# Goals and Objectives 2024-2027
# Clinton County Mental Health And Addiction Services

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## Goal 1

Goal 1: Title Crisis Services
Goal 1: Target Completion Date Jan 01, 2025
Goal 1: Description Strengthen crisis system by providing increased access and appropriate community supports to youth and adults experiencing a mental health or co-occurring crisis
Goal 1: OASAS? Yes Goal 1: OMH? Yes Goal 1: OPWDD? Yes
Goal 1: Need Addressed 1 Cross System Services
Goal 1: Need Addressed 2 Crisis Services
Goal 1: Need Addressed 3 Forensics

Goal 1, Objective 1: Title Crisis Intervention Team
Goal 1, Objective 1, Target Completion Date Jun 01, 2024
Goal 1, Objective 1, Description CIT Steering Committee will continue to train law enforcement and develop protocols and guidelines for those with a behavioral health crisis that includes police intervention and/or creating a dual response with Behavioral Health Agencies. Memorandums of Understanding will be established and implemented.

Goal 1, Objective 2: Title Home and Community Based Crisis Intervention
Goal 1, Objective 2, Target Completion Date May 01, 2024
Goal 1, Objective 2, Description NAMI-Champlain Valley in collaboration with Franklin County Community Connections and Families First will serve children and youth in crisis through a Home and Community Based Crisis Intervention Model, a short-term, peer run, intensive service to avert hospitalization and out of home placements.

Goal 1, Objective 3: Title Crisis Residential
Goal 1, Objective 3, Target Completion Date Jan 01, 2024
Goal 1, Objective 3, Description BHSN will implement Crisis Residential programming to increase therapeutic crisis intervention and decrease preventable hospitalizations for youth and adults.

Goal 1, Objective 4: Title Intensive Crisis Stabilization Center
Goal 1, Objective 4, Target Completion Date Jun 01, 2024
Goal 1, Objective 4, Description Champlain Valley Family Center has been approved and will open an Intensive Crisis Stabilization Center.

Goal 1, Objective 5: Title Co-occurring OMH and OPWDD
Goal 1, Objective 5, Target Completion Date Jan 01, 2025
Goal 1, Objective 5, Description Champlain Valley Physician's Hospital and the Advocacy and Resource Center are meeting to identify barriers to providing services with co-occurring individuals and investigate options such as tele-medicine to provide appropriate and timely treatment.

## Goal 2

Goal 2: Title Housing
Goal 2: Target Completion Date Jan 01, 2027
Goal 2: Description Develop more housing opportunities to support those with a mental health diagnosis, a substance use disorder and/or intellectual/developmental disability.
Goal 2: OASAS? Yes Goal 2: OMH? Yes Goal 2: OPWDD? Yes
Goal 2: Need Addressed 1 Housing
Goal 2: Need Addressed 2 Case Management/Care Coordination
Goal 2: Need Addressed 3 Prevention

Goal 2, Objective 1: Title Additional Apartments for those with an Intellectual/Developmental Disabilitiy
Goal 2, Objective 1, Target Completion Date Aug 01, 2026
Goal 2, Objective 1, Description OPWDD and HCR will review the opportunity to establish another apartment complex that houses those with Developmental Disabilities

Goal 2, Objective 2: Title Empire State Supportive Housing Initiative Planning
Goal 2, Objective 2, Target Completion Date Jan 01, 2026
Goal 2, Objective 2, Description Behavioral Health Services North is conducting planning to support the future development of a 100-120 unit complex with Housing Visions for approximately 40 additional ESSHI beds.

Goal 2, Objective 3: Title Expansion of Permanent Supported Housing
Goal 2, Objective 3, Target Completion Date Oct 01, 2026
Goal 2, Objective 3, Description Local Department of Social Services and Evergreen Town House Community have applied for an expansion grant to add 3 additional units to the CoC Permanent Supportive Housing Program. This program currently has 15 units and houses 16 individuals.

**Goal 3**
Goal 3: Title Case Management/Care Coordination
Goal 3: Target Completion Date Jun 01, 2026
Goal 3: Description Expand collaboration and coordination across all service systems to strengthen support and to individuals in need while identifying barriers, reducing duplicative efforts, developing a comprehensive plan and employing creative solutions
Goal 3: OASAS? Yes Goal 3: OMH? Yes Goal 3: OPWDD? Yes
Goal 3: Need Addressed 1 Case Management/Care Coordination
Goal 3: Need Addressed 2 Forensics
Goal 3: Need Addressed 3 Cross System Services

Goal 3, Objective 1: Title Expanding Care Mangement
Goal 3, Objective 1, Target Completion Date Jun 01, 2024
Goal 3, Objective 1, Description Community Connections will be offering Children's Health Home Care Management, Behavioral Health Services North will increase their number of Care Managers and Champlain Valley Family Center will provide Care Management for Children and Adolescents.

Goal 3, Objective 2: Title Expand the System Of Care
Goal 3, Objective 2, Target Completion Date Dec 01, 2024
Goal 3, Objective 2, Description System of Care (HEARTT) will continue to work with children that have multi-system involvement to coordinate care, identify barriers in the services system and provide support to the family through multi-system collaborative efforts decreasing emergency room visits and out of county placements.

Goal 3, Objective 3: Title Improve Emergency Room Coordination
Goal 3, Objective 3, Target Completion Date Sep 01, 2024
Goal 3, Objective 3, Description Champlain Valley Physician's Hospital has started an Emergency Department Social Worker position to work with the Multi Visit Patient Population list (MVP). Plan is to reengage the multi-agency care coordination team to collaboratively plan for the individual to improve community supports and decrease utilization of the emergency department.

Goal 3, Objective 4: Title Strenthen the Relationship with Law Enforcement and Judicial System
Goal 3, Objective 4, Target Completion Date Jan 01, 2025
Goal 3, Objective 4, Description Provide continued opportunities to train Law Enforcement and to find points of engagement for law enforcement with behavioral health providers and peers to support individuals who are interfacing with the criminal justice system by strengthening programs such as Law Enforcement Mental Health Referral System, NAMI's Forensic Peer Position and Imminent Risk Committee to increase Law Enforcement or Criminal Justice participation and collaboration.

**Goal 4**
Goal 4: Title Prevention
Goal 4: Target Completion Date Dec 30, 2024
Goal 4: Description Improve prevention efforts in schools and community by strengthening the community responses, investing in prevention programs that engage vulnerable populations and providing education regarding the effects of ACES and environments that buffer the effects of trauma.
Goal 4: OASAS? Yes Goal 4: OMH? Yes Goal 4: OPWDD? Yes
Goal 4: Need Addressed 1 Prevention
Goal 4: Need Addressed 2 Adverse Childhood Experiences
Goal 4: Need Addressed 3 Cross System Services

Goal 4, Objective 1: Title Intensive and Sustained Engagement
Goal 4, Objective 1, Target Completion Date Apr 01, 2024
Goal 4, Objective 1, Description Community Connections in partnership with NAMI are applying to an RFP for Intensive and Sustained Engagement Teams (INSET). This grant will support adults over the age of 21 to prevent ER visits, inpatient stays and law enforcement involvement. If awarded the grants, we anticipate the start of the program by the end of Q1 2024.

Goal 4, Objective 2: Title • Youth Development Survey
Goal 4, Objective 2, Target Completion Date Oct 01, 2024
Goal 4, Objective 2, Description Champlain Valley Family Center will conduct the Youth Development Survey in at least 5 Clinton County School Districts during the 2023-2024 school year calendar

Goal 4, Objective 3: Title • Opioid Settlement Funds
Goal 4, Objective 3, Target Completion Date
Goal 4, Objective 3, Description
The Community Services Board is utilizing Opioid Settlement money to support innovative programming for early prevention of substance use.

Goal 4, Objective 4: Title System of Care
Goal 4, Objective 4, Target Completion Date Dec 01, 2024
Goal 4, Objective 4, Description Clinton County's SOC (HEARTT) will partner with school districts to provide continued education and collaboration to understand the impact of ACES and to create environments that buffer trauma and support resiliency.

Goal 4, Objective 5: Title School Support
Goal 4, Objective 5, Target Completion Date Jun 30, 2024
Goal 4, Objective 5, Description BHSN will increase the number of families linked to services in order to reduce the incidents of crisis events in school, reduce suspensions, and time away from class.

# Clinton County Community Services Board
## Local Services Plan Needs Assessment Key Findings

The Community Services Board asked residents to provide feedback to identify unmet needs and priorities for Mental Health, Substance Use and Developmental Disabilities. Surveys were collected from 128 respondents.

### The top 5 community needs for vulnerable populations were identified as:

- Crisis Services (47.12%)
- Housing (42.31%)
- Case Management/Care Coordination (29.81%)
- Inpatient Treatment (25%)
- Outpatient Treatment (20.19%)

**4 in 5**

feel our community needs initiatives to strengthen **recruitment & retention of the workforces** that support/work with vulnerable populations.

**84%**

feel our community needs to expand **non-clinical supports.**

**85%**

feel our community needs more **case management/ care coordination** to support vulnerable populations.

Those respondents feel the need applies to those impacted by:

- 98% mental health
- 92% substance abuse
- 80% developmental disabilities

**3 in 4**

feel our community needs more **respite services.**

**93%**

feel the availability of **outpatient treatment** is a high need in the community.

**8 in 10**

feel strengthening **prevention services** is a high priority in the community.

Those respondents feel the need applies to:

- 98% youth
- 80% adults

**82%**

feel **residential treatment opportunities** for vulnerable populations is a high need in the community.

**9 in 10**

feel **strengthening cross system services** for vulnerable populations is a high need in the community.

**83%**

feel the availability of **inpatient treatment beds** is a high need in the community.

**4 in 5**

feel our community needs more **housing** to support vulnerable populations.

Those respondents feel the need applies to those impacted by:

- 97% mental health
- 95% substance abuse
- 80% developmental disabilities

**9 in 10**

feel education & training on the impact of **adverse childhood experiences** is a high need in the community.

**3 in 5**

feel there is not appropriate access to **transportation** for vulnerable populations.

**4 in 5**

feel our community needs more **employment/ volunteer opportunities** for vulnerable populations.

**67%**

feel **transition age services** for vulnerable populations are a high need in our community.

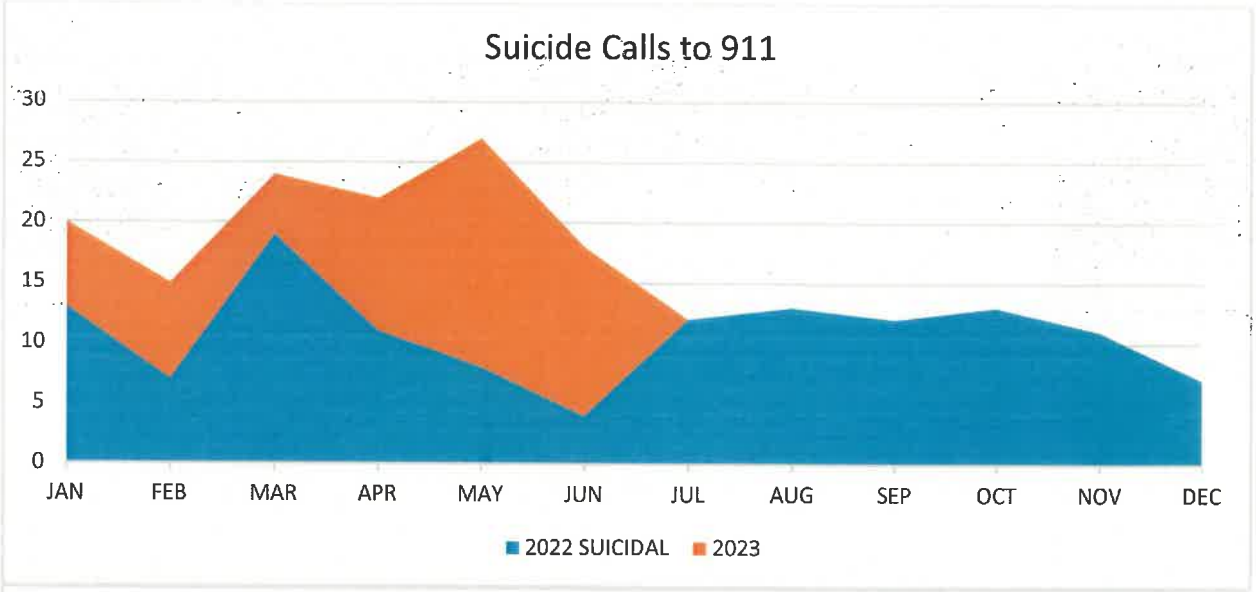
**87%**

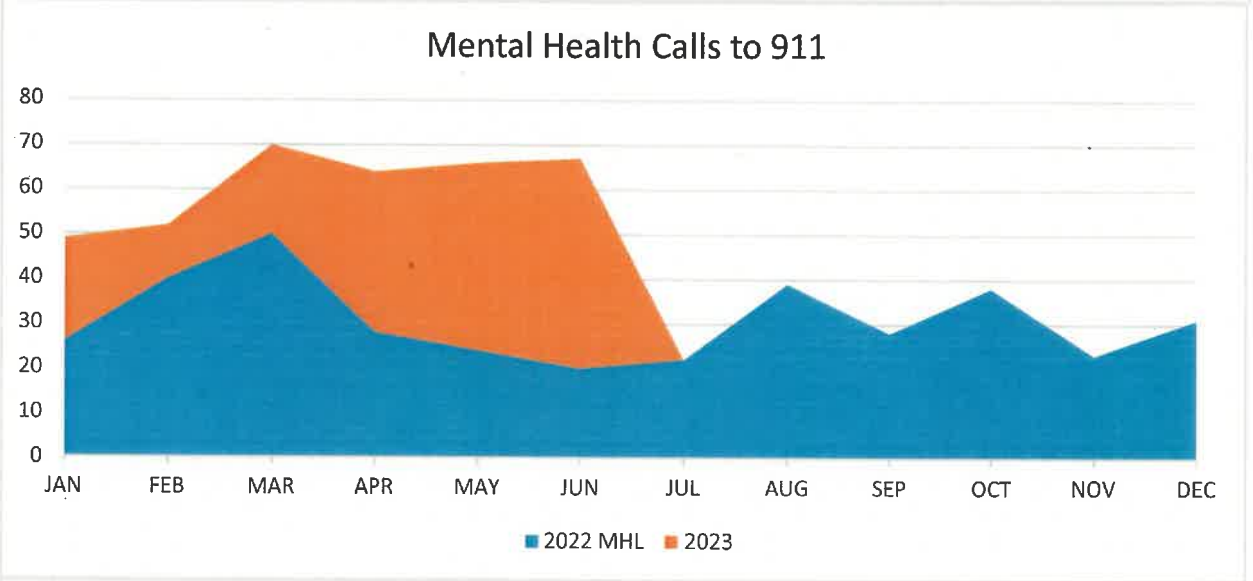
feel strengthening **crisis services** is a high need in our community.

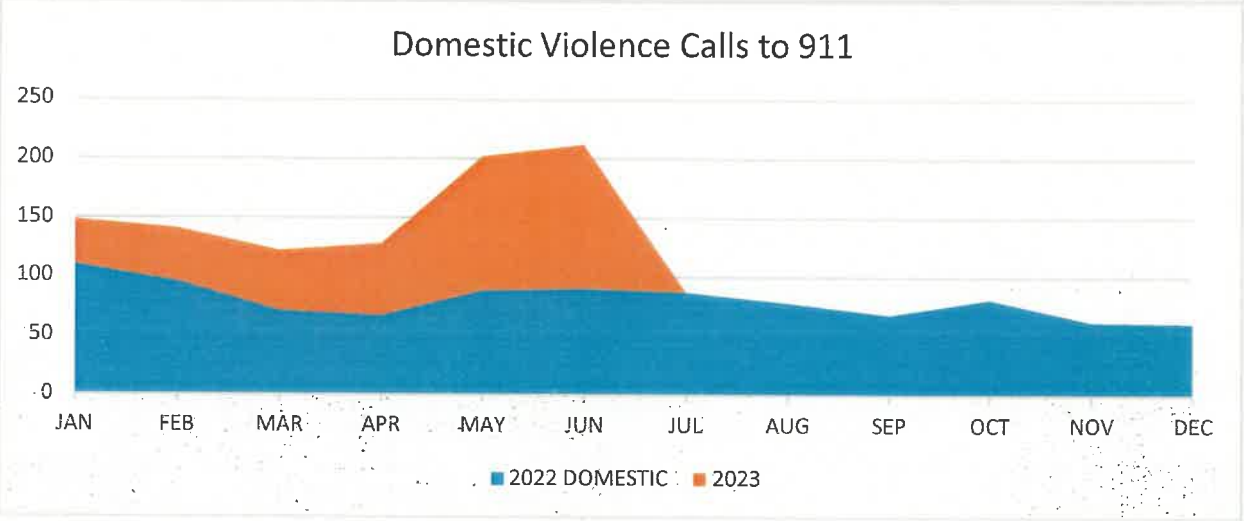
Those respondents feel the need applies to those impacted by:

- 100% mental health
- 91% substance abuse
- 71% developmental disabilities

# CLINTON COUNTY LOCAL DATA 2023



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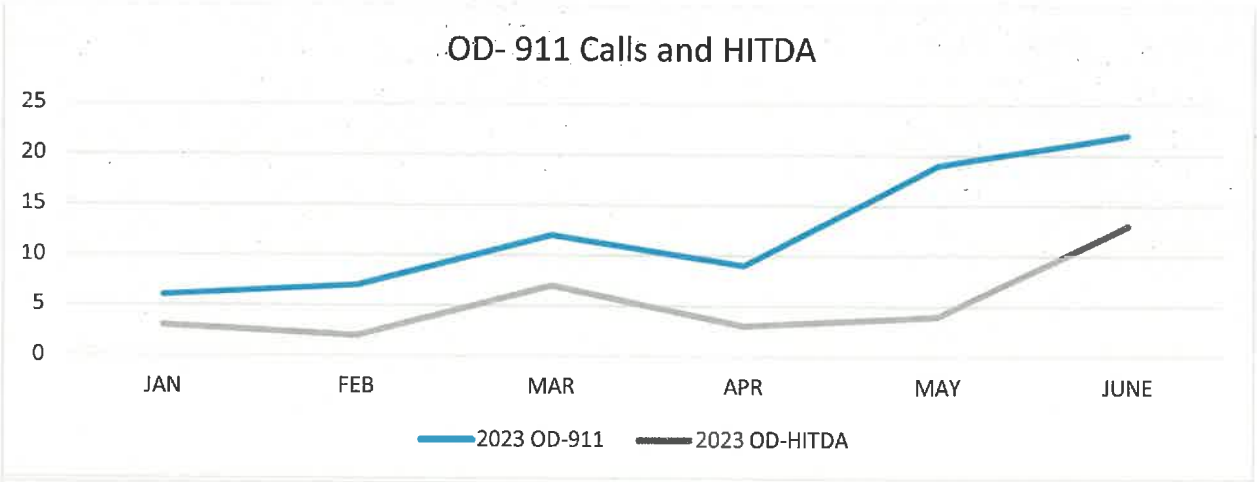


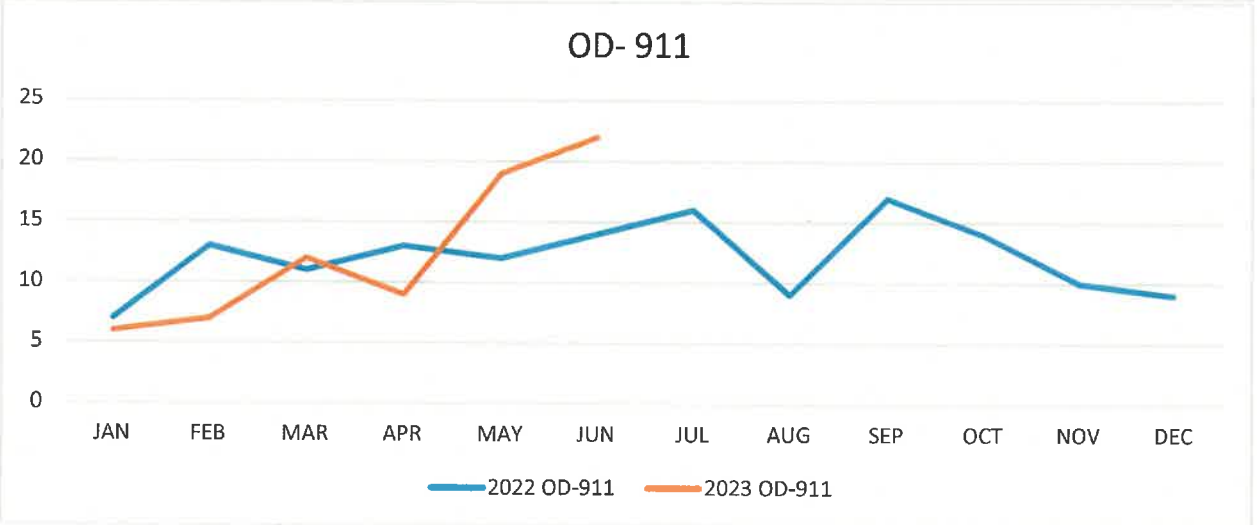


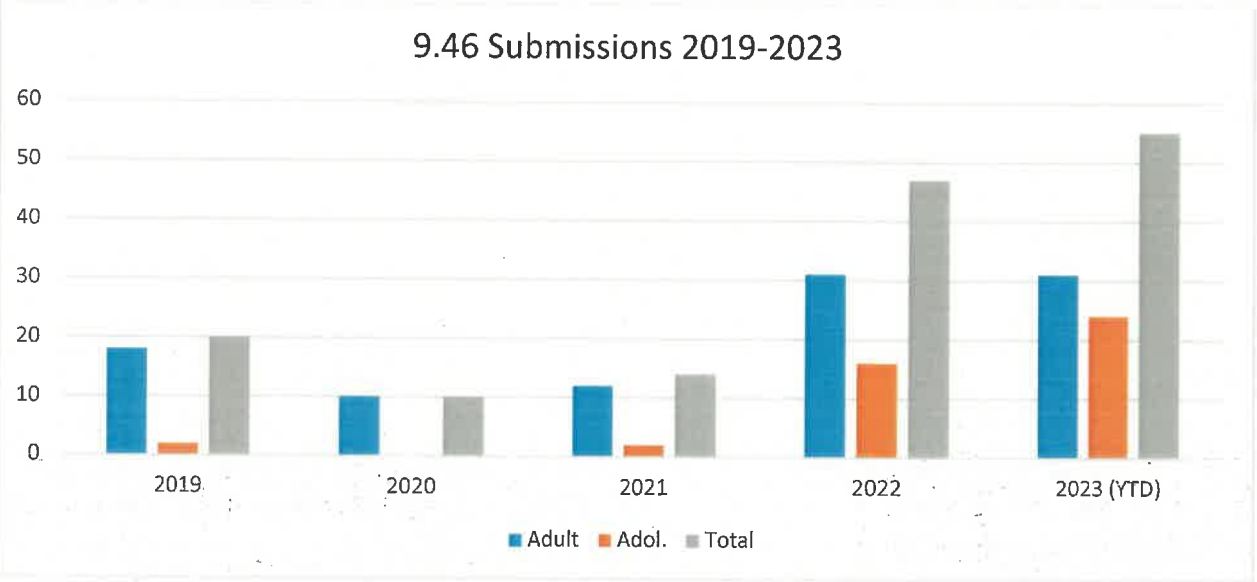

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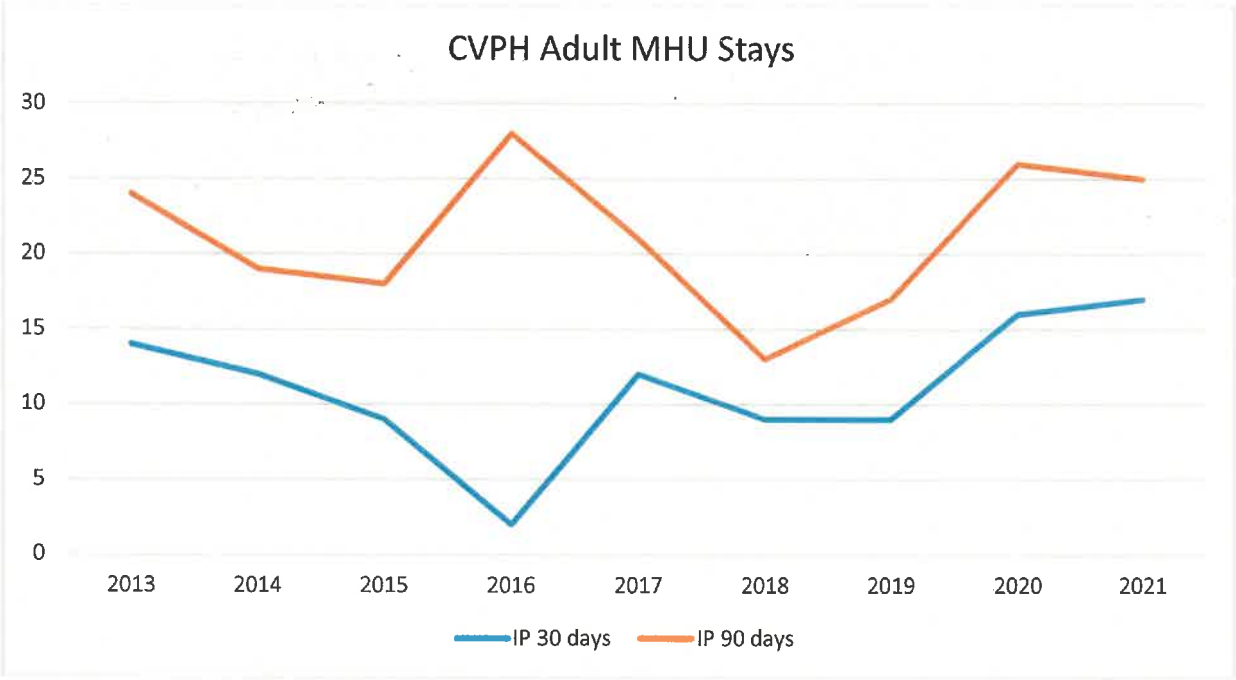


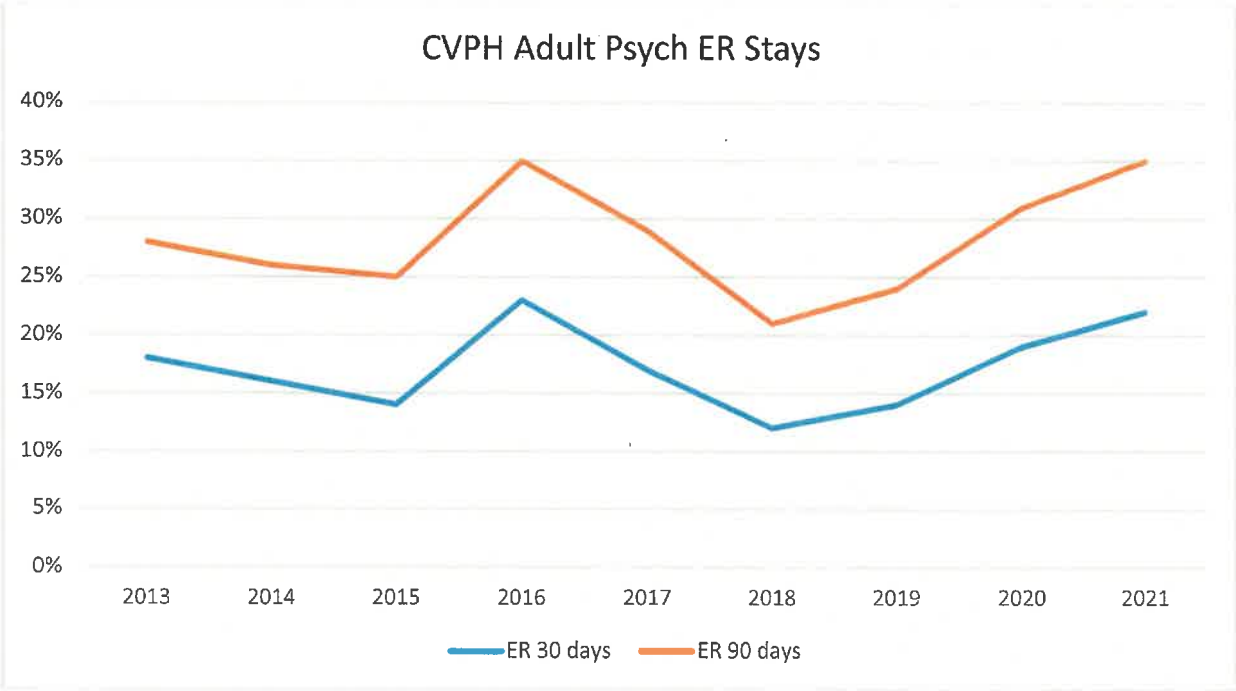

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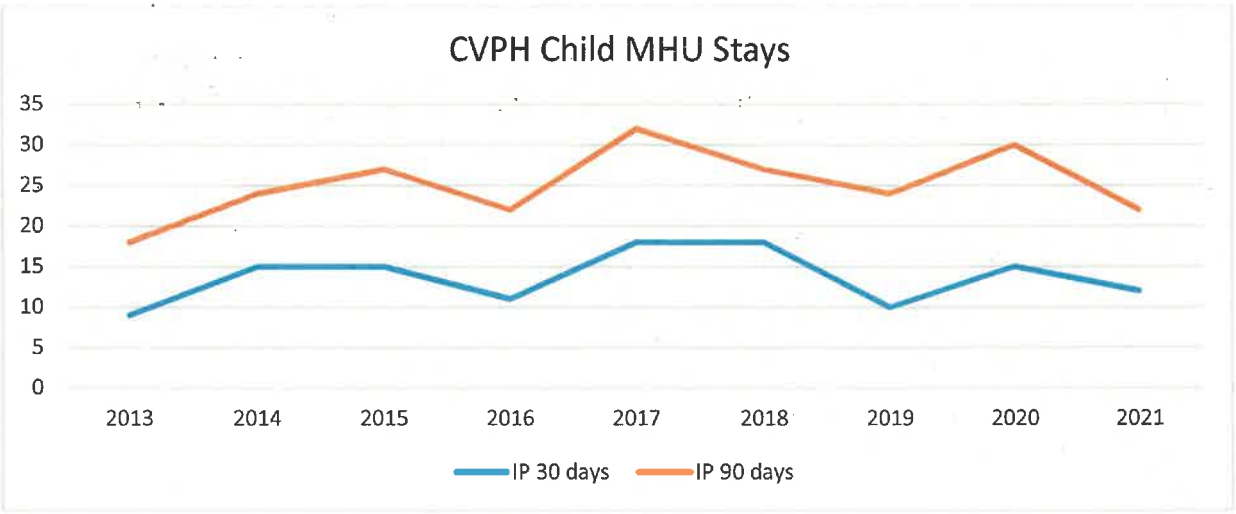


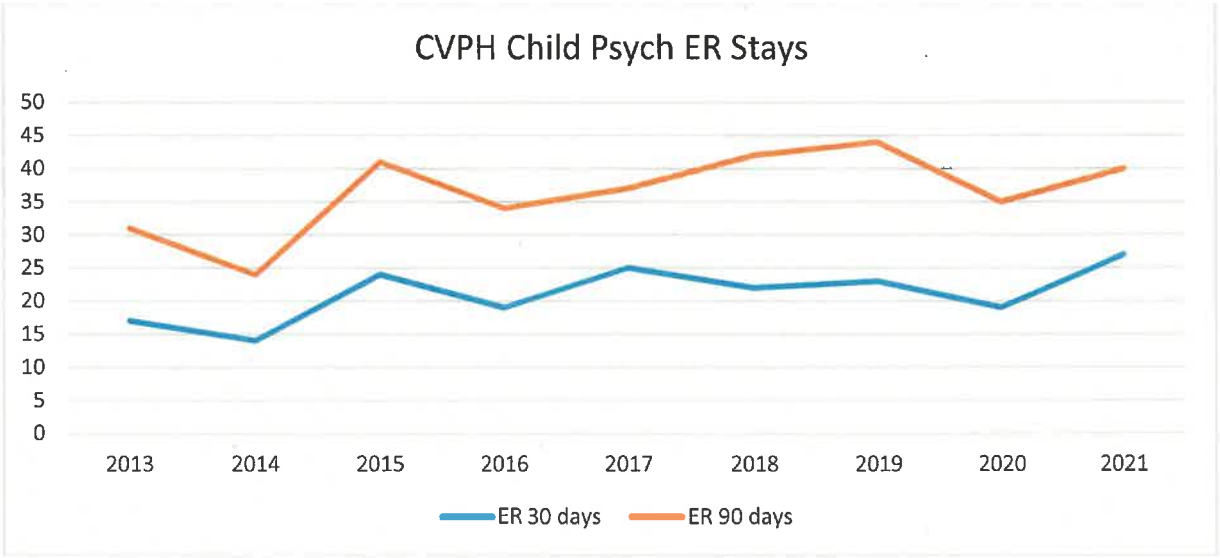


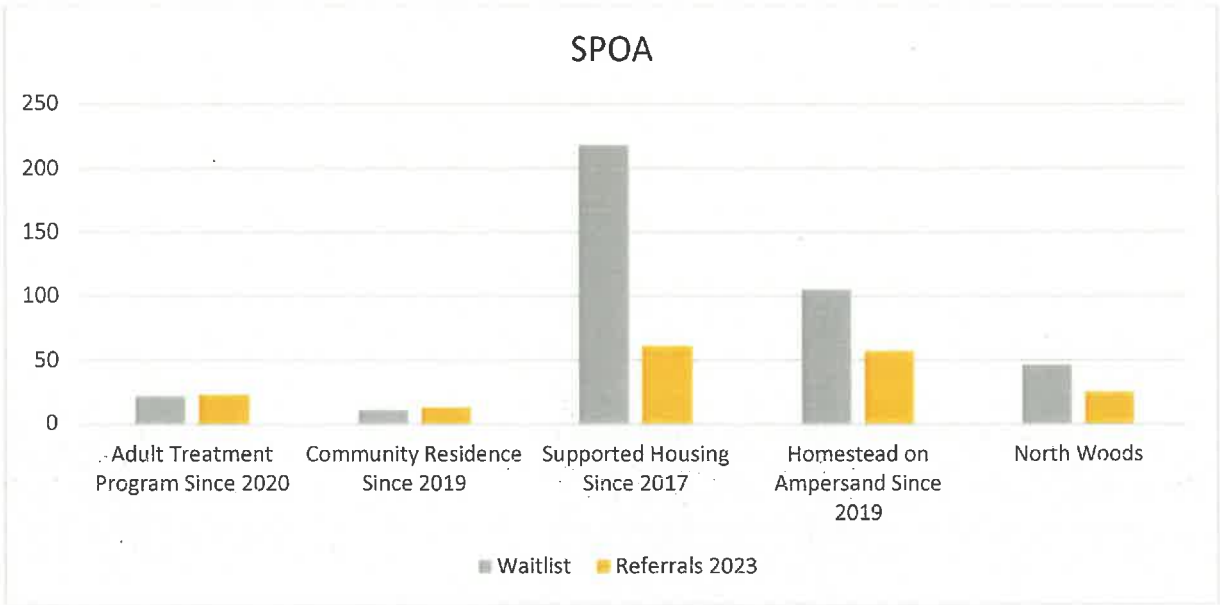

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# Crisis Intervention Team (CIT) Program Development Project

## Sequential Intercept Model Mapping Report

Plattsburgh, New York

March 24, 2023

# Sequential Intercept Model Mapping Report

## Background

Clinton County was selected as a recipient of technical assistance by the New York State Office of Mental Health to develop a Crisis Intervention Team (CIT) program. In January 2023, representatives from Clinton County's mental health system, law enforcement departments, and advocacy groups attended a kick-off meeting with the other selected counties; during this meeting, NYS OMH and consultants provided an overview of the various components of CIT program development, including the Sequential Intercept Model mapping process.

The Sequential Intercept Model[1] (SIM) is a framework for examining the interface of the mental health and criminal justice systems. A Sequential Intercept Model mapping workshop is one of the first steps in CIT program development. It creates a "snapshot" of the current crisis response system and allows community stakeholders to identify strengths and gaps in the system, which highlights opportunities for improvement. The Sequential Intercept Model aligns closely with the first goal of CIT programs by identifying law enforcement alternatives, which can divert individuals in crisis away from the criminal justice system and back "upstream" towards mental health resources and support.

The Sequential Intercept Model mapping workshop in Clinton County was held at the West Side Ballroom in Plattsburgh, NY on March 24, 2023. The workshop was attended by representatives from the county mental health department, Department of Social Services, behavioral health provider agencies, mobile crisis team, local hospital, emergency housing, 911 center, law enforcement, and multiple advocacy groups, including the Veteran's Service Agency. The list of participants is contained in Appendix A.

Don Kamin, Ph.D. (Director, Institute for Police, Mental Health & Community Collaboration) provided a brief overview of CIT programs, and Jennie Dixon, LCSW (Assistant Director, Institute for Police, Mental Health & Community Collaboration) introduced and described the Sequential Intercept Model mapping process. Mark Giuliano, LMSW (Institute Consultant and Director of Community Support, Westchester County Department of Community Mental Health) led the mapping exercise

## Visioning Exercise

As the workshop participants introduced themselves, they were asked to imagine that they or a loved one was experiencing a psychiatric crisis, and to briefly share one thing that they feared would happen in that situation, and one thing that they hoped would happen. Attendees were also asked to disclose whether they or a family member had personal experience with behavioral health challenges.

The fears expressed by the group mostly revolved around the attitudes and actions of emergency responders and the feelings and experiences of a person in crisis. Participants feared that

[1] Munetz, M.R. & Griffin, P.A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services,* 57(4), 544-549.

emergency responders would hold negative attitudes towards individuals in crisis, including judgment about behavioral health issues, cynicism about the possibility of recovery, and a belief that an individual and their behaviors are one and the same. Participants also feared that emergency responders' actions could match these attitudes, resulting in a rushed response, uses of force, and escalation of a crisis scene to the point of criminal arrest and/or unnecessary transport to the hospital. Members of the group also shared from the perspective of the person in crisis, fearing that they would feel confused, isolated, misunderstood, and alienated, and that they would undergo trauma, social media exposure, unnecessary transport, arrest, and a general experience of being passed along and lost in the shuffle of the system. Several participants expressed fears about tragic outcomes such as suicide and injuries or deaths of anyone involved in a crisis scene.

Participants hoped that the crisis response system would be prepared, available, and adequately equipped to provide support; specifically, that emergency workers would be educated, trained, and skilled in crisis response, and that they would be compassionate, understanding, and empathic towards individuals in crisis. Participants hoped that, during a crisis situation, the following would take place: family members would be included and engaged, the scene would be approached with open-mindedness and appropriate pacing, de-escalation would occur in the home, and individuals in crisis would be respected and their strengths would be noticed and emphasized. Members of the group also hoped for positive outcomes: rapid access to services, coordination of care, a person-centered plan, and hope for the future.

## Systems Mapping Exercise

The group participated in a facilitated systems mapping exercise, based on the Sequential Intercept Model, to outline the Clinton County mental health crisis response system. This exercise is an important tool for placing each stakeholder agency's role within the context of the larger system, and for identifying the strengths and gaps in the system. Throughout the five-hour workshop, the widespread commitment to understanding and improving the county crisis response system was evident in the variety of stakeholder representation and the overall participation of group members. Attendees actively engaged in the mapping process and were able to identify many strengths and opportunities for improvement in the process of creating the county map.

### Identified Strengths in the Current Mental Health Emergency Response System

The group identified these strengths in the current crisis response system:

- Collaborative relationships between different sectors and agencies in the crisis response system that support system improvement as well as individual care and connectivity
    - An informal consult group that focuses on triaging and responding to crisis calls, assessment for recommendations to higher levels of care (such as Assisted Outpatient Treatment), and Law Enforcement Mental Health Referral System
    - County mental health leadership meets with all local law enforcement agencies on a biweekly basis to review individuals with imminent risk factors, problem-solve, and identify potential services and resources

- Substance Abuse Prevention and Recovery of Clinton County (SPARCC) is a coalition comprised of multiple agencies, community leaders, and individuals to raise awareness, provide education, and address local issues regarding substance use
- Strong and positive working relationships between all emergency responder groups: Office of Emergency Services (911), police and fire departments, Emergency Medical Services (EMS), and mobile crisis team
- At SUNY Plattsburgh, the University Police Department and the college counseling center are co-located and have a strong working relationship
- County mental health and hospital leadership have collaborated on a pilot project to track individuals through the 9.45 process to identify opportunities for improvement
- In general, the small size of the community has led to strong partnerships and familiarity with individuals who frequently experience crises, which allows the system to individualize some crisis response plans

- Wide variety of services, across multiple levels of need, especially given the size of the community. Services include, but are not limited to:
  - Crisis hotline
    - Resource cards are distributed in the community
  - Mobile Crisis Team (MCT)
    - The MCT has a relatively quick response time, a formal assessment process to determine acuity, and defaults to responding without law enforcement with rare requests for law enforcement to join them on scene
  - The Mobile Integration Team
    - Provides additional crisis and other supports to individuals with serious mental illnesses
  - An Intensive Case Management program
    - The last remaining ICM program in NYS provides support for individuals who need a higher level of care coordination
  - Multiple mental health and substance use providers throughout the county
  - Champlain Valley Physician's Hospital (CVPH)
    - Including an adult inpatient psychiatric unit.
  - Detox, inpatient, and rehab program for substance use

- Multiple points of access into the behavioral health system
  - Most (if not all) of the clinic locations have open access hours
  - Phone and/or in-person crisis support is available 24/7 through the local crisis hotline and the mobile crisis team
  - Several agencies provide bridging support for individuals trying to access mental health and substance use treatment, including Clinton County Mental Health and Addiction Services, National Alliance for Mental Illness (NAMI) Champlain Valley, and Alliance for Positive Health
    - Incarcerated individuals can access mental health and substance use treatment, including Medication Assisted Treatment (MAT) in the county jail

- Ongoing improvement and expansion of crisis services
    - More crisis services are being developed and added in the near future, including 988, a crisis stabilization center, and 24/7 on-call support for substance use through Conifer Park
    - The 911 center already has processes to divert medical calls to EMS only unless law enforcement is needed, and leadership is open to creating similar processes for mental health calls to divert to phone and in-person support as needed

**Identified Gaps and Opportunities for System Enhancement**

In addition to the many strengths outlined above, stakeholders identified various gaps and/or opportunities for improvement, including:

- Community education
    - More education is needed for faith leaders, medical providers, other county departments, and other non-traditional entities about behavioral health and crisis response, so that they can provide appropriate support and guidance for individuals in crisis

- Limited opportunities for diversion at key intercepts
    - The 911 center does not have protocols in place to refer individuals in crisis to phone or in-person mental health support
    - None of the local law enforcement agencies have CIT-trained officers, although this will change this year
    - The local law enforcement agencies do not have documented criteria and protocols in place to request the mobile crisis team to join them on scene
    - The mobile crisis team cannot sign involuntary transport orders themselves, and must rely on county leadership and/or local law enforcement to make these determinations
    - There are no local crisis services specifically designed for individuals with developmental disabilities in the county
    - There are no respite services in the county

- Hospital-related challenges
    - There are no psychiatric evaluations during the overnight shift, so individuals board in the emergency department depending on the time of their arrival
    - Individuals board in the emergency department when inpatient beds are full because of difficulties with coordinating transfers to other, out-of-county hospitals
    - There are challenges with transferring individuals to the state hospital when needed because of their admission criteria
    - Youth with intellectual and/or developmental disabilities can get "stuck" in the emergency department, because they are deemed "not appropriate" for the inpatient program
    - Providers who want to provide information to the hospital about an incoming patient are unsure of how to get that information to the appropriate person (e.g., medical versus psychiatric emergency department, physician versus assessor, etc.)

- Criminal justice system workflows and gaps
    - When a judge orders a psychiatric evaluation and the individual is subsequently released from the emergency room without admission, they are sometimes lost to contact
    - There is no process to release individuals from jail to the hospital for purposes of psychiatric stabilization; individuals are only brought to the hospital if they are actively self-harming, and are otherwise placed on constant observation in the jail
    - Conifer Park is seeking approval for methadone as part of the jail's Medication-Assisted Treatment program, as it is not currently offered

- There are no homeless shelters in the county. Motels are utilized for emergency housing placement, and NAMI sometimes provides tents for individuals who decline placement or cannot access emergency housing because they are banned from those motels.

- There is a need for increased education in and resources for de-escalation and crisis support in school settings to decrease unnecessary transports from school to the hospital.

## Data Collection and Outcome Evaluation

Data collection and outcome evaluation are critical to the success of Crisis Intervention Team programs, as they allow local stakeholders to track progress towards goals and implement corrective interventions as needed. As stakeholders review this report and prioritize recommendations for action, it will be important to identify any related data collection points and/or outcome measurements, as well as any existing documentation systems or tracking tools that can be used to support this process. The list below contains a few suggested metrics, some of which are also referenced in the recommendations portion of this report. While this list is not comprehensive or sufficient for measuring outcomes related to all the recommendations, it can serve as a starting point for discussion.

- Number of crisis hotline calls overall and by time of day
- Number of 911 calls that are primarily related to mental health concerns
- Number of 911 calls that are primarily related to mental health concerns and do not contain any report of safety concerns and/or weapons
- Number of individuals who are referred from law enforcement to the mobile crisis team, both requests to respond to the scene and requests for follow-up connectivity
- Percentage of hospital transports that result in admission, for adults and for youth
- Number of 911 calls initiated by school staff, number of transports from school to hospital, and percentage of those transports that result in admission

## Summary and Recommendations

As noted above, participants in the mapping workshop described many strengths in the Clinton County mental health crisis response system. The strong, collaborative relationships between the systems and agencies represented was evident from participant feedback and from the discussions that took place during the mapping process. The observations and responses from the group also revealed several opportunities to strengthen the current system. The recommendations below are intended to condense the feedback from the workshop, with the goal of supporting stakeholders in prioritizing and implementing practical changes. However, not all the content in the "Gaps and Opportunities" section above is addressed in specific recommendations, and it is recommended that stakeholders examine all the gaps outlined above to determine other opportunities for system improvement.

**Recommendation #1**

- Increase utilization of community-based crisis services that offer an opportunity to avoid calling 911 or visiting the emergency room.
    - Consider convening a small, temporary workgroup to examine the staffing, call volume, and hours of operation at all local crisis hotlines and to explore the possibility of streamlining and/or consolidating multiple lines. Workshop participants noted that there is a primary, well-established crisis hotline in the area that is known by multiple names, and that the community will soon be connected to the 988 regional hub in Essex County. It may be possible to have one local, 24/7 crisis hotline that rolls into 988 if needed, and that both lines could have established pathways to other, more specialized crisis services (e.g., Conifer's forthcoming 24/7 on-call support line for substance use).
    - Ensure that information about 988 and the forthcoming crisis stabilization center is clearly communicated and available to community members, mental health providers, law enforcement, advocacy agencies, and any other entities that may encounter people in crisis. For law enforcement, ensure that all departments are familiar with the location, hours of operation, and any criteria and processes to bring an individual to the center[2].
    - In order to maximize the strong collaboration of the "informal consult group", identify specific individual and situational risk factors that require crisis consultation. Clearly communicate these risk factors to the provider community to ensure that individuals who meet the criteria can benefit from a collaborative and preventive approach to support diversion efforts.

[2] Mental Hygiene Law sections 9.41 and 9.45 now allow for individuals who meet the criteria for involuntary transport to a 9.39 hospital emergency room to be brought to a crisis stabilization center on a voluntary basis.
https://www.nysenate.gov/legislation/laws/MHY/9.41
https://www.nysenate.gov/legislation/laws/MHY/9.45

**Recommendation #2**

- Create and implement protocols at the 911 center to divert calls away from law enforcement and towards mental health support as needed and appropriate[3].
    - Consider convening another temporary workgroup to:
        - Identify criteria (related to needs and safety) for calls that could be appropriate for phone call only support, mobile crisis team response without law enforcement, and mobile crisis and law enforcement co-response
        - Review and revise dispatcher scripts to obtain information related to the above criteria, and to offer "mental health" in addition to "police, fire, or EMS" at the start of each call
        - Create call codes for each response type, to match the above identified criteria to the appropriate response and to allow for tracking numbers of response types and therefore progress towards diversion goals
    - Train 911 personnel to identify mental health calls that are appropriate for diversion to non-law enforcement services[4].

**Recommendation #3**

- Create specific protocols for all law enforcement departments to guide decision-making for mental health calls.
    - Develop protocols to dispatch CIT-trained officers to as many mental health calls as possible, accounting for shifts and geographic areas as needed. These protocols could be department-specific or shared across all departments.
    - Create written guidance for patrol, consistent across all law enforcement departments, for requesting mobile crisis team response to scenes involving mental health needs, partnering effectively with mobile crisis team on scene, and sending referrals to the mobile crisis team for follow-up.
    - Ensure that all law enforcement departments have accurate and up-to-date information about the crisis stabilization center prior to its opening.

**Recommendation #4**

- Provide training and education to school personnel to reduce unnecessary transports.
    - Explore opportunities to provide crisis training and/or support in school settings to reduce the number of voluntary and involuntary transports to the emergency room.
    - Provide recommendations to school leadership and personnel on requesting the mobile crisis team and/or utilizing other alternatives to reduce 911 calls and unnecessary transports to the emergency room.

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[3] https://www.vera.org/downloads/publications/911-analysis-civilian-crisis-responders.pdf

[4] There are multiple options for training dispatchers, including developing a training program internally and/or utilizing existing trainings. Two examples of existing trainings are: https://www.crisisresponseconsulting.net/ and https://citinternational.org/CITST911

**Recommendation #5**

- Housing
  - Homeless was presented as a significant issue at the mapping. While not necessarily directly related to the mental health crisis system, it may be helpful to use an existing meeting to explore this issue further. This discussion could begin with some of the options presented at the mapping, including but not limited to a warming center.

**Recommendation #6**

- Establish and maintain oversight of CIT program development and ongoing operations.
  - Develop and maintain a CIT steering committee.
    A CIT steering committee, which is an essential and required component of CIT programs, will be an important vehicle for setting priorities, implementing changes, and tracking progress related to the improvement of the crisis response system. A CIT steering committee must include representatives from law enforcement, the mental health system, and peer/family advocacy groups. As detailed in Clinton County's initial CIT application for technical assistance, a committee has already been created that appears well-equipped to continue this system transformation work. An initial task for the steering committee is to review the content of this report and begin addressing them in order of immediate importance. Additionally, the steering committee should determine which data points will be useful in measuring progress towards goals and identify sources from which to collect that data.

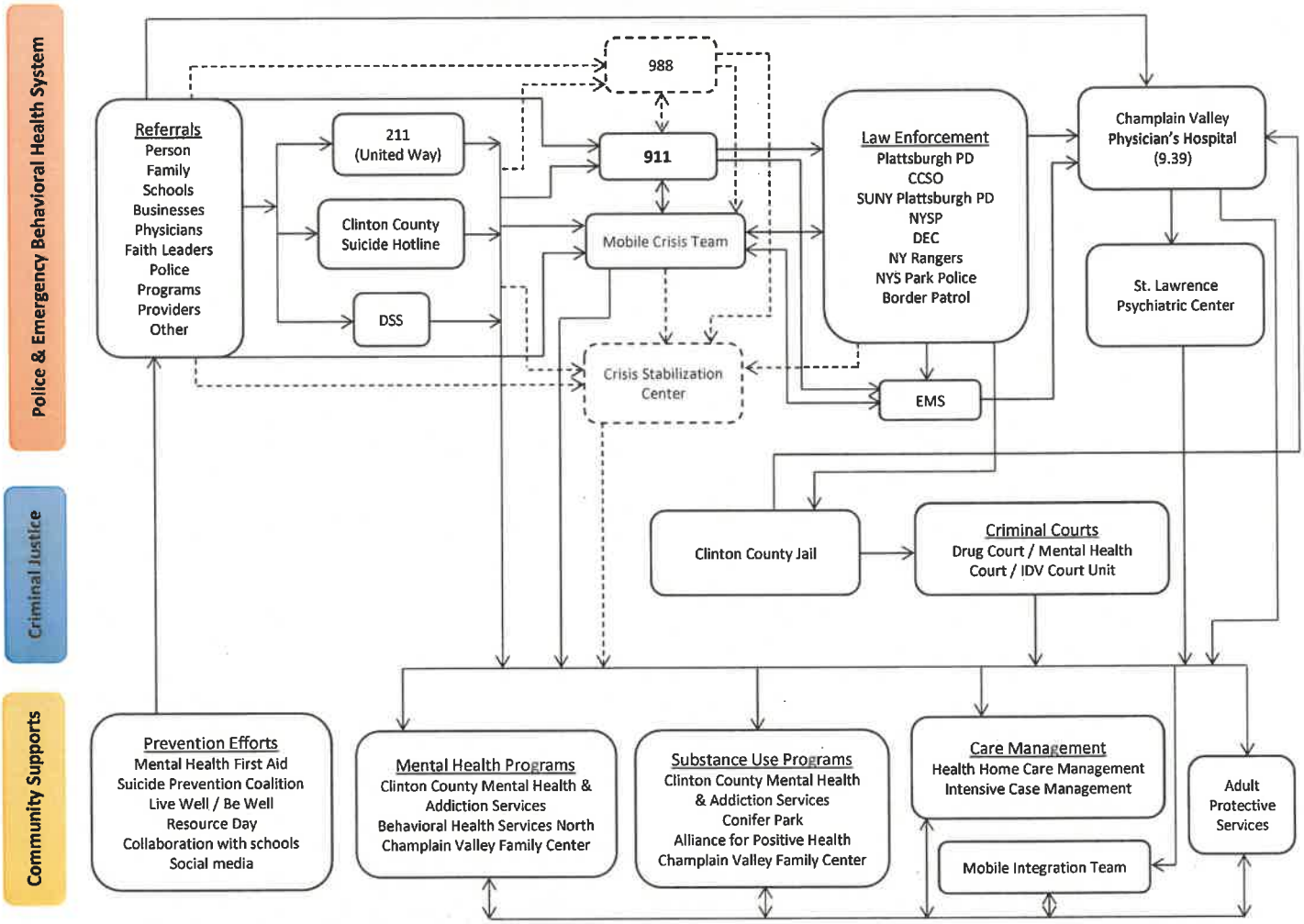
## Conclusion

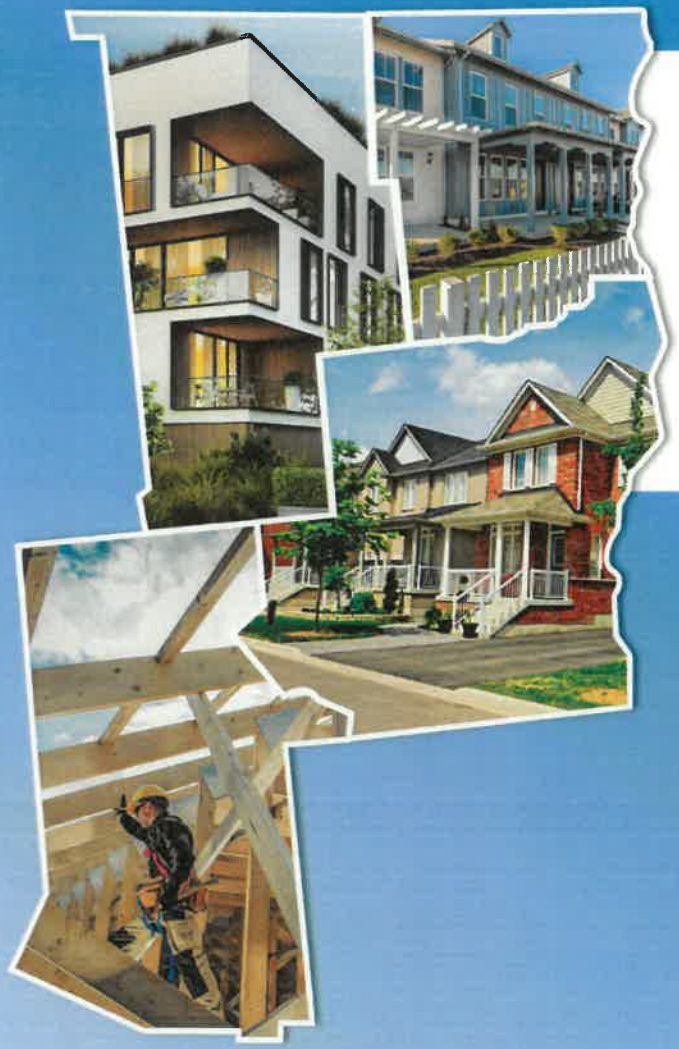
Although Clinton County has just begun its CIT program development work, there is already a robust infrastructure in place to support individuals in crisis. It was clear at this mapping workshop that participants have a thorough understanding of these challenges and, most importantly, a shared commitment to continuous improvement of the local crisis response system. We trust this report will serve as a valuable tool in the ongoing, collaborative work between law enforcement, the mental health system, consumers, and advocates to strengthen the connections between individuals in crisis and safe, effective, trauma-informed care.

Appendix A: Attendees and Affiliations

| Name | Agency |
|---|---|
| Richelle Gregory | Clinton County Mental Health and Addiction Services |
| Chris Arnold | Clinton County Mental Health and Addiction Services |
| Kelly Hornby | Clinton County Mental Health and Addiction Services |
| Christine Peters | Clinton County Department of Social Services |
| Kevin LeBoeuf | Clinton County Veteran's Service Agency |
| Valerie Ainsworth | Essex County Mental Health (988) |
| Aron Steward | Champlain Valley Physician's Hospital |
| Ken Thayer | Champlain Valley Physician's Hospital |
| Mary Baker | Behavioral Health Services North |
| Kourtni Souliere | Behavioral Health Services North |
| Liz Carpenter | Behavioral Health Services North |
| Connie Wille | Champlain Valley Family Center |
| Jake Coulombe | Champlain Valley Family Center |
| Sara Arnold | St. Lawrence Psychiatric Center |
| Beth Parrotte | St. Lawrence Psychiatric Center |
| Amanda Leary | Conifer Park |
| Amanda Haley-Beaudette | Evergreen Townhouse Community |
| Robert Brown | New York State Troopers |
| Tyler Condlin | Clinton County Sheriff's Office |
| Pete Mitchell | Plattsburgh Police Department |
| Jarrod Trombley | Plattsburgh Police Department |
| Pat Rascoe | SUNY Plattsburgh University Police |
| Steven Dube | SUNY Plattsburgh University Police |
| Eric Day | Clinton County Office of Emergency Services |
| Kelly Donoghue | Clinton County Office of Emergency Services |
| Amanda Bulris-Allen | NAMI Champlain Valley |
| Theresa Bennett | NAMI Champlain Valley |
| Carrie Coryer | Alliance for Positive Health |
| Bonnie Black | Coalition to Prevent Suicide |

**Appendix B**
**Systems Map of Community Crisis Response & Law Enforcement Interface**





# BUILDING BALANCED COMMUNITIES FOR THE NORTH COUNTRY:

## A Comprehensive Housing Study and Strategy

MARCH 2023

LAKE CHAMPLAIN-LAKE GEORGE REGIONAL PLANNING

camoin associates

# ACKNOWLEDGEMENTS

This report was developed with input from hundreds of community members and businesses across Clinton, Essex, Franklin, and Hamilton counties. From surveys and one-on-one conversations to public meetings, this report and the subsequent recommendations reflect the feedback received. Additional support came from the following entities.

LAKE CHAMPLAIN–LAKE GEORGE REGIONAL PLANNING

The Lake Champlain-Lake George Regional Planning Board is a regional planning and development organization that represents five counties in Upstate New York.

camoin associates

Camoin Associates has provided economic development consulting services to municipalities, economic development agencies, and private businesses since 1999. To learn more about their experience and projects across all their service lines, please visit www.camoinassociates.com.

Northern Border Regional Commission

Funding for this project was generously provided by the Northern Border Regional Commission, which is a federal-state partnership for economic and community development within the most distressed counties of Maine, New Hampshire, Vermont, and New York.

# TABLE OF CONTENTS



**Appendices**

# INTRODUCTION

The Lake Champlain-Lake George Regional Planning Board (LCLGRPB) commissioned a Regional Housing Assessment and Strategy in March 2022. The analysis focused on four counties in the North Country:

- Clinton County
- Essex County
- Franklin County
- Hamilton County

However, the themes and findings have relevant application to other portions of the region. It is intended that the implementation of these strategies will draw on leadership from LCLGRPB, these four counties, and beyond.

The Regional Housing Assessment and Strategy draws on 10 months of in-depth quantitative and qualitative research. At the outset, understanding the nuances of the data in rural locations and seasonal centers, and getting to know the other features of this region were incredibly important in telling the story of this region. The components of this plan include:

### Findings and Strategy

- Chapter I: Key Themes
- Chapter II: Strategies and Implementation Tactics
- Chapter III: Action Plan Matrix

### Housing Market Analysis

- Chapter I: Housing Inventory and Analysis
- Chapter II: Housing Market Analysis
- Chapter III: Housing Needs Assessment

### Demographics and Economic Conditions

- Chapter I: Demographic Profile
- Chapter II: Economic Profile

### Community Engagement

- Chapter I: Community Engagement Findings and Overview
- Chapter II: Employer Survey Results
- Chapter III: Community Survey Results

### Stakeholder and Public Engagement Snapshot

- **Project steering committee**
- **Dedicated project website**
- **Regional community housing needs survey with 595 responses**
- **Employer survey with 95 responses**
- **Four public workshops (one in each county)**
- **Four municipal leadership meetings (one in each county)**

## ESTABLISHING THE CHALLENGE

This four-county region spans a large portion of Adirondack Park and represents many unique geographical features and federally protected areas. To grasp the specific challenges within the housing sector at both a regional and municipal level, Camoin Associates established 17 themes by distilling the findings of the data analysis, employer and community surveys, public engagement, and stakeholder outreach. More detail on these takeaways is provided in Findings and Strategy – Chapter I.

1. The region's stagnant and declining year-round population is due in large part to housing issues.
2. Housing production has not kept up with demand, contributing to the workforce housing shortage.
3. Income levels are drastically misaligned with housing costs – putting quality housing options out of reach.
4. Regional wages and wage growth have severely lagged behind housing prices.
5. A housing affordability gap, growing over the long term, has been worsened by recent pandemic-related market impacts.
6. A substantial portion of the region's housing stock needs rehabilitation, particularly housing at workforce-attainable price points.
7. Quality rental units at attainable price points for local workers and households are in extremely short supply.
8. Seasonal residents and vacation home buyers have added market pressure and are tipping the balance with year-round households in many portions of the region.
9. Short-term rentals are negatively impacting housing prices and availability in select communities in the region.
10. Many households throughout the region are struggling with housing expenses, including property taxes and utilities.
11. The region has an old and aging population with nowhere to transition to as they age, which is reducing the homes available to the workforce.
12. Workers and their families are being priced out of many employment centers, which results in longer commutes or relocation out of the region.
13. Businesses have struggled to attract and retain employees due to local housing challenges – threatening future regional economic growth and vitality.
14. The region lacks a sufficient workforce in construction, trades, and housing-related jobs that are needed to address the current workforce housing crisis.
15. Increasing the overall regional supply of workforce housing is necessary, but the region will need to overcome land availability and developability challenges.
16. Regulatory constraints on housing development suppress new development and require rethinking and creative approaches.
17. Creating workforce housing will require partnerships and new resources to overcome construction cost limitations on affordability.

## QUANTIFYING HOUSING NEEDS IN THE REGION

After establishing the set of challenges facing each county and the region, Camoin Associates set out to define and quantify the housing needs of the region. Through a Housing Needs Assessment, Camoin Associates provides a quantitative estimate of the housing needs throughout the region and for each county.

The analysis presents the scale of regional housing needs and a detailed breakdown of needs by income level and renting versus ownership. The assessment is further broken down by current regional housing needs in addition to future housing needs. The highlights of that analysis are provided here. The full analysis, along with a detailed breakdown by county, can be found in Housing Market Analysis – Chapter III.

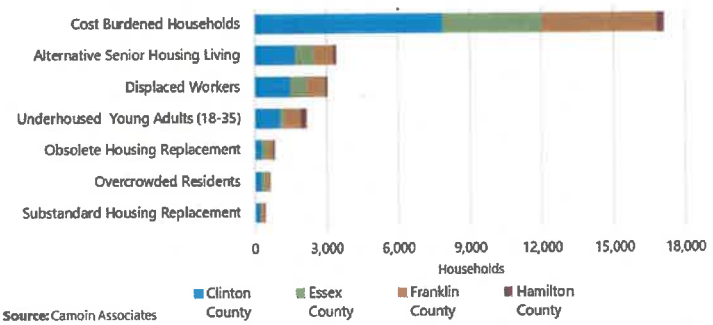
### Current Regional Housing Needs

This component examines what the urgent present-day housing needs are among those living and working throughout the region. The assessment is based on the housing challenges facing workers, including:

- Cost-burned households
- Displaced workers
- Underhoused individuals
- Overcrowded households
- Senior households
- Households in substandard and obsolete housing

The current regional housing needs analysis found that there is an existing need for new, improved, or alternative housing arrangements for at least 20,170 households in the region.

**Current Regional Housing Needs**




**Source:** Camoin Associates

**Current Regional Housing Needs (Households)**

| Source of Housing Need | Clinton County | Essex County | Franklin County | Hamilton County | Four-County Area |
|---|---|---|---|---|---|
| Cost Burdened Households | 7,861 | 4,178 | 4,823 | 271 | 17,133 |
| Displaced Workers | 1,498 | 695 | 774 | 67 | 3,034 |
| Substandard Housing Replacement | 191 | 74 | 145 | 11 | 421 |
| Overcrowded Residents | 269 | 187 | 124 | 1 | 581 |
| Obsolete Housing Replacement | 242 | 258 | 266 | 61 | 827 |
| Underhoused Young Adults (18-35) | 1,040 | 214 | 692 | 236 | 2,182 |
| Alternative Senior Housing Living | 1,701 | 802 | 792 | 141 | 3,436 |
| **Total*** | **9,359** | **4,873** | **5,597** | **338** | **20,167** |

**Source:** Camoin Associates

**Note:** *Total Includes Only Cost Burdened Households and Displaced Workers to Avoid Double Counting

It is important to understand that this is not necessarily the number of new housing units that need to be built in the region as these housing needs can be addressed in a variety of ways. Rather, the region needs 20,170 *housing interventions* to meet existing needs. These interventions are further discussed in the strategy.

## Future Housing Needs

In addition to the present-day housing needs facing the region, projections for the next 10 years indicate an additional need to grow the region's housing stock to accommodate the new workers necessary to sustain the local economy. The projections indicate that the region's existing housing stock and rate of housing production will be woefully insufficient to meet this need. This analysis considers the following factors:

- Projected population growth
- Workforce housing need
- Housing aging into obsolescence

The results of the analysis indicate that the four-county region will need to add approximately 7,500 new housing units to its existing housing stock to accommodate future workforce needs. These units will need to be built above and beyond any new units that are built and occupied by seasonal or vacation homeowners, as well as those occupied by any other non-workforce household or home buyer.

These units are in addition to the current housing need identified in the preceding section. Because it is necessary to address much of the existing and pent-up housing needs over the next 10 years — a portion of which will need to be accommodated through new development — the full scale of housing development needed is greater than the identified 7,500 units.

## Strategy

Overall, strategic and sustained action among all levels of government is imperative to meaningfully address the workforce housing shortage.

The economic conditions of the region and housing availability and affordability are inextricably connected. Earnestly tackling the housing issue is necessary to improve the economic conditions of the region. Maintaining the status quo ensures that the region will fall further behind in housing production, putting further strain on year-round and seasonal workers.

There is no single solution that will address all housing pressures. This strategy is developed around 10 distinct initiatives that are intended to address the most pressing issues facing the four-county region. Tackling the housing crisis facing the region requires a multi-pronged approach, greatest impacts will be seen if multiple initiatives are approached in conjunction with each other. Each initiative will require a champion to advocate and advance the next steps.

# RECOMMENDATIONS

Details on the tactics to advance each initiative can be found in Findings and Strategy – Chapter II and Chapter III.

| # | Initiative |
|---|---|
| 1 | Support and grow the capacity of existing and emerging North Country housing organizations |
| 2 | Re-align workforce housing zoning |
| 3 | Build local: Creating an "ecosystem" for in-region modular (off-site) construction and workforce training |
| 4 | Support workforce housing development through the Adirondack Park Agency and Adirondack Park Agency Act |
| 5 | Work local, live local |
| 6 | Transition housing from retired workers to current workers |
| 7 | Rebalance the region's housing by creating more long-term rentals |
| 8 | Engage employers in regional housing solutions |
| 9 | Stabilize, rehabilitate, and modernize existing housing |
| 10 | Establish a framework for long-term success |

# FINDINGS AND STRATEGY

# Chapter I. Key Themes

# INTRODUCTION

The North Country region is facing a severe and growing workforce housing crisis that threatens to further constrain economic growth, negatively impact local workers' and households' quality of life, and disrupt the balance between a year-round and seasonal population. Key themes that emerged from the data analysis, employer survey, public engagement, and stakeholder outreach include:

1. The region's stagnant and declining year-round population is due in large part to housing issues.
2. Housing production has not kept up with demand, contributing to the workforce housing shortage.
3. Income levels are drastically misaligned with housing costs – putting quality housing options out of reach.
4. Regional wages and wage growth have severely lagged behind housing prices.
5. A housing affordability gap, growing over the long term, has been worsened by recent pandemic-related market impacts.
6. A substantial portion of the region's housing stock needs rehabilitation, particularly housing at workforce-attainable price points.
7. Quality rental units at attainable price points for local workers and households are in extremely short supply.
8. Seasonal residents and vacation home buyers have added market pressure and are tipping the balance with year-round households in many portions of the region.
9. Short-term rentals are negatively impacting housing prices and availability in select communities in the region.
10. Many households throughout the region are struggling with housing expenses, including property taxes and utilities.
11. The region has an old and aging population with nowhere to transition to as they age, which is reducing the homes available to the workforce.
12. Workers and their families are being priced out of many employment centers, which results in longer commutes or relocation out of the region.
13. Businesses have struggled to attract and retain employees due to local housing challenges — threatening future regional economic growth and vitality.
14. The region lacks a sufficient workforce in construction, trades, and housing-related jobs that are needed to address the current workforce housing crisis.
15. Increasing the overall regional supply of workforce housing is necessary, but the region will need to overcome land availability and developability challenges.
16. Regulatory constraints on housing development suppress new development and require rethinking and creative approaches.
17. Creating workforce housing will require partnerships and new resources to overcome construction cost limitations on affordability.

These key themes are discussed further on the following pages.

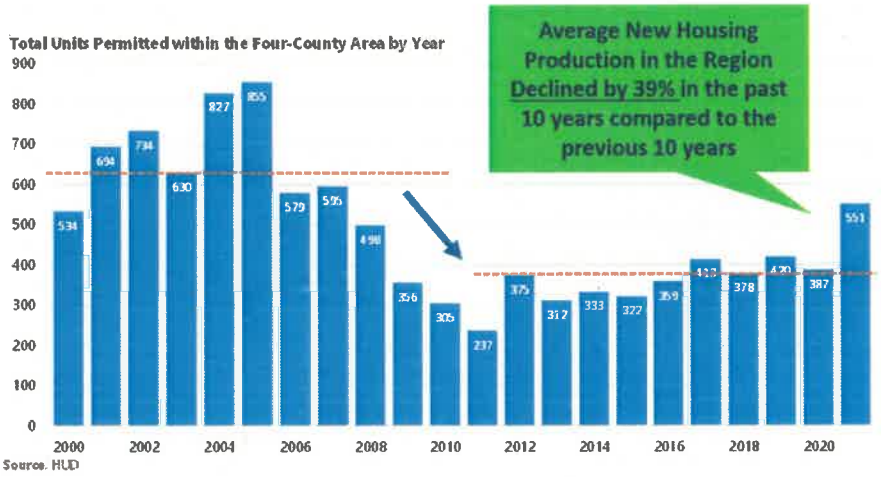
# KEY THEMES

## #1. A STAGNANT AND DECLINING YEAR-ROUND POPULATION IS DUE IN LARGE PART TO HOUSING ISSUES.

The region saw an overall population decline of 4.5% from 2010 to 2020. While population growth is related to a variety of factors including employment opportunities, the lack of workforce housing has undoubtedly constrained population growth as housing demands go unmet.

## #2. HOUSING PRODUCTION HAS NOT KEPT UP WITH DEMAND, CONTRIBUTING TO THE WORKFORCE HOUSING SHORTAGE.

The net growth in the number of housing units in the region was only 0.1% from 2010 to 2020 compared to 8.4% growth during the previous decade. Overall, the average pace of housing development in the region has declined by 39% over the past 10 years compared to the previous 10 years.




The region is not producing nearly enough housing to keep pace with demand, particularly given the competition for housing between year-round residents and seasonal/vacation home buyers. The sluggish pace of housing development is creating a larger gap between supply and demand, which is contributing to escalating housing prices.

## #3. INCOME LEVELS ARE DRASTICALLY MISALIGNED WITH HOUSING COSTS — PUTTING QUALITY HOUSING OPTIONS OUT OF REACH.

The median household income in the region grew by 15% from 2015 to 2020 while the median home price grew by 28% during this timeframe. The mismatch between income levels and housing prices means a typical household would need an additional $20,000 in annual income to afford a typical median-priced home in the region — a gap that is substantially higher in Hamilton and

Essex counties. Home prices are generally out of reach of most workers and year-round households. Homes that are available at more attainable price points often have quality issues or are located far from employment centers, amenities, services, and quality schools.

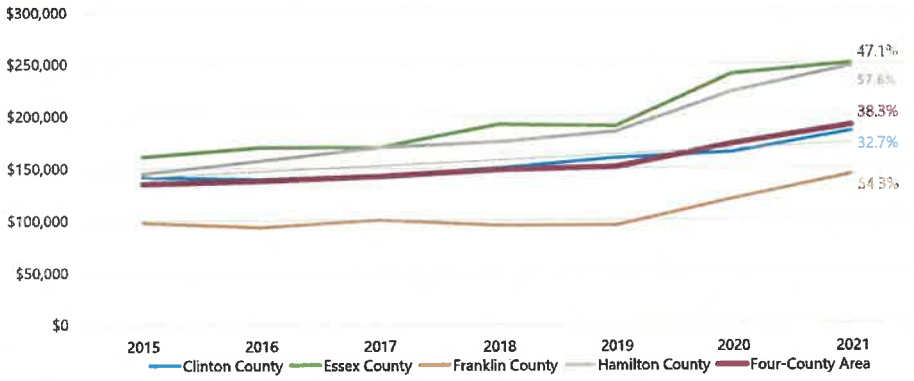
## #4. REGIONAL WAGES AND WAGE GROWTH HAVE SEVERELY LAGGED BEHIND HOUSING PRICES.

Wage growth has not kept pace with housing prices for decades, but this gap has grown more rapidly in recent years. From 2015 to 2020, median job earnings in the region grew 14% — half the growth in home prices (28%) during this time. A worker earning the median annual wage of the most common jobs in the region ($38,000) would need an additional $35,000 in annual income to afford a typically priced home. Even households with two incomes often struggle to afford a quality home in the region.

## #5. A HOUSING AFFORDABILITY GAP, GROWING OVER THE LONG TERM, HAS BEEN WORSENED BY RECENT PANDEMIC-RELATED MARKET IMPACTS.

From 2015 to 2021, the median single-family home price grew 38% regionwide while in Essex and Hamilton counties that price increase was 47% and 58%, respectively. Pandemic-related impacts include higher demand for housing from people migrating to the region, such as remote workers, retirees, and second-home buyers. In sum, these cohorts have driven housing prices dramatically higher in recent years, which has exacerbated affordability issues for the region's workforce.

**Median Single Family Sale Price and 2016 to 2021 Growth**




**Source:** Clinton, Essex, Franklin and Hamilton Counties

## #6. A SUBSTANTIAL PORTION OF THE REGION'S HOUSING STOCK NEEDS REHABILITATION, PARTICULARLY HOUSING AT WORKFORCE-ATTAINABLE PRICE POINTS.

The median age of the region's housing is 55 years old and over 28% of the housing stock was built before 1940. The age of housing is contributing to quality issues. Over 400 households are living in substandard housing conditions and over 820 units are estimated to be obsolete and in need of replacement. This housing could potentially be rehabilitated and/or converted to meet housing needs but many of the owners of these properties lack the resources to invest in these properties.

## #7. QUALITY RENTAL UNITS AT ATTAINABLE PRICE POINTS FOR LOCAL WORKERS AND HOUSEHOLDS ARE IN EXTREMELY SHORT SUPPLY.

Rental housing makes up a smaller share of the region's housing stock compared to the state, with less than 29% of the region's occupied housing being renter-occupied. Rental rates have risen over 24% from 2010 to 2020 due to the shortage of supply. Long-term rentals at attainable price points are very difficult to find throughout the region, particularly outside of major urban and employment centers. The lack of rental units has contributed to long commute times, overcrowded households, and many renter households spending a disproportionate share of income on their monthly rent.

**Year-Round and Seasonal Residency - Four-County Area**


**Source:** American Community Survey, Reports B25004, S1901

## #8. SEASONAL RESIDENTS AND VACATION HOME BUYERS HAVE ADDED MARKET PRESSURE AND ARE TIPPING THE BALANCE WITH YEAR-ROUND HOUSEHOLDS.

More than one in five housing units (22%) in the region are seasonal or recreational in nature (i.e., not occupied year-round). In Hamilton and Essex counties, this proportion is even higher at 81% and 30%, respectively. The decade from 2010 to 2020 saw the addition of approximately 2,300 seasonal/vacation home housing units

representing a 12.5% gain. Without intervention, these trends are likely to continue with seasonal and vacation homes becoming a growing share of the housing stock while the number of homes for the year-round population continues to stagnate or decline.

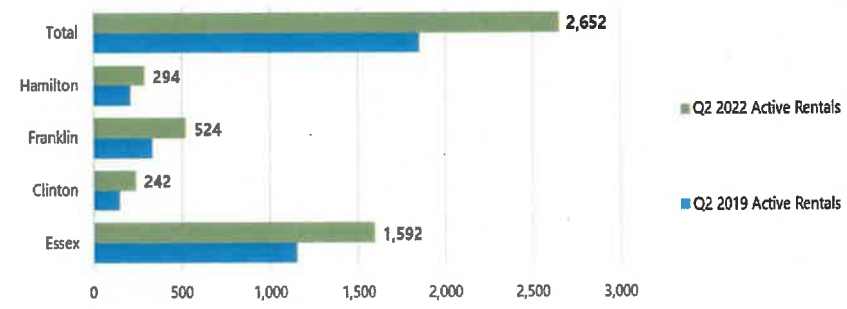
## #9. SHORT-TERM RENTALS ARE NEGATIVELY IMPACTING HOUSING PRICES AND AVAILABILITY IN SELECT COMMUNITIES IN THE REGION.

There are over 2,650 active short-term rentals in the region (nearly half of which are operated full-time as short-term rentals). The number of active short-term rental listings has grown by 43% over just three years from 2019 to 2022. While the impact of short-term rentals on local housing markets is complex and nuanced, these units are undoubtedly having a negative impact on the communities where they are highly concentrated. These units impact affordability for traditional housing by constraining the availability of long-term rentals as many would-be landlords opt for short-term rentals over long-term rentals due to the financial benefit.

## #10. MANY HOUSEHOLDS THROUGHOUT THE REGION ARE STRUGGLING WITH HOUSING EXPENSES.

More than 15,700 households in the region, representing nearly one-quarter of all households, are cost-burdened. These households are spending more than a reasonable percentage (30%) of their income on housing expenses. More alarmingly, 10% are severely cost burdened spending more than 50% of their income on housing expenses. Many of these households must sacrifice other necessities such as heat, food, healthcare, and childcare due to this burden. The high rates of cost burden in the region, particularly among renters and low-income households, are driven in large part by the ongoing workforce and affordable housing shortage.

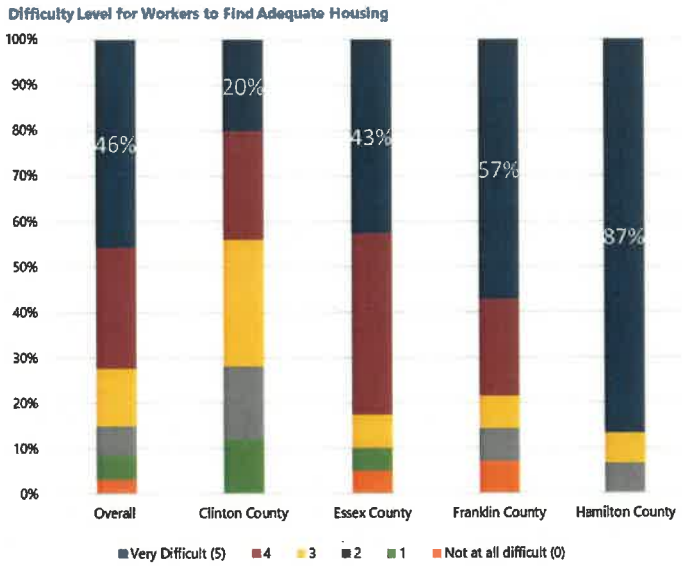
**Growth in Short Term Rental Listings by County (Q2 2019 vs. Q2 2022)**




**Source:** AirDNA. Data current as of July 2022

## #11. THE REGION HAS AN OLD AND AGING POPULATION WITH NOWHERE TO TRANSITION TO AS THEY AGE, WHICH REDUCES THE NUMBER OF HOMES AVAILABLE TO THE WORKFORCE.

Over the past decade, the share of senior households in the region rose significantly from 36% to 45% with the current median age standing at nearly 43 — well above New York State as a whole. Nearly 30% of seniors live alone — many in single-family homes. The lack of housing options for seniors to transition to, particularly in their home communities, is a major contributing factor to the lack of workforce housing. As seniors remain in their homes, housing turnover is reduced, and homes that would have otherwise been available to the workforce and their families are not.




## #12. WORKERS AND THEIR FAMILIES ARE BEING PRICED OUT OF MANY EMPLOYMENT CENTERS, WHICH RESULTS IN LONGER COMMUTES OR RELOCATION OUT OF THE REGION.

Approximately 20% of those working in the region currently live elsewhere. Many workers commute long distances to work, including 23.9% of workers that commute more than 30 minutes each day. The proportion of non-local workers has risen over time due in large part to housing issues and the housing needs analysis estimates that 3,034 workers have been "displaced" out of the region due to the lack of available housing at attainable price points. As workers continue to be pushed out of major

employment and service centers because of housing affordability challenges these commute times and distances have grown, resulting in negative impacts on their quality of life and the environment, and challenges for local businesses.

## #13. BUSINESSES HAVE STRUGGLED TO ATTRACT AND RETAIN EMPLOYERS DUE TO LOCAL HOUSING CHALLENGES – THREATENING FUTURE REGIONAL ECONOMIC GROWTH AND VITALITY.

The employer survey conducted for this study found that 46% of employers reported that it is "very difficult" for their workers to find adequate housing. Approximately 40% of employers also had at least one prospective employee decline a job offer in the past 12 months because they were unable to obtain housing. The lack of workforce housing is one of the most urgent economic development issues in the region, with many businesses unable to expand or relocate to the region as a result.

## #14. THE REGION LACKS A SUFFICIENT WORKFORCE IN CONSTRUCTION, TRADES, AND HOUSING-RELATED JOBS THAT ARE NEEDED TO ADDRESS THE CURRENT WORKFORCE HOUSING CRISIS.

From 2011 to 2021, the number of carpenters and electricians in the region declined by approximately 25%. This trend is indicative of construction and housing-related workforce constraints throughout the region. The region needs substantial growth in its housing stock, but the skilled and unskilled workers needed to build this housing are largely absent. This challenge indicates a critical need for workforce training programs in the trades and other housing-related jobs (such as inspectors).

## #15. INCREASING THE OVERALL REGIONAL SUPPLY OF WORKFORCE HOUSING IS NECESSARY, BUT THE REGION WILL NEED TO OVERCOME LAND AVAILABILITY AND DEVELOPABILITY CHALLENGES.

Nearly 50% of the region's land area is located within the Adirondack Park or is protected New York State Forest Preserve or other state-restricted lands. Only 2.7% of the land is classified by the state as hamlet or moderate intensity, where development can occur at any meaningful scale. In addition to the unique regulations of Adirondack Park, the region is characterized largely by difficult terrain, dense forests, wetlands, and other areas that are difficult to develop for housing. Compounding developability issues is the widespread lack of water and sewer infrastructure in many community centers that prevent housing from being built at scale. The lack of quality building sites and developability challenges throughout the region is one of the primary drivers for the underproduction of housing and the current workforce housing shortage.

## #16. REGULATORY CONSTRAINTS ON HOUSING DEVELOPMENT SUPPRESS NEW DEVELOPMENT AND REQUIRE RETHINKING AND CREATIVE APPROACHES.

Local zoning regulations throughout the region are serving as barriers to the creation of housing that is urgently needed in local communities. Among the regulations constraining the growth of new workforce housing are unreasonable density limitations, particularly in those places where infrastructure and services are located.

Many community centers are much lower density than they were historically and returning to denser development patterns will provide opportunities for workforce housing and enhanced community vitality.

Many communities also place heavy restrictions or prohibitions on multifamily housing types (duplex, triplex, condos, apartments, etc.) in community centers and residential areas where they should be allowed. Addressing these regulatory roadblocks will be difficult but necessary to grow the region's workforce housing supply.

## #17. CREATING WORKFORCE HOUSING WILL REQUIRE PARTNERSHIPS AND NEW RESOURCES TO OVERCOME CONSTRUCTION COST LIMITATIONS ON AFFORDABILITY.

A new (fairly modest) 1,500-square-foot home would cost approximately $375,000 to $525,000 to build in the region, depending on the local context. Even at the low end of that price range, only approximately 14% of households in the region could afford to purchase a new construction home. Perhaps the most significant challenge to the creation of workforce housing in the region is the fact that new housing simply cannot be built at workforce-level price points, whether by a private or non-profit builder. The cost of land, site work, materials, and labor dictate a price point that is out of reach of those most in need of housing in the region.

Overcoming this financial gap (between cost and needed price points) will not only require new funding approaches and strategies, but a recognition that investing in quality housing for workers, families, seniors, and others in the region is an investment in the health, well-being, and prosperity of the region's communities and residents.

# Community Health Assessment

## Working Together to Strengthen Our Community

CCHD
Clinton County HEALTH Department

THE University of Vermont HEALTH NETWORK
Champlain Valley Physicians Hospital

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# Lead Organization Leadership & Organizational Contact Information

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Michelle LeBeau, President/COO

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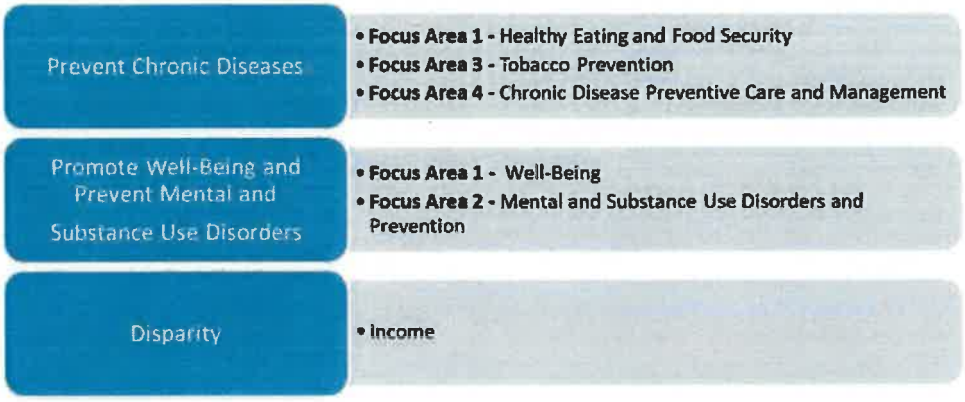
health@clintoncountygov.com

# Table of Contents

## Executive Summary

After a year-long process, Clinton County health partners have selected the two following priority areas and over-arching disparity as most imperative for Clinton County to address as a community over the next three years.




To reach this conclusion, The University of Vermont Health Network- Champlain Valley Physicians Hospital (CVPH) and Clinton County Health Department (CCHD), lead entities in the process, facilitated/ completed the following activities with the Clinton County community:

- Two community based, health focused surveys;
- A review of over 300 health indicators and a secondary data analysis;
- A Community Health Priority Setting Session;
- A Priority and Focus Area Finalization Process; and
- Creation of shared Action Plans.

Health indicators from scores of resources were considered in the process, including data from the NYS Prevention Agenda Dashboard, Community Health Indicator Reports, NYS Office of Mental Health, Division of Criminal Justice Services, NYS Expanded Behavioral Risk Factor Survey, USDA Economic Research Service, American Community Survey, Health Resources and Services Administration, Center for Health Workforce Studies and others. Locally generated and/ or collected data were also considered, when available. Primary data included feedback from resident surveys related to health, social and environmental

concerns as well as qualitative program data from various community based organizations and CCHD.

The newly selected priority areas reflect continued commitment to the priorities selected in the 2016 community health assessment process. While the local process that has been instituted by the lead partners over many years of collaboration was maintained this cycle, several intentional adjustments were made to increase inclusivity and participation over the year. Demonstrative changes of process quality improvement include: increasing reach into the community through a resident survey by 30% over past efforts, extending invitations to participate in the Community Health Priority Setting Session to nearly twice as many stakeholders, piloting a formal disparity selection process and offering a community comment period prior to assessment finalization. Participation in health priority selection represented at least eleven distinct community sectors including healthcare (clinical, population and public health), business, community based organization/service, housing, human services, and mental/behavioral health. These very partners contribute activities and resources to create local action plans. The resulting action plans feature in-progress and planned work related to the selected health priorities and intended to alter health outcomes for the better of all residents. Featured interventions reflect a range of activities and approaches that fall across the Health Impact Pyramid and include service infrastructure, program development and education; many will require high level, cross-sector collaborations.

Ongoing oversight of health improvement progress will continue to be managed by the Action for Health Consortium, which organizes bi-monthly meetings utilizing the NYS Prevention Agenda as its framework. A formal progress update is captured annually and shared with health stakeholders and the community by CCHD and CVPH. These updates serve as an opportunity to celebrate success just as much as a means to adjust course based on emerging needs and new resources in Clinton County.

CCHD and CVPH have and will continue to evaluate the local collaborative approach to community health assessment and improvement planning. At present, direct stakeholder feedback and participation trends along with emerging best-practices greatly

inform and influence the local process. The lead entities monitor awareness and use of the resulting assessment documents among partners, striving to continually increase both process measures.

# Introduction

The University of Vermont Health Network - Champlain Valley Physicians Hospital (CVPH) and the Clinton County Health Department (CCHD) conducted this Community Health Needs Assessment (CHNA) or Community Health Assessment (CHA) (these terms are used interchangeably) to identify and prioritize the community health needs of the patients and communities within Clinton County (CVPH's service area). A CHA 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. Also included in this document is an Implementation Strategy (IS) and CCHD's Community Health Improvement Plan (CHIP), both being a three year plan of action including goals, objectives, improvement strategies and performance measures with measurable and time-framed targets. Interventions align with the NYS Prevention Agenda 2019-2024 and are rooted in sound research and evidence base.

The findings in this CHA result from a year-long process of collecting and analyzing data and consulting with stakeholders throughout the community and the region. This document can be used as a roadmap to guide service providers, especially public health and healthcare, in their efforts to plan programs and services targeted to improve the overall health and well-being of people and communities in our region.

This CHA will address the requirements set forth by the NYS Department of Health (NYSDOH), the Internal Revenue Service through the Affordable Care Act (ACA), and the Commission on Cancer. The NYS Department of Health requires hospitals and local health departments to work together to create a Community Service Plan (CSP) that addresses the findings of the CHA. The CHA and IS are combined to create the CSP. County health departments in NYS have separate yet similar state requirements to conduct a CHA and create a corresponding and actionable CHIP.

The CHA and IS will fulfill the requirements set forth by the Internal Revenue Service through the ACA. The community health needs assessment provision of the ACA 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. Beginning in 2012, all American College of Surgeons (ACOS) Commission on Cancer (CoC) cancer programs are required 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 and data were considered throughout the assessment process. Aligning and combining the requirements of these three entities ensures the most efficient use of resources and supports a comprehensive approach to community and population health management and improvement in the region.

## Lead Organizations in the Community Health Assessment Process

### University of Vermont Health Network – Champlain Valley Physicians Hospital (CVPH)

The mission of CVPH is "Every day, we devote our heads, hands, and hearts to our patients, our peers and our community." The vision of CVPH is "Working together, we improve people's lives." The values of CVPH are "By embracing our strengths and honoring our differences, we learn and grow together through honesty, respect, and teamwork." The mission, vision, and values guide the organization's commitment to community needs.

CVPH is a voluntary, not-for-profit, Article 28 organization that is governed by a voluntary Board of Directors and is licensed for 300 beds. CVPH is located at 75 Beekman Street in Plattsburgh, New York with satellite services at a number of other authorized locations within the Plattsburgh area. CVPH is part of the University of Vermont Health Network, which is comprised of six hospitals, a home health and hospice agency, and an employed medical group. It is affiliated with an academic medical center in Burlington, Vermont. CVPH offers a variety of services including cardiovascular, orthopedics, obstetrics, psychiatry, long term care, and primary care. It has a Family Medicine Residency program to help address primary care shortages in the community. CVPH provides cancer services through the Fitzpatrick Cancer Center. In addition, CVPH has a robust Medical Home as well as the Adirondack Region ACO which are key partners in addressing community health needs.

### Clinton County Health Department (CCHD)

The Clinton County Health Department strives "To improve and protect the health, well-being, and environment of the people of Clinton County." CCHD realizes its mission and vision of "Healthy People in a Healthy Community" through its core values of advocacy, collaboration, excellence, innovation, integrity, and service. Its Director of Public Health oversees five distinct divisions of multi-disciplinary teams. The Department reports to the Clinton County Board of Health and County Legislature.

CCHD plays a critical role in the identification of local health needs, determination of strategies to address issues and collaboration of local partners to bring shared health agendas to life. In addition, CCHD provides essential health services in the community including immunizations, maternal child health programs, infectious disease surveillance, monitoring of local health data and trends of public health significance, and environmental health and safety services. CCHD also provides guidance and leadership during emergencies and disasters, ensuring preparedness in the county's people and supporting community resilience. It has also led the community in the implementation of policy, systems and environmental strategy work aimed at improving the health of all residents by changing the context in which many health related decisions are made. Through long established community partnerships, the health improvement and prevention programs developed and implemented by CCHD are sound and impactful. CCHD is the only local

health department in the Adirondack region to be nationally accredited by the Public Health Accreditation Board (PHAB), demonstrating the Department meets the highest of standards for local health departments.

## Community Health Needs Assessment Stakeholder Groups

### Clinton County Action for Health Consortium

The Clinton County Action for Health (AFH) Consortium is a multi-sector, multi-disciplinary collection of local health system partners working towards community health improvement. The group is facilitated by CCHD. The primary work of the Consortium has been built around data driven identified needs (NYS Prevention Agenda) and available community resources. Partners in the effort include: municipalities, businesses, grassroots community groups, health care providers, the local hospital, human service agencies, schools and local not-for-profits. The group has existed for well over a decade and presently has over forty members that have formally committed to its purpose by signing Partnership Letters. Recruitment of new members is ongoing.

The AFH Consortium meets periodically for updates, issue discussion, and information sharing, including review of new data, resources, and emerging opportunities and potential threats to health. It is the means by which stakeholders update each other on progress in CHIP/IS related activities and other health improvement efforts. The Consortium also contributes to semi-annual updates to the community on CHIP/IS progress through a newspaper insert. A minimum of six meetings are scheduled each year, with additional gatherings scheduled as needed. As lead facilitator, CCHD tracks health improvement progress continually and prepares a year-end report which includes updates on work related to the two featured Priority Areas and a summary of accomplishments by local partners related to each of the NYSDOH Prevention Plan Priority Areas. Captured activities demonstrate work on all tiers of the Health Impact Pyramid.

### Adirondack Rural Health Network

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

Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The CHA Committee, facilitated by ARHN, is comprised of hospitals and county health departments that have developed and implemented a

sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA Committee meets quarterly and is made up of representatives from Adirondack Health, Clinton County Health Department, University of Vermont Health Network - Alice Hyde Medical Center, University of Vermont Health Network - Elizabethtown Community Hospital, Essex County Health Department, Franklin County Public Health, Fulton County Public Health, Glens Falls Hospital, Hamilton County Public Health, Nathan Littauer Hospital, University of Vermont Health Network – Champlain Valley Physicians Hospital, Warren County Health Services, and Washington County Public Health.

In 2018 as CHA Committee members began the assessment process, 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 CHAs, CHIPs, and ISs as well as identify ways to enhance the CHA/CHIP/IS process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a regional stakeholder survey.

The data subcommittee met seven times from mid-July through the end of October 2018. Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 subcommittee members per meeting. Meetings were also attended by AHI staff from ARHN, Population Health Improvement Program (PHIP) and Data teams.

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

## New York State's Prevention Agenda 2019-2024

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 equity in all populations who experience disparities. This is the third cycle for this statewide initiative that started in 2008. The Prevention Agenda serves as a guide to local health departments and hospitals as they work with their communities to complete a CHA, IS and CHIP.

The Prevention Agenda 2019-2024 has five priorities with priority-specific action plans developed collaboratively with input from state-wide community stakeholders. 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.

CCHD and CVPH use the Prevention Agenda as a framework for assessing health, identifying local health priorities and planning collaborative health improvement efforts within Clinton County.

**Prevention Agenda 2019-2024: New York State's Health Improvement Plan**

| Prevent Chronic Diseases | Promote a Healthy and Safe Environment | Promote Health Women, Infants and Children | Promote Well-Being and Prevent Mental and Substance Use Disorders | Prevent Communicable Diseases |
|---|---|---|---|---|
| •**Focus Area 1** - Healthy Eating and Food Security<br>•**Focus Area 2** - Physical Activity<br>•**Focus Area 3** - Tobacco Prevention<br>•**Focus Area 4** - Chronic Disease Preventive Care and Management | •**Focus Area 1** - Injuries, Violence and Occupational Health<br>•**Focus Area 2** -Outdoor Air Quality<br>•**Focus Area 3** - Built and Indoor Environments<br>•**Focus Area 4** - Water Quality<br>•**Focus Area 5** - Food and Consumer Produts | •**Focus Area 1** - Maternal and Women's Health<br>•**Focus Area 2** - Perinatal and Infant Health<br>•**Focus Area 3** - Child and Adolescent Health<br>•**Focus Area 4** - Cross Cutting Healthy Women, Infants, and Children | •**Focus Area 1** - Well-Being<br>•**Focus Area 2** - Mental and Substance Use Disorders and Prevention | •**Focus Area 1** - Vaccine Preventable Diseases<br>•**Focus Area 2** - Human Immunodeficiency Virus (HIV)<br>•**Focus Area 3** - Sexually Transmitted Infections (STIs)<br>•**Focus Area 4** - Hepatitis C Virus (HCV)<br>•**Focus Area 5** - Antibiotic Resistance and Healthcare-Associated Infections |

For more on the Prevention Agenda, visit:
https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/.

## Health Care System Transformation

The Delivery System Reform Incentive Payment Program (DSRIP), facilitated regionally by the AHI PPS (Performing Provider System), has united a network of partners in the region with interest in the restructuring of the Medicaid system. Approximately $8B has been invested in the regional health care system, much supporting innovative projects that are pilot testing new approaches to strengthening the health care workforce and addressing the social determinants of health. (Much more on funded DSRIP projects in our region can be found at www.ahihealth.org.)

Details on the next chapter of DSRIP are just now being determined. It is anticipated focus will be centered on payment reforms that help sustain the successes realized through recent innovations and cross-system collaborations, especially between clinical and community health partners. This type of collective impact work will be fundamental in effectively applying and realizing the core concepts of preventive health on a community level.

The Centers for Disease Control and Prevention has conceptualized a population health and prevention framework in their *3 Buckets of Prevention* model that highlights an extension of care outside the clinical setting, while continuing to support traditional clinical and community-wide preventive interventions. Health care leaders in Clinton County realize this model can only prove successful if cross-sector partnerships that foster shared funding, services, oversight and collective action are prioritized and supported by all health system stakeholders. Evidence of commitment to these concepts is already apparent in the local community, especially in many DSRIP innovations, and can be seen demonstrated in

planned health improvement efforts. As the national health care system continues through a period of unprecedented change, local health partners are positioning themselves for resilience.

## Complementary Community Assessments

Efforts to build healthier communities have the potential for being more successful when agencies, programs and individuals from multiple community sectors work together. Collaboration between the health sector and other community sectors can generate new opportunities to improve health. Recognizing this dynamic, community needs assessments, service plans and strategic plans from other community sectors in the region were reviewed and considered as part as the health assessment process and to identify opportunities for collaboration between local health department/hospitals and other community entities. Documents from such community sectors as behavioral health service providers, community action/economic opportunity agencies, regional economic development councils, business associations and others reveal many opportunities for collaboration and include but are not limited to:

- Local Services Plan for Mental Hygiene Services
- Community Action/Economic Development
- Regional Economic Development Councils.

## Community Profile:

### Description & Discussion of Relevant Supporting and Opposing Factors

Demographics & Disparities

Clinton County's population is 81,224, making it the most populated county in the ARHN region. The county is made up of a number of small, distinct townships and one large rural core, where approximately one quarter of the population lives and a majority of services, jobs and other resources are accessed. Similar to the rest of Upstate New York, Clinton County's population is limited in its ethnic and racial diversity; over 90% of residents are White/non-Hispanics, followed by 4.2% Black/African American, non-Hispanics and 2.8% Hispanic/Latinos. Despite low ethnic and racial diversity, many special populations exist within the community. It is often through these special populations that health and health care experiences are considered and interventions are designed with an equity intent.

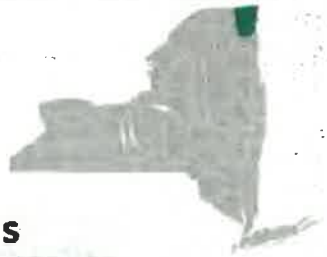
While there are no significant health disparities based on race and ethnicity in Clinton County, there are access to care issues. In fact, in a recent resident survey, over half of the respondents (50.3%) reported experiencing at least one barrier to medical care for themselves or their family in the past year. The most commonly reported barriers, identified by almost 1 in 3 respondents, included: not having dental or vision insurance (32.8%), co-pays or deductibles that were too high (31.9%), no specialist was available locally (30.4%) and could not afford (29.9%). Of note, three of these four most commonly reported barriers directly relate to a lack of financial means.

The percentage of adults with health insurance in Clinton County is at 94.0%, with 88.5% of the population having a regular health care provider. Despite this statistic, the regional health care system falls short of meeting a number of preventive care performance goals, indicating that while residents may have a provider, they are not consistently seeking preventive services, such as annual wellness visits. Furthermore, the rate of age-adjusted preventable hospitalizations per 10,000 population among those 18 years of age and older (129.5) is higher than the rate for Upstate New York (116.8), and the Prevention Agenda benchmark (122.0) rate. The rate of ED visits per 10,000 population in Clinton County (5164.5) is higher than the ARHN region (4,866.3) and significantly higher than Upstate New York (3,865.6).

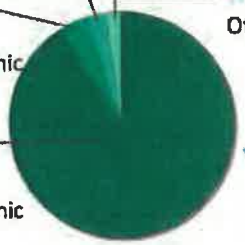
Over 16% of the population is 65 years of age and older. This is slightly lower than the ARHN region (18.0%) and comparable to Upstate New York (16.37%) but has increased since the last assessment, signaling an aging population. The percentage of adults 18 years of age and older in Clinton County with a disability (25.7%) is higher than the ARHN region (25.6%), Upstate New York (22.8%), and the state as a whole (22.9%).

Household income on average is $65,435, with per capita income at $25,833, which is much lower than that of New York State, $93,443 and $35,752 respectively. The percentage of individuals in Clinton County living below the Federal Poverty Level has remained stable at

# CLINTON COUNTY | DATA SNAPSHOT



## POPULATION




| | |
|---|---|
| Under 18 | 14,797 |
| Ages 18-64 | 53,893 |
| Ages 65+ | 12,534 |

## HOUSEHOLDS

| | |
|---|---|
| Mean Household Income | $65,435 |
| % Single Parent Households | 9.9% |

## EMPLOYMENT STATUS

| | |
|---|---|
| % Unemployed | 3.2% |


## SCHOOL SYSTEM INFORMATION

| | |
|---|---|
| Student-to-Teacher Ratio | 10.9 |
| % Free and Reduced Lunch | 47.0% |
| % High School Graduate/GED | 37.1% |
| % Some College, No Degree | 17.9% |
| % Associate's Degree | 9.9% |
| % Bachelor's Degree or Higher | 21.8% |

## AVAILABILITY OF VEHICLES

% Households with One Vehicle or Less Available
42.9%

## HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)

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

## POVERTY

| | |
|---|---|
| % Individuals Receiving Medicaid | 23.2% |
| % Individuals Under Federal Poverty Level | 15.7% |
| Number of ALICE and Poverty Households | 12,062 |

**DATA SOURCES**

The information above 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 System; 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. This document was created in 2019.

15.2%, which is higher than the ARHN (13.9%) region and Upstate New York (11.7%). In total, there are 30,624 households in Clinton County. There is a 15.0% poverty rate and 24.4% Asset Limited, Income Constrained, Employed (ALICE) rate, with a total of 12,062 households designated as either poverty or ALICE. Specific to ALICE households, the majority are white (8,119), which far exceeds the second largest group of ALICE households comprised of black residents (122).

The percent of households receiving SNAP benefits is 17.4%, exceeding NYS and national percentages at 15.2% and 12.7%, respectively. The percentage of individuals enrolled in Medicaid is 24.4%; this is slightly below the NYS percentage of 26.8% but does represent a 35% increase since the last assessment. This is likely more a result of ACA requirements than a major shift in economic conditions as percentages of uninsured adults and children are also extremely low compared to percentages from past assessments.

Of the total population in Clinton County, approximately 37% of individuals 25 years of age and older have a high school diploma or equivalent. Another 30.8% have an Associate's or Bachelor's degree or higher. The percent of the population possessing a high school education has increased since the last assessment but the percent of the population pursuing higher level degrees has remained stable. Fifty six percent of the population 16 years and older is in the workforce, with the highest percentage of individuals in the field of education (26.7%), followed by retail trade (13.3%), manufacturing (12.3%), and arts, entertainment, recreation, hotel and food services (10.8%). The manufacturing industry attributes the largest portion to the Clinton County's Gross Domestic Product at over $489 million.

While over 300 health metrics were reviewed in the community health assessment process, the resident health survey completed as part of the process, was able to capture, perhaps more clearly than any past effort, the extent of concern many residents experience with a range of factors that influence overall health and well-being. Nearly a quarter of all respondents noted securing affordable housing as a challenge for themselves or their families in the past year. Lack of a livable wage was reported as the top social challenge experienced by survey respondents or a family member within the past year (29.7%); it was also the top social challenge identified within the community (37.3%). These same factors, along with good schools and safe, clean environments rounded out the top characteristics of a "healthy community" as defined by residents themselves. Such findings reinforce the importance of the social determinants of health and the need to continue to favor strategies and interventions that address up-stream factors that play a fundamental role in health outcomes. In considering resident and stakeholder input, as well as hundreds of health metrics, low income remains Clinton County's most common and evident disparity.

## Health System Profile

Clinton County has one hospital, Champlain Valley Physicians Hospital (CVPH), with 300 hospital beds, the majority of which are medical/surgical beds, resulting in a rate of 369.3 hospital beds. This rate is higher than the ARHN region (274.2) and higher than all other

counties in the ARHN region, except for Warren County (627.5). There are a total of four nursing home facilities, accounting for 490 beds, and three adult care facilities, accounting for 150 beds. The rate of primary care physicians in Clinton County is 119.2 and 317.9 for total physicians. Clinton County consists of four health professional shortage areas (HPSAs), one in primary care, one in dental care, and two in mental health. About one third of Clinton County's population lives in these designated areas however, because of the county's rural nature, most residents living outside of the rural core, namely the City and Town of Plattsburgh, must travel to receive health care services and/or take advantage of health related opportunities. Travel aside, almost 1 in 5 respondents to the resident survey reported not being able to secure an appointment with either a primary care provider (18.3%) or specialist (19.6%) as a barrier to receiving care.


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

**Top ranked barriers reported:**
- No vision or dental insurance
- High co-pays and deductibles
- Lack of local specialists
- Affordability

*Source: 2019 Community Health Assessment Resident Survey Key Findings*

In an effort to address the Primary Care HPSA, CVPH began a Family Medicine Residency program in 2015. The program became accredited by the Accreditation Council for Graduate Medical Education (ACGME ) in July of the same year. The first class of Family Medicine Residents (4 physicians) graduated from the program in 2019. Of them, three have decided to continue practicing primary care in Clinton County. Currently, 17 Residents are enrolled in the program with anticipated completion dates between 2020 and 2022. In addition to increasing access to primary care in the county, two pediatric dentist offices have opened in Clinton County since the last CHA cycle. One is located within the City of Plattsburgh while the other resides in the outlying town of Peru.

## Education Profile

Within Clinton County, there are nine school districts, with a total enrollment of 10,849 students. Of the enrolled students, 47.0% are eligible for free or reduced lunch, with a majority eligible for free lunch (87% or 4,410). Three school districts began providing universal free breakfast and lunch since the last assessment. For students in districts not providing universally free meals, NYS legislation that went into effect for the 2019-20 school year will provide free breakfast and lunch to students that were eligible for either free or reduced lunch under the established eligibility criteria.


**of Clinton County households participating in SNAP have children under the age of 18.**

*Source: American Community Survey*

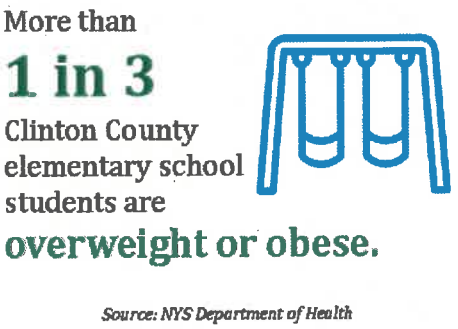
The total annual number of high school graduates is 774 with a dropout rate of 2.0%, which is slightly higher than the ARHN (0.8%) region and Upstate New York (0.64%) dropout rates, but lower than the New York State dropout rate of 3.0%. There are 10.9 students per

teacher in Clinton County, which is comparable to the ARHN region but slightly lower than Upstate New York (12.4). The county is home to two college campuses, a two year and a four year institution. Both schools are associated with the state's university system and are a resource for residents interested in pursuing higher level degrees close to home.

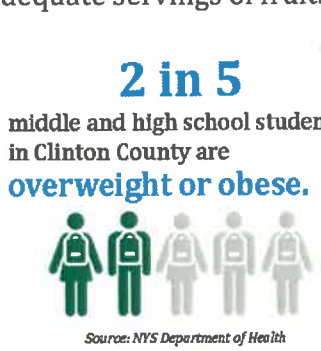
**NYS Prevention Agenda Priority Areas Related Analysis**

Prevent Chronic Diseases

The percentages of adults (36.7%) and children who are obese (20.9%) in Clinton County is higher than their respective Prevention Agenda Benchmarks of 23.2% and 16.7%. Nearly three out of every four adults are overweight or obese. Additionally, the rate of obesity in elementary school children (17.9%) is higher than Upstate New York (16.0%).




The burden of obesity may contribute to higher rates of death due to diabetes (any diagnosis) in Clinton County (22.1) than in Upstate New York (15.4). The percent of adults self-reporting no leisure time physical activity has had a slow increase over the past decade (26%, 2016). Less than one quarter of all residents consume adequate servings of fruits and vegetables daily. Clinton County has seen a decrease in total number of full grocery stores since its last full health assessment with 24.4 stores/ 100,000 population, less than half the state average. Despite this decrease in opportunity, the number of census tracts qualifying as food deserts has remained stable at 7, indicating lost stores may have decreased shopping options but were generally in communities with other food resources. However, there has been nearly a 10 percentage point jump in the populations who are low income and experience low food access since the last full health assessment. A significant increase in the number of non-traditional food outlets, such as convenience stores, drug stores and dollar stores, has increased access to less healthy food options, often closer to home. To combat this trend, Clinton County partners secured and invested over $100,000 in the past three years to increase township food pantry ability to accept, store and redistribute healthier food options safely, among other interventions.




Smoking and smoking-related diseases seem to pose a significant challenge for Clinton County, with seven of the indicators listing as worse than the comparison benchmark. The percentage of adults who smoke in Clinton County (24.7%) is higher than the percentage of smokers in Upstate New York (16.2%), New York State (14.2%) and the Prevention Agenda Benchmark of 12.3%. Chronic lower respiratory deaths are significantly higher, and hospitalizations are higher in Clinton County (58.2 and 31.0, respectively) than in Upstate

New York (45.4 and 28.0) and the state as a whole (34.1 and 30.6).

**1 in 4**
**adults in Clinton County**
**smoke.**

*Source: Prevention Agenda Dashboard*

The rates of lung and bronchus cancer cases are lower in Clinton County (105.9) than in the ARHN region (112.2), but higher than Upstate New York (84.3) and New York State (69.7). Lung and bronchus cancer deaths are also lower in Clinton County (61.3) as compared to the ARHN region (67.4), but higher than Upstate New York (53.0) and New York State (43.5). The rate of colon and rectal cancer cases and deaths is lower in Clinton County than the other geographies. This could be contributed to the fact that the percentage of colorectal screenings for those 50 to 75 years of age in Clinton County (78.3%) is higher than the ARHN region (73.6%), Upstate New York (68.5%), and New York State (69.7%). Clinton County has maintained funding for the next several years to support cancer screening, namely for breast and colon cancers, for those who have low or no insurance coverage.

The local rates of overweight and obesity across the age continuum continue to climb and incidence/ prevalence rates of common chronic disease benchmarks, like hypertension and heart disease, remain high despite emphasis on upstream, population level change work over the past two community health assessment cycles. This delay in evident impact is not entirely unanticipated and many shorter term measures are demonstrating progress. For example, primary data on local breastfeeding rates indicates over a 6% increase since 2013. Multiple communities have passed Complete Streets resolutions, demonstrating commitment to health in new construction projects on the municipality level and many play spaces have been revitalized with accessibility for all ages and abilities in mind over the past few years. In light the data trends and the need to further the impact of environmental change work, more needs to be done.

**78%**
**of Clinton County adults ages 50-75 have been screened for**
**colon cancer.**

*Source: NYS Expanded Behavioral Risk Factor Survey*

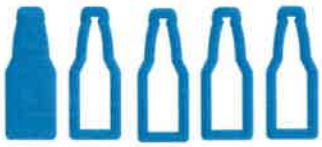
Promote Well-Being and Prevent Mental and Substance Use Disorders

Nearly 15% of the population continues to report poor mental health (14 or more days/ month) and access to mental health providers at 230.9/ 100,000 population lags behind national rates. Hospital discharge rates from inpatient behavioral health services continue to increase for both adults and children. The ratio of population to

**14.8%** of adults in Clinton County stated **poor mental health 14 or more days** in the past month. This is **4 points higher** than the state average.

*Source: NYS Expanded Behavioral Risk Factor Surveillance System*

mental health providers remains higher than the NYS average. UVMHN-CVPH has had success in recruiting additional psychiatrists, increasing capacity for in-patient care. While there remains a shortage of these same professionals in outpatient clinics, collaborative health improvement activities have focused on building infrastructure to support continuity care between inpatient and outpatient mental and behavioral health settings. For example, a mobile crisis team was established in 2017, fielding over 200 referrals in its first 6 months and significantly reducing reliance on the emergency room for service. A local stabilization and rehabilitation center opened in late 2018 and integrated primary care with behavioral health services debuted in the county early 2019.



**1 in 5**

**Clinton County adults have participated in binge drinking within the last month.**

*Source: Prevention Agenda Dashboard*

Like most regions, Clinton County has seen a significant increase in opioid use and issues related to its use. The rate of drug related hospitalizations (17.8/ 100,000 population) remains above the regional rate but below the state rate. Over the past several years, the local Opioid Overdose Prevention Program has trained more than 6,000 community members to respond to opioid overdose and has distributed well over 10,000 Naloxone kits; 202 reversals have been reported.

The rate of self-inflicted hospitalizations in Clinton County (2.7) is lower than Upstate New York (4.1), and New York State (3.5). The percentage of adults in Clinton County who binge drink (21.1%) is higher than the Prevention Agenda Benchmarks of 18.4%. The rate of alcohol-related crashes in Clinton County (48.2) is significantly higher than New York State (38.0). Among 15 to 19-year old's, the 2016 Community Health Indicator Reports listed the rate of suicides at 11.4*, which is slightly higher than the ARHN region (10.7) and Upstate New York (6.1). It is anticipated that the impact of new infrastructure for rehabilitation and supportive/ preventive services will be evident as these measures are updated in the years ahead. However, primary prevention must also be a focus as nearly half of all high school students surveyed report "easy" access to alcohol and other drugs.

**45%**

**of youth (grades 9-12) report easy access to alcohol or other drugs.**

*Source: 2019 Local Services Plan*

Promote a Healthy and Safe Environment

Motor vehicle accidents and speed-related accidents are lower in Clinton County (1,942.5 and 337.1 respectively) than in the ARHN region (2,162.0 and 364.7), but higher than New York State (1,558.5 and 141.6). Additionally, the rate of motor vehicle accident deaths is lower in Clinton County (4.9) than the ARHN region (7.3), Upstate New York (7.1) and the

state as a whole (5.0). The rate of violent crimes (167.7) is slightly lower than the ARHN region (171.8) and significantly lower than that of Upstate New York (214.9) and New York State (355.6).

Air quality and climate data remain limited for the area but water quality, for both recreational and drinking water sources, is a top environmental concern for residents. Nearly half of all respondents to the resident survey identified challenges related to water as the top environmental concern in the community; specifically, 48.4% identified concerns related to stream, river, and lake quality, and 46.6% reported concerns with drinking water quality. While only a few districts enact fluoridated water programs, these districts serve half of the county's total population. Three quarters of the population are served by monitored public water systems but just over a quarter of all residents rely on unregulated, private water systems.

For the past two years, CCHD has assisted residents in managing private water sources through a private well water sampling program. Over 100 samples were tested in 2018. Clinton County has also secured funding to assist residents along water sources in upgrading/ replacing home septic systems. While funding was originally intended just for Lake Champlain homes, CCHD successfully advocated to have target areas extended to cover homes on the shores of other water sources, such as Upper Chateaugay Lake. SUNY Plattsburgh is also spearheading a number of studies on Lake Champlain, including one seeking to understand sources of microplastics pollution and their mitigation.

Nearly **50%** of residents selected **water quality** as a top environmental concern.

*Source: 2019 Community Health Assessment Resident Survey Key Findings*

**1 in 4**

Clinton County residents experience low access to a **grocery store.**

*Source. US Dept. of Agriculture—Food Environment Atlas*

The built environment poses several challenges in Clinton County. The percentage of the population with low-income and low access to supermarkets or large grocery stores is significantly higher in Clinton County (10.1%) than in the ARHN region (6.0%), Upstate New York (3.9%), the state as a whole (2.3%), and the Prevention Agenda Benchmark of 2.2%. The loss of full grocery stores in favor of non-traditional food outlets, like dollar and convenience stores, has negatively impacted the overall food environment. However, farmers market and farm stand participation in local, state and national nutrition incentive programs has been maximized with a 50% increase in sites accepting SNAP from 2015-2018 and an increase of more than two times the number of sites participating in the state's Farmers Market Nutrition Program during the same time frame. In 2018, Clinton County was also selected as a North Country pilot site for the Double Up Food Bucks program run out of the Field and Fork Network of Buffalo, NY, providing additional financial support and buying power to low-income households.

At present, seven out of 19 Clinton County municipal districts have passed complete streets resolutions and 12 have healthy space revitalization activities in progress with a number of others that have been completed in the past several years. Projects include the creation of new walking paths, installation of safety features to support active transportation and revision/ upgrades to more traditional play spaces. However, progress in some areas throughout the county is limited as support and technical assistance for complete streets/ active transportation projects has been unequally distributed based on identified target communities for state funded initiatives.

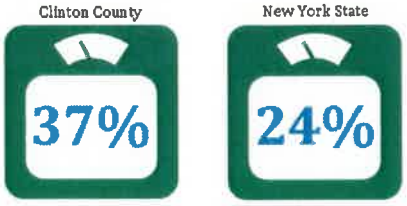
**Affordable housing** is a challenge for nearly **25%** of respondents.

*Source: 2019 Community Health Assessment Resident Survey Key Findings*

Several community partners report increasing challenges related to rising housing costs. Resident survey responses echoed this with a quarter of all respondents listing affordable housing as a social concern for themselves or their family. State data estimates 1 in 3 Clinton County adults is housing insecure; there are a number of initiatives addressing this need, especially among high needs sub-populations. Several key community partners are monitoring this emerging trend.

## Promote Healthy Women, Infants and Children

The percentage of births within 24 months of previous pregnancies in Clinton County (23.0%) is higher than the Prevention Agenda Benchmark of 17.0%, while the percentage of unintended pregnancies in Clinton County (23.7%) is in line with the Prevention Agenda benchmark of 23.8%.




of women enrolled in WIC are **obese** before becoming **pregnant.**

*Source: Prevention Agenda Dashboard*

The percentages of women receiving WIC in Clinton County with either gestational weight gain greater than ideal or gestational diabetes are worse than the ARHN region, Upstate New York, and New York State. The percentage of pre-pregnancy obesity (36.8%) is higher than that of the ARHN region (33.3%) and Upstate New York (28.0%). However, Clinton County WIC childhood obesity rates are dropping and the local program achieved the third highest exclusive breastfeeding rate (at 6 months of age) in NYS in 2018.

A trend favoring increased breastfeeding initiation, duration and exclusivity for all infants is emerging from data collected by CCHD in collaboration with local pediatric practices over the last five years. From 2013 to 2017, average breastfeeding rates in Clinton County experienced an average percentage point increase of 6.5%. According to the UVMHN-CVPH, there was an increase from 2013 to 2017 in both infants initiating breastfeeding within the

first hour of life and infants breastfeeding at hospital discharge. In 2013, 52% of infants initiated breastfeeding within the first hour of life; this number increased to 79% in 2017. Infants breastfeeding at hospital discharge (exclusive and any) also increased, from 63% in 2013 to 86% in 2017. Once in the community, data show more babies are receiving breastmilk and an increase in breastfeeding rates is evident at each milestone well-visit, for exclusively breastfed infants as well as those supplemented with formula. At the two-day well visit, 74.1% of infants born in 2017 attending a Clinton County pediatric practice were breastfeeding, exclusively and in combination with formula. This number decreases to 38.7% by the six-month well visit, and to 25.2% by the one-year well visit. The largest decrease in breastfeeding rates continues to occur between the two-week and two-month well visits. This timeframe remains a target for individual and community level interventions.

The overall increase in breastfeeding in our community may be attributed to community-wide efforts to remove barriers and change the social context of breastfeeding, as well as an increased capacity to provide individualized clinical support through primary care. Local approaches have incorporated activities identified and suggested by community partners and have been designed utilizing existing best practices. While successes are notable given the short time period for change, opportunities still exist to further improve local breastfeeding rates, especially through early infancy. In addition, Clinton County continues to fall short of meeting several Healthy People 2020 targets related to breastfeeding. Over the past several years, local pediatric practices have adjusted approaches to newborn care, especially for breastfeeding families, increasing services and decreasing length of time between hospital discharge and newborn appointments within the pediatric care setting. The number of families accepting in-home newborn visits has decreased from 12% in 2016 to 3% in 2018; this may speak more to the effectiveness of the changes within the pediatric medical home environment than a decrease in the need for newborn support soon after hospital discharge.

**75%**

**of all Clinton County babies born in 2017 received some breastmilk.**

*Source: Clinton County 2017 Breastfeeding Data Summary, 2019*

Referrals into services to address childhood developmental delays are increasing, with a 30% increase in referrals seen for the Early Intervention Program from just 2016 to 2018. Program staff are seeing an increase in referrals related to lack of core muscle strength often associated with "container baby syndrome." Other common referrals include neonatal abstinence syndrome and failure to thrive anomalies. Root cause analysis and mitigation options are under discussion among childhood development stakeholders and findings are likely to be considered in prospective community health improvement plans.

## Prevent Communicable Diseases

The immunization rate for children ages 19-35 months with 4:3:1:3:3:1:4 (76.9%) is lower than the Prevention Agenda benchmark (80.0%). The percentage of females 13 to 17 with three doses of HPV vaccine has increased from 36.1% at last assessment to 50.5% and is now in line with the Prevention Agenda benchmark of 50.0%. However, according to NYSIIS, in 2018 there were 1,316 missed opportunities to provide vaccine to this target group in 2018. Missed opportunities are times when the patient was in the office for an appointment but did not receive vaccines as recommended. Clinical care and public health stakeholders are working together to reduce missed opportunities.

Decreasing the incidence of STIs remains one of Clinton County's biggest challenges. There was a 450% increase in the number of gonorrhea cases in Clinton County, from 6 cases in 2017 to 33 cases in 2018. Investigations have yielded few answers. Increases in gonorrhea are especially alarming due to the increasing antimicrobial resistance with gonococcal treatment. Reported chlamydia cases in Clinton County saw a 10.3% increase from 2017 (273 cases) to 2018 (301 cases), after a slight decrease from 2016 (285 cases). Syphilis cases saw a slight decrease, from 9 reported cases in Clinton County in 2017 to 7 reported cases in 2018.

The local STI Coalition has focused on supporting expedited partner therapy (EPT) within the community as one potential approach to curbing new chlamydia cases and the drop seen most recently may be, at least in part, due to success of this new option. Through an informal survey with a convenience sample of local health care providers, 80% were offering EPT where appropriate. State approval for the use of EPT for gonorrhea is pending. The coalition has provided professional education and up-to-date guidance on EPT use to providers and local pharmacies and will continue to do this into the future as additional uses are approved.

The lowest number of tuberculosis (TB) cases ever reported in the U.S. occurred in 2018, with a provisional total of 9,029 TB cases reported and an incidence of 2.8 cases per 100,000 persons. During this same timeframe, the incidence of TB was 3.8/100,000 in NYS and in 1.2/100,000 in Clinton County. However, this rate is considered unstable due to the low number of cases overall.

**The incidence rate of chlamydia in Clinton County is**

**374.7**

**per 100,000.**

**This is an increase of 20 points in 2 years.**

*Source: NYS Department of Health*

In 2018, CCHD investigated 320 potential rabies exposures and 39 individuals received post- exposure vaccine. From 2014-2018, a total of 614 animals were tested for rabies but only 12 (2%) were positive for rabies, half of which were bats. Participation in local rabies clinics for pets continues to be high, with over 1,500 cats and dogs receiving vaccines at 2018 clinics. Ongoing education regarding the importance of pet rabies vaccination, approaches for safely capturing bats for testing and the need for timely reporting of potential exposures remain key components of CCHD rabies related health messaging.

# Community Health Assessment Process and Methods

## Overview

Described below is the process through which CCHD and CVPH solicited and took into account input from community residents and those who represent the broad interests of the community served, including the medically underserved, low income, and other disparate populations. Such community input was sought to:

- Understand the community's perceived significant health needs and concerns;
- Expand knowledge and gain insights on data findings;
- Identify barriers to accessing and receiving care; and
- Identify assets and resources within in the community.

The process of identifying the priority health care needs of the residents of Clinton County (e.g., the service area) involved health data analysis, review of common population profiles, consultation with key members of the community and direct resident input. CVPH and CCHD, the lead entities in the process, facilitated/ completed the following activities with the Clinton County community:

- Two community based, health focused surveys;
- Review of over 300 health indicators and a secondary data analysis;
- A Community Health Priority Setting Session;
- A Priority and Focus Area Finalization Process; and
- Creation of shared Action Plans.

In early 2019, the ARHN conducted a survey of selected stakeholders representing social service, education, government, and health service-providing agencies within a seven-county region. The survey requested that community stakeholders identify the top two health issues which they believe need to be addressed within their county and give insight into contributing factors that were most influential for those specific health concerns. During the same timeframe, CCHD conducted a health survey directly targeting residents of Clinton County. The results of both surveys were intended to provide an overview of regional needs and priorities, to inform future planning and the development of a shared health care agenda.

The health indicator data referenced is published by New York State and contains nearly 300 different health indicators. Since 2002, the ARHN has compiled and analyzed this data for the region, producing and sharing the reports with regional CHA committee members to inform healthcare and improvement planning. ARHN also provides members population profiles for consideration in the CHA process. The health indicators and provided profile are used as a starting point for the preceding Community Profile. Lead organizations have further developed this baseline profile by contributing additional discussion and reference to supporting and opposing factors influencing health and health improvement progress in our community.

A group of stakeholders was convened for a Health Priority Setting Session in June of 2019. Attendees were tasked with identifying the health priority areas most important for the Clinton County community to focus on collectively. The event was facilitated and hosted by CCHD and CVPH and consisted of a wide range of attendees representing various community sectors. A smaller group of stakeholders was convened following this event to finalize priority selections. A detailed description of this process is outlined in this section. Using the results of an indicator analysis, regional and local survey findings, other community assessments, and stakeholder input, shared action plans were created to address the identified health concerns.

For the first time, prior to finalization, the draft CSP/CHA/CHIP/IS document was shared with the community for a comment period. Facebook and Twitter posts announcing the release of the draft document were posted on October 26th, 2019. The comment period remained open for one week. The Facebook post had a reach of 478 views, received 27 engagements. Only 9 viewers clicked through to the posted document and no formal comments were received through this channel. The corresponding Twitter post announcing the draft document received 16 impressions but no formal engagements.

## Stakeholder Surveys

### Community Resident Survey Process – Clinton County 2019 Community Health Assessment Survey

The CCHD surveyed Clinton County residents to provide the CHA stakeholders with resident perspective about community health. Residents were asked to identify features of a strong, vibrant, healthy community; for their opinions on health, social and environmental challenges in the community; to identify health and social challenges and any barriers to medical care experienced by themselves or a family member within the past year; and for demographic information about individual respondents and their households.

The survey tool was adapted from the Clinton County 2016 Community Health Assessment Community Survey, developed by CCHD. Updates and revisions to the tool were completed in November 2018 and increased the survey's inclusivity in gathering data on health challenges and experiences of those with disabilities and aligned the tool with survey efforts in other regions of the UVM Health Network, thereby allowing data to be aggregated for the region. The fielded survey included 16 questions, 8 of which assessed demographics of the respondents; it was anonymous and no names, addresses or phone numbers were collected. CCHD utilized existing community partners to distribute the survey. It was made available as a web-based link which was shared via email. Paper copies of the survey were also distributed, as well as a small card with the web-based link URL and a poster with the web-based link and QR code. Survey development, fielding and analysis were completed over an 8 month period.

**Results of Clinton County Resident Survey**

A total of 1,573 responses were received, of which, 1,378 were complete surveys from Clinton County residents. Periodic reviews of demographic information provided by respondents during survey fielding allowed the CCHD to target specific pockets of the population not already reached, ensuring that responses received mirrored census data to the greatest extent possible. Final demographic analysis suggest a reasonable representative sample of the Clinton County population was reached.

Almost half of respondents identified overweight/obesity as a health challenge in the community, while just over 40% of respondents reported it as a health challenge experienced by themselves or a loved one within the past year. Interestingly, while substance abuse was the most commonly identified health challenge of concern in the community, identified by 60.2% of respondents, only 16.2% of residents reported substance abuse as a challenge experienced by themselves or a loved one within the past year. Conversely, while 2 in 5 (40.6%) respondents identified issues related to aging as a health concern experienced by themselves or a family member within the past year, only 24.2% of residents identified it as a health challenge in the community. Almost 86% (1,183) of residents reported at least one health challenge experienced by themselves or their families within the past year; most commonly reported were issues related to aging and overweight/obesity. In addition, almost 2 in 5 (37.1%) residents identified chronic disease as a challenge; almost 1 in 3 (29.8%) identified physical activity; and almost 1 in 4 (22.7%) identified access to dental care as a challenge. Over half (50.3%) of respondents reported experiencing at least one barrier to medical care for themselves or their family in the past year.

Approximately one-third of respondents identified good schools, livable wages, and a safe environment as the most important features of a strong, vibrant, healthy community. These features were closely followed by affordable housing, health care services and a clean environment. Younger respondents were more likely to name good schools as an important feature, whereas respondents aged 45 years and older were more likely to name health care services. While 82.7% (1,140) of respondents reported no difficulties, 17.3% (238) self-reported at least one disability.

While the survey was not framed around the *Prevention Agenda 2019-2024: NYS's Health Improvement Plan*, careful consideration was given to the responses in relation to the Prevention Agenda upon analysis so collected perspective could be successfully incorporated into health priority setting activities. When considered against this framework, there is considerable need for interventions that assist residents in managing chronic diseases and accessing quality care, especially for mental and behavioral health services. In fact, the top six reported *Health Challenges of Greatest Concern in Our Community* and five of the top six self-reported health challenges align with the currently selected health priorities.

Further analysis of resident responses will continue to help health partners identify differences between communities and other subpopulations. This information will be

valuable as health improvement activities are developed and implemented.

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

**ARHN 2019 Community Stakeholder Survey**

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.

The survey was developed through *Survey Monkey* 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. CCHD and CVPH opted to personally reach out to all identified non-respondents to maximize participation. 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.

**Results of the ARHN Community Stakeholder Survey**

A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%; 81 or 20% of Clinton County stakeholders responded to the survey. To analyze the chosen priority areas, responses were totaled per county and the priority area that received the most responses was designated 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.

Community stakeholders were also 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%).

*Please see Appendix C for: Summary of 2019 Community Stakeholder Survey*

## Secondary Data Analysis

An analysis of [largely] secondary community health data was used to help identify the significant community needs for Clinton County. Included in this data are multiple population profiles (demographic, health system, education system, etc.) used to better understand the community under assessment. Provided health indicator data was grouped within the five NYS Prevention Agenda Priority Areas for ease of interpretation. Data from each Prevention Agenda Priority Area was considered for selection.

The health data sheets, featuring 271 indicators, provide an overview of population health as compared to the ARHN region, Upstate New York and New York State. The reports feature a status field that specifies whether indicators were met, better, or worse than the corresponding benchmarks. When indicators were worse than the applicable benchmark, their distance from each was calculated. On the report, distances from benchmarks were indicated using quartile rankings. All compiled metrics are featured in Appendix D.

Indicators were broken out by the Prevention Agenda Focus Areas, across ten categories. These include *Mortality, Injuries, Violence and Occupational Health, Built Environment and Water, Obesity, Smoke Exposure, Chronic Disease, Maternal and Infant Health, HIV, STD, Immunization and Infections, Substance Abuse and Mental Health,* and *Other.* Data and statistics for all indicators come from a variety of sources, including:

- NYS Prevention Agenda Dashboard
- Community Health Indicator Reports (CHIRs)
- NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators
- Division of Criminal Justice Services Index, Property, and Firearm Rates
- NYS Traffic Safety Statistical Repository
- Student Weight Status Category Reporting System (SWSCRS) Data
- USDA Economic Research Service Fitness Facilities Data
- NYS Department of Health Tobacco Enforcement Compliance Results
- State and County Indicators for Tracking Public Health Priority Areas
- NYS Department of Health, Asthma Dashboard – County Level
- NYS Department of Health Hospital Report on Hospital Acquired Infections
- NYS Office of Mental Health, PCS.

A full description of the Data Methodology utilized by ARHN and the CHA Committee is available for reference in Appendix E. All metrics were reviewed and a core group of metrics that were most relevant to the population of Clinton County were identified. Relevancy was based on metric performance (county placement compared to

regional/state/national performance and benchmarks) and relation to current or anticipated health improvement activities. These specific metrics were featured in a series of infographics displayed at the Health Priority Setting Session. When appropriate, primary data, collected by local partners, was also featured. One infographic was created for each Priority Area (see Appendix F). The same metrics were revisited during the Priority and Focus Area Finalization process.

Clinton County's performance in the ten referenced categories is listed below. Percentages represent the percent of indicators within each category that were worse than the benchmark.

1. Mortality – 64.29%
2. Smoke Exposure – 57.14%
3. Obesity in Children and Adults – 48.57%
4. Substance Abuse and Mental Health – 47.06%
5. Built Environment, Outdoor Air Quality, Water Quality – 44.44%
6. Chronic Disease – 26.67%
7. HIV, STDs, Immunizations, Infections – 26.67%
8. Maternal and Infant Health – 20.69%
9. Other – 12.50%
10. Injuries, Violence, and Occupational Health – 11.11%

## Community Health Priority Setting Session

Clinton County has a successful history of convening community stakeholders to assist in the identification of priority health issues. On June 26th, 2019 this approach was once again utilized. Approximately 200 Clinton County stakeholders, a 70% increase in invitees over 2016 activities, were invited to the Community Health Priority Setting Session facilitated by CCHD and CVPH. Clinton Community College in Plattsburgh, NY served as the location for the June 2019 event and was chosen specifically for its capacity to accommodate more guests and familiarity with the space among community partners.

The event was three hours in length but did not have a structured agenda like priority setting events in the past. Rather, attendees were free to come and go at any point throughout the morning. Attendees filtered through stations dedicated to the Prevention Agenda Priority Areas. Each station featured a colorful infographic depicting up-to-date data related to the area. Stations were manned by subject matter experts whose line of work aligned with the assigned priority area. Attendees had the opportunity to visit each station, read educational materials, and discuss current activities, progress and challenges with the subject matter experts. Once attendees had visited each station, they were asked to complete a short survey that captured their vote for which areas they believed were most important for Clinton County to address as a community over the next couple of years. The survey also captured their insights related to Focus Area selection.

The event was intentionally designed to encourage interaction between stakeholders from different community sectors. Approximately 55 stakeholders representing a minimum of eleven different sectors attended and shared their views. Sectors represented included community health care, public health, clinical healthcare, government, recreation, human services, planning, business, mental/ behavioral health, media and transportation. Special populations that were represented from within the attendee pool included seniors, low literacy, low income, individuals with disabilities, and youth. Participants' experience with the Prevention Agenda and involvement in community health planning varied. Excitingly, 46% of attendees reported this as their first time contributing to priority setting activities; 54% reported participating in past activities. Based on event feedback, 96% of attendees were satisfied or very satisfied with the event's format and 92% of attendees felt the Priority Area specialists and infographics at each station were helpful in learning more about health improvement work and concerns and in reviewing many metrics quickly. 100% of attendees were satisfied with the timeframe and location of the event.

Responses from health system and community partners participating in the June 15th Prioritization Session overwhelmingly selected *Prevent Chronic Disease* and *Promote Well-Being and Prevent Mental and Substance Use Disorders* as the top two Priority Areas for the next Community Service and Community Health Improvement Plans. Focus Area voting was far less definitive. To help clarify partner contributions relating to the focus areas, a smaller subcommittee was convened. The process they applied is explained in detail in the *Priority and Focus Area Finalization* section.

Participant characteristics, voting results, finalization findings and additional methodology applied in the processes described above can be found in Appendix G.

## Priority and Focus Area Finalization

To finalize Priority and Focus Area selections and to begin developing local strategies and related activities, a subcommittee consisting of members from the Action for Health Consortium and CVPH was convened. Selection finalization was based primarily on the following:

1. Results of stakeholder surveys outlined above;
2. Data analysis outlined above;
3. Health priority setting session outlined above;
4. Application of the Hanlon Method.

**Participants**

The subcommittee was chosen to represent people with community and clinical knowledge, with particular attention to include individuals who are knowledgeable about the needs assessment process, manage services to the underserved, or manage services that address an identified need.

**Process**

The subcommittee was convened on July 29th, 2019 to finalize Priority Area and Focus

Area selection. Members of the subcommittee noted the consistency in findings from the stakeholder survey, community survey, secondary data analysis and community priority setting session voting. Therefore, *Prevent Chronic Disease* and *Promote Well-Being and Prevent Mental and Substance Use Disorders* were accepted as selected Priority Areas for Clinton County.

To clarify the selection of Focus Areas, the subcommittee reconsidered key health metrics and voting input collected from the June 26th event related to the two selected Priority Areas. The members then individually applied the Hanlon Method to each Focus Area. The Hanlon Method is a quantitative process and a NACCHO supported prioritization tool that can be applied to rank specific health problems based on the criteria of: size of the health problem, seriousness of the health problem and effectiveness of interventions. From these ratings, a priority score is calculated using a method related formula. Individual scores were averaged to obtain final Hanlon Method scores.

Lastly, the subcommittee was asked to consider common disparities that influence health. Each were presented a list of seven disparities, which they ranked from 1-7, with one representing the disparity most apparent in our community and across priority areas.

**Outcomes**

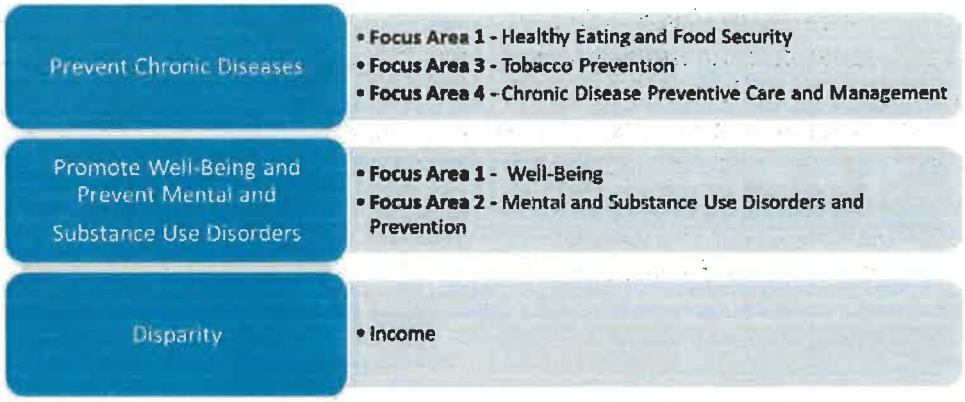
Hanlon Method scores isolated three focus areas under *Prevent Chronic Disease - Healthy Eating and Food Security, Chronic Disease Preventive Care and Management, and Tobacco Prevention.* Both focus areas from *Promote Well-Being and Prevent Mental and Substance Use Disorders* were selected. It was determined by the subcommittee that each of the selected focus areas would be addressed with its own action plan.

Of the seven disparities presented to the subcommittee for consideration, income was identified as the condition most significant in the Clinton County community, meaning the ability to afford health services and practice health behaviors is perceived as the top issue influencing health equity of Clinton County residents.

A summary of participants and finalization scoring results has been included in Appendix G.

## Significant Community Needs *(Aligning Secondary Data and Community Input)*

To identify the significant community needs, the results of the secondary data analysis were combined with the results of the community input and grouped by priority area. The priority areas, focus areas and disparity that emerged were as follows:




## Leveraging Community Assets and Resources

CVPH and CCHD understand the key to successfully impacting the health of Clinton County is partnering with the community and its organizations and combining resources. It is the intent of the lead partners that action plans capture the partnership, contributions and support of many community organizations to strengthen the impact of the planned interventions and assure the responsible use of limited resources. Clinton County is fortunate to have developed a strong network of partners representing many different community sectors and offering a variety of assets and capacities for achieving its shared vision for community health.

Throughout the community health needs assessment process, CCHD, CVPH and their partners have considered existing assets and resources that can be leveraged to help the community to continue to make progress in meeting its long range health goals. A collection of assets and resources identified through the assessment process, key informant dialogues and review of local coalitions/ partnership activities is included in Appendix H. Entries have been organized by common categories used for asset mapping. All assets/ resources listed are potential resources for the implementation of Clinton County's Community Health Improvement Plan and particular attention was given to identifying resources that could assist in engaging residents, disseminating messages, and maximizing reach into disparate/ high needs subpopulations.

## Action Plans

Lead staff from CCHD and CVPH have worked with partners to collect and organize activities and interventions that will address the identified health priorities. This was done utilizing a variety of methods: review of current CHIP/IS activities and progress as well as those of other shared work plans (ie. Community Services Plan), individual meetings with key partners, emails soliciting suggestions and contributions of related activities from AFH participants, and review of information collected from the priority setting event and directly from residents through the survey process. Information was then organized by

goals/ objectives within each focus area, resulting in five action plans and formatted following NYSDOH guidance and provided tools. These action plans become CCHD's CHIP and CVPH's IS for the next three years.

It is impossible to feature all the health improvement work that will occur in Clinton County over the next three years in the Action Plans. Much thought is given to the featured interventions; often it is the items that best demonstrate the local commitment to collective impact work, innovation, and cross-system collaboration. There is also an intentional blend of activities that will vary in duration. As such, there will be progress to acknowledge and celebrate perpetually. This also allows new interventions to be considered and added regularly based on emerging local needs and resources. Target programs and locations for the featured interventions are determined by a number of factors including review of health indicator data, especially to identify high needs populations and areas within the county, and feasibility of activities meeting success (existence of potential sites, accessibility, receptiveness, etc.). Featured interventions and projected outcomes are influenced by partner resources including staff, funding and expertise.

As the CHA process is a recurring cycle and the identified health priorities for this cycle maintain the current course, the new action plans feature a combination of interventions that are carrying over into the new action cycle along with new activities that build off successes and progress realized to date. The final update to the 2016-2018 CHIP/IS, which captures progress through 2019, can be reviewed in Appendix G.

## Maintaining Engagement & Tracking Progress

Active engagement with others in the community to implement change is challenging given diminishing resources and competing priorities. The process of setting shared goals and creating collective action plans has helped define partner roles and has improved the use of available resources. Efficient and effective use of existing assets requires unprecedented collaboration and cooperation by everyone, not just by the agencies or organizations whose primary missions directly relate to health issues. Higher level decision makers from agencies and organizations in the community now participate in the process demonstrating an actionable level of commitment to the health of the community not seen in the past. Increased capacity for community assessment work has allowed more partners, including residents, to be included in the process and through a number of channels.

Clinton County's collaborative strategy can be traced back to the mid 2000's when the Mobilizing for Action through Planning and Partnerships (MAPP) process was first used locally. Clinton County MAPP partners have evolved into the Action for Health Consortium. This group has representatives from a wide variety of community sectors that have implemented effective policy, systems and environmental strategies for over a decade, for the purpose of improving community health. A full description of this group is available earlier in this document.

It has become standard practice for AFH to assemble subcommittees of partners possessing

technical and professional expertise to implement and update priority area action plans. For example, in 2019, a diverse group of food environment stakeholders was convened for a discussion intended to identify next steps for improving the local food system. Members of identified subcommittees and participants of brainstorming work sessions bring subject matter expertise to the AFH Consortium. It is the intent of CVPH and CCHD to continue to use the developed model of partner engagement described while also always seeking ways to improve processes for all involved.

Formal progress updates on the CSP/CHA/CHIP/IS are captured throughout the year and summarized in an annual document, which is displayed on the CCHD and CVPH websites. During the last quarter of each year, responsible parties for each featured "activity" submit a progress update to the AFH Consortium. Activities are then categorized as "completed" or "in progress". When applicable, new activities are integrated into the plan each year and often reflect progress and rely on emerging resources. Annual updates serve as a means of celebrating successes and motivating partners. Progress is reported out to the community at large through a semi-annual newspaper insert intended to maximize awareness of the plan and participation in activities by residents.

## Dissemination of Plan to the Public

CVPH and CCHD will actively disseminate the CSP/CHA/CHIP/IS to the public. The plan will reside conspicuously in PDF format in the "About" section of www.cvph.org. CCHD will post the CHA and CHIP in the *Statistical Data and Annual Reports* section of its webpage found at www.clintonhealth.org. Links to all documents and updates, when available, will be shared via social media and other media channels. Promotional efforts will then drive the community to these locations to view and download the assessment and related plans. Promotional efforts will include a press release sent to all local media outlining the plan; interviews with the media (as appropriate); regular posts on social media sites such as Facebook and Twitter; and mentions in a variety of print and online communications produced by CVPH and CCHD.

CCHD will, as it has in the past, dedicate an edition of its *Public Health Profiles* to the new CHA/CHIP. The short overview document will highlight priority areas, planned work, and partners. It will also provide specific calls to action for residents, health professionals, and community leaders. This document will be posted on CCHD's website and promoted through the standard mechanisms referenced above. Other communication efforts and channels will be considered throughout the year to help increase awareness of shared, community level health improvement plans among partners and residents alike.

Notification will be sent to key stakeholders through a cover letter document announcing community members can access community health assessment related documents. In addition, community presentations will include:

- AFH members (and to their Directors or oversight Boards);
- Targeted local elected officials;

- Clinton County Board of Health;
- Foundation of CVPH;
- All other appropriate and identified community stakeholders.

Active and ongoing distribution and promotion throughout the community will maximize reach and awareness of these documents and shared plans for health improvement. Community presentations will highlight how residents and stakeholders informed the process and can contribute to collective efforts going forward. All dissemination activities will help build the grassroots need to address health improvement efforts across the county by engaging both traditional and nontraditional partners in sustainable and permanent community-based interventions.

## Evaluation Plan

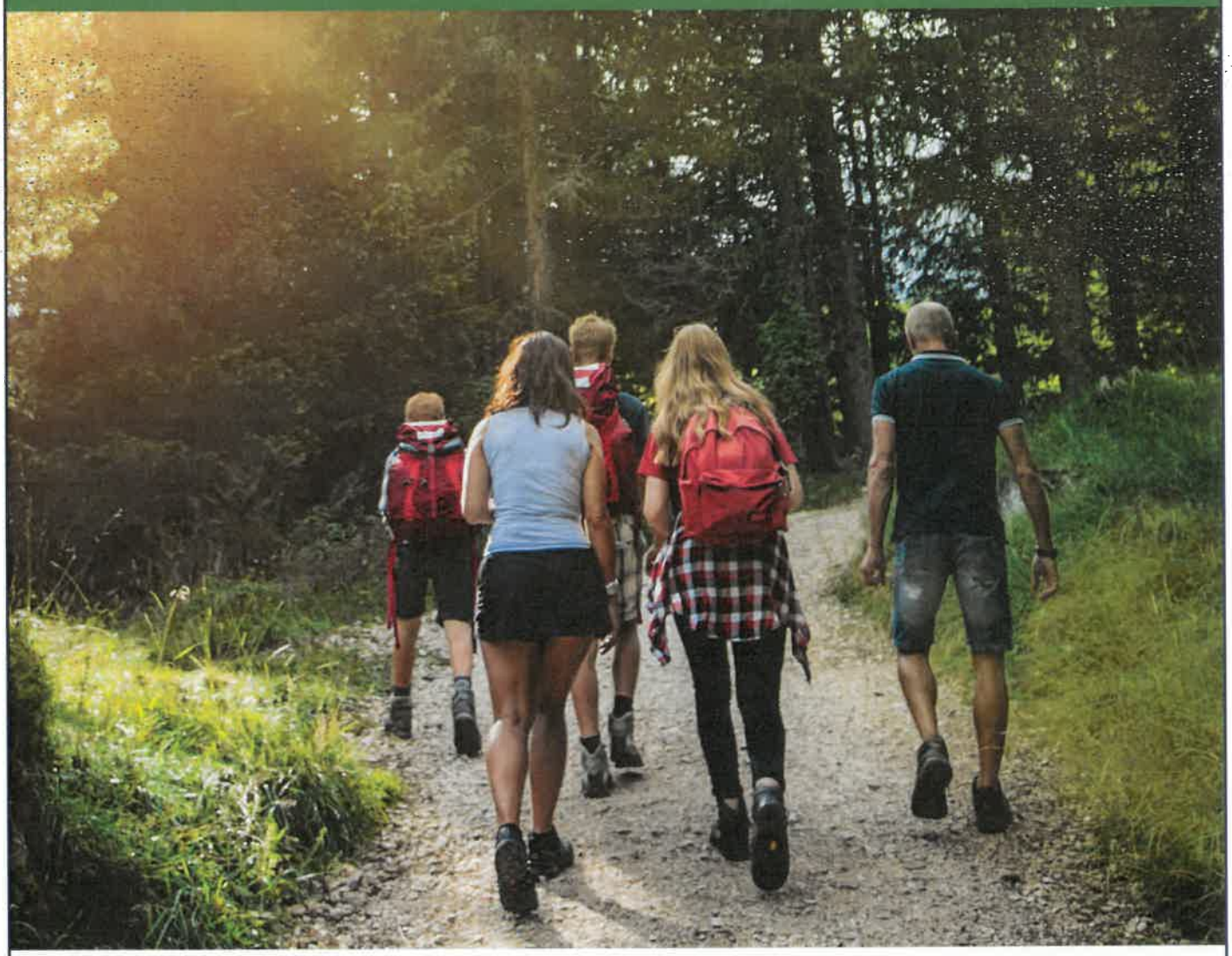
CCHD and CVPH use a number of process and outcome measures to evaluate the community health assessment process and health improvement progress. For example, prior to the assessment, goals are set for the number and demographics of residents reached through survey activities and stakeholder participation in priority setting events. Dates for completing each stage of the process keep all partners on track.

Progress on collaborative health improvement plans are tracked through regular discussions at AFH meetings. These on-going discussions allow new data, resources and emerging conditions to be considered; at times, mid-course corrections are made to assure activity goals and objectives are met. Each AFH meeting agenda is framed around the NYS Prevention Agenda to assure work related to all five priority areas is periodically captured. CCHD produces a formal annual update document that is shared with the community and categorizes featured activities by degree of completion. CCHD and CVPH use feedback from stakeholders to determine use and reach of all the formal documents (CHA/CHNA/CSP/CHIP/IS). On average for the past 4 years, approximately 60% of surveyed partners use these documents for strategic planning, 64% for staff education/ development, and 55% as a data resource. Partners also share these collaborative documents. One third share the documents annually with their advisory boards and link directly to them on their website (connecting directly to the documents on the CCHD or CVPH website); 16% embed the documents within their own websites. A quarter of partners retain hard copy documents in accessible spaces for staff reference/ use; a few partners (6%) display the documents in public spaces.

CCHD and CVPH will continue to monitor trends in use to best meet partner needs and maximize participation in the plans. Lead partners will also continue to look for new opportunities to learn about the effectiveness and efficiency in the current process, modifying the approach as appropriate.

## Hospital Approval

The Business Operations Manager worked with Senior Leadership to present the CHNA and IS, which were combined to create the Community Service Plan, to the Board of Directors of CVPH. The Board was provided with the Executive Summary of the documents in advance of the meeting, as well as the action plan that is associated. A brief presentation was conducted at the meeting to communicate highlights and answer questions. All documents were approved on December 17, 2019. Upon request, the signed documents can be provided.



# Community Health Improvement Plan/Implementation Strategy

## Working Together to Strengthen Our Community

CCHD

Clinton County HEALTH Department

THE University of Vermont HEALTH NETWORK

Champlain Valley Physicians Hospital

# 2019-2021 Community Health Improvement Plan and Implementation Strategy

## NYS Department of Health Prevention Agenda Priority Area: Prevent Chronic Disease

**Focus Area:** Preventive Care and Management

| |
|---|
| Goal: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity |
| **Objective:** Promote evidence based medical management in accordance with national guidelines. (Baseline NA) |
| Goal: In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity |
| **Objective:** Increase the percentage of adults with chronic conditions who have taken a course or class to learn how to manage their condition. (Baseline variable by intervention or NA) |

| Interventions/Activities | Partners (Role) | Measures | Disparity* | |
|---|---|---|---|---|
| Coordinate at least one QI project with local primary care providers with a community education campaign. | CCHD- co-lead, community campaign creation, facilitation<br>Adk ACO- co-lead, data, access to providers, QI project support | # of participating PCPs, # of community messages, message reach, pre/post evaluation scores | | |
| Provide community education on HPV vaccine. | CVPH Fitzpatrick Cancer Center | Grant application submission date, #'s reached, # of events hosted/attended | | |
| Expand CVPH's Diabetes Prevention Program (DPP) into the community. | CVPH, YMCA | MOU execution date | Access | |
| Coordinate referrals to the local DPP. | CVPH, YMCA, CVPH Health Center, NCHHN | # of referrals received, # of referring partners, program dates, # enrolled, # completing the program, participant evaluation/ feedback | Access | |

**Focus Area:** Healthy Eating and Food Security

| |
|---|
| **Goal:** Reduce obesity and the risk of chronic disease |
| **Objective:** Decrease the percentage of adults ages 18 years and older with obesity. (Baseline 36.7%, *Prevention Agenda Dashboard*) |
| **Objective:** Increase the percentage of adults with perceived food security. (Baseline rate for Adults Experiencing Food Insecurity 20.9%, *NYS BRFSS*) |

| Interventions/Activities | Partner (Role) | Measures | Disparity* | |
|---|---|---|---|---|
| Develop a collaborative, comprehensive food action plan. | CCHD- lead facilitator for brainstorming, collecting and organizing ideas; Action for Health partners and food environment stakeholder as partners | # of partners engaged in the process, date plan is finalized, date plan is presented to partners/ community | | |
| Facilitate worksite wellness policies (goal 3-4 sites/year) | CCHD- staff, policy experience, templates, etc.<br>CC worksites | # worksites approached, # of sites recruited, # of policies executed, # of employees impacted | | |
| Assist local school districts in reviewing and updating district level wellness policies (goal - at least 2 districts/yr) | CCHD- staff, policy experience, templates, etc.; school districts & wellness committees as partners | # of schools approached, # of policies updated, policy execution dates, # students impacted | | |
| Offer on-going opportunities to increase food selection and preparation skills (ie. Cooking classes, etc.) | collaborative effort- CCHD, CCE, CCMH&AS for staff, space, class resources, registration, evaluation tools, etc. | # classes offered, # registered, % capacity, post evaluation data | Access, Ability | |
| Educate local health, human and social services professionals on food security screening and local resources. | CCHD- staff, evaluation; CCMH&AS- funding, staff support | # of organizations trained, # of professionals in attendance, community reach, pre/post evaluation metrics | | |
| Establish a locally sensitive data monitoring system for food insecurity through the pediatric primary care. | CCHD- staff, data aggregation, analysis | # of offices approached, # of practices screening, % of peds patients/ families screened, # of offices providing de-identified reports for aggregated data | | |

**Focus Area:** Tobacco Prevention

| |
|---|
| Goal: Promote tobacco use cessation |
| **Objective:** Decrease the prevalence of smoking by adults ages 18 years and older. (Baseline 24.7%, *Prevention Agenda Dashboard*) |
| Goal: Prevent initiation of tobacco use |
| **Objective:** Decrease the prevalence of any tobacco use by high school students. (Baseline TBD, *Youth Risk Behavior Survey*) |

| Interventions/Activities | Partner (Role) | Measures | Disparity* | |
|---|---|---|---|---|
| Complete public health detailing visits with primary care providers aimed at increasing use of the NYSDOH "Talk to Your Patients" intervention | NCHHN- lead, TURN partners- support | # of practices accepting detailing visits, # of providers impacted | | |
| Present local smoking data and policy solutions at the County Legislative Health Committee meeting and at municipality board meetings | Tobacco Use Reduction Network (CCHD, AHI, TFCFE, NCHHN, UVMHN-CVPH)- lead | Dates of legislative and municipal meetings, of municipal districts receiving presentations, community reach | | |
| Offer tobacco cessation assistance through Certified Tobacco Treatment Specialists | CVPH- lead | # of patients impacted, development of vaping "quit kit", collaboration w/ community entities on cessation | | |
| Facilitate Tobacco Free Workplace designations | Tobacco Free Clinton Franklin Essex/ Reality Check- lead; local employers & staff | # of worksites, # of staff impacted | | |
| Facilitate smoke free housing designations | Tobacco Free Clinton Franklin Essex/ Reality Check- lead; local landlords of multi-unit housing | # of housing units designated, # of residents impacted | | |
| Provide "Nothing New Under the Sun" presentations to students, parent groups and school staff | Tobacco Free Clinton Franklin Essex/ Reality Check- lead | Dates of presentations, # of districts participating, # of students impacted | | |

## NYS Department of Health Prevention Agenda Priority Area: Promote Wellbeing and Prevent Mental and Substance Use Disorders

**Focus Area:** Promote Wellbeing

Goal: Strengthen opportunities to build well-being and resilience across the lifespan.

Goal: Facilitate supportive environments that promote respect and dignity for people of all ages.

**Objective:** Reduce the age-adjusted percentage of adult Clinton County residents reporting 14 or more days with poor mental health in the last month to 10.7% (NYS average). (Baseline: 14.8%, *Prevention Agenda Dashboard*)

| Interventions/Activities | Partner (Role) | Measures | Disparity* | |
|---|---|---|---|---|
| Embed outpatient services within the UVMHN-CVPH Behavioral Health Unit (establishment of a Medical Village for comprehensive, coordinated inpatient and outpatient mental and behavioral health services). | CVPH- lead facilitator | Dates of legal/ construction milestones, | Access | |
| Create and sustain inclusive, healthy public spaces (indoor walking trails, SRTG expansion/spur projects) | CVPH/ Foundation of CVPH- lead facilitator | # of promotions, construction benchmarks, space utilization metrics | Ability | |
| Support at least two educational or social events annually (ex. Live Well, Be Well) to reduce stigma and encourage integration and inclusion for those recovering from substance use and other disorders. | CCMH&AS- lead facilitator, supported by SPARCC partnership | event dates, # of partners promoting events, # in attendance (reach) | Ability | |
| Facilitate complete streets and active transportation policies and resolutions that focus on inclusion and integration for residents of all ages and abilities. | CCHD-Lead facilitator, process expertise, template resources, project funding, collection of resident input/ feedback, education with local decision makers | # of resolutions/ policies executed, # of inclusive projects undertaken, qualitative resident input/feedback | Ability, Aging | |

**Focus Area:** Prevent Mental and Substance Use Disorders

| |
|---|
| Goal: Prevent opioid overdose deaths |
| **Objective:** Reduce emergency room visits (including outpatient and admitted patients) involving opioid or other substance misuse, age adjusted rate by 5%. (Baseline TBD, CVPH) |
| Goal: Prevent and address adverse childhood experiences |
| **Objective:** Increase communities reached by opportunities to build resilience by at least 10%. (Baseline variable for intervention or NA) |

| Interventions/Activities | Partner (Role) | Measures | Disparity* | |
|---|---|---|---|---|
| Community will support appropriate referrals to maintain >=90% capacity @ CVFC Stabilization and Rehabilitation Center. | CVFC- lead facilitator, center oversight and management | estimated capacity (quarterly, annually), # of referrals to facility, # of referring agencies | Access | |
| Establish a peer run recovery center at MHAB (transitional housing) as part of a multi-year effort to develop a full skills-building campus. | CVFC- lead facilitator, center oversight and management, peer training | # of trained peers, date of opening, # enrolled/ participating in programming | Access | |
| Host a Peer Recovery training. | CVFC- lead facilitator, training coordination | date of training, # of peers trained, | | |
| Establish a Drug User Health Hub Buprenorphine Bridge Clinic | AFPH- lead facilitator (seeking funding, securing space, training staff, day-day management of clinic) | funding, space secured; opening date, # referrals received, # served | Access | |
| Integrate CRAFFT screening into the pediatric primary care setting. | Pediatric care providers- integration and use, staff training. | # of pediatric practices screening, % of patients screened | | |
| Provide at least one Transforming Trauma/ Adverse Childhood Experience public event annually to increase awareness and management of ACEs. | CCMH&AS lead facilitator, other supporting agencies from the Transforming Trauma in our Community Collaborative and SPARCC | Date of event, # of partners promoting/ supporting, attendance | | |
| Expand use of the PAX Good Behavior Game to 100% of CVES classrooms; expand program usage to at least 3 additional schools | CCMH&AS- lead facilitator, CVES & additional school districts- implementation partners | # of classrooms engaged, # of students impacted, # of school districts participating | | |

*Low-income has been identified as Clinton County's most prevalent cross cutting disparity and is considered in the development and implementation of all activities. Activities that target or benefit additional disparate populations have been identified.

# Appendices

# Appendix A:

## Community Health Needs Assessment Stakeholder Groups
### Committee Members and Meeting Schedules

**Action for Health Consortium Members**

| | |
|---|---|
| Diana Aguglia | Alliance For Positive Health |
| Maria Alexander | Senior Citizens Council |
| Sara Allen | Clinton County Health Department, Contractor |
| Joy Arana | Citizen, Licensed Social Worker |
| Maryann Barto | Clinton County Health Department, Environmental Health Division |
| Laurie Booth-Trudo | Child Care Coordinating Council of the North Country |
| Kara Bordeau | CVPH Wellness and Fitness Center |
| James Bosley | Clinton County Planning/Clinton County Public Transit |
| Donna Boumil | Village of Rouses Point |
| Mary Breyette | Cornell Cooperative Extension |
| Rachel Brown | Senior Citizens Council |
| Dana Bushey | Champlain Valley Family Center |
| Jessica Chanese | Adirondack Health Institute |
| Nichole Christiansen | Champlain Valley Family Center |
| Darleen Collins | Clinton County Office for the Aging |
| Erin Conner | Behavioral Health Services North |
| Dot Crawford | Interfaith Food Shelf |
| Rheannon Croy | Alliance for Positive Health |
| Lisa Cyphers | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Melanie Defayette | Town of Plattsburgh Recreation Department |
| Karen Derusha | Clinton County Health Department, Health Planning & Promotion Division |
| Bob Dickie | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Adele Douglas | Town of Peru Community Development Coordinator |
| Andrew Foster | Behavioral Health Services North |
| Richelle Gregory | Clinton County Mental Health and Addictions |
| Kerry Haley | The Foundation of CVPH |
| Mark Hamilton | City of Plattsburgh Housing Authority |
| Karen Kalman | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| John Kanoza | Clinton County Health Department, Administration |
| Victoria Knierim | Adirondack Health Institute |
| Dorothy Latta | Plattsburgh Interfaith Food Council |
| C. Allan McCoy | SUNY Plattsburgh |
| Catherine McFarland | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Gizelle Menard | University of Vermont Health Network-Champlain Valley Physicians Hospital |

| | |
|---|---|
| Brian Minchoff | Clinton County Mental Health and Addictions |
| Megan Murphy | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Erin Pangborn | Town of Plattsburgh Recreation Department |
| Steve Peters | Elevate 518 |
| Joyce Porter | Adirondack Health Institute |
| Robert Poulin | North Country Center for Independence |
| Sara Rowden | Citizen |
| Scott Ruch | Champlain Valley Family Center |
| Shawn Sabella | Behavioral Health Services North |
| Shey Schnell | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Margaret Searing | Clinton County Health Department, Administration |
| Courtney Shaler-Smith | Adirondack Health Institute |
| Terra Sisco | Clinton County Youth Bureau |
| Mandy Snay | Clinton County Health Department, Health Planning and Promotion |
| Kathy Snow | United Way of the Adirondack Region |
| Sally Soucia | Joint Council For Economic Opportunity |
| Julie Stalker | Joint Council For Economic Opportunity |
| Kaitlyn Tentis | University of Vermont Health Network-Champlain Valley Physicians Hospital |
| Trevor Cole | Town of Plattsburgh Planning Department |
| Lee Vera | Eastern Adirondack Health Care Network |
| Laurie Williams | The Foundation of CVPH, Contractor |
| Steve Williams | Hannaford Supermarket |

**Action for Health Consortium 2018-2019 Meeting Schedule**

January 10, 2018
March 14, 2018
May 16, 2018
July 11, 2018
September 12, 2018
November 14, 2018
January 16, 2019
March 13, 2019
May 15, 2019
July 17, 2019
September 18, 2019
November 13, 2019

**Tentative 2020 Meeting Dates**

January 15, 2020
March 11, 2020
May 13, 2020
July 15, 2020
September 16, 2020
November 18, 2020

## Adirondack Rural Health Network Community Health Assessment

### Committee Members

| Name | Organization |
|---|---|
| Heidi Bailey<br>Dan Hill<br>Tim Lamay | Adirondack Medical Center |
| Cathleen Traver | Glens Falls Hospital |
| Cheryl McGrattan<br>Tammy Merendo | Nathan Littauer Hospital |
| Ginger Carriero<br>Annette Marshall | University of Vermont Health Network – Alice Hyde Medical Center |
| Kaitlyn Tentis<br>Debra Good<br>Gregory Freeman | University of Vermont Health Network - Champlain Valley Physicians Hospital |
| Heather Reynolds<br>Julie Tromblee<br>Alyson Arnold<br>Amanda Whisher | University of Vermont Health Network - Elizabethtown Community Hospital |
| Sara Deukmejian | Adirondack Health Institute |
| John Kanoza<br>Mandy Snay | Clinton County Health Department |
| Linda Beers<br>Jessica Darney Buehler<br>Susan Allott | Essex County Public Health |
| Katie Strack<br>Sarah Granquist | Franklin County Public Health |
| Laurel Headwell<br>Angela Stuart Palmer<br>Alyssa Craig | Fulton County Public Health |
| Dr. Erica Mahoney<br>Daryl Parslow<br>Carriann Grexa-Allen | Hamilton County Public Health |
| Ginelle Jones<br>Dan Durkee<br>J'nelle Oxford | Warren County Health Services |
| Patty Hunt<br>Kathy Jo Mcintyre | Washington County Public Health |

### Meeting Dates

| 2017 | 2018 | 2019 |
|---|---|---|
| March 22 | June 15 | March 8 |
| June 8 | September 11 | June 7 |
| September 8 | December 7 | September 6 |
| December 15 | | December 6 |

# Appendix B:

## Clinton County 2019 Community Health Assessment
## Community Survey Summary

October 2019

## Introduction

The Clinton County Health Department (CCHD) surveyed Clinton County residents to provide the Community Health Assessment (CHA) stakeholders with resident perspective about community health. Residents were asked to identify features of a strong, vibrant, healthy community; for their opinions on health, social and environmental challenges in the community; to identify health and social challenges and any barriers to medical care experienced by themselves or a family member within the past year; and, for demographic information about individual respondents and their households.

## Methods

The Clinton County 2019 Community Health Assessment Community Survey was adapted from the Clinton County 2016 Community Health Assessment Community Survey, developed by CCHD. The survey team consisted of a Senior Public Health Educator, Principal Public Health Educator, and Director of the Division of Health Planning & Promotion; student nurses and other CCHD staff were used throughout the process to field the survey and offer perspective on findings. In coordination with the University of Vermont Health Network-Champlain Valley Physicians Hospital (UVM Health Network-CVPH), CCHD staff reviewed the Clinton County 2016 Community Health Assessment Community Survey along with a community survey recently completed by the UVM Health Network in Vermont. The surveys were found to be very similar, with slight differences in the phrasing of questions and answer choices available.

Notable changes from Clinton County's 2016 Community Survey to the 2019 version include: rephrasing questions asking about "issues" to "challenges"; the addition of response options, based on those present in the Vermont survey as well as what respondents filled in under "other" in the 2016 Community Survey; and the addition of a question defining a healthy community. A question addressing cancer care within the community was also included to assist the Fitzpatrick Cancer Center in fulfilling requirements. This question along with the entire survey tool was aligned with data collected in community surveys throughout the UVM Health Network, allowing responses to be aggregated. Lastly, the demographic section was expanded to include a disability question. With guidance from a Program Analyst for Health and Disability with the National Association of County and City Health Officials (NACCHO), the six standard disability questions[1], used for the U.S. Census and other national surveys, were incorporated into one multiple choice question. In total, the survey included sixteen questions, eight of which assessed demographics of the respondents. However, the survey as anonymous; no names, addresses or phone numbers were collected from respondents. A pdf of the survey is attached to this report. Survey development, fielding and analysis were completed over a five-month period.

[1] Disability and Health - Disability Data | CDC. Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/disabilityandhealth/datasets.html. Accessed November 6, 2018.

The CCHD utilized existing community partners to distribute the survey. It was made available as a web-based link which was shared via email. Paper copies of the survey were also distributed, as well as a small card with the web-based link URL and a poster with the web-based link and QR code. An email with the web-based link URL was sent to many partners throughout the county, including: Clinton County employees, Action for Health Consortium members, Town Supervisors and Mayors, School Superintendents, SUNY Plattsburgh faculty, and Chamber of Commerce registered employers. Survey fielding was also completed in-person at numerous agencies and events within the community. Sites included: University of Vermont Healthcare Network Champlain Valley Physicians Hospital, Childcare Coordinating Council of the North Country, Clinton County Nutrition Program for the Elderly Congregate lunch sites, CCHD WIC Program, Behavioral Health Services North Healthy Minds Healthy Bodies group, and Interfaith Food Shelf. Events included the 2019 Food from the Farm event.

The CCHD utilized SUNY Plattsburgh nursing interns to expand capacity and assist with survey fielding throughout the county. Some agencies also facilitated completion of surveys by their clients, including Cornell Cooperative Extension and Clinton County Office for the Aging. Additionally, letters with the web-based link URL and posters with the web-based link URL and QR code were distributed to Clinton County Libraries. A news release was distributed to local media outlets. This release was followed by a television interview with NBC5, a local television station, and a radio interview with WBNZ, a local radio station. CCHD used its Facebook, Twitter and Instagram pages to promote the survey, providing the web-based link URL to followers, and encouraged local municipalities and school districts to share posts on their social media platforms.

Survey respondents were first asked for their definition of a healthy community; specifically, *"When you imagine a strong, vibrant, healthy community, what are the most important features you think of?"* and asked to choose up to three of seventeen identified features. The survey then assessed health, social and environmental challenges within the community. Residents were asked to choose up to five health challenges (from nineteen identified challenges) that they feel are of greatest concern in the community. They were then asked to choose up to five social challenges (from twenty-two identified challenges) and up to five environmental challenges (from fourteen identified challenges) that they feel are of greatest concern in the community. The survey then asked respondents what individual health and social challenges they or a family member experienced in the past year, and instructed them to check all that apply (from a list of nineteen possible health challenges and twenty-two possible social challenges). Respondents were also asked about barriers to medical care; specifically, *"If there was a time in the past year that you or a family member needed medical care but could not get it, why did you not get care?"* and instructed to select all that apply from a list of fourteen identified possible barriers. Lastly, respondents were asked (based on their experiences with cancer care) to select the cancer services they feel are missing or lacking in the community, and provided a list of twenty-five possible services. In each section an "other" option allowed residents to fill-in a response if their challenge or concern was not listed. The survey then requested that respondents complete eight demographic questions, which collected information on their gender, age, city/ town of primary residence, primary language spoken in the household, race/ethnicity, highest level of education, the household's annual income, and disabilities. CCHD made a concerted effort to reach a representative sample of all Clinton County residents. A periodic review of demographic information provided by

respondents during survey fielding allowed the CCHD to target specific pockets of the population not already reached, ensuring that responses received mirrored census data to the greatest extent possible.

Analysis for this report was conducted by CCHD Health Planning & Promotion (HPP) staff. During analysis, open-ended responses in which the respondent mentioned an offered response but did not mark were manually categorized by staff. Survey findings were formally shared with stakeholders during the 2019 Clinton County Community Health Assessment Priority Setting Session to assist event attendees in selecting priority health areas for the 2019-2021 Community Health Improvement Plan and Community Services Plan.

## Findings

A total of 1,573 responses were received, of which, 1,378 were complete surveys from Clinton County residents. Incomplete surveys and those completed by non-residents were not included in results findings.

*Demographics of Survey Respondents*

While Clinton County is comprised of approximately 48.7% females and 51.3% males[2], just over three-quarters of survey respondents (75.7%) identified as female, with only 23.7% (320) of respondents identifying as male. In addition, 0.44% (6) respondents identified as non-binary, and 0.15% (2) chose "other." Twenty-eight (2.03%) respondents preferred not to identify their gender (see *Table 1* and *Figure 1*). In regards to age, survey respondents more closely mirrored the composition of Clinton County residents; however, individuals aged 18-24 years were slightly underrepresented. While there were no restrictions prohibiting survey completion by any age group, the survey did not specifically target residents 17 years and younger. Persons 17 years and under represent just over 19% of the County's population[2], therefore, a higher percentage of each of the other age groups were targeted accordingly. Five percent (63) of survey respondents were 18-24 years; 37% (514) were 24-44 years; 42% (572) were 45-64 years; 12% (169) were 65-79 years; and 3% (47) were 80 years and older (see *Table 1* and *Figure 2*).

According to the 2010 U.S. Census[2], almost 40% of Clinton County's population resides in just two of fifteen municipalities, namely the City and Town of Plattsburgh. Due to the rural geographic nature of the county, a concerted effort was made to reach a representative sample of residents from each of the townships within the county. See *Table 1* and *Figure 3* for a comparison of survey respondents by township and Census population by township. Approximately 46.5% (641) of survey respondents reside in the City or Town of Plattsburgh.

Of the 1,378 survey respondents, over 99% (1,371) identified English as the primary language spoken in their home. Other primary languages spoken in the households of respondents included: Spanish (2), French (1), Russian (1), German (1), and American Sign Language (1); one respondent preferred not to identify the primary language spoken in their household (see *Table 1*).

[2] Data Access and Dissemination Systems (DADS). American FactFinder. United States Census Bureau. https://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml?src=bkmk. Published October 5, 2010. Accessed January 9, 2019.

Respondents were asked to identify their race/ethnicity and instructed to select all that apply; therefore, responses for this demographic will not total 100%. Of the 1,378 survey respondents, 64 (4.6%) preferred not to identify their race/ethnicity. Ninety-seven percent (1,278) of the 1,314 respondents were White. Two percent of respondents (27) were American Indian, 1.4% (19) were Hispanic, Latino or Spanish origin, 0.8% (10) were Black or African American, 0.8% (10) were Asian or Pacific Islander, and one respondent selected "other" and noted "Mexican" (see *Table 1*). While survey respondents appear to be less racially and ethnically diverse than that of Clinton County residents indicated by the 2010 U.S. Census[2] (with 93.9% identifying as White, 4% as Black or African American, and 2.5% as Hispanic, Latino, or Spanish origin), it should be noted that the Census also includes prison populations, which were not a target population of our survey. According to the 2010 U.S. Census[2], 3,340 Clinton County residents resided in prisons (primarily in the Town of Dannemora). Across the U.S., the racial and ethnic make-up of incarcerated populations is often different than that of the community as a whole; when included in census data, ethnicity percentages may be skewed.

The highest level of education completed by survey respondents was diverse; 4.1% (56) completed some high school but did not finish; 13.4% (184) obtained a high school diploma or GED; 29.7% (408) completed some college or obtained a technical or trade school certificate, or an Associate's degree; 22.7% (312) obtained a Bachelor's degree; and 30.1% (413) obtained a Graduate's degree. One respondent reported eighth grade as their highest level of education, and 4 respondents preferred not to identify their highest level of education (see *Table 1*). Comparatively, according to U.S. Census data[2], of the Clinton County population 25 years and older, 8.7% completed some high school but did not finish, 37.1% obtained a high school diploma or GED, 27.8% completed some college or obtained an Associate's degree, 11.3% obtained a Bachelor's degree, and 10.6% obtained a Graduate's degree.

The household annual income reported by respondents also varied; 5.5% (68) reported a household annual income of less than $10,000; 9.4% (116) reported $10,000-$24,999; 18.5% (228) reported $25,000-$49,000; 33.5% (412) reported $50,000-$99,999; 22.3% (274) reported $100,000-$149,000; and 10.7% (132) reported $150,000 or more. Of the 1,378 survey respondents, 148 (10.7%) preferred not to provide their household's annual income (see *Table 1*). This is comparative to Census data[2], which indicates that of the 31,680 households in Clinton County, 6.8% have annual incomes of less than $10,000; 16.% $10,000-$24,999; 24.7% $25,000-$49,999; 33.1% $50,000-$99,999; 12.4% $100,000-$149,000; and 6.8% $150,000 or more.

While 82.7% (1,140) of respondents reported no difficulties, 17.3% (238) reported at least one disability. Respondents were asked to select all that apply, therefore, responses for self-reported disabilities will not total 100. According to the Centers for Disease Control and Prevention (CDC)[3], 22.2% of adults in New York have some type of disability. The most commonly reported disability among survey respondents was related to mobility, or serious difficulty walking or climbing stairs (44.5%), followed closely by cognition, or serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition (43.3%). In addition, almost 34% (80) indicated difficulty completing errands alone

[3] Disability & Health U.S. State Profile Data: New York | CDC. Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/new-york.html. Accessed October 11, 2019.

(such as visiting a doctor's office or shopping) because of a physical, mental, or emotional condition; 24.8% (59) identified as deaf or having serious difficulty hearing; 13% identified as blind or having serious difficulty seeing (even when wearing glasses); and 7.1% (17) reported difficulty dressing or bathing (see *Table 1* and *Figure 4*). Survey findings align with NYS and national metrics related to frequency in which disabilities are experienced, in order-mobility, cognition, independent living, hearing, vision, self-care. This further supports the assertion a representative of the population was reached with this survey. Disabilities were more commonly reported among individuals 65 years of age and older and those reporting an annual household income of less than $25,000.

*Definition of a Healthy Community*

Approximately one-third of respondents identified good schools, livable wages, and a safe environment as the most important features of a strong, vibrant, healthy community. These features were closely followed by affordable housing, health care services and a clean environment (see *Table 2* and *Figure 5*). Respondents aged 18 to 44 years were more likely to name good schools as an important feature, whereas respondents aged 45 years and older were more likely to name health care services. In addition, female respondents were more likely to identify good schools as an important feature, whereas male respondents were more likely to name economic opportunities.

*Challenges Identified*

Almost half of respondents identified overweight/obesity as a health challenge in the community, while just over 40% of respondents reported it as a health challenge experienced by themselves or a loved one within the past year. Interestingly, while substance abuse was the most commonly identified health challenge of concern in the community, identified by 60.2% of respondents, only 16.2% of residents reported substance abuse as a challenge experienced by themselves or a loved one within the past year. Conversely, while 2 in 5 (40.6%) respondents identified issues related to aging as a health concern experienced by themselves or a family member within the past year, only 24.2% of residents identified it as a health challenge in the community. Almost 86% (1,183) of residents reported at least one health challenge experienced by themselves or their families within the past year; most commonly reported were issues related to aging and overweight/obesity. In addition, almost 2 in 5 (37.1%) residents identified chronic disease as a challenge; almost 1 in 3 (29.8%) identified physical activity; and almost 1 in 4 (22.7%) identified access to dental care as a challenge. See *Table 3* and *Figure 6* for health challenges identified in our community, and *Table 6* and *Figure 9* for health challenges experienced by residents.

Over half (50.3%) of respondents reported experiencing at least one barrier to medical care for themselves or their family in the past year. The most commonly reported barriers, identified by almost 1 in 3 respondents, included: not having dental or vision insurance (32.8%), co-pays or deductibles that were too high (31.9%), and no specialist available locally (30.4%). In addition, almost 1 in 5 respondents reported that no appointment was available with either a specialist (19.6%) or primary care provider (18.3%) (see *Table 8* and *Figure 11*).

More than two-thirds (68.4%) of residents reported experiencing at least one social challenge within the past year. Lack of a livable wage was reported as the top social challenge experienced by survey

respondents or a family member within the past year (29.7%), as well as the top social challenge identified within the community (37.3%). Nearly one in four residents reported opportunities for physical activity (24.9%), lack of employment opportunities (24.6%), street safety (23.5%), and affordable housing (23.4%) as social challenges experienced by themselves or a family member within the past year. Affordable housing (36.3%) and lack of employment opportunities (33.5%) were also recognized by respondents as challenges within the community. In addition, child abuse/neglect (34.6%) and bullying (27.1%) were identified as challenges of great concern within our community; however, respondents reported experiencing these much less frequently, with only 4.2% of respondents reporting child abuse/neglect as a challenge for themselves or their family, and 17.6% identifying bullying as a challenge. See *Table 4* and *Figure 7* for social challenges identified in our community, and *Table 7* and *Figure 10* for social challenges experienced by residents.

Nearly half of all respondents identified challenges related to water as the top environmental concerns in our community; specifically, 48.4% identified concerns related to stream, river, lake quality, and 46.6% reported concerns with drinking water quality. Approximately one in five residents also identified school safety (42.2%), vector-borne disease (41.6%), and climate change (38.2%) as additional environmental challenges in our community (see *Table 5* and *Figure 8*). Two in five (39.7%) respondents 18 to 24 years identified exposure to tobacco smoke as an environmental concern, compared to approximately 1 in 4 (21 to 25%) of respondents aged 25 years and older. In addition, the concern for climate change increased with age; 31.7% of respondents aged 18 to 24 years, 37.2% of respondents 25 to 44 years, 37.9% of respondents 45 to 64 years, and 43.5% of respondents 65 years and older identified climate change as a concern.

Just over half (51.5%) of all survey respondents identified at least one missing or lacking cancer service within our community. The most commonly reported gaps in services included: stress and anxiety resources and treatment; access to clinical trials; and, access to affordable prescription medication coverage (see *Table 9*).

As noted above, overweight/obesity and lack of a livable wage were identified as health and social challenges both within the community and self-reported by residents; however, many of the other health and social concerns identified within the community did not correlate to self-reported individual and family challenges. Also notable is that the top health and social concerns remained relatively consistent throughout the different townships within Clinton County. In addition, male and female responses were also very similar. Responses from most of the different age groups were also fairly similar, with a few exceptions. Respondents 65 years and older had more concerns in regards to aging and chronic disease, as well as transportation, in comparison to overall responses from other age groups and the county as a whole.

## Considerations/Limitations

Having completed a survey of similar magnitude in 2016, the CCHD was able to leverage survey fielding experience and existing partners within the community to efficiently reach almost 1,400 residents. Nevertheless, this equates to only approximately 2.2% of the target audience. The CCHD found that due

to the geographic area of the County, reaching certain subpopulations and communities was sometimes difficult. Females were more likely to complete the survey than males; despite efforts to target males, they proved to be an especially difficult subpopulation to engage.

This survey required that residents self-report their opinions on key challenges prevalent in the community and experienced by themselves and their families; this method has its own limitations in regards to the accuracy of resident's recall as well as what information they choose to disclose. This survey was available both in-person and as an electronic survey. In-person respondents had the advantage of having a staff member explain directions or questions if necessary, but may have not felt as anonymous as those filling out the survey online. Online respondents, therefore, had the advantage of being completely anonymous, but the disadvantage of not having a person that could provide explanations as necessary.

Almost 200 surveys submitted were either completed by residents of a neighboring county or not completely filled out, resulting in 1,378 surveys fully completed by Clinton County residents. Surveys completed by residents of a neighboring county were shared with the identified county. The first question asked respondents to choose "up to 3" features and the second, third, and fourth questions asked respondents to choose "up to 5" challenges; some respondents chose less than three or five, respectively, and some respondents completing the paper survey chose more than three or five, respectively. All responses were counted in the final numbers. The online version of the survey did not allow respondents to choose more than three responses for the first question or more than five responses for the second, third, and fourth questions.

## Conclusions

This survey provided valuable feedback from the community for the CCHD and UVM Health Network-CVPH. It represents the largest reaching approach to community inclusion in the local community health assessment process. This is Clinton County's second large scale effort to collect direct resident insight for consideration in selecting local health priorities. Demographic findings suggest a reasonable representative sample of the Clinton County population was reached.

An overview of the survey process and collected data has been given to a number of community groups and were shared at the Clinton County Priority Setting Session in June 2019. A summary infographic was also created to communicate findings back to county residents (included). It is featured on the CCHD website and has been shared through a number of channels. This full summary will be readily shared with community health stakeholders and featured in the 2019-2021 Community Health Assessment.

While the survey was not framed around the *Prevention Agenda 2019-2024: NYS's Health Improvement Plan*, careful consideration was given to the responses in relation to the Prevention Agenda upon analysis so collected perspective could be successfully incorporated into health priority setting activities. When considered against this framework, there is considerable need for interventions that assist residents in managing chronic diseases and accessing quality care, especially for mental and behavioral health services. In fact, the top six reported *Health Challenges of Greatest Concern in Our Community* and five of the top six self-reported health challenges align with the currently selected health priorities. This survey was able to

capture, perhaps more clearly than any past effort, the extent of concern many residents experience with a range of factors that influence overall health and well-being. Nearly a quarter of all respondents noted securing affordable housing as a challenge for themselves or their families and one out of every three respondents selected the lack of a livable wage as a top social issue. These factors, along with good schools and safe, clean environments also rounded out the top characteristics of a "healthy community" as defined by residents themselves. Such findings reinforces the importance of the social determinants of health and the need to continue to favor strategies and interventions that address up-stream factors that play a fundamental role in health outcomes.

Not surprisingly, community health stakeholders, taking resident input into consideration along with nearly 300 other health indicators, have opted to "hold the course" in collaborative health improvement efforts. Clinton County will maintain its current priority health areas of *Prevent Chronic Disease* and *Promote Well-being and Prevent Mental and Substance Use Disorders* in its next Community Health Improvement Plan.

While survey findings have served their primary purpose (inform the local health priority selection process), there is still much to be gained from more in-depth analysis of the information collected. Such review and analysis will continue in the year ahead and additional findings will be used to inform ongoing collaborative planning intended to improve the health of all residents.

## Tables & Figures

*Table 1.* **2019 Clinton County Community Health Assessment Community Survey, Demographics of Respondents**

| Demographic | | % (#) |
|---|---|---|
| Gender (n = 1,350)* | Female | 75.70% (1,022) |
| | Male | 23.70% (320) |
| | Non-Binary | 0.44% (6) |
| | Other | 0.15% (2) |
| | *Note:* Of all 1,378 respondents, 2.03% (28) declined to answer. | |
| Age (n = 1,378) | 17 years and younger | 0.94% (13) |
| | 18-24 years | 4.57% (63) |
| | 25-44 years | 37.30% (514) |
| | 45-64 years | 41.51% (572) |
| | 65-79 years | 12.26% (169) |
| | 80 years and older | 3.41% (47) |
| Township of primary residence (n = 1,378) | Altona | 1.96% (27) |
| | AuSable | 2.98% (41) |
| | Beekmantown | 6.46% (89) |
| | Black Brook | 0.58% (8) |
| | Champlain (including Rouses Point) | 7.18% (99) |
| | Chazy | 4.35% (60) |
| | Clinton | 1.23% (17) |
| | Dannemora | 2.98% (41) |
| | Ellenburg | 0.87% (12) |
| | Mooers | 3.99% (55) |
| | Peru | 10.81% (149) |
| | Plattsburgh (City of) | 29.75% (410) |
| | Plattsburgh (Town of) | 16.76% (231) |
| | Saranac | 4.57% (63) |
| | Schuyler Falls | 5.52% (76) |
| Primary language spoken in household (n = 1,377*) | English | 99.56% (1,371) |
| | Chinese | 0.00% (0) |
| | French | 0.07% (1) |
| | Haitian-Creole | 0.00% (0) |
| | Italian | 0.00% (0) |
| | Korean | 0.00% (0) |
| | Polish | 0.00% (0) |
| | Russian | 0.07% (1) |
| | Spanish | 0.15% (2) |
| | Other | 0.15% (2) |
| | *Note:* Of all 1,378 respondents, 0.07% (1) declined to answer. | |

| ***Table 1 Continued.*** **2019 Clinton County Community Health Assessment Community Survey, Demographics of Respondents** | | |
|---|---|---|
| Demographic | | % (#) |
| Race/ethnicity (n = 1,314)* | American Indian | 2.05% (27) |
| | Asian or Pacific Islander | 0.76% (10) |
| | Black or African American | 0.76% (10) |
| | Hispanic, Latino or Spanish origin | 1.45% (19) |
| | White | 97.26% (1,278) |
| | Other | 0.08% (1) |
| | **Note:* Of all 1,378 respondents, 4.64% (64) declined to answer. For this question respondents were asked to select all that apply; therefore, responses will not total 100%. | |
| Highest level of education (n = 1,374)* | Some high school (did not finish) | 4.08% (56) |
| | High school diploma or GED | 13.39% (184) |
| | Technical or trade school certificate | 2.98% (41) |
| | Some college | 14.70% (202) |
| | Associate's degree | 12.01% (165) |
| | Bachelor's degree | 22.71% (312) |
| | Graduate degree | 30.06% (413) |
| | Other (1 respondent reported 8th grade as their highest level of education) | 0.07% (1) |
| | **Note:* Of all 1,378 respondents, 0.29% (4) declined to answer. | |
| Household annual income (n = 1,230)* | Less than $10,000 | 5.53% (68) |
| | $10,000 - $24,999 | 9.43% (116) |
| | $25,000 - $49,999 | 18.54% (228) |
| | $50,000 - $99,999 | 33.50% (412) |
| | $100,000 - $149,999 | 22.28% (274) |
| | $150,000 or more | 10.73% (132) |
| | **Note:* Of all 1,378 respondents, 10.74% (148) declined to answer. | |
| Self-reported disabilities (n = 238)* | I am deaf or have serious difficulty hearing. | 24.79% (59) |
| | I am blind or have serious difficulty seeing, even when wearing glasses. | 13.03% (31) |
| | Because of a physical, mental, or emotional condition, I have serious difficulty concentrating, remembering, or making decisions. | 43.28% (103) |
| | I have serious difficulty walking or climbing stairs. | 44.54% (106) |
| | I have difficulty dressing or bathing. | 7.14% (17) |
| | Because of a physical, mental, or emotional condition, I have difficulty doing errands alone, such as visiting a doctor's office or shopping. | 33.61% (80) |
| | **Note:* Of all 1,378 respondents, 82.73% (1,140) reported no difficulties; alternatively, 17.27% (238) respondents reported at least one disability. For this question respondents were instructed to select all that apply; therefore, responses will not total 100%. | |

***Figure 1.*** **2019 Clinton County Community Health Assessment Community Survey, Demographics of Respondents: Gender (n = 1,350)**

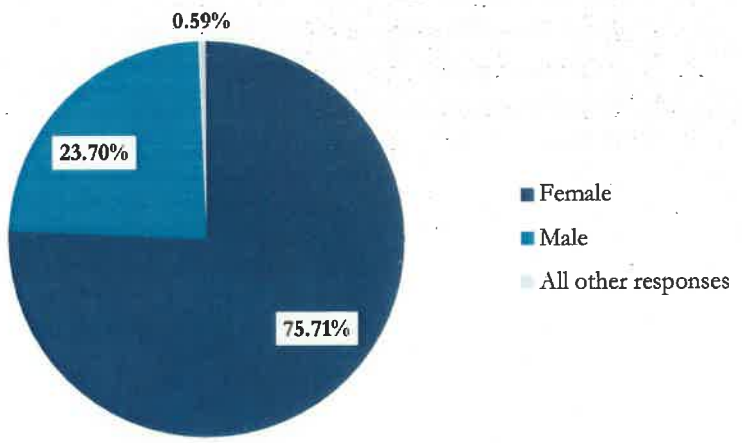



***Figure 2.*** **2019 Clinton County Community Health Assessment Community Survey, Demographics of Respondents: Age (n = 1,378)**

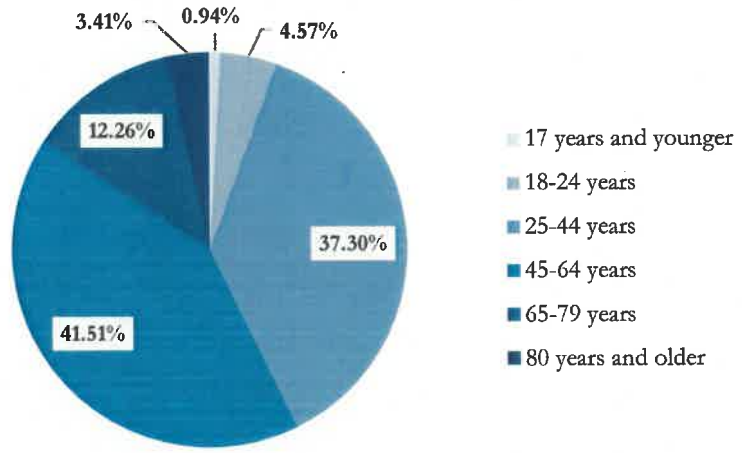
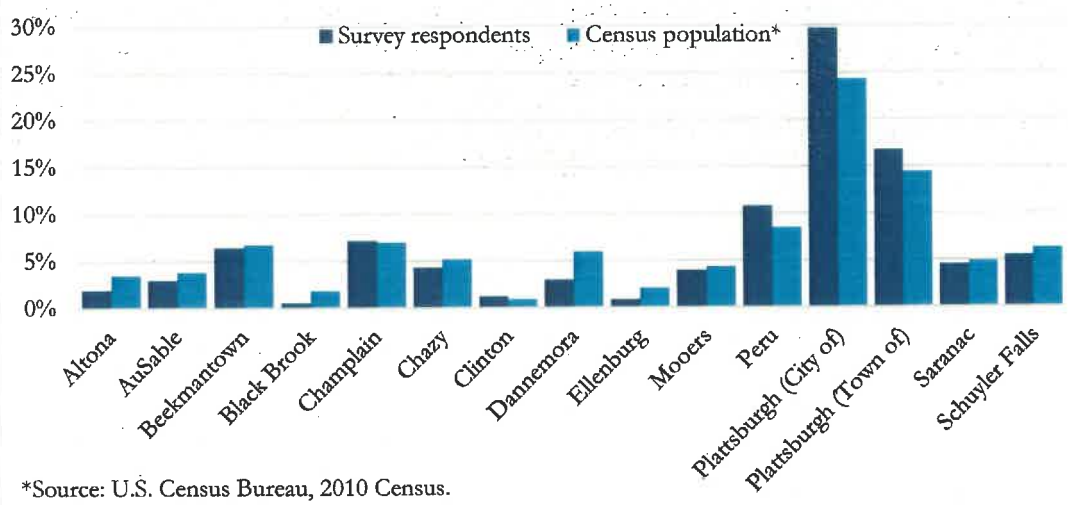
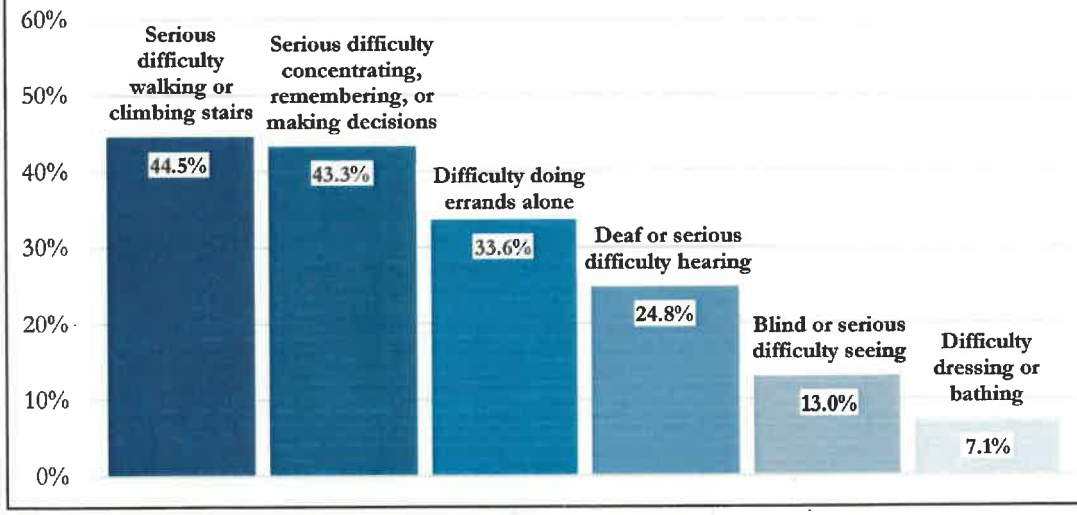


***Figure 3.*** **2019 Clinton County Community Health Assessment Community Survey, Demographics of Respondents: Primary Residence of Respondents vs. Census Population (n = 1,378)**



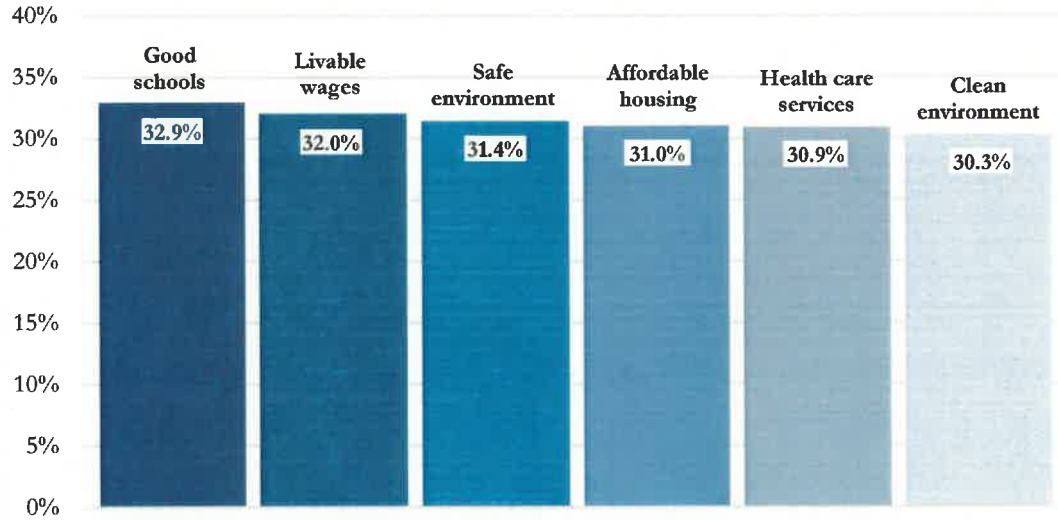

*Source: U.S. Census Bureau, 2010 Census.

***Figure 4.*** **2019 Clinton County Community Health Assessment Community Survey, Demographics of Respondents: Self-reported Disabilities (n = 238)**



| *Table 2.* 2019 Clinton County Community Health Assessment Community Survey, Definition of a Healthy Community | | |
|---|---|---|
| Features | | % (#) |
| Features of a strong, vibrant, healthy community (n = 1,296*) | Affordable housing | 31.02% (402) |
| | Clean environment | 30.32% (393) |
| | Diverse populations | 7.02% (91) |
| | Drug & alcohol free communities | 21.99% (285) |
| | Economic opportunities | 26.08% (338) |
| | Good childcare | 10.19% (132) |
| | Good schools | 32.95% (427) |
| | Health care services | 30.94% (401) |
| | Healthy food choices | 11.50% (149) |
| | Livable wages | 32.02% (415) |
| | Mental health services | 17.82% (231) |
| | Parks & recreation resources | 15.05% (195) |
| | Safe environment | 31.40% (407) |
| | Senior housing | 4.24% (55) |
| | Senior services | 5.63% (73) |
| | Transportation | 6.56% (85) |
| | Walkable & bike friendly communities | 12.73% (165) |
| | Other | 1.77% (23) |
| | **Note:* For this question respondents were instructed to select up to 3 features; therefore, responses will not total 100%. | |

***Figure 5.*** **2019 Clinton County Community Health Assessment Community Survey, Features of a Healthy Community (n = 1,296)**



| *Table 3.* **2019 Clinton County Community Health Assessment Community Survey, Health Challenges of Greatest Concern in Our Community** | | |
|---|---|---|
| Health Challenges | | % (#) |
| Health challenges of greatest concern (n = 1,378*) | Access to dental care | 22.71% (313) |
| | Access to healthcare services | 39.62% (546) |
| | Access to mental health services | 47.02% (648) |
| | Cancer | 28.01% (386) |
| | Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.) | 37.08% (511) |
| | Falls | 7.18% (99) |
| | Immunization rates | 5.59% (77) |
| | Infectious disease (hepatitis A, B or C, flu, etc.) | 8.49% (117) |
| | Health concerns of intellectual or developmental disabilities | 10.74% (148) |
| | Health concerns of physical disabilities | 9.00% (124) |
| | Issues related to aging (arthritis, hearing/vision loss, etc.) | 24.17% (333) |
| | Lung disease (asthma, COPD, etc.) | 8.49% (117) |
| | Overweight/obesity | 47.10% (649) |
| | Physical activity | 29.75% (410) |
| | Prenatal care/maternal & infant health | 6.82% (94) |
| | Sexually transmitted infections (including HIV) | 4.93% (68) |
| | Substance abuse (drugs, alcohol, etc.) | 60.16% (829) |
| | Suicide | 26.78% (369) |
| | Tobacco use | 14.37% (198) |
| | Other | 3.12% (43) |
| | **Note:* For this question respondents were instructed to select up to 5 health challenges; therefore, responses will not total 100%. | |

| *Table 4.* 2019 Clinton County Community Health Assessment Community Survey, Social Challenges of Greatest Concern in Our Community | | |
|---|---|---|
| Social Challenges | | % (#) |
| Social challenges of greatest concern (n = 1,378*) | Access to healthy foods | 25.11% (346) |
| | Access to opportunities for health for those with intellectual or developmental disabilities | 9.94% (137) |
| | Access to opportunities for health for those with physical limitations or disabilities | 12.05% (166) |
| | Affordable housing | 36.28% (500) |
| | Bullying | 27.14% (374) |
| | Child abuse/neglect | 34.62% (477) |
| | Childcare | 19.09% (263) |
| | Crime/vandalism | 15.89% (219) |
| | Domestic violence | 22.21% (306) |
| | Elder abuse/neglect | 12.92% (178) |
| | Homelessness | 17.49% (241) |
| | Hunger | 15.09% (208) |
| | Incarceration rates (number of people in jail) | 7.98% (110) |
| | Lack of employment opportunities | 33.45% (461) |
| | Lack of a livable wage | 37.30% (514) |
| | Lack of support/resources for seniors | 14.01% (193) |
| | Lack of support/resources for youth | 19.38% (267) |
| | Opportunities for physical activity | 17.20% (237) |
| | Racial or cultural discrimination | 11.83% (163) |
| | Safe recreational areas | 12.99% (179) |
| | Street safety (crosswalks, shoulders, bike lanes, traffic, etc.) | 14.37% (198) |
| | Transportation | 18.14% (250) |
| | Other | 3.41% (47) |
| | **Note:* For this question respondents were instructed to select up to 5 social challenges; therefore, responses will not total 100%. | |

*Figure 6.* 2019 Clinton County Community Health Assessment Community Survey, Health Challenges of Greatest Concern in Our Community (n = 1,378)

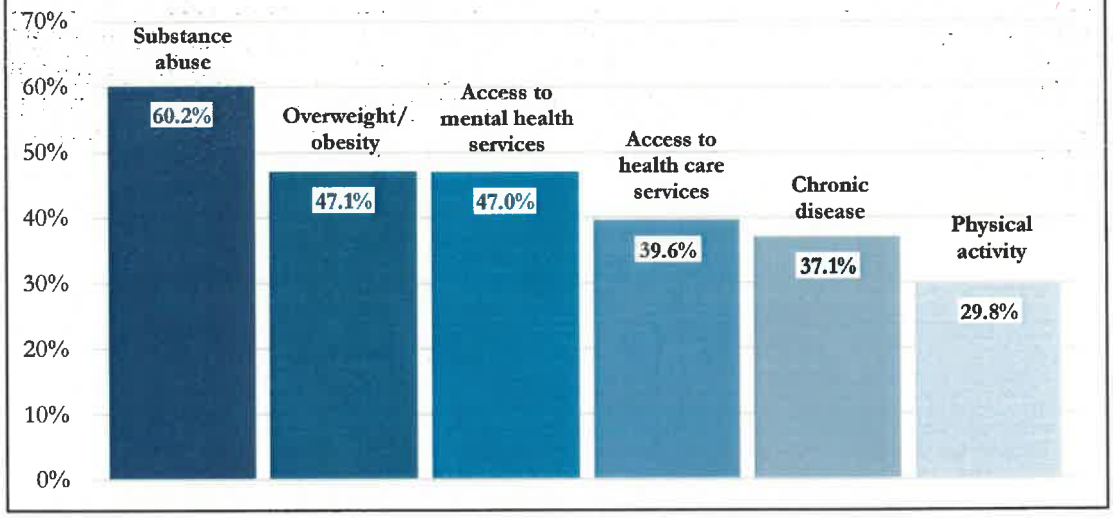
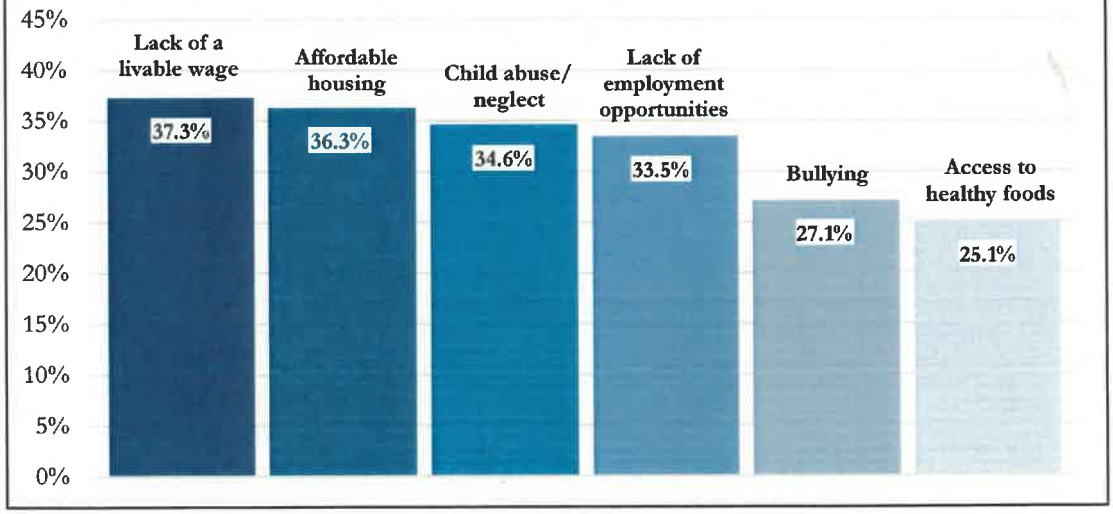
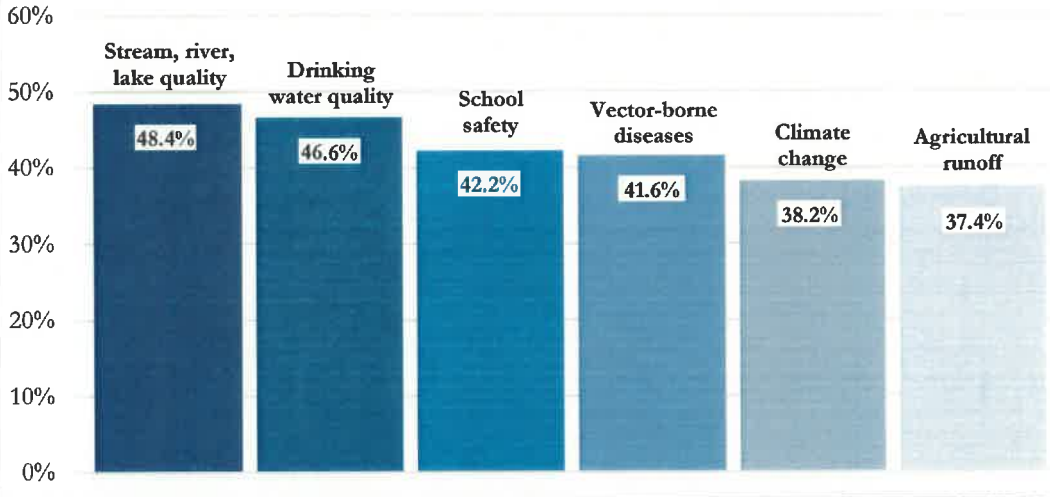



*Figure 7.* 2019 Clinton County Community Health Assessment Community Survey, Social Challenges of Greatest Concern in Our Community (n = 1,378)



| *Table 5.* 2019 Clinton County Community Health Assessment Community Survey, Environmental Challenges of Greatest Concern in Our Community | | |
|---|---|---|
| Environmental Challenges | | % (#) |
| Environmental challenges of greatest concern (n = 1,378*) | Agricultural runoff (manure, pesticides, etc.) | 37.45% (516) |
| | Air pollution | 21.12% (291) |
| | Climate change | 38.24% (527) |
| | Drinking water quality | 46.59% (642) |
| | Exposure to tobacco smoke | 24.17% (333) |
| | Failing septic systems | 11.54% (159) |
| | Flooding/soil drainage | 12.19% (168) |
| | Home safety | 22.21% (306) |
| | Lead-based paint hazards | 7.55% (104) |
| | Nuisance wildlife/stray animals | 11.54% (159) |
| | Safe food | 22.50% (310) |
| | School safety | 42.24% (582) |
| | Stream, river, lake quality | 48.40% (667) |
| | Vector-borne diseases (mosquitos, ticks, etc.) | 41.58% (573) |
| | Other | 2.83% (39) |
| | **Note:* For this question respondents were instructed to select up to 5 environmental challenges; therefore, responses will not total 100%. | |

***Figure 8.*** **2019 Clinton County Community Health Assessment Community Survey, Environmental Challenges of Greatest Concern in Our Community (n = 1,378)**



| *Table 6.* 2019 Clinton County Community Health Assessment Community Survey, Self-reported Health Challenges Experienced by Residents Within the Past Year | | |
|---|---|---|
| Health Challenges | | % (#) |
| Self-reported health challenges (n = 1,183*) | Access to dental care | 23.75% (281) |
| | Access to healthcare services | 20.54% (243) |
| | Access to mental health services | 20.12% (238) |
| | Cancer | 20.37% (241) |
| | Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.) | 39.73% (470) |
| | Falls | 13.95% (165) |
| | Immunization rates | 3.47% (41) |
| | Infectious disease (hepatitis A, B or C, flu, etc.) | 4.99% (59) |
| | Health concerns of intellectual or developmental disabilities | 6.00% (71) |
| | Health concerns of physical disabilities | 13.44% (159) |
| | Issues related to aging (arthritis, hearing/vision loss, etc.) | 40.57% (480) |
| | Lung disease (asthma, COPD, etc.) | 15.47% (183) |
| | Overweight/obesity | 40.07% (474) |
| | Physical activity | 29.25% (346) |
| | Prenatal care/maternal & infant health | 4.23% (50) |
| | Sexually transmitted infections (including HIV) | 2.28% (27) |
| | Substance abuse (drugs, alcohol, etc.) | 16.23% (192) |
| | Suicide | 7.78% (92) |
| | Tobacco use | 13.78% (163) |
| | Other | 6.59% (78) |
| | **Note:* For this question respondents were asked, "What health challenges have you or a family member had in the past year?" and instructed to select all that apply; therefore, responses will not total 100%. Of all 1,378 respondents, 14.15% (195) reported no health challenges in the past year; alternatively, 85.85% (1,183) respondents reported experiencing at least one health challenge in the past year. | |

| *Table 7.* **2019 Clinton County Community Health Assessment Community Survey, Self-reported Social Challenges Experienced by Residents Within the Past Year** | | |
|---|---|---|
| Social Challenges | | % (#) |
| Self-reported social challenges (n = 942*) | Access to healthy foods | 15.07% (142) |
| | Access to opportunities for health for those with intellectual or developmental disabilities | 5.73% (54) |
| | Access to opportunities for health for those with physical limitations or disabilities | 10.83% (102) |
| | Affordable housing | 23.35% (220) |
| | Bullying | 17.62% (166) |
| | Child abuse/neglect | 4.25% (40) |
| | Childcare | 14.97% (141) |
| | Crime/vandalism | 5.84% (55) |
| | Domestic violence | 7.22% (68) |
| | Elder abuse/neglect | 3.82% (36) |
| | Homelessness | 4.35% (41) |
| | Hunger | 4.78% (45) |
| | Incarceration rates (number of people in jail) | 3.93% (37) |
| | Lack of employment opportunities | 24.63% (232) |
| | Lack of a livable wage | 29.72% (280) |
| | Lack of support/resources for seniors | 15.50% (146) |
| | Lack of support/resources for youth | 13.27% (125) |
| | Opportunities for physical activity | 24.95% (235) |
| | Racial or cultural discrimination | 7.64% (72) |
| | Safe recreational areas | 13.38% (126) |
| | Street safety (crosswalks, shoulders, bike lanes, traffic, etc.) | 23.46% (221) |
| | Transportation | 16.35% (154) |
| | Other | 3.82% (36) |
| | **Note:* For this question respondents were asked, "What social challenges have you or a family member had in the past year?" and instructed to select all that apply; therefore, responses will not total 100%. Of all 1,378 respondents, 31.64% (436) reported no social challenges in the past year; alternatively, 68.36% (942) respondents reported experiencing at least one social challenge in the past year. | |

***Figure 9.*** **2019 Clinton County Community Health Assessment Community Survey, Top Self-reported Health Challenges Experienced by Residents Within the Past Year (n = 1,183)**

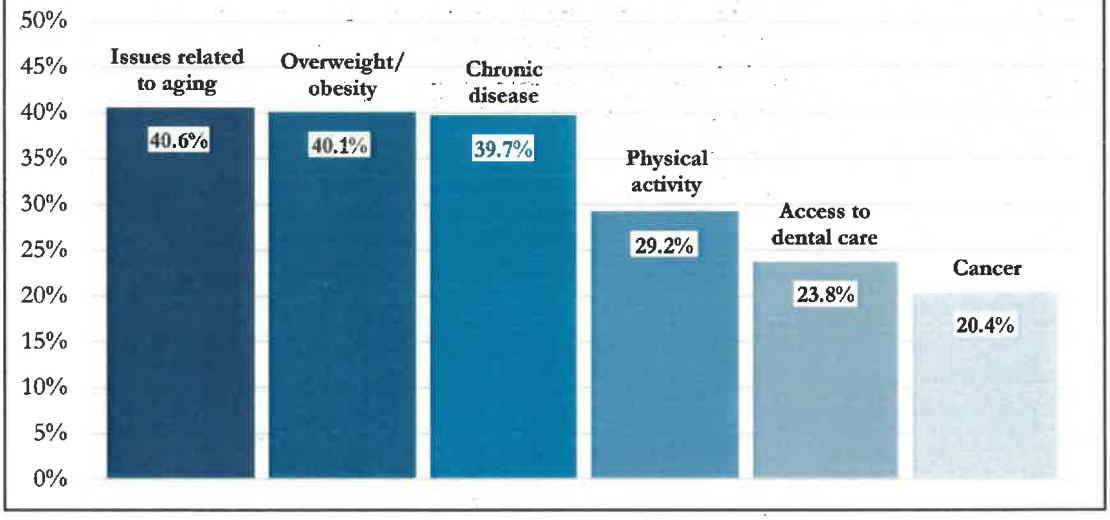
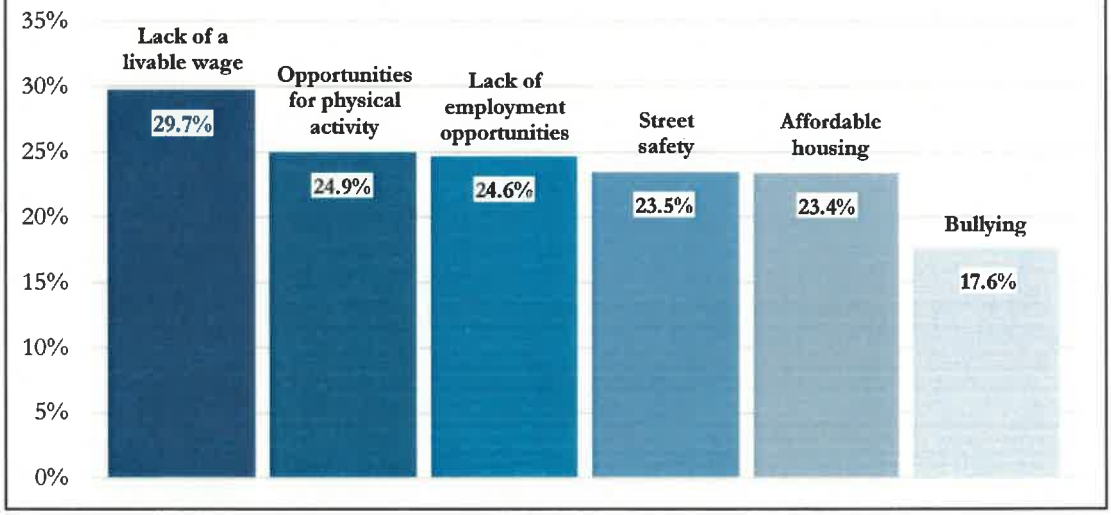
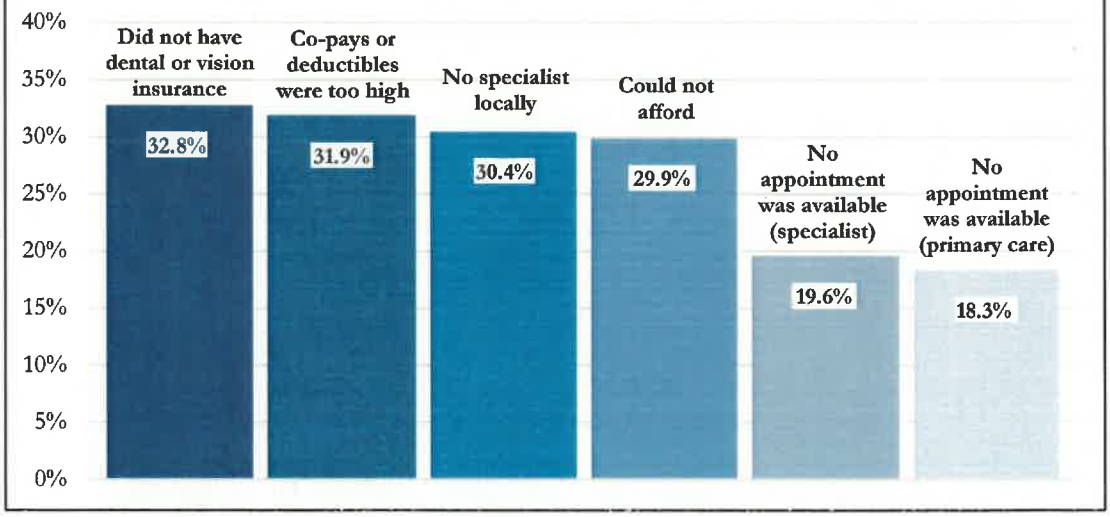



***Figure 10.*** **2019 Clinton County Community Health Assessment Community Survey, Top Self-reported Social Challenges Experienced by Residents Within the Past Year (n = 942)**



| *Table 8.* 2019 Clinton County Community Health Assessment Community Survey, Self-reported Barriers to Medical Care Experienced by Residents Within the Past Year | | |
|---|---|---|
| Barriers to medical care | | % (#) |
| Self-reported barriers to medical care (n = 693*) | Co-pays or deductibles were too high | 31.89% (221) |
| | Could not afford | 29.87% (207) |
| | Could not leave work | 17.60% (122) |
| | Did not have a doctor | 13.42% (93) |
| | Did not have childcare | 4.76% (33) |
| | Did not have dental or vision insurance | 32.76% (227) |
| | Did not have medical insurance | 10.53% (73) |
| | Did not have transportation | 13.13% (91) |
| | No access for people with physical disabilities | 2.60% (18) |
| | No accommodations for people with intellectual or developmental disabilities | 1.44% (10) |
| | No appointment was available (primary care) | 18.33% (127) |
| | No appointment was available (specialist) | 19.62% (136) |
| | No specialist locally | 30.45% (211) |
| | Provider did not speak my language | 0.14% (1) |
| | Other | 9.96% (69) |
| | **Note:* For this question respondents were asked, "If there was a time in the past year that you or a family member needed medical care but could not get it, why did you not get care?" and instructed to select all that apply; therefore, responses will not total 100%. Of all 1,378 respondents, 49.71% (685) reported no barriers to medical care in the past year; alternatively, 50.29% (693) respondents reported experiencing at least one barrier to medical care in the past year. | |

***Figure 11.*** **2019 Clinton County Community Health Assessment Community Survey, Self-reported Barriers to Medical Care Experienced by Residents Within the Past Year (n = 693)**



| *Table 9.* 2019 Clinton County Community Health Assessment Community Survey, Cancer Services Missing or Lacking in Community Based on Resident Experience | | |
|---|---|---|
| Cancer Services | | % (#) |
| Cancer services missing or lacking in community based on resident experience (n = 709*) | Access to advanced care planning | 19.18% (136) |
| | Access to affordable prescription/medication coverage | 31.17% (221) |
| | Access to alternative healthcare providers (acupuncture, chiropractors, etc.) | 24.82% (176) |
| | Access to cancer patient support groups | 15.09% (107) |
| | Access to cancer screenings/resources/information | 18.76% (133) |
| | Access to clinical trials | 33.00% (234) |
| | Access to financial assistance programs for co-pays and bills | 27.79% (197) |
| | Access to genetic testing | 20.87% (148) |
| | Access to help overcome drug/alcohol dependence | 15.23% (108) |
| | Access to Hospice services | 5.78% (41) |
| | Access to mental health services | 20.87% (148) |
| | Access to occupational therapy | 4.51% (32) |
| | Access to physical and exercise therapy | 10.16% (72) |
| | Access to recreation/exercise facilities and services for individuals with physical impairments and disabilities | 7.62% (54) |
| | Access to timely specialist care | 25.95% (184) |
| | Affordable in-home services | 25.67% (182) |
| | Affordable travel options | 22.00% (156) |
| | Assistance with understanding health insurance benefits and coverage | 15.23% (108) |
| | Caregiver support (respite) | 18.62% (132) |
| | Nutrition education/healthy meal planning | 13.68% (97) |
| | Opportunities for social connections | 10.01% (71) |
| | Pain management services | 17.63% (125) |
| | Reduction of tobacco use including e-cigarettes | 9.73% (69) |
| | Resources to help with basic needs (food, housing, paying bills, etc.) | 17.35% (123) |
| | Stress and anxiety resources and treatment | 33.29% (236) |
| | Other | 5.78% (41) |
| | **Note:* For this question respondents were asked, "If you, or someone you love, has ever been diagnosed with cancer please tell us about your experiences when dealing specifically with a cancer diagnosis. Select the cancer services you feel are missing or lacking in the community based on your experience." and instructed to select all that apply; therefore, responses will not total 100%. Of all 1,378 respondents, 48.55% (669) indicated that the question was not applicable; alternatively, 51.45% (709) respondents identified at least one missing or lacking cancer service. | |

2019

# Community Health Assessment

Clinton County, New York

## Community Survey

### Introduction

The Clinton County Health Department (CCHD) and the UVM Health Network-CVPH are completing a community health assessment. As part of this process we are conducting a survey to assess the top health needs of our community. Your input will help shape our goals for future community health initiatives. We want to hear from you!

The survey will take about 5-10 minutes to complete. Your participation is voluntary.

Thank you for your time.

**To take this survey online visit:**
**www.surveymonkey.com/r/CHA2019**

CCHD
Clinton County HEALTH Department

THE University of Vermont HEALTH NETWORK
Champlain Valley Physicians Hospital


November 2018

# Healthy Community

Please tell us your definition of a healthy community.

**1. When you imagine a strong, vibrant, healthy community, what are the most important features you think of?**
**(Choose up to 3.)**

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

# Challenges in Our Community

Please tell us what health, social and environmental challenges you feel are of greatest concern in our community.

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

- ◯ Access to dental care
- ◯ Access to healthcare services
- ◯ Access to mental health services
- ◯ Cancer
- ◯ Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)
- ◯ Falls
- ◯ Immunization rates
- ◯ Infectious disease (hepatitis A, B or C, flu, etc.)
- ◯ Health concerns of intellectual or developmental disabilities
- ◯ Health concerns of physical disabilities
- ◯ Issues related to aging (arthritis, hearing/vision loss, etc.)
- ◯ Lung disease (asthma, COPD, etc.)
- ◯ Overweight/obesity
- ◯ Physical activity
- ◯ Prenatal care/maternal & infant health
- ◯ Sexually transmitted infections (including HIV)
- ◯ Substance abuse (drugs, alcohol, etc.)
- ◯ Suicide
- ◯ Tobacco use
- ◯ Other (please specify) _____
  _____

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

- ◯ Access to healthy foods
- ◯ Access to opportunities for health for those with intellectual or developmental disabilities
- ◯ Access to opportunities for health for those with physical limitations or disabilities
- ◯ Affordable housing
- ◯ Bullying
- ◯ Child abuse/neglect
- ◯ Childcare
- ◯ Crime/vandalism
- ◯ Domestic violence
- ◯ Elder abuse/neglect
- ◯ Homelessness
- ◯ Hunger
- ◯ Incarceration rates (number of people in jail)
- ◯ Lack of employment opportunities
- ◯ Lack of a livable wage
- ◯ Lack of support/resources for seniors
- ◯ Lack of support/resources for youth
- ◯ Opportunities for physical activity
- ◯ Racial or cultural discrimination
- ◯ Safe recreational areas
- ◯ Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)
- ◯ Transportation
- ◯ Other (please specify) _____

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

- ◯ Agricultural runoff (manure, pesticides, etc.)
- ◯ Air pollution
- ◯ Climate change
- ◯ Drinking water quality
- ◯ Exposure to tobacco smoke
- ◯ Failing septic systems
- ◯ Flooding/soil drainage
- ◯ Home safety
- ◯ Lead-based paint hazards
- ◯ Nuisance wildlife/stray animals
- ◯ Safe food
- ◯ School safety
- ◯ Stream, river, lake quality
- ◯ Vector-borne diseases (mosquitos, ticks, etc.)
- ◯ Other (please specify) _____

# Individual Challenges

Please tell us what health and social challenges have been of greatest concern for you or your family members.

**5. What health challenges have you or a family member had in the past year? (Select all that apply.)**

- ◯ Access to dental care
- ◯ Access to healthcare services
- ◯ Access to mental health services
- ◯ Cancer
- ◯ Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)
- ◯ Falls
- ◯ Immunization
- ◯ Infectious disease (hepatitis A, B or C, flu, etc.)
- ◯ Health concerns of intellectual or developmental disability
- ◯ Health concerns of physical disability
- ◯ Issues related to aging (arthritis, hearing/vision loss, etc.)
- ◯ Lung disease (asthma, COPD, etc.)
- ◯ Overweight/obesity
- ◯ Physical activity
- ◯ Prenatal care/maternal & infant health
- ◯ Sexually transmitted infection (including HIV)
- ◯ Substance abuse (drugs, alcohol, etc.)
- ◯ Suicide
- ◯ Tobacco use
- ◯ Other (please specify) _____
  _____
- ◯ N/A

**6. What social challenges have you or a family member had in the past year?**
**(Select all that apply.)**

- ◯ Access to healthy foods
- ◯ Access to opportunities for health for those with intellectual or developmental disabilities
- ◯ Access to opportunities for health for those with physical limitations or disabilities
- ◯ Affordable housing
- ◯ Bullying
- ◯ Child abuse/neglect
- ◯ Childcare
- ◯ Crime/vandalism
- ◯ Domestic violence
- ◯ Elder abuse/neglect
- ◯ Homelessness
- ◯ Hunger
- ◯ Incarceration (time in jail or prison)
- ◯ Lack of employment opportunities
- ◯ Lack of a livable wage
- ◯ Lack of support/resources for seniors
- ◯ Lack of support/resources for youth
- ◯ Opportunities for physical activity
- ◯ Racial or cultural discrimination
- ◯ Safe recreational areas
- ◯ Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)
- ◯ Transportation
- ◯ Other (please specify) _____
  _____
- ◯ N/A

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

- ◯ Co-pays or deductibles were too high
- ◯ Could not afford
- ◯ Could not leave work
- ◯ Did not have a doctor
- ◯ Did not have childcare
- ◯ Did not have dental or vision insurance
- ◯ Did not have medical insurance
- ◯ Did not have transportation
- ◯ No access for people with physical disabilities
- ◯ No accommodations for people with intellectual or developmental disabilities
- ◯ No appointment was available (primary care)
- ◯ No appointment was available (specialist)
- ◯ No specialist locally
- ◯ Provider did not speak my language
- ◯ None of the above
- ◯ Other (please specify) _____
  _____
- ◯ N/A

## Cancer Care

If you, or someone you love, has ever been diagnosed with cancer please tell us about your experiences when dealing specifically with a cancer diagnosis.

**8. Select the cancer services you feel are missing or lacking in the community based on your experience. (Select all that apply.)**

- ◯ Access to advanced care planning
- ◯ Access to affordable prescription/medication coverage
- ◯ Access to alternative healthcare providers (acupuncture, chiropractors, etc.)
- ◯ Access to cancer patient support groups
- ◯ Access to cancer screenings/resources/ information
- ◯ Access to clinical trials
- ◯ Access to financial assistance programs for co-pays and bills
- ◯ Access to genetic testing
- ◯ Access to help overcome drug/alcohol dependence
- ◯ Access to Hospice services
- ◯ Access to mental health services
- ◯ Access to occupational therapy
- ◯ Access to physical and exercise therapy
- ◯ Access to recreation/exercise facilities and services for individuals with physical impairments and disabilities
- ◯ Access to timely specialist care
- ◯ Affordable in-home services
- ◯ Affordable travel options
- ◯ Assistance with understanding health insurance benefits and coverage
- ◯ Caregiver support (respite)
- ◯ Nutrition education/healthy meal planning
- ◯ Opportunities for social connections
- ◯ Pain management services
- ◯ Reduction of tobacco use including e-cigarettes
- ◯ Resources to help with basic needs (food, housing, paying bills, etc.)
- ◯ Stress and anxiety resources and treatment
- ◯ Other _____
  _____
- ◯ N/A

# Demographics

Please tell us more about yourself and your household. This information lets us know we have collected responses from many different residents.

**9. What gender do you identify with?**

- ○ Female
- ○ Male
- ○ Non-binary
- ○ Prefer not to answer
- ○ Other _____

**10. What is your age?**

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

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

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

**12. What is the primary language spoken in your household?**

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

**13. What is your race/ethnicity?**
**(Select all that apply.)**

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

**14. What is your highest level of education?**

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

**15. What is your household's annual income?**

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

**16. Do any of the following apply to you?**
**(Select all that apply.)**

- ○ I am deaf or have serious difficulty hearing.
- ○ I am blind or have serious difficulty seeing, even when wearing glasses.
- ○ Because of a physical, mental, or emotional condition, I have serious difficulty concentrating, remembering, or making decisions.
- ○ I have serious difficulty walking or climbing stairs.
- ○ I have difficulty dressing or bathing.
- ○ Because of a physical, mental, or emotional condition, I have difficulty doing errands alone, such as visiting a doctor's office or shopping.
- ○ N/A

**Thank you for completing our survey!**

# 2019 Community Health Assessment
## Resident Survey Key Findings

The Clinton County Health Department asked county residents for their opinions on health, social and environmental issues in the community. They were also asked to identify any barriers to medical care experienced by themselves or their family in the past year. Surveys were collected from 1,378 residents.

**86%** of respondents experienced **1 or more health challenge** for themselves or family in the past year.

**40%** reported being **overweight or obese.**

**29%** reported **physical inactivity.**

**2 in 5** live with **chronic disease.**

**40%** reported **issues related to aging.**

**1 in 4** experienced no access to **dental care.**

Nearly **1 out of every 3** respondents reported lack of a **livable wage** as a top social issue for themselves or their family.

Nearly **50%** of residents selected **water quality** as a top environmental concern.

**50%** of respondents faced at least 1 **barrier to receiving medical care in the past year.**

**Top ranked barriers reported:**
- No vision or dental insurance
- High co-pays and deductibles
- Lack of local specialists
- Affordability

**Affordable housing** is a challenge for nearly **25%** of respondents.

**1 in 4** individuals reported a lack of **employment opportunities.**

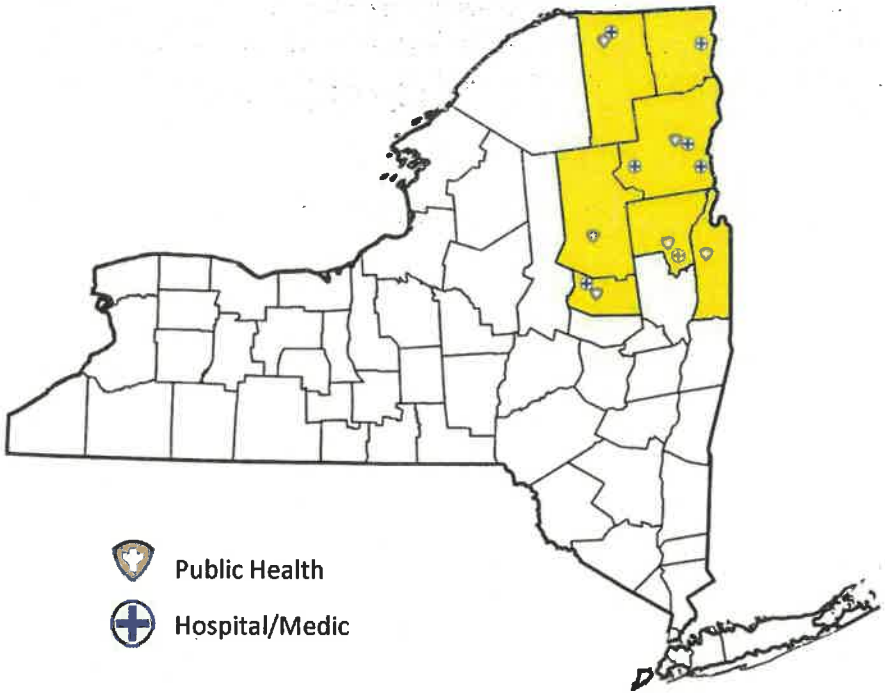
Note: Statistics on issues for individuals and their family are based on those respondents who indicated that they had any issues. 14% of respondents reported no health issues; 31% reported no social issues. Survey responses represented residents from 100% of Clinton County townships, ages 17—80+, and all census income and education categories.

CCHD Clinton County HEALTH Department

# Appendix C:

## Summary of 2019 ARHN Community Stakeholder Survey

# Summary of 2019 Community Stakeholder Survey




## Adirondack Rural Health Network Service Area

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

a·H·I

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

April 8, 2019

**Background:**

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

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

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

**CHA Committee, Ad Hoc Data Sub-Committee:** At the June 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) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

The data subcommittee met seven times from mid-July through the end of October 2018. Meetings were held via conference call/webinar. Attendance ranged from 10 to 12 subcommittee members per meeting. Meetings were also attended by AHI staff from ARHN, Population Health Improvement Program (PHIP) and Data teams.

**Survey Methodology:**

**Survey Creation:** The 2019 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at 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. A full list of survey questions can be found under Appendix A.

**Survey Responses and Analysis:** A total of 409 responses were received through February 8, 2019, for a total response rate of 50.68%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 22 minutes to complete the survey, with a median response time of approximately 17 minutes.

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

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

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

**Summary Analysis**

**1. Indicate county/counties served**

Respondents were asked which county their organization/agency serves. Over 68% of respondents were from Essex and Washington counties. Approximately 16% of respondents listed the county they serve as outside of the seven ARHN counties, including Montgomery, Saratoga and St. Lawrence counties. Twelve percent of respondents identified themselves as serving the Adirondack/North Country region as a whole.

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

| Respondents by County | | |
|---|---|---|
| **County/Region** | **Total Response Count** | **Total Response Percentage** |
| **Adirondack/North Country Region** | 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% |

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

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

Community stakeholders were asked to indicate one community sector that best described their organization or agency. Over 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 Community 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 |

**3. Indicate your job title**

Approximately 42.64% of respondents listed themselves as an *Administrator or Director.* There was a significant number of respondents who identified their title as Other (22.69%). Of those responses, the majority included teachers or education professionals and program coordinators.

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

| Respondent Job Titles | | |
|---|---|---|
| Job Title | Responses | |
| | Count | Percentage |
| Community Member | 5 | 1.25% |
| Direct Service Staff | 94 | 23.44% |
| Program/Project Manager | 40 | 9.98% |
| Administrator/Director | 171 | 42.64% |
| Other | 91 | 22.69% |

**4. NYS Prevention Agenda Priority Areas**

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

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

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

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

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

All seven of the ARHN counties identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* as their top priority. Additionally, Clinton, 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.

| NYS Prevention Agenda Top Priority Area by County | | |
|---|---|---|
| **County** | **First Choice** | **Second Choice** |
| **Clinton** | Promote Well-Being and Prevent Mental and Substance Use Disorders | Tie:<br>• Prevent Chronic Disease<br>• 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:<br>• Prevent Chronic Disease<br>• 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.

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

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

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

Survey respondents felt that the top five health concerns affecting the residents within the ARHN region were *Mental Health (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 Region Health Concerns | | | | | |
|---|---|---|---|---|---|
| **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 |

***Health Concerns by County:***

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

Warren and Washington county respondents felt that *Alzheimer's Disease* was a concern in their area, while Clinton and Hamilton counties included *Heart Disease* as a concern for their counties. Outliers include Hamilton County listing *Diabetes* and Fulton County listing *Tobacco Use* as a top concern in their county.

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

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

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

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

The top five contributing factors identified by survey respondents are *Poverty (12.7%), Addiction to illicit drugs (10.9%), Changing family structures (10.6%), Lack of mental health services (10.3%), and Age of residents (8.3%).* Forty-four percent of respondents chose these factors as either the highest or second highest contributing factors for the health concerns that they had previously identified.

| Response Counts for Top Contributing Factors in the ARHN Region | | | | | |
|---|---|---|---|---|---|
| **ARHN Region Contributing Factors** | **1 (Highest)** | **2** | **3** | **4** | **5 (Lowest)** |
| Addiction to alcohol | 14 | 16 | 12 | 7 | 6 |
| Addiction to illicit drugs | 37 | 36 | 22 | 13 | 5 |
| Addiction to nicotine | 7 | 10 | 6 | 7 | 11 |
| Age of residents | 28 | 11 | 6 | 4 | 7 |
| Changing family structures (increased foster care, grandparents as parents, etc.) | 36 | 22 | 15 | 20 | 8 |
| Crime/violence/community blight | 0 | 1 | 2 | 1 | 4 |
| Deteriorating infrastructure (roads, bridges, water systems, etc.) | 1 | 0 | 1 | 0 | 3 |
| Discrimination/racism | 0 | 0 | 0 | 0 | 1 |
| Domestic violence and abuse | 4 | 6 | 5 | 4 | 7 |
| Environmental quality | 0 | 3 | 4 | 5 | 6 |
| Excessive screen time | 2 | 13 | 11 | 4 | 8 |
| Exposure to tobacco smoke/emissions from electronic vapor products | 1 | 3 | 5 | 1 | 3 |
| Food insecurity | 8 | 13 | 9 | 8 | 7 |
| Health care costs | 16 | 17 | 21 | 20 | 16 |
| Homelessness | 1 | 2 | 4 | 4 | 2 |
| Inadequate physical activity | 5 | 16 | 15 | 17 | 21 |
| Inadequate sleep | 0 | 0 | 2 | 3 | 3 |
| Inadequate/unaffordable housing options | 5 | 9 | 16 | 8 | 13 |
| Lack of chronic disease screening, treatment and self-management services | 3 | 8 | 7 | 7 | 4 |
| Lack of cultural and enrichment programs | 1 | 2 | 1 | 1 | 3 |
| Lack of dental/oral health care services | 1 | 3 | 0 | 6 | 7 |
| Lack of educational opportunities for people of all ages | 1 | 2 | 3 | 2 | 9 |
| Lack of educational, vocational or job-training options for adults | 1 | 1 | 0 | 6 | 1 |
| Lack of employment options | 1 | 3 | 12 | 7 | 7 |
| Lack of health education programs | 3 | 1 | 4 | 3 | 2 |
| Lack of health insurance | 3 | 1 | 4 | 3 | 3 |
| Lack of intergenerational connections within communities | 1 | 0 | 2 | 4 | 8 |
| Lack of mental health services | 35 | 28 | 27 | 26 | 9 |
| Lack of opportunities for health for people with physical limitations or disabilities | 2 | 0 | 1 | 4 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| Lack of preventive/primary health care services (screenings, annual check-ups) | 6 | 5 | 2 | 3 | 3 |
| Lack of social supports for community residents | 4 | 3 | 10 | 8 | 9 |
| Lack of specialty care and treatment | 1 | 4 | 4 | 3 | 2 |
| Lack of substance use disorder services | 8 | 8 | 11 | 4 | 6 |
| Late or no prenatal care | 0 | 0 | 1 | 2 | 3 |
| Pedestrian safety (roads, sidewalks, buildings, etc.) | 0 | 0 | 0 | 0 | 1 |
| Poor access to healthy food and beverage options | 5 | 2 | 6 | 9 | 0 |
| Poor access to public places for physical activity and recreation | 2 | 3 | 1 | 3 | 4 |
| Poor educational attainment | 2 | 8 | 2 | 8 | 8 |
| Poor community engagement and connectivity | 6 | 5 | 4 | 6 | 14 |
| Poor eating/dietary practices | 12 | 15 | 15 | 17 | 12 |
| Poor health literacy (ability to comprehend health information) | 6 | 2 | 4 | 5 | 4 |
| Poor referrals to health care, specialty care, & community-based support services | 8 | 5 | 4 | 4 | 7 |
| Poverty | 43 | 18 | 16 | 16 | 23 |
| Problems with Internet access (absent, unreliable, unaffordable) | 0 | 0 | 0 | 3 | 2 |
| Quality of schools | 0 | 0 | 1 | 1 | 3 |
| Religious or spiritual values | 0 | 0 | 0 | 1 | 1 |
| Shortage of child care options | 0 | 1 | 3 | 1 | 3 |
| Stress (work, family, school, etc.) | 7 | 10 | 15 | 21 | 9 |
| Transportation problems (unreliable, unaffordable) | 9 | 13 | 15 | 13 | 14 |
| Unemployment/low wages | 3 | 6 | 3 | 8 | 13 |

***Contributing Factors by County:***

The majority of the ARHN counties identified contributing factors that fell in line with the overall ARHN region's top five. Another contributing factor indicated by Franklin, Hamilton and Warren counties was *Health Care Costs*.

| Top Five Contributing Factors by County | | | | | |
|---|---|---|---|---|---|
| **County** | **1st** | **2nd** | **3rd** | **4th** | **5th** |
| **Clinton** | Poverty | Food Insecurity | Addiction to Illicit Drugs | Lack of Mental Health Services | Inadequate Physical Activity |
| **Essex** | Poverty | Lack of Mental Health Services | Changing Family Structures | Addiction to Illicit Drugs | Age of Residents |
| **Franklin** | Poverty | Lack of Mental Health Services | Addiction to Illicit Drugs | Changing Family Structures | Health Care Costs |
| **Fulton** | Lack of Mental Health Services | Poverty | Poor Eating/ Dietary Practices | Changing Family Structures | Addiction to Illicit Drugs |
| **Hamilton** | Age of Residents | Health Care Costs | Lack of Mental Health Services | Poverty | Poor Community Engagement and Connectivity |
| **Warren** | Age of Residents | Lack of Mental Health Services | Changing Family Structures | Health Care Costs | Poverty |
| **Washington** | Addiction to Illicit Drugs | Age of Residents | Poverty | Lack of Mental Health Services | Changing Family Structures |

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

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

Many respondents chose *Health and Health Care (29.0%)* as the social determinant of health that they felt most impacted the residents of the counties that they serve, followed by *Economic Stability (22.4%).* Both of these specific Social Determinants of Health align with the chosen health factors and contributing factors listed previously.

| Response Counts per Social Determinants of Health Ranking | | | | | |
|---|---|---|---|---|---|
| **Social Determinants of Health** | **1 (Excellent)** | **2** | **3** | **4** | **5 (Very Poor)** |
| Economic Stability (consider poverty, employment, food security, housing stability) | 54 | 22 | 33 | 53 | 100 |
| Education (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development) | 50 | 67 | 66 | 49 | 27 |
| Health and Health Care (consider access to primary care, access to specialty care, health literacy) | 70 | 64 | 79 | 52 | 49 |
| Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation) | 35 | 67 | 61 | 79 | 43 |
| Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization) | 32 | 58 | 73 | 62 | 38 |

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

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

Every county in the ARHN region chose *Individuals living at or near the federal poverty level (33.3%)* as the population they felt had the poorest health outcomes. For six of the seven ARHN counties, excluding Hamilton, the second population with the highest responses was *Individuals with mental health issues (24.3%).* For Hamilton County, the second population believed to have the poorest health outcomes were *Seniors or Elderly (1.8%).*

| Response Counts for Poorest Health Outcomes by County | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Population** | **Clinton** | **Essex** | **Franklin** | **Fulton** | **Hamilton** | **Warren** | **Washington** |
| Children/Adolescents | 0 | 5 | 1 | 1 | 2 | 5 | 4 |
| Females of reproductive age | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Individuals living at or near the federal poverty level | 35 | 46 | 32 | 14 | 19 | 25 | 39 |
| Individuals living in rural areas | 5 | 6 | 7 | 2 | 8 | 12 | 17 |
| Individuals with disability | 1 | 2 | 0 | 0 | 0 | 1 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Individuals with mental health issues | 19 | 24 | 19 | 11 | 9 | 14 | 29 |
| Individuals with substance abuse issues | 2 | 8 | 4 | 1 | 6 | 7 | 16 |
| Migrant workers | 1 | 1 | 1 | 0 | 0 | 0 | 0 |
| Seniors/Elderly | 5 | 7 | 6 | 6 | 10 | 8 | 17 |
| Specific racial or ethnic groups | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other (please specify) | 0 | 1 | 0 | 1 | 1 | 1 | 2 |
| Total per county | **68** | **101** | **70** | **37** | **56** | **74** | **126** |

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

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

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

| Top Three Prevention Agenda Goals for the ARHN Region | | | |
|---|---|---|---|
| **NYS Prevention Agenda Priority Areas** | **Goal #1** | **Goal #2** | **Goal #3** |
| Prevent Chronic Disease | Increase skills and knowledge to support healthy food and beverage choices | Improve self-management skills for individuals with chronic disease | Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities |
| Promote Healthy Women, Infants and Children | Support and enhance children and adolescents' social-emotional development and relationships | Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age | Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations |
| Promote a Healthy and Safe Environment | Promote healthy home and schools' environments | Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change | Reduce violence by targeting prevention programs to highest risk populations |
| Promote Well-Being and Prevent Mental and Substance Use Disorders | Strengthen opportunities to promote well-being and resilience across the lifespan | Facilitate supportive environments that promote respect and dignity for people of all ages | Prevent opioid and other substance misuse and deaths |
| Prevent Communicable Disease | Improve vaccination rates | Improve infection control in health care facilities | Reduce inappropriate antibiotic use |

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

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

*Prevent Chronic Disease*

Most of the responses contained two specific goals, *Promote the use of evidence-based care to manage chronic diseases* and *Improve self-management skills for individuals with chronic disease.* Five out of the seven ARHN counties also listed *Promote tobacco use cessation.* Washington County was the only county to include *Improving community environments that support active transportation,* which aligns with the top ARHN goals.

| Priority Area: Prevent Chronic Disease | | | |
|---|---|---|---|
| **County/Region** | **Goal #1** | **Goal #2** | **Goal #3** |
| **Clinton** | Improve self-management skills for individuals with chronic disease | Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities | Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use |
| **Essex** | Improve self-management skills for individuals with chronic disease | Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities | Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use |
| **Franklin** | Improve self-management skills for individuals with chronic disease | Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use | Promote the use of evidence-based care to manage chronic diseases |
| **Fulton** | Improve self-management skills for individuals with chronic disease | Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use | Increase skills and knowledge to support healthy food and beverage choices |
| **Hamilton** | Improve self-management skills for individuals with chronic disease | Promote the use of evidence-based care to manage chronic diseases | Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use |
| **Warren** | Improve self-management skills for individuals with chronic disease | Increase skills and knowledge to support healthy food and beverage choices | Promote the use of evidence-based care to manage chronic diseases |
| **Washington** | Improve self-management skills for individuals with chronic disease | Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities. | Increase skills and knowledge to support healthy food and beverage choices |

*Promote Healthy Women, Infants and Children*

All ARHN counties choose *Support and enhance children and adolescents' social-emotional development and relationships* as their number one goal. Clinton, Fulton, Hamilton, Warren and Washington counties also listed *Reduce racial, ethnic, economic and geographic disparities in maternal and child health outcomes* as one of their top three goals.

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

*Promote a Healthy and Safe Environment*

*Promote healthy home and schools' environments* was chosen as the top goal for all seven of the ARHN counties, as well as the ARHN region as a whole. *Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change* was also listed in the top three goals for every county.

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

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

*Strengthen opportunities to promote well-being and resilience across the lifespan* and *Facilitate supportive environments that promote respect and dignity for all ages* were both within the top three goals for every county. Five counties also listed *Prevent opioid and other substance misuse and deaths* in their top three goals.

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

*Prevent Communicable Diseases*

All seven ARHN counties listed *Improve vaccination rates, Improve infection control in health care facilities,* and *Reduce inappropriate antibiotic use* in the top three goals that their organization can assist in improving. *Reduce the annual growth rate for Sexually Transmitted Infections (STIs)* was also included in Fulton County's top three goals.

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

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

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

Approximately 70% of all respondents identified *Participating on committees, workgroups and coalitions* and *Share knowledge of community resources* as the main resources they can contribute to help achieve the NYS Prevention Agenda goals listed above. Respondents also felt strongly that they can deliver education and counseling and provide expertise relevant to achieving the listed goals.

This is the first year that we have asked this question in the stakeholder survey. This would be a helpful resource to explore further once partners begin exacting their approved plans.

| Response Counts and Percentages for Resources Organizations Can Contribute | | |
|---|---|---|
| **Resources** | **Count** | **Percentage** |
| Participate on committees, work groups, coalitions to help achieve the selected goals | 208 | 70.99% |
| Share knowledge of community resources | 204 | 69.62% |
| Deliver education and counseling relevant to the selected goal(s) | 189 | 64.51% |
| Provide subject-matter knowledge and expertise | 182 | 62.12% |
| Promote health improvement activities/events through social media and other communication channels your organization/agency operates | 164 | 55.97% |
| Facilitate access to populations your organization/agency serves | 139 | 47.44% |

| | | |
|---|---|---|
| Provide letters of support for planned health improvement activities | 124 | 42.32% |
| Offer health related-educational materials | 117 | 39.93% |
| Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals | 112 | 38.23% |
| Work to promote changes to policies/laws/community environment to address selected goal(s) | 111 | 37.88% |

## *2019 CHA Stakeholders Survey*

### Introduction

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

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

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

### Your Organization/Agency

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

1. Organization/Agency name:

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

3. Your job title/role:

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

4. Your email address:

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

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

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

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

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

## Health Priorities, Concerns and Factors

The NYS Prevention Agenda for 2019-2024 identifies five main priority areas that are key to improving the health of residents that you serve. These main priority areas are listed in question #7.

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

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

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

- ☐ Adverse childhood experiences
- ☐ Alzheimer's disease/Dementia
- ☐ Arthritis
- ☐ Autism
- ☐ Cancers
- ☐ Child/Adolescent physical health
- ☐ Child/Adolescent emotional health
- ☐ Diabetes
- ☐ Disability
- ☐ Dental health
- ☐ Domestic abuse/violence
- ☐ Drinking water quality
- ☐ Emerging infectious diseases (ebola, zika virus, tick and mosquito-transmitted, etc.)
- ☐ Exposure to air and water pollutants/hazardous materials
- ☐ Falls
- ☐ Food safety
- ☐ Heart disease
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hunger
- ☐ Infant health
- ☐ Infectious disease
- ☐ LGBT health

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

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

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

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

## Social Determinants of Health

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

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

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

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

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

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

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

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

## Improving Health and Well-Being

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

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

**13. Prevent Chronic Diseases**

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

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

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

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

- ☐ Reduce falls among vulnerable populations
- ☐ Reduce violence by targeting prevention programs to highest risk populations
- ☐ Reduce occupational injury and illness

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

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

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

**17. Prevent Communicable Diseases**

- ☐ Improve vaccination rates
- ☐ Reduce vaccination coverage disparities
- ☐ Decrease HIV morbidity (new HIV diagnoses)
- ☐ Increase HIV viral suppression
- ☐ Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
- ☐ Increase the number of persons treated for Hepatitis C
- ☐ Reduce the number of new Hepatitis C cases among people who inject drugs
- ☐ Improve infection control in health care facilities
- ☐ Reduce infections caused by multidrug resistant organisms and C. difficile
- ☐ Reduce inappropriate antibiotic use

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

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

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

- ☐ Yes
- ☐ No

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

# Update to 2024-2027 Goals and Objectives
# Clinton County Mental Health And Addiction Services

Richelle Gregory, Director of Community Services
richelle.gregory@clintoncountyny.gov

| Goal 1 | |
|---|---|
| **Title** | Crisis Services |
| **Update** | |
| **OBJECTIVES** | |
| Crisis Intervention Team | Ongoing |
| Home and Community Based Crisis Intervention | Ongoing |
| Crisis Residential | Ongoing |
| Intensive Crisis Stabilization Center | Ongoing |
| Co-occurring OMH and OPWDD | Ongoing |
| **OBJECTIVE UPDATES** | |

| Goal 2 | |
|---|---|
| **Title** | Housing |
| **Update** | |
| **OBJECTIVES** | |
| Additional Apartments for those with an Intellectual/Developmental Disabilitiy | Ongoing |
| Empire State Supportive Housing Initiative Planning | Ongoing |
| Expansion of Permanent Supported Housing | Ongoing |
| **OBJECTIVE UPDATES** | |

| Goal 3 | |
|---|---|
| **Title** | Case Management/Care Coordination |
| **Update** | |
| **OBJECTIVES** | |
| Expanding Care Mangement | Ongoing |
| Expand the System Of Care | Ongoing |
| Improve Emergency Room Coordination | Ongoing |

| | |
|---|---|
| Strenthen the Relationship with Law Enforcement and Judicial System | Ongoing |
| **OBJECTIVE UPDATES** | |

| **Goal 4** | |
|---|---|
| **Title** | Prevention |
| **Update** | |
| **OBJECTIVES** | |
| Intensive and Sustained Engagement | N/A |
| • Youth Development Survey | Ongoing |
| • Opioid Settlement Funds | Ongoing |
| System of Care | Ongoing |
| School Support | Ongoing |
| **OBJECTIVE UPDATES** | |


# 2024 Needs Assessment Form
# Clinton County Mental Health And Addiction Services

**Adverse Childhood Experiences** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Case Management/Care Coordination** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Crisis Services** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Cross System Services** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Forensics** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Housing** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes

Need Applies to: Adults Only
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Inpatient Treatment** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? No
Need description (Optional): Inpatient stays at the 9.39 hospital has been a concern given staffing shortages, lack of the ability to move individuals from the 9.39 to appropriate placement to stabilize with limited to no access to appropriate treatment facilities for those with co-occurring disorders. We need better care coordination, education for emergency room staff on co-occurring disorders (behavioral, baseline, mental health, I/DD, substance use, aging) and to strengthen the workforce. We also need more placement options that can address, stabilize, appropriately diagnose and work with the community on treatment planning for adults and youth with acute symptoms or co-occurring disorders.

**Outpatient Treatment** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? No
Need description (Optional): We need to strengthen the workforce either by recruiting more prescribers or finding alternatives. We also need to balance the cost of the prescribers with the revenue/lost revenue due to inconsistency with appointments and engagement.

**Prevention** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Residential Treatment Services** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? No
Need description (Optional): Wait lists, staffing shortages and co-occurring disorders have made finding an appropriate residential placement for individuals who can not be stabilized in the community leave families with little options besides cycling in and out of the emergency room. Without proper resources and the ability to find appropriate placements the hospitals and emergency rooms are seeing more acute patients with co-occurring disorders and discharging back to the community without appropriate treatment or stabilization to avoid long-term stays at the local emergency room or mental health units. We need co-occurring residential treatment services for those with co-occurring diagnostic and treatment facilities for the entire life span.

**Workforce** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults

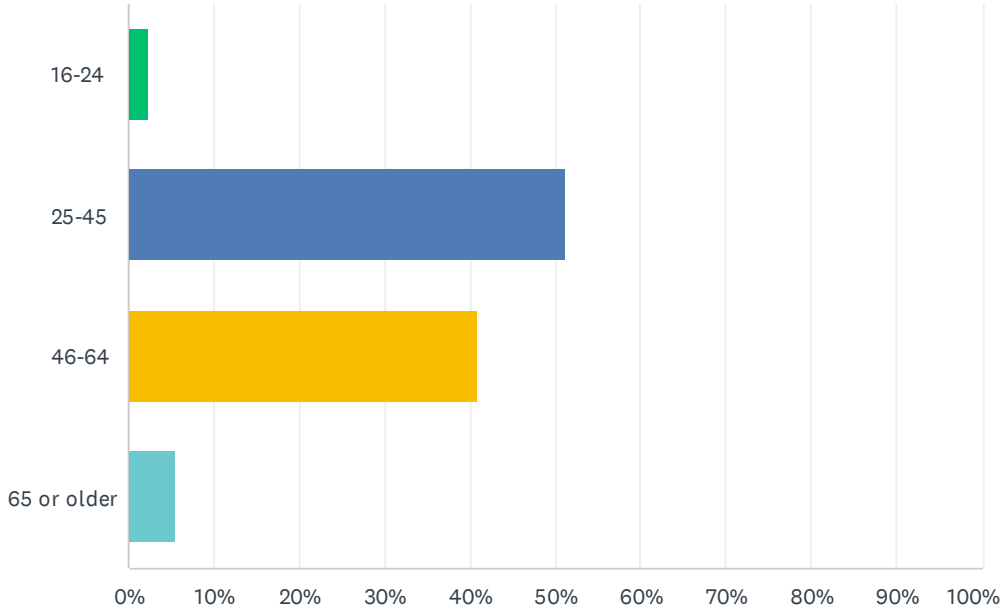
Do any of the Goals on the Goals and Objectives Form address this need? No
Need description (Optional): We need to recruit and retain staff in these fields and expand the service provisions to include non-traditional providers. There needs to be changes in civil service positions and testing. We need to include support staff as vital to serving the vulnerable populations and provide incentives and efforts to recruit and retain support staff.

**LGU Representative**: Richelle Gregory

**Submitted for:** Clinton County Mental Health And Addiction Services

# Q1 What is your age?

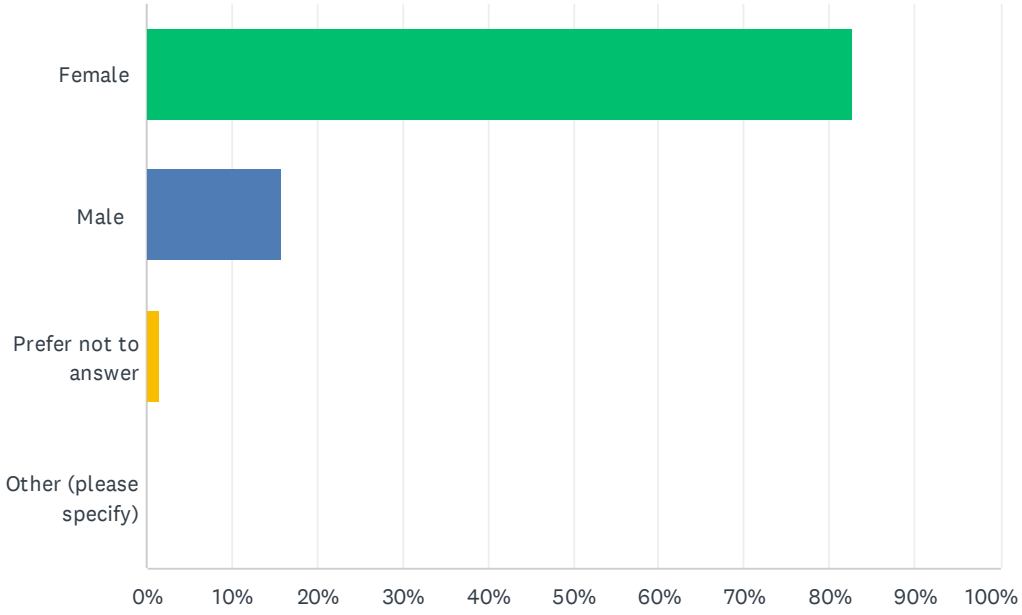
Answered: 127 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| 16-24 | 2.36% | 3 |
| 25-45 | 51.18% | 65 |
| 46-64 | 40.94% | 52 |
| 65 or older | 5.51% | 7 |
| TOTAL | | 127 |

# Q2 What gender do you identify with?

Answered: 127 Skipped: 0

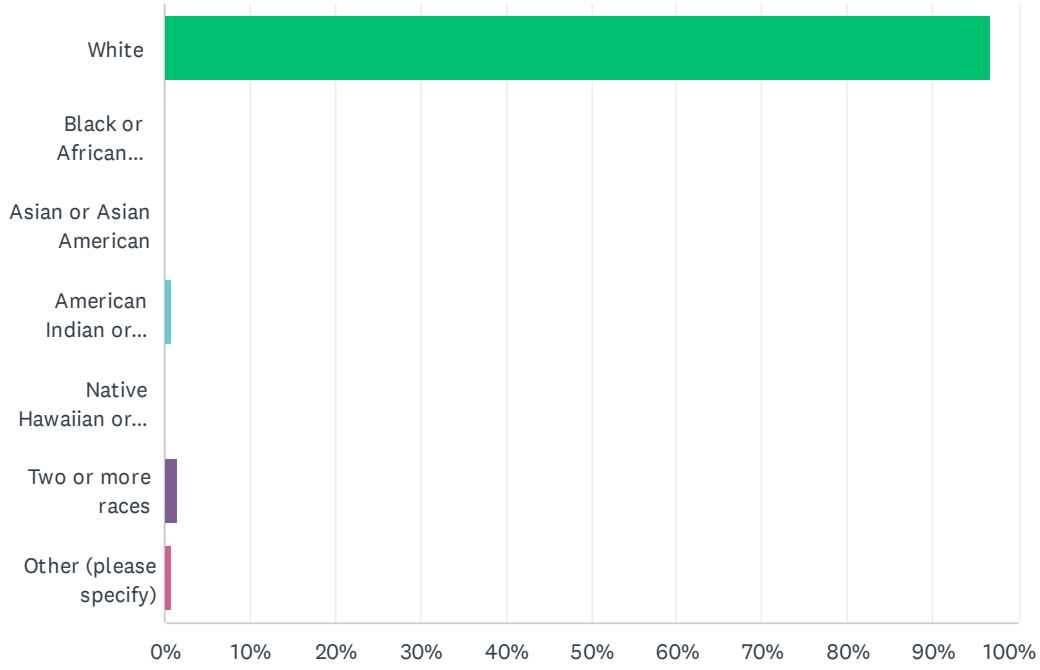



| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Female | 82.68% | 105 |
| Male | 15.75% | 20 |
| Prefer not to answer | 1.57% | 2 |
| Other (please specify) | 0.00% | 0 |
| TOTAL | | 127 |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| | There are no responses. | |

# Q3 What is your race?

Answered: 127 Skipped: 0

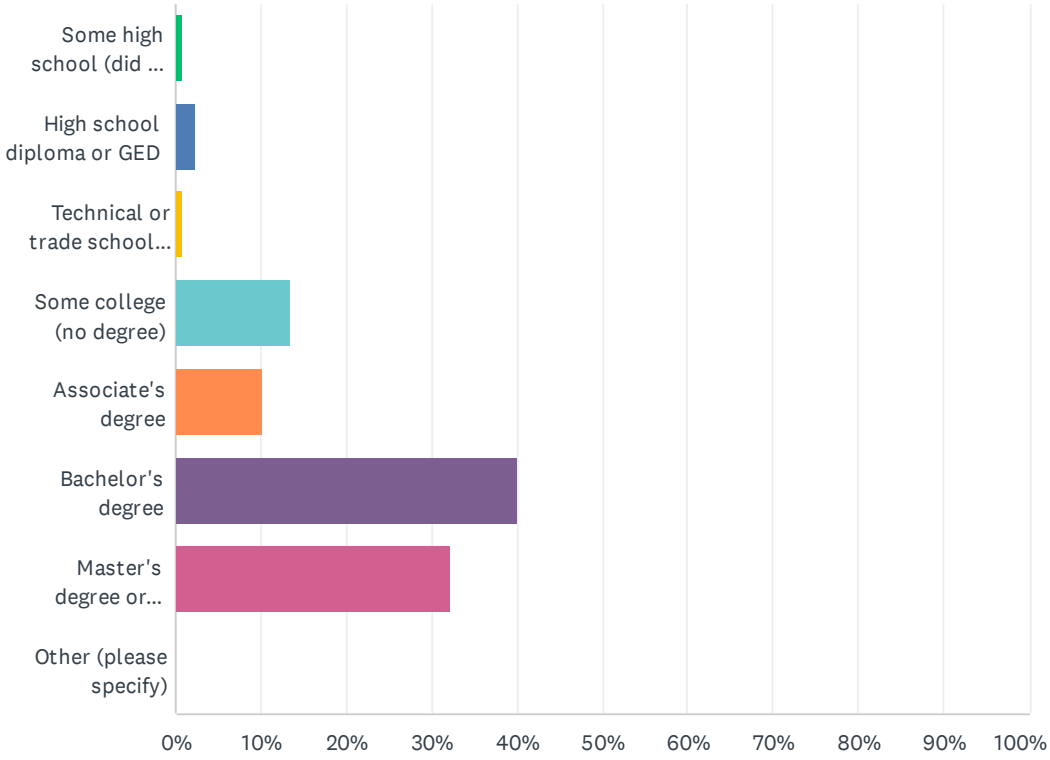



| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| White | 96.85% | 123 |
| Black or African American | 0.00% | 0 |
| Asian or Asian American | 0.00% | 0 |
| American Indian or Alaska Native | 0.79% | 1 |
| Native Hawaiian or other Pacific Islander | 0.00% | 0 |
| Two or more races | 1.57% | 2 |
| Other (please specify) | 0.79% | 1 |
| TOTAL | | 127 |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | Hispanic | 7/13/2023 12:08 PM |

# Q4 What is your highest level of education?

Answered: 127 Skipped: 0

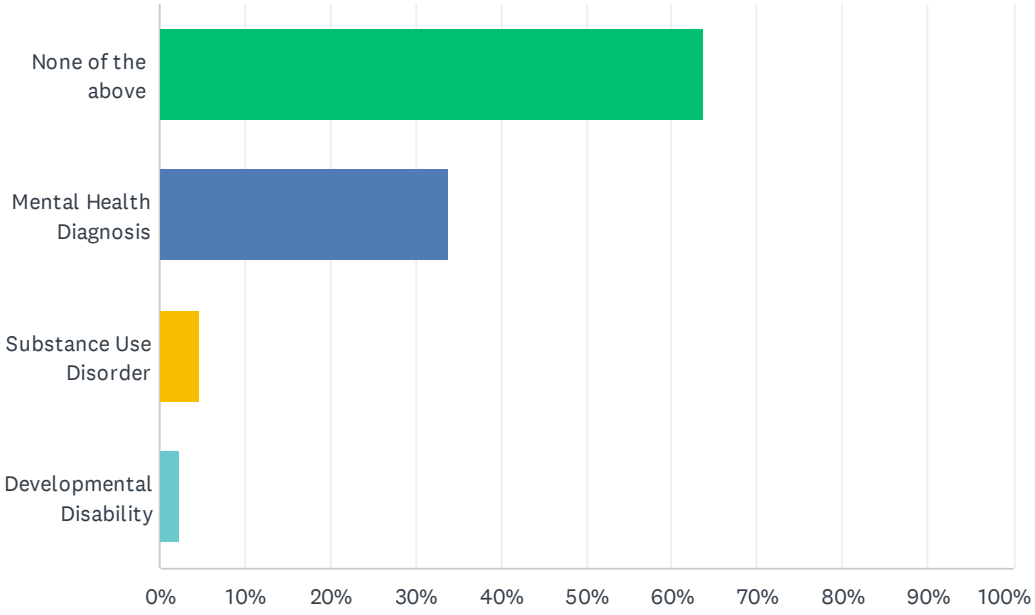



| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Some high school (did not finish) | 0.79% | 1 |
| High school diploma or GED | 2.36% | 3 |
| Technical or trade school certificate | 0.79% | 1 |
| Some college (no degree) | 13.39% | 17 |
| Associate's degree | 10.24% | 13 |
| Bachelor's degree | 40.16% | 51 |
| Master's degree or higher | 32.28% | 41 |
| Other (please specify) | 0.00% | 0 |
| TOTAL | | 127 |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| | There are no responses. | |

# Q5 Do you identify as someone who has a (please select all that apply):

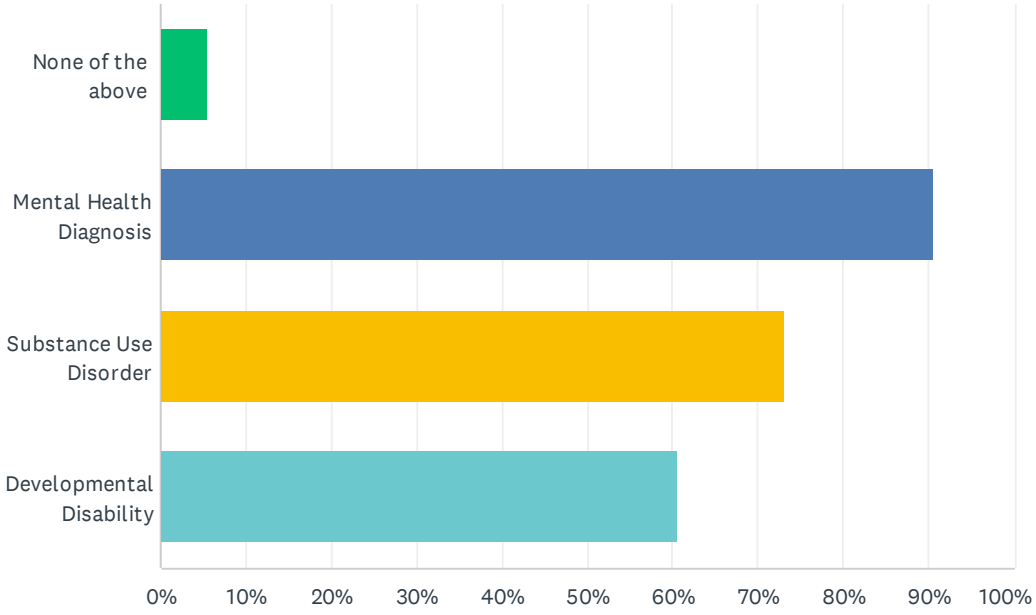
Answered: 127 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| None of the above | 63.78% | 81 |
| Mental Health Diagnosis | 33.86% | 43 |
| Substance Use Disorder | 4.72% | 6 |
| Developmental Disability | 2.36% | 3 |
| Total Respondents: 127 | | |

# Q6 Do you know someone who has a (please select all that apply):

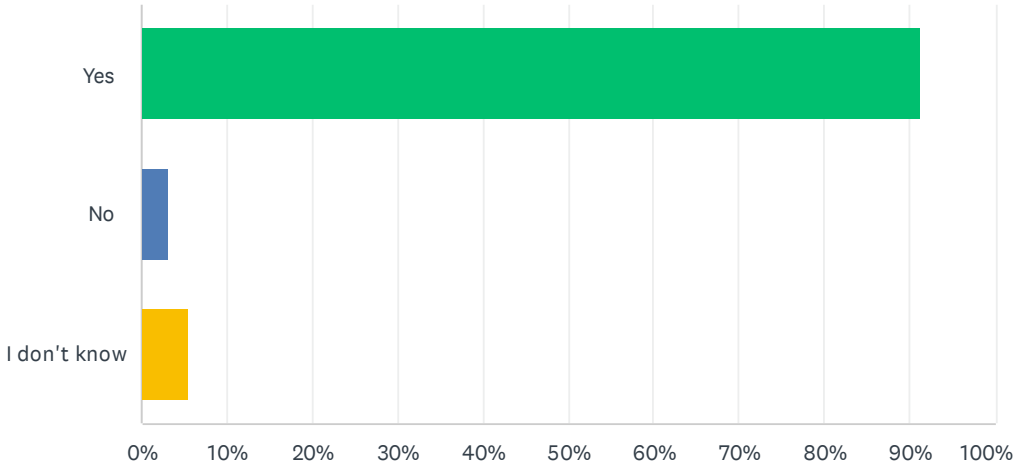
Answered: 127 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| None of the above | 5.51% | 7 |
| Mental Health Diagnosis | 90.55% | 115 |
| Substance Use Disorder | 73.23% | 93 |
| Developmental Disability | 60.63% | 77 |
| Total Respondents: 127 | | |

# Q7 Is education and training on the impact of ACEs a high need in our community?

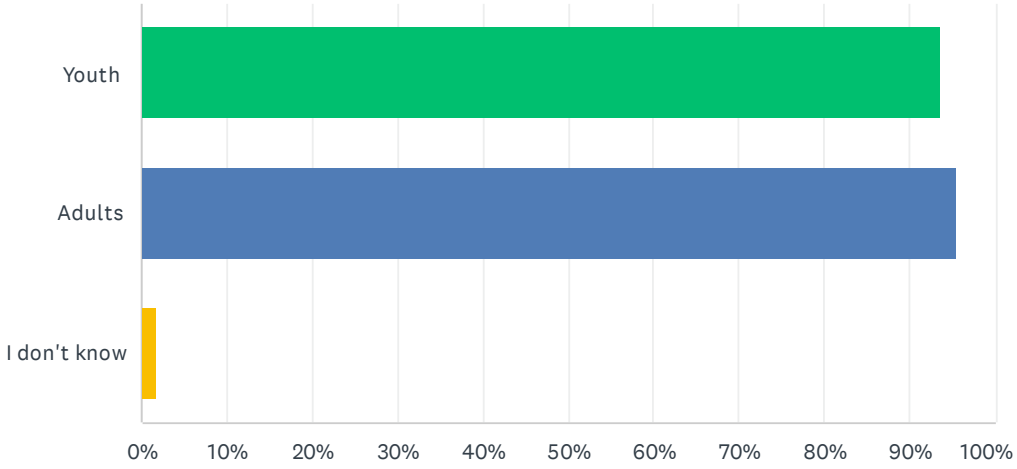
Answered: 125 Skipped: 2




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 91.20% | 114 |
| No | 3.20% | 4 |
| I don't know | 5.60% | 7 |
| TOTAL | | 125 |

# Q8 Does this need apply to (please select all that apply):

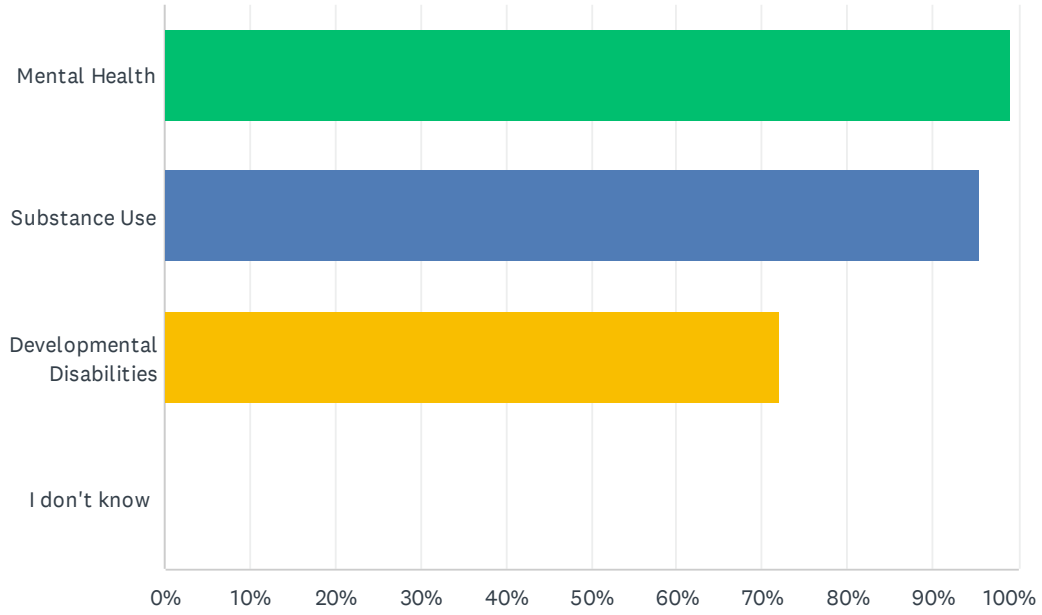
Answered: 111 Skipped: 16




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 93.69% | 104 |
| Adults | 95.50% | 106 |
| I don't know | 1.80% | 2 |
| Total Respondents: 111 | | |

# Q9 Does this need apply to those impacted by (please select all that apply):

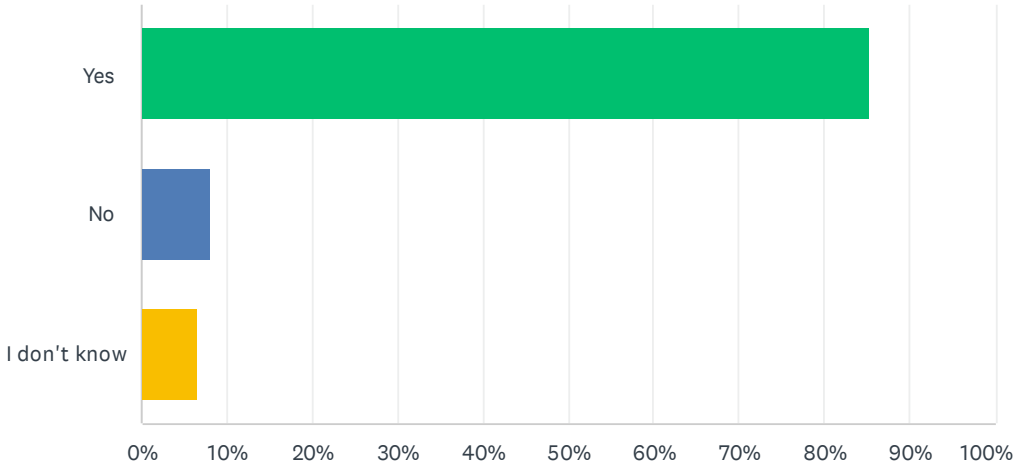
Answered: 111 Skipped: 16




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 99.10% | 110 |
| Substance Use | 95.50% | 106 |
| Developmental Disabilities | 72.07% | 80 |
| I don't know | 0.00% | 0 |
| Total Respondents: 111 | | |

# Q10 Does our community need more Case Management/Care Coordination to support vulnerable populations?

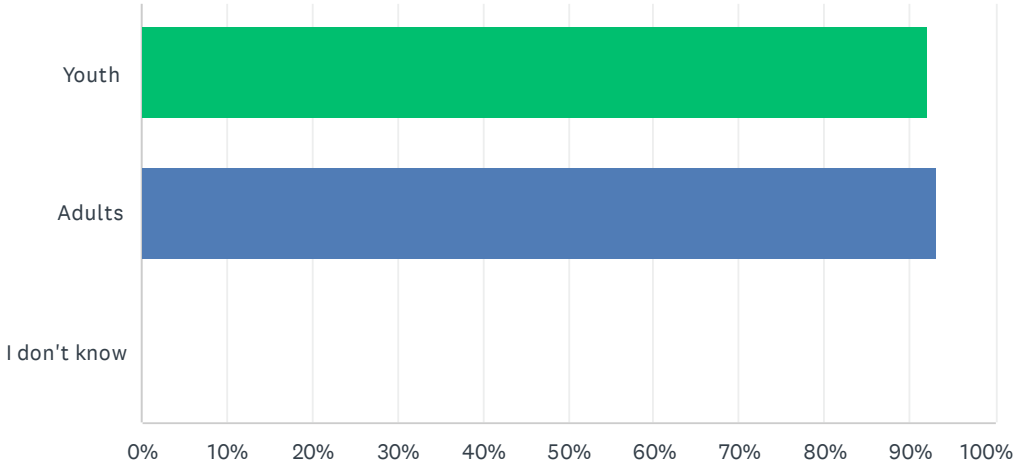
Answered: 122 Skipped: 5




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 85.25% | 104 |
| No | 8.20% | 10 |
| I don't know | 6.56% | 8 |
| TOTAL | | 122 |

# Q11 Does this need apply to (please select all that apply):

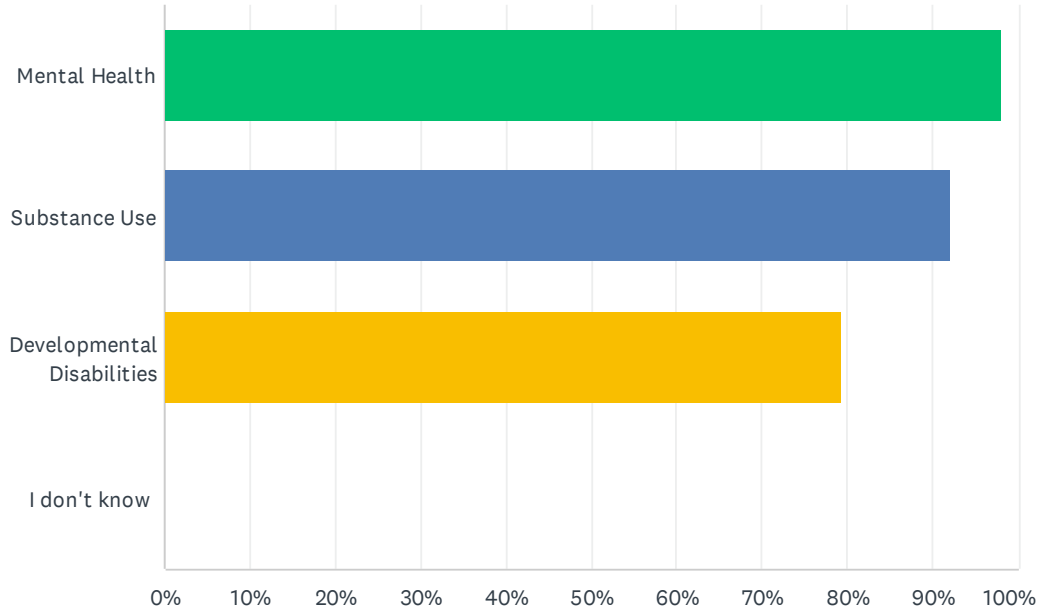
Answered: 102 Skipped: 25




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 92.16% | 94 |
| Adults | 93.14% | 95 |
| I don't know | 0.00% | 0 |
| Total Respondents: 102 | | |

# Q12 Does this need apply to those impacted by (please select all that apply):

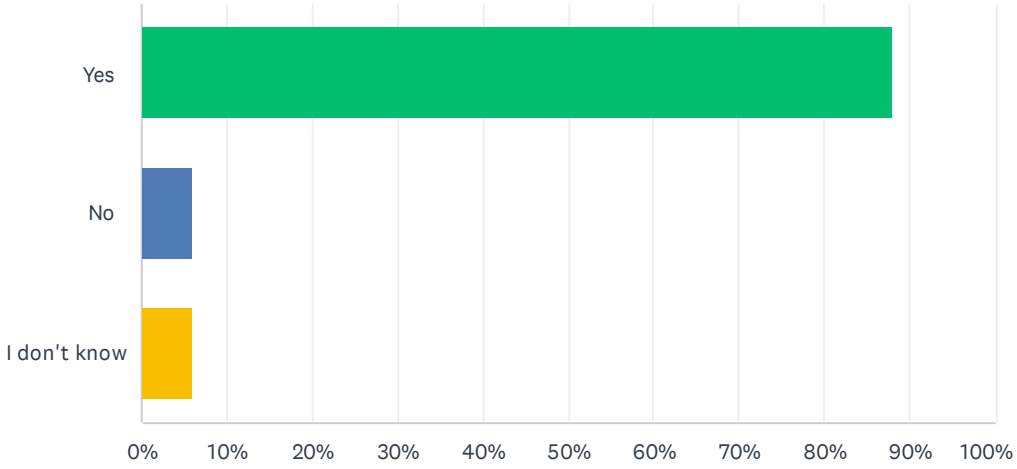
Answered: 102 Skipped: 25




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 98.04% | 100 |
| Substance Use | 92.16% | 94 |
| Developmental Disabilities | 79.41% | 81 |
| I don't know | 0.00% | 0 |
| Total Respondents: 102 | | |

# Q13 Is strengthening crisis services a high need in our community?

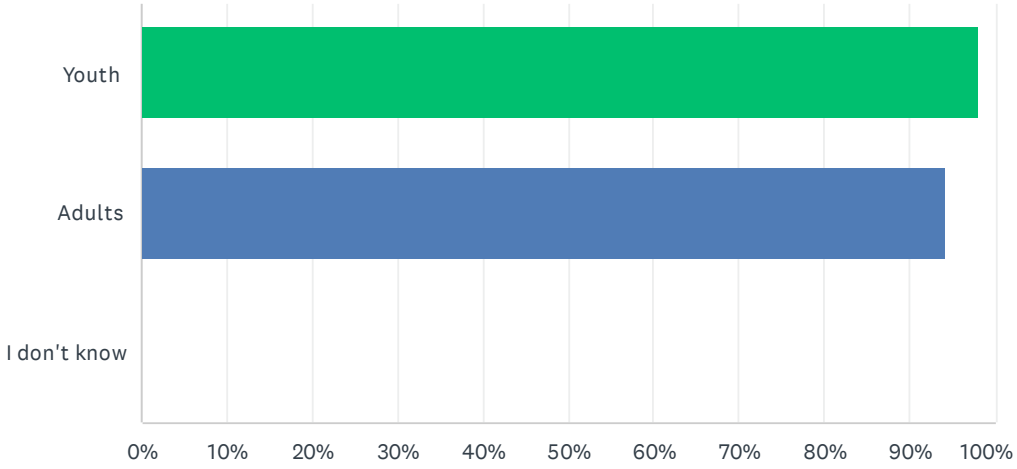
Answered: 118 Skipped: 9




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 88.14% | 104 |
| No | 5.93% | 7 |
| I don't know | 5.93% | 7 |
| TOTAL | | 118 |

# Q14 Does this need apply to (please select all that apply):

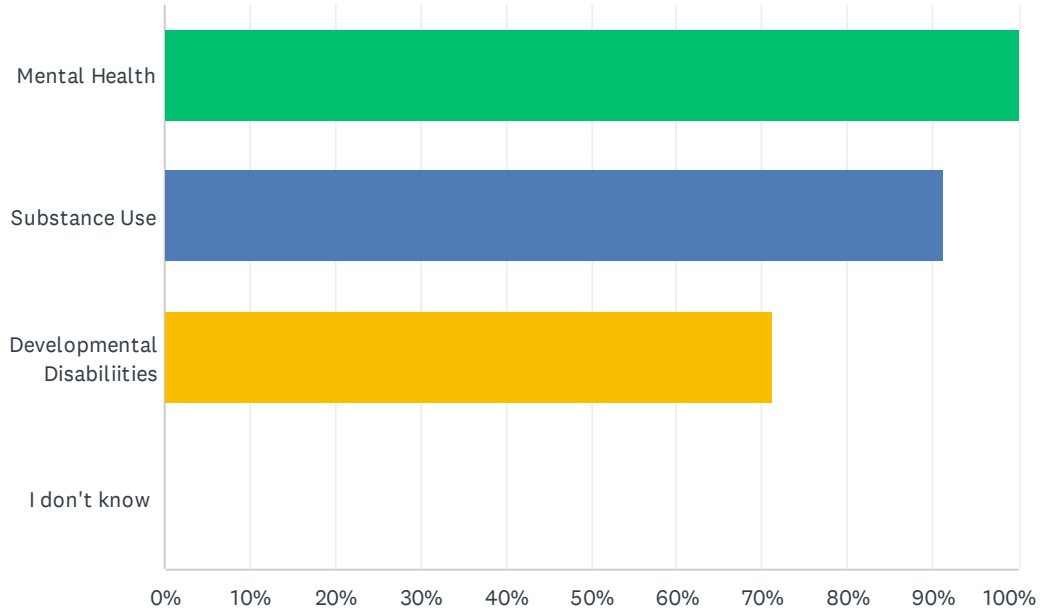
Answered: 104 Skipped: 23




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 98.08% | 102 |
| Adults | 94.23% | 98 |
| I don't know | 0.00% | 0 |
| Total Respondents: 104 | | |

# Q15 Does this need apply to those impacted by (please select all that apply):

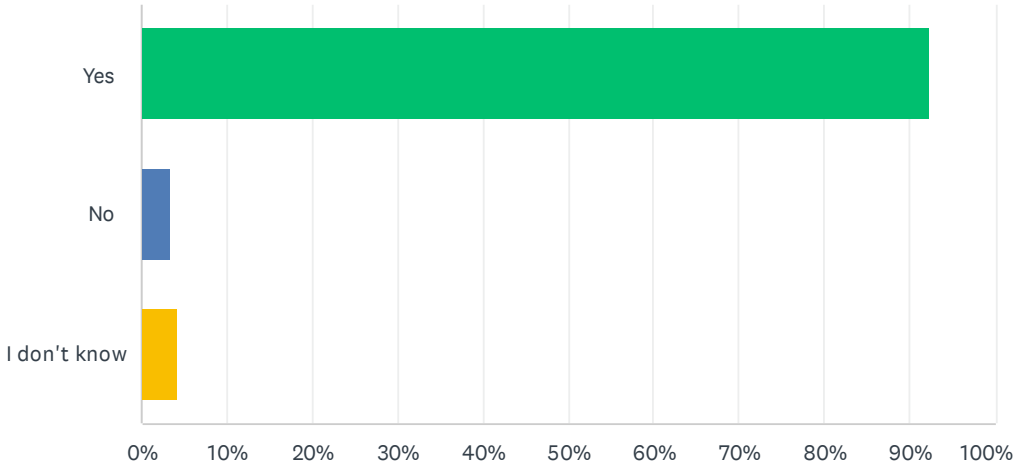
Answered: 104 Skipped: 23




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 100.00% | 104 |
| Substance Use | 91.35% | 95 |
| Developmental Disabiliities | 71.15% | 74 |
| I don't know | 0.00% | 0 |
| Total Respondents: 104 | | |

# Q16 Is strengthening cross system services for vulnerable populations a high need in our community?

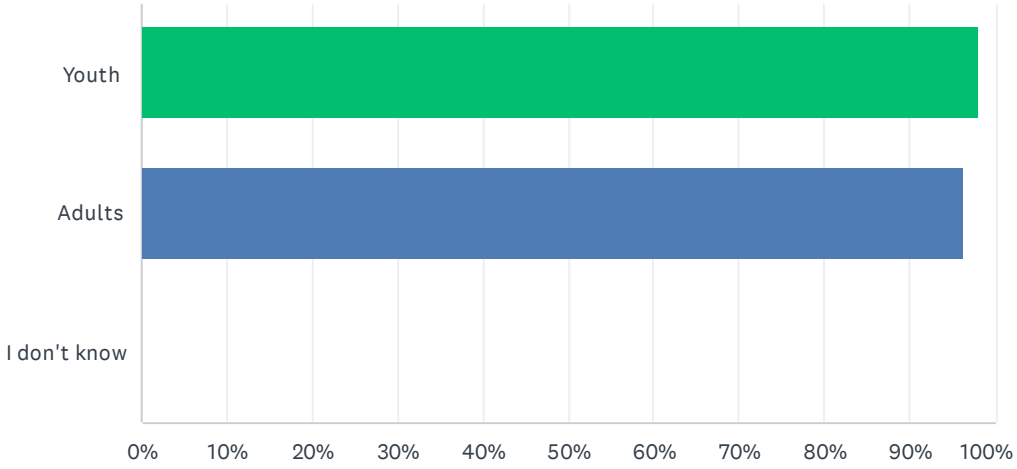
Answered: 117 Skipped: 10




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 92.31% | 108 |
| No | 3.42% | 4 |
| I don't know | 4.27% | 5 |
| TOTAL | | 117 |

# Q17 Does this need apply to (please select all that apply):

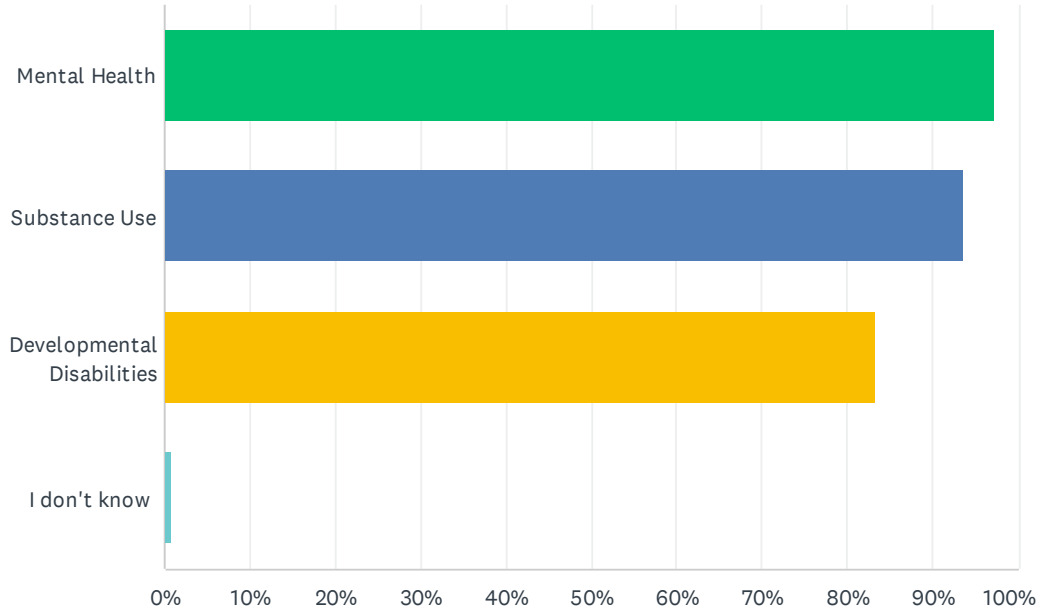
Answered: 108 Skipped: 19




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 98.15% | 106 |
| Adults | 96.30% | 104 |
| I don't know | 0.00% | 0 |
| Total Respondents: 108 | | |

# Q18 Does this need apply to those impacted by (please select all that apply):

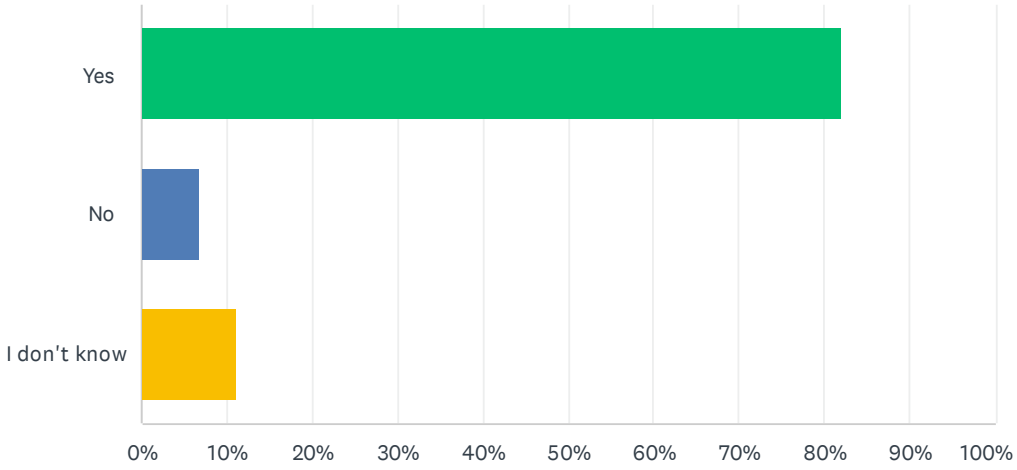
Answered: 108 Skipped: 19




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 97.22% | 105 |
| Substance Use | 93.52% | 101 |
| Developmental Disabilities | 83.33% | 90 |
| I don't know | 0.93% | 1 |
| Total Respondents: 108 | | |

# Q19 Does our community need more employment/volunteer opportunities for vulnerable populations?

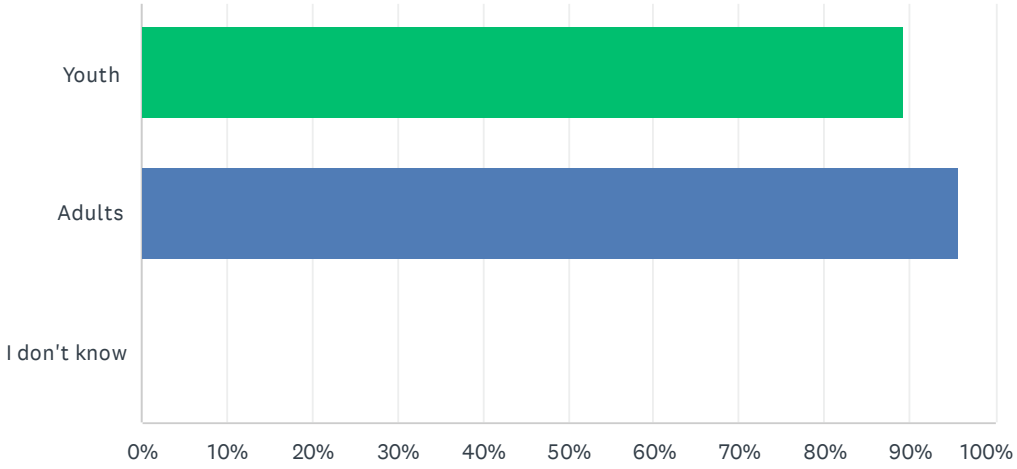
Answered: 117 Skipped: 10




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 82.05% | 96 |
| No | 6.84% | 8 |
| I don't know | 11.11% | 13 |
| TOTAL | | 117 |

# Q20 Does this need apply to (please select all that apply):

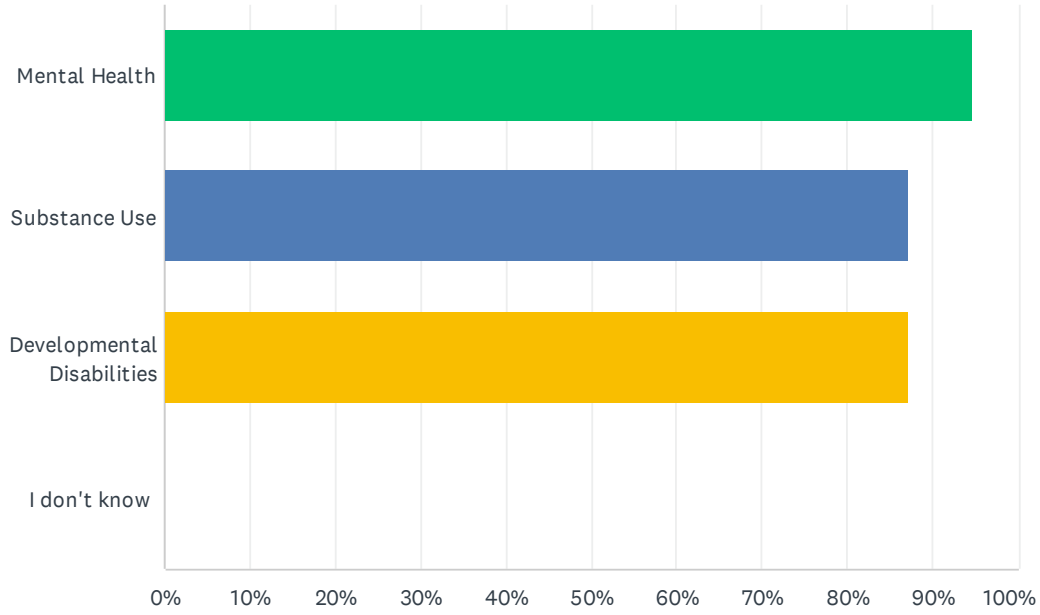
Answered: 94 Skipped: 33




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 89.36% | 84 |
| Adults | 95.74% | 90 |
| I don't know | 0.00% | 0 |
| Total Respondents: 94 | | |

# Q21 Does this need apply to those impacted by (please select all that apply):

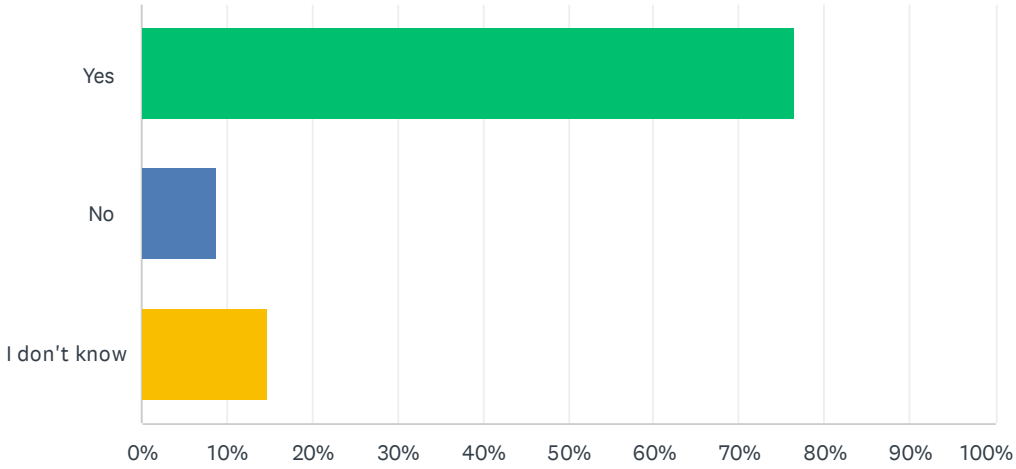
Answered: 94 Skipped: 33




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 94.68% | 89 |
| Substance Use | 87.23% | 82 |
| Developmental Disabilities | 87.23% | 82 |
| I don't know | 0.00% | 0 |
| Total Respondents: 94 | | |

# Q22 Is there a need for additional services or interventions for vulnerable populations in contact with law enforcement or the judicial system in our community?

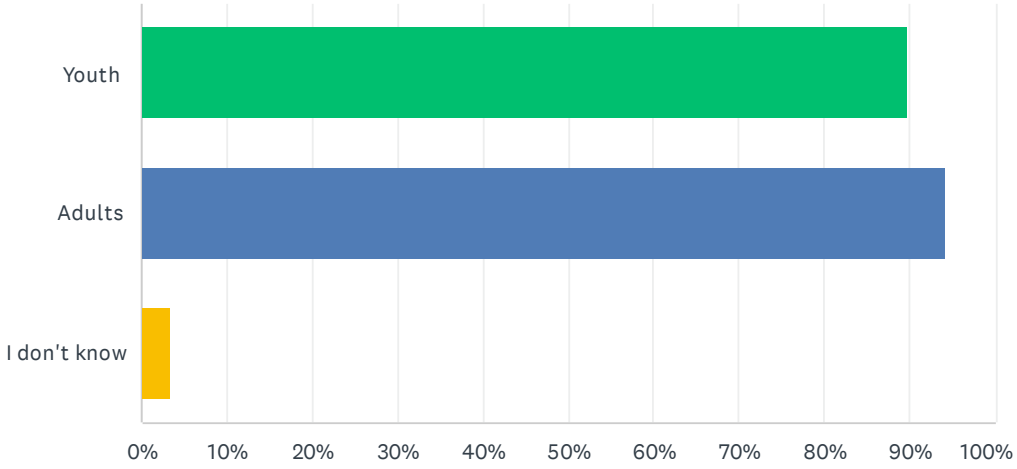
Answered: 115 Skipped: 12




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 76.52% | 88 |
| No | 8.70% | 10 |
| I don't know | 14.78% | 17 |
| TOTAL | | 115 |

# Q23 Does this need apply to (please select all that apply):

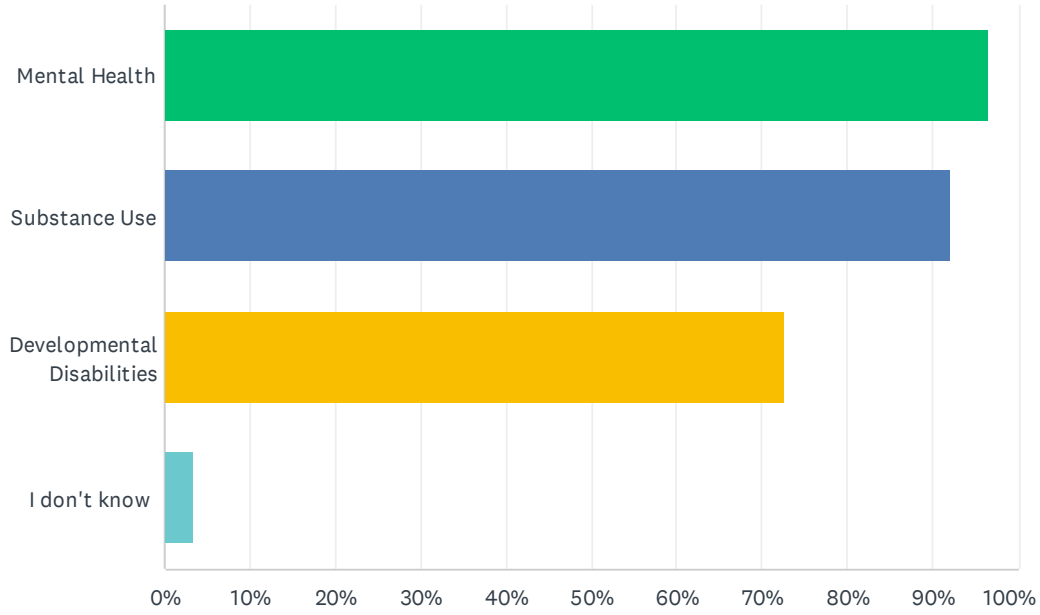
Answered: 88 Skipped: 39




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 89.77% | 79 |
| Adults | 94.32% | 83 |
| I don't know | 3.41% | 3 |
| Total Respondents: 88 | | |

# Q24 Does this need apply to those impacted by (please select all that apply):

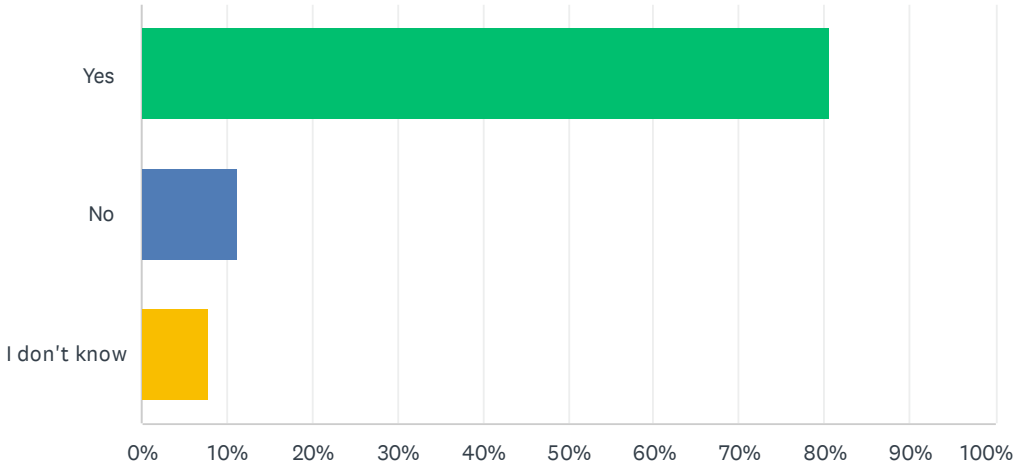
Answered: 88 Skipped: 39




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 96.59% | 85 |
| Substance Use | 92.05% | 81 |
| Developmental Disabilities | 72.73% | 64 |
| I don't know | 3.41% | 3 |
| Total Respondents: 88 | | |

# Q25 Does our community need more housing to support vulnerable populations?

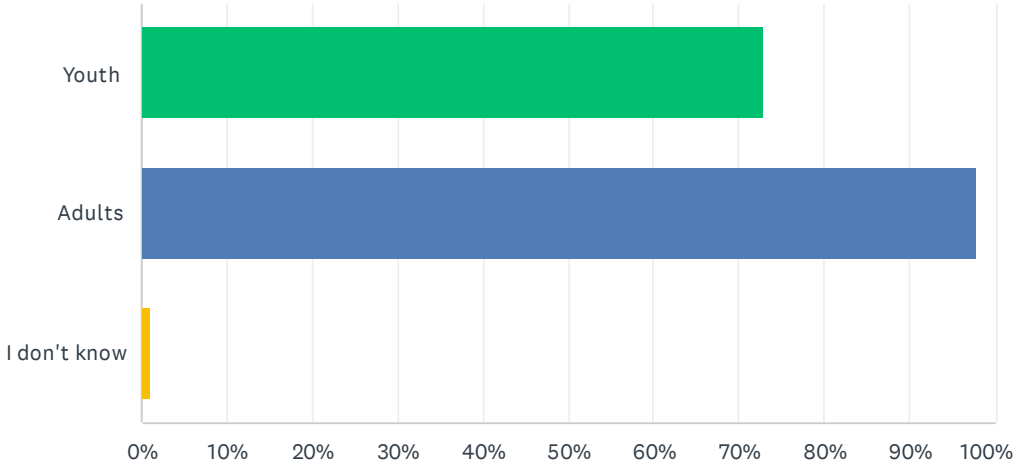
Answered: 114 Skipped: 13




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 80.70% | 92 |
| No | 11.40% | 13 |
| I don't know | 7.89% | 9 |
| TOTAL | | 114 |

# Q26 Does this need apply to (please select all that apply):

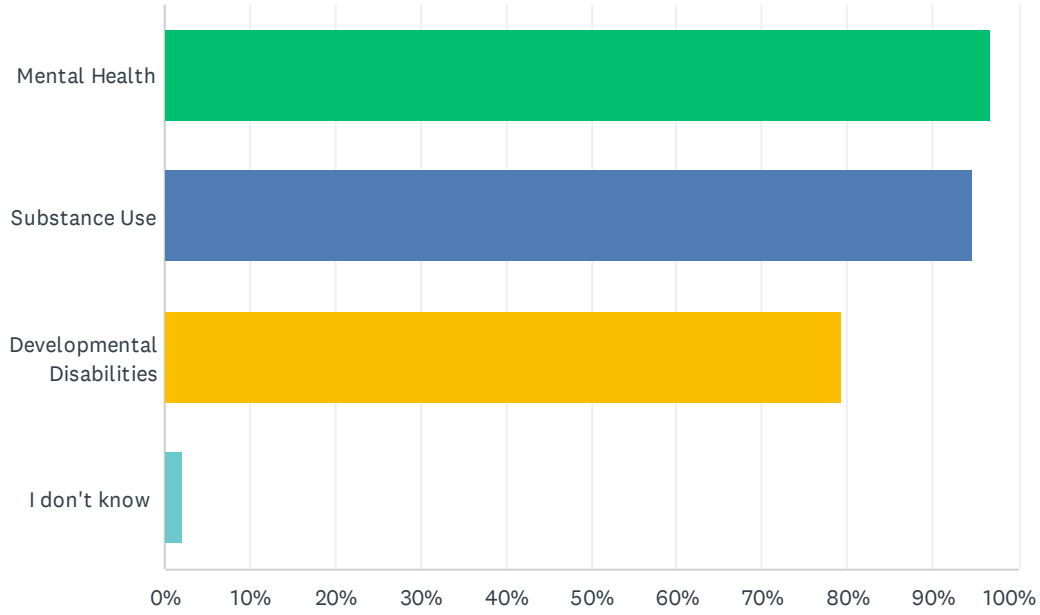
Answered: 92 Skipped: 35




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 72.83% | 67 |
| Adults | 97.83% | 90 |
| I don't know | 1.09% | 1 |
| Total Respondents: 92 | | |

# Q27 Does this need apply to those impacted by (please select all that apply):

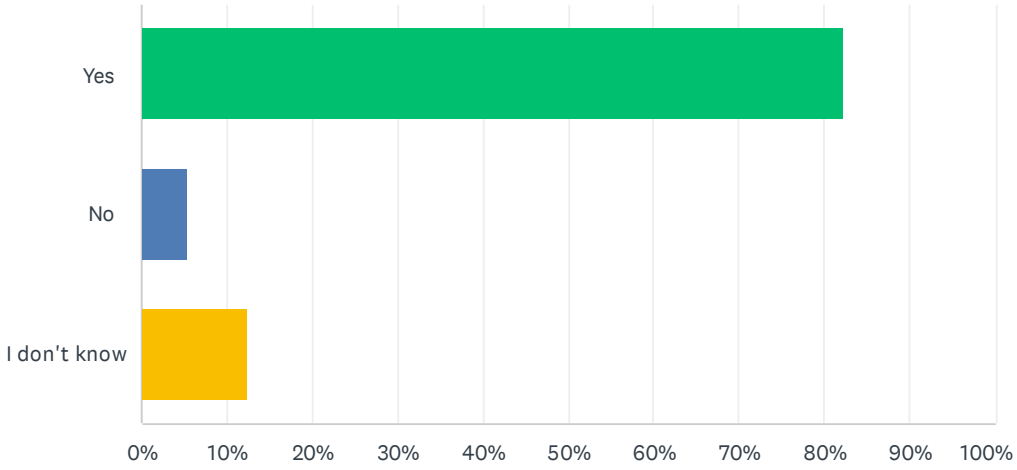
Answered: 92 Skipped: 35




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 96.74% | 89 |
| Substance Use | 94.57% | 87 |
| Developmental Disabilities | 79.35% | 73 |
| I don't know | 2.17% | 2 |
| Total Respondents: 92 | | |

# Q28 Is the availability of inpatient treatment beds a high need in our community?

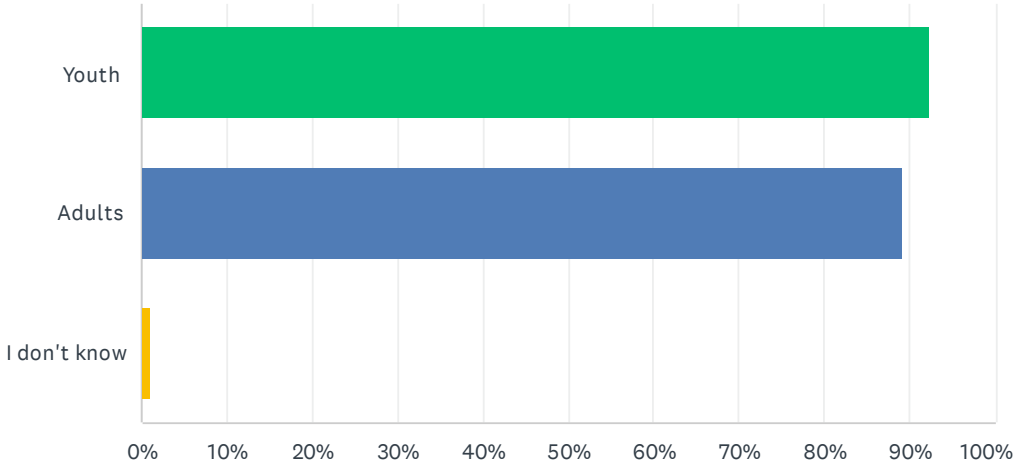
Answered: 113 Skipped: 14




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 82.30% | 93 |
| No | 5.31% | 6 |
| I don't know | 12.39% | 14 |
| TOTAL | | 113 |

# Q29 Does this need apply to (please select all that apply):

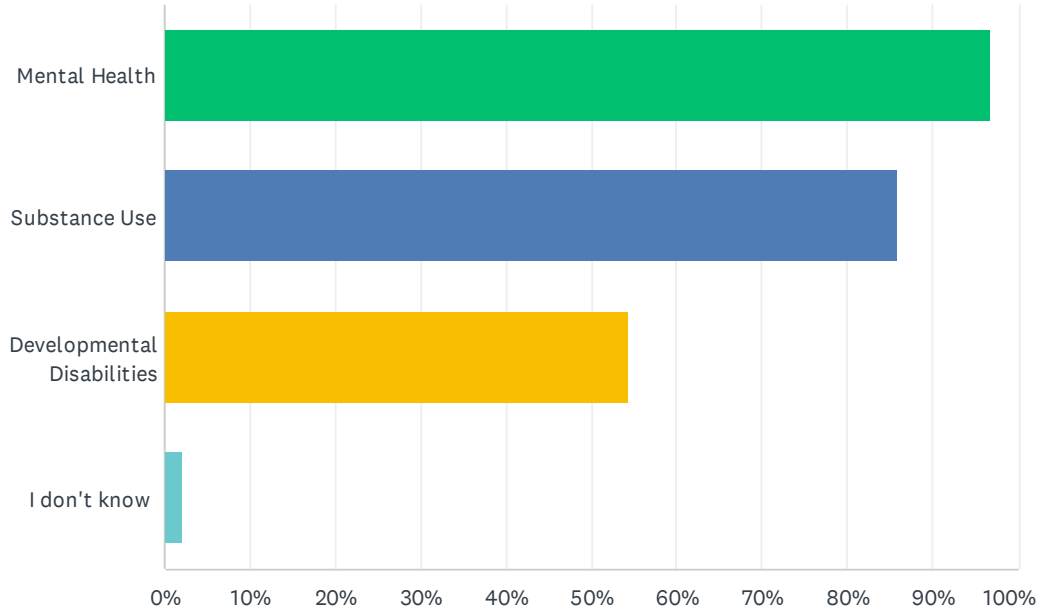
Answered: 92 Skipped: 35




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 92.39% | 85 |
| Adults | 89.13% | 82 |
| I don't know | 1.09% | 1 |
| Total Respondents: 92 | | |

# Q30 Does this need apply to those impacted by (please select all that apply):

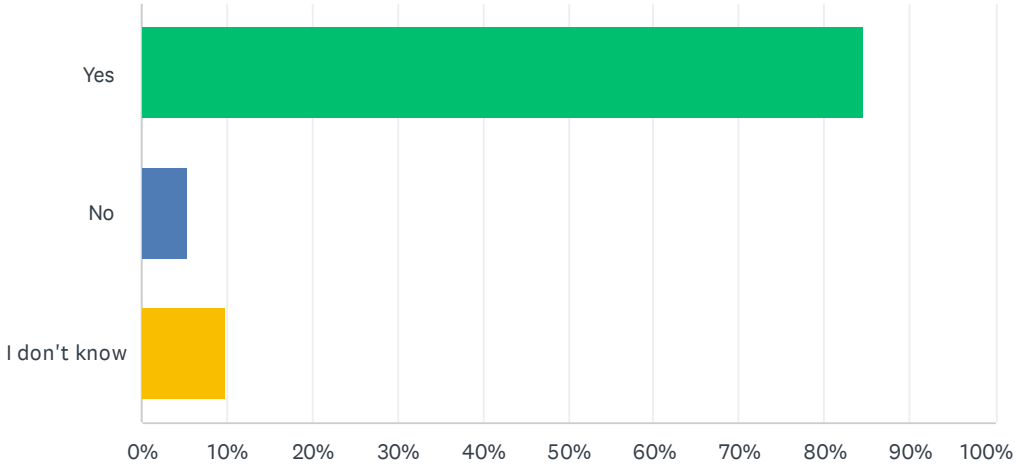
Answered: 92 Skipped: 35




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 96.74% | 89 |
| Substance Use | 85.87% | 79 |
| Developmental Disabilities | 54.35% | 50 |
| I don't know | 2.17% | 2 |
| Total Respondents: 92 | | |

# Q31 Does our community need to expand non-clinical supports?

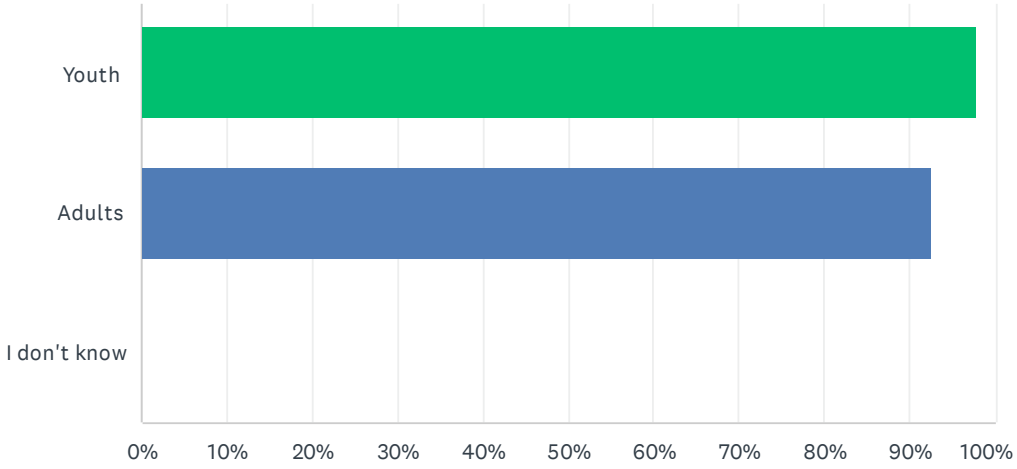
Answered: 111 Skipped: 16




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 84.68% | 94 |
| No | 5.41% | 6 |
| I don't know | 9.91% | 11 |
| TOTAL | | 111 |

# Q32 Does this need apply to (please select all that apply):

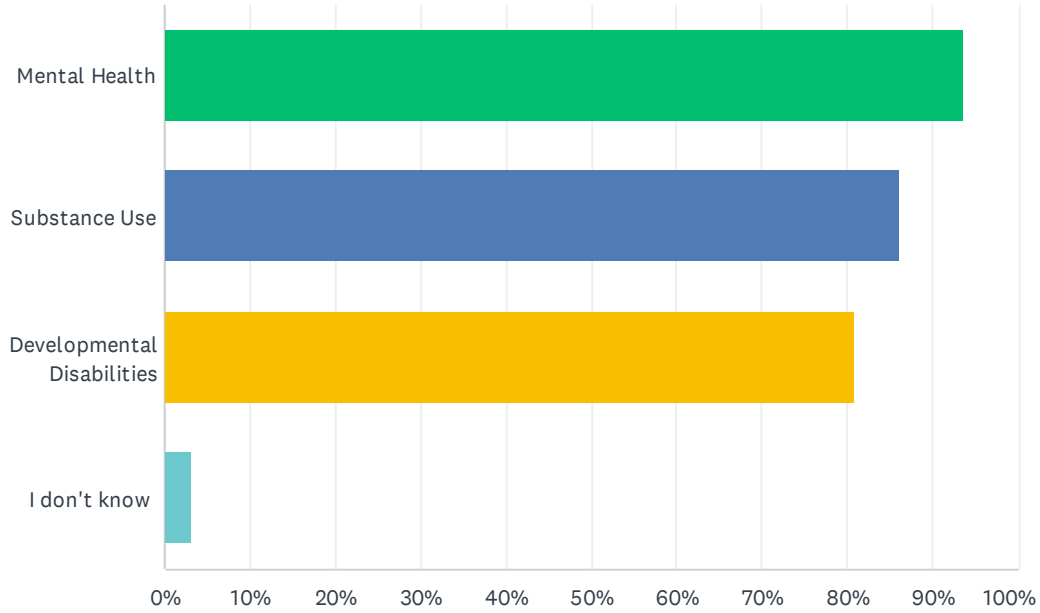
Answered: 94 Skipped: 33




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 97.87% | 92 |
| Adults | 92.55% | 87 |
| I don't know | 0.00% | 0 |
| Total Respondents: 94 | | |

# Q33 Does this need apply to those impacted by (please select all that apply):

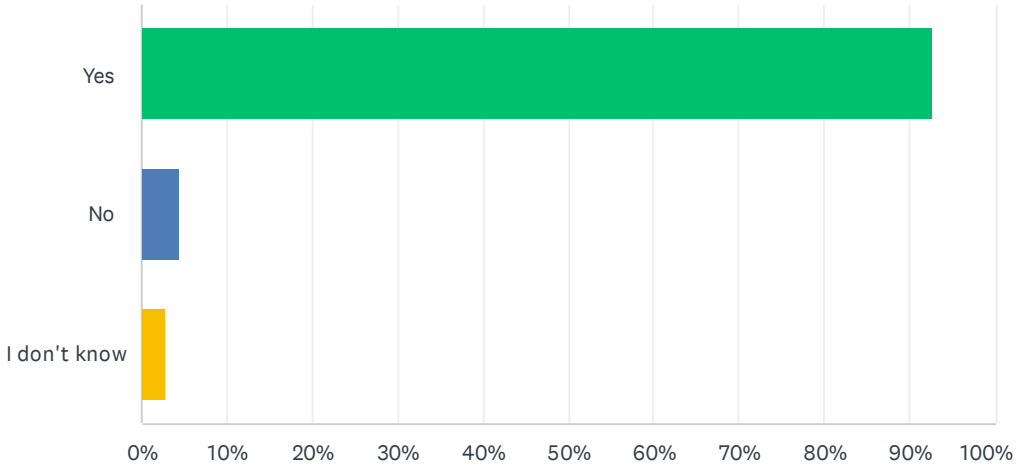
Answered: 94 Skipped: 33




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 93.62% | 88 |
| Substance Use | 86.17% | 81 |
| Developmental Disabilities | 80.85% | 76 |
| I don't know | 3.19% | 3 |
| Total Respondents: 94 | | |

# Q34 Is access and availability to outpatient treatment a high need in our community?

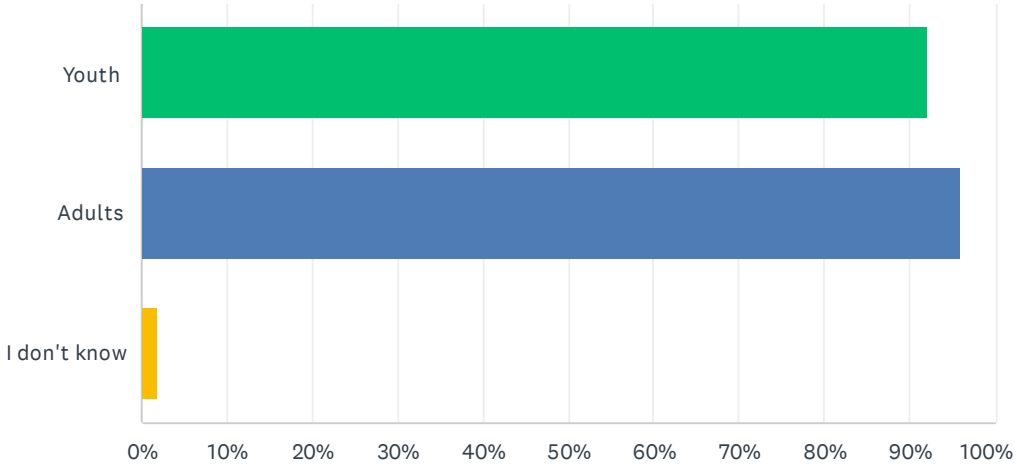
Answered: 110 Skipped: 17




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 92.73% | 102 |
| No | 4.55% | 5 |
| I don't know | 2.73% | 3 |
| TOTAL | | 110 |

# Q35 Does this need apply to (please select all that apply):

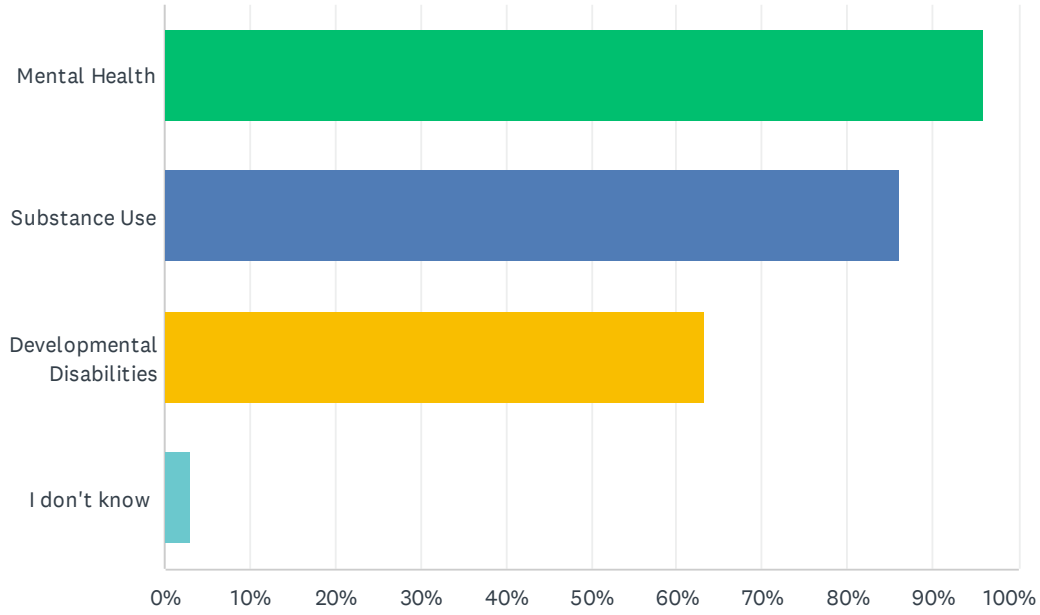
Answered: 101 Skipped: 26




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 92.08% | 93 |
| Adults | 96.04% | 97 |
| I don't know | 1.98% | 2 |
| Total Respondents: 101 | | |

# Q36 Does this need apply to those impacted by (please select all that apply):

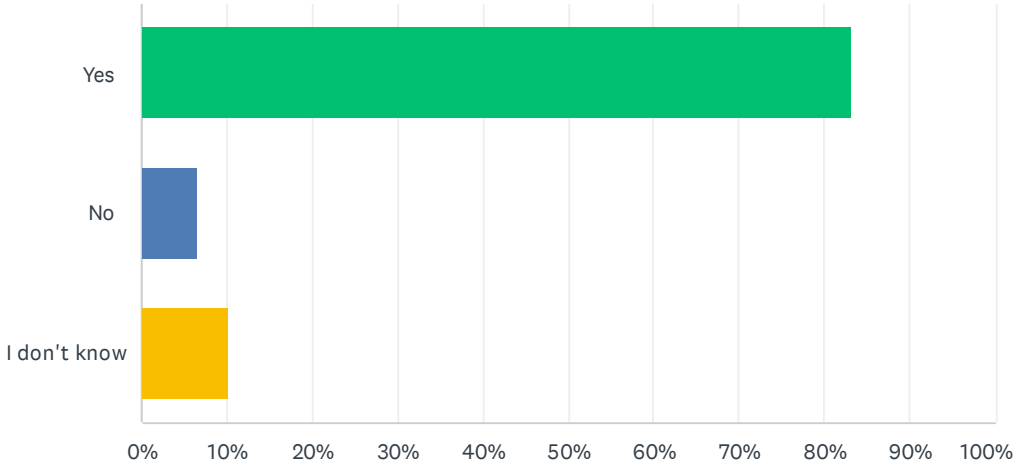
Answered: 101 Skipped: 26




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 96.04% | 97 |
| Substance Use | 86.14% | 87 |
| Developmental Disabilities | 63.37% | 64 |
| I don't know | 2.97% | 3 |
| Total Respondents: 101 | | |

# Q37 Is strengthening prevention services a high priority in our community?

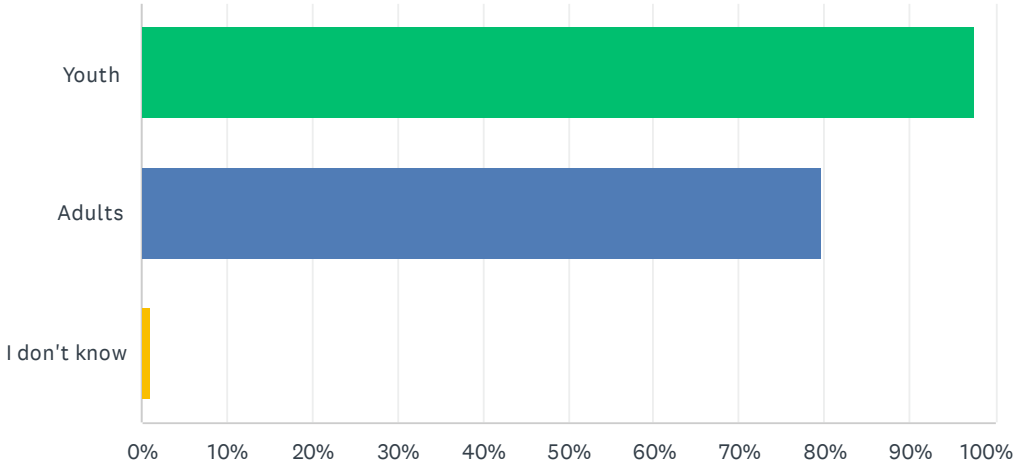
Answered: 107 Skipped: 20




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 83.18% | 89 |
| No | 6.54% | 7 |
| I don't know | 10.28% | 11 |
| TOTAL | | 107 |

# Q38 Does this need apply to (please select all that apply):

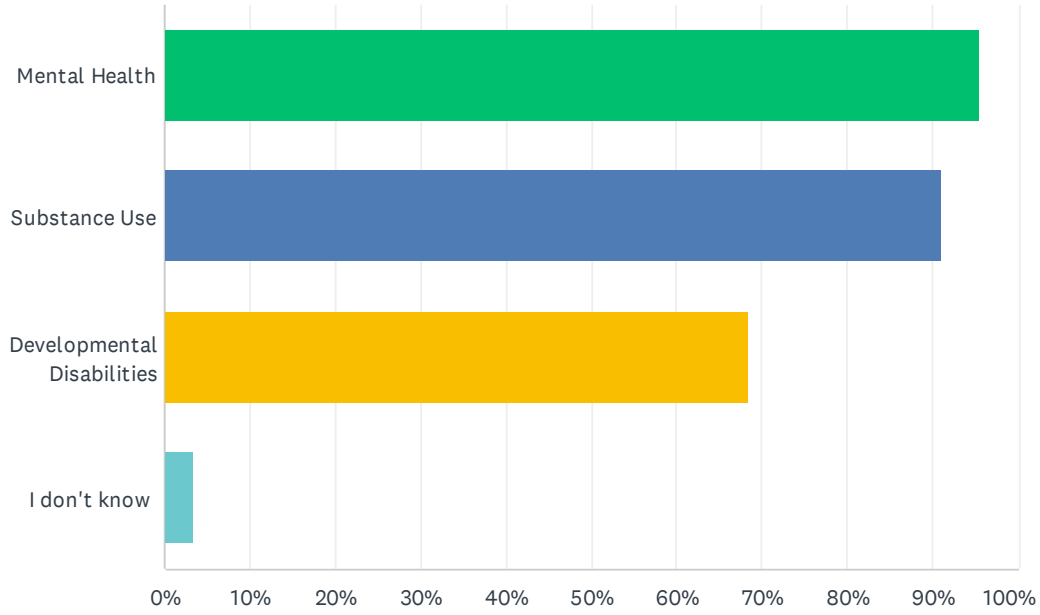
Answered: 89 Skipped: 38




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 97.75% | 87 |
| Adults | 79.78% | 71 |
| I don't know | 1.12% | 1 |
| Total Respondents: 89 | | |

# Q39 Does this need apply to those impacted by (please select all that apply):

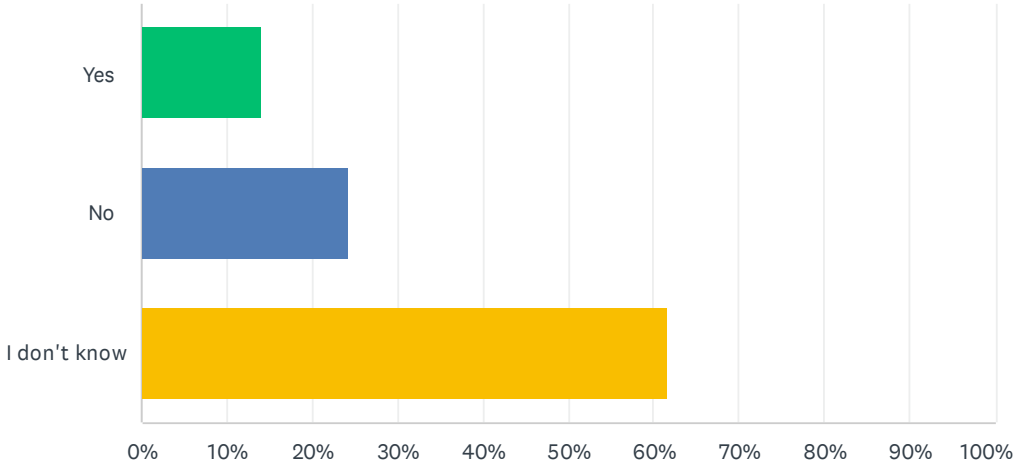
Answered: 89 Skipped: 38




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 95.51% | 85 |
| Substance Use | 91.01% | 81 |
| Developmental Disabilities | 68.54% | 61 |
| I don't know | 3.37% | 3 |
| Total Respondents: 89 | | |

# Q40 Are problem gambling resources a high need in our community?

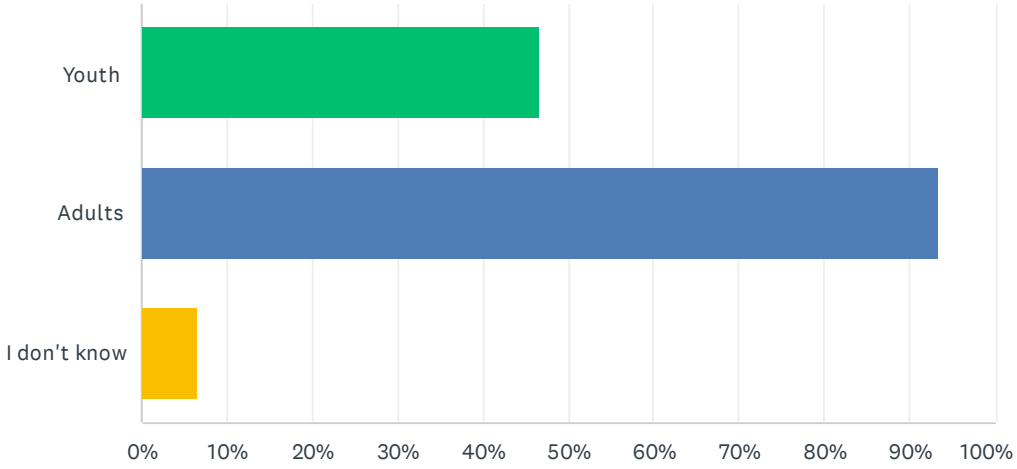
Answered: 107 Skipped: 20




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 14.02% | 15 |
| No | 24.30% | 26 |
| I don't know | 61.68% | 66 |
| TOTAL | | 107 |

# Q41 Does this need apply to (please select all that apply):

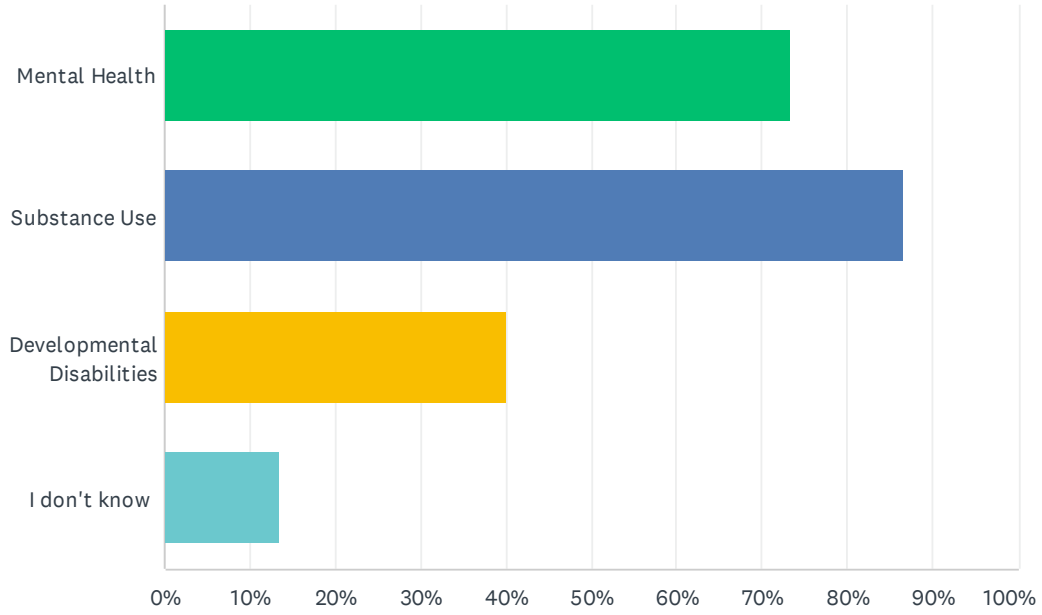
Answered: 15 Skipped: 112




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 46.67% | 7 |
| Adults | 93.33% | 14 |
| I don't know | 6.67% | 1 |
| Total Respondents: 15 | | |

# Q42 Does this need apply to those impacted by (please select all that apply):

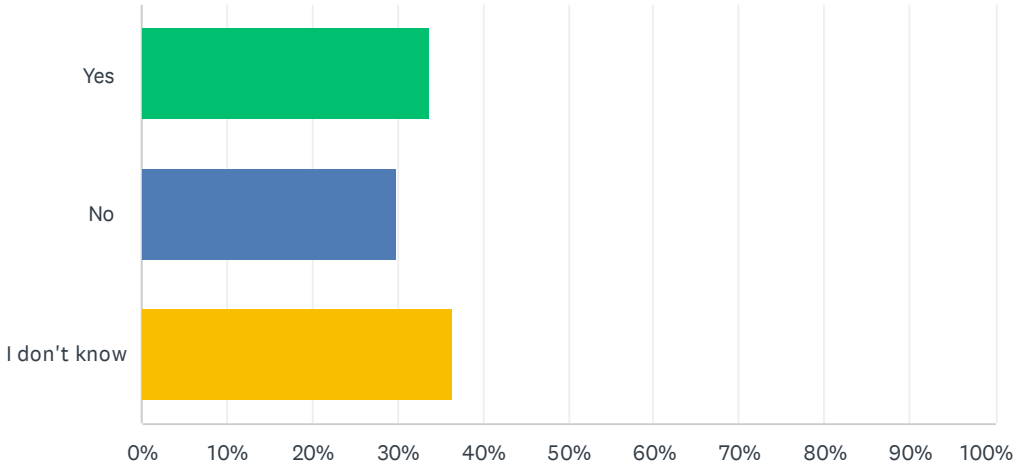
Answered: 15 Skipped: 112




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 73.33% | 11 |
| Substance Use | 86.67% | 13 |
| Developmental Disabilities | 40.00% | 6 |
| I don't know | 13.33% | 2 |
| Total Respondents: 15 | | |

# Q43 Is access to services for refugees and immigrants a high need in our community?

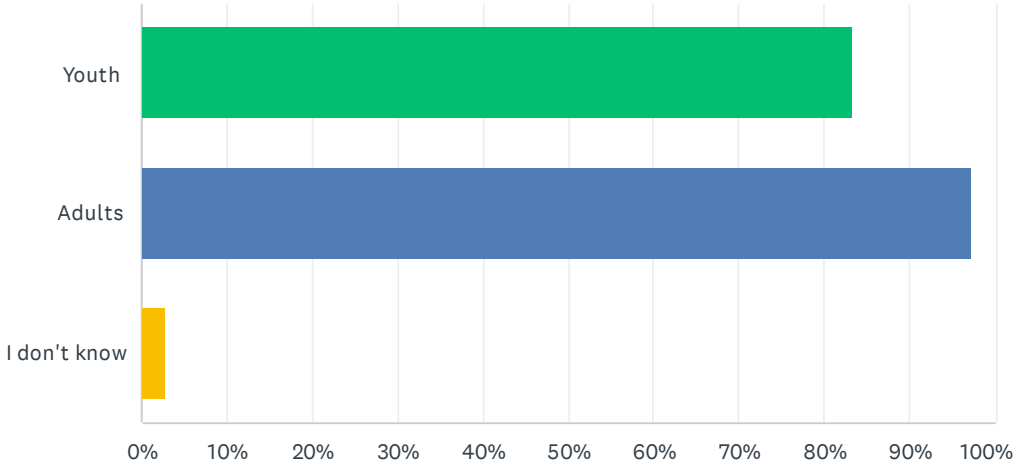
Answered: 107 Skipped: 20




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 33.64% | 36 |
| No | 29.91% | 32 |
| I don't know | 36.45% | 39 |
| TOTAL | | 107 |

# Q44 Does this need apply to (please select all that apply):

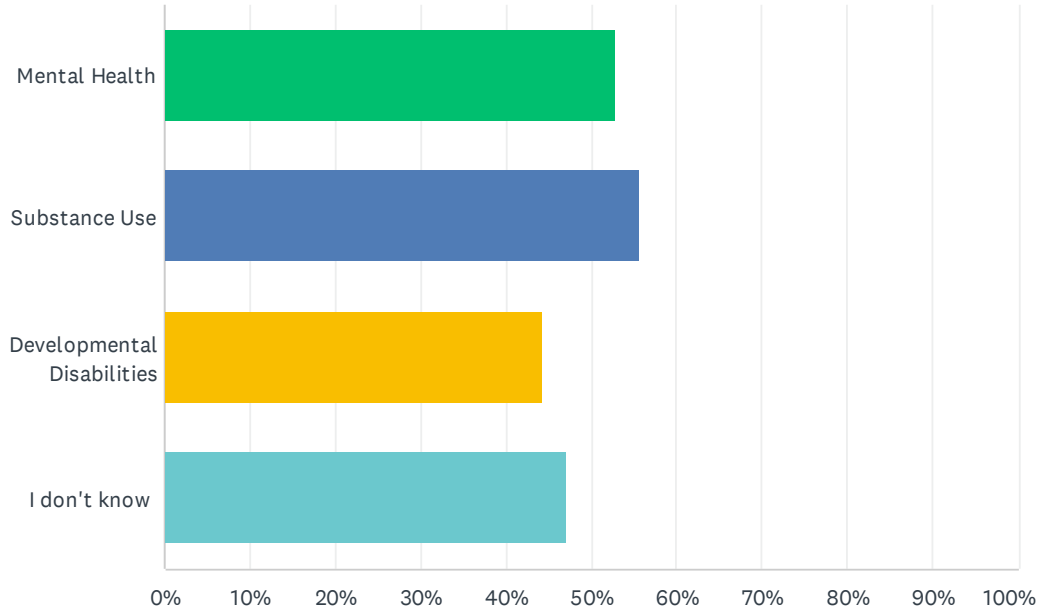
Answered: 36 Skipped: 91




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 83.33% | 30 |
| Adults | 97.22% | 35 |
| I don't know | 2.78% | 1 |
| Total Respondents: 36 | | |

# Q45 Does this need apply to those impacted by (please select all that apply):

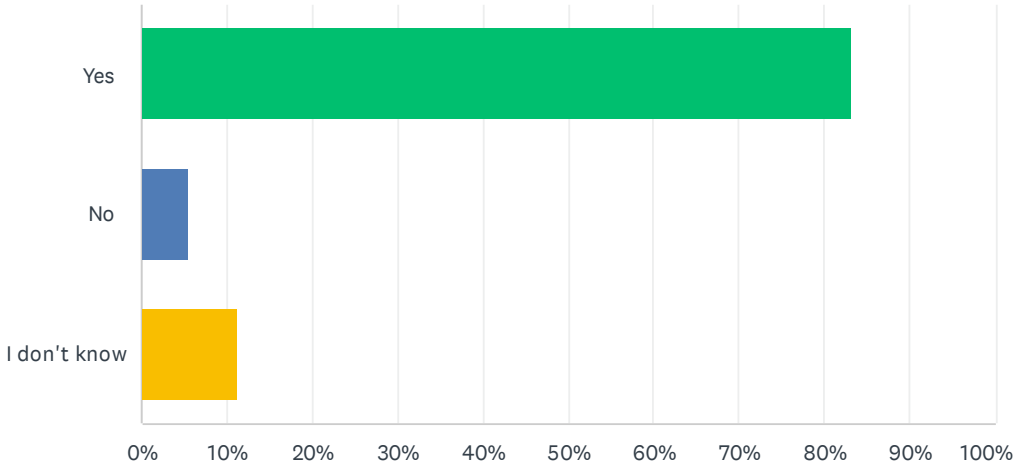
Answered: 36 Skipped: 91




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 52.78% | 19 |
| Substance Use | 55.56% | 20 |
| Developmental Disabilities | 44.44% | 16 |
| I don't know | 47.22% | 17 |
| Total Respondents: 36 | | |

# Q46 Is access to residential treatment opportunities for vulnerable populations a high need in our community?

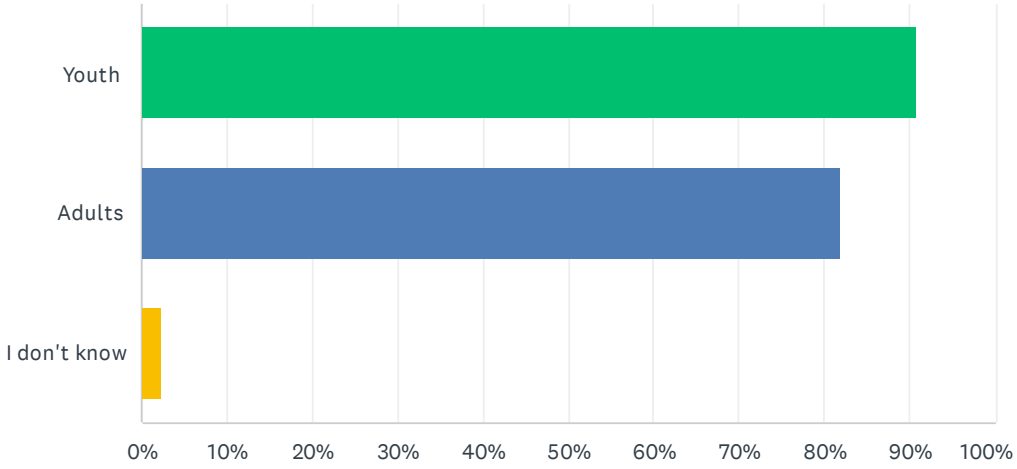
Answered: 107 Skipped: 20




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 83.18% | 89 |
| No | 5.61% | 6 |
| I don't know | 11.21% | 12 |
| TOTAL | | 107 |

# Q47 Does this need apply to (please select all that apply):

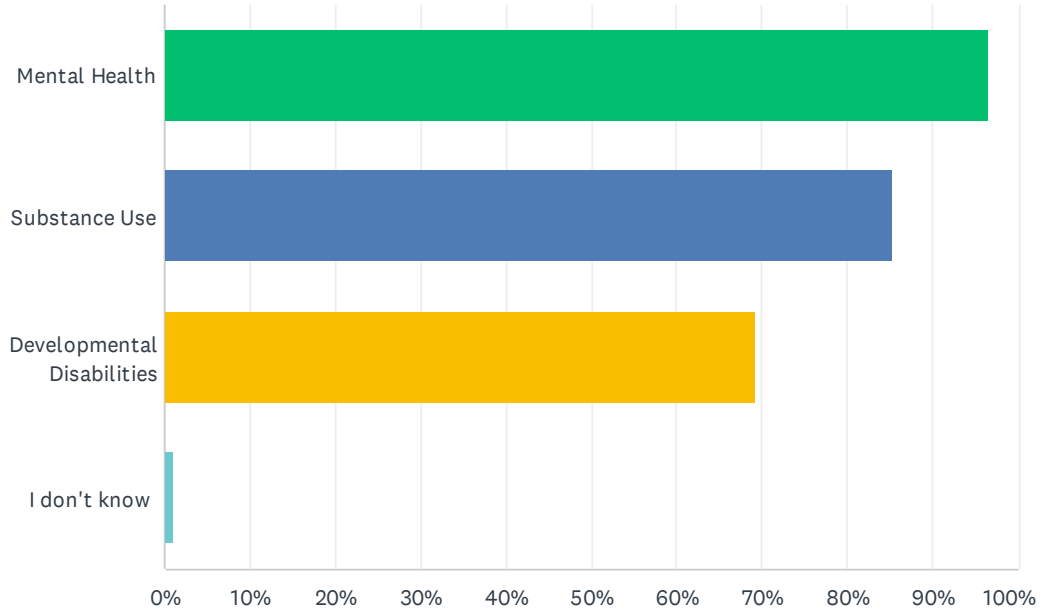
Answered: 88 Skipped: 39




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 90.91% | 80 |
| Adults | 81.82% | 72 |
| I don't know | 2.27% | 2 |
| Total Respondents: 88 | | |

# Q48 Does this need apply to those impacted by (please select all that apply):

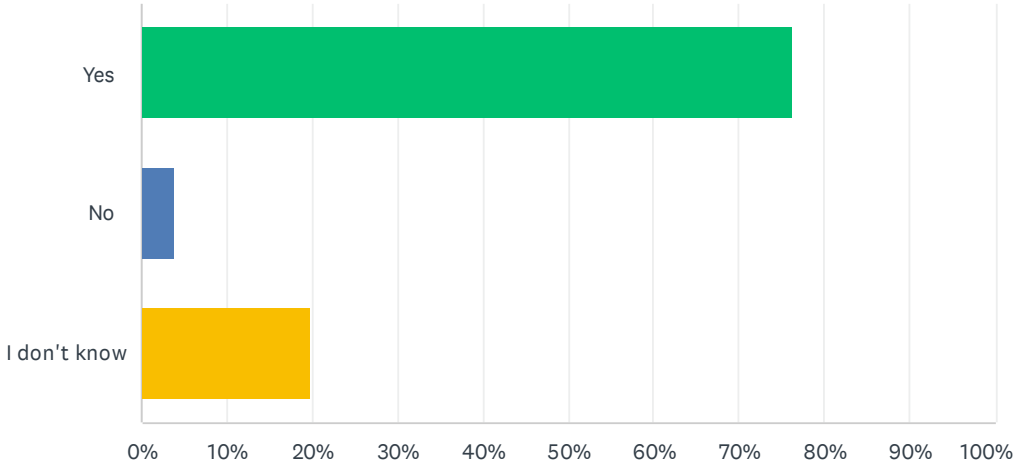
Answered: 88 Skipped: 39




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 96.59% | 85 |
| Substance Use | 85.23% | 75 |
| Developmental Disabilities | 69.32% | 61 |
| I don't know | 1.14% | 1 |
| Total Respondents: 88 | | |

# Q49 Does our community need more respite services?

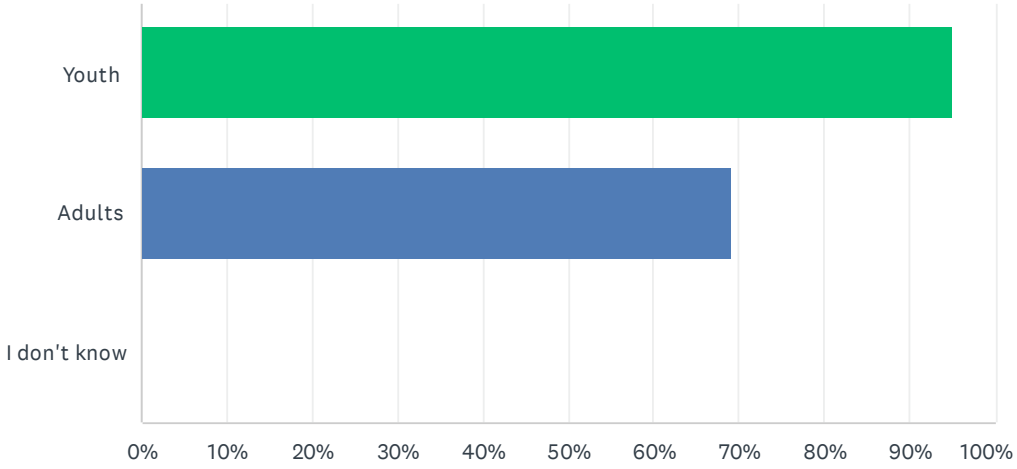
Answered: 106 Skipped: 21




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 76.42% | 81 |
| No | 3.77% | 4 |
| I don't know | 19.81% | 21 |
| TOTAL | | 106 |

# Q50 Does this need apply to (please select all that apply):

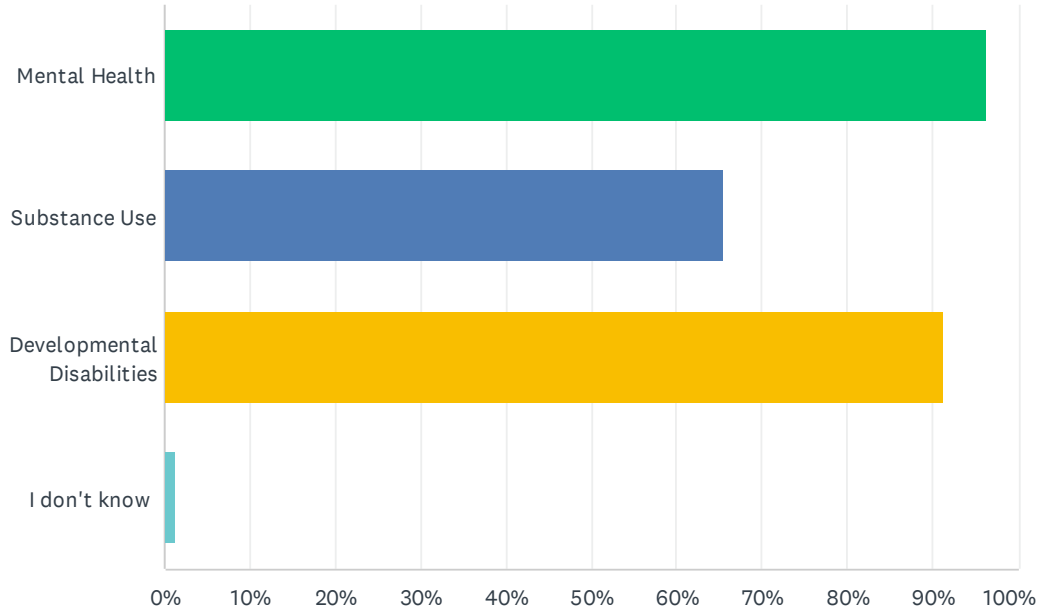
Answered: 81 Skipped: 46




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 95.06% | 77 |
| Adults | 69.14% | 56 |
| I don't know | 0.00% | 0 |
| Total Respondents: 81 | | |

# Q51 Does this need apply to those impacted by (please select all that apply):

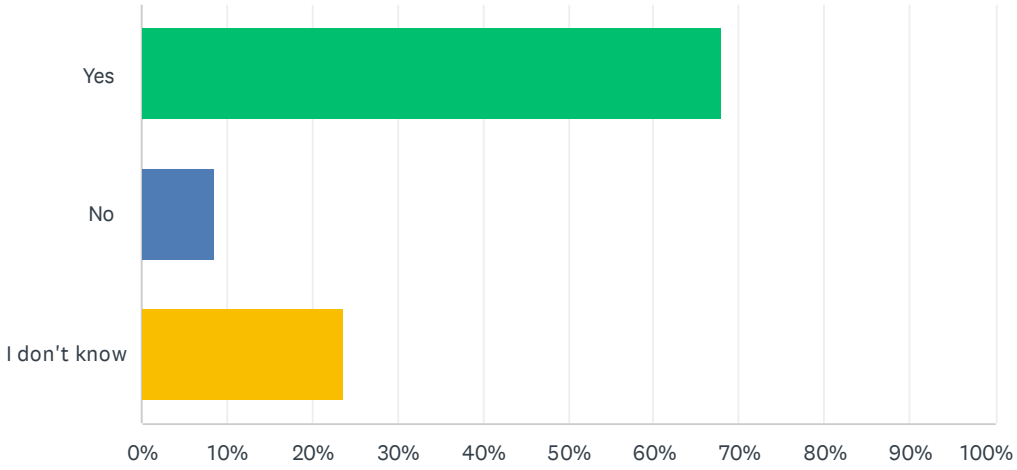
Answered: 81 Skipped: 46




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 96.30% | 78 |
| Substance Use | 65.43% | 53 |
| Developmental Disabilities | 91.36% | 74 |
| I don't know | 1.23% | 1 |
| Total Respondents: 81 | | |

# Q52 Are transition age services for vulnerable populations a high need in our community?

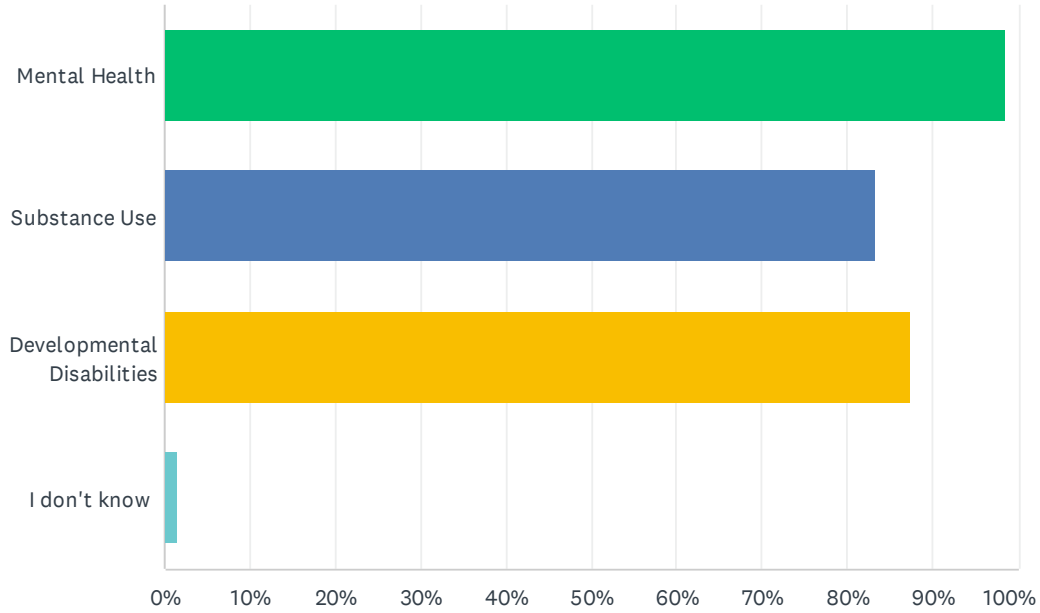
Answered: 106 Skipped: 21




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 67.92% | 72 |
| No | 8.49% | 9 |
| I don't know | 23.58% | 25 |
| TOTAL | | 106 |

# Q53 Does this need apply to those impacted by (please select all that apply):

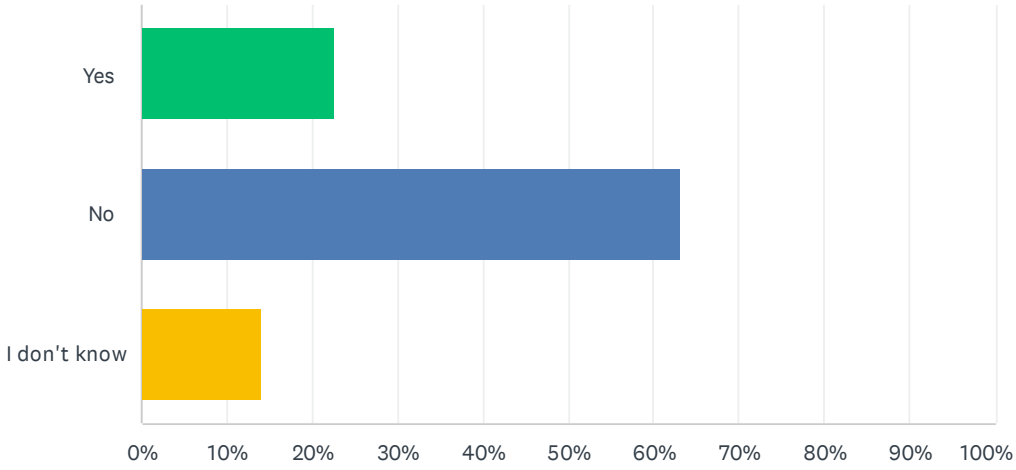
Answered: 72 Skipped: 55




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 98.61% | 71 |
| Substance Use | 83.33% | 60 |
| Developmental Disabilities | 87.50% | 63 |
| I don't know | 1.39% | 1 |
| Total Respondents: 72 | | |

# Q54 Is there appropriate access to transportation across Clinton County for our vulnerable populations?

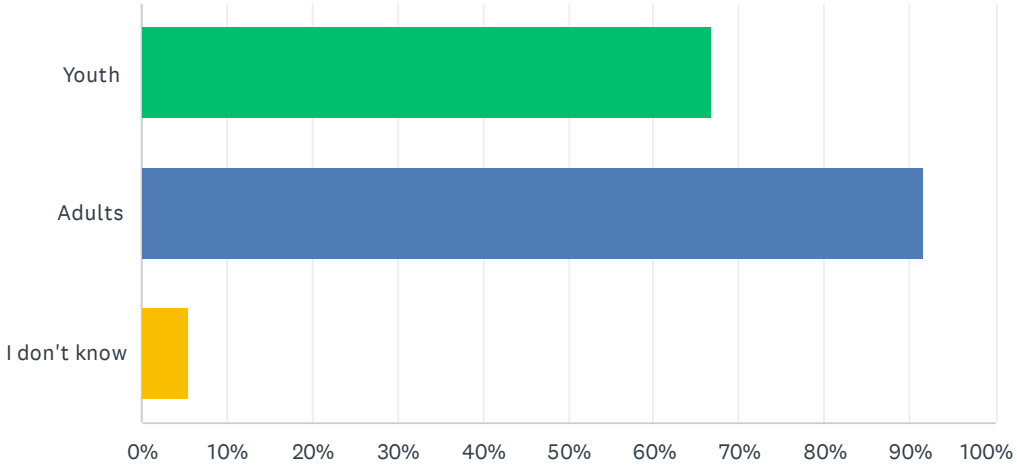
Answered: 106 Skipped: 21




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 22.64% | 24 |
| No | 63.21% | 67 |
| I don't know | 14.15% | 15 |
| TOTAL | | 106 |

# Q55 Does this need apply to (please select all that apply):

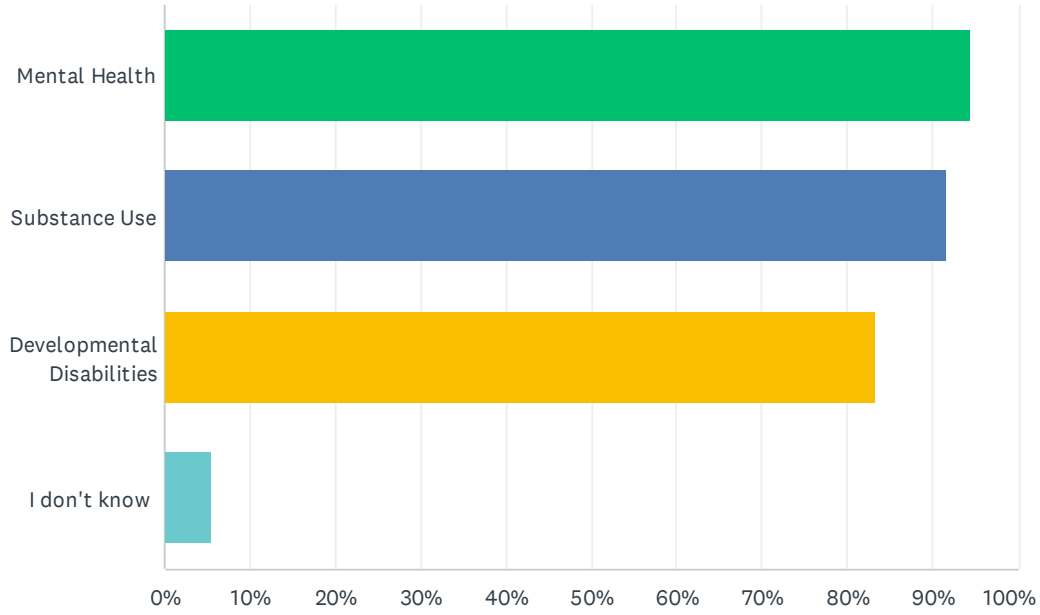
Answered: 36 Skipped: 91




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 66.67% | 24 |
| Adults | 91.67% | 33 |
| I don't know | 5.56% | 2 |
| Total Respondents: 36 | | |

# Q56 Does this need apply to those impacted by (please select all that apply):

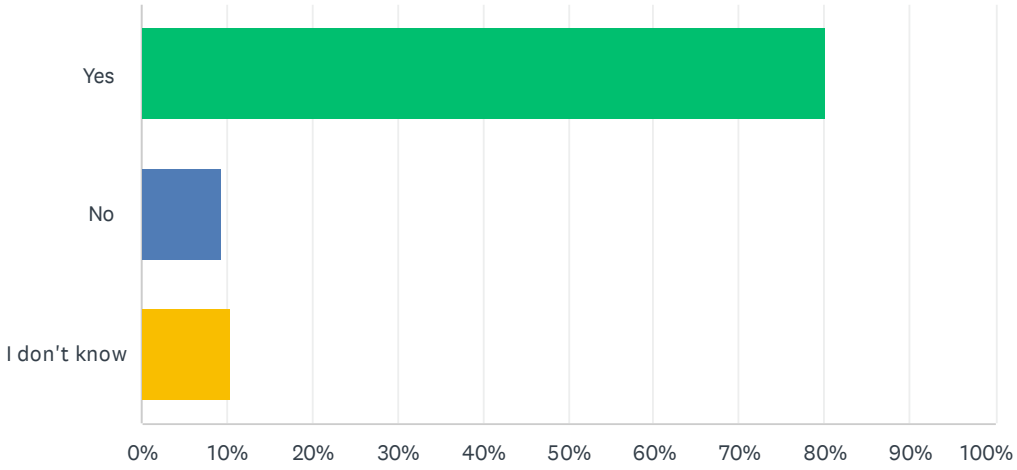
Answered: 36 Skipped: 91




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 94.44% | 34 |
| Substance Use | 91.67% | 33 |
| Developmental Disabilities | 83.33% | 30 |
| I don't know | 5.56% | 2 |
| Total Respondents: 36 | | |

# Q57 Does our community need initiatives to strengthen recruitment and retention of the workforce that supports/works with vulnerable populations?

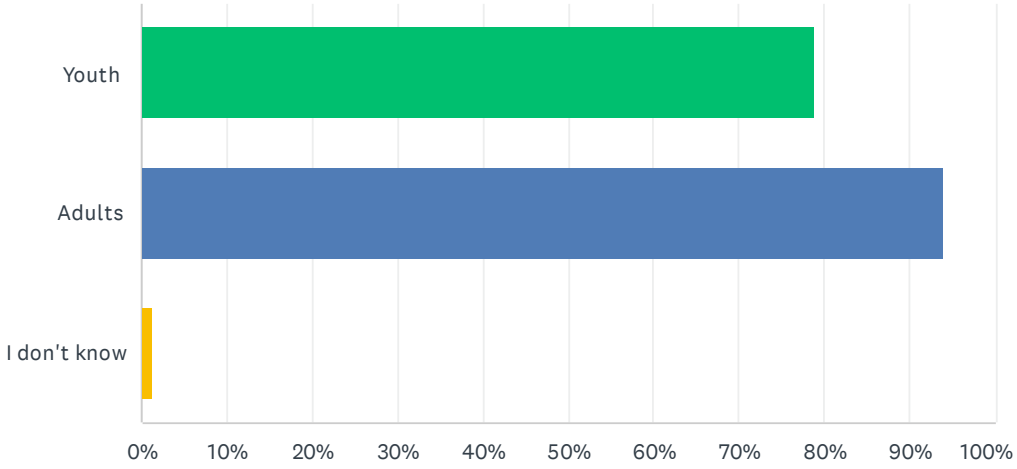
Answered: 106 Skipped: 21




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 80.19% | 85 |
| No | 9.43% | 10 |
| I don't know | 10.38% | 11 |
| TOTAL | | 106 |

# Q58 Does this need apply to (please select all that apply):

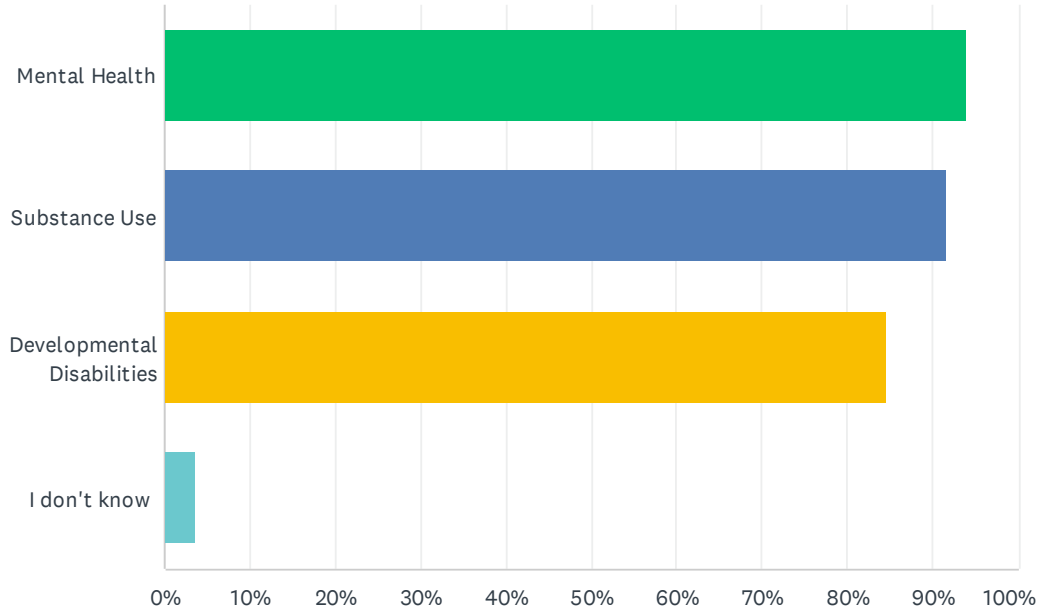
Answered: 85 Skipped: 42




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 78.82% | 67 |
| Adults | 94.12% | 80 |
| I don't know | 1.18% | 1 |
| Total Respondents: 85 | | |

# Q59 Does this need apply to those impacted by (please select all that apply):

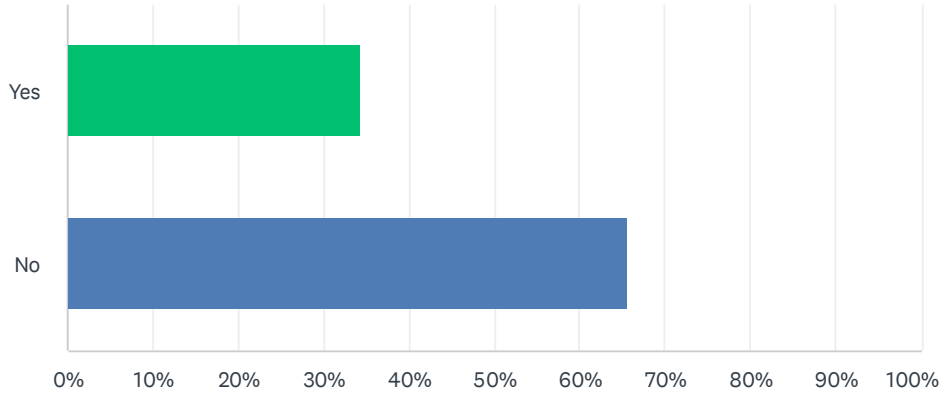
Answered: 85 Skipped: 42




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 94.12% | 80 |
| Substance Use | 91.76% | 78 |
| Developmental Disabilities | 84.71% | 72 |
| I don't know | 3.53% | 3 |
| Total Respondents: 85 | | |

# Q60 Are you aware of any other needs in our community to better support vulnerable populations?

Answered: 105 Skipped: 22




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Yes | 34.29% | 36 |
| No | 65.71% | 69 |
| TOTAL | | 105 |

# Q61 If so, please describe:

Answered: 35 Skipped: 92

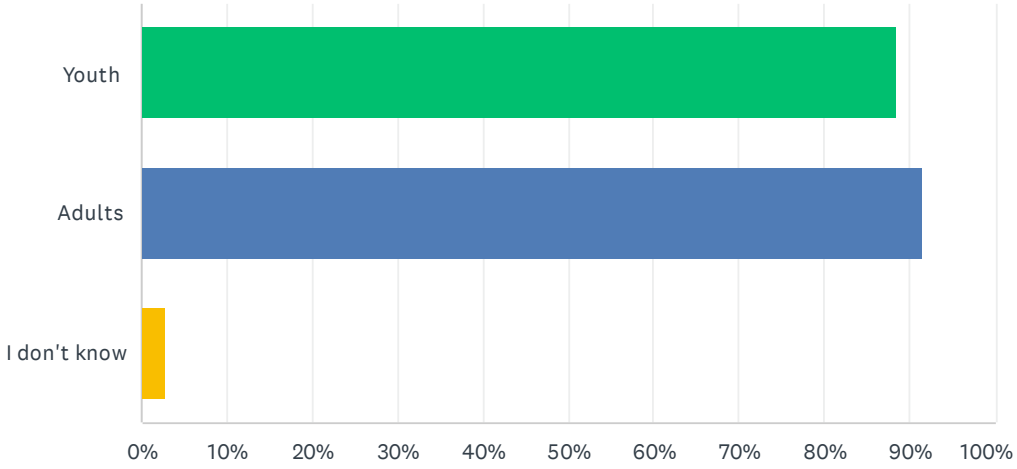
| # | RESPONSES | DATE |
|---|---|---|
| 1 | Homeless housing services Services for pregnant women with mental health and substance abuse difficulties Intensive care management services Community nursing services for those with co-occuring disorders Education to the community for reducing stigma of those with substance use and mental health and development disabilities. | 7/14/2023 12:12 PM |
| 2 | Help for victims of domestic violence, safe houses, safe living arrangements, help with child care, finding jobs, becoming independent, self sufficient, etc. | 7/13/2023 12:17 PM |
| 3 | More local community mental health programs | 7/13/2023 9:16 AM |
| 4 | Warming shelter, homeless shelter | 7/13/2023 7:46 AM |
| 5 | Affordable housing | 7/12/2023 6:52 PM |
| 6 | Significant lack of access to early intervention and special education special education and related services. Long waiting lists and limited providers for counseling and mental health needs - and frequent staff turnover at agencies that do provide these services. | 7/12/2023 3:37 PM |
| 7 | More emphasis on education, life skills, personal responsibility and job training | 7/11/2023 7:02 AM |
| 8 | salary increases for direct line staff | 7/10/2023 3:15 PM |
| 9 | Legal resources Gender affirming care Food security | 7/10/2023 11:36 AM |
| 10 | livable wage for human service providers | 7/10/2023 11:30 AM |
| 11 | Training to law enforcement and other members of the community on individuals with mental and physical disabilities. | 7/7/2023 8:30 AM |
| 12 | Certified foster parents - need more Early intervention speech therapist, occupational therapist there is a lack of these services | 7/7/2023 8:27 AM |
| 13 | Treatment for victims of crime and accessible treatment programs specifically targeted to those suffering from post-crime trauma. | 7/6/2023 1:32 PM |
| 14 | I believe that a spiritual connection to local churches would be an amazing resource so that the need is more localized. We are here to help each other and a church community could be a useful resource. | 7/6/2023 12:11 PM |
| 15 | Emergency mental health services - inpatient treatment. Trauma training for law enforcement. | 7/6/2023 10:09 AM |
| 16 | Confidential mental health and substance abuse resources that won't have an impact on young or adult established careers. Some employers find legal ways to terminate employment of vulnerable people if an issue is known to them. | 7/6/2023 10:06 AM |
| 17 | recreational activities so we're preventing kids and adults getting into trouble or committing crimes. Our community could also use more activities for youth and young adults who are not struggling with anything. We don't have enough to offer everyone. We also need more help caring for our aging polulation. There is not enough help. we need more home health aides and assistance paying for this assitance other than Medicaid. Not everyone is eligible for Medicaid and even if you are there aren't enough aides to go around. Many of us are struggling to care for aging or sick family members at home with little to no help. My mental health is suffering as a result yet i have to go to work every day and also care for my own family. We need help! | 7/6/2023 10:04 AM |
| 18 | - Hoarding services - Crisis intervention in schools to deter ED visits from school - Psychiatric services/medication access - skill-building/CFTSS/HCBS providers (staff retention is an issue) - Big brother/sister/mentor programs - Employment programs for youth (in addition to SWEET), especially for youth ages 14-15 - More providers to conduct evaluations for ADD/ASD/etc (for teens and adults + accept Medicaid) - Transportation providers (Reliable Medicaid transport) - Homemakers (assist adults with daily living skills in their homes: cooking, cleaning, shopping, | 7/6/2023 10:02 AM |

| | | |
|---|---|---|
| | budgeting, child care) - affordable child care (lower and middle income families) - Adventure/nature based programs for youth and adults with serious mental illness - FREE activities for kids (or scholarships for low income youth) sports, arts/crafts, theater, music, etc. - Crisis respite beds for children - Respite providers (therapeutic) - Housing for the homeless (not the Villa) - Expand TIC training to schools to reduce unnecessary ER visits | |
| 19 | Elderly respite | 7/6/2023 10:01 AM |
| 20 | AGENCIES NEED TO WORK TOGETHER TO COORDINATE CARE FOR OUR VULERABLE POPULATIONS. CARE MANAGERS NEED TO HAVE A BETTER UNDERSTANDING OF PROGRAMING RULES AND REGULATIONS. THEY NEED TO DO A BETTER JOB OF COMMUNICATING WITH THEIR CLIENTS. THERE NEEDS TO BE AFFORDABLE HOUSING. WHEN A FACILITY OFFERS ON CALL SERVICES FOR MENTAL HEALTH AND ADDICTIONS THERE SHOULD BE OVERSIGHT ON THE FACILITY. MHAB IS FULL OF DRUGS FOR A SOBER LIVING FACILITY. NORTHWOODS IS SUPPOSED TO OFFER SUPPORTIVE SERVICES FOR THEIR MENTAL HEALTH CLIENTS AND INSTEAD OF WORKING WITH THEM AND THEIR NEEDS THEY ARE EVICTING THEM. | 7/6/2023 9:51 AM |
| 21 | Many of the services that were asked about in this survey are supplied by income-eligibility driven programs like Medicaid. If a person does not qualify for Medicaid or other government programs, many of the services are not available to that person, even if they are vulnerable. Programs like assistance with youth employment, respite, transportation, supported living are not available to families with children, youth or young adults with mental health issues or developmental disabilities that do not reach the OPWDD standards of disability. These populations need to be served as well but this survey does not give an opportunity to indicate that gap. It is an important one to consider when planning for county needs. | 7/6/2023 9:32 AM |
| 22 | food shelter preventive | 7/6/2023 9:28 AM |
| 23 | I feel that there needs to be ongoing improvement with communication between agencies to better serve our community. | 7/6/2023 9:10 AM |
| 24 | More crisis interventions and long term in patient. | 7/6/2023 9:06 AM |
| 25 | Education. People in the workforce (everything from retail to government to the college and beyond) are severely lacking in education and understanding of mental health, developmental disabilities, and addition. The same can be said for local nonprofits. I've worked and volunteered for many of these organizations, and in general the lack of empathy, patience, or awareness of these issues is astonishing. It would go a long way toward inclusiveness and empowerment for these populations, if the general public, workforce, and organizations (such as community theatre, sports/wellness organizations, churches, and schools) were able to be provided with training for sensitivity, plans of action for inclusivity, and overall education on these matters. | 7/6/2023 9:02 AM |
| 26 | Case management services need to actually go into the home and provide hands on services not just phone calls | 7/6/2023 8:51 AM |
| 27 | Help for family members of those afflicted with addiction. I never see anything advertised for the families left in the addict's wake. | 7/6/2023 8:41 AM |
| 28 | Affordable housing, medical access | 7/6/2023 8:40 AM |
| 29 | job training for those populations, help with interviews, clothing for interviews, transportation help | 7/6/2023 8:37 AM |
| 30 | This community is functioning in silos. The wait lists for MH services are long. The community has suffered post-pandemic with many programs not returning to in-person services or allowing clients to opt out of attending in person. In these cases, there is little accountability for the clients and lowered engagement. In my experience -- agencies attempting dual-diagnoses approaches are swatting flies with hammers. At first glance, it seems ineffective. Staff turnover at local agencies is staggering and should really concern leadership within agencies - from the outside - it doesn't seem like agencies have missions, visions or the goals set to meet them - again silos. Has anyone actually reviewed the duplication of some services in the community versus the huge needs this community has? Perhaps that is the purpose of this assessment / survey. Professional / counseling staff that I have spoken to about leaving agencies report poor leadership or agency vision and little or no professional support. What's worse, they will not discuss that in exit interviews for fear it will be shared and this community is too small to chance one's reputation in the field. Transportation is such a challenge in this | 7/6/2023 8:33 AM |

| | | |
|---|---|---|
| | community as well. There are pockets of community members that have no access to services. It is so sad. | |
| 31 | Intervention needs to start with the family. We can provide all of the services possible, but if we don't fix the root cause of ACES, mental health, substance abuse etc.. it will continue to get worse. "If you want to change the world, go home and love your family." People are having children they cannot properly take care of. | 7/6/2023 8:32 AM |
| 32 | Nutrition services- healthier options for families | 7/6/2023 8:07 AM |
| 33 | homeless population needs more services/contact/resources | 7/6/2023 7:59 AM |
| 34 | age based services for the elderly | 7/6/2023 7:54 AM |
| 35 | From first hand experience i know our mental health and advocacy programs are incredibly think, work loads are far too high and because of this clients are suffering. we do not have enough housing and proper care for many in our community. the demand on the programs that do exist is so much that the programs themselves do not work properly. | 7/6/2023 7:45 AM |

# Q62 Does this need apply to (please select all that apply):

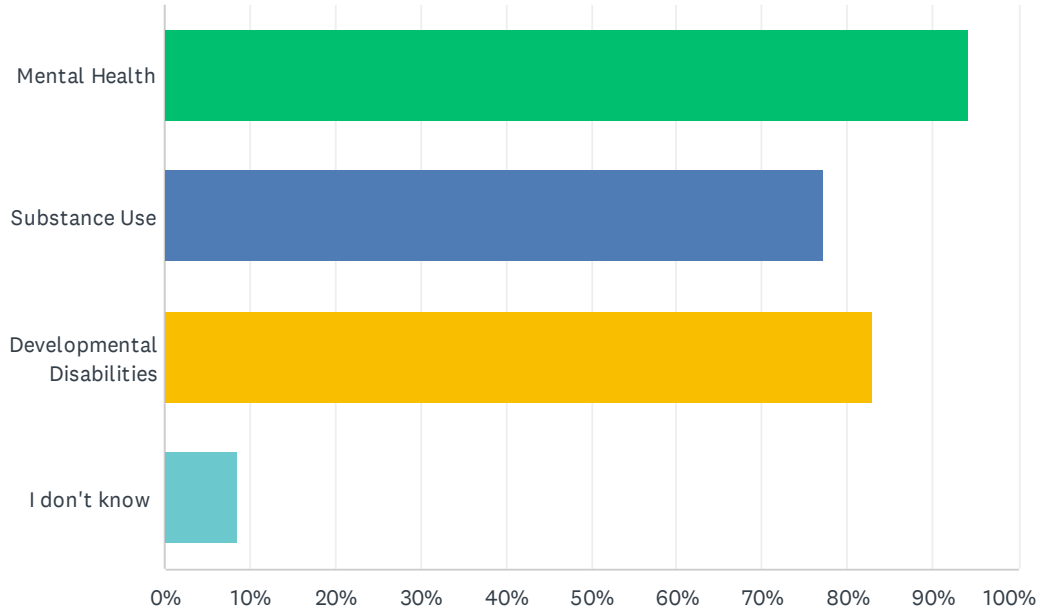
Answered: 35 Skipped: 92




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Youth | 88.57% | 31 |
| Adults | 91.43% | 32 |
| I don't know | 2.86% | 1 |
| Total Respondents: 35 | | |

# Q63 Does this need apply to those impacted by (please select all that apply):

Answered: 35 Skipped: 92

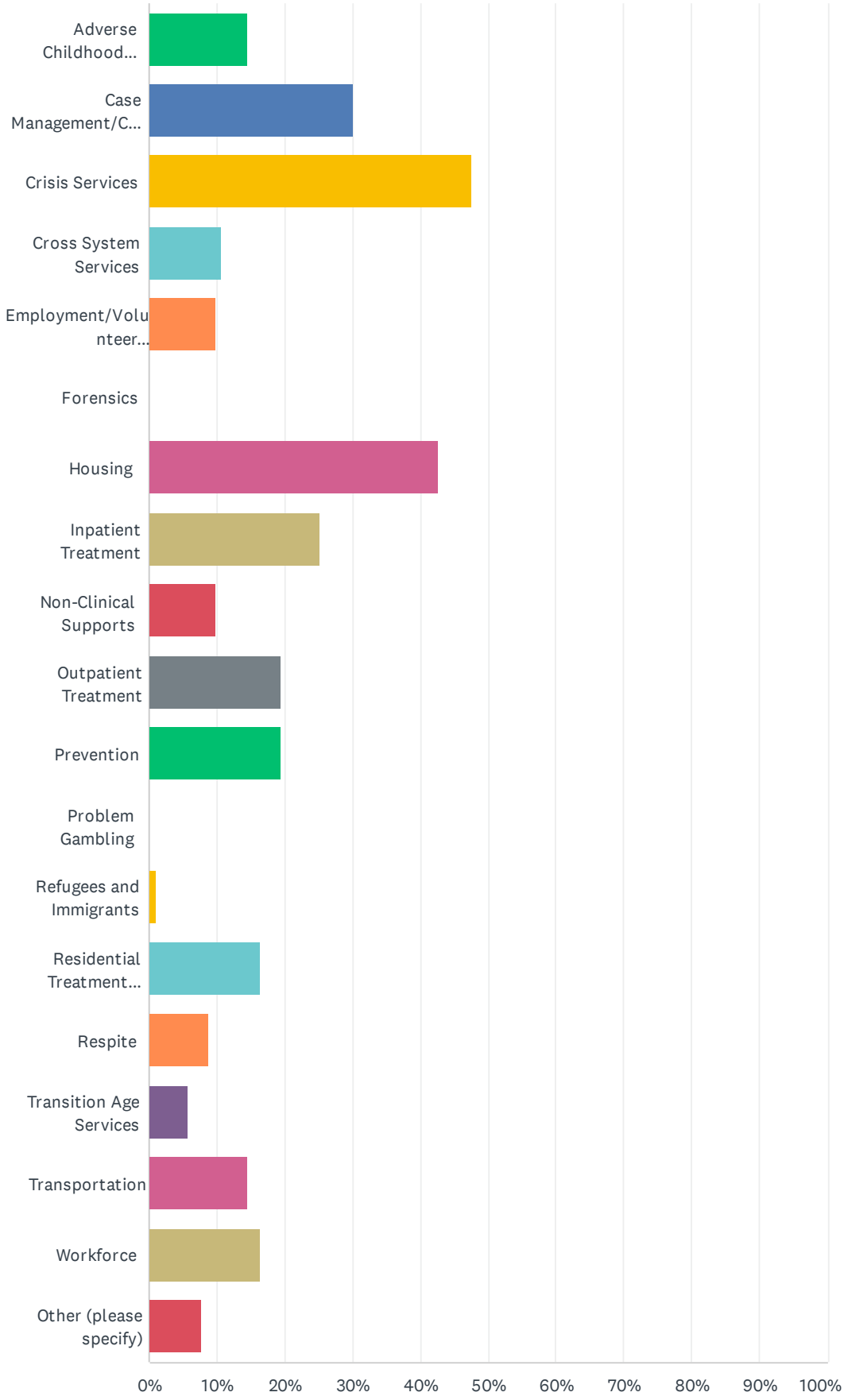



| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Mental Health | 94.29% | 33 |
| Substance Use | 77.14% | 27 |
| Developmental Disabilities | 82.86% | 29 |
| I don't know | 8.57% | 3 |
| Total Respondents: 35 | | |

# Q64 What are the top 3 community needs for vulnerable populations in Clinton County? (please select only 3)

Answered: 103 Skipped: 24

Clinton County Community Services Board Needs Assessment



| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Adverse Childhood Experiences (ACEs) | 14.56% | 15 |
| Case Management/Care Coordination | 30.10% | 31 |
| Crisis Services | 47.57% | 49 |
| Cross System Services | 10.68% | 11 |
| Employment/Volunteer Opportunities | 9.71% | 10 |
| Forensics | 0.00% | 0 |
| Housing | 42.72% | 44 |
| Inpatient Treatment | 25.24% | 26 |
| Non-Clinical Supports | 9.71% | 10 |
| Outpatient Treatment | 19.42% | 20 |
| Prevention | 19.42% | 20 |
| Problem Gambling | 0.00% | 0 |
| Refugees and Immigrants | 0.97% | 1 |
| Residential Treatment Services | 16.50% | 17 |
| Respite | 8.74% | 9 |
| Transition Age Services | 5.83% | 6 |
| Transportation | 14.56% | 15 |
| Workforce | 16.50% | 17 |
| Other (please specify) | 7.77% | 8 |
| Total Respondents: 103 | | |

| # | OTHER (PLEASE SPECIFY) | DATE |
|---|---|---|
| 1 | salary increases | 7/10/2023 3:16 PM |
| 2 | Early intervention speech therapist | 7/7/2023 8:29 AM |
| 3 | Domestic violence services for male survivors | 7/6/2023 10:11 AM |
| 4 | These are the top three, but all of these services are important and needed in our community. | 7/6/2023 9:25 AM |
| 5 | Agencies need to do a better job at collaborating and putting the best interests of the community in front of competing with each other. The Director of Community Services needs to do a better job of strengthening those relationships and prioritizing the community needs. | 7/6/2023 9:24 AM |
| 6 | affordable housing | 7/6/2023 9:11 AM |
| 7 | education: -for affected populations to have the tools and resources they need and how to use them -for the families of affected populations -for employers and organizations to be better equipped to accommodate these populations -the general public, many of whom are part of the affected populations, but are afraid of stigma or do not realize resources are available to help them. | 7/6/2023 9:06 AM |
| 8 | work | 7/6/2023 8:14 AM |

NEW YORK STATE | Office of Addiction Services and Supports | Office of Mental Health | Office for People With Developmental Disabilities

# 2025 Needs Assessment Form
# Clinton County Mental Health And Addiction Services

**Adverse Childhood Experiences** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Case Management/Care Coordination** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Crisis Services** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Cross System Services** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Forensics** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Housing** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Prevention** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes

Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**Respite** Yes
Applies to OASAS? Yes
Applies to OMH? Yes
Applies to OPWDD? Yes
Need Applies to: Both Youth and Adults
Do any of the Goals on the Goals and Objectives Form address this need? Yes
Need description (Optional):

**LGU Representative**: Richelle Gregory

**Submitted for:** Clinton County Mental Health And Addiction Services