ADIRONDACK RURAL HEALTH NETWORK

COMMUNITY HEALTH ASSESSMENT Executive Summary 2019-2021



SEVEN-COUNTY REGION OF NEW YORK STATE Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington

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

This report is also available online at www.ahihealth.org/arhn.





This publication has been made possible through the collaboration of many organizational leaders from the seven-county region. In acknowledgement of their commitment to the health of community residents and diligent efforts for providing education and training to further the New York State Department of Health (DOH) Prevention Agenda, and offer other resources that support the development of the regional health care system, the following organizations comprise the Adirondack Rural Health Network's Community **Health Assessment (CHA) Committee:**

- Adirondack Health
- University of Vermont Health Network - Alice Hyde Medical Center
- University of Vermont Health Network - Champlain Valley **Physicians Hospital**
- Clinton County Health Department

- University of Vermont Health Network - Elizabethtown **Community Hospital**
- Essex County Health Department
- Franklin County Public Health
- Fulton County Public Health
- Glens Falls Hospital

- Hamilton County Public Health Services
- Nathan Littauer Hospital and Nursing Home
- Warren County Health Services
- Washington County Public Health Service



Table of Contents

I. INTRODUCTION TO THE REGION,	PARTNERS,	AND N	IEW Y	ORK	STATE
PREVENTION AGENDA					

	Message to the Community		1
	Adirondack Health Institute (A	AHI)	1
	Adirondack Rural Health Netw	vork (ARHN)	1
	Community Health Assessmen	t (CHA) Committee	2
	Purpose		2
	Guiding Principles		3
		ee	
	New York State Prevention Age	enda 2019-2024	4
	Social Determinants of Health	in the Adirondack Region	5
	Health Disparities in the Adiro	ndack Region	6
	ERVIEW FOR ADIRONDACK R IVIDUAL SEVEN COUNTIES*	URAL HEALTH NETWORK REGION AND	
	ARHN Regional Map		7
	Data Trends in the ARHN Region	on	9
	ARHN Region Snapshot		11
	Clinton County Snapshot		12
	Essex County Snapshot		13
	Franklin County Snapshot		14
	Fulton County Snapshot		15
	Hamilton County Snapshot		16
	Warren County Snapshot		17
	Washington County Snapshot		18
II. CO	MMUNITY STAKEHOLDER SU	JRVEY	
	Community Stakeholder Surve	ey Methodology	19
	Community Stakeholder Surve	ey Content	19
	Community Stakeholder Surve	ey Results and Trends	20
v. co	MMUNITY HEALTH ASSESSM	IENT METHODOLOGY	
	Data Methods and Process		23
/. APF	PENDICES*		
	A. Regional A.L.I.C.E. (Asset Lir	mited, Income Constrained, Employed) Profil	le
	D. Davis and Davis and the David	*I -	

- B. Regional Demographic Profile
- C. Regional Health Systems Profile
- D. Regional Educational System Profile

^{*} The information contained in this publication is comprised of a blending of multiple data sources. Please see page 23 for a detailed list.

INTRODUCTION TO THE REGION, PARTNERS, AND NEW YORK STATE PREVENTION AGENDA



The Adirondack Rural Health Network (ARHN) is proud to present you with this report of a comprehensive collection and analysis of data regarding health issues and needs in Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties in New York State. It was created with support from the NYS DOH and Health Resources and Services Administration (HRSA). See inside back cover for more details.

This report is the result of information gathered from a variety of sources and perspectives to provide valuable insight into the region's needs. The well-being of a community is reflected through a wide array of factors including access to medical services, individual behaviors, socio-demographic characteristics, and the environment in which one lives.

The results enable us to guide strategic planning throughout the Adirondack region, highlight topics for increased public awareness and education, identify areas for training, and support the New York State Department of Health's statewide Prevention Agenda to aid in developing regional health planning activities and resources.

Health is – and must be – an issue of concern and action for all of us. We hope the information in this Executive Summary will provide insight into the needs of the region and help communities identify their strengths, as well as areas where additional resources are needed.

AHI

Founded in 1987, Adirondack Health Institute has supported hospitals, physician practices, behavioral health providers, community-based organizations and others in the region in transforming the health care delivery system and improving population health.

A joint venture of Adirondack Health, Glens Falls Hospital, Hudson Headwaters Health Network, St. Lawrence Health System, and the University of Vermont Health Network - Champlain Valley Physicians Hospital, AHI serves nine counties in the North Country/Adirondack region - Clinton, Essex, Franklin, Fulton, Hamilton, Saratoga, St. Lawrence, Warren, and Washington.

ARHN STAFF

Nancy Gildersleeve, Executive Director — DSRIP Operations and Fulton Population Health Network (PHN) Courtney Shaler, ARHN Manager

Sara Deukmejian, ARHN Coordinator

ADIRONDACK RURAL HEALTH NETWORK

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

Originating in 1992, the ARHN is a strategic partnerdriven, seven-county region rural health network, that supports the NYS Prevention Agenda through advocacy, education, collaboration, training, funding, and data sharing to improve the health and well-being of our rural residents. Regional leaders of public health, community health centers, hospitals, behavioral health organizations, emergency medical services, and other community-based organizations are all active members of the network. ARHN includes organizations from Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.



PURPOSE

The Community Health Assessment (CHA) Committee, made up of the CHA service contract holders with AHI, is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment by working collaboratively on interventions and developing the planning documents required by the New York State Department of Health and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda. Since 2002, ARHN has coordinated the CHA Committee providing a resource for collaborative formal community health planning throughout the region.

CHA COMMITTEE

CLINTON COUNTY

Clinton County Health Department **UVMHN-Champlain Valley Physicians Hospital**

ESSEX COUNTY

Adirondack Health **Essex County Health Department UVMHN-Elizabethtown Community Hospital**

FRANKLIN COUNTY

Franklin County Public Health **UVMHN-Alice Hyde Medical Center**

HAMILTON COUNTY

Hamilton County Public Health

FULTON COUNTY

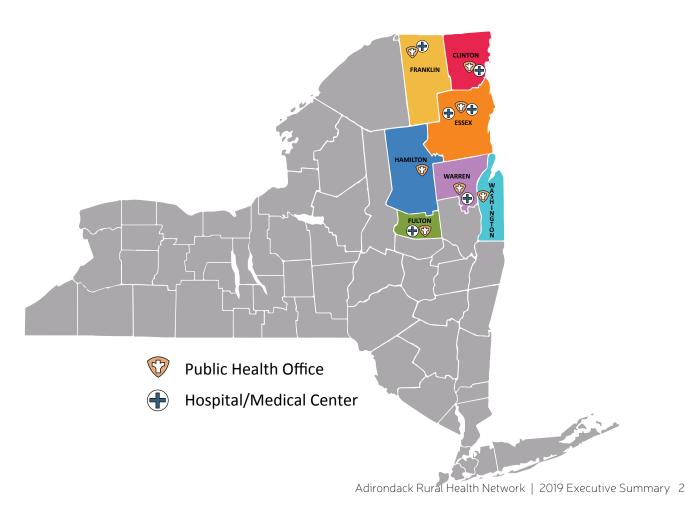
Fulton County Public Health Nathan Littauer Hospital and Nursing Home

WARREN COUNTY

Glens Falls Hospital Warren County Health Services

WASHINGTON COUNTY

Washington County Public Health Service



GUIDING PRINCIPLES FOR THE COMMUNITY HEALTH ASSESSMENT (CHA) COMMITTEE:

- To the best extent possible, committee decisions are developed through an informal organic process resulting in group consensus;
- Voting is used when necessary to help move discussion toward a final decision:
 - o Any committee member can request that a vote be taken on a topic under discussion;
 - o Voting is conducted confidentially;
 - o Each member organization has one vote, cast by the organization's designated representative;
 - o Voting can be delayed and/or conducted electronically when it is essential to have input from members not in attendance at a meeting where a vote is requested;
- Committee members keep an eye on what is happening in the wider health care network to ensure an appropriate context for committee decision-making;
- Committee operations are conducted efficiently and in a manner that is sensitive to the needs and concerns of committee members.

CHA COMMITTEE, AD HOC DATA SUB-COMMITTEE:

At the June 15, 2018 CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA)/ Community Health Needs Assessments (CHNA), as well as identify ways to enhance the Community Health Improvement Plans (CHIP)/Community Service Plans (CSP) process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

Data Sub-committee members concluded the process would be enhanced by:

- Documenting (quantitatively and qualitatively) the impact of social determinants of health on the primary health outcomes and priorities selected by the CHA Committee members; and
- Strengthening CHA members' ability to foster community stakeholders' understanding of the primary health outcomes in their county/region and to enlist stakeholders' active participation in activities to improve those outcomes.

The sub-committee identified the following items to focus on to achieve the outcomes noted above:

- Analyzing and interpreting community health assessment data;
- Engaging stakeholders to solicit feedback on priorities and sharing results of the CHA/CHNA/CHIP/CSP with stakeholders;
- Collecting information about the social determinants of health and "changing environment" that impacts the region's health;
- Identifying assessments conducted by other community sectors/organizations that may help inform and enhance the processes used in the previous cycle;
- Revisiting the tool and process designed to assist in the identification of health priorities; and
- Identifying opportunities to strengthen local health departments' ability to meet Public Health Accreditation standards regarding the community health assessment and planning process.

Summary of Issues Addressed by the Data Sub-committee:

- Developing a 2019 Stakeholder Survey;
- Incorporating a Social Determinants of Health perspective into the 2019 Community Health Assessment process;
- Reviewing processes and tools used to identify health priorities;
- Identifying criteria that could be used to assist in the prioritization process;
- Reviewing methods for community engagement in the community health assessment and health improvement activities; and
- Utilizing community asset mapping as a component of the community health assessment and community health improvement/community service plan efforts.

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

The Prevention Agenda 2019-2024 has five priorities with individual priority-specific action plans developed collaboratively with input from community stakeholders, as shown below. Each priority-specific action plan includes focus areas, goals, objectives, and measures for evidence-based interventions to track their impacts – including reductions in health disparities among racial, ethnic, and socioeconomic groups, age groups, and persons with disabilities. These objectives are tracked on the New York State Prevention Agenda Dashboard: www.health.ny.gov/prevention/prevention agenda/2019-2024/.



PREVENT CHRONIC

Focus Area 1 Healthy Eating and Food Security

Focus Area 2 Physical Activity

Focus Area 3 Tobacco Prevention

Focus Area 4 Preventative Care and Management



PROMOTE A HEALTHY AND SAFE ENVIRONMENT

Focus Area 1 Injuries, Violence and Occupational Health

Focus Area 2 Outdoor Air Quality

Focus Area 3 Built and Indoor Environments

Focus Area 4 Water Quality

Focus Area 5 Food and Consumer Products



PROMOTE WELL-BEING & PREVENT MENTAL & SUBSTANCE USE DISORDERS

Focus Area 1 Well-Being Focus Area 2 Mental and Substance Use **Disorders Prevention**



PROMOTE HEALTHY WOMEN, INFANTS & CHILDREN

Focus Area 1 Maternal and Women's Health

Focus Area 2 Perinatal and Infant Health

Focus Area 3 Child and Adolescent Health

Focus Area 4 Cross Cutting Healthy Women, Infants, and Children



COMMUNICABLE **DISEASES**

Focus Area 1 Vaccine Preventable Diseases

Focus Area 2 Human Immunodeficiency Virus (HIV)

Focus Area 3 Sexually Transmitted Infections (STIs)

Focus Area 4 Hepatitis C Virus (HCV)

Focus Area 5 Antibiotic Resistance and

Healthcare-Associated Infections

The Prevention Agenda Action Plans provide communities with recommended evidence-based interventions, promising practices, and guidance to support implementation (e.g., by highlighting organizations that are well-positioned to take leading or supporting roles). The plans emphasize interventions that address social determinants of health, promote health equity across communities and support healthy and active aging.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the social and environmental factors that influence individual and population health outcomes. Shaped by policy and the resulting distribution of resources, the circumstances in which people are born, grow, live, work and age account for most factors impacting a person's health and wellness. Some of the more frequently-cited unmet social needs in the Adirondack region include reduced access to health care, food insecurity, lack of reliable transportation, lack of safe and affordable housing, low income, and limited employment opportunities.



ADDRESSING SOCIAL DETERMINANTS OF HEALTH

A 2017 survey conducted by the American Academy of Family Physicians found that 83% of family physicians agree they should help with identifying and addressing social factors that influence patients' health outcomes, but 56% felt unable to provide solutions to patients to resolve unmet social needs. This study indicates an ongoing need for greater education and guidance to support health care providers' efforts in this arena.

Our region is in the initial phases of implementing and standardizing processes to screen for social determinants of health and develop referral pathways between clinical providers and community-based organizations to address identified needs. This will enable health care providers to incorporate this information and resulting processes into clinical practice, outcomes measurement, and payment models. Below are recommended steps, informed by lessons learned through our regional initiatives along with recognized best practices, to guide providers in taking steps to address the role social needs play in their patients' and clients' health and wellness:

- Identify unmet social needs through screening. Select a screening tool that's most appropriate for your patient population and that will collect information meaningful to the individual and the practice.
- Leverage patient-centered, culturally-competent patient engagement strategies, such as motivational interviewing, to understand the root cause of the identified need and build rapport with the patient.
- Manage expectations around the ability to address needs. Have a plan in place for responding to urgent needs and those that present an imminent safety risk to the patient or others.
- Refer patients to community-based service providers with the capacity to address identified needs.
- Whenever possible, have standardized care pathways in place for addressing commonly-identified needs, such as through an established partnership with a community service provider. For example, if access to healthy foods impacts many patients in your practice, consider opportunities for collaboration with food providers to create food prescription programs.
- Have a standardized referral and linkage process that includes monitoring and tracking referral outcomes (closed-loop referrals).
- Collect and analyze data from screening and referral processes to better understand needs specific to your
 patient population, as well as to contribute to a larger picture of population health in your region. Data can
 be used at the practice level to inform development of CBO partnerships and selection of interventions to
 implement. At the regional level, data collected can be used to advocate for policy change or support requests
 for funding.





HEALTH DISPARITIES

Inequities in external conditions referred to as social determinants of health lead to health disparities. Health disparities are measurable differences in health outcomes linked to populations living with social, economic, and/or environmental disadvantages. Health disparities adversely affect groups of people who have encountered systemic barriers to health due to characteristics historically linked to discrimination or exclusion. These can include race, ethnicity, religion, socioeconomic status, gender, age, disability, sexual orientation or gender identity, and geographic location among others.

While health disparities in the Adirondack region reflect some similarity to those experienced by groups across New York State, demographic differences must be considered to sufficiently address regional issues. Relative to Upstate New York and New York State as a whole, the Adirondack region is characterized by lower educational attainment, higher unemployment rates, an aging population, higher disability rates, lower household incomes, higher poverty rates, and a vastly rural composition.

Each of these attributes can increase the incidence of significant health disparities. Mental health and substance abuse are significant issues, affecting at least one-third of the Medicaid population, and driving significant emergency department utilization across the region. Poverty in the Adirondacks is exceptionally severe. Of those in poverty, there are greater proportions at or below 138% of the Federal Poverty Line (FPL) and 200% FPL compared to Upstate New York.

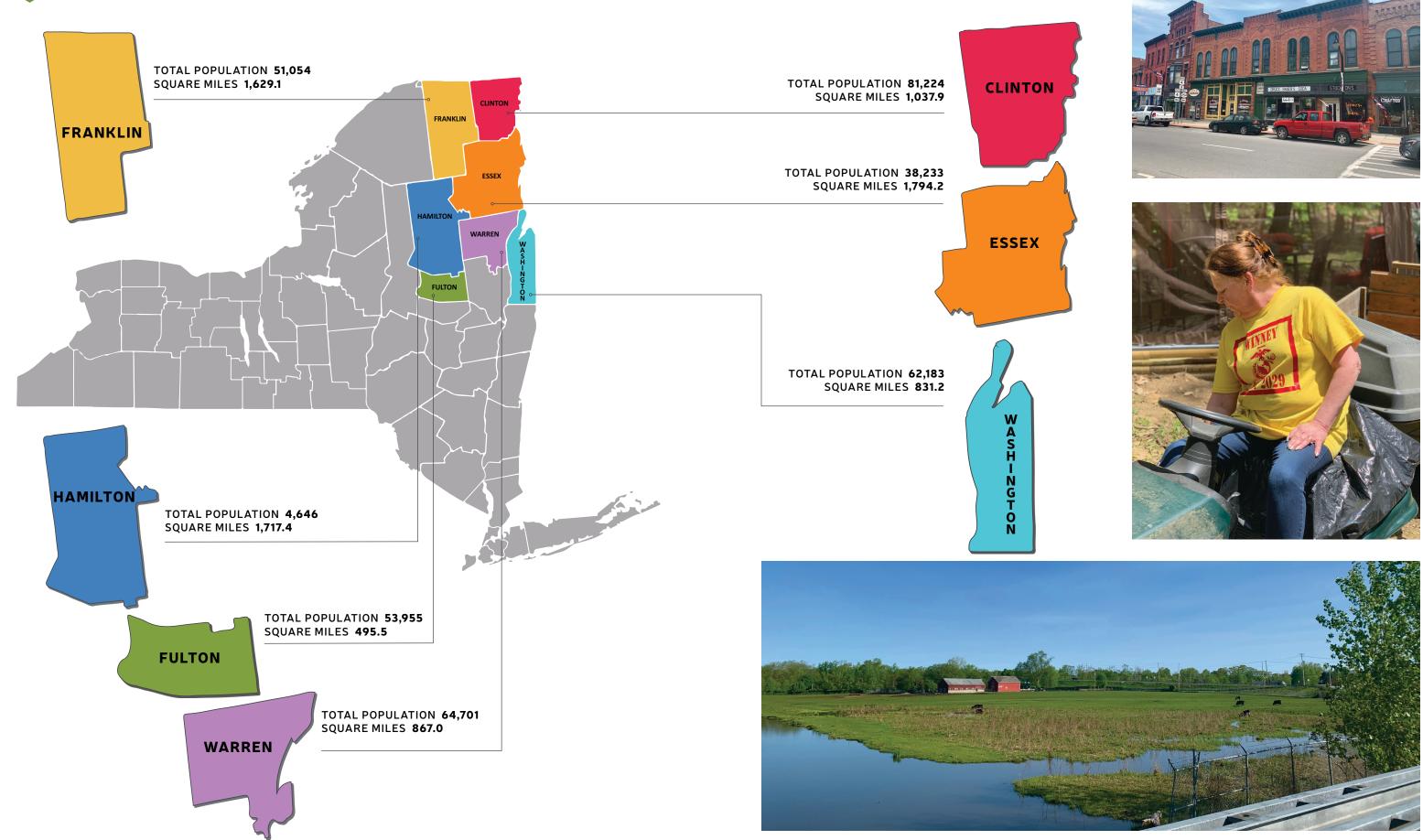
GENERAL GUIDELINES FOR REDUCING REGIONAL HEALTH DISPARITIES

Data, such as that collected through Community Health Assessments, can help identify health disparities and inform targeted interventions to address them. Guidelines include:

- Increasing capacity and reach of primary care and preventative services.
- Strengthening integration and information-sharing infrastructure across the continuum of care.
- Leveraging community-based interventions and resources to address patients' unmet social needs.
- Gathering stakeholder input to inform quality improvement initiatives.
- Implementing culturally competent and health literate health care practices, and guidance to support implementation (e.g., by highlighting organizations that are well-positioned to take leading or supporting roles). The plans emphasize interventions that address social determinants of health, promote health equity across communities and support healthy and active aging.



OVERVIEW FOR ADIRONDACK RURAL HEALTH NETWORK REGION



OVERVIEW/ABSTRACT:

The Adirondack Rural Health Network (ARHN) region includes Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties. There are several health professional shortage areas within the region, resulting in significant disparities in access to care. As a result, the rate of emergency department visits is higher for the ARHN region than Upstate New York. Along with limited access to care, the population with low-income and low access to supermarkets is also significantly higher in the ARHN region (6.0%) as compared to Upstate New York (3.9%) and the state as a whole (2.3%).

DEMOGRAPHICS:

The Adirondack Rural Health Network consists of a population of 355,996. Similar to the rest of Upstate New York, ARHN's population is very limited in its diversity. Over 92% are White/non-Hispanics, followed by 3.3% Black/ African American, non-Hispanics and 2.8% Hispanic/Latinos. Approximately 18.1% of the population is 65 years of age and older, which is comparable to that of Upstate New York at 16.37%. Of the total population, 22.9% of individuals living in the ARHN region are receiving Medicaid.

Household income on average is \$66,618, with per capita income at \$27,377, which is much lower than that of New York State, \$93,443 and \$35,752 respectively. The percentage of individuals in the ARHN region living below the Federal Poverty Level is 13.9%, which is slightly higher than Upstate New York at 11.7%. It should be noted that the ARHN region has seen a decrease in the percentage of individuals under the Federal Poverty Level, from 14.5% in 2014 to 13.9% in 2017. This could be a result of the decrease in unemployment rates for the region, from 6.8% to 3.7%.

Of the total population in the region, 36% of individuals 25 years of age and older have a high school diploma or equivalent, and another 47% have an Associate's or Bachelor's degree or higher. Approximately 58% of the population 16 and older is in the workforce, with the highest percentage of individuals in the field of education (27.1%), followed by retail trade (13.2%), manufacturing (10.5%), and arts, entertainment, recreation, hotel and food services (10.4%).

HEALTH SYSTEM PROFILE:

The ARHN region has six hospitals (Adirondack Health, UVMHN-Alice Hyde Medical Center, UVMHN- CVPH,

UVMHN-Elizabethtown Community Hospital, Glens Falls Hospital and Nathan Littauer Hospital and Nursing Home) with 976 hospital beds, the majority of which are medical/surgical beds, resulting in a rate of 274.2 hospital beds. There are a total of 20 nursing home facilities, accounting for 2,312 beds, and 19 adult care facilities, accounting for 908 beds. The ARHN region consists of 46 health professional shortage areas (HPSAs), 21 in primary care, 12 in dental care, and 13 in mental health.

EDUCATION PROFILE:

There are 60 public school districts in the region, with a total enrollment of 47,911 students. Of the enrolled students, 46.5% are eligible for free and reduced lunch, with a majority of students eligible for free lunch (89.1% or 19,851). The total number of high school graduates is 3,342 with a dropout rate of 0.8%, which is slightly higher than the Upstate New York (0.64%) dropout rate, but much lower than the New York State dropout rate of 3.0%. The ratio of students to teachers is 11.0, standing slightly lower than Upstate New York at 12.4.

ASSET LIMITED, INCOME CONSTRAINED, EMPLOYED (ALICE) PROFILE:

In total, there are 141,778 households in the ARHN region, with approximately 9.5% of residents over 65 years of age. There is a 13.6% poverty rate and 27.4% ALICE rate, with a total of 58,099 households designated as either poverty or ALICE. Specific to ALICE households, the majority are white (39,103), which far exceeds the second largest group of ALICE households comprised of Hispanic residents (637).

HEALTH DISPARITIES:

While there are no significant health disparities based on race and ethnicity in the ARHN region, there are significant health concerns present. The rate of ED visits per 10,000 population in the ARHN region (4,866.3) is significantly higher than Upstate New York (3,865.6). Approximately 10% of the ARHN population did not receive medical care due to costs in 2016, which is comparable to Upstate New York (9.8%) but less than New York State (11.2%). Lastly, the percentage of adults 18 years of age and older in the ARHN region with disability (25.6%) is higher than Upstate New York (22.8%) and the state as a whole (22.9%).

INJURIES, VIOLENCE, AND OCCUPATIONAL HEALTH:

Motor vehicle accidents and speed-related accidents are higher in the ARHN region (2,162.0 and 364.7, respectively) than in New York State (1,558.5 and 141.6).

Additionally, the rate of motor vehicle accident deaths is comparable in the ARHN region (7.3) to Upstate New York (7.1) and higher than the state as a whole (5.0). The rate of violent crimes (171.8) is significantly lower than that of Upstate New York (214.9) and New York State (355.6).

OUTDOOR AIR AND WATER QUALITY AND BUILT ENVIRONMENT:

The built environment poses challenges throughout the ARHN region. The percentage of the population with low-income and low access to supermarkets or large grocery stores is much higher in the ARHN region (6.0%) than in Upstate New York (3.9%), the state as a whole (2.3%), and the Prevention Agenda Benchmark of 2.2%.

OBESITY:

The rate of obesity in elementary school children in the ARHN region (18.3%) is higher than Upstate New York (16.0%). The burden of obesity may contribute to higher rates of death and hospitalization due to diabetes (any diagnosis) in the ARHN region (29.5 and 246.1, respectively) than in Upstate New York (19.8 and 237.2).

CHRONIC DISEASE:

Smoking-related diseases seem to pose a significant challenge for the ARHN region, with seven of the indicators listing as worse than the comparison Benchmark. Chronic lower respiratory deaths and hospitalizations are significantly higher in the ARHN region (72.8 and 31.2, respectively) than in Upstate New York (45.4 and 28.0) and the state as a whole (34.8 and 30.6). The percentage of adults with asthma in the ARHN region (12.0%) is higher, in comparison to Upstate New York (10.1%), and New York State (9.5%).

The rates of lung and bronchus cancer cases are higher in the ARHN region (112.2) than in Upstate New York (84.3) and New York State (69.7), and lung and bronchus cancer deaths are also higher in the ARHN region (67.4) than in Upstate New York (53.0) and New York State (43.5).

WOMEN, INFANTS AND CHILDREN:

The percentage of births within 24 months of previous pregnancies in the ARHN region (23.2%) is higher than the Prevention Agenda Benchmark of 17.0%, and the percentage of unintended pregnancies in the ARHN region (32.9%) is also higher than the Prevention Agenda Benchmark of 23.8%.

The percentage of women receiving WIC in the ARHN region with either gestational weight gain greater than ideal or gestational diabetes are higher than Upstate New York and New York State. The percentage of prepregnancy obesity (33.3%) is higher than that of Upstate New York (28.0%).

HIV/STDS, VACCINE-PREVENTABLE DISEASE, AND HEALTH CARE-ASSOCIATED INFECTIONS:

The immunization rate for children ages 19 – 35 months with 4:3:1:3:3:1:4 (73.9%) is lower than the Prevention Agenda Benchmark (80.0%) and the percentage of females 13 to 17 with three dose HPV vaccine (42.6%) is also lower than the Prevention Agenda Benchmarks of 50.0%. The rate of Pertussis cases in the ARHN region (11.7) is higher than Upstate New York (5.9), and New York State (5.1). The rate of pneumonia/flu hospitalizations for those 65 years of age or older in the ARHN region (93.3) is similar to Upstate New York (93.7) and higher than the state as a whole (87.3).

SUBSTANCE ABUSE AND MENTAL HEALTH:

The rate of alcohol-related crashes, injuries and deaths in the ARHN region (69.1 and 28.8, respectively) is significantly higher than New York State (38.0 and 19.4). The cirrhosis death rate per 100,000 population is 13.8 for the ARHN region, which is significantly higher than Upstate New York (7.4) and New York State (8.0).

As pertaining to mental health, the rate of suicides for adolescents, aged 15-19, is 10.7, which is higher than Upstate New York (6.1). The rate of individuals aged 17 and younger served in a mental health outpatient setting is double that of Upstate New York at 1,279.4. This is a drastic difference as compared to the rate of individuals aged 65 plus served in a mental health outpatient setting, as the ARHN rate is significantly less than that of the New York State rate (141.7 and 311.4, respectively).

OTHER FINDINGS:

The salmonella case rate is the same in the ARHN region (12.0) as in Upstate New York (12.0) and slightly higher than New York State (11.6). The rate of confirmed rabies is significantly higher in the ARHN region (7.3) than in Upstate New York (3.3).

ARHN REGION

DATA SNAPSHOT

TOTAL POPULATION: 355,996 SQUARE MILES: 8,372.2



POPULATION

2.8% 3.3% Hispanic/Latino 1.1% Black, Non-Hispanic Other 92.8% White, Non-Hispanic

Under 18	67,326
Ages 18-64	224,806
Ages 65+	63,864

EMPLOYMENT STATUS

Mean Household Income

% Single Parent Households

FULTON

OUSEHOLDS

% Unemployed 3.7%

CLINTON

ESSEX

WARREN

\$ 66,618

9.7%

FRANKLIN

HAMILTON



% Households with
One Vehicle or Less Available 43.0%

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

Number of Primary Care HPSAs	21
Number of Dental Care HPSAs	12
Number of Mental Health HPSAs	13

SCHO INFO

SCHOOL SYSTEM INFORMATION

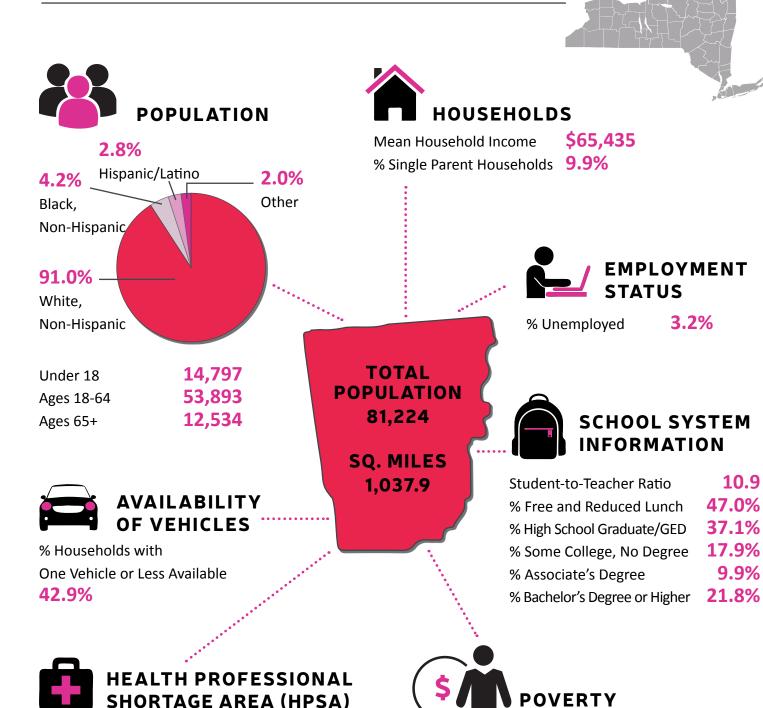
Student-to-Teacher Ratio	10.97
% Free and Reduced Lunch	46.5%
% High School Graduate/GED	36.0%
% Some College, No Degree	18.9%
% Associate's Degree	11.2%
% Bachelor's Degree or Higher	22.3%

\$ POVERTY

22.9%
13.9%
58,099

PLEASE SEE PAGE 23 FOR DATA SOURCES.

CLINTON COUNTY | DATA SNAPSHOT



2

PLEASE SEE PAGE 23 FOR DATA SOURCES.

Number of Primary Care HPSAs

Number of Dental Care HPSAs

Number of Mental Health HPSAs

Number of ALICE and Poverty Households 12,062

% Individuals Receiving Medicaid

% Individuals Under Federal Poverty Level

23.2%

15.7%

ESSEX COUNTY | DATA SNAPSHOT





Non-Hispanic

POPULATION



HOUSEHOLDS

\$69,488 Mean Household Income % Single Parent Households 7.9%

3.2% Hispanic/Latino 0.8% Other Black, Non-Hispanic 92.8% White,

6,455 Under 18 23,602 Ages 18-64 8,176 Ages 65+

VAILABILITY **OF VEHICLES**

% Households with One Vehicle or Less Available 40.2%

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

Number of Primary Care HPSAs	8
Number of Dental Care HPSAs	3
Number of Mental Health HPSAs	3

TOTAL **POPULATION** 38,233

> SQ. MILES 1,794.2

4	
4	

% Unemployed

SCHOOL SYSTEM INFORMATION

EMPLOYMENT

3.8%

STATUS

Student-to-Teacher Ratio	9.1
% Free and Reduced Lunch	50.0%
% High School Graduate/GED	33.3%
% Some College, No Degree	20.2%
% Associate's Degree	10.7%
% Bachelor's Degree or Higher	26.7%

% Individuals Receiving Medicaid	20.4%
% Individuals Under Federal Poverty Level	8.9%
Number of ALICE and Poverty Households	6,161

FRANKLIN COUNTY | DATA SNAPSHOT





Non-Hispanic

POPULATION

3.4% Hispanic/Latino 8.2% 5.9% Other Black, Non-Hispanic/ 82.5% -White,

10,012 Under 18 33,133 Ages 18-64 7,909 Ages 65+



AVAILABILITY **OF VEHICLES**

% Households with One Vehicle or Less Available 44.5%



TOTAL

POPULATION

51,054

SQ. MILES

1,629.1

HOUSEHOLDS

\$62,870 Mean Household Income % Single Parent Households 10.8%



EMPLOYMENT STATUS

4.2% % Unemployed



SCHOOL SYSTEM INFORMATION

10.7 Student-to-Teacher Ratio 57.0% % Free and Reduced Lunch 37.2% % High School Graduate/GED 18.6% % Some College, No Degree 11.8% % Associate's Degree % Bachelor's Degree or Higher 18.6%



HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

Number of Primary Care HPSAs Number of Dental Care HPSAs 2 Number of Mental Health HPSAs



24.6% % Individuals Receiving Medicaid 19.4% % Individuals Under Federal Poverty Level 8,869 Number of ALICE and Poverty Households

PLEASE SEE PAGE 23 FOR DATA SOURCES.

FULTON COUNTY DATA SNAPSHOT





2.8%



OUSEHOLDS

\$61,941 Mean Household Income % Single Parent Households 10.7%

Hispanic/Laţino 0.7% 1.8% Other Black. Non-Hispanic 94.7% -White, Non-Hispanic

11,091 Under 18 33,062 Ages 18-64 9,802 Ages 65+ **SQ. MILES 495.5**

TOTAL POPULATION 53,955



% Unemployed

SCHOOL SYSTEM INFORMATION

EMPLOYMENT

4.5%

13.3 Student-to-Teacher Ratio 51.0% Free and Reduced Lunch 35.7% % High School Graduate/GED 20.0% % Some College, No Degree 13.6% % Associate's Degree % Bachelor's Degree or Higher 17.7%

% Households with One Vehicle or Less Available 45.9%



Number of Primary Care HPSAs	1
Number of Dental Care HPSAs	1
Number of Mental Health HPSAs	1



% Individuals Receiving Medicaid	25.0%
% Individuals Under Federal Poverty Level	16.0%
Number of ALICE and Poverty Households	9,945

HAMILTON COUNTY | **DATA SNAPSHOT**





1.5% Hispanic/Latino 1.0% 0.8% Other Black, Non-Hispanic

96.7% -White, Non-Hispanic

656 Under 18 2,708 Ages 18-64 1,282 Ages 65+



AVAILABILITY **OF VEHICLES**

% Households with One Vehicle or Less Available 36.7%



TOTAL

POPULATION

4,646

SQ. MILES

1,717.4

\$64,039 Mean Household Income % Single Parent Households 11.3%



EMPLOYMENT STATUS

6.2% % Unemployed

SCHOOL SYSTEM INFORMATION

4.9 Student-to-Teacher Ratio % Free and Reduced Lunch 43.0% 32.0% % High School Graduate/GED % Some College, No Degree 23.5% 12.2% % Associate's Degree 20.0% % Bachelor's Degree or Higher



HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

Number of Primary Care HPSAs 0 Number of Dental Care HPSAs Number of Mental Health HPSAs



POVERTY

% Individuals Receiving Medicaid 22.6% 9.7% % Individuals Under Federal Poverty Level 779 Number of ALICE and Poverty Households

PLEASE SEE PAGE 23 FOR DATA SOURCES.

WARREN COUNTY

DATA SNAPSHOT





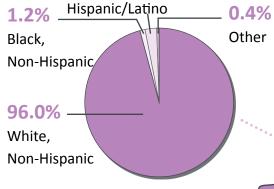
2.4%

POPULATION



HOUSEHOLDS

Mean Household Income \$76,756 % Single Parent Households 7.8%



Under 18 12,148 Ages 18-64 39,426 Ages 65+ 13,127



% Households with
One Vehicle or Less Available
44.4%

TOTAL POPULATION 64,701

SQ. MILES 867.0



% Unemployed

SCHOOL SYSTEM INFORMATION

EMPLOYMENT

3.0%

Student-to-Teacher Ratio	11.4
Free and Reduced Lunch	40.0%
% High School Graduate/GED	32.9%
% Some College, No Degree	18.6%
% Associate's Degree	11.0%
% Bachelor's Degree or Higher	29.3%

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

Number of Primary Care HPSAs	3
Number of Dental Care HPSAs	1
Number of Mental Health HPSAs	2



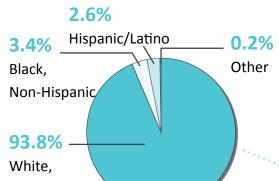
% Individuals Receiving Medicaid	18.8%
% Individuals Under Federal Poverty Level	9.9%
Number of ALICE and Poverty Households	10.079

WASHINGTON COUNTY

DATA SNAPSHOT



POPULATION



Under 18 12,167 Ages 18-64 38,982 Ages 65+ 11,034



Non-Hispanic

AVAILABILITY OF VEHICLES

% Households with
One Vehicle or Less Available
40.0%



POPULATION

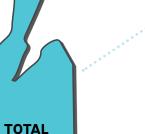
62,183

SQ. MILES

831.2

HOUSEHOLDS

Mean Household Income \$65,798
% Single Parent Households 9.3%



EMPLOYMENT STATUS

% Unemployed 3.9%



SCHOOL SYSTEM INFORMATION

Student-to-Teacher Ratio

% Free and Reduced Lunch

% High School Graduate/GED

% Some College, No Degree

% Associate's Degree

% Bachelor's Degree or Higher

10.8

48.0%

39.2%

18.7%

10.7%



HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

Number of Primary Care HPSAs	1
Number of Dental Care HPSAs	1
Number of Mental Health HPSAs	2



% Individuals Receiving Medicaid
% Individuals Under Federal Poverty Level
Number of ALICE and Poverty Households
10,204

PLEASE SEE PAGE 23 FOR DATA SOURCES.



COMMUNITY STAKEHOLDER SURVEY

SURVEY CREATION

The 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee. The final version was subsequently approved by the full CHA Committee at the December 7, 2018 meeting.

SURVEY FACILITATION

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

SURVEY LOGISTICS

The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a

list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 807 community stakeholders.

An initial email was sent to the community stakeholders in early January 2019 by the CHA Committee partners, introducing and providing a web-based link to the survey. A follow-up email was sent by ARHN staff approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

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

SURVEY CONTENT

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

A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%.

	RESPONDENTS BY COUNT	Y
COUNTY/REGION	TOTAL RESPONSE COUNT	TOTAL RESPONSE PERCENTAGE
Adirondack/North Country Region	49	12.04%
Clinton	81	19.90%
Essex	129	31.70%
Franklin	82	20.15%
Fulton	50	12.29%
Hamilton	69	16.95%
Warren	92	22.60%
Washington	150	36.86%
Other	65	15.97%

Total Response Count will not add up to 409 as a result of organizations covering multiple counties.

INDICATE THE COMMUNITY SECTOR THAT BEST DESCRIBES YOUR ORGANIZATION

Community stakeholders were asked to indicate one community sector that best described their organization or agency. Over 160 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including *Education* (19.0%), *Health Care* (13.2%), *Social Services* (12.5%), *Public Health* (9.2%), and *Health Based Community Based Organizations* (CBO) (7.5%), among many others.

RESPONSE COUNTS BY COMMUN	ITY SECTOR
COMMUNITY SECTOR	TOTAL
Business	4
Civic Association	3
College/University	7
Disability Services	10
Early Childhood	9
Economic Development	6
Employment/Job Training	2
Faith-Based	3
Food/Nutrition	10
Foundation/Philanthropy	1
Health Based CBO	30
Health Care Provider	53
Health Insurance Plan	1
Housing	7
Law Enforcement/Corrections and Fire Department	10
Local Government (e.g. elected official, zoning/planning board)	29
Media	2
Mental, Emotional, Behavioral Health Provider	22
Public Health	37
Recreation	3
School (K – 12)	69
Seniors/Elderly	28
Social Services	50
Transportation	2
Tribal Government	1
Veterans	2

TOP PRIORITY AREA FOR THE ARHN REGION:

Survey participants were asked to rank the NYS Prevention Agenda Priority Areas in order of most to least impact. Overall, respondents in the ARHN region identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* (41.7%) as their top priority, followed by *Promote a Healthy and Safe Environment* (21.9%).

NYS PREVENTION AGE	NDA TOP PRIORITY AREA	FOR THE ARHN REGION
COUNTY	FIRST CHOICE	SECOND CHOICE
ARHN Region	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

TOP PRIORITY AREA BY COUNTY:

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

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

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

NY	S PREVENTION AGENDA TOP PRIOR	RITY AREA BY COUNTY
COUNTY	FIRST CHOICE	SECOND CHOICE
Clinton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Essex	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote Healthy Women, Infants and Children
Franklin	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Fulton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Hamilton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Tie: • Prevent Chronic Disease • Promote a Healthy and Safe Environment
Warren	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment
Washington	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

^{*}Overlapping in county choices is due to several ties in response totals.

HEALTH CONCERNS FOR THE ARHN REGION:

Community stakeholders were asked to choose what they believed to be the top five health concerns affecting the residents in the counties their organization/agency served. The choices were ranked from one, being the highest health concern, to five, indicating the lowest health concern. Survey respondents felt that the top five health concerns affecting the residents within the ARHN region were *Mental Health (16.9%)*, *Substance Abuse (12.3%)*, *Opioid Use (9.5%)*, *Overweight/Obesity (8.8%)*, and *Child/Adolescent Emotional Health (5.7%)*.

RESPONSE COUNTS FOR ARHN F	REGION HEA	LTH	CONC	ERNS	
ARHN Region Health Concerns	1 (Highest)	2	3	4	5 (Lowest)
Adverse Childhood Experiences	20	20	19	13	8
Alzheimer's Disease/Dementia	19	17	8	5	9
Arthritis	1	0	2	3	1
Autism	2	2	2	2	4
Cancers	13	14	19	7	8
Child/Adolescent Physical Health	13	12	10	13	8
Child/Adolescent Emotional Health	20	36	20	22	14
Diabetes	10	14	14	6	16
Disability	4	7	5	5	11
Dental Health	1	5	5	10	14
Domestic Abuse/Violence	4	7	16	18	10
Drinking Water Quality	0	1	1	2	5
Emerging Infectious Diseases	2	1	5	1	8
Exposure to Air and Water Pollutants/Hazardous Materials	1	0	1	0	1
Falls	3	7	5	3	4
Food Safety	3	1	2	3	2
Heart Disease	7	11	9	16	12
Hepatitis C	0	0	1	2	1
High Blood Pressure	1	2	8	6	8
HIV/AIDS	0	0	1	0	2
Hunger	4	10	5	6	5
Infant Health	1	0	8	1	4
Infectious Disease	1	0	2	3	4
LGBT Health	0	1	0	1	2
Maternal Health	3	4	3	3	7
Mental Health Conditions	59	48	36	37	23
Motor Vehicle Safety (impaired/distracted driving)	0	0	1	0	7
Opioid Use	33	18	16	14	11
Overweight or Obesity	31	25	26	23	17
Pedestrian/Bicyclist Accidents	0	0	0	0	2
Prescription Drug Abuse	4	7	11	9	7
Respiratory Disease (asthma, COPD, etc.)	5	10	5	9	8
Senior Health	18	9	12	13	11
Sexual Assault/Rape	2	0	0	3	3
Sexually Transmitted Infections	2	0	0	4	4
Social Connectedness	2	4	9	18	16
Stroke	0	2	2	1	2
Substance Abuse	43	33	38	29	10
Suicide	1	5	2	2	7
Tobacco Use/Nicotine Addiction (smoking, vaping, chewing, etc.)	11	7	11	19	27
Underage Drinking/Excessive Adult Drinking	2	8	5	6	5
Unintended/Teen Pregnancy	2	1	1	4	10
Violence (assault, firearm related)	1	0	1	2	5



COMMUNITY HEALTH ASSESSMENT DATA METHODS AND PROCESS

Methods and Process

The overall goal of collecting and providing this data to the CHA Committee was to provide a comprehensive picture of the individual counties and overview of population health within the ARHN region, as well as Montgomery and Saratoga counties. The process of identifying the important health status and care needs of the residents of the ARHN region involved quantitative and qualitative data collection and analysis. ARHN was tasked to collect data from a variety of sources to assist in developing individual county community needs assessments.

As part of the community health planning and assessment process, the CHA Committee identified 271 data indicators to provide an overview of population health as compared to the ARHN region, Upstate New York, and New York State.

Data Sources

The information contained in this publication is comprised of a blending of multiple data sources, including:

- Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014
- Centers for Medicare and Medicaid Services, CMS **Enterprise Portal**
- **Community Health Indicator Reports**
- Department of Health, Wadsworth Center
- Division of Criminal Justice Services Index, Property, and Firearm Rates
- Health Resources and Services Administration, HPSA Find, 2017-2018
- Institute of Education Sciences, National Center for Education Statistics, 2016-2017
- NYS Department of Health
- NYS Department of Health Hospital Report on Hospital **Acquired Infections**
- NYS Department of Health Tobacco Enforcement **Compliance Results**

- NYS Education Department
- NYS Expanded Behavioral Risk Factor Surveillance
- NYS Office of the Professions, License Statistics, 2019
 - NYS Traffic Safety Statistical Repository
- Prevention Agenda Dashboard
- State and County Indicators for Tracking Public Health **Priority Areas**
- Student Weight Status Category Reporting System (SWSCRS) Data
- United For ALICE
- US Census Bureau, American Community Survey 5-year Estimates
- US Department of Agriculture, National Agriculture Statistics Service, 2012
- USDA Economic Research Service Fitness Facilities Data



		ALICE IS A UNI		ym tnat stand	s tor Asset LIIT	ted way acronym tnat stands for Asset Limited, income Constrained, Employed	instrained, Em	pioyea.				
Adirondack Rural Health Network					County					MUGA	VIA ototoli	JAIN
Summary of ALICE Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	ARTIN	Opstate NT	NTS
ALICE Household Information												
Total Households	30,624	15,298	19,299	22,450	1,239	19,540	93,703	28,841	24,027	141,778	4,101,529	7,216,340
Total Households Over 65 Years of Age	8,150	5,144	4,817	6,339	544	5,484	24,083	8,898	6,738	40,630	705,081	1,839,483
Total ALICE Households	7,350	4,589	5,404	6,511	632	6,448	19,678	6,922	7,208	38,615	1,059,036	2,222,633
ALICE Households Over 65 Years of Age	2,119	1,749	1,590	2,282	261	2,468	6,502	2,936	2,291	13,408	380,182	662,214
Poverty %	15.0%	10.2%	18.2%	15.0%	12.2%	17.6%	%8.9	11.0%	12.1%	13.6%	11.3%	14.4%
ALICE %	24.4%	30.1%	27.8%	29.3%	50.7%	33.2%	21.1%	24.0%	30.4%	27.4%	28.7%	30.8%
Above ALICE %	%9.09	59.7%	54.0%	55.7%	37.1%	49.2%	72.1%	65.1%	57.5%	29.0%	%0.09	54.8%
# of ALICE and Poverty Households	12,062	6,161	8,869	9,945	779	9,928	26,181	10,079	10,204	58,099	1,640,619	3,262,043
Unemployment Rate	2.0%	7.5%	8.5%	8.0%	9.2%	8.4%	2.9%	4.6%	8.1%	n/a	n/a	n/a
Percent of Residents with Health Insurance	95.8%	93.2%	91.3%	91.4%	90.4%	91.2%	96.1%	96.5%	91.9%	n/a	n/a	n/a
Average Annual Earnings	\$36,372	\$37,128	\$35,148	\$32,892	\$32,940	\$37,704	\$47,604	\$40,932	\$38,028	n/a	n/a	n/a
ALICE Households by Race/Ethnicity												
White	8,119	4,449	5,191	6,683	622	6,112	19,596	6,635	7,404	39,103	922,506	1,245,865
Asian	20	n/a	2	28	n/a	28	191	65	27	172	31,141	180,688
Black	122	n/a	13	32	n/a	134	255	100	14	281	125,980	433,433
Hispanic	81	33	41	156	n/a	651	425	126	200	637	134,063	494,216
	ļ		;	i		ć i	(

Appendix B: Demographic Profile

Adirondack Rural Health Network					County						2004	
ıs	Clinton	Essex	Franklin	Fulton Ha	Hamilton	Montgomery	Saratoga	Warren	Washington	ANTIN NEBIOII	Opstate NTS	New Tork State
Square Miles ^{1,4}	ŀ	-	-	ŀ	-			ŀ				
Total Square Miles ¹	1,037.9	1,794.2	1,629.1	495.5	1,717.4	403.0	810.0	867.0	831.2	8,372.2	46,823.75	47,126.4
Total Souare Miles for Farms ¹	230.0	85.7	226.6	49.8	3.2	205.3	123.2	14.9	295.9	906.1	11,223.6	11,224.3
Percent of Total Square Miles Farms	22.2%	4.8%	13.9%	10.1%	0.2%	20.9%	15.2%	1.7%	35.6%	10.8%	24.0%	23.8%
Population per Square Mile ²	78.12	21.24	30.94	108.64	2.64	122.26	280.32	74.48	74.35	42.5	239.4	418.9
Population ⁵			4									
Total Population	81,224	38,233	51,054	53,955	4,646	49,500	226,632	64,701	62,183	355,996.0	11,238,156	19,798,228
Percent White. Non-Hispanic	91.0%	92.8%	82.5%	94.7%	97.9%	88.2%	93.2%	%0.96	98.5%	92.8%	79.8%	63.8%
Percent Back Non-Hispanic	4.2%	3.2%	2.9%		2.6%	1.8%	1.7%	1.2%	3.4%	3.3%	9.2%	15.7%
Derrent Hisnanis/Jation	2.8%	3.2%	3.4%	2.8%	1.5%	13.2%	3.0%	2.4%	2.6%	2.8%	10.9%	18.8%
Derrent Acian/Dacific Iclander Non-Hickanic	1.5%	0.5%	9.0		0.4%	0.8%	2.8%	1.1%	0.5%	0.8%	3.9%	8.3%
reterit Asially adult. Notified in the state of the state	0.2%	0.2%	%6.9%		1.0%	0.1%	0.2%	0.2%	0.2%	1.2%	15.2%	8.7%
Percent Alaskan Native/American Indian Derreat Militis Base/(7)ther	1.5%	3.3%	3.9%		2.5%	9.1%	2.0%	1.6%	2.2%	2.3%	16.3%	10.7%
				-								
	3 8 3 7	1 538	3 478	02.6.6	1/8	3.05/	11 787	2 907	3.051	16 21 1	616 519	1 176 977
Number Ages 0-4	7,00,0	1,330		0,2,7	1 1	4,00,0	11,707	2,302	150,5	10,214	515,010	1,110,677
Number Ages 5-14	8,388	3,544		6,322	3//	6,2/3	26,831	6,892	6,845	37,861	1,347,307	2,300,490
Number Ages 15-17	2,411	1,373			131	1,999	8,830	2,354	2,271	12,630	444,834	725,937
Number Ages 18-64	53,326	23,602	_		2,708	29,322	141,813	39,426	38,982	224,239	6,989,413	12,586,573
Number Ages 65+	13,028	8,176			1,282	8,852	37,371	13,127	11,034	64,358	1,840,083	3,008,351
Number Ages 15-44 Female	14,990	13,125	8,289	9,272	269	8,805	41,090	10,793	10,096	67,134	2,091,141	4,027,930
Family Status ⁵												
Number of Households	31,680	15,257	18,956	22,535 1	19,700	1,095	93,129	27,249	23,988	159,365	4,160,305	7,302,710
Percent Families Single Parent Households	%6.6	7.9%	10.8%	10.7%	11.3%	n/a	6.7%	7.8%	9.3%	9.7%	%6'6	8.9%
Percent Households with Grandparents as Parents	12.5%	24.8%	5.2%	12.1%	5.4%	9.7%	15.2%	9.2%	8.6%	10.7%	27.3%	19.6%
Poverty ^{5,3}												
Mean Household Income	\$65,435	\$69,488	\$62,870 \$	\$61,941 \$	\$64,039	\$62,118	\$96,086	\$76,756	\$62,798	\$66,618	n/a	\$93,443
Per Capita Income	\$25,833	\$29,008	\$24,294 \$	\$ \$26,298	\$24,891	\$25,307	\$39,653	\$33,127	\$26,064	\$27,377	\$40,926	\$35,752
Percent of Individuals Under Federal Poverty Level	15.7%	8.9%	19.4%	16.0%	9.7%	19.6%	%9.9	%6.6	12.8%	13.9%	11.7%	15.1%
Percent of Individuals Receiving Medicaid	23.2%	20.4%	24.6%	25.0%	22.6%	29.7%	12.7%	18.8%	25.1%	22.9%	43.1%	24.8%
Per Capita Medicaid Expenditures ³	\$8,574	\$8,028	\$7,383	\$9,148 \$	\$7,060	\$9,069	\$8,397	\$8,283	\$8,493	n/a	n/a	\$9,670
Immigrant Status ^{5,4}												
Percent Born in American Territories	95.4%	%6.96	95.3%	61.9%	97.1%	96.4%	94.5%	%8:96	82.76	%5'96	%L'L8	76.0%
Percent Born in Other Countries	4.6%	3.1%	4.7%	2.1%	2.9%	3.6%	5.5%	3.7%	2.2%	3.5%	12.3%	24.0%
Percent Speak a Language Other Than English at Home ⁴	2.5%	2.9%	7.5%	3.3%	2.6%	14.3%	%6.9	5.2%	3.3%	5.1%	31.2%	30.6%
Housing ⁵	ŀ	-	-	-	-	-		-				
Total Housing Units		26,114			8,885	23,480	103,766	39,559	29,367	194,863	4,164,398	8,255,911
Percent Housing Units Occupied	87.1%	58.4%			12.3%	83.9%	89.7%	%6.89	81.7%	72.2%	22.0%	88.5%
Percent Housing Units Owner Occupied	%0.89	%0.92			84.7%	%6.89	71.5%	71.9%	72.7%	71.8%	74.7%	54.0%
Percent Housing Units Renter Occupied	32.0%	24.0%	27.1%	28.6%	15.3%	31.1%	28.5%	28.1%	27.3%	28.2%	38.7%	46.0%
	-	-	-	-	-	-		-				
Percent Built Before 1970	45.2%	57.5%			25.9%	72.8%	34.2%	46.9%	25.8%	53.3%	92.2%	%0.89
Percent Built Between 1970 and 1979	14.6%	10.5%	11.6%	9.7%	11.6%	7.7%	14.1%	11.9%	10.8%	11.7%	%02	10.0%
Percent Built Between 1980 and 1989	14.7%	11.0%	12.1%		11.0%	%8.9	16.2%	14.6%	11.6%	12.3%	74.1%	7.6%
Percent Built Between 1990 and 1999	13.5%	8.9%	12.5%		11.9%	%8.9	15.2%	11.9%	%6.6	11.1%	75.3%	6.1%
Percent Built 2000 and Later	12.0%	12.2%	%8.6	8.0%	%9.6	2.7%	20.2%	14.7%	11.9%	11.6%	%6.69	8.2%
Availability of Vehicles ⁵	-	-	-	-	-			-				
Percent of Households with No Vehicles Available	9.3%	7.5%			4.8%	12.7%	4.4%	%0.6	6.3%	8.5%	19.2%	29.0%
Percent of Households with One Vehicle Available	33.6%	32.7%	35.0%	36.5%	31.9%	34.4%	31.9%	35.4%	33.7%	34.5%	58.4%	32.8%

	27 10/	702.07	70 1%	/ /00 40	703 44	70L VE	705 CV	38 ∪%	%€ 0€	%9 8E	82 1%	%c 3c
Percent of Households with Two Vehicles Available		0	27:01		0/7:/	27:15	43.0%	80.50	20.00	200	07:70	0/4:04
Percent of Households with Three or More Vehicles Available	19.9%	19.2%	15.4%	16.9%	15.8%	18.2%	20.0%	17.7%	20.7%	18.4%	89.4%	12.0%
Education ⁵												
Total Population Ages 25 and Older	55,125	28,866	35,862	38,651	3,604	34,126	160,285	47,642	44,765	254,515	7,690,861	13,660,809
Percent with Less than High School Education	13.3%	9.1%	13.7%	13.0%	12.2%	14.8%	6.1%	8.3%	11.6%	11.6%	10.0%	13.9%
Percent High School Graduate/GED	37.1%	33.3%	37.2%	35.7%	32.0%	35.3%	24.8%	32.9%	39.2%	36.0%	28.0%	26.3%
Percent Some College, No Degree	17.9%	20.2%	18.6%	20.0%	23.5%	19.3%	17.1%	18.6%	18.7%	18.9%	17.4%	15.9%
Percent Associate's Degree	%6.6	10.7%	11.8%	13.6%	12.2%	13.6%	11.6%	11.0%	10.7%	11.2%	10.4%	8.7%
Percent Bachelor's Degree	11.2%	14.5%	%0.6	8.6	8.7%	10.1%	23.3%	15.6%	11.6%	11.9%	18.7%	19.9%
Percent Graduate or Professional Degree	10.6%	12.2%	%9.6	7.9%	11.3%	6.9%	17.0%	13.7%	8.2%	10.4%	15.5%	15.4%
Employment Status ⁵												
Total Population Ages 16 and Older	827'89	32,769	42,189	44,129	4,079	39,440	185,143	54,254	51,620	297,268	9,126,563	16,080,981
Total Population Ages 16 and Older in Armed Forces	56	10	6	7	1	39	1,563	9	20	109	20,938	23,203
Total Population Ages 16 and Older in Civilian Workforce	38,304	18,796	21,744	26,241	2,243	23,696	122,689	34,150	30,756	172,234	5,737,902	10,152,999
Percent Unemployed	3.2%	3.8%	4.2%	4.5%	6.2%	4.4%	3.0%	3.0%	3.9%	3.7%	3.8%	4.3%
Employment Sector ⁵												
Total Employed	36,091	17,544	19,960	24,239	1,991	21,956	117,053	32,518	28,741	161,084	5,394,792	9,467,631
Percent in Agriculture, Forestry, Fishing, Hunting, and Mining	2.3%	3.2%	3.1%	%6:0	0.7%	2.2%	0.8%	%9.0	4.0%	2.2%	1.0%	%9.0
Percent in Construction	4.8%	8.2%	%9.9	6.4%	18.5%	%6.9	6.1%	%8.9	8.2%	6.8%	6.1%	2.6%
Percent in Manufacturing	12.3%	8.7%	2.0%	12.3%	%8.9	13.6%	10.5%	8.4%	14.0%	10.5%	8.3%	6.2%
Percent in Wholesale Trade	1.8%	1.2%	1.4%	1.8%	4.7%	2.2%	2.4%	7.6%	1.7%	1.9%	2.6%	2.4%
Percent in Retail Trade	13.3%	11.6%	10.5%	15.3%	9.3%	13.9%	12.1%	13.3%	14.3%	13.2%	11.4%	10.6%
Percent in Transportation, Warehousing, Utilities	4.9%	3.2%	2.8%	2.7%	10.4%	5.3%	3.2%	3.8%	4.6%	4.4%	4.5%	5.2%
Percent in Information Services	1.9%	1.7%	1.2%	1.5%	1.3%	1.1%	1.8%	1.4%	%6:0	1.4%	2.2%	2.9%
Percent in Finance	2.8%	3.9%	3.2%	2.9%	2.0%	4.4%	7.0%	5.2%	4.3%	3.7%	7.0%	8.1%
Percent in Other Professional Occupations	5.2%	5.1%	2.5%	7.1%	2.0%	%2.9	11.9%	8.3%	7.4%	6.5%	10.6%	11.8%
Percent in Education, Health Care and Social Assistance	26.7%	29.1%	33.2%	27.2%	22.9%	26.4%	25.1%	26.6%	23.0%	27.1%	28.2%	27.5%
Percent in Arts, Entertainment, Recreation, Hotel & Food Service	10.8%	13.6%	10.4%	7.8%	7.4%	%5'9	8.7%	12.7%	7.8%	10.4%	8.6%	%9.6
Percent in Other Services	3.8%	4.2%	4.3%	4.7%	2.9%	4.1%	3.7%	4.8%	4.2%	4.3%	4.7%	2.0%
Percent in Public Administration	%9.6	6.3%	12.8%	6.3%	8.2%	6.8%	6.6%	5.5%	2.6%	7.6%	5.1%	4.5%

Percent in Public Administration 9.6%

(n/a) Data Not Available

*ARHN Region consists of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties.

*Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond).

Sources:

(2) USD Department of Macirculture, National Agriculture Statistics Service, 2012

(2) NYS Department of Health, Vital Statistics of New York State 2016

(3) Centers for Medicare and Medical Services, GMS Enterprise Portal

(4) US Census Bureau, 2010-2014 American Community, Survey 5-year Estimates

(5) US Census Bureau, 2013-2017 American Community Survey 5-year Estimates

Appendix C: Health Systems Profile

Adirondack Rural Health Network					County					ARHN	33.14	New York
Summary of Health Systems Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region	Upstate NYS	State
Population, 2013-2017	81,224	38,233	51,054	53,955	4,646	49,500	226,632	64,701	62,183	352,996	11,238,156	19,798,228
Total Hospital Beds ¹												
Hospital Beds per 100,000 Population	369.3	65.4	334.9	137.2	n/a	262.6	75.5	627.5	e/u	274.2	e/u	n/a
Medical/Surgical Beds	214	0	129	47	n/a	70	115	300	n/a	0.069	n/a	n/a
Intensive Care Beds	14	0	14	8	n/a	2	12	12	n/a	48.0	n/a	n/a
Coronary Care Beds	7	0	0	0	n/a	3	7	12	n/a	19.0	n/a	n/a
Pediatric Beds	10	0	3	12	n/a	0	7	14	n/a	39.0	n/a	n/a
Maternity Beds	21	0	13	7	n/a	8	14	23	n/a	64.0	n/a	n/a
Physical Medicine and Rehabilitation Beds	0	0	0	0	n/a	10	0	15	n/a	15.0	n/a	n/a
Psychiatric Beds	34	0	12	0	n/a	20	16	30	n/a	76.0	n/a	n/a
Other Beds	0	25	0	0	n/a	14	0	0	n/a	25.0	n/a	n/a
Hospital Beds Per Facility ¹												
Adirondack Medical Center-Lake Placid Site						,	'		,			,
Adirondack Medical Center-Saranac Lake Site	•		95			•	•		,	,		ı
Alice Hyde Medical Center	•		92			,	,	•	1	,	1	,
Champlain Valley Physicians Hospital Medical Center	300					•	•		1		1	
Elizabethtown Community Hospital		25							ı			1
Glens Falls Hospital								406			1	
Nathan Littauer Hospital	,			74								
Saratoga Hospital	,						171					
St. Mary's Healthcare	,			,	1	120	•	,	ı	,	,	ı
St. Mary's Healthcare-Amsterdam Memorial Campus	ı					10	,	•	,		,	,
Total Nursing Home Beds ²												
Nursing Home Beds per 100,000 Population	603.3	889.3	381.9	667.2	0.0	1191.9	317.3	616.7	849.1		1	,
Nursing Home Beds per Facility ²												
Alice Hyde Medical Center	-		135		1							
Capstone Center for Rehabilitation and Nursing						120	,		1		1	,
Champlain Valley Physicians Hospital Medical Center SNF	34					1	1		1			1
Clinton County Nursing Home	80					1	1		1		1	1
Elderwood at North Creek						•	•	82	1	,	•	,
Elderwood at Ticonderoga		84							,		1	1
Elderwood of Uihlein at Lake Placid	ı	156				•	•		1		1	•
Essex Center for Rehabilitation and Healthcare	•	100					1		1		1	1
Fort Hudson Nursing Center, Inc.						,	,		196		ı	
Fulton Center for Rehabilitation and Healthcare				176					ı			
Glens Falls Center for Rehabilitation and Nursing								117	ı			
Granville Center for Rehabilitation and Nursing	ı					,	,		122		ı	ı
Meadowbrook Healthcare	287					•						ı
Mercy Living Center			09		1		,	1	1			
Nathan Littauer Hospital Nursing Home				84		'			ı		ı	ı
Palatine Nursing Home						70						
Plattsburgh Rehabilitation and Nursing Center	68					1	1		1		1	ı
River Ridge Living Center	ı		1	1	1	120	1	ı	,		,	
Saratoga Center for Rehab and Skilled Nursing Care						1	257					ı
Seton Health at Schuyler Ridge Residential Healthcare						1	120		1	,	1	1
Slate Valley Center for Rehabilitation and Nursing						1	1		88	,	1	1
St Johnsville Rehabilitation and Nursing Center						120	-				•	

The Pines at Glens Falls Center for Nursing & Rehabilitation								120				
Warren Center for Rehabilitation and Nursing	,	,	,	,			,	80	,			,
Washington Center for Rehabilitation and Healthcare			1			,	,	} '	122	,	,	,
Wells Nursing Home Inc				100			1		'			
Wesley Health Care Center Inc						,	342	,	ı		,	
Wilkinson Residential Health Care Facility						160	-		-		-	
Total Adult Care Facility Beds ³												
Adult Care Facility Beds per 100,000 Population	221.6	928.5	176.3	307.7	0.0	8.776	390.1	452.9	403.6	375.0	550.2	404.7
Total Adult Home Beds	150	194	09	114	n/a	294	483	248	142	806	38,328	49,670
Total Assisted Living Program Beds	30	30	30	52	n/a	160	0	45	69	256	7,072	12,192
Total Assisted Living Residence (ALR) Beds	0	131	0	0	n/a	30	401	0	40	171	16,434	18,255
Adult Home Beds by Total Capacity per Facility ³												
Adirondack Manor HFA D.B.A Adirondack Manor HFA ALP			1				1	09	ı	-		,
Adirondack Manor HFA D.B.A Montcalm Manor HFA		40	1				,	1		1	1	1
Ahana House	,	1	1	,			17	1		ı		1
Alice Hyde Assisted Living Program			30				1	1	1		1	
Argyle Center for Independent Living	1	,	1	,	,		,	,	35	1	,	,
Arkell Hall			ı			24	1	ı	ı	ı		ı
Beacon Pointe Memory Care Community			1				52					1
Champlain Valley Senior Community		81	1				,					,
Cook Adult Home			1				13					,
Countryside Adult Home			1					48				1
Elderwood Village at Ticonderoga	1	23	1	1			1	1	1	1	,	1
Emeritus at the Landing of Queensbury	1	1	1	1			1	88	1	1	,	1
Hillcrest Spring Residential	,	,	,	,		80	,	,	,	,	,	,
Holbrook Adult Home			1						33			1
Home of the Good Shepherd at Highpointe						1	98		,			
Home of the Good Shepherd	,		,	,	,		42	ı	1		1	
Home of the Good Shepherd Moreau			1				72	1	ı			1
Home of the Good Shepherd Saratoga			ı				105	1	1			
Home of the Good Shepherd Wilton	,	1	1	,			54	1		1	,	1
Keene Valley Neighborhood House		20							1			
Pine Harbour	99		1									1
Pineview Commons H.F.A.			ı	94				1	ı		1	ı
Samuel F. Vilas Home	44					. :						ı
Sarah Jane Sanford Home	1	ı	ı	ı		40			. :			1
The Cambridge			, 6				ı	ı	40			
The Management Court Haire			30				ı					ı
The Continue of the Continue o			ı			, ,			94			
The periodical dami, the			ı			130		· [
The Terrace at the Gien	, (ı				ı	25	ı	ı		ı
valenaven Home Tor Adults	40			, 6								ı
Willing helpers home for women				70		'	, (,	
Woodlawn Commons					•		47				•	
Health Professional Shortage Areas (HPSAs) ^{4,5}												
Number of Primary Care HPSAs ⁴	1	∞	2	1	2	1	0	က	1	21	111	181
Primary Care HPSA Population ⁵	10,339	4,481	5,997	13,950	2,949	11,456	0	2,168	189	40,073	n/a	n/a
Number of Dental Care HPSAs ⁴	1	8	5	П	0	П	0	1	П	12	87	139
Dental Care HPSA Population ⁵	0	6,368	16,181	0	0	0	0	0	0	22,549	n/a	n/a
Number of Mental Health HPSAs ⁴	2	3	2	1	1	1	0	2	2	13	96	159

Appendix C: Health Systems Profile, continued

Mental Care HPSA Population ⁵	10,339	39,309	51,698	869′9	4,835	11,456	0	0	0	112,879	n/a	n/a
Population, 2013-2017 ⁵												
Primary Care Physicians per 100,000 population	119.2	66.2	101.9	66	84.9	83.9	87.5	153	66.4	n/a	102.8	124.1
Subspeciality per 100,000 population												
Obstetrics/Gynecology	14.9	0.0	18.3	7.4	0.0	5.4	8.4	18.6	0.0	n/a	11.0	14.5
IM Subspeciality	34.8	7.0	13.1	6.6	0.0	37.9	21.1	0.09	0.0	n/a	31.8	49.8
General Surgery	9.9	3.5	10.5	6.6	0.0	2.7	3.6	12.4	2.1	n/a	7.9	8.8
Surgical Subspecialties	23.2	10.5	0.0	7.4	0.0	8.1	10.9	37.2	0.0	n/a	17.8	21.6
General Psychiatry	24.8	0.0	15.7	6.6	0.0	8.1	21.1	20.7	8.6	n/a	18.8	36
Other	107.6	20.9	65.3	32.2	9.99	56.9	33.8	159.2	4.3	n/a	87.8	121.1
Total Physician ⁵												
Total Physician per 100,000 population	317.9	108.0	206.5	168.3	141.5	200.4	179.2	442.5	81.4	n/a	268.0	362.9
Licensure Data ⁶												
Clinical Laboratory Technician	14	9	5	1	0	4	21	6	2	40	1,208	1,649
Clinical Laboratory Technologist	54	19	27	32	1	38	161	50	24	207	7,730	12,064
Dental Assistant	11	2	6	4	0	7	33	10	11	47	1,338	1,435
Dental Hygienist	42	15	16	23	2	26	241	44	38	180	8,035	10,428
Dentist	41	14	17	17	1	25	175	46	15	151	8,771	15,075
Dietition/Nutritionist, Certified	21	6	8	4	1	10	122	22	7	72	3,667	5,492
Licensed Clinical Social Worker (R/P psycotherapy)	42	24	31	21	2	15	592	72	35	227	14,629	25,254
Licensed Master Social Worker (no privileges)	34	22	26	18	2	23	267	53	26	181	14,861	26,884
Licensed Practical Nurse	382	215	321	308	10	362	895	335	438	2,009	48,582	63,082
Physician	211	49	85	59	9	87	528	265	36	711	42,475	75,565
Mental Health Counselor	59	20	32	10	1	13	147	32	13	167	4,647	6,853
Midwife	9	1	3	4	0	2	14	12	5	31	595	1,022
Nurse Practitioner	79	13	36	38	2	27	258	94	29	291	15,282	22,128
Pharmacist	106	29	41	36	2	40	484	64	44	322	13,780	21,306
Physical Therapist	64	40	48	30	ĸ	43	395	29	30	282	13,417	19,277
Physical Therapy Assistant	17	10	18	20	0	26	55	27	16	108	3,988	5,518
Psychologist	11	15	8	10	1	5	109	28	4	77	6,018	11,519
Registered Physician Assistant	43	30	34	21	m	19	199	88	17	236	9,154	13,640
Registered Professional Nurse	1,270	494	744	643	22	714	3,769	1,145	755	5,108	172,978	243,639
Respiratory Therapist	18	3	9	17	0	18	110	21	13	78	4,107	5,763
Respiratory Therapy Technician	9	0	2	2	0	1	12	4	3	17	579	747

Appendix D: Education System Profile

Adirondack Rural Health Network					County	>				ARHN	Upstate	New York
Summary of Education System Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	Region	NYS	State
School System Information 1.2,3												
Total Number of Public School Districts	6	11	8	9	2	9	12	6	12	09	725	733
Total Pre-K Enrollment	250	188	335	377	27	432	399	137	344	1,658	51,063	122,681
Total K-12 Enrollment	10,599	3,618	7,158	7,423	401	7,254	33,329	8,743	8,311	46,253	1,604,870	2,629,970
Number of Students Eligible for Free Lunch	4,410	1,533	3,594	3,504	141	3,869	6,646	3,158	3,511	19,851	592,339	1,263,175
Number of Students Eligible for Reduced Lunch	521	290	471	320	32	310	929	321	477	2,432	69,464	131,974
Percent Free and Reduced Lunch	47.0%	20.0%	27.0%	51.0%	43.0%	22.0%	23.0%	40.0%	48.0%	46.5%	40.0%	53.0%
Number Limited English Proficiency ²	1,259	989	546	965	75	848	6,718	1,684	1,356	6,521	220,797	437,130
Percent with Limited English Proficiency ²	45.0%	43.0%	25.0%	33.0%	45.0%	30.0%	25.0%	48.0%	42.0%	13.6%	13.3%	45.0%
Total Number of Graduates	774	273	505	514	27	474	2,531	889	561	3,342	116,704	179,863
Number Went to Approved Equivalency Program	Н	0	2	0	n/a	ъ	6	21	5	29	1,097	2,653
Number Dropped Out of High School	78	18	48	89	n/a	112	176	38	94	365	10,670	21,368
Percent Dropped Out of High School	2.0%	2.0%	2.0%	4.0%	n/a	2.0%	2.0%	1.0%	4.0%	0.8%	0.64%	3.0%
Total Number of Public School Teachers ³	1,008.9	422.0	701.9	602.8	89.5	627.1	2,277.3	784.2	813.8	4,422.9	132,652.7	209,093.4
Student to Teacher Ratio ³	10.9	9.1	10.7	13.3	4.9	12.6	13.4	11.4	10.8	10.97	12.37	13.05
Education Programs ⁴												
Medical Resident Programs	0	0	0	0	0	0	0	0	0	0	203	296
Medical Resident Graduations/Completions	0	0	0	0	0	0	0	0	0	0	920	5,790
Physician Assistant Programs	0	0	0	0	0	0	0	0	0	0	7	27
Physician Assistant Graduations/Completions	0	0	0	0	0	0	0	0	0	0	103	764
Nurse Practitioner Programs	0	0	0	0	0	0	0	0	0	0	24	58
Nurse Practitioner Graduations/Completions	0	0	0	0	0	0	0	0	0	0	249	725
Pharmacist Programs	0	0	0	0	0	0	0	0	0	0	3	9
Pharmacist Graduations/Completions	0	0	0	0	0	0	0	0	0	0	398	913
Dental Hygienist Programs	0	0	0	0	0	0	0	0	0	0	7	13
Dental Hygienist Graduations/Completions	0	0	0	0	0	0	0	0	0	0	197	429
Licensed Practical Nursing Programs	Н	1	0	0	0	1	П	0	0	7	36	52
Licensed Practical Nurse Graduations/Completions	23	23	0	0	0	26	0/	0	0	46	2,186	3,369
Registered Nursing Programs	2	2	0	0	0	П	1	Т	0	2	89	118
Registered Nurse Graduations/Completions	93	93	0	0	0	32	19	98	0	272	4,606	10,192
Social Worker Programs	0	0	0	0	0	0	0	0	0	0	7	22
Social Worker Graduations/Completions	0	0	0	0	0	0	0	0	0	0	645	3624

^{*}ARHN Region consists of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties.

*Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond).

Sources:

(1) NYS Department of Health, NYS Health Profiles

(2) NYS Department of Health, Nursing Home Weekly Bed Census, 2018

(3) NYS Department of Health, Adult Care Facility Directory

(4) Health Resources and Services Administration, HPSA Find, 2017-2018

(5) Center for Health Workforce Studies, Health Workforce Planning Data Guide, 2014

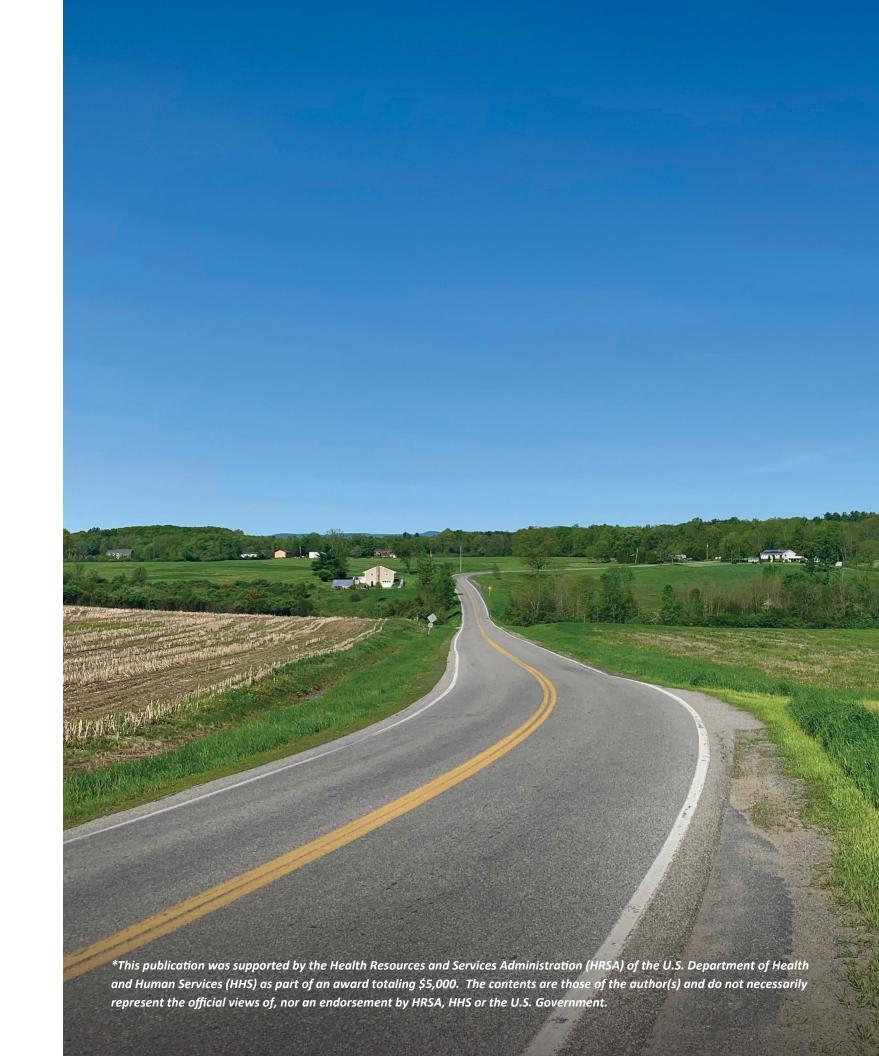
(6) NYS Office of the Professions, License Statistics, 2019

⁽n/a) Data Not Available
*ARHN Region consists of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington counties.
*Upstate is all counties in New York, minus the New York City counties (Bronx, Kings, New York, Queens and Richmond).
Sources:
(1) NYS Education Department, School Report Card Data, 2016-2017
(2) NYS Education Department, 3-8 ELA Assessment Data, 2017-2018
(3) Institute of Education Sciences, National Center for Education Statistics, District Directory Information 2016-2017 School Year Data (4) Center for Health Workforce Planning Data Guide, 2014

Appendix D: Education System Profile, continued

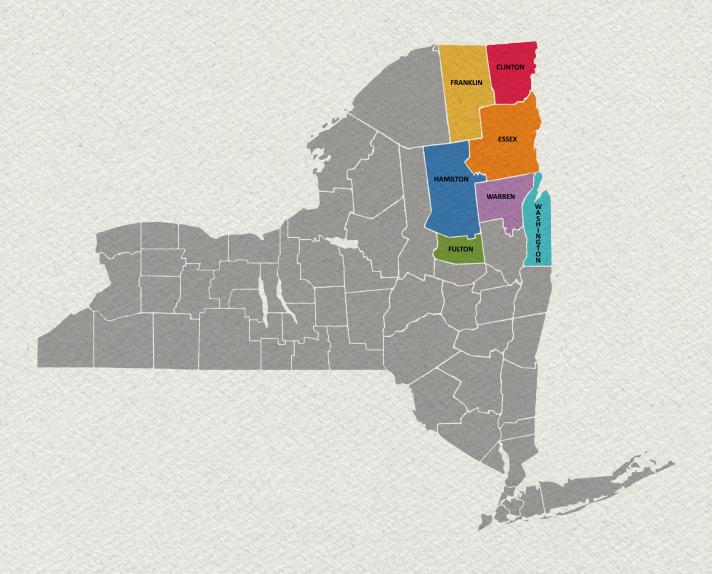
ClintonEssexFranklinFutonAusable ValleyCrown PointBrushton-MoiraBroadalbin-PerthBeekmantownElizabethtown-LewisChateaugayGloversvilleChazyKeeneFranklin-Essex-Hamilton BOCESJohnstownClinton-Essex-Warren-Washington BOCESLake PlacidMaloneMayfieldNorthern AdirondackMinervaSalmon RiverNorthvilleNorthern AdirondackNewcombSaranac LakeWheelervillePlattsburghSchroon LakeTupper LakeTupper LakeSaranacTiconderogaWestportMestport	School District by County ¹				
e Valley Crown Point Elizabethtown-Lewis Reene -Essex-Warren-Washington BOCES Lake Placid Minerva Moriah Newcomb Urgh Crown Point Elizabethtown-Lewis Reene Chateaugay Franklin-Essex-Hamilton BOCES Malone Saint Regis Falls Moriah Newcomb Saranac Lake Schroon Lake Ticonderoga C Westport			Franklin	Fulton	Hamilton
antown Elizabethtown-Lewis Chateaugay Chateaugay Elizabethtown-Lewis Chateaugay Chateaugay Ekene Keene Eranklin-Essex-Hamilton BOCES Lake Placid Malone Malone Minerva Saint Regis Falls Moriah Salmon River Newcomb Saranac Lake Schroon Lake Ticonderoga Ticonderoga Westport		Crown Point	Brushton-Moira	Broadalbin-Perth	Indian Lake
Keene Franklin-Essex-Hamilton BOCES -Essex-Warren-Washington BOCES Lake Placid astern Clinton Minerva rn Adirondack Moriah newcomb Salmon River Newcomb Saranac Lake schroon Lake Ticonderoga r Ticonderoga r Westport			Chateaugay	Gloversville	Inlet
Lake Placid Malone Minerva Saint Regis Falls Moriah Salmon River Newcomb Saranac Lake Schroon Lake Tupper Lake Ticonderoga Westport			Franklin-Essex-Hamilton BOCES	Johnstown	Lake Pleasant
Minerva Saint Regis Falls Moriah Salmon River Newcomb Saranac Lake Schroon Lake Tupper Lake Ticonderoga Westport		Lake Placid	Malone	Mayfield	Long Lake
n Adirondack Moriah Salmon River Newcomb Saranac Lake Schroon Lake Tupper Lake Ticonderoga Westport			Saint Regis Falls	Northville	Wells
Newcomb Schroon Lake Ticonderoga Westport			Salmon River	Wheelerville	
rgh Schroon Lake Ticonderoga Westport			Saranac Lake		
			Tupper Lake		
Westport		Ticonderoga			
		Westport			
Willsboro		Willsboro			

Montgomery	Saratoga	Warren	Washington
Amsterdam	Ballston Spa	Bolton	Argyle
Canajoharie	Corinth	Glens Falls City	Cambridge
Fonda-Fultonville-Fort Plain	Edinburg	Glens Falls Common	Fort Ann
Hamilton-Fulton-Montgomery BOCES	Galway	Hadley-Luzerne	Fort Edward
Oppenheim-Ephratah-St.Johnsville	Mechanicville	Johnsburg	Granville
	Niskayuna	Lake George	Greenwich
	Saratoga Springs	North Warren	Hartford
	Schuylerville	Queensbury	Hudson Falls
	Shenendehowa	Warrensburg	Putnam
	South Glens Falls		Salem
	Stillwater		Washington BOCES
	Waterford-Halfmoon		Whitehall



Please note that this list is exclusive to public school districts only.

*ARHN Region consists of Clinton, Essex, Franklin, Fulton, Hamilton, Warren and Washington c
*Gray highlighting indicates a regional school district
(n/a) Data Not Available
Sources:
(1) Institute of Education Sciences, National Center for Education Statistics, District Directory II







ww.ahihealth.org/arhn