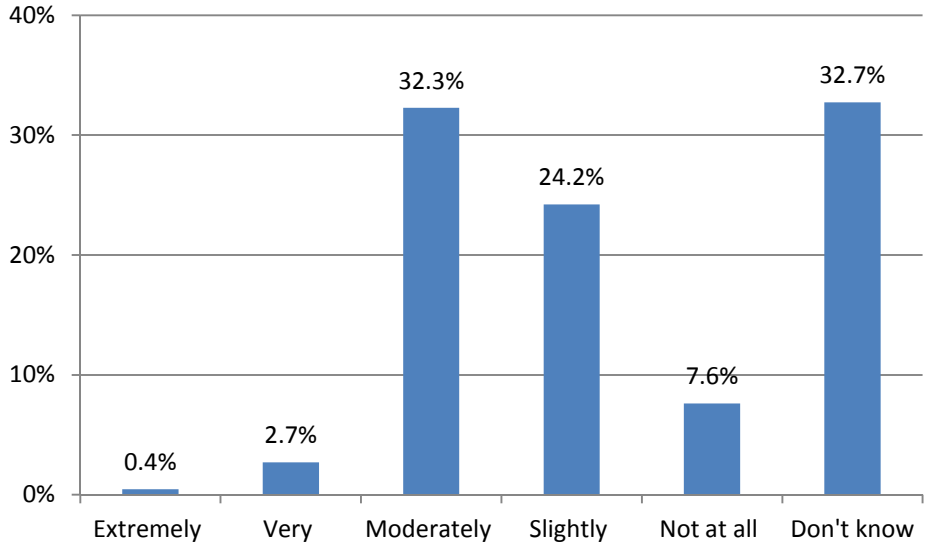
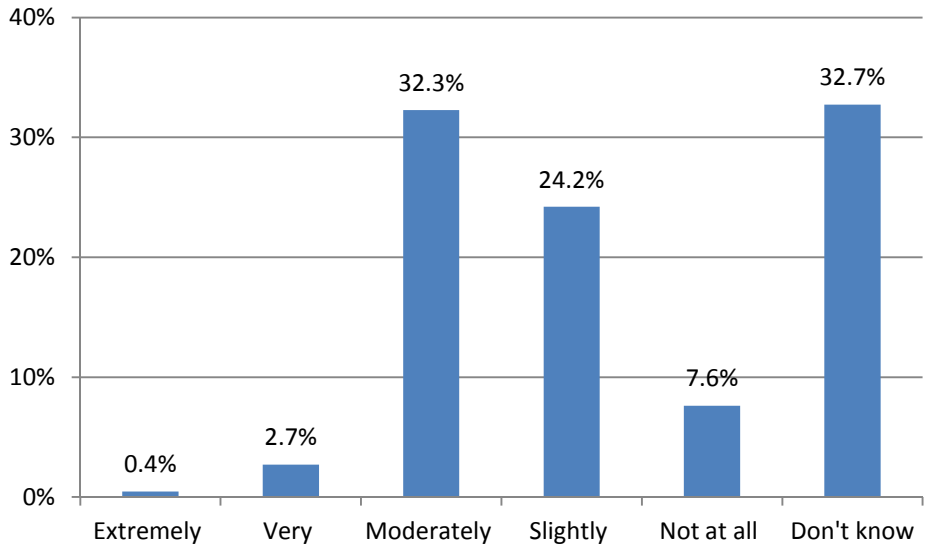


Chart 13.Rating of effectiveness of existing efforts to prevent substance abuse



Respondents were also asked how current regional efforts in both substance abuse prevention and mental health promotion could be improved. In a reflection of the ratings shown in Charts 12 and 13, many simply skipped the question or responded that they were unsure. For mental health promotion, a need for increasing the number of providers and screeners was often mentioned, as was the need to reduce stigma around mental illness in general. Suggestions for improving substance abuse prevention efforts were similar, with demands for increases in funding for services and additional counselors and treatment resources. Population groups identified as being in need of targeting were straightforward and obvious: a majority simply indicated people with mental health issues and people with substance abuse issues.

By a small margin, *the most common strategy for promoting mental health reported by survey respondents was in the category of education, followed by the direct provision of mental health and counseling services* (Table 8). The other two major types of strategies frequently listed by respondents were in the categories of assessment, screening, and referral services, and collaboration or coordination efforts with other agencies in the region.

Table 8.Percent reported as engaged in strategy to promote mental health

Strategy	Percent
Education (Mental health awareness, training for providers)	32.4
Counseling, behavioral health care, and clinical services	31.4
Assessment, screening, and referrals	21.6
Collaboration, coordination with regional mental health programs and service providers	18.6
Other	26.5

As shown in Table 9, *the most common substance abuse prevention strategy was education, cited by 56 percent of respondents*. Examples of educational strategies included prevention programs targeting children, materials explaining the dangers of substance abuse, and training on identifying and dealing with substance abusers in the community. Coordination or collaboration with other agencies was the second most common strategy, with roughly one-in-five respondents indicating their agency primarily worked with other organizations to address substance abuse. In general, it appears that direct approaches to treating substance abuse are not common in the region; screening and referral services, as well as direct counseling or clinical treatment services, were each only cited by 13.2 percent of survey takers that indicated agency efforts in the substance abuse area.

Table 9.Percent reported as engaged in strategy to prevent substance abuse

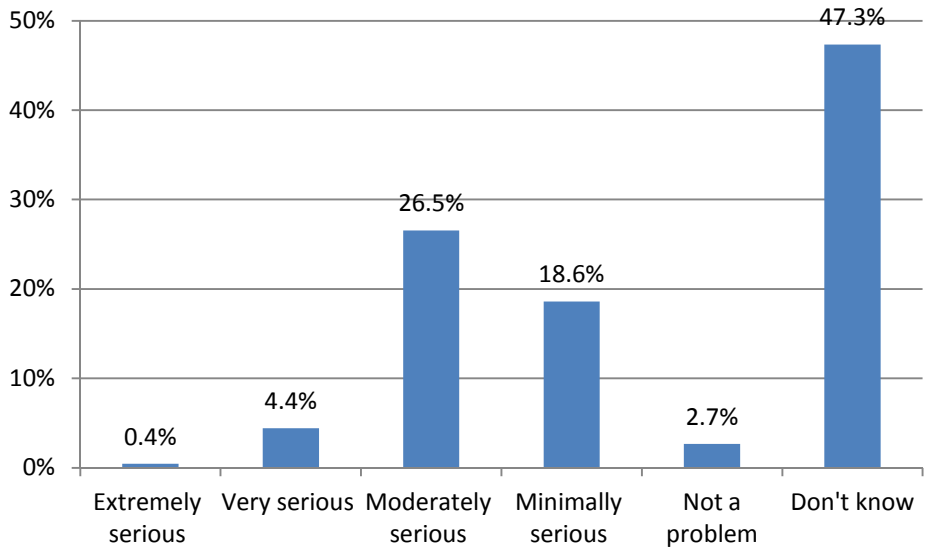
Strategy	Percent
Education (awareness, prevention, and identification materials)	56.0
Coordination and collaboration efforts with other agencies and programs	20.9
Screening and referrals to substance abuse treatment services	13.2
Substance abuse treatment and counseling services	13.2
Policy advocacy, develop or implement regulations	8.8
Other	17.6

Area 5: Prevent HIV, STIs, and vaccine preventable diseases

As a priority area, HIV, STI, and vaccine preventable diseases was rated by survey respondents as a less serious problem relative to issues in the other four priority areas. This corresponds with the findings, discussed earlier, that the area of HIV, STI, and vaccine preventable diseases had both the lowest level of current efforts from surveyed agencies, as well as the lowest level of interest for potential collaboration if selected as a priority area for the region (Chart 2 & 3).

Not surprisingly, given the lower level of involvement and interest in the issue area, fully 47.3 percent indicated that they did not know enough to rate the severity of the problem in the region (Chart 14). Among those that did provide a rating, the most popular choices were moderately or minimally serious; less than 1 percent of respondents indicated that HIV, STIs, and vaccine-treatable diseases are an extremely serious problem.

Chart 14. Rating of severity of HIV, STIs and vaccine preventable diseases as a problem by share of respondents



In addition to not being aware of the extent that HIV, STIs, and vaccine preventable diseases are a problem in the region, survey respondents also broadly indicated that they were not knowledgeable about the effectiveness of any existing efforts to address the problem. A majority of respondents could not rate the effectiveness and most of those that could selected only a moderate rating (Chart 15). The response pattern on this question indicates that health care and service agency stakeholders in the region are less aware of both regional need and current efforts related to this priority area than for any of the four other priority areas.

When queried about areas for improvement, education and awareness were frequent themes; however, more than one respondent indicated that they did not feel that HIV or other similar ailments were a widespread problem for the region. Some also mentioned that there was a need for better data on the extent of the problem for the region. Responses to the question about what populations were in need of targeting also revealed a lack of knowledge about the subject, with "don't know" being the third most popular response behind children and adolescents, and women of reproductive age.

For respondents that indicated that their agency is involved with an HIV, STI, or vaccine preventable disease efforts, the most common strategy employed was education, followed by screening, testing, and referral services, and offering immunization clinics (Table 10). A few others also indicated that compliance with regulations to prevent disease transmission was a strategy, and a few also indicated that their agency provides clinical services to treat HIV, STIs, or other vaccine preventable diseases.

Chart 15.Rating of effectiveness of current efforts to prevent HIV, STIs, & vaccine preventable disease

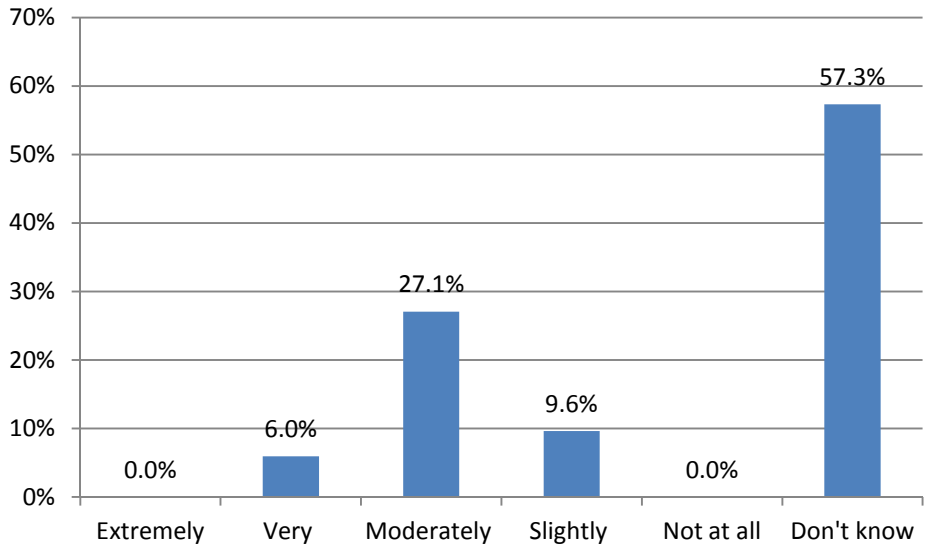


Table 10.Percent engaged in strategy to prevent HIV, STIs, or vaccine preventable disease

Strategy	Percent
Education (Prevention techniques, sex ed, recognition)	60.6
Screening, testing, and service referrals	31.0
Immunization clinics	18.3
Clinical treatment program	9.9
Rule compliance to inform and prevent transmission	5.6
Other	22.5

Technology Use and Upcoming Regional Challenges

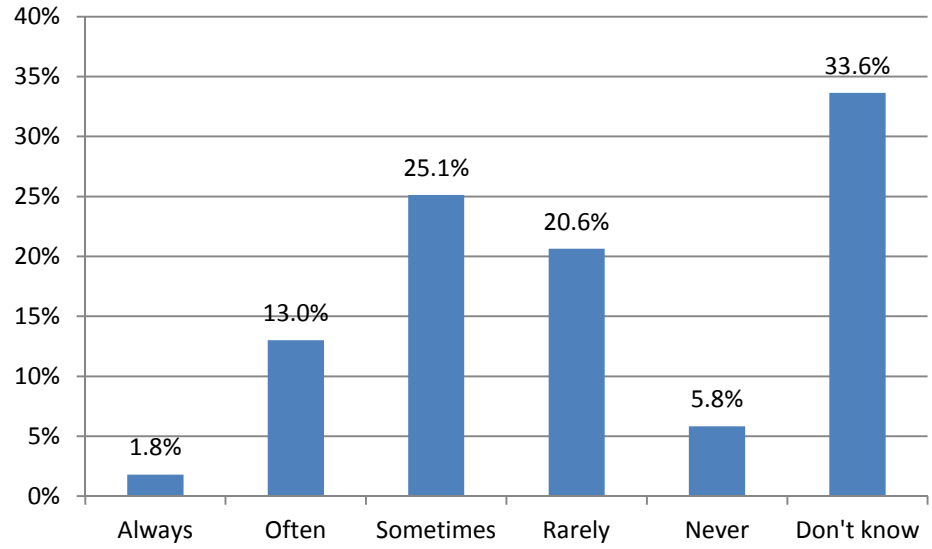
At the end of the survey respondents are asked about the use of technology and were given the opportunity to identify any unique challenges they may be facing over the next few years. This section details these findings providing some insight into possible regional needs and priorities that may not have fit into the five priority areas already identified in the larger state health agenda.

Technology use and prioritization

Survey respondents were asked to rate two aspects of technology in the region: how much technology is currently used and how relevant technology and communication enhancement is as a priority specifically for the Adirondack region. Chart 16 illustrates the extent to which survey respondents indicated that the clients of their agency use technology, such as the internet or information kiosks, to access lab results, address billing issues, or submit questions and communicate with the agency. A large portion, approximately one-third, indicated that they don't know, which may simply reflect the fact that the individuals that received the survey are not directly involved with technical aspects of their agency's day-to-day operations. Among those that were able to assess the frequency of technology usage, most

selected a low-usage rating, with one-in-four indicating that clients sometimes use technology and one-in-five indicating that clients rarely use technology.

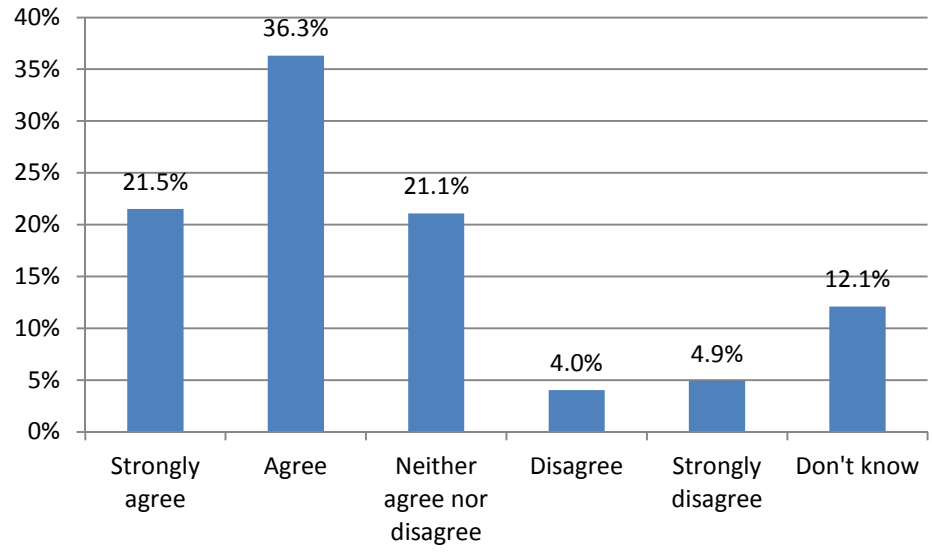
Chart 16. Rating of frequency of technology use by agency clients by share of respondents



The was also a relatively high overall level of support for making the enhancement of technology one of the top five priorities for the region. Over half of all respondents agreed that enhancing technology should be a priority (Chart 17). Additionally, only about 9 percent of respondents indicated any level of disagreement. However, it should be noted that there was a substantial amount of ambivalence about the issue: just over 21 percent are on the fence and could neither agree nor disagree, and 12.1 percent indicated that they don't know enough to answer the question. The share of stakeholders that did not hold a strong opinion on the issue does suggest that support for the issue may grow, or opposition may increase, with additional information on a technology enhancement priority area for the region.

Respondents were also provided an opportunity to offer additional comments about technology; however, only 66 of the 285 chose to provide additional information. Interestingly, *although the numbers indicate high support overall, many of the comments were not supportive of pushing the use of technology in the region or expressed concerns about the utility or cost for rural health care providers*. Most concerns focused on the elderly and poor or rurally isolated residents, who might not have access to the internet or who might find the technology difficult to use. Others indicated that a lack of staff time or the cost of new technology could be difficult barriers for health agencies to overcome. In short, there is strong support for technology as a priority area; however, a smaller group of dissenting voices has serious concerns about the issue.

Chart 17. Rating of agreement that enhancing technology should be among top five priorities



Additional comments and challenges

Throughout the survey, respondents were repeatedly given the opportunity to provide general comments and to provide additional information about topics, such as activities serving specific racial or health groups. Few provided comments and most did not provide information that adds to the core survey results. For example, a few noted that they provide services to Native American groups, and others occasionally listed major diseases such as diabetes or COPD that they frequently see in their work. At the end of the survey respondents were also provided with an opportunity to offer closing thoughts about the challenges facing their organization and the process of setting health priorities in an open-ended format. These comment sections were completed at a slightly higher rate: 162 respondents provided a comment on upcoming organizational challenges, but only 45 provided a comment on the process of setting priorities.

The comments on future challenges predominantly focused on funding issues, specifically declining reimbursements and reduced funding from public sources. According to the comments of survey respondents, many agencies in the region rely heavily on reimbursements from Medicare and Medicaid, or funding from grants and local taxes, which they expect to see decline in the near future. Some also cite workforce problems, particularly the ability to maintain a qualified health care workforce given skill shortages and rising wage and benefit expectations.

Regarding the process of setting community health priorities for the region, multiple survey respondents mentioned the importance of collaboration and communication. Others focused on the unique, rural nature of the region, and mentioned issues such as low volumes of clients, regulations that do not make sense, and a difficulty in achieving economies of scale as being problems specific to the area that should be considered when formulating priorities.

Summary

The results of the ARHN survey reveal several major findings that can be used to guide future efforts to develop a set of unique regional health priorities. *First, survey respondents identified both regional needs and organizational preferences that clearly favored some of the NYS Health Agenda priority areas over others.* The issue of *chronic disease was identified as a problem area for the region and was selected by a large number as a being a top priority to address*. Additionally, many of the emerging trends for the region can be tied to a chronic disease priority area: an aging population, increases in obesity, and a rising rate of diabetes are all associated with long-term conditions that will challenge the health care system. At the other end of the spectrum, respondents also largely agreed that the HIV, STI, and vaccine preventable disease priority area is less important to the region. *Few respondents perceive HIV and STIs as being an emerging health threat in the region, and most ranked the issue as being the least important to the region overall.*

The second major finding that can be derived from the survey results is that *current efforts to address the problems associated with the five NYS Health Agenda priority areas are only moderately effective overall.* Very few respondents rated current efforts on any major issue as either "effective" or "very effective." Instead most described current efforts as only slightly or moderately effective, if they provided ratings at all. Additionally, many current activities do not appear to take a hands-on approach to health issues. The most common agency strategies identified across all issues were educational in nature, and most suggestions for population-targeting simply identified groups that are already afflicted: i.e. targeting substance abuse prevention efforts at individuals with substance abuse issues.

Finally, perhaps the most surprising finding was that a sizable portion of the health care stakeholders that responded to the ARHN survey indicated no knowledge about the Health Agenda priority areas or about major health issues within the Adirondack region. Only about half of respondents indicated that their agency was familiar with the NYS Health Agenda priority areas and only 8.2 percent described themselves as being personally very knowledgeable about the agenda areas. Additionally, when asked about general current conditions, the portion of respondents that indicated that they "don't know" how their own region was faring ranged from 7.1 percent who could not rate the overall health and safety of the region to 47.1 percent for who did not know the severity of the problem of HIV, STIs, and vaccine preventable diseases in the region. This suggests that at least some regional health care stakeholders are in need of additional data on community health conditions and improved connections with service agencies working on different issues.

Appendix G: Regional Community Provider Survey Response List

Name	Organization's Name
William Holmes	Inter-Lakes Health
Ginny Cuttaia	Franklin County Public Health
Sylvia King Biondo	Planned Parenthood of the North Country New York
Gregory Freeman	CVPH Medical Center
Stellla M Zanella	Fulmont Community Action Agency, Inc.
Jessica Lowry	CVPH Medical Center
Kelly Hartz	Nathan Littauer hospital
Mary Lee Ryan	Clinton County Health Dept. WIC Program
Bryan Amell	St. Joseph's Addiction Treatment and Recovery Centers
Carol M. Greco	St. Mary's Healthcare
Steven Serge	Fulton County YMCA
Duane Miller	St. Mary's Healthcare- Behavioral Health
Victor Giulianelli	St. Mary's Healthcare
Daniel Towne	Gloversville Housing Authority
Richard Flanger	Fulton County YMCA Residency
Michael L. Countryman	The Family Counseling Center
Julie Paquin	Franklin County Public Health Services
Irene Snyder	Harrietstown Housing Authority
Patrice McMahon	Nathan Littauer
Patricia McGillicuddy	Franklin County Public Health
Kelly Landrio	Fulton County YMCA
Margaret Luck	Nathan Littauer Hospital Lifeline Program
Laura O'Mara	Saratoga Hospital Nursing Home
Lynn Hart	Saranac Lake Middle School
Julie Demaree	Saratoga Hospital
Michelle Schumacher	YMCA
Deborah J. Ruggeri	Greater Johnstown School District
John M. Kanoza, PE, CPG	Clinton County Health Department
Tammy J Smith	Inter-Lakes Health
Susan Schrader	Association of Senior Citizens
Rick LeVitre	Cornell Cooperative Extension
Cheryl	Nathan Littauer
Barry Brogan	North Country Behavioral Healthcare Network
Maryann Barto	Clinton County Department of Health, Healthy Neighborhoods Program
Sharon Reynolds	PRIDE of Ticonderoga, Inc.
Jerie Reid	Clinton County
Deborah Byrd-Caudle	Parent to Parent of NYS
Julie Marshall	Alice Hyde Medical Center
Hans Lehr	Saratoga County Community Services Board / Mental Health Center
Karen Levison	Saratoga County Public Health Nursing Service
Lesley B. Lyon	Franklin County Dept. of Social Services
Christina Akey	Fulton County Public Health
Mary Rickard	Saratoga County Office for the Aging
Chattie Van Wert	Ticonderoga Revitalization Alliance
Maryalice Smith	Saranac Lake Central School
Anne Mason	Whitehall Family Medicine
Leisa Dwyer	Malone Central Schools
Penny Ruhm	Adirondack Rural Health Network
Dale Woods	Fulton County Public Health
Jackie Skiff	Joint Council for Economic Opportunity of Clinton and Franklin Counties, Inc.
Krista Berger	WIC
Margaret Cantwell	Franklin County Public Health Services
Julie Tromblee, RN	Elizabethtown Community Hospital
Mildred Ferriter	Community Health Center
Melinda Drake	St. Joseph's Addiction Treatment & Recovery Centers

Name	Organization's Name
Michael Vanyo	Gloversville Enlarged School District
William Viscardo	Adirondack Health
Kate Fowler	SMSA
Joe Keegan	North Country Community College
Megan Johnson	Warren-Washington Office of Community Services
John Aufdengarten	Alice Hyde Medical Center
Sue Malinowski	CAPTAIN Youth and Family Services
Misty Trim	Brushton-Moira Central School
Sarah Louer	Mountain Lake Services
Dan	Warren County Health Services
Amanda West	council for prevention of alcohol and substance abuse
Christie Sabo	Warren-Hamilton Counties Office for the Aging
Debra Pauquette	Granville Family Health/ Glens Falls Hospital
Cynthia Ford-Johnston	Keene Central School
Jennifer McDonald	Skidmore College
Vicky Wheaton-Saraceni	Adirondack Health Institute -- Adirondack Rural Health Network
Chrys Nestle	Cornell Cooperative Extension
William Larrow	Moriah Central School
Lisa Griffin	Franklin County DSS
Valerie Capone	Warren-Washington ARC
Denis Wilson	Fulmont Community Action Agency
Donna Beal	Mercy Care for the Adirondacks
Doug DiVello	Alice Hyde Medical Center
Judy Zyniecki	Center for Disability Services/Clover Patch early intervention services
Cathlyn Lamitie	Alice Hyde Medical Center
Joan Draus	Mental Health Association In Fulton & Montgomery Counties
Kelli Lyndaker	Washington County Public health
Jane Hooper	Elizabethtown Community Hospital
Sandra Geier	Gloversville enlarged School District
Janet L. Duprey	NYS Assembly
a	c
Miki L. Hopper	ACAP, Inc. EHS/HS
Tammy Kemp	Senior Citizens Council of Clinton County Inc.
Scott Osborne	Elizabethtown-Lewis Central School
Amanda Hewitt	Senior Citizen Service Center of Gloversville and Fulton County, Inc
TJ Feiden	Minerva Central School
Kim Crockett	Clinton County Youth Bureau
Trip Shannon	Hudson Headwaters Health Network
Brandy Richards	Hamilton County Community Services
Robin Nelson	Families First in Essex County
Deborah Ameden	Hamilton County Community Action Agency
Betsy brown	PPNCNY Planned Parenthood
Theresa Intilli Klausner	Nathan Littauer Hospital
Penny	HCPHNS
Nancy Welch	Cornell Cooperative Extension, Hamilton County
Cathy Valenty	Saratoga County EOC - WIC
Norma Menard	Literacy Volunteers of Clinton County
Michael Piccirillo	Saratoga Springs City School District
Peter Whitten	Shelters of Saratoga, Inc
Keith R. Matott	The Development Corporation
Melissa Engwer	Warren Washington Hamilton County Cancer Services Program at Glens Falls Hospital
Theresa Cole	Akwesasne Housing Authority
Janine Dykeman	Mental Health Association in Fulton and Montgomery Counties
Margot Gold	North Country Healthy Heart Network, Inc.
Cynthia Summo	Keene Central School
Pam Merrick	Malone middle school
Jamie Basiliere	Child Care Coordinating Council of the North Country, Inc.
Michele Armani	North Country Workforce Investment Board
Lia Mcfarline	Inter-Lakes Health

Name	Organization's Name
Sue Cridland	Nathan Littauer Hospital - HealthLink
Cathleen Kerman	Glens Falls Hospital
Brian Bearor	Family YMCA of the Glens Falls Area
Linda Scagel	Community Health Center of the North Country
Priscilla Wheeler	Saratoga County Public Health
Megan Murphy	Adirondack Health
Sue Frasier	Mountain Valley Hospice
Deborah Skivington	The Family Counseling Center
Sue Ann Caron	Essex County Department of Social Services
Leslie Beadle	Nathan Littauer Hospital Nursing Home
Jean Wiseman	Capital District Child Care Council
Susan Patterson	Franklin Co. Public Health
Kathy Varney	Glens Falls Hospital
Kelly Owens	HM AHEC
Crystal Carter	Clinton County Office for the Aging
Stephanie Seymour	Saratoga Hospital
Jamie Konkoski	North Country Healthy Heart Network
Patty Hunt	Washington County Public Health Nursing Service
Bonnie Sue Newell	Mental Health Association of Clinton and Franklin Counties
Beth Lawyer	Citizen Advocates, Inc., North Star Behavioral Health Services
Suzanne M. Goolden	Franklin County
Roseann Doran	Cornell Cooperative Extension in Fulton & Montg. Co.
Katie Strack	Franklin County Public Health Services
Ginelle Jones	Warren County Health Services
Ann Rhodes	HFM Prevention Council
Patricia Gero	Adirondack Health
Chandler M. Ralph	Adirondack Health
Kim McElwain	Saint Regis Mohawk Tribe
Gerald Goldman	Saranac Lake CSD
Elizabeth Zicari	HCR Home Care
Bonnie Yopp ANP	Community Link
Stacey Beebie	Clinton County MH and AS
Vicki Driscoll	Clinton County Health Department
L. Jameson	HM AHEC
Beth Ryan	Hamilton County Public Health Nursing Service
Rebecca Carman	Shenendehowa Central School District
Lisa Harrington	Wait House
Genevieve Boyd	Long Lake Central School
Tracy Mills	Glens Falls Hospital
Robert York	Office of Community Services for Warren and Washington Counties
Shelley Shutler	Mental Health Assoc. of Clinton & Franklin Counties
Dot Jones	Saratoga Hospital
Maria Burke	Literacy Volunteers of Essex/Franklin Counties
Gina Cantanucci-Mitchell	Washington County ADRC
Ernest J. Gagnon	Fulton County Mental Health
S. Cooper	Fulton County Department of Social Services
Pam Dray	Saratoga County EOC Head Start
Patricia Auer	Warren County Health Services
Laurence Kelly	Nathan Littauer Hospital
Susan Dufel	NYS Department of Labor
Sharon Schaldone	Warren County Health Services
Kristen Sayers	NYSDOH
Tari Botto	Franklin County Department of Social Services
Carol Underwood	Center for Lung and Chest Surgery
Sheri Sauve	Plattsburgh One Worksource/NYSDOL Manager
Susan M. Wilson-Sott	Office for the Aging in Franklin Co.
Laurie Williams	Clinton County Health Department
Jessica Darney Buehler	Essex County Public Health
Sharon Luckenbaugh	Glens Falls Hospital

Name	Organization's Name
Peter Groff	Warren Washington Association for Mental Health
James Seeley	Cornell Cooperative Extension
Josh Wilson	North Country Healthy Heart Network, Inc.
Rachel Truckenmiller	ASAPP's Promise
Diane Whitten	Cornell Cooperative Extension Saratoga County
Justin Hladik	Reality Check of Hamilton, Fulton, and Montgomery Counties
Steve Peters	City of Plattsburgh
Sheila Kapper	Elizabethtown-Lewis Central School
Greg Truckenmiller	Fulton-Montgomery Community College
Stuart G. Baker	Town of Queensbury
Sarah Kraemer	Catholic Charities of Fulton & Montgomery Counties
John Nasso	Catholic Charities of Fulton and Montgomery Counties
L. Daniel Jacobs	St. Regis Mohawk Health Services A/CDP Outpatient
Darlene Spinner	Literacy Volunteers of Essex/Franklin Counties
Pam LeFebvre	Clinton County Health Department
Sarina Nicola	Essex County Public Health Nursing Services
Lythia Vera	Eastern Adirondack Health Care Network
Martin Nephew	Mountain Lake Services
Barbara DeLuca	Nathan Littauer Hospital
Cecily Dramm	Saranac Lake High School
Tracey	Planned Parenthood Mohawk Hudson
Patricia Godreau Sexton	St. Regis Falls Central School
Deborah Roddy	The Adirondack Arc
John Sawyer	Hudson Headwaters Health Network
Nichole Louis	HCR Home Care
Stephen Pavone	Gloversville School District
Jackie Mulcahy	Queensbury union free school district
Anita Deming	Cornell Cooperative Extension - Essex County
Frederick Goldberg, MD	Nathan Littauer Hospital
David A Alloy	Glens Falls Hospital
Annie McKinley	Essex County Mental Health
Bonnie Black	BHSN
Eric Day	Clinton County Office of Emergency Services
Douglas Huntley	Queensbury Union Free School District
Rebecca Evansky	STARS
James Dexter	Washington-Saratoga-Warren-Hamilton-Essex BOCES
Steven Bowman	Clinton County Veterans Service Agency
Susan Kelley	STOP Domestic Violence/BHSN
Marjorie Irwin	Washington County WIC
Robert E. Shay	Town of White Creek
Vanetta Conn	Cornell Cooperative Extension Franklin County
Patty Bashaw	Essex County Office for the Aging
Cheryl L. Brown	Oppenheim-Ephratah Central School District
Wes Carr	Saratoga County Youth Bureau
Marjorie Tierney	Ticonderoga central school
Barbara Sweet	Tri County United Way
Kari Cushing	Franklin Community Center
Paul Berry	Hadley-Luzerne CSD
Brian Post	Upward Bound
Erin Krivitski	Glens Falls Hospital
Lorraine Kourofsky	Chateauguay Central School
Susan Delehanty	Citizen Advocates,Inc.
Linda L. Beers	Essex County Public Health
Dr Stan Maziejka	Stillwater CSD
Dawn Tucker	Fort Edward Internal Medicine
Margaret Sing Smith	Warren County Youth Bureau
KEITH TYO	SUNY PLATTSBURGH
Antoinette P Roth	Warren County WIC
Cathie Werly	FRANKLIN COUNTY PUBLIC HEALTH SERVICES

Name	Organization's Name
Dale Breault Jr.	Chateauguay Central School
Linda Ferrara	Adirondack Cardiology - A Service of Glens Falls Hospital
Julie Wright	Glens Falls Hospital
Lori Thompson	St Regis Mohawk Health Services
Robert Kleppang	Hamilton County Community Services
Cora Clark	Lake Placid Middle High School
Amy Brender	HHHN-Ryan White Part C Program
Donna DiPietro	Bolton Central School
Chris Hunsinger	Warren County Employment & Training
Barbara Vickery	Capital District Child Care Coordinating Council
Paul Williamsen	Mayfield Central School District
Andrew Cruikshank	Fort Hudson Health System
Sandra McNeil	Glens Falls Hospital
Garry Douglas	North Country Chamber of Commerce
Steve Valley	Essex County Mental Health Services
Timothy Farrell	Minerva Central School
Patrick Dee	Lake George Central Schools
Kimberly Mulverhill	Malone Central School District
Elizabeth St John	Washington County Public Health
Valerie Muratori	Saratoga Bridges NYSARC , Inc. Saratoga Chapter
Denise Benton	Catholic Charities of Fulton and Montgomery Counties
Melissa Chinigo	Glens Falls Hospital
Vanessa Ross	Washington County CARES
Claire Murphy	Washington County Economic Opportunity Council, Inc.
Dustin Swanger	Fulton-Montgomery Community College
Janice Fitzgerald	Parent to Parent of NYS
Cheryl A Murphy	American Red Cross
Andrea Fettinger	Fulton County Office for Aging
Donn Diefenbacher	Mountain Valley Hospice
Jodi Gibbs	Inter-Lakes Health
Cynthia Trudeau	Inter-Lakes Health
John Redden	Clinton County Social Services
Ellen Gordon	ACAP/OneWorkSource
michele	Malone central school
Heidi	NCHHN
Wayne C. Walbridge	Malone Central School District
Heidi Parisi	Nathan Littauer Hospital
Susan Menke	Wells Central School
Susan Sherman	Gloversville High School
Jane havens	Community, Work and Independence,, Inc.
Stephanie LaPlant	St. Joseph's Community School
MARY DICKERSON	LONG LAKE CENTRAL SCHOOL
Fred Wilson	Hudson Headwaters Health Network
Richelle Beach	Clinton County Child Advocacy Center
Marie Capezzuti	Washington County Public Health
Scott Harding	Church of the Messiah
Suzanne Hagadorn	Cancer Services Program of Fulton & Montgomery Counties
Deborah Battiste	Town of Kingsbury Recreation
Kari Scott	Willsboro Central School
Denise C. Frederick	Fulton County Public Health
Clark Hults	Newcomb Central School District
Lorine Heroth	Gloversville Middle School

Appendix H: Data Consultants

The following list represents the consultants that Glens Falls Hospital or the Adirondack Rural Health Network contracted with to assist in conducting the Community Health Needs Assessment.

Center for Health Workforce Studies, University at Albany School of Public Health

Tracey Continelli, PhD, Graduate Research Assistant

Robert Martiniano, MPA, MPH, Research Associate

Center for Human Services Research, University at Albany

Rose Greene, M.S., Director for the Center for Human Services Research

LuAnn McCormick, Ph.D., Senior Research Scientist

Sarah Rain, B.S., Senior Research Support Specialist

Bradley Watts, Ph.D., Senior Research Scientist

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

The table below represents the NYS Prevention Agenda indicators with data available by county. See http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/ for additional details on the NYS Prevention Agenda and additional indicators that do not have county-level data available.

	NYS Prevention Agenda Indicators 2013 - 2017	Warren	Washington	Saratoga	Comparison Regions/Data			2017 Prevention Agenda Benchmark
					ARHN	Upstate NY	NYS	
Promote healthy and safe environments	**Focus Area: Injuries, Violence, and Occupational Health**							
	1. Rate of Hospitalizations due to Falls for Ages 65 Plus per 10,000 Population, '08 - 10	257.0	218.9	197.1	208.4	215.8	202.1	**204.6**
	2. Rate of ED Visits due to Falls for Children Ages 1 - 4 per 10,000 Population Children Ages 1 - 4, '08 - 10	660.6	505.0	344.7	515.5	511.9	476.4	**429.1**
	3. Rate of Assault-Related Hospitalizations per 10,000 Population, '08 - 10	2.2	1.6	1.4	1.6	2.7	4.7	**4.3**
	4. Ratio of Black, Non-Hispanic Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '08 - 10	N/A	N/A	N/A	N/A	N/A	7.28	**6.69**
	5. Ratio of Hispanic/Latino Assault-Related Hospitalizations to White, Non-Hispanic Assault Related Hospitalizations, '08 - 10	N/A	N/A	N/A	N/A	N/A	3.00	**2.75**
	6. Ratio of Assault-Related Hospitalizations for Low-Income versus non-Low Income Zip Codes, '08 - 10	N/A	N/A	N/A	N/A	N/A	3.26	**2.92**
	7. Rate of ED Occupational Injuries Among Working Adoloscents Ages 15 - 19 per 10,000 Population Ages 15 - 19, '08 - 10	56.5	51.1	57.9	56.1	51.8	36.7	**33.0**
	Focus Area: Outdoor Air Quality							
	1. Number of Days with Unhealthy Ozone, 2007	0	0	2	9	88	122	**0**

NYS Prevention Agenda Indicators 2013 - 2017		Warren	Washington	Saratoga	Comparison Regions/Data			2017 Prevention Agenda Benchmark
					ARHN	Upstate NY	NYS	
	2. Number of Days with Unhealthy Particulate Matter, 2007	0	0	0	4	32	69	**0**
	Focus Area: Built Environment							
	1. Percentage of the Population that Live in Jurisdictions that Adopted Climate Smart Communities Pledge, 2012	0.0%	0.0%	28.8%	18.5%	46.1%	26.7%	**32.0%**
	2. Percentage of Commuters Who Use Alternative Modes of Transportation to Work, '07 - 11	18.3%	19.5%	16.3%	18.1%	22.8%	44.6%	**49.2%**
	3. Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2010	4.2%	4.0%	3.9%	4.6%	4.2%	2.5%	**2.2%**
	4. Percentage of Homes in Vulnerable Neighborhoods that have Fewer Asthma Triggers During Home Revisits, '08 - 11	N/A	N/A	N/A	N/A	N/A	12.9%	**20.0%**
	Focus Area: Water Quality							
	1. Percentage of Residents Served by Community Water Systems with Optimally Fluoridated Water, 2012	4.9%	28.9%	62.8%	42.4%	47.4%	71.4%	**78.5%**
Prevent chronic diseases	**Focus Area: Reduce Obesity in Children and Adults**							
	1. Percentage of Adults Ages 18 Plus Who are Obese, '08/09	27.7%	28.6%	28.9%	29.7%	24.6%	23.2%	**23.2%**
	2. Percentage of Public School Children Who are Obese, '10 - 12	19.7%	20.9%	14.2%	N/A	0.0%	N/A	**16.7%**
	Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure							
	1. Percentage of Adults Ages 18 Plus Who Smoke '08/09	20.5%	23.2%	17.0%	21.1%	18.5%	16.8%	**15.0%**
	Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings							
	1. Percentage of Adults Ages 50 - 75 Who Received Colorectal Screenings Based on Recent Guidelines, '08/09	69.6%	67.0%	70.1%	69.9%	N/A	66.3%	**71.4%**

NYS Prevention Agenda Indicators 2013 - 2017		Warren	Washington	Saratoga	Comparison Regions/Data			2017 Prevention Agenda Benchmark
					ARHN	Upstate NY	NYS	
	2. Rate of Asthma ED Visits per 10,000 Population, '08 - 10	50.48	39.68	30.28	53.2	51.1	83.7	**75.1**
	3. Rate of Asthma ED Visits Ages 0 - 4, per 10,000 Population Ages, 0 - 4, '08 - 10	95.4	85.3	77.5	94.9	122.3	221.4	**196.5**
	4. Rate of Short-term Diabetes Hospitalizations for Ages 6 - 17 per 10,000 Population, Ages 6 - 17, '08 - 10	7.8	7.0	3.8	4.9	3.0	3.2	**3.06**
	5. Rate of Short-term Diabetes Hospitalizations for Ages 18 Plus per 10,000 Population, Ages 18 Plus, '08 - 10	3.5	3.0	3.0	4.4	4.8	5.6	**4.86**
	6. Rate of Age Adjusted Heart Attack Hospitalizations per 10,000 Population, 2010	19.2	15.5	15.3	16.7	16.0	15.5	**14.4**
Promote healthy women, infants and children	**Focus Area: Maternal and Infant Health**							
	1. Percentage Preterm Births < 37 Weeks of Total Births Where Gestation Period is Known, '08 - 10	10.9%	9.9%	10.6%	10.5%	11.2%	12.0%	**10.2%**
	2. Ratio of Preterm Births (< 37 wks) Black/NH to White/NH, '08 - 10	N/A	N/A	1.75	N/A	N/A	1.61	**1.42**
	3. Ratio of Preterm Births (< 37 wks) Hisp/Latino to White/NH, '08 - 10	N/A	N/A	0.90	N/A	N/A	1.25	**1.12**
	4. Ratio of Preterm Births (< 37 wks) Medicaid to Non-Medicaid, '08 - 10	1.03	1.21	1.13	N/A	N/A	1.10	**1.00**
	5. Rate of Maternal Mortality per 100,000 Births, '08 - 10	0.0	0.0	14.6	5.7	17.6	23.3	**19.7**
	6. Percentage of Live Birth Infants Exclusively Breastfed in Delivery Hospital, '08 - 10	64.3%	60.0%	65.8%	63.0%	N/A	42.5%	**48.1%**
	7. Ratio of Infants Exclusively Breastfed in Delivery Hospital Black, non-Hispanic to White, non-Hispanic, '08 - 10	NA	N/A	0.9	N/A	N/A	0.5	**0.57**
	8. Ratio of Infants Exclusively Breastfed in Delivery Hospital Hispanic/Latino to White, non-Hispanic, '08 - 10	1.0	1.1	1.1	N/A	N/A	0.6	**0.64**
	9. Ratio of Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid Births, '08 - 10	0.8	0.9	0.7	N/A	N/A	0.6	**0.66**

NYS Prevention Agenda Indicators 2013 - 2017	Warren	Washington	Saratoga	Comparison Regions/Data			2017 Prevention Agenda Benchmark
				ARHN	Upstate NY	NYS	
Focus Area: Preconception and Reproductive Health							
1. Percent of Births within 24 months of Previous Pregnancy, '08 - 10	24.7%	24.2%	21.7%	23.4%	21.1%	18.0%	**17.0%**
2. Rate of Pregnancies Ages 15 - 17 year per 1,000 Females Ages 15-17, '08 - 10	19.2	23.7	12.8	18.8	20.4	31.1	**25.6**
3. Ratio of Pregnancy Rates for Ages 15 - 17 Black, non-Hispanic to White, non-Hispanic, '08 - 10	0.00	0.88	0.52	N/A	N/A	5.75	**4.90**
4. Ratio of Pregnancy Rates for Ages 15 - 17 Hispanic/Latino to White, non-Hispanic, '08 - 10	1.10	2.15	0.83	N/A	N/A	5.16	**4.10**
5. Percent of Unintended Births to Total Births, 2011	38.5%	35.7%	23.1%	29.8%	28.4%	26.4%	**24.2%**
6. Ratio of Unintended Births Black, non-Hispanic to White, non-Hispanic, '08 - 10	N/A	N/A	2.53	N/A	N/A	2.11	**1.88**
7. Ratio of Unintended Births Hispanic/Latino to White, non-Hispanic, '08 - 10	N/A	N/A	1.21	N/A	N/A	1.59	**1.36**
8. Ratio of Unintended Births Medicaid to Non-Medicaid, '08 - 10	1.45	1.79	2.26	N/A	N/A	1.71	**1.56**
9. Percentage of Women Ages 18- 64 with Health Insurance, '08/09	87.5%	86.3%	91.1%	88.4%	N/A	86.1%	**100.0%**
Focus Area: Child Health							
1. Percentage of Children Ages 0 - 15 Months with Government Insurance with Recommended Well Visits, 2011	97.8%	86.4%	87.5%	88.7%	84.9%	82.8%	**77.0%**
2. Percentage of Children Ages 3 - 6 Years with Government Insurance with Recommended Well Visits, 2011	82.7%	81.1%	83.1%	81.9%	80.3%	82.8%	**77.0%**
3. Percentage of Children Ages 12 -21 Years with Government Insurance with Recommended Well Visits,	67.6%	58.0%	59.1%	59.3%	59.3%	61.0%	**77.0%**

NYS Prevention Agenda Indicators 2013 - 2017		Warren	Washington	Saratoga	Comparison Regions/Data			2017 Prevention Agenda Benchmark
					ARHN	Upstate NY	NYS	
	2011							
	4. Percentage of Children Ages 0 -19 with Health Insurance, 2010	95.1%	94.6%	95.9%	94.9%	95.0%	94.9%	**100.0%**
	5. Percentage of 3rd Graders with Untreated Tooth Decay, '09 - 11	19.9%	38.1%	39.5%	N/A	24.0%	N/A	**21.6%**
	6. Ratio of 3rd Graders with Untreated Tooth Decay, Low Income Children to Non-Low income Children, '09 – 11	1.75	0.92	2.67	N/A	2.50	N/A	**2.21**
Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare-associated infections	**Focus Area: Human Immunodeficiency Virus (HIV)**							
	1. Rate of Newly Diagnosed HIV Cases per 100,000 Population , '08 - 10	2.5	3.2	2.4	3.0	7.4	21.4	**14.7**
	2. Ratio of Newly Diagnosed HIV Cases Black, non-Hispanic versus White, non-Hispanic, '08 – 10	N/A	N/A	N/A	N/A	N/A	N/A	**45.7**
	Focus Area: Sexually Transmitted Disease (STDs)							
	1. Rate of Primary and Secondary Syphilis for Males per 100,000 Male Population, 2010	0.0	0.0	3.7	1.7	2.4	11.2	**10.1**
	2. Rate of Primary and Secondary Syphilis for Females per 100,000 Female Population, 2010	0.0	0.0	0.0	0.3	0.2	0.5	**0.4**
	3. Rate of Gonorrhea Cases for Females Ages 15-44 per 100,000 Female Population Ages 15-44, 2010	87.3	74.2	33.8	50.4	147.0	203.4	**183.1**
	4. Rate of Gonorrhea Cases for Males Ages 15 - 44 per 100,000 Male Population Ages 15-44, 2010	34.9	15.2	21.6	18.8	111.3	221.7	**199.5**
	5. Rate of Chlamydia for Females Ages 15 - 44 per 100,000 Females Ages 15 - 44, '08 – 10	1117.6	1113.7	582.2	775.5	1167.9	1619.8	**1458.0**
	Focus Area: Vaccine Preventable Disease							
	1. Percent of Children Ages 19 - 35 months with 4:3:1:3:3:1:4, 2011	58.2%	58.3%	62.3%	57.6%	47.6%	N/A	**80.0%**

NYS Prevention Agenda Indicators 2013 - 2017		Warren	Washington	Saratoga	Comparison Regions/Data			2017 Prevention Agenda Benchmark
					ARHN	Upstate NY	NYS	
	2. Percent females 13 - 17 with 3 dose HPV vaccine, 2011	38.6%	34.2%	33.4%	31.2%	26.0%	N/A	**50.0%**
	3. Percent of Adults Ages 65 Plus With Flu Shots Within Last Year, '08/09	77.8%	74.0%	70.1%	N/A	N/A	75.0%	**75.1%**
	Focus Area: Healthcare Associated Infections							
	1. Rate of Hospital Onset CDIs per 10,000 Patient Days, 2011	2.2	N/A	1.2	2.4	8.4	8.5	**5.94**
	2. Rate of Community Onset, Healthcare Facility Associated CDIs per 10,000 Patient Days, 2011	1.9	N//A	1.2	1.7	2.8	2.4	**2.05**
Promote mental health and prevent substance abuse	**Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavioral Disorders**							
	1. Percent of Adults Binge Drinking within the Last Month, '08/09	26.1%	21.1%	20.1%	21.1%	N/A	18.1%	**17.6%**
	2. Percent of Adults with Poor Mental Health (14 or More Days) in the Last Month, '08/09	11.3%	10.0%	9.9%	10.2%	N/A	9.8%	**10.1%**
	3. Rate of Age Adjusted Suicides per 100,000 Adjusted Population, '08 - 10	12.0	13.0	8.5	10.0	8.0	6.8	**5.9**

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

The table below outlines the leading causes of premature death by county:

Leading Causes of Premature Death by County

County	1st	2nd	3rd	4th	5th
Warren	Cancer	Heart Disease	Chronic Lower Respiratory Disease	Unintentional Injury	Suicide
Washington	Cancer	Heart Disease	Unintentional Injury	Chronic Lower Respiratory Disease	Suicide
Saratoga	Cancer	Heart Disease	Chronic Lower Respiratory Disease	Unintentional Injury	Stroke
NYS	Cancer	Heart Disease	Unintentional Injury	Chronic Lower Respiratory Diseases	Diabetes

Source: New York State Department of Health - Bureau of Biometrics and Health Statistics, February 2013. Available at http://www.health.ny.gov/statistics/leadingcauses/leadingcauses_death/pm_deaths_by_county.htm

Appendix K: County Health Rankings for Warren, Washington and Saratoga Counties

	NYS	Warren	Washington	Saratoga
Health Outcomes		**12**	**42**	**5**
Mortality		**16**	**33**	**8**
Premature death	5650	5477	6003	4858
Morbidity		**7**	**45**	**6**
Poor or fair health	15%	13%	17%	12%
Poor physical health days	3.5	2.8	3.9	3.1
Poor mental health days	3.4	2.4	3.1	2.6
Low birthrate	8.2%	7.1%	7.8%	6.7%
Health Factors		**17**	**40**	**5**
Health Behaviors		**44**	**56**	**12**
Adult smoking	18%	24%	28%	17%
Adult obesity	25%	30%	29%	26%
Physical Inactivity	25%	21%	31%	24%
Excessive drinking	17%	21%	13%	19%
Motor vehicle crash death rate	7	11	15	9
Sexually transmitted infections	516	247	259	149
Teen birth rate	25	25	31	16
Clinical Care		**2**	**26**	**5**
Uninsured	14%	12%	13%	9%
Primary care physicians	1222:1	888:1	2753:1	1375:1
Dentists	1414:1	1208:1	4155:1	1763:1
Preventable hospital stays	66	63	67	61
Diabetic screening	85%	90%	92%	88%
Mammography screening	66%	77%	70%	70%
Social & Economic Factors		**23**	**28**	**2**
High school graduation	77%	75%	78%	88%
Some college	64%	63%	45%	72%
Unemployment	8.2%	8.2%	7.5%	6.6%
Children in poverty	23%	20%	22%	9%
Inadequate social support	24%	20%	18%	15%
Children in single-parent households	34%	28%	29%	22%
Violent Crime rate	391`	143	141	72
Physical Environment		**3**	**28**	**9**
Daily fine particulate matter	10.9	10.1	10.0	10.2
Drinking water safety	4%	35%	22%	11%
Access to recreational facilities	11	23	9	18
Limited access to healthy foods	2%	4%	4%	4%
Fast food restaurants	45%	31%	44%	43%

Source: Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute County Health Rankings 2013. Available at http://www.countyhealthrankings.org/

Appendix L: CHNA Prioritization Processes

See attached PowerPoint slides.

ARHN
Prioritization Process

- Two suggested methods for identifying priorities
  - Weighted method (mathematical process)
  - Dot method (kinetic/visual method)
- Briefly describes both processes as well as criteria which can be used with each method.

1

Weighted Prioritization Process

2

Weighted Prioritization Overview

- Eight selected criteria are given weights and scores.
- Criteria broken into feasibility, impact, or need.
- The scores adjusted by the weight are summed.
- The higher the score, the more of a priority for the county or community.
- Developed to score focus areas, but can score priority areas or individual data elements.
- The process is that the group would discuss the issues then individually vote.
- The score (5,3,1, or 0) with the plurality would be the group's score.

3

Weighted Prioritization Overview

- There are eight criteria used in the prioritization process.
- Each criteria will have a(n)
  - Relative weight between 2.0 and 0.5
  - A score of 5, 3, 1, or 0
    - 5 = High feasibility, impact, or need
    - 3 = Medium feasibility, impact, or need
    - 1 = Low feasibility, impact, or need
    - 0 = Not applicable

4

Weighted Prioritization Criteria

- Quartile/Severity Score
  - What is the severity of the issue?
  - Measured by taking the higher of the two numbers (both available on the data worksheet)
    - Quartile score (percentage of indicators in one of the four quartiles)
    - Severity score (percentage of indicators in quartiles three or four)

- Stakeholder Survey – what did the community say was the need
  - Taken from the provider survey
  - Need to be determined for health disparities and "other non-prevention agenda indicators." Not assessed in the provider survey.

5

Weighted Prioritization Criteria

What is your perceived need for more interventions or programs to address the focus area/issue?

<u>Scoring</u>

5. Substantial additional interventions or programs are needed
3. There are some but more interventions or programs are needed.
1. There are many interventions or programs and no additional assistance is needed.

6

Weighted Prioritization Criteria

Is funding for the intervention available and sustainable? Consider property tax dollars, reimbursement – government or billable services, and grants when assessing this criterion.

Scoring

5. Funding/revenue not available or insufficient. Support for intervention or program start-up and sustainability are major issues. Substantial additional assistance is needed.
3. Funding/revenue are available. May have long-term problems sustaining the program.
1. Funding/revenue are readily available. Sustainability is not an issue.

7

Weighted Prioritization Criteria

Are evidence based interventions available for implementation? Consider sources:

- New York State Department of Health prevention agenda proposed interventions
- Other evidence-based interventions listed in literature or research.

Scoring

5. A large number of evidence-based interventions are readily available.
3. Some evidenced-based interventions are available.
1. There are little or no evidence-based interventions available.

8

Weighted Prioritization Criteria

What is capacity of the stakeholders to implement interventions to address the focus are or issue? Consider the county, hospital, or other community stakeholders capacity or expertise to implement an intervention as well as how well the potential interventions align with existing organizational priorities.

Scoring

5. There is ample knowledge or expertise in the counties, hospitals, and community stakeholders to implement a strategy.
3. There is some knowledge or expertise in the counties, hospitals, and community stakeholders to implement a strategy but more is needed.
1. There is no county, hospital, or community stakeholder capacity or expertise to implement an intervention.

9

Weighted Prioritization Criteria

What is the effectiveness of current strategies to address the focus area? Consider the ability of the current strategies to reach the target audience and the ability of the current strategies to achieve the desired results.

Scoring

5. Interventions or programs are not effective enough in addressing the focus area or issue. Substantial additional assistance is needed.
3. Interventions or programs are somewhat effective in addressing the focus area or issue but additional assistance is needed.
1. Interventions or programs are highly effective in addressing the focus area or issue. There is little or additional assistance needed.

10

Weighted Prioritization Criteria

Are there multiple health benefits from making this a priority? Consider how the focus area or issue affects overall quality of life., the impact on other health indicators, and whether the focus area has long-term impact on health status for the individuals affected.

Scoring

5. Substantial long-term health benefits result from addressing the focus area or issue. There are many overlapping health care benefits from addressing this focus area or issue.
3. There are some long-term health benefits from addressing the focus area or issue. There are some other overlapping health care benefits from addressing this focus area or issues.
1. There are no long-term benefits from addressing this focus area or issue. There are little or no overlapping health care benefits from addressing this focus area.

11

How the Weighted Prioritization Process Will Work

- Establish a meeting structure (either before or at the beginning of the meeting)
  - Determine who will facilitate the meeting
  - Determine who will record the votes
  - Determine if you want to prioritize a limited number of focus areas
    - Identify the focus areas which will not be discussed through an initial round of voting or through consensus
  - Establish discussion time limits for each focus area and for each criterion
- Determine what material(s) will be needed for the process
  - Data
  - Scoring sheets
  - Pens

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How the Weighted Prioritization Process Will Work

- Determine when voting will occur
  - After each focus area has been discussed
  - Once all focus areas have been discussed
- Determine how voting will be conducted
  - By consensus
  - By plurality
    - Show of hands
    - Secret ballot
    - Electronic voting
- Conduct the discussion and voting
- Present the final prioritization to the group using the spreadsheet after tallying the votes

13

How the Spreadsheet Works

- Scores for quartile/severity and for the stakeholder survey will be entered prior to the meeting.
- Once the score for each focus area and criterion is determined, type it into the appropriate cell.
- The spreadsheet weights the score and aggregates all scores for all criteria.
- The higher the score, the more of a priority for the county or community.
- The spreadsheet is protected as indicated by shaded gray areas. The formulas and weights cannot be modified.

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Dot Method Prioritization Process

15

Dot Method Overview

- Eight selected criteria used to discuss the focus area/issue.
- Each member is given a set of dots for voting.
  - The number of dots can vary.
  - Research suggests 1/3 of the number of area assessed, i.e., each participant gets 6 dots if 18 areas are being assessed.
- Facilitator gives participants an overview of each of the focus area(s) and asks participants to discuss all of the relevant issues.
- At the end of the discussion, participants place one or more dots corresponding to the focus area(s)/issue(s) to show their strong preferences for that focus area(s)/issue(s) as a priority.
- Areas(s) with the most dots is/are the top priority (ies).
- You may wish to conduct this voting in several rounds to quickly eliminate those focus areas/issues where there is no interest to identify as a priority.

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Dot Method Criteria for Discussion

- How severe is the focus area/issue?
  - In considering the data, are there many individuals affected by the focus area/issue?
  - Is this an emerging focus area/issue?
- Does the community view this focus areas/issue as an area which needs to be addressed?
- What is the perceived need for more interventions or programs to address the focus area/issue. Does the community have enough problems currently to address the focus area/issue?
- Is funding for the intervention available and sustainable to address the focus area/issue?
  - Property tax dollars
  - Reimbursement – government or billable services
  - Grants

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Dot Method Criteria for Discussion

- Are evidence based interventions available for implementation? Consider sources:
  - New York State Department of Health prevention agenda proposed interventions, and
  - other evidence-based interventions listed in literature or research.

- What is the effectiveness of current strategies to address the focus area? Consider:
  - the ability of the current strategies to reach the target audience, and
  - the ability of the current strategies to achieve the desired results.

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Dot Method Criteria for Discussion

- What is capacity of the stakeholders to implement interventions to address the focus are or issue? Consider
  - the county, hospital, or other community stakeholders capacity or expertise to implement an intervention
  - the ability of the current strategies to reach the target audience, and
  - how well the potential interventions align with existing organizational priorities.
- Are there multiple health benefits from making this a priority? Consider:
  - how the focus area or issue affects overall quality of life,
  - the impact on other health indicators, and
  - whether the focus area has long-term impact on health status for the individuals affected.

19

How the Dot Method Process Will Work

- Establish a meeting structure (either before or at the beginning of the meeting)
  - Determine who will facilitate the meeting
  - Determine if you want to prioritize a limited number of focus areas
    - Identify the focus areas which will not be discussed through an initial round of voting or through consensus
  - Establish discussion time limits for each focus area and for each criterion
- Determine what material(s) will be needed for the process
  - Data
  - Dots
  - Newsprint with the focus areas written on them so participants can vote by placing their dots
- Conduct the discussion and then vote

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